Meeting Book - Board of Directors - OPEN - Thursday 10 July 2025

and/or the Trust Secretary in advance of the meeting

024 Questions from the Public

025 Reflections and Feedback from the meeting

026 DATE AND TIME OF NEXT MEETING: Thursday, 18 September 2025 at 2.00 – 5.00p.m.

The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 10th July 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, 10 JULY 2025 AT 2.00PM – 5.00PM
VENUE: LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

Living our values:

AGENDA

25/07/	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: Service User presentation on their experience of recent Complaint	Discussion	Clare Scott (Service User attending)	P (on the day)	2.05 (20)	
005	Minutes of the Previous Meeting held on 15 May 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 (15)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
009	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2025/26	Approval	Interim Director of Corporate Governance	E	3.00 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

010	Annual Self-Assessment of Board Committees' Effectiveness 2024/25	Information	Interim Director of Corporate Governance	E	3.10 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
011	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						
012	Quality and Safety (Q&S) Committee Assurance Report	Assurance	Q&S Committee Chair	E	3.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
013	Patient and Carer Race Equality Framework (PCREF) Update	Discussion	Chief Medical Officer	E	3.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
014	Learning from National Reviews: Nottingham review	Discussion	Chief Nursing Officer	E	3.45 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
015	Education and Training (E&T) Committee Assurance Report	Assurance	E&T Committee Chair	E	3.50 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
016	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	Approval	Chief People Officer	E	4.00 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
017	Equality, Diversity and Inclusion Annual Report 2025/26	Discussion	Chief People Officer	E	4.10 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
018	People, Organisational Development, Equality, Inclusion and Diversity (POD EDI) Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.20 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						

019	Performance, Finance and Resources (PFR) Committee Assurance Report	Assurance	PFR Committee Chair	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
020	Finance Report: • Month 1 • Finance Plan 2025/26	Information	Chief Finance Officer	E	4.30 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSING ITEMS						
021	Board Schedule of Business 2025/26	Information	Chair	E	4.40 (15)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
022	Questions from Governors	Discussion	Chair	V		
023	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		
024	Questions from the Public	Discussion	Chair	V		
025	Reflections and Feedback from the meeting	Discussion	Chair	V		
DATE AND TIME OF NEXT MEETING						
026	Thursday, 18 September 2025 at 2.00 – 5.00p.m.					

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 06/06/2025)

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	No perceived conflict
			Member IFR panel NCL Intergrated Care Board (3)	05/04/2020	Present	No perceived conflict
			Spouse is a journalist specialising in health and social care			No perceived conflict
			Nurse member, Liverpool Community health Independent Investigation, NHSE	08/05/2024	Present	No perceived conflict
			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
			Spouse elected Leader of Hertfordshire County Council	20/05/2025	Present	Potential conflict of interests as the Trust have contracts with HCC. As Leader, he is very unlikely to get involved in the detail of any contracts. Will withdraw from any business in relation to HCC discussed by the Tavistock and Portman.
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.

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid
PETER O'NEILL	Interim Chief Financial Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ROD BOOTH	Director of Strategy, Transformation & Business Development	26 June 2023	NIL RETURN			
JANE MEGGITT	Director of Communications & Engagement	24 April 2023	NIL RETURN			
DOROTHY OTITE	Director of Corporate Governance (Interim)	3 February 2025	NIL RETURN			
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 15TH MAY 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 and Safety Committee	CJ
Ken Batty	Non-Executive Director	KB
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality & Safety Committee	JJ
Aruna Mehta	Non-Executive Director and Chair of the Performance, Finance and Resources Committee	AM
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
Jonathan Bell	Interim Chief Finance Officer	JB
Sal Jarvis	Non-Executive Director & Chair of the Education & Training Committee	SJ
Chris Abbott	Chief Medical Officer	CA

Non-Voting

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

IN ATTENDANCE:

Kathy Elliott	Lead Governor (online)	KE
Chidinma Uwakaneme	Public Governor(online)	CU
Pauline Williams	Chair of the Race Equality Network, Staff Governor (online)	PW
Paru Jeram	Staff Governor (online)	PJ
Susie Lendrum	Staff Governor (online)	
Jo Stubley	Trauma Consultant	JS
Nina Dogmetchi	Trauma Psychotherapist	ND
Jasmina Brkic	Panel Member	JB
Annie Wigman	Panel Member	AW
Bev Chipp	Panel Member	BC
John Fielding	Executive Assistant Corporate Governance	JF
Asma Bi	Committee Secretary (Minute Taker)	AB

APOLOGIES:

David Levenson	Non-Executive Director & Chair of the Integrated Audit & Governance Committee	DL

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. JL welcomed Jonathan Bell (JB), who is new in post as Interim Chief Finance Officer.	
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	**SERVICE USER STORY: TRAUMA PANEL**	
	Nina Dogmetchi Trauma Psychotherapist, Jo Stubley Trauma Consultant and Trauma Panel Members Jasmina Brkic, Annie Wigman and Bev Chipp attended the Board. The key points highlighted were: • The panel consists of extraordinary expertise who are diverse with individual lived experiences which is vital to Trauma work. • Members felt that it was crucial for patients to make their own decisions about their treatment. • A variety of work is taking place including focus and research groups alongside engagement with Kaizen events. • It was emphasised that everyone should be Trauma Informed from the top down as people from all walks of life and backgrounds struggle to function in adult life having to carry the heavy weight of the Trauma they experienced. • The aim of Therapy is to support healthy interdependence. • Thoughts were shared around the lack of communication and how this could be improved, quite often Trauma patients are told to be silenced and have feelings of not being heard or listened to therefore communication barriers affect them greatly. • Estates related issue was highlighted as a concern. • There is a notable lack of support after discharge and patients often felt isolated. Groups such as The Next Chapter Group have made a difference. • Board Members were welcomed to attend the Trauma Panel. The Board valued the learning and thanked the team for their time and honesty. JL reiterated that the Chief Nursing Officer was available to provide support to the group. A clear Management Structure would be shared, and it was suggested that voicing recommendations to the Service User Experience Group could be helpful.	

The Board **DISCUSSED** and **NOTED** the Trauma Panel Service User Story.

005 MINUTES OF THE PREVIOUS MEETING HELD ON 15 MARCH 2025

DECISION: The Board **APPROVED** the minutes of the meeting held on 15 March 2025 as a true and accurate record.

006 MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW

The Board reviewed the action log. There were **2** actions not yet due and in progress.

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

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

- As reported previously it is an incredibly challenging time for the NHS. The 10-year Health Plan should be published by Summer 2025.
- The Trust has set clear Cost Improvement Plans to be delivered.
- On 1 April 2025 we confirmed plans to explore a merger by acquisition with North London NHS Foundation Trust (NLFT). Discussions are progressing and a Strategic Outline Case is being produced.
- The London Region Chief Nursing Officer, Karen Bonner, visited the Trust on 1st May 2025 and was very complimentary of our services.

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

008 INTEGRATED QUALITY AND PERFORMANCE REPORT INCLUDING UPDATE ON RISK AREAS

The Trust-wide IQPR reported on Month 11 was shared and Statistical Process Control Charts (SPCs) will be in place by May 2025.

Targeted Support GIC: In this period there was a decrease in activity due to staff Annual Leave and targeted support has been put in place. The move to a national waiting list has been delayed and KB referred to the large number of patients on the waiting list. CS advised the waiting list had been reviewed by GIC service users and there are clear policies and protocols in place.

Autism Waiting List & RTT Progress: The average waiting time in Haringey had reduced to 40 weeks. Hertfordshire waiting times remain at 3 years, although negotiations continue with commissioners regarding 2025/26 funding for waiting list reductions.

Contracts: Surrey Mindworks Team have been served notice, with the team continuing to work within the Alliance for 6 months on the non-recurrent back log.

Patient Carer Race Equality Framework: Data continues to be validated and to ensure accurate recording at the point of referral. The Medical Director will complete an Audit around equality of access.

SP highlighted thoughts about sharing learning from reduced waiting lists and improving digital functions such as IT and the use of AI. CA shared the Trust could potentially utilise ERF funding as discussed to improve the pathway.

CJ queried if the reduced productivity and inefficient multidisciplinary processes were interlinked and queried if we are seeing any progress. CS noted several actions in terms of waiting list management:

- Progress in numbers of new referrals and the learning on national reviews has been implemented.
- There is a lot of work underway on the waiting list review and how to manage this effectively.
- Cultural issues are being managed with teams.
- The Chief Medical Officer and Director of Transformation have met with NHS England to review the data.
- A Quality Improvement Lead has been recruited for the GIC Service to support integration across the team and sharing learning and good practice. The post is currently funded by NHS England and will move over to local commissioning to sit within targeted support.
- The increase in violence and aggression incidents reflected greater transparency in reporting as more staff were reporting incidents than before.

JL reflected on patients who suffered extreme Trauma and how it was dealt with. CS shared that all new referrals would be recorded, and we would write back to the GP which could support funding for this patient group. All those accepted referrals would be seen as promised.

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

009 BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTER (CRR) 2025/26

DO had taken the paper as read and highlighted that a robust process is in place for reviewing risks. 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.

During today's Board Development session members conducted a "Clean Slate" exercise to enable the Board to validate the existing BAF risks and identify any new or emerging risks. A report of the outcome of this exercise will be presented to the relevant Board Committees in the June/ July cycle of meetings and to the Board of Directors.

CJ and JL noted it was helpful to see the summary of discussions at each of the Board Committees and queried when the Board would receive a complete CRR. DO advised the CRR is progressing well, noting further work is required with Operational teams to strengthen the CRR. An updated report would be presented to Board in July 2025.
JL acknowledged the work done by Committees in owning the BAF risks within their remit and requested members to share any comments with DO.

The Board **DISCUSSED** and **NOTED** the Oversight of Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

010 INTEGRATED AUDIT AND GOVERNANCE COMMITTEE ASSURANCE REPORT

SJ had taken the report as read and highlighted:

- 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.
- The Committee was considerably reassured against the progress of External Audit.
- The Committee received a progress update which concluded the 2024/25 internal 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. The CEO informed the Committee that the Executive Directors are being required to carry out a review of controls of key processes within their portfolio.
- The Committee expressed reservations about the Level 3 Internal Audit opinion due to the improvements around governance and risk management over the past year. RSM agreed to reconsider the wording of the opinion in these respects, but that they were unable to revisit the overall rating.

The Board **RECEIVED** and **NOTED** the assurance report from the Integrated Audit and Governance Committee.

011 QUALITY AND SAFETY REPORT

CS shared the report and highlighted:

- Appendix 1 showed an example of the learning poster overview for a Patient Safety Review which was visually effective.
- Complaints: All overdue complaints have been addressed with high quality investigations and compassion. Challenges remain with timely responses with only 23% of complaints completed within the agreed timeframe. A Quality Improvement work stream will address various issues including improving the efficiency of complaints resolution.

JL asked why the team struggled to meet the timeframe and CS reported that the complaints are complex and the focus remains on quality investigations to include key learning. The clock is started from the point when the complaint is received, and investigations are time-consuming. There is also an element of capacity constraints and developing ownership in some areas of the trust. Further training has been offered on complaints investigations.

The Board acknowledged the progress made in terms of a positive change in reporting.

The Board **RECEIVED** and **NOTED** the Quality and Safety Report.

012 QUALITY AND SAFETY COMMITTEE ASSURANCE REPORT

CJ shared the report and highlighted:

- The Committee reviewed the draft Quality Priorities for 2025/26 which had been updated following feedback received from both events. The Committee approved the quality priorities for inclusion in the Trust's Quality Account.
- 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 nationally following an expose in the news. Eleven recommendations were identified in the Trust's review; these will be subsumed into the overarching action plan.
- The Committee received the Internal Audit Complaints Data Quality report and noted work is underway to action the recommendations.
- Overall, the Annual Committee Effectiveness Review Outcome 2024/25 was positive with steady improvements and maturity of the Committee noted.

The Board **RECEIVED** and **NOTED** the assurance report from the Quality and Safety Committee.

013 EDUCATION AND TRAINING (E&T) COMMITTEE ASSURANCE REPORT

SJ shared the report and highlighted:

- 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. This is primarily in response to our desire to retain our OfS registration.
- 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.
- DET plan to launch a Strategy Consultation in mid-June 2025 to be followed with two further meetings for staff to refine and document the strategy.
- Commenced advertising for our new substantive Lecturer and Senior Lecturer positions to replace roles previously held by visiting lecturers which would support post-holders to be more accountable and better supported in their roles.

Members queried the reduction in home student applications and SJ shared that targeted marketing is required in potential growth areas. JJ advised the factor of a new government in post and the current uncertainty around funding is impacting on progress.

The Board **RECEIVED** and **NOTED** the Assurance report from the Education and Training Committee.

014 DET EQUALITY, DIVERSITY AND INCLUSION (EDI) FOCUS

MF had taken the report as read and highlighted:

- There were significant concerns around harassment and bullying of some disabled staff within DET, which requires further consideration in the Staff Experience Programme Board.
- For staff there are signs of some deterioration in the way that disabled staff are feeling and that reasonable adjustments are being made for them to carry out their work.
- The accessibility of the estate is a key focus of the Student Experience Group, chaired by the CETO, as is the upskilling of lecturers to identify and respond to 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.
- SJ emphasised the lack of response in addressing reasonable adjustments could have severe impact on a students' health and well-being, referring to a previous case.

The Board agreed these issues should be escalated to Estates through the Performance, Finance and Resources Committee. It was also suggested a representative from DET should attend the EDI Programme Board.

015 STAFF SURVEY RESULTS AND ACTION PLAN 2024

GD presented the report and highlighted the following:

- The Trust improved in seven of the nine people promise areas and are above the bottom of the benchmark in eight of the nine areas.
- There is a direct improvement in staff engagement aligning with the Trust's new vision and values work.
- The EDI Team were commended for their support in facilitating this.
- The initial action 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.
- A Staff Experience Programme Board had been established, 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.

The Board **RECEIVED** and **NOTED** the Staff Survey Results and Action Plan.

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

SS presented the report and highlighted:

- The Committee undertook a new approach and themed the meeting around three areas of staff experience, EDI, and compliance; the papers received were grouped under these areas for discussion.
- As a result of the discussions held, a new risk was identified in relation to staff engagement/ disengagement. This will be worked into a new BAF risk by the IDOCG and CPO.

The Board **RECEIVED** and **NOTED** the Assurance report from the People, Organisational Development, Equality, Diversity and Inclusion Committee.

017 PERFORMANCE, FINANCE AND RESOURCES COMMITTEE ASSURANCE REPORT

AM presented the report and highlighted:

- Finance Report for M11 was presented to the Committee, with a verbal update relating to the M12 draft position being presented. The cash position was noted as having improved in March 2025, with cash support received as expected and further support not expected to be required until May.
- The Committee noted the positive work being done in Camden CAMHS.
- The Clinical Delivery Group and ELT will further consider the Capital Programme to agree additional schemes to reflect the additional capital allocation, and report back to the next Committee.
- The Committee suggested consideration of the benefits and any ethical issues that may arise from doing business in China. The Board agreed to discuss this item at a future Development Session.

The Board **RECEIVED** and **NOTED** the Assurance report from the Performance, Finance and Resources Committee.

018 FINANCE REPORT: MONTH 12 AND FINANCE PLAN 2025/26

JB presented the report for Month 12 and highlighted:

- The Trust achieved its 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 during the year.
- The CIP plan for 2025/26 represented a significant financial risk, and work continues to deliver this at the weekly Executive led Efficiency Oversight Group.

The Board felt assured on the controls in place and requested JB to share the assurance process on the Equality Impact Assessment processes.

JB

<u>Action</u>: JB to share the assurance process on Equality Impact Assessments.

019 NHS PROVIDER LICENCE SELF-CERTIFICATION 2024/25

The Board **RECEIVED** and **NOTED** the NHS Provider Licence Self-Certification 2024/25 for information.

020 ANNUAL SCHEDULE OF BUSINESS 2025/26

The Board **NOTED** the schedule of business for 2025/26.

021 QUESTIONS FROM THE GOVERNORS

There were no questions from the Governors raised.

022	**ANY OTHER BUSINESS**
	There were no items of other business raised.
023	**QUESTIONS FROM THE PUBLIC**
	There were no questions from the public raised.
024	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	Members were pleased with the open and transparent discussions. The Trauma Panel attendance and presence gave thought to barriers in communication and the Board agreed there is room for improvements. Members adequately challenged where needed and valued the open conversation in terms of the future.

The Chair closed the meeting at 5.00 p.m.

Date of Next Meeting in Public: Thursday, 10 July 2025 at 2.00 – 5.00p.m.

Signature _____ Date _____

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

Actions are RAG rates as follows: ->				Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.07.23	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	15/05/25: The Head of People will share training dates with the Non-Executive Directors. 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.
13.03.25	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.	15.05.25	Mark Freestone, Chief Education and Training Officer (NED Lead for FTSU)	In progress	15/05/25: The Staff Experience Group was well attended and there were good discussions around FTSU. Programme Board has been established. 14/04/25: 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.
15.05.25	18	Finance Report: Month 12 and Financial Plan 2025/26	JB to share the assurance process on Equality Impact Assessment.	10.07.25	Jonathan Bell, Interim Chief Finance Officer	In progress	25/06/25: Verbal update to be provided at Board.

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 10 July 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 15 May 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

I am pleased to announce that we held our Values in Practice (ViP) awards on 26 June to recognise and thank our staff for their dedication, hard work, impact and dedication to our patients, students and colleagues. Staff and teams across the Trust came together to celebrate our Values in Practice (ViP) award winners, at a ceremony held in the Everyman cinema, Hampstead with nominated staff, their friends and family, Governors and the Board of Directors joining us in-person and colleagues attending online. Congratulations to all our ViP winners.

While on reporting of recognition, NHS London's Regional Director, Caroline Clarke, has been recognised in this year's King's Birthday Honours list. Named a Dame Commander of the Order of the British Empire (DBE), Caroline was previously Deputy Chief Executive and then Group Chief Executive at the Royal Free London NHS Foundation Trust. Congratulations to Caroline on this recognition of her contribution to the NHS.

2. Merger update

Following the recent Board discussions, we are now progressing with the due diligence for the proposed merger with North London NHS Foundation Trust (NLFT) due to take effect on 1 April 2026, subject to NHS England and Secretary of State for Health and Social Care approvals. The strategic case was submitted last month. Executive Directors have been interviewed by the transaction team, and we are awaiting the outcome of the rating of the strategic case to move forward to develop the full business case. We believe there will be significant benefits for local people and for both Trusts. We will continue to keep the Board, Council of Governors and our wider stakeholders updated as we progress.

Providing outstanding patient care

3. Patient Portal

Patients at our Gender Identity Clinic (GIC) can now receive appointment notifications and reminders through our patient portal. This will help reduce missed appointments and improve communication, making it easier for patients to stay informed and engaged in their care. The patient portal is a key step in modernising our services. It will help patients take more control of their care, reduce the risk of missed appointments, and help us manage waiting lists more effectively by improving communication and reducing delays.

4. Gender Identity Clinic (GIC)

A Quality Improvement Practitioner seconded from NHSE has now started within the GIC. They will be integrated into the Trust's GIC but also form part of a national quality improvement team led by NHSE. The aim of this approach is to share learning across the network and move towards a uniformed approach to care across all GICs, eliminating unwarranted variation. The first national event as part of this quality improvement work is being held on 2nd July. The priority for this day will to be focus on screening and triage of new referrals.

5. CAMHS Provider Collaborative

A new Community Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative is being developed to improve how services work across North Central London. The collaborative involves four NHS trusts – including the Tavistock and Portman – and aims to simplify access, reduce inefficiencies, and improve outcomes by strengthening collaboration.

The collaborative currently in its shadow form is scheduled to become fully operational from 1 April 2026, subject to final approval by the NCL Integrated Care Board (ICB) in September 2025. We are excited about the potential of this new way of working and the positive impact it will have on the young people and families who rely on these vital services.

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

6. Strategy Away Day

The Department of Education and Training (DET) held a strategy away day in June, which brought together over 100 of our DET staff together with the Chair of the Education and Training Committee (Board Committee) and a lead from the Clinical Directorate. The event was focused around producing a medium-to-long term strategy for the Education and Training department focusing on key areas, including developing our international offering; engagement with the local community; population health; and commercial sustainability.

7. Student Survey

The results of our 2025 student survey have been published and paint a positive picture of our Education and Training work, showing a notable improvement on last year's results. This year saw a 29% response rate (359 responses), up from 25% (312 responses) in 24/25 and against a sector average of 13%, and an increase in overall student satisfaction from 79% in 24/25 to 81%, against a sector average of 77%. Learning and Teaching, Library Resources and Research all showed satisfaction rates of >80%, with Community and Culture (58%) and Research Culture (46%) remaining as work areas identified in previous years. 97% of our students said their courses were 'intellectually stimulating' which I was delighted to see.

8. Student Recruitment

Student applications to our long courses are showing some volatility but at the time of writing were showing a positive trend with an increase of 1% in applications over 2024/25 despite HE sector-wide contraction, including a raised proportion of overseas applications. Because of the earlier opening of admissions, we also have a sustained base of offers and accepted offers (increased 166% vs this time in 2024/25) with several deferrals also potentially reckonable into the numbers, and an increase in overseas applications. This points to a strong performance in terms of long-course student enrolments, with courses closing to applications at the end of July.

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

9. Improving Camden

On 22 May 2025, 'We Make Camden' summit was held by the local authority to look at how to collectively tackle some of the most pressing issues facing the borough. The summit was an

opportunity for organisations, community groups and individuals to come together to look at how collectively we can make a difference in the lives of Camden residents, delve into the challenges we still need to overcome and explore where we can commit to more action. It is recognised that the Tavistock and Portman is committed to being a strong partner in Camden. The focus was on exploring big areas where collective action can shift the dial, including responding to the climate crisis, tackling child poverty and creating inclusive internship and apprenticeship opportunities.

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

10. Industrial Action

The British Medical Association (BMA) has announced that it will ballot its resident doctor members for strike action over pay. The BMA's UK Resident Doctors Committee has voted to re-enter dispute over the lack of an acceptable and timely pay offer from the Doctors' and Dentists' Pay Review Body for 2025/26. The ballot will open on 27 May and close on 7 July 2025. While the impact on the Trust of strike action is minimal, there is a significant impact on the NHS as a whole and we will continue to monitor the situation.

11. Pride Month and Refugee Week

June is pride month, and the Trust marked this with a series of events including a Pride Picnic in the Portman Garden on 11 June that was attended by staff from across the Trust, including the Executive Directors. The LGBT+ Staff Network were invited to join UCLH colleagues on a ‘Queer Walk’ through London celebrating the LGBT+ history of the city.

Refugee Week also took place in June, and we partnered with the University of Essex Centre for Trauma, Asylum, and Refugees (CTAR) to host an open conference on the topic of refugee care and the power of community.

Regional and National Context

12. NHS ConfedExpo 2025 conference

I attended the NHS ConfedExpo conference on 11 - 12 June. The event highlighted major themes shaping the future of the health and care system. A clear strategic direction was set around moving from:

1. Hospital-based to community-led care
2. Analogue to digitally enabled systems
3. Sickness treatment to prevention and population health

- Innovation and Reform: A strong call was made for bolder, system-wide innovation—moving beyond pilot projects to scalable, sustainable transformation rooted in community engagement and local leadership.
- Funding and Infrastructure: The government announced a £29bn annual increase in NHS funding by 2028/29. However, flat capital funding poses risks to estates and digital infrastructure ambitions, prompting exploration of alternative financing models.
- Leadership and Accountability: Key national leaders emphasised the need for clearer governance, devolved decision-making, and greater autonomy for high-performing systems. There was a strong focus on embedding patient voice and improving public trust.

- Public Confidence: With public satisfaction at a 17-year low, leaders acknowledged the urgency of reform to protect the NHS's long-term legitimacy and sustainability.

13. NHS Oversight Framework

The NHS Oversight framework is a key regulatory mechanism developed to ensure delivery, accountability, and improvement across Integrated Care Boards and providers. NHSE published the framework on 26th June 2025. The framework introduces tighter financial oversight with an override to prevent deficit organisations achieving higher ratings. We expect to hear our segmentation rating at the beginning of July.

14. NHS Very Senior Managers Pay Award for 2025/26

The new NHS VSM Pay Framework was published on 15 May 2025. As set out in the new framework, VSMs who work in an organisation designated segment 5 under the new NHS Oversight Framework, will not be eligible for this annual pay award, unless they meet the requirements of an exemption.

Our Remuneration Committee will need to consider carefully the appropriate time to implement VSM pay awards and arrears, as the pay uplift will only be applied after the Trust's segmentation is known.

15. Cavendish Square Group (CSG) Digital Conference

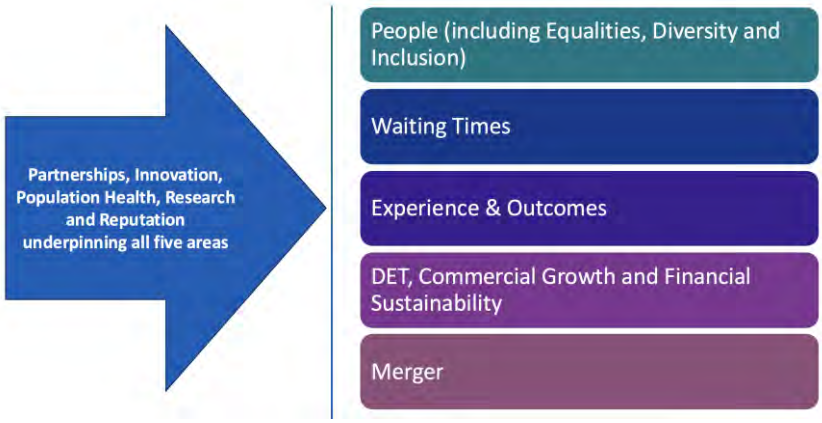
I attended the CSG Digital Conference where the theme of analogue to digital for Mental Health in London was explored. Trusts presented some of their work and workshops were held to help think through how to tackle some of the common challenges that are faced in digital implementation.

The outcome of the conference will be circulated to Trusts in the next few weeks with next steps and priority work areas for collaboration and delivery across London.

16. Chief Executive's meetings with external stakeholders

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

- CICE Neighbourhood workshop;
- Cavendish Square Group of London NHS Mental Health Providers' CEOs;
- Cavendish Square Group Digital Conference;
- 'We Make Camden' Summit 2025;
- NCL ICB System Management Board (SMB);
- NCL Borough Partnership Meeting;
- UCL Health Alliance Execution Group;
- NHS Confederation Conference; and
- NHS England London CEOs Awayday with the London Regional Director.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 10 July 2025			
Report Title: Integrated Quality Performance Report M01			**Agenda No.: 008**
Report Author and Job Title:	Rachel James, Director of Therapies Sheva Habel, Medical Director Hector Bayayi, Managing Director	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer Chris Abbott, Chief Medical Officer Rod Booth, Director of Strategy and Business Development
Appendices:	Appendix 1: IQPR May 2025		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	The Trust Integrated Quality and Performance Report (IQPR) for April 2025 (Month 01) 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 end of June 2025. All but 5 of the SPC charts have been digitised and the project team aim to complete these additional requests by mid-July 2025. This report should be used in conjunction with accompanying slides and respective committee reports.		
Background:	Month 01 was considered in the Trust-wide IQPR meeting on 3 June 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: 		
Assessment:	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.		

Operational Performance

Waiting Times

Two teams, the Gender Identity Clinic and the Trauma Service, continue to be monitored under the Trust's targeted support framework. The focus remains on reducing waiting lists, improving productivity, and enhancing the patient experience. NHSE confirmed the Quality Improvement resource for GIC, commencing with the service, attending the IQPR meeting for the GIC section. The priority areas under targeted support will be reviewed along with the NHSE quality improvement to ensure they are integrated.

Appointment Capacity Shortfall

In April 2025, clinical teams delivered 326 appointments, significantly fewer than the 697 referrals received during the same period. This highlights a substantial capacity gap. However, these figures do not yet reflect the actual number of appointments each team can deliver per reporting period, an essential indicator for assessing progress against the plan.
Ongoing workstreams, including job planning, demand and capacity modelling, pathway management, and PTL digitisation, are expected to provide a more comprehensive understanding. These initiatives aim to address the current variation and complexity, which cannot be fully captured until this foundational work is completed.
This mismatch between referral demand and appointment capacity has led to increased pressure on waiting lists, with the number of patients awaiting a first appointment nearing the upper control threshold of 18,500. These trends underscore the urgency of accelerating the implementation of agreed process controls to manage demand more effectively and improve patient flow.

Priority Actions Identified

- **Referral-to-Treatment (RTT) Clock Stop/Start Logic**:
  A request definition workshop is scheduled for this week to finalise the logic being developed by the IT team for 18-week and 4-week RTT pathways.
- **Enhancement of the Digital Patient Tracking List (PTL)**:
  Upgrades will incorporate clinician input and allow for timely escalation of outstanding actions. *(Target: July 2025)*
- **Implementation of a Centralised Booking System for Trauma Services**:
  (Target: Mid-July 2025)
- **Completion of Pathway Mapping**:
  Includes indicative timelines for each intervention to support operational planning and efficiency. *(Completion: End of July 2025; Implementation: Mid-October 2025)*
- **Acceleration of Workforce and Recruitment Plans**:
  To address ongoing capacity challenges and support sustained service delivery. As part of the annual planning and efficiency work, each unit is expected to have a ratified workforce plan by **mid-July 2025**.

Fragile Clinical Services Review

The Trust Managing Director and Medical Director are leading on a review of fragile services to:

- Develop actionable plans in response to current commissioning concerns
- Build capacity in areas facing workforce and service delivery pressures
- Strengthen alignment with commissioning intentions

The income and expenditure for each clinical service has been mapped and this will be triangulated with the demand and capacity for all services as part of the fragile services review. A series of workshops and delivery plans will be put in place, in collaboration with commissioners and internal stakeholders, particularly for services jointly commissioned with local authorities, to ensure long-term sustainability.

Quality and Safety

Experience and Outcomes

- **Patient Feedback:** Clinical Services reported 86% of ESQ positive responses in April 2025. Communication is a commonly reported cause of dissatisfaction; positives include themes linked to Trust values. The number of forms collected across the Trust continues to be low (n = 57). There is targeted support being offered to teams where no forms are collected. The trust received 3 compliments reported via Radar, one for Camden Unit and 2 for the Adult Unit.
- **Complaints:** A total of 11 complaint contacts were received Trust-wide in April, 8 for the Adult Unit and 3 for Camden Unit. All complaints acknowledged within 3 working days. Trust wide compliance for formal complaints responded to within 40 working days for April is 50%. No complaints were responded to informally in April 2025.
- **Clinical Outcome Measures:** The Trust launched the new NHSE waiting time metrics on 1st April 2025. The data indicates a reduction in OM completed this month, due to a significant drive to complete baseline OM's for open cases in March. There was also a reduction in the use of the "Current View" form which is to be replaced as it is no longer recognized by MHSDS as an outcome measure.
- **Patient and Carer Race Equality Framework (PCREF):** This month's PCREF focus is on the work undertaken in the Camden Wellbeing service to improve accessibility.
- **Incidents:** A total of 14 patient safety incidents were reported in April Trust-wide. Of these, six deaths were recorded, and mortality reviews have been requested on those seen by the GIC.
- **After Action Reviews:** This month 2 AAR's have been initiated. There are 5 outstanding AAR's being monitored by the AAR tracker. Findings and key learning points from all responses will be discussed at the Clinical Incident and Safety Group (CISG).

People:

	• **Appraisal** completion remains low at 50.7%. • The Trust completion for mandatory and statutory training (MAST) is 79.6%, under the Trust target of 90%. • **Staff sickness** was reported at 2.95%. The data reveals that mental health issues, specifically anxiety, stress, and depression are the leading cause of absence across both White and BME ethnic groups. **Finance:** • The Trust is £88k behind its CRES plan at M1, with a recorded deficit of £592k, and the unfunded element of the pay award remains a recurrent issue for 25/26. The Trust has agreed a balanced revenue plan for 25/26, supported by the need to generate efficiency savings of £3.9m. Work is ongoing to generate and deliver plans to achieve this as part of the management of the 25/26 financial position. <u>Contracts By Exception</u> • ***ASD/LD Team:*** the Trust has received a non-recurrent uplift of £227,213 from Hertfordshire ICB to deliver an additional 90 autism assessments to be delivered by the end of quarter 3, as part of the waiting times management investment. The team will work towards recruiting or retaining existing staff at pace to ensure that we meet delivery targets. • ***PCPCS:*** closed on 31st March 2025, with a programme of staff support and redeployment. All but 3 staff have been redeployed. Of the 3 one is anticipated to be redeployed before the end of June 2025. We are waiting for the remaining staff to serve their notice period before we calculate the cumulative redundancy costs. This will be shared with the committees end of July 2025. • ***First Step Haringey:*** closed on 31st March 2025. All staff have been redeployed into First Step Plus - working to a newly agreed service specification. • ***Surrey Mindworks Team:*** notice served by the Lead Provider, Surrey and Borders NHS Partnership Foundation Trust and are to close on 30th September 2025. The service programme closure work has started and a new delivery plan has been agreed for the Team with priorities set through to end September 2025.
Key recommendation(s):	The Board is asked to **REVIEW** the contents for approval, information and assurance.

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

	provider of training & education	research in this area			
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 June 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 May 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

Tavistock and Portman
Our Values and Strategy

The Tavistock and Portman
NHS Foundation Trust

Our 25/26 Objectives are in review and will be updated in due course.

Excellence Inclusivity Compassion Respect

Executive Summary (1/3)

The Tavistock and Portman NHS Foundation Trust

Operational and Service Updates

Core CAMHS Programme Leadership: The Trust were nominated to lead the **Core CAMHS Workshops and Business Case development** on behalf of the **NCL Provider partners.** These workshops will run between **May 2025 to the end of July 2025,** culminating in an integration piece with the other elements of the CYP pathway (Crisis, Neurodevelopmental Disorders (NDD) and the CAMHS single point of Access (Front Door) The work will include, Digital Innovation, Pathway Alignment, Clinical Outcome Measures and agreement on a shared Data Definition Dictionary. The workshops' ambitions are to improve access and reduce variation in the clinical CAMHS offer, ensure alignment to a shared data definition dictionary and outcome measures, improve the pathway aligned to iThrive principles to ensure a cohesive delivery approach across NCL. The **business case** is due **Mid-August 2025**.

ASD/LD: the Trust has received a non-recurrent uplift of **£227,213** from **Hertfordshire ICB** to deliver an additional **90 autism assessments** to be delivered by the **end of quarter 3**, as part of the waiting times management investment. The team will work towards recruiting or retaining existing staff at pace to ensure that we meet the delivery targets.

First Step : First Step **closed** on **31 March 2025.** The outstanding action is the data transfer process which has been challenging to deliver, as we have reached impasse with Haringey Council regarding delivery of their **Data Protection Equality Impact Assessment** and the **Data transfer agreement**. An option appraisal paper will be presented to **ELT early June 2025**. All staff have been redeployed into **First Step Plus** - working to a newly agreed service specification. Some key delivery elements are yet to be agreed; however, the funding remains vulnerable as the service are subject to **ICB review in Quarter 3** with view to making further commissioning decisions preceding the next financial year.

Surrey Mindworks: Has been given notice by the Lead Provider, Surrey Boarders and Partners Foundation Trust and are to **close 30 September 2025**. The Trust was able to retain half the income to deliver an **abridged offer and handover** to system partners in Surrey for the remainder of the contract. The **service programme closure** work has started alongside redrawing of the offer. This adds some complexity as the team are enacting a closure process whilst trying to deliver a revised offer to stakeholders with hard stops against delivery targets. The **income remains vulnerable** as commissioners have proposed a reduction based on whether staff have left the service, which would make the targets difficult to deliver. The team are currently **completing a risk analysis** to inform decisions.

Waiting Times

Two teams, the Gender Identity Clinic and the Trauma Service, continue to be monitored under the Trust's targeted support framework. The focus remains on reducing waiting lists, improving productivity, and enhancing the patient experience. NHSE confirmed the Quality Improvement resource for GIC, commencing with the service, attending the IQPR meeting for the GIC section. The priority areas under targeted support will be reviewed along with the NHSE quality improvement to ensure they are integrated.

Appointment Capacity Shortfall

In April 2025, clinical teams delivered 326 appointments, significantly fewer than the 697 referrals received during the same period. This highlights a substantial capacity gap. However, these figures do not yet reflect the actual number of appointments each team can deliver per reporting period, an essential indicator for assessing progress against the plan.

Ongoing workstreams, including job planning, demand and capacity modelling, pathway management, and PTL digitisation, are expected to provide a more comprehensive understanding. These initiatives aim to address the current variation and complexity, which cannot be fully captured until this foundational work is completed.

This mismatch between referral demand and appointment capacity has led to increased pressure on waiting lists, with the number of patients awaiting a first appointment nearing the upper control threshold of 18,500. These trends underscore the urgency of accelerating the implementation of agreed process controls to manage demand more effectively and improve patient flow.

Executive Summary (2/3)

The Tavistock and Portman NHS Foundation Trust

Priority Actions Identified

•Referral-to-Treatment (RTT) Clock Stop/Start Logic:
A request definition workshop is scheduled for this week to finalise the logic being developed by the IT team for 18-week and 4-week RTT pathways.

•Enhancement of the Digital Patient Tracking List (PTL):
Upgrades will incorporate clinician input and allow for timely escalation of outstanding actions.
(Target: July 2025)

•Implementation of a Centralised Booking System for Trauma Services:
(Target: Mid-July 2025)

•Completion of Pathway Mapping:
Includes indicative timelines for each intervention to support operational planning and efficiency.
(Completion: End of July 2025; Implementation: Mid-October 2025)

Acceleration of Workforce and Recruitment Plans:

- To address ongoing capacity challenges and support sustained service delivery. As part of the annual planning and efficiency work, each unit is expected to have a ratified workforce plan by **mid-July 2025**.

Fragile Clinical Services Review:

- The Trust Managing Director and Medical Director are leading on a review of fragile services to:
- Develop actionable plans in response to current commissioning concerns
- Build capacity in areas facing workforce and service delivery pressures
- Strengthen alignment with commissioning intentions

The income and expenditure for each clinical service has been mapped and this will be triangulated with the demand and capacity for all services as part of the fragile services review. A series of workshops and delivery plans will be put in place, in collaboration with commissioners and internal stakeholders, particularly for services jointly commissioned with local authorities, to ensure long-term sustainability

Workforce:

- The Operations team is working with the People team to agree flexible working principles, following an increase in out-of-process requests to reduce clinical hours. These requests are impacting critical staffing levels, service continuity, and the management of waiting times within teams. The agreed principles and processes aim to:
- Improve timely access for patients;
- Support continuity of care;
- Prevent the proliferation of numerous hard-to-recruit part-time roles.

Affected teams will incorporate **demand and capacity modelling** into their **Annual Business Plans** to develop local approaches that support flexible working without compromising the quality, safety, or continuity of care delivery.

People:

Appraisal completion remains low and stands at **50.7%.** Seven out of eight directorates do not currently hold a high standard.
The Trust completion for mandatory and statutory training (MAST) is **79.6%**, under the **Trust target of 90%.**
Staff sickness is at **2.95%.** The data reveals that mental health issues—specifically anxiety, stress, and depression are the leading cause of absence across both White and BME ethnic groups.

Finance:

The Trust is **£88k behind** its **CRES** plan at **M1**, with a recorded **deficit of £592k**. However, the **unfunded element** of the **pay award** remains a recurrent issue for 25/26.
The Trust has agreed a balanced revenue plan for **25/26**, supported by the need to generate efficiency savings of **£3.9m**. Work is ongoing with colleagues to generate and deliver plans to achieve this as part of the management of the 25/26 financial position. Further workshops are planned in the next 2 weeks to finalise the plans and support staff.

Executive Summary (3/3)

The Tavistock and Portman NHS Foundation Trust

Quality and Safety

Experience and Outcomes:

Patient Feedback: Trust wide we achieved **86%** of **ESQ positive responses** in April 2025. Communication is a commonly reported cause of dissatisfaction; positives include themes linked to Trust values. The number of forms collected across the Trust continues to be **low (n = 57).** There is targeted support being offered to teams where no forms are collected. The trust received **3 compliments** reported via Radar, **one** for **Camden Unit** and **2 for the Adult Unit.**

Complaints: A total of **11 complaint** contacts were received Trust-wide in April. **8** for the **Adult Unit** and **3** for **Camden Unit.** All complaints acknowledged within **3 working days**. Trust wide compliance for formal complaints responded to within **40 working days** for **April is 50%.** No complaints were responded to informally in April 2025.

Clinical Outcome Measures: This month the Trust launched the new **waiting time metrics** on 1st April 2025. The data indicates a **reduction in OM received** this month – due to a significant drive to complete baseline OMs for open cases in March. There has also been a reduction in the use of **"Current View"** which is to be replaced as it is no longer recognized by **MHSDS** as an outcome measure.

Patient and Carer Race Equality Framework (PCREF): This month's PCREF slides focus on the work undertaken in the **Camden Wellbeing service**. Going forward we will showcase individual teams plans and progress on improving accessibility.
Incidents:

A total of **14 patient safety incidents** were reported in April Trust-wide. Of these, **six deaths** were recorded, and mortality reviews have been requested on those seen by the GIC.

After Action reviews: This month **2 AAR's** have been initiated. There are **5 outstanding AAR's** being monitored by the AAR tracker. Findings and key learning points from all responses will be discussed at the Clinical Incident and Safety Group (CISG).

Integrated Quality and Performance Report

Month 01- 25/26

Metric	Waiting List Management	SRO	Chris Abbott	Target	4 wk 18 wk	Measure	

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

Problem Statement

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

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

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

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

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

Vision & Goals

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

G1. Clearly defined pathways for patients within next 4 months

G2. Clear demand and capacity modelling identifying gaps so that they can be addressed by March 2024

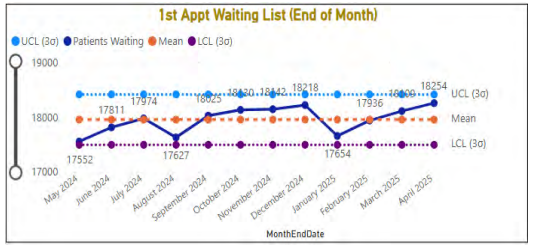
G3. Increase in patients in treatment vs on a waiting list

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

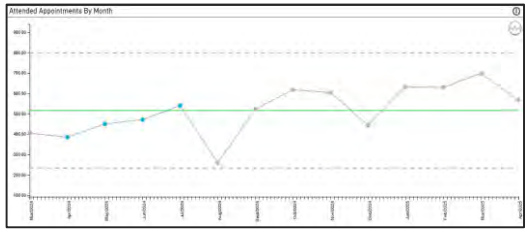
G5. Improve recruitment and retention aligned to the teams' workforce plans

Continued...

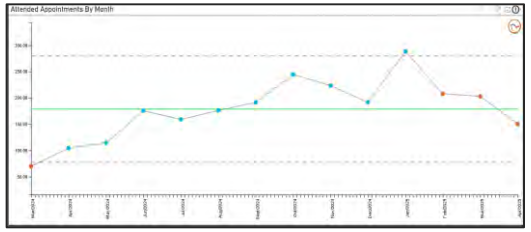
Metric	Waiting List Management (Continued)	SRO	Chris Abbott	Target	4-wk & 18-Wk	Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger



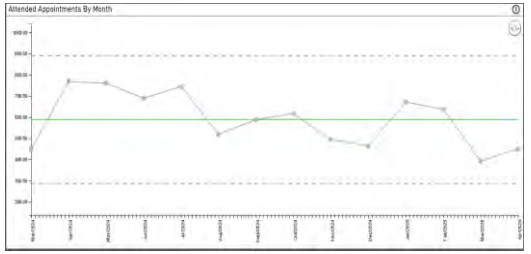
Trauma



Autism Assessment



Adult Gender Identity Clinic (GIC)



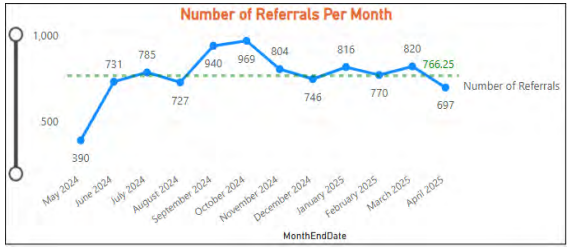
This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

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

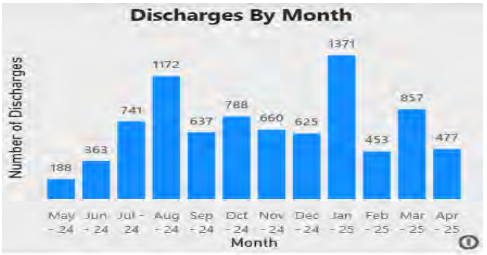
Monthly Stratified Data

A. Number of first appointments conducted

B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
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.by **Jan 25.** This has faced significant delays in some service areas due to cultural pathway and delivery issues. Expected delivery **Sept 25** **MDT ToR** – The Medical Director completed a review of the ToR for MDT meetings, and each unit is implementing the recommendations and approach to ensure consistent review of patients, length of treatment and discharge. – **Sept 25** **PTL** – PTL reporting digitisation was completed in January 2025 – The Unit Operational leads are reviewing the PTL process with view to implementing an improved approach by **July 2025** **Waiting Times form Implementation –** Waiting times form mobilisation to ensure that all first and internal wait are captured accurately – **June 25**	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** – Units to review their job plans and remaining ERF resource and pivot their outputs to ensure they deliver against their targets and end of contract **Sept 25** **Trajectories** - Units modelling increased activity and agreeing trajectories for delivery against this resource (managed through a tracker) – **July 25** **Pathways** - Review of the clinical pathways informed by the Kaizen sessions and NICE guidance and service specifications, as outlined in unit delivery plans – **Aug 25**	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 Care Notes 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**) – The QI Lead for NHSE will commence pathway mapping from **June 25- July 25** as part of the Levy report triangulation, before publication **ASD** – to see an additional 90 patients by **end of q2** **Trauma** – NEW intake process, referral form/criteria, geographic intake patch is reducing referral numbers. – Agree trajectory and workforce plans by – **July 25**	Trauma intake and referral criteria changes are reducing numbers. ERF staff losses can only be mitigated through recruitment in Trauma. Seeking to make GIC ERF staff permanent & within budget to increase CORE activity.	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	Complete SPC and Clinical dashboard reports by **Aug 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/ Ben

Integrated Quality and Performance Report

Month 01 – 25/26

Metric	Outcome Measures	SRO	Chris Abbott	Target		Measure	

Problem Statement

Despite technical and process improvements to Outcome Monitoring (OM), collection remains inconsistent and not yet fully embedded into clinical processes. OM collection is not always seen as a clinically meaningful activity. Improvement data is not currently available or reportable for all measures, which limits our ability to demonstrate impact, improve outcomes, inform service improvement and reduce health inequalities for all clinical services.

Historical Performance

See slide 2 for historical performance on SPC Charts for each measure.
Work taking place to ensure inclusion of a new compliance dashboard to monitor NHSE waiting time compliance with Goal 1.

Vision & Goals

Vision: OMs are routinely, reliably, and meaningfully used across all services to support patient care, inform clinical conversations, drive service improvements, and reduce health inequalities. Outcome measures are seen as a clinically valuable, routine component of personalised care planning and shared decision-making.

G1: At least one mandated OM to be completed at 90% of first appointments by Oct '25

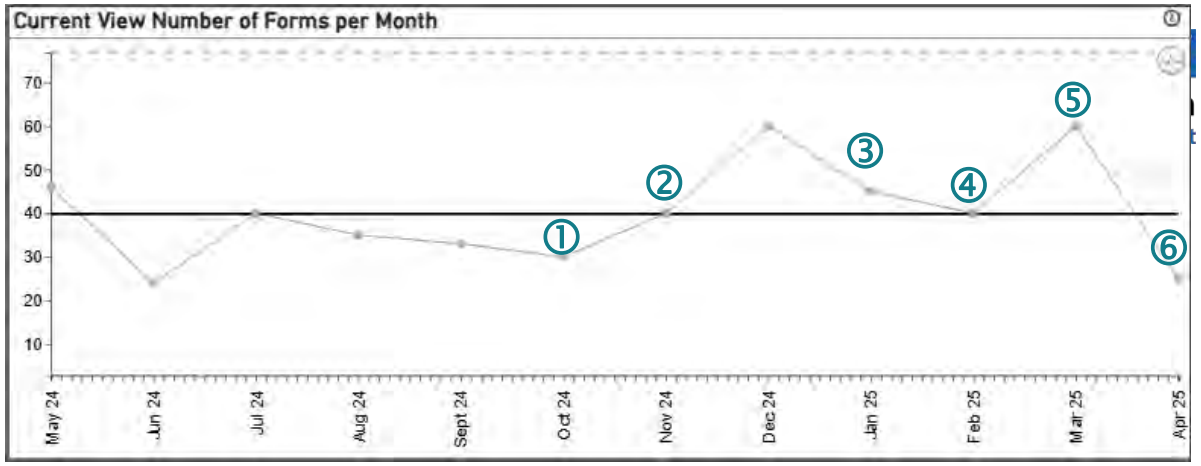
G2: Improve current rates of matched OM pairs by 50% for all Units by Oct '25

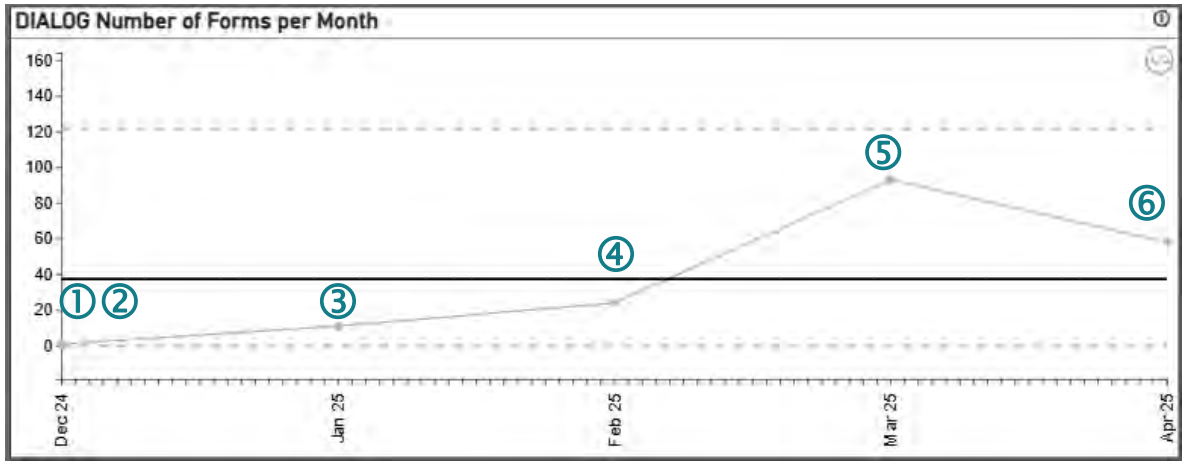
G3: Establish methodology to evidence improvement for all measures by July '25

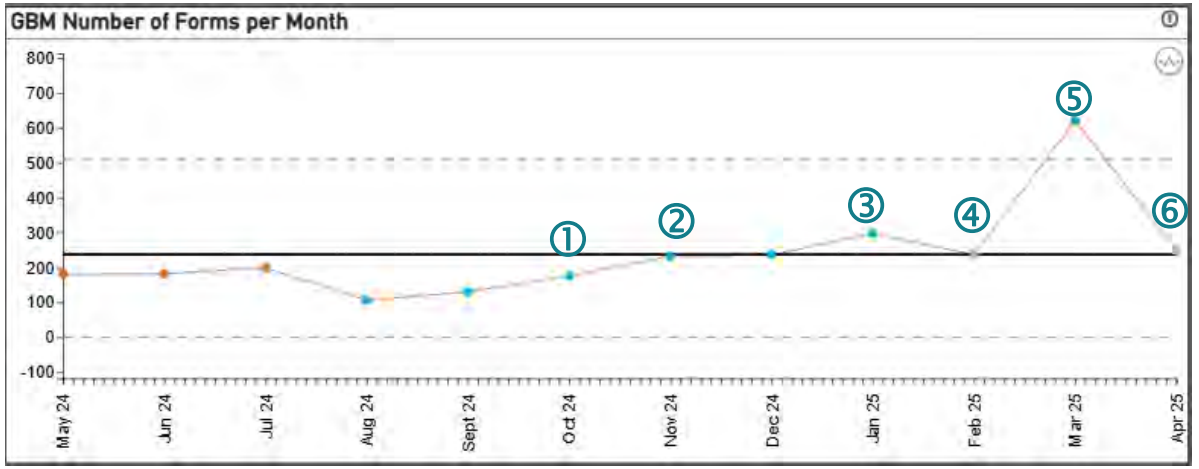
Concern	Causes	Countermeasures	Primary
Integration: OM not fully embedded into clinical workflows or care pathways	1. OM not hard-wired into care plans, reviews, or SOPs 2. OM completion is external to core clinical conversation 3. OM data collected but not routinely acted upon 4. OM results not routinely fed back to patients	1. Embed OM into care plans, templates, and appointment SOPs 2. Build OM prompts into MDT, CPA, supervision templates 3. Establish pan-service SOP requiring OM review in team meetings 4. Pilot OM-informed care planning in one service	Clinical Services
Perception: OMs are not always seen to add clinical value	1. OM positioned as compliance metric historically 2. Clinicians do not always take responsibility for OM conversations 3. Anxieties regarding OM data being used for workforce performance management	1. Refresh comms campaign positioning OM as a clinical tool 2. Training focused on clinical conversations 3. Peer-led MDT case studies using OM in shared decision-making 4. Celebrate positive OM compliance and feedback in CG meetings 5. Targeted support for teams with low compliance	Clinical Services
Systems: OM systems and reports underused by teams	1. Dashboards not fully integrated into team routines 2. Staff are unclear whether the data they see aligns with external data flow to NHSE Mental health Services Data Set (MHSDS) 3. Historical OM's and logic in electronic patient record (EPR) cause confusion	1. Launch clinical dashboard 2. Co-design further simplified dashboards for key roles 3. Train and coach teams on clinical dashboard 4. Install data walls to communicate OM insights in physical and digital areas 5. Review and remove areas of confusion within Carenotes	Clinical Services IM&T
Improvement: OM data does not drive improvement, equity analysis, or redesign	1. OM data seen as compliance rather than clinical requirement 2. No routine demographic or pathway OM analysis 3. OM data disconnected from QI, redesign, and commissioning	1. Build quarterly OM equity dashboards to support demographic analysis 2. Present OM trends in all Clinical Governance, 'All Staff' and QI forums 3. Link OM insights to local QI cycles 4. Use OM data to inform service reviews and business cases	Clinical Services QI + PCREF

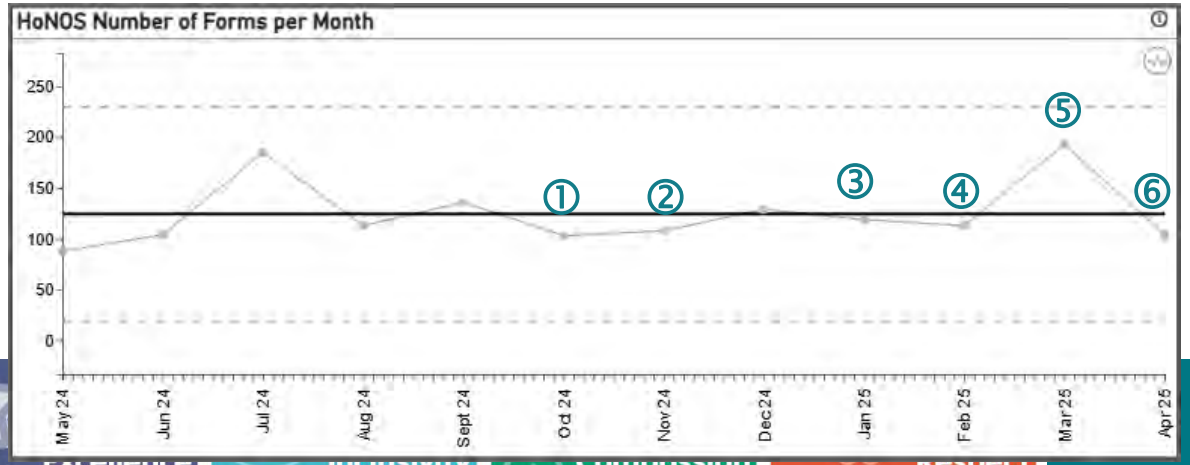
Outcome Monitoring Milestones

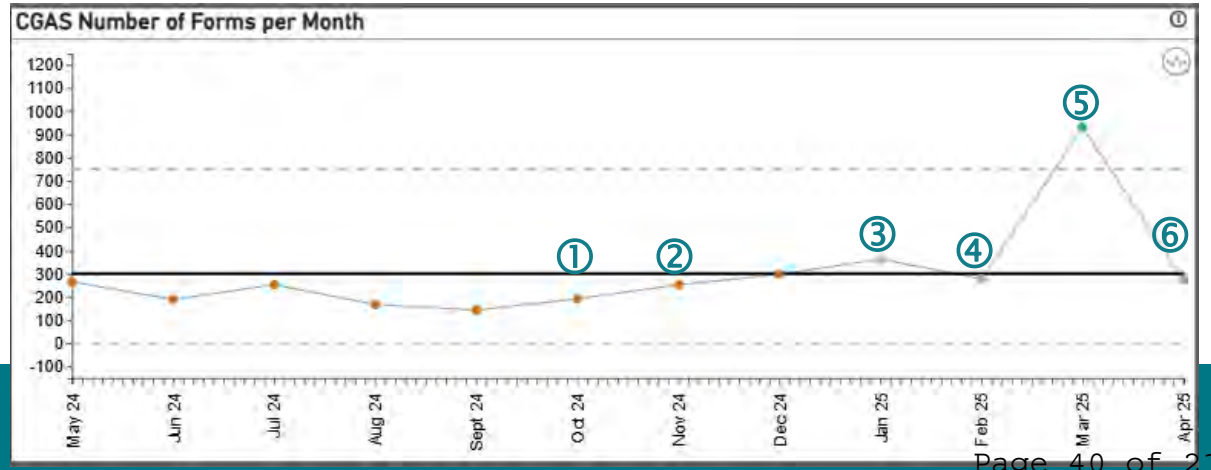
Legend	Countermeasure	Legend	Countermeasure
①	Clinical Governance Presentations	④	All Carenotes changes complete
②	Trust-wide training delivered	⑤	Unit level follow up with clinicians
③	Unit level training delivered	⑥	Clinical Dashboard go-live











Integrated Quality and Performance Report

Month 01 - 25/26

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.

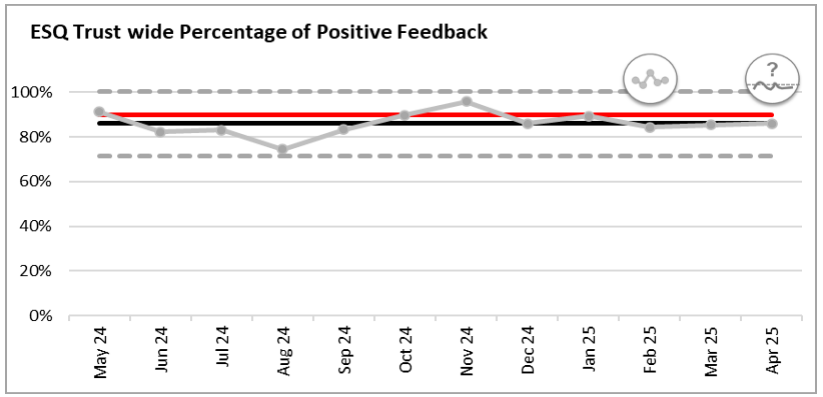
Vision & Goals

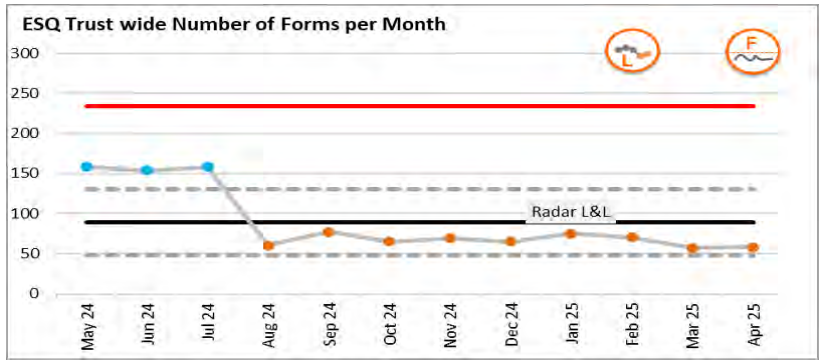
Vision: For all users to have a positive experience across the trust.

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.

Progress on Improvements

Concern	Milestone achieved	Countermeasure in progress	Owner
We have low completion rates for ESQ	• Team targets have been set and shared for annually and monthly based on 30% of open cases in period Dec 2023 – Dec 2024 • SPC charts with new targets created	• We need to strengthen awareness and staff engagement • Not all teams are actively encouraging service users to complete the ESQ in either format • Regular discussion and feedback in Unit Clinical Team meetings • Explore targeted support with teams that have low response rates • Explore options for teams to actively target receiving feedback • Offer more awareness training to teams around importance of Service User Feedback • SMS to be sent • Automated prompts in software • Strengthen staff confidence / training in promoting feedback for both clinicians and administrators – meetings being scheduled – consider a briefing document. • Top tips guide being created and circulated to clinicians with the aim of creating a 'best practice' user stories.	Sonia/Huddle
ESQ form has some remaining accessibility/utilisation concerns	• Paper copies now available in all waiting rooms • QR code clearly displayed in all waiting rooms • Letter templates have been updates to include QR codes • Email signatures have QR code/link • Improvements made on wording and format V2	• Review of form accessibility to be available in different language and neurodiversity friendly • To explore other ways service users can be supported to complete forms e.g. telephone calls, IPADS in waiting rooms • Letter templates kept locally by teams to be updates with QR code • Considering a paper copy to be included in first patient correspondence. • Business card to be printed.	Huddle/ Team managers
There is no feedback loop for services to show what is improvements are being made with the feedback. **There is no assurance at Unit level that this is being progressed**	• Data is being disseminated monthly to Units and all services	• Feedback from teams is actively collected and discussed at Clinical Governance meetings • Review Unit Managers reporting into SUEG around ESQ using template • Most teams aren't aware of the data beyond the circulation list. We need to consider how the data is disseminated within teams so they can identify , own and act on the feedback.	Huddle/SUEG

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.

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.

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).

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%.

Integrated Quality and Performance Report

Month 01 – 25/26

Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

Problem Statement

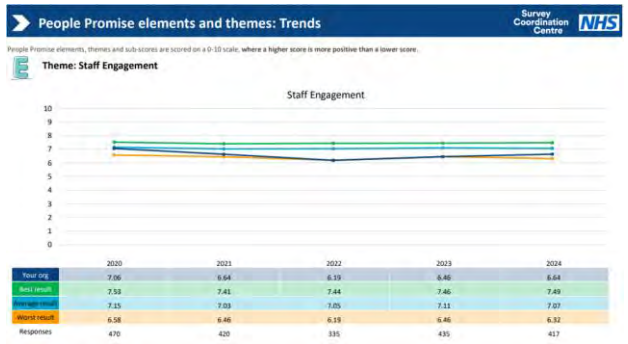
Staff experience across the organisation is inconsistent. We are repeatedly hearing via the staff survey that there is a disparity of treatment, career progression, and development. We need to improve the culture of the organisation and create transparent mechanisms for recruiting, retaining, developing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



- 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

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%

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

SPC Chart Glossary & Key (1/2)

The Tavistock and Portman NHS Foundation Trust

What is an SPC chart? (simpler)

Go to Index

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

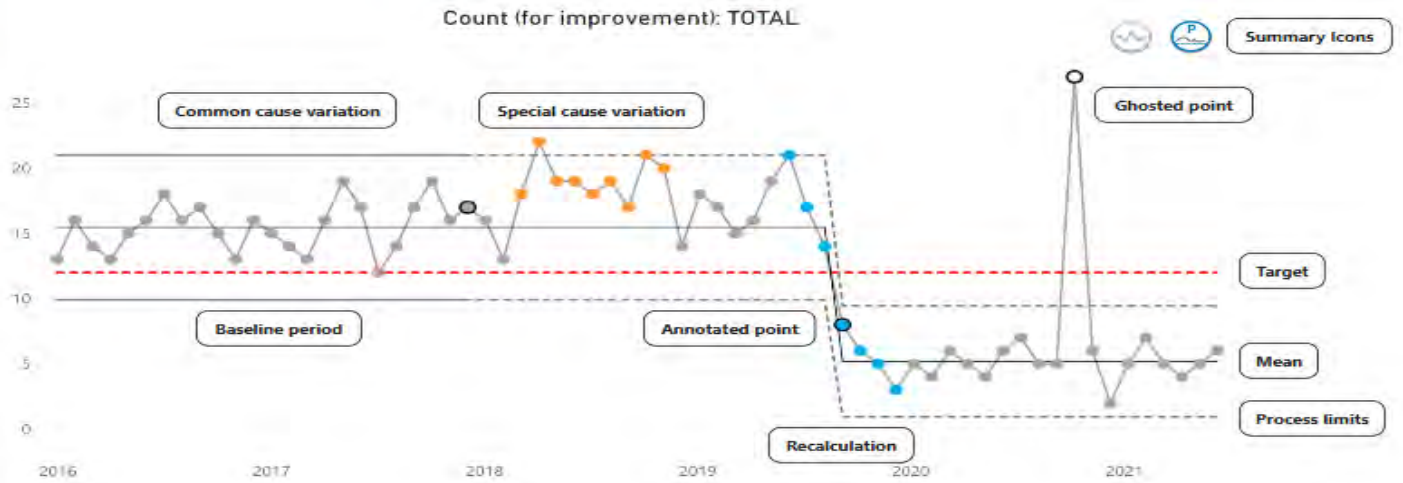
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines
Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

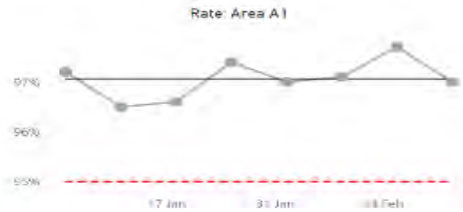
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

Annotations
If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



SPC Chart Glossary & Key (2/2)

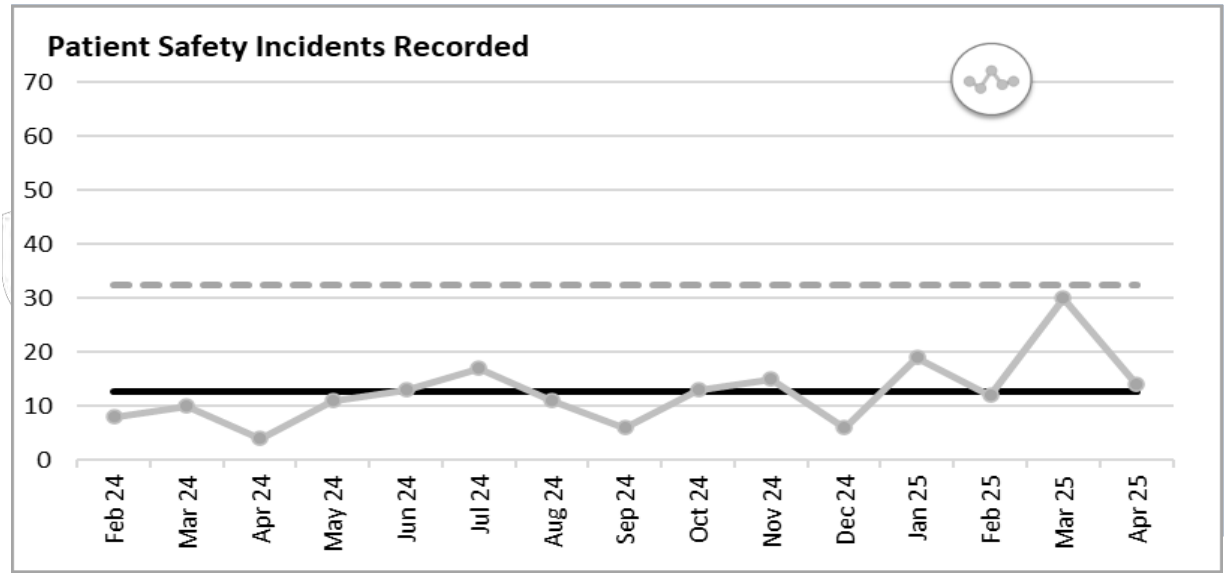
The Tavistock and Portman NHS Foundation Trust

Icon Descriptions

Go to Index

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
~	Common cause variation, NO SIGNIFICANT CHANGE. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, NO SIGNIFICANT CHANGE. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Common cause variation, NO SIGNIFICANT CHANGE. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, NO SIGNIFICANT CHANGE. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning. Assurance cannot be given as there is no target.
○				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

Are We Safe?



The Tavistock and Portman NHS Foundation Trust

Patient Safety Incidents – Trust-wide

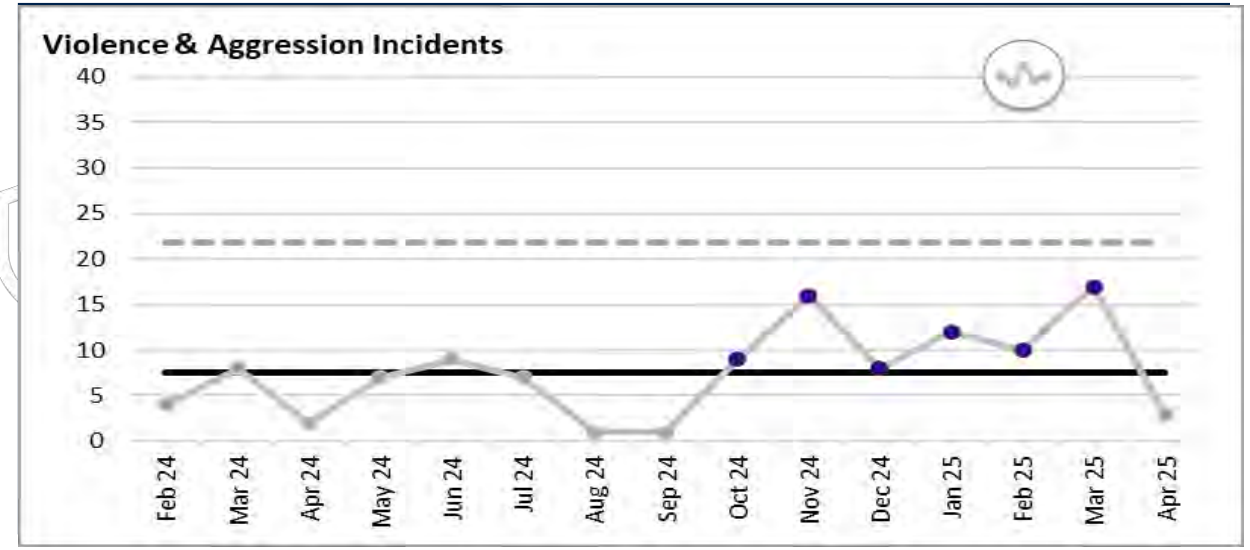
A total of 14 patient safety incidents were reported in April Trust-wide. Of these, six deaths were recorded—five associated with the Adult Unit (specifically the GIC), and one within the Child, Young Person and Family Unit of a patient who was receiving palliative care.

Following the reporting of these incidents, urgent mortality reviews have been requested for the deaths related to GIC patients where the individuals had been seen by the service. The remaining deaths will be added to the mortality review tracker for completion.

In addition, two After Action Reviews (AARs) have been initiated. The first concerns the use of the nurture space at Gloucester House, following an incident in which a staff member became unwell. The second relates to a breakdown in communication among staff, after a failure to process a 'patient-in-crisis' email in a timely manner.

There are currently five outstanding AARs, with progress being monitored via the AAR tracker and review dates diarised accordingly. Findings and key learning points from all responses will be discussed at the Clinical Incident and Safety Group (CISG). Learning will be shared and integrated into the relevant Unit Clinical Governance meetings to support ongoing improvement in practice.

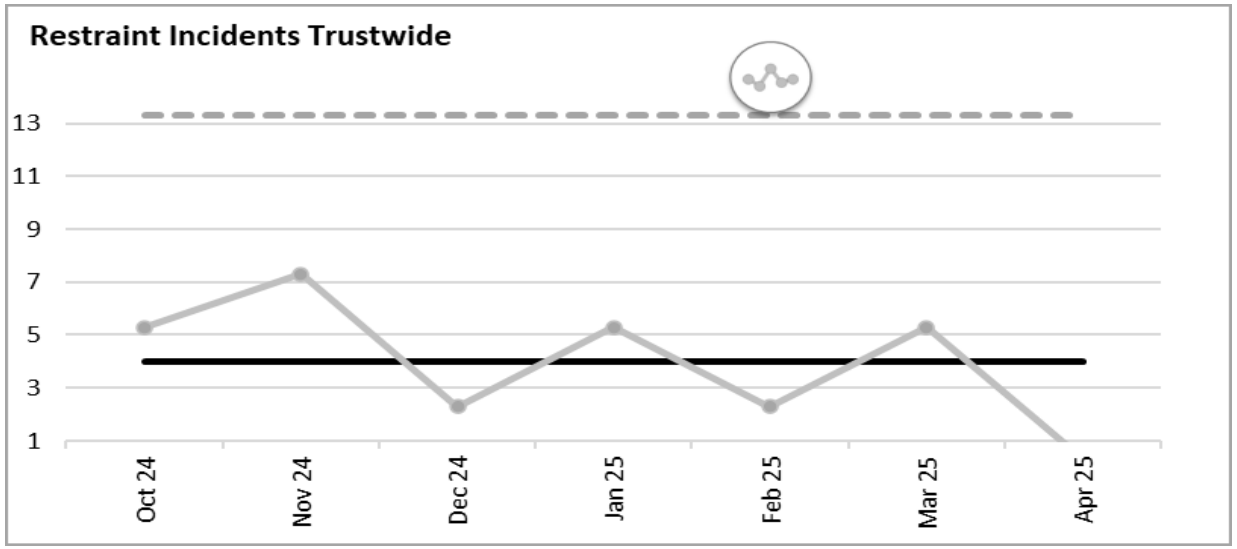
Are We Safe?



Violence & Aggression Incidents

There were 3 incidents involving violence and aggression, all occurring at Gloucester House. This lower number is likely attributable to the school holidays and pupils not being on site.

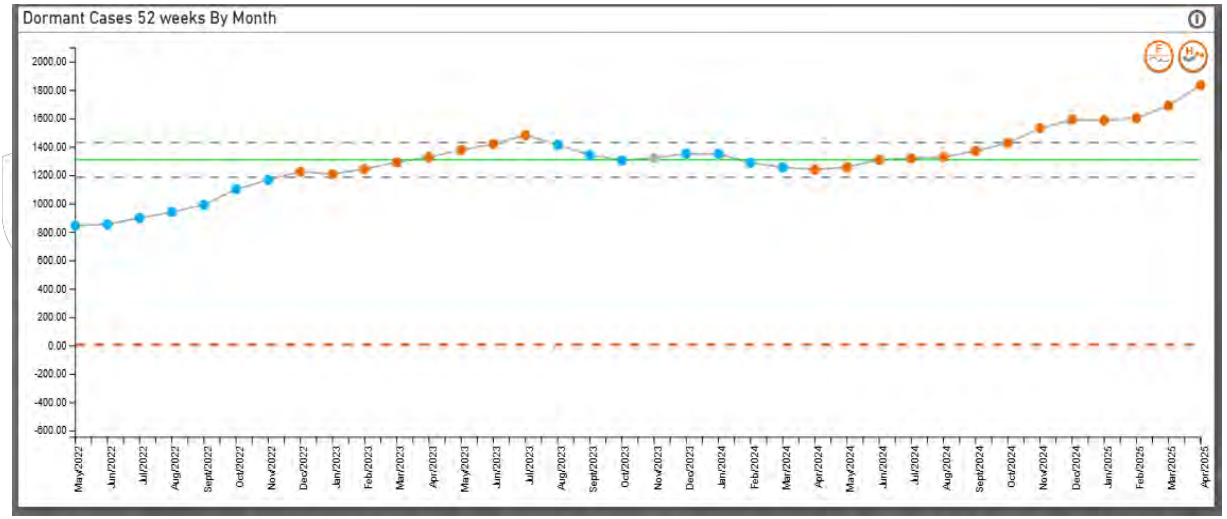
All incidents were triaged as Manager's Review.



Incidents Involving Use of Restrictive Practice

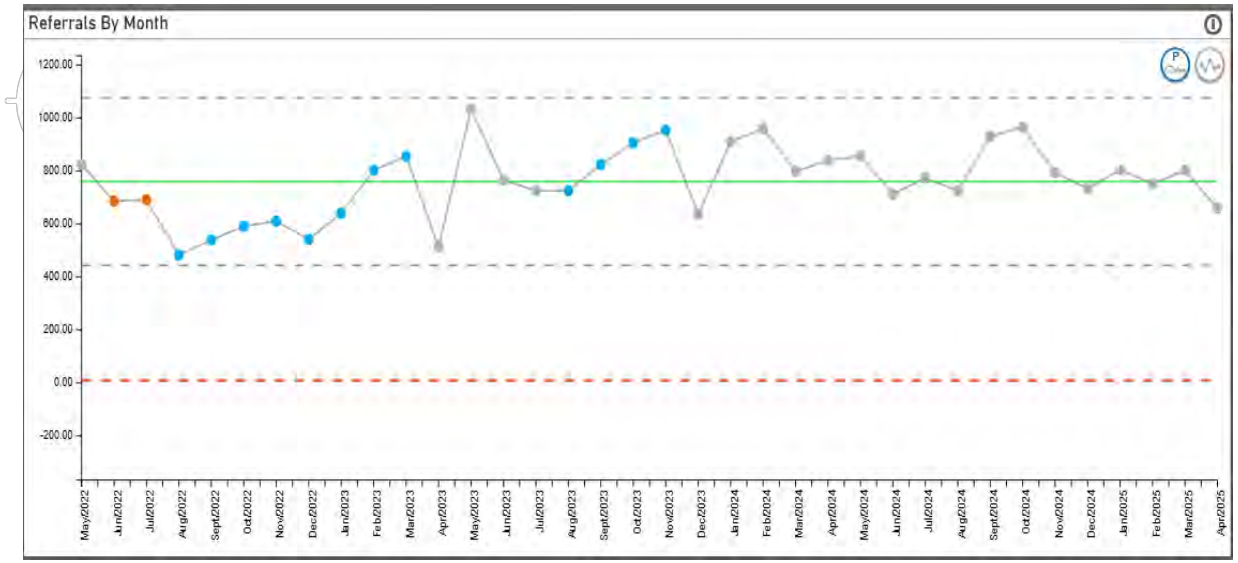
There were no incidents involving the use of restrictive practice for April. As mentioned above, this is likely attributable to the school holidays and subsequent lower number of incidents occurring at Gloucester House involving violent and aggressive behaviour.

Are We Effective?



52+ Week Dormant Cases

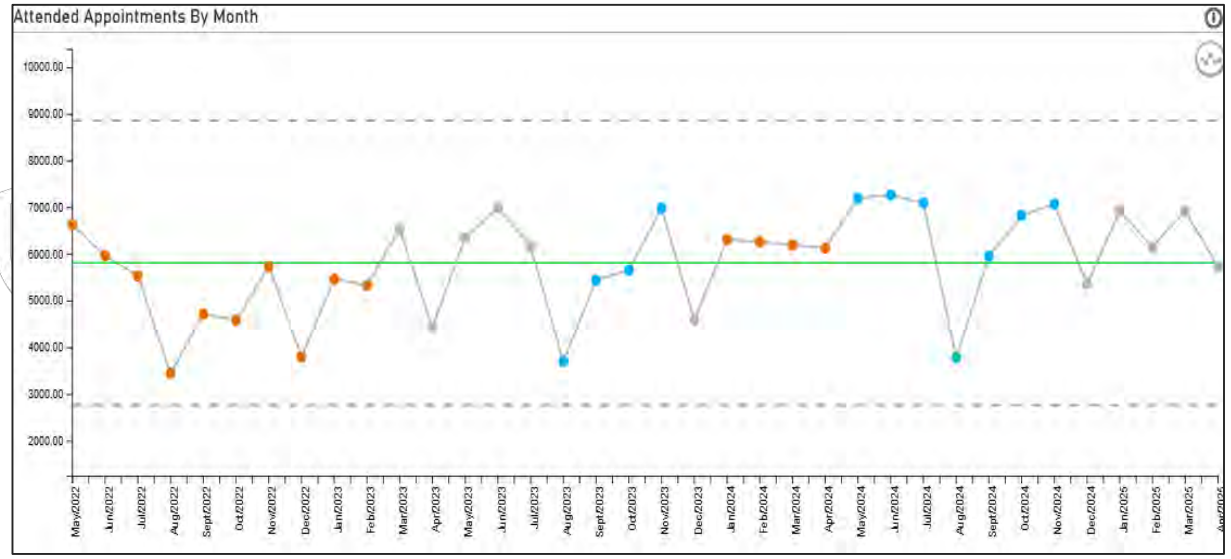
The capacity for the Units to address dormant case loads is influenced by services with prolonged waits. The Adult Unit is engaged in measures to address dormant cases in GIC and Trauma, including post-Kaizen interventions and a QI project. Camden has no cases dormant over 52 weeks. The Child and Family unit have 83, predominantly from the Autism Assessment Pathway.



Number of Referrals (Including Rejections)

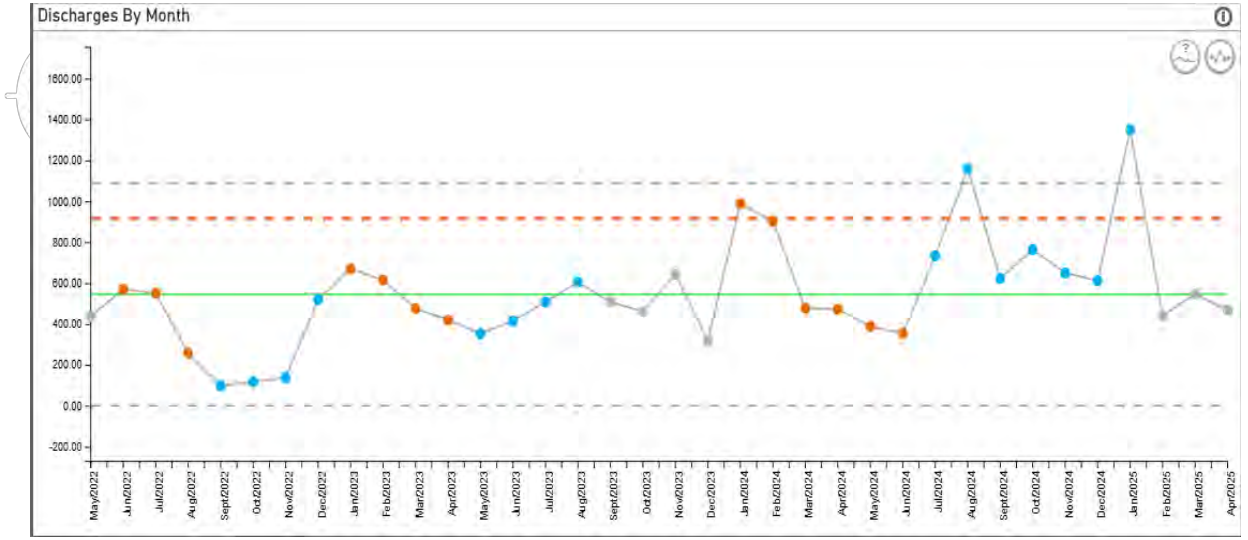
There is seasonal variation in referral patterns however referrals in the first months of 2025 appear to be lower than those in 2024. Trauma have been actively managing their waiting list since January 2025 resulting in a slight reduction in referrals received. The reduction in the GIC referrals merits further exploration. Camden have a slight increase in referrals whereas Child and Family are mirroring referrals received in 2024.

Are We Effective?



Number of Attendances

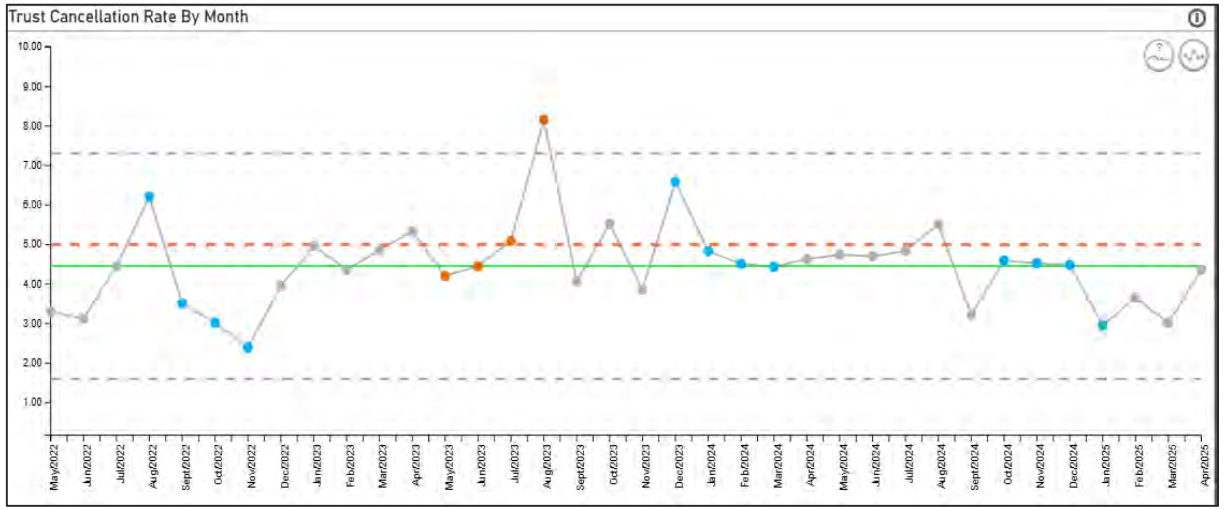
The overall number of attendances this month is slightly lower than the same reporting period in 2024 and significantly lower than March 2025. The lower activity from previous month is due to the Easter bank holidays reducing the number of working days available to see patients. The units are undertaking a review of annual leave and clinical hour reduction requests to ensure they recover any dip in activity across the year.



Number of Discharges

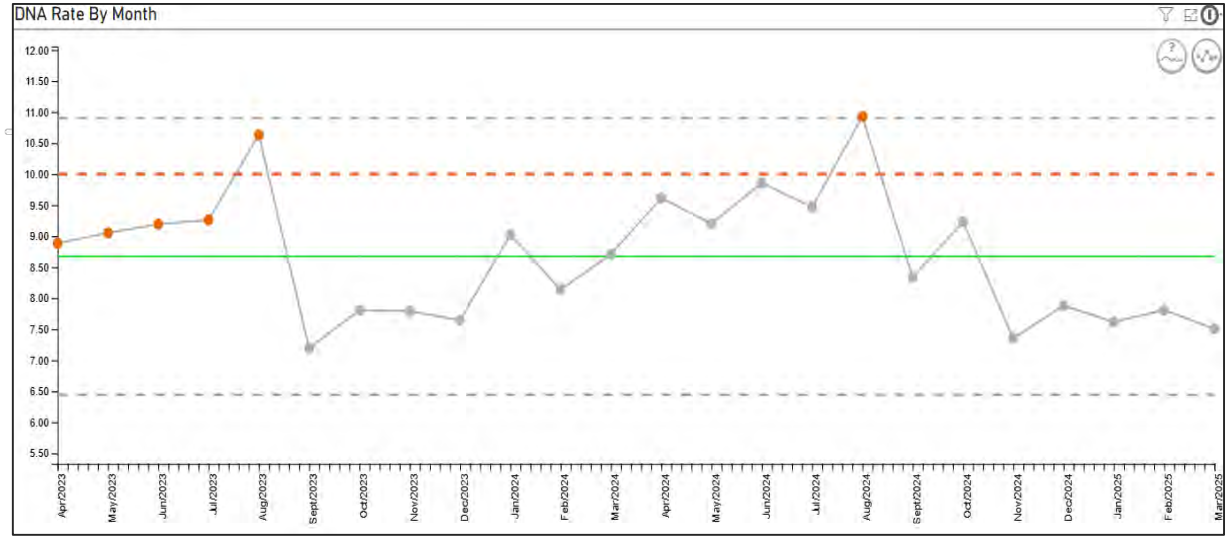
The number of discharged is also lower compared to January 2025. Seasonal increases around August and December reflect the impact of end of term / 6 monthly review and trainee rotation. The Child and Family Unit have set a working target of 10% discharges from the working case load and are working towards this as clinically indicated. Consideration for this to be a target across the units is ongoing.

Are We Effective?



% of Trust-Led Cancellations

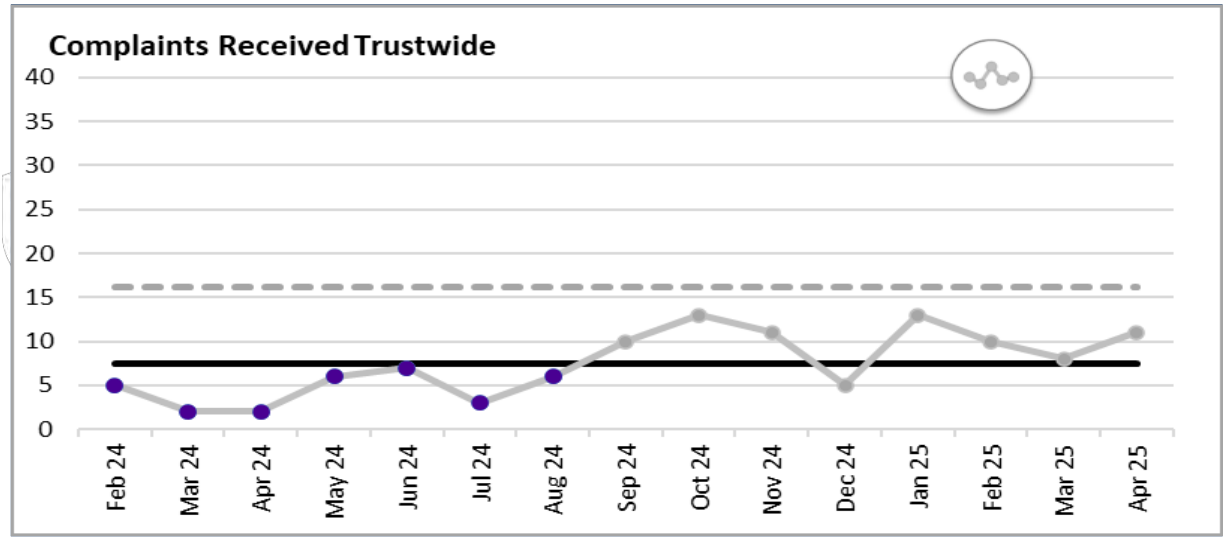
The Trust reports an average of 4.7% Trust-led cancellations, totaling around 34 appointments, mostly in the Adult Unit. Efforts are underway to reduce these cancellations, especially in the GIC where the administrator-led booking system may be a factor

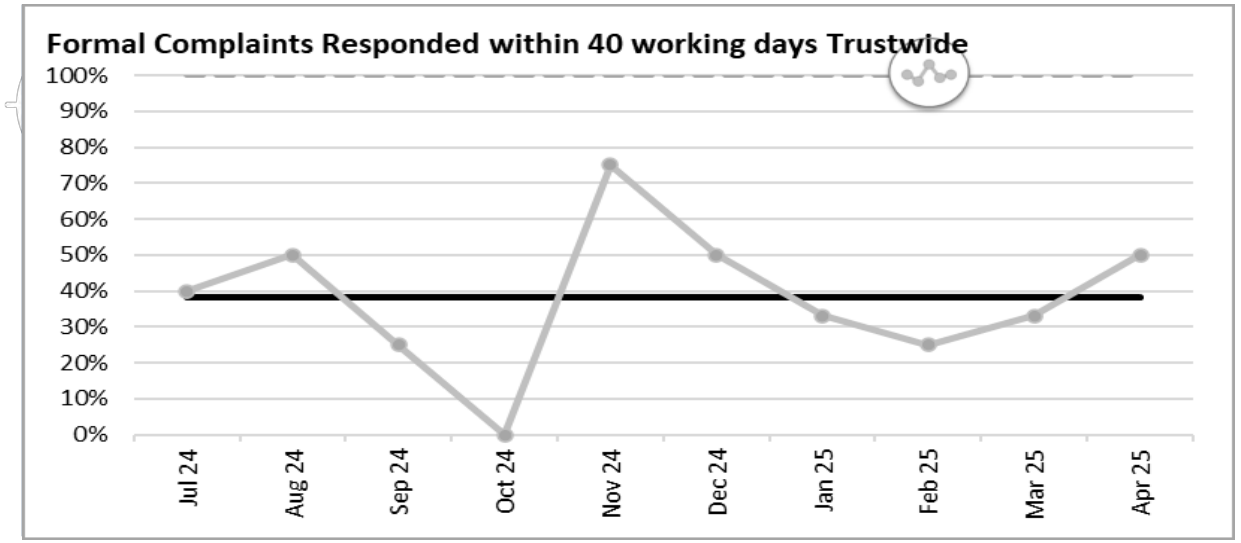


% of DNAs (Did not attend)

The Trust's DNA rate remains below 10%, with significant improvements in the Adult Trauma service. However, granular review at team level indicates that some teams must prioritise DNA management aligned to the policy as their quantum than the cumulative and reported trust-wide 10%. Reporting in the Child and Family Unit has expanded to include services with higher DNA rates, such as Returning Families at 35%, reflecting challenges in familial engagement.

Are We Caring?





Number of Formal Complaints Received

A total of 11 complaint contacts were received Trust-wide in April. Of this number, 8 were received for the Adult Unit and 3 were received for Camden Unit. Complaints in the subject area category of 'Communications' recorded the highest number (4), followed by 'Access to Treatment or Drugs' and 'Patient Care' (3 each) and Appointments (1). All complaint contacts received in April were acknowledged within 3 working days in line with national regulations.

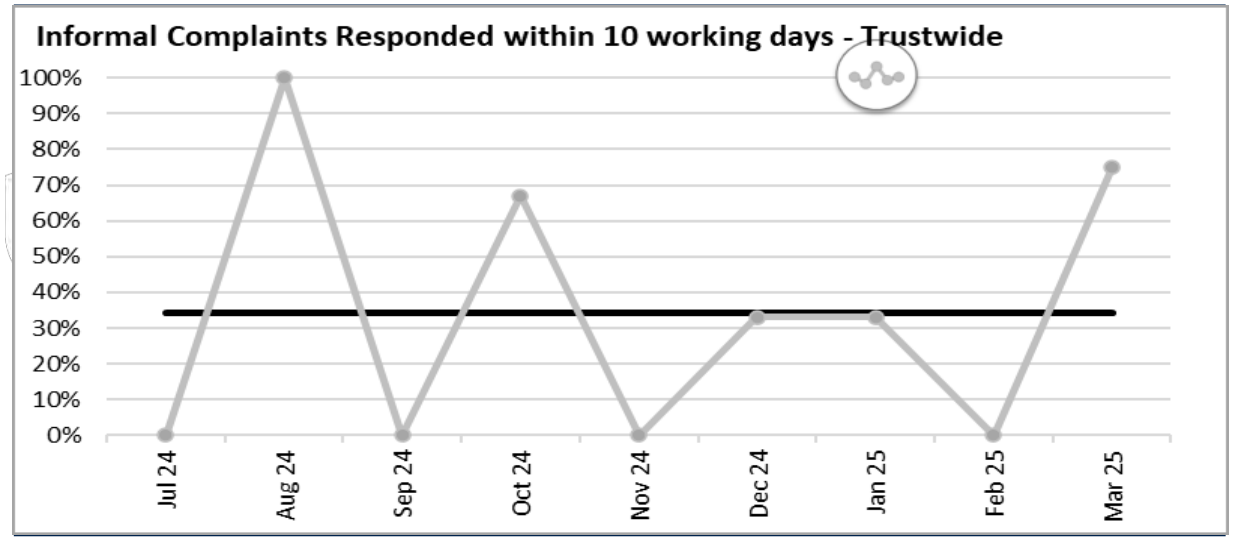
1 quality alert and 1 MP enquiry were also received in April 2025 (not included in the numbers above).

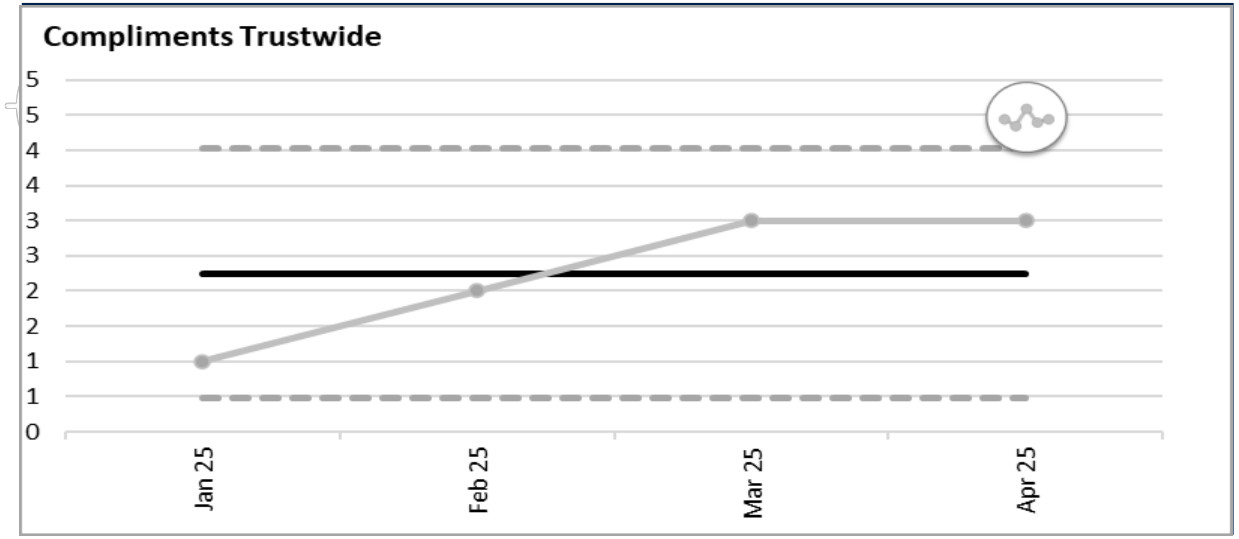
Formal Complaints Response Time Compliance

Trust wide compliance for formal complaints responded to within 40 working days for April is 50% reflecting that 8 formal Trust responses were responded to in the month of which 4 were responded within 40 working days. This reflects the efforts of Complaints team working with Clinical Leads and Investigation Leads to regularly review complaints within the response timeframe e.g. weekly complaints meetings and daily huddles, to ensure complaints are progressed in a timely manner.

Performance against this metric remains subject to fluctuation as the backlog is cleared. This chart reports on Radar data only and therefore the graph will be expanded as more data points become available.

Are We Caring?





Informal Complaints (Local Resolution)

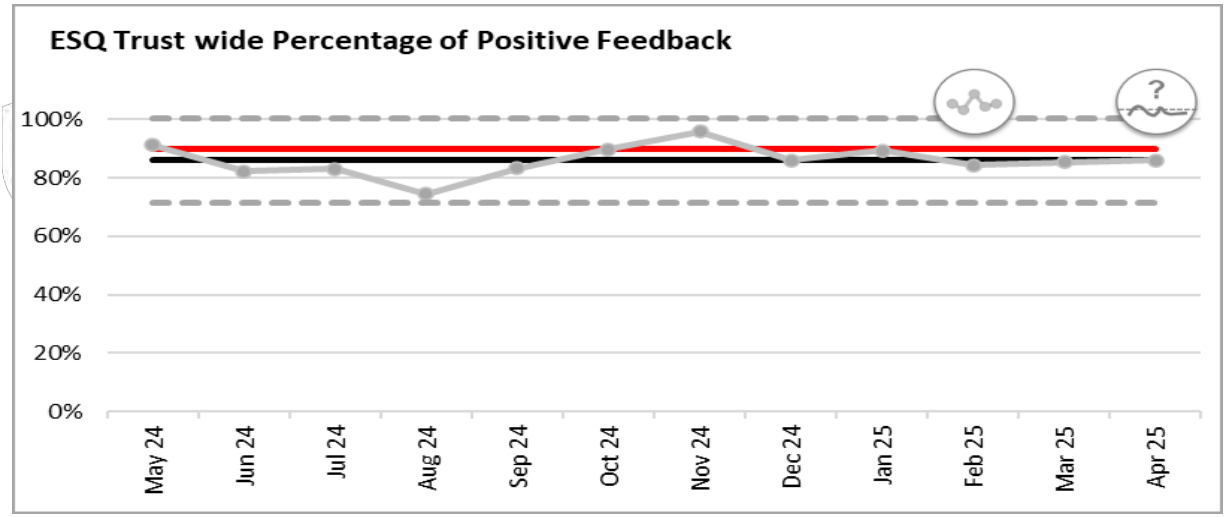
The Trust aims to respond to all complaints informally whenever possible. According to the Complaints Management Policy, informal complaints are those which are resolved by the immediate service with 10 working days. Therefore, although the number of informal complaints resolved in total is higher, the percentages depicted in the chart represent the percentage resolved within the specified period of 10 days e.g. in March 2025, 4 complaints were resolved informally, of which 3 were resolved in 10 working days.

No complaints were responded to informally in April 2025.

Number of Compliments Received

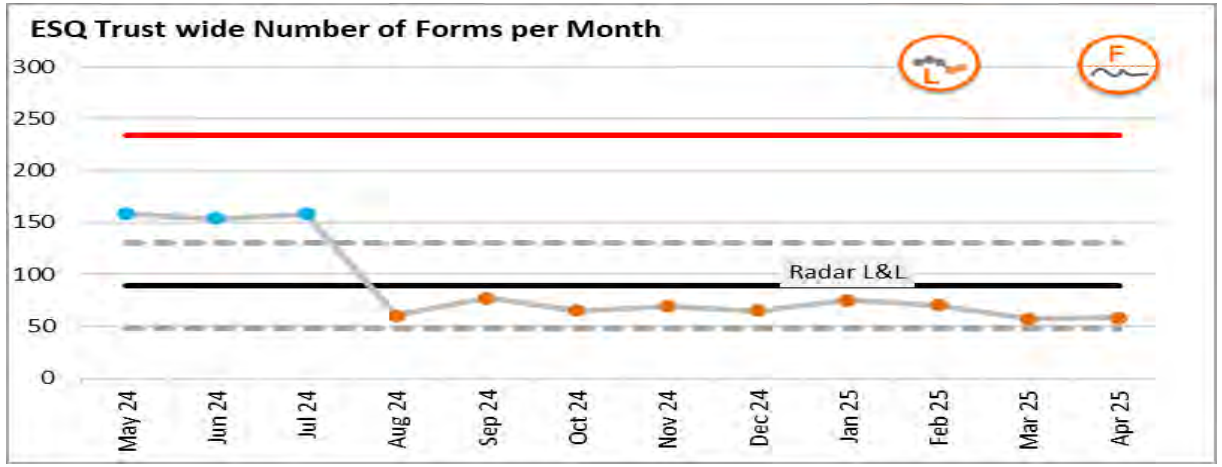
The trust received 3 compliments reported via Radar, one for Camden Unit and 2 for the Adult Unit.
The trust is raising awareness of the process on how to record compliments within the teams.
The compliments are categorised using the KO41a system so, we can compare themes between ESQs, incidents or complaints. In April two compliments were under the category 'Access to Treatment & Drugs' and one under 'Other'.

Are We Caring?



ESQ Positive Responses %

Trust-wide we achieved 86% of ESQ positive responses in April 2025, which is below our target of 90% . Themes from qualitative feedback indicate that communication is an areas that many of our patients report dissatisfaction on, whilst positives include comment's themes linked to Trust values.

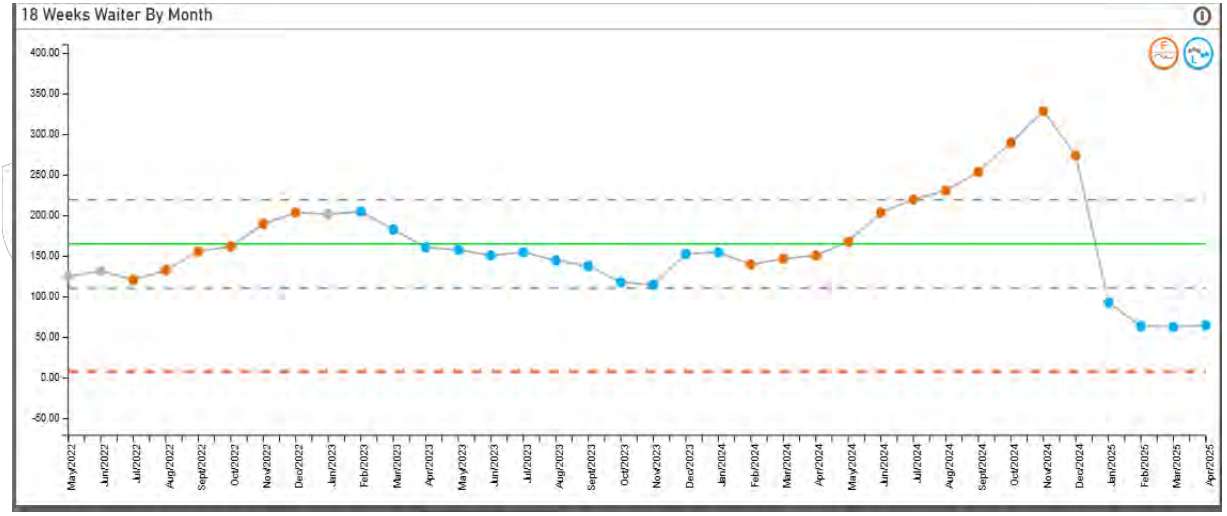


ESQ Number of Forms per Month

The number of forms collected across the Trust continues to be low (n57) despite efforts to improve access through the development of QR codes alongside paper copies. This means we are not hearing from a large proportion of our service users about their experience. There is targeted support being offered to teams where no forms are collected and PPI staff have joined reception areas to proactively approach patients to provide us with feedback. In addition, text reminders with ULR will be sent out at regular periods.

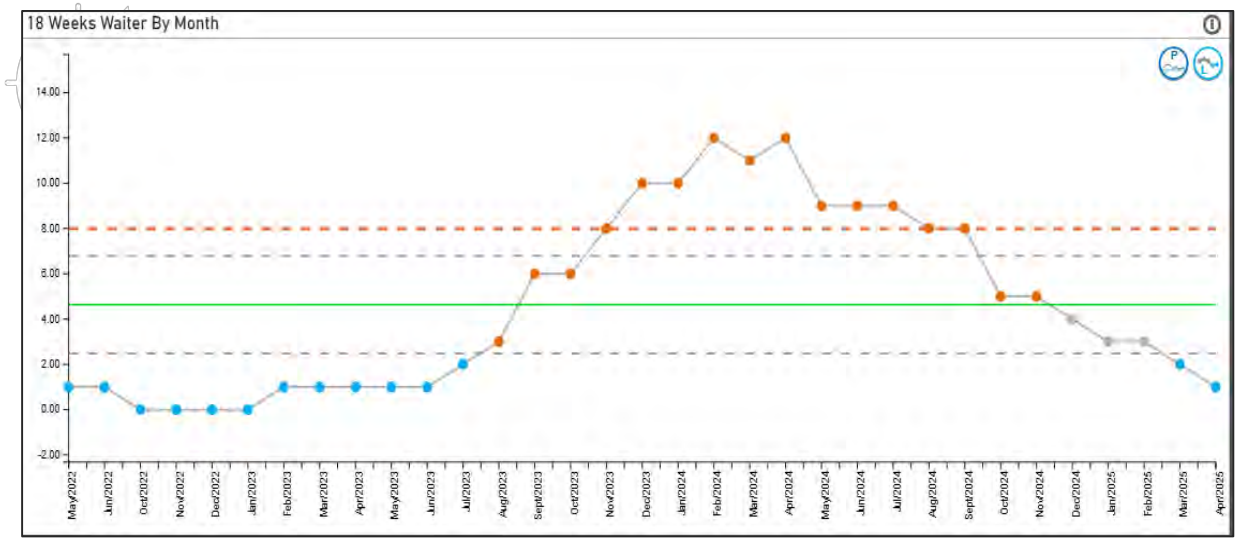
Are We Responsive?

The Tavistock and Portman NHS Foundation Trust



18 Week RTT Breaches Excluding ASC/GIC/Trauma

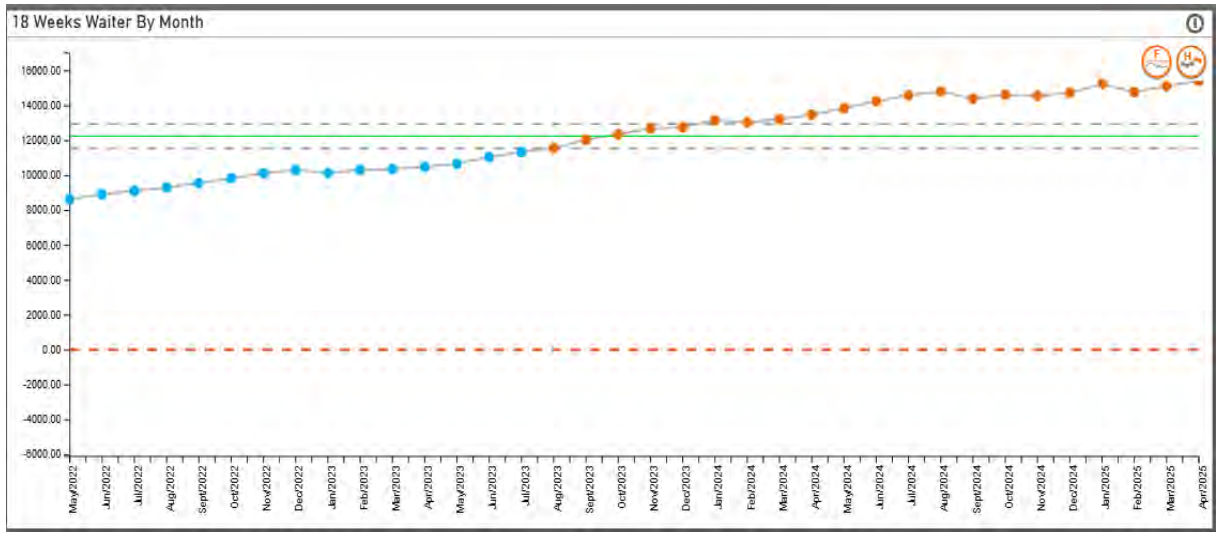
There have been 0 breaches reported by Camden and Child and Family Unit. The Adult Psychotherapy service continues to maintain its significant improvement in reducing the numbers breaching the 18 Week RTT. Exploration of the reasons behind the current number of waiters to occur for aim for further improvement.



18 Week RTT Breaches Autism Assessment (1st Appointment)

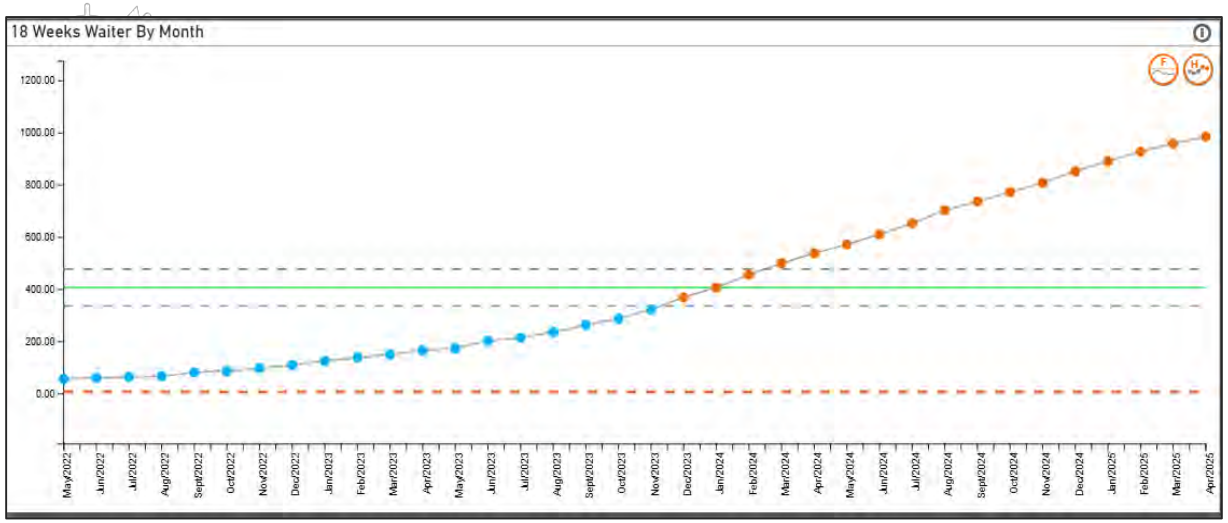
The unit is reporting 1 case breaching at 18 weeks which has been identified. The patient concerned has been contacted.

Are We Responsive?



18 Week RTT Breaches GIC (1st Appointment)

A total of 16,543 patients have yet to be offered a first appointment. To meet the 18-week waiting time target. The team plan is to increase the number of initial appointments through recruitment and consolidation of clinical and administrative staff to address vacancies. The team continue to be supported under Targeted support to achieve this outcome.

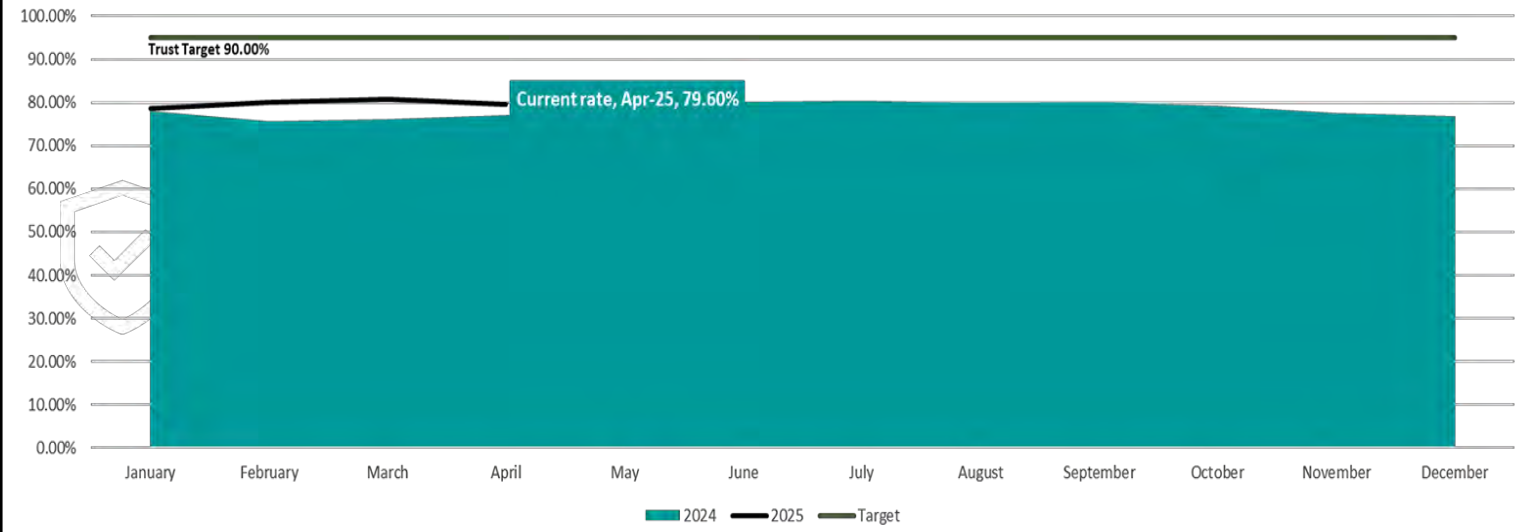


18 Week RTT Breaches Trauma (1st Appointment)

A total of 1,014 patients are waiting to be offered a first appointment. There has been significant efforts to embedded an operational automated booking system which is being reviewed to accommodate specific of the patient group. The team continue to be supported under Targeted support to achieve this outcome. Additional work has been agreed specifically focusing on demand and capacity modelling and pathway review to ensure visibility and improve activity against agreed targets.

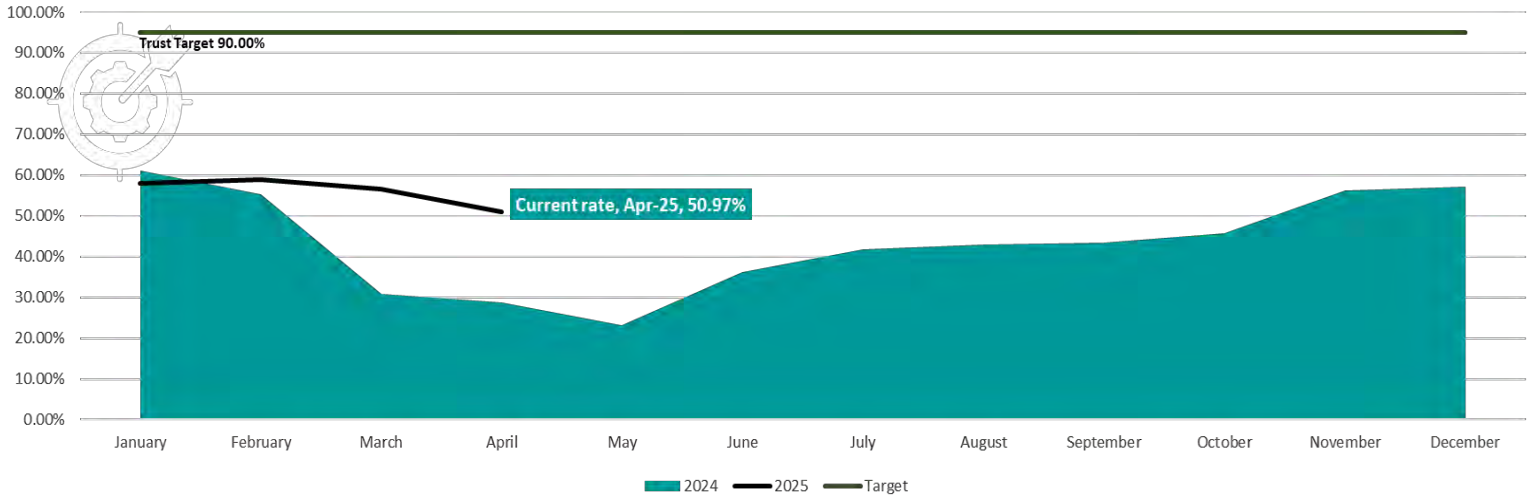
Are We Well-Led?

The Tavistock and Portman NHS Foundation Trust



Mandatory & Statutory Training (Combined)

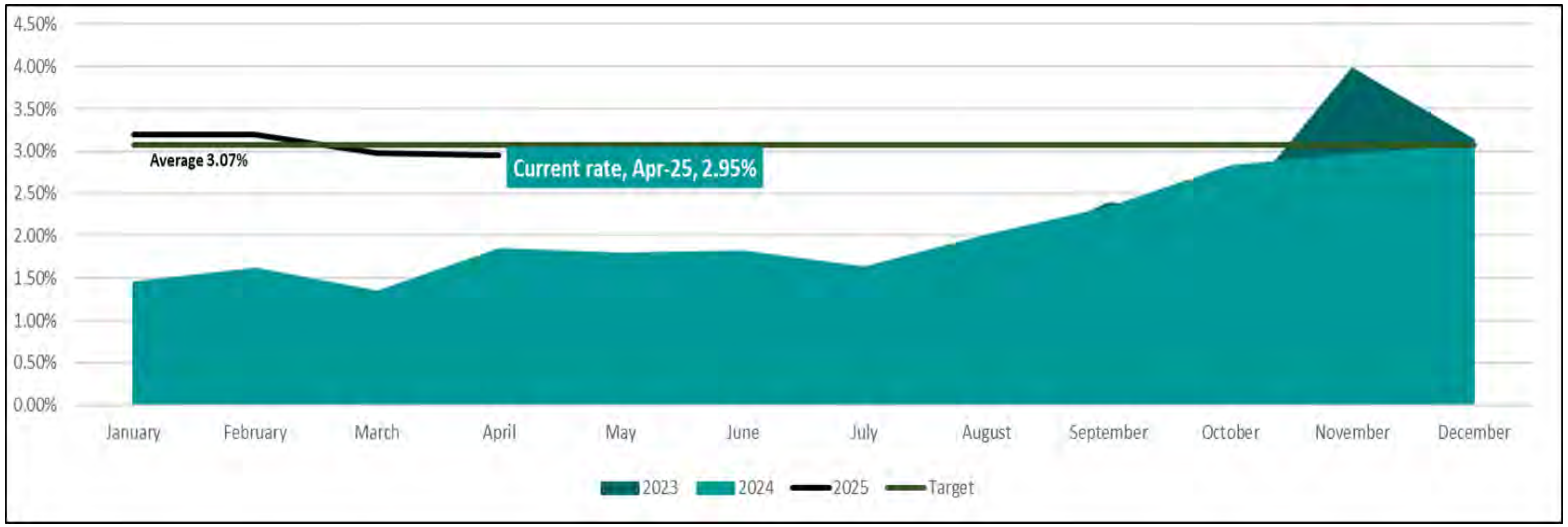
Directorate Apr-25	Compliance %
Chief Strategy & Business Development	94.23%
Chief Financial Officer	91.63%
Chief Executive Officer	90.95%
Chief Education and Training Officer	88.40%
Chief Clinical Operating Officer	76.83%
Chief Medical Officer	72.51%
Chief Nursing Officer	66.87%
Chief People Officer (includes Bank)	60.89%



Appraisal Completion (Combined)

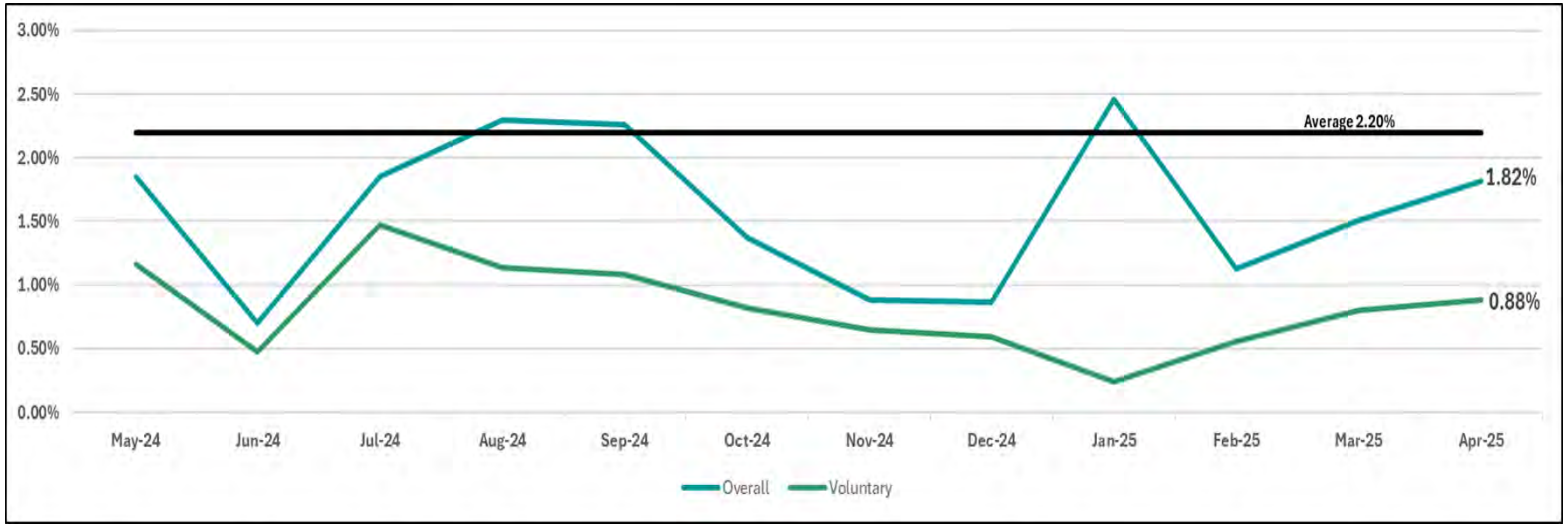
Directorate Apr-25	Reviews Completed %
Chief Nursing Officer	100.00%
Chief Education and Training Officer	64.91%
Chief People Officer	60.00%
Chief Financial Officer	45.45%
Chief Clinical Operating Officer	44.03%
Chief Strategy & Business Development	27.78%
Chief Medical Officer	22.22%
Chief Executive Officer	14.29%

Are We Well-Led?



Staff Sickness (Combined)

The current rate of sickness remains below the 3.07% target, at 2.95%. However, additional work is being completed with specific teams where there is variance compared to the trust-wide achieved figure of 2.95%.



Staff Turnover (Combined)

Delivering our vision – How are we doing? – May 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

All directorates are reporting below the target of 90% completion for appraisals. The units have agreed to meet with the ESR team to resolve some of the recording issues as some of the workforce listed have either left the trust or in different positions. Some clinicians have indicated that they are recording supervision in Carenotes. The Director of Governance and Therapies will lead a task and finish group focusing on delivering a single and shared platform to record supervision as well as complete the data-cleansing exercise with the People Team and the operational unit leads.

There is a decrease from the past three months and shown a 5.65% decrease ending Apr 25.

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

Chief Nursing currently hold the highest at 100%, Chief Education taking second place 64.91%. The Chief Executive directorate hold the lowest at the end of Apr-25 with 14.29% of appraisals carried out.

Seven out of eight directorates do not currently hold a high standard.

% Appraisal completion

50.97%

As a Trust, our current sickness absence rate is below the average benchmark of 3.07% by 0.12%. The level of sickness has decreased, as prior to Mar-25, we had seen an increase over the average

The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 0.77% ending Apr-25.

The sickness absence data from May 2024 to April 2025 reveals that mental health issues—specifically anxiety, stress, and depression are the leading cause of absence across both White and BME ethnic groups.

Among White staff, this is followed by physical health concerns such as cardiac issues, respiratory problems, and other specified medical conditions. In contrast, BME staff show higher absence rates for respiratory illnesses like cold and flu, along with a notable presence of unspecified or general causes.

Overall, the data highlights the consistent impact of mental health on workplace absence and suggests varying secondary health trends between ethnic groups..

% Staff sickness

2.95%

There has been a decrease - 79.60% a 1.18% decrease ending April 25.

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 (%)

79.60%

Contracts and Finance

Delivering our vision – How are we doing?

Finance & CIPS Delivery Effective use of resources

The Tavistock and Portman NHS Foundation Trust

The Trust declared….. The Trust is £88k behind plan at M1, with a recorded deficit of £592k.. The unfunded element of the pay award remains a recurrent issue for 25/26, however.	 **25/26 year-end planned position breakeven**
Financial Plan 25/26 The Trust has agreed a balanced revenue plan for 25/26, supported by the need to generate efficiency savings of £3.9m. Work is ongoing with colleagues to generate and deliver plans to achieve this as part of the management of the 25/26 financial position. The Finance business partners led by the CFO, are running a series of workshops week beginning 9th June to finalise the financial plan and to enact the trackers that demonstrate progress against plan.	 **25/26 M1 actual position £592k deficit**

PCREF

(Patient and Carer Race Equality Framework)

PCREF

- We are starting to develop PCREF in relation to accessibility of services.
- To date:

Focus on improving data collection on ethnicity at point of referral.

- Amendments to Child and Family and AYAS referral form.
- Amendments to Adult Psychotherapy and Trauma referral form to be agreed at May CSDG.
- Agreement at NCL ICB CAMHS collaborative that Ethnicity is required basic information at point of referral.

Every month we will highlight one of the team's work to describe their actions and progress on improving access to their service.

PCREF focus - Camden CAMHS Wellbeing Team

- April 2025 – audit of ethnicity, referrals 2024-2025 and engagement in assessment, 1st and 2nd treatment appointment to identify engagement from different cultural and ethnic groups.

- Qualitative service user project – interviewing 2 service users from global majority population who have struggled to access mental health support for their child. Exploring themes including referrer bias, representation, accessibility and stigma.

- Qualitative project exploring the barriers to accessing the Tavistock for South Camden based service users due to Tavi Central base. Higher proportion of global majority populations live in the South of the barrier. Project may result in a pilot of WBT appointments being offered from family hubs in the South of the borough if geography is a factor in access.

- Qualitative project exploring the cultural accessibility of our waiting room online resource.

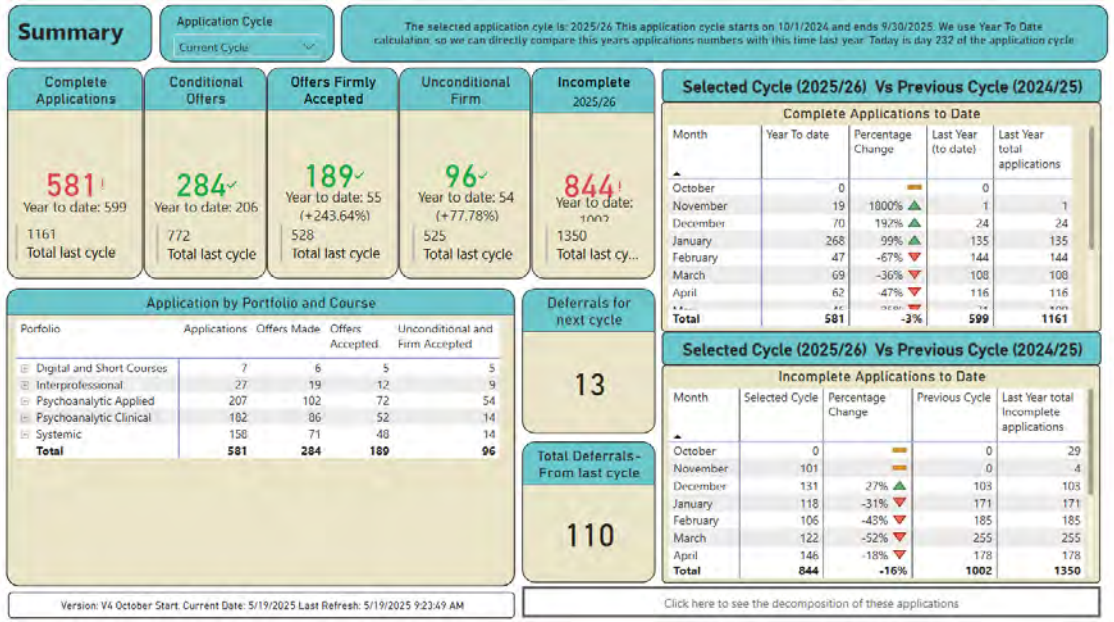
Unit Overviews

Education & Training

The Tavistock and Portman NHS Foundation Trust

Strategic Objectives	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.	• Retaining provider OFS registration through any possible change in governance structure is vital to the continued viability of DET's programmes. We are in discussion with the OfS about how this could be implemented pragmatically and swiftly in the event of a significant change.

Student Recruitment Activity Overview



Not included: M35 (Essex degree), Executive coaching Programme (ECP), Short/CPD courses

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%).

For the 25/26 Academic year, we opened recruitment three months early in October (as opposed to January in 2024) which led to an increase of up to 40% in year-on-year applications. However, since then the pattern has stabilised to within a few % points of the previous year (3% below in May 2025)

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.

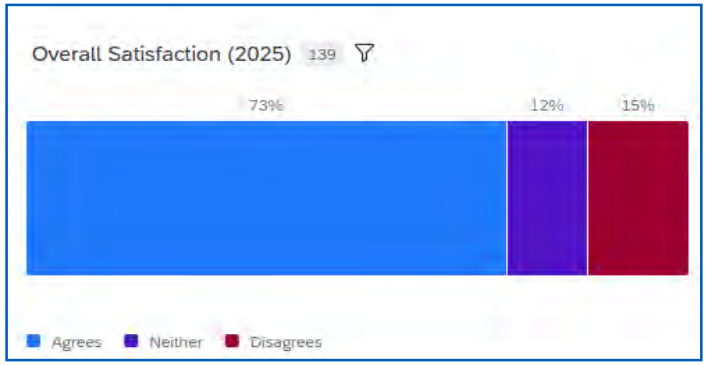
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move Visiting Lecturers into substantive posts, at least 33% reduction from 24/25	CETO / Directors of Education	February 2025
Regulatory changes (OfS)	Office for Students' regulatory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

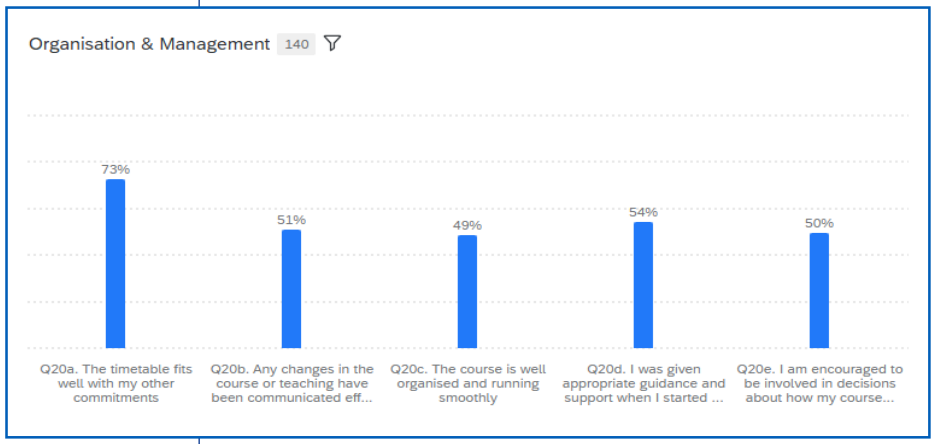
Education & Training – Student Experience

The Tavistock and Portman NHS Foundation Trust

Successes	Challenges
• We have successfully launched the 2025 student survey on the 28th April and the response rate (after 3 weeks) is at 12%, with 3 weeks remaining. If we keep on track, we should meet last year's response rate of 25%. National benchmark of 13% in 2024.	• Early indications show that the percentage satisfaction has fallen, (73% so far in 2025 compared with 79% in 2024) but this may change significantly before the survey closes
• Projects on developing a CPD course for embedding disability into learning & teaching is on course for launch of phase 1 by December 2025.	• Early indications show that students continue to be frustrated with organization and communication within the Trust (55% satisfaction overall so far)
• Projects on International student experience, developing a suicide safe strategy, placements, governance and quality, and creating live student survey dashboards for staff are all underway and progressing well. The data shown here is from the new survey dashboard.	

Student Satisfaction Metrics, 2025





Updates on actions from Student Experience Sub-Committee

Community and Culture: investigations ongoing into improving opportunities for student social or communal events

Disability and Estates: Being considered in Space Utilisation Task & Finish Group

Psychoanalytic and Systemic Portfolios: Placements and academic governance project management support identified

Proportion of students who have completed studies at this point in the cycle (academic month 8)

Number of students who have completed studies at this point in the cycle (academic month 8)

Action

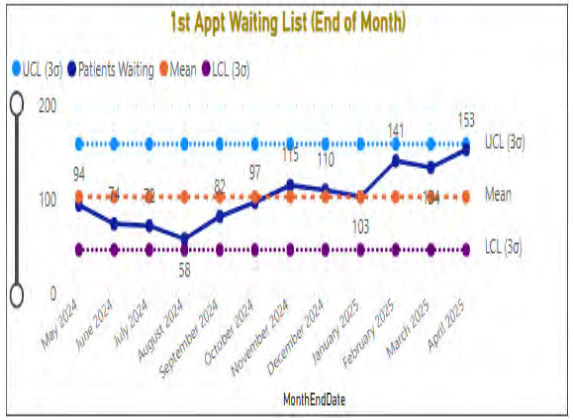
Concern	Cause	Countermeasure	Owner	Due Date
Lack of community and culture	Absence of a Student Union or similar	Action Group related to Student Experience Sub-Committee (SESC)	CETO / Directors of Education	May 2025
Low satisfaction among disabled students	Slow responsiveness to identified needs among disabled students	Discussions ongoing with SESC and escalated to Estates Space Utilisation Project Group	CETO/Estates CETO and CNO	May 2025
Low satisfaction with Psychoanalytic and Systemic Portfolios	Likely related to: i) Clear provision of placements ii) Some inconsistent academic standards	Placement provision to be explored with potential merger partners Academic standards being reviewed by head of registry	Exec Team CETO/Head of Registry	September 2025

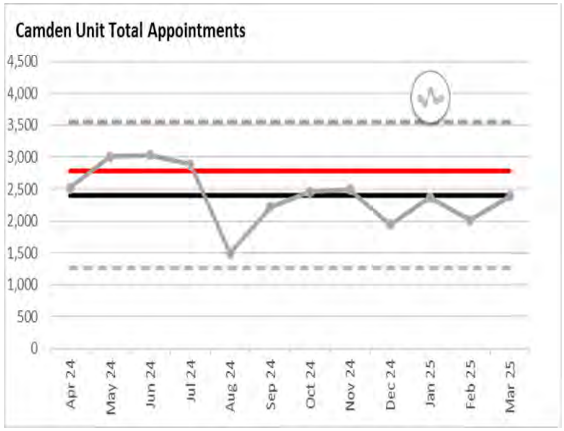
Camden Unit Overview (1/2)

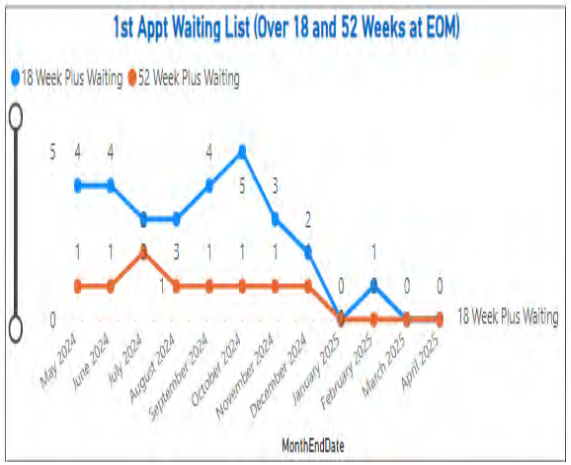
	Successes	Challenges
Safe	• Dormant cases - we have begun the process of asking for explanations of all cases dormant for 6 months or more, 20 cases not on a waiting list were dormant in April, this number has not reduced significantly since March. Spread across 4 teams and is being taken up with them. • Appraisal compliance increased by 10% since January. It now stands at 57.84%. There are some teams having more of an issue and this is due to changes in structures and a need for a wider group of staff to undertake appraisals this year. • MAST compliance now 84.9% - 3% increase since Jan.	• Have found an issue with cases with professional contact continuing to show as dormant – this is a major issue for our WFT/GWY services . Have raised with contracts and if no issues will request the report is changed. • While we continue to achieve high rates of compliance for clinical notes, some teams have seen an increase in recent months. They are aware of the issue and are taking steps to address. • Ongoing issue with priority rating forms and therefore crisis plans not tracking across an episode. Taking up with quality and will make changes to reporting. • We have seen a number of thefts of phones/laptop in recent months.
Effective	• All cases in CAISS met the new waiting time target (appt + OM) in April • 0 Camden YP were admitted to a Tier 4 bed in April. • We are achieving an average of a 3 week wait to first appt (exc. outcome measures) • Camden Wellbeing has achieved 100% compliance for initial care plans. All teams are achieving a high rate of compliance.	• New reports will be created that align with new waiting times metrics remain outstanding. • We continue to have a higher number of missing T2 outcome measures that desirable. This is higher in some teams and data is now being shared with them each month.
Caring	• We received a very positive letter from a parent this month speaking to the excellence of both clinical and administrative staff in SCCT/South MHST. • ESQ Feedback was 100% this month • Work is underway to make reasonable adjustments for neuro divergent service users including ear defenders for reception, the exploration of a quieter waiting space and information to be sent to families ahead of their appointment.	• 40% of cases open in the unit either do not have a safeguarding and risk form OR it is still at draft stage. This has reduced by 10% since February but we remain concerned and continue to bring this to the attention of teams, Have undertaken training for staff to use reports to ID cases without one. Data provided to teams monthly and staff members contacted regarding missing forms.
Responsive	• 0 cases have breached 18 or 52-week waiting times for the last 2 months. • DNA rates for the unit have been below the 10% target since August 2024. • Levels of attended appointments in CAISS have doubled in 6 months • We have restarted job plan reporting this month and are sharing data with teams. The data does however require further validation. • Specialist Intervention (treatment) waiting lists are now on Carenotes – it has taken several years to achieve this, and it means we will now be able to accurately report on waiting times.	• The activity reported below does not include NPA which is essential for Camden – without it the data on our performance is inaccurate. • A higher level of staff absence in NCCT is affecting availability of assessment slots. This is a combination of sickness and special leave. • MHST job plan compliance is very low (33%), this is alongside some other data issues which we are taking up with the team
Well-Led	• CAISS and Whole Family Team are now fully recruited • We have no complaint reports that have passed their deadline. • The LA has increased the number of social workers that they fund in the WFT/WFT-P teams • Awarded money by Camden Kaleidoscope to offer consultation, training and supervision	• Recommended changes to how we undertake job planning has meant we are having some delays in updating plans, but we have begun reporting to teams again for April. Teams are aware of their targets. • Budget has not been finalised making moving ahead with our savings plan challenging.

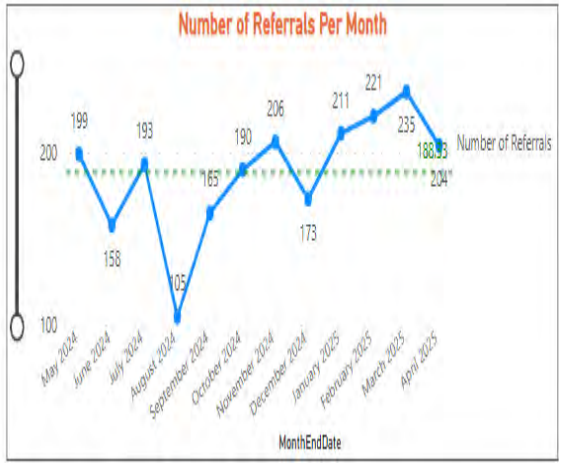
Camden Unit Overview (2/2)

Activity Overview









- The number of people waiting at the end of the month continues to grow. We have now planned our A3 in relation to the clinical intake team and will be implementing over the next 3 months. An updated PTL report is now in testing stage and will be implemented in June which we hope will also improve compliance.
- There was a lower number of appointments and referrals in April which is likely to have been caused by the Easter holiday.

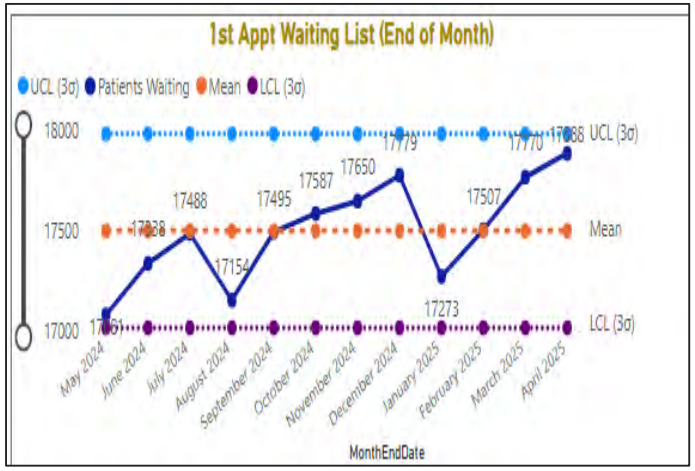
Concern	Cause	Countermeasure	Owner	Due Date
- Activity and Job Planning	Lack of oversight in 24/25, new staff not being given job plans	Job plans in place for all. Is a delay in implementing as a visual for all as agreed. Reporting reinstated in April. A3 to be developed for any teams where activity is a concern	Fiona Hartnett, CSM	Sept 2025
All activity not pulling into reporting	Professional contacts not showing against dormant cases. NPA not reported in this meeting	Professional contracts under discussion with informatics and contracts. NPA being discussed from governance perspective but reporting needs addressing	Fiona Hartnett, CSM	Sept 2025

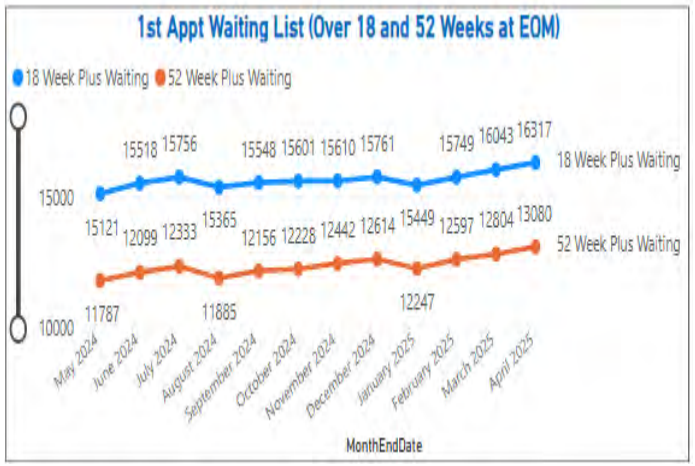
Adult Unit Overview - 1/2

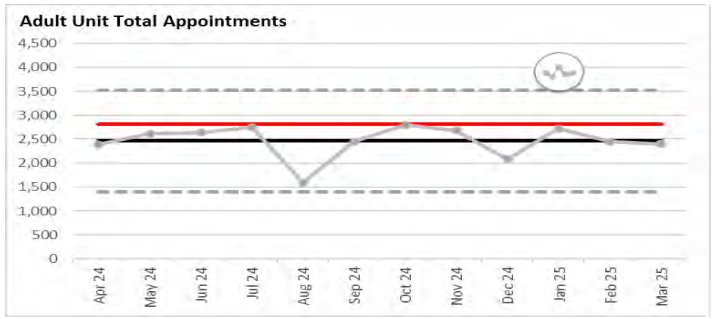
	Successes	Challenges
Safe	• Business Continuity Plans now signed off through Unit Clinical Governance. • Engagement with national GIC QI initiative leading to July workshop to align pathways. • Reception and clinical service working together for safe, respectful and trauma informed entry for patients. • PCPCS staff care - Of 10 staff at risk 3 admin staff and 5 clinical staff have been successfully re-deployed to posts in trust wide services.	•Financial pressures in the context of agreeing CIP Plans which will be appraised against the quality and equality impact assessments with oversight through the CIP Programme Delivery Group and PFRC. •Following PCPCS closure 4 staff were made redundant. •As ERF staff in Trauma wind down due to fixed term contracts the amount of clinical work undertaken by these staff members will reduce. They will be redirected to deliver some of the patient safety and screening elements. •Recent GIC clinical seminar had media consequences. The Trust has responded to concerns raised.
Effective	• More staff now undertaking complaints investigations with mentoring / shadowing & advice from leadership in response – complaints training dates confirmed. • Waiting times to 1st appt reduction in trauma with significant pathway and service adjustments to reduce inappropriate or outside of contract referrals. • Adult Psychotherapy waiting times consistently reduced for last 12 months. . • GIC staff working cohesively to assure safe cover for new rotas.	• GIC and Trauma service continue to require Targeted support with weekly meetings. Further progress is required to assure delivery. • We are seeking to realign to the commissioned activity contract and in tandem build a compelling business case for change to revise commissioning specifications for trauma across the ICS and nationally for GIC (NHSE Review feedback expected soon). • Portman concern over plan to pause D59F having successfully re-established the intake last year. • Waiting list causes ongoing concern however services are delivering controls to mitigate these supported by NHSE and a new digital offer which will launch in May 2025.
Caring	• Positive feedback through ESQ narratives on quality and sincerity of care, time and attention given to patients feeling seen and heard. • More staff resource spread across a greater number at different bands and roles in response to recent increase in complaints. • Revised SOP in GIC for a dual rota system, one for on-site urgent support, the other for email and telephone messages relating to distress and a wider staff group to weather the impact of the work. • Service User and Clinician partnership review of GIC webpage to provide updated, person centered information.	• The CIP improvement plan will challenge the services ability to deliver. This means that services will have to deliver their services differently, aligned to the challenging trajectories that have been agreed. • We may seek to ask staff from the other clinical units to support with the disproportionately larger numbers of adult complaints. -
Responsive	• New OM processes in place in ¾ of teams, good take up but reminders needed whilst bedding in. • Teams are continuing to focus on their primary tasks to provide excellent care to service users both locally and nationally. • PPI groups are meeting regularly • Greatly increased Crisis plan compliance in Trauma Team which is now over 90% • Adult Unit +30% since December 24 on crisis plan completion and updates • Trauma DNA down to 10% in last 2 quarters. • GIC has adapted to two parallel rotas for on-site duty and a remote, phone / email distress rota.	• Finding the most optimal booking system for GIC and Trauma. • The focus on continuous improvement and uncertainty in the NHS landscape can impact morale. The Unit leads recognise this and aim to create a positive work environment.
Well-Led	• The GIC Universal Assessment tool has launched, providing comprehensive assessment and real time data capture amenable to statistical analysis. • Service Clinical lead is keeping teams updated on Merger plans and recent changes to the NHS landscape. • Operations and deputy General managers have held additional responsibility in the absence of their Service Unit Manager since September 2024 and have been supported by the Managing Director .	• The Unit Operational Manager starts in post in June 2025. This post as been vacant since November 2024. • The unit is exploring the NHS Staff Survey at a unit and team level to understand individuals' experiences of the pressures and concern which impact on morale.

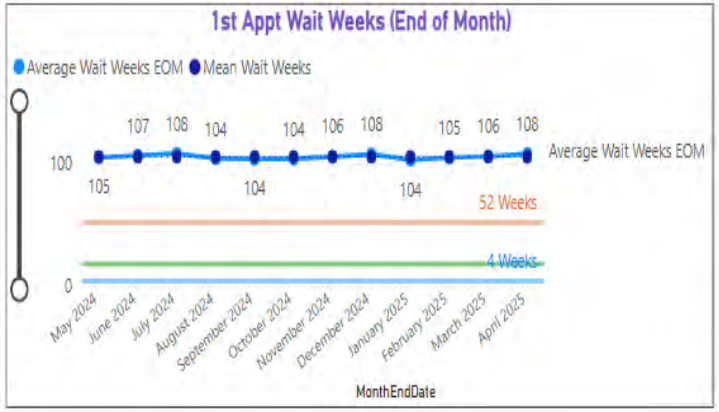
Adult Unit Overview – 2/2

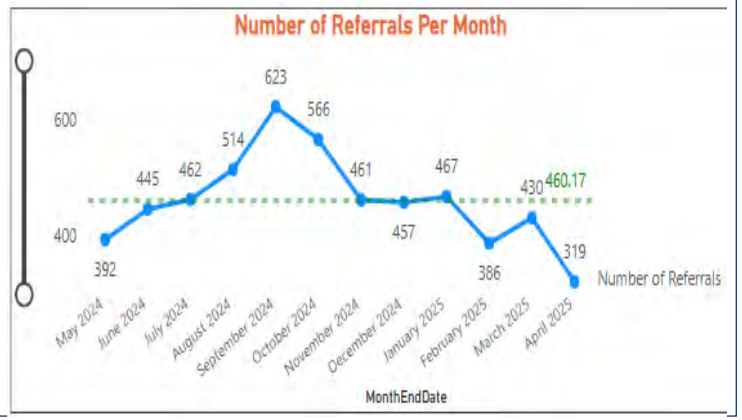
Activity Overview











Analysis

Average wait time in weeks is consistent with the same time last year.

Concern	Cause	Countermeasure
Capacity for waiting list reduction in GIC	This is largely due to increased and increasing national demand in recent years.	We are expecting to work with NHSE and nationwide GIC teams on July 2nd to better understand demand, flow and resources.
Portman seeking to open and widen its potential	Changing profile of potential users	Current work on intake process, advertising and liaison with referring agencies.

Next Steps.

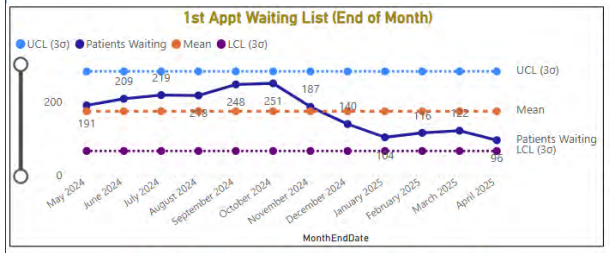
- **The NCL Partnership Board in July is focussed on our Trauma service, systemic demand and system wide responses across the ICS with a proposed closure of our wait list and review of system offers for same population**
- **To act on recruitment to the outstanding GIC posts in process @May 2025**
- **Finalise the last of 8 redeployments from PCPCS, 4 redundancies were unavoidable**

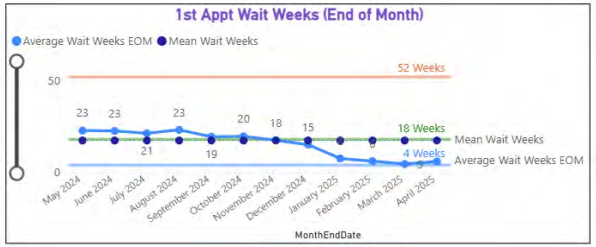
Child and Family Unit overview (1/2)

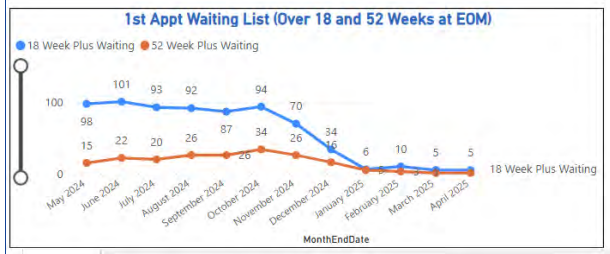
	Successes	Challenges
Safe	**Clinical notes compliance**: Clinical notes compliance continues to improve with an overall 85% compliance rate, Improvement in DNA and Cancelled notes increasing from 60% to 80% in April. Compliance on attended appointments is at 86% across the Unit with EDAS at 98.27%, Returning families at 98.76% and Haringey CWP at 94.57%	Methods of gaining assurance on specific data points and performace from some TCLs and Operational Managers need further development.
Effective	EDAS currently 90.91% seen within 4 weeks and the waiting times for 2nd appointment have decreased from 20+ weeks to 10 weeks. FCAMHS first appointment has reduced to an average of 3 weeks.	Dormant cases across the Unit are at 83 a slight increase on the previous month and indicative of a growth trajectory. In part a reflection of the continued demand for Autism Assessments and the ending of the ERF recovery and in part due to an increase in FMHT which will need to be resolved. EDAS have made significant improvement in 1st appointment but are not meeting 8 week waiting time RTT target, In November RTT for treatment was 25 weeks not reducing to 20 weeks in April and 10 weeks forecast wait in May. There has been an increase in waiting times to 1st appointment to an average of 6.24 weeks including Autism Assessment and CATS at 13.69 weeks. Appraisal rates in the Unit have dropped to 36.47% with staff reporting delays in completing paperwork. Service Leads will develop an A3 approach to resolution. Teams with low compliance include Returning Families and FDAC.
Caring	ESQ return rates have increased to 20 for the month of April – evidence efforts may be improving return rates. In light of the increased return rates, the approval rating has dropped from 100% to 85% which in the context of learning we see this as an improvement.	
Responsive	EDAS team reporting 16 ESQ forms completed for April. 4 patient safety incidents in the Unit with 100% compliance in complaint response times within 40 days.	FMHT team have 11 cases that are Dormant for 52 plus weeks – clincal mamagers will work with the team ton review the cases and action accordingly. Three changes in consultant in the last 6 months have led to some delays in routine medication reviews.
Well-Led	FDAC conference took place in May – very well received with a focus on obtaining new contracts. New contract signed with Hertfordshire for £228k for Autism Assessments, ASD lead has presented a learning event on the Kaizen approach in the Autism Assessment Pathway. FCAMHS stakeholder engagement survey to be launched and negotiations underway with new NCEL commissioners on reporting schedules and requirements. First Step Plus Service SLA to be agreed by May 21st. Efficiency plans put forward for £500K+ of savings. Gloucester House Outreach team have worked with the Business Development Unit to develop a programme of packages of care that when marketed could address the financial deficit within 18 months if delivered according to plan. A series of strategy meetings will take place from May 25 onwards to support financial and operational delivery of the service. Priority will be given to financial viability and data capture	Consultation in Surrey Mindworks team will begin first week of June. TUPE unlikely to apply. Financial position confirmed in May. Staff turnover in Autism team will impact on delivery timescales which will need to be adjusted, FDAC contracts continue to appear vulnerable pending ongoing negotiation with the Business Development Team. ASF terms and conditions have changed following updated guidance from the Government which requires a redesign of the offer. Team working with the BDU team to achieve this. Returning Families contract to end 25/26. Financial position continues to require resolution in relation to budget rightsizing and pay targets. Unit Leadership team working with Finance colleagues to resolve – proposed pay target from finance (as presented in meeting on 20.05.25) will render the unit untenable and clinically unsafe Gloucester House Outreach Service faces challenges going into 25/26. these include • Poor data set to support activity monitoring • Low volume of referrals • Cases spread over a wide geographical area resulting in time lost spent travelling • Forecast deficit position for 25/26 of £96k

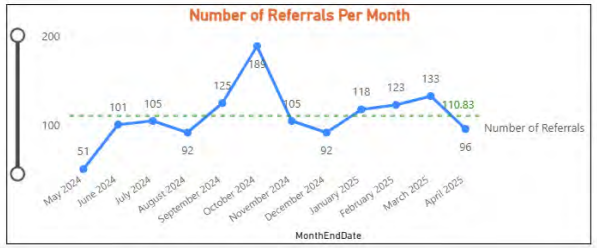
Child and Family Unit overview (2/2)

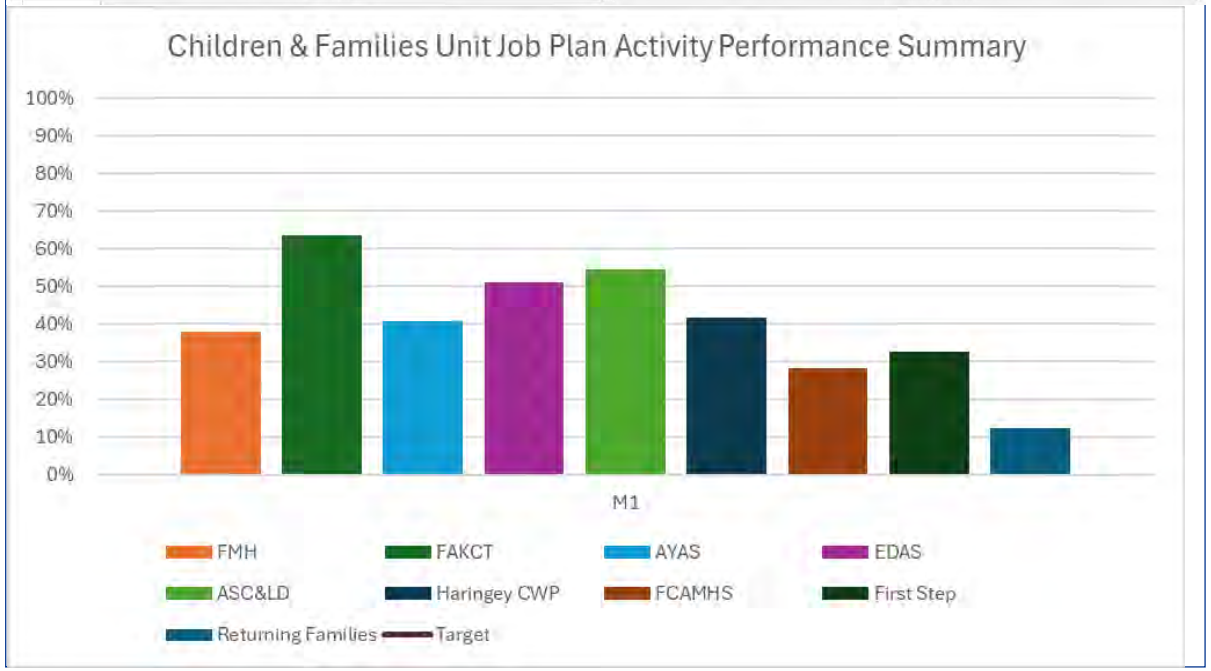
Activity Overview











Analysis : The data now includes all teams in C&F and as a result the figures will show some variation because of new team being added to the data set. The following figures include all teams excluding FDAC.
Activity – 1522 appointments attended for April 2025, a reduction from the previous month of 2116 adjusted for seasonal variation and a marginal increase on April 2024.

Job plan compliance: Job planning reviews still being completed for the new financial year.
Referrals: 111 referrals into the Unit for April 2025.
Waiting times: Across all the teams in the unit we are reporting an average waiting time of 6.24 weeks including Autism Assessment. Excluding Autism Assessment waiting times to 1st appointment are 5.29 weeks. Assessment to 1st appt. ASC LD are declaring 5.36 weeks, Autism Assessment 11.18 weeks, AYAS 4.09 weeks, FMHT 5.22 weeks, EDAS 1.77 weeks. FAKCT 6.64 weeks, Haringey CWP 2.4, FCAMHS 5.44 weeks. CATS 13.69 Weeks

Average waiting time for second appointment is : AYAS 7.38 weeks, ASC/LD 4.5 weeks Autism Assessments 39.2 weeks, FMHT 11.50 weeks, EDAS 2.08 weeks, FAKCT 5.71, Haringey CWP 5.83 weeks. CATS 2.7 weeks FCAMHS 10.83 weeks.

On the Autism Assessment Pathway 11 patients are waiting for a first appointment. The average waiting time to 1st appt has reduced to 7.27 weeks, with 1 patient waiting 52+ weeks for 1st appt. 14 referrals for Assessment were made with 11 accepted,
Dormant cases:

A total of 548 cases are Dormant. Of those 83 are Dormant for 52 weeks plus. This includes 11 cases for Family Mental Health and the remainder are in the Autism Assessment Pathway.

Clinical notes compliance: Clinical notes compliance continues to improve with an overall 85% compliance rate, Improvement in DNA and Cancelled notes increasing from 60% to 80% in April.

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.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 10 July 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 latest update on the full Board Assurance Framework (BAF) risks during Quarter 1 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 Committees.		
Background:	The BAF remains a critical 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. To support effective management of risk, the Board has held two key sessions during Quarter 1 2025/26: 1. Facilitated risk appetite session held in April 2025 which was conducted using a nominal group technique which helped gather and prioritise Board members' views on the Trust's risk appetite levels across different risk domains. 2. "Clean Slate" exercise undertaken as part of the Board Development session in May 2025. This exercise was to enable the Board to validate the continued relevance of existing BAF risks, assess their alignment with the Trust's Strategic Ambitions; and identify any new or emerging risks for inclusion on the BAF.		
Assessment:	**Key developments since the last Board include:** **1. Risk Appetite 2025/26:** During the May/ June reporting cycle, the Board Committees each received an alignment table relevant to the risk profile within their remit. It offered a structured comparison of the Trust's current BAF risk profile against the newly agreed risk appetite levels. The table offered valuable insight into where each BAF risk sits (either within, below or if it exceeds the defined risk appetite) thereby supporting targeted Committee oversight of management actions. **2. BAF Refresh 2025/26 – Output of Board 'Clean Slate' Exercise:** The Board Committees received the initial output of this exercise which highlighted commonalities with the existing BAF risks. Further work is planned with the Executive Leads during Quarter 2 to review and		

	determine any necessary follow-up actions in relation to other areas of risks identified which did not have a clear alignment with the existing BAF risks. This will be reported to Board following further discussions at the Board Committees during the August/ September reporting cycle. **3. BAF:** **i. BAF Risk 15 (Staff disengagement):** A new risk of Staff disengagement has been added to the BAF and agreed by People, Organisational, Development, Equality Diversity and Inclusion (POD EDI) Committee at its last meeting. The risk relates to the Trust's response to issues that matter to staff, and clarity of its plans to improve staff experience, and the resulting impact on staff motivation and morale. The Trust can demonstrate that progress is being made towards improving staff engagement, but there is more work to do to ensure the actions to address the identified gaps in assurances and control will sufficiently mitigate the risk. Further discussion will be held between the Interim Director of Corporate Governance and the Chief People Officer to finalise the wording of BAF Risk 15 to capture discussions at the POD EDI meeting. ii. Emerging risk of "Sustainability of Core Education Funding Contracts". This risk relates to uncertainty surrounding a new contracting process and the potential changes to the current arrangement with the NHS England National Training Contract (NTC), which has supported the majority of Department of Education and Training courses. Further consideration of this risk would be given by the Interim Director of Corporate Governance and the Chief Education and Training Officer in advance of the next Education and Training Committee meeting. **4. CRR:** Work to strengthen the CRR entries is underway. However, progress has been slower than anticipated due to a resourcing gap within the Corporate Governance Team during Quarter 1 2025/26. This is expected to be addressed during Q2 2025/26.
Key recommendation(s):	The Board is asked to: **1. 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. **2. Provide Input on Missing or Inadequate Controls:** • Highlight areas where current controls may require immediate enhancement. • Suggest additional mitigating actions or controls. **3.** Suggest any other potential areas not covered in either or both appendices.
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:	• ELT – June 2025 • PFRC – 12 June 2025 • QSC – 19 June 2025 • POD EDI – 26 June 2025 • ETC – 1 July 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 latest update on the full Board Assurance Framework (BAF) risks and Corporate Risk Register during Quarter 1 2025/26.

2. Report and feedback from May/ June Board Committee meeting cycle:

Quality and Safety Committee Oversight:

BAF update:
The Committee received **3 BAF risks:**

- **Risk 1 - Inequality of Access for Patients;**
- **Risk 2 - Failure to Provide Consistent, High-Quality Care); and**
- **Risk 13 - Failure to achieve required productivity & performance (Quality and Patient Safety focus)**

- **BAF 1** (Inequality of Access for Patients):
  This risk highlights challenges in providing equitable access to services.

Progress:

- PCREF: There is a monthly focus on individual team's actions to address access to services and other projects to ensure equity of access to treatment. All services have been provided with local ethnicity data and their own referral data by ethnicity this is to ensure the referral data best reflects the local population.
- Clinical Harm Reviews: These are now embedded into the first CORE appointment process and will be reportable by end July 2025.

- **BAF 2 (Failure to Provide Consistent, High-Quality Care):**
  This risk pertains to the delivery of high quality and safe patient care and compliance with regulatory and contractual standards.

Progress:

- Standardised job planning framework aligned to service demand has been implemented.
- Strengthened oversight of Learning from Deaths by incorporating the process within the Clinical Incident & Safety Group terms of reference. First meeting is planned by July 2025 (pending new Deputy Chief Medical Officer commencing in post).
- Roll out of learning poster for complaints and incidents.

- **BAF 13 (Failure to achieve required productivity & performance):**
  This risk highlights challenges with waiting time reduction in GIC and Trauma; workforce productivity and the Trust's inability to achieve contracted levels of performance and productivity. The focus remains on reducing waiting lists, improving productivity, and enhancing the patient experience.

Progress:

- Standardised job planning framework aligned to service demand has been implemented.
- Although weekly targeted support meetings continue for GIC and Trauma with monthly reporting to ELT, progress is still yet to be evidenced.

- To address ongoing capacity challenges and support sustained service delivery. As part of the annual planning and efficiency work, each unit is expected to have a ratified workforce plan by mid-July 2025.

- **CRR update**:

Work to strengthen the CRR entries is underway. However, progress has been slower than anticipated due to a resourcing gap within the Corporate Governance Team. This is expected to be addressed during Q2 2025/26.

Education and Training Committee Oversight:

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

- **Risk 3 – Risk of loss of registration with the OfS**
- **Risk 4 – Potential Contraction of Student Recruitment**

- **BAF Risk 3 (Risk of loss of registration with the OfS):**
  - **Change to risk title and description**: There is now a shift in focus to the risk of loss of registration with the OfS as a Higher Education provider if there is a change in the Trust's future governance arrangements.
  - New control added: Board level awareness of Higher Education Regulation. OfS registration requires governing body knowledge of Higher Education procedures. Green assurance rating.
  - Additional assurance to be provided to the OfS highlighting any proposed change to governance arrangements during the OfS registration moratorium (August 2025).
  - The Committee agreed that this risk should be reinstated on the BAF risk register in Public.

- **BAF Risk 4 (Potential contraction of student recruitment):**
  - Work is progressing on the identification of immediate areas of growth in the 2025/26 recruitment cycle;
  - A project to deliver more effective international student recruitment using agents to attract students is planned by August 2025;
  - The recent DET Strategy event on 4 June included thoughts on new subjects for programmes and enhancing student experience.
  - A deep-dive on Student Retention has been requested by the Committee for assurance.

- **New risk**: The Committee were informed of an emerging risk of "Sustainability of Core Education Funding Contracts". The Committee endorsed that further consideration of this risk should be given by the Interim Director of Corporate Governance and the Chief Education and Training in advance of the next Education and Training Committee meeting.

POD EDI Committee Oversight:

BAF update:
The Committee received **4 BAF risks** with particular **focus on the new BAF Risk**:
- **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**
- **Risk 15** – **Staff Disengagement** (**New risk**)

- **BAF Risk 6 (**workforce development, resilience, retention, recruitment)**:**
  - A3s are being developed for mandatory and statutory training (MAST) and appraisals to help identify and address issues in compliance with the current processes.
  - Scrutiny of all recruitment requests via the ECP panel with all requests for corporate recruitment being considered at ELT. There has been a pause on recruitment requests for corporate recruitment while looking at the Efficiency plans. Mechanism is in place for review of service critical requests.
  - Succession planning report to be considered at the September meeting of the Committee.

- **BAF Risk 7 (**fair and inclusive culture)**:**
  - The EDI Programme Board have agreed three priority areas and measurable actions/ metrics to achieving culture change in the Trust:
    - Eradicate Bullying, Harassment and Abuse
    - Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion
    - Formal Disciplinary and Capability Processes
  - EDI metrics are being finalised through discussion at the EDI Programme Board.
  - Structures are now in place to ensure all internal promotions are scrutinised by the Recruitment & Retention Group quarterly.
  - Assurance rating moved from amber to green: Health & Wellbeing group (includes review of cost-of-living issues) Now incorporated within POD Delivery Group and Staff Engagement Group.

- **BAF Risk 8 (**management capability and capacity)**:**
  - The final cohort of the Management Leadership Development Programme (MLDP) – meeting to identify learning from the programme and next steps is planned.
  - HR Policies review: A plan is being finalized to adopt the merger partner policies where they are not contractual. The contractual policies are capability and sickness policies only. It is being proposed to rebadge all other workforce policies.
  - Assurance rating moved from amber to green: Management training in place (Kaleidoscope).

- **BAF Risk 15 (Staff disengagement):**
  This risk was identified at the last meeting of the Committee. The risk record has been populated with the proposed title, risk description, specific controls, assurances and actions, including an assessment of the risk for the Committee's views. The Trust can demonstrate that progress is being made towards improving staff engagement, but there is more work to do to ensure the actions to address the identified gaps in assurances and control will sufficiently mitigate the risk. The Committee discussed the risk and noted further discussion will be held between the Interim Director of Corporate Governance and the Chief People Officer to finalise the wording of BAF Risk 15 to capture discussions at the meeting.

PFRC Committee Oversight:

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**

- **BAF 09** (Financial sustainability): A balanced financial plan has been agreed for 2025/26, supported by a detailed efficiency programme. In addition, a project-based approach is being finalised to ensure robust governance arrangements are in place to support effective delivery of planned targets.

- **BAF 10** (Estate infrastructure): A non-invasive asset performance and detailed 6 facet survey has commenced, this will conclude in July 2025, to take account of the upgrades since the last survey that took place in 2021.

- **BAF 11** (Sustainable income streams): As agreed at the last Committee meeting, a further review of this risk is required with the Lead Executive during June/ July to ensure rewording of the risk in consideration of any emerging commissioning issues and other related contract risks.

- **BAF 12** (IT infrastructure and cyber security): An urgent review of this risk is required to ensure greater clarity over the gaps in assurance/ controls and definitive timelines for implementation of actions. At the time of writing updates were being awaited from the Director of Infrastructure.

- **BAF 13** (Failure to achieve the required levels of performance and productivity): Following discussions at the last Committee meeting, an increase in the residual risk score from (L3 x C4 = 12) to (L4 x C4 = 16) was proposed. This reflects the increased likelihood due to several emerging factors, including the decommissioning of contracts, loss of Elective Recovery Fund (ERF), potential withdrawal of MHIS. This risk is further compounded by broader policy shifts including a growing emphasis on performance-related funding mechanisms over traditional block funding, alongside a projected commissioning funding gap. The Committee did not approve the proposed increase at this meeting, but rather it agreed to review this at the extra-ordinary meeting of the Committee in July following discussions at the IQPR meeting.

- **BAF 14** (Environmental sustainability): To ensure system-wide compliance, the NCL is sharing the Green plans across all Trusts, aiming to align a common set of measures for implementation between July and August. The Trust has signed up to the NHSE Utilities Framework, with the contract commencing during Q1 2025/26. This collaborative approach supports consistency in sustainability commitments across the system.

- **CRR update:**

  Work to strengthen the CRR entries relating to estates, contracting, and strategic commercial risks is underway. However, progress has been slower than anticipated due to a resourcing gap within the Corporate Governance Team. This is expected to be addressed during Q2 2025/26.

The Tavistock and Portman NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK – QUARTER 1 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 Themes/ Levels	
Quality and Safety	Cautious
Service Delivery and Transformation	Open
Regulatory Compliance	Cautious
Reputation	Cautious
Education and Training	Hungry
People and Workforce	Open
Financial Sustainability	Open
Estates	Open
Digital Infrastructure (Cyber Security)	Cautious
Digital Infrastructure (Digital Transformation)	Open
Environmental Sustainability	Open
Service Delivery and Transformation	Open
Growth	Hungry
Research and Development	Open

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 (Provisional)				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)	**16**	**16**	**16**	**12**	**Cautious**
2	Failure to provide consistent, high-quality care	**If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.	20 (4 x 5)	15 (3 x 5)	⟺				10 (2 x 5)	**15**	**15**	**15**	**10**	**Cautious**
To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.														
3	Risk of loss of registration with the OfS	There is a risk that a change in the Trust's governance arrangements may result in a change to the Trust's registration with the OfS as a Higher Education provider.	20 (4 x 5)	12 (3 x 4)	⟺				8 (2 x 4)	**12**	**12**	**8**	**8**	**Cautious**
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)	**12**	**12**	**8**	**8**	**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 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 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	16 (4 x 4)	16 (4 x 4)	↑				6 (3 x 2)	**16**	**16**	**12**	**12**	**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)	**12**	**12**	**9**	**9**	**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)	**9**	**9**	**6**	**6**	**Open**
15	Lack of Staff Engagement/ Staff Disengagement	If we do not address issues that matter to staff and do not have a clear plan to improve staff experience, staff will become disengaged. This will lead to decreased motivation, lower morale, and reduced commitment to the Trust's strategic ambitions and values. This could impact the quality of care/service delivery, hinder innovation, increase staff turnover, and negatively affect patient/service user experience and organisational performance.	20 (5 x 4)	16 (4 x 4)	New!				12 (3 x 4)	**16**	**16**	**12**	**12**	**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)	**16**	**16**	**16**	**12**	**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)	**12**	**12**	**12**	**8**	**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)	**15**	**15**	**15**	**10**	**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)	**12**	**12**	**12**	**12**	**Cautious**
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual targets relating to activity, quality and delivery 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 due to decommissioning of contracts, loss of ERF, potential withdrawal of MHIS, and financial penalties, poor patient experience and patient outcomes, risks to patient's mental health, and reputational risk. Further compounded by policy shifts including growing emphasis on performance-related metrics over block funding and projected Commissioning funding gap.	16 (4 x 4)	12 (3 x 4)	⟺				8 (2 x 4)	**16**	**16**	**16**	**12**	**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 its demand on the environment, the impact will be felt on the provision of its existing and potential new 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 2032 and net zero carbon plus influenced by the NHS ambition to reach 80% 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)	**12**	**12**	**12**	**12**	**Open**

Principal Risk 1	**Inequality of access for patients**		
Description	**If** services within the trust limits access to potential patients through the use of restrictive and non-diagnostic 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 Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	May 2025
Risk Appetite	**Cautious**	4	4	**16**	4	4	**16**	2	4	**8**	⟺				**Date of Next Review**	August 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 have been provided with local ethnicity data and their own referral data by ethnicity this is to ensure the referral data best reflects the local population.	Fully implemented but will be audited in 3 months to assess effect All services to review their inclusion criteria with EDI and people with lived experience to ensure equitable access.	PCREF Implementation group – IQPR report to Board - there is a monthly focus on individual team's actions to address access to services and other projects to ensure equity of access to treatment. 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
	Care of waiter protocol to be embedded by end of Q1.	Autism	Internal	Green
	Clinical Harm Reviews to be reportable by July 2025.	Gender - Clinical Harm Reviews are now embedded into the first CORE appointment process	Internal	Amber
	Form to be socialised and implemented end of Q2.	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

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**	May 2025
Risk Appetite	**Cautious**	4	5	**20**	3	5	**15**	2	5	**10**	⟷				**Date of Next Review**	August 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)
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 responsibilities incorporated into Clinical Incident & Safety Group Terms of Reference. First joint meeting scheduled to take place by July 2025 (pending start of new Deputy Chief Medical Officer).	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 Detailed breakdown of Quality & Safety focussed MaST modules A3 for MaST to be developed, led by Head of OD	Mandatory training compliance reported through the POD EDI Committee bi-monthly MaST paper for 24/25 currently under approval by ELT - approved MaST compliance to be included in IQPR – Included and reviewed monthly in IQPR	Internal	Amber
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 will be strengthened by developing an improved structure through the Safeguarding forum.	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	Internal	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	Learning from Healthcare Deaths Policy ratified in December 2024 Mortality Group responsibilities into Clinical Incident & Safety Group quarterly (previously stand alone group) Electronic Mortality Review form now live Radar	Internal	Amber

		Mortality Reviews reviewed by Clinical Incident & Safety Group; learning shared through Clinical Governance meetings		
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 Staff training sessions scheduled for June and July 2025	-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 Self-assessment of PSIRF roles and responsibilities framework to take place by the end of Q1 25/26	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	Complete - 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
Implement standardised job planning framework aligned with service demand.	Chief Medical Officer/Medical Director	June 2025	Complete

Strengthen oversight of Learning from Deaths process within the Clinical Incident & Safety Group.	Chief Medical Officer	July 2025	In Progress – first meeting planned by July 2025
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)	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	August 2025	In Progress – QI project in place
Complaints Policy		February 2025	Policy Ratified by PAG Amendments requested by group being actioned. Policy to due to be published by end of February.
PSIRF Roles & Responsibilities self-assessment	Associate Director of Quality / Patient Safety Manager	July 2025	In progress

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 3	Risk of loss of registration with the OfS													**Strategic Objective**	**To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.**	
Description	There is a risk that a change in the Trust's governance arrangements may result in a change to the Trust's registration with the OfS as a Higher Education provider.															
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**	31st January 2023
Lead Committee	Education Training Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	11th June 2025
Risk Appetite	**Cautious**	4	5	**20**	3	4	**12**	2	4	**8**	⟺				**Date of Next Review**	August 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)
Ensure the merger has robust provisions to retain OfS registration	Additional assurance to be provided to the OfS highlighting any proposed change to governance arrangements during the OfS registration moratorium (August 2025)	Regular meetings between OfS and validating partner to ensure protection of the student experience.	External	Amber
Appropriate staffing and infrastructure in place to support OfS compliance this ensures there are no regulatory concerns from the OfS relating to returns		Regular meeting with validating partner around OfS returns Quarterly monitoring of HESA returns	Internal	Green
Systems Infrastructure (data quality) adequate to support OfS compliance	Need for systems to support not hinder data returns to partners, OfS and HESA. Limited confidence in certain control measures among staff members. External consultants have made recommendations about the changes to functionality to our SITS implementation. These need to be put in place by the Trust.	Continuing to seek capital investment for our SITS offering as soon as practicable.	Internal	Amber
OfS working group to provide regular updates to Director of Education (Governance & Quality)	The Board needs to be assured that a merger would retain the Trust's OfS registration into the new entity. This would not follow automatically and requires the new entity to be registered.	Weekly merger working group between Exec leads and Directors of Education ETC to review reports and updates and monitor OfS returns.	Internal	Amber
Board level awareness of Higher Education Regulation - OfS registration requires governing body knowledge of Higher Education procedures.		The Board have been given specific briefings by DET Staff on both the broader landscape and particular risks.	Internal	Green
Regulatory conditions to be mapped against the academic year planner to ensure compliance and an action plan to meet ongoing conditions.	Data procedures are cumbersome		Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Continue to engage with the OfS about a potential change of registration.	Chief Education and Training Officer	By September 2025	Additional assurance to be provided to the OfS highlighting any proposed change to governance arrangements during the OfS registration moratorium (August 2025)

Strategic Delivery Metrics

Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
That we comply with Higher Education regulatory requirements and futureproof our position in relation to emerging trends within the sector.	Head of Registry now appointed SITS review complete and additional investment agreed SITS changes to be implemented	Delays in recruitment process Not aligned with traditional HE sectors for recruitment windows Financial position 2025/26	24/25 OfS return successfully completed Complete, aligned for 2025/26 intake New staff member in place leading SITS changes

Associated Risks on the Corporate Risk Register

Risk ID	Description	Current risk score

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**	May 2025
Risk Appetite	**Hungry**	4	4	**16**	3	4	**12**	2	4	**8**	⟷				**Date of Next Review**	August 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	Competing priorities and changes to a number of areas across the directorate, including a delay in recruitment for additional staff	Plans in place and implemented to expedite the process in order to mitigate risks and cover gaps on a temporary basis

	Ongoing improvements to infrastructure (staffing and systems)	Financial plan 25/26 restricts capacity to grow marketing function	

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**	June 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	3	2	**6**	↑				**Date of Next Review**	August 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, 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

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)
ECP approvals by ELT for Corporate roles to ensure ongoing review of skills mix and ensuring robustness of workforce	ECP on pause whilst looking at Efficiency Plans – Mechanism for review of service critical requests still in place.	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
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
Workforce Dashboard in place to provide workforce data on key areas e.g. mandatory and statutory training and appraisals	A3s planned for Statutory Mandatory Training and Appraisals	Report to Recruitment and Retention Group, POD EDI and Board	Internal	Amber

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	Need to identify the current actual vacancies
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	30 September 2025	Succession planning paper to ELT June, Senior Leadership Forum in July POD EDI and to Board in September

Conduct Corporate Services review of current structures	CPO	30 September 2025	Initial discussions planned with merger partner as part of the Culture and Workforce Transaction review with an aim to join up the teams in advance of the transaction.
Develop A3s for Statutory Mandatory Training and Appraisals to help identify and address issues in compliance with the current processes	CPO	30 June 2025	In progress – live document.

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**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**	June 2025
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	⟷				**Date of Next Review**	August 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	Green
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 Structures are now in place to ensure all internal promotions are scrutinised by the Recruitment & Retention Group quarterly.	Internal	Amber

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)
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	March 2026	Action plan streamlined and progress being regularly presented at the EDI Programme Board Three key deliverable outcomes have been identified as key to achieving culture change in the Trust. These are monitored via the EDI Programme Board: i. Eradicate Bullying, Harassment and Abuse ii. Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion iii. Formal Disciplinary and Capability Processes EDI metrics are being finalised through discussion 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**	**Strategic Ambition**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**
Description	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.		

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**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**	June 2025
Risk Appetite	**Open**	4	5	**20**	3	3	**9**	2	3	**6**	⟷				**Date of Next Review**	August 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		Senior Management Leadership Development Programme Feedback from 8B and above	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of People (OD, Culture and Engagement	Ongoing	Final cohort of the MLDP (Management Leadership Development Programme) – meeting to identify learning from this and next steps is planned. 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	Head of People (Business Partnering and Employee Relations)	Ongoing	The plan is to adopt the merger partner policies where they are not contractual. The contractual policies are capability and sickness only. All other policies need to be rebadged. Ongoing, In line with timetable currently on target to meet implementation date.

application, and a starting point of seeking to learn and develop rather than punitive measures			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	This is now complete. Next steps of Kaleidoscope to be discussed at ELT. 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 15	**Lack of Staff Engagement/ Staff Disengagement**	**Strategic Ambition**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**
Description	If we do not address issues that matter to staff and do not have a clear plan to improve staff experience, staff will become disengaged. This will lead to decreased motivation, lower morale, and reduced commitment to the Trust's strategic ambitions and values. This could impact the quality of care/service delivery, hinder innovation, increase staff turnover, and negatively affect patient/service user experience and organisational performance.		

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**	22 May 2025
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**	22 May 2025
Risk Appetite	**Open**	5	4	**20**	4	4	**16**	3	4	**12**	**New!**				**Date of Next Review**	August 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)
Staff Experience Programme is in place to improve engagement	Lack of clear and consistent cascaded information on elements of the Programme Limited line manager capability/confidence in leading engagement Variable engagement levels across teams and departments	• Direct feedback from Staff Experience sessions • Increased Communication channels • Introduction of FTSU and Staff Experience Programme Board • Staff Experience is a key pillar at SDR • Regular updates on Staff Experience to Board and Board Committees	Internal	Amber
Staff survey and pulse survey including WRES and WDES help ascertain if our SE programme is effective and give staff an opportunity to feedback	Only yearly and quarterly surveys don't always give the right feedback in between surveys Delays in developing action plans to address staff surveys	• Staff Survey Action Plans are reviewed at Board and Board Committee level • They are in the public domain which ensures accountability	Internal External	Amber
Merger Drop-in sessions provide opportunities for staff to receive updates and raise questions about the merger process		Happening regularly and feedback to ELT on actions to be taken	Internal	Green
Revamped Service Visits Programme for 2025/26 ensures leadership visibility	Visits have been inconsistent and not always easy to arrange	• Enhanced feedback form is in place that includes the Institute for Healthcare Improvement questions focused staff wellbeing and productivity • Regular item on ELT agenda	Internal	Amber
Learning and Development Opportunities in place including Management training		• Senior Management Leadership Development Programme Feedback from 8B and above • Training Needs Analysis	Internal	Green
Health and Wellbeing considerations as part of the People GANTT chart this keeps the Trust focused on wellbeing of employees	Financial and Estates restraint on replicating some of the offering to offsite teams	• Health & Wellbeing group (includes review of cost-of-living issues) Now incorporated within POD Delivery Group and Staff Engagement Group	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Cascade information to staff on elements of the Staff Experience Programme in a clear and consistent manner	Chief People Officer Director of Communications	Ongoing	
Develop, commence and communicate Staff Survey Action plans	Chief People Officer	September 2025	This is currently being developed as A3s
Roll-out of the Service Visits Programme for 2025/26	Interim Director of Corporate Governance	September2025	Programme for 2025/26 has been developed. Consideration to be had with ELT around rebadging of these visits to be focused on merger.

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

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

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	Jon Bell 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	Jon Bell 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**	June 2025

Risk Appetite	**Open**	5	3	**15**	3	4	**12**	2	4	**8**	⟷				**Date of Next Review**	August 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 has been shared with NCL 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 have been developed. Water drawings will be complete by September - this will give system and location drawings.	Fire and electrical are complete. Water drawings are currently being updated following invasive surveys and upgrades
Develop a soft FM and Hard FM strategy	The fragmented contracts have been consolidated and this is now being assessed for any CIP efficiencies without compromising service levels for both soft FM and for Hard FM. In addition, contract end dates conclude within 25-26 to enable a smooth integration with NLFT	All processes are being reviewed to ensure NHS national standards are maintained.	All contracts have been consolidated in 2025, and are being tracked against contract terms, contract meetings are held regularly.
Asset performance and detailed 6-facet survey	The commencement of a non-invasive 6 facet survey has commenced, this will conclude in July 25, to take account of the upgrades since the last survey that took place in 2021, and will include 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 2025Water and gas – capital investment over 2 years commencing in 24-25 - Surveys have been carried out on some assets- electrical supply, lighting and fire doors and will look at fire alarms (26-27), heating systems (26-27).	Since 2024, there has been limited system drawings and asset data, the information is continually being updated as each asset group is being assessed and upgraded, primarily the focus has been mechanical and electrical assets and will then move to fabric, an aging that is slowing being invested in over a number of years as backlog as infrastructure upgrades have been prioritised	For hard FM - The authorising engineer acts as the assurer by scrutinising the planned maintenance tasks against the HTM For soft FM this is either against NHS national standards or any feedback from services.

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	Jon Bell 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	**Hungry**	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	*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.**

		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					
Executive Lead	Jon Bell Interim Chief Finance Officer														**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	**Cautious**	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 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	Internal	Amber
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. Internal Audit completed and report which serves 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

The Tavistock and Portman NHS Foundation Trust

Principal Risk 13	**Failure to achieve the required levels of performance and productivity**	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability**
Description	**If** the Trust is unable to achieve contracted levels of performance and productivity **Then** - the Trust will be in breach of its contractual targets relating to activity, quality and delivery 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 due to decommissioning of contracts, loss of ERF, potential withdrawal of MHIS, and financial penalties, poor patient experience and patient outcomes, risks to patient's mental health, and reputational risk. Further compounded by policy shifts including growing emphasis on performance-related metrics over block funding and projected Commissioning funding gap.		

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**	June 2025
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⇔				**Date of Next Review**	August 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)
Improved use of clinical data to prospectively *inform controls*. 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. Kaizen Event for Trauma Overview 21 October 24: The focus of Kaizen Week for Trauma will be to review current clinical pathways aligned to best practice and commissioned service specifications, mobilise clinical job plans, and co-create a delivery plan with the team. The event also aims to deliver a culture piece. This plan will include 30-, 60-, and 90-day review periods to ensure that efforts are targeted and impactful.	The service profile pack, including performance data, benchmarked data, and pathways, is still under development. 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 IQPR – Monthly Trust Waiting Times Huddle – weekly Adult Services PTL Meeting – weekly Targeted support – weekly for GIC and Trauma	Internal	Red
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.	Internal	Amber

		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		

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 Delivery Room*.	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.	
Clinical Dashboard and contract data Training to be delivered by ICT via the Clinical Governance and Unit business meetings.	Managing Director	August 2025	

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.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks.	IQPR meetings with contracting updates.

	A streamlined clinical model for appropriate GIC cases has been devised.	Staff levels required to deliver waiting lists	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 its demand on the environment, the impact will be felt on the provision of its existing and potential new 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 2032 and net zero carbon plus influenced by the NHS ambition to reach 80% 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	Jon Bell 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**	June 2025
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⟷				**Date of Next Review**	August 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 oversee the plan and education on climate change impacts.	Education of staff at all levels	Regular trust wide communication.	Internal	Amber
Green Plan	Annual action plans based on net zero measures	ELT AND PFRC to review and approve. Responsible for continued oversight with metrics. The NCL is sharing the Green plans across all Trusts to align a common set of measures for July- August	Internal	Amber
NHSE utilities framework (April implementation)		Signed up to utilities framework. Contract commencement quarter 1 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	August 2025	Develop a sustainability page on the intranet. Will be launched once green plan is aligned with NCL and this will then be brought to the Board for sign off. The national net zero metrics have altered to reflect a revised set of

			targets national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2032 and net zero carbon plus influenced by the NHS ambition to reach 80%by 2040).
Create and Prioritise action plans with input from Directorates.	Director of Estates, Facilities and Capital Projects	September 2025	Groups to be created once green plan has been signed off by Board and intranet page developed. The focus areas will be based on consumption / usage for , waste, utility consumption. One area of focus is to ascertain how to measure 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 September 25, 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 June 2025 (Current Risks rated 15+)

Risk Score Legend:	
	Un scored
1 - 4	Very Low
5 - 8	Low
9 - 12	Moderate
15 - 25	High

Linked BAF Risk	Reference	Description	Category	Impact of risk	Location	Original score	Current score	Target score
BAF 02 - Failure to provide consistent, high-quality care	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.	Patient Experience	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
BAF 12 - IT infrastructure and cyber security	RSK-016	If there are insufficient skilled cybersecurity resources to support the growing demand for cybersecurity and compliance requirements, the Trust may struggle to maintain cybersecurity standards, increasing vulnerability to infrastructure threats and non-compliance with the Data Security Protection Toolkit (DSPT) and other cybersecurity standards.	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 appropriate security measures. Service Delivery: There is an increased risk of cyberattacks, which could disrupt critical services and operations, leading to delays and potential harm to service delivery.	Finance - IM and T	20	20	2
BAF 12 - IT infrastructure and cyber security	RSK-019	If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring immediate action over the weekend, a lack of available resources may result in delays in remediation, leaving systems and data vulnerable to compromise.	Cyber Security	Then, delayed action would compromise the Trust systems, services, and data.	Finance - IM and T	15	15	4
BAF 13 - Failure to achieve required productivity & performance	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

Linked BAF Risk	Reference	Description	Category	Impact of risk	Location	Original score	Current score	Target score
BAF 01 - Inequality of access for patients	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
BAF 13 - Failure to achieve required productivity & performance	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 services that may be unable to fully meet the young persons needs.		16	16	4
BAF 13 - Failure to achieve required productivity & performance	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). Since 2011, both ASD and ADHD can now be diagnosed for the same YP, this has brought in challenges with where best a CYP is assessed for ASD/ADHD with a previous ND diagnosis. The pathways for ADHD and ASD are separated within Camden and this is leading to delays and poor patient experience with confusion around where a CYP/family will be assessed.	Patient Experience	Poor patient experience - delays in being accepted for an assessment (waiting times for assessment also), confusion about where to be referred.			15	4
BAF 9 - Delivering financial sustainability targets	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
BAF 9 - Delivering financial sustainability targets	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

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 10 July 2025			
Report Title: Annual Self-assessment of Committee Effectiveness 2024/25			**Agenda No.: 010**
Report Author and Job Title:	Dorothy Otite, Director of Corporate Governance (Interim)	**Lead Director:**	Dorothy Otite, Director of Corporate Governance (Interim)
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report provides the Board with a summary of the Annual Board Committee Effectiveness Reviews for 2024/25. The Committees (except one at the time of writing) received and discussed the full reports of the outcome of the effectiveness reviews and annual reports during the April / May 2025 cycle of meetings and recommended the reports to the Board. These reports have formed the basis of this summary report to the Board.		
Background:	The Terms of Reference (ToR) of the Committees require an annual effectiveness evaluation against its Terms of Reference and membership to be undertaken and the outcome reported to the Board of Directors within the annual business cycle. The Board Committees agreed a streamlined approach to the annual effectiveness reviews for 2024/25. A timetable was agreed for the process and an agreement reached on survey respondents with the Committee Chair and Lead Executives. The surveys were issued during Quarter 4 2024/25 for completion at the end of March 2025.		
Assessment:	**Annual Committee Effectiveness Survey 2024/25:** **Process** – a robust and comprehensive review was undertaken for each Committee and facilitated by the Interim Director of Corporate Governance in line with the agreed process. **Response rates** – survey response rates although varied by Committee, were adequate across all Committees. Overall, the survey responses received for all Committees were mostly positive. **Annual Effectiveness Survey Report 2024/25:** An annual effectiveness survey report was produced for each Committee providing commentary on what has worked well and what could have been done better, including areas for further development in 2025/26. **Cross Committee analysis shows that key strengths include:** • Year-on-year evidence of steady improvements and maturity of the Committees. • Strengthened Committee administration including improved timeliness of circulation of minutes and actions.		

	• Improved agenda time management which ensures time for reflection at the end of each meeting. • Improved quality of reports to the Committee. • Improved focus on risk management. • Written Terms of Reference which clearly set out their roles and scope of responsibilities. • Frequency of meetings being regular. • Members have a good understanding of their roles with adequate skills and expertise to contribute and scrutinise the Committee business. • Effectively contributing to the effectiveness of the Board of Directors, including providing assurance reports to the Board following each meeting. • Effective monitoring of action logs to ensure timely delivery against actions. • Meetings chaired effectively with clarity of purpose and outcome. • Good attendance at meetings. **Cross Committee analysis shows that areas for development include:** • Streamlining of Committee agendas – there is a consensus on the need to focus agendas on decision, discussion and assurance items to allow in-depth deliberation. Information only items should be deprioritised or placed at the end of agendas with authors required to highlight key points. • Improving quality of reports – Trust-wide improvement in report-writing standards, supported by updated guidance will improve assurance, reduce duplication and support better decision making. • Constructive challenge and oversight – reinforcing Committee roles in challenge and oversight strengthens accountability, especially when underpinned by high-quality reports. • Improved assurance reporting alignment by Operational Reporting Groups – a review of reporting cycles by Groups reporting into Board Committees could improve timeliness and reduce occasions of reporting misalignment. • Communication with Management – maintaining open and transparent relationships with management is key to enabling the Committees challenge and support in equal measure. **Conclusion:** Based on the outcome of the Board Committee effectiveness self-assessment reviews, some areas for further development have been identified and agreed to by the Committees. The areas are noted in Paragraph 5 (Pages 4, 5 and 6) of this report.
Key recommendation(s):	The Board is asked to: - receive **ASSURANCE** from the process undertaken and the summary findings; and - **NOTE** the areas for further development of the Board Committees.

Implications:				
Strategic Ambitions:				
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national &	☒ Developing partnerships to improve population health and building on our reputation	☒ Developing a culture where everyone thrives with a focus on	☒ Improving value, productivity, financial and environmental sustainability

	international provider of training & education	for innovation and research in this area	equality, diversity and inclusion	

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 – as these are assigned to the Committees.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	NHS Foundation Trust Code of Governance requires that the Board of Directors should state in the annual report how performance evaluation of the Board and its Committees has been conducted.				
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:	• People, Organisational Development, Equality, Diversity and Inclusion Committee – 1 May 2025 • Education and Training Committee – 8 May 2025 • Quality & Safety Committee – 17 April 2025 • Integrated Audit and Governance Committee – 8 May 2025 • Performance Finance and Resources Committee – 17 April 2025 • Executive Appointments and Remuneration Committee – 10 July 2025 *(Committee had not met at the time of writing this report).*				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Report Title: Annual Self-assessment of Committee Effectiveness for 2024/25

1. Purpose of the report

1.1. This report provides the Board with a summary of the Annual Board Committee Effectiveness Reviews for 2024/25.

2. Background

Constitutional and Regulatory Requirements:

2.1. **Terms of Reference (ToR)** – The ToR of the Committees requires an annual effectiveness evaluation against its Terms of Reference and Membership to be undertaken, and the outcome reported to the Board of Directors within the annual business cycle.

2.2. **NHS England Code of Governance** – requires that there should be a formal and rigorous annual evaluation of the performance of Board Committees.

3. Process and Timeline

3.1. The Board Committees agreed a streamlined approach to the annual effectiveness reviews for 2024/25. A timetable was agreed for the process and an agreement reached on survey respondents with the Committee Chair and Lead Executives.

3.2. The surveys were issued during Quarter 4 2024/25 for completion at the end of March 2025.

4. Summary findings/ conclusions

Annual Board Committee Effectiveness Survey 2024/25:

4.1. **Process** – A robust and comprehensive review was undertaken for each Committee and facilitated by the Interim Director of Corporate Governance in line with the agreed process.

4.2. **Response rates** – response rates although varied, were adequate across all Committees.

4.3. Overall, the survey responses received for all Committees were mostly positive.

5. Areas for further development

The Committees agreed the following areas for further development:

5.1. **Integrated Audit and Governance Committee:**

1. **Streamlining of Committee agendas**: Ensure Committee agendas are focused on decision and discussion items to allow time for in-depth discussions. Information items may be placed at the end of the agenda for authors to draw any salient points to the attention of the Committee.
2. **Focus on risk and assurance**: The Committee should continue to strengthen its oversight of the Trust's systems of risk management and assurance.

3. **Improving quality of reports:**
   - Report authors should be encouraged to tailor content to the Committee's remit and specific requests, ensuring the Executive
   - Summary section is fully and effectively utilised. This should be reviewed on an ongoing basis as part of Lead Executive sign-off of papers.
   - The Corporate Governance Team will undertake a review of the current report writing guidance to ensure it provides appropriate support to authors and aligns with Board Committee's expectations.

5.2. **Quality and Safety Committee:**

1. **Streamlining of Committee agendas**: Ensure Committee agendas are focused on decision, discussion, and assurance items to allow time for in-depth discussions. Information items may be placed at the end of the agenda for authors to draw any salient points to the attention of the Committee.
2. **Constructive challenge to management**: Continue to provide constructive challenge to management as part of its oversight responsibility.
3. **Improving in-person attendance**: Ensure attendance expectations is clear by encouraging in-person attendance to meetings.
4. **Strengthening the administration of the schedule of business**: The Committee Secretary should provide updates of key changes to the schedule of business including paper deferrals by reporting on the rationale for changes to the Committee.
5. **Alignment of Group assurance reporting to Committee meetings**: Ensure assurance reporting from Groups is aligned to Committee meeting dates.

5.3. **Education and Training Committee:**

1. **Streamlining of Committee agendas**: Ensure Committee agendas are focused on decision, discussion, and assurance items to allow time for in-depth discussions. Information items may be placed at the end of the agenda for authors to draw any salient points to the attention of the Committee.
2. **Consideration of Growth and Strategy**: Make time available in the committee to consider in more depth opportunities and risks associated with growth of education, training and research activities.
3. **Improving Quality of Reports**:
   i. Report authors should be encouraged to tailor content to the Committee's remit and specific requests, ensuring the Executive Summary section is fully and effectively utilised. This should be reviewed on an ongoing basis as part of Lead Executive sign-off of papers.
   ii. The Corporate Governance Team will undertake a review of the current report writing guidance to ensure it provides appropriate support to authors and aligns with Board Committee's expectations.
4. **Constructive challenge**: Continue to provide constructive challenge to management as part of its oversight responsibility.

5.4. **Performance Finance and Resources Committee:**

1. **Streamlining of Committee agendas**: Ensure Committee agendas are focused on decision, discussion, and assurance items to allow time for in-depth discussions. Information items may be placed at the end of the agenda for authors to draw any salient points to the attention of the Committee.
2. **Setting KPIs for Digital and Estates**: Set clear, quantifiable, key performance indicators for IT and Estates as part of the Trust's Integrated Quality Performance Reporting to ensure progress towards achieving set goals is effectively managed.

3. **Improving quality of papers**: Ensure continuous strengthening of the quality of reports to the Committee focusing on clarity and brevity clearly providing assurance or highlighting gaps in assurance.
4. **Assurance route to the Committee**: To review the purpose of (including terms of reference) the new and existing Tier 3 Groups reporting to the Committee, to ensure the 'heavy lifting' relating to some aspects of the Committee's work is conducted by the Groups. Thereby giving the Committee more headroom to carry out its core oversight responsibility.
5. **Communication with management**: Continue to ensure open communication with management while the Committee carries out its oversight function, fostering a collaborative approach that includes constructive challenge.

5.5. **People Organisational Development Equality Diversity and Inclusion Committee:**

1. **Streamlining of Committee agendas**: Ensure Committee agendas are focused on decision, discussion, and assurance items to allow time for in-depth discussions. Information items may be placed at the end of the agenda for authors to draw any salient points to the attention of the Committee.
2. **Improve timeliness in implementing actions**: Set clear expectations, ensuring ownership is assigned to named colleagues and regular progress is reported against plans with appropriate follow through of actions. Encourage discussions about blockages.
3. **Improving quality of reports:**
   - Report authors should be encouraged to tailor content to the Committee's remit and specific requests, ensuring the Executive Summary section is fully and effectively utilised. This should be reviewed on an ongoing basis as part of Lead Executive sign-off of papers.
   - The Corporate Governance Team will undertake a review of the current report writing guidance to ensure it provides appropriate support to authors and aligns with Board Committee's expectations.
4. **Upskilling staff who are new or less experienced Committee attendees:** Line managers should support colleagues who attend Committee meetings by having informal pre-meets to explain the structure, expectation and roles. This will help build confidence and engagement.

5.6. **Executive Appointments and Remuneration Committee** *(The Committee had not met at the time of writing this report – these were the proposed recommendations for discussion and agreement by the Committee):*

1. **Meeting notification to members**: The Committee Administrator will ensure members are notified in advance of status of meetings (i.e. if proceeding with or being cancelled).
2. **Time for reflection at the end of meetings**: The Committee Chair should continue to ensure outcomes are discussed with opportunities for reflections on decisions at the end of each meeting.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday, 10 July 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Extra-Ordinary Meeting of the Integrated Audit & Governance Committee	19 June 2025	David Levenson, Non-Executive Director	Dorothy Otite, Interim Director of Corporate Governance	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 011**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headlines: **1. Approval of the Annual Report and Accounts 2024/25.** **2. This was the last formal meeting of the Committee chaired by David Levenson. Members expressed their appreciation and thanked him for his dedicated and valuable contributions to the Committee and the Trust.**	**Assurance rating**
Annual Report and Accounts including Annual Governance Statement 2024/25 • The Committee **NOTED** the Board of Directors assigned delegated authority to the Committee to sign-off the Annual Report and Accounts 2024/25 on its behalf. • The Committee considered and **APPROVED** the Annual Report (including the Annual Governance Statement 2024/25) subject to addressing minor suggestions for amendments. • The Committee considered and **APPROVED** the Statutory Accounts for the year ended 31 March 2025 subject to finalising the external audit, noting the External Auditors are on track to complete the audit in advance of the statutory deadline of 30 June 2025. • The Committee (on behalf of the Board of Directors) **AUTHORISED** the Chair, Chief Executive Officer and Chief Finance Officer to sign the respective reports where relevant.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Internal Audit Annual Report 2024/25 (including Head of Internal Audit Opinion) • The Committee received and **NOTED** the Internal Audit Annual Report the Head of Internal Audit Opinion which was rated at Level 3. • The Committee noted the opinion was informed by the areas of risk and concern directed by Management and the Committee, and therefore impacting on the overall opinion. However, as management actions and governance changes are implemented and embedded, the Auditors anticipate an improvement in the overall control environment.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

• The Committee noted during 2025/26, the Executive Directors will conduct Executive Portfolio Risk and Control Review to ensure the key risks and controls within each Executive Portfolio are clearly articulated and effectively managed. The outcome of this exercise will be reported to the Committee for oversight at the September meeting. This will support improvements in the overall control environment.	
External Audit Reports • The Committee considered and **NOTED** the External Audit findings for the year ended 31 March 2025. • The Committee considered and **NOTED** the Auditor's Annual Report for the year ended 31 March 2025. This included the value for money recommendations for 2024/25 and a follow-up of previous key recommendations. • The Committee **APPROVED** the content of the Management Representation Letter as presented to the meeting and **AUTHORISED** the Interim Chief Finance Officer to sign this on behalf of the Board.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Consultant Job Planning Internal Audit Progress Update • The Committee received an update from the Chief Medical Officer of the complete implementation of the Consultant Job Planning Internal Audit recommendations, noting an electronic job planning system was now in place in the Trust. • The Committee took assurance from the update; and requested for an update to be brought back by the Internal Auditors of the outstanding internal audit recommendations reflecting the job planning updates.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Internal Audit Plan 2025/26 • The Committee received an update of the proposed changes to the Internal Audit Plan 2025/26 which will be considered at the September meeting of the Committee. • The proposed changes are necessary to ensure that appropriate audits are conducted during 2025/26 considering the impending merger.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

Approved:

- Annual Report and Accounts 2024/25

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
Annual Report and Accounts 2024/25	Information	10 July 2025

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday, 10 July 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	19 June 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. Trauma Service targeted support The Committee received an update on the progress of the Trauma targeted support initiative, focusing on key performance metrics, ongoing challenges, and the strategic direction for the service. The Committee noted the amount of work that has been undertaken in relation to the targeted support however there has been a lack of continued improvement in some of the areas in the targeted support metrics and terms of reference. The Chief Medical Officer has requested the team to refocus on the actions outlined in the A3 quality improvement project.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Independent review of Nottinghamshire Healthcare NHS Foundation and update on Trust National Learning Reviews action plan The Committee received an update on areas of learning that the Trust can take from the recommendations made through the independent investigation, commissioned by NHS England, into the care and treatment provided to Valdo Calocane by Nottinghamshire Healthcare NHS Foundation Trust. The Trust's Associate Director of Nursing and Deputy Chief Medical Officer undertook a review of the findings where this report was most relevant in the Trust (The Portman, EIS and CAISS), including via consultations with teams, focusing on the five identified themes of the independent review: ▪ Dynamic risk assessment ▪ Liaison with external networks e.g. inpatient units, other professionals; having a shared longitudinal view of treatment	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

▪ Involvement of family ▪ Discharge planning e.g. to GP, from inpatient units ▪ Internal Trust oversight – governance and risk The review findings are consistent with the themes identified as gaps through the stakeholder sessions held in September 2024 in response to the national learning reviews which were published in 2024 *(Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024, CQC Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024, The Thirlwall Inquiry - ongoing).* There is an existing improvement plan in place following the stakeholder sessions and the recommendations of the latest internal review will be subsumed into this.	
3. Annual Clinical Audit Report The Committee received an update on the clinical audit programme. The clinical audit programme is actively promoted in the Trust but the resources to support the work are limited and visibility of activity is more evident in some parts of the Trust than others. There has been a staffing gap in the Deputy Chief Medical Officer role who is the senior lead for clinical audit in the Trust. Once the role is in post (anticipated for mid-July 2025, the clinical audit plan for 25/26 will be a priority. Despite this, there has been audit activity documented as outlined in the Trust's Quality Account 25/26. The audit module on Radar went live from November 2024. This has improved the oversight and monitoring of audit work across the Trust but there is ongoing work in progress to optimise the functionality of the system to meet the Trust's needs.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Patient Carer Race Equality Framework (PCREF) The Committee received an update on the Trust's implantation of PCREF, including the work of the PCREF implementation group and focused attention on understanding referrals and front door access. Ethnicity data is now available by ethnicity caseload, referral and attended appointments, and reported via the IQPR. This will be expanded to include reported incidents and complaints to analyse any differences in care. Next steps for the project include a clear focus on engagement with external agencies to ensure the Trust is community and externally focused to act as a catalyst for change.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Summary of Decisions made by the Committee:	
None.	
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
The Committee discussed compliance rates for Safeguarding. It was agreed that an escalation should be made to the POD EDI Committee for an assurance update on the action(s) taken to address this.	Assurance and action	26 June 2025

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 10 July 2025			
Report Title: Patient and Carer Race Equality Framework (PCREF) Report			**Agenda No.: 013**
Report Author and Job Title:	Dr Thanda Mhlanga Dr Sheva Habel	**Lead Executive Director:**	Dr Chris Abbott Chief Medical Officer
Appendices:	Appendix 1: Equality Impact Assessment Form Appendix 2: Camden Wellbeing Team PCREF Audit and Service User Involvement Feedback **(See BoardEffect Reading Room)**		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	National and local data consistently shows that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services.		
Background:	As a result of the National Mental Health Act Review in 2018, it was recommended that Mental Health Trusts should launch the Patient and Carer Race Equality Framework (PCREF) to facilitate a national, systematic way of identifying and changing race inequality within NHS services. The Framework aims is to move to equity in access, experience and outcomes for Culturally and Ethnically diverse communities. NHSE has been working with PCREF early adopters since 2020 and there was a national roll out in 2023. However, in April 2024 PCREF became a contractual required for all Mental Health Trusts.		
Assessment:	To meet our contractual requirements and more importantly address inequalities in our Mental Health Services we set up a PCREF implementation group last year that comprises of key stakeholders inclusive of clinicians and service users from diverse backgrounds. The PCREF Implementation Group is chaired by the Chief Medical Officer. The Group's immediate objective has been to raise awareness about PCREF and support the Trust by undertaking a front-to-back assessment of all clinical services to assess their status in terms of equity of access and develop action plans to address any identified concerns.		
Key recommendation(s):	The Board is asked to: • Commit ongoing support to drive forward PCREF ambitions. • Appoint a NED sponsor to champion the PCREF workstream alongside Executive Lead. • Facilitate strategic community connections to strengthen and expand our community engagement efforts. • Agreement on frequency of report and data reporting to ensure report aligns with 1 Quarterly reporting of referral data 2 Half yearly ESQ data reported with ethnicity demographics		
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 ☐		
	None noted				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Standard NHS Contract (2024), NHS Act (2006), Equality Act (2010), Public Sector Equality Duty (PSED), Carers Leave Act (2023), The Mental Health Units (Use of Force) Act (2018), Children Act (2004), Human Rights Act (2007), Mental Health Act (1983), Health and Care Act (2022), Health and Social Care Act (2008), Mental Capacity Act (2005), Children and Families Act (2014), Care Act (2014)				
Resource Implications:	Yes ☒	No ☐			
	• Community Engagement • Training and Development (Building a responsive and culturally competent workforce).				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	• Tackling Health Inequalities • Removing barriers to access • Staff knowledge and cultural awareness training				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	None				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Patient and Carer Race Equality Framework (PCREF)

1. Purpose of the report

1.1. This paper seeks to share the progress that has been made since the launch of PCREF at the Trust last year. More specifically, it aims to provide insights into how PCREF as an accountability framework is understood and implemented at the Trust as we journey towards improving experiences and outcomes for individuals of diverse ethnic backgrounds.

2. Background

2.1. Health inequalities in the UK are stark: national and local data consistently shows that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services.

To facilitate equity in access, experience and outcomes for culturally and ethnically diverse communities in our services – we are making strides to embed the three core tenets of PCREF summarised below:

- Changing the culture around service delivery: Leadership and Governance.
- Working together to facilitate change (Organisational Competencies) – identifying the root causes of inequity and what we could do collaboratively to change them.
- Are we improving? Patient and Carer feedback mechanism. Measuring if we are improving access, experience and outcomes – and if we are not, what can we do differently?

Furthermore, PCREF challenges mental health services to identify areas of improvement by developing core organisational competencies. Ten national organisational competencies have been identified. However, guidance prioritises six that are perceived as most important viz-viz communities:

(i) Cultural awareness: Recognising and understanding the diverse cultural backgrounds of communities we serve and delivering culturally competent care.
(ii) Staff knowledge and awareness: Recognising and understanding the racialised experiences of the communities we serve and overcoming biases and prejudices by acting upon them.
(iii) Partnership working: Services working more closely with ethnically and culturally diverse communities, leaders, and organisations beyond the NHS.
(iv) Co-production: Ensuring ethnically and culturally diverse patients and carers are treated as equal partners in decision making with their care and treatment plans.
(v) Workforce: A culturally competent and diverse workforce that has a positive impact on patient and carers from racialised diverse communities.
(vi) Co-learning: A two-way process that strengthens collaborative knowledge sharing beyond co-production principles.

In the next section, the report outlines our PCREF key areas of focus.

3. Leadership, Governance and Accountability

As part of our commitment to fulfilling our statutory and legal obligations related to race equality, we launched a PCREF Implementation Group at the Trust last year. The Group currently has 35 members – drawn from all services and inclusive of service users. As will be highlighted in Section 4 below, this Group is a key pillar in the implementation of our PCREF plan, there is need to formalise and clarify its role.

Our statutory and legal obligations include board-level oversight and monitoring of the action plan. The Implementation Group is chaired by an Executive (Chief Medical Officer) who reports progress at Board. Board scrutiny highlights the importance the organisation is giving to PCREF and how it is holding itself accountable for progress. Drawing on good practice from other Trusts, our PCREF plan would benefit from having a nominated Non- Executive Director alongside the Executive Lead.

4. Data and Impact

4.1. Data is crucial for the Patient and Carer Race Equality Framework as it allows for the identification and measurement of disparities in mental health care experiences and outcomes for people from diverse ethnic and racial backgrounds. This data informs targeted interventions, ensures accountability, and drives continuous improvement towards more equitable mental health services.

Consequently, in the past quarter the PCREF progresses in our Clinical Services has focused on the initial stages of the review / intervention cycle, starting with referrals into all clinical services. The aim is to assess accessibility of our services through the comparison of referrals into clinical services with the local age matched referring population. As such, for Camden this is the Camden population, for the NCL based team this is the NCL population and for GIC the measure is the national population identifying as transgender and non-binary on the 2021 Census data. All services have been provided with their team level referral data and a set of comparison data. This data has been reviewed and reflected on. As some teams in the Trust have been focusing on this work pre-PCREF, the first round of a centralised strategy has yielded mixed results in terms of gaps and the degree of work required to improve accessibility for global majority populations in the local communities.

Alongside this process, changes have been made to 4 of the 6 referral forms used in the Trust to improve the collection of ethnicity data and to explain to referrers the importance of providing this information - to support the Trust achieve its PCREF goals (see overpage for table illustrating improvement in data collection). These new referral forms have been processed within the clinical governance structures of the Trust and are now in use.

The data for Q1 will be processed and shared in early July. All divisions are expected to undertake a PCREF self-assessment and develop action plans that are underpinned by QI methodology.

Table below illustrates improvements in the collection of Ethnicity Data from 24/25 Q4 to 25/26 Q1 in many teams as evidenced by a reduction in the percentage of "Not Known" codes recorded

	24/25 Q4 "Not Known" %	25/26 Q1 "Not Known" %
Adult therapy service		
Psychotherapy	12	17
Trauma	11.2	8
Portman	40	7
Camden Unit		
CIT	18.6	0
CWP	21	13
NCCT	7.1	14
SCCT	18	11
MHST N	12	4
MHST S	7.4	11
WFT	3.4	10
WFT-P	21.4	11
GWY	0	0
CAISS	0	0
Child and Family Unit		
AYAS	22	0
ASD Assessment	3.2	6
ASD/LD	11	29
EDAS	25	4
FMHT	10.5	18
CATS	10.8	0
FCAMHS	13	0
FAKT	15	8

5. Experience of Service

As part of our commitment to assessing and improving the quality of care we provide, we gather feedback from patients and their families viz-a-viz various aspects of our services, including accessibility, the quality of care, organisation, and the environment through the Experience of Service Questionnaire (ESQ). The ESQ helps us understand what aspects of a service are working well and what needs improvement – see graph below for positive feedback and number of responses for the period between April to December 2024 for Question 1: *What was your experience of the services you received?*

Figure 1: Ethnicity groups total number of responses (Apr-Dec 2024)

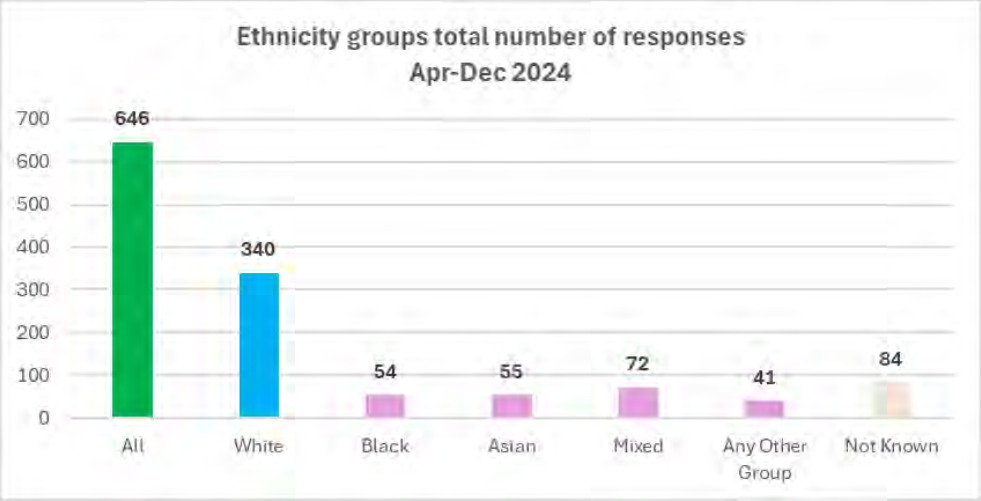
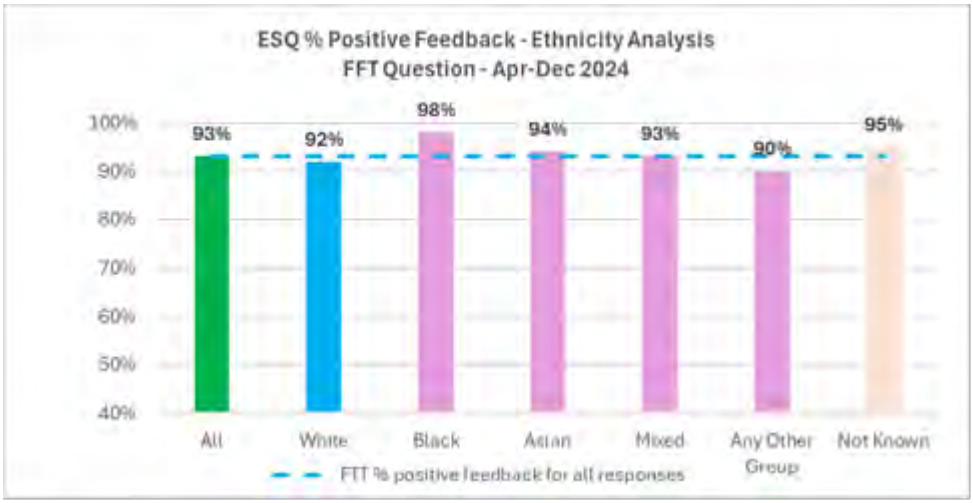


Figure 2: ESQ % Positive Feedback - Ethnicity Analysis (Apr-Dec 2024)



According to Figure 1 and 2, there is a total of 646 responses for all ethnicities including 'Not Known' for Q1 (April to Dec 24), 93% of them were positive. All Ethnic Minorities (in pink) have a total of 222 responses with an average of 94% positive feedback. This is 2% higher than the feedback for the White cohort (92%) and 1% higher when comparing it with 'All Ethnicities' (93%).

6. Staff knowledge and awareness

The PCREF Implementation Group continues to play a central role raising awareness about health inequalities and supporting the organisation build a culturally competent workforce that can understand and respond to the needs of minoritised ethnic groups. It is a space where clinicians share good practice. For instance, at the June meeting clinical leads and trainees from the Camden Wellbeing Team shared three projects – "PCREF Team Audit and Service User Involvement Feedback".
The projects engaged critically with local ethnicity data vs referrals. Through these projects the Group also immersed itself in barriers to access via the experiences of service users. The

Group also benefited from the powerful contribution of one of the members who is a service user.

Recommendation: the learning within the Group's monthly meetings should be shared with the whole organisation. See the presentations in Appendix 2 for more details.

7. Cultural Competence

'Recognising and understanding the diverse cultural backgrounds of communities we serve and delivering culturally competent care' is one of the framework's organisational competencies. We have prioritised this in our PCREF Action Plan – the EDI Team will be developing relevant cultural awareness training over the summer and rolling it out in the autumn.

In the same vein, the Patient and Carer Race Equality Framework is a national anti-racism framework - it' is a key component of the NHS' commitment to becoming an actively anti-racist organisation. To that end, the Tavistock and Portman has publicly committed to becoming an anti-racist organisation. The White Allies Group has developed anti-racism training in collaboration with the Race Equality Network – this training was delivered to the Board in June and feedback was inspiring. It is hoped that the training will be rolled out trust wide. It would be beneficial to embed the anti-racism workstream in our PCREF Plan.

8. Community Engagement

The framework emphasises working in partnership with local services, communities to develop and implement solutions. A few of our services are based in the community, there is room for us to work collaboratively with local communities. Several local services and communities have been identified as potential collaborators, but they are yet to be contacted formally. We remain committed to developing links with community groups and adopting a **"Go where people are strategy".**

9. Equality Impact Assessments

The Trust has overhauled its approach to EIAs and the EDI Team now deliver a monthly workshop that provides practical guidance on how to identify, assess, and address potential impacts of policies, programs, and decisions on different groups, particularly those with protected characteristics under equality legislation. Briefly, every significant change to policies, procedures, practices, services, or functions, whether new or existing, **must** be subject to an EIA. This includes changes that might not seem directly related to equality but could still have unintended consequences for individuals with protected characteristics. In the context of clinical services procedures, the EIA should include relevant research pertaining to the focus of the procedure to ensure that the needs of global majority communities are understood and attended to. This is central to the successful implementation of our PCREF.

10. Workforce

The PCREF advocates for a culturally competent and diverse workforce to address racial disparities in mental health services and improve access, experiences, and outcomes for racialised patients and their carers. A key part of this involves creating a psychologically safe and representative workforce. Currently, we are aware that our clinical workforce is not representative of communities that we serve. This is an area that we are addressing: we launched a new inclusive recruitment ethos that is backed by policy, set up a CPD panel that

approves all applications and promotions are now scrutinised by a panel to facilitate transparency and equity. In addition, it is an aspiration of the DET element of PCREF to work with the Clinical Services and other elements of the trust to increase representation across treatment modalities and identify and develop treatments that are exclusively underpinned by Eurocentric lenses and approaches.

11. Conclusion and Recommendations

Our PCREF strategic ambitions are off to a strong and promising start, with a dedicated core of clinicians and stakeholders actively committed to tackling health inequalities.

In the coming months, we will:

- Refine and finalise our action plan, identifying areas such as community engagement that will require additional resources to deliver effectively. This includes addressing capacity constraints and ensuring our treatment offers resonate with and are relevant to diverse communities.
- Collaborate closely with DET colleagues to co-develop a robust DET plan aligned with PCREF priorities.

Equality Impact Assessment (EIA) Form

Equality Impact Assessments are a tool used to assess all organisational activity including policy, strategies, plans, service delivery and practice or a decision. The general equality duty set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate any form of unlawful discrimination (including direct or indirect discrimination, harassment, victimisation, and any other conduct prohibited under the Act)
- advance equality of opportunity between people who share a relevant characteristic and people who do not, and
- foster good relations between people who share a protected characteristic and people who do not.

Please refer to Equality Impact Assessment Guidance provided if you need further information.

1	**Name and Job Title of person completing the Equality Impact Assessment**	
2	**Title of what you are proposing**	
3	**What are the main objectives or aims of what you are proposing?**	
4	**Date you are completing this form**	
5	**Summary overview** *(What changes have you made following completion of the EIA?)*	

Stage 1: Initial Screening						
6	**What evidence is available to suggest that what you are proposing will have a positive or adverse impact on people with protected characteristics or vulnerable groups?** *Please state how your proposed changes will / will not impact on the protected characteristic groups listed below. Please note: These groups may also experience health inequalities.*					
		Impact *(Positive Impact, No impact, Adverse Impact)*				**Evidence** *State below (**for each protected group**) the evidence you have used in your decision making: demographic data and other statistics including census findings, results of consultations or engagement, research findings, surveys (internal or external), complaints and compliments, incident reports, recommendations of external investigations or audit reports. Are there any key gaps in the data, evidence and findings from published or consultation documents?*
Protected Characteristics	**Positive Impact**	**No Impact**	**Low Adverse Impact**	**Medium Adverse Impact**	**High Adverse Impact**	
Age Older people; middle years; early years; children and young people.						

Protected Characteristics	Positive Impact	No Impact	Low Adverse Impact	Medium Adverse Impact	High Adverse Impact	Evidence *What evidence you have used in your decision making **(for each protected group)**?*
Disability Physical, sensory, and learning impairment; mental health condition, long-term conditions						
Gender Identity Inc. people who identify as Transgender						
Marriage and Civil Partnership People married or in a civil partnership						
Pregnancy/maternity Women before and after childbirth and who are breastfeeding						
Race and Ethnicity Inc. culture, history, language, traditions, ancestry, and national origin						
Religion/belief People with different religions/faiths or beliefs, or none						
Sex Women, Men						
Sexual Orientation Lesbian; Gay; Bisexual; Heterosexual, Gender-fluid						
*** Vulnerable groups** Populations or segments of society that are more susceptible to harm, discrimination, or disadvantage due to various factors like social, economic, or physical circumstances, requiring specific support and protection.						

7. Human Rights (1998)

Are there any Human Rights considerations, if so, please identify which aspects (Equality Impact Assessment Guidance)

Yes *(please explain)*	
No	If applicable, state *"Not applicable in the context of this …"*
Don't know	

(a) If what you are proposing is assessed as **not having impact** - Go to Section 12
(b) If what you are proposing is assessed as **having impact** - Continue to Stage 2 below.

Stage 2: Full Equality Impact Assessment Procedure			
8. **Is there service user, public or staff concerns that what you are proposing may be discriminatory, or have an adverse or positive impact on people from the protected characteristics?** *Please tick as appropriate.*			
8.1	Service users	Yes / No	
8.2	Staff (including contractors)	Yes / No	If 'Yes', please identify and explain in section 9
9	**Can the adverse impact be justified?** *Please provide details.*		
10	**What arrangements will you put in place to monitor the impact of the proposed action or change?** *Please provide details.*		
11	**What actions will you take to address any unjustified impact and promote equality of outcome for individuals from protected characteristics.**		

Action	**Lead**	**Timescales**	**Outcome(s)**

Review Date						
Head of Culture & Inclusion Approval?	**Yes**	**No**				
Name of Head of Culture & Inclusion		**Signature**		**Date of Approval**		

Please send completed EIAs form for review to: eia@tavi-port.nhs.uk

12. **Declaration**: I am satisfied that an Equality Impact Assessed has been completed.

Date:

Author (name and signature):

Job Title:

For activities that have an impact on People or have policy implications, a final copy should also be sent to the Chief People Officer: HR@Tavi-Port.nhs.uk

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 10 July 2025			
Report Title: Independent review of Nottinghamshire Healthcare NHS Foundation and update on Trust action plan			**Agenda No.:014**
Report Author and Job Title:	Dr Liz Searle Deputy Chief Medical Officer Associate Director for Quality Improvement (QI) Nimisha Deakin, Associate Director of Nursing and Patient Experience. Emma Casey Associate Director of Quality Patient Safety Specialist	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer Chris Abbott Chief Medical Officer
Appendices:	Appendix 1: National Learning Reviews – Internal Action Plan Appendix 2: Independent investigation report link: Independent investigation into the care and treatment provided to VC **(also included in BoardEffect Reading Room)**		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	The Independent investigation, commissioned by NHS England, into the care and treatment provided to Valdo Calocane (VC) by Nottinghamshire Healthcare NHS Foundation Trust (NHFT) prior to the tragic events of 13 June 2023 was published in February 2025. The Trust's Associate Director of Nursing and Deputy Chief Medical Officer have undertaken a review of the findings and recommendations in relation to areas within the Tavistock and Portman Foundation Trust (TPFT) where learning can be applied. This paper will provide information and assurance in relation to the report and identify areas that need further review. It will also update on the Trust's action plan in relation to the internal review undertaken in 2024 in response to national learning reports published in the same year (Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024, Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024, The Thirlwall Inquiry).		
Background:	Following the conviction of VC in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of NHFT under section 48 of the Health and Social Care Act 2008. In March 2024, the CQC published the first part of the review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since the last inspection in July 2023. In August 2024 the second part of the review was published. The issues identified in NHFT were noted as not unique to the trust and found		

	systemic issues with community mental health care. The report made recommendations relevant to all providers. NHS England commissioned Theemis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. The report was published in February 2025 and reiterated a number of the points identified in the CQC's prior reports published about the specific provider providing care to VC including dynamic risk assessment and planning, involvement of family, discharge planning including back to primary care, adherence to prescribed medication and service user perception of diagnosis and risk. In addition, the report highlighted the following; • Internal Trust oversight – governance, oversight of data to inform safety issues, oversight of risk • Sharing of information to the wider system • Integrated Care Board (ICB) oversight Specific services within the TPFT where the report is most relevant are: CAISS, Portman and EIS. However, learning can be applied across the Trust. In response to the national learning reviews published in 2024, as referenced as above, the CNO team undertook an internal review to assess the Trust in relation to the themed findings of the reviews. The outcomes of this were reported to the Quality & Safety Committee in October 2024 and the Board in November 2024. An action plan was developed in relation to the findings and has been monitored by the Triumvirate and CNO team. An update on this action plan is detailed in Appendix 1. The review of the findings of the Theemis report builds on and draws on this robust review.
Assessment:	It is emphasised that the review in TPFT found a lot of good practice, but some potential gaps were identified: **i. Dynamic Risk Assessment** Work is ongoing to strengthen Trust risk assessment processes to move towards a more dynamic, formulation-based approach to risk management. **ii. Liaison with External Networks** Services proactively liaise with external professionals, including inpatient units and multi-agency partners. However, there is a need for clarity around when and how to escalate concerns both internally and externally. **iii. Involvement of Family** Services working with young people liaised closely with families and carers. In adult services, there may be a tendency to assume no consent to liaise with families of adult patients unless in crisis. A more proactive approach is needed, with early clarification of consent boundaries to enable appropriate and timely family involvement in care. **iv. Discharge Planning** Discharge processes currently rely heavily on the quality and judgement of individual clinicians rather than clearly defined local SOPs. There is a need to formalise local discharge planning procedures to ensure consistent processes. **v. Internal Trust Oversight – Governance and Risk**

	There is a risk of under-reporting incidents, which can result in limited leadership oversight and missed opportunities for learning. Teams would benefit from further training on incident reporting practices. Additionally, there is a broader concern about the potential for closed cultures, where information is not shared or challenged openly. Ensuring robust managerial oversight and fostering a psychologically safe environment is essential to promote transparency, curiosity, and continuous improvement: through mechanisms such as IQPR, supervision, and clinical governance meetings.
Key recommendation(s):	The Board is asked to **CONSIDER** the recommendations required to address the gaps identified. The Quality and Safety Committee has approved the paper for onward reporting to Trust Board.

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 2: 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**.**				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	No issues highlighted from the review; further work aims to identify any potential implications relating to equality, diversity and human rights, with a particular focus on hearing the voice of patients, carers and families. This will also consider where staff, with a range of protected characteristics, may not feel empowered to speak up and where concerns are raised, how this is heard and responded to.				

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Executive Safety Huddle – 19/05/2025 Clinical Services Delivery Group – 27/05/2025 Executive Leadership Team Meeting – 09/06/2025 Quality and Safety Committee – 19/06/2025			
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

Independent review of Nottinghamshire Healthcare NHS Foundation and update on Trust action plan

1. Purpose of the report

1.1. This paper provides the Committee on areas of learning that the Trust can take from the recommendations made through the independent review the independent investigation, commissioned by NHS England, into the care and treatment provided to VC by Nottinghamshire Healthcare NHS Foundation Trust (NHFT) prior to the tragic events of 13 June 2023 was published in February 2025.

1.2. It will also update on the Trust's action plan in relation to the internal review undertaken in 2024 in response to national learning reports published in the same year (Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024, Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024, The Thirlwall Inquiry).

2. Background

2.1. There have been a number of recent national reviews that are relevant to the services that the Tavistock and Portman provides. The three most relevant ones are:

- Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024
- Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024
- Thirlwall Inquiry - to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of formal neonatal nurse Lucy Letby – ongoing

2.2. NHS England commissioned Theemis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. The report was published in February 2025. The purpose of the investigation was to identify learning from the care and treatment provided to VC. It reiterated a number of the points identified in the CQC's prior reports published about the specific provider providing care to VC including:

- dynamic risk assessment and planning,
- involvement of family,
- discharge planning including back to primary care,
- adherence to prescribed medication
- service user perception of diagnosis and risk.

2.3. The issues identified in the CQC's reports of the provider were noted as not unique to the Trust and found systemic issues within community mental health care.

2.4. In addition to the above, the independent review published also highlighted the following;

- Internal Trust oversight – governance, oversight of data to inform safety issues, oversight of risk
- Sharing of information to the wider system
- Integrated Care Board (ICB) oversight

3. Review of key services

3.1. Key services within the Trust where this report was most relevant were reviewed, including consultations with teams, focusing on the five identified themes:

i. Dynamic risk assessment
ii. Liaison with external networks e.g. inpatient units, other professionals; having a shared longitudinal view of treatment
iii. Involvement of family
iv. Discharge planning e.g. to GP, from inpatient units
v. Internal Trust oversight – governance and risk

3.2. **The Portman Clinic**:

The Portman is a national service which specialises in long-term treatment for adults (and children and young people) with disturbing sexual behaviours, criminality and violence. The client group can often present with risk factors and complex mental health needs.

Our findings highlighted there are areas of good practice around risk assessment that considers multiple factors and is seen as a dynamic process as part of the treatment. Discharge planning procedures were reported as proactive and efforts are made to link with local networks. However, this relied on clinician experience and judgement rather than a formal agreed protocol. Every patient has a therapist and a separate case manager who is responsible for liaison with the network and regular review meetings with the patient. The service has a high level of clinical supervision, mostly internal and peer led, with strong clinical expertise. There is often limited contact with families and carers with an assumption that consent would not be granted. A more proactive approach of this being a routine part of the assessment may be of benefit rather than seeking this at times of crisis.

The service reported that they rarely report incidents: this was considered further, and it was reflected that this may be due to the team's threshold of what is deemed to be a reportable incident. Examples were given of patient-to-patient verbal aggression within a therapy group and incidents of anti-social aggressive behaviour in public. These were discussed within supervision and team meetings, with little external oversight.

3.3. Camden Adolescent Intensive Support Service (CAISS):

CAISS provides intensive treatment to young people in crisis, aged 11-18, within the Camden borough. The service aims to prevent unnecessary hospital admissions and facilitate timely discharge when needed, as well as reducing the length of stay in hospital.

There is evidence of robust systems and practice around risk assessment whereby all cases are reviewed in weekly multidisciplinary meetings (attended monthly by Service Clinical Lead) with focus on risk management. The team work closely and collaboratively with service users, families and networks which supports discharge planning. Some challenges were identified in working with inpatient units where there may be a difference of opinion on assessment and understanding of risk in the community. The team is proactive in organising collaborative discharge planning meetings to support robust effective discharge plans. Consideration should be given to developing a formal escalation process where issues are unresolved, potentially involving the ICS or NCEL collaborative, to support resolution and shared accountability.

There has been an increase in incident reporting in the service which is a positive sign of a growing culture of openness and continuous improvement, supporting better organisational learning and safety oversight. Gaps identified relate mainly to the consistency and sustainability of good practice. While much of what is working well is driven by dedicated staff, there is a risk that this could be lost if not more formally embedded into local standard operating procedures (SOPs), without limiting clinical judgement.

Early Intervention Service (EIS):

EIS provide assessment and treatment for young people in Camden with psychosis. There are complexities around cross-organisational working (patients are under North London Foundation Trust but staff employed by TPFT), which can create a lack of clarity around responsibilities, particularly for incident reporting. Clearer guidance is needed on when to report incidents to TPFT, especially where staff are affected or there are significant patient safety concerns; which the team would welcome. There is a strong emphasis on working with service users, families and networks collaboratively. The team described proactive practice around discharge planning, which requires the need to go beyond the standard discharge policy. Much of the team's good practice is not yet embedded in local SOPs, which may affect consistency and long-term sustainability. Additionally, there are concerns around the police response due to changes in police protocols (e.g. for Mental Health Act assessments), and it is recommended that a senior T&P representative join senior police meetings to ensure the service's perspective is included.

4. Recommendations

i. Dynamic risk assessment

- Ongoing work in progress to update risk assessment procedures
- Roll-out and embed training in updated dynamic, formulation-based risk assessments

ii. Liaison with external networks

- Clarify escalation pathways where disputes over discharge planning with inpatient units are unresolved e.g. via NCEL Clinical Leadership Group.
- Ensure Trust leadership representation at senior police meetings as required.

iii. Involvement of family

- Ensure processes to promote early proactive discussions in adult services to have consent to liaise with families and carers.
- Optimising opportunities for family and carer voice to be heard

iv. Discharge planning

- Develop local SOPs for discharge processes e.g. to GPs or other agencies; to ensure consistent and sustainable good practice.

v. Internal Trust oversight – governance and risk

- Ensure clarity around incident reporting thresholds and provide targeted training on this to teams identified as under-reporting.
- Set clear expectations for manager involvement e.g. regular attendance at team meetings and presence at service level.
- Track culture and reporting trends at Board level: weekly Executive Safety Huddles already implemented to ensure timely leadership oversight of incidents and trends.

5. Update on Trust's action plan

5.1 In response to the national learning reviews undertaken in 2024, a programme of work was undertaken to self-assess the Trust in relation to the themed findings of the reviews. Interactive discussions on the outcomes of the reviews were held with the Executive Leadership Team, Clinical Services Delivery Group and with nursing members of staff.

5.2 The outcomes of the discussions and findings were formed into an action plan which is monitored through the Triumvirate and CNO team. An update on this action plan is detailed in Appendix 1. It is proposed that the recommendations identified through the review of CAISS, the Portman and EIS are subsumed into this existing action plan for ongoing monitoring.

5.3 The Committee is asked to note that some actions in the plan, namely related to Freedom to Speak Up (FTSU) and service user experience are proposed to be deferred to the existing Trust-wide action plans to avoid duplication.

5.4 The Committee is also asked to note that it may be practical to pause or adapt some actions which may be influenced by merger discussions, as reflected in the plan.

6. Conclusion

The review findings are consistent with the themes identified as gaps through the stakeholder sessions held in September 2024. While improvements have been seen in the reporting culture across units, this recent review identified some areas where further work is needed at team level. This will be included in the improvement plan developed in October 2024 and linked directly to quality improvement workstreams relating to Patient Safety Incident Reporting Framework, Service User Experience and Staff Experience priorities.

The improvement plan is monitored through Clinical Services Delivery Group, with discussions held and work progress through unit level clinical governance meetings.

Learning from National Reviews - Improvement Plan

v 1.0 October 2024; latest update May 2025

Excellence Inclusivity Compassion Respect

NHS The Tavistock and Portman NHS Foundation Trust

	Action	Link to existing work	SRO	Management Lead	Target Date	Status	Comments
Leadership	Formalise existing Exec and Non-Exec leadership visits to all Trust teams, including structure, purpose and outcome of visits		Director of Corporate Governance	Director of Corporate Governance	Q1 25/26	In progress	12/02/25: Clarify if this is re director visits and who holds the diaries. HH to liaise with AW to coordinate DLT visits to teams. LC to follow up. 24/02/25: Service visits are on hold at the moment. Due to start again in the coming months. 17/4/25 - EC to check with Umisha about the agreed list for the year. Triumeravate do visit teams, TCLs and SCLs reguarly.
	Review hybrid working arrangements across all teams		Chief People Officer	Managing Director	On hold	On hold	12/02/25: Target start and end date will be agreed once there is a clear policy in place. LC to follow up with Gem Davies. 25/02/25: GD: There is some work centrally across London trusts in relation to hybrid working so we are temporarily holding fire on this. 17/4/25 - on hold still. 27/05/25: GD: The cross London implementation of this is on hold still, however there is already an expectation within the organisation that people have weekly on site presence. Triumverate to discuss with CNO and CMO and see what colleagues in NLFT are doing
	Develop a new starter 'buddy' system (check in for first 6 months)	Staff experience working group	Chief People Officer or delegate	Operational and clinical leads for relevant teams	Q1 25/26	In progress	12/02/25: Need SOP from People Team. Request that there is addition to induction form covering buddy system. LC to follow up with Gem Davies. 25/02/25: GD update: not yet taken forward partly due to capacity, but will be reviewed/taken up 17/4/25 - EC to check with GD 27/05/25: GD: Will need a small amount of resource to administer but loop in Sarah Mountain as part of induction review and see what colleagues in NLFT are doing
Clinical	Develop a consistent approach to gaining feedback from service users	Service User Experience A3	Chief Nursing Officer	Associate Director of Nursing & Patient Experience	Q1 25/26	To close; monitored in other projects	12/02/25: Need team level reports to support improvement project, which will be delivered by clinical governance functions of units. 17/4/25 - to close from this perspective and be covered by SU A3
	Review of Portman through the lens of the Nottingham recommendations		Chief Medical Officer / Chief Nursing Officer	Medical Director / Adult Unit Service Clinical Lead	Q1 25/26	In progress	12/02/25: SH to liaise with EC to clarify expectations from review of Portman. SH emailed Jessica Yakeley to meet to discuss. 17/4/25 - SH met with JY re this and a view of DNA and discharge policy. The Portman will be visited as part of the Quality Review process. 23/5/25: DCMO and ADN completed a review following the independent report of Nottingham commissioned by NHSE. Outcomes to be presented to QSC in June 2025.
	Include review of risk assessments and crisis plans through monthly audit plan		Chief Medical Officer	Deputy CMO	Q1 25/26	In progress	12/02/25: SH to meet with Liz Searle to discuss new plans for risk assessments. 17/4/25 - LS leading on risk assessment framework and flow through to crisis plans, making sure they're formualtion based. Clinical Audit plan for 25/26 to be developed once in post.
	Review discharge and DNA policy		Chief Medical Officer	Triumvirate to identify lead	Jul-25	In progress	12/02/25: There is no separate policy for discharge and DNA's. SH will ask EC for rationale.
	Develop a standardised approach to local induction for all staff		Chief People Officer	Head of OD	Q1 25/26	In progress	25/02/25: Update from GD; this can be done but requires collaboration with all the teams - could this be tied into behaviours implementation? 15/04/25: GD to ask SM to set up working group. 27/05/25: GD:As above re buddy system - to loop into induction review and see what colleagues in NLFT are doing. Standard Trust wide induction in place, under review currently to ensure all the appropriate information included.

Culture	Restorative Just Culture - further implement RJC, including training for leaders at all levels in the Trust, to ensure performance concerns are identified proactively and addressed promptly, fairly and effectively	RJC policy under development	Chief People Officer	Head of People (Business Partnering and Employee Relations)	Q1 25/26	In progress	12/02/25: LC to arrange meeting for DLT with Gem Davies. 24/02/25: HH has arranged meeting for 15/04/25: Policy awaiting approval. 17/4/25: Policy drafted that will go to PAG. Training and comms TBC 27/05/25: GD: Policy has been drafted and reviewed - publication date requested from Head of People.
	Freedom to Speak Up - continue to promote FTSU process	Staff Experience A3	Chief Education & Training Officer	FTSU team	Q1 25/26	To close; monitored in other projects	12/02/25: SH to meet with Mark Freestone to discuss. 15/04/25: MF leading. 17/04/25: changed wording of action 27/5/25: Progessed through FTSU action plan. Plan assured through FTSU & Staff Experience Programme Board and PODEDI Committee
	Freedom to Speak Up - Literature more accessible in different languages and continuing raising the awareness of Guardians	Staff Experience A3	Chief Education & Training Officer	FTSU team	Q1 25/26	To close; monitored in other projects	12/02/25: SH to meet with Mark Freestone to discuss. 15/04/25: MF leading. 27/5/25: Progessed through FTSU action plan. Plan assured through FTSU & Staff Experience Programme Board and PODEDI Committee
	Create an ‘open door’ culture	Staff Experience A3	Chief People Officer / Chief Education & Training Officer	To be identified	Q1 25/26	In progress	12/02/25: LC to arrange meeting for DLT with Emma Casey. 19/02/25: HH has arranged meeting for 03/03/25. 15/04/25: GD & MF to raise at Staff Experience Programme Board. https://www.cqc.org.uk/publications/themed-work/opening-door-change, https://www.cqc.org.uk/sites/default/files/20181218_openingthedoor_summary.pdf 27/05/25: GD to review with input from CNO and CMO as related to patient safety. 11/6/25: To be discussed in Senior Leadership Forum to discuss how to enact
	Introduce ‘Hello my name is’ badges		Chief Finance Officer	Director of Estates	Q1 25/26	In progress	12/02/25: SH confirmed Estates should be leading on this. 15/04/25: GD to check who is leading. 30/05/25: Estates leading; costings have been gathered. Work is needed to understand where staffs preferred name will come from (ESR does not include preferred name). Need to discuss at Service Delivery Group re whether this is a priority with upcoming merger and implications on logo etc.
	Formalise the triangulation of key quality & safety data for a consistent approach across the Trust including all sources of service user and carer feedback		Chief Nursing Officer	Associate Director of Nursing & Patient Experience / Associate Director of Quality	Q1 25/26	In progress	12/02/25: To be addressed in DLT meeting with EC. 19/02/25: Meeting arranged for 03/03/25. 15/04/25: To be clarified with EC. Meeting to be rearranged. Plan to be included in Quality & Safety report 30/5/25: Methods of triangulation developed for Quality & Safety report for June QSC. Deep dives scheduled for SUEG.
	Develop ways to survey children on their experiences so that we don’t only hear from their parents.	Service User Experience A3	Chief Nursing Officer	Associate Director of Nursing & Patient Experience	Q1 25/26	In progress	25/02/25: HH followed up with GD. 15/04/25: Quality Priority for 25/26
	Further local training to teams on the patient safety incident reporting framework (PSIRF) and reporting of incidents	PSIRF A3	Chief Nursing Officer	Associate Director of Quality	Q1 25/26	In progress	27/5/25: Training and reminders for incident reporting through clinical governance meetings. Online videos and training materials of Radar and incident reporting being developed. Year review of PSIRF underway to understand improvements and any gaps in awareness/data etc. Review will be presented PSRIF A3 Implementation Group in July and August QSC.
	Engage external partners more in reviews, e.g., MIND, Healthwatch, FTSUG, Advocacy		Chief Nursing Officer	Associate Director of Nursing & Patient Experience / Associate Director of Quality	Q1 25/26	To close	30/5/25: Healthwatch well included in SUEG meetings. Any shared programmes of work to be raised through that route.

Experience and Governance	Work to further understand how we enact change where issues are identified		Chief Nursing Officer	Director of Therapies & Clinical Governance / Associate Director of Nursing & Patient Experience / Associate Director of Quality	Q1 25/26	To close	15/04/25: To be clarified with EC. 17/4/25: Confirm what this relates to. 30/5/25: Any emergent issues to be raised within the Clinical Services Delivery Group as the formal forum for both clinical and ops elements to be brought together. In relation to enacting change there is onoging work in relation to evidenced and triangulated learning related to incidents, FTSU, complaints, feedback etc. Implemented Executive Safety Huddle paired to Clinical Governance meetings, IQPR, CISG etc
	Review reporting meetings to ensure that the right people are at the appropriate meetings allowing team managers to be more involved and visible		Triumvirate	Triumvirate	Q1 25/26	Proposed to close	15/04/25: To be clarified with EC. 17/04/25: Mandated that TCL and Operational Managers attend CG and business meetings respectively.
	Ensure processes to promote early proactive discussions in adult services to have consent to liaise with families and carers Optimising opportunities for family and carer voice to be heard.						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Ensure clarity around incident reporting thresholds and provide targeted training on this to teams identified as under-reporting.						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Track culture and reporting trends at Board level: weekly Executive Safety Huddles already implemented to ensure timely leadership oversight of incidents and trends.						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Set clear expectations for manager involvement e.g. regular attendance at team meetings and presence at service level.						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
Clinical	Clinical Risk assessment Policy to be reviewed						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Clinical Risk Assessment Training to be implemented						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Escalation process for disputes with other agencies, specifically CAMHS inpatient units						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Leadership attendance at senior police meetings						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025
	Develop local SOPs for discharge processes e.g. to GPs or other agencies; to ensure consistent and sustainable good practice.						Added 11/6/25 - to be discussed at next Clinical Services Delivery Group in July 2025

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday 10 July 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	1st July, 2025	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 015**		

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. Meetings continue to take place at Executive level between our potential merger partners, North London NHS Foundation Trust, with a Board-to-Board session scheduled for the week of this Committee (3rd July). Discussions with the partners are currently convivial and productive, with a high degree of curiosity about the Education and Training offer and its regulatory commitments. 1.2. As part of the process of forward-planning for the potential merger, we have communicated to the Office for Students (OfS) at their request a high-level paper outlining the key changes to the student experience associated with a potential merger. We anticipate this will prompt a streamlined request for further information from the OfS streamlined to those areas where they feel the merger may present a risk to the student experience and thus allowing for a timely decision from OfS on the merger ahead of April 2026. 1.3. We continue to communicate with other stakeholders, including NHS England, the University of Essex and the University of East London about these changes. The University of Essex continue to attend our weekly merger working group and I was delighted to receive some return correspondence from UEL in relation to the merger news.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Success Stories 2.1. Student applications to our long courses are showing a high level of volatility but at the time of writing were showing a positive trend with an increase in 1% of applications over 24/25 despite HE sector-wide contraction, including a raised proportion of overseas applications. Because of the earlier opening of admissions, we also have a sustained base of offers and accepted offers (increased 166% vs this time in 24/25) with a number of deferrals also potentially reckonable into the	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

numbers, and an increase in overseas applications. This points to a strong performance in terms of long-course student enrolments, with courses closing to applications at the end of July. 2.2. The results of the 2025 student survey are in and I am very grateful to our Student Experience team for their prompt and robust analysis of the data using the Qualtrics platform. The highlights of this are very positive: this year saw a 29% response rate (359 responses), up from 25% (312 responses) in 24/25 and against a sector average of 13%, and an increase in overall student satisfaction from 79% in 24/25 to 81%. Learning and Teaching, Library Resources and Research all showed satisfaction rates of >80%, with Community and Culture (58%) and Master's Dissertation (65%) remaining as work areas identified in previous years. I am extremely grateful to DET staff and in particular the student experience team 2.3. I was delighted to host the DET Strategy Away Day on 4th June this year, which brought together over 100 of our DET staff together with the Non-Executive Director of this Committee and a lead from the Clinical Directorate. The event was focused around producing a medium-to-long term strategy for the Education and Training department. We structured the strategy around key areas, including: Developing our International Offering; Engagement with the Local Community; Population Health; and Commercial Sustainability. Analysis of this work is ongoing but early findings will be presented at the July ETC, and our plan is to produce a document that can then be shared with stakeholders in the Trust and outside for further consultation.	
3. Challenge Areas 3.1. Although the overall long-course picture looks positive, there is considerable variation across courses in terms of student interest. We have established a 'fragile courses' group that mirrors the work clinical colleagues are doing on fragile services. Unfortunately, one of our courses delivered in jointly with the University of Essex has been suspended by Essex this year due to lack of interest (only two offers by June 2025) and we have three other courses currently with a red RAG rating for student interest. We have established a weekly recruitment oversight group that considers applications and offers on a course-by-course basis and introduces targeted interventions to better market courses that are struggling to recruit, through open days, webinars and external advertising.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. BAF Risk - Core Education Contracts 4.1. After discussion informed by input from our contracting team, the Committee have endorsed the creation of a new BAF risk around 'Sustainability of Core Education Funding Contracts'. It was noted in the committee that the NHS England National Training Contract (NTC) that supported the majority of DET courses, had been novated for some years and for 2024/25 written reassurance was given of a new contracting process but this was not forthcoming, possibly with the changes to NHS England. NHSE have also indicated they wish to re-tender other large contracts held by the Trust for Child Psychotherapy.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

4.2. The Committee agreed that a BAF risk on this item would be drafted by MF and DO	
5. Ongoing Work of Note 5.1. 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. 5.2. 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. 5.3. 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 06/09/2025.

Risks Identified by the Committee during the meeting:

- BAF risk around Sustainability of Core Education Funding Contracts

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, 10 July 2025			
Report Title: Workforce Race Equality Standard Report 2024-25			**Agenda No.: 016a**
Report Author and Job Title:	Dr Thanda Mhlanga Head of Culture and Inclusion	**Lead Executive Director:**	Gem Davies Chief People Officer
Appendices:	Appendix 1: WRES Report and Improvement Action Plan		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This Workforce Race Equality Standard (WRES) report highlights disparities between global majority staff and their White colleagues across nine key indicators, covering workforce composition, recruitment, people management, discrimination, and Board-level representation.		
Background:	The Workforce Race Equality Standard (WRES) was mandated through the NHS Standard Contract in April 2015, requiring all NHS organisations to publish their performance data and action plans against nine defined indicators. The data presented in this report reaffirms a persistent and concerning trend: staff from a global majority background consistently report significantly poorer experiences compared to their White colleagues, a disparity evident since the inception of the WRES.		
Assessment:	This WRES report presents a complex picture - steady progress alongside persistent challenges: the Trust has advanced in five of nine indicators, while slipping in four. Crucially, three of the declining indicators remain among our strongest, still outperforming national averages. Yet, despite marked improvements in five areas, the Trust remains among the lowest performers nationally on those same metrics. This highlights the deep-rooted challenges we face, the uneven nature of our progress, and the urgent need for sustained, targeted action. **Improvements:** • **Workforce Representation:** The proportion of staff from a global majority background rose by 1.8% to 37.2% - a fifth consecutive year of growth, as the Trust continues working toward the London average of 52.1%. • **Leadership Diversity:** Representation in senior roles has improved, though underrepresentation persists from Band 5 (clinical) and Band 8a (non-clinical) upwards. • **Bullying by Staff:** Incidents involving colleagues dropped by 1.73% to 26.71%. However, this remains 10.27 percentage points higher than abuse from patients and among the worst nationally. • **Discrimination:** Reports of discrimination by managers or colleagues declined by 3.33% to 16.67%, though this still lags the national average of 13.23%. • **Formal Disciplinary Action:** Staff from racially minoritised groups are no longer disproportionately subject to formal disciplinary processes.		

	• **Career Progression or Promotion Perception:** Perceptions of fairness in promotion rose significantly by 12.91% to 38.86% yet remain below the 51.05% national average. **Areas of Regression:** • **Bullying by Patients and the Public:** Reports rose by 7.69% to 16.44%, though this remains better than the national average of 31.64%. • **Recruitment:** Applicants from minoritized ethnic backgrounds remain more likely to be appointed from shortlisting, despite a slight regression. • **Training Access:** White staff are still only marginally more likely to access non-mandatory CPD, staying within the acceptable range (0.80–1.25). • **Board Diversity:** Ethnic minority underrepresentation at Board level widened from -4% to -9%.
Key recommendation(s):	The Board of Directors is asked to support the prioritisation of the following key actions to address the challenges identified in this WRES report: • **Trust-wide dissemination and discussion** of WRES data to build awareness and shared understanding of race-related issues. • **Empower services** to interpret and act on their own WRES data locally. • **Clearly communicate and deliver** the Trust's agreed EDI priorities. • **Address bullying and harassment:** Each service should develop an action plan to tackle abuse by colleagues. • **Embed inclusive recruitment practices** across all levels of the Trust. • **Ensure transparency in internal opportunities** through oversight panels for promotions and CPD access. • **Maintain rigorous oversight:** The EDI Programme Board and POD EDI Committee to closely monitor progress and impact.

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

	provider of training & education	research in this area		

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 5:** Workforce development, retention, recruitment; and **BAF 6:** Lack of inclusive and open culture				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	• Standard NHS Contract • Equality Act (2010) • Public Sector Equality Duty (PSED)				
Resource Implications:	Yes ☒	No ☐			
	• Equalities Training Budget • Inclusive Recruitment Training • Just Culture Training				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	• Equalisation of experience between staff from minoritised ethnic backgrounds and their white counterparts. • Eradication of inequality				
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:	• EDI Programme Board • POD EDI				
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	

NHS
The Tavistock and Portman
NHS Foundation Trust

WRES Report
Workforce Race Equality Standard
2024-25

The Tavistock and Portman NHS Foundation Trust
EDI Team

Excellence Inclusivity Compassion Respect

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Tavistock and Portman WRES Report 2024-25

Workforce Race Equality Standard

Introduction

The Workforce Race Equality Standard (WRES) was mandated through the NHS' standard contract in April 2015: all NHS organisations are required to publish their performance data and action plans against nine indicators of the WRES and make them public.

Consequently, this report presents the Tavistock and Portman's 2024-25 WRES data and associated Action Plan. It provides an overview of the Trust's scores on workplace inequalities between staff from a global majority background and their white counterparts through nine WRES key indicators that focus on workforce composition and people management, recruitment, bullying and harassment and discrimination as well as representation at Board level – see full details of the WRES indicators in the summary of findings on page 4. The report identifies where improvements have been made, where data has stagnated or deteriorated and proposes an action plan / countermeasures for ameliorating the gaps.

Key Findings from the WRES 2024-25 Report

Table 1: WRES 2024-25, Summary of Key Findings

WRES Indicators	Workforce Indicators For each of these four workforce indicators, compare the data for White and staff from a global majority background.	Trend	Summary of Key Findings
Indicator 1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	↑	Workforce representativeness has continued to improve gradually over the last 5 years – it now stands at 37.2% (an improvement of 9.6% since 2020). There is 11.8% overrepresentation in the non-clinical cohort (Bands 1-7) and underrepresentation in more senior roles (Bands 8a to VSM). The underrepresentation in the clinical cohort starts at Band 5.
Indicator 2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to minority ethnic applicants	↓	Applicants from racially minoritised groups are more likely than White staff to be appointed from shortlisting. This has been the trend for the past 5 years. However, there was regression from 0.77 to 0.96 this reporting year, but this score still falls within the non-adverse range of 0.80 to 1.25.
Indicator 3	Relative likelihood of minority ethnic staff entering the formal disciplinary process compared to white staff	↑	Huge improvements have been made in this indicator from a score of 1.76 to 0.54 – meaning staff from a global majority background are no longer more likely to enter the formal disciplinary process than their White peers.
Indicator 4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to minority ethnic staff	↓	There was a slight regression in this indicator this year. However, the Trust's score remains within the non-adverse range of 0.80 to 1.25 – a position the Trust has maintained for the past 5 years.
	National NHS Staff Survey indicators (or equivalent) **For each of the four staff survey indicators, compare the outcomes of the responses for White and staff from a global majority background**		
Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	↓	A 7.69% regression from 8.75% to 16.44%, but the Trust remains well ahead of the NHS average of 31.64%.
Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	↑	A positive improvement of 1.73% was achieved in 2024-25. While there is still progress to be made, the current rate of 26.71% presents an opportunity to work towards closing the gap with the national average of 21.23%.
Indicator 7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	↑	There was a notable improvement of 12.91%, bringing the Trust's score to 38.86%. While there is still room for growth compared to the NHS average of 51.05%, this progress marks a step in the right direction.
Indicator 8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	↑	This year saw a positive improvement of 3.33%, bringing the Trust's score to 16.67% - highlighting ongoing efforts towards NHS average of 13.23%.
	Board representation Indicator ***For this indicator, compare the difference for White staff and staff from racially minoritised groups**		
Indicator 9	Percentage difference between the organisations' Board voting membership and its overall workforce ***Note:** Only voting members of the Board should be included when considering this indicator	↓	Staff from minoritised ethnic backgrounds are underrepresented at Board. The deficit in 2023-24 was -4%, it has widened to -9% this reporting year.

Indicator 1: Workforce Representation

Workforce Representation by Ethnicity

The data presented in **Figure 1** below tells us that there has been a gradual improvement in the representativeness of the workforce profile at the Tavistock and Portman over the last 5 years. In 2023-24, 300 (35.4%) of our workforce came from a global majority background and 527 (62.2%) were White. In 2024-25 representation of staff from ethnic minority backgrounds improved by 1.8% to 311 (37.2%) - the White cohort shrunk by 1.9% to 504 (60.29%). This is a welcome improvement as the trust continues to journey towards aligning with NHS Trust trends in the London region where the average for staff from minoritised ethnic backgrounds is 52.1% and 43% for White staff – see **Figures 1 and 2** below for details.

Figure 2: Global Majority Representation at the T&P

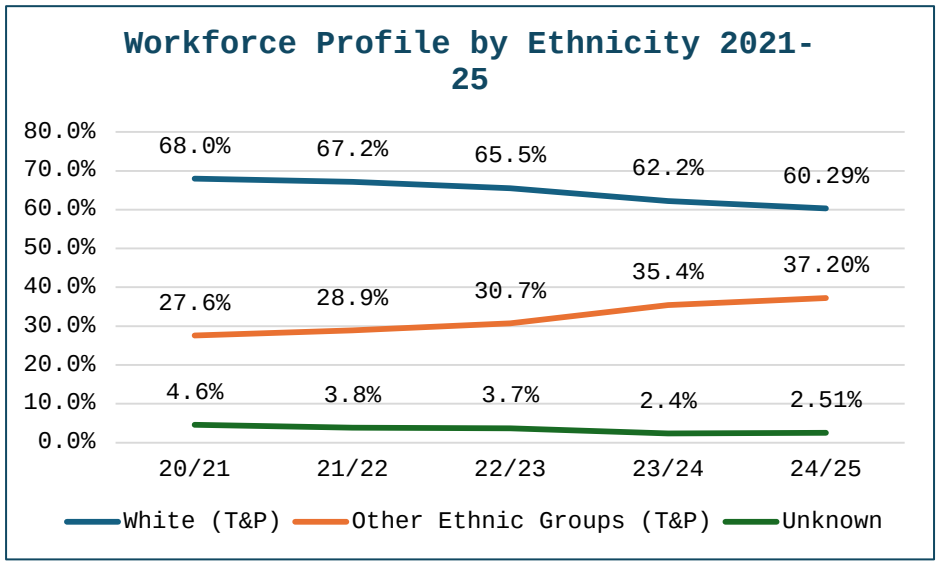
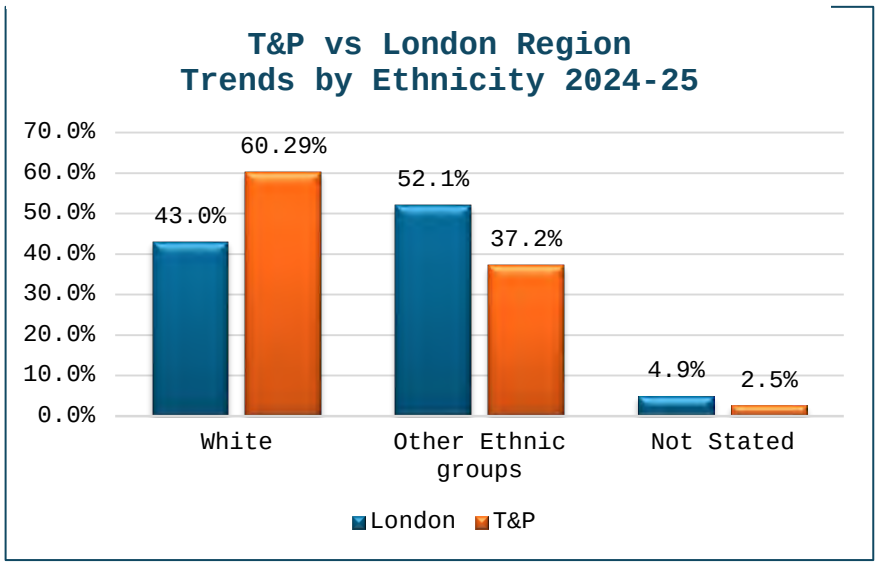


Figure 1: T&P vs London Region Workforce Profile by Ethnicity



Workforce Profile: Non-Clinical Cohort

Table 2: Workforce Profile (Non-clinical Cohort 2020-25)

Workforce Profile: Non-clinical Cohort 2020-2025															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	White	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**
Cluster 1: AfC Bands < 1 *to* 4	31 (36.5%)	50 (58.8%)	4 (4.7%)	30 (38.5%)	45 (57.7%)	3 (3.9%)	26 (38.8%)	37 (55.2%)	4 (6.0%)	19 (25.0%)	55 (72.4%)	2 2.6%	20 (24.4%)	61 (74.4%)	1 (1.2%)
Cluster 2: AfC Bands 5-7	87 (55.8%)	62 (39.7%)	7 (4.5%)	91 (56.2%)	68 (42.0%)	3 (1.9%)	84 (51.2%)	75 (45.7%)	5 (2.8%)	90 (52.0%)	78 (45.1%)	5 (2.9%)	90 (49.2%)	88 (48.1%)	5 (2.7%)
Cluster 3: AfC Bands 8a-8b	37 (69.8%)	12 (22.6%)	4 (7.5%)	36 (69.2%)	13 (25.0%)	3 (5.8%)	39 (70.9%)	13 (23.6%)	3 (5.5%)	43 (68.3%)	19 (30.2)	1 (1.6%)	48 (71.6%)	17 (25.4%)	2 (3.0%)
Cluster 4: AfC Bands 8c-VSM	39 (90.7%)	2 (4.7%)	2 (4.7%)	26 (96.3%)	0 (0%)	1 (3.7%)	26 (76.5%)	8 (23.5%)	0 (0%)	24 (68.6%)	11 (31.4%)	0 (0%)	17 (63.0%)	10 (37.0%)	0 (0%)
Total Non-Clinical	**194 (57.6%)**	**126 (37.4%)**	**17 (5%)**	**183 (57.4%)**	**126 (39.5%)**	**10 (3.1%)**	**175 (54.8%)**	**133 (41.6%)**	**12 (3.4%)**	**176 (50.7%)**	**163 (47.0%)**	**8 (2.3%)**	**175 (48.7%)**	**176 (49.0%)**	**8 (2.2%)**

Workforce Profile: Clinical Cohort

Table 3: Workforce Profile (Clinical Cohort 2020-2025)

Workforce profile: Clinical Cohort 2020-2025															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	White	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**
Cluster 1: AfC Bands < 1 *to* 4	7 (41.2%)	10 (58.8%)	0 (0%)	5 (22.7%)	16 (72.7%)	1 (4.5%)	9 (37.5%)	15 (62.5%)	0 (0%)	5 (29.4%)	12 (70.6%)	0 (0%)	10 (47.6%)	11 (52.4%)	0 (0%)
Cluster 2: AfC Bands 5-7	165 (75.0%)	46 (20.9%)	9 (4.1%)	169 (76.5%)	45 (20.4%)	7 (3.2%)	157 (74.8%)	50 (23.0%)	11 (5.0%)	147 (68.7%)	62 (29.0%)	5 (2.3%)	141 (65.9%)	64 (29.9%)	9 (4.2%)
Cluster 3: AfC Bands 8a-8b	142 (84.0%)	20 (11.8%)	7 (4.1%)	134 (81.2%)	25 (15.1%)	6 (3.9%)	133 (79.2)	29 (17.3%)	6 (3.8%)	131 (75.7%	38 (22.0%)	4 (2.3%)	123 (78.3%)	32 (20.4%)	2 (1.3%)
Cluster 4: AfC Bands 8c-VSM	35 (71.4%)	13 (26.5%)	1 (2.0%)	31 (72.1%)	10 (23.3%)	2 (4.7%)	27 (79.4%)	6 (17.6%)	1 (2.9%)	23 (76.7%)	6 (20%)	1 (3.3%)	13 (68.4%)	6 (31.6%)	0 (0%)
Total Non-Clinical	**347 (76.6%)**	**89 (19.6%)**	**17 (3.8%)**	**339 (75.1%)**	**96 (21.3%)**	**16 (3.5%)**	**324 (71.7%)**	**110 (24.3%)**	18 (4%)	**306 (70.5%)**	**118 (27.2%)**	**10 (2.3%)**	**287 (69.8%)**	**113 (27.5%)**	**11 (2.7%)**

Table 2 is an overview of the non–clinical workforce cohort over five reporting years 2020-24.

What does our data tell us?
There is overrepresentation of staff from a global majority background in the non-clinical cohort. However, the over-representation is in lower bands (2-7).
There is under-representation in senior roles (Band 8a - VSM).

According to **Table 3,** there has been an improvement of 7.9% in the representation of staff from a global majority background in the clinical cohort over the last 5 years.

Bands 1- 4 (Cluster 1) are the lowest AfC pay bands: 11 (52.4%) of that cluster come from minoritised ethnic backgrounds. However, there is underrepresentation at Bands 5 - VSM.

Table 4: Workforce Profile (Medical / Dental Cohort 2019-2024)

Workforce Profile: Medical / Dental Cohort 2020-2025															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	White	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**
Consultants	23 (60.5%)	11 (28.9%)	4 (10.5%)	24 (63.2%)	13 (34.2%)	1 (2.6%)	24 (64.9%)	12 (32.4%)	1 (2.7%)	24 (66%)	10 (27.8%)	2 (5.6%)	23 (63.89%)	11 (30.56%)	2 (5.56%)
Snr Medical Manager	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Non-Consultant Career Grade	4 (80%)	1 (20%)	0 (0%)	4 (80%)	1 (20%)	0 (0%)	4 (80%)	1 (20%)	0 (0%)	6 (85.7%)	1 (14.3%)	0 (0%)	6 (85.71%)	1 (14.29%)	0 (0%)
Trainee Grade	12 (57.1%)	8 (38.1%)	1 (4.8%)	10 (47.6%)	6 (28.6%)	5 (23.8%)	10 (62.5%)	5 (31.3%)	1 (6.25%)	9 (60%)	6 (40.0%)	0 (0%)	9 (64.29%)	5 (35.71%)	0 (0%)
Other	2 (100%)	0 (0%)	0 (0%)	2 (100%)	0 (0%)	0 (0%)	5 (55.6%)	4 (44.4%)	0	6 (75%)	2 (25%)	0 (0%)	4 (44.44%)	5 (55.56%)	0 (0%)
Total	**41 (61.2%)**	**21 (31.3%)**	**5 (7.5%)**	**40 (60.6%)**	**20 (30.3%)**	**6 (9.1%)**	**47 (66%)**	**22 (30.9%)**	**2 (2.8%)**	**45 (68.2%)**	**19 (28.8%)**	**2 (3%)**	**42 (63.64%)**	**22 (33.33%)**	**2 (3.03%)**

What does our data tell us?
According to **Table 4**, the Medical / Dental Cohort was representative of the overall workforce profile from 2020 - 23.

After shrinking by 3 members of staff (2.1%) in 2023-24, the global majority section of the workforce has been underrepresented for two consecutive years.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

Table 5: Relative likelihood of appointment from shortlisting

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24	2024/25
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants **A figure above 1:00 indicates that White candidates are more likely than applicants from a Global Majority background to be appointed from shortlisting.*	Tavistock & Portman	0.73	0.85	0.95	0.77	0.96
		NHS Trusts	1.61	1.61	1.54	1.59	Not yet available

What does our data tell us? According to Table 5, White applicants are generally more likely than applicants from minoritised ethnic backgrounds to be appointed from shortlisting in the NHS. However, at Tavistock and Portman the relative likelihood of White staff being appointed from shortlisting compared to staff from a global majority background is 0.96 which indicates that applicants from racially minoritised groups are more likely than White staff to be appointed from shortlisting. This trend has been maintained for five consecutive years. Increasingly, efforts are being made to ensure that recruitment of applicants from minoritised ethnic backgrounds is not limited to lower banded roles – this will facilitate achievement of the desired changes in the workforce profile.

Indicator 3: Relative likelihood staff entering the formal disciplinary process

Table 6: Relative likelihood of entering formal capability process

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24	2024/25
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff **A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process.*	Tavistock & Portman	0.00	0.00	1.60	1.76	0.54
		NHS Trusts	1.16	1.14	1.14	1.03	Not yet available

What does our data tell us? A figure above 1:00 indicates that staff from minoritised ethnic backgrounds are more likely than White staff to enter the formal disciplinary process – this is the trend nationally. However, a momentous shift has been achieved at Tavistock and Portman – our figure has shrunk from 1.76 to 0.54, meaning that staff from a global majority background are no longer more likely to enter the formal disciplinary process compared to their White counterparts. The progressive improvement captured in **Table 6** needs to be sustained.

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

Table 7: Relative likelihood of staff accessing non-mandatory training and CPD

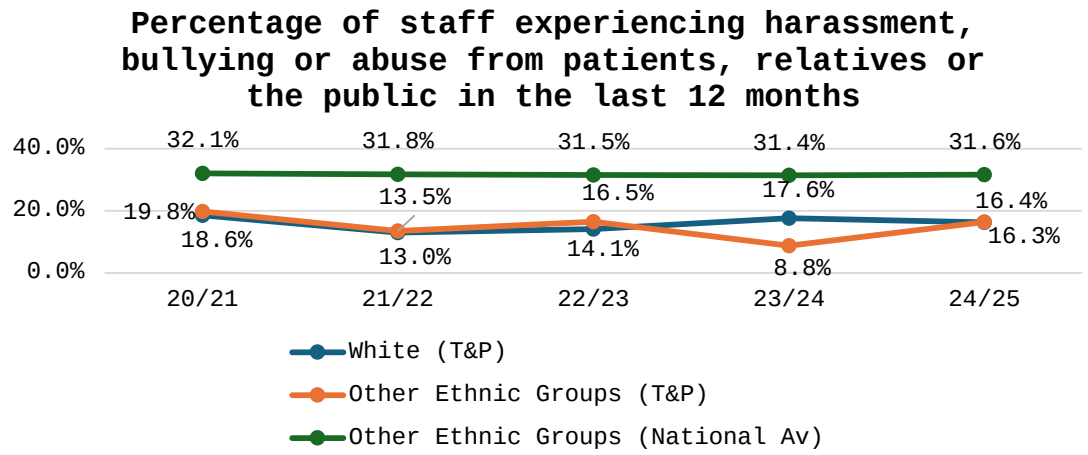
WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22	2022/23	2024/25
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff **A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD.*	Tavistock & Portman	1.49	1.00	1.05	1.02	1.04
		NHS Trusts	1.14	1.14	1.12	1.12	Not yet available

What does our data tell us?

According to **Table 7**, incremental progress has been made in this indicator at the Tavistock and Portman: our figure was 1.49 five years ago – our figure this year (2024-25) it is 1.04. We have been in the non-adverse range of 0.80 to 1.25 for four consecutive years – meaning White staff at the Trust are no longer more likely to access non mandatory training and continued professional development than staff from ethnically diverse backgrounds. Overall, it is encouraging to note that all regions in the NHS now fall within the non-adverse range for this indicator.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse by patients and public

Figure 3: Harassment, Bullying or Abuse in the last 12 months (patients, relatives & public)



What does our data tell us?

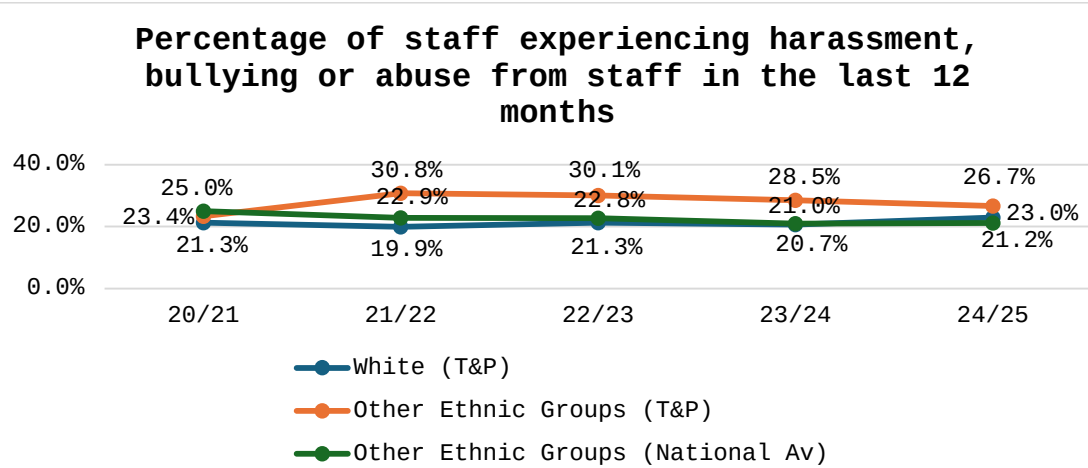
The data in **Figure 3** tells us that the number of staff from a global majority background experiencing harassment, bullying or abuse from patients, relatives or the public has regressed from 8.8% to 16.4% in the las 12 months.

However, while this regression is an unwelcome development, the Trust's score is superior to the national average score of 31.6% for this indicator.

Also, the score of 16.4% suggests that there are negligible differentials in experience: the score for White staff is 16.3%.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff

Figure 4: Harassment, Bullying or Abuse in the last 12 months (staff)

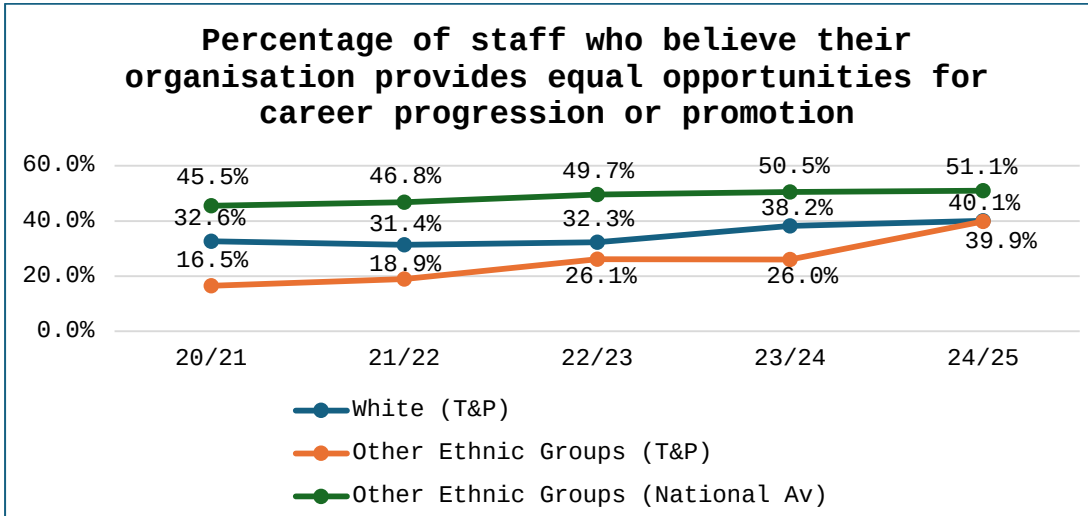


What does our data tell us?

According to the data presented in **Figure 4**, the harassment, bullying and abuse of staff from minoritised ethnic backgrounds by their colleagues has improved for 4 consecutive years. It improved by 1.8% to 26.7% this year. However, when one juxtapositions data in **Figures 3** and **4**, it is regrettable to note that the harassment, bullying or abuse received by ethnic minority staff from their own colleagues at the Trust is 10.3% higher than the 16.4% received from patients and the public. Also, our score in this indicator is 5.5% worse that the national average score and 3.3% worse than our position 5 years ago.

Indicator 7: Perceptions on equal opportunities for career progression or promotion

Figure 5: Perceptions on opportunities for career progression or promotion

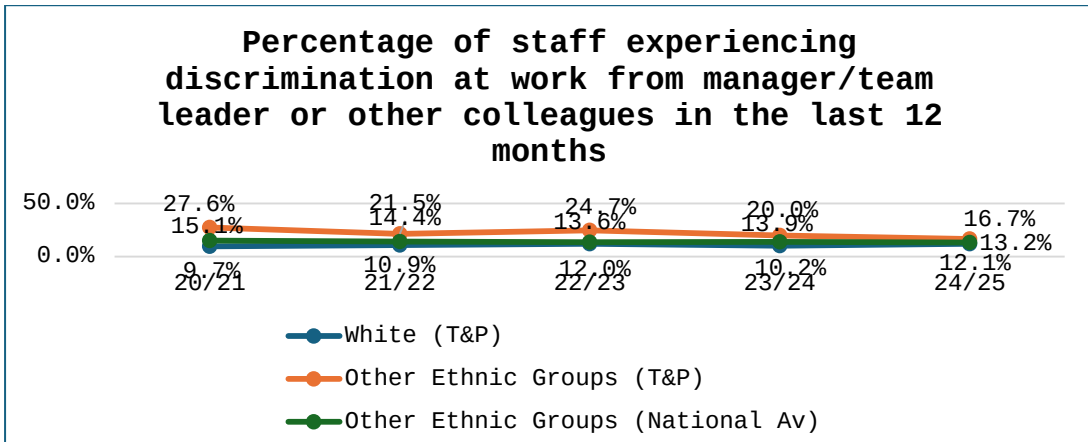


What does the data in Figure 5 tell us?

- Increasingly, staff from minoritised ethnic backgrounds at the Trust believe that efforts are being made to ensure fairness in opportunities for career progression and promotion.
- The Trust's score of 39.9% for staff from a global majority background in this indicator reflects an improvement of 13.9% over the last 12 months and a significant improvement of 23.4% over the last 5 years.
- As we celebrate this positive trajectory, we are mindful that our score of 39.9% positions the Trust 11.2% below the national average of 51.1% for this indicator.

Indicator 8: Discrimination at work from manager/colleagues or team leader

Figure 6: Experience of discrimination at work from manager/team leader or colleagues



What does the data in Figure 6 tell us?

- The number of staff who report to having personally experienced discrimination at work from either their manager, team leader or colleagues fell from 20.0% to 16.7 this year – an improvement of 3.3%.
- Over the last 5 years, the Trust's score has improved by 10.9%.
- This positive trajectory needs to be sustained as we continue to journey towards the national average of 13.2% for this indicator and equalisation of experience between staff from ethnic minority backgrounds and White staff.

Indicator 9: Board Representation

Indicator 9 examines the percentage difference by ethnicity between the organisation's Board voting membership and the overall workforce.

Table 8: Board Representation

Indicator 9: Board Representation and the difference between Board voting membership and its overall workforce															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
Board Representation	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**
Total Board Members by ethnicity	21.4% (3)	78.6% (11)	0.0% (0)	16.7% (2)	75% (9)	8.3% (1)	26.32% (5)	73.68% (14)	0% (0)	31.58% (6)	68.42 (13)	0% (0)	27.78% (5)	72.22% (13)	0% (0)
Voting Board Members by ethnicity	16.7% (2)	83.3% (10)	0% (0)	18.2% (2)	72.7% (8)	9.1% (1)	44.44% (4)	55.56% (5)	0 (0%)	26.67% (4)	73.33 (11)	0% (0)	21.43% (3)	78.57 (11)	0 % (0)
Overall Workforce by ethnicity	26.3% (219)	64.9% (541)	8.8% (73)	27.5% (235)	68% (582)	4.6% (39)	30.7% (255)	65.5% (544)	3.7% (31)	35.42% (300)	62.22% (527)	2.36% (20)	37.2% (311)	60.29% (504)	2.51% (21)
Difference (Total Board – Overall Workforce)	-4.9%	13.6%	-8.8%	-4.70%	10.8%	-3.8%	-4.4%	8.1%	-3.7%	-4%	6%	-2%	-9%	12%	-3%

What does the data in Table 8 tell us?

After a gradual decrease in the deficit of Board members from minoritised ethnic backgrounds over the last 4 years, there has been a regression this year. Currently, (3) 21.43% of voting Board members are from racially minoritised groups, compared to 311 (37.2%) of the Trust's workforce that comes from that background. This means that staff from minoritised ethnic backgrounds are underrepresented - the deficit has increased from -4% in 2023-24 to -9% this year (2024-25).

Conclusion and Next Steps

This WRES report reveals a mixed picture: the Trust has improved in five of the nine indicators while regressing in four of them. However, these trends must be viewed in context. Notably, three of the four indicators showing regression remain among our strongest overall, with scores still exceeding the national average. Conversely, despite achieving significant improvements in five areas, the Trust continues to rank among the lowest performing nationally in those same metrics. This underscores the complexity of the Workforce Race Equality Standard, the challenging baseline from which we started, and the spiky nature of our performance profile.

Improvements in context:

- The size of the global majority workforce in the Trust has increased for five consecutive years – in this reporting year it improved by 1.8% to 37.2%. The Trust remains focused on improving the representativeness of its workforce each year towards the London average of 52.1%.
- The representation of staff from ethnically diverse backgrounds has continued to increase in more senior roles, however underrepresentation starts at Band 5 for clinical roles and at Band 8a for non-clinical roles.
- The bullying, harassment or abuse that staff from a global majority background receive from their colleagues at Tavistock and Portman has decreased by 1.73% to 26.71% this year. However, this is 10.27 percentage points higher than the amount that they receive from patients and the public and positions the Trust among the lowest performers nationally.
- There was a positive improvement of 3.33% in the number of staff from a global majority background experiencing discrimination from their manager, team leader or colleague. However, with a score of 16.67%, the Trust remains among lowest performers nationally for this indicator – the national average is 13.23%.
- Staff from minoritised ethnic backgrounds are no longer more likely than White staff to enter the formal disciplinary process.
- There was an encouraging improvement of 12.91% (25.95% to 38.86%) in the number of staff from racially minoritised backgrounds at the Trust who believe that there is fairness in opportunities for career progression and promotion. However, this score places the Trust in the lowest performing category as the national average for this indicator is 51.05%.

Areas of regression in context:

- The number of staff from racially minoritised groups experiencing harassment, bullying or abuse from patients, relatives or the public has regressed by 7.69% this year to 16.44%. However, despite the regression, this score is superior to the national average score of 31.64%.
- Despite the slight regression, applicants from minoritised ethnic backgrounds continue to be more likely than White staff to be appointed from shortlisting.
- Notwithstanding the regression, the relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to staff from a global majority background is in the non-adverse range of 0.80 to 1.25.
- Underrepresentation of ethnic minorities at Board: the deficit has widened from -4% to -9% in this reporting year.

In response to the data presented in this WRES report, the following areas have been prioritised:

- Reviewing and strengthening the inclusive recruitment process to ensure that the Trust's workforce continues to journey towards a position where it mirrors the communities it serves in the London region. This includes tackling the disparities in representation in higher bands and clinical roles.
- Ensuring equity and transparency around promotions and career progression opportunities.
- Reducing the numbers of ethnic minority staff from experiencing discrimination at work from manager / team leader or other colleagues.
- Reducing the numbers of ethnic minority staff from experiencing bullying, harassment or abuse at work from colleagues.
- Embedding Just and Learning Culture principles in our systems.

- Continuing to improve the demographic composition of our Board.

Next Steps

- The WRES data and its analysis will be disseminated trust-wide to facilitate better understanding of challenges associated with colourism.
- Facilitate local understanding and ownership of WRES data in each service.
- Communicate and facilitate understanding of Trust's EDI priorities.
- Action Trust's EDI priorities.
- The EDI Programme Board and POD EDI Committee to monitor progress against outcomes and actions.
- Each service to discuss the bullying, harassment and abuse of staff by colleagues and come up with a service plan for ameliorating the challenges.
- Ensure inclusive recruitment ethos is embedded across the Trust.
- Facilitate transparency and ensure there is a panel/committee that looks at all internal promotions and CPD requests.

Appendix 1

Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Executive Lead(s)	Timescale

Eradicate Bullying, Harassment and Abuse	Raise awareness about BHA Reduce BHA experienced by staff from minoritised ethnic backgrounds **WRES indicators 5, 6, 7 & 8**	Better understanding of BHA Swift and fair responses to incidents Reduction in BHA Staff role modelling Trust's values	Ensure local level ownership of EDI data Everyone to have an EDI objective All Teams to have EDI reflections EDI Training for managers	Chief People Officer Chief Nursing Officer	
Review and strengthen Inclusive Recruitment Process	Develop a representative workforce Equip all recruiting managers and EDI representatives with inclusive recruitment principles, tools and ethos **WRES indicators 1, 2 & 7**	All interviews have a trained manager and inclusion representative / advisor Improvement in representativeness of the workforce by race and ethnicity in senior roles and Board	Review, standardise and strengthen Inclusive Recruitment Process Communicate Trust's position to all staff Embed Inclusive Recruitment training in current Leadership and Management training	Chief People Officer Chief Nursing Officer	
Address concerns about lack of Equal Opportunities for career progression or promotion	Develop a transparent and equitable internal promotion process **WRES indicators 7 and 8**	Transparency and scrutiny of all internal promotions and non-mandatory CPD training by CPD/Promotion panel Improvement in staff survey scores	Open internal promotions to scrutiny to build trust	Chief People Officer Chief Nursing Officer	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 10 July 2025			
Report Title: Workforce Disability Equality Standard Report 2024-25			**Agenda No.: 016c**
Report Author and Job Title:	Dr Thanda Mhlanga Head of Culture and Inclusion	**Lead Executive Director:**	Gem Davies Chief People Officer
Appendices:	Appendix 1: WDES Report and Improvement Action Plan		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This report leverages 10 Workforce Disability Equality Standard (WDES) metrics to expose and address disparities in experience between Disabled and Non-Disabled staff. Covering workforce composition, recruitment, capability processes, bullying, career progression, inclusion, presenteeism, reasonable adjustments, engagement, and Board representation, the findings provide a critical lens through which the Trust can drive meaningful change and foster a more equitable workplace.		
Background:	The Workforce Disability Equality Standard (WDES) was mandated through the NHS Standard Contract in April 2018. Under this requirement, all NHS organisations must publish their performance data and action plans against ten defined metrics, which evaluate and compare the workplace experiences of Disabled staff and those with long-term health conditions to their Non-Disabled colleagues.		
Assessment:	This report highlights a complex but encouraging picture. Of the 13 areas assessed through the 10 WDES indicators, 8 show positive movements, several with marked improvement - reflecting the Trust's clear commitment to inclusion for staff with Disabilities and Long-Term Conditions. However, performance in many areas still falls short of national benchmarks, reinforcing the urgent need for sustained, targeted action to close the gap and achieve genuine equity. **Improvements:** • **Disability declaration rates** on ESR have steadily risen over five years. • **Board representation** of Disabled staff has gradually increased. • **Equality in capability processes** achieved - Disabled staff are no longer disproportionately subject to formal procedures. • **Bullying by managers** has slightly decreased, though it remains worse than the national average. • **Staff engagement** among Disabled staff continues to improve, showing sustained positive momentum. • **Increased reporting** of bullying and harassment suggests growing trust in internal processes.		

	• **Perceptions of fair promotion** and career progression are trending upward. • **More Disabled staff feel valued** for their work, reflecting improved organisational culture. **Areas of Regression** • **Recruitment bias** persists - Disabled applicants are less likely to be appointed from shortlisting. • **Rising abuse from patients, public, and relatives** towards Disabled staff. • **Bullying and harassment by colleagues** remains a serious concern. • **Manager-led abuse** still exceeds national averages. • **High levels of presenteeism** signal unaddressed pressures and lack of support. • **Inconsistent implementation of reasonable adjustments** continues to hinder workplace accessibility and have a negative impact on staff morale
Key recommendation(s):	The Board is asked to support the prioritisation of the following key actions: • **Enforce a zero-tolerance policy** on harassment, bullying, and abuse by managers. • **Eliminate barriers to reporting**, ensuring staff feel safe and supported when raising concerns. • **Ensure transparency** in career progression and promotion opportunities. • **Raise awareness of presenteeism** through targeted education for staff and managers. • **Introduce recognition initiatives** to value and celebrate the contributions of Disabled staff. • **Review and standardise** the Reasonable Adjustments process, underpinned by a clear, comprehensive policy.

Implications:				
Strategic Ambitions:				
☐ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national &	☐ Developing partnerships to improve population health and building on our reputation	☒ Developing a culture where everyone thrives with a focus on	☐ Improving value, productivity, financial and environmental sustainability

	international provider of training & education	for innovation and research in this area	equality, diversity and inclusion		
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 5:** Workforce development, retention, recruitment **BAF 6:** Lack of inclusive and open culture				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	• Standard NHS Contract • Equality Act (2010) • Public Sector Equality Duty (PSED)				
Resource Implications:	Yes ☒	No ☐			
	• Equalities Training Budget • Reasonable Adjustment Budget • Events to support staff networks				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	• Amelioration of the challenges faced by staff with Disabilities and Long-Term Medical Conditions. • Equalisation of experience between staff with Disabilities and Long-Term Medical Conditions and their counterparts who do not have disabilities.				
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:	• EDI Programme Board • POD EDI 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	

NHS
The Tavistock and Portman
NHS Foundation Trust

WDES Report

Workforce Disability Equality Standard 2024-25

The Tavistock and Portman NHS Foundation Trust
EDI Team

Excellence Inclusivity Compassion Respect

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Tavistock and Portman WDES Report 2022-23

Workforce Disability Equality Standard

Introduction

The Workforce Disability Equality Standard (WDES) was mandated via the Standard NHS Contract in April 2018: all NHS organisations are required to publish their performance data and action plans against 10 metrics of the Workforce Disability Equality Standard and make them public.

Correspondingly, this report presents the Tavistock and Portman's 2024-25 WDES data and associated Action Plan. The 10 WDES metrics focus on workforce composition, recruitment, relative likelihood of entering the formal capability process, bullying and harassment, opportunities for career progression or promotion, feeling valued by the organisation, presenteeism, reasonable adjustments, staff engagement, and Board composition. Nationally, the WDES consistently shows that staff with Disabilities and Long-Term Health Conditions have poorer experiences at work compared to the experiences of non-disabled staff - see full details of the WDES indicators in the summary of findings on page 4. This report identifies where improvements have been made, where data has stagnated or deteriorated and proposes an action plan / countermeasures for ameliorating the gaps.

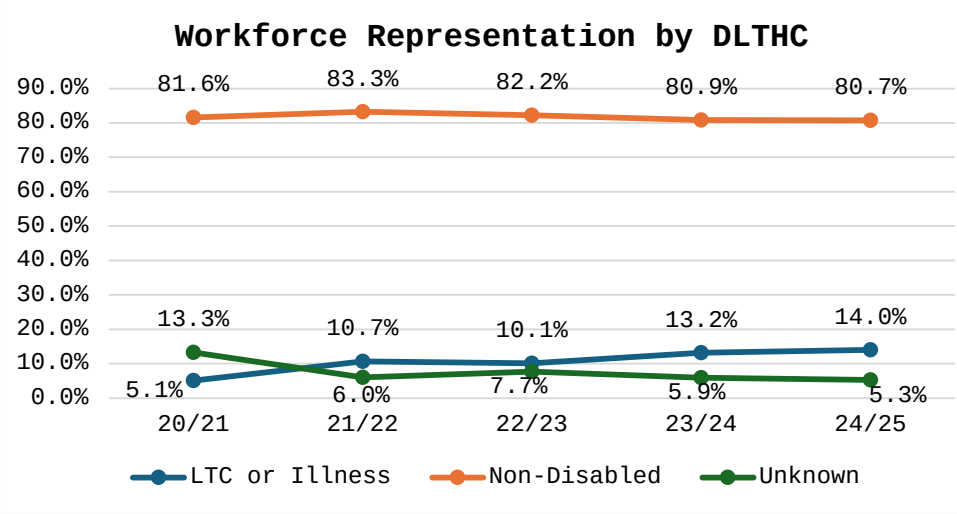
Key Findings from the WDES 2024-25 Report

Table 1: WDES 2024-25 Summary of Key Findings

WDES Metrics	Workforce Disability Equality Standard Metrics based on 2023 Electronic Staff Record and HR recruitment database	Trend	Summary of Key Findings
Metric 1	Workforce representation (Declaration rates) Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and VSM including Exec Board Members compared with % of staff in overall workforce	↑	The number of staff who have shared their Disability or Long-Term Health Condition has increased by 0.8%. Non-clinical cohort is representative, underrepresentation in clinical cohort has stagnated at 1%.
Metric 2	Recruitment: Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants	↓	Regressed: non-disabled applicants are more likely to be appointed from shortlisting than Disabled applicants.
Metric 3	Capability: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance	↑	Disabled staff are no longer more likely to enter the formal capability process compared to non-disabled staff.
Metric 10	Board representation: percentage of the board's membership who have declared a disability.	↑	Representative: there has been gradual improvement over the last 2 years.
Metric 4a	Harassment, bullying or abuse from patients, service users, their relatives or other members of the public	↓	Significant regression of 8.4% in in the last 12 months from 15.6% to 24.0%.
Metric 4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from managers	↑	Improved by 1%, we are still 7.9% shy of the national average score and the disparity is 7.6%.
Metric 4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues	↓	Shot up by 11.1% 9% this year, 14.7 % weaker than the national average, disparity with non-disabled colleagues has widened to 18.1%.
Metric 4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	↑	Impressive improvement of 21.2% (from 45.5% to 66.7%) – growing confidence in reporting systems.
Metric 5	Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion	↑	Huge increase of 8.1% to 35.6%, but significantly behind national average of 55.1%.
Metric 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	↓	Continues to be a challenge - slight regression of 0.3%.
Metric 7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	↑	Improved by 5.7% to 38.1%, but 6.2 percentage points lower than the national average score.
Metric 8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	↓	Regression of 3.1 percentage points this reporting year. Trust's score is 15 percentage points behind the national average score
Metric 9a & b	The staff engagement score for disabled staff from the NHS Staff Survey, compared to non-disabled staff / Voices of disabled staff	↑	Gradual improvement made.

Metric 1: Workforce Representation

Figure 1: Overall Workforce Profile (Disability & Long-Term Health Conditions) 2020-2025



What does our data tell us? The data presented in **Figure 1** indicates that the proportion of the workforce that has declared a Disability on the Trust's ESR has increased by 8.9% over the last 5 years. As part of this gradual increase, the number of staff who have shared their Disability or Long-Term Health Condition (DLTHC) increased from 13.2% in the previous year to 14.0% – an improvement of 0.8%.

However, the number of staff at the Trust who reported a long-term illness or condition through the 2024 NHS Staff Survey is 25.55%: this figure is 10% higher than the internal declaration rate and more reflective of the UK working-age population, where 23% have identified as having a disability through HM Government. We need to create a culture in which staff are comfortable to share the Disabilities

Table 2: (Metric 1a) Non-Clinical Workforce Profile 2020-2025

Workforce Profile: Non-clinical Cohort 2019-2024															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown
Cluster 1: AfC Bands < 1 *to* 4	8.2% (7)	83.5% (71)	8.2% (7)	20.5% (16)	71.8% (56)	7.7% (6)	18.2% (12)	69.7% (46)	12.1% (8)	13.2% (10)	78.9% (60)	6 (7.9%)	15.9% (13)	79.3% (65)	4.92% (4)
Cluster 2: AfC Bands 5-7	6.4% (10)	85.9% (134)	7.7% (12)	14.8% (24)	80.2% (130)	4.9% (8)	14.8% (24)	76.2% (125)	9.15% (15)	13.9% (24)	79.8% (138)	6.4% (11)	12.6% (23)	82.5% (151)	4.9% (9)
Cluster 3: AfC Bands 8a-8b	8.2% (4)	77.6% (38)	14.3% (7)	21.2% (11)	73.1% (38)	5.3% (3)	16.4% (9)	78.2% (43)	5.5% (3)	22.2% (14)	77.8% (49)	0% (0)	16 (23.9%)	76.1% (51)	0% (0)
Cluster 4: AfC Bands 8c-VSM	8.0% (2)	80.0% (20)	12.0% (3)	7.4% (2)	92.6% (25)	0% (0)	17.9% (5)	78.6% (22)	3.6% (1)	17.1% (6)	80.0% (28)	2.9% (1)	22.2% (6)	77.8% (21)	0% (0)
Total Non-Clinical	**7.3% (23)**	**83.5% (263)**	**9.2% (29)**	**16.6% (53)**	**78.1% (249)**	**5.3% (17)**	**16.0% (50)**	**75.4% (236)**	**8.6% (27)**	**15.6% (54)**	**79.3% (275)**	**5.2% (18)**	**16.2% (58)**	**80.2% (288)**	**3.6% (13)**

What does the data in Table 2 tell us?

It is encouraging to note that the:

- non-clinical cohort has been largely representative of the workforce profile presented in **Figure 1** over the last 5 years.
- non-declaration rate has continued to shrink across all AfC Bands in the non-clinical cohort.

Table 3: (Metric 1b) Clinical Workforce Profile 2019-2024

Workforce Profile: Clinical Cohort 2019-2024															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	Disabled	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**
Cluster 1: AfC Bands < 1 *to* 4	0.0% (0)	94.1% (16)	5.9% (1)	9.1% (2)	86.4% (19)	4.5% (1)	8.7% (2)	91.3% (21)	0.0% (0)	17.6% (3)	82.4% (14)	0.0% (0)	23.8% (5)	76.2% (16)	0% (0)
Cluster 2: AfC Bands 5-7	5.5% (12)	86.8% (190)	7.8% (17)	5% (11)	90.5% (200)	4.5% (10)	7.8 % (17)	86.2% (188)	5.9% (13)	12.1% (26)	82..7% (177)	5.1% (11)	11.2% (24)	82.2% (176)	6.5% (14)
Cluster 3: AfC Bands 8a-8b	5.0% (8)	88.1% (141)	6.9% (11)	9.7% (16)	85.5% (141)	4.8% (8)	10.1% (17)	82.1% (138)	7.7% (13)	11.6% (20)	83.2% (144)	5.2% (9)	12.1% (19)	84.1% (132)	3.8% (6)
Cluster 4: AfC Bands 8c-VSM	0.0% (0)	75.6% (34)	24.4% (11)	4.7% (2)	88.4% (38)	7.0% (3)	9.5% (4)	85.7% (36)	4.8% (2)	13.3% (4)	83.3% (25%)	3.3% (1)	15.8% (3)	84.2% (16)	0% (0)
Total Clinical Cohort	**20 (4.5%)**	**381 (86.4%)**	**40 (9.1%)**	**31 (6.9%)**	**398 (88.2%)**	**22 (4.9%)**	**40 (8.2%)**	**421 (86.1%)**	**28 (5.7%)**	**54 (12.2%)**	**366 (82.8%)**	**22 (5%)**	**54 (12.9%)**	**345 (82.3%)**	**20 (4.8%)**

Table 4: (Metric 1c) Medical / Dental Cohort 2019-2024

Workforce Profile: Medical / Dental Cohort 2019-2024															
Pay Band	**2020-21**			**2021-22**			**2022-23**			**2023-24**			**2024-25**		
	Disabled	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**
Consultants	2.6% (1)	84.2% (32)	13.2% (5)	7.9% (3)	89.5 (34)	26% (1)	8.1 % (3)	89.2% (33)	2.7% (1)	8.33% (3)	86.11% (31)	5.56% (2)	11.11% (4)	80.56% (29)	8.33% (3)
Non-Consultant Career Grade	0.0% (0)	100.0% (6)	0.0% (0)	4.3% (1)	87% (20)	8.7% (2)	20% (1)	60% (3)	20% (1)	14.29% (1)	71.43% (5)	14.29% (1)	12.50% (1)	75.00% (6)	12.50% (1)
Trainee Grade	0.0% (0)	61.9% (13)	38.1% (8)	14.3% (3)	42.9% (9)	42.9% (9)	5.9% (1)	76.5% (13)	17.6 (3)	0% (0)	53.33% (8)	46.67% (7)	0% (0)	50.00% (7)	50.00% (7)
Total Medical & Dental	**1 (1.51%)**	**51 (78.5%)**	**13 (20.0%)**	**7 (8.5%)**	**63 (76.9%)**	**12 (14.7%)**	**5 (8.5%)**	**49 (83.1%)**	**5 (8.5%)**	**4 (6.90%)**	**44 75.86%**	**10 17.24%**	**5 (8.62%)**	**42 72.41%**	**11 (18.97%)**

What does the data in Table 3 tell us?

- The overall representativeness of the clinical cohort has improved by 8.4% over the last 5 reporting years and by 0.7% this year.
- Underrepresentation of Disabled staff in the clinical cohort has stagnated at 1%.
- The highest cluster (AfC Bands 8c-VSM has been representative (for two consecutive years).

Table 4 suggests two key points for the Dental / Medical cohort:

- The cohort is relatively small but there has been underrepresentation of Disabled staff for the last 5 years.
- There is a need to address the high non-declaration rate for the Trainee Grade – currently at 50%.

Metric 2: Recruitment - Relative likelihood of Disabled applicants being appointed from shortlisting

Table 5: Relative likelihood of being appointed from shortlisting

Metric	Descriptor	2020-21	2021-22	2022-23	2023-24	2024-25
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants across all posts. **A figure below 1:00 indicates that Disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting.*	0.82	1.33	0.95	*0.98	1.21

What does our data tell us? There has been regression in recruitment trends for two consecutive years. The regression of 0.03 to *0.98 last year in the likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants was negligible as a figure below 1:00 indicates that Disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting at the Trust. However, further regression to 1.21 this year means non-disabled applicants are more likely to be appointed from shortlisting than Disabled applicants now. This is a concerning development.

Metric 3: Relative likelihood of Disabled staff entering the formal capability procedure

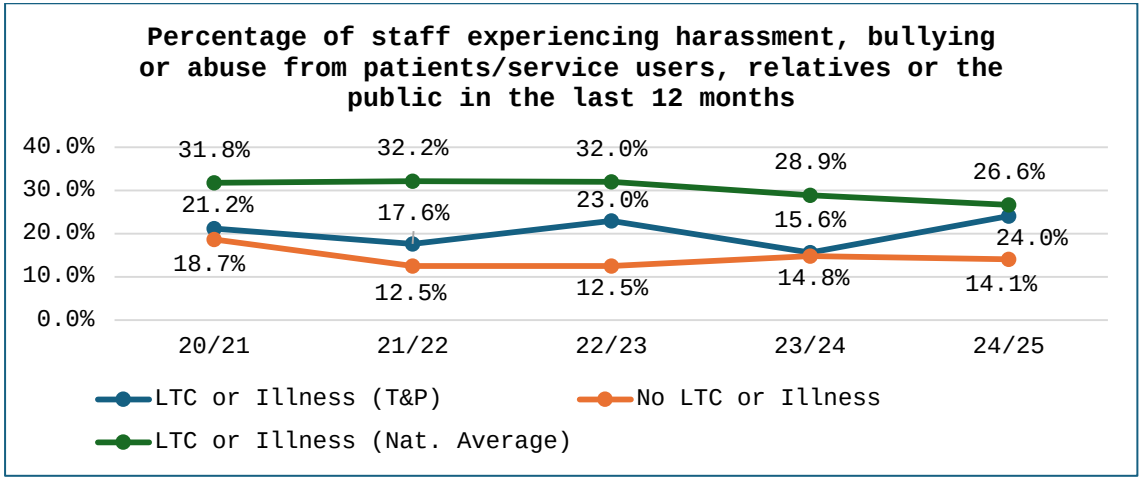
Table 6: Relative likelihood of entering the formal capability procedure

Metric	Descriptor	2020-21	2021-22	2022-23	2023-24	2024-25
3	Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff on the grounds of performance. **This metric will be based on data from a two-year rolling average of the current year and the previous year.* ** A figure above 1:00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process.*	0.00	0.00	0.00	1.52	0.00

What does the data in Table 6 tell us? After a regression in the likelihood of Disabled staff entering the formal capability process compared to non-disabled staff in 2023-24, significant improvements have been made in this metric in this reporting year. Disabled staff are no longer 1.5 times more likely to enter the formal capability process on the grounds of performance compared to non-disabled staff. This progress needs to be sustained.

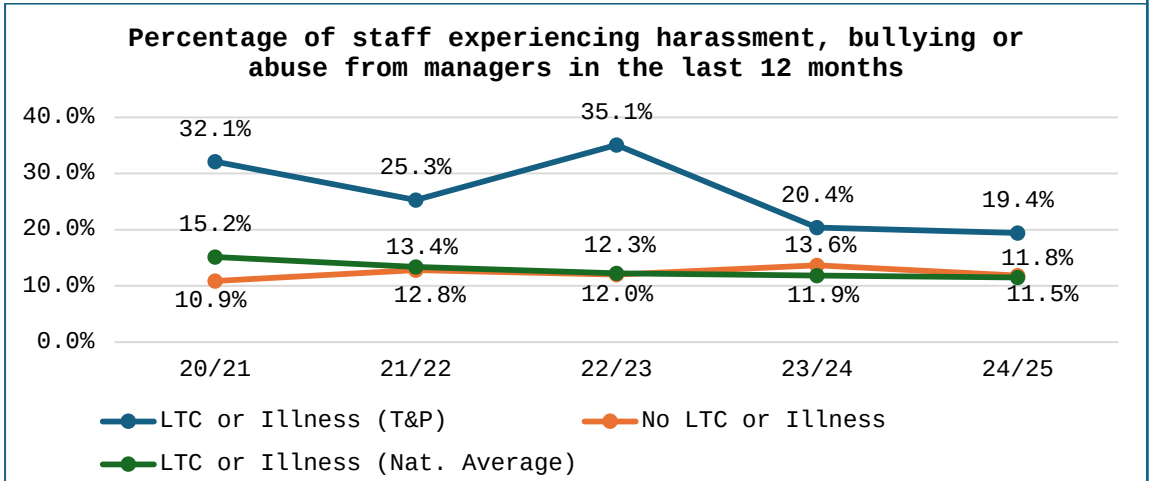
Metric 4a: Harassment, Bullying or Abuse by Patients/Public

Figure 2: Harassment, Bullying or Abuse from patients/service users, relatives or the public



Metric 4b: Harassment, Bullying or Abuse by Manager

Figure 3: Percentage of staff experiencing Harassment, Bullying or Abuse from managers



What does the data in Figures 2 and 3 tell us?

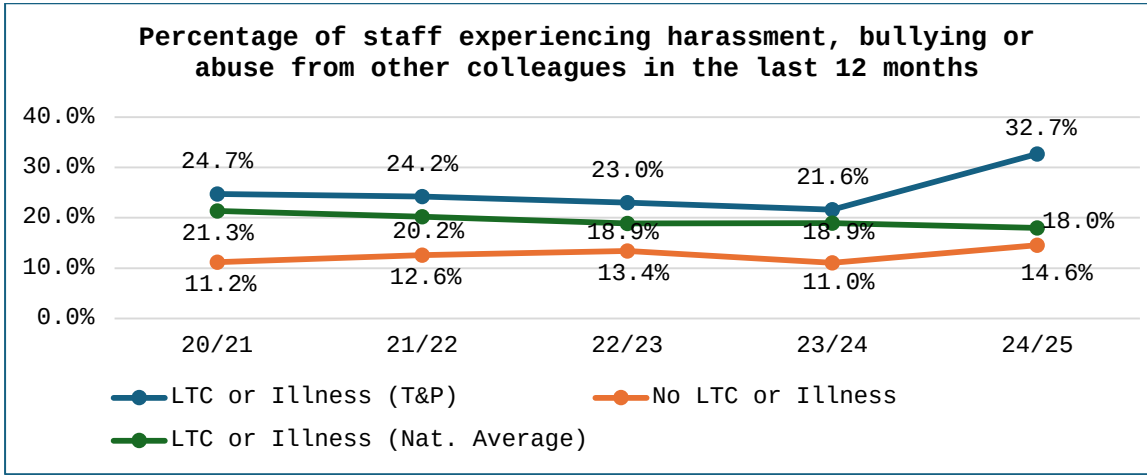
- There has been an irregular rising and falling in the number of Disabled staff experiencing Harassment, Bullying or Abuse from patients, public and relatives over the past 5 years.
- There has been a significant regression of 8.4% in in the last 12 months from 15.6% to 24.0%.
- There was an improvement of 7.4% last year but could not be sustained.
- The disparity in experience between Disabled and non-disabled staff has widened to nearly 10%.
- Nationally (26.6%), about 1 in 4 disabled staff experience HBA from patients, service users or the public. Our score (24.0%) is slightly better, but contrary to our fluctuating trend, the national one is consistently improving.
-

Figure 3 presents the percentage of staff experiencing HBA from managers over the last 5 years.

- The phenomenon only improved by 1% for this reporting year. However, overall, we have progressed by 12.7% over the last 5 years and by an enormous 15.7% (from 35.1% to 19.4%) over the last two years in this indicator.
- Despite this huge improvement we are still 7.9% shy of the national average score (11.5%).
- There is a higher proportion of Disabled Staff, compared to non-disabled staff, experiencing HBA from managers – the disparity is 7.6% at the Trust.
- We need to sustain the phenomenal progress that has been achieved in this indicator.

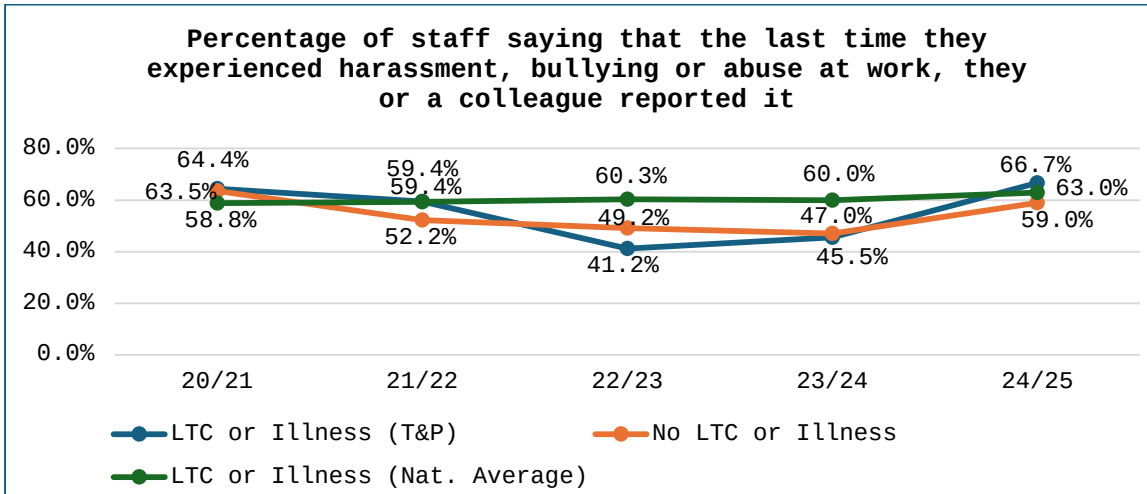
Metric 4c: Harassment, Bullying or Abuse by Colleagues

Figure 4: Percentage of staff experiencing Harassment, Bullying or Abuse from other colleagues



Metric 4d: Reporting Harassment, Bullying or Abuse

Figure 5: Percentage of staff who reported Harassment, Bullying or Abuse they experienced



What does our data tell us?

According to the data presented in **Figure 4:**

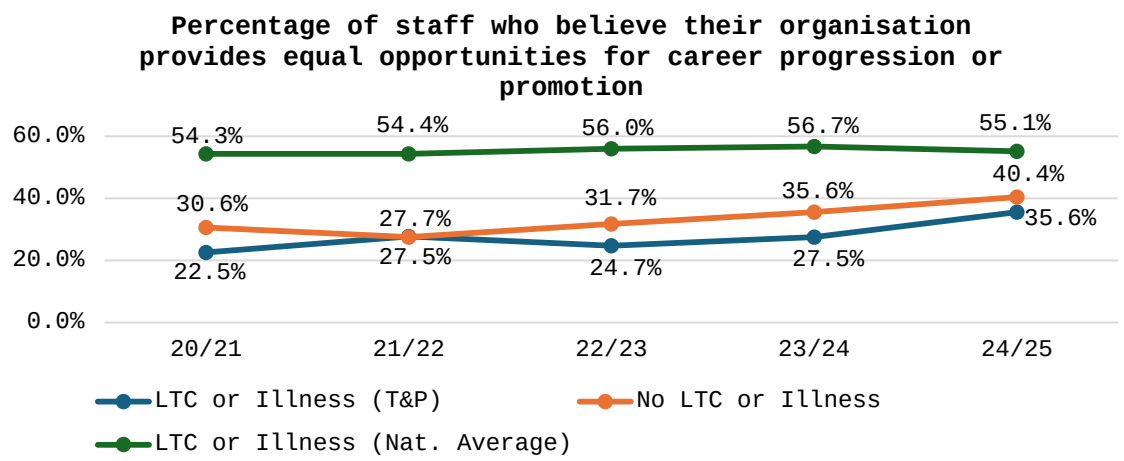
- the percentage of staff experiencing harassment, bullying or abuse from other colleagues shot up by 11.1% this year.
- Our position in this metric is 8% worse than we were 5 years ago (2020).
- we are 14.7 percentage points weaker than the national average score for this indicator.
- The disparity in the experiences of staff with DLTHCs and their non-disabled colleagues has widened to 18.1%.

According to the data in **Figure 5:**

- the percentage of staff saying that the last time they experienced Harassment, Bullying or Abuse at work, they or a colleague reported it has improved by an impressive 21.2% (from 45.5% to 66.7%) this year – suggesting a growing confidence in reporting systems that have been put in place.
- last year the national average in this indicator was 14.2 percentage points better than the Trust's score – we have surpassed it by 3.7 percentage points.
- there is need to sustain the momentum and staff's confidence in our reporting systems.

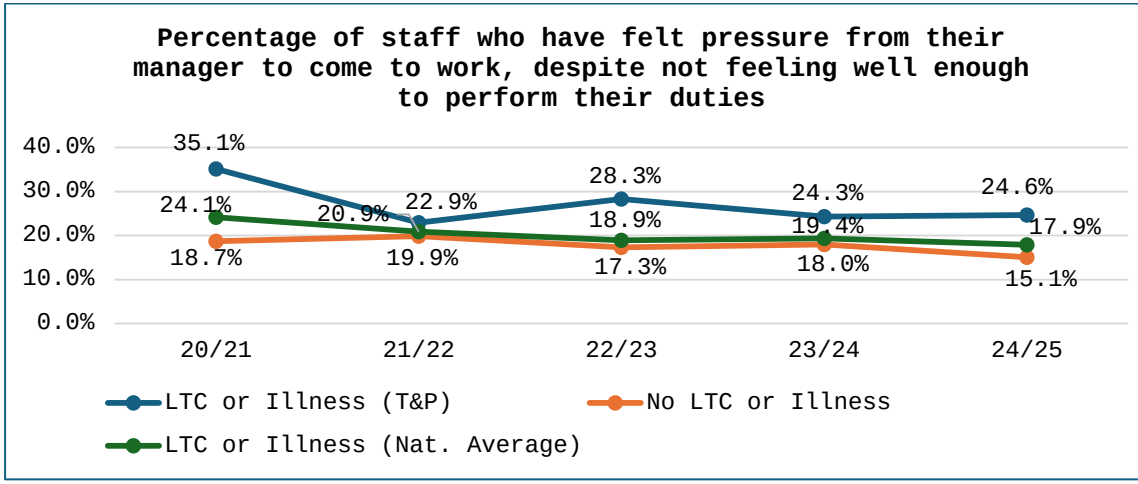
Metric 5: Equal Opportunities for Career Progression or Promotion

Figure 6: Opportunities for career progression or promotion



Metric 6: Presenteeism

Figure 7: Presenteeism



What does our data tell us?

Figure 6 shows that:

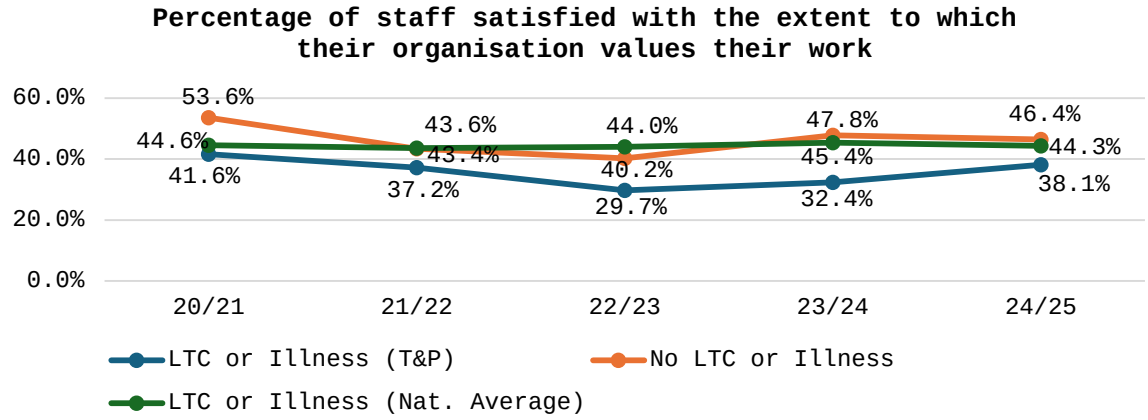
- there was an increase of 8.1% to 35.6% in 2024-25 in the number of Disabled staff believing the Trust provides equal opportunities for career progression or promotion.
- the disparity between Disabled and non-Disabled staff has improved from 8.1% to 4.8%.
- the national average in this indicator is now 55.1%, meaning the Tavistock and Portman score is 19.5 percentage points behind.

Figure 7 demonstrates the following key issues:

- there has been a slight regression of 0.3% in the percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough over the last 12 months.
- our score, 24.6% for this metric is 6.7% behind the national average score.
- there is a disparity of 9.5% between Disabled and non-disabled staff.
- There has been irregular improvement and regression in presenteeism over the past 5 years. There is need to sustain improvements that are achieved.

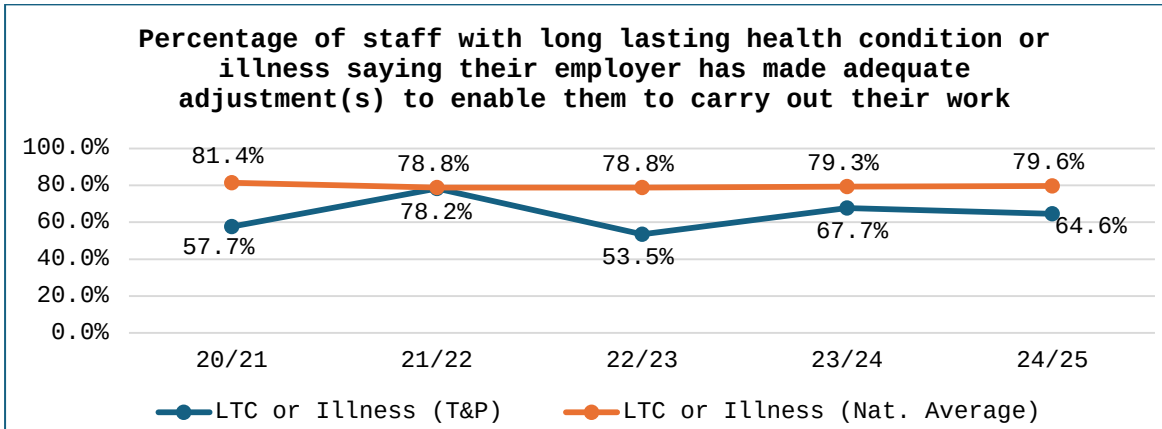
Metric 7: Feeling valued by the organisation

Figure 8: Perceptions of staff on how their organisation values their work



Metric 8: Workplace Adjustments for Disabled Staff

Figure 9: Reasonable Adjustments for Disabled Staff



What does our data tell us?

Figure 8 shows that:

- the proportion of Disabled staff who feel valued by the Trust has improved for two consecutive years: the improvement last year was 2.7%, this reporting year we improved by a further 5.7% to 38.1%.
- our score (38.1%) for this indicator is 6.2 percentage points lower than the national average score.
- there are differentials in experience – the disparity between Disabled and non-disabled staff is 8.3 percentage points.

Figure 9 tells us that:

- after an enormous increase of 14.2 percentage points in the proportion of disabled staff who were satisfied by workplace adjustments they received to perform their work effectively last year, there was a regression of 3.1 percentage points this reporting year.
- the Trust's score (64.6%) is 15 percentage points below the national average score for this indicator (79.6%).
- we must redouble our commitment to supporting colleagues with disabilities and long-term health conditions - because inclusion is not optional, it's essential.

Metric 9: Staff Engagement Score

Table 7: Staff Engagement Score

Metric	NHS Staff Survey and the engagement of Disabled staff	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22	Disabled 2022/23	Non-Disabled 2022/23	Disabled 2023/24	Non-Disabled 2023/24	Disabled 2024/25	Non-Disabled 2024/25
9 National Survey Staff Engagement Score (0-10)	(a) The staff engagement scores for Disabled and Non-Disabled staff	6.4	7.1	6.3	6.7	5.4	6.5	6.1	6.7	6.2	6.7
	(b) Has Tavistock and Portman taken action to facilitate the voices of Disabled staff in your organisation to be heard?	No		Yes		Yes		Yes		Yes	

What does our data tell us?

Table 7 shows that after a 3-year downward trend (2020-23) the staff engagement score for Disabled staff at the Trust has improved slightly for two consecutive years – it improved from 6.1 to 6.2 this year. The average score for staff without Disabilities or Long-Term Conditions at the Trust has stagnated at 6.7. Our score (6.1) places the Trust 0.5 points lower than that the national average for Disabled staff (6.7).

Metric 10: Board Representation

Table 8: Board Representation

Metric 10: Board Representation and the difference for Disabled and Non-Disabled staff															
Board Representation	**2020-2021**			**2021-2022**			**2022-23**			**2023-24**			**2024-25**		
	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown
Total Board Members	0.0%	0.0%	0.0%	0.0%	89.5%	10.5%	(1) 5.26%	(14) 73.68%	(4) 21.05%	(3) 15.79%	(15) 78.95%	(1) 5.26%	(4) 22.22%	(13) 72.22%	(1) 5.56%
Overall Workforce by Disability	5.11%	81.61%	13.28%	10.7%	83.3%	6.0%	10.1%	82.1%	8.%	13.2%	80.9%	5.9%	14.0%	80.74%	5.26%
10.b) Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:															
(a) By voting membership of the Board	-5.11%	81.61%	13.28%	0%	89.5%	0%	-0.35%	-3.37%	3.71%	7%	-8%	1%	15%	-9%	-5%
(b) By Executive membership of the Board	-5.11%	81.61%	13.28%	0%	83.3%	-6.2%	-11.46%	-11.15%	22.6%	-3%	-1%%	4%	-3%	-3%	6%

This return shows that, (i) the Board membership of disabled staff is representative, (4) 22.22%, and (ii) the voting membership is 15%.
1 member of the Board is marked as unknown.

Conclusion and Next Steps

This WDES report reveals a complex yet ultimately promising landscape. Significant strides have been taken to improve the experiences of staff with Disabilities and Long-Term Conditions across the Trust. Notably, positive movement was seen in 8 of the 13 indicators, with several showing substantial progress. These improvements underscore the Trust's ongoing commitment to fostering a more inclusive and supportive working environment. However, despite this momentum, performance on many of these indicators remains below national averages - highlighting the need for sustained and focused efforts to close the gap and deliver truly equitable outcomes.

- The declaration rate on the Trust's ESR has continued to rise gradually over the last 5 years.
- There has been a gradual increase in the percentage of the Board's membership.
- Disabled staff are no longer more likely to enter formal capability process than non-disabled staff.
- The percentage of disabled staff compared to non-disabled staff experiencing Harassment, Bullying or Abuse from managers has slightly improved but it is still worse than the national average score.
- The staff engagement score for Disabled staff has continued to improve.
- Reporting of Harassment, Bullying or Abuse has continued to rise, thus highlighting growing trust in processes that have been put in place.
- Perceptions on equal opposition for career progression or promotion have continued to improve.
- Perceptions on work of Disabled staff being valued are increasingly more encouraging.
- Gradual improvements have been sustained in the Engagement Score of Disabled staff.

Key Areas of Regression – Immediate Action Needed

Despite areas of progress highlighted above, several indicators have shown a backward slide. These areas must be treated as urgent priorities for intervention and improvement.

- Non-Disabled applicants are more likely than Disabled applicants to be appointed from shortlisting.
- A significant increase in the percentage of Disabled staff experiencing Harassment, Bullying or Abuse from patients, public and relatives
- Disabled staff experiencing Harassment, Bullying or Abuse from colleagues.
- The Harassment, Bullying or Abuse of Disabled staff by managers is worse than national average.
- Presenteeism.
- Reasonable Adjustments to enable Disabled staff to carry out their work.

Next Steps:

- Adopting a zero-tolerance approach to harassment, bullying or abuse of staff by managers.
- Removing barriers to reporting experiences of harassment, bullying or abuse.
- Creating transparency around equal opportunities for career progression or promotion.
- Educating staff and managers about presenteeism.
- Development of employer recognition schemes and initiatives.
- Reviewing and standardising the Reasonable Adjustments process and backing it up by a clear and comprehensive policy.

Appendix 1

Improvement Action Plan

Action	EDI Strategy Objective	Target	Next steps	Executive Lead(s)	Timescale
Review, standardise and accelerate reasonable adjustments process	Improve satisfaction rate on workplace adjustments and feeling valued **WDES Metric 7 & 8**	Train managers in Reasonable Adjustments / Access to work Facilitate a common or standard understanding of reasonable adjustments	Trust wide communication of RAs	Chief People Officer Chief Nursing Officer	
Eradicate Bullying, Harassment and Abuse	Raise awareness about BHA Reduce BHA experienced by Disabled staff **WDES Metric 4a, b, c, d**	Better understanding of BHA Swift and fair responses to incidents Reduction in BHA Staff role modelling Trust's values	Ensure local level ownership of EDI data Everyone to have an EDI objective All Teams to have EDI reflections EDI Training for managers	Chief People Officer Chief Nursing Officer	
Address concerns on lack of Equal Opportunities for career progression or promotion	Develop a representative workforce Equip all recruiting managers and EDI representatives with inclusive recruitment principles, tools and ethos **WDES Metric 2 & 5**	All interviews have a trained manager and inclusion representative / advisor Improvement in representativeness of the clinical workforce by Disability.	Review, standardise and strengthen Inclusive Recruitment Process Communicate Trust's position to all staff Embed Inclusive Recruitment training in current Leadership and Management training	Chief People Officer Chief Nursing Officer	
Reduce the number of Disabled staff who come to work even when they are unwell (Presenteeism)	Eliminate the differential between Disabled and Non-Disabled staff **WDES Metric 4b & 6**	Embed Just and Learning Culture approach	Embed understanding of presenteeism in Leadership and Management training	Chief People Officer Chief Nursing Officer	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 10 July 2025			
Report Title: EDI Annual Report 2024-25			**Agenda No.: 017**
Report Author and Job Title:	Dr Thanda Mhlanga Head of Culture and Inclusion	**Lead Executive Director:**	Gem Davies CPO Clare Scott CNO
Appendices:	Appendix 1: EDI Annual Report 2024/25		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☒ Information ☒ Assurance ☒		
Situation:	This EDI Annual report presents a snapshot of the Equality Diversity and Inclusion landscape. It provides an overview of the successes, challenges, and actions that have been taken so far and makes some recommendations.		
Background:	The EDI annual report is a live document that helps us reflect on our EDI challenges: celebrating our successes but most importantly focus on areas where improvements are still required.		
Assessment:	The Trust has established an Equality, Diversity and Inclusion (EDI) Programme Board, with clear accountability for delivering the Annual Inclusivity Plan a strategic cornerstone in our mission to create a more inclusive, respectful, and equitable organisational culture. This Board is a key part of our determined commitment to build a workplace where every individual feels seen, valued, and empowered. Alongside this, the Trust has launched the Patient and Carer Race Equality Framework (PCREF) - a vital initiative aimed at improving our understanding of disparities across the care pathway, from referrals through to outcomes. PCREF is reported on separately and reflects our drive to work in genuine partnership with local communities, and to develop a workforce that is both culturally competent and responsive, helping to address deep-rooted health inequalities across our services. Despite the progress made, our current EDI performance indicators clearly demonstrate that we are not yet meeting the high standards we have set for ourselves. Many of the challenges we face are cultural and therefore complex, nuanced, and slow to shift. EDI cannot be “delivered” as a project or imposed from above; it requires the active engagement, trust, and goodwill of our people. That said, it also demands decisive, consistent leadership and faithful execution of initiatives if we are to meaningfully embed inclusion into the very fabric of our organisation.		
Key recommendation(s):	The Board of Directors is asked to: • **NOTE** our achievements, challenges and future commitments. • **NOTE** the recommendations made in the report. • **SUPPORT** the implementation of our EDI priorities and metrics.		
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 5:** Workforce development, retention, recruitment **BAF 6:** Lack of inclusive and open culture				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Standard NHS Contract, Equality Act (2010), Public Sector Equality Duty (PSED), Patient and Carer Race Equality Framework (PCREF)				
Resource Implications:	Yes ☒	No ☐			
	• EDI budget •				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	• Dismantling of inequalities • Equalisation of experience				
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	

NHS
The Tavistock and Portman
NHS Foundation Trust

Annual Equality Diversity & Inclusion Report 2024-25

Report Produced: June 2025

Report Published: 10th July 2025

Contents

1. Foreword

Over the last year, the Tavistock and Portman has been strengthening its commitment to becoming an authentically inclusive, diverse and equitable organisation. We set up an Equality Diversity and Inclusion (EDI) Programme Board – chaired by the Chief Nursing Officer. This programme board is

accountable for the delivery of the Annual Inclusivity Plan incorporating the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) and other Key Performance Indicators (KPIs) that focus on Equalities. It reports to the People and Organisational Development, Equalities Diversity and Inclusion (POD EDI) Committee, a sub-committee to the Trust Board.

In addition, we launched our Patient and Carer Race Equality Framework (PCREF), a contractual required for all Mental Health Trusts from April 2024. National and local data shows us that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services. Under the executive leadership of the Chief Medical Officer, the organisation has set up a PCREF Implementation Group. The Group has been working on a strategy that aims to facilitate understanding of Health Inequalities and our data viz-a-viz who is referred to our services, who gets accepted and outcomes. The Group is committed to working collaboratively with local communities and to supporting the Trust develop a responsive and culturally competent workforce.

We are consciously pushing ourselves and each other to understand systemic processes and behaviours that perpetuate discrimination and a non-inclusive culture in our organisation. We are proud of the changes we are making in our approach to discrimination and inclusion as an organisation. However, we also humbly reflect on our progress through the evaluation of our staff survey data and other EDI KPIs that highlight that where we are currently falls below our ambition. Our WRES and WDES metrics demonstrate that there are clear and measurable disparities for our staff from traditionally marginalised communities. For instance, staff from a Global Majority background and staff with Disabilities and Long-Term Health Conditions (DLTHC) are more likely to be bullied, harassed, abused and discriminated against by patients, colleagues and managers. Also, there is an enduring perception that career development and progression or promotion opportunities of staff from a Global Majority background and staff with DLTHCs is compromised by their backgrounds.

Our data also suggest that we still have much work to do in making sure our staff feel supported to share any protected characteristic (particularly on the grounds of DLTHCs, gender identity and sexuality). We continue to work towards creating a culture where staff can share their protected characteristics confidently knowing that the information shared will help raise awareness, improve their experiences and that the organisation can support their needs. Our data tells us that we need to better support and educate our leaders on how to manage and understand diversity, recognise and address bullying, harassment, abuse and discrimination and make our recruitment processes and career progression more inclusive.

Set against the national landscape of the 2024-25 NHS staff survey, our results underscore a stark reality: while we have made meaningful strides in certain areas, we remain among the lower-performing NHS Trusts. No organisation is without its challenges - but the data reveals a mixed picture, with isolated examples of improvement overshadowed by stagnation and, in some cases, regression. This is not a moment for complacency. We fully recognise the scale and urgency of the challenge ahead. Our resolve is clear: we are unwavering in our commitment to drive transformative, sustained change - reshaping the cultures, behaviours, and systems that continue to reinforce disparities in staff experience. We are not just aiming for progress - we are determined to change the culture and deliver impact.

2. Our Desired Future State

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

Our vision is to equalise experience for all and become a truly inclusive and anti-discriminatory organisation. Building on recommendations from WRES, WDES and GPG we have prioritised three key overarching areas to implement directed and evidence-based interventions, at pace and with resource, to shift the dial on our progress (see Section 3 for more details):

- Eradicate Bullying, Harassment and Abuse
- Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion
- Formal Disciplinary and Capability Processes

Whilst we acknowledge that EDI challenges are cultural in nature, and thus it may take time to begin to see the benefit and impact on our staff, patients and students' experiences, we will not slow down on our efforts. We will continue to build on our ambition, investment and commitment to becoming one of the leading anti-discriminatory and inclusive organisations where everyone has a positive experience. We are particularly inspired by the impressive progress that we have made towards Gender Pay Equality: our Gender Pay Gap has shrunk and the average bonus pay gap has been completely eradicated.

3. Our Equality Diversity and Inclusion Priorities and Metrics 2025

Priority Area and Trust Values	Personal Accountability	Metrics / Measurable Actions
Eradicate Bullying, Harassment and Abuse • *Championing Inclusivity* • *Placing compassion at our core*	• I will challenge and report any racist, ableist, ageist, sexist, homophobic, transphobic, antisemitic, Islamophobic or classist bullying or abusive behaviour I observe. • I will ensure swift and fair responses to incidents. • I will role model the Trust values, excellence, inclusivity, compassion and respect.	**Contribute to the creation of an environment where everyone feels supported:** • Everyone to have an EDI objective that is linked to our values and evidenced over 12 months. **Managers to create an open culture where staff are comfortable to share or raise concerns:** (i) All team meetings to have EDI reflections. (ii) All managers' appraisals to be linked to the Trust's three EDI priorities. (iii) Follow up National Staff Survey results with bespoke surveys to measure BHA in each service. **Roll out bespoke EDI training for managers (incl. Reasonable Adjustments and Presenteeism)** (i) Each manager to make a relevant EDI pledge after attending training. (ii) Pledges to be publicised and reviewed.
Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion • *Championing Inclusivity* • *Striving for Excellence*	• I will actively champion underrepresented groups by always ensuring fair recruitment with use of an inclusive recruitment advisor. • I will foster an accessible and diverse environment. • I will encourage participation from all voices. • I will provide equal opportunities for career progression and target training opportunities to staff from underrepresented and traditionally marginalised / disadvantaged backgrounds to enable this.	• Clarity regarding the Trust's position on provision of interview questions in advance for neurodiverse candidates. This should not be left to the discretion of recruiting managers. • All staff comms articulating the Trust's position. • Formalise feedback mechanism and process: - *EDI representatives to meet with EDI Team monthly to raise any concerns.* - *EDI representatives to meet quarterly with CPO and/or Chair of EDI Programme Board to ensure they are listened to, supported, valued and respected as members of interview panels.* • Update and standardise all recruitment material to reflect the Trust's position. • Give constructive / developmental feedback to all internal candidates and administer an independent survey to measure individual experiences. • Applications for all non-mandatory CPD training, as well as training identified at TNA stage but not approved by ELT, must be submitted and approved by the CPD panel. • All internal promotions to be scrutinised by an internal CPD/Promotion panel.
Formal Disciplinary and Capability Processes • *Championing Inclusivity* • *Placing compassion at our core*	• I will show compassion, kindness and empathy in all interactions • I will cultivate a supportive and respectful culture for marginalised staff by role modelling our values-based behaviours. • I will promote well-being and understanding • I will apply principles of a Just and Restorative Culture to all disciplinary and capability concerns. • I will follow the Resolutions Policy to promote a mediative approach	• Train staff to increase understanding of just and restorative culture principles • Use internal comms to promote understanding of just and restorative culture (four step approach) • Clarify all stages of formal disciplinary process • Clarify all stages of formal capability process • Increase mediation capacity at the Trust • Review disciplinary and capability cases quarterly and share themes

4. Workforce Race Equality Standard (WRES) – Key Findings 2024-25

The Workforce Race Equality Standard (WRES) is a national metric that was mandated in April 2015 for all NHS Providers. It uses nine indicators to help NHS organisations visualise and address inequalities between employees from BME backgrounds and White staff.

Legal obligation: Equality Act 2010 and the Public Sector Equality Duty (PSED).

WRES Indicators	Workforce Indicators For each of these four workforce indicators, compare the data for White and staff from a global majority background.	Trend	Summary of Key Findings
Indicator 1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	↑	Workforce representativeness has continued to improve gradually over the last 5 years – it now stands at 37.2% (an improvement of 9.6% since 2020). There is 11.8% overrepresentation in the non-clinical cohort (Bands 1-7) and underrepresentation in more senior roles (Bands 8a to VSM). The underrepresentation in the clinical cohort starts at Band 5.
Indicator 2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to minority ethnic applicants	→	Applicants from racially minoritised groups are more likely than White staff to be appointed from shortlisting. This has been the trend for the past 5 years. However, there was regression from 0.77 to 0.96 this reporting year, but this score still falls within the non-adverse range of 0.80 to 1.25.
Indicator 3	Relative likelihood of minority ethnic staff entering the formal disciplinary process compared to white staff	↑	Huge improvements have been made in this indicator from a score of 1.76 to 0.54 – meaning staff from a global majority background are no longer more likely to enter the formal disciplinary process than their White peers.
Indicator 4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to minority ethnic staff	→	There was a slight regression in this indicator this year. However, the Trust's score remains within the non-adverse range of 0.80 to 1.25 – a position the Trust has maintained for the past 5 years.
	National NHS Staff Survey indicators (or equivalent) **For each of the four staff survey indicators, compare the outcomes of the responses for White and staff from a global majority background**		
Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	↓	A 7.69% regression from 8.75% to 16.44%, but the Trust remains well ahead of the NHS average of 31.64%.
Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	↑	A positive improvement of 1.73% was achieved in 2024-25. While there is still progress to be made, the current rate of 26.71% presents an opportunity to work towards closing the gap with the national average of 21.23%.
Indicator 7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	↑	There was a notable improvement of 12.91%, bringing the Trust's score to 38.86%. While there is still room for growth compared to the NHS average of 51.05%, this progress marks a step in the right direction.
Indicator 8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	↑	This year saw a positive improvement of 3.33%, bringing the Trust's score to 16.67% - highlighting ongoing efforts towards NHS average of 13.23%.
	Board representation Indicator *For this indicator, compare the difference for White staff and staff from racially minoritised groups		
Indicator 9	Percentage difference between the organisations' Board voting membership and its overall workforce ***Note:** Only voting members of the Board should be included when considering this indicator	↓	Staff from minoritised ethnic backgrounds are underrepresented at Board. The deficit in 2023-24 was -4%, it has widened to -9% this reporting year.

5. Workforce Disability Equality Standard (WDES) – Key Findings 2024-25

The Workforce Disability Equality Standard (WDES) is a national metric that was mandated in April 2018 for all NHS Providers. It uses ten indicators to help NHS organisations visualise and address inequalities between staff with Disabilities and LTHC and Non-Disabled staff.

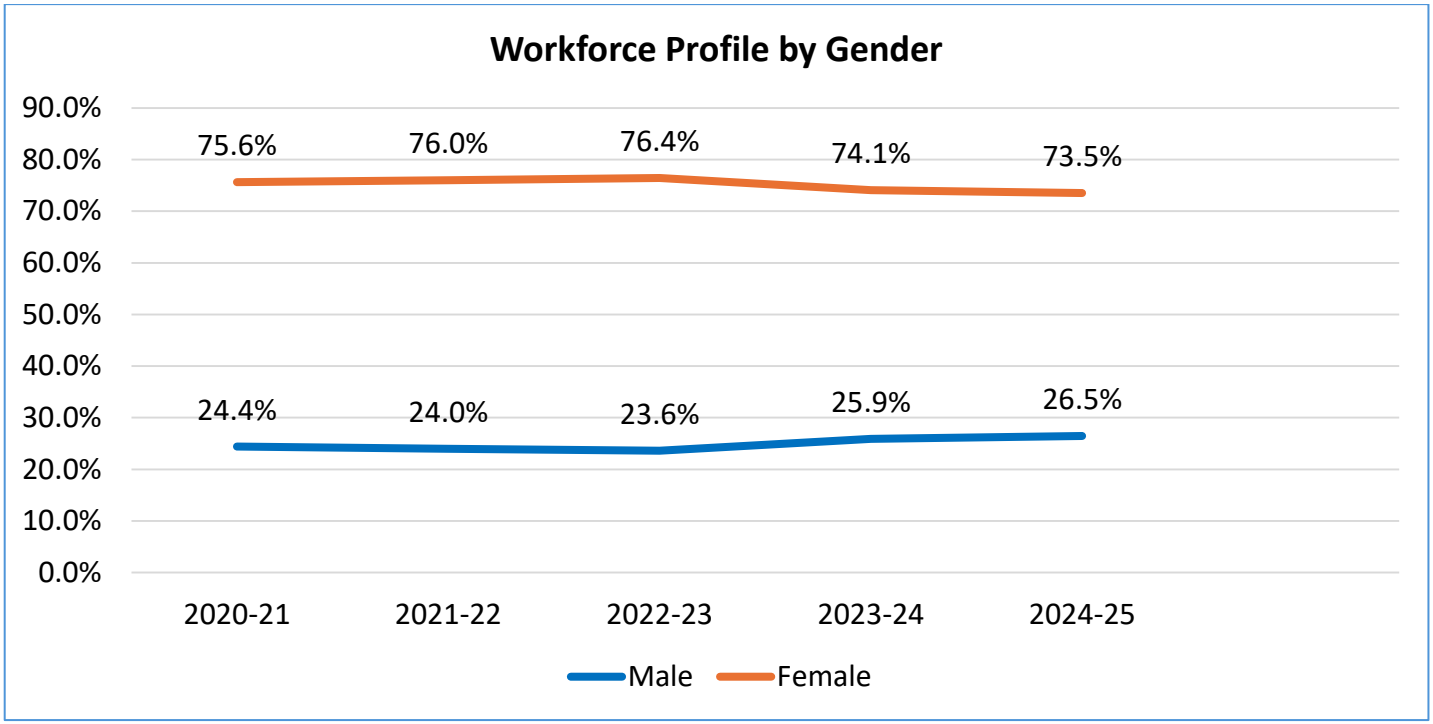
Legal obligation: Equality Act 2010 and the Public Sector Equality Duty (PSED).

WDES Metrics	Workforce Disability Equality Standard Metrics based on 2023 Electronic Staff Record and HR recruitment database	Trend	Summary of Key Findings
Metric 1	Workforce representation (Declaration rates) Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and VSM including Exec Board Members compared with % of staff in overall workforce	↑	The number of staff who have shared their Disability or Long-Term Health Condition has increased by 0.8%. Non-clinical cohort is representative, underrepresentation in clinical cohort has stagnated at 1%.
Metric 2	Recruitment: Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants	↓	Regressed: non-disabled applicants are more likely to be appointed from shortlisting than Disabled applicants.
Metric 3	Capability: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance	↑	Disabled staff are no longer more likely to enter the formal capability process compared to non-disabled staff.
Metric 10	Board representation: percentage of the board's membership who have declared a disability.	↑	Representative: there has been gradual improvement over the last 2 years.
Metric 4a	Harassment, bullying or abuse from patients, service users, their relatives or other members of the public	↓	Significant regression of 8.4% in in the last 12 months from 15.6% to 24.0%.
Metric 4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from managers	↑	Improved by 1%, we are still 7.9% shy of the national average score and the disparity is 7.6%.
Metric 4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues	↓	Shot up by 11.1% 9% this year, 14.7 % weaker than the national average, disparity with non-disabled colleagues has widened to 18.1%.
Metric 4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	↑	Impressive improvement of 21.2% (from 45.5% to 66.7%) – growing confidence in reporting systems.
Metric 5	Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion	↑	Huge increase of 8.1% to 35.6%, but significantly behind national average of 55.1%.
Metric 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	↓	Continues to be a challenge - slight regression of 0.3%.
Metric 7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	↑	Improved by 5.7% to 38.1%, but 6.2 percentage points lower than the national average score.
Metric 8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	↓	Regression of 3.1 percentage points this reporting year. Trust's score is 15 percentage points behind the national average score
Metric 9a & b	The staff engagement score for disabled staff from the NHS Staff Survey, compared to non-disabled staff / Voices of disabled staff	↑	Gradual improvement made.

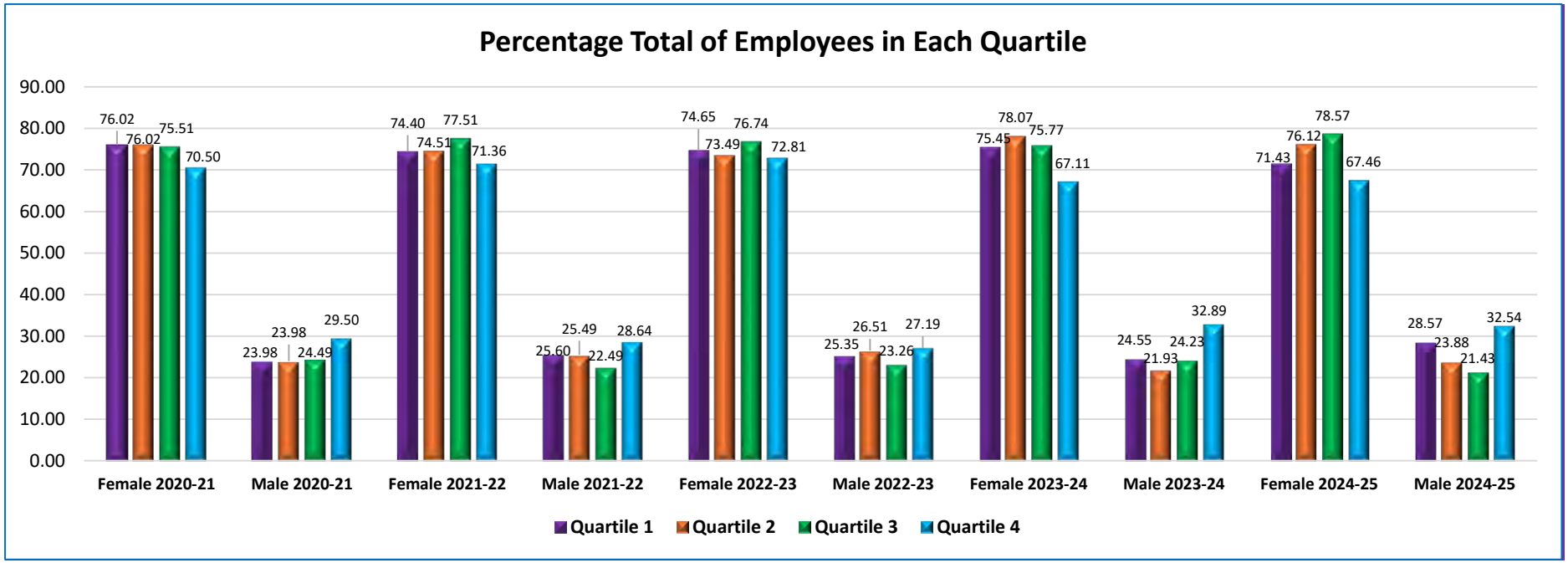
6. Gender Pay Gap

The Gender Pay Gap is a national requirement for all employers with a workforce of 250 or more staff. It reports on the difference between the average earnings of men and women across the workforce.

The tables below show the data as of 31 March 2025.



Like trends in other NHS hospitals, the workforce data presented in the table above indicates that the female workforce at the Tavistock and Portman makes up most of our staffing at 73.5% - a dip of 0.6% from the previous year. The male cohort is 26.5% - an increase of 2.5% over the last 4 years.



The data presented in the graph above breaks down the workforce into four quartiles: Quartile 1 (Q1) is the lowest pay grade and Quartile 4 (Q4) is the highest pay grade. These Quartiles help with the conceptualisation of the Gender Pay Gap at the Tavistock and Portman.

- Since the last reporting year, there has been a decrease of 4.02% in the number of females in the lowest Quartile of pay, Quartile 1 (Q1). Inversely, the number of male staff in this cohort increased by 4.02%.
- In the last year, there has been an increase of 2.8% in the number of females in Quartile 3 (Q3), the second highest Quartile of pay, and a slight increase of 0.35% in Quartile 4 (Q4) – the highest quartile of pay.
- The number of males in the highest Quartile of pay, Quartile 4 (Q4), decreased slightly by 0.35% (from 32.89% last year to 32.54% in this reporting year). This means that the overrepresented of male staff in the highest Quartile of pay in now 6%. Inversely, females are now underrepresented by 6%. See Figure 2 below for more detail.

Gender	Average Hourly Rate 2020-21	Average Hourly Rate 2021-22	Average Hourly Rate 2022-23	Average Hourly Rate 2023-24	Average Hourly Rate 2024-25
Male	26.09	26.56	26.92	30.33	31.62
Female	23.52	23.76	24.90	27.00	28.93
Difference	2.57	2.8	2.02	3.33	2.69
Pay Gap %	9.83%	10.52%	7.50%	10.98%	8.52%

The results presented in the table above show that the pay gap in the average hourly rate reported this year improved by 2.46% (from 10.98% to 8.52%). Deeper analysis demonstrates that one of the major reasons for the reduction of the pay gap is that the number of men in the most senior bands (Quartiles 3 and 4) within the Trust has decreased by 2.8% and 0.35% respectively while the number of men in the lowest pay bands (Quartile 1) has increased by 4.02%. Inversely, the number of women in the lowest Quartile of pay shrunk by 4.02%.

Gender	Average Bonus Pay 2020-21	Average Bonus Pay 2021-22	Average Bonus Pay 2022-23	Average Bonus Pay 2023-24	Average Bonus Pay 2024-25
Male	8,769.02	10,664.66	11,752.30	7,316.10	5,300.45
Female	8,696.17	10,907.56	11.984.86	11,339.45	6,392.63
Difference	72.82	-242.90	-232.56	-4,023.35	-1092,18
Pay Gap %	0.83	-2.28	-1.98	-54.99	-20.61

The data presented in the table above suggests that the average bonus pay gap at the Tavistock and Portman has been completely eradicated (it was 18.33% in 2019-20 and -20.61% in 2024-25) - a trend that has been maintained for four consecutive years.

7. Building our Culture for Inclusion

The Trust is working hard to build an environment and community that values diversity and cultivates inclusion. There have been various activities and interventions that have been undertaken to improve the experience of our students, staff and the care that we provide to our patients and celebrate the representation of the various communities that make up our organisation. Here are some examples from across the organisation.

- We have added an Inclusive Recruitment ethos to our Recruitment and Selection Training Programme delivered by an external organisation. As a result, recruiting managers are becoming more EDI fluent. In addition, we have built a pool of 60 EDI Reps/Recruitment Advisors who sit on our interview panels – a key step towards debiasing our process.
- As part of our Reasonable Adjustments, interview questions are now available in advance.
- To grow and strengthen our staff networks we carried out a survey that facilitated deeper understanding of enablers and barriers to engagement.
- Facilitated local ownership of EDI data and development of bespoke A3s.

7.1 LGBTQI+ Staff Network

The LGBTQI+ staff network plays two crucial roles at the Trust:

- It fosters an inclusive and supportive workplace culture for lesbian, gay, bisexual, transgender, queer, intersex, and other sexual and gender diverse individuals. It facilitates a safe space for employees to connect, share experiences, and receive support.
- It is the Trust's critical friend and thus influences organisational policies and practices to promote equality and inclusion.

Achievements

- Understanding of intersectionality and strong collaboration with other staff networks (Race Equality Network and Purple Circle Network).
- Supportive working relationship between the Co-Chairs.
- Holding successful events including the Pride Picnic, Memoirs Writing Workshop, Joint Winter Celebration, and Staff Networks Day.
- Joint development of a cross-network Comms Plan.
- Consistent and timely support from network's Executive Sponsor.
- Design and distribution of a questionnaire to gather experiences of being an LGBTQI+ member of staff at the Trust.

Challenges

- Low engagement and attendance at network events and meetings.
- Difficulties in managing timely communications and building an effective relationship with the Comms Team.
- A recent survey suggested that the aims and objectives of the Network are not clearly understood.

Priorities for the Future

- Continue collaborative, intersectional work with other staff networks.
- Strengthen comms processes and roll out newly agreed comms plan.
- Use insights from the generic staff networks engagement survey to grow and strengthen the LGBTQI+ Staff Network.

- Use insights from the bespoke staff questionnaire to address gaps and improve the experience of LGBTQI staff.

7.2 Purple Circle Staff Network

The Purple Circle Staff Network is an integral part of Tavistock and Portman's commitment and journey towards creating and fostering a culture where all members of staff have a voice, are heard, listened to, and have a sense of belonging. The Purple Circle Staff Networks play a dual role:

- It provides supportive spaces and psychological safety to staff with Disabilities and Long-Term Health Conditions (DLTHCs).
- It adds value to the organisation as a critical voice that influences and contributes to the implementation of the organisation's Equality, Diversity, and Inclusion agenda.

Achievements

- The 'DLTHC Network' rebranded to Purple Circle Staff Network two years ago – this has allowed the network to continue moving away from 'Dis' Abilities and Long-Term Health Conditions, to include neurodiversity and all hidden disabilities.
- Contributing to discussions that influence implementation of reasonable adjustments.
- Contributing to Equality Impact Assessments.
- Understanding of intersectionality and strong collaboration with other staff networks (Race Equality Network and LGBTQI+ Staff Network).
- Successfully recruited two new Co-Chairs – transition in progress.

Challenges

- Low engagement and attendance at network events and meetings.
- Difficulties in managing timely communications and building an effective relationship with the Comms Team.
- A recent survey suggested that the aims and objectives of the Network are not clearly understood.

Priorities for the Future

- Continue collaborative, intersectional work with other staff networks.
- Strengthen comms processes and roll out newly agreed comms plan.
- Use insights from the staff networks engagement survey to grow and strengthen the Purple Circle Staff Network.
- Support initiatives to improve Reasonable Adjustments and efforts to address presenteeism, bullying, harassment and abuse.

7.3 Race Equality Network

The Race Equality Network (REN) stands as a vital force within the Trust's commitment to equity, echoing the purpose of other staff networks while taking a bold and focused stance against systemic racial inequality. REN is not only a space for solidarity - it is a catalyst for cultural transformation. It champions the voices of staff from racially and ethnically minoritised backgrounds, ensuring they are not only heard, but respected, empowered, and included. REN plays a dual role:

- It offers a safe, supportive environment that fosters psychological safety and belonging for colleagues who have historically faced marginalisation.
- It serves as a critical partner to the organisation - challenging, informing, and shaping the Trust's Equality, Diversity, and Inclusion agenda with lived experience and insight at its core.

Achievements

- Established/regular monthly meetings
- Quarterly attendance and support from Executive Sponsor
- CEO attendance to discuss imminent merger with the staff network.
- Recent recruitment of a Co-Chair – role had been vacant for two-years.
- Understanding of intersectionality and strong collaboration with other staff networks (LGBTQI+ Staff Network and Purple Circle Network).
- Joint development of a cross-network Comms Plan.
- Celebration and acknowledgement of key EDI dates.

Challenges

- Difficulties in managing timely communications of events, awareness days, regular updates and building an effective relationship with the Comms Team – lack of support attributed to staff shortages.
- Archiving/sharing of past work on the REN page.
- A recent staff network engagement survey suggested that the aims and objectives of the Network are not clearly understood.

Priorities for the Future

- Continue collaborative, intersectional work with other staff networks.
- Strengthen comms processes and roll out newly agreed comms plan.
- Use insights from the staff networks engagement survey to grow and strengthen the REN.
- Establish a clear and sustainable collaborative framework with the Communications team to ensure timely publications, enhanced REN intranet page, promotion of awareness campaigns, and the establishment of a dedicated point of contact within the Comms team for staff networks.
- Introduction of the Black History walks initiated by the network's Executive Sponsor.

8. Conclusion & Recommendations

This year's annual report highlights the complex and uneven progress across our equality metrics. While some improvements are evident, signs of stagnation, regression, and persistent disparities - particularly for staff from marginalised and disadvantaged groups remain clear.

To address these inequalities, we must deepen our commitment to delivering the EDI strategic priorities. A closer analysis of our data and staff experiences has revealed specific issues requiring targeted interventions; thus, the following recommendations are made:

Recommendations	
1.	Disseminate findings of the staff survey (WRES/WDES) trust-wide to facilitate better understanding and local ownership of the challenges.
2.	Each service to discuss the bullying, harassment, abuse and discrimination of staff by colleagues and managers and come up with a service plan for ameliorating the challenges.
3	Remove barriers to reporting discrimination bullying, harassment, abuse and discrimination.
4.	Everyone to have an EDI objective that is linked to Trust values and evidenced over 12 months.
5.	Enhancement and standardisation of the reasonable adjustments process backed by a clear and comprehensive policy.
6.	Identify processes to evaluate pre-formal disciplinary and capability action to determine whether there are racial disparities or ableism in cases being resolved at pre-formal stages/being escalated to formal stages. Review the themes and share them quarterly.
7.	Improve the declaration of disability, ethnicity, gender identity and sexuality by increasing staff awareness of how data is used and implementing processes and targets to ensure that ESR declaration is inputted and updated at key milestones (e.g., new starters, 1:1's, appraisals).
8.	All Executives to input and update their demographic data on ESR for improved monitoring of representation and role modelling for the rest of the organisation
9.	Create transparency around career progression opportunities, promotions and ensure that applications for all non-mandatory CPD training, as well as training identified at TNA stage but not approved by ELT, is submitted and approved by the CPD panel.
10.	Update and standardise all recruitment material to reflect the Trust's position ensuring this is communicated to all staff to facilitate faithful and consistent implementation.

9. Acknowledgements

Acknowledgements	
Lead Author	Thanda Mhlanga
Executive Owners	Gem Davies and Clare Scott
Workforce Information	Regaya Aryiku
Staff Networks Information & Support	Luster Alfred
Staff Networks Co-Chairs	Nell Nicholson and Jonathan Stubbs (LGBTQI+ Network) Doyin Bello and Ana Draper (Purple Circle Network) Pauline Williams and Orchid Adeniyan (Race Equality Network)

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday 10 July 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	26 June 2025	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 018**		
Assurance ratings used in the report are set out below:					
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	
The key discussion items including assurances received are highlighted to the Board below:					

Key headline The committee looked at all the People BAF Risk	**Assurance rating**
1. Discussion on current BAF Risks (6,7,8 & 15) • The Committee looked at all three BAF risks for this meeting as well as considering a new risk which had been identified at the May meeting. • The draft new risk title is BAF 15: Lack of Staff Engagement/ Staff Disengagement • The meeting was again themed, this time under 'Performance', 'Staff Experience', and 'Inclusivity'. 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, discuss correlations with other themes, and to more fully ascertain whether the associated risks are being mitigated.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Freedom To Speak Up (FTSU) • Unfortunately, the FTSU Guardian was not available for the meeting and their report was not provided. However, Mark Freestone provided an update on their behalf as well as an action plan. The committee formally ratified the decision made virtually, to contract with The Guardian Service (TGS) to provide FTSU support from shortly after the end of the current Guardians' tenure until the merger. • TGS will provide a 24/7 telephone service as well as a named guardian(s) to provide a FTSU service to the trust.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

• The committee also received an assurance report from the FTSU & Staff Experience Programme Board.	
3. Appraisal and Stat/Mand Training Compliance • An appropriately lengthy discussion was held on compliance, both in relation to performance and staff experience items. • It was explained that compliance will be more closely monitored at IQPR as well as the subject of A3 / QI approaches, and that an IQPR had been held the week of the committee and the importance of compliance had been reiterated. • There was a clear appetite for moving into performance monitoring in this way, and for senior leaders to take more ownership of their teams' compliance.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
4. Reflections • There was consensus that the change in how the meeting was ordered had aided discussion and created the opportunity to consider a new risk. • There was also acknowledgement the evolved layout of the agenda and papers worked well, with an ease of referencing between the topic and relevant papers being discussed. • Our observers commented positively on the level of discussion, consideration, and constructive challenge given to each topic.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

The virtually made decision to contract with TGS was ratified.

Risks Identified by the Committee during the meeting:

No new risk was identified, however it was agreed that further discussion would be held between the IDOCG and the CPO to finalise the wording of Risk 15.

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, 10 July 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance, Finance and Resources Committee	12 June 2025	Aruna Mehta, Non-Executive Director	Jon Bell, Interim CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 019**		

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:	**Assurance rating**
Digital Strategy and IT Projects Update • The Committee received a report on a proposal to pilot Artificial Intelligence (AI) tools, specifically Microsoft Copilot and Ambient Voice Technology (AVT), to enhance productivity and automate tasks for both clinical and administrative staff. • It was noted that the Trust is establishing an AI Innovation Steering Group to explore further AI applications • The Committee wanted assurances that the IT priorities were appropriate and manageable given the significant agenda around the merger and asked the ELT to review.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
System Oversight Framework Update • A verbal update was provided in the meeting with a formal report on SOF3 anticipated for the September 2025 Committee meeting, following discussions with NHSE regarding the Merger Strategic Outline Case (SOC) process.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Activity Reporting – Performance and Contracts • The Committee received a report covering commercial development and contracting activities to support the financial position and identify risks • International student recruitment is a key commercial focus, targeting an increase in overseas students, with China an area being progressed for for education and training opportunities. • Several contracts face challenges, including PCPCS (settlement dispute), Surrey Mindworks (decommissioning by Sept 2025), and First Step (partial retention with future uncertainty). • It was agreed that a 'lessons learned from decommissioning' report would be submitted to a future meeting. • The NHSE Education Contract technically expired on March 31, 2025, but operations continue based on verbal assurances while formal renewal is awaited, which remains a concern.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Finance Report Month 1, including efficiency plan and cash • It was reported that the Trust recorded a net deficit of £592k in Month 01 which is £88k adverse to the planned position. • The cash balance was £2,353k at the end of Month 01, slightly below plan, however, NHSE had not approved anticipated cash support for June. Temporary mitigations for this had been arranged with NHSE and the Trust continues to work with NHSE on accessing the cash support required for July. • The Committee discussed the progress on the efficiency programme which is behind plan and agreed that they were only partially assured. It was agreed that an extra-ordinary meeting would be convened in July to consider progress.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Integrated Quality and Performance Report • The Committee received the IQPR report which highlighted concerns around waiting lists, particularly for the Gender Identity Clinic (GIC) and Trauma Service which are receiving targeted support.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Board Assurance Framework • The Committee reviewed the BAF risks relevant to PFRC. • The paper proposed an increase in the residual risk score for BAF 13 (Performance Delivery) from 12 to 16 (L4 x C4) to reflect the heightened likelihood of not achieving required performance levels due to factors like contract decommissioning, loss of ERF, and policy shifts. • BAF 11 (Sustainable income streams) requires further review and rewording to reflect emerging commissioning issues and contract risks • The report also noted that an urgent review of BAF 12 (IT infrastructure and cyber security) is needed to clarify assurance gaps and set definitive implementation timelines.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee agreed to hold an extra-ordinary meeting in July as the next scheduled meeting is not until September.
- It was agreed that a 'lessons learned from decommissioning' report would be submitted to a future meeting.

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:

An extra-ordinary meeting will be held in July to seek further assurance on progress against the financial plan, the efficiency programme and the cash forecast.

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, 10 July 2025			
Report Title: Finance Report – Month 1 2025/26			**Agenda No. 020**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Jonathan Bell, Interim Chief Financial Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 01 position for the Trust and an update on finalising the budgets with directorates and progress with the cost improvement programme. **Income & Expenditure** The Trust incurred a net deficit of £592k in the period, which is an £88k adverse variance to plan. **Capital Expenditure** To date capital spend is limited, totaling only £26k against the plan for Month 1 of £231k. Expenditure at the year-end is expected to be on plan at £2,774k. **Cash** The cash balance at the end of Month 1 was £2,353k, slightly below the planned cashflow of £2,529k, mainly due to catch-up payments to suppliers. NHSE have notified the Trust that the cash support expected in June has not been approved. In mitigation, NHSE have agreed to pay £2.6m in June for the full year's national training contract value related to existing students. The Trust will continue to work with NHSE London and the national team to secure the cash support. **Budget Setting 2025/26** Draft budgets have been issued to budget holders and finance business partners are working with the budget holders to finalise the budgets and identify the savings required for the cost improvement programme. **Cost Improvement Programme** Progress on completing Plans on a Page (POAPs) for savings schemes has been slower than required. Additional support from the PMO has been agreed and now working with the CFO to ensure plans are completed. Check and challenge meetings have been set up with leadership teams to assess the robustness of the plans and identify where additional support may be required.		
Background:	The Trust has a breakeven plan for 2025/26, with a Capital Expenditure limit of £2.774m and an associated year-end cash position of £1.4m.		
Assessment:	**Income and Expenditure** The efficiency target for the year is to deliver £3.9m of recurrent savings. In addition, the plan requires a contribution of £500k from Tavistock Consulting income growth, £2.4m gain on an asset sale and no carry forward of annual leave at the end of the year.		

	The Trust will continue to identify and pursue further income opportunities not currently included in the 2025/26 plan. These efforts will support the development of medium-term financial plans aimed at achieving a sustainable balanced position in future years — a key element of the ongoing merger planning and delivery work. **Capital Expenditure** The agreed capital expenditure limit for 2024/25 is £2,774k. As of Month 1, actual capital spend is £205k below plan, primarily due to phasing, as most capital projects are scheduled to commence from M03. **Cash** Access to cash is, and will remain, a significant challenge during 2025/26. Delivery of cash releasing savings is also critical to the Trust having sufficient cash to support operations.
Key recommendation(s):	The Board is asked to **NOTE** the position outlined in 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. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.				

Resource Implications:	Yes ☐		No ☒	
	There are no resource implications associated with this report.			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	ELT – June 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: Finance Report 25/26 – At 30th Apr 25 (Reporting Month 01)

1. Overview

1.1 The table below shows a summary of the Trusts reported cumulative position against its agreed financial plan for the month ended 30th Apr 25.

Financial Reporting Summary - Month 01 2025/26

	Current Plan	Actual	Variance
£'000	**Arp 25**	**Apr 25**	**Apr 25**
	YTD	**YTD**	**YTD**
Income	**4,806**	**5,105**	**299**
Operating Expenditure	(5,292)	(5,688)	(396)
Non-Operating Expenditure	(18)	(9)	9
TOTAL Provider Surplus/(Deficit)	**(504)**	**(592)**	**(88)**

1.2 For the period ended 30th Apr 25, the Trust recorded a deficit of £592k. This is an adverse variance of £88k compared to plan.

1.3 Income for the period was £5,105k, which is £299k above plan. This positive variance is primarily due to the phasing of the Directorate of Education and Training (DET) budget and the timing of deferred income released from the Elective Recovery Funding (ERF).

1.4 Staff cost reported a small adverse variance of £10k compared to the plan.

1.5 Non staff cost reported an adverse variance of £385k due to phasing of CIP plans and DET budgets.

2. Income

2.1 Income of £5,105k is favourable to plan for the period, with no identified risks to date.

2.2 The outcome of the contracting round has not significantly changed initial planning estimates at this stage.

3. Staffing Costs

3.1 Cumulative staff costs of £4,292k, are consistent with the original expected profile, with no areas of concern identified to date.

3.2 Total agency costs in the period were £33k, which is favourable to plan by £3k.

4. Non-Operating Costs

4.1 Operating non pay costs for the period were £18k due to higher bank interest compared to plan as the Trust had a higher cash balance at M12 last year and during April.

5. Cash

5.1 The cash position at the end of M01 was £2.3m, in line with the plan.

5.2 NHSE have notified the Trust that the cash support expected in June has not been approved. In mitigation, NHSE have agreed to pay £2.6m in June for the full year's national training contract value related to existing students. The Trust will continue to work with NHSE London and the national team to secure the cash support required.

5.3 It is worth noting that the expected cash support needed during 25/26 is c.£3.3m. This is driven by a combination of the continued operational deficit, capital spend, non-cash income and expenditure items in the plan and movements in working capital balances. This level of cash requirement is also dependent on delivering the efficiency programme.

6. Budget setting and Efficiency Programme

6.1 The efficiency target for the year is to deliver £3.9m of recurrent savings. In addition, the plan requires a contribution of £500k from Tavistock Consulting income growth, £2.4m gain on an asset sale and no carry forward of annual leave at the end of the year.

6.2 Draft budgets have been issued to budget holders, with the main principle being that budgets need to be set at no higher than the 2024/25 month 11 forecast out-turn, adjusted for known service changes, inflation and the required efficiency targets. Finance business partners are working with budget holders to finalise budgets, incorporating the required savings plans.

6.3 Plans on a page (POAPs) are required for all efficiency plans and progress on completing these is behind plan. Additional support from the PMO has been agreed and a series of check and challenge meetings have been held to assess the robustness of the plans and ensure POAPs are completed by the end of Q1.

7. Balance Sheet

7.1 No movements of note to report at Month 01.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 10 July 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 021**
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 ☐		

	All BAF risks.			
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 – 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

The Tavistock and Portman NHS Foundation Trust

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Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
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		D	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	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									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
Annual Patient Experience Report (including complaints, surveys and engagement and involvement).	Discussion	CNO			P				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 2026/27	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		D	P				POD EDI		Developing a culture where everyone thrives	Annual
Informatics Strategy	Discussion	IM&T		D	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