The Tavistock and Portman NHS Foundation Trust

Meeting Book - Board of Directors - OPEN Meeting

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DATE AND TIME OF NEXT MEETING

024. Thursday 15th May 2025 at 2.00pm – 5.00pm

The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 13th 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 13th MARCH 2025 AT 2.00PM – 5.00PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

25/03	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	Student Presentation: Higher Education Landscape	Discussion	Elisa Reyes-Simpson (Director of Education- Governance & Quality), Ravteg Singh Dhesi Director of Education (Operations)	P	2.05 (20)	
005	Minutes of the Previous Meeting held on 16th January 2025	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 (including Merger update)	Discussion	Chair, Chief Executive Officer	E	2.40 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC AMBITIONS)						
008	Integrated Quality and Performance Report (IQPR) Including update on risk areas/ areas in structural support	Discussion	Chief Medical Officer, Chief Nursing Officer	E	2.50 (20)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Integrated Audit and Governance Committee Assurance Report	Assurance	IAGC Committee Chair	E	3.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

010	Freedom to Speak Up Guardian Annual Report	Discussion	Freedom to Speak Up Guardian	E	3.15 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
Comfort Break (10 minutes) 3.25pm – 3.35pm						
PROVIDING OUTSTANDING PATIENT CARE						
011	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.35 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
012	Patient and Public Involvement (PPI) Annual Plan	Discussion	Chief Nursing Officer	E	3.40 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
DEVELOPING PARTNERSHIPS TO IMPROVE POPULATION HEALTH and building on our reputation for innovation and research in this area						
013	Patient and Carer Race Equality Framework (PCREF) Update	Discussion	Chief Medical Officer	E	3.50 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
014	Performance, Finance and Resources Committee (PFRC) Assurance Report	Assurance	PFR Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
015	Finance Report: Month 10 (verbal update on Month 11)	Information	Interim Chief Finance Officer	E	4.10 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
016	Financial Plan 2025/26	Discussion	Interim Chief Finance Officer	E	4.15 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
017	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
018	Education and Training Committee Assurance Report	Assurance	E&T Committee Chair	E	4.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
CLOSING ITEMS						

019	Annual Schedule of Business 2025/26	For Approval	Chair	E	4.35 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
020	Questions from the Governors	Discussion	Chair	V		
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		
DATE AND TIME OF NEXT MEETING						
024	Thursday 15th May 2025 at 2.00pm – 5.00pm					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 03/02/2025)

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
SABRINA PHILLIPS	Associate Non-Executive Director	01 November 2022 (1st Term)	Employed as a Managing Director, adult mental health and learning disability services at Central and North West London NHS FT	04/03/2024	Present	Will withdraw from business decisions in competition with CNWL
			Closed Interests			
			Employed by the Lambeth Living Well Network Alliance as Service Director (The alliance is a partnership of 5 organisations SLaM, SEL ICS (Lambeth),Lambeth ASC,Certitude, Thamesreach) - I was seconded out to the Alliance from SLaM (4) Interim Deputy Chief Operating Officer at SLaM	01/01/2020 20/09/2023	03/03/2024 03/03/2024	No perceived conflict - Will withdraw from any business in relation to the Alliance and SLaM.
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
			Trustee Laurel Trust (Charity working in partnership with schools)	09/12/2024	Present	No perceived conflict
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.

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid
PETER O'NEILL	Interim Chief Financial Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ROD BOOTH	Director of Strategy, Transformation & Business Development	26 June 2023	NIL RETURN			
JANE MEGGITT	Director of Communications & Engagement	24 April 2023	NIL RETURN			
DOROTHY OTITE	Director of Corporate Governance (Interim)	3 February 2025	NIL RETURN			
LEAVERS (LEFT THE TRUST DURING 2024/25)						
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12/11/2016 - 31/08/2024	NIL RETURN			Sally left the Trust 31st August 2024
ADEWALE KADIRI	Director of Corporate Governance	07/08/2023 - 31/01/2025	Partner is an NHS GP in Ipswich, Suffolk	01/10/2023	31/01/2025	Ade left the Trust on 31st January 2025
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 16th JANUARY 2025 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
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:

Kathy Elliott	Lead Governor	KE
Dorothy Otite	Governance Consultant	DO
Tim Kent	Service Clinical Lead	TK
Nimisha Deakin	Associate Director of Nursing and Patient Experience	ND
Barbara Aste	GIC Service User Representatives	BA
Michael Arhin-Acquaah	Governor & GIC Service User Representatives	MAA
Eleanor Rivers	GIC Service User Representatives	ER
Pauline Williams	Chair Race Equality Network (item 17)	PW
Arpan Walia	Business Manager to CEO & Chair	AW
Reena Bass	Executive Assistant	RB

APOLOGIES:

Chris Abbott	Chief Medical Officer
Sabrina Phillips	Associate Non-Executive Director
Janusz Jankowski	Non-Executive Director
Ken Batty	Non-Executive Director

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair welcomed all attendees, including members of the public joining virtually. Apologies were received from Chris Abbott (Chief Medical Officer), Sabrina Phillips (Associate Medical Executive Director), and two Non-Executive Directors (Janusz Jankowski and Ken Batty). The Chair noted that this would be the last Board meeting for the Director of Corporate Governance, Ade Kadiri and wished AK all the best for his future endeavours on behalf of the Board.	
002	**CONFIRMATION OF QUORACY**	
	The meeting was confirmed to be quorate.	
003	**DECLARATIONS OF INTEREST**	
	No additional declarations of interest were noted beyond those already recorded.	
004	**GIC Service User Feedback**	
	TK, Service Clinical Lead and ND, Associate Director of Nursing and Patient Experience facilitated a discussion between GIC Service Users: BA, MAA and ER to explore their experience with the service and how understand their involvement as service users**.** JL introduced the guests, and each representative provided personal accounts reflecting both positive and challenging aspects of their GIC journeys. BA emphasised the need for increased investment to reduce wait times and called for a trauma-informed approach, particularly for young people transitioning to adult services. She highlighted the value of volunteer-led support programmes to provide peer assistance. MAA stressed the importance of improving external communications between the GIC and local mental health services. He cited examples where trans individuals were refused mental health support due to misperceptions that the GIC should handle all trans-related concerns. He urged better outreach and clearer messaging to partner organisations. ER commented on the NHSE review of GIC services, describing the consultation process as "tokenistic" due to the limited time provided for user feedback. She	

requested increased mental health support for those on long waiting lists and questioned whether a national waiting list would address geographical inequities.

Q&A Discussion:

JL inquired whether the GIC had explored volunteer-led support initiatives. Tim Kent responded that while informal peer support exists, a formal volunteer system could be a valuable addition and is under consideration.

MH asked if the NHS England review outcomes would influence future service improvements. Namisha confirmed that the GIC is working closely with NHS England to incorporate user feedback into future planning and improve communication channels.

A Governor via the virtual chat function, asked about support options for individuals awaiting first appointments. MH confirmed that efforts are underway to establish a structured peer support network and to improve mental health provision during the waiting period.

005 **MINUTES OF THE PREVIOUS MEETING HELD ON 14th November 2024**

The Board approved the minutes of the previous meeting as an accurate record subject to amendments.

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

- Oliver McGowan Training: Clarification was needed on whether the second part of the ICB-led training had been completed. CS and GD were to confirm this and determine whether it should be removed from the Trust's training records. The action would remain open for ongoing review. **CS/ GD**

- Mandatory and Statutory Training (Freedom to Speak Up): This had been presented to the Executive Leadership Team (ELT) for additional input. There was a discussion on the next steps and what further actions the Trust should take. It was agreed that Board members would complete FTSU training and include it as part of the ongoing review. **GD**

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

JL provided a verbal update and highlighted the following:

- He met with Paul Najsarek, Chair of North Central London ICB (NCL ICB), noting that the meeting was positive, and that discussions focused on the proposed CAMHS Provider Collaborative which was aimed at improving community and specialist mental health services. Paul Najsarek expressed support for the collaborative effort between different healthcare providers under

one umbrella highlighting the importance of maintaining local authority involvement.

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

- The Chief Executive (MH) outlined upcoming challenges related to the NHS planning framework, which is expected to impose tighter financial constraints. The Board was informed that the Trust is preparing for a more demanding financial year and is awaiting further guidance from NHS England. MH also highlighted positive developments, including the Fitzjohn's Unit's recent recognition for clinical excellence in supporting patients with complex mental health needs.

- Q&A Discussion:
  CJ asked whether the proposed CAMHS collaborative would directly address current gaps in mental health service provision for young people. JL confirmed that the collaborative aims to streamline care pathways and reduce service fragmentation.

- DL asked how financial constraints might impact patient care delivery. MH acknowledged the pressure but emphasised the Trust commitment to maintaining high-quality care while seeking additional funding from NHS England.

008 **BOARD SERVICE VISITS UPDATE**

AK took the lead on this item.

Board service visits were recognised as essential for triangulating messages, ensuring alignment between leadership and frontline experiences, and fostering a comprehensive understanding of both clinical and corporate environments. However, these visits had not been conducted consistently due to capacity challenges, though efforts were underway to address this. A structured process was being developed, including a planned schedule from April to March with a mix of clinical and corporate visits, including to more remote locations. CJ and SS expressed dissatisfaction with the current arrangements, noting that as Board members, they expected to be more actively engaged through these visits, which was not happening at the time. AK acknowledged these concerns and highlighted ongoing improvements to administrative support and pre-meeting arrangements to enhance the process. There was also an opportunity to strengthen engagement through the Senior Leadership Forum, where Board members could participate alongside new executives and governors to foster better connections and improve visibility.

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

CS took lead on this item and the report was taken as read. The discussion on the Integrated Quality and Performance Report (IQPR) focused on several key areas:

1. **Quality and Operational Work**: The report highlighted ongoing efforts to address waiting times, improve quality, and monitor progress through specific workstreams such as those for autism, gender identity clinics, and trauma services. Trauma services were placed into targeted support due to insufficient improvements following initial interventions.
2. **Patient Safety Incidents**: There was a focus on the increase in reported patient safety incidents, which was considered a positive sign of transparency, though concerns remained around their threshold and classification. Work was ongoing to encourage staff to report incidents more proactively, akin to practices in other sectors like aviation.
3. **Workforce Challenges**: A major concern was low compliance with appraisals and statutory training. New measures were being introduced to address these, including career conversations and better systems for tracking multiple assignments. Although data on appraisals had previously appeared improved, it was revealed that prior figures were inaccurate due to system errors. The current compliance rate stood at 80%, but the issue of multiple roles affecting data accuracy was still under review. AM enquired about Action Plans and Mitigations, GD explained that to address these workforce challenges, a new recruitment and retention group was established. Managers had been urged to allocate protected time for appraisals and training. Further improvements were expected from the introduction of new career conversations, which would provide a more qualitative approach to appraisals.
4. **Feedback and Service User Input**: Efforts to increase patient feedback through QR codes and other methods were discussed. The goal was to enhance feedback frequency and use this input to improve services. Although feedback numbers had not risen significantly, there were signs of positive changes, including more frequent reporting from clinical units.
5. **Audit and Governance**: The meeting also touched on the Audit and Governance Committee's ongoing work, particularly regarding job planning and pre-employment checks. DL and AM noted that there were lingering issues with pre-employment checks, and updates were required on the status of the backlog of student debt and performance from two service providers. The committee was generally satisfied with these services but acknowledged areas for improvement.

Overall, the discussion revolved around improving transparency, reporting accuracy, and addressing both patient safety and workforce compliance issues. There was a concerted effort to involve staff more in reporting and feedback and to ensure that systems for monitoring appraisals and training were more effective moving forward.

The content of the report was noted.

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

DL took the lead on this item and the report was taken as read. DL provided an update, noting that the report was available and the committee was in the middle of preparations for end-of-year activities, including audit work for 2024-25. They were

also set to receive internal audits, as scheduled for the next meeting. A request from the Board regarding committee chairs having input on the audit plan was mentioned, and the process would allow chairs to review the plan after the Executive Leadership Team has reviewed it and before it was finalised.

DL highlighted a few ongoing issues from previous audits, particularly concerning overpayments and underpayments to staff. There had been a request to review controls for payments to visiting lecturers, which was still being monitored. The main discussion revolved around a concerning report from RSM regarding job planning. It was noted that the Trust lacked an adequate job planning system, and while an electronic system was being put in place, the actions required to address the issues identified in the report were expected to be managed once the system was operational. The committee planned to follow up on this in their March meeting.

DL explained that a procedural change in IAGC was introduced, where it was agreed that for any substantial assurance reports in the future, the author of the report should attend the committee to answer questions. This was emphasised as necessary for the committee to properly fulfill its role.

Further discussions in the meeting included concerns about pre-employment checks by AM, which had been flagged as a long-standing issue. The committee agreed to look further into the matter, as it had not been fully resolved despite previous attempts. There was also an update on student debt, with the committee reporting progress in addressing the backlog of historical debt. The new processes had prevented new debts from exceeding 90 days, indicating improvements. Lastly, DL updated that the committee reviewed the performance of two service providers – Internal Auditors and External Auditors, concluding that there were no significant issues and that they were satisfied with the service received.

Q&A Discussion:
AM asked about the timeline for implementing the electronic job planning system. CS estimated that full implementation would be achieved by the next financial quarter.

The content of the report was noted.

011 **BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTER (CRR)**

AK took lead on this item and the report was taken as read.

The Board Assurance Framework (BAF) remained a vital tool in ensuring the Trust's risk management processes were effective, with ongoing collaboration across relevant committees. Two committees recently conducted in-depth reviews of specific risks, resulting in a notable reduction of a quality-related risk rating from 16 to 12. This reduction reflected the successful implementation of targeted actions aimed at mitigating the identified risk. However, it should be noted that the Corporate Risk Register (CRR), which tracks and monitors organisational risks, had not been in place for some time. The risk management team had been working

diligently to rebuild the CRR from scratch. The initial efforts began to show positive results, with the current version starting to resemble a formal and structured risk register. That said, the risks identified within it had yet to be approved, meaning that the register was still in development.

The CRR had not yet been presented to any committees for formal review, though it was set to be reviewed by the Integrated Audit and Governance Committee (IAGC) before being presented to the Quality and Safety Committee (QSC) for further assessment. While there were still steps to be taken in this process, there was confidence that both the BAF and the CRR were progressing in the right direction.

A key area of focus in recent discussions had been the mitigation of high-priority risks, such as those related to the quality of care and environmental sustainability. The effective actions taken contributed to a reduction in the severity of these risks, reflected in lower risk scores. Despite this progress, the Board emphasized the importance of ensuring that senior leadership took a more active role in owning and overseeing the corporate risks, as this would help ensure that all risks were appropriately managed.

Concerns were raised specifically around the presence of unapproved high-risk items in the register, which could pose significant challenges if left unaddressed. As a result, these items were escalated to the Audit and Governance Committee for a more thorough examination and to ensure that the proper actions were taken to mitigate these high risks.

The contents of the report were noted.

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

The QSC Chair (CJ) provided assurance on continued oversight of patient safety issues and operational risks.

Significant discussion centered on the need to encourage a proactive reporting culture for patient safety incidents. The QSC Chair emphasised that the Board should foster a "no-blame" environment to reduce barriers to incident reporting. Additional communication strategies will be implemented to address these concerns. CJ noted that the trauma team's inclusion under targeted support will receive close monitoring.

The contents of the report were noted.

013 **GUARDIAN OF SAFER WORKING HOURS REPORT**

The Chief Nursing Officer (CS) reported adequate compliance with safer working hours standards. No significant concerns were raised.

The contents of the report were noted.

014 **QUALITY AND SAFETY REPORT**

CS took the lead for this item and report was taken as read.

CS explained that the Quality and Safety Report was presented as the first iteration, serving as a supplementary report to the Integrated Quality and Performance Report (IQPR). The report focused on emerging themes and learning across clinical units, including updates on after-action review (AAR) training. Two sets of staff had been trained, and the process was progressing well. A summary update on the Trust's quality priorities was provided, with a more detailed plan scheduled for the next Quality and Safety Committee meeting. Recognition was given to Caroline McKenna, who was retiring, for her substantial contributions to mortality tracking throughout her career.

SS inquired about how patient safety incidents were being reported and monitored, to which CS responded that patient safety incident reporting had been improving. Staff were being encouraged to report potential issues, even if they turned out to be non-events, and efforts were ongoing to improve transparency and foster a culture where reporting near misses was standard practice. DL questioned what was being done to improve patient feedback, and CS explained that QR codes for patient feedback had been rolled out across the Trust. Additionally, the Trust was working to implement text message-based feedback mechanisms. The Board requested a detailed update on patient feedback trends at the next meeting.

The contents of the report were noted.

015 **AUTISM ASSESSMENT UPDATE**

CS took lead for this item and Tina Reed joined in the discussion as well, the report was taken as read:

The discussion centered on the significant work done to address the backlog in autism assessments, particularly for young people in Haringey and Hertfordshire. A quality and safety committee meeting in December highlighted the progress made, with a 31% reduction in waiting times, particularly for Haringey, which saw a drop from 78 weeks to 49 weeks. Despite the improvements, the service continues to receive a high volume of referrals, and the waiting list remains lengthy. Challenges such as non-recurrent funding and the uncertainty of future demand were noted, with the risk rating still remaining at 16 due to these factors.

Key initiatives, including the Kaizen event and follow-up improvements, have led to tangible changes, such as a reduction in waiting times from up to two and a half years to around 98 weeks for some. However, with a high number of referrals still incoming, there are concerns about the sustainability of these improvements, especially with the possibility of funding ending. TR also pointed out that despite the progress, additional resources are needed to continue making significant headway. The importance of ensuring that the service doesn't take on roles outside

its commission—such as treating individuals over 18—was emphasised, as this could affect both capacity and funding for younger individuals.

During the Q&A, SJ asked about the referral process for individuals aged 16 to 18, noting the risk that many would be over 18 by the time their appointment arrived. The response from CS clarified that while the service is contracted to assess individuals in this age range, some patients over 18 may still be seen due to ongoing demand. DL raised concerns about the ongoing financial pressure, pointing out that despite improvements, funding from NHS England and the ICB may not be sufficient to sustain the current level of service, especially in the context of high demand. There was also discussion about the potential risk of the service providing adult care for those aged 19 and above, which could lead to further strain on resources.

The discussion concluded with a reminder of the funding gap between capacity and demand, and the concern that without additional resources, the progress made could be undone in the coming years. The team acknowledged the valuable contributions of the leadership, particularly Tina Reed, in driving improvements despite ongoing challenges.

The contents of the report were noted.

016 **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, DIVERSITY, EQUALITY, DIVERSITY AND INCLUSION COMMITTEE ASSURANCE REPORT**

SS took lead on this report and the report was taken as read.

SS explained that the committee focused on key workforce issues, particularly workforce development and retention. A new recruitment and retention group was established to address complex, multifaceted issues across the organisation. While there was concern that the Trust did not fully understand the root causes of workforce retention issues, positive indicators such as low sickness rates suggested that staff were not dissatisfied.

The EDI Programme Board made progress with cultural changes, concentrating on simplifying and prioritising actions. A major area of concern was the support available for middle managers, which the committee actively addressed. AM inquired about the actions being taken to support middle managers, and GD responded that the Trust was developing tailored support programs and leadership training specifically for middle managers to ensure they received adequate guidance and resources.

The contents of the report were noted.

017 **EDUCATION AND TRAINING COMMITTEE ASSURANCE REPORT**

SJ took the lead on this item and the report was taken as read.

SJ reported that the committee focused on student recruitment and the associated risks. Overseas student numbers had increased, which was viewed positively, especially given the sector-wide challenges. However, concerns remained over a slight downturn in domestic postgraduate recruitment. Efforts to mitigate this included starting recruitment earlier and following up on incomplete applications. A significant challenge highlighted was space utilisation and the need to address organisational management issues impacting student satisfaction. The committee planned to improve the timeline for analysing and responding to the student experience survey results.

In the Q&A session, DL queried what measures were being implemented to address the decline in domestic postgraduate recruitment. MF explained that DET was advancing recruitment timelines and enhancing outreach efforts to engage potential domestic candidates more effectively.

The contents of the report were noted.

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

AM took lead on this item and the report was taken as read.

- The PFRC focused on three main areas:
    1. Financial and Commercial Update: Concerns were raised regarding the robustness of financial assumptions related to the merger. Additional work is required to refine assumptions on income and savings.
    2. Business Continuity Plans: An incident involving a water supply failure exposed gaps in business continuity plans. Actions include a planned desktop exercise to identify lessons learned and an internal audit review for future assurance.
    3. IM&T Strategy: The committee identified a need for better metrics to monitor IT infrastructure and cyber resilience. Despite having required cyber certifications, regular reporting on cyber metrics is lacking.
- Risk scores related to infrastructure (risk 12) and estates continuity (risk 10) remain unchanged at 12 due to ongoing gaps.

RB and PON commented that the session felt different from usual and worked well in terms of allowing for detailed discussion. Additionally, there was a discussion on whether there should be one overall business continuity plan or separate plans for

different departments, and it was confirmed that both estates-based and thematic business continuity plans existed.

The committee was also asked about the timeframe for presenting the IM&T strategy to the board, as it had not been reviewed in depth for a considerable period. It was noted that this would be added in one of upcoming Board Seminar

The contents of the report were noted.

019 **FINANCE REPORT MONTH 08**

PON took lead on this item and the report was taken as read.

The finance report for month eight, which covered the period up to the end of November, revealed a £740,000 deficit, primarily due to the additional cost of the pay award and the deficit in pay award funding. Expenditure was stable and aligned with expectations. The cash position was lower than anticipated, a recurring challenge for the Trust. The month nine position was finalised, showing a higher deficit of £140,000 more than expected, due to a one-off income issue. Expenditure remained on track, but the Trust was actively addressing the income shortfall. The cash situation continued to be precarious, and discussions with NHSE and the ICB were ongoing regarding access to cash support.

A point of clarification was raised regarding the comparison between month seven and month eight positions. It was noted that the expected position referenced in the report was based on month six, not month seven, as the pay award had not impacted the finances by that time. The narrative was acknowledged as needing adjustment for clarity.

Additionally, there was discussion about financial planning for 2025-26, which was expected to be challenging, though the formal planning guidance for the NHS had not yet been released. The Board was briefed on the assumptions to be made about income and efficiency requirements, though the exact details were still pending.

The contents of the report were noted.

020 **QUESTIONS FROM THE GOVERNORS**

Kathy Elliott (Lead Governor) mentioned that she was aware of the challenges in organising service visits for both NEDs and Governors at the same time and that options might need to be explored where Governors can visit separately. JL agreed to improve communication and provide clearer justifications if governors could not attend.

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**

	None noted.
022	**QUESTIONS FROM THE PUBLIC**
	Member of public stated that a senior psychologist at the Tavistock, Ross Knight, had been arrested and found guilty of grooming an underage boy online. Member of public inquired whether any concerns had been raised by service users about Ross prior to his arrest, and what safeguards the Trust had in place to address such concerns. CS responded that they were familiar with the case, and it was clarified that Ross was dismissed immediately upon being found guilty. There were no reports of concerns from service users about his behaviour while working at Tavistock. GD reassured that the activities leading to his arrest were unrelated to his work with service users and emphasised the importance of safeguarding policies in place to ensure the quality and safety of services, and ongoing checks on staff to ensure they meet the required standards.
023	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	Not discussed.
024	**DATE OF NEXT MEETING**
	Thursday 13th March 2025 at 2.00 pm – 5.00 pm.
	Close
	The Chair closed the meeting at 5.00 p.m.

Date of Next Meeting in public: Thursday 13th MARCH 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	Dorothy Otite, Interim Director of Corporate Governance	**In progress**	Oliver McGowan Training: Clarification was needed on whether the second part of the ICB-led training had been completed. CS and GD were tasked with confirming this and determining whether it should be removed from the Trust's training records. Suggestion to be kept open for review.
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	Gem Davies, Chief People Officer	**To close**	This had progressed to ELT and SDB for additional input. Ensure Board members complete FTSU training and include it as part of the ongoing review. Suggestion to close.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 13 March 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:	Appendix 1: NCL Health Alliance Governance document		
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 16 January 2025.		
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

It has been a very busy start to the year as colleagues across the Trust have been working on plans to deliver our planning round for 2025/26. The Executive Leadership Team have been busy reviewing the annual plans produced by the clinical and DET teams. These plans underpin the submission the Trust makes to the Integrated Case System (ICS). It is one of the most challenging years on record for the NHS, and we are having to make tough decisions to meet our minimum efficiency savings.

We have also heard the news that Amanda Pritchard is stepping down from being Chief Executive of the NHS at the end of March. I want to thank her for her values-driven leadership of the NHS during what has been a challenging time.

2. Merger update

We continue to work with NHSE and the local Integrated Care system to build a sustainable future for the Trust via delivery of a merger. The challenging 2025/26 planning round has paused plans for the past few weeks as all Trusts work to deliver robust activity, workforce and finance plans for the year ahead. We will restart our merger delivery programme once the planning round has concluded. To support an open and transparent approach I am holding weekly CEO drop-ins for all staff to keep everyone posted and up to date on recent developments.

Providing outstanding patient care

3. Independent investigation into the care and treatment provided to VC

The Independent Investigation report into the care and treatment of VC was published in January 2025. NHS England (NHSE) commissioned an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023.

The purpose of the investigation was to identify learning for NHS delivered care from the care and treatment provided to VC. The investigation covered the period from when VC first came into contact with mental health service in May 2020 up to 13 June 2023 when he killed three people and seriously injured three others. The investigation focused on identifying learning at a local, regional and national level to reduce the likelihood of a reoccurrence of the tragic events perpetrated by VC in June 2023.

Findings identified gaps in the documentation and formulation of risk; the voice of VC's family was not effectively considered to support the dynamic evaluation of risk; the absence of robust Trust discharge processes and a record template, which resulted in limited consideration and quality in the effectiveness of the transfer of care and management of risks. Additionally, there were issues around communication with primary care, there were limitations with the assurance and oversight arrangements at the ICB.

Recommendations were made for NHSE and other national leaders, including people with lived experience, to come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

Recommendations for the Trust were made in relation to improvements around the implementation of Patient Safety Incident Response Framework (PSIRF); family engagement, clinical information sharing, across organisational working, governance arrangements that support triangulation of information and enable system-wide working, peer support, care planning.

The Trust has commenced a review of its own services against the recommendations in the report.

Enhancing our reputation and grow as a leading local, regional, national & international provider of training & education

4. Student Recruitment

Student recruitment for 2025/26 is progressing positively after great efforts by the Department of Education and Training (DET) operations team to open student recruitment in October instead of January. Currently, applications to our courses are at a 42% increase over 2024/25, with a 98% increase on application numbers in January 2025 (the first full month in the cycle) compared to January 2024. This is a very promising situation in a difficult NHS financial context, reflecting the significant staffing and process changes delivered by DET to improve the attraction, processing and enrolment of students.

Developing partnerships to improve population health and building on our reputation for innovation and research in this area

5. NCL Health Alliance updated governance document

I recently attended the NCL Health Alliance (NCL HA) Executive meeting, at the meeting, the provider collaborative CEOs approved the overarching governance document for NCL HA which replaces the previous articles of association. I approved this on behalf of the Board of Directors and the document is attached to this report for information.

The document outlines the purpose, structure, function, and governance of the NCL HA. It builds on the previously approved member board documents that established the Alliance and reflects the scope, function, and structure as approved by NHSE in 2024. The updated sections relate to Board assurance; agreeing priorities; determining scope of decision-making powers; dispute resolution; exit and ongoing collaboration agreement and accountability arrangements.

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

6. Staff Survey

The national staff survey results have now been released (in an embargoed format at the time of writing this report). We had a challenging agenda last year and continue to have a busy year ahead of us, and so we know there are areas where we still have improvements to make, and we are committed to doing so. However, we have also made some tangible improvements in the responses that we should celebrate. We are doing some analysis of the results, and more information will be shared at a future board meeting once the embargo has been lifted.

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.

7. Staff engagement

Following the launch of our values and behaviours framework at the beginning of February 2025, we subsequently introduced two new physical implementations, our pop-up banners and our values cards. The banners serve as a visible reminder across the Trust of ways all employees can demonstrate behaviours that are aligned with our values. We are also encouraging everyone to show their appreciation whenever a colleague demonstrates one of our values; we have placed values cards in staff kitchens which can be used to write a message and give to a colleague who has done something to shout about. An email version is also available. We will be talking to our staff engagement group about other ideas for embedding a behaviours framework throughout the organisation, including career conversations and staff awards.

Improving Value, Productivity, Financial and Environmental Sustainability

8. Development and Delivery of the Trust's strategy and financial plan

The Trust incurred a net deficit of £1,910k in the period up to the end of January 2025, against the plan of £1,907k, a negative variance of £3k. This is an improvement of the position from month 9 by £957k. This improved position reflects the benefit of the non-recurrent rates rebate received in January 25. The Trust is thus now able to achieve its year-end deficit plan of £2,200k. The previously highlighted funding gap relating to the 24/25 pay award is still a concern for future periods but is being offset by this non recurrent income in 24/25.

In line with the agreed NCL timescales the updated the forecast for 2024/25 has been confirmed as part of the month reporting cycle.

The financial planning 'round' for 2025/26 has now started, with the first submissions to the NCL ICB and NHSE being made at the end of February. This first submission showed an initial deficit plan of £3.2m, reflecting the increased pressure in the system in 2025/26. The Trust continues to take a series of recovery actions to the year end, including restrictions on appointments to only essential posts and maximizing the impact of any non-recurrent opportunities. This is still deemed an important part of the preparation for the planned merger and delivery of the likely challenging efficiency targets in 2025/26 plan.

Other Key Internal Updates:

9. Council of Governors' Elections 2025

We have commenced the elections process to fill 4 seats (3 Public and 1 Student) on the Council of Governors. The nominations opened on Monday, 4 March and will close at 5p.m. on Wednesday, 19th March 2025. Three of these seats (Camden – 2; and Student – 1) are currently filled by Governors in their 1st terms of office which come to an end in May 2025. One seat (the Rest of England and Wales seat) is currently vacant. The link to the election's website is provided below:
https://nom.uk-engage.org/tavi-port/

Regional and National Context

10. Department of Health and Social Care (DHSC) consultation on regulation of NHS Managers

In November 2024, the Secretary of State for Health and Social Care launched a 12-week consultation on options for the regulation of NHS managers, as part of a programme of work to meet the government's manifesto commitment to introduce professional standards for, and regulating of, NHS managers.

NHS Employers has recently led on a response to the consultation on behalf of NHS Confederation. The response is informed by views of Chief Executive Officers, Chairs, Chief People Officers and Senior Board workforce leaders across the NHS following a series of engagement activities. Key messages from the consultation response include:

- NHS leaders agree there should not be fear of accountability.
- Any new regulatory framework needs to be clear in its purpose, aims and objectives, as well as, explicit in the problem it is seeking to resolve.
- Regulation must be supported with robust standards for practice, professional development, clear and simple processes, just and restorative cultures, and underpinned by principles of fairness, equality and trust.
- Regulation must be proportionate in its approach and positioned as an opportunity to raise the standards of the profession.
- NHS leaders welcome the introduction of a new professional duty of candour.

11. Chief Executive's meetings with external stakeholders

Since my last Chief Executive's Report to the Board in January, I have attended the following external meetings / events:

- NHS England London CEOs meetings with the London Regional Director
- NHS England London Regional Workshop on the new national Operating Model
- NHS England 10 Year Plan: Mental Health Trust CEO event
- NHS England Mental health productivity session
- NHS England MH UEC BAME Advisory Group
- NHS England Mental Health Trusts Chief Executives meeting
- HSJ Digital Transformation Event
- Cavendish Square Group
- CYP Lead Provider CEO Workshop
- CICE
- UCL Health Alliance Executive Group
- NCL ICB Development Session
- NCL ICB Financial planning
- NCL ICB System Management Board

1. Document purpose

This document outlines the purpose, structure, function, and governance of the NCL Health Alliance (NCL HA). It builds on the previously approved member board documents[1] that established the Alliance and reflects the scope, function, and structure as approved by NHS England (NHSE) in 2024.
The updated sections are

- Board assurance
- Agreeing priorities
- Determining scope of decision-making powers
- Dispute resolution
- Exit and ongoing collaboration agreements
- Accountability arrangements

Should any material changes to the NCL HA be required, prior consultation and approval from NHSE may be necessary. Advice should be sought before implementing any such changes.

2. Introduction and context

The NCL Health Alliance is the multi-sector provider collaborative for North Central London. Its purpose is to enable effective partnership working to improve the outcomes and experience for the population it serves. The scope includes people across North Central London as well as people travelling in across the wider region and in some cases nationally to receive specialist care. The original Alliance Charter is included in the **Appendix 1**

Provider collaboratives are self-convening partnerships, driven by the need to span organisational boundaries that exist within the NHS. Guidance from NHS England published in 2021 set out the requirement for all acute and mental health providers to participate in at least one provider collaborative. This Alliance model maintains the sovereignty of all member organisations and establishes a protocol for the delegation of authority for some elements of collective decision making to the provider alliance for specific shared initiatives.

Established in 2021 as the UCL Health Alliance, the Alliance was formally recognised as a Provider Collaborative by the North Central London NHS Integrated Care Board. In 2023, it transitioned to become a division of UCL Partners, creating a unified innovation partnership for NCL to maximise collective impact on health outcomes.

As part of this transition, the Alliance was renamed the NCL Health Alliance, and UCL ceased to be a member organisation. This change also facilitated the closure of the company limited by guarantee and the establishment of a governance structure aligned with UCLP and NCL HA member organisations.

The Alliance enables NHS partners to collaborate on pressing health and care priorities, addressing the full pathway from prevention to treatment and integrating physical and mental health needs. It aims to deliver best value for taxpayers while helping member organisations sustain high-quality care within resource constraints. With UCL no longer a partner, research and education are no longer primary

[1] UCL Health Alliance – articles of association – May 2022
UCL Health Alliance Charter – October 2020
Member Board papers – Annual plan 22/23 - May 2022

priorities but remain integral to all programmes and will be referenced in the annual business planning process. Established by member boards and governing bodies, the NCL Health Alliance serves as the principal vehicle for system-level collaboration across North Central London

3. **NCL Health Alliance membership**

The member organisations of NCL HA include:

- Acute Providers
- Community Providers
- Mental Health Providers
- Primary care providers
- Specialist providers

The NCL Integrated Care System is a named partner organisation of NCL HA

The terms of reference for the NCL HA Executive Group (**appendix 2)** contains the up-to-date list of the member organisations.

4. **Board assurance**

As part of the development of NCL HA, UCL Partners became accountable for

- The recruitment, retention and line management of the Alliance core team
- Oversight of the finances related to the core team including invoicing, resource allocation and budgetary approval
- Oversight of the programme delivery by the Alliance team.
- Policies and procedures as it relates to programme delivery and core team appointments.
- Risk management as it relates to functions of the core team, programme delivery and participation in NCL HA activities by member organisations.

Member organisations retain responsibility for

- Clinical delivery of services within NCL HA programmes
- Performance and conduct of staff employed directly by those organisations
- Service and organisational performance including against constitutional standards.

The governance structure for providing regular board assurance on the delivery of agreed programmes of work and core team finances includes the following:

i. **Routine reporting** – monthly progress briefings circulated through the CEOs as part of the monthly NCL HA Executive meetings. Additionally, biannual reports are additionally shared with each member organisation's board and UCLPartners board.

ii. **Escalation -** robust arrangements for the timely escalation of programme delivery risks or participation concerns through the UCLP governance structure or to the Alliance Executive where appropriate via the Managing Director.

iii. **Participation**: All members are required to actively contribute to the strategic and operational decision-making, oversight, and direction of the Alliance. Members participate in monthly Alliance Executive meetings and collaborate on Alliance programmes, which serve as the primary drivers of joint action.

A key feature of the Alliance's operation is the leadership role of Chief Executives in guiding these programmes. This provides visible and accessible senior leadership to the communities within the Alliance membership, shaping and delivering shared priorities. Additionally, this model strengthens board-level assurance by creating a direct line of sight from board-level leaders to the programmes across the Alliance.

2. **Information governance**

The core Alliance team will operate under the information governance policies of UCLPartners and will not hold any patient identifiable information. All performance information concerning commissioned services will be within the governance of member organisations and the ICB.

Any staff working to deliver Alliance work programmes (for activities directly related to patient care,) will be hosted/employed by a member organisation and not UCLPartners. These staff will therefore be subject to the mandatory training, policies and procedures of the employing organisation.

3. **Agreeing Priorities for the Alliance**

The process of identifying priorities for the Alliance will be addressed through the annual business planning cycle. During this process, the Alliance Executive—including the UCLPartners CEO and ICB leadership—will agree on the scope of priorities that require collaboration between providers at the system level.

These priorities will be translated into clear objectives, with each programme assigned a CEO lead. The objectives for the upcoming year will undergo scrutiny and ratification by the Alliance Executive group before the business plan is submitted for authorisation by member boards, the UCLPartners board, and other relevant governing bodies where necessary.

These objectives will be developed into programme level plans, specifying:

- Leadership arrangements: the responsible CEO lead, clinical leads and operational leads.
- High level deliverables: to achieve within the coming 12-18 months.
- Benefits: which can be expected in four domains: (1) financial; (2) quality, safety and outcomes; (3) access and (4) health and workforce inequalities.
- Resourcing arrangements: both those devolved within the member organisations as well as any central resource requirement.
- Governance: highlighting governance arrangements outside of the Alliance, such as into the ICB.
- Programme evaluation: highlighting the approach being taken to evaluate and review the outcomes of the programme/project

This process of prioritisation, programme level planning and approvals is an important feature for how the resource and workforce arrangements are determined.

4. **Determining scope of decision-making powers**

The scope of activities and decision-making powers are directly controlled through the member organisation chief executives and the UCLPartners CEO. This includes the ability to design and establish the requisite changes to Alliance governance arrangements.

The annual business plan will include a clear specification of deliverables for each financial year. This plan will require approval from member CEOs and UCL Partners, following the internal governance arrangements specific to their respective organisations.

Once the business plan is finalised and approved, the Alliance Executive Group will be empowered to act and make decisions necessary to deliver the plan. However, certain decisions—such as those involving commissioning—may require additional approval through the Integrated Care Board (ICB) or other relevant bodies.

5. **Exclusions**

The following exclusions were agreed as part of the establishment of the original Health Alliance and remain in place with the reconfiguration of the governance structures without further engagement through all members and the re-engagement and approval of NHSE.

i. Prevent the Alliance (as a part of UCLPartners) taking on provision of CQC licensed services, for example through the direct employment of staff responsible for patient care or ownership of premises used for patient care.

ii. Prevent the Alliance (as part of UCLPartners) being used as a vehicle to transact large contract values for the provision of CQC licensed services, without first re-engaging with NHSE; this does not prevent the Alliance agreeing that a member can function as a lead provider to fulfil this purpose and is consistent with the NHSE guidance for collaboratives to consider governance models that are not mutually exclusive.

iii. Prevent the Alliance (as part of UCLPartners) being used for a vehicle for avoiding the incursion of taxes (such as VAT) which would otherwise be borne by member organisations.

6. **Inclusions**

During the initial formation of the Alliance corporation, a series of explicit inclusions was established to define its functions. The following list highlights the elements that the NCL HA Executive Group and the UCLPartners Executive have determined remain relevant to the ongoing function of the NCL Health Alliance. This list is;

I. Ensure the powers enable the Alliance to make decisions concerning the optimal configuration of service provision, insofar as these are endorsed by the ICB/NHSE and are within the scope of deliverables set out in the annual Alliance Business Plan or otherwise agreed unanimously by members.

II. Ensure the powers enable the Alliance to agree the use of new care models including lead provider arrangements, to achieve optimal provision of both patient facing and corporate services.

III. Ensure the powers enable the Alliance to agree to the optimal usage of finances made available for innovation, education and transformation and enable UCLPartners to function as the organisation responsible for financial administration of these resources, where it represents best value for the member organisations.

IV. Recognise the role of the annual business plan in setting out the scope of objectives pertaining to the priorities which members ascribe to the Alliance and do not require further processes for individual board level authorisations.

It remains important that each member organisation has an equal voice in the decision-making process for the Alliance. The scope of decisions is therefore also linked to the voting arrangements as set out in the Terms of Reference for the NCL HA Executive group **(Appendix 2)** through which the Alliance agree a specific course of action.

7. **Dispute resolution**

Any disputes within the Alliance will be approached through the spirit of collaboration, recognising that failing to work effectively together is to fail both staff and the populations served. The following steps are recognised as a reasonable path of escalating effort to reconcile major differences:

- **Managing Director**: to function as the initial point of contact for members of the Alliance Executive in highlighting potential differences and acting early and swiftly to reach agreement. The Managing Director is ultimately accountable to the UCLPartners CEO.
- **UCLPartners CEO:** in instances where there is a perceived or actual conflict of interest for the Managing Director, or the Managing Director is not able to find a satisfactory agreement within a satisfactory time frame.
- **Chair and Vice chair of NCL HA Executive Group:** depending on the topic in question, the Chair and Vice Chair will function as a point of escalation from the Managing Director where there are issues which have the potential to endure or create a barrier to improving patient care.
- **External mediation:** where the previous steps have not been successful in reconciling differences, there is an option for commissioning expert external mediation to support resolution.

8. **Funding model**

The funding model for the Alliance is expected to comprise two key elements:

1. **Member Subscriptions**: Contributions from member organisations to support core functions and initiatives.
2. **External Funding**: Resources sourced from outside the Alliance membership, either to establish specific functional capabilities across member organisations or to act as a vehicle for delivering on an external contract specification

A central principle of resourcing delivery through the Alliance is to establish the most effective model for providers to collaborate with each other and with partner organisations. This approach aims to achieve meaningful impact on priorities best addressed at the NCL level.

The primary resource for collective action comes from the contributions of provider organisations to the Alliance's work programmes. These contributions represent the most significant portion of the resources dedicated to achieving shared objectives.

The subscription costs are required to cover the pay, non-pay and corporate overheads related to the employment of the core team. As appropriate additional programme related costs may also be applied to member organisations. The specifics of the financial arrangements will be negotiated on a 3 yearly basis and will be approved by the CEO of UCLPartners and the NCL HA Executive Group. The responsibility for the management and use of the annual budget will be the Alliance Managing Director, and accountability will be held by the UCLPartners CEO.

Where additional funds, investment or external grants are awarded to NCL HA, they will typically be held and managed through UCLPartners.

9. **Exit process and ongoing collaboration**

If a member organisation wishes to withdraw from the Alliance, the following provisions are in place:

- A member organisation must give 6 months' notice in writing to the Chair of the Alliance Executive group and the UCLPartners CEO. This must include a proposal to cover the membership fees due for the duration of the existing subscription agreement.

- The Alliance Executive Group and UCLPartners board then confirm in writing the exit process and date that the membership will terminate.

Current legislation requires all acute and mental health trusts to be part of a provider collaborative therefore any acute or mental health organisation leaving the Alliance must ensure that they become part of an alternative formal provider collaborative.

Even if a member organisation chose to withdraw from the Alliance, the duty to collaborate in the service of patients and the population we collectively serve will remain. It is therefore a principle for the Alliance to sustain collaborative working relationships with any member having left the Alliance. This principle will be realised primarily through the ongoing involvement of all organisations in the Alliance programme. It would however not be possible to maintain any form of material decision making rights for departed members through the Alliance Executive Group.

If existing Alliance members form a new organisation through merger the following will occur

- The newly merged organisation will propose their plan on how the organisations will be represented going forward if it would present a material change.

- The original organisations remain committed to their individual subscription responsibilities for the duration of the relevant agreement.

10. **Accountability arrangements**

It is important that there is clarity as to the respective roles and responsibilities of the member organisations, the organisation executives, the UCLPartners and its CEO to ensure that the Alliance can create and deliver its priorities and objectives.

The arrangements in the accountability framework below set out how members and partners (UCLPartners and NCL ICB) set the direction for the Alliance, using national and local priorities as well as a wider spectrum of government policy to create priorities and objectives.

Organisation/Role	**Scope of responsibilities**	**Accountability**
Member organisations	Individually the responsibilities are defined in Trust constitutions and commissioning contracts subject to the relevant CQC licence.	Board of directors NCL ICB

	For NCL HA each member organisation is responsible for approving the annual business plan and delegating responsibility for oversight and implementation to the Chief Executives. Member organisations are also responsible for delegating financial approval in relation to NCL HA activity in line with organisational SFIs.	NHSE
Member Chief Executives	Individually these are defined in the powers specified by member organisations. For NCL HA each CEO has responsibility for contributing to the development of the annual business plan and supporting oversight and delivery of the plan once approved by relevant member boards.	Member boards
UCLPartners ELT	The organisational responsibilities are defined in UCLPartners' articles of association. For NCL HA, UCLPartners' board has a responsibility to approve the annual business plan as it pertains to organisational business delivery	UCLPartners Board
UCLPartners Chief Executive	Individual responsibility is defined in the powers as set out by UCLPartners governance articles For NCL HA the CEO has a responsibility for contributing to the development of the annual business plan and overseeing the Alliance team which is responsible for delivery of the plan once approved by member organisations	UCLPartners Board
NCL ICB	Responsible for holding member organisations to account for delivery of services, contracts and commissions	NHSE and DHSC

Within the scope of this accountability framework, it is useful to consider the arrangements for designing and delivering any major patient service changes. The role of the Alliance in this scenario is circumscribed to the development of options and recommendations concerning new care models, optimal clinical pathways and the case for change. Decisions concerning the commissioning of any new care models or clinical pathways will be the responsibility of the ICB for most NHS services, recognising where relevant the retained duties within NHSE.

APPENDIX 1: Alliance Charter

***Delivery at pace**: the ethos of the partnership will be to deliver results and prove itself by getting things done, and fix things as we go to deliver*

patient/service user, staff and tax payer benefits

2. ***Collaboration as the default:*** *we will only 'opt out' where an existing binding contract precludes us from participation*

3. ***Devolution****: we will be biased towards devolving delivery accountability to individual partners to act on behalf of the overall partnership*

4. ***Sovereignty****: all partner boards will remain sovereign and will delegate authority for collective decision making to the provider alliance for an agreed agenda of shared initiatives*

5. ***Mutual support****: we will expect each partner to act on behalf of the system/resident and taxpayer interest even when that is not in individual institutional benefit but the quid pro quo is that we will strive to "keep each other whole"/we will work to ensure no partner fails*

6. ***No duplication and shared resources****: ICS- HQ workstreams and Provider Alliance- delivery work should be stepped-up and stepped-down in lockstep –we will avoid duplication and be clear about accountability. We should seek to share resources across partner organisations to enable health services, education and research to be focused on the population we serve. A number of people will have different roles / 'wear different hats' and we will use this to be as efficient as possible.*

7. ***Embedded with the system team:*** *Same set of people in the room wherever we can (e.g., transparency between ICS HQ & Provider Alliance Board)*

8. ***Data and analysis****: we will make data-driven decisions and monitor our performance.*

9. ***Honest and transparent****: we do difficult things, we talk about difficult things, we are direct and transparent with each other*

10. ***Learning system****: we have an ethos of 'continuous improvement' adopting a QI approach. Innovation and the spreading of proven best practice will be key.*

Appendix 2 - Terms of Reference for NCL HA Executive Group

North Central London Health Alliance (NCL HA) Executive Committee

Terms of Reference

Purpose

The NCL Health Alliance (NCL HA or the 'Health Alliance') Executive Committee has delegated authority from the UCL Partners Board on all NCL HA matters subject to the exceptions detailed in the NCL HA Board terms of reference. The overall purpose of the committee is to deliver the NCL HA annual business plan which aims to address system-level priorities.

Duties and responsibilities

- To advise the UCL Partners Board on the strategic direction of the NCL HA and provide assurance that the objectives and work plan align with the UCL Partners strategic priorities
- To lead the delivery of the NCL HA business plan
- To agree and oversee the delivery of the NCL HA annual objectives and work programmes
- To ensure the annual objectives appropriately cover all relevant aspects of health services, education and research
- To ensure health care services objectives focus on delivery across physical and mental health care, from prevention to complex tertiary treatment to address health inequality and access to treatment and care
- To be responsible for agreeing programme level CEO, clinical and operational leadership arrangements
- To seek assurance from individual member organisations about the mitigation plans for matters concerning risk to programme delivery
- To inform UCLP board of any matters concerning risks to programme delivery (UCLP board do not hold accountability for individual provider performance and may where necessary escalate concerns to external statutory bodies)

The group will receive regular updates on strategic priorities from the Chief Executives concerning the portfolios they lead on behalf of the wider Health Alliance.

The group will receive reports from system leaders on issues and programmes of work that would benefit from a collective Health Alliance approach and receive reports and proposals from innovation and transformation partners.

Core Membership

- Chair (role to be occupied on a rotational basis for a term of two years)
- Vice chair (role to be occupied on a rotational basis for a term of two years, following which the individual will take the chair)
- Chief Executives for the Partner NHS Trusts
- North London Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- Central and North West London NHS Foundation Trust

- Central London Community Healthcare NHS Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Great Ormond Street Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- University College London Hospitals NHS Foundation Trust
- Royal Free London NHS Foundation Trust - including group and site CEOs
- Whittington Health NHS Trust
- North Middlesex University Hospitals NHS Trust
- Lead for the GP Provider Alliance

In attendance

- NCL ICB Accountable Officer
- NCL ICB Executive Director of Transformation and Performance
- NCL HA Joint Executive Leads
- NCL HA Managing Director
- Chief Medical Officer representative
- Chief Nursing Officer representative
- Chief Financial Officer representative

Deputies may attend at the discretion of the NCL HA Chair but will not count towards the quorum.

N.B. Neither the Chair or Vice Chair shall also sit as members of the UCLP board. The chair and vice chair are appointed following an expressions of interest process led by the Managing Director and UCLP CEO.

Quorum and expected attendance

The meeting is considered quorate if the following people are present

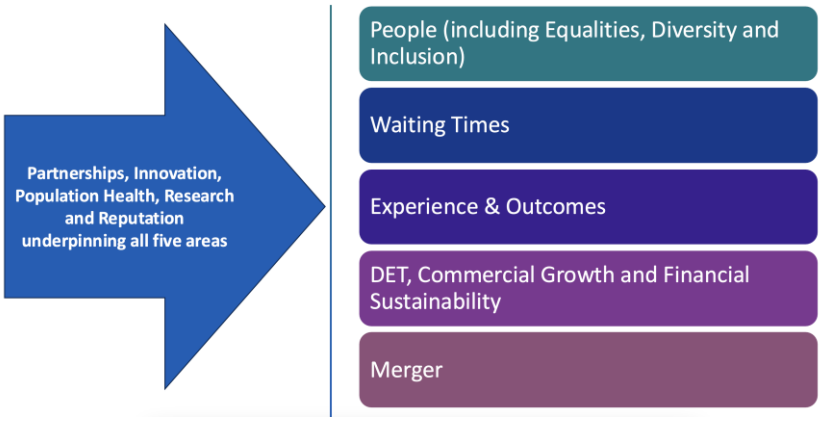
- 50% of the core membership

Frequency of Meetings

Meetings will be held monthly. An annual meeting will be scheduled to which non-executive representatives from each of the partner NHS Trusts and GP Provider alliance will be invited. This will provide non-executive scrutiny from partners and assurance to partner Boards that the health alliance is making progress against its objectives and business plan.

Agenda, Administrative Support and Reporting Arrangements

• Administrative support for the meetings will be provided by a nominated Company Secretary from the providers, this will include taking minutes, and recording actions • The agenda will be set by the NCL HA Chair and Alliance Director, based on emerging issues for discussions and the forward look schedule for the meeting • The agenda, minutes and relevant papers will be circulated electronically five working days in advance of the meeting • Members have been chosen as either their organisational representative, direct employees of the NCL HA or NCL ICB leaders • The NCL HA Executive committee is a subcommittee of the UCL Partners Board • The Terms of Reference will be approved by the UCL Partners Board and reviewed at regular intervals	
Date of Terms of Reference Version Control: Created 13 September 2022 Updated 19 February 2025	
Reviewed by	**UCL Partners Board**
Approved by	**UCL Partners Board**
Required Review Frequency	**Annually**

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Integrated Quality Performance Report			**Agenda No.: 008**
Report Author and Job Title:	Rachel James, DoT Sheva Habel, Medical Director Hector Bayayi, Managing Director	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer Chris Abbott, Chief Medical Officer
Appendices:	Appendix 1: IQPR January 2025		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	This is the Trust Integrated Quality and Performance Report (IQPR) for 2024/25 Month 9 data (December 2024) and provides an overview of delivery against NHS national targets and Trust agreed priorities. The report content has been co-produced and developed and considered "Floor to Board" with all levels of the Trust having the same data and content to ensure there is one version of the Trust across our quality and performance portfolio. This ensures a Trust-wide focus on areas of good practice for shared learning, risk and mitigations. The report combines elements from the previous reporting framework with newly automated templates, with an aim to achieve fully automated reporting of data and metrics by April 2025.		
Background:	Month 9 was considered in the Trust-wide IQPR meeting on 28th January 2025. The content reflects discussion at this meeting to mitigate areas of risk. Trust quality and performance is reviewed (1) weekly via the Executive Leadership Team meeting, Strategic Delivery Room (which has a focus on the quality improvement projects underpinning our five strategic priorities) and Quality Huddles; and (2) monthly via team and delivery unit level performance and clinical governance meetings. The Trust agreed five priorities are set out below:  		
Assessment:	**<u>Quality & Safety</u>** **Patient Feedback:** Clinical Services reported 84% of ESQ positive responses in December, which is below the benchmark of 90%. The new digital platform for the anonymous collection of Experience of Service Questionnaires (ESQ) is being implemented as part of the QI Project on User Experience. Lunch and Learn sessions have been scheduled to take place in		

January to support increased compliance. Work continues to agree team level targets for ESQ feedback, and a new ESQ feedback protocol for sharing Team level data and feedback has been implemented.
Incidents: 16 incidents reported, including 6 patient safety incidents, 8 involving violence & aggression and 2 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: A total of 4 formal complaints were received in December 2024, and the number of complaints overdue was 16. 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. In addition, we will be developing a Quality Improvement project in January 2025 to improve patient experience and the quality of the complaints process, whereby the required timeframes are met.

Performance
The Clinical Services IQPR highlights progress and challenges across several areas.

In GIC, progress has been made in embedding risk management governance frameworks. The IQPR will begin reporting data relating to this from February 2025. However, there was a dip in performance during November and December due to preparation for the National GIC Review by NHSE.

In Trauma services, the mean waiting list increased, reflecting a consistent trend of around 20 additional referrals per month. A potential risk lies in the expiration of ERF-funded post-holder contracts in September 2025, limiting the service's capacity to address the waiting list. The team will move into Targeted Support starting February 2025 to ensure delivery remains on track.

ASD services continue to deliver against their trajectory, with their approach being recognised as a success within NCL. The RTT waiting list for both 18 and 52 weeks has shown a decline, demonstrating the positive impact of recent interventions. Nevertheless, the service anticipates potential instability due to upcoming staffing changes.

At Gloucester House, a dedicated programme delivery group has been formed to unify three separate recovery and improvement plans, fostering cohesive progress. Clinical respiratory risk assessments for staff have been completed although the risk assessments for the pupils are behind schedule. The school nurse is working with a specialist respiratory nurse to address this delay.

Looking ahead, clinical services are working to consolidate key modelling logic to ensure consistent and accurate reporting of waiting time trajectories. This effort is targeted for completion by March 2025. Units are also expected to complete their annual planning processes by 5 February 2025

People
Appraisals stood at 57.2%, a small increase again on previous months (this rate excludes Medical and Dental staff group). Historical data has now been cleaned up in the watch metrics slide to reflect the agreed new criteria as requested at the last board meeting. Continuous work is being carried out by

	the Learning and Development Team to ensure the Trust raise the standard of appraisals. MaST compliance dropped again to 76.8%. 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. In addition, each Executive Director has been requested to provide the CPO with tier action plan for improvement, and a paper on this will be taken to POD EDI Committee in March. The Recruitment and Retention Group will start receiving workforce data from next month to more closely interrogate the information and routes for mitigation where required. **Finance** The Trust is £960k behind plan at Month 9, this is a worsening of the position by £220k from the M08 position. The variance to plan is driven by the unfunded element of the pay award and a one-off income error worth £156k in Month 09. The reported cash position at the end of December was behind plan by £323k at £1,533k. However, cash continues to be a challenge, with the NHSE cash support not agreed for the first time in January 2025. Capital spend is expected to be on plan at £2,468k at the end of the year.
Key recommendation(s):	The Board is asked to review and **DISCUSS** the contents of the report.

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All Related BAF Risks including BAF 2.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	This report includes delivery against NHS national targets.				
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 meeting held in January 2025 Quality and Safety Committee – 27th February 2025 Performance Finance Resource Committee – 27th February 2025 People Organisational Development Equality Diversity and Inclusion Committee – 6th March 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

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report January 2025 (Month 9 January 2025 data)

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

Important Note:

This report is based on data extracted on 3 January 2025, reflecting the performance of December 2024. Please be aware of the following anomalies in historical data presented in the Watch Metrics:

1. **Performance Data**: Unit data structures were revised by the Performance Team in October 2024, with updates applied retrospectively.
2. **HR Data**: Unit data structures were updated from August 2024 onwards; however, historic data prior to August could not be adjusted to align with the new structures.
3. **Quality Data**: Unit updates were implemented from October 2024, however, historic data prior to August could not be adjusted to align with the new structures. The quality team are reviewing the revisions they can progress to align the historic data where possible.
4. **Key Context for Watch Metrics:** Notes included in the Watch Metrics slides clarify that safety and well-led data from January to September 2024 and correspond to the old unit structures.

Future IQPR Board Meetings

10am Tuesday 25th February 2025	10am Tuesday 27th May 2025
10am Tuesday 25th March 2025	10am Tuesday 24th June 2025
10am Tuesday 22nd April 2025	10am Tuesday 22nd July 2025

Executive Summary

The Tavistock and Portman NHS Foundation Trust

The Clinical Services Performance Report highlights progress and challenges across several areas.

GIC - good progress has been made in embedding risk management governance frameworks, though this process remains incomplete. IQPR will begin reporting data relating to this from February 2025. The dip in performance during November and December attributed to preparation for the inspection and annual leave.

Trauma service - the mean waiting list increased from 668 to 683 over the reporting period, reflecting a consistent trend of approximately 20 additional referrals per month. A potential risk lies in the expiration of ERF-funded post-holder contracts in September 2025, which could impact the service's capacity. To mitigate this, the team is leveraging Kaizen outputs to develop effective controls and will move into Targeted Support in February 2025 to ensure delivery remains on track and barriers are addressed.

ASD - services continue to deliver against their trajectory, with their approach being recognised as a success within NCL. The RTT waiting list for both 18 and 52 weeks has shown a decline, demonstrating the positive impact of recent interventions. In December 2025, 19 assessments were completed, with the average waiting time standing at 27.58 weeks. The service anticipates potential instability due to upcoming staffing changes.

Gloucester House - a dedicated programme delivery group has been formed to unify three separate improvement plans. Clinical respiratory risk assessments for staff have been completed. However, the risk assessments for pupils are behind schedule. The school clinical lead is now working collaboratively with the quality team to address this with the aim to finalise by end of January 2025.
Looking ahead, clinical services are working to consolidate key modeling logic to ensure consistent and accurate reporting of waiting time trajectories, due for completion by March 2025. Units are also expected to complete their annual planning processes by 5 February 2025.

Quality
Incidents- there were 16 incidents reported during the reporting period. Of these, six were related to patient safety, eight involved violence and aggression, and two required physical restraint at Gloucester House. Policies and processes for recording incidents and managing challenging behaviors are currently under review as part of Gloucester House's improvement plan. These steps aim to enhance the overall safety and quality of care provided

Patient Feedback: Clinical Services reported 84% of ESQ positive responses in December, which is below the benchmark of 90%. The new digital platform for the anonymous collection of Experience of Service Questionnaires (ESQ) is being implemented as part of the QI Project on User Experience. Lunch and Learn sessions have been scheduled to take place in January to support the QI work and increase compliance. Work continues to agree team level targets for ESQ feedback, and a new ESQ feedback protocol for sharing Team level data and feedback has been implemented.

Complaints: In December 2024, the Trust recorded a total of 4 formal complaints, with 16 complaints overdue. All of the formal complaints were within the Adult Unit, 3 of them were related to GIC. During the same period, 5 formal complaints were closed, and all were responded to within the required 40 working day timeframe. As of the end of December, there were 27 open complaints in total. Of these, 23 were within the Adult Unit, with 13 being overdue. The Children & Families Unit had 3 open complaints, all of which were overdue, and the Camden Unit had 1 open complaint.

People
Appraisals stood at 57.2%, a small increase again on previous months (this rate excludes Medical and Dental staff group). Historical data has now been cleaned up in the watch metrics slide to reflect the agreed new criteria as requested at the last board meeting. Continuous work is being carried out by the Learning and Development Team to ensure the Trust raise the standard of appraisals.

MaST compliance dropped again to 76.8%. 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. In addition, each exec director has been requested to provide the CPO with tier action plan for improvement, and a paper on this will be taken to POD EDI Committee in March.
The Recruitment and Retention Group will start receiving workforce data from next month to more closely interrogate the information and routes for mitigation where required.

Finance
The Trust is £960k behind plan at M09, this is a worsening of the position by £220k from the M08 position. The variance to plan is driven by the unfunded element of the pay award and a one-off income error worth £156k in month 09.
The reported cash position at the end of December was behind plan by £323k at £1,533k. However, cash continues to be a challenge, with the NHSE cash support not agreed for the first time in January 25. Capital spend is expected to be on plan at £2,468k at the end of the year.

Tavistock and Portman
Our Values and Strategy

The Tavistock and Portman NHS Foundation Trust

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

Metric	Waiting List Management	SRO	Chris Abbott	Target	4 wk 18 wk	Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Problem Statement

Three key services within the Trust are failing to meet the NHS 18-week standard for first appointments due to severe demand and capacity constraints:

Adult Gender Identity Clinic (GIC): The waiting list has grown to 14,500 patients as of November 2023, with only 50 new patients seen monthly despite 350 referrals. The gap is widening exponentially.

Adult Trauma Service: With a 350% rise in referrals since 2019, the service now has 650 patients waiting. Many require intensive therapy lasting up to two years.

Autism Assessments (ASC): Referrals have increased by 495% since 2019, leaving 240 patients waiting, while only 30 assessments are completed annually. Non-transparent triaging further compounds delays.

Urgent action is underway to address growing backlogs and ensure timely care. This is being managed through service improvement plans established during Kaizen sessions, alongside regular reviews of waiting times and targeted support huddles.

Vision & Goals

Vision: No user services waiting longer than 18 weeks (Adults) and 4 weeks (CYP) 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

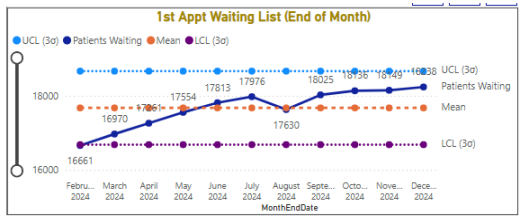
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

G5. Improve recruitment and retention aligned to the teams' workforce plans

Continued...

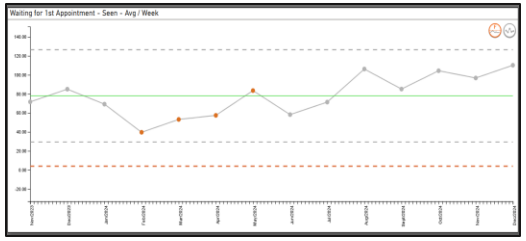
Metric	Waiting List Management (Continued)	SRO	Chris Abbott	Target	4 wk & 18 Wk	Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Historical Peformance

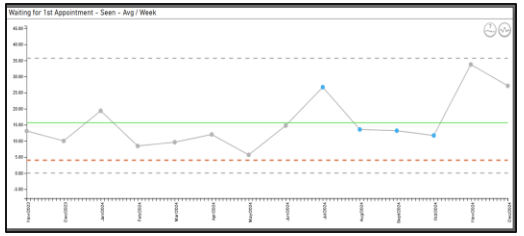


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

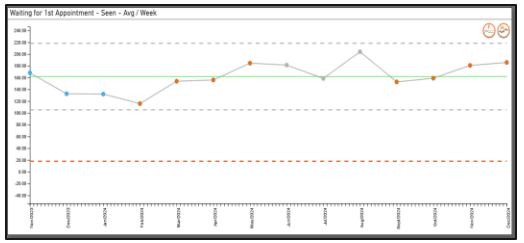
Trauma



Autism Assessment



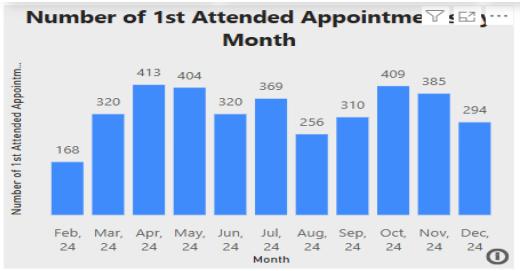
Adult Gender Identity Clinic (GIC)



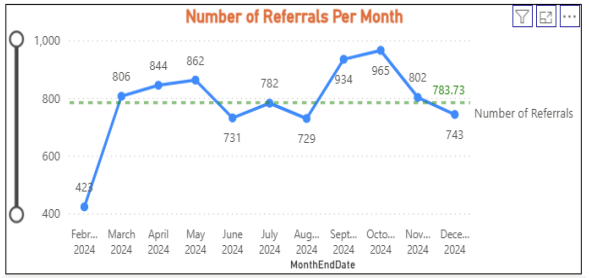
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

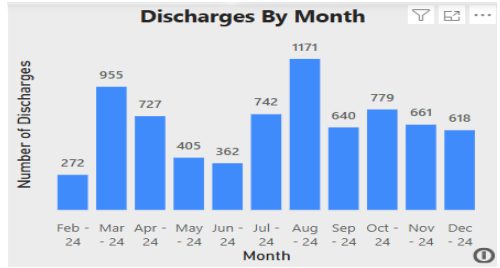
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource allocation but also contributes to longer waiting times for patients awaiting assessment and treatment.	**Increased Demand:** There has been a significant increase in the number of referrals and a focus on delivering first assessments. **MDT Process** - Inefficient clinical review process in MDT that rely on clinician's presenting patients they wish to rather than an iterative review process for all patients. **PTL** - Manual process for enacting PTL function which results in delays in data flow and proactive review of dormant cases	**Ratio of 1st Assessment vs Treatment** – Units and teams to agree the ratio of first appointment vs treatment and discharge they are to complete per reporting period. **(Jan 25)** **MDT ToR** - Medical Director completing the MDT Terms of reference and Clinical Leads to review how patients are presented to MDT regardless of where on the pathway they are. **(Dec 24)** **PTL** - reporting to be digitised and each team and unit to have named operational and clinical roles within each team to fulfil this function. **(Jan 25)** **Waiting Times form Implementation –** Waiting times form mobilisation to ensure that all first and internal wait are captured accurately	Cumulative reduction in the number of patients dormant on clinical caseloads without action. Increase in the number of first assessments and discharges Enhancing access to patient pathway data to enable anticipatory mitigation, rather than relying on retrospective remedial actions."	CSM/Clinical Leads
In some areas, there are insufficient resources to meet the demand from the number of patients being referred	The current budget allocation within the block contracts is misaligned to the increase in demand for some services. Some clinical pathways are misaligned to commissioned population base and evidence based best practice	**ERF** - Recruited staff using non recurrent ERF funding to build capacity for additional activity required to mitigate waiting times in Trauma, GIC and ASD **Trajectories** - Units modelling increased activity and agreeing trajectories for delivery against this resource (managed through a tracker) **Pathways** - Review of the clinical pathways informed by the Kaizen sessions and NICE guidance and service specifications, as outlined in unit delivery plans	Reduction in wait times due to taking more people from the waiting list	Ade/Hahn/ Hector /People/
Pathway Timeline Visibility - Poor visibility of the clinical pathway timelines resulting in some patients sitting in the pathway for longer than recommended	Clinical pathways and the timeline within which treatment is completed is unclear. The pathways are misaligned to the service specifications, contractual targets and patient need The pathway timelines and milestones are ill defined s are not tracked on CareNotes to support timely reporting where there is variance	The mapping of 'as-is' and 'to-be' pathways is taking place across teams with a prioritisation of where there are longer waits. **GIC** – in final stages of completing the "to be" pathway (**Dec 24**, mobilisation from **Jan 25**) **ASD** – TBC **Trauma** – Timeline to be agreed @ Kaizen session **Nov 24**	Having greater standardisation will prevent treatment drift, and with this create capacity which will enable waitlist reduction work	Clinical Leads/ Medical Director/ Director of Therapies
Data and metrics are inconsistent and do not accurately reflect the agreed contractual and clinical targets for performance, quality, and patient safety.	Insufficient clarity regarding contractual targets and requirements Some data fields are not digitized, making it challenging to synthesize and share information for effective planning and mitigation	Work is in progress to digitise the performance data and reporting framework IQPR Business Performance manager starts 14 Oct 24 and will focus on delivering timely and intuitive data – **Dec 24** Digitise the IQPRs reporting framework to flow team and service specific data– **Feb 25**	Enhanced data accuracy and streamlined data flow. Improved tracking of data activities and accountability for team performance in iterative improvement efforts. Greater visibility of contracted and clinical outcome targets to drive performance improvement and patient safety	Hector/Ian/ Adam

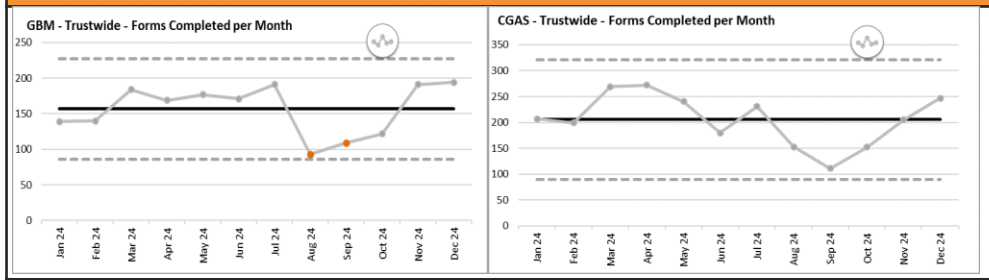
Integrated Quality and Performance Report — Month 9 – 24/25

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.

Historical Performance



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 clinical improvement and impact

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)** Clinicians and teams are not collecting matched pairs of outcome measures **(G2)**	**Min Standard OMs & Logic:** Agree the Minimum Standard OMs and define the logic.	• Minimum required OM agreed through Clinical Governance and Services Delivery Group Meetings – work is ongoing with some teams to finalise Carenotes logic.	RJ / LC
	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. **DET:** OM as part of their training / Digital and Short course	• Recording of training to be circulated to staff and put on a bespoke intranet page – • Unit level Training planned: Child and Family Unit 23rd Jan / Camden Unit 12th Feb / Portman 29th Jan / GIC TBC / Psychotherapy TBC • ***Project risk: dates for Adult services and GIC need confirmation*** • RJ and LC to meeting with training leads to confirm the training content • Exploring the development of OM training within the DET Digital Platform	TK / TL / LL / RJ
	Carenotes Changes: Submitted a proposal to Informatics to make 16 improvement changes to Carenotes, to make the collection of T1 and T2+ data more efficient and consistent.	• Comms for staff sent out in digest and changes to Carenotes made. • Awaiting feedback from focus groups to inform us of the changes to Care Plans. • Changes to all CN logics need to be made after testing with 5 test teams (Start of Feb) • Working with Ops/Admin in CYP MH to update SOPs to reflect the changes being made to Care Plans • **Project Risk / dependency: Comms support still an issue with supporting the project with comms around major changes**	BG / LC
	Improvement pilots: to test improvements and new ideas: • Adult Psychotherapy & Portman (Introducing DIALOG) • First Step (Introduction GBMs in professional consultations) • Autism & LD Team (Digitisation and process improvement)– on hold due to team capacity challenges	• Assistant Psychologist to trial the use of DIALOG with group of Service Users • DIALOG has been activated on Carenotes. • New logic for DIALOG created and testing complete • Work with Adult Psychotherapy and Portman colleagues to understand DIALOG process • This will be introduced at Adult Unit level training • Meeting planned with First Step 27th February to review pilot	NS / BG TK / TR / LL / SB
	Reporting: To fully understand and improve all internal (IQPR) and external (Team Manager) OM reporting and ensuring links with NHSE Waiting Time metrics / SNOMED Codes work. Ensuring that Team Managers and Staff have access to accurate and easily understandable data.	• Met with Quality Assurance colleagues to define SPC charts that report to IQPR and Operational reports. • Quality Assurance drafting new operational reports by end of Jan. Once complete conduct a workshop with Ops colleagues to refine the reports and ensure they are fit for purpose	RJ / LC / SP / EC

Integrated Quality and Performance Report

Month 9 - 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.

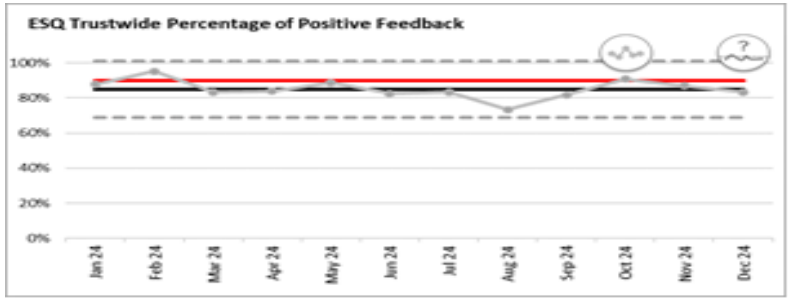
Vision & Goals

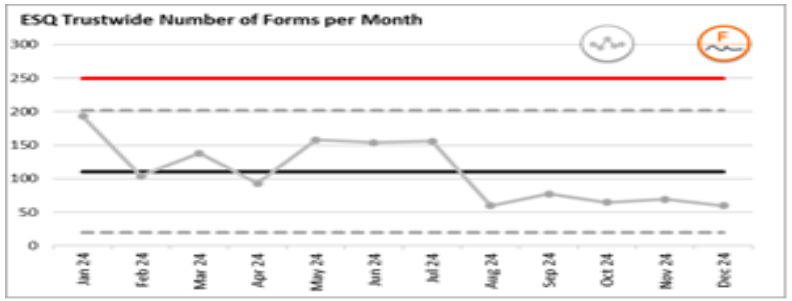
Vision: For all users to have a positive experience across the trust.

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
The ESQ & demographic questions and the logical branching has been finalised however will need to be tested before it can go live.	• Finalise the workflow from the Test environment to be ready to go live	Craig and Sonia
Decision is needed to be made on whether the Service user Expperience QR code will be stand alone or combined with NCL waiting room website.	• Nimisha, Fred to meet to discuss • Posters and Website page to be designed • Comms to support with mock-up of two options and circulated to service users for feedback	Nimisha, Fred Comms
There will be various new ways for service users to provide feedback at any time; support from Comms is needed to help create and finalise the poster, signature for emails and text messages. Service Level engagement in promoting the QR will be needed	• A comms strategy to be developed to help get the message out re new processes and the importance of collecting feedback and create and send the Poster, Footer for the letter template and Email signature. • Dates and for all staff for Lunch & Learn to be arranged	Lloyd
Once the patient correspondence footer has been finalised, support from Informatics will be needed to change all patient correspondence letters to add the footer.	• Confirm the scope of the pt correspondence documents to be updated and begin work to update these.	Barry, Neema
A logic is needed for when the text messages will be sent in different teams based on factors such as regularity of attendances.	• These options will be presented to Managers attending the next A3 meeting on 19/12, to then work with Informatics for roll out: 1. After every attended appt 2. Monthly – if attended appt in month 3. Quarterly	Nimisha, Marcy,
ESQ forms and feedback is moving away from Carenotes to Radar, a transition switch date is needed for a smooth transition	To define a plan for the ESQ forms we currently have on CareNotes and take this to the Carenotes Change Board - How long are we planning to run CareNotes forms and Radar at the same time? - When do we archive the experience questionnaires currently available on CareNotes, so staff cannot use them in error? - Should the completed historical ESQ data from CareNotes be removed and be stored on a secure server?	Nimisha, Marcy, Sonia and Ravneet

Integrated Quality and Performance Report

Month 9 - 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

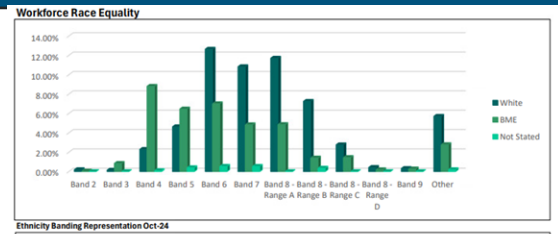
Key achievements so far …

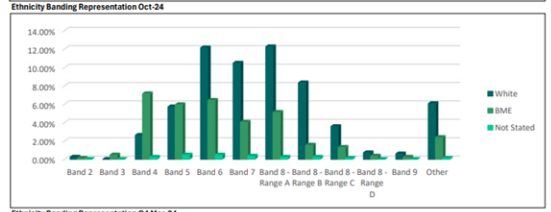
NHS The Tavistock and Portman NHS Foundation Trust

(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%

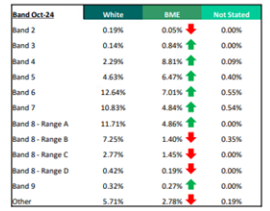
• **Inclusive Recruitment:** all interview panels must now have a trained EDI representative
• All staff networks now have an executive sponsor

Root Cause/ Gap Analysis

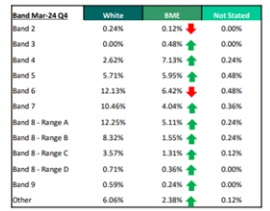




Ethnicity Banding Representation Q4 Mar-24



Band Oct-24	White	BME	Not Stated
Band 2	0.19%	0.05%	0.00%
Band 3	0.14%	0.84%	0.00%
Band 4	2.29%	8.81%	0.09%
Band 5	4.63%	6.47%	0.40%
Band 6	12.64%	7.01%	0.55%
Band 7	10.83%	4.84%	0.54%
Band 8 - Range A	11.71%	4.86%	0.00%
Band 8 - Range B	7.25%	1.40%	0.35%
Band 8 - Range C	2.77%	1.45%	0.00%
Band 8 - Range D	0.42%	0.19%	0.00%
Band 9	0.32%	0.27%	0.00%
Other	5.71%	2.78%	0.19%



Band Mar-24 Q4	White	BME	Not Stated
Band 2	0.24%	0.12%	0.00%
Band 3	0.00%	0.48%	0.00%
Band 4	2.62%	7.13%	0.24%
Band 5	5.71%	5.95%	0.48%
Band 6	12.13%	6.42%	0.48%
Band 7	10.46%	4.04%	0.36%
Band 8 - Range A	12.25%	5.11%	0.24%
Band 8 - Range B	8.32%	1.55%	0.24%
Band 8 - Range C	3.57%	1.31%	0.12%
Band 8 - Range D	0.71%	0.36%	0.00%
Band 9	0.59%	0.24%	0.00%
Other	6.06%	2.38%	0.12%

Progress on Improvements (subject to WRES / WDES refresh)

NHS The Tavistock and Portman NHS Foundation Trust

Priority 1: Eradicate Bullying, Harassment and Abuse

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

- I will challenge and report any racist, ableist, ageist, sexist, homophobic, transphobic, antisemitic, Islamophobic or classist 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.

Priority 1 Metrics / Measurable Actions

- Contribute to the creation of an environment where everyone feels supported:
  (i) Everyone to have an EDI objective that is linked to our values and evidenced over twelve months.
- Managers to create an open culture where staff are comfortable to share or raise concerns:
  (i) All team meetings to have an EDI item on the agenda.
  (ii) All managers' appraisals to be linked to the Trust's three EDI priorities.
  (iii) Follow up National Staff Survey results with bespoke surveys to measure BHA in each service.
- Roll out bespoke EDI training for managers
  (i) Each manager to make a relevant EDI pledge after training.
  (ii) Pledges to be publicised and reviewed.

NHS The Tavistock and Portman NHS Foundation Trust

Priority 2: Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion

- *Championing Inclusivity*
- *Striving for Excellence*

- I will actively champion underrepresented groups by always ensuring fair recruitment with use of an inclusive recruitment advisor.
- 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

Priority 2 Metrics / Measurable Actions

- There needs to be clarity regarding the Trust's position on provision of interview questions in advance for neurodiverse candidates. This should not be left to the discretion of recruiting managers.
- Send all staff comms articulating the Trust's position.
- Formalise feedback mechanism and process:
  EDI representatives to meet with EDI Team monthly.
  EDI representatives to meet quarterly with CPO and/or Chair of EDI Programme Board.
- Update and standardise all recruitment material to reflect the Trust's position

NHS The Tavistock and Portman NHS Foundation Trust

Priority 3: 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

Priority 3 Metrics / Measurable Actions

- Train staff to increase understanding of just and restorative culture principles
- Use internal comms to promote understanding of just and restorative culture
- Clarify all stages of formal disciplinary process
- Clarify all stages of formal capability process
- Increase mediation capacity at the Trust
- Review disciplinary and capability cases quarterly and share themes

Excellence Inclusivity Compassion Respect

Integrated Quality and Performance Report

Month 9 – 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.

Historical Performance

Key Performance Indicators	Trust Average Target	Aug-24	Sept-24	Oct-24	Trend (Against Previous Month)
Sickness Absence	3.07%	2.00%	2.33%	2.82%	⬆
Turnover	2.20%	2.30%	2.26%	1.37%	⬇
Vacancy (To be reviewed)	15.00%	8.29%	10.66%	12.01%	⬆
Statutory and Mandatory Training	95.00%	79.88%	80.22%	79.24%	⬇
Appraisal (Rolling 12 months)	95.00%	43.03%	43.33%	45.80%	⬆

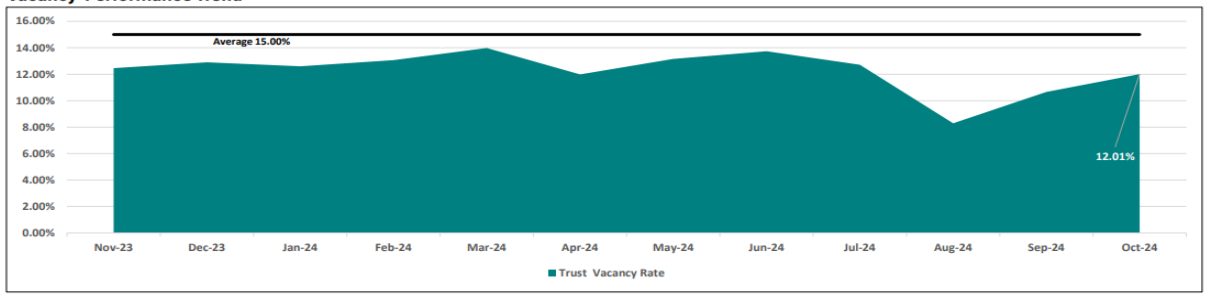
Voluntary Turnover Rates by Years Service

Months	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24
Trust Overall Turnover Rate	1.07%	1.61%	2.46%	0.75%	8.32%	1.32%	1.85%	0.70%	1.85%	2.30%	2.26%	1.37%
of which are Voluntary	0.93%	1.05%	1.15%	0.61%	1.00%	1.28%	1.16%	0.48%	1.47%	1.14%	1.08%	0.82%
<1 Year	0.15%	0.29%	0.25%	0.55%	0.29%	0.16%	0.16%	0.16%	0.00	0.16%	0.00	0.00
1 to 2 Years	0.56%	0.09%	0.54%	0.00	0.12%	0.32%	0.32%	0.16%	0.22%	0.22%	0.00	0.15%
2 to 5 Years	0.15%	0.55%	0.29%	0.00	0.37%	0.47%	0.24%	0.16%	0.32%	0.58%	0.97%	0.37%
5 to 10 Years	0.07%	0.07%	0.00	0.06%	0.22%	0.22%	0.16%	0.00	0.55%	0.09%	0.00	0.15%
10 to 15 Years	0.00	0.05%	0.07%	0.00	0.00	0.00	0.29%	0.00	0.32%	0.09%	0.11%	0.15%
15 to 20 Years	0.00	0.00	0.00	0.00	0.00	0.11%	0.00	0.00	0.07%	0.00	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

Top Sickness Absence Reasons Year on Year Comparison

	FTE Days Lost Oct-24				FTE Days Lost Oct-23			
Absence Reason	Long Term	Short Term	Grand Total	Absence Rate	Long Term	Short Term	Absence Rate	Year On Year Difference
Trust Overall Sickness	320.10	254.64	574.74	2.82%	367.43	107.12	2.23%	⬆
S10 Anxiety/stress/depression/other psychiatric illnesses	151.60	73.24	224.84	1.10%	31.00	11.50	0.20%	⬆
S11 Back Problems	0.00	0.00	0.00	0.00	31.00	0.00	0.15%	⬇
S12 Other musculoskeletal problems	0.00	2.65	2.65	0.01%	0.00	26.50	0.12%	⬇
S13 Cold, Cough, Flu - Influenza	0.00	69.58	69.58	0.34%	0.00	16.00	0.08%	⬆
S15 Chest & respiratory problems	0.00	29.60	29.60	0.15%	0.00	11.00	0.05%	⬆

Vacancy Performance Trend



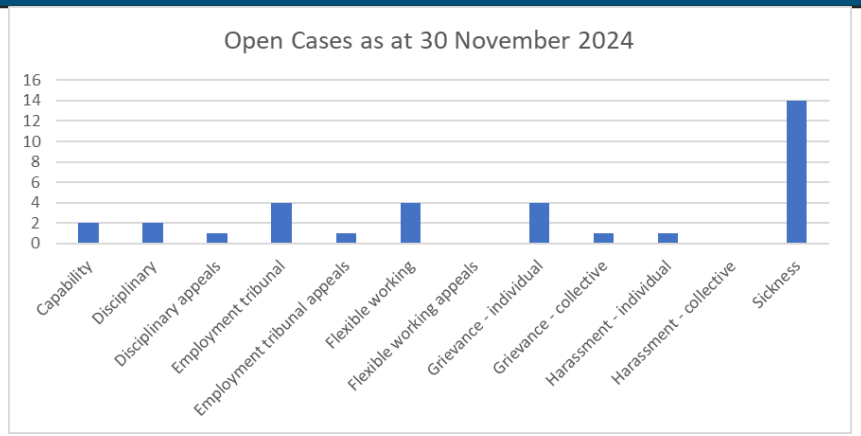
Vision & Goals

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 (ended higher than 2023 on 54.63%)

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

Root Cause/ Gap Analysis



Progress on Improvements

Next steps

December
- Further conversations and refining of behaviours
- Planning for 2025

January
- Executive, POD EDI and Board sign off
- Warm up conversations with clinical, corporate and DET teams and at senior leaders forum
- Launch w/c 20 January 2025
- Aspiration is for conversations across the organisation at 1:1/team and division level about how to embed the behaviours
- Backed up by awareness campaign and embedding in our work e.g. policies and procedures
- Launch 'Values in practice' awards to ask staff to identify examples of best practice in living the values and behaviours

Values in practice awards

- Our staff awards
- Ask staff to nominate colleagues who are living the values and behaviours
- Nominations open in January 2025
- Six categories – one for each value
  - Chair's award
  - Chief Executive's award
- Judging panel of board members, network representatives and others
- Ceremony in March 2025 (date TBC)
- Identify ways to recognise behaviours best practice on an ongoing basis.

Excellence Inclusivity Compassion Respect

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	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	Nov-24	Dec-24
Are we safe?	Patient safety incidents (actual or potential harm)	N/A		↓	10.34	12	18	12	10	9	8	10	4	11	13	17	11	6	13	15	6
	Open SI / PSI investigations	TBC		↓	2.69	3	3	3	3	3	3	2	3	3	3	3	3	2	2	2	2
	Violence & aggression incidents	<5		↓	7.00	8	9	11	6	6	4	8	2	7	9	7	1	1	9	16	8
	Restraint incidents	0		↓	3.38	1	1	0	0	0	1	4	5	6	12	9	0	1	5	7	2
Are we effective?	52-week+ dormant cases	0		↓	1997	2473	2380	2350	2366	2266	2185	2126	2080	1922	2034	2000	2008	1966	1941	1950	1938
	No of referrals (including rejections)	919		↑	834	828	914	977	646	919	981	804	839	868	734	783	734	912	914	783	705
	No. of attendances	7046		↑	6461	6221	6485	7851	5067	6922	6927	6525	6247	7342	7444	7234	3837	6161	6914	6961	5182
	No. of discharges	919		↑	682.75	553	433	680	376	1024	966	943	698	886	847	722	1165	604	747	630	580
	% of Trust led cancellations	<5%		↓	4.09%	3.75%	5.04%	3.20%	5.71%	4.44%	4.06%	3.36%	4.48%	4.20%	4.03%	3.71%	4.89%	2.72%	4.17%	4.04%	3.62%
	% of DNA	<10%		↓	9.85%	9.47%	9.44%	9.00%	9.50%	9.47%	9.08%	9.15%	10.58%	9.76%	10.07%	10.57%	11.84%	10.56%	10.79%	9.29%	8.96%
Are we caring?	Number of formal Complaints received	<10		↓	5.93	7	5	7	3	5	5	2	2	6	7	4	6	10	9	11	4
	Number of compliments received			↓	84.10							81	61	203	124	67	55	54	60	85	51

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous	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	Nov-24	Dec-24
Are we caring?	Number of informal (local resolution) complaints	TBC		→	1.73	0	4	1	1	0	0	4	7	2	0	0	0	2	5	0	0
	ESQ positive responses (%)	90%		↓	85.6%	90%	90%	93%	77%	88%	95%	83%	84%	89%	82%	83%	73%	82%	91%	87%	83%
Are we responsive?	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS/FirstStep	0			28.31	56	58	51	54	53	38	20	26	20	17	12	5	12	10	9	12
	18-week RTT breaches Autism Assessment (1st appointment)	0			80.50	30	40	50	67	77	90	98	107	111	113	104	102	94	97	74	34
	18-week RTT breaches GIC (1st appointment)	0			14009	12792	13061	13174	13429	13296	13456	13814	14053	14365	14772	14923	14490	14594	14545	14559	14620
	18-week RTT breaches Trauma (1st appointment)	0		-	682.94	426	449	480	517	558	607	640	689	720	752	781	821	846	855	878	908
	18-week RTT breaches PCPCS (1st appointment)	0		↓	126.69	61	48	46	70	71	80	114	150	161	181	170	176	191	227	215	66
Are we well-led?	Mand and stat training (combined)	90%		↓	75.3%	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%	77.5%	76.8%
	Appraisal completion (combined)	90%		↑	49.7%	72.2%	63.0%	66.3%	64.1%	61.2%	55.7%	30.8%	28.7%	23.2%	36.3%	41.8%	43.0%	43.3%	45.8%	56.1%	57.2%
	Staff sickness (combined)	3.07%		↑	2.28%	2.39%	2.23%	3.36%	3.17%	1.45%	1.61%	1.34%	1.84%	1.79%	1.82%	1.63%	2.00%	2.33%	2.82%	2.95%	3.06%
	Staff turnover (combined)	2.20%		→	1.9%	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%	0.9%	0.9%
	Vacancy rate (On Hold) (combined)	15%		↑	11.02%	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%	13.47%	13.50%

The Trust reported 6 Patient Safety Incidents

A death reported in the Adult Unit in December has been reviewed via 72-hour report and mortality review. Following this, there has been no indication of a further learning response required for the Trust however there will be contact with the secondary care mental health provider to ascertain if the Trust can contribute to their learning response as required. In the interim, the outcomes of the learning responses undertaken by the team have been discussed at the Clinical Incident & Safety Group and direction given to present at the Clinical Governance meeting to discuss the incident and learning.

The patient safety team continue to work with Leads to ensure the number of outstanding managers reviews is reduced with this data being provided and reported on monthly to Unit Clinical Governance meetings by way of information and escalation.

Patient safety Incidents

6

The Trust reported 8 Violence & Aggression incidents

There were 8 reported incidents involving violent and aggressive behaviour, all of which reported in the Children & Families Unit (Gloucester House team). This is a reduction in number terms from the previous month however it is noted that this will have been affected by the Christmas school holidays and the school being closed.

The Patient Safety team are continuing to progress with a Thematic Review in relation to violence and aggression incidents at Gloucester House with the involvement of one of our Patient Safety Partners. The learning identified following review of themes will be implemented to reduce the risk of future reoccurrence of similar incidents.

V&A Incidents

8

The Trust reported 2 Physical Restraint Incidents

The electronic form to capture restraint details as part of the incident form is now live in the testing site of Radar. The new form will be part of the incident record to enable Gloucester House to move from manual logging to electronic recording. Final testing is now taking place on the staging site before final publishing and go live shortly. It has previously been identified that details of restraints had not always been logged on the incident reporting management system or in the paper records. It is therefore like that the data for restraints will increase in the number of reported incidents as the culture around this improves.

Restraint Incidents

2

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

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

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 4 Formal Complaints December 2024, and the number of complaints overdue was 16. All 4 formal complaints were recorded in the Adult Unit, 3 of which were for GIC. 5 formal complaints closed in the month were responded to within the 40 working day timeframe in the month. As of the end of December, there were 27 open complaints; broken down as follows: - Adult Unit, 23 open complaints, of which 13 were overdue - Children & Families Unit: 3 open complaints, all of which are overdue complaints - Camden Unit: 1 open complaint	**Formal complaints4**
The Trust has recorded 1 Compliment from Radar Compliments recorded via Radar were 1 for the month (categorised as patient care). Clinical team managers are reminded through Clinical Governance meetings to promote this new process in their teams. This new Radar module 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. The number of positive comments/feedback received via ESQ forms continues to be high, with 51 positive comments recorded (Adult; 15, Camden 11, Children & Families 25). Recording and reporting of positive feedback is currently under review as part of the A3 Quality Improvement Project focused on User Experience.	**Compliments** **1**
The Trust recorded 84% of ESQ positive responses in December 2024, which is below the benchmark of 90%. The new digital platform for the anonymous collection of Experience of Service Questionnaires (ESQ) is being implemented as part of the QI Project on User Experience. Lunch and Learn sessions have been scheduled to take place in January to support the QI work and increase compliance. Work continues to agree team level targets for ESQ feedback, and a new ESQ feedback protocol for sharing Team level data and feedback has been implemented.	Positive responses 84%

Delivering our vision – How are we doing? - December 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

We have seen a gradual increase within the past three months. This has progressed in December by 1.06%. A few changes have been made to the extraction of appraisal data, to ensure clear employee compliance activity.

Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals.

Chief People currently hold the highest at 78.57%, taking over from Chief Strategy & Business Development (CSBD) this month. Chief Nursing follows with an achievement of 72.22%

% Appraisal completion
57.19

Overall, at Trust level sickness has increased to 3.06% in Dec-24, by 0.11% from Nov-24.

The Estates staff group continues to hold a high level of sickness at 14.33%. Medical & Dental then follows at 5.58% taking over the Allied staff group in Dec-24.

The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.18% in Dec-24, however, has decreased from Nov-24 by 0.05%.

This month has shown an increase with employee's flu sickness rate with Cold, Cough, Flu – Influenza at 0.40%. This has increased from Nov-24 by 0.06%. This could be due to the fact of a low uptake within flu vaccinations compared to last year.

% Staff sickness
3.06

Compared to last month there has been a decrease by 0.74%

Chief Strategy & Business Development (CSBD) stands at 92.92% compliance, holding a high standard compared to each directorate. Chief Executive follows at 91.74%, taking over from Chief Financial this month.

The Workforce reporting manager sends out a monthly compliance report to monitor and drive improvements in compliance percentage, ensuring continuous progress and alignment with the Trusts standards.

To achieve a high standard, each directorate will need to target above 90%.

MAST training (%)
76.78

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 is £960k behind plan at M09, this is a worsening of the position by £220k from the M08 position. The variance to plan is driven by the unfunded element of the pay award and a one-off income error worth £156k in month 09. The reported cash position at the end of December was behind plan by £323k at £1,533k. However, cash continues to be a challenge, with the NHSE cash support not agreed for the first time in January 25.** **Capital spend is expected to be on plan at £2,468k at the end of the year.**	 **24/25 YTD planned position £1,748k deficit**
The Trust declared….	 **24/25 YTD actual position £2,708k deficit**

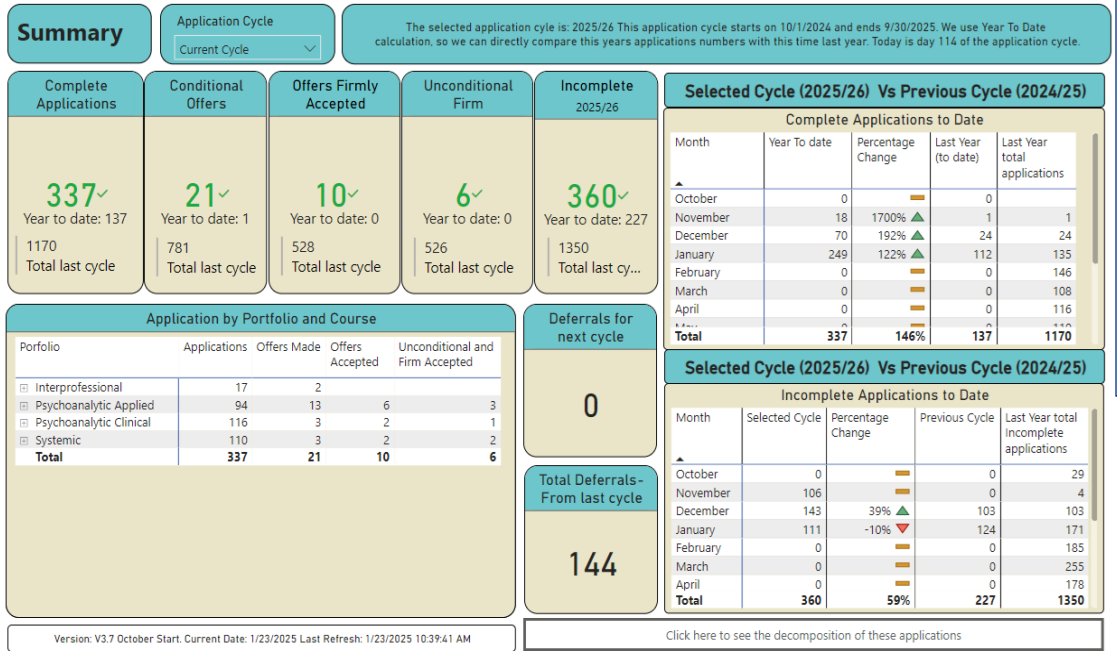
Unit Overviews

Education & Training

The Tavistock and Portman NHS Foundation Trust

Successes	Challenges
• Student recruitment opened three months earlier than the previous year in October 2024, and in M09, student recruitment sits at 337 completed applications, up 82% on 2023/24, and 360 incomplete (up 49% on 23/24).	• Whilst we have seen an increase in the number of applications from international students, we are at a disadvantage when compared with our competitors in converting applications to acceptances owing to our small size (e.g., unable to offer student accommodation).
• We saw a 29% increase in overseas students in 2024/25 (121) against 2023/24 (93), resulting in a £604k increase in student fee income. There was a slight overall contraction in the overall number of students (2024	• Student support: Lack of flexibility in SITS (student monitoring system) to support a more flexible/modular form of delivery as well as ensuring data integrity; lack of staff knowledge and training in SITS operation.
• Our psychotherapy programmes were recommended for full re-accreditation by the British Psychoanalytic Council for a full period of five years following a review in November 2024.	• DET faces an extremely high regulatory burden, needing to honour multiple data returns from higher education validating and regulating agencies, including the University of Essex/HESES, Office for Students (OfS) and Higher Education Statistics Agency (HESA), in addition to NHS requirements.
• The Institutional Review Panel recommended that the Trust be re-approved as a partner institution of the University of Essex for a further five years, following the recent Institutional Review (2023/24) until 2028.	• The possibility of a merger with another NHS Trust raises a number of significant risks due to our need to retain OfS registration to honour contractual obligations but having had advice that a merger will force us to de-register. We are in discussion with the OfS and other stakeholders.

Student Recruitment Activity Overview



Analysis

Student recruitment: At the completion of the 24/25 cycle, the Trust currently has a total of 1516 students, comprising 649 new and 867 returning students, a small decrease on 23/24 (1566). This figure includes significant increases to international student numbers (29%) but a slight decline in home students (8%). Courses in high demand include the Introduction to counselling and psychotherapy (D12/ED12); the MA in Consulting and leading in organisations: psychodynamic and systemic approaches (D10); the consolidated Psychodynamic Psychotherapy (M58) training; and the professional doctorate in Advanced practice and research: social work and social care (D55). We are preparing to launch of several new short courses and have announced the imminent publication of a new online training in ''Child sexual abuse disclosure: how to support adult survivors," with over 100 people registering their interest so far.

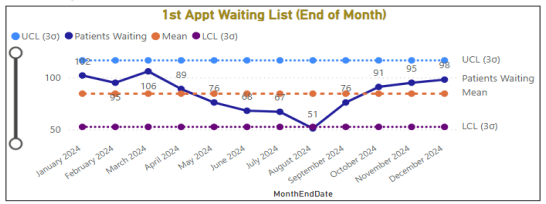
Staffing: We have significantly recruited to our Operations team within DET to reduce operation risk from Registry function and support student growth and are currently consulting with Visting Lecturers to ensure those with significant teaching loads are moved into substantive contracts, allowing us to budget accurately for the future and provide a sustainable foundation for teaching. These initiatives will lead to a significant increase in our Pay costs for 25/26 and beyond with only a smaller reduction in non-pay to offset. These costs will need to be met through increased student recruitment with an emphasis on international learners; a strategy to achieve this is already in place.

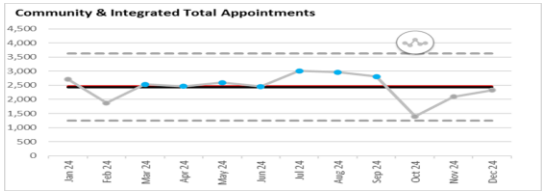
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move Visiting Lecturers into substantive posts, at least 33% reduction from 24/25	CETO / Directors of Education	February 2025
Regulatory changes (OfS)	Office for Students' regulatory focus on franchise/partnership model	Identify stronger institutional partnership with university partner(s) and consult with OfS and other stakeholders.	CETO / Directors of Education	Ongoing
SITS	Our SITS (student academic monitoring) system was implemented in 2017 and in many respects has not been fit for purpose.	An external review of SITS was undertaken and reported in July 2024. Significant issues with staff knowledge and training were identified. Recruitment & training underway to address these.	Director of Education (Operations)	End January 2025

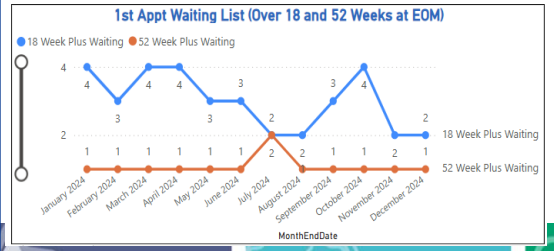
Camden Unit Overview – Please note the data below reflects the old unit name and IT are updating this on the dashboard.

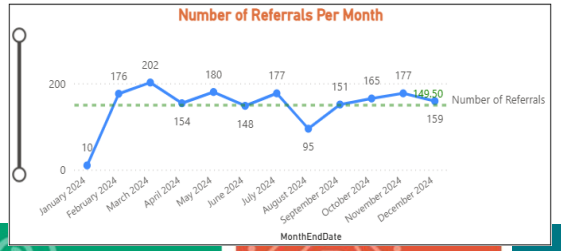
	Successes	Challenges
Safe	Our **Whole Family Service** has expanded its team by recruiting a full-time Systemic Family Therapist and one full-time nurse to enhance their support for young people facing complex challenges, including those on the periphery of gang-related activities. These new roles will play a critical part in addressing the physical, mental, and emotional needs of young people, providing tailored interventions and care. The therapist will focus on mental health support, offering counselling and coping strategies to help individuals navigate difficult circumstances. In addition to this, the nurse who has been recruited will provide essential healthcare guidance and advocacy. Together, they will work collaboratively to deliver holistic, family-focus support, strengthening the service's mission to create safer and more positive future for young people at risk. **Early Intervention Service (EIS)** – Our clinicians in this service who currently work off site in Camden. From December 2024 they now have access to our Carenotes system and can access patient records now using our VDI system. This will allow the clinicians access to their patients' electronic records and to further support the work and their casework with siblings.	• **Camden Local Authority** will be undergoing some changes within their Social Care Services regarding the delivery of their services. Our NCL Community Complex Service Teams will continue to work with the Social Care Team in Camden to ensure careful consideration of how services are delivered and continue to ensure they remain accessible and effective for young people and their families. The key focus will be fostering collaborative working with Camden Local Authority Social Care Team and continue to provide support for our young people linked to both services. The aim is to navigate these transition changes smoothly ensuring that our patients remain at the heart of our service delivery. • **South Camden Community Team** – We have re-launched the opportunity for clinicians to volunteer to pilot the evening late clinic appointments with the initiative to support the on-going room booking issues. We are waiting to find out the number of clinicians who are interested in working the late clinics. • **Dormant Case** have reduced, we have seen a significant reduction with dormant cases from 12 – 18 months. We will continue to run the monthly reports and add Dormant cases to our Patient Tracking List meetings on a weekly basis to ensure the numbers have decreased further. • **Team Clinical Leads** – have reported that post-restructure it appears that some TCL are struggling in their roles in term of time given to carry out their tasks and at times find that they are taking time from clinical roles. • **Sick leave** there was an increase in sick leave this month due to a spike in flu/covid illness. 3.50% November and 5.69% and December • **Room Booking** – Continues to be challenging at the Tavistock and Ampthill sites – still waiting for the working group to be arranged to begin working on a solution.
Effective	•**CAISS Team –** are now fully staffed with 4 new staff members recruited. There have been no inpatient mental health admissions for Camden CYP for the month of December. •**Camden Wellbeing Practitioner Team** - Fully staffed with the new recruitment of trainees for this year, the trainees for 2024 have left the team so there may be challenges in relation to the new referral increase and allocation of these patients to the new trainees. ESQ's feedback has been positive for this service.	• **CAISS** Reports that the Goal Base Measure (GBM) continues to be a challenge to complete with patients in this team – the team will continue to meet and ensure that the completion of these forms are meaningful for their patients and not allowing this to feel like a tick box exercise. The team will continue to ensure patient involvement with goals set is clinically meaningful. There is a workshop for Outcome Monitoring on 12 February, which staff are encouraged to attend. This workshop will support staff to integrate a new way of working with the processes, forms and increasing the compliance with OM form completion which is crucial for tracking and improving patient care.
Caring	**Growing with You (GWY) – CLA & Asylum -Seeking Service** – Care experienced Leavers LAC 18+, this team is officially open for new referrals . Leaflets are now being shared with Camden and GPs to promote the service. The team is also open to offering training, consultations and a reflective space for community practitioners. Patient age range for this service is 0 – 25 years old.	• **Assessment and review summaries –** We now have a deputy operational manager who will lead on ensuring we have limited number of assessment left in draft mode -16 patients. It appears that the forms were started in December and patient 1st appointments were attended in December. Therefore, these patients could possibly be waiting for a 2nd appointment, then a completion date will be added. A reminder email will be sent to clinicians to remind once assessment or review assessment have been completed, a date must be added. • **Annual Leave** –Where the carry-over of annual leave has not been agreed, managers are informing staff that they will need to use up all of their annual leave by the end of March 2025 which poses as a significant challenge, e.g. disrupting patient care and increasing strain on staff to keep our services running.
Responsive	•**Phase 1 Duty of Candor –** Meetings will be scheduled for NCCT, CWP, SCCT staff to have discussions regarding a staff member dismissed last year. Letters have gone out to patients. Therefore, updated conversation will need to take place for assurance in relation to this matter.	• **RADAR** – our Experience of Service Questionnaire (ESQ) for families and patients – the paper versions of this form should be completed by our Team Administrators. The Operational Team Manager has informed the Patient Public Involvement team that our admin teams need to be informed of this process and to ensure our admin teams have access to RADAR and have training to support this work. • **Arsenal Mentoring Programme –** Internal challenges with this service being placed under the NCCT Service which is skewing the 1st and 2nd appointment wait times for Camden. The Operational Team Manager will liaise with Informatics to explore if this service can remain independent and possibly exempt from 1st and 2nd appointment wait times due to the long wait to appoint a mentor from Arsenal.
Well-Led	•**ESQ New Process** – New QR code and Link – our Patient Public Involvement Team have now launched the new ESQ process and will be visiting team meetings to discuss the new process using the relevant links. There is a pilot rolled out for a few clinical services for a Quality Improvement exercise. •**Compliments** - 11 Complements this month - Team Managers would like to explore how the Trust can share the compliments with our clinical service staff.	• **Appraisals** – there has been an increase in the completion of appraisals from 37.5% in November to 43.75% in December. The Operational Team Managers will continue to contact staff on a monthly basis whose appraisals are due. • **MaST – Training:** November shows 84.10% and December indicates a decrease in compliance to 80.54% - this is probably due to modules expiring. Staff are emailed once their modules have expired and the uptake to complete the modules are moving in a positive direction.

Activity Overview









Waiting times – Our waiting time for the 4 week Wait 1st and 2nd appointment list appears to be stable and manageable. On going monitoring on a weekly basis.
Analysis: There could possibly be an increase of breaches within the next few months due to clinicians having to use up all of their annual leave by 31st March 2025. However, this will be monitored weekly.
Referrals – Referrals have decreased for December 2024: 117 referral received compared to 142 for November.
Attendance rates: The % of attended appointments remains strong 77.70% . Whilst the decrease is minimal, its worth noting that the cancellation rates have seen an increase. This rise is likely attributed to seasonal factors such as the widespread Flu and Covid illnesses experienced by staff and patients is prevalent during this period. However, despite these challenges our overall attendance rated remains steady.

Concern	Cause	Countermeasure	Owner	Due Date
Job Planning data. collection unclear – job plans not being adhered to comprehensively leading to low performance figures for some staff.	Unclear process on collecting JP data. Team Managers not holding clinicians to agreed JPs.	**UPDATE:** Job plans for clinicians have been completed and updated. Staff have been informed that JP can be revised they are not fluid therefore subject to change	GM, AD. CSM	28th January 2025
Treatment Waiting	Unsuccessful recruitment or recruitment delays	**UPDATE:** We have around 7 new recruits across the unit this should reduce the number of internal treatment waiting list for our patients. We will continue to monitor fortnightly and remind clinicians to complete the form when patent waiting for treatment has commenced.	CSM/AD/GM	28th January 202

Watch Metrics Score Card – Camden Unit

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous month	Mean	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	Incidents – Serious Incidents	0			0		0	0	0	0	0	0	0	0	0	0	0	0
	Patient safety incidents (actual or potential harm)	N/A		↓	2.33		0	0	0	0	0	0	0	0	0	3	3	1
	Incidents – Open SI / PSI investigations	N/A			0		0	0	0	0	0	0	0	0	0	0	0	0
	Falls with harm - incidents	TBC					0	0	0	0	0	0	0	0	0	0	0	0
	Violence & aggression incidents	TBC			0		0	0	0	0	0	0	0	0	0	0	0	0
	Restraint incidents	TBC		↔	0		0	0	0	0	0	0	0	0	0	0	0	0
Excludes EIS / Gloucester House / First Step / PCPCS / Teams due to nature of their Path ways	52-week+ dormant cases	<5		↔	20	35	32	28	30	26	27	21	14	13	11	11	6	5
	No of referrals (including rejections)	162		↓	202.9	172	230	248	253	232	264	165	200	112	167	207	211	177
	No. of attendances	2456		↓	2434	1925	2602	2523	2641	2515	3010	3033	2884	1489	2216	2450	2463	1893
	No. of discharges	162		↑	166.5	152	202	155	149	159	158	153	190	196	180	161	153	156
	% of Trust led cancellations	<5%		↓	1.35%	1.75%	1.24%	1.61%	1.25%	1.41%	1.60%	1.88%	0.87%	0.87%	0.84%	1.67%	.1.48%	1.25%
	% of DNA	<10%		↑	8.86%	7.67%	8.70%	7.38%	8.49%	9.60%	9.24%	10.08%	9.62%	10.84%	8.82%	9.63%	7.33%	7.75%
	Number of formal Complaints received	<10		↓	1.0											2	1	0
	Number of compliments received			↓	12.33											12	14	11

Jan – Sep 2024 Safety & Complaints Metrics have been taken from the IM Report for the old unit structures.

Watch Metrics Score Card – Camden Unit

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous month	Mean	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	Number of informal (local resolution) complaints	TBC			0.33				0	0	0	0	0	0	0	1	0	0
	ESQ positive responses (%)	90%			93%		95%	100%	100%	95%	100%	73%	94%	86%	92%	94%	100%	82%
	18-week RTT breaches Camden Unit	0			1.54	2	2	1	2	2	2	3	1	0	0	2	3	0
Are we well-led?	Mand and stat training (new structure)	90%			84.4%	80.7%	83.2%	82.6%	84.8%	86.8%	84.2%	84.4%	84.6%	86.2%	85.7%	84.1%	84.5%	81.7%
	Appraisal completion (new structure)	90%	Jan – Sep 2024 Well-Led Metrics have been taken from the IM Report for the old unit structures.		43.1%	82.2%	80.6%	80.3%	38.4%	36.7%	33.1%	45.3%	47.8%	45.2%	40.7%	41.1%	44.3%	44.3%
	Staff sickness (new structure)	3.07%			3.30%	1.31%	1.49%	1.67%	1.46%	3.48%	2.76%	2.90%	2.64%	2.41%	2.56%	2.42%	3.50%	5.59%
	Staff turnover (new structure)	2.20%			1.8%	1.4%	5.4%	0.5%	1.7%	2.2%	2.1%	1.2%	1.8%	0.9%	2.8%	2.3%	1.3%	1.6%
	Vacancy rate (On Hold) (new structure)	15%			4.88%	-10.41%	11.68%	11.62%	8.87%	10.10%	10.66%	13.67%	14.14%	-0.62%	6.01%	4.58%	7.17%	7.28%

Watch Metrics – Camden Unit

New Waiting Time Metric	Target	Comments	Trend from previous month	Mean	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
% waiting <4wks for 1st appt at end of period - Camden Unit			↓	77.90%	75.57%	81.88%	72.66%	74.25%	75.36%	78.40%	81.44%	78.26%	63.86%	88.89%	82.08%	86.82%	73.17%

Camden Unit

The Tavistock and Portman NHS Foundation Trust

Line Manager Supervisions
The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Camden Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	8	8	8
Number due cohort - staff who should have supervision	90	96	96
Number of staff that had supervision in that month	32	28	26
Compliance Rate for October	36%	29%	32%

Clinical Supervisions
The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Camden Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	8	8	8
Number due cohort - staff who should have supervision	95	95	95
Number of staff that had supervision in that month	40	19	17
Compliance Rate for October	42%	20%	18%

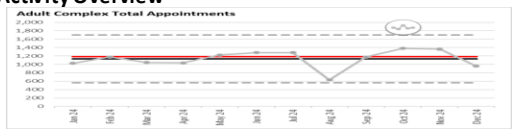
Administration Supervisions
The monthly compliance reports have been set up and reminders where sent.

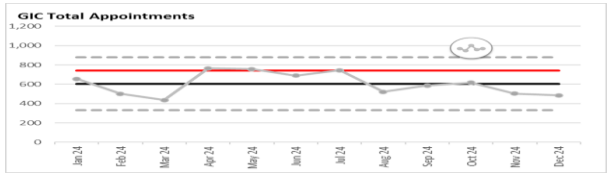
Camden Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	7	7	7
Number due cohort - staff who should have supervision	20	20	20
Number of staff that had supervision in that month	7	3	6
Compliance Rate for October	35%	15%	30%

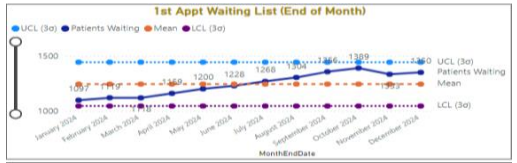
Adult Unit Overview

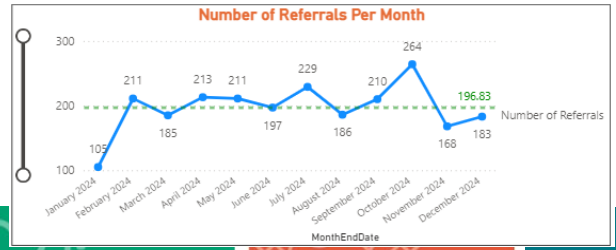
	Successes	Challenges
Safe	•GIC intake screening has been in place now since December , The Distress Rota (aka Duty) SOP is complete with training to follow from Core Lead Nurse together with Deputy GM and the Operations and Admin team. Patient involvement in December in our Trauma Keizen events and planning for GIC service users panel feedback (including NHSE) in January. More complaints have been dealt with informally due to great efforts from the Complaints Team. All PCPCS waiting patients allocated and will finish treatments before service closure in March 2025.	• One theme from patient complaints notes any gaps or discontinuity in communication between our website, 'Waiting Room' service offer (lived experience) and NHSE web-based communications. Important to pay careful attention to content and regular updates. • GIC recruitment plan needs form and action – planning and discussion in place towards an SLT proposal. • The demand and capacity for complaint investigations remains a challenge.
Effective	•Trauma Keizen – multiple service , data, pathway and governance improvements. •OM proejct well engaged and teams adopting the new 'model' Psychotherapy team training complete. •GIC - Rapid implementation of the changes suggested by the NHS review in the portal looks v promising	People - ECP delays and process continues to be a theme in TCL feedback with a wish for teams to have greater authority and direction over their budgets. TCL now meeting regularly with Finance lead and better grounded in new processes. ERF staff find that short-term contracts sits uncomfortably with longer-term clinical work.
Caring	•Lola Barbour and Joseph Anderson has led their team through an unsettling end of contract in PCPCS and now into staff Consultation for re-deployment starting 21.01.25. A challenging process but congratulations to the team for remaining on task to complete treatment for all allocated patients awaiting treatments and remaining together throughout. •Involvement of Experts by Experience iin Trauma Keizen and GIC to Board.	Space and Estates – GIC struggling with working more on site, new flexible working policy may help. There is an argument for some flex in relation to employment of specialist staff, the NHSE Specifications for national gender services may assist in defining skill mix. Ground floor room use needs further consideration, informal complaints from staff and some patients about 'cold/sterile' environment with tech and little comfort. Site opening times may need discussion and confirmation to accommodate clinical and DET schedules.
Responsive	•GIC response to the NHSE Review whilst pressured was ultimately successful and produced resolution to numerous areas of work on SOP, Intake screening and processes requested in the review feedback. A strong group effort. Lived Experience Advisors to Board in January added another layer for development with PPI.	• A minority of staff continue to work remotely up to 100% of the time, this is difficult to monitor and occurs despite being told more than once that attendance on site for minimum of 40% pro rata (until any new guidance emerges).
Well-Led		

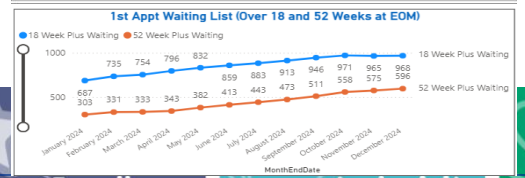
Activity Overview











Analysis

Activity:

Job plan - Waiting times –

Attendance rates –

Concern	Cause	Countermeasure
Waiting list growth in Trauma	Significant increases to demand	• Kaizen and QI A3 review of services. Commissioner engagement. • 1st appointment Clinic model will start in Jan 25 • SOP will be completed by 31 Dec 25 • Clinical delivery model to be reviewed and aligned to service specification and contract – March 25
Job plan performance (trainee and honorary)	• Insufficient WTE staff to provide continuity • Cultural issues regarding job plan agreement • No ratio of 1st appointment vs treatment agreed- which impacts on developing the clinic schedules and 1st appt clinic	• Operations completing clinic schedules supported by job planning • Clinicians to finalise Job Plans

Adult Unit

The Tavistock and Portman NHS Foundation Trust

Line Manager Supervisions

The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Adult Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	4	4	4
Number due cohort - staff who should have supervision	58	60	67
Number of staff that had supervision in that month	17	20	11
Compliance Rate for October	29%	33%	16%

Clinical Supervisions

The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Adult Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	4	4	4
Number due cohort - staff who should have supervision	58	60	67
Number of staff that had supervision in that month	19	24	18
Compliance Rate for October	32%	40%	27%

Administration Supervisions

The monthly compliance reports have been set up and reminders where sent.

Adult Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	4	4	4
Number due cohort - staff who should have supervision	15	16	15
Number of staff that had supervision in that month	3	1	0
Compliance Rate for October	20%	6%	0%

Watch Metrics Score Card – Adult Unit

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	Nov-24	Dec-24
	Incidents – Serious Incidents	0		⇔	0.00			0	0	0	1	0	0	0	0		0	0	0
	Patient safety incidents (actual or potential harm)	N/A		↓	2.33			1	1	2	1	1	2	2	2		2	3	2
	Incidents – Open SI / PSI investigations	N/A	Jan – Sep 2024 Safety & Complaints Metrics have been taken from the IM Report for the old unit structures.	⇔	1.00			1	1	1	2	2	2	2	2		1	1	1
	Falls with harm - incidents	TBC		⇔	0.00			0	0	0	0	0	0	0	0		0	0	0
	Violence & aggression incidents	TBC		⇔	0.33			0	0	1	0	0	0	0	0		1	0	0
	Restraint incidents	0		⇔	0.00			0	0	0	0	0	0	0	0		0	0	0
	52-week+ dormant cases	0		↑	1888.64	2051	2086	2015	1984	1913	1898	1846	1859	1831	1847	1801	1777	1765	1768
	No of referrals (including rejections)	TBC		↓	504.86	592	359	590	599	441	501	491	442	459	517	621	555	458	443
	No. of attendances	TBC		↓	2331.11	2690	1558	2276	2235	2012	2391	2618	2637	2750	1591	2456	2786	2654	1982
	No. of discharges	TBC		↓	394.71	359	102	694	675	238	192	159	138	476	885	373	489	401	345
	% of Trust led cancellations	<5%		↓	36.20%	5.06%	10.43%	8.59%	6.65%	5.73%	7.86%	6.64%	7.07%	6.17%	9.26%	415.00%	5.98%	6.52%	5.85%
	% of DNA	<10%		↓	11.70%	11.34%	12.32%	11.71%	11.59%	10.70%	12.27%	11.30%	11.17%	11.93%	12.63%	12.86%	12.43%	11.12%	10.44%
	Formal complaints - Number received	<3		↓	8.00												9	11	4
	Number of compliments received			↓	35.33												39	52	15

Watch Metrics Score Card – Adult

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from	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	Nov-24	Dec-24
	Number of informal (local resolution) complaints	TBC			1.33			0	0	0.04	0.01	0	0	0	0		4	0	0
	PALS Number received				12.33				10	15	19	21	16				15	8	14
	ESQ positive responses (%) - Adult Unit excl. GIC	90%			83.2%			84%	92%	81%	71%	87%	79%	79%	76%	73%	100%	93%	83%
	ESQ positive responses (%) - GIC (PEQ)	90%			82.0%			86%	86%	96%	77%	86%	84%	83%	85%	69%	78%	89%	65%
	18-week RTT breaches Adult Psychotherapy	<5			18.9	47	48	47	34	15	23	14	10	9	2	9	0	2	4
	18-week RTT breaches Portman	<5			0.57	0	0	0	0	0	1	1	1	0	0	1	2	1	1
	18-week RTT breaches Adult Trauma	<5			718.0	480	517	558	607	640	689	720	752	781	821	846	855	878	908
	18-week RTT breaches PCPCS	<5			137.0	46	70	71	80	114	150	161	181	170	176	191	227	215	66
	18-week RTT breaches GIC	<5			14163.9	13174	13429	13298	13458	13814	14053	14365	14772	14923	14490	14594	14545	14559	14820
	52-week RTT breaches GIC				11309.4	10451	10606	10383	10585	10890	11062	11525	11844	11988	11513	11714	11737	11993	12040
Are we well-led?	Mand and stat training (new structure)	90%	Jan – Sep 2024 Well-Led Metrics have been taken from the IM Report for the old unit structures.		80.8%	75.93%	75.63%	78.05%	80.06%	81.23%	81.56%	81.32%	81.37%		82.87%	81.80%	81.19%	78.33%	79.69%
	Appraisal completion (new structure)	90%			70.0%	74.47%	73.20%	73.96%	23.68%	20.87%	16.28%	38.74%	49.48%		68.67%	69.05%	72.29%	70.24%	69.51%
	Staff sickness (new structure)	3.07%			4.87%	4.31%	0.40%	0.40%	1.11%	1.31%	2.35%	1.84%	1.36%		5.44%	4.47%	5.55%	5.09%	3.80%
	Staff turnover (new structure)	2.20%			1.38%	1.48%	7.09%	1.01%	0.63%	2.02%	0.99%	0.98%	2.15%		1.05%	1.42%	0.92%	1.81%	1.70%
	Vacancy rate (On Hold) (new structure)	15%			10.23%	-7.29%	3.71%	8.73%	10.60%	15.8%	14.51%	13.36%	10.24%		11.45%	11.28%	9.15%	9.36%	9.92%

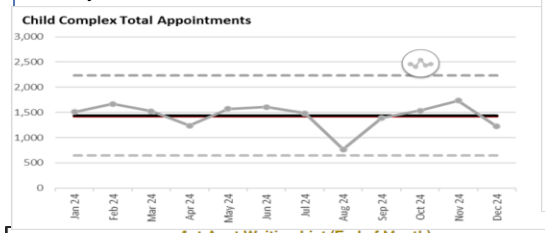
Watch Metrics – Adult

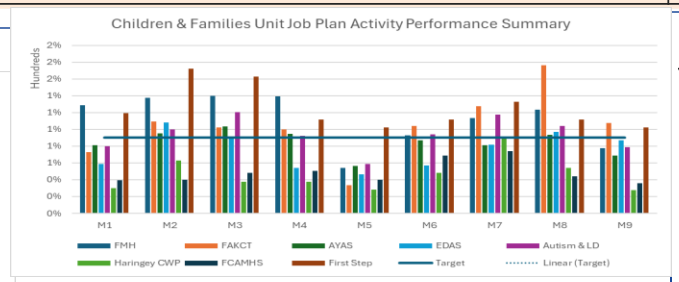
New Waiting Time Metric	Target	Comments	Trend from previous month	Mean	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
% waiting <4wks for 2nd appt at end of period - Adult Unit			↑	2.20%	3.29%	1.93%	3.36%	3.40%	2.07%	2.04%	1.15%	2.12%	2.00%	2.43%	3.21%	0.88%	0.66%	2.24%
% waiting <4wks for 2nd appt at end of period - GIC			↑	1.73%	2.70%	1.43%	2.94%	2.90%	1.62%	1.39%	0.55%	1.60%	1.43%	2.19%	2.86%	0.34%	0.36%	1.97%
% waiting <4wks for 2nd appt at end of period - Adult Psychotherapy			↑	19.87%	9.52%	9.09%	10.32%	12.80%	18.39%	18.27%	19.23%	24.72%	22.67%	15.58%	30.86%	32.50%	23.61%	30.59%
% waiting <4wks for 2nd appt at end of period - Trauma			↑	4.59%	6.63%	5.53%	5.17%	5.88%	4.48%	6.42%	3.33%	4.11%	4.57%	3.92%	4.41%	4.53%	2.50%	2.84%
% waiting <4wks for 2nd appt at end of period - Portman			↑	43.13%	48.28%	44.12%	44.83%	38.89%	46.43%	47.22%	45.83%	40.43%	54.17%	25.53%	43.24%	48.57%	34.09%	42.22%
% waiting <4wks for 2nd appt at end of period - PCPCS			→	8.36%	17.10%	9.35%	12.42%	13.61%	9.67%	11.38%	11.21%	10.36%	9.94%	3.24%	6.04%	2.75%	0.00%	0.00%

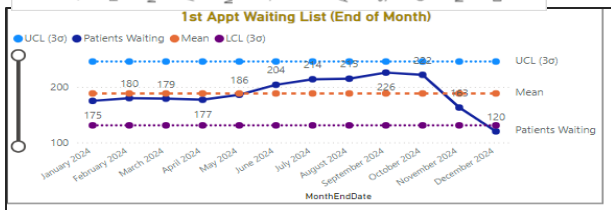
Child and Family Unit overview

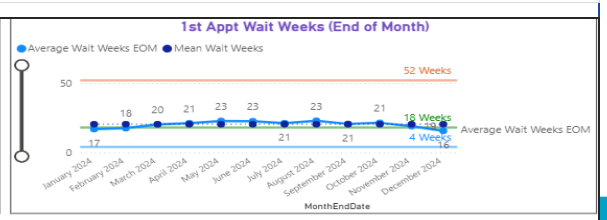
	Successes	Challenges
Safe	Improvement in clinical notes completion across all teams indicating 3 improvement data points to 90% Safeguarding Supervision embedded in all teams Radar Training taking place in all team meetings.	• Treatment waiting lists require additional scrutiny and management • Gloucester House school premises are a concern to staff and pupil health – carers and GPs of pupils informed.
Effective	Average waiting time to First appointment is 5.3 weeks to assessment. A slight increase on Month 9, but an overall trajectory of improvement. RTT 18 week breach has reduced by 61% from 74 to 34 cases after review of all cases waiting in the Autism Pathway who had not had first appointment. AYAS have made sustained improvement in their performance against the 4 week wait time and have reduced from 38 weeks in July 2024 to 5.58 weeks in December.	Surrey Mindworks contract remains unclear due to non-engagement from SaBP. First Step closure ongoing risk, with uncertainty as to final outcomes. EDAS vacancy rate has impacted on service delivery with cases waiting for treatment. ERF funds coming to a close in Autism Pathway.
Caring	Unit specific OM training has taken place (23.01.25) recorded and will be repeated.	GH improvement plan has detailed action plans and timelines for completion across all areas of delivery and associated risks.
Responsive	Creative Arts Therapy service has 104 open cases showing it is a valued service within Camden schools. GH school introducing Pet Therapy. FCAMHS training on Autism and forensic behaviour is sold out at 250 places.	
Well-Led	First Step leadership has responded very well to the change process and have worked hard to make improvements to the data reporting. EDAS – manager vacancy filled. Early intervention parenting group set up.	FDAC options appraisal paper for Trust Board has been drafted to address financial risks. Reduction in referrals to ASF has been noted this year. Team lead and TR working with BDU and have developed a new care pathway with new financial modelling and ready for Spring Marketing Drive. On going Contract Closure Meetings re First Step

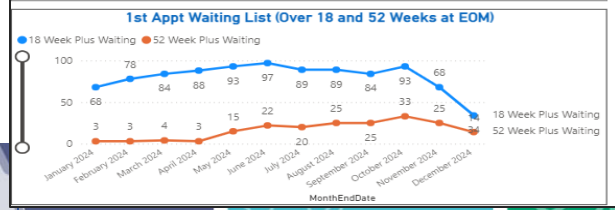
Activity Overview

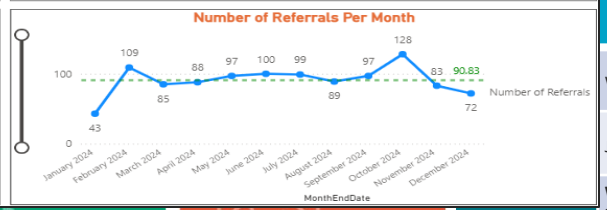












Analysis

Activity – Clinical unit delivered a toral of 1222 appointments in December against 1734 in November. A 29% reduction in activity from the previous month.

Job plan compliance: seasonal reduction in job plan compliance in all teams except for the FAKCT team and First step

Referrals . Overall referrals into the service are up by 3% on the previous year. However referrals into the ASF have dropped as have referrals to FDAC creating a cost pressure in FDAC.

Waiting times: Individual team performance for waiting items for first appointment are: AYAS 5.58 weeks, ASC /LD 4.50,Autism assessment 27.58,FMHT 5.52, EDAS 0.67, FAKCT 4.16. Haringey CWP 1.86. The average waiting time across the unit us 18.77. Without Autism Assessment the average waiting time is 5.3 weeks. The Autism trajectory for first appointment is beginning to correct following an increase in waiting times as part of backlog clearance

Attendance rates – overall attendance rate of 77.88 %

Concern	Cause	Countermeasure
Waiting list growth in Autism	Significant increases to demand	Kaizen and A3 review of services. Commissioner engagement
Job plan performance (trainee and honorary)	To be identified	To be identified - TCL engagement and improvement plan/action plans
Waiting times for 1st appt are now showing a 3 month downward trend and require focussed attention.	Seasonal adjustment and staff vacancies	Robust management through PTL Meetings.

Watch Metrics Score Card – Child & Family

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	Nov-24	Dec-24
	Incidents – Serious Incidents	0		⇔	0.0												0	0	0
	Patient safety incidents (actual or potential harm)	N/A		↓	6.3												8	8	3
	Incidents – Open SI / PSI investigations	N/A		⇔	1.0												1	1	1
	Falls with harm - incidents	TBC		⇔	0.0												0	0	0
	Violence & aggression incidents	TBC		↓	10.7												8	16	8
	Restraint incidents	0		↓	4.7												5	7	2
	52-week+ dormant cases	0		↓	64.36				59	83	62	65	71	58	52	63	62	68	65
	No of referrals (including rejections)	TBC		↓	102.64	106	101	87	121	98	100	103	103	110	97	109	134	92	76
	No. of attendances	TBC		↓	1482.07	1751	1215	1560	1709	1573	1276	1616	1658	1525	780	1439	1604	1782	1262
	No. of discharges	TBC		↓	68.21	98	47	81	76	81	90	61	49	48	73	40	79	67	65
	% of Trust led cancellations	<5%		↓	3.16%	2.97%	4.41%	2.60%	3.88%	3.34%	2.87%	4.21%	2.39%	3.63%	1.56%	2.43%	4.13%	2.89%	2.86%
	% of DNA	<10%		↓	9.18%	7.65%	9.06%	7.80%	9.19%	8.81%	9.51%	8.50%	8.70%	9.85%	12.51%	9.33%	9.89%	9.22%	8.55%
	Formal complaints - Number received	<3		⇔	0.33												1	0	0
	Number of compliments received			↑	17.67												9	19	25

Following the change of structures, these metrics cannot be mapped as they do not align in any way, hence these are left blank.

Narrative December 2024. 52+ week waiters – 4 cases are with FMHT the remainder are on the Autism Assessment waiting list. The cases on the FMHT list have been confirmed as requiring closure and will be actioned this week. Seasonal reduction in activity for December.

Watch Metrics Score Card –Child and Family

The Tavistock and Portman NHS Foundation Trust

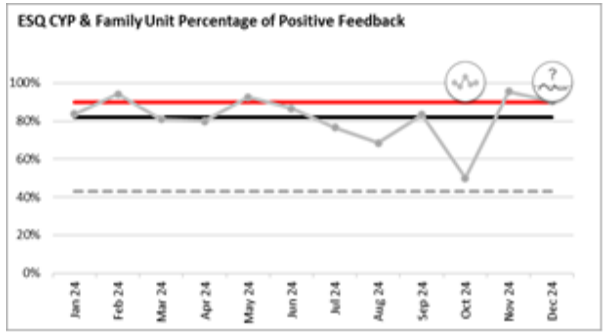
CQC Measure	Metric	Target	Comments	Trend from	Mean	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	Number of informal (local resolution) complaints	TBC			0.00												0	0	0
	PALS Number received				0.33												1	0	0
	ESQ positive responses (%)	90%			82%			84%	94%	81%	80%	92%	87%	77%	68%	83%	50%	95%	90%
	18-week RTT breaches Child & Family (excl. Autism Assessment)	<5			3.1	1	3	4	1	1	1	3	4	3	3	3	6	3	7
	18-week RTT breaches Autism Assessment	<5			87.00	50	67	77	90	98	107	111	113	104	102	94	97	74	34
	Mand and stat training (new structure)	90%			79.65%										83.37%	81.67%	80.04%	77.81%	75.36%
	Appraisal completion (new structure)	90%			52.3%										44.82%	51.19%	54.22%	56.47%	54.65%
	Staff sickness (new structure)	3.07%			3.27%										2.54%	3.63%	4.58%	2.80%	2.81%
	Staff turnover (new structure)	2.20%			2.58%										4.11%	5.30%	1.39%	1.28%	0.83%
	Vacancy rate (On Hold) (new structure)	15%			18.3%										6.6%	15.8%	22.3%	22.9%	24.0%

Following the change of structures, these metrics cannot be mapped as they do not align in any way, hence these are left blank.

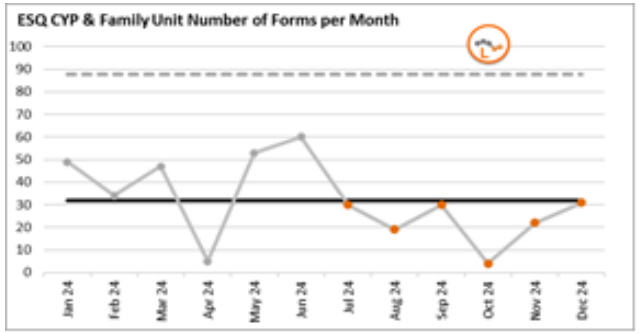
Child and Family Unit Mental Health Quality Overview

Quality Overview

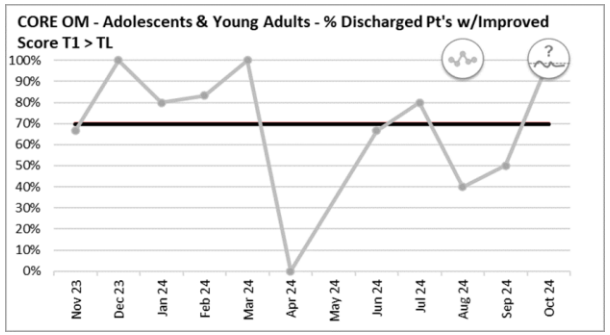
ESQ positive recommendation rate (%)

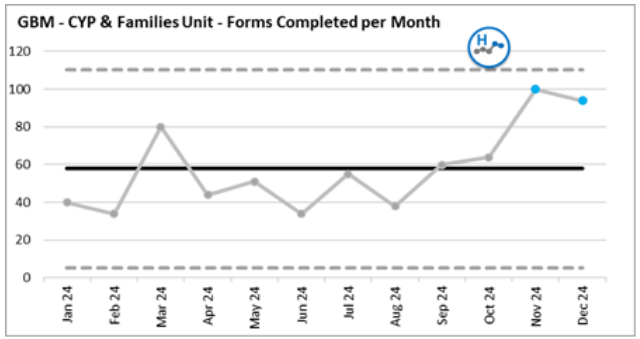


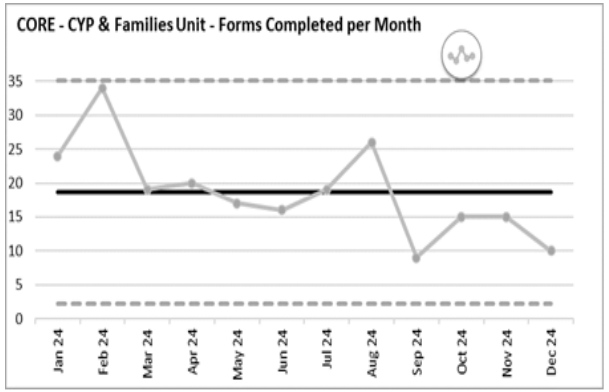
Number of ESQ forms completed

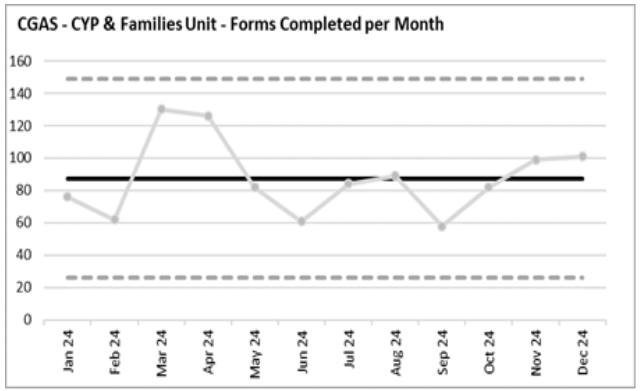


CORE OM IMPROVEMENT SCORES









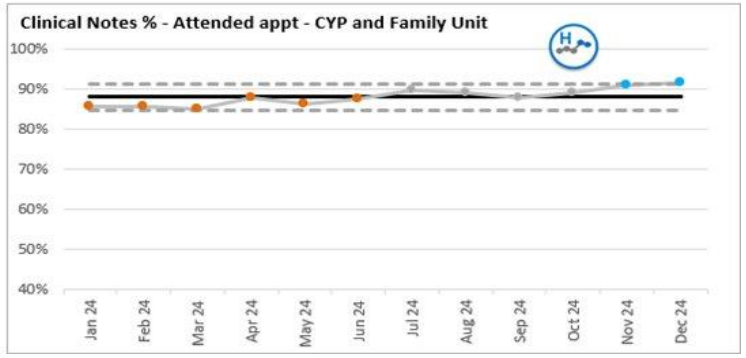
Narrative Analysis

ESQ updates have now been delivered to all teams and we are seeing a trajectory of improvement after a downturn in return rates. This was due to changes in processes not being well understood.

Core Forms for AYAS remain low and require urgent recovery – changes to admin practices have impacted on the return rate.

Q4 priority was the improvement of completed clinical notes which is now at over 90% for attended appointments bad 3 SCV points

GBM return rates for the unit remain high with 32 SCV points indicating sustained improvement.



Next Steps

- OM training being delivered at Unit Level to ensure increased compliance and for OM's to align with 1st appointment.
- A process of developing a Q&A for the Unit regarding OMs and ESQs has been set up.

Concern	Cause	Countermeasure
ESQ collection rates	Limitations of current distribution methods and consistency	Action plan to increase ESQ collection agreed in June workshops
Performance on T1 and T2 outcomes in child complex below CQUIN standard	Practice issue	Service line recovery plan to include team meeting attendance by leads and video reminders.
No routine use of outcomes in First Step	Practice issue	QI prpject
Reduction in return of HONOSCA in FCAMHS	Practice issue	QI project

Delivering our vision – How are we doing?

Responsive – services meet people's needs

The Tavistock and Portman NHS Foundation Trust

Narrative Analysis:

RTT 18 week breach has reduced by 61% from 74 to 34 cases. This is following focused effort to review all cases waiting in the Autism Pathway who had not had first appointment.

RTT breaches 34

Narrative Analysis

Average waiting time for CYP for first appointment reported at 5.3 weeks for Month 9. A marginal increase from the previous month which was at 4.9 weeks. At a team level the performance is as follows : AYAS 5.58 weeks, ASC /LD 4.50,Autism assessment 27.58,FMHT 5.52, EDAS 0.67, FAKCT 4.16. Haringey CWP 1.86.

Average Wait - Patients seen

5.3 weeks

Narrative Analysis:

The unit is declaring a waiting time to first appointment in the Autism Assessment Pathway of 27.58 weeks - a 22% reduction in waiting times. Having increased as a reflection of the recovery work that was happening the waiting time is now on a trajectory to decrease.

Average Wait - Patients seen

27.58 weeks

Delivering our vision – How are we doing? (Child and Family unit)

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

Narrative Analysis: Marginal decrease in percentage of appraisals completed in the Unit. This will be a focus area in Q4 once the improvement work in clinical notes is completed	Appraisal 54.65%
Narrative Analysis the unit is declaring a 2.8% staff sickness ratio Sickness rates continue to be low overall , mainly short-term sickness reported with the highest reasons for absence Pregnancy related and colds, coughs and flu	Staff sickness 2.81%
Narrative Analysis MAST compliance has dropped in month to 75% from 78%. Ops managers sending out individualized reminders to all staff to support recovery.	MAST training 75.36%
Narrative Analysis	Supervision

Child & Family Unit

The Tavistock and Portman NHS Foundation Trust

Line Manager Supervisions

The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Child & Family Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	11	12	12
Number due cohort - staff who should have supervision	97	96	97
Number of staff that had supervision in that month	75	77	63
Compliance Rate for October	77%	80%	65%

Clinical Supervisions

The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs and summary documents.

Child & Family Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	11	12	12
Number due cohort - staff who should have supervision	97	95	95
Number of staff that had supervision in that month	74	75	57
Compliance Rate for October	76%	79%	60%

Administration Supervisions

The monthly compliance reports have been set up and reminders where sent.

Child & Family Unit	Oct 2024	Nov 2024	Dec 2024
Teams that have completed the supervision logs	5	5	5
Number due cohort - staff who should have supervision	23	23	23
Number of staff that had supervision in that month	17	21	9
Compliance Rate for October	74%	96%	39%

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday, 13 March 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit & Governance Committee	06 March 2025	David Levenson, Non-Executive Director	Peter O'Neill, Interim CFO; and Dorothy Otite, Interim DoCG	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 009**		

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 • External audit plan for the accounts process was received by Committee. • Highlighted the agreed improvement in accruals and deferred income working papers, to improve the audit process. • Materiality limit has now been increased to reflect the reduction in assessed risk by Grant Thornton. • Focus on financial stability, and going concern opinion linked to the merger.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit Update • The number of outstanding internal audit actions was highlighted as an area that required further assurance, with the Executive Leadership Team to agree a revised approach to ensuring implementation dates are achievable and that management updates reflect the latest position. • Partial assurance received for three recent internal audit reports was raised by the Committee as an area of concern. • The Committee approved the 2025/26 Internal Audit Plan.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
3. Local Counter Fraud • Pre-employment checks were highlighted as an area that required strengthening. • The Committee approved the 2025/26 Local Counter Fraud Plan.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Oversight of Board Assurance Framework (BAF) and Corporate Risk Registers (CRR) • The Committee received the report noting progress made on the BAF with no significant issues raised. • The Committee also noted progress being made with the Corporate Risk Register.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. HFMA Checklist	Limited ☐ Partial ☐

• The Committee received a report of outstanding issues and agreed with the recommendation that these are best dealt with as part of the merger finance planning.	Adequate ☒ N/A ☐
6. Single Tender Waiver Report • The Committee received the report, and no significant issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. Salary Overpayments and Underpayments Report (Including Losses and Special Payments) • The Committee noted measures in place to mitigate overpayment incidents.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
8. Information Governance Report • The Committee received the report of the Information Governance Programme of work and noted updates in relation to Subject Access Requests, Information Governance Incidents, Freedom of Information Requests and Data Security & Protection Toolkit.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Gifts, Hospitality and Interests Update • The Committee noted the updated Trust registers of interests including the Register of Gifts and Hospitality and Register of Decision Makers' Interest. • No breaches of the policy were reported.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
10. Annual Report and Accounts – Process 2024-25 • The Committee approved the Annual Report and Accounts production timetable and process for 2024/25.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
11. Cyber Security Report • The Committee received the Cyber Security Report with no significant issues raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
12. IAGC Schedule of Business 2025/26 • The Committee approved its schedule of business for 2025/26 and noted the Board and Committee Meeting Schedule for 2025/26.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

Approved:

- Internal Audit Plan 2025/26
- Local Counter Fraud Plan 2025/26
- Annual Report and Accounts 2024/25 Production timetable
- IAGC Schedule of Business 2025/26

Risks Identified by the Committee during the meeting:

There were no new risks identified by the Committee during this meeting.

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

None

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

Item	Purpose	Date
None		

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Annual Report from the Trust's Freedom to Speak Up Guardians			**Agenda No.: 010**
Report Author and Job Title:	Sophia Shepherd & Sarah Stenlake Freedom to Speak Up Guardians	**Lead Executive Director:**	Michael Holland, Chief Executive & Mark Freestone, Executive Director for Speaking Up
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	Significant work is still required to improve speaking up culture and create a psychologically safe open learning culture that is detriment and discrimination free.		
Background:	Data from Freedom to Speak Up Guardians (FTSUGs) and the most recent available NHS Staff Survey continues to highlight significant difficulties with speaking up culture, staff wellbeing and safety, detriment, discrimination, bullying and harassment of staff (particularly those from minoritised groups).		
Assessment:	Efficient progress with multiple FTSU initiatives is needed, and additional FTSUG resource is required to deliver these concurrently and at pace.		
Key recommendation(s):	The following recommendations are being discussed with the ED for FTSU, CPO, and CEO: **Recommendation 1:** The current FTSUG resource does not meet the organisation's needs in terms of creating effective timely change to speaking up culture, and a 1.0/0.8WTE FTSUG with a part-time deputy FTSUG would be a more efficient solution. **Recommendation 2:** The development of a detriment procedure - as part of the wider FTSU policy and procedure review – would improve the processes and support for people raising experiences of detriment and should reduce detriment cases occurring. **Recommendation 3:** A plan and timeline for how and when leadership and management training for 8c and above staff will be delivered should be communicated to all staff when available, to support with addressing ongoing management practice and bullying/harassment concerns raised by staff. **Recommendation 4:** If identified as suitable by the FTSUGs and ED for SU, the additional RADAR module for FTSU should be commissioned and implemented.		
Implications:			
Strategic Ambitions:			

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

	local, regional, national & international provider of training & education	health and building on our reputation for innovation and research in this area	with a focus on equality, diversity and inclusion	environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 7: Lack of a fair and inclusive culture BAF 8: Lack of management capability and capacity				
Legal and Regulatory Implications:	Yes ☒	No ☐			
Resource Implications:	Yes ☒	No ☐			
	Additional funding for FTSUG resource and FTSU RADAR module				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Increased and more effectively targeted support to address specific barriers in relation to speaking up				
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:	POD EDI – 6 March 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: Annual Report from the Trust's Freedom to Speak Up Guardians

1. Purpose of the report

1.1 To provide updates from the Freedom to Speak Up Guardians (FTSUGs) on speaking up cases raised over the last year, progress with initiatives in relation to improving the speaking up culture of the Trust, and updated recommendations in relation to each of these points.

2. Background

2.1 Freedom to Speak Up (FTSU) is everybody's business, as all staff should be supported to speak up about anything that gets in the way of providing high quality and effective care; they should also be thanked when they do, listened to, and followed up with by line managers and senior leaders. Learning from speaking up should also be shared and used to improve patient care and staff wellbeing.

2.2 The CEO and Board have a responsibility to encourage, promote, and protect a positive speaking up culture; the Executive Director for FTSU (ED for FTSU) and Non-Executive Directors for FTSU (NEDs for FTSU) also have specific responsibilities in this regard. The Trust has made an ongoing commitment to promote and support speaking up, listening up, and following up.

2.3 The 2015 Francis Review recommended that all NHS Trusts appoint FTSUG(s) as additional, confidential person(s) for staff to turn to if they want support or advice with speaking up, if they are experiencing barriers to speaking up, or if they are experiencing detriment in relation to speaking up. There was one 0.2WTE FTSUG in role between December 2020 and May 2024; since June 2024 there have been two 0.3WTE FTSUGs (0.6WTE resource in total).

3. New FTSUG cases from April 2023 to December 2024

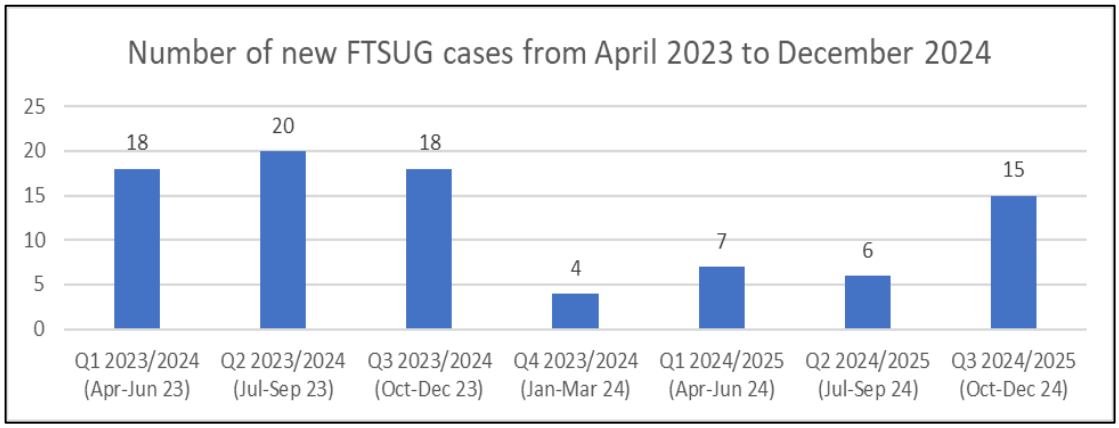


Figure 1

3.1 The number of new cases[1] raised with FTSUGs reduced in 2024 (see Figure 1), from an average of 19 cases per quarter between April and December 2023 to an average of 6 cases per quarter between January and September 2024. This will have been

[1] A FTSUG case is each instance of an individual seeking confidential support, advice, or guidance from a FTSUG about something for the first time. This does not demonstrate further contacts with someone in an ongoing case. If an individual returns at a later stage with a new topic, this is recorded as a new case.

caused by various factors; however there had been a repeated pattern over time of the 0.2WTE FTSUG's successful proactive initiatives leading to increased cases. Consequently, the time available for these strategies is reduced, resulting in a subsequent decrease in cases again.

3.2 There was an increase in the most recent quarter, likely related to the impact of increased FTSUG resource and proactive initiatives. There have been no anonymous concerns raised with FTSUGs during this period.

3.3 The themes of cases brought to FTSUGs between April 2023 and December 2024 are shown in Figure 2.

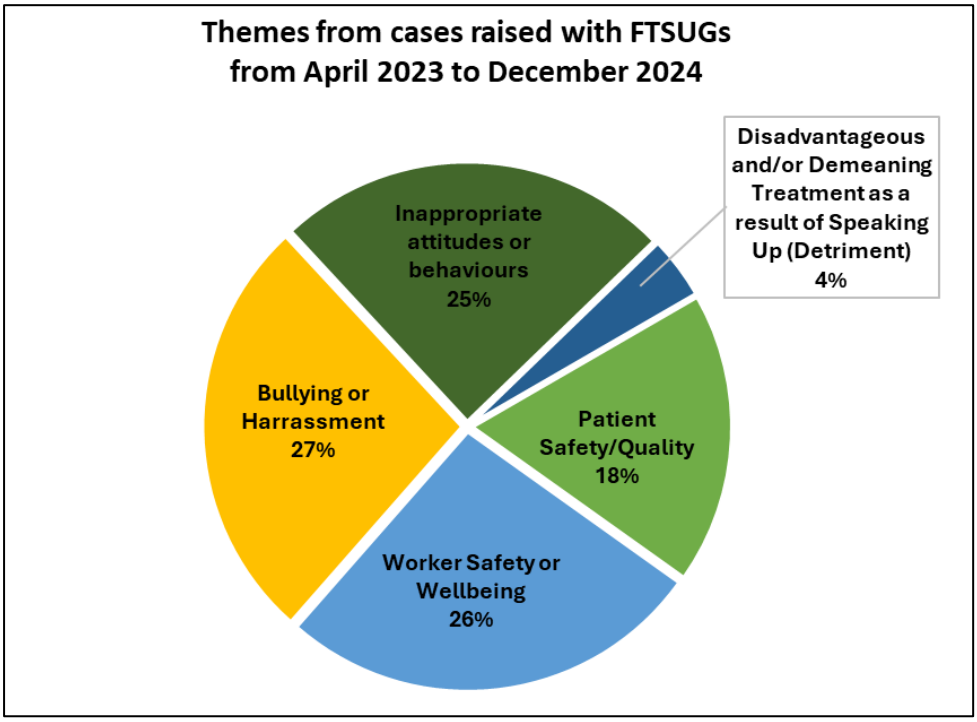


Figure 2

3.3.1 6 cases during this period included detriment; one detriment case from this period was also substantiated following an external investigation. The Trust aim is to have 0 cases involving detriment; detriment in relation to speaking up is concerning in its own right, and behaviours that seek to disadvantage those who speak up are also known to have a significantly negative impact on speaking up culture more broadly. Strategies are required at all levels of the organisation to reduce this happening; the National Guardian's Office (NGO) has recently released guidance for FTSUGs to offer additional structured support to people experiencing or at risk of experiencing detriment due to speaking up.

3.3.2 There continue to be many cases raised relating to management culture and/or bullying occurring from staff in leadership and management roles, with many cases including additional concerns about these issues not being addressed effectively by senior managers, leaders, or Trust processes. A significant proportion of these were also raised by staff with protected characteristics, with concerns about inappropriate attitudes/behaviours such as overt or covert discrimination, and unequal access to opportunities; many also cited concerns about inconsistent or ineffective addressing of issues related to discrimination when raised. Various forms of discrimination were raised, with discrimination related to race described most frequently across cases.

3.3.3 Many patient safety concerns related to the knock-on impact of concerning management practices, inappropriate attitudes/discrimination, concerns raised to seniors not being investigated or addressed effectively, reduced staff wellbeing within the context of wider concerns, or reduced staffing resource following changes to leadership structures.

3.3.4 Some people raising concerns were managers, experiencing challenges trying to escalate concerns of their own or of staff they managed. Some managers also described challenges with reduced autonomy and flexibility in their roles to take actions forward or make decisions for their staff/teams, and yet increased responsibilities and/or expectations on them, particularly following changes to leadership structures. Some also described feeling admonished by senior leaders rather than supported with and listened to around these challenges.

3.3.5 A theme across many cases during this period has been about the energy, resource, and resilience required when staff concerns require escalation, and the negative impact of this on the staff members offering invaluable feedback to the organisation. Staff members described experiencing resistance when raising concerns to managers or senior leaders or being told to take their concerns elsewhere. Developing an organisation-wide learning-oriented culture is essential, so that staff members who do put in this energy and resource are supported with addressing concerns/accessing other processes and consistently valued by the system around them. Increased support for staff during the speaking up process is also required.

4. Formal Speaking Up Investigations logged with the Executive Director for Speaking Up

4.1 Responsibility for maintaining and updating the central register for FTSU concerns that require formal investigation sits with the Executive Lead for FTSU.

4.2 Since the last FTSUG report in July 2023, there have been 6 new cases entered on the speaking up register. Themes include detriment, bullying and harassment culture, allegations of financial mismanagement, and poor management practice. 3 of these cases remain open at present, with ongoing investigation to be completed, and/or learning outcomes to be implemented.

4.3 Of the cases on the register prior to July 2023, 3 remain open at present, with ongoing actions. The oldest ongoing case was raised in November 2022, incorporating concerns raised in 2021; a review is being commissioned to address outstanding concerns.

4.4 Positive learning from register cases has contributed to outcomes such as the new CPD procedure with specific EDI representation, and the Board training and reflection session on reducing detriment and improving FTSU culture in the Trust.

5. NHS Staff Survey Results

5.1. NHS Staff Survey results are useful for considering and contextualising challenges in relation to speaking up culture, as they are an invaluable source of anonymised feedback on staff experiences of the Trust. They include four specific questions in relation to speaking up culture in the Trust, and further relevant questions on harassment, bullying, and abuse in the workplace, emotional exhaustion, burn out, work and home life balance, work related stress and frustration, how likely staff are to report these things to the Trust, whether staff have considered leaving the Trust, and

whether staff members have experienced discrimination at work in relation to protected characteristics.

5.2. The 2023 NHS Staff Survey results were considered as relevant context for the data in this report, and for some of the initiatives described below. A further analysis of these results was originally included in this report; however, as the 2024 results are now complete and will be released shortly (but unfortunately not in time to be included in this report), the 2023 results analysis has been removed as these will likely no longer be the current results at the point of discussing this paper at the board. However, a summary of what was learned from these results is still included below. This report does not seek to address the 2023 staff survey results more broadly, or the Trust initiatives that have been implemented in response to them, aside from FTSU initiatives described below.

5.3. Overall, the 2023 results for the Trust continued to indicate concerningly high rates of bullying and discrimination, including high rates of discrimination in relation to protected characteristics, and low rates of wellbeing and satisfaction. It seems likely that more staff could have benefitted from speaking up about their concerns, and the organisation benefitted from these essential improvement opportunities, and yet the results also demonstrated consistently low speaking up culture scores.

5.4. Although we await the 2024 results, given the significance and consistency of these challenges it seems likely that many staff over the past year experienced similar difficulties and concerns. FTSU initiatives to improve speaking up culture continue to be implemented; both questions relating to feeling safe/secure to raise concerns declined in 2023, and so increasing anonymous reporting options remains necessary.

6. Speaking Up Initiatives within the Trust

6.1 FTSU initiatives that have been implemented or continued in the last year: an increase in FTSUG resource; an increase in online and in-person communication strategies and awareness-raising sessions about FTSU/FTSUGs; the re-introduction of monthly speaking up drop-in sessions for all staff; the re-introduction of a FTSUG session at staff inductions; a Board training and reflection session led by the ED for FTSU to discuss preventing detriment and improving speaking up culture ; FTSUG contributions to the sexual safety planning group and sexual misconduct policy; mandatory e-learning on speaking up; monthly meetings with CEO, ED for FTSU, and FTSUGs; FTSU central register monitoring by the ED for FTSU; meetings with and specific concerns raised to NEDs for FTSU as required.

6.2 In progress initiatives for the year ahead: recruitment, training and supervision of FTSU ambassadors; review of FTSU policy and procedure; anonymous reporting box being introduced at the Tavistock Centre; introduction of mandatory listening up e-learning for all managers and senior leaders (including Board members); introduction of mandatory following up e-learning for all Board members (if approved); introduction of FTSU training workshops for managers/leaders; introduction of a FTSU module within RADAR with anonymous reporting option included (pending suitability discussion); increased “you said, we did” communication to all staff about FTSU feedback/learning; improvements in FTSU procedures and register monitoring; the completion of a FTSU self-reflection tool by the Board/ED for FTSU (to meet NGO and NHSE compliance targets).

6.3 Recommended additional initiatives for the year ahead: the introduction of a detriment procedure for the Trust; the re-introduction of the FTSU steering group or equivalent; increased FTSUG resource in order to efficiently implement FTSU initiatives at pace,

contribute to and collaborate within relevant Trust workstreams, offer increased and more targeted outreach support to address specific FTSU barriers, offer consistent supervision to FTSU ambassadors (highlighted by NGO case studies as essential for retention and wellbeing), offer additional detriment support/training, and manage the positive and intended increase in FTSUG cases.

7. Previously Agreed Recommendations Update

7.1 May 2022 report: mandatory leadership and management training for all staff in relevant roles across the Trust. The training for band 5 to band 8b staff is ongoing and has been delivered to several cohorts of staff, with audits in place to ensure that all staff have completed this. The training for band 8c and above staff has not yet started. A recent update indicated that the plan is to source this from pre-existing CNWL training if possible; a timeline is not yet available for when this will occur.

7.2 May 2022 report: the implementation of a FTSU reporting framework, to capture more informal every day FTSU data, and provide more structure/support to staff required to respond. This action was awaiting the introduction of an incident reporting system that would be suitable for this purpose (RADAR); the additional FTSU Radar module is being reviewed for suitability by FTSUGs and the ED for FTSU.

7.3 July 2023 report: closer monitoring of all formal investigations, with regards to completion, implementation and review of resulting action plans, and better communication/timescale updates to staff involved. Improvement has occurred, but further improvement remains necessary – for FTSU investigations, procedural and register-based improvements are currently being implemented by the ED for FTSU, with support of the FTSUGs.

8. Conclusion and Recommendations

8.1 The recent increase in FTSUG resource has been highly beneficial and is leading to an increase in consistent proactive initiatives after several years of resource challenges limiting this. It is providing cover during leave, improved support if/when cases arise in a FTSUG's other base, peer support, increased creativity of FTSU strategies, and some increased availability for meetings, trainings, and staff induction. FTSU ambassadors will now be recruited, which required increased FTSUG resource to first be trained and in place (as advised by NHSE).

8.2 However, improving the speaking up culture of the organisation is a consistent and significant challenge, and requires sustained concurrent work at all levels. Experiences of detriment are consistently occurring and require urgent multi-level intervention. Additional FTSUG resource is required for timely and effective progress to be made with all necessary FTSU initiatives. Increased availability to join meetings will also enable more integrated and strategic improvement work to occur, and increased resource should support with additional patient safety and staff wellbeing risks often created by major organisational changes such as the upcoming merger.

8.3 The NGO previously shared a case example where a Trust with similar staff survey scores showed significant improvement one year after recruiting a full-time and part-time FTSUG, and advised this Trust to take a similar action. They cited concerns about reduced effectiveness when FTSUG resource is divided into part-time roles, as each FTSUG must fulfil the entire job description, attend FTSUG network meetings and trainings, and have sufficient crossover time to work as an effective team. Both FTSUGs currently work as flexibly as possible but must still spend 70% of their time in other roles.

8.4 Based on this and the data above, the FTSUGs are discussing the following recommendations with the ED for FTSU, CEO, and CPO at present:

8.5 **Recommendation 1:** The current FTSUG resource does not meet the organisation's needs in terms of creating effective timely change to speaking up culture, and a 1.0/0.8WTE FTSUG with a part-time deputy FTSUG would be a more efficient solution.

8.6 **Recommendation 2:** The development of a detriment procedure - as part of the wider FTSU policy and procedure review – would improve the processes and support for people raising experiences of detriment and should reduce detriment cases occurring. This would include detriment prevention being integrated into relevant staff trainings, and increased FTSUG support for cases assessed to be at risk of involving detriment.

8.7 **Recommendation 3:** A plan and timeline for how and when leadership and management training for 8c and above staff will be delivered should be communicated to all staff when available, to support with addressing ongoing management practice and bullying/harassment concerns raised by staff.

8.8 **Recommendation 4:** If identified as suitable by the FTSUGs and ED for SU, the additional RADAR module for FTSU should be commissioned and implemented.

Sarah Stenlake & Sophia Shepherd
Freedom to Speak Up Guardians

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – Thursday, 13 March 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	27th February 2025	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 011**		

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. Oversight of Board Assurance Framework (BAF) The Committee undertook a focused review of BAF Risks 1 and 2, relating to inequality of access for patients and the provision of consistent, high-quality care in line with the national quality standards. It was proposed that BAF Risk 1 (inequality of access) reduced the risk score (from 16 to 12), reflecting measurable improvements in patient access driven by the ongoing PCREF implementation, clinical pathway redesign and triage improvements and clinical harm reviews initiated across services. On review by the Committee this proposed reduction was not agreed as it was recognised that further work was required to truly embed, monitor and evidence the improvements for sustainable change. The Committee agreed to reduce BAF Risk 2 (high quality services) from 16 to 15 aligning the consequence score and reflecting the progress made in mitigating the risk, including strengthened workforce planning, governance structures, and assurance processes. However, to ensure that these improvements are evidenced and sustained, further work is needed to review and evaluate key controls for effectiveness.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. PSIRF Update and PSIRF Transition Group Highlight Report The Committee received an update about the latest actions undertaken as part of the PSIRF A3 project. A verbal update was given about the Trust's participation in the NCL PSIRF Community of Practice 'sprint'. The focus is on safety in transitions of care and the intent is that a number of system safety actions will be	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

developed from the sprint to be trialed by each of the teams involved. The Trust have volunteered to take part with colleagues from the Whittington. A funding request has been submitted to extend the Trust's two patient safety partner (PSP) contracts for a further year. Funding for the first year was based on three PSPs however there are only two currently in role, therefore there has also been a request to split the remaining budget between the two roles, increasing capacity of each to 12 hours per month. A notable amount of work has occurred as part of the induction and orientation period for the PSPs which has focused on development of the roles. As the Trust progresses further with patient safety improvement work in line with PSIRF continued involvement with the PSPs is fundamental. The previous version of the Group's Terms of Reference were issued in October 2023 and have now been reviewed and refreshed. The group will be renamed from PSIRF Implementation Group to PSIRF A3 Implementation Group in light of the significant steps made in implementation of the framework and as the A3 project will be a key tool to monitor and demonstrate success.	
3. LRMS Project Board (Radar) The Committee received an update on the implementation of the Trust's new Local Risk Management System (LRMS), Radar. The recent milestones reached were noted including claims and feedback (for collecting Experience of Survey Questionnaires) modules which are now live for use. A plan to move the implementation project into business as usual is being developed. The Committee noted and extended thanks to the project manager, Abi Omoniyi, who has been instrumental in the successful implementation of the new system.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the Terms of Reference for the PSIRF A3 Implementation Group (previously the PSIRF Transition Group).
- The Committee APPROVED the reviewed Terms of Reference for the Clinical Incident & Safety Group
- The Committee approved the refreshed Terms of Reference for the CQC Improvement Group.

Risks Identified by the Committee during the meeting:

The Committee discussed the Trust's Health & Safety Group and agreed to escalate a concern about the effectiveness of the Group for discussion at the Executive Leadership Team 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

The Committee received an update about the issues with staff access to face-to-face Basic Life Support (BLS) training due to a delay with procuring training. The Committee agreed to escalate this to the POD EDI Committee for an assurance update on the action(s) taken to address this.	Assurance	Next meeting date – 6th March 2025

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Patient & Public Involvement (PPI) Annual Plan			**Agenda No.: 012**
Report Author and Job Title:	Nimisha Deakin Associate Director of Nursing and Head of Patient Experience	**Lead Executive Director:**	Clare Scott, CNO
Appendices:	Appendix 1: PPI Annual Plan 2025-26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	The PPI annual plan 2025-2026 has been developed to ensure that the objectives of the PPI team are met.		
Background:	Team annual plan has been developed to outline the PPI team annual plan of work which will enable resource planning and deliverable targets in line with Trust strategic ambitions.		
Assessment:	The team has made progress against a number of areas as outlined in the PPI annual report. The outstanding work was to finalise a clear plan outlining the key priorities and proposed outcomes for the year ahead. The plan articulates that and has been developed through engagement with the service user experience group.		
Key recommendation(s):	The Board is asked to receive and **DISCUSS** the annual PPI plan of work.		
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 ☒			
	There are no additional legal and regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
	Yes ☒	No ☐			

Equality, Diversity and Inclusion (EDI) implications:	One of the key actions within the PPI action plan is to develop case studies that support the data to reduce inequality to treatment access.			
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 & Safety Committee – February 2025 Service User Experience Group			
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

PPI Annual plan January 2025 – March 2026

Priorities	Key Actions	Timescales	Lead	Status
Increase service user / carer engagement and involvement across the Trust by 50% – to improve service delivery and design.	Increase awareness of service user involvement Trust wide: Via Trust induction and drop-in / lunch time sessions	March- June 2025	PPI Lead	
	Review funding arrangements for service user involvement activities	Feb 2025	PPI Lead	
	Identify and develop Service User champions roles for all services	Feb- May 2025	PPI /Unit managers	
	Improve access to information for staff and patients through development of PPI through website	Feb- June 2025	PPI/Comms	
	Share service user involvement stories through new articles	Monthly on internet	PPI	
	Support the setup of service user forums in GIC and CAMHS	Feb - July 2025	PPI and Service/ Unit managers	
	Embed the new process around onboarding for service users	March 2025	PPI	
Service User Voice to be captured at all levels. Develop a culture that proactively seeks patient experience feedback to support the Trust to develop and improve services based on service user feedback	Embed the new system for gathering service user feedback across the trust through drop on session and team meetings	Feb- April 2025	PPI Lead/A3 group	
	Set team targets and increase engagement with the feedback	Feb 2025	HOPE/PPI lead	

	Improve the access to the feedback at team level through development of dashboard Support regular team and unit level discussion on the feedback and actions taken Produce a “you said we did” feedback loop for patients available on website Review of Trust wide Forum allow more engagement/ feedback from a range of services users representative across the Trust. Increase frequency of meetings. Identify and partner with existing community organisations or co-create a range of spaces for service user voice to be heard especially seldom heard voices e.g. Hive, Brandon Centre, Age Uk	April- June 2025 Ongoing March- Dec 2025 July 2025 March - September 2025	Informatics/Quality Team PPI/ Unit Leads PPI HOPE/PPI PPI team	
Develop the Art Board and community engagement work through this forum	Finalise document review: TOR, JD, Volunteer role, risk assessment Clarify and update financial processes Finalise a comms plan to promote the work of the Art Board more widely Create a clear work plan for internal and external engagement for art at the Tavistock and Portman Complete Artwork Audit – Identify insurance details. Create a catalogue of Art work at the Trust Review of the ART Board plan	March 2025 April 2025 April-September2025 June 2025 July 2025 December 2025 September 2025	PPI/ Art Curator PPI lead PPI /Comms PPI/Art Curator PPI team Estates / Comms / PPI PPI/Art Curator	

Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process	Begin to establish links with CNWL PPI team and align processes Work in collaboration with Communication Team in the Patient and Public engagement work around the Merger -Map existing stakeholder internal and external - Delivery of patient and public engagement activities alongside Communications team -Maintain log of all stakeholder events -Maintain a running log of key themes outlining feedback -Join existing groups or set up set up separate groups/workshops to ensure seldom heard voices -To produce a final engagement report on patient and public engagement to contribute to the comms and engagement section of the Business Case – this will include a summary of the engagement which took place, with qualitative and quantitative analysis.	April 2025 Feb 2025 July 2025 July 2025-April 2026 TBC	HOPE/PPI Lead PPI PPI/Comms HOPE	
Patient and Carer Race Equality Framework (PCREF) Involvement – support engagement of service user/expert by experience and local service user/carer groups.	Develop case studies that support the data to reduce inequality to treatment access.	Sept - Dec 2025	PPI	

Author: Nimisha Deakin Feb 2025

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Patient and Carer Equality Framework (PCREF) Update			**Agenda No.: 013**
Report Author and Job Title:	Dr Chris Abbott, Chief Medical Officer (CMO)	**Lead Executive Director:**	Dr Chris Abbott, CMO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	The Trust has set up a PCREF Implementation Group and has agreed to focus attention on referrals and front door access.		
Background:	PCREF is a mandatory workstream for all Mental Health Trusts with a focus on equity of access to services for the global majority population.		
Assessment:	Progress has been made with the workstream, and data has begun to flow into the Trust's monthly Integrated Quality Performance Report (IQPR) process.		
Key recommendation(s):	The Board is asked to note and **DISCUSS** the contents of the report.		
Implications:			
Strategic Ambitions:			
☒ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☐ Improving value, productivity, financial and environmental sustainability
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☒	Caring ☒	Responsive ☒	Well-led ☐
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF Risk 1: Inequality of Access				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	PCREF will be contractually required for all Mental Health Trusts from April 2024.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Awareness of poor access to care for global majority and plan required to manage this.				
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

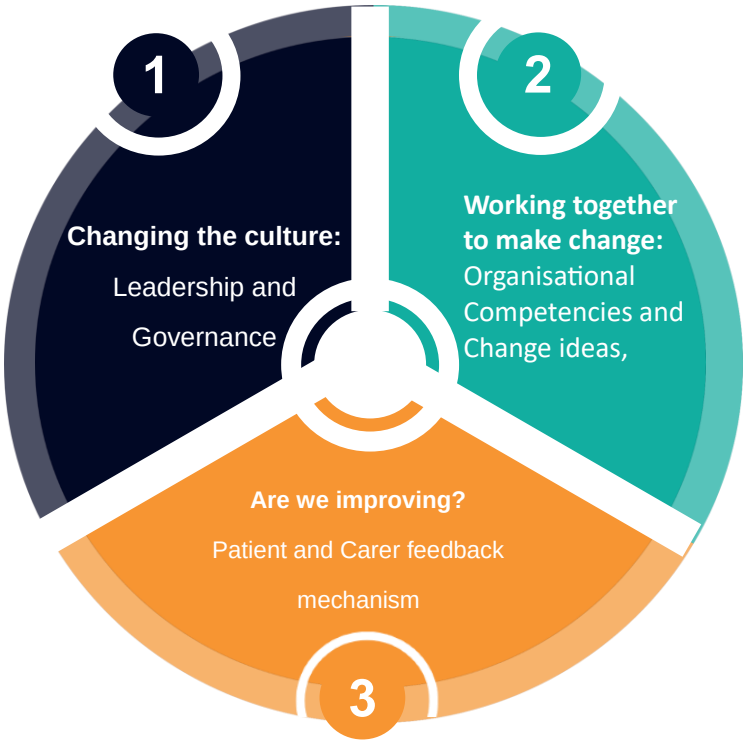
Patient and Carer Equality Framework (PCREF) Update

1. Introduction

- There has never been a national, systematic way of identifying and changing race inequality within NHS services.
- National and local data shows us that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services.
- PCREF was a recommendation following the national Mental Health Act Review in 2018.
- The aim is to move to equity in access, experience and outcomes for Culturally and Ethnically diverse communities**.**
- PCREF will be contractually required for all Mental Health Trusts from April 2024

2. What is PCREF?

- There are three core parts to the work;



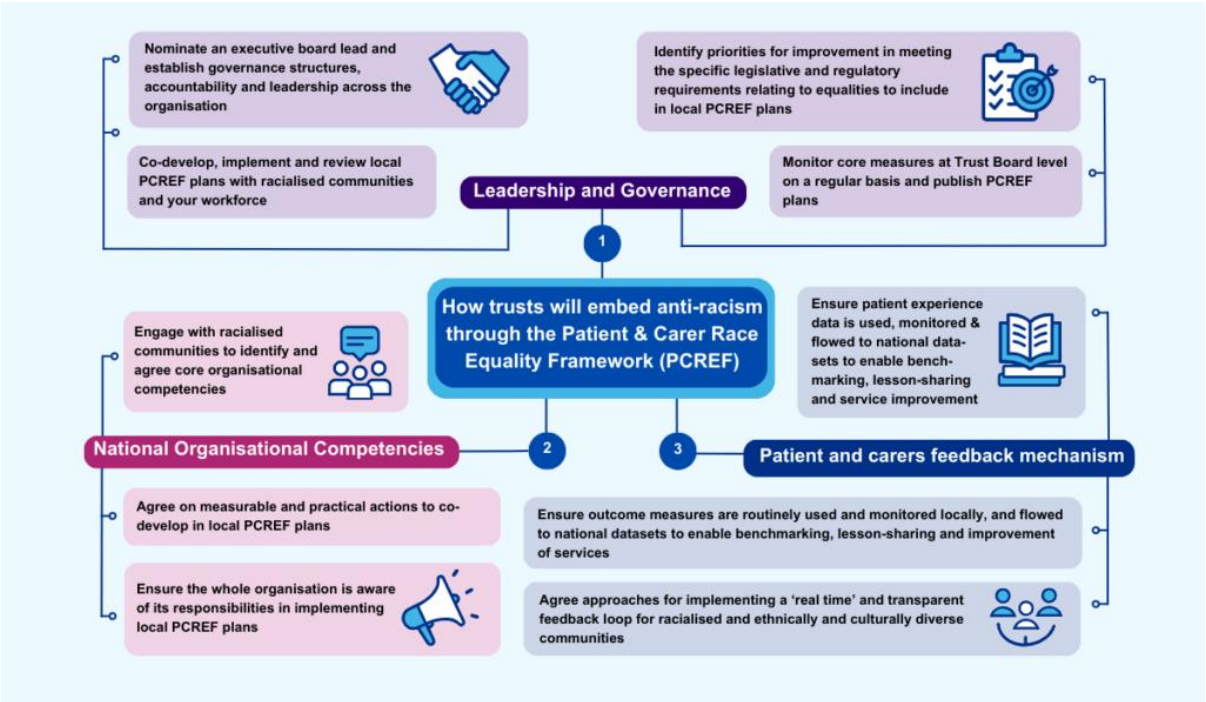
1. **Changing the culture around service delivery**
2. **Identifying the root causes of why there is inequity and what we can do together to change them**
3. **Checking if we are improving access, experience and outcomes – and if we aren't, do something different**

- The PCREF aims to be an accountability framework, enabling organisations to understand and take steps to improve experience and outcomes for individuals of diverse ethnic background
- It aims to identify areas of improvement by developing core organisational competencies. Ten national organisational competencies have been identified, of

which, six where highlighted as the most important competencies from the community:

1. **Cultural Awareness**
   Recognising and understanding the diverse cultural backgrounds of the communities our Trust serves, and being sensitive to those when providing care
2. **Staff Knowledge and Awareness**
   Recognising and understanding the racialised experiences of the communities our Trust serves and overcoming biases and prejudices by acting upon them
3. **Partnership Working**
   Services working more closely with ethnically and culturally diverse communities, leaders and organisations beyond the NHS
4. **Co-production**
   Ensuring ethnically and culturally diverse patients and carers are treated as equal partners in decision making with their care and treatment plans
5. **Workforce**
   A culturally competent and diverse workforce that has a positive impact on patient and carers from racialised diverse communities
6. **Co-learning**
   A two-way process that strengthens collaborative knowledge sharing beyond co-production principles

3. Implementation



4. PCREF Implementation Group

a. The Patient and Carers Race Equalities Framework (PCREF) Steering Group ('the Steering Group') exists:
   (i) To lead and develop the PCREF.
   (ii) To assure and monitor the progress of the PCREF against the agreed programme plan - updating as required, and to support the resolution of risks and issues.
   (iii) To bring together key stakeholders with lived experience and professional expertise to steer and drive the development of the PCREF.

b. The Steering Group will report to the Quality and Safety Committee via the Chair.

c. The Steering group will be supported by the Equity, Diversity, and Inclusion Team.

d. The Steering Group will work in close alignment with the third sector organisations and other key stakeholders to maximise input to the PCREF.

1. The role of PCREF steering group is to:

a. Provide strategic direction for PCREF, which includes steering and overseeing the development and delivery of the PCREF framework for implementation in mental health services.

b. Support engagement and consultation activities to inform the development of the PCREF.

c. Monitor the programme's risks and issues, and to identify and undertake mitigating actions as required. Steering group members are required to escalate risks and issues to the Quality and Safety Committee and other appropriate channels as needed.

d. Monitor the programme's key deliverables and provide both challenge and assurance on work programme delivery, to the Quality and Safety Committee.

e. Ensure that the programme delivers within its agreed parameters and make timely decisions on changes to the programme.

2. Membership

a. The Chief Medical Officer will Chair the Steering Group.

b. External stakeholders and representatives will be invited to attend the group as required. The membership of the Steering Group will be reviewed every 12 months to assess its ongoing effectiveness.

c. Members:
CMO
PCREF Workstream lead – Associate Director of Equality, Diversity and Inclusion
Directorate Leadership Team
Clinical reps
Corporate and Administrative reps
Experts by experience
Patient Experience Team
Strategy and Transformation Team

3. **Workstreams**

a. IQPR
   i. Focus agreed on the front door (referrals and acceptance data)
   ii. Aiming for equity of access

b. Staff engagements
   i. Comms plan to be agreed including use of SLF and ASM
   ii. Plan now for Black History Month 2025
   iii. Team level champions

c. Community engagements
   i. Groups identified and to be reviewed
   ii. Need to build external links

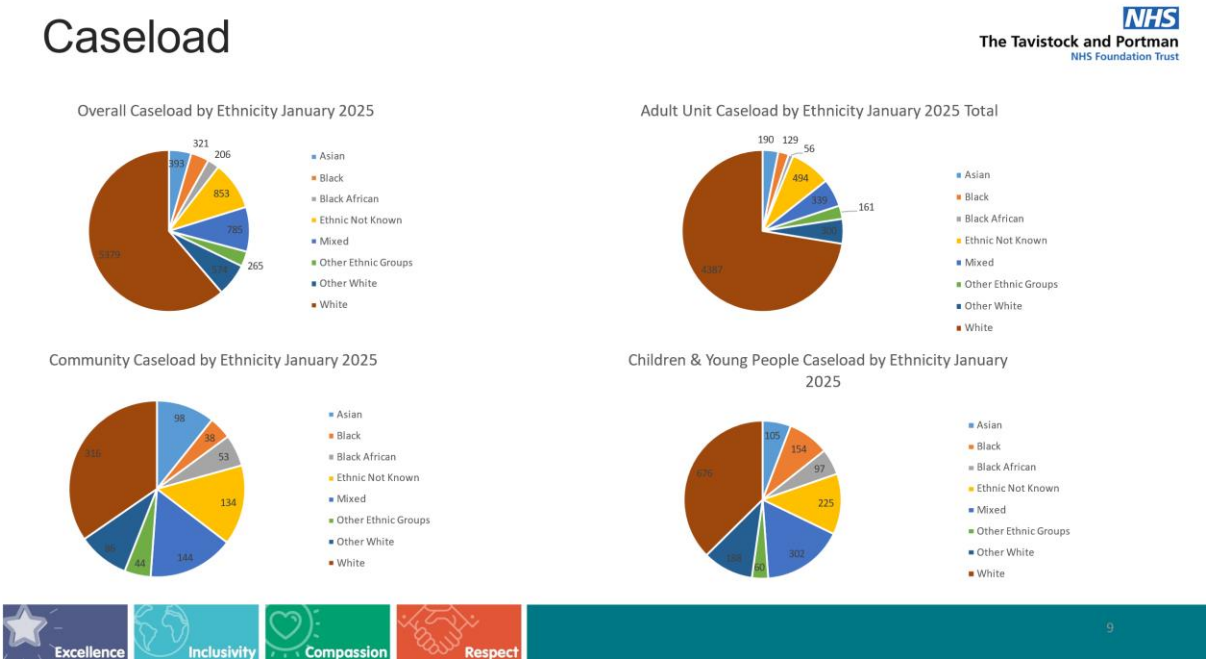
d. NCL Waiting Room
    i. Use of waiting room to share community partners and charity information/signposting

5. Pilot Study

- Units are starting to review the demographic nature of their service users as a proxy to assess accessibility.
- For specialist teams we are looking into the feasibility of upscaling the work initiated in our Adolescent and Young Adult service which has moved their service user profile from an over-representation of white British young people to a demographic that truly reflects the localities they serve through the use of EDI champions embedded in their intake processes.
- Our CAMHS services will be looking for evidence of unmet need and the Gender service will start to understand more about their patient demographics (which is national) and how this is influenced by referral criteria.

6. IQPR Reporting

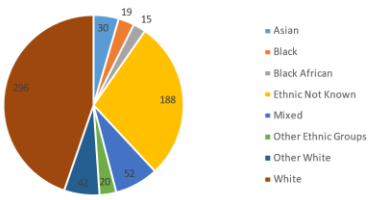
- A first draft of how the relevant data for IQPR has been drawn together by the directorate leadership team.
- Initially the plan was for the PCREF data to be shared as a separate section and this was trialled in the March meeting. It was felt that full integration of the data into the individual unit slides would allow for more ownership of the work and allow for deep dives into particular areas of concern.
- The focus of this area will be referrals and acceptance data with a view of ensuring we are providing services that are suitable and accessible to the relevant population.
- The draft sides are included below.



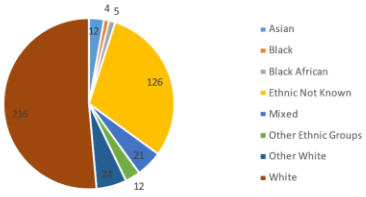
Referrals

NHS
The Tavistock and Portman
NHS Foundation Trust

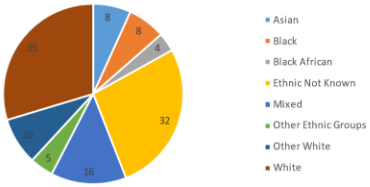
Overall Referrals by Ethnicity January 2025



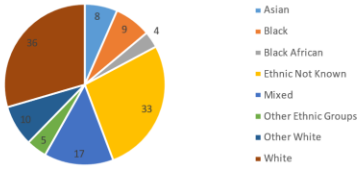
Adult Unit Referrals by Ethnicity January 2025



Community Referrals by Ethnicity January 2025



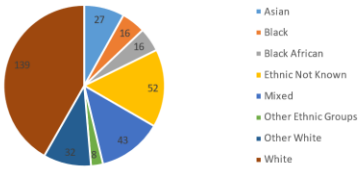
Children & Young People Referrals by Ethnicity January 2025



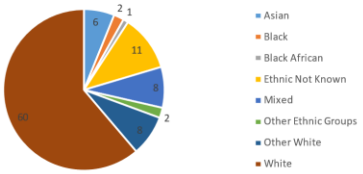
Attendances (1st attended appointment, does not include DNAs or Cancellations)

NHS
The Tavistock and Portman
NHS Foundation Trust

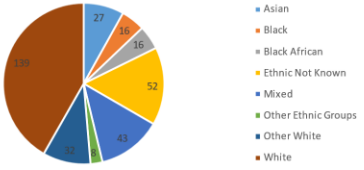
Overall 1st Attended Appointments by Ethnicity January 2025



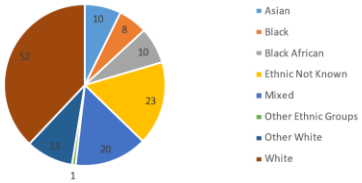
Adult Unit 1st Attended Appointments by Ethnicity January 2025



Community 1st Attended Appointments by Ethnicity January 2025



Children & Young People 1st Attended Appointments by Ethnicity January 2025



7. Plans for the Future

- Clear focus on engagement with external agencies to ensure we are community and external focused rather than internally focused which is more likely to act as a catalyst for change.
- Roll out of front door audit across all services to identify gaps and formulate interventions for improvement.
- Staff engagement plan is now in place starting in March with a PCREF focused ‘CEO update’ and then followed up in the coming months with a section within Senior Leadership Forum and All Staff Meeting.
- Sub group to review third sector organisations suitable for the NCL waiting room.

- Sub group for community engagement.
- Both sub groups will feed into the Implementation Group.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday 13 March 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	27 February 2025	Aruna Mehta, Non-Executive Director	Rod Booth, DSBD and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 014**		

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**
Integrated Quality and Performance report: • The committee commended the overall format and development of the report • It was agreed that the good work being done in some services, e.g. Camden CAMHS needs to be added to give a more balanced position across the Trust • The improvements still required to reduce GIC and Trauma waiting times along with targeted support underway was noted. It was agreed by the Committee to keep a close watch on these areas and to escalate to Board if improvements were not delivered during Q1 of 2025-26.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Finance report: • Finance Report for M10 was presented to the Committee, noting the I&E position was back on plan, with the Trust expecting to achieve its year end deficit target of £2,200k. This being achieved due to the rates rebate received in January 25. • The cash support process continues to be a concern, with the CFO highlighting the ongoing work with NHSE to resolve this issue for future periods.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
BAF Risks • Current risks within the Committee's remit agreed as appropriate. • Risk 9 – Financial sustainability. Risk to be reviewed at the next Committee after the conclusion of the 2025/26 planning round. • Risk 12 – IT Infrastructure and Cyber Security. Committee agreed that the business-as-usual metrics should be added as additional assurance.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Financial Planning 2025/26 • Noted that initial submissions to the ICB and NHSE had been submitted at the end of February, with a deficit position of £3.2m, in line with the early draft received by Board in mid-February.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

• Committee will receive further update in April, including the approach to mitigating the efficiency risk.	
Income Reporting Process • A joint report from the DoS/CFO was received highlighting the work done to strengthen existing processes, reporting and working arrangements between the finance and contracting teams to mitigate any in-year income risk. • As part of this committee received a comprehensive summary of the contracts in place and the risks and issues associated with them. • The new reporting and management processes will be presented to future committee for assurance.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
WTE and Vacancies • It was noted that the report only included the vacancies relating to clinical services, and it was agreed that DET would be added in line with the finance report received by ETC. • After discussion it was agreed to refer the likely 25/26 staffing efficiency challenge in DET to ETC to ensure adequate mitigation plans are developed.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

- The Committee was not required to make any decisions.

Risks Identified by the Committee during the meeting:

Risks to cash and the efficiency challenge in 25.26.

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
DET staffing efficiency in 25/26 referred to ETC.	Action	April 2025

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Finance Report – As at 31 January 2025 (Reporting Month 10)			**Agenda No. 015**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 10 (cumulative position to the 31st January 2025) Finance Report. **Note** a verbal update of the most recent position at M11 will be given at the Board, as additional context. **Income & Expenditure** The Trust incurred a net deficit of £1,910k in the period, against the plan of £1,907k, a negative variance of £3k. This is an improvement of the position from month 09 by £957k, and from the from month 08 (last reported at Board) by £743k. This improved position reflects the benefit of the non-recurrent rates rebate received in January 25. The Trust is thus now able to achieve its year-end deficit plan of £2,200k. The previously highlighted funding gap relating to the 24/25 pay award is still a concern for future periods but is being offset by this non recurrent income in 24/25. In line with the agreed NCL timescales the updated the forecast for 24/25 has been confirmed as part of the M10 reporting cycle. The Trust continues to take what recovery actions it can to the year end, including restrictions on appointments to the year end to only essential posts and maximizing the impact of any non-recurrent opportunities. This is still deemed an important part of the preparation for the planned merger and delivery of efficiencies that will benefit the 25/26 financial position. **Capital Expenditure** To date capital spend to date is £1,726k, £131k ahead of the planned spend to date of £1,525k. 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 initial additional capital allocation of £268k and a more recent distribution of £150k) at £2,618k. 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 £418k. **Cash** The cash balance at the end of M10 was £3,275k against the planned balance of £1,950k. This reflects the cash receipt associated with the rates rebate received in January. The NHSE cash support agreed in the plan, was ultimately not required in January but had already been refused for a second month. This has now been escalated to the regional CFO and work continues with the revenue support team to resolve this ongoing risk. At the time of writing no satisfactory resolution has been secured.		

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):	The Board of Directors 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 ☐		
	BAF 9: Delivering Financial Sustainability Targets.				

	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams** The result of changes in the commissioning environment and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.			
Resource Implications:	Yes ☐		No ☒	
	There are no resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	ELT			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Financial Planning 2025/26 Update – March 2025			**Agenda No.: 016**
Report Author and Job Title:	Peter O'Neill, Interim Chief Finance Officer (CFO)	**Lead Executive Director:**	Peter O'Neill Interim CFO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The Trust submitted its initial headline plan for 25/26 to NCL 21st Feb 25 showing a planned deficit of £3.2m, with submission to NHSE 27th Feb 25. The final submission is to be received by NCL on 21 March 25, then to NHSE 27th March 25.		
Background:	The Trust had a deficit plan of £2.2m in 2024/25.		
Assessment:	The attached paper shows the initial 2025/26 deficit plan of £3.2m submitted with underpinning assumptions. In addition, potential next steps are included, if the initial plan is rejected by NHSE. The key focus of the work in the next two being the generation of detailed income, expenditure, efficiency and workforce plans to populate the templates that form the basis of the submission.		
Key recommendation(s):	The Board is asked to **NOTE** the contents of this report		

Implications:					
Strategic Ambitions:					
☐ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☐ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: **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 ☐	
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:	Draft agreed with ELT and Board.			
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

Financial Planning 2025/26 Update – March 2025

The detail below shows the current position in the development of the 25/26 financial plan and the assumptions and efficiency requirements underpinning them.

Movement in Deficit Plan 24/25 to 25/26

The table below summarises the movements between the forecast outturn in 24/25 to the first submission of the 25/26 plan. It should be noted that this is not yet an agreed plan for 25/26 with a second submission due to NHSE by 27th March 25.

	£000's	
Deficit 24/25	(2,200)	Forecast Outturn 24/25
25/26 Opening Plan	(3,231)	Unconfirmed first draft submitted to NHSE 27th march
Increase in deficit plan	**(1,031)**	

Movements within the plan	**£000's**	
25/6 Cost Uplift Factor	(1,443)	Consequence of Planning Guidance assumptions
Reduction in Non Rec Resource	(4,018)	Year on year difference - various sources
Recurrent Income Movements	(1,011)	Overhead contributions decomissioned services
Expenditure Movements	1,787	Pay and non pay reductions
Pay Cost Pressure	(744)	Full Year Effect of additional posts
Tavistock Consulting Income	500	
Efficiency Plans	3,898	Includes expenditure effciency and income growth
Total of Movements	**(1,031)**	Year on year difference

Assumption/Notes

- Trust 24/25 deficit plan £2.2m being achieved via non recurrent benefits
- Headline plan (first draft) 25/25 sent to NCL/NHSE deficit plan of £3.2m
- Planning guidance has implicit 2% efficiency included in the uplift, c£1.4m for the Trust
- 25/26 plans assumed staffing spend held at 24/25 levels, with no increase in wte count (exception is VL conversion from non-pay). FYE cost pressure of £744k as a consequence
- Reduction in underlying deficit is a key element of the merger planning work, with credibility of plans being tested as part of the business case. The starting point for the updated plans will be outcome from the 25/26 plan.
- Efficiency assumed in plan to date in plan is £3,898k in spend reduction and £500k additional Tavistock Consulting income:
    - Staffing reduction/agency c£1.2m
    - ERF staffing absorbed in vacancies c.£0.9m
    - FYE staffing absorbed c.£0.7m
    - Rates reduction/Other Non Pay c£0.5m
    - Reduction in loss making services c.£0.5m
- Delivery of the above efficiency being the biggest risk to delivery
- Plan also assumes that the non-recurrent benefits of c.£3.5m can be carried forward to support the 25/26 position – subject to agreement with external auditors

Potential Further Movements

- DET income increases planned in MTFP with increased contribution
- Enhanced corporate savings if merger/partner organisation confirmed, examples being:
    - Agency/contracted out spend/staffing
    - Systems costs and other non-pay – not targeted in plan, limited flexibility
    - Further corporate staffing savings
    - Target further rates reductions peripheral sites – limited but consultants think it's possible
    - Estates shared costs – limited by host capacity?
- Further reduction in loss making services – relies on staff turnover
- Assume a level of non-recurrent income in line with previous years –risky given NHS financial position in 25/26

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – Thursday, 13 March 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	9 January 2025	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**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: The Committee reviewed BAF risk 7	**Assurance rating**
1. BAF Risk 7 • The Committee looked at BAF Risk 7 – lack of fair and inclusive culture. • There have been positive developments in the management of the risk. Regular EDI meetings have improved assurance levels from amber to green. These meetings enhance communication, visibility of issues, and alignment with organisational objectives. Policies emphasising fairness are under final consultation. There is possibility to reduce the score with further work required. AK noted work is progressing in the right direction.	Limited ☐ Partial ☒ Adequate ☐ N/A ☒
2. Operational considerations • ECP - Committee felt there is a tighter grip on establishment and was pleased to hear plans to introduce further quality impact assessment criteria when considering requests to recruit. • Recruitment and retention group – the committee was also assured with the progress of the R&R group in setting up process and procedures for fairer progression and implementing the TNA process for 25/26.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. Culture and Values Work • A paper on restorative just and learning culture was presented for information and well received. It was requested that this be shared with the board to help deepen understanding on the purpose.	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 EDI "I" statements to complement the wider behavioural "I" statements in the values work. • The Communications team are looking at launching this alongside other parts of the behaviour's framework.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Reflections • There was a good mix of reports with information and data accompanied by really refreshing papers and productive debate. • It was recognised that there is some work to be done around communication and training for people in order to really disseminate the work that we are doing. • There were notable improvements to the quality of the reports. There is culture shift work to be done however it was pleasing to see inclusivity and empowerment in the room. • It was lovely to see support around the table for HR and ELT. Thanks were noted for all report authors and the staff network chairs' contributions.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

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:

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 – Thursday, 13 March 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	25 February 2025	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training Officer	☒ **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**
1. Merger Update 1.1. DET leadership have agreed to give a paper at this Board (13th March) to explain how the Higher Education Sector is regulated and do a deep dive into the higher-education related DET merger risks. 1.2. We were joined by colleagues from the University of Essex for a very positive meeting with the Office for Students (OfS) earlier in February to discuss the implications of the merger for our OfS registration. This was a very constructive discussion and all parties feel that there is a pathway to ensuring this is retained in every scenario and that disruption to students is kept to an absolute minimum.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Success Stories 2.1. Student recruitment for 25/26 is progressing very positively after considerable efforts by the DET operations team to open student recruitment in October instead of January. Currently, complete applications to our courses are at a 42% increase over the 2024/25 intake, with a 98% increase on application numbers in January '25 (the first full month in the cycle) compared to Jan '24. This is a very promising situation in a difficult NHS financial context and speaks to the major staffing and process changes delivered by DET around attracting, processing and enrolling students. 2.2. CETO attended the Open Day for the Trust on Saturday 1st February and was struck by the level of interest in our courses – with both the Lecture Theatre and overspill in Training Room B being full of prospective students – and the efficiency and smoothness of the event, despite our Marketing Lead having to take early maternity leave. Sincere thanks to all involved but particularly to our Marketing team and to the Student Panel, who were again balanced and eloquent.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

3. Challenge Areas 3.1. The Committee noted a report from the CFO about the general state of financial situation in the NHS and in the Trust specifically, with an emphasis on reducing the underlying deficit ahead of a potential merger. This will likely require efficiencies to be made across all service lines including education, which has had a significant investment over the past two FYs. DET leads will be reviewing student number projections, budgets and course viability over the coming weeks to identify efficiency savings. 3.2. It was agreed that a DET strategy event to help involve all staff in understanding and responding to the Trust's financial situation would be a positive way of addressing these issues positively and collaboratively. DET SLT have begun planning for this in Q1 2025. 3.3. Space utilisation featured in the previous report, but to update on our plans for this, a paper compiled by Corporate during the Kaizen Planning suggests that there may not be sufficient organisational 'grip' on space usage, or an adequate range of policies to cover the different use scenarios. CETO and CNO will be progressing this directly through a Task and Finish Group, meeting first on Monday 17th February.	Limited ☐ Partial ☒ Adequate ☐ N/A ☒
4. Ongoing Work of Note 4.1. Last month I reported on the success of the consultation around the use of the terms 'Lecturer' and 'Senior Lecturer' replacing the title 'Associate Lecturer'. As part of the next phase of our review of the use of visiting lecturers at the Trust, we are intending to advertise 32 new substantive Lecturer and Senior Lecturer positions in the Trust as well as engaging with the visiting lecturer group to help them understand these changes, and to attract interest in the positions from the pool. 4.2. This move has attracted significant attention from the existing visiting lecturers as well as Governors and there are some unhelpful narratives around the abolition of the visiting lecturer role. CETO has responded to several of these concerns and will continue to engage with both groups, but we are very clear that several visiting staff will always be required to keep our courses internationally excellent and efficient.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- Next Committee is 08/05/2025.

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		

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 13 March 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 019**
Report Author and Job Title:	Dorothy Otite, Director of Corporate Governance (Interim)	**Lead Executive Director**	Dorothy Otite, Director of Corporate Governance (Interim)
Appendices:	Appendix 1: Public Board Annual Schedule of Business 2025/26		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This report provides the Public Board Annual Schedule of Business for 2025/26 (attached as Appendix 1) for approval.		
Background:	It is good corporate governance practice for the Board to agree a forward plan of its activities ahead of the new financial year. **Process undertaken:** The process of producing the Board Schedule of Business is conducted annually (ahead of the March cycle of meetings) and is facilitated by the Corporate Governance Team in consultation with the full Board.		
Assessment:	The Board has been consulted in putting together the draft Public Board Schedule of Business for 2025/26. It covers the period April 2025 to March 2026. The Board is asked to note that the schedule of business is a live document, and it may be updated overtime depending on the Trust's priorities, and other external/ regulatory factors. The Public Board Schedule of Business will be presented at each meeting of the Board for discussion highlighting any changes and to give an opportunity to members to discuss any new items for addition. Diary appointments for the 2025/26 meetings have been issued to members. Any future changes to dates will be reflected in the schedule of business.		
Key recommendation(s):	The Board is asked to: 1) **APPROVE** the Public Board Schedule of Business for 2025/26.		
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 Board receives all BAF risks regularly and this is included in the schedule of business.				
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:	Board Seminar – February 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	

The Tavistock and Portman NHS Foundation Trust

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2025					2026			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			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Paper Deadline			**01-May**	**26-Jun**	**04-Sep**	**06-Nov**	**30-Dec**	**05-Mar**				
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/ (	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 Jan 2026)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Questions from the Governors	Discussion	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 covering all strategic ambitions	Bi-monthly
Merger Update	Discussion	DoSBD	P	P	P	P	P	P			Corporate Reporting covering all strategic ambitions	Bi-monthly
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental	Bi-monthly
Quality and Safety Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Providing outstanding patient care	Bi-monthly
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Improving value, productivity, financial and environmental	Bi-monthly
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Developing a culture where everyone thrives	Bi-monthly
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Enhance our reputation and grow as a leading local, regional, national & international provider of	Bi-monthly
Quarterly (3 - 4)												
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Discussion	IDOCG	P			P	P	P			Corporate Reporting covering all strategic ambitions	Quarterly
Integrated Audit and Governance Committee Chair's Assurance Report	Assurance	NED		P			P	P			Corporate Reporting covering all strategic ambitions	Quarterly
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Developing a culture where everyone thrives	Quarterly
Guardian of Safer Working Report	Information	CMO			P		P	P			Providing outstanding patient care	Quarterly
PCREF Update	Discussion	CMO		P		P		P			Developing partnerships to	Quarterly
Quality Update	Discussion	CNO	P		P		P				Providing outstanding patient care	Quarterly
Gloucester House Update	Assurance	CNO		P		P		P			Providing outstanding patient care	Quarterly
Six-monthly (2)												
Mortality / Learning from Deaths	Assurance	CMO		P				P			Providing outstanding patient care	6 monthly
PSIRF Update	Discussion	CNO			P			P			Providing outstanding patient care	6 monthly
Annual (1)												

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			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (IAGC; POD EDI; ETC; PFRC; QSC; EA&R)	Discussion	Chair		P							Corporate Reporting covering all strategic ambitions	Annual
Review of Committee Terms of Reference	Approval	Chair				P					Corporate Reporting covering all strategic ambitions	Annual
Medical Revalidation	Discussion	ICMO				P					Providing outstanding patient care	Annual
Freedom to Speak Up Guardian Annual report	Discussion	IDOCG						P	POD EDI		Developing a culture where everyone thrives	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		Integrated Audit & Governance Committee		Improving value, productivity, financial and environmental sustainability	Annual
Quality Priorities 2025-2026 **(to Board Seminar/ Extra-Ordinary Board in June 2025)**	Discussion	CNO	P						Quality & Safety Committee		Providing outstanding patient care	Annual
Staff Survey Results and Action Plan	Discussion	CPO	P				P		POD EDI		Developing a culture where everyone thrives	Annual
Workforce Disability Equality Standard (WDES)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Workforce Race Equality Standard (WRES)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Gender and Race Pay Gap	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Equality, Diversity and Inclusion Annual Report 2025/26 (including Department of Education & Training)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Research and Development Annual Report	Discussion	ICMO			P						Developing partnerships to improve population health	Annual
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		P					Quality & Safety Committee		Providing outstanding patient care	Annual
Annual Objectives and Strategic Ambitions (Review)	Approval	DoSBD				P					Corporate Reporting covering all strategic ambitions	Annual
Compliance Against Provider Licence	Approval	IDOCG	P								Corporate Reporting covering all strategic ambitions	Annual
Financial Plan update 2024/25	Approval	CFO	P								Improving value, productivity, financial and environmental sustainability	Annual
Non-Executive Director Commitments 2025/26 (including Champions and Committee Membership)	Approval	Chair			P						Corporate Reporting covering all strategic ambitions	Annual
Board and Board Committee Meeting Dates 2026/27	Approval	IDOCG		P							Corporate Reporting covering all strategic ambitions	Annual
Honorary Doctorate Nominations	Approval	CETO					P		Education & Training Committee		Enhance our reputation and grow as a leading local, regional, national & international provider of	Annual
National Annual Patient Survey report (when available)	Discussion	CNO							Quality & Safety Committee		Providing outstanding patient care	Annual
Fit & Proper Persons Test Outcome	Approval	Chair		P						CoG NHSE	Corporate Reporting covering all strategic ambitions	Annual
Board Development & Seminar Programme 2025/26	Discussion	Chair	P								Corporate Reporting covering all strategic ambitions	Annual

The Tavistock and Portman NHS Foundation Trust

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2025					2026			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			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Medium Term Financial Plan update	Approval	CFO	P						Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental sustainability	Annual
Financial Plan 2026/27 (if required)	Discussion	ICFO						P			Improving value, productivity, financial and environmental sustainability	Annual
Board Service Visits	Discussion	Chair			P						Corporate Reporting covering all strategic ambitions	Annual
Strategy / Policy Approval/Ratification (usually every 3 years)												
Year 3 (2025/26)												
External Board/ Governance Review (once every three years) Report	Discussion	Chair									Corporate Reporting covering all strategic ambitions	3 yearly
Modern Slavery Statement	Approval	CNO									Providing outstanding patient care	Annual
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental	3 yearly
Green Plan/ Sustainability Strategy	Approval	CFO				P			Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental sustainability	3 yearly
Staff Engagement Strategy (Internal Communications Strategy)	Approval	DCE		P					POD EDI		Developing a culture where everyone thrives	Annual
Informatics Strategy	Discussion	IM&T		P					Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental sustainability	
Ad hoc/ As Appropriate												
National Learning Reviews/ Invited Reviews (as required)	Discussion	CNO							Quality & Safety Committee		Providing outstanding patient care	Variable
Any areas of emerging or crystallised risk for Board attention (e,g Long waits - triangulated from various sources including IQPR, BAF, Board Committee Assurance Reports etc)	Discussion	CEO							Quality & Safety Committee		Corporate Reporting covering all strategic ambitions	Variable
External Board Review (once every three years) Report	Discussion	Chair							Integrated Audit & Governance Committee		Corporate Reporting covering all strategic ambitions	3 yearly