The Tavistock and Portman NHS Foundation Trust

OPEN - BOARD OF DIRECTORS MEETING

Tavistock Centre, Lecture Theatre

Tavistock Clinic

The Tavistock Centre

London, NW3 5BA

The Tavistock and Portman NHS Foundation Trust

Meeting Book - OPEN - BOARD OF DIRECTORS MEETING

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023. Questions from Public

024. Reflections and Feedback from the Meeting.

DATE AND TIME OF NEXT MEETING

025. Thursday 10th July at 2.00 - 5.00pm***

The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 15th May 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, 15 MAY 2025 AT 2.00PM – 5.00PM
VENUE: LECTURE THEATRE AND VIRTUAL

Living our values:

AGENDA

25/05/	Agenda Item	Purpose Approval Discussion Information Assurance	Lead	Format Verbal Enclosure Presentation	Time	Report Assurance rating (Administrator to select rating on coversheet)
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Service User Story: Trauma Panel	Discussion	Jo Stubley, Trauma Consultant, Nina Dogmetchi, Trauma Psychotherapist. Panel members: Jasmina Brkic, Annie Wigman, Bev Chipp.	P	2.05 (20)	
005	Minutes of the Previous Meeting held on 15 March 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)	Information	Chair and Chief Executive Officer	E	2.35 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC AMBITIONS)						
008	Integrated Quality Performance Report (IQPR) Including update on risk areas/ areas in structural support	Discussion	Executive Directors	E	2.45 (20)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

009	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2025/26	Approval	Interim Director of Corporate Governance	E	3.05 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
010	Integrated Audit and Governance (IAG) Committee Assurance Report	Assurance	IAG Committee Chair	E	3.15 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
Comfort Break (10 minutes) 3.20p.m – 3.30p.m						
PROVIDING OUTSTANDING PATIENT CARE						
011	Quality and Safety Report	Discussion	Chief Nursing Officer	E	3.30 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
012	Quality and Safety (Q&S) Committee Assurance Report	Assurance	Q&S Committee Chair	E	3.35 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
013	Education and Training (E&T) Committee Assurance Report	Assurance	E&T Committee Chair	E	3.40 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
014	E&T Equality, Diversity and Inclusion (EDI) Focus	Discussion	Chief Education and Training Officer	E	3.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
015	Staff Survey Results and Action Plan 2024	Discussion	Chief People Officer	E	3.50 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
016	People, Organisational Development, Equality, Inclusion and Diversity (POD EDI) Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
017	Performance, Finance and Resources (PFR) Committee Assurance Report	Assurance	PFR Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
018	Finance Report: • Month 12 • Finance Plan 2025/26	Information	Interim Chief Finance Officer	E	4.10 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐

019	NHS Provider Licence Self-Certification 2024/25	Information	Interim Director of Corporate Governance	E	4.20 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
CLOSING ITEMS						
020	Board Schedule of Business 2025/26	Information	Chair	E	4.30 (20)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
021	Questions from Governors	Discussion	Chair	V		
022	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
023	Questions from the Public	Discussion	Chair	V		
024	Reflections and Feedback from the meeting	Discussion	Chair	V		
DATE AND TIME OF NEXT MEETING						
025	Thursday, 10 July 2025 at 2.00 – 5.00p.m.					

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 16/04/2025)

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 (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
CLAIRE JOHNSTON	Non-Executive Director	01 November 2022 (1st Term)	Registrant Council Member, Nursing and Midwifery Council	01/09/2018	Present	
			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	
			Closed Interests			
			Chair, Our Time (3)	01/05/2018	01/05/2024	Charity supporting families with serious mental illness
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, 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			
			Magistrate HMCTS (3)	01/11/2019	01/04/2024	No conflict
JOHN LAWLOR, OBE	Chair	06 June 2022 (2nd Term)	Trustee of the national charity, Think Ahead, under contract to DHSC to provide postgraduate education in mental health social work. (3)	01/09/2019	Present	No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by Think Ahead and vice versa
			Wife is an Associate Director at Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) (1)	07/04/2019	Present	No perceived conflict - Will withdraw from any business in relation to CNTW discussed by the Tavistock and Portman
			Employed in the Humber and North Yorkshire ICS and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative/JV working up to one day per week.	11/02/2024	Present	No perceived conflict - Will withdraw from any business in relation to the Humber and North Yorkshire ICS and its associated Mental Health, Learning Disabilities and Autism providers discussed by the Tavistock and Portman and vice versa.
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

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	31/07/2025	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 (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
			Staff Trustee of the Tavistock and Portman Charity	18/11/2024	17/11/2027	No perceived conflict. To note the Charity's stated purpose is to support the Trust.
GEM DAVIES	Chief People Officer	1 February 2023	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	Present	No perceived conflict - This is unpaid.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			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			
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 BOARD OF DIRECTORS MEETING PART TWO
HELD IN PUBLIC
THURSDAY 13TH MARCH 2025 AT 2.00-5.00 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
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
Sal Jarvis	Non-Executive Director & Chair of the Education & Training Committee	SJ

Non-Voting

Sabrina Phillips	Associate Non-Executive Director	SP
Dorothy Otite	Interim Director of Corporate Governance	DO
Gem Davies	Chief People Officer	GD

IN ATTENDANCE:

Kathy Elliott	Lead Governor	KE
Chidinma Uwakaneme	Public Governor	CU
Arpan Walia	Business Manager to CEO and Chair	AW
Pauline Williams	Chair of the Race Equality Network, Staff Governor	PW
Paru Jeram	Staff Governor	PJ
Ravteg-Singh Desi	Director of Education (Operations)	RSD
Elisa Reyes-Simpson	Director of Education Governance & Quality	ERS
Annecy Lax	Stakeholder Governor	AL
Anthony Farthing	Library Assistant	AF
Zoe Anderson	Head of Communications and Engagement	ZA
Sarah Stenlake	Freedom to Speak Up Guardian	ShS
Sophia Shepherd	Freedom to Speak Up Guardian	SaS

APOLOGIES:

Ken Batty	Non-Executive Director	KB
Aruna Mehta	Non-Executive Director and Chair of the Performance, Finance and Resources Committee	AM
Jane Meggitt	Interim Director of Communications	JM

AGENDA ITEM NO.		ACTION
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair (JL) welcomed all to the meeting, including members of the public joining virtually and noted the apologies above.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	No additional declarations of interest were noted beyond those already recorded and the Chair requested members to notify DO of any new declarations.	
004	**STUDENT PRESENTATION: HIGHER EDUCATION LANDSCAPE**	
	ERS and RSD shared the presentation and highlighted the following: • The Trust are pioneers in mental health, social work and leadership education and train many professionals from a range of backgrounds. The Trust's clinician-tutor model and multidisciplinary approach is still very much valued. The department is very grounded in practice. • Approximately 5,000 learners enrol each year in long courses and over 100 short CPD courses are run digitally with high levels of satisfaction. • There are 26 programmes (19 academically validated, 5 professional doctorates, 10 master's degrees, 3 postgraduate diplomas/ certificates and 1 graduate certificate). 13 of which are professionally accredited and 10 are pre-clinical and clinical trainings. • The key regulatory stakeholders are Office for Students (OfS), which is the independent regulator of higher education in England and the Trust have been registered with them since 2018. Noting the Trust remains the only NHS Trust that is registered with the OfS which is very significant. The main validating partners are the University of Essex. There is a joint social work programme with University of East London. There is a dual relationship with quite a complex process undergoing. There are a number of accrediting bodies, and which enables the department to deliver clinical education that qualifies for training. • The main bodies are Association of Child Psychotherapists, Association for Family Therapy and Systemic Practice in the UK, The British Second to Council, which is Psychological Society, Health and Care professionals and the Department of Health. • Like any institution registered with the OfS, there is a requirement to have a student protection plan that sets out a contractual obligation that protects the interests of students should, an institution cease to exist or somewhere in between carrying on in its operations with a change or a deviation in its course. The student protection plan which is reviewed annually and approved by the OfS as well as the University of Essex has a stipulation that should the Trust cease to exist, our education and training offer should make every effort to transfer the teaching provision to another institution or set in place a teach out which is what we have with the University of East London where we have moved our validation over. • With respect to degree awarding powers and the Trust's reliance on university partners, this is reviewed annually to make sure the approach we	

have taken is the correct approach. Currently degree awarding powers cannot be issued. The OfS has placed a moratorium on them and the process itself is lengthy requiring, at best a 50-week process of going through the entire eligibility review assessment and then final sign-off.

- In recent months we have considered the mechanics of the merger. We currently are renewing the terms particularly in relation to the university landscape and higher education. We rely on several bodies to credit programs which we must comply with their requirements. University of Essex will review the provision periodically depending on the professional body, whether it be two years or five years. One of the other requirements from the British Psychoanalytic Council has meant that as an NHS organisation, we must accommodate holding within our structure what they call a member institution within the Trust.
- There are challenges to ensure that as an education provider we can meet the needs of a wide range of stakeholders and fitting a key framework within the NHS. There are resources required to meet the regulatory requirements and the need to ensure we can remain sustainable; it is important for us to deliver well-governed education.

MF highlighted the uptake in requirements for data to flow to the OfS and other potential universities in the local area not making their returns in a timely fashion emphasising the pressure to operate in a very professional robust way in terms of the way we gather, process and return data to regulators. They have also indicated that they wish to shift from quality assurance to quality enhancement.

SJ inquired if there were any opportunities for future growth and what could be the next step for DET. RSD highlighted the potential for international growth as the Trust have an offering which does not exist elsewhere, emphasising the need for a fine balance between commitment to investment. An attractive international students offer could include underwriting students' accommodation. The team had met with former students in China who spoke highly of their time at the Trust and wanting to study further. Conversations had advanced with two organisations in China who are keen to move to Memorandum of Understanding (MOUs) and partnerships.

ERS further suggested an opportunity for modular delivery and micro-credentials. We have been developing capacity in those areas and there is something quite unique to us in being able to think about and work in relation to workforce planning and delivering education which is very accessible. We are in a prime position, particularly in terms of the NHSE to develop courses and provision that would meet the needs of the NHS population.

CJ asked colleagues from accrediting universities for any feedback regarding areas for development. AL shared very close working with colleagues and reflected that the Trust has unique and special courses which have an outstanding reputation in the field. There is real potential and uptake in some of the recruitment profiles to the courses which we have the pleasure of validating. We can see the specialisation and the real way the research work and the professional practice of the Trust feeds into the delivery of courses. This has created a niche in the market that was not replicated elsewhere. Resourcing of excellent colleagues should be a priority in terms of teaching and administration. We share the same perspective that all the work is built on expert professional

services and the need for colleagues to have the time and space to do their job well and be custodians of quality and correct practice around student welfare and experience. It has been a profitable relationship for the University of Essex in building connections to excellent researchers and research outputs over the years.

JL thanked colleagues for the update and noted regulating of education work may become more significant as NHSE regulates those organisations. The Trust's expertise and experience in having been regulated by the OfS would become useful in terms of the offer to other teaching institutions within the NHS.

The Board **DISCUSSED** and noted the Higher Education Landscape presentation.

005 MINUTES OF THE PREVIOUS MEETING HELD ON 16TH JANUARY 2025

DECISION: The Board **APPROVED** the minutes of the meeting held on 16th January 2025 as a true and accurate record.

006 MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW

The Board reviewed the action log. There was **1** action recommended for closure **APPROVED** and the **1** open action regarding Oliver McGowan training required updating as discussed:

All the Non-Executive Directors are required to complete the Oliver McGowan Tier 1 interactive session. Dates are provided centrally through the North Central London workforce programme. The next session that staff can access is 14th April 2025 and can be booked through the Learning and Development team. Trusts have taken the decision to remove this element from their compliance until the pipeline of training sessions is fully available. The Learning and Development team would provide further advice.

DECISION: The Board **APPROVED** the open action recommended for closure.

007 CHAIR AND CHIEF EXECUTIVE'S REPORT (INCLUDING MERGER UPDATE)

JL gave an overview of significant national developments currently impacting the wider NHS landscape. He highlighted the reforms underway within NHS England (NHSE), the Department of Health and Social Care, and the Integrated Care Boards. Of note was the recent announcement that NHSE would be dissolved as a statutory body by 2025/26. Its core functions may be absorbed into the Department of Health and Social Care or further devolved to the ICBs. JL emphasised the likely implications of these changes for providers like the Trust.

The CEO report was taken as read and MH highlighted key points from the report:

- It has been a 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 reviewing the annual plans produced by the clinical and DET teams. These plans underpin the Trust's submission 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.

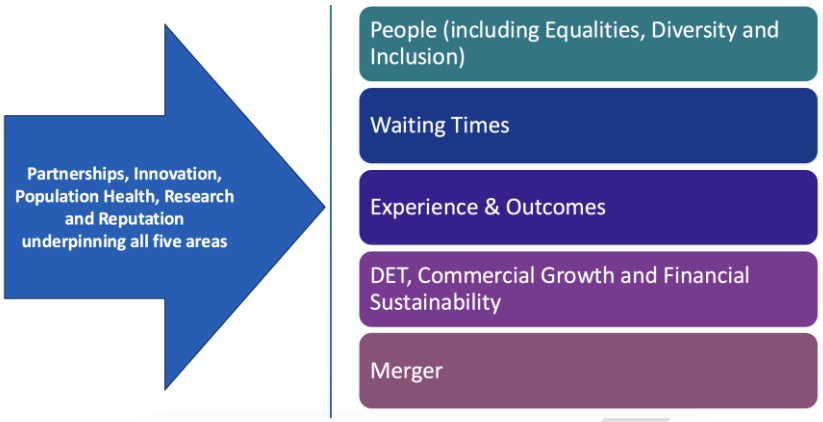
- Amanda Pritchard is stepping down as Chief Executive of NHS England (NHSE) at the end of March and want to thank her for her values-driven leadership during what has been a challenging time.
- We continue to work with NHSE and the local Integrated Care system to build a sustainable future for the Trust 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 programme once the planning round has concluded. To support an open and transparent approach, we are holding weekly CEO drop-in sessions for all staff to keep everyone informed on recent developments. MH reaffirmed the Trust engagement with the Calocane report and its implications, particularly in relation to the Patient and Carer Race Equality Framework (PSIRF) implementation, family engagement, and the provision of clinical information. These were all areas in which the Trust was already actively working, and the report served as a useful checkpoint.
- MH 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. MH approved this on behalf of the Board of Directors and the document is attached to the report for information.
- MH welcomed the publication of the 2024 staff survey, which showed notable improvements across a number of indicators. While these results were encouraging, MH stressed the need to continue efforts to consolidate gains and address the areas still requiring improvement.

The Board **DISCUSSED** and noted the Chair and Chief Executive's report.

008 INTEGRATED QUALITY AND PERFORMANCE REPORT INCLUDING UPDATE ON RISK AREAS/AREAS IN STRUCTURAL SUPPORT

The following are the highlights of the report:

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 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 monthly via team and delivery unit level performance and clinical governance meetings. The Trust agreed five priorities are set out below:



RB referred to the decommissioning of three services including PCPCS with a focus to ensure that there is a safe decommissioning process and the current search for alternative employment for staff affected within current internal vacancies. A meeting with NHSE confirmed there will be a rollover of this year's budget into next year. Business rules would be applied and a small uplift of 2.15% which is positive for next year.

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 responses 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.

Although new reporting systems, such as RADAR, initially suggest an increase in incidents, this is due to more transparent reporting rather than an actual rise in cases. Clinical and teaching teams are working collaboratively to explore strategies for reducing such incidents.

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.

Attention was also drawn to waiting times, with some positive developments. As of December data, the 18-week breach for autism assessments saw a significant reduction of 61%, dropping from 74 to 34 cases. This improvement puts the service on track to clear all 18-week waits by the end of the financial year. This progress is credited to the dedicated work of the autism team, including support from wraparound workers. In contrast, the trauma service continues to experience rising wait times, leading to its placement in targeted support. Efforts are underway to reassess and streamline referral pathways, triage processes, and case handling distinguishing between complex and non-complex cases and clarifying the service's commissioning scope. The team has responded positively to these changes, launching a triage team, adjusting geographical referral criteria, and moving towards only accepting referrals for complex or previously unsuccessful cases.

The gender service remains under targeted support, reflecting national trends. Despite a Kaizen event over a year ago, the desired impact on waiting lists has not materialized. A national initiative by NHSE has introduced a centralized QI program with a QI team member to be embedded in each gender service. The local team expects to appoint someone shortly and plans to re-run the Kaizen once this person is in post, with the clear aim of increasing activity and reducing waiting times.

Dormant cases continue to be a concern, particularly in adult units, where the pathway for gender care requires patients awaiting surgery to remain open to the service. This has inflated dormant case figures, as these individuals may not currently be receiving active interventions. A request has been made to separate

gender-related dormant cases in reporting to ensure that other dormant cases in adult units are not overlooked. Across other units, administrative delays in closing cases have also been flagged. Addressing this is a priority, both to ensure accurate reporting and to mitigate safety risks associated with open but inactive cases.

All units have now completed training in outcome monitoring, ahead of changes from April that require an initial outcome measure to stop the clock on waiting lists. The training, led by the Director of Therapies, emphasized the clinical value of outcome measures—not just as administrative tools but as aids in tracking progress and opening meaningful clinical conversations. The training has been well received, with a gradual increase in the use of outcome measures noted.

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.
Mandatory and Statutory Training 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.

SS noted a number of staff in adult services particularly within the adult gender service are reportedly working 100% from home, despite the organisation encouraging at least 40% in-office attendance. CA shared there is a cultural challenge within the adult gender service where the prevailing (but unsubstantiated) belief is that specialist roles require flexibility in location, including full remote work. Internal guidance (led by CA and CS) has been issued, outlining that clinical appointments should be face-to-face unless explicitly justified otherwise. GD reported a formal hybrid working policy has been repeatedly delayed due to ongoing changes and evolving NHS-wide guidance. However, there are signs that central NHS expectations will soon lean towards increased in-office presence, which the Trust may align with. A critical concern is the EDI impact, as administrative staff (largely from the global majority and often lower-banded) are expected to be on-site more frequently. Travel costs, caring responsibilities, and other disparities must be considered when shaping policy and enforcing expectations. Managers are increasingly ready to engage in more direct conversations with their teams around working arrangements but require institutional backing and tools to do so effectively and sensitively.

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.

Autism Waiting List & RTT Progress

CJ acknowledged success in the sustained reduction in RTT and 18-week breaches in autism and raised whether this progress has come at the expense of quality or staff wellbeing, particularly considering workforce instability. CA advised there is a clear organisational position that has been reiterated that early or initial appointments must not be tokenistic or tick-box in nature. All counted assessments or interventions must be of high clinical value and outcomes-based considered to be meaningful even when further assessment is required. Adjustments are being made to reduce time spent on traditional diagnostic models (e.g., reducing routine use of ADOS unless clinically essential). Use of AI for notetaking and letter generation is being actively explored to reduce administrative burden and increase clinician time with patients.

There is a wide variance in supervision compliance across services particularly in gender services where supervision is being carried out but not consistently recorded. The complexity of supervision types has led to confusion. A policy review and an organisation-wide audit by Professional Leads is underway to standardise recording practices, identify and address genuine gaps and ensure teams have appropriate supervision training.

SJ highlighted that only 30 ASC assessments were reported as completed annually, despite a 495% rise in referrals and 240 patients waiting. CA clarified the number is correct pre-kaizen event and current investment increased this to 50 per annum. The non-recurrent funding bought this up to 190 assessments.

SJ and MF suggested combining into future reporting themes of access, recruitment, and training with DET's remit to support student experience, improve placement and recruitment pipelines.

The Board **DISCUSSED** and noted the IQPR report.

009 INTEGRATED AUDIT AND GOVERNANCE COMMITTEE ASSURANCE REPORT

DL highlighted the following:

- The External Auditors are commencing their second year of auditing the Trust. Audit planning is on schedule and no significant issues have been raised through the audit planning stage.
- The *Value for Money* review will likely highlight ongoing concerns about the Trust's financial sustainability, linked to the upcoming merger.
- Internal Audit dominated the recent meeting due to high volume of outstanding recommendations from previous audits. Emerging concerns about accountability and consequence where actions are not delivered. It was noted that the Executive Leadership Team had prioritised this through regular review at ELT, with the CEO invited to the next IAGC meeting to support assurance discussions. The Committee will continue to maintain focus on this area.

The Board received and noted the **ASSURANCE** report from the Integrated Audit and Governance Committee.

010 FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT

Freedom to Speak Up Guardians, Sarah Stenlake (ShS) and Sophia Shepherd (SaS), jointly presented the annual report and highlighted elements around how speaking up intersects with investigations, grievances, and management of concerns.

The Guardians reported difficulties in navigating people issues, particularly where there is complexity or conflict. Cultural and relational issues often drive staff decisions to leave or disengage. Some staff have reported feeling unheard or misunderstood; difficulty knowing where to take issues when unsure. The Guardians emphasised the continued need for an environment where staff feel safe to speak up and are confident that they will be heard and supported and welcomed the organisation's commitment to improving how concerns are responded to.

Board Reflections

- Valuing staff voice: Board members strongly endorsed the work and its alignment with broader themes around safety, culture, and leadership.
- Recognition that the review offers valuable insights into areas needing sustained focus, particularly around leadership behaviours and psychological safety.
- Agreed that "everyone is a leader," and that cultural improvement requires shared responsibility at all levels.
- Acknowledged that while some issues are complex, this should not delay or dilute the response.

Discussion on Recommendations

The report set out five recommendations to drive improvement. The Board were broadly supportive of the recommendations and noted these were still under review. The Board sought clarity around: oversight and ownership of the programme, pace and ambition – maintaining momentum while allowing time for meaningful engagement and change, embedding staff voice – ensuring FTSU and lived experience perspectives continue to shape the work and integration with existing initiatives – aligning with broader people and culture programmes.

ACTION - Agreed Next Steps:

- Establish a time-limited programme board to drive and oversee delivery to include timeline for action and quick wins.
- Present an update to the May Board, including clarification of ownership and resources.
- Plan for how progress will be reviewed and communicated.
- Embed feedback mechanisms to ensure staff can see change happening and continue to influence the work.

The Board **DISCUSSED** and noted the Freedom To Speak Up Annual Report.

011 QUALITY AND SAFETY COMMITTEE ASSURANCE REPORT

CJ highlighted the following:

- 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. 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.
- 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.

The Board received and noted the **ASSURANCE** report from the Quality and Safety Committee.

012 PATIENT AND PUBLIC INVOLVEMENT ANNUAL PLAN

CS provided an update on the Trust's Patient and Public Involvement (PPI) work, outlining progress over the past year and the development of the revised plan for 2025/26. The plan builds on last year's foundation-setting phase, which focused on moving away from historic models and embedding engagement with current service users.

The original PPI strategy was developed with a board-level audience in mind and did not fully reflect the perspectives of those using services. Last year's annual plan focused on establishing the basics, including shifting from retrospective to real-time engagement with current service users.

Progress to Date:

- Annual progress was reported to the Quality and Safety Committee in December 2024.
- Revised Year Two plan has now been co-developed with service users.

Year Two Priorities (2025/26):

- Promote a culture where staff proactively seek and use feedback to understand and improve experiences of care.
- Expand service user and carer engagement and involvement in the design and delivery of services.
- Art Board and Community Engagement: Develop the Art Board's scope to better represent and work with local communities beyond community services.

Board members welcomed the clear cultural shift in how involvement is now understood and embedded in clinical teams, acknowledging the early challenges and the now positive engagement. The revised plan was praised for being action-oriented and time-bound, with visible outcomes, a format that could be more widely adopted in Trust reporting. JL suggested Committees could reflect on how they support and monitor delivery of key strategic action plans, including how best to use time for meaningful discussion.

The Board **DISCUSSED** and noted the PPI Annual Plan report.

013 PATIENT AND CARER RACE EQUALITY FRAMEWORK UPDATE

CA had taken the report as read and noted this item builds on the PCREF presentation delivered at last month's Board Seminar. The update provided a progress report on the implementation of the framework, with a particular focus on staff awareness, data development, and community engagement.

Key Points:

- The PCREF Implementation Group is now up and running and overseeing delivery of the work programme.
- A staff communications campaign has launched, beginning with a session at the Senior Leadership Forum and a Trust-wide column explaining the purpose and ambition of PCREF. The overarching aim is to create a culture where all staff are familiar with PCREF and understand its significance.
- Data (IQPR Integration): Work is underway to identify and report relevant, actionable data. Early mock-ups of IQPR slides have been developed, but the approach will now focus on integrating PCREF data into standard unit-level reporting, rather than treating it as a separate domain.
- Initial focus is on 'front door' access: referrals by ethnicity, acceptance rates, and insight into non-referral patterns. Future phases will explore engagement, outcomes, and therapeutic experience.
- Black History Month (October) is being considered as a platform for deeper staff-wide involvement.
- Emphasis on inclusivity - ensuring that the implementation group reflects the wider workforce, not just senior leads.
- Community Engagement: Recognised as a challenging area but early progress has been made.
- A working group is now in place to scope meaningful partnerships and engagement with communities to understand their perspectives and needs.
- Exploring the use of the North Central London (NCL) Waiting Room as a tool for sharing information and increasing visibility of non-NHS support (e.g. third sector, community resources), in response to service user preferences.
- Governance: Regular quarterly updates will be submitted to the Quality and Safety Committee. Board will also receive periodic updates to track overall progress.

Board Reflections:

- While the work is welcomed and commended, it was acknowledged that the issues PCREF seeks to address have been known for decades. It was noted that it is long overdue for these disparities to be systematically understood and addressed.
- Camden Health and Wellbeing Board was highlighted as an exemplar of deep and meaningful community engagement. Board members encouraged the Trust to connect with partners there to build on what already exists, particularly around children and young people's services.
- There was a strong steer that effective partnership and system integration, rather than siloed efforts, is key to achieving real community-level change.

The Board **DISCUSSED** and noted the Patient and Carer Race Equality Framework report.

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

PON shared the report and noted the Committee met to review the Trust's financial performance, including in-year delivery, forecasting, and process integrity. The discussion covered the period up to Month 10 and reflected recent improvements in the position.

The Month 10 position showed a significant improvement compared to Month 9, primarily due to a business rates rebate. As a result, the Trust is now reporting a position that is broadly back on plan.

The confirmed Month 11 position shows the Trust is £115k ahead of plan; the forecast is a positive £72k variance compared to the planned £2.2m deficit.

The Committee discussed concerns around income reporting, specifically, an inconsistency of £956k identified during internal review. This highlighted areas which required strengthening and which have since been addressed. It was noted that non-executive scrutiny and challenge remains robust, with constructive questioning of data quality and financial assumptions continuing to support governance. Assurance was provided that corrective actions are in place to strengthen controls going forward.

The Board received and noted the **ASSURANCE** report from the Performance, Finance and Resources Committee.

015	**FINANCE REPORT: MONTH 10 (VERBAL UPDATE ON MONTH 11)**

PON shared the report and highlighted a discrepancy was identified between funded posts and actual workforce data. The issue has been flagged with Digital, Estates, and Transformation (DET) colleagues and is being resolved.

Members reflected positively on the trajectory of long-standing issues such as overpayments and payroll anomalies. While it was acknowledged that problems have not been eliminated, there is cautious optimism with consistent improvement being seen.

Balanced IQPR Reporting:
The Committee discussed the need for the IQPR (Integrated Quality and Performance Report) to better reflect positive developments, in addition to risks and mitigations. This would help present a more balanced picture of Trust performance and learning

In-Year Financial Update:
The Trust's Month 10 financial position shows a marked improvement, mainly due to a significant rates rebate. This placed the Trust back on plan, with further confirmation from the Month 11 position now showing a £115k surplus against plan. Challenges in the cash flow process earlier in the year were resolved following constructive engagement with NHSE and revenue support colleagues. Cash position has since improved significantly.

The Board reflected positively on the consistency and transparency of financial reporting across the year, which contrasts with the volatility seen in other Trusts. This was recognised as a strength and a cultural shift toward better

accountability and forecasting. Despite two key issues during the year non-recurring income being incorrectly classified and partial funding of the pay award, the Trust has generally maintained an accurate and stable reporting position.

The Board **DISCUSSED** and noted the Month 11 verbal update.

016 FINANCIAL PLAN 2025/26

PON shared the report and highlighted the first draft submission was made to the ICB on 21 February 2025, with the next and intended final submission due on 21 March (to NHSE by 27 March).

Current draft plan includes a deficit of £3.2 million, underpinned by a £3.9 million efficiency program (c. 5.7% of turnover), placing the Trust at the higher end of declared efficiency targets nationally. Detailed work is ongoing to finalise recovery plans at business unit level, with appropriate Equality and Quality Impact Assessments (EQIAs) expected to accompany all proposals.

The Trust is also preparing for scenario planning, with models being developed for the current £3.2m deficit plan, a midpoint position (~£2–2.5m deficit), and a balanced budget scenario.

The Board noted growing NHSE pressure to produce balanced plans, with increasing focus on corporate cost reduction, workforce efficiency, and benchmarking against other Trusts which may disproportionately affect organisations like the Trust with relatively high corporate cost ratios.
Staff cost reductions of £1.2m are planned, including £300k in agency spend.
There was a clear commitment to safeguarding clinical services where possible, with initial focus on corporate efficiencies. The need for EQIAs covering clinical, corporate, and training impacts (including EDI considerations) was emphasised.
A new template has been circulated to support this process.

There may be a need for a Board session or NED meeting depending on NHSE feedback and any updated guidance.

The Board agreed the importance of understanding the EQIA process in detail and ensuring all relevant executive leads are engaged, particularly across clinical, workforce, and education areas.

The Board **DISCUSSED** and noted the Financial Plan 2025/26 report.

017 PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE ASSURANCE REPORT

SS shared the report and noted the Committee focused discussion on the strategic risk relating to a lack of a fair and inclusive culture, with a specific emphasis on equality, diversity, and inclusion (EDI).

The Committee welcomed evidence of improving assurance in this area, particularly acknowledging the positive impact of the work led by the EDI Programme Board and the wider HR team, who were commended for going above and beyond business as usual.

Members agreed that while challenges remain, the Trust is making tangible progress in developing a fairer, more inclusive culture. A specific case study illustrating a learning culture "Just Culture" within the Trust was discussed. The Committee found this a powerful example of good practice and recommended that it be shared more widely.

The Board received and noted the **ASSURANCE** report from the POD EDI Committee.

018 EDUCATION AND TRAINING COMMITTEE ASSURANCE REPORT

SJ shared the Committee welcomed PON's attendance, which provided helpful context on the financial planning challenges and what DET needed to contribute within the broader organisational picture.

Members formally recorded the OFS (Office for Students) meeting, acknowledging the strategic implications for the department's ongoing operations and longer-term questions around sustainability, especially in light of potential merger conditions.

Encouraging signs noted in student recruitment, currently complete applications to 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. While growth is currently concentrated among home students, international recruitment is being monitored.

There was discussion around the ongoing review of part-time visiting lecturer arrangements, with a view to improving efficiency and consistency, though the motivation is strategic rather than financial. Planning is underway for a DET Strategy Day, aimed at consolidating these areas and setting future priorities.

The ongoing challenge of space utilisation was acknowledged; while still unresolved, it remains an area under active review. The Board supported including AI within the upcoming informatics strategy discussions, ensuring alignment with evolving digital priorities.

The Board received and noted the **ASSURANCE** report from the Education and Training Committee.

019 ANNUAL SCHEDULE OF BUSINESS 2025/26

DECISION: The Board **APPROVED** the schedule of business for 2025/26.

020 QUESTIONS FROM THE GOVERNORS

There were no questions from the Governors raised.

021 ANY OTHER BUSINESS

There were no items of other business raised.

022	**QUESTIONS FROM THE PUBLIC**
	There were no questions from the public raised.
023	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	Members were pleased with the detail of the reports and found it useful to have specific discussions around FTSU. The meeting was chaired effectively and found to be productive.

The Chair closed the meeting at 5.00 p.m.

Date of Next Meeting in Public: Thursday 15th May 2025 at 2.00pm – 5.00pm

Signature _____ Date _____

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

Actions are RAG rates as follows: ->				**Open - New action added**	**To Close - propose for closure**	**Overdue - Due date passed**	**Not yet due - Action still in date**
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	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. 13/03/25: All of the Non executive directors are required to complete the Oliver McGowan Tier 1 interactive session. Dates are provided centrally through the NCL workforce programme. The next session that T&P staff can access is 14th AprIL and can be booked through L&D. Trusts have taken the decision to remove this element from their compliance until the pipeline of training sessions is fully through. L&D can advise on where NCL are at with this.
	10	Freedom To Speak Up (FTSU) Guardian Annual Report	•Establish a time-limited programme board to drive and oversee delivery to include timeline for action and quick wins. •**Present an update to the May Board, including clarification of ownership and resources.** •Plan for how progress will be reviewed and communicated. •Embed feedback mechanisms to ensure staff can see change happening and continue to influence the work.	13.03.25	Mark Freestone, Chief Education and Training Officer (NED Lead for FTSU)	**In progress**	14/04/24: Progress has been made with establishing a Staff Experience Group which will also oversee delivery of the FTSU action plan. An action plan has been developed and was presented to the POD EDI Committee on 1st May. Report to be brought to Board at a later date.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 May 2025			
Report Title: Chief Executive's Report			**Agenda No.: 007**
Report Author and Job Title:	Michael Holland, Chief Executive	**Lead Executive Director:**	Michael Holland, Chief Executive
Appendices:	None		
Executive Summary:			
Action Required:	**Approval** ☐ **Discussion** ☒ **Information** ☐ **Assurance** ☐		
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.		
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.		
Assessment:	This report covers the period since the meeting on 13 March 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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
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

As I reported last time, it is one of the most challenging years on record for the NHS. There is a big drive from central government to work smarter and harder and, as ever, our teams are rising to the challenge so that we can continue to deliver excellent care and education to patients and students. Through this challenging period, we remain driven by our vision to be a leader in mental health care and education and to make a meaningful difference to people's lives.

I'm pleased to report that we're making good progress with our merger plans.

2. Merger update – Joint announcement with North London NHS Foundation Trust

On 1 April 2025 we confirmed plans to explore a merger by acquisition with North London NHS Foundation Trust (NLFT). We are confident that merging with NLFT will significantly enhance and strengthen children and adult mental health services across North London, as well as end the uncertainty and increase opportunities for our staff, students and patients.

Working with NLFT, we intend to complete the merger process by 1 April 2026, so that we can focus on creating improved care quality and stability for staff, students and patients. To support an open and transparent approach I am holding weekly CEO drop-ins for all staff and monthly informal sessions with Governors to keep everyone informed of recent developments.

Providing outstanding patient care

3. Regional Chief Nursing Officer Visit

The London Region Chief Nursing Officer, Karen Bonner, visited the Trust on 1st May, during the visit she met with nurses from across the Trust and heard about their unique roles within the organisation. It was also an opportunity for the Trust to share the post graduate training for nurses, including the valuable work that we are currently doing with North Central London ICB, Trusts across the system and further afield to embed reflective practice, restorative-based supervision through training, and supporting organisations to develop a sustainable approach to this.

4. International Nurses Day

On 12th May, the Trust celebrated International Nurses Day with the theme "Caring for Nurses Strengthens Economies", showing the importance of the profession for health systems. At the Tavistock and Portman, we held a celebration event, and shared the impact that nurses have on the services they deliver and to the overall service user experience. Ahead of the day, non-nursing colleagues were asked to provide statements on the role of nurses in their teams, there was an overwhelming response that was shared across the Trust.

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

5. Office for Students' (OfS) Changes

I was interested to hear about the changes proposed by the Office for students for their regulatory framework for Higher Education providers and both the Trust Chair and CETO attended briefings on these before Easter. The changes are, firstly, to the conditions around treating students fairly, which introduce a new definition of detriment based on poor behaviour by providers. The second change around effective governance is potentially more impactful to our Trust as it provides a clearer framework for non-University providers to meet the governance requirements of OfS regulation, together with the expectation that leaders and governing bodies have a basic competence and understanding of Higher Education provision. We have informed the Board that we have been seeking to provide this through recent Department of Education and Training briefings at Board Seminars and we will continue to respond to the proposals as they move forward.

6. Student Recruitment

After a very strong start to the year driven by our opening student recruitment to our long courses four months earlier in October 2024, applications to our courses for 2025/26 entry have settled down to 2024/25 levels which is in part disappointing after such a fantastic opening. However, a consequence of the early acceptance of applications is that we are very far ahead of last year's position in terms of the number of offers made to students and acceptance of those offers; up to 350% in the first case. This gives us confidence to forward plan our marketing of courses where we believe we can attract more applicants and enrolments, and to confirm our teaching requirements for the next year. We will monitor this situation closely.

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

7. Staff Experience

We recognise that when there is excellent staff experience, we give the best care to our patients and deliver the best education to our students. To achieve this, we need to create a workplace where our employees feel valued, supported and encouraged to deliver. One of my priorities for the year ahead is to improve the working lives of staff, so they can continue to deliver for patients and students.

We have started a piece of work to explore what needs to be done to achieve this, and we are encouraging everyone to get involved to tell us about what matters to them. We are committed to delivering meaningful outcomes arising from everyone's involvement and from us listening and responding to what we hear. Invitations to drop-in sessions have been sent to all employees, with the first session already producing lots of rich dialogue.

8. Staff Awards

Our first ever Values in Practice awards will be held in June to recognise and celebrate the work and achievements of our staff over the past year. Staff across our organisation work incredibly hard to fulfil our mission to provide high-quality specialist mental healthcare, alleviate emotional distress and pioneer innovative education and research. We aim to provide a safe and supportive workplace where our organisational values – respect, compassion, inclusivity, and excellence – are reflected every day, along with our behaviours which guide who we are and everything we do.

Our Values in Practice awards allow us to recognise and thank our staff for their dedication and hard work. Nominations are open until 21 May, and will recognise individuals or teams for their work, impact and dedication to our patients, students and colleagues.

Key dates

- 21 May – Nominations deadline
- 28 May – 2 June - Shortlisting
- 3 June – Online shortlist event
- 4-9 June: Staff choice awards voting
- W/C 9 June – Judges select winners
- 26 June – Awards event at Everyman Hampstead

Improving Value, Productivity, Financial and Environmental Sustainability

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

The Trust incurred a net deficit of £2,197k in the period up to the end of March 2025, against the plan of £2,200k, a positive variance of £3k. This is subject to confirmation via the normal year end final accounts and external audit process. This improved position reflects the benefit of the non-recurrent rates rebate received in January 25. 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.

The financial planning 'round' for 2025/26 has concluded, with the Trust agreeing a balanced plan for 2025/26. The improvement from the previously deficit position of £3.2m being generated by some additional income from NCL, a commitment to reduce the annual accrual costs by £500k (requiring staff to use all their annual leave in 2025/26) and the planned sale of Gloucester House.

Other Key Internal Updates:

10. Council of Governors' Elections 2025 and New Appointed Governor

I am pleased to announce the results of our recent elections to fill vacancies on the Council of Governors.

Two public seats in Camden have been filled by Natalia Barry (2nd Term) and Peter Ptashko (1st Term as a Public Governor), and the student seat has been filled by Chipo Mukoki. We also welcomed a new Appointed (Stakeholder) Governor in April (Councillor Anna Wright, representing Camden Council).

Regional and National Context

11. Mental Health Network Annual Conference 2025

The Trust was represented at this year's Mental Health Network Conference which included a panel discussion on the 10-year plan and what this means for mental health and learning disabilities and a keynote address from Sir Jim Mackey. Key themes throughout the day focused on the voice of the service user, patient power, with the service user being an equal partner in their care; how we achieve parity for physical and mental health through recognising stigma as a barrier to accessing services.

Discussions around the 10-year plan centred around this not being a plan for specific services, specialisms or pathways but will be on creating services tailored to population

needs, with greater devolved responsibility where local decision making and innovation is encouraged. It was acknowledged that mental health services are at the sharp end of today's challenges, with rising demand and workforce pressures. Yet, amidst this, our sector continues to deliver and is ahead of the curve with the governments key shifts particularly with moving more care from hospital to the community, making better use of technology and focusing on prevention.

Through the presentations on digital innovation and digital solutions, that were shared, there was a focus on patient benefits, not only in reducing waiting lists but also in reducing duplication for patients, and greater accessibility, although there were some words of caution around the need for workforce training, a scaled approach and above all, giving due consideration to digital poverty and any unintentional barriers to accessing services.

The priority for the 10-year plan will undoubtedly focus on rebuilding public confidence in the NHS and in improving staff experience.

12. Supreme Court ruling

The UK Supreme Court has recently ruled on the definition of a "woman" under equality legislation. The implications of this ruling are not yet completely clear, and we await guidance on how this might be applied across the NHS.

In the meantime, we are aware our Trans and non-binary patients, students, staff and their allies may be anxious about what this might mean for them, their everyday life and wellbeing and their safety. At the Tavistock and Portman, we are very clear that we will continue to treat everyone with dignity, compassion, and respect.

13. Changes to Statutory and Mandatory Training across the NHS

NHS England recently announced a universal agreement across the NHS in England to accept a core list of prior statutory and mandatory (StatMand) training. This means that, starting on 1 May 2025, staff will no longer need to repeat training when they move between NHS organisations, resulting in greater efficiency and improved staff experience.

14. Board Member Appraisal Guidance

NHSE published in April, the Board member appraisal guidance, for Chairs, Chief Executives, Executive Directors and Non-Executive Directors, which establishes clear expectations and enhances consistency in standards for board-level appraisals. The Trust has begun to implement this guidance for the 2024/25 Board-level appraisals.

15. Mental Health Strategy Update

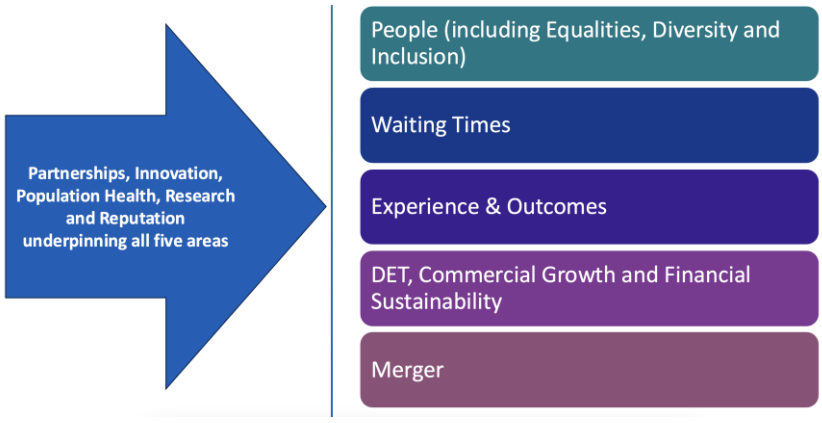
I attended the NHS England London CEOs meetings on 23rd April, where we discussed the Mental Health Strategy for London. We have a shared vision to improve mental health services in London which we can achieve through delivering the mental health strategy. This shared strategy for mental health in London will help us to achieve our vision of ensuring that London is the best global city in which to receive mental health services. The final Strategy document is due to be published in the coming weeks. It offers a good opportunity for the Tavistock and Portman to demonstrate and lead in the Children and Young Persons (CYP) space and demonstrate the outcomes we achieve in this area.

16. Chief Executive's meetings with external stakeholders

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

- Planning check in 2025/26 with NCL Chairs & CEOs
- NHS Providers Chair's and Chief Executives
- CICE Neighbourhood workshop
- London CEO with London Regional Directors
- NHS Leadership Event
- NHS England London CEOs meetings with the London Regional Director

<table>
<tr><td colspan="4">MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 8 May 2025</td></tr>
<tr><td colspan="3">Report Title: Integrated Quality Performance Report M11</td><td>Agenda No.: 008</td></tr>
<tr><td>Report Author and Job Title:</td><td>Rachel James, Director of Therapies,
Sheva Habel, Medical Director,
Hector Bayayi – Managing Director</td><td>Lead Executive Director:</td><td>Clare Scott, Chief Nursing Officer
Chris Abbott, Chief Medical Officer
Rod Booth, Director of Strategy and Business Development</td></tr>
<tr><td>Appendices:</td><td colspan="3">Appendix 1: IQPR March 2025</td></tr>
<tr><td colspan="4">Executive Summary:</td></tr>
<tr><td>Action Required:</td><td colspan="3">Approval ☐ Discussion ☒ Information ☐ Assurance ☒</td></tr>
<tr><td>Situation:</td><td colspan="3">The Trust Integrated Quality and Performance Report (IQPR) for February 25 (Month 11) provides an overview of delivery against NHS national targets and Trust agreed priorities. The report content has been reviewed through quality and performance structures “floor to Board”, ensuring 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.
This report should be used in conjunction with accompanying slides and respective committee reports.</td></tr>
<tr><td>Background:</td><td colspan="3">Month 11 was considered in the Trust-wide IQPR meeting on 25th March 2025, additionally Trust quality and performance is reviewed weekly at Strategic Delivery Room, with a focus on our five strategic priorities and monthly via team and delivery unit level performance and clinical governance meetings.
The Trust strategic priorities:
 
</td></tr>
<tr><td>Assessment:</td><td colspan="3">To ensure we focus on important issues and priority areas, the IQPR paper reports by exception, providing an overview of key highlights, emerging concerns, and a summary of actions being taken Trust to address issues identified for improvement in relation to the delivery of our strategic priorities and on-going clinical and educational service delivery across quality, operational performance, people and finance.</td></tr>
</table>

We received the 2025/26 planning guidance and developed draft plans at unit level. These were reviewed in an event chaired by Executive Leadership Team to provide scrutiny and support in further development of the plans, with a focus on efficiency and productivity whilst improving quality.

Operational Performance

Waiting Times

Two teams are monitored under the Trust targeted support framework, Gender Identity Clinic and Trauma service with a focus on reducing waiting lists, improving productivity and improving patient experience.

GIC

- In this period there was a decrease in activity in GIC.
- The service implemented the patient portal and core clinic model with the full implementation of the Universal Assessment form, wait list validation has been carried out.

Trauma service

- Moved into targeted support in February 2025 and recorded a second month of above job planned activity, with reduced referrals into the service due to improved triaging.

The Autism Spectrum Condition Team is under ELT oversight due to significant demand on the service and the need to ensure the ongoing improvement work continues to balance out activity levels with the referral rate.

- Autism assessments - the average waiting time in Haringey reduced to 40 weeks. Hertfordshire waiting times remain at 3 years, although negotiations with commissioners regarding 2025/26 funding for waiting list reduction. Business as Usual assessment team have increased activity following additional investment.
- Work continues to recruit to the Team Clinical Lead role.

Quality and Safety

Experience and Outcomes

- **Patient Feedback:** Clinical Services reported 84% positive responses to the Friend and Family Test (FFT) question in the Experience of Service Questionnaires (ESQ), below the 90% target. Posters with ESQ QR codes are now displayed in reception areas, QR codes are added to email and letter footers to increase the ways in which people can feedback.
- **Complaints:** 10 formal complaints were received in February 2025, the number of open complaints has reduced from 34 to 20, with 8 overdue. The Trust now holds a daily complaint huddle focusing on overdue complaints, timeliness of response and allocation of new complaints. Lessons learned and action plans arising from complaint investigations are recorded on Radar and shared at unit clinical governance meetings and Trust wide Service User Experience Group.

- **Clinical Outcome Measures:** Services have continued to progress the QI Project to increase the number of outcome measures (OM) collected across all services. In February 2025, this included the development and delivery of a range of OM training resources and information available on the intranet, and the Waiting Room Platform. Further improvements to include OM information within care plans is ongoing with service users. 'You Said, We Did' and patient stories content have been created and will be uploaded to the intranet page. The Quality Team are creating the OM dashboard to track key metrics. This puts the Trust in a strong position for the launch of the new waiting time metrics on 1st April 2025.
- **Patient and Carer Race Equality Framework (PCREF)** implementation and developments will now be reported in IQPR with a focus on referrals and acceptance data.
- **Incidents:** A total of 27 incidents were reported, 12 were identified as patient safety incidents, of which 10 incidents involved violent and aggressive behaviour; 2 incidents involved the use of restrictive practice.
- **After Action reviews:** Three After Action Reviews (AARs) were initiated in February. Two focused on the violence and aggression incidents at Gloucester House, a third concerns an incident where a patient attended the clinic without an appointment. Relevant findings and key learnings will be shared Trust wide.

People:

- Appraisal completion remains low, there has been slow improvement, with an almost 1% increase in February.
- The Trust completion for mandatory and statutory training (MAST) is 80.1%, under the Trust target of 90%.
- The Learning and Development team is developing a quality improvement workstream to improve the completion rates for both appraisals and MAST.

Finance:

- The Trust is £115k ahead of plan at M11, with a recorded deficit of £1,951k. This is an improvement of the position by £118k from the M10 position. The continued improved position has been delivered by the receipt of a one-off rates rebate received in January. The unfunded element of the pay award remains a recurrent issue for 25/26. The reported cash position at the end of February was ahead of plan and capital spend is expected to be on plan at £2,718k at the end of the year. This is an increase from previous months reflecting additional capital distributions received via the ICB. The Trust now expects to deliver its planned deficit of £2,200k in 24/25.

<u>Contracts By Exception</u>

- **PCPCS** will close on 31st March, programme of staff support and redeployment, where possible, in place.
- **First Step Haringey** are in consultation and will close on 31st March 2025.

	• **Surrey Mindworks Team** has been served notice, the team will continue to work within the Alliance for 6 months
Key recommendation(s):	The Board is asked to review the contents for **ASSURANCE**.

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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All Related BAF Risks including BAF 2.				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no specific legal and regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	EDI implications are addressed through the working groups, it is noted that both feedback and waiting lists are focusing on ensuring that ways in which service users can give feedback are made more accessible and that waiting list work focuses on reducing barriers to accessing our services.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			

Assurance:	
Assurance Route - Previously Considered by:	Local IQPR meeting held in 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 March 2025

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:

To focus on Trust priorities and areas of presenting risk with mitigations the IQPR reports by exception. This report and dashboard provide an overview of key monthly highlights, trend over time, emerging concerns and a summary of actions being taken by the Trust to address issues identified for improvement across clinical, education and corporate services.

This report is based on February 2025 (month 11) data, 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 as noted in watch metric slides; this is under review to align the historic data where possible.

Executive Summary

The Tavistock and Portman NHS Foundation Trust

We received the 2025/26 planning guidance and developed draft plans at unit level, these were reviewed in an event chaired by Executive Leadership Team to provide scrutiny and support in further development of the plans, with a focus on efficiency and productivity whilst improving quality. This has set the Trust activity, finance and workforce baseline and trajectories for 2025/26.

Operational Performance

Waiting Times

Two teams are monitored under the Trust targeted support framework, Gender Identity Clinic and Trauma service with a focus on reducing waiting lists, improving productivity and improving patient experience.

GIC

- In this period there was a decrease in activity in GIC due to increased levels of annual leave.
- The service implemented the patient portal and core clinic model with the full implementation of the Universal Assessment form, wait list validation has been carried out and approximately 4000 cases are due to be discharged from the service.

Trauma service

- Moved into targeted support in February 2025 and recorded a second month of above job planned activity, with reduced referrals into the service due to improved triaging.

The Autism Spectrum Condition Team, is under ELT oversight due to significant demand on the service and the need to ensure the ongoing improvement work continues to balance out activity levels with the referral rate.

- Autism assessments - The average waiting time in Haringey reduced to 40 weeks. Hertfordshire waiting times remain at 3 years, although negotiations are taking place with commissioners regarding 2025/26 funding for waiting list reduction. Business as Usual assessment team have increased activity following additional investment.
- Work continues to recruit to the Team Clinical Lead role

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- **Clinical Outcome Measures**: Services have continued to progress the QI Project to increase the number of outcome measures (OM) collected across all services. In February 2025, this included the development and delivery of a range of OM training resources and information available on the intranet, and the Waiting Room Platform. Further improvements to include OM information within care plans is ongoing with service users. 'You Said, We Did' and patient stories content have been created and will be uploaded to the intranet page. The Quality Team are creating the OM dashboard to track key metrics. This puts the Trust in a strong position for the launch of the new waiting time metrics on 1st April 2025.

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Contracts By Exception

- The City and Hackney Primary Care Psychotherapy Consultation Service closed on 31st March. There is a programme of staff support and redeployment, where possible, in place.
- The Local Authority element of the First Step Service in Haringey has been decommissioned and will close on 31st March 2025 with staff consultation underway. The NHS commissioned element of the service remains to support children and young people in the Borough, which also minimises staffing impact.
- The Surrey MindWorks Service will close at end of September 2025 with a programme of work in place until them to deliver i-Thrive training and support communities of practice.

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.

Excellence Inclusivity Compassion Respect

Integrated Quality and Performance Report

Month 11- 24/25

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

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

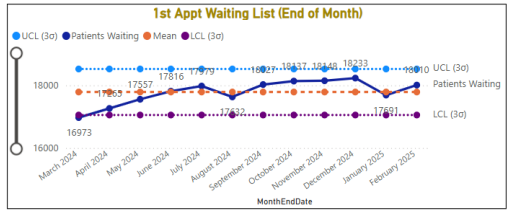
G5. Improve recruitment and retention aligned to the teams' workforce plans

Continued...

Metric	Waiting List Management (Continued)	SRO	Chris Abbott	Target	4-wk & 18-Wk	Measure	

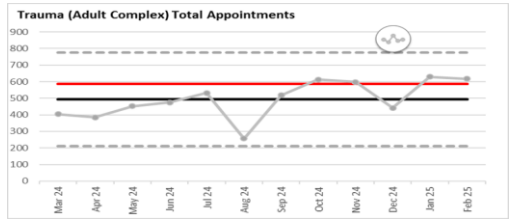
People Culture | Waiting Times | User Experience & Outcomes | DET, Commercial Growth and Sustainability | Merger

Historical Peformance

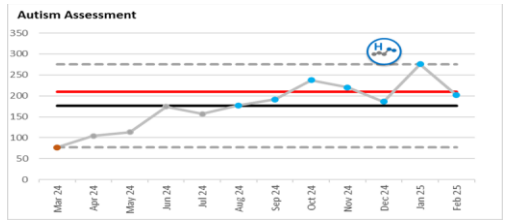


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

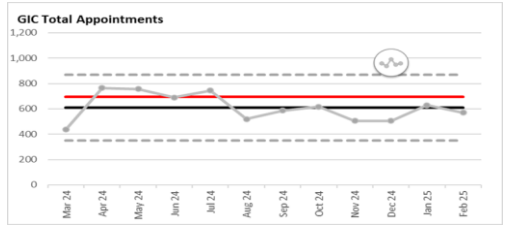
Trauma



Autism Assessment



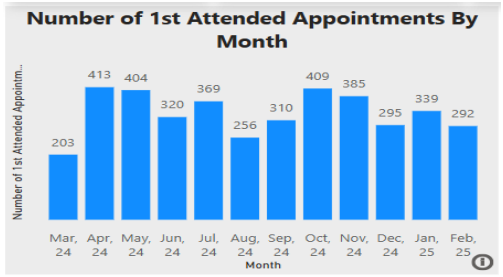
Adult Gender Identity Clinic (GIC)



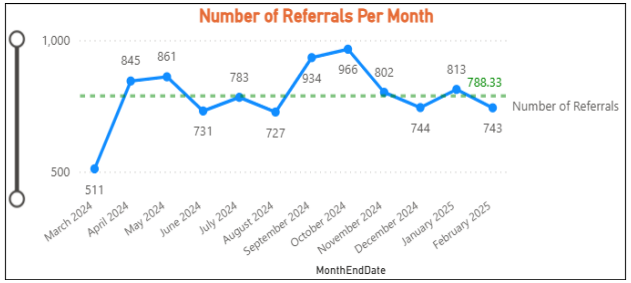
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

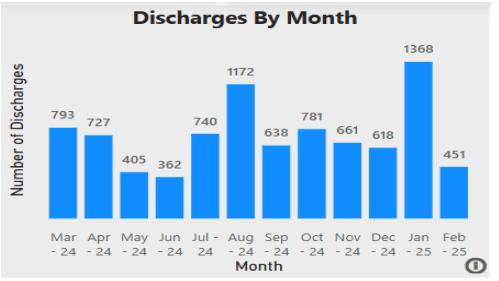
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

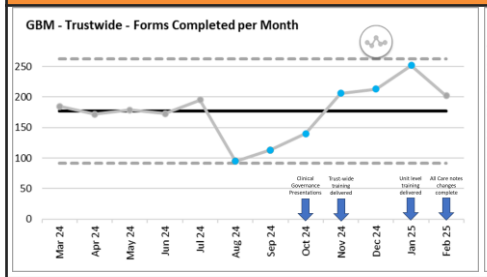
Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource 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

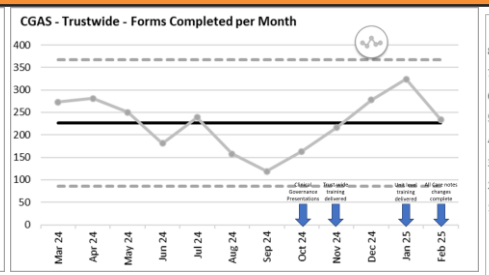
Integrated Quality and Performance Report — Month 11 – 24/25

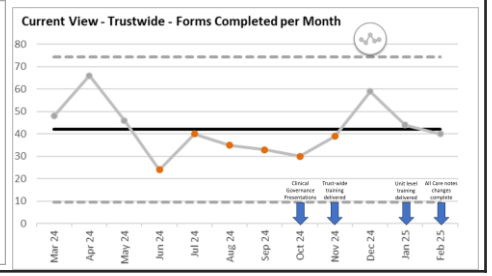
Metric	Outcome Measures	SRO	Chris Abbott	Target		Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

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 improvement and clinical effectiveness

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)**	**Training:** Ensuring all staff know about the upcoming changes with the NHSE WTM and changes the project has made. Creating a yearly training plan for Carenotes and OM collection. **DET:** OM as part of their training / Digital and Short course	• Video recording of key NHSE WTM changes and minimum OM standard created and uploaded to the intranet page. • Lunch and learn on Monday 10th March, Upcoming Lunch and Learns: Wednesday 12th • Met with GIC to train MDT on the use of Goal Based Measures • Working with the Quality Team and Carenotes Trainers to establish yearly OM training • Training slides / videos for all trainees within DET to be created and shared.	RJ / LC
	Carenotes Changes: 13 changes to Carenotes have been complete, with focus groups waiting to happen to enable us to complete the 14th – CYP OM into Care Plans	• Awaiting feedback from further focus groups to inform us of the changes to Care Plans • Changes to Care plans to be enacted once we have feedback from service user focus group • Working with Ops/Admin in CYP MH to update SOPs to reflect the changes being made to Care Plans • Final checks with IM&T colleagues to make sure all Carenotes changes are running smoothly.	AB / RJ PW BG / LC
Clinicians and teams are not collecting matched pairs of outcome measures **(G2)**	**Trust wide comms:** Comms to enact the comms plan submitted to them in mid Feb, to maximise the number of colleagues aware of ongoing / already established changes	• Intranet page set up and posting of the OM training video for mental health services. • Update and amend the intranet page, to include more information about why OM data collection is required and less about the measures themselves. • Publication of the 'you said, we did' piece and the patient stories content • End of the month do a final push to colleagues highlighting all the work that has been done / put into comms. • Agree dates for OM Carenotes Training with Quality Team – awaiting confirmation.	LE SP / LC
	Reporting: To build operational and IQPR dashboards that give staff self-serve access to accurate OM data. Once all complete, begin embedding this into BAU practice.	• Quality Team submitted required information for Informatics to create the missing OM dashboard. • Building of remainder of the dashboard to be completed: the percentage of patients with one attended appt and one mandatory form (PROM ***or*** CROM), the number of people discharged with two or more matched forms, and improvement rates.	RJ / LC / SP / EC

Integrated Quality and Performance Report — Month 11 - 24/25

Metric	User Experience	SRO	Clare Scott	Target	90%

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

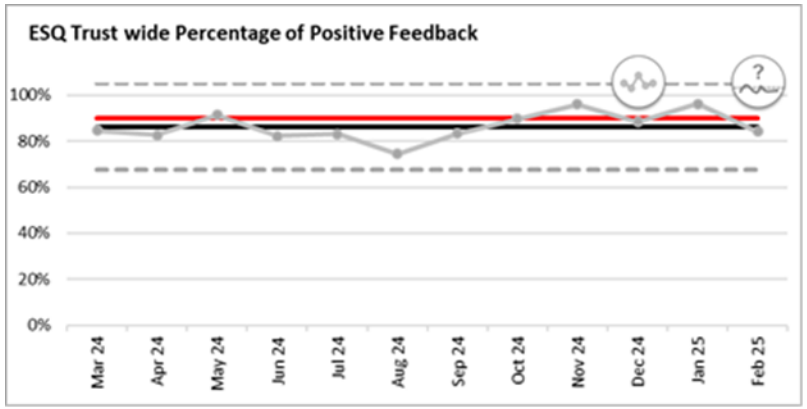
Problem Statement

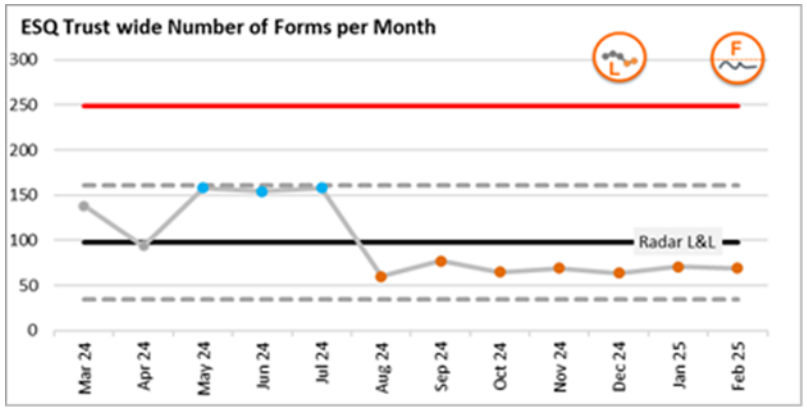
Across the Trust, since April 2023, the average monthly positive feedback percentage is 86% in service user satisfaction (ESQ/FFT) which is less than our target of 90%. This is relative to the amount of feedback that we receive which is low. The average number of monthly forms completed Trust wide was 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 Team level Targets set in February 2025.
G2: To consistently meet 90% positive user satisfaction score.

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	Milestone achieved	Countermeasure in progress	Owner
ESQ version 2 form to be updated based on the feedback received	• Version 1 of the ESQ is on Radar and in use • Qualtrics has been archived	• Reiterations for version 2 have been gathered • Carenotes ESQ process will be archived as soon as paper copies are available.	Informatics & Comms
Paper ESQ form to mirror the Radar form	• CYP form created and distributed on sites	• Adult ESQ form being finalized	Comms
Letter footer- the current patient correspondence via letters does not promote how service users can provide feedback.	• Finalized footer • Confirmed the shorter URL for ESQ on Radar for this link to be available in the footer	• The scope of the pt correspondence documents to be updated has been reviewed, change request submitted for Informatics to update these. • Teams to update the footer on all Non-Carenotes letters	Teams & Informatics
SMS – there is a missed opportunity to receive feedback as we are not requesting service users to complete the ESQ by sending them an SMS.	• Confirmation received from each team re suggestion for frequency of SMS in each team • Meeting with IG taken place to get guidance on content of SMS	• Write contents for SMS in accordance with NHS Transform guidance and check with Caldicott Guardian and IG • Collaborate with Informatics to roll out SMS at the appropriate frequency for each team.	Unit managers, Huddle, Informatics
Signatures- current emails sent to service users do not show how they can provide feedback.	• Wording for signatures finalised and signature created	• Unit Managers to confirm signatures have been updated with the second version on all emails sent to service users.	Unit Managers, Marcy
Targets at team level to be set and monitored.	• Team targets have been set and shared for annually and monthly based on 30% of open cases in period Dec 2023 – Dec 2024	• To create SPC charts with new targets • Monitor teams on set targets and review these targets with aim to increase over next few months	Sonia
Reporting- To have an effective reporting system for qualitative and quantitative ESQ data There is no feedback loop for services to show what is improvements are being made with the feedback.	• Engaged with stakeholders conducted with unit managers, clinical leads to understand their requirements	• Re review the inclusion criteria for the reporting process for how teams receive their ESQ data • Trial new feedback reporting email with stakeholders • Feedback from teams is actively collected and discussed at Clinical Governance meetings	Huddle

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 (we increased again to 7.61 and national average has been adjusted to 8.08).

Historical Performance

WDES Indicators

The Tavistock and Portman NHS Foundation Trust

	Description	Organisation Trend (Overall) 2023-24	2024-25
	WDES Metrics based on NHS Staff Survey Indicators (Organisational Culture)		
4a.	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues	32.3%	34.3%
4b.	Percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, thy or a colleague reported it	48.8%	61.9%
5.	Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion	33.9%	39.4%
6.	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	21.0%	18.3%
7.	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	42.7%	44.4%
8.	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	67.7%	64.6%
9a	The staff engagement score	6.5	6.6

Key Achievements
- Improvements made in 5 of the 7 indicators presented

Key Concerns
- Harassment, Bullying or Abuse from patients, managers or colleagues
- Satisfaction with Reasonable Adjustments

WRES Indicators

The Tavistock and Portman NHS Foundation Trust

	Description	2023 - 2024 Org Overall	White	Ethnic Minorities	2024 – 2025 Org Overall	White	Ethnic Minorities
	WRES Metrics based on NHS Staff Survey Indicators (Organisational Culture)	n = 435	n = 297	n = 131	n = 419	n = 259	n = 147
5	Percentage of staff experiencing harassment, bullying or abuse from patients, managers or public in the last 12 months	14.8%	17.3%	9.2%	16.4%	16.3%	16.4%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12	22.9%	20.7%	28.5%	24.4%	23.0%	26.7%
7	Percentage of staff believing that trust provides equal opportunities for career progression	33.9%	38.2%	26.0%	39.4%	40.1%	39.9%
8	Percentage of staff experiencing discrimination from staff in last 12 months	13.2%	10.2%	20.0%	14.2%	12.1%	16.7%

Overall Organisation Results: regression in 3 of the 4 indicators

Key Achievements (for staff from a Global Minority background)
- 1.8% decrease in number of staff from a Global Majority background experiencing harassment, bullying or abuse from colleagues
- 13.9% increase in the number of ethnic minority staff who believe Trust provides equal opportunities for career progression
- 3.3% decrease in the number of staff from ethnic minority backgrounds experiencing discrimination from staff

Key Challenges
- 7.2% regression in BHA from patients, managers or public (but consistent with experiences of White staff).
- Need to explore why amelioration of the negative experiences of staff from a Global Majority background has led to 2.3% increase in the number of white staff experiencing BHA from staff and 2% increase in those who feeling discriminated against.

Root Cause/ Gap Analysis

Our position has improved within our benchmark, but we must acknowledge that this is partly because other Trusts regressed far more than us this year. We therefore need to now interrogate the data at locality level and centre support on teams that need further development in this area.

We also need to focus on those areas that are scoring well and facilitate them sharing their good practice.

Progress on Improvements (subject to WRES / WDES refresh)

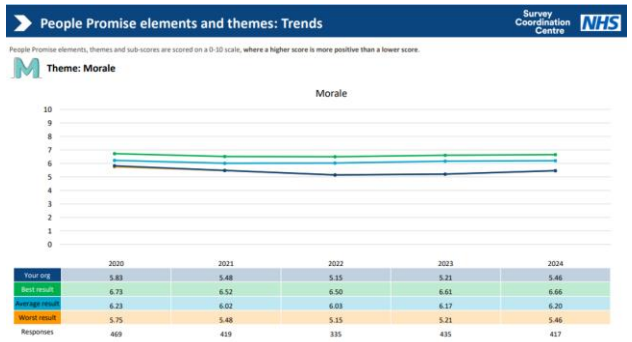
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has regressed from 14.8% to 16.4%.
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has regressed from 22.9% to 24.4%.
- Percentage of staff experiencing discrimination from staff in last 12 months has regressed from 13.2% to 14.2%.
- However, perceptions on equal opportunities for career progression or promotion have improved from 33.9% to 39.4%.

Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

Problem Statement

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



Vision & Goals

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

Goal 1: To achieve a 60% response rate to the next staff survey (2024 ended higher than 2023 on 55%)

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

Root Cause/ Gap Analysis

- Improved in 7 of the 9 people promise areas
- Above the bottom of our benchmark in 8 of the 9 areas
- Can see direct improvements in staff engagement
- At or above average in: acting fairly re career progression /promotion; being kind to each other; being polite and respectful, being valued by team; opportunities to show initiative and make suggestions; and reporting incidents of bullying/harassment/abuse
- Areas for concern remain: people with LTHC and those from global majority feeling bullied by colleagues, managers not caring about concerns, colleagues with LTHC feeling pressured to come to work

Progress on Improvements

- Most improved trust in England
- Staff engagement score has increased two years in a row since the SR dip
- Staff morale score has increased two years in a row since the SR dip
- Staff award work being planned
- Behaviours being implemented

Most improved five in England – 2022 to 2023

Organisation	2022	2023	2024	Change 2023-24	Response rate 2024
Tavistock and Portman	40%	40%	49%	9.7	54%
Leicestershire Partnership	61%	63%	68%	4.6	58%
Barnet, Enfield and Haringey Mental Health	57%	58%	62%	4.3	47%
NAViGO Health and Social Care CIC	78%	78%	82%	4.3	60%
Mersey Care	58%	59%	63%	3.9	48%

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:

- Red for 4 or more periods, 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	Jan-25	Feb-25
Are we safe?	Patient safety incidents (actual or potential harm)	N/A		↓	11.50	12	18	12	10	9	8	10	4	11	13	17	11	6	13	15	6	20	12
	Open SI / PSI investigations	TBC		→	2.56	3	3	3	3	3	3	2	3	3	3	3	3	2	2	2	1	2	2
	Violence & aggression incidents	<5		↓	7.44	8	9	11	6	6	4	8	2	7	9	7	1	1	9	16	8	12	10
	Restraint incidents	0		↓	3.40	1	1	0	0	0	1	4	5	6	12	9	0	1	5	7	2	5	2
Are we effective?	52-week+ dormant cases	0		↓	1969	2473	2380	2350	2366	2266	2185	2126	2080	1922	2034	2000	2008	1966	1941	1950	1938	1832	1825
	No of referrals (including rejections)	919		↓	826	826	914	977	646	919	981	804	840	867	737	785	732	913	927	785	739	803	705
	No. of attendances	7046		↓	6455	6221	6485	7851	5067	6922	6927	6525	6254	7343	7446	7244	3905	6165.5	6920.5	7027	5354.5	6789	5747
	No. of discharges	919		↓	707.94	553	493	680	376	1024	966	943	699	396	348	716	1161	606	754	632	599	1355	442
	% of Trust led cancellations	<5%		↑	3.98%	3.75%	5.04%	3.20%	5.71%	4.44%	4.06%	3.36%	4.61%	4.33%	4.02%	3.74%	5.00%	2.78%	4.28%	3.94%	3.86%	2.45%	3.07%
	% of DNA	<10%		↑	9.83%	9.47%	9.44%	9.00%	9.50%	9.47%	9.08%	9.15%	10.59%	9.80%	10.21%	10.55%	11.69%	10.55%	10.87%	9.27%	8.97%	9.34%	10.07%
Are we caring?	Number of formal Complaints received	<10		→	6.41	7	5	7	3	5	5	2	2	6	7	4	6	10	9	11	4	10	10
	Number of compliments received			↑	79.08							81	61	203	124	67	55	54	60	85	51	45	63

*Trust referral target to be revised as it is not clear how it has been calculated.

Watch Metrics Score Card

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	Jan-25	Feb-25
Are we caring?	Number of informal (local resolution) complaints	TBC		→	1.20			0	0	0.04	0.01	0	0	0	0		4	0	0	2	0
	PALS Number received			↓	12.80				10	15	19	21	16				15	8	14	16	11
	ESQ positive responses (%) - Adult Unit	90%		↓	75.7%				92%	81%	71%	87%	79%	79%	76%	73%	100%	93%	83%	80%	75%
Are we responsive?	18-week RTT breaches Adult Psychotherapy	<5		↑	17.3	47	48	47	34	15	23	14	10	9	2	9	0	2	4	6	7
	18-week RTT breaches Portman	<5		↑	0.81	0	0	0	0	0	1	1	1	0	0	1	2	1	1	2	3
	18-week RTT breaches Adult Trauma	<5		↑	746.2	480	517	558	607	640	689	720	752	781	821	846	855	878	908	931	956
	18-week RTT breaches PCPCS	<5		↓	120.3	46	70	71	80	114	150	161	181	170	176	191	227	215	66	6	0
	18-week RTT breaches GIC	<5		↑	14218.9	13174	13429	13298	13458	13814	14053	14365	14772	14923	14490	14594	14545	14559	14820	14481	14728
	52-week RTT breaches GIC			↑	11367.5	10451	10606	10383	10585	10890	11062	11525	11844	11988	11513	11714	11737	11993	12040	11617	11932
Are we well-led?	Mand and stat training (new structure)	90%		↓	79.93%	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%	81.22%	74.42%
	Appraisal completion (new structure)	90%		→	68.5%	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%	64.71%	64.71%
	Staff sickness (new structure)	3.07%		↑	4.77%	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%	4.04%	4.97%
	Staff turnover (new structure)	2.20%		↑	1.1%	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%	0.00%	0.88%
	Vacancy rate (On Hold) (new structure)	15%		↓	8.35%	-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%	8.57%	-1.26%

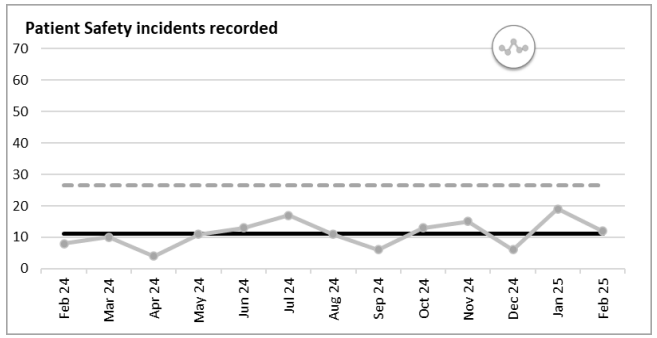
Delivering our vision – How are we doing? February 2025

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 12 Patient Safety Incidents

The categories of reported patient safety incidents related to physical and verbal abuse, appointments/integrated care, damage to property, clinical and facilities.
There has been a positive improvement in staff recognition and recording of patient safety incidents on Radar.
Further training on incident classification and reporting on Radar will continue across each Unit to support and encourage staff to report incidents.

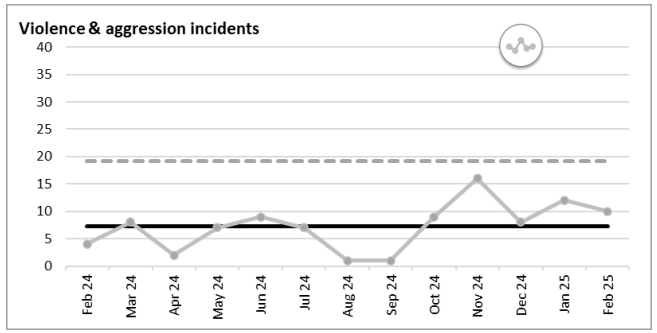


Patient safety Incidents

12

The Trust reported 10 Violence & Aggression incidents

10 incidents involved violent and aggressive behaviour, 9 of which took place at Gloucester House School. After Action Reviews (AARs) have been initiated for two of the incidents reported in February.



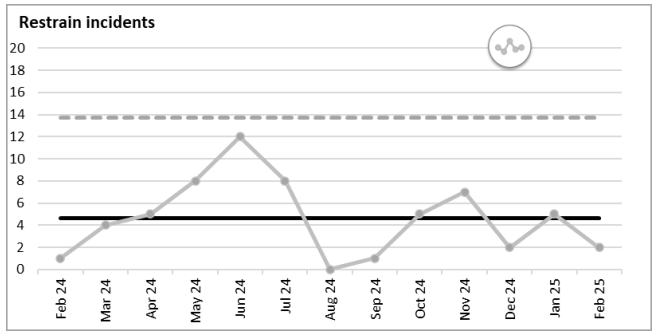
V&A Incidents

10

The Trust reported 2 Physical Restraint Incidents

Two incidents involved the use of restrictive practice in Gloucester House School.

Reporting the use of restrictive practice at Gloucester House formally moved to Radar as of February 2025. The move from manual logging to electronic recording aims to avoid duplication and ensures the data is accessible to identify trends and themes.
In line with Team Teach requirements, Gloucester House is still required to reference the use of restrictive practice in a bound book on-site as best practice.



Restraint Incidents

2

Delivering our vision – How are we doing? February 2025 Data

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

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 10 Formal Complaints in February 2025 As of the end of February there were 20 open complaints, of which 8 were overdue, an improvement from 34 open and 20 overdue at the end of January 2024. There has been a significant improvement in closing the oldest complaints but compliance for closing formal complaints within 40 working days continues. A quality improvement workstream has been established with regular meetings with the Complaints Manager and Unit Service Clinical Leads as well as daily huddles to focus on progressing complaints that are at risk of breaching the timeframe. There is ongoing work to resolve informally at the earliest stage.	**Formal complaints** **10**
The Trust has recorded 2 Compliments from Radar The Radar Compliments event module is live, although training and communications work to promote this is ongoing. Currently the experience of service questionnaire (ESQ) will remain the main source of gathering compliments and examples of positive feedback.	**Compliments** **2**
The Trust recorded 84% of ESQ positive responses in February 2025 The number of forms received in February 2025 remains low, with positive responses falling below the 90% the target. There is a continued focus on increasing the number of ESQ forms received each month, the ways in which feedback opportunities are available to service users and carers. ESQ forms are now collected via Radar and the previous forms on Carenotes have been archived. Key updates in relation to the project include posters with QR codes for patients to give their feedback displayed in reception areas; emails and letters to patients now include a footer message including URL to the ESQ form. Feedback received (quantitative and qualitative) is now shared directly with teams, with an improved process for categorising feedback, aligned to complaints themes.	**Positive responses** **84%**

Delivering our vision – How are we doing? – February 2025 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

The overall completion of Appraisals is recorded at 58.96%

All directorates are reporting below the target of 90% completion for appraisals, although there has been a gradual increase within the past three months.

Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals with a new quality improvement workstream due to commence for appraisals and mandatory training.

% Appraisal completion

58.96%

Trust wide sickness absence rate reported at 3.20%

Trust wide sickness is slightly higher than the target of 3.07%. This slight increase requires further analysis to identify any underlying factors contributing to the rise of sickness and to implement appropriate interventions to support staff wellbeing and reduce absence levels.

The Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 0.80% ending Feb-25. However, we have seen a decrease within the past three months. Cold, Cough, and Flu-related illnesses, currently stands at 0.47%. One of the highest sickness absence reasons. This figure has shown a gradual increase since Oct-24.

% Staff sickness

3.20%

Trust wide Mandatory and Statutory Training is recorded at 80.12%

This remains below the target of 90% but is an improvement on last month by 1.49%

Continued focus on improvement of the rates is led by the learning and development team with a new quality improvement workstream due to commence for appraisals and mandatory training.

MAST training (%)

80.12%

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 M10, student recruitment sits at 382 completed applications, up 40% on 2024/25, and 360 incomplete (up 13% on 24/25).	• 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 (8%) between 23/24 and 24/25.	• 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

Summary

Application Cycle: Current Cycle

The selected application cyle is: 2025/26 This application cycle starts on 10/1/2024 and ends 9/30/2025. We use Year To Date calculation, so we can directly compare this years applications numbers with this time last year. Today is day 138 of the application cycle.

Complete Applications	Conditional Offers	Offers Firmly Accepted	Unconditional Firm	Incomplete 2025/26
382 ✓	61 ✓	32 ✓	26 ✓	447 ✓
Year to date: 273	Year to date: 12	Year to date: 3 (+966.67%)	Year to date: 2 (+1200%)	Year to date: 394
1170 Total last cycle	781 Total last cycle	527 Total last cycle	525 Total last cycle	1350 Total last cy...

Selected Cycle (2025/26) Vs Previous Cycle (2024/25)

Complete Applications to Date

Month	Year To date	Percentage Change	Last Year (to date)	Last Year total applications
October	0		0	
November	18	1700% ▲	1	1
December	70	192% ▲	24	24
January	267	98% ▲	135	135
February	27	-76% ▼	113	146
March	0		0	108
April	0		0	116
Total	**382**	**40%**	**273**	**1170**

Application by Portfolio and Course

Porfolio	Applications	Offers Made	Offers Accepted	Unconditional and Firm Accepted
⊞ Digital and Short Courses	3	1	1	1
⊞ Interprofessional	18	10	5	5
⊞ Psychoanalytic Applied	116	28	13	13
⊞ Psychoanalytic Clinical	126	18	10	4
⊞ Systemic	119	4	3	3
Total	**382**	**61**	**32**	**26**

Deferrals for next cycle: 1

Total Deferrals- From last cycle: 145

Selected Cycle (2025/26) Vs Previous Cycle (2024/25)

Incomplete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle	Last Year total Incomplete applications
October	0		0	29
November	104		0	4
December	142	38% ▲	103	103
January	138	-19% ▼	171	171
February	63	-48% ▼	120	185
March	0		0	255
April	0		0	178
Total	**447**	**13%**	**394**	**1350**

Version: V3.7 October Start. Current Date: 2/17/2025 Last Refresh: 2/17/2025 2:25:07 PM

Click here to see the decomposition of these applications

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.

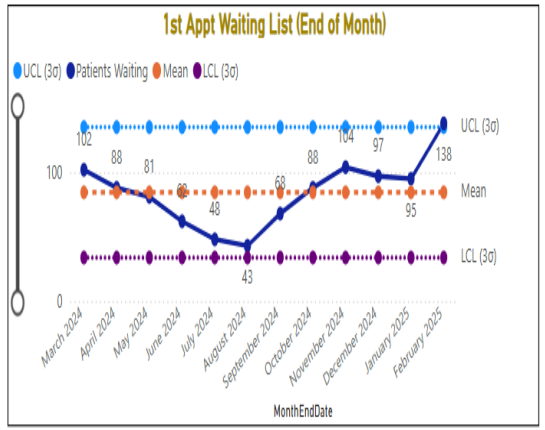
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move Visiting Lecturers into substantive posts, at least 33% reduction from 24/25	CETO / Directors of Education	February 2025
Regulatory changes (OfS)	Office for Students' regulatory 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

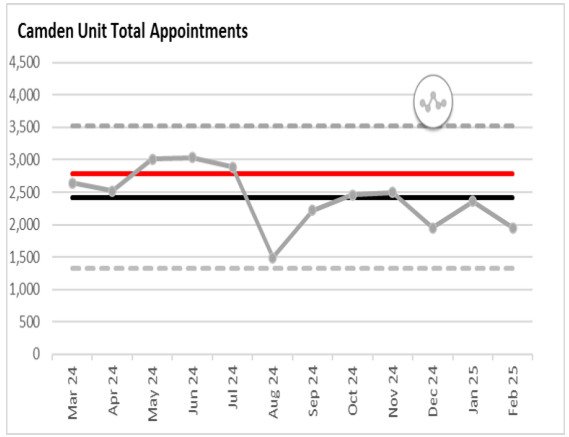
Camden Unit Overview – Please note the data below reflects the old unit name and IT are updating this on the dashboard.

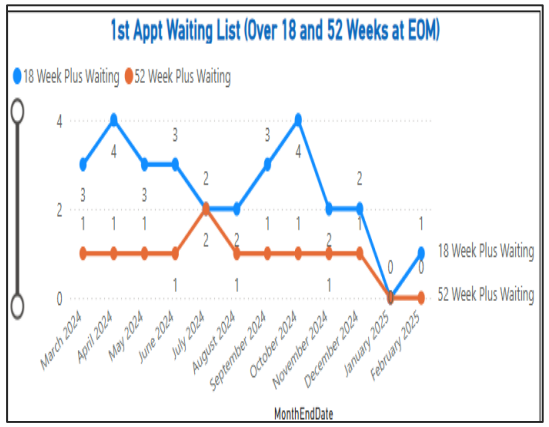
	Successes	Challenges
Safe	• Have commenced A3 on MAST and appraisal compliance. Have agreed a significant number of changes needed in ESR as a first step and the team are working through them. Appraisal compliance increased by 3% in month. • Our supervision recording compliance has doubled in a month. We changed the way staff report on this to make it a little easier and this has led to an increase in numbers.	• Changes to logging safeguarding supervision, continue to work with lead to find a system that is safe, effective and does not increase the workload of clinical staff. • Staff sickness absence remains higher than usual, long-term illness is largely attributed to stress while short term is seasonal colds and flu.
Effective	• Completed 110 CGAS and 88 GBMS in first 2 weeks of March in preparation for the new reporting metric. This is more than we usually complete in a month. NCCT and SCCT halved the number of patients with no OM in the period. • Staff have been supportive and responsive to requests around OM and we continue to try and focus on the positive to support this. • Clinical notes compliance remains high but will restart monthly team reports to support any areas where we could further improve.	• We have noted issues around DNA and cancellation in some teams. This is a varied issue with some teams having higher rates due to the complexity of the patient groups and others finding appts are declined or cancelled due to the lower levels of concern. This learning has been fed into the DNA procedure. We have discussed with the Medical Director to ensure this is accounted for in the updated DNA policy.
Caring	• Ofsted visited Camden LA and gave an outstanding rating. They highlighted the work with the care experienced and whole family teams and the impact it has on them. • Staff have worked hard to continue to see patients and manage services while many clinical and admin staff are on leave. • We achieved 100% positive ESQ feedback	• We have a significant number of patients missing a safeguarding and risk form. This links to wider issues around sharing data with teams and staff and informing people of missing info. We will run drop-in sessions on Caseload management report to help staff be better at self-managing. We will scope this as a QI project.
Responsive	• Work progressing with LA about using space in Family Hubs, site visit planned for April • YTD target 1,782, YTD actual 2,161. • YTD target 27,016, YTD actual 25,388. While we are slightly under, we would like to recognise this as a significant achievement. • Identified variation in targets in different teams, this presents a challenge being worked through. • We continue to maintain an average first appt waiting time of less than 3 weeks	• While a lot of work was undertaken relating to dormant cases, we persistently have a couple of cases dormant for 52 weeks+ (the patients change each month). We feel that 12 months is too high a tolerance for Camden and so will be looking into cases dormant for 6 months +.
Well-Led	• Have confirmed that the unit is in budget • Completed work with finance and HR to correct establishment ensuring correct coding and ESR, this should complete before year end • Staff leaving the Wellbeing team got in touch to tell the team how much they had enjoyed working here and what a supportive environment it was.	• While we are pleased not to not be in the position of being overspent, having to make efficiency savings will course impact staff, in particular morale and workload. We would appreciate support around this. • The new job planning SOP is in place and we are making progress in updating all plans for April. There has been concern about the impact on morale related to achieving a 90% attendance rate to comply with their plan. We will aim to conduct a survey in the summer of the impact of job planning and the reporting linked to non-compliance, to see if we need to make further adjustments

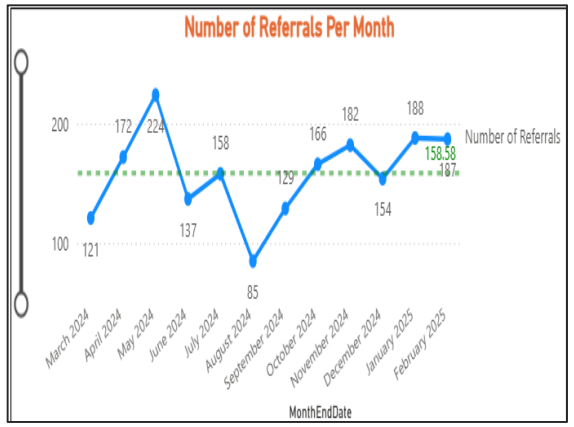
Camden Unit Overview – Please note the data below reflects the old unit name and IT are updating this on the dashboard.

Activity Overview









- The number of people waiting at the end of the month has increased, these patients are largely located in SCCT and CIT. This is at least in part due to absences in the admin team impacting the PTL meetings. We will address this through March.
- Appointment numbers are lower this month and likely will be in March, reflecting the large number of staff on leave, as previously discussed we will be putting in processes to report leave taken through the year to ensure better balance in 25/26. There seem to be different targets in different locations (job plans, contract)
- The case waiting over 18 weeks was a missed discharge and has now been closed. We will be undertaking work with our teams on this as there is a small issue of discharges not being actioned due to admin not being informed/clinicians not responding to follow up requests from admin.
- The number of referrals on the SPC chart does not reflect the figure on the watch metrics page

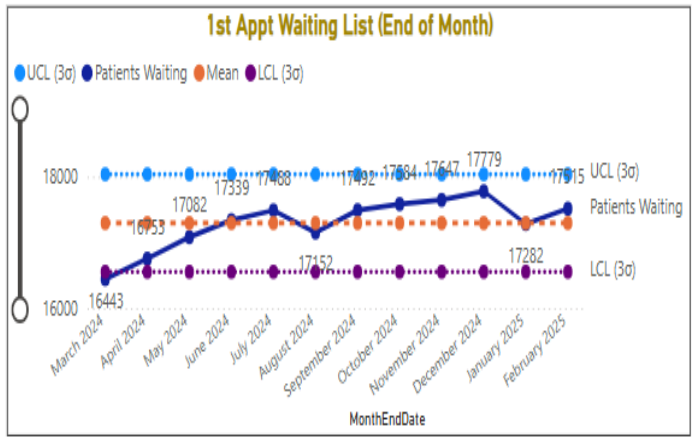
Concern	Cause	Countermeasure	Owner	Due Date
Activity and Job Planning	Lack of oversight in 24/25, new staff not being given job plans	New SOP agreed for completion, monitoring and action planning on job plans. All staff to have a plan going into 25/26 and clear system for set up of new staff going forward	Fiona Hartnett, CSM	April 2025
Cases waiting more than 18 weeks and dormant cases (25 dormant over 6 months and not on a waiting list, more with no contact in period)	Monitoring systems not working effectively, communication problems	Watch metrics in IQPR have too high a tolerance for CAMHS. We will be investigating anyone dormant for 6 months and agreeing a threshold for investigating breaches	Fiona Hartnett, CSM	May 2025

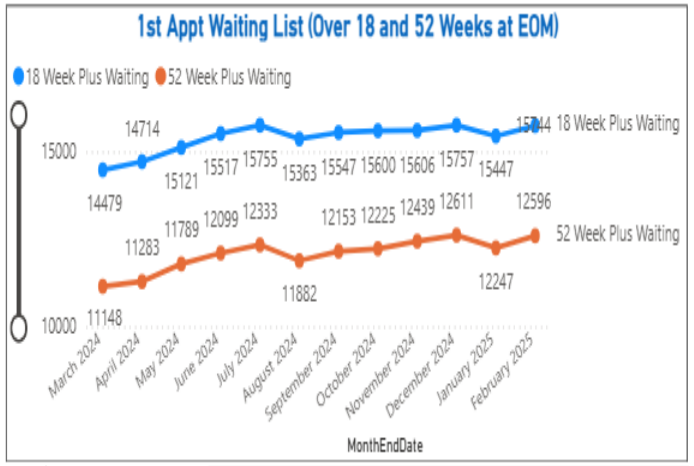
Adult Unit Overview - 1/2

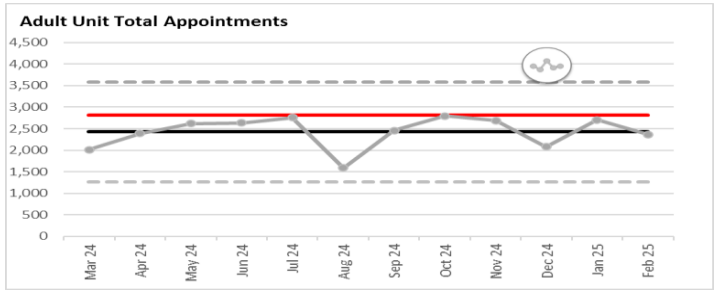
	Successes	Challenges
Safe	• With the help of our data team and Informatics we have made progress with crisis plan completion and an agreement of automatic population of new plans, requiring clinician to review and sign off to note their accuracy and relevance. • An After-Action Review was conducted following an incident, with learning identified and actions implemented.	• The loss of 3 or more trust wide service contracts may result in additional cost pressures on existing service areas to find efficiencies.
Effective	• Gender Identity Clinic (GIC) completed wait list validation through Dr Doctor Portal. • GIC co-ordination with NHS England review around waiting list transfer. • Co-production partners at the Trust-wide forum have asked that clinicians promote involvement work more actively. • Portman - internal training re outcome measures and how to deliver them - implementing HoNOS and Dialog. • Portman - Reflective practice/consultation work with external agencies continues to increase. Morale within team is good.	• Targeted support for Trauma and GIC to address the wait times continues. • We continue to work with commissioners with NHSE Review outcome.
Caring	• Re-deployment of PCPCS has moved to trial periods for some staff • NHSE commissioning quality leads have observed clinical appointments to improve their understanding of pathways for GIC patients.	
Responsive	• GIC - Patient Portal and CX clinic are about to launch, this will improve direct communication between patients and the clinic. • We have improved complaints allocation, response times and resolution. • PPI activity developing in GIC and Psychotherapy, Trauma well established, • Positive feedback from members of the Trust-wide Forum about the quality of care and involvement in the 6 weekly PCPCS Service User involvement Group.	
Well-Led	• GIC - Comprehensive implementation of the new Universal Assessment Form, ensuring that we capture data consistently, improving patient experience. • We continue to engage with staff about the merger.	

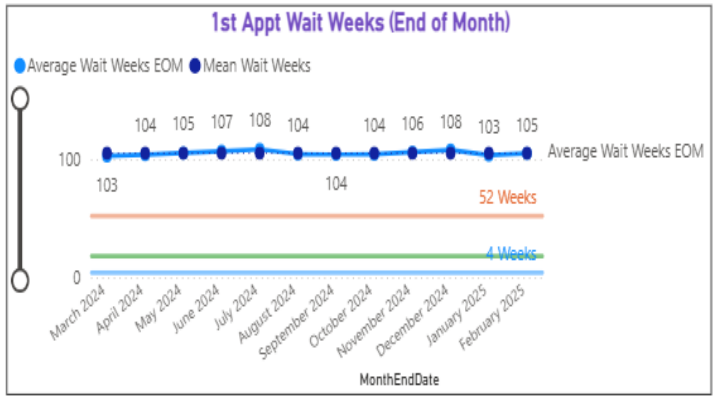
Adult Unit Overview – 2/2

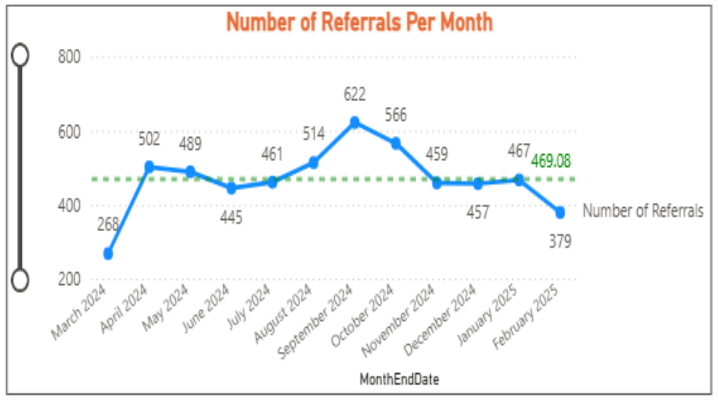
Activity Overview











Analysis

Average waits for treatment remain unchanged, but referrals have reduced. Trauma referrals have reduced because of a targeted and strategic change in intake. The closure of PCPCS has also impacted o a reduction in referrals to Adult Unit.

Concern	Cause	Countermeasure
Capacity for waiting list reduction in GIC	This is largely due to increased and increasing national demand in recent years.	We have agreed a workforce plan, ECP requests have been approved. Meeting with finance to finailse budget and review workforce plan.

Next Steps.

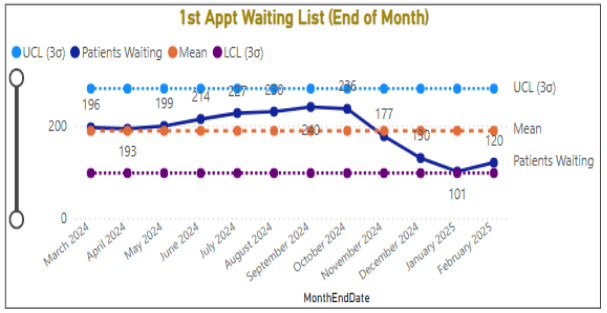
- **The NCL Partnership Board in May is focussed on our Trauma service, systemic demand and system wide responses across the ICS with a proposed closure of our wait list going to ELT.**
- **To act on recruitment to the outstanding GIC posts.**
- **To complete as much re-deployment from PCPCS to other Adult and trust wide posts as possible to reduce impact of job loss and financial impact on trust/NHS.**

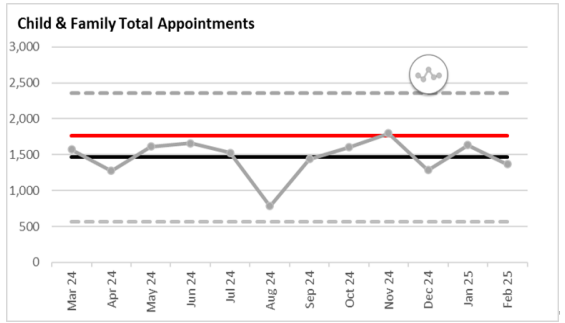
Child and Family Unit overview (1/2)

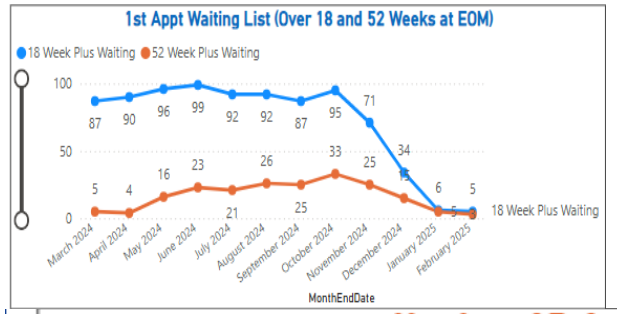
	Successes	Challenges
Safe	There has been a reduction in Dormant cases at 52 + weeks from 74 to 68 reflecting work in the clinical teams to improve case hygiene but there is still further work to do in this regard. 19 Incidents reported across the Unit from 19/02/25 to 19/03/25; 18 in Gloucester House, 1 in FAKCT team. The unit continues to view the increase as evidence of improved reporting.	Delays in engagement over data transfer agreement between T&P and Haringey re First Step Closure will lead to delays in completing the transfer of cases with associated GDPR impacts. Governance team and Caldicott Guardian working with Service Leads to mitigate organizational risks, however if there is no engagement prior to March end the Trust will need an interim arrangement in place to mitigate risk.
Effective	EDAS – new TCL in place and we have agreed a new evidence based clinical pathway and have a plan to cut waiting lists to a third of the current level (6 month wait). A3 4 WWT Improvement project to commence tracking referral pathways into Child and Family Unit to improve 4 WWT performance. and assure teams meet target from April 1st. Focussed efforts with weekly reminders for CGAS and GBM completion before April 1st deadline. The Unit is declaring 0 cases breaching at 18 weeks from the clinical pathway and 4 in the Autism pathway. This is a continuing trend of improvement. FCAMHS have achieved a 100% completion rate of all outstanding OM from April 2024 to March 2025. This was due to consistent messaging, AP support and staff willingness to engage in the request.	Average waiting time for second appointment is : AYAS 7.76 weeks, ASC/LD 11.43 weeks, Autism Assessments 41.16, FMHT 13.86 weeks, EDAS 11.63 weeks, FAKCT 6.21 weeks, Haringey CWP 4.62 weeks. These assessment waiting times are outside the 8- week target and will require an improvement plan. The treatment waiting forms and PTL require an improvement and implementation plan to support improvement of patient flow. Backing data has revealed 6 cases breaching at 18 weeks in the Schools service which is being corrected in March. Supervision performance across the Unit is at 54% for February. It is clear there are issues with data capture as the position for December has improved to 87% as retrospective data flows.
Caring	A pupil in Gloucester House school who has previously caused many incidents with racist behaviour has had a marked reduction in incidents after interventions by the team and is now a pupil EDI representative in the school.	
Responsive	ESQ positive feedback is 100% for the 3rd consecutive month.. Presentation and training in new ESQ QR code has been delivered to Admin colleagues across all units.	There is no Consultant psychiatrist in the Fostering Adoption and Kinship Care Team which presents a clinical risk and is impacting on the level of cases that can be safety accepted. ECP request coming through for Agency locum after failed NHS locum recruitment.
Well-Led	Annual Business Plan developed for the Unit. CRES and CIP programme in development.to address overspend position in the unit. Job planning in all teams in progress to be completed by month end April 25. Gloucester House School improvement plan is progressing with focus on incident management and educational standards. First step team consultation to close March 20th. Clinical teams (Child Complex) have exceeded their job planned activity target by 10% this year delivering 15,508 contacts at Month 11. This is due in part to increased activity under the ERF.	Reduction of cases into FDAC has created a cost pressure and forecast overspend position at year and forecast overspend for 24/25 of £106,760. Reduction of pupils at Gloucester House has created a cost pressure at year end of £350,000 Reduction in referrals into Gloucester House Outreach has created a year end deficit position of £96,000. Business Plan/ CRES and CIP proposals being developed with clear targets and timelines for recovery.

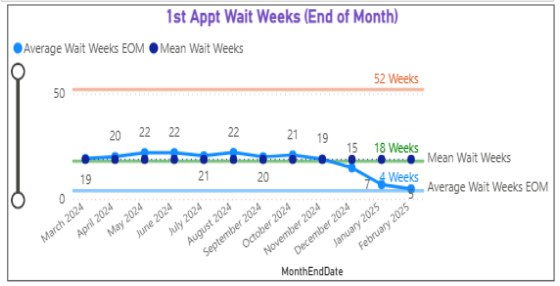
Child and Family Unit overview (2/2)

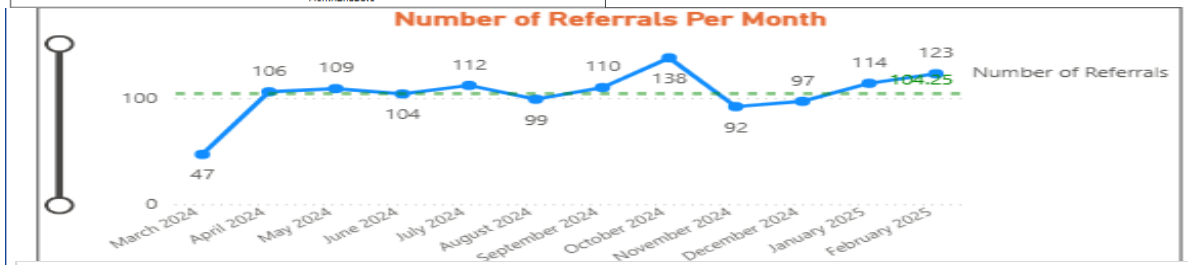
Activity Overview

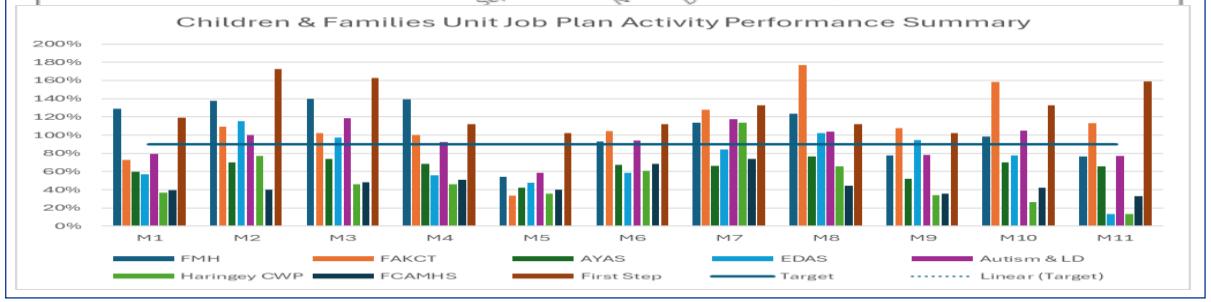












Analysis

Activity – The unit has delivered 1,334 appointments in February. YTD activity is 15,508 against 14,436 24/25. An improvement of 10% against the previous year's activity, but still below contractual target.

Job plan compliance: Across the Unit teams have not met their contracted performance target but have overperformed on job planned activity which was set at 15,052 for the financial year.

Referrals . Referrals into the Complex clinical teams have shown a decline from month 10 to 78 in the month, but the overall trajectory is overall increase. For 24/25. The unit figure for referrals is 123 in month

Waiting times:
Across all the teams in the unit we are reporting 120 patients waiting for 1st appointment with an average waiting time of 5.35 weeks. AYAS average waiting time of 4.93 weeks, ASC LD are declaring 3.54 weeks, Autism Assessment 12.66 weeks, FMHT 4.61 weeks, EDAS 1.53 weeks. FAKCT 9.05 weeks, Haringey CWP 1.92.
Average waiting time for second appointment is : AYAS 7.76 weeks, ASC/LD 11.43 weeks, Autism Assessments 41.16, FMHT 13.86 weeks, EDAS 11.63 weeks, FAKCT 6.21, Haringey CWP 4.62 weeks.
5 patients have waited more than 18 weeks and 3 have waited more than 52 weeks. 1 case is on the Autism Assessment Waiting list breaching at 18 weeks . The 5 patients waiting 18+ weeks and breaching are with Gloucester House and the CATS team and are recording errors.

Dormant cases:
2 patients in Autism Assessment have been dormant for 36 + months. 9 patients have waited 26 + months for an assessment. 1 patient in FMHT is dormant 18-24 months with a reduction from the previous month. 23 patient waiting more than 18 weeks are dormant 18 months plus.. 8 cases in FMHT are dormant 12 months and 28 are on the Autism Assessment pathway.

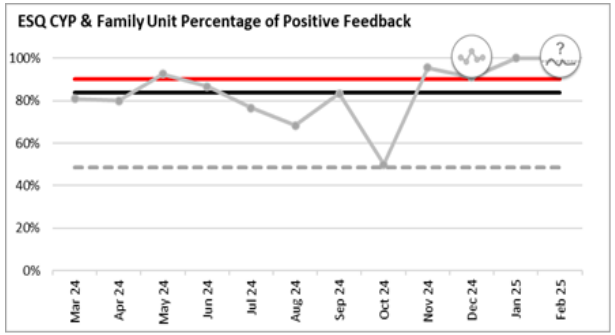
-

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.

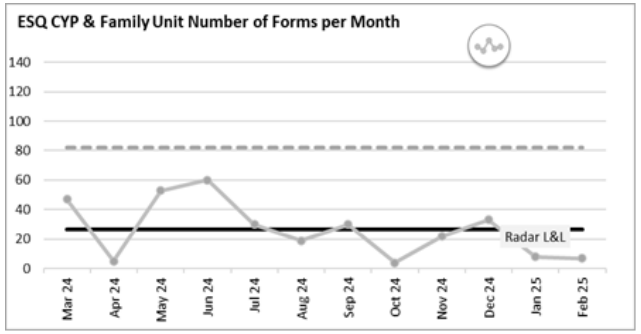
Child and Family Unit Mental Health Quality Overview

Quality Overview

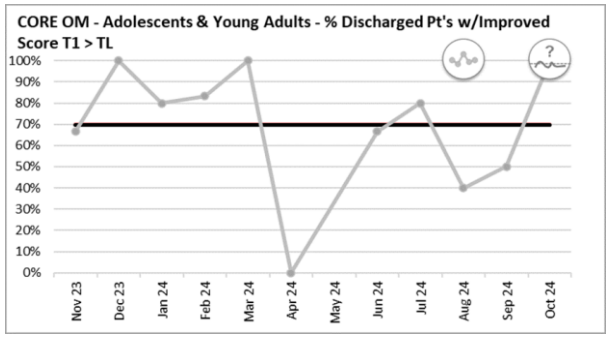
ESQ positive recommendation rate (%)

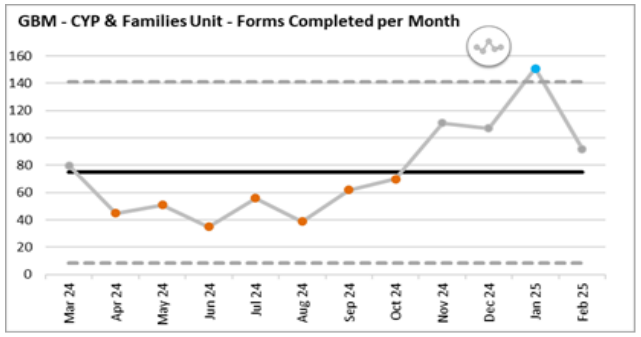


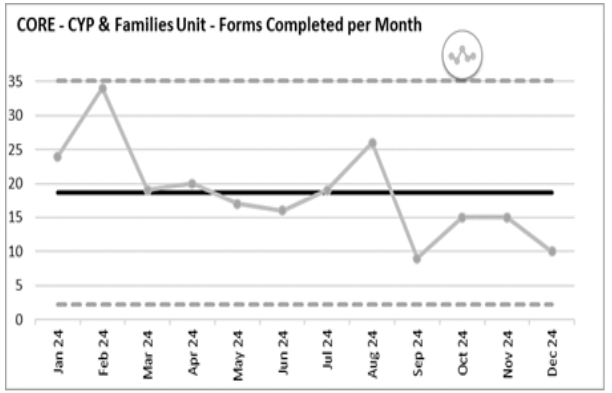
Number of ESQ forms completed

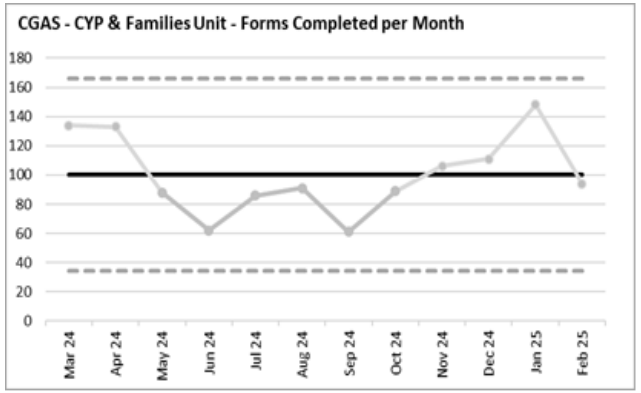


CORE OM IMPROVEMENT SCORES









Narrative Analysis

Approval rating for ESQ feedback remains high for the unit, however number of returns remains very low.

CORE OM for adolescent services is showing a 90% score for patients discharged and showing improvement, however the total number of forms completed has reduced to lower than 10 in the month – suggesting a review of the process at admin is required.

GBM return rates now showing 1 SCV points for improvement having reached in excess of 140 forms completed in the unit for January with a decline in February.

CGAS returns have increased in month for the 3rd successive month.

- OM training being delivered at Unit Level to ensure increased compliance and for OMs to align with 1st appointment.
- A process of developing a Q&A for the Unit regarding OMs and ESQs has been set up
- Recovery plan in place in FCAMHS to upload missing HONOSCA and new logic being implemented in Care Notes to support data entry from March 2025..

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 project
Reduction in return of HONOSCA in FCAMHS	Practice issue	Working with A3 to flow data from April 25

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 £115k ahead of plan at M11, with a recorded deficit of £1,951k. This is an improvement of the position by £118k from the M10 position. The continued improved position has been delivered by the receipt of a one-off rates rebate received in January. The unfunded element of the pay award remains a recurrent issue for 25/26, however. The reported cash position at the end of February was ahead of plan, however cash continues to be a challenge, with the Trust working with the NHSE cash support team to agree support from March 25. Capital spend is expected to be on plan at £2,718k at the end of the year. This is an increase from previous months reflecting additional capital distributions received via the ICB.	£ **24/25 YTD planned position £2,066k deficit**
The Trust declared…. The Trust now expects to deliver its planned deficit of £2,200k in 24/25.	£ **24/25 YTD actual position £1,951k deficit**

PCREF (Patient & Carer Race Equality Framework)

PCREF

We are starting to develop PCREF in relation to accessibility of services. The Proxy for this is initially referral data and will then move on to case load data. The data will be presented quarterly to indicate change as projects will take time to develop.

- **Team Clinical Leads have been asked to:**
- look at the data for their team and discuss in the team meetings.
- outline past or current interventions (QI or other) to mange the challenge around access that the team have identified.
- think about how you are using Service users or could do to understand more about your challenge or address your challenge more directly.
- provide a brief outline on the slide provided by 21st March 2025

PCREF

Unit Clinical Leads have been asked to:

- Review the slides and write short summary for unit
- Following a process of engaging with Teams to receive feedback on PCREF further work is underway to explore how Teams can further engage with the communities we serve to deliver the impact of our ambition
- Bring to PCREF group and CSDG potential changes to Trust wide referral forms to support data collection.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 8 May 2025			
Report Title: Oversight of Board Assurance Framework (BAF) and Corporate Risk Register			**Agenda No.: 009**
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: Board Assurance Framework 2025/26 Appendix 2: Corporate Risk Register 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This report provides the Board with the full Board Assurance Framework (BAF) risks at the end of 2024/25, agreed by the Board Committee's during the April/ May meeting cycle as the starting position for 2025/26. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) continue to evolve to provide the Trust with a comprehensive overview of its strategic and operational risks. This iteration of the BAF incorporates recent updates from risk owners and reflects discussions/ reports to the Board and its Committees.		
Background:	The BAF is the Trust's primary tool for managing strategic risks that could impact the delivery of high-quality, safe patient care, as well as compliance with regulatory and contractual requirements. The Board of Directors agreed a new set of Strategic Ambitions for the Trust in October 2023 following which a revised BAF was developed and approved in 2024/25 to enable the Board and its Committees to identify, understand, manage and mitigate those risks that could prevent the Trust from achieving its strategic ambitions. The Trust's Strategic Ambitions have remained unchanged since October 2023. During 2024/25, the Board Committees monitored the BAF through a cycle of deep dives at each meeting, which in essence provided a rolling programme of oversight and scrutiny of individual BAF risks throughout the year. The CRR complements the BAF by capturing operational risks that may impact service delivery or escalate to strategic risks over time.		
Assessment:	Key developments since the last Board include: **BAF:** 1. The increase in current risk scores for **Risk 6 (Lack of Workforce Development, Retention & Recruitment)** noting this risk is exacerbated by the impact of decommissioning of services; and the imminent merger by acquisition; with potential impact on stability in the workforce and staff morale. 2. Identification of a new risk of "Lack of Staff Engagement/ Staff Disengagement". Further consideration of this risk would be given by the Interim Director of Corporate Governance and the Chief People Officer in advance of the next People, Organisational, Development, Equality Diversity and Inclusion Committee meeting. 3. During the April/ May cycle of meetings, the Committees agreed to adopt the 2024/25 BAF risks as the starting position for 2025/26.		

	4. To support the strengthening of the Board Committee's oversight responsibility of the Trust's principal risks within their remit, the Committees agreed to the introduction of a projected target risk tracker to the risk reports to provide a view of the target risk rating by quarter for the full financial year. This will be a forward-looking position agreed with the Lead Executives. Progress towards the target risk will be evidenced by the successful implementation of those mitigating actions. **CRR:** The development of a credible and reliable Corporate Risk Register is progressing well, supported by the Radar system for incident reporting and risk management. All identified risks have been mapped to their equivalent BAF risks, ensuring alignment with the strategic ambitions. The Risk Manager continues to work with the operational and corporate teams to improve their understanding and ownership of risk management.
Key recommendation(s):	The Board is asked to: **Review and Challenge Risk Scores** • Consider whether the scores accurately reflect the current risk position. • Identify risks where the scores appear to be overstated or understated. **Provide Input on Missing or Inadequate Controls** • Highlight areas where current controls may require immediate enhancement. • Suggest additional mitigating actions or controls. Suggest any other potential areas not covered in either or both documents.

Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity, and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☒	ORR ☐		
	The report considers all risks within the BAF and CRR.				
Legal and Regulatory Implications:	Yes ☒	No ☐			

	The Trust is required to have a BAF in place as part of its Foundation Trust status.			
Resource Implications:	Yes ☐		No ☒	
	There are no additional resource implications.			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no additional EDI issues to note within this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	• QSC – April 2025 • PFRC – April 2025 • POD EDI – May 2025 • ETC – May 2025 • ELT – May 2025 • IAGC – May 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

Oversight of Board Assurance Framework (BAF) and Corporate Risk Register

1. Introduction

1.1. This report provides the Board with the full Board Assurance Framework (BAF) risks at the end of 2024/25, agreed by the Board Committee's during the April/ May meeting cycle as the starting position for 2025/26.

2. Position at end 2024/25 and feedback from April/ May Board Committee meeting cycle:

Quality and Safety Committee Oversight:

BAF update:
The Committee received **2 BAF risks:**

- **Risk 1 - Inequality of Access for Patients; and**
- **Risk 2 - Failure to Provide Consistent, High-Quality Care) at each meeting.**

Both risks remained high throughout the year. There was a slight reduction in the current consequence score for BAF risk 2 to ensure alignment with the inherence consequence

score. Overall, the Committee continued to receive assurance of progress in the management of the BAF risks.

CRR update:
The CRR was at early stages of development at the last update to the Committee. The CRR continues to be refined to ensure it captures the key operational risks linked to the BAF risks. The reporting format has been further improved to provide clear linkage to the related BAF risks.

At the **April** meeting, the Committee **agreed** the following:

- Adopting the 2024/25 BAF risks as the starting position for 2025/26.
- Although noting the potential for duplication with the work of PFRC, it would receive **Risk 13 – Performance & Productivity** for oversight at future meetings.

Education and Training Committee Oversight (the Committee had not met at the time of writing)**:**

BAF update:
The Committee received **2 BAF risks including**:

- **Risk 4** – Potential Contraction of Student Recruitment

Progress has been made in mitigating the risks during 2024/25. BAF Risk 4 remained moderate (amber) throughout the year with no change to the current risk score. Overall, the Committee continued to receive assurance of progress in the management of the BAF risks.

Proposal for ETC BAF risks 2025/26 to the May meeting:
- To consider adopting the 2024/25 BAF risks as the starting position for 2025/26.
- In relation to Risk 4, the Committee would need to remain alert to concerns around the viability of the education and training provision including reliance on funding from the National Training Contract; and the requirement for DET to make approximately £1.1m in efficiency savings and/or growth to contribute to the Trust's balance position.

POD EDI Committee Oversight:

BAF update:
The Committee received **3 BAF risks**:
- **Risk 6** – **Lack of Workforce Development, Retention & Recruitment**
- **Risk 7** – **Lack of a Fair and Inclusive Culture**
- **Risk 8** – **Lack of Management Capability and Capacity**

While progress has been made in targeted workforce and inclusivity initiatives, risks remain in areas such as vacancy rates, recruitment and retention processes, leadership capability and long-term workforce planning. All three risks remained moderate (amber) throughout the year with no change to the current risk scores. Overall, the Committee continued to receive assurance of progress in the management of the BAF risks.

At the **Ma**y meeting, the Committee **agreed** the following:

- Adopting the 2024/25 BAF risks as the starting position for 2025/26.
- BAF 6: The proposal to increase the current risk BAF Risk 6 from 9 (Moderate) to 16 (High) noting this risk is exacerbated by the impact of decommissioning of services;

and the imminent merger by acquisition; with potential impact on stability in the workforce and staff morale.

- Identified a **new risk** of “Lack of Staff Engagement/ Staff Disengagement”. would be given by the Interim Director of Corporate Governance and the Chief People Officer in advance of the next People, Organisational, Development, Equality Diversity and Inclusion Committee meeting.

PFRC Committee Oversight:

BAF update:
The Committee received **6 BAF risks**:

- **Risk 9 – Financial sustainability**
- **Risk 10 – Estate infrastructure**
- **Risk 11 – Sustainable income streams**
- **Risk 12 – IT infrastructure and cyber security**
- **Risk 13 – Failure to achieve the required levels of performance and productivity**
- **Risk 14 – Environmental sustainability (new in 2025/26)**

Most of these risks remained high during 2024/25. Updates now include improved risk descriptions, quarterly risk trajectories, and a clearer articulation of controls and assurance gaps.

CRR update:
The CRR is improving in structure and scope. Risks aligned to PFRC have been updated and refined, particularly those relating to cashflow, income controls, digital risk, and capital delivery. However, there remain gaps in CRR entries for estates, contracting, and strategic commercial risk that are being addressed with divisions in Q1 2025/26.

At the **April** meeting, the Committee **agreed** the following:

- Adopting the 2024/25 BAF risks as the starting position for 2025/26.
- Risk 9: In relation to the Financial Plan 2025/26, maintaining close oversight of the Trust’s efficiency programme 2025/26 and related governance arrangements.

3. Conclusion:

The BAF and CRR updates demonstrate notable progress in refining the Trust's risk management approach, providing oversight, and aligning it with key strategic priorities. While work remains to enhance risk ownership, the current trajectory reflects a strong commitment to risk mitigation and continuous improvement.

The Tavistock and Portman NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2025/26

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

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

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

Risk Ref	Risk Title	Risk Description (Cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Movement of the current risk rating within the Quarter 2025/26				Target Risk	Projected Target Risk Tracker for 2025/26				Appetite Level
					Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4	
Providing outstanding care														
1	Inequality of access for patients	**If** services within the trust continue to limit access to potential patients through the use of restrictive inclusion criteria **Then** outcomes for such individuals would be sub-optimal and they would also have a worse experience than other patients. **Resulting in** the Trust being in breach of its contractual obligations, and potentially non-compliant with equalities legislation	16 (4 x 4)	16 (4 x 4)	⟺				8 (2 x 4)					**Open**
2	Failure to provide consistent, high-quality care	**If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.	20 (4 x 5)	15 (3 x 5)	⟺				9 (3 x 3)					**Cautious**
To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.														
4	Potential contraction of student recruitment	If there is a contraction in post graduate student income, then Trust strategic and commercial aims will be significantly impacted. This risks a shortfall against financial targets and a reduction of impact as a lead in mental health education.	16 (4 x 4)	12 (3 x 4)	⟺				8 (2 x 4)					**Hungry**
Developing a culture where everyone thrives with a focus on equality, inclusion, and diversity														

6	Lack of workforce development, retention, recruitment	If the Trust is unable to effectively plan for and recruit to critical vacancies and strengthen workforce resilience through education, training, and development, the sustainability of quality services and activity levels may be at risk. This could lead to **higher turnover, increased sickness absence, and recruitment challenges, ultimately impacting service delivery and financial stability**. However, by **adopting a managed attrition approach, the Trust can balance workforce sustainability with operational efficiency.**	16 (4 x 4)	16 (4 x 4)	↑				6 3 x 2					**Open**
7	Lack of a fair and inclusive culture	If the Trust does not establish a fair and inclusive organisational culture, where all staff regardless of their background feel that they belong, and that there is an awareness of cultural difference, staff morale and levels of recruitment and retention will be affected, and the quality of patient care will be compromised.	20 (5 x 4)	12 (4 x 3)	↔				9 3 x 3					**Open**
8	Lack of management capability and capacity	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.	20 (4 x 5)	9 (3 x 3)	↔				6 2 x 3					**Open**
Improving value, productivity, financial and environmental sustainability.														
9	Delivering financial sustainability targets	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICS/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	20 (5 x 4)	16 (4 x 4)	↔				8 (2 x 4)					**Open**
10	Maintaining an effective estate function	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	15 (5 x 3)	12 (3 x 4)	↔				8 (2 x 4)					**Open**

11	Sustainable income streams	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.	20 (4 x 5)	15 (3 x 5)	⟺				8 (2 x 4)					**Hungry**
12	IT infrastructure and cyber security	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	20 (5 x 4)	12 (3 x 4)	⟺				9 (3 x 3)					**Cautious** **Open**
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. Resulting sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, including risks to patients' mental health, and reputational risk.	16 (4 x 4)	12 (3 x 4)	⟺				8 (2 x 4)					**Open**
14	Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target	**If** the Trust does not reduce the environmental impact of the provision of its services. **Then** it will be out of step with the NHS-wide goals around environmental sustainability and the Service's attempts to achieve a net-zero status **Resulting** in non-compliance with its statutory obligations, national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2030 and net zero carbon by 2040). The potential impact of this outcome includes inefficient resource and energy use, increased operating costs, legal and regulatory repercussions, missed infrastructure innovation opportunities, reputational damage, and heightened adverse environmental impact.	16 (4 x 4)	L3 x C4 12	⟺				8 (2 x 4)					**Open**

Principal Risk 1	**Inequality of access for patients**		
Description	**If** services within the trust continue to limit access to potential patients through the use of restrictive inclusion criteria **Then** outcomes for such individuals would be sub-optimal and they would also have a worse experience than other patients. **Resulting in** the Trust being in breach of its contractual obligations, and potentially non-compliant with equalities legislation	**Strategic Objective**	**Providing outstanding care**

Executive Lead	Chris Abbott Chief Medical Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	07th March 2024
Lead Committee	Quality & Safety Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	03th April 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	2	4	**8**	⟺				**Date of Next Review**	June 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Screening and triage process: Ensures patients are directed to the appropriate pathway at the start of their journey, reducing delays and inappropriate referrals, which helps improve equity and timeliness of access.	Process designed and implemented -Needs further review is needed to assess effectiveness and to ensure it is fully embedded	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Designed/ reviewed screening and triage process. Go live date achieved.	Internal	Amber
Patient and Carer Race Equality Framework (PCREF) All services to review their inclusion criteria with EDI and people with lived experience to ensure equitable access	Fully implemented but will be audited in 3 months to assess effect	PCREF Implementation group – IQPR report to Board 2025 – Equitable access IQPR Report to QSC and POD EDI PCREF Implementation Group EDI reporting, Action Plan (12 months) front door access	Internal	Amber
Clinical Harm Reviews: Allows for real-time risk stratification of patients on waiting lists, ensuring those most at risk receive timely intervention and care, thereby reducing harm and improving equity.	Inconsistent risk stratification across services	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Autism, gender and trauma GIC targeted support meetings Mondays Trauma-Targeted support meetings Tuesdays	Internal	Amber
		Autism	Internal	Green
		Gender	Internal	Amber
		Trauma	Internal	Amber

Action to address the gap in assurance/control	Lead Officer	Date of implementation	Status
Project to align description of assessment and treatment to the NHS data definition dictionary	Contracts Team -	August 2024	Ongoing - Latest update pending – It must be done in line with pathway maps. Define intervals based on that. End of July define September- IMT to build dashboard. Pathway work. Workshop each service line- what is treatment/assessment based on the data dictionary. Update due March 2025.
Training and workshops are planned as part of the transition to new structures, roles, and responsibilities. The Kaizen events	Chief People Officer	April 2025 ongoing	Training workshop held 2 weeks ago, more planned. Overall working well.
Mobilisation of the Clinical Harm Review	Chief Medical Officer	August 2025	Clinical harm reviews have been mobilised across key service areas like autism, gender, and trauma. The implementation is still progressing with some areas under additional targeted support, especially in trauma services.

Clinical Pathway mapping and redesign post mapping	Managing Director/Medical Director/Director of Therapies	July/August 2025	Process designed and implemented, but a 6-month review is needed to assess effectiveness. Review scheduled for July/August 2025, with findings to be reported to the Quality and Safety Committee on August 21st, 2025. Risk rating remains at Amber until review confirms improved access and outcomes.
Trust wide PCREF rollout	Chief Medical Officer	April 2025	PCREF Rollout: The Patient and Carer Race Equality Framework (PCREF) has been fully implemented and is set for auditing in the next 3 months to evaluate its effectiveness in improving access to services.
Audit and Actions Arising from PCREF	Chief Medical Officer	September 2025	Progress: Ongoing Update: The first audit cycle is scheduled, with findings set to inform further actions. The impact assessment will focus on whether new processes effectively enhance patient access and outcomes. Findings from the audit will be reviewed by the QSC and incorporated into future risk mitigation plans.
Digitising both the RTT waits to ensure PTL is accurate and appropriate remedial action can be taken.	Project Manager & Associate director of IM&T	April 2025	Update: There is an ongoing project to digitise referral-to-treatment (RTT) waiting times, with a go-live expected end of April 2025. Ongoing data validation efforts will ensure that accurate PTL data drives service improvements.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. Streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists	IQPR meetings with contracting updates. As above noting external NHSE meetings to support identification of delivery capacity
Clinical Pathway Mapping & Redesign	Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. Streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists.
Assessment & Treatment Data Alignment	Align description of assessment and treatment to the NHS Data Definition Dictionary.	Work has commenced with an initial review of current descriptors in progress.	Integration with the new waiting time metrics remains a challenge. Full alignment requires system-wide adoption.
Clinical Harm Review Implementation	Mobilisation of the Clinical Harm Review across affected services.	Implementation is progressing with Autism services (Green), Gender services (Amber), and Trauma services (Amber).	Significant delays in trauma services. Gender services require additional monitoring and support.
Pathway Redesign Implementation	Complete redesign of clinical pathways post-mapping phase to improve equity of access.	Pathway redesign in progress to transition from ‘gold standard’ for a few to equitable access for all.	Ensuring revised pathways deliver both access and quality outcomes within resource constraints.
Trust-wide PCREF Rollout	Full implementation of the PCREF framework across all services.	PCREF implementation has transitioned from Red to Amber. Impact monitoring in progress.	Measuring actual service impact to confirm improved access and outcomes.
PCREF Audit & Actions	Conduct audit and implement findings to improve patient access and equity.	First audit cycle scheduled, with results to inform next steps.	Ensuring audit recommendations are embedded into practice and lead to measurable improvements.

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-061	Delays in delivering clinic letters to patients or healthcare professionals.	**15**
RSK-097	We have a 3 PAs of Consultant time within the Social Communication Assessment Service [SCAS] within MOSAIC CAMHS that is vacant and needing to be recruited to as soon as possible. Psychiatry input for the team in relation to diagnostic process is crucial. Recruitment approval is currently stuck with Finance in that the budget is deemed overspent, however there is confusion as to why this is the case, multiple meetings have been had regarding establishment, right sizing and the MOSAIC budget continues to be an issue that prevents prompt ECP approval and recruitment.	**15**

The Tavistock and Portman NHS Foundation Trust

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

Executive Lead	Clare Scott Chief Nurse Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	07 March 2024
Lead Committee	Quality & Safety Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	Q1	Q2	Q3	Q4	**Date of Last Review**	3rd April 2025
Risk Appetite	**Cautious**	4	5	**20**	3	5	**15**	3	3	**9**	⟺				**Date of Next Review**	June2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Clinical staffing structures: Provides the foundation for safe, consistent care delivery by ensuring appropriate skill mix and adequate resourcing.	A small number of services carry vacancies, with reliance on temporary staff or trainees. Some services continue to carry significant levels of vacancies, with heavy reliance on agency and other temporary staffing. Evaluation of new structure planned for end of February 2025	Workforce vacancy levels and recruitment trends monitored via workforce dashboard. Oversight through Board, Committee, Clinical Governance meetings and Integrated Quality and Performance Review (IQPR) meetings. Recruitment & Retention Group established to oversee staffing strategies and reduce reliance on agency staff. Establishment Control Panel in place, with executive membership, ensuring workforce planning aligns with service needs. Clinical staffing structure review integrated into workforce planning, with six-monthly assessments. Restructure complete, implemented in September. 6 monthly reviews planned for end Feb/beginning March 2025.	Internal	Amber
Job planning framework: Supports effective alignment of clinical capacity with service demand, improving workforce productivity, reducing inefficiencies, and enhancing service continuity.	- Electronic system for monitoring medical job plans - Inconsistent job plan reviews across services, leading to misalignment with clinical demand. -Lack of standardisation in consultant work schedules, impacting service delivery and workforce efficiency. -Insufficient oversight of job planning processes, posing operational and financial risks.	Job plans in place for majority of teams. Annual self-assessment submitted Monthly workforce dashboard updates to the Quality & Safety Committee, including consultant job planning progress. The job planning policy Compliance monitored through IQPR	Internal	Amber
The quality and Safety Committee is in place with approved terms of reference. Tier 3 structure and associated Terms of Reference in place.	Further assurance required around Clinical Audit & Effectiveness Group being embedded Mortality Review Group Terms of Reference being deferred to Clinical Incident & Safety Group	Regular quality reporting to QSC via IQPR, Quality & Safety Report and Chair's reports from Tier 3 Groups	Internal	Amber
Statutory and Mandatory training	Inconsistent levels of completion of key modules	Mandatory training compliance reported through the POD EDI Committee bi-monthly	Internal	Amber

	Detailed breakdown of Quality & Safety focussed MaST modules A3 for MaST to be developed, led by Head of OD	MaST paper for 24/25 currently under approval by ELT - approved MaST compliance to be included in IQPR – Included and reviewed monthly in IQPR		
Clinical supervision policy and reporting mechanisms: Provides ongoing professional development and oversight, reinforcing clinical quality, accountability	Policy under review by professional leads Team and clinical leads to focus on accurate reporting	CQC improvement plan Clinical supervision –reported in IQPR and to Clinical Governance monthly. Supervision structures are held at team level, underpinned by Supervision Policy. Teams report supervision in a monthly log. Forms for recording on EPR (carenotes) created, to improve monitoring and reporting.	External (CQC) Internal Internal Internal Internal	Amber
Safeguarding supervision and audit structures: Supports consistent application of safeguarding practices and early identification of patient risks across all services.	Adult Supervision capacity	Safeguarding supervision taking place, this will be strengthened by developing an improved structure through the Safeguarding forum. Included in the Quality report bi-monthly Internal Safeguarding audit – action plan monitored by Integrated Safeguarding Group, reporting to Quality and Safety Committee. Business case for safeguarding supervision training approved, currently being procured for 16 staff, safeguarding champions.	Internal	Amber
Quality assurance and quality improvement tools and methodology	Evaluation process/update on A3 programmes	QSC work plan and forward planner IQPR Quality & Safety Report to QSC Chair's reports from Tier 3 Groups to QSC Clinical Governance meetings Quality Improvement Trust wide work streams to deliver the Trust Strategic Pillar of 'Outstanding Patient Care' to address issues raised in both BAF risks 1 and 2. Focus on service user experience, outcome measures and waiting times. A3 projects in place for key quality assurance programmes of work		Amber
Quality Framework Improvement Plan fully implemented		Quality Framework monitoring report to QSC All professional leads now in place Chief Nurse Officer and Chief Medical Officer In post Tier 3 structure and associated Terms of Reference in place. Chair's reports from Tier 3 Groups to QSC	Internal	Green
Learning from deaths policy and mortality reviews: Improves identification of care quality issues, embeds learning, and ensures accountability	Mortality as part of clinical audit programme 25/26 Learning Lessons events calendar	Draft of Learning from Healthcare Deaths Policy under approval routes Mortality Group established; Tier 3 group of QSC Electronic Mortality Review form now live Radar Learning from Healthcare Deaths policy ratified in December 2025 Responsibilities of previously instated Mortality Review Group will be assumed by the Clinical Incident & Safety Group	Internal	Amber
Clinical Audit Schedule	Full Clinical Audit Plan for 25/26	Clinical Audit & Effectiveness Group established; Tier 3 Group of QSC Electronic recording and reporting module live on Radar Regular audit plan to be developed by Deputy Chief Medical Officer and built into Radar too	Internal	Amber
Complaints Process Complaint's process and structured learning: Improves patient experience, fosters transparency, and enables learning from incidents and service feedback.	Lessons learnt process from complaints Timeliness of response	-Quality & Safety Report to QSC includes thematic review and update on actions -Regular reporting/updates through to SUEG and Clinical Governance meetings -Report to QSC on response rates against target -New complaints process implemented in January 2024. - Structured investigation template introduced to ensure clear and transparent responses. - Executive review & sign-off for all formal complaint responses now in place. - Enhanced tracking & oversight: - Weekly complaints summary shared with unit leads, divisional leadership, and executive team. - Weekly meetings between complaints lead & unit clinical lead to monitor progress. Complaints Quality Improvement A3 project started in January 2024 Learning poster drafted to be trialled for complaints and incidents from February 2025	Internal	Amber

Implementation of RADAR Radar incident reporting system: Enables robust reporting and monitoring of safety incidents, risks, complaints, and claims, ensuring a learning culture.		LRMS Radar Implementation Board in place Incident notification process fully embedded in governance from 3rd February 2025. Radar project manager leading transition to BAU, ensuring sustained oversight and accountability. Leadership team receives regular updates on incident notifications and reporting processes.	Internal	Amber
Implementation of PSIRF Implementation of PSIRF and Patient Safety initiatives: Drives structured learning and improvement from incidents through After-Action Reviews and safety partner involvement.	Data and metrics to articulate progress in implementation is being developed as part of A3 process	PSIRF Transition Group in place and reporting to QSC A3 on PSIRF implementation, supported by GANTT chart Work plan for Patient Safety Partners Work plan for Patient Safety Specialist(s) Updated PSIRP approved by QSC in June 2024. Patient Safety Policy approved and ratified August 2024. After Action Review (AAR) training delivered in September 2024. AARs and learning from incidents shared in clinical governance meetings and Quality and Safety report to Quality and Safety Committee	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
RADAR implementation for PSIRF and risk reporting	Chief Nursing Officer/Director of IT Infrastructure	June – January 2024	Complete – Live since June 2024 Events implemented Incidents, Risk, Audit, Complaints, PALS, Compliments, Claims.
Roll out learning poster for complaints and incidents.	Associate Director Quality/Clinical Governance and Quality Manager/Complaints Manager	February 2025	Planned -Learning poster drafted to be trialled for complaints and incidents from February 2025
Implement standardised job planning framework aligned with service demand.	Chief Medical Officer/Medical Director	June 2025	In Progress
Introduce e-job planning system to enhance transparency and reduce inefficiencies.	Chief Medical Officer/Medical Director/People team	September 2025	Planned
Conduct annual job plan reviews across all clinical services to ensure alignment with workforce needs.	Clinical Leads	Ongoing	In Progress
Strengthen oversight of Learning from Deaths process within the Clinical Incident & Safety Group.	Chief Medical Officer	March 2025	In Progress
Evaluate effectiveness of the new Electronic Mortality Review form in Radar.	Director of Governance	April 2025	Planned
Implement structured monitoring of Clinical Supervision policy and compliance tracking.	Director of Clinical Governance	April 2025	Planned
Roll out electronic job planning system across all services.	Medical Director	September 2025	Planned
Embed safeguarding supervision reporting within the Integrated Safeguarding Group.	Chief Nurse Officer	June 2025	Planned
Improve Complaints Process	Interim Complaints Manager/ Associate Director Quality		Complaints Policy - Update - Policy approved and ratified pending amendments suggested by the Policy Assurance Group - Complaints Quality Improvement A3 project launched (January 2024) to enhance efficiency and learning. - Learning poster developed to improve feedback and service improvements; trial set for February 2025.
Complaints Policy		February 2025	Policy Ratified by PAG Amendments requested by group being actioned. Policy to due to be published by end of February.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Implementation of the Quality Improvement Plan based on 11 defined areas of improvement.	Quality Framework Improvement Plan fully implemented.	Ensuring ongoing compliance and embedding of improvements in service delivery.	Quality Framework Monitoring Report to QSC.
Trustwide Quality Improvement Work Streams aligned to the Outstanding Patient Care strategic pillar.	Workstreams established focusing on service user experience, clinical outcomes, and waiting times.	Embedding initiatives across all service areas and ensuring measurable impact.	IQPR, Clinical Governance Meetings, Quality & Safety Report to QSC.
A3 projects in place for key quality assurance programs.	A3 methodology being applied for structured quality assurance.	Ensuring sustainability and integration into governance structures.	Clinical Governance Meetings, QSC reporting.
Consultant Job Planning Review to standardize planning processes and improve service alignment.	Job planning policy in place. Standardized framework under development.	Gaps in oversight and inconsistent implementation across services.	Monthly Workforce Dashboard updates to QSC, Annual Job Plan Reviews.

Strengthened complaints handling and learning from incidents.	New complaints process implemented (January 2024), structured investigation template introduced.	Ensuring continued improvement in timeliness of response and learning from complaints.	Quality & Safety Report to QSC, Complaints Improvement A3 Project.
Implementation of safeguarding supervision training and governance structures.	Safeguarding supervision training for 16 champions approved and in procurement.	Training completion and embedding of reporting structures in EPR (Carenotes).	Integrated Safeguarding Group, IQPR Reporting.
Radar incident notification process fully embedded into governance.	New process implemented as of 3rd February 2025, transition to BAU in progress.	Ensuring compliance with new reporting structure and ongoing staff training.	Radar project manager oversight, Leadership Team incident reporting updates.
Implementation of the Quality Improvement Plan based on 11 defined areas of improvement.	Quality Framework Improvement Plan fully implemented.	Ensuring ongoing compliance and embedding of improvements in service delivery.	Quality Framework Monitoring Report to QSC.

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-038	**An increase in sickness levels in psychology and core pathways will impact overall service delivery, leading to cancelled appointments, additional workload on already overstretched staff, and same-day appointment cancellations.**	**15**

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

Executive Lead	Chief Education & Training Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th January 2023
Lead Committee	Education and Training Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	8th April 2025
Risk Appetite	**Hungry**	4	4	**16**	3	4	**12**	2	4	**8**	⟺				**Date of Next Review**	June 2025

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

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Prepare and implement a Student Marketing & Recruitment Strategic Plan	Director of Education (Operations) Associate Director of Business Development (DET) Head of Student Marketing, Recruitment & Admissions	Revised to 06 June 2025	Rav, Adam and Premal to start developing a readiness plan, which includes: • Developing a marketing strategy • Admissions process review • Recruitment and conversion • Student Support • UKVI compliance • Technical infrastructure We continue with frequent connects to discuss and manage timeframes, wider stakeholder engagement, and intricacies of each aspect.
Prepare and implement a multi-year International Strategy	Associate Director of Business Development (DET) Directors of Education – as appropriate	By 06 June 2025	Work is underway between Adam, Premal, Paul, Ravteg and Elisa to identify immediate areas of growth in the 2025/26 recruitment cycle, using previous applicant data – focussing efforts on utilising all 40 CAS licences. The next area of focus is to articulate a multi-year International Strategy, focusing on international student recruitment as well as international partnerships, alongside the creation of an

			“international offer” that includes student accommodation, student support and experience, clinical placements etc.
Increase knowledge and responsiveness to workforce needs	Head of Performance & Contracts Associate Director of Business Development (DET)	By July 2025	The new programme development process: a guide developed for proposers of new programmes/provisions, is currently being tested and awaiting final discussion/sign off at the next DET Development Group. Restructure of the DSC Portfolio to provide a dedicated workforce development team.
Implement a project to deliver more effective international student recruitment using agents to attract students	Director of Education (Operations)	By August 2025	Create a process for identifying recruiting and proving oversight of the work of international agents tasked with recruiting overseas students for Trust courses. Ensure this is in place for the latter half of the 2025-26 student recruitment year.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
To have a fit-for-purpose educational offer for sustainable student recruitment	Ongoing review of academic courses (including delivery models) Ongoing discussion with university partner Ongoing improvements to infrastructure (staffing and systems)	Competing priorities and changes to a number of areas across the directorate, including a delay in recruitment for additional staff Financial plan 25/26 restricts capacity to grow marketing function	Plans in place and implemented to expedite the process in order to mitigate risks and cover gaps on a temporary basis

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

Principal Risk 6	**Lack of workforce development, resilience, retention, recruitment**	**Strategic Ambition**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**
Description	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered. This risk is exacerbated by the impact of decommissioning of services, and the imminent merger by acquisition, with a potential impact on stability in the workforce and staff morale. The Trust's ability to respond to this emergent risk at pace by implementing mitigation strategies such as developing career progression pathways; succession plans should there be natural attrition; revisiting the clinical leadership review; and conducting corporate services review.		

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 2022
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	23rd April 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	3	2	**6**	↑				**Date of Next Review**	June 2025

Key Risk Controls (1st line of defence)	**Gaps in Control (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
People plan includes 5-year action plan for the Trust	Stay conversations and career / wellbeing conversations to be relaunched Some actions within the plan still to achieve before going green Talent management and succession planning programmes to ensure cover for critical roles.	POD EDI bi-monthly progress reports including developments with the people plan which covers all areas including recruitment, retention, and resilience. Positive POD EDI Committee discussions held on elements of progress There has been an uptake of career and wellbeing conversations	Internal	Amber
Clinical Service Leadership Review in place to reduce the levels of management between frontline and senior staff and set clearer boundaries of accountability and provide clarity of roles and responsibilities.	Review of outcomes and agree actions	Staff Survey outcome	Internal	Amber
Robust establishment control process (ECP) in place to ensure financial sustainability, governance of process and alignment of the future workforce with corporate strategy and business planning, corporate oversight of all recruitment.		ECP process live and working through improvements organically ECP is in place in principle, and the log is actively updated. RAG log indicates improved workforce planning/skill mix reviews Skill mix and structure reviews occurring. Feedback to recruiting managers is being acted upon. NCL ICS group and control process – assured by the approach of ECP Recruitment and retention group – first meeting on 29th October, monthly. Quarterly CPD panel	Internal External	Green
ECP approvals by ELT for Corporate roles to ensure ongoing review of skills mix and ensuring robustness of workforce		Weekly review at ELT Quality Impact Assessments	Internal	Green
Regular contract management engagement with NLPSS		NLPSS Operations meetings weekly Performance report from NLPSS Reduction in time to hire Exit interview / stay conversation analysis and, in time, onboarding interview analysis Operations Team supervisor meeting with NLPSS fortnightly	Internal	Green

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Trust Recruitment and selection Policy and Procedures – work in progress with NCL and NLPSS to standardise recruitment policy across the ICS.	ESR limitations in reporting recruitment data Improved NLPSS KPIs -room for improvement, 3rd party provider	Formal assurance on adherence to procedures from NLPSS performance report and internal workforce dashboard. Recruitment and selection policy revised in line with NCL standards and includes NLPSS Inclusive recruitment training widely rolled out - Training more inclusive recruitment advisors Recruitment and retention Group	Internal	Amber
KPIs in place for time to hire ensures prompt recruitment and high likelihood of retaining candidates		Vacancy rates and recruitment KPIs included in IQPR packs Improvements in demographic-reflective hiring and declarations of protected characteristics Improved working relationship and communication with NLPSS. Intention to move to streamlined policies and procedures across clients will also improve overall experiences. IQPR Monthly workforce Dashboard	Internal External	Green
Supervisor self service in place to enable managers understand sickness etc they are better to plan workforce		ESR reports Regular ESR / ledger reconciliation	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Reset the baseline on ESR to provide clarity on the optimal workforce basis/ control target	ICFO	TBC with new ICFO	
Relaunch of stay conversations and career / wellbeing conversations to support staff retention	CPO	30 June 2025	Drafted paperwork for career conversations and training is being planned. Stay conversation paperwork to be drafted.
Develop talent management and succession planning programmes to ensure cover for critical roles.	CPO	31 July 2025	
Conduct Corporate Services review	CPO	TBC	

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

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 2023
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	11th February 2025
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	⟺				**Date of Next Review**	May 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Engagement sessions hosted by CEO and Director of Strategy		Records of sessions held	Internal	Green
Health & Wellbeing group (includes review of cost-of-living issues) Now incorporated within POD Delivery Group and Staff Engagement Group		Key issues fed back to POD EDI Committee through the Associate Director of EDI Improvements in health and wellbeing indicators reported	Internal	Amber
Occupational Health and employee assistance programme		OH, and EAP provision aligned with ICS – We have decided not to align to ICS due to potential merger and moving out to another ICS	Internal	Green
Staff Networks feed to EDI team who escalate key outcomes through POD EDI		EDI reporting through the POD EDI includes key outcomes/concerns from network forum meetings. Informal resolutions form majority of outcomes Just and learning culture approach to issues Introduction of revised resolution policy to follow: 30-day consultation about to launch. To include staff networks.	Internal	Green
Recruitment and Selection Policy in place	Policy and process to be revised ensure equity for BAME candidates for senior roles (band 8 and above) Improved process around recruitment and treatment of disabled candidates.	Inclusive recruitment training delivered and practices in place Internal reporting of issues (incl FTSU) to be more reflective of staff survey reporting ECP and CPD processes – Now in place Just and learning culture approaches included in all revised policies Armed forces covenant, disability confident status, and other inclusive statements, implemented competently. Launched new menopause policy. We have menopause awareness status	Internal	Amber
Chief Nursing Officer sponsoring EDI programme and providing link with the Board		EDI-focused Board development sessions held. Challenge from Chair to hold at least one such item on each development day.	Internal	Green
Organisational Development		OD for senior leadership to ensure accountability for decisions and consistency of approach. Commenced 15th October	External	Green
Inclusivity action plan and metrics	Priorities refreshed- metrics to be agreed	EDI Programme Board	Internal	Amber

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

EDI Policy	Associate Director of EDI	April 2025	In progress

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

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th January 2024
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	11th February 2025
Risk Appetite	**Open**	4	5	**20**	3	3	**9**	2	3	**6**	⟺				**Date of Next Review**	May 2025

Key Risk Controls (1st line of defence)	**Gaps in Control (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
Full suite of Trust HR policies in place	These policies are currently due for review, and some require a refresh	Sickness, Grievance, disciplinary levels reported to the POD EDI through the Chief People Officer report. Bi-monthly Planned - Just and learning culture approaches included in all revised policies	Internal	Amber
Management structure in place with revised job descriptions clarifying line management responsibilities	Manager leadership training required	Leadership and management training in place with positive feedback Back to basics training provided for all policies	Internal	Green
Management Training in place	8C and above to be sourced	Senior Management Leadership Development Programme Feedback from 8B and above	Internal	Amber

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of People (OD, Culture and Engagement	Ongoing	Learning and development training (x2) and back-to-basics training in place FTSU training is being designed, and FTSU is to be added to the induction Coaching of managers by HRBP (and senior team where required). Manager's report feeling more competent in resolving issues because of the training packages/coaching from HRBPs Informal resolutions form the majority of outcomes. Appropriate attendance levels at training sessions recorded
All HR Policies to be reviewed over next 12 months (priority to be given to Recruitment & Selection, disciplinary, capability, grievance, and flexible working policies) with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	Head of People (Business Partnering and Employee Relations)	Ongoing	Ongoing, In line with timetable currently on target to meet implementation date. These policies will help with the foundations for psychological safety.
Organisational Development for senior leadership to ensure accountability for decisions and consistency of approach.	Chief People Officer	June 2025	Externally provided. Commenced 15th October It will help with the foundations for psychological safety.

Strategic Delivery Metrics

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

			and through the A3 process report on all metrics relating to staff engagement.

Principal Risk 9	**Delivering financial sustainability targets**		
Description	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability.**

Executive Lead	Peter O'Neill Interim Chief Financial Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19 December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	02 April 2025
Risk Appetite	**Open**	5	4	**20**	4	4	**16**	2	4	**8**	⟺				**Date of Next Review**	July 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
MTFP route to balance developed in conjunction with merger partner. Process re-started March 2025.	Requires updating to reflect the status of the proposed merger	MTFP will form part of the OSC and FBC in the merger transaction process, with a merger partner being actively pursued within NCL. Will continue to develop short- and medium-term efficiency plans to facilitate future merger.	Internal	Amber
Monthly Finance Reports – Keeping track of actual against plan		Reviewed by ELT, PFRC and Board. BAU Report	Internal	Green
In Year Reforecasts		BAU process normally September /October	Internal	Green
2025/26 Annual Plan -		Balanced plan agreed with NCL requiring 3.9 million efficiency programme.	External	Green
Recurrent efficiency programme 25/26 Financial Plan	Still centrally managed till the merger is completed	Recurrent programme – supporting division to manage and deliver identified opportunities.	Internal	Amber
MTFP development	Planned income opportunities to be achieved	Commercial Strategy – to be updated and progress monitored Q1 & Q2	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Updated MTFP	CFO	July 2025	Previous agreed MTFP to be updated with new merger partner. Implementation date changed from May 2025 – updates will reflect outcome of planning round.
2025/26 Financial Plan	CFO	April 2025	Balance plan agreed, work currently in progress to develop the supporting efficiency programmes. Units will be given income expenditure and income targets.
Detailed efficiency programme	CFO	April/May 2025	Process in place, to be established as BAU being a key factor in the delivery of a balanced long term MTFP
Commercial Strategy	Director of Strategy and Transformation	May/June 2025	Being updated Q1/ Q2

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Develop a medium-term financial plan that supports the Trust's strategy & which aligns with ICS plans.	Revision to current MTFP started June 2025, last update October 2024	Finalising efficiency programme and identifying income opportunities to deliver balanced MTFP in line with merger partner.	Jointly agreed MTFP with merger partner that forms part of an agreed FBC.
Deliver the 2025/26 Out-Turn within Plan, supported by a recurrent efficiency programme	Maintain Trust on plan trajectory throughout 25/26	In year financial management of the organisation	Monthly reported position – ELT, PFRC and the Board
Develop and deliver the Action Plan following the HFMA review	Action plan developed. Delivery against plan on-going	Development of CIP key outstanding issue	Regular updates to IAGC.

Commercial Strategy – New income opportunities	Commercial strategy is developed currently at implementation stage -Identifying and delivering specific opportunities	Agreeing final negotiated contracts	Jointly agreed MTFP with merger partner that forms part of an agreed FBC.

Principal Risk 10	**Maintaining an effective estate function**		
Description	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff, and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability.**

Executive Lead	Peter O'Neill Interim Chief Finance Officer	**Inherent Risk** **(Before consideration of controls)**	**Current Risk** **(After considering existing controls)**	**Target Risk** **(Risk after implementing all agreed action)**	**Movement of the current risk rating within the Quarter**	**Original Assessment Date**	19th December 2022

Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Q1	Q2	Q3	Q4	Date of Last Review	03rd April 2025
Risk Appetite	Open	5	3	15	3	4	12	2	4	8	⟺				Date of Next Review	June 2025

Key Risk Controls (1st line of defence)	Gaps in Control (What are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Premises Assurance Model (PAM) / Estates return information collection (ERIC)	PAM – aligns to 5 CQC domains; an assessment was completed in Feb, and work was carried out over a number of months with a submission made in Sept.	Annually a PAM review is undertaken each year (autumn) to review systems and processes, in addition an ERIC annual submission (summer) also made stating maintenance, rates and building costs, along with Estate's operations that is then compared with NHS peers. The focus is around backlog – asset replacement, planned and reactive costs alongside costs related to waste, cleaning etc.	External	Green
10-year Capital plan along with a 6 facet survey National guidance suggests 5 yearly where external surveyors undertake a data gathering exercise, age of assets and if any asset replacement has taken place. .	The 6 facet survey is a moment in time and is non invasive	As this is a 5 yearly assessment that is non-invasive and is undertaken by surveyors. Additional technical advice forms part of the authorising engineer role. The Authorising engineers cover water, asbestos, electrical and lifts as there are no medical gases on these sites. This includes failure rates, consumption and risk assessments for the building structure	Internal/External	Amber
		Fortnightly meetings with finance to review cost and coding to minimise time taken to complete annual ERIC return, thereby improving productivity	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
Detailed Estate revenue model to support finance model, this will follow the Estates Budget	Estates lead	April 2025 budget commencement	Estate's efficiency schemes being developed to support 25/26 financial plan and MTFP.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Premises Assurance Model assessment- a gap analysis, and timeline	Policies for Water, asbestos and Fire have been updated with technical advice.	Further policies are being updated for buildings and services	This has led to a cleaning charter being developed in line with National guidance as this ties into IG.
CAFM (computer aided facilities management system), is used on all sites	All reactive faults will be issued with a fault number and response to acknowledge action.	System drawings are not accurate, electrical and water updates are currently underway and will produce system and location drawings.	Fire, electrical, water drawings are currently being updated following invasive surveys and upgrades
Develop a soft FM and Hard FM strategy	Consolidate fragmented contracts, and staffing model, in line with service operating hours, will look to market test soft FM and for Hard FM – this will be aligned to merger partner.	Ability to deliver as the team are in transition alignment to NHS national standards	Building contracts have been consolidated for all sites in 2025.
Undertake a 6-facet survey	Fire surveys have taken place and capital investment on fire doors and compartmentation has occurred in 22-24. Electrical – main infrastructure upgrades took place in 22-23, Lift assessments – have taken place with capital investment in 24-25 Water and gas – capital investment in 24-25 Surveys have been carried out on some assets- electrical supply, lighting and fire doors and will look at fire alarms, heating systems. The work continues into 25-26..	System drawings have been limited Electrical – Aging estate, will require upgrades over coming years, with infrastructure upgrades prioritised	Fire – Planned maintenance tasks are undertaken as defects period has just concluded Specialist surveys undertaken with authorising engineers and work is planned and reported through H&S group

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

Executive Lead	Peter O'Neill Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th Decemb 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	Q1	Q2	Q3	Q4	**Date of Last Review**	3rd April 2025
Risk Appetite	**Open**	4	5	**20**	3	5	**15**	2	4	**8**	⟺				**Date of Next Review**	July 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Internal Monitoring Reporting on current clinical services to ensure meeting current contractual objectives	Agreed activity plans for some services	IQPR Reporting, PFRC Oversight. New monitoring process developed with commissioning team shared with PFRC To be implemented July 25 after account process completed.	Internal	Amber
Internal Monitoring Reporting on current DET services		DET Exec Review, Education & Training Committee Oversight, PFRC Oversight	Internal	Green
External (Commissioner) Reporting on commissioned services in DET and Clinical		Clinical Leadership Meeting Review, DET Exec Review, PFRC Oversight, Commissioner Review Meetings	Internal / External	Green
Alignment of internal services reporting with financial controls		External Financial Audit (annual)	External	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Review of the income monitoring arrangements and monthly reconciliation process between the contracting and finance teams.	CFO/DSBD	July 2025	Currently work in progress, no significant process issues identified. Updated reporting being developed.
Address service specifications with commissioners during contracting round	Commercial Director	~~October 2024~~ April 2025	Block contracts agreed for 25/26 October 2024 to April 2025 – work continues with commissioners, to update pathways and service specifications.
Development of Internal Reporting for DET Services – ensuring consistency with IQPR process.	Director of Education (Operations)	April 2025	Enhanced DET performance reporting is starting from the PFRC meeting in May 23. This will provide a level of assurance/control but will not be finalised. DET performance will be reported regularly and will improve during the remainder of the year in line with the DET Operations Improvement Programme which is aligned with the IQPR programme. DET performance monitoring integrated with Trust reporting. Part of new income monitoring service. Completion to be confirmed July 25.

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

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

Executive Lead	Peter O'Neill Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	4th April 2025
Risk Appetite	**Open**	5	4	**20**	3	4	**12**	3	3	**9**	⟺				**Date of Next Review**	June 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Implementation of security software on all endpoints	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Implementation of security software on all servers	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Successful completion of IG Toolkit annually	Full compliance with mandatory IG training	NHS DSPT toolkit annual submission. External validation of submission IT has also created a new cyber information video which will assist staff in recognising threats and communication to all staff has been sent.	External	Amber
Compliance with industry standard Cyber Security Accreditations	None presently. However, each year adds additional controls.	External validation with an independent Cyber Essentials agency officially accredited from 11/08/24 includes extended control of mobile devices, which meant implementing a completely new MDM system and rolling it out within a few months. It also includes security testing suppliers, which is a hot area after CareNotes. We will continue this process going forward. An NCL CIO-led Cyber group has been created to combine skills and resources to better tackle potential cyber threats and share rare skills in this area.	External	Green
Implementation of email security infrastructure	None	Secure data tools on email send and receive at a trust level e.g Mimecast. Additional individual email security management via Egress email security software.	Internal/External	Green
Subscription to NHSX cyber threat service	None	NHS issues threat warnings and remedial actions with timescales. These are called CareCerts and we comply with the actions required in the timescales advised where appropriate.	Internal/External	Green
Business continuity plans for all relevant trust areas	Continuous assessment of suitability and regular BCP scenario testing.	Resilience group now responsible for BC plans including testing and After-Action Reviews (AAR) from incidents involving BC planning. Regular BCP scenario testing with feedback loops for continuous improvement approach. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested Lessons learned for the Cyber outage of CareNotes have now been created and relevant functions are implementing the findings	Internal	Amber
		NHSE Emergency Planning Response and Recovery Team and ICB EPRR team	External control	Amber
		Major Incident Plan Business Continuity Policy Emergency Planning Response and Recovery Policy All reviewed annually	Internal	Green
		Established Resilience group in June 2024	Internal	Amber

		The Resilience Group is responsible for the Tactical oversight of the Trust's Emergency Preparedness, Resilience and Response (EPRR), and all related plans associated with Business Continuity All staff trained in tactical response to a major incident Review and Approval of all service specific BCP plans		
Third party system supply cyber assurance	No formal process to ensure suppliers are operating critical systems on the trust's behalf to acknowledged and agree cyber standards.	Regular (suggested annual) update from system suppliers to a structured questionnaire requiring assurances on compliance with evidence. Would be appropriate to engage a 3rd party assessment service	External	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Increased communication and monitoring of IG mandatory compliance	Data Protection Officer	*By June 2025 and annually thereafter.*	In progress – IG lead has confirmed 82% compliance across the Trust. *ESR Data cleansing to help with clarity around actual compliance.*
Annual review and implementation of new standards for cyber safety	Director of Infrastructure	*Annual submission to Cyber Essentials to achieve ongoing accreditation.* *July 2025*	Complete 24/25 part of BAU for 25/26
Review of BCP plans across the trust with recommendations for improvement. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested twice since 2020 and have successfully managed associated risks and maintained trust effectiveness.	Hector Bayayi	By end of FY 25/26	In progress – All BCP plans are reviewed annually, and we have a resilience group. **Senior Leadership Forum** carried out an interactive BCP exercise on 11 February 2025 to help with learning. Annual Board report – Clare Scott as Accountable Executive Officer for emergency planning provides an action plan from the results of annual assurance submission. Moved to BAU
Core standards assurance submission on EPRR	Accountable Executive Officer	*September 2024(Annual update)*	Annual submission. Review meeting in November 2024 with ICB EPRR team. Report (encompassing report findings from ICB and action plan) to the Board due in January 2025
Annual review and update of the following policies Major Incident Plan Business Continuity Policy Emergency Planning Response and Recovery Policy	Accountable Executive Officer	*December 2025*	Reviewed as part of the EPRR core standards assurance
IG annual Toolkit	Data Protection Officer	June 2025	On track for submission at end June 2025. Currently collating evidence Internal Audit commences in March which will serve as a gaps analysis and any gaps identified will be addressed ahead of submission in June.
Review supplier base and engage 3rd party assessment service	Director of Infrastructure	*Q2 FY25/26*	*Update pending*

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Increase external Cyber Essentials accreditation	Cyber security annual update planned, last accreditation August 2024.	None NHS England will move to the Cyber Assurance Framework (CAF) next year. However, the Trust still needs to maintain Cyber Essentials as certain contracts still require this accreditation.	External Cyber Essentials accreditation organisation. Trust Audit program
Engage 3rd party cyber assessment of trust suppliers across all of the infrastructure to ensure compliance to trust / NHS standards	Planning is underway via the recovery of the CareNotes system and will deliver outcomes in Q1 FY23/24. The intention is to pilot with Advanced (CareNotes supplier) and then roll out to all other system suppliers	Will require funding for the service to be acquired. Higher priority work impacting internal technical resource	NHS (digital team) 3rd party assessor Trust audit programme

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

Executive Lead	Clare Scott Chief Nursing Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	20th June 2024
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	04th April 2025
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⟺				**Date of Next Review**	June 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Activity, waiting list and quality impact risk monitoring across key services (including Adult Trauma, GIC and Autism Assessment). Review of internal waiting lists for CAMHS (North and South Camden)	A clear understanding of the capacity to reduce waiting times and meet the increasing demand for some services.	The new three-year strategy ambitions to reduce waiting times to 18 weeks across all services. Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board.	Internal	Amber
Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Some data flow is manual, so there are possible errors. Additional work is required to build forms and ensure data is automated wherever possible.	The Board and Performance, Finance and Resources Sub-Committee consider IQPR report.	Internal	Amber
Job planning to properly understand and manage the capacity of each team to meet the demand for services.	Key systems' reporting structures (Oracle, CareNotes, ESR) are out of date. System upgrades or process improvements are needed to ensure job planning reflects real-time workforce and patient demand data.	Workforce and Finance Platform Update: The workforce and finance platforms have been reviewed and aligned with the new structures. Additional data reconciliation is required to ensure accuracy. This process is conducted through monthly finance, people, and clinical services meetings. The estimated completion date is October 31, 2024.	Internal	Red
Targeted support – both GIC and Trauma have been placed under targeted support following Kaizen events where the progress was slower at meeting identified targets set during the event, outlined below. All areas are incorporated to targeted support.	The service profile pack, including performance data, benchmarked data, and pathways, is still under development. Clear trajectories are still under development	Once agreed and mature, the delivery plan will be shared and monitored at the following fora: PFRC Quality & Safety Committee	Internal	Red

Kaizen Event for Trauma Overview 21 October 24: The focus of Kaizen Week for Trauma will be to review current clinical pathways aligned to best practice and commissioned service specifications, mobilise clinical job plans, and co-create a delivery plan with the team. The event also aims to deliver a culture piece. This plan will include 30-, 60-, and 90-day review periods to ensure that efforts are targeted and impactful.		IQPR – Monthly Trust Waiting Times Huddle – weekly Adult Services PTL Meeting – weekly Targeted support – weekly for GIC and Trauma		
National Review of Gender Identity Clinics (GICs): NHSE is leading the National Review of Gender Identity Clinics (GICs) initiative, which evaluates current service delivery approaches across all adult gender services with the aim of revising the National Service Specification. This review will provide valuable insights into our current service delivery model, complementing our existing delivery plan and risk controls.		The Clinical Services - SOPs, training plans, and job plans. Oversight will sit with the following fora: • Quality Committee/PFRC – monthly • IQPR – monthly • Clinical Governance – Monthly • GIC Targeted Support Group - Weekly • GIC Leadership Group – Weekly	External	Amber
Recourse optimisation and monitoring. The trajectory for a number of first appointments to be conducted – estimated number of pts likely to be seen for a first appointment aligned to the agreed trajectory. - Recourse optimisation and monitoring.		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. The estimated number of first appointments is on track as planned, with ongoing optimisation.	Internal	Amber
Weekly PTL meetings to review dormant cases and throughput. Review of the intake process to minimise hand offs between services. Activity, waiting list and quality impact risk monitoring across key services (including, Adult GIC, Trauma and Autism, PCPCS).	Currently have long waiting times, exceeding the 18wk RTT. Clear understanding of available capacity to reduce waiting times and meet increasing demand for some services. Gap in trt waiting times data, as not fully automated or assured. Data flow is manual so possible errors.	Weekly QI huddles for oversight, Review in Child Complex monthly meeting. Monthly business meetings for all services. IQPR meetings.	Internal	Amber
Clinical pathway mapping to unblock bottle necks		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. A3 Kaizen events	Internal	Green
Workforce recruitment and retention	Recruitment - Number of referrals versus number of pts we can see. Unlikely to recover waiting times best case break even each service, with the exception of GIC which is under NHSE national review	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber
Autism – mitigations seeing an extra 175 pts Trauma -to see an extra 100 patients	Responding to cultural issues. The time required for change management	Waiting times weekly huddle. Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Targeted support weekly meeting for affected service areas, monthly report to ELT. Service lines have started this process this month. Publication of the first cut of data a month in arrears of the start date will inform assurance rating. Lead nurse start 19th August	Internal	Amber

Control Title: DrDoctor Patient Portal Implementation This control helps mitigate the risk of failure to achieve required performance levels by reducing administrative burdens, improving patient throughput, and allowing more senior clinicians to focus on complex cases.				

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
Deliver a trajectory for all service areas, tracking the ambition to reduce waiting times to 18/4 weeks target via the weekly Executive Leadership Team (ELT) Strategy.	Managing Director	March 2025	In progress - Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board.
Key performance and information reporting systems are being automated and aligned to our new management structure, enabling data flow to the correct operational monitoring groups.	Project Manager / Associate Director of IM&T	31 March 2025 – go live date.	Data definitions for IQPR targets are documented and reviewed by data owners. Data is provided directly from IM&T systems to the data definitions. A large number of SPC Charts were created from the data definitions for use in IQPR Reports. Business administrator for reporting advertised and shortlisted.
Once system reporting is aligned with the new structure, ownership and accountability for finance and activity performance will be held locally. We will work within local, Regional, and National care systems to align/increase our income in line with the demand for services.	Managing Director	Noting progress above, final budgets to be validated with Teams during August and finalised in September 2023. – Further work has been conducted between December 24 and February 25.	ELT and DLT completing a review following the unit and team level budget resizing meetings.
Job planning- Complete a workforce and finance platform update, aligning these systems with the new structures.	Medical Director	October 2025	**-Ownership & Process:** Job planning is **clinically led**, with implementation managed by **Operations** through clinic schedules. **-Compliance & Oversight:** Once job plans are ratified by **Clinical Leads**, -**Operations is responsible for compliance reporting**. **-Reconciliation Efforts:** The **People Team and Finance** have been working together to **reconcile data**, supported by ongoing meetings. **-Current Status:** Job planning is now in its **6th iteration**, but adoption remains a challenge as **clinicians have yet to fully accept the plans**. **-Clinical Leadership: Sheva is leading this from a clinical perspective**, ensuring alignment with service needs and workforce capacity.
Kaizen Event: Build a service profile pack to inform prioritisation, co-create a delivery plan, and include 30-, 60-, and 90-day review periods to ensure efforts are targeted and impactful. Delivery will be tracked through PFRC, Quality Committee, IQPR, Trust Waiting Times Huddle, and Adult Services PTL meetings.	Adult Services Lead Clinician	May 2025	The service and project team are currently building the service profile pack, which includes performance data, specification, benchmarked data and an as-is pathway to inform prioritisation.
National Review of Gender Identity Clinics (GICs) - Ratify Standard Operating Procedures (SOPs), mobilise training plans, and integrate job plans into clinic schedules by the following dates:	Managing Director and Medical Director	April 2025	Service Delivery and Performance Update: **Operational Work Completed:** The **Operations team has completed their tasks** and is now awaiting further input from clinical leads. **Next Steps:** The **Unit Clinical Lead (UCL) and Team Clinical Lead (TCL)** must finalize their respective tasks before integration with the completed operational elements can proceed. **Service Alignment:** Full integration will occur once the clinical components are finalized, ensuring alignment with service delivery requirements.
	Managing Director	18 October 2024 – Training plans implemented, and trackers mobilised.	
	Managing Director	14 October 2024 – Job plans built into clinic schedules.	

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

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

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

Executive Lead	Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	15th August 2024
Lead Committee	PFRC Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	04th April 2025
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⟺				**Date of Next Review**	June 2025

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Engagement and awareness campaigns	Education of staff at all levels	Regular trust wide communication.	Internal	Amber
oversee the plan and education on climate change impacts.				
Green Plan	Annual action plans based on net zero measures	ELT AND PFRC to review and approve. Responsible for continued oversight with metrics	Internal	Amber
NHSE utilities framework (April implementation)		Signed up to utilities framework. Contract commencement April 2025	External	Green
H&S meeting agenda item		Quarterly H&S meeting	Internal	Green
Internal/external stakeholders		Attendance of Greener NCL partnership Board	External	Green
Capital Planning will support net zero measures		FIRM meetings	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
NHS sustainability metrics introduced September 2024 - Building a sustainability page on the intranet	Director of Estates, Facilities and Capital Projects	April/May 2025	Building a sustainability page on the intranet. Will be launched once green plan signed off by the board Assess the net zero metric. Metrics available shared with, available
Create and Prioritise action plans based on net zero measure with appropriate directorates- each directorate will	Director of Estates, Facilities and Capital Projects	July 2025	Groups to be created once green plan has been signed off by Board and intranet page developed. The focus areas will be, waste, utility consumption and business/staff travel.

Strategic Delivery Metrics

Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
Refresh of the Green Plan along with an annual action plan.	To be presented to the Board/PFRC March 25, rescheduled to July/August 25	Nationally the green plan is to be updated in 2025-26, as our plan would have just been shared, there will be a further review by the end of 25-26	Once the green plan is updated this will be added to the intranet
An intranet page will be developed showing active monthly waste data, and will move towards adding other metrics	By April 25 completion date to be confirmed, waste data will be visible on the intranet	Other data sources are not as easy to collect will require investment in gathering travel data linked to expenses etc	

Corporate Risk Register May 25

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

Reference	Description	Category	Impact of risk	Location	Original score	Current score	Target score	Target date	Approved state
RSK-038	An increase in sickness levels in psychology and core pathways will impact overall service delivery, leading to cancelled appointments, additional workload on already overstretched staff, and same-day appointment cancellations.	Staff Wellbeing	This may result in a potential rise in complaints due to cancellations and delays, compromised patient safety, and a possible decline in service reputation.	Adult Unit - Gender Identity Clinic	15	15	8	26-Mar-2025	Approved
RSK-016	If there are not enough skilled cyber security resource to support the growing demand and compliance of cyber security, then this may result in Trust to maintaining cyber security compliance and would result in increased vulnerability to infrastructure and Trust not compliant with DSPT and cyber standards	Cyber Security	Financial Impact: Potential fines or penalties due to non-compliance with cybersecurity regulations and standards. Reputational Damage: Loss of trust from patients, stakeholders, and regulatory bodies due to failure to maintain	Finance - IM and T	20	20	2	31-Jan-2025	Approved
RSK-019	Risk: If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring	Cyber Security	Then, delayed action would compromise the Trust systems, services, and data.	Finance - IM and T	15	15	4	31-Jul-2024	Approved
RSK-039	Potential risks for those awaiting interventions If GIC waitlists continue to grow. There may be an increased chance of serious incidents and poor patient experience. Overstretched staff expected to deliver services.	Delivery	This results in an impact on care delivery, a loss of service reputation and non-compliance with regulatory and contract requirements.	Adult Unit - Gender Identity Clinic	20	20	8	30-Jun-2025	Approved
RSK-061	Delays in delivering clinic letters to patients or healthcare professionals.	Patient Experience	May result in patient harm, poor patient experience and care, delays in treatment, reputational damage to the Trust, and increased stress for administrative and clinical staff."	Adult Unit - Gender Identity Clinic	15	15	5	01-Apr-2025	Approved
RSK-128	Increased referrals for CYP seeking ADHD/ASD assessment, these are typically undertaken in external services, Royal Free ADHD service and for ASD - within Social Communication Assessment Service within MOSAIC CAMHS (CNWL service).	Patient Experience	Poor patient experience - delays in being accepted for an assessment (waiting times for assessment also), confusion about where to be referred.	Camden	15	15	4		Awaiting approval
RSK-032	If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services.	Safety	Harm to the young person who needs a diagnosis and pressure on local CAMHS servcies that may be unable to fully meet the young persons needs.	CYP and Families	16	16	4	30-Apr-2025	Approved
RSK-107	The local authority of Haringey has served notice on the Section 75 funding of the First Step Service. This will result in Service Closure. The following risks are associated with this. Delegated Statutory responsibility for the collection and scoring of SDQ will revert to Children's Services and the Tavistock and	Delivery	Impact relates to Clients (CIC) and stakeholder relationships, Staffing wellbeing, Delivery of service	Organisation	16	16	12	25-Feb-2026	Awaiting approval
RSK-086	The absence of a recurrent CIP process may undermine the development and execution of future financial plans, jeopardising the organisation's economic sustainability. There is a need to develop future merger related recovery plans and embed a delivery/governance process.	Finance	The lack of an established recurrent CIP programs will hinder financial sustainability.	Finance - Finance and Procurement	15	15	8	30-May-2025	Approved
RSK-089	If the Trust lost key members of staff, then this results in single points of failure and lack of capacity within the team,	Finance	resulting in the inability of the team to deliver core functions in a timely or adequate manner	Finance - Finance and Procurement	15	15	8	31-Jul-2025	Approved

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday, 15 May 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit & Governance Committee	08 May 2025	David Levenson, Non-Executive Director	Dorothy Otite, Interim Director of Corporate Governance	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 010**		

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 headlines: i. The Committee welcomed two observers (Ken Batty, NED; and Natalia Barry, Governor Observer) ii. The main issue highlighted to the Board of Directors are issues relating to the volume of papers to the Committee at this meeting due to Draft Annual Report and Accounts for 2024/25.	**Assurance rating**
1. Volume of papers • The Committee agreed it did not need to receive the Draft Annual Report and Accounts for 2024/25 at this meeting, although this was noted by the Internal and External Auditors as standard practice across the NHS. The Committee noted the Extra-ordinary IAGC meeting in June would be sufficient to carry out its scrutiny function. • The Committee agreed that information only items should be placed in the Committee reading room at future meetings.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Declarations of Interest • The Internal Auditors (RSM) and External Auditors (Grant Thornton) both declared they were Auditors to North London Foundation Trust (NLFT) noting there was no perceived conflict.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. External Audit Progress Report • The External audit progress report was received by Committee. • The Auditors confirmed they are on track to complete the Audit by June 2025.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Planning Statements Planning Update • The Committee received the proposed accounting treatment with regards going concern, accounting for leases, provision for unused funds from NCL, capitalisation of costs, revaluation of Trusts properties, deferred income. • The Committee sought clarity as to the provision for unused funds from NCL and noted it could not be deferred to 2025/26.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Draft Annual Accounts 2024/25	Limited ☐ Partial ☐

• The Committee received and noted the provisional report based on the expected outcome at the year-end 2024/25. The final reported position being subject to the completion of the external audit and accounts process.	Adequate ☒ N/A ☐
6. Internal Audit Update • The Committee received a progress update which concludes the 2024/25 audit programme noting reasonable assurance rating for one; and partial assurance rating received for three recent internal audit reports. • The Committee raised the partial assurance rating for the reports as an area of concern. Noting from the CEO that Executive Directors are being required to carry out a review of controls of key processes within their portfolio. • The Committee requested for a follow-up of open internal audit recommendations at the June Extra-Ordinary meeting of the Committee. • The Committee noted ELT would be reviewing the Internal Audit Plan 2025/26 to ensure relevance of review topics as the Trust approaches the merger by acquisition.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
7. Annual Internal Audit Report Including Head of Internal Audit Opinion • The Committee discussed the draft Head of Internal Audit (IA) opinion based upon the work performed on the overall adequacy and effectiveness of the organisation's governance, risk management and internal control processes. The IA opinion is rated at Level 3 indicating some weaknesses, which are based upon the outcomes of Internal Audits undertaken in 2024-25, most of which have been rated as 'Partial Assurance', and that a significant number of management recommendations have had revised dates and were still outstanding in the reports to this meeting. • The Committee expressed reservations about the IA opinion due to the improvements around governance and risk management. RSM agreed to reconsider the wording of the opinion in these respects, but that they are unable to revisit the overall rating	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
8. Local Counter Fraud Annual Report • The Committee noted the Local Counter Fraud Annual Report which showed the work completed in 2024/25 against the agreed work plan. • The Committee noted the Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green. The green rating assesses the Trust as fully compliant with the requirements, with demonstrative evidence of the impact of counter fraud work undertaken.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Oversight of Board Assurance Framework (BAF) and Corporate Risk Registers (CRR) • The Committee received the report noting the Board Committees had agreed the 2024/25 BAF and CRR Risk Registers as the starting position for 2025/26.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
10. Aged Debtors Report • The Committee received a report of aged debtors noting that amounts owed to the Trust are regularly tracked and chased with the aim of recovering as much debt as possible. Student age debt in	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

particular was highlighted as being at a higher-than-expected level, with no reduction over time. • The Committee noted the issue relating to 'artificial debt' which was being addressed.	
11. Single Tender Waiver Report • The Committee received the Single Tender Waiver Report, and no significant issues were raised.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
12. Committee Effectiveness Survey • The Committee discussed and agreed the recommendations for further development of the Committee which includes streamlining of agendas and improving quality of reports.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
13. Estates Valuation • The Committee noted the Estates valuation report, and no issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
14. Standing Financial Instructions Update – Procurement Act • The Committee approved the updated SFI to reflect the new Procurement Act.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
15. 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 ☐
16. Gifts, Hospitality and Interests Annual Report • The Committee noted the Gifts, Hospitality and Interests annual report and the updated Trust registers of interests including the Register of Gifts and Hospitality and Register of Decision Makers' Interest.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

Approved:

- Standing Financial Instructions

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, 15 May 2025			
Report Title: Quality & Safety Report April 2025			**Agenda No.: 011**
Report Author and Job Title:	Emma Casey, Associate Director of Quality Lucy Hegarty, Patient Safety Manager Sonia Perez, Quality Assurance Manager Fay Shorter, Complaints & Enquiries Manager	**Lead Executive Director:**	Clare Scott, CNO
Appendices:	Appendix 1 – Example learning poster (INC-263)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	In line with the Trust's refreshed accountability framework, there is a need to refocus and strengthen the way in which we report and assure the quality and safety of our services.		
Background:	This Quality & Safety report expands on the detail in the Integrated Quality and Performance Report (IQPR) and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IQPR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics. The Unit Clinical Governance meetings and the clinical division IQPR meetings inform the narrative of this quality and safety paper, in relation to action taken in respect of thematic and individual areas of focus identified.		
Assessment:	The Board is asked to note and discuss the data for this reporting period. There is not an obvious triangulation of themes across the metrics reported; however, this could be anticipated to change following the work to increase recording and reporting in a number of areas outlined above, and linked to other key pieces of work (replacement quality and risk system, implementation of PSIRF). A way to display triangulation of the cause categories of the metrics in this report is being developed e.g. incident cause category, complaint cause category etc.		
Key recommendation(s):	The Board is asked to: • **DISCUSS** the report and the recommendations for further improvements to identifying and learning from triangulated themes.		
Implications:			
Strategic Ambitions:			

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust will be held to regulatory account if it does not report its quality and safety data in a robust, transparent and accountable way.				
Resource Implications:	Yes ☐	No ☒			
	None				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	There may be opportunities to consider reporting some of the metrics by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does differ between reporting group. This will be guided by the PCREF workstream.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	This report has been presented to the Quality & Safety Committee since March 2024 (the first iteration of this report format); April 2025 (February 2025 data) report presented to April 2025 Quality & Safety Committee.				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Quality & Safety Report – April 2025

1. Background

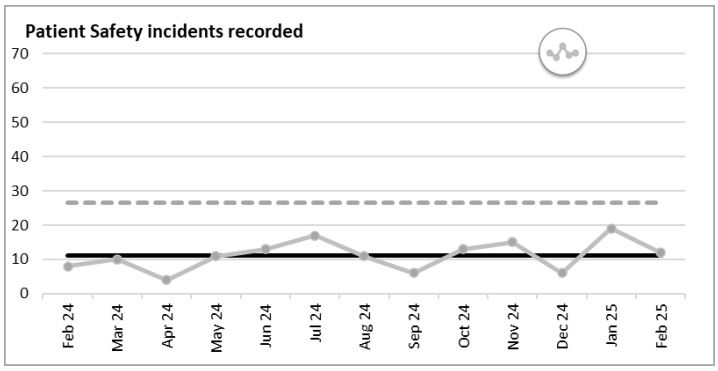
This Quality & Safety report expands on the detail in the Integrated Quality and Performance Report (IQPR) and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IQPR), narrative from clinical teams,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

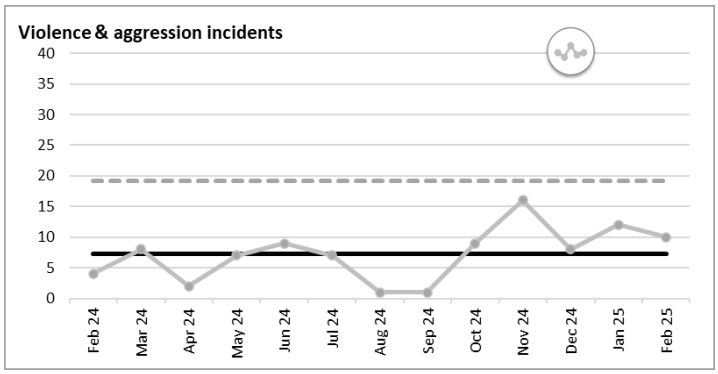
The Unit Clinical Governance meetings and the clinical division IQPR meetings informs the narrative of this quality and safety paper, in relation to action taken in respect of thematic and individual areas of focus identified.

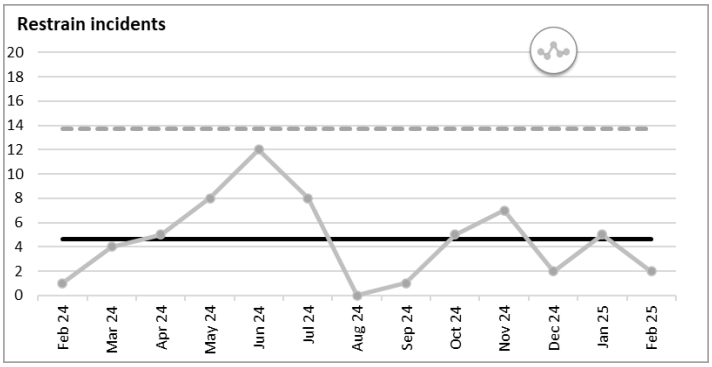
2. Clinical & Patient Safety Incidents

The tables below indicate the data recorded for February 2025. Statistical Process Control (SPC) charts have also been developed for a number of the metrics.

February 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Incidents – Patient Safety incidents	12	0	9	3
Incidents – Open SI / PSI investigations	2	0	1	1
Incidents – Falls with harm	0	0	0	0
Incidents – Violence & Aggression	10	1	9	0
Incidents – Restraint/ Hold	2	0	2	0
Incidents - Number of all deaths	2	0	0	2
72 Hour Reports Requested	0	0	0	0
After Action Reviews Requested	3	0	2	1







The following points are noted;

- The SPC charts illustrate incident reporting for Violence and Aggression (V&A), Restrictive Practice, and Patient Safety incidents. The data for February indicates that the number of reported incidents is within expected levels of normal variation.
- Of the incidents reported, 10 involved violent and aggressive behaviour, with 9 occurring at Gloucester House School. Among these, two incidents required the use of restrictive practices due to challenging pupil behaviour. To improve the reporting process for incidents of behaviour that challenges where staff intervention is required, staff at Gloucester House are now utilising the Radar system to log incidents involving restrictive practices and the strategies used to regulate behaviour. This new electronic reporting process aims to streamline and standardise reporting across the organisation.
- In terms of incident reviews, three After Action Reviews (AARs) were initiated in February. Two of these reviews focus on the violent and aggressive behaviour incidents at Gloucester House, while the third addresses an incident involving a patient who attended the clinic in distress without an appointment. The findings and key learnings from these AARs were presented to the Clinical Incident and Safety Group (CISG) and will be further integrated into the relevant Unit Clinical Governance meetings, with an accompanying learning document. This review process plays a crucial role in identifying areas for improvement and importantly ensuring the implementation of any learning identified. Further detail on two of these AARS conducted is below.

    - *Child & Family Unit; Gloucester House (INC-263)*
      This incident was categorised as violent and aggressive behaviour by pupil against another pupil and staff. The incident was well managed and the incident protocol followed although there was continued dysregulated behaviour with pupils throughout the afternoon. It was later discovered that the incident may

have started after online computer gaming which took place outside of school hours.
- Positive reflections included staff working well to de-escalate the incident, work undertaken to identify the underlying cause of the incident and the case coordinator liaison with both sets of parents.
- Two other points highlighted in the AAR related to the on-call process and the behaviour protocol. Assurance was received at the Clinical Incident & Safety Group that these are in progress separate to the AAR, but the document will be updated to reflect this.
- The learning poster will be presented to the Child & Families Clinical Governance meeting.

- *Adult Unit; Gender Identity Clinic (INC-250)*
- This incident related to a waiting list patient attending, and accessing, the clinic without an appointment. This was a difficult incident for both the staff and service user and included a number of staff over a prolonged period of time.
- Positive reflections included, immediate responsiveness and containment of the incident by staff.
- Learning has already been implemented in some areas including the access to the building and clarity about the on-call process in the GIC.
- The learning from this incident should be considered by all units. To support this, a bitesize training presentation will be developed to be shared across the Trust.

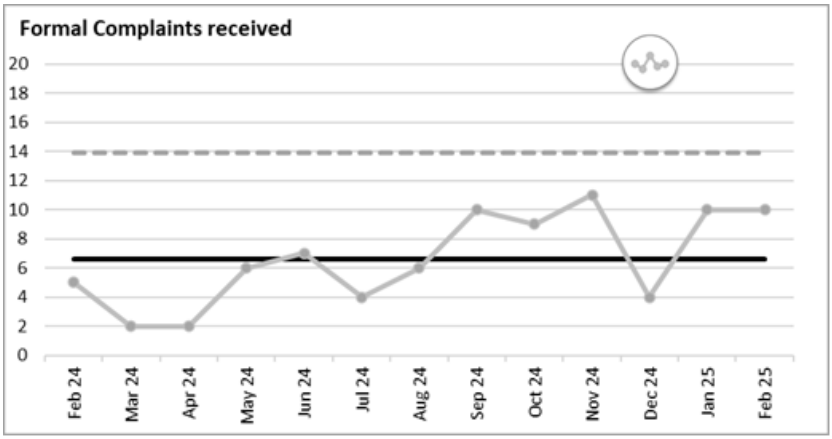
- Learning posters are being developed based on the findings to the learning reviews - an example for INC-263 can be found in Appendix 1. These posters will be disseminated at team level after being discussed at the appropriate Unit Clinical Governance meetings. This approach ensures that key lessons are shared and that continuous improvements are made to enhance the overall safety and quality of care.

6. Complaints & PALS

Complaints:

10 complaint contacts were received during February 2025.

February 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Formal complaints - Number received	10	0	1	9
Formal complaints - Number acknowledged within 3 days	8	0	1	7
Formal complaints - Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	23% *3 of the 13 complaints closed were within 40 days*	N/A	N/A	3
Investigations by PHSO	0	0	0	0
Informal complaints	0	0	0	0
Number of open complaints	20	0	3	17
Number of overdue complaints	8	0	0	5



The main themes for complaints in February 2025 are outlined below (triangulated with PALS categories):

- Communications (unhappy with approach of clinician within appointment, communication with clinic staff, clinical administration communication
- Access to Treatment or Drugs e.g. clarity with regards to waiting times for treatment, unhappy with the outcome of an assessment.

There was a significant decrease in the number of overdue complaints to 8 in February 2025 (from 20 in January). The total number of complaints open has also decreased to 20 as at the end of February 2025.

The Trust reported a compliance rate of 23% of formal complaints responded to within the 40 day timeframe, this is below the Trust target of 90%, but the overall reduction in overdue complaints and open complaints demonstrates the impact the improvement work is having.

There has been a significant improvement in closing the oldest complaints but compliance for closing formal complaints withing 40 working days will be challenged until all overdue complaints have been closed. Regular meetings with the Complaints Manager and Unit Service Clinical Leads helps to focus on progressing complaints that are at risk of breaching the 40-day timeline. There is also a new daily huddle in the Complaints leadership team to discuss upcoming deadlines and review any difficulties.

A new A3 project for Complaints is in the development stage. The quality improvement workstream will include addressing the following;

- Improving the timeliness and efficiency of complaints resolution
- Increasing the number of complaints resolved informally, within the 10 working day timeline
- Continuing the improvement in quality of complaint investigations and outcomes
- Increasing the number of staff that are trained to undertaken complaint investigations
- Increasing staff awareness of the complaints policy and process

For the acknowledgments to complaints, all acknowledgements were completed however 2 were not acknowledged within 3 days due to late registry on the Radar system. This will be an element of focus in the A3 project.

As noted previously, it is important that informal complaints are correlated with an early resolution. The Complaints Management Policy has been reviewed and redrafted to outline definitions and timelines for this (an expected 10 days opportunity to resolve informally).

The Radar system accommodates an auditable and accountable way of logging actions resultant from complaints, which will be a useful way of keeping track of progress of learning. For example, any action plans noted in the investigation report are transposed into an Action Plan on Radar which is assigned to specific staff members with an action date assigned. These action plans are taken to monthly Unit governance meetings for general discussion and assurance that they are followed up. Further, the Trust's clinical governance processes have been refreshed to ensure they are mirrored across the new clinical units and that learning can be clearly evidenced. The new learning poster developed for incidents will also be trialled in Complaints to share learning Trust-wide in an easily digestible format.

The table below references some of the recent learning outcomes from complaints. For some of these, the actions are overdue and further assurance will continue to be sought through the Clinical Governance meetings.

Theme	Learning taken forward	Timeline
Patient confidentiality / Communicating how and with whom patient disclosures made within an appointment is shared. (GIC)	Trust-wide disclosure training to be made available to relevant clinical services, including the GIC. Collaboration between the Trauma Service and GIC for understanding of trauma-informed approaches and techniques in clinical consultations.	Q4, 24/25
Sequencing of counselling psychology appointments for GIC patients.	Counselling psychology appointments are independent and not contingent on other appointments. Patient leaflet to be updated to reflect this.	Q4, 24/25
Adherence to reporting timescales within the ASC Team	A review of cases for the team to identify as early as possible any reasons which may delay the completion of reports. Reminding the team of the importance of adhering to timescales and targets for completion of reports.	Q4, 24/25
Communication with young people/families regarding treatment plan.	Where there is disagreement between a parent and a professional and consensus cannot be agreed, a network meeting should be arranged to facilitate further discussion and seek consensus. Where clinical interventions have the potential to cause acute distress and/or exacerbate a young person's risk, this should be discussed in the team's clinical team meeting or (if this is not practicable) in clinical supervision as part of the young person's wider care plan.	Q4, 24/25
Consideration of written policy on treatment length and ending.	Consideration to be given within service about developing a written policy about treatment lengths and endings to address occasions when sessions have been cancelled.	Q4, 24/25
Communication with patients in relation to decisions regarding their treatment pathway.	Discussion about how assessments and treatment pathways are explained to patients to be raised at Departmental meetings.	Q3, 24/25
Communication with young people/families regarding screening	Need to have timely discussions with young people and families regarding completed screening measures that	Q3, 24/25

measures/Health Records Management/Onward referrals/Care Plans	may or may not indicate the need for further assessment. Compliance with Health Records Management Procedure and that Care Plans need to be up to date. Onward referrals to services as agreed needs to be actioned within one calendar month or sooner. Care Plans are to be updated as and when needed, but no later than 6 months and to be sent to young person/family and GP unless requested otherwise.	
Sensitive questions during clinical assessment (GIC)	GIC Lived Experience Theatre Training has been proposed and is being reviewed. Website information has been updated and information leaflet reflects this and is sent out to all new patients. The new GIC patient platform will also be a key part of this information sharing.	*Lived Experience training discussed at CG meeting in March 2025. Action to be discussed further on who will lead.*

PALS*:*

16 PALS enquiries were received during February 2025.

	Trustwide *External are related to those not known to services*	**Camden Unit**	**CYP & Family Unit**	**Adult Unit**
February 2025	Internal (Queries for other Trust areas) = 3 Total = 16	2	0	11

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

- Access to Treatment/Drugs and Integrated Care (how to access services and what is available) e.g. types of therapy offered, wait times and referrals process, whether referrals have been received, rejected referrals other support services such as housing, benefits, financial support.
- Patient Care (queries regarding treatment provided)
- Appointments (availability/waiting times) ***(triangulation with Complaints themes)***
- Concerns with ending treatment and future options
- Trust Admin/Policies/Procedures including record management
- Concerns with treatment ***(triangulation with Complaints themes)***
- Communication issues (delays in receiving letters, appointment changes, notifications) ***(triangulation with Complaints themes)***
- Queries in relation to the complaints process

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

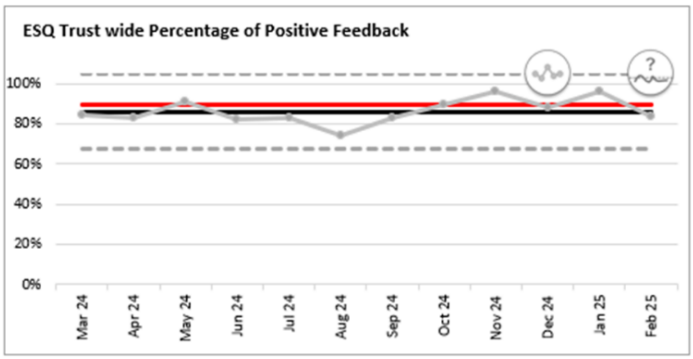
7. ESQ Feedback & Compliments

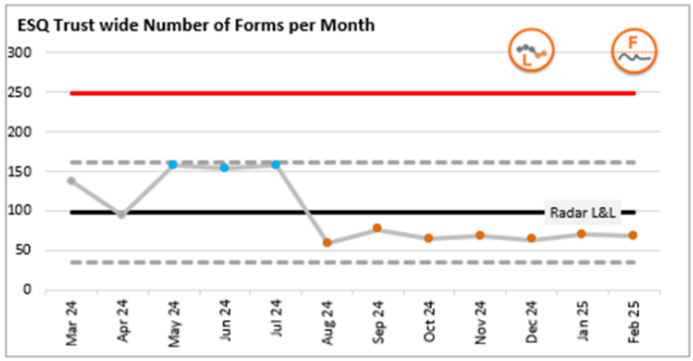
There is a continued focus on increasing the number of ESQ forms received each month, the ways in which feedback opportunities are available to service users and ensuring the process is optimised via the strategic objective.

Key updates in relation to the project include;

- ESQ forms are now collected via the Radar, previous method discontinued.
- Improved process for redacting and categorising feedback provided by service users.
- QR codes posters for patients to give their feedback displayed in reception areas.
- Emails to patients now include a footer message including URL to the ESQ form
- Notifications on feedback received (quantitative and qualitative) now shared directly with teams via the Quality Assurance Team.
- Agreed number of forms targets at team level.
- Data and learning from service user experience is taking place in Unit Governance meetings.

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



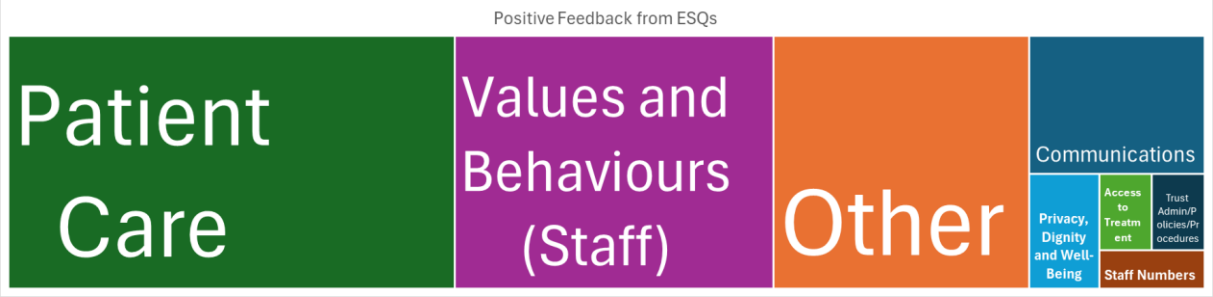


The Trust-wide positive recommendation rate received was 84%. The number of forms received remains low. Further progress is being made on projects to invigorate the number of ESQs received including an automatic text message system to service users requesting feedback after attended appointments and inclusion of QR codes in letter templates.

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

	Trustwide	Camden Unit	Child and Family Unit	Adult Unit
December 2024	51	11	25	15
January 2025	45	13	0	32
Feb	54	9	3	39

Improvements have been made on feedback to teams by capturing themes that emerge from the qualitative feedback. Below is a representation of the themes and how prevalent they are in the feedback received – the larger the box, the more times the category theme has been mentioned.



Further detail related to each category theme is included below.

- **Patient Care:** We consistently received exceptional feedback regarding patients' experiences, with numerous accounts highlighting how they felt well cared for, understood, and supported by all teams.
- **Values and Behaviours (Staff):** In alignment with the recent refresh of our organisational values, patients were able to recognise and provide feedback on how our staff embodied these values in the care they received.
- **Other:** Whilst often positive, we have identified that some negative responses were being submitted through this process. We have identified that there is a need to create a further category for future reporting. Common concerns included reference to waiting times for access to the GIC and issues with correspondence.
- **Communications:** The focus was primarily on communications with therapists (positive feedback).
- **Privacy, Dignity, and Wellbeing:** The primary concerns were related to the impact of long waiting lists and short group sessions.
- **Access to Treatment:** This pertains to the ability to access therapeutic services and the sharing of information between services, among other related aspects.
- **Trust Admin / Policy procedures:** Feedback highlighted concerns about the length of time particular availability of therapy and their experience of not feeling supported by admin staff.
- **Staff Numbers:** The feedback primarily focused on the need to increase the number of clinicians to reduce waiting times, as well as ensuring better representation of diverse clinicians.

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

Radar Compliments	Trustwide (Including trust/external)	Camden Unit	CYP & Family Unit	Adult Unit
December 2025 Number of compliments received	1	-	-	-
January 2025 Number of compliments received	1	-	-	-
February 2025 Number of compliments received	2		1	

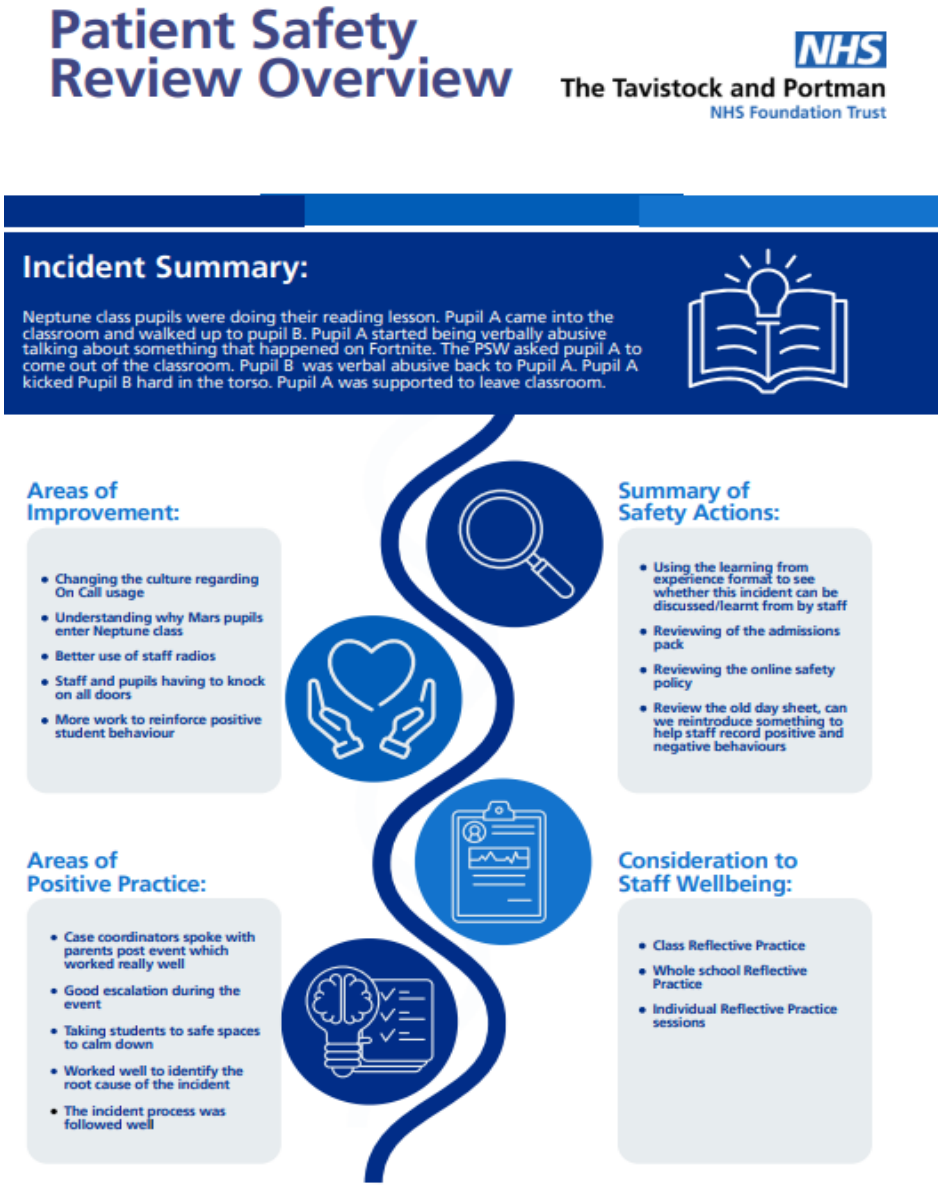
8. Conclusion

The Board is asked to note and discuss the data for February 2025. The review of themes reported via the metrics and supporting narrative will continue and is anticipated to change following the work to increase recording and reporting in a number of areas outlined above,

and linked to other key pieces of work (introduction of the Radar system, implementation of PSIRF etc).

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

Appendix 1 – Example learning poster (INC-263)



CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – Thursday, 15 May 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	17th April 2025	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 012**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Quality and Safety Report The Committee received the April 2025 Quality & Safety Report, which reports on February 2025 data; it was noted that the paper will be presented in full to the Board of Directors in May 2025. The Trust's new learning poster, which has been designed by Lucy Hegarty, Patient Safety Manager, was highlighted as an excellent source of information sharing.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Gloucester House Update including review of calming rooms The Committee received an update of progress against the action plan resulting from the review of Gloucester House, the action plan is monitored at the Gloucester House Steering Committee. Areas of concern continue to be focused on the environment and the gaps in meeting the Independent Schools Regulatory standards. The Committee received a paper on the review of the use of calming rooms at the school, carried out in response to a request by the Children's Commissioner following an expose in the news. Eleven recommendations were identified in the Trust's review, these will be subsumed into the overarching action plan.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Quality Priorities 25/26 The Committee were updated about the work undertaken to set quality priorities for 25/26, including the stakeholder event held in March and the discussion at the Joint Board and Council of Governors meeting in April 2025. The stakeholder event was well attended and included representation from service users, the Board, Council of Governors, Executive Leadership team and staff. Feedback was received at both	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

presentations on the proposed quality priorities for 25/26 and has been incorporated where appropriate. The Committee reviewed the drafted quality priorities for 25/26 which had been updated following feedback received from both events. The Committee approved the quality priorities for inclusion in the Trust's Quality Account.	
4. Internal Audit: Complaints Data Quality The Committee received an update on the outcomes of the audit on Data Quality: Formal Complaints Management, completed as part of the Trust's approved internal audit annual plan for 2024/25. The audit focused on reviewing the arrangements in place to ensure the accuracy and quality of data of information is maintained and reported. The outcome of the audit was an overall rating of partial compliance, and it recommended five medium priority management actions to be taken under the themes of Policies & Procedures, Data Quality and Training & Learning. Two of these recommendations are underway through existing pieces of work and the remainder will be actioned as part of the Complaints quality improvement project or through the work of the Quality Assurance Team.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Annual Plan QIA and EQIA The Committee received a report outlining the approach to quality impact assessments (QIAs) and equality impact assessments (EQIAs) carried out for the efficiency plans proposed in the Trust for 2025/26. The process is used to identify and mitigate against any potential impact on quality and equality of the efficiency programme. An update report will be brought back to each Quality and Safety Committee.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. Terms of Reference The Committee's Terms of Reference (ToR) were reviewed in November 2024 in line with the annual review of all ToR to ensure effectiveness. However, at that time, changes to membership were inadvertently overlooked. It was agreed that the changes were urgent to consider out with the next effectiveness review therefore the Committee agreed the addition of the following roles to the required attendees list; • Patient Safety Partner • Deputy Chief Medical Officer • Medical Director • Director of Therapies & Clinical Governance	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
7. Annual Committee Effectiveness Review Outcome 2024/25 The Committee reviewed the outcomes of the Annual Committee Effectiveness Self-Assessment survey for 2024/25. Overall, the survey responses received were positive with steady improvements and maturity noted around administration, agenda time management, quality of reports to the Committee and the focus on risk management. Recommended actions for further development included streamlining of Committee agendas, the need for members to increase constructive challenges to management, improving in-person attendance, transparency around deferrals in the schedule of business and ensuring alignment to	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

the timings of reporting groups and other meetings in the corporate governance calendar.	

Summary of Decisions made by the Committee:

- The Committee **APPROVED** the updates to the Terms of Reference membership list
- The Committee **APPROVED** the Quality Priorities for 2025/26

Risks Identified by the Committee during the meeting:

The Committee did not identify any new risks during the 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.		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – 15th May 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	8th May, 2025	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	n/a		**Agenda Item:**		
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. Following the announcement of our potential merger with North London NHS Foundation Trust, we have begun preliminary discussions about this with our key stakeholders, including the Office for Students (OfS), The University of Essex and our NLFT colleagues. Despite the change of merger partner, we are optimistic that we remain approximately in the position we would have been with our previous partner. This is due to a higher level of transparency around the merger from our prospective partner and pre-existing relationships between clinical services. 1.2. As with the previous merger partner, the narrative around DET's position in the merger is one of 'lift and shift' of our education provision with negligible variance to our structure or programmes (noting the financial concerns in 3.2 below). This is primarily in response to our desire to retain our OfS registration, validation through the University of Essex and PSRB accreditations, most of which are in place until 2027/28 or beyond. Retaining these links in a merged entity will require minimal variation as well as clarity on student protection plans for various scenarios.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Success Stories 2.1. We are tracking strongly on our offers made to potential students for the 2025/26 intake in offers accepted and unconditional accepts (i.e. students who are very likely to attend our courses), with offers up firm accepts up 370% on 2024/25 and unconditional firms up 156%. This news should be taken in consideration with the slowing application numbers (see 3.1 below) but suggests our internal processes have adjusted well to the earlier opening and that we should have a strong cohort for 25/26	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. Challenge Areas	Limited ☐ Partial ☒

3.1. After a strong start following the early opening of admissions in October 2024, student applications have now fallen back to parity with 2024/25 levels. The DET Senior Leadership Team are working with Marketing colleagues on a targeted plan to bring in more applications to courses with potential capacity, promote conversion of incomplete applications to completes. 3.2. In response to the financial position within the broader NHS, DET will be required to make approximately £1.1million in efficiency savings and/or growth to ensure we contribute to the Trust's balanced position. A Project Initiation Document (PID) has been set up to assure these savings which we are hoping to deliver through a combination of removal of posts in recruitment, increase in student fee income, and a review of courses that are not currently providing a contribution to the organisation, but without redundancies. This work will be ongoing throughout the 2025/26 financial year with monthly reviews of progress.	Adequate ☐ N/A ☐
4. Ongoing Work of Note 4.1. We have now formally begun to advertise for our new substantive Lecturer and Senior Lecturer positions to replace roles previously held by visiting lecturers. We have held two communications events with our visiting lecturer pool to clear up misconceptions about the roles, explain the rationale behind the changes, and outline the process for applying. The work is ongoing but is the culmination of significant work by the Directors of Education for Teaching and Learning and Governance and Quality and our Operations teams, supported by HR over the previous eighteen months, for which I am extremely grateful. 4.2. In a rapidly changing situation in the NHS, it is important that DET are clear about our own vision for the future within potentially a merger partner Trust and our strategy for continuing to deliver internationally excellent training in psychotherapy and other psychosocial disciplines for the medium and long terms. It is important that all DET staff have a say in our identity and strategic intentions, so we have approached several venues about an all-DET staff event to launch our Strategy consultation in mid-June 2025. We will follow this event up with two further meetings for staff to refine and document our strategy. 4.3. On 30th April we will be formally initiating a project to increase our International Student numbers and to improve the experience for those students who come to study with us from overseas. This work, which, includes the use of agents to identify and attract students from outside the UK as well as existing learning and an analysis of potential risks, will be critical in ensuring the long-term financial viability of DET and delivering on our ambitions to raise our CAS allocation.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- Next Committee is 03/07/2025.

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, 15 May 2025			
Report Title: Equality, Diversity and Inclusion in DET – Disability Focus			**Agenda No.: 014**
Report Author and Job Title:	Mark Freestone, CETO Paul Dugmore Director of Education (Learning and Teaching)	**Lead Executive Director:**	Mark Freestone CETO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This is a report on EDI within Education and Training taking into account both staff and student experiences, with a focus on staff and students identifying as disabled.		
Background:	The report contains data from both the 2024 staff and student surveys, analysed and reported to determine whether there is any variance between staff or students identifying as disabled, to enable identification of areas of concern.		
Assessment:	There is evidence of progress in some of the student data sets, particularly in relation to admissions, however the award gap has increased slightly in the disability category. There are significant concerns about harassment and bullying experienced by staff within DET identifying as disabled by 'patients or members of the public'. This requires further consideration in the Staff Experience Programme Board and an exploration of synergies between work being undertaken to improve experiences for disabled students and the staff group.		
Key recommendation(s):	The Board is asked to **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 ☐
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 7: Lack of a fair and inclusive culture				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no regulatory implications associated with this report, however, as part of our compliance with the OfS regulatory framework, we are				

	expected to provide a safe and inclusive education experience for all students.			
Resource Implications:	Yes ☐		No ☒	
	There are no resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	This report is specifically EDI focused.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Equality, Diversity, and Inclusion in DET - Disability Focus

1. **Purpose of the report**

This report provides an update to the Board on progress in relation to the staff and student experience in DET, those identifying as having a disability.

2. Background

2.1 The annual student reporting process follows a data driven approach to the collation and analysis of the student experience to identify trends in relation to specific protected characteristics (disability, race, religion, sex, and sexuality). The term global majority is referred to students identifying as Black, Asian. Minority Ethnic or Global Majority. This data relates to the 2023-4 Academic Year and is drawn from:

- SITS data in relation to recruitment and enrolment, assessment and progression.
- The student survey (A summary report of EDI specific data is appended).
- Qualitative feedback from global majority, LGBTQIA+ disabled student groups.

2.2 Staff data is taken from the 2024 Annual Staff Survey with a specific focus on Workforce Disability Equality Standards (WDES) results, segmented for the DET staff group.

3. Student Findings

3.1 15% of all applicants disclosed having a disability, continuing the increasing trend we have seen year on year and slightly higher than the national average for postgraduate students (13%). Early disclosure is encouraged to enable more effective responses to disabled student's needs.

3.2 The rejection rate for disabled applicants was 7% higher than applicants without or not disclosing a disability, (a 1% increase on the previous year). This variance reduced to 5% in terms of the conversion from application to enrolment, although is higher than last year.

	Applied		**Offered**		**Rejected**		**Enrolled**	
	22-23	**23-24**	22-23	**23-24**	22-23	**23-24**	22-23	**23-24**
Disabled Applicants	192	**124**	129	**81**	17 (9%)	**28 23%**	112	**63**
Non-disabled	1317	**956**	853	**699**	100 (8%)	**150 16%**	739	**536**

3.3 In terms of progression, 93% of disabled students progressed compared to 95% of those without a disability which is a slightly higher variance than the previous year. The Award gap (those achieving a distinction or merit) between students declaring a disability and those without a disability was 14%, an increase of 1% compared to the previous year.

3.4 Overall, these data show that disabled applicants are still less likely to be offered a place on a Trust course and of those who enroll, students declaring a disability perform less well. Whilst significant work has been embedded in how we process and support disabled students through academic processes, these changes are yet to lead to an improvement in student experience and outcome.

3.5 4 (4%) disabled students withdrew in the past academic year compared to 34 (4%) without a known disability. The number of students withdrawing overall has reduced in the past year.

3.6 The number of disabled students completing the annual student survey reduced from 94 to 68. Data show students formally declaring a disability had a satisfaction rate of 69%, a reduction of 5% from the previous year (74%), and 15% lower than students without a disability (overall satisfaction: 84%). This has been a continuing theme for the past three years. Conversely, students who believe they have a disability that has not been diagnosed reported higher satisfaction (84%) than the benchmark and than the previous year. We will continue to review these satisfaction levels and hope that there are improvements in the next student survey that will cover the period when significant enhancements have been implemented such as the Skills Fest, disability-focused staff CPD, and ongoing improvements to our Reasonable Adjustments process.

3.7 The disabled student group continues to be poorly attended, partly due to student availability. Themes arising from the group include:

- Some students take time to realise that they may need additional support partly due to issues of shame and a sense of being a burden when requesting support
- Students are pleased to have a facilitated space to openly discuss their disability.
- Academic staff do not always understand or respond flexibly to the needs of disabled students, which is informing the development of staff CPD.
- The interface with external clinical placements in the support of disabled students.
- Continued positive experiences of support provided by DET DSO who has attended one of the meetings.
- Less understanding of sensory disabilities as physical disabilities are often more visible.

3.8 Overall, the lack of progress across students with disabilities is disappointing despite there being some improvements in the proportion of students sharing their disability and in relation to progression and withdrawals. Significant effort is being focused on developing effective CPD for academic and professional services staff to increase understanding of disability and the obligations to meeting the needs of disabled students.

4. Staff Findings – WDES metrics

4.1 WDES Metrics

WDES metrics indicate some causes for concern within Education and Training. Relative to the wider Trust, DET staff identifying as having a disability report significantly higher levels of harassment and abuse from patients, colleagues or managers (45.5% vs 34.3%), mindful that these high DET numbers are included in the Trust total so the disparity may be higher (see Table below)

WDES Metric	24/25 Trust	23/24 No	23/24 DLTHC	24/25 No	24/25 DLTHC

	Overall (n=419)	DLTHC (74)	(27)	DLTHC (66)	(22)
Percentage of disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues	**34.3%**	**14.9%**	**25.9%**	**16.7%**	**45.5%**
Percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	**61.9%**	**36.4%**	□	**50.0%**	**60.0%**
Percentage of disabled staff compared to non-disabled staff believing their trust provides Equal Opps for career progression or promotion	**39.4%**	**29.7%**	**37.0%**	**36.5%**	**27.3%**
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**18.3%**	**7.1%**	**15.8%**	**11.4%**	**23.1%**
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent their organisation values their work	**44.4%**	**54.1%**	**33.3%**	**53.0%**	**22.7%**
Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	**64.6%**	□	**53.8%**	□	**40.0%**
The staff engagement score	6.6	7.0	5.8%	6.5	**5.7**

4.2 Additionally, disabled staff are only have as likely to report they feel valued at work than those not identifying as disabled (22.7% vs 53.0%), and only 40% within DET feel that reasonable adjustments are being made to enable them to carry out their work, compared to 64.6% in the wider organization and 53.8% in DET last year.

5. Conclusion

5.1 This year's datasets identify both progress and concerns across several reported areas. For students, progress has been slow or minimal for disabled students who are less likely to be offered a place or to achieve higher awards, however, the likelihood of withdrawal has reduced. For staff, there are signs of significant deterioration in the way that disabled staff feel valued by the organization and that reasonable adjustments are being made for them to carry out their work. Very concerningly, nearly half of staff in this category report some form of bullying, harassment or abuse in the past year, almost double the previous year.

5.2 Since they work in the same spaces and very often together, it is very likely that there are shared areas of difficulty between both staff and students and that there are potential shared solutions. The accessibility of the estate is a key focus of the Student Experience Sub-Committee, chaired by the CETO, as is the skilling up of teachers to identify and respond to – in particular – hidden disabilities within the student group. It is possible that DET has a specific need for a more general deployment of this training to all managers.

5.3 We propose the following priority work areas within DET:

- Estate – Several changes to the estate have been proposed to improve the student and staff experience, including a safer entryway and more visible signage, but previously these have not been progressed with urgency. These issues should be raised with the Space Utilisation Working Group.
- Staff Experience – We will share this report with the Staff Experience Programme Board to see if there are any specific actions to be taken within DET that might improve the experience of disabled staff, with a focus on management awareness and training.
- Student Access – Sustained and innovative work in admissions processes to support disabled applicants from initial enquiry through to enrolment.
- Student Award Gap - Further work to reduce the Award gap that exists between global majority and white students and between disabled and non-disabled students. These efforts must continue to be underpinned by enhanced data analysis and reporting.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 May 2025			
Report Title: Staff Survey Final Results 2024 and Draft Action Plan			**Agenda No.: 015**
Report Author and Job Title:	Gem Davies, Chief People Officer (CPO)	**Lead Executive Director:**	Gem Davies, Chief People Officer (CPO)
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	The purpose of the report is to provide headlines of the final staff survey results for 2024 and an initial draft action plan.		
Background:	The staff survey is a national initiative carried out each year by all NHS Trusts. As such, the survey is the Trust's current primary method by which organisational culture is measured. This includes how well-led staff feel and whether they feel sufficiently supported to enable them to fulfil their potential. This can be best described as staff experience. We therefore use the results to inform improvements in working conditions and practices.		
Assessment:	As previously notified, the main headlines for the 2024 responses are: • We have improved in 7 of the 9 people promise areas • We are now above the bottom of our benchmark in 8 of the 9 areas • We can see direct improvements in staff engagement • We are at, or above average, in: acting fairly re career progression /promotion; being kind to each other; being polite and respectful, being valued by team; opportunities to show initiative and make suggestions; and reporting incidents of bullying/harassment/abuse • Our main areas for concern remain: people with LTHC and those from global majority feeling bullied by colleagues, managers not caring about concerns, colleagues with LTHC feeling pressured to come to work An initial action plan has been drafted to respond to the concerns as well as further progressing the areas of improvement.		
Key recommendation(s):	The Board is asked to **DISCUSS** the contents of the report and planned actions.		
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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: **Risk 6 – Lack of Workforce Development, Retention & Recruitment** **Risk 7 – Lack of a Fair and Inclusive Culture** **Risk 8 – Lack of Management Capability and Capacity**				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	The people plan priorities serve to enact improvements both in our legal obligations to our staff and the people agenda within the organisation. As such, there are no negative 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:	Yes ☒	No ☐			
	Due regard will be taken to mitigate any equity of opportunity issues which arise from this report – ongoing EDI projects across the Trust including those described in the report will assure 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:	POD EDI – May 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: Staff Survey Final Results 2024 and Draft Action Plan

1. Purpose of the report

1.1 The purpose of the report is to provide headlines of the final staff survey results for 2024 and an initial draft action plan.

2. Background

2.1 The staff survey is a national initiative carried out each year by all NHS Trusts. As such, the survey is the Trust's current primary method by which organisational culture is measured. This includes how well-led staff feel and whether they feel sufficiently supported to enable them to fulfil their potential. This can be best described as staff experience. We therefore use the results to inform improvements in working conditions and practices.

2.2 As previously notified, the main headlines of the 2024 responses are:

- We have improved in 7 of the 9 people promise areas
- We are now above the bottom of our benchmark in 8 of the 9 areas
- We can see direct improvements in staff engagement
- We are at, or above average, in: acting fairly re career progression /promotion; being kind to each other; being polite and respectful, being valued by team; opportunities to show initiative and make suggestions; and reporting incidents of bullying/harassment/abuse
- Our main areas for concern remain: people with LTHC and those from global majority feeling bullied by colleagues, managers not caring about concerns, colleagues with LTHC feeling pressured to come to work

2.3 An initial action plan has been drafted to respond to the concerns as well as further progressing the areas of improvement.

3. Action Plan

3.1 The initial draft action plan is shown at the end of this paper.

3.2 The plan is intended to complement the work of a number of workstreams, for example there is a separate FTSU action plan and the EDI Programme Board have also mapped their priorities and therefore those actions are referred to rather than duplicated here.

3.3 A Staff Experience Programme Board, has been stood up, to commence in May, and it will be accountable for the development and delivery of a programme of work to improve staff experience across the Trust including this plan. Assurance will be

provided to the Board (via the People, OD and ED&I Committee) on the delivery of all aspects of the plan to improve staff engagement, experience, and FTSU areas.

4 Conclusion

4.1 We are currently undertaking a number of initiatives in order to improve the experience of all our people. The Board are requested to discuss the draft action plan and provide comment on revisions where appropriate.

Objective/Action	Allocated to	Deadline	Notes
Supporting and developing a culture of compassion, belonging and inclusion where all staff feel safe and confident to speak up, express views, and raise concerns.			
Refer to FTSU Action Plan	FTSUGs, People Team Lead, Exec Lead, Comms	Various 30/05/2025 to 31/10/2025	The FTSU Action Plan will be overseen by the Staff Experience Programme Board
Refer to EDI Programme Board Priorities	FTSUGs, People Team Lead, Exec Lead, Comms	Various to 30/04/2026	The EDI Action Plan is overseen by the EDI Programme Board
Service visit refresh	Governance Team / EAs along with Exec, NEDs, Governors	31/05/2025	Service visits to be held throughout the year. Feedback forms to include questions / conversation starters to help gain feedback that really matters to our people
Admin Forum			
Merger drop in sessions			
Senior Leadership Forum Refresh			
Values and Behaviours frameworks			
All Staff Meeting Refresh			
Improving the experience of staff in the organisation.			
Increased sharing of “you said, we did” outcomes from staff experience sessions	Exec Leads, People Team Lead, Comms lead	Monthly item	Incorporate as part of comms calendar and ensure all Exec Leads find opportunities to feedback.
Staff awards based on trust values and behaviours, to recognise individuals or teams for their work, impact and dedication to our patients, students and colleagues.	DOC, CPO	26 June 2025 Awards	• 21 May – Nominations deadline • 28 May – 2 June - Shortlisting • 3 June – Online shortlist event • 4-9 June: Staff choice awards voting • W/C 9 June – Judges select winners

			• 26 June – Awards event at Everyman Hampstead
Staff events calendar refreshed (and share event with new merger partner as soon as is practicable)	Staff Network Chairs, with support from Comms Lead and People Team Leads	31/05/2025	
Set priorities for the Staff Experience Programme Board	Core membership of the Programme Board	30/06/2025	
Create additional actions / refine existing ones off the back of the staff experience drop in sessions	Comms, People Team Lead, Core membership of the Programme Board	30/06/2025	
Merger drop in sessions			
Staff experience drop in sessions			
Free tea and coffee and spoons in every kitchen			
Admin development programme			
Values and Behaviours frameworks			
Supporting the development of inclusive and compassionate leadership, outstanding teams, effective performance management and professional development.			
Introduction of career conversations			
Policy development reflective of a restorative just and learning culture			
Values and Behaviours frameworks			
CPD process and panel			
ECP Process and panel			
Admin development programme			
Leadership and management development programme			
Kaleidoscope Organisational development programme			
Revamp of the Senior Leadership Forum			
Taking a positive and proactive role in prioritising the health and wellbeing of staff and enabling flexible and agile working.			

Burnout response toolkit			
Wellbeing room			
Introduction of a saver meal in Toza's			
Free Yoga sessions for employees			
Ensuring continuity of work through a merger			
Align staff experience processes with merger partner where possible and ensure handover	Exec	01/09/2025	First meetings with potential merger partner colleagues May 2025

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – 15 May 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	1st May 2025	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 016**		
Assurance ratings used in the report are set out below:					
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	
The key discussion items including assurances received are highlighted to the Board below:					

Key headline The committee looked at all the People BAF Risk	**Assurance rating**
1. Discussion on current BAF Risks (6,7,8) • The Committee looked at all three BAF risks for this meeting. The meeting was themed around three areas of staff experience, EDI, and compliance; the papers received were grouped under these areas for discussion. • Each paper author was asked to provide a succinct summary of their paper and the key item(s) to be discussed. By grouping up the papers and summaries under three main topic headings, those present were able to focus on the most important themes, and to more fully ascertain whether the associated risks are being mitigated.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. New risk • As a result of the discussions held, a new risk was identified in relation to staff experience and engagement (or disengagement). This will be worked into a new BAF risk by the IDOCG and CPO.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. Other considerations • It was also discussed at the meeting that the actions log had become quite long, that a number of the actions had potentially become business as usual, and that a number of standing items potentially no longer required separate papers but could be captured either within other headings, or within the CPO report. • The CPO committed to reviewing the open actions, and making recommendations on:	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

1. Actions that could be closed as they have become business as usual 2. Actions that required a paper 3. Associating risks with each action / paper going forward to enable richer dialogue and better assurance	
4. Reflections • There was general consensus that the change in how the meeting was ordered had aided discussion and also created the opportunity to consider a new risk. • There was also acknowledgement that due to the number and length of papers, it would be helpful for the committee notetaker to advise attendees of associated page numbers when starting to discuss a new topic. • Our new staff governor observer was assured by the level of discussion and due consideration given to each topic and reflected that some of the information shared would be beneficial for more staff to hear about.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

A decision was made to consider theming the agenda in relation to the three summary areas going forward. The IDOCG will work with the Committee Chair and the CPO to do this.

Risks Identified by the Committee during the meeting:

A new risk was identified in relation to staff experience and engagement (or disengagement). This will be worked into a new BAF risk by the IDOCG and CPO.

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 at this stage; the new BAF risk will require Board approval in due course however.		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday 15th May 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	17th April 2025	Aruna Mehta, Non-Executive Director	Rod Booth, DSBD and Peter O'Neill, CFO	☒ **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	**Assurance rating**
Integrated Quality and Performance report: • The Committee commended the overall format and development of the report. • The Committee noted the positive work being done in Camden CAHMS. • Waiting times were noted as a concern, with the Committee monitoring the situation at future meetings	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Finance report: • Finance Report for M11 was presented to the Committee, with a verbal update relating to the M12 draft position being presented. I&E position was on plan as anticipated, with the final adjustments to the position not expected to change this position. It was noted this was subject to final confirmation via the external audit/final accounts process. • The cash position was noted as having improved in March 25, with cash support received as expected and further support not expected to be required until May.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
BAF Risks • The Committee noted the recent review of risk appetite at the Board Seminar. • BAF Risk 9 – It was noted the risk was updated to reflect the recent submission of the Financial Plan 2025/26. Therefore, requiring the Committee to maintain close oversight of the Trust's efficiency programme 2025/26 and related governance arrangements. • BAF Risk 11 – Income streams. The risk narrative to be updated to reflect the potential contract risks discussed at the Committee.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Financial Planning 2025/26 • Noted that that the final submission was a balanced plan. The committee did not discuss this in detail as it had previously been discussed and agreed by the Board.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Capital Program Update • The committee noted that the additional capital allocation had yet to be included in the draft capital program. • The clinical delivery group and ELT will further consider the program to agree additional schemes to reflect the additional capital allocation, and report back to the next committee.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Committee Effectiveness • The committee considered the effectiveness survey outcome. • The feedback from committee members was generally positive	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:

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
1. ETC to consider the benefits from the China visits that are yet to develop any quantified / income generating education and training opportunities.; and 2. Board to consider any ethical issues that might arise from doing business in China.	Action	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 May 2025			
Report Title: Finance Report – As at 31st March 2025 (Reporting Month 12)			**Agenda No. 018**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Jon Bell, Interim Chief Financial Officer
Appendices:	Appendix 1 - Finance Report 24/25 Month 12 – March 25		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 12 (cumulative position to the 31st March 2025) Finance Report. **Note:** This is a provisional report based on the expected outcome at the year-end 24/25. The final reported position being subject to the completion of the external audit and accounts process. **Income & Expenditure** The Trust was on plan at the year end with a net deficit of £2,197k, i.e. £3k ahead of plan This improved position reflects the benefit of the non-recurrent rates rebate received in January 25. The Trust was therefore 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. **Capital Expenditure** To capital spend at the year-end was £2,718k, in line with the revised plan for the year. As anticipated the expenditure caught up to the year end with an additional £100k in capital secured in M11 for the patient engagement portal adding to the previously reported year figure of £2,618k. **Cash** The cash balance at the end of M12 was £4,585k against the planned balance of £1,950k. This reflected the cash support received from NHSE of £2.2m and additional student fee income of £500k received earlier than expected. In addition, a few expected payments at the end of March weren't paid until early April.		
Background:	The Trust had 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 was £2,468k, an increase on the original target figure of £2,200k, which was broadly similar to that in 23/24. This has increased in year to £2,718k. The increase is due to the Trust sharing in the additional capital awarded to the ICS for delivering a balanced plan in 24/25, and several further in year allocations from NHSE. Initial planning was based on an expected allocation of c.£1,950k, thus a limited degree of replanning of the capital program will be required in the early part of 24/25 to reflect the additional available capital. **Cash** The agreed plan included a reduction in cash over the year to an outturn of £1,950k, which is driven by the deficit, non-cash income sources in the financial plan for 24/25 and the planned capital spend. This cash flow forecast in the 24/25 plan is reliant on cash support of £7,500k being agreed throughout the year by NHSE. The cash support comes into the Trust via a monthly application for additional non repayable PDC.
Key recommendation(s):	The Board is asked to: • **NOTE** the 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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☐	Compassion ☐	Respect ☐	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 9: Delivering Financial Sustainability Targets **BAF 11:** Suitable Income Streams				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	It is a requirement that the Trust submits an Annual Plan to the ICS and monitors and manages progress against it.				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications associated with this report.				

Equality, Diversity and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	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

Report Title: Finance Report 24/25 – At 31st March 25 (Reporting Month 12)

1. Overview

1.1 The table below shows a summary of the Trusts expected reported cumulative position against its agreed financial plan for the month ended 31st March 25.

Financial Reporting Summary - Month 12 2024/25

	Current Plan	Actual	Variance
£'000	**March 25**	**March 25**	**March 25**
	YTD	**YTD**	**YTD**
Income	**63,211**	**70,693**	**7,482**
Operating Expenditure	(64,911)	(72,540)	(7,629)
Non-Operating Expenditure	(500)	(350)	**150**
TOTAL Provider Surplus/(Deficit)	**(2,200)**	**(2,197)**	**3**

1.2 At the time of writing the Trust is in the early stages of the final accounts and external audit but is anticipating that the year-end deficit will be confirmed as £2,197k, as shown in the table above. This is ahead of plan by £3k. The improvement reflecting the receipt of a rates rebate received in January.

1.3 The income and operating expenditure variances at the year-end reflect the one-off funded employers pension contribution advised in March 25, and the use of rates income to offset the excess cost of pay awards in 24/25 and one-off redundancy and salary back date costs incurred throughout the year.

Recovery Plan

1.4 As a result of the previously expected increase in the forecast in year deficit, the Trust was asked by the ICB and NHSE as part of the SOF3 process to put a recovery plan in place to mitigate as far as possible the expected increase. This recovery work has continued to maintain progress towards savings required as part of the merger process and feeding into the efficiency requirement supporting the 25/26 financial plan.

2. Income

2.1 Income of £70,693k was ahead of the revised plan by £7,482k. The revised income plan only reflecting the additional funding secured for pay awards.

2.2 The positive variance reflects the additional funding received for the additional employer pension contributions paid in March 15, and the utilisation of the rates benefit to offset the excess costs of pay awards and

non-recurrent staffing costs. This was centrally funded and has no impact on the reported position of the Trust, essentially a funded pass-through cost.

3. Operating Costs

3.1 The adverse variance in M12 is the mirror of the income variance, reflecting those costs not included in the updated plan, the most significant being the one-off employer pension contribution of c£3.3m paid in March.

3.2 As previously reported the adverse variance in previous months was driven by the impact of the pay award and one-off expenditure items that were not part of the original plan. Taking these issues into account the underlying staff spend continued to be at expected levels.

3.3 Agency costs in the period, shown below in the attached appendix, were projected to be £1,179k, which is below the year end plan of £1,368k by £189k. Significant users of agency continue to be Finance maintaining flexibility in the structure ahead of the planned merger. Previously high use in GIC and Gloucester House now starting to reduce.

3.4 The individual divisional reports were being finalised at the time of writing but the actual month on month spend across the Trust remains stable, with monthly fluctuations being limited. In addition, the residual budget right sizing queries still being worked through in detail with individual departments, with an overall loss-making service plan being pulled together for inclusion in the 25/26 Trust Financial Plan.

4. Cash

4.1 The cash position at the end of M12 was £4,585k, against the plan of £1,950k for the period. This was boosted in month by the receipt of the NHS cash support of £2.2m and student income received earlier than anticipated of £500k. In addition, this was further increased in month as the payment of a limited number of significant creditors slipped into the early part of April.

5. Efficiency Target Delivery

5.1 The target for the year is £5,156k, being a mix of recurrent schemes of £2,500k plus non-recurrent balance sheet and income benefits of £2,656k.

5.2 Efficiencies of £5,156k delivered in the period are on plan, relating to the reduction in agency spend from the beginning of the year and other reductions relating to the identified management costs reductions. The agency spend is now below that expected in the period, and on target to achieve the targeted reduction in spend, with management posts released from budgets.

6. Balance Sheet

6.1 No movements of note to report at Month 12, beyond the increase in cash reported above.

Directorate	Cost Centre	Full Year £000'S
Corporate	Commercial Directorate	0
Corporate	Communications	70
Corporate	Estates and Property Management	109
Corporate	Finance	362
Corporate	Head of Nursing	100
Corporate	People Services	126
Corporate	Med Dir & Clin Gov Gen	0
Corporate	Trust Wide Management	0
Corporate	Trust Board	0
Corporate	Chief Executive	79
Corporate Total		**845**
CMH, C&I	Child & Family General	0
CMH, C&I	C&F SV Line Camden CAMHS(AW)	0
CMH, C&I	South Camden CAMHS	38
CMH, C&I	Gloucester House	102
CMH, C&I	Gloucester House Outreach	0
CMH, C&I	CI - Admin, Operations and Senior Leadership	0
Clinical Total		**140**
DET	Academic Governance and Quality Assurance(AGQA)	0
DET	Course Administration	0
Education and Training Total		**0**
Gender	G.I.C	157
Gender	Gender Identitiy	0
Gender Total		**157**
Trust Management	Junior Doctors	36
Trust Management Total		**36**
Grand Total		**1,179**

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 May 2025			
Report Title: NHS Provider Licence Self-Certification 2024/25			**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:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	This report provides the self-certification of compliance with the NHS provider licence for information.		
Background:	All Trusts are required to self-certify on an annual basis that they meet the obligations set out in the NHS Provider Licence. This includes requirements to comply with legislation and corporate governance standards. Compliance is also reported in the Trust's Annual Report with annual self-certification specifically on the following conditions: • G3 – Fit and Proper Persons • G5 – Systems for compliance • Continuity of Service condition 7 of the NHS provider licence • NHS1 – Available information • NHS2 – Governance arrangements It is for each Provider to determine the process for assessing their compliance. Although, NHSE had previously indicated that it no longer required returns to be provided, Boards are required to ensure they are meeting the specific requirements set out in the NHS provider licence.		
Assessment:	• Based on the evidence provided on pages 3 to 9 of the report, there is an adequate level of assurance of the Trust's compliance with the provider licence conditions. • Regular reviews of key aspects continue to be undertaken throughout the year to ensure ongoing compliance and improvement.		
Key recommendation(s):	The Board is asked to **NOTE** and: • receive **ASSURANCE** that the Trust is compliant with the NHS Provider Licence.		

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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	There is currently no risk of non-compliance.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Compliance with the NHS Provider licence remains an NHSE regulatory requirement.				
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:	Executive Leadership Team – 5 May 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: Self-declaration on Trust compliance with the NHS Provider Licence 2024/25

1. Background

1.1. NHS Foundation Trusts are required to self-certify annually whether they comply with the following conditions:

- G3 – Fit and Proper Persons
- G5 – Systems for compliance
- Continuity of Service condition 7 of the NHS provider licence
- NHS1 – Available information
- NHS2 – Governance arrangements Compliance against these conditions is set out below.

1.2. This report sets out the assurances to support each self-certification.

2. Self-certification of compliance with condition G3 Fit and Proper Persons

2.1. Requirement

The Trust is required to confirm that it meets the following requirements of G3 (Fit and Proper Persons as Governor and Directors):

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:

a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:

a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or

b. an organisation which is a body corporate, or a body corporate with a parent body corporate:

i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);

ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;

v. which passes any resolution for winding up;

vi. which becomes subject to an order of a Court for winding up; or

vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. *In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.*

2.2. G3 – Sources of assurance

Governors:

- All Governors submit a fit and proper persons declaration (declaration of eligibility) on election or appointment and must declare any change in circumstances that occurs during their tenure.

Board of Directors:

- Board Directors are subject to similar conditions, and additionally must meet the criteria of a fit and proper person under the NHS England Framework for Board Members.
- This framework is incorporated in the recruitment and selection process for all Board appointments and the Directors' appraisals process, including individual annual self-attestations approved by the Chair or Senior Independent Director and submitted to the NHS London Regional Director.

3. Self-certification of compliance with condition G5 Systems for compliance with licence conditions and related obligations

3.1. Requirement

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

a. the Conditions of this Licence,
b. any requirements imposed on it under the NHS Acts, and
c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

b. regular review of whether those processes and systems have been implemented and of their effectiveness.

3.2. G5 – Sources of Assurance

- A Board Assurance Framework (BAF) has been established and is kept updated, enabling the Trust to identify, evaluate and mitigate risks to the delivery of its strategic objectives, taking into consideration the Trust's risk appetite. The corporate risk register is in place and continues to be refined. Operational risk registers are in the process of development.
- Reviews of Standing Financial Instructions
- Annual Board Committee effectiveness reviews
- Annual Board Committee Terms of Reference reviews
- Committee Chairs Assurance reports to Board detailing risks and issues that required escalation
- Internal Auditors undertake risk-based internal audit reviews annually
- The Trust Board retains overall responsibility or detailed scrutiny of specific areas of the Trust's work including relevant risks, is provided by Board Committees.
- The Integrated Audit and Governance Committee (IAGC) assures the Board that probity and professional judgement is exercised in all financial and operational areas and scrutinises the output of all audits undertaken by the Trust's internal and external auditors, reporting any risks identified to the Board accordingly. It has an explicit role to assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework and of the processes for its implementation.
- Annual Head of Internal Audit Opinion included in the Trust's annual report.

4. Self-certification of compliance with NHS1: Information to update the register

4.1. Requirement

2. The Licensee shall make available to NHS England written and electronic copies of the following documents:

a. the current version of Licensee's constitution;

b. the Licensee's most recently published annual accounts and any report of the auditor on them, and

c. the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

4.2. NHS1 – Sources of Assurance

The following documents are available for viewing on the Trust's website and are submitted to NHS England as required:

- The Trust's Constitution
- The Trust's most recently published annual reports and accounts

5. Self-certification of compliance with NHS2 Governance Arrangements

5.1. Requirement

3. the Licensee shall:

- *a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time*
- *b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health*
- *c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and*
- *d. comply with the following paragraphs of this Condition.*

4. The Licensee shall establish and implement:

- *a. effective board and committee structures;*
- *b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and*
- *c. clear reporting lines and accountabilities throughout its organisation.*

5. The Licensee shall establish and effectively implement systems and/or processes:

- *a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;*
- *b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;*
- *c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;*
- *d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);*
- *e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;*
- *f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and*
- *h. to ensure compliance with all applicable legal requirements.*

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

5.2. NHS2 – Sources of Assurance

- The Trust's Constitution provides the Trust's corporate governance framework.
- The Trust also complies with the NHS Code of Governance for provider trusts.

- The Annual Report and Accounts includes an Annual Governance Statement and Accountability Report, which describes further the main arrangements in place to ensure that the Trust applies the principles, systems and standards of good governance.
- The Trust Board's governance structure provides scrutiny and assurance of all aspects of the Trust's performance.
- The Trust works within NHSE's Single Oversight Framework (SOF) and is working closely with NHSE to progress from its current SOF3 segmentation.
- The Trust Board retains overall responsibility or detailed scrutiny of specific areas of the Trust's work including relevant risks, is provided by Board Committees.
- The Board has an effective committee structure in place and each committee has reviewed its Terms of Reference within the past 12 months.
- The Board receives Committee Chair's Assurance Reports following each meeting. The Committees undertake annual effectiveness reviews.
- There is a clear senior leadership structure in place.
- The Integrated Audit and Governance Committee (IAGC) assures the Board that probity and professional judgement is exercised in all financial and operational areas and scrutinises the output of all audits undertaken by the Trust's internal and external auditors, reporting any risks identified to the Board accordingly. It has an explicit role to assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework and of the processes for its implementation.
- The Performance, Finance and Resources Committee (PFRC) is charged with ensuring that the Trust operates in an economic and efficient manner through the holding to account of Executive Directors and Divisional Leads for delivery against agreed income and expenditure positions and cost improvement programme (CIP) targets.
- The Quality and Safety Committee (QSC) assures the Board that the Trust's services are being delivered to the highest possible quality, and that there are plans in place to address any areas where improvement is required. The Committee also assures the Board that there are appropriate policies, processes and governance in place to continuously improve care quality, and to identify gaps and manage them accordingly
- The People and Organisation Development and Equality Diversity and Inclusion Committee (POD EDI) assures the Board on matters related to its staff, and the development thereof to the highest standards and that there are appropriate processes in place to identify any risks and issues and manage them accordingly. This Committee also provides assurance to the Board on the effectiveness of steps being taken to ensure that the Trust meets its statutory obligations around equality and diversity, and that all staff, students and service users are treated with dignity and respect regardless of their backgrounds or personal circumstances.
- The Trust Board reviews financial and operational performance at each meeting with a more detailed financial view being provided by the finance reports which the Board reviews as a standing item on agendas of its closed meetings.
- A Board Assurance Framework (BAF) has been established and is kept updated, enabling the Trust to identify, evaluate and mitigate risks to the delivery of its strategic objectives, taking into consideration the Trust's risk appetite. The corporate risk register is in place and continues to be refined. Operational risk registers are in the process of development.
- The Board reviews financial and operational performance at each meeting through a detailed Integrated Quality and Performance Report (IQPR). This ensures the Board maintains a 'grip' on financial performance and cost effectiveness.
- Where the Board identifies key risks and issues in relation to the Trust's use of resources, it will request investigation to provide a sufficient assurance.
- The PFRC has specific responsibility for financial policy, management and reporting, and in relation to investment policy, management and reporting.

- The oversight role of the Board and PFRC is supplemented by the annual internal audit programme which includes a comprehensive review of the Trust's financial systems and controls.
- The BAF is scrutinised by the Board of Directors quarterly and by the IAGC at every meeting. All the other Board Committees review the risks that are allocated to them at each of their meetings. Risks are also reviewed regularly by the Executive Leadership Team. Each risk listed within the BAF has a single executive lead to ensure accountability for risk management/mitigation.
- Compliance with legal requirements is monitored through the Board, its Committees and by the Interim Director of Corporate Governance.
- There is a clear structure of accountability and responsibility for leadership and delivery of quality with a quality improvement plan.
- The Board considers quality matters at each Trust Board meeting including through the developing integrated performance report.

In addition, the Trust:

- The Trust has rolled out the Radar incident and reporting and risk management tool to ensure compliance with the Patient Safety Incident Response Framework (PSIRF) in reporting on patient safety and learning
- Patient safety incidents are reviewed by the Quality team who escalate or take appropriate action as necessary.
- Serious incidents are investigated, and the findings used to inform learning and quality improvement.
- Patient / Staff / Stakeholder Experience - where patients or carers are invited to present to Board
- The Trust encourages direct patient feedback through multiple formal and informal mechanisms.
- The Board's Remuneration Committee reviews plans for senior succession. From January 2023 onward, the Board has been strengthened by the substantive appointments to the roles of Chief Nursing Officer, Chief Medical Officer, Director of Strategy and Business Development, Director of Corporate Governance and Chief Education and Training Officer.
- The Trust has a suite of leadership development training.
- The Trust is committed to ensuring that all staff abide by its values.
- The Trust has appropriate contractual and operational arrangements for the management of temporary staffing.

6. Self-certification with licence condition CoS7 – Availability of resources

6.1. Requirement

The Trust is required to confirm that it meets the following requirements of continuity of services licence condition 7:

"1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."
(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".
(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

6.2. CoS7 – Sources of assurance

- The Trust has agreed a breakeven plan for 2025/26 that requires efficiency savings of 6.4% of turnover to deliver. The Board of Directors is confident that this target is realistic with a strong focus on improved delivery of operational performance, growth in education and training income and the delivery of the cost improvement plans.

- The Board of Directors therefore has a reasonable expectation that the Trust will have the required resources available to it to provide commissioner requested services in 2025/26.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 15 May 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 020**
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 information.		
Background:	It is good corporate governance practice for the Board to agree a forward plan of its activities for the financial year. This was agreed by the Board in March 2025. The Schedule of Business is a 'live' document and may be amended by the Board during the year to align with business needs.		
Assessment:	There have been **no changes** to the Schedule of Business since the last Board meeting. In future reports, any changes to the Schedule of Business would be highlighted in the appendix as follows: • Agenda items – highlighted in red font. • Deferred papers – noted as 'D' under the relevant month of the meeting. • Discontinued paper – noted as 'X' under the relevant month of the meeting.		
Key recommendation(s):	The Board is asked to **NOTE** 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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
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 of Directors – 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

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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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

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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