The Tavistock and Portman NHS Foundation Trust

Meeting Book - Board of Directors - Open - Thursday 18 September 2025

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Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting

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028. Reflections and Feedback from the meeting

DATE AND TIME OF NEXT MEETING

029. Thursday, 20 November 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 18th September 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, 18 SEPTEMBER 2025 AT 2.00PM – 5.00PM
VENUE: LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

Living our values:

AGENDA

25/09/	Agenda Item	Purpose Approval Discussion Information Assurance	Lead	Format Verbal Enclosure Presentation	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Well-being Team Trainee Experience *Current trainees and graduates to share their training experience and career opportunities for graduates who remain in the team.*	Discussion	Tracey Laroiya, Principal CBT Therapist and Team Clinical Lead	P	2.05 (20)	
005	Minutes of the Previous Meeting held on 10 July 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 and Service Visits 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	Non-Executive Director Responsibilities 2025/26	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 (BoardEffect reading room as meeting is on 16/09)	3.15 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Comfort Break (10 minutes) 3.20p.m – 3.30p.m						
PROVIDING OUTSTANDING PATIENT CARE						
012	012a Quality and Safety Update 012b Patient Safety Incident Response Framework (PSIRF) Update	Discussion	Chief Nursing Officer	E	3.30 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
013	Quality and Safety (Q&S) Committee Assurance Report	Assurance	Q&S Committee Chair	E	3.40 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
014	Annual Patient Experience Report	Discussion	Chief Nursing Officer	E	3.45 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
015	Guardian of Safer Working Hours Report	Information	Chief Medical Officer	E	3.50 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
016	Learning from Deaths	Assurance	Chief Medical Officer	E	3.55 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
017	Winter Plan 2025/26	Assurance	Chief Nursing Officer	E	4.00 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
ENHANCEOUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
018	Education and Training (E&T) Committee Assurance Report	Assurance	E&T Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
019	Research and Development Annual Report	Discussion	Chief Education and Training Officer	E	4.10 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
DEVELOPINGA CULTUREWHERE EVERYONETHRIVES with a focus on equality, diversity and inclusion						

020	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 ☒
021	Revalidation: Framework for Quality Assurance and Improvement (FQAI) Report and Statement of Compliance (2024-25)	Approval	Chief Medical Officer	E	4.25 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
022	Performance, Finance and Resources (PFR) Committee Assurance Report	Assurance	PFR Committee Chair	E	4.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
023	Finance Report: Month 04	Information	Interim Chief Finance Officer	E	4.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSINGITEMS						
024	Board Schedule of Business 2025/26	Information	Chair	E	4.45 (15)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
025	Questions from Governors	Discussion	Chair	V		
026	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		
027	Questions from the Public	Discussion	Chair	V		
028	Reflections and Feedback from the meeting	Discussion	Chair	V		
DATE AND TIME OF NEXT MEETING						
029	Thursday, 20 November 2025 at 2.00 – 5.00p.m.					

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 01/09/2025)

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
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
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.
			Chair, Airedale NHS Foundation Trust	01/08/2025	Present	No perceived conflict as its an acute trust in a different area
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
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	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.
			Closed interest:			
			Deputy Vice Chancellor Education, University of Westminster	06/01/2020	31/07/2025	Will withdraw from business decisions in competition with University of Westminster
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

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
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 Camden)	01/10/2020	Present	No perceived conflict - Will withdraw from business decisions in competition with Inner Circle Educational Trust
			Independent Chair, Nominations Committee Royal College of Emergency Medicine which is a professional body. (3)	01/02/2021	Present	No perceived conflict - Will withdraw from business decisions in competition with Royal College of Emergency Medicine
			Independent member Appointments Board Nursing & Midwifery Council	01/08/2024	Present	No perceived conflict - Will withdraw from business decisions in competition with Nursing & Midwifery Council
			Independent Panel Member for Mayoral Appointments at the GLA	31/10/2024	Present	No perceived conflict - Will withdraw from business decisions in competition with GLA
EXECUTIVE DIRECTORS						
MARK FREESTONE	Chief Education and Training Officer and Dean of Postgraduate Studies	10 June 2024	Honorary position as Professor of Mental Health at Queen Mary University of London	05/06/2024	04/06/2027	Will withdraw from any business decisions relating to QMUL.
			Director, North Thames NIHR ARC (Applied Research Collaboration)	01/04/2021	31/08/2025	No conflict to declare as T&P is a member of the ARC
			Director, Mark Freestone Consulting	08/11/2012	Present	Forensic Mental Health Research Consultancy (Sole trader). No direct conflict of interest.
			Honorary Senior Researcher, East London NHS Foundation Trust	01/07/2013	31/07/2026	Will withdraw from any business decisions relating to ELFT
			Staff Trustee of the Tavistock and Portman Charity	18/11/2024	17/11/2027	No perceived conflict. To note the Charity's stated purpose is to support the Trust.
GEM DAVIES	Chief People Officer	1 February 2023	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	Present	No perceived conflict - This is unpaid.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			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
JONATHAN BELL	Interim Chief Finance Officer	12 May 2025	Trustee, Association of Coloproctology of Great Britain and Ireland	09/10/2017	Present	No perceived conflict - This is unpaid.
			Spouse is a Finance Manager at the University College London Hospitals NHS Foundation Trust (UCLH)	03/07/2023	Present	No perceived conflict - Will withdraw from business decisions in competition with UCLH
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			
DOROTHY OTITE	Director of Corporate Governance (Interim)	3 February 2025	NIL RETURN			

The Tavistock and Portman
NHS Foundation Trust

Wellbeing Team – Trainee Experience

Board of Directors Meeting – 18 September 2025

Wellbeing Team – who we are & what we do

What we do:

- Guided self-help and model specific cognitive behavioural therapy (CBT) for anxiety and depression
- Systemic interventions for depression, self-harm and behavioural difficulties for adolescents and family.
- Parenting interventions for behavioural challenges for primary school aged children
- Training for universal services
- Community outreach to wellbeing events
- Service user involvement
- Projects to improve accessibility and awareness about mental health

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 10th July 2025 AT 2.00 P.M.

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

MEMBERS PRESENT:

Voting

John Lawlor	Chair of the Board of Directors	JL
Ken Batty	Non-Executive Director	KB
Janusz Jankowski	Non-Executive Director & Deputy Chair Quality and Safety Committee	JJ
Sal Jarvis	Non-Executive Director & Chair Education and Training Committee (Agenda item 15 only)	SJ
Claire Johnston	Non-Executive Director & Chair Quality and Safety Committee	CJ
David Levenson	Non-Executive Director & Chair Integrated Audit and Governance Committee (Agenda item 11 only)	DL
Aruna Mehta	Non-Executive Director & Chair Performance, Finance and Resources Committee	AM
Michael Holland	Chief Executive Officer	MH
Chris Abbott	Chief Medical Officer	CA
Jonathan Bell	Interim Chief Finance Officer	JB
Mark Freestone	Chief Education and Training Officer & Dean of Post Graduate Studies	MF
Clare Scott	Chief Nursing Officer	CS

Non-Voting

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

IN ATTENDANCE:

Kathy Elliott	Lead Governor & Stakeholder Governor	KE
Peter Ptashko	Public Governor	PP
SM	Service User, Fitzjohns Unit	SM
Nimisha Deakin	Associate Director of Nursing and Patient Experience	ND
Reni Aina	Interim Corporate Governance Support	RA
Asma Bi	Committee Secretary	AB

APOLOGIES:

Rod Booth	Director of Strategy and Business Development	RB
Shalini Sequeira	Non-Executive Director & Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOMEAND APOLOGIESFOR ABSENCE**	
	The Chair (JL) welcomed all attendees to the meeting and noted the apologies as listed above.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate	
003	**DECLARATIONSOF INTEREST**	
	There were no declarations of interest to be reported beyond those previously recorded. Members were reminded to inform DO of any new or updated declarations.	
004	**SERVICEUSERSTORY: Service User presentation on their experience of recent Complaint**	

A service user of the Fitzjohn's Unit (SM) gave a presentation on the Review Session Programme for Clients with CPTSD: Insights, Difficulties and Recommendations.

SM shared her positive and negative experiences of the service and her use of the Trust's complaints process.

Good experiences of the service included the following :

- Knowledgeable and supportive Clinicians who were willing to support
- Check-ins for clients on waiting list
- Receipt of a prompt and efficient response from the Complaints Manager
- A Senior Psychotherapist Investigator who made a genuine effort to help identify the core issues in her compliant
- A genuine effort to help identify the core issue in my complaint
- A trauma-informed and sensitive Clinician even after I filed the complaint.
- Friendly and welcoming reception staff
- Competent, skilled and compassionate Psychoeducation trainers
- A clean, calm and well-maintained building.

Difficulties experienced with the service included the following:

- Email response times
- Clarity around communication
- Delays in appointment scheduling
- Notification of Clinician's sickness absence
- Stress and uncertainty due to lengthy complaint process
- The Complaints Manager did not seem familiar with my complaint and during discussions did not go through the complaint procedure
- Delays in the Investigator's response leading to the withdrawal of my complaint.

Recommendations for improvements included:

1. Appointments - Set a precise timeframe e.g. set a longer appointment time of 50 minutes instead of 40 minutes.

2. Appointment notice - ask client about their preference for notices and get the clinician and client to agree on a mutually convenient date and time for the next appointment.
3. There should be more attention to the environment.
4. Creating a leaflet for service-users explaining in detail what is Psychodynamic Therapy.
5. Creating an assisted learning module and handouts
6. Clinicians should offer training on how to run the review session.
7. Clinicians should provide a short Trauma-informed refresher workshop
8. Encourage an open and clear communication process, more personalised and reminder of what was discussed at the last appointment.
9. Investigators should review the written complaint in advance.
10. Investigators should offer clients flexible options for discussing the complaint (e.g., phone, video, or an in-person meeting).
11. The complaints team should follow the timeframe and guidance published online.
12. The complaints team should offer clients a sense of safety and reassurance throughout the process.

JL on behalf of the Board informed SM that her recommendations are very useful and apologised for the difficulties she experienced. Other Board Members also thanked SM and felt that better communication and an explanation about the therapy was a key part of the service.

CS confirmed that this information has been shared with the service and the complaints team. The feedback has been useful; improvements have already been implemented to the process of booking appointments and parts of the administration.

005 **MINUTES OF PREVIOUS MEETING**

The Board reviewed and approved the minutes of the previous Public Board Meeting held on 15 May 2025.

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

It was noted that there were no matters arising.

The Board reviewed the action log and noted that all actions listed are progressing with no items ready for closure.

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

Chair and Chief Executive's Report was taken as read. MH presented the report with input from JL highlighting the following key points:

The Trust is progressing with the proposed merger with North London NHS Foundation Trust (NLFT), due to take effect on 1 April 2026. The strategic outline case has been submitted to NHS England. There was a Board-to-Board meeting with the Trust and NLFT, with the CEOs of each Trust giving presentations which were well received.

JL announced that he will be leaving his role as Chair of the Trust and Council of Governors earlier than planned. He confirmed his early departure from the Trust on 30 November 2025. The Council of Governors have been formally notified and there will be a public announcement about the successor at the next Board meeting or sooner.

The Government has released details of the 10 Year Plan for the NHS. The Trust is reviewing the plan and considering the likely impact this will have for the future.

The British Medical Association (BMA) has announced that resident doctors will take strike action from 25 July – 30 July 2025. There will be an impact on the NHS as a whole and the Trust will continue to monitor the situation.

The Board noted that Jane Meggitt has now left the Trust as the Interim Director of Communications and Marketing. MH formally acknowledged and thanked Jane for her hard work.

The Board **DISCUSSED** and **NOTED** the reports from the Chair and CEO.

008 **INTEGRATED QUALITY PERFORMANCE REPORT (IQPR) INCLUDING UPDATE ON RISK AREAS/ AREAS IN STRUCTURAL SUPPORT**

The IQPR report was taken as read. CS presented the report, with input from CA and GD highlighting the following key points:

The Trust strategic priorities are:
1. People (including Equalities, Diversity and Inclusion)
2. Waiting Times
3. Experience and Outcomes
4. DET, Commercial Growth and financial sustainability.
5. Merger

The Trust-wide IQPR reported on progress for Month 1 as follows:

- There were three incidents involving violence and aggression at Gloucester House.

- Trust-wide we achieved 86% of ESQ positive responses in April 2025, which is below our target of 90%.

- Completion of Pathway Mapping includes indicative timelines for each intervention to support proper capacity planning.

- Waiting Times - The Trust is failing to meet the NHS 18-week standard for first appointments at the Adult Gender Identity Clinic (GIC), Adult Trauma Service and Autism Assessments.

- Clinicians managing their own diaries has been a challenge, a move to automated system for booking appointments in the Psychotherapy Unit has led to improvements and will be introduced to the Adult Trauma Service.

- In April the new waiting time metrics 'stop the clock' was launched, the Referral-to-Treatment (RTT) clock will help manage waiting times.

- A total of fourteen patient safety incidents were reported in April Trust-wide – this included six deaths. Mortality reviews have been requested on those seen by the GIC.

- There have been 2 After Action Reviews initiated and five outstanding AARs are being monitored. Findings and key learning points from all responses will be discussed at the Clinical Incident and Safety Group (CISG).

- The members of staff completing the staff appraisal remains low and staff sickness is also below the benchmark. Additional work is being completed to address the variance.

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

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

The BAF report was taken as read. DO presented the report with input from GD highlighting the following key points:

This report provided the latest update on the full Board Assurance Framework (BAF) risks and Corporate Risk Register during Quarter 1 2025/26.

- BAF Risk 15 (Staff disengagement) is a new risk proposed to be added to the BAF.

- The emergent risk of "Sustainability of Core Education Funding Contracts". This is a new risk proposed to be added to the BAF and relates to uncertainty surrounding a new contracting process and the potential changes to the current arrangement with the NHS England National Training Contract (NTC). This will be assessed at the Education and Training Committee.

- Work is underway to strengthen the Corporate Risk Register entries relating to estates, contracting and strategic commercial risks. Progress has been slower than anticipated due to the Risk Manager leaving in May 2025 and there being a resourcing gap within the Corporate Governance Team. This issue is being addressed during Quarter 2 2025/26.

ACTION: JL on behalf of the Board, acknowledged the work done identifying new or emerging risks on the Board Assurance Framework. The Board look forward to receiving further updates and note that further discussions will take place with risk owners and at Board Committees. **DO**

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

010 ANNUAL SELF-ASSESSMENT OF BOARD COMMITTEES' EFFECTIVENESS 2024/25

The report was taken as read. DO presented the report providing a summary of the Annual Board Committee Effectiveness Reviews for 2024/25.

The Board received and noted the annual effectiveness survey report for each Committee, providing commentary on what worked well, things that could have been done better and areas for further development in 2025/26. Overall, the survey responses were mostly positive and there has been steady improvement.

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

011 **INTEGRATED AUDIT AND GOVERNANCE (IAG) COMMITTEE ASSURANCE REPORT**

The report was taken as read, DL presented the report. The highlights included:

The final audited accounts and Annual Report were submitted ahead of the statutory deadline of 30 June 2025.

Internal Audit identified some weaknesses around our ability to respond to recommendations and rated it at Level 3. The Auditors anticipate an improvement in the Trust's overall control environment, following management action and governance changes.

The Board received **ASSURANCE** from the update provided.

JL informed the Board that this was DL's last Board meeting, on behalf of the Board JL expressed appreciation for his hard work and valuable contributions as the longest serving member of the Board.

012 **QUALITY AND SAFETY (Q&S) COMMITTEE ASSURANCE REPORT**

The report was taken as read. CJ presented the report highlighting the following:

- 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.

- 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 work on the clinical audit programme has been limited due to a staffing gap. The Deputy Chief Medical Officer leads the programme and an appointment to this role is being addressed.

The Board received **ASSURANCE** from the updates provided.

013 PATIENT AND CARERRACE EQUALITY FRAMEWORK (PCREF) UPDATE

The PCREF report was taken as read. CA presented the report highlighting the following:

- Work is ongoing to finalise a visible action plan. Key areas include a rolling programme of data at IQPR, referral and acceptance data according to ethnicity, clinical outcomes measures, complaints data and non-attendance data and patient feedback.
- There are plans to develop a robust DET plan aligned with PCREF priorities.
- A new lead is to be appointed for Patient Public engagement.
- At the June meeting clinical leads and trainees from the Camden Wellbeing Team shared three projects.
- JL confirmed the priorities the Trust are looking at with Camden Local Authority are drug dependency, alcohol and neighbourhoods.
- We will be planning an event for Black History Month.

ACTION: SP and JJ responded to a request for NED volunteers to champion the work of PCREF. JL thanked them for volunteering and CA agreed to provide them with further details and dates of PCREF meetings. **CA**

ACTION: It was agreed that PCREF should report to the Board every 6 months ensuring that the report aligns with quarterly reporting of referral data and half yearly ESQ data reported with ethnicity demographics. **DO**

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

014 LEARNINGFROM NATIONAL REVIEWS: NOTTINGHAM REVIEW

The report was taken as read. CS presented the report, with input from CA.

Following the Nottingham review, the Trust undertook an internal review. Overall, the Trust operates good practice however the following potential gaps have been identified:

- Dynamic Risk Assessment - Work is ongoing to strengthen the Trust's risk assessment processes.
- Liaison with External Networks - There needs to be more clarity on how to escalate concerns.
- Involvement of Family - A more proactive approach is needed to ensure timely family involvement in care.

- Discharge Planning - Local discharge planning procedures were found to be inconsistent and needs to improve.

- Internal Trust Oversight - There is a risk of under-reporting incidents. Teams would benefit from further training on incident reporting practices.

The Board received **ASSURANCE** from the updates provided.

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

The report was taken as read. SJ presented the report with input from MF highlights included the following:

- The Trust are having discussions with stakeholders such as the Office for Students (OfS), the University of Essex and the University of East London. about the merger and the effect of any potential changes.

- A 'fragile courses' group has been established to mirror the work clinical colleagues are doing on fragile services.

- A weekly recruitment oversight group has been established to consider applications and offers on a course-by-course basis.

- The Committee endorsed the creation of a new BAF risk on 'Sustainability of Core Education Funding Contracts'.

- The number of accepted or conditionally accepted student offers has slightly increased compared to last year. Agents are assisting to identify and attract students from outside the UK.

The Board received **ASSURANCE** from the updates provided.

016 WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

The report was taken as read. GD presented the report highlighting the following key actions being addressed.

1. The Workforce Race Equality Standard (WRES)

The Trust has improved in the following areas:

- Workforce Representation
- Leadership Diversity
- Bullying by Staff
- Discrimination
- Formal Disciplinary Action.
- Career Progression or Promotion Perception

The Trust needs to make further improvements in the following areas:

- 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%.

The WRES action plan to address the challenges is set out below:

- 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.

2. The Workforce Disability Equality Standard (WDES)

The Trust has improved in eight of the following areas:
- Disability declaration rates
- Board representation of Disabled staff
- Disabled staff are no longer disproportionately subject to formal procedures.
- Bullying by managers
- Staff engagement among Disabled staff
- Increased reporting of bullying and harassment
- Perceptions of fair promotion and career progression are trending upward.
- More Disabled staff feel valued for their work, reflecting improved organisational culture.

The Trust needs to make further improvements in the following areas:
- 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.

The WDES action plan to address the challenges is set out below:

- 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.

The Board **NOTED** the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) reports and **APPROVED** the above action plans.

017 EQUALITY, DIVERSITY AND INCLUSIONANNUAL REPORT 2025/26

The Annual Report was taken as read. GD presented the EDI Annual report 2025/26.

The Priorities are:

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

GD stated that since the last Annual Report, the Gender pay gap has improved and completely eradicated the issue around bonuses.

Recommendations

- Disseminate findings of the staff survey (WRES/WDES) trust-wide to facilitate better understanding and local ownership of the challenges.
- 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.
- Remove barriers to reporting discrimination bullying, harassment, abuse and discrimination.

- All staff to have an EDI objective that is linked to Trust values and evidenced over 12 months.

- 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.

- 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).

- 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.

- 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.

- 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.

The Board **DISCUSSED** and **NOTED** the Annual Report.

018 PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, DIVERSITY AND INCLUSION (POD EDI) COMMITTEE ASSURANCE REPORT

The report was taken as read. GD presented the Board with key information, highlights included:

- The new risk BAF 15: Lack of Staff Engagement/ Staff Disengagement.
- A New Freedom to Speak Up Guardian is to be commissioned. TGS has been asked to provide FTSU support until the merger.
- The Guardian Service (TGS) will provide a 24/7 telephone service as well as a named guardian(s).
- Compliance is being closely monitored at IQPR

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

019 PERFORMANCE, FINANCE AND RESOURCES ASSURANCE COMMITTEE REPORT

The report was taken as read. AM presented the report with input from JB, highlights included:

Activity Reporting – Performance and Contracts:

- A report on a proposal to pilot Artificial Intelligence (AI) tools.

- A verbal update on the System Oversight Framework with a formal report scheduled for the September meeting.

Board Assurance Framework :

- Several contracts faced challenges, including PCPCS (settlement dispute), Surrey Mindworks (decommissioning by September 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.

- It was proposed to increase the residual risk score for BAF 13 (Performance Delivery) from 12 to 16. The Committee requested a review of the scoring to be considered at the IQPR meeting and brought back to the Committee for consideration at the next meeting.

- BAF 11 (Sustainable income streams) and BAF 12 (IT infrastructure and cyber security) required further review.

The Committee agreed to hold an extra-ordinary meeting on 31 July since the next scheduled meeting is not until September.

The Board received **ASSURANCE** from the updates provided.

020 FINANCEREPORT

The report was taken as read. JB presented a financial update of month one, key points highlighted included:

Income & Expenditure
The Trust incurred a net deficit of £592k in the period, which is an £88k adverse variance to plan.

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 Month 3.

Cash Report
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. We continue to submit cash requests.

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
There is a challenge in completing Plans on a Page (POAPs) for savings schemes that have been slower than required.

The Board received **ASSURANCE** from the updates provided and noted the plans in place to ensure that the Trust continues to meet statutory obligations and operational costs.

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

021 BOARD SCHEDULE OF BUSINESS 2025/26

The report was taken as read. DO presented the report. There were no changes since the last Board meeting.

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

022 QUESTIONS FROM GOVERNORS

There were no questions from the Governors.

KE provided the following comments:
It is important to make sure that the Governors remain involved with the Board discussions especially in the run up to the merger.

Whilst not many Governors attended the Board meeting, they do attend informal meetings, service visits and their feedback is included in Committee decisions.

The quality of the reports to the Board provide assurance on transparency.

023 ANY OTHER BUSINESS

There were no other business raised.

024 QUESTIONS FROM THE PUBLIC

There were no questions from the public raised.

025 REFLECTIONS AND FEEDBACK FROM THE MEETING

It was a useful meeting however it ran over the scheduled time.

ACTION: JL suggested in future the Chair is sent the presentation slides in advance. This will enable the Chair to follow the presentation and provide better time management. **DO**

ACTION: The presenters should be informed in advance of the maximum number of slides permitted and should be reminded about the time scheduled for their presentation. **CS**

ACTION: JL and KE will discuss how best to engage with the Governors and make sure that they are up to date with discussions about the merger. **KE/JL**

026 DATE AND TIME OF NEXT MEETING

The Chair closed the meeting at 5.20p.m

Date of Next Meeting in Public: Thursday, 18 September 2025 at 2.00p.m – 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	02/09/25: Oliver McGowan training dates sent to NEDs in May, further dates to be sent in September. 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)	To Close	22/08/25: Third party organisation to provide Freedom to Speak Up service. 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	To Close	22/08/25: Board updated. Assurance to be provided through PFRC and QSC. 25/06/25: Verbal update to be provided at Board.
10.07.25	9	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2025/26	Further BAF discussions to take place with risk owners and Board Committees.	18.09.25	Dorothy Otite, Interim Director of Corporate Governance	To Close	22/08/25: Discussions have taken place, BAF on agenda.

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)
10.07.25	13	Patient and Carer Race Equality Framework (PCREF) update	CA to provide Sabrina Phillips and Janusz Jankowski with further details of PCREF and dates of PCREF meeting	18.09.25	Chris Abbott, Chief Medical Officer	In progress	01/09/25: Verbal update to be provided.
10.07.25	13	Patient and Carer Race Equality Framework (PCREF) update	Ensure PCREF is included on Board agenda every 6 months, aligning with quarterly reporting of referral data and half yearly ESQ data reported with ethnicity demographics	18.09.25	Dorothy Otite, Interim Director of Corporate Governance	To Close	01/09/25: Board Schedule of Business updated accordingly
10.07.25	25	Reflections and feedback from the meeting	To send the Chair the presentation slides in advance of the meeting	18.09.25	Dorothy Otite, Interim Director of Corporate Governance	To Close	01/09/25: Process in place to ensure Chair receives slides in advance of Board meetings along with Board papers.
10.07.25	25	Reflections and feedback from the meeting	To inform presenters in advance of the maximum number of slides permitted and time scheduled for presentation	18.09.25	Clare Scott, Chief Nursing Officer	To Close	01/09/25: Process in place.
10.07.25	25	Reflections and feedback from the meeting	Discuss how best to engage with Governors and ensure they are up to date with discussions around the merger	18.09.25	John Lawlor, Chair of the Board of Directors Kathy Elliott, Lead Governor	To Close	22/08/25: Forms part of governor communication and engagement plan.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 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 10 July 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 hope that everyone has had a nice summer and taken the opportunity of time off to recharge batteries and spend valuable downtime with family and friends.

It has definitely not been a quiet summer here at Tavistock and Portman. We have continued to manage the ongoing development of the full business case for the merger and to focus on our financial plan in the next year.

2. Merger update

Following submission of the joint Strategic Outline Case for the merger by acquisition to the NHS England Transaction Team in June, we have been given the go ahead to proceed to the next stage of the merger transaction (developing a full business case). The letter gave us a Red-Amber-Green (RAG) rating of 'Amber' which means that there are some areas of our proposal that 'require further focus in the development of the case'.

The full business case is now being developed, which is on track to be submitted to NHSE by November, following approval by both Trust Boards in October.

During September, NLFT will be holding a series of engagement events for our staff to discuss our merger. The events will be hosted by Jinjer Kandola, NLFT Chief Executive and Natalie Fox, NLFT Deputy Chief Executive. The events will be an opportunity for staff to hear about our shared vision, North London's people promises; plan for the merger by acquisition; staff engagement in the process; and to ask questions.

Providing outstanding patient care

3. Gender Identity Clinic (GIC)

The GIC service joined the national quality improvement (QI) network workshop, hosted by NHS England in July 2025. The work of the day focused on a whole system approach to delivering the recommendations of the Levy report, once published; improving the patient experience, creating a standardised system approach to reduce variation and support improvement in productivity. Following the workshop the service has developed a workplan and set of metrics which has been submitted to NHS England, London region as part of the contracting process.

4. Gloucester House Ofsted Inspection

Ofsted wrote to the proprietor and the Chair of the governing body to inform them that they would be conducting an independent school standard inspection of Gloucester House School between the 1st July and 3rd July 2025. The inspection team provided verbal feedback on the 3rd July and the school is expecting the written report imminently.

5. Winter Plan

During the summer period, the Trust has been developing the winter plan and participated in a 'resilient together this winter' ICS event on 3rd September. The Trust will participate in a regional mental health winter learning summit on 15th October 2025.

6. Emergency Preparedness, Resilience and Response Core Standards

The Trust conducted the annual self-assessment of the Core Standards for Emergency Preparedness, Resilience and Response (EPRR) to meet the requirements for planning for emergencies under the Civil Contingency Act 2004, NHS Act 2006 and Healthcare Act of 2022, to ensure robust plans to protect the community it serves in the event of any Incident or Emergency. In accordance with the requirements laid out in the EPRR 2024/25 assurance process, the overall level of compliance is RAG rated of the Core Standards. The Trust will review the self-assessment during an assurance meeting with NCL ICB.

7. DrDoctor

The Trust has been approved by the Wayfinder Team at NHSE, to be the first Mental Health Trust in the Country, to be onboarded to the NHS App with DrDoctor. This is a significant milestone that gives the Trust credibility for its digital maturity.

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

8. 2025 Graduation Ceremony

We will be hosting our 2025 graduation ceremony on 11th September, and members of the Board have committed their time to attend the event. It is being held at the Queen Mary People's Palace and will be a great space for our staff and students to mark this important milestone.

9. Student Recruitment

Student applications closed in August with 1122 applications completed, a small drop of 2% on the 2024/25 position. However, this position included an encouraging 15% increase in the number of overseas applications, and the earlier opening of applications has led to a significantly higher number of offers made, an increase of 20% at this point in the cycle relative to 2024/25 as students move into enrolment. We expect that this is a healthy position for the Trust in relation to its long-course educational income.

10. Library Development

The new library development is taking shape, and it is very encouraging to see the clean, contemporary furniture and fittings being installed into a space that has been designed around an extensive consultation with our students and feels far more up to date with the needs of today's learners. The new furniture brings a modern feel aligned with modern University libraries and the removal of most of the desktop computers gives a feeling of space and the opportunity to focus. The library will be re-opening on 3rd September.

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

11. Industrial Action

The BMA's UK Resident Doctors Committee undertook planned strike action at the end of July. While the impact on the Trust of strike action was minimal, within only three doctors choosing to exercise their right to strike, there was a larger impact on the NHS as a whole. There is a potential knock-on impact of pay dissatisfaction among other professional groups, with strike appetite also being balloted by RCN.

12. 10 Point Plan to improve resident doctors' working lives

Along with other NHS Trusts, the Trust received a letter from Sir Jim Mackey, CEO NHS England and Professor Meghana Pandit, National Medical Director NHS England. The letter sets out a 10-point plan to improve the working lives of resident doctors and actions to be taken over the next 12 weeks.

Trust Boards are being asked to take clear ownership of local improvements, develop action plans informed by feedback and national survey results, and report progress publicly. To demonstrate progress, from Autumn 2025 NHS England will begin publishing trust-level data as part of the NHS Oversight Framework.

13. Staff Survey

The next staff survey window has been confirmed to commence on 29 September 2025 and run until 29 November 2025. This year new questions include those centred around socio-economic background, which seek to understand the occupation, income, and type of work undertaken by each employee's main family earner at age 14.

The new ESR portlet named 'My Socio-economic Background' is also now available for all NHS organisations to publish to the My ESR Dashboard, to allow staff to record their socio-economic background information.

Improving Value, Productivity, Financial and Environmental Sustainability

14. Annual Members' Meeting

The Trust's Annual Members' Meeting will be held at 5.30p.m. on Thursday, 2nd October at the Tavistock Centre. It is an opportunity to look back on our work during 2024/25 and look ahead at our plans for the future. The meeting is open to our members and the public.

Internal Updates

15. Recent Board Changes

Executive Directors:

This is the last Board meeting attended by Gem Davies, our Chief People Officer, as she is leaving us at the end of September for her new role at the Barnet Hospital, Royal Free London NHS Foundation Trust. I want to formally thank Gem on behalf of the Board for her contributions over the last two and a half years and wish her well for her new role. The plans for interim cover will be confirmed soon.

Non-Executive Directors:

John Lawlor has announced that he would be stepping down as Chair of the Board of Directors at the end of November 2025 after three years on the Board. John has accepted a role as Chair at his Local Hospital and Community Trust in West Yorkshire, Airedale NHS Foundation Trust.

I am delighted to announce that the Council of Governors have approved the appointment of Aruna Mehta, our current Vice Chair, to step into the role as interim chair effective 1st December until our merger is enacted.

David Levenson, Non-Executive Director left the Board on 31st August at the end of his second term of Office. I want to formally thank David on behalf of the Board for his contributions over the last six years and wish him well.

I am delighted to announce that the Council of Governors have approved the appointment of Sabrina Phillips as a full NED effective 1st September until our merger is enacted. Until this appointment, Sabrina was an Associate Non-Executive Director in the Trust since October 2022.

16. Visits to our Services (Service Visits)

We have a programme of Service Visits for 2025/26 to enable the Board of Directors and Council of Governors keep up to date with current issues with our services and the issues being raised by our staff. Since the July Board, the following services have been visited:

- Surrey Mindworks
- Corporate HR (People Team)
- Psychoanalytic Assessment and Treatment
- Forensic Child and Adolescent Mental Health Team
- Family Mental Health Team
- Complaints and PALS
- First Step Plus (at Bounds Green Health Centre)

Regional and National Context

17. NHS Oversight Framework – Q1 Segmentation Confirmation

The information provided for the Q1 2025/26 NHS Oversight Framework segmentation, underpinning metric scores and league table ranking for each NHS provider was approved at the NHS England Executive Committee meeting on Tuesday 26 August 2025.

The Trust has been notified of its rating remaining at Segment 3 and ranked at 43/61.

18. Provider Capability Self-Assessment

NHSE has introduced the new Provider Capability Assessment process alongside the NHS Oversight Framework.

As part of the NHS Oversight Framework, NHSE will use an assessment of provider capability to judge what actions or support are appropriate at each Trust. This is a key element of NHSE's new approach to provider oversight, intended to provide oversight teams with a more holistic view of Trusts while giving their Boards a framework within which to assess their governance,

grip and ability to deliver. It will also inform whether Trusts go forward to apply for new Foundation Trust status or are considered for the national Performance Improvement Program (PIP).

Trusts have been given 8 weeks to carry out and return the self-assessment, and regions 4 weeks to review the returns and assign a capability rating. The Trust has commenced the self-assessment process using the prescribed self-assessment template developed by the NHSE National team. The draft self-assessment will be brought to the Board Seminar on 2nd October for consideration and discussion, ahead of Board sign-off.

The aim is to have capability ratings in place by the end of November in order to identify PIP candidates in December.

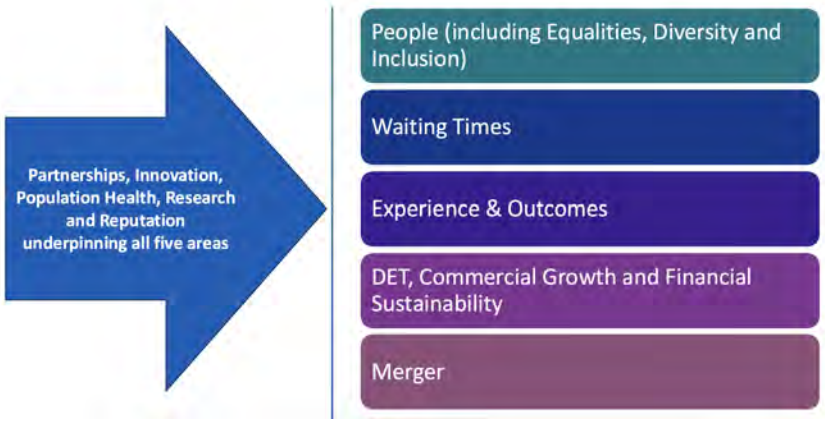
19. New Chair announced for North Central and North West London ICBs

North Central London ICB announced they have a new Chair, Mike Bell. Mike will Chair both North Central London, and the North West London Integrated Care Board, and will eventually become the Chair of the merged Integrated Care Board, which is set to take effect in April 2026.

20. Chief Executive's meetings with external stakeholders

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

- Cavendish Square Group of London NHS Mental Health Providers' CEOs;
- Cavendish Square Group Digital Conference;
- Camden Neighbourhoods Workshop;
- The King's Fund Digital Health and Care Conference;
- NCL ICB System Management Board (SMB);
- NHS England London CEOs Meeting with the London Regional Director; and
- Mental Health Network NHS Confederation - CEO and Chair 10 Year Plan Meeting.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Integrated Quality and Performance Report based on Month 2 (May 2025) Data			**Agenda No.: 008**
Report Author and Job Title:	Sheva Habel, Medical Director, Rachel James, Managing Director	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer, Chris Abbott, CMO Rod Booth, Director of Strategy
Appendices:	Appendix 1: Month 2 (May 2025) Integrated Quality and Performance Report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation: **Background:** **Assessment:**	The Trust Integrated Quality and Performance Report (IQPR) for May 2025 (Month 02) 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 Board reports. Month 02 was considered in the Trust-wide IQPR meeting on 3rd 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:  **1. Operations and Service Delivery** The Gender Identity Clinic and Trauma Service remain under the Trust's targeted support framework. Progress continues to be limited, and urgent action is required to confirm clinical capacity via job planning and pathway		

finalisation. This is essential to align services with national specifications, clarify delivery trajectories, and improve appointment availability.

Key initiatives within the service improvement pipeline include:

- **RTT Clock Stop/Start Logic**: A new clinician-facing reporting tool is under development following a definition workshop in May 2025.
- **Digital PTL Enhancements**: On track for release by July 2025, enabling clinician action and escalation.
- **Centralised Booking (Trauma Services)**: Implementation scheduled for mid-July 2025.
- **Automated Booking (GIC) via DrDoctor Portal**: scheduled to commence August 2025
- **Pathway Mapping**: Finalisation planned by end-July 2025, with implementation to follow in mid-October.
- **Workforce Planning**: All units are to ratify their workforce plans by mid-July 2025, forming the basis for space and capacity planning.

2. Quality and Safety

Experience and Outcomes

- **Patient Feedback**:
  ESQ (Experience of Service Questionnaire) positive response targets were not met in May 2025. Feedback highlights communication as a recurring area of concern, aligning with complaint themes. Positive comments referenced Trust values and respectful interactions.

  Over 100 ESQ forms were collected in May, representing a significant increase compared to previous months, though still below the Trust target. Targeted support is in place for teams collecting few or no forms, aimed at boosting response rates and engagement.

- **Complaints and Compliments**:
  The Trust continues to promote early informal resolution. In May, 4 informal complaints were recorded; 2 were resolved within the 10-working-day target. Thirteen formal complaints were received: 11 from the Adult Unit and 2 from the Child, Young People & Family (CYPF) Unit. Of these, 10 were acknowledged within the required three working days. Additionally, 2 quality alerts and 1 MP enquiry were received.
  Four compliments were formally logged in May—1 for Camden, 1 for CYPF, and 2 for the Adult Unit. Ongoing efforts aim to raise staff awareness of the compliment reporting process.
- **Clinical Outcome Measures (OMs)**:
  The revised waiting time metrics launched in April 2025 show a slow uptake. If this continues into June, team- and unit-level interventions will be considered to ensure compliance with the new OM process.
- **Patient and Carer Race Equality Framework (PCREF)**:
  This month's PCREF focus is on finalising the Action Plan and

identifying metrics for inclusion in future Integrated Quality and Performance Reports (IQPRs).

Incidents and Learning

- **Patient Safety Incidents**:
  A total of 23 incidents were reported in May: Camden – 3, Child & Family – 12, and Adult Services – 8. Five patient deaths were recorded, all within the Gender Identity Clinic. Mortality reviews have been requested.
- **After Action Reviews (AARs)**:
  Two AARs have been conducted (both at Gloucester House involving violent or aggressive behaviour); learning will be reviewed by the Clinical Incident and Safety Group (CISG) and shared in unit clinical governance meetings.
- **Restrictive Practice**:
  Six incidents involving restrictive interventions were reported at Gloucester House in response to challenging behaviours. Monitoring continues through appropriate safeguarding and governance structures.

3. People

The Senior Leadership Team is reviewing 'working-from-home practices' to ensure sufficient clinical presence on site, particularly during peak service demand.

- **Mandatory and Statutory Training (MAST)** compliance rose to 81.93% in May (a 2.33% increase), with Basic Life Support (BLS) being the primary outstanding requirement. BLS sessions are being scheduled for clinical staff.
- **Appraisal Completion** has dropped to 48.98%, prompting the launch of a new quality improvement workstream led by the Learning and Development team.
- **Sickness Absence** remains stable at 3.06%, slightly below the national average. Mental health reasons (stress, anxiety, depression) continue to be the leading cause of absence across both White and global majority staff groups.

4. Finance

As of Month, 2 (M2), the Trust is reporting a year-to-date deficit of **£1.209m** , which is **£84k adverse to plan**. The variance is mainly due to timing differences in pay and non-pay costs, partially offset by above-forecast income. The unfunded element of the 2025/26 national pay award remains a key financial risk.

- **CRES(Cost Reduction Efficiency Savings)**:
  Camden and Child & Family Units have submitted detailed CRES plans, with finalisation expected imminently. The Adult Unit has provided a high-level plan, with further development ongoing. CRES performance continues to be monitored via the established governance framework.

	Early indications suggest the Trust is unlikely to achieve full delivery of its CRES target unless pay-related pressures are factored into planning. Operational leads are currently exploring options to bring forward credible proposals for executive review.
Key recommendation(s):	The Board is asked to **DISCUSS**and **NOTE** the report for assurance.

Implications:

Strategic Ambitions:

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title : BAF 1: Inequality of access for patients BAF 2: Failure to provide consistent, high-quality care BAF 13: Failure to achieve required levels of performance and productivity				
Legal and Regulatory Implications:	Yes ☒	No ☐			
Resource Implications:	Yes ☒	No ☐			
	Workforce and financial resource implications relating to waiting times management and efficiency plans.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			

Assurance:

Assurance Route - Previously Considered by:	Extra-Ordinary Performance Finance & Resources Committee – July 2025 Executive Leadership Team – August 2025

	Quality and Safety Committee – August 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 Month 2 (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.

Executive Summary (1/2)

The Tavistock and Portman NHS Foundation Trust

Operations and Service Delivery

Waiting Times

The Gender Identity Clinic and the Trauma Service remain under the Trust's targeted support framework. Progress continues to be slow and action is required to confirm clinic capacity through job planning and finalising pathways. This will ensure alignment with national service specifications and best practice and will help clarify delivery trajectories and appointment capacity.
GIC continue to work with NHSE and other adult gender services as part of the national improvement collaborative.

- **Service Improvement Pipeline**

- **RTT Clock Stop/Start Logic:** Following a definition workshop in May 2025, the IT team is developing a clinician-facing reporting tool for 18-week and 4-week RTT pathways.
- **Digital PTL Enhancements:** Updates will allow clinician input and escalation of outstanding actions. *(Target: July 2025)*
- **Centralised Booking for Trauma Services:** Implementation planned for *mid-July 2025*.
- Automated booking for GIC patients via DrDoctor Portal to be implemented in August and September
- **Workforce and Recruitment Acceleration:** To address ongoing capacity challenges, each unit is expected to finalise and ratify its workforce plan by *mid-July 2025*.
- l inform space optimisation plans to support this approach.

People

- The Senior Leadership Team has agreed to review current working from home arrangements to ensure sufficient on-site presence across clinical services.
- Mandatory and Statutory Training (MaST) completion rose to 81.93% in May 2025 (a 2.33% increase), driven by efforts from unit operational teams. In several teams, the main outstanding MaST requirement is Basic Life Support (BLS), which will be offered to clinicians in the coming months. However, appraisal completion stands at 48.98%, having declined over the past four months. The Learning and Development team is launching a new quality improvement workstream to drive improvements in both appraisals and MaST compliance.
- The Trust's current sickness absence rate stands at 3.06%, marginally below the national benchmark of 3.07%. Data from June 2024 to May 2025 shows that mental health issues —specifically anxiety, stress, and depression—remain the leading causes of absence across both White and BME staff groups.

Finance

- As of **Month 2,** the Trust reported a year-to-date **deficit of** £1.209m, which is £84k behind plan. The £84k adverse variance primarily reflects timing differences in pay and non-pay costs, partially offset by higher-than-expected income. The unfunded portion of the national pay award remains a recurring pressure for 2025/26.
- **Child and Family Services** and the **Camden Unit** have developed detailed CRES plans, which are being finalised by the end of June 2025. The **Adult Unit's** plan remains less developed, although a high-level version has now been agreed, with further detail expected by month-end. CRES delivery is being monitored via the established governance framework.

Executive Summary (2/2)

The Tavistock and Portman NHS Foundation Trust

Quality and Safety

Patient Feedback:
The Trust-wide target for ESQ positive responses was not achieved in May 2025. Themes from qualitative feedback indicate that communication is an oft reported concern. This triangulates with complaint categories. Positive comments received via the ESQ forms include themes linked to the Trust values.
The number of forms collected across the Trust in May rose to above 100. This is below the Trust target, however a notable increase on previous months. There is continued targeted support being offered to teams where no forms are collected to develop targeted actions to increase engagement.

Complaints:
The Trust aims to respond to all complaints informally whenever possible, enabling an earlier resolution for patients. According to the Complaints Management Policy, informal complaints are those which are resolved by the immediate service with 10 working days. May 2025, 4 complaints were resolved informally, of which 2 were resolved in 10 working days.

A total of 13 formal complaint contacts were received Trust-wide in May. Of this number, 11 were received for the Adult Unit and 2 were received for CYP and Family Unit. 10 of the 13 complaint contacts received in May were acknowledged within 3 working days in line with national regulations. In addition; 2 quality alerts and 1 MP enquiry were also received in May 2025.

Compliments:
The Trust received 4 compliments reported via Radar, one for Camden Unit, one for CYP and Family Unit and two for the Adult Unit. The Trust continues to raise awareness of the process on how to record compliments within the teams.

Clinical Outcome Measures:

The Trust launched the new waiting time metrics on 1st April 2025. The data for May indicates that the update of the new OM is slow. Consideration for unit and team level interventions to ensure the new OMs are being completed if this pattern continues into another month.

Incidents:
A total of 23 patient safety incidents were reported Trust-wide in May: Camden – 3, Child & Family – 12, and Adult Services – 8. Of these, five deaths were recorded, all of which occurred within the GIC. Mortality reviews have been requested. In Gloucester House, there has been 6 incidents where restrictive practices has been used in response to challenging behaviour.

2 After Action Reviews (AARs) were conducted, both concerning incidents of violence and aggression at Gloucester House. Findings and key learning points from all responses will be discussed at the Clinical Incident and Safety Group (CISG) and unit clinical governance meetings.

Patient and Carer Race Equality Framework (PCREF): This month's PCREF slides focus on the development of the PCREF Action Plan and proposed data to be presented in future IQPR meetings.

Integrated Quality and Performance Report — Month 02- 25/26

Risk Ref	Risk Title	Risk Description (Cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
Providing outstanding care						
1	Inequality of access for patients	**If** 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)	**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)	**Cautious**
To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.						
3	Risk of loss of validation of DET degrees	Changes to the OfS regulatory framework and other pressures on DET as a small independent provider whose programmes are validated externally pose a risk to our ability to award degrees (MA, Professional Doctorate). This would severely impact DET income.	20 (4 x 5)	12 (3 x 4)	8 (2 x 4)	**Cautious**
4	Potential contraction of student recruitment	If there is a contraction in postgraduate student income, then Trust strategic and commercial aims will be significantly impacted. This risks a shortfall against financial targets and a reduction of impact as a lead in mental health education.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	**Hungry**
Improving value, productivity, financial and environmental sustainability.						
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. Resulting sanctions against the Trust, including loss of income and financial penalties, poor patient experience and patient outcomes, including risks to patients' mental health, and reputational risk.	16 (4 x 4)	16 (4 x 4)	8 (2 x 4)	**Open**

Integrated Quality and Performance Report

Month 02- 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. At June 25 the treatment waiting list has reduced by 25% in 12 months .

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...

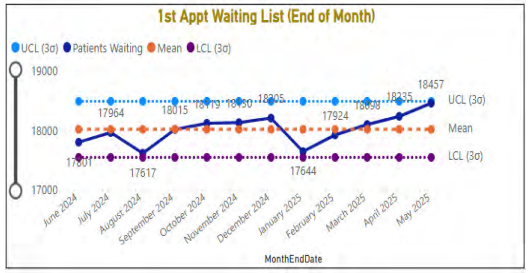
Chris Abbott

Integrated Quality and Performance Report

Month 02 - 25/26

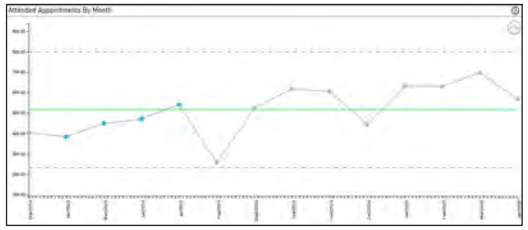
Metric	Waiting List Management (Continued)	SRO	Chris Abbott	Target	4-wk & 18-Wk	Measure	

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

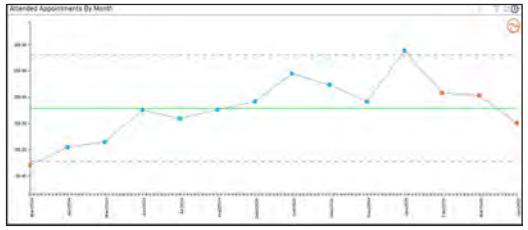


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

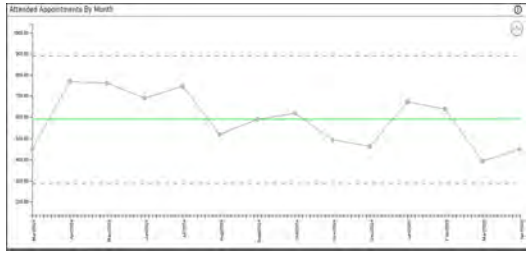
Trauma



Autism Assessment



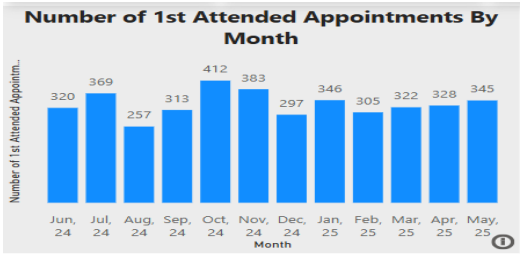
Adult Gender Identity Clinic (GIC)



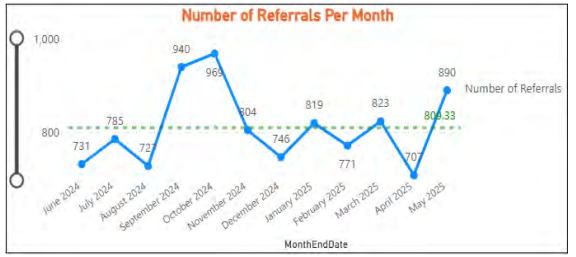
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

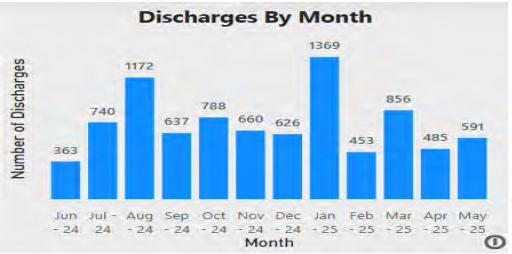
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource allocation but also contributes to longer waiting times for patients awaiting assessment and treatment.	**Increased Demand:** There has been a significant increase in the number of referrals and a focus on delivering first assessments. **MDT Process** - Inefficient clinical review process in MDT that rely on clinician's presenting patients they wish to rather than an iterative review process for all patients. **PTL** - Manual process for enacting PTL function which results in delays in data flow and proactive review of dormant cases	**Ratio of 1st Assessment vs Treatment** – Units and teams to agree the ratio of first appointment vs treatment and discharge they are to complete per reporting period.by **Jan25.** 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 **July2025** **Waiting Times form Implementation –** Waiting times form mobilisation to ensure that all first and internal wait are captured accurately – **June25**	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) – **July25** **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 **Jan25**) – The QI Lead for NHSE will commence pathway mapping from **June25-July25** 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 – **July25**	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

Excellence | Inclusivity | Compassion

Integrated Quality and Performance Report — Month 02 – 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

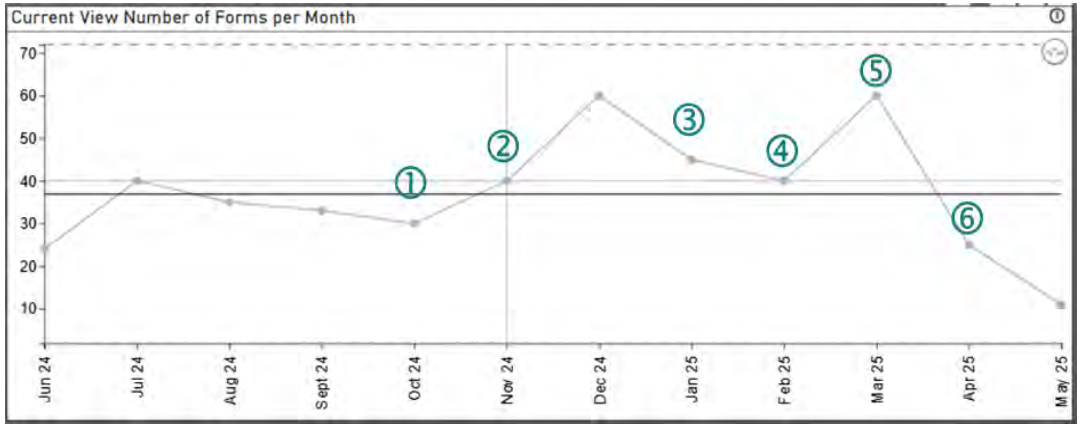
See slide 2 for historical performance on SPC Charts for each measure. Work taking place to ensure inclusion of a new compliance dashboard to monitor NHSE waiting time compliance with Goal 1.

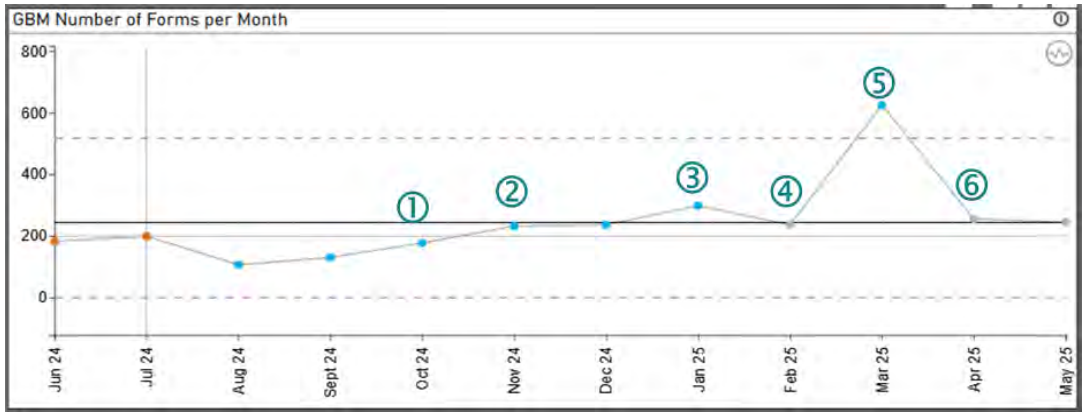
Vision & Goals

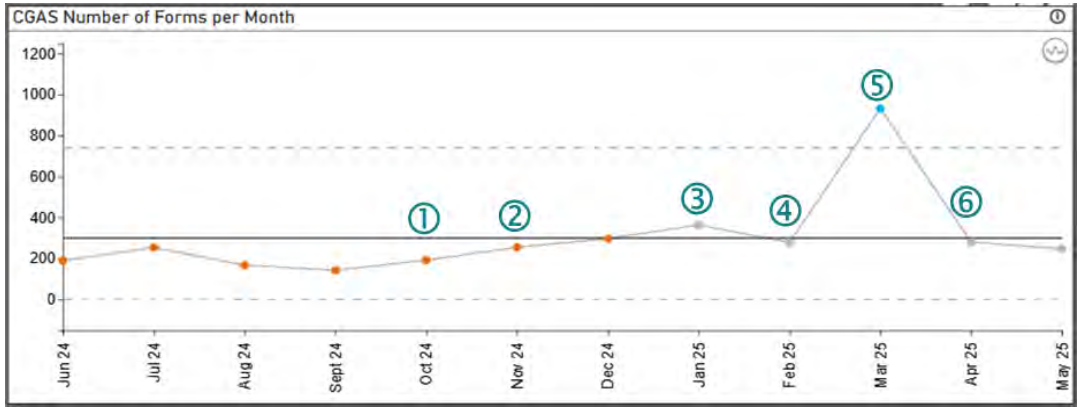
Vision: OMs are routinely, reliably, and meaningfully used across all services to support patient care, inform clinical conversations, drive service improvements, and reduce health inequalities. Outcome measures are seen as a clinically valuable, routine component of personalised care planning and shared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

G1: At least one mandated OM to be completed at 90% of 1st attends 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

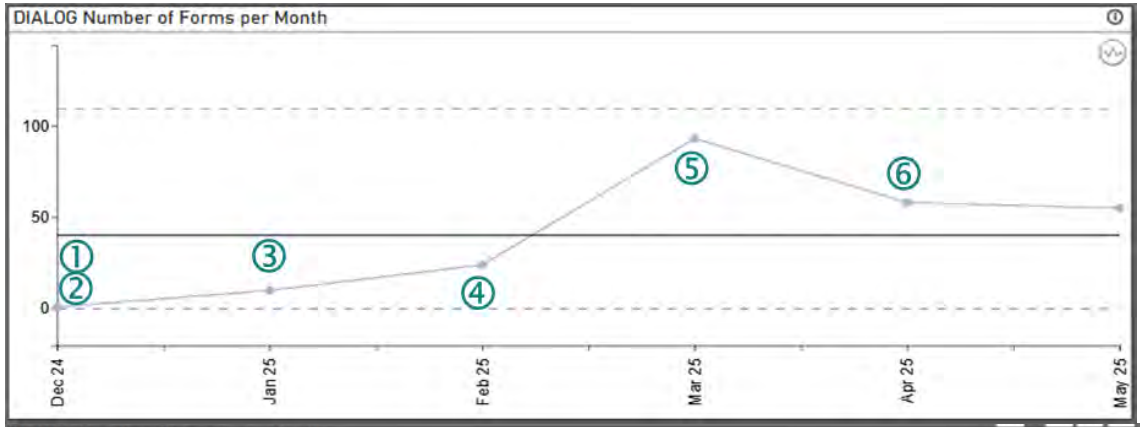
Concern	Causes	Countermeasures	Primary
Integration: OM not fully embedded into clinical workflows or care pathways	1. OM not hard-wired into care plans, reviews, or SOPs 2. OM completion is external to core clinical conversation 3. OM data collected but not routinely acted upon 4. OM results not routinely fed back to patients	1. Liaison with NCL leads to standardize improvement rates / thresholds **(Requires Action)** 2. Embed OM into care plans, templates, and appointment SOPs **(Planned for Q3)** 3. Establish mandated OM agenda item + Standard Work in MDT and supervision **(In Dev)** 4. Pilot OM-informed care planning in one service **(Requires Informatics Dev First)**	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 **(Requires Action)** 2. Develop training focused on clinical conversations **(Planned for Q2)** 3. Peer-led MDT case studies using OM in shared decision-making **(Planned for Q3)** 4. Celebrate positive OM compliance and feedback in CG meetings **(Ongoing)** 5. Targeted support for teams with low compliance **(Ongoing)** 6. GIC measure, logic and process agreed and planned **(Progressing)**	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 (MHSDS) 3. Old OM's and logic in Carenotes cause confusion	1. New dashboard launched and promoted in Clin. Gov meetings **(testing new approach)** 2. Co-design further simplified dashboards for key roles **(Requires Informatics Dev First)** 3. Train and coach teams on use of clinical dashboard **(In Dev + Deliver from August)** 4. Install data walls to communicate OM insights in physical and digital areas **(Planned Q3)**	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 and redesign	1. Build OM equity dashboards to support demographic analysis **(Requires Informatics Dev)** 2. Present OM trends in all Clin. Gov, 'All Staff' and QI forums **(Requires Informatics Dev)** 3. Link OM insights to local QI cycles **(Requires Informatics Dev)** 4. Use OM data to inform service reviews and business cases **(Requires Informatics Dev)**	Clinical Services QI + PCREF

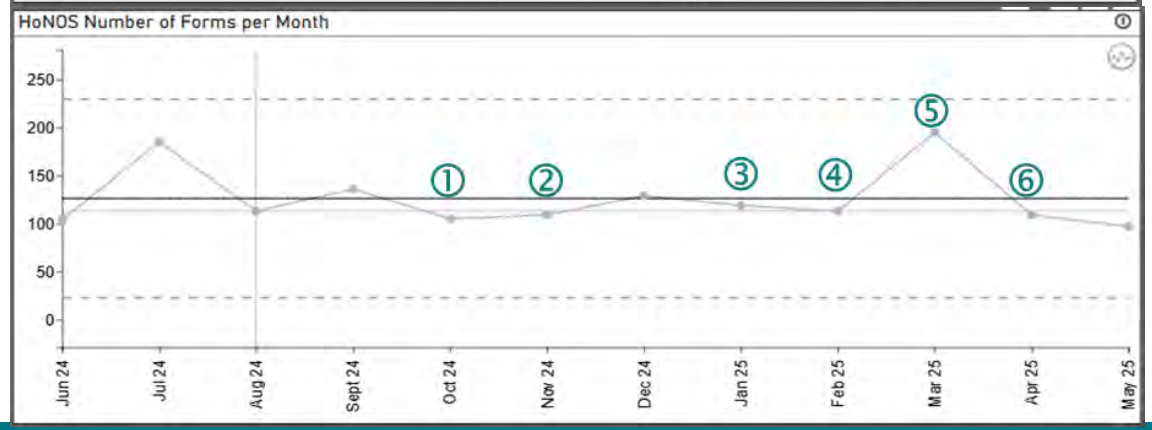






Legend	Countermeasure	Legend	Countermeasure
①	Clinical Governance Presentations	④	All Carenotes changes complete
②	Trust-wide training delivered	⑤	Unit level follow up with clinicians
③	Unit level training delivered	⑥	Clinical Dashboard go-live





Integrated Quality and Performance Report

Month 02 - 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

Service user feedback volumes remain low, averaging <100 forms per month, limiting our ability to understand and act on experiences. Current barriers include the accessibility of the form and process for providing feedback, visibility of feedback mechanisms, the perceived value of giving feedback among service users, and inconsistent staff engagement in encouraging feedback. Addressing these systemic issues is essential to building a more representative and actionable feedback culture.

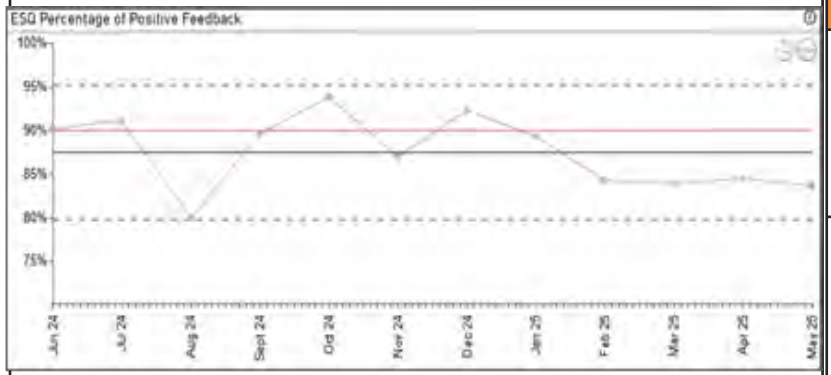
Vision & Goals

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

G1: Number of ESQ forms collected to consistently exceed 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	Causes	Countermeasure in progress
Inaccessibility of the form / process may deter completion for some service users	• Visibility of signs • Question wording • Language barriers • Readability	1. Conduct service user Gemba walks to test signage visibility 2. Establish quarterly cycles of updates to the accessibility / content of the ESQ form 3. Explore question of optional anonymity for completion (where anonymity may deter completion) 4. Review 'negative' question to make it easier for 'negative feedback' to be submitted + heard 5. Explore potential for multi-lingual forms 6. Explore accessibility for neuro cohort with service users
Opportunities to gather feedback are not yet maximised	• Management visibility of 'letters' • Lack of SMS prompts • Staff not currently involved in collection	1. Continue to expand the percentage of patient correspondence containing standardised footer 2. Establish SMS messages going out to all patients following their 1st and Discharge appointments + every 3 months during being open to a Service 3. Introduce Feedback / QR cards for use by clinicians in sessions 4. Introduce SOP / mini-training to enable staff to gather feedback over the phone 5. Pilot iPad in reception for easy form collection 6. PPI targeted support team meeting visits to confirm action
Patients might not understand the value in submitting their feedback, limiting motivation to do so	• No consistent messaging to patients • Requests not tailored based on care stage	1. More prominent posters in waiting areas + improved signage for paper forms / boxes 2. Publicise recent feedback themes and achievements 3. Establish messaging tailored to the treatment stage to increase patient motivation to feedback: a. Create a 'Patient Feedback Flyer' for inclusion with referral acceptance letters b. Within a week of 1st and final appointments send SMS specific to starting / ending care
Staff might not recognise the value of gathering and utilising feedback	• No ESQ dashboard • Lack of local ownership • No process for monitoring utilisation of feedback • No formal QI connection	1. Launch ESQ Dashboard to make feedback data available to all staff 2. Redesign the monthly communication to managers regarding feedback data 3. Establish named 'Patient Feedback Champions' in each Team 4. Request 'Patient Feedback' be added as a standing item on all Team Meeting agendas 5. Rollout new 'feedback utilisation' tracker slide to all services to routinely confirm ownership of responsibility to act on feedback with services and to monitor compliance 6. Flow all feedback to QI Team / Forums, Business Development Team 7. Establish a very brief, regular 'Patient Feedback Headlines' item in All Staff Meetings

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)	
	WDES Metrics based on NHS Staff Survey Indicators (Organisational Culture)	2023-24	2024-25
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	2023 - 2024 White	2023 - 2024 Ethnic Minorities	2024 – 2025 Org Overall	2024 – 2025 White	2024 – 2025 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%	26.5%	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)

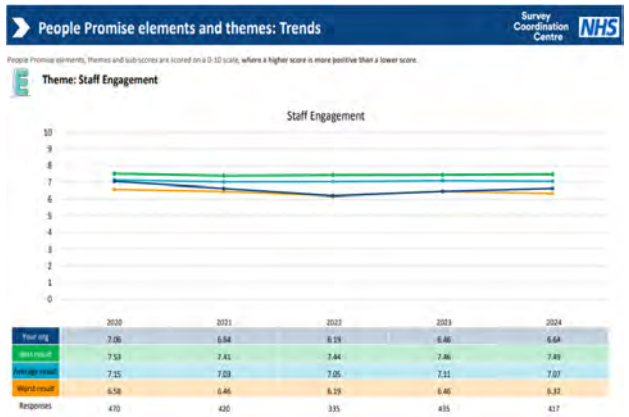
- The pay gap in the average hourly rate reported for 24/25 has improved by 2.46%
- We have introduced a number of improvements in the recruitment process to make it fairer, and more transparent, and we are introducing interventions to make it more accessible
- The EDI Programme Board has streamlined our EDI priorities, and we are working on tangible metrics
- EDI considerations are routinely given more consideration during IQPR

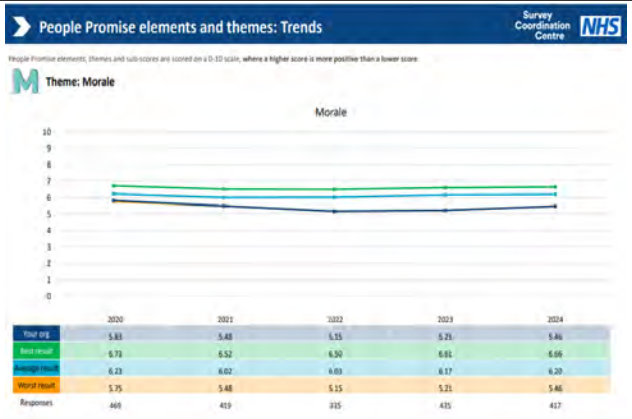
Integrated Quality and Performance Report

Month 02 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.





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%

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 (we achieved over 120 in total!)

Root Cause/ Gap Analysis

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

Progress on Improvements

- Behaviours implemented
- CPD panels running
- Resolution policy to be ratified at PAG 18 June
- Staff awards event booked for 26 June
- Succession planning to be discussed at ELT, SLF, POD EDI and Board
- A3s on appraisal and stat/mandatory training compliance

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

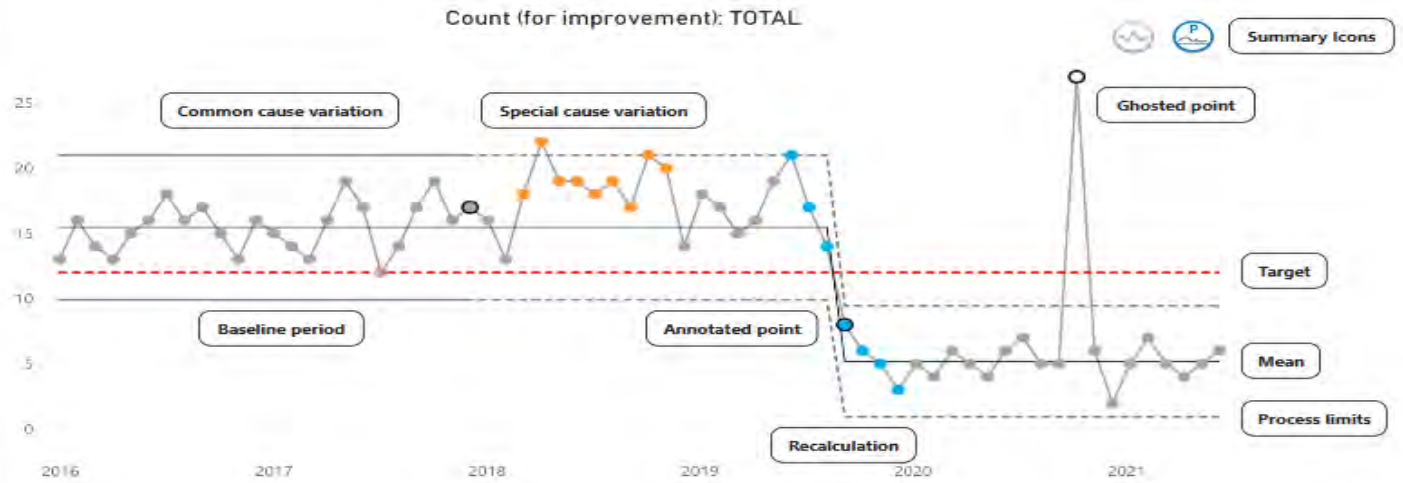
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

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.

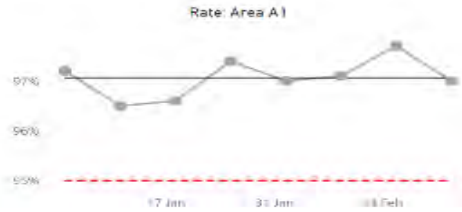
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on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

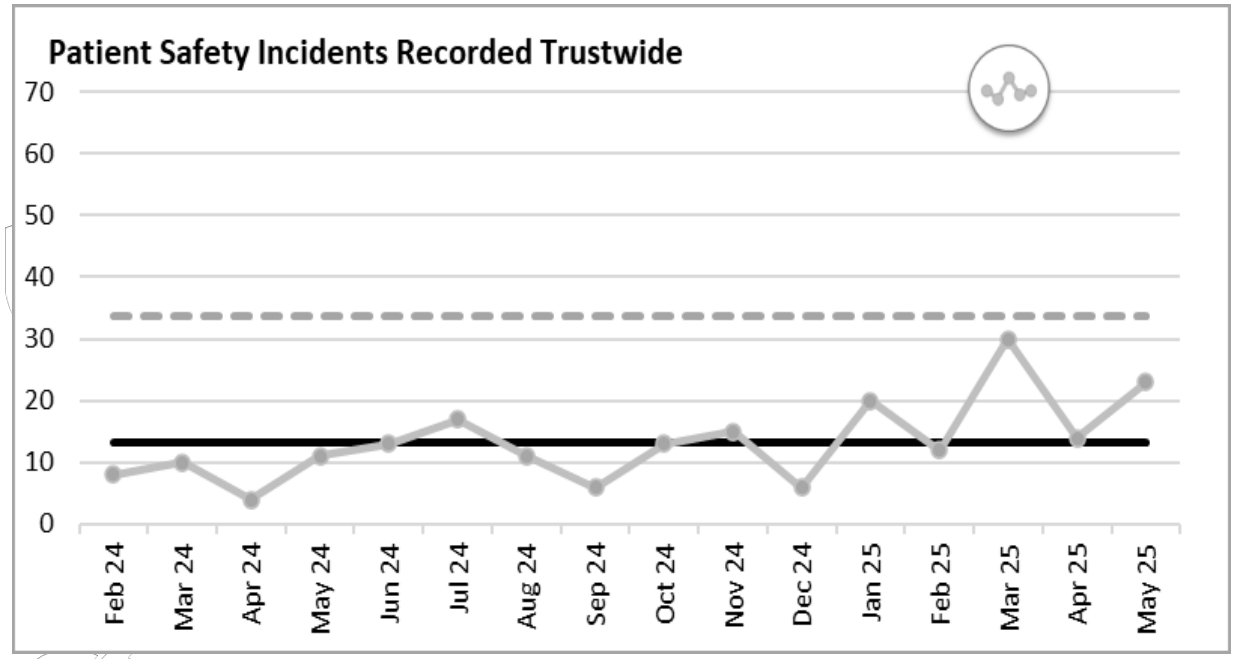
The Tavistock and Portman NHS Foundation Trust

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? – Trust-wide



The Tavistock and Portman NHS Foundation Trust

Patient Safety Incidents

A total of 23 patient safety incidents were reported Trust-wide in May: Camden – 3, Child & Family – 12, and Adult Services – 8. Of these, five deaths were recorded, all of which occurred within the Adult Unit.

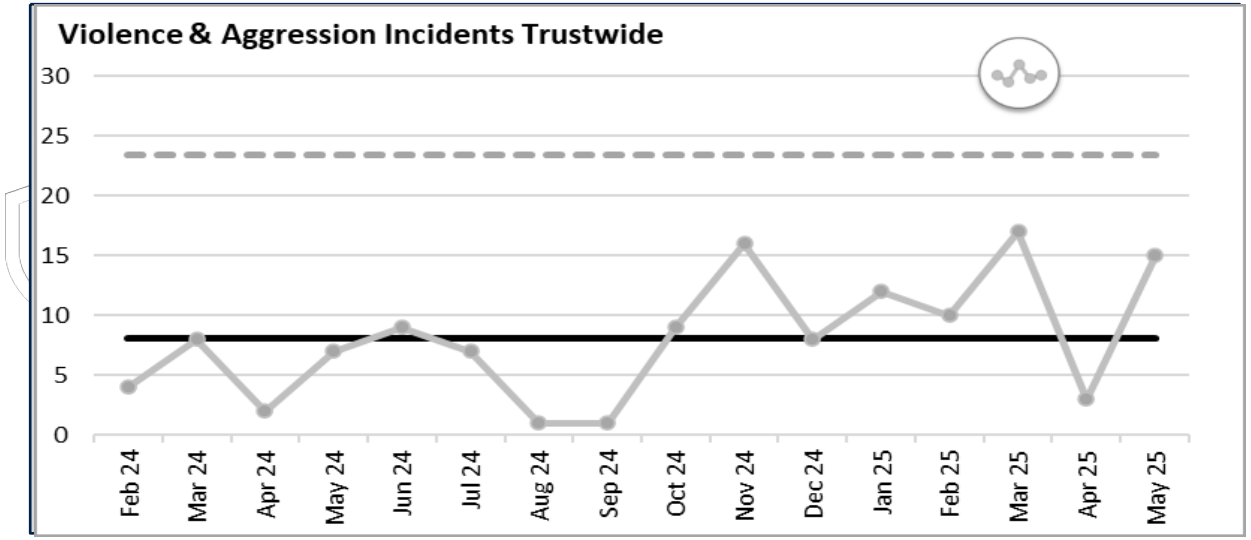
Urgent mortality reviews have been requested for four of these deaths, where the individuals had been seen within the service. The death reported in relation to a patient on the GIC waiting list has been added to the mortality review tracker for completion in line with current processes.

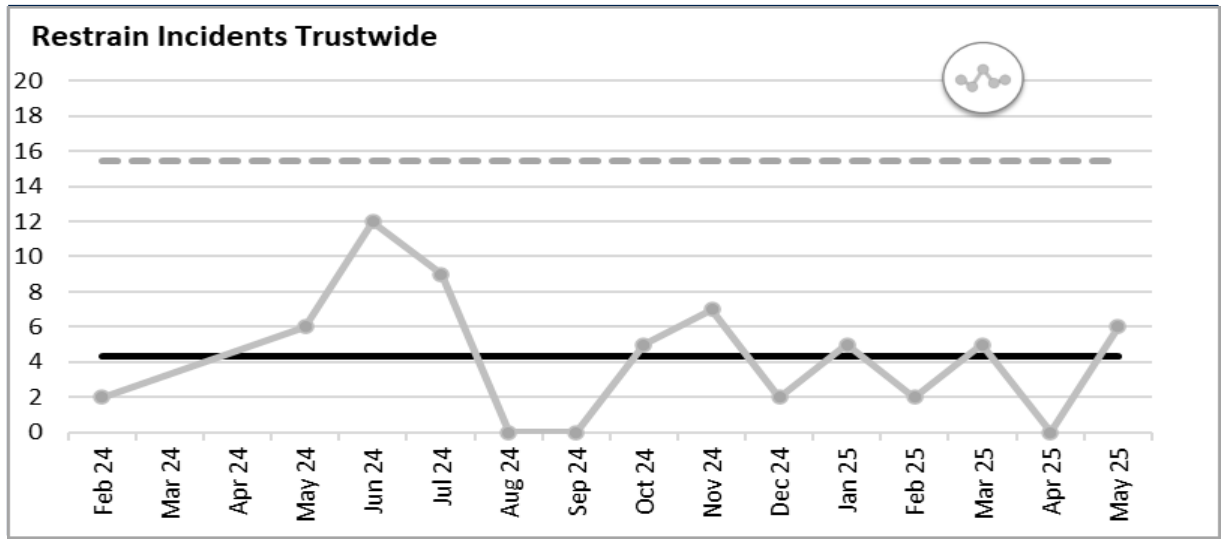
An overview of the remaining patient safety incidents includes reports of violence and aggression at Gloucester House, where there has been 6 incidents where restrictive practices has been used in response to challenging behaviour. Additional incidents included information governance breaches within the GIC, as well as a report from CAISS relating to deliberate self-harm that occurred at home.

In addition to the mortality reviews initiated as part of the learning response process, two After Action Reviews (AARs) have been confirmed, both concerning incidents of violence and aggression at Gloucester House. One involved pupils becoming physically aggressive towards staff and barricading doors to restrict access to rooms within the school. The other related to a report of one pupil pushing another down the stairs.

Currently, there are five AARs pending or outstanding. Progress is being tracked via the AAR tracker, and review dates have been scheduled accordingly. Findings and key learning points from all reviews will be discussed at the Clinical Incident and Safety Group (CISG). Learning will then be cascaded and incorporated into the relevant Unit Clinical Governance meetings to support ongoing improvements in practice.

Are We Safe? – Trust-wide





Violence & Aggression Incidents

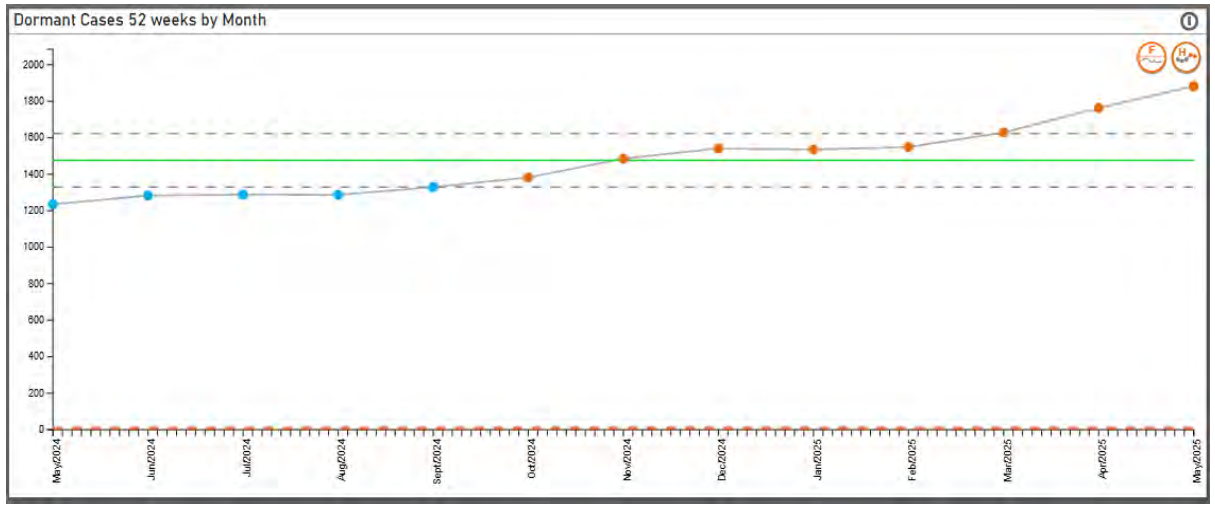
A total of 11 incidents relating to violence and aggression were reported at Gloucester House during May. Of these, six required the use of restrictive practices in response to challenging behaviour exhibited by pupils. Following return from half term, this number falls within the expected range of normal variation.

All incidents were triaged by the Patient Safety Team. Two of the incidents have been confirmed for After Action Reviews to facilitate further learning, while the remaining incidents have been triaged for Manager Reviews.

Incidents Involving Use of Restrictive Practice

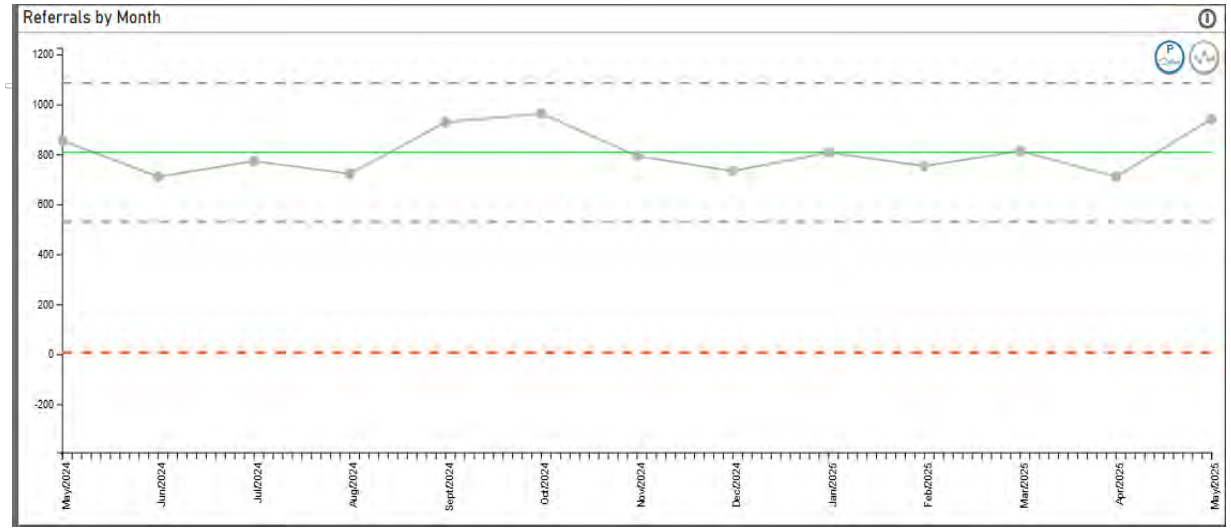
Restrictive practices were used in six incidents at Gloucester House in response to challenging behaviour, including episodes of violence, aggression, and absconding, in order to ensure the safety of pupils. By way of overview, behaviour includes violence to staff and damage to property following dysregulation.

Are We Effective? – Trust-wide



52+ Week Dormant Cases
Camden, Child and Family (excluding Autism assessment) and Portman reporting either 0 or < 10 dormant cases.

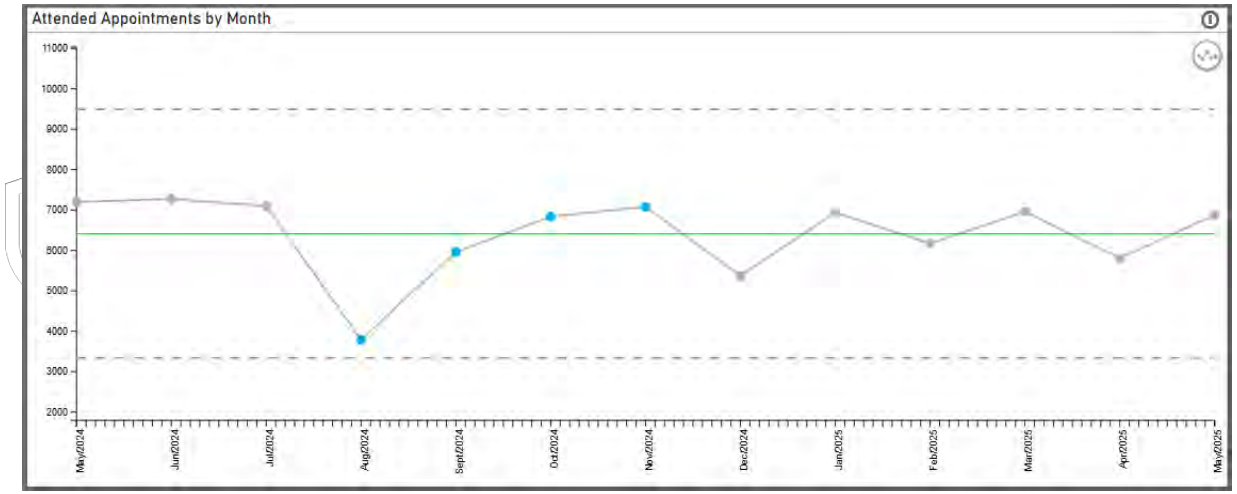
GIC and **Trauma** continue to have long waits for treatment due to demand being higher than capacity. A focus on discharging dormant cases takes place in PTL meetings; although for GIC it is acknowledge that the surgical pathway prevents discharge from GIC until surgery is complete. The Trust is working with NHSE on this pathway.



Number of Referrals (Including Rejections)

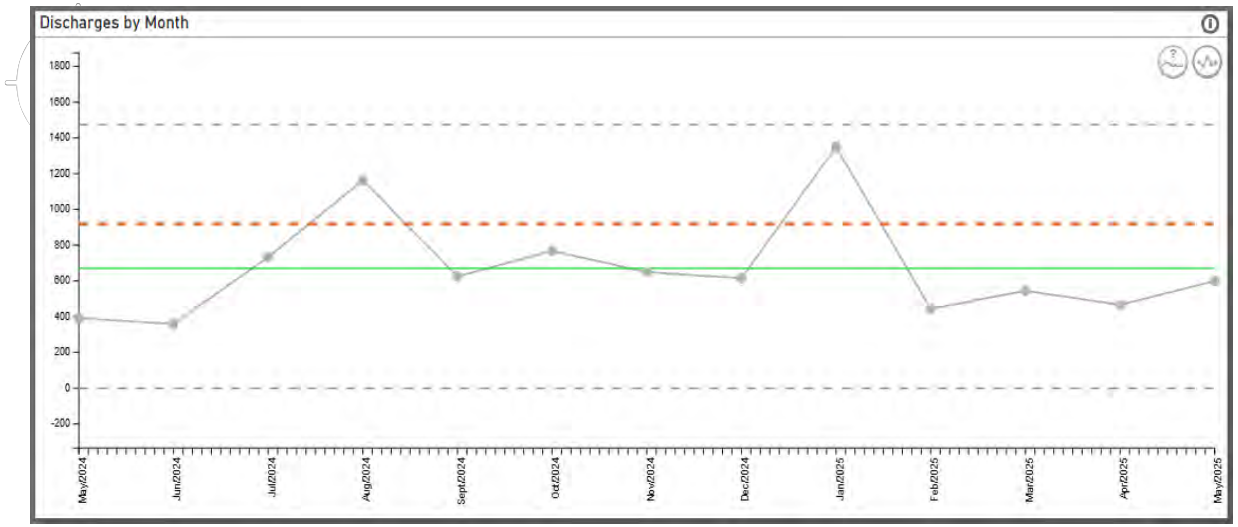
There has been an upward shift in referrals this month, placing the volume approximately halfway between the median and the upper control limit on the control chart. The impact on RTT is described in the unit level narrative.

Are We Effective? – Trust-wide



Number of Attendances

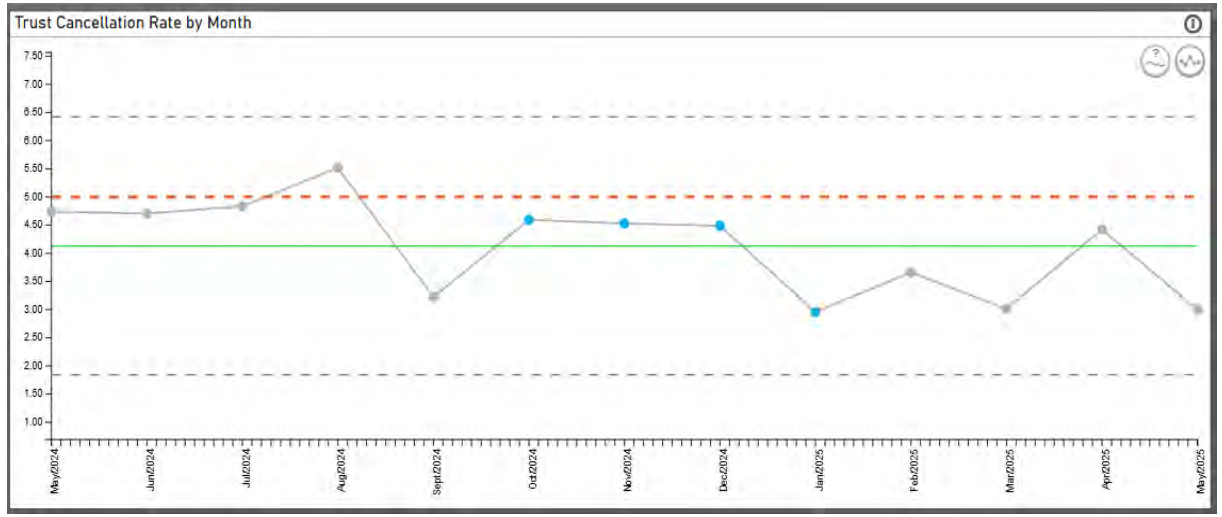
The overall number of attendances this month is in line with expectations, above the median but below the upper control limit.



Number of Discharges

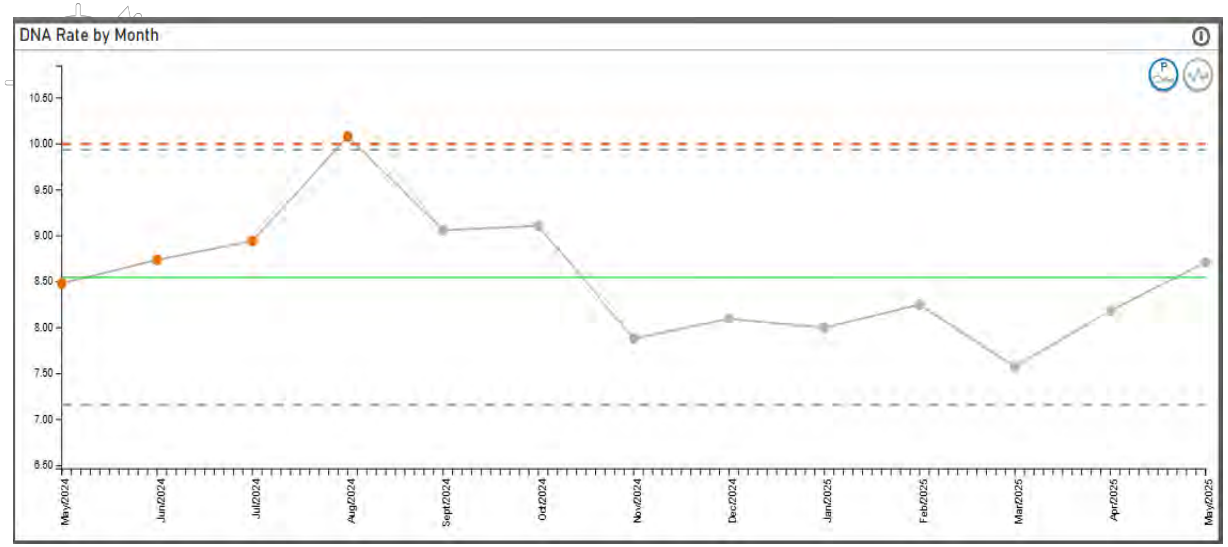
The number of discharges is higher than April 2024, however this does not have a significant impact on the waiting list and dormant cases as currently referrals are outstripping the number of patients discharged. Additional analysis is underway for GIC as part o the national QI work.

Are We Effective? –Trust-wide



% of Trust-Led Cancellations

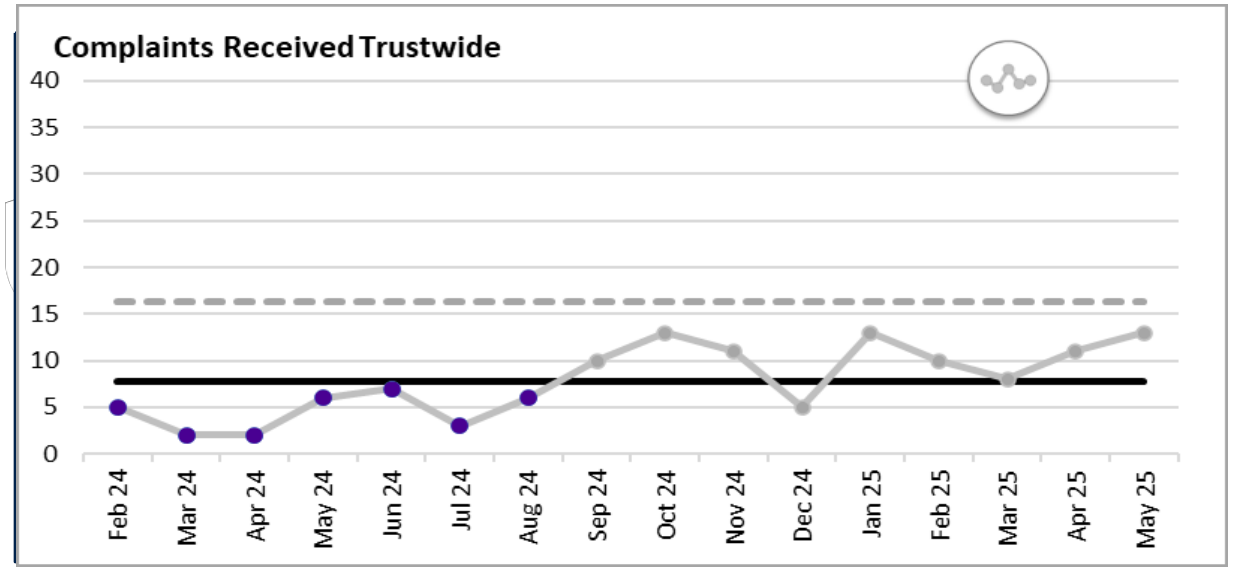
The Trust reports an average of 3% Trust-led cancellations, below the upper limit of 10%, however the figure is higher within some teams. The Unit clinical and operational leads have been asked to review their cancellations against their sickness management, wellbeing and job plans with view to reducing cancellations by Trust in teams affected.

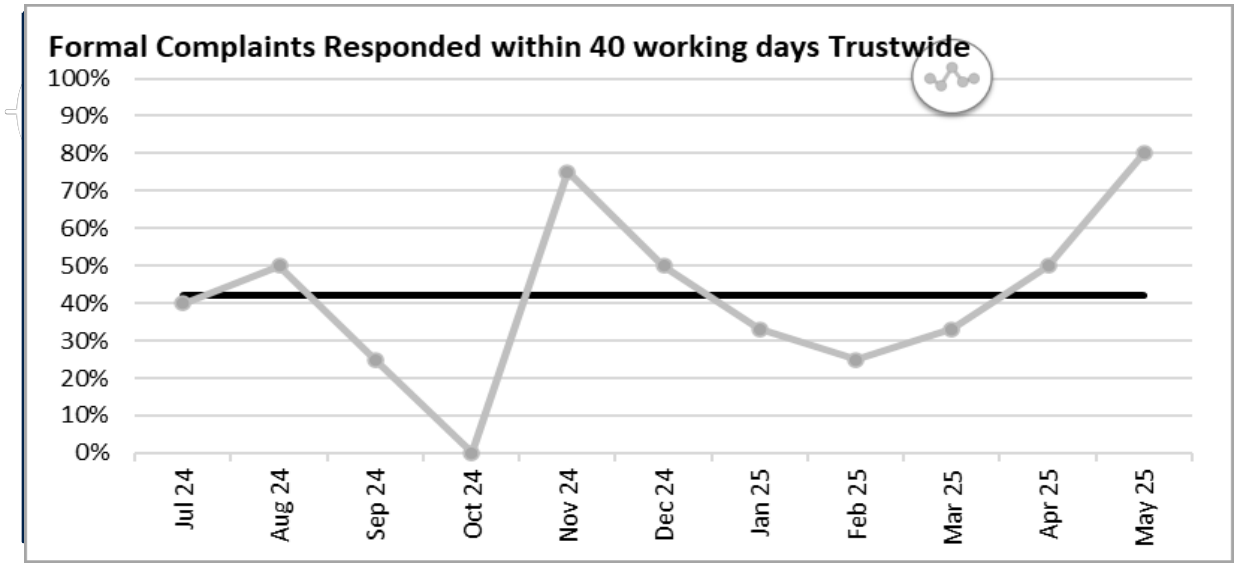


% of DNAs

The Trust's DNA rate remains below 10%. Of note last month's DNA in the Returning Families was 35% and has now reduced to 6.67%.

Are We Caring? - Trustwide





Number of Formal Complaints Received

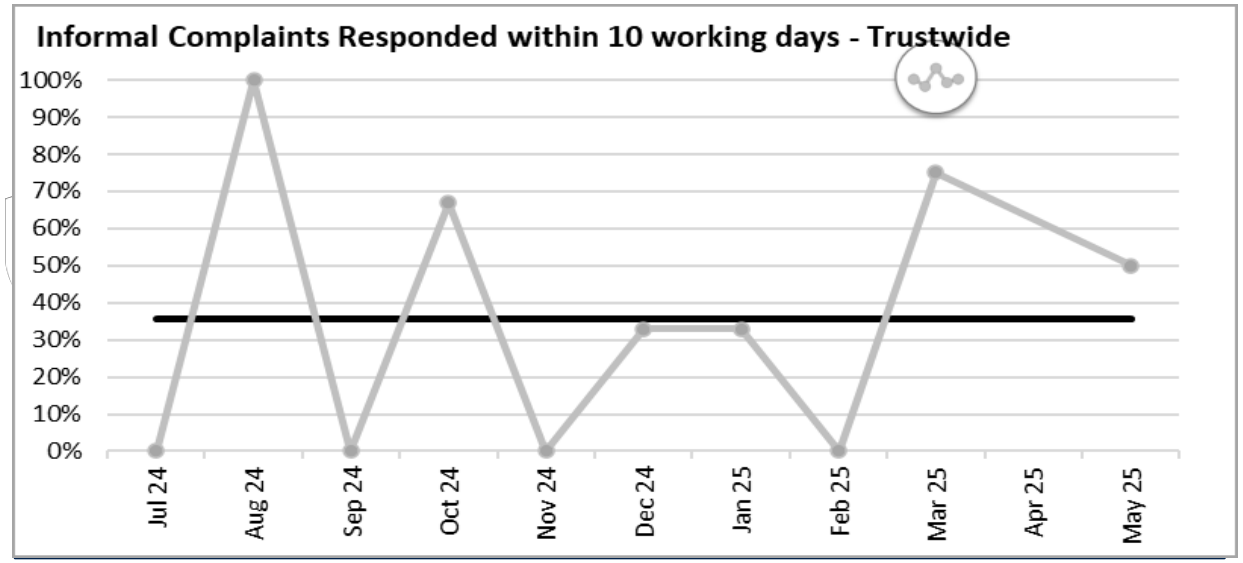
A total of 13 complaint contacts were received Trust-wide in May. Of this number, 11 were received for the Adult Unit and 2 were received for CYP and Family Unit. Complaints in the subject area category of 'Access to treatment or drugs' recorded the highest number (7), followed by 'Communications' (5) and 'Privacy, dignity and wellbeing' (1). 10 of the 13 complaint contacts received in May were acknowledged within 3 working days in line with national regulations. Late acknowledgements were due to human error and delay in forwarding a complaint to the Complaints team.
2 quality alerts and 1 MP enquiry were also received in May 2025 (not included in the numbers above).

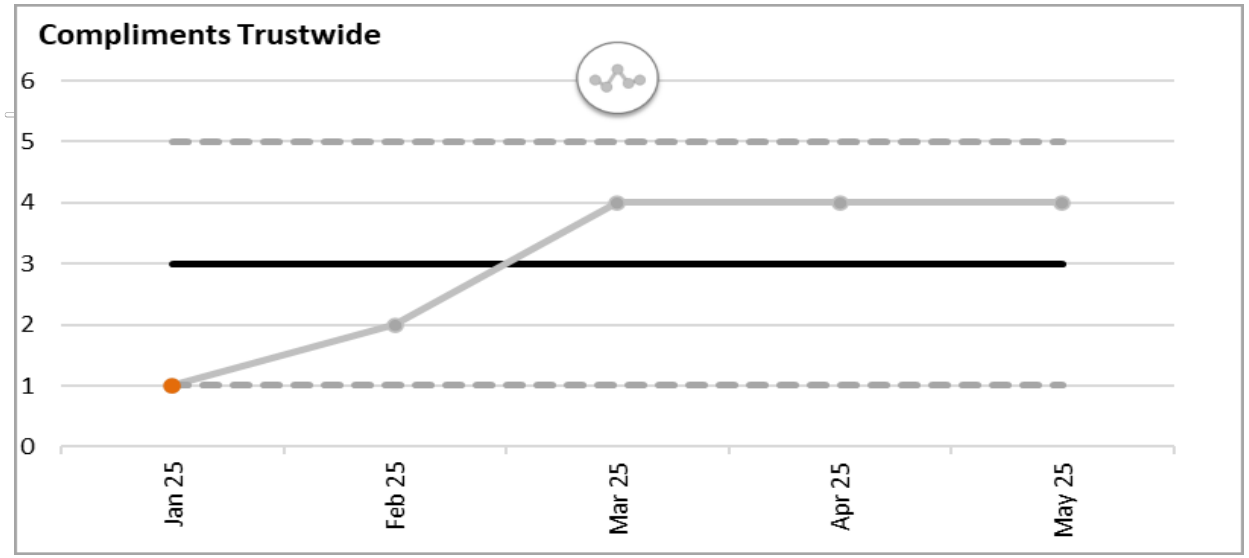
Formal complaints response time compliance

Trust wide compliance for formal complaints responded to within 40 working days for May is 80% reflecting that 5 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? – Trust-wide





Informal Complaints (Local Resolution)

The Trust aims to respond to all complaints informally whenever possible, enabling an earlier resolution for patients. 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 may be higher, the percentages depicted in the chart represent the percentage resolved within the specified period of 10 days e.g. in May 2025, 4 complaints were resolved informally, of which 2 were resolved in 10 working days. This chart reports on Radar data only and therefore the graph will be expanded as more data points become available.

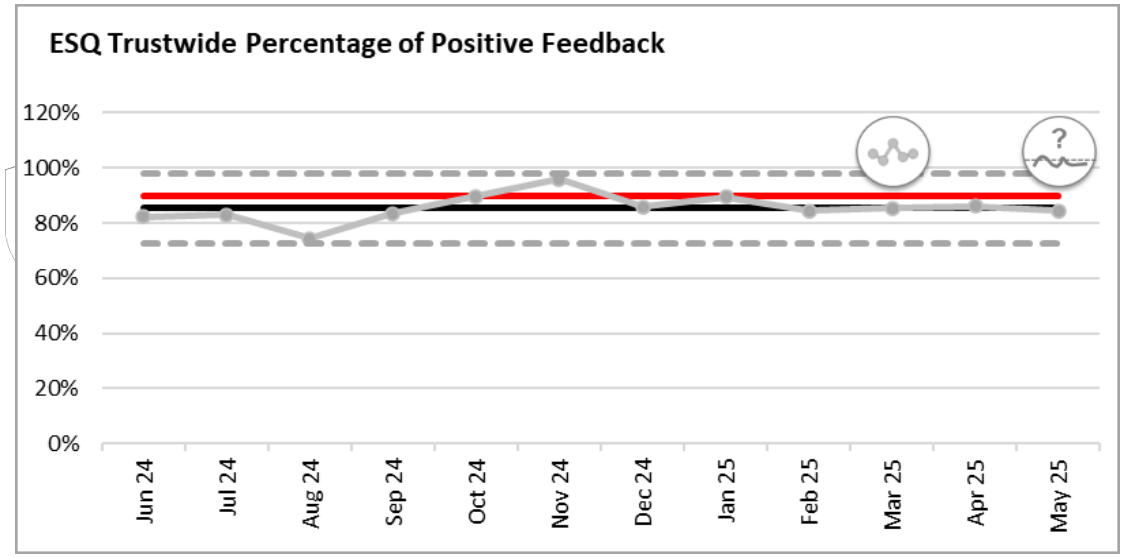
Number of Compliments Received

The Trust received 4 compliments reported via Radar, one for Camden Unit, one for CYP and Family Unit and two for the Adult Unit. The Trust continues to raise awareness of the process on how to record compliments within the teams.

The compliments are categorised using the KO41a system (to match complaint categories) to enable comparison with themes between ESQs and complaints. In May three compliments were under the category 'Patient Care' and one under 'Appointments'.

This metric became live on Radar in January 2025 therefore data is only available since then.

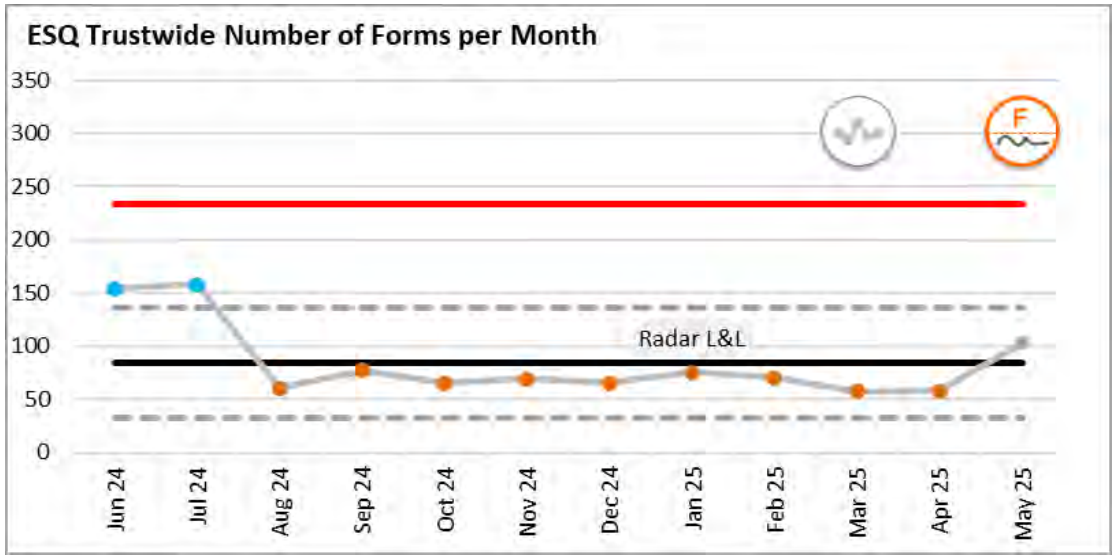
Are We Caring? – Trust-wide



ESQPositive Responses %

The Trust-wide target for ESQ positive responses was not achieved in May 2025. Themes from qualitative feedback indicate that communication is an areas that many of our patients report dissatisfaction on. This triangulates with complaint categories. The Service User Experience Group has requested further detail behind this triangulation.

Positive comments received via the ESQ forms include themes linked to the Trust values.

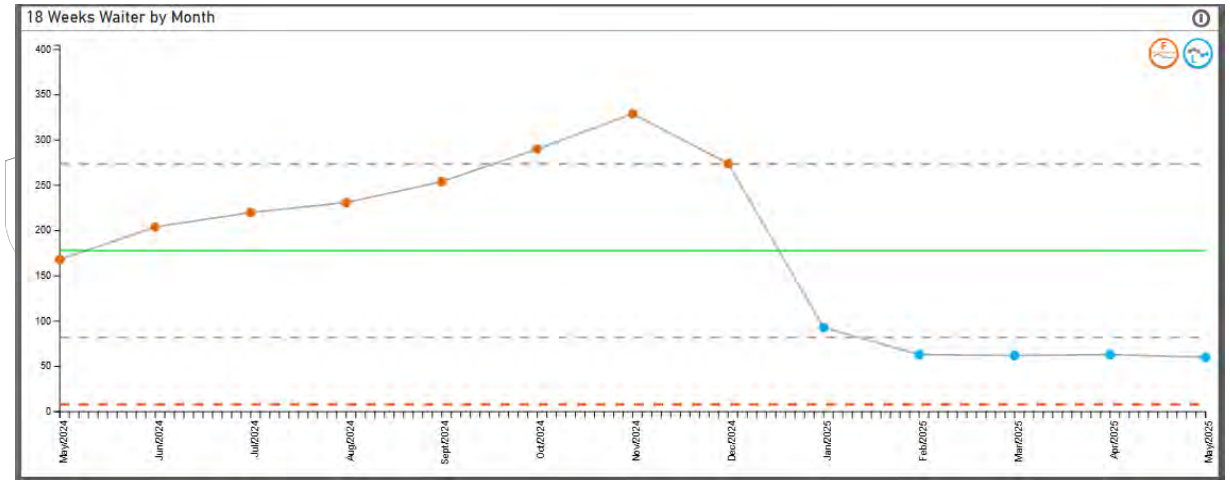


ESQNumber of Forms per Month

The number of forms collected across the Trust in May rose to above 100. This is below the Trust target however a notable increase on previous months. This increase is thought to be attributable to the PPI team joining reception areas to proactively approach patients to provide us with feedback. This has shown that human interaction of requesting feedback in person is effective and important.

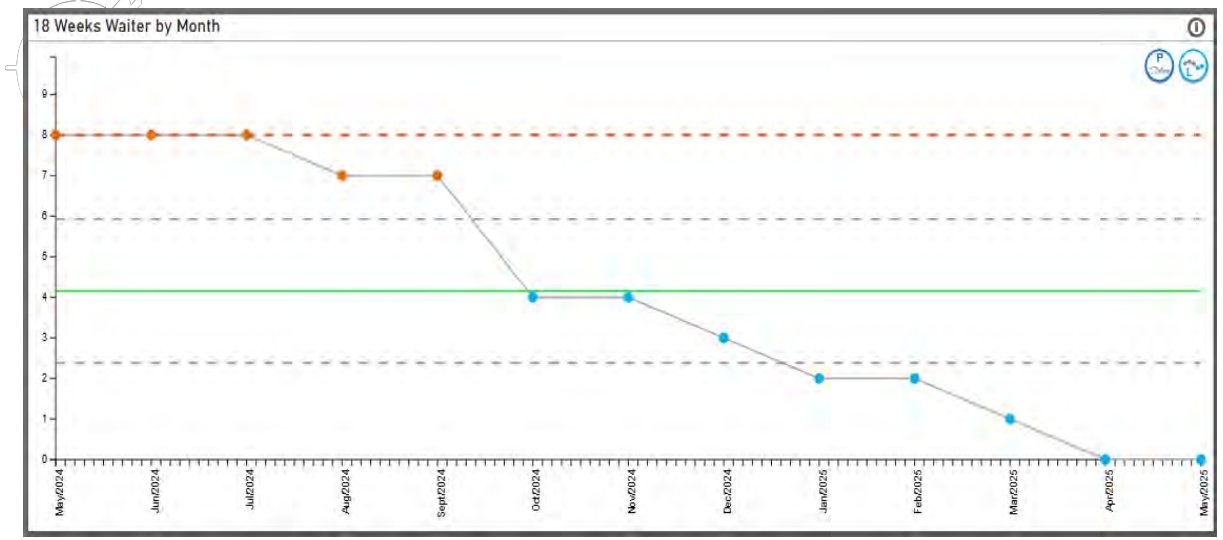
There is continued targeted support being offered to teams where no forms are collected to develop targeted actions to increase engagement. In addition, text reminders with URL link will be sent out at regular periods.

Are We Responsive? – Trust-wide



18 Week RTT Breaches Excluding ASC/GIC/Trauma

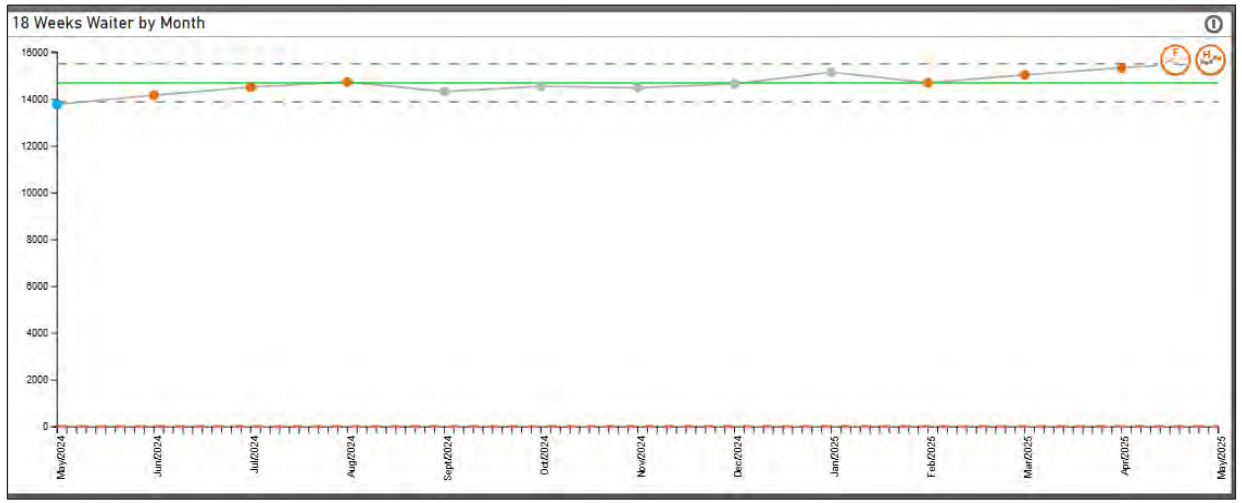
The waiting times for the Adult Psychotherapy team continues to improve and have consistently averaged 4 weeks since February 2024. Child and Family Unit is reporting 10 cases breaching at 18 weeks. 7 cases are at Gloucester House School and are a result of recording processes. 2 are cases that are in Clinical intake that is being investigated, and an incident has been raised. In Camden there is a planned A3 in relation to the clinical intake team and is now being implemented. The majority of cases have not waited more than 4 weeks.

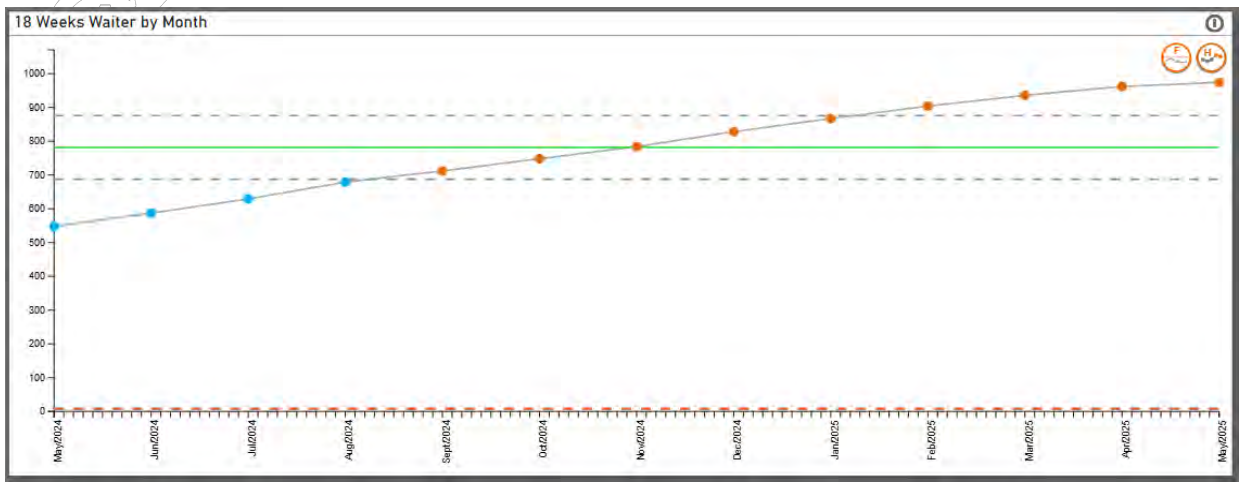


18 Week RTT Breaches Autism Assessment (1st Appointment)

First appointment waits have stabilised at 7.27 weeks in CYP services except Autism. However, they remain high in Adults units.

Are We Responsive? –Trust-wide





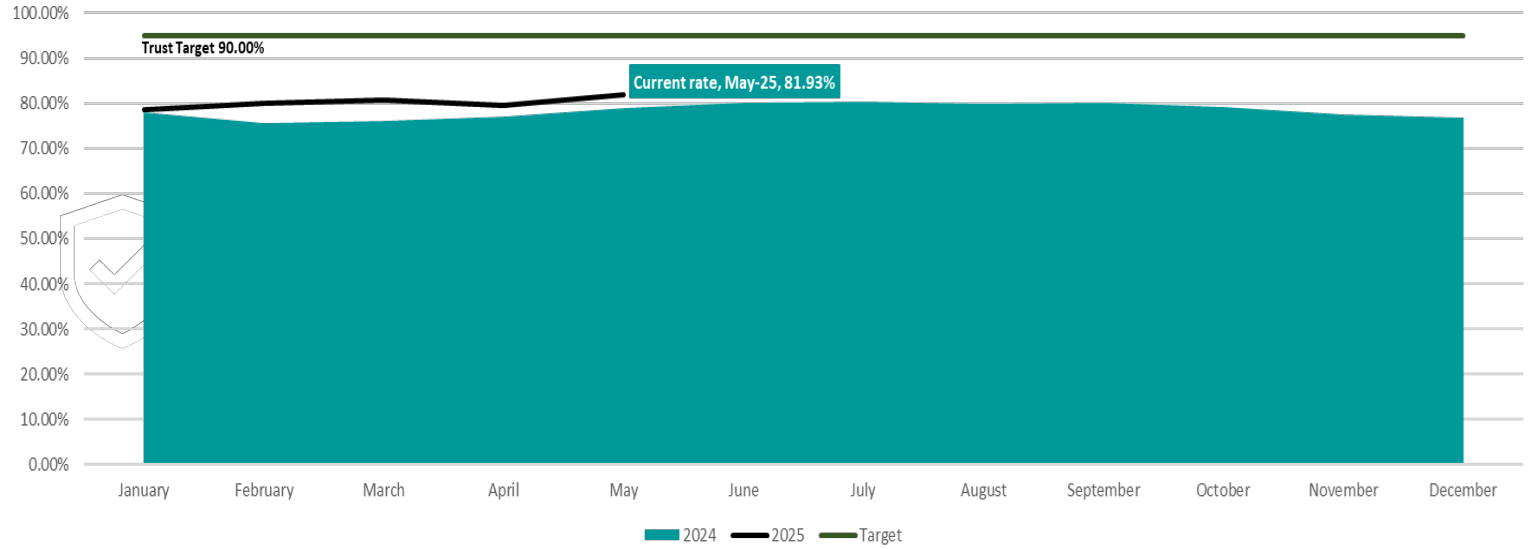
18 Week RTT Breaches GIC (1st Appointment)

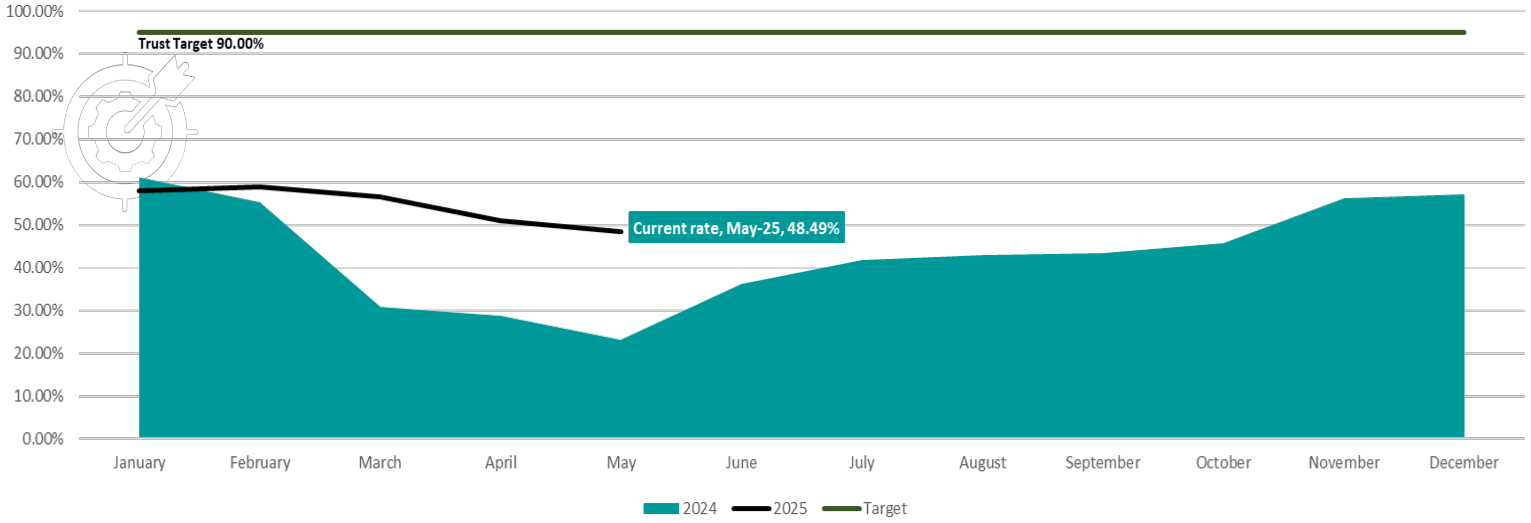
There were 79 first appointments attended in May. This is the highest number of attended appointment since October 24. However, with 351 new referrals per month the waiting list continued to grow. The team has recruitment plans which have been delayed due to the financial planning requirements in the trust however 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)

There are just over 1,000 patients are waiting to be offered a first appointment. The current wait for first appointment is 117 weeks, however there is month by month variability. The team continue to be supported under Targeted support to achieve this outcome.

Are We Well-Led? –Trust-wide





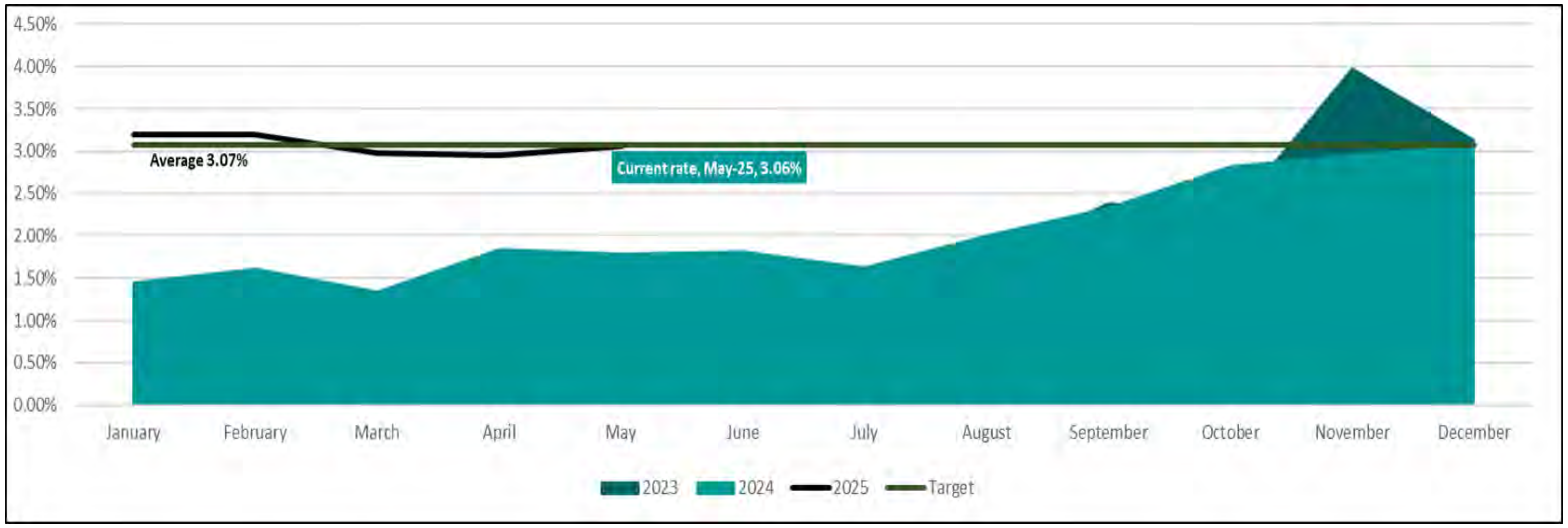
Mandatory & Statutory Training (Combined)

Directorate May-25	Compliance %
Chief Executive Officer	91.43%
Chief Strategy & Business Development	90.36%
Chief Financial Officer	89.62%
Chief Education and Training Officer	86.88%
Chief Medical Officer	83.33%
Chief Nursing Officer	81.88%
Chief Clinical Operating Officer	80.93%
Chief People Officer (Includes Bank)	55.60%

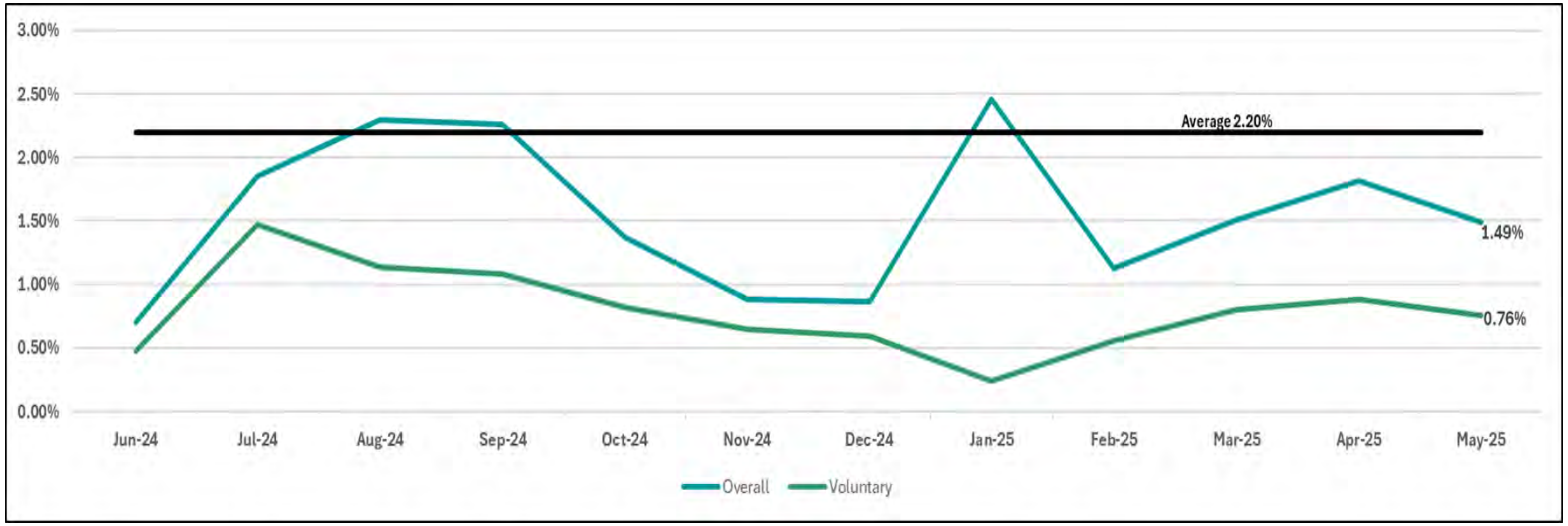
Appraisal Completion (Combined)

Directorate May-25	Reviews Completed %
Chief Nursing Officer	82.35%
Chief People Officer	66.67%
Chief Financial Officer	52.83%
Chief Education and Training Officer	52.07%
Chief Clinical Operating Officer	45.39%
Chief Executive Officer	30.77%
Chief Medical Officer	28.57%
Chief Strategy & Business Development	22.22%

Are We Well-Led? – Trust-wide



Staff Sickness (Combined)



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. There is a decrease from the past four months and shows an 8.13% decrease ending May 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 82.35%, Chief People taking second place 66.67%. The Chief Strategy and Business Development directorate hold the lowest at the end of May-25 with 22.22% of appraisals carried out. Seven out of eight directorates do not currently hold a high standard.	**% Appraisal completion** **48.49%**
As a Trust, our current sickness absence rate is below the average benchmark of 3.07% by 0.01%. However, this month we have seen an increase over the average continuing the trend that we have had in 24/25. 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 June 2024 to May 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** **3.06%**
There has been an increase - 81.93% a 2.33% increase ending May 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 (%)** **81.93%**

Contracts and Finance

Delivering our vision – How are we doing?

Finance & CIPS Delivery

Effective use of resources

The Tavistock and Portman NHS Foundation Trust

Financial Plan 25/26

Income & expenditure summary	Plan	Forecast	Variance	
	£000s	£000s	£000s	%
Operating income	61,125	61,125	0	0.0%
Agency pay	(350)	(350)	0	0.0%
All other employee expenses	(48,582)	(48,582)	0	0.0%
Operating non pay	(11,977)	(11,977)	0	0.0%
Total operating surplus / (deficit)	**216**	**216**	**0**	**0.0%**
Non operating items	(216)	(216)	0	0.0%
Surplus/(deficit) for the period/year	**0**	**0**	**0**	**0.0%**

Efficiency summary	Plan	Forecast	Variance	
	£000s	£000s	£000s	%
Pay	2,405	2,405	0	
Non pay	971	970	(0)	
Income	522	522	0	
Recurrent	398	398	0	
Non recurrent	3,500	3,500	0	
Total efficiencies	**3,898**	**3,898**	**0**	**0.0%**
Recurrent efficiencies as a % of total efficiencies	**10.2%**	**10.2%**	**0.0%**	
Total efficiencies as a percentage of expenditure	**6.0%**	**6.0%**	**0.0%**	

The Trust has set a balanced revenue plan for 2025/26, which includes a requirement to deliver £3.9m in efficiency savings. Work is underway with colleagues to identify and implement plans to support delivery of this target.

25/26 year-end planned position breakeven

YTD 25/26

Income & expenditure summary	Year to date			
	Plan	Actual	Variance	
	£000s	£000s	£000s	%
Operating income	9,495	9,966	471	5.0%
Agency pay	(74)	(60)	14	18.9%
All other employee expenses	(8,490)	(8,665)	(175)	(2.1%)
Operating non pay	(2,020)	(2,431)	(411)	(20.3%)
Total operating surplus / (deficit)	**(1,089)**	**(1,189)**	**(100)**	**(1.1%)**
Non operating items	(36)	(20)	16	44.4%
Surplus/(deficit) for the period/year	**(1,125)**	**(1,209)**	**(84)**	**(0.9%)**

The Trust is £84k behind plan at M2, with a recorded deficit of £1,209k.

The £83k adverse variance is mainly due to timing differences in pay and non-pay costs, partially offset by higher income.

The unfunded element of the pay award remains a recurrent issue for 2025/26.

25/26 M2 actual position £1,209k 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.

Reviewing reporting of IQPR data in relation to PCREF requirements:

- Referral and acceptance data for units
- Restrictive practice data to include ethnicity
- Complaints data to include ethnicity

In development

- Reporting ESQ data to include ethnicity
- Reporting paired outcome measures to include ethnicity
- Detailed Action plan in development

High level PCREF action plan:

Leadership and Governance	Continue to broaden partnerships with community representatives and create a space to engage Map VSC health and wellbeing organisations with a specific focus on global majority communities Improve and strengthen the relationships with the local authority and Voluntary, Community and Social Enterprise (VCSE's) ? Develop a race equity dashboard aligned with the London region template Identify Non - Exceutice Director (NED) lead for PCREF Embedding into patient safety work including complaints - ? Iqpr - report ethinicty
Organsational Competencies	Formalise and clarify PCREF advisory groups role to oversee the implementation of PCREF plan All divisions to undertake a PCREF self assessment - do we want to do? What would this entail - individual areas - alongside? Developmental opportunity Increase access for service users to culturally appropriate advocacy services - PPI to look into Develop how Core 20+5 will be used in the trust - Sheva, Thanda and Chris to look at Develop reporting structures to capture meaningful progress - chris, sheva and thanda Develop cultural competancy for all staff groups - L&D and Sarah mountain Ensure that all trusts procedures have a meaningul EQIA - informed by appropriate published reseach Develop links with community groups - "Go where people are strategy"
DET	In development
Patients and Carers feedback mechanism	Improve and increase the diversity of service users and carers feedback to reflect our communities Develop feedback mechanisms to be stratified by provided ethnicity data Take action on feedback such as considering other locations for clinical work to take place - eg family hubs

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.	• The possibility of a merger with another NHS Trust raises a number of significant risks due to our need to retain OfS registration to honour contractual obligations but having had advice that a merger will force us to de-register. We are in discussion with the OfS and other stakeholders.

Summary

Application Cycle: Current Cycle

The selected application cyle is: 2025/26 This application cycle starts on 10/1/2024 and ends 9/30/2025. We use Year To Date calculation, so we can directly compare this years applications numbers with this time last year. Today is day 267 of the application cycle.

Complete Applications	Conditional Offers	Offers Firmly Accepted	Unconditional Firm	Incomplete 2025/26
777 ✓	392 ✓	266 ✓	158 ✓	957 !
Year to date: 770	Year to date: 313	Year to date: 113	Year to date: 112	Year to date: 1149
1158 Total last cycle	769 Total last cycle	530 Total last cycle	527 Total last cycle	1350 Total last cy...

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

Complete Applications to Date

Month	Year To date	Percentage Change	Last Year (to date)	Last Year total applications
December	70	192% ▲	24	24
January	269	99% ▲	135	135
February	47	-67% ▼	143	143
March	69	-36% ▼	108	108
April	62	-47% ▼	116	116
May	109	0% ▬	109	109
June	132	-1% ▼	134	216
Total	**777**	**1%**	**770**	**1158**

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

Incomplete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle	Last Year total Incomplete applications
March	108	-58% ▼	255	255
April	121	-32% ▼	178	178
May	167	5% ▲	159	159
June	122	26% ▲	97	123
July	0	▬	0	110
August	0	▬	0	29
September	0	▬	0	4
Total	**957**	**-17%**	**1148**	**1350**

Application by Portfolio and Course

Porfolio	Applications	Offers Made	Offers Accepted	Unconditional and Firm Accepted
Digital and Short Courses	12	10	10	10
Interprofessional	54	41	33	27
Psychoanalytic Applied	278	133	93	71
Psychoanalytic Clinical	237	106	66	23
Systemic	196	102	64	27
Total	**777**	**392**	**266**	**158**

Deferrals for next cycle: 26

Total Deferrals- From last cycle: 94

Analysis

Student recruitment: At the completion of the 24/25 cycle, the Trust currently has a total of 1,516 students, comprising 649 new and 867 returning students, a small decrease on 23/24 (1,566). 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 (7% below in June 2025) but a slightly higher number of completed applications (+1% in June 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.

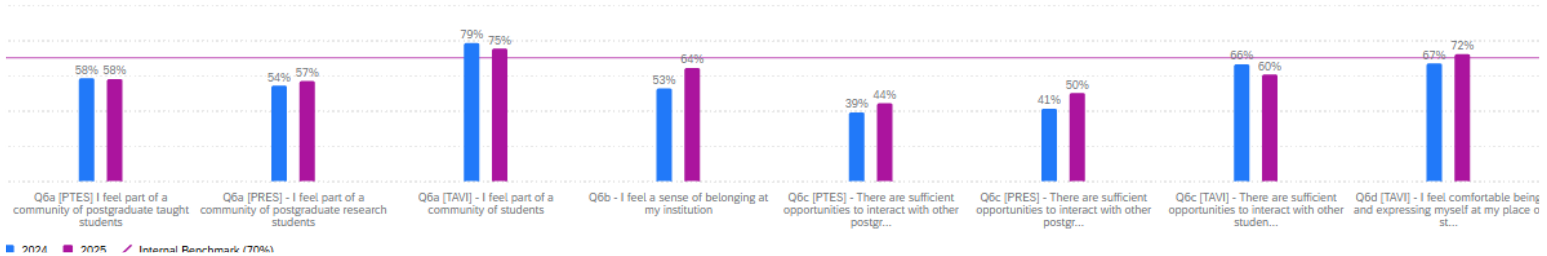
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move Visiting Lecturers into substantive posts, at least 33% reduction from 24/25	CETO / Directors of Education	February 2025
Regulatory changes (OfS)	Office for Students' regulatory 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 completed the 2025 student survey which closed on the 13th June, and the final response rate is 29%, an increase on 25% from the previous year. Survey results dashboards went live for executive team and heads of services on time, and we are on track to launch the Course Leads dashboards before the end of June.	Community and Culture (58%), Master's Dissertation (65%), Organisation & Management (62%), Research Culture (46%) all remain low, with little or no improvement on the previous year.
• Overall satisfaction has increased from 79% to 81%. Learning and Teaching is strong at 84% satisfaction; Library Services is also strong at 85%. Research areas have seen a strong performance across multiple measures. Support for health and wellbeing has increased 18 percentage points in three years (now at 68%, from 50% in 2023).	• Taking projects forward with the current resources is proving challenging – cannot currently find people to lead on the workstreams around student financial support and student buddying/mentoring scheme, for example.
• Projects on International student experience, developing a suicide safe strategy, placements, governance and quality, and creating a CPD course 'embedding disability awareness into the learning & teaching' are progressing well.	• Student disability team have seen an increase of 36% on the previous year of students requiring support, with no increase in capacity within the team.

Community & culture



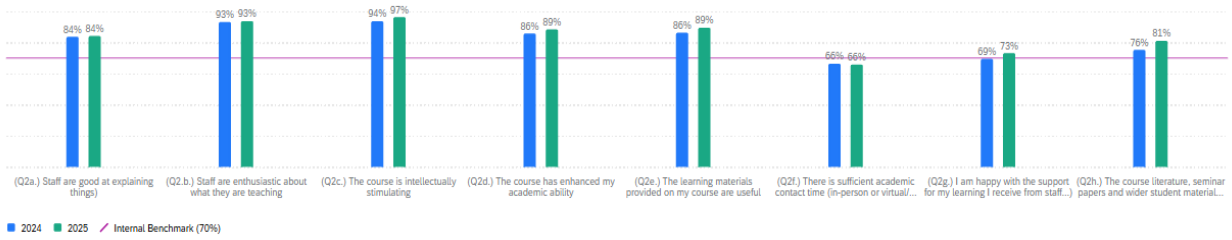
Updates on below actions from Student Experience Sub-Committee

Community and Culture: investigations ongoing into improving opportunities for student social or communal events – **Update June 2025** : mentoring and joining the University of Essex Student's Union being explored.

Disability and Estates: Being considered in Space Utilisation Task & Finish Group (**no update since May**) Other actions being taken in this space – including the development of CPD course 'embedding disability awareness into Learning & Teaching', pursuing signing up to the Disabled Student Commitment.

Psychoanalytic and Systemic Portfolios: Placements and academic governance ~~project management support identified (no update since May)~~

Learning & Teaching



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

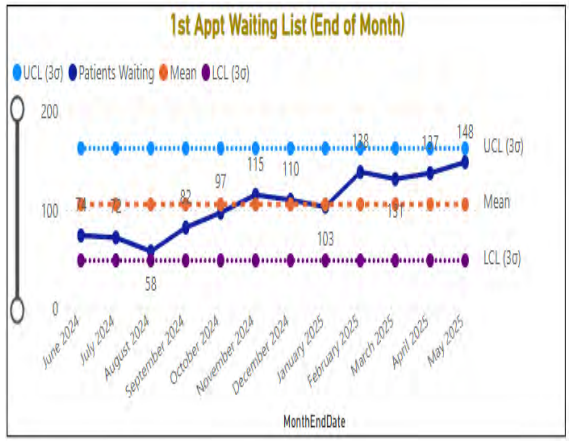
Excellence Inclusivity Compassion Respect

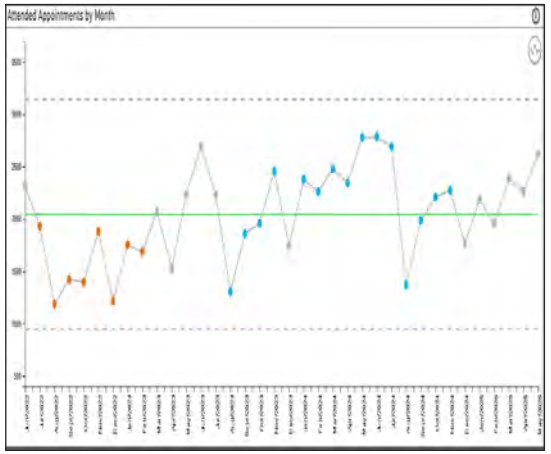
Camden Unit Overview (1/2)

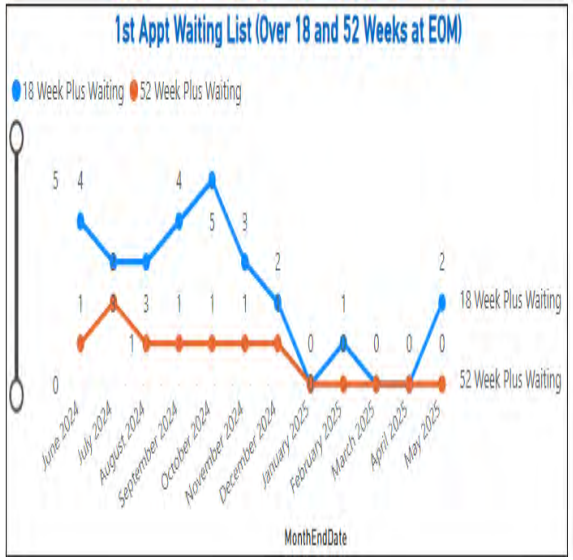
	Successes	Challenges
Safe 	• Appraisal compliance increased to 68% • MAST compliance now 85%. Two teams, CAISS and Wellbeing are close to 100% compliant and we will be sharing learning from them with the wider Unit	• We are struggling to make progress reducing dormant cases and will try a different approach this month. • 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. • Delays in receiving IT equipment is impacting on clinical care and the completion of mandatory tasks. Due to the patient safety risk associated staff have been instructed to log unreasonable delays as incidents. • Linked to the above the MOSAIC service have reported issues accessing the VPN and to access ESR from CNWL devices. This issue has persisted for some time. They cannot access internal system resulting in IT erroneously closing email address because people are not using them. This has been added to the risk register.
Effective 	• All cases in CAISS met the new waiting time target (appt + OM) in April and May • We continue to achieve an average of a 3 week wait to first appt (exc. outcome measures)	• New reports that align with new waiting times metrics remain outstanding. Manual reporting in place indicates a reduction in compliance across the unit. • 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 	• A leaflet has been developed for service users requesting an ADHD assessment, that are not accepted by the Royal Free, to support understanding and clarity for families as to their options. Being finalised by Comms. • The team at SCCT have developed a video on arriving at the site to support service users with NDD needs attending the clinic. We will seek to do the same for other locations. • South Camden and the Wellbeing team both met their ESQ target this month (number of forms)	• CWP have completed a PCREF audit and undertaken several service user involvement activities • We continue to have issues in completing safeguarding forms, assessment forms and an increasing number of missing clinical notes. Next steps will be an A3 once existing projects are completed. -
Responsive 	• We are looking at activity in two ways 1. job plan compliance for staff. 2 total activity for staff and trainees. Overall job plan compliance is 57%. We are 92% compliant with our annual plan target.	• The activity reported below does not include Non-Patient Activity which is essential for Camden resulting in inaccurate performance data due to under reporting. Sheva, Fiona and Lottie to meet with Pia to discuss concerns with current reporting. • Teams are reporting an increasing number of CYPs not taking up offers of appointments and increasing issues making contact for first appts leading to patients being sent opt ins. We will try and quantify this in July.
Well-Led 	• We are providing quarterly reports to teams on staff without leave booked/with less than a proportionate amount of leave booked and asking them to follow up to try and ensure a better balance of leave across the year. • We have made an initial draft of our cost efficiency plan and are taking steps to move this forward. Impact on activity will theoretically be minimal	

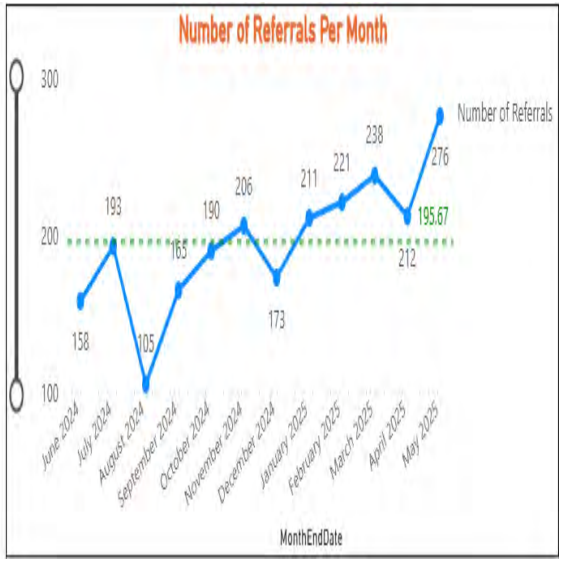
Camden Unit Overview (2/2)

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 is now being implemented. An updated PTL report is now in testing stage and will be implemented in July (delayed) which we hope will also improve compliance. The majority of cases have not waited more than 4 weeks.
- Attended appointments in May is lower than at this point last year.
- The two cases breaching 18 weeks are a data error (appts attached to wrong episodes) and will be corrected.

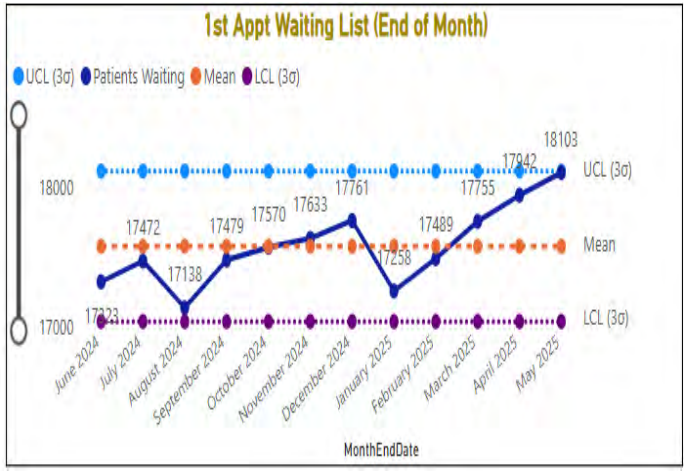
Concern	Cause	Countermeasure	Owner	Due Date
Activity and Job Planning	Lack of oversight in 24/25, new staff not being given job plans	Job plans in place for all. Is a delay in implementing as a visual for all as agreed. Reporting reinstated in April. A3 to be developed for any teams where activity is 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

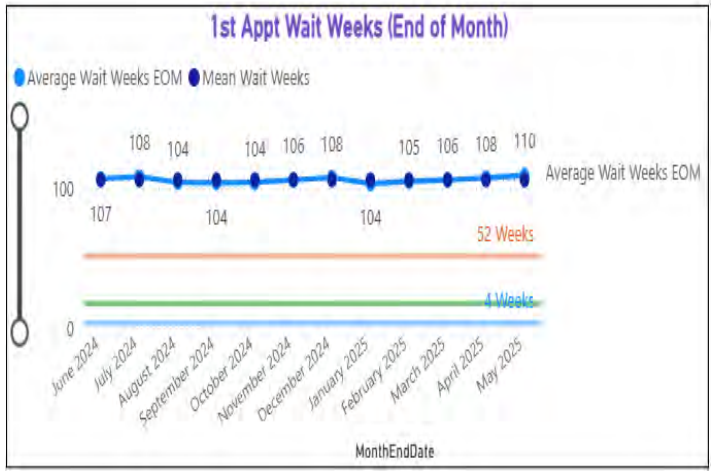
Adult Unit Overview - 1/2

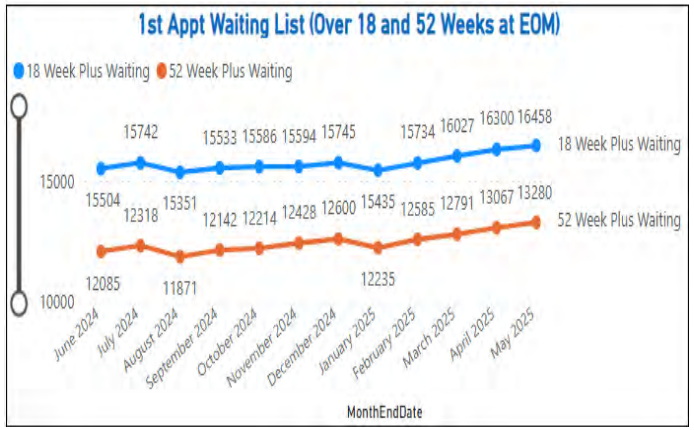
	Successes	Challenges
Safe	• Trauma 2nd cohort of peer support worker recruitment • Co-production groups established in 3 out of 4 services, staff working with PPI leads on creative approaches to ESQ uptake • Trauma and Psychotherapy mandatory training up at 83%. • Estates and clinical joint planning for reception culture, safety and relational approach to patient care.	• Share an agreed approach to operationalising CIPs between Clinical, Operational and Finance. • We continue to have staff in GIC working only 1 day on site, the duty systems are improved as is the distress rota but the core group in office each day remains low. • Clinical services are required to provide clinical placements for DET students, ensuring a successful match between patients and students requires careful thought and consideration. The Adult Psychotherapy team and DET are developing structured, regular meetings to share concerns focusing on patient safety and student experience.
Effective	• EDI - Portman Intake changes have led to referrals of global majority people up from 12% to 50%. • GIC Q.I. project led by NHSE – fantastic work on data, benchamrking, pathways and blockages. • Psychotherapy – co-production group now has three expressions of interest, a facilitator and gratitude to PPI for their support. • Portman referrals up by 45% from 22-23 . • D19 Course recruitment (Trauma) to replace use of honoraries and co-develop trust services with DET • CAMHS in Bath, Wiltshire and Swindon adoption of our trauma model	• 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.
Caring	• Constructive co-development of reception culture and approach to patient care with adult services • Trauma Co-production LEXA Panel presentation to Board	• Efficiency plans across all areas make working life harder and may lead to higher levels of stress and conflict in services. IT and administrative efficiencies may lead to lower clinical productivity in some areas. -
Responsive	• June 2025 Dr Doctor GIC comms platform has 4 trial clinician users for patient contact. • Portman consultation work now routinely captured on Care Notes as 'activity.' • Trauma research partnership with ELFT for body-oriented psychotherapy.	• Efficiency plans across all areas make working life harder and may lead to higher levels of stress and conflict in services. IT and administrative efficiencies may lead to lower clinical productivity in some areas.
Well-Led	• Portman research led by Dr Yakeley in The Lancet with MAJOR MBT-ASPD study. • Scientific meeting re-started with Portman presentation. • NHSE-E EMPH Bid for Pan London Lead provider – re Alliance for trauma and CSA	• Performance requirements and pressures are experienced across the unit.

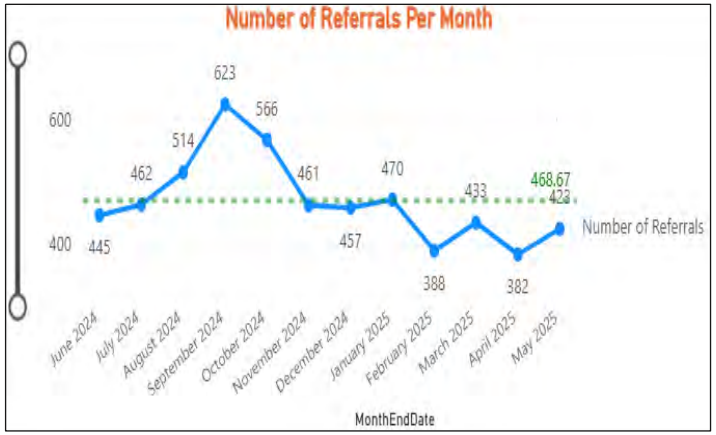
Adult Unit Overview – 2/2

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 due to increased demand, our capacity modelling needs revised metrics i.e. not to include absent staff from data.	NHSE National GIC workshop July 2nd. + Proposal for shared Ops / Clinical responsibility for logging absence. Reflective practice for nursing + MDT staff agreed for GIC.
Portman seeking to open and widen its potential	Changing profile of potential users.	Intake demographics moved from 12% to 50% Global majority in recent evaluation.

Next Steps.

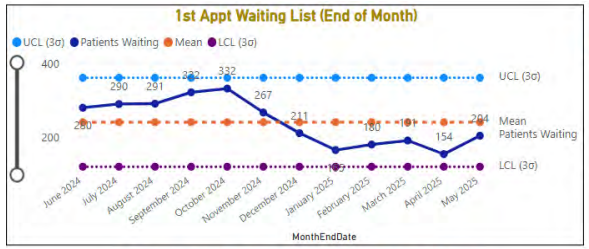
- **GIC Psychology recruitment interviews scheduled 25.6.25**
- **Adult unit finance review achieves 20% contribution and CIP in each service.**

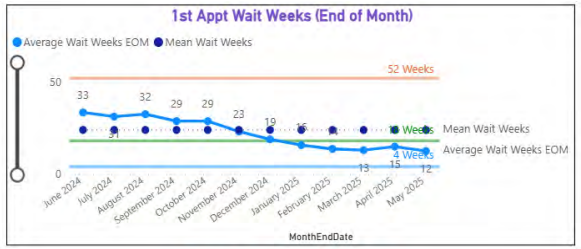
Child and Family Unit overview (1/2)

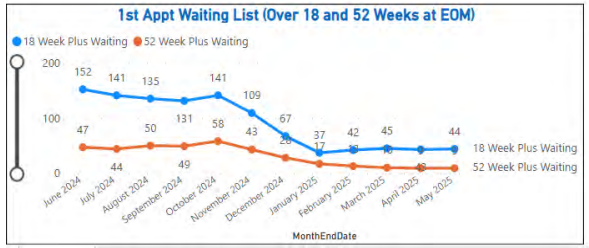
	Successes	Challenges
Safe	Unit mandatory training compliance has increased to 82% following cleansing of ESR and improved reporting.	High number of incidents (14) including 12 Patient Safety Incidents in Gloucester House in May. Increased level of reporting is positive to allow scrutiny and oversight but sustained numbers of violence and aggression against staff.
Effective	Significant uptake by some TCLs and Ops Leads in ownership of performance data and subsequent actions in Clinical Governance meetings, evidenced by returns of Highlight reports to SCL & CSM. AYAS showed a significant increase in recorded clinical activity this month with 392 contacts – the highest level this year. EDAS increase in activity in month to 212 appointments	The unit delivered a total of 1,984 contacts this month which is below contractual targets. • The number of referrals into the CWP has decreased since last year this has been understood as a reflection of the referrals received which have been less appropriate, presenting with a higher level of risk which the CWP service, as an early intervention service is not able to see. Work is required with referrers to support referral process.
Caring	GH school teaching staff all identify as belonging to the Global Majority which is a major step forward in addressing the EDI and racism issues raised last year. Staff wellbeing room set up in Gloucester House School.	Increased staff turnover rate of 4 + % due to ending of ERF fixed term contracts
Responsive	In June FCAMHS will meet with the Provider collaborative who were interested in supporting us to achieve greater reach with our service users through their contacts. This will be achieved by the PC collaborative sharing their key contacts from each borough with FCAMHS so we can then make contact directly. ESQ return rate Improved again in May with 60+ forms completed. 100% compliance across the unit in response times for formal complaints	
Well-Led	New contract signed with Hertfordshire for £228k for Autism Assessments, formal contract received and ECP authorisation in place proceeding with recruitment Meetings scheduled to discuss additional recovery work for the NCL. FCAMHS Stakeholder questionnaire developed pending EDI and Accessibility review of the service. First Step Plus Service SLA agreed. Co-production process with CYP to find new name. Efficiency plans put forward for £ 700 K FYE 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. FCAMHS are exploring growth in the ASD pathway and to implement MBT in the YJS pathway Hackney have confirmed their new cases for FDAC	Consultation in Surrey Mindworks team launched on 5th June and will run for 26 days. Contract ends 30th September. Staff turnover in Autism team will impact on delivery timescales which has now been adjusted, FDAC contracts continue to be negotiated – in particular with Greenwich – Hackney have confirmed making the position more favourable. 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 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

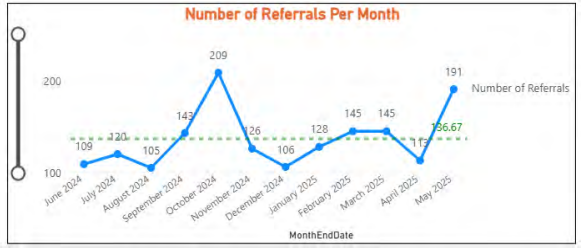
Child and Family Unit overview (2/2)

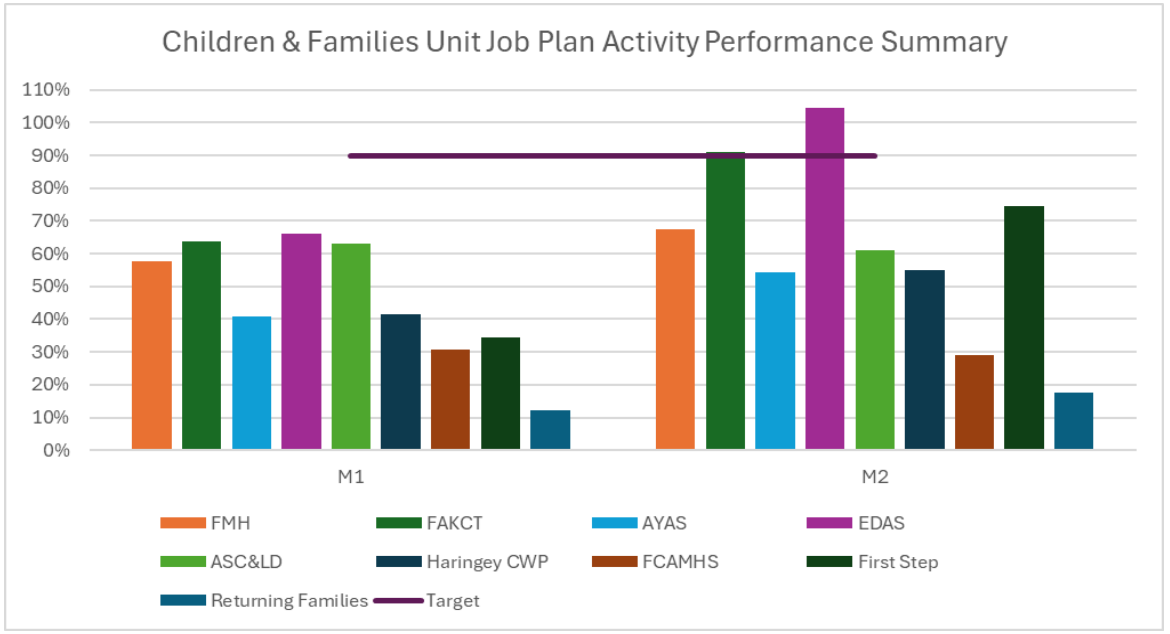
Activity Overview











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 – 1984 clinical contacts for the Unit (Excluding FCAMHS who delivered 31)
Jobplan compliance: Job planning reviews still being completed for the new financial year.
Referrals: Significant increase in referrals into the Unit for May 2025 at 191. A particular rise is seen in FMHT who received 32.
Waiting times : 93 patients are waiting for a 1st appointment (excluding Autism) Across all the teams in the unit we are reporting an average waiting time of 3.93 weeks excluding Autism Assessment. Including Autism Assessment and non NHS funded services, waiting times to 1st appointment are 3.71 weeks.
Assessment to 1st appt. ASC LD are declaring 3.14 weeks, Autism Assessment 2.23 weeks, AYAS 3.85 weeks, FMHT 5.22 weeks, EDAS 1.96 weeks. FAKCT 4.43 weeks, Haringey CWP 3.57, FCAMHS 3.61 weeks. CATS 6.33 Weeks

Treatment waiters : we will be reporting on the treatment waiting list in this section. 718 young people are currently waiting for a specific clinical intervention including the Autism Assessment Pathway. Excluding Autism 203 young people are waiting with an average waiting time of 10.13 weeks. This data set requires further validation over the forthcoming months.

RTT breaches at 18 weeks:
The unit is reporting 10 cases breaching at 18 weeks. 7 cases are at Gloucester House School and are a result of recording processes. 1 is an error in the Fostering and Adoption and Kinship care team and has been corrected, 2 are cases that are in Clinical intake that is being investigated, and an incident has been raised.
Dormant cases:

The unit is reporting 6 cases that have been dormant for 52 weeks (excluding Autism Assessment) 5 in FMHT which is decrease in the previous month and 1 in returning Families.

Clinical notes compliance: Clinical notes compliance continues to improve with an overall 85% compliance rate – a new initiative has been put in place by the ops leads which is proving helpful.

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, 18 September 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 2 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. **Headlines:** **BAF:** • There are **16 BAF risks** in total, split by the Trust's 5 Strategic Ambitions for oversight by 4 Board Committees. This includes one new risk added to the BAF (BAF Risk 16) in relation to the National Training Contract. **CRR:** • There are **12 risks on the Corporate Risk Register** with a current risk score of 12 and above. Although the rollout of the RADAR risk management module commenced during 2024/25 (including training), the development of a robust CRR has been slow due to a capacity gap in the Corporate Governance team since May 2025. It is expected that the recruitment into the Risk Manager role will be complete during Q3 2025/26.		
Background:	**BAF:** 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. During this reporting period, engagement on BAF risks with the Executive Leads continued and the Board Committees monitored the BAF through a cycle of deep dives at each meeting, which in essence provide a rolling programme of oversight and scrutiny of individual BAF risks throughout the year. **CRR:** The Corporate Risk Register (on RADAR) provides a record of operational risks scoring 12 or risks which have an organisation-wide impact. Used correctly, it demonstrates that an effective risk management approach is in operation across the Trust. The CRR complements the		

	BAF by capturing operational risks that may impact service delivery or escalate to strategic risks over time. The 2024/25 Head of Internal Audit Opinion noted that: *"There are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective. Factors which informed this opinion include the opinions associated with the internal audit reviews where, out of eight audits undertaken, one provided minimal assurance; five provided partial assurance; and two provided reasonable assurance".* Recognising the progress made in improving the control environment in 2024/25, the Trust's Chief Executive Officer (CEO) in agreement with the Committee, endorsed the undertaking of an Executive Portfolio Risk and Control Assessment by the Executive Leadership Team (ELT) during 2025/26 to: - ensure all key risks across the Executive portfolios are identified, articulated and effectively managed; - ensure all risks across Executive portfolios are aligned with the Trust's strategic ambitions; - ensure visibility and Executive-level accountability for key risks; - enable Executives allocate resources where they matter most; and equip Executives with a consolidated risk picture so decisions are made with an enterprise-wide perspective.
Assessment:	**Key developments since the last Board include:** **BAF:** i. **BAF Risk 16 (Non-viability of DET in its current form):** A new risk of "Non-viability of DET in its current form" has been added to the BAF and agreed by the Education and Training Committee (ETC) at its last meeting. The risk relates to the residual risk exposure to the Trust following the loss of the NHS National Training Contract and the need to identify and agree options (jointly with the Merger partner) in response to this loss to ensure the medium to long term viability of DET. The consequences of this risk include a potential teach-out arrangement, poor student experience, regulatory concerns including a potential reportable event to the Office for Students, and reputational damage. ii. BAF Risk 3 (Risk of loss of registration with the OfS): The ETC agreed to a reduction in score of BAF Risk 3 from 12 to 8 due to written confirmation received from the OfS that the Trust's OfS registration can be transferred to the merger partner post-merger (with only minor technical changes). The Committee and Board (BoardEffect reading room) received a copy of this letter for assurance purposes. It was noted that the reduction in score meant that the risk was now within appetite. iii. BAF Risk 5 (Risk of non-delivery of a sustainable future for the organisation through the Board agreed merger process): As

	agreed by Board at the Private meeting in July, this risk has now been reinstated to the BAF the Board receives in Public. iv. During the August/ September 2025 cycle of Board Committee meetings, three of four Board Committees received the Executive Portfolio Risk Assessments relevant to their remit, supporting effective oversight and assurance; it was planned that the IAGC will receive the consolidated picture for oversight. At the time of writing, the Performance, Finance and Resources Committee (PFRC) had not yet met, and the relevant Executive Portfolio Risk and Controls assessments were scheduled to be discussed at the Committee meeting on 22 September. **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 Q3 2025/26 as recruitment into this interim post has commenced. It is expected that the Executive Portfolio Risk and Control Assessments will help inform and support the development of a robust CRR for the Trust in advance of the merger by acquisition. **Risk Appetite:** During the reporting period all Board Committee's received an alignment table which offered valuable insight into where each BAF risk sits (either within, below or if it exceeds the defined risk appetite) thereby supporting targeted oversight and management actions. It is recommended that the Board conducts a six-month review of the Trust's Risk Appetite in November 2025 with particular focus on the appetite levels for i. Financial Sustainability; ii. Education and Training; and iii. Growth. This is to ensure the appetite levels set by Board are still appropriate considering the recent withdrawal of the NTC and the imminent merger by acquisition.
Key recommendation(s):	The Board is asked to: 1. **APPROVE** the latest update on the Board Assurance Framework**;** 2. **DISCUSS**whether: • The correct risks are identified on the BAF; • Any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF; • Controls, assurance, gaps and actions are appropriate; • Any further controls may be required to mitigate the risks identified; and • It is assured that risks on the BAF are being appropriately mitigated. 3. **NOTE** the latest update on the CRR; 4. **SUGGEST**any other potential areas not covered in either or both appendices. 5. **AGREE**a six-month review of the Trust's Risk Appetite Statement to be conducted in November 2025.
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:	• PFRC – 31 July 2025 and 22 September 2025 • QSC – 21 August 2025 • ETC – 03 September 2025 • POD EDI – 04 September 2025 • ELT – 08 September 2025 • IAGC – 16 September 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 2 2025/26.

2. Report and feedback from August/ September Board Committee meeting cycle:

Quality and Safety Committee Oversight:

The Committee received **3 BAF risks:**

- **Risk 1 - Inequality of Access for Patients -** This risk highlights challenges in providing equitable access to services**;**
- **Risk 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**; and**
- **Risk 13 - Failure to achieve required productivity & performance (Quality and Patient Safety focus) -** 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.

The Committee noted that the risk alignment remained as previously reported as the risk scores had remained static. It was noted that once the work undertaken to mitigate BAF 1 – Inequality of Access for Patients had been embedded this would reduce the current risk score.

The Committee received the following for oversight:

- 7 risks on the QSC CRR rated 12 and above aligned to the BAF risks; and
- the CMO and CNO's Executive Portfolio Risk and Controls Assessments.

Education and Training Committee Oversight:

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

- **Risk 3 – Risk of loss of registration with the OfS -** 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.
- **Risk 4 – Potential Contraction of Student Recruitment; and**
- **BAF 16 – Non-viability of DET in its current form (New risk)**

The Committee **approved** the addition of BAF 16 with a detailed discussion of the risk undertaken during the meeting this included endorsement of proposed options to mitigate the risk.

The Committee agreed the reduction in score of BAF 3 from 12 to 8 due to written confirmation received from the OfS that the Trust's OfS registration can be transferred to the merger partner was agreed. It was noted that the reduction in score meant that the risk was now within appetite.

The Committee **received** the CETO's Executive Portfolio Risk and Controls Assessments for oversight.

POD EDI Committee Oversight:

BAF update:
The Committee received **4 BAF risks** with particular **focus on BAF Risk 7**:

- **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**

The Committee felt **assured** that the structure for inclusivity was in place, however, the impact was not yet evident across the organisation. Improved performance was acknowledged in the gender pay gap position, WRES, CPD approach and inclusive recruitment. A recommendation was made to use the Senior Leadership Forum to cascade the EDI work being undertaken to ensure staff are aware of inclusivity related actions. An action was taken to include the EDI work undertaken by DET in BAF 7.

The Committee received the CPO's Executive Portfolio Risk and Controls Assessments for oversight.

PFRC Committee Oversight:

At the June meeting (as was reported to the July Board meeting), 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**

At the time of writing, the PFRC had not met (meeting planned on 22 September), and the following key updates were included in the risk report to the Committee:

- **BAF 09** (Financial sustainability): The current consequence of this risk has been reassessed as extreme (5), however, the likelihood has been reduced from 'likely' to occur (4) to 'could' occur (3). This has resulted in a reduction of the current risk score from 16 to 15. As a result of the change in consequence the target risk score has increased from 8 to 10. Noting this risk has further been exacerbated by the impact of the loss of the National Training Contract.

- **BAF 11** (Sustainable income streams): No change in the current risk score during this reporting period. A further review of this risk is planned in September to ensure the wider risks identified in relation to contracts are appropriately aligned to ensure a consolidated picture of the contracts risk profile for the Trust.

Private Board Oversight

- **Risk 5 – Risk of non-delivery of a sustainable future for the organisation through the Board agreed merger process**

At the **July** meeting, the Board received **assurance** from the update on BAF 5, noting the controls in place to enhance the BAF's alignment with strategic ambitions and risk appetite. It was agreed to move the risk to the public BAF linking to the national training contract.

Corporate Risk Register:

The Committees noted:

- 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 Q3 2025/26.
- The monthly IQPR meetings now require the Divisions to present the key risks on Divisional/ Operational risk registers. This process will support engagement and assurance on the management of key operational risks.

BOARD ASSURANCE FRAMEWORK – QUARTER 2 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)	8 (2 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 partnerships to improve population health and building on our reputation for innovation and research in this area														

5	Risk of non-delivery of a sustainable future for the Trust care, education and training offer via delivery of a medium-term financial plan and merger with the North London Foundation Trust	The Trust's sustainable future is closely tied to the successful execution of the Board agreed merger process. If the merger is not delivered within the agreed timescale (1st April 2026) there is a risk to financial viability of Trust from 2026-27 onwards.	20 (4 x 5)	15 (3 x 5)	⟷	⟷			10 (2 x 5)	**15**	**15**	**15**	**10**	**Open**
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)	15 (3 x 5)	⟺	↓			8 (2 x 4)	**16**	**15**	**15**	**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	16 (4 x 4)	12 (3 x 4)	⟺	⟺			8 (2 x 4)	**16**	**16**	**16**	**12**	**Open**

		policy shifts including growing emphasis on performance-related metrics over block funding and projected Commissioning funding gap.												
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**
16	Non-viability of DET in its current form	**If** mitigations cannot be identified following the withdrawal of the National Training Contract **Then** the medium to long term viability of DET in its current form may not be sustainable **Resulting** in a teach-out arrangement, poor student experience, regulatory concerns including a potential reportable event to the OfS, and reputational damage	16 (4 x 4)	16 (4 x 4)		**New**			8 (2 x 4)		**16**	**12**	**8**	**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**	August 2025
Risk Appetite	**Cautious**	4	4	**16**	4	4	**16**	2	4	**8**	⟺	⟺			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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.	Regular audits to commence in Q3 2025/26	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Designed/ reviewed screening and triage process. Quarterly audits built into Clinical Audit Plan Go live date achieved. In GIC it is integrated into the QI work	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 Action Plan being developed	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. Key PCREF aim for 2025/26 is to focus on Equitable access IQPR Report to QSC and POD EDI PCREF Implementation Group monitors implementation across the Trust and ensure correct data is reviewed and acted on EDI/ PCREF data will go to IQPR (starts in Sep 2025)	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 (Autism, Gender and Trauma). All 3 services have full front door screening in place. Audits to ensure consistency.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Autism, gender and trauma GIC targeted support meetings Mondays Trauma-Targeted support meetings Tuesdays	Internal	Amber
		Autism - Care of waiter protocol adopted by service	Internal	Green
		Gender - Clinical Harm Reviews are now embedded into the first CORE appointment process through IQPR	Internal	Green
	Clinical Harm Reviews to be socialised and implemented end of Q2.	Trauma - Still a gap but progress being made	Internal	Amber
Training and workshops as part of the transition to new structure, roles, and responsibilities including the Kaizen events		Training/ workshop records	Internal	Green

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	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	Latest update pending 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/risksto 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**
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**	August 2025
Risk Appetite	**Cautious**	4	5	**20**	3	5	**15**	2	5	**10**		⟷			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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.	One team, GIC has long term vacancies in psychology workforce, resulting in waiting times in that pathway.	Weekly review of recruitment plan in QI meeting 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. Clinical Structure Review AAR conducted with learning about the consultation process but no immediate changes to current structure.	Internal	Amber/Green
Job planning framework: including electronic system for monitoring medical job plans Supports effective alignment of clinical capacity with service demand, improving workforce productivity, reducing inefficiencies, and enhancing service continuity.	Insufficient oversight of job planning processes, posing operational and financial risks. Monitoring clinical non-medical compliance in activity against job plans at team level.	Job plans in place for majority of teams. Electronic system for medical staff introduced with all medical on the system at end of May 2025. All clinical non-medical staff job plans are monitored by team leads and accountable to unit leads, presented in the IQPR monthly. Compliance for staff activity against job plans is place monitored through IQPR Annual Revalidation paper to Trust Board, submitted externally	Internal External	Amber

		Bi-monthly workforce dashboard updates to the POD EDI The job planning policy in place		
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 (safeguarding – children and adult modules, Basic Life Support) 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 Safeguarding, IPC and BLS compliance monitored weekly through Exec Safety Huddle	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. Clinical Supervision Survey sent out to understand barriers to recording	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.	Recording of safeguarding supervision in children's services. Compliance levels below benchmark of 80% Safeguarding will be strengthened by developing an improved structure through the Safeguarding forum.	Cohort of staff in the two children's units trained to facilitate safeguarding supervision. Internal audit action plan closed with all evidence received by auditors. Audit being carried out for children safeguarding supervision training – post training compliance Reviewed through ISG, ICB designated nurses in attendance.	Internal External	Amber
Quality assurance and quality improvement tools and methodology		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. Weekly SDR in place to evaluate progress against A3 programmes Quality Assurance audits carried out by Quality team, shared with team and unit leads monthly for review in Clinical Governance meetings. QSC work plan and forward planner IQPR Quality & Safety Report to QSC bi-monthly and Trust Board 3 times a year. Chair's reports from Tier 3 Groups to QSC Clinical Governance meetings – unit level, monthly A3 projects in place for key quality assurance programmes of work QI workstream for GIC national work with NHSE	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 Mortality Reviews reviewed by Clinical Incident & Safety Group; learning shared through Clinical Governance meetings	Internal	Amber
Clinical Audit Schedule	Full Clinical Audit Plan for 25/26	Clinical Audit & Effectiveness Group established; Tier 3 Group of QSC Electronic recording and reporting module live on Radar Regular audit plan to be developed by Deputy Chief Medical Officer and built into Radar too	Internal	Amber
Complaints Process Complaint's process and structured learning: Improves patient experience, fosters transparency, and enables learning from incidents and service feedback.	Lessons learnt process from complaints Timeliness of response 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: - Daily complaints huddle - 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 circulated through Clinical Governance Meetings and Tier 3 meetings Staff training sessions held in June and July 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.		Radar went live in June 2024 LRMS Radar Implementation moved to Business as Usual Incident notification process fully embedded in governance from 3rd February 2025, with Leadership team receiving 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 Year 1 review of PSIRF and Radar, paper to QSC in August 2025 and Trust Board in September 2025	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Conduct annual job plan reviews across all clinical services to ensure alignment with workforce needs.	Clinical Leads	Ongoing	Part of the annual plan for each unit
Strengthen oversight of Learning from Deaths process within the Clinical Incident & Safety Group.	Chief Medical Officer	July 2025	In Progress – first meeting held in July 2025
Evaluate effectiveness of the new Electronic Mortality Review form in Radar.	Chief Medical Officer	April 2025	Planned
Implement structured monitoring of Clinical Supervision policy and compliance tracking.	Director of Clinical Service	April 2025	Survey to identify barriers, professional leads reviewing policy

Improve Complaints Process	Interim Complaints Manager/ Associate Director Quality	August 2025	In Progress – QI project in place
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/risksto 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.	Strategic Delivery Room, 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**	August 2025
Risk Appetite	**Cautious**	4	5	**20**	~~3~~ 2	4	~~12~~ ~~8~~	2	4	**8**	⟺	↓			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (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. Written confirmation received from the OfS confirming that TPFT registration can transfer to a merger partner with only minor technical changes on partner's behalf. Changes are in hand.	External	Green
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.	Both TPFT and Merger partners	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	Completed July 2025	July 2025: Written confirmation from OfS that registration can be transferred post-merger

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

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

Principal Risk 5	**Risk of non-delivery of a sustainable future for the organisation through the Board agreed merger process**	**Strategic Objective**	**Developing partnerships to improve population health and building on our reputation for innovation and research in this area**
Description	The Trust's sustainable future is closely tied to the successful execution of the Board agreed merger process. If the merger is not delivered within the agreed timescale (1st April 2026) there is a risk to financial viability of Trust from 2026-27 onwards. **Impact:** **1. Service Sustainability:** • Key services may become unsustainable, necessitating their transfer to alternative providers. **2. Financial and Strategic Objectives:** • The Trust's ability to enhance its financial position and meet CIP targets may be significantly impaired. • The resulting financial strain and operational challenges could damage the Trust's reputation and prompt more intensive regulatory intervention. **3. Operational Impact (Clinical and Educational Services):** • A failed merger could precipitate the breakup of integrated clinical and educational services.		

		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	Chief Executive Officer/ Director of Strategy and Business Development														**Original Assessment Date**	8th March 2024
Lead Committee	Board of Directors	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	September 2025
Risk Appetite	**Open**	4	5	**20**	3	5	**15**	2	5	**10**	⟷	⟷			**Date of Next Review**	November 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Board's decision in December 2023 to proceed with merger as a single entity	Possibility that a merger as single entity (clinical and DET) may not be possible.	• Private Board of Directors meeting papers and minutes.	Internal	Green
Preferred partner for merger agreed (NLFT) with joint public announcement on 1st April 2025.	Sign-off for final due diligence (due for consideration in September 2025)	• Private Board of Directors meeting papers and minutes.	Internal	Amber
Merger Communications and Engagement Strategy in place	Joint engagement internal and stakeholder approach to form part of strategic case for merger with NLFT	• Shared merger Communications and Engagement Strategy in place and engagement with the Board and CoG live and iterative.	Internal	Amber *(pending 1st April 2025 Merger Go-Live)*
Merger transaction timetable and governance in place including programme team capacity, legal advice and support from NCL ICS and NHS England.	Sign-off for merger Full Business Case (due for consideration in October 2025)	• Programme governance documentation • Memorandum of Understanding (MoU) and Partnership Agreement in place • Dedicated Programme Team and legal advice in place to support Executive Teams deliver the merger • Legal support / due diligence	Internal and External	Amber
NHSE Regulatory / Performance Oversight	The New Provider Improvement Programme (PIP) segmentation will be taken forward with the Trust and NLFT and woven into the merger process.	Under SOF3 (previously RAG rated green on quality, governance and performance frameworks with sustainability via merger linked to work underway noted in this risk assessment)	External	Amber
Trust cost improvement programme (CIP) to deliver financial stability and a balanced plan in support of a successful due diligence outcome with NLFT.	Full sight and review of both Trust's CIP plans in support of due diligence. Medium Term Financial Plan (MTFP) addressing the plans for the underlying deficit, and efficiency plans.	• Shared merger governance and Joint Merger Transition Programme Board oversight.	Internal and External	Amber
Joint work programme and merger transaction and transition governance arrangements in place to ensure appropriate governance of the transaction		• Terms of Reference of Joint Merger Transition Programme Board approved by Boards • Programme governance and meeting dates in place.	Internal and External	Green

		• Workplan to meet NHSE transaction timeline in place		
Conversations are progressing with the Office for Students on registration requirements for a 'lift and shift' of the education and training offer under alternative arrangements	None – noting ongoing conversations with the OfS	• The critical path for OfS registration is being mapped to the NHSE merger transaction process so both are delivered in tandem	Internal and External	Amber *(pending 1st April 2025 Merger Go-Live)*

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Trust CIP plan and weekly Executive review to keep all on track.	All Exec Leads	1st April 2025	• In progress
Delivery of medium-term Financial Plan (MTFP) linked to merger.	Interim Chief Finance Officer	Q2 of 2025-26 as part of Merger Programme Board	• Financial due diligence on MTFP progressing
NHSE to confirm their firm support of the Merger timeline as our dates our currently indicative.	Director of Strategy and Business Development	31st July 2025	• Progressing in line with merger transaction timetable and all on track
Continue to engage with the OfS about a potential change of registration	Chief Education and Training Officer	30th September 2025	• Positive ongoing conversations with OfS

Strategic Delivery Metrics

Key Strategic deliverables	Progress to date	What are the current challenges/risksto progress?	Sources of Assurance
To merge with the preferred partner *by 1st April 2026.*	The Trust and NLFT have commenced the formal merger by acquisition transaction process, with the first milestone being submission of the strategic case to NHSE by end May 2025 with Full Business Case (FBC) now in development..	Noted in actions to address gaps in assurance.	Internal and External

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

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 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**	August 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	3	2	**6**	↑	↔			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (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
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

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
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
Develop talent management and succession planning programmes to ensure cover for critical roles.	CPO	30 September 2025	Succession planning paper to ELT 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	A3s have been developed to address the issues around mandatory and statutory training (MAST) and appraisal compliance. The Senior Leadership Forum has been tasked to work through the A3 and develop action plans where progress will be monitored through IQPR.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto 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 engagement levels will be impacted, recruitment and retention will be affected, and the quality of patient care, service to students 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**	August 2025
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	⟷	⟷			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
Merger Engagement sessions hosted by CEO		Records of sessions held	Internal	Green
Staff Engagement Group meets monthly is a mechanism to talk to staff about improvement (e.g. awards ceremony values work)		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	Facilitate understanding of roles and responsibilities including alignment with governance structures/arrangements	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) and candidates with protected characteristics 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
EDI Policy in place and under review	Policy to be reviewed in line with Merger partner's		Internal	Amber

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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 in place – 1st level complete	Mini evaluation to take place following 1st level completion and internal review by CEO/CPO on next steps	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 agreed and being embedded	EDI Programme Board	Internal	Amber
Staff survey and pulse survey including WRES and WDES help ascertain if our EDI 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 • WRES and WDES reporting to EDI Programme Board; POD EDI and Board • They are in the public domain which ensures accountability	Internal External	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. Specific item at Senior Leadership Forum on accountability and cascade of information.	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 have been finalised with regular updates to the EDI Programme Board. With escalations via the Chair's assurance report to POD EDI. The EDI priorities and metrics have been introduced to the Senior Leadership Forum at the July meeting and now being cascaded to teams. Localised EDI data shared with teams and as such the teams are identifying countermeasures via the A3 methodology.
EDI Policy	Associate Director of EDI	~~April 2025~~ October 2025	In progress. The EDI Policy has been reviewed but currently the plan is to align it to the Merger partner's EDI policy to support integration following the Merger by Acquisition.
Engagement sessions run with MENTI – checking staff opinion on improvements made and what support is needed for the merger. Aiming to reduce the gap between what people say in person versus staff survey	Chief People Officer	October 2025	This is planned
Facilitate understanding of roles and responsibilities including alignment with governance structures/ arrangements	Chief People Officer/ Chief Nursing Officer/ Interim Director of Corporate Governance	October 2025	

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto 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**	August 2025
Risk Appetite	**Open**	4	5	**20**	3	3	**9**	2	3	**6**	⟷	⟷			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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
Manager ESR in place this ensures managers are empowered to take greater ownership of the appraisal process	Resolve issues on Manager ESR around disconnect between appraiser and uploader in clinical teams	Training records Training delivered jointly by the ESR Manager and the L&D team A step-by-step guide is available on the intranet L&D team provides managers with monthly reports detailing appraisal data for their teams	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of People (OD, Culture and Engagement	Ongoing	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	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

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			policies need to be rebadged. Ongoing, In line with timetable currently on target to meet implementation date. These policies will help with the foundations for psychological safety.
Organisational Development for senior leadership to ensure accountability for decisions and consistency of approach.	Chief People Officer	June 2025	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.
Manager leadership training and development	Head of People (OD, Culture and Engagement)	November 2025	Supporting Performance Improvement training is being delivered to managers to reinforce the importance of appraisals
Manager ESR roll out for appraisal, ensuring resolution of issues around disconnect between appraiser and uploader (clinical teams)	Head of People (OD, Culture and Engagement)	October 2025	An issue has been identified on ESR where staff report to their operational team manager, who may not be the individuals line manager who is conducting the appraisal. This needs to be addressed.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto 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.

The Tavistock and Portman NHS Foundation Trust

Principal Risk 9	**Delivering financial sustainability targets**	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability.**
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 in the current year. This could also jeopardise the merger transaction..		

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**	August 2025
Risk Appetite	**Open**	5	4	**20**	~~4~~ 3	~~4~~ 5	~~**16**~~ **15**	2	~~4~~ 5	~~**8**~~ **10**	⇔	⇩			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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 NLFT NLFT have engaged external support to prepare the MTFP in partnership with the Trust.	Internal External	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 in place from Q1 2025/26	Internal	Green
2025/26 Annual Plan – breakeven plan submitted to NHSE		Balanced plan agreed with NCL requiring 3.9 million efficiency programme and an asset sale..	External	Green
Recurrent efficiency programme 25/26 Financial Plan (including asset sale)	Resources working on the CIP as part of other commitments.	Progress reporting to ELT/ Efficiency Programme Board; with scheme SROs reporting on a regular cycle. Onward assurance provided to PFRC and Board bi-monthly. As part of Due Diligence, the Trust's approach is being assessed by the Merger partner.	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Develop a Medium-Term Financial Plan (MTFP) in conjunction with NLFT that shows a route to Financial Balance under a merger scenario	ICFO	September 2025	Previous agreed MTFP to be updated with new merger partner. Implementation date changed from May to September 2025 – updates will reflect outcome of planning round. NLFT have engaged external support to prepare the MTFP in partnership with the Trust.
Review the resources requirement for the efficiency programme and reprioritise the time allocated	ICFO	August 2025	A review of the current resource requirement will ensure the Efficiency Programme is appropriately resourced for 2025/26.

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.	Implementation date changed from May 2025 to September 2025 – updates will reflect outcome of planning round. NLFT have engaged external support to prepare the MTFP in partnership with the Trust.	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

Principal Risk 10	**Maintaining and 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.

		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**	August 2025
Risk Appetite	**Open**	5	3	**15**	3	4	**12**	2	4	**8**	⟷	⟷			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (What are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
The two national submissions are an external measure of performance against peers. 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.	The ERIC return is an annual submission that compares costs and consumption across its peers in building maintenance, rates, utilities, waste, cleaning. In addition the annual PAM review is undertaken each year (autumn) to review systems and processes. The ERIC return is a historic view of performance, PAM also considers a costed action plan to bring a building back up to condition.	External	Green
10-year Capital plan has been shared with ICB. 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
A 6 facet survey is underway – it will assess the asset type, condition and a costed breakdown of assets to condition	Estates lead	Report will be delivered by Oct 25	This will support the capital plan for the coming years and provide a snapshot in what is required to bring the buildings up to condition B. 6 facet surveys are undertaken every 5 years, with the last survey completed in 2021. 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/risksto progress?**	**Sources of Assurance**
Premises Assurance Model assessment- a gap analysis, and timeline	Policies for Water, asbestos, Fire, Waste and Health and Safety have been updated with technical advice.	There are current no further building related technical policies under review	A cleaning charter has been developed to tie in with IG, clear desk policy and waste streams
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.	Updated drawings have been developed for electrical and water this will be structured under clear control measures.	Fire and electrical are complete. Water drawings will be updated on completion of the project in October.
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**	September 2025
Risk Appetite	**Hungry**	4	5	**20**	3	5	**15**	2	4	**8**	⇔	⇔			**Date of Next Review**	November 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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		(1) IQPR Report WITH activity performance against local and national standards (2) Contractual risk report now in place (3) New process for finance and contracts income reconciliation in place	Internal	Green
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	In place
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 in place via IQPR report

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto progress?**	**Sources of Assurance**
Deliver Medium and Long-term Commercial Strategy for growth – contributing to a balanced MTFP	- Tavistock Consulting operating model changed (moved to an associate model) with income target / contribution agreed - Shared MTFP for commercial growth being developed in partnership with NLFT (with support from Carnall Farrar)	Capacity for commercial leadership to focus on new income generation due to focus on merger delivery (largest commercial activity for 2025-26)	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.

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**	August 2025
Risk Appetite	**Cautious**	5	4	**20**	3	4	**12**	3	3	**9**	⟺	⟺			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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 15/08/25 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 BCPs have recently been updated and the CareNotes Mini system now included in BCP	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 Suppliers are now requested to provide basic information on their cyber security status as part of our DSPT cycle	External	Green

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	*Updatepending*

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto progress?**	**Sources of Assurance**
Increase external Cyber Essentials accreditation	Cyber security annual update planned, last accreditation August 2025.	None NHS England will move to the Cyber Assurance Framework (CAF) next year. However, the Trust still needs to maintain Cyber Essentials as certain contracts still require this accreditation.	External Cyber Essentials accreditation organisation. Trust Audit program
Engage 3rd party cyber assessment of trust suppliers across all of the infrastructure to ensure compliance to trust / NHS standards	Planning is underway via the recovery of the CareNotes system and will deliver outcomes in Q1 FY23/24. The intention is to pilot with Advanced (CareNotes supplier) and then roll out to all other system suppliers	Will require funding for the service to be acquired. Higher priority work impacting internal technical resource	NHS (digital team) 3rd party assessor Trust audit programme

Principal Risk 13	**Failure to achieve the required levels of performance and productivity**	**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.		

		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	Clare Scott Chief Nursing Officer & Director of Strategy														**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**	August 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	2	4	**8**	⟺	⟺			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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* Enhanced oversight through targeted support and quality improvement work focusing on waiting list and patient experience, activity, productivity and 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. GIC part of national QI collaborative led by NHSE with the aims to: • Implement recommendations from Levy report • Improve patient experience and waiting times • Reduce clinical risk • Support improvement in productivity • Create a standardised system approach in variation to delivery and reporting • Develop network capability	Internal External	Amber
Trustwide Integrated Quality and Performance Review (IQPR) meetings for each clinical unit and DET.	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. The Quality and Safety Committee receives IQPR with a focus on the quality metrics in relation to performance	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

		All areas relating to monitoring of and compliance with job planning are outlined in BAF principal risk 2		
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	GIC has moved from Targeted Support to QI work under the national collaborative led by NHSE. Progress is reviewed in weekly GIC QI meetings. Reporting to ELT monthly and Quality and Safety Committee. 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. (see first assurance under this risk for detail) Oversight will sit with the following fora: • Quality Committee/PFRC – monthly • IQPR – monthly • Clinical Governance – Monthly • GIC Targeted Support Group - Weekly • GIC Leadership Group – Weekly	External	Amber
Recourse optimisation and monitoring. The trajectory for a number of first appointments to be conducted – estimated number of pts likely to be seen for a first appointment aligned to the agreed trajectory. - Recourse optimisation and monitoring.		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. The estimated number of first appointments is on track as planned, with ongoing optimisation.	Internal	Amber
Weekly PTL meetings to review dormant cases and throughput. Review of the intake process to minimise hand offs between services. Activity, waiting list and quality impact risk monitoring across key services (including, Adult GIC, Trauma and Autism, PCPCS).	Currently have long waiting times, exceeding the 18wk RTT. Clear understanding of available capacity to reduce waiting times and meet increasing demand for some services. Gap in trt waiting times data, as not fully automated or assured. Data flow is manual so possible errors.	Weekly QI huddles for oversight, Review in Child Complex monthly meeting. Monthly business meetings for all services. IQPR meetings.	Internal	Amber
Clinical pathway mapping to unblock bottle necks		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. A3 Kaizen events	Internal	Green
Workforce recruitment and retention	Recruitment - Number of referrals versus number of pts we can see. Unlikely to recover waiting times best case break even each service, with the exception of GIC which is under NHSE national review	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber
Autism – mitigations seeing an extra 175 pts Trauma -to see an extra 100 patients	Responding to cultural issues. The time required for change management	Waiting times weekly huddle. Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Targeted support weekly meeting for affected service areas, monthly report to ELT. Service lines have started this process this month. Publication of the first cut of data a month in arrears of the start date will inform assurance rating.	Internal	Amber

		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/DeliveryRoom*	Managing Director	*March2025*	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	*31March2025– golive 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 *Teamsduring August and finalised in September 2023 – Furtherworkhasbeenconducted 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	*May2025*	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/risksto 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		**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability**

	Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target
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**	August 2025
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⇔	⇔			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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 with the changes with ICB, sustainability is under review	Director of Estates, Facilities and Capital Projects	Waste intranet page has been developed with quarterly metrics – September 25	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	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 – survey is due for launch in November

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto progress?**	**Sources of Assurance**
Refresh of the Green Plan along with an annual action plan.	Aiming to tie in the sustainability plan with NLFT	Contributed to the ICB green plan update 2025-26, 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	

Principal Risk 15	**Lack of Staff Engagement/ Staff Disengagement**		
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.	**Strategic Ambition**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	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**	August 2025
Risk Appetite	**Open**	5	4	**20**	4	4	**16**	3	4	**12**	**New!**	⟷			**Date of Next Review**	October 2025

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (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
Engagement sessions run with MENTI – checking staff opinion on improvements made and what support is needed for the merger. Aiming to reduce the gap between what people say in person versus staff survey	Chief People Officer	October 2025	This is planned

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

Principal Risk 16	**Non-viability of DET in its current form**		
Description	**If** mitigations cannot be identified following the withdrawal of the National Training Contract **Then** the medium to long term viability of DET in its current form may not be sustainable **Resulting** in a teach-out arrangement, poor student experience, regulatory concerns including a potential reportable event to the OfS, and reputational damage	**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**	25th July 2025
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**	
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	2	4	**8**		New			**Date of Next Review**	August 2025

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
Negotiations with NHS England about the status of the contract and securing income for 25/26 FY	Absence of commitment from NHS England to honour contract for 25/26 intake. Loss of income on this level may constitute a reportable event with OfS and threaten ongoing registration	Records of ongoing engagement with System and merger partners (ICB, NLFT, University of Essex) around this risk and its impact (Letters, emails, minutes)	Internal	Amber
Plans to move DET into a state of independence from the National Training Contract in accordance with Trust Medium Term Financial Plan (MTFP)	Plans for risk mitigation if contract goes into teach out within 25/26 FY Engagement with HE partners around a more efficient offering	Report to PFRC on Fragile Courses review - identifies courses that are heavily dependent upon the NTC and could be removed from portfolio	Internal	Red

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Action plan to engage with NHS England around security of contract for 25/26 student intake	Director of Strategy and Business Development (DOSBD) Chief Education and Training Officer (CETO) Interim Chief Finance Officer (ICFO)	July/August 2025	Briefings Developed for NHS and meetings planned or underway
Modelling of different scenarios around teach-out and reduction in offer and overheads aligned with MTFP	Chief Education and Training Officer (CETO)	September 2025	
Discussions with System partners around shared operational resource	Chief Education and Training Officer (CETO)	September 2025	Discussions underway with HE partners

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risksto 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 partners		

	Ongoing improvements to infrastructure (staffing and systems)		

Associated Risks on the Corporate Risk Register		
Risk ID	**Description**	**Current risk score**
3	Loss of Registration with Office for Students	8

Full Corporate Risk Register List report

Report Date: **15-Aug-2025**

Risk Score Legend:	
	Un scored
1 - 4	Low
5 - 8	Moderate
9 - 12	Significant
13 - 25	High

Linked BAF risk	Reference	Category	Description	Impact of risk	Location	Original score	Current score	Target score	Target date	Approved status
BAF 01 - Inquality of access for patients	RSK-061	Patient experience	Delays in delivering clinic letters to patients or healthcare professionals.	May result in patient harm, poor patient experience and care, delays in treatment, reputational damage to the Trust, and increased stress for administrative and clinical staff."	Adult Unit - Gender Identity Clinic	15	15	5	01-Apr-25	Approved
BAF 02 - Failure to provide consistent, high-quality care	RSK-038	Staff Wellbeing	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.	This may result in a potential rise in complaints due to cancellations and delays, compromised patient safety, and a possible decline in service reputation.	Adult Unit - Gender Identity Clinic	15	15	8	26-Mar-25	Approved
	RSK-004	Inspection / Audit	If complaints are not responded to within regulatory timescales.	then there could be increased negative experience by patients and negative attention, stakeholders, regulators and media	CNO - Complaints and PALS	12	12	2	30-Sep-24	Approved
	RSK-003	Safety	Low staff take-up of flu vaccine annually	could lead to high rates of sickness in winter	CNO - Physical Health	12	12	4	30-Apr-25	Approved
	RSK-147	Safety	Band 8b has not been recruited to since the post was vacated in March 2025. Many of the staff in GWY are lower banded and inexperienced. This puts a lot of pressure on the 3 longer serving team members, one of who is also overseeing another team and another has considerable supervising duties due to the vacancy.	Risk to patients in relation to inexperienced staff carrying risky cases and not able to offer or ask for appropriate support.	Camden - Growing With You	12	12	4	15-Sep-25	Approved
BAF 09 - Delivering financial sustainability targets	RSK-086	Finance	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.	The lack of an established recurrent CIP programs will hinder financial sustainability.	Finance - Finance and Procurement	15	15	8	20-Mar-25	Approved
BAF 10 - Maintaining an effective estate function	RSK-089	Finance	If the Trust lost key members of staff, then this results in single points of failure and lack of capacity within the team,	resulting in the inability of the team to deliver core functions in a timely or adequate manner	Finance - Finance and Procurement	15	15	8	21-Mar-25	Approved
BAF 12 - IT infrastructure and cyber security	RSK-016	Service	If there are not enough skilled cyber security resource to support the growing demand and compliance of cyber security, then this may result in Trust to maintaining cyber security compliance and would result in increased vulnerability to infrastructure and Trust not compliant with DSPT and cyber standards Here's a clearer version of the risk, including the potential impact, controls, actions, and priority: Risk: If there are insufficient skilled cybersecurity resources to support the growing demand for cybersecurity and compliance requirements, the Trust may struggle to maintain cybersecurity standards, increasing vulnerability to infrastructure threats and non-compliance with the Data Security Protection Toolkit (DSPT) and other cybersecurity standards.	Financial Impact: Potential fines or penalties due to non-compliance with cybersecurity regulations and standards. Reputational Damage: Loss of trust from patients, stakeholders, and regulatory bodies due to failure to maintain appropriate security measures. Service Delivery: There is an increased risk of cyberattacks, which could disrupt critical services and operations, leading to delays and potential harm to service delivery.	Finance - IM and T	15	15	2	22-Mar-25	Approved
	RSK-019	Cyber Security	Risk: If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring immediate action over the weekend, a lack of available resources may result in delays in remediation, leaving systems and data vulnerable to compromise.	Then, delayed action would compromise the Trust systems, services, and data.	Finance - IM and T	15	15	4	23-Mar-25	Approved
	RSK-006	Delivery	If additional user authentication measures are not rolled out to all trust end users, their accounts security does not meet recommended cyber security standards.	This will impact CE accreditation failure and compliance failure for meeting DSPT.	Finance - IM and T	15	12	3	24-Mar-25	Approved

Linked BAF risk	Reference	Category	Description	Impact of risk	Location	Original score	Current score	Target score	Target date	Approved status
BAF 13 - Failure to achieve required levels of performance and productivity	RSK-039	Delivery	Potential risks for those awaiting interventions If GIC waitlists continue to grow. There may be an increased chance of serious incidents and poor patient experience. Overstretched staff expected to deliver services.	This results in an impact on care delivery, a loss of service reputation and non-compliance with regulatory and contract requirements.	Adult Unit - Gender Identity Clinic	20	20	8	25-Mar-25	Approved
	RSK-032	Safety	If a patient has an excessive wait to receive an ASD assessment, They will be unable to access appropriate care while they wait and require significant input from local services.	Harm to the young person who needs a diagnosis and pressure on local CAMHS servcies that may be unable to fully meet the young persons needs.	CYP and Families	16	16	4	30-Apr-25	Approved

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 18 September 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 010**
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: NED Responsibilities 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report provides an update on the changes to the composition of the Board of Directors, including Non-Executive Director responsibilities for 2025/26 (attached as Appendix 1) for information.		
Background:	In December 2021, NHS England (NHSE) published guidance on a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. The guidance also confirmed the 5 areas in relation to which they expect boards to continue to have NED champions as: • Maternity (not applicable to the Trust) • Wellbeing guardian • Freedom to speak up • Doctors' disciplinary • Security management The Board received a report in September 2024 confirming the champions, as well as committee memberships and other roles. The purpose of this paper is to update these roles following the end of David Levenson's term of office on 31 August 2025; the appointment of Sabrina Phillips as full Non-Executive Director on 1 September; imminent departure of John Lawlor, Trust Chair on 30 November; and the appointment of Aruna Mehta as Interim Trust Chair from 1 December 2025.		
Assessment:	Following these changes, we have taken the opportunity to review committee memberships and NED champions. It will be for the Council of Governors to appoint the Vice Chair, and a Senior Independent Director, a proposal regarding this will be put to them at their next meeting in October 2025. It was recommended at the Extra-Ordinary PFRC meeting in July 2025 that the Board consider whether there is a NED with property experience who could take an oversight role in relation to the sale of Gloucester House.		
Key recommendation(s):	The Board is asked to: 1. **NOTE** the Non-Executive Director responsibilities for 2025/26; and 2. **CONSIDER** whether there is a NED with property experience who could take an oversight role in relation to the sale of Gloucester House.		

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 ☐		
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, failure to have effective corporate governance arrangements in place will be detrimental to the Trust.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Appointment of the NED champions aligns with NHSE guidance as well as the Code of governance for NHS provider Trusts.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no additional EDI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	None				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

The Tavistock and Portman NHS Foundation Trust

NON-EXECUTIVE DIRECTOR RESPONSIBILITIES – 2025/26 (September to November 2025 – 1 Chair and 7 NEDs)

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
John Lawlor	Trust Chairman	• Remuneration Committee (**Chair**)	None	• Council of Governors (Chair) • Nominations Committee (Chair)	June 2022 (Given notice of early departure 30 November 2025)
Aruna Mehta	NED, Vice Chair	• Performance, Finance & Resources Committee (**Chair**) • Integrated Audit and Governance Committee (Member) • Remuneration Committee (Member)	None	None	November 2021 (2nd 3-year term of office ends November 2027 or until the merger is enacted)
Shalini Sequeira	NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (**Chair**) • Performance, Finance & Resources Committee (Member) • Remuneration Committee (Member)	Wellbeing Guardian/ Champion	None	November 2021 (2nd 3-year term of office ends November 2027 or until the merger is enacted)
Claire Johnston	NED	• Quality and Safety Committee (**Chair**)	Joint Freedom to Speak Up (FTSU) NED Lead	Gloucester House Steering Group (Member)	November 2022 (2nd 3-year term of office ends November 2028 or

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
		• People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)			until the merger is enacted)
Sal Jarvis	NED	• Education & Training Committee (**Chair**) • Integrated Audit and Governance Committee (Member) • Remuneration Committee (Member)	Security Management Champion	None	November 2022 (1st 3-year term of office ends November 2025) *(2nd 3-year term of office ends November 2028 or until the merger is enacted)*
Ken Batty	NED	• Integrated Audit and Governance Committee (**Chair**) • People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	Joint Freedom to Speak Up (FTSU) NED Lead	None	April 2024 (1st term of office ends March 2027 or until the merger is enacted)
Janusz Jankowski	NED	• Quality and Safety Committee (Member) • Education & Training Committee (Member) • Remuneration Committee (Member)	Doctors Disciplinary Champion/ Independent Member PCREF Champion	None	November 2022 (1st 3-year term of office ends November 2025) *(2nd 3-year term of office ends November 2028 or until the merger is enacted)*

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
Sabrina Phillips	NED	• Quality and Safety Committee (Member) • Performance, Finance & Resources Committee (Member) • Remuneration Committee (Member)	PCREF Champion	None	September 2025 (1st 3-year term of office as a full NED ends September 2028 *or until the merger is enacted)*

Tally
POD: 3
IAGC: 3
ETC: 2
QSC: 3
PFRC: 3

NON-EXECUTIVE DIRECTOR COMMITMENTS – 2025/26 (December onward – 1 Chair and 6 NEDs)

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
Aruna Mehta	Trust Chair	• Performance, Finance & Resources Committee (**Chair**)	None	• Council of Governors (Chair) • Nominations Committee (Chair)	November 2021 (2nd 3-year term of office ends November 2027 or until the merger is enacted) Appointed Chair from 1 December 2025
Shalini Sequeira	NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (**Chair**) • Remuneration Committee (**Chair**) • Performance, Finance & Resources Committee (Member)	Wellbeing Guardian/ Champion	None	November 2021 (2nd 3-year term of office ends November 2027 or until the merger is enacted)
Claire Johnston	NED	• Quality and Safety Committee (**Chair**) • People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	Joint Freedom to Speak Up (FTSU) NED Lead	Gloucester House Steering Group (Member)	November 2022 (2nd 3-year term of office ends November 2028 or until the merger is enacted)

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
Sal Jarvis	NED	• Education & Training Committee (**Chair**) • Integrated Audit and Governance Committee (Member) • Remuneration Committee (Member)	Security Management Champion	None	November 2022 (1st 3-year term of office ends November 2025) *(2nd 3-year term of office ends November 2028 or until the merger is enacted)*
Ken Batty	NED	• Integrated Audit and Governance Committee (**Chair**) • People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	Joint Freedom to Speak Up (FTSU) NED Lead	None	April 2024 (1st term of office ends March 2027 or until the merger is enacted)
Janusz Jankowski	NED	• Education & Training Committee (Member) • Integrated Audit and Governance Committee (Member) • Remuneration Committee (Member)	Doctors Disciplinary Champion/ Independent Member PCREF Champion	None	November 2022 (1st 3-year term of office ends November 2025) *(2nd 3-year term of office ends November 2028 or until the merger is enacted)*
Sabrina Phillips	NED	• Quality and Safety Committee (Member) • Performance, Finance & Resources Committee (Deputy Chair)	PCREF Champion	None	September 2025 (1st 3-year term of office as a full NED ends September 2028 *or until the merger is enacted)*

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
		• Remuneration Committee (Member)			

Tally
POD: 3
IAGC: 3
ETC: 2
QSC: 2
PFRC: 3

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Quality & Safety Report Month 2 & 3 (May and June 2025)			**Agenda No.: 012a**
Report Author and Job Title:	Emma Casey, Associate Director of Quality Nimisha Deakin, Associate Director of Nursing & Patient Experience Lucy Hegarty, Patient Safety Manager Sonia Perez, Quality Assurance Manager Fay Shorter, Complaints & Enquiries Manager	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1 – Key Pointers for Incident Reporting		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	In line with the Trust's Quality Framework, there is a need to refocus and strengthen the way in which we report and assure the quality and safety of our services, with specific focus on learning from patient safety incidents and service user experience.		
Background:	This Quality & Safety report expands on the information in the Integrated Quality and Performance Report (IQPR) and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IQPR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics. The Unit Clinical Governance meetings and the Trust wide IQPR meetings inform the narrative of this quality and safety paper, in relation to action taken in respect of thematic and individual areas of focus identified.		
Assessment:	The Board is asked to note and discuss the data for this reporting period (May and June 2025). The review of themes reported and how improvements to services are made in response is an emerging piece of work and will continue. The update on the Quality Priorities 25/26 Quarter 1 progress will be included in September's report.		
Key recommendation(s):	The Board is asked to **NOTE** and **DISCUSS** 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 ☐		
	Risk Ref and Title : BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust will be held to regulatory account if it does not report its quality and safety data in a robust, transparent and accountable way.				
Resource Implications:	Yes ☐	No ☒			
	None				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	There may be opportunities to consider reporting some of the metrics by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does differ between reporting group. This will be guided by the PCREF workstream.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Quality & Safety Committee – August 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	

Quality & Safety Report – Month 2 & 3 (May and June 2025)

1. Background

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

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

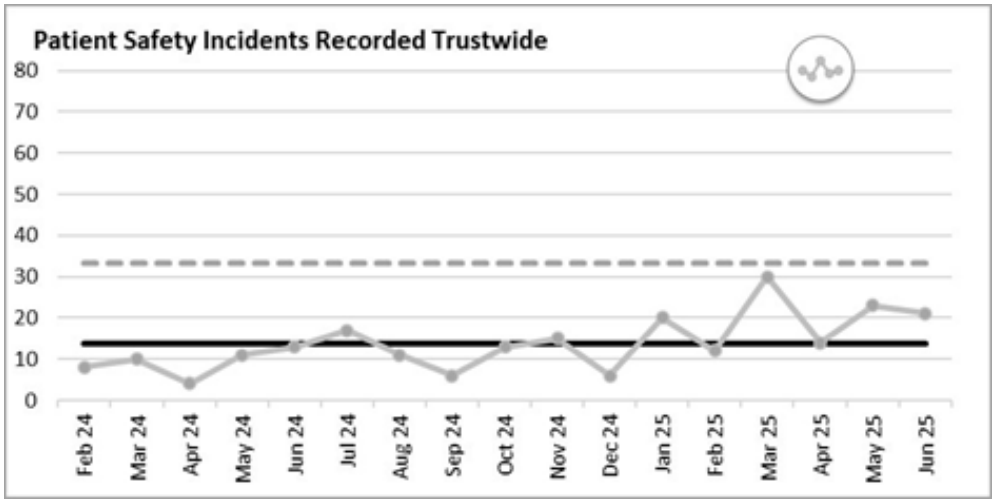
2. Clinical & Patient Safety Incidents

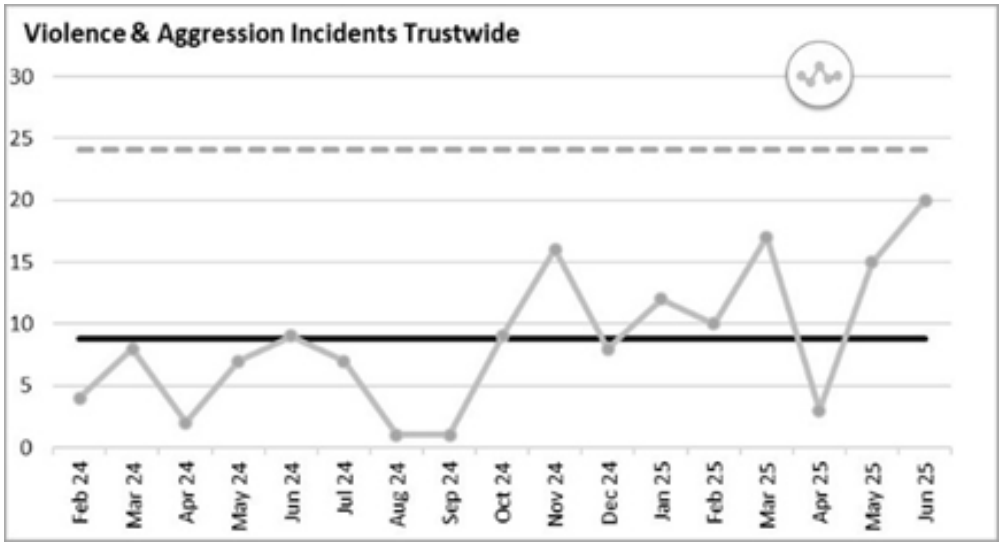
The following tables present clinical and patient safety incident data recorded during May and June 2025, with separate graphs illustrating the level of harm associated with patient safety incidents. Statistical Process Control (SPC) charts have also been included for selected metrics to identify emerging trends or areas of concern.

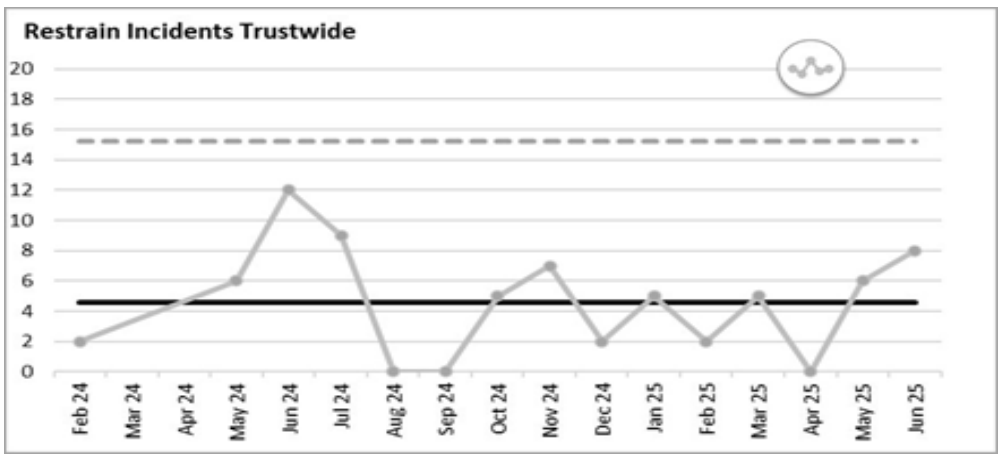
May 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit	Other
Incidents – Patient Safety incidents	23	3	12	8	0
Incidents – Open SI / PSI investigations	1	0	0	1	0
Incidents – Falls with harm	0	0	0	0	0
Incidents – Violence & Aggression	15	0	11	2	2
Incidents – Restraint/ Hold	6	0	6	0	0
Incidents - Number of all deaths	5	0	0	5	0
After Action Reviews Requested	4	0	3	1	0

June 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Incidents – Patient Safety incidents	21	4	15	2
Incidents – Open SI / PSI investigations	1	0	0	1
Incidents – Falls with harm	0	0	0	0
Incidents – Violence & Aggression	20	2	17	1
Incidents – Restraint/ Hold	8	0	8	0
Incidents - Number of all deaths	0	0	0	0
After Action Reviews Requested	3	0	3	0

SPC analysis indicates that overall patient safety incident levels for May and June remain within expected variation. However, a notable rise in violence and aggression (V&A) incidents was recorded in June, the majority of which were in Gloucester House School. Staff at the school explained that behaviours can be more challenging towards the end of summer term. The patient safety team is doing a thematic review of the incidents and will work with Gloucester House Team to plan ahead for anticipated periods in the school year with a focus on reducing violence and aggression in partnership with pupils.







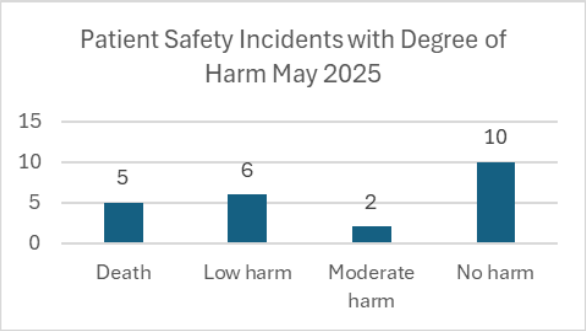
While it is believed that the sustained increase in incidents of violence and aggression may reflect a positive, open reporting culture, especially within the CYP & Families Unit, the Patient Safety team is undertaking further analysis to understand the underlying factors. Outcomes from this review, alongside findings from a recent audit on restrictive practice

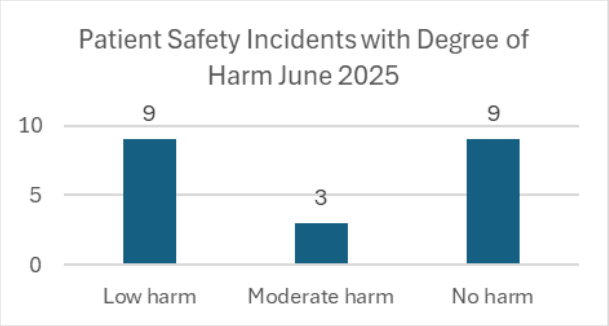
reporting, will be shared within the clinical governance framework and specifically with the Gloucester House team at their INSET day in September 2025, following the summer break.

This feedback will also address improvements required in incident reporting timeliness, as recent data shows as a Trust, for quarter four there was a median delay of six days between incidents and submission to LFPSE. This is being analysed further to understand key reasons for the delays. On initial review there appears to be a discrepancy between reporting the incident on the date we became aware of it as opposed to the date the incident happened.

The charts included below illustrate incidents by level of harm, as reported by those submitting the incidents. In both May and June 2025, the majority of incidents were categorised as 'no harm' or 'low harm', with 5 deaths reported in May and none in June.

While low-severity incidents may appear less critical, they still offer valuable opportunities for learning and improvement. Learning responses continue to be undertaken in alignment with the Trust's safety priorities.





In relation to reported incidents in May and June, the following points are noted.

Learning from Incidents: A number of After Action Reviews (AARs) were conducted during May and June, resulting in the following key learning points:

- **Joint AAR (INC-305, 306, and 328):** Three separate incidents at Gloucester House in relation to the use of the nurture space despite known issues, due to a lack of alternative environments. **Key Learning:**
  - Improve communication and shared understanding between services, estates, and leadership.
  - Strengthen proactive risk assessments and contingency plans.
  - Recognise environmental impacts on staff wellbeing.
  - Promote regular cross-functional meetings to support joint accountability.

- **INC-275:** A pupil assault on a staff member. No restrictive intervention was used; appropriate de-escalation techniques were applied. **Key Learning:**
  - Review use of fixed-term contracts for Pupil Support Workers (PSWs).
  - Improve security measures through enhanced access control.
  - Consider the need for purpose-built facilities.
  - Consideration of potential review of age range of pupils.
  - Recognition given to staff for their professionalism and commitment.

- **INC-444:** A pupil displayed dysregulation behaviour and absconding. **Key Learning:**
  - Enhance individual risk assessments and need to install internal access locks.

- Consider the cumulative effective of staffing pressure and environmental stressors.
- Estates and leadership to jointly review site safety, especially around doors and fire escapes.
- Maintain ongoing staff training in safe holding strategies.
- Recognition given to staff who acted in a trauma-informed, compassionate manner despite feeling anxious and under pressure. Staff used de-escalation and negotiation effectively which was supported by good relationship between staff and pupil.

- **INC-348:** Follow up of an urgent email received. **Key Learning:**
  - Extend reflective groups/supervision to administrative staff.
  - Strengthen email triage processes to include risk identification.
  - Implement out-of-office auto-replies with urgent signposting

Additional AARs are pending and due for completion. These focus on a number of issues, including, admission/discharge processes, patient care, and communication within the CYP & Families Unit. An AAR has also been requested by the Portman team (Adult Unit) in relation to disruptive behaviour during group therapy.

All AAR outcomes and learning will be discussed at the Clinical Incident and Safety Group (CISG) and disseminated through Unit Clinical Governance Meetings.

A Patient Safety Incident Investigation has been commissioned following multiple complaints and two incidents (to date), all relating to issues identified in delays in making referrals to the gender surgery hub. Terms of Reference have been developed and the investigation team is currently being established. The investigation is due to conclude by 3rd September 2025, with learning to be shared through governance processes. The investigation will aim to review and clarify the circumstances surrounding the complaints and incidents, make recommendations for improvement, and identify both individual and systemic contributory factors that led to surgical referrals not being processed as expected. NHS England commissioners and quality leads have been informed, the report will be shared with them.

The open Patient Safety Incident Investigation (PSII) from September 2024 was discussed at the Clinical Incident & Safety Group in May 2025. This update was to provide assurance on the learning and actions undertaken prior to the formal closure of the investigation. A summary of the actions confirmed as completed is provided below:

- *Review of duty rota in the Trust's Adult Psychotherapy Services:* A new Terms of Reference has been finalised. The designated duty clinician is now required to report in person to the main administrative office to provide their office room number and contact telephone number. **Action completed.**
- *Implementation of a new process for monitoring emails in the generic Adult Psychotherapy Service inbox:* This **action has been completed** , with the inbox now being monitored twice daily.
- *Reinforcement to clinicians of the importance of clearly communicating treatment length and post-discharge options:* This has been discussed in both the team meeting and Clinical Governance (CG) Unit meeting. Action completed.
- *Ensure all clinical staff are aware of the policy regarding patient requests for private consultations:* This remains a clinical protocol- formal policy to be developed by Triumvirate.
- *Consideration of whether the term 'next of kin' should be reviewed to ensure inclusivity of non-familial support networks:* To be included on the next Clinical Services Delivery Group agenda for discussion.

- *Consider formalising the agenda structure within Service Management Supervisor groups*: A meeting with DET is scheduled to address this and update will be provided to CISG following the discussion

The PSII remains open until evidence that all actions are completed is received.

Training, Support and Development: To further strengthen the incident reporting culture, the Patient Safety team has developed a new guidance tool (Appendix 1 – Key Pointers for Incident Reporting) to support increased quality of incident reporting.

A training session for staff on delivering Duty of Candour with Empathy is planned for July 2025. Feedback from this event will be included in the next report. A session on the AAR process will also be delivered at the all-staff meeting in July 2025.

The Patient Safety team will also increase their presence at clinical team meetings in the coming months to facilitate open discussions on patient safety and promote timely reporting and awareness.

3. Complaints & PALS

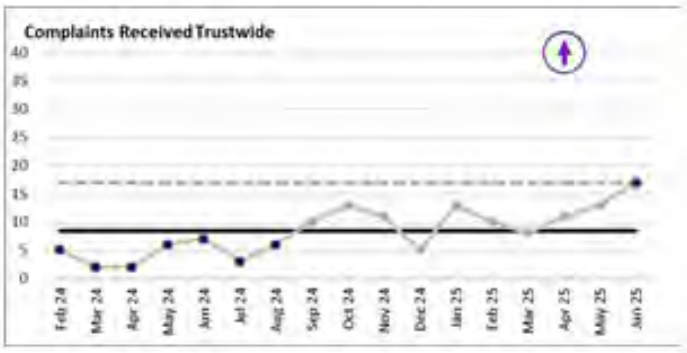
13 and 17 complaint contacts were received during May and June 2025 respectively.

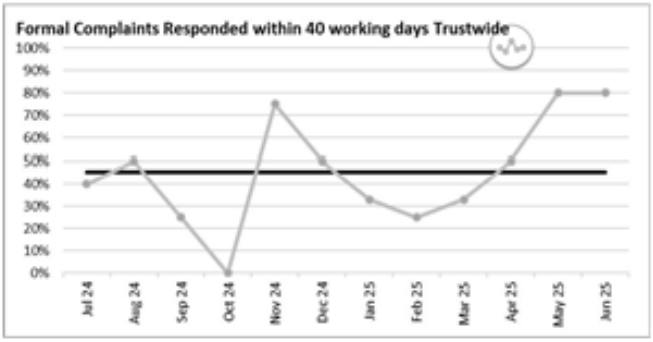
May 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Formal complaints - Number received	13	0	2	11
Formal complaints - Number acknowledged within 3 days	10	0	2	8
Formal complaints - Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	80% *4 of the 5 complaints closed were within 40 days)*	1	1	2
Investigations by PHSO	0	0	0	0
Informal complaints	50% *2 of 4 complaints closed were within 10 days)*	1	1	0
Number of open complaints	22	1	1	20
Number of overdue complaints	7	0	3	4

June2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Formal complaints - Number received	17	3	3	11
Formal complaints - Number acknowledged within 3 days	16	3	3	10
Formal complaints - Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	80% *4 of the 5 complaints closed were within 40 days*	1	0	3
Investigations by PHSO	0	0	0	0
Informal complaints	100% *4 of the 4 informal complaints closed within 10 days*	1	0	3
Number of open complaints	32	1	5	26
Number of overdue complaints	11	0	3	8

The Trust reported a compliance rate of 80% of formal complaints responded to within the 40-day timeframe in May and June 2025, although this remains below the Trust target of 90%, it continues to be an improved position from 12 months ago. As of the end of June

2025, the number of open and overdue complaints increased. This has followed an increasing number of complaint contacts being received month on month since March 2025.





Following the significant improvement in closing the oldest complaints noted at the beginning of the year, the compliance against the Trust's target for responding to complaints in a timely manner remains subject to fluctuation. Regular meetings with the Complaints Manager and Unit Service Clinical Leads helps to focus on progressing complaints that are at risk of breaching the 40-day timeline. There is also a daily huddle in the Complaints leadership team to discuss upcoming deadlines and review any difficulties.

The main themes for complaints in May and June 2025 are outlined below:

- Communications - This included a range of complaints across Units e.g. not updating the patient regarding treatment outcomes, disagreement with the outcomes of an assessment report, unhappiness with progress of therapy sessions, breakdown of communication with clinician and conflicting information given to patient with regards to GIC referrals.
- Access to Treatment or Drugs - including dissatisfaction with the type of treatment recommended and changes to a prescription.
- Patient Care - including complaints raised by patient and carers in relation to the appropriateness of care provided.
- Trust Admin/Policies – including Concerns regarding the accuracy of clinical notes following a SAR request

The A3 project for Complaints helped to focus the Complaints team on the quality improvement workstream to address the points below.

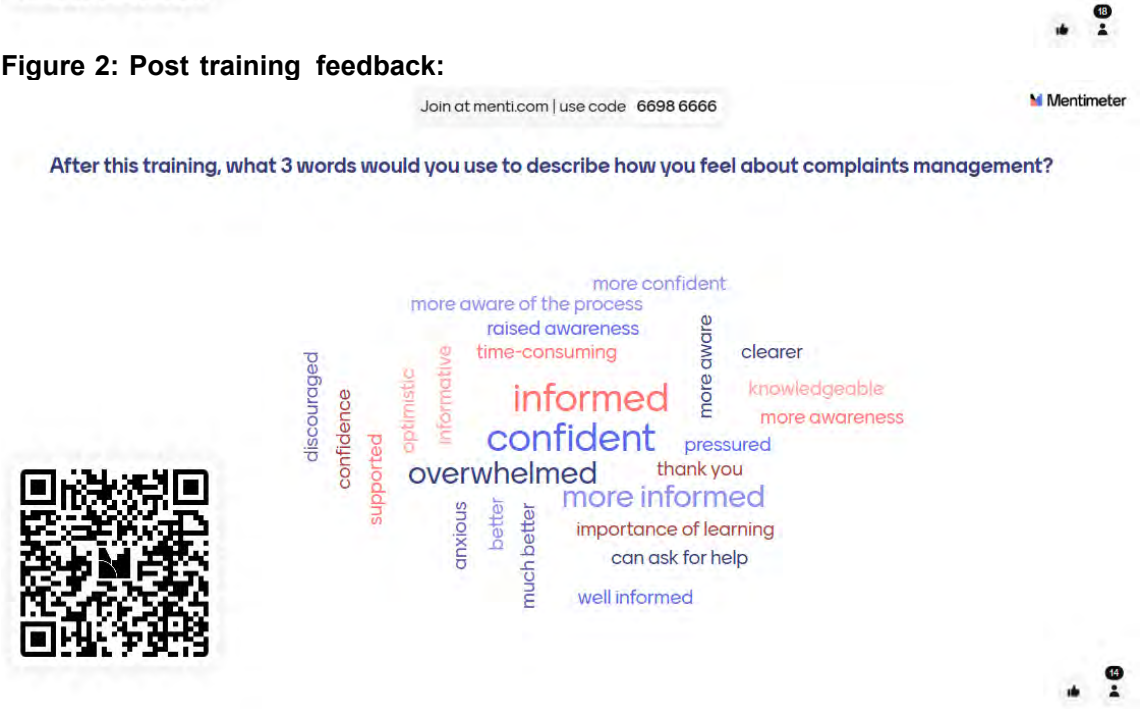
- Improving the timeliness and efficiency of complaints resolution
- Increasing the number of complaints resolved informally, within the 10-working day timeline
- Continuing the improvement in quality of complaint investigations and outcomes
- Increasing the number of staff that are trained to undertaken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

Training for staff was a key action from the QI project during the development stage. The first and second of these Trust-wide training sessions was delivered on 2nd and 18th June 2025. The QI project will be reviewed and refreshed in August following completion of the training.

Attendee feedback on complaints management was captured at the beginning and end of the training session to seek to understand the effectiveness of the training. The two images below indicate a positive impact of the training on staff awareness and preparedness for complaints investigation following the training.

Figure 1: Pre training feedback:

Figure 2: Post training feedback:



The Complaints team will deliver a final training session in July 2025 to address the outcomes of the A3 project and to provide staff with further information and guidance in relation to complaint investigations.

The table below references some of the recent learning outcomes from complaints closed in May and June 2025. For some of these, the actions are overdue, and further assurance will continue to be sought through the Clinical Governance meetings.

Some actions remain outstanding and overdue therefore assurance will continue to be sought internally that they have been completed by the person responsible.

The Service User Experience Group (SUEG) has escalated tangible and evidenced learning from complaints as an area of focus for the corporate and clinical teams.

One notable area of good practice is in the area of informal resolutions and was recorded by the CYP and Family Unit in May. This case referred to a complaint in relation to incorrect

information contained within the care plan and future appointments. The service team responded quickly in writing to the Complainant to confirm the amendments that would be made to the care plan enabling the complaint to be resolved informally.

Theme	Learning taken forward	Timeline
Communication: Conflicting information given by GIC and Transplus in relation to the referral process	The investigation found that incorrect information was given at the time of the enquiry. An apology given and learning was taken forward for re-training staff on how to access and interpret the data from the patient database when responding to queries.	Q1, 25/26
Access to Treatment/Communication: Progress of therapy sessions	Following a detailed and thorough investigation, the following outcomes were stated: 1. Ensuring transparency around the therapeutic approach. 2. Establishing clear, aligned treatment plans and goals 3. Communicating with sensitivity. 4. Using supervision to reflect on patient experience. 3. Sharing learning across the Trust.	Q1, 25/26
Surgery referral process	The investigation found that the referral was initially information only. Further information was included in an addendum to the clinical letter and the referral was subsequently made leading to an action that letters to the GDNRSS (surgical hub) are to be made clear regarding the surgical referral.	Q1, 25/26
Issues with ordering prescriptions	The investigation report included information on the prescribing process, i.e. though we make prescribing recommendations, the GP is also an independent healthcare practitioner who may make other prescribing decisions. An apology was given for delay in the patient's receipt of the clinical letter. The action plan provided training and awareness for staff on timeframes for checking and sending out clinical letters.	Q1, 25/26
Access to Treatment or Care for children & young people gender services	The investigation report provided an explanation of the legal and clinical framework for the GIC service and the commissioning arrangements. Actions related to the timing of letters being sent	Q1, 25/26
ADHD referral and assessment/communication	The investigation concluded that there should have been better communicating with partner agencies to fill any gaps in communication when a young person is on another external assessment waiting list.	Q1, 25/26
Information provided in the clinical report	Successful de-escalation resulting in an informal resolution. The report was revised and redacted to the agreement of the complainant who emailed the Clinician to express their satisfaction regarding the meeting outcomes.	Q1, 25/26

PALS*:*

10 and 6 PALS enquiries were received during May and June 2025 respectively.

	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit

	External are related to those not known to services			
May 2025	Internal (Queries for other Trust areas) = 2 Total = 10	1	0	7
June2025	Internal (Queries for other Trust areas) = 2 Total = 6	0	0	4

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

- Appointments (availability/waiting times)
- Concerns with treatment
- Communication issues (clinical administration, referral queries, delays in receiving letters, appointment changes, endocrine enquiries)
- Access to treatment or drugs – This included how to access services and what is available e.g. types of therapy offered, wait times and referrals process, whether referrals have been received, rejected referrals other support services such as housing, benefits, financial support and discharge enquiries.
- Queries in relation to the complaints process

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

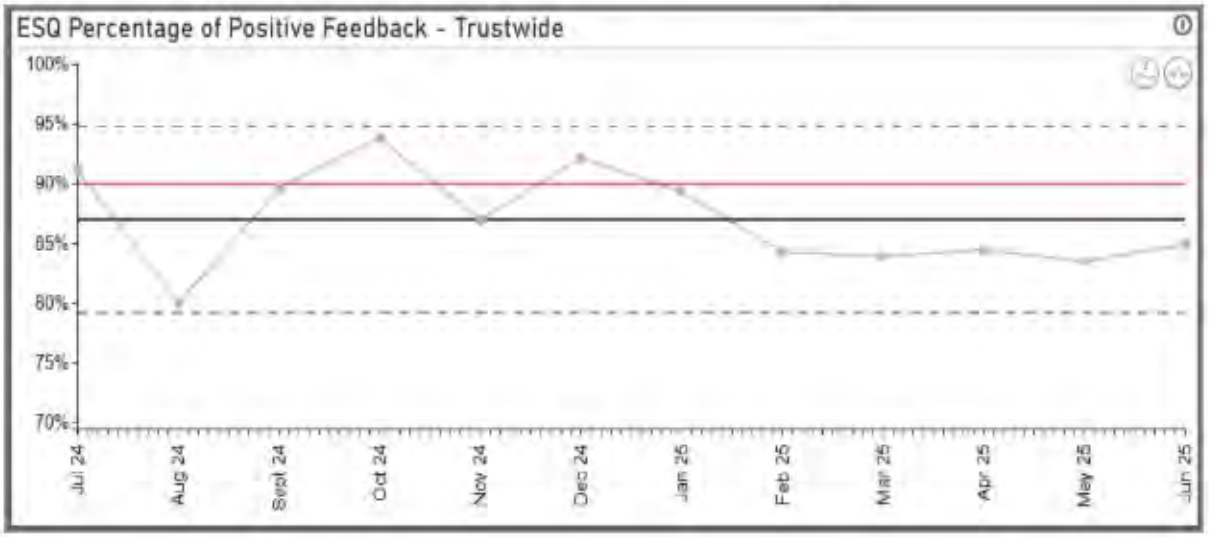
4. ESQFeedback & Compliments

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

The charts below represent a Trust wide view of the number of responses received across the last twelve months, and the positive response rate received from those responses. In June, Trust-wide positive responses to the FFT question were 85%, below our target of 90% positive responses. The number of forms received remains low.

Further progress is being made on projects to invigorate the number of ESQs received:

- Targeted support in reception areas has increased the number of forms collected in May and June. This will continue to support embedding this process to be taken on by teams directly.
- Teams where data reflects no feedback forms have been collected have been supported to identify actions to increase engagement.
- The first batch of text messages have been sent out to encourage further engagements from patients to give feedback.
- A touchscreen laptop has also been sourced and will be trialled in August in one reception area to measure if this improves the number of feedback forms received.
- QR codes posters for patients to give their feedback are displayed in reception areas.
- QR codes business style cards are available for teams that work more remotely.
- Paper forms are available in all reception areas



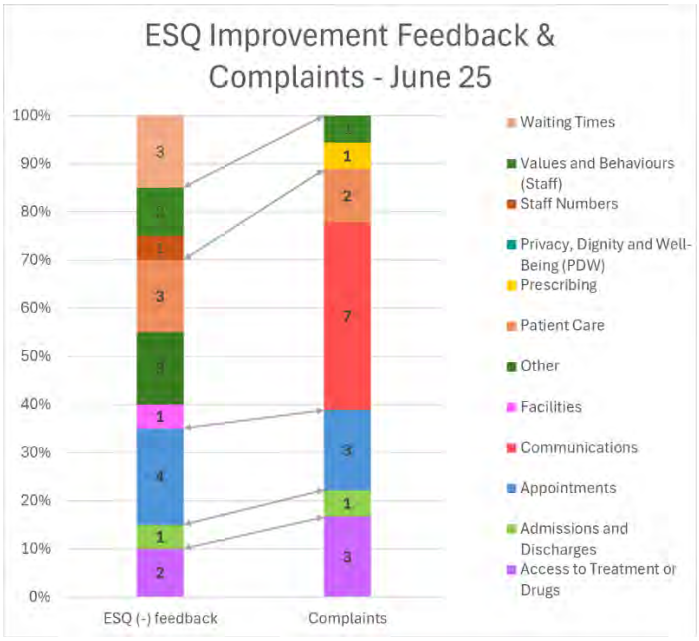
	Trustwide	Camden Unit	Child & Family Unit	Adult Unit
June2025 – ESQ forms received	73	13	46	12

Actions being taken to improve learning from patient feedback include:

- All qualitative feedback is shared with teams.
- All qualitative feedback is categorised on themes.
- ESQ data for the number of forms collected and percentage of positive feedback by teams is available through the clinical dashboard. Informatics are working on enabling access to all ESQ data through the clinical dashboard.
- Teams are actively reviewing service user feedback and capturing learning and actions. This is being discussed at Unit Clinical Governance meetings.

The graph below indicates the areas of negative feedback received via the ESQ process (areas for improvement), triangulated to the categories of complaints received (June 2025 data). The graph indicates a triangulation between negative feedback and complaints

categories related to access to treatment, admission and discharge, appointments, patient care and values and behaviours. These are broad categories and therefore these will be explored further through the Service User Experience Group (SUEG) to understand the true meaning behind each theme.

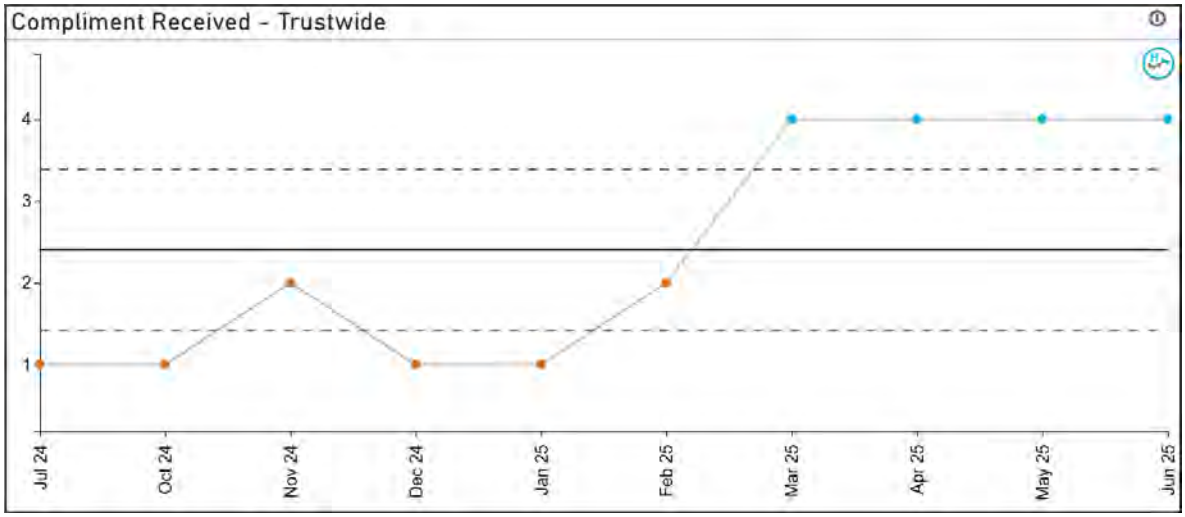


Qualitative data on positive feedback captures the experience of our service users about the care they receive. Below is a visual representation of word that appear in the feedback; the larger the word the more it was used.

Radar Compliments

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

Radar Compliments	Trustwide (Including trust/external)	Camden Unit	CYP & Family Unit	Adult Unit
Jun2025	4	3	-	1



5. Conclusion

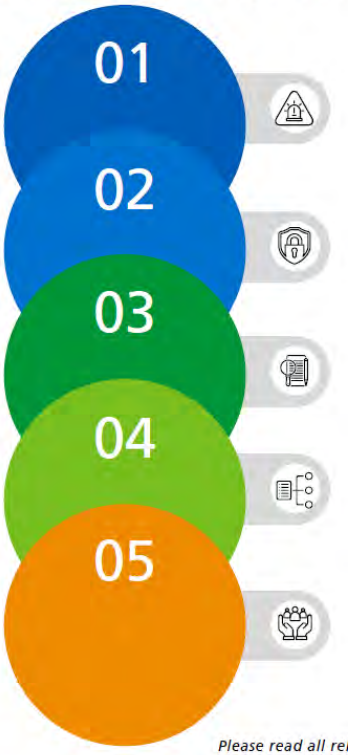
The Board is asked to note and discuss the data for May and June 2025.

The report details the learning from complaints closed in the reporting period. However, there is a lack of assurance that actions arising from complaints are being taken forward in a timely manner and evidenced as improving patient experience.

Appendix 1 –Key Pointers for Incident Reporting

Logging Incidents on RADAR: Guidance and Key Pointers for Reporter

NHS
The Tavistock and Portman
NHS Foundation Trust



When to Log an Incident

- Staff should promptly report incidents on Radar, our incident management system—especially those causing or risking harm, near misses, policy breaches, or safety/system concerns. Early reporting enables timely review, learning, and prevention.

Incident Date and Confidential Incidents

- Mark an incident as confidential if it involves any allegations or abuse concerning a staff member.
- Use the date you became aware of the incident as the incident date, and include details of when it actually occurred in the incident description.

Patient Safety Incidents

- Under LFPSE, patient safety incidents are unexpected events that did or could have caused harm to patients. Select 'yes' if this applies.
- Answer all questions as fully as possible, including 'don't know'—early reporting is crucial, even with limited details.
- Add a full account later in the Trust section of the form.

Dual Categorising

- Dual categorise incidents where applicable to help identify themes, trends, and populate relevant additional questions (i.e use of restrictive practice and de-escalation) for a thorough review and understanding.

Staff Wellbeing Review and Feedback Form

- After submitting the incident, you'll be prompted to complete a short four-question staff well-being and feedback form. Completion is encouraged to help identify any support needed.

Please read all relevant guidance and hint text on RADAR when completing the incident form. Thank you in advance for the reporting of incidents to ensure patient safety is improved through learning from incidents. For any queries, contact the patient safety team at incidents@tavi-port.nhs.uk.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday 18 September 2025			
Report Title: One Year On: A Review of PSIRF Implementation			**Agenda No. 012b**
Report Author and Job Title:	Lucy Hegarty, Patient Safety Manager	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer (CNO)
Appendices:	Appendix 1 – Learning Response Toolkit Appendix 2 – Learning Poster Appendix 3 – PSIRF A3 (QI Project)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	The Trust fully implemented the Patient Safety Incident Response Framework (PSIRF) from the beginning of April 2024. This paper provides a one-year review of the implementation of PSIRF across the Trust. It reflects on progress, identifies ongoing challenges, and makes recommendations to sustain improvements. The report draws on qualitative and quantitative data, including incident reporting trends, staff feedback, and input from Patient Safety Partners.		
Background:	Replacing the Serious Incident Framework 2015, the Patient Safety Incident Response Framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It requires a systemic and compassionate approach to learning from patient safety incidents. This transition was supported locally in the Trust through a quality improvement project (A3 plan on a page) and various engagement strategies. There was also involvement in the PSIRF community of practice across North Central London integrated care system (NCL ICS).		
Assessment:	This review examines the first full year of implementation, focusing on its impact on staff, patients, and organisational learning culture. It considers whether the Trust is in a position to require further improvement work to support implementation, or whether existing processes and systems are sufficient, enabling the Trust to transition to business as usual.		
Key recommendation(s):	The Board is asked to **NOTE** and **DISCUSS** the update.		

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title : BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	The Trust will be held to regulatory account if it does not report its quality and safety data in a robust, transparent and accountable way.				
Resource Implications:	Yes ☐	No ☒			
	None				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There may be opportunities to consider reporting some of the metrics by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does differ between reporting group. This will be guided by the PCREF workstream.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Quality & Safety Committee - Thursday 21st August 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	

1. Executive Summary

In April 2024, the Tavistock and Portman NHS Foundation Trust formally adopted the Patient Safety Incident Response Framework (PSIRF), marking a shift to a system-focused, compassionate, and learning-led approach in a psychologically safe and just culture. One year on, this review evaluates the impact of that shift for both staff and patients. Key developments include the introduction of structured learning responses, clearer visibility of patient safety concerns, and the strategic use of Quality Improvement (QI) methodologies. These efforts were supported by a PSIRF Implementation QI A3 project (appendix 3).

The Quality & Safety Committee have been updated with progress before, during and after implementation of the framework through the A3 Quality Improvement project, assurance reports from the PSIRF Implementation Group and the Quality & Safety report. The Committee also approved the Trust's PSIRF Policy and revised implementation plan (PSIRP) during the year.

While significant progress has been made, there are some challenges around consistent engagement with processes and integration of learning. However, these are not distinct to PSIRF and are indicative of issues in the wider Trust that are being addressed e.g. safety and learning culture.

This review draws on a combination of data and reflections to identify what has been achieved, where gaps persist, and how the Trust can strengthen and sustain its commitment to safer, more inclusive care.

2. Context and Purpose

The move from the Serious Incident Framework 2015 (SIF) to PSIRF represented a national shift towards learning from all safety incidents, not just those classified as serious. For a specialist mental health and educational provider like ours, implementation has required careful adaptation.

This review uses evidence from self-assessment tools, engagement with Patient Safety Partners (PSPs), QI data, and local safety policies. It aims to evaluate the current state of implementation, highlight lessons learned, and provide actionable recommendations. Structured around the System Quality Learning Review (SQLR) questions, this report supports our ambition to further embed a sustainable culture of safety, reflection, and continuous improvement.

Importantly, it considers whether the Trust is in a position to require further improvement work to support implementation, or whether existing processes and systems are sufficient, enabling the Trust to transition to business as usual. This would be with the assurance that the PSIRF principles, as outlined below, remain central and a continued focus within all processes.

- *Compassionate engagement and involvement of those affected by patient safety incidents*
- *Application of a range of system-based approaches to learning from patient safety incidents*
- *Considered and proportionate responses to patient safety incidents*
- *Supportive oversight focused on strengthening response system functioning and improvement*

3. Implementation Journey

Pre-PSIRF Landscape

Historically, incident responses concentrated on root cause analysis and individual accountability. Investigations were predominantly confined to Serious Incidents (SIs), which limited opportunities for wider organisational learning, particularly for us as a Trust, where the majority of incidents did not meet the previous threshold. This significantly constrained our ability to review and learn from the incidents we experienced. The introduction of PSIRF has enabled a more inclusive, tailored and flexible approach to learning from incidents.

Current Position: PSIRF Implementation Highlights

The table below summarises the highlights of the Trust's achievements in the implementation of PSIRF, in line with the four pillars of the framework.

Trust-wide Launch – April 2024

- Dedicated awareness campaign introduced PSIRF across the Trust.

Formal PSP Involvement

- PSPs joined key governance forums:
  - Quality and Safety Committee
  - Clinical Incident & Safety Group (CISG)

Training and Development

- 30+ staff completed accredited PSIRF training.
- Ongoing training sessions covering:
  - Learning responses (After Action Reviews)
  - Duty of Candour with Empathy
  - Compassionate Engagement
- Collaboration and Involvement with North Central London (NCL) Community of Practice for PSIRF including system wide learning Pilot
- Level 1 Essentials of Patient Safety included in mandatory and statutory training for all Trust staff

Learning Tools Introduced

- After Action Reviews (AARs)
- Thematic reviews
- Patient safety investigations
- Shifted focus from individual blame to systemic learning.

Improved Governance

- Daily safety huddles
- Executive Safety Huddle implemented for increased accountability and oversight
- Revised incident management processes
- Supports real-time awareness and accountability
- Strengthened data reporting through reports for Board, Quality & Safety Committe, IQPR, clinical dashboard

Enhanced Reporting Systems

- Radar Healthcare implemented for:
  - Local reporting
  - Integration with national systems

System Enhancements

- Improved reporting processes, particularly at Gloucester House, aligned with Ofsted and Team Teach standards.
- Use of AARs and other flexible learning tools.
- Development of a Learning Hub for sharing insights and best practice
- Qualified Patient Safety Specialist in December 2024
- Strengthened links with Trust Freedom to Speak Up processes
- Just Culture principles incorporated into refreshed People policies

4. Culture and Engagement

Building a Learning Culture which Strengthens Engagement and Transparency

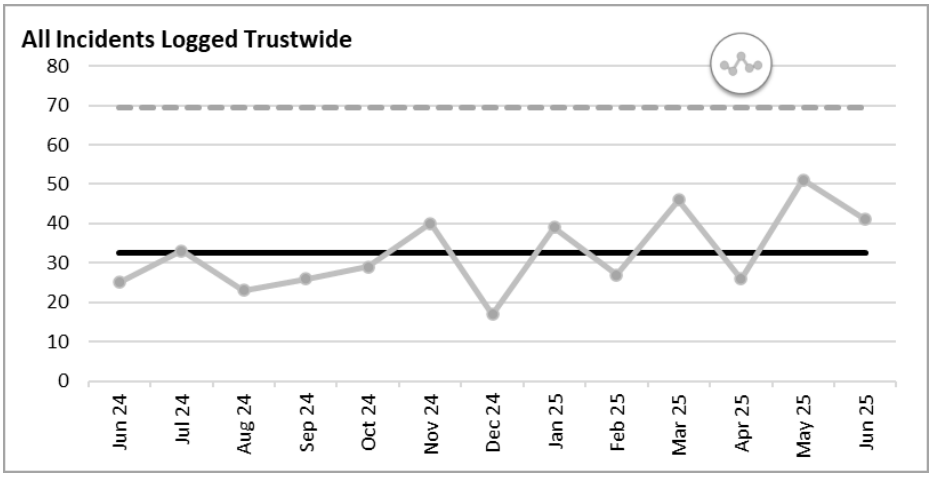
The Trust has placed a strong emphasis on psychological safety, moving away from punitive approaches to investigations. This cultural shift is particularly evident in the adoption of After Action Reviews (AARs) and accompanying learning posters (appendix 2), where psychological safety and a commitment to learning are central to the dialogue.

While AARs and other tools are helping build learning cultures within teams, there is variation in how confidently and consistently they are applied across the organisation.

Patient Safety Partners (PSPs) are now meaningfully embedded within the Trust's governance structures, including the Clinical Incident & Safety Group (CISG), Gloucester House Steering Committee and the Quality and Safety Committee. Their 'critical friend' role has enhanced both scrutiny and support in patient safety discussions, helping to ensure that the patient perspective is actively considered. To fully realise the Trust's priority of embedding the patient voice across all learning responses, PSP involvement must continue to evolve beyond representation, towards meaningful participation in decision-making and challenge.

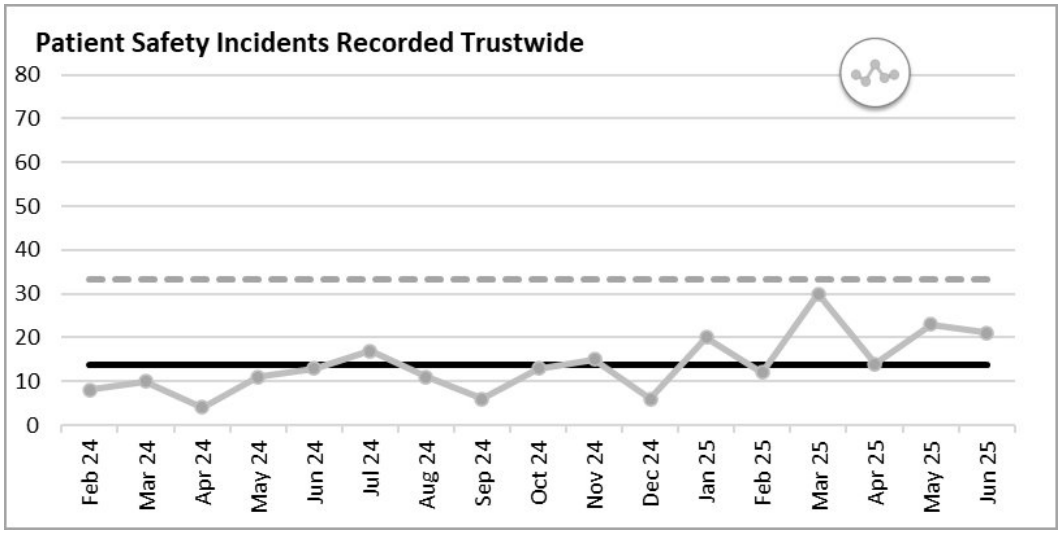
5. Quantitative Data Insights

The SPCs presented below are based on data from **all incidents recorded Trustwide** , including those specifically related to **patient safety, since the implementation of Radar in June2024 through to the present (June 2025).**



All Incidents Logged Trustwide: From June 2024 to June 2025, the total number of incidents logged Trustwide showed regular fluctuations, with noticeable peaks in November 2024, March 2025, and May 2025. Despite these variations, incident levels remained within control limits, and the average rate stayed relatively stable, suggesting consistent reporting with no significant anomalies.

Staff feedback on the functionality of the system, as opposed to the predecessor system, is positive. Radar also facilitates a full view and storage of all steps within an incident, enabling effective monitoring and accountability.

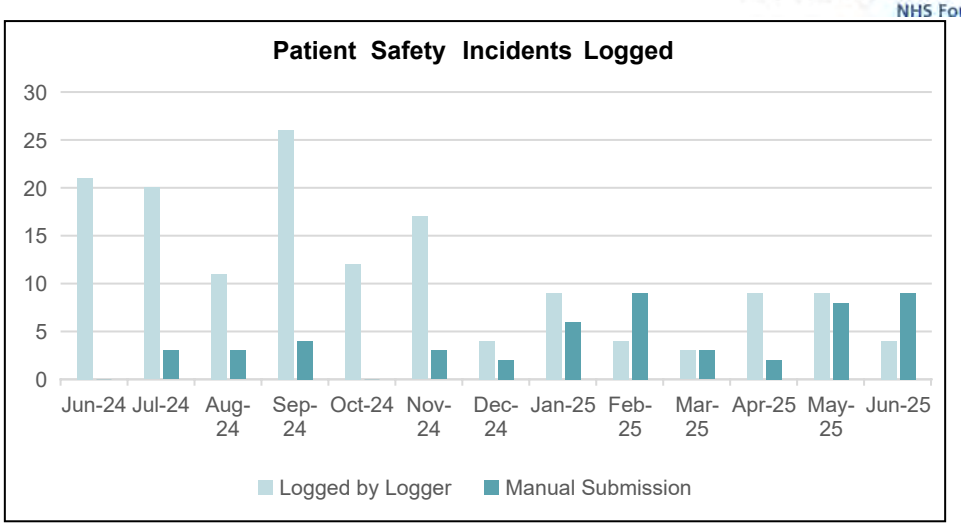


Patient Safety Incidents Recorded Trustwide : Patient safety incidents have fluctuated throughout the year, with a sharp but brief increase in March 2025 likely attributable to increased efforts with incident training amongst teams. Overall, figures stayed within control limits, and the average remained steady.

As part of training and efforts to raise awareness among teams regarding what should be logged as an incident, particularly those classified as 'patient safety incidents', a focus was placed on improving the accuracy of this classification. This followed a pattern of incidents being reported but not correctly identified as patient safety incidents by the logger. Our incident data has not been captured or reported in this way previously and so the increasing staff awareness around these elements is positive.

Following targeted work with teams, we have observed a reduction in 'manual submissions', where the Patient Safety Team previously had to retrospectively classify incidents as patient safety-related. At the same time, there has been an increase in 'logged by logger' entries, indicating that incidents are now being appropriately classified as patient safety incidents by the reporter at the point of entry.

Encouragingly, by June 2025, there were no manual submissions recorded. This marks a positive shift from earlier in the year, where retrospective classification by the Patient Safety Team was still required. The data from January to June 2025 demonstrates a steady reduction in manual entries, reflecting improved confidence and understanding among reporters in correctly identifying patient safety incidents at the point of entry.



To conclude on the data, overall, the slight but consistent increase in the total number of incidents likely indicates a positive shift towards greater transparency and awareness in reporting. Encouragingly, this growing culture of reporting creates further opportunities for learning and improvement.

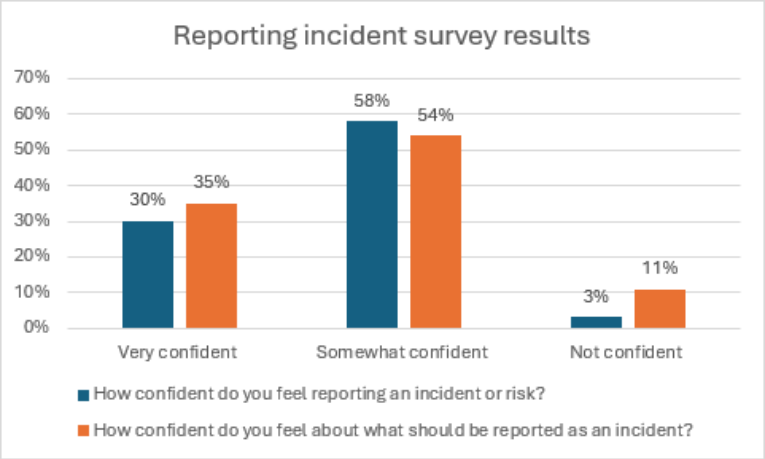
6. Qualitative Data Insights

Feedback gathered via Slido during the Trust-wide 'all staff' meeting in July 2025 (summarised below) highlighted that themes of blame and time pressures remain key barriers to incident reporting. This aligns with discussions held within teams.

To help address these concerns and gain a deeper understanding, the Patient Safety Team will continue to increase their presence at local team meetings. The aim is to stimulate discussion, awareness and encourage reflection, thereby supporting the ongoing development of a positive learning culture in which staff feel psychologically safe.

Furthermore, when staff were asked how confident they felt about reporting an incident or risk**, 58% of respondents indicated they felt 'somewhat confident', 39% reported feeling 'very confident', and 3% stated they were 'not confident'.**

In response to a separate question about their confidence in knowing what should be reported as an incident, **54% of staff reported feeling 'somewhat confident', 35% 'very confident', and 11% 'not confident'.**



While it is clear that teams are increasingly empowered to reflect, speak openly, and learn from incidents through the use of AARs and within a supportive environment (supported by the adoption of processes to give further considerations to staff well being), there remains room for further progress in embedding this ethos.

7. Consideration to System Quality Learning Review Reflective Questions

Drawing on data gathered from the Evalu8 survey and aligned with the criteria set out in NHS England's documentation on PSIRF oversight roles and responsibilities, we incorporated additional questions reflective of those used in system quality learning reviews to support our reflection on implementation.

As an overview, the Evalu8 survey assesses the organisation's maturity and readiness in fulfilling its oversight and responsibility using the self-assessment tool aligned to the core principles of PSIRF.

In summary, the findings indicate that the Trust demonstrates strong engagement, robust governance, and effective response frameworks in line with PSIRF expectations. However, opportunities remain for improvement in equality analysis, resource allocation, and the long-term sustainability of safety initiatives.

a) How have we measured the meaningfulness of the shift for both staff and patients?

The PSIRF A3 self-assessment responses reflect a maturing implementation amongst staff. Staff feedback, PSP involvement, and engagement forums highlight increased awareness of learning approaches, though confidence and consistency vary. For patients, PSP presence in governance structures has improved transparency, yet wider engagement still needs development.

b) To what extent do staff feel that learning is embedded, rather than simply reported?

Staff increasingly recognise that learning is becoming more embedded within the organisation, supported by the use of learning review tools (including accompanying learning posters, appendix 2) that promote a shift from individual blame towards systemic

understanding and a culture of continuous improvement. Feedback on the learning posters and use of them has been positive and encouraging.

Findings from After Action Reviews (AARs) and other learning reviews are being integrated into clinical and corporate governance processes, with a clear emphasis on monitoring the implementation of actions. However, while these governance mechanisms facilitate the dissemination of learning, there is still work to be done to fully embed this culturally across all levels of the Trust.

c) What challenges have we faced in achieving consistent, Trust-wide engagement and implementation?

Challenges have centred on variation in staff confidence, capacity across services, and competing demands on time and resources. Some teams have engaged deeply with PSIRF training and reporting tools, while others have shown lower uptake. This inconsistency has partly stemmed from variability in role-specific responsibilities, existing workloads, and differing levels of familiarity with learning frameworks.

There is also an acknowledged challenge in triangulating learning across departments, suggesting that integration of learning remains somewhat fragmented.

d) What has been the impact of involving PSPs in governance structures?

The involvement of Patient Safety Partners has introduced a critical friend perspective into key governance forums, contributing to more nuanced, compassionate conversations around patient safety. Their presence has enhanced accountability and encouraged greater service user voice in incident response planning.

However, it remains essential to ensure that PSPs are meaningfully empowered rather than symbolically included.

e) How is the psychological safety experienced amongst staff?

In teams using AARs and open discussion, psychological safety is growing. The move away from blame and towards compassionate engagement is positively received. Nonetheless, experiences vary, and uneven confidence in review processes remains a barrier.

f) Have we considered how local context and service complexity influence our application of PSIRF?

The Trust has recognised the unique nature of its services, including specialist mental health and educational services and adapted national PSIRF guidance to reflect this complexity. For instance, the Local PSIRP and Policy have been tailored to include service-specific risks and patient pathways.

Further, the formation of the PSIRF Group, including PSPs and stakeholders across all three service lines, reflects a conscious move to develop a locally relevant implementation model.

g) Do our engagement methods genuinely reflect the diversity of our service users' needs and preferences?

The feedback following the self-assessment indicates a gap in our understanding and response to the diverse needs of service users with protected characteristics. Although PSPs have enhanced service user involvement, more structured efforts are needed to capture a range of lived experiences and to design engagement strategies that are culturally and contextually sensitive.

Future efforts should include inclusive engagement audits, accessible communication tools, and co-designed learning activities to reflect the Trust's diverse population and equity ambitions.

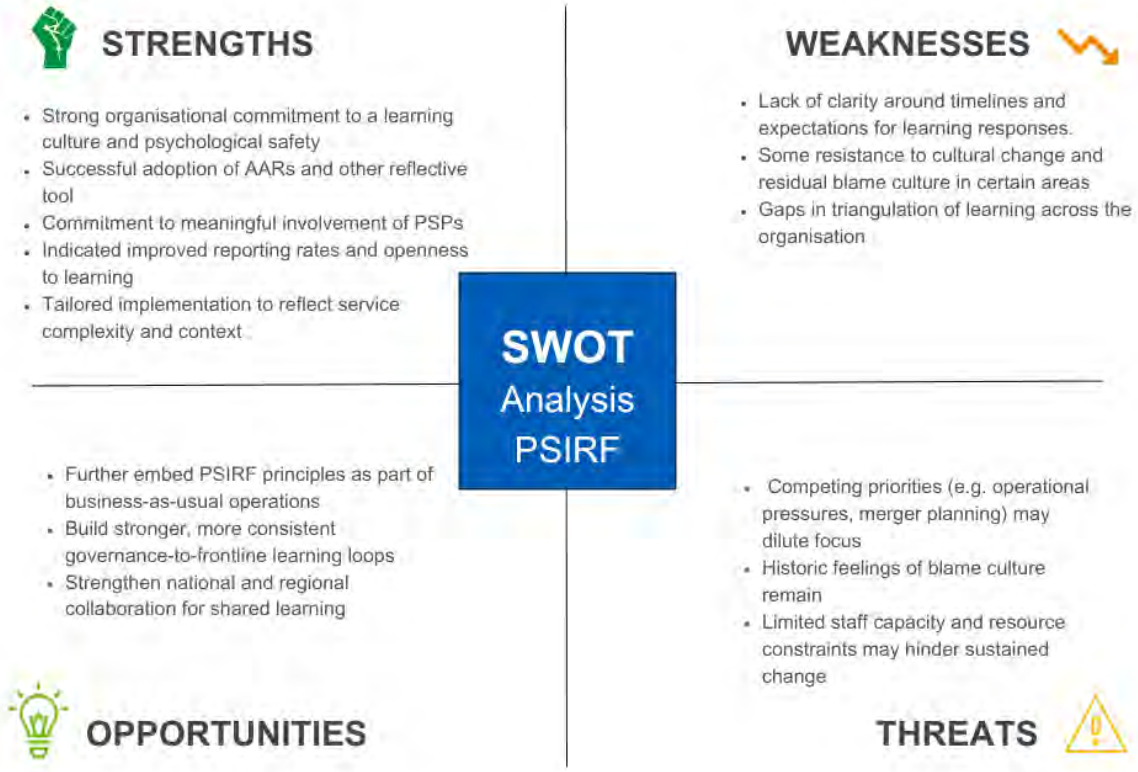
h) What does sustained improvement look like for us, and how will we know when this has been achieved it?

Sustained improvement means that learning is embedded into culture, governance, and daily practice, such that safety is proactively managed rather than reactively addressed. It includes:

- Consistent, confident use of learning methodologies across teams
- Evidence that learning informs measurable safety improvements
- Strong, inclusive patient and staff engagement
- Equity-informed analysis of all incident data
- Regular, transparent feedback loops from frontline to board, and vice versa.

We will know we've achieved this when staff feel safe to raise concerns, patients report increased trust, and safety data trends show a decline in avoidable harm with increased responsiveness to themes and feedback.

8. Impact Assessment: SWOT Analysis



9. Summary of Learning (AAR way of thinking on reflection)

As a reflection on the Trust's experience in implementing PSIRF, an AAR way of thinking has been applied for the purpose of this review in accordance with the four AAR questions.

This approach aims to clarify expectations versus reality, highlighting any discrepancies and the resulting learning opportunities.

10. Recommendations for Sustaining Improvement

Sustained improvement means:

- Learning is built into daily practice, not treated as a separate or reactive process.
- All staff feel safe to speak up, confident in their understanding of learning methods, and supported in applying them.
- Safety improvements are measurable and tracked.
- Patient voices are consistently reflected in learning and review processes.
- Diversity, equity, and inclusion are central to how we report, reflect, and improve.

Work will continue to be undertaken to address consistency in practice, particularly in areas where confidence and integration of learning vary, ensuring that the four PSIRF principles remain firmly embedded across all relevant systems and processes.

Looking ahead, emphasis will turn towards sustainability: enhancing capability, deepening integration (particularly in preparation for the forthcoming merger), and ensuring PSIRF is not only sustained but continues to serve as a catalyst for meaningful change. With continued commitment, PSIRF will remain central to advancing patient safety, supporting staff wellbeing, and strengthening organisational development.

11. Conclusion

Over the past year, the Tavistock and Portman NHS Foundation Trust has made significant strides in embedding PSIRF. This successful implementation demonstrates the Trust's strong organisational commitment to learning, transparency, and continuous improvement.

While the journey is ongoing, the first year has undoubtedly established a solid foundation for delivering safer, more compassionate care, and for fostering a more resilient and reflective workforce.

In line with the self-assessment and the SWOT analysis, there are some areas of further work required, as listed below. These are linked to the principles of PSIRF but successful implementation of the framework is not intrinsic to them. Alongside each of these is a proposal about how these will be taken forward through separate, existing pieces of work.

- **Consistent, confident use of learning methodologies across teams**
  - An AAR quality improvement project will begin during August 2025 to review and embed the process where required. The AAR is our primary learning response and therefore an effective process is imperative. A standard operating procedure has been developed recently been circulated to staff.
  - The Executive Safety Huddle and the Clinical Incident Safety Group (CISG) will continue to be responsible for assuring that the correct learning responses are applied
  -
- **Clinical Governance process and evidence of learning informing measurable safety improvements**
  - New formats to share learning (Appendix 2) have been developed and in are in use. These have been well received by staff but it is apparent that not all staff are accessing these.
  - The Trust's processes to share learning from incidents and feedback, including clinical governance processes, will continue to be an area of focus by the Director of Therapies and the CNO team to ensure that it is effective and accessible for all staff.
  -
- **Strong, inclusive patient and staff engagement**
  - The patient safety team will continue to present to the clinical governance meetings to ensure awareness, oversight and accountability of incidents and safety culture.
  - The team will also begin a series of visits to all clinical team meetings to discuss and guide teams with their incidents and reporting culture
  - Links with the Trust's Freedom to Speak Up team will continue
  -
- **Patient Safety Partners**
  - These roles will continue to be developed and embedded through the existing workplans and supportive line management processes
  -
- **Compassionate Engagement**
  - There is a quality priority for 25/26 that will develop and implement a process to involve patients in the after action review process.
  - Training opportunities and resources for compassionate engagement will continue as part of the patient safety and experience teams workplans

- **Equity-informed analysis of all incident data**

- Reporting of incident data by protected characteristics will be progressed as part of the Trust's Patient Carer Race Quality Framework (PCREF) project

Improved staff engagement, strengthened governance, and a clear cultural shift towards learning and a just culture all indicate substantial progress. Given the achievements to date, and with remaining work now integrated into existing programmes and related initiatives (such as Just Culture collaboration with HR, PSP workplans, and a QI project focused on AARs), the Trust is well placed to transition PSIRF from implementation to business as usual.

Appendix 1 – Learning Response Toolkit

NHS
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After Action Review (AAR)

1 What is it?	2 When would this tool be used?	3 Who leads this learning response review?	4 Supporting research and evidence confirm efficacy	5 Who is involved and timeframes?
A structured, facilitated discussion that helps those involved understand why an event's outcome differed from expectations and identify lessons for improvement.	Following any event where patient care or service was less effective or safe than expected, or when outcomes exceeded expectations.	Led by an accredited facilitator trained in AAR methods within the Trust.	Extensive evidence shows its structured approach improves team performance and patient safety.	Includes those directly involved in the event, others linked to them or the patient pathway. Duration is ordinarily 45-60 minutes but can extend to 90 minutes, depending on issue complexity and participant numbers.

Strengths

- Those involved explore what happened, consider different perspectives, and learn together in a psychologically safe space.
- The focus is on real-time learning, with participants collaborating to drive change and improvement.
- As a group process, it enhances communication, performance, and patient safety, and can be applied across the Trust.
- Highly adaptable, it suits a wide range of events, beyond clinical and patient safety incidents.
- It provides a supportive space for reflection, reducing isolation and rumination after events.

Weaknesses

- While lessons and actions are shared more widely, those involved take primary responsibility for change, reducing reliance on central monitoring.
- Tracking behaviour change or action completion post-AAR can be challenging; however, internal governance processes within the Trust provide assurance through reporting to the Unit Clinical Governance Meeting.
- Conflicting diaries of key attendees can hinder AAR effectiveness, as learning depends on having the right participants in attendance.
- Reliance on strong governance processes to monitor AAR activity and outputs limits access to collective learning.

NHS
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Patient Safety Incident Investigation (PSII)

1 What is it?	2 When would this tool be used?	3 Who leads this learning response review?	4 Supporting research and evidence confirm efficacy	5 Who is involved and timeframes?
This in-depth review is conducted when an incident or near miss indicates significant safety risks, to understand what happened, how and why, and to identify opportunities for learning.	Required when an incident or near miss involves significant actual or potential harm to a patient which requires deeper analysis of potential contributory factors.	Conducted by a trained patient safety investigator/(s) who gathers data, interviews staff, analyses findings, and produces a report with recommendations to support learning and prevent recurrence.	Extensive research has examined the structures, processes, and outcomes of PSII globally.	Those directly involved in the incident such as senior clinicians, the patient and their family members are encouraged to be involved. PSIIs typically require 20–80 hours to complete over several weeks, with the final report due within 3 months.

Strengths

- This well-established approach is widely recognised and valued by patients and their families.
- PSIIs offer a detailed analysis of incidents involving harm, ensuring specific causes are identified.
- Governance arrangements clearly define responsibility for the investigation and implementation of resulting actions.

Weaknesses

- Investigations are time-consuming, and actions from the PSII report may take additional months to implement.
- Outcomes are often less system-focused compared to other methods.
- PSII quality varied before PSIRF introduced mandatory investigator training.
- Staff involvement is typically limited to interviews, which can be highly stressful

Appendix 2 – Learning Poster

Appendix 3 – PSIRF A3 (QI Project)

Step 1: Problem Statement

The NHS Standard Contract for 2024/25 requires all NHS Trusts to be PSIRF compliant, including having a Trust PSIRF Plan and Policy. To maintain high standards of care and patient safety in line with the framework, we will align our efforts with the supporting PSIRF document on *oversight roles and responsibilities*. The Trust will use this as a self-assessment tool to gain assurance, monitor process success, and identify areas for improvement. In accordance with the oversight specification, the Trust will strengthen oversight systems to demonstrate improvement, not just compliance.

Step 2: Current Situation

The Patient Safety Incident Response Framework (PSIRF) outlines the NHS's approach to developing effective systems for responding to patient safety incidents, aiming for continuous learning and improvement in patient safety.

To date, the Trust has reviewed and updated its Patient Safety Incident Response Plan (PSIRP) and PSIRF policy. A cohort of 30 individuals has completed accredited PSIRF training, teams have participated in PSIRF workshops, and PSIRF review tools are being actively used with strong staff engagement. Following the 'PSIRF Launch Week' in April 2024, ongoing training sessions are being offered across the Trust, focusing on key aspects of PSIRF and incident reporting. Special attention has been given to incident reporting trends and themes to support a positive shift towards a just culture.

Step 3: Vision & Goals

Vision:

- To ensure the Trust is able to measure and monitor the impact and success of the Patient Safety Incident Response Framework (PSIRF) to demonstrate good governance and compliance.

Goals:

Compassionate Engagement and Involvement

- **G1.** Patients and/or their families have the opportunity to be involved in the incident review process.
- **G2.** Greater presence of the patient voice through patient safety reviews and processes.

System-based Approaches to Promote Learning

- **G3.** Greater use of new investigation processes and techniques to review patient safety incidents to promote and maximise learning.
- **G4.** PSIRP safety priorities are linked to Trust priorities and are meaningful to ensure focused learning on areas of improvement identified.

Considered and Proportionate Responses to Patient Safety Incidents

- **G5.** Better visibility of learning from patient safety incidents across the Trust.
- **G6.** Triangulation and other forms of feedback to ensure patient safety incident processes and learning responses are effective.

Supportive Oversight and Strengthened Response Systems Which Encourage Improvement

- **G7.** Greater visibility of patient safety at Board level with PSIRF being central to all quality and safety governance across the Trust.
- **G8:** An established Just Culture that is meaningful for staff and one which promotes psychological safety and encourages learning.

Step 4: Root Cause / Gap Analysis


Compassionate Engagement and Involvement
Learning responses are not provided in a timely manner in line with expectations of those affected.
There is currently no guidance externally or internally to govern timelines/response times for reviews under PSIRF.
Patients and families are not routinely given the opportunity to be involved in the incident/review process.
There is a lack of 'patient voice' presence across patient safety reviews and processes.
There is a lack of training and awareness around the requirement to compassionately engage with all those affected in a patient safety incident.
A lack of dedicated resources to support compassionate and effective engagement with patients, families, and staff.
System-based Approaches to Promote Learning
There is concern staff lack of confidence in selecting and using the correct application of PSIRF review tools.
The application, process and criteria for the new review tools is unclear.
There is a lack of thematic reviews conducted where incident themes are present.
Early opportunities for learning are potentially missed.
A lack of system-based approaches to promote learning can increase the risk of incident reoccurrence.
There is the potential for to miss opportunities to improve patient safety.
There is lack of awareness on which constitutes as a 'incident'. The lack of knowledge on incident classification causes under and over reporting.
There is a lack of ownership of incidents reported by Staff.
The current incident reporting management system is not fit for purpose and creates a barrier for staff logging and completing incident reviews.
Quality of incident data is compromised due to insufficient use of current incident reporting management system.
There is concern regarding future PSIRF training requirements for new starters/other staff across the Trust.
There is currently limited opportunity for training on the application of PSIRF tools.
Processes need to be strengthened to ensure PSIRF is central across all quality and safety governance.
Learning from patient safety incidents is not effectively disseminated from floor to board or board to floor.
There is difficulty in successfully implementing a culture change process and shift in staff mindset.
Fear of speaking up when 'thing go wrong'/incidents occur due to historic blame culture within the NHS.
Staff Survey results have indicated low staff morale.
A lack of awareness regarding support systems in place for staff after an incident occurs.
Considered and Proportionate Responses to Patient Safety Incidents
Supportive Oversight and Strengthened Response Systems Which Encourage Improvement

Step 5: Progress on Countermeasures and Improvements

Concern	Cause	Countermeasure in progress	Progress Update and RAG Rating	Expected Impact
1. The maturity of current processes may hinder effective and compassionate engagement with those affected by patient safety incidents.	No routine process to involve patients, families, or staff in reviews. Lack of clear guidance on review timelines under PSIRF, leading to delays and inconsistent communication.	Establish robust processes and guidance for reviews. Ensure clear communication with all involved.	Working group with PSP involvement to support process of further involvement in AARs. Implementation of Staff wellbeing and feedback form on Radar. DoC training and restorative and compassionate engagement planned for September.	Increased involvement and engagement of patients/families in the review process. Improved compassionate communication with patients, families, and staff, including regular updates and clear expectations regarding review timelines.
2. Staff lack confidence in applying system-based approaches to learning for maximising effective learning.	30 staff have completed accredited PSIRF training, but a 'train the trainer' programme for current and new staff is pending. There is also a lack of guidance and criteria for each review type.	Formalise and make PSIRF training accessible. Provide guidance on tool selection and circulate this to staff.	Learning Response Review Toolkit produced to support decision making amongst teams on learning responses. Strengthen processes to support information to Unit Clinical Governance meetings.	Increased number of PSIRF-accredited staff, improved confidence in selecting and applying review tools, and more data on review tool usage. Enhanced patient safety awareness and potentially reduced recurrence of incidents and themes through effective learning.
3. Difficulty in providing considered and proportionate responses to patient safety incidents.	Lack of ownership and understanding of incident classification, leading to over/under reporting, poor data quality, and delayed responses. Miscommunication conflicts timely learning and learning dissemination processes.	Train staff on incident classification and best practices in the Radar reporting system. Ensure staff understand the review process and have supportive oversight from the patient safety team. Standardise learning dissemination protocols.	Further training dates on incident reporting planned at team level. Learning documents in use for cascading of learning following incidents.	Increased quality and quantity of reported incidents, enhanced learning opportunities, improved response systems, and more consistent and proportionate responses leading to broader patient safety improvements.
4. Without effective oversight and a Just Culture, learning and improvement from patient safety incidents may be limited.	Opportunity to strengthen communication to Board level. Further work is needed to promote a Just Culture and reduce staff fear of blame during incident processes.	Formalise a process for communication from the patient safety team to the Board. Ensure staff are aware of available support systems.	Data strengthened on Patient Safety data to Board through use of SPC charts.	PSIRF will be central to quality and safety governance. A cultural shift towards greater safety accountability, with increased staff confidence in reporting incidents and contributing to patient safety improvements.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS ON THURSDAY, 18 SEPTEMBER 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	21st August 2025	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	N/A		**Agenda Item: 013**		

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. GIC Targeted Support The Committee received an update on the Gender Identity Clinic's targeted support process. The service has made progress against the areas outlined in the targeted support framework however an improvement in waiting times has not been realized due to demand exceeding capacity. Following the national review of all adult gender services, led by NHS England, a national quality improvement programme was established. The data collated through this has helped develop an understanding of how the London GIC benchmarks against other services and identify areas for learning across the gender services. It was noted that the Executive Leadership Team have approved the proposal to step-down the service from targeted support and to replace this with the QI workstream, to prevent duplication and ensure efforts are aligned to the national work. The quality improvement programme will continue to report into the Executive Leadership Team, monthly, and the Quality & Safety Committee every 4 months.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Patient Experience Annual Report 24/25 The Committee received the annual report which provides an account of the key pieces of work undertaken in 2024/25 in relation to Patient Experience and Involvement, including the annual complaints data for 2024/25. The report included highlights of the significant amount of work undertaken in the year to improve processes for the management and collection of experience and feedback data. A key focus of 2025/26 will be improving processes to acting on and improving the way in which the	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Trust learns from the data that is now more readily available e.g. tangible improvements to practice. This includes the continuation of the service user experience and complaints quality improvement projects.	
3. Learning from Deaths Quarters 3 & 4 2024/25 The Committee received an update on deaths reported for Q3 and Q4 of the year 2024/25 for patients known to the Trust or where death occurred within six months of discharge. Deaths that occurred on waiting lists where patients had not yet been seen by Trust services and overarching themes from mortality reviews were also highlighted. The report identified key themes of learning, identified risks and gaps and six recommendations to be taken forward.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Annual Safeguarding Report - Integrated Adult and Children The Committee received the annual report which covers the period 2024/25 and sets how the Trust have met the statutory responsibilities to safeguard children, young people and adults at risk under the Safeguarding Accountability and Assurance Framework (SAAF). The report highlights the safeguarding achievements and challenges during 2024/25 demonstrating increased activity in all areas with improved processes that underpin effective safeguarding practice.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. PSIRF: A year in review The Committee received the paper which summarised a one-year review of the implementation of the Patient Safety Incident Response Framework (PSIRF) across the Trust. The report integrated qualitative and quantitative data, including incident reporting trends, staff feedback, and input from Patient Safety Partners. It examined the first full year of implementation, focusing on its impact on staff, patients, and organisational learning culture. In line with the self-assessment and the triangulated analysis the paper identified some areas of further work required however it was noted that, whilst these are linked to the principles of PSIRF, successful implementation of the framework is not intrinsic to them. The paper included proposals about how these will be taken forward through separate, existing pieces of work in the Trust. The Committee were asked to consider whether the Trust is in a position to require further improvement work to support implementation, or whether existing processes and systems are sufficient, enabling the Trust to transition to business as usual. The Committee approved the decision to move the PSIRF implementation project to business as usual.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Summary of Decisions made by the Committee:	
The Committee approved the decision to move the PSIRF implementation project to business as usual.	
Risks Identified by the Committee during the meeting:	
The Committee noted the following new risks; • The open patient safety incident investigation (PSII) that is reviewing surgical hub referrals • Physical health related deaths, noted in the Learning from Deaths update	

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 the outstanding CQC recommendations relevant to Health & Safety *(item number 016 Assurance Report: CQC Improvement Group*). This was escalated to the Performance Finance & Resource Committee for action and assurance.	Assurance and action	Escalation to be made by 29 August 2025
The Committee requested assurance from the Education and Training Committee about the Research & Development Group, to confirm that the Committee's ToR include oversight of Research	Assurance	Escalation to be made by 29 August 2025

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Annual Patient Experience & Involvement Report 2024/25			**Agenda No. 014**
Report Author and Job Title:	• Nimisha Deakin, Associate Director of Nursing & Head of Patient Experience • Emma Casey, Associate Director of Quality • Gary Sell, Senior PPI Lead • Fay Shorter, Complaints & Enquiries Manager	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1: Annual Patient Experience & Involvement Report 2024/25		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	This annual report provides an account of the key pieces of work undertaken in 2024/25 in relation to Patient Experience and Involvement. This report also includes the overall annual complaints data for 2024/25.		
Background:	Work carried out within the Trust in relation to Patient Experience, Involvement, Complaints & Enquiries is overseen by the Service User Patient Experience Group (SUEG), which is chaired by the Associate Director of Nursing & Head of Patient Experience. A chair's assurance report is provided to every meeting of the Quality & Safety Committee, outlining work undertaken in the previous period and escalating any risks or delays to progress against the plan.		
Assessment:	There has been a significant amount of work undertaken in the year to improve processes for the management and collection of experience and feedback data. Key highlights in the year include the following: • Continuing the Trust Strategic Pillar of 'outstanding patient care' which aims to increase patient experience response rates to our friends and family test, and the satisfaction scores received through those • Improvements in the way that service users and carers can provide feedback by expanding the ways in which this can be done, through QR codes and hyperlinks, allowing service users to give feedback on their experience at any time during their care • In 2024/25, 86% of patients reported positive feelings about their experience of care/treatment • A new standardised and improved way for qualitative and quantitative feedback to be communicated to teams, allowing more timely access to data to inform service-level improvements • A new Complaints Management Policy launched in December 2024 • Since the beginning of 2024/25 the number of open and overdue complaints has significantly reduced. The number of open complaints at the end of the year was 21 of which 4 were overdue • During the year 2024/25, the Trust resolved a total of 32 complaints informally. This approach aims to provide a quicker and more		

	responsive process for patients and their families when issues are raised. By empowering staff to address concerns promptly and empathetically at the point of care or service, we can enhance trust, reduce escalation, and improve overall satisfaction with the complaints experience • Trust-wide training in effective complaints investigation and management was delivered in May 2024 and September 2024 and further training is planned for 2025/26 • The launch of Radar, our local risk management system, for complaints management and collecting and reporting of the Experience of Service Questionnaires (ESQ) • Focus from the PPI team on engaging with clinical and education leads to develop a shared understanding of the benefit of working in partnership with service users and experts by experience to develop and improve services • Several Patient Engagement projects have taken place in the clinical services and resulted in changes to service following these • Regular updates on involvement, experience and feedback work into the Service User Experience Group (SUEG), reporting into the Quality & Safety Committee A key focus of 2025/26 will be improving processes to acting on and improving the way in which we learn from the data that is now more readily available e.g. tangible improvements to practice. There have been challenges in enacting some of our goals – such as consistently achieving our formal complaints response times and the target of feedback forms completed each month – however the year saw many improvements in processes and projects to support a good patient experience, such as those detailed in this annual report. Key areas to work on in the current year include: • Strengthening the ways in which we can clearly evidence and embed the learning we gain from patient feedback, and sharing this with our patients • Using data to consistently triangulate the themes identified from feedback • Reporting our feedback data in line with protected characteristics so that we can easily identify any potential variation in care and experience • Advancing the complaints quality improvement project to enable us to consistently achieve the formal complaints timeframes so that patients have their concerns resolved in a timely manner • The Quality Priority for Patient Experience in 2025/26 will focus on a review and refresh of the Trust wide service user forum and work to develop innovative ways of collecting feedback from children & young people • Our plans to recognise and mark Patient Experience week at the end of April 2025. This will be a space for patients and staff to engage in discussion about our commitment to promote patient voice and the positive impact it can have on safeguarding and service development, through meaningful feedback.
Key recommendation(s):	The Board is asked to **DISCUSS**and **NOTE** the report.

Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title : Principal Risk 2 Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☐	No ☐			
	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009				
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Service User Experience Group (SUEG) 22 July 2025 Quality & Safety Committee Thursday 21 August 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

Annual Patient Experience & Involvement Report 2024/25

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Executive Summary

This annual report provides an account of the key pieces of work undertaken in 2024/25 in relation to Patient Experience and Involvement. This report also includes the overall annual complaints data for 2024/25.

Work carried out within the Trust in relation to Patient Experience, Involvement, Complaints & Enquiries is overseen by the Service User Patient Experience Group (SUEG), which is chaired by the Associate Director of Nursing & Head of Patient Experience. A chair's assurance report is provided to every meeting of the Quality & Safety Committee, outlining work undertaken in the previous period and escalating any risks or delays to progress against the plan.

Key highlights in the year include the following:

- Continuing the Trust Strategic Pillar of 'outstanding patient care' which aims to increase patient experience response rates to our friends and family test, and the satisfaction scores received through those
- Improvements in the way that service users and carers can provide feedback by expanding the ways in which this can be done, through QR codes and hyperlinks, allowing service users to give feedback on their experience at any time during their care
- In 2024/25, 86% of patients reported positive feelings about their experience of care/treatment
- A new standardised and improved way for qualitative and quantitative feedback to be communicated to teams, allowing more timely access to data to inform service-level improvements
- A new Complaints Management Policy launched in December 2024
- Since the beginning of 2024/25 the number of open and overdue complaints has significantly reduced. The number of open complaints at the end of the year was 21 of which 4 were overdue
- During the year 2024/25, the Trust resolved a total of 32 complaints informally. This approach aims to provide a quicker and more responsive process for patients and their families when issues are raised. By empowering staff to address concerns promptly and empathetically at the point of care or service, we can enhance trust, reduce escalation, and improve overall satisfaction with the complaints experience
- Trust-wide training in effective complaints investigation and management was delivered in May 2024 and September 2024 and further training is planned for 2025/26
- The launch of Radar, our local risk management system, for complaints management and collecting and reporting of the Experience of Service Questionnaires (ESQ)
- Focus from the PPI team on engaging with clinical and education leads to develop a shared understanding of the benefit of working in partnership with service users and experts by experience to develop and improve services
- Several Patient Engagement projects have taken place in the clinical services and resulted in changes to service following these
- Regular updates on involvement, experience and feedback work into the Service User Experience Group (SUEG), reporting into the Quality & Safety Committee

There has been a significant amount of work undertaken in the year to improve processes for the management and collection of experience and feedback data. A key focus of 2025/26 will be improving processes to acting on and improving the way in which learn from the data that is now more readily available e.g. tangible improvements to practice.

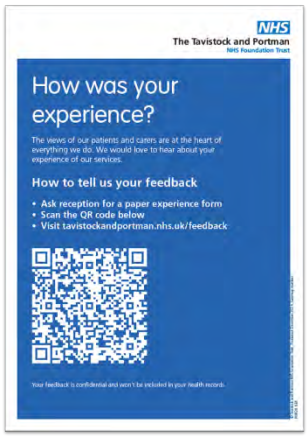
Our behaviours framework, linked to our Trust values of Excellence, Inclusivity, Compassion and Respect, are at the core of our interactions with patients and their families.

Experience of Service

Under the Trust Strategic Pillar of 'outstanding patient care' sits the service users experience priority. The use of Quality Improvement methodology has been implemented to focus on:

- Increasing patient experience response rates to our friends and family test
- Improving patient satisfaction of service scores

We have made improvements in the way that service users and carers can provide feedback by expanding the ways in which this can be done, through QR codes and hyperlinks, allowing service users to give feedback on their experience at any time during their care. The feedback we receive from service users, carers and families allows us to broaden the way that we hear their voices, and how we respond to what we hear to make continuous improvements.

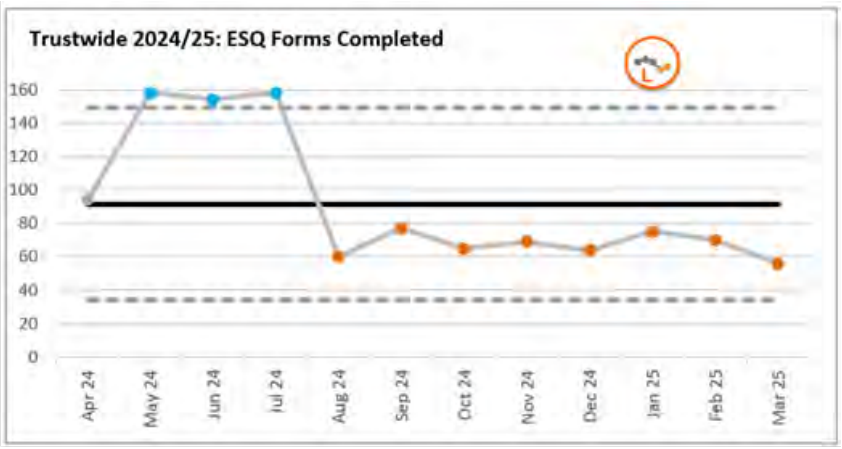


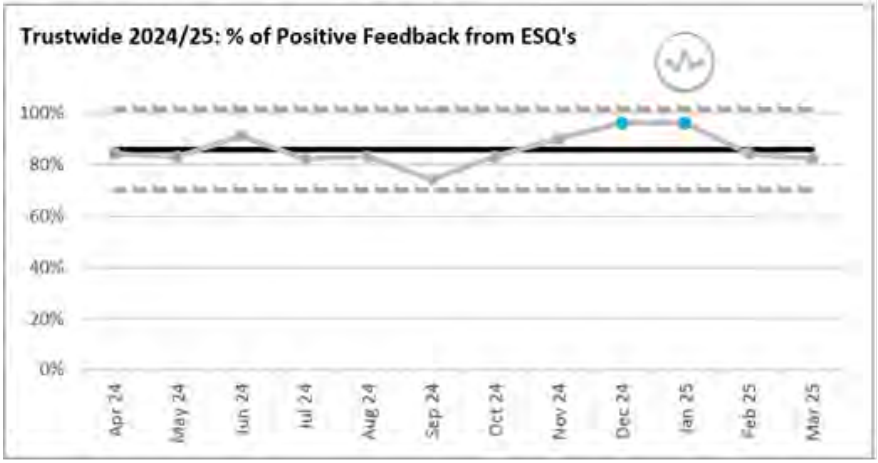
To support the clinical services with accessing and responding to the feedback significant work has been caried out to create clear processes around collating, recording, and reporting on the feedback from our service users. We have standardised and improved the way qualitative and quantitative feedback is communicated to teams, allowing more timely access to data to inform service-level improvements. Improvements include:

- Feedback is now shared monthly (previously quarterly)
- Feedback is anonymised and available as paper form or QR code
- Improvements have been made to categorising and capturing themes (allowing us to review and triangulate with other quality data)
- Ethnicity and protected characteristics are linked to feedback
- Reporting on service user feedback is clearly embedded in our governance structures to provide assurance that patient voice is present in the development and improvements of our services.

The Trust collects Experience of Service Questionnaires (ESQs) forms which include the Friends & Family Test (FFT) question ‘Overall, how was your experience of our services?’. In 2024/25, 86% of patients reported positive feelings about their experience of care/treatment, as reported by service users and/or their families in the Trust’s Experience of Service Questionnaire (ESQ) which is lower than in previous years. One of the main contributing factors for this is due to increasing the opportunities for service users to provide feedback and that teams with extended waiting lists now have feedback captured.

The charts below indicates the percentage of positive feedback received throughout the year by month, in the form of a Statistical Process Control (SPC) chart.





Complaints & Enquiries

Complaints Quality Improvement

Building on the work to review and improve our complaints management process in the previous year, a quality improvement project was started in 2024/25 with the Trust's Quality Improvement team to address a number of key priorities including ensuring the investigation and response are prioritised, and the way in which the Trust learns from complaints and enquiries. The Quality & Safety Committee approved a new complaints process in January 2023 and one of the key changes was the extension of the Trust's timeframe for responding to complaints from 25 to 40 working days. The Trust's new Complaints Management Policy was ratified in December 2024.

The Complaints Quality Improvement project seeks to ensure:

- Prioritising an early and local resolution process where possible.
- Reducing the length of time a new complaint is allocated to the Investigation Lead.
- The number of Investigating Leads within the Trust is increased.
- Investigation Leads are supported throughout the investigation process, including the drafting of the complaint investigation report.
- Complaint investigations are completed on time and within the 40 working-day time frame.
- Complaint quality assurance, and sign-off process is improved.
- Complainants receive regular updates throughout the complaints process.
- Complaints Managers can manage the complaints process flow more efficiently.

Trust-wide training in effective complaints investigation and management was delivered in May 2024 and September 2024 and further training is planned for 2025/26 as part of the Quality Improvement project. Senior clinical and operational staff have been involved in the improvement process and the work to create a culture of learning not blame in the process.

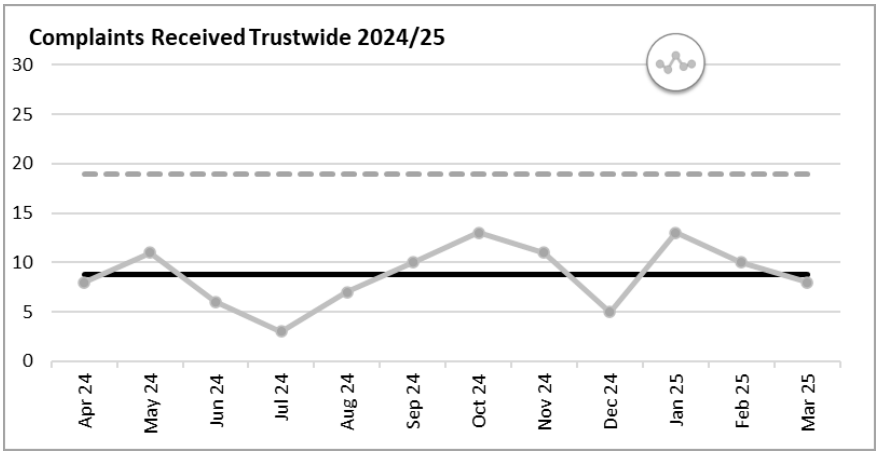
In June 2024, the introduction of a new complaints management portal, Radar, improved oversight, escalation, support and monitoring of complaints for managers and investigation leads as well as other Trust staff.

Complaints

During the year 2024/25, the total number of formal complaints received by the Trust was 61, representing a reduction of 33 formal complaints on the previous year. As part of our ongoing quality improvement work in complaints management, we have prioritised supporting staff in achieving an earlier, informal resolution of concerns. This approach aims to provide a quicker and more responsive process for patients and their families when issues are raised, and the reduction of formal complaints is understood to be attributable to this. By empowering staff to address concerns promptly and empathetically at the point of care or service, we can enhance trust, reduce escalation, and improve overall satisfaction with the complaints experience.

	2020/21	2021/22	2022/23	2023/24	2024/25
Formal Complaints Received	116	144	103	94	61

The total number of all complaint contacts (those resolved formally and informally) received in the year is 93, detailed in the chart below.



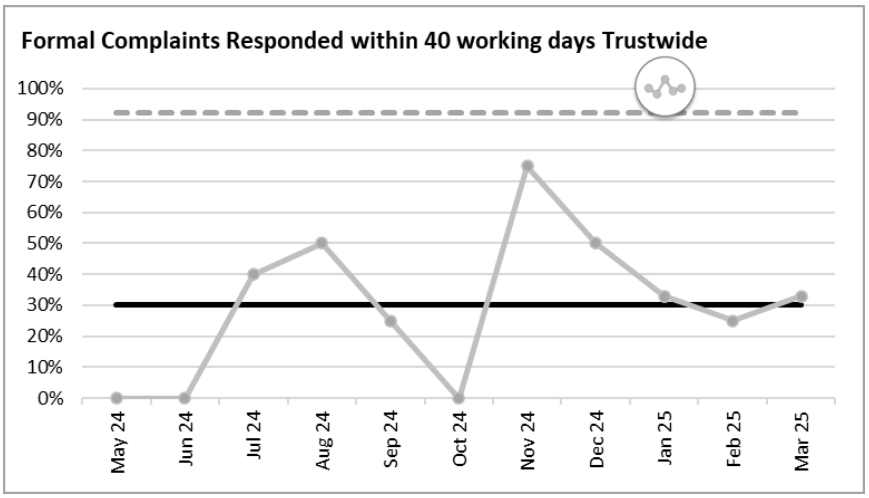
By unit, the highest number of formal complaints was received by the Adult unit (51), followed by Children and Families (6) and Camden (4). Within the Adult Unit, the highest number of formal complaints was received by GIC (34), followed by Psychotherapy (8) and Trauma (5). The categories of complaint reasons are summarised below.

Complaint Categories 2024/25	No. of Complaints
Access to Treatment or Drugs	16
Admissions and Discharges	1
Appointments	5
Communications	22
Other	1
Patient Care	6
Prescribing	1
Privacy Dignity Wellbeing	1
Restraint	1
Trust Administration	3
Values and Behaviours	1
Waiting Times	3

The highest sub-category is ‘Communication with Patient (11). Within this sub-category, there was a diversity in topics including waiting times, disagreement with clinical outcomes, delays in communication and administration issues. A full chart of the sub-category breakdown is depicted in the diagram below. Most notable are the subcategories of ‘Communication with Patient’ and ‘Method/Style of Communication’ and work is currently being done to support service leads with the learning outcomes and actions plans that can be taken from complaints in these categories.

The complaints policy states that all complaints are to be acknowledged within 3 working days of receipt. For 2024/25 the percentage of complaints that were acknowledged within 3 days was 86%. The timely acknowledgement of Complaints and Enquiries is being addressed as part of the Complaints Quality Improvement project.

In line with the new Complaints Management Policy, our compliance to responding to formal complaints in 40 working days has fluctuated throughout the year. However, there has been a significant amount of work undertaken by the Complaints & Enquiries teams and the clinical service to reduce the backlog of open and overdue complaints. Since the beginning of 2024/25 the number of open and overdue complaints has significantly reduced. The number of open complaints at the end of the year was 21 of which 4 were overdue i.e. outside of the 40-day time limit. Prior to May 2024, data on response times was not reported by percentage and therefore is not included in the chart below.



We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. Each complaint gives us a better understanding of the patient’s experience of our services. To ensure that improvements to our services are made, we are able to create an action plan where applicable. Themes and actions following complaints are reported to the Quality & Safety Committee and the Service User Engagement Group (SUEG) and reports are provided to unit leads to share within their clinical governance structures. Complainants are also invited to participate in the Trust’s Patient Public Involvement (PPI) programme of work where they can use their knowledge and experience to help improve the Trust’s provision of services to our patients.

Informal Complaints

Under the new Complaints Management Policy, informal complaints are defined as those that can be resolved in 10 working days, enabling the Trust to resolve complaints wherever possible without a formal investigation, and in agreement with the complainant. During the year 2024/25, the Trust resolved a total of 32 complaints informally. However, not all of those were resolved within the 10 working day timeline – this will be an area of work in 2025/26.

We see the reduction of formal complaints as a positive due to the number of complaints and concerns we have successfully resolved, in liaison with the complainant, in the year. This has been a process and culture change for staff and something that will continue to be worked on through the Quality Improvement project.

Ombudsman Investigations

If a complainant is unhappy with the Trust's response to a complaint, they can ask the Parliamentary Health Service Ombudsman (PHSO) to review their case. If the PHSO decides to investigate formally, the Trust is notified whilst the PHSO carries out their own investigation. During 2024/25, the PHSO did not formally investigate any Trust complaints.

We have kept up-to-date with PHSO advice and guidance and promote their guidance as best practice to support complaint resolution.

MP Enquiries

During the year, we received 7 enquiries from Members of Parliament on behalf of their constituents. These were received for services in Adults Unit (3), Camden Unit (3), and Children & Families Unit (1).

Quality Alerts

The Quality Alert system is for healthcare professionals, such as GPs or community mental health teams, to raise quality concerns regarding patient care at the Trust. During the year 2024/25 the Trust received 5 Quality Alerts including Adult (4) and CYP and Families (1).

Involvement

Achievements

We have been working on ensuring service user involvement is valued and respected across the Trust. The Patient and Public Involvement (PPI) team works collaboratively across our Trust departments, and with community colleagues, to embed involvement in clinical and educational work and in the business as usual of all departments. The team works with patients, family members, carers, local community partners and members of the public in various aspects of our work to help develop and improve the services we offer, in a meaningful and informed way. It is about empowering patients and the public to have a say and for professionals in the NHS, listening and responding to these views, creating actionable outcomes. We believe this promotes a cultural change that will improve patients' experiences of the NHS.

Over the past year the team has been focussed on engaging with clinical and education leads to develop a shared understanding of the benefit of working in partnership with service users and experts by experience to develop and improve services. Underpinning this is a new PPI policy, documentation and leaflets.

The Service user Involvement leaflet and information sheet has been co-produced with service user involvement and approved through the Service User Experience Group (SUEG) in October 2024. These are available in reception areas and through the **website.**

Policies

Our Service User representatives supported the development of our new PPI Policy. The policy was written in partnership with service users and further consultation was sought through service user forums and approved through SUEG in November 2024.

Through the review of the policy there was some important changes made to the use of language in the policy which referenced service users needing to be “referred” by clinicians and “assessed” for engagement. We believe the removal of these terms in the process will place service users in the position of having a more equal voice within the organisation.

A large part of what has been achieved over the past year has been in relation to a culture shift within the organisation, whereby service users are actively involved across the organisation. Service User involvement work can be seen at various levels across the Trust for example in Recruitment, Governance Groups, Patient Safety, external reviews and patient-led forums.

One of the priorities for the Patient and Public Involvement team has been to increase the number of service users on our database. This has seen a positive improvement and the number has doubled. Although the numbers are not where we want them to be in relation to our ambitions for the range of involvement work, we have improved representation from a range of services across the Trust and a wider more diverse group.

Service User Experience Group (SUEG)

We continue to embed service user voice through our Service User Experience Group that reports into the Quality and Safety Committee. The scope of the group is to provide the Quality Committee members with an independent and objective review of all aspects of experience for patients, family and carers who are seen in the Trust.

The experts by experience role within this group is essential and has been maintained through support and feedback on how best to make presentations and information accessible in order to allow active participation.

Trust Wide Forum (TWF)

The forum aims to work at the highest level of patient involvement, giving priority to the ideas and feedback of service user representatives relating to all aspects of care, access and involvement across the Trust. A Terms of reference for this group were co-produced with service users and the meeting is co-chaired by a service user representative.

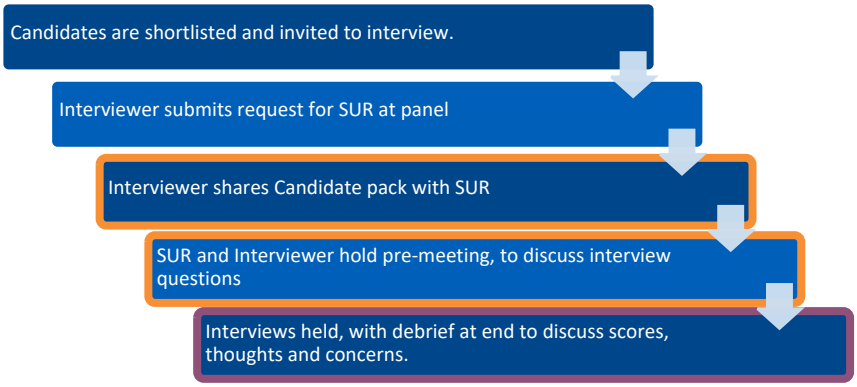
Service User forums are being developed by a number of teams across the Trust. Our Trauma service has an active Service user forum and has recruited some Peer Support Workers.

Board presentations

This year the Trust Board and Council of Governors have heard directly and indirectly about patient experience from a variety of services. This shows a commitment to listening and learning from service users about their experience. Presentations have been a rich source of understanding for the groups in understanding the experience of our service users. These have included presentations from the *Mental Health in Schools Team (MHST), Family Drug and Alcohol Court (FDAC) service, the Whole Family Team and our Patient Safety Partners.*

Interview Panels

Service users were increasingly involved in interview panels in the year. Training and information to teams on involving service users has begun to have an impact. Recent feedback from a Service User representative on an interview panel reported that the way they were involved now compared to when they started over a year ago was more inclusive and no longer felt like a token gesture. The process for involving service users in recruitment processes is outlined below, alongside a patient story on their experience in this.



I have been an active service user representative (SUR) for several years. In addition to regular meetings to discuss the work of the Trust, I have been invited to sit on a variety of interview panels. I became a SURto give something back and make things better for future service users. Sitting on interview panels is an important part of this as staff recruitment is key.

Panels can be most effective when there is SURinput, such as with the choice of candidate questions. When I first became involved as a SURin interviews I had no input into the choice of questions, which felt slightly tokenistic, so I put forward some questions of my own, which felt more inclusive and collaborative. I have also found there is a difference in perspective when assessing a candidate's performance during the interview. Although candidates may be equally appointable, some have a natural empathy that a service user is particularly well placed to pick up on.

I have met a wide range of staff as fellow interview panel members and this has been very enjoyable and given me a good insight into the work of the Trust. I am passionate about user engagement and believe this can help make health care more effective and successful.

Patient Safety Partners

We have maintained and developed the Patient Safety Partners, a new role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. This is a key part of the Patient Safety Incident Response Framework (PSIRF) and one that we are continuing to develop. Our Patient Safety Partners are involved in a number of workstreams including developing ways in which we compassionately engage following incidents, and are key members of our quality & safety meeting governance structures including the Clinical Incident & Safety Group and the Quality & Safety Committee.

Service User Experience projects

There have been a number of projects undertaken by clinical services in relation to service user experience.

Focus Groups **:** Involving service users in shaping mental health services is essential for ensuring accessibility, inclusivity, and effectiveness. Service user initiatives within the Wellbeing Team collaborated with patients and service users to identify barriers and develop solutions for improved service delivery. The voices of service users provide invaluable insights into the strengths and challenges of our services. Key themes that emerged from these focus groups over the years have included:

- **Barriers to Access**: Long waiting times, lack of awareness, stigma, work and education commitments and availability of services outside working hours.
- **Cultural and Socioeconomic Factors** : Stigma within certain communities, language barriers, and financial constraints that hinder access.
- **Neurodiverse Perspectives** : The need for service adaptations to better accommodate young people with ADHD and autism.

- **Gender-Specific Challenges**: Young men face unique barriers to accessing mental health services due to stigma, traditional masculinity norms, and self-stigmatisation.
- **Group Therapy Engagement** : Factors influencing engagement in group CBT include facilitator approach, session structure, and support from the professional network and parents enable young people to engage.
- **Enhancing Engagement with Service Users**: Addressing accessibility concerns across different demographics, including cultures, neurodivergent, LGBTQ+ individuals and young men and fathers is key to improving service quality.

Extended hours for CAMHS appointments

The Camden CAMHS Evening Clinic piloted after-school and evening appointments, which received positive feedback from young people and their families.

While these extended hours improved accessibility, clinician feedback highlighted challenges with available staff resources and the impact on young people of attending evening appointments following educational demands.

Service accessibility review

A study involving young people and parents identified the need for increased community awareness about CAMHS, use of everyday language in leaflets, translated guided self-help materials, flexibility of online or face to face appointments and school-based awareness programs to normalise mental health discussions.

Service developments included a revised leaflet, translation of GSH materials and feedback to MHST about the wish for more awareness of services within schools.

Neurodiversity-focused adaptations

Interviews with neurodiverse young people and carers emphasised the need for visual CBT resources to support effective use of coping strategies and guidance for new starters in helpful approaches in clinical care for neurodiversity.

Addressing barriers for boys in mental health services

Research identified stigma, traditional masculinity norms, and lack of awareness as key factors preventing boys from seeking support.

Strategies to improve engagement include normalising mental health discussions, setting clear therapy expectations, and fostering trust with clinicians.

Service developments included posters in the waiting room and at community events normalising boys seeking mental health support/coming to CAMHS and how it helped them.

Clinicians addressing early on stigmas around boys accessing mental health support and having open conversations within the clinical care.

Enhancing engagement in group therapy

Group CBT has been identified as a cost-effective intervention, but engagement can be impacted by anxiety, scheduling conflicts, and lack of clarity about expectations.

Facilitators play a crucial role in making young people feel comfortable and ensuring inclusivity in group settings.

Difficulties being normalised through meeting other young people experiencing similar difficulties is one of the main benefits of attending group CBT interventions.

The systems around young people (family, school) should play a role in supporting young people to engage in groups. Where these systems have difficulties prioritising a young person's mental health over other demands (e.g. schoolwork and exams) attendance to groups can be impacted. Support should be provided to the system around CYP to understand the function/expectations/aims of the group to help recognise its importance alongside competing demands.

Individual therapy can complement group therapy and for anxious CYP may be required first to make attending a group possible. Inversely the 'top-up' of group therapy following individual support may make engagement with the group more difficult due to reduced need. Services should consider the order of therapies offered where group CBT is being used in combination with individual interventions.

Inclusive approaches to service user engagement

Focus groups indicated that personalising interventions to address social and cultural differences enhances accessibility.

Service users from LGBTQ+ and culturally diverse populations valued curiosity from practitioners about their identity as these conversations aided their understanding of themselves and the relationship with the therapist.

It was unhelpful if these questions felt scripted and there was preference for conversations that evolved naturally.

Engaging parents in clinical work for children

Interviews with parents engaging in individual and parent led CBT interventions found that interventions were most effective if both parents engaged in therapy.

Barriers to both parents engaging included work and childcare commitments, gender and cultural stigmas for men accessing psychological care.

Service developments included developing guidance to stress the benefits of both parents engaging and the development of catch-up videos and resources when the second parent is not able to attend.

Community engagement / Service Improvement

Our Camden Wellbeing team undertook a quality improvement project to better understand the needs of the community, existing forms of support and awareness the service.

A range of services (64 local services) , including counselling services, digital therapy SEND organisations, local community groups, youth clubs, libraries, family hubs, leisure centres, were engaged with. This also included services that are supporting children and young people and families from minority backgrounds as we wanted to increase access for these CYP (e.g. Black Thrive x Mind in Haringey, 4-22 Foundation, Polish European Christian Centre, TCCA, Hopec, Father 2 Father).

This has led to increased understanding of the needs of the community and collaborative working eg focus groups, psycho-education workshops to children and young people, staff training and referring CYP to our service. The engagement has also drawn other themes from results (e.g. limited access to Tavistock due to location of clinic).

Stakeholder Involvement

Our relationship with Camden Healthwatch is embedded into our work through the Service User Experience Group and allows us to identify opportunities to involve them more in work across the Trust.

Art at the Tavistock and Portman

The work of the Art Board is a good example of our commitment to partnership working with our service users. Art plays an important role to the life of our Trust, and we are always looking to find new ways to engage our staff, our patients and everyone connected with our work. The aims of the Art Board are:

- To support greater community engagement, making art at the Tavistock more accessible to the wider community.
- To further the public and patient involvement by providing an open, safe space for artistic expression.
- To facilitate artistic events and opportunities at the Trust that will generate further interest and awareness in mental health through art.

The third edition of our annual group art show, **the Tavi Open,** took place in April & May 2024. The Tavi Open celebrates the creativity and talent of our service users, students, staff, and local artist. The exhibition featured artworks from 27 artists: paintings, drawings, photography as well as collage and textile works. This is an annual event that has also been planned for June 2025.

Summary and Next Steps

There has been a significant amount of work undertaken in the year to improve processes for the management and collection of experience and feedback data. A key focus of 2025/26 will be improving processes to acting on and improving the way in which learn from the data that is now more readily available e.g. tangible improvements to practice. There have been challenges in enacting some of our goals – such as consistently achieving our formal complaints response times and the target of feedback forms completed each month – however the year saw many improvements in processes and projects to support a good patient experience, such as those detailed in this annual report. There is also a lot to look forward to in 2025/26 including;

- Strengthening the ways in which we can clearly evidence and embed the learning we gain from patient feedback, and sharing this with our patients
- Using data to consistently triangulate the themes identified from feedback
- Reporting our feedback data in line with protected characteristics so that we can easily identify any potential differences in care and experience

- Advancing the complaints quality improvement project to enable us to consistently achieve the formal complaints timeframe so that patients have their concerns resolved in a timely manner
- The Quality Priority for Patient Experience in 2025/26 will focus on a review and refresh of the Trust wide service user forum and work to develop innovative ways of collecting feedback from children & young people
- Our plans to recognise and mark Patient Experience week at the end of April 2025. This will be a space for patients and staff to engage in discussion about our commitment to promote patient voice and the positive impact it can have on safeguarding and service development, through meaningful feedback.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 18 September 2025			
Report Title: Guardian of Safe Working Hours Report (GoSWH)			**Agenda No.: 015**
Report Author and Job Title:	Dr Gurleen Bhatia Consultant Psychiatrist	**Lead Executive Director:**	Dr Chris Abbott, Chief Medical Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report details concerns raised by trainees regarding fine payments and Doctors Rostering System (DRS) login issues resulting in reporting breaches on later dates. This relates to trainees working on other sites, however employed by the trust.		
Background:	The GoSWH report details the exception reporting by the trainees, breaches relating to on-calls, fines resulting and any ongoing concerns.		
Assessment:	This report details fines for Q1 2025/26. We continue to encourage the junior doctors to report breaches and encourage the use of the GoSWH fund for their professional development.		
Key recommendation(s):	The Board is asked to **NOTE** the contents of this report.		

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

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

Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐
	Risk Ref and Title : No Linked Risks		
Legal and Regulatory Implications:	Yes ☐	No ☒	
	There are no legal and/ or regulatory implications associated with this report.		
Resource Implications	Yes ☐	No ☒	
	No current resource implications associated with this report.		
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒	
	No current EDI issues arising from 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:	Report submitted to Local Negotiating Committee (LNC) prior to this submission.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Guardian of Safe Working Hours Report

1. Purpose of the report

1.1. The report details concerns raised by trainees on various sites, Doctors Rostering System (DRS) login issues and fine payments. This has now been resolved for trainees on other sites and discussion about spending fines money was discussed in JDF. Also impact of merger on current GOSWH fund discussed.

2. Background

2.1 The Guardian of Safe Working Hours provides a report for the Trust Board on a quarterly and annual basis.

3. Exception report

3.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
April	6	1	6	0
May	5	2	5	0
June	2	0	2	0

3.2. Work schedule reviews

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

3.3. Vacancies

3.3.1. The Child and Adolescent training scheme has no vacancies.

3.4. Locum

3.4.1. The Non-Resident On-Call (NROC) is currently being staffed by trainees and occasionally an external locum.

3.4.2. The trainees undertake 1 locum shift per month in addition to their normal working schedules and on-call rota (1 in 9.8)

3.5. **Fines** – as per penalty rate guidance circulated by BMA and GoSWH regional meeting

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
	hrs	hrs	£	£	£
April	0	21.30	3359.83	1260	2049.76
May	1.3	25	3943.98	1479.07	2464.91
June	0	8	1209.12	453.44	757.44
Total	1hr 30min	54hrs 30min	8512.93	5203.98	5277.11

4. Junior Doctors Forum (JDF)

4.1. The next JDF is on 8th September 2025.

5. Local Negotiating Committee (LNC)

5.1. This report will be shared with the LNC Chair Dr Sarah Wynick.

6. Conclusions and Recommendations

6.1 The Board are asked to note the report.

6.2 We continue to encourage the junior doctors to report breaches and encourage to use the GoSWH fund for their professional development.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025					
Report Title: Learning from Deaths Report				**Agenda No.: 016**	
Report Author and Job Title:	Dr Chris Abbott, Chief Medical Officer (CMO)		**Lead Executive Director:**	Dr Chris Abbott, CMO	
Appendices:					
Executive Summary:					
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐				
Situation:	This paper provides information on deaths for Q3 and Q4 of the year 2024/25 of patients known to the Trust or where death occurred within six months of discharge. Deaths that occurred on waiting lists where patients had not yet been seen by Trust services are also reported.				
Background:	The Trust is committed to accurately monitoring, reporting, reviewing and where appropriate investigating deaths of patients known or recently known to the service and on waiting lists for Trust services. The main purpose is to ensure that any issues identified are addressed in order to improve patient safety and quality of care outcomes and to highlight good practice.				
Assessment:	Overarching themes from mortality reviews are highlighted.				
Key recommendation(s):	The Board is asked to **REVIEW** and **DISCUSS** the report; and **NOTE**: • The Trust should continue the work to ascertain cause of death for all people who were connected with Trust services and a report on identified causes of death should be presented to the Board each year. • The harm review process for people on waiting lists for Trust specialist services should be continually prioritised.				
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 Risk 2: Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust must respond promptly to requests from Coroners Officers for witness statements and to attend Coroner's inquests. There may be legal and				

	regulatory implications related to Prevention of Future Death Reports (Regulation 28).			
Resource Implications:	Yes ☒		No ☐	
	It is likely that there are resource implications in relation to measures to reduce the length of waiting lists in several of the Trust specialist services – Adut Gender Service, Adult Trauma Service, ASD Service.			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒		No ☐	
	Timely access to some of the Trust services is not available to a significant number of people due to long waiting lists and as evidenced in this report deaths from a range of causes have occurred on Trust waiting lists. The Trust is actively seeking solutions to this issue but recognises the distress this causes to people seeking services and to their families.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Quality and Safety Committee 21 August 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: Learning from Deaths Report

1. Purpose of the report

1.1. The aim of the report is to update the Trust Board on mortality data and on learning from deaths.

2. Background

2.1 The Trust supports a learning culture in relation to deaths of patients known to services or on waiting lists for Trust services. The Trust is committed to accurately monitoring, reviewing, and understanding mortality to improve patient safety and quality of care and to highlight good practice. This approach is underpinned by guidance, reports and strategy published over the last several years and includes National Guidance on Learning from Deaths (National Quality Board 2017 nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk), NHS England's Serious Incident Framework (2015), CQC Review – Learning, candour and accountability (20161213-learning-candour-accountability-full-report.pdf (cqc.org.uk)) and the NHS Patient Safety Strategy 2019 (NHS England » The NHS Patient Safety Strategy). In 2023, the Patient Safety Incident Response Framework (PSIRF) replaced the Serous Incident Framework of 2015(NHS England » Patient Safety Incident Response Framework).

2.2 The Trust also seeks to monitor current national data on the relationship between health inequalities, provision of health care and population morbidity and mortality (www.ons.gov.uk).

2.3 The Trust seeks to work with families/carers of patients who have died and recognises the importance of their insights to improve services and learn lessons.

2.4 The Trust has a system to identify, and record known deaths of service users and of those on waiting list for services on the Trust electronic patient record system.

2.5 All deaths (open, waiting list, deceased within 6 months of case closure) are reported as incidents and reviewed including those deaths where the Trust is not the main care provider. Deaths are reported irrespective of cause of death, if known.

2.6 Deaths of patients discharged i.e. if care provided in the last six months prior to death, are reported as incidents and investigated where appropriate.

3. Assessment

3.1 Demographic Batch Service Trace is a national system which allows the Trust to check patients who have an electronic patient record with the Trust against the NHS Spine to see if any are marked deceased on the Spine. The trace report shows any changes to patient details such as date of death. The Trust runs a report three times per week.

3.2 All deaths are logged on the Trust management and reporting system (recent system change in June 2024 following procurement process). A safety huddle takes place each day (Monday-Friday) and in the event of a death, relevant clinical staff are alerted, and a request is made to a senior clinician to complete a mortality review and

to consider duty of candour. Subsequently, if indicated, a Patient Safety Incident Investigation (PSII) or After-Action Review (AAR) is commissioned.

3.3 Mortality reviews are completed in all cases and subsequently reviewed and discussed at the monthly Clinical Incident and Safety Group meeting.

3.4 The Trust Patient Safety Partners attend the Clinical Incident and Safety Group monthly meeting.

3.5 The clinician completing the mortality review attempts to ascertain the cause of death usually by contacting the GP and/or if indicated a Coroner's Officer.

3.6 However, as some of the Trust specialist services have a national remit and without knowing where a death occurred, it may not be possible for the Trust to liaise with a Coroner's officer, or it may not be known if it is relevant to liaise with a Coroner's Officer.

3.7 Attempts are consistently made by clinicians over an extended period to ascertain information on cause of death. Despite these efforts the cause of death is as yet unknown in a significant number of deaths reported during 2023/24 (open cases and waiting lists).

3.8 The cause of death may subsequently be confirmed at Coroner's inquest.

3.9 The data reported here is crude mortality which gives a contemporaneous view of mortality data across the Trust but cannot give a risk adjusted view. Until more information is available about cause of death it is not possible to relate the findings to population data.

3.10 This paper summarises findings from mortality reviews conducted between January and June 2025 by the Clinical Incident Steering Group (CISG). A total of 21 patient deaths were reviewed, including one from the Adult Trauma Service. This report outlines themes, risks, and service improvements to support quality assurance and patient safety.

3.11 Please note that the Mortality Meetings, a subgroup within The Incident Panel, chaired by the Deputy Chief Medical Officer has just restarted after a pause due to staffing. The first meeting has taken place and this will continue to be a key part of the Trust's assurance process in regards to learning from deaths.

4. Overview of Cases

- **Total deaths reviewed** : 21
- **Age range** : 18 to 77 years
- **Median age** : 44 years
- **Service breakdown** :
  - **Adult Gender Identity Clinic (GIC)** : 20 cases (95%)
  - **Adult Trauma Service** : 1 case (5%)

4.1 Treatment status at time of death

- **In treatment** : 15 patients (71%) (includes trauma case)
- **On waiting list** : 6 patients (29%)

4.2 Source of death notification

- **Via Trust Informatics Department** : 20 cases (95%)
- **Via clinician/partner contact** : 1 case (5%) - Trauma case

4.3 Cause of Death

Of the 21 deaths reviewed, cause of death was specified or known in 13 cases (67%). For the remaining 8 cases (33%), the cause was either unknown or not formally recorded in the clinic's system at the time of review.

4.4 Breakdown of Known Causes:

Cause Category	Number of Cases	% of Total
Suicide (e.g., ligature suspension)	1	5%
Multidrug toxicity / pneumonia	1	5%
Cardiac-related (e.g., arrest, ischaemia, SADS)	3	14%
Cancer-related (e.g., colon, parotid)	2	10%
Infectious disease (e.g., pneumonia, COVID)	2	10%
Renal failure / complications	1	5%
Rare metabolic/genetic disorders (e.g., OTC deficiency)	1	5%
Unknown or unconfirmed	8	33%

5. Key Observations:

5.1 Multiple comorbidities were common among patients who died of natural causes — often involving cardiovascular, metabolic, or respiratory issues.

5.2 In 3 cancer-related deaths, GIC teams were not informed of the diagnosis during the patient's lifetime, indicating a breakdown in communication from other services.

5.3 Overall, numbers are too small to be able to draw valid conclusions however, with the majority of known deaths being physical health related it highlights the importance of good physical health screening and liaison with our acute partners.

6. **Key Themes of Learning**

6.1 Good Clinical Practice

- In 38% (8 cases), there was clear evidence of timely GP liaison, risk recognition, and proactive actions.
- Capacity assessments were documented in 3 cases.
- Several assessments showed strong multidisciplinary collaboration.
- In the Adult Trauma Service case (MR018 / INC 363), the patient's partner reported appreciation for the clinic's communication, highlighting positive bereavement care and staff engagement.

6.2 Screening and Referrals

- 20% (4 cases) showed referral pathway confusion, especially for GIDS 17+ and private services.
- In 3 cases (15%), the clinic was unaware of critical diagnoses prior to death, usually due to lack of communication with acute or external services.

6.3 Use of New Risk Tools

- CORE assessments and Carenotes flags were used effectively in some cases.
- 6 cases (29%) showed inconsistencies or gaps in risk flagging.

7. Identified Risks and Gaps

7.1 Systemic and Communication Issues

- 33% (7 cases) had delayed or incomplete death notifications.
- One patient was mistakenly booked for an appointment posthumously.
- 3 cases (15%) involved clinicians unaware of key health deterioration before death.

7.2 Documentation and Assessment Issues

- **6 cases** (29%) had RAG ratings without supporting comments.
- **4 cases** (19%) used unclear abbreviations or language, affecting review clarity.
- **2 cases** (10%) had no risk assessment recorded at last clinical contact.

Overall, communication appears to be one of the core issues running through morality reviews. This appears to be the case between acute, private and specialist services with ourselves with information often not being shared in a timely, safe manner. This is not unique to one particular service and effort needs to focus on minimising these communication issues moving forward.

8. Actions Taken

- Referral screening is now in place for all new patients to ensure early clinical oversight. Lack of adequate screening at the front door has been a key theme in mortality reviews so the fact that this has now been successfully implemented should have a significant impact on future data.
- Mandatory RAG commentary has been implemented.
- A new Carenotes SOP ensures risk flags are activated following CORE assessments.
- Internal communication processes have been tightened to prevent appointment errors or missed deaths.

9. Recommendations for Consideration

1. Quarterly audits of referral screening effectiveness to be built into the audit cycle. This will help us further develop our front door to services to ensure patients have comorbid risk issues identified early and dealt with in a timely manner.
2. Consideration needed as to whether further policies/procedures focusing on communication expectations with external providers would be helpful alongside the new screening processes.
3. Clarify referral pathways, especially:
    - 17+ transitions to adult GIC – discussion underway with NHSE/Region
    - External mental health or private care interfaces

4. Include mortality review learnings in training and supervision, focusing on:
    - Risk documentation
    - Referral protocols
    - Next-of-kin communication
5. GIC to carry out a ‘learning event’ looking at learning from complaints and incidents and it should include learning from deaths as a session.
6. Consideration in regard to training for physical health screening at the point of first contact

10. Conclusion

This review of 21 patient deaths has yielded important insights into clinical practice, communication, and systemic processes. Many patients received safe and responsive care, while improvements have been made to address risks identified. Continued focus on learning from deaths will support a safer, higher quality service.

MEETING OF THE TRUST BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Winter Plan Board Assurance Statement			**Agenda No.017**
Report Author and Job Title:	Sheva Habel, Medical Director Clare Scott, Chief Nursing Officer	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1 – Board Assurance Statement – Winter Plan 2025/26 Appendix 2 – Urgent and Emergency Care Plan 2025/26		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☒		
Situation:	In June 2025 NHS England published the Urgent and Emergency Care Plan**, with the expectation that both ICBs and NHS Trusts develop winter plans during the summer period, covering both preparatory actions that need to be taken now (e.g. vaccination programmes and capacity planning) as well as detail on the operational response during winter itself. The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair. All NHS Trusts are asked to: • Develop an organisational winter plan, completing a draft by end August. • Ensure preparatory actions, including staff vaccination programmes, are in progress now. In consultation with CEO's, NHS England has refined the approach and do not require the detailed plans but has provided a checklist to support organisations and systems in their preparations. NHE England requires assurance that Tavistock and Portman Foundation Trust's Board has robustly tested the key lines of enquiry to make sure patients can access the care they need this winter. Additionally plans will be tested in an exercise scenario against different levels of surge depending on the influenza profile, and to ensure everyone in the system understands their respective roles, especially given operating model changes. Tavistock and Portman will participate in a regional, NHS England-hosted, exercise in September/October 2025. Completed Board Assurance Statements should be submitted by 30th September 2025.		
Background:	The Tavistock and Portman NHS Foundation Trust has previously engaged in winter planning and submitted plans to NHS England.		

Assessment:	While there are specific areas of impact outlined in the Urgent and emergency care plan 2025/26 (Appendix 2) that are not directly relevant to the services provided by the Tavistock and Portman Foundation Trust, this should be approached at a system level and there are plans in place to focus on admission prevention/avoidance and supporting a timely discharge for children and young people.
Key recommendation(s):	The Board is asked to review and **APPROVE** the Trust Board Assurance Statements for submission to NHS England by 30 September 2025; and **NOTE** the Board assurance statement does not need to be assured by the ICB before submission.

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 Risk 2: Failure to provide consistent high-quality care BAF Risk 13: Failure to achieve required levels of performance and productivity		
Legal and Regulatory Implications:	Yes ☒	No ☐	
	The Trust must respond promptly to requests from NHS England and has a duty to plan efficient use of resources to meet the needs of the population it serves, sustaining planned care whilst managing any additional pressures through the winter period.		
Resource Implications:	Yes ☒	No ☐	
	It is likely that there are resource implications in relation to maintaining services through the winter period, particularly where staff sickness levels increase coupled with any potential impact on vacancies due to the efficiency programme and pending merger by acquisition.		
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐	
	Timely access to some of the Trust services is not available to a significant number of people due to long waiting lists and as evidenced in this report deaths from a range of causes have occurred on Trust waiting lists. It is essential that the work maintains it's focus on planned care delivery during the winter period and any additional winter pressures.		
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to	

			information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	This is the first version of 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

**UEC Plan for 25/26

Appendix 2 Urgent and emergency care plan 2025/26

Actions	Impact for patients and carers
Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter	By the year-end, with improvement over winter, we expect to: – reduce ambulance wait times for Category 2 patients – such as those with a stroke, heart attack, sepsis or major trauma – by over 14% (from 35 to 30 minutes) – eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard, helping get 550,000 more ambulances back on the road for patients – ensure a minimum of 78% of patients who attend A&E (up from the current 75%) are admitted, transferred or discharged within 4 hours, meaning over 800,000 people a year will receive more timely care – reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time. This will improve patient safety for the 1.7 million attendances a year that currently exceed this timeframe – reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month – tackle the delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually – increase the number of children seen within 4 hours, resulting in thousands of children every month receiving more timely care than in 2024/25

Actions	Impact for patients and carers
Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter	– improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points – increase the number of patients receiving urgent care in primary, community and mental health settings, including the number of people seen by Urgent Community Response teams and cared for in virtual wards – meet the maximum 45-minute ambulance handover time standard – improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours, and making progress on eliminating corridor care – set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings – reduce length of stay for patients who need an overnight emergency admission. This is currently nearly a day longer than in 2019 (0.9 days) and needs to be reduced by at least 0.4 days
National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference	Allocating over £370 million of capital investment to support: – around 40 new same day emergency care centres and urgent treatment centres – mental health crisis assessment centres and additional mental health inpatient capacity to reduce the number of mental health patients having to seek treatment in emergency departments – expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Tavistock and Portman Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Based on The QIAs and EQIAs developed for the efficiency plans, reviewed at ELT and Quality & Safety Committee.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	In partnership with all relevant partners and in discussion with system partners and ICB
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	September exercise
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	CNO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Through the QIAs, mitigations are identified.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	N/A	

Provider CEO name	Date	Provider Chair name	Date
Dr Michael Holland		John Lawlor	

Provider:	Tavistock and Portman Foundation Trust

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	A flu steering group is in place for frontline flu vaccination campaign, with a clear coms plan, data cleansing , voucher scheme and target to achieve more than the 'at least 5 %' more than 28% achieved last year. The lead for the flu vaccination programme is engaged in the NHSE national flu programme and KloEs were returned to NCL ICB in July 2025.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	N/A	
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	For Children and Family and Camden CAMHS units, the winter resilience plan will be put in place for the Unit to ensure cover, NCL Crisis Line will be operational OOH, as will the NCL Crisis services for CYP in North and South NCL. The larger Community CAMHS teams have daily rotas throughout the 52 weeks ensuring there is sufficient staffing to include senior staff

			(Band 8a+) available each day. We will be requesting all teams start to give consideration for the Winter period cover this month onwards with the plan to have rotas covered by late October 2025; this will inform capacity planning and support staff wellbeing. There are provisions to support Camden CYP with mental health support out of hours – to include the NCL CAMHS Crisis Line, CAMHS Crisis South Hub and the Home Treatment Team within NCL. For adult unit, there is an on-call rota for senior management, and someone will be on site and contactable every day that the Trust is open. Duty rota cover and senior cover across all adult Units in place, in person.
4.	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	N/A	
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	

Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	N/A	
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	N/A	
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Director on Call rota, including CMO and CNO. Service Clinical Leads and Clinical Service Managers, in liaison with the Medical Director and Director of Therapies ensure that leave is well planned to ensure adequate senior clinical cover, and that all teams will have rotas by late October 2025. There will be cover from a Unit Lead throughout the Winter period. Adult services have an MDT duty provision as well as trust wide medical and nursing support. Table top exercise held in February 2025, next exercise planned for October 2025.

10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	The CAISS team are aware of all Camden CYP that are requiring admissions to either local paediatric A&E departments or mental health general admission units, they work closely with partners to prevent admission or to facilitate safe discharge back into the community, working directly with the CYP, Family and external partners such as Children's Social Care. The unit leads receive reports through NCEL about admissions and this will be reported to IQPR from August 2025, with any trends or increase in admissions being identified and understood at an early stage, with mitigations put in place to reduce admissions through partnership working. The CAISS team have close working relationships with the local hospitals and have been established for many years now, they are contacted when a Camden CYP is admitted to hospital and typically are aware of all Camden CYP that requires this additional support.

		The Community CAMHS Team and CAISS work closely with the CAMHS Crisis South Hub who support Camden CYP throughout the week, they offer same day appointments (Mon-Fri) and 7 Day Follow-Ups from paediatric A&E's, this is to support the diversion of CYP from emergency departments into community provision of care. There are NCL Touch Point meetings every Monday, 9:30-10am and the Service Clinical Lead attends this, reporting back any admission escalations that need NCL attention, this can support getting the right package of support in place and prompter discharges.
Specific actions for Mental Health Trusts		
11. A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Crisis line 24/7 – email sent out in August to all staff to include in email signatures. OOH services in place in North and South Camden. There will be rotas and cover to include senior clinician presence (Band 8a+) within Camden CAMHS Unit, the CAISS team are part of the Camden CAMHS Unit

		provision and will continue to support Camden CYP whereby there is heightened risk. CAISS team works closely with the Community CAMHS Teams and will work in collaboration with the teams to support any Camden CYP whereby there is risk to self/others has increased and requires increased mental health support. The Community CAMHS Teams have two Complex Care Coordinators whose focus is supporting those Camden CYP who may not be ready for talking therapy support at this time, but there continues to be a mental health need and risk concerns, the clinicians are full time and work in tandem with Community CAMHS and CAISS. Within T&P Trust there are Psychiatry on call rotas whereby there is psychiatry cover across the Trust, this is in addition to Psychiatry that will be in place during the Winter period as business as usual. There are provisions to support Camden CYP with mental health support out of hours – to include the NCL CAMHS Crisis Line, CAMHS

			Crisis South Hub and the Home Treatment Team within NCL. Our work and patient need is much broader than the groups of provisions e.g. housing, 3rd sector, GP, local MH services (for HIC) so less dependent on necessarily the same resources as SMI populations.
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	The services will have in place a reviewed priority and 'red rag rated' patients to ensure crisis plans are in place for every patient identified as high risk. CAISS team work intensively with Camden CYP whereby there is heightened risk and at all times ensure there are tailored crisis and relapse plans in place which are regularly updated according to need. We have reminded all other teams to ensure they have up to date Safeguarding and Risk Plans, to include crisis plans in place ahead of the winter. Within Camden CAMHS Unit we have created a document that details clinical recording

		priorities and the first of these is Safeguarding and Risk Forms. Comms will be sent to all teams as we approach the winter to prompt teams to continue to consider this on a regular basis. This is further discussed in the 1:1's between Operational Team Managers and Team Clinical Leads whereby reports – on Safeguarding and Risk Forms amongst other clinical recording needs are discussed on a regular basis. We have monitored and improved compliance with crisis plans in 2025. Our work and patient need is much broader than the groups of provisions e.g. housing, 3rd sector, GP, local MH services (for HIC) so less dependent on necessarily the same resources as SMI populations.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC - THURSDAY, 18 SEPTEMBER 2025

Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	3rd September 2025	Sal Jarvis, Chair, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 018**		

Assurance ratings used in the report are set out below:

Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

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

Key headline	Assurance rating
1. Success Stories 1.1. Student applications closed on 14th August with 1122 applications completed, a small drop of 2% on the 2024/25 position. However, this position included an encouraging 15% increase in the number of overseas applications, and the earlier opening of applications has lead to a significantly higher number of offers made (179 conditional and 585 unconditional vs 100 cond/540 uncond) an increase of 20% at this point in the cycle relative to 24/25 as students move into enrolment. It is early to estimate how this will translate into enrolments and income, but it is a healthy position for the Trust in relation to its long-course educational income. 1.2. The new library development is taking shape, and it is very encouraging to see the clean, contemporary furniture and fittings being installed into a space that was beginning to look a little tired. The new furniture brings a modern feel aligned with modern University libraries and the removal of most of the desktop computers gives a feeling of space and the opportunity to focus. The space should be re-opening on the date of this committee (3rd September) so we would encourage members to look at the new space. 1.3. We will be hosting our 2025 graduation ceremony on 11th September, and I can see that several Executives have already committed their time to the event. It is in a venue – the Queen Mary People's Palace - that the CETO is very familiar with having attended QMUL graduations there for most of the last 11 years – and will be a great space for our staff and students to mark the end of (this part of) their Tavistock journey.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Challenge Areas 2.1. On 3rd July the Trust was formally notified by NHS England that the National Training Contract for provision of education and training	Limited ☐ Partial ☒ Adequate ☐ N/A ☒

services, funded to £5.2million by NHS England was being withdrawn and replaced by a teach-out arrangement, limiting this year's income to £2.6million with further incremental reductions based on the teach-out of the 2024/25 cohort (e.g. £1.4million for 2025/26). The Trust is currently reviewing options for its response to this change, although further cost improvement plans have been ruled out. A separate paper on these options was provided to the Committee, a copy of which has also been provided to the Private Board. 2.2. The Committee discussed the options on the paper and endorsed the proposed solution which focused on four areas: • A focus on mitigating this loss in the Medium-Term Financial Plan, through deepening partnerships with existing validation partner the University of Essex (UoE) to explore cost savings through sharing operational costs. • A focus on maximising short course income through right-sizing the number of courses offered and removing barriers to income generation. • A maximalist approach to increasing long-course income with a default increase of 10% proposed (as against 3.1% for 24/25). • Working with partners including UoE and agencies to maximise overseas student income. • Exploring a more long-term partnership with a University, without prejudice as to the identity of that partner, to ensure the continued viability of our courses. 2.3. Additionally, the Committee recognised the importance of individual courses becoming self-sustainable for the future and therefore added a recommendation that work should be done to ensure that all courses should be self-sustaining without the National Training Contract funding, which may involve re-visiting the model of delivery without impacting the distinctiveness of a Tavistock and Portman education.	
3. Challenge Areas 3.1. The Committee RECEIVED a report on the Directorate of Education and Training's financial position. The Committee was ASSURED on the robustness of the calculations used around this position but had LIMITED assurance on the achievability of the Directorate's financial plans given the loss of the NTC funding.	Limited ☒ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the options put to it in relation to mitigation of the National Training Contract income loss.
- The Committee made an additional RECOMMENDATION in relation to a further review of course-level viability.
- Next Committee is 13/11/2025.

Risks Identified by the Committee during the meeting:

- No additional risks

Items to come back to the Committee outside its routine business cycle:		
No items to note.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
POD-EDI: To ensure the process for onboarding and payment of Associate (formerly visiting) lecturers	Assurance around robust processes and governance in the Trust.	04/09/2025
PFRC: To note the Committee's endorsement of the proposed options around NTC mitigation.	Joined-up response to financial risks.	23/09/2025

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Annual Research and Development (R&D) Report – 2024/25			**Agenda No.: 019**
Report Author and Job Title:	Dr Eilis Kennedy, Director of Research & Development	**Lead Executive Director:**	Professor Mark Freestone, Chief Education and Training Officer
Appendices:	Appendix 1: References Appendix 2: Recruitment to Studies		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	An annual update on Trust Research and Development.		
Background:	This report provides an update on Trust research over the last year.		
Assessment:	The Trust continues to be engaged in a range of research activities.		
Key recommendation(s):	The Board is asked to **DISCUSS** the annual report and note the plans to: • Ensure successful delivery of the Trust's portfolio of research studies. • Ensure alignment with R&D at North London NHS FT including the joint research strategy with University College London (UCL). • Ensure alignment with the strategic objectives of the Department of Education and Training. • Strengthen existing academic partnerships and links and where possible seek to build new links and create new opportunities. • Recognise the importance of research in relation to the identity and profile of the Tavistock and the potential for making a positive contribution within the new organization.		

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 : New risk on CETO Executive Portfolio Risk Assessment: Lack of a clear strategy to realise new income to the Trust and ensure collection of overheads due to Trust.		
Legal and Regulatory Implications:	Yes ☐	No ☒	
	There are no legal and/or regulatory implications associated with this report		
Resource Implications:	Yes ☒	No ☐	
	There are potential resource implications in relation to future investment in research capability and capacity.		
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐	
	1. To ensure adherence to best practice EDI guidance in relation to recruitment of patients to research studies. Reporting on this is a requirement of most funders. 2. To recognise barriers to participation in research and to ensure this is taken into account in relation to recruitment of researchers employed on studies, career progression and access to opportunities for research skills development for Trust staff and students. 3. To ensure that the research team is aware of Trust EDI guidance and also the EDI strategies of the three major funders of Mental Health Research 1. NIHR Equality, Diversity and Inclusion Strategy 2022-2027 | NIHR) 2. UKRI Equality, diversity and inclusion (EDI) – UKRI 3. Wellcome Diversity and inclusion | Wellcome 4. Ongoing participation in EDI initiatives in relation to Mental Health research, via links with Noclor, as a Noclor partner Trust.		
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:			
Assurance Route - Previously Considered by:	Quality and Safety Committee – Thursday, 19 June 2025 (future reporting will be to the Education and Training 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

Research and Development Annual Report

1. Purpose of the report

1.1. To provide an annual update on Trust Research.

2. Background

2.1. This report provides an update on Trust Research over the last year.

3. Intervention research

3.1. The final report and final statement of expenditure (FSTOX) for our National Institute of Health and Care Research (NIHR) Programme Grant for Applied Research (PGfAR) on *'personalised assessment and intervention packages for children with conduct problems in child mental health services'* have recently been submitted to the NIHR. Work is ongoing in collaboration with Kings College London Clinical Trials Unit to finalise the study database and analyses of the findings from the Randomised Controlled Trial (RCT). A paper presenting the main findings from the RCT will shortly be submitted to the Journal *Child and Adolescent Mental Health* and further papers are in preparation. Qualitative findings from the RCT are also ready for submission for publication. The study aims to make an important contribution to advancing understanding of how best to personalise interventions in mental health services.

3.2. Our NIHR Research for Patient Benefit study (RfPB), '*A feasibility trial of remotely delivered Video Interaction Guidance (VIG) for families of children with a learning disability referred to specialist mental health services'* is also now complete having successfully recruited from a range of sites across England (including Alder Hey Children's, Guy's and St Thomas's and Lancashire and South Cumbria, NHS Foundation Trusts). Video Interaction Guidance is increasingly used by practitioners within the NHS and this is one of only a few studies to evaluate VIG within children's specialist mental health services. The study, led by Professor Vaso Totsika at UCL, successfully met its recruitment target with the anticipated number of participants randomised. The recommendation from the Centre for Trials Research at Cardiff University, following the success of the feasibility trial, is to apply for funding for a full-scale multi-centre effectiveness Randomised Controlled Trial. The study protocol has been published and the main study findings have been submitted to a Journal and are under review. In addition, the Challenging Behaviour Foundation is co-producing an accessible version of the findings from the study to share with families.

3.3. The Trust has also had a successful partnership with the Centre for Trials Research at Cardiff University in relation to the study *'Watch Me Play! A pilot feasibility study of a remotely-delivered intervention to promote mental health resilience for children (age 0-8) across UK early years and children's services'*. This study was funded by 'What Works for Children's Social Care' which has now merged with the Early Intervention Foundation in a new organisation called 'Foundations: What Works Centre for Children and Families' which has a remit for generating actionable evidence to improve services to support family relationships. The final study report is published on the 'Foundations: What Works Centre for Children and Families website': (Watch Me Play: A feasibility study of a remotely-delivered intervention to promote mental health resilience for children - Foundations). The study protocol has

also been published and paper describing the main study findings is under review with a Journal. Work is currently underway in collaboration with UCL and the Centre for Trials Research at Cardiff University to apply for further funding in order to take forward the recommendations of the feasibility study.

3.4. The Trust continues to engage in important research collaborations and has been closely involved in the NIHR Health Technology Assessment (HTA) funded study, *'Mentalisation for Offending Adult Males'* (MOAM). This study led by Professor Peter Fonagy at University College London evaluated the effectiveness of Mentalisation Based Treatment (MBT) for individuals under the supervision of the National Probation Service. The trial which started in January 2016, was the largest RCT to date for people with Antisocial Personality Disorder (ASPD) involving 13 sites across England and Wales. Jessica Yakeley at the Portman led the development and delivery of the clinical services in which the trial took place. The main study findings were published in March in the *Lancet Psychiatry.* The Trust is also a collaborator on the NIHR HS&DR funded data linkage study *'evaluating the real-world implementation of the Family Nurse Partnership'* led by Professor Katie Harron at University College London, Institute of Child Health. Findings from this study continue to be published with recent publications in BMJ Public Health, Archives of Diseases in Childhood and Public Library of Science (PLoS) One.

4. Health and Wellbeing across the Life course

4.1. The NIHR Health and Social Care Delivery Research (HS&DR) funded LOGIC study 'Longitudinal Outcomes of Gender Identity in Children', a collaboration between two NHS Trusts and three Universities (UCL, Liverpool and Cambridge) is one of the largest and longest running studies in the field to date with 5 waves of data collection in total. Recruitment to the study closed in July and the research team is working closely with the statistical team at Priment Clinical Trials Unit, University College London to finalise analyses of the follow up findings. The study has generated an immensely rich database providing novel insights in relation to trajectories and outcomes for this cohort of children and young people. A large number of papers from the study are currently being planned with several recently published or under peer review. The study is included in the *'Catalogue of Mental Health and Wellbeing Measures in UK Cohort and Longitudinal studies'* and was represented at the Wellcome Trust's launch of the '*Atlas of Longitudinal Datasets a New Discoverability Tool for Longitudinal Research'*. In addition, a grant application, in collaboration with international partners, was submitted in July to the Wellcome Trust Mental Health Award *'Leveraging longitudinal data to transform early intervention in mental health'.*

4.2. The LOGIC study team is working with Professor Simon Baron-Cohen and colleagues at the Autism Research Centre in Cambridge with a focus on Autism in relation to the LOGIC cohort. A further study, the MAGIC study (Markers of Autism and Gender Incongruence in Children), led by Professor David Williams at the University of Kent is also looking at Autism within the LOGIC cohort and in addition has recruited children and families through the Kent Child Development Unit (KDCU). A number of papers from the UK Research and Innovation Economic and Social Research Council (UKRI ESRC) funded MAGIC study have recently been submitted to Journals and are currently under review or accepted for publication.

4.3 The Trust has collaborated on work focused on the impact of poverty on child development and specifically the relationship between poverty, child abuse and neglect. Papers relating to this work have been published in recent months. Researchers from the Trust were invited by UK Primary Sclerosing Cholangitis (UK PSC) support to present on *'The Mind:*

What does wellbeing look like living with a chronic illness?'. The presentation was at a national PSC meeting in Birmingham on 19.10.24 and drew on findings from the 'PSC Wellbeing Study' led by the Trust in collaboration with UCL Division of Medicine, the Royal Free Hospital and UK PSC support.

5. Research Governance and Support

5.1. The Trust is a noclor partner Trust, aligning with North London NHS Foundation Trust (NLFT) who are also a noclor partner Trust and thereby facilitating integration in relation to research governance and support following the merger. Noclor provide regulatory and research governance support to the Trust and offer regular research trainings for Trust staff and students throughout the year advertised with the support of the Trust communications team. Research training and development opportunities are also provided locally by UCLPartners and the NIHR Applied Research Collaboration (ARC) North Thames. The NIHR incubator for Mental Health Research is another important source of advice and guidance regarding career development and funding opportunities for health care professionals interested in Mental Health Research.

6. Research Funding

6.1. The Trust has been successful in securing competitive external grant funding for research over the recent years and is one of a number of Trust's nationally to receive income-based Research Capability Funding (RCF) from the NIHR. The Trust's track record in this regard aligns well with NLFT who have a strong record in attracting income based RCF.

6.2. Unlike some Trusts the amount of funding from charitable sources is relatively small. However, the Tavistock Charity have recently launched a fellowship and large grants scheme to support research projects or service innovation.

6.3. The Trust is eligible to receive funding from UK Research and Innovation (UKRI) and is registered on the UKRI Joint Electronic Submission system (Je-S) system, enabling the submission of grants in recent years to the UKRI Medical Research Council (MRC), the Economic and Social Research Council (ESRC) and Innovate UK as either a lead or partner organisation.

6.4. Trust staff have been successful in securing an NIHR Development and Skills Enhancement award, an NIHR pre-application support funding award and fellowship funding from the Tavistock charity. Three members of the research team have recently moved to academic posts at the University of Cambridge (one subsequently securing a 5-year Wellcome Trust early career fellowship).

6.5. While the Trust is always keen to support NIHR portfolio studies wherever possible the small size of the Trust and eligible patient population, inevitably means that recruitment to NIHR portfolio studies is constrained (see appendix 2). However, the Trust's role as a 'parent site' in recruiting to studies across the UK is recognised by the NIHR North Thames Regional Research Delivery Network leadership.

7. Recommendations

7.1. A key priority is the ongoing successful delivery of our portfolio of research studies in order to optimise the beneficial impact for patients, society and the NHS.

7.2. Trust R&D has recently moved from the CMO's portfolio to the CETO's portfolio. An important priority over the coming months is to ensure alignment with the strategic objectives of the Department for Education and Training and also in anticipation of the merger with North London NHS Foundation Trust next year, alignment with R&D at NLFT, including NLFT's joint research strategy with University College London.

7.3. To investigate potential new opportunities arising from the merger for example the potential to develop research links with the UCL Institute of Mental Health (IoMH) and within the UCLH Biomedical Research Centre (BRC) Mental Health Theme. NLFT has strong representation within both the IoMH and the BRC so it would be good to explore how T&P might contribute for example to the UCLH BRC Mental Health sub-theme *'preventative interventions for child and adolescent mental health'* or engage in the doctoral research training programmes offered through the BRC.

7.4. Potential new research opportunities are also available at NLFT in relation to: a) access to a larger population from which to recruit to studies (NLFT serves a population of just under 1.5million and 428,400 residents are under 25) b) access to the CRIS (Clinical Record Interactive Search) system. CRIS enables clinical records to be used in research. It is safe and secure and patients' personal details cannot be accessed by the researchers who use it. CRIS is part of the UKRI MRC funded Datamind.

7.5. To continue to build and strengthen existing links with NLFT and across North London. T&P has for many years shared a joint R&D office with NLFT and is alongside NLFT, part of the NIHR North London Regional Research Delivery Network (RRDN), the NIHR Applied Research Collaborative (ARC) North Thames and UCL Partners.

7.6. To continue to strengthen links with UCL and the University of Essex as well as the wide range of University, NHS and other partners involved as collaborating partners in research.

7.7. While small, Trust research has a potentially important contribution to make in maintaining the ongoing profile of the Tavistock within the new organisational structure. It might be helpful to consider ways in which the historical legacy of the Tavistock's contribution could be represented by naming centres or roles after key figures, for example John Bowlby and Mary Ainsworth. Research is also an important means whereby the innovation, curiosity and new ideas long associated with the Tavistock identity can be nurtured and sustained.

8. Conclusion

8.1. The Tavistock has a longstanding tradition of research that has made a positive contribution to shaping the clinical, educational and training environment for staff, students and those using our services as well as being a key aspect of the Trust's international reputation. It is important to build on this legacy to ensure that research continues to play a central role in the ongoing work of the Tavistock as part of North London NHS Foundation Trust.

Appendix 1. Publications 24/25

1. Supporting qualitative practitioner research in child and adolescent mental health. Archard PJ, O'Reilly M, Awhangansi S, Grant L, Adan A, Majumder P, Lewis M, Bostock L, Kennedy E. Ir J Psychol Med. 2025 Aug 28:1-3. doi: 10.1017/ipm.2025.10092. Online ahead of print.PMID: 40873388

2. Mentalisation-based treatment for antisocial personality disorder in males convicted of an offence on community probation in England and Wales (Mentalization for Offending Adult Males, MOAM): a multicentre, assessor-blinded, randomised controlled trial. Fonagy P, Simes E, Yirmiya K, Wason J, Barrett B, Frater A, Cameron A, Butler S, Hoare Z, McMurran M, Moran P, Crawford M, Pilling S, Allison E, Yakeley J, Bateman A.Lancet Psychiatry. 2025 Mar;12(3):208-219. doi: 10.1016/S2215-0366(24)00445-0.

3. Bridging the Gap: A Qualitative Study Exploring the Impact of the Involvement of Researchers With Lived Experience on a Multisite Randomised Control Trial in the National Probation Service in England and Wales. Simes E, Butler S, Allison E, Barrett B, Bateman A, Cameron A, Crawford M, Frater A, Hoare Z, McMurran M, Moran P, Pilling S, Wason J, Yakeley J, Fonagy P.Health Expect. 2025 Feb;28(1):e70162. doi: 10.1111/hex.70162.

4. Characteristics and outcomes of children and adolescents referred to gender services in the UK and Netherlands: A retrospective cohort study. Lane C, Fysh MC, Gronostaj-Miara A, Spinner L, Stynes H, Ranieri V, Vickerstaff V, Omar R, Hunter RM, Carmichael P, Senior R, Butler G, de Graaf NM, Steensma TD, de Vries AL, King M, Kennedy E.Clin Child Psychol Psychiatry. 2025 Jun 26:13591045251353547. doi: 10.1177/1359104525135354

5. Effects of the Family Nurse Partnership on all eligible mothers: a data linkage cohort study in England. Harron K, Cavallaro F, van der Meulen J, Kennedy E, Gilbert R.PLoS One. 2025 Apr 3;20(4):e0320810. doi: 10.1371/journal.pone.0320810. eCollection 2025.PMID: 40179042

6. Characteristics and outcomes associated with fidelity in the Family-Nurse Partnership in England: a data linkage cohort study. Clery A, Cavallaro F, Kennedy E, Gilbert R, Harron KL.Arch Dis Child. 2025 Jun 19;110(7):545-550. doi: 10.1136/archdischild-2024-327654.

7. Remotely Delivered Video Interaction Guidance for Families of Children With an Intellectual Disability Referred to Specialist Mental Health Services: Protocol for a Feasibility Randomized Controlled Trial. Kohn C, Turner L, Yang Z, Absoud M, Casbard A, Gomes M, Grant G, Hassiotis A, Kennedy E, Levitt S, McNamara R, Randell E, Totsika V.JMIR Res Protoc. 2024 Dec 5;13:e54619. doi: 10.2196/54619.PMID: 39636678

8. The cost of poverty for child development: The adverse impact on maltreatment, education and mental health outcomes cannot be ignored. Skinner GC, Kennedy E.Clin Child Psychol Psychiatry. 2025 Apr;30(2):309-313. doi: 10.1177/13591045241302121. Epub 2024 Nov 20.

9. Mapping the pathway and support offered to children with an intellectual disability referred to specialist mental health services in the UK.

Totsika V, Yang Z, Turner L, Kohn C, Hassiotis A, Kennedy E, Absoud M, McNamara R, Randell E, Levitt S, Grant G, Casbard A, Jacobs L, Di Santo C, Buckley C, Hignett E, Liew A.BJPsych Bull. 2025 Jun;49(3):157-162. doi: 10.1192/bjb.2024.63.

10. Stories of absence: Experiences of parental and familial rejection among gender-diverse children and young people. McKay K, Kennedy E, Wright T, Young B.Clin Child Psychol Psychiatry. 2025 Apr;30(2):294-308. doi: 10.1177/13591045241288749. Epub 2024 Oct 25

11. McKay, K., Kennedy, E., Wright, T., & Young, B. (2025).“I was being true to myself”: Listening to young people talk about gender identity and transition. *SSM-Qualitative Research in Health*, *7*, 100550. https://doi.org/10.1016/j.ssmqr.2025.100550

12. Watch Me Play!: protocol for a feasibility study of a remotely delivered intervention to promote mental health resilience for children (ages 0-8) across UK early years and children's services. Randell E, Nollett C, Henley J, Smallman K, Johnson S, Meister L, McNamara R, Wilkins D, Segrott J, Casbard A, Wakelyn J, McKay K, Bordea E, Totsika V, Kennedy E.Pilot Feasibility Stud. 2024 Apr 4;10(1):55. doi: 10.1186/s40814-024-01491-7.PMID: 38576026

13. "Behavioural Phenotypes of Autism in Autistic and Nonautistic Gender Clinic-Referred Youth and Their Caregivers" Kallitsounaki A., Fysh M C, Williams D M , Spinner L, Kennedy E. (accepted for publication in Autism)

Appendix 2. Recruitment to Studies (2024/25)

Recruiting Study Name	IRAS	Recruitment Numbers
ESRC MAGIC study	312288	29
Personalised Programmes for Children RCT	268597	33

Additional Studies (2024/25)	Study host	Status	Study closing date
Narratives of health and illness for Healthtalkonline.org	University of Oxford	PIC site	31/01/24
National Confidential Inquiry into suicide and homicide by people with mental illness	University of Manchester	Research site	31/03/27
The cross-sector pilot implementation of trauma-focused CBT for care-experienced young people with posttraumatic stress disorder	University College London	Research site	31/01/24
How do social workers in adoption services conceptualise CYP MH?	Kingston University	Research site	27/09/24
The effects of gender-affirming hormone treatment in trans women on morphological, functional and molecular markers of performance relevant to combat and collision sports	Manchester Metropolitan University	Research site	30/04/25
The cross-sector pilot implementation of trauma-focused CBT for care-experienced young people with posttraumatic stress disorder	University College London	Research site	31/01/24
Autism Transition to Adulthood Group - ATAG	University of Bath	PIC site	01/06/25
ATTEND - MAC Implementation Evaluation Protocol	UCL	PIC	10/06/24
BDD Vignette Study: The Identification and Psychological Treatment of Body Dysmorphic Disorder in Youth: An Experimental Vignette Study to Understand Clinical Practices. (PALS.AIM)	UCL	PIC	31/12/25

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	04 September 2025	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 020**		
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**
Focus BAF Risk 7 • The Committee focused on BAF Risk 7 for this meeting and continued with the revised, evolved, thematic layout of the agenda and papers. • 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 ☐
1. Headlines • Performance / compliance has improved across the trust and there was a helpful and constructive discussion about how best to improve the position further. A specific item at SLF on accountability and cascade of information (including annual leave, MAST, appraisal etc.) was recommended. • EDI successes were noted and discussed, including: – Strong gender pay gap position – Improvement in WRES – Improvement in CPD approaches – Improvement in inclusive recruitment – Progress and finalising the dashboard for EDI metrics • It was acknowledged that the next staff survey is fast approaching and that a useful mechanism for both reminded staff of our progress to date, and increasing the staff survey response rate, would be to	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

showcase the people team (and various interventions and successes) via the digest. • One escalation was received from ETC, however it was agreed that as it related to the employment terms of a specific individual, it would be progress and finalised by the CETO and CPO outside of the meeting.	
2. Reflections • Assurance was gained during the meeting on a substantial number of items; R&R Group, Establishment Control, HR Policies, EDI Programme Board, Gender Pay Gap. • There was also acknowledgement of the hard work of the people teams over the last 2.5 years and the resulting significant improvements made. Thanks were given to be passed onto the team. • Thanks were also given to the DET leads responsible for providing EDI data and recognition made that DET considerations should be woven into BAF Risk 7 • Cascading and communicating expectations and successes across the organisation is now a key priority to continue the work the committee oversees • Our observers were unfortunately unavailable for this committee date.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

No decision were required

Risks Identified by the Committee during the meeting:

No new risk was identified, however it was agreed that DET considerations should be added to BAF Risk 7.

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 to refer; the item received from the ETC will be progressed outside of the committee.		

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Revalidation: Framework for Quality Assurance and Improvement (FQAI) Report and Statement of Compliance (2024-25)			**Agenda No.: 021**
Report Author and Job Title:	Dr Liz Searle, Deputy Chief Medical Officer	**Lead Executive Director:**	Dr Chris Abbott, Chief Medical Officer
Appendices:	Annex A – Revalidation: Framework for Quality Assurance and Improvement (FQAI) Report and Statement of Compliance		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This is the yearly statement of compliance that will be submitted to NHS England for relevant medical staff's engagement with appraisal and revalidation process as required by the General Medical Council.		
Background:	The Revalidation: Framework for Quality Assurance and Improvement (FQAI) Report and Statement of Compliance (2024-25) is a document from NHS England that helps NHS organisations and their Responsible Officers (ROs) to show they are meeting statutory revalidation requirements and continuously improving the quality of patient care. The framework provides templates and guidance, and the annual report and statement of compliance is the output of this framework, with the organisation using the framework's tools to produce a report and statement of their compliance with standards for the previous year.		
Assessment:	It is confirmed that the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).		
Key recommendation(s):	The Board is asked to **APPROVE** the paper for submission to NHSE.		

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 : No related risk.				

Legal and Regulatory Implications:	Yes ☒		No ☐	
	It is a regulatory requirement from the GMC that all doctors engage in revalidation. Notice of non-engagement with the process to the GMC from the RO may result in the doctor not being able to practice clinically.			
Resource Implications:	Yes ☐		No ☒	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐		No ☒	
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	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

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

The Tavistock and Portman NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	N/A

Comments:	The Chief Medical Officer Dr Chris Abbott is the Trust Responsible Officer since September 2023.
Action for next year:	N/A

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Continue to monitor
Comments:	Yes, an appropriate level of finding is available to the RO.
Action for next year:	Continue to monitor

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue to monitor our processes and if indicated make any adjustments to enhance our efficiency.
Comments:	The Trust maintains accurate records of all doctors who have a prescribed connection, and these are reviewed/updated regularly through the Responsible Officer's Advisory Group (ROAG) which meets monthly. A designated HR Business Partner attends the ROAG meeting.
Action for next year:	Continue to monitor

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	N
Action from last year:	Review Appraisal and Revalidation Procedure on yearly basis.

Comments:	In process
Action for next year	Procedure to be reviewed in line with NLFT procedures in view of forthcoming planned Trust merger in 2026

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	N
Action from last year:	In light of the possible merger in 2025 between the Trust and another Trust consider peer review once plans known.
Comments:	Merger process still ongoing
Action for next year:	Consider peer review once planned merger for 2026 is complete

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	To continue to support this group of doctors when these doctors are in post in the organisation.
Comments:	The Trust has a small number of locum and short term placed doctors working in the organisation currently. The appraisal lead meets with each doctor to support their CPD and their appraisal. They are each signed up to our appraisal and job planning system (SARD).
Action for next year	To continue to support this group of doctors when these doctors are in post in the organisation.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Continue to monitor our processes.
Comments:	The statement above is correct for this organisation. The expectation of an annual appraisal is embedded in the policy, medical employment contracts and in job planning. The appraisal lead reviews the summary of each completed appraisal, with a more detailed focus on those just before revalidation, to ensure all is in order. ROAG continues to meet monthly and monitor and includes the CMO/RO, Appraisal Lead/Deputy CMO, Revalidation Manager, HR Business Partner for Medical Workforce, Medical Director, and a Non- Executive Director who is a senior medical practitioner. All doctors are expected to provide their appraiser with a Manager's Report from each of their employments. The RO has regular meetings with the GMC ELA.
Action for next year:	Continue to monitor our processes.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	
Comments:	
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Continue to review
Comments:	As above, the policy needs updating to be aligned with the new Trust in view of the planned merger for 2026
Action for next year:	Review and update policy

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Continue to review training need and number of appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	The Trust has the necessary number of trained appraisers to carry out timely appraisals. All new eligible consultants have been encouraged to complete appraiser training. All consultants are requested to appraise at least 2 doctors to share this task and to ensure experience is kept up-to-date. The need for training new appraisers and running refresher training for current appraisers is considered at the termly appraisers meeting. A refresher training for appraisers is being planned for Autumn term 2025.
Action for next year:	Continue to review training need and number of appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue internal peer reviews meetings. Canvas appraisers for their thoughts on development events and arrange same.
Comments:	Following consultation with appraisers at appraiser meetings, appraiser refresher training is being planned for Autumn term 2025. There are termly peer appraisers' meetings in which any issues can be discussed including standards expected. The appraisal lead and revalidation manager attend relevant external training/update events e.g. the appraisal lead has recently completed Responsible Officer (RO) training.
Action for next year:	Appraiser refresher training to take place as above. Continue termly appraisers meetings These processes may be reviewed in line with the planned merger in 2026 to align with the new Trust processes.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue.
Comments:	Report presented to Trust board in September 2025
Action for next year:	Continue.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue to monitor
Comments:	The RO continues to make timely recommendations to the GMC about all doctors with prescribed connection to the designated body as required. The RO also meets regularly with the ELA.
Action for next year:	Continue

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue to monitor and discuss our processes at ROAG.

Comments:	The above statement is correct in relation to this Trust as designated body.
Action for next year:	Continue to monitor and discuss our processes at ROAG.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	New leadership structures in place since 1 September 2024 including clinical governance structures. Review effectiveness of these new structures in relation to doctors.
Comments:	Effective clinical governance structures are in place to support doctors. The new leadership structures have tightened governance processes and systems across the Trust
Action for next year:	Continue to monitor

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	Continue to review and monitor
Comments:	The above statement is correct in relation to this Trust and designated body.

Action for next year:	Continue to review and monitor

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	N/A
Comments:	All doctors are provided with access to the SARD system to complete their appraisals. They are also supported by the Revalidation manager to obtain any necessary information and can also access their own data via Trust dashboard.
Action for next year:	Continue

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	Continue to review and monitor.
Comments:	The above statement is correct in relation to this Trust and designated body. The Trust has appropriate structures and processes in place.
Action for next year:	Continue to review and monitor.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Continue to review and monitor processes.
Comments:	The above statement is correct in relation to this Trust and designated body. Appropriate structures and processes are in place. The ROAG considers any individual issues. If necessary, concerns are discussed with the Practitioner Performance Advice Service at NHS Resolution and with the GMC ELA.
Action for next year:	Continue to review and monitor processes.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Continue to review and monitor.
Comments:	The statement above is correct in relation to this Trust and designated body. The RO continues to respond to all requests for transfer of information using the Medical Practitioner Transfer Form (MPIT)
Action for next year:	Continue to review and monitor.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	Continue to monitor and discuss at ROAG.
Comments:	The above statement is correct in relation to the Trust and designated body.
Action for next year:	Continue to monitor and discuss at ROAG.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	N/A
Comments:	The above statement is correct in relation to the Trust and designated body. For example, reviews of processes within the Trust have been carried out this year in relation to the Independent Mental Health Homicide Review into the tragedies in Nottingham and the Thirlwall Inquiry: the learning from these have been presented to Trust board and shared across the Trust.
Action for next year:	Continue to monitor for relevant reports and enquiries and review Trust processes accordingly

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/A
Comments:	Trustwide leadership training has been provided to all staff in leadership and management roles to ensure a consistent leadership approach.
Action for next year:	Continue to embed leadership training for relevant staff

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	Continue to receive input from HR BP.
Comments:	The above statement is correct. There is a dedicated HR Business Partner for the medical discipline who attends ROAG.
Action for next year:	Continue to monitor via ROAG and receive input from HR BP.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	N/A
Comments:	A Values in Practice (ViP) awards process took place in 2025 whereby colleagues and Trust leaders could vote for staff who demonstrate the behaviours of the Trust values: this was celebrated in an awards ceremony in June 2025.
Action for next year:	Aim to repeat the above process, depending on the approach of the new Trust in view of the planned merger in 2026.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	N/A
Comments:	The Trust is implementing a PCREF plan to support us to become an actively anti-racist organisation Teams are encouraged to have EDI spaces to review processes and continually learn. Improvement projects around EDI are encouraged and supported across the Trust e.g through QI forums.
Action for next year:	Continue

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y

Action from last year:	N/A
Comments:	The roles of the Freedom to Speak up guardians have been widely shared across the Trust, with regular drop-in sessions available to all staff.
Action for next year:	Continue, in line with process of new Trust in view of panned merger in 2026

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	N/A
Comments:	The Trust procedures related to professional standards, such as the Disciplinary procedure, include appeal processes.
Action for next year:	Continue

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Y
Action from last year:	N/A
Comments:	The EDI team monitor parity around disciplinary processes across the Trust and widely disseminate learning from this, including ensuring teams have local action plans.

Action for next year:	Continue to monitor

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	N/A
Comments:	The RO liaises with other ROs in local networks and attends regular network meetings
Action for next year:	Continue

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	31
Total number of appraisals completed	27
Total number of appraisals approved missed	2
Total number of unapproved missed	2
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	17
Total number of late recommendations	0
Total number of positive recommendations	12
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	0
Total number of trained case managers	0
Total number of concerns received by the Responsible Officer[2]	1
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	0
Median duration of concerns processes closed (working days)[3]	TBC
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	11
Total number of new employment checks completed before commencement of employment	11
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
All doctors now have electronic job plans, which includes SPA time in accordance with their contracts, allowing time for appraisal work. 0 of the 38 of the doctors for whom this Trust (TPNSHFT) is the designated body is currently subject to GMC fitness to practice procedures or any imposed conditions or undertakings. Appraisers continue to meet three times per year to ensure standards are maintained.
Actions still outstanding
Policies and procedures related to medical appraisal and revalidation to be aligned with new Trust in view of merger planned in 2026.
Current issues

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Many doctors require chasing to complete their appraisal in a timely manner. A quality improvement (QI) project is in progress to try to improve this, including streamlining the appraisal process, introduce automated reminders, and move to an appraisal window from 2026.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
The Trust will be moving to a new appraisal cycle of April to June in 2026. Continue with other current processes
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The Trust values its medical workforce for the significant contribution they make to ensuring delivery of high-quality services for our patient population. The systems and processes within the Trust support medical appraisal and revalidation. Any issues or concerns are discussed at the monthly Responsible Officer's Advisory Group (ROAG). This group is effective and is well supported by the HR function. All these processes will be reviewed over the coming year in view of the planned merger in 2026, with processes being aligned to the new Trust.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Tavistock and Portman NHS FT

Name:	Dr Chris Abbott
Role:	Chief Medical Officer & RO
Signed:	
Date:	

Name of the person completing this form:	Dr Liz Searle, Deputy CMO
Email address:	LSearle@tavi-port.nhs.uk

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025

Committee:	Meeting Date	Chair	Report Author	Quorate	
Extraordinary Performance, Finance and Resources Committee	31 July 2025	Aruna Mehta, Non-Executive Director	Jon Bell, Interim CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 022**		

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
• An extraordinary meeting of the PFRC was held on the 31st July mainly to review the financial performance up to Month 3. • The Integrated Quality and Performance Report (IQPR) was noted for information and the Digital Metrics report was deferred to the September meeting. • A revised Digital Metrics report is expected to be discussed at ELT on August 4, 2025, before being presented to the PFRC meeting in September.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Finance Report Month 3, including efficiency plan and cash • It was reported that the financial performance for Month 3 is £275k adverse to plan due mainly to delays in delivery of the Cost Improvement Programme (CIP). • It was reported to the Committee that the Trust was notified in July that the National Training Contract will not be renewed, with a loss of £2.6m income in 2025/26. This increases to a total loss of £5.2m over three years. The impact of the 2025/26 loss is not yet reflected in the year to date position. • The original cash request for the year has been adjusted from £3.3m to £4.2m due to the impact of the national training contract income loss, partly mitigated by reducing the cash held each month and at year end. • A further request for £1.6m cash support in August had been submitted and was awaiting approval. Alternative mitigations, in the event that NHSE reject the cash support request, were being discussed with NCL ICB. • CIP development and delivery remain a critical focus of the Trust. It was reported that the CIP plan assumes a reduction of 42 WTE. The Trust has a large CIP target which includes the original	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

planning assumption of £3.9m plus a further stretch required to address pressures arising from the full year effect of prior year recruitments coupled with much lower staff turnover. The original CIP target is largely identified but overall the Trust is behind plan and has a significant level of unidentified CIP. There is also a significant risk that reducing pay spend in an environment of very low bank and agency spend, will require consultation and potential redundancies cost not in the plan. • The Committee received an update on the plans to sell Gloucester House. Gloucester House is currently used as a school and also houses the FDAC service. Plans are being progressed to relocate both services. An alternative site for the school has been identified and the Trust is working with Camden local authority to progress this by November half-term however there are a number of risks to achieving this timescale. It was suggested that oversight by a NED with property experience would be beneficial. This item was specifically noted for feedback to the Board of Directors. • An update was received on contracts and income. It was noted that income is at risk in the consulting and i-Thrive contracts with unfilled vacancies impacting service delivery. However, no significant risks are identified for NHSE clinical contracts (GIC, Portman) or NCL Block contracts (CAMHS), with 2025-26 values already agreed. It was agreed by the Committee that a more detailed discussion on contracts and income risks will take place at the next meeting	
Integrated Quality and Performance Report • The Committee noted the report for information.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
National Training Contract and Options: • The Committee received the briefing paper that set out the background to the loss of the National Training Contract and the options that are being explored as a consequence of the loss of this funding. • Weekly meetings are taking place with NHS England to assess each option and a paper will come to a future meeting setting out the outcome of this assessment.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

No decisions were required by the Committee

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:

- No items required to come back to the Committee outside of the routine business cycle

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

Item	Purpose
• It was recommended that the Board consider whether there is a NED with property experience who could take an oversight role in relation to the sale of Gloucester House	• Provide assurance to the Board that appropriate steps are being taken in the relocation of Gloucester House services and subsequent sale.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 18 September 2025			
Report Title: Finance Report - As at 31st July 25 (Reporting Month 04)			**Agenda No.: 023**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Jon Bell, Interim Chief Financial Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	The report provides the Month 04 financial position for the Trust.		
Background:	The Trust has a breakeven plan for 2025/26, with a Capital Expenditure limit of £2.774m.		
Assessment:	**Income and Expenditure** The Trust's financial plan for 2025/26 includes a £3.9m recurrent efficiency target, alongside assumed contributions from Tavistock Consulting income growth, a gain from the sale of Gloucester House and the release of annual leave accrual due to a policy of no annual leave carry forward in 25/26. The Trust is reporting a year-to-date deficit of £3,008k, which is £861k adverse to the plan submitted to NHSE. The variance is largely driven by the loss of £2.6m in income from the National Training Contract and shortfalls on CIP delivery, offset by additional income above plan. Delivery against the efficiency target remains a key area of focus and risk, with progress continuing to be monitored closely. **Capital Expenditure** The approved capital expenditure limit for 2025/26 is £2.774m. As at Month 4, actual capital spend is £356k, which is below the planned profile of £1.017m. The variance is largely attributable to phasing delays, with most major capital projects expected to commence from Month 5 onwards. The full-year capital spend is expected to remain in line with plan. **Cash** Cash flow remains under significant pressure. As of July 2025, the Trust had a cash balance of £1.529m, equating to nine days of operating expenditure. For August, the Trust secured £1.58m in approved cash support from DHSC. A further request for £1.02m was submitted for September however NHSE only approved support at 50% of the value requested. The receipt of an outstanding debtor was in September, earlier than expected, has mitigated the impact of the reduced cash support in month. The current cash forecast projects a cash support requirement of £2.17m in November. NHSE have stated that no further requests will be approved until they have confidence in the plan to resolve the underlying deficit. This will be		

	set out in the merger business case which is due to be submitted by the end of October. The total cash support required for the year remains at £4.2m, reflecting both the impact of the £2.6m loss of income from the National Training Contract and the Trust's constrained underlying cash position. Th
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:	Executive Leadership Team			
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 – Year to 31st Jul2025 (Reporting Month 04)

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 31st July 25.

Financial Reporting Summary - Month 04 2025/26 (compared to submitted plan)

	Current Plan	Actual	Variance
£'000	**Jul25**	**Jul25**	**Jul25**
	YTD	**YTD**	**YTD**
Income	**19,139**	**18,886**	**(253)**
Operating Expenditure	(21,214)	(21,837)	**(623)**
Non-Operating Expenditure	(72)	(57)	15
TOTAL Provider Surplus/(Deficit)	**(2,174)**	**(3,008)**	**(861)**

1.2 Summary Narrative

At the end of Month 4, the Trust reported a cumulative deficit of £3.008m, representing a shortfall of £861k against the submitted plan. The primary drivers of this underperformance include the loss of £2.6m in income from the National Training Contract, under-delivery of efficiency savings (CIP), and unforeseen non-pay cost pressures. The internal forecast has now been realigned with the submission to NHSE for greater clarity.

Although some controllable variances (e.g., agency spend) are better than plan, systemic issues in recurrent income loss and delayed savings delivery pose significant risks to achieving breakeven at year-end. The Trust has no ability to mitigate the loss the education contract in year and is in discussion with NCL ICB regarding a system solution to this adverse variance.

1.3 Key Financial Pressures Identified

- Income shortfall of £253k is primarily linked to the termination of the National Training Contract for new intakes, reducing core education funding streams, offset by additional income not in the original plan.
- Pay costs exceeded plan by £235k, driven largely by CIP shortfalls of £202k, reflecting delayed implementation and dependency on staff turnover.
- Non-pay overspend of £413k includes non-recurrent pressures (VAT adjustment and prepayment reversal) and again reflects the timing and delivery risk of non-pay CIPs.

2. Income

As of month 4 (July 2025), total income is reported at £18,886k, which is £253k behind plan. This adverse variance is driven primarily by the loss of

income from the National Training Contract, following confirmation from NHSE that the contract would not be extended for new students beyond the 2024/25 cohort.

The Trust has since updated the forecast position to reflect this lost income, which is now fully incorporated into the revised Forecast Outturn (FOT) for 2025/26. In addition, while some income areas remain on track, others are emerging as potential risk zones requiring closer scrutiny and active mitigation.

2.1 Risks and Forward Look

- Confirmed Income Loss: The non-renewal of the National Training Contract presents an ongoing structural risk to income. While the 2025/26 impact is £2.6m, the full effect of £5.2m will materialise over the next four years.
- Income Delivery Risk: £400k of planned income from Tavistock Consulting and I-Thrive is currently at risk due to delays in contract execution and delivery slippage.
- CETO Activity Drop: Student enrolment on short courses is significantly below the planned level, particularly affecting Q1, leading to an in-year shortfall. This will be monitored monthly.
- Research and Development (R&D): While not currently adverse to plan, the R&D income stream is flagged for closer review in Q2 due to potential timing and delivery risk.

3. Staffing Costs

As of Month 4, total staffing costs are adverse to the plan by £235k. This overspend is mainly driven by under-delivery of planned CIP savings related to pay.

3.1 Pay CIP Shortfall

The 2025/26 financial plan included significant efficiency savings from staffing reductions, vacancy management, and other workforce measures. However, in the first four months, the Trust has fallen short of its pay-related CIP target by approximately £202k, contributing to the adverse variance on Pay. While some initial progress has been made — such as partial vacancy holds and early-stage restructure work — the full impact of the planned pay savings has not yet been realised.

3.2 Agency Cost Position

Agency costs remain within target levels. Total agency spend for the period is £115k, which is £33k better than plan, driven by tighter controls over temporary staffing approvals and the use of fixed-term contracts to mitigate gaps. This favourable variance in agency use provides partial offset to the CIP shortfall but is not sufficient to close the gap entirely.

4. Non staff costs

As at Month 4 (July 2025), non-staff costs totalled £5,619k, resulting in an adverse variance of £413k compared to the submitted plan of £5,206k. The

overspend is mainly due to timing and phasing issues, alongside some unplanned adjustments and shortfalls in non-pay efficiency savings. This variance represents a critical area for focus, as the Trust seeks to manage operational pressures while progressing its cost improvement programme (CIP).

4.1 Key Drivers of the Variance:

Cost Item	Variance to Plan	Explanation
VAT Adjustment	£115k (Adverse)	Technical accounting adjustment not reflected in original plan assumptions.
Prepayment Reversal	£97k (Adverse)	Reversal of prepayments from 2024/25 into current year – non-recurrent.
Non-Pay CIP Shortfall	£201k (Adverse)	Under-delivery of CIP savings planned in corporate and CETO areas.
Other Variances (net)	Neutral	Minor variances across departments within tolerance levels.

5. Non-Operating Costs

Operating non-pay costs for the period were £49k, which is £9k better than the planned figure.

6. Cash

6.1 As at 31st July 2025 (Month 4), the Trust's cash position remains under significant strain. The reported cash balance is £1.529m, equivalent to nine days of operational expenditure, highlighting a critically low liquidity position.

Although the Trust withdrew its July cash support request due to higher-than-expected income receipts, the overall pressure on cash resources is expected to persist for the remainder of the year. The Trust continues to require external support in order to meet its working capital needs and statutory obligations.

6.2 Cash Support Programme – 2025/26

To manage this constrained position, the Trust has developed a phased cash support strategy and submitted applications accordingly. Below is a summary of the cash support status:

Month	Cash Support Required	Status	Purpose
Jul-25	£0.0m	Withdrawn	Higher income receipts removed the need for July support.

Aug-25	£1.58m	Approved by DHSC	Support for August pay award impact.
Sep-25	£1.02m	Approved at 50% of requested value	Supports operational pressures and delays in contract income.
Nov-25	£2.17m	Planned	Supports operational pressures and delays in contract income. Revised to reflect 50% reduction in Sept-25

6.3 Total cash support required for the year remains at £4.2m, aligned to earlier forecasts and inclusive of the impact of the £2.6m loss in income from the National Training Contract.

6.4 The cash request of £1.02m for September was reduced by 50% by NHSE. A payment for an outstanding debtor was received in September, earlier than planned, and this has mitigated the impact reduced cash support. The current cash forecast projects a further cash support requirement of £2.17m in November. NHSE have stated that any no further requests will be approved until they have confidence in the plan to resolve the underlying deficit. This will be set out in the merger business case which is due to be submitted by the end of October.

7. Balance Sheet

No movements of note to report at Month 04.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 18 September 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 024**
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 ☐		

Link to the Risk Register:	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

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2025					2026			Board / Committee / Meeting	
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Paper Deadline			**01-May**	**26-Jun**	**04-Sep**	**06-Nov**	**30-Dec**	**05-Mar**				
Standard monthly meeting requirements												
Opening / Standing Items (every meeting)												
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/ (	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly
Closing Matters (every meeting)												
Annual Board Schedule of Business (For approval in Jan 2026)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Questions from the Governors	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly
Bi-monthly (6)												
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting covering all strategic ambitions	Bi-monthly
Merger Update	Discussion	DoSBD	P	P	P	P	P	P			Corporate Reporting covering all strategic ambitions	Bi-monthly
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental	Bi-monthly
Quality and Safety Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Providing outstanding patient care	Bi-monthly
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Improving value, productivity, financial and environmental	Bi-monthly
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Developing a culture where everyone thrives	Bi-monthly
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Enhance our reputation and grow as a leading local, regional, national & international provider of	Bi-monthly
Quarterly (3 - 4)												
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Discussion	IDOCG	P			P	P	P			Corporate Reporting covering all strategic ambitions	Quarterly
Integrated Audit and Governance Committee Chair's Assurance Report	Assurance	NED		P			P	P			Corporate Reporting covering all strategic ambitions	Quarterly
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Developing a culture where everyone thrives	Quarterly
Guardian of Safer Working Report	Information	CMO			P		P	P			Providing outstanding patient care	Quarterly
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
PCREF Update	Discussion	CMO		P			P				Developing partnerships to	6 monthly
Annual (1)												

The Tavistock and Portman NHS Foundation Trust

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Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (IAGC; POD EDI; ETC; PFRC; QSC; EA&R)	Discussion	Chair		P							Corporate Reporting covering all strategic ambitions	Annual
Review of Committee Terms of Reference	Approval	Chair				P					Corporate Reporting covering all strategic ambitions	Annual
Medical Revalidation	Discussion	ICMO				P					Providing outstanding patient care	Annual
Freedom to Speak Up Guardian Annual report	Discussion	IDOCG						P	POD EDI		Developing a culture where everyone thrives	Annual
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Prepardness, Resilence and Response (EPRR)	Discussion	ICNO					P		Integrated Audit & Governance Committee		Improving value, productivity, financial and environmental sustainability	Annual
Quality Priorities 2025-2026 **(to Board Seminar/ Extra-Ordinary Board in June 2025)**	Discussion	CNO	P						Quality & Safety Committee		Providing outstanding patient care	Annual
Staff Survey Results and Action Plan	Discussion	CPO	P				P		POD EDI		Developing a culture where everyone thrives	Annual
Workforce Disability Equality Standard (WDES)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Workforce Race Equality Standard (WRES)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Gender and Race Pay Gap	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Equality, Diversity and Inclusion Annual Report 2025/26 (including Department of Education & Training)	Approval	CPO		P					POD EDI		Developing a culture where everyone thrives	Annual
Research and Development Annual Report	Discussion	ICMO			P						Developing partnerships to improve population health	Annual
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		P					Quality & Safety Committee		Providing outstanding patient care	Annual
Annual Objectives and Strategic Ambitions (Review)	Approval	DoSBD				P					Corporate Reporting covering all strategic ambitions	Annual
Compliance Against Provider Licence	Approval	IDOCG	P								Corporate Reporting covering all strategic ambitions	Annual
Financial Plan update	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

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**				
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