The Tavistock and Portman NHS Foundation Trust

Meeting Book - Board of Directors in Public - 20 November 2025

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DATE AND TIME OF NEXT MEETING

024. Thursday 15th January at 2.00-5.00pm

The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 20th November 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, 20 NOVEMBER 2025 AT 2.00PM – 5.00PM
VENUE: BOARD ROOM, THE TAVISTOCK CENTRE AND MS TEAMS

Living our values:

AGENDA

25/11/	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	Department for Education and Training Presentation - Complex Trauma: The Tavistock Model (D19)	Discussion	D19 Course Lead / Strategic Lead for Trauma and Clinical Lead, Trauma Service	P	2.05 (20)	
005	Minutes of the Previous Meeting held on 18 September 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 Board 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	Review of Board Committee Terms of Reference	Approval	Director of Corporate Governance (Interim)	E	3.00 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Comfort Break (10 minutes) 3.10p.m – 3.20p.m						

010	Provider Capability Self-Assessment	Information	Director of Corporate Governance (Interim)	E	3.20 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
011	Integrated Audit and Governance (IAG) Committee Assurance Report	Assurance	IAG Committee Chair	E and to follow	3.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
PROVIDING OUTSTANDING PATIENT CARE						
012	Gloucester House Action Plan Update	Discussion	Chief Nursing Officer	E	3.35 (5)	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 ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
014	Education and Training (E&T) Committee Assurance Report	Assurance	E&T Committee Chair	To follow	3.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
015	People, Organisational Development, Equality, Inclusion and Diversity (POD EDI) Committee Assurance Report	Assurance	POD EDI Committee Chair	To follow	3.50 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
016	Equality, Diversity and Inclusion Annual Report	Discussion	Acting Chief People Officer	E	3.55 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
017	Performance, Finance and Resources (PFR) Committee Assurance Report	Assurance	PFR Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
018	Finance Report: Month 06	Information	Interim Chief Finance Officer	E	4.10 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSING ITEMS						
019	Board Schedule of Business 2025/26	Information	Chair	E	4.15 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

020	Questions from Governors	Discussion	Chair	V		
021	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
022	Questions from the Public	Discussion	Chair	V		
023	Reflections and Feedback from the meeting	Discussion	Chair	V		
DATE AND TIME OF NEXT MEETING						
024	Thursday, 15 January 2026 at 2.00 – 5.00p.m.					

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 03/11/2025)

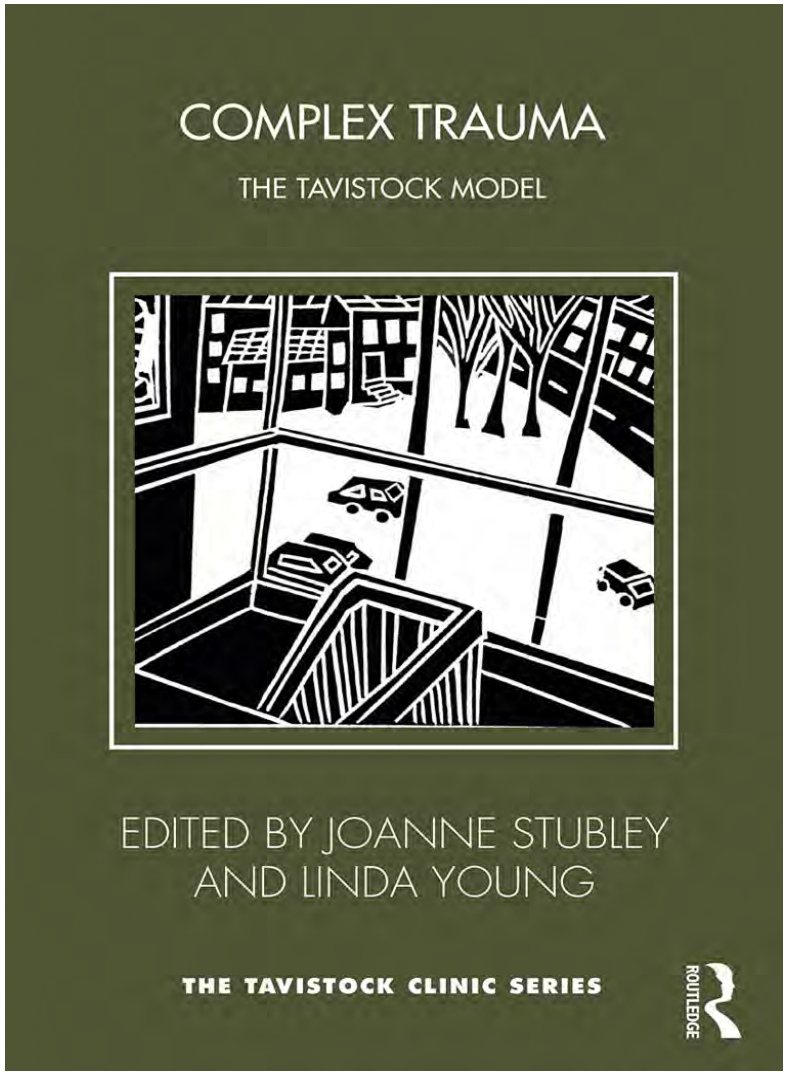
NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
NON-EXECUTIVE DIRECTORS						
ARUNA MEHTA	Chair	01 November 2021 (2nd Term)	Director, Dr A Mehta Limited (1)	01/04/2012	Present	Personal company – no conflict
			Chair, Surrey and Borders Partnership FT	01/04/2024	Present	No perceived conflict as it's a **mental health 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 (2nd 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 (2nd 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
SABRINA PHILLIPS	Non-Executive Director	01 September 2025 (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 (2ndTerm)	Professor Emeritus, University of Westminster	01/08/2025	Present	None remunerated position. Will withdraw from business decisions in competition with University of Westminster
			Governor, Londale PNI School, Brittan Way, Stevenage	18/09/2018	Present	No perceived conflict - Will withdraw from business decisions in relation to the school as discussed by The Tavistock and Portman
			Trustee Laurel Trust (Charity working in partnership with schools)	09/12/2024	Present	No perceived conflict
			Spouse elected Leader of Hertfordshire County Council	20/05/2025	Present	Potential conflict of interests as the Trust have contracts with HCC. As Leader, he is very unlikely to get involved in the detail of any contracts. Will withdraw from any business in relation to HCC discussed by the Tavistock and Portman.
			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
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

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			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.
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			
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			
LIZ SEARLE	Interim Joint Chief Medical Officer	3 November 2025	Private clinical work as a Child Psychiatrist	2013	Present	No perceived conflict - This is outside of Trust contracted hours and does not affect NHS work or current role as interim CMO
SHEVA HABEL	Interim Joint Chief Medical Officer	3 November 2025	NIL RETURN			
LEAVERS (LEFT THE TRUST DURING 2025/26)						
DAVID LEVENSON	Senior Independent Director and Non-Executive Director	01/09/19 - 31/08/25	Director, The Executive Service Limited t/a Coaching Futures (1)	01/04/2016	N/A	
			Academy member, Institute of Chartered Accountants of England and Wales	01/10/2020	N/A	

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
GEM DAVIES	Chief People Officer	01/02/23 - 30/09/25	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	N/A	
CHRIS ABBOTT	Chief Medical Officer	21/08/2023 **- 31/10/25**	NIL RETURN			
JOHN LAWLOR, OBE	Chair	06/06/22 - 31/10/25	Chair, Airedale NHS Foundation Trust	01/08/2025	N/A	

Complex Trauma: The Tavistock Model (D19)

- Emily Mercer - D19 Course Lead and Senior Clinician, Trauma Service
- Dr Joanne Stubley - Strategic Lead for Trauma and Clinical Lead, Trauma Service



Background and Course Overview

The Tavistock and Portman NHS Foundation Trust

- Development from D18 and return to clinical / DET model
- Formalises honorary roles and provides more structure and containment for honorary therapists working in the Trauma Service

- Clinical placement central to the learning
- Experiential group
- Academic programme

- Qualified psychodynamic or psychoanalytic psychotherapist, group analyst, integrative psychotherapist or art psychotherapist whose core training included a significant psychodynamic or psychoanalytic component
- 2 years
- On track for BPC Kitemark accreditation

The Clinical Placement

- Tavistock Trauma Service
- Weekly group supervision by senior staff in the service – 3 people per group
- 2 patients individual 18 months therapy
- Monthly attendance unit meetings
- Presentation in a unit meeting

The Experiential Group

The Tavistock and Portman NHS Foundation Trust

- Weekly, in-person space to support students in processing the emotional and relational demands of complex trauma work.

- Protected setting to develop clinical sensitivity and reflective capacity.

- Dual task:
  To reflect on your internal emotional experience, as it relates to the clinical work and training, while also taking into account the impact of wider institutional and systemic contexts.
  Observe and explore unconscious group dynamics within the group.

- Central focus:
  Countertransference - powerful emotional responses in trauma work.
  Builds reflective capacity around internal responses.
  Explore group dynamics to deepen understanding of therapeutic relationships and trauma's impact on practitioners.

The Academic Programme

- Runs throughout both years, combining lectures, discussion, and set reading, to support the development of a psychoanalytic and trauma-informed understanding of trauma.

- Grounded in psychoanalytic theory, we also explore attachment theory, neurobiology, and the multimodal Tavistock approach – all within a trauma-informed frame and considered through the lens of intersectionality and the wider systemic context.

- Consists of 5 core modules:
  Complex trauma
  Child sexual abuse
  Different populations
  Multimodal approach
  Deepening our understanding

Progression

The Tavistock and Portman NHS Foundation Trust

Successful completion is based on:

- *Submission of satisfactory twice-yearly clinical and supervisor reports*
- *Demonstrated development of clinical understanding and reflective capacity*
- *Satisfactory attendance and engagement in all components*
- *A recommendation for qualification by the Progression Board*

Future Developments

- One-year introductory year offered to a broader range of people

  Placement for stabilisation work in the Trauma Service

- Stream for clinical psychologist that includes Introductory Year and individual therapy
- International interest in adapted D19 courses (China)

Tavistock Trauma Training

The Tavistock and Portman NHS Foundation Trust

1 Entry Level

- Online Courses

Disclosure NRCSA Training
All health and social care

Trauma Informed Care
All health and social care

Psychodynamic Perspectives on Complex Trauma
All health and social care
**currently in development*

Bespoke Training

Online & In Person teaching and reflective practice

2 Intermediate Level

- External Trauma Lecture Series
  Variety of professionals interested in trauma

Regular Conferences
Variety of professionals interested in trauma

Introductory year

Variety of professionals interested in trauma and included in stream for clinical psychologists
**early development phase*

3 Advanced Level

- D19

Qualified psychodynamic or psychoanalytic therapists

group analyst, integrative psychotherapist or art psychotherapist whose core training included a significant psychodynamic or psychoanalytic component

Stream for clinical psychologist in early development phase

Thank you

The Tavistock and Portman
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 18th SEPTEMBER 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, Chair Integrated Audit and Governance Committee	KB
Janusz Jankowski	Non-Executive Director & Deputy Chair Quality and Safety Committee	JJ
Sal Jarvis	Non-Executive Director & Chair Education and Training Committee	SJ
Claire Johnston	Non-Executive Director & Chair Quality and Safety Committee	CJ
Aruna Mehta	Non-Executive Director & Chair of the Performance, Finance and Resources Committee	AM
Sabrina Phillips	Non-Executive Director	SP
Shalini Sequiera	Non-Executive Director & Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Michael Holland	Chief Executive Officer	MH
Chris Abbott	Chief Medical Officer	CA
Jonathan Bell	Interim Chief Finance Officer	JB
Rod Booth	Director of Strategy and Business Development	RB
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

IN ATTENDANCE:

Sheena Bolland	Public Governor	SB
Nimisha Deakin	Associate Director of Nursing and Patient Experience	ND
Kathy Elliott	Lead Governor & Stakeholder Governor	KE
Eilis Kennedy	Director of Research and Development	EK
Tracey Laroiya	Service Lead for Camden CAMHS Wellbeing Team	TL
Chipo Mukoki	Student Governor	CM
Amu	Service User (Item 4)	AMu
MS	Parent of Service User (Item 4)	MS
Pauline Williams	Staff Governor	PW
Rhiannon Adey	Interim Deputy Company Secretary	RA
John Fielding	Executive Assistant	JF

APOLOGIES:

DRAFT

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair (JL) welcomed all attendees to the meeting and noted the apologies as listed above. JL thanked GD for her huge contribution to the Trust and wished her luck in her new role as the workforce director at Barnet Hospital.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate.	
003	**DECLARATIONS OF 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	**WELL-BEING TEAM TRAINEE EXPERIENCE**	
	TL introduced MS whose daughter had used the well-being service and interviewed her in relation to the service her daughter had received. TL asked how the experience had been. MS fed back that due to bereavement and medical diagnosis within the family her daughter had felt very isolated and had increased anxiety. She had been referred to CAMHS and was introduced to Emma who worked with the service user. Since their introduction her daughter has increased confidence and feels that she is back to herself. She has returned to school having been out for a year. MS commented that Emma was approachable and took everything at her daughter's speed and within a year she had her confidence back. TL asked whether there was anything that could be improved. MS said that appointment times were not a problem as her daughter was homeschooled so they could attend during the day, however, this may have been a problem were she at school. MS also commented that the waiting room could be very busy which can be overwhelming if you have anxiety. The Board thanked MS for sharing the experience of herself and her daughter. TL introduced AMu, a service user of the well-being service and interviewed her in relation to her experience. TL asked what the service had been like? AMu told the Board that the service has been very helpful, and they found it very good. They thought it would be like school, and they would have to work alone but they have been taught lots of techniques that have helped them. They commented that it has been easier for them to control their panic attacks and use their techniques when they need to speak in front of a big group. AMu practices techniques with Sophie, then tries the techniques in front of others, Sophie makes it fun. They told the Board that they were grateful to be here and there is nothing that they would want to change.	

	TL asked how we could engage other children. AMu thought that advertisements could be shared on social media, using their language so that they can understand. TL asked whether AMu had enough information before they came. AMu told the Board that they had an introduction where they were told what would happen and asked what they needed help with. They then explained what they would do to help. The letter about the first appointment explained when, where and how and that was really helpful. The Board thanked AMu for their courage to come and present.	
005	**MINUTES OF PREVIOUS MEETING**	
	The Board **REVIEWED** and **APPROVED** the minutes of the previous Board Meeting (public) held on 10 July 2025.	
006	**MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW**	
	The Board reviewed the action log and **APPROVED** the closure of seven actions. Two items remained open.	
007	**CHAIR AND CHIEF EXECUTIVE'S REPORT**	
	JL took the report as read and highlighted the following. - The new Provider Oversight Framework assessment by NHS England have categorised the Trust as remaining within SOF3 due to our financial deficit. This new framework provides transparency around local organisations and enables those Trusts that are assessed as being category 1 or 2 to be considered for additional freedoms and autonomy, and those in category 4 or 5 to receive additional support. - NHS England invited applications to the National Neighbourhood Implementation Programme, unfortunately there was not a successful application made in Camden. - JL updated that he would be stepping down as Chair at the end of November. ML highlighted the following. - Gloucester House received a 'good' rating from their recent Ofsted Inspection. Staff have worked extremely hard to improve in a short space of time which is a huge achievement for staff at the school. - The annual graduation ceremony was held at the People's Palace at Queen Mary's last week which was very well attended. - The library has been renovated ready for students returning to the Trust in September. - A letter has been received from NHSE regarding the loss of the National Training Contract resulting in a formal governance review. The report has been received with a draft response and action plan being developed with NLFT to submit to NHSE. - A letter has also been received from North Central London ICB to review our clinical contracts held with them which we will be working through in the coming weeks. A query was raised regarding the Gender Identity Clinic national quality improvement network workshop. MH updated that the workplan had been submitted and an NHSE	

	QI facilitator had been working with us on improvement plans. We await the final report which is not likely to be issued for a number of weeks. 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**	
	CS took the report as read, noting that the data was from month 2. The Executive Team have worked to make sure future reports are timelier and the November meeting will receive a full quarter 2 report. The targeted support for GIC was formally stepped down in July with improved data and benchmarking now available. CA updated that this was the second month of using the stop the clock metric which was now integrated into services. Targeted support from the trauma service had reviewed the geography of acceptance criteria and would be moving to an automated waiting list and text reminder to reduce the number of DNAs. SP queried whether we were seeing a reduction in the waiting list as this was a key metric in the new oversight framework. CA updated that a reduction had been seen in both gross numbers on the trauma waiting list and the time spent on the waiting list. There will be a reduction in staffing as ERF funding ends, concern remains in relation to the demand and capacity. In regard to gender services, the national waiting list has been delayed due to changes in NHS England. An outcome dashboard has been developed on EPR to empower individual teams to manage their data. A high-level cost improvement programme has been developed by adult services, however, ring-fenced money for the gender identity clinic cannot be included as a cost saving so the focus is on increasing productivity. There is a focus on quality and equality impact assessments to ensure there is no negative impact on areas with significant waits, these will be presented to the Quality and Safety Committee. Gender Identity Clinic national quality improvement network workshop has supported the team with identifying their demand and capacity. This has highlighted that most national referrals are made to TPFT. The NHSE QI Lead is now working with the Trust five days a week, looking at AI to streamline record keeping and improving culture through learning from complaints and patient experience. The roll out of the DrDoctor portal has the potential to release time for administrative and medical staff. GD updated that issues with room booking for basic life support training had now been resolved with the help of DET. The appraisal window has been set for the end of the year to allow appraisals to be completed. The Board **DISCUSSED** and **NOTED** the IQPR report.	
009	**BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTER (CRR) 2025/26**	
	DO took the paper as read highlighting - The Education and Training Committee received a new risk BAF 16 – Non-viability of DET in its current form. There is a residual risk exposure as a	

	result of the loss of the National Training Contract. This risk poses a threat to current discussions around merger - The Education and Training Committee also received BAF 3 risk of loss of OfS registration as the residual score had reduced from 12 to 8 due to written confirmation from OfS that registration will be transferred to our merger partner. This risk was now within the risk appetite. - BAF 5 in relation to the merger is now included within the BAF received by the Board of Directors in public. - Work has been undertaken as an Executive Team to develop an Executive Portfolio risk and control assessment following concerns raised by internal audit around the risk and control environment. This has been to all Board Committees excluding PFRC, this will be received next week. - The Board agreed the risk appetite in May; it was recommended that this is reviewed now reporting on risk appetite was in place through Board sub-Committees. It was highlighted that the IAGC had reviewed both the BAF and the portfolio risk and control assessments and the Committee felt that there was not sufficient alignment between the two. **DECISION**: It was **AGREED** that the Board sub-Committees should undertake a BAF review during the October/November meeting cycle and feedback to the Board in November. The Board **APPROVED** the latest updated on the Board Assurance Framework and **AGREED** a six-month review of the Trust's risk appetite statement to be conducted in November 2025. **ACTION**: Ensure risk appetite item is scheduled for November Board meeting.	**RA**
010	**NON-EXECUTIVE DIRECTOR RESPONSIBILITIES 2025/26**	
	The report was taken as read. Congratulations were extended to SP on appointment to substantive NED. It was highlighted that there was now an opportunity to appoint a vice-Chair and a senior independent director that would be presented to the Council of Governors Nominations Committee next week. The Board were also asked to consider whether there is a NED with property experience to oversee the sale of Gloucester House. **ACTION**: Review quoracy of the POD EDI terms of reference and remove KB, CJ to be removed from the Gloucester House Steering Group. Revised version to be shared with NEDs. The Board **NOTED** the report.	**DO**
011	**INTEGRATED AUDIT AND GOVERNANCE (IAG) COMMITTEE ASSURANCE REPORT**	
	KB provided a verbal updated on the IAGC meeting held on 16 September. There had been a focus on reducing the size of the meeting book including information items being available outside of the distributed papers.	

	It was noted that the Executives had ensured actions were updated ahead of the meeting which ensured focus within the meeting. KB highlighted that an audit had been undertaken where improvement was required. Improvements had already been completed when the audit was presented to the meeting which was commended. The Board received **ASSURANCE** from the update provided.	
012	**QUALITY AND SAFETY UPDATE** **PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE**	
	CS presented the quality and safety update noting that there had been an increase in violence and aggression incidents in June, work had been undertaken linked to the end of school term and excitement in the school. A patient safety incident investigation had been commissioned in the gender identity clinic concerning referrals for surgery. A task and finish group has been established to identify the scope. This has been escalated to NHSE with referrals for the affected individuals sent to the hub. A meeting was taking place next with individuals to undertake Duty of Candour. The investigation was due to be completed by 15 October. A query was raised regarding the complaints to the GIC. The majority of complaints relate to waiting times which is reflective of the number of patients on the waiting list. There has been learning around pathways which is being presented to Clinical Governance meetings and work is being undertaken in relation to the DrDoctor portal. The one-year review of PSIRF was received at the Quality and Safety Committee. Work is being undertaken with NLFT for a joint clinical governance review. Targeted work has been undertaken to identify areas of low reporting with compassionate engagement training. The three units now have standardised clinical governance agendas and are learning from each supported by the CNO Associate Directors. There has been improvement in reporting of complaints and incidents by protected characteristics and ethnicity. There is an aim to include this within the IQPR by the beginning of next year. The Board **DISCUSSED** and **NOTED** the update.	
013	**QUALITY AND SAFETY (Q&S) COMMITTEE ASSURANCE REPORT**	
	The report was taken as read. An outstanding CQC recommendation in relation to H&S had been escalated to PFRC. The Board received **ASSURANCE** from the report.	
014	**ANNUAL PATIENT EXPERIENCE REPORT**	
	The report was taken as read. CS highlighted that this was a combined patient participation and involvement and complaints report. The Patient Safety Partners, experts by experience, were now members of the Quality and Safety Committee and provided feedback that the culture had changed for the better.	

	The number of complaints has reduced with an increasing number of complaints resolved informally. Most complaints received are in relation to GIC regarding access to treatment and hormones. CA has been working with NHSE as there are an increasing number of GPs refusing to prescribe hormones. CJ noted that the increase in informal resolution of complaints was positive but queried whether there was a risk of a lack of oversight by the complaints team. CS reassured that informal complaints are recorded on the Radar system and all require a formal written letter outlining the agreed approach that is overseen and monitored. Complainants are able to escalate if they are not satisfied with the response. The significantly improved complaints position was commended highlighting a more inclusive and positive learning culture. It was noted that a quality priority related to collecting feedback from service users. Work is being undertaken as part of the NCL collaborative within the Camden Unit to ensure we capture outcomes and experiences. KB suggested that posters could be sent to schools within Camden with a QR code. The Board **DISCUSSED** and **NOTED** the report.	
015	**GUARDIAN OF SAFER WORKING HOURS REPORT**	
	CA took the report as read, noting that the guardian of safer working hours post had been extended to the date of the merger. The resident doctors felt that their rota was supportive. There were a few breaches reported, however the number was small. A discussion was held in regard to money being spent ahead of the merger as it is unclear as how this money will be allocated post-merger. It is hoped that the positive feedback received from our resident doctors will ensure they remain with NLFT in the future. CA updated the Board that the 10-point plan requires approval at an extra-ordinary Board on 02 October. The Board **NOTED** the report.	
016	**LEARNING FROM DEATHS**	
	CA took the report as read noting that the paper covers deaths from quarter 4 2024/25. There had been 21 deaths, the majority of which were relating to service users of the gender identity clinic and the cause of death related to their physical health. This has highlighted the need to request physical health histories from primary care if not received and ensuring that our transgender patients are seen through the relevant national screening programme if their medical records differ from the gender assigned at birth. SS commented that the report was helpful and felt that there was more that could be done at a system level to support these service users. It was recommended that the power held by the trust at a national level should be used to highlight the risks.	

	JJ queried whether TPFT should be undertaking research in this area as previous research relates to the correlation between serious mental illness and physical health complications but the link to gender had not been explored. CA reported that this would be shared with gender clinic colleagues and incorporated in a learning event. The level of data provided in this report moving forward will support identification of the issues. The Board **NOTED** the Learning from Deaths report.	
017	**WINTER PLAN 2025/26**	
	CS took the report has read. The Winter Plan focuses on the prevention of admission to CAMHS beds and needs to be submitted by 30 September. The trust has engaged in the NCL System-wide Winter Plan, however, we have been informed that we have been stood down from the system wide plan. It was suggested that we could revisit extending services as part of the admission avoidance work as part of the NCL collaborative. The Board **APPROVED** the Trust Winter Plan Assurance Statement.	
018	**EDUCATION AND TRAINING (E&T) COMMITTEE ASSURANCE REPORT**	
	SJ took the report as read highlighting that our target for student recruitment had been met. The Committee had focused on the loss of the National Training Contract and the mitigating options, noting that any cost reduction should not impact the distinctive training delivery that could be offered by TPFT. There was a risk to delivery of the cost improvement programme target in light of the loss of the National Training Contract. The number of students attending the programmes this year is not yet known although there has been an increase in the number of applications and offers made. A timely decision will need to be taken around recruitment of students for the next academic year, recruitment for this academic year began in October 2024 and is attributed to the increased number of applications received. The Board received **ASSURANCE** from the report.	
019	**RESEARCH AND DEVELOPMENT ANNUAL REPORT**	
	Eilis Kennedy attended to present the report. It was noted that the majority of grants were ending in the next 12 months unless new projects were identified, however, the merger presents opportunities. There are currently applications in progress for funding with reliance on competitively awarded grants; charitable funding needs to be considered. A discussion was held around sustainability and consideration of a prevention focus with trust strengths in forensics and early intervention. The LOGIC and MAGIC studies are starting to have an impact with international interest. Funding options and potential partnerships were discussed.	

	The recommendations of the report were **NOTED**.	
020	**PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY (POD EDI) COMMITTEE ASSURANCE REPORT**	
	SS presented the assurance report. The meeting focused on BAF 7, creating an inclusive and fair culture. It was identified that a residual risk remains of an inclusive culture not being embedded and a discussion had been held regarding the Senior Leadership Forum being critical in cascading these messages to embed the culture. It was noted that the staff survey would be disseminated imminently. The results from the previous survey had not long been received which reduced the time to demonstrate achievements. GD updated that positive improvements have been seen with the Senior Leadership Forum presenting a clearer and more positive picture. It was noted, however, that staff in positions that do not attend structured meetings feel there are issues with cascade. A Director of Organisational Development and Culture has been appointed at NLFT and opportunities to work more closely to integrate the cultures of the two organisations would be explored in the coming months to ensure all voices are heard. A discussion was held around how we ensure that all staff have the opportunity to respond to the staff survey. Information will be disseminated through multiple channels to ensure open routes of communication.	
021	**REVALIDATION: FRAMEWORK FOR QUALITY ASSURANCE AND IMPROVEMENT (FQAI) REPORT AND STATEMENT OF COMPLIANCE (2024-25)**	
	CA took the paper as read highlighting that those individuals not engaged with revalidation have been discussed with the GMC which has resulted in engagement. It was noted that there is a Revalidation Advisory Group which is held monthly to address any concerns. The appraisal system has been updated which now better reflects good medical practice guidelines with increased opportunity for reflection. Positive feedback on these changes has been received. The trust is now in the process of moving into an appraisal window to align with job planning which reflects the NLFT process. JJ commended the leadership shown by CA and his team. This revalidation statement of compliance was **APPROVED.**	
022	**PERFORMANCE, FINANCE AND RESOURCES (PFR) COMMITTEE ASSURANCE REPORT**	
	AM presented the assurance report from an extra-ordinary PFR Committee on 31 July with the next scheduled meeting due to be held on 22 September which would receive an update on digital metrics. It was noted that there would be a monthly meeting due to the continually changing picture.	

	RB presented an update on Gloucester House Programme Board that is reviewing the move, sale and commercial future to increase class numbers. The trust are working with the local authority around the move and have contacted Ofsted to notify of the material change. The planned move date of November risks being delayed to February which may impact the sale. The trust financial plan assumes sale completion within the year so escalation to the local authority around the planned move is required as a matter of urgency.	
023	**FINANCE REPORT: MONTH 4**	
	JB presented the month 4 position noting that the trust is currently £860k adverse to plan which is equivalent to the loss of the National Training Contract monies. The focus will be on delivery of the cost improvement programme plans and containing expenditure. Further detail will be provided to the Performance, Finance and Resources Committee on Monday 22 September. Cash support has been sought as the cash position is incredibly tight. The financial plan needs to be resubmitted to NHSE as a result of the withdrawal of the National Training Contract. There is an ongoing discussion with the ICB around that change. Further cash support will be required in November, which is dependent on the financial plan to reduce the deficit. The Board received **ASSURANCE** from the updates provided.	
024	**BOARD SCHEDULE OF BUSINESS 2025/26**	
	DO took the paper as read. It was requested that an update on Gloucester House was added to the Board agenda. **Action:** Add Gloucester House update to the Board schedule of business	**RA**
025	**QUESTIONS FROM GOVERNORS**	
	KE noted that the Council of Governors were to be briefed on the implications of the loss of the National Training Contract during September. A Governor had observed the Education and Training Committee and would have important contributions to make. It is important to understand what this means for the planned merger with NLFT and the engagement with the Council of Governors will need to increase in the coming months. KE met the Lead Governor of NLFT and noted the differences in cultures between the two organisations. The importance of ensuring Governors are fully informed was highlighted.	
026	**ANY OTHER BUSINESS**	
	JL passed his thanks to CA for his contribution to TPFT ahead of his departure.	
027	**QUESTIONS FROM THE PUBLIC**	
	None.	
028	**REFLECTIONS AND FEEDBACK FROM THE MEETING**	

	JJ fed back that discussions had been constructive despite the challenges. It was noted that resilience within the organisation was key to deliver the merger.	
029	**DATE AND TIME OF NEXT MEETING**	
	Meeting was closed at 16.50.	

Date of Next Meeting in Public: Thursday, 20 November 2025 at 2.00p.m – 5.00p.m.

Signature _____ Date _____

DRAFT

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.
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	Sheva Habel, Interim Joint Chief Medical Officer	**To Close**	06/11/25: PCREF meeting dates sent and meeting arranged with Interim Joint CMO to review action plan.
18.09.25	9	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2025/26	Ensure risk appetite item is scheduled for November Board meeting	20.11.25	Rhiannon Adey, Interim Deputy Company Secretary	**To Close**	06/11/25: Item scheduled for Board Development Session in November 25
18.09.2025	10	Non-Executive Director Responsibilities 2025/26	Review quoracy of the POD EDI terms of reference and remove KB. CJ to be removed from the Gloucester House Steering Group. Revised version to be shared with NEDs	20.11.25	Dorothy Otite, Interim Director of Corporate Governance	**To Close**	06/11/25: NED responsibilies updated and shared with Non-Executive Directors on 17 October 2025
18.09.2025	24	Board Schedule of Business 2025/26	Add Gloucester House update to the Board schedule of business	20.11.25	Rhiannon Adey, Interim Deputy Company Secretary	**To Close**	06/11/25: Gloucester House update included on the November Board agenda

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 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 18 September 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

Since the last Board meeting there have been some changes to our Board of Directors. John Lawlor, Trust Chair left the Board and Aruna Mehta our previous Vice-Chair has taken over as Interim Trust Chair from 1 November until the merger by acquisition is enacted.

I would like to thank John for all his contributions to the Trust and wish him the very best in his new role as Chair at his local hospital and community trust in West Yorkshire, Airedale NHS Foundation Trust.

We held a successful Annual Members' Meeting on 30 October at the Tavistock Centre where our previous Trust Chair, John Lawlor; Lead Governor, Kathy Elliott; members of the Executive team and I looked back at the Trust's performance and achievements of 2024/25. The meeting was well attended by Governors and Members. Lena Samuels, Chair of North London NHS Foundation Trust (NLFT) also attended and she gave a few remarks about our imminent merger by acquisition. Information about the meeting is available on our website.

2. Merger by Acquisition update

Work on the proposed merger by acquisition continues to progress, with the merger aiming to take effect on 1 April 2026, subject to NHS England and Secretary of State for Health and Social Care approvals.

Work is now well advanced to complete the required Full Business Case, due to be submitted to NHS England in due course, following approval by both Trust Boards.

During September, NLFT held a series of engagement events for our staff to discuss the merger by acquisition. The events were hosted by Jinjer Kandola, NLFT Chief Executive and Natalie Fox, NLFT Deputy Chief Executive. A further event hosted by Jinjer is planned for our staff on 6 November where staff will hear from Jinjer about the "North London Way" and set her expectations for how they will work together.

I continue with the regular All Staff Meetings and merger drop-in sessions which also give staff an opportunity to ask questions about the merger by acquisition.

Providing outstanding patient care

3. Gloucester House Ofsted Inspection

The Trust received the Ofsted report for the inspection carried out in July 2025. All areas received a '"Good" rating and it was recognised for strong collaborative approach with staff working across education, health and therapy working together to meet each pupil's needs. The report highlighted the calm and respectful atmosphere in the school and noted evidence of rapid improvements over a short period, reflecting strong leadership and responsiveness.

4. Nursing and Midwifery Job Evaluation

The Trust submitted the self-assessment providing Board assurance around local job evaluations for nurses. Nursing & midwifery job evaluation was one of the 37 recommendations from the Agenda for Change pay deal (2023).

A letter from NHSE in May 2025 emphasised the importance of ensuring staff receive the correct pay for the work they are asked to do. The letter also asked employers to prepare for and prioritise work following publication of the NHS Staff Council's (NHSSC) updated job evaluation profiles for nursing and midwifery and accompanying guidance. While Boards are legally accountable for ensuring compliance with national job evaluation (JE) standards, NHS England's regional workforce directors will provide assurance supported by a new national JE dashboard.

5. Clinical Services

Over the past six months there has been extensive collaboration between The Tavistock and Portman NHS Foundation Trust (TPFT) and NLFT Clinical and Operational leadership with the North Central London (NCL) ICB Clinical leads to develop a proposal for the Core CAMHS offer across NCL. This work is culminating in November with an NCL wide agreement of a baseline mandatory clinical offer following which a business case will be developed. This will ensure the best outcomes for children and young people across the patch, reducing inequalities of access and ensuring the provision of appropriate treatment modalities and interventions embedded within a THRIVE aligned needs-based approach.

6. Patient and Carer Race Equality Framework (PCREF)

The PCREF developments within the Trust are progressing well, during October, as part of Black History Month the Trust held two speaking events where the lived experience of members of the Black community was explored through powerful first-person testimony. The response from attendees was positive and provided important if ongoing commitment to ensuring our PCREF goals are to be achieved.

In the IQPR in Month 5 data was presented in relation to the acceptance and rejections from intake processes to explore evidence of bias in this process acting as a further barrier to treatment; there was no evidence of this, however due to low numbers, the data was insufficient to draw meaningful conclusions therefore indicating the need for ongoing review.

In Month 6 the IQPR PCREF data reported on the association between ethnicity and patient safety markers such as complaints, incidents and in relation to Gloucester House School incidents of violence and aggression and restraints. This data provided insights into the low number of complaints from global majority communities, highlighting the need for a clearer understanding around the basis of this. The data from Gloucester House showed appropriate mirroring between incidents of violence and aggression and restraints, there was not an overrepresentation of these events occurring within the Black population of the school however there was an overrepresentation within children of White and Mixed Black and White ethnicity which will be reviewed and monitored.

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

7. Student enrolment for 2025/26

I am pleased to report that over 97% of our new students have enrolled onto their programmes of study for the 2025/26 academic year, with 631 new learners now joining us. We also have an 88% re-enrolment rate, adjusted to 95% when intermissions are removed,

comprising a further 755 to a total of 1506 students, an increase of 51 over 2024/25 (1455) with another c.60 new students expected on the M23 (Social Work) programme with UEL. This is excellent news for the Trust from a sustainability perspective and challenges the accepted wisdom of a contracting HE market. I am very grateful to all our Course Leads, Marketing and Admissions colleagues for their hard work in delivering this excellent outcome.

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

8. Industrial Action

The British Medical Association (BMA) has announced further resident doctor industrial action from 14 to 18 November. The Trust has robust contingency plans in place to ensure appropriate rota cover for out-of-hours services and to maintain patient safety during this period.

While the direct impact on the Trust is expected to be minimal, the wider impact across the NHS remains significant, including for local partner Trusts, and we will continue to closely monitor the situation.

9. 10 Point Plan for resident doctors' working lives

NHS England has launched a 10-point plan for resident doctors, aimed at improving their working lives and supporting workforce retention. The plan sets out national priorities to strengthen leadership accountability, ensure fair and sustainable rota practices, and enhance wellbeing and pastoral support for doctors in training.

The Trust is currently reviewing the requirements of the national plan and developing a local action plan to align with these priorities. Liz Searle has been appointed as the Executive Lead, and Dr Chen Kailayapillai will serve as the Resident Doctor representative to support this work. Key areas of focus are addressing payroll issues and liaising with external hospital Trusts regarding facilities available when on-call.

A detailed update and proposed action plan will be presented to the Board in January.

10. Staff Survey

The national staff survey launched on 29 September and we have an ambitious (but achievable) target response rate of 60%. The survey remains open until 28 November, and as at 3 November our response rate was 37.92%. We have chosen three local questions this year - the first is a repeat of last year's question relating to the impact of protected characteristics on experience working in the trust, and the other two are linked to living our Trust values.

Since the last survey we have been working closely with our colleagues to understand what matters most to them in order to improve staff experience in the organisation. We will review and update this work once we have the results of this current survey. The feedback will inform the staff engagement plan pre and post-merger by acquisition.

Improving Value, Productivity, Financial and Environmental Sustainability

11. Finance Update

At the halfway point in the year, the Trust is reporting a deficit of £4.0m which is £1.4m behind plan. The main reason for this adverse variance is the loss of the National Training Contract income which accounts for £1.3m of the £1.4m variance. The Trust is in discussion with NHSE to find a solution to this shortfall in 2025/26. Although good progress is being made on identifying and delivering efficiency savings, there remains a level of unidentified savings which is a significant risk to achieving the year end breakeven plan.

The Cash position for the Trust continues to be very challenging and further working capital support of £2.17m in November has been requested. At the time of writing, the Trust is waiting for the decision on this request.

The Trust continues to invest in Information Management & Technology (IM&T) and improving the environment with £1.1m spent to date of the £2.8m annual capital plan.

Internal Updates

12. Recent Board Changes

Executive Directors:

Chris Abbott, our Chief Medical Officer left the Trust in October 2025.

This is the last Board meeting attended by Dorothy Otite, our Interim Director of Corporate Governance, as she is leaving us at the beginning of December.

I want to formally thank Chris and Dorothy on behalf of the Board for their contributions and wish them well for the future.

The plan for the Chief Medical Officer's interim cover have been announced. Joint Chief Medical Officers (Liz Searle and Sheva Habel) have been appointed from 3 November 2025.

The plans for the Director of Corporate Governance interim cover are being finalised and will be confirmed soon.

Non-Executive Directors:

The Council of Governors approved the appointment of Sal Jarvis as Vice-Chair of the Trust effective 1 November 2025 until our merger by acquisition is enacted.

Following support from the Council of Governors, the Board approved the appointment of Shalini Sequeira as Senior Independent Director effective 10 October 2025 until our merger by acquisition is enacted.

13. 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 September Board, the following services have been visited:

- Family Mental Health Team (FMHT) and CWP
- Camden Adult Administrators Forum
- Family Drug and Alcohol Cout (FDAC)
- Tavistock Consulting

Regional and National Context

14. Changes in key personnel at national, London and ICB levels

The former National Director for Mental Health, Claire Murdoch and the National Director for Learning Disability and Autism, Tom Cahill, have both recently resigned from their national roles. There is currently a recruitment process for the National Programme Lead for Mental Health that replaces their previous roles.

I also wanted to advise Board of a key change at the NHS England London Regional Office. Helen Pettersen, currently London Chief Operating Officer, has announced that she is retiring and leaving the role in December. Helen has been in the role since 2020 and before that was the Chief Executive of the former North Central London Clinical Commissioning Group. Dame Caroline Clark, London Regional Director, has recently announced that Edmund King has been appointed as the new London Regional Director of Operations, succeeding Helen from 15 December.

As the Board will be aware NCL and NWL are in the process of merging and Frances O'Callaghan has been appointed to be the CEO of the merged ICBs. She has also recently appointed the new exec for the merged ICB.

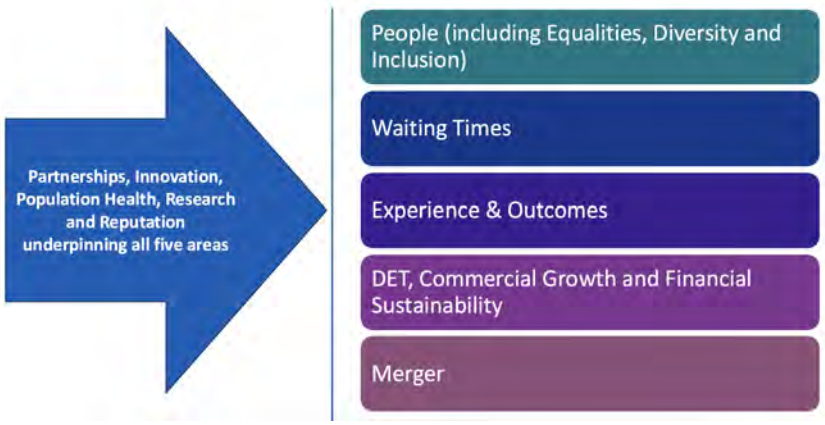
15. Medium Term Planning Framework

The Medium-Term Planning Framework for 26/27 to 28/29 was published at the end of October 2025, setting out planning expectations and a shift from annual plans to a five-year strategic planning approach. The Trust will be working with North London NHS Foundation Trust to support the submission of the medium-term financial plan for the merged organisation.

16. Chief Executive's meetings with external stakeholders

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

- Camden Integrated Care Executive (CICE);
- Cavendish Square Group of London NHS Mental Health Providers' CEOs;
- NHS Federated Data Platform (FDP) Mental Health Roundtable;
- London Digital Mental Health Forum;
- KPMG & Catalysis Continuous Improvement Conference 2025;
- Economist Impact's Future of Health Europe and AI in Health Summit;
- Joint NCL/ NWL CEO Meeting;
- UCL Partners Executive Forum;
- KCL Business School Panel discussion;
- NHS England Mental Health Trusts CEOs meeting (with Regional Leads and SROs);
- NCL Borough Partnership Chairs Meeting;
- Mental Health Digital Strategic Oversight Group;
- eMHIC Fireside Chat: Digital Mental Health is Here: Ensuring the Quality of Care - a Global Perspective;
- NHS England London CEOs meeting with the London Regional Director; and
- Community and Mental Health User Forum.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: Integrated Quality and Performance Report M5 2025 ***based on August (M05) 2025 Data***			**Agenda No.: 008**
Report Author and Job Title:	Rachel James, Director of Clinical Services Sheva Habel, Interim Joint Chief Medical Officer	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer, Rod Booth, Director of Strategy.
Appendices:	Appendix 1: M05 Integrated Quality and Performance Report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	The Trust Integrated Quality and Performance Report (IQPR) for August 2025 (Month 05) 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. This report provides a summary of the data presented in the Trust-wide IQPR meeting on 23rd September 2025. The data presented relates to August 2025 as committee report data runs 2 months in arrears after IQPR has ratified data from the previous reporting period. This report should be used in conjunction with accompanying slides and respective committee reports.		
Background:	In addition to month 05 data being considered in the September Trust-wide IQPR, additionally, Trust quality and performance is reviewed weekly at Strategic Delivery Room, with a focus on the Trust's five strategic priorities and monthly via team and delivery unit level performance and clinical governance meetings. The Trust strategic priorities are as follows: 		
Assessment:	To ensure we focus on important issues and priority areas, the IQPR paper reports by exception, providing an overview of key highlights, emerging concerns, and a summary of actions being taken to address		

Key recommendation(s):	The Board of Directors 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 14: Effective Performance and Risk management arrangements. BAF 13: Waiting Times				
Legal and Regulatory Implications:	Yes ☐	No ☒			
Resource Implications:	Yes ☒	No ☐			
	Workforce and financial resource implications relating to waiting times management				
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:	Integrated Quality and Performance Report Meeting – 23 September 2025 Quality and Safety Committee – 23 October 2025 Performance, Finance and Resources Committee – 03 November 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: Integrated Quality and Performance Report M05 September 2025 – See attached Slide deck.

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report M5 2025

NOTE: THIS REPORT USES DATA FROM AUGUST 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

Operational

Waiting Times

The Gender Identity Clinic is under the National Quality Improvement work (moving from the Trust's targeted support in July 2025). The Trauma Service remains under the Trust's targeted support framework. GIC has seen their waiting list grow to 16,516 patients as of August 2025, with 106 new patients in August 2025 seen monthly with 343 referrals received.
Trauma has reviewed the acceptance criteria following a 350% rise in referrals since 2019; and has now seen a reduction in referrals, although there are 1,037 patients waiting to be seen. The therapy pathway has been reviewed with the longest length of therapy planned for 18 months.
At August 25, the treatment waiting list reduced by 25% over a 12-month period.

Service Improvement Pipeline

- **NCL CAMHS provider collaborative:** Business case submitted with ongoing work regarding an agreed mandatory treatment offer and activity levels, and the development of the clinical strategy as priorities for Q3.
- **NCEL CAMHS provider collaborative:** FCAMHS undertaking a survey to understand more around localities who underuse the service and to take appropriate action through stakeholder events and other engagement methods. Camden Unit are supporting the development of the NCEL Intensive Support Service in partnership with Camden Local Authority to provide input for a small number of young people in Islington, Camden and Barnet who would otherwise need inpatient admission.
- **Camden (NLFT) Trauma pathway development:** The Trauma service have met with NLFT colleagues to develop a trauma pathway for Camden.
- **Cost Improvement plans:** All units have submitted plans, weekly Trust level meetings taking place to provide support and monitor progress against plans.

Clinical Services updates:

- **Surrey MindWorks** completed the closure consultation, with the service closing on 30th September 2025.
- Returning Families served notice of closure by the Home Office, with the service end date being 31st March 2026.

People

- Mandatory and Statutory Training (MAST) compliance this month stands at 85.71%, a 0.07% increase in August 2025. There has been a gradual positive change to MAST compliance within the past three months. The main outstanding MAST requirement is Basic Life Support (BLS) for clinical staff, training sessions are ongoing with increased capacity to provide training for the all clinicians in addition to the nursing and medical workforce in line with the annual training needs analysis.
- Appraisals, currently stands at 54.14%. This has increased by 4.66% at the end of August 2025. Continuous work is being carried out by the Learning and Development Team to ensure the Trust raise the standard of appraisals. The Trust has opened an appraisal window from now to end of the calendar year to ensure that all staff have an in in-date appraisal by the end of Q3.
- The Tavistock & Portman Trust sickness rate stands at 2.82% at the end of August 2025. The Trust's current sickness absence rate is below the average benchmark of 3.07% by 0.25%. The level of sickness has decreased from the previous month by 0.35%.The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.06%. Data from September 2024 to August 2025 reveals that mental health issues, specifically anxiety, stress, and depression, are the leading cause of absence across both White and BME ethnic groups.

Finance

The Trust is £1,098k behind plan year-to-date at Month 5. This adverse variance is primarily due to a shortfall in income from the National Training Contract (NTC).

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

Risk: Uncertainty around income from the NTC in CETO and Tavistock Consulting in Corporate may affect the delivery of the CETO plan and the overall 2025/26 Trust plan.

Executive Summary (2/2)

The Tavistock and Portman NHS Foundation Trust

Quality and Safety
Experience and Outcomes:

Patient Feedback:
The Trust-wide target 90% for ESQ positive responses achieved in August 2025. Themes from qualitative feedback indicate that Patient Care, Trust Values and Communications are the areas most commented on for positive feedback. Due to patient and workforce holidays resulting in fewer appointment, fewer forms were collected in August than in the previous month, with 70 ESQ's collected.

Complaints:
A total of 6 complaint contacts were received by clinical services in August, all within the Adult Unit. Complaints were in the subject categories of 'Patient Care' (2), 'Appointments' (2), Access to Treatment or Drugs (1) and 'Privacy Dignity and Well-being' (1). All complaints were acknowledged within 3 working days.

Trust wide compliance for formal complaints responded to within 40 working days was 25% in August. 12 formal Trust responses were sent to complainants in the month, of which 3 were responded to within 40 working days. 3 complaints were resolved informally: two in the Adult Unit and one in the Child & Families Unit. At the end of August 2025, 20 complaints were open, of which 8 were overdue. All overdue complaints are within the Adult Unit. The Complaints Quality Improvement project continues and is seeking to further improve the timely acknowledgement of complaints, and to work with Clinical Leads and Investigation Leads to investigate complaints within the response timeframe.

Compliments:
2 compliments were recorded in Radar in August; one by the CYP and Family unit and one by the Adult Unit. The Trust continues to raise awareness of the importance of recording compliments across clinical services.

Clinical Outcome Measures (OM):
NHSE launched new waiting time metrics on 1 April 2025, explicitly linked to OM collection. August data demonstrated consistent outcome measure (OM) capture across clinical services, although there were fewer appointments due to patient and workforce holidays. Trust-wide quality improvement approaches continue, supported by the development of dashboards and team-level training to enable practitioner and team-level self-monitoring of compliance to drive continued progress across all services.

Patient and Carer Race Equality Framework (PCREF):
PCREF data reviewed in Month 5 focused on the referrals accepted and rejected by services. Learning included the need to identify wider consequences of any changes made to clinical intake processes, and the need for increased data to enable accurate conclusions regarding potential acceptance bias.

Incidents:
A total of 11 incidents were reported in August: Camden – 4, Child & Family – 0, and Adult Services – 7. A total of three incidents of violence and aggression were reported in the month, with no incidents of restrictive practice. Although this represents a lower level of reporting, this remains within normal variation and is consistent with reporting levels for August last year. The reduction in incidents reported is likely due to the absence of incidents within the CYP & Families Unit, reflecting the school summer holiday period at Gloucester House.

The open patient safety incident investigation (PSII) relating to surgical hub referrals within the GIC is ongoing, with completion scheduled for 15th October 2025.

One AAR was requested related to the disclosure of sensitive information through the subject access request (SAR) process. Progress against outstanding AARs is monitored through the AAR Tracker, reviewed weekly at the Executive Safety Huddle. Four AARs took place in the month of August. Key findings and lessons learned from these reviews are shared with the Clinical Incident and Safety Group (CISG). Learning is disseminated and embedded within unit Clinical Governance meetings to support ongoing improvement in practice. A scoping meeting for an AAR Quality Improvement project has been held to review and improve the process, ensuring prompt learning.

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 16,516 patients as of August 2025, with 106 new patients in August 2025 seen monthly with 343 referrals received. The gap is widening exponentially.

Adult Trauma Service: With a 350% rise in referrals since 2019, as of August 2025 this is now 1037 patients waiting. Many require intensive therapy lasting up to two years. At August 25 the treatment waiting list has reduced by 25% in 12 months .

Autism Assessments (ASC): Referrals have increased by 495% since 2019. After a year long waiting list recovery with the ERF funds an additional 220 assessments were carried out, reducing the waiting list for Haringey to 70 young people with an average current waiting time of 40 weeks to assessment. The NCL ICB have increased investment into the service as part of the NCL NDD programme and have provided 3 additional posts to clear backlog and to provide sustained investment into the pathway. Hertfordshire ICB have invested £227K in 90 additional assessments. However, at month 5 there remained 229 CYP waiting for assessment with 158 CYP waiting more than 52 weeks.

Vision & Goals

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

G1. Clearly defined pathways for patients within next 4 months

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

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

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

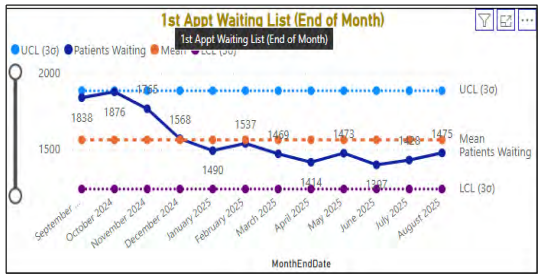
G5. Improve recruitment and retention aligned to the teams' workforce plans

Continued...

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

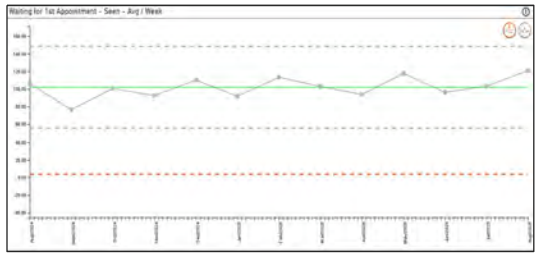
People Culture | Waiting Times | User Experience & Outcomes | DET, Commercial Growth and Sustainability | Merger

Mental Health Services Excluding GIC

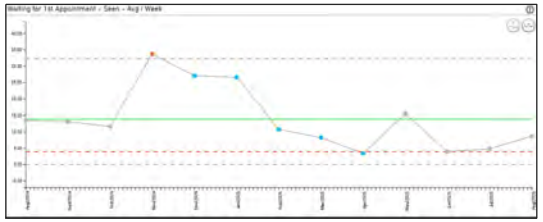


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

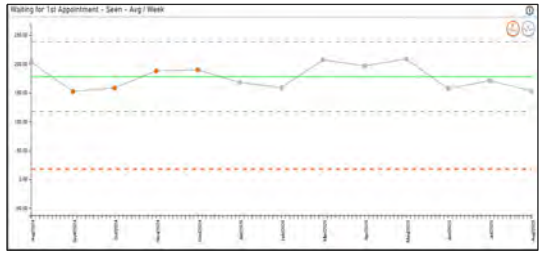
Trauma



Autism Assessment



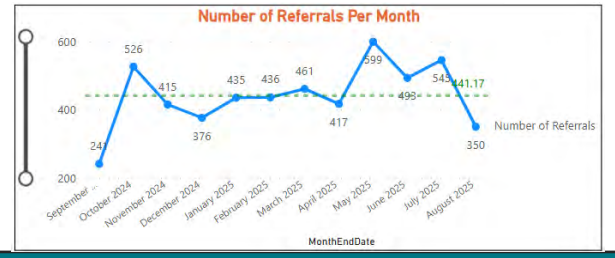
Adult Gender Identity Clinic (GIC)



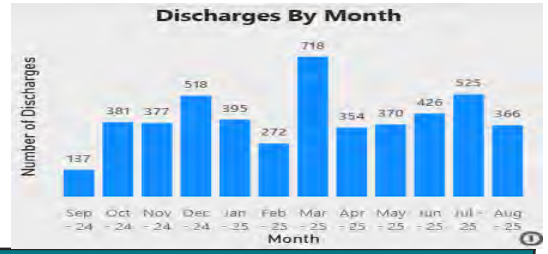
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

A. Number of first appointments conducted (exc. GIC)

B. Number of referrals by month (exc. GIC)



C. Number of discharges per month (Exc. GIC)

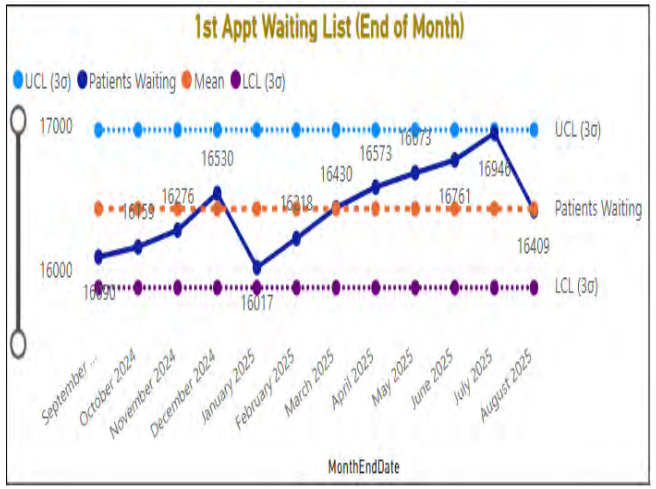


Progress on Improvements

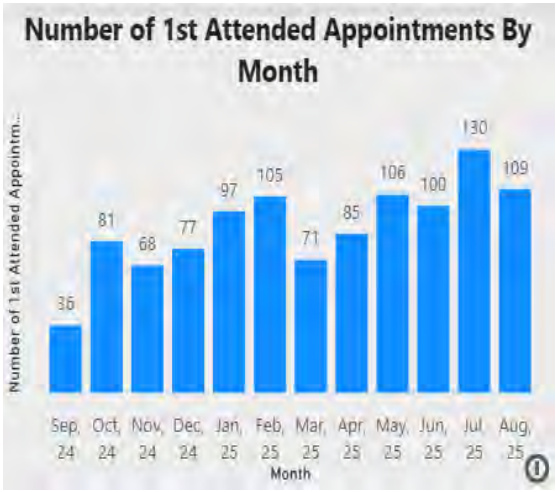
Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource allocation but also contributes to longer waiting times for patients awaiting assessment and treatment.	**Increased Demand:** There has been a significant increase in the number of referrals and a focus on delivering first assessments. **MDT Process** - Inefficient clinical review process in MDT that rely on clinician's presenting patients they wish to rather than an iterative review process for all patients. **PTL** - Manual process for enacting PTL function which results in delays in data flow and proactive review of dormant cases	**Ratio of 1st Assessment vs Treatment** – Units and teams to agree the ratio of first appointment vs treatment and discharge they are to complete per reporting period.by **Jan 25.** This has faced significant delays in some service areas due to cultural pathway and delivery issues. Expected delivery **Sept 25** **MDT ToR** – The Medical Director completed a review of the ToR for MDT meetings, and each unit is implementing the recommendations and approach to ensure consistent review of patients, length of treatment and discharge. – **Sep 25** **PTL –** PTL reporting digitisation completed in Jan 2025. The CSM reviewed the PTL process in July to support further improvements. GIC PTL has a focus on dormant cases of >36 months to establish whether they can be discharged due to having completed surgery or be discharged due to non-engagement. The GIC PTL is well established. **Aug 25** **Waiting Times form Implementation –** Waiting times form mobilisation has been implemented across all units to ensure that all first and internal waits are captured accurately – **Sep 25**	Cumulative reduction in the number of patients dormant on clinical caseloads without action. Increase in the number of first assessments and discharges Enhancing access to patient pathway data to enable anticipatory mitigation, rather than relying on retrospective remedial actions."	CSM/Clinical Leads
In some areas, there are insufficient resources to meet the demand from the number of patients being referred	The current budget allocation within the block contracts is misaligned to the increase in demand for some services. Some clinical pathways are misaligned to commissioned population base and evidence based best practice	NCL NDD transformation programme has increased investment by £159K and Herts by £227K for 25/26. However, trajectories are not currently being met due to staffing issues. **Trajectories** - Units modelling increased activity and agreeing trajectories for delivery against this resource (managed through a tracker) – **July 25** **Pathways** - Review of the clinical pathways informed by the Kaizen sessions and NICE guidance and service specifications, as outlined in unit delivery plans – **Aug 25** NLFT pathway meeting help in September with system clinical leads across 2nd Care Psychological Therapies. – **Sep 25**	Reduction in wait times due to taking more people from the waiting list .	Finance/Director of Clinical Services /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. Autism pathway now has new appointment types to allow for more accurate data capture. GIC NHSE QI project underway with launch of digital patient platform mid Sept to optimise pathway, communication and efficient booking. Evaluation and review of DNA/Cancellations underway. ASD – to see an additional 90 patients by end of q2 The new Trauma team intake criteria are in place and has reduced intake by 50% in 12 months and agreed an NCL only intake. The workforce plan is agreed with one position outstanding linked to the DET D19 course which provides income for the trust and increased clinical capacity for waiting list patients. The waiting list has reduced by 105 patients since May.	Trauma intake and referral criteria changes are reducing numbers. ERF staff losses can only be mitigated through recruitment in Trauma. GIC ERF nursing staff in CORE team now on permanent contracts. . Trauma is expected to leave targeted support with a view to fortnightly Qi approach.	Clinical Leads/ Medical Director/ Director of Clinical Services
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 Data capture remains manual in Autism.	Complete SPC and Clinical dashboard reports by **Aug 25,** As at August 2025, Waiting List SPC charts have been sent out to Ops leads for testing.	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	Director of Clinical Services/Project Management /Commercial Director

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

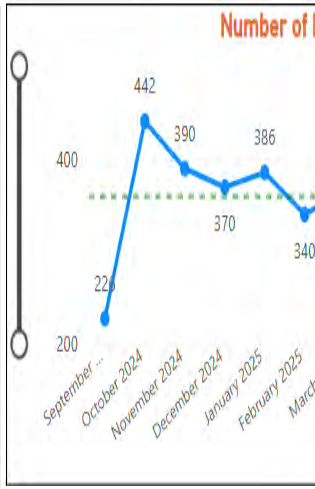
A. Adult GIC Number of first appointments conducted

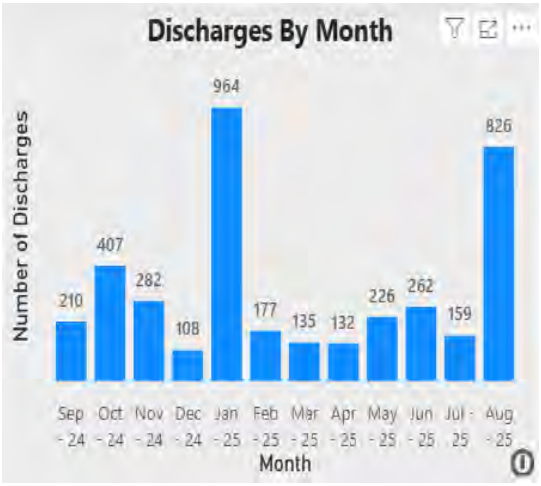


B. Adult GIC Number of referrals by month



C. Adult GIC Number of discharges per month





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

Integrated Quality and Performance Report — Month 05 – 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

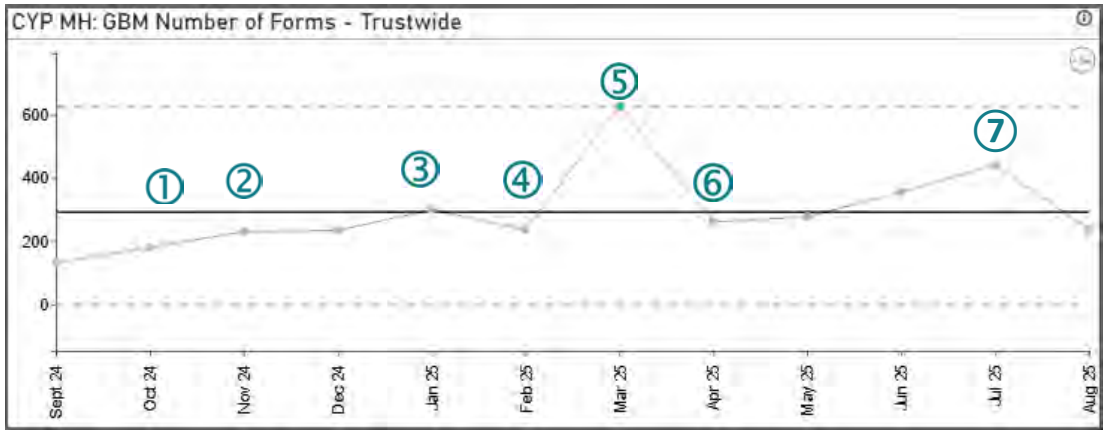
G2: Improve current rates of matched OM pairs by 50% for all Units by Oct '25

G3: Establish methodology to evidence improvement for all measures by July '25 – delayed due to work needed with partner providers. Aiming for Dec '25

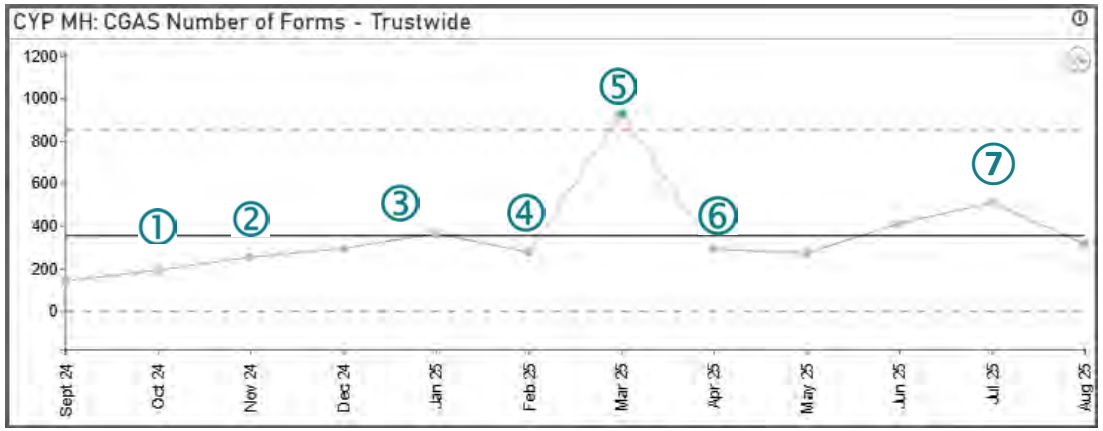
Concern	Causes	Countermeasures	Primary
Integration: OM not fully embedded into clinical workflows or care pathways	1. OM not hard-wired into care plans, reviews, or SOPs 2. OM completion is external to core clinical conversation 3. OM data collected but not routinely acted upon 4. OM results not routinely fed back to patients	1. Liaison with NCL leads to standardize improvement rates **- 30/07/25 met with NLFT & NCL CYPMHS Provider Collaborative - work commencing to develop shared vision** 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 progress)** 4. OM-informed care planning in one service **– Camden Wellbeing Team piloting Q3**	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	5. Refresh comms campaign positioning OM as a clinical tool**- Highlight comms in dev** 6. Develop training focused on clinical conversations **– SCL engagement 14/08/25** 7. Peer-led MDT case studies using OM in shared decision-making **(Planned for Q3)** 8. Celebrate positive OM compliance and feedback in CG meetings **(Ongoing and linked with 5.)** 9. Targeted support for teams to self-monitor and address compliance **- Ongoing and surgeries planned Q3** 10. GIC measure, logic and process agreed and planned **- Progress in implementing SOP with a view to testing by end of Q3**	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	11. New dashboard launched and promoted in Clin. Gov meetings **Linked with countermeasures 5&6 above** 12. HONOSCA now included and validated within clinical dashboard and SPC for FCAMHS **(completed)** 13. Co-design further simplified dashboards for key roles **(Requires Informatics Dev First)** 14. Train and coach teams on use of clinical dashboard **- continues into Q3** 15. Install data walls to communicate OM insights in physical and digital areas **(Planned Q3)**	Clinical Services IM&T
Improvement:	1. OM data seen as compliance rather than clinical	16. Build OM equity dashboards to support demographic analysis **(Requires Informatics Dev)**	Clinical

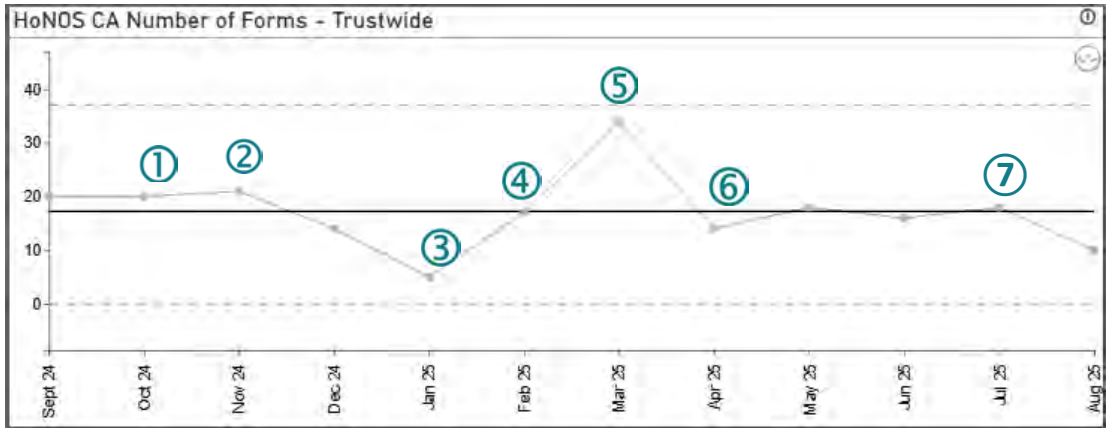
OMs: Under 18s

The Tavistock and Portman NHS Foundation Trust



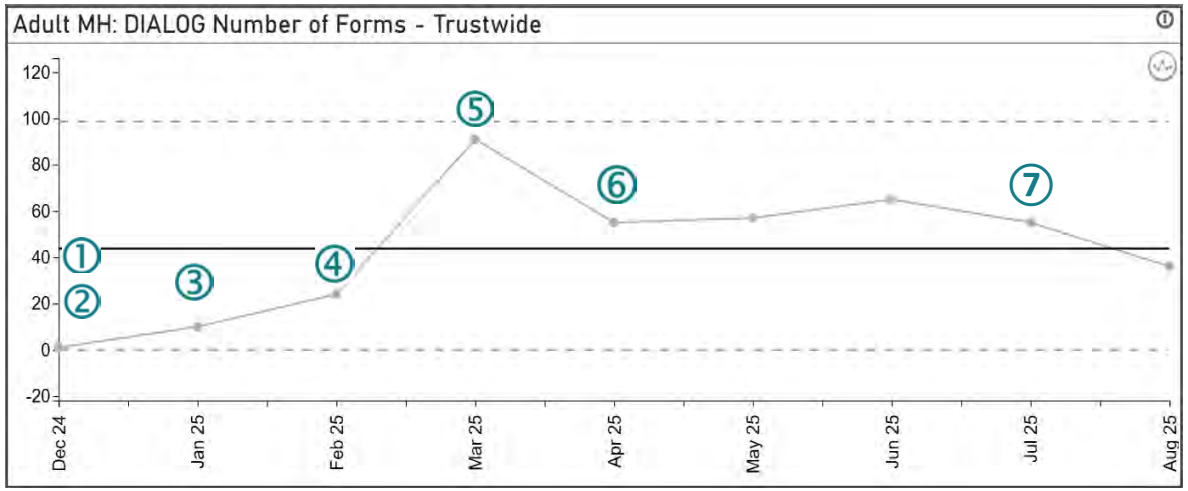
Legend	Countermeasure	Legend	Countermeasure
①	Oct 24- Clinical Governance Presentations	②	Feb 25 -All Care notes changes complete
③	Nov 25 -Trust-wide training delivered	④	Mar 25 - Unit follow up with clinicians
⑤	Jan 25 - Unit level training delivered	⑥	April 25 - Clinical Dashboard go-live
⑦	Jul 25 - Team Level bespoke training offered and taken up by 3 teams		

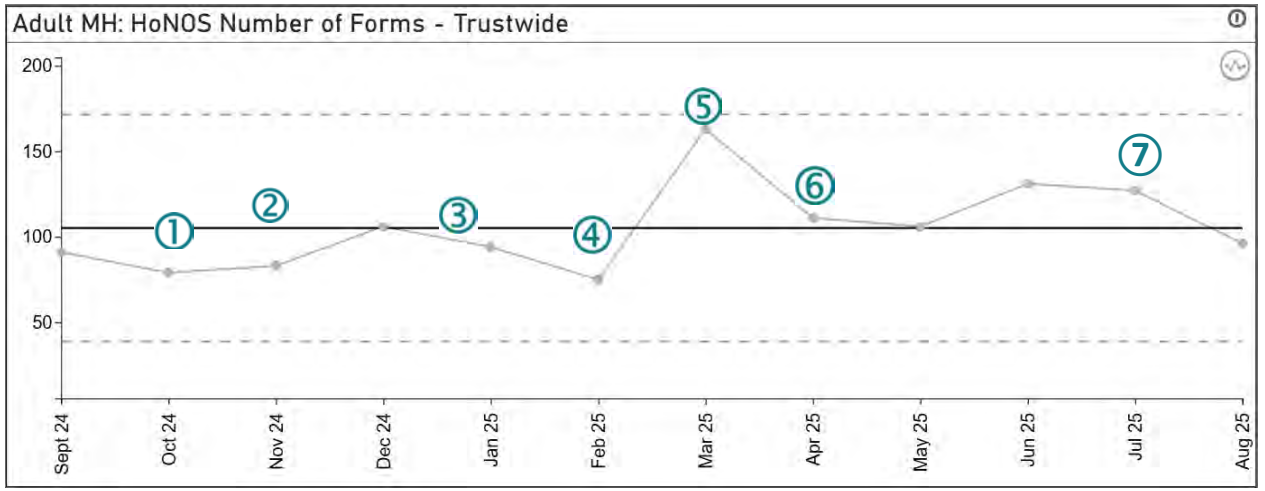




OMs: Over 18s

Legend	Countermeasure	Legend	Countermeasure
①	Oct 24- Clinical Governance Presentations	②	Feb 25 -All Care notes changes complete
③	Nov 25 -Trust-wide training delivered	④	Mar 25 - Unit follow up with clinicians
⑤	Jan 25 - Unit level training delivered	⑥	April 25 - Clinical Dashboard go-live
⑦	Jul 25 - Team Level bespoke training offered and taken up by 3 teams		





Integrated Quality and Performance Report — Month 05 - 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 has improved, averaging <200 forms per month, some teams and Units reaching targets but still below Trust Wide target, and teams starting to report responses in Clinical Governance. 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.

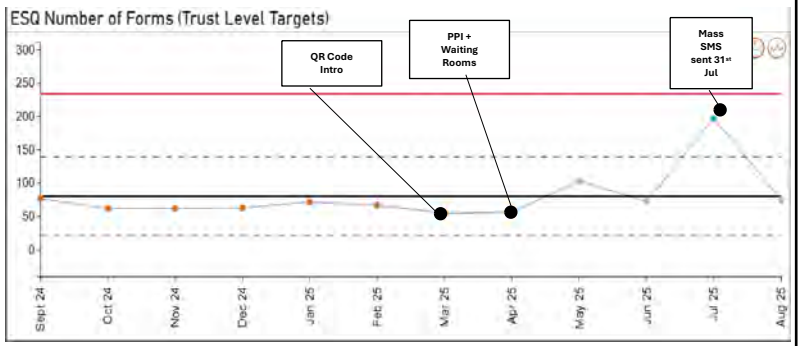
Vision & Goals

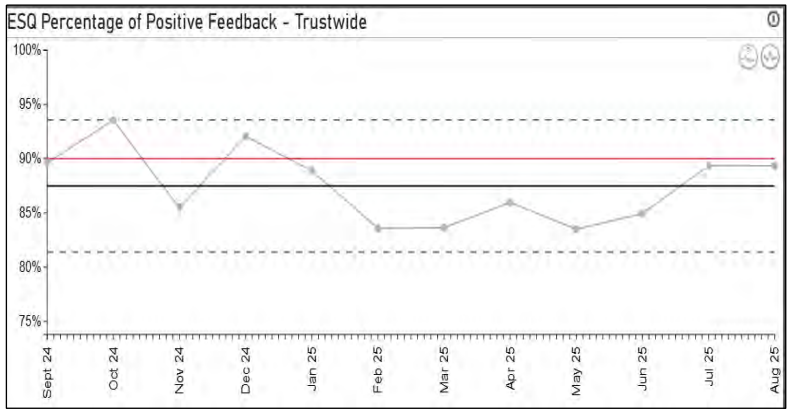
Vision: For all users to have a positive experience across the trust.

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. Began **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

Integrated Quality and Performance Report

Month 05 25/26

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

Problem Statement

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

Vision & Goals

Vision: To consistently match or exceed the national average score

G1: Improve EDI from 7.36 to national average (was 8.3) by March 2025 (we increased again to 7.61 and national average has been adjusted down to 8.08).

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%	28.5%	24.4%	23.0%	26.7%
7	Percentage of staff believing that trust provides equal opportunities for career progression	33.9%	38.2%	26.0%	39.4%	40.1%	39.9%
8	Percentage of staff experiencing discrimination from staff in last 12 months	13.2%	10.2%	20.0%	14.2%	12.1%	16.7%

Overall Organisation Results: regression in 3 of the 4 indicators

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

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

Root Cause/ Gap Analysis

Our position has improved within our benchmark, but we must acknowledge that this is partly because other Trusts regressed far more than us this year. We therefore need to now interrogate the data at locality level and centre support on teams that need further development in this area. We also need to focus on those areas that are scoring well and facilitate them sharing their good practice.

Progress on Improvements (subject to WRES / WDES refresh)

- 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
- CPD Panels have been holding robust conversations and a separate TNA session with professional leads has been held
- Recruitment and retention group now review the monthly dashboard and provide input / ideas into improvements
- Next step to hold Menti sessions with staff on improvements achieved and support pre-merger (before next staff survey round)

Integrated Quality and Performance Report

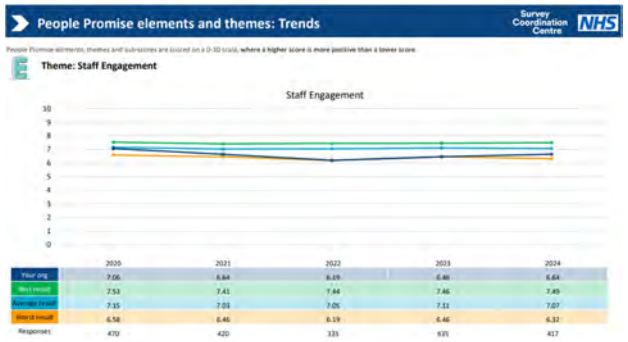
Month 05 25/26

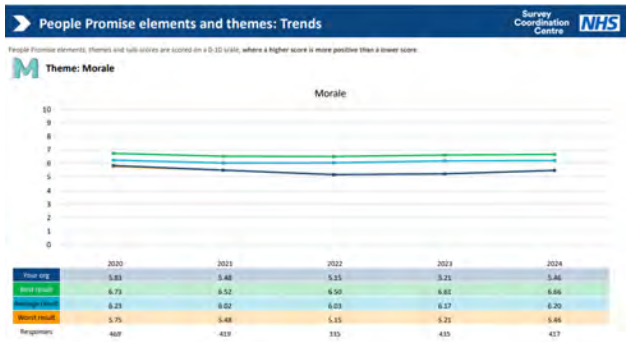
Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

- Staff awards event held 26 June and well received
- A3s on appraisal and stat / mandatory compliance produced and shared with SLF
- Appraisals, stat / mandatory compliance and staff experience now being monitored via IQPR
- Next step to hold Menti sessions with staff on improvements achieved and support pre-merger (before next staff survey round)

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

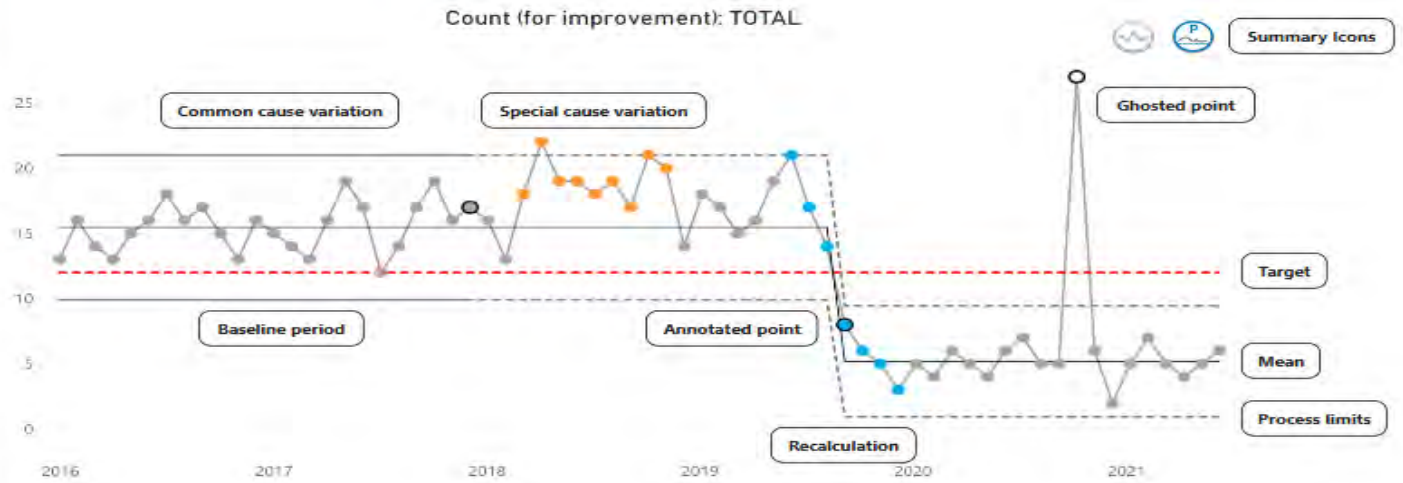
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

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.

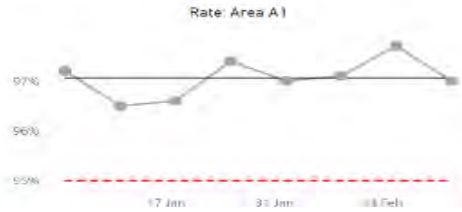
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on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



Excellence Inclusivity Compassion Respect

SPC Chart Glossary & Key (2/2)

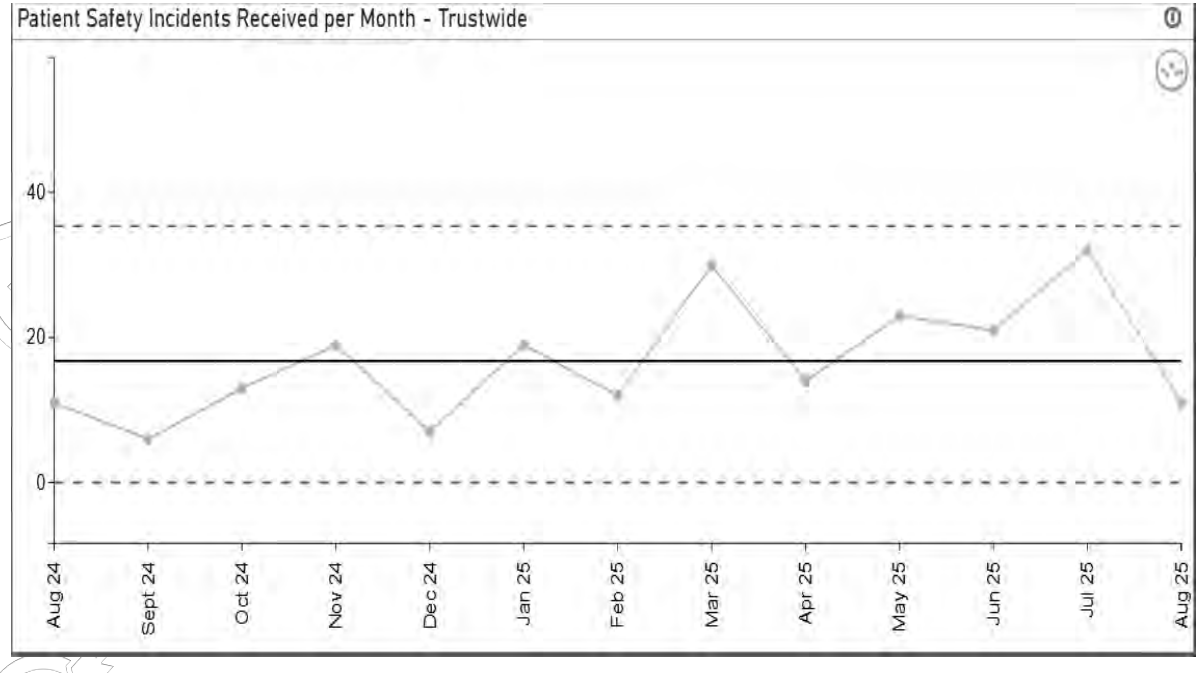
The Tavistock and Portman NHS Foundation Trust

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 11 patient safety incidents were reported across the Trust in August: Camden - 4, Adult - 7, and CYP & Families - 0. While this represents a lower level of reporting, the SPC chart indicates the figure remains within normal variation and is correlated to the reporting for the month of August last year. The reduction is likely attributable to the absence of incidents within the CYP & Families Unit, reflecting the summer holiday period at Gloucester House.

Incidents recorded in August included:

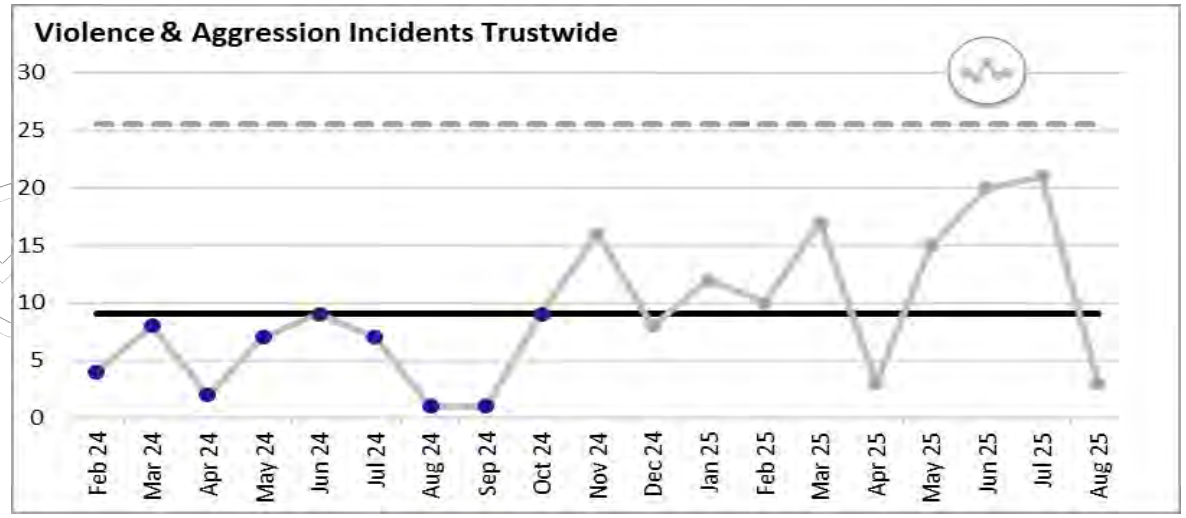
- Four incidents related to patient deaths, all within the Adult Unit. Mortality reviews will be undertaken for each case, with findings reported to CISG on completion.
- Infection prevention and control incidents related to transmittable infections
- Safeguarding concerns of physical abuse in the Child & Families Unit
- Incidents related to self-harm attempts in the Camden and Adult Units

Excluding the deaths, all other incidents reported on Radar in August were triaged for manager review. Where initial assessments indicated learning opportunities, the Patient Safety Team prompted further action.

One after action review (AAR) was requested related to the disclosure of sensitive information through the subject access request (SAR) process. Currently, three AARs remain pending and one PSII relating to surgical hub referrals within the GIC is ongoing, with completion scheduled for the 15th October 2025. Progress is monitored through the AAR Tracker, reviewed weekly at the Executive Safety Huddle.

Key findings and lessons learned will be reported to CISG and disseminated through Unit Clinical Governance meetings to support continuous improvement in practice. The AAR A3 project has also been presented to the Quality Improvement Forum and to trained AAR conductors, where further feedback has been obtained to inform refinements to the process and strengthened countermeasures for improvement.

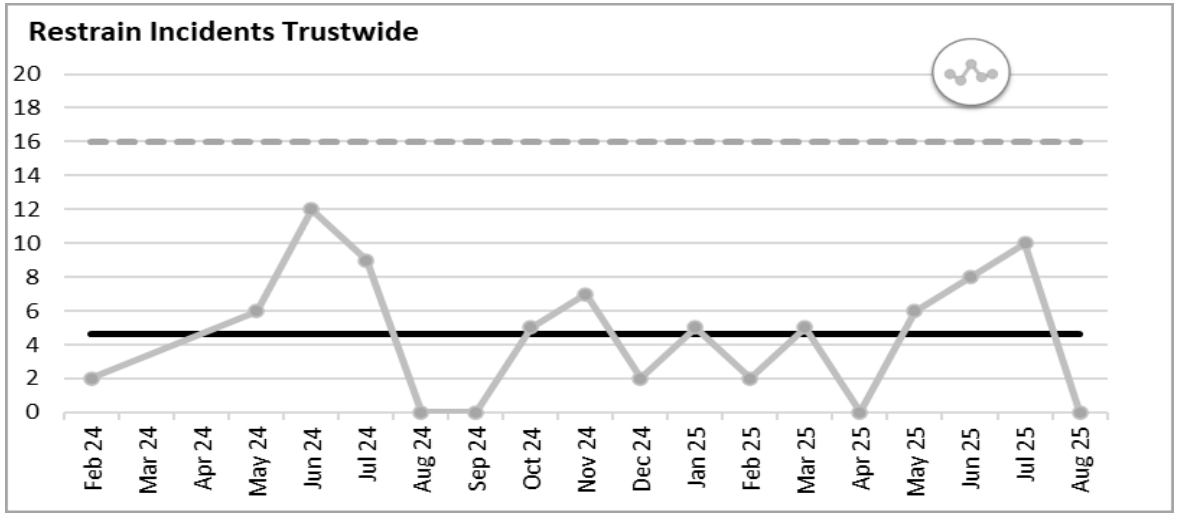
Are We Safe? – Trust-wide



Violence & Aggression Incidents

A total of three incidents of violence and aggression were reported in the month. Although this represents a lower level of reporting, the SPC chart indicates that the figure remains within normal variation and is consistent with reporting levels for August last year. The reduction is due to the absence of incidents within the CYP & Families Unit, reflecting the summer holiday period at Gloucester House.

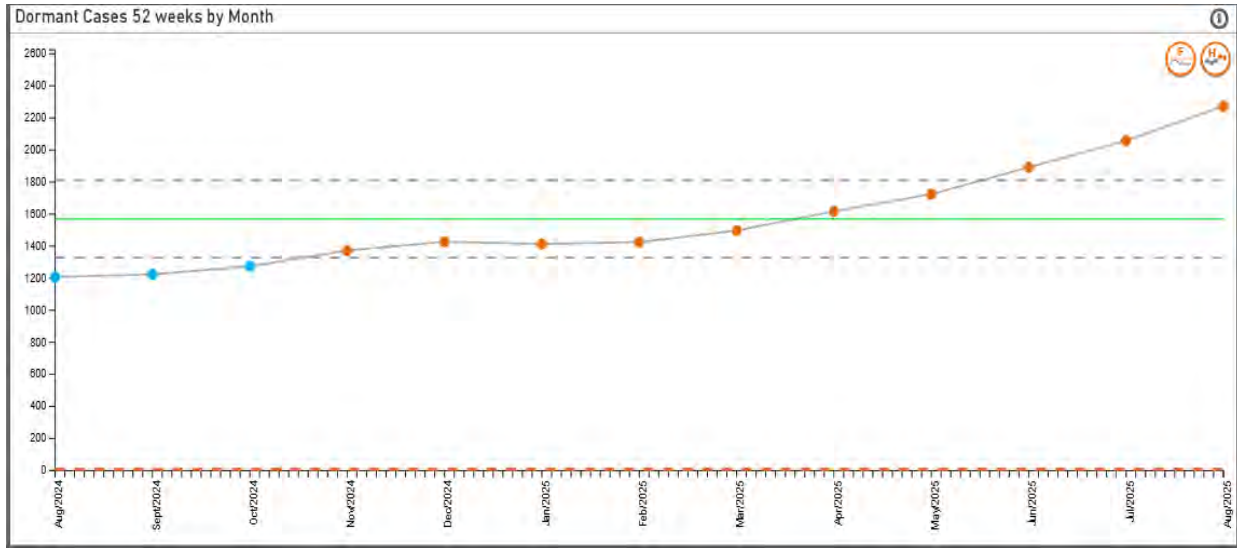
In all cases, appropriate immediate local action was taken, and the incidents were triaged for managerial review by the Patient Safety Team, with relevant escalation noted.



Incidents Involving Use of Restrictive Practice

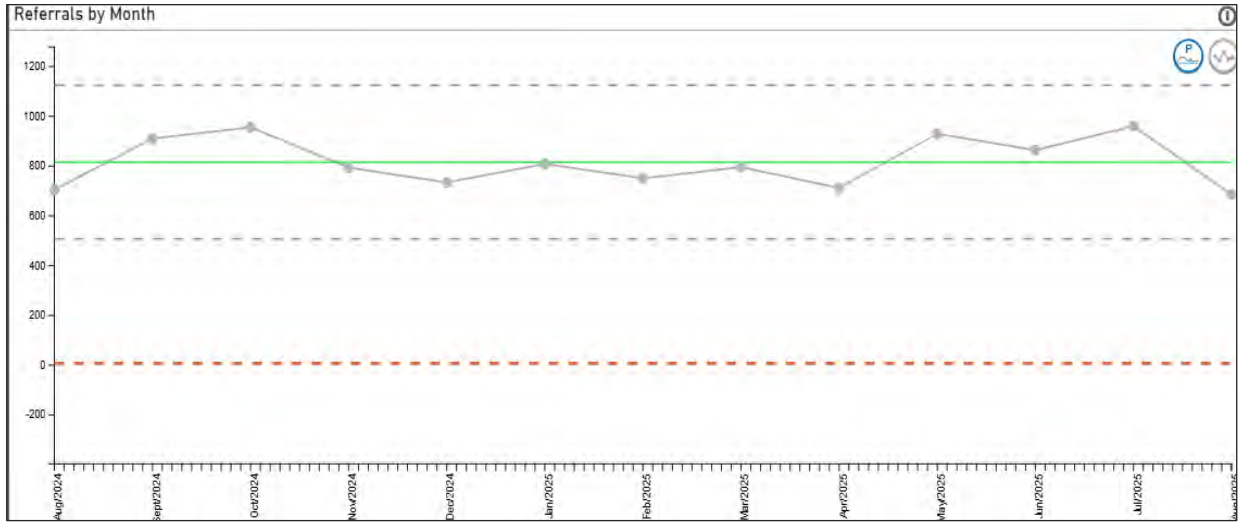
There were no incidents of restrictive practices reported in August 2025. The reduction is due to the absence of incidents within the CYP & Families Unit, reflecting the summer holiday period at Gloucester House.

Are We Effective? – Trust-wide



52+ Week Dormant Cases

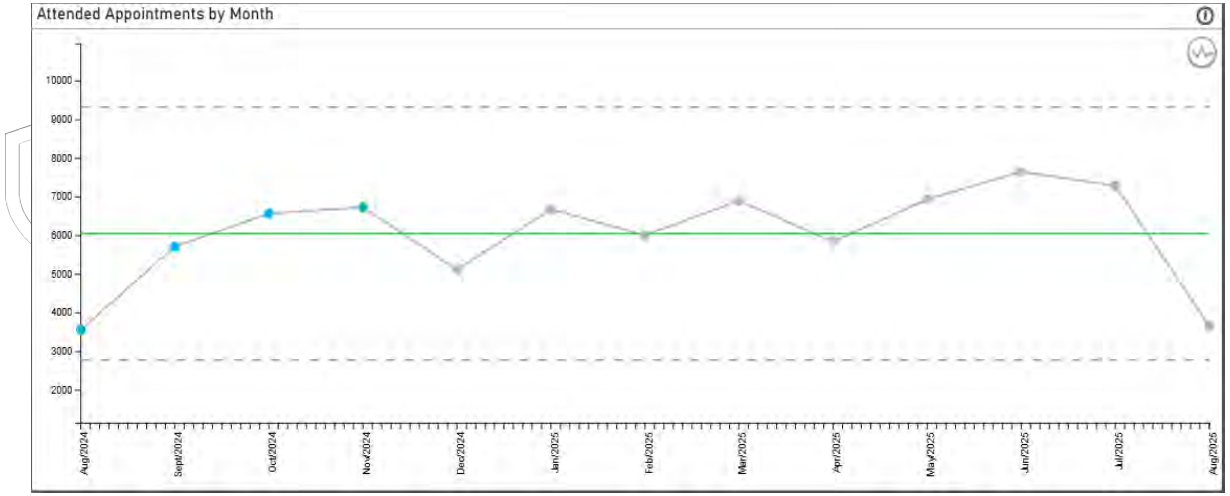
Due to continued long waits in GIC and Trauma Teams, dormant cases continue to rise.



Number of Referrals (Including Rejections)

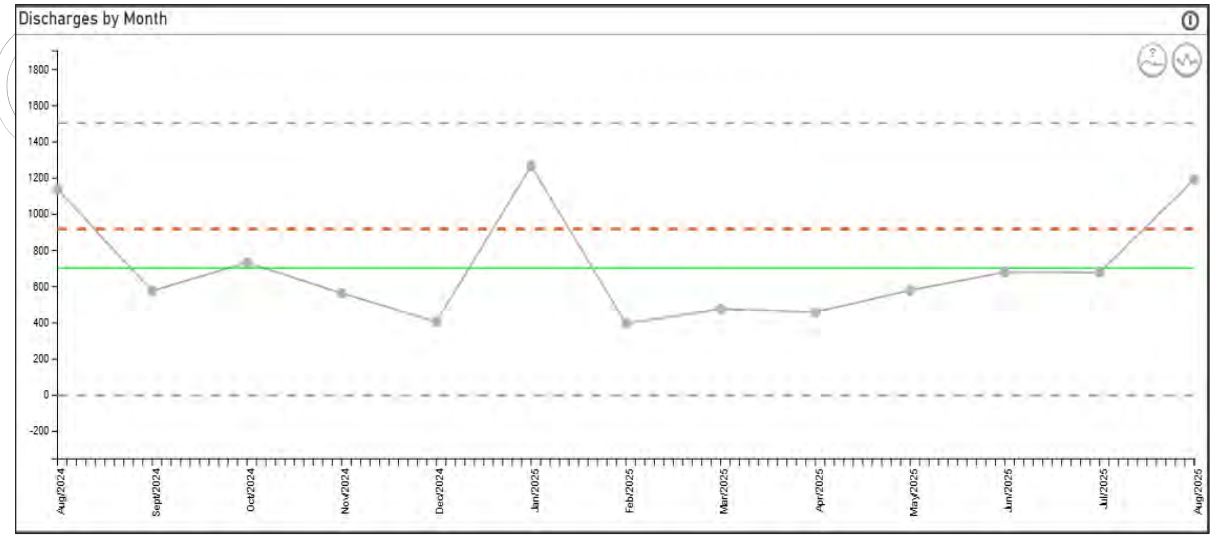
The trust received 691 referrals in M5 with only 31 cases rejected across the Trust. The number of referrals the trust received in M5 is the lowest number since the equivalent month in 24/25.

Are We Effective? – Trust-wide



Number of Attendances

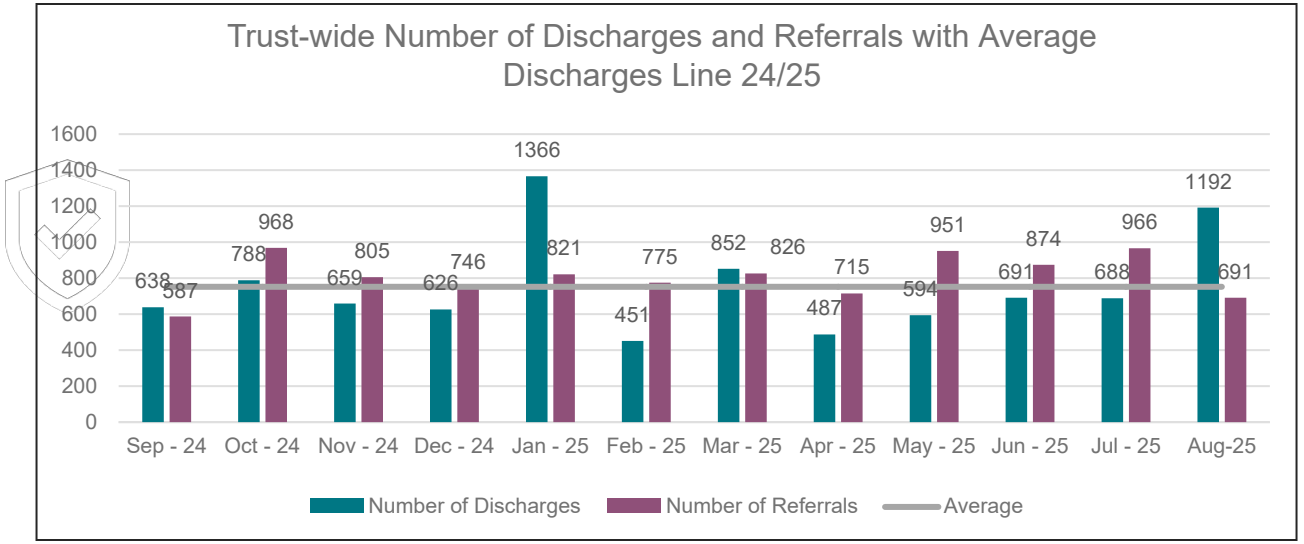
The overall number of attendances in M5 is 7,210, this is slightly lower than M4 2025 which at > 7,500 is the highest number of attended appointments for over 12 months. The M4 and M5 data was in line with expectations and indicated a potential increasing understanding of the need to manage periods of lower activity as has happened in August where there are higher numbers of staff taking leave with periods of higher activity abutting with 3,836 attendances recorded in M5.This is 273 higher than the equivalent month in 24/25.

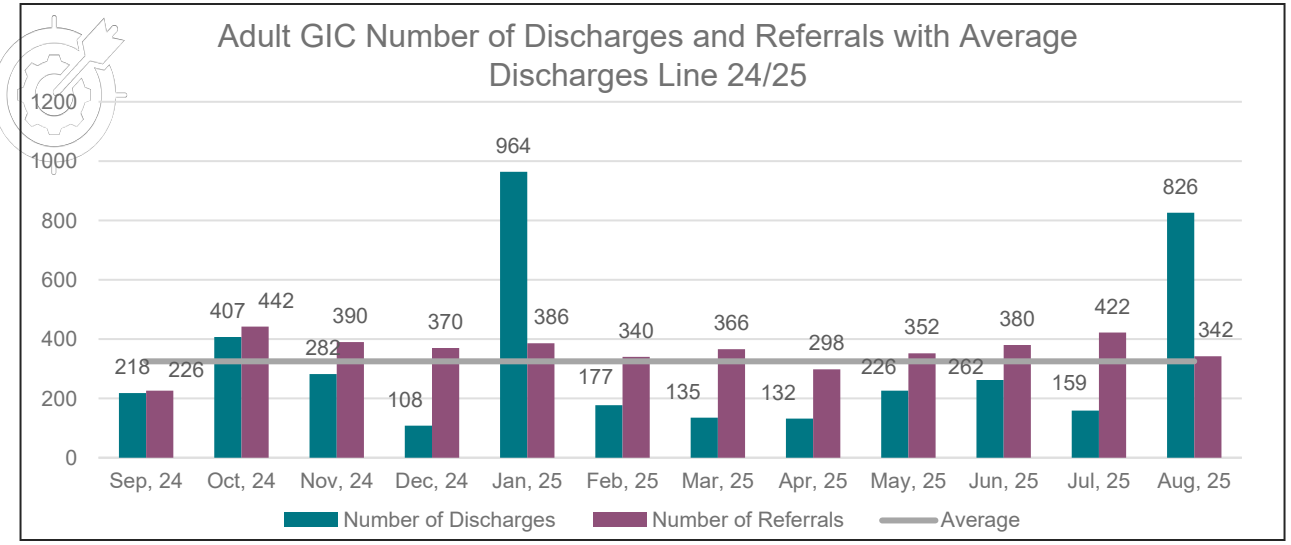


Number of Discharges

The rise in the number of discharges in M5 has been due to the bulk transfer of cases transferred from GIC to another provider. Referrals are outstripping the number of discharges meaning that the waiting list trust wide will continue to increase.

Are We Effective? – Trust-wide

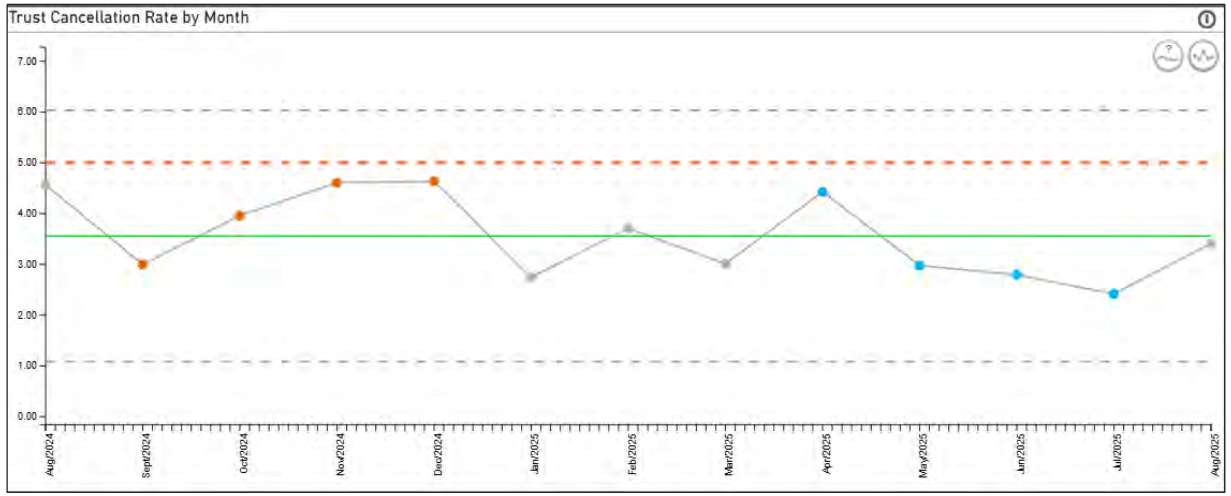




Number of Discharges with Average Line:

The bar chart indicates that the number of discharges is above the average line. It should be noted however that the average discharge number is significantly skewed by the large number of discharges in M10 24/25 due to a transfer of over 1,000 from GIC to another provider. If this number is removed from the average line, the average discharge per month is around 600. This indicates that the number of discharges in M5 is below average as 826 out of the 1,192 discharges from the trust were from the GIC service.

Are We Effective? –Trust-wide



% of Trust-Led Cancellations

The Trust reports a cancellation rate of 3.92%. The unit level data indicates that the GIC continue to be the predominant driver of Trust led cancellations due to the Clinic Booking model with a trust cancellation rate of 11.4% in Month 5.

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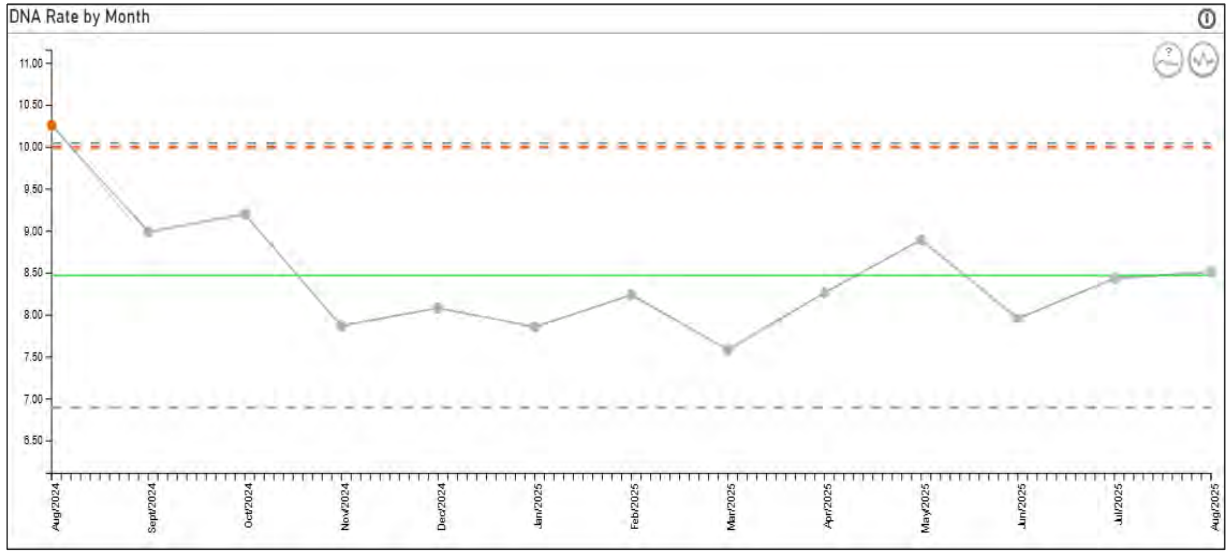
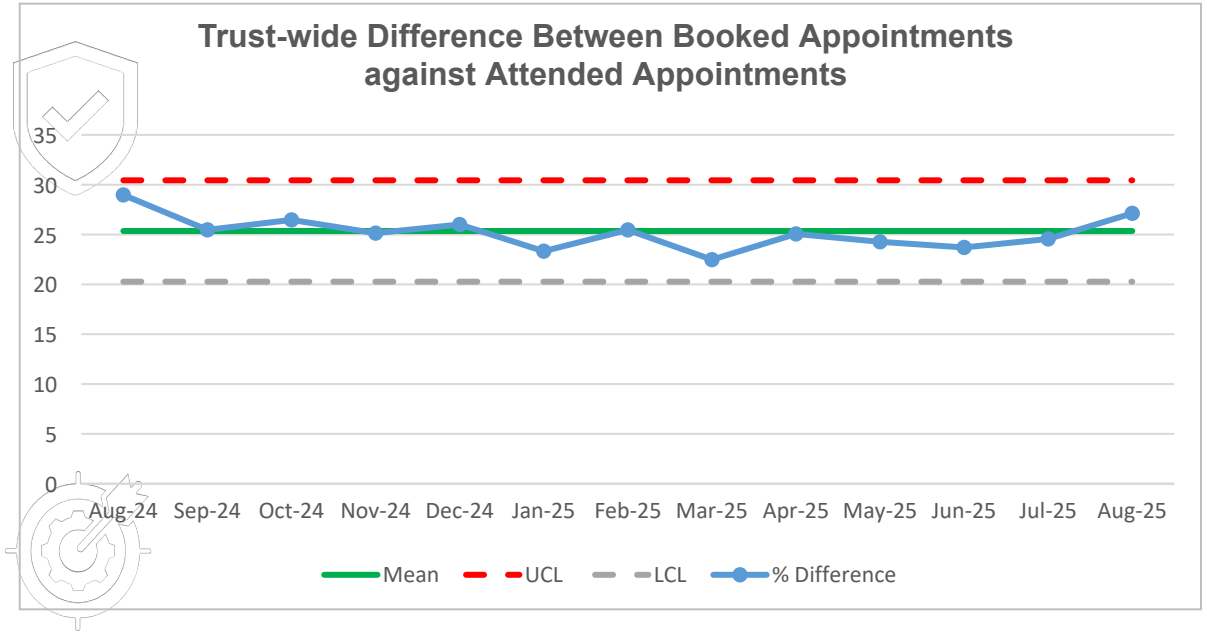


% of DNAs

There has been a small increase in the Trust's DNA rate in the last month, but it remains below the 10% upper control limit.

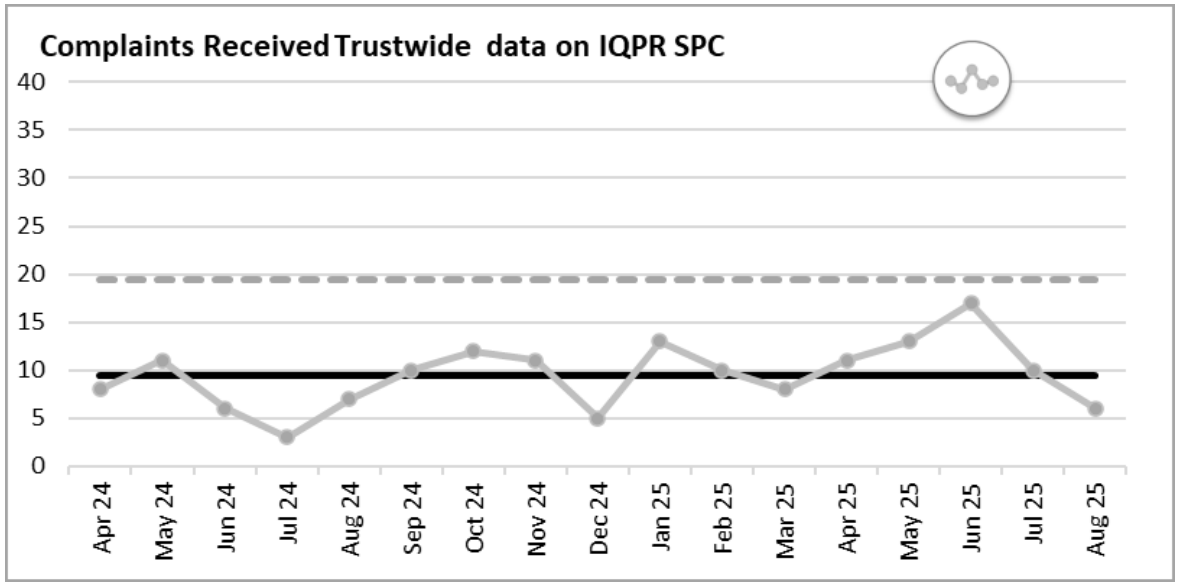
Are We Effective? –Trust-wide

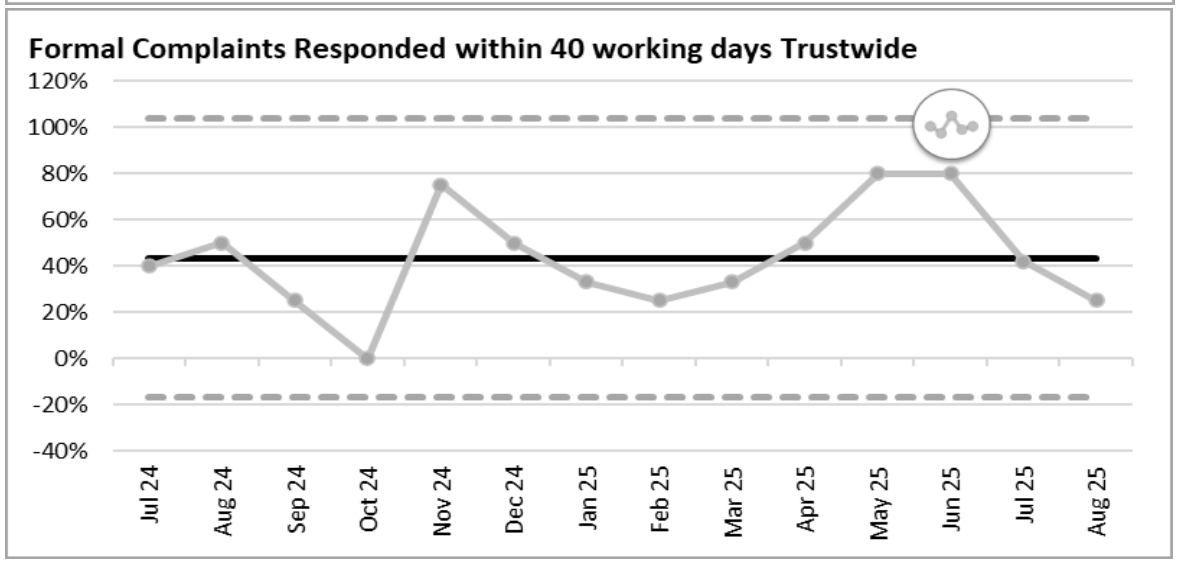


Booked vs Attended Appointments

- The number of attended appointments continues to remain below the mean, approximately 1% above the lower control limit, but still falls short of the total number of booked appointments.
- Clinical services are currently working to establish more accurate upper and lower control limits, taking into account job plans and clinic schedules.
- While the current report highlights trends, it does not fully reflect the actual capacity required to deliver activity across teams.
- The cancellation rate by patient of 13.25% of all booked appointments in M5 2025 accounts for just under half of all cancellations in that month and is the highest number in the past year. DNA rates have fluctuated around 7-8% of all booked appointments and the trust has cancelled 3.91% of all booked appointments in August 2025, which is an increase of almost 1% on July.
- It is envisaged that future iterations of this metric will measure performance against a national benchmark.

Are We Caring? - Trustwide





Number of Formal Complaints Received

A total of 6 complaint contacts were received Trust-wide in August all of which were received by the Adult Unit. Complaints in the subject area category of 'Patient Care' and 'Appointments' recorded the highest number of 2 each with Access to Treatment or Drugs and 'Privacy Dignity and Well-being' recording 1 each.

6 of the 6 complaint contacts received in August were acknowledged within 3 working days in line with national regulations.

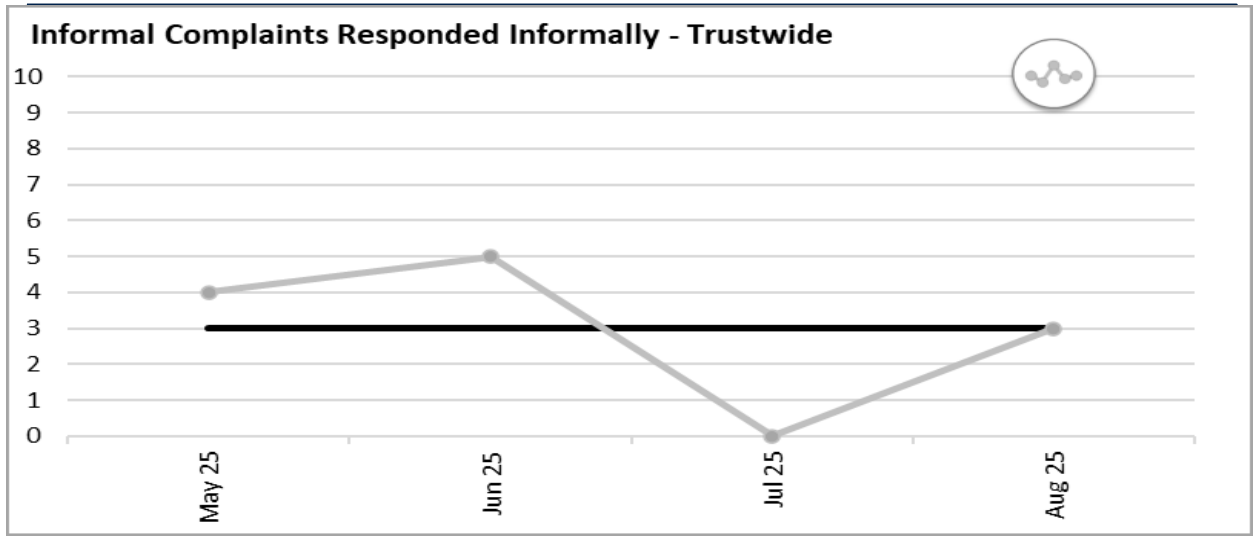
Formal complaints response time compliance

Trust wide compliance for formal complaints responded to within 40 working days for August is 25% reflecting that 12 formal Trust responses were sent to complainants in the month, of which 3 were responded within 40 working days.

The Complaints team continue to work 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. The Complaints team also continue to work on the quality improvement project to identify areas of the complaints process that can be improved.

As of the end of August 2025, 20 complaints were open of which 8 were overdue. All of the overdue complaints are registered to the Adult Unit.

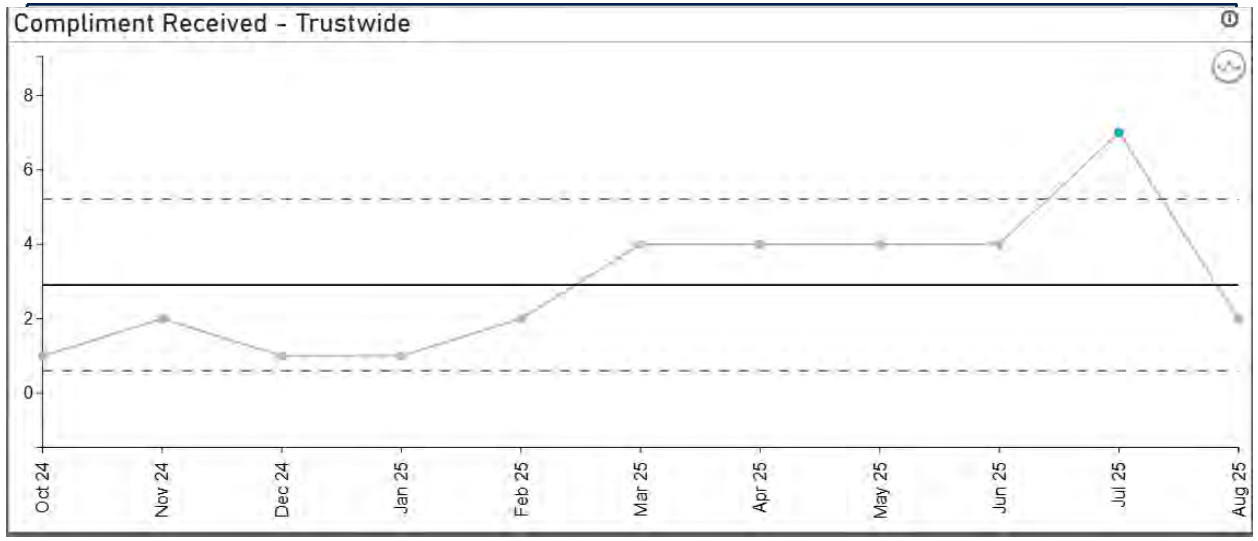
Are We Caring? – Trust-wide



Informal Complaints (Local Resolution)

In August 2025, 3 complaints were resolved informally; 2 in the Adult Unit and 1 in the Child & Families Unit.

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, Investigating Leads can contact the complainant at a very early stage of the complaints process to discuss the complaint and help to resolve concerns informally by the Service team.

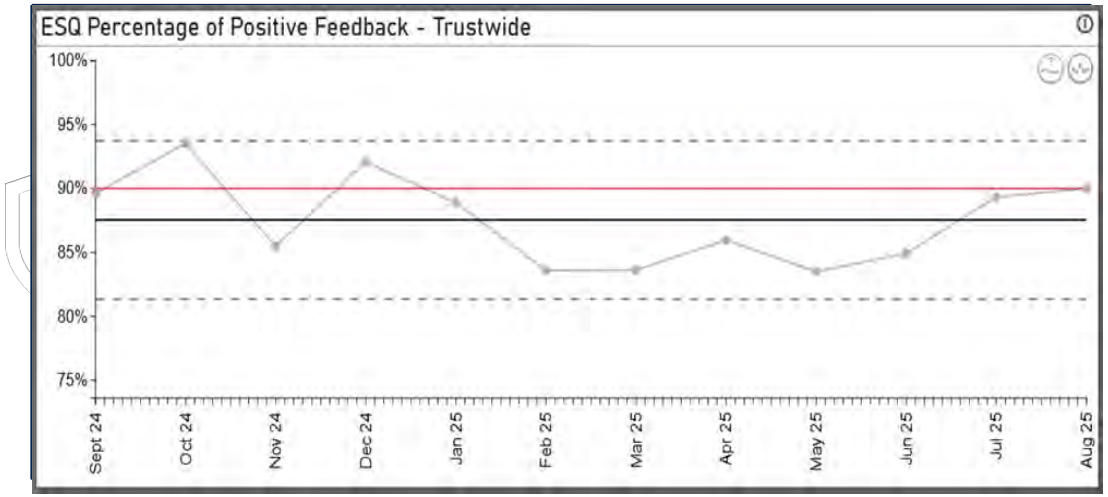


Number of Compliments Received

2 compliments were recorded in Radar in August; one by the CYP and Family unit and one by the Adult Unit. Both compliments were categorised as Values and Behaviours. Compliments are categorised using the KO41a system (to match complaint categories) to enable comparison with themes between ESQs and complaints.

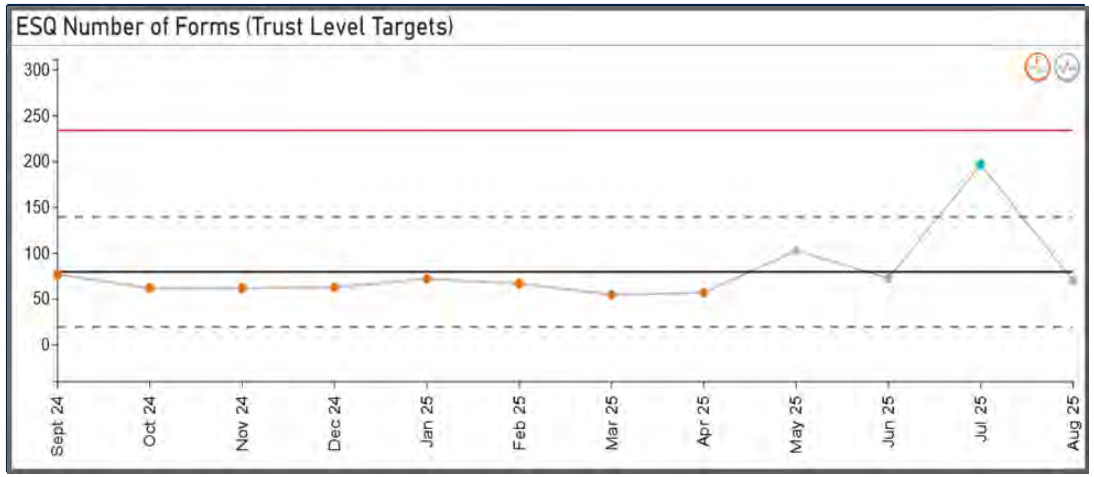
This metric became live on Radar in January 2025, so historical data is not formally available. The Trust continues to raise awareness of the process on how to record compliments within the teams.

Are We Caring? – Trust-wide



ESQ Positive Responses %

The Trust-wide target 90% for ESQ positive responses was achieved in August 2025. Themes from qualitative feedback indicate that once again Patient Care, Trust Values and Communications are the areas most commented on under positive feedback. Comments were linked to staff being compassionate, caring, respectful and listening. Thematic analysis has also been applied to negative feedback/areas for improvement received. Here communication, patient care, waiting times and values and behaviour featured most regularly. Again, feedback highlights request from patients for more information from services on care and treatment.

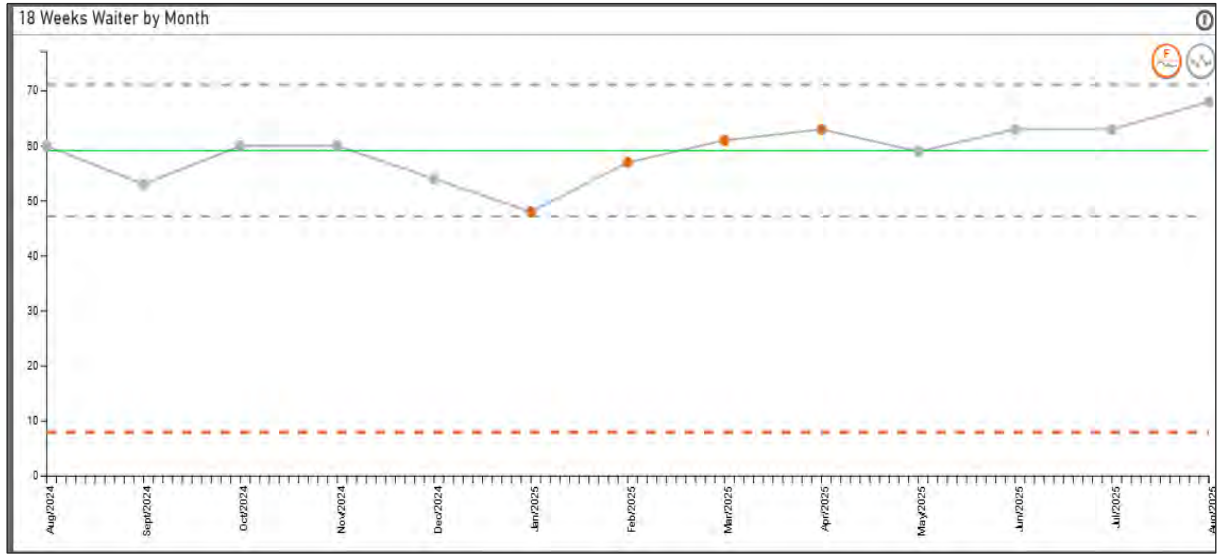


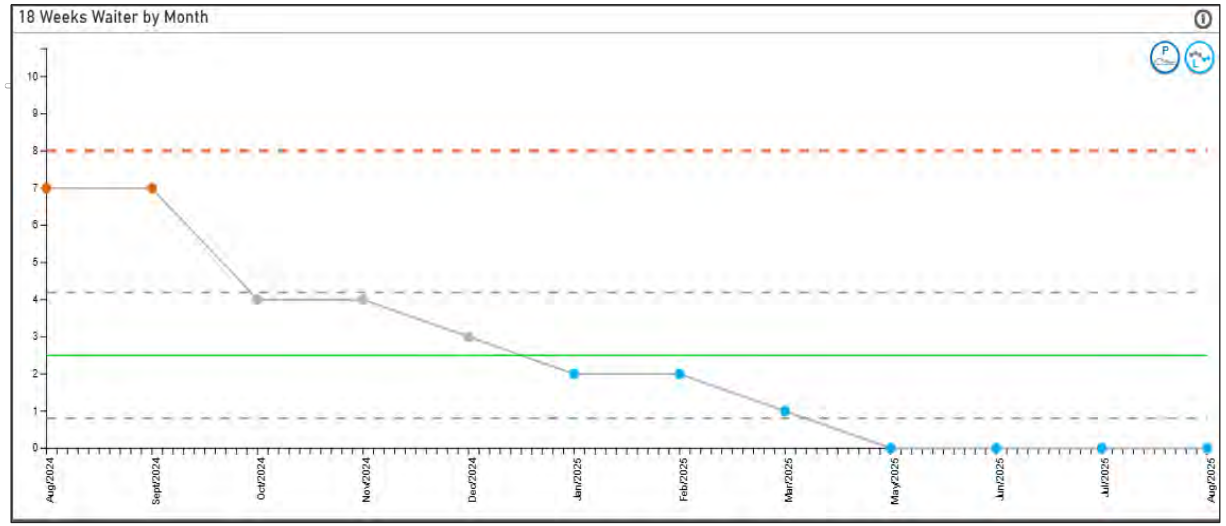
ESQ Number of Forms per Month

The number of forms collected across the Trust in August less than the previous month with 70 forms collected. Similar trends of fall in number of forms in August have been noted due to the workforce and patient holiday period. Furthermore, with the increase in paper forms collected, admin staff have reported delays in uploading all the forms in the month they are collected. This has been highlighted to Unit leads. PPI team continues to send out reminders to OMs. PPI team continue to offer support through presence in reception areas and active engagement with patients requesting feedback.

There is continued targeted support being offered to teams where no forms are collected to develop targeted actions to increase engagement. Text messaging to support request for feedback started at the end of July. A touchscreen laptop has also been sourced and will be trialled in one reception area to measure if this improves number of feedback forms received.

Are We Responsive? – Trust-wide





18 Week RTT Breaches Excluding ASC/GIC/Trauma

Referral to Treatment (RTT) Performance Summary

Most services are currently meeting their Referral to Treatment (RTT) targets—4 weeks for Children and Young People (CYP) and 18 weeks for Adults. However, further work is needed at the team level in two areas:

- **Neurodevelopmental Disorders (NDD) Pathway:** This is close to meeting its RTT target, but additional improvements are still required.
- **Adult Unit:** Significant work is needed to meet RTT targets. Current figures are skewed by data from Trauma and Gender Identity Clinic (GIC) services.

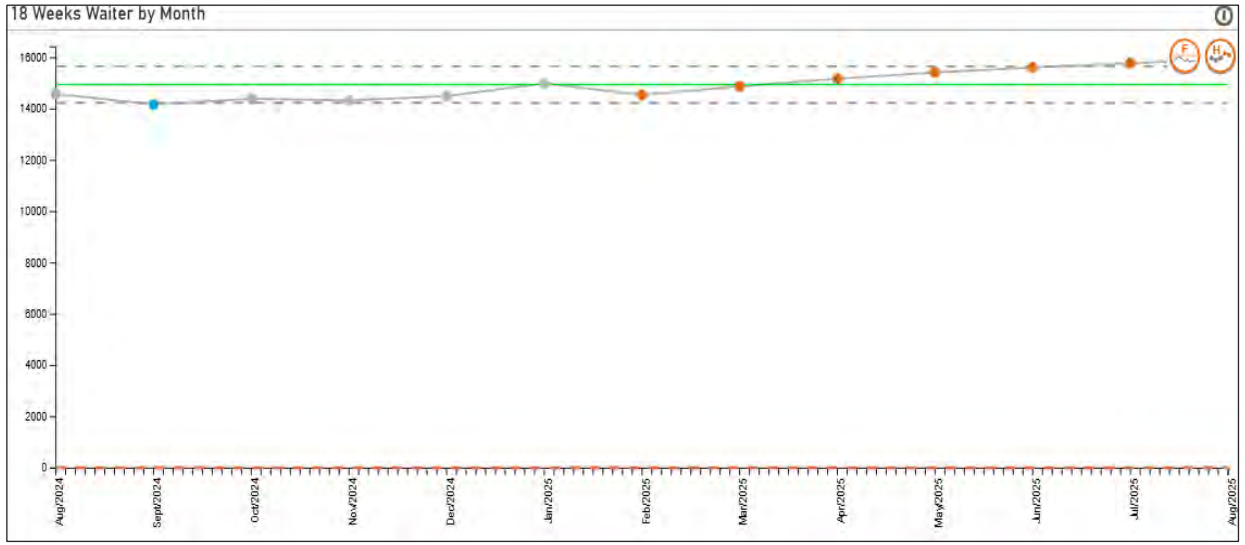
Despite these challenges:

- **Adult Psychotherapy Services**—excluding GIC and Trauma—continue to improve. Most clinical services within this team have maintained an average RTT of 4 weeks since February 2024.

Child and Family Unit (CFU)

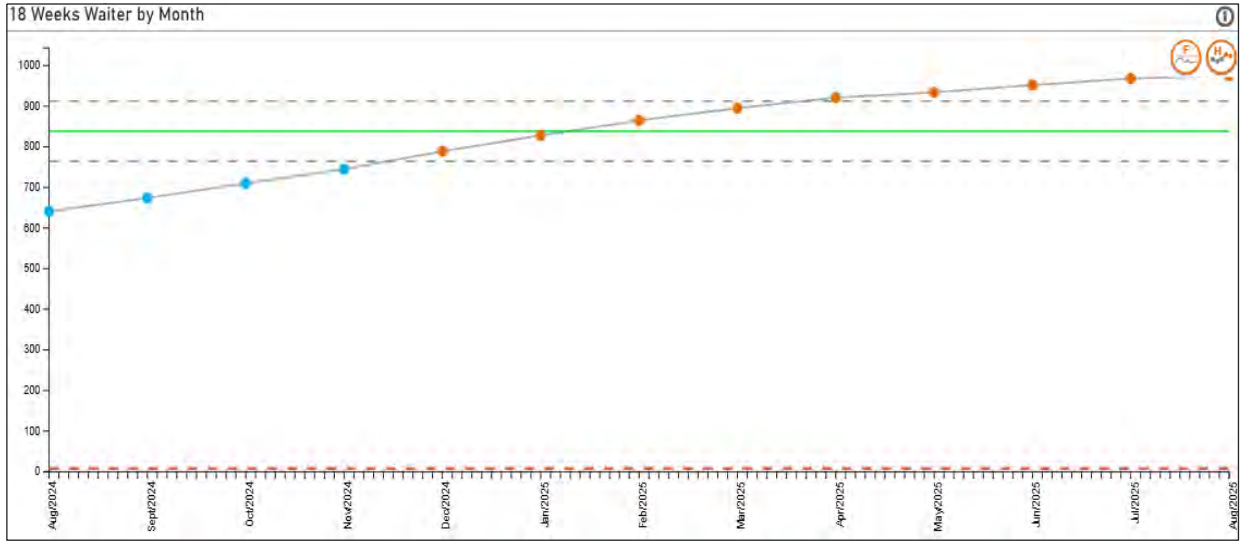
- The CFU currently reports **10 cases breaching the 18-week RTT threshold**.
- In **Camden**, an A3 improvement plan related to the Clinical Intake Team is now in implementation.
- Encouragingly, most **cases in CFU have not exceeded 4 weeks** in waiting time.

Are We Responsive? –Trust-wide



18 Week RTT Breaches GIC (1st Appointment)

- As of August 2025, there are 16,516 individuals waiting for a first appointment, reflecting ongoing pressure on the service. However, the waiting list continues to grow due to an increase in referrals, with 342 new referrals in August.
- The four GIC nursing ERF posts, created to support the Core service (waiting list) have been converted to permanent contracts, which in turn means an adjustment to the overall workforce plan.
- We expect the new patient portal to create more efficient booking opportunities for patients and a form of inclusion / engagement for patients.

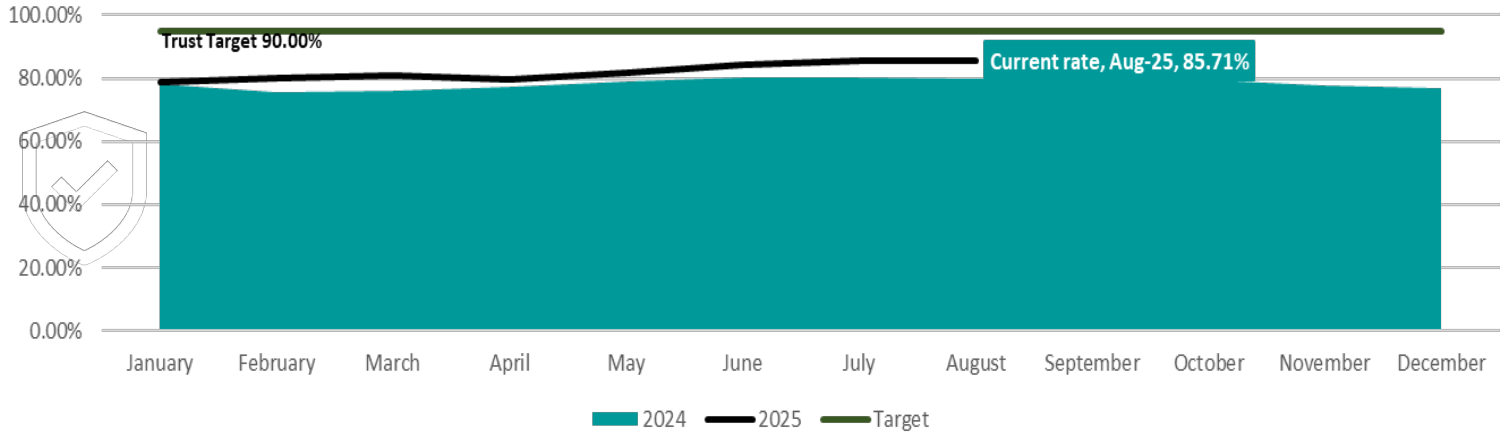


18 Week RTT Breaches Trauma (1st Appointment)

The service decreased their number of attended appointments from 672 in July to 315 in August 2025. There are just over 1,037 patients waiting to be offered a first appointment. In August 2025, 15 patients attended their first appointment, out of a total of 315 appointments delivered. The current wait time for a first appointment is approximately 121 weeks, though this varies from month to month. The team continues to receive support under the Targeted Support programme to help address these challenges and improve access.

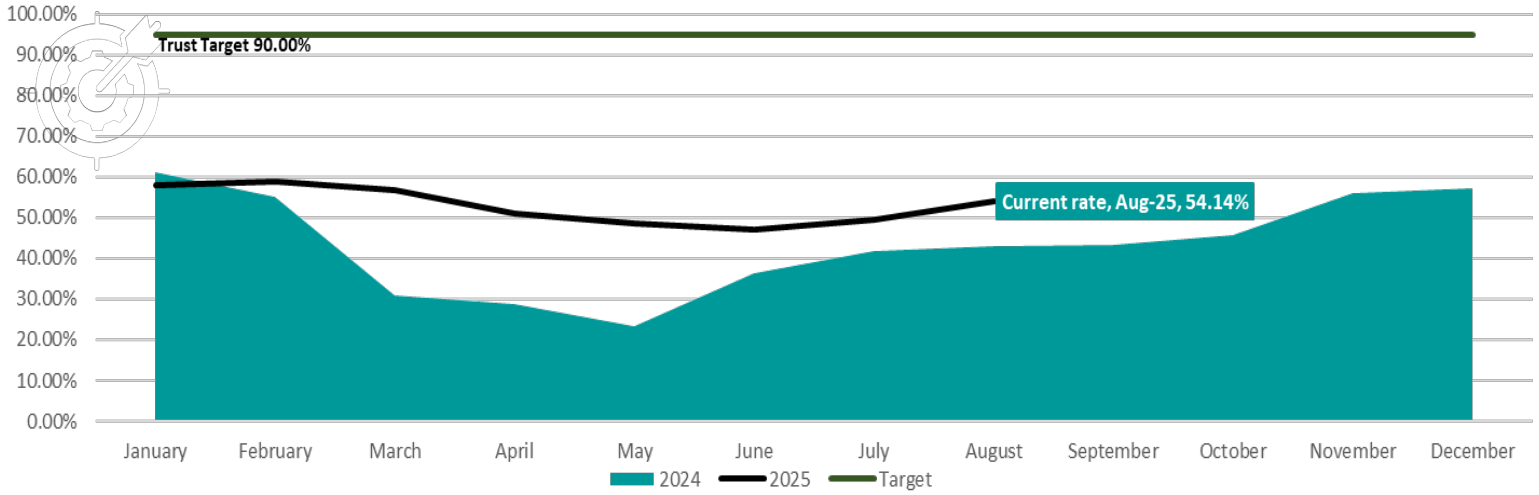
Are We Well-Led? –Trust-wide

The Tavistock and Portman NHS Foundation Trust



Mandatory & Statutory Training (Combined)

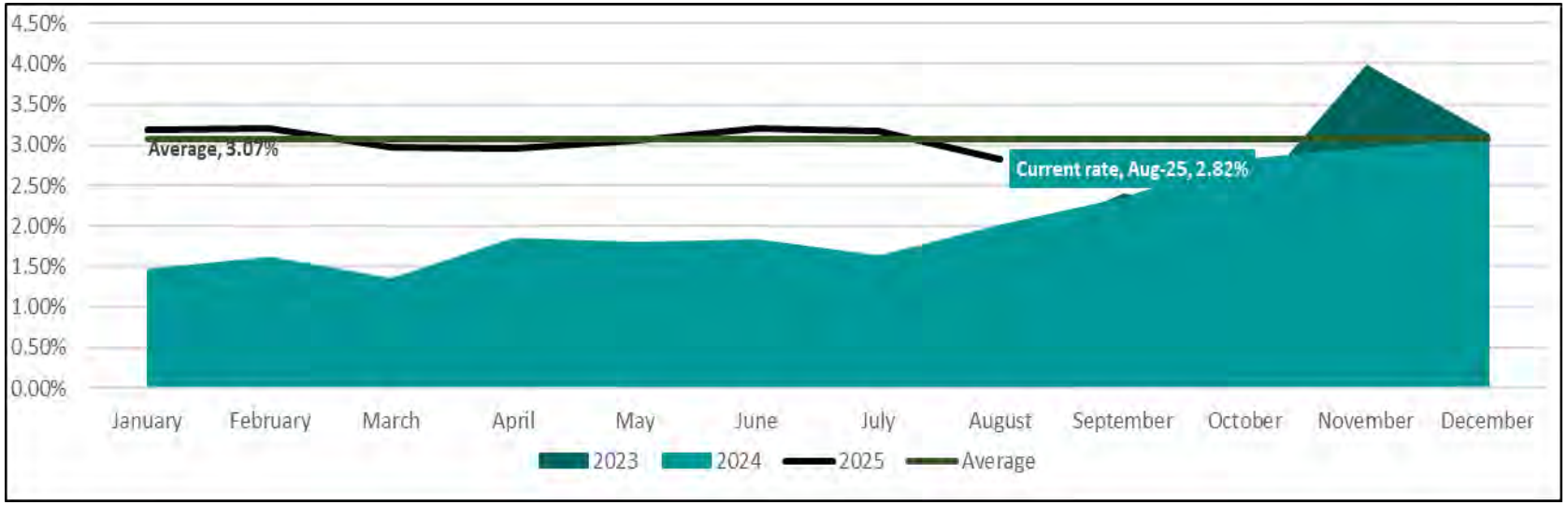
Directorate Aug-25	Compliance %
Chief Financial Officer	95.47%
Chief Strategy & Business Development	92.90%
Chief Executive Officer	91.71%
Chief Nursing Officer	88.04%
Chief Clinical Operating Officer	86.30%
Chief Education and Training Officer	85.98%
Chief Medical Officer	70.36%
Chief People Officer (Includes Bank)	65.68%



Appraisal Completion (Combined)

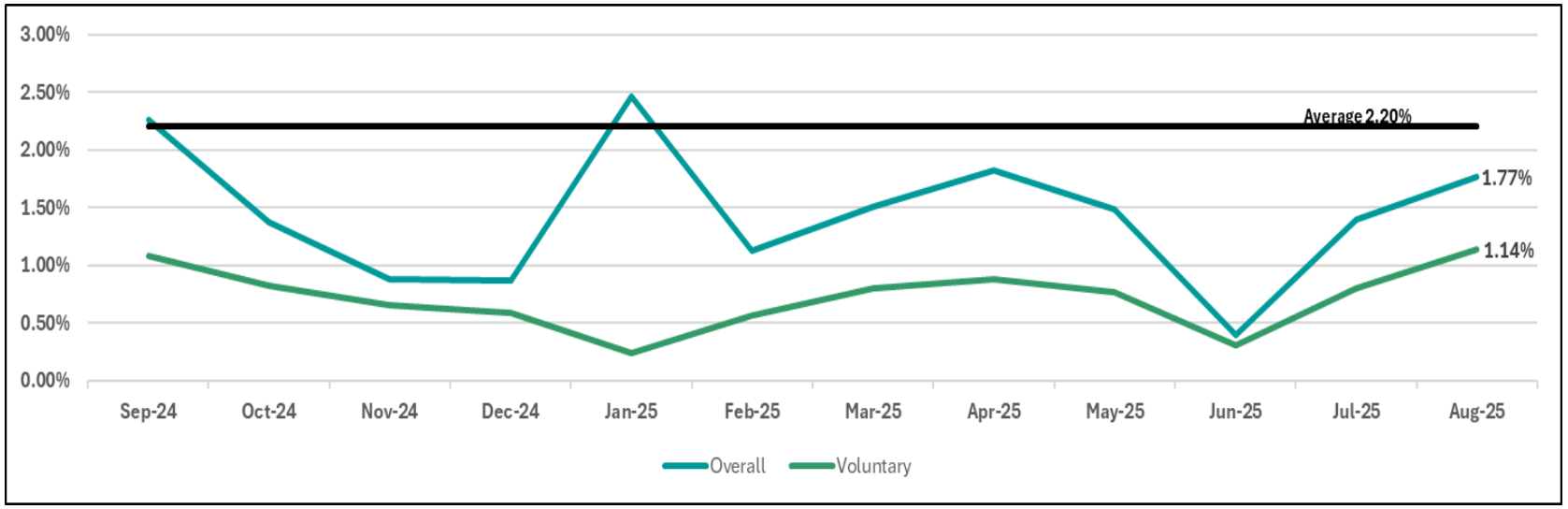
Directorate Aug-25	Reviews %
Chief Medical Officer	100.00%
Chief Nursing Officer	100.00%
Chief People Officer	84.62%
Chief Financial Officer	64.15%
Chief Executive Officer	58.82%
Chief Clinical Operating Officer	53.76%
Chief Education and Training Officer	45.90%
Chief Strategy & Business Development	37.50%

Are We Well-Led? – Trust-wide



Staff Sickness (Combined)

Directorate Aug-25	Absence FTE %
Chief People Officer	13.03%
Chief Executive Officer	5.06%
Chief Clinical Operating Officer	3.42%
Chief Financial Officer	2.28%
Chief Education and Training Officer	1.48%
Chief Medical Officer	0.20%
Chief Nursing Officer	0.18%
Chief Strategy & Business Development	0.15%



Staff Turnover (Combined)

Turnover	Overall	Voluntary
Chief Clinical Operating Officer	1.86%	1.70%
Chief Education and Training Officer	0.34%	0.00%
Chief Executive Officer	4.12%	0.00%
Chief Financial Officer	0.00%	0.00%
Chief Medical Officer	14.67%	0.00%
Chief Nursing Officer	5.55%	5.55%
Chief People Officer	0.00%	0.00%
Chief Strategy & Business Development	4.08%	4.08%

Voluntary - resigned, F.T.C ended. Overall - resigned, F.T.C, ended, dismissal, misconduct. Honorary are not employed by the trust. All information is based on Substantive employees.

Delivering our vision – How are we doing? – August 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 appraisal reviews. Appraisals, currently stands at 54.14%. This has increased by 4.66% at the end of Aug-25. Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals. Chief Nursing Directorate have achieved an outstanding 100% of appraisal reviews completed. Chief People follows at 84.62%.	**% Appraisal completion** **54.14%**
The Tavistock & Portman Trust sickness rate currently stands at 2.82% at the end of Aug-25 As a Trust, our current sickness absence rate is below the average benchmark of 3.07% by 0.25%. The level of sickness has decreased from the previous month by 0.35%. The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.06%. A slight increase from the previous month by 0.05% ending Aug-25. The sickness absence data from September 2024 to August 2025 reveals that mental health issues—specifically anxiety, stress, and depression is the leading cause of absence across both White and BME ethnic groups. Overall, the data highlights the consistent impact of mental health on workplace absence and suggests varying secondary health trends between ethnic groups.	**% Staff sickness** **2..82%**
Compliance this month stands at 85.71%, a 0.07% increase ending Aug-25. Chief Financial stands at 95.47% compliance, holding a high standard continuing from the previous month. Chief Executive follows, at 92.90%. There has been a gradual positive change to MaST compliance within the past three months increasing.	**MAST training** **85.71 %**

Contracts and Finance

Delivering our vision – How are we doing?

The Tavistock and Portman NHS Foundation Trust

Finance & CIPS Delivery Effective use of resources

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%**	

25/26 year-end planned position breakeven

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.

YTD 25/26

Income & expenditure summary	Year to date		
	Plan, £'000	Actual, £'000	Variance, £'000
Income	23,893	23,414	- 479
Pay	- 21,433	- 21,476	- 42
Non-Pay	- 5,004	- 5,595	- 591
Non Operating expenditure	- 90	- 76	14
Total	**- 2,635**	**- 3,733**	**- 1,098**
Please note: Income "+", expenditure "-"			

The Trust is £1,098k behind plan year-to-date at Month 5.

This adverse variance is primarily due to a shortfall in income from the National Training Contract (NTC).
The unfunded element of the pay award remains a recurrent pressure for 2025/26.

Risk: Uncertainty around income from the NTC in CETO and Tavistock Consulting in Corporate may affect the delivery of the CETO plan and the overall 2025/26 Trust plan.

25/26 M5 YTD position: £1,098k deficit

PCREF M5: Accepted and Rejected referrals by Ethnicity

This month we are looking at accepted and rejected referrals into services.

Due to a change in alignment on Carenotes it is no longer possible to identify rejected referrals by team in Child and Family. We will be exploring this unintended consequence with CSM and IM&T.

The data presented is that of the Adult psychotherapy services as these currently provide this data. The data has been discussed with the Psychology Assistants in Adult Psychotherapy and the Portman. The Portman are undertaking a large piece of work looking at the Accessibility of the service to the Global Majority. The Adult psychotherapy service are at an earlier stage of maturity with their work but are developing frameworks to monitor and ensure a better understanding of this area of PCREF.

Due to the low numbers the data is currently of insufficient to draw any conclusions. The data will be reviewed at end of each quarter to develop an understanding of the number of quarters data required to draw meaningful conclusions.

Accepted and Rejected referrals by Ethnicity for Adult Therapies

The Tavistock and Portman NHS Foundation Trust

	REFERENCE %	Psychotherapy n = 69		Trauma n = 86		Portman n = 68	
		Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
White British	35.9	15	6	10	7	21	10
White other	21.3	7		1	2	1	3
Any other	8	2	3	1			1
Black British: African	7.3	3	1		1	3	
Black British: Carribean	3.6	1	2				
Black British: Black other	1	1	1	1	2	4	1
Asian British: Indian	4.6		1		1		1
Asian British: other asian	4.1	2	1		2	2	2
Asian British:Pakistani	1	1		1			
Asian British:Bangladeshi	2.2	3		1		1	1
Asian British:Chinese	1.8	1					1
Asian and White	0.6	2		1			
Black African and White	0.5					1	
Black Carribean and White		1			2		1
Mixed other	1.2	2	2	1	2	3	1
Arab	1				4		
Irish	2.7	1	1	2	1		
Iranian				2			
Not Known		4	2	1	1	6	1

DET & Unit Overviews

Education & Training

Month 05 25/26

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.

Student Recruitment Activity Overview

Summary

Application Cycle: Current Cycle

The selected application cyle is: 2025/26 This application cycle starts on 10/1/2024 and ends 9/30/2025. We use Year To Date calculation. so we can directly compare this years applications numbers with this time last year. Today is day 352 of the application cycle.

Complete Applications	Conditional Offers	Offers Firmly Accepted	Unconditional Firm	Incomplete 2025/26
1104	775	540	349	1010
Year to date: 1113	Year to date: 716	Year to date: 485	Year to date: 483	Year to date:
1114 Total last cycle	725 Total last cycle	527 Total last cycle	524 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
February	47	-63%	134	134
March	69	-35%	106	106
April	61	-45%	110	110
May	109	1%	108	108
June	243	17%	207	207
July	171	-23%	221	221
August	28	-56%	63	63
September	15	67%	9	10
Total	**1104**	**-1%**	**1113**	**1114**

Application by Portfolio and Course

Porfolio	Applications	Offers Made	Offers Accepted	Unconditional and Firm Accepted
Digital and Short Courses	29	26	23	21
Interprofessional	90	80	61	47
Psychoanalytic Applied	438	304	199	153
Psychoanalytic Clinical	275	164	107	41
Systemic	272	201	150	87
Total	**1104**	**775**	**540**	**349**

Deferrals for next cycle: 126

Total Deferrals- From last cycle: 49

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	95	-63%	255	255
April	112	-37%	178	178
May	142	-11%	159	159
June	146	19%	123	123
July	78	-29%	110	110
August	7	-76%	29	29
September	3	0%	3	4
Total	**1010**	**-23%**	**1316**	**1350**

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

Analysis

Student recruitment: For the 25/26 Academic year, we opened recruitment three months early in October (as opposed to January in 2024). Despite earlier applications in the Autumn, the overall numbers are currently down on this point last year (3% below in August 2025) with completed applications at 1072 (compared to 1101 in July 2024) but our firmly accepted Offers currently at 463 compared to 361 in July 2024, with fewer Unconditional Firm offers (299 compared t0 359)

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.

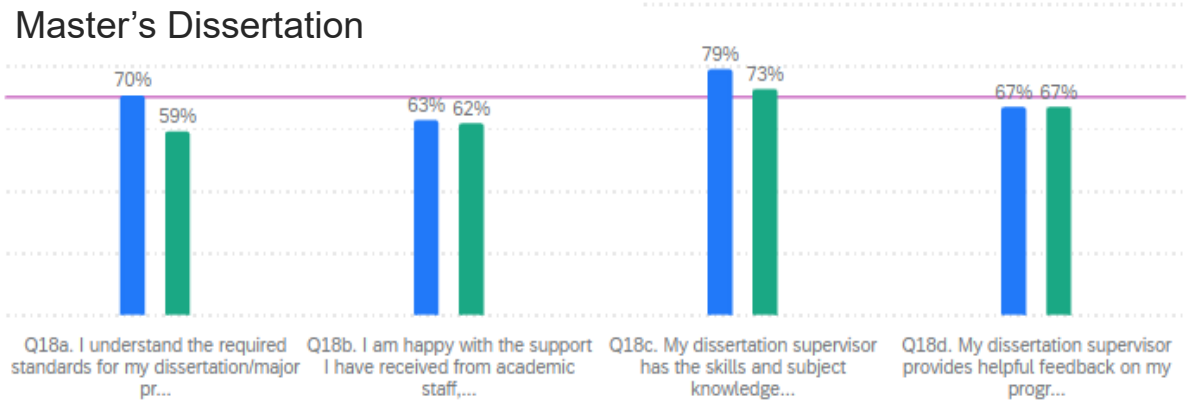
Concern	Cause	Countermeasure	Owner	Due Date
Growing income to meet pay costs	Rise in DET ops staff 2023-25	Increased long-course student income Agreed uplifts for AY 2026/7 International Project Income	CETO / Directors of Education	November 2025
Ensuring sustainability of DET	Withdrawal of National Training Contract	Stronger University Partnerships Discussions with NLFT about sustainability	CETO / Directors of Education	March 2026
SITS Infrastructure work	Our SITS (student academic monitoring) system was implemented in 2017 and in many respects has not been fit for purpose.	£200k of capital investment released and implementation work being scoped	Director of Education (Operations)	January 2026

Education & Training - Student Experience

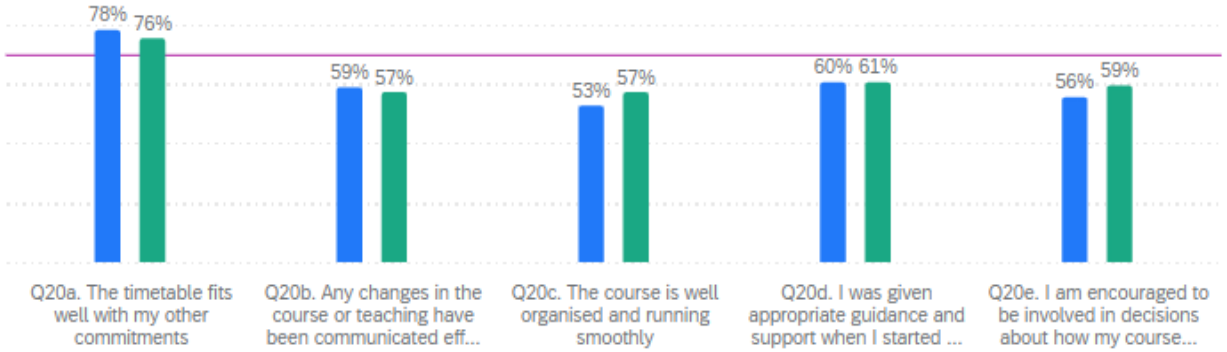
Month 05 25/26

Successes	Challenges
• We celebrated graduation on 11th September which was very successful. • The Educational Recordings Policy recently got approved at the Policy Approval Group. The Reasonable Adjustments policy has also been considered there, and approved subject to minor alterations. • The Library refurbishment completed on time.	• Previous (2024) concerns remain, relating to community and culture, resources for Disability Support and Estates provision for disability. At the present time, disabled student numbers are continuing to rise, with 221 students currently registered with student support for the 2025/26 academic year, against 83 students by this time last academic year. A business case is being drawn up to propose ways of sustainably managing increasing demand on a very small team.
• Master's dissertation survey results for 2025 hit 73% satisfaction (3% above the internal benchmark) to the question 'My dissertation supervisor has the skills and subject knowledge to adequately support my dissertation / major project' • Organisation and Management for the same survey reached 76% satisfaction to the question 'The timetable fits well with my other commitments'.	• Overall satisfaction in the Masters dissertation section of the student survey has fallen from 70% in 2024 survey to 65% in 2025. The student experience workstream will review this issue and consider ways to improve satisfaction, once the embedding disability inclusion project is complete. • Overall satisfaction in the Organisation and Management section of the student survey has remained low at 62% for both 2024 and 2025. In concurrent years, students repeatedly cite poor communication and the lack of clear, consistent information sharing as the main sources of dissatisfaction in this area.

Master's Dissertation



Organisation & Management



Updates on below actions

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. **Update July:** A buddying system is being trialled as part of Welcome Week/orientation preparation – to offer to international students as a starting point.. **Update Aug:** Buddying trial is postponed to next academic year. Several student experience workstream projects are under consideration to launch over the 2025/26 academic year. **Sep:** Welcome Week is coming up, with two social events taking place. We have also worked with the Art Curator to ensure student art is being displayed. A regular Dean's newsletter to students may also help with community and culture, but this is not currently resourced.

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' **Update July:** pursuing signing up to the Disabled Student Commitment. Exploring how to make efficiency savings to accommodate the 36% increase in demand for disability services without new staff, through solutions such as Symplicity..**Aug:** Student Reasonable Adjustments Policy is in the final stages of being approved, which should have a positive impact on disabled students. Disability data for student survey will be presented in the IQPR as it becomes available. **Sep:** No further updates

Psychoanalytic and Systemic Portfolios: Placements and academic governance project management support identified: an audit of all placements is in progress (September 2025).

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); social events planned, Deans Forums scheduled,	CETO / Directors of Education	December 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	Nov 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	End September 2025

DET Risks — Month 05- 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
Improving value, productivity, financial and environmental sustainability.							
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.	Risk mitigated following confirmation of OfS registration continuing.	12	12	8	
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.	Whilst applications are tracking similarly to last year (22 lower), firmly accepted offers are 102 higher. Whilst this is positive, until enrolments close in October, we won't know the exact position.	12	12	8	
5	Loss of the National Training Contract	If the Trust cannot draw down the full funds related to the contract, there will be a shortfall of £2.6m this year and £.8m in the 26-26FY.	Discussions are taking place with NHSE to try and mitigate this loss.	12	12	8	

Are We Caring? – Education and Training

August 2025

AY24-25 to date

The Tavistock and Portman NHS Foundation Trust

This month, the Trust received no new complaints, and no existing cases were escalated to the next stage of the process. An informal complaint was closed due to no contact from the student. This means that the Trust is currently processing **1 informal complaint**, **4 formal complaints**, and **1 internal review request**.

The informal complaint was submitted by a student on the D59I course in the Equality law/human rights category. Three of the formal complaints were submitted in the Service issues category, two by students on M7 and one by a student on M80, and the other was submitted by a student on M7 in the Financial category.

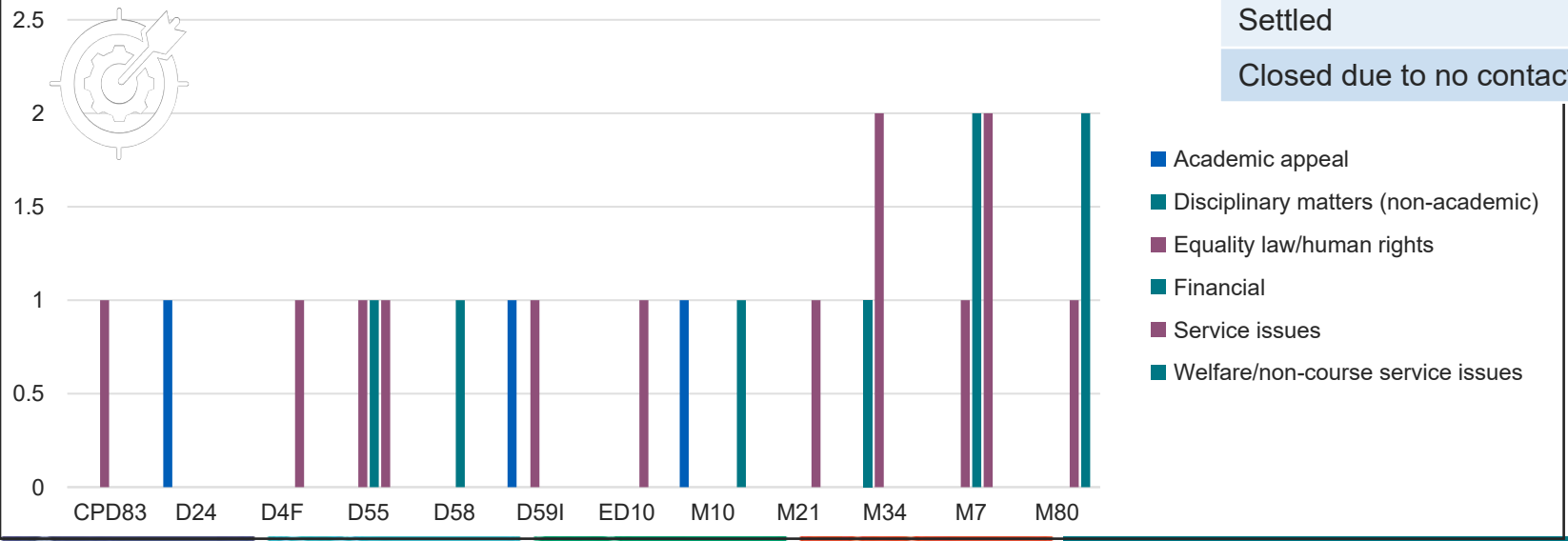
The internal review request relates to a complaint submitted by a group of seven students on CPD83. Three of the students requested an internal review.

This year, the Trust has received **24** complaints under the Student Complaints Procedure. Of these, **16** have been raised at the **informal stage**, **15** have been raised at or escalated to the **formal stage**, and **1** has been escalated to the **internal review stage.** No complaints about the Trust have been submitted to the OIAHE or other body for external review.

For the cases which are now closed, the outcomes are as follows:

Outcome	Number of complaints
Local resolution successful	3
Local resolution unsuccessful	9
Not Upheld	1
Partly Upheld	6
Upheld	1
Settled	3
Closed due to no contact	5

Number of complaints by course (AY24-25 to date)

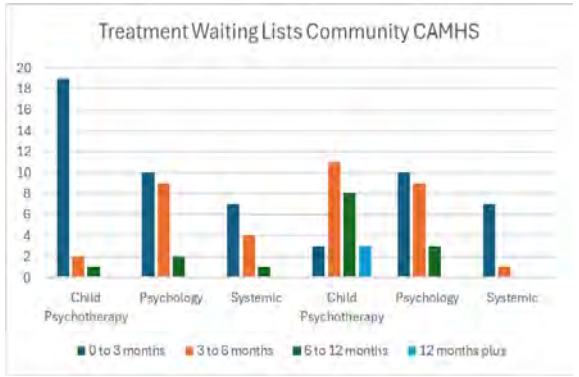


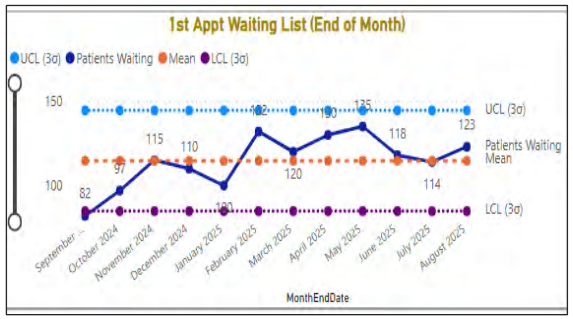
Camden Unit Overview (1/2)

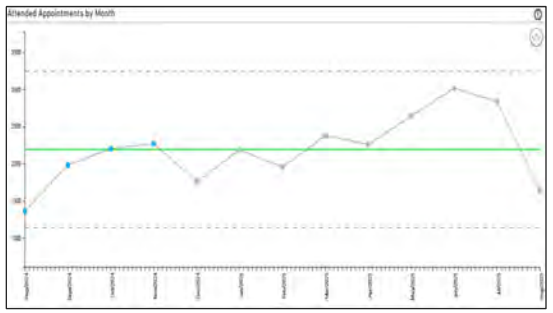
	Successes	Challenges
Safe	• Our MAST compliance is now at 92%. Our admin and ops teams have worked hard to support staff to undertake this training, sending reminders etc. An A3 was completed in some teams. • There are 2 young people in inpatient beds in Camden that are known to CAISS. • We stayed within our DNA target of 10% in August. This has not happened for at least the last 2 years.	• Appraisal compliance is at 61% which is a 7% fall since August. We often experience delays in receiving paperwork and would welcome clarity on when we can mark the appraisal as complete. • While we are 92% compliant as a Unit, we continue to see high numbers of clinical notes missing in one of our teams. This is being addressed with training as the issue is largely down to incorrectly attaching the notes. • There is now a gap in admin across Wellbeing and MHST which will be increasingly difficult to manage. We are working through options to fill one of the posts.
Effective	• We have seen an 8% reduction in the number of missing CGAS (534/488) and 5% in missing GBMs (714/675) since August. We are working with the OM improvement project to try and increase compliance in the unit. We previously had success with messages regarding missing measures coming from the Clinical Service Manager and are trying this again. • We continue to achieve an average of a 3 week wait to first appt (exc. outcome measures) • PTL and adding appointment on Carenotes training has now concluded, we hope to see the effects in our September data. • We have agreed to flow data on consultation and training type activities (that are not linked to specific patients) to MHSDS, and a change will be requested. This will further increase our activity.	• Waiting times data is still difficult to use and is not validated. This is being progressed this month. • There have been some issues in recording activity in MHST. Annual data has now been submitted, and our performance is not in line with other providers in the borough. We have been clear this is about data quality and will be working with the team on this in the coming weeks.
Caring	• We saw a further reduction in the number of missing safeguarding and risk forms this month.	• ESQ response rates fell in month
Responsive	• We received 50% more referrals this August than we have in the last 2 years. • While activity reduced in August, SCCT achieved 70% with their job plan target and Wellbeing 60%. CAISS delivered more appointments in August than July. Overall, there was a 20% increase in activity in the month compared to 2023 and 2024. • The number of cases pending more than 10 days (decision to accept or not) fell significantly in August (39 to 17)	• The Growing with You team is seeing a higher level of absence than usual due to emergency leave and sickness. This is significantly impacting the team's capacity. This is further exacerbated by senior posts being vacant – now appointed internally which will mean a gap elsewhere. • We are concerned about activity in MHST particularly when compared to other boroughs. The team is developing an A3 and focusing on training and support for staff to record all activity. • We still have 13 cases dormant over 6 months that are not progressing, these are concentrated in 3 teams, and most are not a result of medication reviews. This is now reviewed weekly in PTL and we expect to see improvement.
Well-Led	• We have reviewed our annual plan and completed a mid-year review. We are now realigning our goals and setting milestones and a project plan for the next 6 months. • Some teams are running QI projects including QI on safety planning and developing a patient support group in CAISS. Activity in MHST. CGAS Language in CWP and others. This demonstrates the team's engagement with the data.	• Delays in decision making regarding CIPs mean that we are getting close to a point where processes will not be concluded this financial year. • Staff are still experiencing issues getting laptops – we have previously raised this with IT and continue to log incidents.

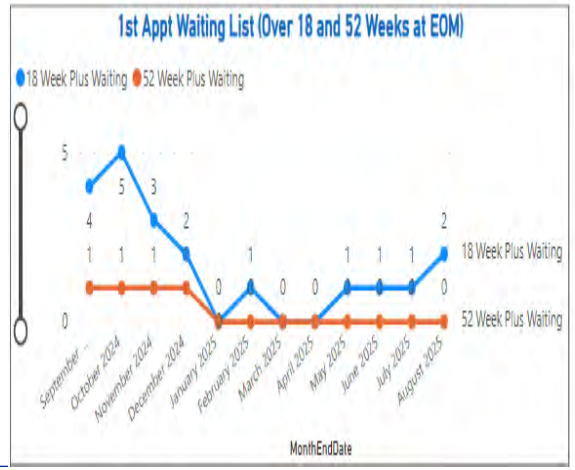
Camden Unit Overview (2/2)

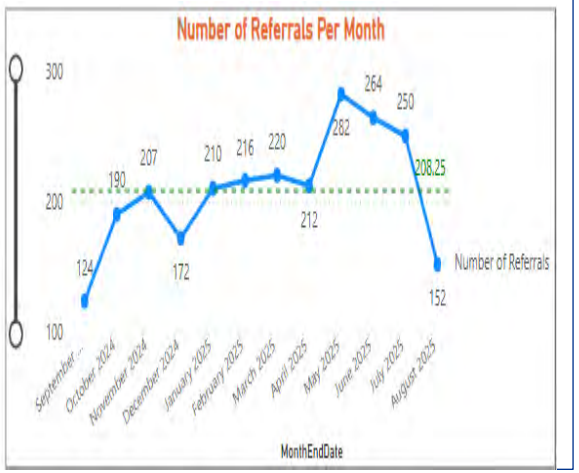
Activity Overview











- We saw the usual drop in referrals in August but note the number received was 50% higher than August 2024 and 2023.
- Attended appointments in August were 20% higher than last year.
- 18-week breaches are being investigated but this should now be addressed via PTL. One should have been closed at the point of referral and the other seems to be a data error as they are not open to the team.
- The number of cases waiting less than 6 months has fallen this month however the number waiting over a year has increased. This should be addressed when the new Child Psychotherapy trainees start this month (Note: left is NCCT, right SCCT)

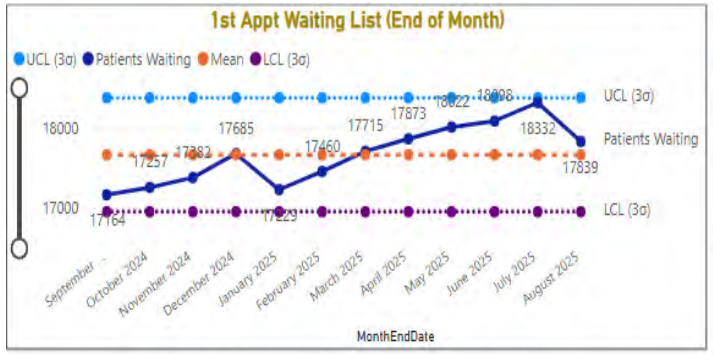
Concern	Cause	Countermeasure	Owner	Due Date
Activity and Job Planning	Lack of oversight in 24/25, new staff not being given job plans	Job plans in place for all. Is a delay in implementing as a visual for all as agreed. Reporting reinstated in April. A3 to be developed for any teams where activity is a concern	Fiona Hartnett, CSM	Sept 2025
All activity not pulling into reporting	NPA not reported in this meeting	Report has been requested and is waiting for build	Fiona Hartnett, CSM	Sept 2025

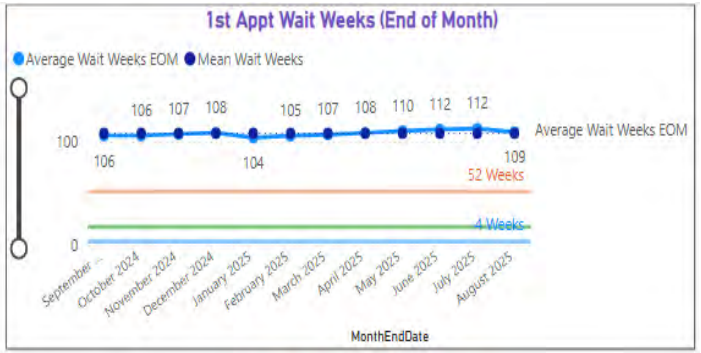
Adult Unit Overview - 1/2

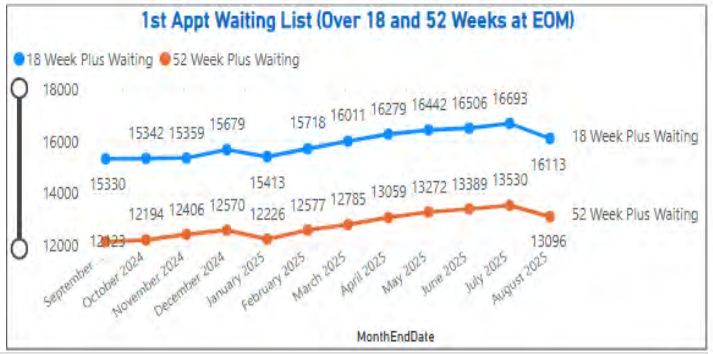
	Successes	Challenges
Safe	• The GIC team has launched a major PSII project reviewing all referrals to the surgical hub, following a pattern of complaints with similar themes. We take this very seriously. • The number of patients waiting for their first appointment decreased from 18,332 to 17,839, a reduction of 493 compared with the previous month. • Adult Psychotherapy has suspended treatment for two patients seeking to use political slurs and aggression to 'cancel' each other's politics in a group session.	• Balancing the need for CIP with equality impact on service delivery, safety and care. • We want to be able to safely offer appointment to GIC forensic patients on site. • Security on the third floor GIC corridor requires review with options brought to ELT for decision making. • Risk assessment regarding having phones in the clinical rooms is in progress but slowly, this is an urgent and outstanding action, but phone lines have not been activated.
Effective	• GIC recovery plan was completed and submitted for approval, focusing on waiting time management, productivity, improve patient experience, reporting, clinical governance and workforce • The number of overall referrals declined in adult service for the first time since April 2025, There were 501 referrals in July and 393 in August, which is 107 fewer than the previous month. • Dr Doctor patient portal – initial training complete with trial use in September for improved access to booking & more direct communication with a large group of patients.	• Trauma waiting list communication to 500 patients regarding new criteria and updates brings pressure to the administrative team. • Clinical, operations and contracts are working together to optimize reporting requirements, reducing the number of separate reports required for small contracts and improving efficiency. • Adult Unit leads have identified there is variation in systems for reporting and monitoring sickness across units. Adult leads will explore this and identify most efficient option and socialise to the unit. • Dialog Outcome Monitoring lacks a 'risk' question which is a gap in global assessment of risk and care, it may be possible innovate
Caring	• GIC team recruited a QI lead for a fixed term contract to focus on QI project including implementation of Dr Doctor portal. • Portman clinic has taken steps towards a PPI / Co-production forum. • Positive feedback noted from caring individuals in ESQ and wider patient feedback, some clinicians would like to see personalised feedback which they find motivational.	• Clinical and Operational leads are encouraged to use ESR as the central system for reporting annual and sick leave, to ensure transparency and avoid duplication through local systems.
Responsive	• Trauma team reduced referrals, new criteria, clear pathway and waiting list reductions. • T&P engaged in an NLFT pathways meeting to review system partnerships and build relationships. • Portman – co-production / PPI group in development initially tasked with reviewing and constructing patient facing information.	• A review of all outstanding incidents is required to complete the actions in Radar • Vacancies and CIPs may contribute to clinicians reported time pressures when asked to investigate complaints, take on champion roles or assist with AARs or PSII investigations.
Well-Led	• Green Button alert reviewed in favour of a more immediate and audible solution and 3rd floor swipe access. • Staff are encouraged to take regular breaks by taking annual leave to support their health and well-being, as leave can not be carried over under the merger with the NLFT • Appriasal rates are improving.	• We are confident of clinical supervision is being conducted on a regular basis, however recording of attendances is consistently low there is a need for a QI approach with leadership within each service to identify causes and solutions. • Sickness in GIC is higher than we would expect and requires careful understanding. • Staff are encouraged to take the sessional vaccine for their well-being

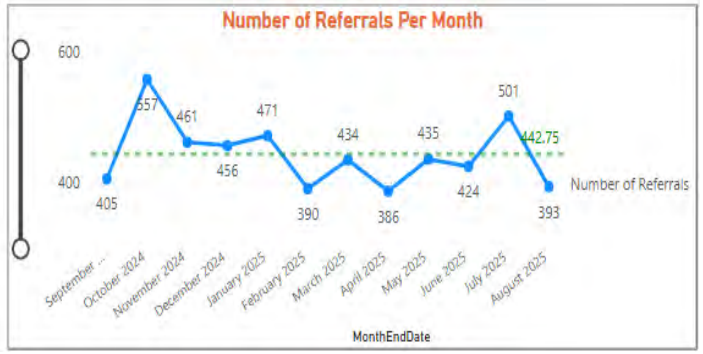
Adult Unit Overview – 2/2

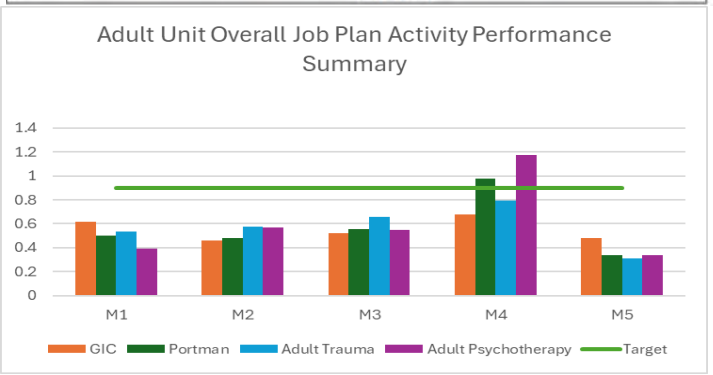
Activity Overview











Analysis

Waiting times and referrals were reduced during August according to predictable seasonal variation. This is due to holiday break times for some staff and some patients. The majority of adult activity outside of GIC is planned therapeutic interventions which includes forward planning for breaks in treatment, traditionally during seasonal holiday periods. Full duty and backup cover is provided during break times and patients are informed of the clinical model before commencing treatment..

Concern	Cause	Countermeasure
Unable to recruit to recurrent posts in trauma due to ERF costs for 1 yr only and not aligned to model.	ERF budgeted costs did not cover actual costs and due to no carry over to yr 2 our core budget has had to carry ERF staff costs.	We propose to slightly re-model the team structure in order to re-cycle sessions that will be vacated by staff into the new model, including the new D19 course which creates capacity for up to 30 patients to be seen.
GIC revised Workforce plan will be submitted by 19.09.25	It appears that 8a and above Psychologists with adequate Gender experience to supervise are limited in the London area.	

Next Steps.

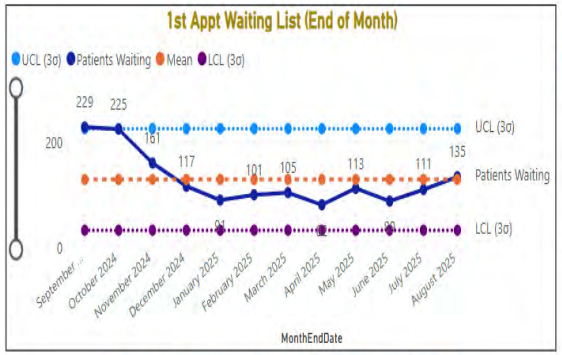
- **To agree a small core group meeting for optimisation and reduction of reporting complexity – clinical and operations in partnership with contracts.**
- **To ensure appraisal dates agreed and diarised by end of September for outstanding (including job planning and CDP) .**

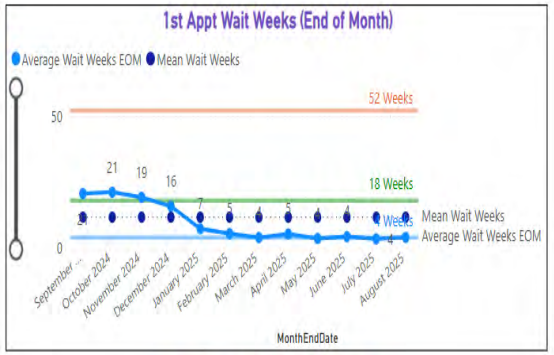
Child and Family Unit overview (1/2)

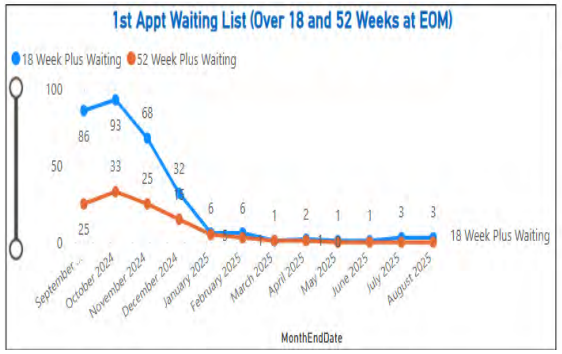
	Successes	Challenges
Safe	Unit mandatory training compliance has maintained performance level is at 86.83%. Meetings are diarised with TCLs and Ops Leads to plan the CQC self-assessments. Treatment waiting time in EDAS is down to 8.5 weeks.	19 outstanding Manager Reviews on incidents from past. There are currently 1,185 missing clinical notes for attended appointments in the unit. The leadership team have decided this requires urgent and focused attention under a **rapid improvement and recovery plan** and will be implementing this over the next few weeks.
Effective	In EDAS the 4-week wait was met in August for 71.43% of patients with the average wait for 1st appointment 3.29 weeks Waiting times; 186 patients waiting for 1st appointment which is an increase on 169 last month but the figure has remained under 200 this calendar year (314 a year ago). Average waiting time across the Unit of **4.52** weeks which is a significant reducing trajectory from 16.93 in January 2025. The number of referrals into the Unit has remains high compared to the previous year at 141 despite the usual August dip in numbers. 120 discharges in August which is the 4th highest of the last 12 months and shows an increasing overall trend.	The Unit is reporting 1 case breaching at 18 weeks. Appraisal rates in the Unit have increased slightly to 41.8% . List of outstanding and due appraisals have been distributed across teams again. Autism Assessment waiting times for 1st appointment has increased as has the number of patients waiting due to staffing vacancies. The number of cases waiting for 1st appointment is 45.
Caring	Ofsted rated Gloucester House school as 'Good'. We have been given a moving date of 3rd November for the school to new premises which would mean an increase in numbers. The Unit is showing a 2.33% sickness rate for August which is down from 3.69% in July.	Bounds Green Health Centre building and maintenance is a concern due to rodents, ligature risks and general maintenance, and these incidents have been reported. There has been a slight drop in the number of recorded clinical supervisions in the Unit in June at 54% in July (40% in June). Administrative staff supervision reporting has fallen to 67%.
Responsive	Haringey CWP proactive in reaching out to new referral resources in response to an overall decrease in demand. TCLs and Ops leads informed to carry out recovery plan on missing clinical notes and OMs. FCAMHS saw their highest number of referrals in the last 12 months at 20. Unit wide planning for CQC underway with all teams carrying out self analysis of areas for improvement.	There are 918 missing CGAS forms (compared to 919 missing last month) across the unit and over 1000 missing GBMs for the Unit. TCL's and Ops leads informed. . The Hertfordshire Commissioned pathway for Autims Assessment has not met its monthly targets due to delays to recruitment. Commissioners have been informed of the delays 14/09/2025.
Well-Led	Exit planning programme for Returning Families has now been implemented. An agreed approach and project plan set up with Home Office. Consultation launch forecast for November 2025. First Step + team gave a presentation to the Best Practice Forum of the IRCT at the House of Lords on 12th September which was well received, focussing on best practice models of mental health care for children in Care.	Surrey Mindworks service closes on 30/09/2025. Deliverables completed. Redundancy risks and likely stranded costs of £161,000 will impact on overall financial recovery plan. Gloucester House Outreach has a number of issues affecting its ability to be sustainable - discussions taking place re the financial viability of a vulnerable service. Additional potential stranded costs for Returning Families Autism Recovery project for Hertfordshire is not meeting its targets currently due to difficulties in recruiting to posts – ICB aware, however recovery plan is now required. .

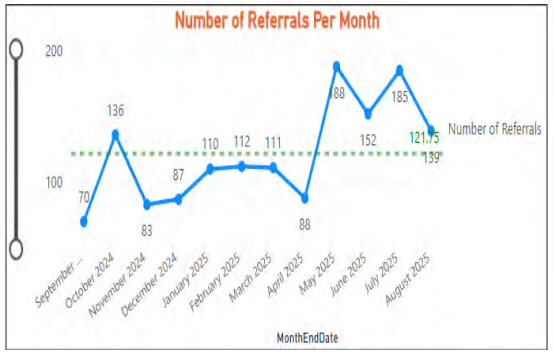
Child and Family Unit overview (2/2)

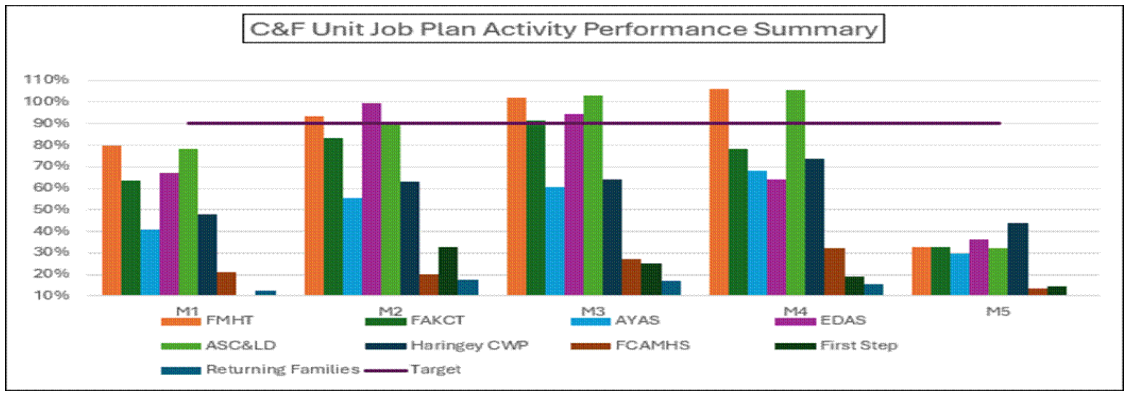
Activity Overview (Excluding FDAC Service)











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 – 767 clinical contacts for the Unit in August.

Job plan compliance: Job planning reviews still being completed in some teams. Activity against job plan is increasing overall but slowly - more progress is needed. TCLs of higher risk teams have been informed, and job planning continues.

Referrals: 139 referrals in the month indicating an ongoing trajectory of increase since May 2025.

Waiting times: 135 patients in total are waiting for a first appointment, 85 in the Clinical Services and x in the Autism Assessment pathway where the number of waiters has grown due to staffing absences. The average Waiting time for patients seen was at 4 weeks with a mean of 12 weeks. 3 patients have waited more than 18 weeks for their first appointment – 2 are from ASF awaiting contracts and 1 is on the Autism Assessment Pathway.
Treatment waiters : 764 (an increase of 30) young people are currently waiting for a specific clinical intervention including the Autism Assessment Pathway. Excluding Autism, 231 young people are waiting with an average waiting time of 3.42 weeks. This data set requires further validation over the forthcoming months.

RTT breaches at 18 weeks: 3 cases are breaching at 18 weeks – 2 are with the adoption support fund awaiting contract confirmation and one is in the Autism Assessment Pathway.

Dormant cases: the Unit is reporting 3 cases that have been dormant for 52 weeks, excluding Autism Assessment and all clinicians requested clinicians to review the files and ensure patients are either reviewed or files are closed.

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Concern	Cause	Countermeasure	Owner	Due Date
Activity and Job Planning	Some TCLs and Ops managers not overseeing plans against activity.	Job plans in place for all. Is a delay in implementing in some teams. A3 to be developed for any teams where activity is a concern	TR & SB	September 2025
Missing clinical notes, CGAS & GBM forms	Unknown as yet	Recovery plan. TCLs and Ops leads informed - clinicians to be identified.	TR & SB & TC	End of October

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: Review of Committee Terms of Reference 2025/26			**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: Education and Training Committee Revised Terms of Reference Appendix 2: Executive Appointment and Remuneration Committee Revised Terms of Reference Appendix 3: People, Organisational Development, Equality, Diversity, and Inclusion Committee Revised Terms of Reference Appendix 4: Performance, Finance and Resources Committee Revised Terms of Reference Appendix 5: Integrated Audit and Governance Committee Revised Terms of Reference Appendix 6: Quality and Safety Committee Revised Terms of Reference		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This report provides the Board with the revised Terms of Reference (ToR) of the six Board Committees for ratification following approval by the Committees.		
Background:	**Terms of Reference (ToR):** The ToR of Board Committees should be reviewed annually to ensure they are operating at maximum effectiveness; and any proposed changes presented to the Board of Directors for approval. The latest versions of the Board Committee Terms of Reference were approved by the Board in November 2024.		
Assessment:	All Board Committees received and approved the proposed revisions to their ToR; and made recommendations to the Board of Directors for ratification. **Cross Committee summary of key changes:** • Required attendees – removal of Associate NED as this role is no longer applicable. Previous Associate NED has been made a full NED from 1 September. • Membership and Quorum – reduction of NED membership (for some Committees) from three to two; and reduction of quoracy from two to one due to recent changes in Board composition. • Committee governance structure – updated to reflect current arrangements.		
Key recommendation(s):	The Board is asked to **APPROVE** the revised Terms of Reference of the six Board Committees attached as appendices 1 – 6 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 ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All BAF risks – as these are assigned to the Committees.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Board of Directors established the Committees in accordance with the Trust's Constitution. The Terms of Reference of the Committees should therefore be read in conjunction with the Trust's constitution. Proposed changes to the Terms of Reference of Committees are required to be presented to the Board of Directors for approval.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐			
	POD EDI Committee: The Terms of Reference of the Committee include the Committee's oversight and assurance responsibility for the Trust's Equality, Diversity, and Inclusion strategy, plans and delivery. Quality and Safety Committee: The Terms of Reference of the Committee support the focus on quality impact assessments. This will ensure due regard is had to the elimination of unlawful discrimination and promotion of equality of opportunity. Executive Appointment and Remuneration Committee: The Terms of Reference of the Committee include the Committee's appointment role by ensuring that the Trust is compliant with all relevant standards of good practice including those relating to equality, diversity, and inclusion. Education and Training Committee: The Terms of Reference of the Committee include the Committee's oversight responsibility for EDI matters for the Department of Education and Training.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					

Assurance Route - Previously Considered by:	• Quality and Safety Committee – 17 April 2025 and 23 October 2025. • People, Organisational Development, Equality, Diversity, and Inclusion Committee – 6 November 2025. • Performance Finance and Resources Committee – 3 November 2025. • Education and Training Committee – 3 September 2025. • Integrated Audit & Governance Committee – 3 September 2025. • Executive Appointment and Remuneration Committee – Chairs action (18 October 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

Education and Training Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Chief Education and Training Officer
Date issued:	November 2025 v 0.4
Review date:	November 2026

Education and Training Committee
Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal committee of the Board to be known as the Education and Training Committee ("the Committee"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to oversee the implementation of strategies relating to the provision of Training and Education (including research and development) services and to ensure resources are sufficiently aligned/ allocated to enable delivery and future development to ensure achievement of strategic aims and objectives.

2.2. The Committee will also provide assurance to the Board that appropriate and effective governance mechanisms are in place to ensure the provision of high-quality education and training services and that requisite standards are met.

3. OBJECTIVES

The principal duties of the Committee are set out below:

3.1. To consider and resolve strategic issues relating to training and education and its interface with other areas of the work of the Trust.

3.2. To oversee plans for the development of our training and education activities including student recruitment, portfolio development and new business development.

3.3. To oversee plans for the development of digital education and transnational education by the Trust.

3.4. To have oversight of strategic relationship with our University Partners.

3.5. To review key metrics relating to the financial and operational performance of training and education.

3.6. To regularly review education and training related risks within the Board Assurance Framework and the Corporate Risk Register for which the Committee is deemed to have oversight; and seek assurance that effective controls are in place to mitigate such risks.

3.7. To have oversight of issues on the interface between training and education and other activities of the Trust.

3.8. To have oversight of the Annual Student Survey process and enhancement of student experience.

3.9. To have oversight of fundraising and utilisation of the bursary fund within the Department of Education and Training.

3.10. To have oversight of compliance with Office for Standards (OfS) regulations and scrutinise related compliance reports, ensuring that actions are taken to address all issues identified in the compliance reports.

3.11. To have oversight and review of all matters relating to equality, diversity and inclusion in the Department of Education and Training.

3.12. To have oversight of the Trust's research and development activities.

Other:

3.13. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

4.1.1. Non-Executive Directors x 2 (one designated Chair)

4.1.2. Chief Education and Training Officer and Dean of Postgraduate studies

4.1.3. Interim Joint Chief Medical Officer x 1

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Director of Corporate Governance or representative
- Director of Education, Learning & Teaching
- Director of Education, Operations
- Director of Education (Governance and Quality)
- Senior Finance Business Manager
- Associate Director of Nursing
- Director of Research & Development

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair, Vice Trust Chair and Chief Executive Officer to attend.

4.4. The Committee will be open to nominated members of the Council of Governors (including the Student Governor) attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

4.5. At the discretion of the Committee Chair, other persons (Trust managers and staff, and other interested persons) may be invited to attend and participate in Committee meetings. However, only members of the Committee have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.6. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

4.7. If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends, they must be able to fully participate in the meeting but will have no voting rights).

4.8. Attendees who are deputising for members and/or required attendees must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

Voting:

4.9. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. This shall be a minimum of one Executive Director and one Non-Executive Director.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet on a bi-monthly basis. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee will report to the Board of Directors with an update on its activities.

7.2. The minutes of Committee meetings shall be formally recorded, and an assurance report will be drafted by the Lead Executive on behalf of the Chair to be submitted to the next available Board meeting. This assurance report will draw attention to the Board any issues requiring disclosure or action.

8. SOURCES OF INFORMATION

8.1. The Committee will receive and consider sources of information from any individual or department relevant to the case under consideration.

9. AUTHORITY

9.1. The Committee has the authority to establish groups (including task and finish groups).

9.2. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

9.3. The Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.4. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. SERVICING ARRANGEMENTS

10.1. The administration of the meeting shall be supported by member of the Corporate Governance team (Committee Secretary) who will draft agendas, arrange to take minutes of the meeting, create and chase actions in the action log and provide other appropriate administrative support to the Chair and Members.

10.2. Meetings of the Committee will be called by the Committee Chair. The agenda will be approved by the Committee Chair prior to circulation.

10.3. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time if possible. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

10.4. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

10.5. The Committee Chair's assurance report will be submitted to the Board following each meeting.

10.6. The Committee will maintain an Annual Schedule of Business that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. RELATIONSHIPS WITH OTHER COMMITTEES/ GROUPS

11.1. The Committee will receive assurance reports from the following meetings:

- Academic Governance and Quality Group
- Learning and Teaching Group
- Student Experience Group
- Research and Development Group

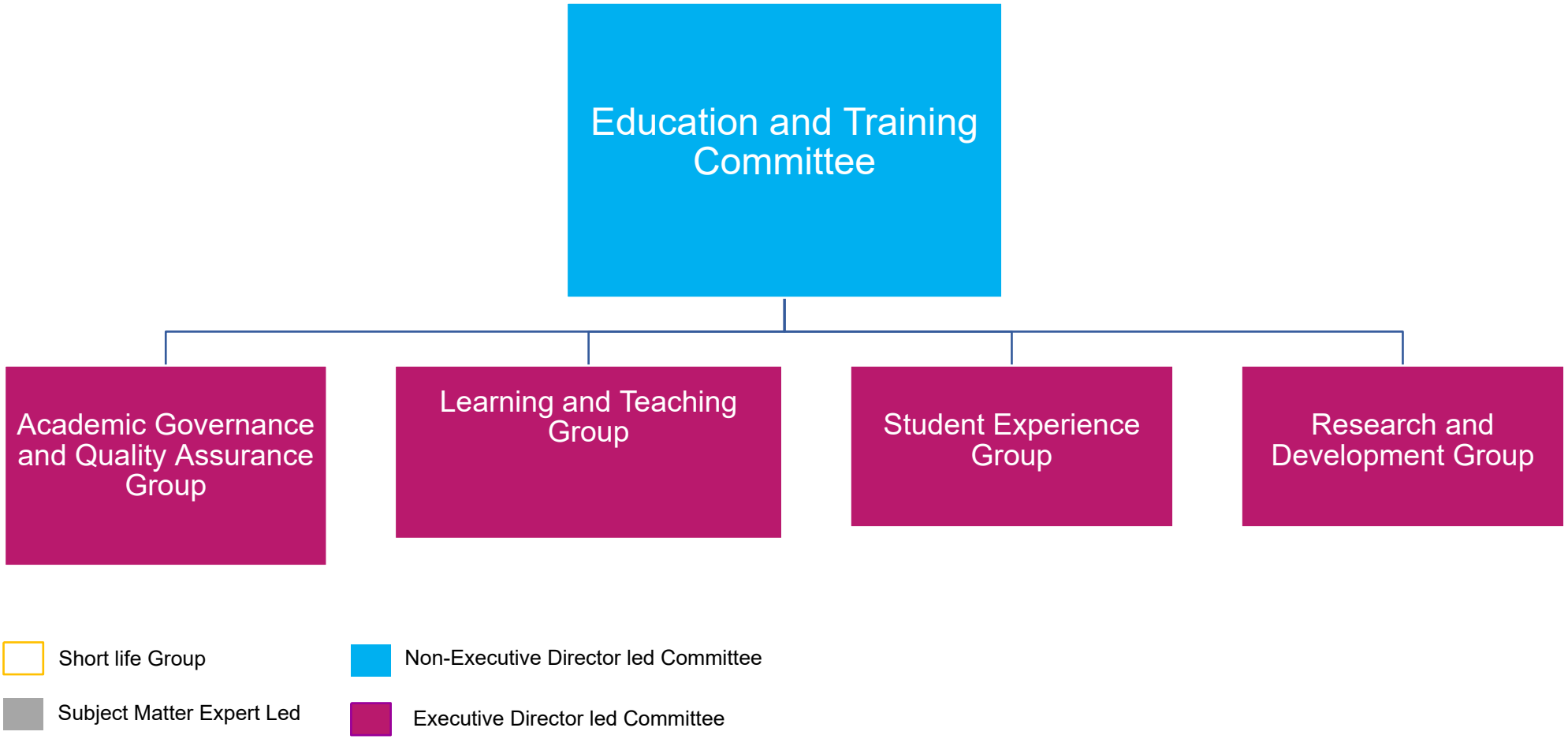
11.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

11.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board committee terms of reference.

12. MONITORING EFFECTIVENESS AND REVIEW

12.1. At least once a year the Committee will review its own performance against its terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

Appendix 1 – Education and Training Committee Governance structure



The Tavistock and Portman NHS Foundation Trust

Executive Appointment and Remuneration Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Director of Corporate Governance
Date issued:	November 2025 v 0.4
Review date:	November 2026

Executive Appointment and Remuneration Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors **("Board")** hereby resolves to establish a standing committee to be known as the Executive Appointment and Remuneration Committee ("**the Committee**"). This Committee has no executive powers other than those delegated in these terms of reference.

2. PURPOSE

2.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the board and for determining their remuneration and other conditions of service.

2.2. The Executive Appointment and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for Executive Directors described in the Trust's constitution and the Code of Governance of NHS Provider Trusts.

2.3. The Committee's Executive Appointments role aims are to:

- Ensure effective recruitment processes for Executive Director positions.
- Make effective appointment decisions that are based on robust assessment evaluations and a fair, equitable and transparent process.
- Seek assurance the Trust is compliant with all relevant standards of good practice including those relating to equality, diversity and inclusion.

2.4. The Committee's Remuneration role aims to ensure that the Trust has a remuneration policy that is sufficient to attract, retain and award individuals with the right skills and experience and this policy is sufficiently competitive in the wider employment market.

3. OBJECTIVES

The principal duties of the Committee are set out below:

Remuneration Role:

The Committee will:

3.1. Establish and keep under review a remuneration policy in respect of Executive Board Directors.

3.2. Approve the design of, and determine targets for, any performance-related pay schemes operated by the Trust.

3.3. Consult the Chief Executive Officer about proposals relating to the remuneration of the other Executive Directors.

3.4. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors and Senior Managers on locally-determined pay, including:

3.4.1 Salary, including any performance related pay or bonus;

3.4.2 Provisions for other benefits, including pensions and cars;

3.4.3 Allowances;

3.4.4 Payable expenses;

3.4.5 Compensation payments.

3.5. In adhering to all relevant laws, regulations and Trust policies:

3.5.1 establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

3.5.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors (and senior managers on locally-determined pay), while ensuring that increases are not made where trust or individual performance do not justify them;

3.5.3 be sensitive to pay and employment conditions elsewhere in the Trust.

3.6. Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

3.7. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments to avoid rewarding poor performance.

3.8. Approve redundancy payments of £100,000 or more.

Appointments Role

The Committee will:

3.9. Regularly review the structure, size and composition (including the balance of skills, knowledge and experience on the board, and its diversity), making use of the output of board evaluation processes as appropriate, and make recommendations to the Board, and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.

3.10. Give full consideration to and make plans for succession planning for the Chief Executive Officer and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

3.11. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

3.12. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

3.13. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

3.14. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

3.15. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.16. In order to ensure that poor performance is not seen to be rewarded, carefully consider what compensation commitments (including pension contributions) the Directors' terms of appointment would give rise to in the event of early termination. Contracts should allow for appropriate claw back provisions to be considered in case of a Director returning to the NHS within the period of any putative notice.

3.17. Ensure that a proposed Executive Director is a "Fit and Proper Person" as defined under the regulation under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and meets the Fit and Proper Person Requirements as described in the NHS England Fit and Proper Person Test Framework for Board Members.

3.18. Consider the re-appointment of any Executive Director at the conclusion of their term of office (if applicable) having given due regard to their performance and ability to continue to contribute to the Board of Directors in the light of the knowledge, skills and experience required.

3.19. Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Other:

3.20. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

4.1.1. The Committee comprises the Trust Chair and all Non-Executive Directors of the Trust.

4.1.2. The Trust Senior Independent Director (SID) shall Chair the Committee.

Attendance by Other Officers or Individuals:

4.2. Only members of the Committee have the right to attend Committee meetings, and the authority to vote and determine decisions on behalf of the Committee.

4.3. At the invitation of the Committee, meetings shall normally be attended by the:

4.3.1. Chief Executive Officer

4.3.2. Chief People Officer

4.3.3. Director of Corporate Governance

4.4. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

4.5. Any non-member, including the Committee Administrator, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Voting:

4.6. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. Business will only be conducted if the meeting is quorate. The Committee will be quorate with four members present.

5.2. If the meeting is not quorate the meeting can progress if those present, determine. However, no business shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet as required, but at least twice in each financial year. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee is accountable to the Board of Directors.

7.2. The minutes of Committee shall be formally recorded, and an assurance report will be drafted by the Lead Executive on behalf of the Chair to be submitted to the next available Board meeting. This assurance report will draw attention to the Board any issues requiring disclosure or action.

7.3. The Committee will prepare and submit an annual report of the Trust's remuneration practices that will form part of the Trust's Annual Report and ensure each year that it is put to Members at the Annual General Meeting.

7.4. The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

8. SOURCES OF INFORMATION

8.1. The Committee will receive and consider sources of information relating to NHS remuneration, provided by the Chief People Officer or from other sources as required.

9. AUTHORITY

9.1. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

9.2. The Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.3. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

10. SERVICING ARRANGEMENTS

10.1. The Committee will be supported by a member of the Corporate Governance team (Committee Administrator).

10.2. Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Administrator and approved by the Committee Chair prior to circulation.

10.3. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time.

10.4. The Committee Administrator will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

10.5. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

The Tavistock and Portman NHS Foundation Trust

People, Organisational Development, Equality, Diversity and Inclusion Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Chief People Officer
Date issued:	November 2025 v 8.0
Review date:	November 2026

People Organisational Development, Equality, Diversity and Inclusion Committee (POD EDI)

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("**Board**") hereby resolves to establish a formal committee of the Board to be known as the People, Organisational Development, Equality, Diversity and Inclusion Committee ("**POD EDI Committee**"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

2. PURPOSE

2.1. The POD EDI Committee is the primary Board committee for providing assurance and raising any concerns to the Board about delivery of the people related duties listed below.

2.2. The POD EDI Committee will give attention and scrutiny to the Health and Wellbeing of the Trust's People.

2.3. The POD EDI Committee will ensure that due attention and scrutiny is given to the oversight and assurance on the Trust's Race Equality and broader Equality, Diversity, and Inclusion strategy, plans and delivery.

2.4. The Chair of the POD EDI Committee will provide an assurance report to the Board after each meeting.

2.5. The POD EDI Committee will take responsibility for the risks pertinent to the people agenda as described in the Board Assurance Framework (BAF).

2.6. The Committee will be serviced by four primary operational delivery groups noted in Appendix 1.

2.7. The Committee will have close links to the staff diversity network groups which will be advisory to the Committee and will be routes for engagement and consultation as well as providing contributions to Committee assurance. The Staff network groups will be invited to assist in organisational agenda setting, undertake environment scanning, intelligence and idea generation.

3. OBJECTIVES

The principal duties of the Committee will be to provide the Board with independent and objective assurance in relation to:

3.1. National People Plan Promises (PPP):
- (a) Team working
- (b) Flexible working
- (c) Learning & Development
- (d) Health and Wellbeing
- (e) Speaking up and listening
- (f) Recognition and Reward
- (g) Compassion and inclusivity

3.2. Trust People Plan

3.3. Race Equality Strategy (RES) and Race Action Plan (RAP)

3.4. Equality, Diversity and Inclusion Strategy and Action Plan

3.5. Staff Health and Wellbeing

3.6. Trust Workforce plans (including succession planning and talent management)

3.7. Metrics and reporting:
(a) The Trust's workforce performance and sustainability indicators (including but not limited to, sickness absence, training, appraisal, employee relations, people practices and bank, EDI, interim and agency usage and expenditure, recruitment activity and checks and establishment control processes) and any necessary corrective plans and actions.
(b) The effective identification and mitigation of workforce and organisational development risks
(c) The HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
(d) CQC / Ofsted/ OFS people related regulatory requirements and reporting

3.8. Oversight of regulatory framework:
(a) Meeting legal and regulatory requirements in relation to the workforce (such as WRES, WDES and Gender Pay Gap).

3.9. External drivers and opportunities:
(a) National reports and best practice relating to workforce and organisational development.

3.10. Other:
(a) To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

- Non-Executive Director (Chair)
- Non-Executive Director (x 1)
- Chief People Officer or Representative (Lead Executive)
- Chief Nursing Officer
- Chief Education and Training Officer

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Staff side Representative
- Deputy Chief People Officer
- Head of Culture and Inclusion
- Staff Diversity Network Chairs (on rotation)
- Director of Corporate Governance or representative

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair and Chief Executive Officer to attend.

4.4. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

4.5. Other staff may be invited to attend meetings as considered appropriate on an ad-hoc basis.

4.6. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.7. Members are expected to attend at least 75% of meetings annually and be allowed to send a Deputy to one meeting per annum. An annual register of attendance of members will be published by the Committee.

4.8. The Committee is focussed on the staff of the Trust and notes the NHS Patient Experience Improvement Framework and the positive impacts on patient care that is made by engaged staff. The Committee does not include Patient or student representatives as the interests of these groups are represented elsewhere in the Trust governance.

4.9. Associate members: The Committee will accept associate members of its main membership in order to enable development of Trust leaders and where this can be used to increase committee diversity.

Voting

4.10. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. GROUPS

5.1. The POD EDI Committee has the authority to establish groups (including task and finish groups).

6. QUORUM

6.1. This shall be a minimum of one Non-Executive Directors and one Executive Director.

6.2. Business will only be conducted if the meeting is quorate. If the Trust Chair is in attendance, this will count towards the quorum.

6.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee

7. CHAIR

7.1. The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, another Non-Executive Director will take on the chairing of the Committee.

8. FREQUENCY

8.1. The Committee shall meet up to 6 times per annum, normally two weeks before the Board meeting. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

9. ACCOUNTABILITY AND REPORTING

9.1. The POD EDI Committee shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

9.2. The minutes of the Committee will be available to the Board on request.

9.3. The POD EDI Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit or where action or improvement is needed.

9.4. The Committee will report on its activities at least once a year to the Board to fulfil the requirements set out in the Equality Act 2010 (Specific Duties) Regulations 2011.

9.5. The Chair shall attend the Annual Members' Meeting (AMM) and be prepared to respond to any questions on the Committee's activities.

10. AUTHORITY

10.1. The POD EDI Committee is authorised by the Board to instigate any activity within its terms of reference.

10.2. It is authorised to seek information it requires from any staff, and to call any staff to attend a meeting as and when required.

10.3. All staff are directed to co-operate with any request made by the POD EDI Committee.

10.4. The POD EDI Committee is authorised to obtain outside legal advice or other professional advice at the Trust's expense, and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10.5. The POD EDI Committee is authorised to establish standing groups in order to deliver its purpose.

10.6. The POD EDI Committee is authorised to establish limited life task and finish groups in order to deliver its purpose.

11. SOURCES OF INFORMATION

11.1. The POD EDI Committee will receive and consider sources of information from any relevant individual or department.

12. SERVICING ARRANGEMENTS

12.1. The administration of the meeting shall be supported by member of the Corporate Governance team (Committee Secretary) who will draft agendas, arrange to take minutes of the meeting, create and chase actions in the action log and provide other appropriate administrative support to the Chair and Members.

12.2. Meetings of the Committee will be called by the Chair. The agenda will be drafted by the Committee Secretary and approved by the Chair prior to circulation.

12.3. Notification of the meeting, location, time, and agenda will be forwarded to members, and others called to attend, at least seven days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance, then they will be forwarded to Members at the same time as the agenda.

12.4. The agenda will be clearly split at each meeting to ensure that appropriate Committee time is given to both general people matters and EDI and race matters.

12.5. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the POD EDI Committee, including recording names of those present and in attendance.

12.6. The POD EDI Committee Chair's assurance report will be submitted to the Board following each meeting.

12.7. The Committee will maintain an Annual Schedule of Business that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

13. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

13.1. The Committee will receive assurance reports from the following POD EDI group meetings (see Appendices 1 and 2 for the POD EDI Governance Structure charts):

- EDI Programme Board
- People and Organisational Development Delivery Group
- Staff Experience Programme Board

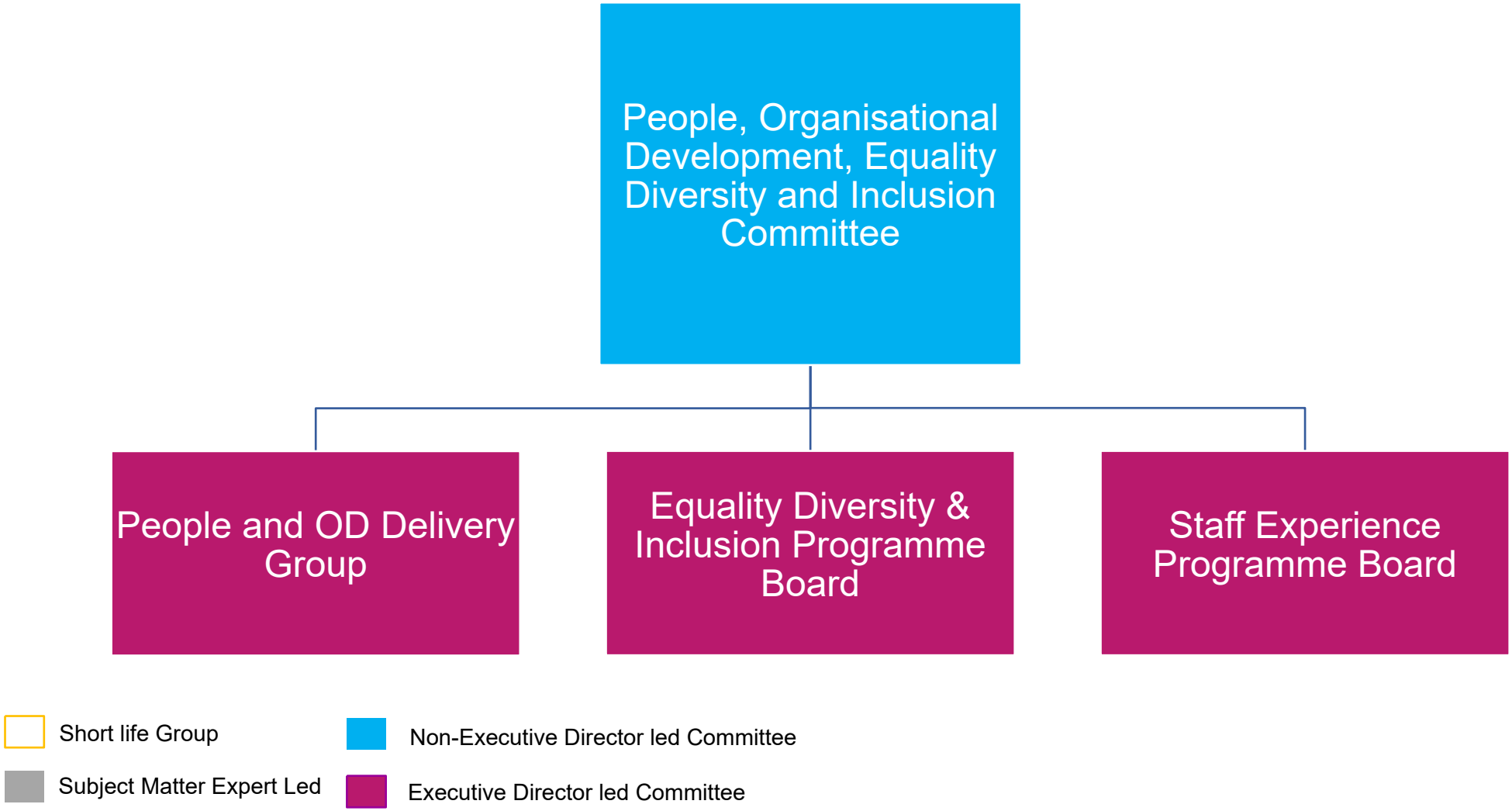
13.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

13.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board committee terms of reference.

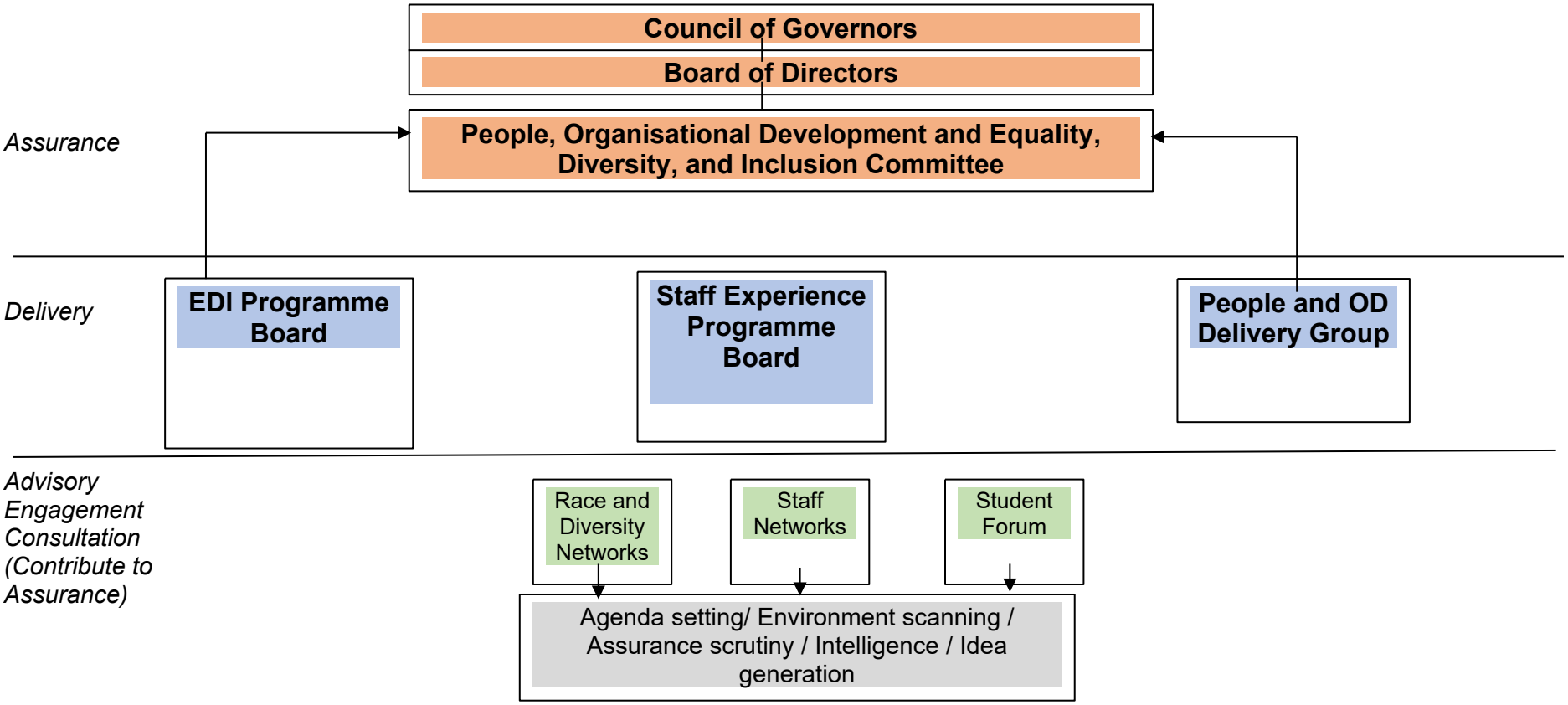
14. MONITORING EFFECTIVENESS AND REVIEW

14.1. At least once a year the POD EDI Committee shall review its own performance against its terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

Appendix 1 – POD EDI Governance structure



Appendix 2 - **Relationship with other Assurance, Advisory and Operational Groups and Committees**



The Tavistock and Portman NHS Foundation Trust

Performance, Finance and Resources Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Chief Finance Officer / Director of Strategy and Business Development
Date issued:	November 2025 v 4.0
Review date:	November 2026

Performance, Finance and Resources Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") of The Tavistock and Portman NHS Foundation Trust ("Trust") hereby resolves to establish a formal committee of the Board to be known as the Performance, Finance and Resources Committee ("Committee"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to maintain an overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. In addition to overseeing the financial and operational performance of the Trust, and receiving appropriate assurances from Executive Directors.

2.2. In particular, the Committee will seek assurance that finances, workforce and other resources are being used in an effective and efficient manner and that this is reflected in operational activity.

2.3. As part of its oversight and assurance of these matters, the Committee will:

a. Consider relevant financial and operational strategies, prior to submission to the Board for approval;

b. Review risks associated with the strategies defined in and their mitigation;

c. Consider finance and other relevant reports;

d. Approve business cases with delegated authority from the Board, in accordance with the Trust's Standing Financial Instructions ("SFIs") and Scheme of Delegation ("SoD");

e. Review progress against the delivery of business plans previously approved by the Committee;

f. Oversee the development of specific financial plans as may from time to time be required by NHS England (NHSE) including financial recovery plans, and other financial undertakings;

g. To consider the impact of the Integrated Care System plans on the Trust;

h. Review and monitor financial plans and their link to operational performance;

i. Ensure that there is good triangulation between financial, performance, quality and safety and workforce plans;

j. Oversee financial risk evaluation, measurement and management;

k. Oversee the capital programme;

l. Maintain oversight of the finance function, key financial policies and other financial issues that may arise;

m. Maintain oversight of the Trust's performance against the contract activity plan;

n. Maintain oversight of the Trust's performance across its clinical, education and training and corporate activities;

o. Escalate appropriate matters to the Board.

3. SCOPE

3.1. The Committee's work will be focused on testing the robustness of assurances received that finances and resources (notably, but not exclusively, workforce resources) of the Trust are utilised to achieve effective and efficient operational performance across clinical, education and training and corporate activities.

4. OBJECTIVES

The principal duties of the Committee are set out below:

Financial Strategy and Performance

4.1. To consider the Financial Strategy, ensuring that the financial objectives are consistent with the Trust's strategic direction and quality priorities.

4.2. To review and consider the annual revenue and capital budgets, in-year reforecasts, and longer-term financial plans of the Trust before their submission to the Board for approval.

4.3. To review and monitor annual operational plans including performance of efficiency targets and savings plans.

4.4. To review key medium term planning assumptions.

4.5. To monitor the achievement of the financial strategy, and financial targets; associated activity targets and how these relate to the performance of the Trust in non-financial domains such as patient safety and effectiveness.

4.6. To monitor productivity, cost improvement and savings targets.

Operational Performance

4.7. To scrutinise the Trust's operational performance across its clinical, education and training and corporate activities (noting that the primary responsibility for the scrutiny of education and training operational performance is held by the Education and Training Committee).

4.8. In scrutinising the operational performance of the Trust's clinical services attention will be paid, in particular, to levels of activity (including clinician productivity), waiting lists, patient outcomes and compliance with contractual requirements, together with other key relevant measures / performance indicators.

4.9. In scrutinising the operational performance of the Trust's corporate services, the Committee shall focus its attention on the following functional areas:

a. Finance, Contracts and Procurement

b. Estates and Facilities (including Health & Safety)

c. Information Management and Technology

d. General Data Protection Regulation (GDPR); and Cyber Security

e. Human Resources.

4.10. To support and oversee the development of a revised Integrated Quality Performance Report (IQPR).

Operational Strategies and Business Case consideration

4.11. The Committee shall scrutinise, consider and, if appropriate, recommend relevant operational strategies prior to submission to the Board for approval.

4.12. The Committee shall scrutinise, consider and, if appropriate, approve business cases, in accordance with the Trust's SFIs and SoD.

4.13. The Committee shall receive regular updates on the progress of business cases which it has approved.

4.14. The Committee shall review the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

Risk Management

4.15. At each meeting the Committee shall consider the risks associated with the strategies and business plans which it has approved together with reviewing the risks within the Board Assurance Framework and the Corporate Risk Register for which the Committee is deemed to have oversight.

Other

4.16. To review proposals for land and property development and / or other transactions prior to submission to the Board of Directors, in line with the Trust's SFIs and SoD.

4.17. To oversee the Trust's cash management policies in line with NHSE guidance on Managing Operating Cash.

4.18. To oversee arrangements for outsourced financial functions.

4.19. To undertake any other tasks delegated to the Committee by the Board.

5. MEMBERSHIP AND ATTENDANCE

Members:

5.1. Membership of the Committee shall be as follows:

- Non-Executive Directors x 3 (one designated Chair and one designated Deputy Chair)
- Chief Finance Officer (Joint Executive Lead)
- Director of Strategy and Business Development (Joint Executive Lead)

5.2. If members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Required Attendees:

5.3. The following staff will be required to attend meetings of the Committee:

- Director of Corporate Governance or representative
- Director of Education (Operations)
- Deputy Chief Finance Officer

Attendance by Other Officers or Individuals:

5.4. The Committee will be open to the Trust Chair; Vice Chair; and Chief Executive Officer to attend.

5.5. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

5.6. The Committee may also invite other senior officers of the Trust and specialist advisors (internal or external) to present papers on an ad-hoc basis.

5.7. Attendees hold no voting rights.

5.8. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

5.9. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

Voting:

5.10. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

6. QUORUM

6.1. A quorum for the Committee shall be three members, to include at least two Non-Executive Directors and at least one Executive Director of the Board.

6.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

6.3. If the meeting is not quorate the meeting can progress if those present, determine. However, no business shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

7. FREQUENCY

7.1. The Committee shall meet six times per financial year. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

8. ACCOUNTABILITY AND REPORTING

8.1. The minutes of Committee meetings shall be formally recorded.

8.2. A Chair's assurance report will be submitted to the next available Trust Board meeting. This summary will also draw attention to the Board any issues requiring disclosure or action.

9. AUTHORITY

9.1. The Committee has the authority to establish groups (including task and finish groups) as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

9.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

9.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

10. SERVICING ARRANGEMENTS

10.1. The Committee shall be supported administratively by a member of the Corporate Governance Team (Committee Secretary) whose duties in respect of this include:

a. Calling of meetings
b. Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
c. Ensuring that those invited to each meeting, attend
d. Taking the minutes and helping the Chair to prepare reports to the Board
e. Keeping a record of matters arising and action points to be carried forward between meetings
f. Arranging meetings for the Chair
g. Advising the Committee on pertinent issues/areas of interest/policy developments

10.2. The Committee will maintain an Annual Schedule of Business that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

11.1. The Committee will receive assurance reports from the following group meetings (see Appendix 1 for the Committee's Governance Structure chart).

11.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

11.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board committee terms of reference.

12. MONITORING EFFECTIVENESS AND REVIEW

12.1. The Committee will undertake an annual effectiveness evaluation against its Terms of Reference and Membership, the outcome of which will be reported to the Board in accordance with the Annual Business Cycle.

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Appendix 1 – Performance, Finance and Resources Committee Governance Structure

The Tavistock and Portman NHS Foundation Trust

Integrated Audit and Governance Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Director of Corporate Governance
Date issued:	November 2025 v 9.1
Review date:	November 2026

Integrated Audit and Governance Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("**Board**") hereby resolves to establish a formal committee of the Board to be known as the Integrated Audit and Governance Committee ("**Committee**"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board on its work in support of the Annual Report, Quality Account, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, and the completeness of risk management arrangements. Its key responsibilities are to:

2.1.1 monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;

2.1.2 review the Trust's internal controls (clinical and financial) and risk management systems;

2.1.3 review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;

2.1.4 make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;

2.1.5 develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;

2.1.6 monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;

2.1.7 approve the appointment and/or removal of the internal auditors;

2.1.8 report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;

2.1.9 review arrangements by which staff within the Trust may speak-up /raise confidential concerns over financial control and reporting, clinical quality and patient safety and other matters.

3. OBJECTIVES

The principal duties of the Committee are set out below:

Integrated Governance, Risk Management and Internal Control

3.1. The Committee will review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's strategic objectives. In particular, the Committee will review the adequacy of:

3.1.1 All risk and control-related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

3.1.2 The structures, processes and responsibilities for identifying and managing key strategic risks facing the organisation;

3.1.3 The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance;

3.1.4 Any significant audit adjustments and changes in accounting policies and practices;

3.1.5 The policies and procedures for all work related to fraud and corruption as required by current legislative bodies;

3.1.6 The Board Assurance Framework in identifying the Trust's strategic objectives and the assurances required to evidence control of the financial risks to their achievement.

3.1.7 Arrangements for the oversight of procurement and non-pay spend.

3.1.8 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud Specialists and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

3.2. The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors, by the:

3.2.1. Determination of the specification for an internal audit service through the procurement process to identify a provider and make a recommendation to the Board of Directors for their appointment; including any questions of resignation and dismissal;

3.2.2. Review and approval of the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Board Assurance Framework and co-ordination with the work of external audit;

3.2.3. Consideration of the major findings of internal audit work and management responses. In the case of limited assurance audit reviews, the Committee may request attendance of the appropriate director in whose portfolio the actions sit in order to provide assurance;

3.2.4. Where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the Committee for approval;

3.2.5. Monitor and review of the effectiveness of the internal audit function on an annual basis;

3.2.6. The Head of Internal Audit will have unhindered and confidential access to the Chair of the Committee

3.3. External Audit

3.3.1. Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance;

3.3.2. Report to the Board of Directors identifying any matters where action or improvement is needed and making recommendations for action;

3.3.3. Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements;

3.3.4. Discuss with external audit, the main issues and parameters for audit planning in preparation for the Annual Audit Plan;

It is the role and responsibility of the Council of Governors to appoint, or remove, the external auditor.

The Committee will:

3.3.5. Develop and agree with the Council of Governors, the criteria for the appointment, re-appointment and removal of the external auditors;

3.3.6. Make recommendations to the Council of Governors in relation to the above;

3.3.7. Approve the remuneration and terms of engagement of the external auditor;

3.3.8. The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

3.3.8.1. consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.

3.3.8.2. review and agree, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan.

3.3.8.3. discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

3.3.8.4. review of all audit reports that are specifically drawn to the attention of the Committee by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.3.8.5. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

3.3.8.6. The External Audit (Partner) will have unhindered and confidential access to the Chair of the Committee.

3.4. Counter Fraud Services

3.4.1. The Committee will ensure that there is an effective counter fraud function that meets the NHS Counter Fraud Authority (NHSCFA) requirements, and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors, by the:

3.4.1.1. Determination of the specification for a counter fraud service through the procurement process to identify a provider and make a recommendation to the Board of Directors for their appointment;

3.4.1.2. Review and approval of the annual counter fraud plan, ensuring that there is consistency with the potential risks and needs of the organisation;

3.4.1.3. Receipt of quarterly reports on the work of the counter fraud service in the delivery of the annual plan;

3.4.1.4. Receipt of reports on referrals to and the outcome of investigation carried out by the counter fraud service, including assurance on the actions taken against perpetrators and additional controls recommended to avoid recurrence;

3.4.2. The Committee will also receive and review the Trust's Counter Fraud Functional Standard Return (CFFSR) and monitor the implementation of any actions arising from requirements where the Trust is rated as non-compliant or partially compliant either through this return or following NHSCFA quality assessment activity.

3.4.3. Monitor and review of the effectiveness of the counter fraud service.

3.5. Financial Reporting

3.5.1. Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements. In doing so, the Committee shall additionally utilise the findings of the Performance, Finance and Resources Committee;

3.5.2. The Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

3.5.2.1. changes in, and compliance with, accounting policies and practices and estimation techniques;

3.5.2.2. major judgmental areas;

3.5.2.3. significant judgements in the preparation of the financial statements;

3.5.2.4. significant adjustments resulting from the audit;

3.5.2.5. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

3.5.2.6. letters of representation;

3.5.2.7. explanations for significant variances;

3.5.2.8. unadjusted misstatements in the financial statements.

3.5.3. The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.6. Partnerships / Joint ventures

3.6.1. The Committee will ensure that suitable and sufficient governance arrangements are in place between the Trust and any partner(s) to ensure that the Trust's legislative, financial, operational and reputational interests are protected. This will include reviewing legal or formal documentation or falls within the remit of the NHSE Transaction guidance.

4. MEMBERSHIP AND ATTENDANCE

Membership:

4.1. The membership of the Committee will be confined to Non-Executive Directors only, not including the Trust Chair and shall comprise a minimum three named Non-Executive Directors appointed by the Board of Directors, one of whom shall be the Chair of the Committee.

4.2. The Board of Directors will appoint the Chair of the Committee.

4.3. Members are required to attend at least 3 out of 4 meetings per year. An annual register of attendance of members will be published by the Committee.

Attendees:

4.4. The External Auditor, Internal Auditor, Local Counter Fraud Specialist, Chief Finance Officer and Director of Corporate Governance will normally be in attendance at the Committee meetings. However, at least once a year the Committee will meet with the External and Internal Auditors without any Executive Directors being present.

4.5. The Chief Executive; and other Directors may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director, in order to provide additional assurance.

4.6. The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

4.7. The Committee will be open to the Trust Chair and the Trust Vice Chair to attend.

4.8. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

Voting

4.9. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. A quorum for the Committee shall be two members.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Trust Vice Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet as a minimum on a quarterly basis with additional meetings being called by the Chair of the Committee where necessary.

6.2. One meeting should include a discussion of the Governance Report (ISA260) between the External Auditors and the Non-Executive Directors.

6.3. The External Auditor or Head of Internal Audit may request a meeting, at any time, if they consider that one is necessary.

7. ACCOUNTABILITY AND REPORTING

7.1. The minutes of Committee meetings shall be formally recorded.

7.2. The Committee shall report to the Trust Board on how it discharges its responsibilities.

7.3. The Chair's assurance report will be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

8. AUTHORITY

8.1. The Committee has the authority to establish groups (including task and finish groups) as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

8.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

9. SERVICING ARRANGEMENTS

9.1. The Committee shall be supported administratively by a member of the Corporate Governance Team (Committee Secretary) whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair of the Committee and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend.
- Taking the minutes.
- Keeping a record of matters arising and action points to be carried forward between meetings.
- Arranging meetings for the Chair of the Committee
- Advising the Committee on pertinent issues/areas of interest/policy developments

9.2. The Committee will maintain an Annual Schedule of Business that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

10. RELATIONSHIPS WITH OTHER COMMITTEES

10.1. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

10.2. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board committee terms of reference.

10.3. The Committee will have oversight of all Board Committee to Board Committee escalations.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

The Tavistock and Portman NHS Foundation Trust

Quality and Safety Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	*20 November 2025*
Responsible Executive Director:	Chief Nursing Officer
Date issued:	November 2025 v 0.4
Review date:	November 2026

Quality and Safety Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal committee of the Board to be known as the Quality and Safety Committee. This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of Trust Board, the prime purpose of the Committee is to seek and obtain assurance that the safety, rights and quality of service delivery is maintained to all of our service users, carers, staff and the public.

2.2. The Committee will also provide assurance to the Board that appropriate and effective governance mechanisms are in place for all aspects of quality including patient experience, health outcomes and compliance with national, regional and local requirements.

2.3. The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3. OBJECTIVES

The principal duties of the Committee will be to provide the Board with independent assurance in relation to:

3.1. Quality and Safety Strategy and Performance, Annual Plan & Report

3.1.1. To scrutinise and recommend to the Board of Directors the Trust's Quality and Safety Strategy.

3.1.2. To ensure that the Trust's Quality and Safety Strategy and performance are consistent with mandatory requirements and national guidance.

3.1.3. To scrutinise the Quality Performance metrics on the Integrated Quality Performance Report (IQPR) and to ensure the Committee supports appropriate triangulation and benchmarking.

3.1.4. To oversee the delivery of the Trust's Quality Improvement Programmes seeking assurance that key milestones, targets and outcomes are achieved.

3.1.5. To scrutinise the Strategic content and direction of the Quality Account for approval by the Board of Directors and Council of Governors.

3.1.6. To gain assurance that the quality priorities set out in the Quality Account are being implemented.

3.2. Safeguarding

3.2.1. To gain assurance that safeguarding is compliant with national and local requirements such that patients are safe in the Trust's care.

3.2.2. To review and recommend to the Board the Adult and Child Safeguarding Annual report.

3.3. Mental Capacity Act and Mental Health Act

3.3.1. To gain assurance that the Trust is compliant with the relevant requirements of the Mental Capacity Act; Mental Health Act; and other related acts or legislation.

3.4. Patient safety

3.4.1. To support the development of the Trusts approach to Patient Safety.

3.4.2. To scrutinise a quarterly report on the themes from serious incidents and gain assurance that they are understood and actions to reduce recurrence are implemented.

3.4.3. Oversee an effective system for safety within the Trust, aligning with the National Patient Safety strategy reporting principles of:

- Openness and transparency
- Just culture
- Learning and continuous improvement

Supporting a particular focus on; patient safety, and including the quality impact assessments for financial improvement, staff safety and wider health and safety requirements.

3.5. Patient Experience

3.5.1. Oversee the review and development of a revised patient engagement strategy.

3.5.2. The Committee will consider reports from the Patient Experience team, which will consider Complaints, feedback from PALS and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

3.5.3. The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

3.6. Clinical Effectiveness and Outcomes

3.6.1. To review and recommend for approval by the Integrated Audit and Governance Committee the annual clinical audit programme.

3.6.2. To gain assurance, via clinical audit reports that practice is clinically effective.

3.6.3. To gain assurance that Clinical outcomes are effectively monitored to ensure high quality care is delivered.

3.6.4. To gain assurance that the Trust is complaint with NICE guidelines and other related bodies.

3.6.5. To oversee the development of the learning from deaths process, seeking assurance that key milestones, targets and outcomes are achieved.

3.7. Infection Prevention & Control

3.7.1. To gain assurance that the Trust has in place such systems of work and controls that ensure infection prevention and control is effectively managed and compliant with legislative requirements.

3.7.2. To approve the annual infection prevention and control plan.

3.7.3. To scrutinise and recommend to the Board the Annual Infection Control Statement.

3.8. Regulatory Assurance

3.8.1. To scrutinise Care Quality Commission (CQC); the Office for Standards in Education, Children's Services and Skills (Ofsted); and other quality related compliance reports and ensure that actions are taken to address all issues identified in the compliance reports.

3.9. Assurance Framework

3.9.1. The Committee shall maintain the Quality section of the Board Assurance Framework and the Corporate Risk Register.

3.10. Other

3.10.1. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1. Membership of the Committee shall be as follows:

a) Non-Executive Directors x 2 (one designated Chair)
b) Chief Nursing Officer (Executive Lead)
c) Chief Medical Officers x 2 (with at least one attending each meeting)

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Patient Safety Partner
- Director of Corporate Governance or representative
- Director of Clinical Services
- Associate Director of Quality
- Associate Director of Nursing

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair, Vice Trust Chair and Chief Executive Officer to attend.

4.4. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

4.5. Other staff or individuals may be invited to attend meetings as considered appropriate on an ad-hoc basis. Such attendees will hold no voting rights.

4.6. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.7. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

4.8. If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

4.9. Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

Voting:

4.10. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. A quorum for the Committee shall be three members, to include one Non-Executive and one Executive Director of the Board.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee shall meet on a bi-monthly basis. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee shall report to the Trust Board on how it discharges its responsibilities.

7.2. The minutes of Committee meetings shall be formally recorded.

7.3. A Chair's assurance report will be submitted to the next available Trust Board meeting. This report will also draw attention to the Trust board of any issues requiring disclosure or action.

8. AUTHORITY

8.1. The Quality and Safety Committee has the authority to establish groups and task and finish groups.

8.2. The Committee will have close links to the staff diversity network groups which will be advisory to the committee and will be routes for engagement and consultation as well as proving contribution to committee assurance. The Staff network groups will be invited to assist in organisational agenda setting, undertake environment scanning, intelligence and idea generation.

9. SERVICING ARRANGEMENTS

9.1. The Committee shall be supported administratively by the Corporate Governance Team (Committee Secretary) whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

9.2. The Committee will maintain an Annual Schedule of Business that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

10. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

10.1. The Committee will receive assurance reports from meetings of its groups (see Appendix 1 for the Committee Governance structure chart).

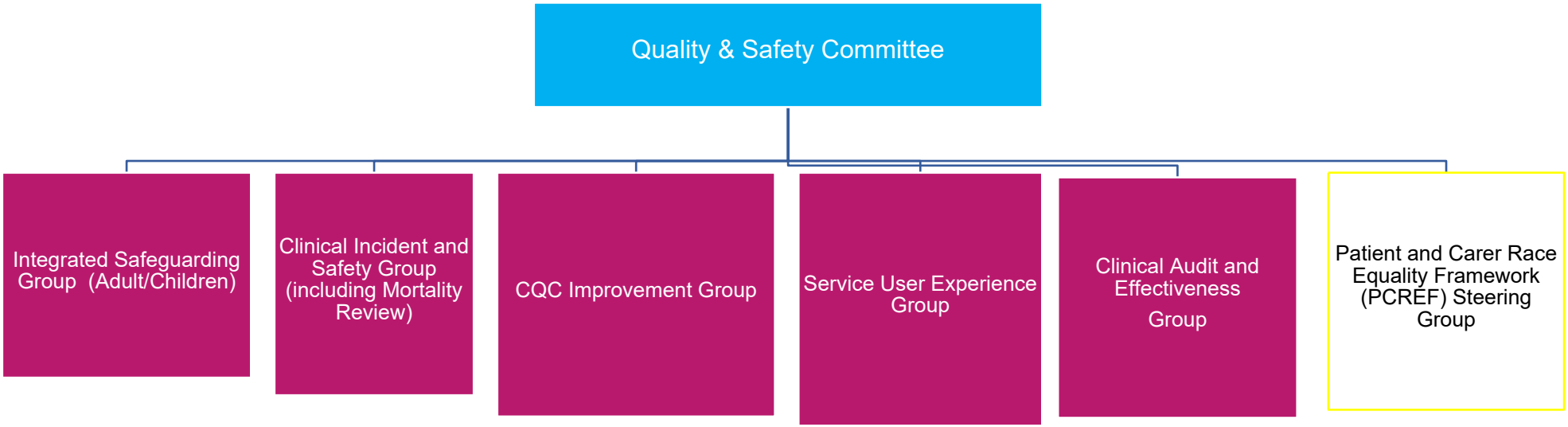
10.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

10.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board committee terms of reference.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Appendix 1 - Quality & Safety Committee Governance structure



Short life Group

Subject Matter Expert Led

Non-Executive Director led Committee

Executive Director led Committee

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: Provider Capability Self-Assessment 2025			**Agenda No.: 011**
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: Provider Capability Self-Assessment 2025		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report presents to the Board of Directors the Trust's Provider Capability Self-Assessment which was submitted to the NHSE Regional team on 22 October 2025. **Key timelines:** **2 October**: At the Board Seminar, the Interim Director of Corporate Governance facilitated a Board session to enable the full Board to 'check and challenge' the self-assessments carried out by Lead Executives to ensure a robust and assurance based process. Following discussions across the six domains, agreement was reached by Board on the self-assessment ratings noting the gaps and mitigations. These were incorporated into the final document. **16 October**: At the Extra-Ordinary Private Board meeting, the Board approved the final document for submission to NHSE subject to minor amendments which were made prior to submission. **21 October**: The Trust submitted the approved Provider Capability Self-Assessment to NHSE London Region.		
Background:	As part of the National Oversight Framework (NOF), and alongside the NOF metrics and segmentation scores, NHSE regional teams will assess the overall capability of provider Trusts. The stated purpose of this capability assessment is to: • Support NHSE to judge whether improvement actions or external support is appropriate at each Trust. • Support Trust Boards to be aware of the challenges faced by their organisation and the actions required to address these. • Focus Trust Board attention on key expectations related to their core functions. • Support an open culture of 'no surprises' between NHSE and Trusts Trusts are required to complete a self-assessment of their organisational capability. This self-assessment is organised around the six domains set out in the Insightful Provider Board framework as follows: 1. Strategy, leadership, and planning 2. Quality of care 3. People and culture 4. Access and delivery of services		

	5. Productivity and value for money 6. Financial performance and oversight Across these six domains there are 16 self-assessment criteria and 51 individual lines of enquiry. The completed self-assessment must be approved by the Board and submitted to NHSE. For each of the six domains the Board must confirm whether the self-assessment criteria have been confirmed, partially confirmed, or not met.
Assessment:	**Self-assessment summary for the Trust** The table below sets out the self-assessment summary for the Trust:

Domains	**Self-Assessment ratings**
Strategy, leadership, and planning	Partially Confirmed
Quality of care	Confirmed
People and culture	Partially Confirmed
Access and delivery of services	Partially Confirmed
Productivity and value for money	Not Met
Financial performance and oversight	Partially Confirmed

Key recommendation(s):	The Board is asked to **NOTE**: **1.** The Trust's Provider Capability Self-Assessment submission to NHSE London Region made on 22nd October 2025; and **2.** The Trust will develop an action plan to address gaps identified in the Self-Assessment for oversight by Board Committees during 2025/26; with assurance provided to Board.

Implications:

Strategic Ambitions:

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☒	ORR ☐		
	The report considers all risks within the BAF.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Failure to engage appropriately with the Provider Capability Self-Assessment may incur regulatory damage to the Trust.				

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:	• Board Seminar – 2 October 2025 • Executive Leadership Team – 13 October 2025 • Extra-Ordinary Board of Directors held in Private – 16 October 2025 **(Approval)**			
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

Provider Capability - Self-Assessment - The Tavistock and Portman NHS Foundation Trust 2025/26

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Partially confirmed**	*1) The Trust has a clear 3-year strategy in place (2023-24 to 2026-27) with clear targets for delivery of its strategic ambitions.* *2) Floor to Board quality and performance governance underpins delivery of the strategy across the organisation. Annual planning is undertaken to ensure the Trust delivers against NHS England (NHSE) and Integrated Care Board (ICB) commissioning specifications, financial and service targets. This is underpinned by job planning, productivity, cost improvement and Quality Improvement (QI) initiatives.* *3) Recognising the specialist nature of the Trust's services, local planning also takes place with Camden Council, University College London (UCL) and many other partners to deliver preventative services close to home with many student placements within these services developing our future workforce.* *4) The Trust is planning with its Merger partner, North London NHS Foundation Trust (NLFT) to align reporting and planning linked to merger delivery dates from 1st April 2026 onward.* *5) The Trust confirms it is compliant with the conditions of its NHS Provider licence. While no breaches are identified, the longer term financial sustainability of the Trust remains an area of significant concern which is monitored closely via the NHS Oversight Framework (NoF) to ensure ongoing compliance.* *6) Under SoF3 (now NoF3) the Trust was RAG rated green in 2024/25 for improvements in Trust governance, quality governance, safe closure of the GIDs service and performance management. There are two outstanding areas that need to be delivered which are outside full control of the Trust (noting strong inputs and partnerships we have in these areas (i) Implementing recommendations of the national gender identity clinic review (not yet published); and (ii) long term sustainability for education and clinical services via delivery of a Board approved merger with NLFT.* *7) The Board considers that the Non-Executive Directors bring a wide range of skills including performance management; strategic planning; people leadership, organisation and culture; risk management; stakeholder management; legal and governance; clinical; mental health services; and transformation and change/ programme management.* *8) The Board has clear accountabilities for all areas of its operations. Named Executive Leads are responsible for quality, delivery and access standards, operational planning, and finance, with established reporting and assurance processes ensuring transaparency and continuous improvement.* *9) The Chief People Officer position has recently become vacant and should other Executive roles become vacant during 2025/26, which represent a gap, these will not be filled substantively due to the imminent merger by acquisition. Succession plans are currently being strengthened to ensure leadership capacity and capability is maintained during the merger process.The Trust is making/ will make joint arrangements with its merger partner to strengthen these capacity gaps.* *10) There are currently two Interim Executive Directors in post (Chief Finance Officer; and Director of Corporate Governance). These two positions will not be filled substantively during 2025/26 due to the imminent merger by acquisition.* *11) The Trust is working closely with ICB, NLFT, Royal Free and Whittington partners to deliver a Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative in North Central London. ICB sign-off for the CAMHS collaborative Business Case is being taken forward via close joint working with ICB colleagues and open and transparent ways of working including the sharing of finances.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*1) The Trust confirms compliance in this area. The Trust has in place standards for monitoring patient safety, patient experience and effectiveness including Integrated Quality Performance Report (IQPR), via the Governance structures at Board and Operational levels; Accountability Framework with Targeted support where required; Patient Safety Incident Response Framework (PSIRF) is fully implemented; Engagement meetings with the Care Quality Commission (CQC) relationship manager with updates on improvement work; A3 Quality Improvement work is in place under 'outstanding patient care' pillar of strategic priorities; Ofsted Inspection July 2025 - 'Good Rating'* *2) Patient Experience is a Trust priority under 'outstanding patient care' strategic pillar. There is Board oversight via qualitative and quantitative information in relation to complaints, compliments, concerns. Including structured planned Board level service visits with feedback form to aid triangualtion of qualitative and quantitative data.* *3) The Board receives qualitative and quantitative information in relation to complaints, compliments and concerns received along with the experience of service questionnaire and friends and family test.* *4) There is a robust complaints investigation and response process with action plans for each response; learning themes and improvements made are reported to Board in the IQPR and Quality and Safety reports.* *5) The Board receives and considers the volume of feedback received and has expectations around the priority to increase the volume and the clinical ownership of this and evidencing and communicating the response to feedback to service users, families and complainants.* *6) Service User Involvement - the Trust has an annual plan for service user involvement in quality assessment and improvement work.* *7) The Board receives reports on Patient & Carer Race Equality Framework (PCREF) which has provided some data on variation in access for those with protected characteristics to the services provided by the Trust, along with the impact that local improvement work has had. The Board is to receive reports on experience by ethnicity for complaints, incidents and experience of service in the next quarter.* *8) There are historic gaps in clinical audit and National Institute for Health and Care Excellence (NICE) compliance assurance. The Clinical Audit Plan is in place, with oversight via the Quality and Safety Committee.* *9) Patients with long waits to access a service - service is engaged in national work led by NHSE.*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Partially confirmed**	*1) WRES and WDES as well as gender reporting are provided to Board as well as workforce dashboards as part of IQPR.* *2) There is an Executive lead for each staff network. There is good evidence of staff experience improvements as a result of staff survey and service visit feedback. Freedom To Speak Up (FTSU) and staff experience programme board, Equality Diversity and Inclusion (EDI) Programme Board both feed into People Organisaional Development Equality Diversity and Inclusion (POD EDI) Committee which in turn reports up to the board.* *3) There is limited evidence to the Board that staff feedback and improvements in staff experience translate into improved quality of care.* *4) Statutory & mandatory training and appraisal reporting is reviewed monthly within IQPR and regularly discussed at every board. Additional training identified via yearly Training Needs Analysis (TNA) process. Bespokely designed Management and Leadership Development Programme (MLDP) run for all managers as well as Kaleidoscope development work.* *5) Some areas of the organisation are not as responsive as others in completing the TNA annually.* *6) There is limited evidence of the impact of Organisational Development (OD) work on the senior management layer of the Trust.* *7) Skills and capacity are not always reviewed on the basis of patient demand and experience.* *8) FTSU processes report bi-annually to POD EDI Committee and to annually to Board. There is a clear and contractually agreed escalation process under the new FTSU Guardian arrangements (from September 2025). Reports to Board demonstrate that the FTSU service is being utilised by staff members, although use has declined since September 2024. This may be an impact of several initiatives around Trust values and behaviours.* *9) Delayed contracting/onboarding of new FTSU service has left a service gap over the summer. However, staff with concerns have reached out to the Executive Lead for guidance. It remains to be seen whether staff will engage with the new, external provision but this is noted as a corporate risk and will continue to be monitored.* *10) Formal processes initiated following FTSU concerns have previously taken a long time to resolve. This has impacted the Trust's ability to demonstrate FTSU concerns being visibly addressed. The Trust has developed a management training package to address this with all managers including Board members, and the new escalation schedule that runs up to the Trust Chair in 48 working-hour steps should mitigate this concern.* *11) In relation to FTSU issues, the Trust remains a negative outlier. We are more confident that the new, experienced FTSU Guardian provision will help to address this.*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*1) A3 Quality Improvement is in place.* *2) Two services with the longest waits:* *- Trauma - under targeted support with Executive, Chief Medical Officer, lead - reports to ELT, IQPR, Quality andSafety Committee (QSC) and Trust Board* *- GIC - previously under Targeted support, now part of national quality improvement work. Reports to ELT, IQPR, QSC, Board, NHSE (London and National)* *3) GIC waiting list is a national issue and work is underway with NHSE to mitigate this including an updated service specification and move to a national waiting list. Trauma remains in targeted support with Executive and Board Committee oversight in place. The waiting list numbers are starting to reduce but unlikely to reach national target within 2025/26 despite significant improvements in place.* *4) The Trust has enhanced its collection and analysis of equality data, improving visibility of variation in access to services across its population. However, not all directorates have fully implemented action plans to address identified disparities, and work remains to embed accountability at all levels.* *5) PCREF has set its main objective as tackling inequalities in access to care across the Trust with new reporting mechanisms being launched allowing data to flow into IQPR. The PCREF steering group will review this data and lead on change processes to ensure targets are met. Oversight is being provided by Trust Non Executive Directors and quarterly reports flow to QSC as well as Board.* *6) Some data is still hard to access and work is taking place with our IT teams to manage this. Community engagement has been slow to progress but this has now started to build momentum.* *7) The Trust works closely with Camden Local Authority and the THRIVE framework used by the Trust allows a better understanding of the link between population health, social determinants and mental ill health. The Trust is also working in partnership with Camden Local Authority and UCL to establish a Centre for Prevention of Mental Ill Health for the borough of Camden. This will take a population health approach across the age range to better support the local population and tackle many of the issues that lead to mental ill health across the Borough.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Not met**	*1) Largest clinical service GIC - now using benchmarking data against other adult gender services. NHS England plan to reduce variation, improve patient experience and increase productivity.* *2) Children and Young People (CYP) services benchmarked across North Central London (NCL) and North Central and East London (NCEL)* *3) Plans are in place for Teams under targeted support to monitior planned productivity rates as part of weekly meetings.* *4) The Trust has used the annual planning cycle to develop plans to include activity targets, increase productivity and ensure efficiency. This is reported through monthly IQPR meetings; targeted support and Quality Improvement workstreams for services as required.* *5) Noting for some services there is no data to benchmark against.*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Partially confirmed**	*1) The Integrated Audit and Governance Committee (IAGC) approved an internal audit plan that was reviewed by Executive Directors to ensure all areas of risk are covered. The plan focusses on key processes, systems and risks relevant to an organisation that will be merging on the 1st April.* *- The Trust has one significant contract dispute relating to the National Training Contract (NTC) and the dispute process is currently in progress. The Trust is working with NHSE to resolve the contract dispute. There are no other material contract disputes* *- The Trust has very low agency and bank usage* *2) Electronic Staff Record (ESR) and Finance systems are mostly aligned although there is more work to do in this area* *3) Efficiency Programme Board established for 2025/26 efficiency programme. Equality Impact Assessment (EQIA) and Quality Impact Assessment (QIA) process is in place and reviews are currently underway. Cost Improvement Programme (CIP) reporting process has been established and is now reporting to the Performance Finance and Resources Committee (PFRC) monthly. Board session on CIP process and delivery was held in September.* *4) CIP process is new to the Trust in 2025/26. Engagement is good however leadership teams do not have significant experience delivering cost improvement programmes.* *5) Executives are engaged with system processes and work collaboratively with ICB and Regional partners in relation to financial and operational plans* *6) All plans are aligned with system plans and the Trust works closely with the system to ensure local priorities are aligned with system priorities*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

	John Lawlor
Name	John Lawlor, Trust Chair
Date	Thursday, October 16, 2025

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC - 20 NOVEMBER 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit and Governance Committee	16th September 2025	Ken Batty, Non-Executive Director	Jonathan Bell, Interim Chief Finance Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item:** 11		

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. Overall Assurance and Key Direct Feedback to the Board The Chair noted specific feedback to be incorporated into the Assurance Report to the Board: • Review of the risk register at Board level is required, focusing on key areas in light of the merger. • The Committee noted a positive picture for the Trust, with the number of concerns having reduced greatly and effective resolutions being implemented. Members praised the hard work at Executive Level and within the teams.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit Oversight The Committee received reports from the internal auditors in the following areas: • Emergency Planning and Preparedness Report (EPPR): This review provided reasonable assurance and a positive picture regarding the Trust's arrangements for business continuity. An action plan was agreed to ensure roles, responsibilities, and key plans are clearly understood and shared with staff. • Data Security Protection Toolkit (DSPT): The finalised report noted significant challenges regarding management assessment and evidence of compliance. An action plan was agreed, and 11 of the 12 actions have been implemented. The issue is not systemic across the entire business, and management maintains a strong position on follow-up. • Audit Delivery: Internal Audit is overall confident the plans will be delivered on time to inform the Head of Internal Audit Opinion. • Overdue Actions: There are two overdue actions (one medium, one high) that have been shared and continue to be progressed and monitored at the Executive level.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

The Committee approved the Updated Internal Audit Plan for 2025/26.	
3. External Audit Oversight The Committee received and discussed the External Audit Report. • Planning and risk assessment procedures are scheduled for January 2026, with final fieldwork planned between May and June 2026. • It was noted that the External Audit process this year will be different given the post-merger context. It was agreed that the Interim Chief Finance Officer will liaise with NLFT counterparts to discuss the continuation of the External Audit post-merger to ensure a smooth transition.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Risk and Governance The Committee received and noted the Oversight of Board Assurance Framework and Corporate Risk Register. • Members raised concern over the Trust's overall risk picture, questioning whether it accurately reflects the position ahead of the merger, particularly given the loss of the National Training Contract. • The Committee asked that the Executive Leadership Team (ELT) review the full risk register and scoring in light of the merger and escalate findings to the Board. • One new risk (BAF Risk 16) was added relating to the National Training Contract. • Corporate Risk Register (CRR) Development: Development of a robust CRR has been slow due to a capacity gap in the Corporate Governance team since May 2025. Recruitment for a Risk Manager is expected to be completed during Q3 2025/26. • The Committee also received and noted the Executive Portfolios Risk and Control Assessment, with identified operational risks to be transferred to the RADAR System to inform the robust CRR development ahead of the merger.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Information Governance (Annual Report 2024/25) The Committee received and noted the Annual Information Governance Report 2024/25. • The Trust submitted a "standards met" Data Security and Protection Toolkit for 2024/25, demonstrating good data security practice. • Response compliance rate for FOI requests was 99% for 2024/25, meeting the ICO performance measure. • 48 confidentiality incidents were recorded during 2024/25 (mostly human error), and none reached the threshold to report to the Information Commissioner's Office (ICO). • Significant improvements were made in relation to Subject Access Request (SAR) compliance.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. Counter Fraud and Financial Administration The Committee received and discussed the Local Counter Fraud Progress Report.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

• The review found the Trust's Declarations of Interest policies and processes were positive, yielding no actions. However, the review identified several instances where interests or gifts/hospitality had not been declared and recorded by staff. • An action was agreed for a wider publicity campaign to ensure staff awareness of their responsibilities regarding declarations. • Five new referrals related to dual working and payroll matches are currently at the point of enquiry.	
7. Financial and Debt Reporting • The Committee received and noted reports on Aged Debtors, Single Tender Waivers and Salary Overpayments	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

A wider publicity campaign to be undertaken to ensure staff awareness of their responsibilities regarding declarations of interest

Risks Identified by the Committee during the meeting:

None identified

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

No Items

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

Item	Purpose	Date
Review of the risk register at Board level is required, focusing on key areas in light of the merger.		TBD

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: Gloucester House progress report			**Agenda No.: 012**
Report Author and Job Title:	Nell Nicholson, Strategic Lead for Education & Partnerships	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1: Ofsted Report July 2025 Appendix 2: Relocation Board workbook – (Due to sensitivity this item is available in the BoardEffect Reading Room)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	The purpose of this report is to provide an update on the Gloucester House Review Improvement Plan and the relocation project.		
Background:	Following the *Gloucester House Review* in Spring/Summer 2024, an Improvement Plan was implemented to address the 61 recommendations outlined in the report. Key concerns identified included governance and safeguarding, quality of education, equality, diversity and inclusion (EDI), and staff wellbeing. To oversee the implementation of the Improvement Plan, a Delivery Group was established. In recognition of the interdependent challenges faced by the school, additional workstreams focusing on finance and estates were included. The delivery framework was structured around eight core workstreams, each with an identified lead: • Estates • Finance • Governance and Safeguarding • Educational and Regulatory Outcomes • Clinical Outcomes • Workforce Planning • Equality, Diversity and Inclusion (EDI) • Staff Wellbeing In July 2025, the school underwent an Ofsted inspection and was rated *Good* in all areas. Earlier, in February 2025, a potential new site for relocation was identified. This site has since been confirmed as viable, and relocation planning is currently underway. Gloucester House Outreach became a standalone service in September 2022. However, it has not grown as anticipated, particularly in terms of training delivery and collaboration with Local Authorities. The service has faced increasing challenges with pupil numbers, as many Local Authorities opt for more cost-effective local provisions. While the current training offer remains steady, profits are shared with DET, and expanding the offer presents risks that, at present, do not appear viable.		

Assessment:	Following the *Good* rating across all areas in the July 2025 Ofsted inspection and the confirmation of plans to relocate Gloucester House, as well as ongoing challenges faced by Gloucester House Outreach, the focus of the Improvement Plan and Delivery Group now needs to shift. While the original workstreams remain relevant, the improvements specifically related to the 2024 Review have been separated out. This strand of work is expected to close by 24 October 2025, with outstanding actions either resolved, embedded into business-as-usual processes, or carried forward into ongoing workstream targets. Substantial progress has been made across the workstreams, with the overall Improvement Plan currently 89% complete. Individual workstream completion rates range between 76% and 100%. Staff sickness levels and attrition in the service have been another area of identified concern. However, improvements have been seen through successful recruitment, the transition of PSWs (Pupil Support Workers) from fixed-term to permanent roles, and increased senior management oversight, including return-to-work interviews and other attendance initiatives. Financial pressures continue, and pupil numbers remain below the breakeven point. Despite five pupil departures in July 2025, the plan to increase enrolment is progressing. The current pupil roll stands at 16, with an aim to reach 18 this term—though this is subject to potential risks associated with the relocation. Despite these efforts, a financial deficit is likely for this financial year. Gloucester House School received £1.263 million in income (full-year equivalent for 16 pupils) against costs of £1.2 million. This would provide a 3% contribution for the whole year, which is not sustainable in the long term. Due to numbers on roll remaining at 14 in term one of the financial year (April to July) and the planned relocation, it is not certain that the school will be able to reach and maintain 18 pupils (14% contribution). The school should reach 16 pupils imminently and two further referrals are under assessment, but numbers will need to be kept under review during the relocation. Work is ongoing to develop a financially sustainable model in the longer term through possible increase in numbers in the new site and workforce planning. Gloucester House Outreach (GHOR) forecasts are also below target. A new marketing strategy is being implemented this term to assess and enhance the service's viability. The relocation project is underway. A Relocation Programme Board has been established, and a dedicated Project Manager is in place. A Material Change application has been submitted to Ofsted, who have responded with queries regarding site visits and potential building works. There have been meaningful advances in staff wellbeing and equality, diversity, and inclusion (EDI), with recent staff feedback reflecting positively on improvements and renewed efforts to address equality-related concerns.

Key recommendation(s):	The Board of Directors is asked to: 1) Take **ASSURANCE** from the updates provided; and 2) **NOTE** proposed Focus for the Improvement Plan and Delivery Group (October 2025 Onwards): • Monitor a detailed timeline for relocation, ensuring adherence to key milestones. • Maintain standards of quality, safety, staff and pupil wellbeing, and EDI throughout the relocation process. • Continue addressing interdependencies between estate management, financial planning, and the evolving needs of the school. • Strengthen financial stability by increasing or maintaining pupil numbers without compromising on quality, safety, wellbeing, or EDI. • Continue developing a financially sustainable long-term model for both the school and outreach service. • Set clear targets and monitor progress on improvement areas identified by Ofsted. • Support the integration of Gloucester House Outreach (GHOR) into the wider Gloucester House structure. • Identify, agree, and monitor key risks related to the school's priorities and associated workstreams.

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: Details of risks and mitigations can be found in both the Improvement Plan Project Plan and the Relocation board Project Plan. The key risks for attention at this time pertain to maintaining quality and safety within the relocation project particularly within the desired time frame.				
	Yes ☒	No ☐			

	Ofsted Material Change inspection of new site and current practice including assurance that Gloucester house continues to meet the Independent School Standards			
Resource Implications:	Yes ☒		No ☐	
	Relocation Board New site			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	New site -distance to work/school; accessibility and safety of new site			
Freedom of Information (FOI) status:	☐ This report is disclosable under the FOI Act.		☒This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	ELT Quality & Safety Committee			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Update – Gloucester House

1. Purpose of the report

1.1 This report provides an update on the progress of the Gloucester House School (GHS) Improvement Plan. The update addresses recommendations outlined in the Improvement Plan, formally received by the Trust Board in September 2024. The core aim was to implement a rapid improvement plan following the April–July 2024 review. Updates have been provided to ELT and the Board in May and July 2025, and to the Quality and Safety Committee.

1.2 While progress has been substantial across the workstreams, the school continues to face complex, interdependent issues relating to estates, finance, staff wellbeing, and workforce stability. Despite significant advances, full resolution of these concerns, alongside the relocation project, the Ofsted outcomes, and plans to subsume the Outreach Service back into Gloucester House, will require coordinated, strategic action across the organisation.

2. Background

2.1 Following the Gloucester House Review in Spring and Summer 2024, an Improvement Plan was implemented in response to the 61 recommendations outlined in the report. The review highlighted key concerns relating to governance and safeguarding, quality of education, equality, diversity, and inclusion (EDI), and staff wellbeing. A Delivery Group was established to oversee progress, with interdependent workstreams added in finance and estates.

2.2 The school continues to manage pressures arising from the poor condition of the current building, including damp and structural issues. A decision to relocate was made, and a suitable site has been identified. However, the project will require significant input to ensure both safety and quality.

2.3 After a prolonged period of low pupil numbers, active work is underway to increase admissions. However, financial instability persists due to cost–income pressures and pupil attrition. The relocation may also affect steady growth in numbers.

2.4 The staff team is stabilising, with staff sickness rates being proactively addressed through strengthened systems and processes.

3. Gloucester House Improvement Plan Update

3.1 Strategic Aim:

The strategic aim of the Improvement Plan is to ensure GHS delivers excellence in educational, clinical, social, and emotional outcomes for children and young people achieved through:

- Financial optimisation and efficiency
- Safe and sustainable estate management
- Robust clinical and educational governance

- A supported, diverse, and effective workforce
- A strong safeguarding culture and regulatory compliance framework

The plan is structured around:

- Monitoring the Action Plan from the 2024 Review
- Tracking workstream progress
- Addressing outstanding areas

Governance and oversight are provided by the Gloucester House Delivery Group, which has been chaired by the Managing Director. The group meet fortnightly, with each workstream led by a designated owner responsible for project planning and updates.

From September 2025 this group is chaired by the Strategic Lead for Education and Partnerships and actions from the 2024 Gloucester House Review Action Plan will be closed, move to BAU or become subsumed into the relevant open work stream.

In the light of this, the progress and next steps for the 2024 Action Plan is reported below separately to the other workstreams.

In the context of relocation, the Ofsted outcomes and financial stability priorities across the workstreams are likely to change/develop.

3.2 Progress to Date :

3.2.1 Improvement Metrics - The overall Improvement Plan is **89% complete**. Substantial progress has been achieved across the workstreams. Details are outlined below.

3.2.2 Gloucester House Review Action Plan (2024) - The Action Plan is 89% complete. Remaining 11% (14 actions referred to in the table below) are due to be resolved by **24 October 2025**.

Outstanding Action	**Number of actions**	**Resolution**	**Lead**	**Next Step**
Steering Committee assurance activities	5	to be addressed via ensuring these activities are included in structures within Steering Committee meetings and member visits to the school	NN	Move to BAU following resolution
Outcome data analysis	2	in progress, final report due 24.10.25	NN	Close following resolution
Quality of education for pupils offsite	1	Remains relevant & a priority for Delivery Group	CG	To remain in Educational Outcomes workstream & is part of School

				Development Plan
EDI outcomes	2	Update needed in Delivery Group – then move to BAU	CG	Move to BAU following resolution
Parental engagement (part of EDI)	1	Remains relevant & a priority for Delivery Group	CG/SW	To remain in EDI workstream & is part of School Development Plan
Curriculum implementation	1	Remains relevant & a priority for Delivery Group	CG	To remain in Educational Outcomes workstream & is part of School Development Plan
Suspension criteria	1	Sign off needed by Steering Committee - then move to BAU	SW	Move to BAU following resolution
Staffing structure review	1	Remains relevant & a priority for Delivery Group	NN/SB	To remain in Workforce Development workstream

3.2.3 Estates: Completion: 91%

Outstanding: decluttering, classroom access locks, and nurture/decompression space.

Next step: the outstanding actions will be addressed as part of relocation, with risk/finance considerations managed via the Delivery Group. As the relocation project moves forward additional actions will be likely to be included in this workstream.

A separate section on relocation is included in section 5 of this report.

3.2.4 Finance: Completion: 92**%**

Outstanding: plan for non-pay items not fully completed; budget right sizing for 25/26 & sign off of financial plan

Next step: Update required from workstream lead at 7.10.25 Delivery Group

Financial Position of Gloucester House School – general update

Currently operating with 14 pupils (expected to rise to 16 this half term). While demand is strong (26 on waiting list), financial viability is not yet secure due to operating costs of the service and potential cost implications of relocation. A phased admissions plan aims to reach 18 pupils by December 2025, but this must be balanced against relocation, pupil complexity and adjustment to increased pupil numbers in the setting.

3.2.5 Governance & Safeguarding: Completion: 94**%**

Outstanding: Steering Committee monitoring of Independent School Standards, Team Teach training update, Implementation of PBS strategies into PHPs

Next step: Though full compliance with regulatory expectations was achieved as evidenced by the Ofsted visit, ensuring there are systems and structures in place to ensure this compliance is maintained is crucial to ensure the school consistently maintains the required standards.

The remaining outstanding items areas will remain in the workstream to ensure this.

Behaviour and Safeguarding

The Behaviour Handbook and related policies have been updated and consultation with staff, pupils and families is underway, alongside revised safeguarding protocols and a comprehensive restraint reduction plan. Staff surveys have been reissued to monitor thematic trends.

This is an extensive piece of work and though it has taken some time is a fundamental part of the Gloucester House model and therefore needs this level of attention.

Next step: Steering Committee approval. This will remain part of the Delivery Group.

3.2.6 Educational Outcomes: Completion: 81%

General update: The *Quality of Education* remains a priority improvement area. Though the school was rated as ‘good’ in all domains there has been significant instability in the education team at Gloucester House and the imperative to fully embed and monitor the curriculum needs close monitoring. We have now recruited to permanent posts across the team including the teachers and the headteacher and the PSW permanent recruitment is currently underway.

Outstanding: thorough investigation and action plans in relation to attendance and Steering Committee assurance in relation to this.

Next step: Will be monitored in the workstream in line with attendance data

There is a separate section about the Ofsted visit and outcomes further on in this report

3.2.7 Clinical Outcomes: Completion: 99%

General update: A Quality Assurance Review was scheduled for 30th June 2025, focusing on the school’s readiness for CQC but was not able to take place due to notification regarding the impending Ofsted inspection. However, the clinical lead is liaising with the Quality and Safety leads to plan and prepare for a possible CQC visit.

The revised care coordinator role was ratified in June 2025 and has been implemented with the new clinical team.

A Quality Improvement (QI) project was piloted using the Trauma Outcome Measure for Schools (TOMS). This is now being implemented and enables more robust monitoring of clinical progress and impact at the individual and cohort level.

A clinical staffing review is ongoing for the longer term but in the shorter term a clinical staffing model has been implemented to maintain clinical safety whilst addressing financial efficiencies.

Outstanding: update needed regarding the framework to define psychiatric involvement, clinical risk governance, and medication review processes. (Sarah Wynick and Selina Wightman)

Next step: Defining psychiatry involvement, reviewing parent work, and finalising the clinical staffing model.

3.2.8 Workforce Planning: Completion: 97%

Outstanding: Staff Service structure review not complete

General update: The school continues to navigate several workforce-related challenges but some of these are now nearing fulfilment. The Headteacher left at the end of April 2025, having been absent since January 2025 with the Deputy Headteacher acting up into the role to ensure continuity of leadership. We have now recruited the acting headteacher into the role.

Though two substantive teachers resigned, and a first round of recruitment to the posts was not successful, requiring interim cover via agency staff, a second round of recruitment has been successful and there is a full complement of permanent teachers as of September 2025.

In response to these pressures and the planned increase to an 18-pupil roll, the staffing model has been reviewed to ensure it meets the needs of a growing and complex cohort.

The school has also experienced high levels of sickness absence, particularly among Progress Support Workers (PSWs). Some of this was due to long term absences that are now resolved and the short term absences are being managed proactively within the service through increased managerial oversight & support. Temporary agency staffing has been authorised where necessary to ensure safe operation. However, the intention remains to reduce reliance on agency staff through planned recruitment into substantive roles. Staffing levels will be determined by the acuity of pupils and the pace of new integrations.

The team has also developed a clear staffing model for teaching and support functions and recruitment to planned posts will align with pupil numbers which may enable some financial efficiency.

The current clinical structure is also under review. Future proposals include:

- Evaluation of clinical staff roles and capacities
- Exploration of Service Level Agreements (SLAs) with neighbouring NHS trusts to address gaps in key specialist provision areas such as Speech and Language Therapy (SLT) and Occupational Therapy (OT)

The revised workforce model demonstrates a responsive, needs-led approach to staffing, designed to ensure educational and therapeutic stability as pupil numbers increase. Ongoing evaluation and planned reviews will ensure both value for money and alignment to the evolving needs of the school population.

Next step: Continuation of review of 1:1 (EPOC) funding usage with the intention to maximise its flexibility and value in meeting pupil needs. Further work on workforce model for current cohort and in context of possible plans for expansion/increase in pupil numbers.

3.2.9 Staff Wellbeing: Completion: 81**%**

Outstanding: On call protocol and development of a recovery team, post incident questionnaire not yet complete.

In response to concerns raised in December 2024, further measures have been introduced, including improved information sharing, regular updates, and a staff wellbeing room, which has been positively received. Continuous staff feedback remains central to shaping wellbeing interventions.

Next step - a structured training programme is in its infancy. Staff surveys have been recirculated to monitor improvement and analysis of these needs to be completed.

3.2.10 Equality, Diversity and Inclusion (EDI): Completion: 77%

General update: EDI initiatives are progressing. Regular meetings between Gloucester House SLT and EDI representatives with the EDI team from the Trust have been established to address concerns on an ongoing basis.

Work with parents is being addressed through the development plan from an educational and a clinical perspective.

This mainly due to a delay in updates which can be resolved in the forthcoming Delivery Group (7.10.25)

Outstanding: EDI focus in team meeting system/structure, historic data analysis, focus on parent feedback. Updates required in forthcoming Delivery Group (7.10.25)

3. Gloucester House Outreach

The outreach service has a 2025/26 income target of £220,500, but current forecast income stands at just £75,015 as of 28.08.25. A revised marketing model is scheduled for launch in September 2025. To enhance sustainability, it is proposed that the outreach service be merged into Gloucester House School. While this would not generate a cost improvement plan (CIP), it may streamline service delivery and financial oversight.

4. Ofsted

4.1 An Ofsted inspection took place at the school from 1-3 July 2025**.** The school was judged as good across all the Ofsted areas (the quality of education, behaviour and attitudes, personal development, leadership and management and overall effectiveness). It also met all the Independent School Standards. Safeguarding arrangements were judged as effective.

4.2 Strengths: Strengths were noted in the collaborative work of the multi-disciplinary team; the re-evaluation of work in relation to curriculum and approach to pupil behaviour and the understanding of and meeting of the pupils' SEND needs. The school's range of

leisure and enrichment activities (including pupil parliament) for pupils were also positively commented on.

4.3 Areas for improvement: it was identified that due to staff turnover – including at the senior level - the curriculum was not fully embedded or delivered consistently and with precision and that this impacted pupil progress. It was also noted that a minority of parents were unhappy with the school.

4.4 Next steps: to continue to monitor progress against the Ofsted identified improvement areas in the Delivery Group.

5. Relocation Project

5.1 A new site was identified in February 2025 and visited in April 2025. The site was assessed as a viable option; however, the estates relocation project continues to encounter delays and this needs to be factored into the timeline. Though initial assessments suggest that the relocation is a viable option the full operational and financial viability has not yet been completed.

There are steps that need to be addressed before any actual relocation can take place. For example:

- assurance that the school stakeholders are fully aware of the nature and cohort of the Gloucester House pupils.
- Safety measures in new premises identified and addressed.
- A material change inspection has been conducted by Ofsted both in relation to the Independent School Standards being met in the new site.

We are aware of the imperative for the sale of the school premises as part of the financial plan to address the Trust deficit so management of delays needs to be carefully considered.

5.2 The Relocation Programme Board is overseeing progress, including the material change application for increased pupil numbers to 35 and an age range expansion to Key Stage 4. Stakeholder mapping has been completed, and written communications have been circulated for staff, pupils, parents, and local authorities, with engagement events planned. EDI considerations, including travel times for staff and pupils, have been incorporated into scoping.

6 Recommendations and Next Steps

1. **Ongoing Oversight:** Due to the number of interdependencies, a cohesive, integrated approach—linking estates, clinical, educational, and financial workstreams —is required to ensure long-term viability and the continued delivery of high-quality outcomes.

It is proposed that fortnightly Delivery Group meetings continue but with an emphasis on relocation, finance, workforce development, quality of education, EDI & Staff wellbeing during the forthcoming academic year

2. **Workforce Model:** further review and modelling to ensure long term viability.

3. **Merger of Services:** Proposed merger of GHO into GHS to increase service efficiency and improve financial viability.

7 Conclusion

Despite facing ongoing structural and financial challenges, Gloucester House School and Outreach Service has made commendable progress across clinical, educational, and safeguarding domains. Continued support from the Executive Leadership Team is essential, particularly in relation to recruitment, estates decision-making, and service integration, to ensure the future viability, safety and effectiveness of the service.

Inspection of Gloucester House, The Tavistock Children's Day Unit

33 Daleham Gardens, London NW3 5BU

Inspection dates:	1 to 3 July 2025

Overall effectiveness	**Good**
The quality of education	**Good**
Behaviour and attitudes	**Good**
Personal development	**Good**
Leadership and management	**Good**
Overall effectiveness at previous inspection	Good
Does the school meet the independent school standards?	**Yes**

What is it like to attend this school?

Pupils are well supported by a team of staff made up of both education and health professionals. These adults work collaboratively to ensure that pupils' special educational needs and/or disabilities (SEND) are well understood and effectively met. Over the last year, the school has re-evaluated its curriculum and approach to pupils' behaviour. It has set high expectations and pupils are rising to these.

Pupils join this school after difficult experiences in other settings. Many have been out of school for some time. In this school, they develop positive relationships with staff. Over time, pupils learn to trust staff and understand and manage their emotions and behaviour.

The school ensures that pupils have opportunities to experience a range of leisure and enrichment activities, including through 'well-being Fridays'. On Friday afternoons, pupils from different classes enjoy a variety of sporting or craft activities, developing their social skills alongside learning a new skill. Pupils also have opportunities to influence the school's development, including through membership of the 'pupil parliament'.

Most parents and carers appreciate the school's work to support their child. However, a few are dissatisfied and feel that the school does not listen or respond well to their concerns.

What does the school do well and what does it need to do better?

The school's curriculum is ambitious. It has an appropriate focus on English, mathematics and personal, social and health education (PSHE). Recently, the school has reviewed its curriculum across all subjects. The revised curriculum sets out clearly what should be taught.

In subjects which are well established, such as mathematics, lessons are consistently designed to develop pupils' knowledge. Carefully chosen activities interest pupils and extend their learning. However, in some other subjects, the curriculum is very new and less familiar to those delivering it. In these cases, teaching activities are not aligned consistently with the school's intended curriculum, and the lessons delivered lack coherence.

Education and health teams work closely together to ensure that pupils' needs are accurately understood. This enables them to craft personalised approaches for individual pupils.

Pupils are taught individually or in small groups. However, sometimes teaching does not involve precise questioning or clear explanations. For example, when questions are too abstract and not tightly linked to the subject content, pupils do not make as much progress as they could.

The school has prioritised reading. It has established daily opportunities for staff and pupils to share books. The school develops pupils' confidence in reading aloud. A phonics programme is used effectively to support pupils who have gaps in their phonics knowledge or lack fluency in their reading.

The school has brought about a significant shift in culture with regard to pupils' behaviour. It has established high expectations that are consistent across the school, but mindful of each pupil's needs. Over time, pupils learn to understand their emotions and the impact of their behaviour on others.

Around the school, the atmosphere is generally calm. Pupils respond well to familiar staff. They are polite and courteous. Staff help pupils sort out any friendship issues. Any incidents of bullying are taken seriously. The school takes suitable action to ensure that these are dealt with.

Absence from school is followed up swiftly. The school identifies and tackles any barriers to attendance. Some pupils' attendance improves significantly. A few pupils receive home tuition delivered by school staff. This is delivered over a short period with a clear rationale and plans for swift reintegration into school.

PSHE and relationships and sex education and health education programmes are clearly set out. Where required, content is adapted based on pupils' needs and any issues that arise. This work is strengthened by the integration of therapeutic approaches. Pupils learn about healthy and unhealthy relationships and consent in an age-appropriate manner. They are taught about 'grooming' and the possible implications of 'holding things' for others.

Visitors to the school support pupils' readiness for life beyond school. For example, police officers visit to help pupils understand the consequences of inappropriate behaviour. The school works effectively to develop pupils' respect for others. For example, the school identified that discriminatory language was infrequently challenged. The school successfully raised awareness of the impact of these words. Use of discriminatory language has significantly decreased. Weekly equality, diversity and inclusion champions are proud to receive recognition.

The school provides some trips off site, usually in the local area. Pupils learn about different faiths and cultures and mark events such as PRIDE and Black History Month.

The school works closely with partners to prepare pupils for their next steps. This is achieved through visits and information sharing. From Year 7 onwards, pupils benefit from the school's structured careers education programme.

The school has made significant improvements in a short space of time following a period of instability. However, there have been many changes over a short period. Some of these changes are not embedded. Leaders are mindful of staff well-being and workload. For example, staff welcome the introduction of the 'well-being' space.

Steering committee members have the appropriate expertise to support the school well. They ensure that the independent school standards are met. They receive helpful information about pupils' learning and behaviour. Committee members attend school events where they may speak with parents. They are seeking ways to strengthen this area of engagement.

The school complies with schedule 10 of the Equality Act 2010.

Safeguarding

The arrangements for safeguarding are effective.

What does the school need to do to improve? (Information for the school and proprietor)

- The school's work to improve the quality of education has been impeded by high staff turnover, including at senior levels. The curriculum is not embedded fully in practice across all subjects. As a result, pupils do not consistently receive clear, coherent sequences of lessons in some subjects. The school should ensure that the curriculum is consistently delivered in line with the school's expectations.
- Sometimes, curriculum delivery lacks precision. For example, questions posed and explanations provided by staff are not clear, so pupils do not understand what is being asked of them. As a consequence, pupils do not make as much progress through the curriculum as they could. The school should ensure that the curriculum is consistently delivered with clarity and precision.

How can I feed back my views?

You can use Ofsted Parent View to give Ofsted your opinion on your child's school, or to find out what other parents and carers think. We use information from Ofsted Parent View when deciding which schools to inspect, when to inspect them and as part of their inspection.

The Department for Education has further guidance on how to complain about a school.

School details

Unique reference number	135167
DfE registration number	202/6401
Local authority	Camden
Inspection number	10391739
Type of school	Other independent special school
School category	Independent day school
Age range of pupils	5 to 14
Gender of pupils	Mixed
Number of pupils on the school roll	14
Proprietor	The Tavistock and Portman NHS Foundation Trust
Chair	John Lawlor
Headteacher	Chilo Graham (Acting Headteacher)
Annual fees (day pupils)	£78,106
Telephone number	020 7794 3353
Website	www.gloucesterhouse.camden.sch.uk
Email address	gloucesterhouseadmin@tavi-port.nhs.uk
Date of previous inspection	29 November to 1 December 2022

Information about this school

- Since the previous inspection, there have been changes to leadership roles. The acting headteacher joined the school as deputy headteacher in June 2024 and became acting headteacher in April 2025.
- The proprietor appoints a steering committee to oversee the work of the school. The chair of the steering committee took up their role in February 2025.
- The school caters for pupils who have social, emotional and mental health needs. All pupils have an education, health and care plan linked to their social, emotional and mental health needs.
- The school does not make use of alternative provision.
- The school is registered to admit up to 21 pupils.

Information about this inspection

Inspectors carried out this inspection under section 109(1) and (2) of the Education and Skills Act 2008. The purpose of the inspection is to advise the Secretary of State for Education about the school's suitability for continued registration as an independent school.

Inspections are a point-in-time judgement about the quality of a school's education provision.

The school meets the independent school standards. These are the requirements set out in the schedule to the Education (Independent School Standards) Regulations 2014.

- Inspectors discussed any continued impact of the pandemic with leaders and have taken that into account in their evaluation of the school.
- Inspectors met with the acting headteacher and clinical lead professional. They also met with teachers, support staff and clinical professionals working in the school.
- Inspectors met with members of the steering committee and the proprietor's strategic lead for education and partnerships.
- Inspectors carried out deep dives in these subjects: reading, mathematics and PSHE. For each deep dive, inspectors held discussions about the curriculum, looked at curriculum plans, visited a sample of lessons, spoke to teachers, spoke to some pupils about their learning and looked at samples of pupils' work.
- Inspectors also looked at curriculum plans and spoke to leaders about the curriculum experienced by individual pupils.
- To evaluate the effectiveness of safeguarding, the inspectors reviewed the single central record; took account of the views of leaders, staff and pupils; and considered the extent to which the school has created an open and positive culture around safeguarding that puts pupils' interests first.

- Inspectors also considered the school's work to support pupils' behaviour and attendance. They scrutinised a range of documentation and spoke to leaders and staff about the school's work to support pupils' personal development.
- Inspectors toured the school premises and scrutinised a range of documentation to check the school's compliance with the independent school standards.
- Inspectors took into account the responses to Ofsted's surveys for parents, pupils and staff.

Inspection team

Gaynor Roberts, lead inspector	Ofsted Inspector
Deborah Walters	His Majesty's Inspector

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CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – Thursday, 20 November 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	23 October 2025	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**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. Trauma Targeted Support The Committee received an update on the Trauma team's progress in the improvement areas identified through targeted support. The team developed an action plan to address significant waiting times, high referral rates and limited capacity relative to population need and demand. Criteria, intake, model and throughput have been significantly re-designed this year. Key improvements were noted related to communication with patients, referrals, intake geography, activity, patient engagement and co-production, work with DET, pathway development and merger preparation. The waiting time for first appointments is reducing, referrals greatly reduced with new criteria and conversations are underway with the merger partner about the service's place in the local pathway.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Patient and Carer Race Equality Framework (PCREF) Implementation Update The Committee received an update on the implementation of PCREF as monitored through the PCREF action plan which covers three aspects of the framework as utilised by all NHS Mental Health Trusts. There is an additional section developed by DET colleagues to address aspects of education and training impacted by systemic racism and the drive to develop antiracist practice within the Trust and the wider NHS. There is progress in all aspects of the PCREF action plan, with some aspects more developed than others, particularly the development of data reporting within the Integrated Quality & Performance Report (IQPR). There will be a focus within the team on developing the community facing aspects of the work culminating in a marketplace event in Quarter 3 2025/26. The PCREF team are working towards completing the current	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

action plan within the current fiscal year, with the exception of the DET sections which will be completed within the current academic year.	
3. Infection Prevention Control Report including Annual Infection Prevention Control Plan and Statement including Board Assurance Framework The Committee received the six monthly Infection Prevention & Control update report, including an update on the National Infection Prevention Control Board Assurance Framework (NIPC BAF) compliance. The BAF document consists of 54 Key Lines of Enquiry • 29 are deemed not to be applicable to the Trust • 22 were assessed as fully compliant (a positive increase from 19) • 3 were assessed as partial compliant (a positive reduction from 6 previously) The partial compliance relates to actions needed in relation to infection prevention and control training and competency relative to roles and food hygiene training. There are plans in place to address each of these.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Quality Improvement (QI) Report The Committee received an update about the progress of the Trust's QI programme. The annual QI programme for 25/26 is progressing according to plan and is well placed to integrate with the merger partner's QI programme from April 2026. This year, the priority is to establish a Trust-wide, structured QI culture. There have been recent recruitments to vacant posts within the team. The new QI team have been working at pace since starting with the Trust with the focus on embedding QI practices, building staff capabilities, and ensuring a strong foundation for the Trust as it transitions into new leadership and QI methodology.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Gloucester House Review - Improvement Plan Progress Update The Committee received an update on the Gloucester House Review Improvement Plan and the relocation project. Following the Gloucester House Review in Spring/Summer 2024, an Improvement Plan was implemented to address the 61 recommendations outlined in the report. Key concerns identified included governance and safeguarding, quality of education, equality, diversity and inclusion (EDI), and staff wellbeing. The plan is monitored through the Delivery Group. Substantial progress has been made across the improvement workstreams, with the overall Improvement Plan currently 89% complete. Individual workstream completion rates range between 76% and 100%. While the original workstreams remain relevant, the improvements specifically related to the original review have been separated out. This strand of work is expected to close by the end of October 2025, with outstanding actions either resolved, embedded into business-as-usual processes, or carried forward into ongoing workstream targets. In July 2025, the school underwent an Ofsted inspection and was rated Good in all areas. Two areas for improvement were identified and these will also be monitored in the Delivery Group.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

In relation to the relocation, a potential new site for has been confirmed as viable and relocation planning is currently underway. A Relocation Programme Board has been established, and a dedicated Project Manager is in place. A Material Change application has been submitted to Ofsted, who have responded with queries regarding site visits and potential building works.	

Summary of Decisions made by the Committee:

The Committee agreed the proposed revisions to its Terms of Reference.

Risks Identified by the Committee during the meeting:

The Committee noted the following new risk:

- There are repeated issues related to agreeing the process and responsibilities of shared care agreements between the gender service and primary care. This has been escalated to NHS England through a quality alert and remains under discussion as part of commissioning meetings. *(reference Quality & Safety Report September 2025; themed learning from complaints)*

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

None.

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

Item	Purpose	Date
None.		

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: EDI Annual Report 2024-25			**Agenda No.: 016**
Report Author and Job Title:	Dr Thanda Mhlanga Head of Culture and Inclusion	**Lead Director:**	Kasia Parfenyuk Deputy Chief People Officer
Appendices:	Appendix 1: EDI Annual Report 2024-25.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This EDI Annual Report is an overview of the Equality Diversity and Inclusion landscape at Tavistock and Portman. It provides the reader with a window through which they can visualise the challenges and actions that have been taken so far. It concludes by making some recommendations and amelioration strategies.		
Background:	The EDI Annual Report is a live document that helps us reflect on our EDI challenges: celebrating our successes but most importantly focusing on areas where improvements are still required.		
Assessment:	The Trust continues to make meaningful progress on its journey towards lasting cultural transformation. Yet our EDI performance indicators make clear that we have not yet reached the level of inclusion and equity we aspire to. Some of the challenges we face are deeply cultural, demanding courage, consistency, and resilience to overcome. To drive real change, we have identified three priority areas that will remain our unwavering focus until they are fully embedded in the fabric of our organisation. We recognise this transformation will take time, but our commitment is steadfast, and our direction is clear.		
Key recommendation(s):	The Board of Directors is asked to: • **REAFFIRM COMMITMENT** to the three EDI priorities that have guided our work over the past two years. • **CHAMPION AND ENDORSE** the EDI Annual Report and its key findings. • **APPROVE AND DRIVE IMPLEMENTATION** of the report's recommendations to ensure measurable progress.		

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

	provider of training & education	research in this area			
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☒	Responsive ☐	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☐	Compassion ☐	Respect ☐	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: **BAF Risk 7 – Lack of a Fair and Inclusive Culture**				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	• Standard NHS Contract • Equality Act (2010) • Public Sector Equality Duty (PSED)				
Resource Implications:	Yes ☒	No ☐			
	• Equalities Training Budget • Events to support staff networks				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Addressing inequalities.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	EDI Programme Board and People and Organisational Development, Equality Diversity and Inclusion Committee – 6 November 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	

NHS
The Tavistock and Portman
NHS Foundation Trust

Annual Equality Diversity & Inclusion Report 2024-25

Report Produced: June 2025

Report Published: 10th July 2025

Contents

1. Foreword

The Tavistock and Portman NHS Foundation Trust remains steadfast in its commitment to becoming a truly inclusive, diverse and equitable organisation. Our Equality, Diversity and Inclusion (EDI) Programme Board, chaired by the Chief Nursing Officer, continues to drive delivery of the Annual Inclusivity Plan, which brings together the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) and other key equality indicators.

Alongside this, we launched the Patient and Carer Race Equality Framework (PCREF) in line with national requirements for mental health trusts. Led by the Chief Medical Officer, our PCREF Implementation Group is deepening our understanding of health inequalities, analysing access, experience and outcomes, and working collaboratively with communities to build a culturally competent and responsive workforce.

We are deliberately challenging systemic barriers and behaviours that sustain inequity. While we are proud of the progress made, we recognise that our journey is far from complete. Staff survey results and equality metrics reveal persistent disparities: colleagues from Global Majority backgrounds and those with Disabilities or Long-Term Health Conditions continue to experience higher rates of bullying, harassment and discrimination, and face barriers to progression.

We also acknowledge that many staff still do not feel confident sharing protected characteristics, particularly around disability, gender identity and sexuality. Building a culture of trust, openness and psychological safety remains central to our ambition.

Nationally, the 2024-25 NHS Staff Survey highlights that while we have achieved improvements in some areas, we continue to underperform compared to our peers. This reinforces the urgency for meaningful, sustained change.

Our focus is clear: to move beyond compliance towards cultural transformation and embedding compassion, fairness and accountability in everything we do. We are not content with incremental progress; we are committed to creating a workplace where every colleague feels valued, respected and able to thrive.

2. Our Desired Future State

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

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

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

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

3. Our Equality Diversity and Inclusion Priorities and Metrics 2025

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

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

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

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

Table 1: Tavistock and Portman WRES 2024-25 Synopsis

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

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

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

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

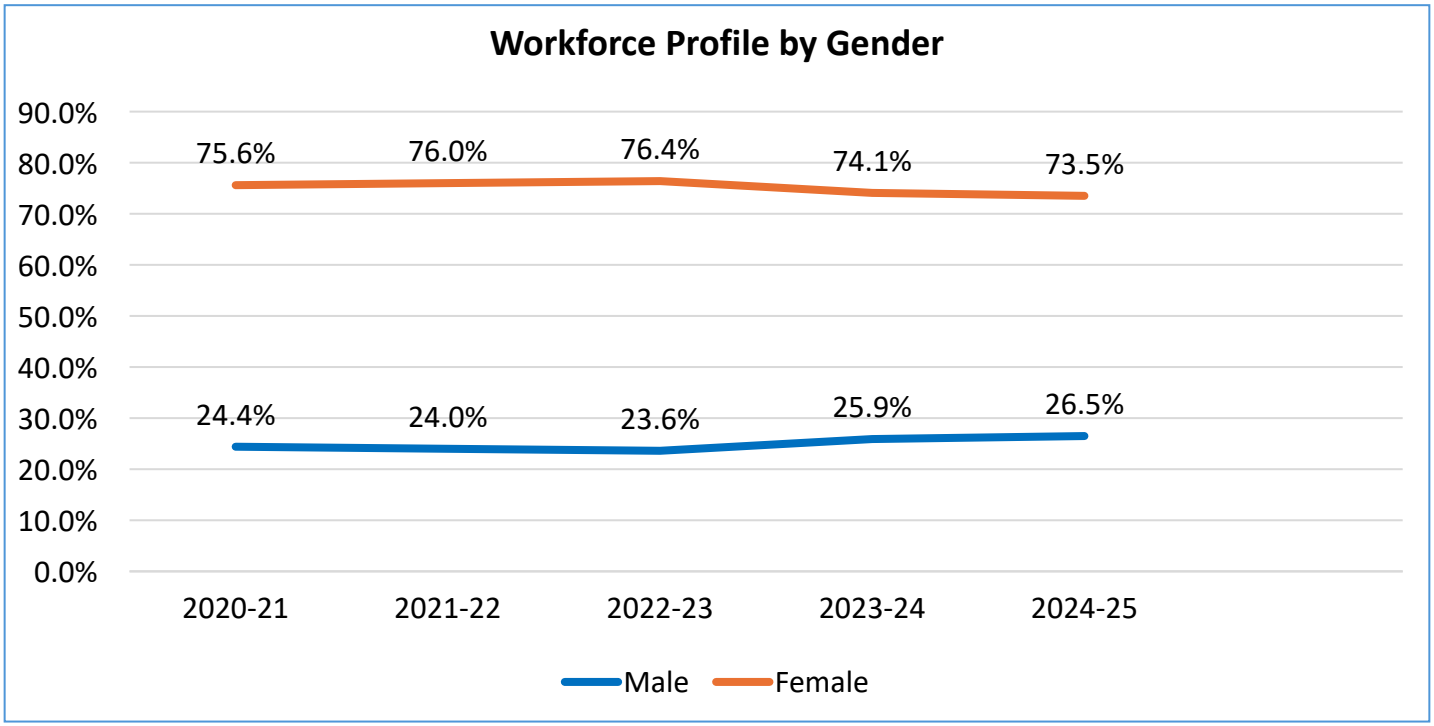
Table 2: Tavistock and Portman WDES 2024-25 Synopsis

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

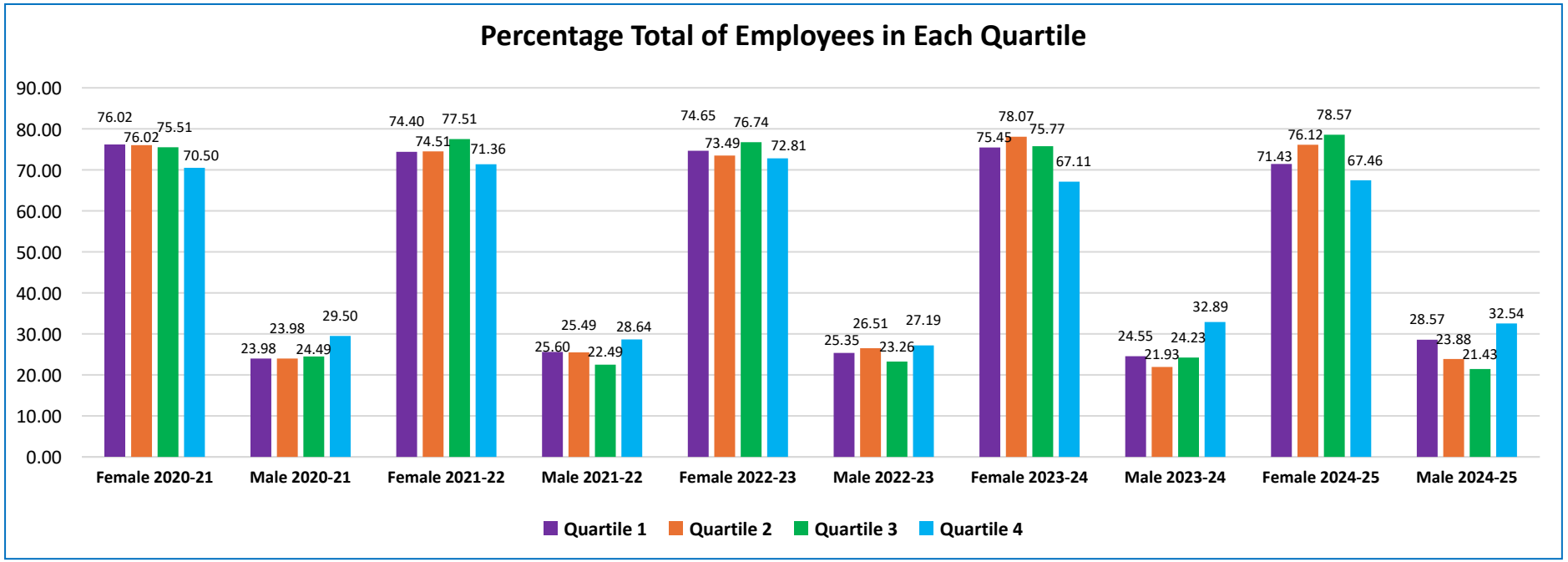
6. Gender Pay Gap

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

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



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



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

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

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

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

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

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

7. Building our Culture for Inclusion

The Trust continues to advance its commitment to fostering an environment where diversity is valued, inclusion is embedded, and equity underpins all that we do. Over the past year, a range of targeted initiatives have been implemented to enhance the experiences of our staff and students, improve the care we deliver to patients, and celebrate the rich diversity within our organisation.

Key highlights include:

- **EDI data by locality:** Breaking down EDI data at the locality level has enabled greater ownership and accountability, allowing teams to develop tailored improvement strategies through the A3 methodology.
- **Inclusive recruitment:** We have strengthened our inclusive recruitment practices by formalising feedback from EDI panel representatives to the Chief Nursing Officer and Chief People Officer. The EDI Programme Board also approved the sharing of interview questions 48 hours in advance - an important step towards levelling the field for neurodiverse applicants and advancing our Disability Confident Employer commitments.
- **Equality Impact Assessments (EIAs):** Awareness and application of EIAs have been strengthened across the Trust, ensuring that all new processes, policies, services, and strategies are assessed for their impact on equality and inclusion.

7.1 LGBTQI+ Staff Network

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

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

Achievements

- Strong collaboration with the Race Equality Network and Purple Circle Network, working with an intersectional scope and supporting each other.
- Planning and holding successful events including the Pride Picnic, Memoirs Writing Workshop, Joint Winter Celebration, and Staff Networks Day – all of which boosted visibility and brought in new members.
- Positive and supportive working relationship between the co-chairs.
- Joint development of a comms plan with other staff networks.
- Consistent and timely support from our executive sponsor.
- Designing and distribution of a questionnaire to gather staff experiences of being LGBTQI at the Trust.

Challenges

- Low engagement and attendance at network events and meetings.
- Difficulties in managing timely communications and building an effective relationship with the comms team.

Priorities for the Future

- Continue collaborative, intersectional work with other staff networks.
- Strengthen comms processes and roll out a new comms plan.

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

7.2 Purple Circle Staff Network

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

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

Achievements

- Wellbeing Event: Initiated a dedicated wellbeing event for network members, extending its reach to other staff networks and the wider Trust community.
- Allergy Awareness Campaign: Initiated a campaign promoting awareness, consideration, and respect for all staff members, aligning with the Trust's reasonable adjustment and self-care priorities.
- Contribution to HR Policies: Provided input into the development of new HR policies and procedures, embedding Equality, Diversity, and Inclusion (EDI) principles to support and reflect the Trust's core values.
- Increased Membership: Achieved growth in network membership and participation.
- Enhanced Engagement: Strengthened engagement across the Trust through collaborative initiatives and inclusive practices.

Challenges

- Low Attendance: Limited participation in network events and meetings, impacting engagement and overall momentum.
- Budget Constraints: A budget freeze has restricted the ability to progress with planning and delivery of the wellbeing event.

Priorities for the Future

- Collaborate with the Wellbeing Team: Develop and deliver an awareness outreach programme for the Trust, focusing on how perimenopause and menopause impact women's productivity in the workplace.
- Support During the Merger: Continue serving as a point of contact for network members pre- and post-merger until all members are fully integrated into the new structure.
- Strengthen Communications: Enhance communication processes and implement the newly agreed communications plan to ensure consistent and effective engagement.
- Grow and Strengthen the Network: Utilise insights from the Staff Networks Engagement Survey to inform strategies for expanding and reinforcing the Purple Circle Staff Network.
- Promote Inclusion and Wellbeing: Support initiatives aimed at improving Reasonable Adjustments and addressing issues related to presenteeism, bullying, harassment, and abuse within the workplace.

7.3 Race Equality Network

The Race Equality Network (REN) stands as a vital force within the Trust's commitment to equity, echoing the purpose of other staff networks while taking a bold and focused stance against systemic

racial inequality. REN is not only a space for solidarity - it is a catalyst for cultural transformation. It champions the voices of staff from racially and ethnically minoritised backgrounds, ensuring they are not only heard, but respected, empowered, and included. REN plays a dual role:

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

Achievements

- Established online monthly meetings.
- Quarterly attendance and engagement from Executive who has initiated Black History walks.
- CEO has engaged with the network regarding the merger.
- Successful filling of the role of Co-Chair after a two-year vacancy – a development expected to bring renewed energy, leadership, and closer alignment with the Trust's Race Equality Priorities.
- Remaining a vital component of the Trust's commitment to inclusion, anti-racism, and staff engagement, with ongoing executive support.

Challenges

- The main challenge is ongoing difficulties in managing timely communications and building an effective relationship with the comms team – a challenge attributed to staff shortages. This has resulted in a noticeable absence of opportune intranet updates and visibility, promotion of events and awareness days, and archiving/sharing of past work on the REN page. Communication support has been minimal since January 2025, leading the network to feel the need to re-establish connection with the Comms team.

Priorities for the Future

- Continue collaborative, intersectional work with other staff networks.
- Establish a clear and sustainable collaborative framework with the Communications team to ensure timely publishing of events and updates, regular updates to the REN intranet page, promotion of awareness campaigns aligned with Trust-wide EDI goals.
- Establishment of a dedicated point of contact within the Comms team for the network.

8. Patient Carer Race Equality Framework (PCREF)

Now in the second year of our PCREF commitment - a pledge to unmask, understand, and address health inequalities. We have made steady progress:

- An Executive Board Lead for PCREF is in place.
- Governance structures are established.
- A bi-monthly PCREF Implementation Group drives delivery.
- Accountability and leadership for PCREF are being strengthened.
- Co-development with racialised communities and staff is a core priority.
- High-profile events with external speakers have raised awareness – we aim to foster a culturally responsive workforce.

9. Conclusion & Recommendations

As with previous years, this report underscores the inherent complexity of measuring progress in Equality, Diversity and Inclusion (EDI): a domain that is as much qualitative as it is quantitative.

Our latest WRES and WDES results reveal a mixed but instructive picture, for instance:

- **WRES:** We improved in 5 of 9 indicators. Notably, the proportion of staff from Global Majority backgrounds who believe we offer fair opportunities for progression rose by 12.9%, though it remains 15 points below the national average. Conversely, while reports of bullying, harassment and abuse from patients and the public increased by 7.9%, we still perform better than the national benchmark.
- **WDES:** We improved in 8 of 13 measures. The most significant gain - a 21.2% rise in disabled staff reporting bullying and harassment incidents places us 3.7% above the national average, reflecting growing confidence in our reporting culture.

This uneven progress highlights the multifaceted nature of EDI improvement - marked by advances, stagnation, and persistent inequities, particularly among marginalised and disadvantaged groups. To address these disparities, we must confront the uncomfortable truths revealed by our data and redouble our commitment to the three EDI strategic priorities launched two years ago.

A closer analysis of staff experiences has identified clear areas for focused action. Accordingly, the following recommendations are made to drive sustained and equitable progress.

Recommendations	
1.	**Standardise Reasonable Adjustments:** Establish a clear, Trust-wide process and policy for reasonable adjustments, supported by manager training to ensure consistency and accountability.
2.	**Tackle Presenteeism & Foster Compassion:** Promote a culture where staff with disabilities or long-term conditions feel supported to take time off when unwell, without fear or pressure.
3	**Share Staff Survey Insights Widely:** Disseminate WRES/WDES findings Trust-wide (by locality area) to build awareness of EDI challenges and drive bespoke responsibility for improvement.
4.	**Address Bullying, Harassment & Discrimination:** Require every service to review internal issues, discuss findings, and develop targeted improvement plans.
5.	**Remove Barriers to Reporting Bullying, Harassment and Abuse:** Strengthen mechanisms that make reporting discrimination, bullying, and harassment safe, simple, and effective.
6.	**Audit Disciplinary and Capability Processes:** Regularly review pre-formal and formal cases for racial or disability bias; share themes and learning quarterly.
7.	**Expand Informal Mediation Capacity:** Enhance access to early, confidential mediation to resolve conflicts before they escalate.
8.	**Standardise Recruitment Communications:** Update all recruitment materials to consistently reflect the Trust's values and ensure consistent application across services.
9.	**Ensure Fair Access to CPD Opportunities:** Route all non-mandatory and non-ELT-approved training requests through the CPD panel for transparent decision-making.
10.	**Increase Transparency in Promotions & Secondments:** Require all internal promotions and secondments to be reviewed and approved by a panel to ensure fairness and equity.

10. Acknowledgements

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

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC - 20 NOVEMBER 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance, Finance & Resources Committee	22nd September 2025	Aruna Mehta, Non-Executive Director	Jonathan Bell, Interim Chief Finance Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item:** 17a		

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. Financial Performance at Month 5 The Committee received a report from the Interim Chief Financial Officer setting out the financial performance at Month 4 and 5. Key messages include: • The Trust is reporting a year to Month 5 deficit of £3,733k, which is £1,098K 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 (NTC) and shortfalls in Cost Improvement Plan (CIP) delivery. • Pay costs are over plan, largely reflecting a shortfall in pay-related CIP due to delays in delivery and reliance on staff turnover. • Members requested that all non-pay areas be reviewed to support efficiency targets. • The cash request for September was reduced by 50% by NHSE. The current cash forecast projects a further cash support requirement of £2.17m in November. NHSE will not approve any further support until the Trust provides a plan for financial sustainability. • The set up of a Cash Committee will be explored.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Efficiency Programme and Land Sale • Cost Improvement Plan (CIP) delivery against the target remains a key area of focus and risk. The submitted breakeven plan is dependent on delivering a significant level of savings and other non-recurrent measures.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

• The financial plan requires a net gain of £2.4m from the sale of Gloucester House. Members discussed the need for NED oversight and clarification on the technical accounting of the transaction.	
3. Risk and Governance Assurance • The CFO's executive risk register identified three high-scoring financial risks (scoring 20 each): Insufficient cash flow; failure to deliver CIP and; failure to deliver break-even. • Digital Metrics: The Committee was ASSURED that the digital metrics are fit for purpose. • Business Continuity: Deadlines for Business Continuity Plans have been achieved, and the EPPR Audit provided reasonable assurance. • System Oversight Framework (SOF 3): The Trust remains in Segment 3.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

None

Risks Identified by the Committee during the meeting:

No New Risks

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

No items

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

Item	Purpose	Date

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC - 20 NOVEMBER 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Extra-Ordinary Performance, Finance & Resources Committee	2nd October 2025	Aruna Mehta, Non-Executive Director	Jonathan Bell, Interim Chief Finance Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item:** 17b		
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. Financial Recovery and Cost Improvement Programme (CIP) • The Committee reviewed the oversight of the Cost Improvement Programme (CIP) Plan, acknowledging the highly challenging financial targets. • It was reported that CIP Governance processes are in place, including weekly Efficiency Programme Board meetings chaired by the CEO and supported by the business development and strategy team. Senior Responsible Owners (SROs) present progress on a rolling, four-weekly cycle. • The original savings plan was £8.4 million, including £3.9m of CIP, £4.0m of non-recurrent measures and an increase in income from Tavistock Consulting. A further stretch target has been set to address the full year effect of 2024/25 recruitment and deliver a breakeven position. Delivery of the CIP targets is very challenging, particularly due to the high proportion of substantive staff combined with the lowest staff turnover rate among all NHS Mental Health trusts. Achieving workforce changes to meet CIP targets would require redundancies for which there is no funding. • The savings plan does not incorporate any additional savings that would be required due to the loss of the National Training Contract (NTC). Unless the £2.6 million NTC income is recovered, the Trust faces a £2.6 million deficit as it has no capacity to deliver additional savings. A letter has been sent to NHSE regarding the withdrawal of the NTC funding and a meeting is planned to discuss mitigations to this loss. • A Mutually Agreed Resignation Scheme (MARS) was discussed but is not being pursued due to concerns regarding its limited impact given the low staff turnover. Furthermore, the cost of MARS is prohibitive.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

• Recovery actions are in place, including a freeze on recruitment (unless it creates a risk to patient safety) and a non-pay oversight group is being set up. • The Committee requested that quality impact assessments are added to the Quality and Safety Committee agenda in October and equality impact assessments are included in the EDI Programme Board Assurance Report.	
2. Asset Sale • The financial plan for 2025/26 is reliant on key asset sales and the cash position remains precarious. The financial position assumes the completion of the sale of Gloucester House within the financial year. A red book valuation of the asset has been received, for both with and without planning permission. The Committee agreed that exploring the feasibility of obtaining planning permission within the necessary timeframe should be pursued. • Relocation of the services current using Gloucester House entails upfront costs that could negatively impact this year's financial balance if the sale is not finalised by the end of the year. • Engagement with the school, local authority, school governors, and parents of pupils transferring over has been positive.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. Cash Position • The receipt of Public Dividend Capital (PDC) in November is dependent on the Trust evidencing a sustainable financial position. The PDC decision is scheduled close to the current planned date for the merger Full Business Case submission date.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

None

Risks Identified by the Committee during the meeting:

No New Risks

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

None Identified

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

Item	Purpose	Date
The Committee requested that quality impact assessments are added to the Quality and Safety Committee agenda in October	Assurance	October 2025

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC - 20 NOVEMBER 2025					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance, Finance and Resources Committee	3rd November 2025	Aruna Mehta, Non-Executive Director	Jonathan Bell, Interim Chief Finance Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item:** 17c		

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. Current Financial Performance (to Month 6) • The financial position remains challenging, impacted by historical risks and dependent on future asset sale realisations. • Month 6 Deficit: The Trust is reporting a year-to-date deficit of £3.996 million, which is £1.4million adverse to the submitted plan. • The adverse variance stems from income loss (National Training Contract - NTC) and non-pay deficits. A significant portion of the adverse non-pay variance (£672K) is attributed to phasing misalignment related to provision releases (PCPCS/NCL provision) that is expected to phase out over the next six months. Other unanticipated costs included an unfunded VAT liability adjustment (£115K) and redundancy for the decommissioned Surrey Mindworks contract.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Year-End Forecast • The Committee received a paper on the year-end forecast: The likely scenario forecast projects a Year-End deficit of around £5.0million of which £2.6m relates to the loss of the NTC and £2.4m is slippage on CIP and additional in-year pressures. • The reported Month 6 deficit (and the likely forecast) assumes the completion of the sale of Gloucester House, which is intended to deliver a gain of approximately £2.4million in the second half of the year (originally planned for January).	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. Cost Improvement Programme • Achieving the Cost Improvement Programme (CIP) target is highly challenging. Pay savings would require redundancy costs, which are problematic to implement due to proximity to the merger TUPE process	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

and cost. The possibility of implementing a voluntary redundancy scheme funded by transaction monies is being discussed with NLFT.	
4. Cash Position and Contingency Planning • The short-term cash outlook remains very challenging, requiring external working capital support. • Cash Support Application: An application for £2.1million in cash support for November has been submitted to NHSE and the Trust is currently awaiting the decision. • NTC Income Recovery: It was reported that Management is working with NHSE to find a solution to the £2.6million income loss in 2025/26 that is currently reflected in the forecast	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Estates Update • Progress is being made in critical areas related to the merger with NLFT. • Estates Capital: The majority of capital expenditure since 2021 has focused on asset replacement (e.g., new library, lifts). The Six-Facet Survey reports that the Trust's estate carries an asset level of risk C, with 73% of the estate in Condition C. This report will be shared with NLFT for due diligence purposes. • The committee received a report from Tavistock Consulting setting out risks in relation to financial performance against plan in 2025/26, along with an assessment of the growth challenges and options for an operating model for delivering a financial contribution to the Trust. The committee asked the Executive to work with NLFT on a strategic plan (including a SWOT analysis) for growing the TC business in future, to report back into the Board in January.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. IT/Digital and Risk Management • The Committee received a report on the Digital initiatives and were pleased to hear that these initiatives are advancing, with a strong focus on alignment with the merger partner and efficiency. • The Trust has achieved re-accreditation for Cyber Essentials for another 12 months and discussions are underway with NLFT regarding maintaining accreditation post-merger. • The Trust is exploring the use of AI and an AI steering group is looking at the use of Copilot in Microsoft Office and piloting ambient voice technology (AVT) for clinical note-taking. The steering group will ensure that any AI initiatives meet clinical and data safety requirements and will prohibit the use of tools that store data outside the UK. The adoption of these tools is expected to deliver future efficiency gains. • Clinical Systems: The plan to migrate the existing Care Notes system to the Rio system used by NLFT is targeted for the end of 2026. This project involves complex data migration and staff training requirements.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. Contracts Risk Overview: • The committee received a report on current contract risk and was assured on contract performance metrics and that contract risks are being actively managed. The Committee requested that future contract	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

risk reporting explicitly include contract values, noting that the highest current risk score (5) represents over £1million in risk.	
8. Governance and Administration • Minor updates to the PFRC ToR were approved, notably clarifying the Committee's role to oversee cash management policies, not develop them. • Minutes for the September 22 meeting and the extra-ordinary meeting on October 2 PFRC meetings were approved. • The Committee noted an escalation from the Quality and Safety Committee regarding outstanding CQC recommendations related to Health and Safety and the action was logged for follow-up at the next meeting.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

None

Risks Identified by the Committee during the meeting:

None

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

None

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

Item	Purpose	Date

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 20 November 2025			
Report Title: Finance Report - As of 30th Sep 25 (Reporting Month 06)			**Agenda No.: 018**
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 06 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 £3,966k, which is £1,404k, 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 in 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 in Month 6, actual capital spend is £1.086m, which is below the planned profile of £2.099m. The variance is largely attributable to phasing delays, with most capital projects expected to commence from Month 6 onwards. The full-year capital spend is expected to remain in line with plan. **Cash** Cash flow remains under significant pressure. As of Sep 2025, the Trust had a cash balance of £910k, equating to 5 days of operating expenditure. For September, the Trust requested £1.028m and only secured £500k in approved cash support from DHSC. The receipt of an outstanding debtor 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. The Trust submitted an application on the 10th October for the £2.170 PDC cash support required in November and the support was confirmed in full on the 10th November. The total cash support required for the year remains at £4.266m, reflecting both the impact of the £2.6m loss of income from the National Training Contract and the Trust's constrained underlying cash position.		

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 DEI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Performance and Finance Committee (3rd November 2025)				

Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Finance Report 25/26 – Year to 30th Sep2025 (Reporting Month 06)

1. Overview

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

Financial Reporting Summary - Month 06 2025/26 (compared to submitted plan)			
£'000	**Sep-25 YTD Plan**	**Sep-25 YTD Actual**	**Sep-25 YTD Variance**
Income	29,126	28,641	(485)
Pay	(25,619)	(25,780)	(161)
Non-Pay	(5,991)	(6,757)	(766)
Non-Operating Expenditure	(108)	(100)	8
TOTAL Provider Surplus/(Deficit)	**(2,592)**	**(3,996)**	**(1,404)**

The Trust closed Month 6 with a year-to-date deficit of £3.996m, £1.404m adverse to plan.

Performance is driven by three factors:

(i) a structural loss of income following cessation of the National Training Contract (NTC)
(ii) slippage in the efficiency (CIP) programme across pay
(iii) phasing/technical effects within non-pay and provisions.

These pressures have been partly offset by favourable ERF phasing and unplanned allocations (notably the NCL block), alongside tight control of agency usage and release of legacy provisions.

Cash remains constrained at £0.91m (≈5 days' operating cost), with approved PDC support in August/September and a further £2.17m approved for November.

There are no material balance-sheet movements this month; the capital programme is behind profile but expected to accelerate in the second half.

2. Income – Month 6 (YTD)

2.1 Position

- YTD income £28.641m vs plan £29.126m — £485k adverse.

- The variance is structural in nature (loss of NTC - £1.3m YTD, £2.6m FYE) with partial in-year offsets (ERF phasing and unplanned allocations, partly off-set by costs).

3. Pay

3.1 Substantive pay

Pay is £161k over plan year-to-date. The variance is mainly driven by a £298k shortfall on pay-related CIP, reflecting delivery slippage and reliance on natural staff turnover. There is also a £74k one-off pension cost for Gloucester House teaching staff, and an overspend on bank of £67k to cover vacancies.

These pressures were partly mitigated by:

- a £235k release of clinical provisions, and
- £43k additional capitalised staff costs in I&MT and Capital Accounting compared with plan.

3.2 Agency cost position

Agency spend: £288k, £6k above plan. Overall agency use remains under tight control, supported by pre-approval and greater use of fixed-term contracts to cover gaps. While helpful, this does not fully offset the pay CIP shortfall.

The pay variance is consistent with the wider I&E picture: efficiency delivery remains the key risk into 2nd half of the financial year. The immediate focus is to tighten establishment controls, time-limit bank/agency cover and deliver confirmed pay CIPs to reduce the run-rate.

Assurance: monthly review of vacancy factors and CIP delivery by scheme/owner, with corrective actions agreed through PFRC or ELT where slippage is identified.

4. Non pay

4.1 Non Pay Position.

Non-pay is £766k over plan YTD. The variance is almost entirely explained by one-off/technical items and timing, partly offset by delivery of non-pay

4.4 Actions to deliver H2:

- Seek commissioner contribution for Surrey decommissioning costs
- identify line-item offsets (consultancy, training, travel) via non pay oversight group (NPOG).
- Tighten spend controls: maintain No-PO/No-Pay, catalogue-first, and pre-approvals (consultancy, training, events, subscriptions). Use directorate envelopes with recovery next month for any overshoots.
- Procurement levers: top-supplier re-price (2–3%), consolidate maintenance contracts, and T-90 licence renewals to remove idle/duplicate subscriptions.

5. Non-Operating Costs

Operating non-pay costs for the period were £100k, which is £8k better than the planned figure.

6. Cash

As at 30th Sep 2025 (Month 6), the Trust's cash position remains under significant strain. The reported cash balance is £910k, equivalent to 5 days of operational expenditure, highlighting a critically low liquidity position.

PDC Cash support received to date total £2.096m (£1.582 Aug 2025 and 0.514m Sep 2025). Payments due in November total c. £5.384m, against inflows of c. £3.0m, creating a gap of c. £2.384m. To maintain payroll and statutory/critical supplier payments, the Trust requires £2.170m Working Capital Support PDC in November. PDC cash support application was submitted the Trust was notified on 10th November that the request has been approved in full.

6.1 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	Approved	Supports operational pressures and delays in contract income. Revised to reflect 50% reduction in Sept-25

Total cash support required for the year remains at £4.266m, aligned to earlier forecasts and inclusive of the impact of the £2.6m loss in income from the National Training Contract.

The cash request of £1.02m for September was reduced to £0.5m 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 and this has been confirmed.

7. Balance Sheet

No movements of note to report at Month 06.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 20 November 2025			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 019**
Report Author and Job Title:	Rhiannon Adey, Interim Deputy Company Secretary	**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 **four changes** to the Schedule of Business since the last Board meeting. Deferred item • The Green Plan/Sustainability Strategy has been deferred to the January meeting New items • 10-point plan to improve resident doctors working lives action plan added to the schedule for January Board following presentation of the 10-point plan at the Extra-ordinary Board of Directors in Private in October. • Gender Identity Clinic update added to the schedule for January Board following the Annual Members Meeting on 30 October 2025. • Higher Education Sector Risks added to the schedule for January Board following the Board Development Session in November. 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,	☒ Developing partnerships to improve population health and building	☒ Developing a culture where everyone thrives with a focus on	☒ Improving value, productivity, financial and

	national & international provider of training & education	on our reputation for innovation and research in this area	equality, diversity and inclusion	environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All BAF risks.				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no specific legal and regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no additional EDI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Board of Directors – 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	

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

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**				
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	CETO						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		D		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

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2025					2026			Board / Committee / Meeting	
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**
Date of Meeting			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Medium Term Financial Plan update	Approval	CFO	P						Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental sustainability	Annual
Financial Plan 2026/27 (if required)	Discussion	ICFO						P			Improving value, productivity, financial and environmental sustainability	Annual
Board Service Visits	Discussion	Chair			P						Corporate Reporting covering all strategic ambitions	Annual
Strategy / Policy Approval/Ratification (usually every 3 years)												
Year 3 (2025/26)												
External Board/ Governance Review (once every three years) Report	Discussion	Chair									Corporate Reporting covering all strategic ambitions	3 yearly
Modern Slavery Statement	Approval	CNO									Providing outstanding patient care	Annual
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental	3 yearly
Green Plan/ Sustainability Strategy	Approval	CFO				D	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
10-point plan to improve resident doctors working lives action plan	Discussion	CMO					P					
Gender Identity Clinic Update	Discussion	CNO					P		Quality & Safety Committee		Providing outstanding patient care	Variable
Higher Education Sector risks	Discussion	CETO					P		Education and Training Committee		Enhance our reputation and grow as a leading local, regional, national & international provider of training & education	Variable