The Tavistock and Portman NHS Foundation Trust

Meeting Book - Board of Directors in Public

TABLE OF CONTENTS

The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 15th January 2026

Tavistock Centre, 120 Belsize Lane, NW3 5BA and Virtual

Please refer to the agenda for timings.

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY, 15 JANUARY 2026 AT 2.00PM – 5.15PM
VENUE: BOARD ROOM, TAVISTOCK CENTRE AND VIRTUAL

Living our values:

AGENDA

26/01/	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	Minutes of the Previous Meeting held on 20 November 2025	Approval	Chair	E	2.05 (5)	
005	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.10 (5)	
006	Chair and Chief Executive's Report (including Merger and Board Service Visits update)	Information	Chair and Chief Executive Officer	E	2.15 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC AMBITIONS)						
007	Integrated Quality Performance Report (IQPR) Including update on risk areas/ areas in structural support	Discussion	Executive Directors	E	2.25 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
008	National Oversight Framework Update	Discussion	Director of Strategy and Business Development	E	2.40 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	10-point plan to improve resident doctors working lives action plan	Discussion	Interim Joint Chief Medical Officer	E	2.50 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
010	Integrated Audit and Governance (IAG) Committee Assurance Report	Assurance	IAG Committee Chair	E	3.00 (5)	Limited ☐ Partial ☐ Adequate ☐

						N/A ☒
PROVIDING OUTSTANDING PATIENT CARE						
011	Quality and Safety (Q&S) Assurance Report	Assurance	Q&S Committee Chair	E	3.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
012	Guardian of Safer Working Report	Information	Interim Joint Chief Medical Officer	E	3.05 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
013	Patient and Carer Race Equality Framework (PCREF) Update	Discussion	Interim Joint Chief Medical Officer	E	3.10 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Comfort Break (10 minutes) 3.20p.m – 3.30p.m						
014	Gender Identity Clinic Update	Discussion	Chief Nursing Officer	E	3.30 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
015	Quality Update	Discussion	Chief Nursing Officer	E	3.45 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
016	Service User Story: Eating difficulties and avoidant restrictive food intake disorder (EDAS) service	Discussion	Thomas Hawksworth, Specialised CAMHS Clinician	V	4.00 (20)	
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
017	Higher Education Sector Risks	Assurance	Chief Education and Training Officer	E	4.20 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
018	Education and Training (E&T) Committee Assurance Report	Assurance	E&T Committee Chair	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
019	People, Organisational Development, Equality, Inclusion and Diversity (POD EDI) Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
020	Finance Report: Month 07	Information	Interim Chief Finance Officer	E	4.35 (10)	Limited ☐ Partial ☒ Adequate ☐

						N/A ☐
021	Performance, Finance and Resources (PFR) Committee Assurance Report	Assurance	PFR Committee Chair	E	4.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
022	Emergency Planning Annual Report, Letter of Declaration and Self-Assessment against Core NHS Standards for Emergency Preparedness, Resilience and Response (EPRR)	Discussion	Chief Nursing Officer	E	4.50 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CLOSING ITEMS						
023	Board Schedule of Business 2025/26	Information	Chair	E	5.00 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
024	Questions from Governors	Discussion	Chair	V		
025	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		
026	Questions from the Public	Discussion	Chair	V		
027	Reflections and Feedback from the meeting	Discussion	Chair	V		
DATE AND TIME OF NEXT MEETING						
028	Thursday 19 March 2026 at 2.00 – 5.00p.m.					

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 05/01/2026)

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 (2nd Term)	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			
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			
KATE BOWDITCH	Acting Chief People Officer	3 November 2025	Interim Chief People Officer of North London NHS Foundation Trust			
KARL MILNER	Acting Director of Communications, Marketing and Engagement	3 November 2025	Director of Communications, Marketing and Engagement of North London NHS Foundation Trust			
			Occasional consultancy - PR and Communications advice, Plain Speaking Ltd;			
			Voting and dividend rights, 10% of total share issue in GenNorth Limited, a construction consultancy based in Teesside who work on NHS and educational build programmes			
			Adviser on corporate rebrand, occasional consultancy, NHS AQUA (Salford, Manchester).			

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
TERRY WILLOWS	Acting Director of Corporate Governance	1 December 2025	Director of Corporate Governance of North London NHS Foundation Trust			
			Director of Happy Healthy Longer Ltd, a health and wellness coaching business			
			51 ordinary shares in Happy Healthy Longer Ltd.			
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	
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	
DOROTHY OTITE	Director of Corporate Governance (Interim)	03/02/25 - 03/12/25	NIL RETURN			

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 20th NOVEMBER 2025 AT 2.00 P.M.

BOARD ROOM,
THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST,
120 BELSIZE LANE, LONDON NW3 5BA
AND VIRTUALLY VIA MS TEAMS

MEMBERS PRESENT:

Voting

Sal Jarvis	Vice-Chair of the Board of Directors	SJ
Ken Batty	Non-Executive Director, Chair Integrated Audit and Governance Committee	KB
Janusz Jankowski	Non-Executive Director & Deputy Chair Quality and Safety Committee	JJ
Claire Johnston	Non-Executive Director & Chair Quality and Safety Committee	CJ
Sabrina Phillips	Non-Executive Director	SP
Shalini Sequeira	Non-Executive Director & Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
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

Non-Voting

Kate Bowditch	Acting Chief People Officer	KBo

IN ATTENDANCE:

Sheena Bolland	Public Governor	SB
Kathy Elliott	Lead Governor & Stakeholder Governor	KE
Emily Mercer	D19 Course Lead	EM
Thanda Mhlanga	Head of Equality and Inclusion	TM
Jo Stubley	Strategic Lead for Trauma and Clinical Lead, Trauma Service	JS
Pauline Williams	Staff Governor	PW
Rhiannon Adey	Interim Deputy Company Secretary	RA

APOLOGIES:

Sheva Habel	Interim Joint Chief Medical Officer	SH
Michael Holland	Chief Executive Officer	MH
Aruna Mehta	Chair of the Board of Directors	AM
Dorothy Otite	Director of Corporate Governance (Interim)	DO
Clare Scott	Chief Nursing Officer	CS

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair (SJ) welcomed all attendees to the meeting and noted the apologies as listed above. The Chair welcomed KBo as Acting Chief People Officer. The Board noted their thanks to DO for her contribution to the Trust as Governance Consultant and more recently as the Interim Director of Corporate Governance.	

002	**CONFIRMATION OF QUORACY**	
	SJ confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest to be reported beyond those previously recorded.	
004	**DEPARTMENT FOR EDUCATION AND TRAINING PRESENTATION – COMPLEX TRAUMA: THE TAVISTOCK MODEL**	
	EM and JS presented to the Board on course D19 provided by the Department of Education and Training (DET). The course is named Complex Trauma: The Tavistock Model. It was queried whether those attending the course, which is on track for a British Psychoanalytic Council Kitemark accreditation, receives a specific title. It was confirmed that on completion of the course, which has NHS placements, students are able to use the title Trauma Therapy Practitioner. JS updated the Board that the team are considering the long-term strategy for the department of education and training and how clinical service delivery is linked with training. This is a key reason for students to choose the Trust as an education provider. JS acknowledged that the cost of courses could be prohibitive and the team were working with the Tavistock and Portman charity to determine whether it was possible to offer bursaries to enable representative attendance. The trauma service has been working to increase research which has been limited due to resource. There are now trauma specific outcome measures and the team are keen to receive a six-month follow up. Psychology graduates and trainees from the University of Essex are supporting with both qualitative and quantitative research around the trauma service. There has also been a one year pilot with East London Foundation Trust in research on body-oriented psychotherapy. It was acknowledged that the team provided the clinical trauma service as well as education and the merger with North London NHS Foundation Trust (NLFT) would provide an opportunity to increase placements. KBo updated that NLFT's cultural development programme had trauma-informed care as a key component, so acknowledged opportunities that the merger would bring.	
005	**MINUTES OF PREVIOUS MEETING**	
	The Board **APPROVED** the minutes of the previous Board Meeting (public) held on 18 September 2025.	
006	**MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW**	
	The Board reviewed the action log and **APPROVED** the closure of four actions. One item remained open relating to Oliver McGowan training.	

	Action: RA to confirm whether a certificate of completion is received for Oliver McGowan training	**RA**
007	**CHAIR AND CHIEF EXECUTIVE'S REPORT**	
	RB presented the report on behalf of MH noting that there had been significant changes to the Board since the last meeting with John Lawlor leaving the Board as Chair and AM, previously vice-Chair now Interim Chair until the merger by acquisition was enacted. John Lawlor was thanked for his excellent leadership and support, and the Board wished him well in his new role as Chair of Airedale NHS Foundation Trust. The Trust held their Annual Members Meeting on 30 October at the Tavistock Centre with the Chair of North London NHS Foundation Trust (NLFT) in attendance. The Trust continues to work with NLFT on the merger by acquisition planned for 01 April, subject to approval by NHS England and the Secretary of State for Health and Social Care. MH continued to hold monthly staff drop-ins to provide updates on the merger and executives from NLFT had been holding engagement sessions. The Board will continue to be updated with progress. The Trust received the Ofsted report for Gloucester House School with all areas receiving a "good" rating. The school will be moving to a new site imminently. The Trust continued to maintain student numbers with over 1450 students enrolled which is an increase of 120 on the previous year. The number of international students had met the visa cap which would allow the Trust to increase the number of visas in following years, an exceptional achievement where other higher education providers were seeing contractions. The National Staff Survey launched on 29 September and staff were encouraged to complete the survey to enable feedback to inform staff engagement plans pre and post-merger. It was queried whether there were targeted actions being undertaken to ensure an increased response rate to the staff survey. It was confirmed that each Executive Director was working with teams to ensure as many staff complete the survey as possible. CJ passed her thanks to MF and the Department for Education and Training for their efforts to enrol students. It was queried whether the joint service visits with Non-Executive Directors (NEDs) and Governors were continuing. It was confirmed that the visits would continue and KE offered to support with coordination of the Governors. **Action:** KE to work with the Trust to organise service visits for Governors SS queried how the learning was shared from service visits. It was agreed that this would be included with the Chief Executive's Report to Board confirming that the feedback had been shared with the team.	**KE**

	KBo commented that NLFT undertook quality and safety visits with the NEDs using a targeted approach. Data available to the Trust enabled the Executives and NEDs to understand information relating to the services prior to the visit and feedback was shared with the team to close the loop. 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**	
	RB presented the Integrated Quality Performance Report noting the significant demand on the Gender Identity Clinic. Quality improvement support has been provided by NHS England with the implementation of the DrDoctor portal and a review being undertaken of Did Not Attend rates. Job planning had been undertaken which showed that demand and capacity were not aligned. The Child and Adolescent Mental Health Service (CAMHS) were the best performers nationally, working closely with NLFT and the Royal Free London NHS Foundation Trust on the CAMHS collaborative. The Surrey Mindworks service closed at the end of September and the returning families service will close at the end of the year due to a lack of demand and referrals into the service. Mandatory and statutory training figures continued to improve; however, appraisal rates remained low. KBo noted that the appraisal rates were concerning, however, there were best practice initiatives that had been undertaken at NLFT that could be shared to support improvement. NLFT are implementing a new learning management system which will be available to Tavistock and Portman NHS Foundation Trust (TPFT) staff post-merger. The system has improved appraisal rates with staff feeling more engaged in the process. It was confirmed that the figures did not include medical appraisals. It was queried whether estates concerns impacting on patient safety were being addressed through the Clinical Incident Safety Group. MF commented that there were also obligations as a higher education provider to make reasonable adjustments to the estate for accessibility. **Action:** RB to ensure estates issues are addressed through the weekly executive safety huddle. The Board **DISCUSSED** and **NOTED** the IQPR report.	**RB**
009	**REVIEW OF BOARD COMMITTEE TERMS OF REFERENCE**	
	RB presented the review of the Board Committee Terms of Reference noting this was an annual review of the terms of reference with some changes to membership of the Committees. MF confirmed that the Gloucester House Steering Group reports directly to Board.	

	It was requested that the member of the Education and Training Committee should remain as the Chief Medical Officer to ensure this carries forward after the merger. **Action:** RA to make minor amendment to the Education and Training Committee Terms of Reference The Board **APPROVED** the revised Terms of Reference of the six Board Committees subject to the minor amendment noted.	**RA**
010	**PROVIDER CAPABILITY SELF-ASSESSMENT**	
	RB presented the provider capability self-assessment report noting that the self-assessment had been completed at a Board Seminar session to ensure that this was submitted ahead of the deadline. The submitted assessment was provided for the Board to note, acknowledging that an action plan would be developed to address areas of non-compliance. **Action:** RB to present the Provider Capability action plan to the Board in January. The Board **NOTED** the Provider Capability Self-Assessment submission.	**RB**
011	**INTEGRATED AUDIT AND GOVERNANCE (IAG) COMMITTEE ASSURANCE REPORT**	
	KB presented the report noting that the Board Assurance Framework required a review to ensure this captured the risks ahead of the merger. KB also updated that the Gifts, Hospitality and Conflict of Interest Policy had been reviewed last year to extend the number of staff required to make a declaration which had reduced our compliance when audited. It was noted that work was ongoing to improve compliance rates for this financial year. The Board received **ASSURANCE** from the update provided. KB highlighted that the next and last IAG Committee was due to be held in February which will be too early to review annual accounts. This had been raised at the meeting, and it was noted that any Board Sub-Committee would need to report back to the Board of Directors. KB recommended that an additional IAG Committee is held to provide a handover of information to NLFT. KB noted that the information governance annual report was received with a freedom of information compliance rate of 99% and a reduction in confidentiality incidents with no incidents reportable to the Information Commissioners Office. Thanks were passed to DO for the turnaround in confidentiality incidents.	
012	**GLOUCESTER HOUSE ACTION PLAN UPDATE**	
	MF presented the Gloucester House action plan noting the school's "good" Ofsted rating. The inspectors noted that the rating was commendable given the significant changes within the school with a new curriculum and high turnover of teachers at the beginning of the year.	

	The Gloucester House Review Action Plan had outstanding actions in the equality, diversity and inclusion workstream; however, it was expected that these actions would be closed imminently. A new site has been identified for the school in Highgate and consultation was ongoing with the owners of the site and Camden local authority partners. The current Gloucester House site had been marketed for sale. It was noted that the quality of assurance received through the Gloucester House Steering Group was more consistent and provided better clarity. KB noted that he had visited the site last week and undertaken a curriculum review of the children's workbooks which showed clear feedback from the teachers and a consistent marking structure. The workbooks showed evidence of progression from the students and it was clear that they understood the lesson content. The school provided feedback to KB that there were IT issues which were being resolved. **Action:** MF to confirm action owners and deadlines for the outstanding items in the action plan CJ commented that the paper did not evidence financial viability due to the number of students currently within the school noting that there was a plan to double the number of students in the new school location, however, there was a risk that local authority budgets are stretched which may impact the funding available for those students. It was also highlighted that the Gloucester House outreach forecast was below target. It was queried whether achieving financial balance was achievable. RB updated that the move to the new site would provide opportunity to increase the student numbers to 24 which would create a sustainable contribution. It was acknowledged that work was required for the move to enable this to happen. Conversations were ongoing with Camden Council around the medium to long term financial plan, however, it was acknowledged that this was a risk that would need to be managed. RB confirmed that a report on the Gloucester House outreach service would be reported to a future meeting of the Board. **Action:** RA to schedule Gloucester House outreach service report to the Board It was noted that the priorities relate to meeting the Ofsted action plan rather than educational and clinical outcomes. The Board received **ASSURANCE** from the updates provided and **NOTED** the proposed focus for the improvement plan and delivery group.	**MF** **RA**
013	**QUALITY AND SAFETY (Q&S) COMMITTEE ASSURANCE REPORT**	
	CJ presented the Quality and Safety Committee Assurance report highlighting that progress had been made on all prioritised areas. The Committee had received assurance from the six-monthly infection control report, noting that not all criteria were applicable to the Trust.	

	The quality improvement report had been received and highlighted the work that was being undertaken by the Interim Joint Chief Medical Officers including a reviewed and refreshed clinical audit programme. It was noted that NLFT have a well-established clinical audit programme and with the quality improvement culture at TPFT there was opportunity to build on those capabilities. There was one item escalated in relation to shared care agreements between the national gender service and primary care. This has been escalated to NHS England, one of the Joint Chief Medical Officers had been invited to attend a regional working group to review training provided to GPs. There had been one Patient Safety Incident Investigation that would be presented to the Board for sign-off in December. The Board received **ASSURANCE** from the report.	
014	**EDUCATION AND TRAINING (E&T) ASSURANCE REPORT**	
	JJ presented the Education and Training Committee Assurance report noting that the Committee had received an update on the planned merger with the DET working with NLFT to ensure the Office for Students registration is transferred which is vital as one of the regulators. The Trust were working with the University of Essex to ensure compliance with the Freedom of Speech Code of Practice; it is expected that compliance would be achieved imminently. The Committee received an update that the there was a high re-enrolment rate for the 2025/26 academic year and an increase in the number of new students recruited. The 2025 graduation ceremony was well attended which was positive for the reputation of the Trust. It was however noted that the Trust became aware that they had not been listed as a sub-contractor for the University of Essex which has reduced recoverable funding. The Committee were reassured of the mitigation in place. The Board received **ASSURANCE** from the report.	
015	**PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, DIVERSITY AND INCLUSION (POD EDI) COMMITTEE ASSURANCE REPORT**	
	SP presented the report noting that the there was an amendment to be made to the report as the Board Assurance Framework risk was not included in this meeting. The Committee triangulated information presented to identify that the Senior Leadership Forum was a key group of leaders that will be instrumental in supporting staff as we progress towards the merger. The importance of cascading information clearly was discussed. The Interim Deputy Chief People Officer attended the Committee for the first time and would be considering how we ensuring consistency of the messages disseminated.	

	SP also noted the important of high-quality appraisals and ensuring that staff had the time to complete mandatory and statutory training. The staff networks had provided feedback that they were struggling with engagement with the networks. It was felt that the merger could be impacting on this. It was noted that NLFT have established networks that staff would be able to access once the merger had been enacted. The Committee received a presentation from one of the Freedom to Speak Up Guardians which is a positive development in having an external service that provides freedom to speak up support. They informed the Committee that they were visiting services across the Trust. The Board received **ASSURANCE** from the report.	
016	**EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT**	
	The Board welcomed TM, Head of Culture and Inclusion to present the equality, diversity and inclusion annual report. TM informed the Board that when he joined the organisation there was no equality, diversity and inclusion (EDI) framework or governance in place. The organisation now has clear priorities, and this was due to the support and challenge from the Board, colleagues with different protected characteristics and allies. TM was thanked for the significant amount of work undertaken to ensure the Trust was in the position that it was in. It was noted that the number of staff that perceive TPFT as a fair organisation was encouraging. The EDI representatives on all interview panels ensured inclusive recruitment. SS updated that the report had been presented to the POD EDI Committee where there was interesting challenge. SS commended TM, CS and the EDI Programme Board for work undertaken to ensure actions progress. KBo commented that NLFT had developed a new process regarding reasonable adjustments which could be replicated at TPFT. It was noted that there had been improvements in five categories of the Workforce Race Equality Standard and the Workforce Disability Equality Standard, however, some areas had worsened which would need focus. KBo recommended that the recommendations and action plan for the metrics be reported back through the Board to enable oversight. CJ noted that she had recently been a member of a recruitment panel with a patient representative who made a significant contribution to the process. It was clear that the training they had received had given them the confidence to make a meaningful difference to inclusive recruitment. The Board **REAFFIRMED** their commitment to the EDI Priorities, **CHAMPIONED** and **ENDORSED** the EDI Annual Report and **APPROVED** the reports recommendations.	
017	**PERFORMANCE, FINANCE AND RESOURCES (PFR) COMMITTEE ASSURANCE REPORT**	

	SP presented the three PFR Committee assurance reports noting a deficit of £4m which is £1.4m adverse to plan. The majority of the deficit resulted from the loss of the national training contract. Work remained ongoing to mitigate this, however, there were also challenges around delivery of the cost improvement programme with low turnover. Delivery of the cost improvement programme was also reliant on the sale of land within the financial year which was progressing, however, there was a risk of slippage. The Trust were successful in receiving cash support of £2.17m in November, however it was likely that further cash support would be required before the end of the financial year. A detailed forecast presented to the PFR Committee showed a risk of a £5m deficit at year end. There had been £1m capital expenditure year to date of a planned £2.7m capital programme. There may be a requirement to amend the programme to support the work to move Gloucester House which the Board will be appraised of once known. The Board received **ASSURANCE** from the three reports.	
018	**FINANCE REPORT: MONTH 06**	
	The paper was taken as read. The Board **NOTED** the position outlined in the report.	
019	**BOARD SCHEDULE OF BUSINESS 2025/26**	
	The Board **NOTED** the Public Board Schedule of Business for 2025/26.	
020	**QUESTIONS FROM GOVERNORS**	
	KE felt that the Provider Capability Self-Assessment provided a fair overview of the domains and felt reassured that an action plan would be presented to the Board in January. It was noted that the papers and discussion highlighted alignment between TPFT and NLFT. KE commented that the Trust continued to work with the Governors and supported them with the joint work with NLFT. It was noted that the Governors had appreciated being observers on the Trust Board sub-Committees, however, this practice was not replicated at NLFT and there would be changes as the Trust merges which came with feelings of sadness for the Governors. KE recommended that the last Council of Governors meeting which is due to be held on 27 March 2026 was a celebration of the Governors commitment to the NHS. PW provided feedback that the meeting was productive with clear reports. It was positive to hear from the NEDs that processes are moving forward in the right direction and it was good to see KBo at the meeting.	
021	**ANY OTHER BUSINESS**	
	There were no items of any other business.	

022	**QUESTIONS FROM THE PUBLIC**	
	A member of the public raised a question relating to the merger, highlighting that at the Annual Members Meeting the Chair of NLFT commented that the attraction of TPFT was the legacy, brand and reputation. They queried how the Trust was continuing to develop with original and innovative work to demonstrate those capabilities. MF highlighted that from an education perspective there are a number of initiatives around workforce development that DET are working on to grow the offer. RB commented that colleagues across the two organisations were working together on the modelling to ensure the drivers of good practice from TPFT are retained. There were also opportunities for more clinical placements and more challenge in the larger organisation. It was requested that developments are a standing agenda item on the Board of Directors and the Council of Governors to ensure this remained a focus.	
023	**REFLECTIONS AND FEEDBACK FROM THE MEETING**	
	The Board reflected on the comment made by a member of the public that the Board should be reviewing new developments noting that the presentation from the department of education and training showed new courses that were being delivered. It was noted that whilst the Trust are focused on the merger, there is a need to ensure we continue to explore innovation. KBo commented that the meeting was open and went into a good level of detail, she felt very welcomed. CJ acknowledged the challenge from the member of the public, noting that accountability is monitored through performance metrics. LS commented that it was reassuring to see the gentle challenge and the care and concern that the Board show about the organisation.	
024	**DATE AND TIME OF NEXT MEETING**	
	Meeting was closed at 16.25.	

Date of Next Meeting in Public: Thursday, 15 January 2026 at 2.00p.m – 5.00p.m.

Signature _____ Date _____

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

Actions are RAG rates as follows: ->				Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.07.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Rhiannon Adey, Interim Deputy Company Secretary	Open	05/01/26: All NEDs will have undertaken Tier 1 Oliver McGowan training by 29 January 2026. 17/11/25: All NEDs will have undertaken Tier 1 Oliver McGowan Training by 03 December 2025. 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
20.11.25	6	Matters arising and action log	RA to confirm whether a certificate of completion is received for Oliver McGowan training	15.01.26	Rhiannon Adey, Interim Deputy Company Secretary	To Close	06/01/26: Head of People has confirmed that certificates are issued for Oliver McGowan training.
20.11.25	7	Chair and Chief Executive's Report	KE to work with the Trust to organise service visits for Governors	31.03.26	Kathy Elliott, Lead Governor	Not yet due	09/01/26: This remains ongoing as we work towards the merger
20.11.25	8	Integrated Quality Performance Report	RB to ensure estates issues are addressed through the weekly executive safety huddle	15.01.26	Rod Booth, Director of Strategy and Business Development	To Close	09/01/26: This is business as usual as part of the escalations process
20.11.25	9	Review of Board Committee Terms of Reference	RA to make minor amendment to the Education and Training Committee Terms of Reference	15.01.26	Rhiannon Adey, Interim Deputy Company Secretary	To Close	06/01/26: Amendment made to Education and Training Committee Terms of Reference
20.11.25	10	Provider Capability Self-Assessment	RB to present the Provider Capabiltiy Self-Asessment action plan to the Board in January	15.01.26	Rod Booth, Director of Strategy and Business Development	To Close	06/01/26: Item added to the Board agenda for March as no feedback received from NHSE London region at the time of January Board
	12	Gloucester House Action Plan Update	MF to confirm action owners and deadlines for the outstanding items in the action plan	15.01.2026	Mark Freestone, Chief Education and Training Officer	Open	09/01/26: Verbal update to be provided
	12	Gloucester House Action Plan Update	RA to schedule Gloucester House outreach service report to the Board	15.01.2026	Rhiannon Adey, Interim Deputy Company Secretary	To Close	06/01/26: Gloucester House item added to the Extra-ordinary Performance, Finance and Resources Committee with the full Board in attendance

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 January 2026			
Report Title: Chief Executive's Report			**Agenda No.: 006**
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 20 November 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. Dorothy Otite, Director of Corporate Governance (Interim) left the Board. I would like to thank Dorothy for her contributions to the Trust and wish her the very best for the future.

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.

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. Clinical Services

Clinical services continue to be very busy with record numbers of first appointments in October.

Our CAMHS teams consistently see children and their families referred within 2 – 3 weeks with 270 first appointments offered across all the CAMHS teams and another 144 in the Adult unit.

In the last quarter clinical services outcomes data demonstrated improved capture and compliance with the minimum required measures at Time 1 and reported statistically significant improvements on the number of matched pairs for both DIALOG and CGAS in November 2025.

The Adult Gender Service and Clinical Services leads welcomed the Levy Review into Gender Dysphoria Service, published in December 2025. The wide-ranging recommendations will be implemented across all GIC's with the intention of improving patient care and reducing the extremely long waits our gender patients currently experience.

GIC

The operational and delivery review of NHS adult gender dysphoria clinics (GDCs) in England was published on 19th December 2026. The report summarised findings and recommendations following a review of the 9 commissioned NHS GDCs led by Dr Levy.

The review surfaced findings around 4 key themes:

- access
- quality (including safety)
- productivity

- culture, leadership and governance

The review panel set out 20 recommendations to improve patient care, calling for a wider response from national and local commissioning teams, gender dysphoria clinics, NHS Trusts, ICBs, primary care and other healthcare constituents. This joint approach will be driven by the proposed National Quality Improvement Programme for Adult Gender Services and a new National GDC Oversight Board.

The CEO and CNO for TPFT met with Dr Levy and the national improvement director for GIC; each GDC will receive a report relating to their service and will be required to provide a response to NHSE. We are currently working with NHSE to implement improvements within GIC to address the outcomes from the Levy report.

4. Patient and Carer Race Equality Framework (PCREF)

The PCREF Implementation group is in the process of maturation with the intention to deliver on the current PCREF action plan. There is a planned event in March 2026 with a focus on community engagement.

Month 8 (November) IQPR presented ESQ data indicating a reasonable reflection of completed ESQ forms for most ethnic groups receiving treatment in the trust. Global majority populations were more likely to report a positive experience of care, feel listened to and rate their overall experience more positively than White populations.

In contrast Month 9 IQPR presented the Did Not Attend (DNA) and Cancelled by Patient (CBP) data; section 3 of the PCREF framework “Patient and carers feedback mechanism”. Across all unit’s DNA and CBP rates demonstrate that global majority families who identify as Black, Mixed or other Ethnicity are more likely to DNA or cancel their appointment than those who identify as Asian or White ethnicities. This matches national DNA and CBP trends and are broader systemic issues and health inequalities.

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

5. Industrial Action

Further resident doctor industrial action took place from 17th to 22nd December 2025. The Trust made robust contingency plans to ensure appropriate rota cover for out-of-hours services and to maintain patient safety during this period. The direct impact on Trust service delivery was minimal, although it is acknowledged that the wider impact across the NHS was significant, including for local partner Trusts.

Improving Value, Productivity, Financial and Environmental Sustainability

6. Finance Update

At month 7, the Trust is reporting a deficit of £4.4m which is £1.6m behind plan. The main reason for this adverse variance is the loss of the National Training Contract income. Delivery against the efficiency target remains a key area of focus and risk, with progress continuing to be monitored closely.

The Cash position for the Trust continues to be very challenging and further working capital support of £2.17m was received from the Department of Health and Social Care in November.

Internal Updates

7. Recent Board Changes

Executive Directors:

Ahead of our merger with North London NHS Foundation Trust, we have agreed a service level arrangement with NLFT to provide executive support to cover several vacancies within our leadership team.

Support will be provided by Kate Bowditch, Interim Chief People Officer, Karl Milner, Director of Communications, Marketing and Engagement and Terry Willows, Director of Corporate Governance.

Regional and National Context

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

The Chief Executive of North Central and North London Integrated Care Boards (ICBs), Frances O'Callaghan has announced her resignation from the role, to take up a new role as Chief Executive at NHS Blood and Transplant starting in February. Further updates on leadership arrangements will be announced in due course.

The Chief Nursing Officer for the new North West Central London ICB visited the Trust on 30th December. They were interested in hearing about the specialist community services and Gloucester House School and how we are working with Camden Local Authority to provide integrated services for the local population.

9. Medium Term Planning Framework

The Medium-Term Planning process across the NHS was launched in November 2025. The Trust submitted a two-year plan on 17 December 2025. The submitted plan shows a significant deficit as there is very limited ability to mitigate this outside of the proposed merger with North London NHS Foundation Trust.

10. Chief Executive's meetings with external stakeholders

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

- Virtual Hospital
- NCEL CAMHS PC Strategy Board
- London Data Quality Improvement Group
- Chair and Chief Executive Network
- Camden Council Health scrutiny committee
- Camden Council Health and Wellbeing Board
- London Neighbourhood Health Delivery Board
- Cavendish Square Group CEO meeting

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 January 2026			
Report Title: Integrated Quality and Performance Report November 2025 ***based on October (M07) 2025 Data***			**Agenda No.: 007**
Report Author and Job Title:	Rachel James, Director of Clinical Services Sheva Habel, Medical Director	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer Rod Booth, Director of Strategy
Appendices:	Appendix 1: M07 Integrated Quality and Performance Report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	The Trust Integrated Quality and Performance Report (IQPR) for October 2025 (Month 07) 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 25th November 2025. The data presented relates to October 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 the accompanying slides and respective committee reports.		
Background:	In addition to data being considered in the monthly Trust-wide IQPR meetings, 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 Trust to address issues identified for improvement in relation to the delivery of our strategic priorities and on-going clinical and educational service delivery across the following areas: Operations and Service Performance; Quality and Safety; People, and; Finance.		

1. Operations and Service Performance

Gender Identity Clinic (GIC) continues under the Quality Improvement (QI) assurance framework. As of October 2025, there were 16850 individuals waiting for a first appointment, reflecting ongoing service pressure. A focus of the QI work has been to reduce Did Not Attend's (DNAs) and cancellations by patients and Trust, with positive impact. Month 7 (M7) data demonstrated the lowest recorded DNA rate for a year, and the lowest rate of cancellation by patients for over a year. NHS England Commissioners have thanked the Trust for improvements in this area.

The Trauma Service remained in Targeted Support in October. In this month 24 patients attended their first appointment, which is the second highest number of 1st appointments attended in a month in the last year. A total of 777 appointments were attended in total, almost 100 more than the previous month. In addition to productivity improvements the Team leadership continues to innovative and is working with North London Foundation Trust colleagues to deliver an all-age trauma pathway in Camden.

Key initiatives within the service improvement pipeline include:

- **GIC Surgical Referrals Recovery and Mitigation Plan:** Following several complaints the GIC service identified that the surgical referral pathway had not always resulted in referrals reaching the NHS Gender Dysphoria National Referral Support Service (GDNRSS). Extensive data review identified a total of 101 missed surgical referrals. These individuals will be contacted under duty of candor with an explanation of the error, the offer of a review appointment, and where an appointment is attended a clinical harm review will be completed. The service has developed several mitigations to reduce the risk of this occurring in future including additional controls in the Electronic Patient Record (EPR), audit and monitoring. There is a Patient Safety incident investigation (PSII) in process to learn about what happened, why it happened, and what can be done to make sure that it doesn't happen again.
- **Trauma Targeted support:** The Trauma Service are in the process of moving out of Trust directed targeted support and into a unit directed QI framework. The QI focus will be on prioritising clinical activity and quality whilst mitigating the impact of Elective Recovery Funding (ERF) ending. This will include monitoring of first appointments, mapping treatment vacancies and focused work to review group attendance thereby improving engagement and patient pathway flow.

Clinical Services updates:

- **Returning Families** have been served notice of closure with an end date of March 2026, and the service closure consultation therefore launching in November 2025.

2. Quality and Safety

Experience and Outcomes:

- **Patient Feedback**:
  In October 2025 there was an increase in the number of Experience of Service (ESQ) forms collected across the Trust, with 280 forms collected. 95% of responses were positive which is above our target of 90%. Unit and team level data indicates that there are still some teams where the number of forms collected is significantly below target. Targeted support is ongoing to implement team level focussed actions to increase engagement and improve response rates.

- **Complaints and Compliments**:
  A total of 10 complaint contacts were received across clinical services in October: 7 for the Adult Unit; 2 for Children & Family Unit; and 1 for Camden Unit. 7 of the 8 complaint contacts received in October were acknowledged within 3 working days in line with national regulations. Trust wide compliance for formal complaints being responded to within 40 working days in October was 37.5%, and all of these were from the Adult Unit. At the end of October 2025, 9 complaints (7 Adult & 2 Children & Families) were open of which 2 were overdue, both of which are registered to the Adult Unit. 7 complaints were also resolved informally in the month; 5 of which were in the Adult Unit. Camden and the Children & Families Unit each resolved one complaint informally.

  Two compliments were recorded in Radar in October 2025; one by the Children and Families Unit categorised as patient care, and one by the Adult Unit categorised as values and behaviours.

- **Clinical Outcome Measures (OMs)**:
  NHSE launched new waiting time metrics on 1 April 2025, explicitly linked to OM collection. Across all clinical services the October OM data demonstrated significant improvements in compliance with the minimum required measures at first contact. 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)**:
  Month 7 focused on ESQ data; section 3 of the PCREF framework “Patient and carers feedback mechanism”. ESQ data indicated a reasonable reflection of feedback for most ethnic groups receiving clinical services, except for patients identifying as White British where there was an under representation (30% of forms completed, but this patient population represents 56% of the total). Global majority populations were more likely to report a positive experience of care, feel listened to and rate their overall experience more positively than White British and White other populations. Black British, Asian British and other ethnicities were more likely to recommend the service to a friend or family compared to other groups. Responses from patients who did not wish to share their ethnicity were more likely to report a neutral

experience through ESQ responses, which is of interest. These results indicate that the experience of global majority populations receiving treatment in the trust is broadly positive. The PPI team have plans to develop the ESQ questions to be able to be more discerning for groups that may be less likely to report negative experiences.

Incidents and Learning:

- **Incidents**:
  In October 2025, a total of 27 patient safety incidents were reported across the Trust as follows: Camden Unit (6), Adult Unit (1), Children & Families Unit (19), and Estates and Facilities (1).

  A total of 21 incidents of violence and aggression were reported in October: 18 within Children & Families; 2 within the Camden Unit; and 1 by the Estates and Facilities team. The two incidents within the Camden Unit related to a physical altercation between two patients in a waiting room. An After Action Review (AAR) will be carried out for this incident.

  Gloucester House reported incidents included aggressive behaviour, discriminatory and inappropriate language, the throwing of objects/items at staff, and assaults on staff members, including punching, spitting, kicking, and hitting. In October, there were 15 reported incidents of restrictive practice, marking the highest level of restraint reporting to date. The incidents of violence and aggression and restrictive practice have been escalated to the Unit Clinical Lead and discussed at both the Executive Safety Huddle and the Clinical Incident & Safety Group (CISG).

  An AAR was requested in October concerning the care provided to a young person who had been arrested. This incident was reported in September, and a multi-agency review was undertaken by the local authority at that time. Whilst confirmation of that process is awaited, an internal AAR was requested in the interim and these AAR findings will be discussed at December CISG.

3. People

- **Mandatory and Statutory Training (MAST)** compliance in October 2025 stands at 85.69%, a 1.40% increase on the previous month. Chief Finance Officer stands at 96.98% compliance, holding a continued high standard from the previous months. Chief Nursing follows, at 96.69%. To achieve a high standard, each directorate will need to target 90% and above, with currently four out of eight directorates achieving this.
- **Appraisal Completion** stands at 56.05%, increasing by 2.62% at the end of October. Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals. Chief Medical Directorate holds the lead with an outstanding 100% of appraisal reviews completed, and Chief Nursing follows at 85%. We are looking to adopt a QI

	approach to strengthen our appraisal compliance, improve the consistency and quality of approvals and provide the Board with stronger assurance regarding workforce capability and alignment. A working group is being established to lead and coordinate this piece of work. • **Sickness Absence** stands at 3.26% at the end of October, with a 0.31% increase from the previous month. However, the rate remains below the average benchmark of 4% across the NHS. The T&P Trust sickness absence within the category of anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 0.62%, however declining by 0.24% from the previous month. • The sickness absence data from November 2024 to October 2025 reveals that mental health issues, specifically anxiety, stress, and depression, is the leading cause of absence across both White and BME ethnic groups. **4. Finance** • **Income & Expenditure**: As of Month 7, the Trust reported a year-to-date deficit of £4.413m, which is £1.685m adverse to the NHSE plan. The variance is primarily driven by £2.6m loss of income from the National Training Contract; shortfalls in Cost Improvement Plan (CIP) delivery; partially offset by additional income above plan. Delivery against the efficiency target remains a key risk area, requiring close monitoring and corrective actions to mitigate further deterioration. • **Capital Expenditure**: The approved capital expenditure limit for 2025/26 is £2.774m, later increased to £2.982m following an additional £208k funding approval. As of Month 7, actual capital expenditure totals £1.292m, compared to the planned profile of £2.498m. This shortfall is largely due to phasing delays, as most major projects were scheduled to commence from Month 6 onwards. Despite this, the full-year capital spend is expected to align with the approved plan. • **Cash Position**: Cash flow remains under significant pressure. At the end of October 2025, the Trust held a cash balance of £1.245m, equivalent to six days of operating expenditure. To maintain liquidity, the Trust secured £2.170m in DHSC cash support for November, with further requirements projected at: £4.200m in January; £0.850m in February; £0.400m in March 2026. • These projections assume the sale of Gloucester House will not complete before year-end, meaning the associated £1.454m savings will not materialise in this financial year. Consequently, total cash support required for 2025/26 has increased from £4.266m to £9.072m, reflecting: The £2.6m income loss from the National Training Contract; Delayed asset sale: Non-delivery of planned savings: The Trust's constrained underlying cash position.
Key recommendation(s):	The Board of Directors are 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 – 25th November 2025 Performance, Finance and Resources Committee – 11th December 2025 Quality and Safety Committee – 18th December 2025			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report M7 2025

NOTE: THIS REPORT USES DATA FROM OCTOBER 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
The Gender Identity Clinic continues under the Quality Improvement Assurance Framework. As of October 2025, there are 16850 individuals waiting for a first appointment, reflecting ongoing pressure on the service. The number of referrals dropped back to 350. A focus of the QI work has been to reduce DNA's and cancellations by patients and trust. M7 saw the lowest recoded DNA rate for a year and the lowest cancellation rate by patients for over a year.
The Trauma service remains in Targeted Support in October. In this month 24 patients attended their first appointment which is the second highest number of 1st appointment attended in the last year. A total of 777 appointments were attended in total, almost 100 more than the previous month.

Service Improvement pipeline:

GIC Surgical Referrals Recovery and Mitigation Plan:
Following several complaints the GIC service identified that the surgical referral pathway had not always resulted in referrals reaching the GDNRSS . Extensive data review identified a total of 101 missed surgical referrals. These individuals will be contacted under duty of candor with an explanation of the error, the offer of a review appointment and if an appointment is attended a clinical harm review will be completed. The service have developed several mitigations to reduce the risk of this occurring in future including additional controls in the EPR, Administrative and audit and monitoring. There is a PSII in process.

Trauma Targeted support – The trauma service are in the processes of moving out of targeting support and into a QI framework to progress work within the team with a change in focus from Trust directed to Unit directed. QI focus will prioritise clinical work whilst mitigating the impact of the ending of ERF funding within the service through monitoring of first appointment, mapping treatment vacancies and a focused piece of work reviewing group dropout rates to improvement engagements and flow through the pathway,

Referrals and Activity

In M7 the trust completed a record number of 464 first appointments and 361 second appointments with an overall activity at 7,497 attendances.

Camden unit received 266 referrals which is 40% higher than the same time last year and 158 first appointments with an average wait of 2.6 weeks from referral to 1st appointment. Their overall Job plan compliance of 75%.

The Child and Family unit received 245 compared to 204 referrals in the same month last year 170 first appointments. There were 1,974 clinical contacts for the Child and Family Unit in October and a record 186 1st appointments in the month. At month 6 the Unit delivered 9,175 clinical for the NCL services against an annual target of 17,169, an over performance of 627 contacts at month 6.

The Adult unit received 414 referrals (350 GIC, Therapies services 64) and completed 136 first appointments and delivered 2634 appointments in total. The Adult Trauma Team's overall job plan compliance is 80%.

Clinical Services updates:
Returning Families have been served notice of closure with an end date of March 2026, with the service closure consultation launching November 2025.

People

- Mandatory and Statutory Training (MAST) compliance this month stands at 85.69%, a 1.40% increase ending October 2025. Chief Financial stands at 96.98% compliance, holding a high standard continuing from the previous months. Chief Nursing follows, at 96.69%. To achieve a high standard, each directorate will need to target 90% and above. Currently four out of eight directorates have achieved this.
- Appraisals completion rate currently stands at 56.05%, increasing by 2.62% at the end of October.
  Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals. Chief Medical Directorate holds the lead with an outstanding 100% of appraisal reviews completed. Chief Nursing follows at 85%.
- The Tavistock & Portman Trust sickness rate stands at 3.26% at the end of October, with a 0.31% increase from the previous month. However, the rate remains below the average benchmark of 4% across the NHS. The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 0.62%, however declining by 0.24% from the previous month.
- The sickness absence data from November 2024 to October 2025 reveals that mental health issues, specifically anxiety, stress, and depression, is the leading cause of absence across both White and BME ethnic groups.

Finance

Income & Expenditure
As of Month 7, the Trust reports a year-to-date deficit of £14.313m, which is £1.685m adverse to the NHSE plan. The variance is primarily driven by £2.6m loss of income from the National Training Contract; shortfalls in CIP delivery; partially offset by additional income above plan. Delivery against the efficiency target remains a key risk area, requiring close monitoring and corrective actions to mitigate further deterioration.

Capital Expenditure
The approved capital expenditure limit for 2025/26 is £2.774m, later increased to £2.982m following an additional £208k funding approval. As of Month 7, actual capital expenditure totals £1.292m, compared to the planned profile of £2.498m. This shortfall is largely due to phasing delays, as most major projects were scheduled to commence from Month 6 onwards. Despite this, the full-year capital spend is expected to align with the approved plan.

Cash Position
Cash flow remains under significant pressure. At the end of October 2025, the Trust held a cash balance of £1.245m, equivalent to six days of operating expenditure. To maintain liquidity, the Trust secured £2.170m in DHSC cash support for November, with further requirements projected at: £4.200m in January; £0.850m in February; £0.400m in March 2026.

These projections assume the sale of Gloucester House will not complete before year-end, meaning the associated £1.454m savings will not materialise in this financial year. Consequently, total cash support required for 2025/26 has increased from £4.266m to £9.072m, reflecting: The £2.6m income loss from the National Training Contract; Delayed asset sale: Non-delivery of planned savings: The Trust's constrained underlying cash position.

Executive Summary (2/2)

The Tavistock and Portman NHS Foundation Trust

Quality and Safety
Experience and Outcomes:

Patient Feedback:
In October 2025 there was an increase in the number of ESQ forms collected across the Trust, with 280 forms collected. 95% of responses were positive which is above our target of 90%. Unit and team level data indicates that there are still some teams where the number of forms collected is significantly below target. Targeted support is ongoing to help these teams implement focussed actions to increase engagement and improve response rates.

Complaints: Clinical Services:
A total of 10 complaint contacts were received Trust-wide in October, 7 for the Adult Unit, 2 for Children & Family Unit and 1 for Camden Unit. 7 of the 8 complaint contacts received in October were acknowledged within 3 working days in line with national regulations.

Trust wide compliance for formal complaints responded to within 40 working days in October was 37.5%. All formal complaints responded to within the month were from the Adult Unit. As of the end of October 2025, 9 complaints (7 Adult & 2 Children & Families) were open of which 2 were overdue. Both of the overdue complaints are registered to the Adult Unit. 7 complaints were also resolved informally in the month;, 5 of which were in the Adult Unit. Camden and the Children & Families Unit resolved one complaint informally each.

Complaints: Directorate of Education and Training:
The Trust received 2 informal complaints and 1 formal complaint in DET in October. One of the informal complaints was subsequently withdrawn by the student because the issues had already been resolved. The other informal complaint was submitted by a student on M58 in the Financial category, and the formal complaint was submitted by a student on BM58 in the Service issues category.

Compliments: 2 compliments were recorded in Radar in October 2025; 1 by the Children and Families Unit categorised as patient care, and one by the Adult Unit categorised as values and behaviours.

Clinical Outcome Measures (OM):
NHSE launched new waiting time metrics on 1 April 2025, explicitly linked to OM collection. Across all clinical services the October OM data demonstrated improved capture and compliance with the minimum required measures at Time 1. 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.

PCREF – ESQ data:
This month we are presenting the ESQ data; section 3 of the PCREF framework "Patient and carers feedback mechanism". The ESQ data indicates that there a reasonable reflection of completed ESQ forms for most ethnic groups receiving treatment in the trust except for patients identifying as White British where there is an underrepresentation (30% of forms completed but the patient population makes up 56% of the total). Other groups have smaller levels of discrepancy. Global majority populations were more likely to report a positive experience of care, feel listened to and rate their overall experience more positively than White British and White other populations. Black British, Asian British and other ethnicities were more likely to recommend the service to a friend or family compared to other groups. Responses from the group who did not wish to share their ethnicity were more likely to report a neutral experience to ESQ responses which is of interest. These results indicate that the experience of global majority populations receiving treatment in the trust is broadly positive. The PPI team have plans to develop the questions to be able to be more discerning for groups which might be less likely to report negative experiences.

Incidents:
In October, a total of 27 patient safety incidents were reported across the Trust as follows: Camden Unit (6), Adult Unit (1), Children & Families Unit (19), and Estates and Facilities (1).

A total of 21 incidents of violence and aggression were reported in October: 18 within Children & Families; 2 within the Camden Unit, and; 1 by the Estates and Facilities team. The two incidents within the Camden Unit related to a physical altercation between two patients in a waiting room. An After-Action Review will be carried out for this incident.

Gloucester House reported incidents included aggressive behaviour, discriminatory and inappropriate language, the throwing of objects/items at staff, and assaults on staff members, including punching, spitting, kicking, and hitting. In October, there were 15 reported incidents of restrictive practice, marking the highest level of restraint reporting to date. The incidents of violence and aggression and restrictive practice have been escalated to the Unit Clinical Lead and discussed at both the Executive Safety Huddle and the Clinical Incident & Safety Group.

An AAR was requested in October concerning the care provided to a young person who had been arrested. This incident had been reported in September, and a multi-agency review was discussed with the local authority at that time. Whilst confirmation of that process is awaited, an internal AAR was requested in the interim. The AAR findings will be discussed at the December 2025 Clinical Incident and Safety Group.

Metric	Waiting List Management	SRO	Sheva Habel	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 increased by 226 patients from last month to 16,866 patients as of October 2025, with 80 new patients in October 2025 seen monthly with 347 referrals received.

Adult Trauma Service: With a 350% rise in referrals since 2019, as of October 2025 this is now 994 patients waiting. Many require intensive therapy lasting up to two years, and in October the treatment waiting list increased by 50 patients in 12 months with an increase of 89 patients in the last 12 months on the open caseload list.

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 in 2024-2025, reducing the waiting list for Haringey to 70 young people with an average current waiting time of 40 weeks to assessment. 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, due to staff turnover and vacancies in the pathway the waiting times have increased as has the number of young people on the waiting list. At October end a total of 399 young people are waiting for assessment which is a significant increase at Month 6 end. There has also been an increase in patients waiting for 1st assessment appointments due to vacancy rates.

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...

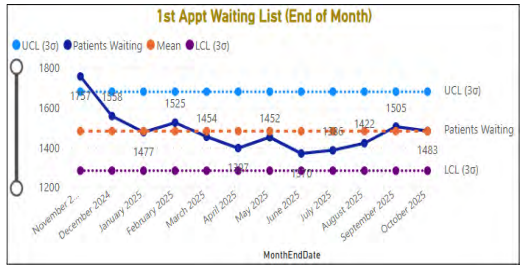
Integrated Quality and Performance Report

Month 07 - 25/26

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

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

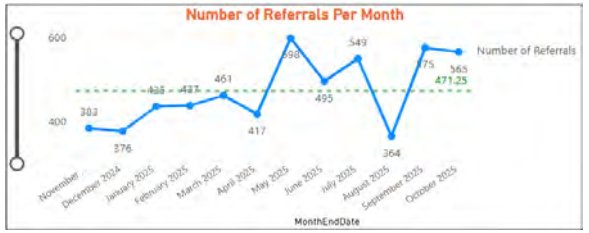
Mental Health Services Excluding GIC



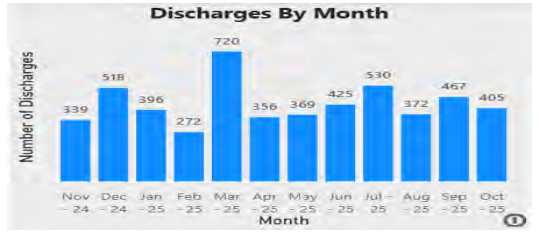
This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

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

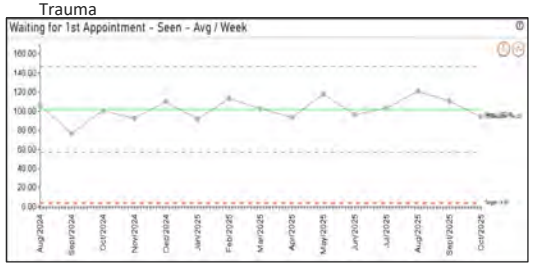
B. Number of referrals by month (exc. GIC)



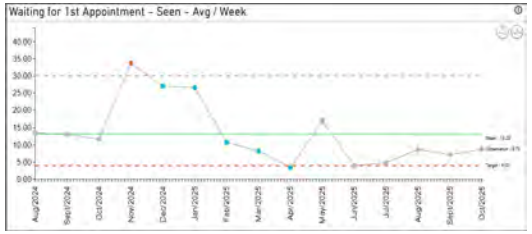
C. Number of discharges per month (Exc. GIC)



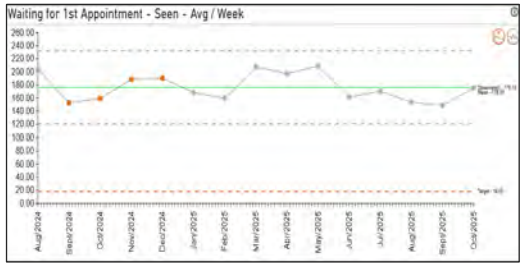
Trauma



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

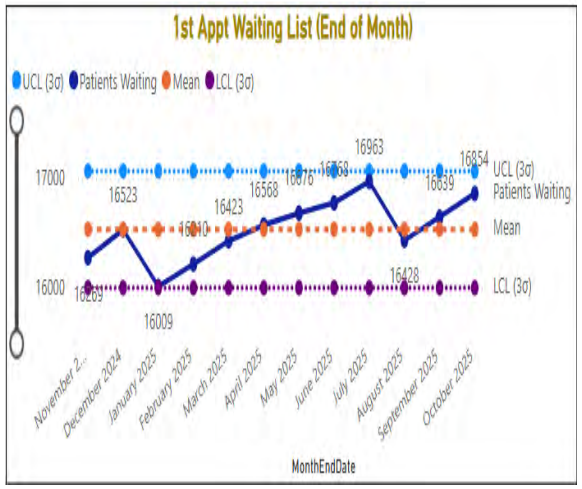
Progress on Improvements

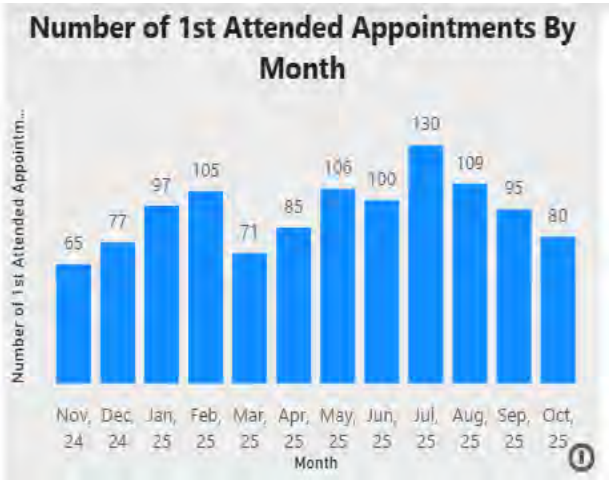
Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource 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.** QI work using Dr Doctor has improved the ratio for Trauma and Adult GIC. For ASD, this was part of the ERF project and is now closed. **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. This has been completed – **Sept 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 2-year programme has increased investment by £159K and Herts by £227K for 25/26. Additional funding of £154K has been provided to reduce waiting lists by 50%. However, trajectories are not currently being met due to staffing issues such as sickness absence, staff turnover and a change in leadership. **Trajectories** - Units modelling increased activity and agreeing trajectories for delivery against this resource (managed through a tracker) **Pathways** - Review of the clinical pathways informed by the Kaizen sessions and NICE guidance and service specifications, as outlined in unit delivery plans – **Aug 25** NLFT pathway meeting held in September with system clinical leads across 2nd Care Psychological Therapies. – **Sep 25** Trauma is closely monitoring the drop in first appointments and mapping the current treatment vacancies with staff to address the impact of ERF staff loss – **October 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. A new TCL is reviewing the outputs of the Kaizen work in 24/25 against current practice in which report writing timescales have increased again. 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 25/26. This trajectory has not been reached as posts have not been able to be recruited to, and this has delayed the start of the project. 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. This has now gone to advert. The waiting list has reduced by 105 patients since May. – **Oct 2025**	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	Complete SPC and Clinical dashboard reports by **Aug 25,** As at **October 2025**, Waiting List SPC charts have been tested and validated and have gone live on the SPC dashboard. Met NLFT in October 2025 for discussion of alignment of dashboards. Awaiting receipt of colour scheme from NLFT.	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	Director of Clinical Services/Project Management/Commercial Director

Excellence | Inclusivity | Compassion

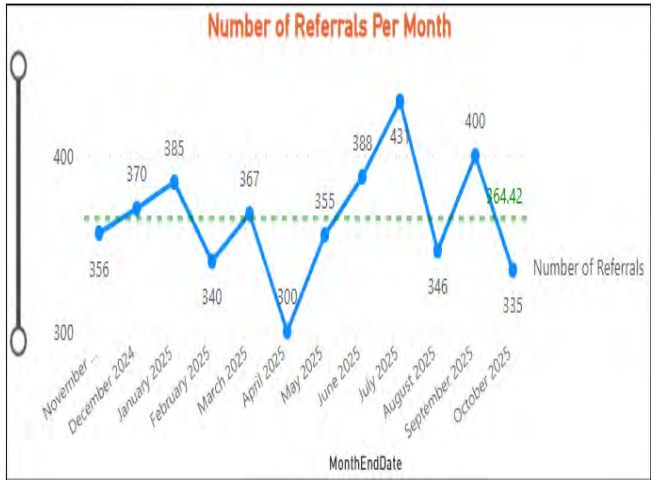
Metric	Waiting List Management (Continued)	SRO	Sheva Habel	Target	4-wk & 18-Wk	Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

A. Adult GIC Number of first appointments conducted

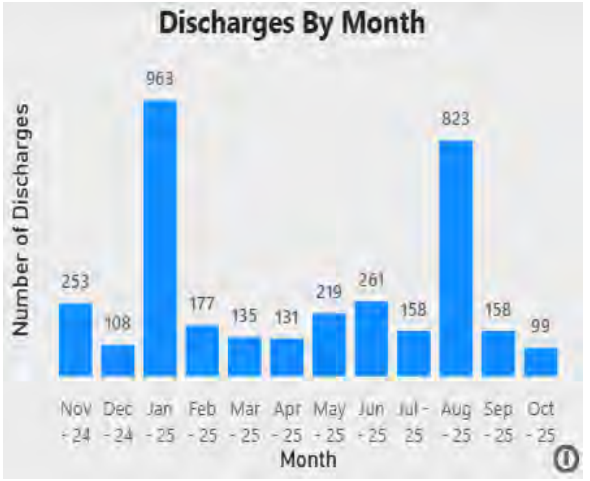




B. Adult GIC Number of referrals by month



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 07 – 25/26

Metric	Outcome Measures	SRO	Rachel James	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 with IMT & Quality Team to ensure inclusion of a new compliance dashboard to monitor NHSE waiting time compliance with Goals visually.

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 personalized care planning and shared decision-making.

G1: At least one mandated OM to be completed at 90% of 1st attends by Oct '25- Expected Nov 2025 due to clinical dashboard improvements

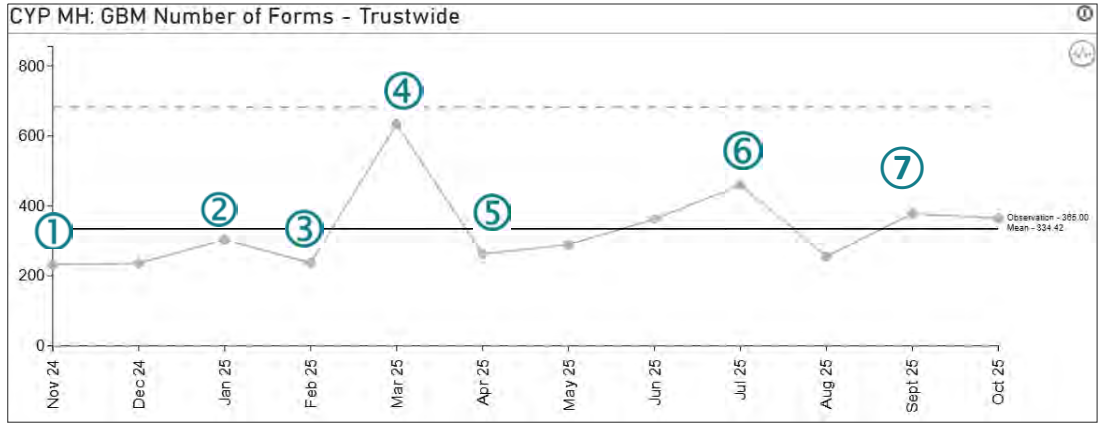
G2: Improve current rates of matched OM pairs by 50% for all Units by Oct '25 – Available on SPC dashboard

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

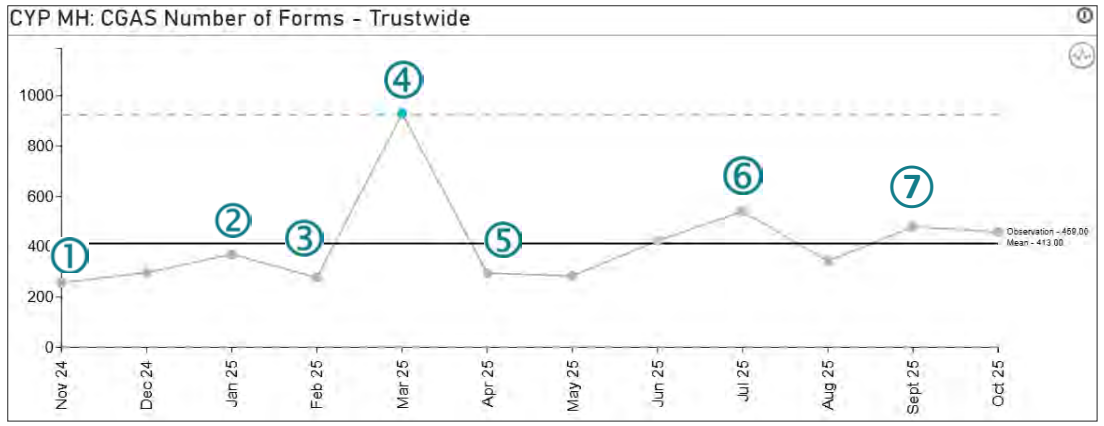
Concern	Causes	Countermeasures	Primary
Integration: OM not fully embedded into clinical workflows or care pathways	1. OM not hard-wired into care plans, reviews, or SOPs 2. OM completion is external to core clinical conversation 3. OM data collected but not routinely acted upon 4. OM results not routinely fed back to patients	1. Liaison with NCL leads to standardize improvement rates **– Continuing liaison with NCL CYPMH Provider Collaborative and NHSE – IMT calculating CGAS improvement dashboard** 2. Embed OM into care plans, templates, and appointment SOPs **- Pilot underway for CGAS in Q3** 3. Establish mandated OM agenda item + Standard Work in MDT and supervision **- SCL attending QI meetings on regular basis** 4. OM-informed care planning in one service **– Camden Wellbeing Team piloting Q3**	Clinical Services
Perception: OM's 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- **Quarterly highlight comms published 10/11/2025** 6. Develop training focused on clinical conversations **– Clinical support provided by EB going forward** 7. Peer-led MDT case studies using OM in shared decision-making **(linked to 4 & 6)** 8. Celebrate positive OM compliance and feedback in CG meetings **- Ongoing reviewed by SCL** 9. Targeted support for teams to self-monitor and address compliance **– Training sessions scheduled for Dec and direct support from EB** 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)	11. New dashboard launched and promoted in Clin. Gov meetings - **regular comms ongoing** 12. HONOSCA now included and validated within clinical dashboard and SPC for FCAMHS **(completed)** 13. Co-design further simplified dashboards for key roles 14. Train and coach teams on use of clinical dashboard **- unit wide sessions planned for Dec** 15. Install data walls to communicate OM insights in physical and digital areas **(Planned Q3)**	Clinical Services IM&T

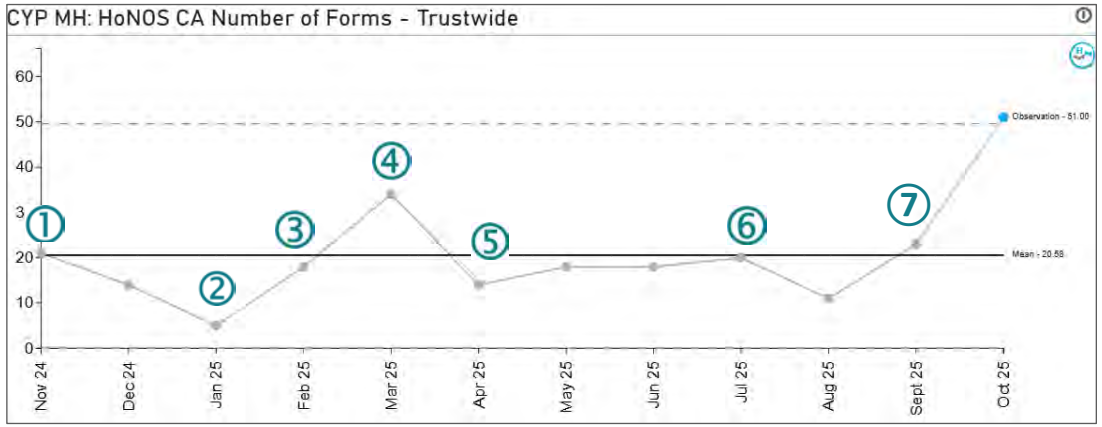
OM's: Under 18's

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 team's		





OM's: Over 18's

The Tavistock and Portman NHS Foundation Trust

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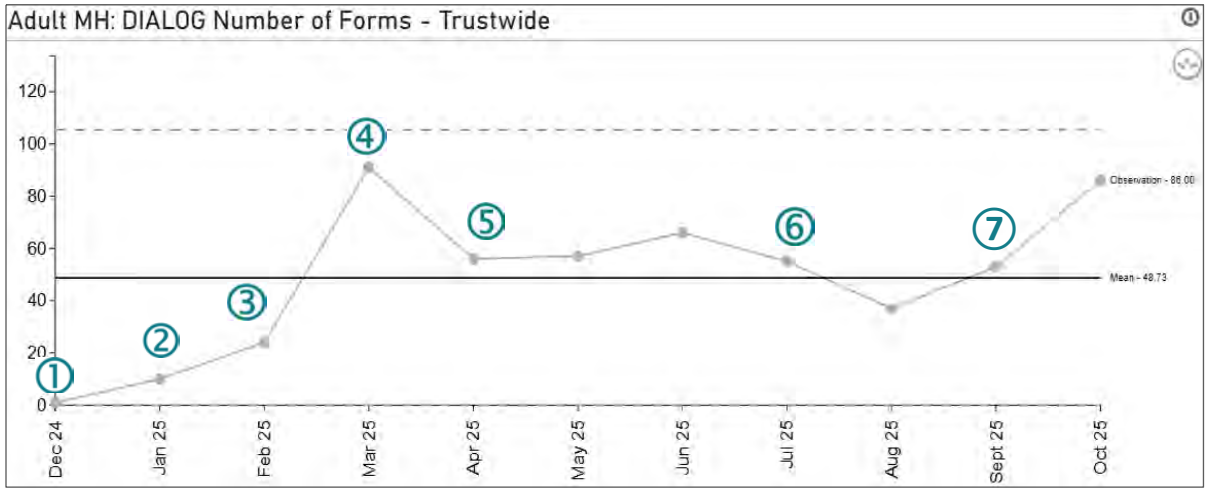

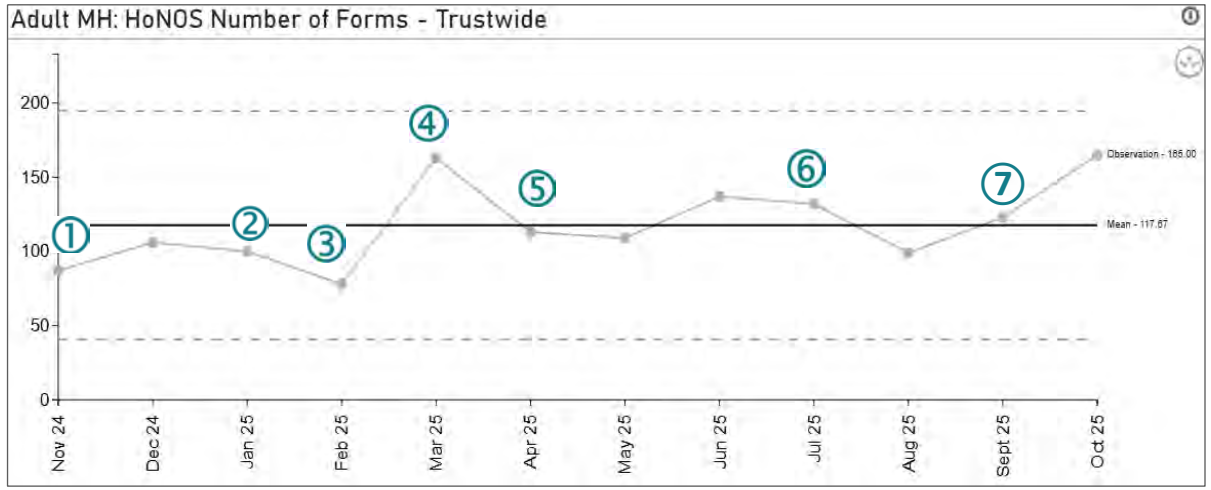

OM's: Under 18's

The Tavistock and Portman NHS Foundation Trust

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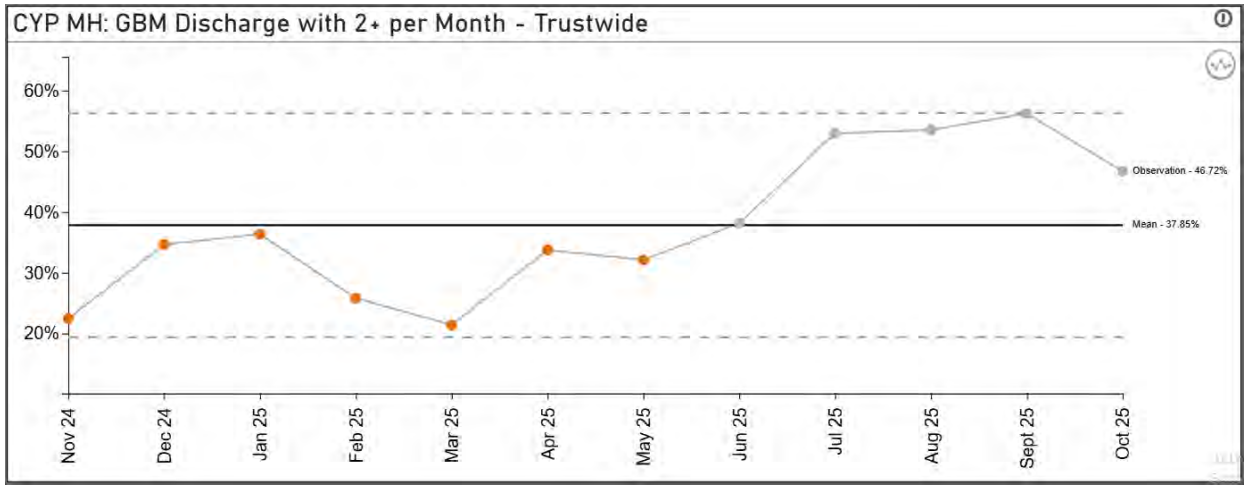
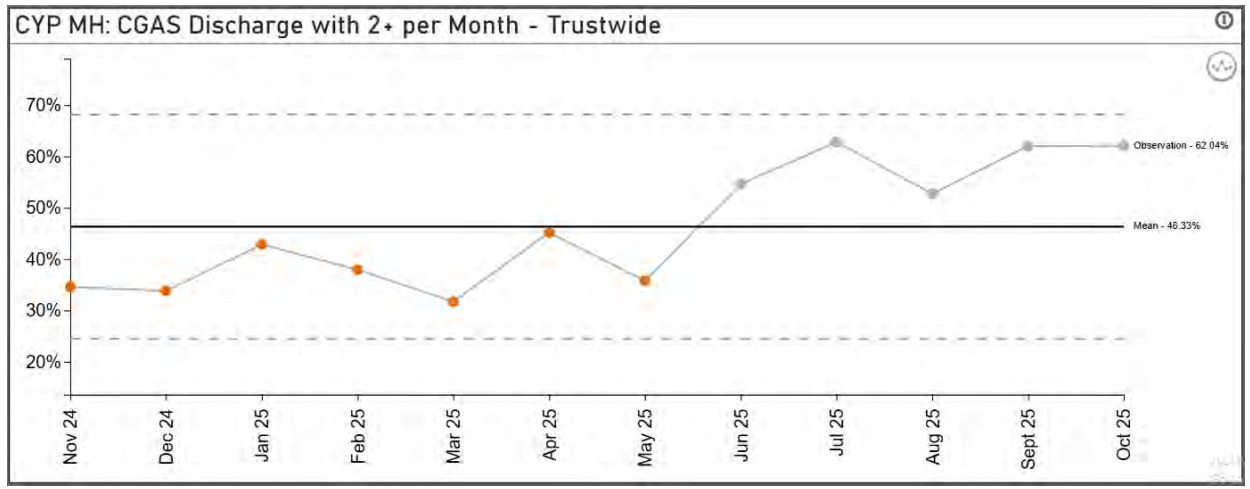
⑦	Jul 25 - Team Level bespoke training offered and taken up by 3 team's		

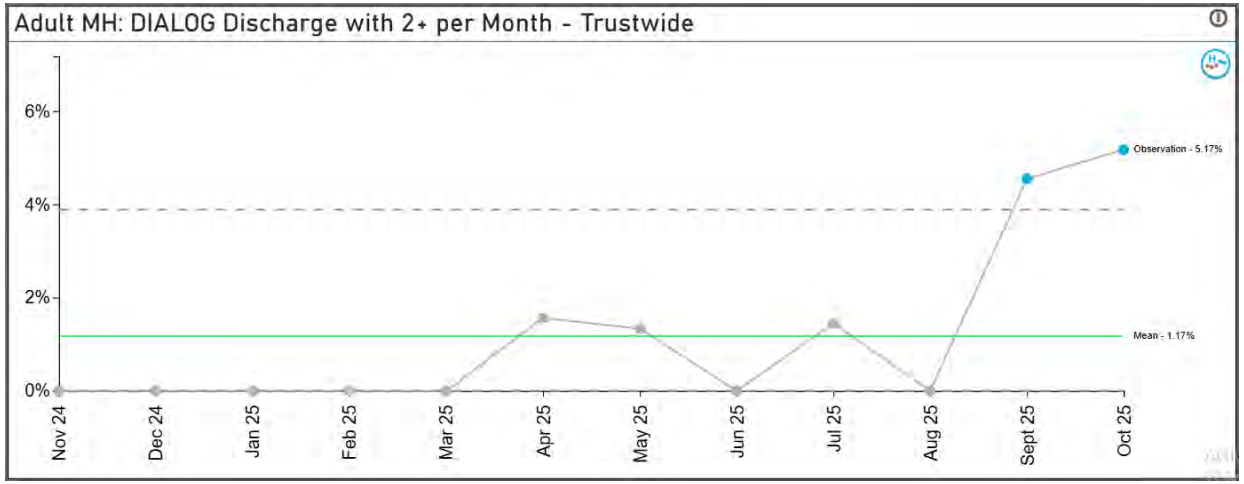


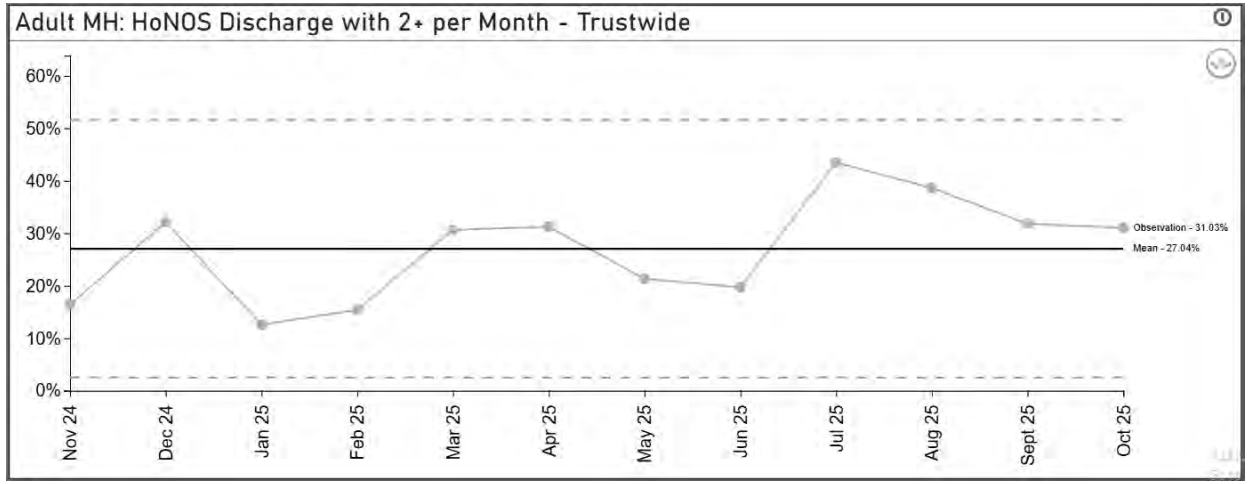


OM's: Under 18's

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 team's		





Integrated Quality and Performance Report

Month 07 - 25/26

Metric	User Experience	SRO	Clare Scott	Target	90%

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

Problem Statement

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

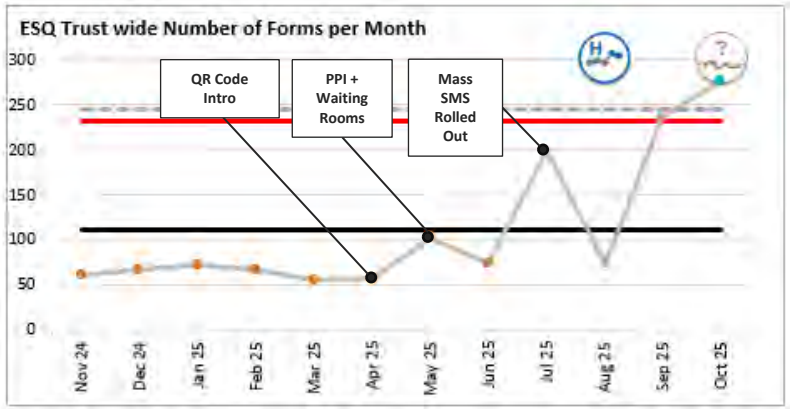
Vision & Goals

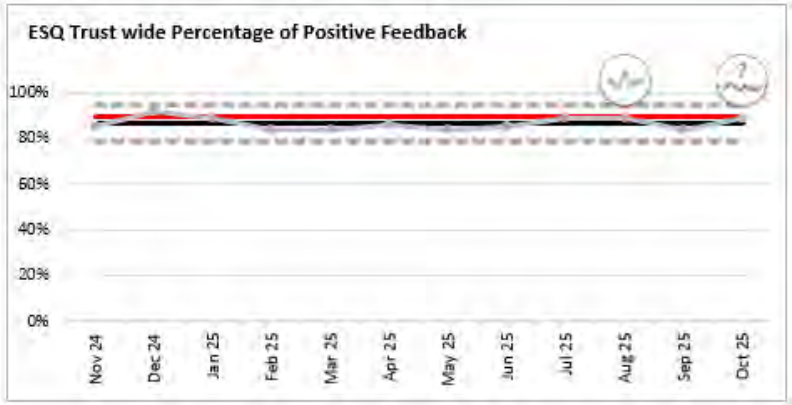
Vision: For all users to have a positive experience across the trust.

G1: Number of ESQ forms collected to consistently exceed Team level Targets set in February 2025.

G2: To consistently meet 90% positive user satisfaction score.

Historical & Current Performance





- Normal data variation in data, is marked in grey.
- Significant improvement would be marked in blue.
- Deterioration or failing to meet the target is marked in amber.

Progress on Improvements

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

Metric	EDI score	SRO	Kasia Parfenyuk	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 (2024) 7.61, with the median score being 8.28 nationally and the best performing trusts being 8.68. 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 8.33) by March 2025 (we increased again to 7.61 and national average has been adjusted down to 8.28).

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.
- Every service has been given their bespoke EDI data and have been encouraged to develop A3s on EDI countermeasures.
- 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
- Trained EDI rep on all job interview panels to cater for Neurodiverse applicants
- Next step to hold Menti sessions with staff on improvements achieved and support pre-merger (before next staff survey round).

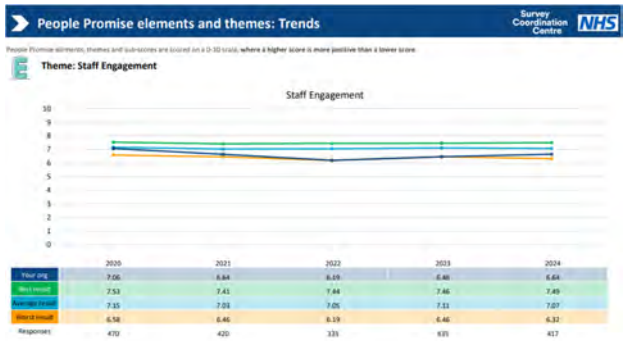
Integrated Quality and Performance Report

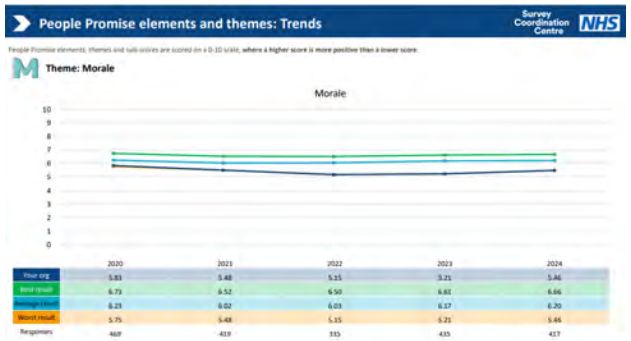
Month 07 25/26

Metric	Staff Experience	SRO	Kasia Parfenyuk	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, now being monitored via IQPR
- Stat/man compliance is increasing and we have implemented an appraisal window for staff to complete before 31/12/25
- Currently in staff survey period. At 42% response rate, continuing to encourage staff to complete. The survey also asks staff about the values and behaviours and how they relate to them
- Staff Experience and FTSU programme board ToR reviewed to consider staff experience over the next 5 months until merger

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

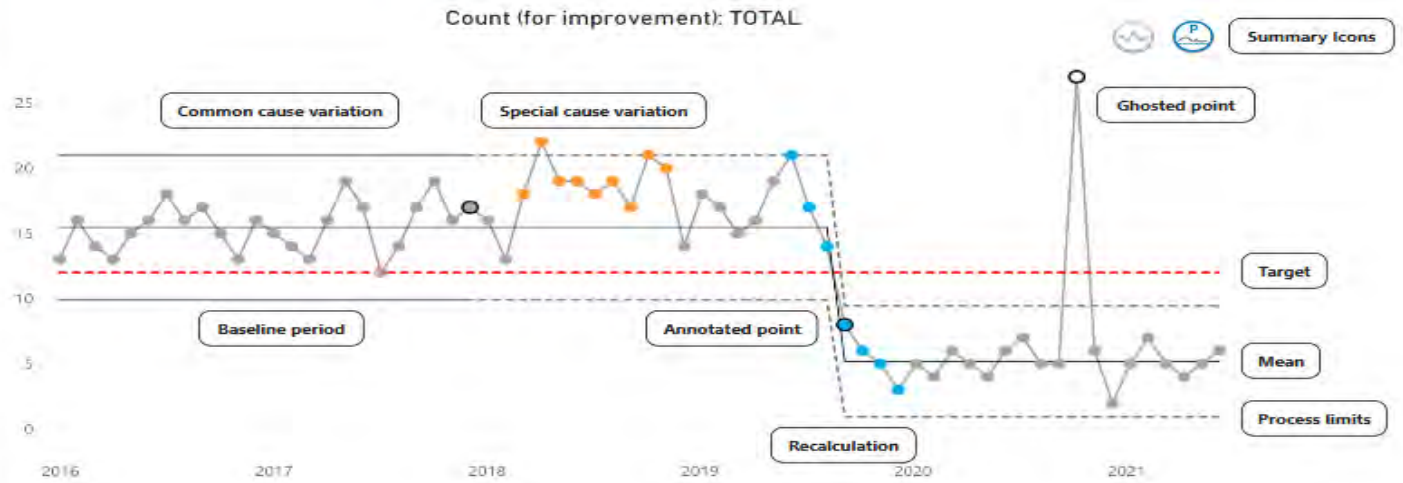
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

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.

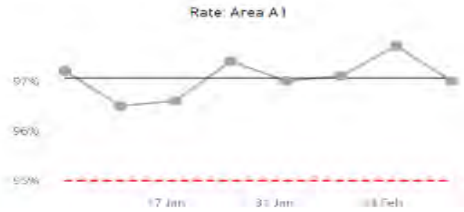
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on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

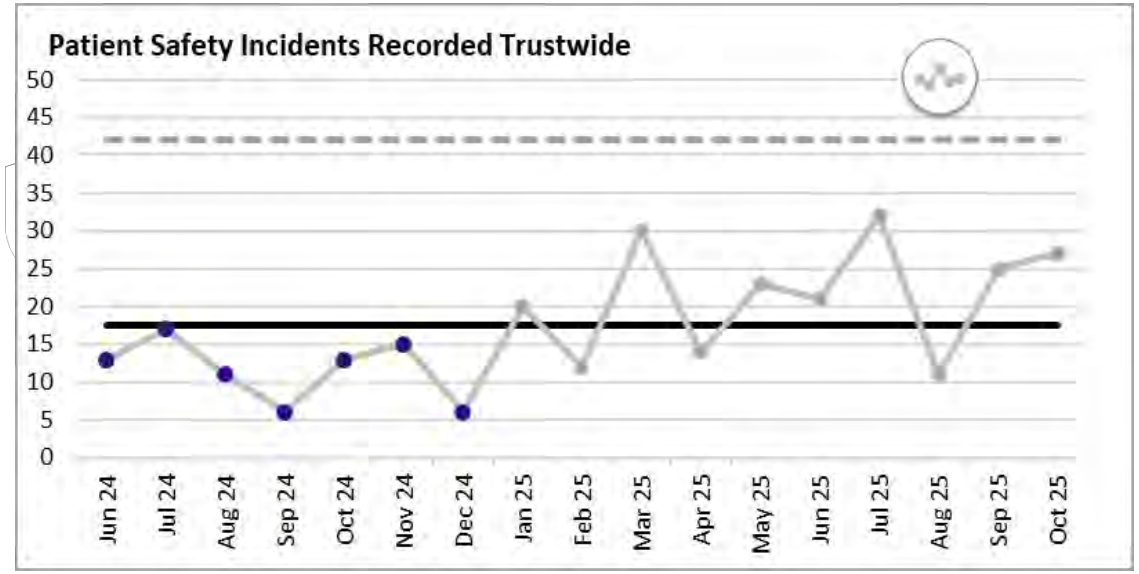
The Tavistock and Portman NHS Foundation Trust

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



Patient Safety Incidents

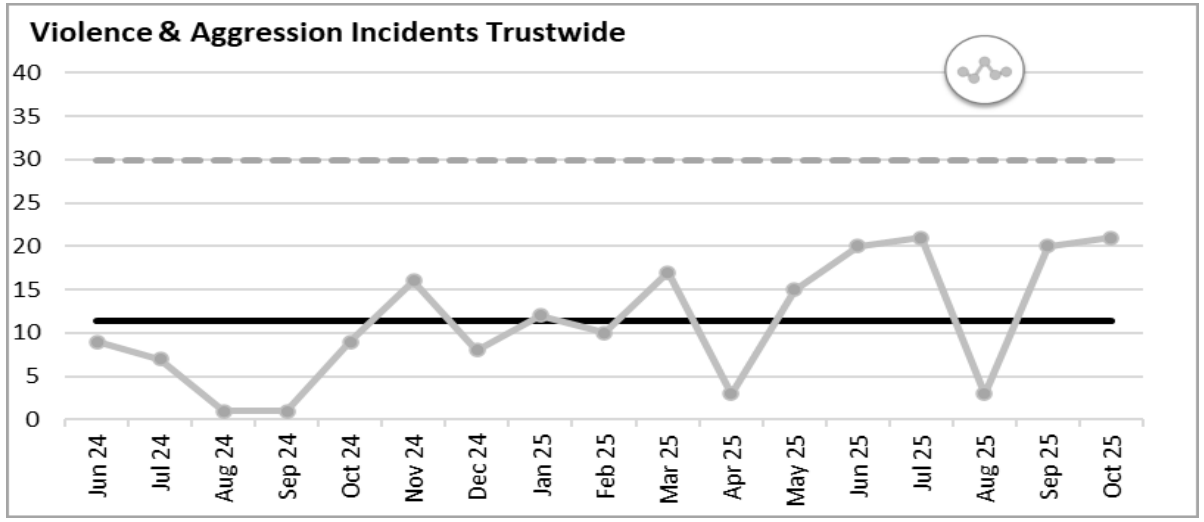
In October, a total of 27 patient safety incidents were reported across the Trust, reported by teams as follows: Camden Unit (6), Adult Unit (1), Children & Families Unit (19), and Estates and Facilities (1).

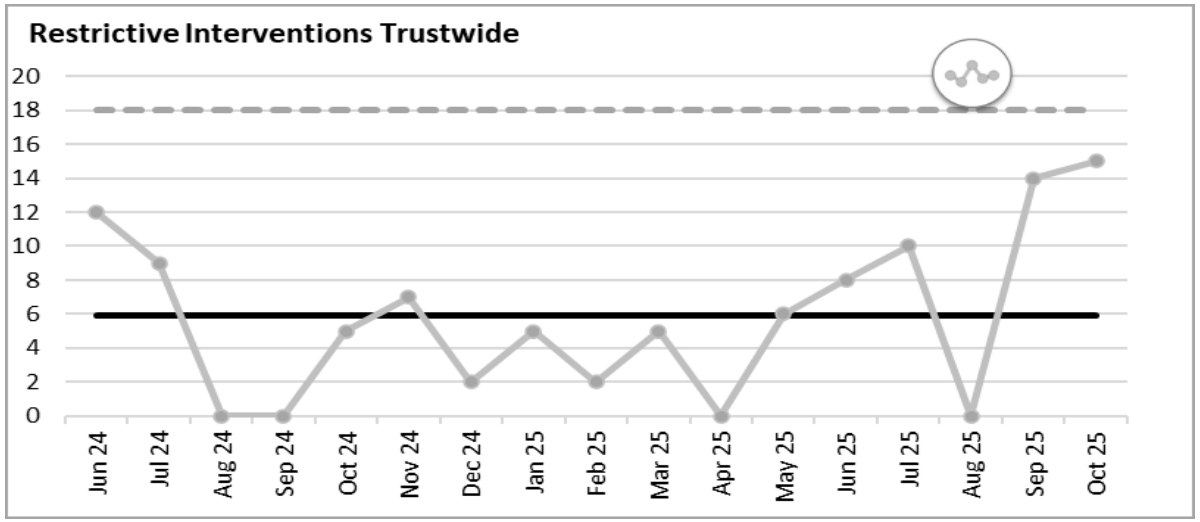
The incidents recorded in October included:

- A death reported by the Adult Unit involving a patient on the GIC waiting list. A mortality review has been requested and will be discussed at the Clinical Incident & Safety Group (CISG) once completed.
- 21 incidents of violence and aggression, of which 18 occurred within the Children & Families Unit.
- Incident of serious self-harm involving a young person within Camden. Immediate local action was taken, including a review, safety plan, and referral to CAISS.
- Incident reported in the Camden Unit of absconding from a placement without informing staff.
- Incident categorised as Slip, Trip, Fall on an uneven paving slab outside the library.
- Incident related to difficulties accessing the NCL crisis line after multiple attempts.
- An 'other' category incident, where a patient was contacted regarding a research project that was not known to the Trust.

An AAR was requested in October concerning the care provided to a young person who had been arrested. This incident had been reported in September, and a multi-agency review was discussed with the local authority at that time. Whilst confirmation of that process is awaited, the internal AAR was requested in the interim. as the Trust internal response to the incident logged in September. The findings will be discussed at the CISG in December 2025.

Are We Safe? – Trust-wide





Violence & Aggression Incidents

A total of 21 incidents of violence and aggression were reported in October: 18 within Children & Families, 2 within the Camden Unit, and 1 logged by the Estates and Facilities team. This aligns with the incident reporting seen in the previous month.

The two incidents within the Camden Unit related to a physical altercation between two patients in a waiting room. An After-Action Review has been requested for this incident. The incident recorded by the Estates and Facilities team related to disruptive behaviour from a patient in the reception area.

At Gloucester House, reported incidents included aggressive behaviour, discriminatory and inappropriate language, the throwing of objects/items at staff, and assaults on staff members, including punching, spitting, kicking, and hitting. In all cases, immediate local action was taken as appropriate. The incidents were triaged for managerial review by the Patient Safety Team, with relevant escalations recorded where necessary.

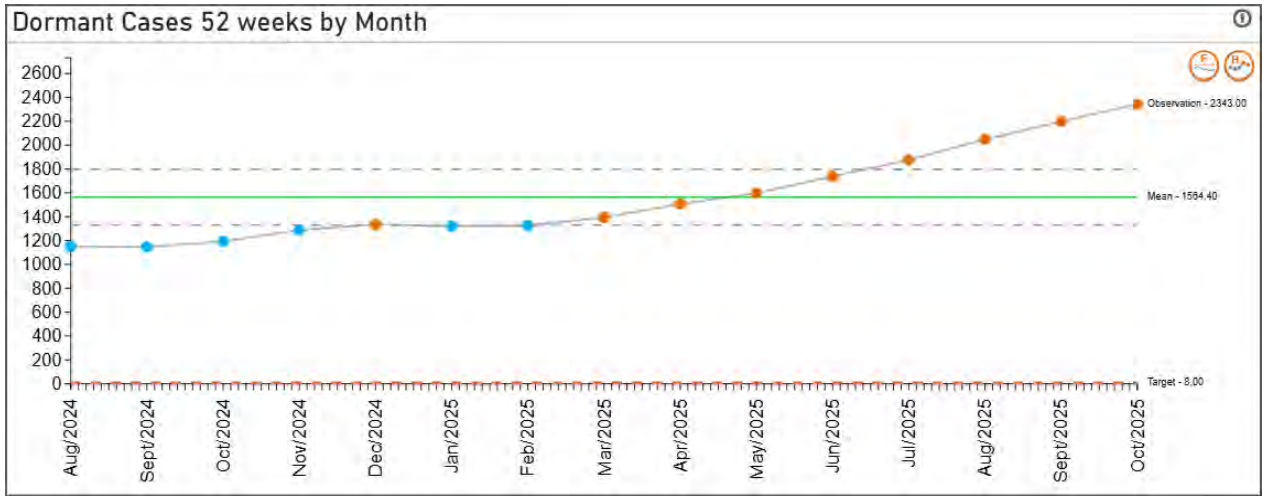
Incidents Involving Use of Restrictive Practice

In October, there were 15 reported incidents of restrictive practice, marking the highest level of restraint reporting to date. This aligns with the trend observed in last month's restrictive practice reports.

The increase has been escalated to the Unit Clinical Lead and has been discussed at both the Executive Safety Huddle and the Clinical Incident & Safety Group. The Patient Safety Team continues to collaborate with Gloucester House to better understand the escalations in behaviour and preventative actions being put in place.

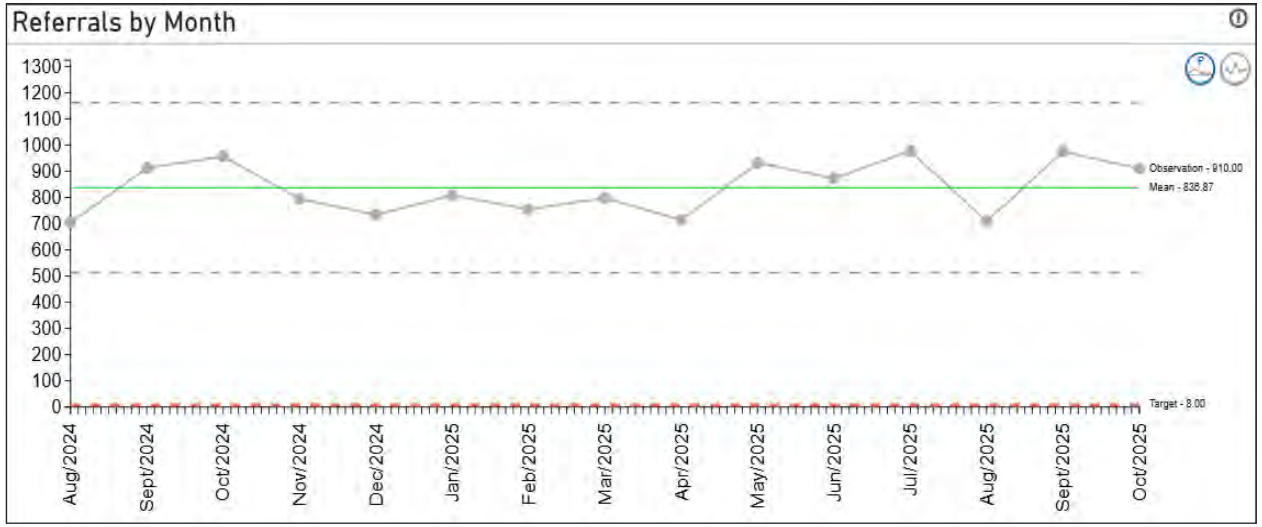
Initial managerial reviews have been initiated, with additional consideration to be given to any further learning opportunities once these reviews are concluded. Support for staff will also be prioritised to ensure their ongoing safety and wellbeing.

Are We Effective? – Trust-wide



52+ Week Dormant Cases

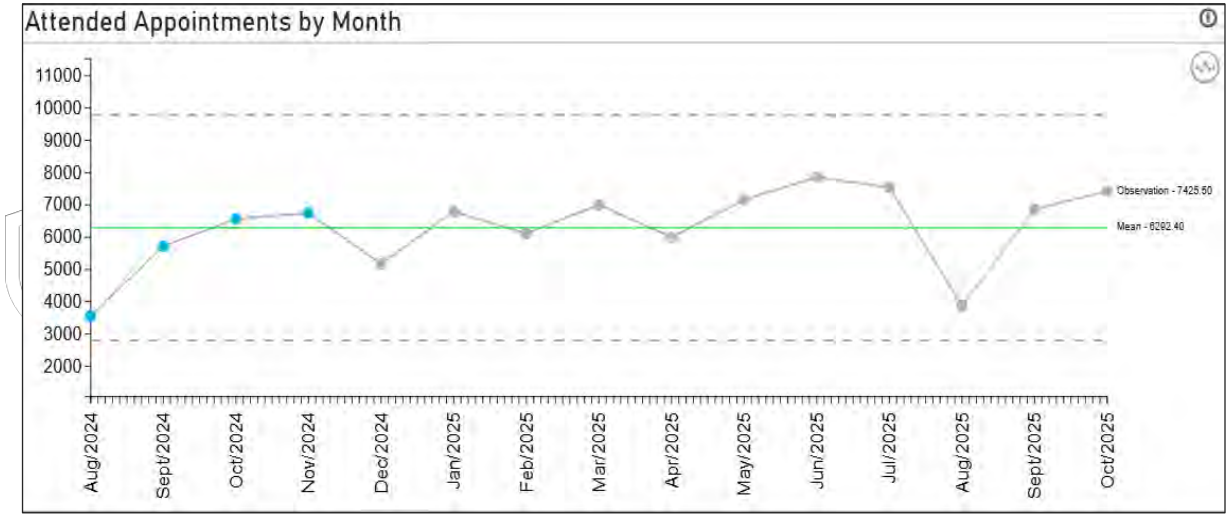
The trauma service has spent the last 12-18 months focusing on how to reduce the length of wait without more resource. This has been the focus on Kaizen and the structured support and remains the focus of ongoing quality improvement now. The Adult Trauma team is facing the loss of ERF staff which is almost half the team, but is focusing on how to continue to deliver high quality care and minimize the impact of this loss.



Number of Referrals (Including Rejections)

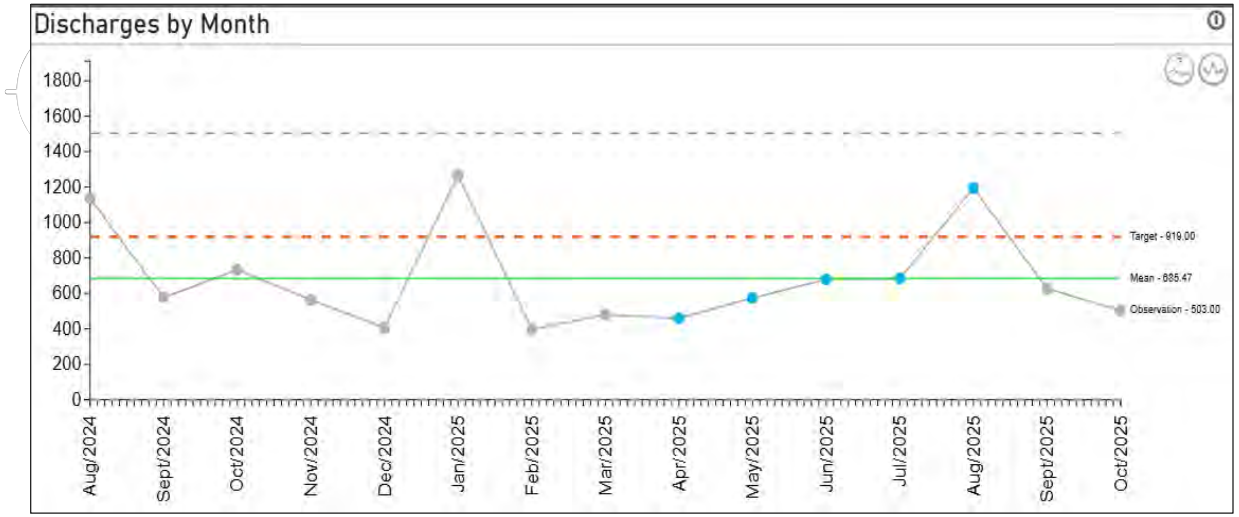
The trust received 929 referrals in M7 with only 63 cases rejected across the Trust. The number of referrals the trust received in M7 shows that demand across the trust and in all units remains high.

Are We Effective? – Trust-wide



Number of Attendances

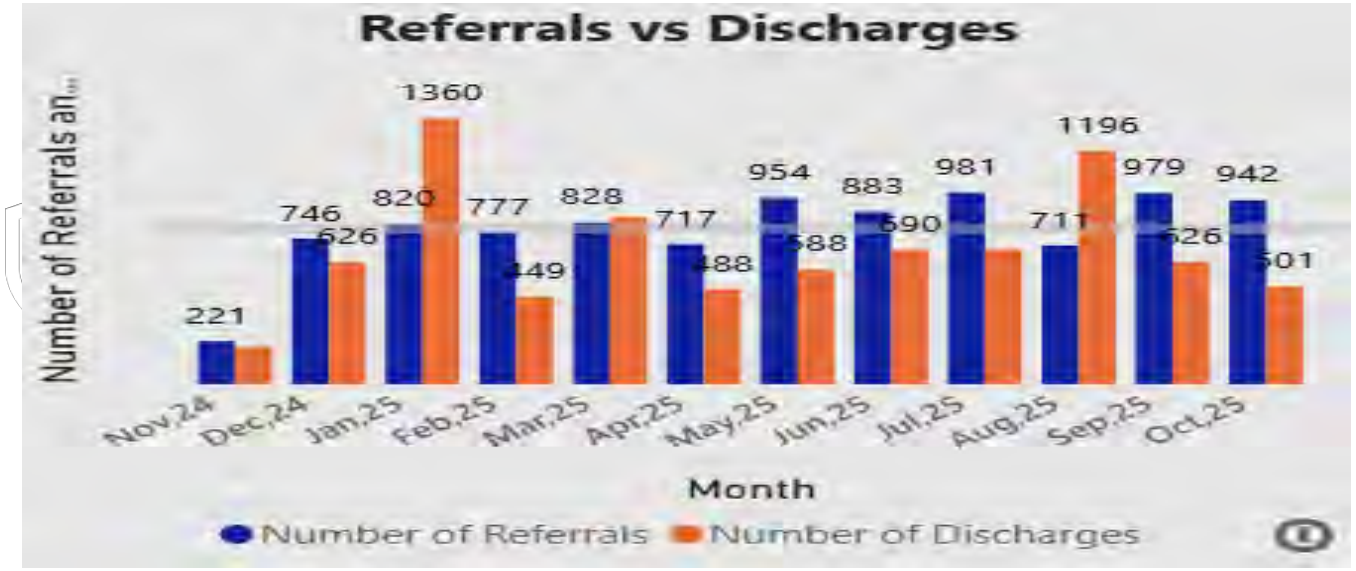
The overall number of attendances in M7 is 7,497, this shows a continued rebound from August activity but is lower than M3 2025 which at > 7,500 is the highest number of attended appointments for over 12 months. The M3 and M4 data was in line with expectations and indicated a potential increasing understanding 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 3,868 attendances recorded in M5.This is 271 higher than the equivalent month in 24/25. The equivalent M7 figure for 24/25 was 6,565 which is 932 lower than this year's figure and shows continuing increased activity year on year.

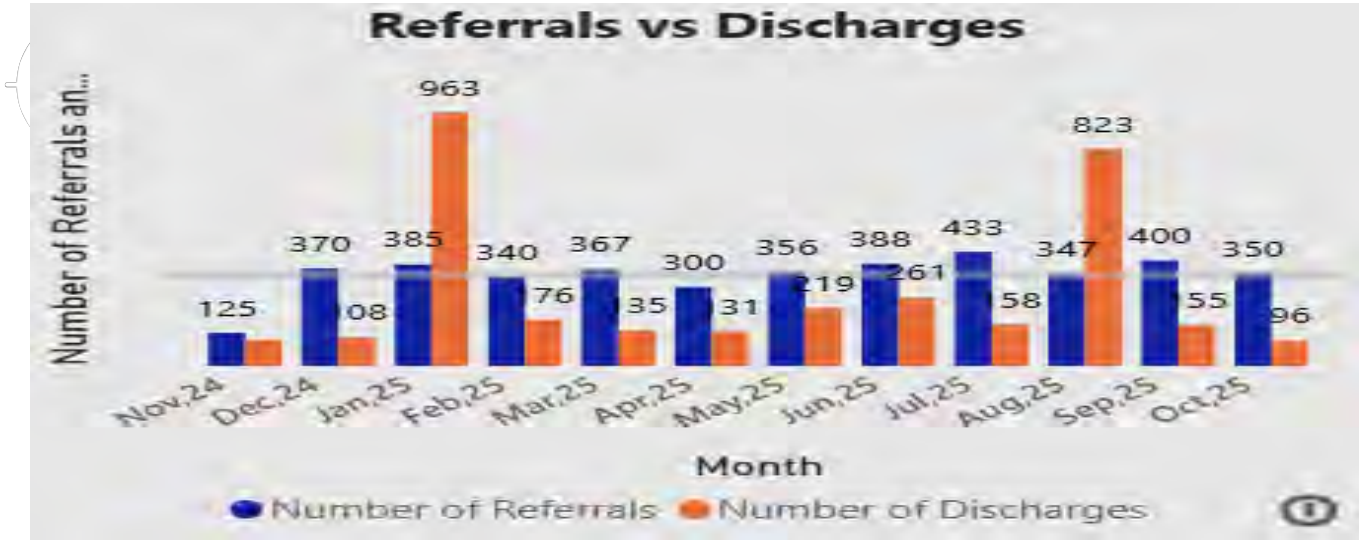


Number of Discharges

The number of discharges has returned to the trend shown in M3 and M4 after the rise in the number of discharges in M5 due to a large number of cases being transferred from GIC to another provider. Referrals are being received at a higher rate than the number of discharges, resulting in an increasing waiting list trust-wide.

Are We Effective? – Trust-wide

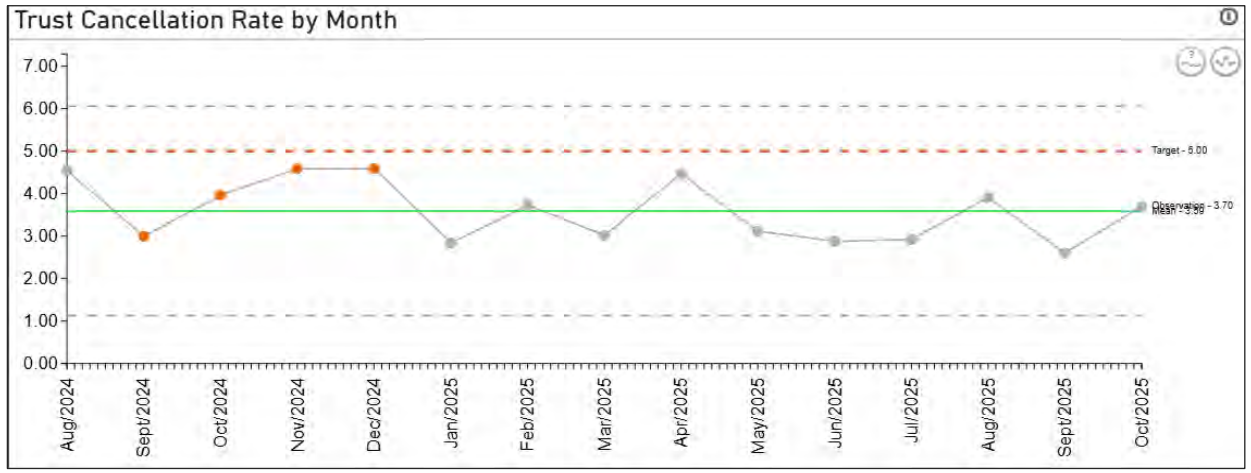




Number of Discharges with Average Line (2nd chart Adult GIC only):

The graph indicates that the number of discharges is below 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. However, this indicates that the number of discharges in M7 is still below the 12-month trust average.

Are We Effective? –Trust-wide



% of Trust-Led Cancellations

The Trust reports a cancellation rate of 3%, an increase on last month's figure of 2.60%. 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% in Month 7.

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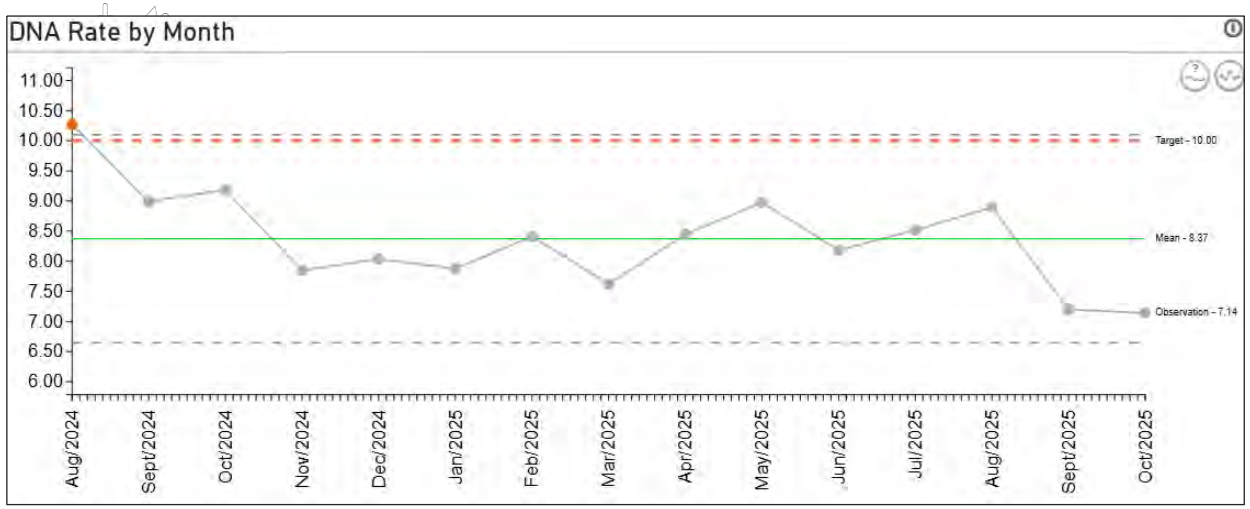
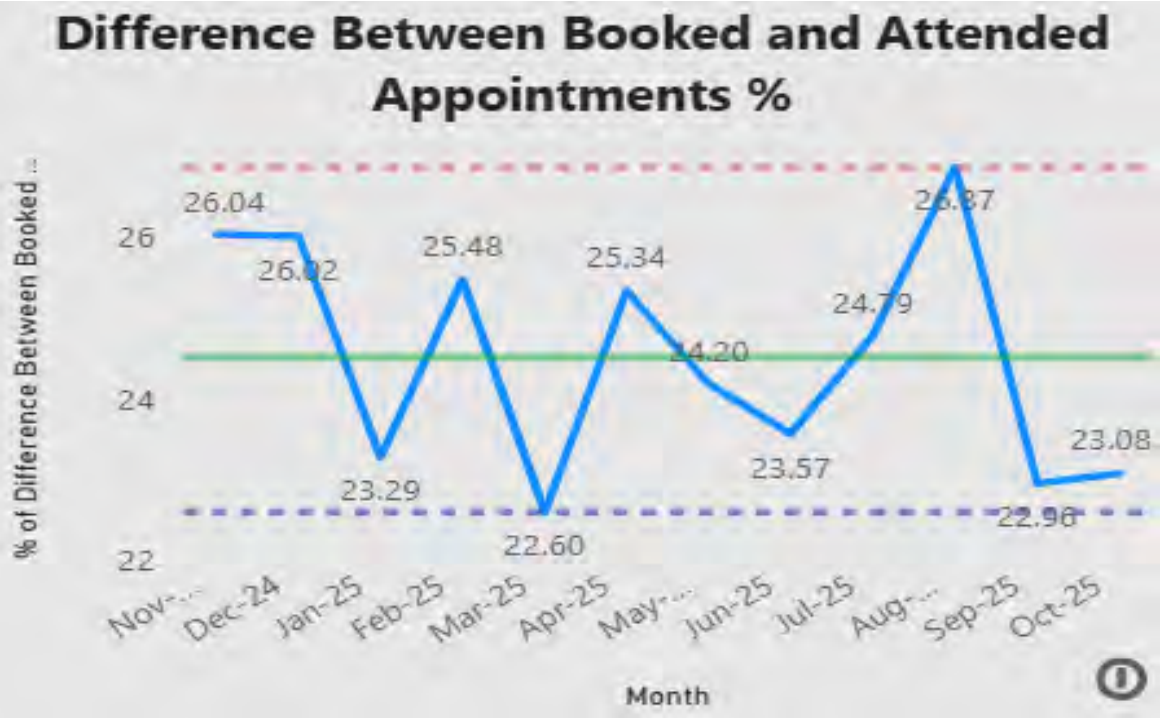


% of DNAs

There has been a large decrease in the Trust's DNA rate in recent months, and it remains below the 10% upper control limit.

Are We Effective? –Trust-wide

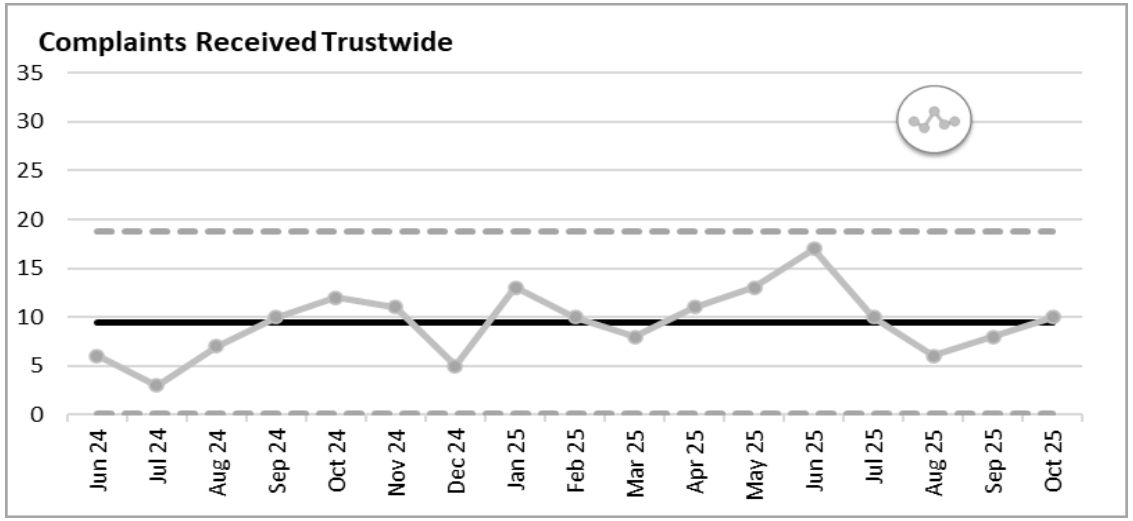


Booked vs Attended Appointments

- The number of attended appointments is now above the mean and approximately 3% below the lower control limit. However, this remains below the total number of booked appointments.
- Clinical services are currently working to establish more accurate upper and lower control limits, considering 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 11% of all booked appointments in M7 2025 accounts for just under half of all cancellations in that month and is the lowest since March 2025. DNA rates have fluctuated around 7-8% of all booked appointments and the trust has cancelled 3% of all booked appointments in September 2025.
- It is envisaged that future iterations of this metric will measure performance against a national benchmark.

Are We Caring? - Trustwide

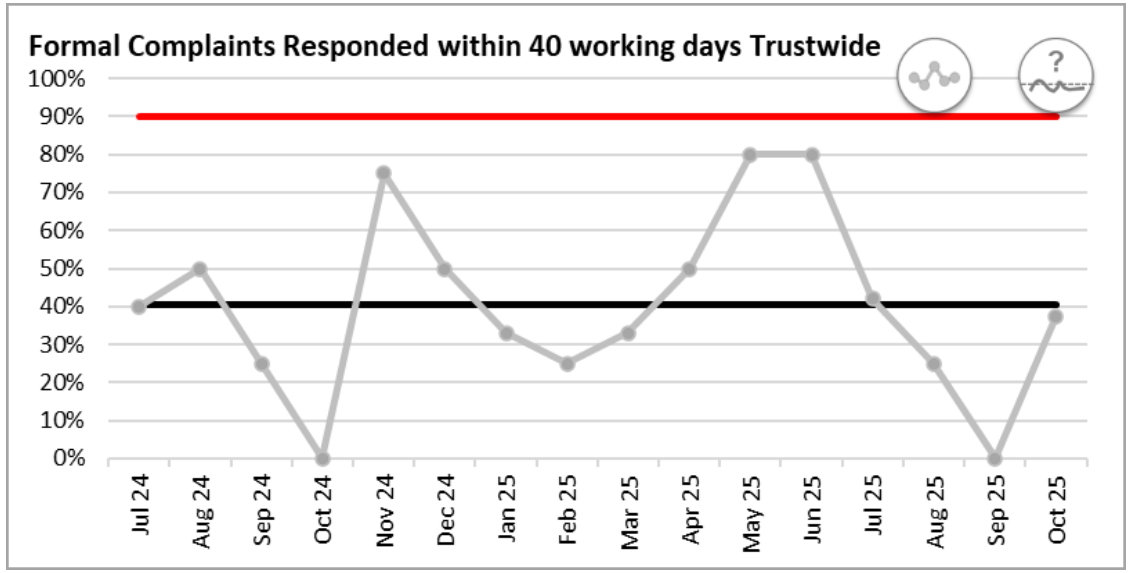
The Tavistock and Portman NHS Foundation Trust



Number of Formal Complaints Received

A total of 10 complaint contacts were received Trust-wide in October; 7 were received by the Adult Unit, 2 for the Children & Family Unit and 1 for Camden Unit.

9 of the 10 complaint contacts received in October were acknowledged within 3 working days in line with national regulations. The one complaint that was not acknowledged within 3 working days was due to oversight of the email in the complaints inbox.



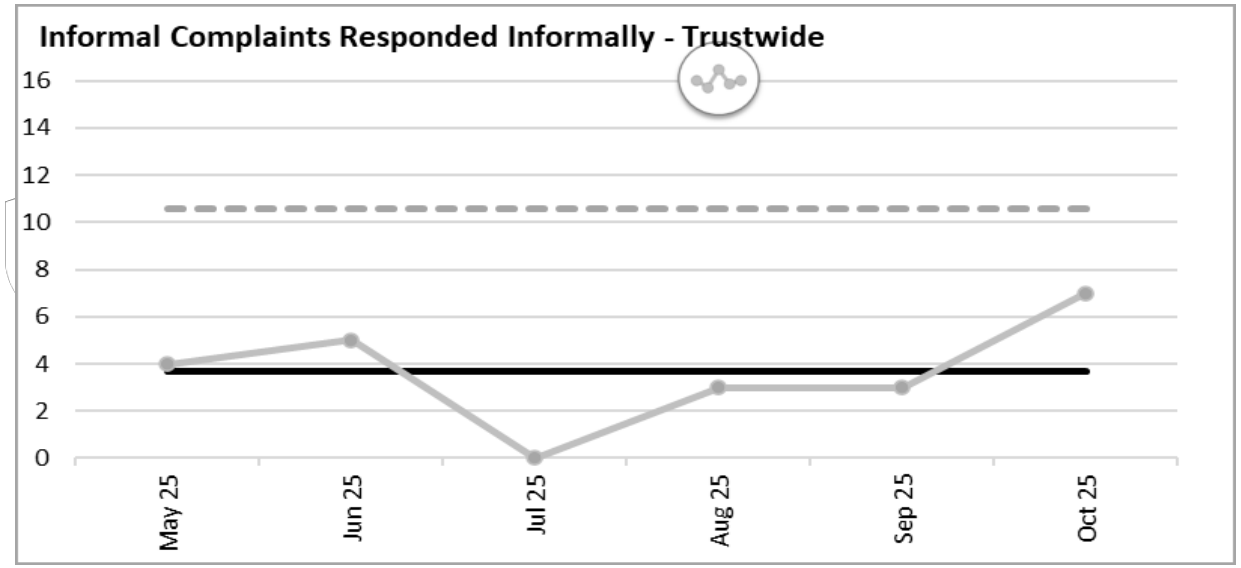
Formal complaints response time compliance

Trust wide compliance for formal complaints responded to within 40 working days in October was 37.5%. All formal complaints responded to within the month were from the Adult Unit.

As of the end of October 2025, 9 complaints (7 Adult & 2 Children & Families) were open of which 2 were overdue. Both of the overdue complaints are registered to the Adult Unit.

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.

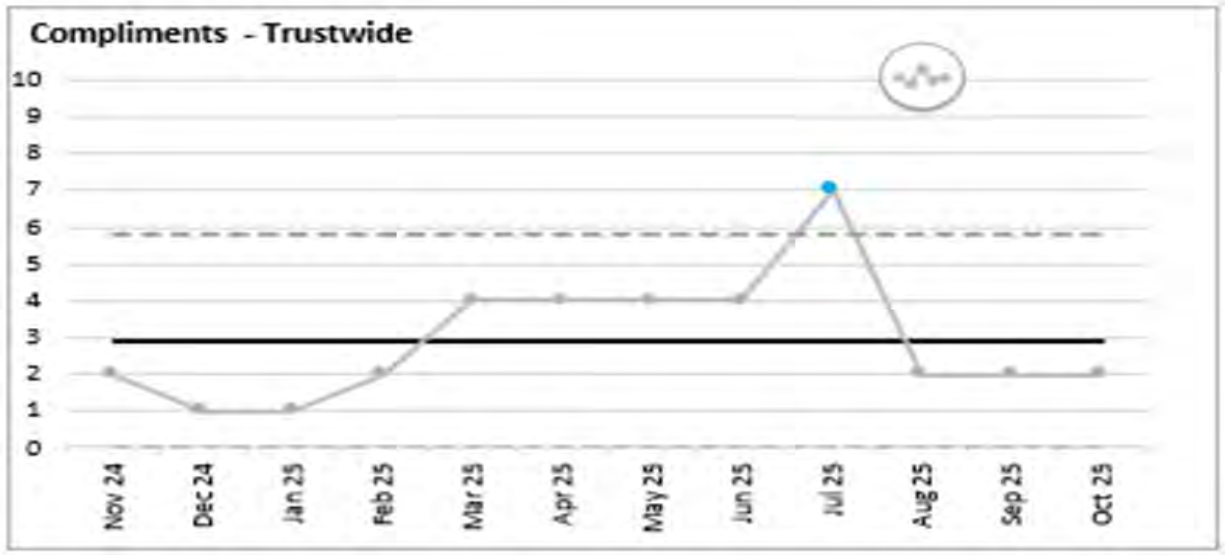
Are We Caring? – Trust-wide



Informal Complaints (Local Resolution)

In October 2025, 7 complaints were resolved informally, 5 of which were in the Adult Unit. Camden and the Children & Families Unit resolved one complaint informally each.

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.



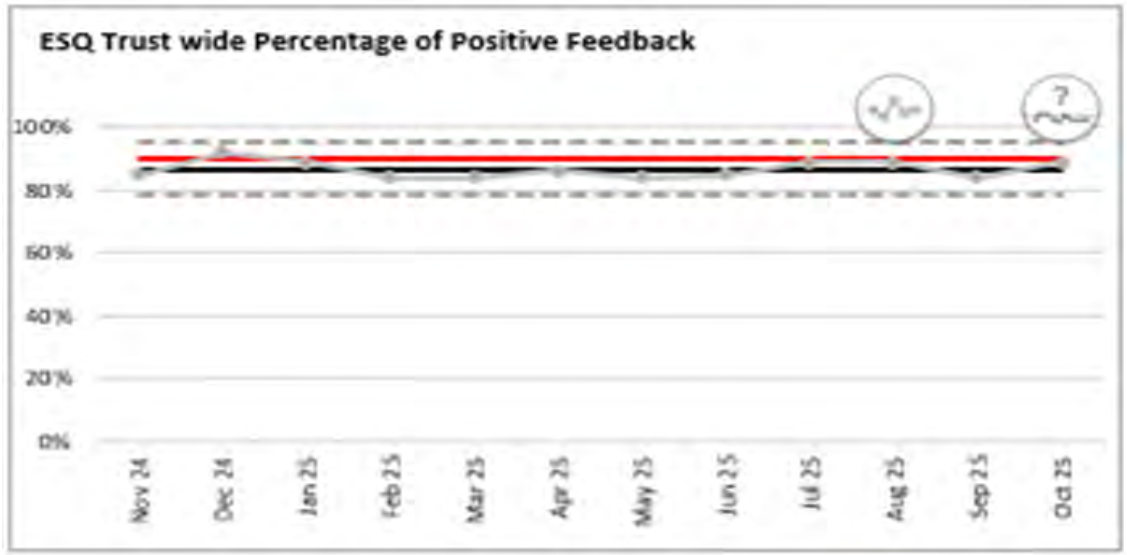
Number of Compliments Received

2 compliments were recorded in Radar in October 2025; 1 by the Children and Families Unit categorised as patient care, and one by the Adult Unit 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.

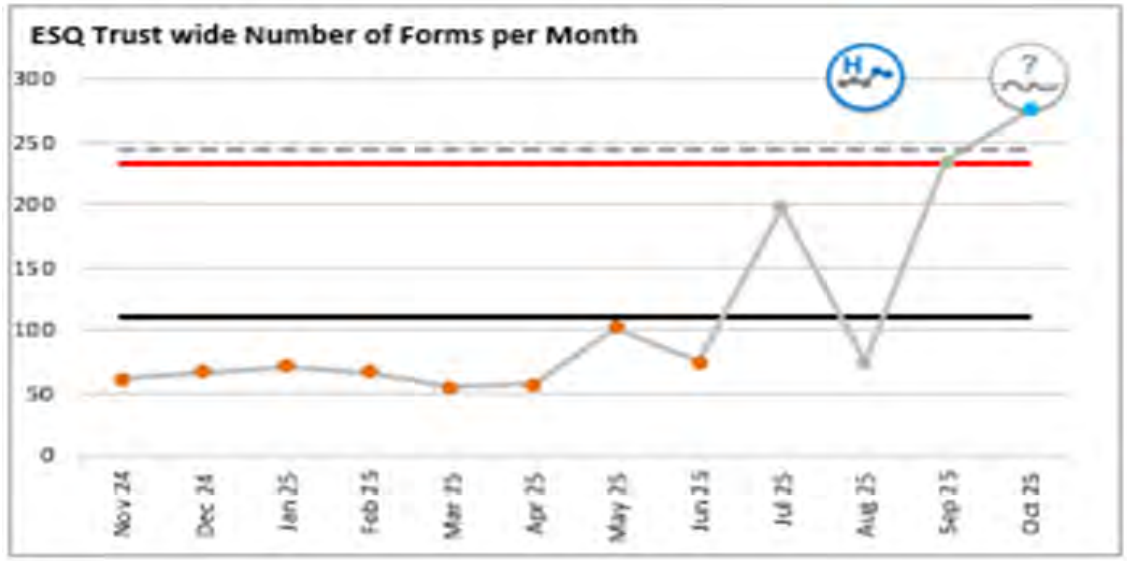
This metric became live on Radar in January 2025, so historical data is not formally available. The Trust continues to raise awareness of the process on how to record compliments within the teams.

Are We Caring? – Trust-wide



ESQ Positive Responses %

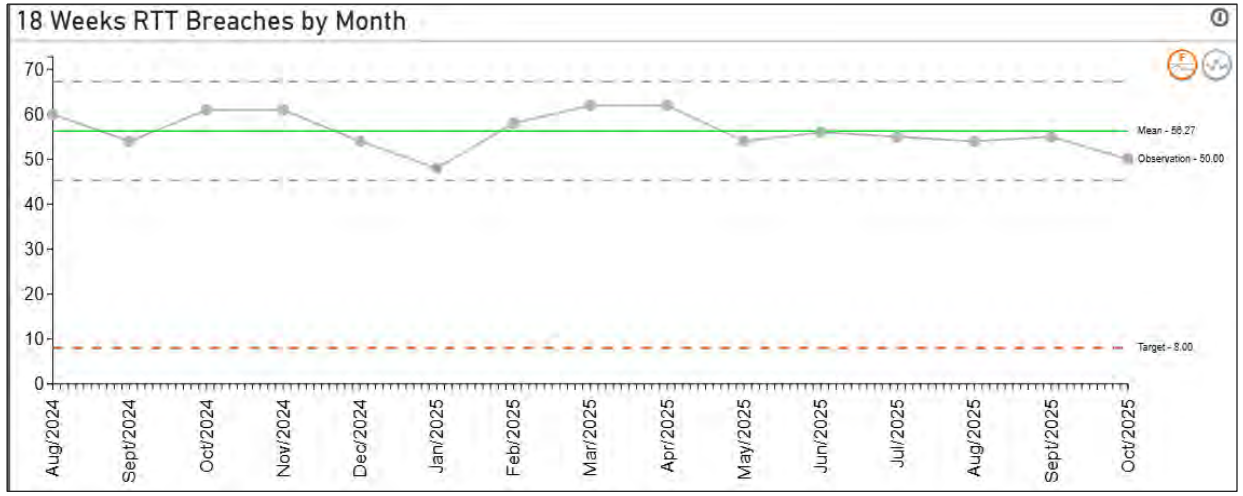
In October 2025 we achieved our Trust target of 90% ESQ positive responses. Patient care and Values and behaviour are the most common themes reported by our patients. Communication continues to be a theme where improvements are needed. Teams are reviewing data and planning improvements through a QI framework.

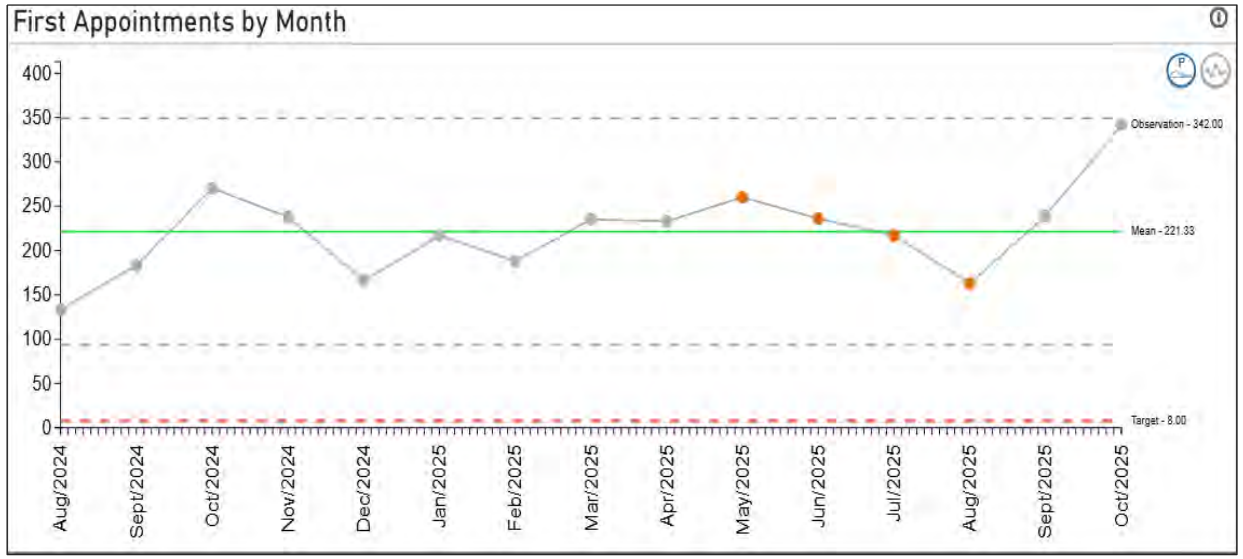


ESQ Number of Forms per Month

In October 2025 we exceeded our Trustwide target for number of forms collected. Unit level and team level data indicates that there are still some teams where the number of forms collected is significantly below target. There is continued targeted support being offered to these teams to develop targeted actions to increase engagement. Regular text messaging to request for feedback is taking place.

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:

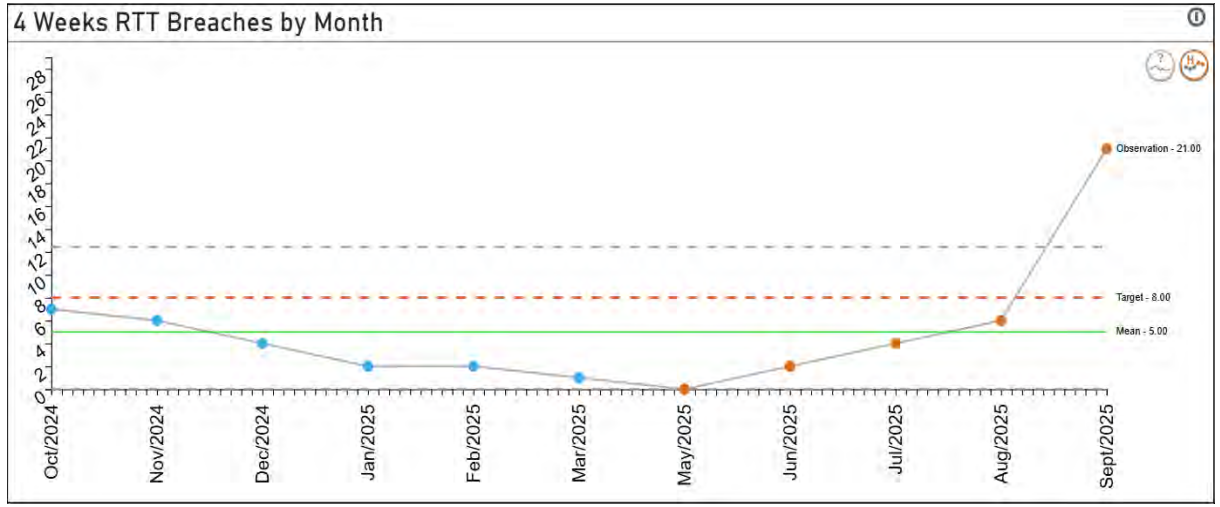
- **Neurodevelopmental Disorders (NDD) Pathway:** This was close to meeting its RTT target, but additional improvements are still required.as performance has recently deteriorated.
- **Adult Unit:** Significant work is needed to meet RTT targets. Current figures are skewed by data from Trauma and Gender Identity Clinic (GIC) services, but 18-week RTT breaches have been increasing in other teams in the unit.
- **Adult Psychotherapy Services**—The number of 18-week RTT breaches has increased from a figure of 2 in September 2024 to 12 in September 2025.

Child and Family Unit (CFU)

- The CFU (excluding Autism Assessment) currently reports **83 cases breaching the 4-week RTT threshold**. This shows an improvement compared to the same month last year which reported 91 cases.
- In **Camden**, an A3 improvement plan related to the Clinical Intake Team is now in implementation.
- The mean average waiting time for cases in the CFU is currently 3.59 weeks (excluding Autism Assessment).

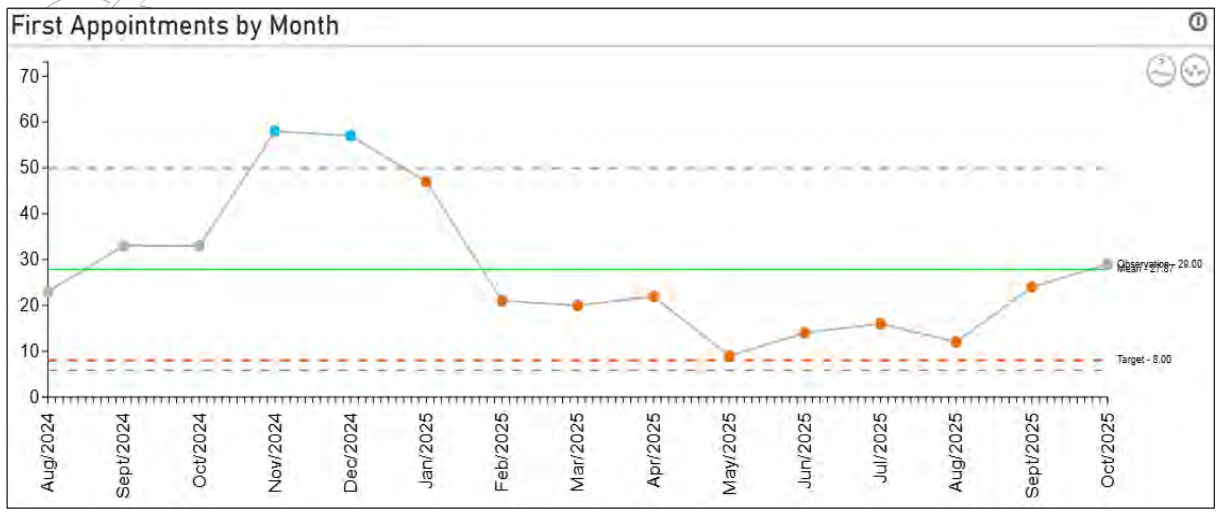
Are We Responsive? – Trust-wide

The Tavistock and Portman NHS Foundation Trust



Under-18s Autism Assessment 4-week RTT Breaches

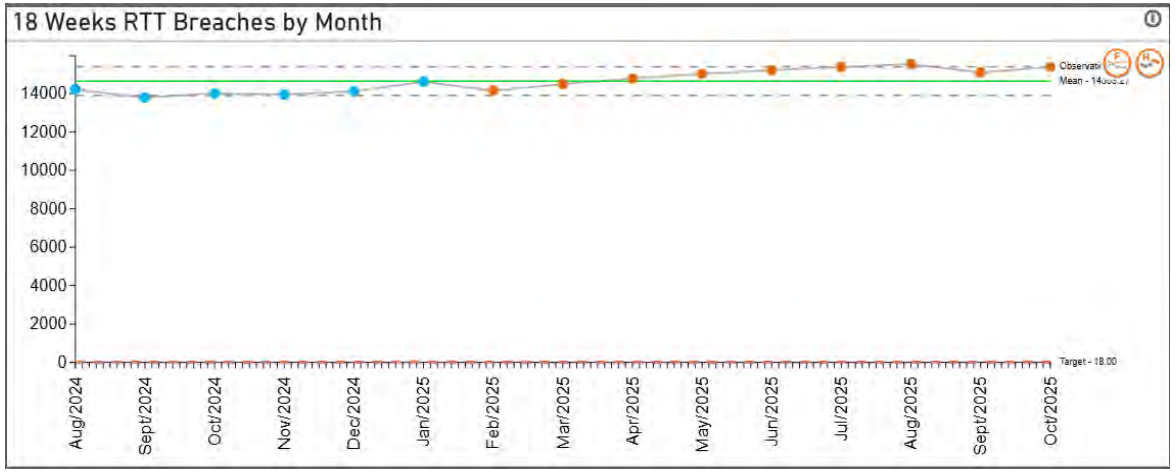
As at October 2025, there are 21 individuals who have breached the 4 - week RTT target. This is the highest total reported in the period covered. However, there is now increased capacity to offer triage appointments, which will reduce the wait time to first appointment. The increase in waiting times has been an overall reduction in staffing for this pathway.



Under-18s Autism Assessment 1st Attended Appointments

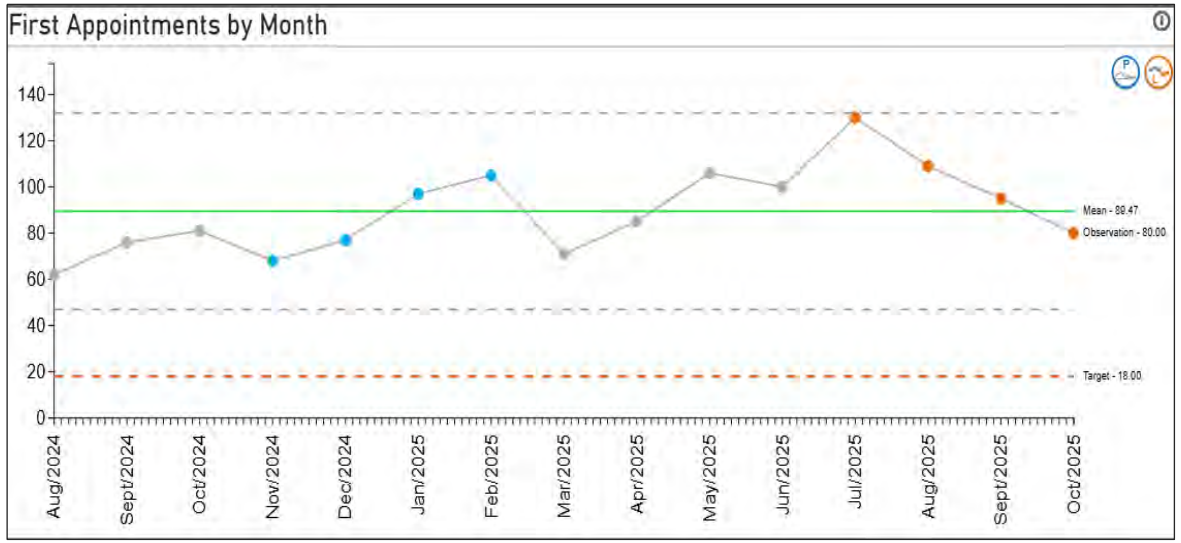
There were 29 1st appointments in October, out of a total of 114 attended appointments. This is the highest number recorded since M10 24/25 and is above the long-term average.

Are We Responsive? –Trust-wide



Over-18s GIC 18 Week RTT Breaches (1st Appointment)

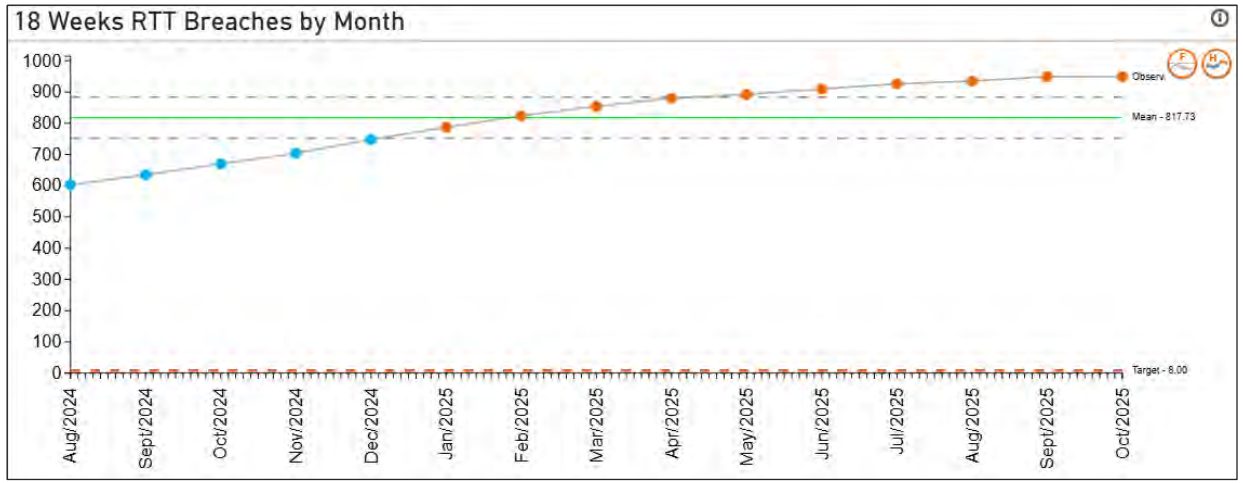
- As of October 2025, there are 15,368 individuals waiting for a first appointment, reflecting ongoing pressure on the service with a rise of 199 cases on the previous month as the number of referrals fell from 400 to 368.
- The four GIC nursing ERF posts, created to support the Core service (waiting 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.



Over-18s GIC 18 Week Attended Appointments (1st Appointment)

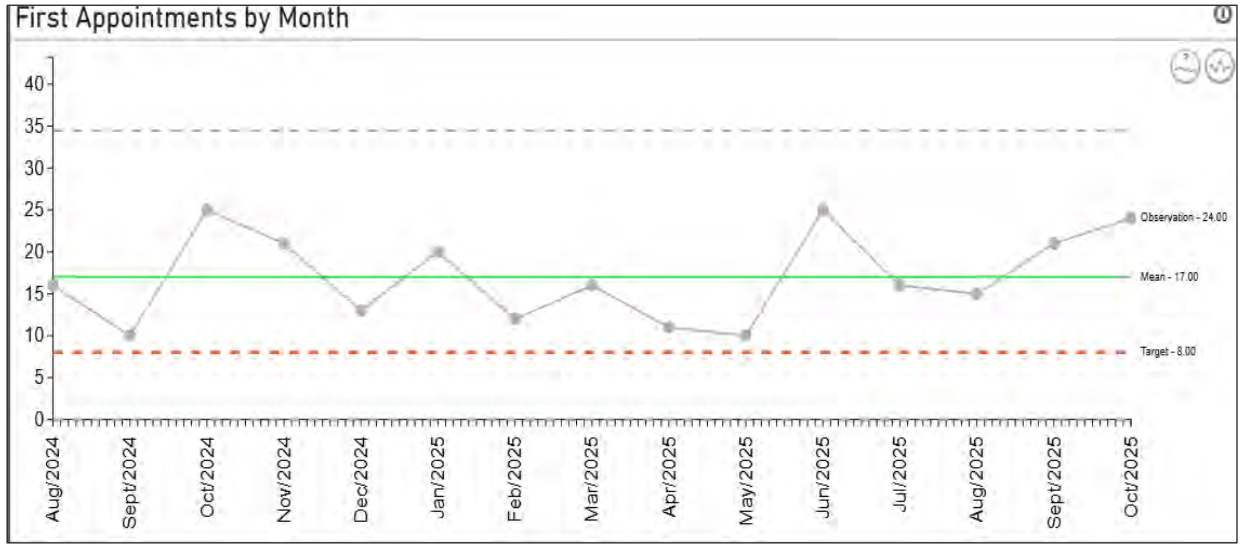
The service decreased their number of 1st attended appointments from a peak of 130 in M4 24/25 to 80 in October 2025. The current wait time for a first appointment is approximately 175 weeks, though this varies from month to month. The team continues to receive support under the GIC Quality Improvement huddle to help address these challenges and improve access.

Are We Responsive? –Trust-wide



Over-18s Mental Health 18 Week RTT Breaches: Trauma (1st Appointment)

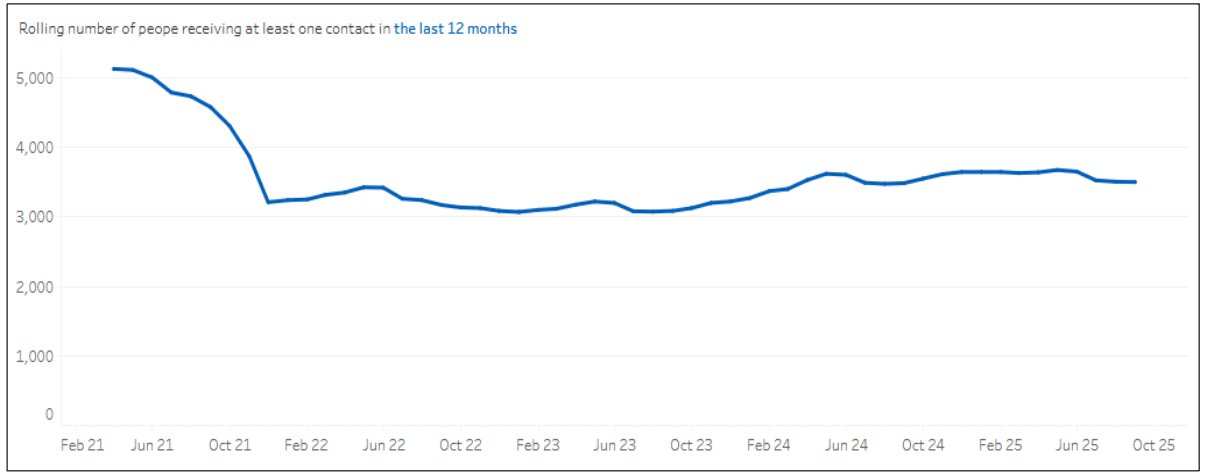
- As of October 2025, there are 948 individuals waiting for a first appointment, reflecting ongoing pressure on the service.
- The trauma service has spent the last 12-18 months focusing on how to reduce the length of wait without more resource. This has been the focus on Kaizen and the structured support and remains the focus of ongoing quality improvement now. We are facing loss of ERF staff which is almost half the team, but we are focusing on how to continue to deliver high quality care and minimise the impact of this loss.



Over-18s Mental Health 18 Week Attended Appointments: Trauma (1st Appointment)

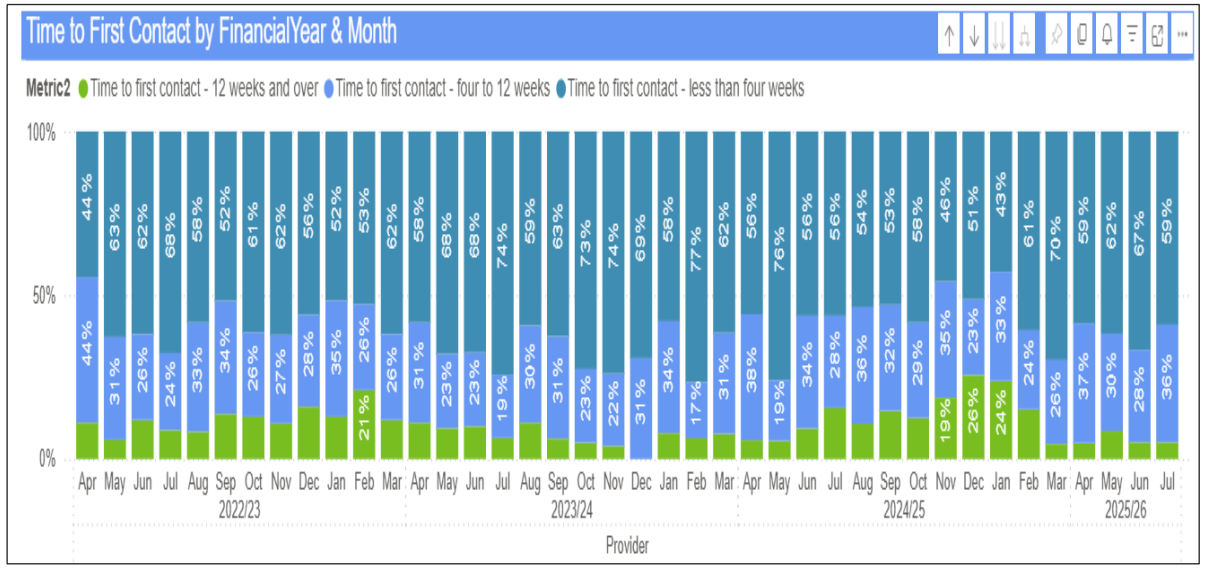
The service increased their number of attended appointments from 684 in September to 777 in October 2025.
In October 2025, 24 patients attended their first appointment, out of a total of 777 appointments delivered. The current wait time for a first appointment is approximately 94 weeks, which is the continuation of an observed downward trend from 121 weeks in August 2025. The team continues to receive support under the Targeted Support programme to help address these challenges and improve access.

Are We Responsive? –Trust-wide



Rolling number of people receiving at least one contact in the last 12 months (CYP)

- As of September 2025, 3,495 individuals have received at least one contact from the trust in the last 12 months. This is very similar to the figures of 3,480 reported for September 2024.

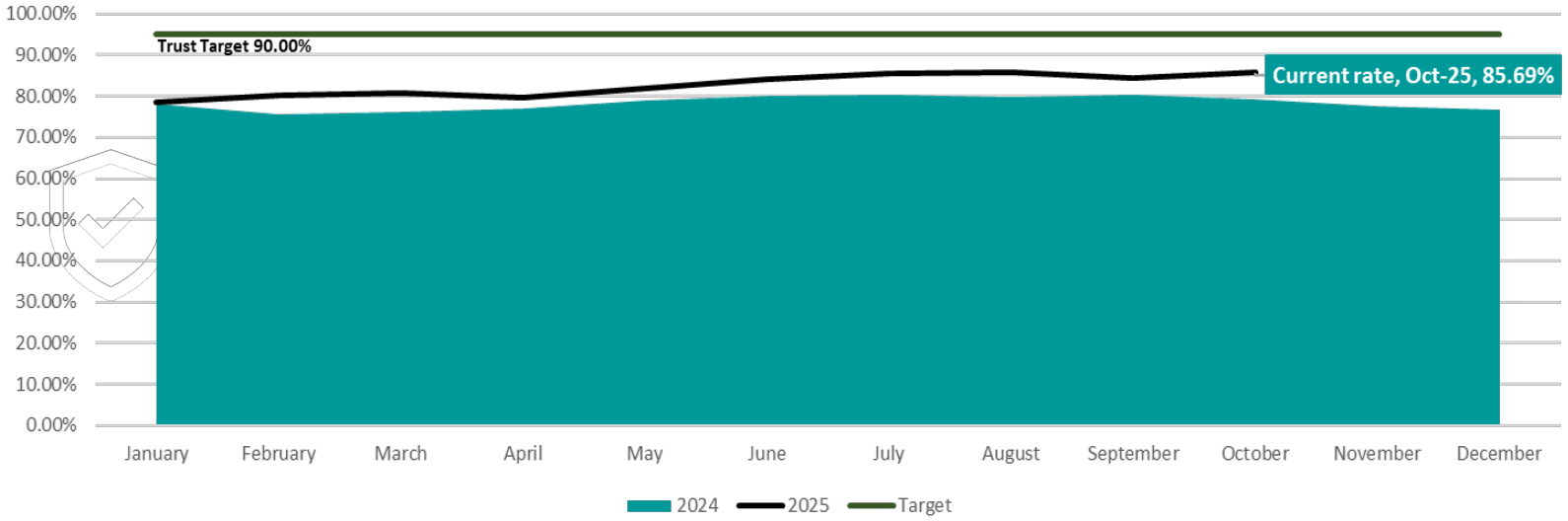


Time to First Contact by Financial/Year & Month (CYP)

- In the latest month reported (July 2025), 59% of all CYP service users received a first contact within 4 weeks of referral. This is the lowest figure since January 2025. This may reflect the situation of the service before the investment was made into the service to reduce waiting times.

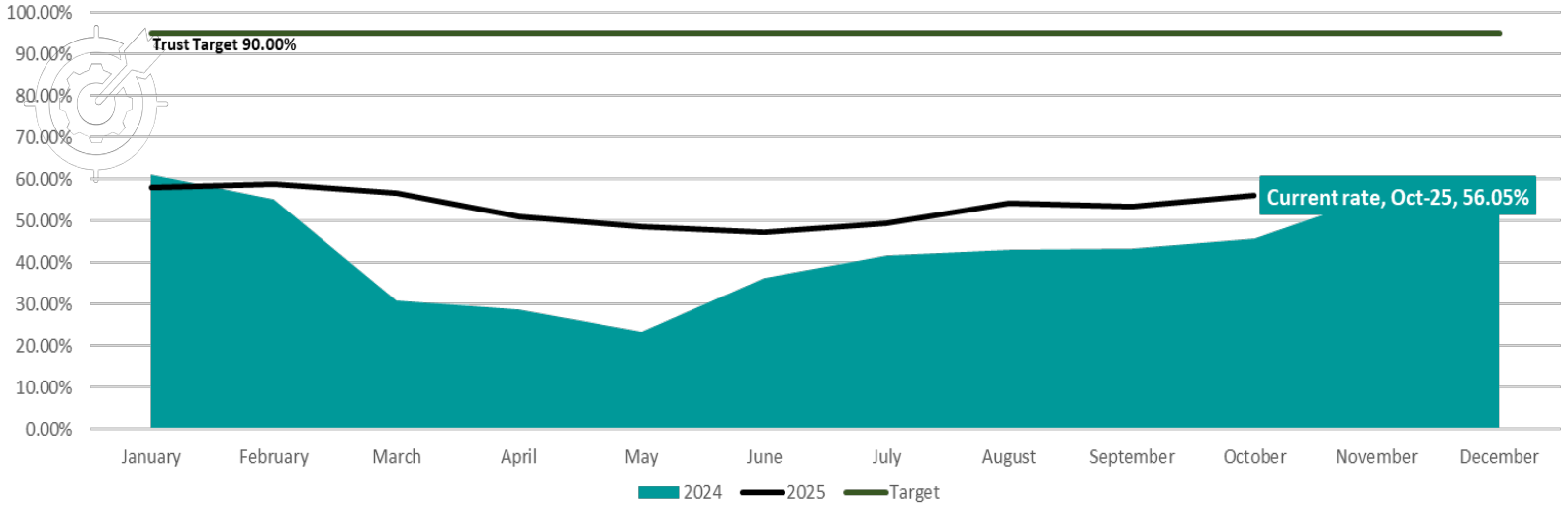
Are We Well-Led? –Trust-wide

The Tavistock and Portman NHS Foundation Trust



Mandatory & Statutory Training (Combined)

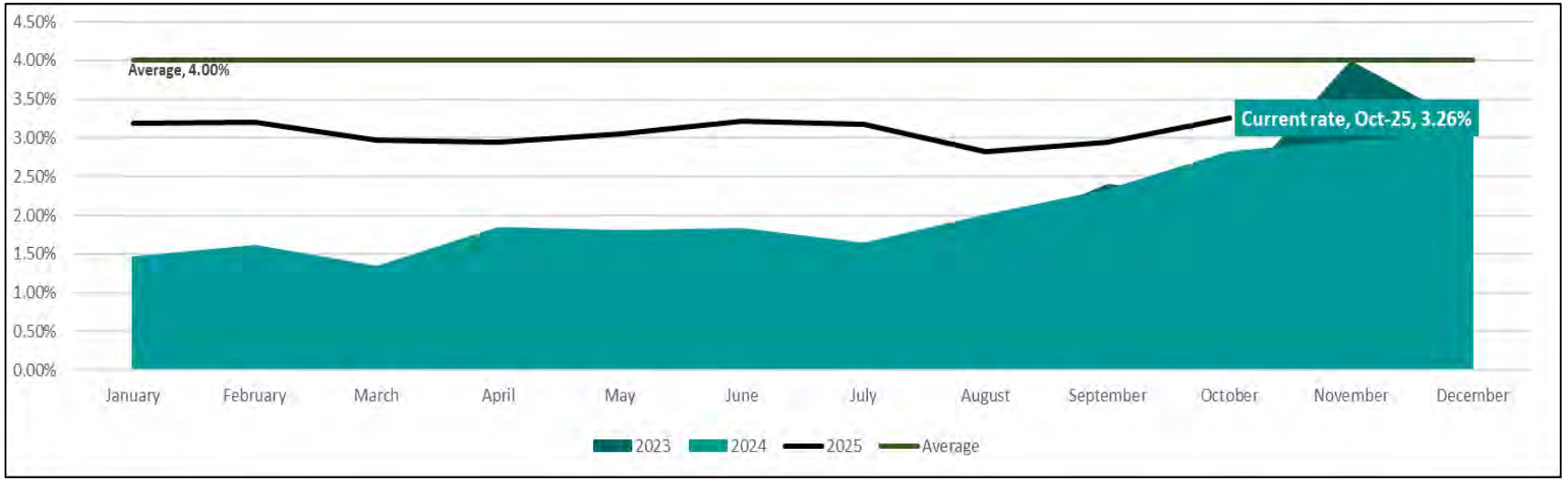
Directorate Oct-25	Compliance %
Chief Financial Officer	96.98%
Chief Nursing Officer	96.69%
Chief Strategy & Business Development	94.94%
Chief Executive Officer	91.46%
Chief Clinical Operating Officer	86.46%
Chief Education and Training Officer	83.31%
Chief Medical Officer	74.48%
Chief People Office (Includes Bank)	70.10%



Appraisal Completion (Combined)

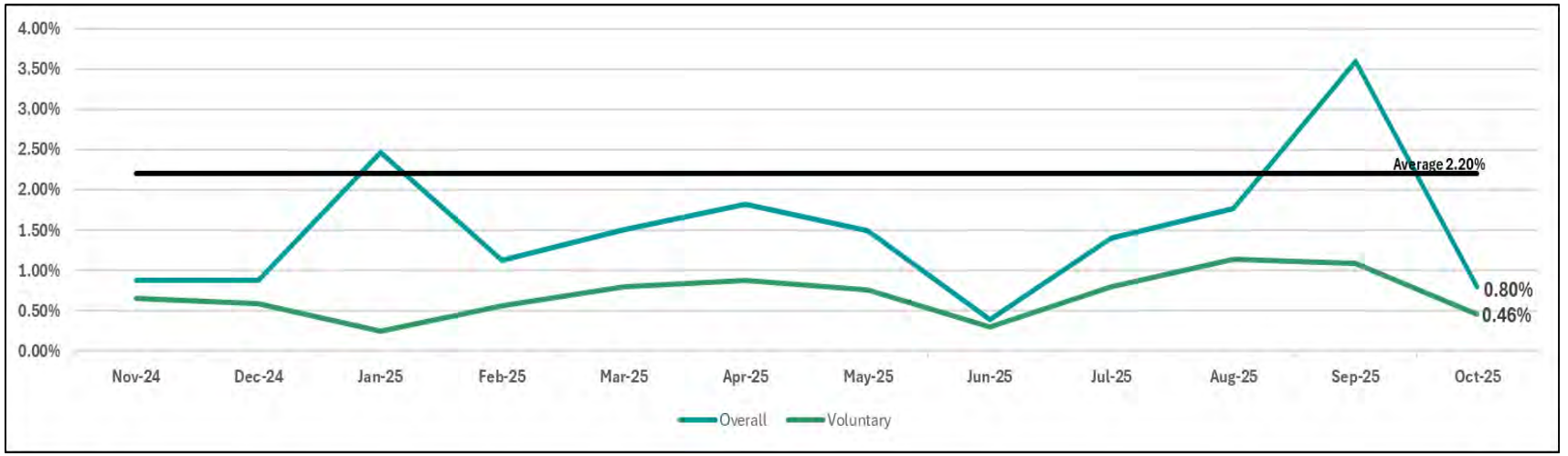
Directorate Oct-25	Reviews %
Chief Medical Officer	100.00%
Chief Nursing Officer	85.00%
Chief People Officer	78.57%
Chief Executive Officer	63.16%
Chief Clinical Operating Officer	63.07%
Chief Financial Officer	60.00%
Chief Strategy & Business Development	52.94%
Chief Education and Training Officer	38.95%

Are We Well-Led? – Trust-wide



Staff Sickness (Combined)

Directorate Oct-25	Absence FTE %
Chief People Officer	15.68%
Chief Nursing Officer	4.57%
Chief Clinical Operating Officer	4.39%
Chief Strategy & Business Development	3.12%
Chief Executive Officer	2.50%
Chief Financial Officer	1.86%
Chief Education and Training Officer	0.82%
Chief Medical Officer	0.00%



Staff Turnover (Combined)

Turnover	Overall	Voluntary
Chief Clinical Operating Officer	1.01%	0.63%
Chief Education and Training Officer	0.56%	0.00%
Chief Executive Officer	0.00%	0.00%
Chief Financial Officer	0.00%	0.00%
Chief Medical Officer	0.00%	0.00%
Chief Nursing Officer	0.00%	0.00%
Chief People Officer	0.00%	0.00%
Chief Strategy & Business Development	4.74%	4.74%

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? – October 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

Appraisals, currently stands at 56.05%. This has increased by 2.62%% at the end of Oct-25.

Chief Medical have achieved an outstanding 100% of appraisal reviews completed. Chief Nursing follows at 85%

The Chief Education directorate hold the lowest at the end of Oct-25 at 38.95% of appraisals carried out

Appraisal completion 56.05%

The Tavistock & Portman Trust sickness rate currently stands at 3.26% at the end of Oct-25, below the average benchmark of 4.00% by 0.74%.

The level of sickness has increased from the previous month by 0.31%.

The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 0.62%. This has decreased from the previous month by 0.24% ending Oct-25.

The second highest sickness absence rate is related to cold, cough, flu – Influenza — accounted for 0.58% of total recorded cases. This represents an increase from 0.29% in Sep-25, meaning the proportion of flu-related illnesses has roughly doubled month-on-month. Across the NHS, there has been a decline in the number of employees receiving the flu vaccination, which may be contributing to the observed rise in flu cases within the Tavistock & Portman Trust.

Overall, the data highlights the consistent impact of mental health on workplace absence and suggests other known causes, cold, cough, flu – Influenza as secondary health trends between ethnic groups.

Anxiety, stress, depression and other psychiatric illnesses is the current leading cause of sickness absence in NHS Trusts across England. This trend highlights the significant mental health challenges faced by NHS employees. Addressing these challenges remains critical to supporting staff wellbeing and maintaining service delivery across NHS trusts

Sickness Absence 3.26&

Compliance this month stands at 85.69%, a 1.40% increase ending Oct-25

Chief Financial stands at 96.98% compliance, holding a high standard continuing from the previous month. Chief Nursing follows, at 96.69%.

To achieve a high standard, each directorate will need to target 90% above. Four out of eight have achieved this.

MAST training 85.69%

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%**	

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

25/26 year-end planned position breakeven

YTD 25/26

Income & expenditure summary	Year to date		
	Plan, £'000	Actual, £'000	Variance, £'000
Income	34,015	33,713	(302)
Pay	(29,676)	(29,962)	(287)
Non-Pay	(6,941)	(8,044)	(1,102)
Non Operating expenditure	(126)	(120)	6
Total	**(2,728)**	**(4,413)**	**(1,685)**
Please note: Income "+", expenditure "-"			

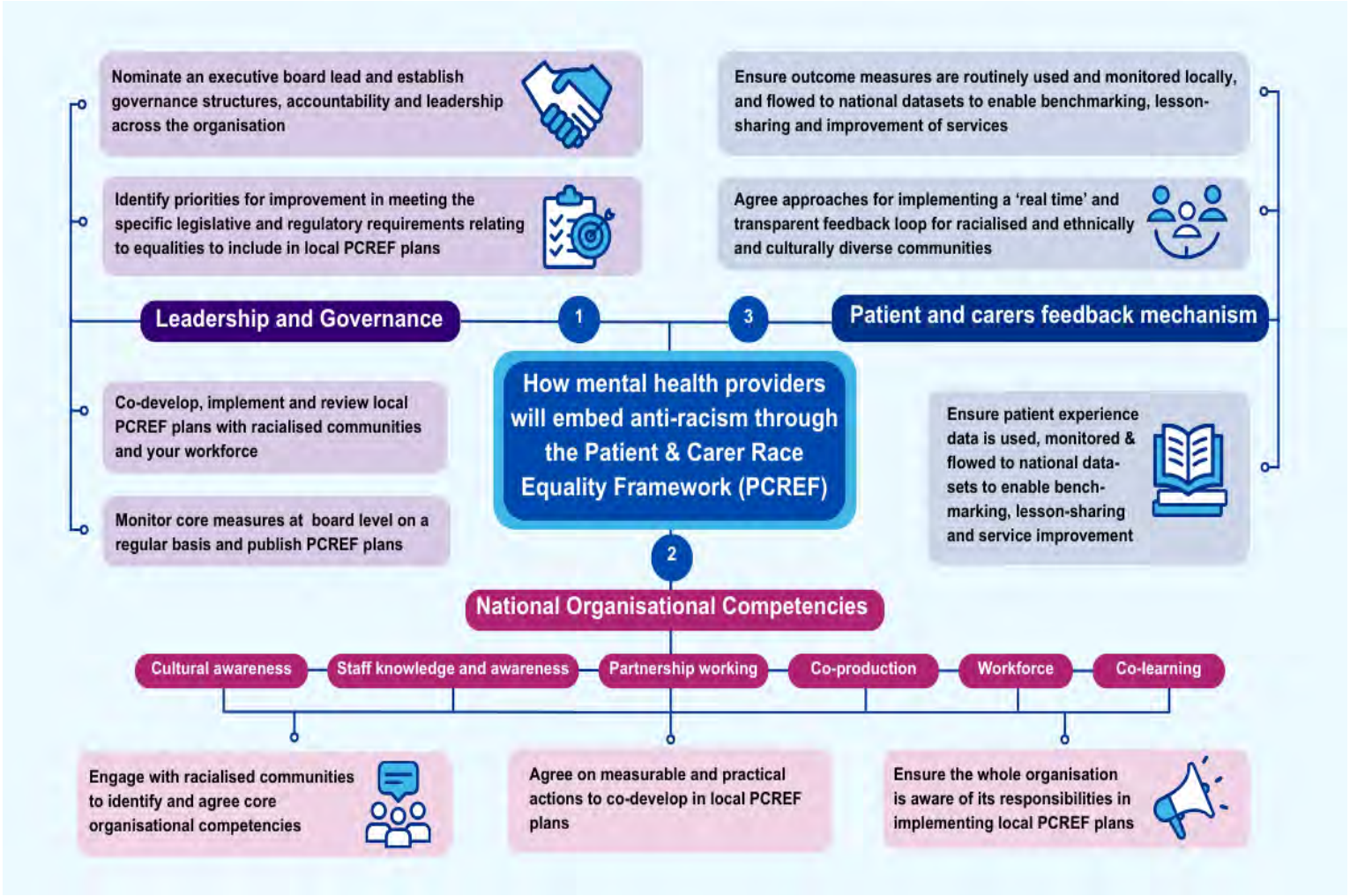
Performance (M7): YTD deficit £4,413m, £1,685m adverse to plan — income is £302k below plan, pay is £287k above plan, non-pay is £1,102k above plan (with 32% driven by pass-through costs in Clinical service.

Key risks:

- **NTC structural gap** remains unresolved (with current in-year mitigations mainly non-recurrent).
- **Income delivery challenges** in Tavistock Consulting and I-Thrive.
- **CIP delivery risks**, including turnover/restructures and spend-control compliance issues.
- **Cash risk** -currently high, as the Trust has no cash buffer and existing balances covers a maximum of eight days spend. The position will deteriorate further if income reduces or planned benefits are delayed.

25/26 M7 YTD position: £1,685k deficit

PCREF : ESQ


How mental health providers will embed anti-racism through the Patient & Carer Race Equality Framework (PCREF)
1
Leadership and Governance
Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation
Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans
Co-develop, implement and review local PCREF plans with racialised communities and your workforce
Monitor core measures at board level on a regular basis and publish PCREF plans
2
National Organisational Competencies
Cultural awareness
Staff knowledge and awareness
Partnership working
Co-production
Workforce
Co-learning
Engage with racialised communities to identify and agree core organisational competencies
Agree on measurable and practical actions to co-develop in local PCREF plans
Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans
3
Patient and carers feedback mechanism
Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services
Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities
Ensure patient experience data is used, monitored & flowed to national data-sets to enable bench-marking, lesson-sharing and service improvement

Comparison of ESQ and Active Caseload Contribution

The Tavistock and Portman NHS Foundation Trust

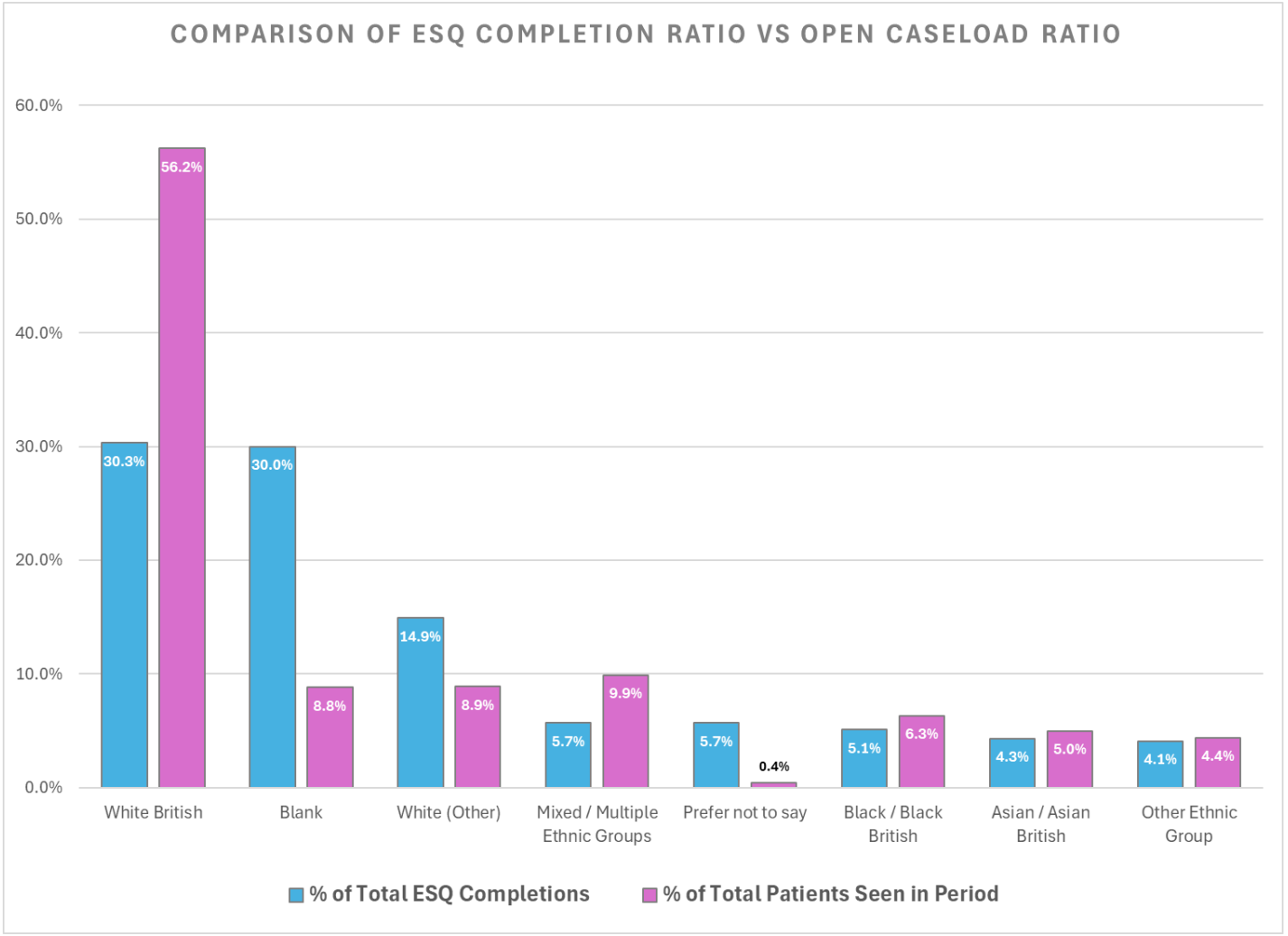
Ethnicities of Patients w/Completed ESQ's	
White British	112
	30.3%
Blank	111
	30.0%
White (Other)	55
	14.9%
Mixed / Multiple Ethnic Groups	21
	5.7%
Prefer not to say	21
	5.7%
Black / Black British	19
	5.1%
Asian / Asian British	16
	4.3%
Other Ethnic Group	15
	4.1%

Ethnicities of Patients Seen	
White / White British	6689
	56.2%
Blank	1049
	8.8%
White (Other)	1063
	8.9%
Mixed / Multiple Ethnic Groups	1178
	9.9%
Prefer not to say	51
	0.4%
Asian / Asian British	597
	5.0%
Other Ethnic Group	527
	4.4%
Black / Black British	753
	6.3%

This slide compares the % of the total ESQs completed during this period for each ethnic group with the % of the total patients seen over the same period across the Trust.

To use a worked example from the graph to the right; White British patients made up **56.2%** of the patients seen during this period but only completed **30.3%** of the ESQs completed during this time.

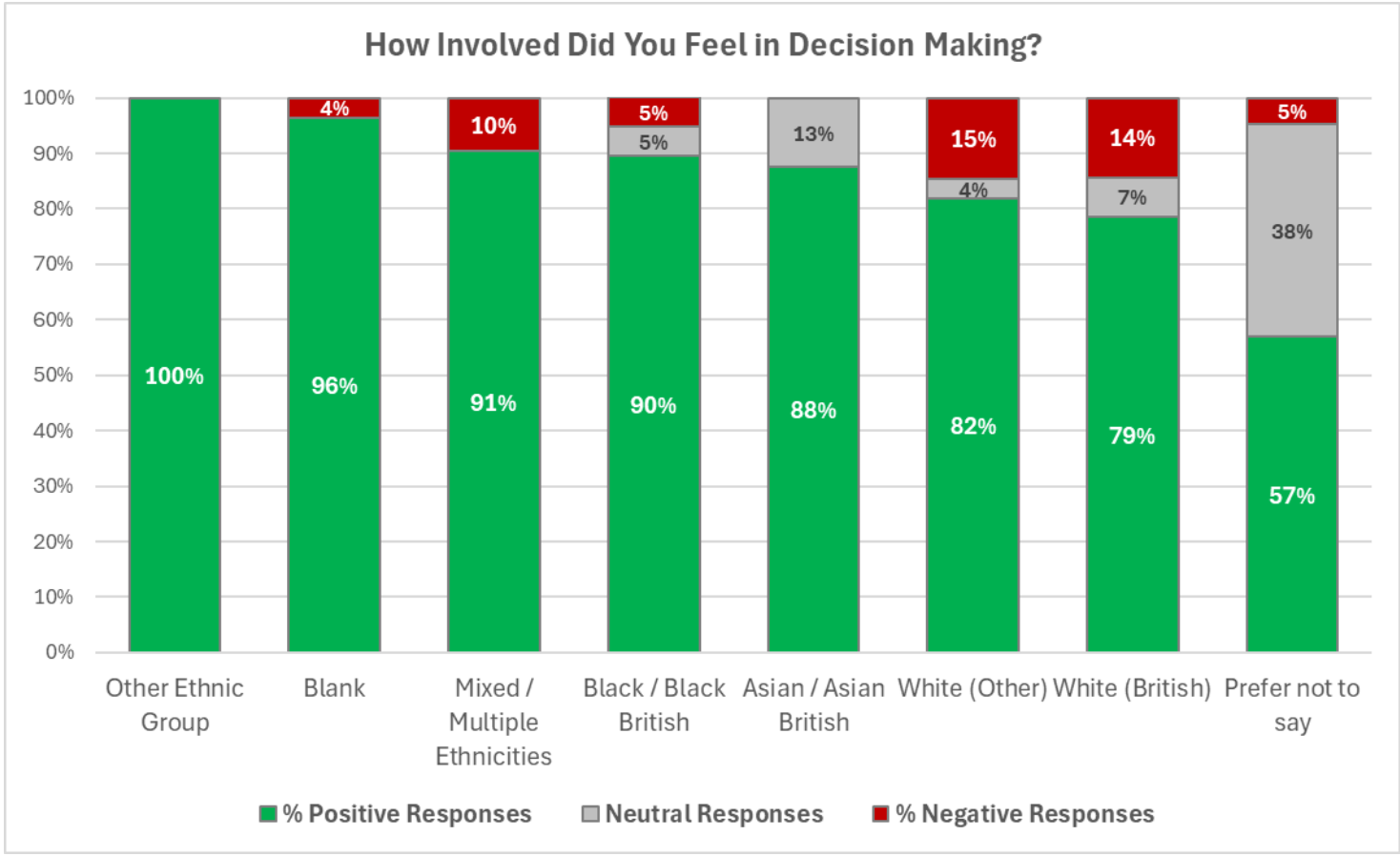
Conversely, White (Other) patients made up **8.9%** of the patients seen during this period but accounted for **14.9%** of the ESQ forms completed.



Did you feel involved in the decisions made about the care/treatment?

The Tavistock and Portman NHS Foundation Trust

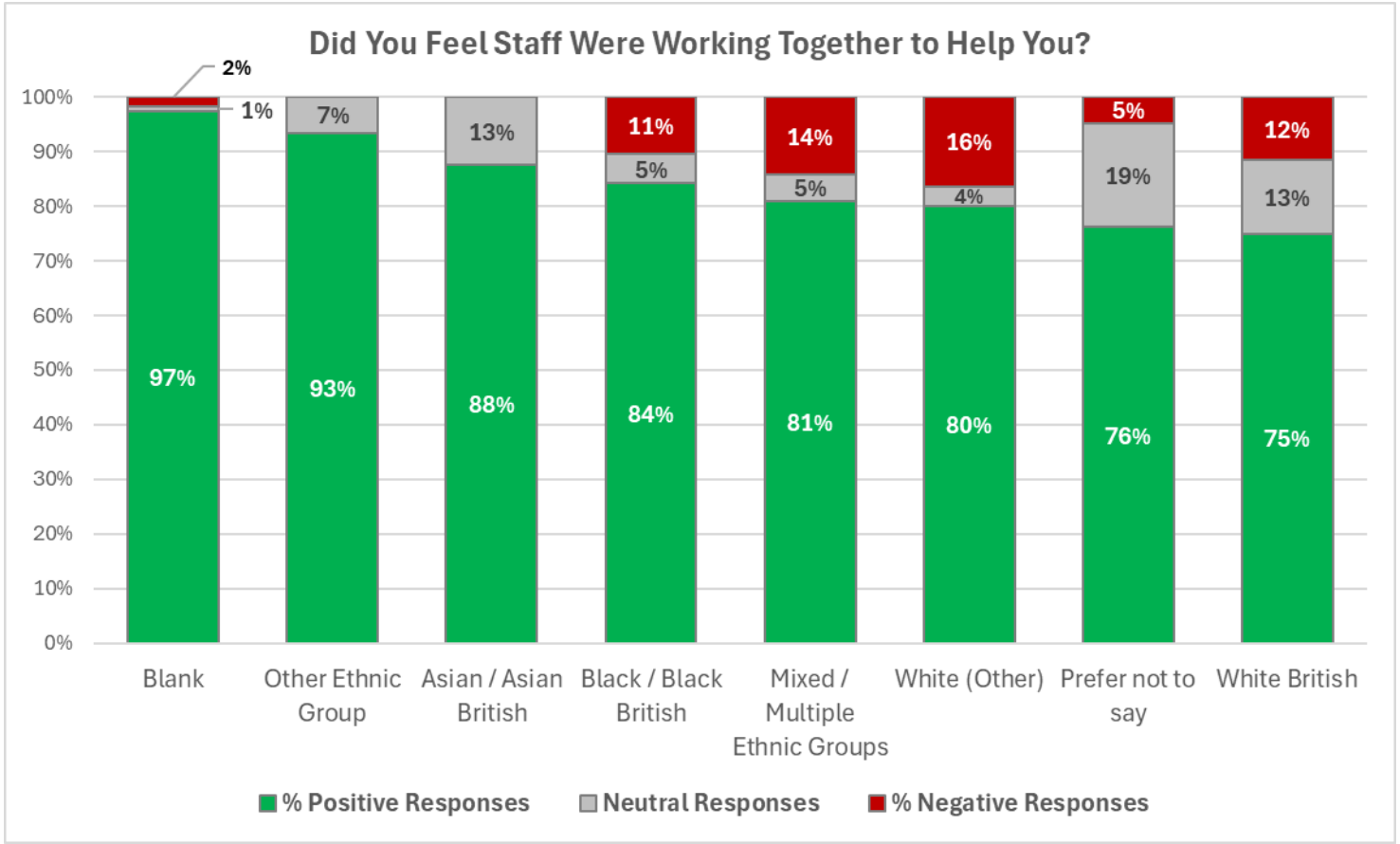
	% Positive Responses	Neutral Responses	% Negative Responses
Other Ethnic Group	100.0%	0.0%	0.0%
Blank	96.4%	0.0%	3.6%
Mixed / Multiple Ethnicities	90.5%	0.0%	9.5%
Black / Black British	89.5%	5.3%	5.3%
Asian / Asian British	87.5%	12.5%	0.0%
White (Other)	81.8%	3.6%	14.5%
White (British)	78.6%	7.1%	14.3%
Prefer not to say	57.1%	38.1%	4.8%



Did you feel staff were working together to help you?

The Tavistock and Portman NHS Foundation Trust

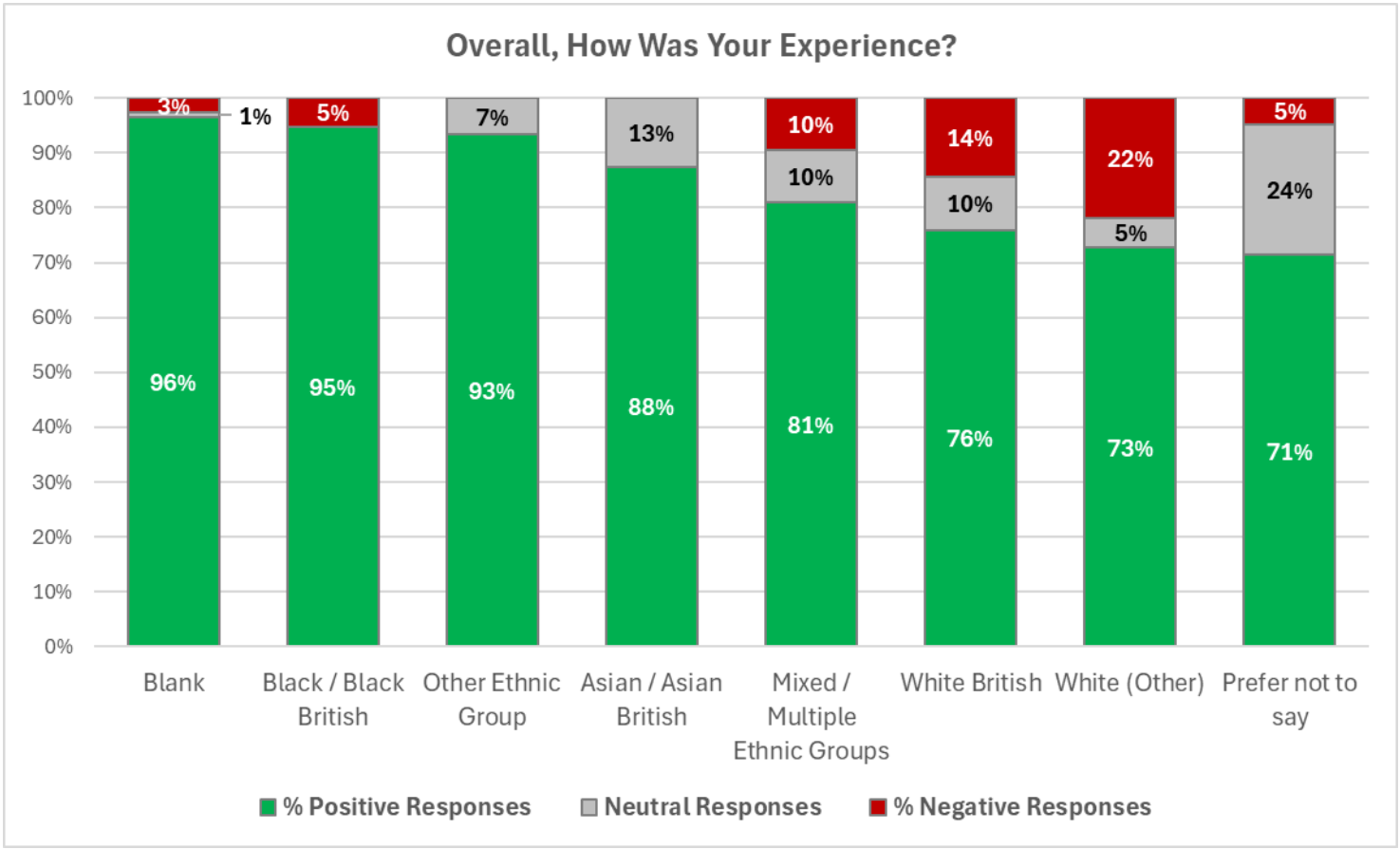
	% Positive Responses	Neutral Responses	% Negative Responses
Blank	97.3%	0.9%	1.8%
Other Ethnic Group	93.3%	6.7%	0.0%
Asian / Asian British	87.5%	12.5%	0.0%
Black / Black British	84.2%	5.3%	10.5%
Mixed / Multiple Ethnic Groups	81.0%	4.8%	14.3%
White (Other)	80.0%	3.6%	16.4%
Prefer not to say	76.2%	19.0%	4.8%
White British	75.0%	13.4%	11.6%



Overall, how was your experience?

The Tavistock and Portman NHS Foundation Trust

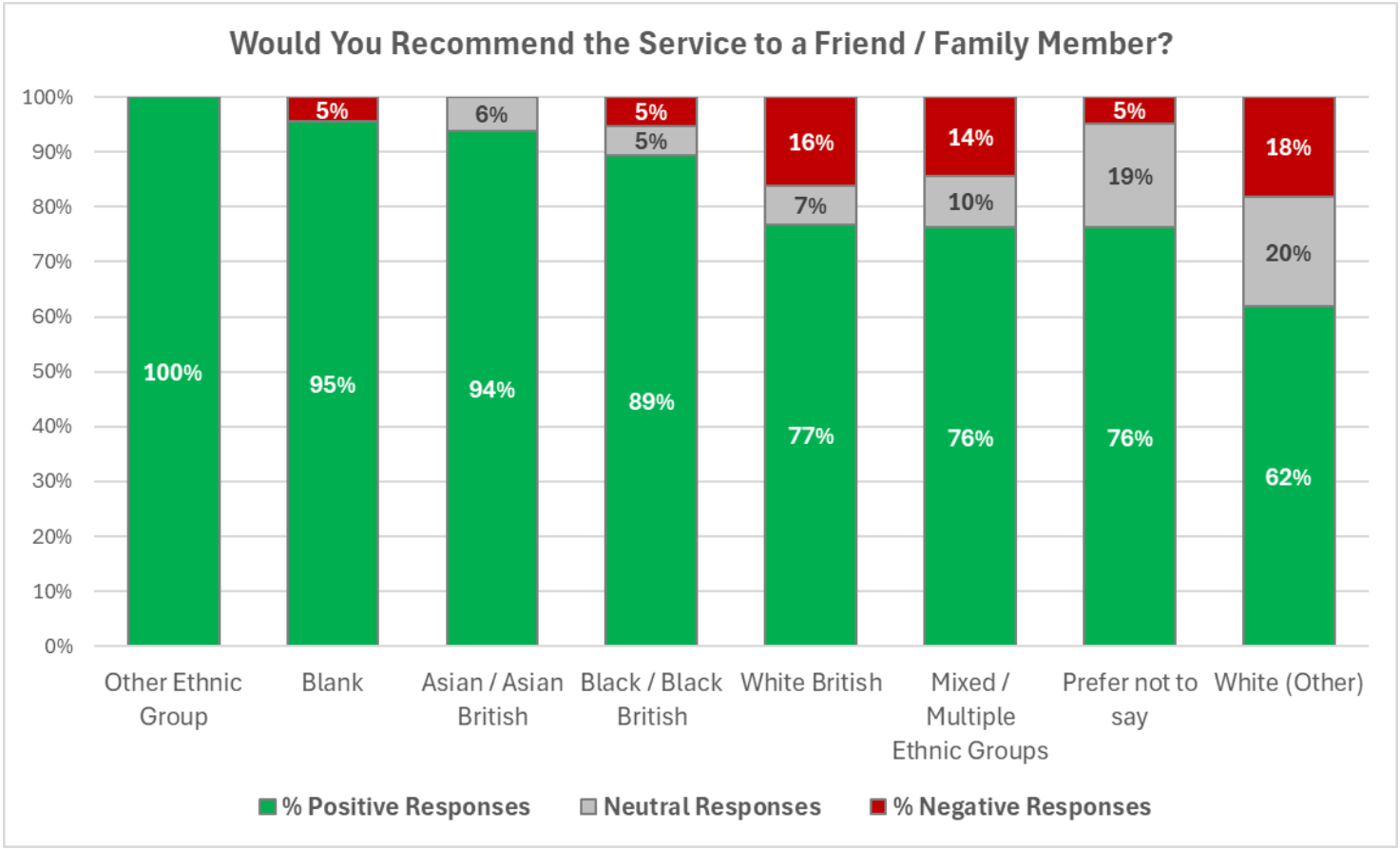
	% Positive Responses	Neutral Responses	% Negative Responses
Blank	96.4%	0.9%	2.7%
Black / Black British	94.7%	0.0%	5.3%
Other Ethnic Group	93.3%	6.7%	0.0%
Asian / Asian British	87.5%	12.5%	0.0%
Mixed / Multiple Ethnic Groups	81.0%	9.5%	9.5%
White British	75.9%	9.8%	14.3%
White (Other)	72.7%	5.5%	21.8%
Prefer not to say	71.4%	23.8%	4.8%



Would you recommend this Service to a Friend/Family Member?

The Tavistock and Portman NHS Foundation Trust

	% Positive Responses	Neutral Responses	% Negative Responses
Other Ethnic Group	100.0%	0.0%	0.0%
Blank	95.5%	0.0%	4.5%
Asian / Asian British	93.8%	6.3%	0.0%
Black / Black British	89.5%	5.3%	5.3%
White British	76.8%	7.1%	16.1%
Mixed / Multiple Ethnic Groups	76.2%	9.5%	14.3%
Prefer not to say	76.2%	19.0%	4.8%
White (Other)	61.8%	20.0%	18.2%



DET & Unit Overviews

Education & Training

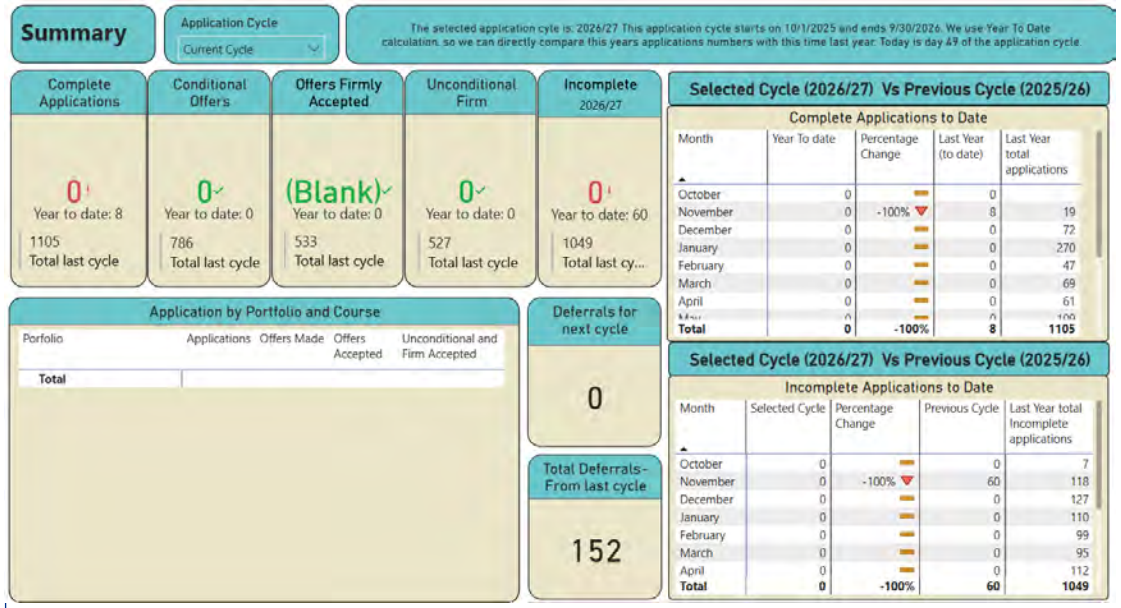
Month 07 25/26*

There is no data on applications in M7 due to a delay in the cycle going live

The Tavistock and Portman NHS Foundation Trust

Strategic Objectives	Challenges
• Student recruitment opened three months earlier than the previous year in October 2024,.	• 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



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

Analysis

Student recruitment: For the 25/26 academic year, the Trust enrolled 676 new students (vs 610 in 24/25, an increase of 11%) and re-enrolled 763 returners (vs 670 in 24/25, an increase of 14%), to a total increase in student numbers of 159 or 12.4%.

For the 26/27 Academic year, recruitment has not yet opened, it is expected to open in the next week.

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	COMPLETE
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 07 25/26

- We held our first Dean's Forums of the academic year, which were well-attended. The discussion centred around the merger.
- We also held our first Student Experience Sub-Committee of the new academic year, and student disability support was discussed.

- 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 356 students currently registered with student support for the 2025/26 academic year, against 281 students by the **end** of last academic year (July 2025). A business case is being drawn up to propose ways of sustainably managing increasing demand on a very small team.

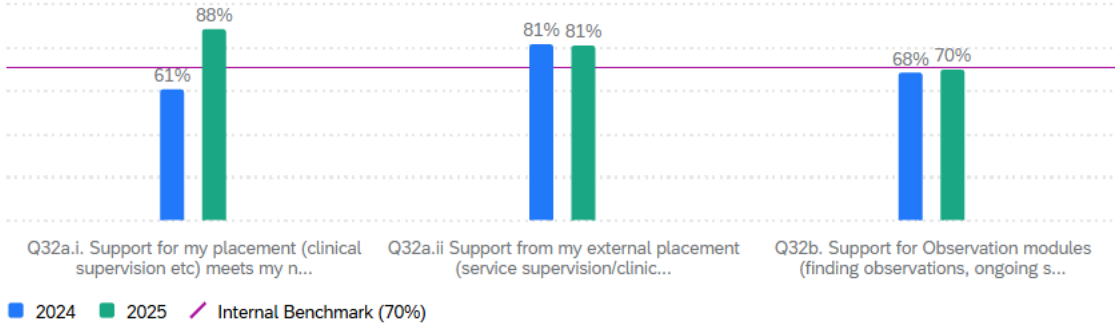
2025 student survey results.

- For Placements & Observations, satisfaction with support for clinical supervision increased significantly (by 27%, 61% ↑ 88%). Satisfaction for external placement supervision also remained high at 81%. Support for observation modules reached our internal benchmark of 70%.
- For Skills Development, satisfaction was above the 70% internal benchmark for confidence in independent study (72%), confidence in their own innovation skills (76%), being encouraged to develop skills (74%), feeling better prepared for the future (79%), and managing projects (70%). Extremely high satisfaction in increasingly managed own workload (89%), improving approach to job (80%) and helping them to deepen their thinking (86%)

2025 student survey results

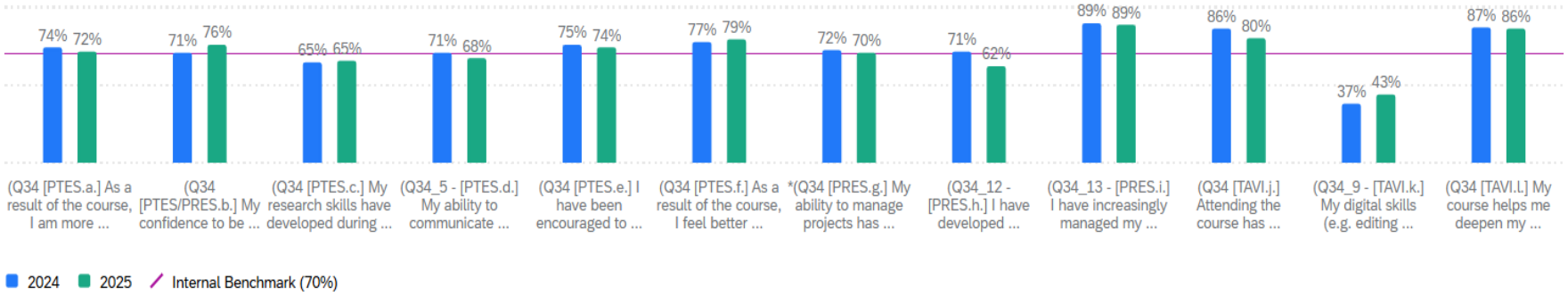
- Developing research skills (65%), communication skills (68%), developing networks (62%) and digital skills (43%) all fell short of the 70% internal benchmark. There is a new digital skills toolkit self-paced course available for free for all students, but it is likely that any intervention will take time to impact on survey results.

Placements & Observations



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

Skills Development



Updates on above actions

Community & Culture: Student Union investigations have stalled, but other actions have taken place (student representatives project and enhanced social events for students) may enhance satisfaction with community & culture.
Disability and Estates: Being considered in Space Utilisation Task & Finish Group (**currently stalled**) Other actions being taken in this space – including the development of CPD course 'embedding disability awareness into Learning & Teaching' **Oct::** Student Reasonable Adjustments Policy has been launched. Disability data for student survey will be presented in the IQPR as it becomes available.
Psychoanalytic and Systemic Portfolios: Placements project is in progress.

Are We Caring? – Education and Training

M7 - October 2025

AY25-26 to date

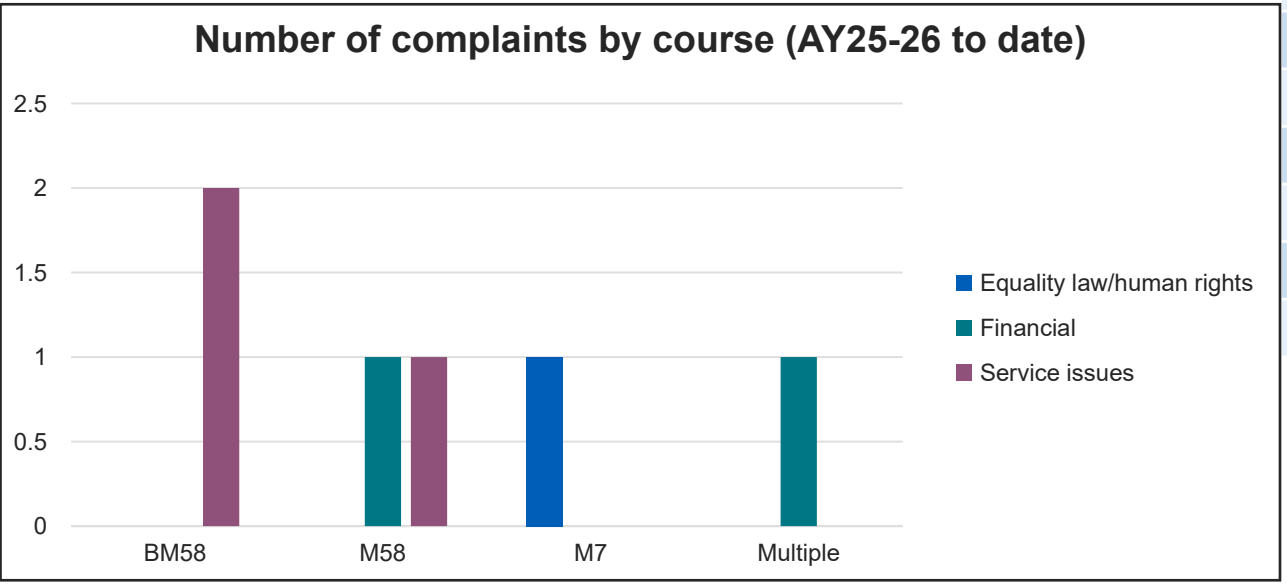
The Tavistock and Portman NHS Foundation Trust

This month, the Trust received **2 informal complaints** and **1 formal complaint**.

One of the informal complaints was submitted by a student on BM58 in the Service issues category but was subsequently withdrawn by the student because the issues had already been resolved. The other informal complaint was submitted by a student on M58 in the Financial category.

The formal complaint was submitted by a student on BM58 in the Service issues category.

The Trust is currently processing **4 informal complaints** and **5 formal complaints**.



This year, the Trust has received **6** complaints under the Student Complaints Procedure. Of these, **4** have been raised at the **informal stage** while **2** have been raised at or escalated to the **formal stage**.

No complaints have been escalated to the **internal review stage** and no complaints about the Trust have been submitted to the OIAHE or other body for external review.

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

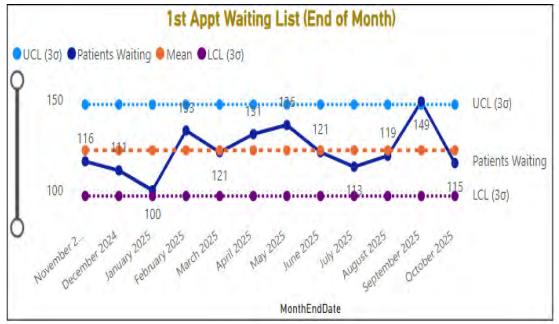
Outcome	Number of complaints
Local resolution successful	0
Local resolution unsuccessful	0
Not Upheld	0
Partly Upheld	0
Upheld	0
Settled	0
Withdrawn	1
Closed due to no contact	0

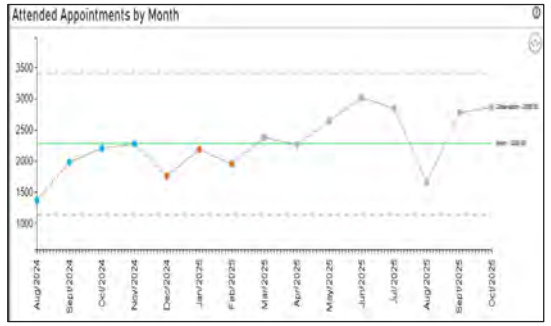
Camden Unit Overview (1/2)

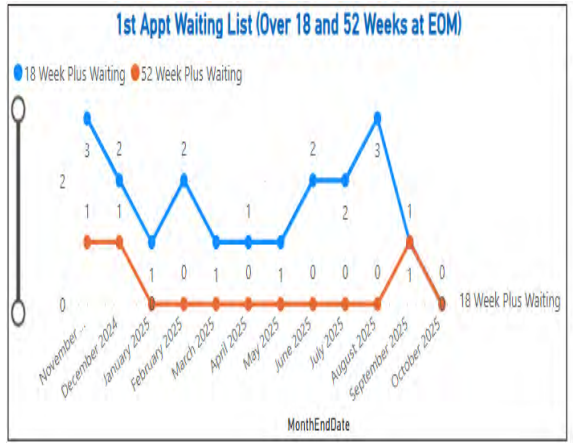
	Successes	Challenges
Safe	• There is 1 young person in an inpatient bed in Camden that is known to CAISS. • Risk register is now up to date and updates are scheduled for each month	• Appraisal compliance is steadily increasing and is now at 68%. We do still have some issues in uploading documents.
Effective	• We continue to see a reduction in the number of missing CGAS and GBM. We have seen a 23% reduction in missing CGAS since August. Further, most missing forms are now less than 2 months old (historically most were older) • We continue to achieve an average of less than 3 week wait to first appt (exc. outcome measures) • We delivered 2,865 appts in October a 30% increase on last year. CAISS and the Wellbeing team both delivered their highest number of appts ever (for CAISS beating last month's record). We are now exceeding our annual plan activity target for the year. • 75% compliance to job plans overall, 100% in SCCT for the second month in a row. Wellbeing achieving 99% compliance and WFT/WFTP hitting over 80%.	• Assessment waiting times data is still difficult to use and is not validated. We seem to have seen a significant increase in cases breaching the 4WW in October, but we cannot ID who this is easily. We are working on ways to gather themes for breaches. • Treatment waiting times are still variable between NCCT and SCCT, initial conversation with TCL has taken place regarding merging waiting list and a follow up with discipline leads will take place shortly • We remain concerned about activity in MHST. We have agreed amendments to job plans linked to the profiles of staff in the team and travel and in December are holding a session with the whole team on activity recording.
Caring	• We saw a further reduction in the number of missing safeguarding/risk and assessment/review forms this month and now have our lowest number of missing in the last year. • ESQ response rates increased in month. We received 104 which is over our target and our best result since April beating September's record.	• We still do not have a lone working policy in place, and this places staff and patient safety at risk. It has been added to the risk register. SCL and CSM will follow up with teams and ensure we have interim arrangements in place. • Feedback given in relation on patients seen on Mondays and the impact holidays have on care, team are considering this.
Responsive	• We received 266 referrals in October which is 40% higher than last October. • DNA rate was under 6% in October • 1 young person in Camden currently inpatient GAU. There has still only been 1 admission to Tier 4 (GAU) inpatient so far for 25/26.	• The Growing with You team and SCCT capacity remains an issue. Risks logged for both teams. • We are not seeing movement on our dormant cases with 13 people still dormant over 6 months. This has been raised with TCLs and they have bene instructed to give updates on all at our next performance meeting if they are not closed. • The rate of appointments cancelled by Trust did increase in October, we believe that this is linked to staff sickness.
Well-Led	• Revised annual plan goals and milestones etc in place and being monitored. The following slide gives further details. • As of M7 our cost per appointment is £341, this is below last years London average of £454. The excludes MOSAIC and EIS income and activity and does not include NPA activity. • QI underway in GWY to support the collection of ESQs • All staff in NCCT/SCCT asked to have a meaningful EDI objective in their appraisal	• We are struggling to accurately report on our CEP. We are meeting finance w/c 17th November to try and resolve the issue. • Staffing and senior leadership are rapidly changing in the LA. This is impacting our relationships and the way we work with staff there as well as putting increasing demands on teams for data.

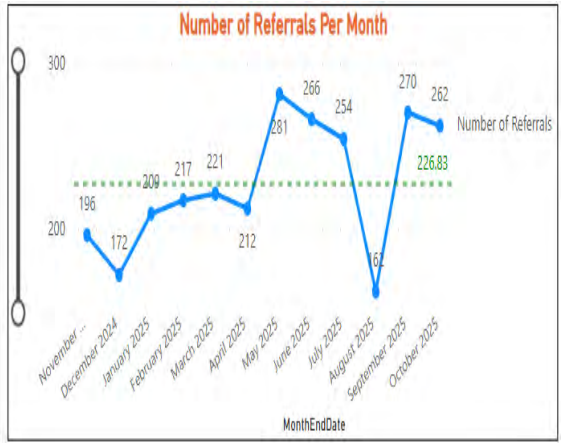
Camden Unit Overview (2/2)

Activity Overview









- Job plan compliance has remained at a higher level in October. We are considering how we progress our A3 on activity while maintaining a positive message and momentum.
- The number of people waiting over 18 weeks is now 0.
- The number of patients waiting at the end of October appears to be lower than previous months which is positive given the higher numbers of referrals.

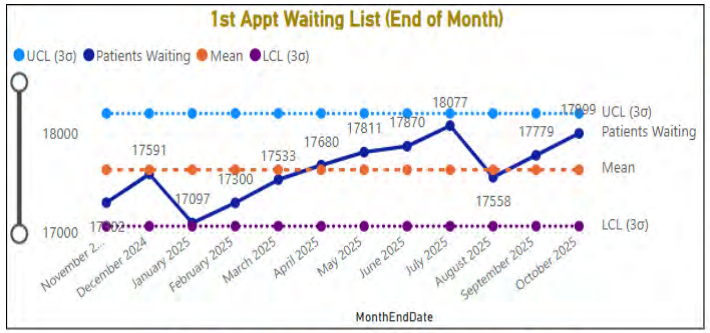
Concern	Cause	Countermeasure	Owner	Due Date
- Activity in MHST	Challenges in recording all the work the team undertake	A3 in place and more senior support being offered to the team	FH/LS	December 26
Number of cases with missing outcome likely to impact waiting times	Challenges in completing in some teams due to contact type	Reminders from admin. PTL in place	FH/LS	December 26

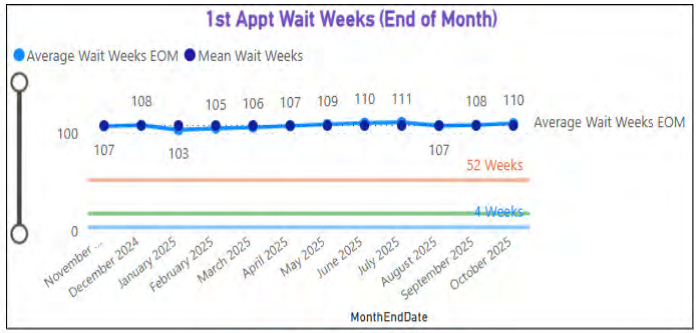
Adult Unit Overview - 1/2

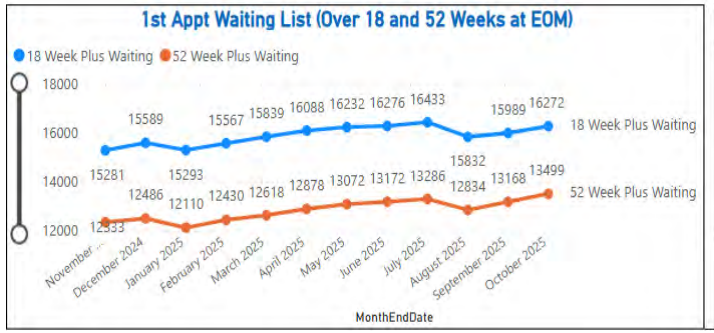
	Successes	Challenges
Safe	• The new GIC triage form and assessment process provide greater clinical safety assurance compared with previous systems, and support the accurate collection of information on detransition, surgical referrals, and risk. • A learning culture is embedded within team meeting schedules, with reflective practice taking place in three out of four teams. An inter-unit swap is being explored to enable a fourth reflective practice offer (potentially in partnership with Camden 1). • Complaints are decreasing, with more issues being resolved quickly and informally. Additionally, more staff are now undertaking complaint investigations under supervision. • All teams have in-person duty systems with senior support available. In some services (such as GIC), a 'Distress Rota' is in place to respond to email and telephone enquiries. • A strong learning culture is embedded across MDT, clinical team meetings, and business meetings—supporting reflection on our own data and helping clinicians to understand each other's work. This ensures patients receive accurate, well-informed information about what we do and how we do it.	• We continue to balance the need to meet CIP requirements with the equality impact on service delivery, safety, and patient care. • The increase in trainee numbers is creating additional demand for room space. Possible mitigations include opening rooms for trainee sessions during evenings or weekends, with appropriate duty cover. • Admin staff in GIC are struggling to keep up with demand from referrers, email enquiries, and endocrinology queries. • Some paper files are still awaiting transfer to the London archive. • The Portman Quality Review has highlighted the need for improved recording of team meeting minutes, including a clear action log.
Effective	• We have received excellent feedback from the Trauma Grounding Group, with patients reporting that this support is not available elsewhere and has had a beneficial impact on their wellbeing. • The DrDoctor platform will begin sharing GIC outcome monitoring before Christmas. • Trauma discharges are greater than intakes. Even with limited resources, this will greatly support flow and capacity. • Psychotherapy outcome measures (OM) and ESQ completion rates have both increased, supported by a governance review and Q&A sessions to help staff stay up to date and work efficiently with the systems. In addition, the Psychoeducation QI evaluation continues alongside outcome measures. • Trauma T1 HoNOS (OM) scores are improving significantly. However, Dialog returns remain lower, as both patients and clinicians perceive it to have less relative value. • Psychotherapy continues to offer first appointments within 8–9 weeks, remaining within the threshold before breach.	• Governance review of Psychotherapy team identified some gaps in staff understanding of core processes, re clinical notes. • Portman finances – not all income streams and new revenue appear to be accurate in the Portman ledger. The SCM will work with finance and contracts work to integrate up to date information about new income and small contracts value into the ledger. -
Caring	• Christmas rotas have been organised, with most slots now filled. The team has taken a whole-group approach, supporting one another by taking turns to provide cover. • The Portman co-produced leaflets are not yet at final draft. They will re-frame the service offer, access information, and FAQs about what to expect.	• We received seven PALS concerns. Of these, five were resolved informally; two related to treatment and mediation; three to appointments; one to prescribing; and one to another issue. • Admin staff are expected to complete the flexible working form and submit it to their managers, so all HR-related documentation is ready ahead of the merger plan.
Responsive	• Portman's first assessments are at a seven-year high, along with wider health activity. • We received 409 referrals in October, which is a 14.79% decrease compared with September. • Admin supernation rate is 82% for October, which is lower than September's 89%. Staff sickness and annual leave may be contributing factors.	• There is a number of outstanding managers reviews on RADAR and an action plan to address this is being developed within the unit. • PS1ii & surgical case review has taken longer and been more complex than anticipated.
Well-Led	Trauma international conference in November has 120 applications. Portman patient leaflets with PPI / co-production input suggest shift in EDI culture. GIC	• Mandatory training compliance remains low in some of the adult teams. We have asked HR to provide a breakdown of compliance for each team so that we can target support and follow-up more effectively. • Supervision logs, statutory/mandatory training, and appraisals are part of a weekly follow-up process for all teams. • Staff are reminded to complete the NHS Staff Survey and to take up the flu vaccination.

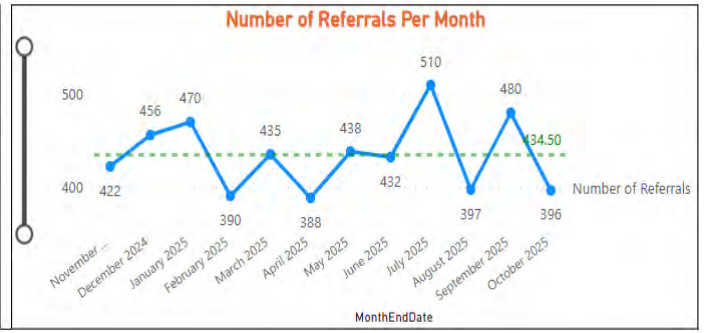
Adult Unit Overview – 2/2

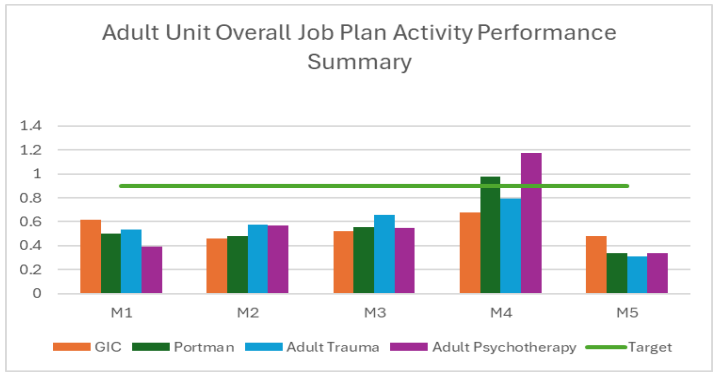
Activity Overview











Analysis

Variation in monthly referrals rate is expected and not indicative , the reduced trauma referrals may contribute to the picture but as the numbers of GIC referrals relative to other services are higher it is more likely that we are seeing typical month variance rather than a trend. Portman activity / referral is around 8% down on the same time last year but broadly more open to a wider range of referral, especially noting EDI/demographic changes. .

Concern	Cause	Countermeasure
Our fiscal position inevitably has an impact on efficiency and outputs, staff morale and stress.	Increased central services costs to 40% mean that our core income from clinical contracts is not able to support adequate contribution whilst also allowing adequate establishment staffing to maintain good performance relative to KPIs and activity.	All teams are taking an approach of constant improvement and reflection on activity, process and governance, managers are more sued to the dashboards, and we have strong systems for accountable oversight of job plans in most areas.

Next Steps.

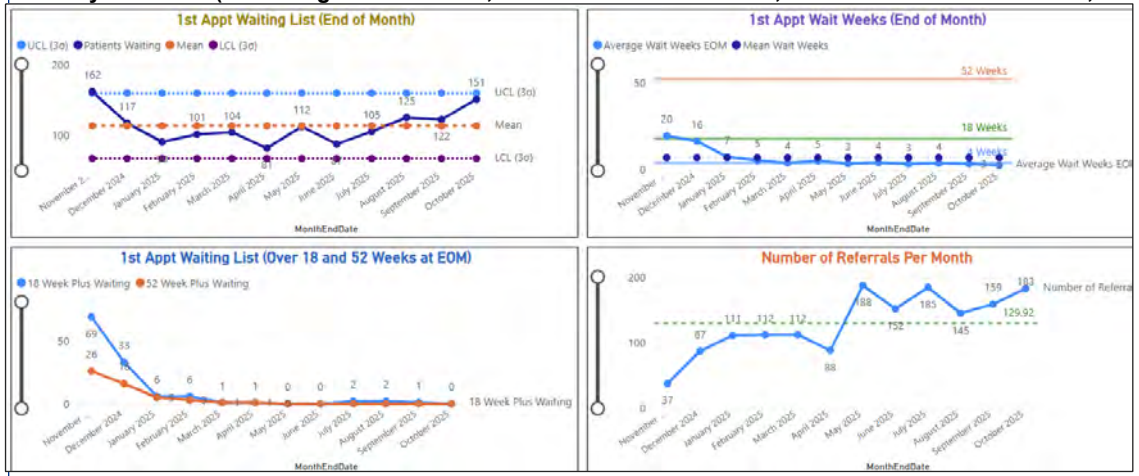
- To review job plans in GIC to understand underperformance as well as reducing capacity for 2 or 3 over performers. Levelling up and down is fairest. GIC workforce plan has also been reviewed in light of increased nurse staffing relative to psychology which has been hard to recruit. .

Child and Family Unit overview (1/2)

	Successes	Challenges
Safe	Unit mandatory training compliance has increased from last month to 86.95%. BGHC has had its ligature risk assessment undertaken with recommendations for improvement to come to ELT The Unit has 77% reported clinical supervision rate for October an increasing trend (66% in August). Missing Clinical Notes Targeted support has seen an 18% improvement in compliance in the first month of operating.	18 total incidents in Gloucester House in October and 15 restraint incidents in October which is unusually high and an increased trend. SLT have analysed the potential causes and identified actions relating to specific circumstances of several pupils. Factors behind increase include increased number of younger children, higher number of new starters and leavers. GH SLT are refining behaviour policy. 77% of our clinical staff are reported as having had clinical supervision and 84% of administrative staff. The Business Support Manager has set up the monthly auditing of compliance reports, which includes the supervision logs.
Effective	Activity – 1,974 clinical contacts for the month and a record 186 1st appointments. Across the Unit the 4-week wait target was met in September at 3.18 weeks. FMHT is 2.68 weeks to 1st appointment.EDAS waiting time to first appointment is at 3.79 weeks . 182 patients waiting for a 1st Appointment and 39 in the Autism Assessment pathway. This is the highest since Dec 2024 and an increasing trajectory. The average waiting time for patients seen was **2.67** which is the lowest in the last 12 months, for all teams across the unit excluding Autism Assessment. This is a significant reducing trajectory from 16.93 in January 2025. The number of referrals into the Unit continues to increase with 236 in October (211 in September and 141 in August) and this is the highest in the year so far. Autism Assessment team completed 29 first appointment in September – highest since January 2025 and waiting time to 1st appointment in October is 8.76 weeks which is an increase from 7.25 weeks in September – a decrease from 29 weeks lin November 2024.	Appraisal rates in the Unit have increased slightly to 54.55% (13% increase since August). List of outstanding and due appraisals have been distributed across teams again. Autism Assessment service: the number of cases waiting for 1st appointment is 38 (44 in September). Referral rates into the First Step + service have increased (6 for October) but remain below target numbers. Only 103 discharges in October compared to 158 in September but Q2 showed the highest number of discharges in the last 4 years.
Caring	The Unit has an open caseload of 1845 which is an increase from 1728 patients in September.	Moving date for Gloucester House has been pushed back to January 2026. 4.56 % sickness rate in the Unit which is an increase from 2.59% in September. Staff have been reminded of the flu vaccination process.
Responsive	FAKCT have seen increase in referrals (14 in October compared to 11 in September) and the highest in the last 12 months. Partly due to greater use by Enfield and Barnet. Percentage approval rating in ESQ feedback is at 95% and October saw the highest number of forms completed at 93. Workforce Race Equality – there has been an increase in the number of staff in the Unit who are from the Global Majority, up from 34.78% in March 2025 to 36.22% in October. AYAS saw their 3rd highest number of appointments in the last 2 years at 362 for October but only 14 referrals (3rd lowest in the last 12 months).	The Hertfordshire Commissioned pathway for Autism Assessment has not met its monthly targets due to delays to recruitment. Commissioners have been informed of the delays 14/09/2025. 120 Dormant cases at 52 weeks on the Autism Assessment Pathway.
Well-Led	Exit planning programme for Returning Families has now been implemented and regular meetings diarised. IG team engaged. Consultation launch forecast 23rd November 2025. From months 1-7 the unit has received 1220 referrals against 1071 discharges which is a 88 % patient flow rate. Activity – 1,974 clinical contacts for the Unit in October and a record 186 1st appointments in the month. At month 6 the Unit delivered 9,175 clinical for the NCL services against an Annual target of 17,169, an over performance of 627 contacts at month 6.	Gloucester House Outreach consultation document drafted – waiting for ELT response and decision. Potential risk of redundancy costs for Returning Families service closure scheduled for March 2026.

Child and Family Unit overview (2/2)

Activity Overview (Excluding FDAC Service, Gloucester House School, Gloucester House Outreach, CATS)



Activity – 1,974 clinical contacts for the Unit in October and a record 186 1st appointments in the month. At month 6 the Unit delivered 9,175 clinical for the NCL services against an Annual target of 17,169, an over performance of 627 contacts at month 6.

Referrals: 236 referrals in the month indicating an ongoing trajectory of increase since May 2025.

Waiting times: 151 patients in total are waiting for a first appointment including the autism assessment pathway. Excluding Autism Assessment there are 112 patients waiting for 1st appointment.

There is trajectory of increase in patients waiting since May 2025 aligned to significant increases in referrals into the Services since the implementation of the SPOA in NLFT.

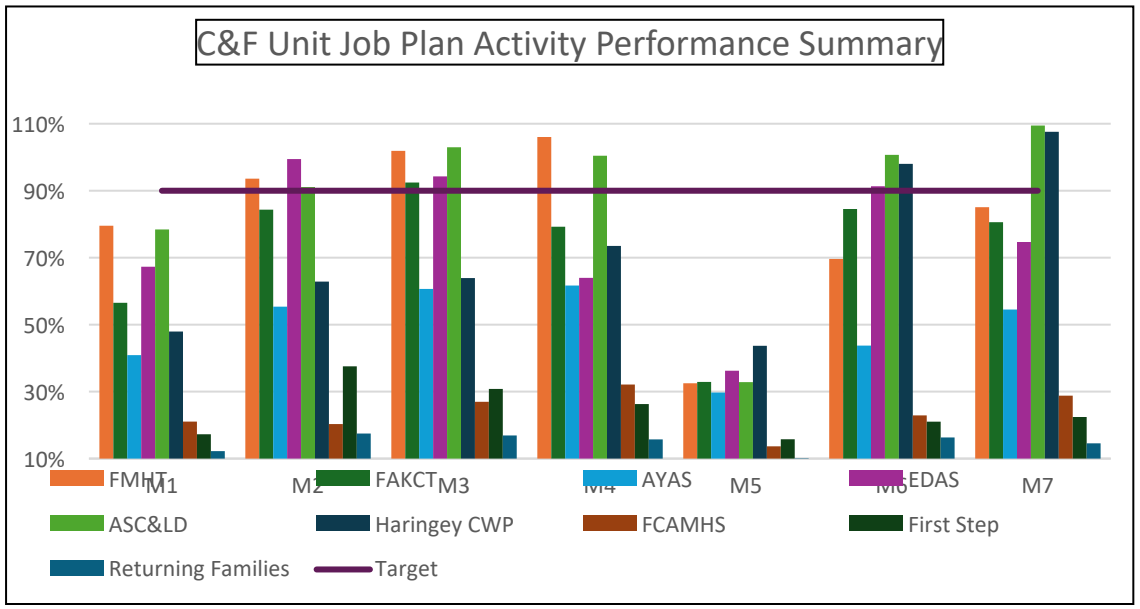
The average Waiting time for patients seen was at 2.26 weeks for all teams excluding Autism Assessment. The average waiting time for 1st appointment including Autism Assessment is 2.57 weeks with a mean of 7 weeks.

Waiting time for 1st appointment in Autism Assessment 3.48 weeks, with a mean of 14 weeks, a decrease from the previous month. However, 39 patients are still waiting for their first appointment. These cases will be allocated through December and January.

Treatment waiters : 176 patients waiting for treatment across the clinical teams. 16 have waited more than 52 weeks. 346 Patients waiting for an Autism Assessment

RTT breaches at 18 weeks: The unit is reporting 3 cases breaching at 18 weeks. 3 in the Autism Assessment Pathway.

Dormant cases: 11 cases are reported as Dormant for more than 52 weeks which is a significant increase on 3 in the previous month. 6 in FMHT and 5 in FAKCT. Chasing emails have been sent for case closure in all teams other than the Autism Assessment Pathway. 120 Cases Dormant in the Autism Assessment Pathway.



Concern	Cause	Countermeasure	Owner	Due Date
Activity and Job Planning	Jobs plans now in place for all teams – not being routinely used in supervision..	A3 to be developed for any teams where activity is a concern	TR & SB	January 2026
Missing clinical notes,	Gaps in recording and in linking appointments	Targeted Support..	TR & SB & TC	January 2026
The number of young people waiting for Autism Assessment is increasing as are waiting times	End of non recurrent funding	Implement Targeted Support Process	CW/TR	January 2026

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: National Oversight Framework (NOF) Assessment			**Agenda No.: 008**
Report Author and Job Title:	Rod Booth, Director of Strategy	**Lead Executive Directors:**	Michael Holland, Chief Executive
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This report provides the Board with an overview on the outcome of the most recent NHS England National Oversight Framework (NOF) assessment for the Trust. The report summarises the Trust's current oversight segment, the key themes arising from the assessment, and the actions being taken to support improvement.		
Background:	The National Oversight Framework is used by NHS England to assess the performance and sustainability of NHS trusts. It considers a range of information across quality and safety, access and outcomes, leadership and governance, workforce, finance, and delivery of strategic priorities. Trusts are placed into oversight segments which reflect the level of support required. Following the latest assessment, Tavistock and Portman NHS Foundation Trust has been placed in NOF Segment 4, which indicates that NHS England has identified the need for additional support. The assessment recognises that the Trust operates in a complex and highly specialised environment and that progress is being made in several areas, while also identifying aspects of performance and delivery that require further improvement. The NOF assessment reflects our challenging financial position, due in part, to the loss of the national training contract which NHSE England has agreed to pay for 2025-26; and noting we are in the process of agreeing a merger with the North London Foundation Trust to support longer term financial sustainability with NHS England fully engaged in this process. The assessment highlighted several positive areas, including: • Quality and safety: Continued focus on safeguarding, clinical governance, and learning from incidents • Leadership and openness: Constructive engagement with NHS England and other partners, with a clear focus on improvement • Strategic direction: Development of transformation plans aligned to national policy and service change requirements There is an Oversight Meeting on 13 January 2026 with the NHS England Regional Chief Operating Officer to discuss the NOF assessment with a focus on finance, productivity, staff survey actions and eliminating 104 week waits. A further update on the outcome of this meeting, a first within the new NOF framework, will be presented to the next meeting of Board along with any associated action plan.		
Assessment:	(1) The NOF assessment has identified: • Financial challenges that are consistent with risks already recognised by the Trust and are subject to active management. • Strengths that provide a platform for continued improvement with our focus on improved outcomes to demonstrate the value we bring to both patients and students, and to continue to improve staff experience to make the Trust a great place to work.		

	(2) There is a meeting with NHS England Regional colleagues to discuss the assessment, Trust actions plans and any further support required at a meeting on 13 January 2026.
Key recommendation(s):	To **NOTE** the Trust NOF assessment and meeting with NHS England on 13 January to discuss.

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: BAF9 Delivering Financial Sustainability Targets BAF13 Productivity and Performance				
Legal and Regulatory Implications:	Yes: ☒	No: ☐			
	NOF assessment is part of the NHS England Regulatory Framework				
Resource Implications:	Yes: ☒	No ☐			
	Trust sustainability linked to delivery of merger				
Equality, Diversity and Inclusion (EDI) implications:	Yes: ☒	No: ☒			
	Staff survey improvement actions.				
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:	N/A			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: Trust response to NHS 10-point plan to improve Resident Doctors' working lives			**Agenda No.: 009**
Report Author and Job Title:	Dr Myooran Canagaratnam, Director of Medical Education	**Lead Executive Director:**	Dr Liz Searle, Interim Chief Medical Officer
Appendices:	None.		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	The NHS 10-point plan has been published with the aim of improving the working lives of resident doctors due to concerns being raised nationally. This paper is details of an audit and an update on our response to this plan, further to previous presentation in October 2025.		
Background:	The Tavistock and Portman NHS Foundation Trust has an established role in the training of doctors in child psychiatry and medical psychotherapy. The provision of high-quality medical education has been important in maintaining the trust's reputation as a leader in the teaching and training of mental health professionals. It has also promoted the recruitment and retention of psychiatrists locally and nationally. The Tavistock and Portman NHS Foundation Trust currently employs a total of around 15 resident doctors during daytime working hours.		
Assessment:	The paper presents the Trusts response to the 10 point plan, including action plan.		
Key recommendation(s):	The Board is asked to **APPROVE** the Trusts' response to the NHS 10-point action plan.		

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:				
Legal and Regulatory Implications:	Yes ☐	No ☒			

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

The Tavistock and Portman NHS Foundation Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Paper for Tavistock and Portman Public Board Meeting

15th January 2026

Update on Trust response NHS 10-point plan to improve Resident Doctors' working lives (IRDW)

The NHS 10-point plan has been published with the aim of improving the working lives of resident doctors. Each point in the plan is presented below, followed in italics by an update on the Trust's current position and planned action.

1. **Improve workplace wellbeing for our resident doctors**

Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:

• where possible, [provide designated on-call parking spaces]

• the autonomy to complete portfolio and self-directed learning from an appropriate location for them

• access to mess facilities, rest areas and lockers in all hospitals, including new builds

• a 24/7 out-of-hours menu offering hot meals and cold snacks for staff.

Within the next 12 weeks every trust should conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plan must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.

The Tavistock and Portman organises the Child and Adolescent Psychiatry resident doctor out of hours rota for the three acute hospitals. However, the Trust itself does not directly provide out of hours services on the premises. Facilities such as on call parking spaces, mess facilities, hot meals etc. will therefore need to be provided by the acute hospitals. An audit has been carried out gathering data on current facilities at each of these sites, and is included in the Appendix.

2. **Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice.**

From now, and for all rotations going forward NHS England must provide at least 90% of trainee information to Trusts 12 weeks prior to rotations commencing.
From now, Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by Trusts, and NHS England will monitor and report on national compliance across all stages of the process.

Tavistock and Portman Human Resources Department have confirmed that North London People Shared Services currently send work schedules 8 weeks in advance. Work schedules within the Tavistock are correct regarding pay, and the rota is trainee generated and will be issued within the specified time frame.

3. **Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing. It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.**

Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all Trusts.

Resident Doctors currently request annual leave by discussing plans with their Clinical Supervisor in their placements and submitting their requests on the ESR system. Resident Doctors employed by the trust have not reported any issues with annual leave. The out of hours rota is generated by trainees with leave requests in advance, which maximises the opportunity for annual leave to be taken as per RD preference. In the last rotation, all annual leave requests for RDs when designing the out of hours rota were honoured.

4. **All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the Board.**

Within 6 weeks, Trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the Board.

The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable Trust Boards to hear directly from resident doctors themselves. They should be invited to attend Board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses.

Dr Liz Searle has been appointed as Senior Lead for resident doctor issues.
Dr Chen Kailaypillai has been appointed as peer representative for resident doctors and will be attending the Board meeting in January.

5. Resident doctors should never experience payroll errors due to rotations

Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts. Within the next 12 weeks, every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a Board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.

The Trust will participate in the national payroll improvement programme.

The previous Trust Chief People Officer advised that the HR department are already submitting an overpayments paper that goes to a Board sub-Committee as well as holding regular payroll contract meetings which has resulted in significant improvements in payroll accuracy as a result. Going forward, HR and Finance team will report on specific data on payroll errors for resident doctors. No concerns regarding resident doctor pay have been raised.

6. **No resident doctor will unnecessarily repeat statutory and mandatory training when rotating**

Within the next 12 weeks if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of

prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.

Tavistock and Portman Human Resources Department have confirmed that the trust complies with the agreements in the MoU. All resident doctors training from their previous trust is taken into consideration and their records are updated through Inter authority transfer (IAT) on ESR.

7. **Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours**

A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.

Resident Doctors employed by the Tavistock and Portman are encouraged to exception report. The trust will participate in the roll out of the new national framework agreement by NHS England. Improvement is required as to the current processing time of exception reports.

8. **Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims**

We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor attended a course / activity to one where reimbursement is provided as soon as possible after the expense is incurred. Within the next 12 weeks every trust should: review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave related expenses, including travel and subsistence.

Processes for reimbursement have been reviewed by the Director of Medical Education and Medical Education Manager. Current study leave processes already enable resident doctors to be reimbursed on submission of receipts, which will normally be processed in the next pay run.

9. **We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery**

A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.

The Trust provides placements as part of the North Central London rotations in Child and Adolescent Psychiatry and Medical Psychotherapy. The Trust awaits publication of NHS England Review of rotation management, and will implement recommended actions.

10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model

NHS England is committed to extending the Lead Employer model to cover all resident doctors and dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience. By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system.

The Trust will implement the NHS England framework on expanding the Lead Employer arrangements once it has been published.

Dr Myooran Canagaratnam
Director of Medical Education

Dr Chen Kailaypillai
Specialist Trainee Child and Adolescent Psychiatry
Peer Representative IDRW

Kasia Parfenyuk
Deputy Chief People Officer (Interim)

Dr Liz Searle
Interim Chief Medical Officer/Senior Lead IDRW

Appendix:
Tavistock and Portman Audit of Resident Doctors' Working Environment
5th November 2025

Background to Audit

The NHS 10-point plan has been published with the aim of improving the working lives of resident doctors. The plan states that Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so Trusts can adapt implementation to reflect local needs and operational realities in these and other areas:

- where possible (provide designated on-call parking spaces)
- the autonomy to complete portfolio and self-directed learning from an appropriate location for them
- access to mess facilities, rest areas and lockers in all hospitals, including new builds
- a 24/7 out-of-hours menu offering hot meals and cold snacks for staff

NHS England has requested that every Trust should conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plan must be approved by the Trust's people committee or equivalent body. The Trust will be expected to provide updates for national reporting on progress.

Tavistock and Portman Context

The Tavistock and Portman organise the Child and Adolescent Psychiatry resident doctor out of hours rota for the three local acute hospitals (The Royal Free, The Whittington and UCLH). The Tavistock and Portman itself does not directly provide out of hours services on the premises. Facilities such as on call parking spaces, mess facilities, hot meals etc. would therefore be provided by the acute hospitals.

An audit has been carried out to gather data on current facilities at each of these acute hospitals:

1. Access to designated on call parking spaces
    - Royal Free Hospital - No

    The Royal Free Hospital has advised that parking is very limited at the site.

- The Whittington Hospital – Yes

Resident Doctors should apply for a permit.

- UCLH - Yes

On-call parking is available behind offices at 250 Euston Rd (opposite UCLH tower). Resident doctors need to inform reception and sign a book to put in their registration.

2. Do Resident Doctors have the autonomy to complete portfolio and self-directed learning from an appropriate location for them?
    - Yes. Resident Doctors are not resident on call, and therefore able to complete portfolio and self-directed learning at home

3. Access to mess facilities, rest areas and lockers in all hospitals, including new builds
    - The Royal Free Hospital Mess is closed for refurbishment. There is currently no completion date.
    - The Whittington Hospital has a mess which Resident Doctors can join.
    - UCLH has a mess with rest facilities which Resident doctors can have access to. UCLH will clarify if Resident doctors have access to lockers

4. Access to a 24/7 out-of-hours menu offering hot meals and cold snacks for staff
    - Royal Free Hospital - Yes
    - Whittington Hospital – Access to cold snacks 24/7
    - UCLH - Yes. There is a vending machine with hot and cold food in atrium at 250 Euston Rd (opposite tower) and also canteen in ground floor of main building.

Action Plan

To contact Senior Leads for 10-point plan / Directors of Medical Education in the three acute Trusts requesting updates on their action plans.

Dr Myooran Canagaratnam
Director of Medical Education

Dr Chen Kailaypillai
Specialist Trainee Child and Adolescent Psychiatry/Peer Representative IDRW

Tavistock and Portman NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC
Thursday 15 January 2026

Committee:	Meeting Date	Chair	Report Author	Quorate	
Integrated Audit and Governance Committee	13 November 2025	Ken Batty, Non-Executive Director	Jonathan Bell, Chief Finance Officer	☒ **Yes**	☐ **No**
Appendices:	N/A		**Agenda Item: 010**		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Overall Assurance and Key Direct Feedback to the Board • The Committee confirmed a quorum was established with two Non-Executive Directors (NEDs) present and minutes of the previous meeting were accepted. Significant effort was directed toward clearing the action log. • The core focus of the meeting was confirming the necessary transition arrangements required to successfully hand over financial assurance responsibilities ahead of the anticipated merger date of April 1st. • Following discussion on the necessity of a qualified accountant on the committee, the NHS Code of Governance was referenced. It states that the Board of Directors should satisfy itself that at least one member has recent and relevant financial experience, but it does not specify a qualified accountant is a "must". It was agreed that the Director of Corporate Governance would discuss this requirement with the Chair of the Board of Directors.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. External Audit Oversight GT outlined three responsibilities the current committee must discharge before March 31st, as a different audit committee will ultimately sign off the annual accounts: • **Agree Audit Plan:** The current committee must agree and approve the audit plan for the year. • **Management Representations:** Detailed responses from management (e.g., concerning estimates and fraud awareness) must be obtained **prior to March 31st**. • **Chair's Assurance:** The Audit Committee Chair must provide a response to a condensed set of questions regarding awareness of fraud and whistleblowing before March 31st.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

It was agreed that the interim CFO will coordinate the necessary work, including items typically signed off in April or May, to be completed and focused on by March 31st to facilitate a smooth handover. The committee also agreed on the need for either a formal or informal handover meeting with NLFT's Audit Committee before the merger to ensure transparency and reliance on assurances.	
3. Internal Audit Oversight The Committee received and discussed the Internal Audit Report. • Internal Audit reported progress, including the issuance of a draft report on agency staffing and payments. They are concluding audits on student experience, lessons learnt, and visiting lecturers payroll. • The final planned audit on risk management starts next month. The Chair requested that draft reports (like the student experience report which is at QA stage) be circulated to NEDs as soon as available to avoid delays until the February meeting. • The annual healthcare benchmarking paper indicated that the Trust is an outlier, tending to receive more negative assurance opinions and having a higher average number of management actions compared to other healthcare clients.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Counter Fraud Assurance The Committee received and discussed the Local Counter Fraud Progress Report. The report noted two proactive pieces of work were jointly undertaken with Internal Audit. In relation to outstanding recommendations, following the submission of papers to IAGC, three actions related to procurement policy review/ratification were updated with a revised date of December 31st. Counter Fraud is managing six open cases related to dual working, including a referral received since the last meeting. Dual working concerns (staff sick or holding two jobs) are investigated in parallel with HR, who hold the responsibility for following disciplinary procedures if concerns are substantiated.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Aged Debtor, Salary Overpayments and Single Tender Waivers The committee received reports on aged debtors, salary overpayments and single tender waivers. Points noted included: • Overall 90-day debt increased by £56,000, primarily due to an NHS and non-NHS contract dispute valued at approximately £350K. • Student debt showed significant improvement, dropping from £921K to £283K. • In relation to salary overpayments, the Committee noted the large outstanding sum under "leavers," which is not included in the Aged Debtor report. Assurance was provided that the current process for recovering debt from leavers involves three chasing letters before escalating to debt collectors. Further analysis on the aging profile of these overpayments was requested • There were 13 single tender waivers reported, justified largely by the impending merger and the need for short extensions up to April 1st. The Committee was satisfied with the rationale	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. Scheme of Delegation (SoD)	Limited ☐ Partial ☐

The Committee approved the revised SoD, confirming that updates involved aligning approval rates with NLFT figures and updating titles (Associate/Deputy Directors) rather than adding new signatories.	Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

The updated Scheme of Delegation was approved.

Risks Identified by the Committee during the meeting:

None identified

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

The Committee requested that Internal Audit Reports are circulated to the members as soon as available.

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

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS IN PUBLIC Thursday 15 January 2026					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality and Safety Committee	18 December 2025	Claire Johnston, Committee Chair, Non-Executive Director	Asma Bi, Committee Secretary	☒ **Yes**	☐ **No**
Appendices:	Appendix A - Patient and People Involvement Annual Report		**Agenda Item: 011**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. DrDoctor (Patient Portal) Implementation The Committee received an update on the DrDoctor (Patient Portal) implementation in GIC. The Trust has led the way in the country as the first mental health trust to onboard the DrDoctor platform to the NHS App. The implementation has been entered for the Health Service Awards 2026 under the category 'Optimising Clinical Pathways through the use of digital technology'. The Trust has also recently secured funding on the basis of replicating the use of forms in the NHS App. Work on the development and use of forms in the platform is ongoing. It is planned to upload for quality testing to NHS England in January 2026. The focus of the project is now shifting to the wider organisation to identify process improvements in other areas. Stakeholders views were sought for implementation of DrDoctor. The Committee **NOTED** the contents and **ENCOURAGED** stakeholder engagement.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Update on CQC preparedness Unit Clinical Leads were tasked to undertake collaborative self-assessments of their unit against the four CQC domains of safe, effective, responsive and caring. The findings and resultant actions were presented at the December CQC Improvement Group.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Quality reviews have also taken place in the Children & Families Unit Gloucester House) and in the Adult Unit (The Portman). The date for the Camden Unit (CAISS) is set for 14th January 2025. Three recommendations from previous CQC inspections remain open. Open recommendations have been escalated to the ELT for oversight, action and traction of evidence. It is essential that these actions are completed and closed before the merger. The Committee **NOTED** and **DISCUSSED** the report and received an escalation in relation to the remaining open CQC recommendations from previous inspections.	
3. Efficiency plans quality impact assessments (QIAs) and equality impact assessments (EQIA) The Committee received the QIA and EQIAs that have been presented to the Efficiency Programme Board since this paper was last presented to the Committee in April. The services that these QIA and EQIAs covered are: - Adult Unit - Camden Unit - Mental Health Admin and Operations - Corporate Nursing – Quality and Safety The Committee **NOTED** the approach and updated plans.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Gender Identity Clinic Surgical Referrals Recovery and Mitigation (Patient Safety Incident Investigation) The Committee received a report on the actions being undertaken to review and remediate missed gender surgical referrals. The review found 101 cases where surgical referrals were not made at the time they should have been. The CNO and the interim Joint CMO are working closely with NHSE's specialist commissioning team to minimise any detriment to patients and agree next steps. All patients affected will receive a letter with an explanation of the error, offer of an appointment to discuss their individual next steps and a clinical harm review. The draft letter has been received by the ELT for formal approval. Mitigating actions have been undertaken to reduce the likelihood of recurrence, including audits on a monthly basis to identify and address any missing referrals. The patient safety incident investigation (PSII) report was received and discussed by the Board on 11 December 2025. Further work has been requested before approval. The Committee **NOTED** the report.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Patient and People Involvement Annual Report There have been significant improvements made to ensure the Trust is hearing from a wide proportion of service users that supports services to engage in quality improvement. There has been a notable shift in culture around the importance of feedback and patient involvement in quality improvement initiatives as can be seen from the increase in ESQ response rates and in number of current services users available for	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

involvement activities. There remains some work to support services to act on the feedback received and fully embed this through a quality improvement framework. The Committee **NOTED** the progress against the annual plan. The Committee requested the full paper is included in the next update to the Board of Directors (appendix A).	

Summary of Decisions made by the Committee:

- Endorsed the extended rollout of DrDoctor implementation in other services and suggested engagement with the software and project through the Clinical Services Delivery Group
- CPO to ensure current Staff Development opportunities are cascaded via Trust wide Communications. This is in the context of emphasizing the importance of appraisals despite the current freeze to funded CPD (discussed under item 008 Integrated Quality Performance Report)
- Agreed with the proposal to contribute to the North London Foundation Trust's refreshed Suicide Prevention Strategy in 2026 in anticipation of the merger

Risks Identified by the Committee during the meeting:

There were no new risks identified during the meeting.

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

There were no items identified to return outside the routine business cycle.

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

Item	Purpose	Date
CPO to ensure current Staff Development opportunities are cascaded via Trust wide Communications. This is in the context of emphasizing the importance of appraisals despite the current freeze to funded CPD *(discussed under item 008 Integrated Quality Performance Report)*	Action	18/12/25

The Tavistock and Portman NHS Foundation Trust

Appendix A

MEETING OF THE QUALITY AND SAFETY COMMITTEE – Thursday 18 December 2025			
Report Title: Patient & People Involvement Annual Report			**Agenda No.: 014**
Report Author and Job Title:	Nimisha Deakin Associate Director of Nursing and Patient Experience Gary Sell Senior PPI Coordinator	**Lead Executive Director:**	Clare Scott, CNO
Appendices:	Appendix 1: PPI Annual plan		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☒ Information ☐ Assurance ☒		
Situation:	The Trust has set itself a strategic priority to improve patient feedback and patient voice at all levels. An annual plan of work was drawn up to allow the PPI team to focus on key areas of work as well as being accountable to governance processes for the progress they are making in these areas. There has been progress across many areas setting the foundation for enabling the Trust to make Quality improvements based on patient feedback and with patient involvement. There is also greater visibility and accountability at all levels from Board to floor of how patients experience our services.		
Background:	Patient experience and involvement has historically been limited in the Trust. The PPI annual plan of work (see appendix 1) was developed and approved by the Quality and Safety Committee in December 2024 and is held to account via the bi-monthly Service User Experience Group. Priorities in the plan included: ■ Increase service user / carer engagement and involvement across the Trust ■ Service User Voice to be captured at all levels ■ Supporting community engagement through Art Board ■ Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process ■ Supporting Trust in Patient and Carer Race Equality Framework (PCREF) Involvement work The Patient Public Involvement Lead left the Trust in September following a significant period of absence. Despite this the team have continued to achieve across all areas of the plan		
Assessment:	There are clear systems, structures and processes to support service user feedback and involvement. There have been significant improvements made to ensure we are hearing from a wide proportion of our service users that supports services to engage in quality improvement. There has been a notable shift in culture around the importance of feedback and patient involvement in quality improvement initiatives as can be seen from the increase in ESQ response rates and in number of current service users available for involvement activities. There remains some work to support services to act on the feedback received and fully embed this through a quality improvement framework.		
Key recommendation(s):	The Committee is asked to **NOTE** the progress made against annual plan and approve the continuation of this plan over the next quarter.		
Implications:			

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☐	No ☒			
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	There are opportunities to report some of the metrics by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does not differ between reporting group. This will be guided by the PCREF workstream.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Contents and progress discussed in this report is regularly presented at Service User Experience Group				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Report Title: Patient & People Involvement Annual Report

1. Purpose of the report

1.1. This report seeks to highlight the areas where progress has been made to ensure the Trust is able to effectively engage with service users and listen and learn to feedback from patients about the experience of receiving care. The report will also highlight where there are gaps and outline the plans to address these.

2. Background

2.1 Patient voice is an essential and invaluable resource to the Trust. It ensures our work is grounded, critiqued and supportively challenged by people who have experienced the services we offer. The Patient and People Involvement (PPI) team works collaboratively across our Trust departments and with community colleagues to embed involvement in clinical and educational work and in the business as usual of all departments. The team works with patients, family members, carers, local community partners and members of the public in various aspects of our work to help develop and improve the services we offer, in a meaningful and informed way.

2.2 Historically there has been limited engagement with our service users to inform us how we develop and deliver our services.

2.3 An annual plan of work (see appendix 1) was developed and approved by the Quality and Safety Committee in December 2024 and is held to account via the bi-monthly Service User Experience Group.

2.4 Priorities in the plan included:

- Increase service user / carer engagement and involvement across the Trust
- Service User Voice to be captured at all levels
- Supporting community engagement through Art Board
- Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process
- Supporting Trust in Patient and Carer Race Equality Framework (PCREF) Involvement work

2.5 The Patient Public Involvement Lead left the Trust in September following a significant period of absence. This role has not been replaced. Despite this the team have made progress against the plan.

3. Increase service user / carer engagement and involvement across the Trust

3.1 Historically there was a culture within the Trust of only having patients participate in involvement activities after they have been discharged. Whilst there is an important role for hearing the views of those who have previously experienced our services it is important that we support the those currently using our services to also be engaged.

3.2 We have therefore supported making the distinction in language between experts by experience (EBE/ex-patients) and service user representatives (SUR/ current service users).

3.3 This year we have increased the number of service user representatives available for involvement activities across all services. This is more than double the number we had last year and has been achieved through:

- Increase awareness of service user involvement Trust wide: via Trust induction and drop-in / lunch time sessions
- Identify and develop Service User champions roles for all services

- Improve access to information for staff and patients through development of PPI news articles
- Share service user involvement stories through new articles
- Raising awareness and focus through patient experience week events.
- Developing and promoting awareness through our patient involvement leaflet.

3.4 There have been a number of activities undertaken by service users. This ranges from attendance on Interview panels, scoping and designing of service communication, Trust induction, DET trainee indications and forums. There has also been co-production of information leaflets and development of parent groups based on experience of service feedback.

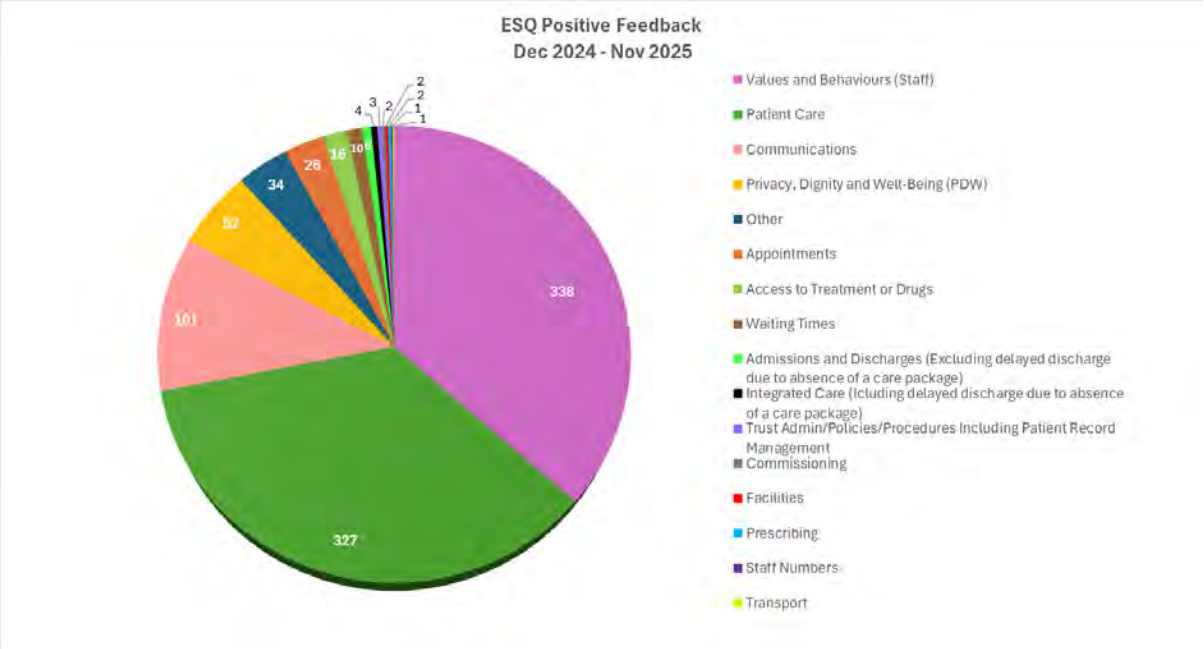
3.5 Following the implementation of the PPI policy last year significant work has been undertaken to support the plan around onboarding of representatives to our staff bank lite system. Unfortunately, this led to implications around involvement reimbursement being seen as “paid employment” which had implications for our representatives. As such we have moved to a new system which is in line with NLFT and supported service users to address issues related to benefits and tax.

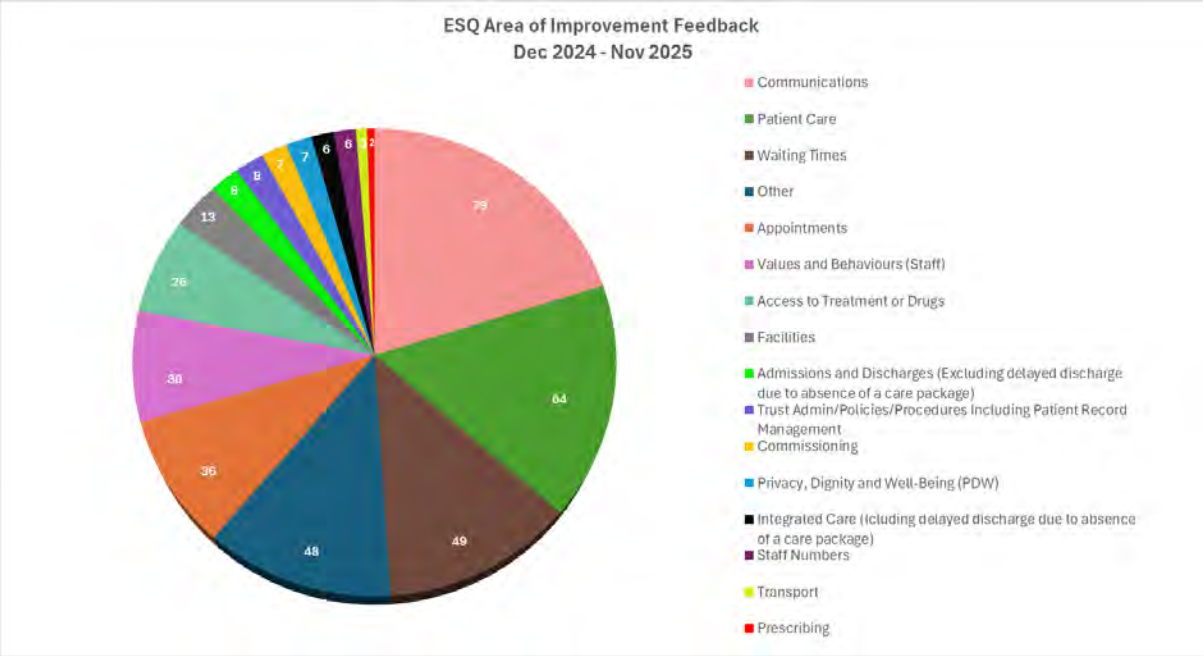
4. Service User Voice to be captured at all levels

4.1 The PPI team have been working with services across the Trust to ensure service user voice is captured at all levels. This has been achieved in several ways:

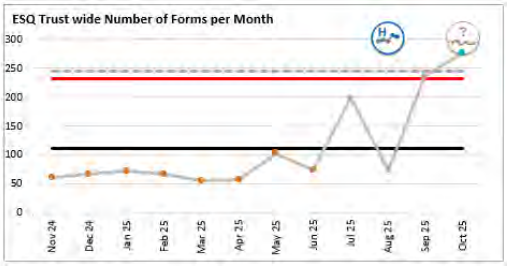
4.2 ***Through our A3 Quality improvement project to meet the Trust strategic target of increasing service user feedback through patient feedback*.**
The PPI team have been actively supporting teams through targeted support to identify and overcome barriers to gather patient feedback. This has allowed us to:

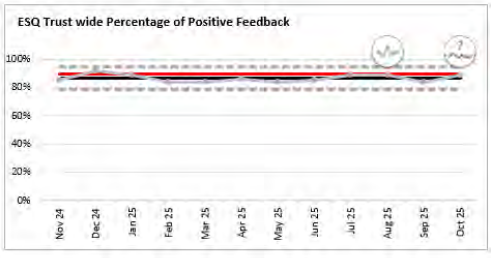
- develop and launch the QR code and URL link for remote feedback
- Set team targets to allow monitoring of teams that need further support
- Improve the access to the feedback at team level through development of dashboard
- Support regular team and unit level discussion on the feedback and actions taken
- Produce a “you said we did” feedback loop for patients available – this will be shared on the patient experience poster and on the website
- Set up systems for text messages to be sent out to request feedback
- Attended waiting rooms across the Trust to actively engage patients in providing feedback
- Data on feedback is thematically categorised to allow teams to be able to easily review this alongside other experience data such as complaints. The charts below show a summary of all themes for positive and areas for improvement reported through Experience of Service (ESQ) qualitative feedback.





The charts below indicate the percentage of positive feedback received throughout the year by month, in the form of a Statistical Process Control (SPC) chart. There has been significant improvement in the number of forms collected and we have reached our target of 90% positive feedback based on Friends and Family Test (FFT) question.





4.3 **Patient Forums**: Another area of development around increasing patient voice and feedback is through supporting teams to develop and support patient feedback forums. PPI team supported our Gender service to co-develop their patient forum. The model adopted offers service users a monthly peer-led coffee morning, which takes place in person at the Tavistock Centre, with a quarterly online formal forum, co-chaired between one of the service users and a member of the gender service. The forum has offered direct input into the decoration of the waiting area and will support the update of the GIC's website which will allow for user informed language and information to be considered.
The forum feeds into the Trust wide forum to ensure there is a Trust wide awareness of improvement projects within teams.

This model for forums has been taken up by our CAMHS service and Adult Psychotherapy. The PPI team continue to work with our Trauma service which has a longstanding patient forum to support this forum to be more integrated through the Trust Wide forum.

4.4 **Governance structure**
We have also worked to ensure that reporting on service user feedback is clearly embedded in our governance structures to provide assurance that patient voice is present in the development and improvements of our services. This is done at team, unit, committee and Trust Board level.

- We continue to have patient voice at Service User Experience Group, with regular and active participation and challenge from our EBE and SUR who are part of the group.
- Our Camden Unit has begun to have a SUR at the Unit Governance meeting to ensure patient perspective is attended to throughout discussions. We will continue to build on this practice with the other units.
- There is a commitment to listening and learning from service users about their experience at the Trust Board and Council of Governors through direct feedback. These sessions have been rich and diverse in allowing us to understand how our services are experienced. This year presentations have included presentations from *Patient Safety Partners, Gender Identity Clinic, Adult Psychotherapy, Camden Wellbeing Team, CAISS, Mosaic teams.* We continue to explore opportunities with teams for their patients to be supported to present their experience.

5. Supporting community engagement through Art Board

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

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

5.2 The Art Board now sits under PPI has seen some significant developments to ensure that there is clarity on process and procedures in line with Trust policies. Terms of Reference and Standard Operating Procedures have been developed, which includes loan and donation agreements. This will be important in supporting plans through the merger.

5.3 The trust has active volunteers that support all art board activities and events.

5.4 PPI team has completed an Art Audit, a multi-phased project to account and record all art across the Trust. Approximately **800** pieces have been recorded across the Trust including

external sites. This will allow us to produce an accurate catalogue of artist work which will help us to effectively manage the work.

5.5 Next steps will be to compare that to existing records and identifying gaps and update loan agreements.

5.6 The Art board has hosted eight exhibitions in the Art Space plus the annual Tavi-Open, which saw the highest level of submissions from the community: including staff, patients, service users and the public.

6. Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process

6.1 This is an area of the annual plan that we are beginning to pick up now that the merger plans are becoming clearer. The foundations around having systems and structures within the Trust for patient voice, patient feedback and involvement is key to supporting us moving through the merger. With increased engagement from patients and staff around patient experience and involvement we are able to ensure we can support our patients to be well informed and supported through the merger.

6.2 We have outlined a plan for how our patients will be communicated with and supported through the changes through the merger. Service users will be given information in a variety of ways and made aware of our PALS team for any enquires or concerns. Furthermore, we can utilise informal team forum spaces for further opportunities to communicate and listen to our patients about what they need to feel assured. There has also been a mapping exercise collating a list of existing stakeholders internal and external for us to communicate with.

7. Supporting Trust in Patient and Carer Race Equality Framework (PCREF) Involvement work

7.1 PPI and EDI are co-developing a Stakeholders Market Stall Event for PCREF, with an aim to bring together community organisations that represent marginalised groups and teams across the Trust. On the 17th February staff will have the opportunity to engage with various organisations, charities, government bodies and community groups to build and develop service-specific relationships to support the needs of our patients.

8. Recommendations

8.1 The PPI team to continue to strengthen the impact from actions linked to the plan and use this as the framework to guide priorities for the team over the coming quarter and into the merger.

9. Conclusion

There has been a great deal of work undertaken by the team to ensure that there are clear systems, structures and process to support service user feedback and involvement. This is essential to ensure that we are continuously learning and improving based on patient experience.

There has been significant improvements made to ensuring we are hearing from a wide proportion of our service users and ways for the team to be able to respond to this feedback in a meaningful way.

There has been a noticeable impact from raising awareness around the importance of feedback and patient involvement in quality improvement initiatives.

A key focus of 2025/26 will be improving processes to acting on and improving the way in which learn from the data that is now more readily available e.g. tangible improvements to practice.

The Tavistock and Portman NHS Foundation Trust

PPI Annual plan January 2025 – March 2026

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

	Produce a "you said we did" feedback loop for patients available on	March- Dec 2025	NS	Ongoing
	Review of Trust wide Forum allow more engagement/ feedback from a range of services users representative across the Trust. Increase frequency of meetings.	July 2025	GS/ND	Ongoing
	Identify, partner or co-create a range of spaces for service user voice to be heard e.g. youth boards, listening events	September 2025	GS	In progress with PCREF
Develop the Art Board and community engagement work through this forum	Finalise document review: TOR, JD, Volunteer role, risk assessment	March 2025	GS/ MZ	Completed
	Clarify and update financial processes	April 2025	ND/MZ	Completed
	Finalise a comms plan to promote the work of the Art Board more widely	April-Sept2025	MZ /Comms	Completed
	Create a clear work plan for exhibitions for the year	June 2025	MZ/GS	2025 completed. 2026 in progress
	Complete Artwork Audit – Identify insurance details?	July 2025	GS	Phase 1 completed Phase 2 compare
	Create a catalogue of Art work at the Trust	December 2026	Estates / Comms / PPI	In progress
	Review of the ART Board plan	January 2026	GS/Art Curator	In progress
Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process	Begin to establish links with CNWL PPI team and align processes	April 2025	GS/ND	In progress

	Work in collaboration with Communication Team in the Patient and Public engagement work around the Merger -Map existing stakeholder internal and external - Delivery of patient and public engagement activities alongside Communications team -Maintain log of all stakeholder events -Maintain a running log of key themes outlining feedback -Join existing groups or set up set up separate groups/workshops to ensure seldom heard voices -To produce a final engagement report on patient and public engagement to contribute to the comms and engagement section of the Business Case – this will include a summary of the engagement which took place, with qualitative and quantitative analysis.	Feb 2026 March 2026 July 2025-April 2026 TBC TBC TBC	PPI GS/PCREF PPI PPI PPI PPI	In progress with PCREF
Patient and Carer Race Equality Framework (PCREF) Involvement – support engagement of service user/expert by experience and local service user/carer groups.	Develop case studies that support the data to reduce inequality to treatment access.	Dec 2025	GS/EDI	In progress

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: Guardian of Safe working Hours (GOSWH)			**Agenda No.: 012**
Report Author and Job Title:	Dr Gurleen Bhatia Consultant Psychiatrist	**Lead Executive Director:**	Dr Sheva Habel, Interim Joint CMO
Appendices:	None.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report details concerns raised by trainees regarding fine payments, DRS login issues resulting in reporting breeches on later dates. This relates to trainees working on other sites, however employed by the Trust.		
Background:	The GOSWH report details the exception reporting by the trainees, breaches relating to on calls, fines resulting and any ongoing concerns. We continue to encourage the junior doctors to report breaches and encourage them to use the GOSWH fund for their professional development.		
Assessment:	This report details fines for Q3 2025.		
Key recommendation(s):	The Board is asked to **NOTE** the report.		

Implications:					
Strategic Ambitions:					
☐ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☐ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title: No Linked Risks				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications	Yes ☐	No ☒			
	No current resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	No current EDI issues arising from this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the			

			public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Report submitted to Local Negotiating Committee (LNC) prior to this submission.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

Guardian of Safe working hours Q3 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the Trust Board on a quarterly and annual basis.

2. Exception reports

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
October	3	0	3	0
November	11	0	11	0
December	0	0	0	0

2.2 Work schedule reviews

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

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

The NROC is currently being staffed by Trainees and occasionally an external locum.

The trainees do 1 locum shift/month in addition to their normal working schedules and on call rota (1 in 9.8)

2.5 Fines- as per penalty rate guidance circulated by BMA and GOSWH regional meeting.

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
	hrs	hrs	£	£	£
September	4	10hr 30min	2028.25	760.66	1267.59
November	0	39hrs	5894.46	2210.52	3690.1
December	0	0	0	0	0
Total	4hrs	49 hrs 30min	7922.71	2971.18	4957.69

3. Junior Doctors Forum (JDF)

Next JDF is scheduled for February 2026 (date to be confirmed)

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sarah Wynick

Conclusions and Recommendations

4.1. Members of the Board are asked to note the report.

4.2. We continue to encourage the junior doctors to report breaches and encourage them to use the GOSWH fund for their professional development.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: Patient and Carer Race Equality Framework (PCREF) Report			**Agenda No.: 013**
Report Author and Job Title:	Dr Thanda Mhlanga Dr Sheva Habel	**Lead Executive Director:**	Dr Sheva Habel Joint Interim Chief Medical Officer
Appendices:	Appendix 1: PCREF Action Plan Appendix 2: Workstreams		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	National and local data consistently shows that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services.		
Background:	As a result of the National Mental Health Act Review in 2018, it was recommended that Mental Health Trusts should launch the Patient and Carer Race Equality Framework (PCREF) to facilitate a national, systematic way of identifying and changing race inequality within NHS services. The Framework aims is to move to equity in access, experience and outcomes for Culturally and Ethnically diverse communities. NHSE has been working with PCREF early adopters since 2020 and there was a national roll out in 2023. However, in April 2024 PCREF became a contractual required for all Mental Health Trusts.		
Assessment:	**PCREF Implementation – Board Update - Executive Summary** The Patient and Carer Race Equality Framework (PCREF) Implementation Group continues to translate intent into action. Reporting into the Quality and Safety Committee, the Group meets bi-monthly to drive grip, pace and accountability as the Trust moves decisively towards being an actively anti-racist organisation. This is not at a rhetoric stage; we have progressed to operational change, grounded in co-production, evidence, and assurance. **Our Strategic Delivery Model** Delivery is structured around four core pillars, designed to hard-wire racial equity into culture, practice, and outcomes. **1. Culture: Building PCREF Fluency** Our ambition is clear: PCREF fluency for all staff, not pockets of expertise. During Black History Month, we hosted two high-impact learning events where community advocates (Shocka, Aji and Colin) and a white ally (Simon) brought lived experience, professional insight and moral authority to the centre of our work at the Tavistock. These sessions challenged complacency, exposed structural inequities, and sharpened our collective competence in culturally responsive care. The signal to the organisation was unequivocal: cultural competence is a clinical and safety issue, not an optional extra. **2. Community: "Go Where People Are"**		

Historically this was a gap at the Tavistock; now it has become a priority. We have adopted a proactive engagement strategy, strengthening relationships with community groups, Local Authorities and VCSE partners. Working with the PPI and EDI Team, we are mapping community assets to enable meaningful, service-level partnerships.
Next step: a market-stall engagement event (March), creating a practical marketplace where staff can identify, test and build partnerships aligned to service needs. This marks a shift in our ethos from transactional consultation to relational engagement.

3. **Clinical Services: Evidence, Accountability, Action**

All clinical teams are completing PCREF self-assessments. This data-driven "mirror" enables teams to identify inequities, develop bespoke action plans, and be held to account for progress.
In parallel, we are strengthening governance by embedding robust Equality Impact Assessments (EIAs) across Trust policies and service changes. Monthly EIA workshops are building capability and consistency. To date, 50 decision-makers have been trained, thus significantly improving understanding of "*due regard"* and resulting in more rigorous, defensible decision-making.

4. **Patient Experience: Safety Through an Equity Lens**

PCREF is being embedded into patient safety systems, including complaints handling, restrictive practice, incident reporting, and violence and aggression processes. The objective is simple and uncompromising: equitable, safe, and responsive care, underpinned by transparent reporting and clear accountability.

Leadership and Governance

- **Strengthened Oversight:** Two Non-Executive Directors have joined the Group, providing independent challenge, strategic oversight and visible Board-level commitment to PCREF.
- **Formalised Governance:** Agreed Terms of Reference now clearly define the Group's remit, authority and reporting lines, strengthening assurance and sustainability.

Data, Insight and Ownership
Interrogation of ESQ data is now a standing agenda item, led by the Group Chair. Crucially, this is not passive reporting. Clinical teams are actively sense-making their own data, owning disparities, and cascading learning and actions within services. Data is becoming a lever for change at the Tavistock, not a retrospective explanation.

Education and Training (DET)
The Department of Education and Training is a critical enabler of PCREF delivery. DET representation on the Group ensures alignment, and a dedicated PCREF action plan will be presented at the next meeting. Key competency areas include:

- Cultural Awareness
- Staff Knowledge and Awareness

	• Partnership Working • Co-Production • Workforce Development **Reflections/Summary** PCREF is moving from policy to practice. Governance is stronger, capability is growing, and accountability is sharpening. The next phase is about depth, consistency and measurable impact on patient experience and outcomes. The direction of travel is right; the challenge now is to maintain momentum and embed this work as *"How we do business"*, not a parallel programme.
Key recommendation(s):	The Trust Board is asked to: • **COMMIT** ongoing support to drive forward PCREF ambitions. • **FACILITATE** strategic community connections to strengthen and expand our community engagement efforts. • Provide **FEEDBACK** and challenge on progress to date.

Implications:

Strategic Ambitions:

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☐
Alignment with Trust Values:	Excellence ☐	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 1 - Inequality of access to mental health and gender care services to the population served by the Trust's contract				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Standard NHS Contract (2024), NHS Act (2006), Equality Act (2010), Public Sector Equality Duty (PSED), Carers Leave Act (2023), The Mental Health Units (Use of Force) Act (2018), Children Act (2004), Human Rights Act (2007), Mental Health Act (1983), Health and Care Act (2022), Health and Social Care Act (2008), Mental Capacity Act (2005), Children and Families Act (2014), Care Act (2014)				
Resource Implications:	Yes ☒	No ☐			
	• Community Engagement • Training and Development (Building a responsive and culturally competent workforce).				

Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	• Tackling Health Inequalities • Removing barriers to access • Staff knowledge and cultural awareness training			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	QSC – 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

Report Title: Patient and Carer Race Equality Framework (PCREF)

1. Purpose of the report

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

2. Background

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

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

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

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

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

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

3. Leadership, Governance and Accountability

PCREF Implementation Group –
Our statutory and legal obligations include board-level oversight and monitoring of the action plan. Since the departure of Dr Chris Abbott (Chief Medical Officer), the Implementation Group is now chaired by Dr Sheva Habel as Joint Interim Chief Medical Officer. The continuity of this change has ensured ongoing executive oversight. Board scrutiny highlights the importance the organisation is giving to PCREF and how it is holding itself accountable for progress. Drawing on good practice from other Trusts, our PCREF Implementation Group now includes two Non-Executive Director Sponsors, fulfilling an outcome of the previous board paper dated 15th July 2025.

The Implementation Group has grown to 42 members and has been visited by the Trust's lead Governor who has expertise in community engagement which was highly valued. Developments over the past six months have included formalising the meeting with an agreed Terms of Reference and the regular sharing of data presented at the Trust Level IQPR in addition to the sharing of knowledge and interventions across the trust clinical services. In the new year the meetings will continue to be held on a bimonthly basis with members asked to identify a work stream to join to drive implementation across the trust. The workstream meetings will meet on a bimonthly basis, alternating with the Implementation group where the workstreams will feedback progress against plan.

4. Data and Impact

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

Data relating to PCREF is currently presented within the IQPR framework and to the PCREF implementation group. There has been significant progress in reporting of initial data.

Complaints, incidents; incidents of violence and aggression and restraints:

In the October IQPR (reporting M6) Complaints, incidents; incidents of violence and aggression and restraints over the previous Quarter were reported related to ethnicity

Research consistently shows that patients from Global Majority backgrounds often have worse experiences with NHS services compared to white British patients and are less likely to raise concerns when they encounter problems.

Discrimination: A significant percentage of Global Majority patients report experiencing some form of discrimination. For example, a 2025 report indicated that 49% of Black participants and 38% of Asian participants felt primary care providers treated them differently due to their ethnicity.

Communication and Involvement: Global Majority groups frequently report worse experiences with communication and feeling less involved in decisions about their care and treatment.

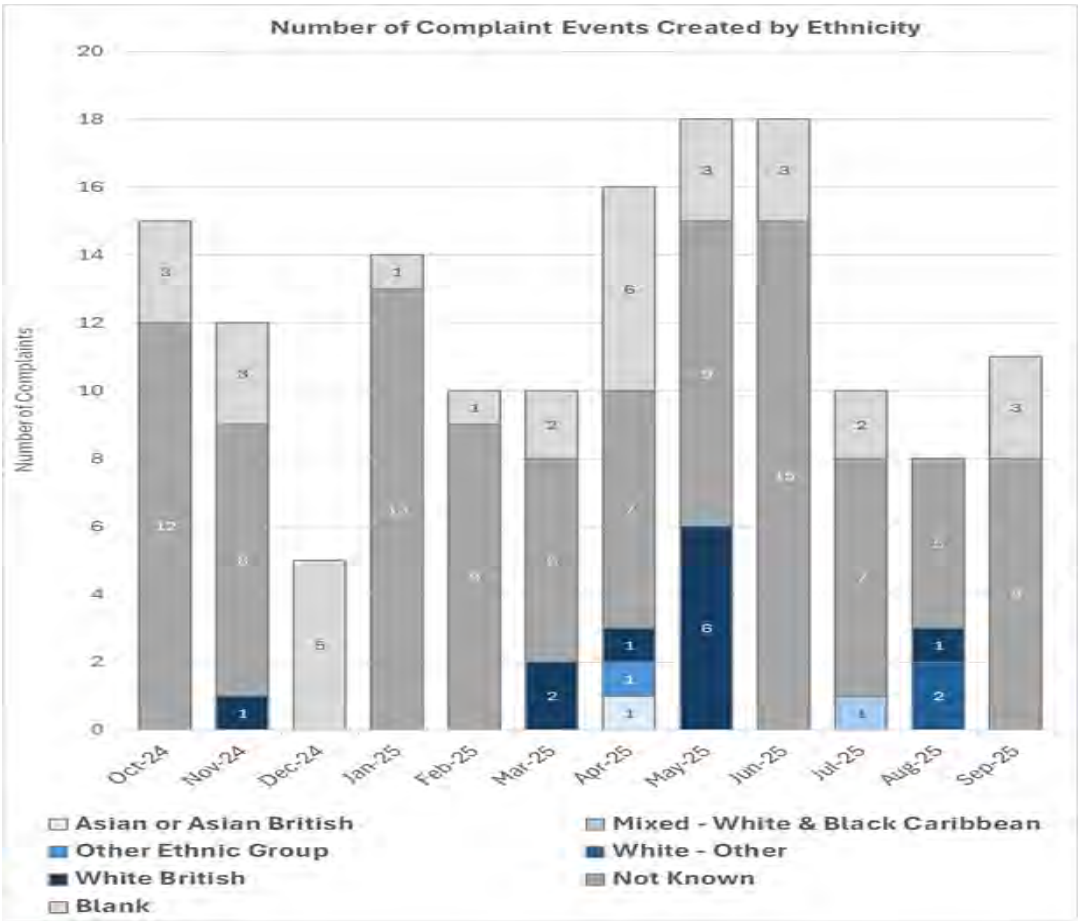
Access and Waiting Times: Global Majority patients are less likely to report positive experiences regarding access to services and waiting times, including delays in emergency departments.

Mental Health: Global Majority people are disproportionately detained under the Mental Health Act and are more likely to be subject to coercive powers like physical restraint.

Impact of Staff Experience: There is a direct link between the experiences of Global Majority staff and patient satisfaction; when Global Majority staff experience discrimination, patient satisfaction scores tend to be lower.

Barriers to complaining:
Despite having more negative experiences, Global Majority individuals are less likely to formally complain. Reasons include: A desire not to cause trouble, a feeling that speaking up would not lead to any change. Past experiences of racist treatment by healthcare professionals can lead people to delay seeking help or disengage from services altogether.

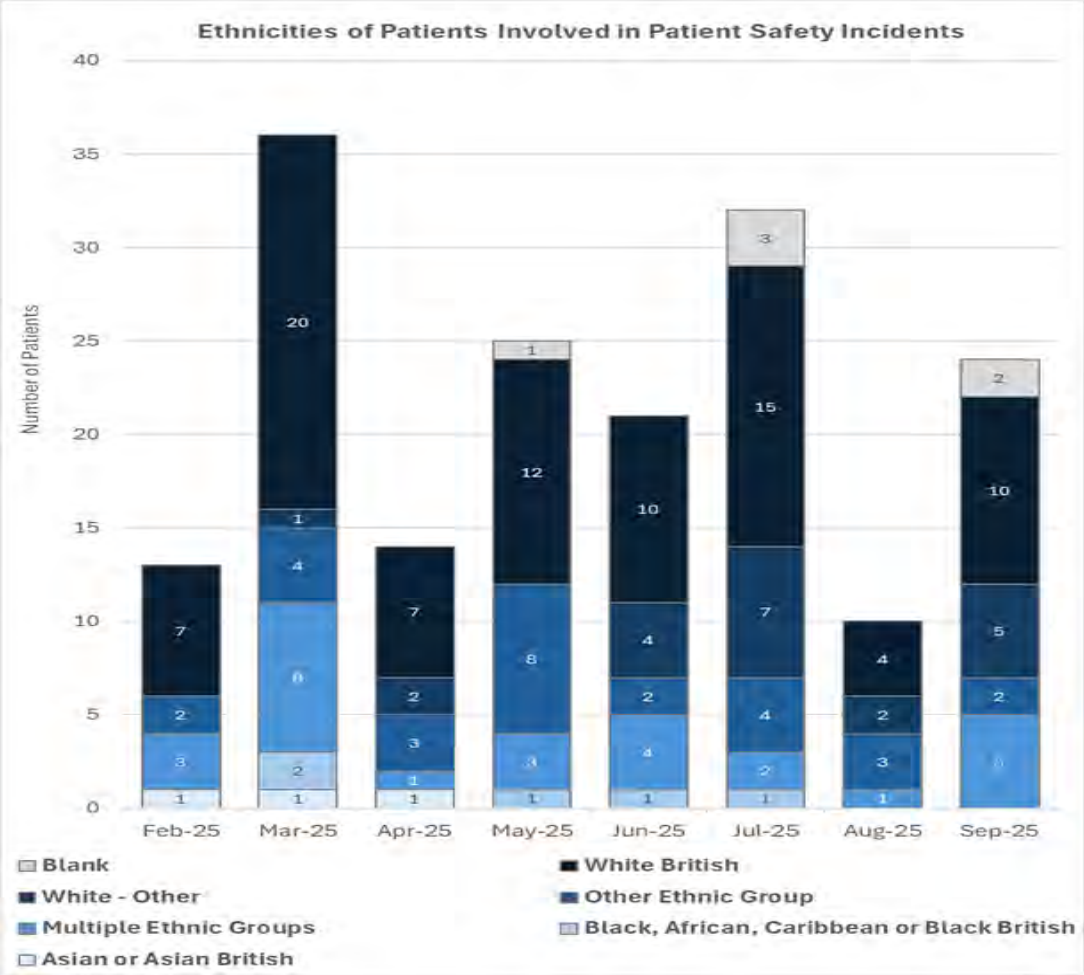
Complaints reported by Ethnicity



The graph indicates that there is a significant number of complaints where the ethnicity of the patient is not recorded. The understanding behind this requires further exploration, possibly due to patients on waiting lists making complaints.

When the ethnicity of the complaint is known there are no complaints from patients with Black ethnicity recorded which warrants further exploration

Incidents reported by Ethnicity



Incidents reported by staff cover individuals from a range of ethnicities. Consideration of refining this data would be helpful to gain a greater understanding of the basis of the incidents to draw any firm conclusions about the performance of the trust in this area.

Incidents of Violence and Aggression and Restraints

This data is primarily related to incidents at GH School and indicates a relative over representation of restraints used on white pupils and those of mixed ethnicity

Percentage of children at the school by ethnicity	The V&A incidents for September:	The restraints incidents for September:
White British 46% Black African, Caribbean, British 24% Mixed Black Caribbean and White: 15% White Other: 15%	White British 42% Black African, Caribbean, British 0% Mixed Black Caribbean and White: 16% White Other: 16% Not known: 26%	White British 54% Black African, Caribbean, British 0% Mixed Black Caribbean and White: 23% White Other: 15% Not known: 8%

Did not attend and Cancellation by Patient Data

NHS data for 2024-25 shows variations in DNA rates per 100,000 population across different ethnic groups in England:

- Black patients had the highest DNA rate per 100,000 population (23,200).
- 'Other' ethnic groups followed closely (25,000, though this group also had the highest rate of total appointments).
- Asian patients had a rate of 14,900.
- White patients had the lowest rate (10,300 per 100,000 population).
- Other studies corroborate these findings, noting that patients with "Black", "Mixed", or "Other" ethnicities were up to 50% more likely to not attend their outpatient appointments compared to patients with "White - British" ethnicity

Reasons and Contributing Factors

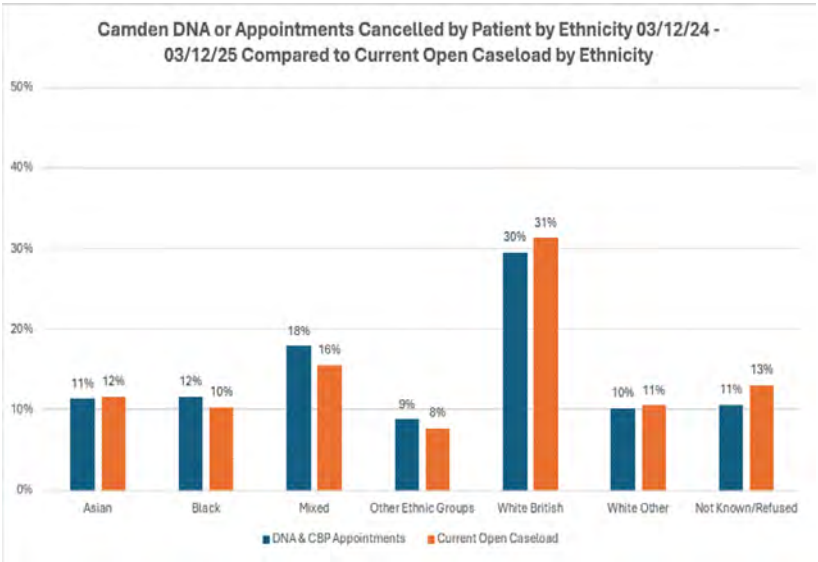
The disparities are complex and linked to broader health inequalities and systemic issues, rather than individual patient behavior.

Key factors include:

- **Socioeconomic Deprivation**: There is a strong link between living in deprived areas and higher DNA rates, which often intersects with ethnicity.
- **Communication Barriers**: Issues can arise from a lack of access to digital devices, limited digital literacy, or healthcare information/applications not being available in languages other than English.
- **Systemic Factors**: These include long waiting times, which make patients more likely to miss appointments, and a lack of patient choice in appointment times and dates.
- **Mistrust of Healthcare Systems**: Some evidence suggests a degree of mistrust of how data is used by government agencies can affect engagement with services among ethnic minority groups

Camden Unit

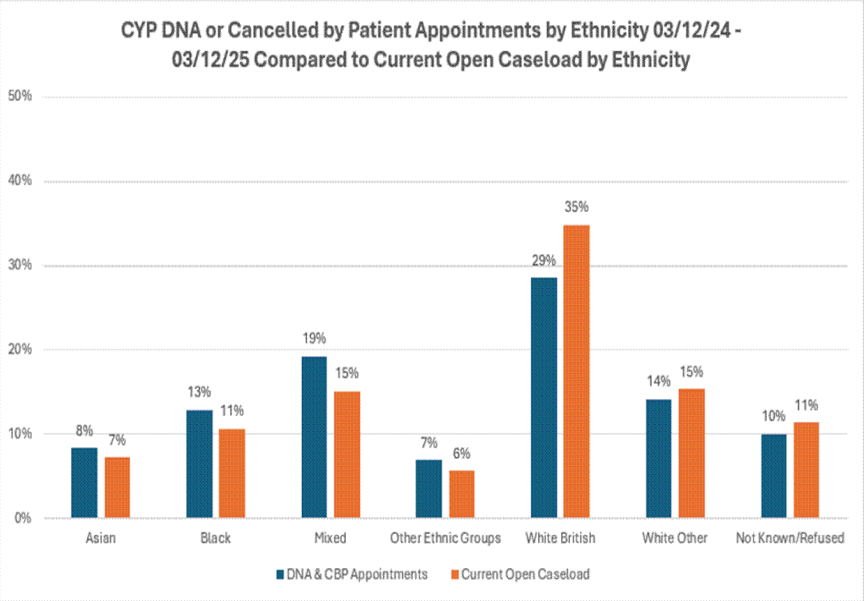
DNA and CBP rates in the Camden unit indicate that global majority families who identify as Black, Mixed or other Ethnicity are more likely to DNA or cancel their appointment (12.5 % higher) than those who identify as Asian or White ethnicities.



Child and Family Unit

DNA and CBP rates in the Child and Family unit indicate that global majority families who identify as Asian, Black, Mixed or other Ethnicity are more likely to DNA or cancel their appointment than those who identify as White ethnicities.

This is particularly marked in those identifying as mixed with a 28% increased likelihood of the families not attending an appointment.

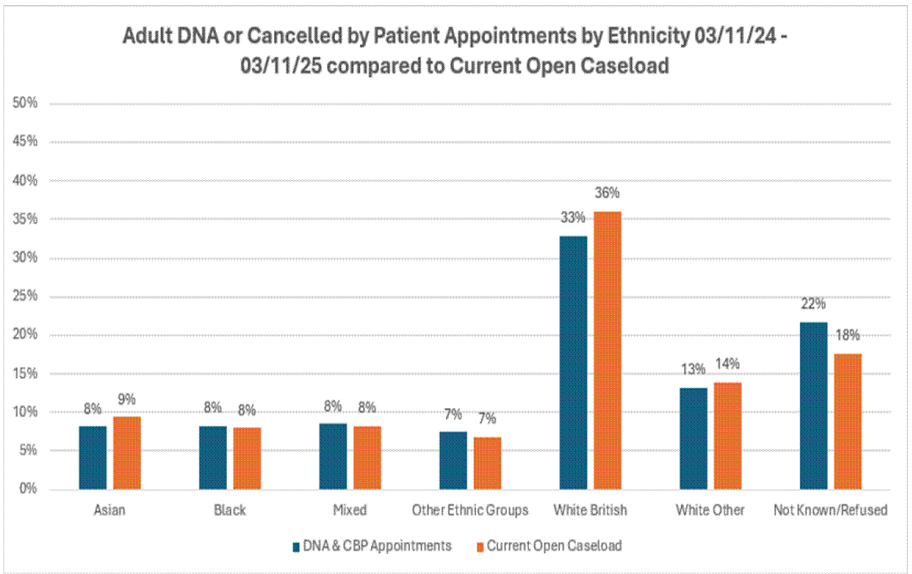


Adult Unit – Therapies

DNA and CBP rates in the adult unit indicate that global majority patients who identify as Black, Mixed or other Ethnicity are more likely to DNA or cancel their appointment than those who identify with White ethnicities. However, all these levels are in line with expected levels of DNA and CBPs.

Of note, the adult unit continues to have a higher percentage of "Not Known" as a recorded ethnicity and in this group, there is a significant overrepresentation of DNA's and cancellations which warrants exploration and action.

5.

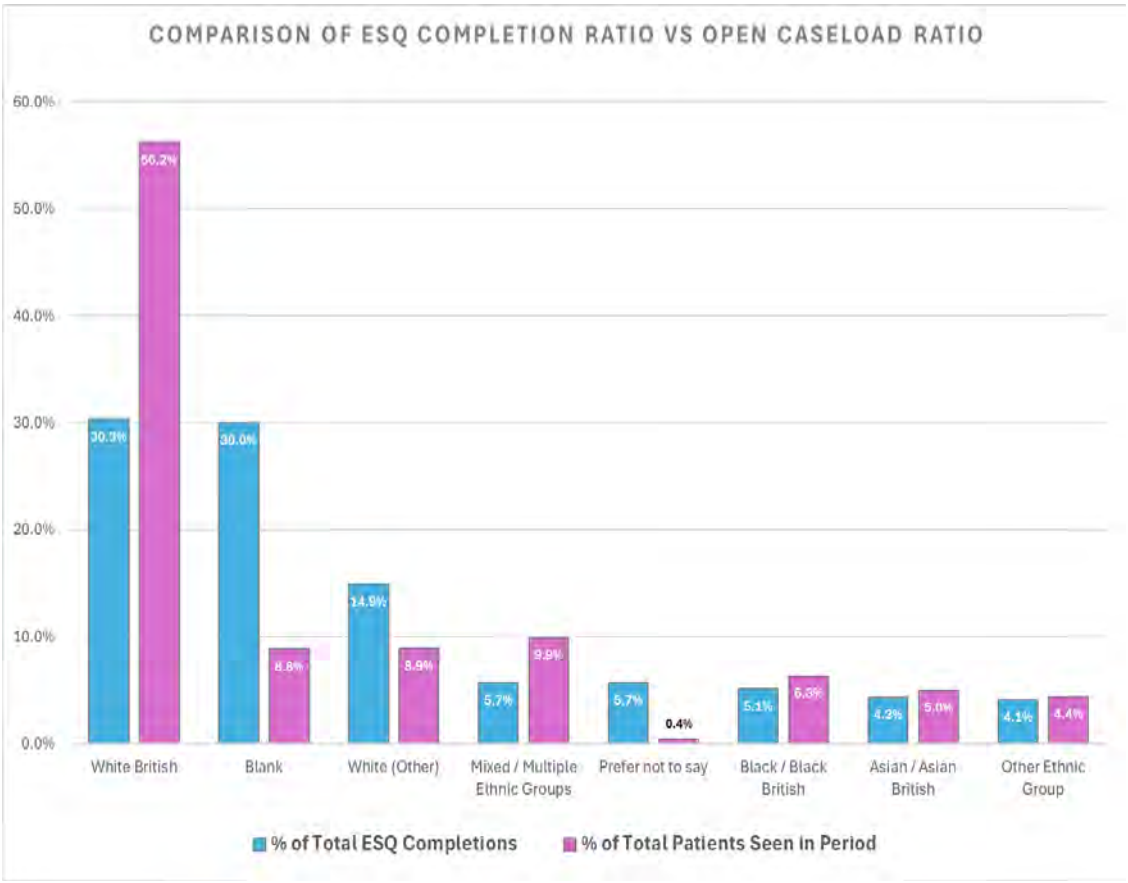


Experience of Service

Research into the experience of global majority

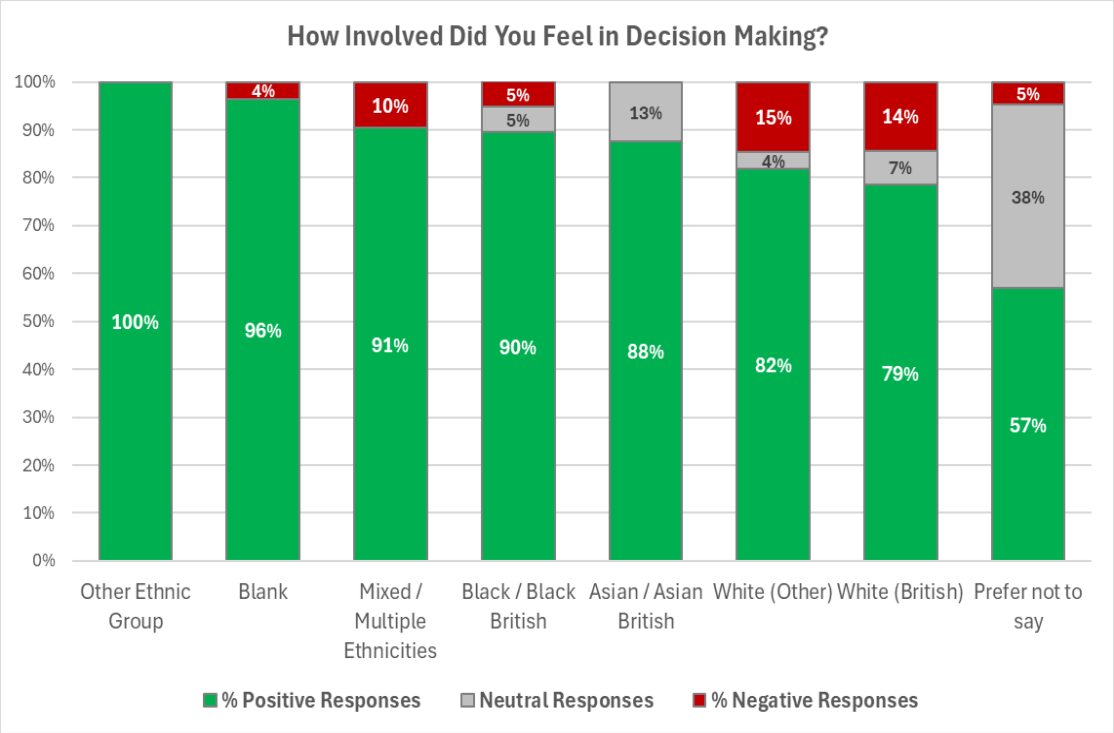
communities accessing healthcare repeatedly reports concerns around trust, discrimination and poor experience. As part of our commitment to assessing and improving the quality of care we provide, we gather feedback from patients and their families in relation to various aspects of our services, including accessibility, the quality of care, organisation, and the environment through the Experience of Service Questionnaire (ESQ). The ESQ helps us understand what aspects of a service are working well and what needs improvement. In the November IQPR (reporting Month 7) ESQ Data by ethnicity from Q1 and Q2 25/26 was shared.

Comparison of ESQ and Active Caseload Contribution

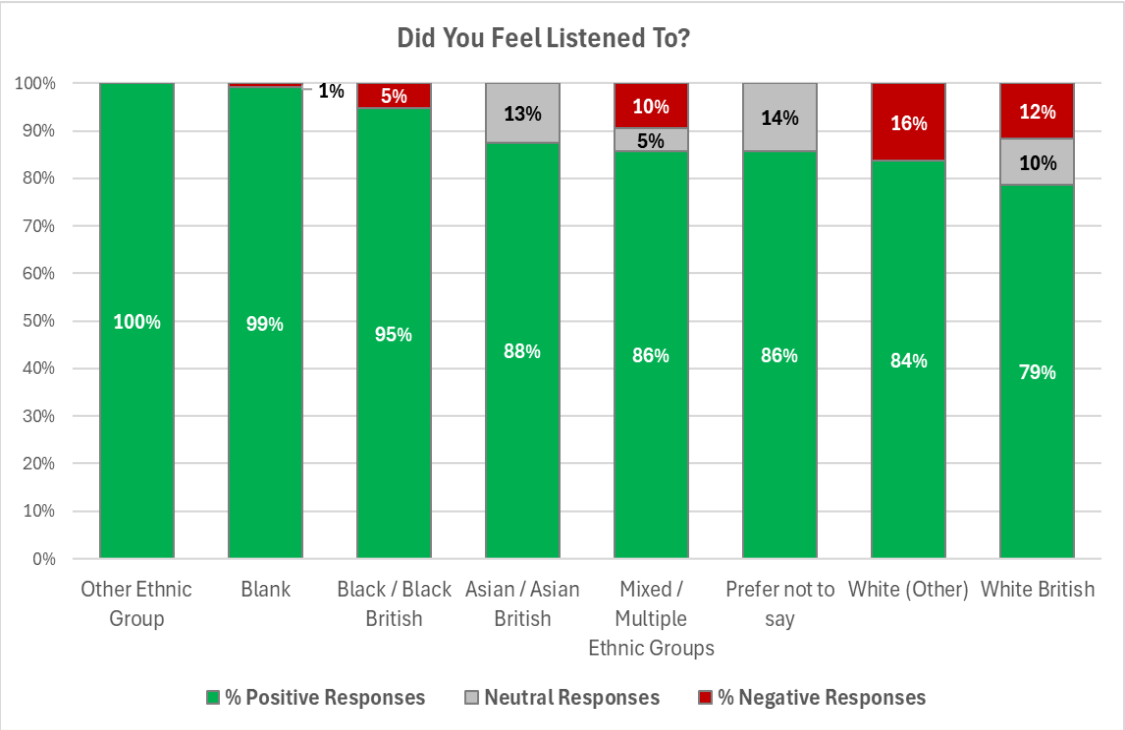


This graph compares the % of the total ESQ's completed during this period for each ethnic group with the % of the total patients seen over the same period across the Trust.
To use a worked example from the graph to the right; White British patients made up 56.2% of the patients seen during this period but only completed 30.3% of the ESQ's completed during this time.
Conversely, White (Other) patients made up 8.9% of the patients seen during this period but accounted for 14.9% of the ESQ forms completed.

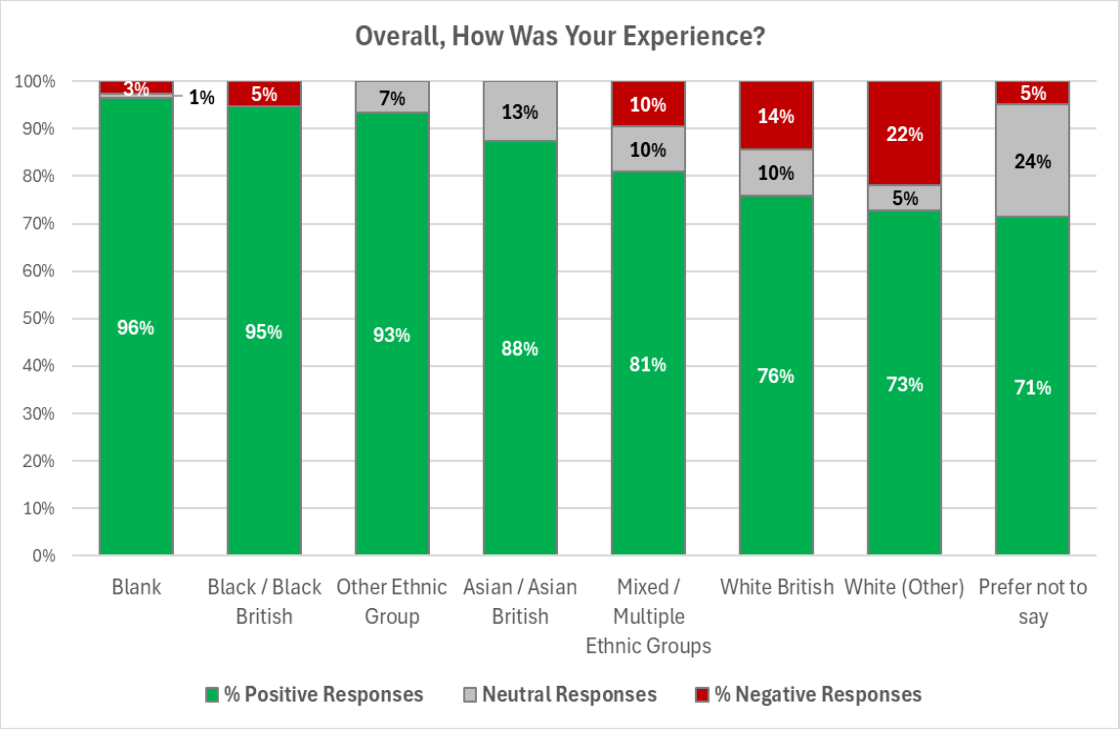
Did you feel involved in the decisions made about the care/treatment?



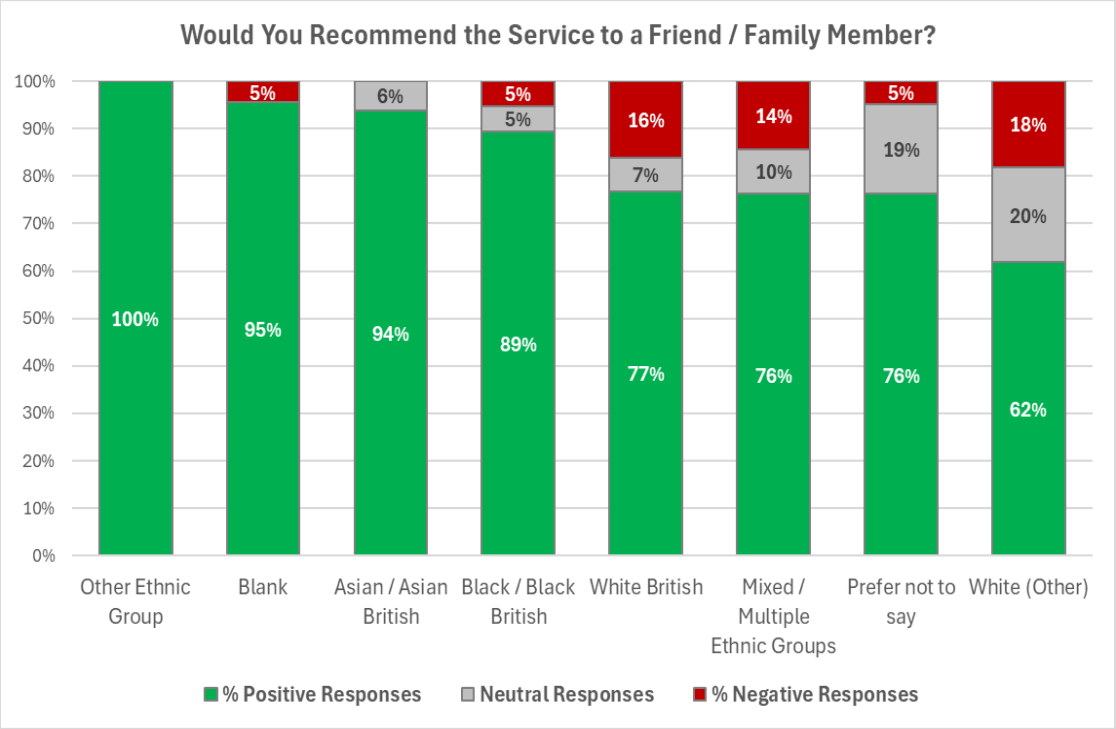
Did you feel like staff listened to what you had to say?



Overall, how was your experience?



Would you recommend this Service to a Friend/Family Member?



Overall, the ESQ data indicates that Global Majority communities report a generally positive experience of the treatment they receive from the trust. There is a recognition within the Clinical Services and the PPI team that improvements could be made in relation to the wording of the ESQ's to gather more effective feedback and to encourage elaboration on forms to further our understanding of where areas of improvement are required. This work will be taken forward within the PCREF action

plan where community engagement and patient and carer feedback will be used to develop feedback mechanisms.

6. Cultural competence, Staff knowledge and awareness

The PCREF Implementation Group continues to play a central role raising awareness about health inequalities and supporting the organisation build a culturally competent workforce that can understand and respond to the needs of minoritised ethnic groups. It is a space where clinicians share good practice. At the December meeting Haringey CWP Team shared their Community Engagement Project in Haringey (Appendix 1)

In celebration of Black History Month (October 2025), the PCREF and EDI Team in conjunction with REN and in recognition of PCREF arranged two separate speaking opportunities. On Thursday 15th October in line with Black History Month 2025: theme: “Standing Firm in Power and Pride”. The EDI Team & Race Equality Network invited

Colin King (Lived experience activist and consultant) and Aji Lewis (Lawyer, mother of Seni Lewis, and tireless campaigner for justice) to come and speak to the Trust about their experiences. This includes the creation of the Mental Health (Use of Force) Act 2018 – “Seni’s Law”, a landmark piece of legislation that:

- Demands transparency & accountability in mental health services
- Requires improved police training and use of body-worn cameras
- Aims to end unnecessary restraint and prevent tragic loss of life

Colin and Aji shared their stories and challenged those attending to question their practice and assumptions in a powerfully meaningful way.

On Monday 20th October as part of our work to embed PCREF, we invited Shocka to speak to our staff and invited guests. Shocka, aka Kenneth Erhahon, is a rapper, author, mental health activist and Rethink Mental Illness ambassador from Tottenham. After experiencing symptoms of schizophrenia and being detained under the Mental Health Act, Shocka has worked to raise awareness of mental illness, been a TEDx speaker and released his book *A Section of My Life*. The feedback from Colleagues around both events was extremely positive. As a result, the PCREF team have committed to provide at least quarterly opportunities for trust colleagues to further develop their cultural competencies.

An unexpected outcome of these events was a greater recognition by the PCREF team of pockets of the Trust who had less exposure and understanding of PCREF and the need to engage with a wider audience. This action point is being taken forward as part of the PCREF action plan.

7. Community Engagement

The framework emphasises working in partnership with local services, communities to develop and implement solutions. A key element of the community engagement work will be a Market place PCREF Event in March 2026. This will be led by Gary Sell from PPI and Luster Alfred from the EDI team and will be supported by three, final year psychology trainees on leadership placement within the Trust.

8. Equality Impact Assessments

The Trust has overhauled its approach to EIAs and the EDI Team now deliver a monthly workshop that provides practical guidance on how to identify, assess, and address potential impacts of policies, programs, and decisions on different groups, particularly those with protected characteristics under equality legislation. To date 50 members of staff have been trained and the feedback has been that the EQIA process is now experienced as more meaningful and structured.

9. Workforce

The PCREF advocates for a culturally competent and diverse workforce to address racial disparities in mental health services and improve access, experiences, and outcomes for racialised patients and their carers. A key part of this involves creating a psychologically safe and representative workforce. Currently, we are aware that our clinical workforce is not representative of communities that we serve. This is an area that the Trust is keen to address however due to the financial situation the Trust is not currently holding CPD panels which reduces the opportunities available to underrepresented groups to gain further qualifications. In addition, the loss of the National Training Contract will have a negative impact on the entry level courses which enabled those without degrees to progress into clinical trainings.

10. Conclusion and Recommendations

The past six months have seen significant development within the data and patient experience elements of our PCREF action plan. The implementation group now has NED representation. There have been two successful and inspiring speaking events and clinical services continues to be very engaged in the work.

In the coming months, we will be moving towards 5 workstream reporting into the Implementation group:

- Culture:
  - Improve awareness and understanding of PCREF across the trust
  - Roll out Anti Racism training across the trust
  - Have an external PCREF speaker once a quarter
- Community:
  - Develop community links to ensure ongoing relationships which go beyond individuals.
  - Hold a community Market place event in March 2026.
- Clinical:
  - Complete the PCREF self-assessment form for all Clinical Teams
  - Develop on individualised team level action plans
- Patient Experience:
  - Continue to develop a data driven approach to ensuring equality of access
  - Develop SPC charts of paired outcome measures reported by ethnicity
- DET
  - Collaborate closely with DET colleagues to implement and update the DET plan aligned with PCREF priorities.

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

Leadership and Governance	Current Position	Gap Analysis	Actions	Measures	Owner	Timeline
Continue to broaden partnerships with community representatives and create a space to engage	Informal links to community projects	Knowledge is not shared. Loss of memory when people leave, no formalised arrangements	develop market place event and invite communicty partners to visit and trust . Develop PCREF leaflets	Community engagement project	SH / TM / GS Project Lea	Completed by end of Q4 25/26
Map VSC health and wellbeing organisations with a specific focus on global majority communities	The trust has a list of 20 organisations	The list needs to be vetted clinically	Review list and make contact with organisations and develop links Engage PCREF implementation group to share names and addressed of known contacts		GS and LA	end of q3
Improve and strengthen the relationships with the local authority and Voluntary, Community and Social Enterprise (VCSE's)	The trust does not have any firm relationships with local VSE's (see point 2)		The Trust will hold a market place event and round table in March 2026	GS to develop idea and link in with LA and TM in relation to point 2	SH, TM, GS (PPI)	Completed by March 26
Non - Exceutice Director (NED) lead for PCREF	Board level support achieved	To develop board to floor support of PCREF	To identify a NED with interested in PCREF development to support work in the trust	NED identified who would attend PCREF meetings	SH	Completed October 25
Targetted IQPR PCREF Matrx development - Access focus	Q4 24/25 Ethnicity Referral Data provided to all services along with appropriate reference data	Need to develop a clear target in the IQP packs for the Trust to achieve.	Teams and unit to review referral data and develop plans to address discrepancies between this and local population. Nuanced understanding of barriers to referrals being made etc	Ethnicity Referral Data provided to all services along with appropriate reference data on a Quarterly basis to assess impact	SH & BY	Next reporting to occur in July IQPR for Q1 25/26

Embedding into patient safety work - complaints	Complaints are currenntly reported in IQPR with no ethincity data included	To develop a clear understanding of how members of the global majority expereince the trust and themes around complaints		Embed ethnicity reporting into IQPR complaints data	EC	Repoted in IQPR M7
Embedding into patient safety work - restrictive practice	Restrictive practice is currently reported in IQPR with no ethincity data included	To develop a clear understanding of the impact of ethnicty on the restrictive practice which occurs in the trust.		Embed ethnicity reporting into IQPR restrictive practice data	EC	Repoted in IQPR M7
Embedding into patient safety work - incident	Incident numbers currently reported in IQPR with no ethincity data included	To develop a clear understanding of the impact of ethnicty on number and types of incidents reported		Embed ethnicity reporting into IQPR restrictive practice data	EC	Reported in IQPR M7
Raise awareness of PCREF across the trust	People who attend PCREF are aware however it has been come apparent that understanding is not widespread and needs to improve.	Lack of awareness of PCREF. No consistent communication and sign posting.	Develop leaflets and posters to promote PCREF. Develop a presentation to circulate to clinical teams and have psychology trainees to speak to this. Develop a page on the intranet	Develop interventions. Invite a speaker every quarter to speak to the subject. Implement surveys to understand current position.	SH / TM	completed by Q4

Patients and Carers Feedback	Current Position	Gap Analysis	Actions	KPIs / Measures	Owner	Timeline
Improve and increase the diversity of service users and carers feedback to reflect our communities	Explore data provided by trust	Due to low levels of reporting data can only be meaningfully colated on a 6 monthly basis	Ensure that the ESQ is available in other languages	increase ESQ numbers collected	NM	ongoing
Develop feedback mechanisms to be stratified by provided ethnicity data	ESQ data currently collects ethnicity data and the responses can be stratified.	Due to low levels of reporting data can only be meaningfully colated on a 6 monthly basis	To run the ESQ report by ethnicity on a 6 monthly basis	ESQ data report	SP	Nov 2025 for IQPR
Take action on feedback such as considering other locations for clinical work to take place - eg family hubs	Some teams have worked direclty with services user and are explaning into family hubs	Currently action is taken on ESQ data but this is independent of PCREF	To present ESQ data with ehtnicity to IQPR, to the PCREF steering group and to teams for action plans to be developed	Actions plans developed once data is availabl	SH, LL, SB, TK	end of January2026

Organisational Competencies	Current Position April 225	Concerns	Actions	Measures	Owner	Timeline
Formalise and clarify PCREF advisory groups role to oversee the implementation of PCREF plan	Each service should have a PCREF Lead who attends PCREF Implementation Group and is responsible for cascading PCREF to service level. Currently no formal roles	This current advisory group does not have clear structures,lines of accountability and clarity around reporting outputs. There are no formal roles allocated in the group.	Implement governance structure and develop ToR. Develop reporting structures to capture meaningful progress	Ratified TOR Clarified outputs Clearly defined roles	SH, TM	TOR to be completed by start of Q3 Allocation of roles to run concurrently with preparation of TOR's
All divisions to undertake a PCREF self assessment	All teams have been provided with their referral data by ethnicity and will be reflecitng on this and implementing plans.	This will be an incremental process where the focus of the work will move from the front door to the end of treatment	Action plans to be developed to describe current situation and potential actions to improve accessibility	Action plans to improve accessibility and understanding of barriers to achieving this - this can be through A3 or other QI methodology	SH, LL, TK, SB	Services to collate and report on PCREF metrics disaggregated by ethnicity, with regular reporting to (EDI Programme Board?)
Increase access for service users to culturally appropriate advocacy services - PPI to look into	The PCREF team are currently unaware of any culturally appropriate advocacy services used in the trust	To work with the PPI team to identify potential services and engage	To work with the PPI team to identify potential services and engage		GS	
Develop framework for embedding Core 20+5 at the Trust	This has been reviewed and the elements are not aligned to a mental health trust	This framework is not going to be used	This framework is not going to be used		SH, TM	
Develop reporting structures to capture meaningful progress - 6 elements detailed below	None of the 6 identified elements are reported in relation to ethnicity or any other protected characteristics	Develop capacity to report on 6 elements identified as potentially influenced by ethinicity and expereince of health care	These elements will be incorporated into the Monthly IQPR and reported on quarterly	There is capacity to report various elements alongside ethnicity data, prior to PCREF this was not reported centrally.	SH	
Referrals as percentage	There is no current reporting	Develop reporting capacity	1. Report developed 2. Reports to be repeated for all teams quarterly for review 3. Value of reports to be discussed in PCREF group to agree ongoing reporting	1. Reports produced 2. Shared with TCL's and others involved in PCREF 3. Teams encouraged to develop local interventions to address any identified concerns	SH & BY	Reported on 24/25 Q4 & 25/25 Q1
Referrals- acccepted and rejected	There is no current reporting	Develop reporting capacity	Report developed	1. Reports produced 2. Shared with TCL's and others involved in PCREF 3. Teams encouraged to develop local interventions to address any identified concerns	SH & BY	Reported on 25/26 Q1

Complaints and Incidents	There is not current reporting of complaints and incidents by ethnicity	Develop reporting capacity	Quality Team to develop report to identify any relationship between ethnicity and complaints, incidents and restricitve practice	Meetings with Complaints team	EC & SH	report to iqpr in October 2025
DNA / CBP	There is not current reporting of DNA and CBP rates by ethnicity	Develop reporting capacity	Develop reporting capacity to understand the impact of ethnicity on DNA's and CBP. To report this to IQPR and to PCREF advisory group for consderation and action.	1. Meeting with Informatics completed 2. To report Q1 & Q2 in December IQPR	SH & BY	IQPR December 2025
ESQ	A report has been developed to illustrate the impact of treatment by ethnicity	Due to low numbers this data can be reported twice yearly		Meeting with Quality team To report to IQPR in November 2025	SP & SH	IQPR November 2025
OM	There is no current reporting	Develop reporting capacity				Tbc
Develop cultural competancy for all staff groups	Our workforce is not representative of communities we serve		Cultural Awareness Training Arrange one speaker per quarter to provide this competancy	Evaluate the program Design feedback mechanism through comms to gather after event impact	REN / RENAG TM	ongoing
Ensure that all trusts procedures have a meaningul EQIA - informed by appropriate published reseach	Inconsistent application of EIA in Trust policies and procedures. There is no clear evidenc-based research regarding impact on ethnicity and other characteristics.		Embed EDI to the Staff Appraisal process - ensuring all members of staff have an EDI objective.	New EQIA form requiring evidence base and due regard Monthly training session to reflect on the impact	LA	ongoing
Develop links with community groups - "Go where people are strategy"					All	

PCREF Competencies	PCREF Self-assessment checklist	Current Position	Gap Analysis	Actions	Measures	Owner	Timeline
Cultural awareness	Make sure you understand the diverse needs of the community you serve.	DET already collects, analyses and reports on student data relating to race equality at all stages of the student experience from admissions to graduation	DET has a national profile so its proportion of Global Majority applicants (34%) and enrolments (30%) is higher than the propoprtion of ethnic minorities in England (18%).	To identify which cultural groups are not choosing to apply to or enrol on T&P courses .	Student enrolments more reflective of regional populations	Director of Education (Learning and Teaching)	2025-6 AY
Cultural awareness	Co-design culturally appropriate services that reflect the needs of the community you serve.	Courses are not automatically co-designed at present but there are examples of short courses being co-produced by people with lived experience and some long courses such as M4 (Educational Psychology)	This will be a challenge to do for all courses particualry those already validated but could be a recommenation for revalidation	To build this into criteria for developing new courses	Criteria for new courses developed	Director of Education (Learning and Teaching)	Autumn term 2025
Cultural awareness	Collect and monitor evidence to assess cultural competence and embed improvements that is an anti-racism and anti-oppressive approach, including clinical practices and equality, diversity and inclusion practices across the Trust workforce.	DET offers a CPD course for its staff on working with EDI in education. The aim of the course is to increase awareness and confidence in discussing diversity, sameness and difference in the teaching & learning context and think about our own identity and how it impacts on our work.	The only evidence collected is which staff have undertaken this course	Ensure all staff complete the course as mandatory appraisal objective	Undertake audit across Faculty and extend to professional services	Director of Education (Learning and Teaching)	2025-6AY

2. Staff knowledge and awareness	Think about how your training standards, your policies and practices support staff to respond to the diverse needs of ethnic communities and make improvements where necessary.	DET has implemented training and support offered to increase staff knowledge and awareness of race inequalities as per above. Each Portfolio produces an annual EDI action plan which is informed by demographic data on student experience, course committee meetings, annual student survey and student support groups and identifies concerns and initiaitves to address these. A DT wide action plan is also produced and reviewed anually.	Some policies in need of review. Challenge is to ensure alignment across all portfolios and courses.	Extend staff EDI CPD to professional services. EIA could be undertaken on major DET policies and procedures	EIA on policies	CETO	25-26 AY
3. Partnership working	DET has actively built connections within their local communities which include ethnic led voluntary sector organisations, patients, carers and ethnically and culturally diverse communities.	Little evidence of this currently	This is a significant gap currently. Previously the Trust ran Thinking Space in Haringey which was a great example of community engagement	To work with wider Trust in identifying which community groups best to approach	TBC	TBC	TBC

4. Co-production	Co-production is ensuring ethnically, and culturally diverse students are treated as equal partners in decision making on their course and actively involved in the design, development and review of courses and DET services	DET has a Student Experience Committee which has student representatives. The Committee is responsible for overseeing the Student Engagement Strategy and Key Priorities, implementing and reviewing strategies for student experience, widening access and participation in line with the wider DET strategy. Student reps on each course could be better coordinated and fed into the	We are currrently undertaking an effectiveness review of the Student Experience Committee.	To implement actions arising from review	TBC	CETO	2025-6 AY
5. Workforce	A culturally competent and diverse workforce that has a positive impact on patient and carers from racialised and ethnically and culturally diverse communities; and creates a safe space where the workforce champions inclusive leadership, shares learning, intentionally embeds anti-racism approaches and tracks progress.	Trust submits the annual WRES/WDES report as required and show progress against the agreed indicators of workforce equality. DET away day looked at areas of disatisfaction from staff survey from a lens of race and soughtfeedback at staff away day on possible improvements in DET	Highlight areas from WRES specific to DET	To produce a DET specific action plan that addresses issues in WRES and Staff Survey	Improved metrics in WRES and Staff Survey	CETO	2025-6 AY

6. Co-learning	Co-learning is a two-way process that strengthens collaborative knowledge sharing beyond co-production principles and focuses on how Trusts can raise awareness of early intervention support amongst racialised and ethnically and culturally diverse communities and learn more about community concerns and barriers in return.	Students are engaged in validation, revalidation, course variation and professional accrediatation processes and an annual student survey gathers student feedback from which an action plan is developed. Termly course committees also take place to seek in time feedback from student representatives	DET does not routinely engage with ethnically and culturally diverse community groups and could do much more in this area	To develop a plan of community engagement building on the Trustwide initaitves in this area	To better understand the needs of specific communities and use this to design and develop relevant education and training	CETO	2025-6 AY

PCREF Workstreams

PCREF Development

- The PCREF implementation group is now very large.
- In order to deliver on our PCREF action plan the implementation group is going to break out into 5 workstreams.
- Culture
- Community
- Clinical
- Patient Experience
- DET
- Each workstream will have their own tracker.
- Workstream meetings will be held on the alternate month to the implementation group and the workstream lead will feedback into the main meeting.

Culture

Lead: Thanda Mhlanga
PT: Georgia Harvey
Develop cultural competency for all staff groups
Ensure Trust procedures have meaningful EQIA informed by research
Raise awareness of PCREF across the Trust
Staff survey inclusion scores
EQIA compliance audits
Awareness campaign reach
Advisory group effectiveness reviews

Community

Lead: Gary Sell
PT: Emily Bell
Develop links with community groups (“Go where people are” strategy)
Broaden partnerships with community representatives and create engagement spaces
Map VCSE health and wellbeing organisations (focus on global majority communities)
Strengthen relationships with local authority and VCSEs
Community Engagement Lead | - Number/diversity of community events
Representation in advisory forums
Uptake of services

Clinical

Lead: Sheva Habel
Lottie Laverty, Tim Kent and Steve Bamborough
PT:
Completion of team level self-assessments
Develop team level PCREF action plans
Access equity metrics in IQPR
Act on referrals %, accepted/rejected, complaints/incidents, DNA/CBP, ESQ, OM

Patient Experience

Patient Experience		
Lead: tbc		
PT: tbc		
Act on feedback (e.g., family hubs)		
Increase access to culturally appropriate advocacy services		
Reporting structures: referrals %, accepted/rejected, complaints/incidents, DNA/CBP, ESQ, OM		
Embed PCREF into patient safety work (complaints, restrictive practice, incidents)		
Patient Experience Officer / PPI Team | - Feedback response rates		
|	| - Advocacy uptake	
|	| - Reduction in disproportionality in complaints/incidents	
|	| - Dashboard metrics reviewed monthly	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: GIC Quality Improvement Work Update			**Agenda No.: 014**
Report Author and Job Title:	Shy Teli, Quality Improvement Lead	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1 - GIC Quality Improvement Update Slide – Data Pack Appendix 2 – QI for AGS Oct 25 dashboard guide		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	To provide the Trust Board with an update on recent progress and outcomes from the work undertaken by the GIC, supported by the National Quality Improvement (QI) Programme (Appendix 2). The operational and delivery review of NHS adult gender dysphoria clinics (GDCs) in England was published on 19th December 2025. The report summarised findings and recommendations following a review of the 9 commissioned NHS GDCs led by Dr Levy. The review surfaced findings around 4 key themes: • access • quality (including safety) • productivity • culture, leadership and governance The review panel set out 20 recommendations to improve patient care, calling for a wider response from national and local commissioning teams, gender dysphoria clinics, NHS Trusts, ICBs, primary care and other healthcare constituents. This joint approach will be driven by the proposed National Quality Improvement Programme for Adult Gender Services and a new National GDC Oversight Board. The CEO and CNO for TPFT met with Dr Levy and the national improvement director for GIC; each GDC will receive a report relating to their service and will be required to provide a response to NHSE.		
Background:	The GIC has engaged very effectively with the National QI Programme and has successfully translated national aims into four clearly defined areas of local focus.		
Assessment:	There is strong alignment in areas of focus between the clinic, the Trust, and the National QI Programme. Work is progressing at pace, with clearly defined milestones and target dates. The individual report to the London GIC is not expected to highlight concerns that have not already been addressed through the initial response and action plan dated 20th December 2024. Once the report is received by the Trust, it will go through factual accuracy and then a response provided to the final report. The CNO and CMO will work with NLFT colleagues to agree the future reporting and governance route post-merger by acquisition.		

Key recommendation(s):	The Board of Directors is asked to **REVIEW** and **NOTE** the proposed next steps across the identified areas of focus.				
Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 1: Inequality of access for patients BAF 2: Failure to provide consistent, high-quality care BAF 13: Failure to achieve required levels of performance and productivity				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	There are regulatory implications in this report which are being mitigated through the Quality Improvement work aligned to the aims of the national work following the National Review of Gender Services and provisional recommendations.				
Resource Implications:	Yes ☐	No ☒			
	The potential use of Ambient Voice Technology but otherwise all resources mentioned are already accounted for.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	Potential EDI implications around the patient portal – consideration has been given to patients who are digitally disadvantaged / digitally excluded. For these few, the clinic contacts them by phone and offers in-person appointments. There are potential EDI issues highlighted in this report regarding access to the service for local population in London and home counties.				
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:	GIC QI Huddle – 5th January 2026 ELT – 5th January 2026			
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

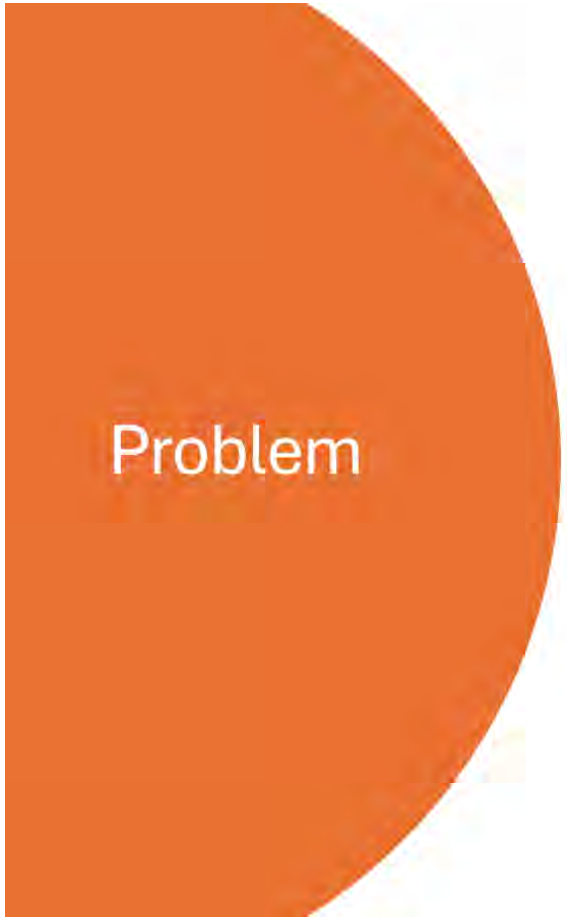
The Tavistock and Portman
NHS Foundation Trust

GIC Quality Improvement Work Update – Dec 2025

Four Main Areas of Focus

1. Increasing our activity, productivity and efficiency
   - Increasing the number of patients we see, increasing the number of patients we discharge, improving our patient flow
2. Patient portal integration
3. Reducing clinical admin time and burden
4. Increasing patient engagement

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

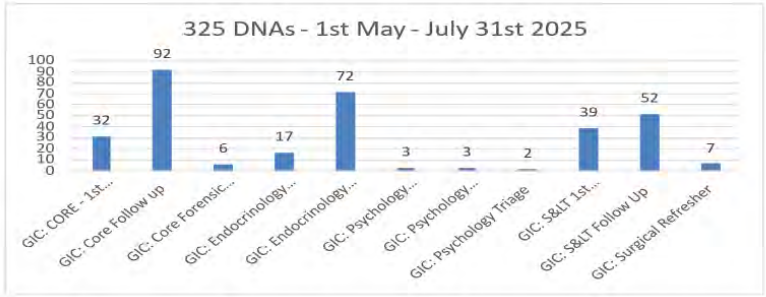


- Our patients are waiting an incredibly long time for an appointment
- **However, 1/8 of our capacity is currently lost to patient DNAs (patient Did Not Attend)**
- Financial cost + this also causes great frustration for:
  - Appointments staff who often must rebook the patient
  - Clinicians as the appointment slot was wasted and could have been better used

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

The Tavistock and Portman NHS Foundation Trust

Baseline data – DNA rate



- Average **20** patient DNAs a week between Sept 2024 and August 2025 for individual appointments

DNA Rate by Time of Day and Day of Week

Week Day	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
Monday	11.84%	12.09%	15.09%	21.00%	15.79%	13.33%		
Tuesday	10.10%	13.73%	16.13%	15.66%	16.13%	15.04%	7.14%	
Wednesday	13.59%	17.14%	10.31%	8.06%	12.05%	10.45%	4.00%	
Thursday	10.00%	15.24%	16.67%	15.71%	4.35%	16.47%	12.24%	16.67%
Friday	13.33%	11.43%	11.11%	24.14%	18.46%	16.36%	18.75%	6.67%
Total	11.66%	14.12%	14.31%	16.57%	13.07%	14.63%	9.56%	5.56%

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

The Tavistock and Portman NHS Foundation Trust

Target by when

- To reduce the DNA average to **7** patients per week by 31st Jan 2025.

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

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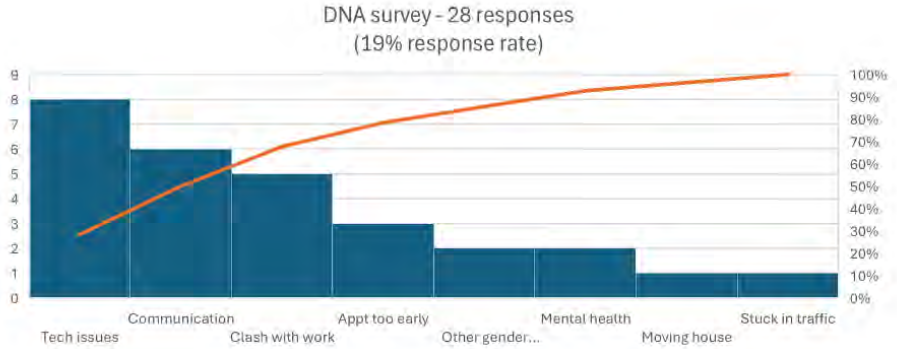
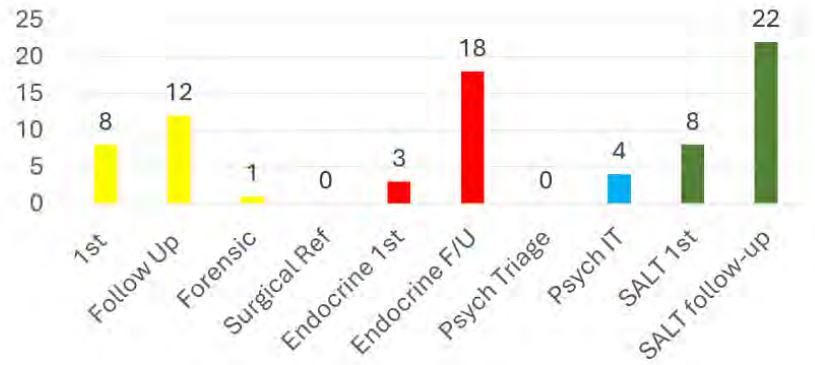
Understanding reasons why people DNA at the GIC



Last 5 weeks (10th Nov – 12th Dec)
76 DNAs by appointment type



1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

PDSA cycles – current (see previous at end of pack)

Date & Step	What do you expect & metric	What happened? (Study)	What we learned (Act)
11/11/25 - Text message reminders for rest of clinic changed from "mental health appointment" to "Endocrine," or "Psychology," or "Gender Assessment."	Due to previous change, expecting DNA reduction to 5.	All reminder messages changed to specify appointment type - Gender assessment, voice coaching, endocrinology and psychology.	100% of patients knew what appointment they were due to attend with slight increase in Psychology DNAs! One to monitor over next few weeks. Initial messages still cannot be changed due to NHS app.
01/12/25 - DNA data to be published on GIC website	To make community aware of DNA rates at the GIC. To publish last 12 months rate + last fortnight. Expecting DNA reduction to 5.	Most visited page of the Tavistock and Portman website but no feedback on the publishing of DNA rates as of yet…	No immediate / noticeable impact

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

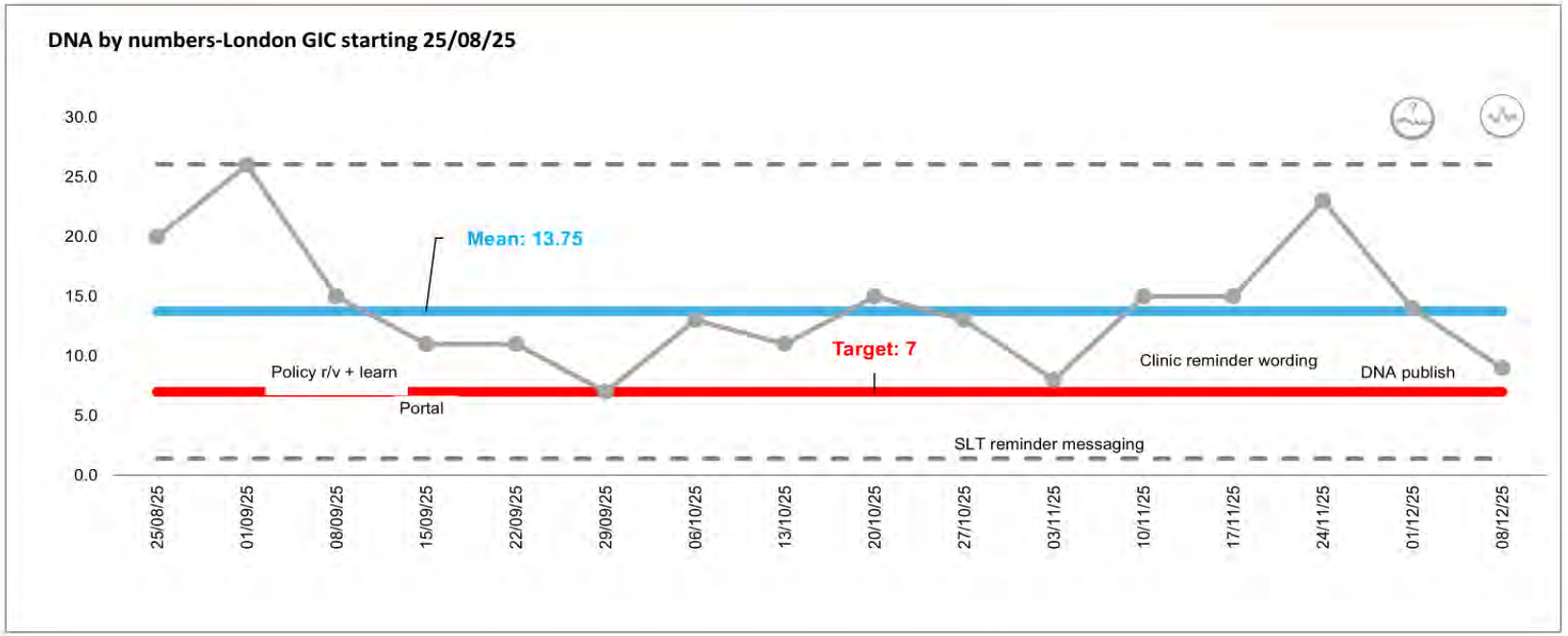
Current plan and next steps

- Let things continue as they are over the Christmas period + early Jan
- Targeted approach on Endocrine follow-up and SaLT follow-up appointments
  - Meetings arranged with Endocrine and SaLT staff w/c 5th Jan

1. Increasing our Activity by tackling DNAs (patient Did Not Attend)

The Tavistock and Portman NHS Foundation Trust

Current results up to 15th December



2. Patient Portal Integration

- Aim: Optimising the use of the patient portal to increase clinic efficiency, productivity and improve communication with patients (improve overall patient experience) by 28th Feb 2026.

- Key metrics:
  - Reduction in patient appointment cancellations
  - Reduction in admin appointment booking time
  - Reduction in specific communication complaints (2nd most common cause of GIC complaints)

2. Patient Portal Integration

- Most recent update:
  - Triage form piloted with 59 patients
  - 55 responses within 2-week period
  - Being sent to 90 patients w/c 5th Jan 2026

- Next steps:
  - To implement direct messaging feature

3. Reducing Clinical Admin Time and Burden

- Aim: To reduce clinical admin time by 50% by 31st March 2026.

- Key metrics:
  - 1 hour of clinical admin time for every 1 hour of patient appointment time
  - Target for patients to receive letter with 10-14 days of appointment
  - Variation in letters amongst clinicians

- Use of technology: Ambient voice technology use being discussed in the trust with potential plan to pilot in the GIC in 2026

3. Reducing Clinical Admin Time and Burden

- Most recent update:
  - Discussion held with clinicians and admin staff regarding what needs to be in a letter following an appointment
  - 3 changes initially made to letter template 22/12/2025, impact to be reviewed and discussed with team w/c 12/01/2026
    - Further changes to follow

- Next steps:
  - Engage with patients regarding what they want in a letter following an appointment
  - Engage with GPs regarding what they would want in a letter following an appointment

4. Increasing Patient Engagement

- Aim: To increase our Experience of Survey Questionnaire (ESQ) response rate and Patient and Public Involvement (PPI) group attendance to inform clinical improvement routines by 31st March 2026.

- Key Metrics:
  - PPI group attendance + actions
  - ESQ response rate

4. Increasing Patient Engagement

- Most recent update:
  - Stopped coffee mornings
  - Engagement with other GIC PPI leads to understand what they are offering

- Next Steps:
  - Development of specific task focused PPI groups rather than a general PPI group
  - ESQ sent automatically to patient via the portal following an appointment

National Qi programme for AGS -Oct 25 dashboard guide

- Support recommendations of Dr Levy's review
- Improve the patient experience and waiting times
- Reduce clinical risk
- Support improvement in productivity across the pathway
- Create a standardised system approach to variation in delivery and reporting
- Develop network capability

Purpose of shared dashboard

Aims

- One version of system performance and variation
- Build a shared understanding of local and system opportunity
- Understand where variance / different practice in drivers of key aspects exists
- Promote application of system best known ways and convergence on system design

Contents

- Will contain High level data on provider and systems metrics
- Also contain local status on key driver aspects of service delivery

Proposed Circulation

Provider Exec leads, clinical leads and service managers – for all providers; regional commissioners; Programme Board, Chair of Provider Network

Caveats/cautions

- We are not trying to create a performance dashboard but are trying to show providers the measured variance and opportunity to serve patients and staff better.
- We do understand that currently there is quite a range in delivery models which may also drive the data, the Provider Improvement network will be looking into pathways of care as part of its remit.

System key metrics headlines – October 2025

System monthly referrals at 897 in Oct exceeded monthly 1st's (381 attended) by **516**.

System range of date for first appointment range , waiters from Jun17 to Mar 23 depending on clinic.

System Median waits between 1st and 2nd appointments, range from 4 weeks to 73 weeks

Booking efficiency- remains challenging but variable , range of **6% to 37% of non attended appointments (DNA and cancellations)**.

System productivity increased to 30.80.8 appointments/per clinical

Variation in impact of appointment (number of core assessments / discharges- closures) from **0.8 appts to 10 appts per closure**. (balancing measure to productivity above)

Total waiting list for 1st Assessment rose to **43769** people. (and caseload of 22214)

Next update we will try to provide key system metric graphs

Notes to Part 1

Reminder that all data used , is from submitted GD3 templates

- Referrals and waiting list variance, has been impacted by the only e-RS listed provider being T&P, this is intended to be corrected before national waiting list implementation.
- Percentage not attended is = NA/(NA + attended) as a %.
- Clinical productivity would be happy to exclude LTS and Maternity leave- to reflect reality of delivery. This may not be reflected appropriately for August data
- We are seeking a meaningful balancing measure looking at effectiveness of appointments - using core assessments per closure .
- Data recording/accuracy is still being reviewed in some providers

Happy to receive feedback

National Qi programme for AGS monthly dashboard phase 2

issued 12/12/25

Part 1 - All data - taken from GD3 submission for October

	row ref	Month October 2025	Newc	L&Y	Sheff	no QIP Indigo	no QIP Transcend	Notts	North	T&P	no QIP Trans+	Devon	Pilots Eof E	Pilots Sussex	total/ ave	units	Notes
Waiting and waits	A	Total number waiting 1st	2713	6990	2284	1254	454	4294	2205	16861	1019	5517	4	174	**43769**	people	Clear aim to reduce variance in gap between 1st to 2nd appointments.
	B	currently offering 1st to	Nov-18	Jul-19	Jun-20	Jan-24	Jan-24	Mar-23	Dec-19	Jun-20	Nov-20	Jun-17		Dec-22		month/yr	
	C	median wait 1st to 2nd	12.9	8.5	73.1	12.5	18	70	29.9	18.00	4	6	11	7		ave weeks	
	D	total on caseload	997	1698	1271	1668	875	4830	1397	5606	1790	574	823	685	**22214**	people	
Flow and Utilisation	E	monthly accepted referrals	65	142	0	78	25	117	42	333	32	63	0	0	**897**	people	Clear aim to increase flow and system balance of capacity. Reduce variation in 'not attended'. Not attended is DNA and all cancellations.
	F	cases closed (excludes tx out)	23	21	53	16	14	94	10	97	15	17	21	0	**381**	number	
	G	new 1st's attended	20	19	28	55	33	35	4	77	60	18	20	30	**399**	people	
	H	all other ax's attended	47	15	7	53	37	39	4	1	43	153	27	28	**454**	people	
	I	all appointments attended	383	426	195	218	616	657	166	513	875	338	243	249	**4879**	number	
	J	not attended (all reasons)	223	235	89	13	313		39	177	296	67		72	**1524**	number	
	K	percentage not attended	37%	36%	31%	6%	34%		19%	26%	25%	17%		22%	**21%**	calc	
Productivity and balancing measure	L	clinical productivity Appts/wte	**22.16**	**25.42**	**16.96**	**51.90**	**55.50**	**33.35**	**22.34**	**23.75**	**47.30**	**18.47**		**25.94**	**30.8**	appt/wte	Aiming to increase productivity and awareness for effectiveness of appt.
	M	Ax's per closure	2.91	1.62	0.66	6.75	5.00	0.79	0.80	0.80	6.87	10.06			**2.24**	Ax/closure	
Establishment	O	WTE (adjusted for LTS and Mat)	17.28	16.76	11.50	4.20	11.10	19.70	7.43	21.60	18.50	18.30	2.20	9.60	**158.17**	staff	
	P	vacancies	0.00	1.20	1.20	0.00	2.10	1.40	2.00	0.00	0.00	6.00	1.60	0.00	**15.5**	wte gap	

checking with provider missing data

Dashboard – Part 2 – Qualitative status of drivers- guide

- Have established key drivers towards Qi goals- they have been self assessed by providers and used simple framework below to highlight status

Guide to status	access to on line support/ links	admin use of tech and BKW's	numerated job plans	model monthly appoints	Estimated Capacity gap	Patient centred booking	Using PIFU for follow up	active patient survey	Prior diagnosis pathway	reducing delay to hormone
set as 'none' if	hard copy	minimal tech	no clear expectations	not yet due	not yet due	no active patient involvement in booking	none	not engaged with data	not used or reworked	being redefined
set as developing if..	web offer	examples of Ai and letter standardised	written weekly summary			sms/ check before book	defined group application	uses F&F plus other surveys	adhoc acceptance via mdt	being redefined
set as advanced if,,	interactive web offer	using Ai/EPR automation and letter standardised	reviewed and monitored			patient books via portal	clear groups used for high proportion patients	regular patient views sought	clear formal pathway with good feedback	prescribe
the Qi aim	providing awareness of supprot offers	Reduce clinical admin time to provide more value	System equity of access and VFM	Development of regional and system capacity ability to match referrals with balanced capacity,		Minimise DNA and rebooking waste	Appropriate use of patient choice on FU	keeps impact of what people value clear	improves access/ reduces waits for patients	improves key barrier for patients

Part 2 - Qi drivers collected via provider self assessment

Significant activity at most providers on job planning and expectation and on capacity planning; plus use of patient portal for booking.

Qi programme will seek input from Indigo, Transcend and Trans+ on future returns.

National Qi programme for AGS monthly dashboard phase 2

Part 2 - Qi drivers collected via provider self assessment — Oct-25

Collected at each GDC with Qip and discussed prior to monthly submission

At Sept 15th 2025	Newc	L&Y	Sheff	Indigo	Transcend	Notts	North	T&P	Trans+	Devon
access to on line support/ links	Advanced	Advanced	Developing	not requested	not requested	Advanced	Developing	Developing	not requested	Developing
admin use of tech and BKW's	Developing	Developing+	Developing		Advanced	Advanced	Developing	Developing	Developing	Developing
numerated job plans	Developing	Developing	Advanced			Advanced	Developing	Advanced	Advanced	Developing
model monthly appoints	Under development - draft balanced capacity tool being tested by QIP's									
Estimated Capacity gap	For use once capacity tool validated									
Patient centred booking	Developing	Developing	None			None	None	Developing	Advanced	None
Using PIFU for follow up	Developing	Advanced	None			None	None	Developing	None	Developing
active patient survey	Advanced	Advanced	Advanced			None	None	Developing	Developing	Developing
Prior diagnosis pathway	Advanced	Advanced	None			None	None	Advanced	Advanced	Advanced
Reducing delay to hormones	being redefined	being redefined	being redefined	being redefined	prescribe	being redefined	being redefined	being redefined	prescribe	being redefined
		Self-assessment by providers - their assessment								

Timetable and queries

- Aim to issue within one week of data returns, but a little catch up to do
- Each provider will have agreed status of qualitative return locally
- Establish feedback on draft – then go into monthly process
- Eg next issue will be Nov data issued early January
- Will be compiled by National Qi team from GD3 returns and self assessment

- Feedback to Richard Best please.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday 15 January 2025			
Report Title: Quality and Safety Report December 2025			**Agenda No.: 015**
Report Author and Job Title:	Emma Casey, Associate Director of Quality Nimisha Deakin, Associate Director of Nursing & Patient Experience Lucy Hegarty, Patient Safety Manager Sonia Perez, Quality Assurance Manager Fay Shorter, Complaints & Enquiries Manager	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	In line with the Trust's Quality Framework, there is a need to refocus and strengthen the way in which we report and assure the quality and safety of our services, with specific focus on learning from patient safety incidents and service user experience.		
Background:	This Quality & Safety report expands on the information in the Integrated Quality and Performance Report (IQPR) and includes detail against the agreed set of quality and safety metrics. The report is informed by the data within the Integrated Quality & Performance Report (IQPR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics. This report is in line with timeframe of the IQPR data also reported to the Committee.		
Assessment:	This report was presented to the Quality & Safety Committee at its meeting of Thursday 18th December 2025. The Committee was asked to note and discuss the data for this reporting period (September and October 2025). This report also includes a summary to date of progress against the Trust's Quality Priorities for 2025/26 (Appendix A). The review of themes reported and how improvements to services are made in response is an emerging piece of work and will continue.		
Key recommendation(s):	The Board of Directors is asked to **NOTE** and **DISCUSS** the report.		
Implications:			
Strategic Ambitions:			

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

	local, regional, national & international provider of training & education	health and building on our reputation for innovation and research in this area	with a focus on equality, diversity and inclusion	environmental sustainability

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust will be held to regulatory account if it does not report its quality and safety data in a robust, transparent and accountable way.				
Resource Implications:	Yes ☐	No ☒			
	None				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Some of the metrics are now being reported by protected characteristic, where appropriate, to review and ensure that quality, safety and experience of care does differ between reporting group. This has been guided by the PCREF workstream and was first received in IQPR meeting for Month 6.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	This report has been presented to the Quality & Safety Committee since March 2024 (the first iteration of this report format).				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Quality and Safety Report – December 2025

1. Background

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

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

This report also includes a summary to date of progress against the Trust's Quality Priorities for 2025/26 (Appendix A).

2. Clinical & Patient Safety Incidents

The tables below present clinical and patient safety incident data recorded during September and October 2025, accompanied by separate graphs illustrating the levels of harm associated with these incidents. Statistical Process Control (SPC) charts are also included for selected metrics to highlight emerging trends and potential areas of concern.

September 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Incidents – Patient Safety incidents	25	2	19	4
Incidents – Open PSII	2	0	0	2
Incidents – Falls with harm	0	0	0	0
Incidents – Violence & Aggression	20	2	18	0
Incidents – Restraint/ Hold	14	0	14	0
Incidents - Number of all deaths	1	0	0	1
After Action Reviews Requested	1	0	0	1

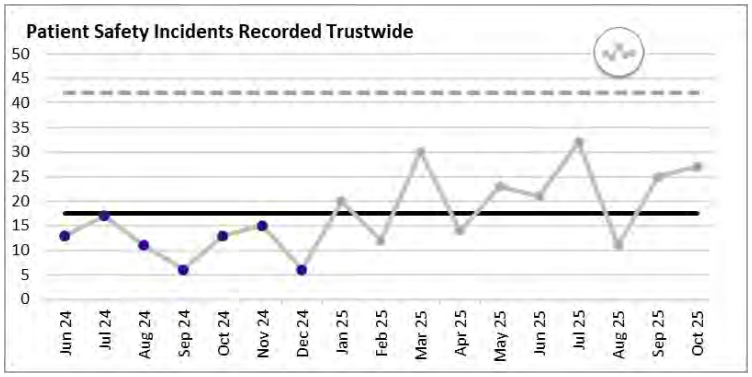
October 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit	Other
Incidents – Patient Safety incidents	27	6	19	1	1
Incidents – Open PSII	2	0	0	2	0
Incidents – Falls with harm	1	0	0	0	1
Incidents – Violence & Aggression	21	2	18	0	1
Incidents – Restraint/ Hold	15	0	15	0	0
Incidents - Number of all deaths	1	0	0	1	0
After Action Reviews Requested	1	0	1	0	0

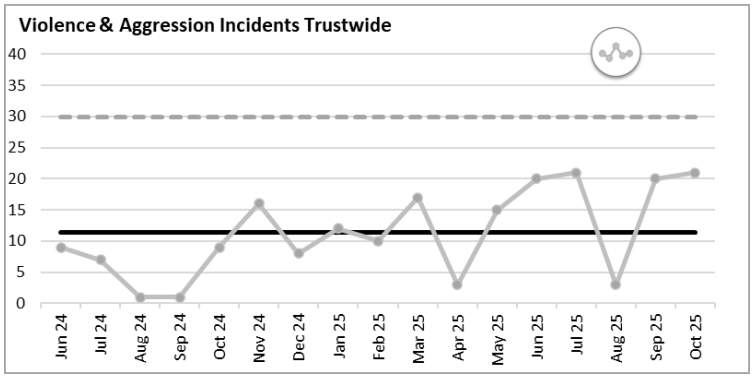
SPC analysis indicates that overall level of patient safety incidents reported for September and October remained within the expected range of variation.

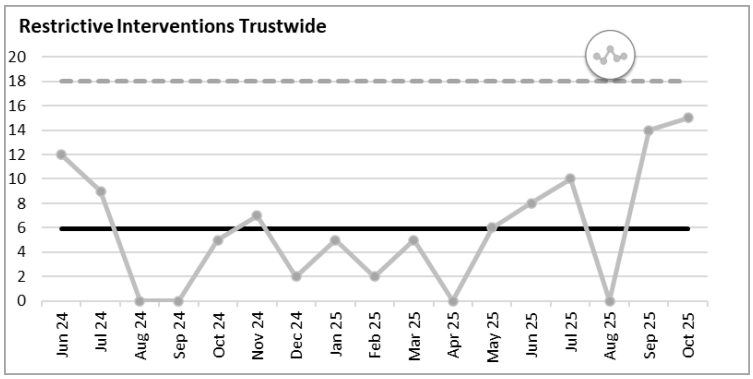
Following Gloucester House's return from the summer break, recorded incidents of violence and aggression (V&A) have been consistent with pre-summer trends. However, there has been a continued rise in the use of restrictive practices, with October representing the highest reporting point to date. This increase has been escalated to the Unit Clinical Lead and discussed at both the Executive Safety Huddle (ESH) and the Clinical Incident and Safety Group (CISG). While further work is under way to understand the underlying causes, assurance has been provided regarding the support offered to staff experiencing challenging behaviour from pupils.

The patient safety team continues to meet weekly with Gloucester House to better understand escalation in behaviours and review preventative actions. Gloucester House has reported that the apparent increase in behavioural incidents may be linked to the recent changes to those on roll call, and the impact of this on both new and existing pupils. In addition, consideration has been given to staff levels and the anticipated move of the school contributing to heightened anxiety and apprehension among pupils, resulting in a destabilising effect on the school environment. Work is underway with the Clinical and Service Lead to confirm, understand and explore these factors further.

Updates on these issues have been shared with ESH and CISG, with further updates in relation to this work and progress to be reported. The patient safety team will work the Quality Improvement (QI) team and Gloucester House to strengthen and refine processes for understanding and addressing incidents more effectively and, importantly, capturing improvements that have already been implemented internally at Gloucester House to ensure progress and effectiveness can be monitored to determine effectiveness.

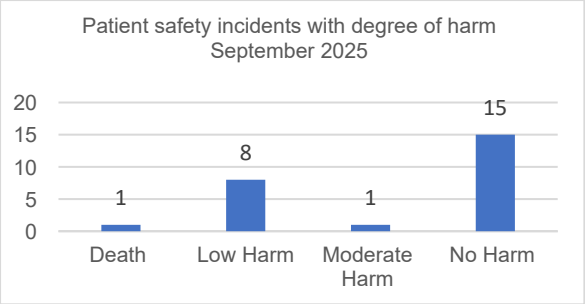


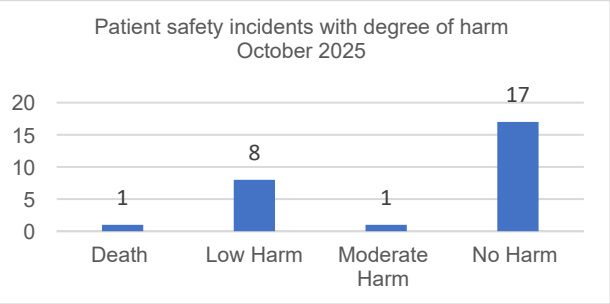




The charts below illustrate incidents by level of harm, as reported by those logging the incidents on Radar. In both September and October 2025, the majority of incidents were

categorised as ‘no harm’ or ‘low harm’, with one death reported in both September and October. For the deaths recorded, mortality reviews will be conducted as in line with current processes.





Learning from Incidents: *Highlighted key learning points from patient safety learning review responses conducted throughout September and October.*

- **After Action Review (AAR): INC-543**: A subject access request (SAR) was submitted and notes were subsequently provided to the patient. However, these notes contained information relating to other group members. **Key Learning:**
    - The importance of providing reflective space or supervision for staff in non-clinical roles when they encounter clinical data.
    - The need for clear processes and expectations when reviewing and recommending redactions in a SAR.
    - Strengthening integration between the SARs process and clinical teams to support effective decision-making.
    - Greater clarity required regarding the procedure for recording group notes.
    - A review of how group risk is documented in Carenotes for group sessions.
    - Establishing a process for SAR requests that enables patients to review notes with their clinician for support, ensuring this option is available within the legal timeframe.

Outstanding AARs due for completion will be presented and learning points discussed at the next Clinical Incident and Safety Group meeting in December. All learning from learning review responses will be disseminated via Unit Clinical Governance meetings to ensure shared learning and service improvement.

Patient Safety Incident Investigation (PSII): A thematic issue was identified following the reporting of several complaints and two incidents, relating to Gender Identity Clinic (GIC) surgical referrals that had not been processed as expected to the Gender Dysphoria National Referral Support Service (GDNRSS). In response, the Trust decided to review all referrals that should have been submitted by the GIC and commissioned a PSII to examine and explore potential issues within the surgical referrals process, recognising that additional referrals may also not have been submitted as intended. In addition, a separate process has been established outside the scope of the PSII, comprising a dedicated working group that has undertaken a clinical data review of all assessments involving surgical correspondence from April 2020. This group has been tasked with further examining the extent and nature of the issue, including the number of patients affected, and is operating in parallel with the PSII. The draft report was finalised and submitted during October 2025 and will be reviewed by the Clinical Incident & Safety Group in November. Following this, the report will be submitted to the Trust Board for approval in December 2025.

The learning and action points identified through the PSII will be monitored via the Adult Unit Clinical Governance meeting, with regular updates provided to CISG as assurance until all learning has been fully evidenced.

3. Complaints & PALS

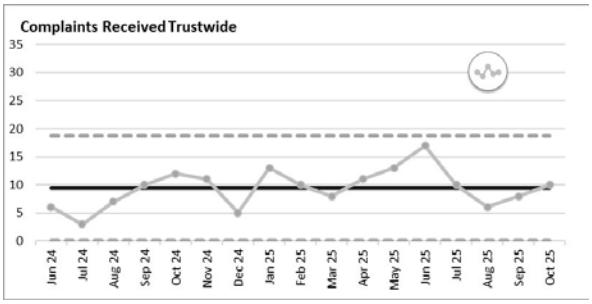
A total of 8 and 10 complaint contacts were received during in September and October 2025 respectively.

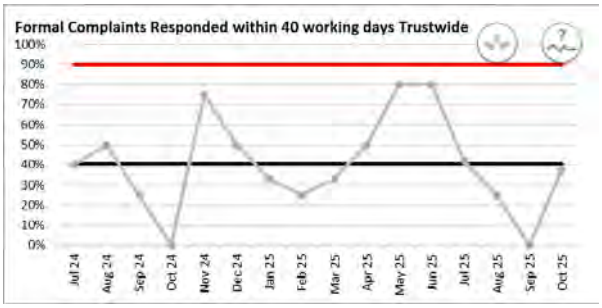
September 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Complaint contacts - Number received	8	0	1	7
Complaint contacts - Number acknowledged within 3 days	8	0	1	7
Formal complaints - Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	0% *0% of complaints closed were within 40 days*	0	0	0%
Investigations by PHSO	1	0	0	1
Informal complaints	3	0	0	3
Number of open complaints	15	0	1	14
Number of overdue complaints	5	0	0	5

October 2025	Trustwide	Camden Unit	CYP & Family Unit	Adult Unit
Complaint contacts - Number received	10	1	2	7
Complaint contacts - Number acknowledged within 3 days	9	1	2	6
Formal complaints - Compliance against response time of 40 days *(% of complaints closed in month that were completed within 40 days)*	37.5% *3 of the 8 complaints closed were within 40 days*	0	0	37.5%
Investigations by PHSO	0	0	0	0
Informal complaints	7	1	1	5
Number of open complaints	9	0	2	7
Number of overdue complaints	2	0	0	2

The Trust reported a compliance rate of 0% of formal complaints responded to within the 40-day timeframe in September. In October, 3 complaints closed were responded to in time: a compliance rate of 37.5%. This remains below the Trust target of 90% and continues to fluctuate month on month. As of the end of October 2025, the number of open complaints decreased to 9 in addition to overdue complaints at 2.

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





The main themes for complaints in September and October 2025 are outlined below:

- Communications - This included a range of complaints across Units e.g. not updating the patient regarding treatment outcomes, conflicting or incorrect information with regards to surgical hub referrals and a communication error with regards to a scheduled appointment.
- Access to Treatment or Drugs - including dissatisfaction with the type of treatment recommended and changes to prescription, surgical hub referrals and requests for further treatment sessions.
- Patient Care - including delay in shared care agreement and a complaint related to therapeutic approach of the clinician.
- Privacy/Dignity/Wellbeing – including group therapy sessions and confidentiality of communication with primary care.

The Complaints team will refocus the quality improvement project to identify further improvements that can be made to the complaints process including how common learning outcomes and themes from complaints can be used to improve service delivery. To date, focus has been on training staff on complaints management and investigation however there are evident steps in the overall process that need to be addressed.

The table below references some of the recent learning outcomes from complaints closed. For some of these, the actions are overdue, and further assurance will continue to be sought through the Clinical Governance meetings. The complaints team are now able to support and focus Unit Governance meetings with data relating to complaint action plans that are overdue.

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

Theme	Learning taken forward	Timeline
Communication with Patients	Patient's discomfort addressing aspects of their care with clinicians. The investigation recommended a further meeting/call with patient for them to be more supported with their care.	Q2, 25/26
Discriminatory behaviour and psychological safety in therapy groups	The investigation recommended: 1. Updated training re: equalities and safeguarding guidance and legislation. 2. Work with director to establish responsibilities under Equalities Act 3. Updated complaints training for Team 4. Review of how group therapies is described in literature	Q3, 25/26

PALS*:*

9 PALS enquiries were received in the months of September and October 2025 each.

	Trustwide *External are related to those not known to services*	Camden Unit	CYP & Family Unit	Adult Unit
September 2025	Internal (Queries for other Trust areas) = 6 Total = 9	0	0	3
October 2025	Internal (Queries for other Trust areas) = 2 Total = 9	0	0	7

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

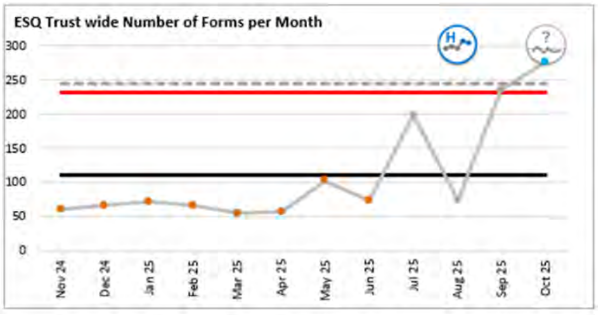
- Appointments (availability/waiting times)
- Concerns with treatment
- Communication issues (clinical administration, referral queries, delays in receiving letters, appointment changes, endocrine enquiries)
- Access to treatment or drugs – (how to access services and what is available e.g. types of therapy offered, wait times and referrals process, whether referrals have been received and discharge enquiries).
- Trust/Admin/Policies – query in relation to a travelling expense claim
- Prescribing

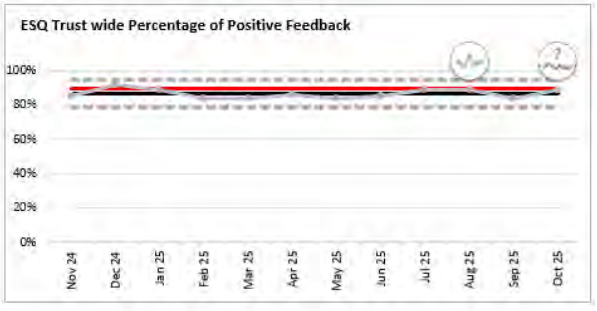
Enquirers range from patients/service users themselves, to parents, partners, carers, siblings, family friends and professionals seeking information about our services.

4. ESQ Feedback

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

The charts below represent a Trust wide view of the number of responses received across the last twelve months, and the positive response rate received from those responses.



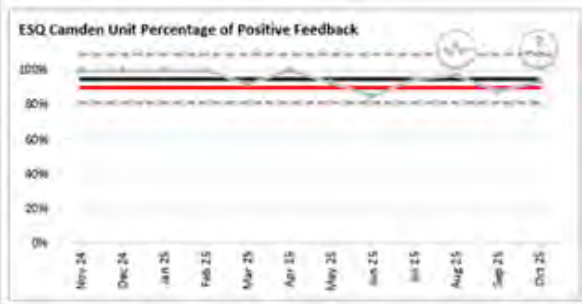


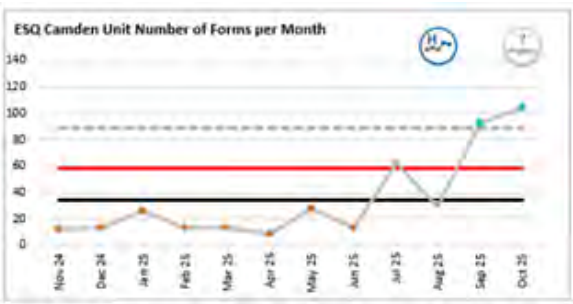
There was a positive improvement in the number of forms received in September and the target was exceeded in October. This is likely to be linked to the introduction of text messaging to request feedback as well as increased engagement at team level.

The Trust-wide target 90% for ESQ positive responses was achieved in October 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 and waiting times featured most regularly.

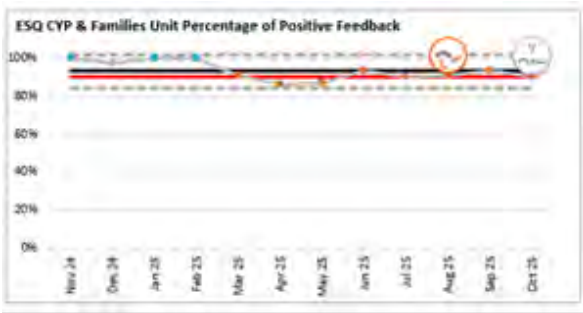
Unit level data
The charts below show unit view of the number of responses received across the last twelve months, and the positive response rate received from those responses.

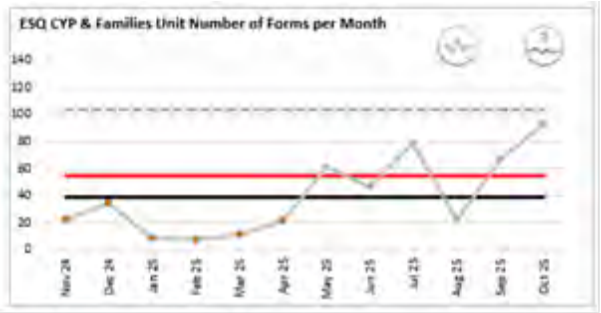
Camden Unit



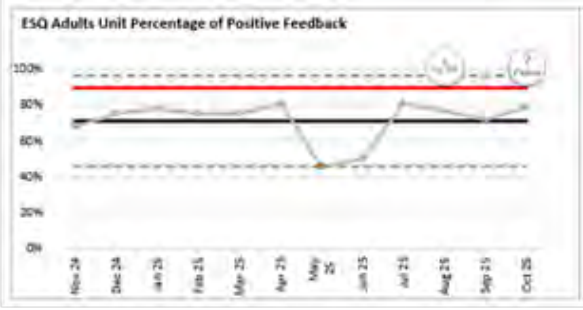


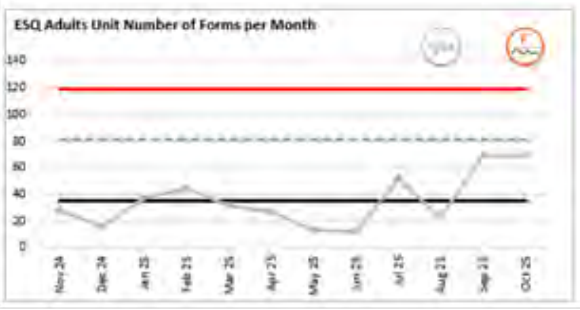
CYP & Families Unit





Adult Unit



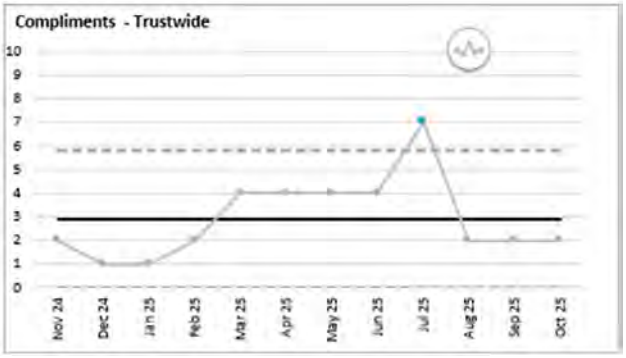


As can be seen from the data, the Adult Unit has the fewest forms and the number of positive responses are below the target of 90%. There are plans in place for improving on the number of forms collected through the use of DrDoctor platform. It is anticipated that there will be a significant improvement as a result of this. The teams are also reviewing data and will be identifying quality improvements to improve patient experience.

The new dashboard function has been launched which allows teams greater access to all ESQ data and the ability to review the qualitative feedback. However due to issues with the data flow between Radar into the Trust data warehouse system, the dashboard has been unavailable to staff for the past month. The Quality Assurance team have been able to support through manual collating of the data in the interim.

Radar Compliments
Compliments are categorised using the KO41a system (to match complaint categories) to enable comparison with themes between ESQs and complaints. This will enable a strengthened reporting framework as all compliments received will be categorised. 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. However, for the time being, the ESQ form will remain the main source of gathering compliments and examples of positive feedback.

2 compliments were recorded in Radar in October 2025; 1 by the Children and Families Unit categorised as patient care, and one by the Adult Unit categorised as values and behaviours.



5. Protected Characteristics

In line with the Trust's Patient Carer Race Equality Framework (PCREF) program of work, there has been an initial piece of work to report complaints and incidents data by specific protected characteristics. This is an ongoing piece of work and will continue to develop; both in how the data is reported and how it is assessed and analysed and shared with the clinical teams.

The complaint data in the initial draft is difficult to draw conclusions or assurances from as the majority of the patient data has not been captured on the complaint record on the Radar system. This is understood to be for one of the reasons below;

- Ethnicity not recorded on RADAR, Ethnicity not available on Carenotes (either on the patients profile or on a referral form)
- Ethnicity not recorded on RADAR, Ethnicity not recorded on Carenotes, but is available on the patients referral documentation
- Ethnicity not recorded on RADAR but Ethnicity is recorded on Carenotes (on the patients profile)

This data will be discussed further with the corporate Complaints team and the clinical services to improve the way in which ethnicity is recorded. This will help to analyse and understand where there are any potential differences in experience associated to these reported protected characteristics.

For patient safety incidents, violence & aggression incidents, and those involving restrictive practice, the data is being further refined to analyse any further areas of focus. As an example, incidents with restrictive practice are only reported by the Gloucester House team. Whilst white British appears to be the largest number of patients involved in restrictive practice, this correlates to the representation proportion of that ethnicity at the school.

6. Conclusion

The Committee is asked to note and discuss the data for September and October 2025.

Appendix A

Quality Priorities 2025/26

Quarterly Update Table

NHS
The Tavistock and Portman
NHS Foundation Trust

		Quarter 1 Updates	Quarter 2 Updates	Quarter 3 Updates	Quarter 4 Updates
Patient Safety	Develop processes to involve service users in After Action Reviews	Preliminary scoping meetings have taken place, and a proposal is currently being prepared that will outline best practice and provide examples of engagement processes.	The Patient Safety team have engaged with PSPs to explore the most effective approaches to engagement, with particular focus on communication. Considerations and discussions have taken place to identify the most appropriate teams and services in which to pilot service user involvement. In addition, a Quality Improvement initiative, structured as an A3 project, has been launched to examine the timeliness of AARs. This work will further define the timeframes for subsequent steps to align with the AAR SOP.		
	RAG Status				
Clinical Effectiveness	Implementation of PCREF (Patient & Carer Race Equality Framework) – Year 2		The PCREF implementation group is meeting on a bimonthly basis. Preparation for the data reporting is underway with the intention of reporting in Q3 and Q4. This Quarters IQPR reported on accepted and rejected referrals within teams by Ethnicity. Planning for Black History month with speakers commissioned under PCREF. DET have presented their action plan to the implementation group.		
	RAG Status				
Patient Experience	Review & Refresh Trustwide Service User Forum	Discussion on review of this forum began at last forum. We are working on ensuring other forums are feeding into TWF.	Service User Forums/Panels now have a dedicated slot in TWF to share their feedback.		
	RAG Status				
	Develop Innovative Ways of Collecting Feedback from Children & Young People	Touch Screen device for engaging young people to give feedback has been accessed. Stickers are being trailed as a way to further encourage children to feedback. Young people's forum for our CAMHS service is beginning with a view to widening membership once established.	PPI currently conducting a QI project to co-produce an interactive ESQ Scrapbook, using coloured crayon to signify ESQ question responses. A focus group is being planned to review this before it is implemented.		
	RAG Status				

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: Higher Education Sector Risks			**Agenda No.: 017**
Report Author and Job Title:	Mark Freestone, CETO	**Lead Executive Director:**	Mark Freestone, CETO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	As a provider of Higher Education, the Trust received a letter from the Chair of the Office for Students, Professor Edward Peck, on 5th November 2025 outlining the emerging sector risks to Higher Education provision in the UK. The Board has requested a report on this paper.		
Background:	UK Higher Education provision currently faces a number of significant financial challenges after decades of continuous growth. In his letter of November 5, 2025, Professor Edward Peck, Chair of the Office for Students (OfS), issued a stark warning to UK higher education providers regarding sector-wide financial instability. The summary of his key directives includes: • Financial Realism: He cautioned boards against "over-optimistic" student recruitment forecasts, urging more prudent planning as nearly half the sector faced potential deficits. • Strategic Oversight: Peck emphasized that cost-cutting measures must not compromise essential governance, internal audits, or risk management. • Franchise Risks: He flagged increasing concerns regarding the oversight and financial dependency on third-party subcontracting arrangements. • Freedom of Speech: Re-iterated the need for Providers to be compliant with the OfS Freedom of Speech directives. • Regulator Shift: The letter signalled a pivot to a "critical friend" model—defined as "Ambitious, Collaborative, Vigilant, and Vocal"—which includes the creation of a new Provider Panel to improve dialogue between the OfS and providers. The letter calls on Directors to exercise rigorous "vigilance" during a period of unprecedented economic constraint.		
Assessment:	The Board discussed these risks and its response in detail at the Board Seminar on 20th November, 2025. This paper is presented to permit a minuted record of that discussion.		
Key recommendation(s):	The Trust Board, and the merged Board following a successful potential merger with NLFT, should be aware of the increasing emphasis placed on Board-level oversight of Higher Education functions by the OfS. • The Trust should bring itself into compliance with the OfS requirements for a Code of Practice on Freedom of Speech as soon as practicable.		

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 3: Risk of loss of registration with the OfS BAF 4: Potential contraction of student recruitment BAF 16: Non-viability of DET in its current form				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	OfS registration is contingent upon an organisation being able to demonstrate financial sustainability enabling it to maintain its commitment to students.				
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	None				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

OfS Chairs' Briefing

November 2025

Financial Pressures

- Rising costs, increasingly in response to OfS requirements (+£1200k since 2023).
- Potentially a 6% levy on overseas students – could reduce overseas numbers by up to 14,000 per year.
- Small providers really feeling this (IHE).
- TPFT is rowing against the tide on student numbers, with a rise of 12.4% in students for 25/26.
- Considering value for money from our OfS regulation due to the burden vs. return on investment.

Significant Change Programmes

- Merger has been very helpful in “shaking the tree” and showing where assurance around governance is lacking.
- Provides an opportunity to “onboard a new Board” at the same time as the OfS conditions place more emphasis on board leadership.
- Although this is a Board with very little prior experience of HE.
- As an Approved (post-grad only) provider we have a stay of execution on LLE but need to prepare this year for Jan 2027 (?)

3rd party and Off campus

- Tavistock has a significant amount of off-campus delivery through associate centres (Milan, Belfast, Leeds, Birmingham) and online teaching (ED10, ED24).
- These are formally part of the Trust and do not pose governance risks.
- As smaller providers close (e.g. LYPT) we are being asked to absorb programmes because of this expertise.
- However, this brings additional risk, particularly through “arms-length” 3rd parties providing placements.

Misuse of Public Funds

- Tightening of regulations has led to the potential loss of £500k pa in Research England funding although we may still be eligible.
- We are happy our admissions processes are robust.
- Note the requirement for increased Board/CEO/CFO input in new Conditions of Registration

Freedom of Speech

- We need a clear Code of Practice for FoS at the Trust.
- We received guidance from the University of Essex to all Partners on 28th October
- Code of Practice approved by the Education and Training Committee at its January meeting, presented to the Board for approval

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS
Thursday 15 January, 2026

Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	8th January, 2026	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	Appendix 1: Code of Practice on Freedom of Speech		**Agenda Item: 018**		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Merger Update 1.1. There has been little direct progress on the merger since the previous update as NHSE have not yet reached agreement on a financial envelope to NLFT around the merger that will support the merged Trust. 1.2. Extensive due diligence work is progressing, but pre-day 1 integration work has paused as measures cannot be agreed without joint Board approval. 1.3. There are some potential ramifications for this delay on the registration of the new, merged Trust with the Office for Students, who have been accommodating of the complexities of the process but have set deadlines for the sharing of financial information from NLFT in January to evidence Condition D of registration. If these are not met, there is a risk of a significant delay to the registration of the new Trust with the OfS. This risk has been raised with NLFT's Executive, but there are few potential mitigations available if OfS are unable to change their timelines beyond a 'holding registration' which would permit the onward use of TPFT's registration for up to 28 days. 1.4. As a result of this, the Committee is recommending a revision to BAF risk 3 (Continued Registration with the OfS) that reflects the Merger Programme Board's narrative as the Tavistock and Portman's registration with the OfS is no longer a material risk	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Success Stories 2.1. With the exception of the financial information speaking to condition D of registration, OfS have assessed the majority of the remaining criteria for the Conditions of Registration and made only minor requests for	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

changes, two relating to the Code of Practice for Freedom of Speech that was presented to the Committee for Approval as a separate paper. 2.2. The CETO was very pleased to see that the Trust's relationship with the University of East London (UEL) is improving after a difficult period following the move of primary validating partner to the University of Essex and some complicated teach-outs. The CETO is meeting with the Dean of Childhood and Social Care in the New Year to review our relationship and see where we might collaborate further. The CETO expressed gratitude to Paul Dugmore, Elisa Reyes-Simpson and Michael Rustin who have all been promoting a better link with UEL.	
3. Challenge Areas 3.1. DET has a significant challenge ahead in terms of its continued sustainability, as other papers presented to the Committee demonstrated. NHS England have indicated they will reimburse the Trust for the £2.6million withdrawn from the National Training Contract this year, although the funding mechanism for this is as yet unclear, but this will not affect the wind-down arrangement which will mean that DET barely breaks even in 2026/27 and goes into an operating deficit from 2027/28. 3.2. The Committee received two papers on this topic: 3.2.1. Strategic Vision for the Future: Drafted by DET SLT, this paper outlined a series of changes to portfolio and strategic initiatives that would represent a minimum of £1.4million in savings, with additional potential savings due to a reduction in operating costs yet to be costed out. The Committee noted that resourcing costing support from finance business partners was proving a major challenge to this work; however the CFO was able to provide reassurance on this point and that meetings were arranged. 3.2.2. Strategic Options Appraisal: Drafted by the CETO and CFO, this paper outlined the Terms of Reference for an external review of the DET operating model, including: continued hosting of the directorate within the NHS as opposed to a charity, University or subsidiary; the current academic model and use of Associate Lecturers; and opportunities for development of new courses and income streams. 3.3. The Committee welcomed these papers as presenting a bold vision for a revised Education and Training offer that would move to a contribution position by 2027/28 and thanked the authors. The Committee agreed it would continue to monitor progress.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Code of Practice on Academic Freedom **4.1.** The Committee noted an action point from its previous meeting that the Trust is required to have a Code of Practice on Academic Freedom as part of its OfS registration. The Committee received a draft copy of the Code of Practice, which has been developed by the DET Operations team in consultation with the University of Essex.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

4.2. The Committee recommended that the Code of Practice is adopted by the Trust following Board Review and Approval.	

Summary of Decisions made by the Committee:

- **APPROVE** the new Code of Practice on Freedom of Speech subject to Board Agreement
- Next Committee is 25/02/26.

Risks Identified by the Committee during the meeting:

- On review of the BAF, the Committee recommended that Risk 3 (Registration with the OfS) is changed to reflect the Merger Transition Board risk relating to the merged Trust
- It is also recommended that BAF Risk Items 4 (Contraction of Student Recruitment) and 16 (DET Sustainability) are merged into a revised version of Risk 16 to better reflect that a contraction in student recruitment may be desirable if it comes with a more efficient operating model for DET.

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

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

Item	Purpose	Date
Board: To approve new Code of Practice on Academic Freedom.	Ensure compliance with OfS requirements	15/01/2026

Appendix 1: Code of Practice: Academic Freedom and Freedom of Speech

Version 1.1. Last updated: 09/01/2026

Values

1. Academic freedom and freedom of speech within the law are fundamental commitments at the heart of our mission at the Tavistock and Portman NHS Foundation Trust ("the Trust"), which we promote as core values and vital components of being an inclusive community. We recognise in full our statutory obligations, with this Code forming an important part of how we fulfil them.

2. Academic freedom and freedom of speech are essential parts of academic and higher education life, and flourish where there is tolerance of a wide range of ideas and opinions which are lawfully expressed. Promoting the lawful expression of diverse ideas and opinions or the sharing of information by means of speech, writing, images (including in electronic form) or through events that we hold is an important part of our responsibility to be inclusive. This may include the lawful expression of ideas and opinions that some may find objectionable, shocking, disturbing or offensive. It enables all members of the Trust to feel able to express their ideas and opinions within the law and be encouraged to be active members of our higher education community.

3. By exercising these freedoms with due regard to the values we share as a community, we can make our own contribution to the Trust, which flourishes when new ideas are generated and different viewpoints are debated, in the context of being an inclusive community. As members of the Trust, we can do this by engaging in debate in a constructive manner that supports freedom of thought and expression within the law, promoting an enabling and inclusive environment which respects the rights of others.

4. We celebrate the passion of our Trust members and recognise that there may be occasions when different opinions expressed lawfully by some members of our community (or visitors to our campuses) conflict with those of others. Through our policies and procedures, we acknowledge that counter-speech and protest are also characteristics of a higher education institution committed to academic freedom, freedom of speech within the law and inclusion. However, the right to protest against the expression of ideas and opinions should never prevent others from exercising their right to freedom of speech within the law.

5. Higher Education Institutions play an important role in society as places of debate and discussion within the law, where ideas can be tested, where students learn to challenge received wisdom and think for themselves, and where rationality underpins the pursuit of knowledge. The Trust is fully committed to promoting an environment in which intense inquiry and informed argument can generate lasting ideas. This commitment is of long standing.

The Code

6. In accordance with the statutory duties[1] imposed upon it, the Board of the Trust has instituted this Code, which sets out how we secure, and promote the importance of, academic freedom and freedom of speech within the law for members of the Trust and for external speakers.

[1] Currently through the Education (No. 2) Act 1986 and the Education Reform Act 1988 and the Higher Education (Freedom of Speech) Act 2023.

7. The Code also considers and responds to the Trust's obligations under:

    a. Equality Act 2000 and Equality Act 2010, and the Public Sector Equality Duty

    b. Human Rights Act 1998, and

    c. Counter Terrorism and Security Act 2015, and the Prevent Duty Guidance 2023

Definitions

8. UK Legislation requires the Trust, having regard to the importance of freedom of speech, to take reasonably practicable steps to secure freedom of speech within the law for:

    a. staff of the Trust
    b. members of the Trust (as defined by the Trust constitution and to include patients, students, staff members, stakeholders and others interested in the work of the Trust)
    c. students of the Trust, and
    d. external speakers (defined sometimes as 'visiting speakers')

9. Staff of the Trust are defined as those individuals with current contracts of employment in place at the time of any event or occasion in relation to which questions about academic freedom or freedom of speech have been raised.

10. Students of the Trust are defined as those people who are currently registered on a programme of study.

11. For the purposes of this Code of Practice, those from outside the Trust community speaking or making discussion contributions to Trust activities, and who have been invited to the Trust, are defined as External Speakers[2].

12. The Trust is also required to develop and maintain this Code, including procedures for the organisation of meetings or other activities held or managed on Trust premises, in fulfilment of the Trust's duties. For the purposes of the fulfilment of these duties, these activities are defined as events and meetings that take place on any Tavistock & Portman NHS Foundation Trust premises, and are either in support of the Trust's charitable objects and in the control of the Trust or its members. For the avoidance of doubt, these activities do not include those undertaken by individuals or groups who have hired space for their own purposes on Trust premises, or individuals or groups who have not been invited to speak at the Trust. The Trust also has a duty to ensure that academic staff have freedom within the law to question and test received wisdom, and to put forward new ideas and controversial or unpopular opinions, without placing themselves in jeopardy of losing their jobs or privileges they may have. Academic staff are defined as those members of staff with an employment contract for teaching and/or research.

Steps to secure academic freedom and promote the importance of freedom of speech and academic free

[2] This includes, but is not limited to, members of the public, employers, industry representatives, politicians, professionals, faith and community leaders, campaigners, activists, authors, journalists and other external contributors.

13. In order to give expression to the Trust's obligations and commitments in relation to academic freedom and freedom of speech within the law, so far as is reasonably practicable, access to the premises of the Trust in relation to Trust activities, which would otherwise have been authorised in line with the Trust's policies, shall not be denied to any member of the Trust or to any invited external speaker (being an individual or body of persons), on any grounds relating to their ideas or opinions or their policies or objectives, unless the expression of such ideas, opinions, policies or objectives shall be unlawful, and where it is reasonably anticipated that the unlawful expression of such beliefs, views, policies or objectives might occur on the relevant occasion. It should be noted that the Trust campuses are private property, and no outside organisation or individual has a legal right to invite themselves onto our campuses without permission, or to host events that have not been approved through this Code and its related protocols.

14. The Trust will take reasonably practicable steps to secure that a person who makes an application to become a member of academic staff is not adversely affected because they have exercised their academic freedom.

15. The Trust will not use non-disclosure agreements relating to a relevant complaint in connection with members of the Trust and external speakers which purports to any extent to preclude the person from publishing information about the relevant complaint or disclosing information about the relevant complaint to any one or more other persons.

16. Rights relating to academic freedom and freedom of speech within the law are not absolute. In addition to affirming the Trust's commitment to promoting academic freedom and freedom of speech within the law, this Code also specifies circumstances in which academic freedom and freedom of speech might properly be restricted.

17. The Trust may apply restrictions in circumstances where they are necessary for the Trust:

    a. to discharge its obligations as set out in law and those specified by the Trust's regulatory body

    b. to safeguard the safety, health and welfare of its registered students, employees and other persons lawfully upon the premises or engaged in activities associated with the Trust, or

    c. to enable use of the Trust's premises to be lawfully consistent with maintaining and promoting the efficient conduct and administration of the Trust's functions

18. Just as the Trust will not restrict debate or deliberation simply because the views being expressed might be considered unwise or even offensive, it also expects members of the Trust community to show commitment to this same principle by not obstructing or interfering with the lawful rights of others to express views with which they might disagree profoundly.

19. The Trust is committed to ensuring that it will bring the provisions of its statutory duties to the attention of all currently registered students at least once a year. All members of the Trust

community are required to adhere to this Code of Practice, which is embedded into essential training for staff and, through registration and supporting communications, for students.

Decision-making framework and protocols

20. The Trust has established this framework to secure and promote academic freedom and freedom of speech for all speakers, including external speakers. This Code and its decision-making framework apply to all speakers participating in and contributing to all Trust activities, including all staff, students, members and external speakers.

21. The framework is made up of:
    a. the decisions of the Trust's Board, and relevant committees, including the Education & Training Committee and the Trust Events Committee

    b. the proportionate and risk-based process outlined in The Speaker Protocol, which ensures that anyone invited from outside our community to speak on the Trust's premises is aware of our expectations to promote academic freedom and freedom of speech within the law, and

    c. the proportionate and risk-based approach to managing and facilitating safe, on-campus protests through the Protest and Demonstration Management Protocol.

22. All members of the Trust are obliged to comply with the provisions of the decision-making framework, and the associated protocols, when making decisions or adopting any policy that may directly or indirectly affect freedom of speech or academic freedom, both positively and negatively, in a manner that is consistent with the operation of this Code.

23. The operation of this Code is supported by a range of guidance and material available for members of the Trust community.

Expectations of conduct

24. We recognise in full the rights of all to free speech within the law. All current students are required to comply with the provisions of this Code, in line with their obligations under their Student Terms & Conditions and the Code of Student Conduct. All currently employed members of staff are required to comply with the provisions of this Code, in line with their obligations under their contracts of employment, and to undertake essential training on the matters referred to in this Code, where this has been made available.

25. Where there is evidence of non-compliance, action will be taken to prevent future occurrences and address barriers to compliance. Appropriate action may include additional support and training. Where necessary and appropriate, such matters will be dealt with using standardised disciplinary and/or conduct procedures.

26. It is noted that if, when speaking, a speaker goes beyond the law, it is the speaker who is culpable.

Complaints

27. The management of complaints or concerns about academic freedom and freedom of speech within the law in relation to action taken or not taken by the Trust is explained in the Trust's Freedom of Speech Complaints Policy.

Code of Practice Oversight and Review

28. On behalf of the Trust Council, the Head of Academic Registry is responsible for ensuring that this Code operates effectively and is reviewed appropriately and remains fit for purpose in meeting its aims and supporting the Trust's mission

29. On behalf of the Head of Academic Registry, a nominated postholder with suitable seniority co-ordinates all aspects of the administration and operational delivery of the Code, providing a focal point for its operational management and a first point of contact.

30. The operation of the Code of Practice is reviewed regularly and at least annually to ensure it continues to meet the Trust's legal obligations and strategic and operational requirements, with changes considered and approved by the Trust's Board as appropriate, and annual assurance of compliance reported to the Council of Governors.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) Thursday 15 January 2026					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
POD EDI Committee	08 January 2026	Shalini Sequiera, Chair of POD EDI	Asma Bi, Committee Secretary	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 019**		
Assurance ratings used in the report are set out below:					
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	
The key discussion items including assurances received are highlighted to the Board below:					

Key headline	**Assurance rating**
1. FTSU Guardians Update The Guardians Service presented the results of all speaking up events conducted at the Trust by TGS between October and November 2025. Six cases were received by TGS between 2nd October and the end of November 2025. These were spread broadly between different areas of the Trust (clinical Units, Corporate) and across a range of themes, including patient safety, bullying, and management. On-going promotion Trust wide and drop in sessions have taken place with SLT. Focus is now on individual appointments with SLT for visibility supported by Communications Team. The Committee **NOTED** the paper.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Chief People Officer Report On the 28 January 2026 the Board plan to discuss specific priorities over the next few months. An important part of the work will be to collaborate with the service leads to identify staff support needs across the teams ahead of the merger and agree the best ways to address them. This could be through upskilling, provision of guidance and/or health and wellbeing support. The staff survey closed on 28th November 2025 with a provisional final response rate of 49.06% for the Tavistock and Portman Trust. Over the next months focus remains on maintaining the quality of services and improving relevant functions to ensure that the Trust are in the best possible place ahead of the merger and working collaboratively with NLFT colleagues to align processes and systems to enable a smooth transfer and effective operation as a single organisation from day one. The Committee **DISCUSSED** the content of the report.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

3. Integrated Performance Report: Workforce Metrics Dashboard The Committee received an overview of key workforce metrics such as sickness absence, mandatory and statutory training compliance, appraisal, turnover, right to work and DBS. There is a focus on staff experience given the Merger by Acquisition. The Committee NOTED the content of the report.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. EDI Programme Board Assurance Report The new EDI Policy was approved by the EDI Programme Board on the 26th of November and ratified by the Policy Assurance Group on the 17th of December. Work continues to enhance inclusive recruitment processes and ensure consistency in implementation. The EDI Programme Board will ensure alignment of EDI initiatives with NLFT and review the Appraisal Template to embed EDI objective in the Performance Appraisal process ensuring that all members of staff have an EDI objective.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Supporting staff and students through the merger and future for the Division A thinking space is being developed where staff can raise any concerns of which the learning would be shared moving forward with NLFT. There is a wider Communications and a Strategic Plan involving the CEO of NLFT. The Committee **NOTED** the presentation on supporting staff and students through the merger.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

The Committee agreed to focus on BAF Risk 6 Staff Engagement/Disengagement and an update to the descriptors and control in light of the merger.

Risks Identified by the Committee during the meeting:

There were no new risks identified during the meeting.

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

There were no items identified to return outside the routine business cycle.

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

Item	Purpose	Date
DoCG to share a verbal update to the Board on BAF Risk 6 Staff Engagement/Disengagement following the review of controls.	Approval and Action	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 15 January 2026			
Report Title: Finance Report - As of 31st Oct 25 (Reporting Month 07)			**Agenda No.: 020**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Jon Bell, Interim Chief Financial Officer
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 07 financial position for the Trust.		
Background:	The Trust has established a breakeven plan for 2025/26, with a capital expenditure limit of £2.774 million. The Department of Health and Social Care (DHSC) has approved £208,000 in PDC capital funding under the Wayfinder programme to support the implementation of the Patient Engagement Portal (PEP).		
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 £4,413k, which is £1,685k, 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 £2.774 million, which has increased to £2.982 million following the approval of an additional £208,000 in funding. As of Month 7, actual capital expenditure totals £1.292 million, which is below the planned profile of £2.498 million. This variance is largely attributable to phasing delays, as most major capital projects are scheduled to commence from Month 6 onwards. Nevertheless, the full-year capital spend is expected to align with the plan. **Cash** Cash flow remains under significant pressure. As of October 2025, the Trust held a cash balance of £1.245 million, equivalent to just six days of operating expenditure. For November, the Trust requested and received £2.170 million in approved cash support from the Department of Health and Social Care (DHSC). Further cash support requirements are projected at £4.200 million in January, £0.850 million in February, and £0.400 million in March 2025.		

	These projections assume that the sale of Gloucester House will not be completed before year-end and that the associated savings of £1.454 million will not be realised within the current financial year. The total cash support required for the year has increased from £4.266 million to £9.072 million. This increase reflects the combined impact of a £2.6 million loss of income from the National Training Contract, the delay in completing the Gloucester House sale before year-end, the non-delivery of planned savings within the expected timeframe, 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 EDI implications associated with this report.		

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Executive Leadership Team; Performance, Finance and Resources 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: Finance Report 25/26 – Year to 31ˢ Oct 2025 (Reporting Month 07)

1. Overview

The Trust closes Month 7 with a year-to-date deficit of £4.413m, which is £1.685m adverse to plan. This position reflects a combination of structural income loss, efficiency delivery challenges, and technical phasing effects. While some favourable movements have been secured through non-recurrent allocations, the underlying run-rate remains a concern.

Financial Reporting Summary - Month 07 2025/26 (compared to submitted plan)			
£'000	**YTD Oct-25**	**Oct-25**	**Oct-25**
	YTD	**YTD**	**YTD**
Income	34,015	33,713	(302)
Pay	(29,676)	(29,962)	(287)
Non-Pay	(6,941)	(8,044)	(1,102)
Non-Operating Expenditure	(126)	(120)	6
TOTAL Provider Surplus/(Deficit)	**(2,728)**	**(4,413)**	**(1,685)**

Three key themes underpin the financial narrative:

a) **Income volatility and structural risk**

- DET remains the most significant risk driver, with a £1.76m adverse variance linked to the cessation of the National Training Contract and lower course uptake.
- Clinical and Corporate divisions show favourable income positions; however, the corporate income variance is largely technical. It reflects the release of balance sheet provisions, which were originally planned to offset non-pay costs but have instead been recognised in income and pay. This accounting treatment creates a misalignment between income, pay, and non-pay variances, rather than a true operational gain.

b) **Cost pressures and CIP delivery**

- Pay overspend is concentrated in Clinical services, driven by CIP slippage and reliance on temporary staffing.
- DET has achieved nearly 50% of its CIP targets across income and pay, demonstrating partial progress. However, like Clinical, DET currently lacks a clear plan to deliver the remaining CIP requirement within this financial year.
- Non-pay variance is primarily due to timing and technical adjustments (VAT, provision phasing), alongside redundancy costs. While non-pay CIP delivery has helped, further action is required to normalise the run-rate.

c) **Liquidity constraints and reliance on cash support**

- Cash reserves remain critically low at £1.245m (≈6 days' operating cost), requiring phased DHSC support totalling £9.7m for the year.
- The delay in completing the Gloucester House sale and non-delivery of planned savings compound the risk.

d) **Run-rate analysis**
- The run rate analysis shows that while some corrective actions have slowed cost growth, the underlying trajectory for pay and non-pay remains above plan.

e) **Contribution rate:**
- the combined contribution from all service lines is 18.2% YTD at Month 7 vs 24.4% plan, with Clinical Services and DET below plan and Gloucester House above plan but still under the Trust target.

2. Agency

Agency spend: £277k, with an adverse variance of £28k. The higher agency cost is due to gaps in clinical staffing, which have been covered by agency consultants at a high rate.

AGENCY FORECAST M7

Directorate	Cost Centre	YTD £000's	YTD WTE
Chief Financial Officer	Hard FM	42	0.58
Chief Financial Officer	Finance	65	1.08
Chief Nursing Officer	Head of Nursing	23	0.28
Chief Financial Officer	CENTRAL RESERVES	(14)	-
Corporate Total		**116**	**1.94**
Children and Family Unit	FMHT	10	0.05
Children and Family Unit	Gloucester House Outreach	53	1.10
Children and Family Unit	FAKT	32	0.18
Camden Unit	NCCT	33	0.16
Camden Unit	SCCT	33	0.16
Clinical Total		**161**	**1.65**
Grand Total		**277**	**3.59**

3. Non-Operating Costs

Operating non-pay costs for the period were £120k, which is £6k better than the planned figure.

4. Cash

As at 31 October 2025 (Month 7), the Trust's cash position remains under significant strain. The reported cash balance stands at £1.245 million, equivalent to six days of operational expenditure, highlighting a critically low liquidity level.

To date, the Trust has received £4.266 million in PDC cash support (£1.582 million in August, £0.514 million in September and £2.170 million in).

The Trust is planning to apply for further cash support of £4.200 million in January, due to the anticipated delay in completing the Gloucester House which is now expected to complete at the end of March. Additional support of £0.850 million in February and £0.400 million in March will be required due to the deterioration in the forecast position against a breakeven plan.

The total cash support required for the year has increased from £4.266 million to £9.716 million driven by the anticipated slippage in the Gloucester House sale and the non-delivery of planned savings.

5. Balance Sheet

No movements of note to report at Month 07.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) Thursday 15 January 2026					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	11 December 2025	Aruna Mehta, Chair of PFRC	Asma Bi, Committee Secretary	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 021**		

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. Board Assurance Framework and Corporate Risk Register The Director of Corporate Governance, NLFT (DoCG) presented the report which suggested a reduction in the score for BAF Risk 9 Financial Sustainability (not reflected in the report). At present the Trust's financial position remained the same and given the absence of an approved Full Business Case at this point in time the score reduction could not be supported. The Committee **REVIEWED** the current risk scoring based on the current and future position of the Trust and **RECOMMENDED** a full review at the Board in January 2026.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Activity Reporting: Performance, Contracts and Commercial Update (DoSB) shared an update on performance, contracts, and associated risks as the organisation enters Q4. Unit level annual plans have undergone a six month review triangulating the work within North Central London (NCL) teams. A contract notice was issued, and subsequent discussions between the CEO and Regional Lead for Education have resulted in agreement that a settlement will be reached through merger negotiations, mitigating the risk of in-year loss. Gloucester House considerations include development of a new service model, alongside a robust business development and growth plan to attract sufficient student numbers and ensure the service contributes at the required level. It was noted that work is underway with NLFT to align performance reporting as part of merger preparations. This may result in revised reporting formats aligned to NLFT governance requirements. The Committee asked that future reports present contracted financial risk in the same format as the	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

finance report table for monthly position and projected risk. The Committee **NOTED** content of the report with an **ACTION** to update the report format on financial impact of contracted risks.	
3. IM&T Integration Progress Significant planning has already taken place at a high level, and the programme is now moving into delivery planning and a detailed project plan covering all underlying activities. Two phases are being planned: 1.Pre-merger requirements: What must be in place by the legal merger date (currently 1 April, subject to change). Includes essential activities such as the new ODS code, which must be live at merger. 2.Post-merger: Many integration activities extend beyond merger. The high-level plan finishes at merger but several workstreams continue significantly. Nothing is currently regarded as fully fixed or definitive, aside from the ODS code requirement. The Committee **NOTED** the work completed to date and the draft schedule for the digital merger workstream and **RECOMMENDED** the Merger Programme Board to oversee IM&T Integration Workstream.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Month 7 Finance Report 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 reported a year-to-date deficit of £4,413k, which is £1,685k, 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. The Committee **NOTED** the position outlined in the report.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. CIP Progress Report Month 7 Of the £11.7m target, Gross savings of £10.8m (93%) have been identified in-year, with £0.8m (7%) unidentified. Delivered Savings: As of Month 7, £5.2m of the identified savings have been delivered (net). This is 101% of the identified CIP plans, but only 76% of the YTD target. Overall the CIP Programme is rated Red, with significant risks to identifying recurrent/FYE savings and in implementing schemes which require staff consultation. The Committee **NOTED** the position outlined in the report.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
6. Month 7 Forecast The Committee received a report detailing the financial forecast out-turn position for the Trust. The Trust is currently forecasting a likely case deficit of £5.37m against a breakeven plan. The deficit is due to a combination of the loss of the National Training Contract income (£2.6m) which is under discussion and shortfalls in the planned cost recovery and income growth assumptions that were	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

made when the breakeven plan was agreed. Discussions to secure support for the £2.6m income loss remain in train however, the Trust would still have an unmitigated forecast deficit even if this support was forthcoming. The Committee discussed the need to formally declare this adverse forecast at month 9 if no mitigation is found. The Committee **NOTED** the position outlined in the report.	
7. National Cost Collection The CFO reported the National Cost Collection results published earlier this year show that the Trust has a very high cost index of 137 compared with the national average of 100, indicating services are significantly more expensive than peers. For around £37m of clinical activity actual costs are £9.88m higher than expected, largely reflecting known issues around scale and the allocation of high corporate overheads rather than frontline clinical inefficiency. The Committee **NOTED** the position outlined in the report.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
8. Cash Management The Committee discussed the very challenging cash position for the trust and received details on the cash support request submitted for January 2026. The need for cash in January is mainly driven by slippage to March of an asset sale originally planned for January. The Committee **NOTED** the position outlined in the report.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

- Merger Programme Board to oversee IM&T Integration Workstream and update its terms of reference to reflect.
- The Committee **APPROVED** the Procurement Strategy and Policy.

Risks Identified by the Committee during the meeting:

There were no new risks identified during the meeting.

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

There were no items identified to return outside the routine business cycle.

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

Item	Purpose	Date
Board Discussion and Review of full BAF on 15 January 2026.	Review	15 January 2026

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 15 January 2026			
Report Title: Emergency Preparedness, Resilience and Response Core Standards – Annual Assessment 2025			**Agenda No.: 023**
Report Author and Job Title:	Lisa Tucker as Emergency Preparedness Lead	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer and Accountable Executive Officer (AEO) for EPRR.
Appendices:	Appendix 1: London EPRR Core Standards Letter Appendix 2: EPRR Core Standards Assurance letter from EPRR Leads for NCL ICB		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☒ Information ☒ Assurance ☒		
Situation:	On 21st September 2025, the AEO and Emergency Preparedness lead met with Emergency Preparedness Resilience and Response (EPRR) leads from North Central London Integrated Care Board (NCL ICB) and NHSE (London region). The Core Standards were reviewed and agreed on compliance status for Tavistock and Portman's self-assessment. The Trust's EPRR status is Fully Compliant.		
Background:	All NHS funded services and Healthcare organisations are legally required to comply with the requirements for planning for emergencies under the Civil Contingency Act 2004, NHS Act 2006 and Healthcare Act of 2022, to ensure they have robust plans to protect the community it serves in the event of any Incident or Emergency.		
Assessment:	In accordance with the requirements laid out in the EPRR 2025/26 Assurance Process, the overall level of compliance is RAG rated of the Core Standards. The Tavistock and Portman Foundation Trust is confirmed as **Fully Compliant** for 2025.		
Key recommendation(s):	The Board is asked to **NOTE** the Trust is fully compliant and that the EPRR lead will work with the NLFT EPRR lead to prepare the organisation for a merger by acquisition and the Core Standard 49.		
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: EPRR and Business Continuity Planning			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	Civil Contingency Act 2004, NHS EPRR Core Standards NHS Act 2006 and Healthcare Act of 2022			
Resource Implications:	Yes ☐		No ☒	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐		No ☒	
	All EPRR related Policies and Procedures have completed and ratified with singed EQIA statements from			
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 for assurance for pre submission for 1st Sept 2025. ICB and NHSE Assurance meeting 21st Oct 2025 ICB and NHSE Assurance report confirming Fully Compliant for 2025 Submission to the Audit and Risk Committee Q3 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

To:
- **EPRR Leads – Integrated Care Boards; Acute; Community; Mental Health; Specialist; NHS111; London Ambulance Service**

cc.
- **AEOs – Integrated Care Boards; Acute; Community; Mental Health; Specialist; NHS111; London Ambulance Service**

NHS England - London
10 South Colonnade
Canary Wharf
London
E14 5EA

1 July 2025

Dear Colleagues

Emergency Preparedness, Resilience and Response (EPRR) 2025/26 core standards annual assessment process

Your dedication to the resilience of London has been instrumental in maintaining high quality health services across the city. Thank you to you and your teams for what you all do every day.

As we all know the NHS is currently undergoing unprecedented change and in light of this we are adapting and simplifying our regional approach to the annual national EPRR core standards assurance process this year. This letter sets out the streamlined approach we will be taking and the rationale for this, which I hope you will welcome. My team will continue to support you and your organisation through this process.

The arrangements set out below are aligned to the national EPRR assurance letter issued by NHS England on Monday 01 July 2025 (Publishing Approval Reference: PRN01970).

The focus of this year's assurance process will be a review of the organisational self-assessments and the impact this has on system preparedness and wider regional resilience. In London we will continue a supportive delivery model between the regional office and Integrated Care Boards (ICBs) that remains both flexible and achievable.

A full list of roles and responsibilities can be found at the end of this letter.

All organisations are required to complete their self-assessment and ensure it is an accurate reflection of their preparedness. The self-assessment must be signed off by the organisational Accountable Emergency Officer and presented to a board meeting (or equivalent for Community Interest Companies) at the earliest opportunity.

All organisations are asked to submit their self-assessment on the Futures platform by 01 September 2025.

The only evidence requested this year will be from Acute trusts who are asked to submit their CBRN plan for peer review by LAS. The decision not to request standard evidence is based on the anticipated reduced availability of resources at ICB and regional level to review but is balanced by the previous years' reviews and submissions. In recent years EPRR policies and Incident Response Plans have flagged no significant concerns across the system. Regional, ICB and peer networks are still available for colleagues to access for comments and reviews outside of the formal assurance process.

NHS England – London and ICBs will coordinate assurance meetings for organisations to take place through September and October. Building on the process for 2024/25 each meeting will review an organisation's self-assessed return and provide an opportunity for the ICB, the trust and the region to discuss successes, challenges and risks - particularly in relation to areas of partial or non-compliance. Any concerns for preparedness will be highlighted, discussed and recorded but the outcome will remain the decision of the organisation's AEO on behalf of their board.

After the assurance meeting the organisation will be given one week to review their self-assessment in light of the discussion, if required. NHS England – London and the ICB will confirm in writing the submitted self-assessed compliance level and any headline discussion points. Organisations are invited to provide a note taker should they wish the meeting to be recorded.

As part of the 2025/26 assurance process, London Ambulance Service (LAS) will support the reviewing and checking of CBRN equipment and review of acute CBRN plans.

For 2025/26 the region will not be requesting peer review nominations due to the lack of consistency and resource intensity of this process.

A report detailing London's overall assurance outcomes will be tabled at the Spring 2026 London Local Health Resilience Partnership (LLHRP) meeting, following submission to NHS England National as is the usual practice.

Many thanks for your co-operation with this important assurance process.

Yours sincerely

Will Huxter
Regional Director of Commissioning and EPRR SRO

2025/26 EPRR core standards assurance roles and responsibilities

NHS England – London:

- Oversight of the regional process
- Compilation of a self-assessment to be signed off by the regional EPRR Senior Responsible Officer (SRO) and submitted to NHS England National
- Coordination of assurance meetings with the five ICBs, LAS and 111 providers
- Support to review submissions from all London's organisations
- Administration of a submission platform (Futures)
- Submission of the collated regional return to national

London ICBs:

- Oversight of their system process
- Compilation of a self-assessment to be signed off by the AEO and presented to the board
- Coordination of assurance meetings for their providers
- Submission of a collated system return to region

London trusts and providers

- Compilation of a self-assessment to be signed off by the AEO and presented to the board

North Central London
Integrated Care Board

EPRR assurance confirmation 2025/26

The Tavistock and Portman NHS Foundation Trust

Dear Colleagues,

Thank you for your EPRR core standards self-assessment submitted 01 September 2025 and the work you have done in both preparedness and response over the last 12 months. The assessment was reviewed and discussed on 21 October 2025 with a panel consisting of North Central London Integrated Care Board and NHS England – London representatives.

North Central London ICB can confirm your submitted level of compliance, agreed by your Accountable Emergency Officer, was **Fully Compliant** and this will be reported to NHS England in line with the national process.

The level of self-assessed compliance must also be reported to your public board (or equivalent) at the next available opportunity.

Meeting attendees

Name	Organisation
Lisa Tucker – EPRR Lead	Tavistock & Portman NHS FT
Clare Scott – Chief Nursing Officer (AEO)	Tavistock & Portman NHS FT
Katy John – NHSE Relationship Manager	NHS England - London
Nathan Welch – Head of EPRR	North Central London ICB
Robyn Cassidy – EPRR Manager	North Central London ICB

Key Discussion points

High level points on areas of good practice or successes, areas where further clarification was asked, risks or issues identified by the organisation and any actions that will be taken:

1. **EPRR Assurance Core Standards Review**
    - No concerns were raised by Tavistock and Portman NHS Foundation Trust.
    - Supporting policies were submitted although they were not required this year.
    - Tabletop exercises have become routine, with another planned for Q4.
    - Both staff awareness and engagement with EPRR and business continuity has significantly improved at the trust.
    - A Resilience Group is established to monitor and support emergency planning.
    - On call directors are trained and therefore structured in their approach.
    - Encouragement to document specific exercises in future assurance spreadsheets.

2. **Tavistock and Portman Feedback**
    - Tavistock and Portman will merge with North London NHS Foundation Trust (NLFT) on 01 April 2026.
    - Policy alignment is underway with plans to adopt NLFT policies post-merger.
    - EPRR Lead if coordinating with NLFT counterparts to share core standards and prepare for integration.
    - EPRR Lead is undertaking the DipHEP which is adding to her experience and insight.

3. **North Central London ICB Feedback**
    - North Central and North West ICBs will merge
    - NCL ICB confirmed the trust is fully compliant with EPRR standards.
    - The EPRR roles will be covered by a small team, but no immediate changes are expected.

4. **NHS England Feedback**
    - Regional governance for EPRR remains uncertain; current operations continue as usual.
    - EPRR Lead was praised for her dedication and leadership in improving EPRR.

5. **Closing Remarks**
    - The EPRR Lead role has been restructured which has helped focus on emergency planning.
    - Tavistock and Portman are fully compliant with the EPRR Core Standards.

If you have any questions regarding the above, please send them to nclicb.eprr@nhs.net. Thank you for taking the time to complete the process which helps provide a valuable benchmark for NHS preparedness across the capital.

Kind regards,

NCL ICB EPRR Team

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC - Thursday, 15 January 2026			
Report Title: Public Board Annual Schedule of Business 2025/26			**Agenda No.: 023**
Report Author and Job Title:	Rhiannon Adey, Interim Deputy Company Secretary	**Lead Executive Director**	Terry Willows, Director of Corporate Governance, NLFT
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. Removed items • Board Assurance Framework and Corporate Risk Register moved to the Board Development Session • Board Development and Seminar Programme 2026/27 moved to the Board of Directors in Private • Honorary Doctorate Nominations moved to the Board of Directors in Private • Staff Survey Results and Action Plan deferred to the March meeting as results not yet received In future reports, any changes to the Schedule of Business would be highlighted in the appendix as follows: • Agenda items – highlighted in red font. • Deferred papers – noted as 'D' under the relevant month of the meeting. • Discontinued paper – noted as 'X' under the relevant month of the meeting.		
Key recommendation(s):	The Board is asked to **NOTE** the Public Board Schedule of Business for 2025/26.		

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

	provider of training & education	research in this area		

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All 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 – 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	

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	X	P			Corporate Reporting covering all strategic ambitions	Quarterly
Integrated Audit and Governance Committee Chair's Assurance Report	Assurance	NED		P			P	P			Corporate Reporting covering all strategic ambitions	Quarterly
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Developing a culture where everyone thrives	Quarterly
Guardian of Safer Working Report	Information	CMO			P		P	P			Providing outstanding patient care	Quarterly
Quality Update	Discussion	CNO	P		P		P				Providing outstanding patient care	Quarterly
Gloucester House Update	Assurance	CNO		P		P		P			Providing outstanding patient care	Quarterly
Six-monthly (2)												
Mortality / Learning from Deaths	Assurance	CMO		D	P						Providing outstanding patient care	6 monthly
PSIRF Update	Discussion	CNO			P			P			Providing outstanding patient care	6 monthly
PCREF Update	Discussion	CMO		P			P				Developing partnerships to	6 monthly
Annual (1)												

The Tavistock and Portman NHS Foundation Trust

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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					X		Education & Training Committee		Enhance our reputation and grow as a leading local, regional, national & international provider of	Annual
Annual Patient Experience Report (including complaints, surveys and engagement and involvement).	Discussion	CNO			P				Quality & Safety Committee		Providing outstanding patient care	Annual
Fit & Proper Persons Test Outcome	Approval	Chair	P							CoG NHSE	Corporate Reporting covering all strategic ambitions	Annual
Board Development & Seminar Programme 2026/27	Discussion	Chair					P				Corporate Reporting covering all strategic ambitions	Annual

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Date of Meeting			**15-May**	**10-Jul**	**18-Sep**	**20-Nov**	**15-Jan**	**19-Mar**				
Medium Term Financial Plan update	Approval	CFO	P						Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental sustainability	Annual
Financial Plan 2026/27 (if required)	Discussion	ICFO						P			Improving value, productivity, financial and environmental sustainability	Annual
Board Service Visits	Discussion	Chair			P						Corporate Reporting covering all strategic ambitions	Annual
Strategy / Policy Approval/Ratification (usually every 3 years)												
Year 3 (2025/26)												
External Board/ Governance Review (once every three years) Report	Discussion	Chair									Corporate Reporting covering all strategic ambitions	3 yearly
Modern Slavery Statement	Approval	CNO									Providing outstanding patient care	Annual
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Improving value, productivity, financial and environmental	3 yearly
Green Plan/ Sustainability Strategy	Approval	CFO				D	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				Corporate Reporting covering all strategic ambitions	Variable
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
Provider Capability Self-Assessment Action Plan	Discussion	DoSBD					D	P			Corporate Reporting covering all strategic ambitions	Variable