Meeting Book - Board of Directors in Public - 26 March 2026

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The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 26th March 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, 26 MARCH 2026 AT 10.30AM – 1.00PM
VENUE: BOARD ROOM, TAVISTOCK CENTRE AND VIRTUAL

Living our values:

AGENDA

26/03/	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	10.30 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Minutes of the Previous Meeting held on 15 January 2026	Approval	Chair	E	10.35 (5)	
005	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	10.40 (5)	
006	Chair and Chief Executive's Report (including Merger and Board Service Visits update)	Information	Chair and Chief Executive Officer	E	10.45 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
007	Legacy Video	Information	Communications Team	V	10.55 (10)	
CORPORATE REPORTING (COVERING ALL STRATEGIC AMBITIONS)						
008	Integrated Quality Performance Report (IQPR) Including update on risk areas/ areas in structural support	Discussion	Executive Directors	E	11.05 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Approval	Director of Corporate Governance (Interim)	E	11.20 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
010	Integrated Audit and Governance (IAG) Committee Handover Report	Assurance	IAG Committee Chair	E	11.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Comfort Break (10 minutes) 11.35a.m – 11.45a.m						

PROVIDING OUTSTANDING PATIENT CARE						
011	Gloucester House Improvement Plan Update	Discussion	Director of Strategy and Business Development / Chief Nursing Officer	E	11.45 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
012	NHS England Review of Gender Identity Clinic	Discussion	Chief Nursing Officer	E	11.55 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
013	Quality and Safety (Q&S) Committee Handover Report	Assurance	Q&S Committee Chair	E	12.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
014	Education and Training (E&T) Committee Handover Report	Assurance	E&T Committee Chair	E	12.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
015	Staff Survey Results and Action Plan	Discussion	Chief Executive Officer	E	12.10 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
016	Freedom to Speak Up Guardian Annual Report	Discussion	Chief Education and Training Officer	E	12.20 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
017	People, Organisational Development, Equality, Inclusion and Diversity (POD EDI) Committee Handover Report	Assurance	POD EDI Committee Chair	E	12.30 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
018	Finance Report: Month 10	Information	Interim Chief Finance Officer	E	12.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
019	Performance, Finance and Resources (PFR) Committee Handover Report	Assurance	PFR Committee Chair	E	12.45 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
CLOSING ITEMS						
020	Further Handover Matters	Discussion	Director of Corporate	E	12.50 (10)	Limited ☐ Partial ☐ Adequate ☐

			Governance (Interim)			N/A ☒
021	Questions from Governors	Discussion	Chair	V	13.00 (5)	
022	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
023	Questions from the Public	Discussion	Chair	V		
024	Reflections and Feedback from the meeting	Discussion	Chair	V		

REGISTER OF DIRECTORS' INTERESTS - 2025/26 (LAST UPDATED 16/03/2026)

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
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
			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

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			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
			Director of a Yoga charity			
			Director of a Residential freehold company			
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).			
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			

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
JANUSZ JANKOWSKI	Non-Executive Director	01 November 2022 (2nd Term)	Non-Executive Director RDASH NHS Doncaster (1)	01/11/2022	N/A	
			Consultant Advisor and Provost, Dubai Medical University, United Arab Emirates	13/12/2023	N/A	
			Hon Professor University College of London	01/02/2020	N/A	
			Chair EU Translational Cancer Panel (3)	01/08/2022	N/A	
			Consultant Industry ad hoc	01/08/2021	N/A	
			Healthnix (HealthTec Start up London)	01/12/2023	N/A	

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 15th JANUARY 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

Aruna Mehta	Chair of the Board of Directors	AM
Ken Batty	Non-Executive Director, Chair Integrated Audit and Governance Committee	KB
Janusz Jankowski	Non-Executive Director & Deputy Chair Quality and Safety Committee	JJ
Sal Jarvis	Non-Executive Director & Chair Education and Training Committee	SJ
Claire Johnston	Non-Executive Director & Chair Quality and Safety Committee	CJ
Shalini Sequeira	Non-Executive Director & Chair of the People, Organisational Development, Equality, Diversity and Inclusion Committee	SS
Michael Holland	Chief Executive Officer	MH
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
Sheva Habel	Interim Joint Chief Medical Officer	SH
Clare Scott	Chief Nursing Officer	CS
Liz Searle	Interim Joint Chief Medical Officer	LS

Non-Voting

Kate Bowditch	Acting Chief People Officer	KBo
Terry Willows	Acting Director of Corporate Governance	TW

IN ATTENDANCE:

Chen Kailayapillai	Specialty Registrar in Child and Adolescent Psychiatry	CK
Nimisha Deakin	Associate Director of Nursing and Patient Experience	ND
Ros Dharampal	Public Governor	RD
Thomas Hawksworth	Specialised CAMHS Clinician	TH
DW	Parent of a child who received care from EDAS service	DW
ML	Parent of a child who received care from EDAS service	ML
Rhiannon Adey	Interim Deputy Company Secretary	RA

APOLOGIES:

Sabrina Phillips	Non-Executive Director	SP

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	AM welcomed everyone to the Board of Directors.	
002	**CONFIRMATION OF QUORACY**	

	AM confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest to be reported beyond those previously recorded.	
004	**MINUTES OF THE PREVIOUS MEETING HELD ON 20 NOVEMBER 2025**	
	The Board **APPROVED** the minutes of the previous Board Meeting (public) held on 20 November 2025.	
005	**MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW**	
	An update was provided to the action in relation to mandatory training, it was expected that this action would be closed at the next meeting. MF confirmed that the Gloucester House action plan was now complete and the action could be closed.	
006	**CHAIR AND CHIEF EXECUTIVE'S REPORT**	
	MH presented the report passing thanks to Dorothy Otite in her role as Interim Director of Corporate Governance and thanked those staff that had responded to a critical incident earlier in the week when a pipe burst on the Tavistock Centre site. The Trust performance around recording clinical outcomes continues to improve with the Children and Adolescent Mental Health Service (CAMHS) recording the highest number of clinical outcomes in London. SS queried the outcomes for CAMHS. SH updated that the structure of first appointments meant that this was now embedded with a statistical improvement in outcome measures. The Levy report had been published at the end of December and the Trust response to the actions identified was being presented later at this meeting.	
007	**INTEGRATED QUALITY PERFORMANCE REPORT (IQPR) INCLUDING UPDATE ON RISK AREAS/ AREAS IN STRUCTURAL SUPPORT**	
	RB presented the report highlighting that the gender identity clinic continued to utilise the quality assurance framework which involved a quality lead being based within the service, allowing benchmarking against other gender identity clinics. This had shown improvement within the service with month 7 data showing a reduced number of Did Not Attend (DNA) appointments and had supported positive relationships with NHS England. The Trust continued to have one of the longest waiting lists identified within the Levy report with nearly 17,000 patients waiting. It was noted that NHS England had confirmed that original referral dates to the surgical hub would be honoured for those patients whose referrals were lost. 24 patients attended their first appointment within the trauma service which was the highest number of first appointments attended. The trauma service remains in targeted support whilst a trajectory is developed to ensure two week waiting times are met.	

	The Returning Families service have been served notice of closure with an end date of March 2026. There had been an increase in the number of experience of service questionnaires received which showed positive patient experience of 95%. An increase had been seen in the incidents of violence and aggression and restrictive practices used at Gloucester House school. It had been considered that this was due to improved reporting although there was also an acknowledgement that pupils are aware of the upcoming site move. A QI approach had been adopted, led by the clinical lead which had shown key times of day when incidents occurred. KB passed their thanks for the resolution that had been found for the lost referrals to the surgical hubs with NHS England. CJ highlighted that due to delays in reporting the paper had not shown that all patients whose referrals had been lost had been contacted. It was confirmed that elective recovery funding had been received for the trauma waiting list. AM queried why the trajectory had not shifted. SH updated that the funding had resulted in some improvement, however, the core team remained small. Work was ongoing to review pathways and resource utilisation. A trauma course had been developed with the department of education and training to add additional resource through trainees, and targeted work was being undertaken on very long waiting patients. Patients on the waiting list could contact the service for support and the vast majority were within the North London NHS Foundation Trust (NLFT) area. It is highly likely that these patients are also being seen within NLFT community services whilst waiting for trauma care. The Board **NOTED** the report for **ASSURANCE**.	
008	**NATIONAL OVERSIGHT FRAMEWORK UPDATE**	
	RB presented the paper noting that this provides an update at the end of quarter 2. The national oversight framework is used by NHS England to assess the performance of the Trust with the Tavistock and Portman NHS Foundation Trust (TPFT) being placed in segment four. This was due to financial challenges and the level of risk the Trust was holding. Work is in place to address these risks. Strengths were also identified in quality improvement, quality and safety, improved staff survey results. RB had recently met with NHS England to discuss the National Oversight Framework. **Action:** RB to present a further update on the National Oversight Framework at a future meeting of the Board in Public. The Board **NOTED** the Trust National Oversight Framework assessment.	**RB**
009	**10-POINT PLAN TO IMPROVE RESIDENT DOCTORS WORKING LIVES ACTION PLAN**	
	CK attended to present the 10-point plan action plan noting that this was reported to NHS England around the structure between payroll, human resources, working conditions and access to facilities.	

	CK noted that there was no requirement for resident doctors to be on call within TPFT, however, this was required on rotation with neighbouring acute Trusts, so liaison had been undertaken to determine how this could be improved. This resulted in allocated parking spaces being made available for resident doctors on-call at the Whittington hospital. CK was working with the Deputy Chief People Officer to ensure resident doctors did not encounter payroll challenges when they moved between Trusts. An area for improvement that had been identified was the induction for new doctors. There were also ongoing challenges around leave as doctors moved rotation during the annual leave year. It was noted that the merger could provide a resolution to this and CK was working with NLFT about this moving forwards. It was queried how a sense of identity would be maintained post-merger. Resident doctors have a sense of independence within the Trust and best practice was being explored with other Trusts to ensure this was maintained through relationships with acute trusts. JJ queried how the TPFT rotation felt compared with other rotations. CK updated that there was a close working environment with a stable consultant body and a broad range of training experiences. It was however noted that the financial challenges that the Trust faced impacted on the resident doctors. CJ queried the outcome of the General Medical Council surveys for TPFT. **Action:** LS to consider how learning from General Medical Council surveys are disseminated. The Board **APPROVED** the Trust's response to the NHS 10-point action plan.	**LS**
010	**INTEGRATED AUDIT AND GOVERNANCE (IAG) COMMITTEE ASSURANCE REPORT**	
	KB presented the report noting that the meeting had focused on work required for the merger. The internal and external audit plans had been agreed and a meeting of the IAG Committee had been scheduled for the end of March to sign off key items ahead of the merger. The Board received **ASSURANCE** from the update provided.	
011	**QUALITY AND SAFETY (Q&S) ASSURANCE REPORT**	
	CJ presented the report noting the work ongoing to implement the DrDoctor platform to the NHS app. It was also noted that a modified approach to CQC self-assessment had been implemented with all three clinical services having undertaken the self-assessment. Quality reviews had been undertaken in some services with further service quality reviews planned. It was noted that the lone working policy had been updated and approved and the issuing of personal alarms had been approved with colleagues at NLFT. There	

	remained one open action in relation to a previous CQC inspection which was being progressed through the Health and Safety Group. The Public and Patient Involvement Annual Report was received and is presented to the Board. The Board received **ASSURANCE** from the update provided.	
012	**GUARDIAN OF SAFER WORKING REPORT**	
	SH noted that the guardian of safer working report was a statutory requirement of the resident doctor contract and would be part of a unified structure within NLFT in the future. It was highlighted that there were a small number of exceptions reported which were managed within the Trust as fines which were received as expected. MH queried which activities the fines had financed. LS confirmed that the fines were used for continued professional development that may not otherwise be accessed.	
013	**PATIENT AND CARER RACE EQUALITY FRAMEWORK (PCREF) UPDATE**	
	SH provided an update on the PCREF interventions highlighting that the PCREF implementation group was well attended with formalised terms of reference and two Non-Executive Director members. The implementation group had commissioned five workstreams to begin in February. PCREF data reporting was now included within the IQPR and there had been a focus on complaints, incidents of violence and aggression and restrictive practices. This highlighted that data collection required improvement for complaints and further work was required on understanding the ethnicity data for incidents reported at Gloucester House. There had been focus on the DNA and cancellation data which highlights a greater number for global majority populations. A review of experience of service questionnaires showed that global majority populations had a positive experience when accessing services, however, there was a risk that this was overstated. This was being taken forward by the Patient and Public Involvement Group to hold focus groups to review these elements more closely. The Head of Culture and Inclusion was working with the patient and public involvement and equality, diversity and inclusion teams to increase understanding of PCREF, with events being held in October for Black History Month. Planned engagement was underway with local community groups involving a marketplace and round table, to better understand how we could meet the needs of our population. SS commented that the paper was helpful and covered a large breadth of work. It was noted that the paper referred to national and local data that Black African, Black Caribbean and Mixed Black people were more likely to have poorer access, experience and outcomes when they used mental health services, however, the Bangladeshi population in Camden is particularly underserved. SH agreed that the	

	paper could be clearer and confirmed that work is being undertaken to improve access to services for the Bangladeshi population and other less well represented global majority populations of Camden. SJ noted appreciation for the exploration of the data to understand whether the reported experiences of the global majority population was reflective of the true experience. CJ commented that the data had not been presented together before and queried how this would be incorporated within NLFTs work. SH noted that NLFT were early adopters of PCREF and there was benefit from being part of a larger system and learning from each other. It was also asked whether GPs would be invited to the community event, SH would take this back to the group. MH asked whether there would be reporting on access to our national services and whether there would be reporting on outcomes. SH confirmed that once paired outcome measures were implemented for the Trust, this could then be reported by ethnicity. There were challenges around recording diagnoses due to the services provided. LS added that there were improvement projects being undertaken for CAMHS to review whether there were differences in the treatments offered dependent on ethnicity. SJ commented that the connection with the department for education and training was important for the racial equality work for our students and involving students in PCREF gave the opportunity to influence the clinicians of the future. It was noted that further exploration was required around whether there were barriers in referral to the gender identity clinic as there was significant underrepresentation. There were concerns around access to the Portman Clinic, however, work has been undertaken to improve this, resulting in better representation of the local population. **Action:** Q&SC to review IQPR report that looks at referrals and provide assurance to March Board.	**SH**
014	**GENDER IDENTITY CLINIC UPDATE**	
	CS presented the report providing an update on the quality improvement work being undertaken by the gender identity clinic. The Operational and Delivery Review for National Gender Clinics in England, undertaken by Dr Levy was published on 15 December with four key findings around access, quality (including safety), productivity and culture, leadership and governance. The report sets out 20 recommendations which would be driven by the national quality improvement work. CS and MH met with Dr Levy and the national quality improvement director who confirmed that each of the nine gender identity clinics would receive an individual report. They also recognised the amount of work that had been undertaken by the Trust to engage with them.	

	For this current month the focus had been around reducing cancellations and DNA appointments. Patient portal integration will help to increase capacity and reducing clinical admin time by increasing the usage of letter templates. Artificial intelligence is being explored with the quality lead supporting one day a week. A service user forum has also been created for the gender identity clinic. The report also includes benchmarking data. SJ queried how the DNA appointments had been reduced. CS confirmed that texts were being sent as a reminder, the administrative team were phoning people ahead of appointments, reminders were shared with service users and staff of the DNA policy and future work with the DrDoctor people would offer choice to people around their appointment times. KB noted that 40% of the total national waiting list was with the Trust, however, the workforce was not representative of this. CS confirmed that this had been a benefit of the national quality improvement work as it was identified that the Trust was the only gender clinic on the electronic system to GP referrals are received by the Trust. The Board passed their thanks to the Gender Identity Clinic team for the work that had been undertaken and to the national team for the support they had given. CJ noted that Shy Teli had brought real benefit to the team through their motivation and challenge. **Action:** AM and MH to write to the gender identity clinic and the national team to pass the thanks of the Board.	**AM / MH**
015	**QUALITY UPDATE**	
	CS presented the report highlighting the triangulated data around experience, complaints, feedback and patient safety incidents. Work was being undertaken in collaboration with NLFT and their improving experience in mental health programme to reduce restrictive practices. A patient safety incident investigation had been completed and would be presented to the Trust Board for approval. All affected patients had been notified. The paper detailed improvements being undertaken following after action reviews, and it was noted that consideration was given to identifying timely learning and embedding change.	
016	**SERVICE USER STORY: EDAS SERVICE**	
	ND introduced ML and DW, parents of a service user who had accessed our services. TH introduced the Eating Difficulties and Avoidant/Restrictive Food Intake Disorder (ARFID) service who work with young people at risk of developing an earing disorder. The service offers short term psychological based treatment for different types of eating challenges and sensory difficulties. The service also offers consultation to other services and a parent group.	

	ML highlighted how important it was to have a service for eating difficulties that focused on prevention and the work with children and their families. Their experience of the service was positive as they felt heard and able to work collaboratively with their clinician due to the time they were given. ML also commented positively on the communication with themselves and other professionals such as school and therapists. It was also noted that appointments were kept as planned. DW highlighted that there were multiple assessments required which was a challenge for young people to share this information repeatedly. There was fatigue by the time they saw the clinician that could support them. The assessment with the Trust was professional and understanding and the family appreciated direct two-way communication with their therapist. DW noted that the content of the training attended was excellent, however, the delivery of the presentation could have been improved. The parent group was informative but there was a feeling that others in the group were not aware of its purpose and the professionals did not give enough guidance. JJ noted that it was key to engage with parents of children with eating difficulties. SS asked how the child's experience could have been better. DW commented that streamlining the referral process would have made the process easier. TH commented that parental involvement is key, however, the team should explore that this is balanced between the knowledge of parents and clinicians. SJ queried the methods employed to ensure the family felt heard. ML provided feedback that as a family they had been given the time and space to talk, and TH shared his thought processes which felt collaborative. MH asked whether the family were aware of the service before they were referred. DW commented that they were not aware of the service and had previously been referred to the eating disorder service which was not the right service for their children. ML highlighted that their GP was not aware of the service either. MH noted that there should be further promotion of the service.	
017	**HIGHER EDUCATION SECTOR RISKS**	
	MF took the report as read noting an outstanding action in relation to the Code of Practice for Freedom of Speech which was included within the assurance report for the Education and Training Committee. SS queried how we were supporting with smaller providers closing. MF confirmed that an agreement had been reached with NHS England to provide support for Leeds and York Partnership Trust for two courses. Further discussion was being undertaken in relation to psychotherapy doctoral training. MH queried whether the Code of Practice for Freedom of Speech had been reviewed in line with our Equality, Diversity and Inclusion Policy. MF noted that the Code of Practice was a statutory requirement and that work had been undertaken with the Department of Education and Training equality, diversity and inclusion team. It was	

	also noted that there were further procedures in development to support the implementation of the Code of Practice. The Board discussed whether differentiation was required between the Department for Education and Training and the rest of the Trust within the Code of Practice for Freedom of Speech. **Action:** Education and Training Committee to review the Code of Practice for Freedom of Speech with the Equality, Diversity and Inclusion Policy The Board **APPROVED** the Freedom of Speech Code of Practice with the above action.	**MF**
018	**EDUCATION AND TRAINING COMMITTEE (E&T) COMMITTEE ASSURANCE REPORT**	
	SJ presented the report noting that the Committee considered two papers in relation to the future sustainability of the Department of Education and Training. It was noted that the viability of short courses was discussed at the Committee and careful planning would be required. SJ commented that the Committee had discussed the Board Assurance Framework risk in relation to the registration with the Office for Students and whilst this did not present an immediate risk any delays to the merger would impact this, therefore, the decision was made to continue monitoring. CJ queried whether decisions had been made around closing short courses. MF would be proposing to the Executive Leadership Team that some courses were closed, these relate to courses that are not financial sustainable due to the number of students on the courses. SJ added that these courses would continue to be provided for those students currently enrolled on the course. MF added that NLFT had provided financial projections for the five-year period following the merger and this had been submitted to the Office for Students. All baseline obligations have been fulfilled to maintain registration. The Board received **ASSURANCE** from the update provided.	
019	**PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY DIVERSITY AND INCLUSION (POD EDI) COMMITTEE ASSURANCE REPORT**	
	SS presented the paper, and noted that there had been a focus on staff engagement and staff disengagement ahead of the merger. The Freedom to Speak Up Guardian attended and described the systematic programme of work to publicise their service. This provided assurance that Freedom to Speak Up was more embedded within the Trust and we expect more Freedom to Speak Up cases over the next few months. The EDI Programme Board also reported to the Committee noting that inclusion representatives had been trained to attend interview panels, however, they had not been in attendance at recent interviews. The staff governor commented that she had been engaging with the inclusion representative at the beginning of the process ahead of interview which had seen an improvement.	

	A paper was also received in relation to support for staff during the merger that documented a wide range of initiatives in place, however, it was acknowledged that this would be a difficult time for staff. KBo noted that BAF risk 6 required a review of the description to include the merger transaction and ensure that all controls were captured given the work being undertaken to support staff. The Board received **ASSURANCE** from the update provided.	
020	**FINANCE REPORT: MONTH 07**	
	JB presented the finance report at month seven, noting that a PFR Committee had been held this morning that had received a month eight report. The data across the two reports was consistent, excluding a swing in the adverse variance in month eight. As this was anticipated the forecast was as expected, £1.7m adverse to variance with a £2.6m full year effect of the national training contract and delivery of the cost improvement programme. Controls had been implemented to limit expenditure for the rest of the financial year. Additional capital funding had been received in year which is currently underspent in information management and technology. The Trust was looking to reallocate these funds to estates as additional funding is required for the new site for Gloucester House School. Cash continues to be a significant pressure in the organisation with a request submitted for £2.85m cash in January. The cash support had been received as a loan until the Gloucester House sale is complete.	
021	**PERFORMANCE, FINANCE AND RESOUCES COMMITTEE (PFR) ASSURANCE REPORT**	
	JB presented the report noting that the Committee reviewed the IQPR and contract risks. A report had been received around the work that was happening with information management and technology as we move towards the merger with good progress. There are challenges around the cost improvement programme and the full year effect of savings. Work has begun on the plan for the following financial year to ensure traction of recurrent savings. The forecast shows £5.4m shortfall to plan with discussion around mitigation ongoing. The Board will be informed as this progresses and if necessary, an adverse movement to our forecast will be submitted. The Committee received a paper on the national cost collection exercise benchmarking activity and costing. The benchmark suggests the Trust is nearly £10m more expensive than the average due to the high level of overheads. The Board received **ASSURANCE** from the update provided.	

022	**EMERGENCY PLANNING ANNUAL REPORT, LETTER OF DECLARATION AND SELF-ASSESSMENT AGAINST CORE NHS STANDARDS FOR EMERGENCY PREPAREDNESS, RESILIENCE AND REPSONSE**	
	CS presented the emergency preparedness, resilience and response core standards noting that NHS organisations are required to carry out a self-assessment. The self-assessment was undertaken, a check and challenge meeting with North Central London Integrated Care Board and NHS England London Region. The Trust received a rating of fully compliant, an improvement on previous submissions. The Trust was working closely with colleagues in North London NHS Foundation Trust around the structures post-merger. The Board passed their congratulations to the team.	
023	**BOARD SCHEDULE OF BUSINESS 2025/26**	
	The last meeting of the Board of Directors was scheduled to be held on 19 March; this may be rescheduled to 26 March 2026.	
024	**QUESTIONS FROM GOVERNORS**	
	There were no questions raised from governors.	
025	**ANY OTHER BUSINESS**	
	There were no items of other business raised.	
026	**QUESTIONS FROM THE PUBLIC**	
	A member of the public queried how the Trust would be addressing the Gender Identity Clinic waiting list. It was confirmed that a full response would be provided outside of the meeting.	
027	**REFLECTIONS AND FEEDBACK FROM THE MEETING**	
	SS noted that the patient and service user story was interesting and inspiring. It was noted that papers should be presented through the Executive Leadership Team before being presented to the Board of Directors. LS noted that it was a challenging time with uncertainty, however, the papers showed that the quality of work remained high. SJ noted that the support received from NLFT colleagues had enabled quality discussion. The Board passed their thanks to NLFT.	

Date of Next Meeting in Public: Thursday, 26 March 2026 at 10.00a.m – 1.00p.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	To Close	19/03/26: All NEDs now compliant with Oliver McGowan level 1 training. 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.
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	To Close	16/03/26: Governor focus has been on ensuring relevant information is handed over to the Board sub-Committees
15.01.26	8	National Oversight Framework Update	RB to present a further update on the National Oversight Framework at a future meeting of the Board in public	26.03.26	Rod Booth, Director of Strategy and Business Development	To Close	13/03/26: National Oversight Framework update included in Chair and Chief Executive's report
15.01.26	10	10-point plan to improve resident doctors working lives action plan	LS to consider how learning from General Medical Council surveys are disseminated	26.03.26	Liz Searle, Interim Joint Chief Medical Officer	To Close	19/03/26: There were no areas of concern from the 2025 survey. Following publication of results any areas for learning are discussed at the Trust Medical Education Board Meeting and disseminated to all trainers in the Trust
15.01.28	13	Patient and Carer Race Quality Framework Update	Q&SC to review IQPR report to review referrals and provide assurance to March Board	26.03.26	Sheva Habel, Interim Joint Chief Medical Officer	To Close	26/02/26: Referral data included in PCREF report to QSC February 2026
15.01.29	14	Gender Identity Clinic update	AM and MH to write to the gender identity clinic and national team to pass the thanks of the Board	26.03.26	Aruna Mehta, Chair and Michael Holland, Chief Executive	Open	
15.01.30	17	Higher Education Sector Risks	ETC to review the Code of Practice for Freedom of Speech with the Equality, Diversity and Inclusion Policy	26.03.26	Mark Freestone, Chief Education and Training Officer	Open	19/03/26: Work is in progress to align the Code of Practice for Freedom of Speech with NLFT policies. Action to be taken forward by NLFT.

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 26 March 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 15 January 2026.		
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. Janusz Jankowski, Non-Executive Director left the Board. I would like to thank Janusz for his contributions to the Trust and wish him the very best for the future.

2. Merger by Acquisition update

Our Council of Governors have unanimously approved the merger going ahead, with the merger aiming to take effect on 1 April 2026, subject to Secretary of State for Health and Social Care approval.

I continue with the regular All Staff Meetings and merger drop-in sessions which give staff an opportunity to ask questions about the merger by acquisition. There are also weekly drop-in sessions held by the Executive Teams of both Trusts.

Providing outstanding patient care

3. Clinical Services

Clinical services continue to be very busy with 348 first appointments and 253 second appointments in December. The number of referrals to our services remains high with 249 referrals to the Camden Unit; 141 for the Children and Families Unit and 262 for the Adult Unit in December.

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.

The Trust received the Gender Dysphoria Clinic level draft report on 3rd March 2026 and will respond to the factual accuracy request by 13th March. The final report is expected by the end of March 2026. The service is devising an action plan to address the recommendations from both the local report, giving consideration to the national recommendations.

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 9 IQPR presented data on referrals compared to open caseload and population levels. The closer the referral and open case load data is to the population level data the more equal the access the service is. All Units show there is an under representation of Asian and Black children, young people and adults. The continuing discrepancies in access are a concern and the need for continued community engagement is paramount to ensure the local population is aware of the services offered by the Trust and how to access them.

5. Returning Families service closure

And finally, I wanted to acknowledge the contribution of the staff in the Returning Families service, which closes at the end of the month following a decision by the Home Office to no longer fund the service. The team has supported families with significant long term psychological and social needs and their contribution has been much appreciated.

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

6. Staff Survey

The 2025 NHS staff survey results have now been published with 49% of eligible staff responding to the survey, a slight decrease in the number of respondents from 2024. The results show an upward trajectory, with improved results in seven out of the nine survey areas including staff engagement. These have been shared with NLFT colleagues to inform a way forward which incorporates findings from the Tavistock and Portman staff survey results and NLFT staff survey results.

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

7. Watch Me Play!

An important research paper on Watch Me Play! has been published in the *Journal of Child Psychotherapy*. Watch Me Play! was developed at the Tavistock and Portman NHS Foundation Trust by Dr Jenifer Wakelyn, a child and adolescent psychoanalytic psychotherapist. It is rooted in psychoanalytic infant observation and child development research on attention, joint attention and responsive caregiving.

Improving Value, Productivity, Financial and Environmental Sustainability

8. National Oversight Framework

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.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.

At an NHS England oversight meeting on 13th January 2026, it was recognised that financial challenges are consistent with risks already recognised by the Trust and are subject to active management. Following the meeting the Trust shared the following plans with NHS England colleagues:

- Monthly finance reporting and 2025/26 FOT mitigations

- Trust performance on CAMHS waiting times which is in the national upper quartile for 1st and 2nd appointments
- Our FTSU, EDI and staff support plans.
- An update on our education and training courses

9. Finance Update

At month 9, the Trust is reporting a deficit of £5.97m which is £3.06m 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 £2.85m was received from the Department of Health and Social Care in January.

Regional and National Context

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

Katie Fisher has been appointed as the new interim Chief Executive Officer for North Central London and North West London ICB, taking a secondment from her substantive role as Chief Executive Officer at South West London ICB.

She will oversee the launch of West and North London ICB, which will come into effect from 1 April. It will be the largest ICB in England.

11. Medium Term Planning Framework

The Medium-Term Planning process across the NHS was launched in November 2025. The Trust submitted a three-year plan on 12 February 2026. The submitted plan sets out the financial, workforce and activity plans for the next three years on the basis of a merger.

12. Chief Executive's meetings with external stakeholders

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

- London CEO and Regional Directors meeting
- London Data Quality Improvement Group
- London Neighbourhood Health Delivery Board
- London Adult ADHD Reference Group
- West and North London CEO meeting
- London Mental Health Digital Strategic Oversight Group
- Cavendish Square Group meeting
- Mental Health Trust Chief Executive meeting
- UCL Health Alliance Executive Group

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Integrated Quality and Performance Report February 2026 *based on December (M09) 2025 Data*			**Agenda No.: 008**
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: M09 Integrated Quality and Performance Report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	The Trust Integrated Quality and Performance Report (IQPR) for December 2025 (Month 09) 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 27th January 2026. The data presented relates to December 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

The Adult Gender Service and Clinical Services leads welcomed the Levy Review into Gender Dysphoria Services being published in December 2025. The wide-ranging recommendations will be implemented nationally across all GICs with the intention of improving patient care and reducing the extremely long waits gender patients currently experience. National implementation meetings have been arranged alongside monthly implementation board meetings for trust Chief Medical Officers.

Service Improvement pipeline:

- **GIC Surgical Referrals Recovery and Mitigation Plan:** NHSE have agreed to backdate all GIC surgical referral errors. The service is working with GDNRSS to ensure this occurs in a timely manner with reviews for those requiring refresher appointments.
- **Trauma Targeted support:** The Trauma Team continues to be supported within a targeted support framework. They are starting to work with the QI team to review options to move them into a QI framework. However, the Trauma waiting list continues to grow with 300 patients waiting more than 104 weeks for their first appointment. The team wish to review the closure of the waiting list to safeguard the risks of waiting for current waiters alongside our review of out of area patients, some of whom may return to local care pathways.

Referrals and Activity

In M09 the Trust completed 348 first appointments and 253 second appointments with an overall activity at 6,303 attendances.

The Camden unit received 249 referrals which is 42% higher than the same reporting period last year. 102 first appointments were attended with an average wait of 2.54 weeks from referral to 1st appointment. The unit reported and overall job plan compliance of 63%.

The number of referrals into the Children & Families Unit remains high at 141 for M09 (compared to 96 in December 2024). From months 1-9 the unit has received 1,719 referrals . There were 1,368 clinical contacts for the Child and Family Unit in December, adjusted for seasonal variation and a record 118 1st appointments in the month. At M09 the Unit delivered a total of 14,733 clinical appointments for the NCL/NHSE services on all contracts against an annual target of 17,169.

The Adult unit received 262 referrals (231 GIC, 31 Therapies services) and delivered 128 first appointments and 1,981 appointments in total in M09. The Adult Trauma Team's overall job plan compliance was 40%.

Clinical Services updates:

- **Returning Families** have been served notice of closure with an end date of March 2026.The service closure consultation closed on 21.12.2025. Individual meetings with staff have started and redeployment opportunities are being explored with all staff in service at risk of redundancy or redeployment.
- **Trauma**: The alliance of providers has won a bid for the Enhanced Mental Health Pathway for Sexual Assault and Abuse. The Adult Unit is an associate member of this group. We are not providing a lead or co-lead role due to ongoing service delivery pressures.

2. Quality and Safety

Experience and Outcomes:

- **Patient Feedback:** In December 2025, performance against number of forms received and positive responses was just below target for both metrics. There has been a positive increase in number of forms received following text reminders being sent. There were several forms not uploaded in November due to workforce absence within the admin team, and these have now been included in December's data. There is continued targeted support being offered to teams to develop actions to increase workforce and patient engagement and improve feedback rates. "Patient care" and "Values and behaviour" continue to be the most common themes reported by patients. “Communication" continues to be a theme where improvements are needed. Teams are reviewing data and planning improvements through a QI framework.

- **Complaints: Clinical Services:** A total of 11 complaint contacts were received Trust-wide in December; 10 were received by the Adult Unit and 1 by the Child & Family Unit. This remains within normal variation. All complaint contacts received in December were acknowledged within 3 working days in line with national regulations.
  Trust wide compliance for formal complaints responded to within 40 working days in December was 100%, meaning that of the 2 complaints closed formally in the month, both were within the 40 working day timeline. 3 complaints were also resolved informally in the month; all of which were in the Adult Unit. As of the end of the month, 16 complaints (13 Adult & 3 Children & Families) were open, 2 of which are overdue.

- **Complaints: Directorate of Education and Training:** The Trust received 1 formal complaint in DET in December 2025, submitted by a group of students on BM58 in the Service Issues category. The Trust closed 1 informal complaint, which was successfully resolved at the local stage, and1 formal complaint, which was Partly Upheld.

- **Compliments:** 4 compliments were recorded on Radar in December 2025; 3 in the Camden Unit and 1 by Children & Family Unit. The content was categorised as Patient Care (13) and 'Other'

(1) categories.

- **Clinical Outcome Measures (OM):** NHSE launched new waiting time metrics on 1 April 2025, explicitly linked to OM collection. December (M9) saw the delivery of training sessions on assist panels within the EPR and improved clinical dashboards. This month's successes include 68.4% of children and young people discharged with a paired CGAS Score, maintaining momentum from November, and an improvement in the number of GBM recorded. Over 18 OMs are dipping towards the mean following a sustained period of improvement indicating a potential need for a unit level intervention to increase usage. The Trust is currently testing SPC charts to demonstrate improvement rates within the clinical dashboard.

- **Patient and Carer Race Equality Framework (PCREF)**:
  Month 09's PCREF focus was to compare the data on referral compared to open caseload and population levels. The closer the referral and open case load data is to the population level data the more equal the access the service is. All Units demonstrated an under representation of Asian and Black children, young people and adults. The degree of underrepresentation is different across services; the largest discrepancy in Camden is for those of Asian ethnicities. In the Child and Family Unit the main discrepancies is around both Asian and Black communities' representation for both referrals and caseload compared to local population. However, there is not significant evidence that Global Majority young people are less likely to be accepted.
  In the Adult Therapies service there is evidence Black service users are more likely to not progress into the open caseload than other ethnicities. This is also the case for the Portman Clinic. All NCL specific services have higher levels of people identifying as a Mixed ethnicity being referred and seen in the units compared to the population level data. The continuing discrepancies in access are a concern and the need for continued community engagement is paramount to ensure the local population is aware of the services offered by the Trust and how to access them.

Incidents and Learning:

- **Incidents**:
  In December 2025, a total of 19 patient safety incidents were reported across the Trust, recorded by Camden Unit (1),Adult Unit (4), and Children & Families Unit (14). This included three deaths reported by the Adult Unit in relation to GIC; one related to a former patient, and two who were on the waiting list at the time of death. Mortality reviews have been requested and will be considered by the Clinical Incident & Safety Group (CISG) once completed.

  A total of 14 incidents of violence and aggression were reported, 12 of which occurred within the CYP & Families Unit at Gloucester House. One incident was reported in Camden Unit (South Camden) of a patient assault against clinician, and one incident

was reported in the Adult Unit (GIC) related to verbal aggression towards staff and disruption of the clinical assessment.

Three incidents of restrictive practice were reported in the month; all by the Gloucester House team. The reduction from the previous month is largely attributable to the school holiday period during December however the SPC chart indicates a rise above normal variation in November 2025. This has been discussed with the school's senior leadership team, and a dedicated Quality Improvement project has been initiated.

Two After Action Reviews (AARs) were indicated in December as a learning response where potential opportunities for improvement were identified. One AAR related to the CYP and Families service, where a pupil became dysregulated and was physically and verbally abusive towards staff over an extended period. An AAR was initiated due to identified learning in relation to staff rotation. The second AAR was raised within the Adult Unit following an appointment being incorrectly recorded via the Dr. Doctor app. Following discussion at the Executive Safety Huddle, it was agreed that both AARs would be stood down, as alternative review processes were deemed more appropriate.

3. People

- **Mandatory and Statutory Training (MAST)** compliance stood at 79.28% (697), a 7.38% (65) decrease ending December 2025. Chief Financial stands at 94.83% (56) compliance, holding a high standard continuing from the previous months. Chief Nursing follows, at 92.40% (21). To achieve a high standard, each directorate will need to target 90% and above and the People Team are leading a Quality Improvement project to support trust-wide improvements across all areas.
- **Appraisal** completion rate stood at 62.92% (553), increasing by 1.66% (15) at the end of December. Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisal compliance. Chief Executive has achieved 73.68% (17) of appraisal reviews completed. Chief Clinical follows at 69.90% (321).
- The Tavistock & Portman Trust sickness rate stood at 3.61% (32) at the end of December and continues to rise, increasing by 0.39% (3) since the previous month. However, the rate remains below the average benchmark of 4% across the NHS. The Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.47% (13).
- The sickness absence data from January 2025 to December 2025 reveals that mental health issues, specifically anxiety, stress, and depression remain the leading cause of absence across both White and BME ethnic groups.

4. Finance

	• **Income & Expenditure:** As of M09, the Trust reported a year-to-date deficit of £5.974m, which was £3.063m 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 capital expenditure limit for 2025/26 has increased to £3.021m from £2.774m, following additional funding for the PEP project (£208k) and IFR16 equipment projects (£39k). By Month 9, capital spend totals £1.614m against a planned £3.269m. The original plan assumed that £1.780m from the Gloucester House sale would be reinvested into capital projects. However, due to cash shortages during the financial year, the proceeds from the Gloucester House sale will no longer be available for capital investment. • **Cash Position:** As of December 2025, cash reserves were £1.012m, equivalent to approximately five days of operating expenditure. The Trust's cash PDC application of £2.850m has been approved to prevent cash shortages in January 2026, with the condition that £2.4m will be repaid once the Gloucester House sale completes. The sale of Gloucester House is now expected to complete by the end of February. If everything proceeds as planned, the Trust will not require any additional cash support for the remainder of the financial year. However, if the Gloucester House sale is delayed into the next financial year, the Trust will require additional cash PDC support of £1.9m in March 2026. Overall, total cash support required in 2025/26 has increased from £4.266m to £7.102m. This rise is driven by the £2.6m loss of National Training Contract income, the delayed property sale, non-delivery of planned savings, and the Trust's already constrained underlying cash position.
Key recommendation(s):	The Board is asked to **DISCUSS** and **NOTE** the report for assurance.

Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☐	Compassion ☐	Respect ☐	
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		

	Risk Ref and Title: BAF Risk 1 - Inequality of access for patients BAF Risk 2 - Failure to provide consistent high-quality care BAF Risk 13 – Failure to achieve required levels of performance & productivity BAF 14: Effective Performance and Risk management arrangements.			
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 – 27th 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

Integrated Quality and Performance Report M9 2025

NOTE: THIS REPORT USES DATA FROM DECEMBER 2025

Our vision is to be a leader in mental health care and education, promoting talking therapies, to make a meaningful difference to people's lives

Tavistock and Portman
Our Values and Strategy

The Tavistock and Portman NHS Foundation Trust

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

Excellence Inclusivity Compassion Respect

Executive Summary (1/2)

The Tavistock and Portman NHS Foundation Trust

Operational

The Adult Gender Service and Clinical Services leads welcomed the Levy Review into Gender Dysphoria Services being published in December 2025. The wide-ranging recommendations will be implemented nationally across all GICs with the intention of improving patient care and reducing the extremely long waits our gender patients currently experience. National implementation meetings have been arranged alongside monthly implementation board meetings for trust CMOs.

Service Improvement pipeline:

GIC Surgical Referrals Recovery and Mitigation Plan:
NHSE have agreed to backdate all GIC surgical referral errors. The service is working with GDNRSS to ensure this occurs in a timely manner with reviews for those requiring a "refresher".

Trauma Targeted support – The Trauma Team continues to be supported within a targeted support framework. They are starting to work with the QI team to review options to move them into a QI framework. However, the Trauma waiting list continues to grow with 300 patients waiting more than 104 weeks for their first appointment. The team wish to review the closure of the waiting list to safeguard the risks of waiting for current waiters alongside our review of out of area patients, some of whom may return to local care pathways.

Referrals and Activity

In M09 the Trust completed 348 first appointments and 253 second appointments with an overall activity at 6,303 attendances.

The Camden unit received 249 referrals which is 42% higher than the same time last year. 102 first appointments were attended with an average wait of 2.54 weeks from referral to 1st appointment. The unit reported and overall job plan compliance of 63%.

The number of referrals into the Children & Families Unit remains high at 141 for M09 (compared to 96 in December 2024). From months 1-9 the unit has received 1,719 referrals . There were 1,368 clinical contacts for the Child and Family Unit in December, adjusted for seasonal variation and a record 118 1st appointments in the month. At M09 the Unit delivered a total of 14,733 clinical appointments for the NCL/NHSE services on all contracts against an annual target of 17,169.

The Adult unit received 262 referrals (231 GIC, 31 Therapies services) and delivered 128 first appointments and 1,981 appointments in total in M09. The Adult Trauma Team's overall job plan compliance was 40%.

Clinical Services updates:

Returning Families have been served notice of closure with an end date of March 2026.The service closure consultation closed on 21.12.2025. Individual meetings with staff have started and redeployment opportunities are being explored with all staff in service at risk of redundancy or redeployment.
Trauma: The alliance of providers has won a bid for the Enhanced Mental Health Pathway for Sexual Assault and Abuse. The Adult Unit is an associate member of this group. We are not providing a lead or co-lead role due to ongoing service delivery pressures.

People

- Mandatory and Statutory Training (MAST) compliance this month stands at 79.28% (697), a 7.38% (65) decrease ending December 2025. Chief Financial stands at 94.83% (56) compliance, holding a high standard continuing from the previous months. Chief Nursing follows, at 92.40% (21). To achieve a high standard, each directorate will need to target 90% and above and the People Team are leading a Quality Improvement project to support trust-wide improvements across all areas.
- Appraisals completion rate currently stands at 62.92% (553), increasing by 1.66% (15) at the end of December. Continuous work is being carried out by the learning and development team to ensure the Trust raise the standard of appraisals. Chief Executive has achieved 73.68% (17) of appraisal reviews completed. Chief Clinical follows at 69.90% (321).
- The Tavistock & Portman Trust sickness rate stands at 3.61% (32) at the end of December and continues to rise, increasing by 0.39% (3) since 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 1.47% (13).
- The sickness absence data from January 2025 to December 2025 reveals that mental health issues, specifically anxiety, stress, and depression remain the leading cause of absence across both White and BME ethnic groups.

Finance

Income & Expenditure
As of M09, the Trust reports a year-to-date deficit of £5.974m, which is £3.063m 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 capital expenditure limit for 2025/26 has increased to £3.021m from £2.774m, following additional funding for the PEP project (£208k) and IFR16 equipment projects (£39k). By Month 9, capital spend totals £1.614m against a planned £3.269m. The original plan assumed that £1.780m from the Gloucester House sale would be reinvested into capital projects. However, due to cash shortages during the financial year, the proceeds from the Gloucester House sale will no longer be available for capital investment.

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As of December 2025, cash reserves were £1.012m, equivalent to approximately five days of operating expenditure. The Trust's cash PDC application of £2.850m has been approved to prevent cash shortages in January 2026, with the condition that £2.4m will be repaid once the Gloucester House sale completes. The sale of Gloucester House is now expected to complete by the end of February. If everything proceeds as planned, the Trust will not require any additional cash support for the remainder of the financial year.

However, if the Gloucester House sale is delayed into the next financial year, the Trust will require additional cash PDC support of £1.9m in March 2026. Overall, total cash support required in 2025/26 has increased from £4.266m to £7.102m. This rise is driven by the £2.6m loss of National Training Contract income, the delayed property sale, non-delivery of planned savings, and the Trust's already constrained underlying cash position.

Executive Summary (2/2)

The Tavistock and Portman NHS Foundation Trust

Quality and Safety

Experience and Outcomes:

Patient Feedback:
In December 2025, performance against number of forms received and positive responses was just below target for both metrics. There has been a positive increase in number of forms received following text reminders being sent. There were several forms not uploaded in November due to workforce absence within the admin team, and these have now been included in December's data. There is continued targeted support being offered to teams to develop targeted actions to increase workforce and patient engagement and improve feedback rates.

"Patient care" and "Values and behaviour" continue to be the most common themes reported by patients. "Communication" continues to be a theme where improvements are needed. Teams are reviewing data and planning improvements through a QI framework.

Complaints: Clinical Services:
A total of 11 complaint contacts were received Trust-wide in December; 10 were received by the Adult Unit and 1 by the Child & Family Unit. This remains within normal variation. All complaint contacts received in December were acknowledged within 3 working days in line with national regulations.

Trust wide compliance for formal complaints responded to within 40 working days in December was 100%, meaning that of the 2 complaints closed formally in the month, both were within the 40 working day timeline. 3 complaints were also resolved informally in the month; all of which were in the Adult Unit. As of the end of the month, 16 complaints (13 Adult & 3 Children & Families) were open, 2 of which are overdue.

Complaints: Directorate of Education and Training:
The Trust received 1 formal complaint in DET in December 2025, which was submitted by a group of students on BM58 in the Service issues category. The Trust closed 1 informal complaint, which was successfully resolved at the local stage, and 1 formal complaint, which was Partly Upheld.

Compliments: 4 compliments were recorded in Radar in December 2025; 3 in the Camden Unit and 1 by Children & Family Unit. The content was categorised as Patient Care (13) and 'Other' (1) categories.

Clinical Outcome Measures (OM):
NHSE launched new waiting time metrics on 1 April 2025, explicitly linked to OM collection. December (M9) saw training sessions on assist panels within the EPR and improved clinical dashboards. This month's successes include 68.4% of children and young people discharged with a paired CGAS Score, maintaining momentum from November, and an improvement in the number of GBM recorded; possibly due to the tendency to review progress in treatment at the "end of term". Over 18 OMs are dipping towards the mean following a sustained period of improvement indicating a potential need for a unit level intervention to increase usage. The Trust is currently testing SPC charts to demonstrate improvement rates within the clinical dashboard.

PCREF (patient carer race equality framework):

The M09 PCREF focus is data on referrals compared to open caseload and population levels. The closer the referral and open case load data is to the population level data the more equal the access the service is. All Units show there is an under representation of Asian and Black children, young people and adults. The degree of under representation is different across the services; the largest discrepancy in Camden is for those of Asian ethnicities. In the Child and Family unit the main discrepancies is around both Asian and Black communities' representation for both referrals and case load compared to local population. However, there is not significant evidence that Global Majority young people are less likely to be accepted.

In the Adult Therapies service there is evidence Black service users are more likely to not progress into the open caseload than other ethnicities. This is also the case for the Portman Clinic. All NCL specific services have higher levels of people identifying as a Mixed ethnicity being referred and seen in the units compared to the population level data. The continuing discrepancies in access are a concern and the need for continued community engagement is paramount to ensure the local population is aware of the services offered by the Trust and how to access them.

Incidents:

In December, a total of 19 patient safety incidents were reported across the Trust, recorded by Camden Unit (1), Adult Unit (4), and Children & Families Unit (14). This included three deaths reported by the Adult Unit in relation to GIC; one related to a former patient, and two who were on the waiting list at the time of death. Mortality reviews have been requested and will be considered by the Clinical Incident & Safety Group (CISG) once completed.

A total of 14 incidents of violence and aggression were reported, 12 of which occurred within the CYP & Families Unit at Gloucester House. One incident was reported in Camden Unit (South Camden) of a patient assault against a clinician, and one incident was reported in the Adult Unit (GIC) related to verbal aggression towards staff and disruption of the clinical assessment.

Three incidents of restrictive practice were reported in the month; all by the Gloucester House team. The reduction from the previous month is largely attributable to the school holiday period during December however the SPC chart indicates a rise above normal variation in November 2025. This has been discussed with the school's senior leadership team, and a dedicated Quality Improvement project has been initiated.

Two After Action Reviews (AARs) were indicated in December as a learning response where potential opportunities for improvement were identified. One AAR related to the CYP and Families service, where a pupil became dysregulated and was physically and verbally abusive towards staff over an extended period. An AAR was initiated due to identified learning in relation to staff rotation. The second AAR was raised within the Adult Unit following an appointment being incorrectly recorded via the Dr. Doctor app. Following discussion at the Executive Safety Huddle, it was agreed that both AARs would be stood down, as alternative review processes were deemed more appropriate.

Metric	Waiting List Management	SRO	Sheva Habel/Liz Searle	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 19 patients from last month to 17,120 patients as of December 2025, with 101 new patients in December 2025 seen monthly with 231 referrals received.

Adult Trauma Service: With a 350% rise in referrals since 2019, as of December 2025 this is now 963 patients waiting. Many require intensive therapy lasting up to two years. In December, the treatment waiting list has decreased further and below the level recorded 12 months ago although there has been an increase of 72 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.

At December end 122 young people are waiting for assessment in Haringey with an average waiting time of 42 weeks to assessment and 244 young people are waiting for Hertfordshire with an average waiting time of 125 weeks to assessment.

Vision & Goals

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

G1. Clearly defined pathways for patients within next 4 months

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

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

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

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

Continued...

Chris Abbott

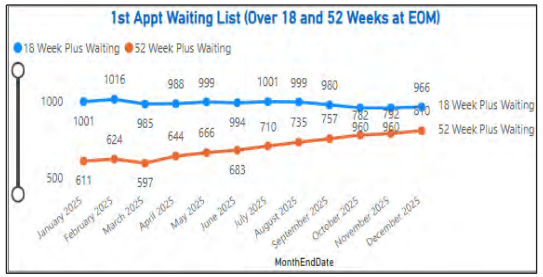
Integrated Quality and Performance Report

Month 09 - 25/26

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

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

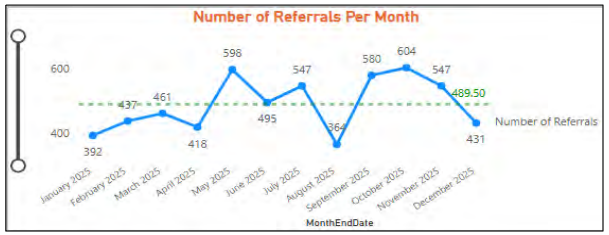
Mental Health Services Excluding GIC



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

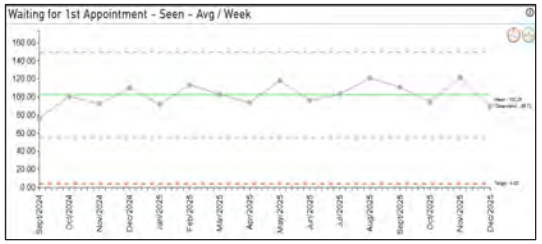
A. Number of first appointments conducted (exc. GIC)

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

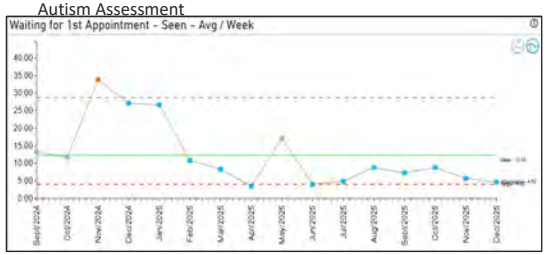


C. Number of discharges per month (Exc. GIC)

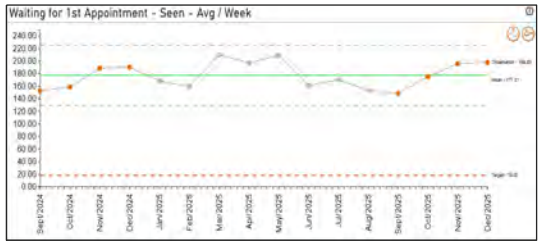
Trauma



Autism Assessment



Adult Gender Identity Clinic (GIC)



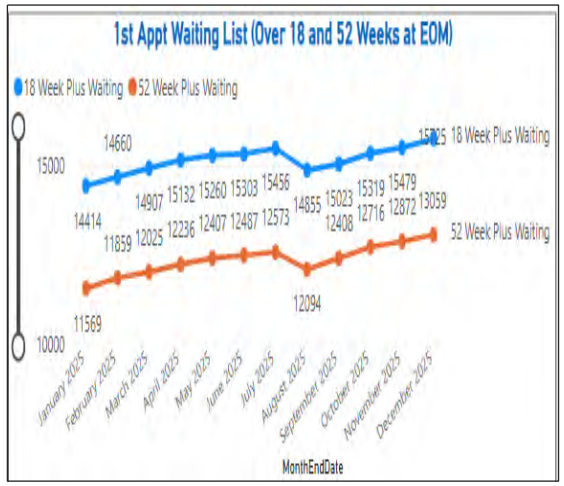
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Progress on Improvements

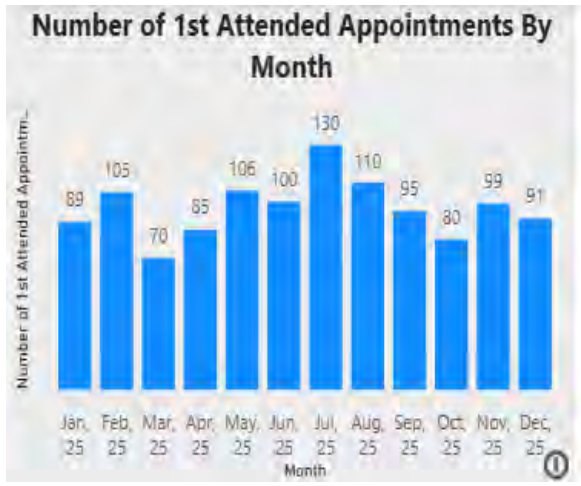
Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients who have not been seen by their service for over 12 months, resulting in a backlog of cases that require urgent review and appropriate discharge planning. This situation not only impacts patient health outcomes and resource 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** 3rd T&P / NLFT pathway meeting held in S with system clinical leads across 2nd Care Psychological Therapies & PD . – Dec 25 Trauma is closely monitoring the drop in first appointments and mapping the current treatment vacancies. 90% of ERF staff have now left which has left cost pressure, however in 26/27 the team will need to recruit to permanent positions in order to manage demand – **December 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 embedded with LIVE DR Doctor portal now in use. QI has focussed on optimal efficiency in booking slots and avoiding CBP/CBT, we have submitted a clinical rep for the NEW National GIC pathways working group. National QI project group considering if they can offer T&P help with A.I. for processing records. 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 until March 26 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 approximately 105 patients since May. – **Nov 2025. Interview December 2025 with anticipated start in January 2026**	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	Insufficient clarity regarding contractual targets	Complete SPC and Clinical dashboard reports by **Aug 25,** As at **October 2025**, Waiting List	Enhanced data accuracy and streamlined data flow.	Director of Clinical

Excellence Inclusivity Compassion

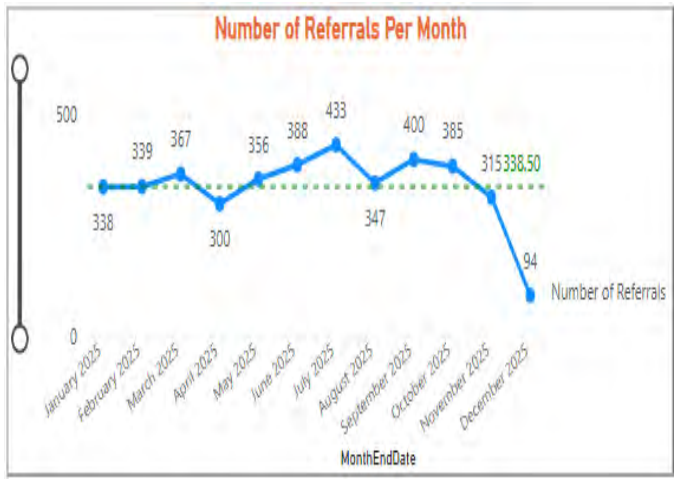
Metric	Waiting List Management (Continued)	SRO	Sheva Habel/Liz Searle	Target	4-wk & 18-Wk	Measure	



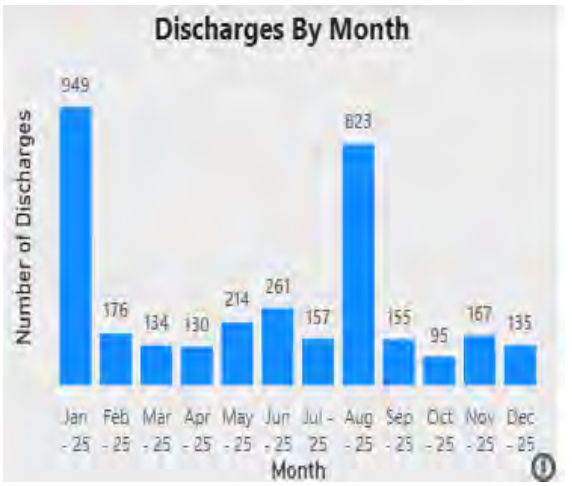
A. Adult GIC Number of first appointments conducted



B. Adult GIC Number of referrals by month



C. Adult GIC Number of discharges per month



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

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. OMs 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-** In testing, exp end of Jan 2026.

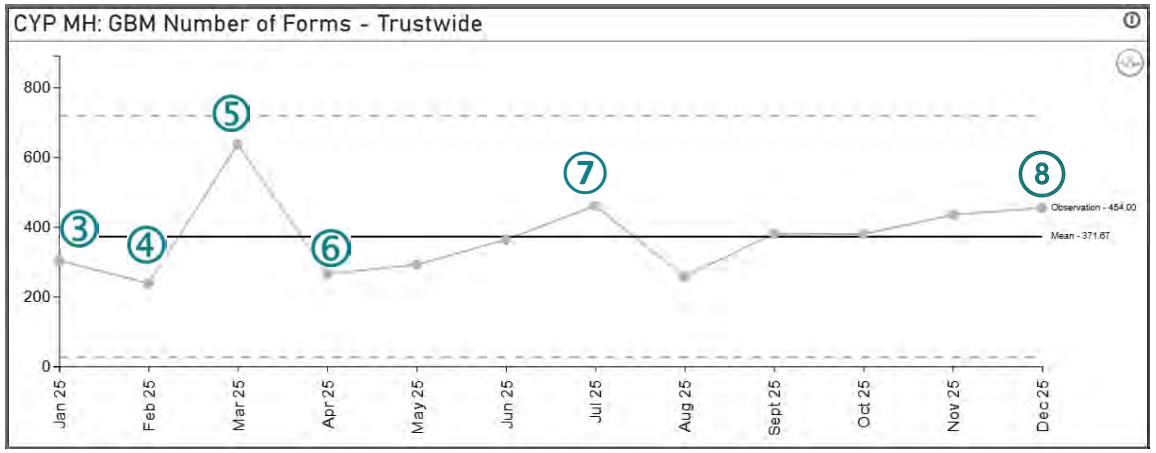
G2: Improve current rates of matched OM pairs by 50% for all Units by Oct '25 – Available on SPC dashboard

G3: Agree methodology to evidence improvement for all measures by **March' 26** – delayed due to work needed with adult partner providers. CGAS and GBM in

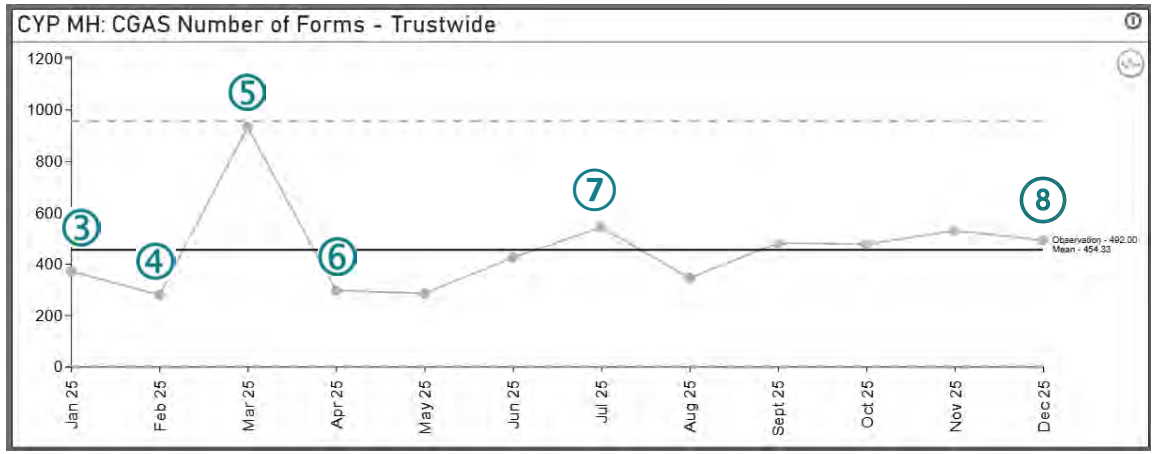
Concern	Causes	Countermeasures	Primary
Integration: OM not fully embedded into clinical workflows or care pathways	1. OM not hard-wired into care plans, reviews, or SOPs 2. OM completion is external to core clinical conversation 3. OM data collected but not routinely acted upon 4. OM results not routinely fed back to patients	1. Liaison with NCL leads to standardize improvement rates **– Continuing liaison with NCL CYPMH Provider Collaborative and NHSE – IMT CGAS improvement dashboard, now in testing.** 2. Embed OM into care plans, templates, and appointment SOPs **- Pilot for CGAS live in Dec.** 3. Establish mandated OM agenda item + Standard Work in MDT and supervision **– Discussed in unit wide meetings. Pilot work underway to discuss OM at team level.** 4. OM-informed care planning in one service **– Camden Wellbeing Team began pilot in Dec.**	Clinical Services
Perception: OMs are not always seen to add clinical value	1. OM positioned as compliance metric historically 2. Clinicians do not always take responsibility for OM conversations 3. Anxieties regarding OM data being used for workforce performance management	5. Refresh comms campaign positioning OM as a clinical tool- **Quarter 4 highlight comms to be published March.** 6. Develop training focused on clinical conversations **– Blending existing training.** 7. Peer-led MDT case studies using OM in shared decision-making to be incorporated into training **(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 **– Direct support from EB uptake is slow. Tailored training sessions to be offered.** 10. GIC measure, logic and process agreed and planned **– OM now in testing, logic still to be confirmed.**	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. Clinical 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 **– ongoing collaboration with IM&T.** 14. Train and coach teams on use of clinical dashboard **- unit wide sessions taken place within Dec. Amending support offer from feedback.**	Clinical Services IM&T

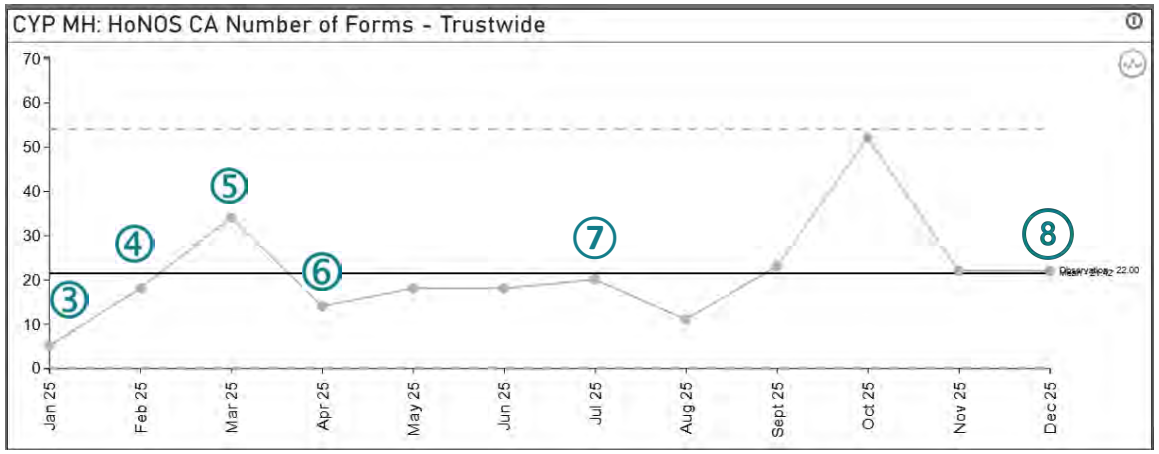
OMs: Under 18s - Number of OMs completed each month

The Tavistock and Portman NHS Foundation Trust



Legend	Countermeasure	Legend	Countermeasure
①	Oct 24- Clinical Governance Presentations	②	Nov 24 -Trust-wide training delivered
③	Jan 25 - Unit level training delivered	④	Feb 25 -All Care notes changes complete
⑤	Mar 25 - Unit follow up with clinicians	⑥	April 25 - Clinical Dashboard go-live
⑦	Jul 25 - Team Level bespoke training offered and taken up by 3 teams	⑧	Dec 25 - Training sessions on assist panel & dashboards





OMs: Over 18s - Number of OMs completed each month

The Tavistock and Portman NHS Foundation Trust

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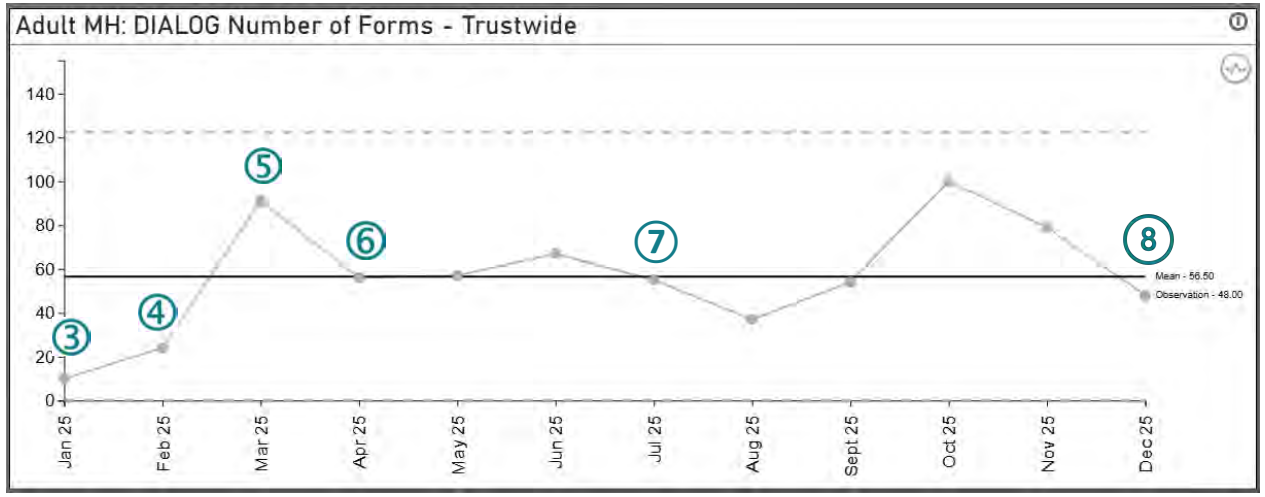

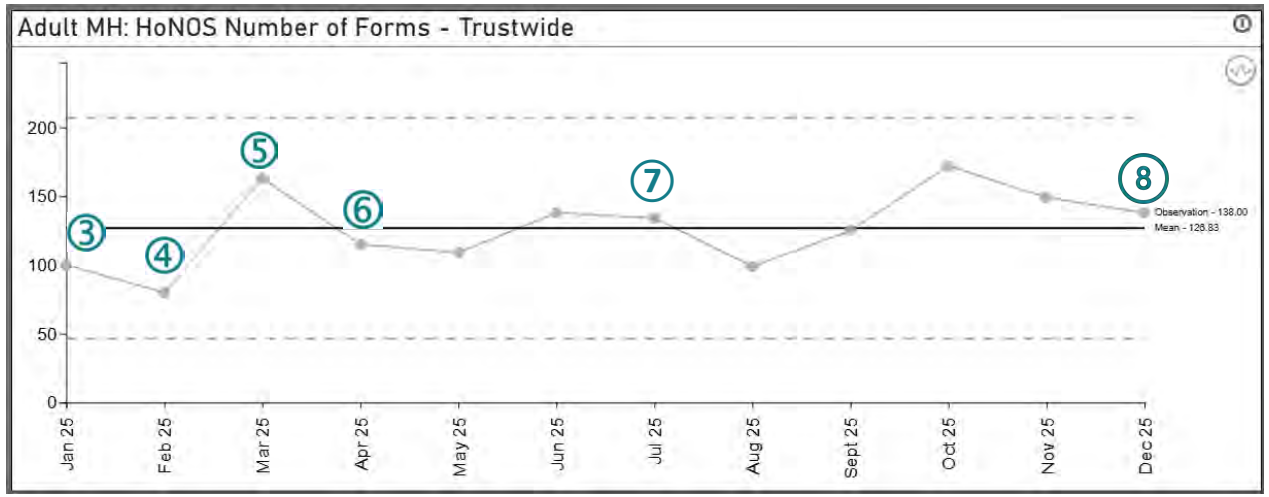

OMs: Under 18s – Percentage of patients discharged with a matched pair

The Tavistock and Portman NHS Foundation Trust

Legend	Countermeasure	Legend	Countermeasure
①	Oct 24- Clinical Governance Presentations	②	Nov 24 -Trust-wide training delivered
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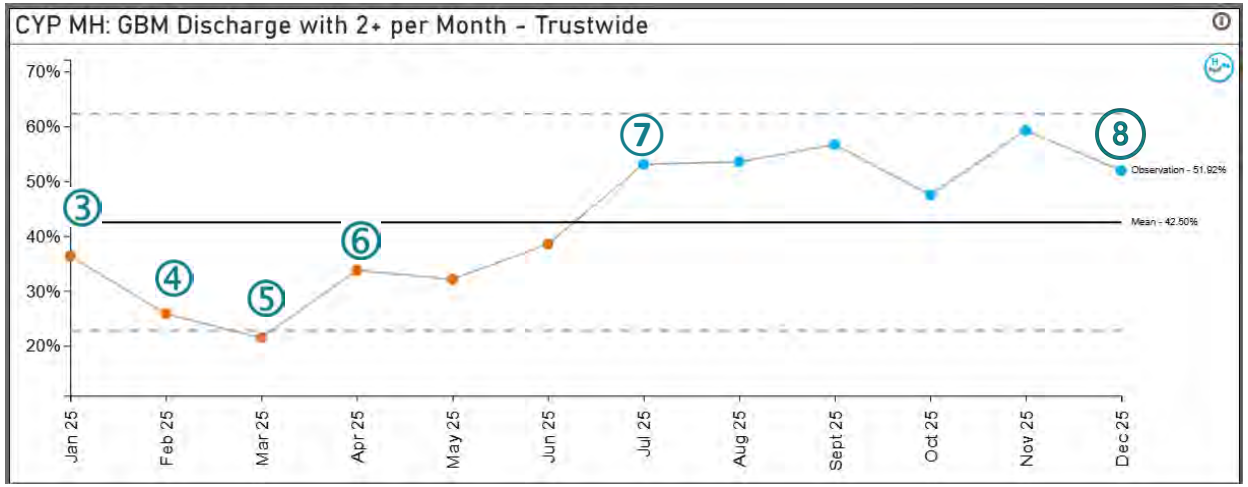

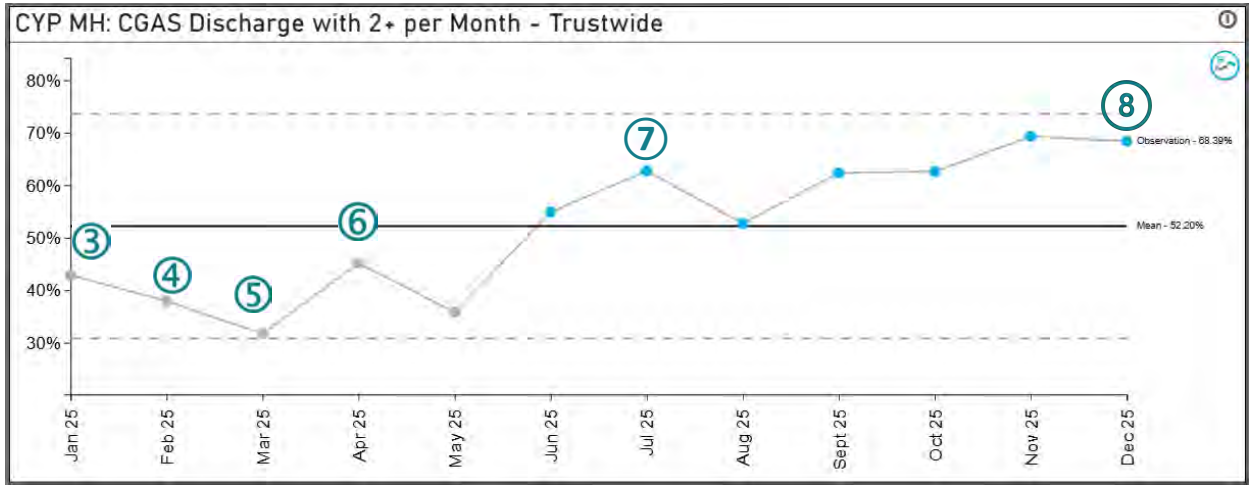

OMs: Over 18s – Percentage of patients discharged with a matched pair

The Tavistock and Portman NHS Foundation Trust

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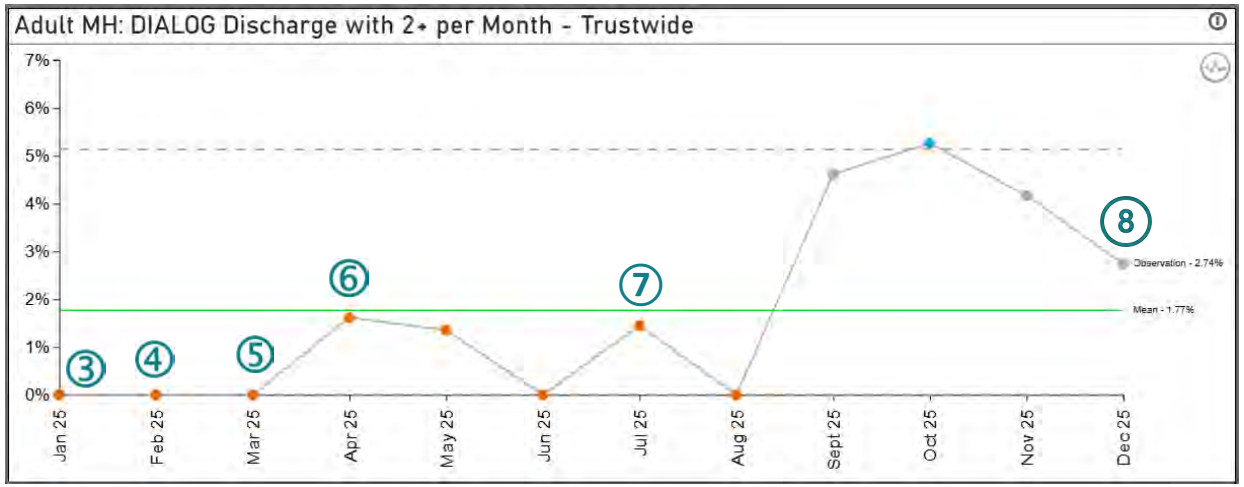
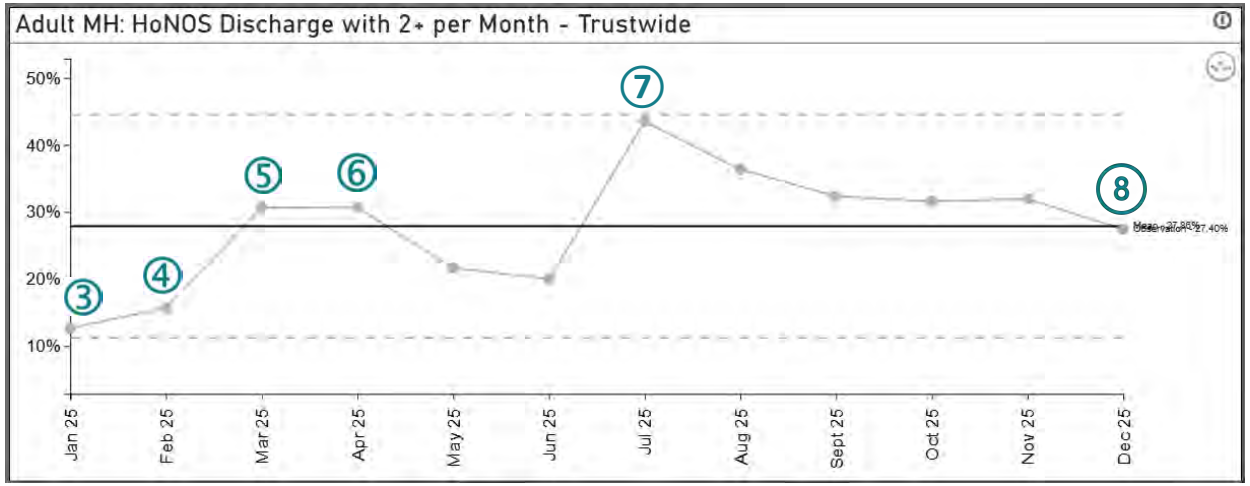




Integrated Quality and Performance Report

Month 09 - 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.

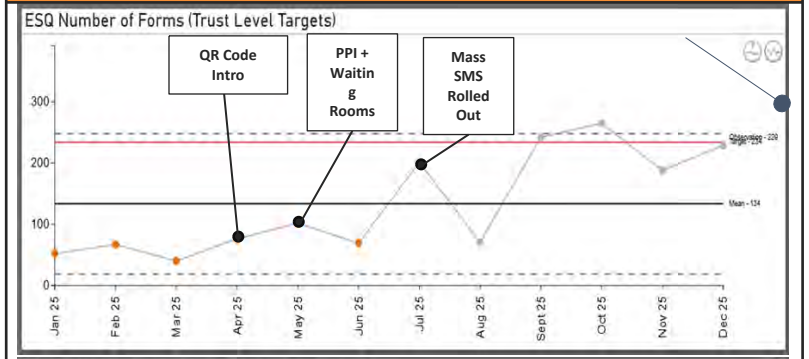
Vision & Goals

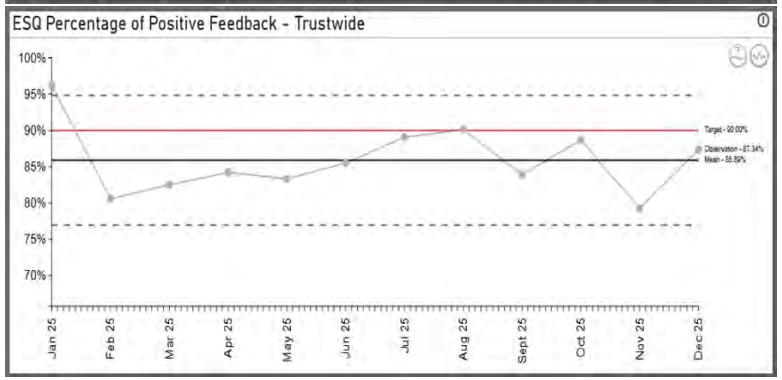
Vision: For all users to have a positive experience across the trust.

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

Integrated Quality and Performance Report

Month 09 25/26

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.

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

Overall Organisation Results: regression in 3 of the 4 indicators

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

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

Vision & Goals

Vision: To consistently match or exceed the national average score

G1: Improve EDI from 7.36 to national average (was 8.33) by March 2025 (we increased again to 7.61 and national average has been adjusted down to 8.28).

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.

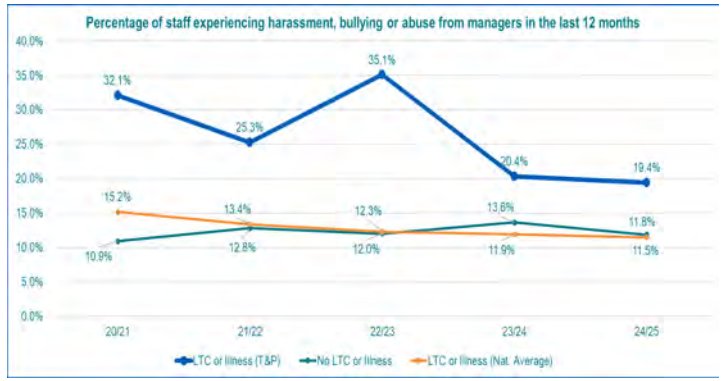
Progress on Improvements (subject to WRES / WDES refresh)

- The EDI Programme Board has streamlined our EDI priorities, and we are working on tangible metrics. These are bullying/harassment & abuse, equalising career progression opportunities and reforming the formal disciplinary and capability procedure.
- 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).

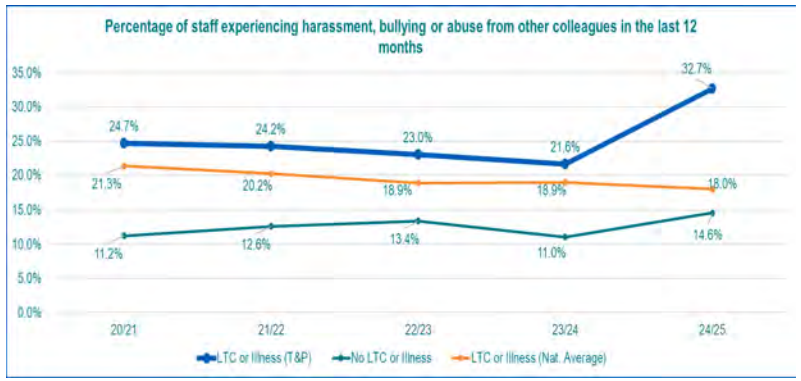
Metric	EDI score	SRO	Kasia Parfenyuk	Target		Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Historical Performance

WDES



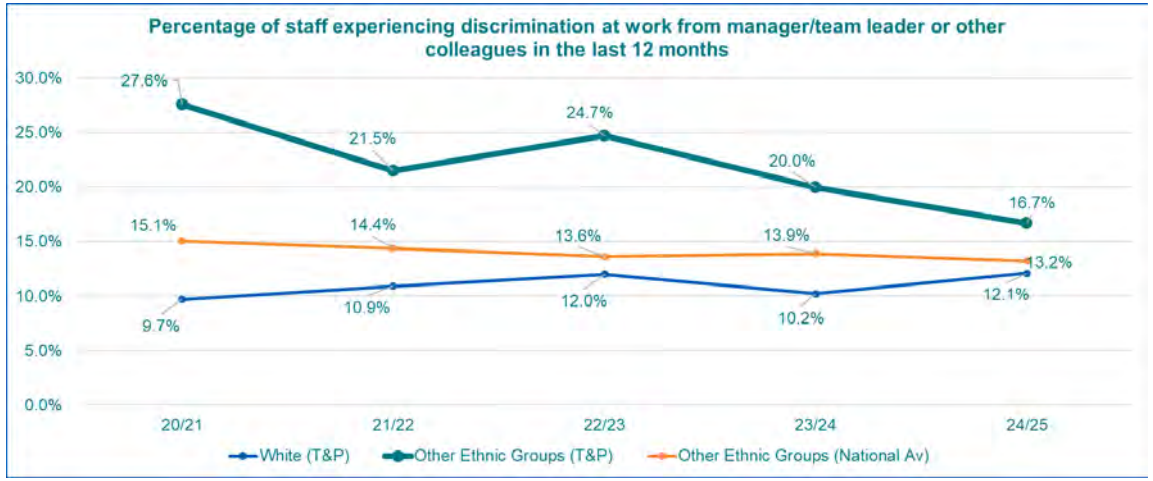
Trust has progressed by 15.7% over last 2 years but is 7.9% below national average score.



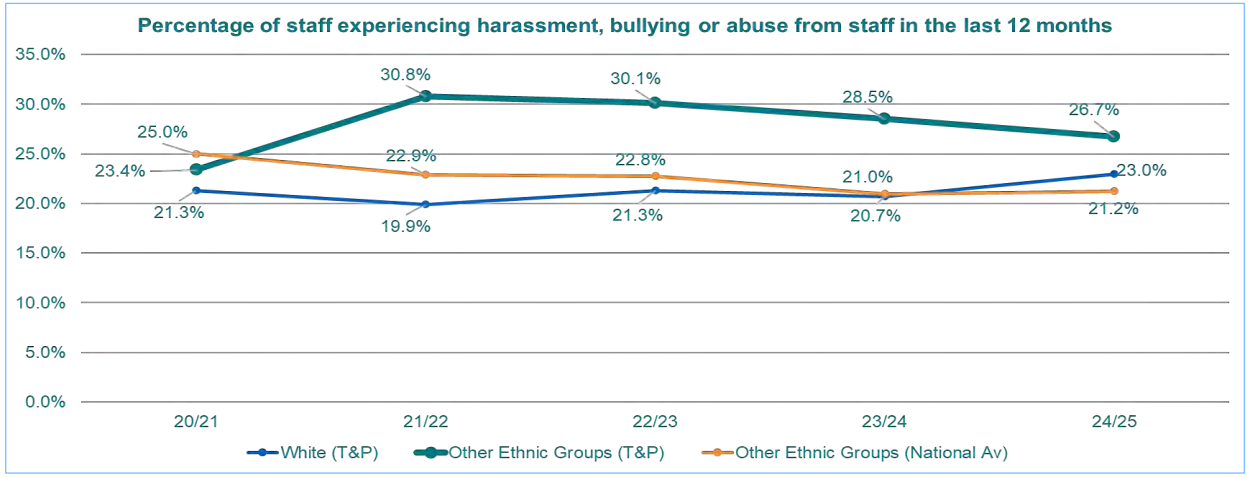
Trust score has regressed by 11.1% this year and trust position is 8% worse than in 2020. Trust is 14.7% below national average on this metric.

Trust has recorded an increase of 8.1% on last year's score. Trust is still 19.5% below national average score.

WRES



Trust score has improved by 10.9% over last five years and is gradually approaching national average score for minority groups.



4th consecutive year of positive improvement for the trust although current score is 3.3% worse than 5 years ago. Trust is 5.5% below the national average score.

Integrated Quality and Performance Report

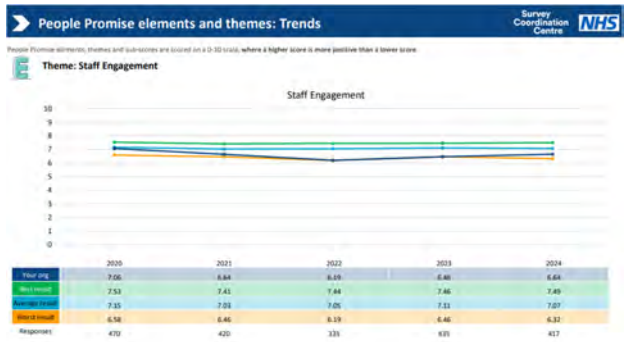
Month 09 25/26

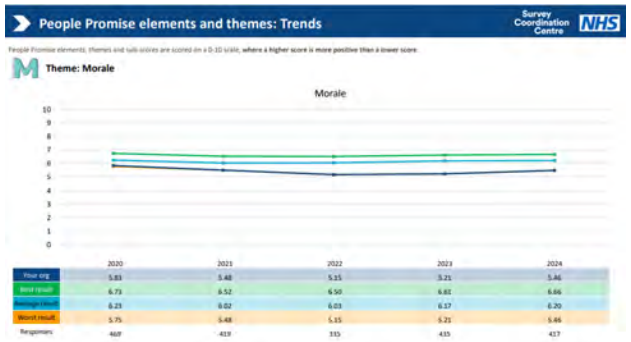
Metric	Staff Experience	SRO	Kasia Parfenyuk	Target		Measure	

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. With the upcoming merger it is recognised that there is risk of staff being disengaged which could impact retention. Due to budget restrictions with CPD staff are reporting not feeling supported with development.





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. To have staff engaged in the merger process.

Goal 1: To ensure staff are engaged in the merger process

Goal 2: To support staff in their roles and with development opportunities to enhance their skill set and ensure career progression

Root Cause/ Gap Analysis

- Uncertainty regarding the upcoming merger and roles is creating anxiety the workforce
- Prospect of change and loss of identity is a concern in the workforce
- CPD panel stepped down due to budget constraints and reduction in non-mandatory training
- Recruitment freeze adding resourcing issues to teams
- Managers need to be equipped to support staff during this period

Action Plan:

- Running People and Culture sessions on the T&P/ NLFT Values
- Thinking Spaces to be ran for staff to allow space to reflect
- MHFA training for managers to be delivered to managers in the organisation so they can support their teams with the merger process
- Promote development opportunities that sit outside the CPD process to allow development

Progress on Improvements

- Staff Experience and FTSU programme board set up with the first meeting in January
- Recruitment and CPD freeze due to financial constraints. Training, development and wellbeing support information produced for staff.
- Proposal to train managers in Mental Health Awareness training to support staff during the merger – waiting for funding approval
- Thinking space proposal approved by POD EDI
- People and Culture sessions ran jointly by NLFT and T&P on values and seeking views on the People and OD Strategy post 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

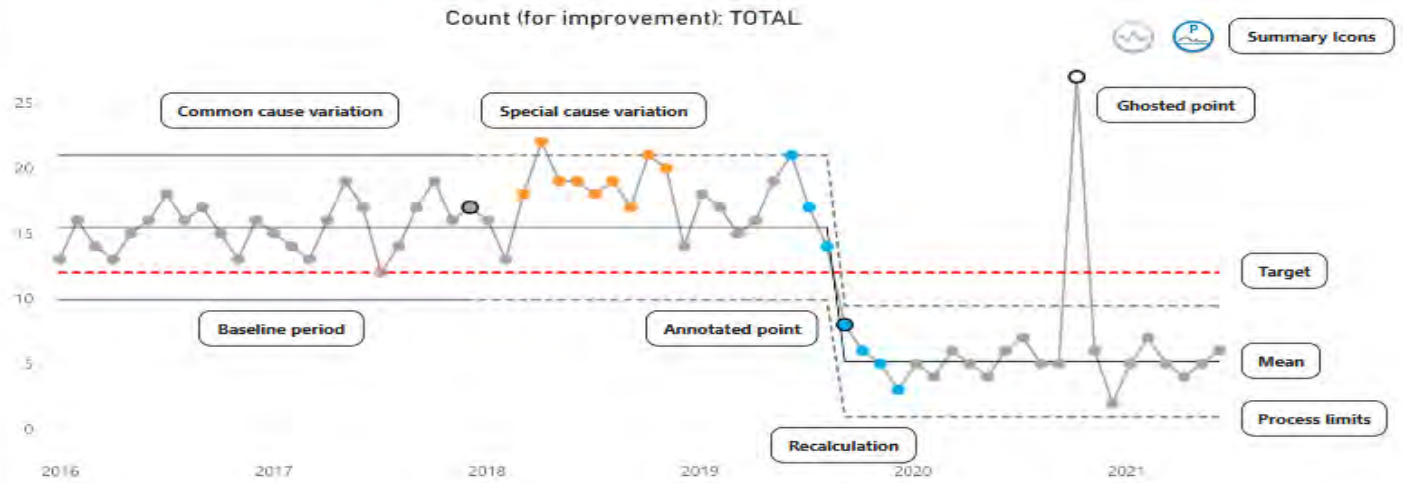
Recalculations
After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

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.

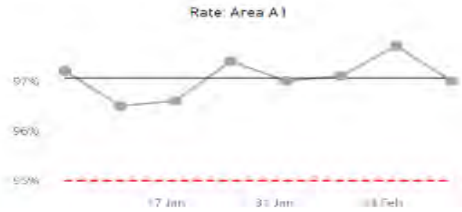
Ghosting
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on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

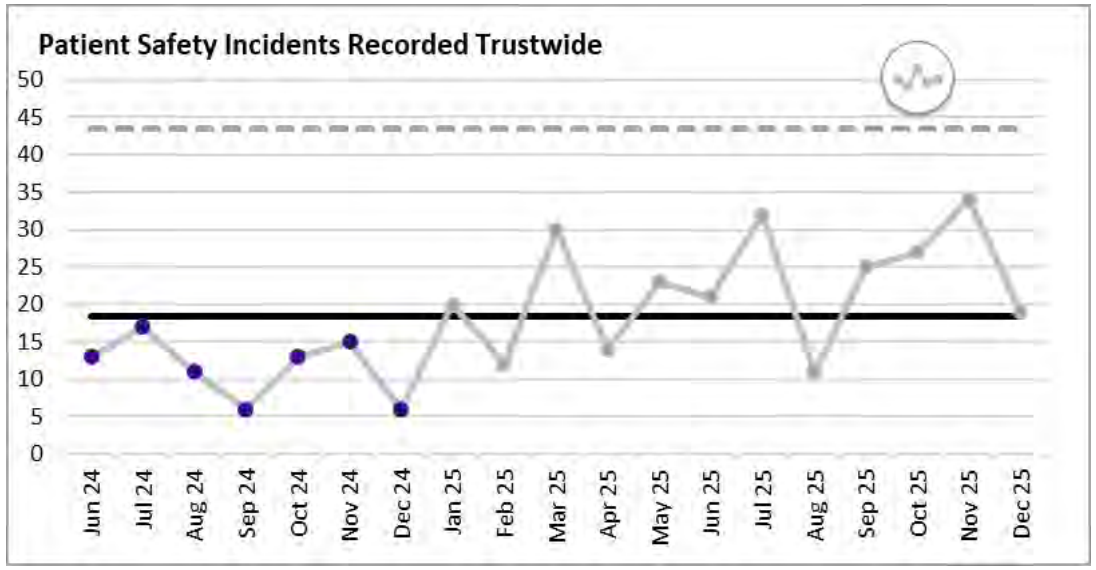
Icon Descriptions

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

The Tavistock and Portman NHS Foundation Trust



Patient Safety Incidents

In December, a total of 19 patient safety incidents were reported across the Trust. These incidents were submitted by the following services: Camden Unit (1), Adult Unit (4), and Children & Families Unit (14).

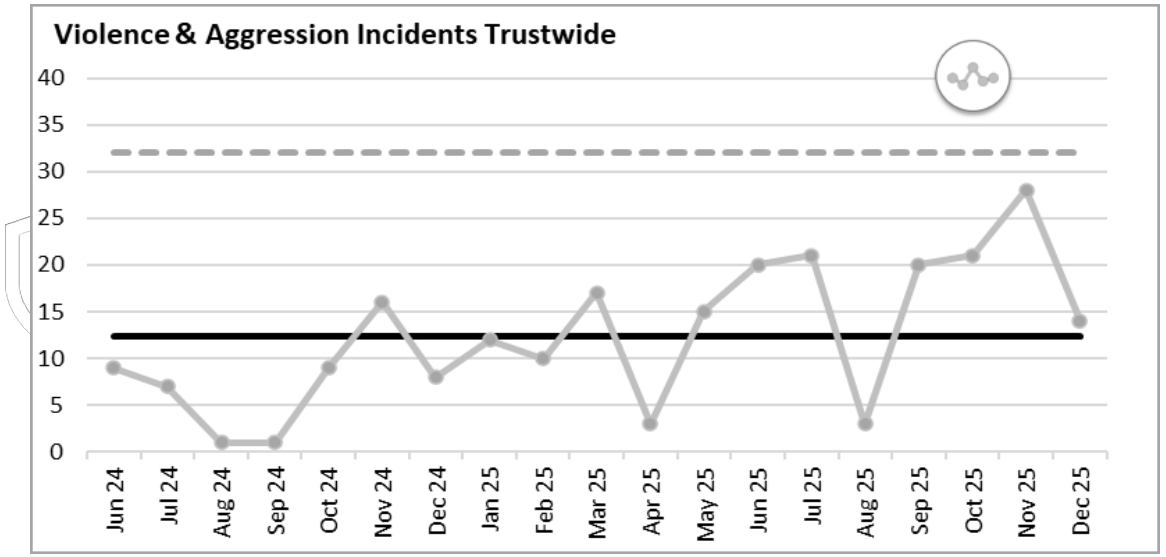
The SPC chart indicates that the number of reported incidents remains within normal variation and is consistent with established reporting trends during the festive period. This is particularly relevant given that Gloucester House was closed for part of the month due to the festive break. By way of overview, and in addition to the subsequent narrative on restrictive practice and violence and aggression incidents, the patient safety incidents reported during December included the following:

- **Deaths (Adult Unit):** Three deaths were reported by the Adult Unit in relation to the Gender Identity Clinic (GIC). One related to a former patient, and two concerned individuals who were on the waiting list at the time of death. Mortality reviews have been requested and will be considered by the Clinical Incident & Safety Group (CISG) once completed.
- **Clinical Incident (Camden Unit):** A clinical incident relating to deliberate self-harm was reported within the Camden Unit. Appropriate immediate action was taken, including safety planning with the young person concerned.
- **Information Technology:** Two information technology incidents were reported, relating to difficulties accessing Wi-Fi and authentication issues.

Mortality reviews were requested and conducted for all of the deaths. All other patient safety incidents were triaged by the Patient Safety Team and escalated to the Executive Safety Huddle (ESH) for further discussion.

Two After Action Reviews (AARs) were indicated in December as a learning response where potential opportunities for improvement were identified. One AAR related to the CYP and Families service, where a pupil became dysregulated and was physically and verbally abusive towards staff over an extended period. An AAR was initiated due to identified learning in relation to staff rotation. The second AAR was raised within the Adult Unit following an appointment being incorrectly recorded via the Dr. Doctor app. Following discussion at the Executive Safety Huddle, it was agreed that both AARs would be stood down, as alternative review processes were deemed more appropriate.

Are We Safe? – Trust-wide

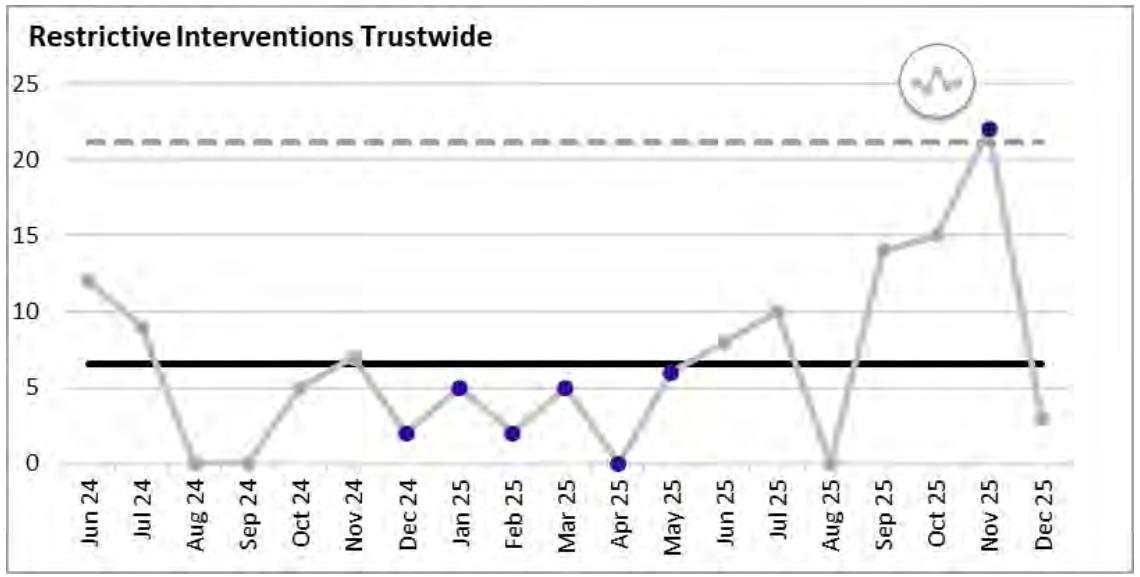


Violence & Aggression Incidents

In December, a total of 14 incidents of violence and aggression were reported, 12 of which occurred within the CYP & Families Unit at Gloucester House. The incidents at Gloucester House primarily involved pupils displaying verbal and physical aggression towards staff. This included behaviours such as hitting, headbutting, kicking, spitting, pulling hair, and making threats. There were also incidents of pupil-to-pupil aggression, including hitting.

One incident was reported in Camden Unit (South Camden) of a patient assault against a clinician.

One incident was reported in the Adult Unit (GIC) related to verbal aggression towards staff and disruption of the clinical assessment.



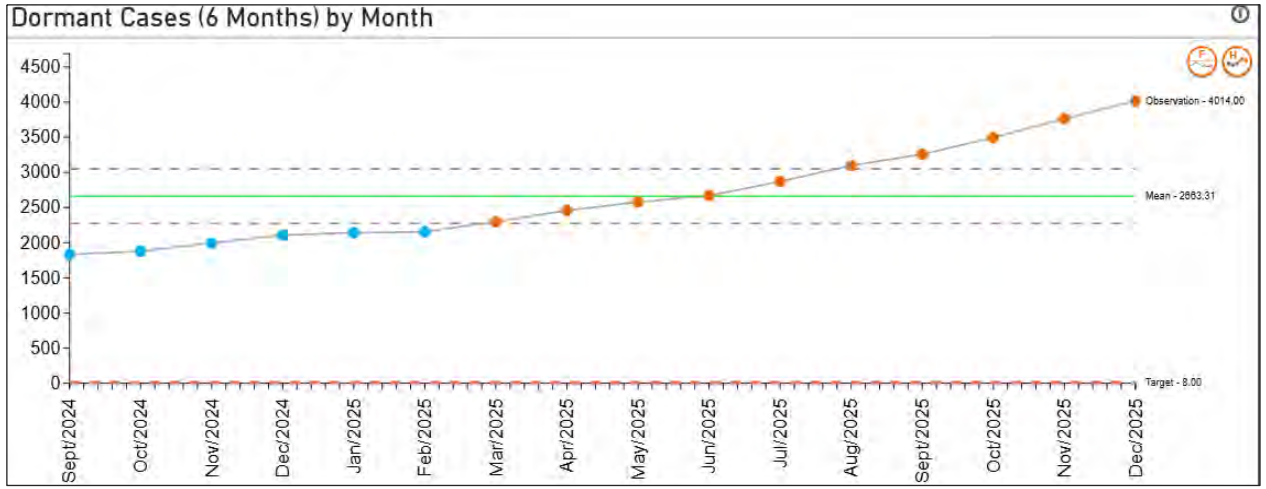
Incidents Involving Use of Restrictive Practice

In December, three incidents of restrictive practice were reported. This reduction is largely attributable to the school holiday period during December, which resulted in Gloucester House being open for fewer days. As such, the reduced number of incidents should not be interpreted as a significant or sustained reduction in the use of restrictive practice.

All incidents of restrictive practice reported in December were recorded by Gloucester House.

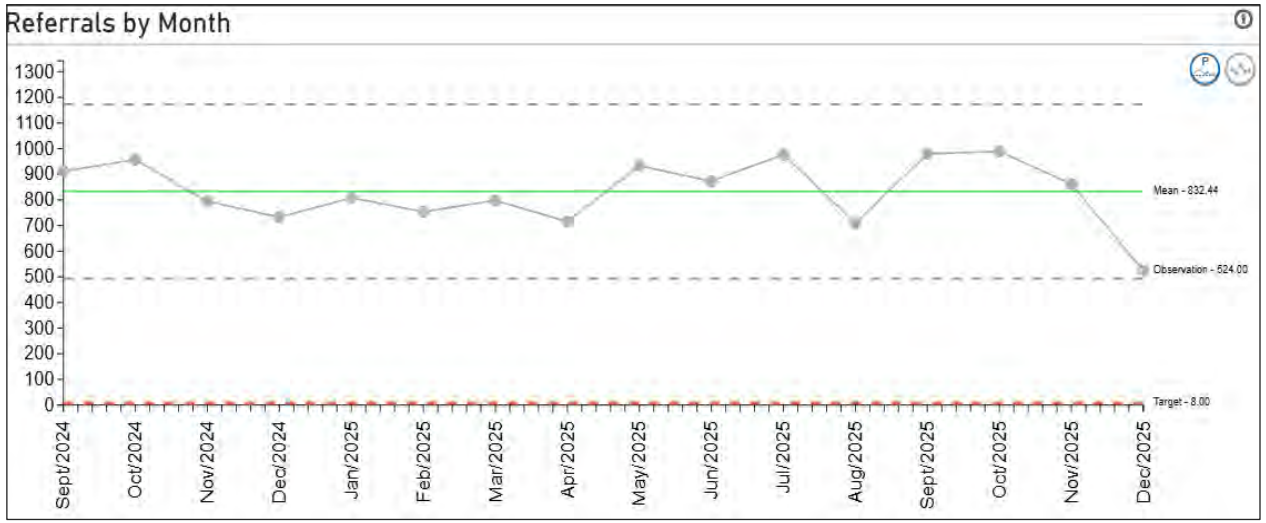
The SPC chart indicates a rise above normal variation in November 2025. This has been discussed with the school's senior leadership team, and a dedicated Quality Improvement project has been initiated.

Are We Effective? – Trust-wide



26+ Week Dormant Cases

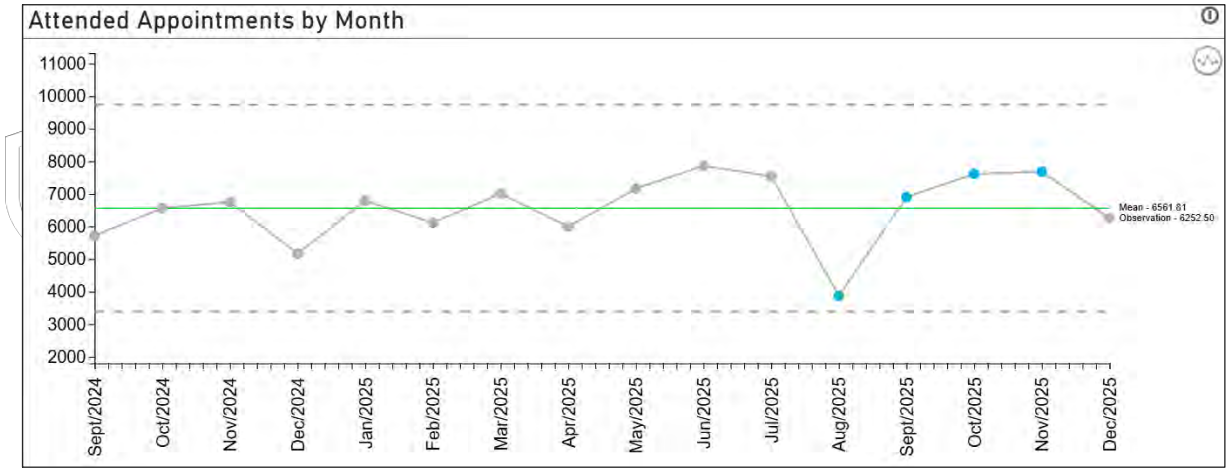
This metric has been altered to 26 weeks instead of 52 to align with system partner reporting. The trauma service has spent the last 12-18 months improving waiting times. This has been the focus on Kaizen and the structured support and remains the focus of ongoing quality improvement work. The Adult Trauma team is focusing on maintaining the delivery of high-quality care whilst the ERF funding comes to a close. The number of 26+ week dormant cases continues to increase in all teams in the Adult Unit and in the Autism Team in the Children & Families' unit.



Number of Referrals (Including Rejections)

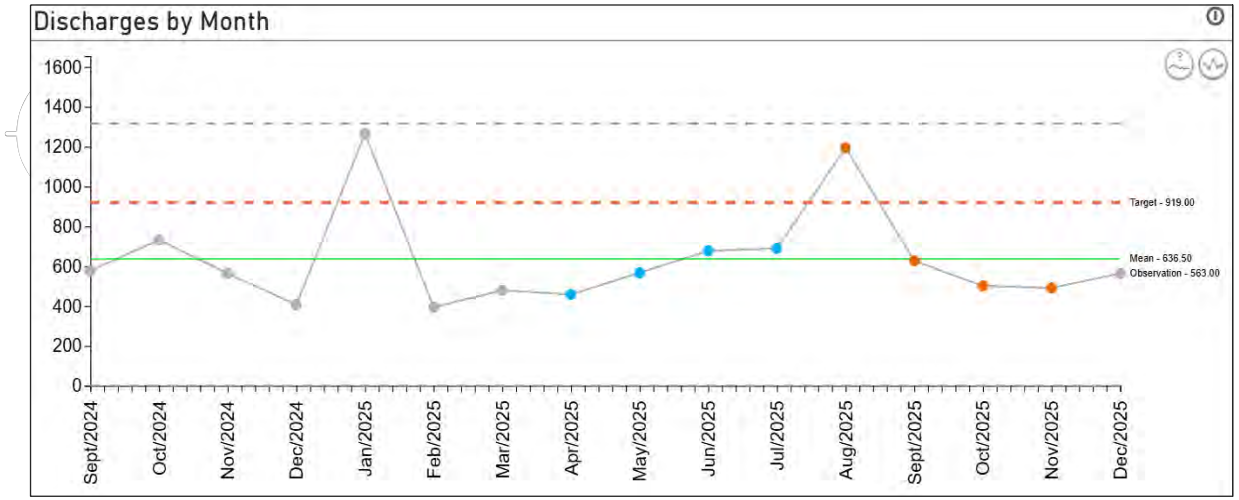
The trust received 524 referrals in M9, which is a reduction from last month. This appears to have been caused by an ongoing reduction in referrals to Adult Unit teams and the seasonal holidays. There were 48 referrals rejected across the Trust in December.

Are We Effective? – Trust-wide



Number of Attendances

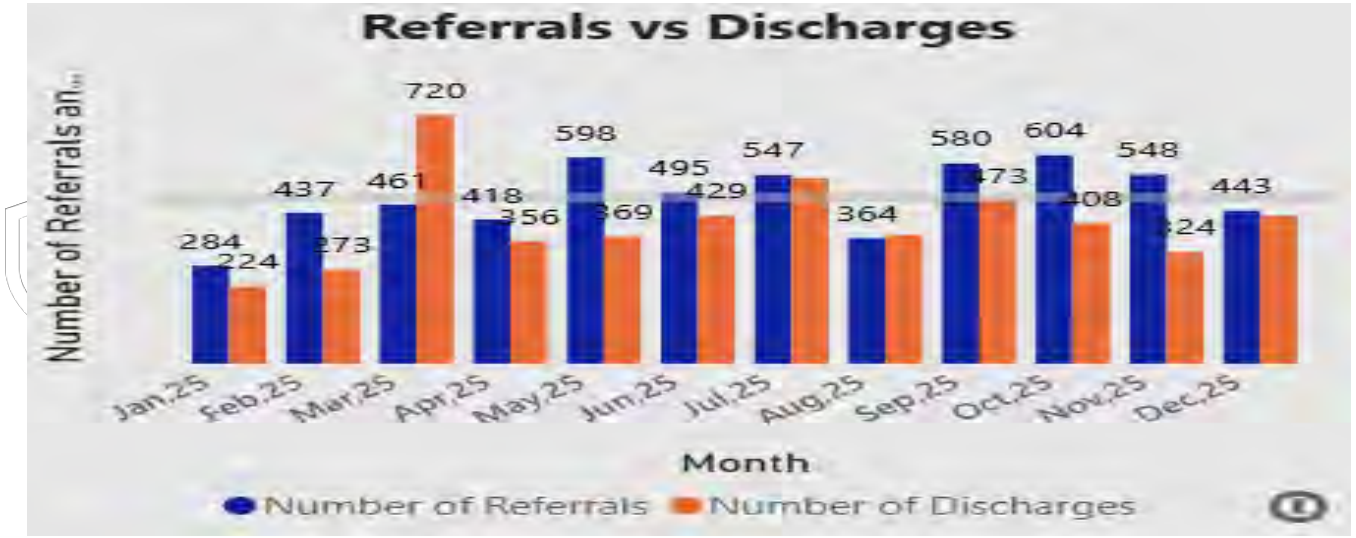
The overall number of attendances in M9 is 6,622, which continues a return to trend, excluding August activity. The M3 and M4 data was in line with expectations and indicated a potential increasing understanding of the need to manage periods of lower activity as has happened in August where there are higher numbers of staff taking annual leave with periods of higher activity abutting with 3,868 attendances recorded in M5.This is 308 higher than the equivalent month in 24/25. The equivalent M9 figure for 24/25 was 5,170 which is 1,452 lower than this year's figure and shows continuing increased activity year on year.

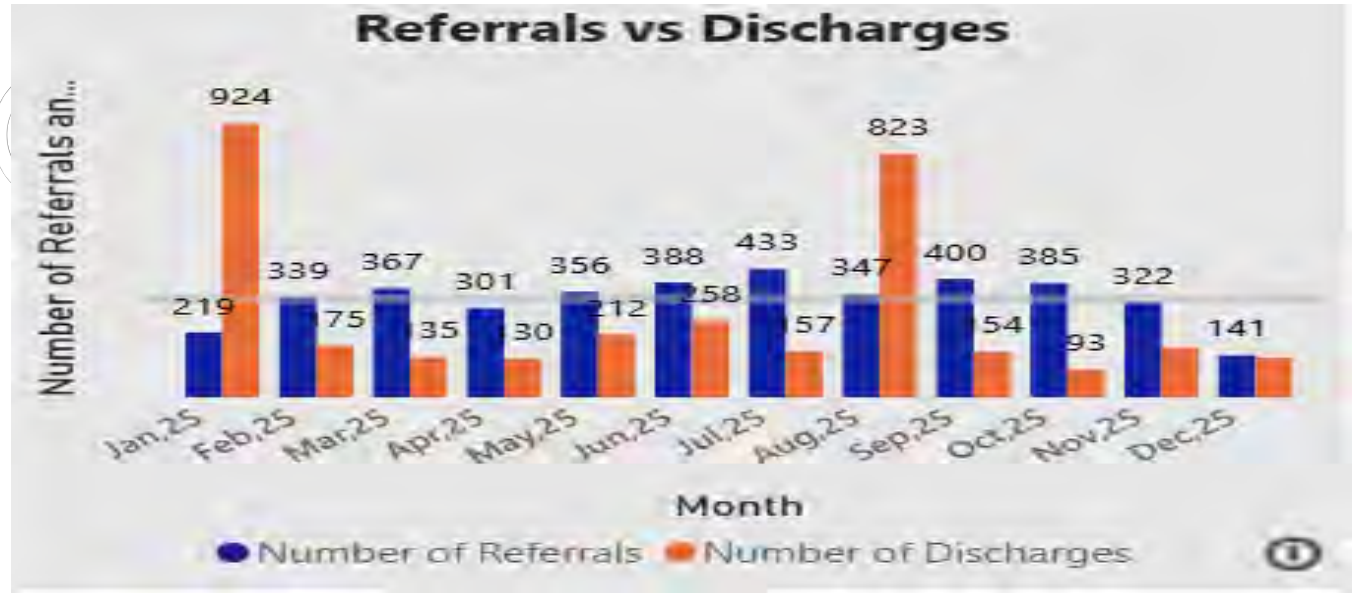


Number of Discharges

The number of discharges has continued to return 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. However, it is noticeable that the number of discharges in M9 is 169 higher than for the equivalent month last year.

Are We Effective? – Trust-wide



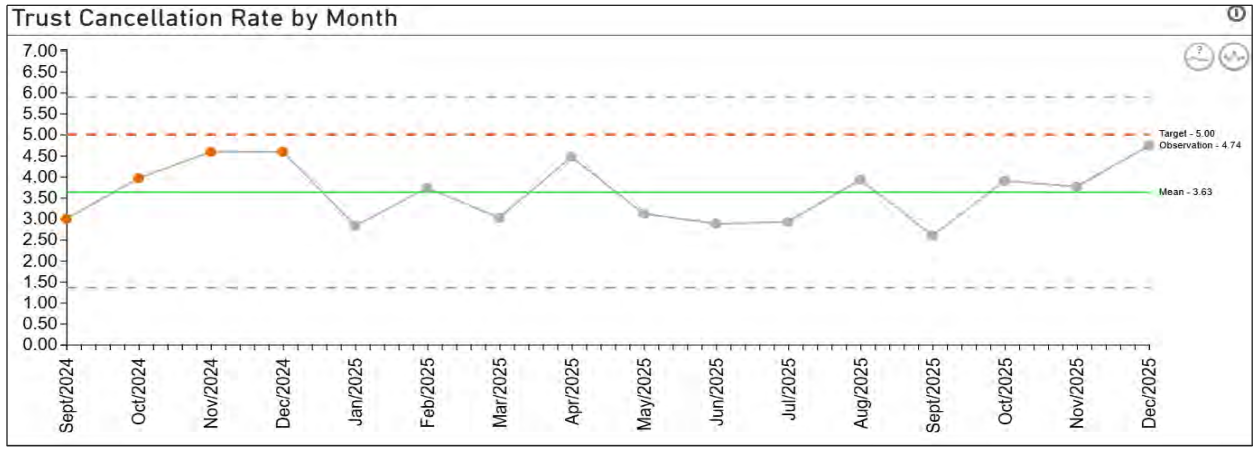


Number of Discharges with Average Line (2nd chart Adult GIC only):

The graph indicates that the number of discharges continues to be below the average line. It should be noted however that the average discharge number is significantly skewed by the large number of discharges in M12 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 M9 is still below the 12-month trust average with discharges from Adult GIC at a very low level due to seasonal factors.

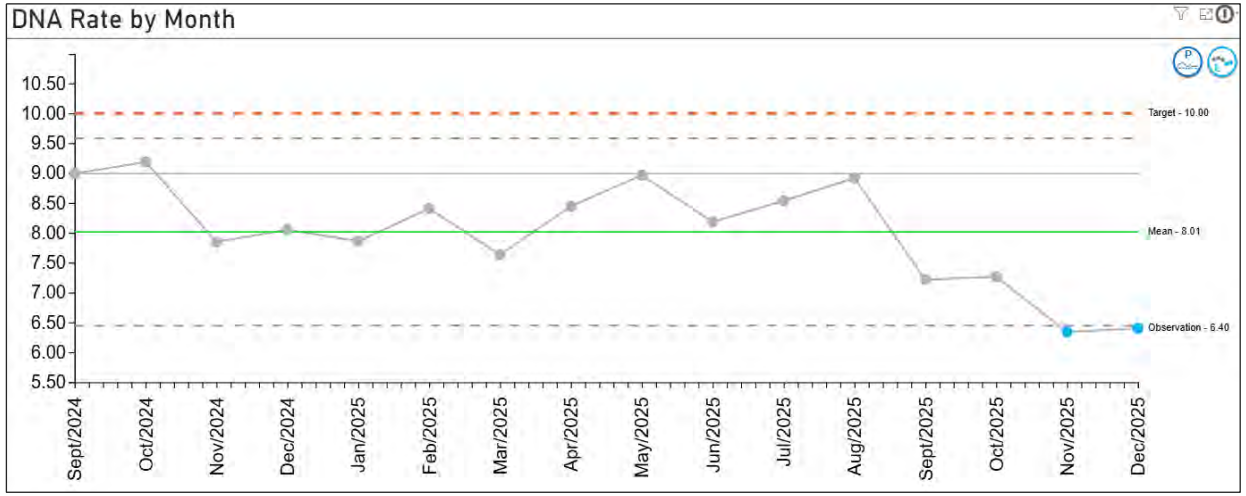
A contributing factor to the low rate of absolute discharge from the GIC is the requirement for patients to be discharged only when they have experienced their last episode of scheduled surgery. Current surgical waiting lists for vaginoplasty are estimated to be five years and for phalloplasty over twenty years.

Are We Effective? –Trust-wide



% of Trust-Led Cancellations

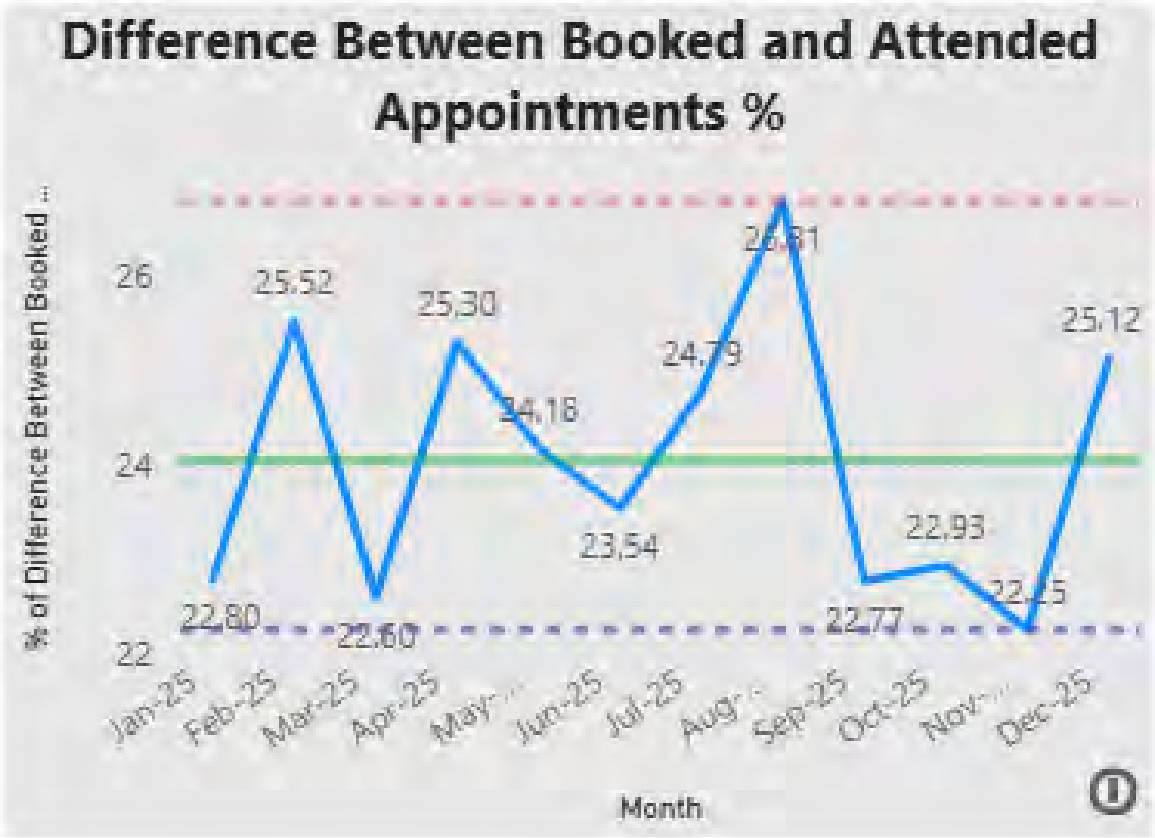
The Trust reports a cancellation rate of 4.74%, an increase of almost 1% on last month's figure of 3.76%. The unit level data indicates that both the Adult and the Children & Families units were the predominant driver of Trust led cancellations in Month 9 with figures of 4.94% and 6.51% respectively due to staff sickness absence in both Camden and in Children & Families Units. Big increases have been noted in Adult Trauma and the Adolescents and Young Adults teams. This is the 3rd consecutive month of increase in the Children & Families Unit.



% 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. QI work in Adult GIC and work on missing clinical records in Children & Families have contributed to this reduction.

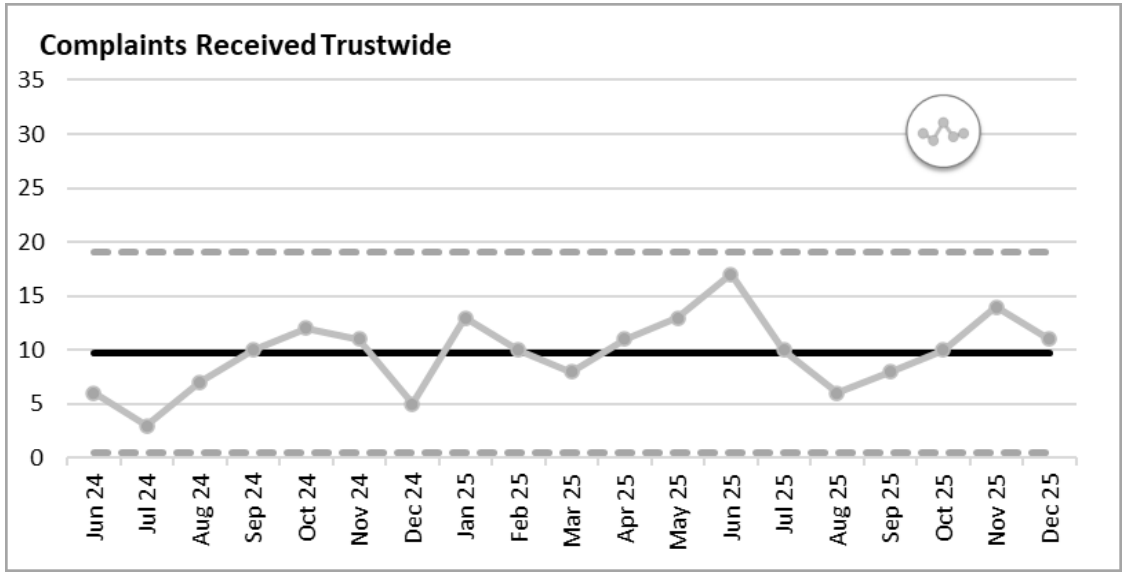
Are We Effective? –Trust-wide

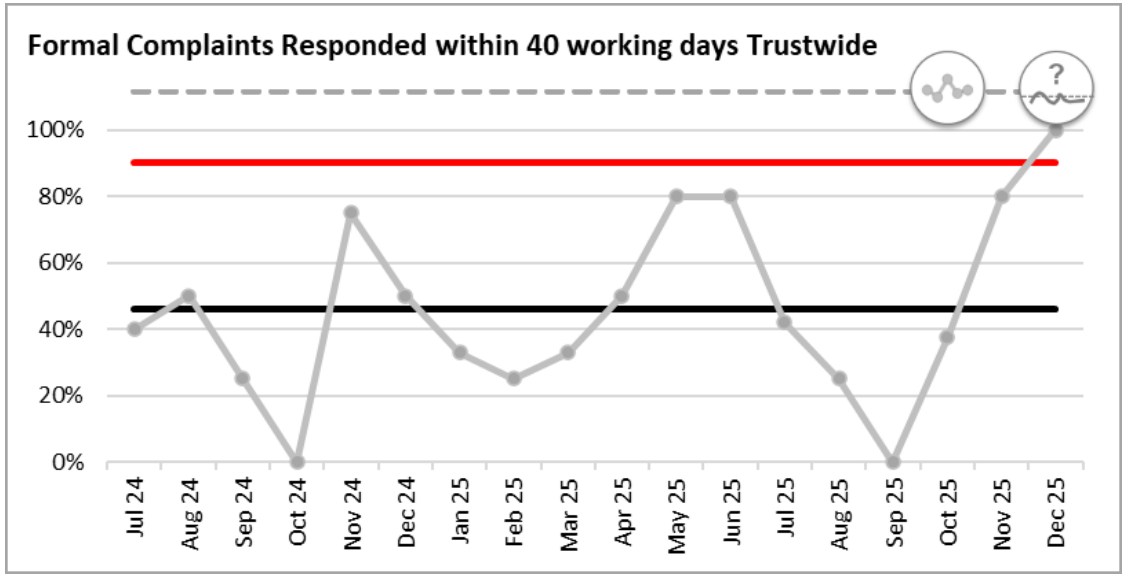


Booked vs Attended Appointments

- The number of attended appointments is around the mean level with just under 75% of all booked appointments being attended.
- Clinical services are currently working to establish more accurate upper and lower control limits, aligning job plans and clinic schedules to clarify capacity.
- While the current report highlights trends, it does not fully reflect the actual capacity required to deliver activity across teams.
- The cancellation rate by patients of 11.39% of all booked appointments in M9 2025 accounts for just under half of all cancellations in that month. DNA rates have reduced to 6.40% of all booked appointments and the trust has cancelled 4.74% of all booked appointments in November 2025.
- It is envisaged that future iterations of this metric will measure performance against a national benchmark.

Are We Caring? - Trustwide





Number of Formal Complaints Received

A total of 11 complaint contacts were received Trust-wide in December; 10 were received by the Adult Unit and 1 for the Children & Family Unit.

All complaint contacts received in December were acknowledged within 3 working days in line with national regulations.

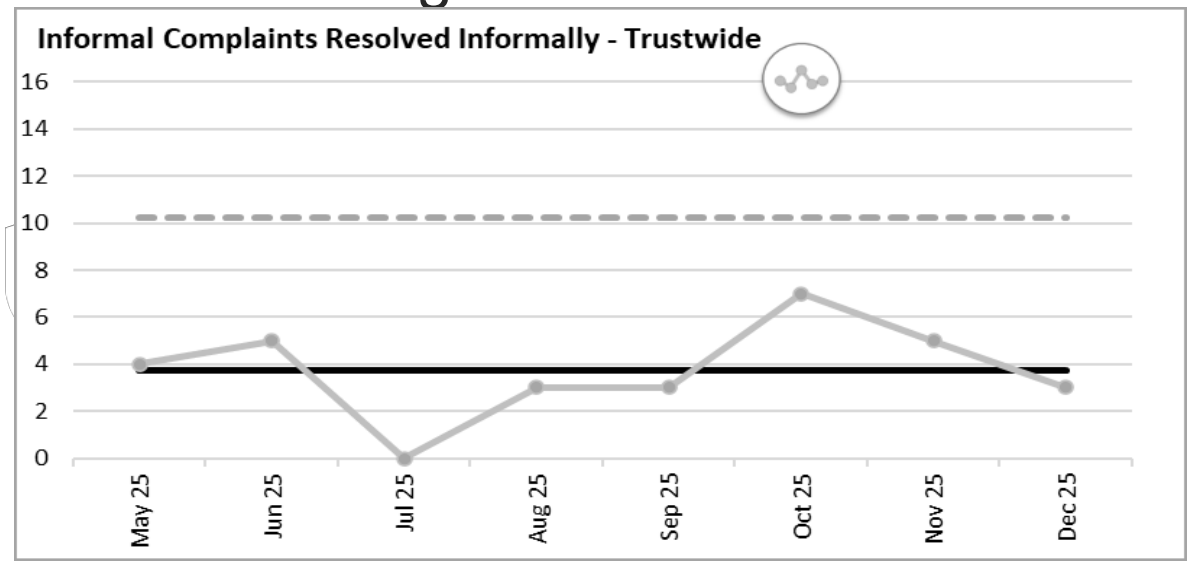
Formal complaints response time compliance

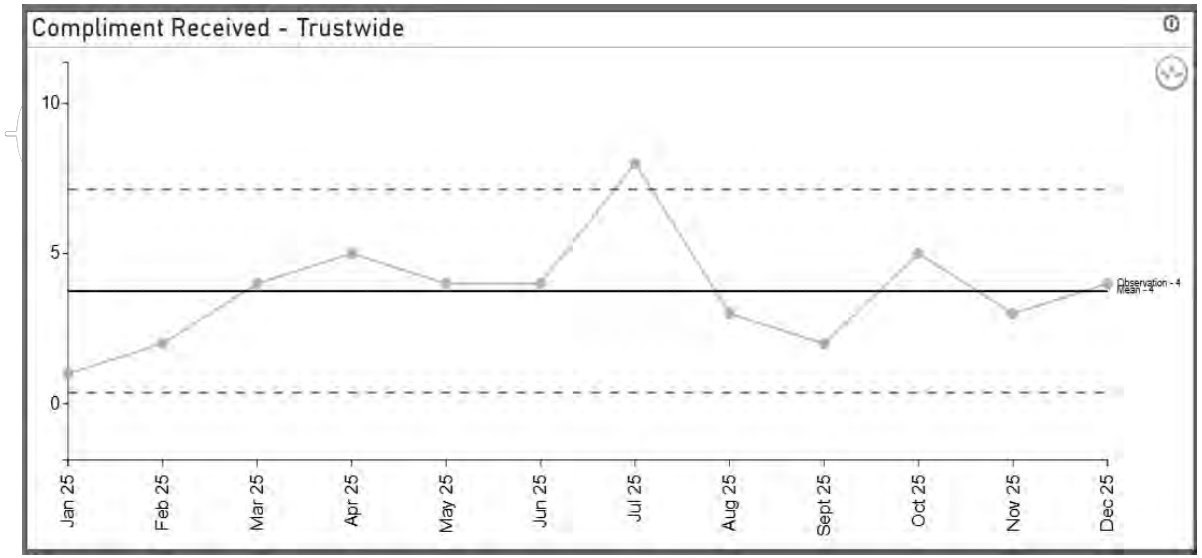
Trust wide compliance for formal complaints responded to within 40 working days in December was 100%, meaning that of the 2 complaints closed formally in the month, both were within the 40 working day timeline.

As of the end of December 2025, 16 complaints (13 Adult & 3 Children & Families) were open. Of that number, 1 complaint in Adult and 1 complaint in Children & Families were overdue.

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; in anticipation of the merger this will focus on must-dos to improve the process.

Are We Caring? – Trust-wide





The Tavistock and Portman NHS Foundation Trust

Informal Complaints (Local Resolution)

In December 2025, 3 complaints were resolved informally all of which were in the Adult Unit.

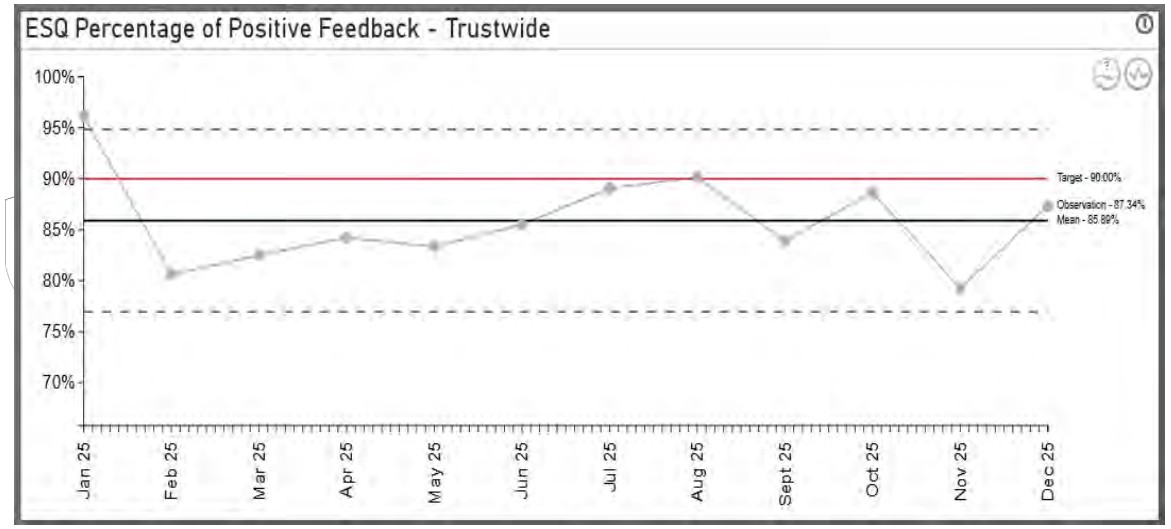
The Trust aims to respond to all complaints informally whenever possible, enabling an earlier resolution for patients. According to the Complaints Management Policy, informal complaints are those which are resolved by the immediate service with 10 working days. Therefore, Investigating Leads can contact the complainant at a very early stage of the complaints process to discuss the complaint and help to resolve concerns informally.

Number of Compliments Received

4 compliments were recorded in Radar in December 2025, 3 of them were recorded by the Camden Unit and 1 by Children & Family P Unit. The content was categorised as follows – 3 were related to Patient Care and 1 was under the 'other' category.

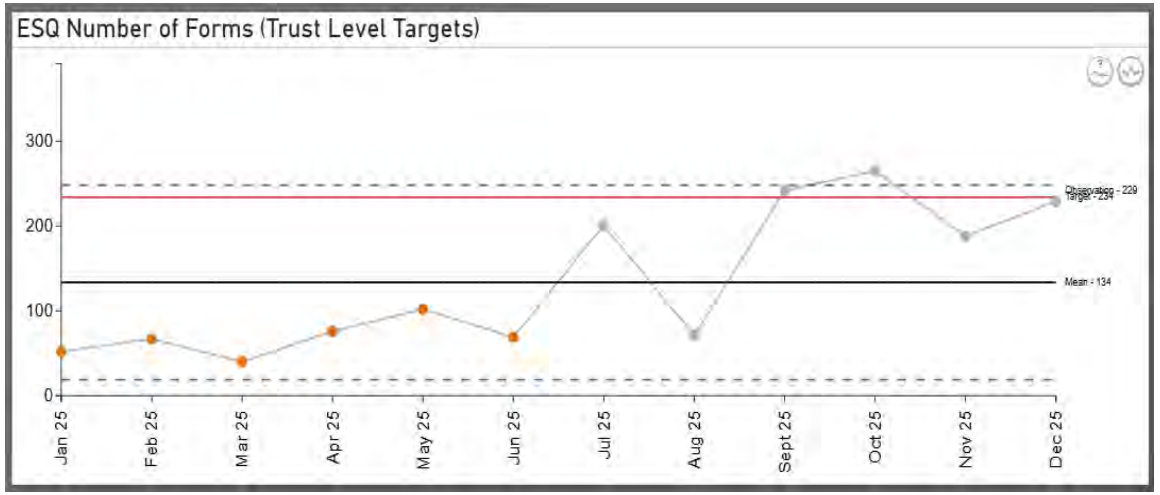
Compliments are categorised using the KO41a system (to match complaint categories) to enable comparison with themes between ESQs and complaints.

Are We Caring? – Trust-wide



ESQ Positive Responses %

In December 2025 our number of ESQ positive responses was 87.3% which is just below our Trust target of 90%. Patient care and Values and behaviour continue to be the most common themes reported by patients. Communication continues to be a theme where improvements are needed. Teams are reviewing data and improvement strategies through a QI framework.

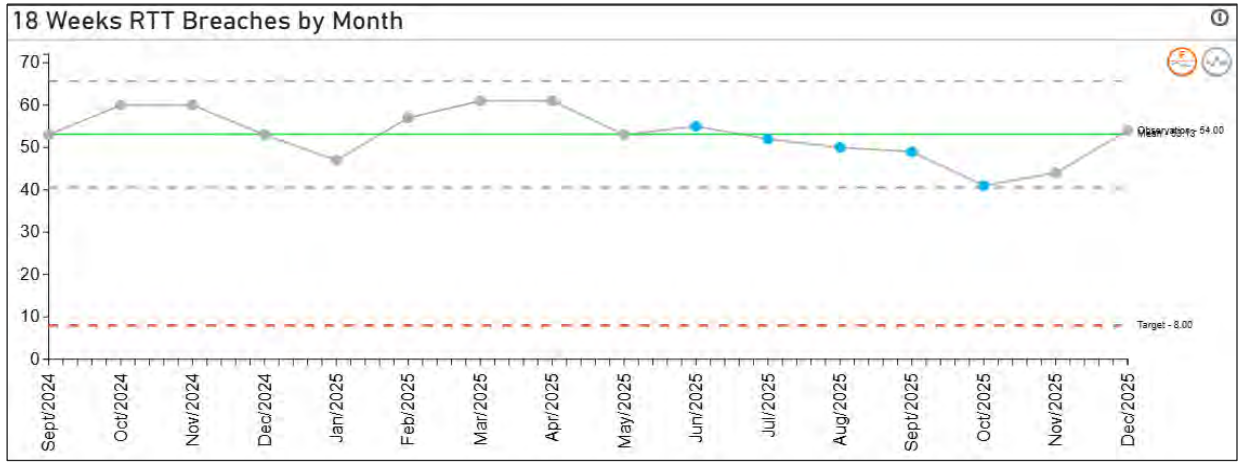


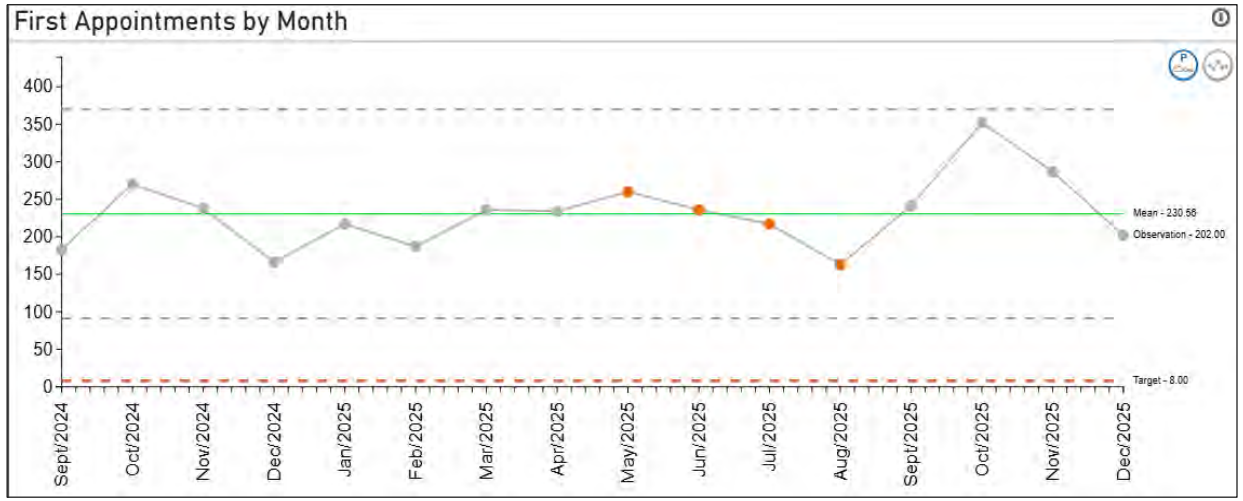
ESQ Number of Forms per Month

In December 2025 we received just below our target number of forms. We have seen a positive increase in number of forms received following text reminders being sent. There were also a number of forms that were not uploaded in November due to sickness and absence within the admin team which have now been included in December data. 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

The Tavistock and Portman NHS Foundation Trust





18 Week RTT Breaches Excluding ASC/GIC/Trauma

Referral to Treatment (RTT) Performance Summary

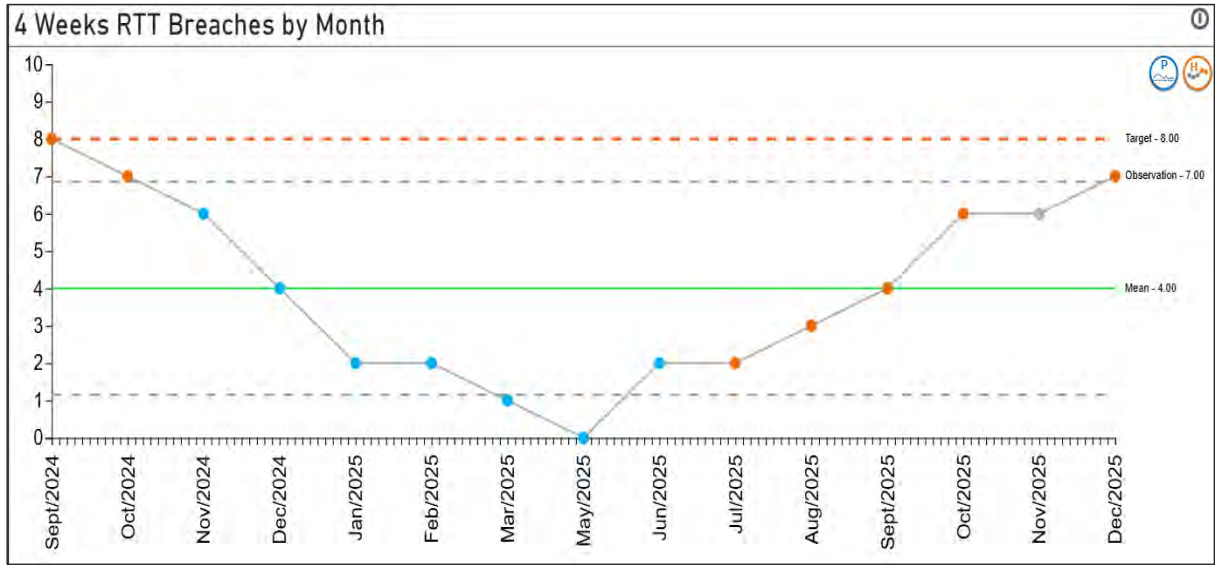
Most services are currently meeting their Referral to Treatment (RTT) targets - 4 weeks for Children and Young People (CYP) and 18 weeks for Adults. However, further work is needed at the team level in two areas:

- **Neurodevelopmental Disorders (NDD) Pathway:** This was close to meeting its RTT target, but additional improvements are still required.as performance has recently deteriorated in the last 6 months.
- **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 1 in September 2024 to 22 in December 2025.

Child and Family Unit (CFU)

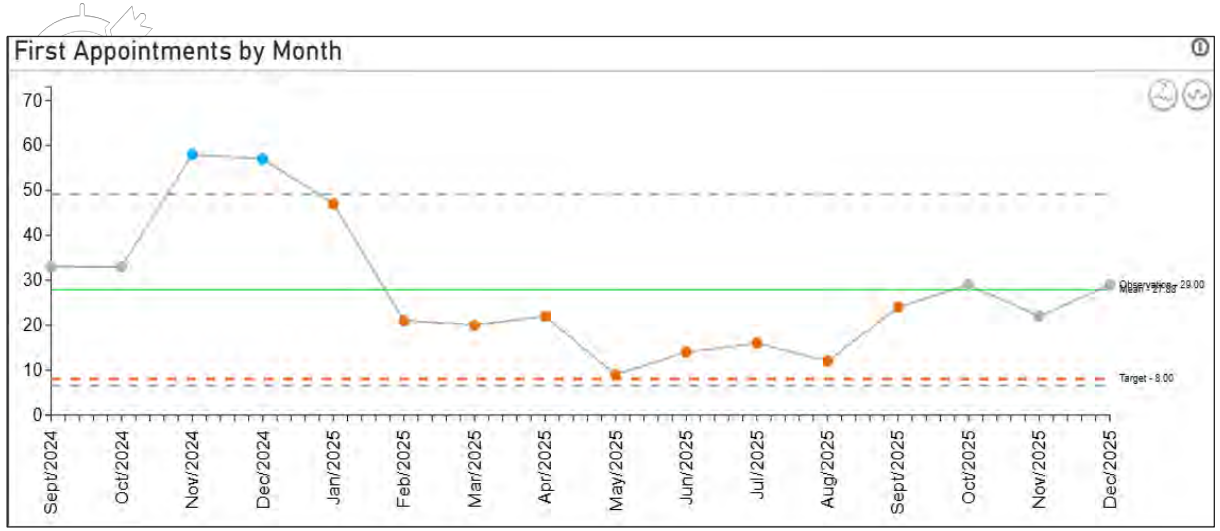
- The CFU (excluding Autism Assessment) currently reports **116 cases breaching the 4-week RTT threshold**. This shows a deterioration compared to the same month last year which reported 97 cases and an increase of 50 cases on M8.
- The mean average waiting time for cases in the CFU is currently 2.95 weeks (excluding Autism Assessment).
- In **Camden**, an A3 improvement plan related to the Clinical Intake Team is now in implementation.

Are We Responsive? – Trust-wide



Under-18s Autism Assessment 4-week RTT Breaches

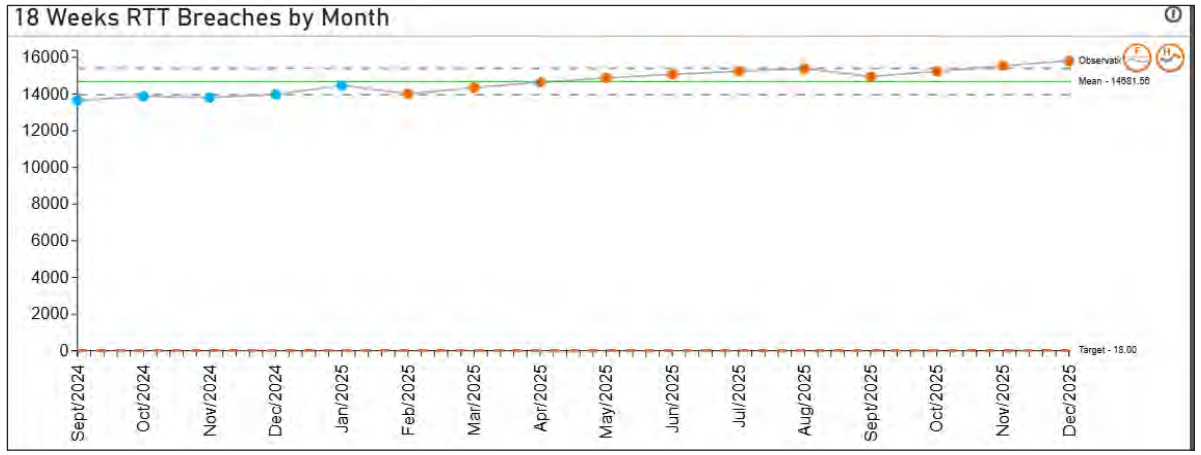
As at December 2025, there are 7 individuals who have breached the 4 -week RTT target. This is the highest total reported since September 2024. However, there is now increased capacity to offer triage appointments, which will reduce the wait time to first appointment. The increase in waiting times is due to a reduction in the workforce within the pathway which resulted in capacity reduction.



Under-18s Autism Assessment 1st Attended Appointments

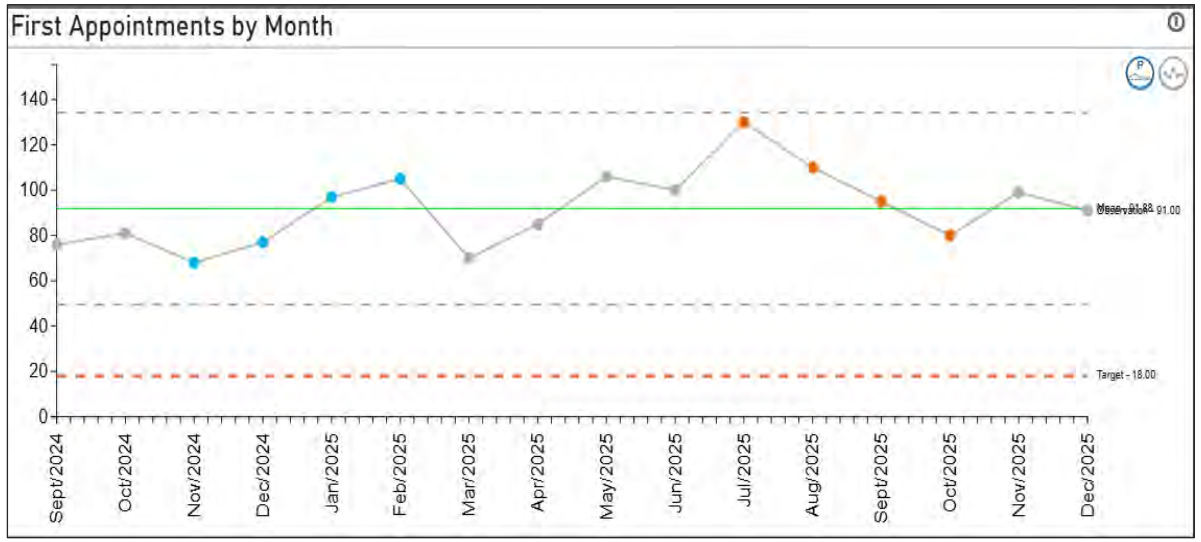
There were 29 1st appointments in December, out of a total of 120 attended appointments, returning to the same number reported in M7.

Are We Responsive? –Trust-wide



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

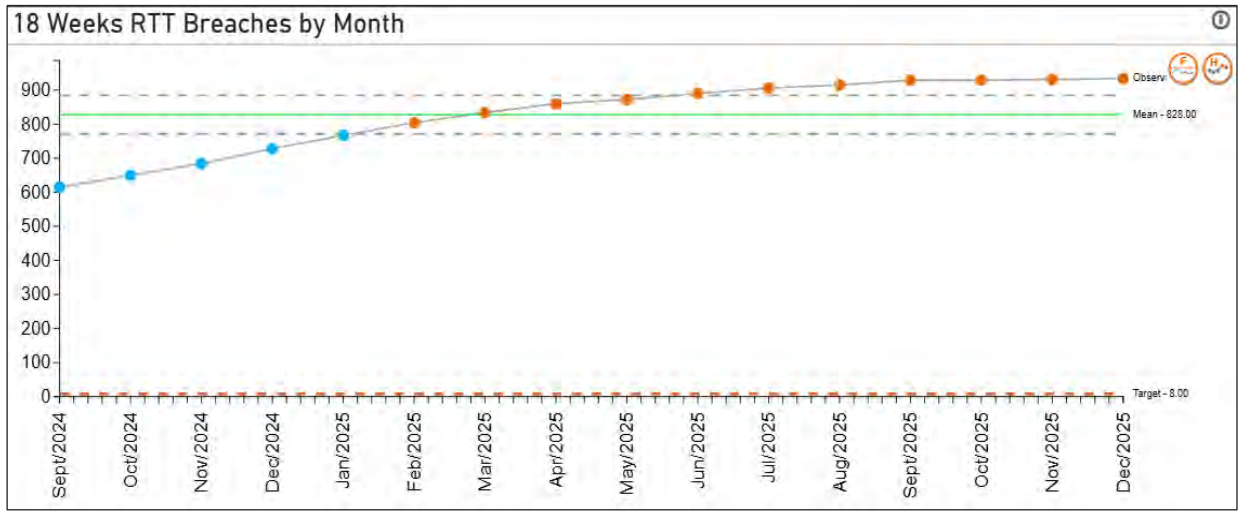
- As at December 2025, there were 15,808 individuals waiting for a first appointment, reflecting ongoing pressure on the service with a rise of 273 cases on the previous month as the number of referrals fell from 322 to 153 caused by a backlog of GIC referrals that were not processed due to reduced administrative capacity.
- 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.
- The new patient portal is expected to create more efficient booking opportunities and increased patient engagement.



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

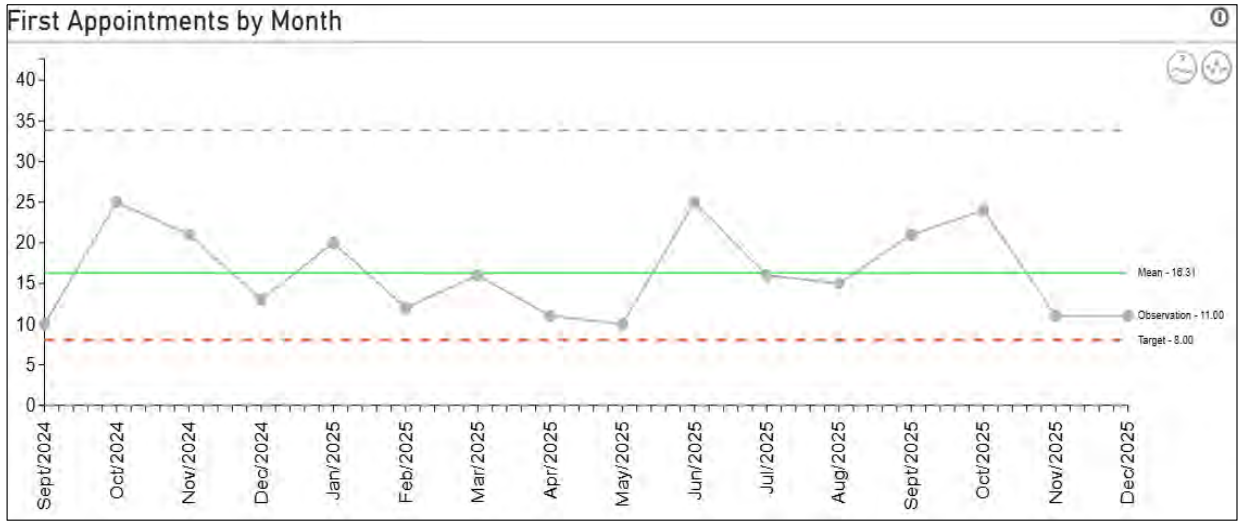
There was a small decrease in the number of 1st attended appointments from 97 in November to 94 in December 2025, maintaining the improvement work to date. The current wait time for a first appointment is approximately 195 weeks, which is a slight decrease on the previous month although this does vary from month to month. Improvement work continues through the GIC Quality Improvement Huddle to continue to address these challenges and improve access.

Are We Responsive? –Trust-wide



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

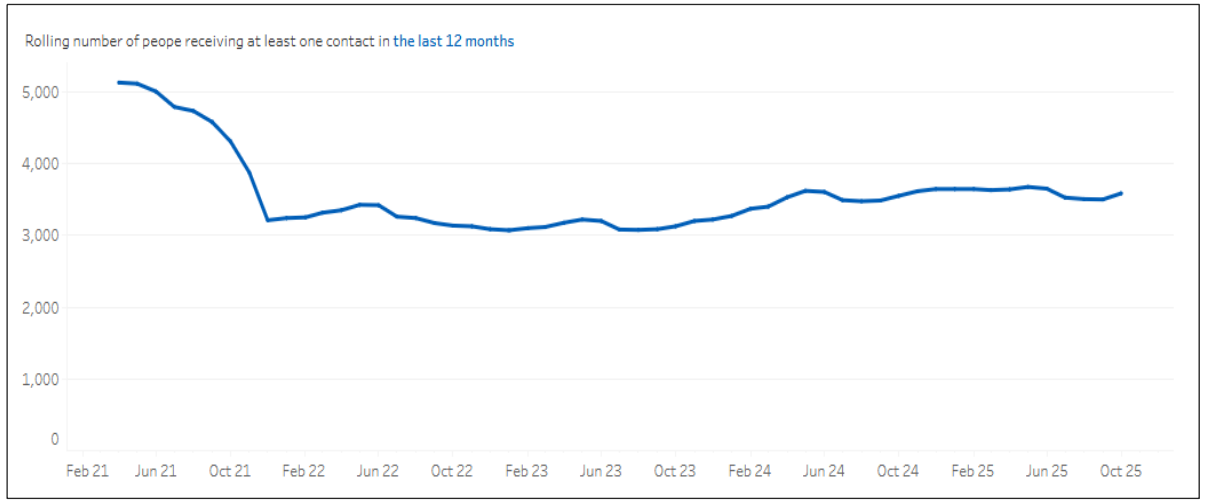
- As of December 2025, there were 934 individuals waiting for a first appointment, reflecting ongoing pressure on the service with the number of 18-week RTT breaches remaining constant.
- The trauma service has been focussing on improvement strategies to reduce the length of wait within the current establishment following the ending of the ERF funded resource. This has been the focus of Kaizen and targeted support and remains the focus of ongoing quality improvement work.



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

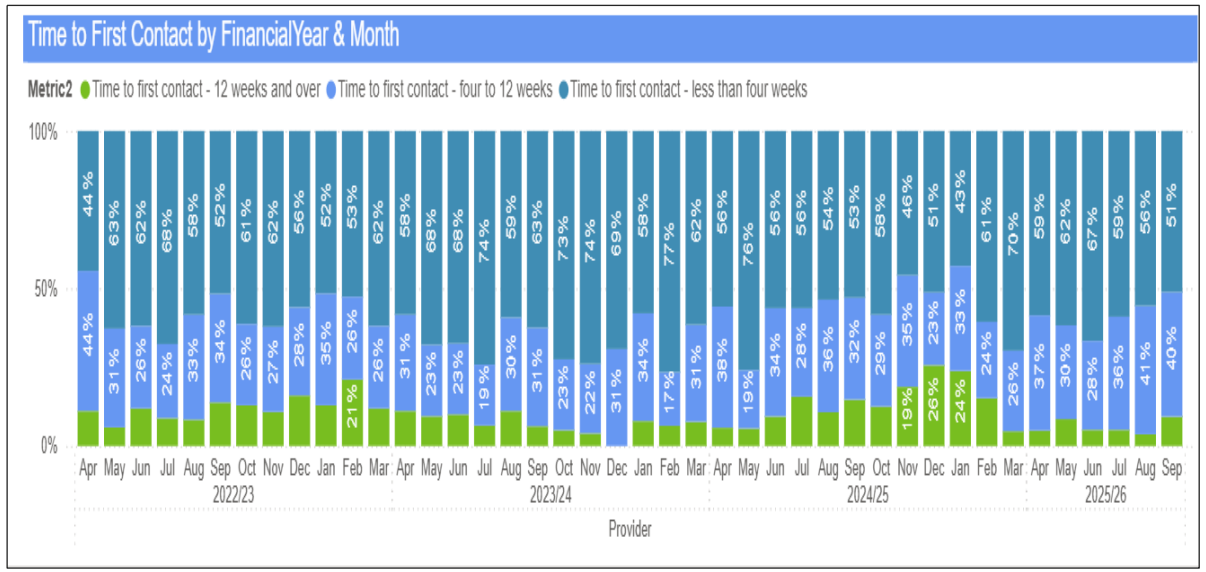
There was a reduction in the number of attended appointments from 619 in October to 401 in December 2025 due to workforce reduction.
In December 2025, 11 patients attended their first appointment, out of a total of 401 appointments delivered. The current wait time for a first appointment is approximately 89 weeks, which is the lowest figure since September 2024 although the number of 1st appointments has remained the same. 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)

- This chart is provided by NHS Futures, and hence there is a data lag. As of October 2025, 3,580 individuals have received at least one contact from the trust in the last 12 months. This is very similar to the figures of 3,545 reported for October 2024.

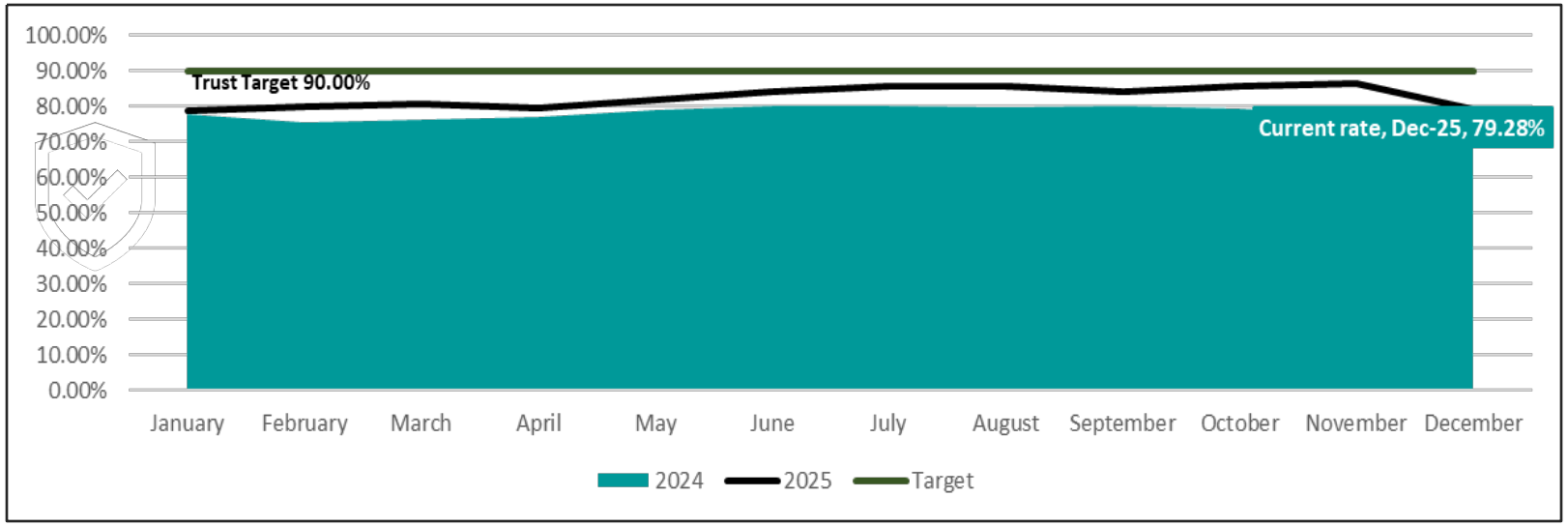


Time to First Contact by Financial/Year & Month (CYP)

- In the latest month reported by NCL ICB (September 2025), Across all T&P CYP MH services, 51% of service users received a first contact within 4 weeks of referral. We are seeking clarification from the ICB regarding the background metrics contributing to this data.

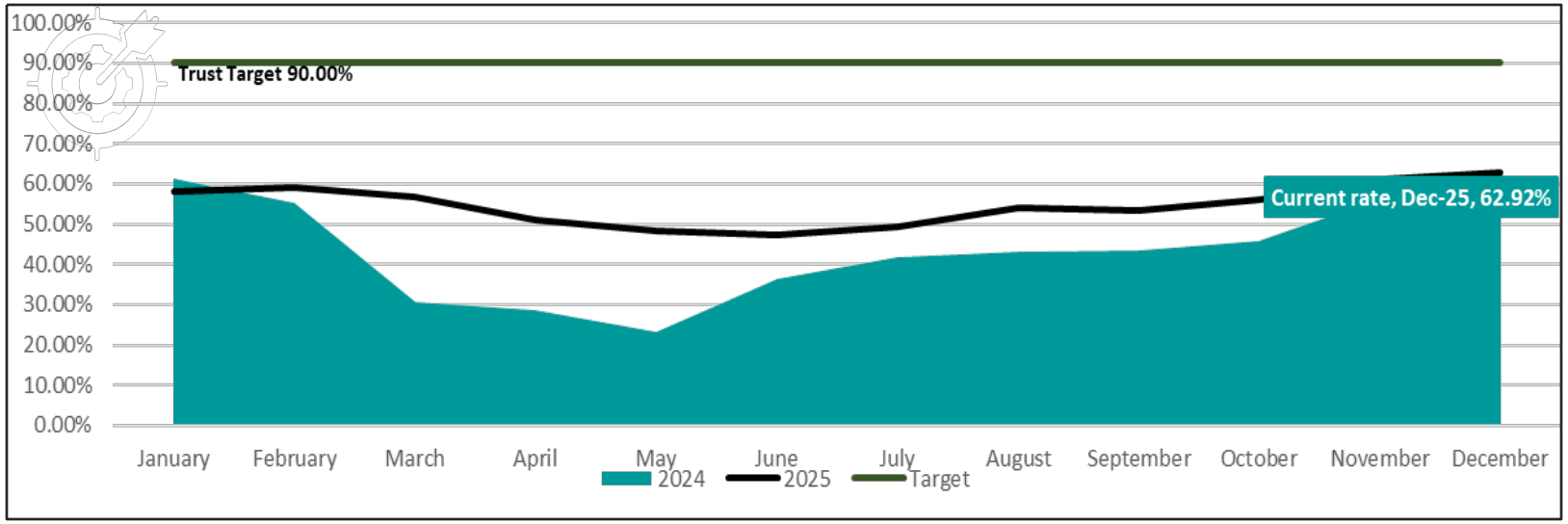
Are We Well-Led? –Trust-wide

The Tavistock and Portman NHS Foundation Trust



Mandatory & Statutory Training (Combined)

Directorate Dec-25	Compliance %
Chief Financial Officer	94.83%
Chief Nursing Officer	92.40%
Chief Strategy & Business Development	89.87%
Chief Executive Officer	82.98%
Chief Clinical Operating Officer	79.89%
Chief Education and Training Officer	76.01%
Chief Medical Officer	66.59%
Chief People Officer (Includes Bank)	57.63%

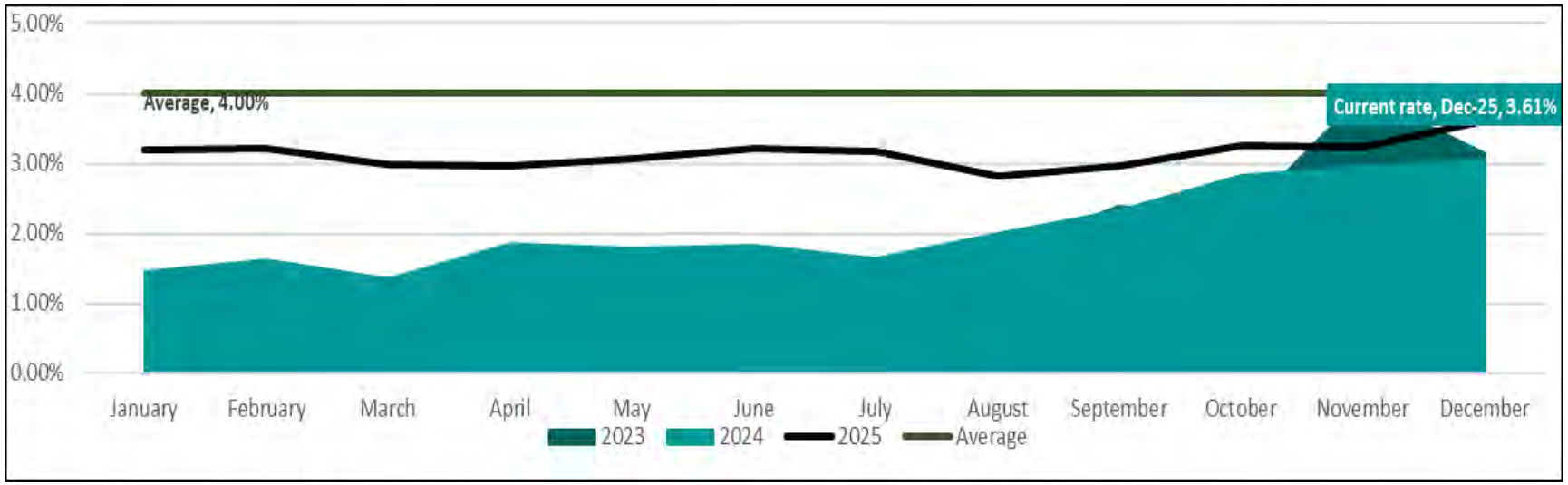


Appraisal Completion (Combined)

Directorate Dec-25	Reviews %
Chief Executive Officer	73.68%
Chief Clinical Operating Officer	69.90%
Chief Financial Officer	67.86%
Chief People Officer	58.33%
Chief Nursing Officer	57.14%
Chief Strategy & Business Development	52.38%
Chief Education and Training Officer	52.06%
Chief Medical Officer	0.00%

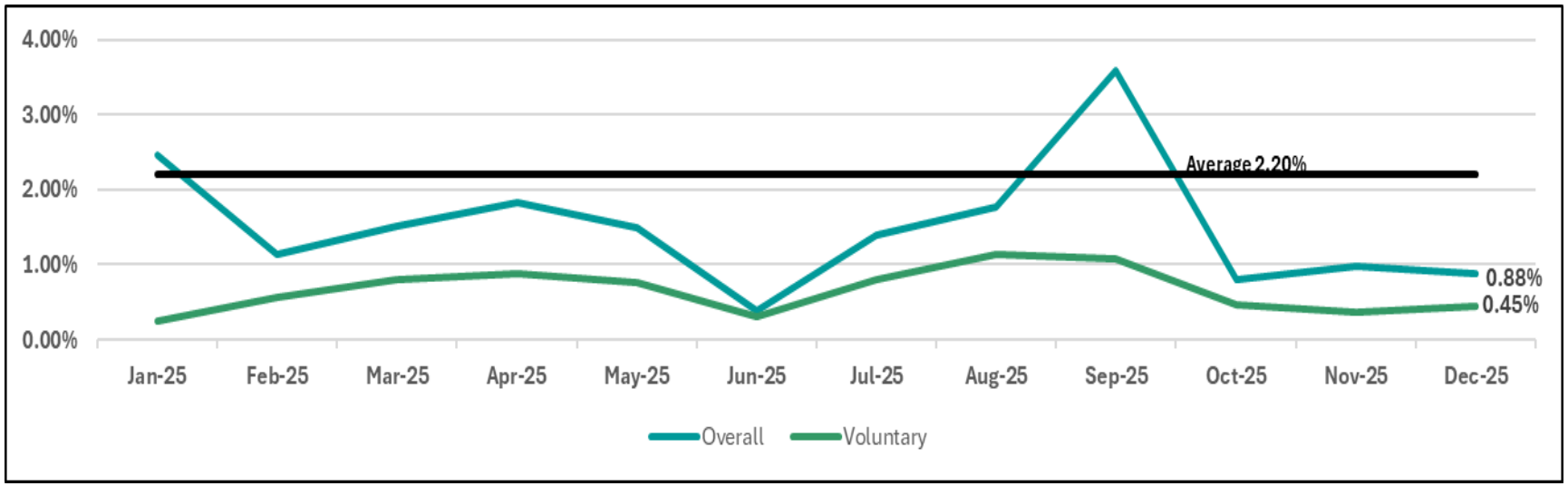
Are We Well-Led? – Trust-wide

The Tavistock and Portman NHS Foundation Trust



Staff Sickness (Combined)

Directorate Dec-25	Absence FTE %
Chief People Officer	17.51%
Chief Clinical Operating Officer	5.37%
Chief Executive Officer	4.62%
Chief Financial Officer	2.59%
Chief Nursing Officer	1.39%
Chief Strategy & Business Development	0.62%
Chief Education and Training Officer	0.29%
Chief Medical Officer	0.00%



Staff Turnover (Combined)

Turnover	Overall	Voluntary
Chief Clinical Operating Officer	**1.16%**	**0.60%**
Chief Education and Training Officer	0.00%	0.00%
Chief Executive Officer	**4.40%**	**4.40%**
Chief Financial Officer	**1.71%**	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	0.00%	0.00%

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? – December 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 62.92% (553). This has increased by 1.66% (15) at the end of Dec-25.

•Chief Executive have achieved 73.68% (17) of appraisal reviews completed. Chief Clinical follows at 69.90% (321).

•There has been no AfC appraisal activity completed by Chief Medical Directorate to date resulting in a 0% completion rate.

Appraisals
62.92%

•The Tavistock & Portman Trust sickness rate currently stands at 3.61% (32) at the end of Dec-25, below the average benchmark of 4.00% by 0.39%.
•The level of sickness has increased from the previous month by 0.39% (3).

•The T&P Trust sickness absence within anxiety/stress/depression/other psychiatric illnesses continues to hold the highest rate at 1.47% (13).
This has increased from the previous month by 0.21% (2) ending Dec-25.

•The second highest sickness absence rate is related to cold, cough, flu – Influenza — accounted for 0.58% (5) of total recorded cases.
•The sickness absence data from January 2025 to December 2025 reveals that mental health issues—specifically anxiety, stress, and depression is the leading cause of absence.

•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
3.61%

•Compliance this month stands at 79.28% (697), reflecting a decrease of 7.38% (65) ending Dec-25.

•This reduction is primarily due to the addition of new statutory and mandatory training requirements, including Understanding sexual safety in the workplace, Oliver McGowan Tier 1 and Tier 2 training, amongst a few more.

•Chief Financial stands at 94.83% (56) compliance, holding a high standard continuing from the previous month. Chief Nursing follows, at 92.40% (21)
•To achieve a high standard, each directorate will need to target 90% above. Two out of eight have achieved this.

MAST
79.28%

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	43,840	42,424	(1,416)
Pay	(38,317)	(39,503)	(1,186)
Non-Pay	(8,280)	(8,734)	(455)
Non Operating expenditure	(154)	(160)	(6)
Total	**(2,911)**	**(5,974)**	**(3,063)**

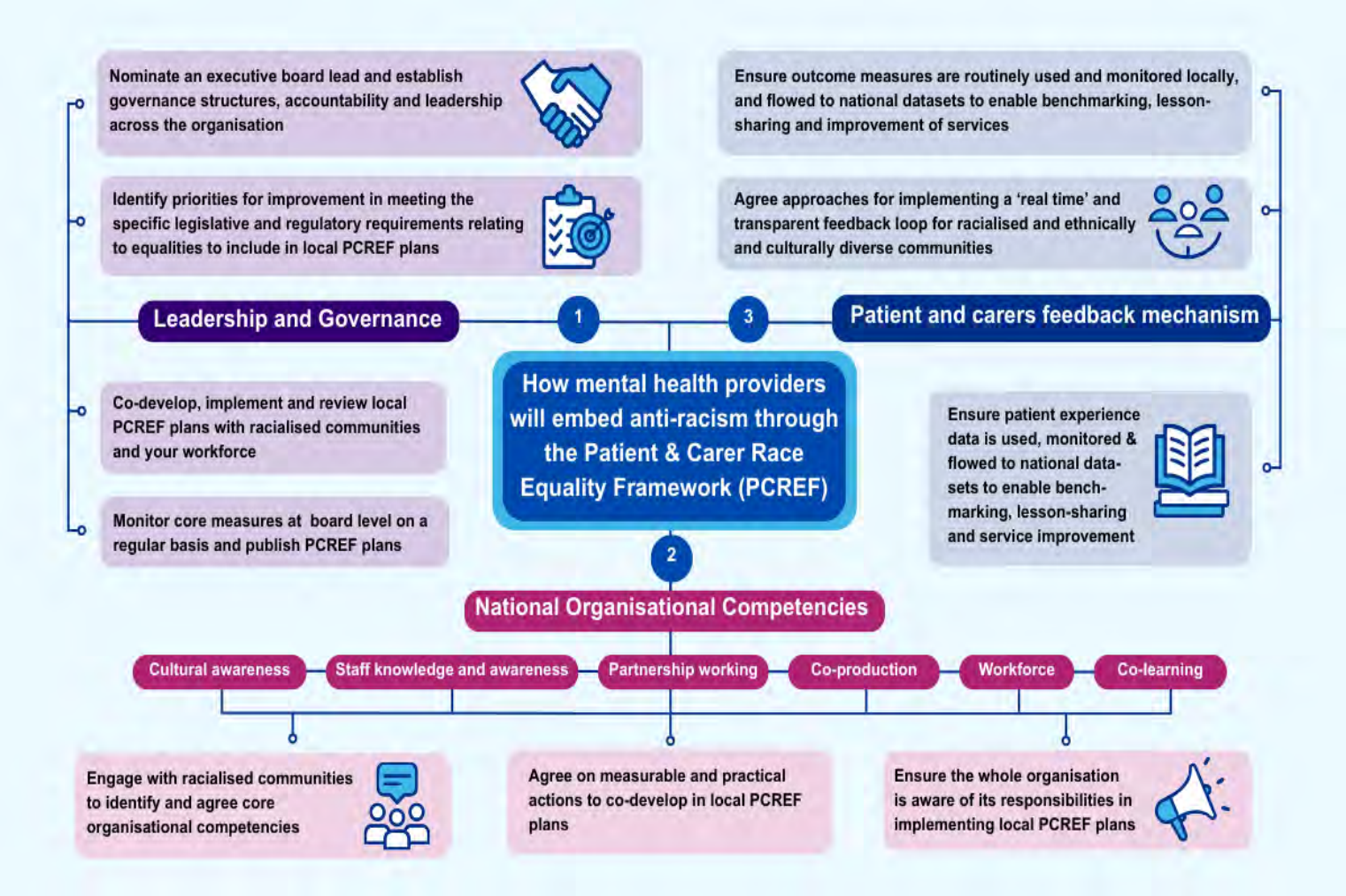
Performance (M9): YTD deficit £5,974k, £3,063k adverse to plan. Income is £1,416k below plan, with pay £1,186k and non-pay £455k above plan. Pay pressures primarily reflect non-delivery of planned savings targets.
CIP: We have reported that the £3.9m CIP stated in the PFR has been achieved. However, to deliver breakeven, we also need to implement the additional local CIP required to meet the financial plan. This remains challenging, particularly within Clinical Services and CETO, due to ongoing operational requirements and a level of unidentified savings. The local CIP is the one that has not been achieved.
Key risks:

- **NTC structural gap:** Unresolved, current mitigations mainly non-recurrent.
- **Income delivery:** Ongoing pressure within CETO, driven by lower intake across short courses, and within Tavistock Consulting and I-Thrive due to lower-than-expected demand.
- **CIP delivery:** Continued risk arising from staff turnover, restructures, and compliance with spend-control measures.
- **Cash position:** As of December 2025, cash reserves were £1.012m, equivalent to approximately five days of operating expenditure. The Trust's cash PDC application of £2.850m has been approved to prevent cash shortages in January 2026, with the condition that £2.4m will be repaid once the Gloucester House sale completes. The sale of Gloucester House is now expected to complete by the end of February. If everything proceeds as planned, the Trust will not require any additional cash support for the remainder of the financial year. However, if the Gloucester House sale is delayed into the next financial year, the Trust will require additional cash PDC support of £1.9m in March 2026.

25/26 M9 YTD position: £3,063k deficit

The Tavistock and Portman NHS Foundation Trust

Patient Carer Race Equality Framework (PCREF)



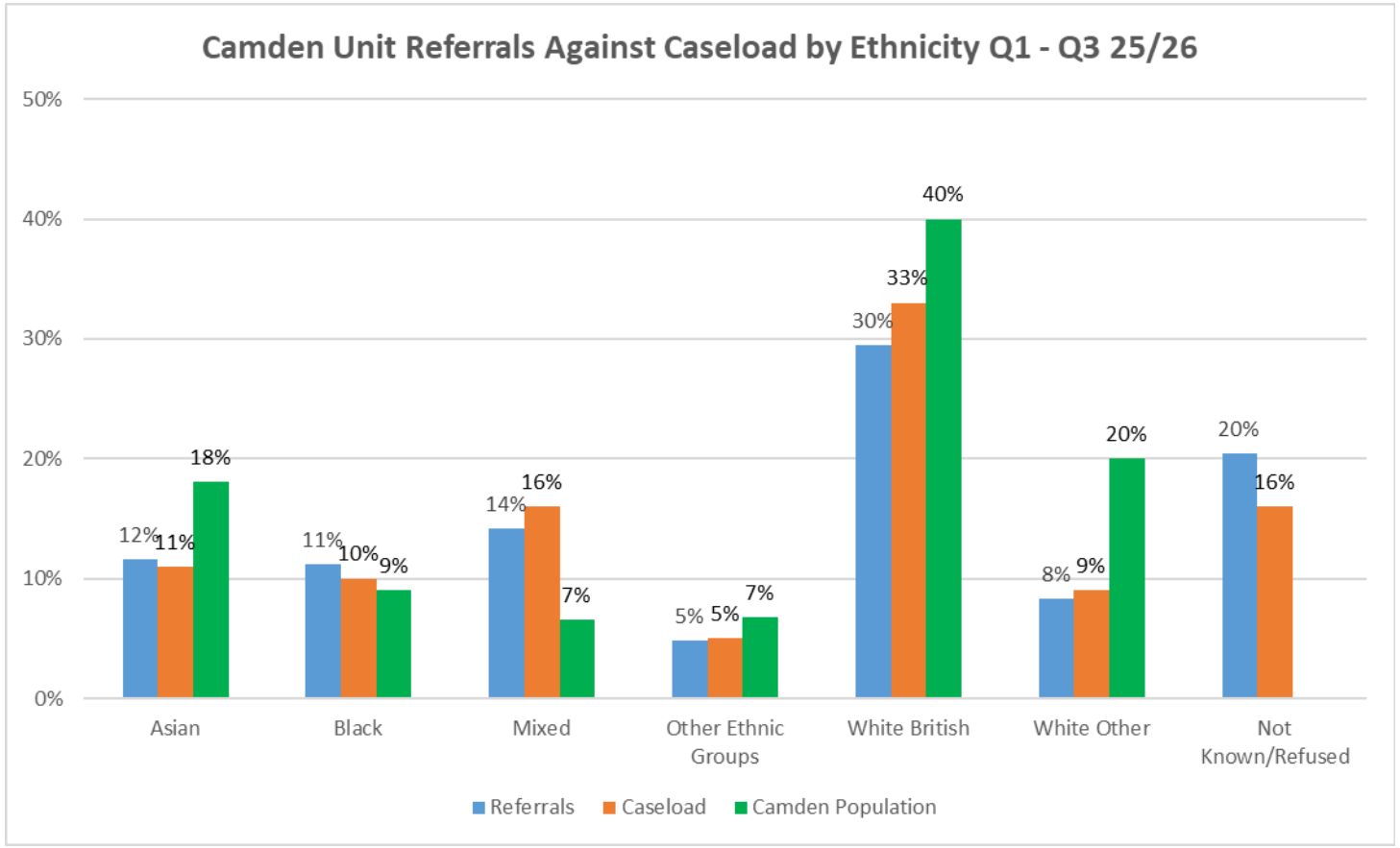
Accessibility

- Accessibility of NHS by ethnicity reveals significant inequalities, with global majority communities facing longer waits, poorer experiences, and barriers like discrimination, language issues, and cultural insensitivity, especially for planned care and mental health, leading to worse outcomes despite efforts to improve data and standards.
- Data published by the NHS show patients (Waiting List Minimum Data Set) show that in the poorest communities and those from an Asian or Asian British background are more likely to be waiting longer than 18 weeks than any other group.
- Ethnic minority patients are less likely to be referred for talking therapies, facing distrust and cultural stereotyping in mental health services. With experiences of discrimination, lack of cultural understanding, and systemic bias contribute to poorer engagement and outcomes. This is in addition to challenges related to online access and ensuring information is provided in accessible formats for diverse communities.

The Tavistock and Portman NHS Foundation Trust

Camden Unit

- When comparing referral data to caseload data there does not appear to be a significant concern around specific ethnic groups being declined a service.
- Camden Unit data shows that there continues to be a relative under-representation of children and Young people from Asian background referred to the Trust.
- There is also a significant over-representation of young people of Mixed ethnicities accessing CAMHS.



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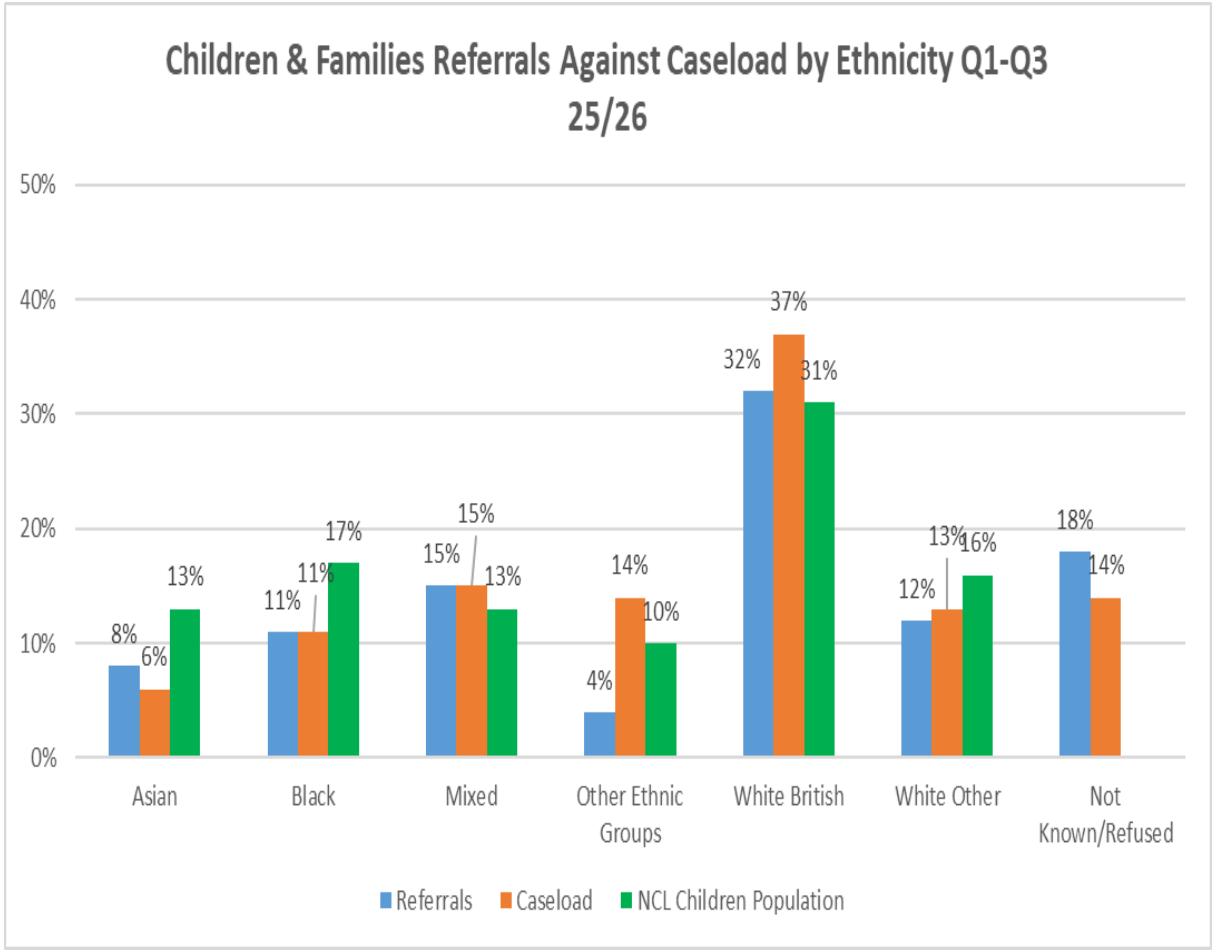
Child and Family Unit

- The Child and Family Unit data indicates unrepresentation in referrals by both Asian and Black ethnicities.
- Children of Black ethnicities are accepted at the same rate they are referred. (Referred 11%, Accepted 11%, Population 17%).
- Children of Asian ethnicities a less likely to be accepted. (Referred 8%, Accepted 6%, population 13%)
- There is a significantly higher percentage of those identifying as "Other Ethnic Group" in terms of case load relative to both referrals and population data.
- There is also an overrepresentation of White British children and an underrepresentation of White other children. Taken as a single group the White population is equally represented in terms of caseload (50%) and population (47%) with a lower number of referral received (44%). This indicates that more White children are accepted for treatment than would be expected compared to other groups.



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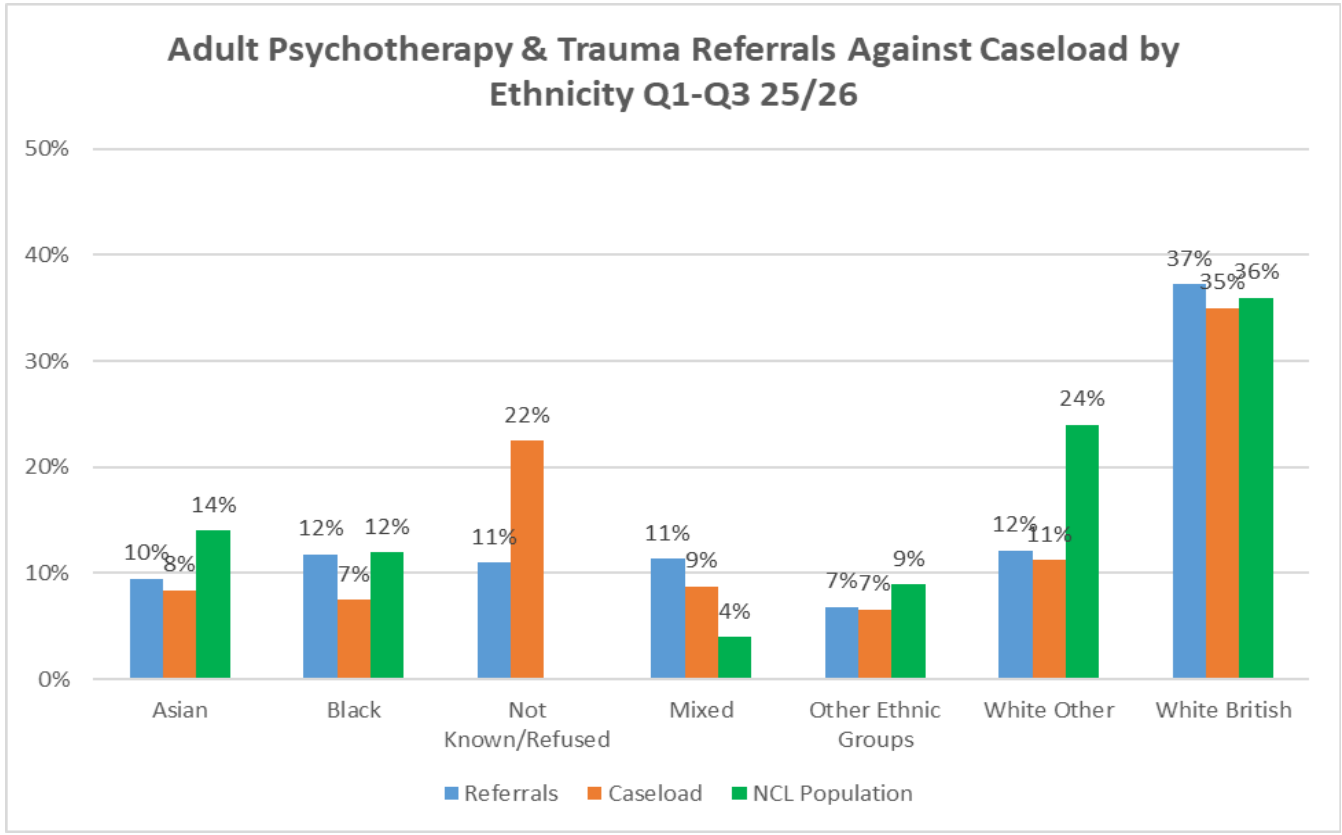
Adult Unit – Therapy services

- There is a significantly higher percentage of those identifying as Mixed ethnicity in both referrals and case load compared to population level data.
- The caseload level data holds the highest percentage of not known ethnicities across the clinical services.
- The Adult Therapies services data indicates a Black service user being referred close to the population level but accepted at much lower rates. The percentage of Asian service users referred is closer to the accepted referrals, but both are lower than the population data



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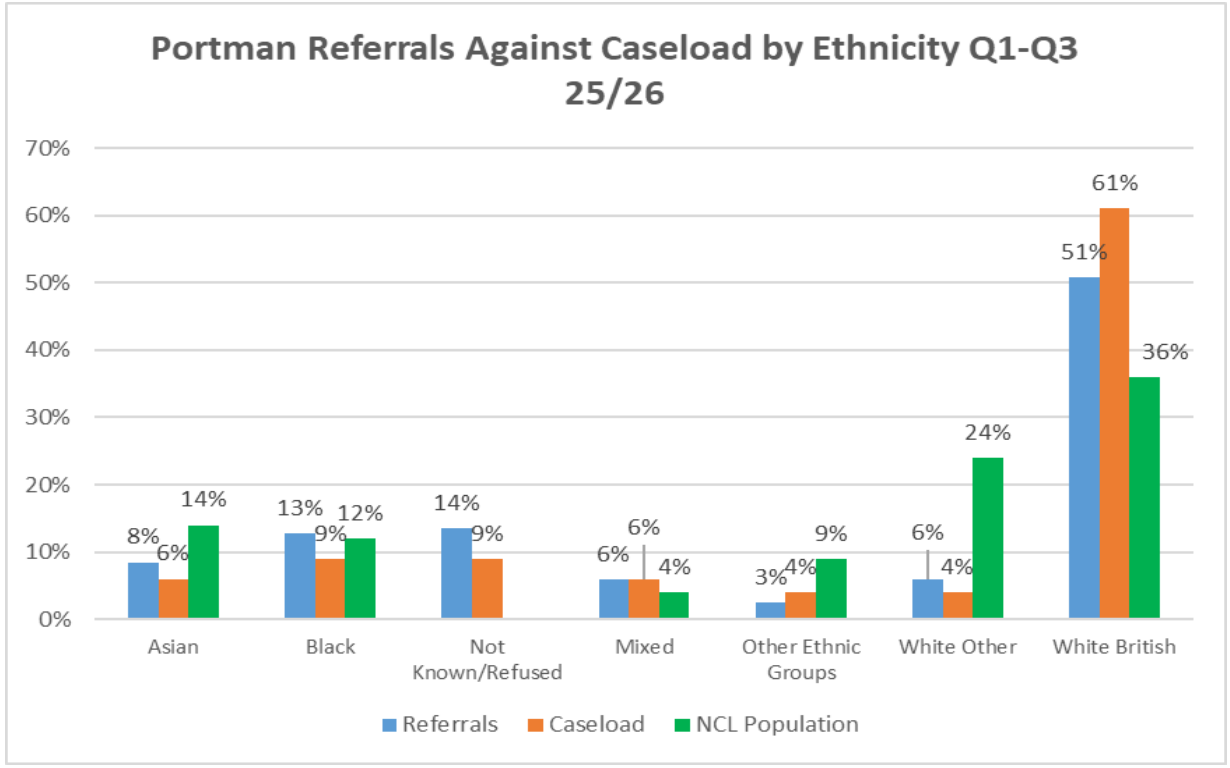
Adult Unit – Portman

•The Portman Teams data indicates that Black service users are referred at levels but accepted at much lower rates. There is a similar picture for Asian service users.

•Taken as a single group the percentage of White service users (65%) is close to the population data (60%) with a referral percentage of 57%. This is the only group in the service where the caseload is significantly greater than the percentage of people referred to the service.

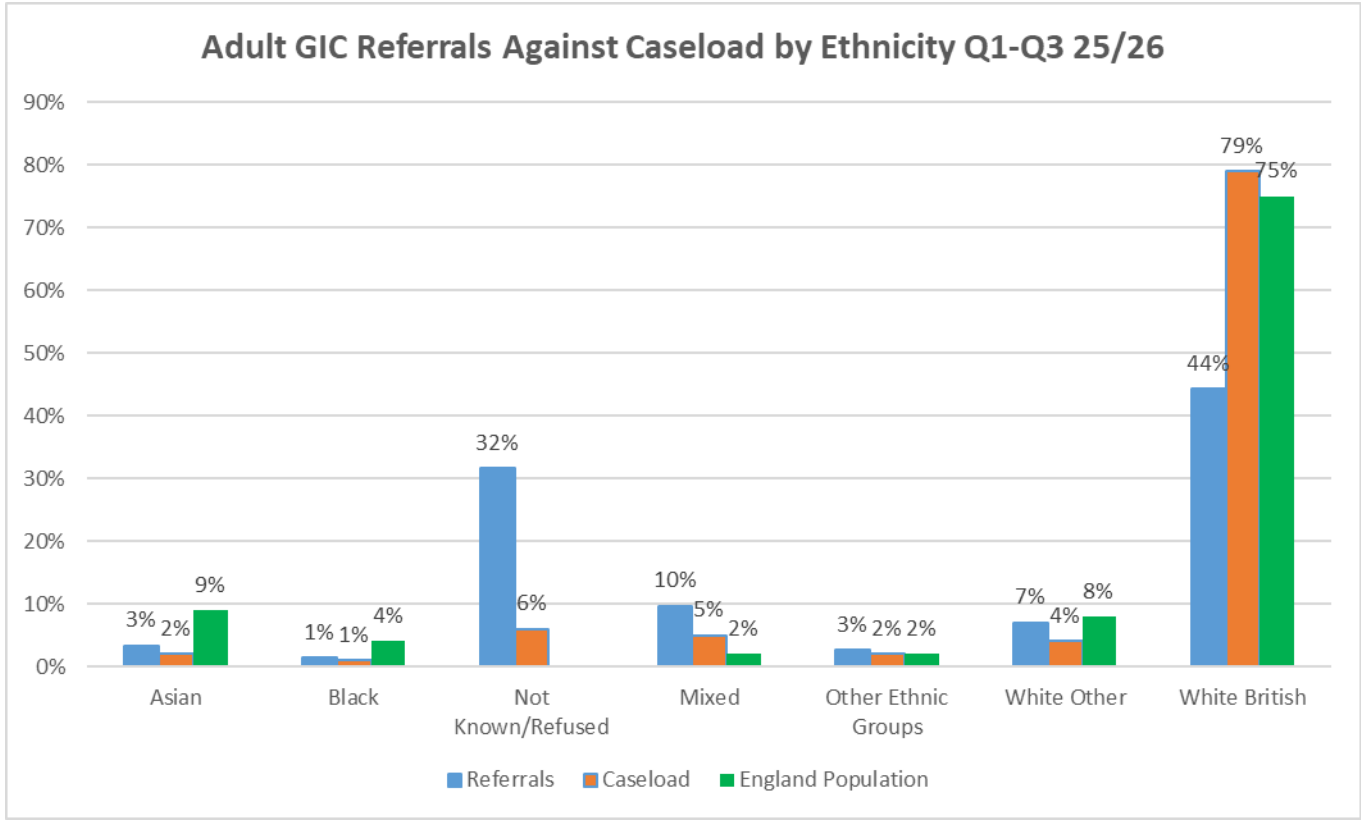
•The caseload data held in the teams is the lowest numbers in their caseload with unknown ethnicity.



The Tavistock and Portman NHS Foundation Trust

Adult Unit – Gender

- The majority to the service users referred to the GIC are White British.
- There is a high number of unknown ethnicities within the referred population, but this is likely to be due to the long waiting list.
- There is an underrepresentation of Asian and Black individuals referred



DET & Unit Overviews

Education & Training

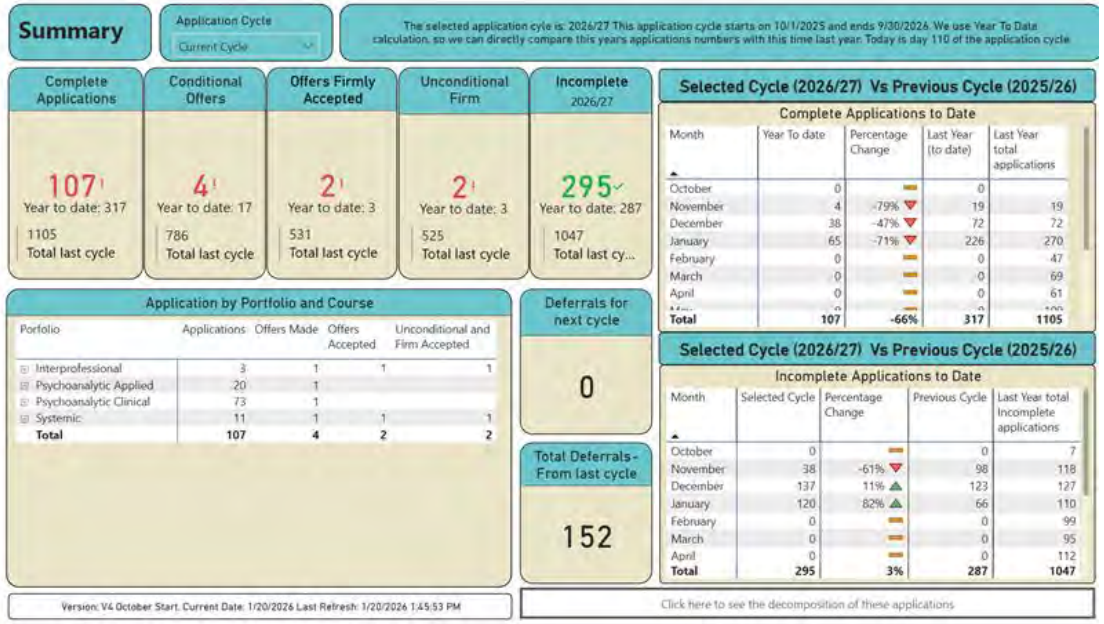
Month 09 25/26*

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 in early November 2025. .	• 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).
• This is a new reporting cycle so recruitment figures will be low.	• 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.
	• 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 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: The **2026/27** cycle is showing clear signs of recovery following an expected seasonal slowdown over the Christmas period and some possible merger related uncertainty. Complete applications have increased steadily, particularly from **Dec** into **Jan**. Overall applicant engagement remains strong, with incomplete applications slightly higher than last year, indicating sustained interest. While completions and firm activity are still behind the same point last cycle, this reflects timing and conversion dynamics rather than reduced demand. A sizeable pool of incomplete applications and carried forward deferrals presents a strong opportunity to build momentum. Focus should now shift from rebuilding volume to accelerating conversion and decision making, this approach should help in capitalising on this momentum and help performance over the next phase of the cycle.

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.

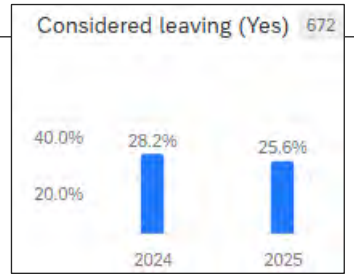
Concern	Cause	Countermeasure	Owner	Due Date
Growing income to meet pay costs	Rise in DET ops staff 2023-25	Increased long-course student income Agreed uplifts for AY 2026/7 International Project Income	CETO / Directors of Education	COMPLETE
Ensuring sustainability of DET	Withdrawal of National Training 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

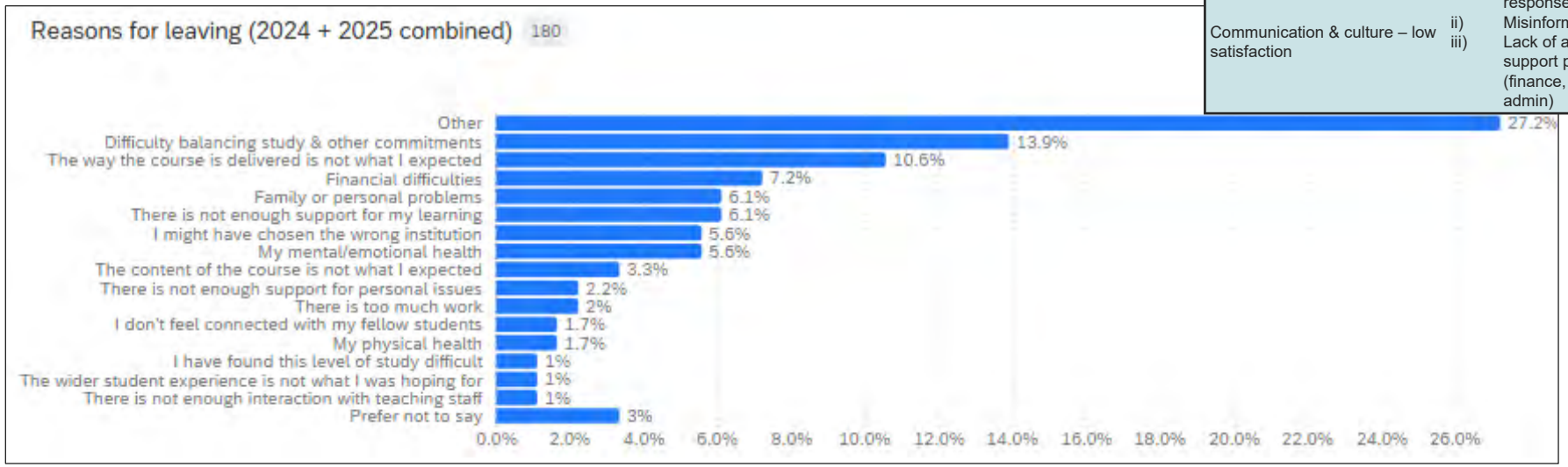
Education & Training - Student Experience

Month 09 25/26

Successes	Challenges
• A new student Quiet Space is about to launch, which will be particularly helpful for disabled students, and those with long-term health conditions who need to decompress from noise and social expectations. • The CPD 'embedding disability' is on track for delivery in February. • The student experience overview report (incorporating survey and other forms of feedback, benchmarking against the sector and analysing EDI demographic data) was well-received by the Education and Training Committee. Actions arising from the report have been discussed at Student Experience Group, Learning & Teaching Group and Academic Governance & Quality Assurance Group.	• 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 416 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. • In the latest student experience overview report 2025, the report identifies communication as an area that needs attention. There is already activity taking place in this area, around enhancing DET staff inductions, creating a staff handbook to ensure more consistent knowledge and information is available for staff.
2025 student survey results. • Overall Response rate was up 4% year on year to 29% (vs 17% sector average) • Overall Satisfaction was 81% (up 1% on previous year)	• 26% of students considered leaving in 2025. This compares with 21.8% of students studying 'subjects allied to medicine' who completed the PTES survey, and 25.4% of PRES students on 'other health subjects'. Therefore, the Trust's score is high, This rises to 34% of disabled students considering leaving. • 'Other' reasons for leaving include: financial, assessment, placements, observations, discrimination/feeling excluded based on protected characteristics, juggling commitments, institutional organisation/communication.

Retention (Considering Leaving)





Concern	Cause	Countermeasure	Owner	Due Date
Low satisfaction among disabled students	Slow responsiveness to identified needs among disabled students	Discussions ongoing with SESC and escalated to Estates	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. Placement project ongoing. Academic standards being reviewed by head of registry	Exec Team CETO/Head of Registry	End September 2025
Communication & culture – low satisfaction	i) Non-response or slow response to emails ii) Misinformation iii) Lack of awareness of support provision (finance, disability, admin)	• Enhancing DET staff inductions & developing staff handbooks • Implementing service level agreements in emails (e.g. your email will re responded to in xx days)	Head of DET Ops	July 2026

Updates on above actions

Disability and Estates: **Dec 2025:** Is an ongoing agenda item on the Student Experience Group. 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

M9 - December 2025

AY25-26 to date

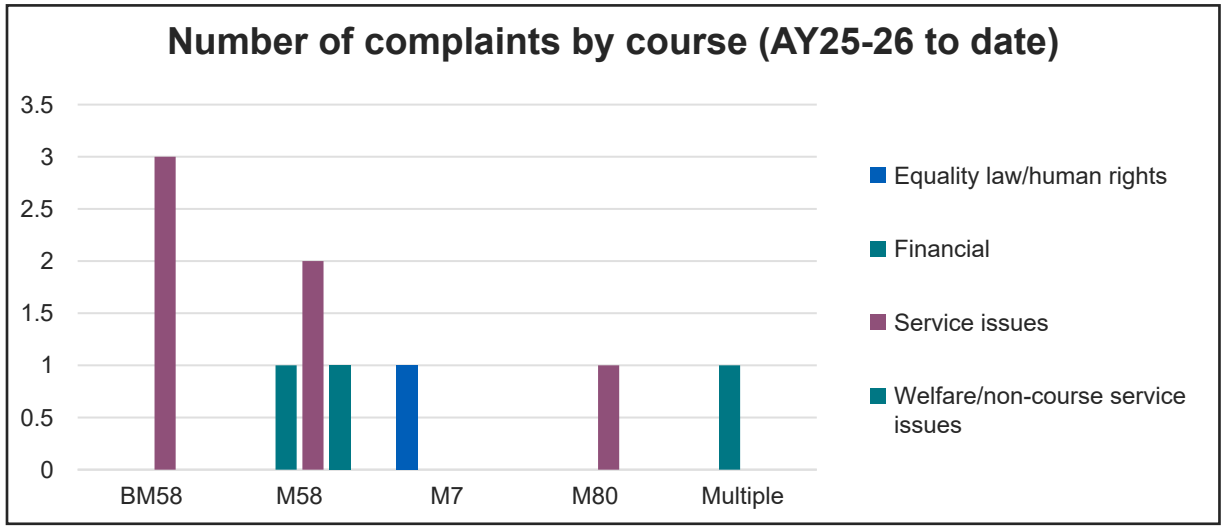
The Tavistock and Portman NHS Foundation Trust

This month, the Trust received **1 formal complaint**, which was submitted by a group of students on BM58 in the Service issues category.

The Trust closed **1 informal complaint**, which was successfully resolved at the local stage, and **1 formal complaint**, which was Partly Upheld. One good practice recommendation for the Trust arose from the formal complaint, which will be tracked via the Academic Governance and Quality Assurance Group.

Additionally, the complainant for **1 formal complaint** which was closed as Partly Upheld in November 2025 accepted a settlement offer which was made by the Trust, so this complaint is now recorded as Settled.

The Trust is currently processing **6 informal complaints** and **2 formal complaints**.



This year, the Trust has received **10** complaints under the Student Complaints Procedure. Of these, **8** 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 have been closed this year, the outcomes are as follows:

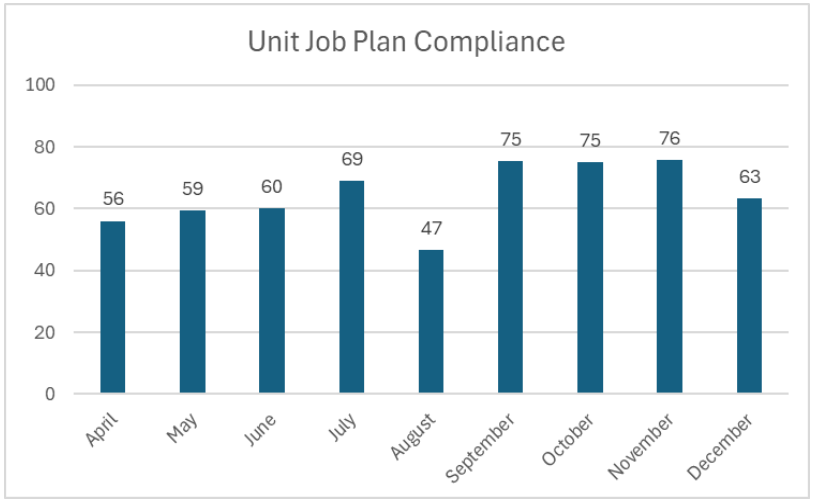
Outcome	Number of complaints
Local resolution successful	1
Local resolution unsuccessful	0
Not Upheld	0
Partly Upheld	2
Upheld	0
Settled	1
Withdrawn	1
Closed due to no contact	0

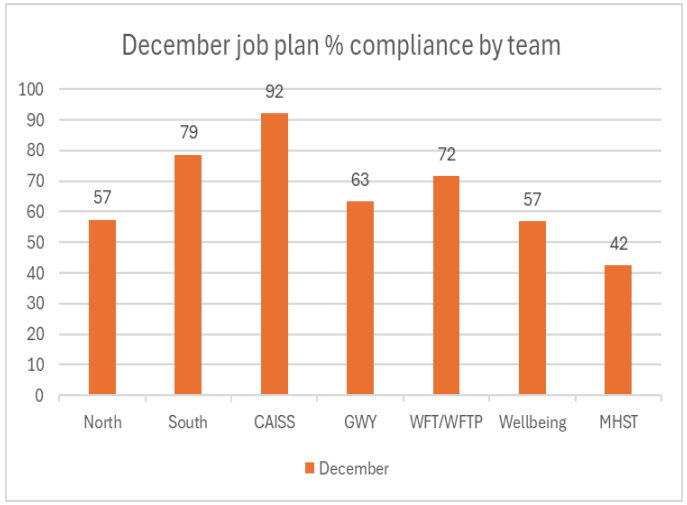
Camden Unit Overview (1/2)

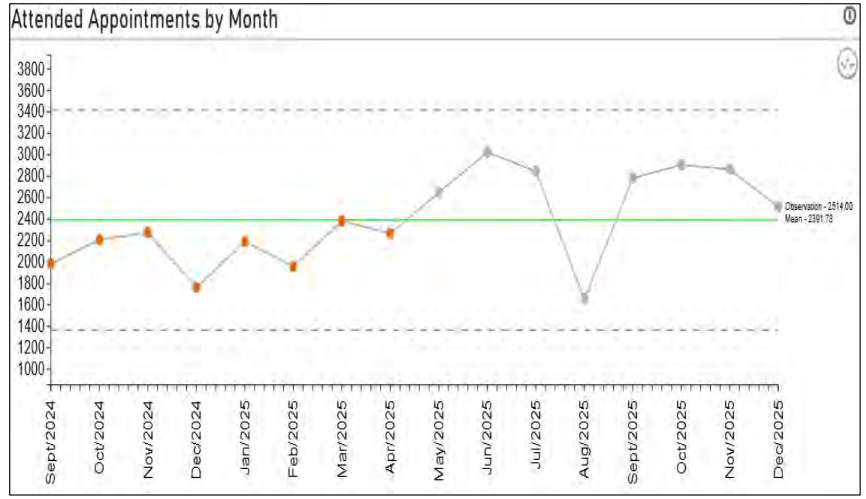
	Successes	Challenges
Safe 	• Appraisal compliance has increased to 80% (from 61% in October). • We have started a piece of work to reduce our safeguarding and risks forms outstanding for over 2 months and have seen a 36% fall in a month. Many of these are old forms that are unconfirmed and this does raise questions about the process.	• Camden Unit MAST compliance dropped below 90% this month. Staff have been advised of changes in the system and asked to look at ERS to check outstanding courses. • Dormant cases have not reduced. As we experiencing challenges in gaining momentum for this work we will consider the development of a QI project.
Effective 	• We continue to achieve an average of less than 3 week wait to first appt (exc. outcome measures) • We delivered 2,544 attended appointments in December a 44% increase on last year. We have sustained this increase in activity since September. • The CAISS team had another record month offering more activity in December than any month in the last 2 years and a more than 50% increase on their November appointments. They achieved 92% compliance to job plans in month.	• Assessment waiting times data is still difficult to use and is not validated, we have seen a draft dashboard and given feedback. • We continue to work with the OM project and IM&T to develop the dashboard to show improvement in outcomes. • We are struggling to support NCL Home Treatment Team [HTT] who are NLFT clinicians to have Care Notes access. The team support Camden CYP within NCL and having access to our EPR would enable more continuity of care and improve info sharing. Current process is honorary contracts which involves NLFT staff completing application forms on TRAC.
Caring 	• There is just 1 young person from Camden in an inpatient bed. • ESQ responses increased in month exceeding our target. They remain mainly positive.	• Exec and divisional leads joined a visit to Ampthill Square to review the building, which highlighted significant Estates improvements need to be made to support the workforce and patients through the ongoing delivery of high quality and safe care
Responsive 	• The Camden Unit received 249 referrals in December which is 45% higher than last year – this increase has now been sustained for 4 months. • DNA rate was under 7% in December and now has been for 4 months. • Job plan compliance was 64% in December, while lower than recent months it is higher than the whole of Q1 this year. There was significant variance by team as per the next slide.	• While PTL is in place across the Unit, there are concerns related to the consistnet use of the SOP and robust processes across all teams. • We are looking at how we can include access data in these slides and hope to do so from next month. • We have identified a need to ensure regular reviews of job plan reporting to ensure accuracy, and that team level capacity is amended to appropriately reflect staff turnover and new starters.
Well-Led 	• We have had an initial meeting with NLFT to discuss how they measure productivity and are working to align our job planning methods to theirs – awaiting final points of clarification to support this work. • MHST Process mapping meeting has taken place, and we will be speaking to the strategy team this week about support • We continue to work on our annual plan and are communicating with our teams about the Unit and team level goals for 2026/27 • We are on track to meet our savings target for 25/26	• While we are waiting on finalised budgets, we will likely need further plans to meet the 26/27 savings target. • Team have expressed frustration in the delays around lone working processes, and we will be moving forward to trial personal alarms in the Unit.

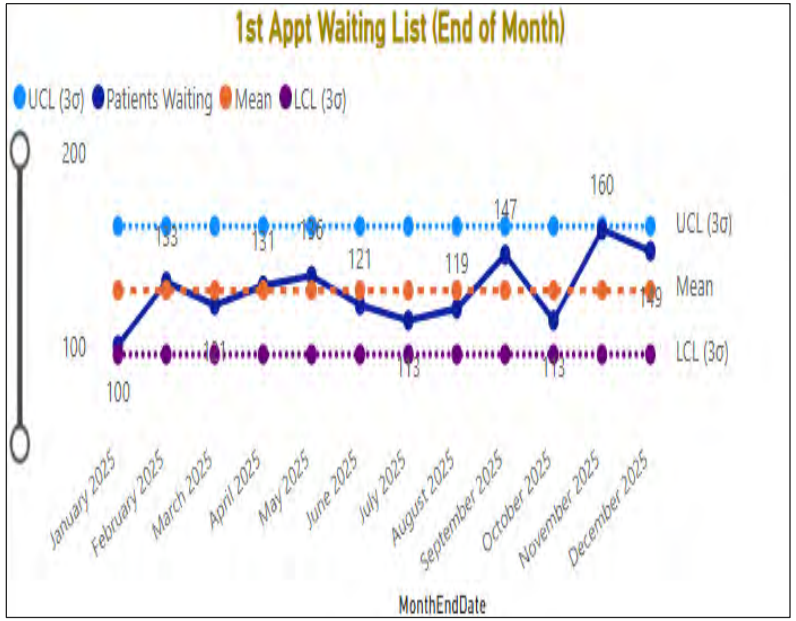
Camden Unit Overview (2/2)

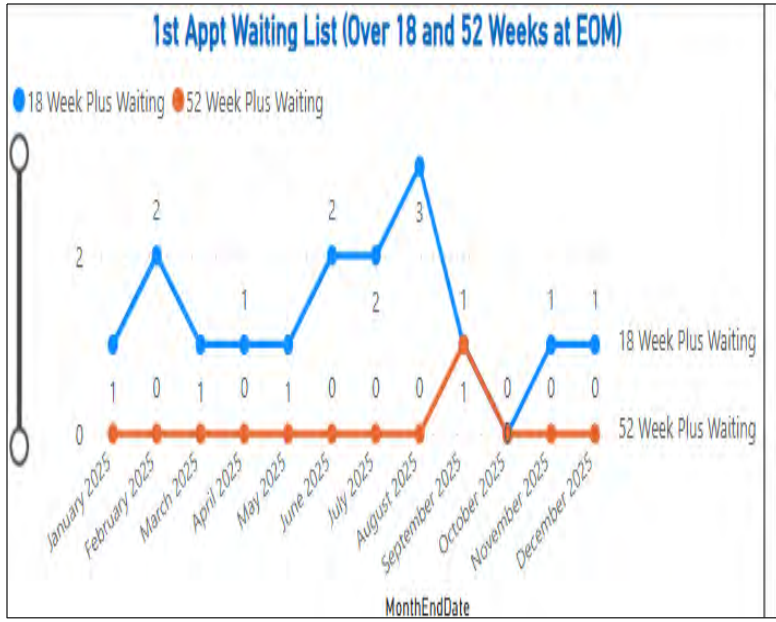
Activity Overview

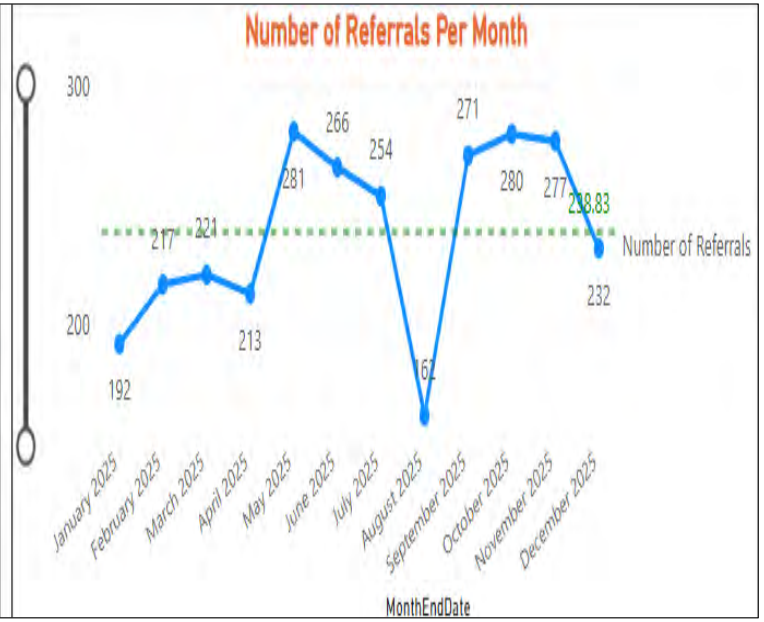










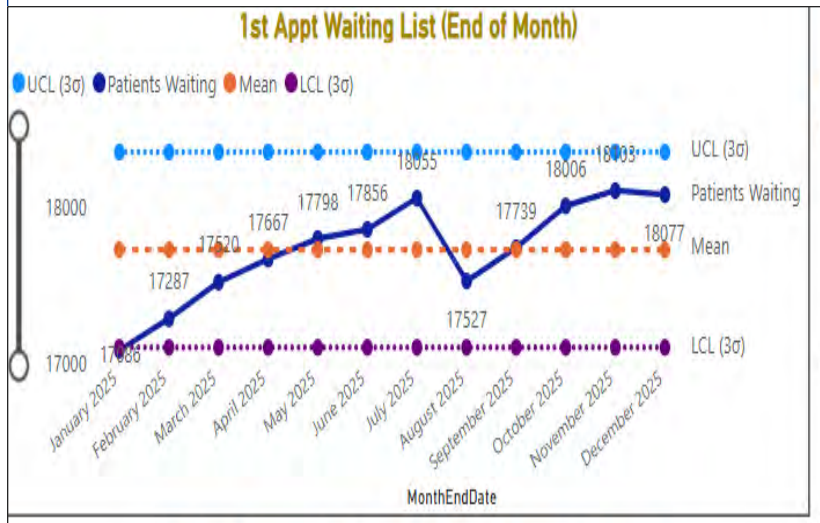


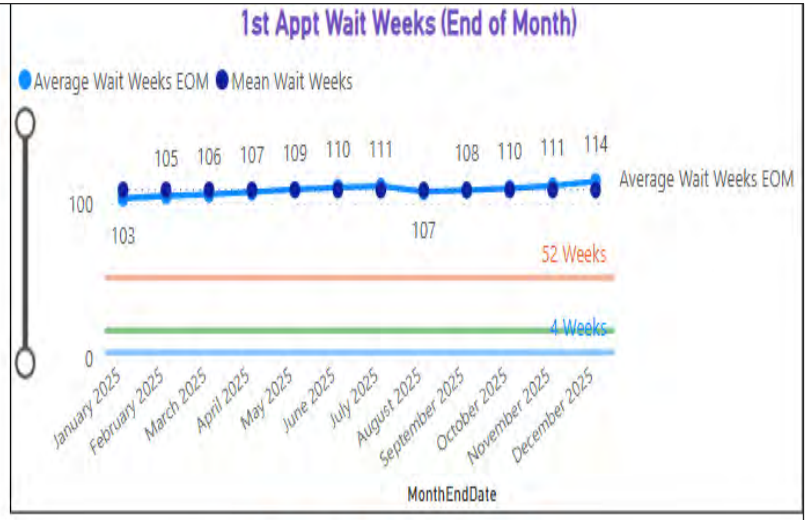
Adult Unit Overview - 1/2

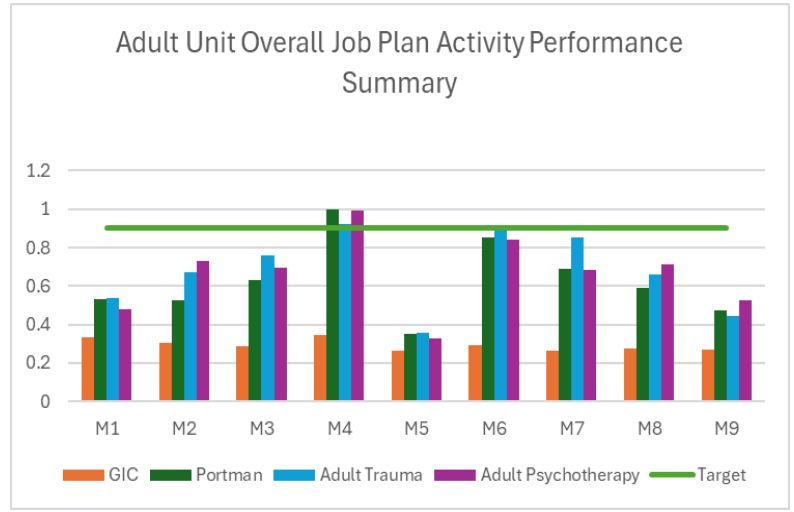
	Successes	Challenges
Safe	• We are seeing a gradual trend of more complaints resolved informally, staff confidence and awareness is increasing. • Adult held a successful consultation with NLFT security advisor who provided simple and affordable recommendations for staff safety devices and an additional security door. This requires a decision about purchase of personal alarms.	• Patients in Trauma and Psychotherapy have complained about frequency of text message ESQ reminders and did not give consent to the frequency of contact. We are informed that patients can opt out of specific aspects of text reminders. • The Trauma waiting list continues to grow. The team wish to review the closure of the waiting list to safeguard the risks of waiting for current waiters alongside our review of out of area patients, some of whom may return to local care pathways. • Re organizing team CIPs and contributions to higher targets has impacted contract delivery due to reduced clinical capacity. • Space / Rooms – there continues to be difficulties with clinical spaces being moved or poorly maintained impacting on patient experience and service delivery. • Trauma has identified a number of waits greater than 104 weeks, breaching NHS England's target to eliminate all 2 tyear waits. This has meant that the planned move from Targeted support to a QI framework has paused and is under review. • The variation between the number of referrals (262) and discharges (175) is 87 and indicate an imbalance between service input and output. • There is a backlog of referrals in GIC waiting to be processed, QI work will focus on pathways in the administrative teams within GIC.
Effective	• The number of ESQs has decreased from 83 to 74, representing an 11% reduction since November. Psychotherapy received 26 ESQs, exceeding its target of 13. Trauma received 10 ESQs against a target of 8, while Portman received 11 ESQs against a target of 6. GIC received 27 ESQs, which remains below its target. • Portman OM project has been fruitful in this period with a significant burst of activity and hard work by Ops and AP colleagues alongside our clinical workforce. • Psychotherapy Psych ED group has continued to receive positive feedback and is being rolled out to all intake patients as a first step. This will address some of our complaint themes around knowing and understanding the nature and modality of treatment. • Psychoeducation groups in Psychotherapy Team now including educational aspects of Group Therapy – understanding its use, model and ways of working.	• In Psychotherapy the average waiting times have recently increased from 9 to 12 weeks, due to reduction in staff and patient preferences (e.g., gender of clinician, time of appointment and uncertainty about extension of contract). • Adjustment to Complex Needs budget to accommodate resource for Trauma wait list cases may level down average wait times across both teams. • Portman income streams remain incomplete with some invoices needing to be processed, this can have a knock-on impact in relation to staffing and oversight of expenditure. • % of Job Planned activity was lower than usual across the unit with Adult psychotherapy underperforming and GIC consistently low. Teams have been asked to review their Job Planning ledger to ensure this is up to date.
Ca	• The GIC team held an away day on 8 December, which was well received, with the majority of staff attending. A range of informative sessions were delivered, and overall feedback was very positive • Christmas and New Year periods had planned cover across the MH Team. • We are working with Camden Public Health and cross-London partners to promote the T&P developed Waiting Room in the face of a pan-London Mental Health promotion of 'Hub of Hope' which links to fee paying services and is under-regulated. • We are inviting NLFT MD to our team / business meetings to support transition to NLFT..	• Scheduling and clinical services are seeking leadership support in determining clear trust wide comms about rooms usage rules and boundaries after disruption to spaces. • GIC On-site rota cover has continued to be inconsistent with overreliance on the goodwill of clinicians working onsite to cover. Further work to ensure all members of the GIC have appropriate flexible working arrangements in place with a focus on patient safety and service need are met.
Res nsive	• NHSE has supported backdated referrals for the patient group with GIC surgical errors following a thorough PSII which has identified a number of actions to support improved governance, process and insight to mitigate further issues. • Admin supervision rates continue to be healthy and well reported, clinical supervision recording remains an area for improvement.	• Complaint response times and number of informal resolutions have improved however there continues to be significant clinical time and capacity required to complete high quality complaint investigation reports and follow up on multiple recommendations. We are working to stratify recommendations into small clusters to minimise unnecessary additional work where possible. • Psychotherapy- 1st appointment waiting times up from 9 –12 weeks, Clinical and Operational leads cite inconsistent and delayed ECP process and changes in pay savings targets mid-year frustrating their workforce plans.
W l-Le	• The alliance of providers has won a bid for the Enhanced Mental Health Pathway for Sexual Assault and Abuse. The Adult Unit is an associate member of this group and are not providing a lead or co-lead role due to ongoing service delivery pressures.	• Statutory and Mandatory training compliance continues to fluctuate and will be addressed across clinical and educational realms to ensure line manager engagement and action.

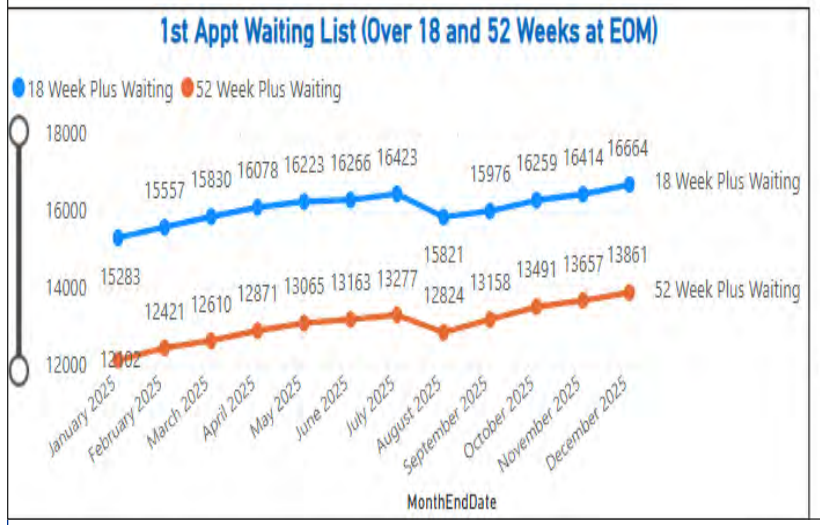
Adult Unit Overview – 2/2

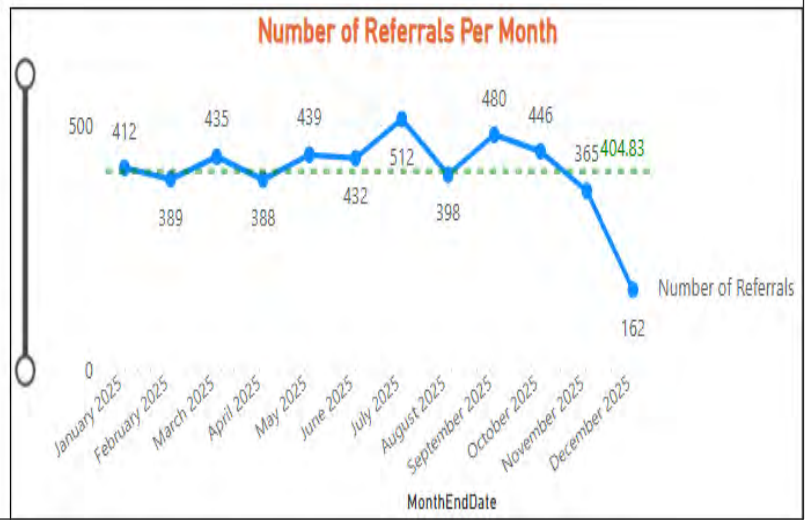
Activity Overview









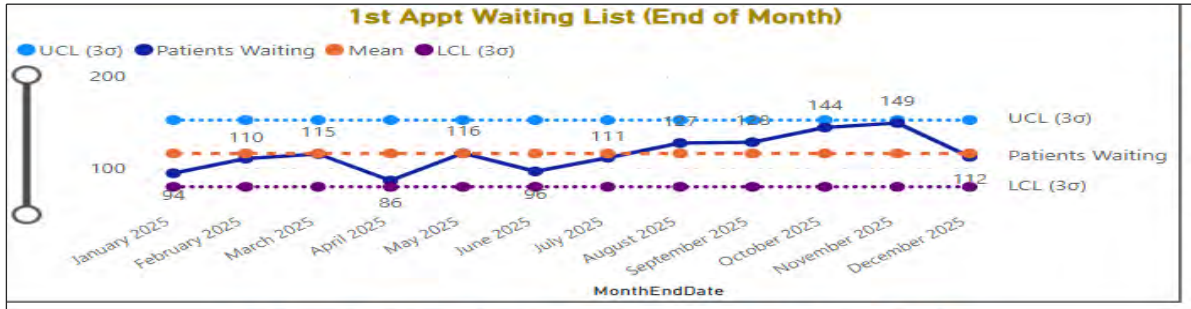


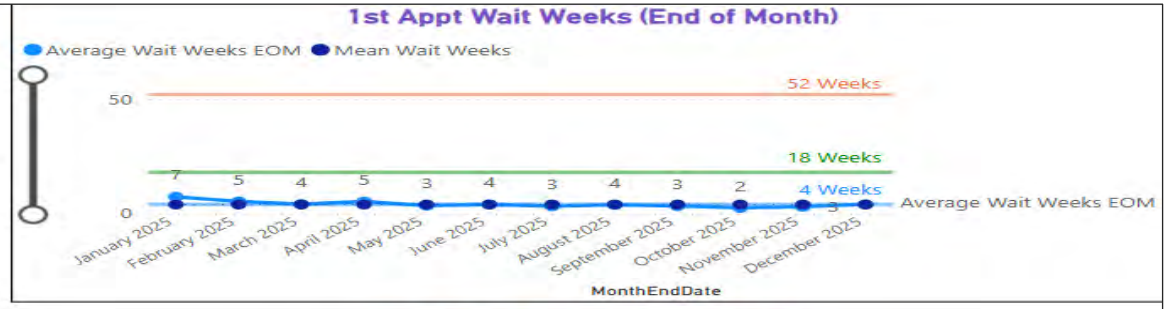
Child and Family Unit overview (1/2)

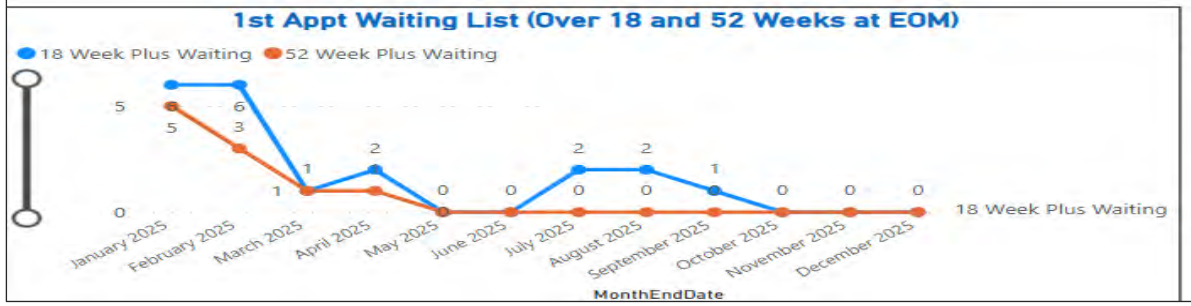
	Successes	Challenges
Safe	Unit mandatory training compliance has increased again and is 80.44% in December. The Unit is reporting a 69% compliance in Clinical Supervision it the reporting month and 84% compliance in the Admin and Operations workforce.	A total of 12 violence & aggression incidents in December in Gloucester House and 3 restraints. We are designing a QI project in Gloucester House School with a focus on the increase in restraints in the school – this will pull together all the other QI projects in the school. A paper is being prepared to review the use of Access Locks in the school and will be presented to ELT as part of the restrictive practice review.
Effective	Activity – 1,779 clinical contacts for the month, an increase on December 2024 when the Unit saw 1,541 appointments. 118 1st appointments in the month which was the 3rd highest of the calendar year. Across the Unit the 4-week wait target was met in December at 3.36 weeks. FMHT is 5.44 weeks to 1st appointment, and the team saw 367 appointments in December (compared to 265 in December 2024). EDAS waiting time to first appointment is at 3.17 weeks The Unit has an open caseload of 1,793 – the highest of the last 12 months (1,420 in Jan 2025). DNA rate overall is 7% and the 3rd lowest it has been all calendar year. 146 discharges across the Unit in December, an increase on 111 discharges in November.	**Autism Assessment service:** The waiting list for second appointment is increasing as is the Waiting list for assessment. At December end 122 young people are waiting for assessment in Haringey with an average waiting time of 42 weeks to assessment and 244 young people are waiting for Hertfordshire with an average waiting time of 125 weeks to assessment. The Hertfordshire Commissioned pathway for Autism Assessment and the NCL pathway have not met the monthly targets due to delays to recruitment however with 20 assessments started in the last two months the trajectory is one of improvement.
Caring	Percentage approval rating in ESQ feedback is at 88% in December and we had 72 forms returned. We have received particular feedback on the responsiveness of admin teams and will be reviewing for improvement planning.	The C&F Unit sickness absence rate in December was 4.41% which was a reduction from the previous month (5.14%). Staff who will be relocated from Bounds Green to T&P will be subject to a temporary change in work base. People Services working closely with unit leadership to implement.
Responsive	We continue to see an ongoing trend of increased referrals into the Unit. The number of referrals into the Unit remains high at 141 in December 2025, compared to 96 in December 2024. From months 1-9 the unit has received 1,685 referrals against 1,310 discharges and current caseload across the Unit is 1,793 - the highest level to date. Autism Assessment team completed 29 first appointments in December, up from 22 in November and waiting time to 1st appointment in December is 4.62 down from 8.76 in October, a decrease from 29 weeks in November 2024. Autism and LD and FAKCT are on track to deliver against contractual activity targets. Total activity at Month 9 for the NCL services is 14,733 attended appointments against a target of 17,169. Month 9 baseline is 12,876 so Unit wide is on track to deliver.	As a number of clinical teams are not on track to deliver against their contractual activity targets, a programme of training and visits to team meetings is being implemented in Q4 to increase recording of activity and evidence productivity..
Well-Led	Exit planning programme for Returning Families has now been implemented and regular meetings diarised. IG team engaged. Consultation closed on 21/12/25 and re deployment opportunities being explored. Work continuing on the Unit's Annual Plan and work beginning on 26/27. Appraisal rates in the Unit have increased to 65.22% (up from 58.% in November and a 25% increase since August). List of outstanding and due appraisals have been re-distributed across teams.	Potential redundancy costs for Returning Families ongoing BGHC – Whittington Health have informed the Trust that due to concerns about the building structure, 1st Step and clinical services by FAKCT and FMHT will have to vacate the premises by 23rd January. At Month 9 the Business Continuity Plan has been implemented to support a safe transfer of location. Consultation on Gloucester House Outreach is proposed for Q4

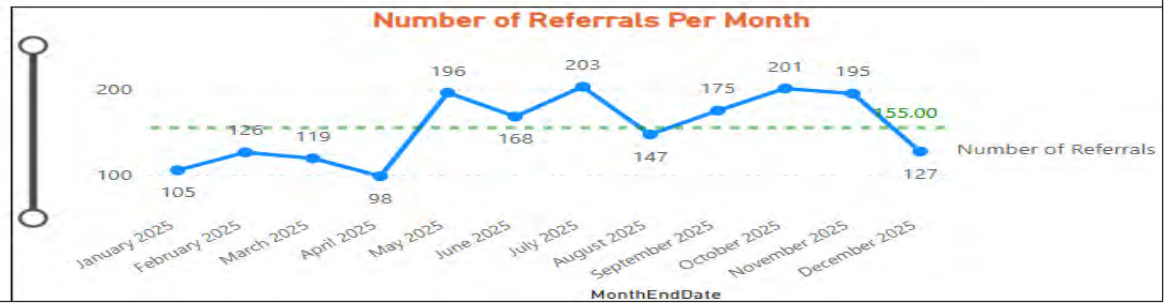
Child and Family Unit overview (2/2)

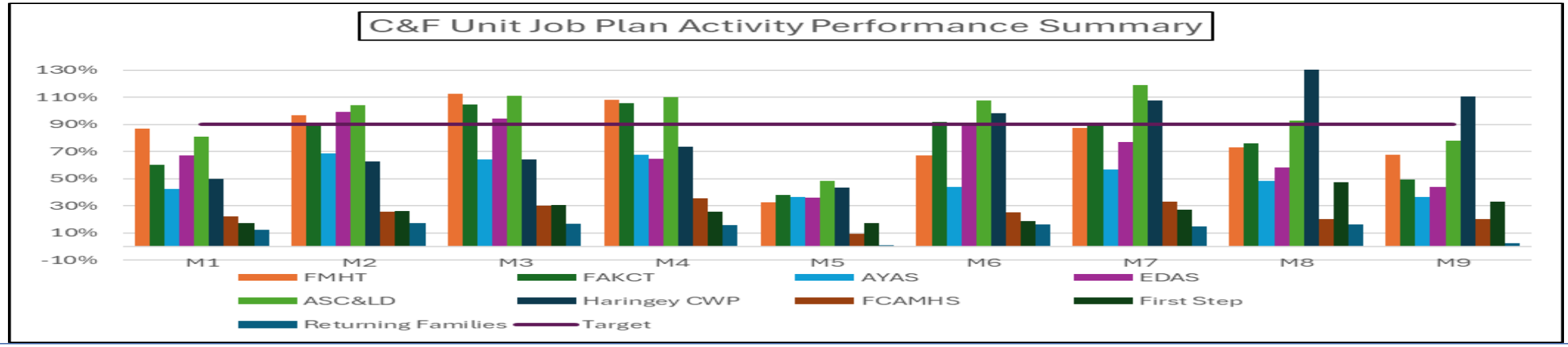
Activity Overview (Excluding FDAC Service, Gloucester House School, Gloucester House Outreach, CATS)











MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Board Assurance Framework and Corporate Risk Register			**Agenda No.: 009**
Report Author and Job Title:	Rhiannon Adey, Interim Deputy Company Secretary	**Lead Executive Director:**	Terry Willows, Acting Director of Corporate Governance
Appendices:	Appendix 1: Full Board Assurance Framework Q4 Appendix 2: Corporate Risk Register Mar-26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	The report provides overall BAF risks position for the trust.		
Background:	**BAF:** The Board Assurance Framework (BAF) remains critical in supporting the achievement of the Trust's strategic ambitions. Through continuous review and monitoring, it enables the identification and management of gaps in assurances and control, ensuring appropriate actions are in place to address them. By highlighting key strategic risks that could impact the delivery of the organisation's financial sustainability, digital resilience, commissioning arrangements, infrastructure, and performance delivery, the BAF plays an essential role in ensuring the Trust manages risk effectively and remains resilient over the long-term.		
Assessment:	**Board Assurance Framework** The Trust currently has **13 BAF risks,** a reduction of 1 since the last report. **Changes since the last report** Following review at the Performance, Finance and Resources Committee BAF Risk 9 Delivering financial sustainability targets has increased from a high 15 to a **high 20** and BAF Risk 11 Sustainable income streams has increased from a moderate 10 to a **high 20**. Following review at the People, Organisational Development, Equality, Diversity and Inclusion Committee BAF Risk 6 Lack of workforce development, retention and recruitment has been closed. BAF Risk 15 has been revised to ensure a merger focus, the new risk description is Lack of staff morale and resilience in the transition to the newly merged Trust. **Corporate Risk Register** The Trust currently has **15 CRR risks**, an increase of 2 since the last report. **Changes since the last report** There have been three new risks added since the last report. **Risk-175** Cisco releases critical security update for unified communications products **Risk-096** Risk of data theft through USB devices **Risk-178** There is a risk of malicious cyber attacks on the T&P telephony systems and network		

	Risk-180 Patients and clinicians report that GPs are often reluctant to prescribe medication, including hormones, and monitor bloods as part of their shared care arrangement. T&P have also received letter from GPs and ICBs refusing to prescribe. ICB formulary also has a role to play in red-flagging drugs. This is a national issue for GIC services and is a local issue in prescribing across T&P services. The matter has been escalated to NHSE for GIC services and has been discussed with NLFT Chief Pharmacist at workstream level There have been two risks removed from the CRR since the last report **Risk-003** Low staff take-up of flu vaccine annually has reduced in score and therefore no longer meets the threshold for inclusion on the CRR. **Risk-004** If complaints are not responded to within regulatory timescales then there could be increased negative experience by patients and negative attention, stakeholders, regulators and media has reduced in score and therefore no longer meets the threshold for inclusion on the CRR.
Key recommendation(s):	The Board is asked to **NOTE** and **AGREE** the Trust's Board Assurance Framework and Corporate Risk Register position, and to endorse the handover of these risks to the NLFT.

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 ☐			
	Performance and finance and Education and training BAF Risks have resource implications.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	BAF EDI risks have EDI implications.				

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 Audit and Governance Committee – 25 March 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

BOARD ASSURANCE FRAMEWORK – QUARTER 4 2025/26

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

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

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

Risk Ref	Risk Title	Risk Description (Cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Movement of the current risk rating within the Quarter 2025/26				Target Risk	Projected Target Risk Tracker for 2025/26 (Provisional)				Appetite Level
					Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4	
Providing outstanding care														
1	Inequality of access for patients	**If** services within the trust continue to limit access to potential patients through the use of restrictive inclusion criteria **Then** outcomes for such individuals would be sub-optimal and they would also have a worse experience than other patients. **Resulting in** the Trust being in breach of its contractual obligations, and potentially non-compliant with equalities legislation	16 (4 x 4)	12 (3 x 4)	⟷	⟷	↓	⟷	8 (2 x 4)	**16**	**16**	**16**	**12**	**Cautious**
2	Failure to provide consistent, high-quality care	**If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.	20 (4 x 5)	15 (3 x 5)	⟷	⟷	⟷	⟷	10 (2 x 5)	**15**	**15**	**15**	**10**	**Cautious**
To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.														
3	Risk of interruption of registration with the OfS	There is a risk that a change in the Trust's governance arrangements may result in a change to the Trust's registration with the OfS as a Higher Education provider.	20 (4 x 5)	12 (3 x 4)	⟷	⟷	↑	⟷	8 (2 x 4)	**12**	**12**	**8**	**8**	**Cautious**
16	Non-viability of DET in its current form	**If** an alternative funding or delivery model cannot be identified following the withdrawal of the National Training Contract **Then** the medium to long term viability of DET in its current form may not be sustainable **Resulting** in a teach-out arrangement, poor student experience, regulatory concerns including a potential reportable event to the OfS, and reputational damage	16 (4 x 4)	16 (4 x 4)		**New**	⟷	⟷	8 (2 x 4)		**16**	**12**	**8**	**Open**
Developing partnerships to improve population health and building on our reputation for innovation and research in this area														

5	Risk of non-delivery of a sustainable future for the Trust care, education and training offer via delivery of a medium-term financial plan and merger with the North London Foundation Trust	The Trust's sustainable future is closely tied to the successful execution of the Board agreed merger process. If the merger is not delivered within the agreed timescale (1st April 2026) there is a risk to financial viability of Trust from 2026-27 onwards.	20 (4 x 5)	15 (3 x 5)	⟷	⟷	⟷		10 (2 x 5)	**15**	**15**	**15**	**10**	**Open**
Developing a culture where everyone thrives with a focus on equality, inclusion, and diversity														
~~6~~	~~Lack of workforce development, retention, recruitment~~	~~If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for This risk is exacerbated by the impact of decommissioning of services; and the imminent merger by acquisition; with potential impact on stability in the workforce and staff morale~~	~~16 (4 x 4)~~	~~16 (4 x 4)~~	↑	⟷	⟷		~~6 (3 x 2)~~	~~**16**~~	~~**16**~~	~~**12**~~	~~**12**~~	~~**Open**~~
7	Lack of a fair and inclusive culture	If the Trust does not establish a fair and inclusive organisational culture, where all staff regardless of their background feel that they belong, and that there is an awareness of cultural difference, staff morale and engagement levels will be impacted, recruitment and retention will be affected, and the quality of patient care, service to students will be compromised.	20 (5 x 4)	12 (4 x 3)	⟷	⟷	⟷	⟷	9 (3 x 3)	**12**	**12**	**9**	**9**	**Open**
8	Lack of management capability and capacity	If people issues are not fairly and effectively managed, in line with the Trust's vision and values, including a focus on staff health and wellbeing and workforce planning, the resilience of the Trust's workforce will be affected, and this could have an adverse impact on the Trust's sustainability.	20 (4 x 5)	9 (3 x 3)	⟷	⟷	⟷	⟷	6 (2 x 3)	**9**	**9**	**6**	**6**	**Open**

15	~~Lack of Staff Engagement/ Staff Disengagement~~ Lack of staff morale and resilience in the transition to the newly merged Trust	~~If we do not address issues that matter to staff and do not have a clear plan to improve staff experience, staff will become disengaged. This will lead to decreased motivation, lower morale, and reduced commitment to the Trust's strategic ambitions and values. This could impact the quality of care/service delivery, hinder innovation, increase staff turnover, and negatively affect patient/service user experience and organisational performance.~~ If the Trust is unable to support its staff in the transition to the newly merged Trust, this will impact staff wellbeing and morale. This will lead to enhanced levels of turnover, sickness and future recruitment issues. It could also impact the quality of care/service delivery, negatively affect patient/service user experience, hinder innovation and organisational performance.	20 (5 x 4)	16 (4 x 4)				New!	12 (3 x 4)				**16**	**Open**
Improving value, productivity, financial and environmental sustainability.															
9	Delivering financial sustainability targets	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICS/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	20 (5 x 4)	~~15~~ ~~(3 x 5)~~ 20 (5 x 4)	⟺	↓	⟺	↑	~~8~~ ~~(2 x 4)~~ 10 (2 x 5)	**16**	**15**	**15**	~~**12**~~ **10**	**Open**
10	Maintaining an effective estate function	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	15 (5 x 3)	8 (2 x 4)	⟺	⟺	↓	⟺	8 (2 x 4)	**12**	**12**	**12**	**8**	**Open**
11	Sustainable income streams	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.	20 (4 x 5)	~~10~~ ~~(2 x 5)~~ 20 (4 x 5)	⟺	⟺	↓	↑	8 (2 x 4)	**15**	**15**	**15**	**10**	**Hungry**
12	IT infrastructure and cyber security	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	20 (5 x 4)	12 (3 x 4)	⟺	⟺	⟺	⟺	9 (3 x 3)	**12**	**12**	**12**	**12**	**Cautious**
13	Failure to achieve required levels of performance and productivity	If the Trust is unable to achieve contracted levels of performance and productivity Then - the Trust will be in breach of its contractual targets relating to activity, quality and delivery obligations to its commissioners and will not be able to deliver services to	16 (4 x 4)	12 (3 x 4)	⟺	⟺	↓	⟺	8 (2 x 4)	**16**	**16**	**16**	**12**	**Open**

		meet the needs of the population and to the standard of care that is required. **Resulting** in sanctions against the Trust, including loss of income due to decommissioning of contracts, loss of ERF, potential withdrawal of MHIS, and financial penalties, poor patient experience and patient outcomes, risks to patient's mental health, and reputational risk. Further compounded by policy shifts including growing emphasis on performance-related metrics over block funding and projected Commissioning funding gap.													
14	Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target	**If** the Trust does not reduce its demand on the environment, the impact will be felt on the provision of its existing and potential new services. **Then** it will be out of step with the NHS-wide goals around environmental sustainability and the Service's attempts to achieve a net-zero status **Resulting** in non-compliance with its statutory obligations, national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2032 and net zero carbon plus influenced by the NHS ambition to reach 80% by 2040). The potential impact of this outcome includes inefficient resource and energy use, increased operating costs, legal and regulatory repercussions, missed infrastructure innovation opportunities, reputational damage, and heightened adverse environmental impact.	16 (4 x 4)	12 (3 x 4)	⟷	⟷	⟷	⟷	8 (2 x 4)	**12**	**12**	**12**	**12**	**Open**

Principal Risk 1	**Inequality of access to mental health and gender care services to the population served by the Trust's contract**	**Strategic Objective**	**Providing outstanding care**
Description	**If** services within the trust are not accessible to the population it serves due to the protected characteristics of individuals **Then** outcomes for such individuals would be sub-optimal and they would have significant poor health outcomes and experience. **Resulting in** the Trust being in breach of its contractual obligations, and non-compliant with equalities legislation		

Executive Lead	Sheva Habel Interim Joint Chief Medical Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	07th March 2024
Lead Committee	Quality Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	March 2026
Risk Appetite	**Cautious**	4	4	**16**	3	4	**12**	2	4	**8**	⇔	⇔	⇓	⇔	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Screening and triage process: Ensures patients are directed to the appropriate pathway at the start of their journey, reducing delays and inappropriate referrals, which helps improve equity and timeliness of access. To ensure that individuals are not discharged This happens in all clinical cases. In some sections for protected characteristics which means they may likely be rejected.	Not implemented Trustwide noting complexity in implementation in GIC	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Designed/ reviewed screening and triage process. Quarterly audits built into Clinical Audit Plan to enable inequalities of access to be identified and acted upon In GIC it is integrated into the QI work	Internal	Amber
PCREF- all services have completed the PCREF self assessment. Developing local action plan to address the specific needs.	Time constraints and data quality. Multiple competing priorities	A3 quality improvement project reporting into PCRAF implementation group. Which will then be reported up to quality and safety committee.	Internal	Amber
PCREF - ESQ data - reviewing ESQ data to understand service user experience as related to ethnicity. This will occur on a 6 monthly basis.	The number of questionnaires can sometimes be quite low. The questions asked may be phrased in a way to reduce people expressing concerns. It is possible that certain groups of people are less likely to express dissatisfaction even if they have had a negative experience due to concerns around discrimination.	The ESQ data will be presented to the PCREF implementation group and in IQPR on a 6 monthly basis, with reporting up to the QSC.	Internal	Amber
PCREF - Patient safety incidences - Complaints, incidents, violence and aggression. This is presented on a quarterly basis into the IQPR and to the PCREF implementation group.	The radar data sometimes does not contain ethnicity data. It is possible that certain groups of people are less likely to complain even if they have had a negative experience due to concerns around discrimination.	The data is presented on a quarterly basis into the IQPR and to the PCREF implementation group.	Internal	Amber
PCREF - Assessing impact of treatment through paired outcome measures. This will be reported on a 6 monthly basis to PCREF implementation and IQPR.	The IM&T backing for this intervention is in development. At present we are not able to undertake this action.	Once the data has been provided we will report through unit Clinical Governance structures, IQPR and PCREF implementation group to QSC. However at present this has not occurred.	Internal	Red
Patient and Carer Race Equality Framework (PCREF) All services have been provided with local ethnicity data and their own referral data by ethnicity this is to ensure the referral data best reflects the local population.	Fully implemented but will be audited in 3 months to assess effect All services to review their inclusion criteria with EDI and people with lived experience to ensure equitable access. PCREF Action Plan being developed	PCREF Implementation group – IQPR report to Board - there is a monthly focus on individual team's actions to address access to services and other projects to ensure equity of access to treatment. Key PCREF aim for 2025/26 is to focus on Equitable access IQPR Report to QSC and POD EDI PCREF Implementation Group monitors implementation across the Trust and ensure correct data is reviewed and acted on EDI/ PCREF data will go to IQPR (starts in Sep 2025)	Internal	Amber

Clinical Harm Reviews: Allows for real-time risk stratification of patients on waiting lists, ensuring those most at risk receive timely intervention and care, thereby reducing harm and improving equity.	Inconsistent risk stratification across services (Autism, Gender and Trauma). All 3 services have full front door screening in place. Audits to ensure consistency.	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Autism, gender and trauma GIC targeted support meetings Mondays Trauma-Targeted support meetings Tuesdays	Internal	Amber
		Autism - Care of waiter protocol adopted by service	Internal	Green
		Gender - Clinical Harm Reviews are now embedded into the first CORE appointment process through IQPR	Internal	Green
	Clinical Harm Reviews to be socialised and implemented end of Q2.	Trauma - Still a gap but progress being made	Internal	Amber

Action to address the gap in assurance/control	Lead Officer	Date of implementation	Status
Mobilisation of the Clinical Harm Review	Chief Medical Officer	August 2025	Clinical harm reviews have been mobilised across key service areas like autism, gender, and trauma. The implementation is still progressing with some areas under additional targeted support, especially in trauma services.
Audit and Actions Arising from PCREF	Chief Medical Officer	September 2025	Progress: Ongoing Update: The first audit cycle is scheduled, with findings set to inform further actions. The impact assessment will focus on whether new processes effectively enhance patient access and outcomes. Findings from the audit will be reviewed by the QSC and incorporated into future risk mitigation plans.
Digitising both the RTT waits to ensure PTL is accurate and appropriate remedial action can be taken.	Project Manager & Associate director of IM&T	April 2025	Latest update pending Update: There is an ongoing project to digitise referral-to-treatment (RTT) waiting times, with a go-live expected end of April 2025. Ongoing data validation efforts will ensure that accurate PTL data drives service improvements.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Assessment & Treatment Data Alignment	Align description of assessment and treatment to the NHS Data Definition Dictionary.	Work has commenced with an initial review of current descriptors in progress.	Integration with the new waiting time metrics remains a challenge. Full alignment requires system-wide adoption.
Clinical Harm Review Implementation	Mobilisation of the Clinical Harm Review across affected services.	Implementation is progressing with Autism services (Green), Gender services (Green), and Trauma services (Amber).	Significant delays in trauma services.
Trust-wide PCREF Rollout	Full implementation of the PCREF framework across all services.	PCREF implementation has transitioned from Red to Amber. Impact monitoring in progress.	Measuring actual service impact to confirm improved access and outcomes.
PCREF Audit & Actions	Conduct audit and implement findings to improve patient access and equity.	First audit cycle scheduled, with results to inform next steps.	Ensuring audit recommendations are embedded into practice and lead to measurable improvements.

Associated Risks on the Board Risk Register		
Risk ID	**Description**	**Current risk score**
RSK-061	Delays in delivering clinic letters to patients or healthcare professionals.	15

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

Executive Lead	Clare Scott Chief Nurse Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	07 March 2024
Lead Committee	Quality & Safety Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	March 2026
Risk Appetite	**Cautious**	4	5	**20**	3	5	**15**	2	5	**10**	⟷	⟷	⟷	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Clinical staffing structures: Provides the foundation for safe, consistent care delivery by ensuring appropriate skill mix and adequate resourcing.	One team, GIC has long term vacancies in psychology workforce, resulting in waiting times in that pathway.	GIC reviewing workforce plan aligned to Levy report. Lowest turnover among other mental health trusts. Weekly review of recruitment plan in QI meeting Workforce vacancy levels and recruitment trends monitored via workforce dashboard. Oversight through Board, Committee, Clinical Governance meetings and Integrated Quality and Performance Review (IQPR) meetings. Recruitment & Retention Group established to oversee staffing strategies and reduce reliance on agency staff. Establishment Control Panel in place, with executive membership, ensuring workforce planning aligns with service needs. Clinical staffing structure review integrated into workforce planning, with six-monthly assessments. Clinical Structure Review AAR conducted with learning about the consultation process but no immediate changes to current structure.	Internal	Amber/Green
Job planning framework: including electronic system for monitoring medical job plans	Insufficient oversight of job planning processes, posing operational and financial risks. Monitoring clinical non-medical compliance in activity against job plans at team level.	Job plans in place for majority of teams. Electronic system for medical staff introduced with all medical on the system at end of May 2025.	Internal External	Amber

Supports effective alignment of clinical capacity with service demand, improving workforce productivity, reducing inefficiencies, and enhancing service continuity.		All clinical non-medical staff job plans are monitored by team leads and accountable to unit leads, presented in the IQPR monthly. Compliance for staff activity against job plans is place monitored through IQPR Annual Revalidation paper to Trust Board, submitted externally Bi-monthly workforce dashboard updates to the POD EDI The job planning policy in place		
The Quality and Safety Committee is in place with approved terms of reference. Tier 3 structure and associated Terms of Reference in place.		QSC received the annual plan for clinical audit, including NICE compliance Interim CMO in post and annual report presented to QSC and approved. MRG ToR reviewed and combined with CISG ToR Regular quality reporting to QSC via IQPR, Quality & Safety Report and Chair's reports from Tier 3 Groups	Internal	Green
Statutory and Mandatory training	Inconsistent levels of completion of key modules Detailed breakdown of Quality & Safety focussed MaST modules (safeguarding – children and adult modules, Basic Life Support) A3 for MaST to be developed, led by Head of OD	Mandatory training compliance reported through the POD EDI Committee bi-monthly MaST paper for 24/25 currently under approval by ELT - approved MaST compliance to be included in IQPR – Included and reviewed monthly in IQPR Safeguarding, IPC and BLS compliance monitored weekly through Exec Safety Huddle Learning and development team cleansing data and working on ESR and aligning to skills matric	Internal	Amber
Clinical supervision policy and reporting mechanisms: Provides ongoing professional development and oversight, reinforcing clinical quality, accountability	Policy under review by professional leads Team and clinical leads to focus on accurate reporting	Clinical supervision –reported in IQPR and to Clinical Governance monthly. Supervision structures are held at team level, underpinned by Supervision Policy. Teams report supervision in a monthly log. Forms for recording on EPR (carenotes) created, to improve monitoring and reporting. Clinical Supervision Survey sent out to understand barriers to recording	Internal Internal Internal Internal Internal	Amber
Safeguarding supervision and audit structures: Supports consistent application of safeguarding practices and early identification of patient risks across all services.	Recording of safeguarding supervision in children's services. Compliance levels below benchmark of 80%	Cohort of staff in the two children's units trained to facilitate safeguarding supervision. Internal audit action plan closed with all evidence received by auditors. Audit being carried out for children safeguarding supervision training – post training compliance Reviewed through ISG, ICB designated nurses in attendance. Safeguarding supervision structure in place	Internal External	Amber
Quality assurance and quality improvement tools and methodology		Quality Improvement Trust wide work streams to deliver the Trust Strategic Pillar of 'Outstanding Patient Care' to address issues raised in both BAF risks 1 and 2. Focus on service user experience, outcome measures and waiting times. Weekly SDR in place to evaluate progress against A3 programmes Quality Assurance audits carried out by Quality team, shared with team and unit leads monthly for review in Clinical Governance meetings. QSC work plan and forward planner IQPR Quality & Safety Report to QSC bi-monthly and Trust Board 3 times a year. Chair's reports from Tier 3 Groups to QSC Clinical Governance meetings – unit level, monthly A3 projects in place for key quality assurance programmes of work QI workstream for GIC national work with NHSE	Internal	Amber
Quality Framework Improvement Plan fully implemented		Quality Framework monitoring report to QSC	Internal	Green

		All professional leads now in place Chief Nurse Officer and Chief Medical Officer In post Tier 3 structure and associated Terms of Reference in place. Chair's reports from Tier 3 Groups to QSC		
Learning from deaths policy and mortality reviews: Improves identification of care quality issues, embeds learning, and ensures accountability	Mortality as part of clinical audit programme 25/26 Learning Lessons events calendar	Learning from Healthcare Deaths Policy ratified in December 2024 Mortality Group responsibilities into Clinical Incident & Safety Group quarterly (previously stand alone group) Electronic Mortality Review form now live Radar Mortality Reviews reviewed by Clinical Incident & Safety Group; learning shared through Clinical Governance meetings Learning from death paper received six-monthly	Internal	Amber
Clinical Audit Schedule		Clinical Audit & Effectiveness Group established; Tier 3 Group of QSC Electronic recording and reporting module live on Radar Regular audit plan to be developed by Deputy Chief Medical Officer and built into Radar too Clinical audit plan approved in QSC	Internal	Amber
Complaints Process Complaint's process and structured learning: Improves patient experience, fosters transparency, and enables learning from incidents and service feedback.	Timeliness of response Staff training sessions scheduled for June and July 2025	-Quality & Safety Report to QSC includes thematic review and update on actions -Regular reporting/updates through to SUEG and Clinical Governance meetings -Report to QSC on response rates against target -New complaints process implemented in January 2024. - Structured investigation template introduced to ensure clear and transparent responses. - Executive review & sign-off for all formal complaint responses now in place. - Enhanced tracking & oversight: - Daily complaints huddle - Weekly complaints summary shared with unit leads, divisional leadership, and executive team. - Weekly meetings between complaints lead & unit clinical lead to monitor progress. Complaints Quality Improvement A3 project started in January 2024 Learning poster circulated through Clinical Governance Meetings and Tier 3 meetings Staff training sessions held in June and July 2025 Lessons learnt process from complaints in place Focus is on achieving 90% compliance with responses. Responding through early resolution and ownership in units of complaints responses and learning.	Internal	Amber
Implementation of RADAR Radar incident reporting system: Enables robust reporting and monitoring of safety incidents, risks, complaints, and claims, ensuring a learning culture.		Radar went live in June 2024 LRMS Radar Implementation moved to Business as Usual Incident notification process fully embedded in governance from 03 February 2025, with leadership team receiving regular updates on incident notifications and reporting processes.	Internal	Green
Implementation of PSIRF Implementation of PSIRF and Patient Safety initiatives: Drives structured learning and improvement from incidents through After-Action Reviews and safety partner involvement.	Data and metrics to articulate progress in implementation is being developed as part of A3 process Self-assessment of PSIRF roles and responsibilities framework to take place by the end of Q1 25/26	PSIRF Transition Group in place and reporting to QSC A3 on PSIRF implementation, supported by GANTT chart Work plan for Patient Safety Partners Work plan for Patient Safety Specialist(s) Updated PSIRP approved by QSC in June 2024. Patient Safety Policy approved and ratified August 2024. After Action Review (AAR) training delivered in September 2024. AARs and learning from incidents shared in clinical governance meetings and Quality and Safety report to Quality and Safety Committee Year 1 review of PSIRF and Radar, paper to QSC in August 2025 and Trust Board in September 2025	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Conduct annual job plan reviews across all clinical services to ensure alignment with workforce needs.	Clinical Leads	Ongoing	Part of the annual plan for each unit

Implement structured monitoring of Clinical Supervision policy and compliance tracking.	Director of Clinical Service	April 2025	Survey happened with ongoing monitoring and supervision structure in place
Improve Complaints Process Implement escalation process where delays occur	Interim Complaints Manager/ Associate Director Quality	August 2025 January 2026	In Progress – QI project in place

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Implementation of the Quality Improvement Plan based on 11 defined areas of improvement.	Quality Framework Improvement Plan fully implemented.	Ensuring ongoing compliance and embedding of improvements in service delivery.	Quality Framework Monitoring Report to QSC.
Trustwide Quality Improvement Work Streams aligned to the Outstanding Patient Care strategic pillar.	Workstreams established focusing on service user experience, clinical outcomes, and waiting times.	Embedding initiatives across all service areas and ensuring measurable impact.	Strategic Delivery Room, Clinical Governance Meetings, Quality & Safety Report to QSC.
A3 projects in place for key quality assurance programs.	A3 methodology being applied for structured quality assurance.	Ensuring sustainability and integration into governance structures.	Clinical Governance Meetings, QSC reporting.
Consultant Job Planning Review to standardize planning processes and improve service alignment.	Job planning policy in place. Standardized framework under development.	Gaps in oversight and inconsistent implementation across services.	Monthly Workforce Dashboard updates to QSC, Annual Job Plan Reviews.
Strengthened complaints handling and learning from incidents.	New complaints process implemented (January 2024), structured investigation template introduced.	Ensuring continued improvement in timeliness of response and learning from complaints.	Quality & Safety Report to QSC, Complaints Improvement A3 Project.
Implementation of safeguarding supervision training and governance structures.	Safeguarding supervision training for 16 champions approved and in procurement.	Training completion and embedding of reporting structures in EPR (Carenotes).	Integrated Safeguarding Group, IQPR Reporting.
Radar incident notification process fully embedded into governance.	New process implemented as of 3rd February 2025, transition to BAU in progress.	Ensuring compliance with new reporting structure and ongoing staff training.	Radar project manager oversight, Leadership Team incident reporting updates.
Implementation of the Quality Improvement Plan based on 11 defined areas of improvement.	Quality Framework Improvement Plan fully implemented.	Ensuring ongoing compliance and embedding of improvements in service delivery.	Quality Framework Monitoring Report to QSC.

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

Principal Risk 3	Risk of interruption of registration with the Office for Students (OfS)	**Strategic Objective**	**To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.**
Description	There is a risk that a change in the Trust's governance arrangements through a merger may result in a change to the Trust's registration with the OfS as a Higher Education provider. This registration is reputationally very important to the Trust's Higher Education offering.		

Executive Lead	Chief Education & Training Officer/	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	31st January 2023
Lead Committee	Education Training Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	March 2026
Risk Appetite	**Cautious**	4	5	**20**	3	4	**12**	2	4	**8**	⟷	↓	↑	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
NLFT are currently engaged in discussions with the OfS with support from Trust DET about a shift of registration from Tavistock and Portman to NLFT	OfS are currently working through a backlog of applications, therefore the window for approval of the transfer is limited and delays could introduce a risk of non-registration by the merger date (April 2026). Non-registration of the new Trust by April 2026 would have a knock-on effect on NLFT's application for UKVI student sponsor license at Day 1	Regular meetings between OfS and validating partner to ensure protection of the student experience. ~~Written confirmation received from the OfS confirming that TPFT registration can transfer to a merger partner with only minor technical changes on partner's behalf. Changes are in hand.~~ ~~There is a plan for NLFT's team to provide all relevant assurance documents for Conditions C1, C3, D, E1 and E2 to OfS in a timely fashion by mid-Jan 2026.~~ All assurance documentation provided to OfS by 15/02/26. Decision expected late March 2026. Discussions underway with the University of Essex as a potential space for savings provision, extending the time available to NLFT to secure UKVI license if OfS delays	External	Amber
Appropriate DET staffing and infrastructure in place to support OfS compliance this ensures there are no regulatory concerns from the OfS relating to returns	Resignation of Academic Registrar, Jan 2026	Regular meeting with validating partner around OfS returns Quarterly monitoring of HESA returns	Internal	Amber
Systems Infrastructure (data quality) adequate to support OfS compliance	Need for systems to support not hinder data returns to partners, OfS and HESA. Limited confidence in certain control measures among staff members. External consultants have made recommendations about the changes to functionality to our SITS implementation. These need to be put in place by the Trust.	Capital Investment for SITS/HEFS system is agreed for FY 25/26.	Internal	Green
Board level awareness of Higher Education Regulation - OfS registration requires governing body knowledge of Higher Education procedures.	Both TPFT and NLFT must have Board-level awareness of HE processes and regulation.	TPFT Board and the Merger Programme Board have been given specific briefings by DET Staff on both the broader landscape and particular risks.	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Continue to engage with the OfS about a potential change of registration.	Chief Education and Training Officer	April 2026	Jan 2026: Provision of all relevant materials to OfS by deadline currently on track July 2025: Written confirmation from OfS that registration can be transferred post-merger

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

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

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

Executive Lead	Chief Executive Officer/ Director of Strategy and Business Development	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	8th March 2024
Lead Committee	Board of Directors	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	September 2025
Risk Appetite	**Open**	4	5	**20**	3	5	**15**	2	5	**10**	⟷	⟷	⟷		**Date of Next Review**	November 2025

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

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

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

Strategic Delivery Metrics

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

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 2023
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	December 2025
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	⟷	⟷	⟷	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
Merger Engagement sessions hosted by CEO		Records of sessions held	Internal	Green
Staff Engagement Group meets monthly is a mechanism to talk to staff about improvement (e.g. awards ceremony values work)		Key issues fed back to POD EDI Committee through the Associate Director of EDI Improvements in health and wellbeing indicators reported	Internal	Green
Occupational Health and employee assistance programme		OH, and EAP provision aligned with ICS – We have decided not to align to ICS due to potential merger and moving out to another ICS	Internal	Green
Staff Networks feed to EDI team who escalate key outcomes through POD EDI	Facilitate understanding of roles and responsibilities including alignment with governance structures/arrangements	EDI reporting through the POD EDI includes key outcomes/concerns from network forum meetings. Informal resolutions form majority of outcomes Just and learning culture approach to issues Introduction of revised resolution policy to follow: 30-day consultation about to launch. To include staff networks.	Internal	Amber
Recruitment and Selection Policy in place	Policy and process to be revised ensure equity for BAME candidates for senior roles (band 8 and above) and candidates with protected characteristics Improved process around recruitment and treatment of disabled candidates.	Inclusive recruitment training delivered and practices in place Internal reporting of issues (incl FTSU) to be more reflective of staff survey reporting ECP and CPD processes – Now in place Just and learning culture approaches included in all revised policies Armed forces covenant, disability confident status, and other inclusive statements, implemented competently. Launched new menopause policy. We have menopause awareness status Structures are now in place to ensure all internal promotions are scrutinised by the Recruitment & Retention Group quarterly.	Internal	Amber
EDI Policy in place		Policy approved by the Policy Assurance Group December 2025	Internal	Green

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Chief Nursing Officer sponsoring EDI programme and providing link with the Board		EDI-focused Board development sessions held. Challenge from Chair to hold at least one such item on each development day.	Internal	Green
Organisational Development in place – 1st level complete	Mini evaluation to take place following 1st level completion and internal review by CEO/CPO on next steps	OD for senior leadership to ensure accountability for decisions and consistency of approach. Commenced 15th October	External	Green
Inclusivity action plan and metrics	Priorities refreshed- metrics agreed and being embedded	EDI Programme Board	Internal	Amber
Staff survey and pulse survey including WRES and WDES help ascertain if our EDI programme is effective and give staff an opportunity to feedback	Only yearly and quarterly surveys don't always give the right feedback in between surveys Delays in developing action plans to address staff surveys	• Staff Survey Action Plans are reviewed at Board and Board Committee level • WRES and WDES reporting to EDI Programme Board; POD EDI and Board • They are in the public domain which ensures accountability	Internal External	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Inclusivity action plan refreshed. Full GANTT chart reviewed regularly at EDI programme board and overall EDI issues reviewed at Board via WRES, WDES, FTSU, Staff Survey etc. Specific item at Senior Leadership Forum on accountability and cascade of information.	CEO/Execs/ Associate Director of EDI	March 2026	Action plan streamlined and progress being regularly presented at the EDI Programme Board Three key deliverable outcomes have been identified as key to achieving culture change in the Trust. These are monitored via the EDI Programme Board: i. Eradicate Bullying, Harassment and Abuse ii. Inclusive Recruitment & Equal Opportunities for Career Progression or Promotion iii. Formal Disciplinary and Capability Processes EDI metrics have been finalised with regular updates to the EDI Programme Board. With escalations via the Chair's assurance report to POD EDI. The EDI priorities and metrics have been introduced to the Senior Leadership Forum at the July meeting and now being cascaded to teams. Localised EDI data shared with teams and as such the teams are identifying countermeasures via the A3 methodology.
Engagement sessions run with MENTI – checking staff opinion on improvements made and what support is needed for the merger. Aiming to reduce the gap between what people say in person versus staff survey	Chief People Officer	October 2025	This is planned
Facilitate understanding of roles and responsibilities including alignment with governance structures/ arrangements	Chief People Officer/ Chief Nursing Officer/ Interim Director of Corporate Governance	October 2025	

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Revised, refreshed Inclusivity action plan to be created and presented to POD EDI Committee	Action plan streamlined and progress being regularly presented at the POD EDI Programme Board which feeds into POD EDI Committee	EDI review is currently underway and will seek to further improve governance and processes	New Inclusivity action plan communicated, and progress updates received Rolled out with staff survey action plan. In progress
Reasonable adjustments process implemented	This has commenced, with funding secured from finance and reasonable adjustments are being signed off	Reasonable adjustments policy: ratified August 2024. Relaunch of process and policy.	EDI programme Board reporting. Continued use of reasonable

			adjustments process and staff reporting RA in place in staff survey
Employee relations policies being refreshed with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	CPO has feedback on first round of policy drafts viewed, and these are being amended. Support employee wellbeing policy training is in place and policy being published.	Managers need to attend the training	New policies and training (once complete) Training in progress delivered HR Business partner.

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

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th January 2024
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	August 2025
Risk Appetite	**Open**	4	5	**20**	3	3	**9**	2	3	**6**	⟷	⟷	⟷	⟷	**Date of Next Review**	February 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Full suite of Trust HR policies in place	These policies are currently due for review, and some require a refresh	Sickness, Grievance, disciplinary levels reported to the POD EDI through the Chief People Officer report. Bi-monthly Planned - Just and learning culture approaches included in all revised policies	Internal	Amber
Management structure in place with revised job descriptions clarifying line management responsibilities	Manager leadership training required	Leadership and management training in place with positive feedback Back to basics training provided for all policies	Internal	Green
Management Training in place		Senior Management Leadership Development Programme Feedback from 8B and above	Internal	Green
Manager ESR in place this ensures managers are empowered to take greater ownership of the appraisal process	Resolve issues on Manager ESR around disconnect between appraiser and uploader in clinical teams	Training records Training delivered jointly by the ESR Manager and the L&D team A step-by-step guide is available on the intranet L&D team provides managers with monthly reports detailing appraisal data for their teams	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of People (OD, Culture and Engagement	Ongoing	Final cohort of the MLDP (Management Leadership Development Programme) – meeting to identify learning from this and next steps is planned. Learning and development training (x2) and back-to-basics training in place FTSU training is being designed, and FTSU is to be added to the induction Coaching of managers by HRBP (and senior team where required). Manager's report feeling more competent in resolving issues because of the training packages/coaching from HRBPs Informal resolutions form the majority of outcomes. Appropriate attendance levels at training sessions recorded
All HR Policies to be reviewed over next 12 months (priority to be given to Recruitment & Selection, disciplinary, capability, grievance, and flexible working policies) with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	Head of People (Business Partnering and Employee Relations)	Ongoing	The plan is to adopt the merger partner policies where they are not contractual. The contractual policies are capability and sickness only. All other policies need to be rebadged. Ongoing, In line with timetable currently on target to meet implementation date. These policies will help with the foundations for psychological safety.
Organisational Development for senior leadership to ensure accountability for decisions and consistency of approach.	Chief People Officer	June 2025	This is now complete. Next steps of Kaleidoscope to be discussed at ELT. Externally provided. Commenced 15th October It will help with the foundations for psychological safety.

Manager leadership training and development	Head of People (OD, Culture and Engagement)	November 2025	Supporting Performance Improvement training is being delivered to managers to reinforce the importance of appraisals
Manager ESR roll out for appraisal, ensuring resolution of issues around disconnect between appraiser and uploader (clinical teams)	Head of People (OD, Culture and Engagement)	October 2025	An issue has been identified on ESR where staff report to their operational team manager, who may not be the individuals line manager who is conducting the appraisal. This needs to be addressed.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
New suite of policies	As above		
Three training programmes	Learning and development training (x2) and back to basics training in place		
KPIs and associated dashboard	People relations KPIs consulted on with managers and SEG and implemented		SEG report feeling confident in new approaches. POD EDI comm receives updates on employee R case data PFRC receives updates on WTE and vacancies and through the A3 process report on all metrics relating to staff engagement.

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

Executive Lead	Jon Bell Interim Chief Financial Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19 December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	February 2026
Risk Appetite	**Open**	5	4	**20**	~~3~~ 4	5	~~15~~ 20	2	5	**10**	⇔	⇩	⇔	⇧	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
MTFP route to balance developed in conjunction with merger partner. Process re-started March 2025.	Requires updating to reflect the status of the proposed merger	MTFP will form part of the OSC and FBC in the merger transaction process, with NLFT NLFT have engaged external support to prepare the MTFP in partnership with the Trust.	Internal External	Amber
Monthly Finance Reports – Keeping track of actual against plan		Reviewed by ELT, PFRC and Board. BAU Report	Internal	Green
In Year Reforecasts		BAU process in place from Q1 2025/26	Internal	Green
2025/26 Annual Plan – breakeven plan submitted to NHSE		Balanced plan agreed with NCL requiring 3.9 million efficiency programme and an asset sale..	External	Green
Recurrent efficiency programme 25/26 Financial Plan (including asset sale)	Resources working on the CIP as part of other commitments.	Progress reporting to ELT/ Efficiency Programme Board; with scheme SROs reporting on a regular cycle. Onward assurance provided to PFRC and Board bi-monthly. As part of Due Diligence, the Trust's approach is being assessed by the Merger partner.	Internal	Amber

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

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Develop a medium-term financial plan that supports the Trust's strategy & which aligns with ICS plans.	Implementation date changed from May 2025 to September 2025 – updates will reflect outcome of planning round. NLFT have engaged external support to prepare the MTFP in partnership with the Trust.	Finalising efficiency programme and identifying income opportunities to deliver balanced MTFP in line with merger partner.	Jointly agreed MTFP with merger partner that forms part of an agreed FBC.
Deliver the 2025/26 Out-Turn within Plan, supported by a recurrent efficiency programme	Maintain Trust on plan trajectory throughout 25/26	In year financial management of the organisation	Monthly reported position – ELT, PFRC and the Board

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

Executive Lead	Jon Bell Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	February 2026
Risk Appetite	**Open**	5	3	**15**	2	4	**8**	2	4	**8**	⟷	⟷	↓	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (What are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
The two national submissions are an external measure of performance against peers. Premises Assurance Model (PAM) / Estates return information collection (ERIC)	PAM – aligns to 5 CQC domains; an assessment was completed in Feb, and work was carried out over a number of months with a submission made in Sept.	The ERIC return is an annual submission that compares costs and consumption across its peers in building maintenance, rates, utilities, waste, cleaning. In addition the annual PAM review is undertaken each year (autumn) to review systems and processes. The ERIC return is a historic view of performance, PAM also considers a costed action plan to bring a building back up to condition.	External	Green
10-year Capital plan has been shared with ICB. A 6 facet survey National guidance suggests 5 yearly where external surveyors undertake a data gathering exercise, age of assets and if any asset replacement has taken place.	The 6 facet survey is a moment in time and is non invasive	As this is a 5 yearly assessment that is non-invasive and is undertaken by surveyors. Additional technical advice forms part of the authorising engineer role. The Authorising engineers cover water, asbestos, electrical and lifts as there are no medical gases on these sites. This includes failure rates, consumption and risk assessments for the building structure	Internal/External	Amber
		Fortnightly meetings with finance to review cost and coding to minimise time taken to complete annual ERIC return, thereby improving productivity	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
A 6 facet survey has been completed and report published in October 2025	Estates lead	Survey Report delivered in October 2025	Based on the survey findings the key recommendations are below- • The development of the 26-27 capital plan • To focus attention on higher risk items for the coming year (this survey will be shared with NLFT) • Prioritise any Statutory Compliance and Physical Condition investments within Year 1–2 of the programme. • To develop a rolling five-year investment plan balancing backlog reduction with operational resilience. • To develop a 10 year capital plan

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Premises Assurance Model assessment- a gap analysis, and timeline	Policies for Water, asbestos, Fire, Waste and Health and Safety have been updated with technical advice.	There are current no further building related technical policies under review	A cleaning charter has been developed to tie in with IG, clear desk policy and waste streams
CAFM (computer aided facilities management system), is used on all sites	All reactive faults will be issued with a fault number and response to acknowledge action.	Updated drawings have been developed for electrical and water this will be structured under clear control measures.	Fire and electrical are complete. Water drawings will be updated on completion of the project in October.

Develop a soft FM and Hard FM strategy	The fragmented contracts have been consolidated and this is now being assessed for any CIP efficiencies without compromising service levels for both soft FM and for Hard FM. In addition, contract end dates conclude within 25-26 to enable a smooth integration with NLFT	All processes are being reviewed to ensure NHS national standards are maintained.	All contracts have been consolidated in 2025, and are being tracked against contract terms, contract meetings are held regularly.
Asset performance and detailed 6-facet survey	The commencement of a non-invasive 6 facet survey has commenced, this will conclude in July 25, to take account of the upgrades since the last survey that took place in 2021, and will include capital investment on - fire doors and compartmentation has occurred in 22-24. - Electrical – main infrastructure upgrades took place in 22-23 - Lift assessments – have taken place with capital investment in 2025Water and gas – capital investment over 2 years commencing in 24-25 - Surveys have been carried out on some assets- electrical supply, lighting and fire doors and will look at fire alarms (26-27), heating systems (26-27).	Since 2024, there has been limited system drawings and asset data, the information is continually being updated as each asset group is being assessed and upgraded, primarily the focus has been mechanical and electrical assets and will then move to fabric, an aging that is slowing being invested in over a number of years as backlog as infrastructure upgrades have been prioritised	For hard FM - The authorising engineer acts as the assurer by scrutinising the planned maintenance tasks against the HTM For soft FM this is either against NHS national standards or any feedback from services.

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

Executive Lead	Rod Booth Director of Strategy and Business Development Jon Bell Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	19th Decemb 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	February 20
Risk Appetite	**Hungry**	4	5	**20**	~~2~~ 4	5	~~10~~ 20	2	4	**8**	⟷	⟷	↓	↑	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Internal Monitoring Reporting on current clinical services to ensure meeting current contractual objectives	Agreed activity plans for some services	(1) IQPR Report WITH activity performance against local and national standards (2) Contractual risk report now in place (3) New process for finance and contracts income reconciliation in place	Internal	Green
Internal Monitoring Reporting on current DET services		DET Exec Review, Education & Training Committee Oversight, PFRC Oversight	Internal	Green
External (Commissioner) Reporting on commissioned services in DET and Clinical		Clinical Leadership Meeting Review, DET Exec Review, PFRC Oversight, Commissioner Review Meetings	Internal / External	Green
Alignment of internal services reporting with financial controls		External Financial Audit (annual)	External	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Review of the income monitoring arrangements and monthly reconciliation process between the contracting and finance teams.	CFO/DSBD	July 2025	In place
Address service specifications with commissioners during contracting round	Commercial Director	April 2025	Block contracts agreed for 25/26 October 2024 to April 2025 – work continues with commissioners, to update pathways and service specifications.
Development of Internal Reporting for DET Services – ensuring consistency with IQPR process.	Director of Education (Operations)	April 2025	Enhanced DET performance reporting in place via IQPR report

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

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

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Movement of the current risk rating within the Quarter					
Executive Lead	Jon Bell Interim Chief Finance Officer														**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	February 2026
Risk Appetite	**Cautious**	5	4	**20**	3	4	**12**	3	3	**9**	⟷	⟷	⟷	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Implementation of security software on all endpoints	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Implementation of security software on all servers	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Successful completion of IG Toolkit annually	Full compliance with mandatory IG training	NHS DSPT toolkit annual submission. External validation of submission IT has also created a new cyber information video which will assist staff in recognising threats and communication to all staff has been sent.	External	Amber
Compliance with industry standard Cyber Security Accreditations	None presently. However, each year adds additional controls.	External validation with an independent Cyber Essentials agency officially accredited from 15/08/25 An NCL CIO-led Cyber group has been created to combine skills and resources to better tackle potential cyber threats and share rare skills in this area.	External	Green
Implementation of email security infrastructure	None	Secure data tools on email send and receive at a trust level e.g Mimecast. Additional individual email security management via Egress email security software.	Internal/External	Green
Subscription to NHSX cyber threat service	None	NHS issues threat warnings and remedial actions with timescales. These are called CareCerts and we comply with the actions required in the timescales advised where appropriate.	Internal/External	Green
Business continuity plans for all relevant trust areas	Continuous assessment of suitability and regular BCP scenario testing.	Resilience group now responsible for BC plans including testing and After-Action Reviews (AAR) from incidents involving BC planning. Regular BCP scenario testing with feedback loops for continuous improvement approach. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested Lessons learned for the Cyber outage of CareNotes have now been created and relevant functions are implementing the findings BCPs have recently been updated and the CareNotes Mini system now included in BCP	Internal	Amber
		NHSE Emergency Planning Response and Recovery Team and ICB EPRR team	External control	Amber
		Major Incident Plan Business Continuity Policy Emergency Planning Response and Recovery Policy All reviewed annually	Internal	Green

		Established Resilience group in June 2024 The Resilience Group is responsible for the Tactical oversight of the Trust's Emergency Preparedness, Resilience and Response (EPRR), and all related plans associated with Business Continuity All staff trained in tactical response to a major incident Review and Approval of all service specific BCP plans	Internal	Amber
Third party system supply cyber assurance	No formal process to ensure suppliers are operating critical systems on the trust's behalf to acknowledged and agree cyber standards.	Regular (suggested annual) update from system suppliers to a structured questionnaire requiring assurances on compliance with evidence. Would be appropriate to engage a 3rd party assessment service Suppliers are now requested to provide basic information on their cyber security status as part of our DSPT cycle	External	Green

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

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

Principal Risk 13	**Failure to achieve the required levels of performance and productivity**		
Description	**If** the Trust is unable to achieve contracted levels of performance and productivity **Then** - the Trust will be in breach of its contractual targets relating to activity, quality and delivery obligations to its commissioners and will not be able to deliver services to meet the needs of the population and to the standard of care that is required. **Resulting** in sanctions against the Trust, including loss of income due to decommissioning of contracts, loss of ERF, potential withdrawal of MHIS, and financial penalties, poor patient experience and patient outcomes, risks to patient's mental health, and reputational risk. Further compounded by policy shifts including growing emphasis on performance-related metrics over block funding and projected Commissioning funding gap.	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability**

Executive Lead	Clare Scott Chief Nursing Officer & Rod Booth Director of Strategy	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	20th June 2024
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	March 2026
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⟷	⟷	↓	⟷	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	**Gaps in Control and Assurance (what are we missing)**	**Sources of Assurance (2nd and 3rd lines of defence)**	**Type of Assurance (Internal / External)**	**Assurance Rating (RAG)**
Improved use of clinical data to prospectively *inform controls*. Enhanced oversight through targeted support and quality improvement work focusing on waiting list and patient experience, activity, productivity and risk monitoring across key services (including Adult Trauma, GIC and Autism Assessment). Review of internal waiting lists for CAMHS (North and South Camden)	A clear understanding of the capacity to reduce waiting times and meet the increasing demand for some services. Demand for GIC outstrips resource to achieve 18 week target. Trauma- number of 104 weeks wait 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.	The new three-year strategy ambitions to reduce waiting times to 18 weeks across all services. Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board. Trauma remains as a targeted support GIC part of national QI collaborative led by NHSE with the aims to: • Implement recommendations from Levy report • Improve patient experience and waiting times • Reduce clinical risk • Support improvement in productivity • Create a standardised system approach in variation to delivery and reporting • Develop network capability • Liaison with NCL leads to standardise improvement rates – **Continuing liaison with NCL CYPMH Provider Collaborative and NHSE – IMT calculating CGAS improvement dashboard** • Embed OM into care plans, templates and appointment SOPs – **Pilot underway for CGAS in Q3** • Establish mandated OM agenda item + Standard Work in MDT and supervision – **SCL attending QI meetings on regular basis** • OM-informed care planning in one service – **Camden Wellbeing Team piloting Q3**	Internal External	Amber

Trustwide Integrated Quality and Performance Review (IQPR) meetings for each clinical unit and DET.	Some data flow is manual, so there are possible errors. Additional work is required to build forms and ensure data is automated wherever possible.	The Board and Performance, Finance and Resources Sub-Committee consider IQPR report. The Quality and Safety Committee receives IQPR with a focus on the quality metrics in relation to performance	Internal	Green
Job planning to properly understand and manage the capacity of each team to meet the demand for services.	Key systems' reporting structures (Oracle, CareNotes, ESR) are out of date. System upgrades or process improvements are needed to ensure job planning reflects real-time workforce and patient demand data.	Workforce and Finance Platform Update: The workforce and finance platforms have been reviewed and aligned with the new structures. Additional data reconciliation is required to ensure accuracy. This process is conducted through monthly finance, people, and clinical services meetings. The estimated completion date is October 31, 2024. All areas relating to monitoring of and compliance with job planning are outlined in BAF principal risk 2	Internal	Amber
Targeted support – both GIC and Trauma have been placed under targeted support following Kaizen events where the progress was slower at meeting identified targets set during the event, outlined below. All areas are incorporated to targeted support. Kaizen Event for Trauma Overview 21 October 24: The focus of Kaizen Week for Trauma will be to review current clinical pathways aligned to best practice and commissioned service specifications, mobilise clinical job plans, and co-create a delivery plan with the team. The event also aims to deliver a culture piece. This plan will include 30-, 60-, and 90-day review periods to ensure that efforts are targeted and impactful.	The service profile pack, including performance data, benchmarked data, and pathways, is still under development. Clear trajectories are still under development	GIC has moved from Targeted Support to QI work under the national collaborative led by NHSE. Progress is reviewed in weekly GIC QI meetings. Reporting to ELT monthly and Quality and Safety Committee. Once agreed and mature, the delivery plan will be shared and monitored at the following fora: PFRC Quality & Safety Committee IQPR – Monthly Trust Waiting Times Huddle – weekly Adult Services PTL Meeting – weekly Targeted support – weekly for GIC and Trauma	Internal	Amber
National Review of Gender Identity Clinics (GICs): NHSE is leading the National Review of Gender Identity Clinics (GICs) initiative, which evaluates current service delivery approaches across all adult gender services with the aim of revising the National Service Specification. This review will provide valuable insights into our current service delivery model, complementing our existing delivery plan and risk controls.		The Clinical Services - SOPs, training plans, and job plans. (see first assurance under this risk for detail) National GIC review report published in Dec 25 Oversight will sit with the following fora: • Quality Committee/PFRC – monthly • IQPR – monthly • Clinical Governance – Monthly • GIC Targeted Support Group - Weekly • GIC Leadership Group – Weekly	External	Amber
Recourse optimisation and monitoring. The trajectory for a number of first appointments to be conducted – estimated number of pts likely to be seen for a first appointment aligned to the agreed trajectory. - Recourse optimisation and monitoring.		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. The estimated number of first appointments is on track as planned, with ongoing optimisation.	Internal	Amber
Weekly PTL meetings to review dormant cases and throughput. Review of the intake process to minimise hand offs between services. Activity, waiting list and quality impact risk monitoring across key services (including, Adult GIC, Trauma and Autism, PCPCS).	Currently have long waiting times, exceeding the 18wk RTT. Clear understanding of available capacity to reduce waiting times and meet increasing demand for some services. Gap in RTT waiting times data, as not fully automated or assured. Data flow is manual particularly quality data so possible data quality issue.	Weekly QI huddles for oversight, Review in Child Complex monthly meeting. Monthly business meetings for all services. IQPR meetings.	Internal	Amber
Clinical pathway mapping to unblock bottle necks		Integrated Quality and Performance Review (IQPR) meetings for each operational service area. A3 Kaizen events	Internal	Green

Workforce recruitment and retention	Recruitment - Number of referrals versus number of pts we can see. Unlikely to recover waiting times best case break even each service, with the exception of GIC which is under NHSE national review	Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Workforce assurance data on ESR	Internal	Amber
Autism – mitigations seeing an extra 175 pts Trauma -to see an extra 100 patients	Responding to cultural issues. The time required for change management	Waiting times weekly huddle. Integrated Quality and Performance Review (IQPR) meetings for each operational service area. Targeted support weekly meeting for affected service areas, monthly report to ELT. Service lines have started this process this month. Publication of the first cut of data a month in arrears of the start date will inform assurance rating. Lead nurse start 19th August	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of Implementation	Status
Deliver a trajectory for all service areas, tracking the ambition to reduce waiting times to 18/4 weeks target via the weekly Executive Leadership Team (ELT) *Strategy Delivery Room*.	Managing Director	Completed in January 26	In progress - Delivery Room and Monthly Integrated Quality and Performance Review (IQPR) meetings, reporting to the Board.
Key performance and information reporting systems are being automated and aligned to our new management structure, enabling data flow to the correct operational monitoring groups.	Project Manager / Associate Director of IM&T	*31 March 2025 – go live date.*	Data definitions for IQPR targets are documented and reviewed by data owners. Data is provided directly from IM&T systems to the data definitions. A large number of SPC Charts were created from the data definitions for use in IQPR Reports. Business administrator for reporting advertised and shortlisted.
National Review of Gender Identity Clinics (GICs) - Ratify Standard Operating Procedures (SOPs), mobilise training plans, and integrate job plans into clinic schedules by the following dates:	Managing Director and Medical Director	*April 2025* *National report published Dec-25*	Service Delivery and Performance Update: **Operational Work Completed:** The **Operations team has completed their tasks** and is now awaiting further input from clinical leads. **Next Steps:** The **Unit Clinical Lead (UCL) and Team Clinical Lead (TCL)** must finalize their respective tasks before integration with the completed operational elements can proceed. **Service Alignment:** Full integration will occur once the clinical components are finalized, ensuring alignment with service delivery requirements.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. A streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists	IQPR meetings with contracting updates. As above external NHSE meetings to support the identification of delivery capacity
GIC- Response to service level report and engagement in national QI workstream	Trust wait service level report due eminently Good engagement with national QI work.	Vacancy and absence of workforce plan	Weekly QI meeting Monthly report to ELT Quarterly report QSC and Trust board. Regular exec meeting with NHSE. Service engagement with QI leads.

Principal Risk 14	**Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target**	**Strategic Objective**	**Improving value, productivity, financial and environmental sustainability**
Description	**If** the Trust does not reduce its demand on the environment, the impact will be felt on the provision of its existing and potential new services. **Then** it will be out of step with the NHS-wide goals around environmental sustainability and the Service's attempts to achieve a net-zero status **Resulting** in non-compliance with its statutory obligations, national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2032 and net zero carbon plus influenced by the NHS ambition to reach 80% by 2040). The potential impact of this outcome includes inefficient resource and energy use, increased operating costs, legal and regulatory repercussions, missed infrastructure innovation opportunities, reputational damage, and heightened adverse environmental impact.		

Executive Lead	Jon Bell Interim Chief Finance Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	15th August 2024
Lead Committee	PFRC Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	February 2026
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	⟷	⟷	⟷	⟷	**Date of Next Review**	March 2026

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

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
NHS sustainability with the changes with ICB, sustainability is under review	Director of Estates, Facilities and Capital Projects	Waste intranet page has been developed with quarterly metrics – September 25	Develop a sustainability page on the intranet. Will be launched once green plan is aligned with NCL and this will then be brought to the Board for sign off. The national net zero metrics have altered to reflect a revised set of targets national targets, the NHS Long Term Plan, and the 'For a Greener NHS' initiative (80% emission reduction by 2032 and net zero carbon plus influenced by the NHS ambition to reach 80%by 2040).
Create and Prioritise action plans with input from Directorates.	Director of Estates, Facilities and Capital Projects	September 2025	The focus areas will be based on consumption / usage for , waste, utility consumption. One area of focus is to

			ascertain how to measure business/staff travel – survey is due for launch in November

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Refresh of the Green Plan along with an annual action plan.	Aiming to tie in the sustainability plan with NLFT	Contributed to the ICB green plan update 2025-26, there will be a further review by the end of 25-26	Once the green plan is updated this will be added to the intranet
An intranet page will be developed showing active monthly waste data, and will move towards adding other metrics	By September 25, waste data will be visible on the intranet	Other data sources are not as easy to collect will require investment in gathering travel data linked to expenses etc	

Principal Risk 15	~~**Lack of Staff Engagement/ Staff Disengagement**~~ **Lack of staff morale and resilience in the transition to the newly merged Trust**	**Strategic Ambition**	**Developing a culture where everyone thrives with a focus on equality, inclusion and diversity**
Description	~~If we do not address issues that matter to staff and do not have a clear plan to improve staff experience, staff will become disengaged. This will lead to decreased motivation, lower morale, and reduced commitment to the Trust's strategic ambitions and values. This could impact the quality of care/service delivery, hinder innovation, increase staff turnover, and negatively affect patient/service user experience and organisational performance.~~ If the Trust is unable to support its staff in the transition to the newly merged Trust, this will impact staff well being and morale. This will lead to enhanced levels of turnover, sickness and future recruitment issues. It could also impact the quality of care/service delivery, negatively affect patient/service user experience, hinder innovation and organisational performance.		

Executive Lead	Chief People Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	22 May 2025
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	March 2026
Risk Appetite	**Open**	5	4	**20**	4	4	**16**	3	4	**12**				**New!**	**Date of Next Review**	March 2026

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Clear communications with staff on process to move to the new Trust, including TUPE consultations – and access to the supporting information	Inconsistent information as the plans progress Information which is not yet available	• Consultation events – Q&A sessions with exec leadership including NLFT • Merger drop in sessions with People Team • FAQ documents kept update on intranet • Feedback form for staff to ask questions and provide comments • Designated consultation inbox • Senior Leader Forum sessions	Internal	Amber
Merger workstream activity	Complexity of the work and timescale	• Align processes and work priorities post-merger	Internal	Amber
Support mechanisms for staff	Process to manage switch of providers in transition Capacity to provide effective support to staff Freeze on learning and development opportunities	• Occupational health • Freedom to Speak Up service • Employee Assistance Programme • StaffSide • People Team providing guidance to managers and staff • Staff Networks	Internal	Amber
Staff survey analysis and initial action plan	Staff survey is key pillar of staff feedback and experience. Risk of lost momentum in acting on the result, given the merger	• Staff Survey to be reviewed at Board • They are in the public domain which ensures accountability	Internal External	Amber
~~Staff Experience Programme is in place to improve engagement~~	~~Lack of clear and consistent cascaded information on elements of the Programme~~ ~~Limited line manager capability/confidence in leading engagement~~ ~~Variable engagement levels across teams and departments~~	~~• Direct feedback from Staff Experience sessions~~ ~~• Increased Communication channels~~ ~~• Introduction of FTSU and Staff Experience Programme Board~~ ~~• Staff Experience is a key pillar at SDR~~ ~~• Regular updates on Staff Experience to Board and Board Committees~~	~~Internal~~	~~Amber~~
~~Staff survey and pulse survey including WRES and WDES help ascertain if our SE programme is effective and give staff an opportunity to feedback~~	~~Only yearly and quarterly surveys don't always give the right feedback in between surveys~~ ~~Delays in developing action plans to address staff surveys~~	~~• Staff Survey Action Plans are reviewed at Board and Board Committee level~~ ~~• They are in the public domain which ensures accountability~~	~~Internal~~ ~~External~~	~~Amber~~
~~Merger Drop-in sessions provide opportunities for staff to receive updates and raise questions about the merger process~~		~~Happening regularly and feedback to ELT on actions to be taken~~	~~Internal~~	~~Green~~

Key Risk Controls (1st line of defence)	Gaps in Control and Assurance (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
~~Revamped Service Visits Programme for 2025/26 ensures leadership visibility~~	~~Visits have been inconsistent and not always easy to arrange~~	• ~~Enhanced feedback form is in place that includes the Institute for Healthcare Improvement questions focused staff wellbeing and productivity~~ • ~~Regular item on ELT agenda~~	~~Internal~~	~~Amber~~
~~Learning and Development Opportunities in place including Management training~~		• ~~Senior Management Leadership Development Programme Feedback from 8B and above~~ • ~~Training Needs Analysis~~	~~Internal~~	~~Green~~
~~Health and Wellbeing considerations as part of the People GANTT chart this keeps the Trust focused on wellbeing of employees~~	~~Financial and Estates restraint on replicating some of the offering to offsite teams~~	• ~~Health & Wellbeing group (includes review of cost-of-living issues) Now incorporated within POD Delivery Group and Staff Engagement Group~~	~~Internal~~	~~Amber~~

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Continuity of Chief People Officer leadership role	Chief People Officer	Ongoing	
Effective handover to NLFT which gives visibility to key issues for TPFT staff and their wellbeing	Chief People Officer	Ongoing	
~~Cascade information to staff on elements of the Staff Experience Programme in a clear and consistent manner~~	~~Chief People Officer~~ ~~Director of Communications~~	~~Ongoing~~	
~~Develop, commence and communicate Staff Survey Action plans~~	~~Chief People Officer~~	~~September 2025~~	~~This is currently being developed as A3s~~
~~Roll-out of the Service Visits Programme for 2025/26~~	~~Interim Director of Corporate Governance~~	~~September2025~~	~~Programme for 2025/26 has been developed. Consideration to be had with ELT around rebadging of these visits to be focused on merger.~~
~~Management & Leadership development programme rolled out across the Trust. Three separate programmes, one for Bands 5-8b, one for Bands 8c and above and back to basics training on core process and policy.~~	~~Head of People (OD, Culture and Engagement~~	~~Ongoing~~	~~Learning and development training (x2) and back-to-basics training in place~~ ~~FTSU training is being designed, and FTSU is to be added to the induction~~ ~~Coaching of managers by HRBP (and senior team where required). Manager's report feeling more competent in resolving issues because of the training packages/coaching from HRBPs~~ ~~Informal resolutions form the majority of outcomes.~~ ~~Appropriate attendance levels at training sessions recorded~~
~~Engagement sessions run with MENTI – checking staff opinion on improvements made and what support is needed for the merger. Aiming to reduce the gap between what people say in person versus staff survey~~	~~Chief People Officer~~	~~October 2025~~	~~This is planned~~

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

The Tavistock and Portman NHS Foundation Trust

Principal Risk 16	**Non-viability of DET in its current form**	**Strategic Objective**	To enhance our reputation and grow as a leading local, regional, national & international provider of training and education.
Description	**If** an alternative funding or delivery model cannot be identified following the withdrawal of the National Training Contract **Then** the medium to long term viability of DET in its current form may not be sustainable **Resulting** in a teach-out arrangement, poor student experience, regulatory concerns including a potential reportable event to the OfS, and reputational damage		

Executive Lead	Chief Education & Training Officer	**Inherent Risk (Before consideration of controls)**			**Current Risk (After considering existing controls)**			**Target Risk (Risk after implementing all agreed action)**			**Movement of the current risk rating within the Quarter**				**Original Assessment Date**	25th July 2025
Lead Committee	Education and Training Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Q1**	**Q2**	**Q3**	**Q4**	**Date of Last Review**	December 2025
Risk Appetite	**Open**	4	4	**16**	4	4	**16**	2	4	**8**		New	⟷	⟷	**Date of Next Review**	February 2026

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

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Action plan to engage with NHS England around security of contract for 25/26 student intake	Director of Strategy and Business Development (DOSBD) Chief Education and Training Officer (CETO) Interim Chief Finance Officer (ICFO)	July/August 2025	Briefings Developed for NHS and meetings planned or underway
Modelling of different scenarios around teach-out and reduction in offer and overheads aligned with MTFP	Chief Education and Training Officer (CETO)	September 2025	Financial modelling of DET options presented to the Board of Directors 16 October 2025
Discussions with System partners around shared operational resource	Chief Education and Training Officer (CETO)	September 2025	Discussions underway with HE partners

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
To have a fit-for-purpose educational offer for sustainable student recruitment	Ongoing review of academic courses (including delivery models) Ongoing discussion with university partners Ongoing improvements to infrastructure (staffing and systems)		

Full Corporate Risk Register List report

Report Date: **18-Mar-2026**

Status Legend:
NotApplicable
Compliant
Planned
Pending
Overdue

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

Linked BAF risk	Reference	Created on	Description	Impact of risk	Last review	Original score	Current score	Target score	Target date
BAF 01 - Inequality of access for patients	RSK-061	11-Oct-24	Delays in delivering clinic letters to patients or healthcare professionals. Monitoring KPIs Limited for staff to cover sickness currently in general Endocrine team is up to date, but staff member due to go on maternity leave DrDr looking at ways that the platform may be able to help in this	May result in patient harm, poor patient experience and care, delays in treatment, reputational damage to the Trust, and increased stress for administrative and clinical staff."	10-Mar-2026	15	15	5	30-Apr-2026
	RSK-180	23-Oct-25	Patients and clinicians report that GPs are often reluctant to prescribe medication, including hormones, and monitor bloods as part of their shared care arrangement. T&P have also received letter from GPs and ICBs refusing to prescribe. ICB formulary also has a role to play in red-flagging drugs. This is a national issue for GIC services and is a local issue in prescribing across T&P services. The matter has been escalated to NHSE for GIC services and has been discussed with NLFT Chief Pharmacist at workstream level	May result in patient harm, poor patient experience and care, delays in treatment, an increase in patient complaints, reputational damage to the Trust, and increased stress for staff	18-Mar-26	16	16	4	30-Apr-28
BAF 02 - Failure to provide consistent, high-quality care	RSK-127	10-Apr-2025	If Trust policies and procedures are not reviewed, updated, and ratified in line with agreed schedules,	Then outdated or inconsistent guidance may be used in clinical and operational settings, resulting in increased risk of harm, regulatory non-compliance, and reputational damage to the organisation.	14-Mar-26	12	12	2	31-Mar-26
BAF 09 - Delivering financial sustainability targets	RSK-084	13-Dec-2024	Budgets were not consistent with the structure in ESR and the perceived outcome from the Strategic Review process.	This could lead to budgets not reflecting agreed-upon structures and a potential lack of clarity of available resources for budget managers—poor financial control.	10-Mar-2026	12	12	9	30-Apr-2026
	RSK-086	13-Dec-2024	The absence of a recurrent CIP process may undermine the development and execution of future financial plans, jeopardising the organisation's economic sustainability. There is a need to develop future merger related recovery plans and embed a delivery/governance process.	The lack of an established recurrent CIP programs will hinder financial sustainability.	10-Mar-2026	15	15	8	30-Apr-2026
	RSK-089	13-Dec-2024	If the Trust lost key members of staff, then this results in single points of failure and lack of capacity within the team,	resulting in the inability of the team to deliver core functions in a timely or adequate manner	10-Mar-2026	15	15	8	30-Apr-2026
	RSK-093	17-Dec-2024	Failure to respond to Subject Access Requests (SARs) within the specified timeframes	may lead to service users escalating concerns to the ICO, resulting in negative publicity and potential reputational damage to the organisation."	10-Mar-2026	12	12	8	30-Apr-2026
BAF 10 - Maintaining an effective estate function	RSK-071	22-Nov-2024	If there are inadequate governance arrangements related to statutory reporting, the Trust Board may not be adequately appraised on statutory compliance status and issues,	resulting in increased costs to the Trust of responding to compliance issues in an unplanned manner, reputational damage, litigation or regulatory action against the Trust	10-Mar-2026	8	12	6	30-Apr-2026

	RSK-175	09-Feb-2026	NHS cyber alert service •(CC-4738) Cisco Releases Critical Security Update for Unified Communications Products ItemDescriptionRecommended Actions Cisco Releases Critical Security Update for Unified Communications Products CC-4738 Severity: High Published: 22 January 2026Cisco has released security updates to address a critical vulnerability in Unified Communications Manager (Unified CM), Unified Communications Manager Session Management Edition (Unified CM SME), Unified Communications Manager IM & Presence Service (Unified CM IM&P), Unity Connection, and Cisco Webex Calling Dedicated Instance. •CVE-2026-20045 – Unauthenticated Remote Code Execution (RCE) vulnerability – CVSSv3 score: 8.2 Note: Cisco has assigned this security advisory a Security Impact Rating (SIR) of Critical rather than High because exploitation of this vulnerability could result in an attacker elevating privileges to root. Risk to the T&P Cisco Telephony system Exploitation attempts of CVE-2026-20045 Cisco is aware of attempted exploitation of this vulnerability in the wild. The NHS England National CSOC assesses further exploitation as likely. Affected platforms: Cisco Unified Communications •Unified Communications Manager (Unified CM) •Unified Communications Manager Session Management Edition (Unified CM SME) •Unified Communications Manager IM & Presence Service (Unified CM IM&P) •Unity Connection	Note: Cisco has assigned this security advisory a Security Impact Rating (SIR) of Critical rather than High because exploitation of this vulnerability could result in an attacker elevating privileges to root. Exploitation attempts of CVE-2026-20045 Cisco is aware of attempted exploitation of this vulnerability in the wild. The NHS England National CSOC assesses further exploitation as likely.	16-Feb-2026	16	16	4	
	RSK-096	10-Jan-2025	Risk of data theft through USB devices	potentail breach of confidentiality and reputational damage	27-Jan-2026	12	12	1	24-Apr-2025

BAF 12 - IT infrastructure and cyber security	RSK-178	11-Feb-2026	There is a Risk of malicious cyber attacks on the T&P Cisco telephony system systems and network. Security Impact Rating (SIR) of Critical rather than High because exploitation of this vulnerability could result in an attacker elevating privileges to root. NHS cyber alert service •(CC-4738) Cisco Releases Critical Security Update for Unified Communications Products Item Description Recommended Actions Cisco Releases Critical Security Update for Unified Communications Products CC-4738 Severity: High Published: 22 January 2026 Cisco has released security updates to address a critical vulnerability in Unified Communications Manager (Unified CM), Unified Communications Manager Session Management Edition (Unified CM SME), Unified Communications Manager IM & Presence Service (Unified CM IM&P), Unity Connection, and Cisco Webex Calling Dedicated Instance. • CVE-2026-20045 – Unauthenticated Remote Code Execution (RCE) vulnerability – CVSSv3 score: 8.2 Note: Cisco has assigned this security advisory a Security Impact Rating (SIR) of Critical rather than High because exploitation of this vulnerability could result in an attacker elevating privileges to root. Exploitation attempts of CVE-2026-20045 Cisco is aware of attempted exploitation of this vulnerability in the wild. The NHS England National CSOC assesses further exploitation as likely. Affected platforms: Cisco Unified Communications • Unified Communications Manager (Unified CM)	potential loss of all telephony services and threats to The ICT infrastructure	27-Feb-2026	20	20	4	
	RSK-019	28-May-2024	Risk: If the Trust does not have 24/7 cybersecurity resources, managed services, or appropriate resource arrangements in place, critical alerts or cyberattacks that occur outside of standard working hours (e.g., weekends) may not be responded to within the 24-hour target timeline. In the event of urgent incidents requiring immediate action over the weekend, a lack of available resources may result in delays in remediation, leaving systems and data vulnerable to compromise.	Then, delayed action would compromise the Trust systems, services, and data.	10-Mar-2026	15	15	4	30-Apr-2026
	RSK-056	29-Aug-2024	If there is an problem with the current telephony system (which has many of its software componets out of support) there may be limited options that can be taken to correct any issues.	Users may be unable to use their telephony handsets to receive or make outward calls	10-Mar-2026	9	16	8	06-Apr-2026
	RSK-016	28-May-2024	If there are not enough skilled cyber security resource to support the growing demand and compliance of cyber security, then this may result in Trust to maintaining cyber security compliance and would result in increased vulnerability to infrastructure and Trust not compliant with DSPT and cyber standards Here's a clearer version of the risk, including the potential impact, controls, actions, and priority: Risk: If there are insufficient skilled cybersecurity resources to support the growing demand for cybersecurity and compliance requirements, the Trust may struggle to maintain cybersecurity standards, increasing vulnerability to infrastructure threats and non-compliance with the Data Security Protection Toolkit (DSPT) and other cybersecurity standards.	Financial Impact: Potential fines or penalties due to non-compliance with cybersecurity regulations and standards. Reputational Damage: Loss of trust from patients, stakeholders, and regulatory bodies due to failure to maintain appropriate security measures. Service Delivery: There is an increased risk of cyberattacks, which could disrupt critical services and operations, leading to delays and potential harm to service delivery.	10-Mar-2026	20	15	2	30-Jun-2026
BAF 13 - Failure to achieve required levels of performance and productivity	RSK-039	31-Jul-2024	Potential risks for those awaiting interventions If GIC waitlists continue to grow. There may be an increased chance of serious incidents and poor patient experience. Overstretched staff expected to deliver services.	This results in an impact on care delivery, a loss of service reputation and non-compliance with regulatory and contract requirements.	10-Mar-2026	20	20	8	31-Mar-2026

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Update – Gloucester House Improvement Plan and Delivery Group - February 2026			**Agenda No.: 011**
Report Author and Job Title:	Nell Nicholson, Strategic Lead for Education & Partnerships	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	None.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	The purpose of this report is to provide an update on the Gloucester House Improvement Plan. The areas covered in this report are: • The Gloucester House Improvement Plan – covering the 2024 Review Action Plan and the additional workstreams of Estates, Finance, Governance and Safeguarding, Educational and Regulatory Outcomes, Clinical Outcomes, Workforce Planning, Equality, Diversity and Inclusion (EDI), Staff Wellbeing.		
Background:	A Gloucester House Improvement Plan was implemented following the Gloucester House Review in Spring/Summer 2024. A number of gaps and concerns arose during this process that required a robust plan to address them. The interdependencies in relation to the Gloucester House building and finances were included within the Improvement Plan. A Delivery Group was set up in Autumn 2024 to monitor progress against this plan. This was chaired by the then Managing Director for Clinical Services. In Autumn 2025 chairing of this group moved to the Strategic Lead for Education and Partnerships. The paper submitted to the Quality and Safety Committee in September 2025 outlined the progress and next steps for the Gloucester House Improvement Plan. Since that time substantial progress has been made. Most work streams are closed or nearing completion. A verbal update was sought by the Chair of the Steering Committee (Chief Education and Training Officer - CETO) on 13.1.26 who provided an update to Trust Board on 15.1.26. CETO fed back that Trust board were satisfied that the Improvement Plan was nearing completion and would be likely be closed and formally signed off in the next Steering Committee on 27.2.26. This report proposes that the Improvement Plan and the Delivery Group are closed in the context that any outstanding strategic areas are being managed and monitored through other systems and structures, i.e. the school Self Evaluation Framework and Development Plan which is monitored by the school Senior Leadership Team (SLT) and the Strategic Lead for Education and Partnerships and the Gloucester House Steering Committee. The interdependencies of finance and the building are led and managed operationally between the school SLT, the Operational Clinical Manager and the Head of Estates. The relocation is led by the Director of Strategy,		

	overseen by a Relocation Programme Board and a regular operational Relocation Working Group. This paper proposes that the Delivery Group slot could be repurposed for relocation work as most strategic leads involved in Gloucester House already attend that meeting.
Assessment:	Improvement Plan - Substantial progress has been made across the workstreams. The overall Improvement Plan stands at 100% complete. Individual workstream completion rates range between 99% and 100%. The 2024 Gloucester House Review strand is now 100% complete, minor outstanding tasks were already in other workstreams, so this strand was closed in December 2025. The school continues to face complex, interdependent issues relating to estates, finance, quality of education, staff wellbeing, and workforce stability. Monitoring and ongoing work in the context of the finances, relocation project and the Ofsted outcomes continues to require coordinated, strategic action across the organisation. This report proposes that the Delivery Group is repurposed to work together to resolve ongoing matters related to the governance of Gloucester House and the 'staffing structure in line with budget, considering staff numbers and deployment for longer term development'.
Key recommendation(s):	The Board is asked to: **1) NOTE** the closure of the Improvement Plan, approved by Gloucester House Steering Committee, in the context of the other systems and structures to ensure progression is sustained. **2) NOTE** the repurpose of Delivery Group to maintain additional focus on workforce and Gloucester House model.

Implications:

Strategic Ambitions:

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

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

	Risk Ref and Title: Details of risks and mitigations can be found in both the Improvement Plan Project Plan and the Relocation board Project Plan. The key risks for attention at this time pertain to maintaining quality and safety within the relocation project - particularly within the uncertainty of the time frame, the current estate challenges, and ongoing financial challenges.			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	Ofsted Material Change inspection required for the relocation and for the merger. It is imperative that Gloucester House continues to meet the Independent School Standards.			
Resource Implications:	Yes ☒		No ☐	
	Relocation Board New site			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	New site - distance to work/school; accessibility and safety of new site			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Trust Board ELT Quality & Safety Committee Steering Committee			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Update – Gloucester House

1. Purpose of the report

1.1 This report provides an update on the progress of the Gloucester House School (GHS) Improvement Plan. The update addresses the recommendations outlined in the 2024 Gloucester House Review, the ongoing open workstreams and the relocation plans. The last report to the Board of Directors was in November 2025.

2. Background

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

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

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

3. Gloucester House Improvement Plan Update

3.1 Strategic Aim and the Delivery Group:

Though the Improvement Plan was devised as a finite plan to bring the school back to functioning within the existing systems and structures we set broad strategic aims to ‘ensure GHS delivers excellence in educational, clinical, social, and emotional outcomes for children and young people achieved through:

- Financial optimisation and efficiency
- Safe and sustainable estate management
- Robust clinical and educational governance
- A supported, diverse, and effective workforce
- A strong safeguarding culture and regulatory compliance framework’

Governance and oversight have been provided by the Gloucester House Delivery Group, chaired by the Strategic Lead for Education and Partnerships. The group have met fortnightly, with each workstream led by a designated owner responsible for project planning and updates.

The Delivery Group - since September 2025, has been structured around:

- Tracking workstream progress and addressing outstanding areas
- Gloucester House relocation

If approved, this will be the last update on the Improvement Plan as we believe structures and systems are in place to achieve the above strategic aims.

3.2 **Improvement Plan -** Progress to Date:

Improvement Metrics - The overall Improvement Plan is 100**%** complete. The progress achieved across the workstreams is detailed below through a summary of each workstream (3.2.2- 3.2.10)

3.2.2 **Gloucester House Review Action Plan (2024)** - The Action Plan is 100% complete. The resolution of the previously outstanding areas are detailed in the table below.

Outstanding Action	Number of actions	Resolution	Progress	Lead	Next Step	To close (y/n)	Due date
Steering Committee assurance activities	5	ensuring these activities are included in structures within Steering Committee meetings and member visits to the school	SC members have visited the school & carried out assurance tasks. A format for the visits was created to support focused, meaningful visits Training/preparation was offered and taken up by some.	NN	Dates for SC visits to school to be planned for year Assurance relating to Independent School Standards to be discussed in next SC	Yes	Next SC meeting 27.2.26
Outcome data analysis	2	Completion of report	Report completed Dec 25 Quality Assured by EDI	NN	NN/CG/TM have met to finalise following the QA Circulate to SC	Yes	Next SC meeting 27.2.26
Quality of education for pupils offsite	1	This work is underway & being addressed by HT (CG)	Report is completed and circulated to DG. Has been discussed in GH SLT and	CG	Report to be updated and circulated to SC Some staff training may be required	Yes	Next SC meeting 27.2.26

		QE for pupils offsite is now being monitored for quality by teaching team	Delivery Group;		This is also part of School Development Plan		
EDI outcomes	2	Now 100% complete System in place to monitor EDI outcomes	Regular meetings with Tavi EDI, school SLT & reps monitoring & addressing EDI matters	SW/CG	Update as part of regular update at SC	Yes	Next SC meeting 27.2.26
Parental engagement (part of EDI)	1	Parent feedback used to inform activities on parent/carer days Complaints being managed in a structured systematic way and used to improve parent experience	Work with parents underway Improvements noted in questionnaire feedback Work with PPI who are supporting parent engagement Improved attendance at events Parent work/model has been reviewed	CG/SW	To remain in EDI and SLT agendas Is part of SDP Report on progress is within feedback to SC	Yes	Next SC meeting 27.2.26
Curriculum implementation	1	Curriculum fully implemented and improves quality of teaching & learning	There have been some IT technical delays which have impeded progress in aspects of this but these are now resolved and full implementation is underway	CG	This is in the School Development Plan & will be reported to SC and evaluated & assured with School Improvement visits by NN & SC member visits	Yes	Next SC meeting 27.2.26
Suspension criteria	1	This is incorporated into updated Behaviour Policy which is due to be signed off by GH SC in Feb 2026		SW	Behaviour Policy will be signed off at SC	Yes	Next SC meeting 27.2.26
Staffing structure review	1	Staffing structure has		NN/SB	To be worked through as part of	Yes	

		been adapted in line with pupils in the school Longer term models are currently being considered to be finalized as part of relocation			the relocation work Meetings that can currently continue this are: Delivery Group Relocation working group Additional meetings with BD		

3.2.3 **Estates:** Completion: 100%

General update: the current estate continues to present challenges and a balance of attending to current needs, in the context of the relocation, is being carefully considered in relation to the relocation timeline.

Relocation matters are being considered in the Relocation Programme Board and the Relocation Working Group.

Areas not fully resolved: breakdown of items for relocation, classroom access locks, clear desk policy.

Next step:

The unresolved matters have been closed within the Delivery Group as they are being dealt with in existing systems and structures:

The clear desk policy – is being managed through the regular cycle of estates and GH meetings.

The breakdown of items for relocation is not a current priority until the move date is identified.

A paper re access locks was submitted to, and discussed in, Delivery Group on 17.11.25. It was subsequently amended with information from the DFE re practice in schools and submitted to Clinical Services Delivery Board on 2.2.26. Further actions in relation to this are:

1. That a QIA and EQIA are to be completed (SW leading on this)
2. That an expert view is obtained in relation to the current site and new site at pace (i.e. within the next two weeks) to provide expert security and legal advice which will then go back to GSDG for review. (TR & BM leading on this)
3. That we give consideration to how we will monitor impact post implementation (if approved)

3.2.4 **Finance**: Completion: 99**%**

General update: The remaining finance action related to non-pay and items which are essential in relation to IT programmes in particular going into 26/27.

To support the closure of the Delivery Group the finance lead (TR) proposes to send a breakdown to the headteacher and clinical lead at the school to confirm which costs will go into next year and they will set a new target for non-pay. This will be managed in the regular finance meetings that the Clinical Operations Manager (TR) holds with the school leads.

It has been agreed at the Efficiencies Board that there will be a finalised budget by the end of February 2026.

Areas not fully resolved: A review historical non pay spend in order to inform the budget accurately.

Next step: to be managed in the regular finance meetings that the Clinical Operations Manager (TR) holds with the school leads.

3.2.5 **Governance & Safeguarding**: Completion: 100**%**

General update: As part of the relocation plans and the merger a Material Change Application has been submitted to Ofsted and there will be an Ofsted visit to ensure compliance against the Independent School Standards. The behaviour handbook and related policies have been updated including consultation with staff, pupils and families. Safeguarding policies and procedures are all up to date.

Areas not fully resolved: no outstanding areas

Next step: governance of the school to be reviewed – this work has begun and is an ongoing piece of work that could be considered in the repurposed Delivery Group.

Steering Committee approval for policies; information share for procedures. To be signed off/shared at or before the forthcoming meeting (27.2.26).

3.2.6 **Educational Outcomes**: Completion: 99%

General update: The systems to ensure monitoring and improvement of the curriculum and pupil progress are now in place.

Though there has been significant progress in this area, the Quality of Education remains a priority improvement area. Ofsted identified that the curriculum was not fully embedded or delivered consistently and with precision and that this impacted pupil progress. It was also noted that a minority of parents were unhappy with the school. These areas are embedded into the School Development Plan.

Areas not fully resolved: Ongoing work around home education and staff deployment for this; moderation in the foundation subjects and science.

Next steps: home education work – a report by the headteacher was presented in Delivery Group. This will be shared with Steering Committee. The work related to this is being addressed through the School Development Plan. Moderation across all subjects is also being addressed within the School Development Plan. These will be monitored in the Steering Committee meetings and through Steering Committee visits.

3.2.7 **Clinical Outcomes**: Completion: 100%

General update: Clinical Outcomes, and clinical work is managed and monitored through the Clinical Meetings in the school and the wider Trust. Outcomes are reported and monitored in the Steering Committee.

Areas not fully resolved: none

Next step: A clinical staffing review is ongoing for the longer term and reviewing clinical interventions model and parent/family work is also an area for longer term. This is an area that we may want to consider in the repurposed Delivery Group space.

3.2.8 **Workforce Planning**: Completion: 98%

General update: The team has developed a short-term staffing model for teaching and support functions to align with pupil numbers and enable some financial efficiency.

Areas not fully resolved: Staff Service structure review not complete. Proposed longer term revisions are being considered and modelled with the support of Business Development.

Next step: Continuation of review of 1:1 funding usage with the intention to maximise its flexibility and value in meeting pupil needs. Further work on workforce model for current cohort and in context of possible plans for expansion/increase in pupil numbers. This is an area that we may want to consider in the repurposed Delivery Group space.

3.2.9 **Staff Wellbeing**: Completion: 100**%**

General update: A continued focus on information sharing, regular updates and a model of continuous staff feedback remains central to shaping wellbeing interventions. The staff wellbeing room was positively received and enabling staff wellbeing space in the new site is being considered. Staff surveys were recirculated and evaluated. Some staff wellbeing matters have arisen recently in relation to a number of areas. These are being managed through GH SLT & other senior colleagues.

Areas not fully resolved: none

Next step: To consider staff wellbeing in the context of various contextual factors including delays and uncertainty around relocation, within the EDI meeting, the relocation meetings and potentially the repurposed Delivery Group.

3.2.10 **Equality, Diversity and Inclusion (EDI):** Completion: 99%

General update: EDI initiatives are progressing. Regular meetings between Gloucester House SLT and EDI representatives with the EDI team from the Trust are in place. Work with parents is being addressed through the development plan from an educational and a clinical perspective.

Next step: Report on pupil outcomes to be shared with EDI Team and Steering Committee to consider evaluation and lessons learned.

6 Recommendations and Next Steps

To repurpose Delivery Group to pick up matters that need a more frequent focus than the termly Steering Committee and need the range of staff that are members of the

Delivery Group. For example, the workforce and operational model including finance, staff wellbeing, relocation.

7 Conclusion

The Improvement Plan is complete and any ongoing and new areas are being led and managed in existing structures. For those issues (identified within the report) that need further work outside of existing structures it is proposed to repurpose the Delivery Group.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: NHS England Review of Gender Identity Clinic - Update			**Agenda No.: 012**
Report Author and Job Title:	Clare Scott, CNO	**Lead Executive Director:**	Clare Scott, CNO Liz Searle, Interim CMO
Appendices:	Appendix 1 – Notification of immediate risk and serious concerns – December 2024 Appendix 2 – Response letter and action plan to notification letter Appendix 3 – NHS England's Initial response to Dr Levy Report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	NHS England carried out their inspection of our Gender Identity Clinic on 5th November 2024 as part of the national review of all adult gender services. The Trust received an initial letter outlining immediate actions to be addressed. All requirements were responded to. Nationally, there are three parts to the review outcome: • Operational and Delivery Review of NHS Adult Gender Dysphoria Clinics (GDCs) Report – published 18th December 2025 • Gender Dysphoria Clinic Specific Report – draft received 3rd March 2026 • NHS England Response Plan – due to be published.		
Background:	In June 2024 NHS England asked Dr Levy to lead a review of all 9 commissioned NHS adult gender dysphoria clinics (GDCs) in England. The task was to consider whether these services met the requirements of the current non-surgical interventions service specification and the needs of patients seeking their support. Between October and December 2024, the panel conducted 1-day visits to each of the 9 GDCs. The panel examined evidence provided both in advance and during the visits to identify challenges, recognise best practice and pinpoint where improvements could be made against key lines of enquiry. The Board received the initial letter detailing immediate actions, along with the response and action plan in January 2025.		
Assessment:	The Trust responded to the initial notification letter which set out one immediate risk and four immediate concerns, all of which required immediate actions from the Trust. The action plan for the immediate risk was submitted to NHSE on 6th December 2024 and the action plan for the immediate concerns was submitted on 20th December 2024. The action plan was monitored through the weekly targeted support meetings, reporting monthly to Executive Leadership Team, overseen at the Quality and Safety Committee. Evidence presented to Executive Leadership Team in July 2025 and Quality and Safety Committee in August 2025, led to the decision to close the plan as complete and transition the service from targeted support framework to the national quality improvement collaborative led by NHS England. The reporting and oversight cycle remained the same.		

	The Trust received the GDC level draft report on 3rd March 2026 and will respond to the factual accuracy request by 13th March. The final report is expected by the end of March 2026. The service is devising an action plan to address the recommendations from both the local report, giving consideration to the national recommendations.
Key recommendation(s):	The Board is to **NOTE** the Trust's response to and engagement with the national review and improvement work, both local and national.

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:				
Legal and Regulatory Implications:	Yes ☐	No ☒			
Resource Implications:	Yes ☒	No ☐			
	Movement of clinical staff to implement triage system and possible impact on administrative staff regarding letter response times.				
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:	January 2025 – NHSE review paper to Board April 2025 – Quality & Safety Committee, Targeted support progress, including NHSE Review action plan August 2025 – Quality & Safety Committee, Targeted support progress, including NHSE Review action plan March 2026 – Executive Leadership Team Meeting – GDC individual report			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

	in assurance or action plans			

Report Title: NHSE REVIEW OF GIC - UPDATE

1. Purpose of the report

1.1. This report is to update the Board regarding the national review of the nine commissioned Gender Dysphoria Clinics.

2. Background

2.1 One of the recommendations of the Cass Review was a review of the adult service specification. To respond to this, NHS England has taken the decision to conduct a review of the operation and delivery of the adult Gender Dysphoria Clinics.

2.2 In June 2024 NHS England asked Dr Levy, Medical Director of Lancashire and South Cumbria Integrated Care Board, and previously NHS England's North West Regional Medical Director, to lead a review supported by an expert panel. The review included all nine commissioned NHS adult gender dysphoria clinics (GDCs) in England. The task was to consider whether these services met the requirements of the current non-surgical interventions service specification and the needs of patients seeking their support. Between October and December 2024, the panel conducted 1-day visits to each of the 9 GDCs. The panel examined evidence provided both in advance and during the visits to identify challenges, recognise best practice and pinpoint where improvements could be made against key lines of enquiry.

2.3 NHSE started the review process in September 2024 and visited the Trust's Gender Identity Clinic on the 5th November. During their day with the team, inspectors met with experts by experience, administrators, clinicians and senior leads including the CNO and CMO.

2.4 The Trust responded to the initial notification letter which set out one immediate risk and four immediate concerns, all of which required immediate actions from the Trust (Appendix 1). The action plan for the immediate risk was submitted to NHSE on 6th December 2024 and the action plan for the immediate concerns was submitted on 20th December 2024. The action plan was monitored through the weekly targeted support meetings, reporting monthly to Executive Leadership Team, overseen at the Quality and Safety Committee. Evidence presented to Executive Leadership Team in July 2025 and Quality and Safety Committee in August 2025, led to the decision to close the plan as complete and transition the service from targeted support framework to the national quality improvement collaborative led by NHS England. The reporting and oversight cycle remained the same.

2.5 However, due to variation in capacity in the administration team, a new backlog in responding to clinical queries, processing referrals and clinical letters being sent out has been identified and a recovery plan devised in response to this, comprising of additional interim bank staff to provide additional short-term capacity to prepare for the national waiting list.

3. Assessment

3.1 There are three parts to the review outcome:

- Operational and Delivery Review of NHS Adult Gender Dysphoria Clinics (GDCs) Report – published 18th December 2025.
- Gender Dysphoria Clinic Specific Report – draft received 3rd March 2026
- NHS England Response Plan – due to be published.

3.2 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 nine 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.

3.3 The Senior Leadership in GIC has reviewed the recommendations from the national report and considered the services contribution to the national work and work required locally to achieve this.

3.4 The Trust received the GDC level draft report on 3rd March 2025 and will respond to the factual accuracy request by 13th March. The final report is expected by the end of March 2026. The service is devising an action plan to address the recommendations from both the local report, giving consideration to the national recommendations.

3.5 The report highlighted many areas of good practice, along with a number of areas for improvement. In total 77 points have been extracted to be included in the local improvement plan, some of these are related to engagement in the national improvement work. Given the time between the review and receipt of the report, over half of the recommendations have been addressed, although to ensure robust governance around the plan the service is expected to provide evidence for each recommendation before the action is complete.
Trusts are expected to take the response to the review through public board in Q1 2026/27.

3.6 Additionally, the National QI Programme Lead for Adult Gender Services confirmed the programme will continue into next year, with the importance of pace in delivering change. It was noted that Executive leads and sighted and sponsoring key changes, that these now should be aligned with actions from Levy Review.

3.7 The clinic continues to work with the national QI team and other clinics nationally. The clinic is supported by a quality improvement practitioner as part of the national work. The service has received positive feedback from the national team on their engagement and presented on their improvement work at a recent national event.

4. Conclusion

4.1 Action has been taken to respond to the factual accuracy and address the recommendations in the GDC specific report. The factual accuracy will be returned by 13th March. An action plan is in the first draft, final version will be shared with NHSE.
The clinic continues to work with the national QI team and other clinics nationally. The clinic is supported by a quality improvement practitioner as part of the national work. The service has received positive feedback from the national team around their engagement and presented on their improvement work at a recent national event.

4.2 Regarding the immediate risk and serious concerns received in December 2024, immediate action was taken to mitigate the risk regarding untriaged referrals and GIC Nursing Team started to clinically triage referrals from Monday 2nd December.
Action was taken to manage the crisis escalation plan and the GIC Nursing Team are now managing the 'distress rota'. The nursing team work closely with the administrative team on a daily basis to ensure there is a clear route of escalation to manage any patients contacting the clinic in distress.
The action plan was monitored and the team was kept accountable through the weekly Targeted Support Meetings. From January 2025, the plan became business as usual for the team.

Appendix 1

Notification of Immediate Risk – December 2024:

An “immediate risk” is an issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes and therefore requires immediate action.

Key Theme	Immediate Risk
Lack of clinical oversight of new referrals	There was no evidence that new referrals are reviewed or seen by a qualified member of staff unless the administrator chooses to escalate a concern. This presents a significant risk as the administrators are not qualified to assess the risk or the safeguarding information requested on the referral form.

Notification of Serious Concerns:

A serious concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care and therefore requires urgent action to resolve.

Key Theme	Serious Concern
Lack of governance	There is no MDT meeting guidance, clear governance structure or MDT meeting terms of reference to identify where individual patients should be discussed either at MDT meetings or at professional development meetings. The impact of this is that gender clinic staff may not be clear as to where they should take a case for discussion and therefore a patient may not be discussed in the correct forum with all relevant professionals present to feed into the diagnosis and treatment plan. Additionally, there are no contemporaneous notes of discussion of individual patients, therefore the patient notes which are later updated may not be a complete and accurate reflection of discussions about the treatment plan.
Lack of clear escalation for individuals in crisis, placing the health and wellbeing of those individuals and staff at risk	There is no clear process for administration to respond to and escalate crisis calls and emails, and unclear health and well-being support for those dealing with the calls. The impact of this is that a crisis call may not be escalated to the correct individual in a timely manner impacting on the patient’s care. The

	health and well-being of the administration staff taking the call could also be compromised due to the lack of support in dealing with the distressing situation. Additionally, email responses to crisis emails seen by the review team were unhelpful, with no clinical value or signposting to other services to support a patient reaching out during crisis.
Delayed letters	Clinic letters were noted to have delays in the letter being sent two to five months after the clinic appointment. The impact of this is that there is no record of the discussions shared with other healthcare professionals or the patient for significant timescales, preventing other professionals from having a holistic understanding to support the patient in their healthcare journey. Additionally, it was noted that there were numerous grammar mistakes and poor language within the letters, and an unclear disclaimer at the end of each letter, with the purpose of its inclusion also being unclear.
Lack of clinical governance	There was poor clinical governance, including a lack of detailed information. Meeting documentation and local documents/SOPs were not appropriately signed off through a robust process. It was unclear to reviewers that the planned introduction of the electronic assessments had been through a robust risk assessment and clinical governance sign-off process. Therefore, the patient may be put at risk through the assessment not being as robust as a clinical assessment from a professional clinician. Additionally, there was a lack of understanding of number of incidents within the service, lack of ownership of safeguarding referrals, limited evidence of implementation of recommendations by HM Coroner set out in Regulation 28 Reports, and no clear oversight of the risk register or recording of discussions to mitigate any of these risks. Therefore, risks may not be robustly actioned and changes may not be embedded to prevent the potential recurrence of an incident.

The Tavistock and Portman
NHS Foundation Trust

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20th December 2024

Dear Dr Levy,

Further to our letter to you dated the 6th December 2024, we are sharing an update to the action plan in response to your concerns. As you know, our previous letter included an action plan for both the immediate risk and the serious concerns. We now share with you the progress we have made to address the areas that you highlighted.

Please note, as before, we have shared the high-level plan with you, there is a detailed project plan behind this; and will be used to provide progress summaries and evidence during our commissioner meetings.

Please do let us know if you have any queries or require anything further at this stage.

Yours sincerely



Dr Chris Abbott
Chief Medical Officer

Clare Scott
Chief Nursing Officer

Dr Michael Holland
CEO

	NHSE Notification	Action No	Trust Plan	Key Actions	Timescale for Completion	Complete?	Lead	Status	RAG	Notes
Immediate Risk	**Lack of clinical oversight of new referrals** There was no evidence that new referrals are reviewed or seen by a qualified member of staff unless the administrator chooses to escalate a concern. This presents a significant risk as the administrators are not qualified to assess the risk or the safeguarding information requested on the referral form.	1.0	To establish a robust process ensuring all new referrals are reviewed by a qualified staff member to mitigate risks associated with non-qualified staff assessing risk and safeguarding information	Registered Mental Health Nurses will screen all new referrals from 2nd December 2024, using standardised screening template.	12/12/2024	Complete	Team Clinical Lead	Completed and signed off at Unit Clinical Governance on 12/12/24.		New Screening template document is now signed off and being used.
				Develop a standardised referral triage process. Standard Operating Procedure (SOP) approved by GIC team; to be signed off at next Unit Clinical Governance Meeting - 12th December	12/12/2024	Complete	Unit Clinical Lead	Completed and signed off at Unit Clinical Governance on 12/12/24.		New Referrals Intake/Screening SOP is has been signed off through clinical governance committee.
				Define roles and responsibilities for administrators and qualified staff.	02/12/2024	Complete	Team Operational Lead	Completed on 02/12/2024.		This is already in place, documentation to outline roles and responsibilities for Clinical Admin, Admin and Operational Staff is present.
				Audit documentation and reporting mechanisms for compliance.	16/12/2024	Complete	Nurse Lead	Completed 16/12/24, there are Audit reports available.		
	Lack of governance There is no MDT meeting guidance, clear governance structure or MDT meeting terms of reference to identify where individual patients should be discussed either at MDT meetings or at professional development meetings. The impact of this is that gender clinic staff may not be clear as to where they should take a case for discussion and therefore a patient may not be discussed in the correct forum with all relevant professionals present to feed into the diagnosis and treatment plan. Additionally, there are no contemporaneous notes of discussion of individual patients, therefore the patient notes which are later updated may not be a complete and accurate reflection of discussions about the treatment plan.	2.1	To develop and implement clear guidance, governance, and documentation practices for MDT meetings to ensure consistent, accurate, and comprehensive discussions about patient cases.	Develop Comprehensive MDT meeting Terms of Reference to include escalation points and outputs of MDT.	12/12/2024	Complete	Head of Speech & Language Therapy	Completed and signed off at Unit Clinical Governance on 12/12/24.		MDT Meeting TOR is complete which includes escalation points and outputs of MDT.
				Create template for all clinical discussions to be entered into electronic patient records during the MDT meeting to ensure contemporaneous record to ensure a complete and accurate reflection of discussion and actions.	12/12/2024	Complete	Head of Speech & Language Therapy and Lead administrator.	Completed and signed off at Unit Clinical Governance on 12/12/24.		MDT Meeting Templates for Cases as well as Formal discussion templates are have been created and signed off.
	Lack of clear escalation for individuals in crisis, placing the health and wellbeing of those individuals and staff at risk There is no clear process for administration to respond to and escalate crisis calls and emails, and unclear health and well-being support for those dealing with the calls. The impact of this is that a crisis call may not be escalated to the correct individual in a timely manner impacting on the patient's care. The health and well-being of the administration staff taking the call could also be compromised due to the lack of support in dealing with the distressing situation. Additionally, email responses to crisis emails seen by the review team were unhelpful, with no clinical value or signposting to other services to support a patient reaching out during crisis.	2.2	To implement a process for responding to and escalating crisis calls and emails, while ensuring health and well-being support for administration staff handling such situations.	Develop Crisis communication escalation SOP / Policy.	16/12/2024	Complete	Clinical Nurse Specialist (MH)	Completed as of 16/12/24.		
				Reinstate training for non-clinical and clinical staff on handling and escalating crisis situations.	20/12/2024	Complete	Team Clinical Lead and Team Operational Lead.	The first training sessions was held on 20th December 2024 at 11am, subsequent dates are being currently discussed based on availability. It has been acknowledged in management meetings that the revised distress rota will include a clinician present on site always to support operational staff.		
				Develop Health and well-being support framework for administrative staff.	20/12/2024	Complete	Team Operational Lead and Unit Clinical Lead	The Kaizen event was developed for this in December 2023. The Plan and outputs for 2024 is documented and present. Birthday club, GIC away every 6 months, well being budget.		
				Implement distress rota to ensure clinical qualified staff are available throughout clinic operational hours.	02/12/2024	Complete	Clinical Nurse Specialist (MH)	This is complete and in place as of 16/12/2024. Every clinic morning all staff receive email confirmation of rota's staff for the day. The rota is held in the primary GIC folder under Distress Rota Policy.		
				Review Induction Process for Administrative Staff	20/12/2024	Complete	Team Operational Manager and Unit Clinical Lead	Induction process for new starters is in place and in use.		

Serious Concern	**Delayed letters** Clinic letters were noted to have delays in the letter being sent two to five months after the clinic appointment. The impact of this is that there is no record of the discussions shared with other healthcare professionals or the patient for significant timescales, preventing other professionals from having a holistic understanding to support the patient in their healthcare journey. Additionally, it was noted that there were numerous grammar mistakes and poor language within the letters, and an unclear disclaimer at the end of each letter, with the purpose of its inclusion also being unclear.	2.3	To address delays in sending clinic letters and improve their quality, ensuring timely communication with healthcare professionals and patients, to meet contractual requirement (within 2 weeks of appointment).	Develop a process for sending clinic letters within two weeks of appointment.	16/12/2024	Complete	Team Operational Lead and Team Clinical Lead	Completed on 16/12/24.		
				Deliver targeted support for Hygiene of letters including grammar and spelling errors	16/12/2024	Complete	Team Clinical Lead	Work to address issues with clinical and admininstive staff complete Initial round of addressing this issue took place on 16/12/2024. Identified staff have received targeted support from Clinical Lead. Further attention to this item on Clinical Governance Agenda 17.01.2025. Randomised Audit of letters proposed for Q1 & 2 2025.		
	Lack of clinical governance There was poor clinical governance, including a lack of detailed information. Meeting documentation and local documents/SOPs were not appropriately signed off through a robust process. It was unclear to reviewers that the planned introduction of the electronic assessments had been through a robust risk assessment and clinical governance sign-off process. Therefore, the patient may be put at risk through the assessment not being as robust as a clinical assessment from a professional clinician. Additionally, there was a lack of understanding of number of incidents within the service, lack of ownership of safeguarding referrals, limited evidence of implementation of recommendations by HM Coroner set out in Regulation 28 Reports, and no clear oversight of the risk register or recording of discussions to mitigate any of these risks. Therefore, risks may not be robustly actioned and changes may not be embedded to prevent the potential recurrence of an incident.	2.4	Establish a clinical governance framework, ensuring clear oversight of processes, documentation, and risk management to enhance patient safety.	Develop Updated Process for clinical SOPs, to include governance route for approval.	16/12/2024	Complete	Clinical Nurse Specialist (Core) and Team Clinical Lead	This is agreed and in process. Clinical governance standard agenda attached and MDT SOP. GIC has monthly Clinical Governance meeting in place & Adult Unit wide clinical governance which GIC report into.		
				Develop SOP for function and use of DrDoctor, including clinical review of information received from patients via the platform	31/12/2024	Complete	Unit Clinical Lead and Team Clinical Lead	DrDoctor SOP has been provided for its' function.		Note: CX clinic is not an electronic assessment process.
				Re-commence Team Clinical Governance Meetings. Develop clear reporting structure in the governance framework to ensure floor to board and board to floor reporting and learning. , outlining roles and responsibilities and standardised agenda. To include all aspects of patient experience, safety and effectiveness.	16/12/2024	Complete	Clinical Nurse Specialist (core) and Team Clinical Lead. Supported by Unit Clinical Lead and Trust Director of Therapies & Clinical Governance.	First Team Clinical Governance Meeting held under the new Trust clinical structure with standardised agenda.		GIC Clinical Governance Meetings fall on 4th Monday of the month at 3:30pm Clinical Governance Meeting for entire Adult unit falls on 2nd Thursday of the month 10:30 to 12:00pm. Decisions from the GIC GovMeeting are ratified by the unit meeting two weeks later.
				Develop an operational risk register with clear ownership, mitigation plans, review dates, and next review dates.	20/12/2024	Complete	Team Operational Lead and Team Clinical Lead	**Operational Risk:** Current risk register updated to version held on Radar software. This provides a regular report on BAF risks to GIC Clinical Governance with any trust wide sign off needed to the Adult Unit wide Governance meeting. Operational Service Manger creates ad-hoc Meetings with risk manager whenever a risk is needed to be uploaded and scored. Last meeting early December. **Clinical Risk:** There currently exists clinical incident panel is completed monthly - 3rd Tuesday at 11:30 to 13:00. This is chaired by CNO or Associate Director of quality, MDT including patient safety reps (peer supports). Minutes are shared and circulated with the memberships, amendments are made to radar with the outputs of that meeting. With RADAR, for example, if someone is assigned to do a mortality review, that person gets assigned a new tasks on Radar itself which emails the assigned person.		We have a risk register on Radar and will be uploading any local risk to the Trust system.

Date published: 18 December, 2025
Date last updated: 18 December, 2025

NHS England's initial response to Dr Levy's Report

Publication (/publication)

Content

To: **Dr David Levy**, Independent Chair of the Review of Adult Gender Clinics

Dear Dr Levy,

We would like to thank you and your panel for your important work conducting this independently led review into the operation and delivery of NHS Adult Gender Dysphoria Clinics.

NHS England is committed to supporting people who need these specialist services and that is why we commissioned this review. Waiting times have remained unacceptably long and this is not just distressing for patients but also for those staff working within these services whose motivation is to provide the very best care they can.

We also wanted to better understand variation in practice between services; the opportunities for improving quality – clinical effectiveness, safety and experience – across services; and the challenges facing the clinical teams providing these services, whether that be adjusting to the needs of a changing demographic or managing the growing waiting lists.

Your final report, together with its findings and recommendations directly responds to these challenges and presents a clear framework from which a comprehensive plan of action can be taken forward.

As you know, we have not simply sat back and waited for your report before taking action to improve these services. Since the review was commissioned NHS England has:

- established a National Improvement Programme to share best practice and learning across services and support urgent quality improvement efforts within services. We are pleased to see that your report recognises this as an important mechanism for tackling many of the issues identified by the review;
- commissioned a new adult gender service in Cheshire and Merseyside, following an evaluation as a pilot. This has increased the number of newly commissioned and additional services to three since 2023. A provider selection process is currently in train to establish a fourth new regional service for the East of England by April 2026
- formed detailed plans for creating a new single, national waiting list for adult gender services to be implemented in April 2026. This will allow us to support meaningful demand and capacity modelling at provider level and support the regionalisation of the Adult Gender Services (most of which have historically operated as national services); and achieve greater transparency about who is on the waiting list to support clinical risk reduction measures.

In addition to the above, the government has also announced a new support service (https://www.gov.uk/government/news/support-for-adults-facing-staggering-waits-for-gender-services) for some of the longest waiters in the country.

Next steps

NHS England, in full partnership with the Department of Health and Social Care, will now lead the next stage of the system-wide response.

We will establish a National Portfolio Board, in line with your recommendation, to build and develop a full implementation plan, which will address each of your recommendations in turn and be aligned with the ambitions of the Government's 10 Year Health Plan for England (https://www.gov.uk/government/collections/10-year-health-plan-for-england). It will describe how the National Quality Improvement Network for Adult Gender Services will reinforce its use of experienced quality improvement (QI) practitioners, embedded in each of the Adult Gender Services, to secure a standardised and impactful approach using established QI techniques and tools. The Network will also seek to embed a culture of quality improvement in the NHS Adult Gender Services from Board to clinic.

Immediate priorities will also include:

- raising the referral threshold to 18 years to align with the age of discharge from the NHS Children and Young People's Service;
- bringing an end to self-referrals into the service and, in parallel, providing advice and guidance for those finding it difficult to secure a referral;
- establishing challenging but achievable productivity goals for every service which can then guide and inform the commissioning of additional services, underpinned by a clear understanding of the regional demand through the national waiting list;
- changing the role of the Adult Gender Services, so that patients are discharged from the service at an earlier stage of the clinical pathway and for the surgical units to take on responsibility for assessment of suitability for surgery;
- working with professional bodies to establish a new professional role of *GP with an Extended Role in Gender Medicine*, to provide support to those who have completed their care within the Adult Gender Service clinics and provide leadership and knowledge sharing with primary care in every neighbourhood;
- redesigning the financial framework for Adult Gender Services, moving away from block contracts to incentivise efficiencies and clinical activity;
- extending the role of the existing National Research Oversight Board for Children and Young People's Gender Services to cover research and audit activities relating to the adult pathway;
- defining the role of integrated care boards in the adult gender pathway, and support them in implementing your recommendations.

Importantly, your report has highlighted a need for the providers of these services to improve productivity quickly and to rapidly implement recovery actions. To that end, we are pleased that you have accepted NHS England's offer to take on the role of independent chair of a newly formed national provider collaborative for Adult Gender Services, that will begin its work in January 2026. In this role you will work with NHS England and the Department of Health and Social Care in supporting the Adult Gender Services in a coordinated and systematic approach to quality improvement and productivity recovery.

We thank you and your team for leading this important review. Your report will help us to improve both services and the lives of the patients who need them.

John Stewart, National Director, Specialised Commissioning, NHS England
Professor James Palmer, Medical Director, Specialised Commissioning, NHS England

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Date last updated: 18 December, 2025
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MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Quality and Safety Committee Handover			**Agenda No: 013**
Report Author and Job Title:	Magda North, Assistant Director of Corporate Governance	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1: Quality and Safety Committee Handover business Appendix 2: Annual Report 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	Subject to final approvals, the Trust will merge through acquisition by North London NHS Foundation Trust (NLFT) on 1 April 2026. This paper sets out the final Education and Training Committee handover that will be passed to NLFT.		
Background:	Following the final ordinary meeting of the Committee, a formal handover meeting was held on 17 March 2026. The handover documents will ensure that NLFT's Quality and Safety Committee can take account of risks, issues and work outstanding from TPFT Quality and Safety Committee.		
Assessment:	The Board is asked to note • The explicit focus on handover by Committee members and attendees at the last ordinary meeting of the Committee. This included **closing matters arising and sub-groups** of the Committee. • Existing discussions at **merger work stream level** and **Transitional Executive** which have already socialised at management level many of the items raised in the handover. This is supported by a merger risk register. • The drafting of **Terms of Reference for NLFT's Committee structure** from 1 April with a view to managing the business of the enlarged Trust. There is a strong read across from TPFT's ToR to that of NLFT. • The development of **Committee workplans 2026/27** to reflect the business of the enlarged Trust and to build in items to understand the work of TPFT.		
Key recommendation(s):	The Board is asked to take **ASSURANCE** on the Quality and Safety Committee Handover.		

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 ☐		
	The BAF and corporate risk register are relevant to this paper in setting out the strategic risks of the Trust.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The merger by acquisition of TPFT by NLFT is planned on 1 April 2026.				
Resource Implications:	Yes ☒	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	None identified.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Quality and Safety Committee				
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	

Appendix 1: QSC Committee Handover Business

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Governance				
Quality Account 2025/26	Regulatory requirement for TPFT entity to publish. The first draft will have narrative up to and including the end of January 2026. This will be presented to the handover Quality & Safety Committee on 17th March 2026.	Chief Nursing Officer	To track through NLFT processes: TPFT Care Group, EMC, QSC (May) and Board (May)	Publication by 30 June 2026
Board Assurance Framework	The QSC risks on the BAF have been updated since the February 2026 QSC meeting, in preparation for TPFT's Board in March.	Director of Corporate Governance	**TPFT BAF and NLFT Board Assurance Framework** to be reviewed at NLFT Board workshop in May 2026 to design 2026/2027 BAF for enlarged Trust. The BAF will then progress through relevant committees onto the Board in the usual way.	Q1 2026/27
Corporate Risk Register	Corporate risk register has been updated in March, including QSC related risks GP shared care agreement to be added in time for the TP Board (see later on list)	Chief Nursing Officer (owner of QSC BAF and corporate risks)	TPFT and NLFT existing risk management systems will operate in tandem until the Autumn when In-Phase will be adopted across the enlarged Trust. Alignment to a single **Corporate Risk Register** will be undertaken manually from Q1.	Q1-Q2 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	Agreement to progress risk register training through relevant merger workstream (and to close the outstanding action on the action log)			
Internal audit: learning from complaints and incidents	Partial-compliance internal audit, with factual accuracy check completed, final report under negotiation. Two high and two medium actions to be completed. Overall TPFT internal audit plan 2025/26 will form TPFT Head of Internal Audit Opinion	Director of Corporate Governance (SRO for internal audit)	To track through NLFT processes: TPFT Care Group, EMC, and AGC Closedown of TPFT internal audit plan 2025/26 and actions to route through NLFT AGC	June 2026 Board sign off of Annual Report and Accounts Q1 2026/27
Levy review of NHS adult gender dysphoria clinics in England: - Tavistock and Portman GIC individual Clinic Summary Report - NHSE response	National report published in December 2026. T&P summary report received in March and factual accuracy returned. Requirement to share the report and action plan at Board in Public – likely to be NLFT Board in May. Action plan is being drafted (Emma Casey) and many of the actions are completed or underway NHSE response is expected	Chief Medical Officer	Reports will be managed through TPFT Care Group and track through NLFT process as appropriate – EMC, QSC and Board Visibility to NLFT Board and follow up	Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Gender Surgery Referrals	NHSE has supported backdated referrals for the patient group with GIC surgical errors following a thorough Patient Safety Incident Investigation which has identified a number of actions to support improved governance, process and insight to mitigate further issues.	Chief Nursing Officer	Actions to be monitored by TPFT Care Group and track through NLFT process as appropriate	BAU reporting from Q1.
Gender Identity Clinic	GIC is no longer in targeted support and has moved to focus on the national quality improvement aims. The waiting list has increased to 17,120 patients as of December 2025, with 101 new patients in December 2025 seen monthly with 231 referrals received.	TBC Chief Medical Officer	Reporting through NLFT Integrated Performance Report: EMC, QSC and the Board	BAU reporting from Q1.
Internal review of national inquiries	This relates to TPFT's action plan arising from its own 2024 internal review in response to national learning reviews (Independent Review of Greater Manchester Mental Health NHS Foundation Trust, Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust, The Thirlwall Inquiry). Four actions remain open relating to risk assessments/crisis plans, developing local SOPs for discharge processes, adult	Chief Nursing Officer	Closed down actions have been circulated to NLFT Committee Chair To be monitored by TPFT Care Group and track through NLFT process as appropriate Propose to connect with NLFT Mark Pritchard who led NLFT response on assertive outreach	In accordance with action plan

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	services – early & proactive discussions with family and carers, and clinical risk assessment policy			
Highlights of Q&S business				
GP Shared Care Agreement	Patients and clinicians report that GPs are often reluctant to prescribe medication, including hormones, and monitor bloods as part of their shared care arrangement. T&P have also received letters from GPs and ICBs refusing to prescribe. ICB formulary also has a role to play in red-flagging drugs. This is a national issue for GIC services (where prescribing is not funded within the current GP contract) and is a local issue in prescribing across T&P services. The matter has been escalated to NHSE for GIC services and has been discussed with NLFT Chief Pharmacist at workstream level. The issue may result in patient harm, poor patient experience and care, delays in treatment, an increase in patient complaints, reputational damage to the Trust, and increased stress for staff. Quantum is estimated quantum is c30 cases in the last quarter.	Chief Medical Officer	Risk to added to the corporate register in time for TPFT Board TPFT CMO to raise with NLFT CMO. Continued discussion with NLFT Chief Pharmacist at workstream level.	March 2026/Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Adult Trauma targeted support	Targeted support continues as the Adult Trauma waiting list continues to grow with 300 patients waiting more than 104 weeks for their first appointment. The Adult Trauma Team's overall job plan compliance was 40% at month 9.	TBC Chief Operating Officer	Reporting through NLFT Integrated Performance Report: EMC, QSC and the Board	BAU reporting from Q1.
Violence and Aggression and Restrictive practice at Gloucester House	QI project initiated to address rise in restrictive practice in November 2025. This includes estates issues. QSC supported closure of GH Improvement Plan and Delivery Group (action plan completed). Gloucester House issues outside the domain of QSC include the sale of the building and lease.	Chief Nursing Officer	Discussions in hand at workstream level to learn from NLFT work on restrictive practice. NLFT Executive Management Committee is working through governance arrangements to be put in place for Gloucester House. The group will report into NLFT's Operational Management Group, a sub-group of EMC. NLFT QSC and ARC to provide ongoing scrutiny including: •Oversight of compliance with Independent School Standards •Scrutiny of Ofsted inspection outcomes and action plans •Safeguarding reporting from the school •SEND compliance •Curriculum quality	BAU reporting from Q1.
PSIRF Incident Reporting	TPFT reviewed PSIRF implementation in June 2025. Recommendations have been implemented and readiness to	Chief Nursing Officer	TPFT historic data to be shared for context.	BAU from Q1

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	sustain PSIRF practices during organisational transition.		To track through NLFT processes: TPFT Care Group, EMC and QSC as appropriate	
CQC improvement group	This is a sub-group of TPFT QSC and there is one open action re-fire warden process aspect of the following recommendation: The trust should complete its work to ensure health and safety issues including fire safety are addressed across the trust sites. The trust should ensure fire safety of the environment and quality assurance processes such as fire drills are completed as per trust policy.	Chief Finance and Investment Officer	This has been escalated to TPFT's SRO for Health and Safety. The fire drills' requirement relates to Tavistock Centre – the other sites are reported to be compliant.	BAU reporting/ closedown from Q1
Clinical Incident & Safety Group	Final sub-group meeting held in March, including update on outstanding mortality reviews	Chief Nursing Officer	To track through NLFT processes: TPFT Care Group, EMC and QSC as appropriate	BAU from Q1
Points raised in the meeting	Work required to align NLFT use of Mazars classification and TPFT's in-house mortality screening tool. Assurance provided that TPFT CMO and NLFT (Koye Odutoye) have connected on Medical Appraisal Validation. Assurance provided that there are no MHPS cases outstanding at TPFT.	Chief Medical Officer	BAU post merger No action required No action required	Q1 onwards

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	There is one high-risk inquest case on which NLFT's CMO will be briefed.		TPFT CMO to brief NLFT CMO	March 2026

QUALITY & SAFETY COMMITTEE – ANNUAL REPORT 2025–26

1. Introduction

This Annual Report provides the Board with a comprehensive overview of the work of the Quality & Safety Committee (QSC) during the period April 2025 – December 2025, in line with its remit to provide assurance on the quality and safety of clinical services, the effectiveness of clinical governance, patient experience, compliance with regulatory requirements, and oversight of key quality risks. The report summarises the Committee's activities, thematic areas of scrutiny, the assurances received, risks escalated, and areas identified for continued focus.

The Committee reviewed a wide range of reports relating to clinical quality, patient safety, safeguarding, clinical audit, complaints, quality improvement, risk management, and regulatory readiness across five formal meetings held during the year.

2. Committee Membership and Attendance

Members: Claire Johnston (Chair NED), Clare Scott (Joint Executive Lead), Chris Abbott (until October 2025), Liz Searle and Sheva Habel (from November 2025), Janusz Jankoski (NED) (until November 2025) and Sabrina Phillips (NED from September 2025)

Attendance from Executive leads for Nursing, Medical, Therapies/Clinical Governance, and Quality ensured full triangulation of clinical assurance. The Committee also benefited from consistent engagement from Patient Safety Partners, contributing valuable challenge and service-user-centred perspectives across the year. There was regular attendance from the Director of Corporate Governance.

During the year continuity was retained with a number of attendees becoming members of the Committee across the year.

Attendance was sufficient to maintain quoracy at all meetings.

Committee Secretary: Asma Bi

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3. Meetings and Coverage

Meetings were held in:

- April 2025
- June 2025
- August 2025
- October 2025
- December 2025

Across these, the Committee discharged all responsibilities set out in the Schedule of Business for 2025–26, receiving reports on:

- Integrated Quality & Performance Reporting (IQPR)
- Quality and Safety Reports
- Learning from Deaths

- Complaints and Patient Experience
- Safeguarding
- Infection Prevention & Control (IPC)
- Clinical Audit & Effectiveness
- PSIRF implementation
- Risk (Board Assurance Framework and Corporate Risk Register)
- CQC Preparedness
- Quality Priorities and Quality Accounts
- Quality improvement plans

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4. Work of the Committee in 2025–26

4.1 Quality & Performance Assurance

Integrated Quality Performance Report (IQPR)

The Committee received regular thematic analysis through the IQPR. Key areas of focus included:

- Variable performance against outcome measures, with significant improvements in later months driven by strengthened clinical ownership and reporting.
- Ongoing work to improve patient engagement through Friends and Family Test / Experience of Service Questionnaire (ESQ), with early gains and shifts in culture noted across several services.
- Improved reporting on Patient Carer Race Equality Framework data, enabling better insight into ethnicity-related experience and outcomes.
- The Committee observed a positive trend in outcome measure completion, a stronger approach to unit-level data visibility, and improvements in mandatory training compliance.

Patient Experience & Involvement

Recurring themes in feedback included communication, access to services and timeliness of information. The Committee welcomed:

- Strong improvements in ESQ returns during Q2/Q3, despite seasonal variation.
- Strengthened governance structures, with Patient and People Involvement (PPI) reporting routinely to Service User Experience Group (SUEG) and the Committee.
- Successful learning events with high levels of engagement from service users, particularly from the GIC patient community.

The Committee recognised a maturing culture in which patient voice increasingly informs local governance and improvement work.

Complaints Management

The Committee monitored a substantial programme of improvement across the year:

- Early backlogs were significantly reduced.
- The quality and timeliness of responses improved following structured training.
- Fluctuating volumes in the Adult Unit remained under close scrutiny.
- Changes to internal structures and the move to a unified Complaints and Enquiries (PALS) Team were noted as contributing to greater consistency, alongside collaborative working with the PPI team.

Incidents and PSIRF

The Committee reviewed incident data at all meetings, noting:

- Incident volumes generally remained within statistical control.
- A steep rise in restrictive interventions in Gloucester House was scrutinised, with targeted actions put in place (audit, observational work, training, estates review, safety processes).
- Patient Safety Incident Response Framework (PSIRF) implementation matured, with improved learning pathways and more accessible formats for staff.
- New learning poster formats improved dissemination of themes and learning.

Learning from Deaths

The Committee reviewed Learning from Deaths reports and noted key issues including:

- High proportion of deaths are among Gender Identity Clinic (GIC) patients and a majority of known deaths are physical-health related.
- Lack of adequate screening has now been addressed by referral screening for all new patients to ensure early clinical oversight.
- Clarify referral pathways.
- The importance of learning from mortality reviews, through GIC learning events and national learning and research.

Quality Improvement

The Committee welcomed a strengthening QI culture across the Trust:

- Significant increase in QI project activity
- New QI dashboard
- Transition planning towards NLFT's IHI model
- Strong QI leadership from clinical teams, especially in outcomes-led work.

The Committee affirmed that QI remained a vital driver for cultural and operational improvement.

4.2 Clinical Services Oversight

Gender Identity Clinic (GIC)

The Committee engaged extensively with the GIC services which was placed in targeted support, due to several significant issues:

- Significant referral backlogs and national performance pressures
- Issues relating to surgical hub referral failures, leading to a comprehensive review, Duty of Candour, full case audit, and NHSE support, ensuring original referral dates were honoured for affected patients.
- DrDoctor implementation to support digital triage, improved communication and pathway automation.
- Performance remained an area of intense scrutiny, with ongoing national oversight and structural change anticipated.

Adult Trauma Service

The Committee oversaw a major period of improvement:

- Transition from targeted support to a QI framework, reflecting improved triage, clearer referral criteria, reduced non-commissioned activity, better pathway clarity and month-on-month waiting list reductions.
- However, sustainability risks were noted due to significant dependency on Elective Recovery Fund (ERF)-funded posts.

The Committee recognises that the service had made meaningful progress, supported by strong clinical leadership.

Gloucester House

Significant improvements were noted across the year in response to the improvement plan which followed the Gloucester House Review in 2024:

- Substantial progress against 61 improvement recommendations (89% completed).
- Strong leadership, improved morale, and successful Ofsted outcome (“Good”).
- Financial pressures continue, and pupil numbers remain below the breakeven point (16 pupils at October 2025).
- Continued concerns around restrictive interventions and environmental constraints remained under review.
- A relocation project was underway with revised timelines.

4.3 Regulatory and Compliance

CQC Preparedness

The Committee reviewed a revised self-assessment and oversight process covering:

- Corporate-led quality reviews
- Unit self-assessments

- Progress against three open recommendations (Lone Working, Fire Orders/Estates compliance, Crisis Planning policy)
- Progress was broadly positive, with most actions on track for completion by early 2026.

Safeguarding

The Committee received the Annual Safeguarding Report, acknowledging:

- Comprehensive work across adult and children's safeguarding
- High quality assurance and improvements
- Need for sustained focus on L3 training compliance

Infection Prevention & Control (IPC)

Key findings included:

- Significant improvements in BAF compliance (increase in fully compliant areas from 10 to 19).
- Good progress with audit tools and estate-related mitigations.
- Outstanding actions relating to food hygiene and training were escalated for follow-up.

Clinical Audit

The Committee oversaw the refresh of the Clinical Audit Plan, noting:

- Re-establishment of Clinical Audit and Effectiveness Group (CAEG)
- Strengthening of links between audit and QI
- Work underway to improve NICE compliance

Audit was identified as an area needing continued investment and cultural embedding.

4.4 Risk Management

The Committee routinely reviewed:

- **BAF Risks 1 and 2**: persistent high risks relating to inequality of access (rated 16) and failure to provide consistent high-quality care (15)
- **BAF Risk 13**: Failure to achieve required productivity & performance (in relation to key services including GIC and Trauma Services) (rated 12) (overseen by Performance, Finance and Resources Committee)

The Committee supported proposals to strengthen BAF reporting, including a quarterly projected risk tracker. Additional risks identified during the year included:

- GP Shared Care Agreement issues for GIC patients
- Risks emerging from surgical hub referral failures

The Committee noted improvements in the corporate risk register and emphasised need for ongoing maturity.

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5. Governance

5.1 Terms of Reference Review

The Committee approved the QSC ToR for 2025/26 and updated membership.

5.2 Committee Effectiveness

The annual self-assessment confirmed:

- Continued maturation of Committee function
- Stronger administration and timeliness of papers
- More effective NED challenge
- Clear improvements in quality of reports
- Need to ensure manageable agendas, improved scrutiny, and better alignment of assurance group reporting

Members also noted the importance of ensuring staff maintain motivation amid financial and system pressures.

5.3. Groups Reporting to the Committee

- Integrated Safeguarding Group (Adult/Children)
- Clinical Incident and Safety Group (including Mortality Review)
- CQC Improvement Group
- Service User Experience Group
- Clinical Audit and Effectiveness Group
- Patient and Carer Race Equality Framework Steering Group (short life group)
- The Local Risk Management System Board also reported into the Committee for a time limited period. This was the group responsible for the implementation of Radar.

5.4. Escalations to the Board

Across the year, the Committee escalated:

- GIC surgical hub issues and patient safety risks
- Trauma service progress and remaining challenges
- Complaints improvement trajectory
- Safeguarding and IPC successes
- Risk management developments and new/emerging risks
- Gloucester House progress and vulnerabilities
- CQC preparedness

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6. Conclusion

The Committee concludes that significant progress has been made across multiple quality domains during 2025–26, with clear evidence of strengthened governance, improved learning systems, and increasing staff engagement. While notable challenges remain—particularly relating to GIC demand and capacity, complaints response times consistency, restrictive interventions in Gloucester House, and the ongoing alignment work required for merger readiness—the Committee is assured that robust plans are in place.

The QSC recommends continued Board focus on:

- Nationally influenced risks (GIC performance, shared care agreements)
- Regulatory preparedness
- Embedding of QI and audit culture
- Sustaining improvements ahead of organisational transition in 2026

The Committee commends the dedication of staff across clinical and corporate areas and expresses gratitude to all contributors for their work over the year.

February 2026

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Education and Training Committee Handover			**Agenda No: 014**
Report Author and Job Title:	Magda North, Assistant Director of Corporate Governance	**Lead Executive Director:**	Mark Freestone, Chief Education and Training Officer
Appendices:	Appendix 1: ETC Handover business Appendix 2: ETC Annual report 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	Subject to final approvals, the Trust will merge through acquisition by North London NHS Foundation Trust (NLFT) on 1 April 2026. This paper sets out the final Education and Training Committee handover that will be passed to NLFT.		
Background:	Following the final ordinary meeting of the Committee, a formal handover meeting was held on 17 March 2026. The handover documents will ensure that NLFT's new Education and Research Committee can be appropriately established and take account of risks, issues and work outstanding.		
Assessment:	The Board is asked to note • The continuity provided by the NED Chair and Chief Education and Training Officer • The explicit focus on the handover by Committee members and attendees at the last ordinary meeting of the Committee. This included closing matters arising of the Committee. • Existing discussions at merger work stream level and Transitional Executive which have already socialised at management level many of the items raised in the handover. This is supported by a merger risk register. • The drafting of Terms of Reference for NLFT's Committee structure from 1 April with a view to managing the business of the enlarged Trust. There is a strong across from TPFT's ToR to NLFT's new Education and Research Committee. • The development of Committee workplans 2026/27 to reflect the business of the enlarged Trust and to build in items to understand the work of TPFT.		
Key recommendation(s):	The Board is asked to take **ASSURANCE** on the Education and Training Committee Handover.		

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 ☐		
	The BAF and corporate risk register are relevant to this paper in setting out the strategic risks of the Trust.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The merger by acquisition of TPFT by NLFT is planned on 1 April 2026.				
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	None identified.				
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:	Education and Training Committee				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Appendix 1: Education and Training Committee Handover Business – confirmed with minor update on 17 March 2026

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Governance				
Office for Students Registration and UKVI	This relates to NLFT registration with OfS as a Higher Education provider. In addition, TPFT UKVI sponsor licence lapses on dissolution (31 March 2026) and NLFT does not yet hold a sponsor licence – this will impact 44 students.	Chief Education and Training Officer	The risk is on the BAF (BAF risk 3) and the merger risk register. Progress is being tracked through the Transitional Executive.	April 2026/27
NLFT's Education and Research Committee	New NLFT Committee needs to be properly constituted with membership, terms of reference, dates and workplan	Director of Corporate Governance	NLFT Terms of Reference for Committees to be approved at its Board on 24 March 2026 NLFT Trust Chair and Director of Corporate Governance to agree membership across committees of the enlarged Trust. Meeting dates are proposed: 18 June 22 October,17 December and 18 February	By April 2026
Board Assurance Framework	The ETC BAF risks were confirmed at the meeting on 25 February 2026 QSC meeting, and will progress to TPFT's Board in March.	Director of Corporate Governance	**TPFT BAF and NLFT Board Assurance Framework** to be reviewed at NLFT Board workshop in May 2026 to design 2026/2027 BAF for enlarged Trust. The BAF will then progress through relevant	Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
			committees onto the Board in the usual way.	
Internal audit: student experience	Partial-rated internal audit. Two high and four medium actions to be completed. Overall TPFT internal audit plan 2025/26 will form TPFT Head of Internal Audit Opinion	Director of Corporate Governance (SRO for internal audit)	To track through NLFT processes: TPFT Care Group, EMC, and ARC Closedown of TPFT internal audit plan 2025/26 and actions to route through NLFT ARC	June 2026 Board sign off of Annual Report and Accounts Q1 2026/27
Highlights of ETC business				
TPFT's Education and Research portfolio	The importance of fostering TPFT's creative and strategic heritage in education and research within the NHS as part of NLFT.	Chief Education and Training Officer Chief Medical Officer	Through NLFT's Education and Research Committee	BAU from Q1
DET Sustainability	This is the proposed work to develop options to address the financial sustainability of TPFT's Education and Training activity.	Chief Education and Training Officer	The risk is on the BAF (BAF risk 16) and is being progressed in discussion with NLFT's Executive Management Committee.	BAU from Q1
Associate Lecturers	This relates to contract arrangements for Associate Lecturers. It has since been agreed by NLFT that Associate Lecturers will transfer to NLFT from 1 April.	Chief Education and Training Officer / Chief People Officer	Arrangements for Associate Lecturers transferring to NLFT to be managed from 1 April.	BAU from Q1
Charity funded EDI Bursaries For Students	For several years, the Trust has offered a bursary to attract applicants from underrepresented groups onto courses. For the past three years, the Tavistock and Portman Charity has provided	Chief Education and Training Officer	To note the support of Education and Training Committee to the ongoing work of the Charity and DET to continue offering bursaries.	BAU from Q1

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	funds for the bursary programme and has engaged fundraising support in pursuing this.		This will be progressed through NLFT's Education and Research Committee	
Student Support and Reasonable Adjustments	The Student Support Team is now managing 409 students (25% over recent months) requiring disability support and reasonable adjustments. Of these, 100 students are not eligible for Disabled Students' Allowances and require Trust-funded provisions. A range of issues are relevant to addressing reasonable adjustments including accessing materials, inclusive teaching and estates issues.	Chief Education and Training Officer Chief Finance and Investment Officer (estates issues)	Managed through NLFT processes: TPFT Care Group, NLFT's estates activity and EMC as appropriate	BAU from Q1

EDUCATION & TRAINING COMMITTEE — ANNUAL REPORT

Reporting Year: 2025–26

Chair: Sal Jarvis (NED)

Members: Janusz Jankowski (NED), Mark Freestone (Chief Education & Training Officer, "CETO")

Regular Attendees: Paul Dugmore (Director of Education, Learning & Teaching), Elisa Reyes-Simpson (Director of Education, Governance & Quality), Ravteg Singh-Dhesi (Director of Education, Operations), Bhavna Tailor (Senior Finance Business Partner), Michael Holland (Chief Executive, by exception), Dorothy Otite (Interim Director of Corporate Governance to Nov 2025), Magda North (Assistant Director of Corporate Governance, North London NHS Foundation Trust (NLFT) - providing interim service to T&P)

Committee Secretary: Asma Bi

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1. Introduction

The Education & Training Committee (ETC) is a formal sub-committee of the Board, providing strategic oversight and assurance across the Trust's higher education and training portfolio, including academic governance, quality and student experience; financial and performance oversight for DET; and risk management related to education and training. The Committee's remit, as reflected in its annual Schedule of Business, encompasses scrutiny of the Board Assurance Framework (education-related risks), oversight of Department for Education and Training (DET) strategy and performance, and assurance from sub-groups (Academic Governance & Quality Assurance Group; Learning & Teaching Group; Student Experience Group).

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2. Membership and Attendance

Membership comprised two Non-Executive Directors and the CETO, supported by senior DET leaders and corporate governance/finance colleagues. Throughout the cycle, attendance ensured quoracy. There were changes in governance support during the year as Dorothy Otite departed (Nov 2025) and Magda North (NLFT) commenced interim support pre-merger. Governor and Student Governor observers attended regularly.

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3. Meetings, Coverage and Declarations

The Committee met in line with its **ETC Schedule of Business 2025–26**, with meetings on **8 May 2025**, **1 July 2025**, **3 September 2025**, **13 November 2025**, and **8 January 2026**. Declarations noted included Magda North's role with NLFT while providing interim support to T&P.

Minutes reviewed:

- **8 May 2025 (Confirmed)**
- **1 July 2025 (Confirmed)**

- **3 September 2025 (Confirmed)**
- **13 November 2025 (Confirmed)**
- **8 January 2026 (Unconfirmed)**

Declarations: Magda North declared current NLFT role while supporting T&P (Jan 2026).

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4. Strategy & Major Programmes

4.1 Merger/Office for Students (OfS) Registration

ETC received periodic updates on the merger programme and the pathway to OfS registration for NLFT following acquisition. Operational issues with the OfS portal were noted, but no delay was anticipated at that time. The Committee requested continued briefings to NLFT and the Board.

4.2 DET Vision and Strategic Options

Across Nov 2025–Jan 2026, ETC scrutinised options to secure DET's sustainability, including:

- **Course portfolio rationalisation** and redeployment to growth areas (e.g., trauma, nursing, leadership/Chartered Management Institute-accredited offerings, forensic programmes).
- **International growth**, with China identified as the largest opportunity (significant incremental income if allocations are increased and filled).
- **Operating model changes**, exploring efficiencies via partner-provided student support/admissions (subject to contractual terms), digitisation (e.g., Customer Relationship Management software), and potential structural options (e.g., wholly owned subsidiary) to reduce regulatory friction and better enable scholarship. The Committee agreed the work was urgent, requested robust financial modelling, and sought a final options appraisal, noting alignment with NHS England and merger timelines.

4.3 National Training Contract (NTC)

ETC tracked deterioration and dispute events regarding the NTC, including the end of the 2023/24 framework, the 2024/25 extension, and governance findings within NHSE processes. Preferred mitigations included deeper Higher Education partnerships, a maximalist approach to 2026/27 fee uplifts (with equity exceptions), maximising overseas recruitment and short-course income, and securing a longer-term validating/operational partner. The dispute discussions considered repayment mechanics and in-year financial impacts. Items were escalated to the Board/Performance, Finance and Resources Committee as appropriate.

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5. Academic Governance, Quality & Student Experience

ETC received **assurance reports** from sub-groups and considered targeted deep-dives:

- **Academic Governance & Quality Assurance Group (AGQAG):** periodic reviews (e.g., M4) and policy updates (assessment/marking; extension arrangements).

- **Learning & Teaching Group:** Continuing Professional Development (disability-inclusive teaching), digital skills modules, and a proposed artificial intelligence online event (Jan 2026).
- **Student Experience Group:** participation incentives; estates/information management and technology attendance to address accessibility adjustments; Terms of Reference updates to ensure the right membership.

Internal Audit — Student Experience: ETC noted **Partial Assurance**, with good overall experience but systemic/process weaknesses requiring continued action and integration into merger planning.

Student Surveys & Cases: The Committee reviewed a full comparative analysis (overall satisfaction 81%, with gaps for disabled, overseas and Asian students in community/organisation domains) and the first consolidated **Student Cases** report; actions included staff continuing professional development on inclusive practice and website/communications improvements to clarify complaints/appeals.

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6. Performance & Finance (DET)

ETC oversaw DET's Integrated Performance Report throughout the cycle, focusing on income pipeline, cost pressures, and efficiency programme delivery:

- **Income & CIP:** Month 8 position showed c. **£2.1m** below plan, primarily NTC shortfall (£1.7m) and short-course income (£0.4m). **46%** of the annual efficiency programme achieved to date, largely non-recurrent; recurrent plans for 26/27 being developed. Short-course run-rate expected to improve but still below plan by year-end (approx. £450k).
- **Pay/Non-pay:** Reclassification of Associate Lecturer costs from non-pay to pay impacted reported variances; recruitment to Associate Lecturer roles for the new academic year commenced.
- **Recruitment outcomes:** 2025/26 cycle yielded **701** new postgraduate students (vs 640 in 2024/25), with **687** new enrolments and **763** re-enrolments; earlier opening, targeted marketing and close late-cycle management supported uplift.
- **Operational levers:** Portfolio-specific updates (e.g., Interprofessional Portfolio's Chartered Management Institute accreditation path; digital/short-course commissioning; psychoanalytic portfolio workforce moves) were reviewed for growth potential and risk.

Committee assurance: Across meetings, ETC often concluded **Substantial assurance on data quality** and **Limited assurance on meeting budget targets**, reflecting external uncertainties (e.g., NTC) and internal transformation in-flight.

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7. Risk Management: Board Assurance Framework (BAF) & Corporate Risks

Risk oversight was a standing item each meeting, with particular attention to:

- **Risk 3** (OfS registration/validation): met target score per corporate assessment; ETC did **not** support closure pending merger assurance, seeking Programme Board review and Board discussion.

- **Risk 4** (Regulation/Compliance & education risks) and **Risk 16** (Non-viability of DET in current form): alignment/merger of risks requested given intertwined sustainability themes; risk appetite to be reviewed.
- **Emerging/operational risks:** National Training Contracts (timely), student retention trends, system constraints (SITS Student Record System/Customer Relationship Management software), estates accessibility barriers, and Research England research degree programme supervision funding eligibility.

The Committee consistently used the BAF to drive mitigations (e.g., marketing in Risk 4; alignment of merger risks; clear escalation to the Performance, Finance and Resources Committee/Board on estates-related adjustments and OfS correspondence).

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8. Governance & Policy Oversight

- **Terms of Reference (ETC):** revised and **approved/recommended to Board** (Sept 2025); subsequent confirmation recorded.
- **Sub-group Terms of Reference:** Learning & Teaching Group and Student Experience Group Terms of Reference approved (Jan 2026); Academic Governance & Quality Assurance Group Terms of Reference scheduled for next meeting.
- **Code of Practice: Freedom of Speech:** benchmarking with University of Essex; **approved by ETC** (subject to minor amendments) and recommended to the Board.
- **Honorary Doctorates:** nominations reviewed; one approval to progress; subsequently approved by the Board.

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9. Committee Effectiveness

The Committee completed its **annual self-assessment**, identifying improvements in strategic focus, agenda streamlining, and report quality. Members emphasised constructive challenge, annual strategic events, and clearer criteria for assurance gradings across meetings. The **ETC Schedule of Business 2025–26** supported complete coverage and cadence with bi-monthly duty items and periodic deep-dives.

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10. Key Themes & Learning

Across 2025–26 the Committee observed cross-cutting themes:

- **Securing DET sustainability:** portfolio focus on high-demand courses (e.g., M58/M7/M16), fee strategy, and international growth (notably China), underpinned by robust financial modelling.
- **Strengthening the operating model:** digitisation (Customer Relationship Management Software), potential partner-delivered services (admissions/support), and structural options to reduce regulatory friction and enable scholarship.
- **Improving student experience and inclusion:** targeted continuing professional development for staff; addressing estates accessibility; clearer complaints/appeals pathways; closing satisfaction and attainment gaps (especially disabled and overseas cohorts).

- **Risk integration and escalation discipline:** proactive use of the BAF; merging overlapping risks; timely escalations on OfS sector letters and NTC impacts.
- **Assurance maturity:** consistent articulation of **substantial vs limited** assurance on finance/performance; using deep-dives (e.g., student retention) to target interventions.

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11. Conclusion

In a challenging external context and amid organisational transition toward merger, the ETC **discharged its responsibilities effectively**, providing scrutiny and direction across strategy, academic governance, student experience, risk, and finance for DET. The Committee's oversight supported improved recruitment outcomes, clearer risk articulation (particularly on DET viability and OfS matters), advances in inclusive education practice, and a structured pathway to decisions on DET's future model. Continued focus is required on financial modelling, execution of the portfolio strategy (including international growth), recurrent efficiency programme delivery, estates accessibility, and maintaining assurance through the merger.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Staff Survey Results and Action Plan			**Agenda No.: 015**
Report Author and Job Title:	Kasia Parfenyuk, Deputy Chief People Officer	**Lead Executive Director:**	Kate Bowditch, Acting Chief People Officer
Appendices:	Appendix 1 – Staff Survey 2025 Scores		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report sets out a summary of the key results of the 2025 Staff Survey. As the organisation progresses towards the merger, the survey findings have been shared with NLFT who will provide strategic direction for future action planning to address key themes identified through the survey.		
Background:	The initial embargoed results were received in December 2025, with the national publication of results taking place in March 2026. While participation has reduced marginally compared with the 2024 survey, the response rate continues to provide a meaningful level of feedback to inform organisational learning and improvement.		
Assessment:	The results have shown improvement in seven out of nine survey areas, including staff engagement.		
Key recommendation(s):	The Trust Board is asked to: • Consider the information contained within this report.		
Implications:			
Strategic Ambitions:			
☐ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☐ Improving value, productivity, financial and environmental sustainability
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☐	Caring ☒	Responsive ☐	Well-led ☐
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: Risk 6 – Lack of Workforce Development, Retention & Recruitment Risk 7 – Lack of a Fair and Inclusive Culture Risk 8 – Lack of Management Capability and Capacity				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	The NHS staff survey is a nationally mandated workforce survey coordinated by NHS England and forms part of the NHS People Promise				

	and workforce improvement framework. It does not in itself create direct statutory obligations.			
Resource Implications:	Yes ☐		No ☒	
	There are no direct resource implications arising from this report. The staff survey is coordinated nationally, and the analysis presented reflects the results received through the national process.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	The staff survey provides important insight into the experiences of staff across different demographic groups and supports the organisation in monitoring and progressing its duties under the Equality Act 2010.			
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:				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Staff Survey Results and Action plan

1. Purpose of the report

1.1 The purpose of the report is to provide the Board with an overview of the Trust's performance against the national benchmark group for Mental Health and Learning disability organisations. The report highlights key strengths, areas requiring improvement, and proposed actions to support workforce experience.

2. Background

2.1. The 2025 Staff Survey provides insight into staff experience across nine key themes aligned with the NHS People Promise

2.2. The Trust's final response rate was 49% which was slightly below the average response rate for Mental Health trusts at 52% and slightly lower compared with the number of respondents from the 2024 staff survey.

2.3. We received the embargoed staff survey results at the end of December 2025, which were shared with Executive Leadership Team to review. The results were released nationally on 12 March 2026 along with the benchmark reports.

2.4. The responses were collected between September and November 2025. It has taken some time to share the results due to the national process.

2.5. Whilst the merger transition progresses, we will work together as a single trust to review the findings and develop shared action plans that support staff experience across the organisation.

3. Summary of key results

3.1 Overall performance shows gradual improvement in several themes over recent years, continued strengths in compassionate leadership, diversity and inclusion, and line management, and ongoing challenges relating to staff morale, workload pressures, and recognition. Across the nine headline themes, the Trust scored below the benchmark average, although most scores have improved incrementally since 2021.

3.2 Some of the key areas where we have seen improvement include:

- Staff reporting that they feel safer to speak up about concerns;
- Staff feel that the organisation takes action when concerns are raised;
- Staff believe the care provided to patients is a top priority.

3.3 We have also seen an improvement in staff reporting how valuable they find their appraisals in helping them set objectives and feel valued in their roles.

3.3 Staff with disabilities and long-term health conditions, as well as staff from a global majority background reporting a reduction in bullying, harassment and abuse from patients, service users and their relatives.

3.4 As we progress into the merged organisation there will be opportunities to work collectively to improve our organisational culture and continue to build on areas where we are showing improvement.

3.5 While there are some improvements, the results also highlight key areas that need to be addressed. These include:

- Staff reporting a reduction in opportunities to develop their career in the organisation;
- Staff having the access to the right learning and development opportunities
- A slight regression in the percentage of staff with protected characteristics experiencing harassment, bullying or abuse from staff.
- A reduction in staff morale, with an increase in the amount of staff thinking about leaving the organisation

4. Performance Against People Promise Themes

	Benchmark average	2024 Score	2025 Score	Change
Compassionate and Inclusive	7.61	7.34	7.45	↑
Recognised and Rewarded	6.37	6.18	6.15	↓
Voice That Counts	6.89	6.41	6.58	↑
Safe and Healthy	6.34	5.98	6.18	↓
Always Learning	5.83	5.29	5.26	↑
Work Flexibly	6.84	6.48	6.71	↑
We Are a Team	7.17	6.97	6.98	↑
Staff Engagement	7.02	6.65	6.8	↑
Morale	6.12	5.46	5.48	↑

5. Key Strengths

Compassionate and Inclusive Culture (Score: 7.45)
- Strong diversity and equality score of 8.23
- High levels of staff reporting that their work makes a difference to patients
- Positive perceptions of line management support

Team Working and Line Management
- Theme score: 6.98
- Strong scores for line management support and collaboration

Staff Engagement
- Increased from 6.65 in 2024 to 6.80 in 2025, indicating continued staff commitment.

6. Areas for Improvement

6.1 Staff Morale
- Morale score: 5.48 vs benchmark 6.12
- Work pressure score: 4.82

6.2 Learning and Development
- Theme score: 5.26 vs benchmark 5.83
- Appraisal score: 4.72

Although the score for appraisals is low for our benchmark group there is an improvement year on year with how valuable staff are finding the appraisals.

6.3 Recognition and Reward

- Theme score: 6.15
- Approximately 54% satisfied with recognition for good work
- Around 42% feel the organisation values their work.

9. Key Organisational Risks

- Workforce morale: risk of burnout and disengagement due to workload pressures.
- Development and progression: weakness in development processes.

10. Proposed Priority Actions for 2026

As part of the merger transition, the Trust results have been shared with NLFT. Future action planning will be developed within the framework of the people and OD strategy, which will provide the direction for addressing the key themes arising from the survey.

Over the coming weeks, senior leaders will be spending time in services and with teams to understand the results in more detail. What we hear will shape our shared priorities for action. We will then share these priorities clearly and keep staff updated on progress.

We remain committed to acting on what staff have told us and to building a workplace where all staff feel supported, valued, and able to do their best work.

In preparation for the next steps:

- Results have been shared with the Senior Leadership group and published on the staff intranet
- As part of the merger work there are existing workstreams reviewing systems and processes and ensuring improvement works are aligned.
- There is a project group set up with representation from both NLFT and T&P looking at designing and implementing a new appraisal process.
- Work has commenced on cultural alignment to improve staff engagement post-merger, with staff contributing to the behaviours framework and people and OD strategy.
- Our EDI teams are working closely together to identify key priorities post-merger and work has commenced to link our staff networks.

11. Recommendations

The Board is asked to:

- Note the results of the 2025 NHS Staff Survey.

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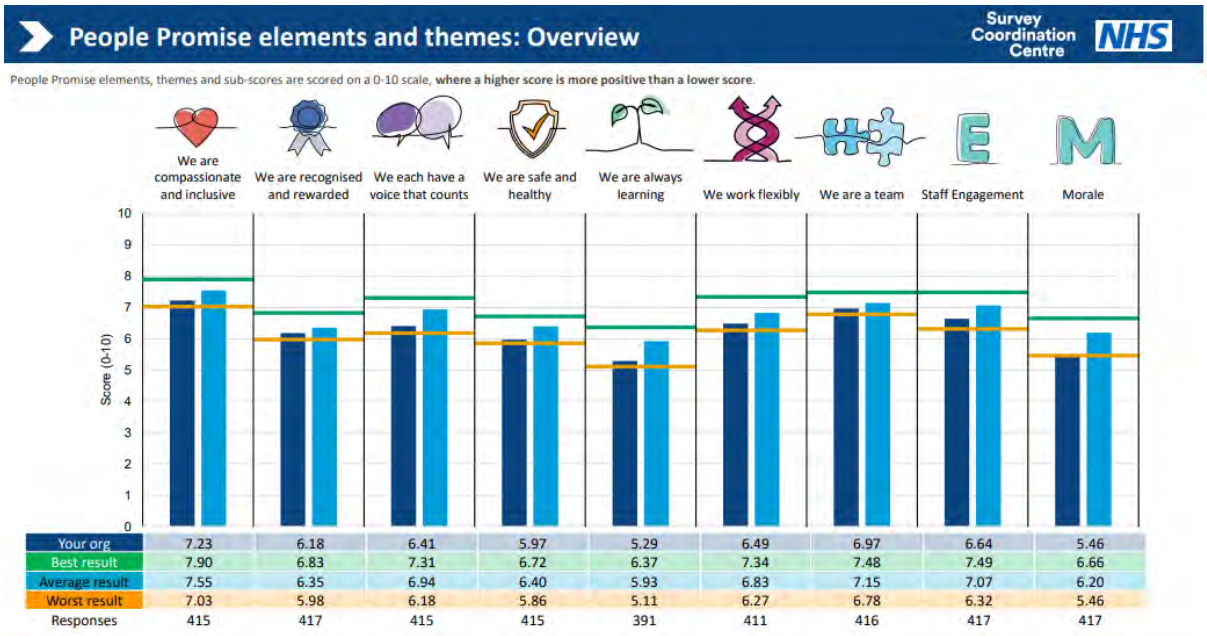
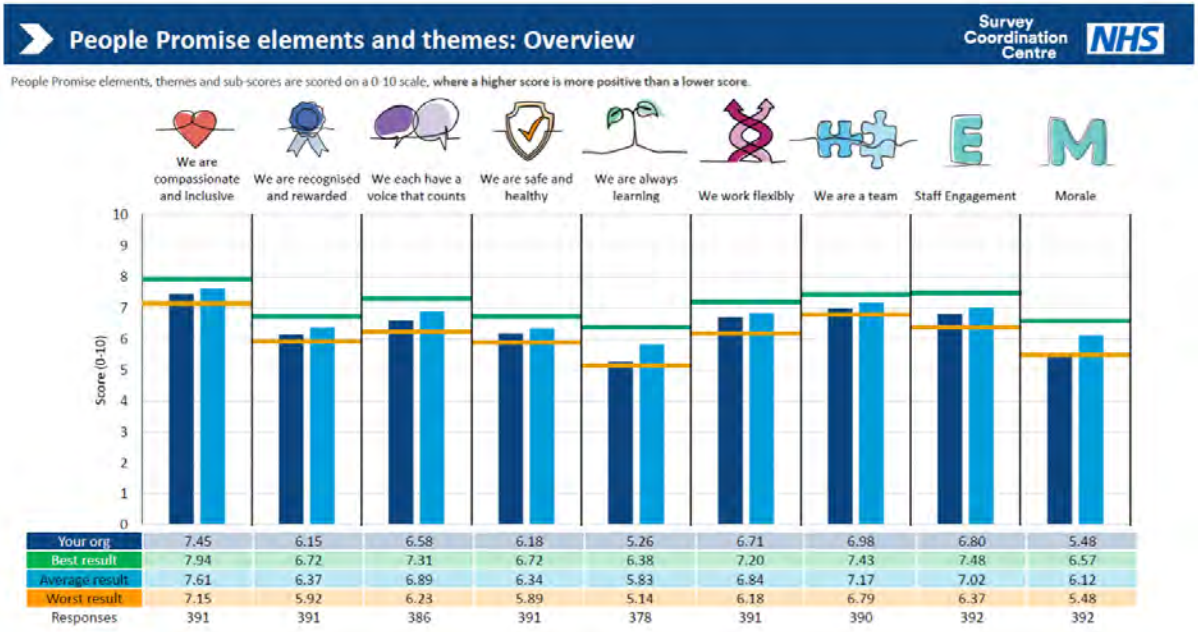
Appendix 1

Overview of People Promise scores 2024



Overview of People Promise scores 2025



Appendix 2

Significance Testing 2024 v 2025

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.34	415	7.45	391	Not significant
We are recognised and rewarded	6.18	417	6.15	391	Not significant
We each have a voice that counts	6.41	415	6.58	386	Not significant
We are safe and healthy	5.98	415	6.18	391	Not significant
We are always learning	5.29	391	5.26	378	Not significant
We work flexibly	6.48	411	6.71	391	Not significant
We are a team	6.97	416	6.98	390	Not significant
Themes					
Staff Engagement	6.65	417	6.80	392	Not significant
Morale	5.46	417	5.48	392	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

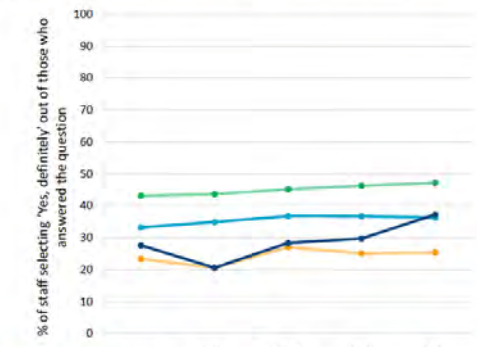
Appendix 3

We are always learning: Appraisals

People Promise elements and theme results – We are always learning: Appraisals

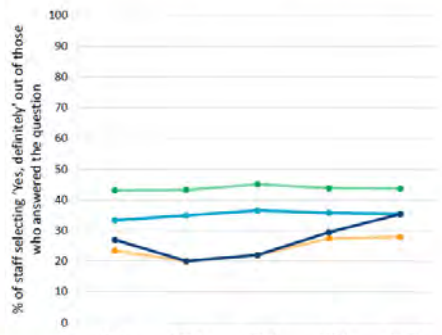
Survey Coordination Centre NHS

Q23c It helped me agree clear objectives for my work.



	2021	2022	2023	2024	2025
Your org	27.63%	20.59%	28.38%	29.78%	37.28%
Best result	43.14%	43.65%	45.14%	46.27%	47.20%
Average result	33.25%	34.97%	36.79%	36.75%	36.37%
Worst result	23.38%	20.59%	27.07%	25.15%	25.40%
Responses	349	207	348	317	306

Q23d It left me feeling that my work is valued by my organisation.



	2021	2022	2023	2024	2025
Your org	26.92%	19.99%	21.97%	29.38%	35.33%
Best result	43.03%	43.17%	44.98%	43.74%	43.58%
Average result	33.30%	34.89%	36.49%	35.74%	35.35%
Worst result	23.32%	19.99%	21.97%	27.36%	27.91%
Responses	349	207	348	318	306

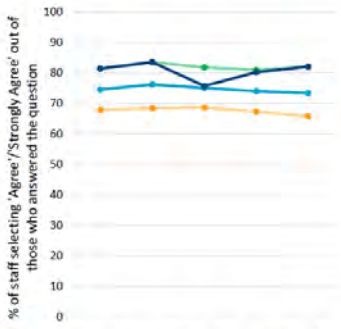
Tavistock and Portman NHS Foundation Trust Benchmark report

We are always learning: Development

People Promise elements and theme results – We are always learning: Development

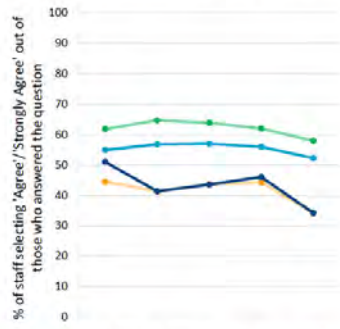
Survey Coordination Centre | NHS

Q24a This organisation offers me challenging work.



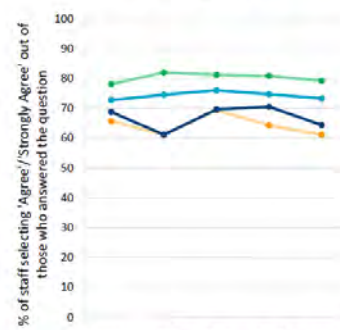
	2021	2022	2023	2024	2025
Your org	81.39%	83.53%	75.68%	80.23%	82.07%
Best result	81.39%	83.53%	81.82%	80.98%	82.07%
Average result	74.55%	76.19%	75.02%	74.00%	73.34%
Worst result	67.84%	68.43%	68.68%	67.32%	65.80%
Responses	410	334	435	414	391

Q24b There are opportunities for me to develop my career in this organisation.



	2021	2022	2023	2024	2025
Your org	50.90%	41.27%	43.49%	45.91%	34.21%
Best result	61.70%	64.61%	63.73%	61.91%	57.87%
Average result	54.83%	56.74%	56.91%	55.85%	52.16%
Worst result	44.41%	41.27%	43.49%	44.17%	34.21%
Responses	410	334	434	415	391

Q24c I have opportunities to improve my knowledge and skills.

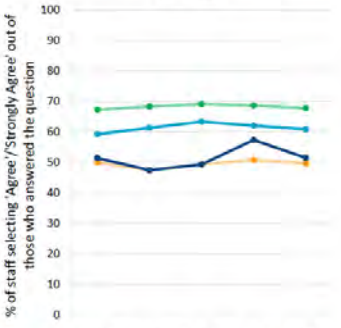


	2021	2022	2023	2024	2025
Your org	68.82%	61.17%	69.66%	70.55%	64.41%
Best result	78.11%	81.99%	81.25%	80.82%	79.21%
Average result	72.79%	74.60%	76.02%	74.73%	73.37%
Worst result	65.75%	61.17%	69.35%	64.33%	61.20%
Responses	410	334	435	415	390

People Promise elements and theme results – We are always learning: Development

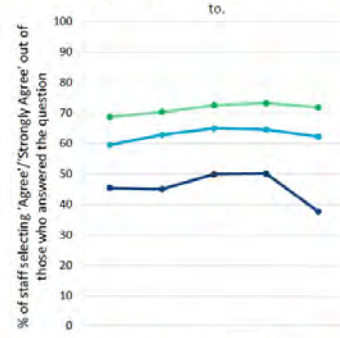
Survey Coordination Centre | NHS

Q24d I feel supported to develop my potential.



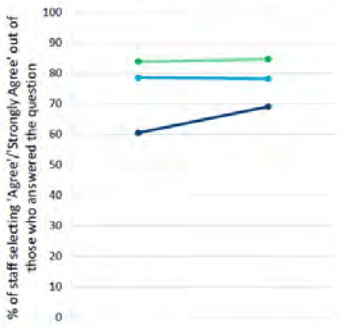
	2021	2022	2023	2024	2025
Your org	51.40%	47.41%	49.30%	57.34%	51.47%
Best result	67.30%	68.36%	69.14%	68.73%	67.75%
Average result	59.26%	61.36%	63.35%	62.07%	60.87%
Worst result	50.01%	47.41%	49.30%	50.81%	49.65%
Responses	410	333	435	415	390

Q24e I am able to access the right learning and development opportunities when I need to.



	2021	2022	2023	2024	2025
Your org	45.28%	44.90%	49.80%	50.01%	37.54%
Best result	68.61%	70.20%	72.42%	73.17%	71.73%
Average result	59.45%	62.73%	64.90%	64.46%	62.17%
Worst result	45.28%	44.90%	49.80%	50.01%	37.54%
Responses	410	333	434	414	390

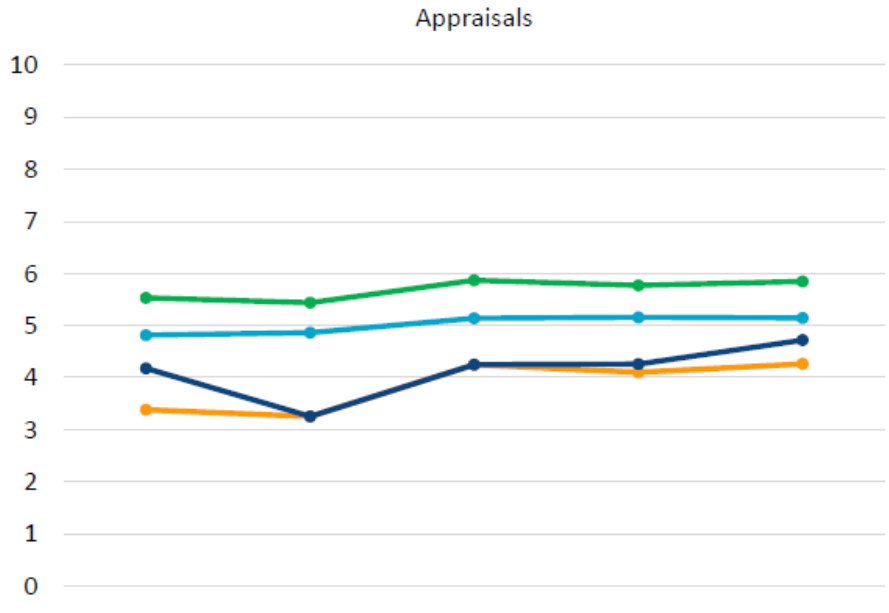
Q24f* I am able to access clinical supervision opportunities when I need to.



	2024	2025
Your org	60.41%	69.05%
Best result	83.80%	84.60%
Average result	78.50%	78.16%
Worst result	60.41%	69.05%
Responses	285	263

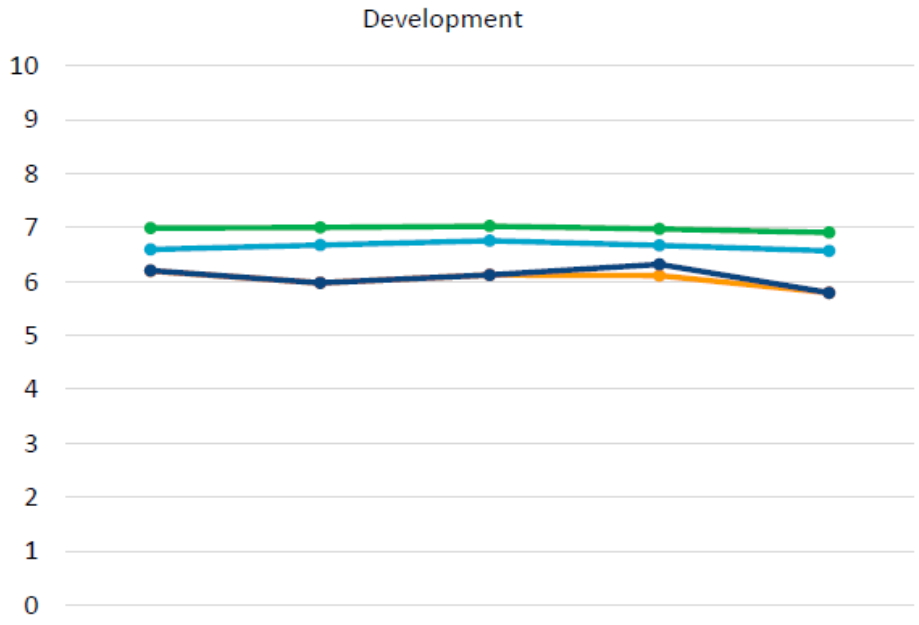
*Q24f was introduced in 2024 and does not currently contribute towards any People Promise element score, theme score or sub-score to protect trend data over five years.

Appraisals Score



	2021	2022	2023	2024	2025
Your org	4.18	3.25	4.25	4.26	4.72
Best result	5.53	5.44	5.87	5.77	5.85
Average result	4.81	4.86	5.14	5.16	5.14
Worst result	3.38	3.25	4.25	4.10	4.26
Responses	398	315	413	392	379

Development Score

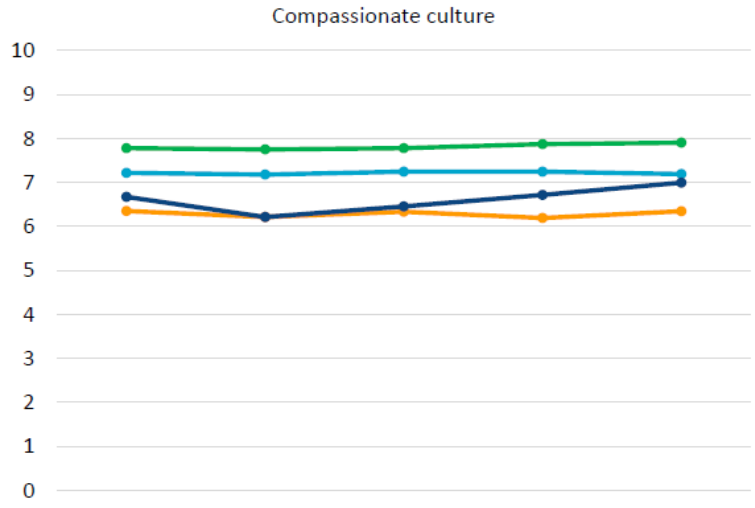


	2021	2022	2023	2024	2025
Your org	6.20	5.98	6.12	6.32	5.79
Best result	6.99	7.00	7.03	6.97	6.91
Average result	6.59	6.68	6.76	6.67	6.57
Worst result	6.19	5.98	6.12	6.11	5.79
Responses	410	334	435	415	391

Apprendix 4

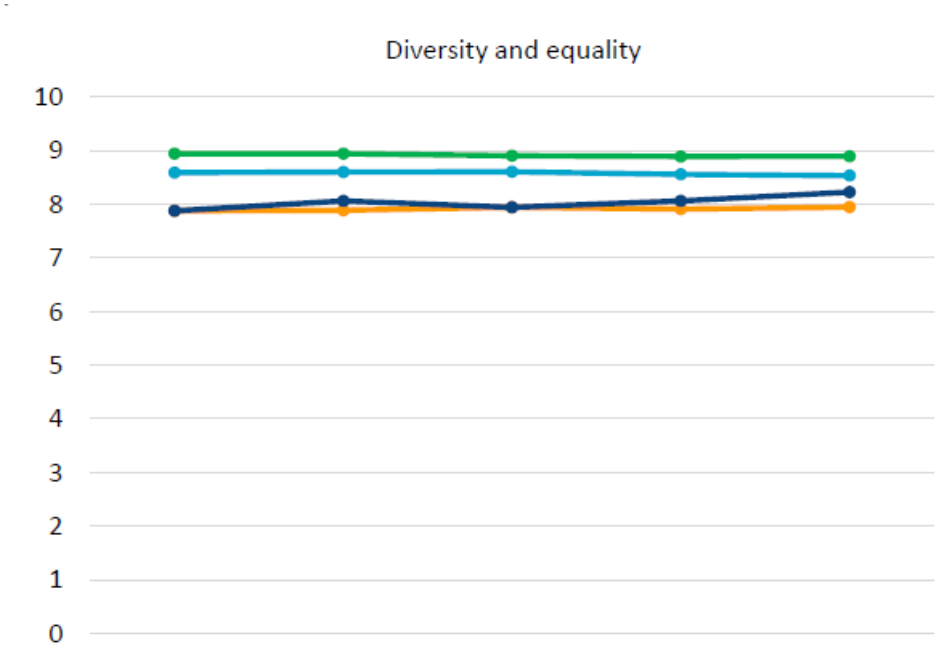
Compassionate and inclusive

Promise element 1: We are compassionate and inclusive



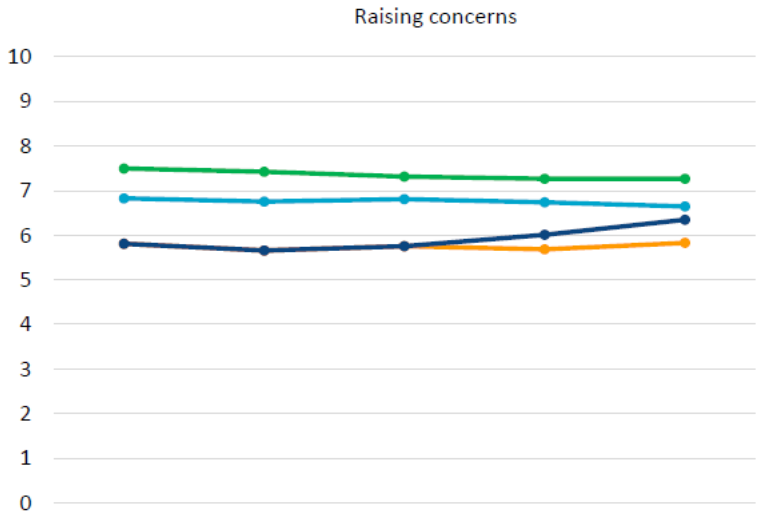
	2021	2022	2023	2024	2025
Your org	6.67	6.21	6.45	6.71	6.99
Best result	7.78	7.75	7.78	7.87	7.90
Average result	7.22	7.18	7.24	7.24	7.19
Worst result	6.35	6.21	6.33	6.19	6.34
Responses	409	334	432	416	390

Diversity and equality



	2021	2022	2023	2024	2025
Your org	7.88	8.06	7.94	8.06	8.23
Best result	8.94	8.94	8.90	8.89	8.90
Average result	8.59	8.60	8.60	8.55	8.53
Worst result	7.88	7.89	7.94	7.91	7.95
Responses	411	335	435	414	392

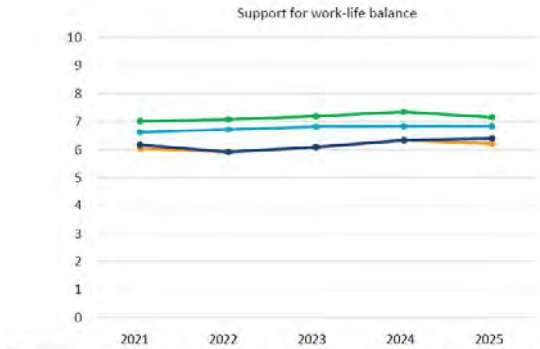
Raising concerns



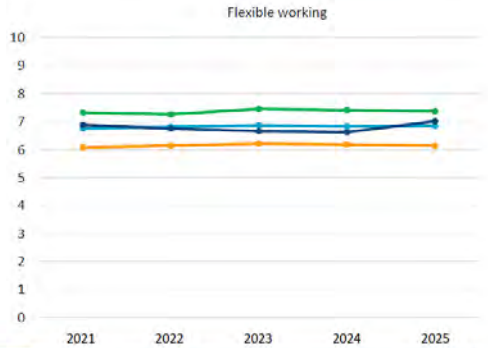
	2021	2022	2023	2024	2025
Your org	5.81	5.66	5.75	6.01	6.35
Best result	7.49	7.42	7.31	7.26	7.26
Average result	6.83	6.76	6.81	6.74	6.64
Worst result	5.81	5.66	5.75	5.68	5.83
Responses	408	332	429	415	387

Appendix 5

Flexible working

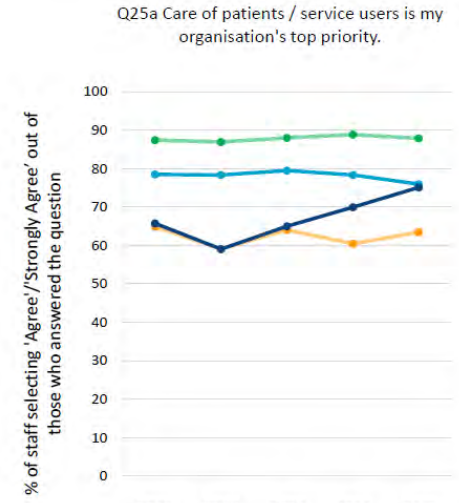


	2021	2022	2023	2024	2025
Your org	6.17	5.92	6.09	6.34	6.40
Best result	7.02	7.08	7.19	7.34	7.15
Average result	6.62	6.72	6.82	6.84	6.84
Worst result	6.05	5.92	6.09	6.33	6.21
Responses	418	335	434	414	392

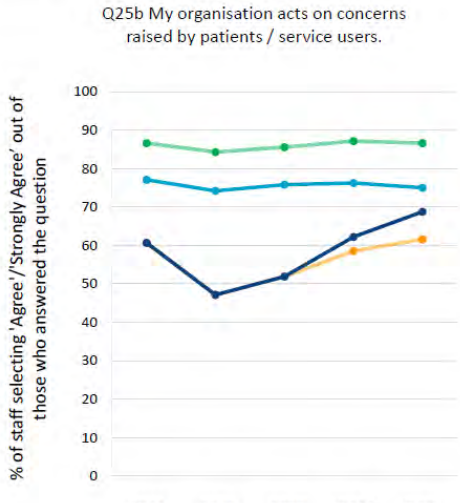


	2021	2022	2023	2024	2025
Your org	6.89	6.75	6.66	6.62	7.02
Best result	7.31	7.26	7.45	7.40	7.37
Average result	6.76	6.82	6.87	6.84	6.85
Worst result	6.08	6.15	6.22	6.18	6.15
Responses	418	335	434	414	391

Care of patients



	2021	2022	2023	2024	2025
Your org	65.72%	59.04%	64.97%	69.93%	75.11%
Best result	87.43%	86.93%	87.99%	88.86%	87.85%
Average result	78.46%	78.32%	79.49%	78.32%	75.94%
Worst result	64.89%	59.04%	64.03%	60.43%	63.46%
Responses	408	334	433	416	389



	2021	2022	2023	2024	2025
Your org	60.68%	47.13%	51.90%	62.20%	68.77%
Best result	86.63%	84.30%	85.58%	87.14%	86.59%
Average result	77.10%	74.19%	75.80%	76.23%	75.03%
Worst result	60.68%	47.13%	51.90%	58.53%	61.59%
Responses	408	334	432	416	388

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Freedom to Speak-Up Guardians Update			**Agenda No.: 016**
Report Author and Job Title:	Mark Freestone (CETO) Vonnie DeBrett, FTSU Guardian	**Lead Executive Director:**	Mark Freestone, Executive FTSU Lead
Appendices:	Appendix 1: Activity Report February 2026.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	This report presents a summary of the activity conducted by the new Freedom to Speak Up (FTSU) Guardian Service, TGS, between October 2025 and February 2026.		
Background:	The Trust previously employed two internal guardians, however this situation had limitations and there was limited practical visibility of the Guardians around the Trust. The two internal guardians gave notice in June and July 2025, requiring the Trust to investigate alternative provision. The Guardian Service (TGS) was approached as the provider in July 2025 and commenced provision in October. This report presents a thematic summary of all speaking up instances reported to TGS between October 2025 and February 2026.		
Assessment:	New Cases – 2 in February 2026 to a total of 20 cases raised since October. We have seen mainly Amber concerns with themes focused around Patient and Worker Safety/ Bullying and Harassment/ System and Process.		
Key recommendation(s):	The Board is asked to **REVIEW** the paper.		

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 7 – Lack of a Fair and Inclusive Culture			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	Provision of FTSU Guardians remains a statutory obligation despite the imminent closure of the National Guardian's Office.			
Resource Implications:	Yes ☐		No ☒	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	An active FTSU function mitigates our risks in complying with a number of legal areas including mitigation of discrimination and whistleblowing detriments.			
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 – at decision stage

The Guardian Service
Here to listen

Date produced 09 Mar 2026 9:15

Produced by NATALIE MORGAN

Title	**GUARDIAN ACTIVITY REPORT**
Guardians	**Vonnie DeBrett**
Period	**February - 2026**
Trust	**The Tavistock and Portman NHS Foundation Trust**

Think before you print. Protect our environment.

The Guardian Service
Here to listen

The Tavistock and Portman NHS Foundation Trust

February - 2026

Cases

New cases this month	2
Cases closed this month	3
Open cases year to date	17
Closed cases year to date	3
Total cases year to date	20

RAG status

	Open Cases This Month	Total Cases This Year
Red	0	0
Amber	1	15
Green	1	4
White	0	1
	2	20

Outcomes

	This Month	This Year
Written / Verbal	2	2
Chose not to pursue	1	1
No further contact	0	0
	3	3

Themes

	Primary only		All themes inc. primary	
	Month	Year	Month	Year
Patient safety / quality	0	4	0	4
Worker safety / wellbeing	0	5	0	7
Bullying / harassment	1	6	1	7
Other inappropriate behaviour or attitudes				
Behaviour / relationship	1	1	1	2
Discrimination / inequality	0	0	0	0
Management issue	0	1	0	3
Sexual misconduct	0	0	0	0
Additional Themes				
System / process	0	2	0	3
Other	0	1	0	1
Totals	2	20	2	27

Activity / Visits

	This Month	This Year
Promotion	3	8
Site briefing	2	4
Online briefing	2	7
Site meeting	0	0
Online meeting	0	13

Case-related activity

	This Month	This Year
Email	84	288
Telephone	3	48
Face to face	22	70

Cases raised anonymously

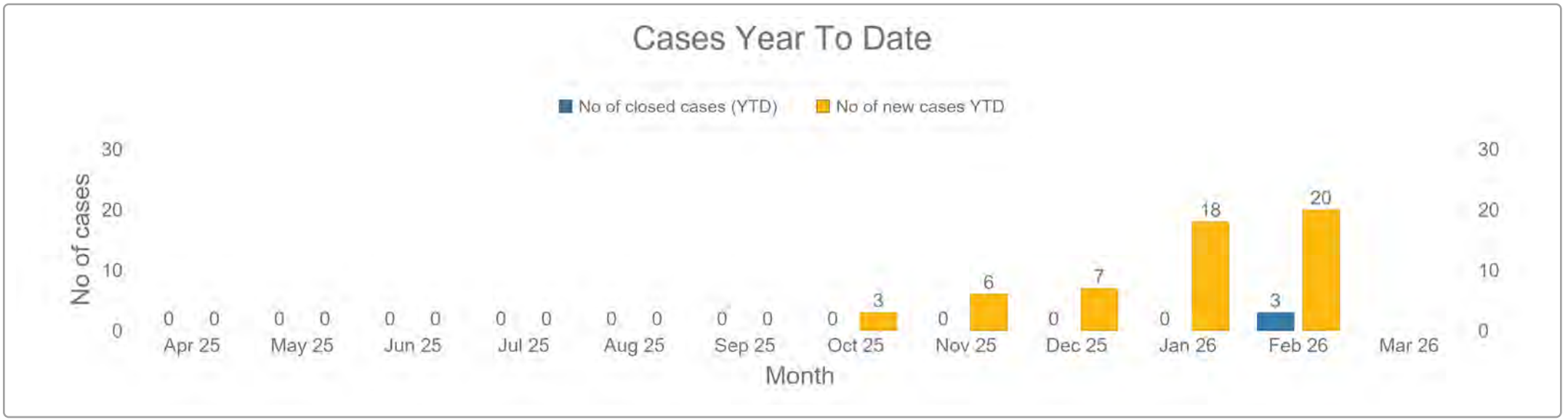
This Month	This Year
0	0

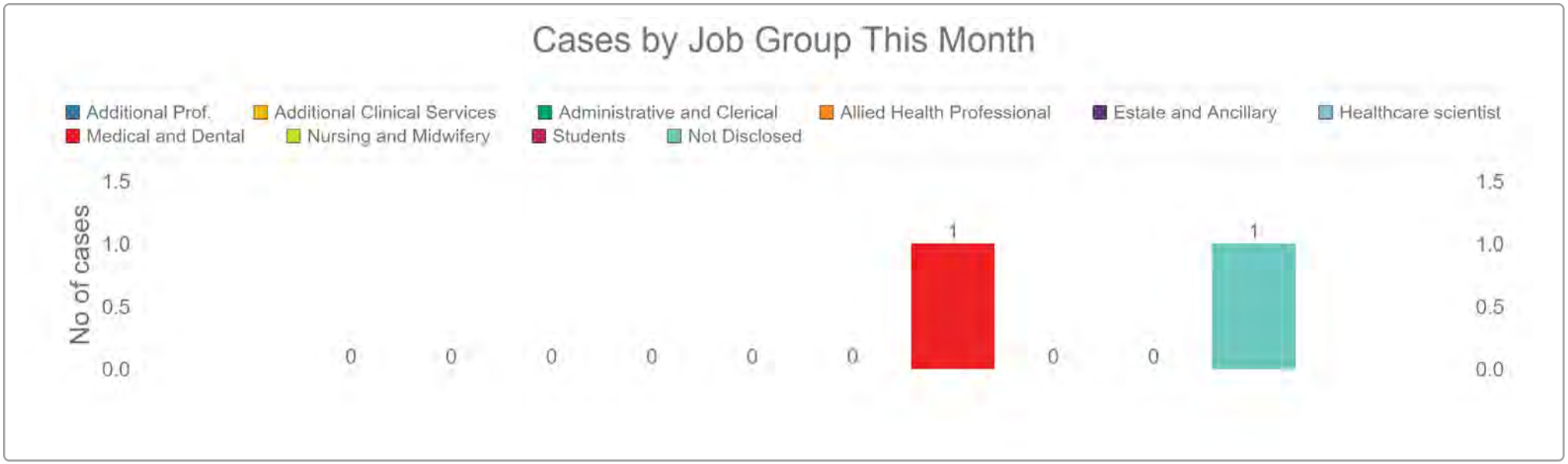
Detriment

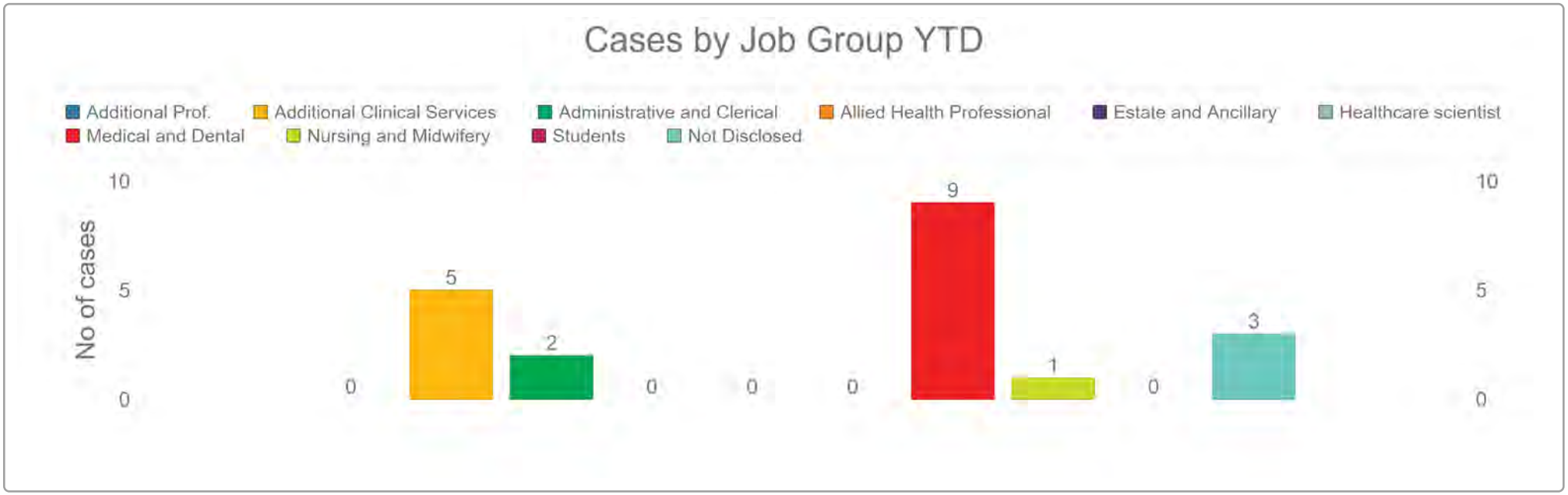
This Month	This Year
0	0

The Tavistock and Portman NHS Foundation Trust

February - 2026




Cases by Job Group This Month
Additional Prof.
Additional Clinical Services
Administrative and Clerical
Allied Health Professional
Estate and Ancillary
Healthcare scientist
Medical and Dental
Nursing and Midwifery
Students
Not Disclosed
No of cases
1.5
1.0
0.5
0.0
0
0
0
0
0
0
1
0
0
1


Cases by Job Group YTD
Additional Prof.
Additional Clinical Services
Administrative and Clerical
Allied Health Professional
Estate and Ancillary
Healthcare scientist
Medical and Dental
Nursing and Midwifery
Students
Not Disclosed
No of cases
10
5
0
0
5
2
0
0
0
9
1
0
3

Case Status by Job Group

Case No	Start Month	Open	Closed	Add. Prof. Scientific Technical	Add. Clinical Services	Administrative & Clerical	Allied Health Professional	Estates & Ancillary	Heatlhcare Scientist	Medical & Dental	Nursing & Midwifery	Students	Not Disclosed
TAVI-25-01	Oct	✓								✓			
TAVI-25-02	Oct		✓			✓							
TAVI-25-03	Oct	✓				✓							
TAVI-25-04	Nov	✓								✓			
TAVI-25-05	Nov		✓							✓			
TAVI-25-06	Nov	✓								✓			
TAVI-25-07	Dec	✓									✓		
TAVI-25-08	Jan	✓								✓			
TAVI-25-09	Jan	✓								✓			
TAVI-25-10	Jan	✓								✓			
TAVI-25-11	Jan	✓								✓			
TAVI-25-12	Jan	✓			✓								
TAVI-25-13	Jan	✓			✓								
TAVI-25-14	Jan	✓			✓								
TAVI-25-15	Jan	✓			✓								
TAVI-25-16	Jan	✓											✓
TAVI-25-17	Jan	✓											✓
TAVI-25-18	Jan		✓		✓								

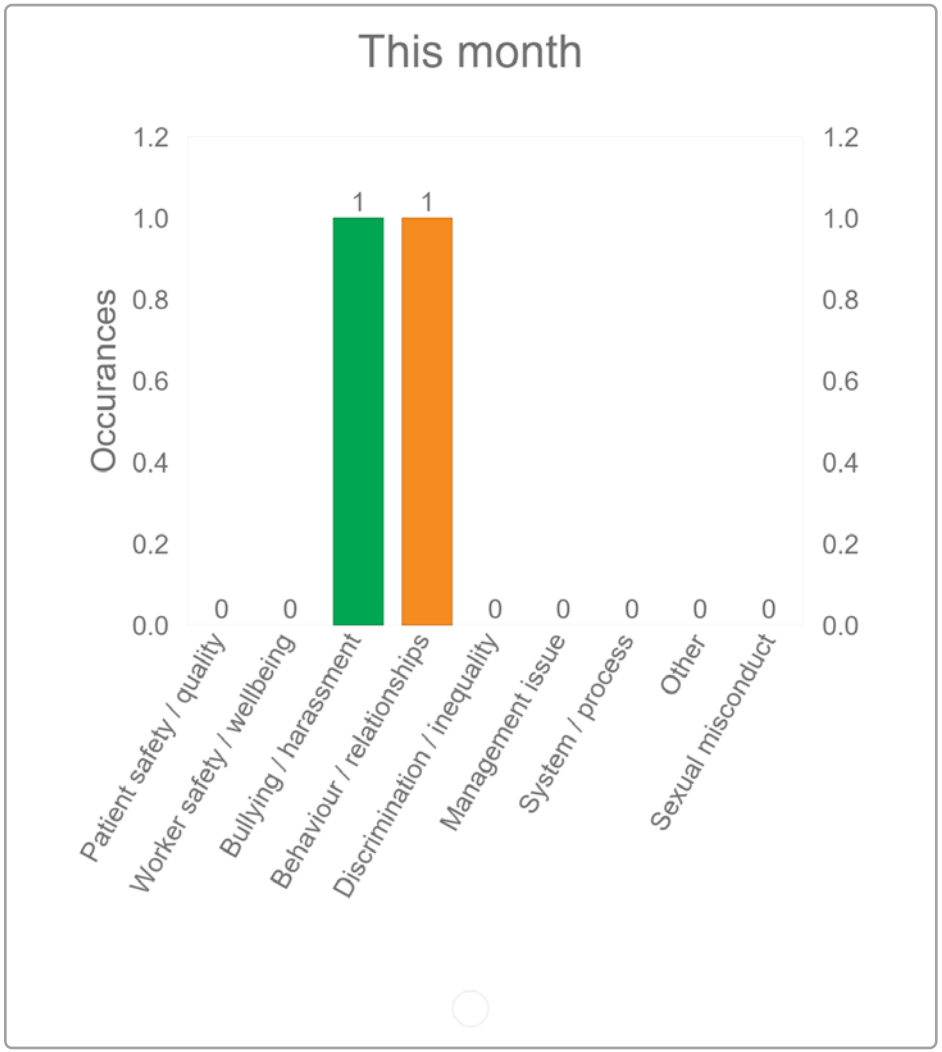
The Tavistock and Portman NHS Foundation Trust

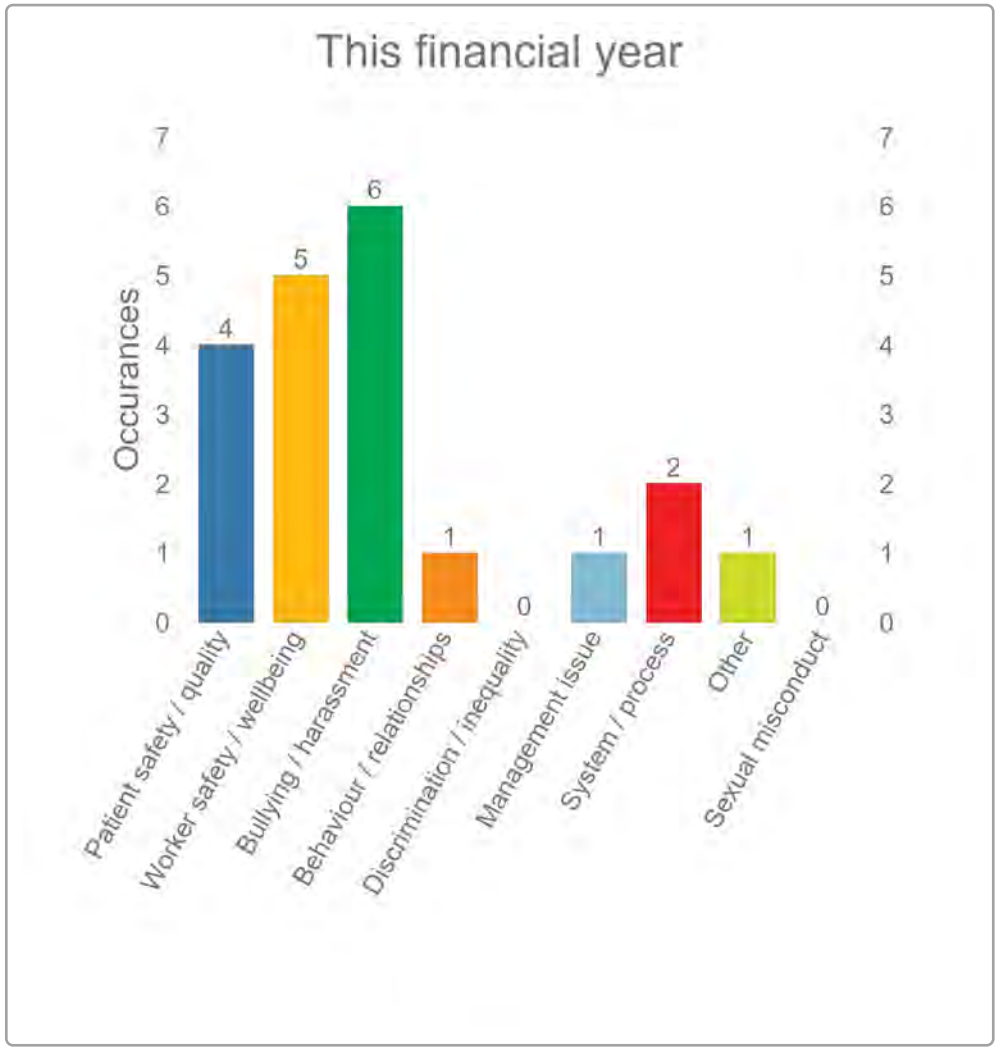
February - 2026

Case Status by Job Group

Case No	Start Month	Open	Closed	Add. Prof. Scientific Technical	Add. Clinical Services	Administrative & Clerical	Allied Health Professional	Estates & Ancillary	Heatlhcare Scientist	Medical & Dental	Nursing & Midwifery	Students	Not Disclosed
TAVI-25-19	Feb	✓								✓			
TAVI-25-20	Feb	✓											✓
	Totals	17	3		5	2				9	1		3

Primary Themes





Cases by Primary Theme

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TAVI-25-01	Oct	✓		✓									
TAVI-25-02	Oct		✓				✓						
TAVI-25-03	Oct	✓				✓							
TAVI-25-04	Nov	✓					✓						
TAVI-25-05	Nov		✓								✓		Fraud
TAVI-25-06	Nov	✓				✓							
TAVI-25-07	Dec	✓					✓						
TAVI-25-08	Jan	✓		✓									
TAVI-25-09	Jan	✓								✓			
TAVI-25-10	Jan	✓								✓			
TAVI-25-11	Jan	✓								✓			
TAVI-25-12	Jan	✓								✓			
TAVI-25-13	Jan	✓		✓									
TAVI-25-14	Jan	✓					✓						
TAVI-25-15	Jan	✓		✓									
TAVI-25-16	Jan	✓			✓								
TAVI-25-17	Jan	✓					✓						
TAVI-25-18	Jan		✓							✓			

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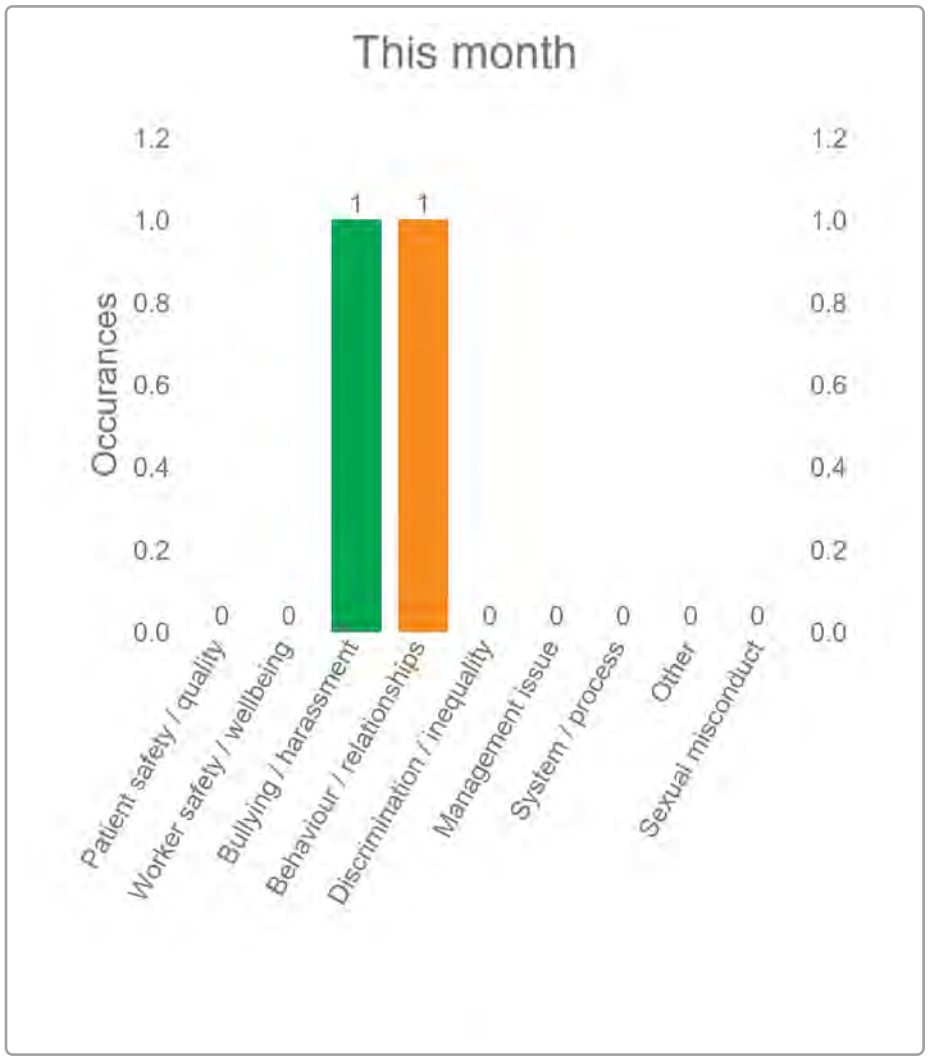
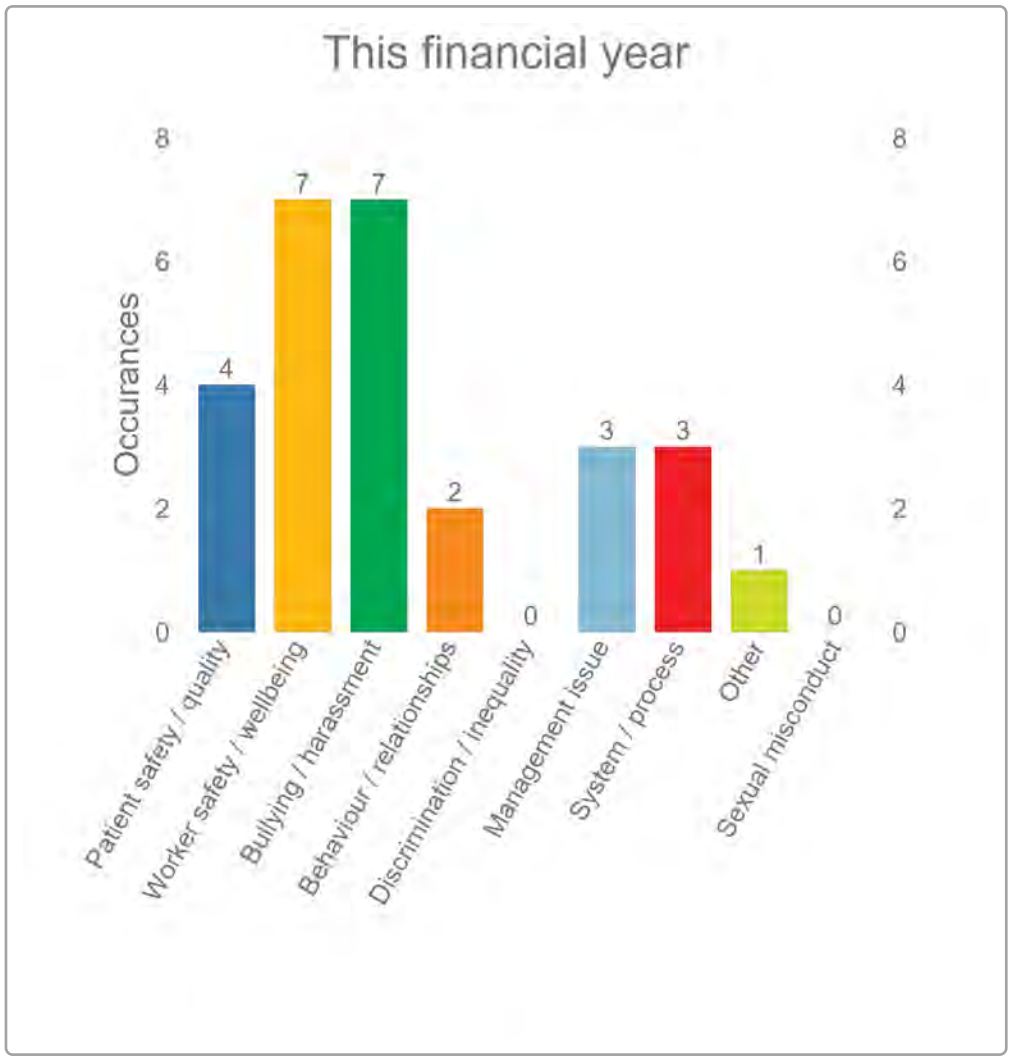
Cases by Primary Theme

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TAVI-25-19	Feb	✓					✓						
TAVI-25-20	Feb	✓							✓				
Totals		17	3	4	1	2	6		1	5	1		

Multi-theme Occurences





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Cases by Multi-Theme

✓ = *Primary theme*

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TAVI-25-01	Oct	✓		✓									
TAVI-25-02	Oct		✓				✓						
TAVI-25-03	Oct	✓			✓	✓							
TAVI-25-04	Nov	✓					✓						
TAVI-25-05	Nov		✓								✓		Fraud
TAVI-25-06	Nov	✓				✓							
TAVI-25-07	Dec	✓					✓						
TAVI-25-08	Jan	✓		✓									
TAVI-25-09	Jan	✓								✓			
TAVI-25-10	Jan	✓								✓			
TAVI-25-11	Jan	✓								✓			
TAVI-25-12	Jan	✓					✓			✓			
TAVI-25-13	Jan	✓		✓	✓				✓				
TAVI-25-14	Jan	✓					✓			✓			
TAVI-25-15	Jan	✓		✓						✓			
TAVI-25-16	Jan	✓			✓	✓							
TAVI-25-17	Jan	✓					✓						
TAVI-25-18	Jan		✓							✓			

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Cases by Multi-Theme

✓ = *Primary theme*

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TAVI-25-19	Feb	✓					✓						
TAVI-25-20	Feb	✓							✓				
Totals		17	3	4	1	2	6		1	5	1		

Case Status by Outcome

Case Number	Start Month	Status	Outcome
TAVI-25-01	Oct	Open	
TAVI-25-02	Oct	Closed	2. Chose not to pursue
TAVI-25-03	Oct	Open	
TAVI-25-04	Nov	Open	
TAVI-25-05	Nov	Closed	1. Written / verbal outcome
TAVI-25-06	Nov	Open	
TAVI-25-07	Dec	Open	
TAVI-25-08	Jan	Open	
TAVI-25-09	Jan	Open	
TAVI-25-10	Jan	Open	
TAVI-25-11	Jan	Open	
TAVI-25-12	Jan	Open	
TAVI-25-13	Jan	Open	
TAVI-25-14	Jan	Open	
TAVI-25-15	Jan	Open	
TAVI-25-16	Jan	Open	
TAVI-25-17	Jan	Open	
TAVI-25-18	Jan	Closed	1. Written / verbal outcome
TAVI-25-19	Feb	Open	
TAVI-25-20	Feb	Open	

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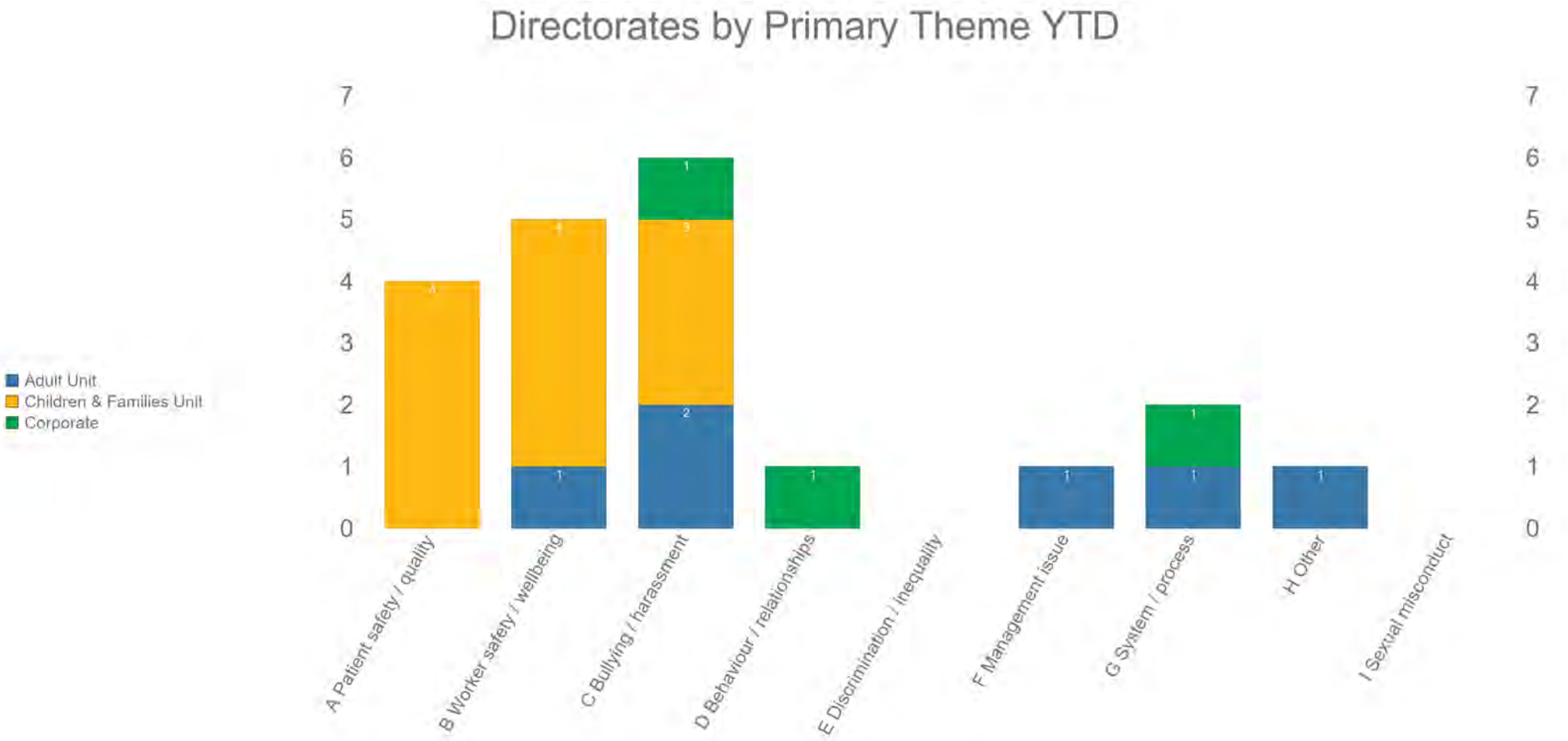
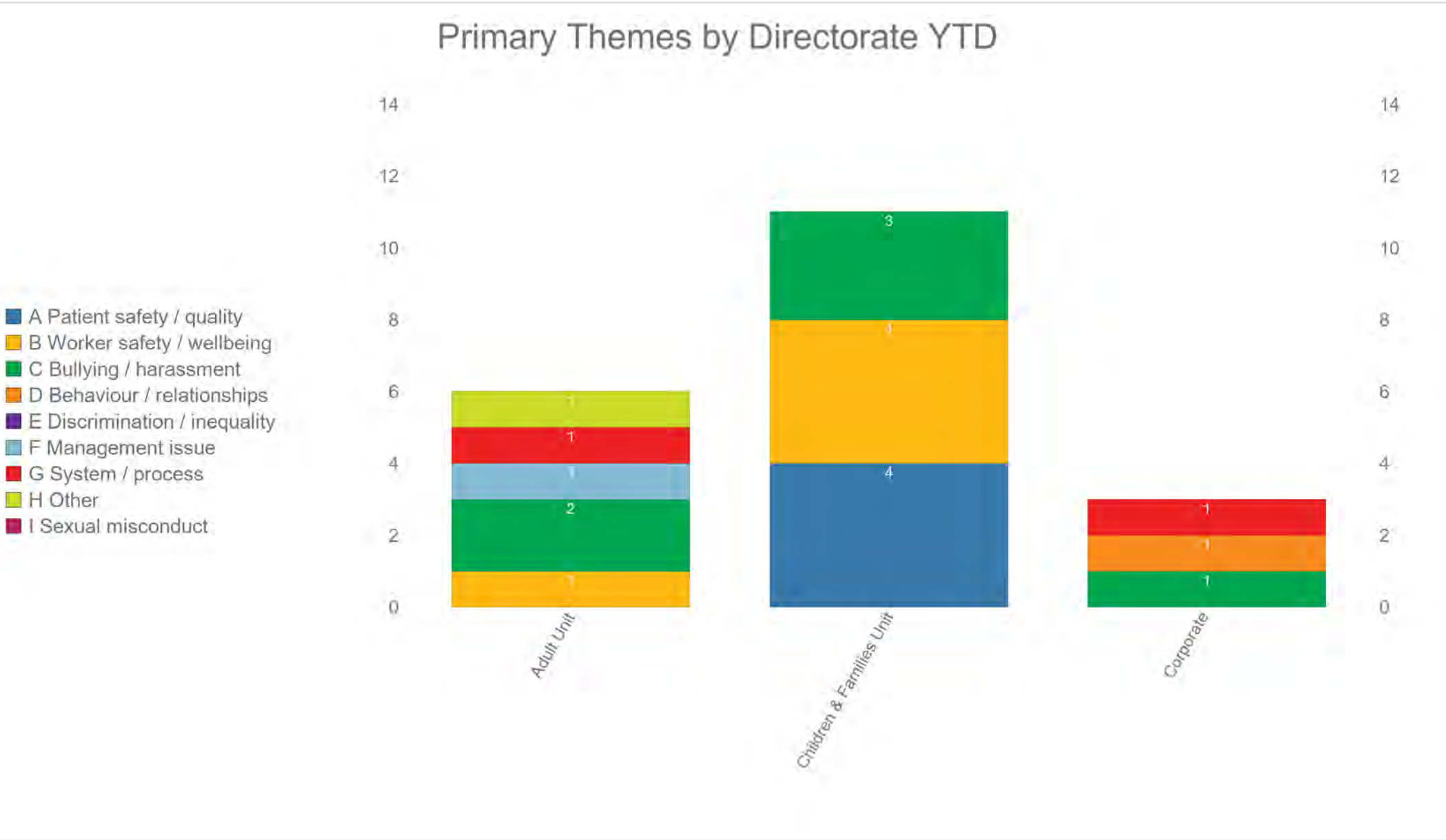
Case Status by Outcome

Case Number	Start Month	Status	Outcome

Totals

Open Cases	17	Written / Verbal	2	No further contact	0
Closed Cases	3	Chose not to pursue	1		


Directorates by Primary Theme YTD
Adult Unit
Children & Families Unit
Corporate
0
1
2
3
4
5
6
7
A Patient safety / quality
B Worker safety / wellbeing
C Bullying / harassment
D Behaviour / relationships
E Discrimination / inequality
F Management issue
G System / process
H Other
I Sexual misconduct


Primary Themes by Directorate YTD
A Patient safety / quality
B Worker safety / wellbeing
C Bullying / harassment
D Behaviour / relationships
E Discrimination / inequality
F Management issue
G System / process
H Other
I Sexual misconduct
14
12
10
8
6
4
2
0
1
1
1
2
1
3
1
4
1
1
1
Adult Unit
Children & Families Unit
Corporate

Summary - Directorates by Theme

A Patient safety / quality

Directorate	This Month	Year to Date
Children & Families Unit	0	4

B Worker safety / wellbeing

Directorate	This Month	Year to Date
Adult Unit	0	1
Children & Families Unit	0	4

C Bullying / harassment

Directorate	This Month	Year to Date
Adult Unit	1	2
Children & Families Unit	0	3
Corporate	0	1

D Behaviour / relationships

Directorate	This Month	Year to Date
Corporate	1	1

F Management issue

Directorate	This Month	Year to Date
Adult Unit	0	1

G System / process

Directorate	This Month	Year to Date
Adult Unit	0	1
Corporate	0	1

Summary - Directorates by Theme

H Other

Directorate	This Month	Year to Date
Adult Unit	0	1
Total	2	20

The Guardian Service
Here to listen

The Tavistock and Portman NHS Foundation Trust

February - 2026

Cases by Directorate - Summary

Directorate	This Month	Year to Date
Adult Unit	1	6
Camden Unit	0	0
Children & Families Unit	0	11
Corporate	1	3
Education & Training	0	0
Totals	2	20

Why use the Guardian service? (Year to date)

Reason	Number	Percentage
A Impartial support	2	10.00%
B Fear of reprisal	2	10.00%
C Believe they will not be listened to	2	10.00%
D Have raised concern before but have not been listened to	13	65.00%
E Other	1	5.00%
	20	100.00%

Confidentiality	Number	Percentage
1 Keep confidential	3	15.00%
2 Permission to escalate with name	5	25.00%
3 Permission to escalate anonymously	12	60.00%
4 Permission to escalate without name	0	0.00%
	20	100.00%

The Guardian Service
Here to listen

The Tavistock and Portman NHS Foundation Trust

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Case Escalations, Actions & Outcomes

✓ *Closed this month*

Case Number	Case Date	Open	Closed	Escalation Date	Org Response Time	Action taken	Outcome After Action Taken
TAVI-25-01	Oct	✓		14/01/2026 Head of Service	2 days		
TAVI-25-02	Oct		✓				Provided support to Staff member raising concern. They do not wish to proceed at this time.
TAVI-25-03	Oct	✓		10/10/2025 Head of People	Same day		
TAVI-25-04	Nov	✓		27/11/2025 Medical Director	1 day		
TAVI-25-05	Nov		✓	27/11/2025 Medical Director	1 day	FTSU raised concern with the Medical Director.	Full investigation was undertaken.
TAVI-25-06	Nov	✓		27/11/2025 Medical Director	1 day		
TAVI-25-07	Dec	✓					
TAVI-25-08	Jan	✓		08/01/2026 DON	1 day		
TAVI-25-09	Jan	✓		08/01/2026 DON	1 day		
TAVI-25-10	Jan	✓		08/01/2026 DON	1 day		

The Guardian Service
Here to listen

The Tavistock and Portman NHS Foundation Trust

February - 2026

Case Escalations, Actions & Outcomes

✓ *Closed this month*

Case Number	Case Date	Open	Closed	Escalation Date	Org Response Time	Action taken	Outcome After Action Taken
TAVI-25-11	Jan	✓		08/01/2026 DON	1 day		
TAVI-25-12	Jan	✓		27/01/2026 Medical Director	1 day		
TAVI-25-13	Jan	✓		29/01/2026 Medical Director	1 day		
TAVI-25-14	Jan	✓		28/01/2026 Medical Director	1 day		
TAVI-25-15	Jan	✓		28/01/2026 Medical Director	1 day		
TAVI-25-16	Jan	✓		23/01/2026 CEO	1 day		
TAVI-25-17	Jan	✓		29/01/2026 Senior HR	2 days		
TAVI-25-18	Jan		✓	23/01/2026 CEO	1 day	FTSU Guardian raised the concern with the CEO	CEO taken the comments on board.
TAVI-25-19	Feb	✓		09/02/2026 Medical Director	1 day		
TAVI-25-20	Feb	✓					
Totals		17	3				

The Tavistock and Portman NHS Foundation Trust

February - 2026

Cases by Professional level	This Month	Year to Date
Worker	2	6
Senior Leader		
Manager		7
Not Disclosed		7
Totals	2	20

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: People, Organisational Development, Equality, Diversity and Inclusion Committee Handover			**Agenda No: 017**
Report Author and Job Title:	Magda North, Assistant Director of Corporate Governance	**Lead Executive Director:**	Kate Bowditch, Acting Chief People Officer
Appendices:	Appendix 1: POD EDI Handover business Appendix 2: POD EDI Annual Report 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	Subject to final approvals, the Trust will merge through acquisition by North London NHS Foundation Trust (NLFT) on 1 April 2026. This paper sets out the final Education and Training Committee handover that will be passed to NLFT.		
Background:	Following the final ordinary meeting of the Committee, a formal handover meeting was held on 17 March 2026. The handover documents will ensure that NLFT's People and Culture Committee can take account of risks, issues and work outstanding from TPFT People, Organisational Development, Equality, Diversity and Inclusion Committee.		
Assessment:	The Board is asked to note • The explicit focus on handover by Committee members and attendees at the last ordinary meeting of the Committee. This included **closing matters arising and sub-groups** of the Committee. • **Substantive revision to the BAF** to reflect the risk on staff wellbeing (BAF risk 15) and BAF risk 6 has been removed. • Existing discussions at **merger work stream level** and **Transitional Executive** which have already socialised at management level many of the items raised in the handover. This is supported by a merger risk register. • The drafting of **Terms of Reference for NLFT's Committee structure** from 1 April with a view to managing the business of the enlarged Trust. There is a strong read across from TPFT's ToR to that of NLFT. • The development of **Committee workplans 2026/27** to reflect the business of the enlarged Trust and to build in items to understand the work of TPFT.		
Key recommendation(s):	The Board is asked to take **ASSURANCE** on the People, Organisational Development, Equality, Diversity and Inclusion Committee Handover.		
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 ☐		
	The BAF and corporate risk register are relevant to this paper in setting out the strategic risks of the Trust.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The merger by acquisition of TPFT by NLFT is planned on 1 April 2026.				
Resource Implications:	Yes ☐	No ☒			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	None identified.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	People, Organisational Development, Equality, Diversity and Inclusion Committee				
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	

Appendix 1: POD EDI Committee Handover Business

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Governance				
Board Assurance Framework	Agreement by the Committee to update BAF to reflect a key theme from the meeting on the risk to staff wellbeing for TPFT staff ahead of the merger (now BAF risk 15). BAF risk 6 has been retired.	Director of Corporate Governance	BAF risk 15 substantively updated to reflect the risk of lack of staff morale and resilience in the transition to the newly merged Trust **Overall TPFT BAF and NLFT Board Assurance Framework** to be reviewed at NLFT Board workshop in May 2026 to design 2026/2027 BAF for enlarged Trust. The BAF will then progress through relevant committees onto the Board in the usual way.	Q1 2026/27
Highlights of POD EDI business				
Staff Survey	Feedback from TPFT staff in the staff survey needs actioning in newly merged Trust. Embargo on staff survey is lifted on 12 March 2026.	Chief People Officer	To align with NLFT processes and the staff survey action plan will track action plan through EMC, People and Culture Committee and the Board	Q1 2026/27
Freedom to Speak Up and other support to staff	TPFT is recently contracted with The Guardian Service and the service is embedding. NLFT is currently also contracted with The Guardian Service	Chief People Officer	Alignment of NLFT FTSU processes and reporting through NLFT's ARC and People and Culture where relevant.	Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	Other staff support such as occupational health, employee assistance have an important role in supporting TPFT staff during the merger.		Signposting of NLFT support services is in train and part of Day 1 readiness	
EDI	Feedback from POD EDI was that TPFT commitment on EDI has improved considerably and there are pockets of great practice to be celebrated such as North and South Camden CAMHS. However, the Committee noted that TPFT commitment to BAF Risk 7 could be viewed as performative. There is more work to do on disabilities, long term conditions and LGBTQI.	Chief People Officer	BAF risk 7 to be managed through the overall BAF process Overall EDI work to align with NLFT processes and contribute through NLFT's EDI Programme Board	Q1 2026/27
Staff Networks	The work of TPFT's Staff Networks should not be lost in the move to the enlarged Trust, and an integration plan was proposed.	Chief People Officer	Respective EDI teams are in contact and working together. To align with NLFT processes on staff networks	Q1 2026/27

PEOPLE, ORGANISATIONAL DEVELOPMENT / EQUALITY, DIVERSITY & INCLUSION (POD EDI) COMMITTEE – ANNUAL REPORT 2025–26

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1. Introduction

This Annual Report provides the Board with an overview of the work of the POD EDI Committee during the period **May 2025 – January 2026**, in line with its remit to assure the Board on staff experience, workforce performance, Freedom to Speak Up (FTSU), and the Trust's Equality, Diversity & Inclusion (EDI) agenda, including statutory duties (Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES)/gender pay gap) and merger-related people risks. The report summarises activity, themes of scrutiny, assurances received, risks escalated, and areas for continued focus.

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2. Committee Membership and Attendance

Members (during the year):

- Shalini Sequeira (Chair, Non-Executive Director)
- Gem Davies (Chief People Officer) → **left Sept 2025**; succeeded operationally by Kasia Parfenyuk (Deputy CPO) and subsequently by **Kate Bowditch (Chief People Officer, NLFT)** participating from Jan 2026
- Mark Freestone (Chief Education & Training Officer)
- Clare Scott (Chief Nursing Officer)
- Claire Johnston (Non-Executive Director)
- Ken Batty (Non-Executive Director) *(May 2025 only)*

The Committee was supported by regular attendance from the EDI leadership team, Staff Network Chairs, Staff Side, Corporate Governance, Risk and Policy, HR (OD/Culture/Employee Relations), FTSU Guardians (from Oct 2025), Governor Observer, and others as noted in minutes. Meetings were quorate throughout.

Committee Secretary: Asma Bi.

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3. Meetings and Coverage

Formal meetings were held on: **1 May 2025; 26 June 2025; 4 September 2025; 6 November 2025; 8 January 2026**. Across these, the Committee discharged responsibilities per the Schedule of Business for 2025/26.

Core coverage included:

- **Integrated Performance/Workforce Metrics dashboard** (sickness, turnover, appraisal/Mandatory and Statutory Training (MAST) compliance).
- **Staff Survey** results and action plan; “You said, we did”.
- **FTSU**: guardian model transition to The Guardian Service; onboarding, outreach and usage updates.
- **EDI Programme Board assurance** (anti-racism, inclusive recruitment, networks, Patient and Carer Race Equality Framework (PCREF) alignment, annual reporting under Equality Act duties).
- **Risk management**: review of **BAF risks**, notably **staff engagement/ disengagement**; associated corporate/operational risks.
- **Policies and governance** (ToR; policy prioritisation; EDI Policy ratification; Staff Experience Programme Board ToR).
- **Merger preparedness** (communications, engagement, TUPE context, North London NHS Foundation Trust (NLFT) alignment).

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4. Work of the Committee in 2025–26

4.1 Workforce Performance & Staff Experience Assurance

Integrated Performance / Workforce Metrics

- **Sickness absence** remained broadly stable, with stress/anxiety/depression the leading cause; targeted manager support and training were discussed (including better ESR recording).
- **Turnover** remained low for much of the year, with a modest rise anticipated amidst merger uncertainty; leavers’ thematic insight and BI improvements were requested.
- **Appraisal and MAST compliance**: persistent variation and overall under-performance; a Quality Improvement based approach, weekly manager training/masterclasses, and executive oversight were instituted; NLFT’s learning management system go-live (Nov 2025) flagged alignment opportunities post-merger. The Committee repeatedly pressed for tangible improvement trajectories.

Staff Survey and Experience

- 2024/25 survey showed improvements in **7 of 9 People Promise areas**, with focused actions on bullying/harassment (notably for staff with long term conditions/disability) and manager responsiveness; weekly drop-ins and a Staff Experience Programme Board established to drive delivery.
- 2025 survey campaign management included targeted communications, incentives and senior leader forum cascades; completion rates and manager enablement to attend briefings were monitored.

Accommodation & Space Utilisation

- The Committee received assurance on the **Accommodation Strategy/Space Optimisation** work led through the Executive Leadership Team, noting links to wellbeing, belonging, and productivity; emphasis on cultural adherence to new etiquette and accurate on-site presence data.

4.2 Freedom to Speak Up (FTSU)

- Following guardian vacancies, the Committee **ratified** contracting **The Guardian Service** from October 2025, providing a 24/7 telephone line, on-site visibility, and structured onboarding; subsequent usage reports evidenced positive early engagement, strong communications, and a maturing outreach plan (inductions, webinars, drop-ins). Tracking via the **Staff Experience Board** was supported.
- A refreshed **FTSU Action Plan** emphasised manager training beyond e-learning, the introduction of local **Champions/Ambassadors**, and stronger follow-through on concerns; this approach was considered **substantially assured**.

4.3 Equality, Diversity & Inclusion

Programme oversight & priorities

- The **EDI Programme Board** provided routine assurance on inclusive recruitment (aiming for EDI representation on interview panels/Establishment Control Panel), anti-racism work aligned with NLFT, and staff network development; embedding remains variable with c. **20%** of vacancies progressing via the formal EDI route, highlighting the need to extend influence across the remaining 80%.
- The **Annual Equality Act duties report** noted: improved **mean hourly gender pay gap** (down 2.46% to **8.52%**) and sustained reversal of **bonus pay gap** (−20.61% in 2024/25), alongside qualitative progress across PCREF and staff network activity; **adequate assurance** was recorded.
- Earlier in the year, the Committee reviewed **WDES/WRES** outcomes: mixed performance with several indicator improvements but persistent national under-performance in others, reinforcing the need for focused, sustained action.

- The Committee repeatedly emphasised the importance of **communications**, "**You said, we did**" visibility, and leadership accountability for EDI delivery, with actions to unblock messaging and align with network priorities.

Policy & systems

- Agreement in principle to utilise **NLFT policies** (re-branded) where T&P documents were due for review pre-merger; the **EDI Policy** was subsequently **ratified** by PAG and will be embedded through leadership practice.

4.4 Risk Management

- The Committee initiated and then focused on **BAF risk on Staff Engagement/Disengagement** (score held at **16** during January 2026 pending descriptor/controls refresh), triangulating qualitative insights (merger anxiety, role clarity) with performance data (MAST/appraisal). Targeted mitigations included thinking spaces, structured engagement, and leadership visibility.
- Cross-linkages were noted to **PCREF** and workforce equality risks; communication gaps were recorded as an emerging risk (November 2025).

4.5 Merger Preparedness (with NLFT)

- The Committee maintained oversight of **TUPE context**, staff and student communications, FAQs, joint NLFT engagement, and OD/network alignment; the Department of Education and Training would **remain a single directorate**, with Office for Students requirements safeguarded via a **Student Protection Plan**.
- Executive Leadership Team supported **thinking spaces** and weekly drop-ins were designed to surface concerns, harvest learning, and inform the BAF; an internal and joint strategic communications plan was progressed via the Merger Programme Board.

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5. Governance

5.1 Terms of Reference (ToR)

ToR were reviewed and **approved**; assurance groups were **repurposed**, with the **Staff Experience Programme Board** (re-titled from Staff Experience Board) established and ToR circulated.

5.2 Committee Effectiveness

The annual self-assessment (May 2025) evidenced increasing maturity: stronger administration/timeliness; BAF deep dives; and areas to further develop—manageable agendas, action timeliness, report quality, and upskilling new attendees.

5.3 Groups Reporting to the Committee

- **Staff Experience Programme Board** (including FTSU)
- **EDI Programme Board**
- **Recruitment & Retention Group** *(stood down during the year due to recruitment freeze)*
- **Staff Networks** (Race Equality Network; Purple Circle; LGBTQI+)
- **Policy Assurance Group** (for EDI policy ratification)
  Coverage varied through the year due to repurposing and scheduling associated with the merger.

5.4 Escalations to/ from Other Committees

- **From** Education and Training Committee (September 2025): Associate Lecturer post/pay—actioned by Chief Education and Training Officer/Chief People Officer outside meeting.
- **From** Quality and Safety Committee (June 2025): **Safeguarding training compliance**—POD EDI sought a clear plan and urgent messaging; escalation to triumvirate agreed.
- **No** Committee-to-Committee escalations were raised in Nov 2025 or Jan 2026 meetings.

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6. Assurance Summary (by theme)

- **Staff Experience & Engagement:** *Partial to adequate assurance overall.* Improvements in People Promise areas and robust engagement offers were offset by persistent appraisal/MAST gaps and variable leadership ownership.
- **FTSU:** Transition to The Guardian Service and visible outreach provided **substantial/strengthening assurance**; culture change to be monitored via Staff Experience Board.
- **EDI Delivery:** *Adequate to partial assurance.* Clear gains in pay gap metrics and policy ratification; embedding across recruitment and communications requires further spread and consistency.
- **Risk Management:** Active oversight of engagement-related BAF risk with controls under refresh; communications identified as an emerging risk (Nov).

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7. Key Achievements

- **FTSU Guardian model** re-established rapidly with external provider; strong early uptake and comprehensive outreach plan.
- **Gender pay gap** narrowed to **8.52%**; **bonus pay gap** reversed and sustained over four years.
- **EDI Policy** ratified; anti-racism work aligned with NLFT.
- **Staff Experience Programme Board** stood up; routine drop-ins and leadership-led engagement embedded.

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8. Ongoing Challenges / Areas for Continued Focus

- **Appraisal & MAST compliance**: deliver sustained, measurable improvements with clear trajectories by unit and corporate area, leveraging NLFT Learning Management System alignment and targeted manager support.
- **Staff engagement/disengagement risk**: refresh descriptors/controls, triangulate with qualitative insights from thinking spaces, and evidence impact of mitigations in-year.
- **Inclusive recruitment at scale**: increase the proportion of vacancies following the full EDI route beyond 20% via earlier panel planning and Establishment Control Panel embedding.
- **Communications**: maintain a visible “You said, we did” narrative across staff survey, EDI, and merger updates; address identified gaps.
- **Network sustainability through merger**: preserve identity and progress while integrating with NLFT structures through OD-supported design and joint proposals.

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9. Recommendations to the Board (2026 focus)

1. **Endorse a time-bound improvement plan** for appraisal/MAST with monthly Committee tracking and exception escalation via Executive Leadership Team.
2. **Approve refreshed BAF entry** for Staff Engagement/Disengagement reflecting merger phase, leadership accountabilities, and measurable engagement indicators.
3. **Support scaling of inclusive recruitment**, mandating forward-planned interview dates and EDI representation/Establishment Control Panel integration as default.

4. **Maintain investment in FTSU visibility and manager capability**, ensuring the Champions/Ambassadors model is fully deployed and reported via the Staff Experience Board.

5. **Sustain EDI communications and network support** during merger transition, including a joint NLFT-T&P communications plan with regular Board sight of “You said, we did” deliveries.

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10. Conclusion

The Committee concludes that **meaningful progress** has been achieved across FTSU, EDI policy/metrics, and staff experience infrastructure, with strong foundations laid for merger integration. Persistent challenges remain—most notably appraisal/MAST compliance, scaling inclusive recruitment practice, and addressing staff engagement/disengagement risks amidst organisational change. The Committee is **assured** that clear plans are in train, but **continued Board focus** is required to sustain momentum and evidence impact through 2026.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Finance Report - As of 31st Jan 26 (Reporting Month 10)			**Agenda No.: 018**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Jon Bell, Interim Chief Financial Officer
Appendices:	None.		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	The report provides the Month 10 financial position for the Trust.		
Background:	The Trust has established a breakeven plan for 2025/26, with a capital expenditure limit of £2.982m. This comprises an initial budget of £2.774m, £208k of PDC capital funding under the Wayfinder programme to support the implementation of the Patient Engagement Portal (PEP).		
Assessment:	**Income and Expenditure** The Trust's 2025/26 financial plan incorporates a £3.9m recurrent efficiency target, alongside the release of the annual leave accrual (under a no-carry-forward policy) and the planned sale of Gloucester House. Other previously assumed measures, including balance sheet releases, remain in place. Delivery of the efficiency target continues to be a key focus and risk. Growth in Tavistock Consulting income, previously assumed, is no longer considered achievable. At Month 10, the Trust reports a year-to-date deficit of £6.677m, which is £6.212m adverse to the plan submitted to NHSE. This variance is primarily driven by the £2.6m loss of National Training Contract income, a £2.4m delay in the Gloucester House sale, lower than planned income from Tavistock Consulting and I-Thrive, and shortfalls within CETO due to low intake and incomplete CIP delivery. These pressures are partially offset by Clinical income above plan. **Forecast Out-Turn** The year end forecast is currently estimated to be a deficit of £5.4m which is marginally behind the expected deficit support funding of £5.336m. However, there are a number of emerging risks that the Trust is working through which could materially impact on the year end position, including slippage of the land sale into April. The Trust is working with NLFT and the ICB on mitigations for these risks. The Executive Team continues to monitor recovery actions and cost pressures closely to mitigate the risk of an increased year-end deficit. **Capital Expenditure** The capital budget is increased from £2.774m to £2.982m, reflecting the following adjustments: • £0.208m: PEP PDC funding received		

As the Estates budget continues to change due to new project requirements, some original projects have been postponed, and funding has been reallocated to new priorities. Even after these internal reallocations, the Estates budget remained insufficient to meet the current project needs. As a result, £105k has been transferred from the IMT budget to Estates to cover the additional requirements.

IMT

- Spend from M1–M10 totals £0.713m, leaving £0.515m to be utilised over the next two months.

Estate

- Spend from M1–M10 totals £1.004m, leaving £0.750m to be utilised over the next two months.

Overall Position

- As of Month 10, actual capital expenditure stands at £1.717m, against a planned profile of £3.648m.
- The variance is mainly due to the expected Gloucester House sale, which is planned to be reinvested. As the proceeds from the sale will not be spent on new capital budgets, the planned capital programme for the full year remains £2.982m. Spend has also slowed due to Trust cash-flow constraints
- In November 2025, the Trust applied for £1.452m of capital cash support due to the anticipated delay in the Gloucester House sale to April 2026. The application was successful. As the sale is now expected to complete early in the next financial year, the Trust has drawn down the approved PDC capital cash.
- The Trust's confirmed capital envelope for 2025/26 was £2.774m. Additional PDC funding of £0.208m has been received for the PEP programme, increasing the total to £2.982m.

Capital Plan 2026/27

- Our confirmed capital allocation for 2026/27 is £2.478m, in line with the Trust's 10-year plan. However, the current estimated cost of planned capital projects totals £3.090m, which is £612k above the available allocation. The capital plan will be re-prioritised to align with the approved capital allocation of £2.478m.

Cash

The Trust is managing a highly constrained cash position for the financial year, with additional PDC revenue support received totaling £7.102m.

The Trust has sufficient cash to meet its obligations through the end of February 2026 without requiring additional support. The sale of Gloucester House is now expected to complete at the end of February, with a risk of slipping into March 2026. Upon receipt of the proceeds, the Trust will repay the £2.4m PDC support previously provided by NHSE.

It is also noted that £5.3m of revenue support is expected to offset the forecast deficit; however, this cash has not yet been reflected in the current cashflow projections.

	The Trust applied for £1.452m in capital cash support (PDC) in November 2025 on the basis that the Gloucester House sale might slip into the next financial year. The Trust has now drawn down the capital cash support, as the sale of Gloucester House is now expected to complete after 31st March 2026. The Trust will also receive £5.3m deficit support cash.
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. The Trust is focused on achieving a medium- to long-term financial plan, including delivery of a recurrent efficiency programme. While there is a risk if targets are not met, ongoing monitoring and recovery actions ensure the Trust is actively managing this risk to remain financially sustainable and maintain operational autonomy. **BAF 11: Suitable Income Streams** The Trust is focused on maintaining and growing income through achieving contracted activity levels and exploring opportunities within the current service configuration. While there is a risk that changes in the commissioning environment or under-delivery could affect baseline income, active monitoring and strategic planning are in place to protect financial sustainability and secure new income streams.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no DEI implications associated with this report.				

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.		
Assurance:				
Assurance Route - Previously Considered by:	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 Jan 2026 (Reporting Month 10)

1. Overview

The Trust is reporting a Year-to-Date deficit of £6.677m, which is £6.212m adverse to plan. This position is primarily driven by the YTD loss of £1.950m National Training Contract income and a £2.720m delay in income recognition for GH, alongside income shortfalls within Tavistock Consulting and I-Thrive due to lower than planned demand, and pressures within CETO arising from low intake and delays in delivering planned efficiency savings.

Financial Reporting Summary - Month 10 2025/26 (compared to submitted plan)

(red = expenditure or unfavourable variance, black = Income or Favourable Variance)

£000	YTD Jan-26 Plan	YTD- Jan 26 Actual	YTD Jan-26 Variance
Income	51,430	46,901	- 4,529
Pay	- 42,230	- 43,654	- 1,424
Non-Pay	- 9,493	- 9,644	- 151
Non-Operating Expenditure	- 172	- 280	- 108
Total Surplus/(Deficit)	**- 465**	**- 6,677**	**- 6,212**

Divisional Performance

Adverse performance is mainly evident within Education (£2.923m adverse), Clinical (£0.686m adverse), and Corporate (£2.603m adverse), with the latter driven by delays in the sale of GH. Income shortfalls and CIP slippage remain the key risks. Run-rate trends show income running 5.1% below the Month 1–9 average, with pay expenditure 5.4% lower and non-pay expenditure 4.1% higher. The Trust's overall contribution rate stands at 16.9%, which is below the planned level of 24.9%, reflecting continued pressure on margins across key service lines.

Liquidity and Cash

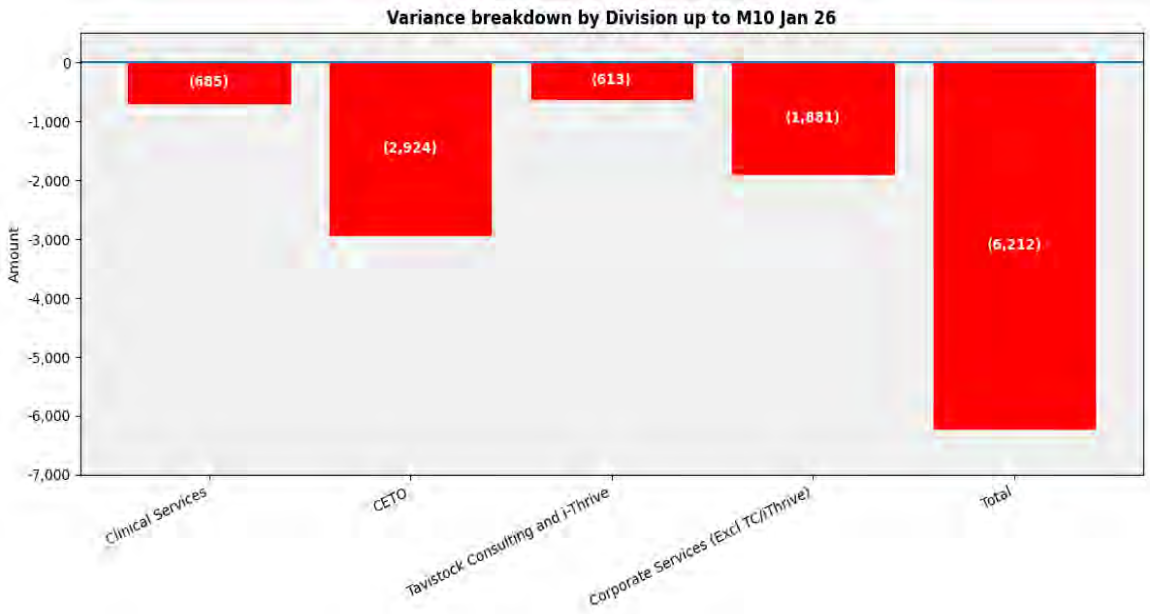
At the end of January 2026, the Trust held £2.080m in cash, equivalent to twelve days of operating expenditure. The sale proceeds from Gloucester House, which were expected in February, are now not expected until the next financial year however, the Trust is expecting £5.3m of deficit support which will provide sufficient cash to meet obligations during March.

Capital Expenditure

Against an approved capital limit of £2.982m, actual spend to Month 10 is £1.717m, compared with a planned profile of £3.648m. IMT has spent £713k against a budget of £1.228m, leaving £515k to be delivered in the final two months. Estates spend totals £1.004m against a budget of £1.754m, leaving £750k to deliver in the remaining two months.

Divisional analysis M10

The charts illustrate the Year-to-Date variance to plan by service. The most significant pressures continue to relate to income within CETO and pay costs within Clinical Services. Corporate performance is impacted in Month 10 due to delays in the sale of GH. This highlights the continued need to focus on the delivery of recurrent savings.



2. Run rate analysis

The Table below compares Month 10 (Jan-26) to the average of Months 1–9 (Apr–Dec 25)

Segment £'000	M1–M9 average	Month 10	Change vs M1–M10
Income	-4,723	-4,484	-5.1% (reduction in income)
Pay	4,402	4,162	-5.4% (reduction in pay cost)
Non-Pay	0.985	1,025	4.1% (increase in non-pay cost)

Income:
Income is 5.1% below the Month 1–9 average, reflecting higher pass-through funding and additional income in earlier months, partially offset by corporate technical income. CETO income remains below expectations following the National Training Contract loss and the delayed sale of GH.

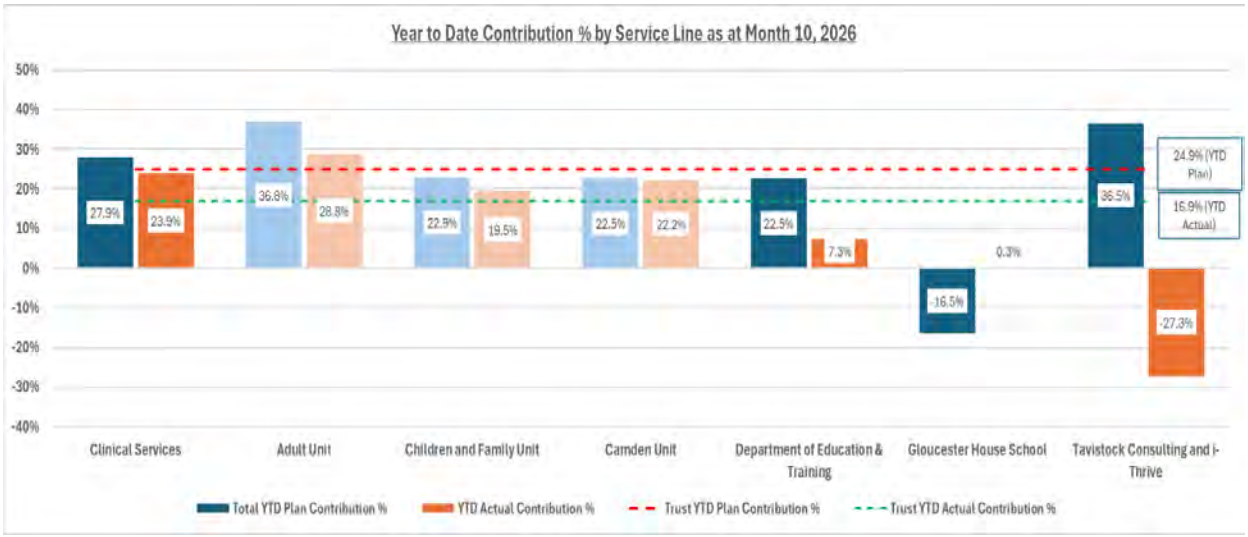
Pay:
Pay costs are 5.4% lower, primarily due to the partial release of the annual leave provision. Clinical and CETO pay pressures persist in line with previous months.

Non-Pay:
Non-pay expenditure is 4.1% higher, driven by UCL partner membership costs.

3. Contribution rate analysis

	YTD_Budget at Month 10, 2026					
	INCOME	PAY	NON-PAY	INTEREST,DEPRECIATION,PDC	TOTAL (Contribution)	CONTRIBUTION %
Clinical Services	(26,581)	18,714	441	0	(7,425)	27.9%
Adult Unit	(9,914)	6,132	132	0	(3,650)	36.8%
Children and Family Unit	(6,857)	5,097	192	0	(1,568)	22.9%
Camden Unit	(9,810)	7,486	117	0	(2,208)	22.5%
Department of Education & Training	(18,421)	11,657	2,717	0	(4,046)	22.0%
Gloucester House School	(986)	1,086	63	0	163	-16.5%
Tavistock Consulting and i-Thrive	(1,289)	640	178	0	(471)	36.5%
Corporate Services (Excl TC/iThrive)	(4,162)	10,263	4,196	1,948	12,244	
Total	**(51,439)**	**42,361**	**7,595**	**1,948**	**465**	**24.9%**
Check					-	

	YTD_Actual at Month 10, 2026					
	INCOME	PAY	NON-PAY	INTEREST,DEPRECIATION,PDC	TOTAL (Contribution)	CONTRIBUTION %
Clinical Services	(27,481)	19,875	1,034	0	(6,572)	23.9%
Adult Unit	(9,974)	6,944	160	0	(2,870)	28.8%
Children and Family Unit	(6,785)	5,157	306	0	(1,322)	19.5%
Camden Unit	(10,722)	7,774	568	0	(2,380)	22.2%
Department of Education & Training	(15,469)	11,792	2,554	0	(1,123)	7.3%
Gloucester House School	(1,278)	1,223	52	0	(4)	0.3%
Tavistock Consulting and i-Thrive	(521)	604	59	0	142	-27.3%
Corporate Services (Excl TC/iThrive)	(2,157)	10,287	4,252	1,852	14,234	
Total	**(46,906)**	**43,781**	**7,951**	**1,852**	**6,677**	**16.9%**



At a Trust level, the combined contribution stands at 16.9% YTD, compared with a planned 24.9%, highlighting a continued shortfall.

4. Year End Forecast

The year end forecast is currently estimated to be a deficit of £5.4m which is marginally behind the expected deficit support funding of £5.336m. However, there are a number of emerging risks that the Trust is working through which could materially impact on the year end position, including the slippage of the land sale into April. The Trust is working with NLFT and the ICB on mitigations for these risks.

5. Agency

Agency costs are £378k above budget, reflecting reliance on agency consultants to cover clinical staffing gaps at premium rates.

Directorate	Cost Centre	YTD £000's	YTD WTE
Chief Financial Officer	Hard FM	59	0.57
Chief Financial Officer	Finance	87	1.00
Chief Nursing Officer	Head of Nursing	23	0.20
Chief Financial Officer	CENTRAL RESERVES	(17)	-
Corporate Total		**152**	**1.77**
Children and Family Unit	FMHT	10	0.04
Children and Family Unit	Gloucester House Outreach	53	0.77
Children and Family Unit	FAKT	32	0.13
Camden Unit	NCCT	65	0.22
Camden Unit	SCCT	66	0.22
Clinical Total		**226**	**1.38**
Grand Total		**378**	**3.15**

6. Non-Operating Costs

Operating non-pay expenditure is £100k above budget, reflecting additional PDC cash support received by the Trust during the year, which has increased the PDC dividend payable.

Cash
As of 31 January 2026 (Month 10), with a reported cash balance of £2,080, equivalent to twelve days of operating expenditure.

To date, the Trust has received £7.102m in PDC revenue cash support (£1.582m in August, £0.500m in September, £2.170m in November, and £2.850m in January). Of the total support received, £2.400m was provided on the condition that it will be repaid once the Gloucester House sale is completed.

In addition, the Trust applied for £1.452m in capital cash support (PDC) in November 2025 on the basis that the Gloucester House sale might slip into the next financial year. The Trust has now drawn down the capital cash support, as the sale of Gloucester House is now expected to complete after March 2026.

In addition, the Trust will receive the deficit support as part of the merger agreement and this will ensure that the Trust has sufficient cash to meet its obligation in March.

7. Balance Sheet

No movements of note to report at Month 10.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Performance, Finance and Resources Committee Handover			**Agenda No: 019**
Report Author and Job Title:	Magda North, Assistant Director of Corporate Governance	**Lead Executive Director:**	Jon Bell, Interim Chief Finance Officer
Appendices:	Appendix 1: PFRC Handover business Appendix 2: PFRC Annual report 2025/26		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	Subject to final approvals, the Trust will merge through acquisition by North London NHS Foundation Trust (NLFT) on 1 April 2026. This paper sets out the final Education and Training Committee handover that will be passed to NLFT.		
Background:	Following the final ordinary meeting of the Committee, a formal handover meeting was held on 23 March 2026. The handover documents will ensure that NLFT's Finance and Investment Committee can take account of risks, issues and work outstanding from TPFT Performance, Finance and Resources Committee.		
Assessment:	The Board is asked to note • The explicit focus on handover by Committee members and attendees at the last ordinary meeting of the Committee. This included **closing matters arising and sub-groups** of the Committee. • Existing discussions at **merger work stream level** and **Transitional Executive** which have already socialised at management level many of the items raised in the handover. This is supported by a merger risk register. • The drafting of **Terms of Reference for NLFT's Committee structure** from 1 April with a view to managing the business of the enlarged Trust. There is a strong read across from TPFT's ToR to that of NLFT. • The development of **Committee workplans 2026/27** to reflect the business of the enlarged Trust and to build in items to understand the work of TPFT.		
Key recommendation(s):	The Board is asked to take **ASSURANCE** on the Performance, Finance and Resources Committee Handover.		

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 ☐		
	The BAF and corporate risk register are relevant to this paper in setting out the strategic risks of the Trust.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The merger by acquisition of TPFT by NLFT is planned on 1 April 2026.				
Resource Implications:	Yes ☒	No ☐			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	None identified.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Performance, 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	

Appendix 1: Performance, Finance and Resources Committee Handover Business

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
Governance				
Board Assurance Framework	The PFRC risks on the BAF have been updated since the last meeting, in preparation for TPFT's Board in March.	Director of Corporate Governance	**Overall TPFT BAF and NLFT Board Assurance Framework** to be reviewed at NLFT Board workshop in May 2026 to design 2026/2027 BAF for enlarged Trust. The BAF will then progress through relevant committees onto the Board in the usual way.	Q1 2026/27
Corporate Risk Register	The PFRC corporate risks have been updated since the last meeting, in preparation for TPFT's Board in March.	Director of Corporate Governance	TPFT and NLFT existing risk management systems will operate in tandem until the Autumn when In-Phase will be adopted across the enlarged Trust. Alignment to a single **Corporate Risk Register** will be undertaken manually from Q1.	Q1-Q2 2026/27
Highlights of Performance, Finance and Resources Committee business				
Gloucester House (GH)	Issues outstanding: (1) Relocation of the GH service to the new school - lease arrangements at La Sainte Union (2) Relocation of services from GH site – Family Drug and Alcohol Court service from Monroe to Tavistock Centre	Chief Operating Officer	Future governance for Gloucester House is being worked through at NLFT's Executive Management Committee. Proposal for operational reporting through NLFT's Operational Management Group which reports to NLFT's Executive Management Committee.	Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	(3) Existing school - Sale of the current GH school site (4) Existing school - Service impact from neighbours planned work (5) A separate paper is planned on the new operating model for the GH service to meet demand, grow sustainability and deliver an income growth model.		Clinical assurance through QSC. Regulatory assurance through ARC.	
Contractual risks: GIC contract risk of clawback	There is a potential financial risk associated with NHS England quarterly service spending reviews for 2026/27; the current national review of GIC services may increase scrutiny of financial performance and potential underspend linked to vacancies (currently 11 WTE reported). The likelihood of financial clawback was previously assessed as low but recent developments may increase the likelihood.	Chief Medical Officer / Chief Finance and Investment Officer	Contracts report to be provided at the PFRC meeting where risk will be reviewed for handover to NLFT's Finance and Investment Committee The risk has visibility at workstream level	Q1 2026/27
Contractual risks: University of East London	The University of East London has issued notice on its social work contract, citing a change of control clause associated with the merger. If enacted, this would require a "teach-out" arrangement for current students and no new students would be recruited. The maximum potential contract value	Chief Education and Training Officer / Chief Finance and Investment Officer	Contracts report to be provided at the PFRC meeting where risk will be reviewed for handover to NLFT's Finance and Investment Committee Legal position being explored. The risk has visibility at workstream level	Q1 2026/27

Item	Risks and Issues	NLFT owner	Handover arrangements	Due date
	is c£329k per year and costs would be incurred from teach-out arrangements. The risk has reputational and student impacts.			

Performance, Finance & Resources Committee — Annual Report

Reporting Year: 2025–26

Chair: Aruna Mehta

Members (during the year): Aruna Mehta (Chair), Shalini Sequeira (NED, attending as SID from November 2025), Sabrina Phillips (Associate NED to October 2025, NED and Deputy Chair from November 2025), David Levenson (until July, invited/attending as SID), Executive leads: Jonathan Bell (Interim Chief Finance Officer), Rod Booth (Director of Strategy & Business Development)

Executive Lead(s): Jonathan Bell (Interim Chief Finance Officer), Rod Booth (Director of Strategy & Business Development)

Committee Secretary: Asma Bi

Governance Support: Interim Director of Corporate Governance: Dorothy Otite (to Nov 2025); from Dec 2025 support via Terry Willows, NLFT Director of Corporate Governance

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1. Introduction

The Performance, Finance & Resources Committee (PFRC) is a formal sub-committee of the Board established to provide oversight and assurance on the Trust's financial sustainability, operational performance across clinical, education and training and corporate services, capital programme, estates & facilities, information management and technology (including cyber), procurement, and the delivery of the efficiency programme. Its remit and delegated authorities are set out in the PFRC Terms of Reference last ratified by the Board in November 2025.

During 2025–26, PFRC's focus reflected a deteriorating in-year financial position, the withdrawal of the National Training Contract, cash management risks, efficiency programme delivery, estates compliance and programme oversight (including Gloucester House), Information Management & Technology (IM&T) integration and Artificial Intelligence (AI) initiatives, and contracting performance.

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2. Membership and Attendance

Membership comprised Non-Executive Directors and the two Executive Joint Leads. During the year there were a number of changes in Non-Executive Director membership of the Committee.

Attendees included the Interim Director of Corporate Governance, Chief Executive Officer, Deputy Chief Finance Officer, Director of Infrastructure, Estates Consultant, and service and contracting leads as required.

Quoracy was maintained at all meetings.

The Committee invited **all NEDs** to selected financial-risk-focused sessions (e.g., September and October Extra-Ordinary), improving transparency and collective challenge on PFRC matters.

3. Meetings, Coverage and Declarations

PFRC met in line with its **Annual Schedule of Business 2025–26**, with additional **Extra-Ordinary** sessions to address financial risk and cash flow. The agenda followed the ToR scope, covering standing financial reports, Integrated Quality and Performance Report (IQPR), capital, financial investment review group meeting (FIRM), estates and compliance, digital/IM&T, contracting and commercial, Board Assurance Framework (BAF)/Corporate Risk Register (CRR), and efficiency programme progress. Declarations were recorded and there were **no material conflicts preventing participation**.

Minutes reviewed:

- **17 Apr 2025 (Confirmed)**
- **12 Jun 2025 (Confirmed)**
- **31 Jul 2025 – Extra-Ordinary (Confirmed)**
- **22 Sep 2025 (Confirmed)**
- **02 Oct 2025 – Extra-Ordinary (Confirmed)**
- **03 Nov 2025 (Confirmed)**
- **11 Dec 2025 (Unconfirmed)**

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4. Key Areas of Assurance and Oversight

4.1 Financial Strategy, In-Year Income and Expenditure and Forecast

- The Committee moved from early-year **partial assurance** (June) through deepened scrutiny at Extra-Ordinary sessions, given the **National Training Contract (£2.6m) income loss** and **efficiency programme slippage**, to Month 6 and 7 reports projecting a **full-year deficit (£5.0m at M6; revised £5.37m at M7)** versus a planned breakeven. The Committee recognised improvement actions (pay/non-pay controls, run-rate reporting, contribution analysis) but noted material external drivers and timing/cash dependencies (e.g., Gloucester House sale).
- **Contribution analysis** introduced at Month 7 evidenced: Clinical Services 23.7% contribution, DET contribution reduced (10%) reflecting National Training Contract impact; Tavistock Consulting under-delivering.
- Committee steers included: **quantification of risks in reporting**, scenario-based forecasting, and recalibration of land-sale timing assumptions in the official forecast while continuing external engagement.

4.2 Cash Management and Going Concern Considerations

- PFRC monitored cash daily/weekly via **13-week rolling forecasts** and oversight of national **cash support applications** (e.g., November/January requests). The Committee recorded the **risk to meeting payroll,** timely national support and agreed last-resort mitigations (temporary deferral of statutory payments), consistent with prior precedent; commissioners' advance payments were no longer permitted.

- A **Cash Committee** and enhanced **IM&T/finance controls** were put in place; PFRC required options appraisals and escalation support across the system.

4.3 Efficiency Programme

- PFRC oversaw a **total 2025/26 programme value of c. £11.7m** (including balance-sheet measures and other mitigations). The Committee required **weekly Efficiency Programme Board** reporting, **Quality Impact Assessment/Equality Impact Assessment routes** via Quality and Safety Committee and People and Organisational Development, Equality Diversity and Inclusion Committee, and transparent **RAG status** distinguishing in-year versus next-year deliverability. In-year delivery was constrained by **redundancy funding** and **TUPE/merger timing**, so the focus shifted to **recurrent** savings for 2026/27.

4.4 Capital Programme, Estates & Compliance

- PFRC received **FIRM/capital** oversight and **estates compliance** updates including six-facet survey results, Estates Returns Information Collection/Premises Assurance Model context, and progress on projects (e.g., lifts, library, asset replacement). Committee noted structural risks (aged roofs/windows/paving), and the strategic dependency on **Gloucester House** relocation/sale for both operational and financial planning.

4.5 Digital / IM&T and Cyber

- The Committee tracked **Cyber Essentials accreditation** (including Cyber Assessment Frameworks standards) and the formation of **Executive-led IM&T Steering** with an **AI workstream** (e.g., Co-pilot, Ambient Voice Technology pilots), balancing ambition with capacity and merger alignment. It also oversaw **integration planning** (Organisation Data Service (ODS) code readiness; transfer of electronic patient record from CareNotes to RiO post-merger 2026/27) and requested **staff-reassurance communications** emphasising continuity and clinical safety.

4.6 Commercial, Contracts & Performance

- PFRC received **contract risk matrices** (values added at Committee request) and monitored specific areas: Gender Identity Clinic (ring-fenced funding; quality improvement oversight), Family Drug and Alcohol Court (contribution improving with proactive engagement), Surrey Mindworks (debtor/clawback issues under resolution), Department for Education and Training portfolio (National Training Contract decommissioning negotiations; settlement linked to merger), and iThrive prospects.
- The **IQPR** and **SOF 3** updates were scrutinised with explicit triangulation to financial risk and BAF entries, especially where performance pressures could crystallise as contractual or financial exposure.

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5. Risk Management: BAF and Corporate Risk Register

PFRC considered the BAF and CRR at each meeting for risks within its remit (notably **BAF 9 — Financial Sustainability**; **cash flow; efficiency programme and break-even; productivity & performance**). The Committee **did not support a reduction** in BAF 9 during December, given the **absence of an approved full business case and continued in-year uncertainty**, instead steering an **increase in the likelihood score** and a **Board-**

level discussion in January 2026 to align merger risk and BAF profile. PFRC also requested clearer mapping of **in-year vs future-year** impacts in contracting risk reports to strengthen financial planning.

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6. Governance, Policies & Terms of Reference

PFRC **approved its revised Terms of Reference (Nov 2025)**, reaffirming scope across **financial performance, operational performance, estates, IM&T, procurement, capital, cash and risk**. It also approved the **Procurement Strategy and Policy update** with alignment to NLFT policies through merger transition. The **Annual Schedule of Business** provided structured coverage and was updated to include **Extra-Ordinary** sessions where needed.

6.1. Committee Effectiveness

The Committee operated in line with its Terms of Reference and business cycle, enhanced cadence when risk warranted, and strengthened the **quality of financial reporting** (run-rate, contribution analysis, scenario forecasts, contract values, clearer assumptions and sensitivities). It emphasised **assurance (not operations)**, routed quality impact assessment/equality impact assessment and safety/culture items to other Board sub-committees as appropriate and maintained **cross-committee escalations** and feedback to Board. Member reflections noted **robust papers**, **constructive challenge**, and **clear chairing**, with **governor observers** engaged throughout.

6.2 Groups Reporting to the Committee

Handovers will need to be prepared from the reporting groups to the Committee.

- Efficiency Programme Board
- Financial Investment Review Group Meeting
- Integrated Quality and Performance Assurance Group Meetings
- Health and Safety Group

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8. Key Themes & Learning

- **Financial Grip & Transparency:** Move to granular run-rate, contribution and scenario reporting improved shared understanding and enabled more realistic forecasting and targeted mitigations.
- **Cash Risk & System Working:** Early, candid articulation of cash risk and constraints (no commissioner advances) supported timely national applications and governance of last-resort mitigations.
- **Efficiency Programme Deliverability & Recurrent Focus:** Structural constraints (redundancy/TUPE/merger) limited in-year options; PFRC re-weighted towards **recurrent savings** to stabilise 2026/27.
- **Contracting Visibility:** Addition of **values** and differentiation of **in-year vs out-year** impacts enhanced PFRC's ability to judge financial exposure and prioritise actions.

- **IM&T Integration & Assurance:** Clear phasing (pre/post-merger), **Cyber Essentials** continuity and measured AI adoption under governance helped balance opportunity with capacity and risk.
- **BAF Calibration:** Committee pressed for **realistic BAF scoring** pending full business case/merger decisions and improved alignment with portfolio/merger risk logs.

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9. Conclusion

PFRC has **discharged its responsibilities** in a **high-risk** and **fast-moving** financial year by intensifying oversight of **income and expenditure, cash, efficiency programme, capital/estates, IM&T, and contracting**; sharpening risk articulation (BAF/CRR); and maintaining transparent, constructive challenge and escalation to the Board. While **material risks remain** (notably the in-year deficit, cash dependence on national support and transaction timing, and structural drivers in the Department for Education and Training/ Tavistock Consulting), the Committee has **strengthened financial governance and controls**, set expectations for **recurrent improvement into 2026/27**, and ensured alignment of its work with the Board's strategic decision-making through the merger process.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday 26 March 2026			
Report Title: Final suite of Board handover documents			**Agenda No.: 020**
Report Author and Job Title:	Terry Willows – Director of Corporate Governance	**Lead Executive Director:**	Terry Willows – Director of Corporate Governance
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	Subject to final approvals, the Trust will merge through acquisition by North London NHS Foundation Trust (NLFT) on 1 April 2026. This paper sets out the final handover documents that will be passed from the Trust's Board to the Board of NLFT.		
Background:	The merger by acquisition of TPFT by NLFT is scheduled to take place on 1 April 2026. All TPFT committees have now been through a full handover process which has included the following: • Counterpart NLFT Committee chairs have been invited to attend the meetings of TPFT committees, alongside the relevant lead NLFT executive • 1:1 briefing sessions have taken place for TPFT Committee chairs with the incoming committee chairs with lead execs invited Each TPFT committee has produced a full handover report which sets out the key issues it has been discussing, the areas on which it has been seeking assurance, any risks or issues it wants to handover, and any outstanding actions. These committee handover reports have been presented to the Board at its final meeting on 26 March 2026, alongside the Board Assurance Framework and Corporate Risk Register. Along with the minutes and papers from this last Board meeting, these papers form the suite of handover material that the Board has now reviewed.		
Assessment:	Before finalising the handover pack, the Board is asked to consider if there are any other matters that it wishes to highlight to NLFT's Board. It will then be for the NLFT Board to "receive" on 1 April the handover material and ensure matters are formally documented and allocated to NLFT committees for oversight and assurance as appropriate.		
Key recommendation(s):	The Trust Board is asked to approve the full and final suite of handover materials to be presented to NLFT's Board at the point of merger on 1 April 2026.		
Implications:			
Strategic Ambitions:			

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Alignment with Trust Values:	Excellence ☒	Inclusivity ☒	Compassion ☒	Respect ☒	
Link to the Risk Register:	BAF ☒	CRR ☒	ORR ☐		
	The full Board Assurance Framework and Corporate risk Register will form part of the suite of handover materials to be received by NLFT's Board.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	Subject to Secretary of State approval, the order under section 56A of the NHS Act 2006 will mean that the Trust ceases to exist at midnight on 31 March with all of its functions, assets and liabilities transferring in their entirety to North London NHS Foundation Trust. The handover arrangements will ensure appropriate continuity and focus on the issues that the Board has been focused on before the Trust's merger by acquisition.				
Resource Implications:	Yes ☐	No ☒			
	None directly.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	None directly.				
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:	All committees of the Board during their February and March 2026 meetings.				
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	