Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 12th September 2024

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

Please refer to the agenda for timings.

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY 12th SEPTEMBER 2024 AT 1.30PM – 4.00 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

24/00	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Service Presentation – DET M58 Psychoanalytic Psychotherapy	Discussion	Rodrigo Sanchez, Psychoanalyst & Course Lead for Adult Psychotherapies	V	2.05 (15)	
005	Minutes of the Previous Meeting held on 11 July 2024	Approval	Chair	E	2.20 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.25 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.30 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	V	2.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Comfort Break (10 minutes) 2.50pm – 3.00pm						
PROVIDING OUTSTANDING PATIENT CARE						
010	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
011	Research and Development Annual Report	Discussion	Chief Medical Officer	E	3.05 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

WELL-LED & EFFECTIVELY GOVERNED						
012	Board Assurance Framework Update	Assurance	Director of Corporate Governance	E	3.10 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
013	Non-Executive Director Responsibilities	Information	Director of Corporate Governance	E	3.15 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
GREAT & SAFE PLACE TO WORK, TRAIN & LEARN						
014	Guardian of Safer Working Hours Report	Information	Chief Medical Officer	E	3.20 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
015	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	3.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
016	Workforce Race Equality Scheme/Workforce Disability Equality Scheme Updates	Discussion	Chief People Officer	V	3.30 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
017	Education and Training Committee (ETC) Assurance Report	Assurance	E&T Committee Chair	E	3.40 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
018	Performance, Finance and Resources Committee (PRFC) Assurance Report	Assurance	PFR Committee Chair	V	3.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
019	Finance Report – Month 04	Information	Chief Finance Officer	E	3.50 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSING ITEMS						
020	Board Schedule of Business 2024/2025	Information	Director of Corporate Governance	E	3.55 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
021	Questions from the Governors	Discussion	Chair	V	4.00 (5)	
022	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		
023	Questions from the Public	Discussion	Chair	V		

024	Reflections and Feedback from the meeting	Discussion	Chair	V	4.05 (5)	
DATE AND TIME OF NEXT MEETING						
025	Thursday 14th November 2024 at 2.00pm – 5.00pm					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 05/09/2024)

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
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) Interim Deputy Chief Operating Officer at SLaM	01/01/2020 20/09/2023	Present 30/11/2023	Full time employment - No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by the Alliance.
			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 included Barts and the London Medical School	01/01/2022	Present	No perceived conflict - Will withdraw from business decisions in competition with QMUL, Barts and London Medical School
			Chair, Mosaic LGBT+ Young Persons Trust based in Camden (3)	01/09/2019	Present	No perceived conflict - Will withdraw from business decisions in competition with MOSAIC LGBT+ Young Persons Trust
			Vice Chair, Inner Circle Educational Trust (provides support for Looked After Children in Canden)	01/10/2020	Present	No perceived conflict - Will withdraw from business decisions in competition with Inner Circle Educational Trust
			Independent Chair, Nominations Committee Royal College of Emergency Medicine which is a professional body. (3)	01/02/2021	Present	No perceived conflict - Will withdraw from business decisions in competition with Royal College of Emergency Medicine
EXECUTIVE DIRECTORS						
MARK FREESTONE	Chief Education and Training Officer and Dean of Postgraduate Studies	10 June 2024	Honorary position as Professor of Mental Health at Queen Mary University of London	05/06/2024	04/06/2027	Will withdraw from any business decisions relating to QMUL.
			Director, North Thames NIHR ARC (Applied Research Collaboration)	01/04/2021	31/08/2025	No conflict to declare as T&P is a member of the ARC
			Director, Mark Freestone Consulting	08/11/2012	Present	Forensic Mental Health Research Consultancy (Sole trader). No direct conflict of interest.
			Honorary Senior Researcher, East London NHS Foundation Trust	01/07/2013	31/07/2026	Will withdraw from any business decisions relating to ELFT
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.

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

Adult Psychotherapy training

CONSOLIDATION PROJECT

D58+D59I/D59F

BD58 + D58L/D59L

THE NEED FOR CHANGE

Competitor analysis:

- We offered 3 hours less teaching on average compared to 1 day + in other HEIs
- We were the only ones providing in-house supervision and clinical seminars, similar to WPF, which has since closed
- The student experience is weaker as we lack a campus or facilities comparable to UK or international universities. While we are part of the NHS, only a small number of students secure NHS placements, and no many of our Tavistock clinicians want to teach in our course
- Students needed to complete two courses to graduate, often causing delays of 1–2 years
- The course required 40 VLs compared to teams of 4 or 5 part and full time staff

INTERNAL ISSUES

We have more than 40 VL over the different courses

- Inconsistency in:
- Teaching: seminars with different styles, and only 1 hour. BD58: there is no interaction with the recordings
- Assessment: Too many VL makes consistency impossible. Some VLs are marking for the first time, some are punitive
- VL Tutors are not part of the staff team. Inconsistent advice and approach; send the student to admin/ course lead,- poor student experience nor cost effective
- Requirements: supervisors reports are inconsistent, and requires a lot of chasing

TEACHING TIME AND COST?

Baby observation seminar

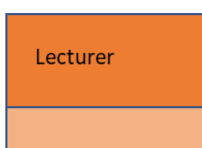
Cost per year (30 students):
S=£12,285
E=£945
SL:6

Clinical seminars

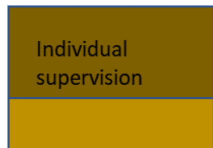
Cost per year (30 students):
S=£5,670
E=£945
SL: 3

Supervision seminars

Cost per year (30 Students):
S=£17,010
E=£945
SL: 9



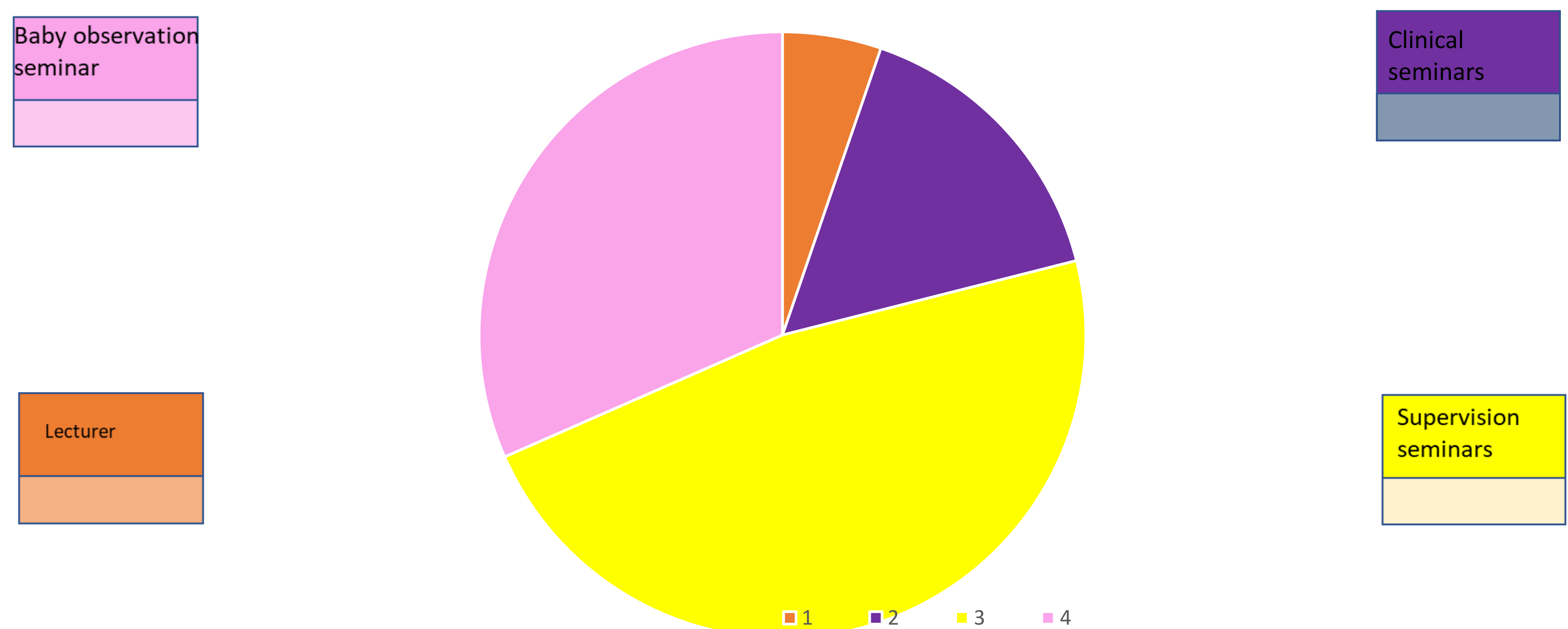
Cost per year (30 students):
S=£1,890
E=£945
SL: 1



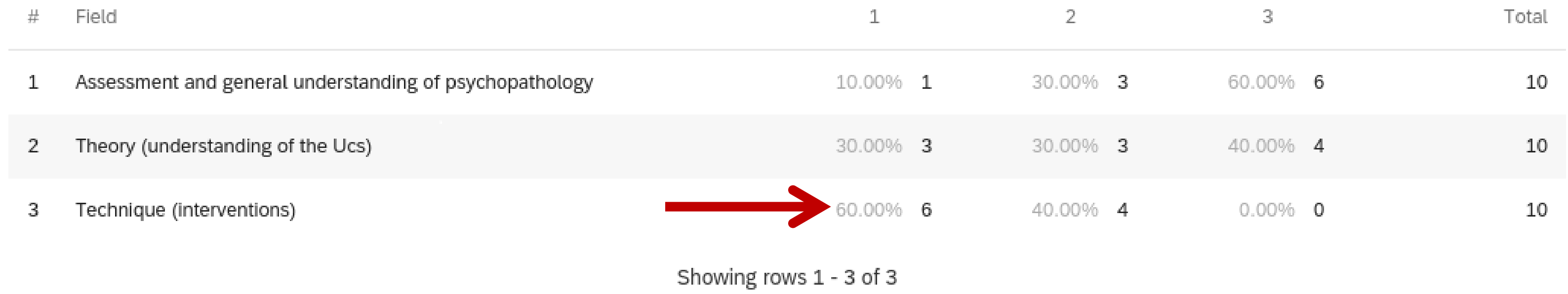
Individual supervision:
18 Months patient 21 supervisions (£1,050 per student)
12 Months patient 14 supervision (£700 per student)

S= Seminars E= Essays SL: Seminar Leaders per session

STAFFING FOR 35 STUDENTS



FEEDBACK FROM STUDENTS?



#	Field	1		2		3		Total
1	Assessment and general understanding of psychopathology	10.00%	1	30.00%	3	60.00%	6	10
2	Theory (understanding of the Ucs)	30.00%	3	30.00%	3	40.00%	4	10
3	Technique (interventions)	60.00%	6	40.00%	4	0.00%	0	10

Showing rows 1 - 3 of 3

- Even with the resources spent on supervision, students feel they need more support with psychodynamic technique

FEEDBACK FROM VL

When supervising a group, where do you think your students need more support in? (VL and Staff)

#	Field	1		2		3		Total
1	Assessment and general understanding of psychopathology	10.00%	1	30.00%	3	60.00%	6	10
2	Theory (understanding of the Ucs)	30.00%	3	30.00%	3	40.00%	4	10
3	Technique (interventions)	60.00%	6	40.00%	4	0.00%	0	10

Showing rows 1 - 3 of 3

TEACHING METHODS

Baby observation seminar

Supervision seminars

Individual supervision

Conclusion:

- They are expensive to run
- Only run during term time
- Increases staffing issues that are linked to problems with **recruitment** and **consistency**
- In order to offer this, **we sacrifice other options**
- As a course we spend **more than competitors** and **offer less** time face to face teaching

WHAT COULD WE DO BETTER?

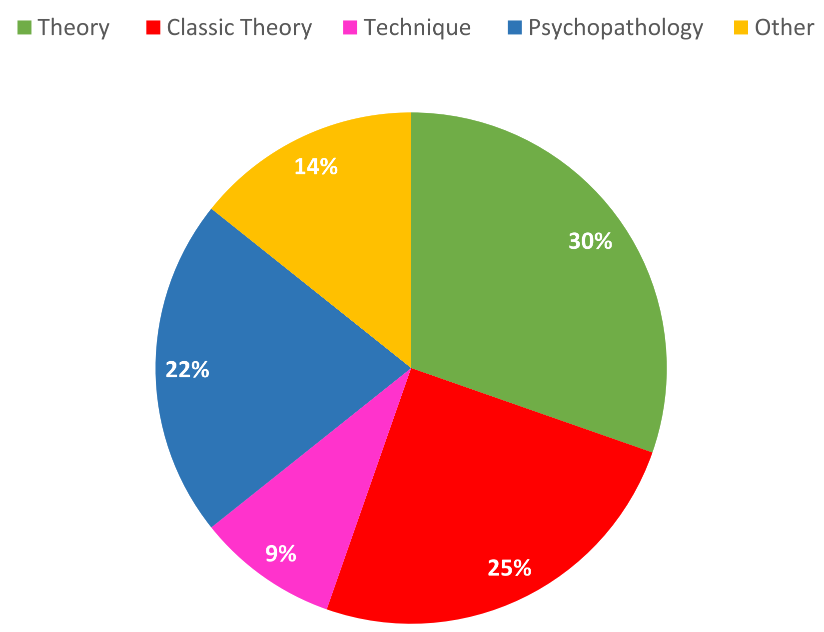
- Offer more hours of teaching
- Increase our consistency by reducing VL
- Provide clarity in curriculum and in teaching methods
- Integrate the two courses, making the student journey a clearer, consistent experience and with less delays
- Discontinue supervision groups and baby observation
- Shared content across delivery sites (London, Leeds)
- Focus on growth and stability for the north of England

THE NEW MODEL M58

M58, BM58 and M58L
Training in Psychodynamic Psychotherapy

D58 CURRICULUM

- The previous curriculum (56 seminars 1 hours D58)



Seminar 1: What Is Psychoanalytic Psychotherapy?

Seminar 2: The Setting for Psychotherapy

Seminar 3: Finding a Patient

Seminar 4: The Unconscious

Seminar 5: Unconscious Phantasy and Internal Objects

Seminar 6: Transference/Countertransference

Seminar 7: Symbolisation and Dreams

Seminar 8: Freud's Notion of Sexual Instinct

Seminar 9: Little Hans

Seminar 10: Tuning into the Psychotic Wavelength

Seminar 1: The Oedipus Complex I

Seminar 2: The Oedipus Complex II

Seminar 3: Narcissism

Seminar 4: Life and Death Drives

Seminar 5: The Structural Theory

Seminar 6: Anxiety and Guilt

Seminar 7: The Ego & Defences

Seminar 8: Infant Development: An Object Relations Perspective I

Seminar 9: Infant Development: An Object Relations Perspective II

Seminar 10: Hysteria

Seminar 1 - Mourning and Melancholia

Seminar 2 - Depressed States

Seminar 3 - The Rat Man

Seminar 4 - Reflections on Mourning and Obsessional States in the Analysis of a Child and Its Links to Work with Adults

Seminar 5 - Separation and Breaks

Seminar 6 - Childhood Sexual Abuse & Adult Psychopathology

Seminar 7 - Borderline and Narcissistic Personality Disorder

Seminar 8 - Perversion & Perverse States of Mind

Seminar 1: Introduction to Melanie Klein

Seminar 2: The Paranoid Schizoid Position I

Seminar 3: The Paranoid Schizoid Position II

Seminar 4: The Depressive Position I

Seminar 5: The Depressive Position II

Seminar 6: Unconscious Phantasy

Seminar 7: The Oedipus Complex in Kleinian Thinking

Seminar 8: Pathological Organisations

Seminar 9: The Death Instinct: Envy and Destructiveness

Seminar 10: Aspects of Technique

Seminar 1: Winnicott and His Place in Psychoanalytic Thinking

Seminar 2: The Baby and the Holding Environment

seminar 3: Splitting, Projective and Introjective Identification

Seminar 4: Mind and its relation to the Psych- Soma

Seminar 5: Playing and transitional space

Seminar 6: Use of an object

Seminar 7: The superego in Klein and Hate in the Counter Transference

Seminar 8: Fear of Breakdown and psychosis

Seminar 9: Attachment Theory Lecture

Seminar 10: Attachment Theory and Later Developments

Seminar 1 - Bion I

Seminar 2 - Bion II

Seminar 3 - Internal Racism I

Seminar 4 - Internal Racism II

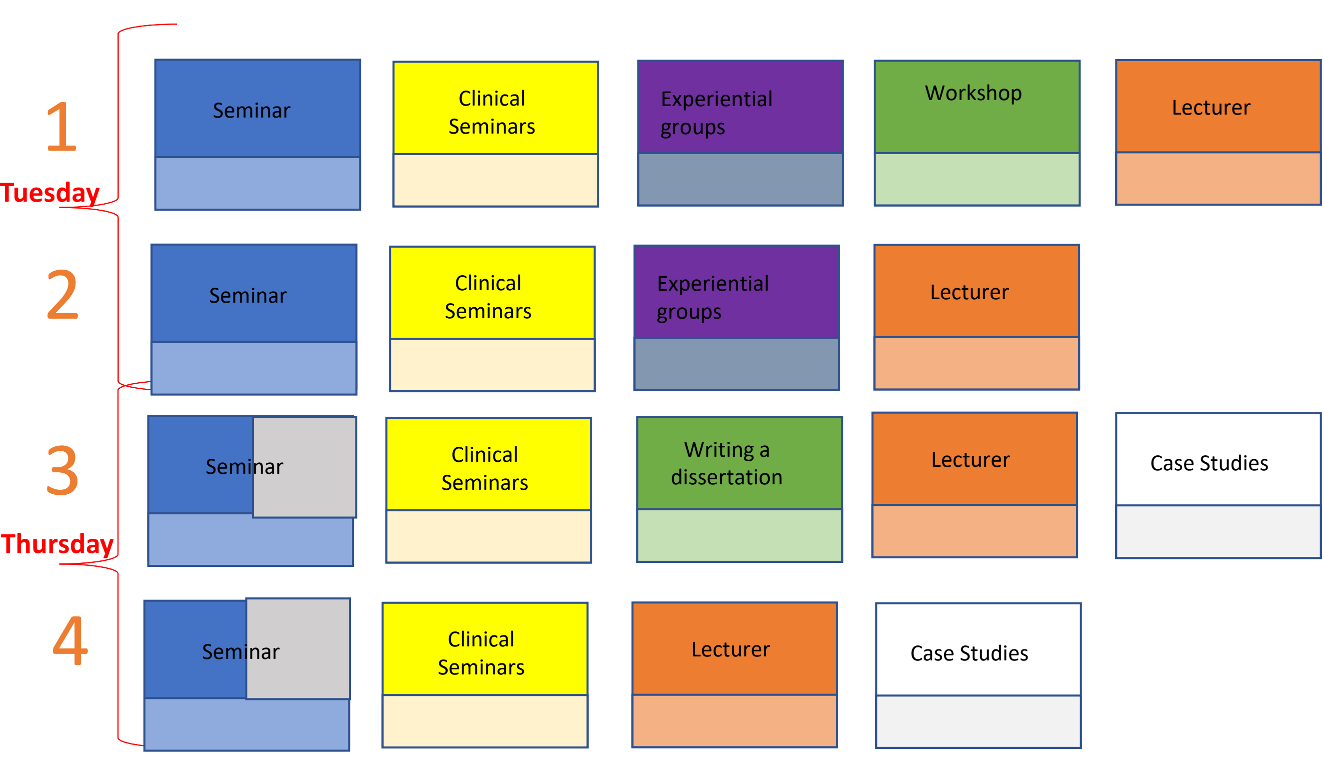
Seminar 5 - Understanding Trauma

Seminar 6 - Working with Complex Trauma (Including Refugees)

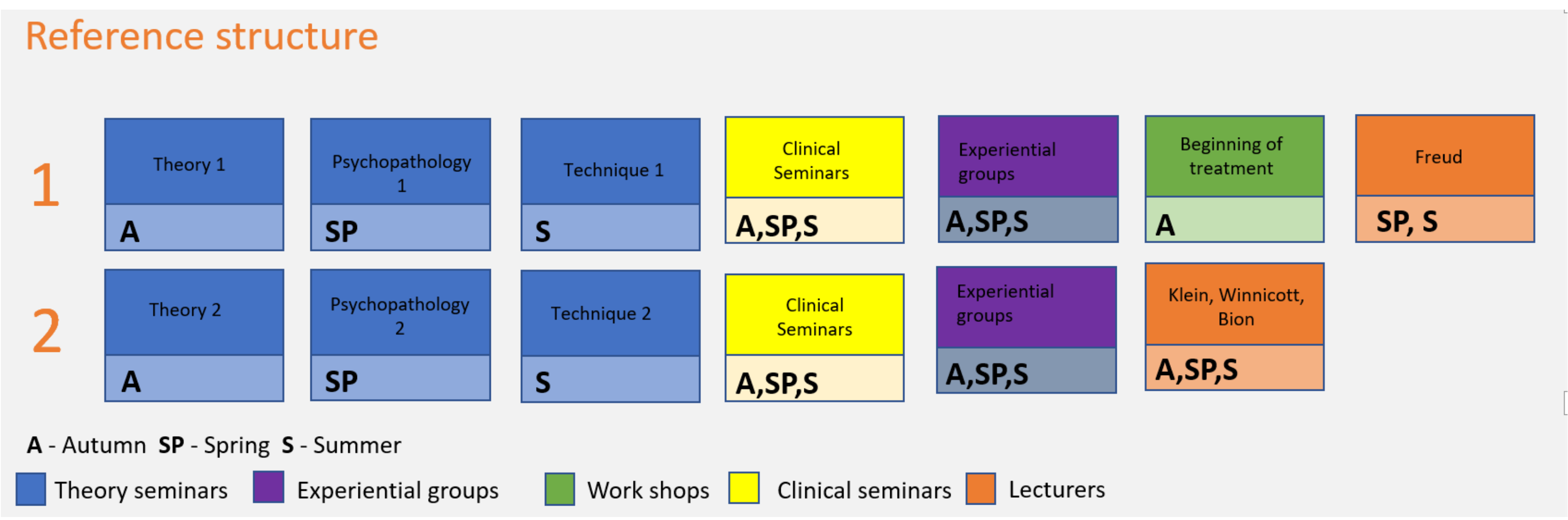
Seminar 7 - Evidence Based Treatment I

Seminar 8 – Separation and Ending

Reference structure



A - Autumn **SP** - Spring **S** - Summer


Reference structure
1
Theory 1
A
Psychopathology 1
SP
Technique 1
S
Clinical Seminars
A,SP,S
Experiential groups
A,SP,S
Beginning of treatment
A
Freud
SP, S
2
Theory 2
A
Psychopathology 2
SP
Technique 2
S
Clinical Seminars
A,SP,S
Experiential groups
A,SP,S
Klein, Winnicott, Bion
A,SP,S
A - Autumn SP - Spring S - Summer
Theory seminars
Experiential groups
Work shops
Clinical seminars
Lecturers

TEACHING METHODS

Baby observation seminar

Cost per year (30 students):
S=£12,285
E=£945
SL:6

Supervision seminars

Cost per year (30 Students):
S=£17,010
E=£945
SL: 9

Individual supervision

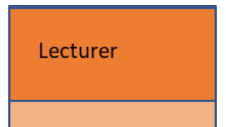
Cost per Students:
S=£1,750 +

Workshop

Cost peer year (30 students):
S=£1,890
E=variable
SL: 1

Experiential groups

Cost peer year (30 students):
S=£5,670
E=£0
SL: 3

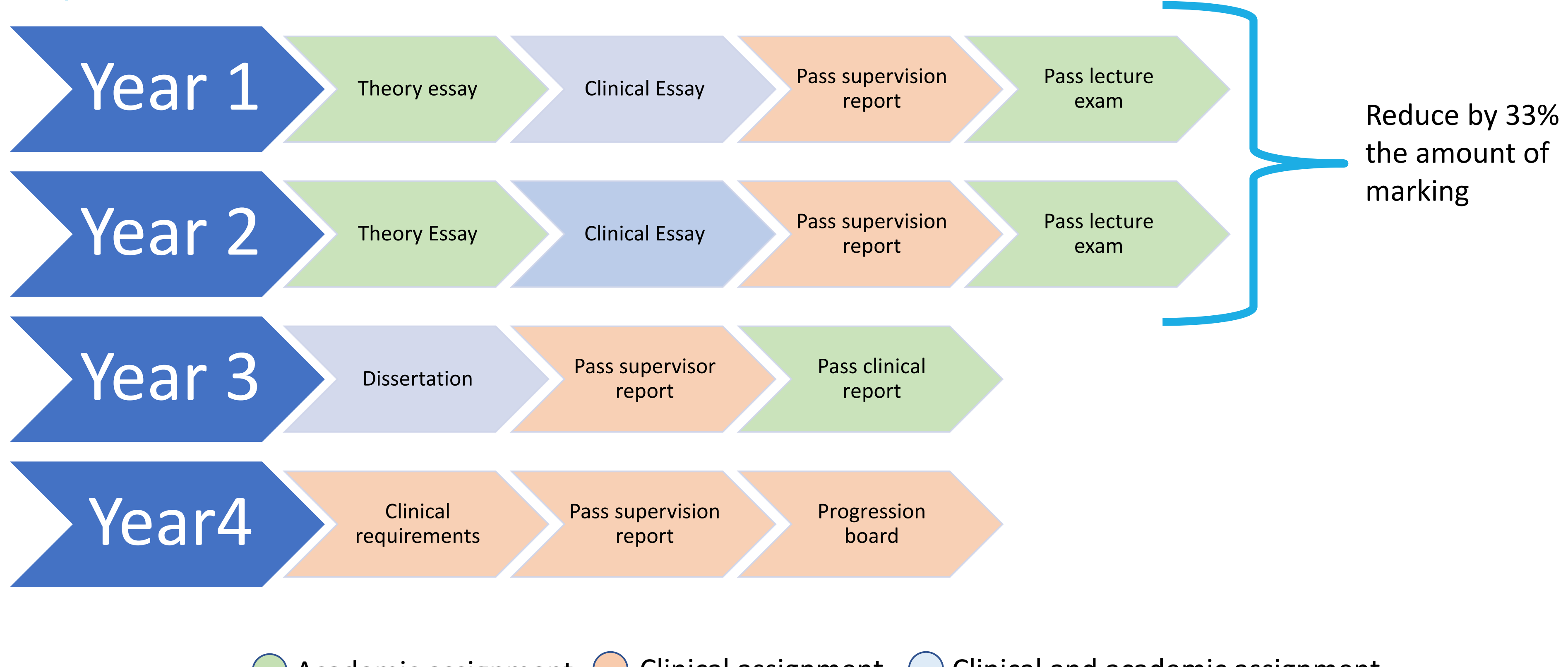


Cost peer year (30 students):
S=£1,890
E=£945 Out
SL: 1

Cost peer year (30 students):
S=£5,670
E=0
SL: 3

Individual supervision is private now

MARKING AN ASSESSMENT



FACE TO FACE TEACHING

- From 56 hrs in two years, to 100 hrs (lecturer) & 84 hours (Seminars)
- From 4 hrs on technique , to 45 hrs on technique + 7 workshops
- From a muddled curriculum over two courses, to an organised progression of knowledge that facilitates assessment

BM58 (IMPROVEMENTS)

- The four years are offered in the evenings
- Our online platform includes weekly exercises, they have two recordings instead of one
- They have the option of attending the lectures if they arrive at 4pm

CHALLENGES FOR M58

- VL:

Reducing the use of VLs to ensure consistency, can only be achieved with more AL

- Placements:

There are not enough. Many charities do not assess patients the way we would prefer, and they have different expectations. Need to increase Trust placements

- Resources:

Competing with universities remains a challenge in terms of accommodation, resources and student support

CONCLUSION

- M58: Year 1 intake significantly increased compared to D58 (late August, 36% increase).
- Leeds intake: 20 students total, with a promising future.
- B58M (evenings): Innovative and forward-looking.
- Moving towards a more substantive teaching workforce by increasing Associate Staff (AS).
- Need to increase Trust placements and teaching contributions in the course to highlight the advantage of being part of the NHS instead of a university campus.

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 11th JULY 2024 AT 2:00 P.M.

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

DRAFT

PRESENT:

John Lawlor	Chair of the Board of Directors	JL
Shalini Sequeira	Non-Executive Director and Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Claire Johnston	Non-Executive Director and Chair Quality & Safety Committee	CJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality & Safety Committee	JJ
Ken Batty	Non-Executive Director	KB
Michael Holland	Chief Executive Officer	MH
Sally Hodges	Deputy Chief Executive and Chief Clinical Operations Officer	SH
Clare Scott	Chief Nursing Officer	CS
Mark Freestone	Chief Education and Training Officer and Dean of Postgraduate Studies	MF
Peter O'Neill	Interim Chief Finance Officer	PON

IN ATTENDANCE:

Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Gem Davis	Chief People Officer	GD
Jane Meggitt	Interim Director of Communications and Marketing	JM
Sheena Bolland	Public Governor	SB
Ellie Rudd	Manager, Fitzrovia Youth Action CAMHS (item 4)	ER
Fathiya Saleh	Youth Leadership Coordinator, Fitzrovia Youth Action CAMHS (item 4)	FS
Siham	Peer Support, Fitzrovia Youth Action (item 4)	S
Rachel James	Clinical Services Director (item 4)	RJ
Fiona Fernandes	Corporate Governance Business Manager	FF

APOLOGIES:

David Levenson	Non-Executive Director & Chair of the Integrated Audit & Governance Committee	DL
Aruna Mehta	Non-Executive Director & Chair of the Performance, Finance and Resources Committee	AM
Chris Abbott	Chief Medical Officer	CA
Rod Booth	Director of Strategy, Transformation & Business Development	RB
Sal Jarvis	Non-Executive Director and Chair Education and Training Committee	SJ

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL welcomed all in attendance. Apologies were noted from David Levenson, Aruna Mehta, Rod Booth and Chris Abbott.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	No new declarations of interest were made.	
004	**SERVICE PRESENTATION**	
	Rachel James, Clinical Service Director, Fathiya Saleh, Youth Leadership Coordinator, Fitzrovia Youth Action CAMHS, Ellie Rudd, Manager, Fitzrovia Youth Action CAMHS and Siham, Peer Support Fitzrovia Youth Action were in attendance to present the work of the Fitzrovia Youth Action CAMHS. Rachel James provided an overview of the work of Fitzrovia Youth Action CAMHS whilst Fathiya Saleh and Siham presented a video about the peer support work and the importance of it. Siham gave an overview of how she got involved with the Fitzrovia Youth Action CAMHS and how she became a Perr Support worker. The board thanked all for the presentation and commended them for the continued good work.	
005	**MINUTES OF THE PREVIOUS MEETING HELD ON 21st February 2024**	
	The minutes of the previous meeting held on 9th May 2024 were agreed as an accurate record pending minor amendment of GD and KE's surnames.	
006	**MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW**	
	It was noted that there were no matters arising. It was noted all actions proposed for closure were approved.	

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007	**CHAIR AND CHIEF EXECUTIVE'S REPORT**
	JL provided a verbal update and highlighted the following: • He attended the Health and Wellbeing Board in Camden and was encouraging to hear how much influence they have with the new government. • Changes have been made to the NED roles following Debbie Colson leaving. Claire Johnston will be the NED lead on the Quality and Safety Whistleblowing/Freedom to Speak Up cases, and Ken Batty will be the NED lead for Human Resource issues as well as being the NED link on the Gloucester House Sterring Group. • Aruna Mehta will be asked to become the Vice Chair pending approval from the Governors. The CEO Report was taken as read. MH advised that the Clinical Structure review is almost completed, and the implementation of the new structure will be finalised next week. The next stage is to ensure that all the individuals understand their roles and responsibilities and can act into these roles and responsibilities. Adult Gender Service (GIC) - the Chief Medical Officer will be doing further work to scope and manage the affordability and, to ensure that the review focusses on the critical aspects of the work of GIC. The Trust had received the Terms of Reference. The reports from the Chair and CEO were noted.
008	**INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)**
	The report was taken as read. SH advised that the IQPR was discussed in full at the Performance, Finance and Resources Committee (PFRC) on 21st May 2024 and had been through other committees. SH highlighted that the A3's are linked to the Strategic Objectives and are discussed on a weekly basis at the Executive Leadership Team (ELT). The key areas of focus were waiting lists, data reporting as well as quality and safety. Quality and safety links to the waiting lists times which came out as a significant concern at the PFRC. The Quality Improvement meeting huddles take place weekly and the quality improvement prospects have moved forward. SH noted that with the impact of the GIC waiting lists continuing to grow, some of the practices have been changed and are working closely with NHSE who continue to open up places for GIC patients and 280 patients are going to the Sussex service.

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	CS presented the Quality section of the IQPR. With regards to the service user experience A3, although the quality of the feedback had improved, the target was not achieved. The main area of focus is the way service users can feedback and we are developing QR codes to help improve this area. We are also working on the way the data is captured in a standardised way. A detailed process mapping exercise was undertaken. The watch matrix has improved and there is more transparency in reporting. Previously data was reported in paper format and work has been done with Gloucester House staff on the use of the new system RADAR for reporting. There have been a lower number of aggressions reported around the reporting mechanism. Work is being done to get the module on RADAR as part of Phase 2. CS noted that there had been an increased number of complaints that were resolved informally and, that was well received from staff and service users. The Watch Metrics had been laid out and are working on SPC charts to help better understand the trajectories and liaising with other organisations to ensure that it is aligned. Responding to KB, SH noted that a lot of the case on the watch metric were dormant cases and are working with the individuals on how to close them. These are mainly related to GIC. These are patients who have not been seen for a year and are referred to the next stage and, been dormant, which skews the data, we are exploring ways to remove this set of dormant cases. CJ noted that it was good to see positive service user performance. CJ asked what about the service users who have not had a positive experience? Responding to CJ, CS noted that they were working with the teams to get this data. The report was noted.
009	**INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) ASSURANCE REPORT**
	PON noted that the IAGC had only an extra-ordinary meeting in June 2024 to finalise the Accounts for the Annual Report and Accounts 2023/2024. The external and internal auditors presented their positions, and the committee accepted the Accounts subject that there were no significant changes and they were signed off. The verbal report was noted.
010	**OUR FUTURE DIRECTION – UPDATE & NEXT STEPS**
	The report was taken as read. MH noted that the Trust was progressing with the merger following approval at a Closed Board meeting in June 2024. The Trust will be looking at Central and North West London NHS Foundation Trust (CNWL)/University College London (UCL)/Camden Council partnership within the Integrated Care Board (ICB)

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and, at CNWL on the future of CAMHS commissioning in Camden and where the estate sits as well as the transactional costs.

The relationship with the Single Oversight Framework (SOF) is supportive and is helping ICB support the transaction.

The report was noted.

011 **SELF-DECLARATION ON TRUST COMPLIANCE WITH THE NHS PROVIDER LICENCE**

The report was taken as read.

AK noted that all NHS Foundation Trusts are required to self-certify to meet the compliance of the license. There are three areas for compliance, which are:

- complied with the conditions of the NHS provider license (**G6**)
- complied with governance requirements (**CoS7**)
- the required resources available if providing commissioner requested services (CRS) (**FT4**)

NHS England (NHSE) have indicated that it no longer requires returns to be provided, and indeed it was unclear whether this self-declaration was still required. However, it is for each Provider to determine the process on how they will assess their compliance. Despite the uncertainty, there is a possibility that NHSE would ask the Trust to present evidence used to inform its self-certification.

Foundation Trusts are also required to confirm that they ensure that members of the Council of Governors have the skills and knowledge to fulfill their role. The Trust Governors have had training and have attended the GovernWell courses which are provided by NHS Providers, however there is still more to do.

Overall, the Trust has met the requirements and the recommendation is to self-declare compliance. AK noted that there was a template that is signed off by the Chair and Chief Executive which will be uploaded on to the Trust website.

The report was noted, and the Board approved the self-certification.

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

The report was taken as read.

CJ highlighted the following:

- Patient Safety Incident Response Plan (PSIRP) – following approval of the first iteration of this in September 2023, a significant amount of work had been undertaken to ensure compliance with the new framework. It was encouraging to see the improvements made and, how staff embraced the training sans saw it as a development for the patients.

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- GIDS/GIC – this fell in the remit of IAGC, the QSC discussed this as it was relevant to patient safety and considering that there was a significant increase in Freedom of information requests (FOIs) since January.
- The committee received updates on the new Local Risk Management System (LRMS) and RADAR. The next stages of delivery for the remaining aspects of Radar (including compliments, excellence reporting and clinical audit etc) were being worked through.
- The new updated version of the Board Assurance Framework (BAF) risks was reviewed. It was noted that the Corporate Risk Register was being reviewed and updated as part of the data transfer process.

AK noted that the area of FOI interest was mainly on GIDS from a group called Good Law Project who are looking at the impact of the decision to remove puberty blocker.

The report was noted.

013	**QUALITY PRIORITIES 2024-2025**

The report was taken as read.

CS noted that Organisations are required under the Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum.

A stakeholder event was held in March 2023 in developing the quality priorities for 2024/2025. The plan was to align the new quality priorities (patient safety, patient experience and clinical effectiveness) to the Trust's new values and strategic pillars and build on quality improvement work in these areas as well as focussing on the patient safety experience and improvements of patients along the way. We are tracking and monitoring the progress and there is evidence of improvement on average.

The report was noted.

014	**ANNUAL SEL-ASSESSMENT OF COMMITTEES' EFFECTIVENESS AND COMMITTEE ANNUAL REPORTS**

The report was taken as read.

AK highlighted that six committees were reviewed and, that this was another area of annual reporting process for the Trust which was linked to Governance. This was included in the Annual Report and Accounts 2023/2024.

The report summarises the themes of the work Dorothy Otite, Governance Consultant led with the Chairs and members of the committees.

All committees have robust Terms of Reference to ensure that the process supports the work of the committees.

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There are some areas of improvement and processes have been agreed to progress this and to ensure consistency across all committees.

The other area of work is to get more deeply into the BAF risk and to ensure that they are used appropriately to drive the work of the committees to gain assurance. Work has started on deep dives for some individual risks.

Following an administrative review, it was agreed that there should be a dedicated Committee Secretary to take on the administrative work of all the committees. The post is out to advert, closing next week. There has been great interest in the applications, and we are hopeful that we will be able to appoint someone.
Huge thanks to the Executive Assistants who have been undertaking this work alongside their substantive roles.

SS noted her thanks to Doroty Otite and the work that she has done on the Terms of Reference and Committee Effectiveness, which is a huge leap forward.

The report was noted.

015 **WORKFORCE RACE EQUALITY STANDARD (WRES) & WORKFORCE DISABILITY EQUALITY STANDARD (WDES)**

The reports were taken as read.

TM noted that the this was the latest data from the Staff Survey. He highlighted the salient points:

- improvements have been made in the seven indicators, WRES has improved by 9.2% and WDES improved by 9.9%.
- There was a significant improvement of 4.7% in the number of staff from racially minoritised groups experiencing discrimination from their manager, team leader or colleague. However, with a score of 20%, the Trust remains among lowest performers nationally for this indicator.
- WDES - progress was made in 8 of the 10 indicators and in 2 of them there was an improvement of over 14%.
- The WDES declaration rate had increased to 9.9% over the last 5 years and there was 15% reductions in staff being bullied by the managers.

Despite these improvements, the Trust still remains amongst the lowest performing Trusts for both WRES and WDES.

The key areas to focus on are:

- Inclusive recruitment
- Removing barriers to reporting experiences of harassment, bullying or abuse.
- Creating transparency around equal opportunities for career progression or promotion.
- Address the concerns surrounding formal disciplinary where it shows that more staff from ethnic minorities are subjected to this compared to their white colleagues.

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JL noted that each member of the board should evaluate and expand the reciprocal mentoring programme.

Responding to SP, TM noted that the EDI team were a small and in order to progress the work of the action plan, ore resources are required. Another area that support is required is to ensure that internal recruitment is fair and equitable.

TM noted the Board of Directors is asked to support the prioritisation of the following actions that have been identified for improving the challenges emerging in the report:

- A deep dive into Bullying, Harassment and Abuse to facilitate deep understanding trust wide.
- Embedding of Just Culture approach to reduce likelihood of staff from minoritised ethnic backgrounds entering formal disciplinary process.
- Develop a transparent and equitable internal promotion process.
- Review and strengthen Inclusive Recruitment Process introduced last year.
- Removing barriers to reporting.

The Board noted the reports and supported the recommended actions.

016 **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE (POD EDI) ASSURANCE REPORT**

The report was taken as read and SS highlighted the key points from the meeting:

- The committee had a deep dive on the BAF risk 7 – lack of fair and inclusive culture at the beginning of the meeting.
- Bullying and harassment – as an organisation we believe this is under reported; as such we discussed the reasons underpinning this and steps that could be taken to achieve a more accurate and realistic picture of the extent of incidents.
- A lot of the time was spent of the EDI piece and the capacity of colleagues.

GD noted that behaviours and consequences were integral to staff culture and zero tolerance. All staff should have an EDI objective.

JL noted that members of the board need to look at ‘Catching up’, ‘Delivery for today’ and Planning for tomorrow’.

The report was noted.

017 **EDUCATION AND TRAINING COMMITTEE (ETC) ASSURANCE REPORT**

The Education and Training Committee did not meet prior to the board meeting. However, MF provided a verbal update on the following:

- Finance and Performance – a new lecturer role had been approved to support the delivery of the M4 3-year course programme.

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	• At the next committee meeting, the committee will be discussing the revised BAF risks around the merger and the Office for Students (OfS) accreditation. • The DET Merger Board had been re-instated with a clear set of objectives and associated risk factors relating to various options to secure a sustainable HE partner and ensure DET's long-term viability. • Student recruitment has shown a year-on-year increase of 10.8% from 2023-24, with 799 applications for 24-25, up from 721 at this time in 23/24. We had also received 10 applications for the executive coaching programme, parity with last year. JL noted that is was very encouraging regarding the number of applications. The report was noted.
018	**PERFORMANCE, FINANCE AND RESOURCES COMMITTEE (PFRC) ASSURANCE REPORT**
	The report was taken as read and SH highlighted the key points: • The IQPR elements were addressed • Finance - The final plan reflected month two actuals as target, so no variance to plan. The report highlighted that month 2 reported position was very close to the previous versions of the plan, so no delivery risks identified. The cash support included in the plan was explained to committee, with the interest payable on this support specifically highlighted by the chair. • The Committee went through a number of BAF risks in detail with specific focus on Finance, Estates, IT and Performance. IT risk didn't at the time of writing reflect the lapse in Cyber Essentials accreditation, which had only come to the attention of the Contracting Team that week. This will be resolved immediately and the risk narrative updated, plus the committee agreed a minor adjustment to the risk score also. • The waiting list risk for GIC was escalated to the Board. The report was noted.
019	**FINANCE REPORT – MONTH 02**
	The report was taken as read. PON noted that for month 02, the Trust: • The Financial Plan for 2024/2025 was agreed and finalised, and there was no variance for month 2. • Capital Expenditure -To date capital spend is limited, totalling only £66k, slightly behind the planned spend to date of £107k. Anticipated expenditure at the year-end is expected to be on plan at £2.2m. • Income & Expenditure - The Trust incurred a net deficit of £439k in the period, that was consistent with the revised final plan submitted to NHSE 12th June 2024. The Trust is anticipating achieving its year-end deficit plan of £2,200k, with no significant risk to plan known.

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- Cash - The cash balance at the end of month two was £1,468k consistent with the revised final plan. This cash flow forecast in the 24/25 plan is reliant on cash support of £7,500k being agreed throughout the year by NHSE.
- Month 3 – positive impact from audit and ahead of plan by £160k. We will be doing a refresh of the internal plan. On plan and accessing cash support for month 4. As part of the merger process, we will commission an external and independent open market value of the building.

Annual Report and Accounts 2023/24
PON noted that the Trust missed the submission deadline of the Annual Report and Accounts for 2023/24 by two days mainly due to last minute queries that arose from the external auditors Grant Thornton.

We have reported a deficit of £2.47m with a Control Total of £41k noting that this arose in the audit process that will have an impact on the 2024/2025 plan. We are working with Grant Thornton.

AK noted that the Annual Report and Accounts 2023/2024 was submitted to Parliament to be laid by 17th July 2024. The provisional date for the Annual Members Meeting is scheduled for 17th September 2024 where members of the Trust will receive the Annual Report and Accounts for 2023/2024.

The Board thanked the Finance, Governance and People teams for the work on the Annual Report and Accounts.

The report was noted.

020	**BOARD SCHEDULE OF BUSINESS**
	The Schedule of Business for 2024/2025 was noted.
021	**QUESTIONS FROM THE GOVERNORS**
	There were no questions from the Governors.
022	**ANY OTHER BUSINESS**
	None
023	**QUESTIONS FROM THE PUBLIC**
	There were no questions from the public.
024	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	• The EDI aspects of the meeting were good and although there has been progression, there is still more work to do.

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- JL noted that as the Chair he found it difficult to generate energy into the meeting.
- It was noted that it was a long day, with the Board Development Session in the morning and the Closed and Public meetings in the afternoon, especially as the WDES and WRES were on the agenda at all three meetings.

Close

The Chair closed the meeting at 4.05 p.m.

Date of Next Meeting in public: Thursday 12TH SEPTEMBER 2024 at 2pm, LECTURE THEATRE, TAVISTOCK CENTRE 120 BELSIZE LANE NW3 5BA.

Signature ______________________________ Date ______________________________

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

			Actions are RAG rates as follows: ->	Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	In progress	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified. NHSE are providing Teams to assist with the second part of the training which is going to rolled out shortly.
09.05.24	8	Integrated Quality & Performance Report (IQPR)	To provide a list of what Mandatory & Statutory should be, and which are relevant	July Board meeting on 11.07.24	GD	In progress	the Statutory and Mandatory training list has been given to the Clinical Services Delivery Meeting to decide / approve
09.05.24	23	Reflections and Feedback from the meeting	Communications team to circulate and promote the dates of the Board meetings to encourage staff attendance.	for the July Board meeting on 11.07.24	JM	Propose to close	Dates for the Board meetings was included in the Tavistock Digest of 10th July as well as on the staff intranet. This will be done on a regular basis.

MEETING OF THE TRUST BOARD OF DIRECTORS PART II (PUBLIC) 12 September 2024					
Report Title: Chief Executive's Report				**Agenda No.: 7**	
Report Author and Job Title:	Michael Holland, Chief Executive		**Lead Executive Director:**	Michael Holland, Chief Executive	
Appendices:					
Executive Summary:					
Action Required:	**Approval** ☐ **Discussion** ☒ **Information** ☐ **Assurance** ☐				
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.				
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.				
Assessment:	This report covers the period since the meeting on 11 July 2024				
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against the leadership responsibilities within the CEO's portfolio.				
Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	**Safe** ☐	**Effective** ☐	**Caring** ☐	**Responsive** ☐	**Well-led** ☐
Link to the Risk Register:	**BAF** ☒		**CRR** ☐	**ORR** ☐	
	All BAF risks				
Legal and Regulatory Implications:	Yes ☐		No ☒		
	There are no legal and/or regulatory implications associated with this report.				
Resource Implications:	Yes ☐		No ☒		
	There are no resource implications associated with this report				
Equality, Diversity and Inclusion (EDI) implications:	There are equality, diversity and inclusion implications associated with different aspects of this report.				

<table>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="2">☒ This report is disclosable under the FOI Act.</td><td colspan="2">☐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.</td></tr>
<tr><td colspan="5">Assurance:</td></tr>
<tr><td>Assurance Route - Previously Considered by:</td><td colspan="4">None</td></tr>
<tr><td>Reports require an assurance rating to guide the discussion:</td><td>☐ Limited Assurance: There are significant gaps in assurance or action plans</td><td>☐ Partial Assurance: There are gaps in assurance</td><td>☐ Adequate Assurance: There are no gaps in assurance</td><td>☐ Not applicable: No assurance is required</td></tr>
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Chief Executive's Report

I hope that everyone has had a nice summer and taken the opportunity of time off to recharge batteries and spend valuable downtime with family and friends.

Sadly, we will all recall that the latter part of July and early August were marred by the horrific displays of racist and hate-filled rioting and disorder that followed the unbelievably sad murders in Southport. I was very heartened to witness the strong response of the NHS family in wholeheartedly rejecting the divisive and lawless rhetoric that the rioters were seeking to promote in the face of such tragedy.

As an organisation, here at the Tavistock and Portman we acted promptly to set up open sessions and support mechanisms both for our senior leaders and our wider workforce. This included empowering managers to undertake local risk assessments, agreeing the use of alternative modes of transport for affected staff, and holding drop-in sessions and listening events. The support is iterative and ongoing; it continues to change to respond to the needs of our staff, having listened and learned to their feedback throughout the last few weeks.

Providing outstanding patient care

1. Clinical Structure review

The final structure and organogram for our clinical services was published in August 2024 with an implementation date of 2 September 2024. An implementation plan has been developed to include training and development to support people in taking up new roles, and organisational development to prepare the new leadership in working together to lead a high quality, high functioning team for the newly formed clinical division.

2. Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust: independent report

On 19 July 2024, the Department of Health and Social Care published Professor Louis Appleby's independent report on the review of suicides and gender dysphoria at Tavistock and Portman NHS Foundation Trust. The report reviewed data provided by NHS England on suicides by young patients of the gender services, based on an audit at the Trust. The specific aim was to examine evidence to support allegations by some campaigners that there had been a large rise in suicides. Among a number of conclusions, the summary confirmed that there was no evidence to support that claim.

3. Implementing advice from the Cass Review

On 7 August 2024, NHSE published the implementation plan for the Cass Review recommendations. The Cass Review was an independent review of NHS gender identity services for children and young people, commissioned by NHS England in

2020, and published in April 2024. The implementation pack outlines the steps that NHSE has already taken, guided by interim advice from Dr Cass, and sets out how they will take forward the recommendations made in the final report.

4. New Medical Director

I am pleased to announce that Dr Sheva Habel has been successfully appointed as Medical Director for the Trust, and she took up post on 1 September 2024. This is a new post and is the third and final part of the new triumvirate clinical leadership structure alongside the managing director and director of therapies, and reporting into the executive team. Dr Habel currently works as a consultant within the Adolescent and Young Adult Service. She will be working 5 sessions as medical director and continue to work 4 sessions clinically. Dr Habel will line manage the service lead clinicians and will report to the Chief Medical Officer.

5. General Practice Collective Action

On 1 August 2024, the British Medical Association announced that GP contractor/partner members in England had voted to take collective action. Collective action refers to actions taken by general practices that do not breach their contracts. The England General Practice Committee, the BMA committee that represents the interests of GPs, has issued a list of ten suggested actions that general practice could take as part of collective action, and are encouraging practices to consider which of the ten they would want to engage in, should collective action begin, noting that this could change over time. The GPCE list can be found on https://www.bma.org.uk/our-campaigns/gp-campaigns/contracts/gp-contract-202425-changes. Currently we have not experienced significant impact and we continue to work with NCL ICS and regional colleagues to respond to this.

6. NHSE Reviews of Gender Clinics

NHSE start their reviews of gender clinics across the country in September, and the program is likely to be completed in December. The key aim is to review fidelity to service specification and reasons for deviation. Our GIC is due to be reviewed on 5 November and more details on this is included in the board papers.

7. Special review of mental health services in Nottinghamshire Healthcare NHS Foundation Trust (NHFT)

The CQC published part 2 of its rapid review on 12 August 2024, following publication of part 1 in March 2024. The review had been commissioned by the Secretary of State for Health and Social Care following the conviction of Valdo Calocane over the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber.

The review covers the period during which VC received care from NHFT from point of contact in May 2020 to discharge back to his GP in September 2022. It looked at evidence related to VC's care, and also reviewed 10 benchmarking cases. The outcome of this second piece of work supports many of the findings of the wider

review of patient safety and quality of care provided by NHFT. The CQC identified concerns with:

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

8. New patient portal for GIC

During September, we will be implementing a new patient portal for our Gender Identity Clinic, to help improve patients' access to their health information and care. We recognise that there are often long waiting times for an appointment at the clinic, and the patient portal will help ensure that there is better ongoing communication with patients, while also providing advice and guidance during their time on the waiting list.

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

9. Student recruitment

Student recruitment for the 2024/25 cycle has been very positive. All courses are now closed to recruitment, and we can confirm that there has been an 18.5% increase in applications for our long courses, with commensurate increases to both unconditional offers and firm acceptances. We expect that these increases will result in higher student numbers when enrolment takes place in October.

10. Development of the Trust's international strategy

I am pleased to announce that the development of our international strategy is underway. This will enable us to grow our international partnerships and develop a range of areas across our organisation, including expanding our education and training offer. During August, colleagues from our Education and Training Department took part in discussions with a training centre in Shanghai to explore potential collaboration, including on international student recruitment, course development, knowledge transfer and staff exchange opportunities.

Developing Partnerships to Improve Population Health and Building on our Reputation for Innovation and Research in this area

11. NHS Providers review of NHS trust strategies for addressing health inequalities

At the end of August, NHS Providers published outcomes from a review it had conducted of trust health inequality strategies. The team found that 78% of trusts

reported that health inequalities are embedded within their organisational strategy and priorities, with half indicating that they had developed a specific strategy for addressing them. However, the review found that despite these best efforts trusts often struggle to overcome the significant barriers that prevent them from making further progress and turning strategy into action. The review report can be found here: review-of-nhs-trust-strategies-for-addressing-health-inequalities.pdf (nhsproviders.org)

12. Staff Survey

The national staff survey round is again about to commence and this year we have chosen an early commencement window - we will be launching the survey on Monday 16 September. We have chosen three local questions this year - the first is a repeat of last year's question relating to the impact of protected characteristics on experience working in the trust, and the other two are linked to living our new values.

13. Staff engagement

Continuing the mission, vision, and values work, we have now scheduled further staff engagement sessions centred around the co-development of a values and behaviours framework, so that we are consistent in how we apply our values throughout the Trust. This work will feed into a number of other areas such as our strategic ambitions in relation to equality, diversity and inclusion, our work on a restorative just and learning culture, and developing new career conversations to make appraisal of our people's performance a much richer dialogue.

14. Menopause policy launch

The Trust is committed to ensuring the health, safety and wellbeing of all its staff, and that everyone is treated with dignity and respect. With this in mind, a new menopause policy is about to be launched. The aim of this policy is to enable those who are either going through or are about to go through the menopause to understand the support that is available to them. It will also help colleagues understand how to support each other and to ensure that managers are conscious of their responsibilities. The new policy will shortly be published on the Trust intranet and its launch will be publicised.

Improving Value, Productivity, Financial and Environmental Sustainability

15. Merger update

We continue to have useful conversations with colleagues with a view to progressing our proposed merger with CNWL, UCL and Camden Council. In particular I would like to highlight that close work continues with Camden Council and CNWL colleagues in responding to population health needs across the all-age life pathway in Camden. We are working together on a local centre for prevention with a focus on shared data to drive an evidence base for new initiatives across family hubs, schools, supported housing, relational workforce practice and transition pathways.

We are also linking in with UCL colleagues to support the future development and sustainability our education and research activities building on our proud history in these areas.

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

The Trust incurred a net deficit of £775k in the period from 1 April to 31 July 2024, against a planned deficit of £810k, a positive variance of £35k. We are currently anticipating achieving our year-end deficit plan of £2.2m with no significant risk of non-achievement currently.

Regional and National Context

17. Impact of recent global IT issues on the NHS

During July, parts of the NHS, particularly primary care and some Trust diagnostic services, were heavily impacted by the global IT issues that affected some Microsoft based applications. NHSE has paid homage to the efforts made by many within the affected services to maintain safe patient care and coordinate responses and recovery. While it is acknowledged that the NHS can do little to prevent global incidents like this from happening, the incident highlighted the need for everyone across the system to be as prepared as possible and to ensure that business continuity plans are robust and kept up to date.

18. Lord Darzi leading a comprehensive analysis of the NHS

In July it was announced that the former health minister Lord Darzi and his team would be carrying out a comprehensive analysis of what the NHS does now and the scale of the challenges it faces. It is expected that this work will be the starting point for the development of a 10-year plan for health – which will be led by Sally Warren, formerly Director of Policy at the King's Fund. The initial phase of Lord Darzi's work was expected to last around six weeks, meaning that the outcomes should shortly be shared.

19. New Chief Nursing Officer for England

In August, it was announced that Duncan Burton has been appointed as the Chief Nursing Officer for England, replacing Dame Ruth May, who retires soon. Duncan has been a nurse for more than 25 years and is currently the Deputy Chief Nursing Officer. He has led national work on the maternity and neonatal programme, workforce policies and the children and young people's transformation programme.

MEETING OF THE BOARD OF DIRECTORS - PUBLIC – Thursday, 12 September 2024			
Report Title: Integrated Quality Performance Report			**Agenda No.: 8**
Report Author and Job Title:	Amy Le Good, Acting Commercial Director Hector Bayayi, Managing Director	**Lead Executive Director:**	Rod Booth, Chris Abbott, Gem Davies, Peter O'Neill & Clare Scott (executive directors)
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	This is the IQPR for 24/25 Month 3 data		
Background:	This data has been through local committees (DET and IQPR's) with the detail of areas of performance that need attention being brought to this committee Focus is on A3's. A3's are now discussed weekly in ELT and in QI huddle driving a clear focus on improvement in relation to the strategic ambitions.		
Assessment:	**Quality & Safety** • The Trust reported 13 patient safety incidents where there was actual or potential harm. The Trust's new incident reporting system, Radar, went live on 3rd June 2024, enabling the automatic upload of all patient safety incidents to the Learning from Patient Safety Events (LFPSE) portal, a key objective in the implementation of PSIRF. All incidents are reviewed at a daily safety huddle. • The Trust reported 9 incidents of Violence & Aggression incidents in June, the majority of these reported by Gloucester House team. The school also records a number of 'lower level' incidents of violence and aggression in paper format and this but will move to reporting on Radar which may result in a higher number of incidents. • 12 incidents of physical restraint were reported in June; all restraints reported occurred in Gloucester House School. The increase on the previous month is a result of moving from paper records to electronic recording on Radar with a requirement for all physical interventions to be reported. **Performance** • Waiting times over the 18-week target have continued to rise across the trust, primarily because of the long waits in GIC, autism and trauma. There are pockets of improvement in wait times for example in complex mental health owing to a new clinic booking system and Camden are now performing within target with the average first appointment at 3.82 weeks. • Mandatory and statutory training has been slowly improving but is still below the 95% target at 80%. Appraisal completion is well below target at 36.3%, however an issue with the inclusion of medical appraisals (which are on a different cycle) and the change in process re having an appraisal season to the link with pay progression has created a lag which is currently being addressed.		

	• The three strategic areas of focus for waiting times now all have trajectories that performance is being measured against. This has allowed the visibility of increased activity in areas where the elective recovery funding was focused. We launched a weekly waiting time huddle where this work is monitored. GIC is receiving additional input through a targeted support programme which also meets weekly.
Key recommendation(s):	

Implications:

Strategic Objectives:

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

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Principal Risks: 1, 2, 8, 9				

Legal and Regulatory Implications:	Yes ☐	No ☒
	There are no specific legal and regulatory implications associated with this report.	
Resource Implications:	Yes ☐	No ☒
	There are no additional resource implications associated with this report.	
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒
	There are no additional EDI implications associated with this report.	
Freedom of Information (FOI) status:	☐ This report is disclosable under the FOI Act.	☒This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:

Assurance Route - Previously Considered by:	Local IQPRs held in July, Quality Assurance Committee held in August, Performance, Finance and Resources Committee September.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

	in assurance or action plans			

8a. September 2024 IQPR Board coversheet_

Integrated Quality and Performance Report
Board September 2024

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

Executive Summary

Quality & Safety

- The Trust reported 13 patient safety incidents where there was actual or potential harm. The Trust's new incident reporting system, Radar, went live on 3rd June 2024, enabling the automatic upload of all patient safety incidents to the Learning from Patient Safety Events (LFPSE) portal, a key objective in the implementation of PSIRF. All incidents are reviewed at a daily safety huddle.

- The Trust reported 9 incidents of Violence & Aggression incidents in June, the majority of these reported by Gloucester House team. The school also records a number of 'lower level' incidents of violence and aggression in paper format and this but will move to reporting on Radar which may result in a higher number of incidents..

- 12 incidents of physical restraint were reported in June; all restraints reported occurred in Gloucester House School. The increase on the previous month is a result of moving from paper records to electronic recording on Radar with a requirement for all physical interventions to be reported.

Performance

- Waiting times over the 18-week target have continued to rise across the trust, primarily because of the long waits in GIC, autism and trauma. There are pockets of improvement in wait times for example in complex mental health owing to a new clinic booking system and Camden are now performing within target with the average first appointment at 3.82 weeks.

- Mandatory and statutory training has been slowly improving but is still below the 95% target at 80%. Appraisal completion is well below target at 36.3%, however an issue with the inclusion of medical appraisals (which are on a different cycle) and the change in process re having an appraisal season to the link with pay progression has created a lag which is currently being addressed

- The three strategic areas of focus for waiting times now all have trajectories that performance is being measured against. This has allowed the visibility of increased activity in areas where the elective recovery funding was focused. We launched a weekly waiting time huddle where this work is monitored. GIC is receiving additional input through a targeted support programme which also meets weekly.

Tavistock and Portman – Our Values and Strategy

Our 24/25 Objectives are in review and will be updated in due course.

Metric	Waiting List Management	SRO	Sally Hodges	Target		Measure	

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

Problem Statement

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

Vision & Goals

Vision: No user services waiting longer than 18 weeks for treatment
G1. Clearly defined pathways for patients within next 4 months
G2. Clear demand and capacity modelling identifying gaps so that they can be addressed by March 2024
G3. Increase in patients in treatment vs on a waiting list
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

Historical Performance

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

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

Trauma

Autism Assessment

Adult Gender Identity Clinic (GIC)

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

Monthly Stratified Data

A. Number of first appointments conducted

Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
48	300	330	415	219	283	349	317	413	403	318	366

B. Number of referrals by month

August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
112	830	912	967	644	917	970	801	836	829	642	615

Average: 756.25

C. Number of discharges per month

Aug - 23	Sep - 23	Oct - 23	Nov - 23	Dec - 23	Jan - 24	Feb - 24	Mar - 24	Apr - 24	May - 24	Jun - 24	Jul - 24
112	568	510	699	393	1036	975	956	724	409	345	748

Progress on Improvements

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

Integrated Quality and Performance Report — Month 4 - 24/25

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

Problem Statement

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

Vision & Goals

Vision: No patients waiting longer than 18 weeks for Assessment

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

Historical Performance

Waiting for 1st Appt (End of Month)

Month	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Number of Patients	66	87	93	114	120	133	142	140	145	142	144	158

The number of patients waiting for 1st appt has stabilised due to the increased number of triage calls being undertaken

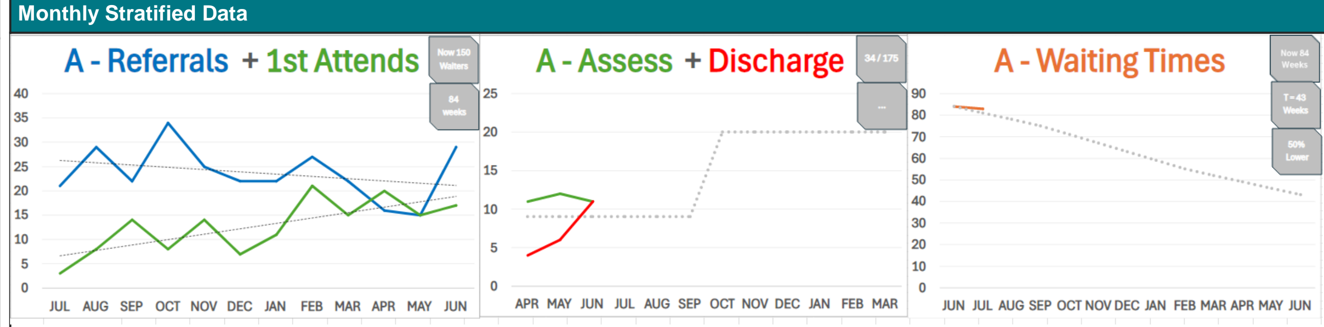
Average Waits to Assessment Start (Weeks)

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

Herts — Haringey — Service Total

The average wait for patients assessed reduced in May, we are validating this data but its also due to some longer waiting patients deferring their assessments due to exams.

Monthly Stratified Data



Progress on Improvements

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

Integrated Quality and Performance Report

Month 2 24/25

Metric	Waiting List Management – Trauma	SRO	Sally Hodges	Target		Measure	

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

Problem Statement

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

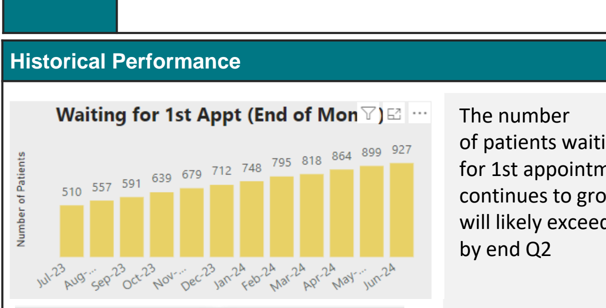
Vision & Goals

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

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

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

Historical Performance

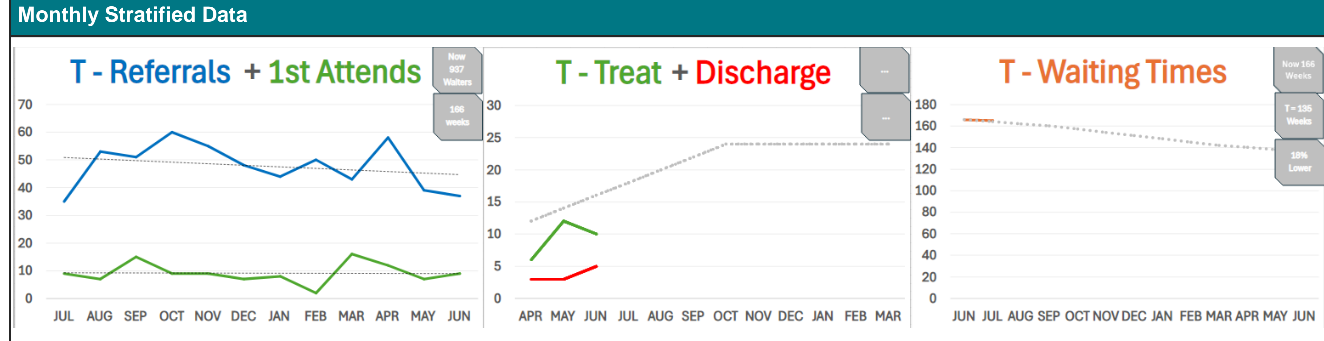


The number of patients waiting for 1st appointment continues to grow + will likely exceed 1k by end Q2

The average wait for first appointment is over 1 year, with waits for consultation and treatment being 2+ years

Treatment WL data being added to PowerBi July 2024

Monthly Stratified Data



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Patients aren't being seen for initial assessment quickly enough	To be identified	To review in Kaizen event	Reduction of Waiting List by 15%	RB/PP/AH
Patients are waiting too long for their Treatment Episode to start	To be identified	To review in Kaizen event	An additional 100 Treatment starts above last year's baseline (still TBC)	RB/PP/AH
Team is not yet at full capacity	Recruitment, onboarding and job planning of staff still ongoing / outstanding for final few new staff	Onboarding and job planning for remaining new staff	Full capacity by October 2024	

Integrated Quality and Performance Report

Month 4 – 24 / 25

Metric	Waiting List Management - GIC	SRO	Sally Hodges	Target		Measure	

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

Problem Statement

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

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

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

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

Vision & Goals

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

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

G2. Clear demand and capacity modelling for 1st appointments

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

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

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

Historical and Current Performance

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

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

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

Monthly Stratified Data

A. Planned V Actual first assessment activity

B. Number of referrals by month registered

C. PTL review of dormant cases

D. No. Of Discharges

Concern	Cause	Countermeasure	Owner and Deadline
Unclear how much clinical capacity the service has for 1st appointments for Core and CP	Job planning is not completed therefore demand and capacity modeling has not taken plan.Poor visibility on activity using Trajectories for expected planned activity vs actual service delivery	Job plans will be completed 12th July after which Gloria will complete the D&C modelling including vacant posts due to be filledMap out planned 1st assessments for relevant staff and report planned vs actual activity weekly, Clear trajectories of service activity of BAU and ERF posts	GL/JB 19/07/24
Recruitment Challenges	Difficulties obtaining candidates with relevant skills	Review posts being readvertised and update/enact workforce plan	JB/DA/GL 31/07/24
Increasing waiting list with high number of long waiters	Poor engagement with long waiters	The service will complete a waiting list validation using the digital platform, texting 16,000 (with SMS consent recorded)if GIC appointment is still needed	GL/AC/JB 31/07/24
Low number of discharges	Lack of clarity on reduction of patients in PTL, SOP around team actioning discharge outcomes	Report PTL reviews monthly in IQPR showing discharges and patient who need appointments	GL/AC
To-Be pathway mapping	Clarity on patient pathway and impact on waiting times	Improved patient experience by redirecting non-complex patients to junior staff resulting in patients being seen quicker	JB/RJ/AC
Incremental transfers to pilot clinics	Unable to transfer to multiple pilot sites at a time as it may lead to duplication of data being shared resulting in poor patient experience	Bulk transfers to be completed by the end of July for Sussex to enable further transfers.	GL/Referral Team
High number of referrals on ERS system	Skeleton staff and performance issues in team and referral form mandatory fields to be reviewed.	Liaise with people team to ensure policy and procedures are being followed. Bank staff approved to support until September. Develop recovery plan to improve numbers of referrals added to CN	GL/AC

Metric	User Experience	SRO	Clare Scott	Target	90%

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

Problem Statement

Across the Trust, 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 limited feedback received is impacting on services ability to respond to people's experiences and make improvements where needed.

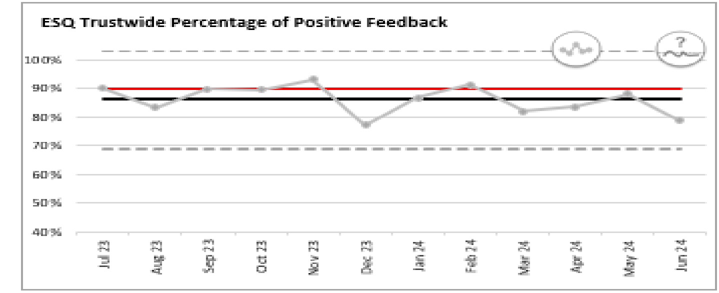
Vision & Goals

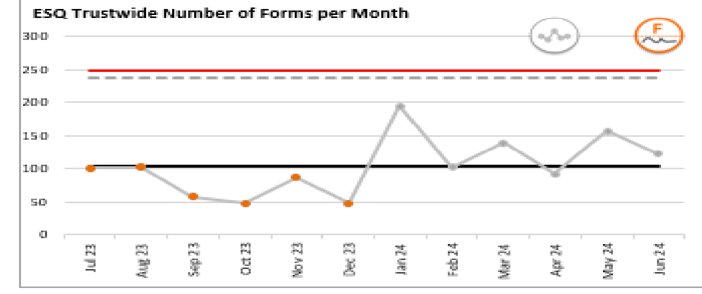
Vision: For all users to have a positive experience across the trust.

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

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

Historical & Current Performance





- SPC charts available for all service lines: C&I, CMH and GIC - these are designed to identify normal data variation in data, marked in grey. When significant improvement occurs data points are marked in blue and significant deterioration in amber.
- The number of forms completed includes Trust Internal ESQ and GIC PEQ forms

Progress on Improvements

Concern	Countermeasure in progress	Owner
Ensure newly set benchmarks for service lines for ESQ responses are monitored and services are supported to develop action plans to meet targets	• Benchmark baseline rates of 200% now established for each service line and is incorporated in SPC charts. • Deep dive invites with service lines have occurred, PDSA cycles to be used to explore successes and challenges to understand what is working well and what are some of the barrier/challenges to ESQ distribution are • Highlight service lines and teams within this who are doing well to share learnings with other clinical areas to increase their ESQ responses.	Sonia, Marcy, Ravneet & Service Leads
There is a wide range of ESQ's being used and varying ways to collect feedback	• Co-production of ESQ form with service users • Ensure contractual reporting requirements are fulfilled (MHSDS)	Marcy/GM
Different teams have different processes for distributing and collecting ESQs	• Process map created to show the current process of collecting feedback and how and when this data is recorded • A 'To Be' Process map to be created and shared Trust wide	Sonia, Marcy, Ravneet
There are limited communications to train staff on the importance of collecting feedback and to educate service users of the importance of their feedback and what is done with it	• Develop a comms strategy: • Work with comms to develop an intranet page for Service User experience work • Create a video to talk through the process and the importance of collating feedback • To create posters for the waiting rooms with QR codes	Marcy, Clare, Ravneet
Qualtrics contract is due for renewal Oct 2024, cost to renew is £22,722 ex VAT	• To produce a comparison functionalities doc for Radar, IWGC and Qualtrics to determine if Qualtrics should be renewed	Marcy, Nimisha
QR codes are not currently displayed on posters or on appointment letters	• QR workshop to understand all technicalities such as QRs based on location, services • Mandatory QR code for Mental Health Crisis for National patient feedback survey for using the QR code to promote the survey	Sonia, Marcy, Ravneet Informatics
Benchmarks have been set per service line at 200% increase from baseline, this was done pre consultation and so may not be accurate	• Review the current benchmarks against the new Trust structure to determine if new benchmarks will need to be set and what those will be.	Sonia, Marcy, Ravneet, Nimisha

Integrated Quality and Performance Report — Month 4 – 24/25

Metric	Outcome Measures	SRO	Chris Abbott	Target		Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Problem Statement

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

Vision & Goals

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

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

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

Historical Performance

CGAS Trustwide Forms Completed per Month

GBM Trustwide Forms Completed per Month

CORE Trustwide Forms Completed per Month

Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Clinicians report the current OMs being used aren't clinically meaningful or helpful to their patients.	• Conduct a trust wide review of all the OMs being used across the organisations and specifically for the Under 5s and those with Learning Disabilities.	• Take a proposal to the wider stakeholder group for sign off and then to Clinician Service Delivery Board to agree which OMs are going to be completed as a minimum.	Rachel / Luke
	• Ensure OMs are more meaningful to patients/being available for patients to see their own outcomes, such as ensuring that OMs collected are pulled through into people's Care Plans	• Conduct a workshop with the smaller stakeholder group to understand what key changes can be made to Carenotes to make OM navigation easier and less overwhelming. For example, making OM mandatory in the assessment summary.	Neema
	• Create a suite of training resources for staff in how OMs affect the new NHSE waiting time metric and how OMs that are captured can be useful for the Trust and patients	• Set up a meeting with training stakeholders to understand who would be able to deliver elements of training for example, contracts to create a presentation on the new NHSE Waiting Time Standards.	Pia
There is currently no standard/centralized/automated way in which OMs are collected across the Trust	• Define a new centralized and digitized process for OM collection, that takes away administrative tasks from clinicians and their admin teams	• Understand how staff would be able to see returned OM scores if they were returned centrally by the Quality Team, for example, receiving an email or being able to see scores on Carenotes. • Luke to meet with the highest returning OM team to understand their process and what they find or would find more useful.	Luke
	• Review the logic for when OMs should be collected, ensuring consistency across all teams	• Hali to set up a meeting with wider stakeholders so we can obtain approval for the new centralised process and new logic for how outcome measures are collected	Rachel / Luke

9

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

Problem Statement

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

Vision & Goals

Vision: To consistently match or exceed the national average score

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

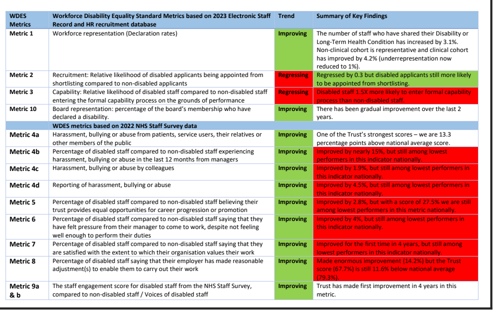
Historical Performance

2021 2022 2023

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

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

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



WDES Metrics	Workforce Disability Equality Standard Metrics based on 2023 Electronic Staff Record and HR recruitment database	Trend	Summary of Key Findings
Metric 1	Workforce representation (Declaration rates)	Improving	The number of staff who have shared their Disability or Long-Term Health Condition has increased by 3.1%. Non-clinical cohort is representative and clinical cohort has improved by 4.2% (underrepresentation now reduced to 1%).
Metric 2	Recruitment: Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants	Regressing	Regressed by 0.3 but disabled applicants still more likely to be appointed from shortlisting.
Metric 3	Capability: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance	Regressing	Disabled staff 1.5X more likely to enter formal capability process than non-disabled staff.
Metric 10	Board representation: percentage of the board's membership who have declared a disability.	Improving	There has been gradual improvement over the last 2 years.
	WDES metrics based on 2022 NHS Staff Survey data		
Metric 4a	Harassment, bullying or abuse from patients, service users, their relatives or other members of the public	Improving	One of the Trust's strongest scores – we are 13.3 percentage points above national average score.
Metric 4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from managers	Improving	Improved by nearly 15%, but still among lowest performers in this indicator nationally.
Metric 4c	Harassment, bullying or abuse by colleagues	Improving	Improved by 1.9%, but still among lowest performers in this indicator nationally.
Metric 4d	Reporting of harassment, bullying or abuse	Improving	Improved by 4.5%, but still among lowest performers in this indicator nationally.
Metric 5	Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion	Improving	Improved by 2.8%, but with a score of 27.5% we are still among lowest performers in this metric nationally.
Metric 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Improving	Improved by 4%, but still among lowest performers in this indicator nationally.
Metric 7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Improving	Improved for the first time in 4 years, but still among lowest performers in this indicator nationally.
Metric 8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	Improving	Made enormous improvement (14.2%) but the Trust score (67.7%) is still 11.6% below national average (79.3%).
Metric 9a & b	The staff engagement score for disabled staff from the NHS Staff Survey, compared to non-disabled staff / Voices of disabled staff	Improving	Trust has made first improvement in 4 years in this metric.

This WDES report paints a very mixed picture:

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

Root Cause/ Gap Analysis

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

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

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

Percentage of staff who believe their organisation provides equal opportunities for career progression or promotion
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
19/20
20/21
21/22
22/23
23/24
47.0%
45.5%
46.8%
49.7%
50.5%
45.8%
32.6%
31.4%
32.3%
38.2%
26.0%
16.5%
18.9%
26.1%
26.0%
White (T&P)
Other Ethnic Groups (T&P)
Other Ethnic Groups (National Av)

Progress on Improvements (subject to WRES / WDES refresh)

At the end of each of the WRES and WDES reports is an action plan: there are 6 actions for WDES and 5 for WRES. It was agreed at the EDI Programme Board on 19th June that the next meeting would be solely dedicated to reviewing the required action and prioritizing them to allow for a smaller number of meaningful actions to be implemented.
These will subsequently be updated here.

Integrated Quality and Performance Report

Month 4 – 24/25

Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

Problem Statement

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

Vision & Goals

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

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

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

Historical Performance

Key Performance Indicators	Trust Target	Feb-24	Mar-24	Apr-24	Trend (Against Previous Month)
Sickness Absence	3.07%	1.61%	1.34%	1.84%	↑
Turnover	2.20%	0.75%	8.32%	1.32%	↑
Vacancy	15.00%	13.06%	13.98%	11.98%	↓
Mandatory & Statutory Training Compliance	95.00%	75.68%	76.21%	77.08%	↑
Appraisal (Rolling 12 months)	95.00%	80.36%	30.77%	28.67%	↓

Turnover Performance Trend

9.00% 8.00% 7.00% 6.00% 5.00% 4.00% 3.00% 2.00% 1.00% 0.00%

May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24

1.32% 1.28%

Overall Voluntary

Workforce Race Equality

Directorate	White Headcount	Apr - 2024 BME Headcount	Not Stated Headcount	Total of Staff	Current BME
Trust	487	278	18	783	35.50%
Chief Clinical Operating Officer	259	150	9	418	35.89%
Chief Education and Training Officer	146	53	5	204	25.98%
Chief Executive Officer	19	9	0	28	32.14%
Chief Financial Officer	17	38	1	56	67.86%
Chief Medical Officer	23	10	1	34	29.41%
Chief Nursing Officer	12	3	0	15	20.00%
Chief People Officer	5	10	1	16	62.50%
Chief Strategy & Business Development	6	5	1	12	41.67%

Root Cause/ Gap Analysis

What would improve your experience

8 Key themes have been identified centering around communication; training and the culture of the organisation but also physical resources such as free milk, tea and coffee and cutlery in the staff kitchens.

Gap analysis:

- What are the next steps after MLDP?
- ALS / OD work
- QI, Data Mgmt., IQPR
- What does mgmt. training look like at CNWL?
- Community of practice / learning directed free / internal training, NHS Employers data training
- Re-survey people once one or two cohorts of admin development programme have been run
- CPD panels and promotion panels

Progress on Improvements

Week commencing 29 April:

- Monday 29 April, 1.30 to 2.30pm Staff Network Chairs' meeting
- Monday 29 April, Create Intranet survey
- Tuesday 30 April, 2 to 3pm, online via Zoom – Future Options session
- Thursday 2 May, 2 to 3 pm, Admin Forum

Week commencing 6 May:

- Toza lunch time event tbc
- Thursday 9 May, LGBTQI+ Staff Network

Week commencing 13 May:

- Monday 13 May, 11am, Staff Engagement Group
- Toza lunch time event tbc
- Tuesday 14 May, 12 to 1pm, Senior Leadership Forum
- Tuesday 14 May, 1 to 2pm, REN meeting
- Friday 17 May, 1 to 2pm, online via Zoom – Future Options session
- Friday 17 May – Publish a weekly update on the intranet giving an indication of emerging themes

Week commencing 20 May:

- Toza lunch time event tbc
- Wednesday 22 May, People Delivery Board
- Thursday 23 May, 11am to 12pm, online via Zoom – Future Options session
- Friday 24 May – Publish a weekly update on the intranet giving an indication of emerging themes

Week commencing 27 May:

- Tuesday 28 May, All-staff meeting
- Wednesday 29 May, 11am to 12pm, online via Zoom – Future Options session
- Toza lunch time event tbc
- Thursday 30 May, 2pm JSCC
- Friday 31 May – Publish a weekly update on the intranet giving an indication of emerging themes
- Collate all evidence gathered and produce summary report for ELT

Initial action plan to create and launch VMV piece completed. ISE initial action plan now met: 9 facilitated online sessions including sessions at all staff networks; Online survey ran for 6 weeks with 52 responses from staff; Feedback box in Toza Café. **New action plan to be created.**

Metric	Merger	SRO	Rod Booth	Target	

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

Problem Statement

There is a risk of failure to identify a potential merger partner /organisation leading to a potential dissolution or break up of the Trust.

This is quantified by having one potential partner in the bid and inability to proceed to the next stage in due diligence until initial hurdle criteria is completed.

The impact is multifaceted. It would mean the merger does not proceed leading to unsustainability of some services and transfer to other providers; inability to improve quality leading to patient safety concerns, poor patient experience and regulatory concerns; inability to improve the Trust's financial position and deliver CIP targets; worsening reputation; increased regulatory intervention; unsustainable services and loss of services to local provision.

Vision & Goals

The overall vision is to merge with a preferred partner by June 2025.

Success will be measured by completion of the merger transaction with the preferred partner and Go Live by the agreed date.

Current Situation

(10 July 2024 update)

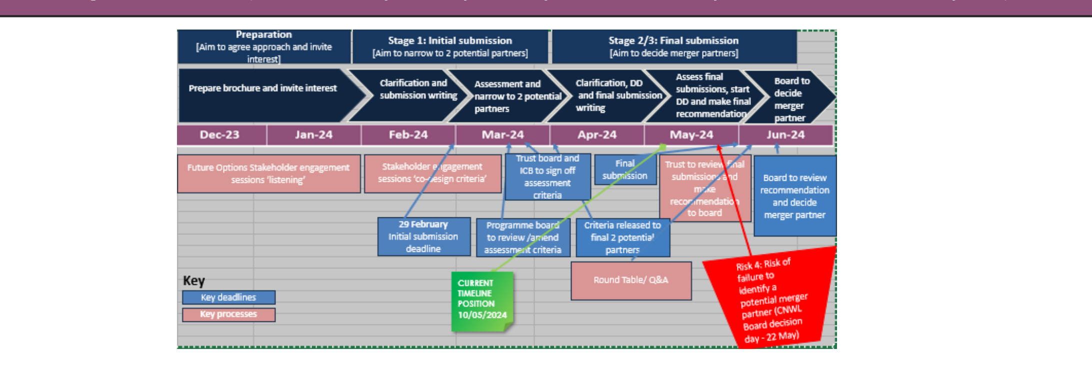
The Trust is working closely with CNWL, NCL ICB and NHSE on four items requiring mitigation before further work on the Strategic Case is progressed. These areas are (i) Financial; (ii) System Support for the transaction; (iii) NCL CAMHS; and (iv) Estates ownership and impact of transaction.

Staff continue to be engaged in the merger process during all phases to ensure positive staff morale and consensus is sustained throughout the process. The initial outcome of staff engagement formed part of the assessment criteria following receipt of the Expressions of Interest from potential partners.

There are 4 remaining items to resolve before further work on the Strategic Case / FBC is progressed:

1) NCL ICB support for the transaction – NCL ICB has advised that they will be writing to the bidder to confirm that they support the proposal. 2) NCL CAMHS – the ICB reserves the right (as with any other service they commission) to carry out a strategic clinical evidenced based review of CAMHS provision across the ICB. A potential consequence of such a review may be a recommissioning process. Potential timescales (of the review and recommissioning) would support transaction planning and stabilising the workforce. All are fully committed to core offer and to best outcomes for residents of Camden. 3) Finances - meeting scheduled with regional CFO to cover a.Plans to close the recurrent underlying deficit, and any potential impact of transfer between ICBs; b.Transaction support costs eg PMO, Clinical back fill; and c.NR transaction costs e.g. potential redundancy costs. 4) Estates ownership and impact on transaction.

Overall Programme Timeline (this is an example from previous phase and will be updated for the Transaction phase)



Countermeasures

Concern	Countermeasure in progress	Owner
Risk of delays in completing the merger transaction within the agreed programme timeline (Strategic Case by end September 2024)	- Delays in completing the hurdle criteria (initial due diligence) - Compounded by capacity of the NHSE Transactions Team due to the Pre-Election period.	1. NCL ICB support for the transaction. 2. Underlying deficit work to close gap /Finance hurdle - Building the bridge. 3. Clarity on NCL commissioned services. 4. Clarity around Transaction costs; Assets and Estates.
Risk the Trust fails to merge with an organisation with which the Trust shares similar values and culture, and with whom there would be synergies in terms of service provision, training, education and research, which would be an existential risk to the future of the Trust.	Choices we make around a preferred merger partner (this includes process followed for selection of a preferred partner)	1. Robust criteria for evaluating potential merger partners, including cultural compatibility, financial stability, and operational efficiency. 2. Merger transaction process in place. 3. Agreed merger process with NCL ICB and NHSE. 4. Robust ICB Stop/Go criteria

Watch Metrics Score Card

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

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

Watch Metrics Score Card

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

CQC Measure	Metric	Target	Comments	Trend from previous month	Mean	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Are we safe?	Patient safety incidents (actual or potential harm)	N/A		↑	10.70	12	18	12	10	9	8	10	4	11	13
	Open SI / PSI investigations	TBC		↔	2.90	3	3	3	3	3	3	2	3	3	3
	Violence & aggression incidents	<5		↑	7.00	8	9	11	6	6	4	8	2	7	9
	Restraint incidents	0		↑	2.86	1	1	0	0	0	1	4	5	6	12
Are we effective?	52-week+ dormant cases	0		↑	2041	2473	2380	2350	2366	2266	2185	2126	2080	1922	2034
	No of referrals (including rejections)	919		↓	786	828	914	977	646	919	975	765	728	648	456
	No. of attendances	7046		↓	6685	6221	6485	7851	5067	6922	6927	6525	6302	7366	7190
	No. of discharges	919		↓	647.90	553	493	680	376	1024	965	949	701	405	333
	% of Trust led cancellations	<5%		↓	4.24%	3.75%	5.04%	3.20%	5.71%	4.44%	4.06%	3.36%	4.48%	4.22%	4.12%
	% of DNA	<10%		↑	9.52%	9.47%	9.44%	9.00%	9.50%	9.47%	9.08%	9.15%	10.39%	9.62%	10.04%
Are we caring?	Number of formal Complaints received	<10		↑	4.90	7	5	7	3	5	5	2	2	6	7
	Number of compliments received			↓	117.25							81	61	203	124

Watch Metrics Score Card

CQC Measure	Metric	Target	Comments	Trend from previous month	Mean	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Are we caring?	Number of informal (local resolution) complaints	TBC		↓	1.90	0	4	1	1	0	0	4	7	2	0
	ESQ positive responses (%)	90%		↓	86.1%	90%	90%	93%	77%	87%	91%	82%	84%	88%	79%
Are we responsive?	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS/FirstStep	0		↓	39.10	56	58	51	54	53	38	20	26	20	15
	18-week RTT breaches Autism Assessment (1st appointment)	0		↑	78.30	30	40	50	67	77	90	98	107	111	113
	18-week RTT breaches GIC (1st appointment)	0		↑	13617.30	12792	13061	13174	13429	13298	13458	13814	14053	14365	14729
	18-week RTT breaches Trauma (1st appointment)	0		↑	583.80	426	449	480	517	558	607	640	689	720	752
	18-week RTT breaches PCPCS (1st appointment)	0		↑	98.20	61	48	46	70	71	80	114	150	161	181
Are we well-led?	Mand and stat training	95%		↑	73.1%	56.3%	55.7%	75.8%	76.9%	78.0%	75.7%	76.2%	77.1%	79.0%	80.1%
	Appraisal completion	95%		↑	60.0%	79.7%	78.9%	79.6%	81.5%	80.7%	80.4%	30.8%	28.7%	23.2%	36.3%
	Staff sickness	3.07%		↑	2.16%	2.39%	2.23%	3.98%	3.17%	1.45%	1.61%	1.34%	1.84%	1.79%	1.82%
	Staff turnover	2.20%		↓	2.0%	1.9%	0.6%	1.1%	1.5%	2.5%	0.8%	8.3%	1.3%	1.9%	0.7%
	Vacancy rate (On Hold)	15%		↑	10.58%	15.41%	12.35%	12.46%	-12.90%	12.60%	13.06%	13.98%	11.98%	13.16%	13.74%

Delivering our vision – How are we doing?

Safe – People are protected from abuse and avoidable harm

The Trust reported 13 Patient Safety Incidents in June Patient safety incidents are recorded where there was actual or potential harm. The Trust's new incident reporting system, Radar, went live on 3rd June 2024, it is positive to note that there has not been a reduction in reporting since transitioning to the new system. Radar enables the automatic upload of all patient safety incidents to the Learning from Patient Safety Events (LFPSE) portal, a key objective in the implementation of PSIRF. The Patient Safety Team lead a daily huddle to review all incidents reported in the previous 24 hours and identify incidents where further review is needed. The team are in the process of trialling an approach to thematic reviews, in line with the implementation of PSIRF. These are planned for violence and aggression and information governance incidents in the first instance.	**Patient safety Incidents** 13
The Trust reported 9 incidents of Violence & Aggression incidents in June The number is higher than the target metric with the majority of these reported by Gloucester House team. The Patient Safety team has worked with the school to streamline how and where incidents are reported to capture this on Radar. The school also records a number of 'lower level' incidents of violence and aggression in paper format and this will move to Radar which may result in a higher number of incidents in the future. The patient Safety team are in the process of carrying out a thematic review of violence and aggression in the school.	**V&A Incidents** **9**
The Trust reported 12 physical restraint Incidents in June All restraints reported occurred in Gloucester House School. This is an increase on the number of restraints recorded for the previous month and is a result of work carried out with the school to move to the electronic recording of restraints on via the new Radar system, enabling ease of robust, transparent recording and reporting.	**Restraint Incidents** **12**

Delivering our vision – How are we doing?

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

The Trust recorded 7 Formal Complaints in June The Trust continues to focus on investigating and responding to all overdue complaints and have reduced the number to 16 complaints overdue, with clear timeframes for responding to all 16. In total there are 25 complaints open, 9 of which are within the timeframe for response. The Trust has moved to a new investigation template which is shared with the complainant along with a response letter, this provides transparency around the investigation.	**Formal complaints 7**
The Trust has recorded 124 Compliments in June The number of compliments received continues to exceed the number of concerns or complaints received. Recording and reporting of compliments is currently under review for improvement and to ensure the logic used is accurate. This sits as part of the A3 quality improvement project focused on User Experience. The event module for Compliments in the new Radar system is now live, this will enable a strengthened reporting framework as all compliments received will be categorised. The next step is to ensure that compliments are consistently shared with teams and used for learning in the same way as complaints are.	**Compliments 124**
The Trust has recorded 79% of ESQ Positive Responses in June There is an A3 QI plan in place to increase the amount of feedback that the Trust receives, to increase the positive responses and implement a system for using the feedback to improve services. There has been a sustained increase in the numbers of feedback the Trust receives achieving the quarter 1 target, Work is currently underway to provide a number of ways in which service users and carers can provide feedback, including through QR codes with the aim of making it easier to provide feedback..	**Positive responses 79%**

Delivering our vision – How are we doing?

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

The Trust declared 36.3% of Appraisal Completion in June 2024 Further to the recent change in the Trust appraisal cycle, the people team continue to work with senior leaders to improve on the Trust appraisal position. Whilst there have been some improvement in comparison to the previous month, we remain further away from the Trust target. There was a slight delay to the recording of appraisals m due to a central issue with ESR. This was resolved on the 27th June.	 **% Appraisal completion 36.3**
The Trust declared 1.82% of Staff Sickness in June 2024 The number of reported health-related absence cases has fallen for the fourth month in a row. The business partnering team continues to support managers to expedite staff's return to work from sickness absence in line with the policy. The people team continues to deliver sickness absence training sessions to managers in line with the support health and well-being policy. These sessions are now opened to all staff, and we will be providing new dates shortly.	 **% Staff sickness 1.82**
The Trust declared 80.1 % of MAST Completion Managers have been advised to book MAST dates into diaries to ensure staff have the 'protected' time to complete their MAST modules. The people team are also escalating non-compliance through the appropriate channels for urgent action. There has been some improvement from the previous month's compliance of 77.08%. However, a further drive is required to attain the expected compliance level of 95%.	 **MAST training (%) 80.1**

Service Line Overviews

Education & Training

Successes	Challenges
• A more standardised approach to the student recruitment and admissions cycle, including firm application deadlines for the 2024/25 cycle and an earlier recruitment opening for 25/26 (October) in line with the sector and to increase the number of expected applications.	• Whilst we have seen an increase in the number of applications from international students, we are at a disadvantaged when compared with our competitors in converting applications to acceptances owing (e.g. unable to offer student accommodation).
• 16.7% increase applications compared to the same point last year in an increasingly challenging environment for HE student recruitment	• Student support: Lack of flexibility in SITS (student monitoring system) to support a more flexible/modular form of delivery as well as ensuring data integrity; lack of staff knowledge and training in SITS operation
• Introduction of a dedicated Project Management Officer within DET through the redeployment of experienced project management staff from NWSDU.	• To meet the increasing demands placed on the Trust – regulatory; statutory data returns; institutional conditions imposed by University partners; and the need to deliver a high student experience with increasing numbers – we require all posts in Professional Services approved at ELT and FIRM (January 2024) to be recruited well in advance of the start of the 2024/25 academic year.
• The Institutional Review Panel recommended that the Trust be re-approved as a partner institution of the University of Essex for a further five years, following the recent Institutional Review.	• Our clinical psychoanalytic psychotherapy training (M1) has recruited very poorly this year and needs to be repositioned.

Student Recruitment Activity Overview

Summary

Application Cycle: Current Cycle

The selected application cyle is: 2024/25 This application cycle starts on 12/1/2023 and ends 11/30/2024. We use Year To Date calculation, so we can directly compare this years applications numbers with this time last year.

Complete Applications 2024/25	Conditional offers	Unconditional Offers	Unconditional Firm	Incomplete 2024/25
1022 Previous Year: 876 (+16.67%)	153 Previous Year: 136 (+12.5%)	367 Previous Year: 243 (+51.03%)	229 Previous Year: 189 (+21.16%)	1337 Previous Year: 1161 (+15.16%)

Click here to see the decomposition of these applications

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

Complete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle
December	24	-17.2% ▼	29
January	135	-1.5% ▼	137
February	146	19.7% ▲	122
March	108	35.0% ▲	80
April	116	56.8% ▲	74
May	110	0.9% ▲	109
June	221	57.9% ▲	140
July	162	-12.4% ▼	185
Total	**1022**	**16.7%**	**876**

Total Applications by Portfolio

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

Incomplete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle Incompletes
December	108	-16.9% ▼	130
January	173	-1.1% ▼	175
February	189	85.3% ▲	102
March	258	92.5% ▲	134
April	180	78.2% ▲	101
May	169	15.0% ▲	147
June	130	-18.8% ▼	160
July	130	-38.7% ▼	212
Total	**1337**	**15.2%**	**1161**

Version: V2.5 (December Cycle) Current Date: 7/30/2024 Last Refresh: 7/30/2024 9:23:31 AM

Analysis

Student recruitment: Postgraduate recruitment cycle is now almost complete: 1022 applications were received via MyTAP, an increase of 16.7%. This figure does not include the 367 applications received via a separate portal for our M4 training in educational psychology, or the 12 applications submitted to our Executive Coaching Programme via our website. 1,337 incomplete applications are in progress.

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

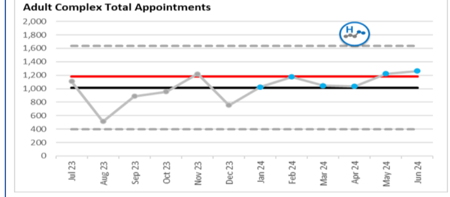
Staffing: Current Professional Services staffing, and structures fail to meet operational needs or support growth ambitions. Teams face single points of failure, posing risks to operations, finances, and Trust reputation. Academic Registry has approved 7.0 WTE new positions to meet statutory and university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

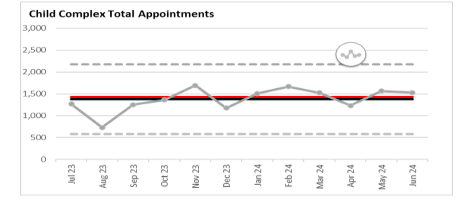
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move to a Senior Lecturer/Lecturer/ Associate Lecturer model; consultation with affected staff.	CETO / Directors of Education	October 2024
Regulatory changes (OfS)	Office for Students'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

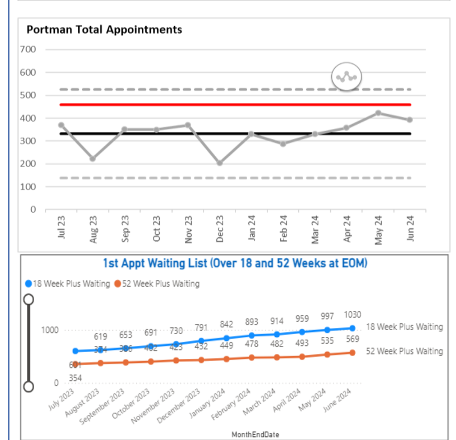
Complex Mental Health Overview

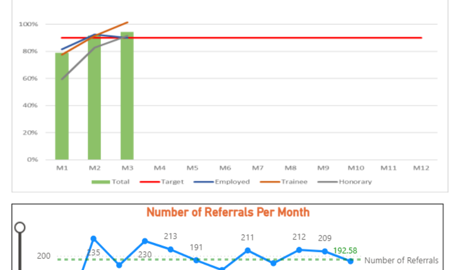
	Successes	Challenges
Safe		• Appraisal rates at <40% for third month in a row despite 22% increase Line managers reporting many have been undertaken but documents still being finalized before being submitted. Issue with consultant staff not being updated. Working with managers with backlogs to book meetings and submit forms.
Effective	• **Activity above plan in Adult and Child Complex for 2nd month in a row, with job plan compliance being above 90% in the same periods.** • 2nd highest ever completion of CORE forms in June following focus on distribution at reception and via Qualtrics	• Completion of CGAS and GBM back in line with 12-month average following peaks in March & April. Further work on clinician engagement required.
Caring	• User experience of the services remains high with an average 84% positive ESQ score over the past 12 months. Significant increase in volume of forms being collected with CMH now collecting 50+% of trust total each month. • Continued progress on reducing number of outstanding complaints with 3 being closed in June, leaving 15 open. Weekly meeting with service leads and complaints team in place since May helping keep up momentum.	• Need to switch focus on ESQ to identifying learning and establishing actions plans, that are visible to patients
Responsive	• 90% reduction in patients waiting over 18 weeks for 1st appt in Adult Psychotherapy since November following QI into booking process, with average waits in June being 11 weeks. • Child Complex & Portman average waits to 1st appointment continue to be low at 4 & 6 weeks respectively.	• 18w breaches continue to grow and are now at 878 with Trauma at 752. Further investment is required & request will be made to temporarily close waiting list for Trauma and Autism (Herts only)
Well Led	• Improvements in job plan compliance, management of complaints and outcome measures	• CMH supervision reported compliance remains low with clinical supervision at 44% .Team manager compliance with returning data on time has been an issue. We anticipate increased compliance when operational managers take this on post leadership review

Activity Overview









Number of Referrals Per Month

Analysis

Activity - Child Complex activity in June was above target for the 6th time in the past 8 months. Adult Complex was also above plan for the second month in a row. Portman activity has increased in M2 & M3 but is still below target. Each team manager has been sent individual level data and will review and address areas of concerns via line management 1:1s.

Job plan compliance for CMH was at 94% in June and is 89% year to date. This slight underperformance was largely driven by honorary staff but does vary from team to team. All underperformances are being reviewed to identify the route cause(s) and an action plans are created where required.

Referrals for Q1 continue to be high. Rejection rates in Portman and AYAS to be audited in June/July.

Waiting times – 1st appt waiting times across CMH remain low for most teams with child complex at 4 weeks, Adult Psychotherapy at 11 weeks and Portman being 6 weeks. However, waits for Trauma and Autism assessments continue to grow because of the significant increase in demand. Autism Kaizen event was undertaken in May and several key improvement initiatives agreed to improve the efficiency of the assessment process (detail in appendix).

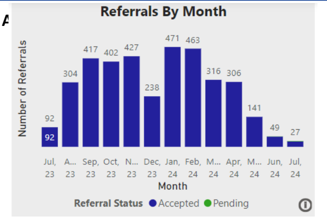
Attendance rates have remained stable for the past 12 months and was 74% in June. The DNA rate was 7.6%, Patient Cancellation rate was 13.2% and the Trust cancellation rate was 3.6%.

Next Steps

Concern	Cause	Countermeasure
Waiting list growth in Autism and Trauma	Significant increases to demand	Kaizen and A3 review of services. Commissioner engagement
Job plan performance (trainee and honorary)	To be identified in June/July	To be identified in June/July

GIC

	Successes	Challenges
Safe	• The service is expanding the endocrinology service, Endocrine is one of GIC's most time critical services and means a wider team can respond to more questions. A significant number of enquiries are related to hormone treatent.	○ Some services (SLT and CP) have very limited staff due to a combination of sickness and staff leaving, this will impact service delivery and increase internal wait times.
Effective	• The DNA policy has been enacted and there is a significant increase of service discharges	○ Transfers to pilot clinics are a challenge as it is unclear which patients should be transferred. We are also receiving patients sent back after they have been transferred due to pilot clinics identifying complexities
Caring	• The service successfully tested the broadcast messaging function on the digital platform with live patients.	○ Trust led cancellations have increased by approx. 5% in the last month
Responsive	• The service are resolving complaints more efficiently by calling and speaking with patients directly.	○ The number of referrals continues to increase, this is less visable because of the backlog in uploading, which will be fully recovered by september
Well Led	• The staff wellbeing QI project is making progress and there appears to be positive staff engagement to the planned Birthday Club	○ It has been difficult to see where clinical staff are in their training to ensure activity is planned efficiently. A training manual is being developed with a clear sign-off mechanism

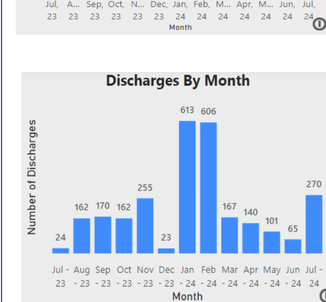


The service have experienced delays in recording referrals this is due to several factors which the service has developed some actions to help reduce an increasing backlog;

- The service has reviewed the GIC referral forms to decrease mandatory fields which go above the NHS minimum dataset.
- There are August start dates for 2 vacancies currently occupied by bank staff to help record the referrals quicker.
- Sickness has reduced amongst the team, and we should see an increase of referrals being recorded
- The system has been unavailable for serval hours which can cause further delays

Number of 1st Attended Appointments By Month

Number of 1st assessments continue to increase month on month. There will be a job plan analysis which will include the number of job planned 1st assessments to ensure delivery for patients on the waiting list. 25% of clinician activity will be targeted towards first assessment.



There are low reported numbers of discharges for June however in month data shows a significant increase in discharges, this is attributed to discharges post appointment (DNA discharge policy) being actioned in the PTL meetings as a byproduct which further decreases the dormant caseload

Analysis

Activity

The activity levels have decreased in the last month. The focus for the service has been to complete and implement job plans to line of sight of activity. A Job plan analysis tool has been developed to measure compliance and will be included in future IQPR reporting. Administrative activity has also declined in the last month due to inadequate performance and sickness; the service is working with the people team to ensure staff are supported with improvement plans and that we are complaint with current policies.

Waiting list

The service are in train to validate the GIC waiting list. There will be some communication sent out to all patients using the digital platform asking if they wish to remain on our waiting list and hope to reduce the waiting to by 10%.

Recruitment

Workforce planning meetings have also taken place with the people team due to the high vacancy rate int the GIC reported at 15.57%. The service are looking at more flexible ways of recruiting into clinical roles and reviewing the current establishment to better reflect service needs.

CX Clinic

The CX clinic will impact patients at their 1st appointment and therefor directly impact the waiting list. The service is developing a new **scre**ening pathway contacting patients 6 months before their first appointment to gather more up to date personal information about where they are in their transition. This will streamline patients into pathways which will enable non-complex patients to be seen quicker along the pathway.

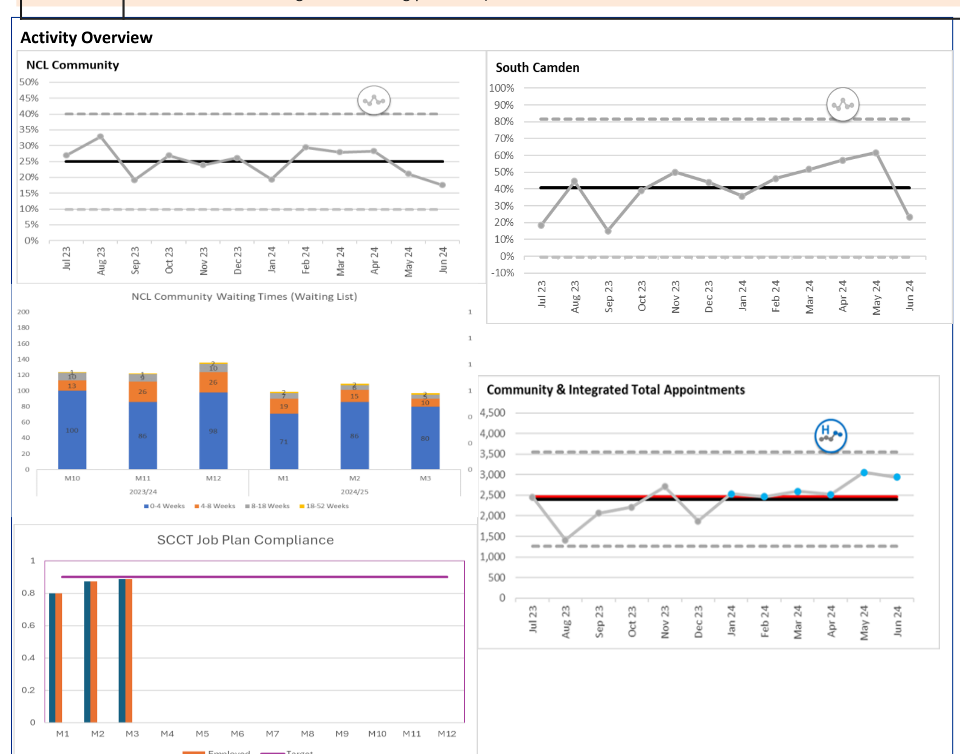
Next Steps

Concern	Cause	Countermeasure
Recruitment challenges	Leavers/skill mix	Enact agreed workforce plan for each service line
Transfers to pilot clinics	Delays in receiving data	Regular meeting with Pilot service to gage timeframes clear on NHSE directives
State minimum expected 1st assessments		Activity tracking through job plans
Delayed turnaround times for letters	Resources	Recruit to full establishment and investigate performance management across teams particularly in critical services

Community and Integrated Services

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

Activity Overview



Analysis

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

PCPCS continues to show high levels of wait times, a reduction in referrals and recruitment challenges for vacant posts. Detailed negotiations have been taking place with commissioners to re-define the clinical model.

The total number of **appointments** has shown an increase across the service line and is above target. There is ongoing work to improving pathways and allocation processes.

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

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

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

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

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

Next Steps

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

Contracts, Finance and Business Development

Delivering our vision – How are we doing?

Effective use of resources

The Trust declared £564k deficit YTD planned position for month 3, with a year end forecast deficit of £2,200k.	**24/25 YTD planned position £564k deficit**
The Trust declared £404k deficit YTD actual position for month 3, a positive variance of £160k against plan. This was due to the timing of some high value payments, and is not a trend expected to continue. The Trust still anticipates delivering its planned year end deficit. .	**24/25 YTD actual position £404k deficit**

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

Committee:	Meeting Date	Chair	Report Author	Quorate	
Quality & Safety Committee	22nd August 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	X Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

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

Key headline	Assurance rating
1. Patient Safety Incident Response Framework (PSIRF) Policy Following approval of the first iteration of the Trust's Patient Safety Incident Response Plan (PSIRP) a significant amount of work has commenced and progress made which focuses on the quality of the embedding of PSIRF. Based on what was learnt through implementation, the Trusts' Patient Safety Incident Response Plan (PSIRP) had been revised and approved by the Committee in June 2024. The PSIRF policy has now been developed to ensure it is in line with the PSIRP and that roles and responsibilities are correct as per current structures and processes. It sets out how the Trust approaches the development and maintenance of effective systems and processes for responding to patient safety incidents, system learning and improving patient safety. The revised policy has been provided to the PSIRF Transition Group for comments which have been incorporated into the final iteration presented to the Committee. The Committee approved the Patient Safety Incident Response Framework (PSIRF) Policy	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. GIC Targeted Support The Committee noted the update provided about the Gender Identity Clinic (GIC) being placed under internal targeted support. This follows six consecutive months of concern identified in a number of areas through the Integrated Quality and Performance (IQPR) meetings. A clear set of improvement metrics, and subsequent exit criteria from targeted support, has been issued to the service to focus on.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

The Trust has not previously had a robust accountability framework. Work has progressed at pace through the development of the IQPR and there is now progression to the next stage of identifying the indicators that would inform a decision about placing a service into targeted or mandated support. GIC is the first service to be placed in targeted support and learning will be taken from this to further refine the framework.	
3. Care Notes Incident Assurance Report The Committee reviewed the assurance report on the actions taken following the Carenotes incident reported in February 2024. In summary, in February 2024, the leadership team in Child Complex and Community and Integrated were made aware of an error on Carenotes whereby not all the intended information in Care Plan letters had pulled through, with the consequence that clinical information was potentially missing in correspondence with GPs and families. The Committee noted the updates received in relation to the governance processes to evaluate and address the incident, the review of clinical records affected, the assessment on any potential and actual harm and the confirmation around Duty of Candour requirements. The Committee were assured by the thoroughness of the investigative review and the collaboration between operational and corporate teams An after action review of the incident and the resultant process will take place.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. BAF The Committee reviewed the analysis of the actions taken to address the identified risks. A focused analysis of Risk 2 *(Failure to Provide Consistent High-Quality Care*) was undertaken at the meeting. For Risk 2, the focus has been on improving staffing structures, job planning, and implementing quality assurance tools to maintain high standards of care. For Risk 1, key updates included the implementation of weekly PTL meetings, QI huddles, and enhanced clinical pathway mapping to improve patient access. The Committee agreed that Risk 1 *(Inequality of Access for Patients)* should be further reviewed to ensure that it identifies and clearly defines the key elements of the risk. There was an additional action to consider whether the Trust's mortality risk should be further outlined, in particular the risk held whilst waiting for first appointments.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Safeguarding reports The Committee reviewed the Annual 23/24 and Quarter 1 24/25 Safeguarding Adults and Safeguarding Children reports. It was noted that work has continued to reduce areas for improvement identified in the internal safeguarding audit review.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Summary of Decisions made by the Committee:	
• The Committee APPROVED the Patient Safety Incident Response Framework (PSIRF) Policy	

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 – 12th September 2024			
Report Title: Research and Development Annual Report			**Agenda No.:11**
Report Author and Job Title:	Dr Eilis Kennedy, Director of R&D	**Lead Executive Director:**	Dr Chris Abbott, Chief Medical Officer
Appendices:	Appendix 1: References Appendix 2: Recruitment to Studies		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	An annual update on Trust R&D		
Background:	This report provides an update on Trust research over the last year.		
Assessment:	The Trust continues to be actively engaged in a range of research activities.		
Key recommendation(s):	• To focus on how future research capability and capacity can be ensured • To build on current work in relation to developing academic partnerships • To explore ways of increasing investment in research including from charitable sources and NIHR infrastructure funding. • To consider how the research environment can be further enhanced for staff, students and service users.		

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 ☐		
Legal and Regulatory Implicationsds	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				

Resource Implications:	Yes ☒	No ☐		
	There are potential resource implications in relation to future investment in research capability and capacity.			
Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☒	No ☐		
	1. To ensure adherence to best practice EDI guidance in relation to recruitment of patients to research studies. Reporting on this is a requirement of most funders. 2. To recognise barriers to participation in research and to ensure this is taken into account in relation to recruitment of researchers employed on studies, career progression and access to opportunities for research skills development for Trust staff and students. 3. To ensure that the research team is aware of Trust EDI guidance and also the EDI strategies of the three major funders of Mental Health Research 1. NIHR Equality, Diversity and Inclusion Strategy 2022-2027 | NIHR) 2. UKRI Equality, diversity and inclusion (EDI) – UKRI 3. Wellcome Diversity and inclusion | Wellcome 4. Ongoing participation in EDI initiatives in relation to Mental Health research, via links with Noclor, as a Noclor partner Trust.			
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:	Trust R&D group 09/01/24			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

11. Annual RD Report final corrected version 030924

Report Title: Same title as on the cover report
Research and Development Annual Report

1. Purpose of the report

1.1. To provide an annual update on Trust Research

2. Background

2.1. This report provides an update on Trust Research over the last year.

3. Intervention Research

3.1 The Trust is fortunate in having been awarded two significant grants to investigate interventions focused on improving and promoting mental health and wellbeing in children and young people. These two intervention studies are undertaken in collaboration with University College London and the Clinical Trials Unit at Cardiff University. The first study, the '*Watch Me Play! Pilot Feasibility Study of a Remotely-delivered Intervention to Promote Mental Health Resilience across UK Early Years and Children's Services*' was funded by What Works for Children's Social Care as part of a themed call on children and young people's mental health. This study has recruited from a number of sites across the UK (London, the Midlands, Norfolk, the North of England and Scotland). The Watch Me Play! intervention was first developed in the Tavistock Haringey First Step Service for children in care and has been manualised and translated into many different languages as well as being taken up and used by an increasing number of services nationally and internationally (e.g. Japan, Italy, Ukraine, Estonia, Norway, Greece and South Africa). The study protocol has recently been published in the Journal Pilot Feasibility Studies (Randell et al., 2024). The findings of the study are being written up in preparation for submission to a Journal and the study report is currently undergoing peer review with the funder prior to being disseminated on the funder's website.

3.2 The second of these studies, '*A feasibility trial of remotely delivered Video Interaction Guidance (VIG) for families of children with a learning disability referred to specialist mental health services'* is funded by the National Institute for Health and Care Research, Research for Patient Benefit programme and has recruited from a range of sites across England (including Alder Hey Children's, Guy's and St Thomas's and Lancashire and South Cumbria, NHS Foundation Trusts). Video Interaction Guidance

is increasingly used by practitioners within the NHS and this is one of only a few studies to evaluate VIG within children's specialist mental health services. The study has successfully met its recruitment target with the anticipated number of participants randomised. Data collection for 3- and 6-month follow-ups is currently underway as is a qualitative process evaluation, interviewing both parents and clinicians. A number of papers relating to the study are currently under review with Journals. Findings from the study were presented at the annual AVIG UK conference in June 2024.

3.3 The final stage of the Trust's National Institute for Health and Care Research, Programme Grant for Applied Research, the *'Personalised Programmes for Children'* study is also ongoing. Families in child and adolescent mental health services across North and South London are being recruited to a Randomised Controlled Trial undertaken in collaboration with the Clinical Trials Unit at Kings College London. The study has faced significant challenges in recruiting families, but the team is working hard to boost recruitment including advertising through social media, education publications, clinic waiting rooms and schools. The study is evaluating a newly developed personalised intervention for children aged 4 to 9 years with conduct and oppositional problems who have not been helped by parent training groups or whose parents have declined to participate in groups. The novel personalised approach, developed by the study team, is being compared to facilitated parent-led education with sign-posting to on-line resources and other materials. Both arms of the study are highly innovative and build on feedback from parents. A non-technical summary of the research assessment is shared with parents. This is an important quality improvement opportunity across North Central London ICS addressing a neglected group of children. It is also a training and education opportunity by informing clinical staff in CAMHS about precision mental health approaches to enhance treatment outcomes. The PPC study has been awarded generous funding in NHS excess treatment costs enabling the development of this new specialist treatment pathway. The study was presented at the Pan London Child and Adolescent Psychiatry conference on 03.07.24.

3.4 The Trust continues to engage in important research collaborations and has been closely involved in a National Institute for Health and Care Research, Health Technology Assessment funded study, *'Mentalisation for Offending Adult Males'* (MOAM). This study led by Professor Peter Fonagy at UCL evaluates the effectiveness of Mentalisation Based Treatment (MBT) for individuals currently under the supervision of the National Probation service. The trial started in January 2016 and is the largest

RCT to date for people with ASPD involving 13 sites across England and Wales. The primary aim is a reduction in violence; secondary aims are to improve health outcomes, reduce service use and evaluate cost effectiveness. Jessica Yakeley at the Portman led the development and delivery of the clinical services in which the trial took place as well as providing supervision to 4 of the research sites. Recruitment was completed in 2018 but there were delays due to Covid in data collection. However, this is now complete, the data has been analysed and the results will be known soon

3.5 In addition to undertaking primary research the Trust has made important contributions to evidence reviews. Notable recent examples of this include a Cochrane Systematic Review of personalised interventions for children with conduct problems which was recently published in the Journal of Forensic Psychology and Psychiatry as well as in the Cochrane Database of Systematic Reviews (Lane et al., 2023; Skinner et al., 2024) and work on an updated review of the evidence for child psychotherapy (led by Professor Nick Midgley at UCL) which was cited in a recent *Lancet Psychiatry* article regarding WHO guidance on evidence-based psychotherapy (Leichsenring et al. 2024).

4. Research on Health and Wellbeing across the Life-course

4.1. The Trust leads on the National Institute for Health and Care Research funded LOGIC study (Longitudinal Outcomes of Gender Identity in Children). This study is one of the largest internationally and involves collaboration between two NHS Trusts and three Universities (UCL, Cambridge and Liverpool). The study is included in the ESRC funded Mental Health Catalogue of UK cohort studies and includes a qualitative companion study LOGIC-Q. The study has an active and engaged PPI advisory group involving children, young people and their families participating in the study. This group provides very helpful guidance on study processes and procedures and interpretation of study findings. Key findings from the study have been written up and a number of papers are currently under review with Journals. Findings from the study were presented at the National Children and Young People's Gender Dysphoria Research Oversight Board on 17.01.24 and at the Pan London Child and Adolescent Psychiatry Conference on 3.07.24. It has been a very challenging time for families participating in the study and the research team are immensely grateful for their ongoing commitment and contribution.

4.2. The Economic and Social Research Council have awarded funding to undertake a study focused on Autism and Gender Incongruence. This study, the 'MAGIC' study

(Markers of Autism and Gender Incongruence in Children: Cognition in Autistic and Non-Autistic Gender Incongruent Children and their Families) is led by Professor David Williams at the University of Kent, with postdoctoral researchers funded by the study based at the Kent Child Development Unit (KCDU; Dr Aimilia Kallitsounaki) and at the Tavistock (Dr Matt Fysh). Recruitment to this study is on schedule and findings from the study are in preparation for publication.

4.3. The Trust has collaborated on work focused on the impact of poverty on child development and specifically the relationship between poverty, child abuse and neglect. A number of papers linked with this work have been published or submitted to Journals (e.g. Skinner et al., 2023). An evaluation of the Camden Adolescent Intensive Support Service (CAISS) service has also been undertaken this year with findings from the evaluation submitted for publication. The Trust was a collaborator on *Waiting Times*, a six-year (Sept 2017 to July 2023) multi-stranded inter-disciplinary project about the temporalities of healthcare, funded by the Wellcome Trust and led by Birkbeck College, University of London and the University of Exeter - see https://waitingtimes.exeter.ac.uk/. While the study has now concluded outputs from the study include an Essay in the *Lancet* (Salisbury et al., 2023).

5. Research governance and support:

5.1 The Trust along with many Mental Health Trusts in North London is a Noclor partner Trust and has a service level agreement with Noclor. Noclor provide an important research support service for the Trust, in particular ensuring that the necessary regulatory compliance and governance checks for research are undertaken. Noclor offer advice and guidance for Trust staff and students alongside a small support team based at the Trust. In addition, Noclor provide regular research Training (Training & Events | Noclor).

5.2 Research training and development opportunities for staff and students are also provided locally by UCL Partners and the NIHR, Applied Research Collaboration (ARC), North Thames. The NIHR, Incubator for Mental Health Research is another important source of advice and guidance regarding career development and funding opportunities for health care professionals interested in mental health research. The Trust has been actively collaborating on the NIHR ARC North Thames Research Champion initiative which is focused on engaging clinicians and non-research staff in

research. The objective is to foster a culture of research involvement and participation across various disciplines within participating NHS Trusts. The focus is on encouraging staff members to participate in research activities as well as introducing roles such as that of Principal Investigator or Associate Principal Investigator. The overall aim is to enhance the integration of research into clinical practice and promote evidence-based approaches to patient care.

6. Research funding

5.1. The Trust has been particularly successful in securing competitive external grant funding for research over recent years. In recognition of this the Trust's annual Research Capability Funding, awarded each year in proportion to NIHR grant income in the previous year, compares favourably to many other much larger Mental Health and Acute Hospital Trusts, locally and nationally. The Trust has maintained this high level of Research Capability Funding for the coming year 2024/25. This is a noteworthy achievement, particularly as the Trust is not the beneficiary of direct NIHR infrastructure support funding.

5.2 Unlike some NHS Trusts the amount of funding from charitable sources is small. It is hoped it will be possible to grow income from charitable sources to support research as well as looking to secure a greater share of NIHR infrastructure funding.

5.3 The Trust is eligible to receive funding from UK Research and Innovation (UKRI) and is registered on the UKRI Joint Electronic Submission (Je-S) system, enabling the submission of grants in recent years to the UKRI Medical Research Council (MRC), the Economic and Social Research Council and Innovate UK as a lead or partner organisation

5.4 While the Trust is always keen to support NIHR portfolio studies wherever possible the small size of the Trust and associated eligible patient population, inevitably means that recruitment to NIHR portfolio studies is constrained (see appendix 2). However, the Trust, as noted, leads on several studies recruiting from multiple sites across the UK. In recognition of this, discussions are ongoing with the NIHR North Thames Clinical Research Network, to identify a way of acknowledging the Trust's role as a 'parent site' for NIHR portfolio studies whereby the Trust contributes significantly to patient recruitment elsewhere in the NHS.

7. Recommendations

7.1. There needs to be a focus on ensuring future research capability and capacity. This is important not only to maintain the Tavistock's longstanding and unique contribution to research but also to support ongoing innovation in clinical services and further strengthen the Trust's profile as a leading national provider of education and training.

7.2. To build on ongoing work in relation to the development of academic partnerships. This would include consideration regarding investment in joint clinical-academic and other posts, identifying pathways for career progression for research staff, supporting the development of a stronger research culture and ensuring the best research environment to facilitate success in relation to research training fellowships and research grant applications for staff, trainees and students.

8. Conclusion

The Tavistock has a longstanding tradition of research that has made a positive contribution to shaping the clinical, educational and training environment for staff and students and is a key aspect of the Trust's international reputation. It is important to build on this legacy to ensure that research continues to play a central role in the ongoing work of the Tavistock.

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Appendix 1. References:

1. Watch Me Play!: protocol for a feasibility study of a remotely delivered intervention to promote mental health resilience for children (ages 0-8) across UK early years and children's services. Randell E, Nollett C, Henley J, Smallman K, Johnson S, Meister L, McNamara R, Wilkins D, Segrott J, Casbard A, Wakelyn J, McKay K, Bordea E, Totsika V, Kennedy E.Pilot Feasibility Stud. 2024 Apr 4;10(1):55. doi: 10.1186/s40814-024-01491-7.PMID: 38576026

2. Personalised Interventions for Subgroups of Children with Conduct Problems. Skinner, G. C. M., Lane, C., Hogg, E., Karwatowska, L. A., French, L., Ranieri, V. F., Jesnick, L. G. D., Roberts, C., Scott, S., Senior, R., & Kennedy, E. Journal of Forensic Psychiatry and Psychology (2024). doi: 10.1080/14789949.2024.2314642

3. Personalised interventions for subgroups of children with conduct problems.
Lane C, Hogg E, Karwatowska LA, French L, Ranieri VF, Jesnick LGD, Roberts C, Scott S, Senior R, Skinner GC, Kennedy E. Cochrane Database Syst Rev. 2023 Apr 28;4(4):CD012746. doi:10.1002/14651858.CD012746.
pub2.PMID: 37115724

4. WHO treatment guideline for mental disorders.
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Appendix 2. Recruitment to Studies (2023/24)

Recruiting Study Name	IRAS	Recruitment Numbers
ESRC MAGIC study	312288	113
Personalised Programmes for Children RCT	268597	24
REDUCE-Carbon	285768	1

Additional approved studies (2023/24)	Study host	Status	Study closing date
Narratives of health and illness for Healthtalkonline.org	University of Oxford	PIC site	31/01/24

11. Annual RD Report final corrected version 030924

National Confidential Inquiry into suicide and homicide by people with mental illness	University of Manchester	Research site	31/03/24
Young people distressed by gender-related dysphoria	University of York	PIC site	30/08/23
The cross-sector pilot implementation of trauma-focused CBT for care-experienced young people with posttraumatic stress disorder	University College London	Research site	31/01/24
How do social workers in adoption services conceptualise CYP MH?	Kingston University	Research site	27/09/24
The effects of gender-affirming hormone treatment in trans women on morphological, functional and molecular markers of performance relevant to combat and collision sports	Manchester Metropolitan University	Research site	30/04/25
Autism Transition to Adulthood Group – ATAG	University of Bath	PIC site	01/06/25

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – 12 September 2024			
Report Title: Oversight of Board Assurance Framework (BAF)			**Agenda No.: 12**
Report Author and Job Title:	Nadia Munyoro Interim risk manager	**Lead Executive Director:**	Adewale Kadiri Director of Corporate Governance
Appendices:	Appendix A: Board Assurance Framework 2024/25		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This paper introduces the current iteration of the Board Assurance Framework (BAF). Each risk continues to be actively managed between the executive leads and the lead committees, and they have been through two cycles of committee meetings since the BAF was approved in May. Overall, the Trust is actively managing its risks, with a combination of green and amber assurances. Most risks show a trajectory towards lower target scores, indicating ongoing mitigation efforts. However, certain areas, particularly in IT security, workforce culture, operational performance and financial sustainability, require continued attention to fully achieve the desired risk levels. On a more technical level, work is being done to ensure that the identified controls and assurances are suitably effective to enable achievement of the target scores. Questions are also being asked at committee level as to the appropriateness of some of the target scores.		
Background:	The 2024/25 BAF contains 13 strategic risks that could prevent the Trust from achieving its strategic objectives. These risks span various domains, including patient access, quality of care, financial sustainability, workforce management, and IT infrastructure. In addition, a new Risk 14 is being developed in conjunction with the Performance, Finance and Resourcing Committee around the environmental sustainability of the Trust's activities. This will be discussed at the Committee's next meeting in September and once approved included when the BAF is next presented to the Board at the meeting in January 2025.		
Assessment:	Steps are being taken to improve the overall effectiveness of the Trust's risk management processes, and improvements are being made to the Corporate Risk Register following the introduction of Radar incident reporting and risk management tool. However significant improvements are still required in order to align the BAF and CRR and create a reliable overall approach to the management		

	of corporate risk. The Integrated Governance and Risk Committee will continue to oversee the development of this work. Regarding the BAF specifically, the corporate governance team is continuing to work with leads to update actions and to ensure that such actions will indeed lead eventually to the elimination of gaps in control and assurance. It is also important that issues such as outdated reporting systems, fragmented contract management, and inadequate staff training are addressed to avoid further escalation especially among the higher rated risks.
Key recommendation(s):	The board is asked to: • Note and discuss the current status of the strategic risks outlined in the BAF and the "Amber" assurance ratings across all identified risks. • Note the proposed actions to address the identified gaps in controls and the work that the committees are doing to oversee this process. • Raise questions, issues, concerns and suggestions relating to any of the risks, and also suggest any areas in relation to which there ought to be consideration for the inclusion of further BAF risks.

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 ☐
	The report considers all risks within the BAF.		

Legal and Regulatory Implications:	Yes ☒	No ☐
	The Trust is required to have a BAF in place as part of its Foundation Trust status.	
Resource Implications:	Yes ☐	No ☒
	None	
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒
	There are no specific EDI issues to note within this report.	

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Board Meeting 05/24			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Introduction

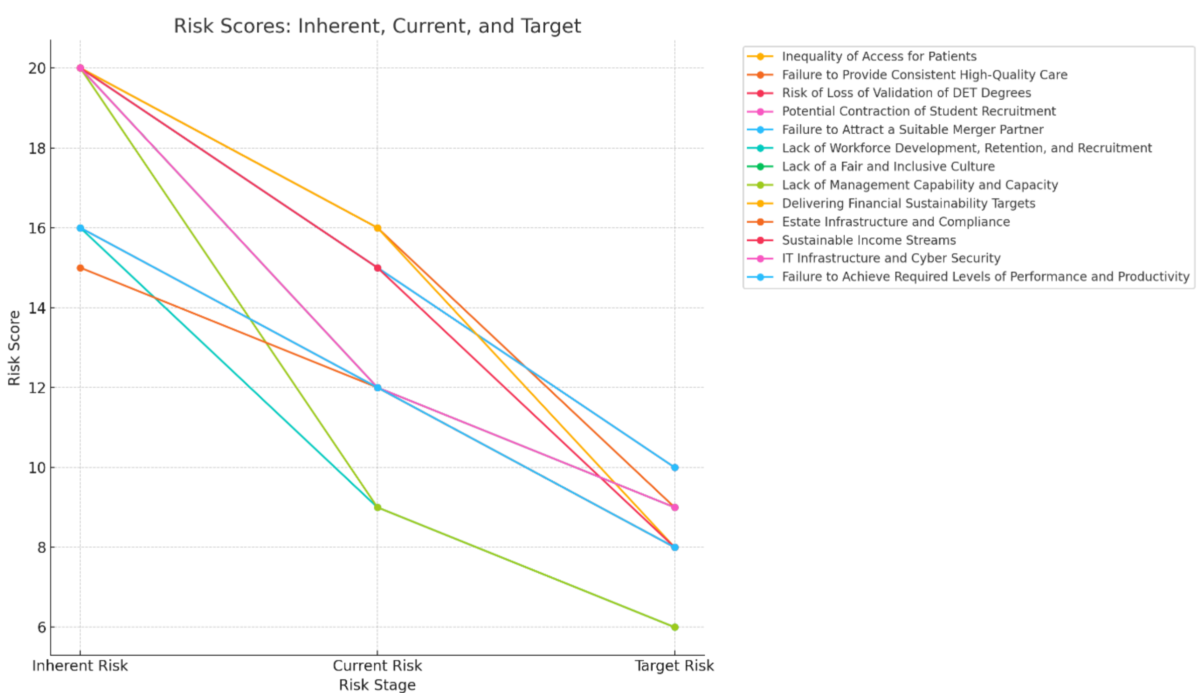
The Board Assurance Framework (BAF) for 2024-25 sets out the key strategic risks facing the Trust, highlighting the potential threats to achievement of its strategic objectives. The BAF also considers the effectiveness of the controls currently in place to mitigate these risks. This document is a critical tool for the Board, offering insights into the organisation's risk management processes, the level of assurance provided by existing controls, and the areas that require further attention to ensure the Trust's sustainability and the quality of care and service provided to its patients, students and learners.

The analysis conducted on the current risks, as outlined in the BAF, shows that while the Trust has made significant strides in managing these risks, several areas still require ongoing focus and improvement. The current risk ratings across all strategic risks have predominantly been classified as "Amber," indicating that while controls are in place, gaps must be addressed to enhance their overall effectiveness. This report aims to provide a detailed evaluation of these risks, a trend analysis to track progress over time, and strategic recommendations to guide the Board in strengthening the Trust's risk management practices.

Focus on the BAF

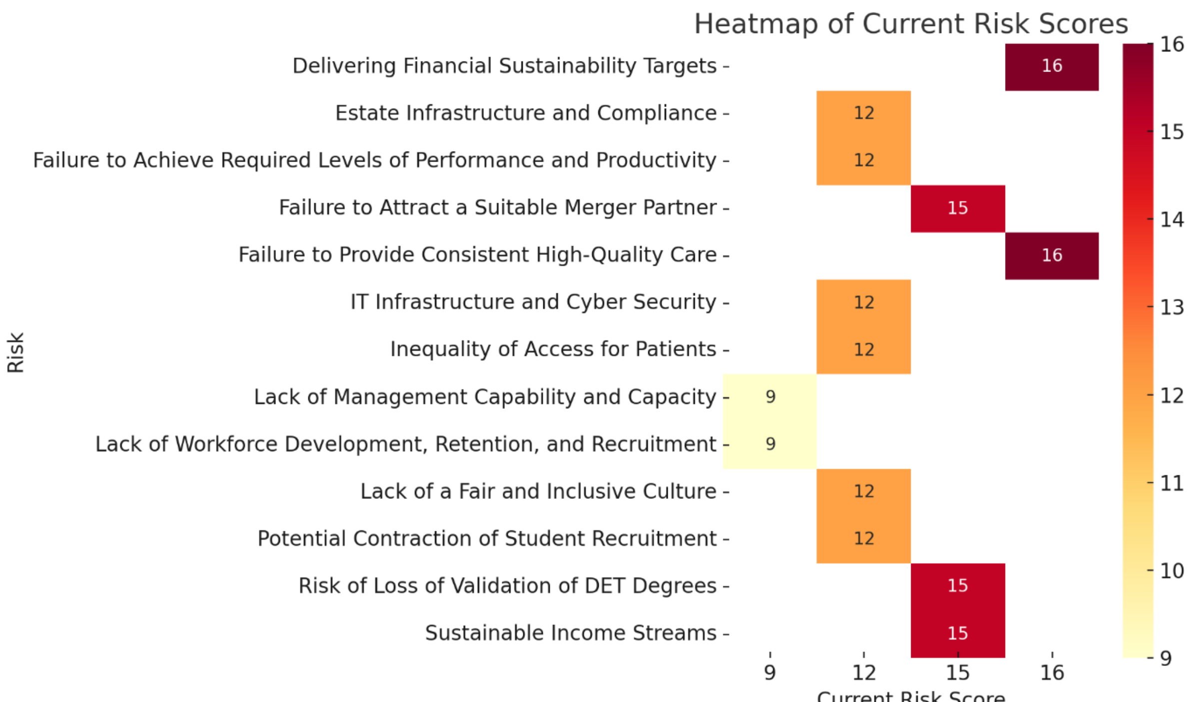
Graph 1: the inherent, current, and target risk scores for each of the strategic risks

The graph below illustrates the progression of risk management efforts, showing how the current risk scores have been mitigated from their inherent levels and the target scores that the Trust aims to achieve through ongoing and future actions



Graph 2: Heatmap of current risk scores

The heatmap represents the current risk scores for each strategic risk. The colour intensity indicates the current risk level, with darker shades representing higher risk scores. This visualisation helps to identify areas where the risk is currently most significant quickly



BAF Risks summary progress update

1. Inequality of Access for Patients

- **Current Risk Score**: 12 (3x4)
- **Key Controls**: Weekly PTL meetings, integrated quality and performance review, and job planning.
- **Gaps in Control**: Data flow is manual, which could lead to errors. Reporting structures are outdated.
- **Assurance Level:** Amber has ongoing data automation and manual process challenges.
- **Score Commentary:** Current mitigation efforts have reduced the risk slightly, and work is ongoing to improve data accuracy and reduce waiting times.

2. Failure to Provide Consistent High-Quality Care

- **Current Risk Score**: 16 (4x4)
- **Key Controls**: Statutory and mandatory training, quality audits, and peer reviews.

- **Gaps in Control**: Staffing levels and leadership capacity.
- **Assurance Level:** Mixed, with Amber ratings for staffing and training issues.
- **Score Commentary:** The Trust is progressing, but significant risks remain, particularly around staffing and training compliance.

3. Risk of Loss of Validation of DET Degrees

- **Current Risk Score**: **15** (3x5)
- **Key Controls**: Regulatory conditions mapped against the academic year, proactive merger partner search.
- **Gaps in Control**: Recruitment delays and the need for enhanced board oversight of regulatory compliance.
- **Assurance Level:** Amber, with gaps in resource allocation and system infrastructure.
- **Score Commentary:** Current risk rating is high, but the Trust is actively addressing gaps in control to mitigate the impact.

4. Potential Contraction of Student Recruitment

- **Current Risk Score**: **12** (3x4)
- **Key Controls**: Targeted marketing and recruitment strategies, continual course review.
- **Gaps in Control**: Recruitment infrastructure and NHS England relationship management.
- **Assurance Level:** Amber, with ongoing improvements in recruitment strategy.
- **Score Commentary:** The risk level has been managed down, but further actions are required to meet target levels.

5. Failure to Attract a Suitable Merger Partner

- **Current Risk Score**: **15** (3x5)
- **Key Controls**: Merger communications and engagement strategy, robust evaluation criteria.
- **Gaps in Control**: Stress testing of evaluation criteria and stop/go criteria.
- **Assurance Level:** Mixed, with amber and green ratings depending on the aspect of the merger process.
- **Score Commentary:** The current risk remains high due to the complexity of merger negotiations, but mitigation efforts are ongoing.

6. Lack of Workforce Development, Retention, and Recruitment

- **Current Risk Score**: **9** (3x3)
- **Key Controls**: Management and leadership development programs, back-to-basics training.
- **Gaps in Control**: Training attendance, informal resolution processes.
- **Assurance Level:** Amber, with progress being made in recruitment processes and retention strategies.
- **Score Commentary:** The risk has been significantly reduced, but ongoing efforts are needed to ensure sustainability.

7. Lack of a Fair and Inclusive Culture

- **Current Risk Score**: 12 (4x3)
- **Key Controls**: Cultural awareness programs and fair and consistent policy application.
- **Gaps in Control**: Policy review and implementation timelines.
- **Assurance Level:** Amber, with areas of improvement identified in bullying and harassment processes.
- **Score Commentary:** The Trust is working to address cultural issues, but the current risk remains moderate.

8. Lack of Management Capability and Capacity

- **Current Risk Score**: 9 (3x3)
- **Key Controls**: Leadership training, policy reviews.
- **Gaps in Control**: Managerial training and policy consistency.
- **Assurance Level:** Amber, with improvements in leadership training and policy reviews.
- **Score Commentary:** The Trust has made substantial progress, reducing the risk considerably, with further policy and training enhancements planned. Questions have been raised about this rating considering evidence such as the staff survey results, MaST compliance and appraisal levels.

9. Delivering Financial Sustainability Targets

- **Current Risk Score**: 16 (4x4)
- **Key Controls**: Long-term financial plan, budget approvals, monthly finance reports.
- **Gaps in Control**: Updated MTFP is required, as well as efficiency program development.
- **Assurance Level:** Mixed assurance with areas rated Green (approved budgets and monthly finance reports) and Amber (long-term financial plan updates).
- **Score Commentary:** The current risk score is moderate due to ongoing efforts to update financial plans and improve efficiencies. A target score indicates further planned reductions in risk.

10. Maintaining an Effective Estate Function

- **Current Risk Score**: 12 (4x3)
- **Key Controls**: 10-year capital plan, soft and hard FM strategies.
- **Gaps in Control**: Fragmented contracts and staffing models.
- **Assurance Level:** The assurance is primarily Amber, reflecting the need to improve the estate's management and implement asset replacement plans.
- **Score Commentary:** The current score reflects ongoing challenges in estate management. The target is to reduce risk through planned infrastructure upgrades and strategic alignment.

11. Sustainable Income Streams

- **Current Risk Score**: **15** (3x5)
- **Key Controls**: Internal and external monitoring, commercial strategy development.
- **Gaps in Control**: Service specification alignment, income growth strategy.
- **Assurance Level:** Mixed with both Green (internal and external monitoring) and Amber (gaps in service specifications and alignment).
- **Score Commentary:** The risk remains high but is being actively managed, with efforts focused on aligning services with commissioning requirements and developing new income streams.

12. IT Infrastructure and Cyber Security

- **Current Risk Score**: **12** (4x3)
- **Key Controls**: Cyber Essentials accreditation, third-party assessments.
- **Gaps in Control**: Resource allocation and technical expertise.
- **Assurance Level:** Mostly Green with some Amber and Red (cyber security resource gaps).
- **Score Commentary:** While progress has been made in securing systems, the score reflects ongoing challenges in ensuring comprehensive cyber security, with a target indicating continued improvements.

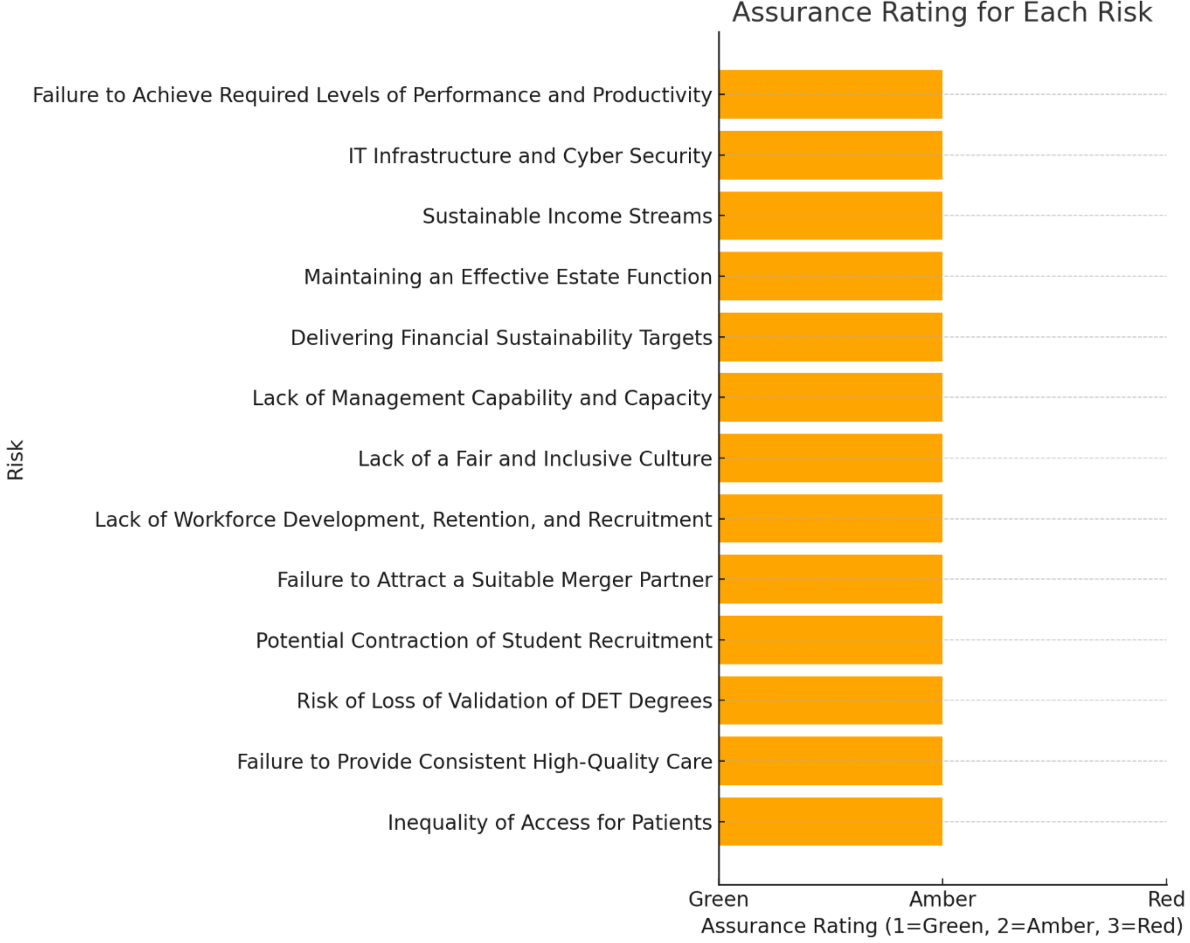
13. Failure to Achieve Required Levels of Performance and Productivity

- **Current Risk Score**: **12** (3x4)
- **Key Controls**: Job planning, performance reviews.
- **Gaps in Control**: Manual data flow and outdated reporting systems.
- **Assurance Level:** Predominantly Amber, with significant data management and reporting systems challenges.
- **Score Commentary:** The score indicates that while risks are being addressed, substantial work is needed to fully automate and align performance reporting systems. Again there are some questions about this score in light of the length of some of the waiting lists.

This summary reflects the current state of each risk, the controls in place, gaps that need addressing, and the overall assurance rating.

Graph 3: The aggregated assurance rating for each risk.

All the risks currently have an "Amber" rating, which is reflected in the uniformity of the bars. This indicates that while there are some controls in place, there are still gaps that need to be addressed to improve the overall level of assurance



Conclusion

The analysis of the BAF reveals that the Trust is actively managing a complex array of risks that have the potential to significantly impact its operations, financial stability, and quality of care. While the current mitigation strategies have effectively prevented further escalation of these risks, the consistent "Amber" ratings across all strategic risks underscore the need for continued improvement. The Trust's commitment to addressing these challenges is evident in its ongoing efforts to refine controls, enhance compliance, and adapt to the evolving healthcare landscape. However, achieving the desired "Green" assurance levels will require a more targeted approach to risk management, particularly in areas such as financial sustainability, IT infrastructure, and workforce development

BOARD ASSURANCE FRAMEWORK 2024/25

Likelihood	
1	Very Unlikely to occur
2	Unlikely to occur
3	Could occur
4	Likely to occur
5	Almost certain to occur

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

Risk Appetite		
1	Averse	Avoidance of risk exposure
2	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of the risk occurring after the application of controls.
3	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of the risk occurring after the application of controls.
4	Open	We are willing to consider a range of options subject to continued application and / or establishment of controls: recognising that there could be a high-risk exposure.
5	Hungry	We are eager to be innovative and take on a very high level of risk but only in the right circumstances.

Risk Assurance Rag Rating	
Substantial	The identified control provides a strong mechanism for helping to control the risk.
Good	The identified control provides a strong mechanism for helping to control the risk, albeit there is scope to strengthen this further.
Reasonable	The identified control provides a reasonable and partial mechanism for controlling the risk but there are notably weaknesses in this.
Weak	The identified control does not provide an effective mechanism for control

Risk Ref	Risk Title	Risk Description (Cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
Providing outstanding care						
1	Inequality of access for patients	If the Trust is unable to meet increasing demands for its services. Then - the Trust will not be able to meet the needs of its patient population in a timely fashion, to the standard of care that is required. Resulting in - increased waiting times for patients to access Trust services, and in turn leading to poor patient experience, including risk of harm to patients, and non-compliance with the Trust's contractual obligations, national standards, and regulatory requirements.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Cautious**
2	Failure to provide consistent, high-quality care	**If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.	20 (4 x 5)	16 (4 x 4)	9 (3 x 3)	**Cautious**
To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.						
3	Potential contraction of student recruitment	If there is a contraction in post graduate student income, then Trust strategic and commercial aims will be significantly impacted. This risks a shortfall against financial targets and a reduction of impact as a lead in mental health education.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Open**
4	Risk of loss of validation of DET degrees	Changes to the OfS regulatory framework and other pressures on DET as a small independent provider whose programmes are validated externally pose a risk to our ability to award degrees (MA, Professional Doctorate). This would severely impact DET income.	20 (4 x 5)	15 (3 x 5)	10 (2 x 5)	**Cautious**
Developing partnerships to improve population health and build on reputation for innovation and research in this area						

5	Failure to attract a suitable merger partner	1) There is a risk the Trust fails to identify / attract a suitable merger partner. Impact: It would mean the merger does not proceed leading to unsustainability of some services and transfer to other providers; inability to improve quality leading to patient safety concerns, poor patient experience and regulatory concerns; inability to improve the Trust's financial position and deliver CIP targets; worsening reputation; increased regulatory intervention; unsustainable services and loss of services to local provision. 2) There is a risk the Trust fails to merge with an organisation with which the Trust shares similar values and culture, and with whom there would be synergies in terms of service provision, training, education and research, which would be an existential risk to the future of the Trust. Impact: It would threaten the Trusts educational and service delivery model, and lead to poor outcomes for patients and students, wasted resources, negative impact on staff morale and engagement; and future decisions on commissioning of services.	20 (4 x 5)	15 (3 x 5)	10 (2 x 5)	
Developing a culture where everyone thrives with a focus on equality, inclusion, and diversity						
6	Lack of workforce development, retention, recruitment	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered.	16 (4 x 4)	9 (3 x 3)	6 3 x 2	**Open**
7	Lack of a fair and inclusive culture	If the Trust does not establish a fair and inclusive organisational culture, where all staff regardless of their background feel that they belong, and that there is an awareness of cultural difference, staff morale and levels of recruitment and retention will be affected, and the quality of patient care will be compromised.	20 (5 x 4)	12 (4 x 3)	9 3 x 3	**Open**
8	Lack of management capability and capacity	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.	20 (4 x 5)	9 (3 x 3)	6 2 x 3	**Open**
Improving value, productivity, financial and environmental sustainability.						

9	Delivering financial sustainability targets	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	20 (5 x 4)	16 (4 x 4)	8 (2 x 4)	**Cautious**
10	Maintaining an effective estate function	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	15 (5 x 3)	12 (3 x 4)	8 (4 x 2)	**Cautious**
11	Sustainable income streams	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.	20 (4 x 5)	15 (3 x 5)	8 (4 x 2)	**Cautious**
12	IT infrastructure and cyber security	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	20 (5 x 4)	12 (3 x 4)	9 (3 x 3)	**Cautious**
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. Resulting sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, including risks to patients' mental health, and reputational risk.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Cautious**

Principal Risk 1	Inequality of access for patients	Strategic Objective	Providing outstanding care
Description	**If** the Trust is unable to meet increasing demands for its services and referral to treatment target **Then** the Trust will not be able to meet the needs of its patient population in a timely fashion, to the standard of care that is required. **Resulting in -** increased waiting times for patients to access Trust services, and in turn leading to poor patient experience, including risk of harm to patients, and non-compliance with the Trust's contractual obligations, national standards and regulatory requirements.		

Executive Lead	Hector Bayayi Managing Director	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	07th March 2024
Lead Committee	Quality Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	08th August 2024
Risk Appetite	Cautious	4	4	16	4	4	16	3	4	12	Date of Next Review	20th September 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Weekly PTL meetings to review dormant cases and throughput. Review of the intake process to minimise hand offs between services. Activity, waiting list and quality impact risk monitoring across key services (including, Adult GIC, Trauma and Autism, PCPCS).	Currently have long waiting times, exceeding the 18wk RTT. Clear understanding of available capacity to reduce waiting times and meet increasing demand for some services. Gap in trt waiting times data, as not fully automated or assured. Data flow is manual so possible errors.	Weekly QI huddles for oversight, Review in Child Complex monthly meeting. Monthly business meetings for all services. IQPR meetings.	Internal	Amber
Clinical pathway mapping to unblock bottle necks		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. A3 Kaizen events	Internal	Green
Screening and triage- view to ensuring pts access the right pathway at the start of their treatment		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Designed/ reviewed screening and triage process. Go live by December 31st, 2024.	Internal	Amber
Clinical Harm review GIC -ensure that pts on the waiting list receive timely urgent care where required	Service lines are yet to agree consistent risk stratification matrix for their pts cohorts	Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Internal	Amber
Trajectory for number of first appointments to be conducted – estimated number of pts likely to be seen for a first appointment aligned to the agreed trajectory. - Recourse optimisation and monitoring. Assurance and oversight,		Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Internal	Amber
Workforce recruitment and retention	Recruitment - Number of referrals versus number of pts we can see. Unlikely to recover waiting times best case break even each service.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber/red

Autism – mitigations seeing an extra 175 pts Trauma -to see an extra 100 patients	Responding to cultural issues. The time required for change management	Waiting times weekly huddle. Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Targeted support monthly meeting for affected service areas Service lines have started this process this month. Publication of the first cut of data a month in arrears of the start date will inform assurance rating. Lead nurse start 19th August	Internal	Amber
Job planning to properly understand the capacity of each Team to meet demand for services. Ownership of key information on finance and activity is not available at local level where required.	Trust not using NHS descriptions of treatment Current reporting structures are out of date for key systems (Oracle, Carenotes, ESR).		Internal	Red
Patient and Carer Race Equality Framework (PCREF)	This work is currently in the very early stages		Internal	Red

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Implement PCREF	Chris Abbott		
Project to align description of assessment and treatment to the NHS data definition dictionary	Contracts	August 2024	Must be done in line with pathway maps. Define intervals based on that. End of July define September- IMT to build dashboard. Pathway work. Workshop each service line- what is treatment/assessment based on data dictionary
Training and workshops planned as part of the transition to new structures roles and responsibilities. The Kaizen events	CPO		Commissioning a piece of OD work for senior leaders in relation to team performance being solution focused. Relates to the new clinical services structures.
Finance – lack of visibility around current flow which impacts on decision making regarding how to mitigate the workforce planning needs related to waiting times, recruitment, and retention **(Share with Peter)**	CFO	TBC	
Mobilisation of the Clinical Harm review	TBC		Currently waiting for services to agree risk stratification to mobilise the framework. Workshop to agree stratification for consistency.
Clinical Pathway mapping	TBC		In progress across all affected service lines aligned to the prioritisation framework agreed.
Digitising both the RTT waits to ensure PTL is accurate and appropriate remedial action can be taken.	Ian Curr & Muhammad Akram	TBC	Templates are in testing phase. Further work is required to deliver a data validation framework. HB,TR

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. Streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists	IQPR meetings with contracting updates. As above noting external NHSE meetings to support identification of delivery capacity

Principal Risk 2	**Failure to provide consistent high-quality care**	**Strategic Objective**	**Providing outstanding care**
Description	If the Trust is unable to meet nationally recognised quality standards across its clinical services,		

	Then, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.		

Executive Lead	Clare Scott Chief Nurse Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	07 March 2024
Lead Committee	Quality & Safety Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	20th June 2024
Risk Appetite	**Cautious**	4	5	**20**	4	4	**16**	3	3	**9**	**Date of Next Review**	22nd August 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Clinical staffing structures	Some services continue to carry significant levels of vacancies, with heavy reliance on agency and other temporary staffing	POD EDI staffing report to each meeting (latest Jan 2023) includes current staff vacancies. Committee and Board oversight through IQPR Workplans progressed and new clinical services delivery Board commencing September Clinical restructure consultation outcomes expected into effect as of September 2024	Internal	Amber
Job planning		Job planning policy approved by Policy Approval Group 15th May 2023. Compliance monitored through IQPR	Internal	Amber
Quality and Safety Committee in place with approved terms of reference. Tier 3 structure and associated Terms of Reference in place.		Regular quality reporting to QSC via IQPR, Quality & Safety Report and Chair's reports from Tier 3 Groups	Internal	Green
Statutory and Mandatory training	Inconsistent levels of completion of key modules	Mandatory training compliance reported through the POD EDI Committee bi-monthly MaST paper for 24/25 currently under approval by ELT MaST compliance to be included in IQPR	Internal	Amber
Supervision/clinical safeguarding Process		CQC improvement plan Clinical supervision –reported in IPQR monthly. Supervision structures are held at team level, underpinned by Supervision Policy. Teams report supervision in a monthly log. Safeguarding supervision taking place, this will be strengthened by developing an improved structure through the Safeguarding forum. Included in the Quality report bi-monthly.	External (CQC) Internal Internal Internal Internal	Amber
Quality assurance tools and methodology		QSC work plan and forward planner IQPR Quality & Safety Report to QSC Chair's reports from Tier 3 Groups to QSC		Amber

		Clinical Governance meetings		
Quality Framework Improvement Plan in place		Quality Framework monitoring report to QSC All professional leads now in place Chief Nurse Officer and Chief Medical Officer In post Tier 3 structure and associated Terms of Reference in place. Chair's reports from Tier 3 Groups to QSC Process under review, trajectory and timeframe for overdue complaints to be closed.	Internal	Green
Learning from deaths process CMO		Draft of Learning from Healthcare Deaths Policy under approval routes Mortality Group established; Tier 3 group of QSC Electronic Mortality Review form being incorporated into Radar	Internal	Amber
Senior Clinical Management structure		Clinical restructure consultation outcomes expected into effect as of September 2024		Green
Clinical Audit Schedule	Full Clinical Audit Plan for 24/25	Clinical Audit & Effectiveness Group established; Tier 3 Group of QSC Electronic recording and reporting module being drafted on Radar	Internal	Amber
Complaints Process	Lessons learnt process from complaints Timeliness of response	Quality & Safety Report to QSC includes thematic review and update on actions Regular reporting/updates through to SUEG and Clinical Governance meetings Report to QSC on response rates against target	Internal	Amber
Implementation of RADAR		LRMS Radar Implementation Board in place Detailed project plan in place Live for a number of event types since 3rd June 2024. Plan for remaining event types		Amber
Implementation of PSIRF		PSIRF Transition Group in place and reporting to QSC A3 on PSIRF implementation, supported by GANTT chart Work plan for Patient Safety Partners Work plan for Patient Safety Specialist(s) Updated PSIRP approved by QSC in June 2024. Policy due on QSC agenda in August 2024 for approval.	Internal	Green
Staff sickness and absence reporting		IPQR includes sickness and absence reporting ESR live for sickness and absence reporting on 1 April 2024 Quality & Safety Committee receive reports at each meeting on sickness and absence levels via IQPR	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
RADAR implementation for PSIRF and risk reporting	Clare Scott/Ade Kadiri		
PSIRF implementation			

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

Implementation of the Quality Improvement Plan based on the 11 defined areas of improvement required			

12a. Board Assurance Framework 2024-25 Master Aug 24 (002)

Principal Risk 3	Risk of loss of validation of DET degrees	Strategic Objective	To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.
Description	Changes to the OfS regulatory framework and other pressures on DET as a small independent provider whose programmes are validated externally pose a risk to our ability to award degrees (MA, Professional Doctorate). This would severely impact DET income.		

Executive Lead	Chief Education & Training Officer/	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	05st July 2024
Lead Committee	Education Training Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	08th July 2024
Risk Appetite	Cautious	4	5	20	3	5	15	1	5	5	Date of Next Review	03rd September 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Appropriate staffing	Lack of resources identified as a problem necessitating resolution	Established infrastructure to support the functions required for delivery of governance to maintain OfS registration.	Internal	Amber
Systems Infrastructure (data quality)	Limited confidence in certain control measures among staff members. For example, quality portal not being used effectively due to a lack of confidence in its functionality and/or reliability.	Commissioned external consultants to carry out full discovery of SITS with forthcoming recommendations for changes to improve functionality.	External	Amber
Training and Awareness	Lack of awareness among staff regarding existing control measures; lack of standard processes	Introduction of standard operating procedures complemented by training and awareness across all staff and teams.	Internal	Amber
OfS working group to provide regular updates to Director of Education (Governance & Quality)	Director of Education (Operations)	ETC to review reports and updates	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Regulatory Conditions to be mapped against the academic year planner to ensure compliance and an action plan to meet ongoing conditions.	Head of Academic Registry reporting to Director of Education (Governance & Quality)	By 2nd September 2024	Amber
Pro-actively seek a merger partner or partners to encompass validation work for all current and future long courses, irrespective of ongoing NHS merger work.	Chief Education & Training Officer Chief Executive Officer	Ongoing	Amber
Enhance Board Oversight: need to improve board-level awareness and understanding of regulatory functions related to education and training. Suggestion that the PFRC could play a role in providing a second assurance check over financial returns and regulatory compliance.	Chief Education & Training Officer	By 12th September 2024	Amber

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance

That we comply with Higher Education regulatory requirements and futureproof our position in relation to emerging trends within the sector.	Due to appoint permanent Head of Academic Registry Ongoing appointment of additional staffing resource Ongoing systems review	Delays in recruitment process Not aligned with traditional HE sectors for recruitment windows	Plans in place and implemented to expedite the process in order to mitigate risks and cover gaps on a mporary basis

Principal Risk 4	Potential contraction of student recruitment	Strategic Objective	To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.
Description	If there is a failure to recruit efficiently, then the Trust's strategic and commercial aims will be significantly impacted, resulting in not meeting financial targets and a reduced impact as a sector lead in mental health education.		

Executive Lead	Chief Education & Training Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th January 2023
Lead Committee	Education and Training Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	05th August 2024
Risk Appetite	Open	4	4	16	3	4	12	2	4	8	Date of Next Review	03rd September 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Targeted and proactive approach to student marketing and recruitment	Clearly defined student marketing and recruitment strategic plan (including International Strategy)	Following the review of the Student Marketing function – this has been moved from Communications to DET Operations (Student Marketing, Recruitment and Admissions) New staff have been appointed in the Admissions team, with further staff to be recruited for Marketing and Recruitment teams. Scoping of CRM to provide a data-led approach.	Internal	Amber
Continual review and (re)development of courses including modes of delivery to meet the needs of the workforce	More effective liaison and relationship with NHS England, as well as internal infrastructure (SITS / staffing model)	HR led task-and-finish group on Visiting Lecturers Ongoing review of SITS Recent appointment of Associate Director of Business Development (DET) Increased engagement between Head of Performance & Contracts and NHSE	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Prepare and implement a Student Marketing & Recruitment Strategic Plan	Head of Student Marketing, Recruitment & Admissions Associate Director of Business Development (DET)	By 30th September 2024	Amber
Prepare and implement a multi-year International Strategy	Associate Director of Business Development (DET) Directors of Education – as appropriate	By 30th September 2024	Amber
Increase knowledge and responsiveness to workforce needs	Head of Performance & Contracts Associate Director of Business Development (DET)	Ongoing	Amber

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance

To have a fit-for-purpose educational offer for sustainable student recruitment	Ongoing review of academic courses (including delivery models) Ongoing discussion with university partner Ongoing improvements to infrastructure (staffing and systems)	Competing priorities and changes to a number of areas across the directorate, including a delay in recruitment for additional staff	Plans in place and implemented to expedite the process in order to mitigate risks and cover gaps on a temporary basis

Principal Risk 5	**Failure to attract a suitable merger partner.**	Strategic Objective	Improving value, productivity, financial and environmental sustainability.
Description	1) There is a risk the Trust fails to identify / attract a suitable merger partner. **Impact**: It would mean the merger does not proceed leading to unsustainability of some services and transfer to other providers; inability to improve quality leading to patient safety concerns, poor patient experience and regulatory concerns; inability to improve the Trust's financial position and deliver CIP targets; worsening reputation; increased regulatory intervention; unsustainable services and loss of services to local provision. 2) There is a risk the Trust fails to merge with an organisation with which the Trust shares similar values and culture, and with whom there would be synergies in terms of service provision, training, education and research, which would be an existential risk to the future of the Trust. **Impact**: It would threaten the Trusts educational and service delivery model, and lead to poor outcomes for patients and students, wasted resources, negative impact on staff morale and engagement; and future decisions on commissioning of services.		

Executive Lead	Chief Executive Officer/ Director of Strategy and Business Development	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	8th March 2024
Lead Committee	Integrated Audit & Governance Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th April 2024
Risk Appetite	TBC	4	5	20	3	5	15	2	5	10	Date of Next Review	21st May 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Board's decision in December 2023 to proceed with merger as a single entity	Possibility that a merger as single entity may not be possible	Private Board of Directors meeting papers and minutes.	Internal	Amber
Merger Communications and Engagement Strategy in place	Shared approach to engagement to be agreed with potential partners in Phase 2	• Merger Communications and Engagement Strategy agreed by Merger Programme Board and Board of Directors. • Phase 1 completed and evidenced constant loop-closing of 'you said we did'. Output of Phase 1 used to develop the scoring criteria.	Internal	Green
Merger transaction process in place		• Key Lines of Enquiries - Due Diligence records established and capture all key lines of enquiries being pursued as part of the merger process. • Clarification logs contain all enquiries from potential partners and responses.	Internal	Green
Agreed merger process with NCL ICB and NHSE		Merger Programme Board membership includes representatives from NCL ICB and NHSE	External	Green
Robust criteria for evaluating potential merger partners, including cultural compatibility, financial stability, and operational efficiency.	Evaluation criteria not yet stress tested	• Evaluation criteria agreed by Board. • External legal review of process to be carried out (see action to address gap)	Internal/ External	Amber
Robust ICB Stop/Go criteria	Stop/Go criteria not yet stress tested though this is planned	• Stop/Go criteria agreed by ICB. • External legal review of process to be carried out (see action to address gap)	External	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
In-process review of options by Board	Michael Holland	May 2024	Planned for future Board Development Session / Private Board discussion
Seek legal advice on merger process including review of evaluation and Stop/ Go criteria	Ade Kadiri	April/ May 2024	In progress - comprehensive brief sent to Legal Adviser. Meeting to planned to progress.
Meetings with Potential Partners to agree shared approach to next steps of engagement	Rod Booth	April/ May 2024	Dates agreed for meetings.

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance

Principal Risk 6	Lack of workforce development, resilience, retention, recruitment	Strategic Objective	Developing a culture where everyone thrives with a focus on equality, inclusion and diversity
Description	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered.		

Executive Lead	Chief People Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	POD EDI Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th August 2024
Risk Appetite	**Open**	4	4	**16**	3	3	**9**	3	2	**6**	Date of Next Review	October 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
People plan includes 5-year action plan for the Trust	Stay conversations and career / wellbeing conversations required	POD EDI bi-monthly progress reports including developments with the people plan which covers all areas including recruitment, retention, and resilience. Positive POD EDI Committee discussions held on elements of progress Talent management and succession planning programmes in future. There has been an uptake of career and wellbeing conversations	Internal	Amber
Recruitment and approval group approval of roles for recruitment to be replaced by a more robust establishment control process (ECP)	Establishment Control Process (ECP) required Recruitment and retention group required	ECP in place in principle and log actively updated. RAG log indicates improved workforce planning / skill mix reviews Skill mix and structure reviews occurring. Feedback to recruiting managers is being acted upon. Recruitment and retention group set up and meeting regularly	Internal	Amber
NLPSS Operations meetings weekly		Performance report from NLPSS Reduction in vacancy rates Exit interview / stay conversation analysis and, in time, onboarding interview analysis	Internal	Amber
AD of People Operations meeting with NLPSS fortnightly		Performance report from NLPSS	Internal	Amber
Trust Recruitment and selection Policy and Procedures	ESR limitations in reporting recruitment data No current performance pack for directorate on compliance	Formal assurance on adherence to procedures from NLPSS performance report and internal workforce dashboard. Recruitment and selection policy revised in line with NCL standards and includes NLPSS	Internal	Amber

		Inclusive recruitment training widely rolled out - Training more inclusive recruitment advisors Improved NLPSS KPIs		
Some KPIs in place for time to hire	Not all recruitment processes have KPIs currently	Vacancy rates and recruitment KPIs included in IQPR packs Improvements in demographic-reflective hiring and declarations of protected characteristics Improved working relationship and communication with NLPSS. Intention to move to streamlined policies and procedures across clients will also improve overall experiences.		Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
CPO and Associate Director of HR to design and implement full ECP with support and input from finance colleagues	Chief People Officer	30 April 2024	ECP in place in principle. Going live 19th August 2024 This will be further underpinned by the organogram and budget implementation
Align ESR and Oracle information to improve reporting capability	Associate Director of HR	31st March 2025	ESR is up to date and is being regularly cleansed.
Regular ESR / ledger reconciliation Supervisor self service	Associate Director of HR	31st March 2025	Working with finance colleagues on regular reconciliation Supervisors are being updated to allow the implementation of ESR self-service across the organisation by the end of the calendar year.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Upscaling managers on the recruitment process	Inclusive recruitment training delivered and practices in place	Need to roll out further training and guidance to managers on best practice recruitment	Initial internal workforce dashboard was created and presented on 23rd March at POD EDI Committee Subsequent POD EDI committees have been provided up to date dashboard and these are well received.
Review of productivity, establishment, finance	Process has started with the Clinical division and will then move to Corporate followed by DET.		ESR is up to date and is being regularly cleansed. Working with finance colleagues on regular reconciliation Supervisors are being updated to allow the implementation of ESR self-service across the organisation by the end of the calendar year.

Principal Risk 7	**Lack of a fair and inclusive culture**	Strategic Objective	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**
Description	If the Trust does not establish a fair and inclusive organisational culture, where all staff regardless of their background feel that they belong, and that there is an awareness of cultural difference, staff morale and levels of recruitment and retention will be affected, and the quality of patient care will be compromised		

Executive Lead	Chief People Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2023
Lead Committee	POD EDI Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th August 2024
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	Date of Next Review	October 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Engagement sessions hosted by CEO and Director of Strategy		Records of sessions held	Internal	Green
Health & Wellbeing group (includes review of cost-of-living issues)		Key issues fed back to POD EDI Committee through the Associate Director of EDI Improvements in health and wellbeing indicators reported	Internal	Amber
Occupational Health and employee assistance programme		OH and EAP provision aligned with ICS	Internal	Green
Staff Networks feed to EDI team who escalate key outcomes through POD EDI	Lack of clarity around Bullying & harassment process being followed	EDI reporting through the POD EDI includes key outcomes/concerns from network forum meetings. Informal resolutions form majority of outcomes Just and learning culture approach to issues Introduction of revised resolution policy to follow: 30-day consultation about to launch. To include staff networks.	Internal	Amber
	Process to ensure equity for BAME candidates for senior roles (band 8 and above)	Inclusive recruitment training delivered and practices in place Internal reporting of issues (incl FTSU) to be more reflective of staff survey reporting ECP and CPD processes	Internal	Amber
	Improved process around recruitment and treatment of disabled candidates.	Just and learning culture approaches included in all revised policies Armed forces covenant, disability confident status, and other inclusive statements, implemented competently. Launched new menopause policy. We have menopause awareness status	Internal	Amber

Chief Clinical Operating Officer sponsoring EDI programme and providing link with the Board		Feedback through EMT Board development sessions implemented on EDI considerations	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Inclusivity action plan refreshed. Full GANTT chart reviewed regularly at EDI programme board and overall EDI issues reviewed at Board via WRES, WDES, FTSU, Staff Survey etc.	CEO/Execs/ Associate Director of EDI	TBC	Action plan streamlined and progress being regularly presented at the EDI Programme Board

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Revised, refreshed Inclusivity action plan to be created and presented to POD EDI Committee	Action plan streamlined and progress being regularly presented at the POD EDI Programme Board which feeds into POD EDI Committee	EDI review is currently underway and will seek to further improve governance and processes	New Inclusivity action plan communicated, and progress updates received Rolled out with staff survey action plan. In progress
Reasonable adjustments process implemented	This has commenced, with funding secured from finance and reasonable adjustments are being signed off	Reasonable adjustments policy :ratified August 2024. Relaunch of process and policy.	Continued use of reasonable adjustments process and staff reporting RA in place in staff survey
Employee relations policies being refreshed with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	CPO has feedback on first round of policy drafts viewed, and these are being amended. Support employee wellbeing policy training is in place and policy being published.	Managers need to attend the training	New policies and training (once complete) Training in progress delivered HR Business partner.

Principal Risk 8	Lack of management capability and capacity	Strategic Objective	Developing a culture where everyone thrives with a focus on equality, inclusion and diversity
Description	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.		

Executive Lead	Chief People Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th January 2024
Lead Committee	POD EDI Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th August 2024
Risk Appetite	Open	4	5	20	3	3	9	2	3	6	Date of Next Review	October 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Full suite of Trust HR policies in place	These policies are currently due for review, and some require a refresh	Sickness, Grievance, disciplinary levels reported to the POD EDI through the Chief People Officer report. Bi-monthly Planned - Just and learning culture approaches included in all revised policies	Internal	Amber
Management structure in place with revised job descriptions clarifying line management responsibilities	Manager leadership training required	Leadership and management training in place with positive feedback Back to basics training provided for all policies	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of HR	Ongoing	Learning and development training (x2) and back to basics training in place Coaching of managers by HRBP (and senior team where required). Managers' report feeling more competent to resolve issues as a result of the training packages / coaching from HRBPs Informal resolutions form majority of outcomes Appropriate attendance levels at training sessions recorded
All HR Policies to be reviewed over next 12 months (priority to be given to Recruitment & Selection, disciplinary, capability, grievance, and flexible working policies) with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	Head of HR	December 2024 completion for all policies	Ongoing, currently on target to meet implementation date.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
New suite of policies	As above		
Three training programmes	Learning and development training (x2) and back to basics training in place		
KPIs and associated dashboard	People relations KPIs consulted on with managers and SEG and implemented		SEG report feeling confident in new approaches. POD EDI comm receives updates on employee R case data PFRC receives updates on WTE and vacancies and through the A3 process report on all metrics relating to staff engagement.

Principal Risk 9	Delivering financial sustainability targets	Strategic Objective	Improving value, productivity, financial and environmental sustainability.
Description	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.		

Executive Lead	Peter O'Neill Interim Chief Financial Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19 December 2022
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th August 2024
Risk Appetite	Cautious	5	4	20	4	4	16	2	4	8	Date of Next Review	October 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Long term financial plan (LTFP) – superseded by MTFP developed in conjunction with merger partner. Process starting June 2024.	Requires updating to reflect merger	Changed red to amber – MTFP will form part of the OSC and FBC in the merger transaction process will be signed of by NHSE.	Internal	AMBER
2023/24 Annual Plan / Budget		Approved by Board on 6 July 2023	Internal	GREEN
Monthly Finance Reports		Reviewed by ELT, PFRC and Board. Report for 12 months ended March 2023 shows Trust on Plan	Internal	GREEN
In Year Reforecasts		At PFRC in January and Board in February, unchanged full year forecast noted	Internal	GREEN
2024/25 Annual Plan / Budget	Required for 24/25	Initial version submitted to NCL ICS (28 April) Board approved, final version submitted to NHSE 12th June reflecting agreed revised plans across the ICS. Changed amber to green	External	GREEN
Part of 24/24 Financial Plan	No recurrent efficiency programme	Recurrent programme – supporting division to manage and deliver identified opportunities	Internal	AMBER
MTFP development	We haven't started to achieve the planned income opportunities	Commercial Strategy – developed Q3 23/24 giving a short/medium term view of opportunities	Internal	AMBER

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Updated MTFP	CFO	June 2024	Currently work in progress with merger partner
2024/25 Budget	CFO	June 2024	Draft financial plan submitted to April Board. Final version of team level budgets to be completed in line with agreed financial plan.
Detailed CIP programme	CFO	June 2024	Process in place, programme continues to be developed throughout the year.
Commercial Strategy	Director of Strategy and Transformation	October 2024	Implementation stage

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Develop a medium-term financial plan that supports the Trust's strategy & which aligns with ICS plans.	Revision to current MTFP started June 2024	Finalising efficiency programme and identifying income opportunities to deliver balanced MTFP in line with merger partner.	Jointly agreed MTFP with merger partner that forms part of an agreed FBC.
Deliver the 2024/25 Out-Turn within Plan, supported by a recurrent efficiency programme	Maintain Trust on plan trajectory throughout 24/25	In year financial management of the organisation	Monthly reported position – ELT, PFRC and the Board
Develop and deliver the Action Plan following the HFMA review	Action plan developed. Delivery against plan on-going	Development of CIP key outstanding issue	Self-Assessment (October / March / May Audit Committee) Internal Audit review – follow up in July/August
Commercial Strategy – New income opportunities	Commercial strategy is developed currently at implementation stage -Identifying and delivering specific opportunities	Agreeing final negotiated contracts	Jointly agreed MTFP with merger partner that forms part of an agreed FBC.

Principal Risk 10	Estate infrastructure and compliance	Strategic Objective	Improving value, productivity, financial and environmental sustainability.
Description	If the Trust fails to assure compliance of its Estate and deliver appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy		

Executive Lead	Peter O'Neill Interim Chief Finance Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	21st June 24
Risk Appetite	**Cautious**	5	3	**15**	4	3	**12**	4	2	**8**	Date of Next Review	30th September 2024

Key Risk Controls (1st line of defence)	Gaps in Control (What are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Leases are in place for tenant's premises - Maintenance is fulfilled as per statutory obligations through Hard FM contractors for all sites	PAM – aligns to 5 CQC domains, this assessment is carried out annually for a Sept national submission	The PAM assessment included governance, hard and soft FM, patient experience, effectiveness, and efficiency.	Internal	Amber
10-year Capital plan –6 facet survey has provided an asset replacement plan and is reviewed annually	Capital plan is risk based with defined backlog asset replacement, it is manual process, and involves review of any failures and assets are replaced	This replacement plan was aligned to the Trust strategies, as the Trust strategies are being refreshed, the Estates strategy will follow suit. The aim is to maintain a functioning building when required, with an aim to replace assets based on failure rates	Internal	Amber
Current cleaning standards are higher than the NHS national standards, informal arrangement around assurance	NHS National cleanliness standards 2021, assurance model has not been introduced into the Trust, adherence is due by July 23	Training has commenced with staff and will involve several interventions as a root and branch assessment of what frequency areas are cleaned and an assurance model developed. Aim to market test the cleaning contracts during 24-25.	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Detailed Estate revenue model to support finance model, this will follow the Estates Budget	Estates lead	December 2023- Dec 24	Planning in progress

Strategic Delivery Metrics

Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
Premises Assurance Model assessment- a gap analysis, and timeline	Assessment and timeline was shared in autumn 23. As this is an annual assessment this will be undertaken in Oct 24	The review has highlighted gaps, the aim is to make annual improvements. 23-24 focused on hard FM, fire, asbestos and electrical. This has led to backlog upgrades the focus for 24-25 is water, LOLER, heating reviewed through the independence of Authorizing engineers	External
Introduction of a CAFM (computer aided facilities management system), this will automate the asset failure rates and provide a better understanding of the systems across our estate	The reactive system is online, the hard FM provider is picking up jobs via system,	Asset will be coded, and staff trained over the coming year	internal
Develop a soft FM and Hard FM strategy	Consolidate fragmented contracts, and staffing model, in line with service operating hours, will look to market test soft FM and for Hard FM – this will be aligned to merger partner.	Ability to deliver as the team are in transition alignment to NHS national standards	PAM review – Sept 24

10-year capital plan based on the 6-facet survey	Surveys have been carried out on some assets- electrical supply, lighting and fire doors and will look at fire alarms, heating systems over the coming months to support 24-25 planning cycle.	Aging estate, will require upgrades over coming years, with infrastructure upgrades prioritised	Specialist surveys undertaken with authorising engineers and work is planned and reported through H&S group

Principal Risk 11	Sustainable income streams	Strategic Objective	Improving value, productivity, financial and environmental sustainability.
Description	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.		

Executive Lead	Peter O'Neill Interim Chief Finance Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	07th June 2024
Risk Appetite	Cautious	4	5	20	3	5	15	2	4	8	Date of Next Review	06st August 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Internal Monitoring Reporting on current clinical services to ensure meeting current contractual objectives	Agreed activity plans for some services	IQPR Reporting, PFRC Oversight	Internal	Amber
Internal Monitoring Reporting on current DET services		DET Exec Review, Education & Training Committee Oversight, PFRC Oversight	Internal	Green
External (Commissioner) Reporting on commissioned services in DET and Clinical		Clinical Leadership Meeting Review, DET Exec Review, PFRC Oversight, Commissioner Review Meetings	Internal / External	Green
Alignment of internal services reporting with financial controls		External Financial Audit (annual)	External	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Address service specifications with commissioners during contracting round	Commercial Director	June 2024	The commissioner has requested that we work through a fully developed proposal on the service specifications throughout 23/24, aligning our services with NCL core services. This was completed but will need to be updated refreshed to reflect 24/25 contract agreements. Regular process of review needs to be established to maintain progress.
Development of Internal Reporting for DET Services – ensuring consistency with IQPR process.	Director of Education (Operations)	Completed 23/24	Enhanced DET performance reporting is starting from the PFRC meeting in May 23. This will provide a level of assurance/control but will not be finalised. DET performance will be reported regularly and will improve during the remainder of the year in line with the DET Operations Improvement Programme which is aligned with the IQPR programme.

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
Deliver Medium and Long-term Commercial Strategy for growth – contributing to a balanced MTFP	Commercial strategy developed, specific income opportunities being perused and finalised. Internal structure to continue to develop opportunities in line with the commercial strategy being developed by CFO and Director of Strategy	Finalising and agreeing additional income opportunities and identifying new markets.	Board approval of balanced MTFP including future income growth strategy

Principal Risk 12	IT infrastructure and cyber security	Strategic Objective	Improving value, productivity, financial and environmental sustainability.
Description	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.		

Executive Lead	Peter O'Neill Interim Chief Finance Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	20th August 2024
Risk Appetite	Cautious	5	4	20	3	4	12	3	3	9	Date of Next Review	October 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Implementation of security software on all endpoints	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Implementation of security software on all servers	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Successful completion of IG Toolkit annually	Full compliance with mandatory IG training	NHS DSPT toolkit annual submission. External validation of submission IT has also created a new cyber information video which will assist staff in recognising threats and communication to all staff has been sent.	External	Amber
Compliance with industry standard Cyber Security Accreditations	None presently. However, each year adds additional controls.	External validation with independent Cyber Essentials agency officially accredited from 11/5/23. Including extended control of mobile devices which meant implementing a completely new MDM system and roll it out within a few months. It also includes security testing suppliers as well which is a hot area after CareNotes. We will continue this process going forward. An NCL CIO led Cyber group has been created to combine skills and resource to better tackle potential cyber threats and share rare skills in this area.	External	Green
Implementation of email security infrastructure	None	Secure data tools on email send and receive at a trust level e.g Mimecast. Additional individual email security management via Egress email security software.	Internal/External	Green
Subscription to NHSX cyber threat service	None	NHS issues threat warnings and remedial actions with timescales. These are called CareCerts and we comply with the actions required in the timescales advised where appropriate.	Internal/External	Green
Business continuity plans for all relevant trust areas	Continuous assessment of suitability and regular BCP scenario testing.	Regular BCP scenario testing with feedback loops for continuous improvement approach. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested Lessons learned for the Cyber outage of CareNotes have now been created and relevant functions are implementing the findings	Internal	Amber
Third party system supply cyber assurance	No formal process to ensure suppliers are operating critical systems on the trust's	Regular (suggested annual) update from system suppliers to a structured questionnaire requiring assurances on compliance with	External	Amber

	behalf to acknowledged and agree cyber standards.	evidence. Would be appropriate to engage a 3rd party assessment service		
Cyber security personal resource dedicated for cyber role	Cyber security personnel resource.	Cyber Security functions and personal resource proposal has been presented to Director of Infrastructure. JD for Cyber Security Manager, and associated role.	Internal	Red

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Increased communication and monitoring of IG mandatory compliance	Data Protection Officer	By June 2024 and annually thereafter.	In progress
Annual review and implementation of new standards for cyber safety	Director of Infrastructure	Annual submission to Cyber Essentials to achieve ongoing accreditation. 24th July 2024	Complete
Review of BCP plans across the trust with recommendations for improvement. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested twice since 2020 and have successfully managed associated risks and maintained trust effectiveness.		By end of FY 23/24	To be agreed
Review supplier base and engage 3rd party assessment service	Director of Infrastructure	Q2 FY23/24	To be agreed
PFRC support and approval for adequate cyber security personnel resource.	Director of Infrastructure	Q2 FY23/24	To be agreed

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Increase external Cyber Essentials accreditation	Cyber Essentials accreditation was officially granted on 11/5/23 having implemented a number of extended controls including additional software for mobile device management.	None NHS England is now moving to Cyber Assurance Framework (CAF) from next year. However, Trust still needs to maintain Cyber Essentials as certain contracts still require this accreditation.	External Cyber Essentials accreditation organisation. Trust Audit program
Engage 3rd party cyber assessment of trust suppliers across all of the infrastructure to ensure compliance to trust / NHS standards	Planning is underway via the recovery of the CareNotes system and will deliver outcome in Q1 FY23/24. Intention is to pilot with Advanced (CareNotes supplier) and then roll out to all other system suppliers	Will require funding of the service to be acquired. Higher priority work impacting internal technical resource	NHS (digital team) 3rd party assessor Trust audit programme

Principal Risk 13	Failure to achieve required levels of performance and productivity	Strategic Objective	Improving value, productivity, financial and environmental sustainability
Description	**If** the Trust is unable to achieve contracted levels of performance and productivity **Then** - the Trust will be in breach of its contractual obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. **Resulting** sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, including risks to patients' mental health, and reputational risk.		

Executive Lead	Hector Bayayi Managing Director	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	20th June 2024
Lead Committee	PFRC Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	15th August 2024
Risk Appetite	Cautious	4	4	16	3	4	12	2	4	8	Date of Next Review	05th September 2024

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Activity, waiting list and quality impact risk monitoring across key services (including Adult Services, GIC and Autism Assessment).	Clear understanding of capacity to reduce waiting times and meet increasing demand for some services.	New three-year strategy has reduction of waiting times to 18 weeks across all services as an ambition. Teams are in the process of delivering a trajectory for all service areas. Delivery of this ambition will be tracked via weekly ELT Strategy Delivery Room and Monthly IQPR meetings which report through to Board.	Internal	Amber
Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Data flow is manual so possible errors.	IQPR report is considered by Board and Performance, Finance and Resources Sub-Committee.	Internal	Amber
Job planning to properly understand the capacity of each Team to meet demand for services.	Current reporting structures are out of date for key systems (Oracle, Carenotes, Quality Portal, ESR).	Existing systems still report previous monitoring group structures and therefore ownership of key information on finance and activity is not available at local level where required.	Internal	Red
Patient and Carer Race Equality Framework (PCREF)	This work is currently in the very early stages			Red

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Key performance and information reporting systems are in the process of being automated and aligned to our new management structure which will enable data flow to correct operational monitoring groups.	Hector Bayayi	Draft Team budgets were issued at end of July 2023 and the Informatics Team are working to deliver initial Statistical Process Control data sets (for GIC and Trauma services) during August 2023.	Update pending
Ownership and accountability for finance and activity performance to be held at local level once system reporting aligned to new structure and working within local, Regional and National care systems to align / increase our income in-line with demand for services.	Sally Hodges	Noting progress above, final budgets to be validated with Teams during August and finalised in September 2023.	Update pending
Job planning implementation in place	Hector Bayayi	October 2023	Update pending
Data improvement project	Ian Curr		Update pending

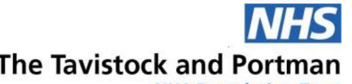
Strategic Delivery Metrics

Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. Streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists	IQPR meetings with contracting updates. As above noting external NHSE meetings to support identification of delivery capacity

MEETING OF THE BOARD OF DIRECTORS (PUBLIC) 12 September 2024			
Report Title: Non-Executive Director Responsibilities			**Agenda No.: 13**
Report Author and Job Title:	Adewale Kadiri, Director of Corporate Governance	**Lead Executive Director:**	Adewale Kadiri, Director of Corporate Governance
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	Following a change to the composition of the Board of Directors, this report provides an update on the current Non-Executive Director (NED) commitments and responsibilities for 2024/25.		
Background:	In December 2021, NHS England (NHSE) published guidance on a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. The guidance also confirmed the 5 areas in relation to which they expect boards to continue to have NED champions as: • Maternity • Wellbeing guardian • Freedom to speak up • Doctors' disciplinary • Security management The Board received a report in February 2023 confirming the identities of the champions, as well as committee memberships and other roles. The purpose of this paper is to update these roles following the end of Debbie Colson's term of office on 31 March 2024 and the appointment of Ken Batty on 1 April.		
Assessment:	Following Ken Batty's appointment in April 2024, we have taken the opportunity to review committee memberships, NED champions and NED lead for Gloucester House. It will be for the Council of Governors to appoint the Vice Chair, and a proposal regarding this will be put to them at their next meeting in October 2024.		
Key recommendation(s):	The Board is asked to **NOTE**: 1. The Non-executive Director commitments for 2024/25		
Implications:			

Strategic Ambitions:
(tick)

☐ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading	☐ Developing partnerships to improve population	☐ Developing a culture where everyone thrives	☐ Improving value, productivity, financial and



	local, regional, national & international provider of training & education	health and building on our reputation for innovation and research in this area	with a focus on equality, diversity and inclusion	environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain: (tick)	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register: (tick)	BAF ☐	CRR ☐	ORR ☐		
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, failure to have effective corporate governance arrangements in place will be detrimental to the Trust.				
Legal and Regulatory Implications: (tick)	Yes ☒	No ☐			
	Appointment of the NED champions aligns with NHSE guidance as well as the Code of governance for NHS provider trusts				
Resource Implications: (tick)	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☐	No ☒			
Freedom of Information (FOI) status: (tick)	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:					
Reports require an assurance rating to guide the discussion: (tick)	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

NON-EXECUTIVE DIRECTOR COMMITMENTS – 2024/25

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
John Lawlor	Trust Chairman	• Remuneration Committee (**Chair**)	None	• Council of Governors (Chair)	June 2022 (2nd term of office ends 4 June 2025)
Aruna Mehta	NED	• Performance, Finance & Resources Committee (**Chair**) • Remuneration Committee (Member)	None	None	November 2021 (First 3-year term of office ends November 2024)
David Levenson	NED	• Integrated Audit and Governance Committee (**Chair**) • Education & Training Committee (Member) • Performance, Finance & Resources Committee (Member) • Remuneration Committee (Member)	• Security Management Champion	None	September 2019 (Second term of office ends September 2025)
Shalini Sequeira	NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (**Chair**) • Remuneration Committee (Member)	• Wellbeing Guardian/ Champion	None	November 2021 (First 3-year term of office ends November 2024)

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
		• Performance, Finance & Resources Committee (Member)			
Claire Johnston	NED	• Quality and Safety Committee (**Chair**) • People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	Joint Freedom to Speak Up NED Lead	Gloucester House Steering Group (Member)	November 2022 (First 3-year term of office ends November 2025)
Sal Jarvis	NED	• Education & Training Committee (**Chair**) • Integrated Audit and Governance Committee (Member) • Remuneration Committee (Member)	None	None	November 2022 (First 3-year term of office ends November 2025)
Ken Batty	NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	Joint Freedom to Speak Up (FTSU) NED Lead	None	April 2024 (First term of office ends March 2026)
Janusz Jankowski	NED	• Quality and Safety Committee (Member)	Doctors Disciplinary Champion/ Ind dependent Member	None	November 2022 (First 3-year term of office ends November 2025)

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
		• Education & Training Committee (Member) • Remuneration Committee (Member)			
Sabrina Phillips	Associate NED	• Quality and Safety Committee (Member) • Remuneration Committee (Member)	None	None	November 2022 (First 3-year term of office ends November 2025)

MEETING OF THE BOARD OF DIRECTORS - 12th September 2024			
Report Title: Guardian of Safe working Hours (GOSWH)			**Agenda No.: 014**
Report Author and Job Title:	Dr Gurleen Bhatia Consultant Psychiatrist	**Lead Executive Director:**	Dr Chris Abbott
Appendices:	1. Introduction 2. Exception reports 3. Junior doctor's forum (JDF) 4. Local Negotiating Committee (LNC)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report details about concerns raised by trainees regarding fine payments, DRS login issues resulting in reporting breeches on later dates. This relates to trainees working on other sites however employed be the trust.		
Background:	The GOSWH report details about the exception reporting by the trainees, breeches relating to on calls, fines resulting and any ongoing concerns.		
Assessment:	This report details fines for Q1 2024.		
Key recommendation(s):	We continue to encourage the junior doctors to report breeches and encourage to use the GOSWH fund for their professional development.		

Implications:				
Strategic Ambitions: (tick)				
☐ 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: No Linked Risks		
Legal and Regulatory Implications:	Yes ☐	No ☒	
	There are no legal and/ or regulatory implications associated with this report.		
Resource Implications	Yes ☐	No ☒	
	No current resource implications associated with this report.		
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒	
	No current EDI issues arising from 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:	Report submitted to Local Negotiating Committee (LNC) prior to this submission.			
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: Same title as on the cover report
(Use this template for the main report)

14a. Guardian of Safe working Hours (GOSWH)

1. Purpose of the report

1.1. xxx

2. Background

2.1. xxx

3. Body of Report

3.1. xxx

4. Body of Report

4.1. xxx

5. Body of Report

5.1. xxx

6. Options

6.1. xxx

7. Recommendations

7.1. xxx

8. Conclusion

8.1. xxx

Report to	Date
Trust Board	05/08/24

Guardian of Safer Working Hours Q1 2024

Executive Summary

The report details about concerns raised by trainees regarding fine payments, DRS login issues resulting in reporting breeches on later dates. This relates to trainees working on other sites however employed be the trust.

Recommendation to the Board

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Gurleen Bhatia (GOSWH)	Chris Abbott

Guardian of Safe working hours Q1 report

1. Introduction

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

2. Exception reports

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
April	1	0	1	0
May	3	3	2	0
June	1	0	1	0

2.2 Work schedule reviews

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

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

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

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

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

	Extra hours worked Normal	Enhanced	Total fine	Amount paid to trainees	Fine Remaining
	hrs	hrs	£	£	£
April	0	5	866.7	325.05	541.065
May	1	17	3073.3	1152.62	1920.68
June	0	1	173.34	65.01	108.33
Total	1	23	4113.34	1542.68	2570.075

3. Junior Doctors Forum (JDF)

Last JDF meeting on 3rd June 24.

4. Local Negotiating Committee (LNC)

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

Conclusions and Recommendations

4.1. Members of the Board are asked to note the report.
4.2. We continue to encourage the junior doctors to report breeches and encourage to use the GOSWH fund for their professional development.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) - September 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	27 June 2024	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **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	

Key headline	**Assurance rating**
1. EDI considerations • We focussed on BAF Risk 7 (inclusive culture) for this meeting and used it to inform and underpin our discussions throughout the committee. • Bullying and harassment - we believe this to be under reported and we talked about the reasons as well as potential mitigations to receive a realistic picture of the extent of the issue. • Race Equality Network – it was noted and commended that great work had been undertaken by the network; 14 events in 3 months, all led by Pauline as she has no co-chair at present. • WRES/ WDES action plans - robust high-level actions identified which the committee is assured will make a difference. We have little time to make an impact before the next staff survey commences in September. However, these are being triaged by the EDI Prog Board to identify which areas to tackle first.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. L&D and OD updates • LMDP - good progress have been made in getting managers onto the cohorts. We will disseminate the learning to groups at lower levels - further info on what this looks like to come. • Some gaps were identified in the LMDP e.g. freedom to speak up, dealing with bullying and harassment and we will be exploring other mechanisms to tackle these. • Appraisal compliance - we can see where the gaps are; we now need to address them. Compliance of this area as well as statutory and mandatory training is covered in the IQPR dashboard.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Wellbeing and environment • Room usage was discussed, and it was acknowledged that there is not enough data about how rooms are being used at T&P; we are collecting and have agreed principles for the new room usage system.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

• Yoga room I it was noted that we will lose the funding for this soon unless we use it. Benita has been tasked with finding an alternative solution (and this has now been sourced since the meeting took place).	
4. Reflections • It was noted that it had been helpful centring the meeting around a themes; allowing more discussion on the papers there were deeper issues. • Enabling the committee to spend more time on two-three topics allowed the committee to have a proper discussion. • Also valuable to keep coming back to the BAF • Linking in with EDI programme board.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

There was no specific item requiring decision making.

Risks Identified by the Committee during the meeting:

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

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

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

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

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – 12 September 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	3rd September, 2024	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	BAF risks 3 &4		**Agenda Item: 17**		
Assurance ratings used in the report are set out below:					
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Development of Education & Training BAF risks • ETC has discussed and proposed new changes to BAF risks 3 and 4 - related to DET - that the board is asked to approve. • These risks relate to continued validation (degree awarding) of our long courses and sustainable student recruitment.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. SITS • ETC reviewed a deep-dive investigation into the SITS (Strategic Information Technology System) that underpins our student enrolment and progression. • A recent independent review by STU3 observed that the initial implementation of SITS in 2015 was incomplete and has posed several problems for DET, including necessitating staff manual workarounds in some cases. • Staff turnover and the accompanying loss of expertise has adversely impacted our ability to use SITS effectively including to pass information to our partners and accrediting bodies (including OfS and HESA, adversely affecting income for the 23/24 FY). • A recovery plan is in place together with agreement for up to £100,000 of additional capital investment.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Student Debt • Student Debt has been a concern to the committee for the previous six months: it is not clear what debt is recoverable and what needs to be written off and finance resource has been dedicated to audit over this period meaning understanding has not progressed. • The Committee noted a new Student Credit Controller role was now in recruitment to assist in debt identification and recovery. • ETC feel able to offer assurance on this for the present time but if the scale of the problem feels unmanageable it may be escalated.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Development	Limited ☐ Partial ☐

• ETC noted over £641k in new tenders had been submitted by DET since July with additional work in progress including a £200k international contract. • DET will be present on a further Trade Mission to China in October together with a new prospectus.	Adequate ☒ N/A ☐
5. Student Recruitment • Student recruitment for the 2024 -25 cycle has been very positive. Now that all courses are closed to recruitment, we have 1134 applications (an increase of 18.5%) for our long courses, with commensurate increases of 50.6% to unconditional offers made and 11.9% firm acceptances. • Enrolment will take place into October, when we will hopefully see this translate into higher student numbers for 2024/25. • Finance Partners	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- Next committee is 23/10/2024

Risks Identified by the Committee during the meeting:

- Please see attached BAF risk update

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

None.

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

Item	Purpose	Date
None		

<table>
<tr><td colspan="4">MEETING OF THE BOARD OF DIRECTOR (Public) – September 12th, 2024</td></tr>
<tr><td colspan="3">Report Title: Finance Report – As at 31st July 24 (Reporting Month 04)</td><td>Agenda No. 19</td></tr>
<tr><td>Report Author and Job Title:</td><td>Hanh Tran, Deputy Chief Finance Officer</td><td>Lead Executive Director:</td><td>Peter O’Neill, Interim Chief Financial Officer</td></tr>
<tr><td>Appendices:</td><td colspan="3">None</td></tr>
<tr><td colspan="4">Executive Summary:</td></tr>
<tr><td>Action Required:</td><td colspan="3">Approval ☐ Discussion ☐ Information ☒ Assurance ☐</td></tr>
<tr><td>Situation:</td><td colspan="3">The report provides the Month 04 (cumulative position to the 31st July 24) Finance Report.
Income & Expenditure
The Trust incurred a net deficit of £775k in the period, against the plan of £810k, a positive variance of £35k. The operating expenditure to date however is behind plan by £775k, with an offset of a positive income variance of £810k. The expenditure variance is expected to reduce in future periods with the M4 position generated by one-off costs in both pay and non-pay. The overperformance in income is due in some part to the timing of receipts and is expected to reduce closer to plan in future periods also.
The Trust is expecting to achieve its year-end deficit plan of £2,200k, with no significant risk to plan known at the time of writing.
Capital Expenditure
To date capital spend is limited, totaling only £160k, £188k behind the planned spend to date of £348k. The reduced spend is due in the main to slower than expected spend on backlog maintenance to date, that is expected to catch up in future periods. Anticipated expenditure at the year-end is expected to be on plan (including the additional capital allocation of £268k) at £2,468k.
Cash
The cash balance at the end of M04 was £658k against the planned balance of £1,850k. This was due in the main to the late receipt of an NHSE income source. This is therefore anticipated to be a short-term deficit with the timing of payments and receipts in future periods expected to bring the balance back towards plan.</td></tr>
<tr><td>Background:</td><td colspan="3">The Trust has an agreed deficit revenue plan for 2024/25 of £2.2m, with a Capital Expenditure limit of £2.2m and a planned year-end cash position of £1.9m, based on accessing £7.5m cash support in year.</td></tr>
<tr><td>Assessment:</td><td colspan="3">Income and Expenditure
The Trusts agreed deficit plan of £2,200k is contingent on the delivery of recurrent efficiency targets of £2,500k and the release of non-recurrent balance sheet opportunities of £2,656k, a total of £5,156k.
The Trust will in addition continue to identify and pursue additional income opportunities, not currently part of the 24/25 plan, as part of its development of the medium-term financial plans designed to achieve a balanced financial position in future periods. This being a key part of the merger development and delivery work.</td></tr>
</table>

	Capital Expenditure The agreed capital spend limit for the year is £2,468k, an increase on the previously advised figure of £2,200k, which was broadly similar to that in 23/24. The increase is due to the Trust sharing in the additional capital awarded to the ICS for delivering a balanced plan in 24/25. Initial planning was based on an expected allocation of c.£1,950k, thus a limited degree of replanning of the capital program will be required in the early part of 24/25 to reflect the additional available capital. **Cash** The agreed plan included a reduction in cash over the year to an outturn of £1,950k, which is driven by the deficit, non-cash income sources in the financial plan for 24/25 and the planned capital spend. This cash flow forecast in the 24/25 plan is reliant on cash support of £7,500k being agreed throughout the year by NHSE. The cash support comes into the Trust via a monthly application for additional non repayable PDC.
Key recommendation(s):	The Board is asked to **NOTE** the position outlined in the report.

Implications:

Strategic Objectives:

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 9: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.		

Legal and Regulatory Implications:	Yes ☒	No ☐
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.	

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

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

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

NHS
The Tavistock and Portman
NHS Foundation Trust

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Date of Meeting			**09-May**	**11-Jul**	**12-Sep**	**14-Nov**	**16-Jan**	**13-Mar**							
Items to consider - Gloucester House	Approval	ICNO				P					Well-led & Effectively Governed				
Items to consider - Informatics Strategy	Discussion	IM&T				P			Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan				