NHS

The Tavistock and Portman
NHS Foundation Trust

Council of Governors Part Two

Agenda and papers of a meeting to be held in public

Thursday, 17th October 2024

For timings and venue, please refer to the agenda.

The Tavistock and Portman
NHS Foundation Trust

COUNCIL OF GOVERNORS – PART TWO
MEETING HELD IN PUBLIC
17 OCTOBER 2024 at 3.10 – 5.30 p.m.
Lecture Theatre, 5th Floor
The Tavistock and Portman NHS Foundation Trust, as well as Online (via Zoom)

AGENDA

24/05	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	3.10 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Council of Governors' Declarations of Interest	Information	Chair	E		
004	Service Presentation - Patient Safety	Discussion	Afia Nkrumah & Elizabeth Newington, Patient Safety Partners and Lucy Haggerty, Patient Safety & Clinical Governance Manager	V	3.15 (15)	
005	Minutes of the Previous Meeting held on 30 May 2024	Approval	Chair	E	3.30 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	3.35 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	3.40 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
008	Governor Feedback (including training, visits, etc)	Information	All Governors	V	3.50 (10)	
009	Governor Elections	Information	Director of Corporate Governance	E	4.00 (5)	
010	Board Assurance Framework (BAF)	Information	Director of Corporate Governance	E	4.05 (5)	
Comfort Break (5 minutes) 4.10pm – 4.15pm						

PROVIDING OUTSTANDING PATIENT CARE						
011	Integrated Quality and Performance Report	Discussion	Managing Director	E	4.15 (5)	
012	Trust Response to Recent External Reviews	Discussion	Chief Nursing Officer	E	4.20 (5)	
013	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Quality and Safety Committee (QSC) Governor observer feedback	Discussion	QSC Governor Observer	V	4.30 (5)	
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
014	People, Organisational Development, Equality, Inclusion and Diversity Committee (POD EDI) Assurance Report	Assurance	POD EDI Committee Chair	E	4.35 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	People, Organisational Development, Equality, Inclusion and Diversity Committee (POD EDI) Governor observer feedback	Discussion	POD EDI Governor Observer	V	4.40 (5)	
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
015	Education and Training Committee (ETC) Assurance Report	Assurance	E&T Committee Chair	E	4.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Education and Training Committee (ETC) Governor observer feedback	Discussion	ETC Governor Observer	V	4.50 (5)	
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
016	Performance, Finance and Resources Committee (PRFC) Assurance Report	Assurance	PFR Committee Chair	E	4.55 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Performance, Finance and Resources Committee (PRFC) Governor observer feedback	Discussion	PRFC Governor Observer	V	5.00 (5)	
017	Finance Report – Month 5	Information	Chief Finance Officer	E	5.05 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
018	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	E	5.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

	Integrated Audit and Governance Committee (IAGC) Governor Observer feedback	Information	IAGC Governor Observer	V	5.15 (5)	
CLOSING ITEMS						
019	Questions from the Public	Discussion	Chair	V	5.20 (5)	
020	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V	5.25 (5)	
021	Issues to be escalated to the Board of Directors	Discussion	Chair	V	5.30 (5)	
022	Reflections and Feedback from the meeting	Discussion	Chair	V	5.35 (5)	
DATE AND TIME OF NEXT MEETING						
023	Thursday 5th December 2024 at 3.00pm – 5.00pm					

REGISTER OF GOVERNOR INTERESTS - 2024/25 (LAST UPDATED 28/03/24)

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

1

NAME	POSITION HELD (INCLUDING CONSTITUENCY)	FIRST APPOINTED	DESCRIPTION OF INTERESTS DECLARED	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
Maisam Datoo	Staff - Admin & Technical	December 2022 (1st term)	NIL RETURN			
Paru Jeram	Staff - Education & Training	December 2021 (1st term)	NIL RETURN			
Katharine Knight	Student	May 2022 (1st term)	Honorary Contract at Oxford Health NHS Trust	01/09/2022	present	Trainee psychotherapist voluntary placement.
David O'Mahony	Stakeholder - University of Essex	May 2021 (1st term)	NIL RETURN			
Peter Ptashko	Stakeholder - Local Authority	March 2022 (1st term)	NIL RETURN			
Kathy Elliott (Lead Governor)	Stakeholder - Voluntary Action Camden)	December 2020 (2nd term)	Trustee and Vice Chair of Voluntary Action Camden (3)	Sep-20	present	Stakeholder Governor representing Voluntary Action Camden
			Vice Chair Caversham Practice Patient Participation Group (3)	06/01/2014	present	no perceived conflict
			Chair Registration Panel; and Assessor UK Public Health Register (3)	06/01/2014	present	no perceived conflict
Robert Waterson	Stakeholder - University of East London)	December 2022 (1st term)	NIL RETURN			
	Categories:					
1	Directorships including non-executive directorships, held in private companies or PLCs (with the exception of directorships of dormant companies)					
2	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS					
3	Position(s) of authority in a charity or voluntary organisation in the field of health and social care					
4	Any connection with a voluntary or other body contracting for NHS services					
5	Any connection with an organisation, entity or company considering entering into, or having entered into, a financial arrangement with the Trust, including but not limited to lenders or banks					

2

UNCONFIRMED MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN PUBLIC THURSDAY 30TH MAY 2024, 3.30 – 5.35PM. LECTURE THEATRE, TAVISTOCK & PORTMAN NHS FOUNDATION TRUST 120 BELSIZE LANE, LONDON, NW3 5BA AND VIRTUALLY VIA ZOOM

PRESENT:

John Lawlor	Trust Chair and Chair of the Council of Governors	JL
Kathy Elliott	Stakeholder Governor and Lead Governor	KE
Ffyona Dawber	Public Governor	FD
Jessica Anglin d'Christian	Staff Governor	JAC
Jocelyn Cornwell	Public Governor	JC
Katharine Knight	Student Governor	KK
Kenyah Nyameche	Public Governor	KN
Michael Rustin	Public Governor	MR
Michelle Morais	Public Governor	MM
Michael Arhin-Acquaah	Public Governor	MAA
Maisam Datoo	Staff Governor	MD
Natalia Barry	Public Governor	NB
Paru Jeram	Staff Governor	PJ
Sheena Bolland	Public Governor	SB
Stephen Frosh	Public Governor	SF

IN ATTENDANCE:

Michael Holland	Chief Executive	MH
Rod Booth	Director of Strategy and Business Development	RB
Peter O'Neill	Interim Chief Finance Officer	PON
Dorothy Otite	Governance Consultant	DO
Jane Meggitt	Interim Director of Communications	JM
Aruna Mehta	Non-Executive Director	AM
David Levenson	Non-Executive Director	DL
Janusz Jankowski	Non-Executive Director	JJ
Ken Batty	Non-Executive Director	KB
Sabrina Phillips	Non-Executive Director	SP
Sal Jarvis	Non-Executive Director	SJ
Rachel James	Clinical Service Director (item 4)	RJ
Emma Casey	Associate Director of Quality (item 11)	EC
Sally Hodges	Chief Clinical Operations Officer (item 12)	SH
Gem Davies	Chief People Officer (items 13 and 14)	GD
Fiona Fernandes	Business Manager Corporate Governance (minutes)	FF

APOLOGIES:

Adewale Kadiri	Director of Corporate Governance
Julian Lousada	Public Governor
Peter Ptashko	Stakeholder Governor Local Authority
David O'Mahony	Stakeholder Governor University
Sebastian Kraemer	Public Governor
Robert Waterson	Public Governor
Claire Johnston	Non-Executive Director
Shalini Sequeira	Non-Executive Director

Page 1 of 9

24/001	**WELCOME AND APOLOGIES FOR ABSENCE**	

JL welcomed all to the meeting.

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

24/002	**CONFIRMATION OF QUORACY**

The Chairman **NOTED** and confirmed the meeting was quorate.

24/003	**DECLARATIONS OF INTEREST**

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

24/004	**SERVICE PRESENTATION – FITZROVIA YOUTH ACTION CAMHS**

Rachel James, Clinical Service Director presented the work of the Fitzrovia Youth Action CAMHS.

Rachel James provided an overview of the work of Fitzrovia Youth Action CAMHS and presented a video about the peer support work and the importance of it.

KE noted that it would be beneficial to get wider coverage for the service through social media.

Responding to KE, RJ noted that the Fitzrovia are paid by the local authority and have a social prescribing CAMHS offer.

MR suggested that as there was a need for growth and research, it would be advantageous to put in expressions of interest to all the CAMHS as well as other providers who have the appetite.

MAA noted that the information was enthralling and found that peer mentoring and peer support very beneficial. TransPlus were hiring other Trans who worked as peer support, and it would be good to connect with them. Noting that having this service pre-CAMHS was really helpful and would like to see it rolled out nationally.

KB noted that this service should be taken to Trusts who have adult services with no funding after 18 years of age. It was a necessary service, and it would be beneficial if the merger partners saw the video.

The Council thanked RJ for the presentation and commended the service for the continued good work.

Page 2 of 9

| 24/005 | **MINUTES OF THE PREVIOUS MEETING HELD ON 28th MARCH 2024** |

DECISION: The Council of Governors **APPROVED** the minutes of the previous meeting held on 28th March 2024 as an accurate record pending the minor amendment of Letby's spelling.

| 24/006 | **ACTION LOG and MATTERS ARISING FROM THE MINUTES ON xxx** |

One open action was **APPROVED** for closure.

The action regarding the Service Visits and Engagement events were to remain open.

There were no other matters arising raised.

| 24/007 | **CHAIR'S AND CHIEF EXECUTIVE'S REPORTS** |

The Chief Executive's report was taken as read. MH provided the following key highlights:

- The Patient Safety Incident Response Framework (PSIRF) was launched on 22nd April 2024. To align with the new framework, the Trust will be implementing the use of RADAR.
- Patient and Care Race Equality Framework (PCREF) implementation plan had been formally approved by the Quality and Safety Committee. An engagement plan will be launched to ensure the work is integrated in frontline clinical governance and that the services that the Trust provides is fully accessible to all sections of the communities it serves.
- The financial plan for 2024/25 was submitted to the Integrated Care Board (ICB) for inclusion in the consolidated Integrated Care System (ICS) summary for NHSE, on 29 April. This continues to show a planned deficit of £2.4m and was developed in line with the ICS planning process. The Trust is planning to achieve a balanced financial plan in 2025/26.

Responding to SF, MH noted that in relation to the delegation to China, he had spoken to Prof Mark Freestone, Chief Education and Training Officer and we will need to look at how this is incorporated in the business development plans.

The Council received and **NOTED** the Chief Executive's report.

| 24/008 | **GOVERNOR FEEDBACK** |

KE provided the following verbal feedback:

- The focus for AK was to get Governor observers on the Board Committees and this has got off to a good start. Governors are learning more about the work of

the Committees, however there were a lot of papers to read.
- Working with the Chairs of the Committees to bring views to the meetings.
- Thanks to the Governors who contributed to the Quality Statement, which formed part of the formal statement that KE as the Lead Governor had to provide.
- Thanks to the Governors who provided feedback for the appraisal of the Trust Chair.
- It would be beneficial to build contacts with the Stakeholders around the merger.
- Looking at different ways of keeping the Governors more informed.

The Council **NOTED** the verbal update.

24/009	**UPDATED COUNCIL OF GOVERNORS' DEVELOPMENT PROGRAMME**

DO presented this on behalf of AK. The report was taken as read and DO provided the following highlights:
- Initial proposals were presented to the Council of Governors last December, but these had not been implemented. Appreciating that all our Governors are volunteers and can only devote so much time to Trust business, it is important that the right balance is struck between providing the training and development that Governors need and not demanding too much additional time.
- When the Trust approaches the key decision-making point in the merger process, the Council has a specific statutory role in this process. It is important therefore to ensure that all governors are fully equipped and supported to perform their functions effectively.
- The areas for improvement are the Induction Programme, and an ongoing training and development plan. As many existing Governors did not undergo a formal induction when they joined the Trust, all Governors may benefit from a refresher training. It would be good to hear from Governors what would be useful to include in the refresher training.
- The first few months of the new development programme set out in the report was **AGREED** in principle by the Governors noting that in view of the merger, Governors will be provided an introduction to the Significant Transactions regime.

Responding to a query raised by KK, JL noted that Governors can claim travel expenses.

The Council **DISCUSSED** the report and noted the proposals.

24/010	**INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) ASSURANCE REPORT**

The report was taken as read. DL highlighted:

- That he had arranged to meet with the Governor observer, PP next month.
- The Committee received three reports with partial assurance from internal audit.
- DL explained to the Governors the functions/remit of the internal and external auditors.
- Grant Thornton were appointed to do the external audit on getting value for money. They have been providing excellent service and are thorough. Meetings

Page 4 of 9

are held fortnightly with the auditors and PON and, weekly with the Finance team.

- The progress report indicated the Audit was on track to meet the national submission deadline.
- Following the external auditor's opinion of the Value for Money (VFM) assessment for 2022/23, the Governance review was noted as not fully implemented. An Integrated Governance Action Plan Task and Finish Group was developed to oversee the implementation of the Governance review actions. The Group was chaired by MH with DL, SP and AK as members and supported by DO. At the end of 2023/24, the Group was satisfied with the progress made and concluded that the concerns around Governance were addressed and were therefore given a clean opinion on the VFM report.
- The Internal Auditors highlighted in their preliminary reports, Safeguarding concerns and assured the Committee that this was reported to the Quality and Safety Committee and CS had devised an action plan of what needed to be addressed.

The Council received the IAGC assurance report.

24/011	**QUALITY AND SAFETY COMMITTEE (QSC) ASSURANCE REPORT**

The report was taken as read. EC highlighted:

- The Patient Safety Incident Response Framework (PSIRF) was being implemented.
- Good progress was being made on the implementation of the new Local Risk Management System and noted plans to address the capacity challenges in the project team.
- Discussion of the Quality priorities for the coming year.
- The Committee approved its revised Terms of Reference.
- The Committee reviewed and discussed the new format of the Quality & Safety report which included details against the new set of quality and safety metrics.

Feedback from the Governor observers KE and PJ
PJ noted that it was a learning process for her and that it was the first meeting she had attended.

KE noted that she met with the Committee Chair prior to the meeting. The meeting was well attended, focussed and everyone seemed to be working well together. It gave an insight to understanding how everyone communicates and where there are serious concerns. Noting how different initiatives like Kaizen links to quality as well as how GIC and autism were also linked. KE commented that she felt much more informed to write the Quality Assurance Statement.

The Council received the QSC assurance report.

24/012	**INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)**

The report was taken as read and SH provided the following highlights:

- The IQPR data had been discussed and reviewed within the local teams, clinical service line IQPRs and the Performance, Finance and Resources Committee (PFRC).
- The ultimate aim is for the Teams to have all the data across all the domains to target issues at team level. There are several different dashboards pulling the data from all the different systems and a working group that reviews the data to ensure that the data flow is integrated for ease of review. We are looking at unifying the way the way the data is pulled through as currently there are different cut off times. We constructed A3s which are aligned to the Trusts Strategic priorities, and these are discussed weekly at the Executive Leadership Team (ELT) and in the weekly Quality Improvement (QI) huddles driving a clear focus on improvement in relation to the strategic ambitions. Any issues are taken to the QI huddle to be addressed. The Strategic Areas and A3 are tracking progress and have a watch metrics moving to the Statistical Process Control (SPC) charts.SH noted that it would be useful to get feedback from the Governors on what is helpful and what they would like to see. We are looking into getting the data earlier and this will flow up to the IQPR meetings at service level, then to the PFRC who would look at it in detail. Following this it goes to the Board and would then go to the Council of Governors.SH highlighted that the data for the last drawdown required strengthening. There were issues identified such as different cut off points, and a lag on inputting appointments. This was being reviewed by the Team.

- FD noted that it was good to see this information and see detailed information on the wait times. FD asked if the wait times increased as the referrals increased.

SH responded that the issue was the data and the different cut off points. The Kaizen events targeted services with long waiting lists. We have targeted areas where these are bigger especially in the Autism service.

Responding to SF, SH noted that compliance was non-negotiable and that conversations are still being held on making the staff understand that it is part of their clinical remit to ensure that they comply.

The Council **NOTED** the IQPR report.

24/013	**PEOPLE, ORGANISATION DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSTIY (POD EDI) ASSURANCE REPORT**

The report was taken as read. GD highlighted that the Committee:
- Received an overview of the EDI Governance review report which had been updated to include accountability for the recommended actions.
- Received a paper from the LGBTQI+ network highlighting the events that have been held over the last couple of years.
- Noted that there was an increase in reporting of sickness absence since ESR training for Managers had been implemented.
- There has been a little improvement on appraisal compliance rates, and these have been included in the IQPR watch metrics and can be escalated via this route.

Page 6 of 9

Feedback from the Governor observer FD

FD noted that the meeting was chaired well and that agenda items were given sufficient time for discussions. Everyone that attended were respectful towards each other.

The Council received the POD EDI assurance report.

| 24/014 | **STAFF SURVEY RESULTS AND ACTION PLAN** |

The report was taken as read and GD highlighted the following key points:

- The Trust received a good response rate on the national survey conducted online with 53% of the Trust's staff responding, this is a significant increase on the previous year and a higher response rate than our benchmarked average (52%) and although we were the most improved Trust, we were still bottom of the group.
- The Trust scored significantly higher than the previous year on 3 of the 9 themes.
- Areas for improvement were identified including speaking up and low morale.
- An action plan has been developed for the HR Business Partners who meet with the relevant service leads. There is also work being done around staff engagement and working with the Associate Director of EDI on the EDI issues.

The Council received the report.

| 24/015 | **EDUCATION AND TRAINING COMMITTEE (ETC) ASSURANCE REPORT** |

The report was taken as read and SJ noted that:

- Enhancements had been made to the structure of DET and on data management. Appointments are going to be made to ensure that there is robust governance and student experience.
- Data - There has been a review on SITS and there are still concerns and risks associated with historical issues and the need to secure additional resources to mitigate future challenges on the management of student debt.
- The National Workforce Skills Development Unit has been closed and the staff were redeployed where possible, and those that could not were offered redundancies.

Feedback from the Governor observers SB and MR

SB noted that the meeting was chaired well and there was a lot of information that was succinctly discussed. MR agreed with SB's feedback.

DL added that the Committee acknowledged Elisa Reyes-Simpson who acted as Interim Chief Education and Training Officer and thanked her for her service.

The Council received the ETC Assurance report.

| 24/016 | **PERFORMANCE, FINANCE AND RESOURCES COMMITTEE ASSURANCE (PFRC) REPORT** |

The report was taken as read and AM highlighted the following key points:

- The Committee has more visibility on data, and gaps in performance.
- Concern was raised about the status of PCPCS and the HEE funding based on the contracts at risk item on the IQPR.

Feedback from the Governor observers SF
SF noted that the chairing of the meeting was exemplary. There were debates on the duplication/cross referencing. There were responsible discussions held and the Chair raised the right level of challenge while remaining respectful of staff.

The Council received the PFRC assurance report.

24/017	**FINANCE UPDATES**

The report was taken as read and PON highlighted the following key points:

- PON updated on the position at Month 12 and reported that the Trust incurred a net deficit of £2,517k in the period and was on track with the plan.
- The cash balance at the end of month 12 is £2,350k against the planned figure of £3,091k. The negative variance of £741k reflects the timing of income receivables from NHS sources, the payment of some GIDS estates related decommissioning costs before the cash was received, and an overpayment of PDC to NHSE.
- To date the capital spend totals £2,224k, versus the plan of £2,196k. The small variance against the original plan of £28k is offset by an agreed M12 distribution of unused capital in the ICS.

The Council received the Finance update report.

24/017	**FINANCIAL PLAN 2024/2025**

PON informed the Council that the Trust submitted the latest version of its Financial Plan to the Integrated Care Board (ICB) on 29th April 2024. Following this in line with the national deadlines, the Trust submitted the plan directly to NHS England (NHSE) on 2nd May 2024 showing a deficit plan of £2.4 million.

This revenue plan has since been updated as part of NHSE's drive on improvement to the Integrated Care System (ICS) overall plan to achieve a balance across the ICS. The Trust's share of this reduction is £200k, leaving a revised deficit plan of £2.2 million for 2024/2025.

The agreed capital spend for the year is £2,200k, the same as 2023/2024. This was confirmed by the ICB and is an increase of the initially indicated funding of £1.95m.

The Trust is predicting to run out of cash in Q1 and has accessed the NHS cash support mechanisms in the early weeks of 2024/2025.

The Council **NOTED** the Financial Plan 2024/25 report.

| 24/018 | **QUESTIONS FROM THE PUBLIC** |

There were no questions submitted.

| 24/019 | **ANY OTHER BUSINESS** |

There was no other business raised.

| 24/020 | **ISSUES TO BE ESCALATED TO THE BOARD OF DIRECTORS** |

To ensure that the Council of Governors receive updates on the progress of the potential merger.

| 24/021 | **REFLECTIONS AND FEEDBACK FROM THE MEETING** |

There were none

The Chair closed the meeting at 5.35pm.

Date of Next Meeting in public: Thursday, 17th October 2024 at the Tavistock & Portman NHS Foundation Trust.

Council of Governors Part 2 - Public
Action Log (Open Actions)

					Actions are RAG rated as follows: ->	Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date

Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Action Due date	Action owner (Name and Job Title)	Status **(pick from drop-down list)**	Progress Note / Comments **(to include the date of the meeting the action was closed)**
14.09.23		Freedom to Speak Up Guardian Report	As there was no mention in the BAF and the risk register of psychological safety, it was agreed that there should be a review of the risks considered in the inclusion of BAF and risk register.	14.09.23	Sarah Stenlake, Freedom to Speak Up Guardian & Adewale Kadiri, Director of Corporate Governance	To Close	The BAF has been updated for 2024/25 and all principal risks included. Assurance is via Board Committees and IAGC and then to Board of Directors. Governor Observers at Committees will see the risks being scrutised in action. BAF 7 (Lack of fair and inclusive culture) covers FTSU related measures. **Propose this action to be closed.**
28.03.24	6	Governor Feedback	A service visit programme to be done for all service not only clinical. The programme should include other services like, Education, Corporate, Finance, Estates, etc	May-24	Adewale Kadiri, Director of Corporate Governance	Open	In progress - Service visit programme to be developed in consultation with Governors. This will be progressed at pace ahead of the next CoG meeting.
28.03.24	9	Membership & Engagement Update	To provide information to the Governors regarding feedback from members on the merger information from the website.	Jun-24	Jane Meggitt, Interim Director of Communications	Open	In progress - in addition to the informal sessions with Governors, the Director of Communications and Director of Corporate Governance are working on a Communication and Engagement plan for Governors during the Merger transaction phase.
28.03.24	9	Membership & Engagement Update	To arrange events for the membership – sessions for Young People and sessions for Adults.	Jun-24	Jane Meggitt, Interim Director of Communications	Open	In progress - Previously planned events for May and June 2024 did not proceed due to the Pre-election period guidance. Verbal update on current arrangements to be provided at the meeting.

MEETING OF THECOUNCIL OF GOVERNORS (PUBLIC) – Thursday, 17 October 2024

Report Title: Chief Executive's Report			Agenda No.: 7	
Report Author and Job Title:	Michael Holland, Chief Executive	**Lead Executive Director:**	Michael Holland, Chief Executive	
Appendices:	None			
Executive Summary:				
Action Required:	**Approval** ☐ **Discussion** ☒ **Information** ☐ **Assurance** ☐			
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.			
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Council of Governors should be sighted on.			
Assessment:	This report covers the period since the Board meeting on 11 July 2024			
Key recommendation(s):	The Council of Governors 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.			

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.		
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Chief Executive's Report

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 implemented 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 this month.

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 has commenced for this year, with the Trust choosing an early commencement window - the survey was launched 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 has now been reported on, and the Trust has been engaging with other organisations to understand its implications for the provision of mental health in particular.

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 COUNCIL OF GOVERNORS PART 2 (PUBLIC) – Thursday, 17 October 2024

Report Title: Governor Elections Update			Agenda No. 09
Cover Report Author and Job Title:	Fiona Fernandes, Business Manager Corporate Governance	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Elections Timetable - The Tavistock and Portman		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides an update on Governor Elections for 2024.		
Background:	The term of office for Governors is three years, with eligibility for re-election at the end of the first three-year term.		

With "Background:" cell continuing:

As some members of the Council of Governors are coming to the end of their current terms of office, to fill the vacancies, the Trust is required to go through an election process, where members of the Trust elect Governors to represent their constituencies.

The elections process for the vacant posts is being run on the Trust's behalf by UK Engage, and it commenced on 10 October 2024, with the expectation that it would be completed by 6 December 2024. This was earlier communicated to the Council of Governors by email and each of the Governors affected have been notified individually.

Please note the following sections of the Trust's Constitution which apply to Governors' tenure in office:

14.1   An elected Governor may hold office for a period of up to three years.

*14.2   An elected Governor shall be **eligible for re-election at the end of his first term**. However, **no Governor may stand for election having served two terms or six years**, whichever is the less.*

Assessment:

Vacancies:
There are a total of 8 vacancies on the Council of Governors as follows:

Constituency	Number of seats required	Number of Vacancies	Current Governors
Rest of London	6	4	Michael Rustin – End of 2nd term 20 Oct 2024 Michelle Morais – End of 1st term 20 Oct 2024 Michael Arhin-Acquaah – End of 1st term 20 Oct 2024 Julian Lousada – End of 1st term 20 Oct 2024
Rest of England & Wales	2	2	Kenyah Nyameche – End of 1st term 20 Oct 2024

				Sheena Bolland – End of 1st term 21 Dec 2024
Staff Governors • Clinical, Academic, Senior • Education & Training	1 1	1 1		Jessica Anglin d'Christian – End of 2nd term 20 Oct 2024 Paru Jeram – End of 1st term 21 Dec 2024

There are 2 elected Governors who have completed their second terms and therefore, will not be eligible to stand again:
• Michael Rustin (Rest of London)
• Jessica Anglin d'Christian (Staff Governor, Clinical, Academic, Senior) (left end July 2024)

A separate report was considered by the Council of Governors in Private on 17 October 2024, to cover the vacant seats for the period from 21 October until 20 December.

Election Timetable:

The Election Timetable is attached as Appendix 1 and summarised below for ease:

Action	Date
Last Day for Publication of Notice of Election	10/10/2024
Deadline for receipt of nominations	28/10/2024
Publication of Statement of Nominations	29/10/2024
Deadline for candidate withdrawals	31/10/2024
Notice of Poll/Issue of ballot packs	12/11/2024
Close of Poll 5.00pm	05/12/2024
Count and Declaration of Result	06/12/2024

Publicity for elections:

• The Corporate Governance team, UK Engage and the Communications Team will send out the election material/information to all members and staff.

• The elections will be publicised on the Trust's website Notice Of Council of Governor Elections October 2024 - Tavistock and Portman and on the intranet as well as on 'X' formerly Twitter. Posters and leaflets will be put up around the building and sent to the satellite sites.

• Governors who have only served one term have been informed that they are entitled to stand for one further term on the Council of Governors.

• Governors will be encouraged to pass on details of elections to any eligible members who may be interested in serving on the Council of Governors as the nomination deadline is 5.00p.m. on 5 December 2024.

Key recommendation(s):	The Council is asked to **NOTE** the contents of this report.
Implications:	
Strategic Ambitions:	

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

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

Link to the Risk Register:	BAF ☐		CRR ☐		ORR ☐	
	There are no related BAF risks.					

Legal and Regulatory Implications:	Yes ☒	No ☐
	The Elections	

Resource Implications:	Yes ☐	No ☒
	There are no specific resource implications.	

Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒
	There are no specific EDI implications.	

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:		
Assurance Route - Previously Considered by:	None	

Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC – Thursday, 17 October 2024

Report Title: Oversight of Board Assurance Framework (BAF)		Agenda No.: 10	
Report Author and Job Title:	Nadia Munyoro, Interim Risk Manager	**Lead Executive Director:**	Adewale Kadiri, Director of Corporate Governance
Appendices:	Appendix 1: Board Assurance Framework 2024/25		

Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This paper introduces the latest iteration of the Board Assurance Framework (BAF). Each risk continues to be actively managed between the executive leads and the lead Board committees, and they have been through two cycles of committee meetings since the BAF was approved in May. Overall, the Trust is managing its strategic risks well, 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, at the time that this iteration of the BAF was presented at the September Board meeting, 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 was subsequently approved at the PFRC meeting in September and will be presented as part of the full BAF at the next public Board meeting in November 2024.		
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 to better 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 Council of Governors is asked to: • **NOTE** the status of the strategic risks outlined in the BAF. • **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 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

<u>**Graph 1: the inherent, current, and target risk scores for each of the strategic risks**</u>

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

Risk Scores: Inherent, Current, and Target

Legend:
- Inequality of Access for Patients
- Failure to Provide Consistent High-Quality Care
- Risk of Loss of Validation of DET Degrees
- Potential Contraction of Student Recruitment
- Failure to Attract a Suitable Merger Partner
- Lack of Workforce Development, Retention, and Recruitment
- Lack of a Fair and Inclusive Culture
- Lack of Management Capability and Capacity
- Delivering Financial Sustainability Targets
- Estate Infrastructure and Compliance
- Sustainable Income Streams
- IT Infrastructure and Cyber Security
- Failure to Achieve Required Levels of Performance and Productivity

<u>**Graph 2: Heatmap of current risk scores**</u>

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

Heatmap of Current Risk Scores
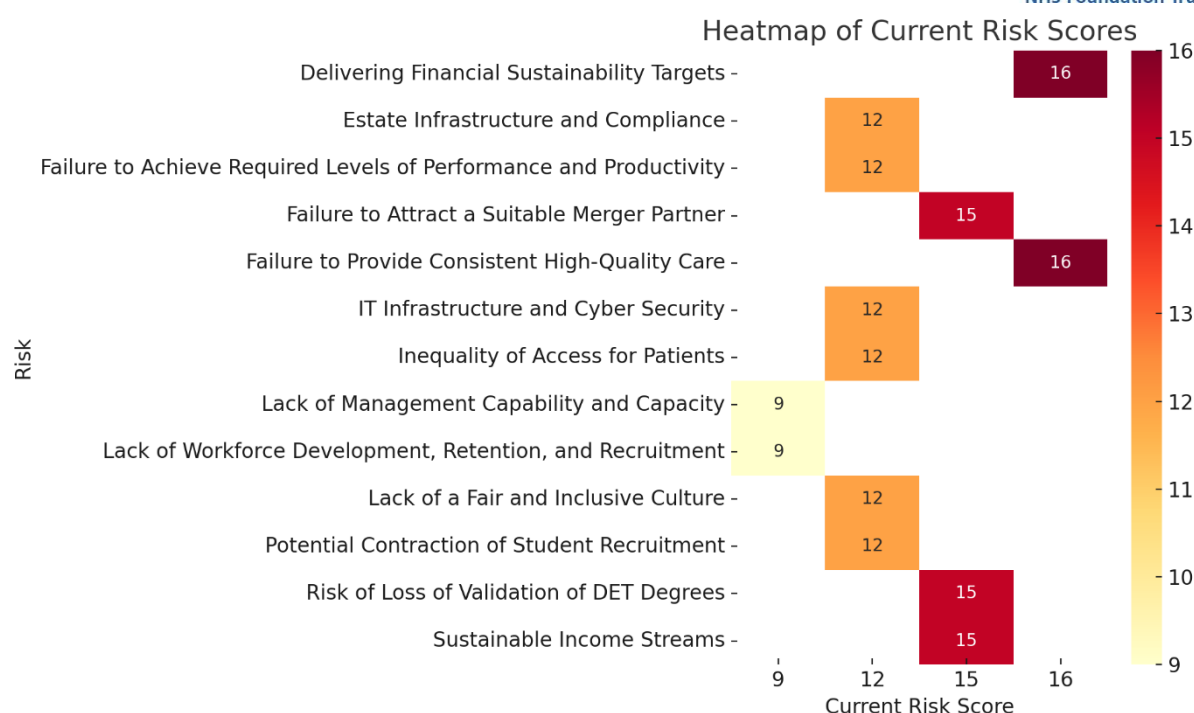
BAF Risks summary progress update

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

Assurance Rating for Each Risk

Failure to Achieve Required Levels of Performance and Productivity

IT Infrastructure and Cyber Security

Sustainable Income Streams

Maintaining an Effective Estate Function

Delivering Financial Sustainability Targets

Lack of Management Capability and Capacity

Lack of a Fair and Inclusive Culture

Lack of Workforce Development, Retention, and Recruitment

Failure to Attract a Suitable Merger Partner

Potential Contraction of Student Recruitment

Risk of Loss of Validation of DET Degrees

Failure to Provide Consistent High-Quality Care

Inequality of Access for Patients

Risk

Green · Amber · Red

Assurance Rating (1=Green, 2=Amber, 3=Red)

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

1

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 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**

2

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**

3

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**

4

Principal Risk 1	Inequality of access for patients		
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.	Strategic Objective	Providing outstanding care

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 ensure 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 on a consistent risk stratification matrix for their pts cohorts.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Internal	Amber
The trajectory for a 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,	Move to risk 13	Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Internal	Amber
Workforce recruitment and retention	Recruitment: The Number of referrals versus the number of PTs we can see. Waiting times are unlikely to recover; in the best case, break even for each service.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber/red

5

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 the 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	It 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 the data dictionary
Training and workshops are 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 about team performance being solution focused. Relates to the new clinical services structures.
Mobilisation of the Clinical Harm Review	TBC		Currently waiting for services to agree risk stratification to mobilise the framework. Workshop to agree on stratification for consistency.
Clinical Pathway mapping	TBC		Progress is being made across all affected service lines in a way that is aligned with the agreed prioritisation framework.
Digitising both the RTT waits to ensure PTL is accurate and appropriate remedial action can be taken.	Ian Curr & Muhammad Akram	TBC	The templates are in the 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

6

Principal Risk 2	**Failure to provide consistent high-quality 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.	Strategic Objective	Providing outstanding care

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 are expected into effect as of September 2024	Internal	Amber
Job planning		The job planning policy was approved by Policy Approval Group on 15th May 2023. Compliance monitored through IQPR	Internal	Amber
The quality and Safety Committee is 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	External (CQC)	Amber
		Clinical supervision –reported in IPQR monthly.	Internal	
		Supervision structures are held at team level, underpinned by Supervision Policy.	Internal	
		Teams report supervision in a monthly log.	Internal	
		Safeguarding supervision taking place, this will be strengthened by developing an improved structure through the Safeguarding forum. Included in the Quality report bi-monthly.	Internal	
Quality assurance tools and methodology		QSC work plan and forward planner		Amber

7

		IQPR Quality & Safety Report to QSC Chair's reports from Tier 3 Groups to QSC Clinical Governance meetings		Amber
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. Patient Safety Policy approved and ratified August 2024.	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	June 2024	Complete – Live since June 2024
PSIRF implementation			

8

Improve Complaints Process	Interim Complaints Manager/ Associate Director Quality		Timeliness– introduction of Radar includes weekly reminders. Improved monitoring of the timelines for complaints. Increased response time for a complaint to 40 days period Changed the reporting template, enabling the investigator to focus on the key lines of enquiry.
			Lessons learnt – Radar and new investigation reporting template allow the focus on lessons learnt, and action plan the result from lessons. Able to allocate and monitor action progress.
			Regularly report on lessons learned and response rates from complaints to relevant committees (QSC, SUEG, and Clinical Governance meetings.
Complaints Policy		October 2024	Policy approved by SUEG. Ratification October 2024
Implement the outcomes of the clinical restructure consultation.		September 2024	Complete as of September 2024.

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			

9

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	31st January 2023
Lead Committee	Education Training Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	28th September 2024
Risk Appetite	Cautious	4	5	20	3	5	15	1	5	5	Date of Next Review	03rd November 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)
Secure a long-term validation solution	Our existing validation solution for most courses with the University of Essex could be vulnerable to OfS changes.	The potential merger includes a University partner – UCL – within the consortium who could validate T&P degrees sustainably. Other partner options are being explored.	External	Amber
Appropriate staffing to support OfS compliance	Lack of resources to ensure that the Trust can be OfS compliant either independently or with a long-term partner.	We are growing Established infrastructure to support the functions required for delivery of governance to maintain OfS registration.	Internal	Amber
Systems Infrastructure (data quality) adequate to support OfS compliance	Need for systems to support not hinder data returns to partners, OfS and HESA. Limited confidence in certain control measures among staff members.	Commissioned external consultants to carry out full discovery of SITS with forthcoming recommendations for changes to improve functionality.	External	Amber
OfS working group to provide regular updates to Director of Education (Governance & Quality)	Director of Education (Operations)	ETC to review reports and updates and monitor OfS returns.	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

10

Pro-actively seek a partner or partners to encompass validation work for all current and future long courses.	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.	Head of Registry now appointed SITS review complete and additional investment agreed	Delays in recruitment process Not aligned with traditional HE sectors for recruitment windows	23/24 OfS return successfully completed Recrtuiment aiming for aligmment for 24/25

11

Principal Risk 4	Potential contraction of student recruitment									
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.			Strategic Objective		To enhance our reputation and grow as a leading local, regional, national & international provider of training and 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

12

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 6	**Lack of workforce development, resilience, retention, recruitment**		
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.	Strategic Objective	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**

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

13

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 Inclusive recruitment training widely rolled out - Training more inclusive recruitment advisors Improved NLPSS KPIs	Internal	Amber
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

14

				self-service across the organisation by the end of the calendar year.

Principal Risk 7	**Lack of a fair and inclusive culture**		
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	**Strategic Objective**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**

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

15

	Improved process around recruitment and treatment of disabled candidates.	Just and learning culture approaches included in all revised policies	Internal	Amber
		Armed forces covenant, disability confident status, and other inclusive statements, implemented competently. Launched new menopause policy. We have menopause awareness status		
Chief Clinical Operating Officer sponsoring EDI programme and providing link with the Board		Feedback through EMT	Internal	Amber
		Board development sessions implemented on EDI considerations		

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.

16

Principal Risk 8	**Lack of management capability and capacity**		
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.	Strategic Objective	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**

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		

17

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.

18

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

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

19

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.

20

Principal Risk 10	Estate infrastructure and compliance		
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	Strategic Objective	Improving value, productivity, financial and environmental sustainability.

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

21

| 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 |

22

Principal Risk 11	Sustainable income streams		
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.	Strategic Objective	**Improving value, productivity, financial and environmental sustainability.**

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 the 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 refreshed to reflect 24/25 contract agreements. A regular review process needs to be established to maintain progress.
Development of Internal Reporting for DET Services – ensuring consistency with the IQPR process.	Director of Education (Operations)	Completed 23/24	Enhanced DET performance reporting will start from the PFRC meeting on 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

23

Principal Risk 12	IT infrastructure and cyber security		
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.	Strategic Objective	Improving value, productivity, financial and environmental sustainability.

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 an independent Cyber Essentials agency officially accredited from 11/5/23 includes extended control of mobile devices, which meant implementing a completely new MDM system and rolling it out within a few months. It also includes security testing suppliers, 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 resources 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 Care Notes 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 |

24

	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 proposals have been presented to the 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 after that.	In progress
Annual review and implementation of new standards for cyber safety	Director of Infrastructure	24th July 2024	Complete - Annual submission to Cyber Essentials to achieve ongoing accreditation.
Review of BCP plans across the trust with recommendations for improvement.	Health and Safety Manager	By the end of FY 24/25	Note that due to the responses to the pandemic and, later, to the CareNotes outage, BCP plans have been stress tested twice since 2020, and they have successfully managed associated risks and maintained trust effectiveness.
Review supplier base and engage 3rd party assessment service	Director of IM&T	Q2 FY23/24	To be agreed
PFRC support and approval for adequate cyber security personnel resources.	Director of IM&T	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 after the company implemented several extended controls, including additional software for mobile device management.	None NHS England will move to the Cyber Assurance Framework (CAF) next year. However, the 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. The 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

25

Principal Risk 13	**Failure to achieve the required levels of performance and productivity**										
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** in sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, risks to patient's mental health, and reputational risk.					**Strategic Objective**		**Improving value, productivity, financial and environmental sustainability**			

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**	01st October 2024
Risk Appetite	**Cautious**	4	4	**16**	3	4	**12**	2	4	**8**	**Date of Next Review**	05th November 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).	A clear understanding of the capacity to reduce waiting times and meet the increasing demand for some services.	The new three-year strategy ambitions to reduce waiting times to 18 weeks across all services. Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board.	Internal	Amber
Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Some data flow is manual, so there are possible errors. Additional work is required to build forms and ensure data is automated wherever possible.	The Board and Performance, Finance and Resources Sub-Committee consider IQPR report.	Internal	Amber
Job planning is to properly understand and manage the capacity of each team to meet the demand for services.	Key systems' reporting structures (Oracle, CareNotes, Quality Portal, ESR) are out of date.	Workforce and Finance Platform Update: The workforce and finance platforms have been reviewed and aligned with the new structures. Additional data reconciliation is required to ensure accuracy. This process is conducted through monthly finance, people, and clinical services meetings. The estimated completion date is October 31, 2024.	Internal	Red
Kaizen Event for Trauma Overview 21 October 24: The focus of Kaizen Week for Trauma will be to review current clinical pathways aligned to best practice and commissioned service specifications, mobilise clinical job plans, and co-create a delivery plan with the team. The event also aims to deliver a culture piece. This plan will include 30-, 60-, and 90-day review periods to ensure that efforts are targeted and impactful.	The service profile pack, including performance data, benchmarked data, and pathways, is still under development.	Once agreed and mature, the delivery plan will be shared and monitored at the following fora:\n\nPFRC\n\nQuality Committee\n\nIQPR – Monthly\n\nTrust Waiting Times Huddle – weekly\n\nAdult Services PTL Meeting – weekly	Internal	Red

26

National Review of Gender Identity Clinics (GICs): NHSE is leading the National Review of Gender Identity Clinics (GICs) initiative, which evaluates current service delivery approaches across all adult gender services with the aim of revising the National Service Specification. This review will provide valuable insights into our current service delivery model, complementing our existing delivery plan and risk controls.		The Clinical Services - SOPs, training plans, and job plans. Oversight will sit with the following fora: • Quality Committee/PFRC – monthly • IQPR – monthly • Clinical Governance – Monthly • GIC Targeted Support Group - Weekly • GIC Leadership Group – Weekly	External	Amber

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
Deliver a trajectory for all service areas, tracking the ambition to reduce waiting times to 18 weeks via the weekly Executive Leadership Team (ELT) Strategy.	Hector Bayayi	March 2025	In progress - Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board.
Key performance and information reporting systems are being automated and aligned to our new management structure, enabling data flow to the correct operational monitoring groups.	Ian Curr/Muhammad Akram	November 2024	Data definitions for IQPR targets are documented and reviewed by data owners. Data is provided directly from IM&T systems to the data definitions. A large number of SPC Charts were created from the data definitions for use in IQPR Reports. Business administrator for reporting advertised and shortlisted.
Once system reporting is aligned with the new structure, ownership and accountability for finance and activity performance will be held locally. We will work within local, Regional, and National care systems to align/increase our income in line with the demand for services.	Hector Bayayi	Noting progress above, final budgets to be validated with Teams during August and finalised in September 2023.	Update pending
Job planning- Complete a workforce and finance platform update, aligning these systems with the new structures.	Hector Bayayi	October 2023	Data reconciliation to ensure accuracy is required, and it is estimated to be completed by October 31, 2024. Monitoring - Monthly finance, people, and clinical services meetings will oversee this.
Kaizen Event: Build a service profile pack to inform prioritisation, co-create a delivery plan, and include 30-, 60-, and 90-day review periods to ensure efforts are targeted and impactful. Delivery will be tracked through PFRC, Quality Committee, IQPR, Trust Waiting Times Huddle, and Adult Services PTL meetings.	Tim Kent	November 2024	The service and project team are currently building the service profile pack, which includes performance data, specification, benchmarked data and an as-is pathway to inform prioritisation.
National Review of Gender Identity Clinics (GICs) - Ratify Standard Operating Procedures (SOPs), mobilise training plans, and integrate job plans into clinic schedules by the following dates:	Hector Bayayi	31 October 2024 – SOPs ratified and mobilisation to start 1 November 2024.	Service Delivery and Performance Update: The service implements standard operating procedures and measures the pathway against the national service specification and evidence-based approaches. However,

27

			performance remains below the agreed job plans, and additional support is needed to address cultural and recruitment challenges. Regular monitoring through Quality Committee, PFRC, IQPR, Clinical Governance, GIC Targeted Support Group, and GIC Leadership Group.
	Hector Bayayi	18 October 2024 – Training plans implemented, and trackers mobilised.	
	Hector Bayayi	14 October 2024 – Job plans built into clinic schedules.	

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. A 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 external NHSE meetings to support the identification of delivery capacity

28

MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC – Thursday, 17 October 2024			
Report Title: Integrated Quality Performance Report			**Agenda No.:** 11
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:	Appendix 1: IQPR October 2024		
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 Committee focus on A3's. A3's are now discussed weekly in ELT and in the Quality Improvement 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):	The Council of Governors is asked to **NOTE** the contents of the report.

Implications:

Strategic Ambitions:

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

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

Link to the Risk Register:	BAF ☒		CRR ☐		ORR ☐
	BAF 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 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

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.

2

Tavistock and Portman – Our Values and Strategy

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

3

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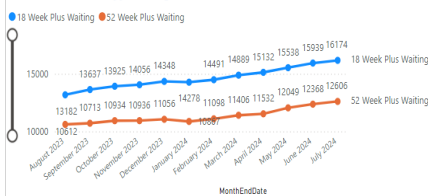
This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)
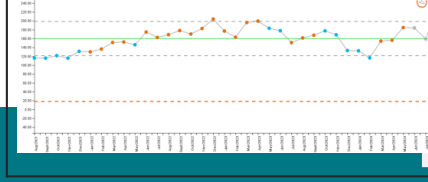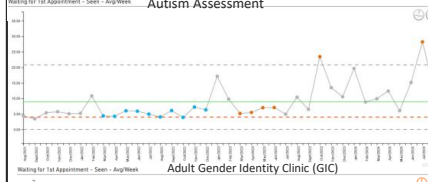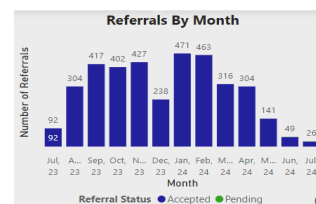
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

A. Number of first appointments conducted
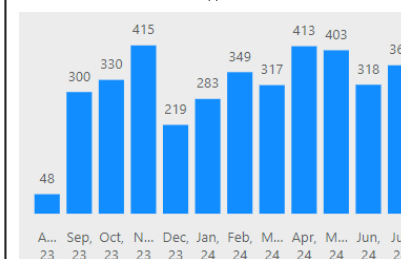
B. Number of referrals by month
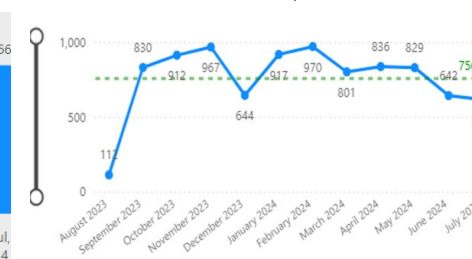
C. Number of discharges per month

Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
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

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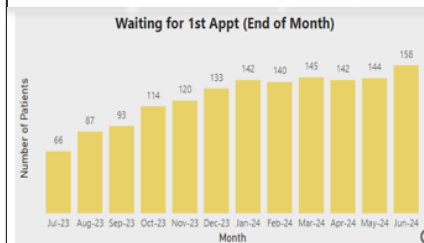
The number of patients waiting for 1st appt has stabilised due to the increased number of triage calls being undertaken

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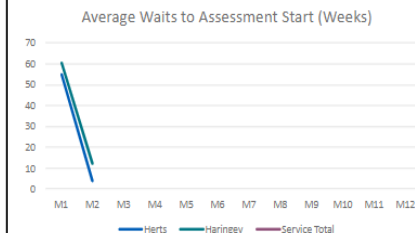
The average wait for patients assessed reduced in May, we are validating this data but its also due to some longer waiting patients deferring their assessments due to exams.

Monthly Stratified Data

A - Referrals + 1st Attends

A - Assess + Discharge

A - Waiting Times

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

11b. IQPR October 24 CoG

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

Waiting for 1st Appt (End of Month)

510 557 591 639 679 712 748 795 818 864 899 927

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

Average Waiting Weeks to 1st Appt

125.00 81.89 103.86 71.13 71.67 85.00 69.25 50.50 61.50 93.86

Jun, 23 Jul, 23 A... Sep, Oct, N... Dec, Jan, Feb, M... Apr, M...

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

T - Referrals + 1st Attends — Now 937 Waiters — 168 weeks

T - Treat + Discharge

T - Waiting Times — Now 166 Weeks — T = 135 Weeks — 15% Lower

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	

11b. IQPR October 24 CoG

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
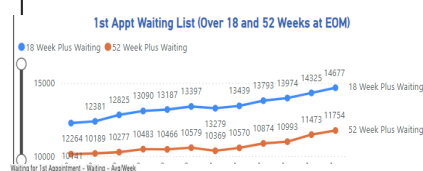
This chart indicates the number of patients that have been waiting over 18 weeks (blue) and 52 weeks (orange)
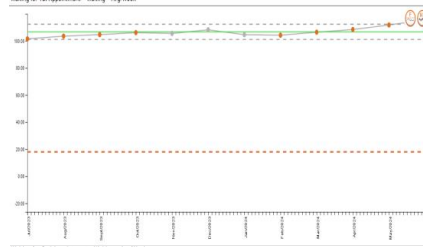
These 2 charts indicate the average time pts have waited each month for 1st and 2nd appts.

Monthly Stratified Data

A. Planned V Actual first assessment activity
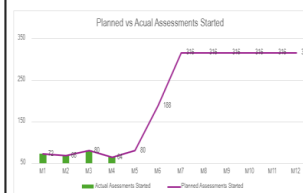
B. Number of referrals by month registered

C. PTL review of dormant cases
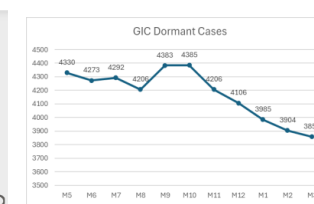
D. No. Of Discharges
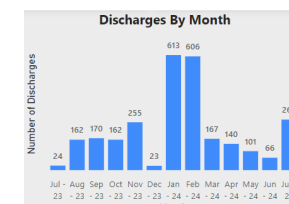
Concern	Cause	Countermeasure	Owner and Deadline
Unclear how much clinical capacity the service has for 1st appointments for Core and CP	Job planning is not completed therefore demand and capacity modeling has not taken plan. Poor visibility on activity using Trajectories for expected planned activity 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 filled Map 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

NHS Foundation Trust

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

ESQ Trustwide Percentage of Positive Feedback

ESQ Trustwide Number of Forms per Month

- 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

8

11b. IQPR October 24 CoG

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. • 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 • 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	• 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. • 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. • 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.	Rachel / Luke Neema 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 • Review the logic for when OMs should be collected, ensuring consistency across all 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. • 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	Luke 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
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

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.

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

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.

11b. IQPR October 24 CoG

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

Turnover Performance Trend

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

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

NHS Foundation Trust

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)
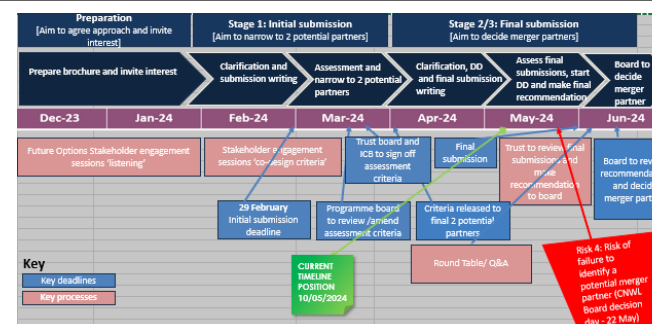
Countermeasures

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

11b. IQPR October 24 CoG

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)

13

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

14

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%

11b. IQPR October 24 CoG

15

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

16

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%**

17

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

NHS
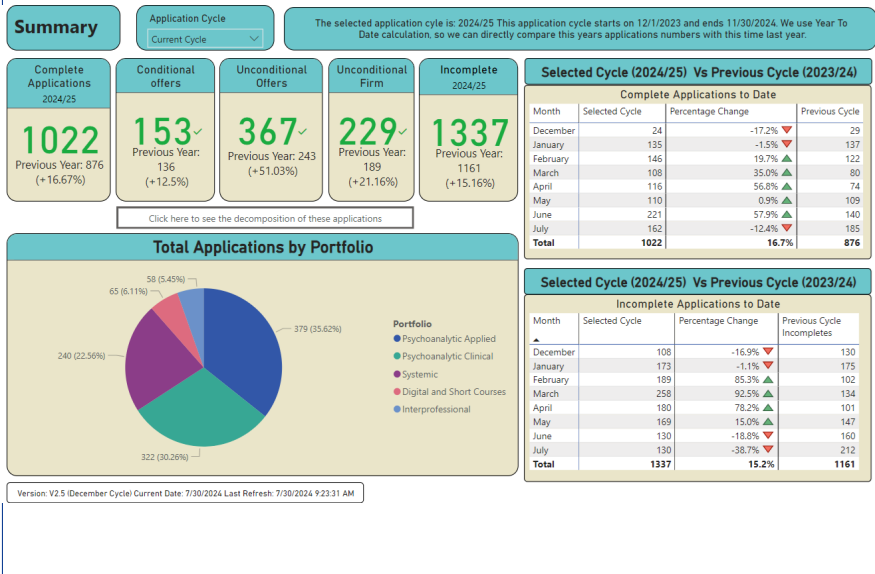**The Tavistock and Portman**
NHS Foundation Trust

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

18

Service Line Overviews

19

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	**153** ✓	**367** ✓	**229** ✓	**1337**
Previous Year: 876 (+16.67%)	Previous Year: 136 (+12.5%)	Previous Year: 243 (+51.03%)	Previous Year: 189 (+21.16%)	Previous Year: 1161 (+15.16%)

Click here to see the decomposition of these applications

Total Applications by Portfolio

Portfolio
- Psychoanalytic Applied — 379 (35.62%)
- Psychoanalytic Clinical — 322 (30.26%)
- Systemic — 240 (22.56%)
- Digital and Short Courses — 65 (6.11%)
- Interprofessional — 58 (5.45%)

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

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**

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**

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.
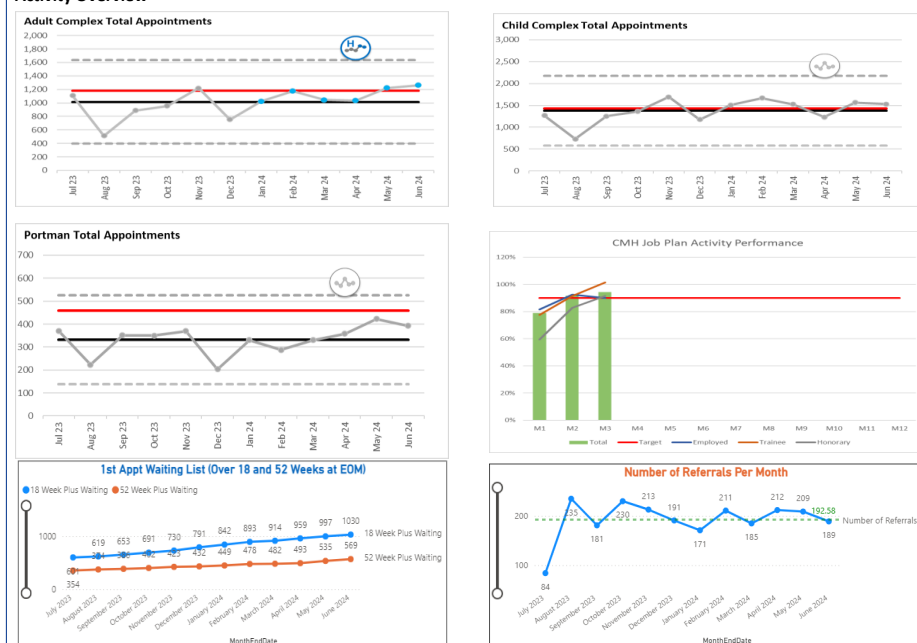
Staffing: Current Professional Services staffing, and structures fail to meet operational needs or support growth ambitions. Teams face single points of failure, posing risks to operations, finances, and Trust reputation. Academic Registry has approved 7.0 WTE new positions to meet statutory and university 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

Adult Complex Total Appointments

Child Complex Total Appointments

Portman Total Appointments

CMH Job Plan Activity Performance

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

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.		o 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		o 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.		o 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.		o 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		o 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

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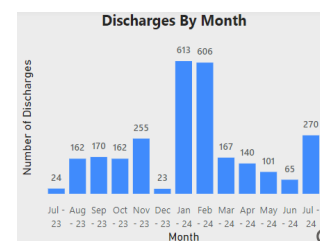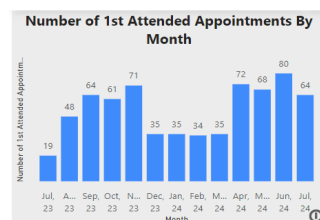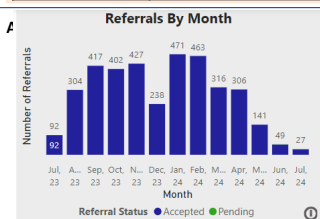
The service have experienced delays in recording referrals this is due to several factors which the service has developed some actions to help reduce an increasing backlog;

- 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.

Discharges By Month

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 screening 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.
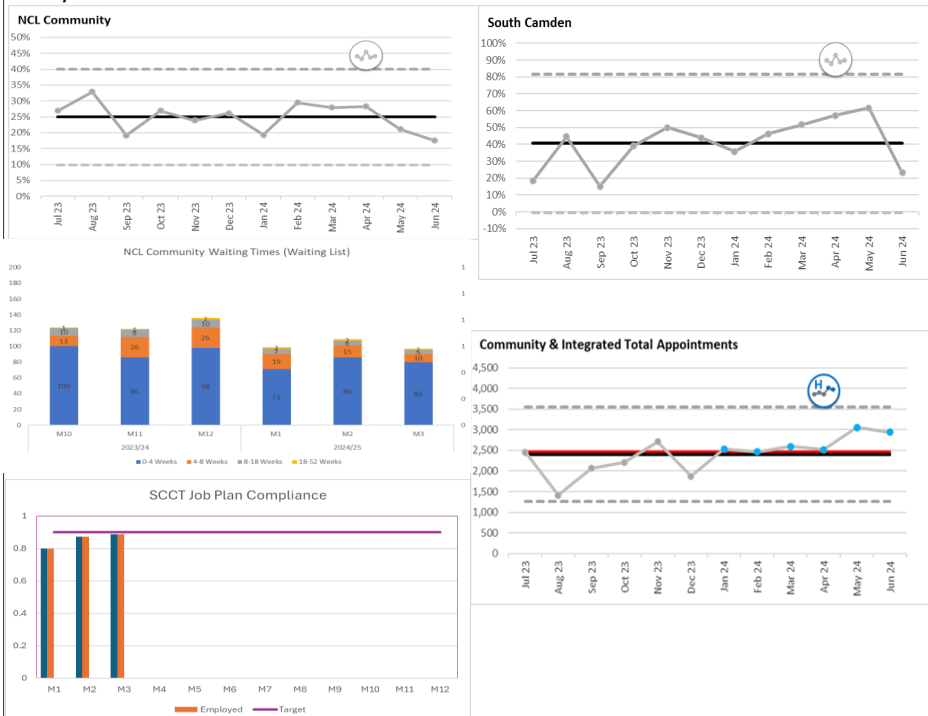
Next Steps

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

NCL Community

South Camden

NCL Community Waiting Times (Waiting List)

Community & Integrated Total Appointments

SCCT Job Plan Compliance

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

24

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.

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24/25 YTD actual position £404k deficit

11b. IQPR October 24 CoG

25

MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC – Thursday, 17 October 2024

Report Title: Trust Response to National Reviews			Agenda No.: 12a	
Report Author and Job Title:	Clare Scott, Chief Nursing Officer	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer	
Appendices:	Appendix 1: Trust Responses to recent National Reviews - slide deck			

| **Executive Summary:**	
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒
Situation:	To provide the Council of Governors with information and assurance on the Trust's response to three national reviews of relevance to the Trust and the services provided.
Background:	There have been a raft of national reviews carried out recently which are relevant to the Trust and where the Trust can derive learning from areas of good practice and identify areas for development. This report highlights three national reviews: • Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024 • Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024 • Thirwall Inquiry - to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of formal neonatal nurse Lucy Letby – ongoing.
Assessment:	The Trust's response to the three national reviews of relevance are included in the slide deck.
Key recommendation(s):	The Council of Governors is asked to **NOTE** the report.

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒		CRR ☐		ORR ☐
	BAF 2: Failure to Provide Consistent High-Quality Care				

Legal and Regulatory Implications:	Yes ☒		No ☐	
	As the national reviews have been commissioned by NHSE and / or the CQC, recommendations from the reviews are often applicable to the wider NHS.			
Resource Implications:	Yes ☐		No ☒	
	None			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒	
	No issues highlighted from the initial gap analysis; further work aims to identify any potential implications relating to equality, diversity and human rights, with a particular focus on hearing the voice of patients, carers and families. This will also consider where staff, with a range of protected characteristics, may not feel empowered to speak up and where concerns are raised, how this is heard and responded to.			
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:	Clinical Services Delivery Group Board Seminar			
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

Trust Response to Recent National Reviews

Council of Governors – October 2024

Excellence Inclusivity Compassion Respect

Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024

Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024

Thirwall Inquiry
Lucy Letby - ongoing

Excellence   Inclusivity   Compassion   Respect
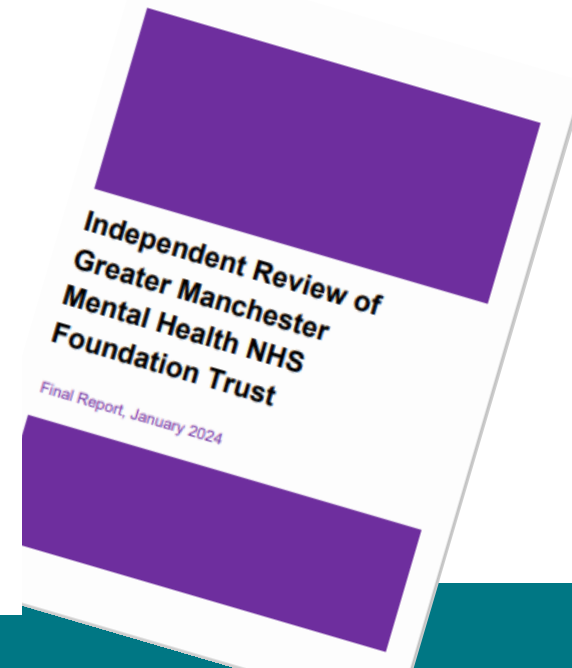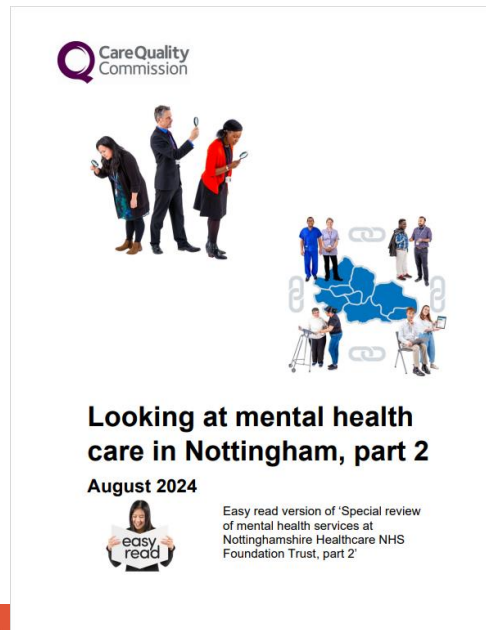
Independent Review of Greater Manchester Mental Health NHS Foundation Trust

8 key areas of focus:

- The voice of patients, families, and carers
- Leadership
- Culture
- Workforce
- Organisational learning & responsiveness
- Elsewhere in the organisation
- System oversight

Findings

- Not focused on understanding experiences of patients, families and carers.
- Operational targets over quality of care
- Staff not listened to, felt disconnected from Trust leadership
- Staff fearful to speak up
- Failure to respond to concerns
- Poor leadership visibility
- Weak governance processes (floor to board)
- Healthy debate and challenge discouraged
- Exec did not work well together
- Some Trust leads lacked compassion & empathy
- Senior managers treat staff poorly, culture of fear and intimidation
- Diversity was lacking
- A weak and fragmented clinical voice

Excellence Inclusivity Compassion Respect

Recommendations – what do these mean to us

Patients, families and carers

Recommendation 1: The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services. They have developed a strategy in this area, which now needs to be implemented and evaluated to understand its impact.

Clinical Leadership

Recommendation 2: A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

Culture

Recommendation 3: The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor. This culture must ensure that no staff experience discrimination.

Recommendation 7: The Trust must ensure that Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve this.

Excellence   Inclusivity   Compassion   Respect

12b. Trust Response to Recent National Reviews

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

CQC published part 2 of its rapid review on 12 August 2024, following publication of part 1 in March 2024.

Review commissioned following conviction of Valdo Calocane over three killings in Nottingham. Covers period that VC received care from NHFT from point of contact in May 2020 to discharge back to his GP in September 2022.

Excellence   **Inclusivity**   **Compassion**   **Respect**

Findings from Rapid Reviews

Waiting List and timely access to care

Involving families and carers

Case load Management and Staffing levels

Cross service and system communication
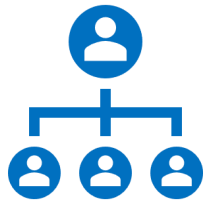
Leadership and support for teams

Risk assessment and care planning

Medication Management
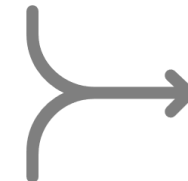
Discharge Planning

Excellence   Inclusivity   Compassion   Respect

Recommendations

MDT Working

Family involvement, consent, risk assessment and care planning

Primary Care

Autism and LD training

Assertively outreaching

Evidence based care Use of the MHA

CQC Review – Community Services

National Standards – Psychosis

Excellence · Inclusivity · Compassion · Respect

Lucy Letby

Paper brought to Trust Board Oct 2023 following receipt of letter from NHSE in response to the verdict in the trial of Lucy Letby.

NHSE asked Boards to ensure:

1. *All staff have easy access to information on how to speak up.*

2. *Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.*

3. *Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.*

Excellence | Inclusivity | Compassion | Respect

Thirwall Inquiry – examine events at the Countess of Chester Hospital.

On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

Excellence   Inclusivity   Compassion   Respect

ToR – 3 broad areas

A. Experiences of the Countess of Chester Hospital & other relevant NHS services, of the parents of babies named in the indictment.

B. Conduct of those working at the Hospital (board, managers, doctors, nurses & midwives) with regard to the actions of Lucy Letby while she was employed there and subsequently, including:

(i) whether suspicions should have been raised earlier, whether LL should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions.

(ii) the responses to concerns raised about LL from those with management responsibilities within the trust

(iii) did the trust's culture, management & governance structures contribute to failure to protect babies from LL

C. Effectiveness of NHS management & governance structures, external scrutiny and professional regulation in keeping babies in hospital safe, how accountability of senior managers should be strengthened. Consideration of NHS culture.

Excellence   Inclusivity   Compassion   Respect

Themes

Although all three are separate incidents with separate reviews, there are themes in common:

➤Hearing patient, carer, family voice

➤Hearing staff voice

➤Responding to feedback

➤Greater focus on productivity and finance than quality and safety.

Culture of Curiosity

A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The CQC believes that closed cultures are more likely to develop in services where people are removed from their communities, inpatient services where people stay for long periods or where there is weak leadership.

Constant honesty, curiosity and energy are necessary to continue driving continuous improvement (NHSE Safety Culture).

Trust Response and Approach

Held sessions to discuss findings and ask ourselves key questions:

➢ Nurse away day
➢ Clinical services delivery group
➢ Senior managers meeting
➢ Clinical team discussions

Review of data (both quantitative and qualitative).

➢ Patient & Carer Experience – complaints, compliments and surveys
➢ Patient Safety – Incidents at all levels
➢ HR data – disciplinary cases, grievances, staff survey
➢ Student Feedback
➢ Safeguarding - Sexual Safety Data Review:

Questions we asked ourselves

Could this happen here? And how would we know?

How robust is the assessment of services and the culture of services?

How is the voice of the patient (and their families) captured?

Is the clinical voice heard strongly within the organisation? How does this work in your teams?

Are we visible enough and do we hear enough from patients, their families, and all staff e.g., support staff, cleaners, admin?

Do we have evidence of a closed culture in the Trust?.... Or a culture of curiosity?

What is the current mechanism for Board to Floor feedback?

Excellence Inclusivity Compassion Respect

Key developments over the last year

❖ Developed Trust Strategic Pillars – Focus On:
  - outstanding patient care with QI workstreams focus on wait times and patient experience.
  - Staff experience and EDI (equality, diversity, inclusion)
❖ Implemented PSIRF (Patient Safety Incident Response Framework) – focus on learning
  - Introduce Patient Safety Partners (PSP).
  - New risk management and incident reporting system
❖ Development of values, vision and mission framework – co-produced with staff.
❖ Formal Board sign up to Sexual Safety Charter and Anti-Racism Statement & Action Plan
❖ Recruitment of second FTSUG (freedom to speak up guardian)
❖ Clinical Structure Review–strengthen responsibility & accountability; training programme and organisational development for new clinical structure.
❖ Development of Integrated Quality Performance report & floor to Board reporting structures
❖ Implementation of targeted support framework where Implemented PSIRF (Patient Safety Incident Response Framework) – focus on learning

Excellence **Inclusivity** **Compassion** **Respect**

Next Steps

Review of data and discussion themes to identify areas of good practice and areas for development.

Develop improvement plan with services

Paper to Quality and Safety Committee and Trust Board – November 2024.

Excellence   Inclusivity   Compassion   Respect

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS (CoG) - 17 October 2024					
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:	None		**Agenda Item: 13**		

Assurance ratings used in the report are set out below:				
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	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		

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS (CoG) – 17 October 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: 14**		

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

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

Key headline	**Assurance rating**
1. 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	Limited ☐ Partial ☒ Adequate ☐

collecting and have agreed principles for the new room usage system. • 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).	N/A ☐
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 COUNCIL OF GOVERNORS – 17 October 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	3rd September, 2024	Sal Jarvis, Non-Executive Director	Mark Freestone, CETO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 15**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Development of Education & Training 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 ☐ Adequate ☒

• 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 representing the Trust on a further Trade Mission to China in October, together with a new prospectus.	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 late October, when we will hopefully see this translate into higher student numbers for 2024/25. • Finance Partners have estimated we are likely to meet a minimum of 85% of our portfolio income target based on these figures.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

• Next committee is 01/11/2024

Risks Identified by the Committee during the meeting:

• Please see BAF risk register.

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		

CHAIR'S ASSURANCE REPORT TO COUNCIL OF GOVERNORS – 17 October 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	5 September 2024	Aruna Mehta, Non-Executive Director	Rod Booth DoS and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 16**		

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

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

Key headline	**Assurance rating**
1. **Integrated Quality and Performance report:** • It was noted that waiting times remained the most significant performance risk and continued to increase. • Although the receipt of Elective Recovery Fund monies was anticipated to result in increased activity and reduced waiting times, this expectation had not yet been realised, noting new staff in post were expected to make an impact on waiting times next month. • It was proposed to hold a Board development session to explore strategies for addressing waiting times more thoroughly and the Trust response.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
2. **Finance report:** • The Trust's reduced cash position was primarily due to the late payment of £1.9 million in HEE income from NHSE. The contract and payment arrangements were still being pursued with NHSE, which had stipulated that the Trust must sign contracts before any payments are made—a change from previous practices. This issue appeared to be widespread, affecting multiple trusts across the country rather than being specific to this Trust. • It was noted that three contracts were at various stages of risk, including decommissioning of the psychotherapy service in Hackney and a renegotiation of contracts with commissioning partners in Surrey and Haringey.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
3. **Escalation** • Board development session on waiting times.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:
• The Committee was not required to make any decisions.

Risks Identified by the Committee during the meeting:		
• Delays on NHSE cashflow payments being mitigated with escalation		
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**
Board development session on waiting times.		

MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC – Thursday, 17 October 2024			
Report Title: Finance Report – As at 31st August 24 (Reporting Month 05)		**Agenda No. 17**	
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 05 (cumulative position to the 31st August 24) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £989k in the period, against the plan of £996k, a positive variance of £7k. Both pay and non-pay spend are on plan and are expected to be stable to the year end. The Trust is anticipating achieving 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 £424k, £54k behind the planned spend to date of £478k. This is significantly closer to the plan than previous months with the anticipated catch up in spend starting to impact on the reported position. 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 M05 was £576k against the planned balance of £1,850k. This is anticipated to be a short-term deficit due to the timing of payments and receipts, the stabilization of these flows is expected to bring the balance back towards plan in future months.		
Background:	The Trust has an agreed deficit revenue plan for 2024/25 of £2.2m, with a Capital Expenditure limit of £2.47m (including the additional allocation from NHSE) and a planned year-end cash position of £1.9m, based on accessing £7.5m cash support in year.		
Assessment:	**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. **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.		

1 / 3

	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 Council of Governors is asked to **NOTE** the contents of the report.

Implications:

Strategic Ambitions:

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

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

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

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

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

Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒
	There are no EDI implications associated with this report.		

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐ This paper is exempt from publication under the FOI Act which allows for the application of various

2 / 3

		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

3 / 3

The Tavistock and Portman NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – 17 October 2024					

Committee:	Meeting Date	Chair	Report Author	Quorate	
Integrated Audit & Governance Committee	03 September 2024	David Levenson, Non-Executive Director	Dorothy Otite, Governance Consultant	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 18**		

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. The main issue highlighted to the Board of Directors are issues relating to the outstanding Internal audit management actions.	Assurance rating
1. External Audit Progress Report • Relationship with External Auditors is progressing positively. • A "Wash-up" session is planned to review the 2023/24 audit cycle and identify areas for improvement. • Importance of accountability was highlighted by the Committee and an annual private discussion with the Committee is to be planned to follow the wash-up session.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit Update • Data Security and Protection Toolkit report – further work is required to ensure alignment of the Trust's responses with evidence provided. • With regards the outstanding management actions, the Committee were re-assured that the outstanding actions would be discussed regularly at the Executive Leadership Team meetings to promote continuous improvement and better alignment.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
3. Local Counter Fraud • No significant issues were raised by RSM. • The Director of Corporate Governance highlighted the need for more focus on gifts and hospitality declarations through raising staff awareness of the policy.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Oversight of Board Assurance Framework (BAF) and Trust Risk Registers (TRR)/ Operational Risk Register • The Committee noted progress made on the BAF and the need for better alignment between the Corporate Risk Register and the BAF to ensure efficiency and streamlined processes.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Breaches of Gifts, Hospitality and Interests Policy • No breaches of the policy were reported. • The Committee requested for the Gifts, Hospitality and Interests Policy to be brought back to the next meeting following a review of the policy, to ensure it is fit for purpose.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
6. Information Governance Report	Limited ☐ Partial ☒

• While there were no reportable IG incidents during 2023/24, the Committee noted a Training Needs Analysis was planned for 2024/25 to ensure senior managers received the appropriate training.	Adequate ☐ N/A ☐
7. Cyber Security Report • No significant issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
8. Terms of Reference • Revised Terms of Reference for the Committee was agreed and recommended to Board for ratification.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Single Tender Waiver Report • No significant issues were raised. • The Committee sought assurance around the tender process to ensure proper governance and compliance arrangements are in place. The item will be brought back to the next meeting of the Committee.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
10. Overpayments/ Underpayments to Staff (Referred from PFRC) • The Committee noted measures in place to mitigate overpayment incidents including a payroll audit; and required a detailed overpayment report (redacted to protect individual's privacy) to be brought back to the Committee to ensure effective oversight.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
11. Losses and Special Payments Report • No significant issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

• Approval of the revised IAGC Committee Terms of Reference

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:

None

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

Item	Purpose	Date
Revised IAGC Terms of Reference	Approval	To Board on 14 November 2024

18. IAGC Chairs Assurance report to CoG - October 2024