The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 16th January 2025

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

Please refer to the agenda for timings.

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY 16th JANUARY 2025 AT 2.00PM – 5.00PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

25/01	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	GIC Service User Feedback	Discussion	Service Users	V	2.05 (20)	
005	Minutes of the Previous Meeting held on 14th November 2024	Approval	Chair	E	2.25 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.30 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.35 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
008	Board Service Visits Update	Discussion	Director of Corporate Governance	E	2.45 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
CORPORATE REPORTING (COVERING ALL STRATEGIC AMBITIONS)						
009	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Medical Officer, Chief Nursing Officer	E	2.55 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
010	Integrated Audit and Governance Committee Assurance Report	Assurance	IAGC Committee Chair	E	3.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
011	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Assurance	Director of Corporate Governance	E	3.05 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
Comfort Break (10 minutes) 3.15pm – 3.25pm						

PROVIDING OUTSTANDING PATIENT CARE						
012	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
013	Guardian of Safer Working Hours Report	Information	Chief Medical Officer	E	3.30 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
014	Quality and Safety Report	Discussion	Chief Nursing Officer	E	3.35 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING PARTNERSHIPS TO IMPROVE POPULATION HEALTH and building on our reputation for innovation and research in this area						
015	Autism Assessment Update	Discussion	Chief Medical Officer	E	3.45 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
016	People, Organisational Development, Equality, Diversity and Inclusion Committee Assurance Report	Assurance	POD EDI Committee Chair	E	3.55 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
017	Education and Training Committee Assurance Report	Assurance	E&T Committee Chair	E	4.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
018	Performance, Finance and Resources Committee (PFRC) Assurance Report	Assurance	PFR Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
019	Finance Report Month 08	Information	Chief Finance Officer	E	4.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
CLOSING ITEMS						
020	Questions from the Governors	Discussion	Chair	V	4.15 (30)	
021	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
022	Questions from the Public	Discussion	Chair	V		

023	Reflections and Feedback from the meeting	Discussion	Chair	V		
024	Schedule of Business 2024/25	Information	Chair	E		
DATE AND TIME OF NEXT MEETING						
025	Thursday 13th March 2025 at 2.00pm – 5.00pm, Lecture Theatre, Tavistock Centre					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 07/01/2025)

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
NON EXECUTIVE DIRECTORS						
ARUNA MEHTA	Non-Executive Director	01 November 2021 (1st Term) 01 November 2024 (2nd Term)	Director, Dr A Mehta Limited (1)	01/04/2012	Present	Personal company – no conflict
			Chair Surrey and Borders Partnership FT	01/04/2024	Present	No perceived conflict as its an acute trust in a different area
			Associate, The Value Circle	01/04/2020	Present	Consultancy work for organisations outside of London- no conflict
			Closed Interests			
			Non-Executive Director, Clarion Housing (1)	01/11/2013	19/11/2022	No conflict
			Member, Kemnal Academy Trust	01/01/2020	01/12/2021	No conflict
			Non-Executive Director, Epsom St Helier NHS Trust (1)	01/02/2016	31/01/2024	No perceived conflict as its an acute trust in a different area
			Governor, University of Greenwich (4)	01/09/2020	31/08/2023	No conflict
CLAIRE JOHNSTON	Non-Executive Director	01 November 2022 (1st Term)	Registrant Council Member, Nursing and Midwifery Council	01/09/2018	Present	
			Chair, Our Time (3)	01/05/2018	Present	Charity supporting families with serious mental illness
			Member IFR panel NCL Intergrated Care Board (3)	05/04/2020	Present	
			Spouse is a journalist specialising in health and social care			
			Nurse member, Liverpool Community health Independent Investigation, NHSE	08/05/2024	Present	
DAVID LEVENSON	Senior Independent Director and Non-Executive Director	01 September 2019 (2nd Term)	Director, The Executive Service Limited t/a Coaching Futures (1)	01/04/2016	Present	Personal Service Company – provides coaching and training services – no conflict
			Academy member, Institute of Chartered Accountants of England and Wales	01/10/2020	Present	Design and teach ICAEW Academy's courses on Corporate Governance, paid consultancy – no conflict
			Closed Interests			
			Non-Executive Director, Qualitas Housing CBS (1)	01/01/2022	06/12/2023	Housing provider for people with long term disabilities – no conflict
			Non-Executive Director, Industrial Dwelling Society (1)	01/01/2022	31/05/2024	Registered social housing provider – no conflict
JANUSZ JANKOWSKI	Non-Executive Director	01 November 2022 (1st Term)	Non-Executive Director RDASH NHS Doncaster (1)	01/11/2022	Present	No conflict
			Consultant Advisor and Provost, Dubai Medical University, United Arab Emirates	13/12/2023	Present	No conflict
			Hon Professor University College of London	01/02/2020	Present	No conflict
			Chair EU Translational Cancer Panel (3)	01/08/2022	Present	No conflict
			Consultant Industry ad hoc	01/08/2021	Present	No conflict
			Healthnix (HealthTec Start up London)	01/12/2023	Present	No conflict
			Closed Interests			
			Clinical Consultant Placement Agency ad hoc (3)	01/10/2021	01/01/2024	No conflict
			Magistrate HMCTS (3)	01/11/2019	01/04/2024	No conflict
JOHN LAWLOR, OBE	Chair	06 June 2022 (2nd Term)	Trustee of the national charity, Think Ahead, under contract to DHSC to provide postgraduate education in mental health social work. (3)	01/09/2019	Present	No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by Think Ahead and vice versa
			Wife is an Associate Director at Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) (1)	07/04/2019	30/09/2024	No perceived conflict - Will withdraw from relevant business in relation to CNTW discussed by the Tavistock and Portman
			Wife is a Trustee of Carers' Resource serving parts of West and North Yorkshire	01/07/2023	30/09/2024	No perceived conflict - Will withdraw from relevant business in relation to Carers' Resource discussed by the Tavistock and Portman
			Providing advice and guidance to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative	11/02/2024	Present	No perceived conflict - Will withdraw from relevant business in relation to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service discussed by the Tavistock and Portman

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			Employed at Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative working one day per week	01/03/2024	Present	No perceived conflict - Will withdraw from relevant business in relation to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service discussed by the Tavistock and Portman
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	23/02/2023	Will withdraw from business decisions in competition with University of Westminster
			Governor, Londale PNI School, Brittan Way, Stevenage	18/09/2018	Present	No perceived conflict - Will withdraw from business decisions in relation to the school as discussed by The Tavistock and Portman
SHALINI SEQUEIRA	Non-Executive Director	01 November 2021 (1st Term) 01 November 2024 (2nd Term)	Director, Sonnet Consulting Services Limited (1)	10/07/2018	Present	Personal company for consulting work - no conflict
KEN BATTY	Non-Executive Director	01 April 2024 (1st Term)	Council member QMUL, which included Barts and the London Medical School	01/01/2022	Present	No perceived conflict - Will withdraw from business decisions in competition with QMUL, Barts and London Medical School
			Chair, Mosaic LGBT+ Young Persons Trust based in Camden (3)	01/09/2019	Present	No perceived conflict - Will withdraw from business decisions in competition with MOSAIC LGBT+ Young Persons Trust
			Vice Chair, Inner Circle Educational Trust (provides support for Looked After Children in Canden)	01/10/2020	Present	No perceived conflict - Will withdraw from business decisions in competition with Inner Circle Educational Trust
			Independent Chair, Nominations Committee Royal College of Emergency Medicine which is a professional body. (3)	01/02/2021	Present	No perceived conflict - Will withdraw from business decisions in competition with Royal College of Emergency Medicine
			Independent member Appointments Board Nursing & Midwifery Council	01/08/2024	Present	No perceived conflict - Will withdraw from business decisions in competition with Nursing & Midwifery Council
			Independent Panel Member for Mayoral Appointments at the GLA	31/10/2024	Present	No perceived conflict - Will withdraw from business decisions in competition with GLA
EXECUTIVE DIRECTORS						
MARK FREESTONE	Chief Education and Training Officer and Dean of Postgraduate Studies	10 June 2024	Honorary position as Professor of Mental Health at Queen Mary University of London	05/06/2024	04/06/2027	Will withdraw from any business decisions relating to QMUL.
			Director, North Thames NIHR ARC (Applied Research Collaboration)	01/04/2021	31/08/2025	No conflict to declare as T&P is a member of the ARC
			Director, Mark Freestone Consulting	08/11/2012	Present	Forensic Mental Health Research Consultancy (Sole trader). No direct conflict of interest.
			Honorary Senior Researcher, East London NHS Foundation Trust	01/07/2013	31/07/2026	Will withdraw from any business decisions relating to ELFT
GEM DAVIES	Chief People Officer	1 February 2023	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	Present	No perceived conflict - This is unpaid.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12/11/2016 - 31/08/24	NIL RETURN			Sally left the Trust 31st August 2024
PETER O'NEILL	Interim Chief Financial Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ADEWALE KADIRI	Director of Corporate Governance	7 August 2023	Partner is an NHS GP in Ipswich, Suffolk	01/10/2023	Present	No conflict - no connection to the Trust
ROD BOOTH	Director of Strategy, Transformation & Business Development	26 June 2023	NIL RETURN			
JANE MEGGITT	Director of Communications & Engagement	24 April 2023	NIL RETURN			
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					

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 14th November 2024 AT 2.00 P.M.

LECTURE THEATRE,
THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST,
120 BELSIZE LANE, LONDON NW3 5BA
AND VIRTUALLY VIA ZOOM

MEMBERS PRESENT:

Voting

John Lawlor	Chair of the Board of Directors	JL
Michael Holland	Chief Executive Officer	MH
Shalini Sequeira	Non-Executive Director and Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Claire Johnston	Non-Executive Director and Chair Quality & Safety Committee	CJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality & Safety Committee	JJ
Ken Batty	Non-Executive Director	KB
David Levenson	Non-Executive Director & Chair of the Integrated Audit & Governance Committee	DL
Clare Scott	Chief Nursing Officer	CS
Rod Booth	Director of Strategy, Transformation & Business Development	RB
Mark Freestone	Chief Education and Training Officer and Dean of Postgraduate Studies	MF
Chris Abbott	Chief Medical Officer	CA
Peter O'Neill	Interim Chief Finance Officer	PON

Non-Voting

Adewale Kadiri	Director of Corporate Governance	AK
Gem Davies	Chief People Officer	GD
Jane Meggitt	Interim Director of Communications and Marketing	JM

IN ATTENDANCE:

Sheena Bolland	Public Governor	SB
Kathy Elliott	Lead Governor	KE
Kenyah Nyameche	Public Governor	LH
Dorothy Otite	Governance Consultant	DO
Lucy Haggerty	Patient Safety & Clinical Governance Manager (item 4)	LH
Afiah Nkrumah	Patient Safety Partner (item 4)	AN
Elizabeth Newington	Patient Safety Officer (item 4)	EN
Pauline Williams	Chair Race Equality Network (item 17)	PW
Luster Alfred	Equality, Diversity & Inclusion Manager (item 17)	LA
Fiona Fernandes	Business Manager Corporate Governance	FF

APOLOGIES:

Aruna Mehta	Non-Executive Director & Chair of the Performance, Finance and Resources Committee
Sal Jarvis	Non-Executive Director and Chair Education and Training Committee
Sabrina Phillips	Associate Non-Executive Director

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL, welcomed all in attendance. Apologies were noted from Aruna Mehta, Sal Jarvis and Sabrina Phillips.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate. JL noted that at the Council of Governors meeting held on 17th October 2024, the Governors had agreed to second terms of office for the Non-Executive Directors SS and AM and, the extension of KB's first term from two to three years to align his tenure with the other Non-Executive Directors. The Council of Governors had also approved Aruna Mehta becoming the Trust Vice Chair.	
003	**DECLARATIONS OF INTEREST**	
	JL and KB noted that they submitted their new declarations to AK prior to the meeting.	
004	**SERVICE PRESENTATION**	
	Lucy Haggerty, Patient Safety & Clinical Governance Manager gave a brief overview of how the Patient Safety Partners (PSP) role had been introduced and its key responsibilities. The NHS Patient Safety Strategy recognises the importance of relationships between patients, family and carers to improving the care across the NHS. There is a particular advantage to having PSPs contribute to trusts' governance and management processes for patient safety and to compassionately engage with all those affected by patient safety incidents. The PSPs have been in post in the Trust since February 2024. The role of PSPs has been further strengthened through the introduction and implementation of the Patient Safety Incident Response Framework (PSIRF). The PSPs attend meetings of the Clinical Incident Safety Group and the Quality and Safety Committee, and their involvement is fundamental in key aspects of the patient safety remit, including the work with Gloucester House and the Quality Improvement (QI) work in relation to PSIRF. While the overall aim of PSPs is consistent, the role of PSPs varies across the NHS, depending on the organisation and its specific needs, priorities and resources.	

Lucy Haggerty thanked Afiah Nkrumah and Elizabeth Newington for all their contributions to the Trust in their work to date.

Elizabeth and Afiah both introduced themselves and gave an overview of their connections to the Trust, noting they had both been volunteers at the Trust, their backgrounds - bringing valuable insights from their lived experiences which attracted them to the role. As PSPs, they provide unique perspectives to the work that is done in a compassionate and meaningful way that ensures that safety initiatives are patient centred.

CS stressed the Trust's intention of having PSPs in all areas of quality and safety, as their ability to challenge at meetings is invaluable. She acknowledged the need to think about the time capacity for this role which is currently only two hours a week. CJ agreed that the PSPs are adding a great deal of value, and concurred that the time capacity needs to be looked at.

Responding to DL, Afiah stated that from her perspective, it was still early days in terms of what she would be able to contribute, but that support from the Board would be beneficial.

MH thanked the PSPs for all the work that they are doing, and he made the point that the Trust also needs to learn from when things go well, and what we should be doing more of. This needs to include learning from the After Action Reviews. GD added that from a staff perspective, we need to think about how to incorporate the patient voice into the people policies and the training provided for staff on working with patients.

The Board thanked Afiah, Elizabeth and Lucy for the informative and inspiring presentation and commended the team for the excellent work they are doing.

005 **MINUTES OF THE PREVIOUS MEETING HELD ON 12th September 2024**

The minutes of the previous meeting held on 12th September 2024 were agreed as an accurate record pending a minor correction to the CPO's surname.

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

GD noted with regard to the attendance section of the minutes that both her's and AK's names ought to be included under the Members section and not the 'In attendance' section. The same would be for SP, Associate NED.

ACTION: To ensure that the attendance reflects Voting and Non-voting members of the board.

AK/FF

All actions proposed for closure were approved.

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

JL noted that the BoardEffect portal has now been introduced and encouraged everyone to use it. Training was available for anyone who required it.

JL provided a verbal update and highlighted the following:

- The Annual Members Meeting (AMM) took place on 29th October 2024 and there was a good turnout. There were good presentations on the achievements of 2023-2024 and the plans for the rest of 2024-2025. There was a presentation from Michael Rustin, Governors regarding his concerns about the merger. Most of the questions raised related to this.
- He had attended the two-day NHS Providers Conference in Liverpool at which leaders from across the country were in attendance. There was an interesting presentation from Amanda Pritchard, CEO NHS England focusing on financial rigour, quality and safety, working with primary care, and a big push around technology particularly the NHS app.
- The point was also made that ICBs should no longer be performance managing the trusts in their patch; this role sits within the regional offices.
- Primary Care is in a dire situation.

The CEO Report was taken as read. MH highlighted the following:

- The NHSE Review of the GIC had taken place last week and the report is awaited.
- MH advised that the first two sessions to support implementation of the new clinical structure were held in September and October in person with the clinical and operations leads.
- Staff Survey completion was currently at 35% and there is a focus on encouraging as many staff as possible to complete it ahead of the closing date in a week and half's time.
- October was 'Speak Up Month'. This year's theme was 'Listen Up' emphasising the importance of listening when encouraging people to feel confident to speak up.

GD stated, in relation to the Staff Survey, that members of the People Team will be setting up a stall to support staff in filling out the forms. There will also be information from the last survey made available.

On Freedom to Speak Up, JL stated that it would be useful to know how many staff have engaged and whether there been any more cases. In response, AK indicated that the Freedom to Speak Up Guardians annual report would be presented at the January Board meeting, that there is to be a session on the topic at the next Board Seminar.

The reports from the Chair and CEO were noted.

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

The report was taken as read.

CS reported that in August the Trust had recorded 74% positive responses on ESQ, below the 90% target, which was probably due to the high levels of annual leave, and therefore lower activity during that period. Work is being progressed to set team level targets for amount of feedback to be collected each month and to ensure that teams can review the feedback comments monthly. A QR code has been developed to provide more choice in how service users and carers can give feedback.

CA highlighted the three key areas in the Adult GIC Trauma and Autism services:

- Autism/Trauma/GIC – weekly meetings are being held on managing the waiting list. Data up to the end of month 6 indicates that the service is close to reaching its targets, although there will be some variation because of delays in recruitment. At the end of month 6 the list has reduced from 320 to 222.
- Triage of referrals – the service needs to decide whether it is a primary or tertiary care service. The Kaizen events were completed last week and RB, CS and CA met with the team to sign off the plans.
- GIC – the waiting lists will be nationalised at the end of the financial year, subject to public consultation. In the meantime, there is a need to work on implementing a proper triage system.

GD highlighted the following in the report:

- Mandatory and statutory training (MAST) has been static for the past 4 months at approximately 80% against a target of 95%. Managers are being encouraged to provide 'protected' time for their staff to complete their outstanding MAST modules. The people Team continues to escalate non-compliance through the appropriate channels for urgent action.
- Appraisal completion is well below target at 43%. There are some mitigating factors behind the low figures, including where staff have multiple assignments, and the people team is looking at solutions to this. Colleagues have met with the individuals to input the assignments onto the Electronic Staff Record (ESR) system.
- The Trust declared 2.0% of sickness absence rate in August 2024. The number of reported health-related absence cases has risen slightly in comparison to the previous months. The People Team continue to support managers regarding the management of sickness absence in line with the policy.

CA made the point, in response to a question about the trauma service, that he and Sheva Habel, Medical Director, are working with the team and with the Clinical Lead on how to preserve the Trauma point of care. He acknowledged the difficulty in providing a “gold” standard of care but stressed the need to find a balance. He hoped that the Kaizen event would help. SS agreed on the importance of finding a balance as the service is likely to be more in demand.

Responding to CJ in relation to Autism referrals, RB noted that a report will be brought to the Board in context of the three waiting times.

The report was noted.

009 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) ASSURANCE REPORT**

DL noted that there is a revision to the report, as the rating for the Internal Audit Report is partial not limited. A private meeting was held with the external auditors Grant Thornton and their first year's performance has been assessed as satisfactory. A "Wash-up" session is planned to review the 2023/24 audit cycle and identify areas for improvement. The importance of accountability was highlighted by the Committee and an annual private discussion with the auditors is to be held to follow the wash-up session.

PON noted that an initial session had been held to mitigate work pressures going forward with more of a focus on Going Concern regarding the merger and future financial sustainability, and some testing will be done. We are between the audit cycles at the moment.

CJ raised several questions/comments:

- Internal Audit – outstanding management actions. Can assurance be given on the non-priority actions?
- Does the Board see what is in the internal audit forward plan?
- Payroll is back on the list.
- Gifts and hospitality – there are no breaches. Is a review being proposed?

Responding to these points, DL noted that progress is being made on payroll and although it is still not perfect things are going in the right direction.

On internal audit, DL stated that there is the HFMA self-assessment of financial management, and that there is an improvement plan linked to this which is progressing well. Managers are now getting to grips with their team budgets.

The auditors have prepared a long-term plan that is seen and reviewed by the IAGC and amended accordingly. The annual plan falls out of this and is reviewed in detail by the Executives after which it goes back to the IACG. JL remarked that it would be preferable for the board committees see the plan rather than the board. DL made the point that if other board committees have concerns or want to refer anything to the IAGC, this can be done.

Responding to the point on Gifts and Hospitality, AK noted that there is a regular review, and any breaches can be reported to the corporate governance team or the counter-fraud providers.

The report was noted.

010 **REVIEW OF COMMITTEE TERMS OF REFERENCE**

The report was taken as read.

AK highlighted that the six board committees had received and approved the proposed revisions to their Terms of Reference. All of the Terms of Reference now include a new clause allowing for the attendance of nominated members of the Council of Governors as observers of the meetings. The documents also reflect the appointment of the new Committee Secretary who now supports all of the committees.

The Board APPROVED the revised Board Committee Terms of Reference.

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

The report was taken as read.

CJ highlighted the following:

1. **Complaints**: It is expected that the Patient Safety Partners (PSP) will make a difference in the way that complaints and other processes are handled. By way of example, CJ highlighted the situation of a person who did not have family or advocate support but had been supported by one of the PSPs.
2. **GIC Targeted Support**: The Gender Identity Clinic (GIC) has entered internal targeted support due to ongoing access concerns. Improvement metrics and exit criteria have been established, marking the GIC as the first service in this framework.
3. **Clinical Audit Plan 2024/25**: The Committee noted that compliance against the audit plan is currently behind schedule. However, with the recent launch of the Radar module, (Local Risk Management System) the Audit team are optimistic of catching up on outstanding audits by the end of the year through PSIRF and PCREF.
4. **PPI annual engagement plan**: The Committee reviewed the progress against the annual plan and concluded that there was a lack of progress overall. Verbal assurance was provided to the Committee about the welcome shift underway to involve current service users in the PPI register rather than only former patients, with a broadening of the types of roles they are taking up. A recovery plan is now in place to mitigate against further delays in delivering the objectives. A positive area of improvement was noted as the number of service users involved in PPI since the start of year has doubled to 30, and there is a plan in place to further increase engagement.
5. **DrDoctor Implementation (new patient Portal)**: The Committee received an update of this new procured portal which has been designed as a centralised information source for patients, including reminder for appointments, letters, etc. The portal will integrate with the NHS app and it was noted that the Trust was the first mental health organisation to have this. The opportunity has been taken to participate in an NHS England bidding round to expand this. It is being trialled in three services with waiting list concerns.

Responding to MH, CS noted that the compliments module on Radar is now live and receiving compliments.

The report was noted.

012 **MORTALITY REPORT – LEARNING FROM DEATHS**

The report was taken as read.

CA highlighted key points:

- The Trust continues to have difficulties in finding the causes of death and cannot draw down comparisons which is challenging for those on the waiting lists at GIC. The Deputy Medical Director had been trying to get the data and had been informed that a request and payment was required for individual death certificates.
- There is significant risk on the numbers on the waiting lists for GIC, Autism and Trauma. A proper harm review and triage at the point of referral is vital, and this is now part of the nurses' role.

JJ stressed the need for robust Standard Operating Procedures (SOPs) for mortality, and he suggested contacting the GPs to get this information as an avenue to explore. CA responded that the Terms of Reference and SOPs for morbidity and mortality have been approved, but that they could be reviewed again. GPs have sometimes responded to say that they cannot share the cause of death, and this has been raised with NHSE. JJ added, on the data protection point, that rights of privacy lose their validity upon death, and there is an argument that disclosure would be for the greater good of the community.

AK added that the Legal Services Manager will in due course be doing some work on learning from inquests.

The report was noted.

013 **FINAL REPORT OF THE CASS REVIEW OF GENDER IDENTITY SERVICE FOR CHILDREN AND YOUNG PEOPLE**

The report was taken as read.

CA highlighted the key points from the report:

The summary of this work had been presented at the board seminar. The Cass Review makes 32 recommendations and many of these are relevant to services the Trust currently provide and so the learning points must be considered.

The actions tackle the key areas across the organisation, which are:

- Working alongside NHSE to review the skill mix and disciplines in GIC with an aim to enrich the MDT.
- Review and update of the Trust Transition Policy to ensure it is fit for purpose and followed appropriately.
- Pathway work – the need for a strong evidence base to avoid variation in pathways already started.
- Research – Conversations have started with consultants. An event is to be held on psychodynamic and psychoanalysis.
- Discussions with clinical leadership teams regarding the use of audit to manage case variation and to ensure NICE guidelines are being followed. This should become part of the annual audit plan.

Responding to DL in relation to transition data, CA noted that data can be provided. In terms of referrals, Arden and Gem are taking on the national waiting list so as to introduce more consistency. It is unclear how many people may be on multiple waiting lists.

The report was noted.

014 **LEARNING FROM RECENT NATIONAL INVESTIGATIONS**

The reports were taken as read.

CS noted that the outline of the Trust's approach had been seen by the Quality and Safety Committee.

CS highlighted that all three revies had recommendations around:

- Patient Safety
- Voice of service users
- Voice of Staff
- Responding to feedback

A number of sessions had been held with front line staff and the Board, and these were overwhelmingly positive. There were concerns at all levels in the organisation that patient and staff voices were not being heard consistently. There was a consistent theme of the need to strengthen visibility of leadership, with a strong sense that there are gaps in communication from board to floor, with discussions not taking place at team level.

The review also identified that the clinical voice is not being heard as strongly as it should be, with concerns that operational elements and productivity are prioritised. Where the clinical voice is heard, it is from a few senior clinicians with some 'more junior' clinicians feeling silenced or not valued.

Areas of good practice that were identified:

- The Executive team being more visible and accessible
- The CEO's weekly updates
- The all-staff meetings

In terms of governance, priority areas of focus have included improving patient voice and involvement, FTSU accessibility, clear reporting structures (IQPR), embedding PSIRF, incident reporting and patient safety partners.

A number of the recommendations have been drafted into an action plan which will be monitored by the Service Delivery Group and then taken to the Quality and Safety Committee for assurance as well as to the other committees.

The report was noted.

015 **GLOUCESTER HOUSE REVIEW ON PROGRESS OF ACTION PLAN**

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

CS noted that MF will be taking over leadership of the Gloucester House Steering Committee. This report was an updated action plan following the review held on 4th July 2024. There has been progress in some areas, but the evidence needs to be seen and will be reviewed through the Gloucester House Review Oversight Group and monitored by the Steering Committee.

There are some inter-dependencies between the business plan for the service, the recovery plan to achieve financial sustainability, balanced with the ambition to safely increase pupil numbers and provide good quality and education in the current environment. A number of the rooms have damp issues and will need investment that the Trust is currently unable to provide. CS and RB are meeting with Camden to seek possible alternative accommodation. The Unit Manager is providing a plan on the risk, sustainability (finance) and the areas for improvement.

KB noted that things are starting to improve, and some traction is being observed with regard to the curriculum. It is vital that, going forward, the focus remains on the key actions.

The report was noted.

MEDICAL REVALIDATION REPORT

The report was taken as read.

CA noted that this was a yearly report to the board to provide assurance on the fitness to practise of the medical staff in the Trust, and that the doctors have engaged in the process during the last financial year.

10 doctors' dates have been pushed back due to sickness and it was noted that there are high sickness levels among a number of psychiatric colleagues. Overall, they are engaging and ROAG monitors this.

The report was noted and APPROVED by the Board.

017 **FEEDBACK FROM BLACK HISTORY MONTH EVENTS**

Pauline Williams (PW), Chair of the Race Equality Network and Luster Alfred (LA), Equality, Diversity & Inclusion Manager provided their presentation from the Black History Month Event. The presentation at the event had included videos clips of a poem recital by Natasha Trent who works in the People Team, a clip from BBC News about the British Black Power Movement, Leila Hassan Howe being interviewed by Bryan Knight from the comms team, BBC clip on the events of 1981 and the Black Lives Matter global campaign.

PW observed that the event had been the most powerful, emotional and informative that the Trust had held and the feedback from staff was powerful, with more determination to support the drive towards mainstreaming EDI. Although Black History Month had concluded on 31st October 2024, The Race Equality Network, EDI Team, Peoples Team and Communications Team will continue to commit to celebrating Black history, culture, and achievements will not stop there.

LA commended the role played by the Communications team in bringing the event to life. He reflected that the environment within the Trust has changed and there is room to challenge. He also felt that it was beneficial having Executive allies.

The Board commended the huge amount of work that has been put in and, thanked Pauline, Luster, Bryan and all involved in changing the culture and mindset.

ACTION: Share the presentation with the board.

The report was noted.

018 **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE (PODEDI) ASSURANCE REPORT**

The report was taken as read.

SS provided highlights from the POD EDI Committee meeting:

- It was positive to see the EDI Programme making headway and doing in dealing with the actions.
- There is concern about the capacity and capabilities of managers. Although there has been some headway made in the Management Development Programme, there needs to be more of a focus on middle management.
- There is also concern about the Appraisal and MAST data as the Trust does not appear to be able to get a handle on this. The Committee has been asking for an action plan for addressing this, but it still does not have assurance.
- The Committee found that reviewing the BAF risks one at a time was more conducive and was going well. Each of the risks has now been reviewed in detail and the sequence has now restarted with the EDI risk.

GD added that reviewing the BAF risks over the last couple of months has introduced more depth into the conversations. The People Team are also becoming more open with the information.

JL noted that without and OP plan the Trust would not be able to achieve the change in culture that it is seeking.

The report was noted.

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

MF presented this report.

He highlighted the following key areas from the report:

- The Committee heard the success story of one of the Course Leads who was nominated for the award of Social Worker of the Year and won.
- The team is developing a plan to move away from the reliance of Visiting Lecturers, with the aim that these will be consolidated into substantive roles. The consultation will go live next week.
- The OfS have released a briefing paper about their plans for what are now referred to as sub-contracting agreements (formerly 'franchising').
- Student recruitment – there is a slight reduction in numbers from the previous year.

The report was noted.

020 **PERFORMANCE, FINANCE AND RESOURCES COMMITTEE (PFRC) ASSURANCE REPORT**

The report was taken as read.

PON highlighted the following key areas from the report:

- The Committee heard that work is being done on the team level budgets annual planning process to ensure it all aligns.
- The Committee received the Trust Green Plan.
- The Committee heard about the IQPR risk.

DL noted that the debt with HEE is down to £400k and that there wasn't a great deal of explanation of what this represented. The Committee are keeping a watching brief.

The report was noted.

021 **FINANCE REPORT – MONTH 06**

The report was taken as read.

PON highlighted that the Trust had incurred a net deficit of £1,144k in the period, against the plan of £1,182k, a positive variance of £38k. The expectation is that the Trust will achieve its year-end deficit plan of £2,200k, subject to the emergence of a new risk, a funding gap relating to the 24/25 pay award, being mitigated in full.

This has become a risk because of the way it has been funded this year. The Trust's income, unlike other trusts, is not all generated from the NHS, and the Trust would need to seek other avenues to generate an uplift. Work is being done on a contract-by-contract basis to seek to mitigate the gap.

For now, the Trust has been advised not to declare a variance against plan in month 7, but there is no indication of any additional funding. The outturn is £7m away from plan. PON noted that the returns have been submitted but these can be changed in future.

The report was noted.

022 **GREEN PLAN/SUSTAINABILITY STRATEGY**

The report was taken as read.

PON advised that this was work in progress. Included within the report are the results from the survey on the Trust's carbon footprint. It is a live plan and will continue evolving as the Trust has committed to the NHSE-wide carbon reduction target. By 2032 the NHS would need to demonstrate an 80% reduction in its carbon footprint and become carbon neutral by 2040.

There is more that the Trust can do, and work will continue with patients, staff and students to embed sustainability awareness throughout the organisation and to reduce the impact on public health and the environment, save money and reach net carbon zero.

The next steps that have been identified are:

- Section to be added on the outcome of the all-staff interactive session
- Service Delivery Group – clinical input
- To re-describe the Governance via ELT, PFRC and then the Board. The Senior Leadership Team has a key role in helping to turn the plan into a set of tangible actions.
- Potential for 'fume absorbing plants' to be added to all sites
- The possibility of setting up a net zero group in conjunction with merger partners is to be investigated.

CJ noted that on several occasions she had noticed that the lights in the building have been on very late at night, and she wondered of a message could be put on the staff computer screens to remind staff to turn off the lights.

The report was noted.

023 **BOARD SCHEDULE OF BUSINESS**

The Board schedule for 2024-25 was noted.

024	**QUESTIONS FROM THE GOVERNORS**	
	There were no questions raised by the Governors. JL noted that this would be Kenyah Nyameche's last meeting as her term of office as a Governor comes to an end in December. He thanked her for her contributions.	
025	**ANY OTHER BUSINESS**	
	MF noted that it was that time of the year for nominations for the Honorary Doctorates and as there will not be another board meeting before the deadline, he queried how this could be taken forward. JL responded that MF should send an email to the board regarding the nominations. **ACTION:** Honorary Doctorate nominations to the emailed to the Board.	MF
026	**QUESTIONS FROM THE PUBLIC**	
	There were no questions from the public.	
027	**REFLECTIONS AND FEEDBACK FROM THE MEETING**	
	• It was interesting to see the work of the Quality Safety Committee coming to the Board. • The presentations from the Patient Safety Partners and Race Equality Network Chair were informative and powerful. • There was a lot more information on quality and safety and EDI which made the meeting more interesting.	
	Close	
	The Chair closed the meeting at 5.10 p.m.	

Date of Next Meeting in public: Thursday 16TH JANUARY 2025 at 2pm, LECTURE THEATRE, TAVISTOCK CENTRE 120 BELSIZE LANE NW3 5BA.

Signature _____ Date _____

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

Actions are RAG rates as follows: ->				**Open - New action added**	**To Close - propose for closure**	**Overdue Due date passed**	**Not yet due Action still in date**
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	In progress	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified. NHSE are providing Teams to assist with the second part of the training which is going to rolled out shortly.
09.05.24	8	Integrated Quality & Performance Report (IQPR)	To provide a list of what Mandatory & Statutory should be, and which are relevant	July Board meeting on 11.07.24	GD	In progress	the Statutory and Mandatory training list has been given to the Clinical Services Delivery Meeting to decide / approve
14.11.24	6	Matters arising and action log	To ensure that the attendance section of the minutes reflects the voting and non-voting status of Board members	January Board meeting on 16.01.25	AK/FF	To close	Changes have now been made to the template
14.11.25	25	Any other business	Details of Honorary Doctorate nominations to be emailed to the Board	January Board meeting on 16.01.26	MF	To close	These have now been communicated

MEETING OF THE TRUST BOARD OF DIRECTORS PART II ON THURSDAY 16TH JANUARY 2025			
Report Title: Chief Executive's Report			**Agenda No.: 007**
Report Author and Job Title:	Michael Holland, Chief Executive	**Lead Executive Director:**	Michael Holland, Chief Executive
Appendices:	None		
Executive Summary:			
Action Required:	**Approval** ☐ **Discussion** ☒ **Information** ☐ **Assurance** ☐		
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.		
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.		
Assessment:	This report covers the period since the meeting on 14 November 2024		
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against the leadership responsibilities within the CEO's portfolio.		
Implications:			
Strategic Ambitions:			
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability

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

Link to the Risk Register:	**BAF** ☒	**CRR** ☐	**ORR** ☐
	All BAF risks		
Legal and Regulatory Implications:	Yes ☐	No ☒	
	There are no legal and/or regulatory implications associated with this report.		
Resource Implications:	Yes ☐	No ☒	
	There are no resource implications associated with this report		
Equality, Diversity and Inclusion (EDI) implications:	There are equality, diversity and inclusion implications associated with different aspects of this report.		

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

1. Introduction

I would like to take the opportunity to welcome everyone to our first meeting of 2025. I hope you all had a joyous and restful festive break. Here at the Tavistock and Portman we enter the New Year with a mixture of excitement and trepidation, as we approach a most pivotal period in our history. However, we are determined that whatever the coming months hold, we will ensure that the best interests of our service users, students and our staff remain our key priority.

November 2024 marked two years since I joined the Trust. When I arrived, it is fair to say that we were in a difficult place, and change needed to happen. I am pleased to see that we have now laid firm foundations for our longer-term future, through strengthening the services we offer to patients and students, improving our financial outlook and making good progress on providing a better experience for our staff, particularly around our approach to ensuring equality, diversity and inclusion. There is still much that we need to do, but none of what we have achieved so far could have been done without the hard work and support of our staff, and I would like to thank you all for your continued support.

2. Merger update

We continue to work positively with Central and North-West London NHS Foundation Trust (in partnership with Camden Council and University College London) and NHS England on our merger.

2025 has brought about a renewed focus on our shared ambition of improving educational outcomes for students, and health and care outcomes for patients and their carers supported by delivery of the merger. We are committed to improving local community support for children, young people and adults struggling with mental ill health, learning disabilities or autism, and having a clear understanding of the need to provide integrated place-based services that work better for those individuals who access them.

This unique partnership offers the opportunity to deliver truly translational clinical services, research, training, education, and place development. We believe that the merger will bring significant benefits to the new shared organisation, the national training offer for social work and psychotherapy, the NCL Integrated Care System and Camden as a 'place'.

Providing outstanding patient care

3. North Central London CAMHS Provider Collaborative

On 7 January 2025 colleagues from the Tavistock and Portman, North London, Royal Free and Whittington Trusts met to discuss plans for establishing a CAMHS Provider Collaborative to continuously improve services and deliver a core offer for children and young people across North Central London. Discussions were supported by hearing from two young people with lived / peer support experience which highlighted the need to focus on access, waiting times, digital innovation, flexibility on where care and support is delivered, school support and stigma. A key theme was the need to work collaboratively in the delivery of care supported by learning from the i-Thrive model. Partners will meet again on 24 January to develop an action plan and governance for the CAMHS Provider Collaborative in support of meeting the needs of children, young people and their families across North

Central London. All partners involved are fully committed to learning from each other and improving the outcomes and experience for all those children, young people and families accessing CAMHS services.

4. Fitzjohn's Unit wins Innovative Excellence Award

I was very pleased to learn that on 23 November, the Trust's Fitzjohn's Unit, which provides a specialist outpatient service for adult patients with complex needs, won the Innovative Excellence Award at the British Psychoanalytic Council's Psychoanalytic Psychotherapy Now Conference. The award celebrates what was described as "a striking example of groundbreaking work", and the BPC recognised that the service offers psychotherapy to a population of patients that mental health services struggle to effectively support. My congratulations go out to the whole team.

5. NHSE Adult Gender Service Inspection

The Trust received the initial notification of the high-level findings from the inspection from NHS England on 22 November. In their letter, they outlined areas of practice that required immediate attention with a deadline of 6 December for the action plan to manage immediate risk and the 20th of December for the serious concerns. The team have been supported by our Chief Nursing and Medical Officers to implement the plan to mitigate all potential risks identified and to ensure that actions have all been signed off prior to the final deadline of 20 December.

NHSE have invited the Trust's staff and patients to engage in a survey to share thoughts around the current service specification and we are working with the service to ensure we publicise this opportunity. This will feed into the larger review of the service specification that will then go to public consultation around summer 2025 prior to implementation towards the end of the year. Finally, we have been notified that NHSE will be moving all adult gender waiting lists to a national waiting list by the end of the current financial year. We will work alongside NHSE colleagues to ensure that this is a smooth transition.

6. Clinical Structure review

The final planned session to support implementation of the new clinical structure was held at the end of November. As with the previous sessions, this was held in person with clinical and operational leads. It allowed time for reflection on the move to their new roles and co-working to develop a clear plan for how clinical and operational leaders will work together to achieve the aims and objectives of the team. While this was the final session of the induction programme, training will be ongoing and the lead for this will pass from CNO and CMO to the Divisional Leadership Team (Triumvirate). The healthcare consultancy, Kaleidoscope will continue to provide organisational development support alongside this complementary work.

7. GP Collective Action

GPs across the country continue to carry out collective action with the aim of negotiating a new contract for primary care service delivery. While this has been ongoing for a number of months, it is only recently that we have felt the impact within our own services. Those worse hit are services that use 'shared care' prescribing arrangements which are mainly CAMH services and our Adult Gender Service. GIC has seen a number of GPs recently stop prescribing medication that has been recommended and this is a direct result of the action being taken. This is leaving patients without access to medication as we are not commissioned to prescribe. The situation has been escalated nationally.

8. Our response to Change NHS

On 2 December, along with other NHS organisations across the country, the Trust submitted its response to the Department of Health and Social Care and NHS England's "national conversation" on the future of health services. This process will inform the new 10-year Health Plan, and views have been sought both from the public and NHS organisations. We were asked to share our views on three key areas – prevention, technology and care in the community – in addition to highlighting what has been working well for us, what needs to change.

To ensure that our response captured the views and ideas of a cross section of our patients, staff and students, as well as the public, we launched our own Tavistock and Portman Change NHS exercise. This was hosted on the online engagement platform Slido and could be completed as a survey or used in live engagement sessions. We received 255 contributions in total, all of which informed our final submission. You can read the submission on our website: Our response to Change NHS. Members of the public can continue to have their say on the online portal Change NHS.

Developing a culture where everyone thrives with a focus on equality, diversity and inclusion

9. Staff Survey

The national staff survey launched on 30 September and closed on 29 November. We set ourselves an ambitious target of a 60% response rate and whilst we were only able to achieve a 54.63% response rate by the end of the completion window, we improved on last years' response rate of 53% and did better than the average rate for our benchmarked peers.

We have received a high-level, embargoed management report and will be doing some early analysis in the coming weeks before presenting more information at a future board meeting.

10. Staff engagement

Last year, we co-developed with staff, patients and students, a new vision, mission and values for the Trust. These are now displayed and evident throughout the organisation. The agreed next step was to seek to bring the values to life and to develop a set of behaviours that will underpin and shape everyday working practices and relationships, and to co-develop a values and behaviours framework so we are consistent in how we apply our values throughout the Trust.

Over the summer and autumn, we have been working with staff via engagement sessions and presentations at away days to draw out what the values mean to them. In the last month we have held six sessions and received over 400 responses; we are now turning these into 'I' statements which will form the basis of 'our behaviours'. These behaviours will also be integral to the career conversations and the restorative just and learning culture approach to employee relations that we will shortly be rolling out.

11. Equality, Diversity and Inclusion priorities

The EDI Programme Board reviewed the progress made against the Trust's Inclusivity Action Plan and acknowledged that although many of the actions have been progressed,

there is little evidence of a shift in culture across the organisation. In response, the Programme Board developed a 'future state' statement and agreed three priority areas, each of which have clear 'I' statements so that they are known and owned by everyone across the Trust.

In November 2024 the future state and priorities were presented to the Trust's senior leadership team and senior leaders were challenged to think about how they will take this forward. They were asked to take the priorities back to their teams and facilitate local discussions with commitments to be sent back to the Associate Director of EDI, following which they would be collated into an overarching plan using the A3 methodology for quality improvement.

12. Employment Rights Bill consultation

NHS Employers has recently consulted on, and responded to, four aspects of the government's Employment Rights Bill. They had worked with national stakeholders and government to understand the implications of measures proposed in the bill for the NHS workforce, contracts and employment relations to ensure appropriate consideration of these impacts is given, as the bill makes its way through the Parliamentary process:

1) Application of zero hours contracts measures for agency workers
2) Creating a modern framework for industrial relations
3) Collective redundancy fire and rehire
4) Strengthening statutory sick pay

Early indications show that items 1 and 2 are of the most concern to NHS organisations with items 3 and 4 unlikely to create many issues. As the bill continues through its Parliamentary processes, there are likely to be further iterations; it is unlikely to become law before 2026.

13. Workforce Grip and Control

We have been working closely as part of the ICS to submit updates on our workforce position including reducing our reliance on agency staff. The use of agency workers is now also incorporated into the new Establishment Control Procedure (ECP) approach that we recently rolled out and will be more closely overseen by the finance and people teams. The grip and control submissions we have made to date have been well received by ICS colleagues and we remain on target in terms of our workforce expenditure.

The annual planning round for 2025/26 has not yet been released. Amanda Pritchard, the Chief Executive of the NHS, in her Christmas update message noted "One of the NHS' Christmas traditions has been the publication of planning guidance for the following financial year. Colleagues will know from our regional meetings on Friday that this won't be the case this year, as we continue to work with the DHSC and wider Government to finalise the details as soon as possible in the new year, to allow colleagues to plan for April onwards."

14. Transgender Day of Remembrance vigil

On 20 November the LGBTQI+ network held a vigil for Transgender Day of Remembrance. This is a day in which people across the world honour the memory of transgender people whose lives were lost in acts of anti-transgender violence.

15. Staff networks winter celebration

On 10 December, our staff networks hosted a well-attended winter celebration bringing together colleagues from across the Trust. The event highlighted the importance of creating

an inclusive workplace where all voices are heard and valued. The room was adorned with banners and posters providing insights into cultural and religious celebrations such as Hanukkah, Christmas, Kwanzaa, Lunar New Year and Bodhi Day, showcasing the diversity of traditions and shared humanity that this season represents.

Improving Value, Productivity, Financial and Environmental Sustainability

16. Delivery of the Trust's financial plan

The Trust incurred a net deficit of £2,296k in the period up to 30 November 24, against the plan of £1,556k, a negative variance of £740k. This is a worsening of the position from the previous month by £66k but in line with the expected position. The Trust has submitted a revised forecast outturn of c.£3.5m deficit (as part of the month 8 reporting cycle), being unable to achieve its year-end deficit plan of £2,200k. This deterioration in the reported position and the forecast outturn is due entirely to the funding gap relating to the 2024/25 pay award.

As a consequence of the deterioration of the expected outturn position, the Trust has been asked to take a series of recovery actions to the year end to reduce the forecast deficit as much as possible. This will include restrictions on appointments to the year-end to only essential posts and maximizing the impact of any non-recurrent opportunities. At the time of writing several mitigations have been identified which will reduce the forecast deficit from that submitted at month 8 to c£3.1m. Work will continue to the end of the financial year to reduce this figure further, with regular reporting on progress given to the ICB.

17. Annual planning for 2025/26

Annual planning is underway. It sets out the way by which the Trust will progress our strategy by producing an Annual Plan in line with National and local requirements and managing the business planning cycle for 2025/26. All planning is underpinned by the Trust's vision, mission, values and strategic ambitions. The approach and template for our annual plan was considered and signed off by our Performance, Finance and Resources Committee in November 2024.

The function of the 2025/26 business planning cycle is to deliver a single integrated plan that brings together quality, activity, workforce and finance, setting targets and deliverables expected at Trust, Unit and Service level. Annual planning will take place across (1) Clinical and Department of Education and Training Operational Units; and (2) Corporate Directorates.

The business planning process will be integrally aligned to budget setting, quality improvements, workforce and operational performance targets ensuring there is a single plan which demonstrates what will be achieved, how this is achieved and the cost of doing so.

The Annual Plan for 2025/26 is framed to support delivery of our merger and continued focus on all our strategy ambitions:

- 18-week referral to treatment
  Our aim is that no service user waits longer than 18 weeks for access to first treatment.
- User experience
  Our aim is for 90% performance in service user satisfaction / experience scores.

- Student intake
  To grow our international student intake by 15% annually and increase our national reach.
- Sustainable partnerships
  To have in place income generating international partnerships that support innovation and care improvements on a global scale.
- Prevention centre for children and young people
  To have established a prevention centre for children and young people's mental health to support service users, carers and families in Camden and beyond
- Host an annual thought leadership conference
  To position ourselves as thought leaders in thinking about how best to meet the mental health and wellbeing needs of Londoners
- Improve equality, diversity and inclusion (EDI) scores
  To improve our EDI score by the end of March 2025
- Reduction of bullying, harassment and abuse
  Our aim is for a reduction of bullying, harassment and abuse by 5% per annum
- A financially balanced plan
  To have a financially balanced plan for each year of the strategy and medium-term financial strategy in place
- Enhanced budgetary controls
  To have enhanced budgetary controls and monthly reconciliation of activity, finance and workforce.

Regional and National Context

18. Winter pressures

We are aware that the wider NHS has had an incredibly difficult start to winter, with more people in general and acute hospital beds than in the corresponding weeks last year, driven in part by a far higher number of flu cases than we would usually see this early, as well as the impact of circulating RSV, Covid and norovirus. As a specialist mental health trust, the best form of support we can offer to our acute and community colleagues, is to try not to become patients ourselves, principally by having our flu jabs. Unfortunately take up of the jab among our frontline staff remains low, but we continue to encourage all colleagues to take it, despite reports of non-availability of vaccines at some of the nearby community locations.

19. Health and Social Care Committee hearing on the 10-year Health Plan

On 11 December, the Health and Social Care Committee held an evidence session as part of its work on the 10-year Health Plan. Among those called to give evidence at this first session were Safron Cordery, interim CEO of NHS Providers and Professor Kamila Hawthorne, Chair of the Royal College of General Practitioners. Lord Ara Darzi, who had published a report of the state of the Heath Service in September, had attended to give evidence to the Committee in November.

20. Consultation on the regulation of NHS managers

On 28 November DHSC launched a consultation on proposals to regulate NHS managers. In setting out the reasons for this move, the Government acknowledged that delivery of the 10-year plan would require the "best leadership talent", and that support for managers and leaders needs to be improved. However, they also drew attention to the failures highlighted by the Francis Inquiry, the ongoing Thirlwall Inquiry and the Infected Blood Inquiry as examples of poor leadership and accountability.

The consultation, which will be open until 18 February 2025, is seeking views from stakeholders on:

- the type of regulatory system that would be most appropriate for managers
- which managers should be in scope for any future regulatory system
- what kind of body should exercise such a regulatory function
- what types of standards managers should be required to demonstrate as part of a future system of regulation.

MEETING OF THE BOARD OF DIRECTORS PART II – 16 January 2025			
Report Title: Board Service Visits Update			**Agenda No.: 8**
Report Author and Job Title:	Adewale Kadiri, Director of Corporate Governance	**Lead Executive Director:**	Adewale Kadiri, Director of Corporate Governance
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	Service visits are an important part of the roles of Non-Executive Directors and members of the Council of Governors. The Trust is in the process of pulling together a programme of service visits for NEDs and Governors, picking up from the opportunities for such visits that had been put forward during 2024. Once this has been completed, NEDs and Governors would be invited to book onto the available slots.		
Background:	During 2024, a number of NEDs and Governors were able to join visits, virtually and in person, to various operational and corporate services across the Trust. However, not enough visits were made available at times that suited all, and in 2025, therefore, work is being done to increase the number and range of available visits.		
Assessment:	To enhance the value of these visits, a simple template will be produced to enable NEDs and Governors record brief details of their visits so that any emerging messages and learning can be shared.		
Key recommendation(s):	The Board is asked to NOTE the content 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 CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 2 – Failure to provide consistent, high-quality care BAF 4 – Risk of loss validation of DET degrees BAF 8 – Lack of management capability and capacity BAF 10 – Maintaining an effective estate function				
Legal and Regulatory Implications:	Yes ☐	No ☒			

Resource Implications:	Yes ☐		No ☒	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐		No ☒	
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:				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Board Service Visits Update

1. Purpose of the report

1.1. The aim of this report is to report on visits by Non-Executive Directors and Governors that took place during 2024 and introduce the process for 2025.

2. Background

2.1. It is an important part of the role of non-executive directors for them to be able to visit as many of the Trust's locations as possible. This is both to enable them to engage with staff, and where appropriate, service users and students, and also to give them as Board members a more direct understanding of the successes, challenges and ambitions of each service. Visits of this sort can also act as a good source of triangulation with information that they receive via other sources.

Governors, as representatives of the local communities served by the Trust and other stakeholders, also have a duty to get to know the services provided as part of their general duty to represent the interests of the FT members.

3. Opportunities for service visits

3.1. As a small specialist trust that does not provide any inpatient services, or run traditional community bases, opportunities for conventional service visits are limited. The changes to the way that many of the Trust's services work that largely came about during the pandemic also limit the chances for the sorts of visits that other trusts could provide.

That notwithstanding, the Trust was able to arrange a number of visits for NEDs and Governors during 2024, as set out below. In some cases, visitors sat in on pre-arranged team meetings, while in others, bespoke engagements were set up

	Team	Date	Virtual/In person	NED	Governor
1	South Camden Community CAMHS	4th April	Hybrid	David Levenson	Peter Ptashko
2	North Camden Community CAMHS	25th April	In person	Aruna Mehta	Kathy Elliott
3	Camden MOSIAC	7th May	In person	Sal Jarvis & David Levenson	
4	Adult Trauma	24th June	Hybrid	Shalini Sequeira (attended virtually)	Ffyona Dawber & Kathy Elliott
5	City & Hackney Primary Care Psychotherapy	10th July	in person	Shalini Sequeira	

	Consultation Service (PCPCS)				
6	the Strategy and Transformation team meetings	11th September	Virtual	David Leveson	Kenyah Nyameche
7	Head of Portfolio - DET	2nd October	Virtual	John Lawlor	
8	Gloucester House	October	Virtual	John Lawlor	Sheena Bolland
9	Estate Team Meeting	15th November	Tavistock	Claire Johnston Kathy Elliott	
10	Tavistock Consulting Team meeting	25th November	Tavistock	David Leveson Shalini Sequeira	
11	HR Team Meeting	4th December	Virtual	Ken	Sheena
12	HR Team Meeting	8th January	Virtual	Shalini	

4. Proposals for the future

4.1 For 2025, it is proposed that more opportunities will be provided in a wider range of services and with more choices of dates and times, taking account of the fact that most NEDs and Governors have many other time commitments. The Corporate Governance team is engaging with all services, clinical, educational and corporate to ensure that all colleagues have the opportunity to host visits – colleagues in DET in particular, will be encouraged to participate, as this is a part of the Trust's work that is unique to this organisation, and yet does not always enjoy the profile it should. Governors and NEDs would also be encouraged to suggest locations or services within the Trust that they would like to visit.

4.2 In order to make these visits as useful as possible for both the visitors and the hosts, a simple template will be designed that the Governors and NEDs can complete after their visit, recounting briefly what they saw, and what they were told. This would enable any learning to be recorded and shared and may also enable the service to raise urgent issues that they may otherwise not have been able to.

MEETING OF THE BOARD OF DIRECTORS – Thursday, 16th January 2025			
Report Title: Integrated Quality Performance Report			**Agenda No.: 009**
Report Author and Job Title:	Rachel James, DoT Sheva Habel, MedD	**Lead Executive Director:**	Clare Scott, CNO Chris Abbott, CMO
Appendices:	Appendix 1: IQPR Report		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☒ Assurance ☒		
Situation:	This is the IQPR for 24/25 Month 7 (October 2024) data		
Background:	This Integrated Quality and Performance Report (IQPR) was co-produced with clinical and operational leads across the units, combining elements from the previous reporting framework with newly automated templates. The Trust and Division Leadership Team (DLT) aim to achieve fully automated reporting of data and metrics by April 2025. The Quality Improvement A3's are reviewed in the weekly Strategy Delivery Room, providing the focus on improvement in relation to the strategic aims.		
Assessment:	• **Waiting times:** The primary challenge is meeting the 4- and 18-week Referral to Treatment (RTT) targets. Progress includes Autism and Gender Teams: Pathway mapping, trajectory setting, and job plan completion have seen improvements. Trauma Team: Ongoing work following recent Kaizen workshops to formulate improvement and delivery plans. • **Quality & Patient Safety:** 13 patient safety incidents were reported; 9 involving violence/aggression and 5 requiring physical restraint at Gloucester House. A recovery plan is in place with committee oversight. • **Complaints:** Nine formal complaints were received in October 2024, and the number of complaints overdue was 14. The Trust continues to focus on investigating and responding to all overdue complaints in a timely way through weekly meetings with Service Clinical Leads to troubleshoot any issues. • **Positive Feedback:** Clinical Services recorded 93% of ESQ positive responses in October, which is above the benchmark of 90%. Although a lower number of responses was received in this period, the reduction is not statistically significant. The new ESQ collection process using a QR code has been agreed and is in the process of being implemented. Future reporting will include thematic analysis of the qualitative comments received. Work continues to set team level targets for the ESQ feedback, and to enable a team level review of feedback received on a monthly basis, to be delivered end of January 2025. • **Workforce**: Appraisals stood at 45.80%; an increase by 2.47% in month (this rate excludes Medical and Dental staff group). Continuous work is being carried out by the Learning and		

	Development Team to ensure the Trust raise the standard of appraisals.MaST compliance dropped by 0.98% to 79.24%. Non-compliance is escalated by the people team to the appropriate channels including the relevant executive director for the directorate. Managers have been advised to provide staff with 'protected time' within the confines of their working hours to complete their MaST. The Recruitment and Retention Group will start receiving workforce data from next month in order to more closely interrogate the information and routes for mitigation where required.
Key recommendation(s):	The Board of Directors is asked to review the contents for approval, information and assurance.

Implications:

Strategic Objectives:

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

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 2				
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 ☒			
	EDI implications are addressed through the working groups, it is noted that both feedback and waiting lists are focusing on ensuring that ways in which service users can give feedback are made more accessible and that waiting list work focuses on reducing barriers to accessing our services.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			

Assurance:

Assurance Route - Previously Considered by:	Local IQPR held in November 2024			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report December 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

The Tavistock and Portman NHS Foundation Trust

Performance

Waiting times: The primary challenge is meeting the 4- and 18-week Referral to Treatment (RTT) targets. Progress includes Autism and Gender Teams: Pathway mapping, trajectory setting, and job plan completion have seen improvements. Trauma Team: Ongoing work following recent Kaizen workshops to formulate improvement and delivery plans.

Quality & Patient Safety

Incidents: 13 incidents reported, including 9 involving violence & aggression and 5 requiring physical restraint at Gloucester House. Policies and processes for the recording of incidents and management of behaviour that challenges are under review as part of the improvement plan for the school.

Complaints: Nine formal complaints were received in October 2024, and the number of complaints overdue was 14. The Trust continues to focus on investigating and responding to all overdue complaints in a timely way through weekly meetings with Service Clinical Leads to address any issues or delays.

Positive Feedback: Clinical Services recorded 93% of ESQ positive responses in October, which is above the benchmark of 90%. Although a lower number of responses was received in this period, the reduction is not statistically significant. The new experience of service (ESQ) collection process using a QR code has been agreed and is in the process of being implemented. Future reporting will include thematic analysis of the qualitative comments received.

Work continues to set team level targets for the ESQ feedback, and to enable a team level review of feedback received on a monthly basis. To be delivered end of January 2025.

Finance

Deficit: Reported £2,043k net deficit, a variance of £674k against the planned £1,369k deficit.

Revised forecast indicates a £3.6m deficit, driven by unfunded pay awards.

Budget Alignment: Clinical unit budgets are being reviewed via Establishment Cleanup Meetings and further DLT analysis to align resources with contractual targets.

An ambition has been set to finalize the position by **December 15, 2024**.

Contracts

Risks have been stratified, with PCPCS, Trauma, ASC & LD contracts scoring 16 on the risk scale.

PCPCS: Service closure programme underway, with inherent risks related to redundancy or redeployment costs. CFO discussions are planned within the next two weeks.

Tavistock and Portman
Our Values and Strategy

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

Integrated Quality and Performance Report

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

Problem Statement

In 3 teams are not reaching the NHS Referral to Treatment 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. The service currently receives 350 referrals per month and has capacity to offer 50 new patient appointments per month, with the consequence that the waiting list is growing exponentially and the gap is increasing month on month.

The Adult Trauma pathway currently has significant demand/capacity constraints. In November 2023 ~650 patients were waiting for a first appointment. 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 Team for CYP aged 12-18 years has seen a 285% increase in referrals for assessment since 2019 with an associated increase in waiting lists and waiting times. Due to the nature of the way patient are triaged, the waiting time for the actual assessment could be non-transparent. In November 2023 there were 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

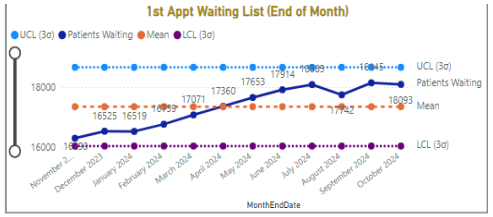
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

Continued…

Metric	Waiting List Management (Continued)	SRO	Chris Abbott	Target		Measure	

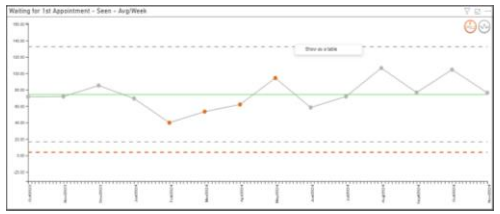
People Culture | Waiting Times | User Experience & Outcomes | DET, Commercial Growth and Sustainability | Merger

Historical Peformance

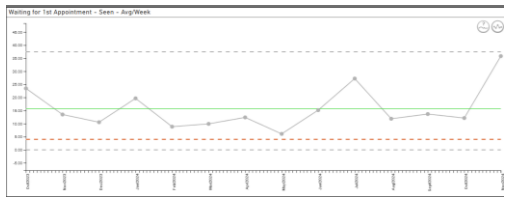


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

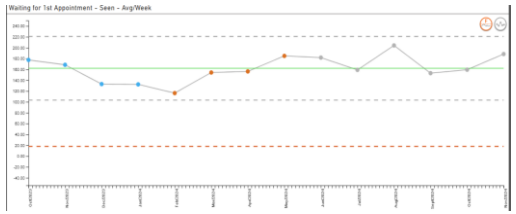
Trauma



Autism Assessment

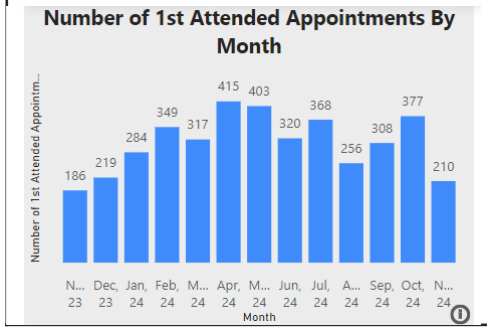


Adult Gender Identity Clinic (GIC)

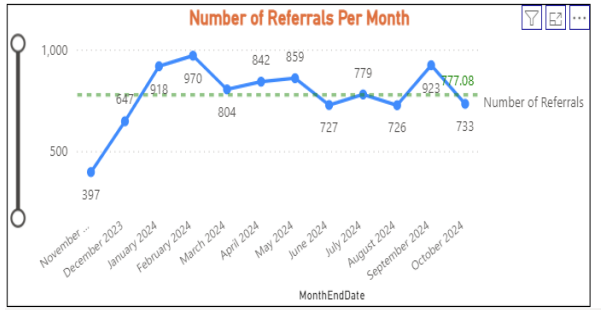


Monthly Stratified Data

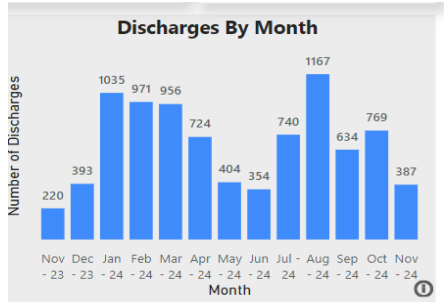
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

		Countermeasure in progress	Expected impact	Owner
In some areas there is not enough resource for the numbers of patients being referred	Funding doesn't match demand 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 and indicative timelines it requires to complete each intervention within the pathway	Personalised or individualised care has driven care to patients already open	The mapping of 'as is' and 'to be' pathways is taking place across teams with a prioritisation of where there are longer waits	Having greater standardisation will prevent treatment drift, and with this create capacity which will enable waitlist reduction work	Sally Hector and ops teams
Data and metrics are inconsistent and not targeted	Lack of clarity about contractual requirements	IQPRs to flow team and service specific data that will allow better tracking of activity and improvement work	Team managers will have better resources to manage activity and with this greater accountability for team performance	Sally

Integrated Quality and Performance Report

Month 7 - 24/25

Metric	User Experience	SRO	Clare Scott	Target	90%

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

Problem Statement

Across the Trust, since April 2023, the average monthly positive feedback percentage is 86% 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. The average number of monthly forms completed Trust wide was 99 and this may impact the positive feedback 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.

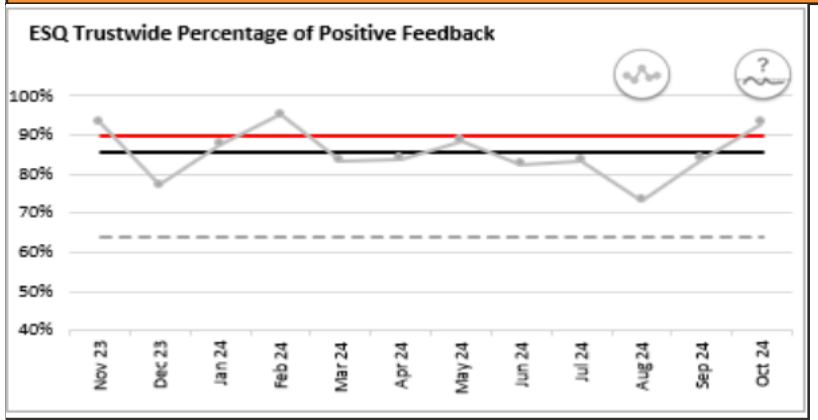
Vision & Goals

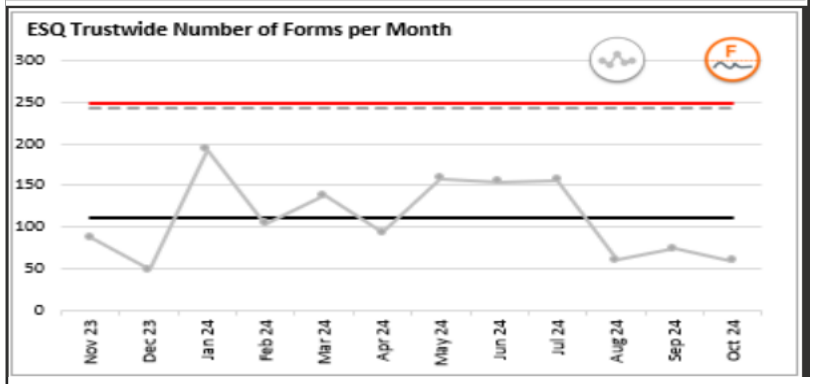
Vision: For all users to have a positive experience across the trust.

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





- Normal data variation in data, is marked in grey.
- Significant improvement would be marked in blue.
- Deterioration or failing to meet the target is marked in amber.
- The number of forms completed includes Trust Internal ESQ and GIC PEQ forms.

Progress on Improvements

Concern	Countermeasure in progress	Owner
There isn't a standardised **ESQ form** being used Trust wide and the demographic questions need revising	• Agreement from GIC to align PEQs to ESQs to standardise processes • Agreement to use Radar instead of Qualtrics • MHST, GH and GHOR have different forms attempting to amalgamate to an anonymized standardized ESQ process	Nimisha, Sonia, Marcy, Ravneet
The **collection process** for ESQs needs to be reviewed including deciding which system to use, where the feedback will be stored, whether the logic will continue to be used and what the role and responsibilities are for collection.	• To understand roles and responsibilities of collecting and disseminating feedback for the PPI, Quality Assurance team and Managers once the new Radar system for feedback collection is in place • An agreement on the collection process has been reached we are moving to implementation.	Nimisha, Sonia, Marcy, Ravneet
There will be various new ways for service users to provide feedback at any time; currently, there is no **training** developed to train staff of these upcoming changes such as patient correspondence being updated to have a URL/QR code to direct them to provide feedback.	• A process map to be created to show the new processes to collect feedback • A comms strategy to be developed to help get the message out re new processes and the importance of collecting feedback (draft posters, letter templates, All staff meeting etc.)	Nimisha, Sonia, Marcy, Ravneet
There is a discrepancy between when **quantitative and qualitative data** is distributed to Managers There is lack of clarity of where feedback is being discussed at team level	• An agreement on the distribution process has been reached and a move to sharing data collectively. • Develop a process for feedback to then be disseminated to the wider team and engage Managers to understand what this feedback loop will look like. • To have a process in place for services to show what they have done with the feedback	Nimisha, Sonia, Marcy, Ravneet
We need to develop how **impromptu feedback** can be provided.	• This includes creating ways to provide feedback on patient correspondence, paper ESQ forms, QR codes being added in patient spaces including in physical spaces via posters and digital spaces such as NCLwaitingroom • Paper ESQ form in development to facilitate the collection of data anonymously.	Nimisha, Sonia, Marcy, Ravneet, Comms
There are no team level **targets** for how much feedback should be received per team each month,	• The process to set these has begun and will be available for the end of this month.	Nimisha, Sonia, Marcy, Ravneet

Integrated Quality and Performance Report — Month 7 – 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.

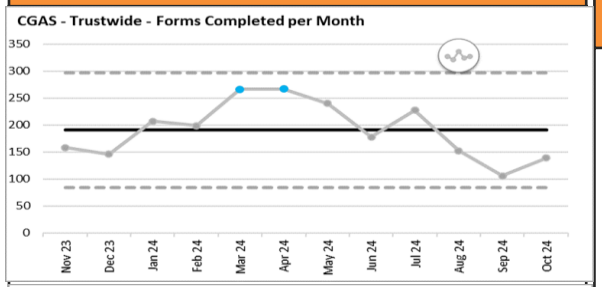
Vision & Goals

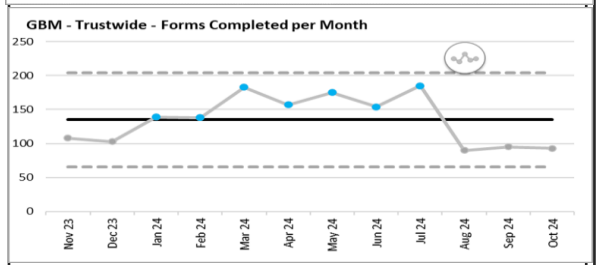
Vision: The overall vision is to ensure compliance with the new NHSE waiting time standards and have increased matched pairs of outcome measures to help us improve our services, evidence their effectiveness, and reduce health inequalities.

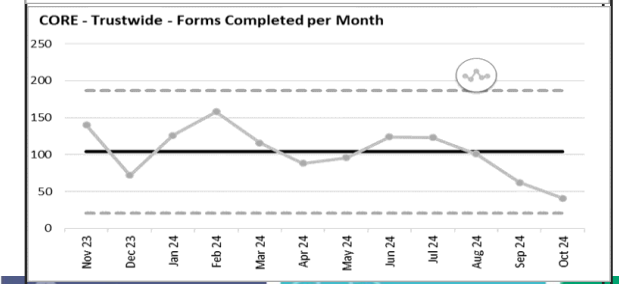
G1: Our first goal is to ensure that we begin collecting OM from a patients first appointment

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







Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Clinicians and teams are not aware of the need to collect Outcome Measures from the first appointment, aligned with the new NHSE waiting time metrics. **(G1)**	**Carenotes Changes:** Submitted a proposal to Informatics to make 10 changes to Carenotes, to make the collection of T1 and T2 easier. Some changes include: • Cleaning up the assist panel so it only shows missing OMs and removes OMs that have not been completed once an episode (intervention) has ended • Letter templates to pull through CGAS and GBM data, making it meaningful for CYP service users (sharing learning for Adults) • A text box reminder to pop up once someone opens an assessment summary, asking them to complete OMs • Enabling clinicians to save GBMs even if there is only one goal	• All changes requested to Carenotes were signed off by Change Board on the 8th of October. Informatics to agree a timeline for when changes will be made. • Comms to be designed and circulated to ensure all staff are aware of all Carenotes changes before they happen. • Set up a service user co-production group to incorporate feedback into changes	IM&T LC & RJ AB/PPI
Clinicians and teams are not collecting matched pairs of outcome measures **(G2)**	**3 improvement pilots:** to test improvements and new ideas: • Adult Psychotherapy (Introducing DIALOG) (Date TBC) • Autism and LD (Increase collection through process design / digitization) (23rd October) • First Step (Introduction GBMs in professional consultations) (21st November)	• Rachel and Luke to meet with First Step team to initial their GBM pilot. • Meet with Autism Team / Ops and Admin Manager to set up new process for collecting RCADS pre-appointment using Qualtrics. • Meet with Adult Psychotherapy team to find some power users of DIALOG to test the roll out of the new measure.	RJ, LC & MW RB/TR MM/TK
	Training: Creation of a 3 phased training plan that will deliver improvement training at a Trust-level, Unit Level, Ops/Admin and Team Manager Level. The initial Trust-wide training discusses: • The clinical importance of collecting OMs both at first appointment and in pairs • How OMs can improve the clinical outcome for patients • How OMs can be useful at a team and organizational level • What service user voice and why they feel OMs are important • Setting out the new standardized logic for when T1 and T2 is required • Adaptations for culture, diversity and complexity • Some do's and don't of best practice	• Work in partnership with Training working group to finalise the Trust-wide training slides. • Conduct two training sessions beginning in late November early December. • During November and December engage with Service and Clinical leads to develop specific Unit level training. • Deliver Unit training in December/New Year.	RJ/LC RJ/LC/TL RJ/LC SCL's & TCL's

Integrated Quality and Performance Report

Month 7 - 24/ 25

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

Problem Statement

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

Vision & Goals

Vision: To consistently match or exceed the national average score

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

Historical Performance

2021 2022 2023

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

Key achievements so far …

NHS The Tavistock and Portman NHS Foundation Trust

(WRES) Global Majority	(WDES) Disabilities and Long-Term Health Conditions
• The overall workforce profile has improved by 9.2% over the last 5 years. • Band 8a-8b representation (non-clinical cohort) was 25.7% in 19/20, 5 years later (23/24) it's at 30.2%. • Band 8c-VSM representation (non-clinical cohort) was 10.7% in 19/20, 5 years later (23/24) it has quadrupled to 31.4%. • Bands 8a-8b representation (clinical cohort) was 12.7% in 19/20 – it has almost doubled, now it's 22%. • Underrepresentation at Board has shrunk by over 50% (from -9.8% in 19/20 to -4%). • Launched PCREF steering committee in September	• The overall workforce profile has improved by 9.2% over the last 5 years. • All Agenda for Pay Bands (non-clinical cohort) are representative. • Clinical cohort was 3% in 19/20 – it has quadrupled to 12.2% in 5 years. • Harassment, bullying or abuse from managers plummeted by 14.7% in the last 12 months • Reasonable Adjustments improved by 14.2%

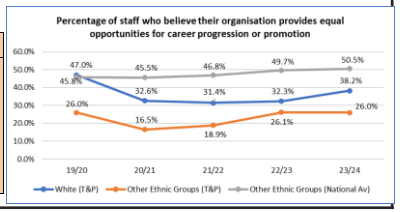
- **Inclusive Recruitment:** all interview panels must now have a trained EDI representative
- All staff networks now have an executive sponsor

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

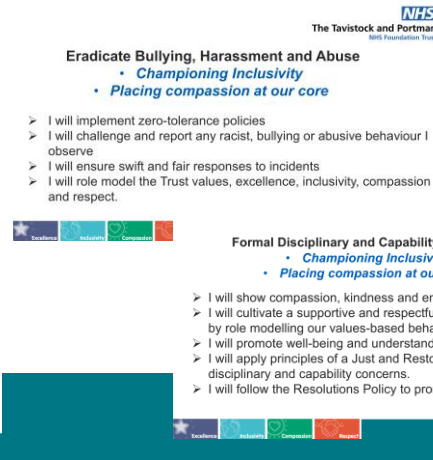


Progress on Improvements (subject to WRES / WDES refresh)


NHS The Tavistock and Portman NHS Foundation Trust

Our Desired Future State

The Tavistock and Portman envisions a fair, inclusive workplace where all staff are respected, discrimination is eliminated, and everyone can thrive and reach their full potential.


NHS The Tavistock and Portman NHS Foundation Trust

Eradicate Bullying, Harassment and Abuse

- *Championing Inclusivity*
- *Placing compassion at our core*

- I will implement zero-tolerance policies
- I will challenge and report any racist, bullying or abusive behaviour I observe
- I will ensure swift and fair responses to incidents
- I will role model the Trust values, excellence, inclusivity, compassion and respect.

NHS The Tavistock and Portman NHS Foundation Trust

Inclusive RecruitmentEqual Opportunities for Career Progression or Promotion

- *Championing Inclusivity*
- *Striving for Excellence*

- I will actively support underrepresented groups through fair recruitment with an inclusive recruitment advisor at all times.
- I will foster an accessible and diverse environment
- I will encourage participation from all voices
- I will provide equal opportunities for career progression and target training opportunities to staff from underrepresented and traditionally marginalised/disadvantaged backgrounds to enable this.

NHS The Tavistock and Portman NHS Foundation Trust

Formal Disciplinary and Capability Processes

- *Championing Inclusivity*
- *Placing compassion at our core*

- I will show compassion, kindness and empathy in all interactions
- I will cultivate a supportive and respectful culture for marginalised staff by role modelling our values-based behaviours.
- I will promote well-being and understanding
- I will apply principles of a Just and Restorative Culture to all disciplinary and capability concerns.
- I will follow the Resolutions Policy to promote a mediative approach

Excellence Inclusivity Compassion Respect

Integrated Quality and Performance Report

Month 7 – 24/25

Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

Problem Statement

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

Vision & Goals

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

Goal 1: To achieve a 60% response rate to the next staff survey (current return is 26%)

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

Historical Performance

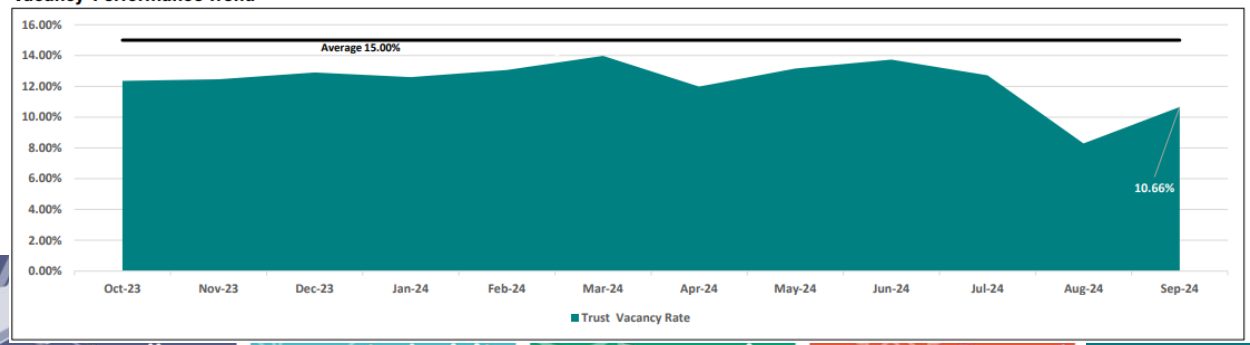
Key Performance Indicators	Trust Average Target	Jul-24	Aug-24	Sept-24	Trend (Against Previous Month)
Sickness Absence	3.07%	1.63%	2.00%	2.33%	↑
Turnover	2.20%	1.85%	2.30%	2.26%	↓
Vacancy (To be reviewed)	15.00%	12.71%	8.29%	10.66%	↑
Statutory and Mandatory Training	95.00%	80.35%	79.88%	80.22%	↑
Appraisal (Rolling 12 months)	95.00%	41.80%	43.03%	43.33%	↑

Voluntary Turnover Rates by Years Service

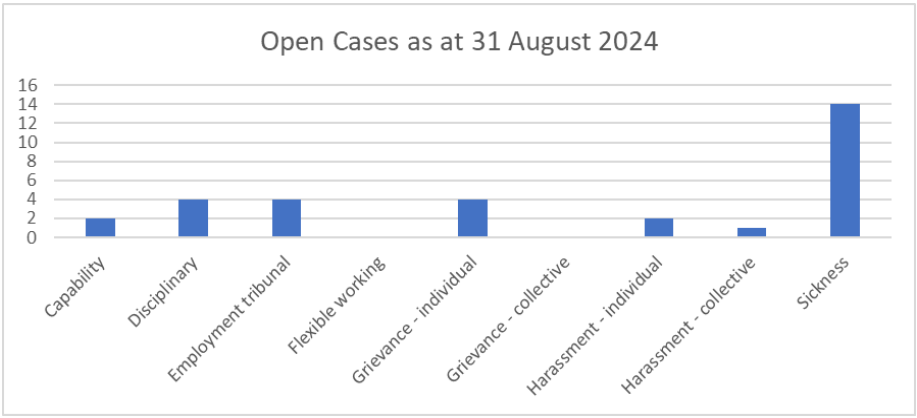
Months	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24
Trust Overall Turnover Rate	0.57%	1.07%	1.61%	2.46%	0.75%	8.32%	1.32%	1.85%	0.70%	1.85%	2.30%	2.26%
of which are Voluntary	0.50%	0.93%	1.05%	1.15%	0.61%	1.00%	1.28%	1.16%	0.48%	1.47%	1.14%	1.08%
<1 Year	0.15%	0.15%	0.29%	0.25%	0.55%	0.29%	0.16%	0.16%	0.16%	0.00	0.16%	0.00
1 to 2 Years	0.00	0.56%	0.09%	0.54%	0.00	0.12%	0.32%	0.32%	0.16%	0.22%	0.22%	0.00
2 to 5 Years	0.26%	0.15%	0.55%	0.29%	0.00	0.37%	0.47%	0.24%	0.16%	0.32%	0.58%	0.97%
5 to 10 Years	0.00	0.07%	0.07%	0.00	0.06%	0.22%	0.22%	0.16%	0.00	0.55%	0.09%	0.00
10 to 15 Years	0.09%	0.00	0.05%	0.07%	0.00	0.00	0.00	0.29%	0.00	0.32%	0.09%	0.11%
15 to 20 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.11%	0.00	0.00	0.07%	0.00	0.00
20 to 25 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
25 to 30 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
>=30 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

	FTE Days Lost Sept-24				FTE Days Lost Sept-23			
Absence Reason	Long Term	Short Term	Grand Total	Absence Rate	Long Term	Short Term	Absence Rate	Year On Year Difference
Trust Overall Sickness	253.40	196.18	449.58	2.33%	351.90	130.10	2.39%	↓
S10 Anxiety/stress/depression/other psychiatric illnesses	81.60	60.13	141.73	0.74%	44.50	6.00	0.25%	↑
S11 Back Problems	0.00	0.00	0.00	0.00	0.00	6.00	0.03%	↓
S12 Other musculoskeletal problems	0.00	0.00	0.00	0.00	0.00	1.00	0.00%	↓
S13 Cold, Cough, Flu - Influenza	0.00	22.60	22.60	0.12%	0.00	7.00	0.03%	↑

Vacancy Performance Trend



Root Cause/ Gap Analysis



Progress on Improvements

Training & Development

- CPD panel
- Staff engagement group meetings
- Admin Development Programme
- Management & Leadership Development Programme
- Values work and Behaviours being developed

Quick wins agreed and coming up

Some of the initiatives staff reported that would improve their experience at the Trust which are upcoming:

- Free yoga sessions
- Staff canteen – a cheaper option
- Wellbeing room
- Spoons in the kitchens
- Tea/ coffee (decaf and non decaf) / sugar and milk
- Lockers
- Cycling facilities

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

Business Rules: The IQPR will provide a summary view of all strategic objective metrics, including a RAG rating for metrics that have either:

- Been red for 4 or more months, or
- Breached the upper or lower SPC control limit.

Our business rules work alongside SPC alerts to prompt specific actions. This approach allows us to respond to natural variation without needing to investigate every metric monthly. Metrics not included in our strategic objectives but critical to service delivery will be placed on a watch list, with thresholds monitored closely. We expect that more of these metrics will appear green and maintain that status. "Watch Metrics" are those we are monitoring to ensure they do not deteriorate. The metrics associated with these objectives have challenging improvement targets. The scorecard will initially show a red status until the final goal is reached, at which point it will turn green. Once achieved, we may set a more ambitious target, reverting the metric back to red, or we may choose to focus on a different metric.

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

Watch Metrics Score Card

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

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous month	Mean	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Are we safe?	Patient safety incidents (actual or potential harm)	N/A		↑	11.00	12	10	9	8	10	4	11	13	17	11	6	13
	Open SI / PSI investigations	TBC		→	2.79	3	3	3	3	2	3	3	3	3	3	2	2
	Violence & aggression incidents	<5		↑	6.29	11	6	6	4	8	2	7	9	7	1	1	9
	Restraint incidents	0		↑	3.18	0	0	0	1	4	5	6	12	9	0	1	5
Are we effective?	52-week+ dormant cases	0		↓	2010	2350	2366	2266	2185	2126	2080	1922	2034	2000	2008	1966	1941
	No of referrals (including rejections)	919		↓	817	977	646	919	981	804	836	864	730	782	728	874	549
	No. of attendances	7046		↑	6501	7851	5067	6922	6927	6525	6244	7342	7446	7238	3877	6142.5	6725
	No. of discharges	919		↑	693.29	680	376	1024	966	943	698	397	344	724	1163	604	741
	% of Trust led cancellations	<5%		↑	4.13%	3.20%	5.71%	4.44%	4.06%	3.36%	4.48%	4.23%	4.03%	3.70%	4.93%	2.74%	4.15%
	% of DNA	<10%		↑	9.96%	9.00%	9.50%	9.47%	9.08%	9.15%	10.60%	9.76%	10.11%	10.54%	11.93%	10.58%	10.79%
Are we caring?	Number of formal Complaints received	<10		↓	5.69	7	3	5	5	2	2	6	7	4	6	10	9
	Number of compliments received			↑	88.13					81	61	203	124	67	55	54	60

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

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	Jul-24	Aug-24	Sep-24	Oct-24
Are we caring?	Number of informal (local resolution) complaints	TBC		↑	2.00	0	4	1	1	0	0	4	7	2	0	0	0	2	5
	ESQ positive responses (%)	90%		↓	86.0%	90%	90%	93%	77%	88%	95%	83%	84%	89%	82%	83%	73%	84%	93%
Are we responsive?	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS/FirstStep	0		↑	30.86	56	58	51	54	53	38	20	26	20	17	12	5	12	10
	18-week RTT breaches Autism Assessment (1st appointment)	0		↓	84.29	30	40	50	67	77	90	98	107	111	113	104	102	94	97
	18-week RTT breaches GIC (1st appointment)	0		↓	13912	12792	13061	13174	13429	13298	13458	13814	14053	14365	14772	14923	14490	14594	14545
	18-week RTT breaches Trauma (1st appointment)	0		↑	652.93	426	449	480	517	558	607	640	689	720	752	781	821	846	855
	18-week RTT breaches PCPCS (1st appointment)	0		↑	124.71	61	48	46	70	71	80	114	150	161	181	170	176	191	227
Are we well-led?	Mand and stat training (combined)	95%		↓	75.0%	56.3%	55.7%	75.8%	76.9%	78.0%	75.7%	76.2%	77.1%	79.0%	80.1%	80.4%	79.9%	80.2%	79.2%
	Appraisal completion (combined)	95%		↑	55.2%	79.7%	78.9%	79.6%	81.5%	80.7%	80.4%	30.8%	28.7%	23.2%	36.3%	41.8%	43.0%	43.3%	45.8%
	Staff sickness (combined)	3.07%		→	2.17%	2.39%	2.23%	3.98%	3.17%	1.45%	1.61%	1.34%	1.84%	1.79%	1.82%	1.63%	2.00%	2.33%	2.82%
	Staff turnover (combined)	2.20%		↓	2.0%	1.9%	0.6%	1.1%	1.5%	2.5%	0.8%	8.3%	1.3%	1.9%	0.7%	1.9%	2.30%	2.26%	1.4%
	Vacancy rate (On Hold) (combined)	15%		→	10.66%	15.41%	12.35%	12.46%	-12.90%	12.60%	13.06%	13.98%	11.98%	13.16%	13.74%	12.49%	8.29%	10.66%	12.01%

Delivering our vision – How are we doing? October 2024

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 13 Patient Safety Incidents	**Patient safety Incidents**
The Trust reported 9 Violence & Aggression incidents, all of which were recorded for Gloucester House School.	**V&A Incidents**
The Trust reported 5 physical restraint Incidents, all reported for Gloucester House School	**Restraint Incidents**

Delivering our vision – How are we doing? October 2024 Data

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

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 9 Formal Complaints, the majority being in the adult unit. Adult Unit has allocated all outstanding complaints and closed two informally without the need for escalation due to prompt and skillful handling. The revised protocol automatically allocates to the respective clinical or operational lead within a service unless there is high complexity , sensitivity or confidentiality that warrants a lead clinician investigation. ST (psychiatry senior staff) are routinely allocated one complaint each.	**Formal complaints**
The Trust has recorded 1 Compliment from Radar and received 60 ESQ positive pieces of feedback	**Compliments**
The Trust has recorded 93% of ESQ Positive Responses against a benchmark of 90%.	**Positive responses**

Delivering our vision – How are we doing? - October 2024 data

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

The Tavistock and Portman NHS Foundation Trust

• Appraisals, currently stands at 45.80%. This has progressed in October by 2.47%. **Excludes Medical and Dental staff group.** • Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals. • The Chief Education Directorate hold the lowest at 28.41%, at the same time have made improvements from last month by 2.35%. • Adult Unit Appraisal rate is 69.5% • All directorates do not currently hold a high standard.	**% Appraisal completion 45.8**
• Overall, at Trust level sickness has increased to 2.82% in Oct-24, by 0.49% from Sept-24 • As a Trust we remain under the sickness average by 0.25%. • The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.10% in Oct-24. • Compared to Oct-23, sickness has increased by0.59% in Oct-24.	**% Staff sickness 2.82**
• Compliance this month stands at 79.24%, a 0.98% decrease from Sept-24 • Chief Strategy & Business Development stands at 94.29% compliance, holding a high standard compared to each directorate. Chief Nursing follows at 89.86%, taking over Chief Financial this month. • Adult Unit is 81% • To achieve a high standard, each directorate will need to target 95% above.	**MAST training (%) 79.2**

Unit Overviews

Update

Care Plans

- Possibility that a lower % of care plans have been finalised in month of October/November, potentially linked to staff planning to focus on clinical documentation towards end of year when they have a 'quieter period' and capacity to focus on this.

RADAR Access

- There appears to be continued restricted access for TCLs in viewing incidents, many TCLs do not have sight of these on Radar; need to review the access rights for each team and ensure that this is synching up for the right people.

Outcome Measures

- Reflected on the low % for CGAS and GBMs. OTM's will be checking in with staff regarding OMs needing completion.
- Restructure has left confusion around line management and caseload management; this is beginning to settle but it has taken several months.
- CAISS highlighted reduced staffing and a wish to consider how best to use CGAS/GBM in a meaningful way with CYP/families.

Internal Waits: the Treatment Waiting List is not currently being used in all teams within Camden CAMHS Unit, for some teams they do not have internal waits (CAISS, for the most part: WFT, WFTP), however there is still a need for improvement in this area. In running a recent Treatment Waiting List report, there were lengthy waiters and this was likely down to clinician needing to add in a ending date on the form and concluding that wait.

DNAs %

- Community CAMHS teams work on the basis of having planned CAMHS Assessment slots in staff diaries for future months, these are then booked into and offered to YP/families. At times, the YP/Family may not be able to attend this and so the appointment is then cancelled. There is a need to show the offering of this appointment as we are trying to achieve this within 4 weeks.

Appraisals at 37.5%

Reminders sent out with positive staff responses detailing when appraisals are taking place and it is anticipated that this % will rise in Nov/Dec reports.

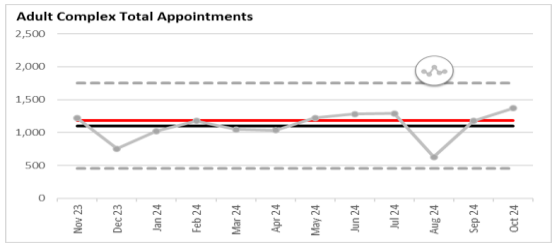
Staff acknowledged that with more staggered appraisals throughout the year, it is harder to keep in mind who is needing what and when. OTMs will start to share reports with TCLs about staff who are approaching their appraisal within 3 months vs staff who are outstanding.

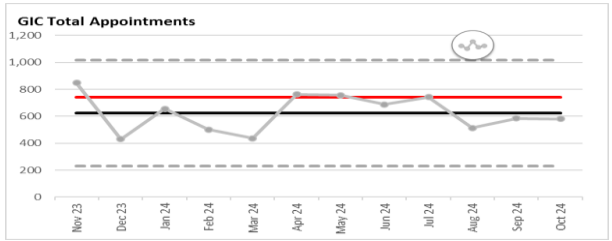
Vacancies: Whole family team continue to have vacant senior posts within the team, to include WFT Team Clinical Lead and senior Psychologist, these are in recruitment, but this continues to impact the containment and capacity of the team.

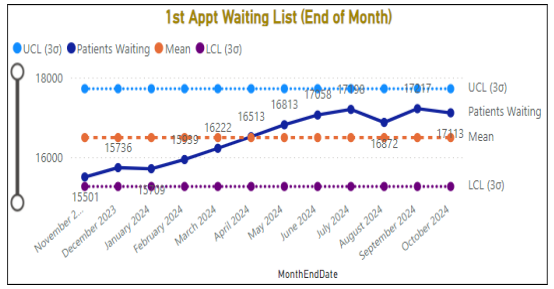
Adult Unit Overview

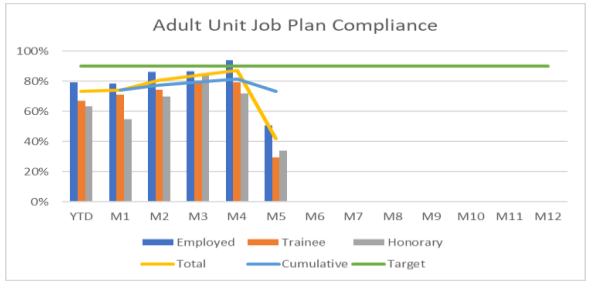
	Successes	Challenges
Safe	•GIC Leadership review of flexible working practice VS policy- 40% working on site is our expectation and direction, some staff may apply this on a monthly basis (e.g. several days together). A new GIC Clinical Governance lead has been identitied through EOI and a MH nursing lead for organising the duty rota according to the SOP.	•PCPCS Contract Ending – after 15 years this service is closing. Lack of clear information from the local ICS leaves us unable to launch a Staff Change Consultation yet.
Effective	•SNOMED, Carenotes and OM programme to enhance evidence of impact and outomes.	• NHSE are seeking to review Gender Services nationally.
Caring	•Weekly complaints meetings to seek informal resolution and personal engagement. Engagement with complex FOI processes in person to avoid long & successive email trails. Co-production partners in GIC and Trauma privileged for support and de-brief for the Trauma Kaizen event and GIC NHSE Review.	•SNOMED codes, now rectified showed some invalid data going to MHDS - anticipate the changes will ensure that our patient facing engagement data better represents the type and quantity of activity, and in doing so strengthens contract security.
Responsive	• Ground floor clinical treatment rooms improves mobility access. Co-production in both Trauma Kaizen and recent NHSE GIC review. Expert by experiences feedback needs to be incorporated into findings for both services.	•System wide demand for services continues to remain high in Trauma and Gender. •Management calculations of capacity vs demand have shown a need for a further 10 wte posts if we are to keep up with trauma demand (350% increase in 5 years).
Well Led	• Reflective practice to start in GIC Core & potentially across disciplines / services. RP also in PCS, Portman and Trauma. Staff morale is supported through weekly clinical meetings in all teams. PCPCS - all waiters allocated to end treatment before end of contract pending drop outs, DNA or ruptures in treatment.	

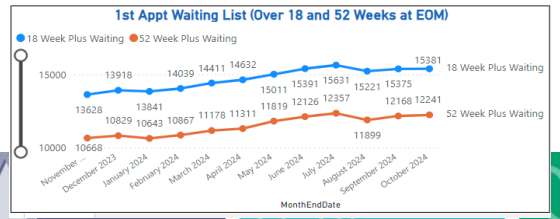
Activity Overview

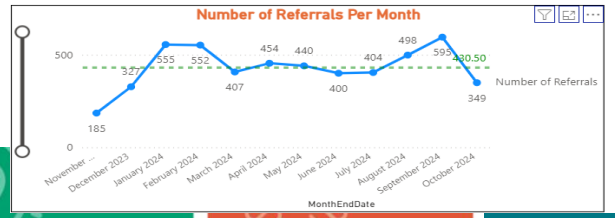












Analysis

Activity for Adult Complex MH Team has risen to a new high with GIC seeing a temporary plateau, given recent trends we do not assume this to be indicative or predictive.

Job plan compliance for the unit remains around 75% /pa but recent data is not available.

Referrals Portman intake process fully revised and incorporated in NHSE Pan London Anti-Racism work stream by EDI, TK & NN. Dashboard is showing 45 pending referrals at 24.11.24.

Waiting times – . We are pleased to report 0 18-week breaches in Adult Psychotherapy . Trauma appointments offered going up, GIC recruitment to vacancies is our priority alongside NHSE Review feedback high level actions.

Attendance rates – Adult MH increasing significantly from last Are, GIC level , neither are necessarily indicative.

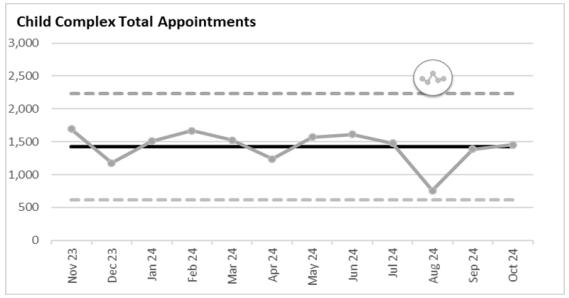
Next Steps

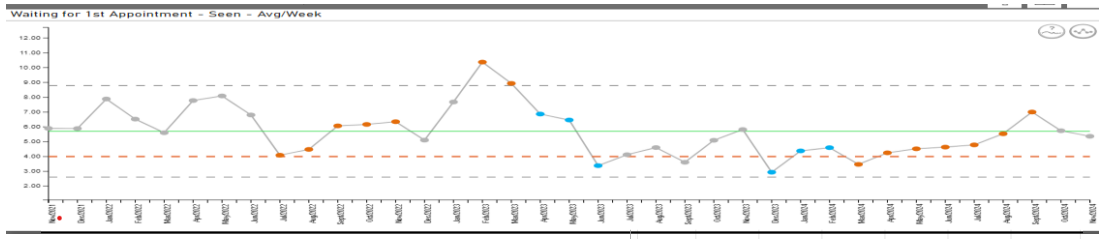
Concern	Cause	Countermeasure
Waiting list growth in Trauma	Significant increases to demand	Kaizen and A3 review of services. Commissioner engagement
Job plan performance (trainee and honorary)	TBC	

Child and Family Unit overview

		Successes	Challenges
Safe		• Safeguarding supervision being rolled out across all clinical teams. • High level of incident reporting at GH evidencing good practice	• Access to the RADAR system does not currently allow leads to review risks across the Unit. Team are aware and are trying to resolve.
Effective		• Overall trajectory of increased activity in key clinical teams including AYAS, CWP, FMHT and EDAS all of whom have shown two months sustained activity increases. • FMHT, Autism Assessment, FAKCT and First Step have all performed above job plan. • Autism Assessment team have reduced DNA's to 6.7% and cancellations to 4.9% • Haringey CWP have reduced DNA rate to 3%.	• DNA and Cancellation rates in AYAS are higher than average 14.2 and 16.92 % combined. • Total waiting list numbers for Autism Assessment have increased to 341 • 53.9% of all young people across the Unit have waited less than 4 weeks for first appointment.
Caring		• User experience of the services remains high with an average 84% positive ESQ score over the past 12 months. • Continued progress on reducing number of outstanding complaints – 2 remaining across the Unit.	
Responsive		• Autism A3 have delivered 115 assessments at month 7 end with a reduction in waiting times in Haringey to 52 weeks. • Waiting times for first appointment in Autism have reduced to 18.2 weeks from 49 weeks in Month 1	Poor adherence to supervision recording is resulting in very low return rates for Supervision Across the Unit. CMH supervision reported compliance remains low with clinical supervision at 13% for line management and 13% Clinical Supervision in the month
Well Led		• New Structures implemented across the Unit with first Clinical Governance Meeting on 27.11.2024 • SNOMED Code definitions are close to completion.	. Vulnerable contracts in First Step and Surrey Borders under review and actions being progressed. Appraisal rates at 50% Mandatory training at 83%

Activity Overview





Average Wait Times to 1st Appointment (weeks) - Patients seen

	2024/25						
	M1	M2	M3	M4	M5	M6	M7
Child Complex Service							
AYAS	2.8	2.2	3.3	1.9	2.0	1.8	4.2
ASC&LD	4.8	4.8	4.7		2.1	4.7	3.5
Autism Assessment	46.9	21.8	26.8	21.6	25.4	27.1	18.2
FMHT	6.5	5.9	5.0	5.7	6.4	7.6	6.7
EDAS	2.5	4.0	5.6	8.4	7.0	11.3	9.3
FAKCT	5.7	7.6	5.6	5.5	9.1	2.6	3.1
Haringey CWP	8.6	9.9	8.3	6.1	8.6	10.8	4.2
Child Complex Total	6.2	4.9	7.6	13.3	7.7	10.0	7.8

Analysis

Activity - Child Complex activity in September showed a return to baseline activity rates which has been sustained in October.

Job plan compliance for CMH is 89% year to date. 4 teams have performed above target : Family Mental Health, Fostering and adoption, ASCLD and First Step

Referrals overall referrals into the Unit = 217 referrals received with 186 accepted in month an acceptance rate of 85%. Largest number of rejected referral in AYAS (7), Autism and Autism Assessment (10), EDAS (5) and Haringey CWP (2).

Waiting times – Average 4 week wait time performance across the Unit is 5.37 weeks for patients seen. Waiting times across the unit as calculated by active waiters at month end is 5.15 weeks excluding Autism Assessment. 53.9% of all young people (active waiters) have waited less than 4 weeks.

Waiting times for First Appointment in Autism Assessment has reduced from 49 weeks in Month 1 to 18.2 weeks in Month 7.

Attendance rates 76.53 across the unit DNA 7.57% Trust Cancellation 3.43% Patient Cancellation 9.99%

Concern	Cause	Countermeasure
		Kaizen and A3 review of services. Commissioner engagement
		To be identified - TCL engagement and improvement plan/action plans
		Robust management through PTL Meetings

focussed attention.

Excellence Inclusivity Compassion Respect

Contracts and Finance

Delivering our vision – How are we doing?

Effective use of resources

The Tavistock and Portman NHS Foundation Trust

The Trust declared….. The Trust incurred a net deficit of £2,043k in the period, against the plan of £1,369k, a negative variance of £674k. The Trust has submitted a revised forecast outturn of c.£3.6m deficit, being unable to achieve its year-end deficit plan of £2,200k. The deterioration in the reported position at M07 and the FOT is due entirely to the unfunded element of the recently announced pay awards.	£ **24/25 YTD planned position £1,396k deficit**
The Trust declared…. The Trust is on course to spend its capital allocation of £2,468k at the year end. Cash continues to be an issue, with additional cash support received from the ICB on top of the NHSE support in the agreed plan, to offset additional pay award costs. .	£ **24/25 YTD actual position £2,043k deficit**

2024/25 Clinical Services Update

- We are working with North East London Integrated Care System (NEL ICS) commissioners on the safe closure of our City and Hackney primary care psychotherapy consultation service (PCPCS).
- We are working with Haringey commissioners on a reconfigured First Step service offer following formal notice of a service budget reduction.
- We are working with Surrey and Borders commissioners on a reconfigured service offer (introducing a digital waiting room) following informal notice of a potential budget reduction.
- We continue to work with NHS England on the delivery of an action plan following the national review of adult Gender Identity Clinics
- We continue to work with Local Authority commissioners across London to secure new income for our Family Drug and Alcohol Court (FDAC) service

2024/25 Department of Education and Training Update

- NHS England has advised it will be rolling over its 2024/25 education and training contracts (formerly our Health Education England service portfolio) into 2025/26

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS ON 16TH JANUARY 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit & Governance Committee	05 December 2024	David Levenson, Non-Executive Director	Peter O'Neill, Interim CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 10**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline. 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 • Pre-Audit work for 24/25 accounts has started with a full plan due early in the new year. • A "Wash-up" session to review 2023/24 audit cycle and identify areas for improvement, had yet to be done at the time of the committee. This was picked up as a matter of urgency by GT and CFO and scheduled for following week, with improvements in face to face engagement and detail included in working papers supporting key balances.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit Update • RSM advised that the Head of Internal opinion is likely to be unchanged for this year's accounts process, remaining as requiring improvement. • Outstanding management actions are now being discussed regularly at the Executive Leadership Team meetings as requested at September Committee. • The Job Planning report and concerns about the ability to respond to management actions by the due date in early January, was raised as a concern. The CFO agreed to pick up directly with the CMO, with a potential referral to POD EDI to be considered.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Local Counter Fraud • No significant issues were raised by RSM, although Committee members expressed concerns about the feasibility of meeting deadlines for policy updates by 31st December • Greater urgency required to address longstanding high-priorities, eg pre-employment checks.	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 with no significant issues raised. • The Board will receive quarterly updates on progress with Trust Risk Registers.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Breaches of Gifts, Hospitality and Interests Policy	Limited ☐

• No breaches of the policy were reported. • The Committee received updated policy, as requested at the previous committee.	Partial ☐ Adequate ☒ N/A ☐
6. Single Tender Waiver Report • No significant issues were raised.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
7. Overpayments/ Underpayments to Staff (Referred from PFRC) • The Committee received the report noting that the overpayment of leavers is still a cause for concern, particularly the time taken to progress corrections of process issues. • Committee asked that ELT regularly receive the report and the progress on the recovery of all overpayments. RSM were requested to review controls in place for payments to Visiting Lecturers (VLs).	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
8. Age Debt Report • The Committee noted progress to reduce aged debt, particularly those relating to students. • Committee asked for clarification for rationale and reporting of debt relating to students whose courses had been paused. It was noted that there is an outstanding secondment debt of £285,000 owed by NHSA. The debt is still pending resolution.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
9. Escalations from other committee • No new escalation requests were received by the Committee this quarter •	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
10. Review of External and Internal Audit Providers • The performance of both providers was assessed in a private section of committee.	

Summary of Decisions made by the Committee:

- None

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

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC ON 16TH JANUARY 2025			
Report Title: Oversight of Board Assurance Framework (BAF)			**Agenda No.: 011**
Report Author and Job Title:	Nadia Munyoro, Risk Manager	**Lead Executive Director:**	Adewale Kadiri Director of Corporate Governance
Appendices:	Appendix A: Board Assurance Framework 2024/25 Appendix B Corporate Risk Register Appendix C Escalation Risk Register		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This report presents the updated Board Assurance Framework (BAF) for Board scrutiny, and it also provides an update on the progress around development of the Trust's Corporate Risk Register (CRR). The individual BAF risks continue to be subject to detailed scrutiny at each of the Committees, and in turn, the focus remains on ensuring that the need to manage and mitigate the risks drives Committee business. The CRR continues to evolve, supported by the Radar system for incident reporting and risk management. All identified risks have been mapped to their equivalent BAF risks, ensuring alignment with strategic objectives. The Risk Manager continues to work with the operational and corporate teams to improve their understanding and ownership of risk management, but some gaps still remain in the identification of controls and the accuracy of risk scores.		
Background:	The BAF outlines 14 risks that could, if unmanaged, prevent the Trust from achieving its strategic objectives. These include risks related to patient care, workforce culture, financial sustainability, IT infrastructure, and environmental sustainability. The CRR on the other hand, serves as the pinnacle of operational risk management, highlighting the most highly scored operational risks, and linking these to the BAF to ensure the maintenance of an effective thread in the management of risk across the organisation.		
Assessment:	Key developments since the BAF was last presented at Board include the reduction of scores for **Risk 2 (Failure to Provide Consistent High-Quality Care)** and **BAF Risk 14 (Failure to Deliver Sustainable Reductions in Environmental Impact)**, both attributed to targeted mitigation efforts. Despite this progress, challenges persist, in relation to some of the risks, in agreeing and performing suitable actions to address some of the more longstanding gaps in control. Also, for many of the risks, the route to achieving the target rating remains unclear.		
Key recommendation(s):	The Board is asked to: **Review and Challenge Risk Scores** • Consider whether the scores accurately reflect the current risk position.		

	• Identify risks where the scores appear to be overstated or understated. **Provide Input on Missing or Inadequate Controls** • Highlight areas where current controls may require immediate enhancement. • Suggest additional mitigating actions or controls. Suggest any other potential areas not covered in either or both documents.

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

BAF Risks summary progress update

Risk 2: Failure to Provide Consistent High-Quality Care

- **Strategic Objective**: Ensuring outstanding patient care.
- **Risk Description**: Inability to consistently meet quality standards, which could lead to poor patient experience, reputational damage, and regulatory penalties.
- **Risk Scores**:
  - **Inherent**: 20 (Likelihood: 4 x Consequence: 5).
  - **Current**: 16 (4 x 4) – reduced to 12 (3 x 4).
  - **Target**: 9 (3 x 3).

Key Actions Taken

1. Strengthened clinical supervision structures.
2. Improved statutory and mandatory training compliance.
3. Revised complaints processes, ensuring lessons learned are integrated into action plans.

Impact of Changes

- Reduced vacancies and reliance on temporary staff.
- Better alignment of workforce to service demand.
- Strengthened oversight via the Integrated Quality and Performance Review (IQPR).

Risk 14: Failure to Deliver Sustainable Reductions in Environmental Impact

- **Strategic Objective**: Achieving environmental sustainability.
- **Risk Description**: Failure to align with NHS net-zero goals could lead to legal repercussions, inefficiencies, and reputational harm.
- **Risk Scores**:
  - **Inherent**: 16 (4 x 4).
  - **Current**: 16 - reduced to 12 (3 x 4)
  - **Target**: 8 (Likelihood: 2 x Consequence: 4).

Key Actions Taken

1. **Governance**:
   - Annual action plans aligned with NHS net-zero goals, monitored by the Performance, Finance, and Resources Committee (PFRC).
2. **Sustainability Initiatives**:
   - Implementation of the NHSE Utilities Framework.
   - Energy efficiency measures, such as LED lighting and improved heating systems.
3. **Consultation**:
   - Appointed a consultant for developing net-zero metrics.

Impact of Changes

- Enhanced focus on sustainable estate planning.
- Tangible progress towards NHS environmental targets.

Corporate Risk Register

Progress Update

The draft CRR is included at Appendix B. Work is still ongoing on this new Register, part of which is to help the operational and corporate teams to understand its function and importance. The Board will have noted that not all of the issues that have been raised recently are reflected here. This is in part to do with the relative novelty of a working CRR that is owned by the Trust's senior operational leadership, but also that there is still work to do to build the knowledge and confidence of Trust managers in this area. The Risk Manager has done some work on this with a number of managers, and risk management is included within the leadership development packages currently being rolled out.

In the meantime, in relation to the risks that have been identified for inclusion on this iteration of the CRR the following actions have been taken:

1. **Development of the Corporate Risk Register**
    - All risks identified have been mapped to their corresponding BAF risks.
    - Risk scores (inherent and residual) have been assigned based on available information and initial assessments. Going forward, the template will be updated to reflect both scores.
2. **Alignment with Strategic Objectives**
    - Risks have been categorised to ensure alignment with the organisation's strategic priorities, including patient safety, financial sustainability, and regulatory compliance.
3. **Control Gaps**
    - Controls and actions to address gaps are under review. It is fair to say that this is a development area for a number of the teams.
    - Efforts are underway to improve the quality of controls and implement new mitigating actions where required.

Conclusion

The Trust demonstrates progress in mitigating strategic risks, with notable improvements in Risks 2 and 14. However, significant work needs to be done in developing the CRR to truly reflect the Trust's operational risks and how these are being managed. The Executive Team will continue to work with the senior leadership on this.

BOARD ASSURANCE FRAMEWORK 2024/25

Likelihood	
1	Very Unlikely to occur
2	Unlikely to occur
3	Could occur
4	Likely to occur

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

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

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

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

Developing a culture where everyone thrives with a focus on equality, inclusion, and diversity						
6	Lack of workforce development, retention, recruitment	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered.	16 (4 x 4)	9 (3 x 3)	6 3 x 2	**Open**
7	Lack of a fair and inclusive culture	If the Trust does not establish a fair and inclusive organisational culture, where all staff regardless of their background feel that they belong, and that there is an awareness of cultural difference, staff morale and levels of recruitment and retention will be affected, and the quality of patient care will be compromised.	20 (5 x 4)	12 (4 x 3)	9 3 x 3	**Open**
8	Lack of management capability and capacity	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.	20 (4 x 5)	9 (3 x 3)	6 2 x 3	**Open**
Improving value, productivity, financial and environmental sustainability.						
9	Delivering financial sustainability targets	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	20 (5 x 4)	16 (4 x 4)	8 (2 x 4)	**Cautious**
10	Maintaining an effective estate function	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	15 (5 x 3)	12 (3 x 4)	8 (4 x 2)	**Cautious**

11	Sustainable income streams	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.	20 (4 x 5)	15 (3 x 5)	8 (4 x 2)	**Cautious**
12	IT infrastructure and cyber security	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	20 (5 x 4)	12 (3 x 4)	9 (3 x 3)	**Cautious**
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. Resulting sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, including risks to patients' mental health, and reputational risk.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Cautious**

14	**NEW** Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target	**If** the trust does not reduce the environmental impact of the provision of its services. **Then** it will be out of step with the NHS-wide goals around environmental sustainability and the Service's attempts to achieve a net-zero status **Resulting** in non-compliance with its statutory obligations, national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2030 and net zero carbon by 2040). The potential impact of this outcome includes inefficient resource and energy use, increased operating costs, legal and regulatory repercussions, missed infrastructure innovation opportunities, reputational damage, and heightened adverse environmental impact.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Cautious**

Principal Risk 1		**Strategic Objective**	**Providing outstanding care**
Description	**If** services within the trust continue to limit access to potential patients through the use of **Then** outcomes for such individuals would be sub-optimal and they would also have a **Resulting in** the Trust being in breach of its contractual obligations, and potentially non-		

Executive Lead		**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	
Lead Committee											L4 x C4 **16**	L4 x C4 **16**	L4 x C4 **16**		**Date of Last Review**	
Risk Appetite				**16**			**16**				⟷	⟷	⟷		**Date of Next Review**	

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)**
Screening and triage- view to ensure pts access the right		Integrated Quality and Performance Review (IQPR) meetings for Designed/ reviewed screening and triage process. Go live by		
All services to review their inclusion criteria with EDI and	This work is currently in the very early			Red
services -ensure that pts on the waiting list receive timely controls where a patient has come to harm relating to	Service lines are yet to agree consistent risk			

Action to address the gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
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			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	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

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-002	Loss of Staff for Physical Health / Living Well Services, Specialist Clinical Lead and Admin support. We are currently unable to offer service to patients.	15
RSK-030	PCPCS will be without team manager as of 1st July or clinical leadership as of 31st July. Leaving staff without clinical management or supervision.	16
RSK-064	WFT & WFT-P have a number of senior vacancies including the Team Clinical Lead in WFT. This results in gaps in senior leadership and oversight that can't be mitigated by sharing responsibilities across teams. Integrated services funded and delivered in partnership with LB Camden, with particular need for senior liaison with partners	20

Principal Risk 2	**Failure to provide consistent high-quality care**	**Strategic Objective**	**Providing outstanding care**
Description	**If** the Trust is unable to meet nationally recognised quality standards across its clinical **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement		

Executive Lead		**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	07 March 2024
Lead Committee							**Risk Score**				L4 x C4 **16**	L4 x C4 **16**			**Date of Last Review**	28th November 2024
Risk Appetite				**20**			**16**				⟺	⟺	⇩		**Date of Next Review**	22nd December 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	A small number of services carry vacancies, with reliance on temporary staff or trainees. Some services continue to carry significant levels of vacancies, with heavy reliance on agency and other temporary staffing.	POD EDI – workforce dashboard reviewed at each meeting, includes current staff vacancies. Unit, committee and board oversight through Clinical Governance meetings and IQPR meeting. Teams with high number of vacancies have workforce and recruitment plans. New Recruitment and Retention Group established, reports to POD EDI. New Establishment Control Panel established, with executive membership. New Clinical Structure implemented in September 2024 with additional clinical sessions released from streamline of management structure. 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		Job plans in place for majority of teams. Annual self-assessment submitted Gap in process – plans to progress to e-job planning for medical.	Internal	Amber

		The job planning policy was approved by Policy Approval Group on 15th May 2023. Compliance monitored through IQPR		
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 - approved MaST compliance to be included in IQPR – Included and reviewed monthly in IQPR	Internal	Amber
Supervision/clinical safeguarding Process		CQC improvement plan Clinical supervision –reported in IQPR monthly. Supervision structures are held at team level, underpinned by Supervision Policy. Teams report supervision in a monthly log. Safeguarding supervision taking place, this will be strengthened by developing an improved structure through the Safeguarding forum. Included in the Quality report bi-monthly. Internal Safeguarding audit – action plan monitored by Integrated Safeguarding Group, reporting to Quality and Safety Committee. Business case for safeguarding supervision training approved, currently being procured for 16 staff, safeguarding champions. Forms for recording on EPR (carenotes) created, to improve monitoring and reporting.	External (CQC) Internal Internal Internal Internal	Amber
Quality assurance and quality improvement tools and methodology		QSC work plan and forward planner IQPR Quality & Safety Report to QSC Chair's reports from Tier 3 Groups to QSC Clinical Governance meetings Quality Improvement Trustwide work streams to delivery the Trust Strategic Pillar of 'Outstanding Patient Care' to address issues raised in both BAF risks 1 and 2. Focus on service user experience, outcome measures and waiting times.		Amber
Quality Framework Improvement Plan fully implemented		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 Restructure complete, implemented in September. 6 monthly reviews planned for end Feb/beginning March 2025.		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 Policy approved and ratified. New process commenced January 2024 New template with structured investigation and transparent response to complainant in place. Executive review and sign off for every formal complaint response. Weekly summary of complaints with stage in process outlined, sent out to unit leads, divisional leadership team and executive leadership team. Weekly meetings held between complaints lead and unit clinical lead.	Internal	Amber
Implementation of RADAR	Gap – project lead is working with patient safety lead and Radar Trust link to address incident notification issues and hierarchy of reporting. Interim measures to manually send out notifications to relevant leads in place.	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. After Action Review (AAR) training delivered in September 2024. AARs and learning from incidents shared in clinical governance meetings and quality and safety report to Quality and Safety Committee	Internal	Green
Staff sickness and absence reporting		IQPR 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/Jon Rex	June – January 2024	Complete – Live since June 2024 Events implemented Incidents, Risk, Audit, Complaints, PALS, Compliments, Claims.
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		November 2024	Complete - Policy Ratified November 2024
Learning from Deaths Policy		January 2024	Policy approved. Ratification due January 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			

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-004	If complaints are not responded to within regulatory timescales.	12
RSK-060	There is a risk of confidentiality breaches when sending correspondence to service users and external healthcare professionals.	12
RSK-082	If the relative humidity in occupied spaces remains above recommended levels (52% to 85%), then it will cause damp conditions conducive to hidden mould growth and elevated allergens,	12

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

Executive Lead		**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	
Lead Committee															**Date of Last Review**	
Risk Appetite				**16**							⟺	⟺	⟺		**Date of Next Review**	

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	Rav, Adam and Premal to start developing a readiness plan, which includes: • Developing a marketing strategy • Admissions process review • Recruitment and conversion • Student Support

			• UKVI compliance • Technical infrastructure We are to continue with frequent connects to discuss and manage timeframes, wider stakeholder engagement, and intricacies of each aspect.
Prepare and implement a multi-year International Strategy	Associate Director of Business Development (DET) Directors of Education – as appropriate	By 30th September 2024	Attached is the start of an international strategy, with the intention of forming sub-strategies to create the multi-year plan. Paul, Amy and I met in the summer to discuss, but ultimately took a pause so that the focus could be on China.
Increase knowledge and responsiveness to workforce needs	Head of Performance & Contracts Associate Director of Business Development (DET)	Ongoing	he new programme development process. a guide developed for proposers of new programmes/provisions, that is currently being tested and awaiting final discussion/sign off at the next DET Development Group meeting in January.

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

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	19th December 2022
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	L3 x C3 9	L3 x C3 9	L3 x C3 9		**Date of Last Review**	20th December 2024
Risk Appetite	**Open**	4	4	**16**	3	3	**9**	3	2	**6**	⟷	⟷	⟷		**Date of Next Review**	05th February 2025

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)		ECP process live and working through improvements organically ECP is in place in principle, and the log is 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. NCL ICS group and control process – assured by the approach of ECP	Internal External	Green

		Recruitment and retention group – first meeting on 29th October, monthly. Quarterly CPD panel		
NLPSS Operations meetings weekly		Performance report from NLPSS Reduction in vacancy rates Exit interview / stay conversation analysis and, in time, onboarding interview analysis	Internal	Green
				Green
				Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
			ECP in place in principle. Going live 19th August 2024

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Upscaling managers on the recruitment process	Inclusive recruitment training delivered and practices in place	Need to roll out further training and guidance to managers on best practice recruitment	Initial internal workforce dashboard was created and

			presented on 23rd March at POD EDI Committee Subsequent POD EDI committees have been provided up to date dashboard and these are well received.
Review of productivity, establishment, finance	Process has started with the Clinical division and will then move to Corporate followed by DET.		ESR is up to date and is being regularly cleansed. Working with finance colleagues on regular reconciliation Supervisors are being updated to allow the implementation of ESR self-service across the organisation by the end of the calendar year.

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-003	Low staff take-up of flu vaccine annually	12
RSK-029	If clinical staff or trainees do not have the space and resources needed to complete clinical administration tasks or sufficient space to see patients, then the activity may not be recorded accurately. and staff may be unable to meet their job plans Which may result in incorrect clinical decision making or unsafe care and increased waiting times.	12

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

Executive Lead		**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**							**Original Assessment Date**		
Lead Committee															**Date of Last Review**		
Risk Appetite				**20**											**Date of Next Review**		

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) Now incorporated within POD Delivery Group and Staff Engagement Group		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 – We have decided not to align to ICS due to potential merger and moving out to another ICS	Internal	Green
Staff Networks feed to EDI team who escalate key outcomes through POD EDI	Gap removed	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	Green

				Green
				Green

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	Ongoing	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.

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	19th January 2024
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**							L3 x C3 9	L3 x C3 9	L3 x C3 9		**Date of Last Review**	20th December 2024
Risk Appetite	**Open**	4	5	**20**							⟺	⟺	⟺		**Date of Next Review**	05th February 2025

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 FTSU training is being designed, and FTSU is to be added to the induction Coaching of managers by HRBP (and senior team where required). Managers report feeling more competent in resolving issues as a result of the training packages/coaching from HRBPs Informal resolutions form the 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	Head of HR	December 2024 completion of all policies	Ongoing, currently on target to meet implementation date. These policies will help with the foundations for psychological safety.

starting point of seeking to learn and develop rather than punitive			
Organisational Development for senior leadership to ensure accountability for decisions and consistency of approach.	Head of HR		Externally provided. Commences 15th October It will help with the foundations for psychological safety.

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

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**

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)**			**Q1**	**Q2**	**Q3**	**Q4**	**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**	L4 x C4 16	L4 x C4 16	L4 x C4 16		**Date of Last Review**	15th December2024
Risk Appetite	**Cautious**	5	4	**20**	4	4	**16**	2	4	**8**	⟺	⟺	⟺		**Date of Next Review**	February 2025

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)
MTFP route to balance developed in conjunction with merger partner. Process starting June 2024. -	Requires updating to reflect the status of the proposed merger	MTFP will form part of the OSC and FBC in the merger transaction process will be signed off by NHSE. Will continue to develop individual elements of plan, in conjunction with merger partner.	Internal	AMBER
		Reviewed by ELT, PFRC and Board. September 2024 Trust on agreed plan, expected to achieve the deficit plan, subject to pay award funding shortfall being mitigated.	Internal	GREEN
In Year Reforecasts		At PFRC in January and Board in February, unchanged full year forecast noted. Reforecast 24/25 due month 7 will potentially include the impact of the pay award funding shortfall.	Internal	GREEN
		Initial version submitted to NCL ICS (28 April) Board approved, final version submitted to NHSE 12th June reflecting agreed revised plans across the ICS.	External	GREEN
Recurrent efficiency programme 24/25 Financial Plan	Still centrally managed till the merger is completed	Recurrent programme – supporting division to manage and deliver identified opportunities.	Internal	AMBER
	We haven't started to achieve the planned income opportunities	Commercial Strategy – developed Q3 23/24 giving a short/medium term view of opportunities. Additional risk generated by unfunded pay award 24/25 currently being assessed with mitigations identified.	Internal	AMBER

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Updated MTFP	CFO	October 2024	Currently work in progress with merger partner
2024/25 Budget	CFO	November 2024	Draft financial plan submitted to April Board. Team level budgets were completed as part of 24/25 plan and, budget right sizing exercise being finalised in November 24, reflecting the need to update staffing structures across the trust..
Detailed efficiency programme	CFO	June 2024	Process in place, programme continues to be developed throughout the year.
Commercial Strategy	Director of Strategy and Transformation	October 2024	Implementation stage

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

Principal Risk 10	Estate infrastructure and compliance		
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.**

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-082	If the relative humidity in occupied spaces remains above recommended levels (52% to 85%), then it will cause damp conditions conducive to hidden mould growth and elevated allergens,	12
RSK-083	There is a risk that the trust may not meet the new reporting requirements, which are set to go live in April. These requirements are directly linked to the funding received for key activities.	12

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)**			**Q1**	**Q2**	**Q3**	**Q4**	**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**	L3 x C4 12	L3 x C4 12	L3 x C4 12		**Date of Last Review**	15th November2024
Risk Appetite	**Cautious**	5	3	**15**	3	4	**12**	4	2	**8**	⟺	⟺	⟺		**Date of Next Review**	January 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)
Premises Assurance Model (PAM)		The PAM review is underway, due for national submission in September. The PAM review is an annual undertaking that supports iterative improvement over the life of the building. Has been in place for a number of years.	External	Amber
10-year Capital plan –6 facet survey has provided an asset replacement plan and is reviewed annually		This replacement plan was aligned to the Trust strategies; as the Trust strategies are being refreshed, the Estates strategy will follow suit, to replace assets based on life cycle and any trending analysis around failure.. ERIC measure – where we compare against peer groups in mental health. Measures all services covered within the estates arena inclusive of cleaning, maintenance.	Internal/External	Amber
		Fortnightly meetings with finance to review cost and coding to minimise time taken to complete annual ERIC return, thereby improving productivity	Internal	Amber
Business Continuity plans		BCPs for asset groups such as fire, utilities, flood, and local cleaning.	Internal	Amber
Technical specialists – assure systems in line with HTM		Systems are maintained in line with HTMs and involve assurance through technical specialist -authorising engineers who attend site	External	Amber

		to validate documentation around performance of asset and trending analysis.		

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
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 –	Ability to deliver as the team are in transition alignment to NHS national standards	the estates merger plan will look to consolidate and further align to its merger partner.
10-year capital plan based on the 6-facet survey	Updated surveys will commence from the new year in line with 6 Facets. and will include - electrical supply, lighting and fire doors fire alarms, heating systems to support 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

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**
	If the relative humidity in occupied spaces remains above recommended levels (52% to 85%), then it will cause damp conditions conducive to hidden mould growth and elevated	12
	There is a risk that the trust may not meet the new reporting requirements, which are set to go live in April. These requirements are directly linked to the funding received for key	12
		12

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

Executive Lead		**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	
Lead Committee											L3 x C5 15	L3 x C5 15	L3 x C5 15		**Date of Last Review**	
Risk Appetite				**20**			**15**				⟷	⟷	⟷		**Date of Next Review**	

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)**
				Green
				Green
				Green

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
			The commissioner has requested that we work through a fully developed proposal on the This was completed but will need to be updated refreshed to reflect 24/25 contract agreements. Regular process of review needs to be established to maintain progress. Ongoing annual process – Trauma and Autism pathway being updated as part of ongoing
Development of Internal Reporting for DET Services – ensuring consistency with IQPR process.			Enhanced DET performance reporting is starting from the PFRC meeting in May 23. This will provide a level of assurance/control but will not be finalised. DET performance will be reported regularly and will improve during the remainder of the year in line with the DET

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 MTFPc c	Commercial strategy developed, specific income opportunities being perused and finalised. Internal structure to continue to develop opportunities in line with the	Finalising and agreeing additional income opportunities and identifying new markets.	Board approval of balanced MTFP including future income growth strategy

	commercial strategy being developed by CFO and Director of Strategy		

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**

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

Executive Lead	Peter O'Neill Interim Chief Finance	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance			**Risk Score**							L3 x C4 12	L3 x C4 12	L3 x C4 12		**Date of Last Review**	20th December 2024
Risk Appetite	**Cautious**	5	4	**20**							⟺	⟺	⟺		**Date of Next Review**	February 2025

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 11/08/24 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.	Resilience group now responsible for BC plans including testing and After-Action Reviews (AAR) from incidents involving BC planning.	Internal	Amber

		Regular BCP scenario testing with feedback loops for continuous improvement approach. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested Lessons learned for the Cyber outage of CareNotes have now been created and relevant functions are implementing the findings		
		NHSE Emergency Planning Response and Recovery Team and ICB EPRR team	External control	
		Major Incident Plan Business Continuity Policy Emergency Planning Response and Recovery Policy All reviewed annually	Internal	Green
				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 – IG lead has confirmed 82% compliance across the Trust. *"Some work is ongoing to try and improve the figures – hampered by it being unclear just how many staff the Trust is responsible for, and we are trying to do some data cleansing".* We still have an issue with identifying Honorary contracts and Visiting Lecturers on ESR. Source of update – EPRR action plan progress report for May ELT

Annual review and implementation of new standards for cyber safety			
Review of BCP plans across the trust with recommendations for Note due to the responses to the pandemic and latterly to the CareNotes successfully managed associated risks and maintained trust effectiveness.			In progress – All BCP plans are reviewed annually, and we have a Annual Board report – Clare Scott as Accountable Executive Officer for emergency planning provides an action plan from the results of annual
			Report (encompassing report findings from ICB and action plan) to the
Annual review and update of the following policies			Reviewed as part of the EPRR core standards assurance
Review supplier base and engage 3rd party assessment service			

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 11/08/24 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 outcomes 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 for the service to be acquired. Higher priority work impacting internal technical resource	NHS (digital team) 3rd party assessor Trust audit programme

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-006	If additional user authentication measures are not rolled out to all trust end users, their accounts security does not meet recommended cyber security standards.	**15**
RSK-016	If there are insufficient skilled cybersecurity resources to support the growing demand for cybersecurity and compliance requirements, the Trust may struggle to maintain cybersecurity standards, increasing vulnerability to infrastructure threats and non-compliance with the Data Security Protection Toolkit (DSPT) and other cybersecurity standards.	**20**
RSK-019	If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring immediate action over the weekend, a lack of available resources may result in delays in remediation, leaving systems and data vulnerable to compromise.	**15**
RSK-091	Failure to achieve DSPT compliance	**12**
RSK-092	Failure of Procurement to engage with Information Governance (IG) to perform due diligence on IT and clinical systems procurement	**12**
RSK-093	Failure to respond to Subject Access Requests (SARs) within the specified timeframes	**12**

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

Executive Lead	Clare Scott Chief Nursing Officer	**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	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	L3 x C4 12	L3 x C4 12	L3 x C4 12		**Date of Last Review**	December 2024
Risk Appetite	**Cautious**	4	4	**16**	3	4	**12**	2	4	**8**	⟷	⟷	⟷		**Date of Next Review**	February 2025

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: PFRC Quality Committee IQPR – Monthly	Internal	Red

		Trust Waiting Times Huddle – weekly Adult Services PTL Meeting – weekly		
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
Recourse optimisation and monitoring. 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.		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. The estimated number of first appointments is on track as planned, with ongoing optimisation.	Internal	Amber
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
Workforce recruitment and retention	Recruitment - Number of referrals versus number of pts we can see. Unlikely to recover waiting times best case break even each service.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber
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

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
	Managing		
	Managing Director	18 October 2024 – Training plans implemented, and trackers mobilised.	
	Managing Director	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

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-039	Potential risks for individuals awaiting interventions due to growing GIC waitlists include an increased likelihood of serious incidents and a deteriorating patient experience. Additionally,	20
	If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services.	

NEW RISK Principal Risk 14		**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability**
Description	**If** the trust does not reduce the environmental impact of the provision of its services. **Then** it will be out of step with the NHS-wide goals around environmental sustainability Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2030 and net zero carbon by 2040). The potential impact of this outcome includes inefficient resource and energy use, increased operating costs, legal and regulatory		

Executive Lead		**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Q1**	**Q2**	**Q3**	**Q4**	**Original Assessment Date**	
Lead Committee											L4 x C4 16	L4 x C4 16			**Date of Last Review**	
Risk Appetite		–	–	**16**	–	–		–	–	–	⟺	⟺	⇩		**Date of Next Review**	

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)**
				Green
				Green
				Green

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Create and Prioritise action plans based on net zero measure with appropriate			

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

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**

Corporate Risk Register

Report Date: **02-Jan-2025**

Risk Score Legend:	
	Un scored
1 3	Low
4 - 7	Moderate
8 12	Significant
13 25	High

Reference	Category	Description	Impact of risk	Location	Latest comment	Current score	Target score	Target date	Controls outstanding	Controls implemented	Latest review comment	Approved state
RSK-030	Delivery	PCPCS will be without team manager as of 1st July or clinical leadership as of 31st July. Leaving staff without clinical management or supervision.	Re; clinical risk; service unable to assure safety and appropriateness of treatment interventions. Re; team manager absence: unable to assure management of patient safety and clinical governance.	Adult Unit - Primary Care Psychotherapy Consultation Service	Score changed from 16 to 16 (11-Dec-2024)	16	4	27-Mar-2025			Review when return from annual leave.	Awaiting approval
RSK-081	Staffing	Staffing Context: Long-term sickness, temporary recruitment, and vacancies for15 months. Unclarity about, and delay in recruiting for positions as part of the received uplift. Current additional risk situation: 1 WTE clinician is leaving our service end of November. ECP approval now achieved and post to be put on TRAC. However, the recruitment process will take time, leaving our service with only 2WTE clinicians from next week. We are a small service engaged with a large population of children in care (330+ children). We do not operate a waiting list and are required to respond timely to requests.	Risk to operating: This further reduction in clinical staff from December will mean that we will have to consider how to reduce our clinical activities. This is something we have never done in the decade we are operating as a service. I am concerned about safe operating from a clinical point of view, and the implication for our contract and relationships with commissioners during an already pressured time. Risk regarding staff retainment: We have a competent and highly committed long-term staff team here at First Step but the ongoing pressure on the very small team is significant and impacts on staff.	CYP and Families - First Step	Score changed from 6 to 12 (20-Dec-2024)	12	12	05-Dec-2024				Awaiting approval
RSK-091	Information Governance	Failure to achieve DSPT compliance	May result in limited assurance for partner organisations and merger partners regarding data security, potential disadvantages when pursuing new business opportunities, and the inability to meet contractual requirements that mandate Cyber Essentials certification.	Corporate - Corporate Governance	Score changed from 12 to 12 (17-Dec-2024)	12	4	31-Mar-2025				Awaiting approval
RSK-092	Information Governance	Failure of Procurement to engage with Information Governance (IG) to perform due diligence on IT and clinical systems procurement	may result in implementing systems that do not comply with data protection and security standards, leading to data breaches, operational inefficiencies, regulatory non-compliance, and potential patient harm."	Corporate - Corporate Governance	Score changed from 12 to 12 (17-Dec-2024)	12	4	31-Mar-2025				Awaiting approval
RSK-093	Information Governance	Failure to respond to Subject Access Requests (SARs) within the specified timeframes	may lead to service users escalating concerns to the ICO, resulting in negative publicity and potential reputational damage to the organisation."	Corporate - Corporate Governance	Score changed from 12 to 12 (17-Dec-2024)	12	4	31-Mar-2025				Awaiting approval
RSK-029	Safety	If clinical staff or trainees do not have the space and resources needed to complete clinical administration tasks or sufficient space to see patients then the activity may not be recorded accurately. and staff may be unable to meet their job plans Which may result in incorrect clinical decision making or unsafe care and increased waiting times.	Space has become more challenging in some teams (NCCT.SCCT/MHST) with some staff having no desk at all/some moving daily/booking on the day as the only option. There are not enough desks at Ampthill to accommodate all the staff based there and not enough therapy rooms to offer the number of appointments they are job planned to undertake. ERF funding has significantly increased staffing in Trauma and Autism teams, increasing the number of rooms required	Camden - North Camden Community CAMHS	Score changed from 12 to 12 (09-Dec-2024)	12	3	28-Feb-2025			Janis to review risk aligned with the space optimisation work taking place at Ampthill in collaboration with Estates	Awaiting approval
RSK-002	Delivery	Loss of Staff for Physical Health / Living Well Services, Specialist Clinical Lead and Admin support. We are currently unable to offer service to patients,	Poor Practice, not meeting patient need, Poor Clinical Service provision	CNO - Physical Health	Score changed from 15 to 15 (30-Dec-2024)	15	1	31-Mar-2025	Funding in place for open Post and budget., Staffwide communications sent to all about current lack of service and support/ signposting for staff/patients on the intranet (23-Dec-2024)	Service re-design scoping work of service, including patient and staff engagement(19-Aug-2024), Re-designed physical health form approved and implemented on Carenotes. Approved at CSDG in July 2024, for Carenotes Change Board in September 2024(19-Aug-2024)		Approved

Reference	Category	Description	Impact of risk	Location	Latest comment	Current score	Target score	Target date	Controls outstanding	Controls implemented	Latest review comment	Approved state
RSK-003	Safety	Low staff take-up of flu vaccine annually	could lead to high rates of sickness in winter	CNO - Physical Health	Score changed from 12 to 12 (30-Dec-2024)	12	4	31-Mar-2025		AAR done recommendations for change in approach to Flu programme (23/24) approved at ELT(27-May-2024), Planning for flu campaign underway and communications to increase awareness(27-May-2024)		Approved
RSK-004	Inspection / Audit	If complaints are not responded to within regulatory timescales.	then there could be increased negative experience by patients and negative attention, stakeholders, regulators and media	CNO - Complaints and PALS	Score changed from 12 to 12 (30-Dec-2024)	12	2	30-Sep-2024		Improvement plan endorsed by Quality Committee in July 2023; progress to be reported to the same group(27-May-2024), Recruitment of interim and permanent Complaints Manage underway in July 2023(27-May-2024), New Complaints policy approved by SUEG in October 2024(09-Dec-2024)	Review risk again post permanent recruitment process for Manager role and increased focus to close overdue complaints.	Approved
RSK-083	Contracts	There is a risk that the trust may not meet the new reporting requirements, which are set to go live in April. These requirements are directly linked to the funding received for key activities.	Failure to implement and report on the required metrics in time could result in a clawback of funding, negatively impacting the trust's financial stability and operational capacity.	Corporate - Strategy and Transformation	Score changed from 12 to 12 (30-Dec-2024)	12	4	31-Mar-2025	Embedding Reporting Requirements: The operations team is ensuring that appropriate reporting requirements are fully integrated into the relevant fields within the Care Notes system, enabling accurate and compliant data reporting. (11-Dec-2024)	The IT department will design, test, and deploy updated forms within the Care Notes system to capture and report the required metrics. This process will include thorough testing and a scheduled go-live date of 31 March 2025, ensuring the system is fully operational and compliant ahead of the reporting requirements deadline.(11-Dec-2024), Review of Forms Usage: The clinical team is actively assessing which forms are used to ensure they are relevant and appropriate for the reporting requirements.(11-Dec-2024), Alignment of Care Notes Fields: A comprehensive review of all fields in Care Notes has been completed to ensure alignment with the new reporting criteria for both Adults' and Children's services.(11-Dec-2024)		Awaiting approval
RSK-082	Safety	If the relative humidity in occupied spaces remains above recommended levels (52% to 85%), then it will cause damp conditions conducive to hidden mould growth and elevated allergens,	Resulting in health issues such as asthma attacks, allergic reactions, and chronic respiratory sensitivity, particularly in vulnerable groups such as children and individuals with pre-existing conditions.	CYP and Families - Gloucester House	Score changed from 12 to 12 (09-Dec-2024)	12	4	20-Dec-2024		Dehumidifiers were added to affected areas to help maintain indoor humidity levels within the recommended 30-50% range.(09-Dec-2024)		Awaiting approval
RSK-039	Delivery	Potential risks for those awaiting interventions If GIC waitlists continue to grow. There may be an increased chance of serious incidents and poor patient experience. Overstretched staff expected to deliver services.	This results in an impact on care delivery, a loss of service reputation and non-compliance with regulatory and contract requirements.		Score changed from 20 to 20 (02-Dec-2024)	20	4	21-Nov-2024		GIC to commence harm reviews for those on the waiting list due to an appointment within 6 months.(31-Jul-2024), Team to record all non-patient activity using the NPA tab on care notes(31-Jul-2024), The implementation of the patient portal - currently in phase 1 of the waiting list validation (WLV) of patient on the clinic's waiting list. The patient portal will also bring 2		Approved
RSK-060	Inspection / Audit	There is a risk of confidentiality breaches when sending correspondence to service users and external healthcare professionals.	Patients could come to mental or physical harm, the potential increase in complaints, and legal action, the trust could also receive a fine resulting in reputational damage	Adult Unit - Gender Identity Clinic	Score changed from 12 to 12 (02-Dec-2024)	12	2	09-Jan-2025				Awaiting approval
RSK-064	Delivery	WFT & WFT-P have a number of senior vacancies including the Team Clinical Lead in WFT. This results in gaps in senior leadership and oversight that can't be mitigated by sharing responsibilities across teams. Integrated services funded and delivered in partnership with LB Camden, with particular need for senior liaison with partners	- Lack of capacity for oversight of clinical care, including triage and allocation of referrals - Partner relationships with LB Camden and other agencies cannot be maintained - partners not assured of quality and consistency of delivery (threat to contract) - Morale of the team (staff retention)	Camden - Whole Family Team	Score changed from 15 to 15 (09-Dec-2024)	15	6	31-Mar-2025	Interim TCL sought			Awaiting approval
RSK-032	Safety	If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services.	Harm to the young person who needs a diagnosis and pressure on local CAMHS servcies that may be unable to fully meet the young persons needs.		Score changed from 16 to 16 (17-Dec-2024)	16	4	31-Jan-2025	Paper submitted to board re contractual position for HERTS. Paper to be presented to Board in November, Contract discussion meeting with Herts set for 13.12.2024	A3 recovery programme following increased investment under the ERF(24-Jul-2024), Secured temporary increase in funding for both Herts & Haringey to reduce waiting lists.(24-Jul-2024), Outsourcing 20 cases for assessment in the private sector(24-Jul-2024), Changed clinical pathway to stop triage calls for lower risk patients.(24-Jul-2024)	Risk remains the same as agreed in C&F workforce and performance meeting in October. No decrease possible at this time.	Awaiting approval

Reference	Category	Description	Impact of risk	Location	Latest comment	Current score	Target score	Target date	Controls outstanding	Controls implemented	Latest review comment	Approved state
RSK-042	Quality	The child Complex Service line has the highest number of missing and unlinked clinical notes in the Trust. The reasons for this are not fully understood. Priority focus for Q1 24/25	Add a description of the impact		Score changed from 6 to 12 (17-Dec-2024)	12	4	31-Mar-2025		Regular reminders sent to team managers with individualised reminders sent in Jan 24(09-Aug-2024), Service line has prioritised missing clinical notes and has seen minor improvements.(09-Aug-2024), Q4 priority action due to no improvement in outcomes(17-Dec-2024)		Awaiting approval
RSK-061	Patient Experience	Delays in delivering clinic letters to patients or healthcare professionals.	may result in patient harm, poor patient experience and care, delays in treatment, reputational damage to the Trust, and increased stress for administrative and clinical staff."	Adult Unit - Gender Identity Clinic	Score changed from 15 to 15 (17-Dec-2024)	15	5	01-Apr-2025		Weekly review of outstanding letters and escalation(11-Oct-2024)		Approved
RSK-041	Safety	If we have inadequate procedural controls monitoring the performance of compliance checks related to Water safety,	The Trust may not successfully identify gaps in compliance / poor process, Resulting in potential lapses in elevated risk of waterborne infection and/or poor response in the event of an incident including increased likelihood of personal injury	Finance - Estates and Facilities	Score changed from 12 to 12 (06-Dec-2024)	12	6	31-Jan-2025		water policy defines the criteria and accountability including AE(06-Dec-2024)		Approved
RSK-006	Delivery	If additional user authentication measures are not rolled out to all trust end users, their accounts security does not meet recommended cyber security standards.	This will impact CE accreditation failure and compliance failure for meeting DSPT.	Finance - IM and T	Score changed from 15 to 15 (18-Dec-2024)	15	3	30-Aug-2024	Implement MFA (18-Dec-2024)	The issuing of Username and password process is strictly controlled Policy to ensure robust passwords are in use Brute force protections are in place (account locking) If a user is identified as high risk we apply MFA(27-May-2024)		Approved
RSK-016	Cyber Security	If there are not enough skilled cyber security resource to support the growing demand and compliance of cyber security, then this may result in Trust to maintaining cyber security compliance and would result in increased vulnerability to infrastructure and Trust not compliant with DSPT and cyber standards Here's a clearer version of the risk, including the potential impact, controls, actions, and priority: Risk: If there are insufficient skilled cybersecurity resources to support the growing demand for cybersecurity and compliance requirements, the Trust may struggle to maintain cybersecurity standards, increasing vulnerability to infrastructure threats and non-compliance with the Data Security Protection Toolkit (DSPT) and other cybersecurity standards.	Financial Impact: Potential fines or penalties due to non-compliance with cybersecurity regulations and standards. Reputational Damage: Loss of trust from patients, stakeholders, and regulatory bodies due to failure to maintain appropriate security measures. Service Delivery: There is an increased risk of cyberattacks, which could disrupt critical services and operations, leading to delays and potential harm to service delivery.	Finance - IM and T	Score changed from 20 to 20 (18-Dec-2024)	20	2	31-Jan-2025	Cybersecurity Workforce Planning: Conduct an audit of current cybersecurity capabilities and forecast future resource needs based on the growing demand. Develop a recruitment strategy to attract skilled cybersecurity professionals. Explore partnerships with external cybersecurity firms to supplement internal capacity. (18-Dec-2024), Continuous Training and Development: Offer regular cybersecurity training programs for existing staff to ensure they stay updated on the latest threats and compliance standards. Implement certifications and professional development plans for the cybersecurity team to enhance their skills. (18-Dec-2024), Automated Tools and Technologies: Invest in advanced cybersecurity tools and technologies that can automate routine tasks, reducing the reliance on manual intervention. Implement monitoring and alert systems to detect and respond to threats in real time, thus minimising the need for constant manual oversight. (18-Dec-2024), Cybersecurity Governance and Oversight: Perform regular internal and external audits to assess the Trust's cybersecurity posture. (18-Dec-2024)	Incident Response and Contingency Planning: Develop a robust incident response plan to mitigate the impact of any potential cyberattacks or breaches. Ensure regular testing and updates to the response plan.(11-Dec-2024)		Approved
RSK-019	Cyber Security	Risk: If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring immediate action over the weekend, a lack of available resources may result in delays in remediation, leaving systems and data vulnerable to compromise.	Then, delayed action would compromise the Trust systems, services, and data.	Finance - IM and T	Score changed from 15 to 15 (18-Dec-2024)	15	4	31-Jul-2024	Informally Associate director of IMT, Senior iInfrastructure enginer respond to high Severity Carecert alert to remain compliant with 24 hours response time, however mitigations if are urgent might not be possible by these resources. (19-Dec-2024), 24/7 Cybersecurity Monitoring and Response: Implement a managed cybersecurity service provider (MSSP) to provide continuous monitoring and incident response support outside regular working hours. Develop a contract with an MSSP or third-party vendor to ensure immediate response to critical alerts and incidents, regardless of time. (19-Dec-2024), Incident Response Plan (IRP):		Will be reviewed post CE certification	Approved

Reference	Category	Description	Impact of risk	Location	Latest comment	Current score	Target score	Target date	Controls outstanding	Controls implemented	Latest review comment	Approved state
RSK-038	Staff Wellbeing	An increase in sickness levels will impact overall service delivery, leading to cancelled appointments, additional workload on already overstretched staff, and same-day appointment cancellations.	This may result in a potential rise in complaints due to cancellations and delays, compromised patient safety, and a possible decline in service reputation.	Adult Unit - Gender Identity Clinic	Score changed from 15 to 15 (10-Dec-2024)	15	8	26-Mar-2025	Wellbeing initiatives to improve morale - these implementation of the birthday club, social gathering outside the GIC, implementing 1hr lunch breaks on the phone lines, suggestion box in the tea room. (18-Nov-2024)	Active monitoring of sickness absence and following trust sickness policy and procedures(31-Jul-2024), Oversight in the leadership and clinical governance meetings- Monitoring activity and ensuring contingency planning is in place.(31-Jul-2024), Weekly review and escalation of vacant posts within the service.(15-Oct-2024)		Approved

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	19th December 2024	Claire Johnston, Committee Chair, Non-Executive Director	Clare Scott, Chief Nursing Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 012**		

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. Board Assurance Framework The committee received and reviewed the updates to the Board Assurance Framework (BAF) risks allocated to the Quality and Safety Committee, specifically, Risk 1 (Inequality of Access for Patients) and Risk 2 (Failure to Provide Consistent High-Quality Care). Recent updates to Risk 2 have led to a reduced risk score (from 16 to 12), reflecting improvements in clinical structures and oversight mechanisms. However, more needs to be done to ensure sustained progress, particularly in relation to safeguarding, training, and incident reporting systems. The focus remains on improving outcomes and service delivery, and to the experience of those using the services. Key developments that have occurred during the period under review include: • Completion of the Quality Framework Improvement Plan for BAF Risk 2. • Introduction of a new **After-Action Reviews (AARs)** process. The RADAR module for manual notifications of incident reporting Interim is in place to ensure continuous incident reporting during RADAR system updates.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Autism Presentation – Kaizen Improvement Work The committee received a paper and presentation from Tina Reed, Clinical Service Manager, Child and Family Unit outlining their approach to	Limited ☐ Partial ☐

the huge growth in demand for autism assessment, in line with the national picture. Referrals into the Autism Assessment pathway have increased by 285% since 2021 and referral rates for 24/25 are aligned to the previous year. Through the implementation of A3 Quality Improvement initiatives the team has redesigned its pathways to optimise resources without impacting on patient care. Non recurrent additional investment has enabled waiting times improvement and the stabilisation of the waiting list. However overall referrals into the service are not showing any decline and without additional sustained investment into 25/26 the waiting list and waiting times will revert to previous numbers. The Hertfordshire contract carries particular risk due to investment levels and referral numbers. Clinical risk for patients on the waiting list should be considered. With individual caseloads at 60+ patients for clinical staff it is not possible to review the patients with a frequency that assures risk management within the current structure. In light of this a care of waiters' protocol is planned for the Service Delivery Group in the New year for approval and which will provide a comprehensive process for the care of young people who are waiting for an Autism Assessment. The Committee acknowledged the great achievements for CAMHS, ADHD and Autism for the Trust.	Adequate ☒ N/A ☐
3. Quality & Safety Report This Committee reviewed and approved the report for onward reporting to Trust Board in January 2025. The committee noted the improvements to the quality of complaints investigations and response letters to complainants, demonstrating transparency and compassion that have, in some cases, received positive feedback from complainants.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Duty of Candour Audit The Committee noted the progress report for the Duty of Candour audit, which covered Q1 and Q2 2024/25, although compliance with Duty of Candour should be audited quarterly as per the Trust audit plan 2024/25. The current audit seeks to measure compliance against the Trust Duty of Candour Policy published in June 2023, now due for review. The findings of the current audit may be relevant to policy updates, but this will be determined once the audit has been completed.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Discussion around further consideration of duty of candour, knowing what the limits are of engagement and psychological harm and impact. To be picked up by incoming Deputy Chief Medical Officer.	
5. NHSE Review of GIC The Committee received the paper on the review carried out by NHSE of our GIC on 5th November 2024 as part of the national review of all adult gender services. It noted the initial letter received outlining immediate actions that are required; which sets out one immediate risk and four immediate concerns all of which require immediate actions from the Trust. The action plan for the immediate risk is to be submitted to NHSE by 6th December 2024 and the action plan for the immediate concerns must be submitted by 20th December 2024. The action plan is being monitored through the targeted support meetings that take place every Monday at 9am. The Trust will have the opportunity to see the review's draft report and check the factual accuracy of the contents early next year. The final report will be published once the review has completed its visits to all nine NHS adult gender clinics, likely towards the end of this financial year/start of the next financial year.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. Patient and Public Involvement (PPI) Team Annual Plan The progress against the annual plan was presented. The Committee noted areas of progress, that although may seem small, should be understood in the context of where the Trust was at the start of the plan and the achievements in a short space of time. A positive area of improvement was noted that the number of service users involved in PPI since the start of year has doubled to 30. There is a plan in place to further increase engagement and ensure that the service users recruited are representative of the populations the Trust serves. Under the Trust Strategic Pillar of 'outstanding patient care' sits the service users experience annual priority. The PPI team have led work to increase the amount of feedback we receive from service users, carers and families and broaden the way that we hear their voices, and how we respond to what we hear to make continuous improvements. The team has a wide remit across all services within the Trust; several factors have hindered progress on the annual plan. These include staffing gaps, a change in the way that the team works with current service users and an absence of current policies and procedures to support staff and service users in this work. Implementation of the plan has revealed more areas to be addressed, particularly the Trust-wide challenge of transforming the culture of how teams' approach and hold service user feedback and involvement. This has resulted in the team needing to return to the basics principles to set the foundations that the engagement and involvement work is built on. While notable progress has been made toward partnership working with service users, considerable work remains. There are concerns about the pace of change, and progress against the annual plan which have been addressed through a priority action plan.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Our focus has been on building strong foundational systems and processes to support future developments. Next steps include recruitment to vacant posts in the team; expanding our service user representative pool, helping teams establish more Service User Forums, and creating additional opportunities to understand patient experience. These initiatives will help us develop services that better meet our population's needs.	
7. National Learning Improvement Plan The paper provided a comprehensive plan to address the gaps identified through the Trust's approach to responding to the three nationals reviews and inquiries. From the internal review areas of good practice were identified; these included the executive team being more accessible and visible; the CEOs weekly coms and the all-staff meetings. It was noted that the trust has responded to areas where there were known gaps and have introduced priority areas of focus including improving patient voice and involvement, FTSU accessibility, clear reporting structures (IQPR), embedding PSIRF, incident reporting and patient safety partners. Furthermore, the clinical structure review has been implemented to strengthen responsibility and accountability, allowing us to look at ways of improving on leadership oversight and better board to ward communication. The recommendations set out encompass all themes identified as gaps through the stakeholder sessions; a high-level improvement plan has been developed for existing Quality Improvement collaboratives and workstreams to report into with some new workstreams identified and developed over the current financial year. Progress against the improvement plan will be monitored in the Services Delivery Group and will report up to ELT and Quality and safety Committee.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the reduction of BAF risk 2 from a current score of 16 to 12 (Likelihood: 3, Consequence: 4).

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:

To receive a full update on progress against the quality priorities, along with the proposed approach to setting the quality priorities for 2025/2026.

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

Item		Date
Acknowledgement of Dr Caroline McKenna's contribution to Quality and Safety during her time as Interim CMO and current Deputy CMO ahead of retirement in January 2025.		

MEETING OF THE PUBLIC BOARD OF DIRECTORS ON THE 16TH JANUARY 2025			
Report Title: Guardian of Safe Working Hours (GOSWH) Q2 report			**Agenda No.: 013**
Report Author and Job Title:	Dr Gurleen Bhatia Consultant Psychiatrist	**Lead Executive Director:**	Dr Chris Abbott, Chief Medical Officer
Appendices:	1. Introduction 2. Exception reports 3. Junior doctor's forum (JDF) 4. Local Negotiating Committee (LNC)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report highlights the total number of exception reports and fines incurred because of breaches of junior doctors' agreed working hours.		
Background:	The Guardian of Safe Working Hours is responsible for monitoring exception reporting by trainees of breaches in agreed work schedules. The role was introduced as part of the 2016 Junior Doctor contract to be independent of the management structure of the trust, with its primary aim being to represent and resolve issues relating to working hours for the junior doctors employed by it.		
Assessment:	This report relates to Q2 of 2024/25.		
Key recommendation(s):	The Board is asked to NOTE the content 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 CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 2 – failure to provide consistent, high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☒			
	The requirement to protect junior doctors from overwork and burnout is contractual				
Resource Implications	Yes ☐	No ☒			
	No current resource implications associated with this report.				
	Yes ☒	No ☒			

Equality, Diversity and Inclusion (EDI) implications:	Pressure to work long hours is likely to impact more negatively on doctors with young families or other caring responsibilities			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Report submitted to Local Negotiating Committee (LNC) prior to this submission.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Guardian of Safe working hours Q2 report

1. Introduction

1.1. The Guardian of Safer Working Hours provides a report to the Trust Board on a quarterly and annual basis on exception reporting by trainee doctors on breaches in agreed work schedules.

2. Exception reports

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
July	0	0	0	0
August	4	0	4	0
September	4	0	4	0

2.2 Work schedule reviews

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

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

The non-resident on-call (NROC) is currently staffed by Trainees and occasionally an external locum. The trainees do 1 locum shift per month in addition to their normal working schedules and on call rota (1 in 9.8)

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

	Extra hours worked Normal Enhanced		Total fine	Amount paid to trainees	Fine Remaining
	hrs	hrs	£	£	£
July	0	0	0	0	0
August	0	18	2898.12	1086.88	1813.34
September	0	12	1924.68	721.81	1204.41
Total	0	30	4822.80	1808.69	3017.75

3. Junior Doctors Forum (JDF)

The last JDF was held on 4th November 2024.

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sarah Wynick

Conclusions and Recommendations

5. The Trust continues to encourage the junior doctors to report breaches and encourage to use the GOSWH fund for their professional development. Liaison with the CNWL GOSHW is to be undertaken in due course.

6. The Board is asked to NOTE the contents of this report.

Dr Gurleen Bhatia
Guardian of Safer Working

MEETING OF THE PUBLIC BOARD OF DIRECTORS ON THE 16TH JANUARY 2025			
Report Title: Quality & Safety Report – January 2025			**Agenda No: 014**
Report Author and Job Title:	Lucy Hegarty, Patient Safety Manager	**Lead Executive Director:**	Clare Scott, CNO
Appendices:	Appendix 1 - Progress against the Quality Priorities for 2024/25.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	In line with the Trust's refreshed accountability framework, there is a need to refocus and strengthen the way in which we report and assure the quality and safety of our services.		
Background:	This Quality & Safety report expands on the detail in the Integrated Quality and Performance Report (IQPR), and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IPQR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics. The Unit Clinical Governance meetings and the clinical division IQPR meetings informs the narrative of this quality and safety paper, in relation to action taken in respect of thematic and individual areas of focus identified. The report is presented at each Quality and Safety Committee; this is the first time to Trust Board and will be presented every other Trust Board in the future reporting cycle.		
Assessment:	The Board is asked to note and discuss the data for this reporting period, October and November 2024, and any themes emerging from preceding months. There is not an obvious triangulation of themes across the metrics reported; however, this could be anticipated to change following the work to increase recording and reporting in a number of areas outlined above, and linked to other key pieces of work (replacement quality and risk system, implementation of PSIRF). This report will also be strengthened to include triangulation from clinical audits. The clinical audit function went live on Radar on 22nd October 2024. Progress against the Quality Priorities for 2024/25 is detailed in Appendix 1.		
Key recommendation(s):	The Trust Board is asked to: • Note the report and the recommendations for further improvements to identifying and learning from triangulated themes.		
Implications:			
Strategic Ambitions:			

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	Risk Ref and Title: BAF Principal Risk 1 - Inequality of access for patients BAF Principal Risk 2 - Failure to provide consistent high-quality care		
Legal and Regulatory Implications:	Yes ☒	No ☐	
	The Trust will be held to regulatory account if it does not report its quality and safety data in a robust, transparent and accountable way.		
Resource Implications:	Yes ☐	No ☒	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐	
	There may be opportunities to consider reporting some of the metrics by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does differ between reporting group. This will be guided by the PCREF workstream.		
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	

Assurance:				
Assurance Route - Previously Considered by:	This report has been presented to the Quality & Safety Committee since March 2024 (the first iteration of this report format).			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Quality & Safety Report – December 2024

1. Background

This Quality & Safety report expands on the detail in the Integrated Quality and Performance Report (IQPR), and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IPQR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics.

The Unit Clinical Governance meetings and the clinical division IQPR meetings informs the narrative of this quality and safety paper, in relation to action taken in respect of thematic and individual areas of focus identified.

2. Clinical & Patient Safety Incidents

October 2024	Trustwide	Camden Unit	CYP & Family Unit	Adult	Other
Incidents Serious Incidents	0	0	0	0	N/A
Incidents Patient Safety incidents	13	3	8	2	N/A
Incidents Open SI / PSI investigations	2	0	1	1	N/A
Incidents Falls with harm	0	0	0	0	N/A
Incidents Violence & Aggression	9	0	8	1	N/A
Incidents Restraint/ Hold	5	0	5	0	N/A
Incidents Number of all deaths	2	0	0	2	N/A
72 Hour Reports Requested	1	0	1	0	N/A
After Action Reviews Requested	1	0	0	0	1

November 2024	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit	Other
Incidents Serious Incidents	0	0	0	0	N/A
Incidents Patient Safety incidents	15	3	8	3	1

Incidents Open SI / PSI investigations	2	0	1	1	N/A
Incidents Falls with harm	0	0	0	0	N/A
Incidents Violence & Aggression	16	0	16	0	N/A
Incidents Restraint/ Hold	7	0	7	0	N/A
Incidents Number of all deaths	5	2	0	3	N/A
72 Hour Reports Requested	1	1	0	0	N/A
After Action Reviews Requested	2	0	0	1	1

The following points are noted;

- There has been an increase in the number of incidents reported via the incident and risk management system, Radar. This is a positive increase and move towards fostering a psychologically safe culture where staff feel empowered to report incidents, likely due to ongoing work across the Trust in relation to incident reporting. In particular, work has been undertaken with Gloucester House and the importance of dual categorising incidents where necessary. Further training on incident reporting is due to be provided across each Unit in January 2025. This will focus on the incident reporting culture and also oversight of incidents in line with PSIRF.
- Benchmarking of the number of reported incidents by the Trust, compared to the number reported by other similar organisations, will be included in the next report to understand and review any areas of further action we may need to take.
- There has been a noticeable increase in the reporting of violence and aggression and restrictive practice incidents at Gloucester House. In October there were 8 violence and aggression incidents of which 5 involved the use of a restrictive practice. In November an increase was seen where there were 16 reported violence and aggression incidents at Gloucester House, of which 7 involved the use of a restrictive practice.
- The team at Radar are progressing with building the restraint form which was approved internally in October 2024. This will form part of the incident record to enable Gloucester House to move from manual logging to electronic recording linked with the incident on Radar. This should be available and live in the Radar system in December 2024.
- A 72 Hour Report had been requested in November following the Mental Health Support Team (MHST) being informed of the death of a young person previously known to the service in May 2024. The Trust were part of the joint agency meeting as part of the Child Death Overview Panel (CDOP) process. A mortality review has been undertaken internally which identified areas of learning. This will be discussed further at the Clinical Incident and Safety Group (CISG) in December 2024 and learning cascaded more widely.
- Two After Action Reviews (AAR) have been requested for incidents in November: one concerning a GIC validation text message being sent to a non-patient. The other incident relates to issues with the lack of water supply at the Tavistock building which resulted in discussion about the potential closure of the site. Once both AARs have been conducted, learning will be brought to CISG and monitored through the appropriate Unit Clinical Governance meetings.
- The Patient Safety team have progressed with the two thematic reviews in relation to incidents in relation to information governance and violence and aggression incidents at Gloucester House. The information governance thematic review is now ready in

draft form. Initial learning is around identification and reporting of incidents, appropriate follow with affected patients and clarity about policy and process. The violence and aggression thematic review is underway with involvement of one of our Patient Safety Partners.

4. Complaints & PALS

Complaints:

25 complaint contacts were received during October and November 2024; 20 of these were formal complaints.

October 2024	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Formal complaints Number received	9	2	1	6
Formal complaints Number acknowledged within 3 days	7	2	1	4
Formal complaints Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	0%	0%	0%	0%
Investigations by PHSO	0	0	0	0
Informal complaints	5	1	0	4
Number of open complaints	28	2	2	21
Number of overdue complaints	14	0	4	10

November 2024	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Formal complaints Number received	11	1	0	10
Formal complaints Number acknowledged within 3 days	9	1	0	8
Formal complaints Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	33.33%	100%	0%	0%
Investigations by PHSO	0	0	0	0
Informal complaints	0	0	0	0
Number of open complaints	31	1	4	26
Number of overdue complaints	12	0	3	9

The data above highlights the continued reduction in overdue complaints. For compliance against timeframes for responding to formal complaints, although we have not yet achieved the target, there has been a significant improvement but this remains fluctuating month on month.

For the acknowledgments to complaints, all acknowledgements were completed albeit not within 3 days.

In September, following the restructure, the Trust moved to single clinical units. Reconfiguration to the new clinical structures in Radar is now complete and complaints that that were recorded under the previous organisational structure have been updated to the new structure and Service Leads are now able to view complaints at their region (Unit Level) and location (Service Level).

As noted previously, it is important that informal complaints are correlated with an early resolution. The Complaints Management Policy has been reviewed and redrafted to outline definitions and timelines for this (an expected 10 days opportunity to resolve informally). The amount of complaint contacts being resolved informally is a positive reflection of the work undertaken to date in respect of strengthened processes to resolve concerns as early as possible.

The new Radar system will accommodate an auditable and accountable way of logging actions resultant from complaints, which will be a useful way of keeping track of progress of learning. For example, any action plans noted in the investigation report are transposed into an Action Plan on Radar which is assigned to specific staff members with an action date assigned. Further, the Trust's clinical governance processes are being reviewed and refreshed to ensure they are mirrored across the new clinical units and that learning can be clearly evidenced.

Theme	Learning taken forward	Timeline
Communication with young people/families regarding screening measures/Health Records Management/Onward referrals/Care Plans	Need to have timely discussions with young people and families regarding completed screening measures that may or may not indicate the need for further assessment. Compliance with Health Records Management Procedure and that Care Plans need to be up to date. Onward referrals to services as agreed needs to be actioned within one calendar month or sooner. Care Plans are to be updated as and when needed, but no later than 6 months and to be sent to young person/family and GP unless requested otherwise.	Q3, 24/25
Preparation about the pathway – prescribing, referral to surgery, process for gender recognition certificates (GIC)	Website information has been updated and information leaflet reflects this and is sent out to all new patients. The new GIC patient platform will also be a key part of this information sharing. Awaiting any further update from Clinical Governance meeting.	Q2 24/25
Sensitive questions during clinical assessment (GIC)	GIC Lived Experience Theatre Training has been proposed and is being reviewed. Website information has been updated and information leaflet reflects this and is sent out to all new patients. The new GIC patient platform will also be a key part of this information sharing.	Q2 24/25
Approach of clinician during assessments / disagreement with clinician approach (GIC & Mental Health)	Shadowing of clinical assessments where required for clinician development and learning. GIC Lived Experience Theatre Training has been proposed and is being reviewed. Awaiting further update from Clinical Governance meetings.	Q2 24/25

Concerns over line of questioning and comments during assessment (Mental Health)	Awaiting update from Clinical Governance meetings	Q2 24/25
ESQ Feedback	ESQs feedback to be considered as potential complaints and a procedure developed to help people who complain on ESQs to be fed into the complaints procedure.	Q2 24/25
Delays in waiting times	Patients are made fully aware of the potential waiting times so they can make decisions about their preferences for treatment. The new GIC patient platform will also be a key part of this information sharing.	Q2 24/25

PALS*:*
41 enquiries were received during October and November 2024.

	Trustwide *External are related to those not known to services*	**Camden Unit**	**CYP & Family Unit**	**Adult Unit**
October 2024	Internal = 18 External = 6 Total = 24	2	1	15

	Trustwide *External are related to those not known to services*	**Camden Unit**	**CYP & Family Unit**	**Adult Unit**
November 2024	Internal (Including 6 PALS enquiries for other Trust areas) = 15 External = 2 Total = 17	1	0	8

The total number of PALS enquiries received will be higher as not all enquiries received are related to each of the three Units clinical teams and can relate to other service areas within the Trust.

The main themes of these are outlined below. These are similar to previous themes.

- Access to Treatment/Drugs and Integrated Care (how to access services and what is available) e.g. types of therapy offered, wait times and referrals process, whether referrals have been received, rejected referrals other support services such as housing, benefits, financial support.
- Appointments (availability/waiting times) ***(triangulation with Complaints themes)***
- Concerns with ending treatment and future options
- Concerns with treatment ***(triangulation with Complaints themes)***
- Communication issues (letters, appointment changes, notifications) ***(triangulation with Complaints themes)***

Enquirers range from patients/service users themselves, to parents, partners, siblings, family friends and professionals seeking information about our services.

5. Compliments and ESQ Positive Feedback

ESQ positive feedback and Radar Compliments

The number of positive comments/feedback received through ESQs continues to exceed the number of complaints, issues and concerns, with 145 during this reporting period. Recording and reporting of positive feedback is currently under review as part of the A3 Quality Improvement Project focused on User Experience. During November the Trust improved the communication loop with clinical teams. There is an ambition to bring consistency across teams and to increase the opportunities for Service Users to provide feedback.

The table counts each positive reflection captured in the ESQ form:

	Trustwide	Camden Unit	Child and Family Unit	Adult Unit
October 2024	60	12	9	39
	Trustwide	**Camden Unit**	**Child and Family Unit**	**Adult Unit**
November 2024	85	14	19	52

The Radar Compliments event module is now live, although training and communications work is ongoing to promote this. This will enable a strengthened reporting framework as all compliments received will be categorised. However, for the time being, the ESQ form will remain the main source of gathering compliments and examples of positive feedback.

	Trustwide	Complex Mental Health	Community & Integrated	GIC
October 2024	1	-	-	-
	Trustwide	**Camden Unit**	**Child and Family Unit**	**Adult Unit**
November 2024	2	2	TBC	TBC

Experience of Service Questionnaire (ESQs)

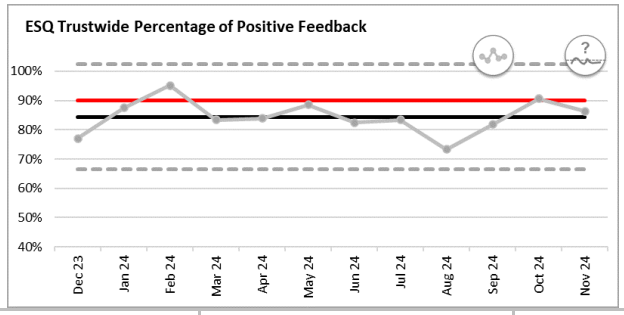
There is a continued focus on improving the number of ESQ forms received each month, and ensuring the process is optimised via the strategic objective of User Experience, and the A3 Quality Improvement Project related to that. This piece of work includes improvements on the learning and communication plan, ensuring the feedback is shared appropriately and timely within the services. It is positive to note that the implementation of some of these improvements took place during November and that they were received positively by the teams.

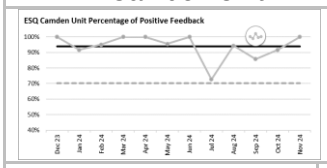
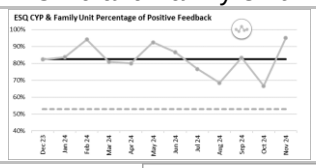
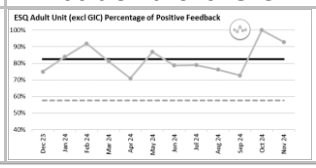
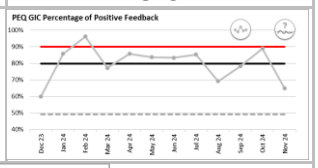
The User Experience Quality Improvement Project continues to focus on reviewing the collection process for experience and feedback data to ensure it is consistent across all Trust services. This is also an agreed Quality Priority for the Trust in 2024/25. There has been significant progress in developing a new ESQ collection strategy and the preparation work is nearing completion.

The charts below report a Trustwide view of responses received throughout the last twelve months, and the positive recommendation rate received from those responses.

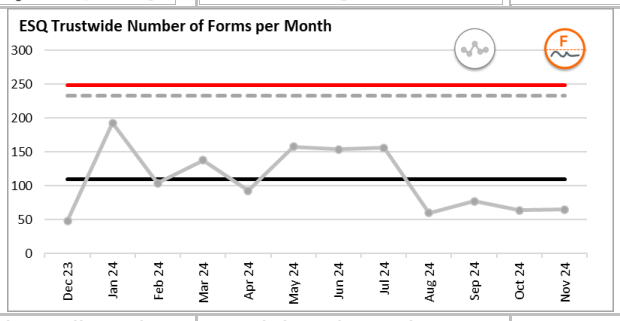
ESQs - SPCs	Trustwide

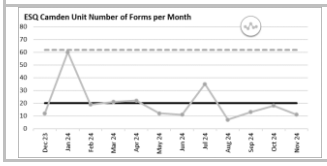
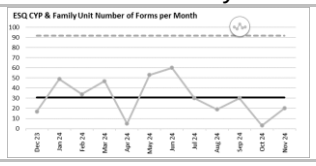
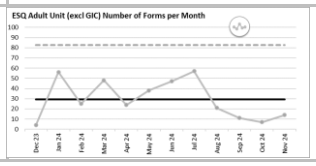
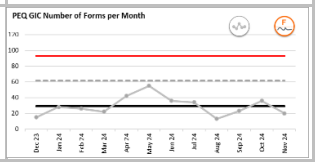
ESQ positive recommendation rate FFT question (%)



Camden Unit	Child and Family Unit	Adult Unit- excl GIC	GIC
			

Number of ESQ forms completed



Camden Unit	Child and Family Unit	Adult Unit- excl GIC	GIC
			

In October the Trust-wide positive recommendation rate was on target (90%) and in November just below target. We are hopeful that the launch of our new electronic ESQ platform will invigorate the engagement with ESQs.

6. After Action Review (AAR) Conductor Development Training and Learning

As the Trust continues to review patient safety incidents in line with the Patient Safety Incident Response Framework (PSIRF), there has been an increase in the number of After Action Reviews (AARs) requested by way of learning response to encourage and promote continuous learning and improvement of patient safety.

While some staff members were familiar with the AAR methodology, the Trust has not implemented AARs at scale across the organisation prior to the implementation of PSIRF. To encourage and allow teams to effectively apply a system-based approach to learning and use considered and proportionate responses to patient safety incidents, the Trust secured an opportunity for staff to receive accredited After-Action Review Conductor training by Transition Partners in Health and Care in October 2024.

Learning: Enablers Attendees will use to take forward AARs

Me	My Team	Organisation
Time management • Planning and prioritising AARs • Good diary management • Making them regular part of personal development **Support and Collaboration** • AAR buddies • Sharing lessons learned • Drawing on experience of other professionals **Mindset approach** • Keeping a neutral perspective • Being curious and open minded **Top down approach (exec team)**	**Creating a positive culture** • Conducting informal AARs • Encouraging participation **Learning and Improvement** • Putting learning into practice • Viewing incidents as opportunities – reframing • Shared learning **Organisational Support** • Focus on improvement • Recognising AARs as Reflective Practice	**Continuous Improvement** • Encouraging informal AARs • Clear action plans **Whole Trust Approach** • Bringing teams together • AAR buddy system • Regular AARs **Communication and Engagement**

The Value of the Training - Comments from Attendees

- *How to confidently and effectively conduct an AAR.*
- *How to conducts an AAR and how to be more reflective and less leading.*
- *That power and influence can be creative as well as corrupting.*
- *Confidence in AAR.*
- *The structure of AAR and how to conduct focus on experience and expectations.*
- *How to introduce AARs as an improvement and reflection tool.*
- *What AARs are, how to facilitate them and lots about psychological safety and how to make the most of AARs.*
- *The importance of planning before the AAR and the importance of keeping to the framework ad agreeing ground rules. Also the need to focus on expectations.*

Evaluation Data

The Training	Strength of agreement				
Rate how much you agree with the statements below where 1 is totally disagree and 5 is totally agree.	1	2	3	4	5
Has given me sufficient knowledge to be able to introduce AAR to my colleagues.				3	6
Has given me the confidence and skills to lead AARs.				3	6
Has provided me with valuable insights into how to support effective team performance through learning collectively.				4	5

Photos from the training session

Following the training, staff trained have taken a proactive approach in considering an AAR as a learning response tool and several trained conductors have facilitated reviews for recent incidents across the Trust.

A further opportunity has been offered to Trust staff with a second cohort scheduled to be trained in December 2024.

7. Conclusion

The Committee is asked to note and discuss the data for October and November 2024, and the themes emerging from the data for the previous months. The review of themes reported via the metrics and supporting narrative will continue and is anticipated to change following the work to increase recording and reporting in a number of areas outlined above, and linked to other key pieces of work (introduction of the Radar system, implementation of PSIRF etc).

The Committee is also asked to discuss the format of the report and recommend where it may be strengthened for further assurance.

2024/25 Quality Priorities
Strengthening Our Patient Safety Culture

NHS
The Tavistock and Portman
NHS Foundation Trust

Workstream Definition	2024/25 Q1 Update	2024/25 Q2 Update
85% of staff will be trained in the Level 1 Essentials of Patient Safety syllabus Workstream lead: **Emma Casey / Lucy Hegarty**	**Trust overall compliance** for the Level 1 Essentials of Patient Safety Syllabus is currently at **66.38%.** The patient safety team have sourced the data by directorate, division and team to allow follow up with teams with the lowest completion rates. This will encourage an increase in compliance to reach the target of 85% and efforts by the patient safety team will continue to achieve this by Quarter 2.	**Trust overall compliance** for the Level 1 Essentials of Patient Safety Syllabus in Quarter 2 is **72.07%.** With a positive increase from Quarter 1, work continues to reach the compliance target of 85% and efforts will be furthered by the patient safety team with further comms.
Training for staff in new PSIRF investigative techniques Workstream lead: **Emma Casey / Lucy Hegarty**	Further to the formal and accredited PSIRF Training provided to a cohort of 30 individuals in January 2024, further training and update has been provided as follows: • Discussions across the NCL community continue in relation to a **formal collaborative training offer**. • Lunch and Learn Sessions have been provided to all staff on the **four principles of PSIRF** during the launch week held in April 2024. • **Radar Lunch and Learn session** to take place on Thursday 8th August 2024 which will cover the new incident management system, the incident reporting process and review tools under PSIRF. • CNO **Training Analysis has been approved** and training will be provided on the following three areas: - **AAR Conductor Training** due to take place in September 2024 (20 places) - **Compassionate Engagement** (20 places) - **Duty of Candour with Empathy** (10 places) We expect to be in a position to provide an update in Quarter 2 once training has been completed.	• **In-house training slides** are being produced in **collaboration with the NCL Community of Practice** for PSIRF with the view for this training to be offered to Trust staff throughout the year with multiple opportunity for staff to attend and further their knowledge on PSIRF and investigation techniques. • **A Trust-wide Radar Lunch and Learn session has taken place** which covered incident reporting through the new incident management system, and review process under PSIRF. • An **overview of PSIRF in Practice** offered to new cohort of trainees in September. • Patient Safety team have provided **specific teams** with support and training of **reviews under PSIRF, enablers for fostering a safety culture and incident reporting**. This sessions will continue to be offered. • A cohort of staff received **AAR Conductor Training** in October with a **further opportunity to be offered** for Trust Staff in November/December. A community of trained AAR Conductors are now available within the Trust and will facilitate AARs under PSIRF. • **Compassionate Engagement** and **Duty of Candour with Empathy** providers selected with **training to take before the end of the year.**
100% of patients/families involved in Patient Safety Incident Investigations are included in the investigation process Workstream lead: **Emma Casey / Lucy Hegarty**	• A **QI focused project** using the A3 methodology is underway in relation to the **Trust's compliance with PSIRF**. An area of focus is on **patient and family involvement** throughout incident review processes. Countermeasures have been identified to **streamline and create robust processes** which allow for this meaningful involvement support by the **contribution of our Patient Safety Partners**. • The **monitoring of the measures** as detailed in the A3 will be **reported on in Quarter 2**. • As part of our efforts to ensure patients and families are involved in patient safety we have **reviewed and amended review templates** for After Action Reviews (AAR) and Patient Safety Incident Investigations (PSII) to ensure **compassionate engagement and involvement.**	• The QI work for PSIRF is ongoing and **metrics have been agreed and will formally be reported on under each PSIRF pillar**. For compassionate engagement this will include data on patient/family involvement in patient safety reviews compared to those eligible. • Findings and learning around patient/family involvement following the Trust's first PSII (Patient Safety Incident Investigation) has been fed into the PSIRF A3 to ensure **recommendations made strengthen and support processes further** . • **Processes for engagement** are also being **further refined** under PSIRF with our Patient Safety Partners to ensure the patient voice is elevated both **pre and post incident**.

2024/25 Quality Priorities
Clinical Effectiveness

NHS
The Tavistock and Portman
NHS Foundation Trust

Workstream Definition	2024/25 Q1 Update	2024/25 Q2 Update
Implementation of PCREF (Patient and carer race equality framework) Workstream lead: **Chris Abbott**	This quarter has seen membership of the implementation group agreed and a first meeting has been arranged. Engagement work has started across the Trust, including within DET where aims were discussed at the Education and Training Committee. External groups have been identified and will be approached in Q2 to see if they would be willing to work with us. Comms strategy regarding PCREF being put in place to raise awareness across all areas of the Trust.	PCREF Implementation group is now up and running with engagement from service leads. Terms of reference for the group and frequency of meeting has been agreed. Agreement on foundation data requirements to set baseline. Discussion now including faith groups as well. DET representation has also been invited to join the implementation group. Moving towards recruitment of front-line clinicians to support workstreams. Initial contact with community groups slightly behind schedule but will take place at end of Q2 and start of Q3.
Outcome Measures performance that meets the NHSE standards and includes matched pairs of outcome measures Workstream lead: **Rachel James**	• Created an A3 and socialised this with all clinical governance meetings to obtain feedback • Development of a proposal for Trust wide OM to be standardised across all clinical services • Development of a new centralised process for how certain OMs will be collected • Created a proposal for standardising the logic of when OMs should be collected • All proposals and processes awaiting sign off by wider stakeholder group in Q2 • Created an implementation plan that will enable us to move forward with making required changes once we have approval to move forward with the proposals outlined above..	• Began a series of meetings with key leads in CNWL to understand their use of OMs and potential for alignment, starting with CYP MH • Submitted a Change Request document setting out 10 changes for Carenotes to improve OM data capture • Commenced development of a service user involvement group to test the Carenotes changes • Set up 4 sessions for trust-wide training on the NEW NHSE Waiting Time Metric and Wider OM Training, to be conducted in Q3 (November) • Held initial meetings with 2 pilot groups to improve OM data capture, including DIALOG implementation in the Adult Unit and the applicability of GBMs in First Step. One pilot meeting with the ASC/LD Team was cancelled due to staff sickness and will be rescheduled for Q3 (October)
Reviewing the harm assessment process for services that have extended waiting times Workstream lead: **Hector Bayayi**	Policy has been drafted and reviewed by Clinical Services Group and ELT.	Awaiting update on implementation.

2024/25 Quality Priorities
Patient Experience

NHS
The Tavistock and Portman
NHS Foundation Trust

Workstream Definition	2024/25 Q1 Update	2024/25 Q2 Update
Increase ESQ feedback received by 200% per service line (based on previous baseline rates) Workstream lead: **Clare Scott / Nimisha Deakin**	Benchmarks had been set and agreed before the consultation. These will now be reviewed for the new structure in Q2.	Following the consultation, new targets will be set and assigned to each team ahead of the implementation of the digital capturing of feedback onRadar.
Reporting experience metrics by protected characteristics / demographics Workstream lead: **Sonia Perez**	Work completed to have an ESQ data by all ethnic groups within the mental health Service Users cohort. The ESQ form is due to be reviewed at trustwide level. This should allow us to also collect ethnicity data also for Gender Service Users. Data analysis will become more reliable and meaningful as we increase the number of forms received. AESQ A3 working group has scheduled PDSAs to increase number of forms.	The trust has now approved a Digital platform for ESQs - Radar. We have successfully tested the ESQ's demographic questions on Radar. The plan includes a field to collect ethnicity, options compatible with the National Census. Data analysis will become more reliable and meaningful as we increase the number of forms received. A digital ESQ should help us increase the number of forms.
Developing a digital drop box for 'live feedback' Workstream lead: **Sonia Perez / Marcy Madzikanda**	Variation of online platforms available in the Trust continues to be discussed and an impact of where responses are located to facilitate quarterly reporting. A digital drop box would facilitate timely feedback teams could respond to in a timely manner and support introduction of 'You said, We did' communication. A discussion with Service Users as we reviewed Terms of Reference for Trust Wide Forum about creating avenues to listen to the patient voice.	We have prioritised the development of the QR Code / URL link which will enhance the user experience of collecting feedback. This will no longer be linked to Carenotes and increases the opportunities to provide feedback at any time. The long-term aim will be the development of a digital dashboard that staff can access, view and analyse in addition to responding to feedback in a timelier manner as opposed to quarterly reporting
Innovative ways of collecting feedback from children & young people Workstream lead: **Nimisha Deakin**	To be discussed as part of the Service User Experience A3 activity.	We are still exploring options but have been focusing on QR code and ULR as this will support this. Still looking into young children feedback.

MEETING OF THE BOARD OF DIRECTORS ON 16TH JANUARY 2025			
Report Title: Autism Assessment Update			**Agenda No.: 015**
Report Author and Job Title:	Tina Read, Clinical Service Lead, Child and Family Unit.	**Lead Executive Director:**	Chris Abbott, Medical Director
Appendices:	Appendix 1: Autism Kaizen slides		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	The purpose of this report is to provide detailed information on the current status of the Autism Assessment pathway delivered by the Autism and Learning Disability team. The report will cover the associated risks with an increased waiting list for assessment and the current status of risk mitigations and improvement plans that have been put in place during 24/25.		
Background:	The Autism and Learning Disability Team is contracted to deliver Autism Assessments to Haringey residents aged 12-18 year olds and to Hertfordshire residents aged 16 to 18 years. In line with a national picture, demand for Autism Assessment across these two contracts has grown 495 % since 2019. Both contracts have seen a significant rise in referral numbers. With additional funding via the NHSE Elective Recovery Fund and from the NCL ICB in 24/25, this report will show that with additional investment and pathway optimisation we have been able to significantly decrease waiting times for assessment and have maintained a stable waiting list. In April 2024 330 young people were waiting for an Autism Assessment. The average waiting time for young people from Haringey was 18 months (78 weeks) and from Hertfordshire 2.5 years (130 weeks). A total of 168 assessments were delivered in the same period, with the result that the average waiting time for Haringey is now at 49 weeks and for Hertfordshire 98 weeks. A 31% decrease in waiting times. However gains from increases in assessment capacity in waiting times have been mitigated by sustained levels of demand. 200 new referrals were received between April 24 and November 24 with the outcome that at November 2024, there remain 333 young people on the waiting list for assessment. A second target was set by NHSE in October 2024 to eliminate all patients waiting more than 52 weeks for first appointment by March 2025. 97 cases were breaching at 52 weeks plus for first appointment in the Autism Assessment pathway. Following improvement initiatives, at December 2024, the number of young people waiting 52+ weeks for 1st appointment had reduced to 26 patients and the team are on target to eliminate all waiters at 52 weeks for first appointment by March 2025.. The number of first appointments offered has increased from 11 to 58 a month. The average waiting time for first appointment has reduced from 49 weeks to 18 weeks and is on course to meet the 4 week target by March 24/25.		

`Assessment:	Non recurrent additional investment for 24/25 of £521,257K has enabled waiting times improvement and the stabilisation of the waiting list. In addition, through the implementation of A3 Quality Improvement initiatives the team has redesigned its pathways to optimise resources without impacting on patient care. At month 8 end the business as usual team have carried out 32 assessments (against previous year performance of 36 assessments at month 12) and the recovery team have carried out an additional 136 assessments against a target of 185 by Month 12. The outcome on waiting times has been positive. Young people from Haringey who are being seen for assessment have waited 49 weeks and from Hertfordshire 98 weeks. However overall referral rates into service have not slowed and without additional, sustained investment into 25/26 the waiting list and waiting times will revert back to previous waiting list numbers and waiting times.
Key recommendation(s):	The Trust Board is asked to: Review the report, take assurance and review recommendations for risk management associated with waiting lists and waiting times in the Autism Assessment Pathway.

Implications:

Strategic Ambitions:

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

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

Link to the Risk Register:	BAF ☒	CRR ☒	ORR ☐
	Risk Ref and Title: CRR RISK 032 If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services. There is risk of Clinical Harm to a young person who needs a diagnosis and pressure on local CAMHS services that may be unable to fully meet the young person's needs. Current Risk score 16. BAF Risk 13 Failure to achieve the required levels of performance and productivity. Current Risk score 12.		

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

	There are resource implications associated with this report. Additional funding has been made available via the NCL ICB and via NHSE (Elective Recovery Fund) in 24/25. Despite these additional waiting list initiatives waiting lists and waiting times continue to grow due to the increase in referral demand. Without sustained recurrent funding there is a risk that the gains achieved in waiting time reduction will be reversed and patients waiting lists and waiting times will continue to grow. The Hertfordshire contract is significantly under resourced for the current demand and as a result is a vulnerable contract. Discussions are taking place with the ICB and ELT as to contract viability.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	Young people who are unable to access an assessment in a timely manner are often unable to access the support they need with regards to educational outcomes and social and emotional wellbeing.			
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:	Quality and Safety Committee 16/12/2024 ELT : Autism Waiting Lists Recovery Proposal August 2024 ELT : 06/01/2025.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Autism Assessment Pathway

1. Purpose of the report

The purpose of this report is to provide detailed information as to the current status of the Autism Assessment pathway. The associated risks with an increased waiting time and the current status of mitigations and improvement plans in place.

2. Background

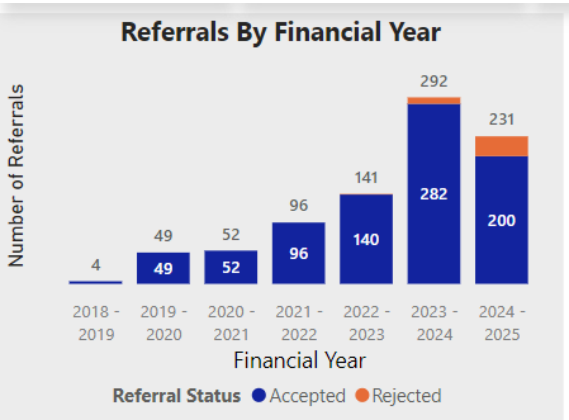
2.1 Introduction

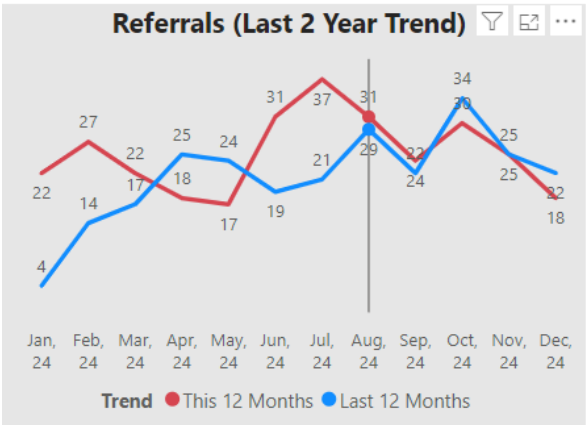
The Autism and Learning Disabilities service at the Tavistock and Portman has a long history of excellence and innovation in the field of Autism, dating back to 1986 by Sue Reid and Anne Alvarez' 'The Autism Clinical and Research workshop and the Tavistock and Autism Service'. And further back to the work done by Neville Symington and Valerie Sinason, under the learning disability workshop and learning and complex disability service in 1979.

The current team provides 2 pathways, one delivering Autism Assessments to young people aged 12 to 18 years from Haringey and for young people aged 16 to 18 years for Hertfordshire. The second pathway is a specialist psychological therapies service providing treatment and intervention for co-concurring mental health needs in autistic young people and young people with Learning Disabilities.

The pathway under consideration for this paper is the Autism Assessment pathway. The team has developed a particular specialism for the assessment of young autistic women.

Since 2019 the assessment pathway has seen a 495 % increase in referrals from 49 in 2019 to 292 in 23/24 across all referrers.





When broken down by individual boroughs referrals for Haringey young people have increased from 31 in 19/20 to 108 in 24/25. Referrals for Hertfordshire have increased from 15 in 19/20 to 122 in 23/24.

At the end of November 24/25 a total of 231 referrals have been received suggesting if 60 are received in Q4 the referral rate of 23/24 will be sustained for the financial year 24/25.

The core Autism Assessment Service currently comprises a qualified clinical staff of 1.5 WTE. An additional 0.8 WTE of assistant psychologist is added to make 2.3 WTE in the team.

Qualified Clinicians	Band	WTE
Consultant	medical	0.3
Clinical Psychologist	8B	0.2
Clinical Psychologist	8A	0.2
Speech and Language Therapist	7	0.2
Psychotherapist	7	0.3
Clinical Psychologist	7	0.3
Sub total		1.5

Assistant Psychologist	5	0.8
Total		2.3

This team historically delivered an average of 30 assessments a year. In the first paper to the Child Complex Service Line in (July 2023) identifying the risk associated with increased referrals, it was identified that the average waiting time for young people from Haringey and Hertfordshire was 2.5 years and the waiting time for assessment for Hertfordshire patients was predicted to be 9 years by 2024 end if no remedial action was taken.

2.1.2 Finance

Core recurrent funding from the NCL ICB for Haringey is £113,529.00 and for Hertfordshire £63,186.00. A further NCL uplift of £41,156 was baselined in 23/24 making the total gross investment into the Autism Assessment Service £217,871.00.

In 24/25 non-recurrent Specialised Commissioning Funding of £662,822 (gross) was secured via the Elective Recovery Fund (ERF) to support the reduction of waiting times and Waiting Lists. This finding resulted in a 12-month temporary staffing increase as follows:

Role	Band	WTE
Consultant	Medical	0.8
Clinical Psychologist	8B	1
Clinical Psychologist	8A	2
Speech and Language Therapist	7	1
Assistant Psychologist	5	1
Administrator	4	1
Total		6.8

At the mid-point of 24/25 additional recurrent and non-recurrent funding was made available via the NCL as indicated in the table below. Total part year effect of £153,549.

Table 1: T&P CYP Investment for 24/25 and beyond

Service	Benefits aligned to addressing the core offer gap	24/25 Part Year	Recurrent FYE
Neurodevelopmental disorder (NDD) diagnosis	(pan NCL) Additional capacity to reduce waiting list assessment backlog and to support implementation of standardised NCL NDD pathway, thereby reducing waiting times for diagnosis assessments.*	£ 153,549	£ 159,105
Total		£ 153,549	£ 159,105

*Note: Activity plans for backlog clearance and subsequent activity trajectories to be agreed betwe ICB and providers.

Table 2: Summary of NDD investment by provider and area for investment

Provider	24/25 PYE (substantive roles)	24/25 PYE (backlog clearance)	FYE (incl. 20% overheads)
BEH/NLMHP*	£ 427,644	£604,482	£ 1,241,916
Royal Free	£91,224	£228,360	£322,840
T&P	£46,085	£107,464	£159,105
WH	£100,148	£ 241,793	£, 358,534
CNWL (via T&P)	£ 64,192	£ 161,195	£ 223,125
Total	£ 729,293	£ 1,343,294	£2,305,521

As part of an agreed approach to service redesign, the following posts have been recruited to and will join the service by March 2025 to support the delivery of increased assessments in Haringey.

Role	Band	WTE
Clinical Psychologist	7	0.6
NDD Care Coordinator	6	0.5
Assistant Psychologist	5	1.00

The non-recurrent funding for 24/25 will be deployed to increase the backlog clearance for an additional 50 young people from Haringey. Due to the late notification of funds, the impact of the additional NCL funding has not yet been seen. For the purpose of this paper we will focus on the activity associated with core funding and the Elective Recovery Fund.

The Hertfordshire contract is currently under review with Herts ICB. The contract value is at significant variance when compared to the current demand and discussions are taking place with the Commissioners for a single non recurrent fund of £200K to reduce the waiting list and ongoing discussions about contract viability if increased recurrent funding is not available.

3. Waiting Times

As part of the Trust assurance process, waiting times and waiting lists in the Autism Assessment Pathway for both first appointment and for assessment are reviewed weekly. Waiting Times is where the most significant improvement is seen.

In May 2024 patients seen for assessment from Haringey had waited an average of 18 months (78 weeks) for assessment and from Hertfordshire, 2.5 years (130 weeks). With a contractual capacity for 16 assessments a year for Hertfordshire, without additional investment the exponential increase in waiting times for Hertfordshire was predicted to be 532 patients waiting an average of 25 years by 2029.

Following service improvement and increased funding, a total of 168 assessments have been delivered in the same period, with the result that there are currently 333 young people on the waiting list at November 2024, 99 have waited more than 52 weeks for assessment, 76 of whom are from Hertfordshire. The average waiting time for assessment for Haringey is reduced to 49 weeks and for Hertfordshire to 98 weeks.

In the same period 200 new referrals were received. The variance between the total number of patients waiting, referrals and assessment completed is due to waiting list management and young people being removed from the list when they no longer required a service.

4. Risk

All previous Clinical Risks related to the Autism Assessment pathway have been amalgamated into a single risk 032 at a risk score of 16.

RISK 032	If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services. There is risk of Clinical Harm to the young person who needs a diagnosis and pressure on local CAMHS services that may be unable to fully meet the young person's needs	16

In addition to the overall clinical risk over the last 4 years there have been two patient safety incidents relating to the unexpected deaths of young people whilst on the waiting list.

Throughout 2024 a comprehensive risk mitigation plan has been put in place alongside improvement planning via Kaizen methodology. Although significant improvement has been made, the detail of which will follow in this report, the leadership team and clinical team have elected to retain the risk at 16 throughout the year due to the ongoing potential for clinical harm, despite measures being taken.

The second risk the pathway relates to is BAF Risk 13

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

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)								
Executive Lead	Clare Scott Chief Nursing Officer														Original Assessment Date	20th June 2024
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	L3 x C4 12	L3 x C4 12	L3 x C4 12		Date of Last Review	December 2024
Risk Appetite	Cautious	4	4	16	3	4	12	2	4	8	⟷	⟷	⟷		Date of Next Review	February 2025

5. Risk Issues

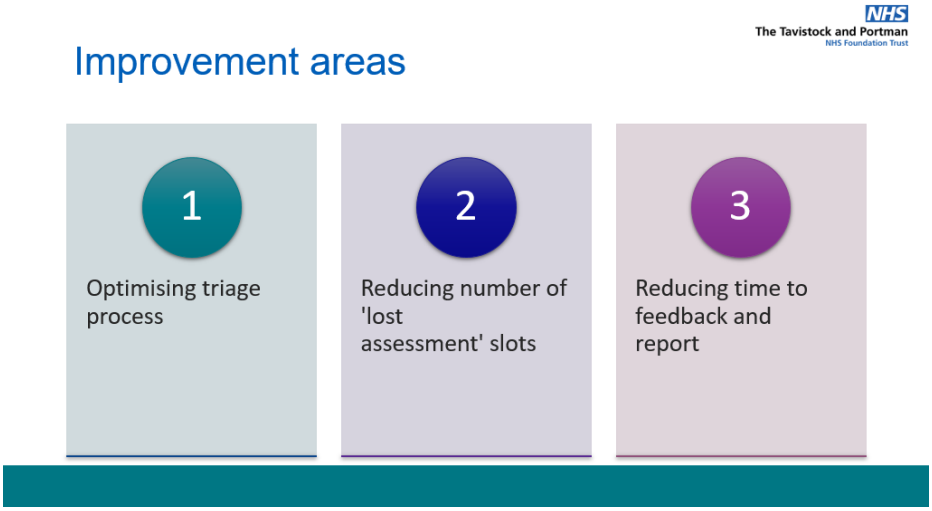
In the spring of 2024, as part of the service improvement plan, the team identified the following risks associated with the growing waiting lists and waiting times.

- **High demand for Autism Assessments had resulted in longer waiting times** and there was a failure to meet the NICE guidance recommendation that assessments should start within 12 weeks of referral.
- **Potential clinical harm resulting from an extended wait for an autism assessment** impacting on the emotional, social and academic well-being of a young person alongside a delay in accessing appropriate support due to the absence of a diagnosis.
- **Failure to meet the 4 week RTT target for first appointment**. In March 2023, in response to increasing demands for care coordination associated with the increased caseload, The Complex Leadership Team made a decision to reduce pre assessment activity which typically took the form of a triage contact with all young people referred to the service. It was hoped that the reduction in triage activity would maintain the capacity for assessments.
- The reduction meant that those RAG rated as green (low risk) following a paper triage would not receive a personalised contact but those presenting with higher complexity or risk (rated amber or red) continued to receive a full first assessment to determine risk and acuity.
- Mitigations were in place to manage emerging risk, including clear documentation and guidance to CYP and their families, as to how to seek support whilst waiting (waiting well) and how to seek support in crisis. The service also required a core CAMHS team to remain involved in a young person's care whilst on the assessment waiting list.
- **By September 2024 the service was reporting 97 patients in the assessment pathway breaching 1st appointment RTT at 52+ weeks**. This wait potentially impacted on patient experience, as these young people had not received individualised contact from the service and the team could not assured as to the risk status of these young people. As a result the team no longer felt it was viable to not offer individualised contact to all young people.
- **The long waiting lists, meant that the risk profile of cases requiring prioritisation was increasing**, which in turn increased the waiting time for those who were not prioritised and led to potential equalities issues in the process.

6. Mitigations and Improvement Planning

To address the complex challenges the increased referrals for assessment presented, the service was identified as a priority area for improvement using A3 QI improvement methodology, aligned to the Trust Strategic aim of improving waiting times. From February 2024 onwards the teams engaged in an improvement process that included appreciative inquiry followed by the Kaizen A3 process for service improvement.

The agreed aims for the Kaizen process which the service felt would have the most impact on waiting times reduction were:



Improvement Area 1 Optimising The Triage Process
Target Resuming Triage of all cases referred within 4 weeks of referral.

Based on an assessment of clinical acuity, 11% of all cases were rag rated Red or Amber, indicting significant complexity with associated clinical risk. 44% were rag rated yellow and 45% were rag rated green. Based on individualised contact being made with only red or amber cases, the team were triaging approximately 13 out of 21 cases a month and required additional clinical capacity to triage all 21.

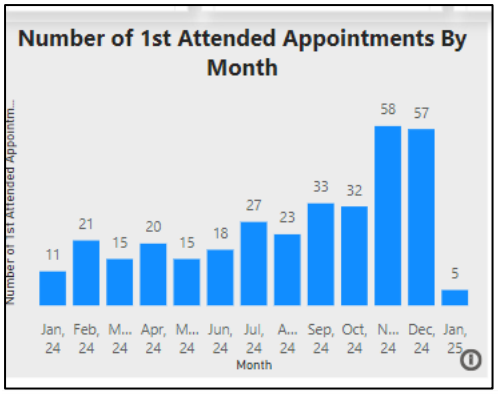
To enable this the team redefined the initial assessment process and pathway and the function of the contact, adopting a single session approach ensuring that contact was meaningful for the young person and their family. Enhanced risk assessment has improved the clinical content of the appointment.

Additional resource and leadership has been achieved by the creation of a new nursing role and the allocation of triage activity to this role and the assistant psychologists with oversight from the Team Clinical Lead.

The introduction of a first appointment clinic booked in by the administrators, who also ensure that DNA's and cancellations are mitigated by offering out appointments to other patients.

The table below indicated the increased number of first appointments now being delivered with an increase from 11 in January 2024 to 58 in October 2024.

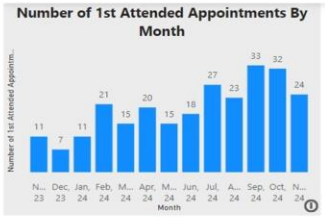
The outcome of these initiatives is that the waiting time for first appointment has come down from 49 weeks to 18 weeks and is on course to meet the four-week target by the end of 24/25.



A second target was set in November 2024 to eliminate all patients waiting more than 52 weeks for first appointment by March 2025. 97 cases were breaching at 52 weeks plus for first appointment. By reviewed job planned activity and using the newly created triage clinics. At December end 2024, the number of young people waiting 52+ weeks for 1st appointment has reduced to 26 patients.

NHS
The Tavistock and Portman
NHS Foundation Trust

4 week wait time target First Appointment – Waiting Times [Patients seen)



1st Appt	M1	M2	M3	M4	M5	M6	M7
Herts	6.4	7.9	11	29.67	3.09	7.38	4.77
Haringey	17.6	3.75	26.7	27.43	15.27	19.24	16.42
Service Total	**12**	**5.825**	**18.85**	**28.55**	**9.18**	**13.31**	**10.595**

Analysis/ Issues:
Sustained intervention in the Triage clinic is beginning to show impact on waiting times for first appointment with an overall average waiting time of 10.5 weeks for first appointment at Month 7.

Plan:

Allocate 12 new cases a month plus 12 legacy cases a month to clear backlog. Will achieve elimination of all 52 week waiters by March 2025. Team endeavouring to overperform on target .

Improvement Area 2 **Reduce the number of lost assessment slots through DNA's and Cancellations**
Target **Achieve 5% DNA from an average baseline of 8%**

In this regard we continue to see seasonal variation with DNA's increasing in the holiday periods and have implemented a process for contacting patients at short notice to fill cancellation slots.

The table indicates this remains an improvement area for the team until March 2025.

Improvement area 3 **Reduce the time a young person spends on the assessment pathway enabling clinicians to increase the number of young people assessed**.
Target **To reduce from 15 weeks to 8 weeks on pathway.**

The team identified that their patients waited up to 50% longer to get through their assessment than required, negatively impacting their experience and impacting on service capacity through a variety of wastes associated with holding a larger active caseload and by taking 28 hours + per assessment per qualified clinician.

The baseline was an average of 15 weeks on the assessment pathway and a target set to 8 weeks by March 2025. This would also include a reduction in time spent writing reports which accounts for 50% of assessment activity.

Through the improvement planning process and aligned to an agreed approach within the NCL, the time spent in assessment has been reduced to 11 hours for qualified clinicians and 11 hours for report writing by other members of the assessment MDT.

Following the implementation of change ideas seeking to optimise the existing pathway, from January 2025 the number of assessment slots that will be offered with the existing team will increase from 34 a year to 54 a year. Early indications are that the time spent on pathway has already been reduced to an average of 9 weeks and the BAU team have already carried out 32 assessments at Month 8 suggesting a 16% in activity before the new roles have been implemented.

6. Implementation of increased investment

As part of the improvement plan, the Elective Recovery Funds (ERF) were allocated to develop a team dedicated to Autism Assessments that would run from April 2024 to March 2025. The team have been used to pilot new pathway approaches that are efficient and aligned to the NCL's ambitions for improved assessment pathways. The team deploys a constant PDSA process which enables them to make changes as lessons emerge.

They are required to deliver 185 additional autism assessments in the year.

At month 8 end the team had delivered 136 Autism Assessments and are on track to deliver 175 by the end of April. Not all posts were recruited to at the start of the project, which means that two clinicians will remain with the project for a further 6 months delivering approximately 10 assessments a month which means the predicted outcome of the increased assessment will be 217 additional assessments delivered.

The impact of the ERF at month 8 end has been as follows :

- The overall waiting list was 333 cases waiting at the end of November 2024. As anticipated, referrals continued to be made at the same rate as the previous year and overall numbers of patients waiting has not significantly reduced with some seasonal and in month adjustments appearing.

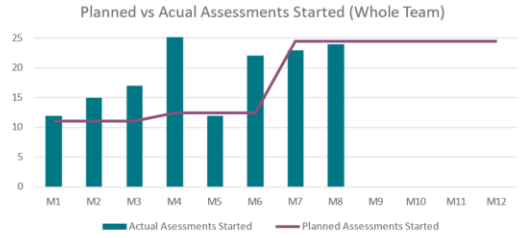
- However the waiting time for assessment (patients seen) in Haringey is now 48 weeks and for Hertfordshire is 97 weeks. A 31% decrease in waiting times.

The data below illustrates the monthly improvement we have seen via the ERF project and the activity. The monthly variation in waiting times for patients seen is explained by prioritisation of patients due to legal status and risk which means the waiting times of patients allocated is not always linear.

EXCELLENCE FOR SERVICE USERS – OPERATIONAL PERFORMANCE

Number of assessments started in month – ERF and BAU against target .

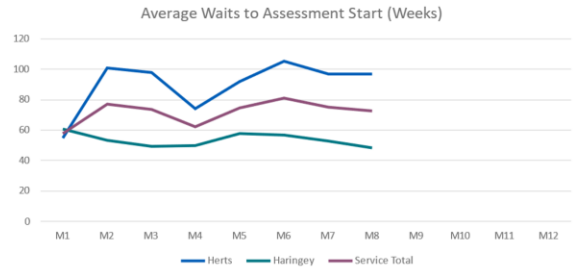
The Tavistock and Portman



Analysis/ Issues:
BAU : High level of unplanned sickness absence has impacted on BAU team ability to deliver assessments. With team commencing 2 assessments against a trajectory of 5.
ERF – 21 Assessments delivered in November 2024.
Haringey waiting time to assessment at 48.46 weeks.

Assessment Start	M1	M2	M3	M4	M5	M6	M7	M8
Herts	54.86	100.62	97.94	74.21	91.68	105.29	97.11	97.11
Haringey	60.65	53.31	49.33	49.92	57.95	56.72	52.94	48.46
Service Total	**57.755**	**76.965**	**73.635**	**62.065**	**74.815**	**81.005**	**75.025**	**72.785**

	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Haringey BAU	0	3	1	2	1	x	0	1	
Herts BAU	1	1	5	0	1	x	3	1	
Haringey ERF	9	9	7	14	5	17	10	21	
Herts ERF	2	3	2	10	5	1	7 (+3)	1	



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7. Additional improvement planning

The allocation of £153,149 additional funds from the NCL ICB have allowed for the substantive recruitment of clinicians and a care co-ordinator to support increased assessment activity following the closure of the ERF project in April. These new clinicians will support the introduction of the new NCL clinical model into the Business as Usual team which will allow for an additional increase in clinical activity which we anticipate to work towards the NCL target of 8 assessments per WTE per month.

Non recurrent funds will be deployed to support the reduction of 50 assessment cases from Haringey which will further reduce waiting times across the NCL.

We have been in discussions with the Hertfordshire Commissioners re a waiting list recovery and increased investment and the viability of the contract.

8. Conclusion

Referrals into the Autism Assessment pathway have increased by 495% since 2019 and referral rates for 24/25 are aligned to the previous year.

Through the implementation of A3 Quality Improvement initiatives the business as usual team has redesigned its clinical pathways to optimise resources without impacting on patient care. They are on trajectory to deliver a 16% increase in activity before additional investment is taken into account.

Non recurrent additional investment has enabled waiting times improvement and the stabilisation of the waiting list. Waiting times (patients seen) overall have reduced by 31%.

However overall referrals into the service have not declined and the waiting list has stabilised. Without additional sustained investment into 25/26 the waiting list and waiting times will revert back to previous numbers and will increase again.

The Hertfordshire contract carries particular risk due to investment levels and referral numbers.

Clinical risk for patients on the waiting list should be considered. With individual caseloads at 60+ patients for clinical staff it is not possible to review the patients with a frequency that assures risk management within the current structure.

In light of this a care of waiters protocol is planned for the Clinical Service Delivery Board in the New year for approval and which will provide a comprehensive process for the care of young people who are waiting for an Autism Assessment.

Appendix 1:
Autism A3 Kaizen work

Step 1: Problem Statement (Missed Appointments)

Around 14-20% of missed assessment appointments impact on patient satisfaction, trust in the service, waiting times, efficient use of clinician's and administration time, loss of revenue and patient and clinician's wellbeing.

Step 2: Current Situation

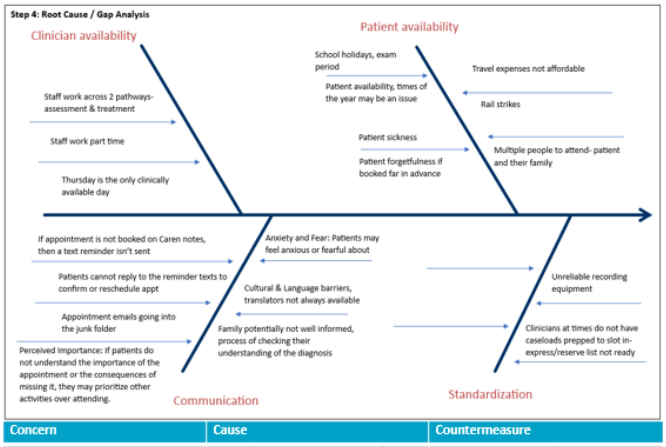
- There are 2 clinicians allocated to each case- Assessment Lead & ADOS Clinician. Clinicians contact families to book appointments.
- Post triage, a first initial family meeting takes place followed by a neuro development interview.
- This is followed by an ADOS assessment which take 60-120 mins after which a detailed report is written, and a feedback meeting takes place with the patient and their family.
- If the patient DNA's, the ADOS, the clinician telephones the patient and the rebooks them for the next cycle of ADOS appointments.
- A text reminder is sent 1 day before the appointment.
- The text reminder is only sent if the Clinician add the appointment on Carenotes prior to the appointment. But often, the appointment is added to Carenotes after the appointment and so the appt text reminder is not sent to the patient.
- If the Clinician cannot get hold of the patient to rebook them after a DNA, there is a n opt-in process. The opt-in letter has a 14-day window in which the patient can be contact the team to be rebooked. If there is no contact from the patient in this period, the Clinician can discharge them. If the patient gets in touch after the 14-day period, their case can be re-opened within 3 months without re-referral.
- At present due to long waiting times, after triage, the family meeting is taking place 3 years since the patient has been referred for Hertfordshire clients. For Haringey clients, the wait is around 1 year from the point of referral.

Step 3: Vision & Goals

Increase service satisfaction, clinician wellbeing and the provision of quality of care.

- Reducing DNAs, missed appointments and late cancellations
- Quality of service could be more efficient with aim to reduce DNAs to 5-7% and meet the Trust target of 10% DNA rate

Step 4: Root Cause / Gap Analysis



Concern	Cause	Countermeasure
When there is a late patient cancellation, another pt from the waiting list cannot be booked due to other cases not being prepared in advance.	There isn't a system in place to have a few cases prepped so that a second pt can be booked at short notice.	To have a process in place for there to be a patient reserve list and for these patients to know they are on this list and may be invited to come in at short notice.
There are some communication challenges with the text messaging system	-Text messages are not sent if appts are not booked in advance of the appt -Text reminders are currently only sent a day in advance - Pts cannot respond to texts to confirm attendance	Text messages to be sent a few times prior to the appt and to work with informatics to enable pts to confirm attendance All clinicians to book appts on carenotes weeks prior to the appt.
We have narrative reasons for pt DNA and cancellations, but no quantitative data is being reviewed.	Currently there isn't any data being reviewed to understand reasons for missed apps	APs to conduct an audit to include quantitative and qualitative data for DNA and cancellations

Step 1: Problem Statement (Triage Process)

Inefficiencies within the triage process e.g. scheduling, logistics and administration are leading to patients being delayed in getting their first appointment, which is impacting on patient and staff experience.

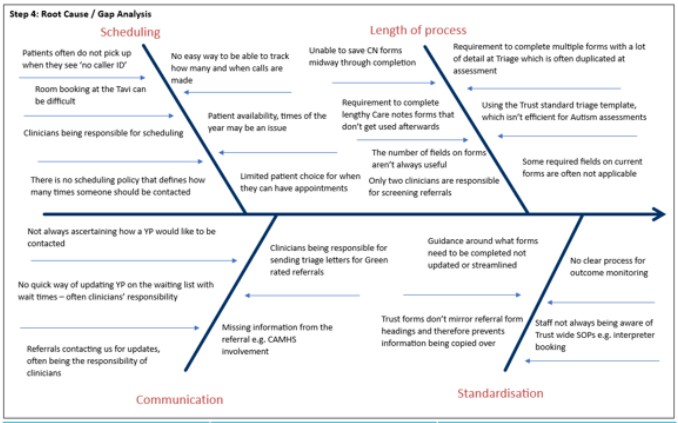
- **Step 2: Current Situation**

- Referrals comes in and is screened/reviewed → Decision is made on whether to accept → Admin are informed of the decision → admin allocate to next available clinician to take on case → appt. scheduled by clinician.
- The breach time for contact is 4 weeks from referral to acceptance/non-acceptance
- Myooran and Roupen use a RAG rating system to work out risk for each referral this rating determines whether a patient goes straight onto the waiting list (Green) or attends a triage appointment (Amber or Red). For green risk rated patients they are automatically added to the waiting list and information about their care and explanation of process is sent. Once a case has been triaged clinical responsibility is held by the Trust.
- Current demand is 21.5 referrals a month, with approx. 12 cases needing triage per month. Current job plans allow 4 hours per triage + an additional 4 hours for risk management/liaison = one triage per month.
- The average acceptance rate for referral is 96.29%. Based on an average from Q1 2023 to Q4 2023. Factors that hinder acceptance are risk and comms issues with referrers.
- If it is decided that a patient needs a triage appointment the assigned clinician will get in touch with the family to confirm the appointment.
  - The young person & family are seen via Zoom / in person / by telephone – depending on preference
  - The young person and family can either be seen together or separately or both.
- After triage the clinician needs to fill out the following required forms:
  - Care notes: Assessment forms, risk assessment, RAG rating, physical health and CGAS.
  - Triage Letter: clinical info, process of waitlist, rss. of support and signposting
- There is a triage guide for clinicians to help them with triage, although the use of this is inconsistent.
- When surveyed staff commented that the triage process can take between 4-8 hours.
- If a call or query arises from a YP on the waiting list it is the responsibility of the Care Coordinator/Clinician to respond to this query.

Step 3: Vision & Goals

1. To create a smoother triage process for staff with less inefficiencies, which will improve the experience for staff and service users.
2. To increase the capacity for other clinician activity
3. To continue to ensure that clarity for patients is upheld meaning that they feel listened to and understood.

Step 4: Root Cause / Gap Analysis



Concern	Cause	Countermeasure
Staff currently feel that they have too many forms to complete at triage, that do not add any value for the patient.	The service is required to complete Trust forms as standard	The team to review all forms currently required to be completed and decide which forms can be removed or streamlined
Staff currently feel that the triage forms they are required to complete contain too much information, which takes too long to complete	The service is required to complete Trust forms as standard	The team to review the current triage form and decide what parts of the form can be removed or streamlined
There is a lack in standardisation across some key processes within the pathway such as letter writing, outcome measures, which leads to some staff using up more time than required	There is no centralised document that contains all required information that new and current staff can refer to when needing guidance on best practice	Create a staff induction booklet to be used as a reference point of good practice to help staff produce in a more standardised way
Patients often lack key pieces of information at acceptance that often leads to them contacting clinicians with queries	At acceptance, patients only receive a limited amount of information, which leads to them getting in contact with the service	Create a suite of comms and FAQ document that admin can use to reduce the need for clinician involvement in queries
Clinicians are responsible for sending out green triage letters that do not require letters to be changed, leading to more time pressure on their workload.	No process for how admin can handle these letters has never been set up or explored	Explore how admin can be solely responsible for sending out Green Triage letters to reduce the admin burden on clinicians
Clinicians are still heavily involved in the appointment booking process, which adds to their workload and limits patient choice in when they can be seen.	No process for how admin can book appointments has never been set up or explored	Pilot a new booking process within the service that makes admin responsible for booking appointments, if successful roll out across the service

Step 1: Problem Statement

Our patients wait up to 50% longer to get through their assessment than they otherwise might, negatively impacting their experience and impacting service capacity through a variety of wastes associated with holding a larger active caseload.

Step 2: Current Situation

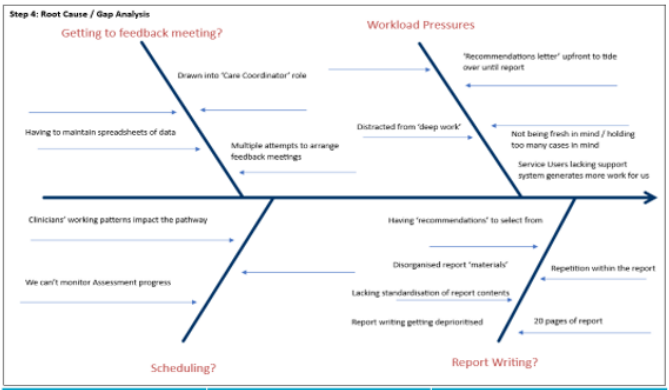
- Currently don't always have the right info to proceed so have to email
- The 'materials' of report production are not as orderly as could be
- The length / quality of the report is arguably too high / beyond needs
- CbP and DNA causes some waste (PARKED FOR OTHER GROUP)
- There are multiple contributors (MDT approach) to each report
- Sometimes the first assessment is the first time they come in
- Sometimes we need to do work to 'tide them over until the report'
- Some key people / assessment leads are very part time
- Sometimes the scheduling of assessment clinics can be burdensome
- Sometimes a lack of report impacts readiness for post-diagno. group
- Hard to 'protect' time for report completion / it's easy to deprioritize
- There is no reporting / monitoring metric for counting assessments
- Task switching to 'triage' is disruptive and prevents report writing
- Sometimes booking via phone calls can be beneficial
- Assessment pathway meetings use a good chunk of valuable time
- Admin aren't always able to respond to patients re waiting times

Step 3: Vision & Goals

To improve patient and family experience by maintaining an optimal pathway length, where newly available monitoring data informs a needs-driven approach to assessment prioritisation and scheduling, allowing for a more bespoke experience where an increasingly standardised approach won't work.

This will be evidence by higher user satisfaction metrics, a decreasing / stable pathway length (average weeks in assessment) near to the defined optimal length, and reports of greater staff satisfaction with the process.

Step 4: Root Cause / Gap Analysis



Concern	Cause	Countermeasure
Assessment Lead capacity (the bottleneck)	Triage and other distractions limit our bottle Assessment Lead capacity / delays reports	Review current triages that go to the assessment leads Reduce Assessment Lead triages to only those most complex cases
Scheduling	Scheduling of appointments drains clinical time while adding little 'value' beyond initial call	Liaise with teams already running a 'clinic booking model' Draft SOP and trial a 'clinic booking model' where admin book
Roles & responsibilities	Admin not always sufficiently empowered to handle enquiries themselves / overburdened	Review admin pressures including quality team and OM tasks Reduce admin workload + reduce escalations to team (e.g. parking)
Report 'Quality' / scope	Long report and it's questionable whether everything is always required	Explore whether ADOS must be a standard component for all Trial and iterate the new assessment report template
Lack of standardisation	Waiting times queries handled ad hoc and all letters manually compiled each time	Establish a standardised response to waiting times queries Introduce template letters for all correspondence
Shared drive orderliness	Need to consider how current drive / report components could be made more efficient	Compare new and old shared drives and improve
Monitoring	Lack of Carenotes reports to monitor progress and reliance on Excel trackers	Survey service users regarding what they think of our reports Establish service specific appointment types on CN for tracking

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – 16 January 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	7 November 2024	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 016**		

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 committee looked at the BAF risk around capacity and capability of managers	**Assurance rating**
1. BAF Risk 6 • The Committee looked at BAF Risk 6 (workforce development and retention). Overall conclusions: – We have made strides as an organisation to improve what we do around development, recruitment and retention e.g. development for leaders, managers and admin teams; more trained inclusive recruitment advisors; a new CPD panel and Recruitment and retention committee. – This is a complex cross organisation risk with many strands. More work is needed to improve on where we are now. – Some of our data (e.g. low sickness rates) is at odds with the extent of the challenges being raised – meaning that we may not understand exactly what the risk is here for T&P and may not be addressing the real risk effectively.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Workforce Metrics • Particular discussion was around MAST and appraisals. • We are not meeting our trust wide targets	Limited ☐ Partial ☒

• There are a number of factors, many of which are known to the committee, including the lack of accuracy of the numbers for appraisal completion • MAST has a direct implication for patient safety – the committee questioned whether we can appeal to people on this basis • A paper is to come back to POD EDI at the end of the financial year on the action plan for appraisals and MAST, and the impact of the actions we are taking.	Adequate ☐ N/A ☐
3. Culture and Values Work • There was a strong story about the collaborative work being done across the organisation to produce will and won't do actions for each of the Trust values. • The language uses "I" statements • Several staff sessions have been held with more to come to gather ideas, develop and test out the wording and refine.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. EDI Programme Board • POD EDI noted the assurance from EDI Programme Board on the work being done on the Trust's desired future state re EDI and the "I" statements around EDI to complement the "I" statements in the values work. • EDI Programme Board reported that every person in the group has taken on actions and work, a good example of the EDI work being shared out and not falling solely on the EDI team.	
5. Supporting Middle Managers • There was a helpful paper on middle managers written by Thanda based on his PhD research, and a few key recommendations for supporting this group: – More development as managers – Clarity on their role, both as a manager and as a leader – Sound promotion prospects and pipeline • The committee discussed where we are with these, and the support needed for middle managers (coaching and mentoring) from their own managers. • It was felt that we are at the start of this journey and a further paper is to come to POD EDI refining the approach and actions to support middle managers based on the POD EDI discussion.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
6. Reflections • This was an exceptionally full and committed meeting • The meeting has been helpful in terms of the EDI involvement.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Summary of Decisions made by the Committee:	
The revised terms of reference were approved.	

Risks Identified by the Committee during the meeting:

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

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

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

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

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS ON 16TH JANUARY 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	14th January 2025	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	n/a		**Agenda Item: 017**		

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. Merger Update The CETO has now met with relevant colleagues at CNWL to prepare the ground for a possible merger within the next 18 months. Primary areas of discussion include securing ongoing OfS registration, ensuring staff retention, and future relationships with University partners. CETO was extremely impressed with the thoughtfulness and respect for Tavistock and Portman's E&T work from CNWL but aware that we need to be the ones to provide clear direction about OfS and HE arrangements throughout.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Success Stories 2.1. Student recruitment to our long courses (degree-awarding programmes) has increased by over £600,000 this year, including a 29% increase in overseas student enrolment (from 94 in 23/24 to 121 in 24/25) which is a huge testament to the work completed by all our DET staff in marketing and advertising our programmes internationally. A slight fall of 8% in our home enrolments is less promising but in line with sector performance. We are optimistic that an earlier opening date for applications for 25/26 will further increase accessibility of our courses for overseas applicants who require additional time for visa and accommodation arrangements, and also potentially address the decline in our home applicants. 2.2. Ms Shantel Thomas, leader of our M23 MSc social work and her Anti-Racist Movement (ARM) team were nominated for a Social Justice award by the Social Worker of the Year board in August and I was delighted to note that they were successful in winning this award in the November event. This is a high-profile national event with award winners invited to a reception in Parliament. Very well done to Shantel and her colleagues for their groundbreaking work in this area.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

2.3. A second trade mission to China took place in October with Ravteg Singh Dhesi and Paul Dugmore, participating in the Department of Business and Trade (DBT) mission in Hangzhou, Wuhan and Chongqing. This included engaging with key Chinese healthcare authorities, top medical universities, leading public hospitals, private medical institutions, 8 mental health departments/clinics and taking part in Conferences, networking receptions, business matchmaking and roundtable meetings. One contact from the mission has already undertaken a further return visit to the Tavistock.	
3. Challenge Areas Space utilisation across the Tavistock and Portman HQ remains problematic with several instances of confusion arising during Semester 1 impacting DET adversely. The long-term plan is to address this via a Kaizen ('positive change') but in the interim a bigger audit of processes and utilisation is being conducted to report to ELT by January 20th. At that point a timetable for further work will be decided.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Ongoing Work of Note 4.1. The consultation event on the use of the tile 'Associate Lecturer' resulted in no concerns that would prevent the change going forward so over the next year all Associate Lecturers will be moved to either Lecturer or Senior Lecturer (module or course leadership) titles and new job advertisements will make use of this terminology.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- Next Committee is 25/02/25.

Risks Identified by the Committee during the meeting:

- BAF adequately reflects the risks facing the Education and Training Directorate.

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

n/a,

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

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS ON 16TH JANUARY 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	19th Dec 2024	Aruna Mehta, Non-Executive Director	Rod Booth, DSBD and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 018**		

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**
• **Financial And Commercial Plan Update** • Update presented by CFO/DSBD, covering in year position, Medium Term Financial Plan (MTFP) update, and the supporting Commercial Plan. • The committee received a detailed explanation of the deterioration of the in-year position relating to the unfunded pay award and the agreed recovery actions being taken to the year end. The additional risk relating to cash flow to be added to the BAF separately. • The previously agreed MTFP update was discussed, with the scale of the income element of the plan being highlighted and the impact on cost reductions if not wholly achieved. It was agreed that further detail relating to the baseline assumptions (including the unconfirmed deficit funding supporting the merger), and a risk assessment to be added to the plan. • In addition, a separate note relating to potential transaction costs to be added, recognising these are assumed to be separately funded and will probably fall into CNWLs position. • Committee received an update on the commercial plan development, with the supporting breakdown of the income opportunities being pursued as part of the MTFP. • It was agreed that all Trust income / contracts would be risk assessed for 2025-26 and brought back to the next meeting.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
1. Estates Business Continuity Plan • Committee received the plan, in the standard NHS format, including action cards. • It was noted that the plan will be updated when the outcome of the after-action review, relating to the recent water outage, is concluded. • Likely outcomes will include: i. Updated action cards for specific scenarios (water, electricity, gas, flood) to be developed and included in the Directors on call information.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

ii. Plans to be tested with Execs via desk top exercises on a regular basis. iii. Updated communications to be developed as part of the action learning. • Committee asked if Internal Audit could be used to assure updated plans.	
2. IM&T Strategy Update • The Director of Infrastructure presented the updated draft of the IM&T Strategy. • It was agreed that a section for the metrics to track business as usual activity to be added, with a more detailed view of the likely merger impact. • A shortened version with the two additions above to be presented to Board for approval.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Escalation • None identified	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- Additional cashflow risk to be added to the BAF.

Risks Identified by the Committee during the meeting:

- Risks to cash and reported deficit position at the year end.
- Unconfirmed merger deficit funding.
- Additional income and cost reductions underpinning the MTFP.

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

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

Item	Purpose	Date
None		

The Tavistock and Portman
NHS Foundation Trust

Board of Directors (Public) – 16th January 2025			
Report Title: Finance Report – As at 30th November 24 (Reporting Month 08)			**Agenda No. 019**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	N/A		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 08 (cumulative position to the 30th November 24) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £2,296k in the period, against the plan of £1,556k, a negative variance of £740k. This is a worsening of the position from month 07 by £66k but in line with the expected position. The Trust has submitted a revised forecast outturn of c.£3.5m deficit, being unable to achieve its year-end deficit plan of £2,200k. This deterioration in the reported position and the forecast outturn is due to the funding gap relating to the 24/25 pay award. At the time of writing the extent of the pay award risk has now been moderated to £1.1m from the original estimated gap of £1.3m. Because of the deterioration of the forecast the Trust has been asked to take a series of recovery actions to the year end to reduce the projected deficit as much as possible, this includes restrictions on appointments to the year end to only essential posts and maximizing the impact of any non-recurrent opportunities. The pay award deficit is due to the additional cost of the recently announced pay award not being matched by additional income across all sources in the baseline plan for 24/25. In previous years all of the funding for the pay award flowed from NHSE via NCL. The Trust continues therefore, to try to secure additional funding from its various commissioners as part of the actions to mitigate the increase in the in-year deficit. **Capital Expenditure** To date capital spend to date is £1,381k, £237k ahead of the planned spend to date of £1,144k. This reflects the expected catch up of spend from previous months with the anticipated expenditure at the year-end expected to be on the revised plan (including the additional capital allocation of £268k) at £2,468k. Note the additional agreed capital spend is not reflected in the target on the monthly returns and hence will show a year end variance of £268k. **Cash** The cash balance at the end of M08 was £702k against the planned balance of £1,850k. This reflects the ongoing cash deficit caused by the unfunded pay award and timing differences of receipts against payments.		
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 was 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. **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):	For information.

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 9: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams**		

	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.			
Resource Implications:	Yes ☐		No ☒	
	There are no resource implications associated with this report.			
Diversity, Equality and Inclusion (DEI) implications:	Yes ☐		No ☒	
	There are no DEI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	ELT, PFRC and Board of Directors.			
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 PUBLIC BOARD OF DIRECTORS ON THE 16TH JANUARY 2025			
Report Title: Public Board of Directors Annual Schedule of Business 2024/25			**Agenda No.: 024**
Report Author and Job Title:	Asma Bi Committee Secretary	**Lead Executive Director** Michael Holland, CEO	John Lawlor, Trust Chair
Appendices:	Appendix 1: Public Board of Directors Annual Schedule of Business 2024/25		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report provides the Board Schedule of Business for 2024/25 (attached as Appendix 1) for information.		
Background:	It is good corporate governance practice for Board to agree a forward plan of its activities ahead of the new financial year and in line with the terms of reference.		
Assessment:	There have been no updates to the Schedule of Business since the last meeting.		
Key recommendation(s):	The Committee is asked to **NOTE** the latest version of the Board Schedule of Business for 2024/25.		
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 received by the Committee. There are no BAF risks associated with this paper.				
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:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2024					2025			Board / Committee / Meeting	
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**09-May**	**11-Jul**	**12-Sep**	**14-Nov**	**16-Jan**	**13-Mar**				
Paper Deadline			**25-Apr**	**27-Jun**	**29-Aug**	**31-Oct**	**02-Jan**	**27-Feb**				
Standard monthly meeting requirements												
Opening / Standing Items (every meeting)												
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/ C	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Closing Matters (every meeting)												
Annual Board Schedule of Business (For approval in May 24)	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Bi-monthly (6)												
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			High Quality Clinical Services	Bi-monthly
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Develop & Deliver a Strategy & Financial Plan	Bi-monthly
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Bi-monthly
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly
Integrated Governance Action Plan Report	Assurance	CEO		P	P	P	P	P	Audit Committee		Well-led & Effectively Governed	Bi-monthly
Quarterly (3 - 4)												
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDOCG	P			P	P	P			Well-led & Effectively Governed	Quarterly
Audit Committee Chair's Assurance Report	Assurance	NED		P			P	P			Well-led & Effectively Governed	Quarterly
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Great & Safe Place to Work, Train & learn	Quarterly
Guardian of Safer Working Report	Information	ICMO			P		P	P			High Quality Clinical Services	Quarterly
Six-monthly (2)												
Mortality / Learning from Deaths	Assurance	ICMO			D	P		P			High Quality Clinical Services	6 monthly
Annual (1)												
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (Audit; POD EDI; ETC; PFR; Quality; EA&R)	Discussion	Chair		P							Well-led & Effectively Governed	Annual
Review of Committee Terms of Reference	Approval	Chair				P					Well-led & Effectively Governed	Annual
Medical Revalidation	Discussion	ICMO				P					Great & Safe Place to Work,	Annual
Freedom to Speak Up Guardian Annual report	Discussion	IDOCG			D				POD EDI		Great & Safe Place to Work,	Annual
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Prepardness, Resilence and Response (EPRR)	Discussion	ICNO					P		Audit Committee		Well-led & Effectively Governed	Annual
Quality Priorities 2024-2025	Discussion	ICNO	P						Quality Committee		High Quality Clinical Services	Annual
Staff Survey Results and Action Plan	Discussion	CPO	P				P		POD EDI		Great & Safe Place to Work,	Annual
Workforce Disability Equality Standard (WDES)	Approval	CPO		P					POD EDI		Great & Safe Place to Work,	Annual
Workforce Race Equality Standard (WRES)	Approval	CPO		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual
Gender and Race Pay Gap	Approval	CPO						P	POD EDI		Great & Safe Place to Work,	Annual
Equality, Diversity and Inclusion Annual Report 2023/24 (including Department of Education & Training)	Approval	CPO		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual
Research and Development Annual Report	Discussion	ICMO			P						High Quality Clinical Services	Annual
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		P					Quality Committee		High Quality Clinical Services	Annual
Annual Objectives and Strategic Priorities (Final)	Approval	CEO				P					Corporate Reporting	Annual
Compliance Against Provider Licence	Approval	IDOCG		P					Audit Committee		Well-led & Effectively Governed	Annual
Financial Plan update 2024/25	Approval	CFO	P								Develop & Deliver a Strategy &	Annual
Non-Executive Director Commitments 2025/26 (including Champions and Committee Membership)	Approval	Chair						P			Well-led & Effectively Governed	Annual
Board and Board Committee Meeting Dates 2025/26	Approval	IDOCG		P							Well-led & Effectively Governed	Annual

The Tavistock and Portman NHS Foundation Trust

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Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**09-May**	**11-Jul**	**12-Sep**	**14-Nov**	**16-Jan**	**13-Mar**				
Honorary Doctorate Nominations	Approval	ICETO					P		Education & Training		Great & Safe Place to Work,	Annual
National Annual Patient Survey report (when available)	Discussion	ICNO							Quality Committee		High Quality Clinical Services	Annual
Board Skills Review	Discussion	Chair							RemCo		Well-led & Effectively Governed	Annual
Fit & Proper Persons Test	Discussion	Chair		P					RemCo		Well-led & Effectively Governed	Annual
Board Development Programme	Discussion	Chair			P				RemCo		Well-led & Effectively Governed	Annual
Medium Term Financial Plan update	Approval	CFO	P						Performance, Finance &		Develop & Deliver a Strategy &	Annual
Annual Plan 2025/26	Discussion	CEO						P			Develop & Deliver a Strategy &	Annual
Board Service Visits	Discussion	CEO					P				Well-led & Effectively Governed	Annual
Strategy / Policy Approval/Ratification (usually every 3 years)												
Year 1 (2023/24)												
Modern Slavery Statement	Approval	ICNO									Well-led & Effectively Governed	Annual
Scheme of Delegation	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual
Standing Financial Instructions	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual
People Strategy and Plan	Approval	CPO							POD EDI		Great & Safe Place to Work,	Annual
Staff Engagement Strategy (Internal Communications Strategy)	Approval	DCE		P					POD EDI		Great & Safe Place to Work,	Annual
Year 2 (2024/25)												
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly
Green Plan/ Sustainability Strategy	Approval	CFO			D	P			Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly
External Board Review (once every three years) Report	Discussion	Chair							RemCo		Well-led & Effectively Governed	3 yearly
Year 3 (2025/26)												
Ad hoc/ As Appropriate												
Items to consider - Gloucester House	Approval	ICNO				P					Well-led & Effectively Governed	
Items to consider - Informatics Strategy	Discussion	IM&T				D			Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	
Items to consider - Greater Manchester Review	Discussion	ICNO				P			Quality Committee		High Quality Clinical Services	
Items to consider - Patient Safety	Discussion	ICNO				P			Quality Committee		High Quality Clinical Services	