The Tavistock and Portman
NHS Foundation Trust

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Annual Report and Accounts 2017/18

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NHS Foundation Trust

Annual Report 2017/18

Contents

Foreword to the Report

An Annual Report is an account of the stewardship of the Board and its Directors for the mission and work of the organisation. It provides a picture of the work the Trust has done over the last twelve months to improve and grow the range and quality of its services.

Over the past four years the Trust has more than doubled the number of people of all ages that it serves through our diverse range of services across both our local Camden and national footprints.

During the year the Charing Cross Gender Identity Clinic became part of the organisation. As a result the Trust is now the largest single provider of Gender Identity Services for both children and adults in the United Kingdom.

Having the largest adult gender service and the children and young people's service in a single Trust has created opportunities to improve the arrangements for transitioning into the adult service. It also makes the Trust a leading international centre of expertise on gender identity.

Waiting times for gender remain an important issue for us. The teams are working incredibly hard and our commissioner, NHS England, has provided extra resources, despite this demand is rising and the workforce challenges of recruiting and training a specialist staff is not a small one. There remains more to do and this will be a continued focus for the Board in the coming year.

Quality is always a central focus for the Board and as this Annual Report demonstrates against the key measures of performance we score well. Waiting times are an important marker for the Board and we are proud of the strides our staff have made to improve waiting times and manage risk.

Open Mind, our Child and Adolescent Service (CAMHS) in Camden, is seen as a model of the kind of integrated care that young people need. Our working relationship with Camden Children's Services was singled out for praise in Camden Council's OFSTED inspection. Embedding clinicians in children's teams and in our schools has led to effective collaboration and problem solving. Over forty per cent of all CAMHS referrals come from our schools,

and more than eight out of ten referrals are accepted into service. This is a critical marker of quality and makes a huge difference to the young people who get the right help at the right time.

Training and Education is a key focus for the Trust. The Academic Year 2017/8 saw a record number of students enrolling on our long courses. We have also been developing, as part of our National Training Contract with Health Education England and with the creation of the National Workforce Skills Development Unit, a wider profile on work force development in mental health. This is an area where we expect to focus further in the coming year.

Last year the Parliamentary Health and Education Select Committees jointly visited our service and highlighted it in their report on CAMHS and school based mental health. More recently the Trust has offered advice and input on the Government's Green Paper proposals for schools based mental health.

Another measure of Trust performance is what our staff say about us. The Board takes the annual staff survey very seriously. This year's survey placed the Trust as the top mental health Trusts for staff engagement and satisfaction. We also saw a significant reduction in concern about bullying, a result of a series of steps we have taken over the past two years.

One area where the Trust's ambition has not been reflected in the staff survey is on race equality. The Board is absolutely committed to ensuring that all our BAME staff feel enabled to progress in the organisation and fulfil their potential. This year we set in place a race equality strategy and action plan. I am determined that from the Board to the front-line we become ever more representative of the populations we serve. But there is still more to do.

As the Trust's Chief Executive, Paul Jenkins, says in his performance report the past twelve months have been busy, positive and challenging. That is in no small part down to the dedication and hard work of our staff and the strong sense of purpose and service that drives the organisation forward.

Rt Hon Prof Paul Burstow
Trust Chair

Performance Report

Overview

The purpose of this overview is to give readers a short summary providing sufficient information to understand the Trust, its purpose, key risks to achieving that purpose and our performance over the year.

Statement from CEO providing perspective on performance

The Trust has had a busy and positive year despite the challenging overall operating environment for the NHS.

In April 2017 the Charing Cross Gender Identity Clinic joined the Trust. We welcome the addition of this important service to our work and are proud of being one of the most significant centres of expertise in this area in the world. The work of our gender services was the focus of our annual general meeting in October 2017.

The Trust is exploring a range of new service opportunities and has been successful in winning tenders to deliver from 2018/9 onwards a Forensic CAMHS service covering North Central and North-East London. The Trust is also a partner in a successful bid to deliver a Child House in North London, an innovative model of providing integrated support for young people who have been the victims of sexual exploitation.

The Trust has further developed its work as a provider of training and education, recruiting a record number of 602 students to its long courses starting in September 2017. In total there are 1,150 students enrolled on our long courses with a further number of 2,135 students benefitting from our short course provision in 2017/8. As part of its national contract with HEE the Trust is taking a national role in supporting the development of the mental health workforce. To support this, it has established a Workforce Skills Development Unit.

The Trust is proud of its reputation in providing high quality and safe clinical care. In the last year we have taken steps to strengthen this further. We are continuing the implementation of our clinical quality strategy which has included the provision of quality improvement training to key staff and the identification of local quality improvement projects across our clinical services. The Trust experiences a low level of serious clinical incidents. We take our responsibility for learning from incidents very seriously and have, this year, taken measures to strengthen our reporting of incidents in the public part of Board meetings and to hold events for staff focused on learning from incidents.

The Trust remains committed to work with our partners in North London to support the development of integrated care through the sustainability and transformation partnership (STP). We have also been active, in the wake of the recent Government's Green paper, in supporting the development of thinking around effective models of schools based mental health provision for children and young people.

The quality and commitment of the Trust's staff remain central to the quality of our services and the effectiveness of the organisation. The Trust secured a very positive outcome from the 2017 NHS Staff Survey with an overall increase in the score for staff engagement and some positive shifts in areas where there had been previous concerns. The Trust is committed to further developing its people. In the last year we have published a People Strategy. We have also published our Race Equality Strategy with the aim of promoting genuine equality of opportunity for BAME staff across our organisation.

Despite wider external pressures the Trust continues to perform well financially and has delivered a surplus (including sustainability and transformation funding – STF) of £2.8m in 2017/8.

Statement of purpose and activities of the Trust.

The Tavistock and Portman NHS Foundation Trust is a specialist mental health trust focused on psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental health. It has a national and international reputation based on excellence in service delivery and clinical innovation, and high-quality clinical training and workforce development.

The Trust is proud of its history of innovation and excellence, and seeks to build on this in the future. The Trust's two largest areas of activity are patient services, and education and training services. The Trust:

- offers a wide range of generic and specialist outpatient mental health services to children, families, adolescents (CAMHS) and to adults. Whilst CAMHS comprise the majority of the Trust's patient services, through our Adult and Forensic Services (AFS) the Trust also offers a range of specialist and generic applied psychological therapy services to adults, including forensic services. Many of our services are now located in community or primary care settings.

- provides a wide range of mental health education and training, offering 14 taught postgraduate courses, 6 professional doctorates and 12 Trust certified programmes with a range of professional and clinical accreditations. In addition there is a dynamic programme of short courses for Continuing Professional Development (CPD) and career development. Courses are offered locally, nationally and internationally. The Trust enrols in excess of 3,000 students each year and has strong University partnerships.

In addition, the Trust has a strong research tradition, and a consultancy service where the Trust:

- is active in research into the origins of mental health problems, models of social care, and research aimed at establishing the evidence base for

its treatment methods. The Trust seeks to influence and develop new ideas by research, publication and participation in policy making.

- provides an extensive programme of organisational and management consultancy to the NHS, the public, commercial, and industrial sectors. The Trust is well known for its original and influential work in this field.

Structurally the organisation comprises of two clinical directorates, the directorate of education and training and a number of corporate directorates which support the delivery of our clinical, academic and research endeavours.

Organisationally we are located in north central London and commissioned by local and national agencies in the health, care and education sectors.

Annually we set our strategic objectives which align to our longer term ambitions.

Brief history of the Trust and statutory background

The Tavistock and Portman NHS Foundation Trust achieved authorisation as an NHS Foundation Trust in 2006. Prior to this it was the Tavistock and Portman NHS Trust, established in 1994, bringing together the Tavistock Clinic, founded in 1920, and the Portman Clinic, founded in 1933.

Key issues and risks that could affect delivery on objectives

The Trust will continue to be affected by the wider financial pressures facing the NHS and the need to meet significant efficiency targets in future years. An important issue will be the ability to identify opportunities for growth in both clinical services and training and education. Additionally, new contracts in relevant fields of work are being sought, including those with a geographical reach beyond the Trust's traditional field.

The Trust will need to continue to sustain and improve the quality of its clinical and educational work. We are preparing for a further inspection from CQC during the course of the year and will continue to focus on the implementation of our clinical quality strategy.

The Trust will be affected by a national procurement exercise for adult gender services. We will support staff during this process and will work with partners to position the Trust's expertise in this field in support of best outcomes for patients.

With further changes in the financial support available through the National Training Contract, the Trust will need to look at the scope to deliver efficiencies in its training and education work without impacting on the quality of the educational experience offered. This will include the development of a project to establish a Digital Academy to assist in the delivery of blended teaching models.

The Trust recognises the pressure on staff in the current economic environment. We will continue to support staff through the implementation of our People Strategy and work to maintain and improve the positive results from the 2017 NHS Staff Survey.

The Trust will continue its work to find a viable long-term option for its future accommodation needs.

Going Concern disclosure

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

The Trust regularly assesses performance. Some of the Trust's key performance indicators are outlined below. At Board level, in 2017-18 performance has primarily been reviewed and assessed by regular reports to our Trust Board which include trend data where appropriate, as indicated below.

- A suite of quality measures for patient services including outcomes, DNA rates, user satisfaction, waiting times and complaints which are assessed quarterly by the Board via the Trust's Performance Dashboard.
- Training: A key domain in the assessment of performance is student satisfaction and the impact of our education and training programmes in enabling staff to be more resilient in their workplace and organisational settings and enhance their knowledge and skills.
- Variance against budget – assessed monthly at the Trust Board
- Staff morale, appraisals, training and stress- through annual national staff survey and quarterly HR reports.

In 2015/16 the Trust developed a more integrated system for performance management, which utilises a number of dashboards. These provide the Trust with visual presentation of performance, which identify trends, illustrates where further interrogation and attention is needed and enables total visibility of the whole system instantly. These were updated in 2017/18 and have continued to be regularly used by the Trust Board in 2017/18 to review and assess performance.

The Trust monitors the outcomes of care being delivered to patients. An overview of quality indicators for 2017/18 can be found in the Quality Report along with full details on our compliance against the quality priorities we agreed for 2017/18. We achieved a significant proportion of our priorities by the end of March 2018.

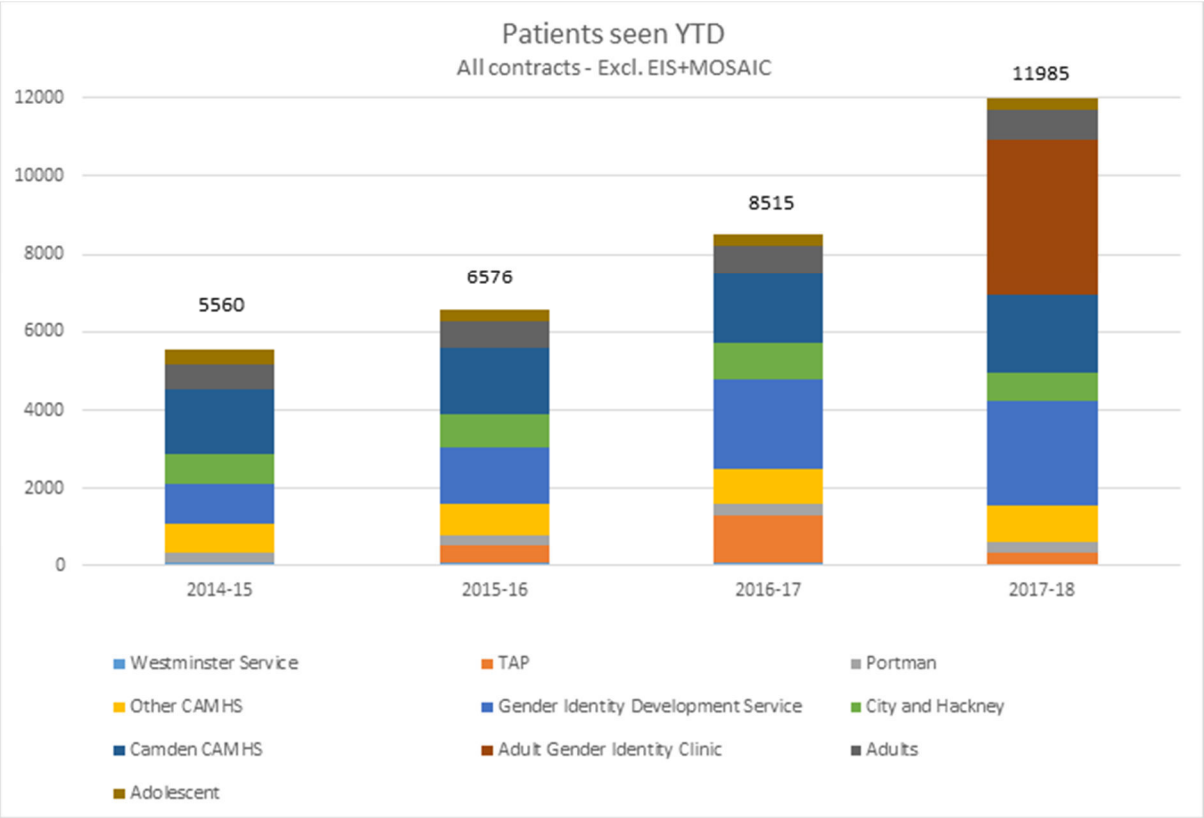
The Board of Directors receives a quarterly report on Quality, where performance against our Key Performance Indicators, Commissioning for

Quality and Innovation (CQUIN) and Quality Indicator targets is presented. The measures examined include waiting times, DNA rates, staffing measures such as sickness rates, clinical outcome measures, and measures of complaints, incidents and safeguarding.

In addition to the above the Board of Directors are presented with a comprehensive Board Assurance Framework and risk registers which detail what may challenge either our continued performance or delivery of our strategy objectives. Further information about our approach is detailed in the Accountability Report.

Key Areas of Performance

Trust Reach



The Trust continues to see an increase in patient numbers year on year, in accordance with our strategy for growth across services. Much of the growth has come from our nationally commissioned Gender Identity Development Service (GIDS), and adult Gender Identity Clinic (GIC) which joined the Trust in April 2017, where demand continues to rise.

We are in our third year of CAMHS transformation and in 2017-18 benefited from funding to support a waiting list initiative to speed up access to the most helpful service as quickly as possible. We used the funding to trial having two waiting list clinicians attached to the Joint Intake service, in order to trial telephone first appointments, and provide THRIVE advice and signposting, and to employ additional sessions to support the waiting times for Autism Spectrum Disorder (ASD) assessments.

Having clinical staff in the Joint Intake team has been a support for the chair of the Joint Intake service because additional information regarding referrals can be obtained efficiently. There was mixed feedback about the telephone first appointments. Patients were pleased to be contacted promptly, but were not happy that they then had to repeat their stories to another clinician at the first face to face appointment. Also, from the referral information we were not able to predict who would be suitable for advice and signposting and who would not. This initiative has informed our practice going forward in that we are planning to bring clinical staff into the joint intake service permanently to support the chair of joint intake, and to do direct face to face triage, and advice and signposting from within the Joint Intake team. We will continue to make contact with families by telephone ahead of a first appointment, but will not continue with telephone triage. Waiting times for ASD assessments came down from 6 months to 3 months and are being maintained at this level.

The Trust has also seen a significant increase in 2017/18 academic year (September 2017 to August 2018) in the number of students enrolled on its courses.

Staff Engagement

MORALE

Staff sickness

1.3%	4.0%
Trust	Benchmark (16/17) - all NHS Trusts

Source: TPNHSFT HR

Staff motivation at work

Trust 2014/15 Score	3.91
Trust 2015/16 Score	3.99
Trust 2016/17 Score	3.87
Trust 2017/18 Score	3.94
MH Trust 2016/17 Average	3.91

Source: NHS Staff Survey

Staff recommend Trust as place to work

71%	71%
Q3	Q4
National Average 16/17	61%

Source: TPNHSFT HR

Disclosure and Barring Service Compliance

% of staff with a compliant DBS Check	97%

Source: TPNHSFT HR

TRAINING

Staff appraised

100%	95%
2017/18	Q4

Source: TPNHSFT HR

Staff opinion on quality of appraisals

Trust 2015/16 Score	3.05
Trust 2016/17 Score	3.05
Trust 2017/18 Score	3.31
MH Trust 2017/18 Average	3.22

Source: NHS Staff Survey

Mandatory training: % staff

94%	95%
Q3	Q4

Source: TPNHSFT HR

Staff opinion of training

Trust 2015/16 Score	3.97
Trust 2016/17 Score	4.01
Trust 2017/18 Score	4.18
MH Trust 2017/18 Average	4.06

Source: NHS Staff Survey

MANAGEMENT

Support from immediate managers

Trust 2014/15 Score	4.01
Trust 2015/16 Score	3.95
Trust 2016/17 Score	3.85
Trust 2017/18/Score	4.05
MH Trust 2016/17 Average	3.95

Source: NHS Staff Survey

% staff reporting good comms between senior mgmt and staff

Trust 2014/15 Score	43%
Trust 2015/16 Score	46%
Trust 2016/17 Score	45%
Trust 2017/18 Score	54%
MH Trust 2016/17 Average	36%

Source: NHS Staff Survey

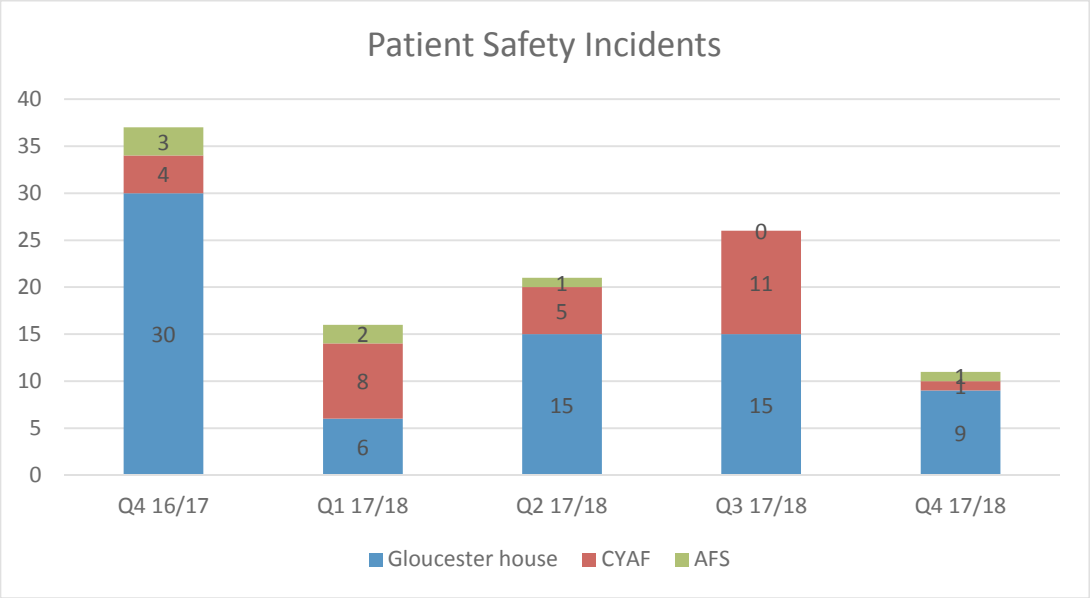
Recognition and value of staff by managers and the organisation

Trust 2015/16 Score	3.92
Trust 2016/17 Score	3.61
MH Trust 2016/17 Average	3.56

Source: NHS Staff Survey

The NHS staff survey showed that our staff were committed and would recommend the Trust both as a place to work, it was pleasing to receive a high engagement score. Sickness absence remains low compared to other mental health trusts. Further details can be found in the staffing chapter of this report.

Patient Safety



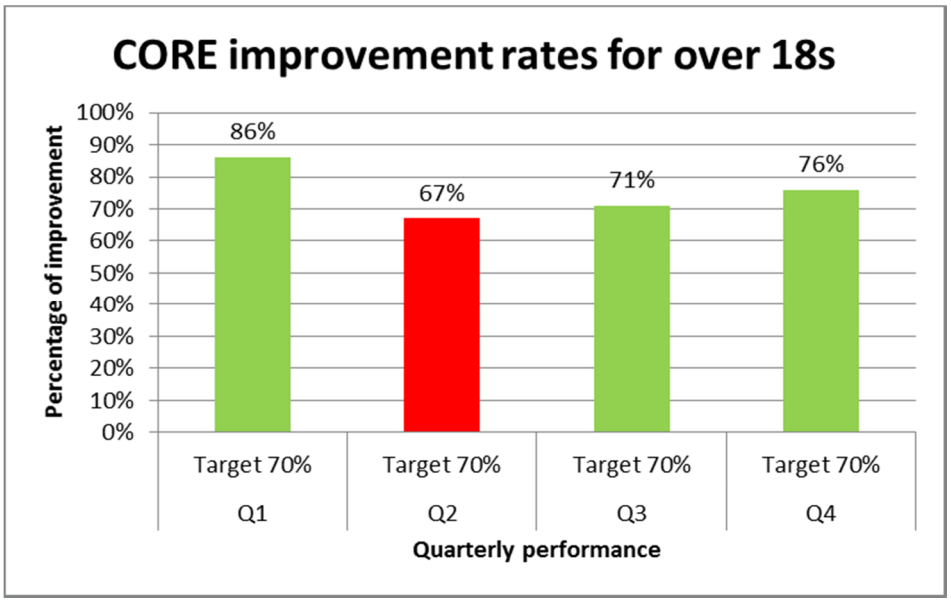
The Board encourages an open and transparent culture throughout the Trust, and feels the learning that can be taken from incidents is one of the best ways to improve the quality of our services. Gloucester House continues to provide over 64% of the Trusts Incident numbers in this financial year, due mainly to reporting all violence to staff and damage to property. All incidents are discussed and debriefed at the end of the school day with senior staff.

All Serious Incidents are reported to the Board and the full investigation reports are considered by the Clinical Quality Safety and Governance Committee which provides assurance to the Board about the adequacy of the investigation and the associated action plan to address any lessons learned. The lessons learned from both incidents and complaints are shared with the relevant team, and also at induction and mandatory training events and via the 'Quality News', an internal communication to all staff. Two Trust-wide

'learning from incidents' events have been held during the year and these are now planned quarterly.

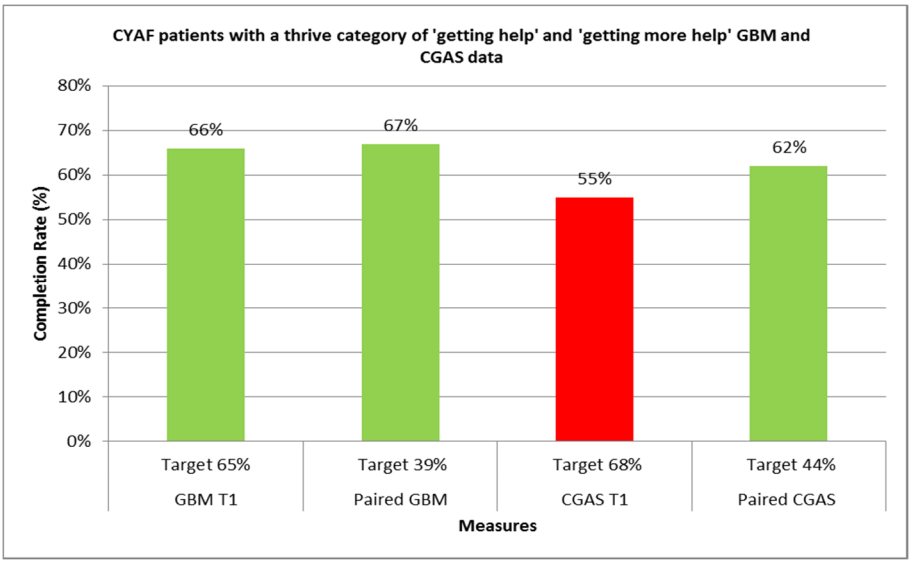
Outcomes

The Trust monitors the outcomes of care being delivered to patients. An overview of quality indicators for 2017/18 can be found in the Quality Report along with full details on our compliance against the quality priorities we agreed for 2017/18. We are pleased to have met a significant proportion of our priorities by the end of March 2018.



Our outcomes measures reporting changed during 2017/18, for the Children and Adolescent Mental Health services (CAMHS). The targets were redefined to include in the cohort, only those patients who were receiving treatment. We met our target of 70% improvement rate for the Clinical Outcomes Routine Evaluation measure (CORE) by quarter 4 with 76% of patients displaying improvement after receiving treatment. This was the same throughout the financial year except quarter 2 when the improvement rate fell slightly to 67% due to our clinical administrative processes which we have continued to develop throughout the year.

We met the target to collect an initial Goal Based Measure (GBM) score (Time 1 – T1) from all relevant patients in 2017-18 with 66% and also exceeded the target for collection of review scores (paired GBM) by 28%. Initial completion of the Children's Global Assessment Scale (CGAS) was under the 68% target with only 55% of relevant patients completing this. However, of those who had completed the initial measure 62% completed the second review (paired CGAS) exceeding the target by 18%.



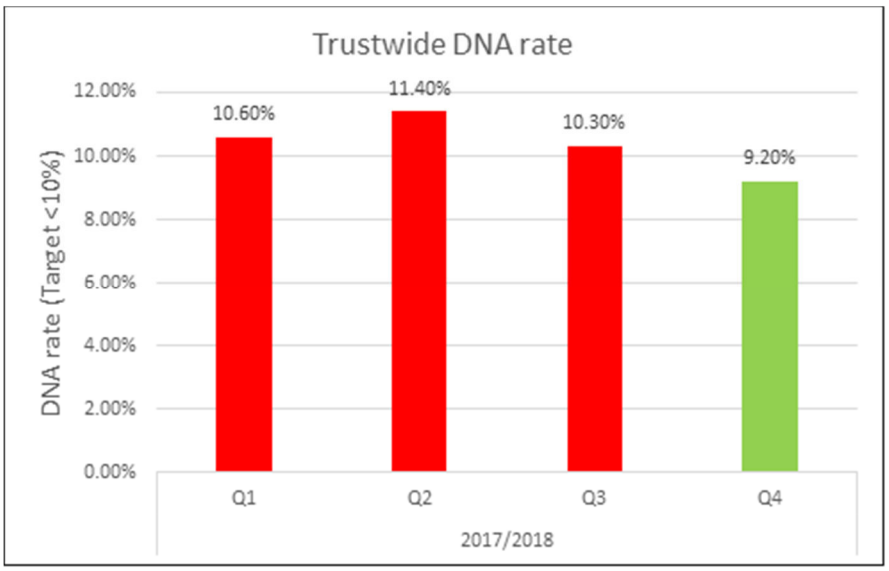
For 2018-19 the trust is working with commissioners to focus more on collection rates rather than improvement rates.

Our Experience of Service Questionnaires showed that 95% of patients rated the overall help they had received as good and 99% would recommend the Trust to others.

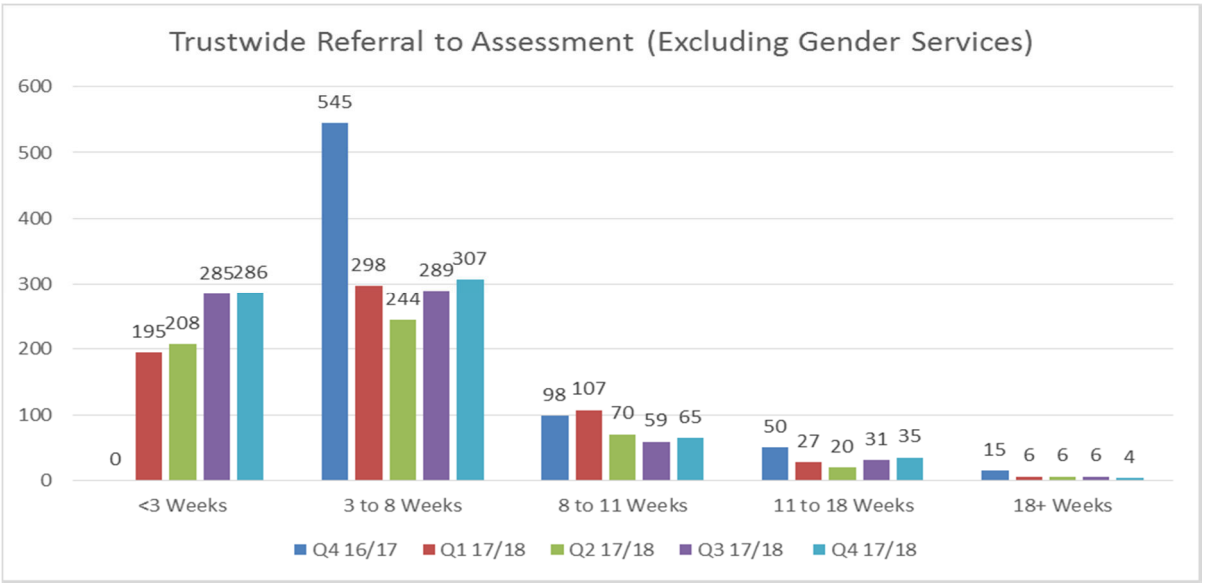
Service Responsiveness

Our Did Not Attend (DNA) rate for patients rose in the first 3 quarters of the financial year, but reduced again to under the 10% target for quarter 4 (9.2%). We have invested in SMS text reminders for patients in the GIC service and will

be going live with this facility in the GID service from April 2018 to help reduce DNAs in these areas and look to extend the facility more widely across services in 2018-19.



Waiting Times

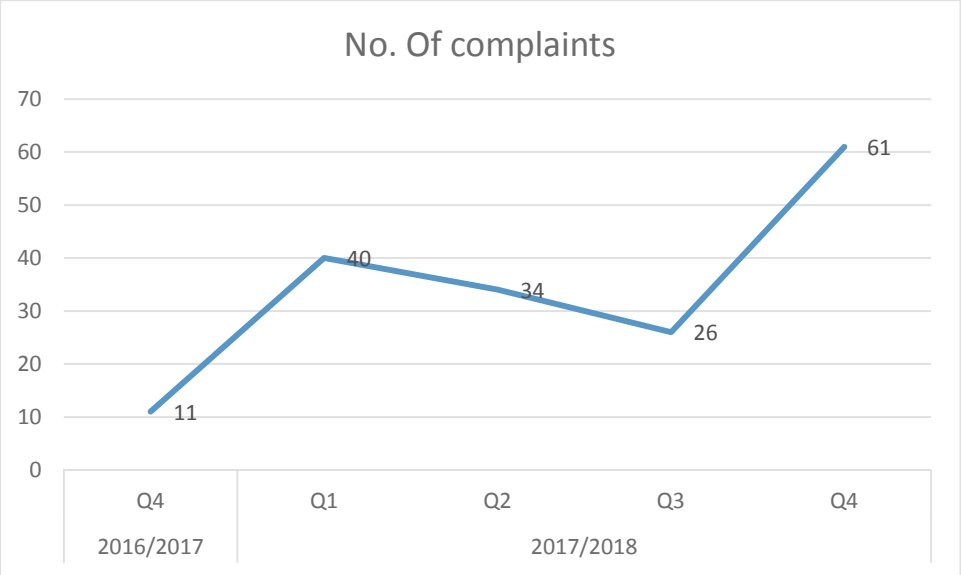


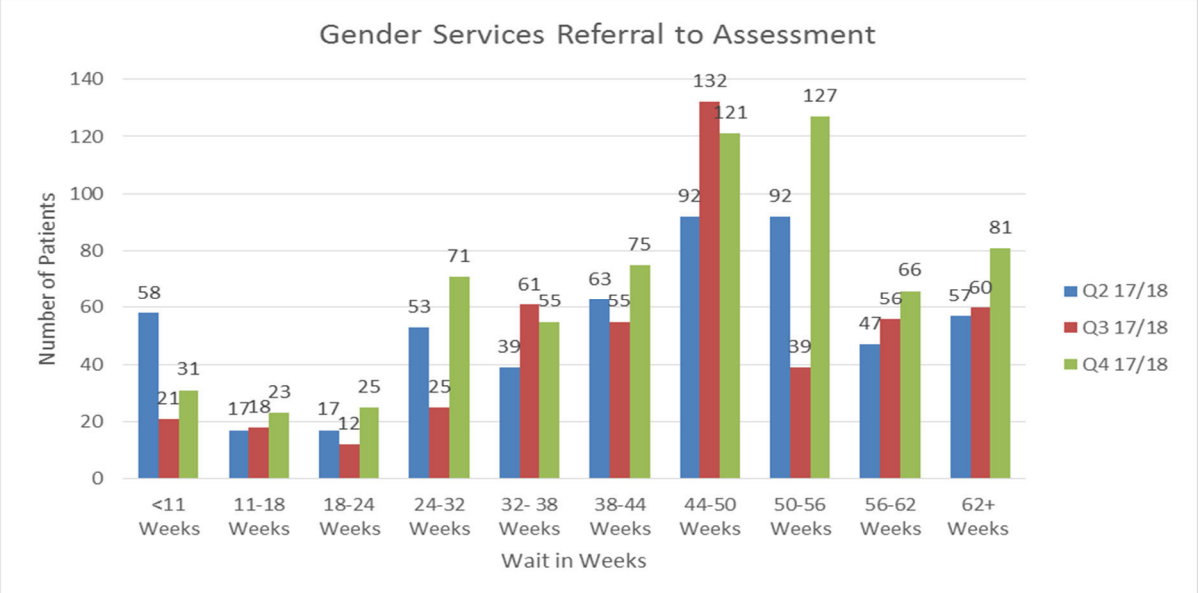
Overall the Trust has seen an increased number of patients. In many services, patients are seen within our waiting time targets and in some services well before the target date. Waiting times for first appointments remained an area of concern in the both the Gender Identity Service (Under 18 years age) and Gender Identity Clinic (Over 18 years age). Although significant efforts are being made to improve the waiting times for patients the increase in referrals

year after year means these efforts are not yet enough to cover the demand of the gender services.

Over the year, we have seen a significant improvement in waiting times in City and Hackney Primary Care Psychology Consultation Service (PCPCS) due to greater clarity about general intake criteria, improved intake processes and full administrative staffing. We are pleased that even with the increased numbers of patients we are seeing, patients continue to feel that their concerns and worries are taken seriously and that they are involved in important decisions about their care.

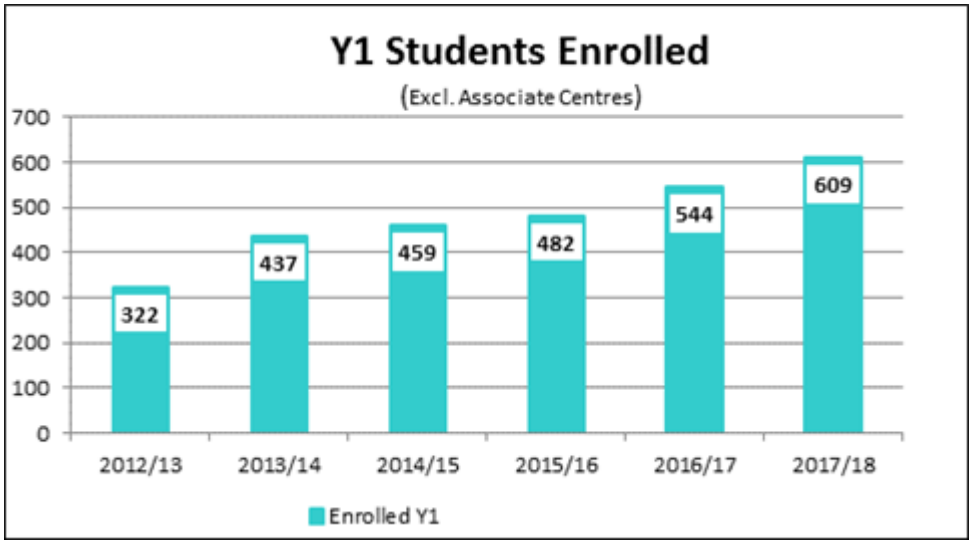
Complaints





We saw an increase in complaints over the last year, particular from the new adult gender identity clinic service. The service moved to the Trust in April 2017 and a lot of work has been undertaken to address issues raised, particularly concerning communications. In general we are pleased that patients feel that they can raise concerns with us and provide us with opportunities for improvement where possible. We continue to look carefully at all complaints, formal and informal, to establish whether they point to persistent problems within our services.

Education and Training



The Directorate of Education and Training (DET) makes a significant contribution to the development and strengthening of the NHS workforce to provide better and more effective mental health provision to people in a range of sectors, including social care. This is a key part of the Trust's provision. The Trust has again achieved considerable growth this year in Y1 student numbers across both long and short courses, which provides some grounds for optimism set against the prevailing trend in part-time postgraduate education in the UK.

We have continued to embed the changes made in our professional support services and are nearing completion of the implementation of our new student information system, MyTap, which will improve student experience, our capacity to support our students, and improve the data available to the organisation and key stakeholders including regulators and commissioners. These achievements have not been without challenge and pressure on staff and visiting lectures. However the recent results of the NHS staff survey show just how engaged, committed and passionate people in the organisation are about what we do and how we aim to develop.

This year has also seen the continued implementation of the revisions to our National Training Contract. We value and appreciate the significant contribution Health Education England make to enable us to develop and deliver quality and relevant educational programmes that positively impact patient care and organisational capability. These revisions also provides the Trust with the opportunity to make a more visible and significant contribution to broader workforce issues through our newly established National Workforce Development Skills Unit. This is supplemented by the Mental Health Workforce Development Collaborative, with six other provider organisations in England, is creating the opportunities for genuine collaboration and joint working to deliver the best possible outcomes for workforce planning and development nationally.

The Trust has made significant headway in realising several of its supporting objectives to develop learning and teaching this academic year. The Trust's accredited HEA Recognition Scheme has seen four staff members successfully achieve fellowship at the level of Fellow. Planning is underway for the next annual cycle of applications, with work continuing to embed the process institutionally.

The Trust has offered its second year of learning and teaching CPD seminars for staff, to help develop their skills, and support them in applying for fellowship of the HEA. The 2018-19 programme of CPD will be launched at the third annual learning and teaching conference in June - *Navigating Boundaries and Creating Connections.* The annual conference is a lively event which enables staff to come together in an informal space to develop their learning and teaching practice; to share best practice and to innovate.

The Trust has recently launched its Foundation programme in Learning & Teaching for the nursing discipline. This is a new ten-week programme; developed to enable more Trust nurses to be able to teach and contribute to the Institution's task of learning and teaching, inside and outside the Trust. At the end of the process, attendees will be in the position to apply for Associate Fellowship of the HEA. After this programme has been reviewed, it will be made available to other staff within the Trust.

Working with our university partners, University of Essex, the University of East London and a number of accrediting professional bodies, the Trust offers a distinctive, high quality approach, delivered by clinician-trainers and grounded in the experiences and challenges of everyday clinical practice. Both universities reviewed Trust degree provision in March and April 2018 and, amongst other commendations, both highlighted the quality of teaching offered. The Trust was approved by both institutions to offer validated courses for another five years.

Students continue to have members on key DET committees and this year have spoken to university reviewers and the QAA. The learning and teaching committee is working with student representatives to review and revise the guidance and advice which the Trust gives to them.

Our annual student survey is a key measure of performance for our education and training provision. The response rate from students, to the annual student survey this year improved markedly on the rate achieved in the previous year, from 26% to 49%. Importantly, students continue to report high satisfaction with the stimulating nature of our courses and with the enthusiasm of our teaching staff. This suggests that the distinctive approach and the delivery of provision continues to be appreciated. Some of the key areas of improvement include: resources, equality and student support and the overall doctorate experience. The areas showed lower levels of satisfaction include: the timeliness of assessment feedback, some operational aspects of course delivery and communication, the culture of research, and sufficient disability and learning support.

Action plans are now in place to address the issues that have been identified. While there are some areas for improvement, we can see that the achievements we have made in restructuring our professional support services to better attend to the needs of our students, the shift of university partner, and the implementation of a new student information system, will give greater benefit to our students as we bed down with these changes.

The Trust was visited for a day by the QAA in May 2017 to review progress against the action plan resulting from the full review in 2016. Two QAA representatives met the Head of Academic Quality, a number of students and DET staff. The resulting report confirmed that the Trust continues to make progress against its objectives and gave some guidance for future development. This annual monitoring has been repeated in May 2018 and the outcome is awaited.

Financial Performance

	2017/18 £'000 Excluding STF	2016/17 £'000 Excluding STF		2017/18 £'000 Per Accounts	2016/17 £'000 Per Accounts
Income					
Patient Services	27,694	25,508		27,694	25,508
Education and Training	21,370	21,454		21,370	21,454
Research	733	488		733	488
Other	1,114	1,358		1,114	1,358
STF				2,183	1,309
Total	50,911	48,808		53,094	50,117
Expenditure					
Pay	(36,403)	(32,600)		(36,403)	(32,600)
Non-Pay	(12,031)	(14,057)		(12,031)	(14,057)
Total	(48,434)	(46,657)		(48,434)	(46,657)
EBITDA	**2,477**	**2,151**		**4,660**	**3,460**
Depreciation and amortisation	(957)	(748)		(957)	(748)
Bank interest	9	10		9	10
Other finance costs	(2)	(1)		(2)	(1)
Dividend to the Dept. of Health	(595)	(571)		(595)	(571)
Retained surplus before compensation costs	932	841		3,115	2,150
Compensation scheme	(225)	(336)		(225)	(336)
Impairment of fixed assets	(90)	(76)		(90)	(76)
Loss on disposal of fixed assets	-	(62)		-	(62)
Retained surplus	617	367		2,800	1,676
EBITDA margin	4.9%	4.4%		8.8%	6.9%
Net surplus margin	1.2%	0.8%		5.3%	3.3%

Notes

Income figures are extracted from the information in the Statement of Comprehensive Income and Note 4 of the Accounts.

Expenditure figures are extracted from Note 5 of the Accounts.

EBITDA is earnings before interest, tax, depreciation and amortisation.

STF is Sustainability and Transformation Fund payment.

Commentary

STF income in the year was £2.2m (up from £1.3m in the prior year). As this income is considered to be non-recurring (and is not within the control of the Trust), the rest of this commentary refers to income and expenditure excluding STF income.

Excluding STF monies, income is up by £2.1m (4.3%), whilst operating costs are up by £1.8m (3.8%) driving an improvement in EBITDA of £0.3m.
The increase in income is principally within Patient Services and, primarily, within Child, Young Adults and Adolescents, where a 24% increase compensates for declines in Adult Forensic Services (down by 37%) and a small decrease in Education and Training. Recruitment on long courses was a record for the Trust, however, the revised National Training Contract with Health Education England has built in annual decreases.

The decrease in income for Adult Forensic Services is mainly the result of the end of the One Hackney contract. The increase in income for, Young Adults and Adolescents reflects, in the main, new income from the Gender Identity Service which the Trust took over from West London Mental Health Trust and expansion of the Trust's CAMHS (children and adolescent mental health services) in Camden.

The 11.7% increase in pay-related costs reflects the 10% increase in staff numbers (from 581 to 644 whole time equivalents); the annual (1%) pay award; and annual increments. The increase in staff numbers reflects, primarily, the expansion of services by the Child, Young Adults and Adolescent department. The cost of employing agency staff is down on the prior year and well below the Trust's NHS Improvement-assigned agency cap.

Non-pay costs have decreased by 14.4%. The increase in consultancy costs reflects, in particular, the use of third parties / non Trust staff to provide services for research and other one-off projects.

Depreciation and amortisation have increased as a result of on-going investment by the Trust in capital projects, notably a refresh (in 2017/18) of the Trust's e-mail system and intranet.

The Trust's Control Total for 2017/18 was £950k (including STF monies of £500k). The Trust actually achieved a Control Total of £2,890k (of which £2,183k was STF monies). The following table reconciles the retained surplus to the Control Total:

	2017/18	2016/17
	£'000	£'000
Retained surplus	2,800	1,676
Add back:		
- Impairment of fixed assets	90	76
- Loss on disposal of Fixed Assets		62
Control Total achieved	2,890	1,814
Control Total required	950	800
Surplus over required Control Total	1,940	1,014

Full details of the financial position of the Trust can be found in the Accounts section of this report.

Media Work

Our communications team continued to promote the work of our Trust, teams and individual clinicians through 2017/18, resulting in 273 pieces of print coverage mentioning *Tavistock and Portman, Portman Clinic,* or the *Gender Identity Development Service*, and broadcast stories across television and radio.

As with the previous year, coverage was dominated by stories about the gender identity development service and also our new stewardship of the adult gender identity clinic. We supported our gender identity clinicians with interviews for a variety of national and international outlets, including *ITV Tonight*, *BBC Inside Out*, *Radio 4*, *RTÉ (Ireland), La Repubblica (Italy),* and the Sunday Times.

In addition to providing comment and clarification on issues relating to gender identity, we focussed this year on increasing proactive coverage of our other key services.

Highlights included a Paul Burstow blog in *Yahoo News* ("Five priorities for improving children's mental health."), supportive regional coverage of our new partnership with Gloucestershire Counselling Service, and a *Marie Claire* piece on labelling, including interview with child psychotherapist Ruth Glover. There was also positive coverage of a new report highlighting that our CAMHS has one of the lowest rates of unaccepted referrals and a profile of David Wyndham-Lewis in the *New Statesman*.

Other proactive highlights included a *BBC Victoria Derbyshire* programme piece on FDAC, a *Guardian* piece about resolutions featuring interview with David Bell, and a *Nursery World* interview with Kathryn Fenton about age-inappropriate media. Laverne Antrobus was also featured as a recurring guest expert in the Channel 4 series, *The Secret Life of 4 & 5 year olds*.

We participated in a Science Media Centre briefing about fertility preservation options for transgender people, and support for the launch of the Pan-London FDAC service. Our press release and promotion for the FDAC launch resulted in favourable coverage in the *Times*, the *Economist*, *Community Care*, and several legal trade publications.

We also provided interview for a well-received *Guardian* feature on the workplace burnout featuring comment from our Director of Education and Training / Dean of Postgraduate Studies, and Tavistock Consulting representative.

This year we also hosted visits from journalists for the *Camden New Journal* and the *Mail on Sunday*, and we facilitated *Sunday Times Magazine* and *BBC London* access to Portman Clinic clinicians for two forthcoming stories.

Environmental Performance

The Tavistock and Portman NHS Foundation Trust is committed to meeting its targets for the Carbon Reduction Commitment for Public Sector Organizations. The Board is aware of the pressures within public sector organizations to adhere to energy and carbon legislation, reduce energy costs and improve energy and carbon targets around corporate and social responsibility (CSR).

The Trust priorities for 2017 / 18 were to:

- Continue investment in energy reduction lighting in all office refurbishments and proactive replacement in key shared spaces
- To send zero waste to landfill
- Nominated paperless office space by 2018
- Build on current Trust Cycle Strategy
- Continued commitment to energy reduction and reduced car use
- Continue to promote culture of change for waste and energy

Over the course of 2017/18 the Trust completed a programme for the replacement of all the old florescent lighting in office upgrades and communal areas to LED efficient lighting.

We have continued work to better manage our energy consumption following improvements made to the Building Management System (BMS) in 2016/17. This has limited increases in energy utilization despite a prolonged winter season and an increase in building use.

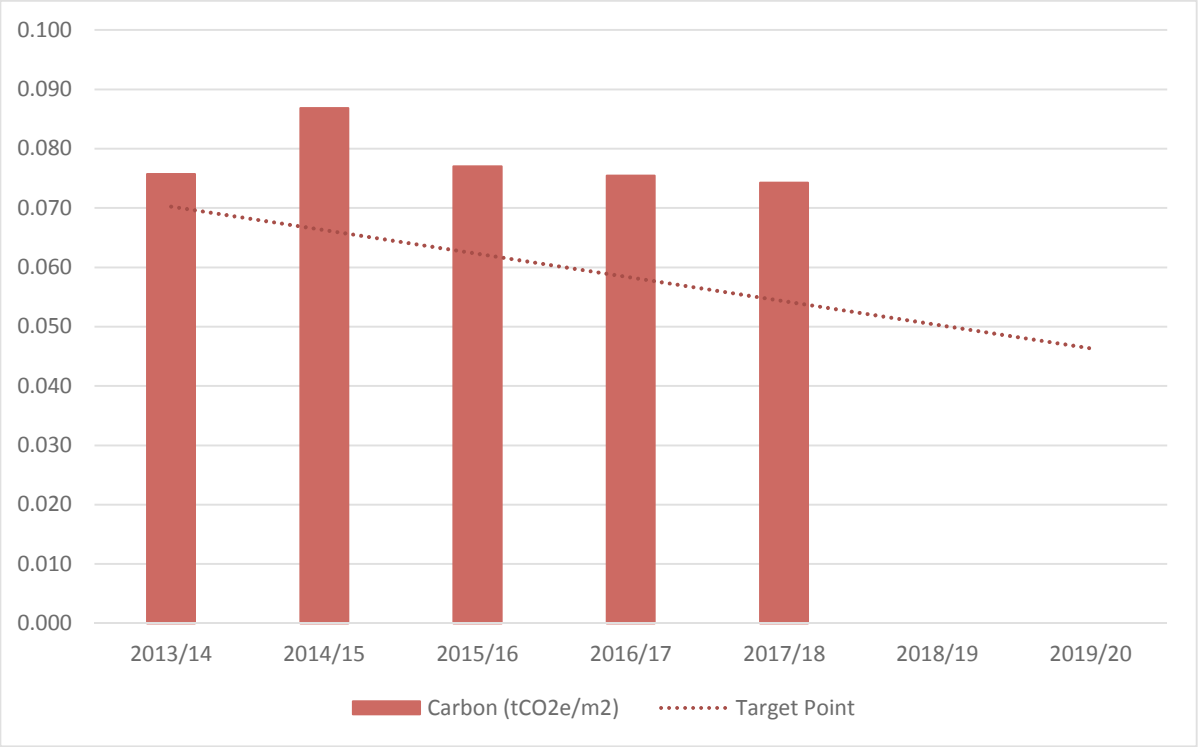
We have achieved zero waste to landfill through a combination of recycling schemes and revised waste management contracts that divert suitable waste to energy production.

As in previous years, the Trust has commissioned an assessment of its environmental impact at end of year. It should be noted that 2017/18 figures below are estimated based on changes in year on year profile in consumption of energy and generation of waste. Some limited variation can be expected between the estimated figures and the final report. The 2016/17 figures now presented below are consistent with the final report for that year.

The Trust's environmental impact remains proportionate to both the number of people it employs and the floor space of the Trust's buildings. As noted in previous years, the increase in floor space within the Trust between 2013/14 and 2014/15 reports relates to the introduction of temporary accommodation attached to the Tavistock Centre, the Garden Wing.

	2013/14	2014/15	2015/16	2016/17	2017/18
Direct Emissions (tCO_2e)	510	725	643	630	620
Floor Space (m^2)	6,733	8,347	8,347	8,347	8,347
Number of Staff (WTE)	472	479	485	485	444

This data has been used to normalise our direct emissions and compare progress against our target of 34% reduction by 2019/20. It can be seen from the figures below that the Trust's primary emissions have broadly stayed flat when the organisation is normalised by floor space.



While the Trust has achieved its goal of zero waste to landfill the Trust recognises that more can be done to shift further towards a recycling goal in place of waste to energy generation. The Trust therefore has continued work related to the placement and the utilization of recycling bins.

Regarding our effort to reduce car travel, cycle and motor cycle spaces are provided and additional secure cycle area have now been made available in the underground car park.

Car use as a means of travel to the Trust by staff has been reduced again in 2017/18. An automated number plate recognition system has been implemented to control access to the underground car park. This has resulted in an improved understanding of the actual usage of the car park. This insight is expected to support future efforts at further reductions in overall care use.

For the 2018/19 year, the Trust intends to continue it work on environmental priorities in the following areas:

- Continue investment in energy reduction lighting in areas not already addressed

- To maintain zero waste to landfill and investigate means of rebalancing towards recycling
- To undertake a review into existing environmental attributes of our freehold sites and revisit considerations of how improvement to energy efficiency can be included in our broader capital works
- Continued commitment to energy reduction and reduced car use

Social and Community Work

Experience informs us that patient involvement is a relational activity. Flyers and posters advertising involvement opportunities have limited effectiveness, whereas a recommendation from a clinician, who has explored and considered their patient's potential interest in involvement, is most effective in sustaining interest and engagement in the work.

The Trust has started to develop a public and patient involvement strategy to reflect on involvement work already undertaken in the Trust, to share a vision of embedded involvement and to emphasise the need for this to be recognised and owned by all staff and not seen as a standalone activity in relation to the Patient and Public Involvement (PPI) team.

Our work to date has included:

Experience of Service Questionnaire

The PPI team report on quarterly quantitative findings from the experience of service questionnaire (ESQ), the more detailed area of work on the ESQ findings is collating, analysing and theming the free text qualitative patient feedback. This information is broken down at team level and provided to clinical directors. The team are working to have an accountable method of providing this feedback to service users and commissioners. A procedure for this is being worked on with clinical directors and team leads, essentially 'closing the loop' for feedback. Major areas for improvement for 2018/19 have been identified such as: estates and trust accommodation, access to sites and parking, communication and information. This work feeds into the clinical quality and patient experience work plan.

Service User Representatives (SUR's) on interview panels

Employing service users on our interview panels has been one of the most successful pieces of work for patient and public involvement to date. This work embodies principles of co -production and the process recognises the value of lived experience within mental health development. We have seen a shift in organisational culture as Trust staff have become more familiar with the benefits and rewards of having service users' input on panels. The training of service users and families is undertaken by the PPI team, the training is very well received, and feedback shows that it has empowered service users to upskill themselves for external interviews and prepare for work opportunities. By being on a panel the SUR's have direct influence on shared decision making.

Bid for Better

In 2011 the PPI team launched the Trust Bid for Better scheme and continue to run the scheme each year. The scheme offers awards of up to £400 to support bids for activities or equipment which will improve the patient/service user experience, promote mental wellbeing and/or make our services more accessible. The scheme started as a membership engagement project and bidders do still need to be members of the Trust. The scheme has become a valued annual event and is used as an opportunity to try creative projects and schemes that may not otherwise be possible due to budget constraints. Bid for Better enables the PPI team to make links with external organisations as it is open to the public and we have supported a number of external projects. Allocation of the awards is decided by a panel made up of Trust staff and service user representatives.

Newsletters

The team produce a quarterly newsletter in collaboration with the communications team, updating service users on all activities that have occurred within the past few months, also to let people know of all upcoming activities they can become involved in. This includes art projects, boards and stakeholder groups, training for interview panels and signposts readers to other community activities. The newsletter is distributed across the trust throughout waiting rooms. This was a progression and improvement from this information previously forming part of the Annual report, which reached

internal staff but not service users. The newsletters are well received and there has been positive feedback about the content and presentation.

PALS

The PALS (Patient Advice and Liaison Service) is part of the PPI team and the PALS Officer works alongside the PPI team to think about patient involvement and feeds back on issues concerning the patient clinical experience and contact generally with the Trust. PALS also feeds directly into the Complaints process and communication between members of PPI, Complaints and PALS helps to highlight and resolve issues that relate to involvement and patient care more widely.

The PPI team members provide cover for the PALS when the PALS Officer is on leave and frequently assist patients that drop in to reception to resolve enquiries and concerns. The PPI team structure has been vital for ensuring that the PALS Service operates a good service and that staff members have adequate support.

Anti-bribery

The Trust has put in place, in the financial year, a new anti-fraud and bribery policy which was co-authored with the Trust's counter fraud service. The policy makes a Board level commitment to taking preventative and reactive steps to ensure that we have adequate and appropriate controls in place.

Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

There have been no important events since the end of the financial year affecting the NHS Foundation Trust.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

Accountability Report

Directors' Report

For nearly a 100 years, the Tavistock and Portman has represented a unique tradition in thinking about mental health and well-being, grounded in psychoanalytical, psychodynamic and systemic thinking. This has involved an interest in the unconscious as well as conscious aspects of mental distress, the investigation of the impact for individuals of experience in early lives and a focus on the importance of relationships and social context in promoting mental health and well-being.

The Trust has developed these traditions through the delivery of high quality clinical services for young people and adults, the provision of training and education, research and thought leadership and organisational consulting. The organisation has played a key role as innovator, developing new interventions, services and models of care.

The Tavistock and Portman aims to continue to this tradition and to work with others in applying it to find solutions to contemporary challenges facing health, care and other sectors by:

- Continuing to deliver and develop high quality and high impact clinical services
- Offering training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors.
- Being a UK centre of thought leadership, organisational consultancy and research.
- Supporting the development of new models of care and innovation approaches to addressing systemic issues in the delivery of care and other services.

The Trust's intention is to continue to improve productivity, engage with commissioners and local organisations, and work in innovative ways to ensure that it continues to provide the high-quality services that its reputation is

based upon. The overall strategy is for measured growth to enable our services to be available more widely.

In the current period of austerity, we believe that growth is still possible and will be achieved through close collaboration with commissioners and partners to re-shape services and trainings, building on the models we have developed. The Directors are not aware of any events that have arisen since the end of the year which have affected or may significantly affect the operations of the Trust. We are developing our strategies for technology-enhanced learning and for the use of digital technology in our clinical services. We are undertaking a project to review our use of our current buildings and assess our future needs and the options available to best meet them.

No political donations have been made by or to the Trust. The Trust has no branches outside the United Kingdom.

The Trust continues to invest in research on the work we do, both through the clinical outcomes of our treatment and surveys of our patients, details of which can be found in our Quality report, but also through large scale research projects such as our Tavistock Adult Depression Study (TADS).

The Care Quality Commission (CQC) last inspected the Trust in January 2016, and followed up with a further expected but unannounced inspection of our adult and forensic services in autumn of 2016. The rating that has been given to the Trust is Good overall, and Good for all domains. After their visit in January, the CQC team commended the clear evidence they found in all teams of the caring values and behaviours of staff, both clinical and non-clinical, and the sense of commitment they had to the people who used their services. They commented on the breadth of good practice they saw in individual teams and across the organisation. They particularly drew out our focus on supervision and training, partnership working, patient and public involvement, safeguarding and meeting the needs of the populations we serve. The team highlighted areas where we could improve, and a consistent theme was the opportunity for us to develop a more systematic approach to quality improvement across the organisation. The Trust has acted on this advice by extending the Clinical Quality Strategy to include a Trust wide quality improvement strategy, developed in collaboration with staff across the Trust.

The Trust has a number of staff trained in established quality improvement methodologies has a quality improvement programme which is congruent with our established psychoanalytic/ systemic, contextually aware approach to understanding mental health. The Trust has continued to self-assess against CQC key lines of enquiry and licence conditions. The next CQC inspection of the Trust is expected later in the financial year, with preparation work underway to ensure service users and staff are well engaged with the process. We recognise that the future inspection will focus its attention on the well-led domain, our approach to how we assure our performance in this area is detailed in the annual governance statement.

The Trust has an Equal Opportunities Policy, and a Policy and Procedure on Recruitment and Selection, which explain our commitment to giving full and fair consideration to applications for employment made by disabled persons, and detail how we achieve this. In addition the Trust has been awarded the 'Two Ticks' symbol by Jobcentre Plus showing our commitment to encouraging applications from disabled people, and to providing continued support to disabled employees.

This year the Equality and Diversity Committee has carried out an extensive consultation to develop the Race Equality Strategy, which was approved by the Board of Directors in September and officially launched in October 2017. The strategy showed a commitment to create a race diversity champion to take forward the actions committed to. As well as this, two cohorts of an internal aspiring leaders development programme were launched, a bespoke BAME staff development session was held and offers of one-to-one BAME staff career coaching were made. A dedicated budget has been set aside to support ongoing BAME staff development. A race diversity champion post was also agreed upon.

Within the Education and Training directorate, a student equality survey was undertaken to look at protected characteristics. A strategy and action plan were developed as a result of this, in order to show commitment to addressing issues relating to race and culture within Trust services and education offering.

The number of staff trained as mental health first aiders has also been increased to 40. There are also regular meetings to discuss staff wide health promotion activities.

Looking to 2018/19, the committee will have a strong focus on disability, as well as building on the work already taking place on LGBT, inclusion, data and race quality. The Race Equality Strategy will be continually reviewed to strive towards a more inclusive and fair organisation. The equality, diversity and inclusion committee will continue to promote equality, diversity and inclusion for all staff, students, patients and other service users.

The Trust regards consultation with staff as essential to our work, and works hard to keep staff informed of issues of concern to them. Measures include our Joint Staff Consultative Committee, the Leadership Group conferences, frequent meetings between staff and directors, monthly email newsletters from the CEO, CEO drop in question sessions, and feedback on the results of the staff survey. Communications address issues such as the financial situation of the Trust and wider NHS, cultural issues such as our approach to the Duty of Candour or our work supporting staff, as well as more local team or clinical issues. These measures are in place to encourage the involvement of staff with the aims and performance of the Trust.

The Trust has policies in place to ensure that all directors, staff and governors observe the Trust's values and accepted standards of behaviour in public life. All directors and governors meet the 'fit and proper' person test as described in the Trust's licence as issued by Monitor (now known as NHS Improvement). The Trust has in place a Board Assurance Framework and Risk Register which highlight the key risks facing the Trust. These are reviewed on a regular basis by the Board of Directors. Three key risks currently facing the Trust are: management capacity; achieving productivity savings; generating income growth. In terms of management capacity, the Trust is seeking, where possible to pool resources with other organisations. More critically, the Trust regularly reviews its strategic plan to review pressures and resolve tensions over priorities. In terms of efficiencies, the Trust has annual targets and regular reviews to ensure these are met. Generating income growth is, perhaps, the largest challenge facing the Trust. A review of the mechanisms and resources

dedicated to this aspect of the Trust's activities is in the process of being undertaken in order to increase the Trust's capacity in this area.

Quality is central to the Trust's strategy and directors focus consistently on key aspects of providing safe, effective care and positive patient and carer experience. The Annual Report, including the Quality Report, Annual Governance Statement and Board Assurance Framework explains in further detail the Trust's arrangements for the governance of service quality. These arrangements ensure that services meet the best possible standards. Directors are provided with high quality information which is robustly examined to determine whether standards are being maintained. Where there are indications that we may fall short of standards, remedial action plans are devised, implemented and reported upon. The Trust has a formal quality governance structure which is formally linked to the Board through the Clinical Quality Safety and Governance Committee chaired by the Medical Director. The Trust is compliant with Monitor's quality governance framework. The Board receives quarterly quality and performance reports, service line reports, and patients present their stories to the Board. Board members have the opportunity to examine service quality in more detail through membership of relevant committees and work streams and a programme of visits to clinical services

A full list of the name of the directors can be found in the Governance section of this report. The register of the interests of directors and governors is published on our website, www.tavistockandportman.uk/about-us
As far as the directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Accounting policies for pensions and other retirement benefits are set out in the accounts and details of senior employees' remuneration can be found in the remuneration report.

It is the responsibility of the directors of the Tavistock and Portman NHS Foundation Trust to prepare the annual report and accounts, and we consider

that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Foundation Trust's performance, business model and strategy.

Income disclosures required by Section 43(2A) of the NHS Act 2006

In 2017/18, the Trust's total income from the provision of goods and services for the purposes of the health service in England was 81% of the total income (2016/17, 81%). A further 13% of income was received from local authorities, and 3% from other central government bodies (2016/17, 13% and 3% respectively). The remaining 3% with bodies external to government (2016/17 3%) was used to ensure the sustainability of the organisation and had no adverse effect on the provision of healthcare.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better Payment Practice Code

The Trust has a target of 95% being paid within 30 days as agreed terms. The Trust paid by number 69% of NHS Invoices (156 out of 227) totalling £1.3m 75% by value within the target and 89% of Non NHS invoices by number (5626 out of 6350) totalling £20.3m 95% within target.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

Remuneration Report

Information Not Subject to Audit

Annual Statement on Remuneration

In the past year no substantial changes were made to the remuneration of, or to our policy on the remuneration of, senior managers. We continue to have no elements of performance related pay or bonuses for senior managers, nor are there any differences between our policies on remuneration of senior managers or any other employee.

The Executive Appointment and Remuneration Committee met three times to consider the substantiation of the director of adult and forensic services; to ratify the decision of the Clinical Excellence Awards Committee; and, to consider the recruitment process for a successor medical director.

Senior Managers' Remuneration Policy

Senior managers are normally employed on permanent contracts. Those who are medical consultants are remunerated under the 2003 Consultants Contract. Non-medical senior managers are paid on spot salaries and have terms and conditions which are set by the Trust. Notice periods are in accordance with local agreements, and there are no special provisions for termination periods, payments for loss of office or service contract obligations.

Directors and Non-Executive Directors' remuneration is set following a review of the salaries of the other members of the board of directors, and comparisons to the remuneration of similar roles across the NHS. The Trust does not currently consult with employees in setting the senior managers' remuneration. In looking at benchmarking comparisons for remuneration, comparisons are drawn from a range of Mental Health Foundation Trusts, and separately from a number of trusts with comparable turnovers, in order to establish what the average remuneration is across the sector.

The intention of the Foundation Trust in the next financial year is to maintain the current system of remuneration, which does not include any performance based awards.

Annual Report on Remuneration

Service Contracts for Senior Managers

	Date of commencement	Unexpired term	Details of notice period.
Non-Executive Directors			
Professor Paul Burstow	November 2015	Seven months	Three months
Professor Dinesh Bhugra	Reappointed November 2017 (second term)	Two years and seven months	Three months
Ms Helen Farrow	November 2016	One year and seven months	Three months
Ms Jane Gizbert	Reappointed November 2017 (second term)	One year and seven months	Three months
Mr David Holt	Reappointed November 2016 (second term)	One year and seven months	Three months
Ms Edna Murphy	November 2014	N/A – Resigned and Left October 2017	Three months
Dr Deborah Colson	November 2017	Two years and six months	Three months
Executive Directors			
Ms Chris Caldwell	November 2016	No term of office	Three months
Dr Sally Hodges	November 2015	No term of office	Three months
Mr Paul Jenkins	February 2014	No term of office	Three months
Ms Louise Lyon	March 2008	No term of office	Three months
Mr Terry Noys	October 2016	No term of office	Three months
Mr Brian Rock	January 2015	No term of office	Three months
Dr Rob Senior	December 2006	No term of office	Three months
Dr Julian Stern	February 2017	No term of office	Three months

Remuneration Committee – Composition & Attendance

Composition & Attendance at Remuneration Committee Meetings 2017/18

	May 2017	November 2017	January 2018
Paul Burstow (Chair)	✓	✓	✓
Paul Jenkins	✓	✓	✓
David Holt	✓	✓	✓
Jane Gizbert	✓	✓	✓
Edna Murphy	✓	✓	N/A
Dinesh Bhugra	✓	✓	✓
Helen Farrow	✓	✓	✓
Deborah Colson	N/A	N/A	✓

The Director of Human Resources provided advice to the Committee.

Director and Governor Expenses

Travel and subsistence expenses totalling £1,624 were reimbursed to five directors, out of 16 in total, and expenses totalling £1,976 were reimbursed to three of the 17 governors. By comparison in 2016/17 travel and subsistence

expenses totalling £5,140 were reimbursed to three governors during the year, out of 15 governors in total; and £1,882 reimbursed to three directors, out of 15 in total.

Information Subject to Audit

Senior Manager Definition

In the following sections the report discloses remuneration details of the Trust's senior managers. These are those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Foundation Trust. These individuals have been determined by the accounting officer as falling within the scope of this definition.

Payments for Loss of Office

There was one payment for a loss of office, as a result of compulsory redundancy, in 2017/18 for a senior official. This was a capped redundancy sum of £95,000. The ordinary terms for loss of office are set out in the NHS terms and conditions of service handbook.

Payments to Past Senior Managers

There were no payments made to past senior managers in 2017/18.

Remuneration of Senior Managers

Remuneration of senior managers is in compliance with the Senior Managers' Remuneration Policy set out in this report. The oversight of the policy is undertaken by the Executive Appointments and Remuneration Committee.

2017/18 - Single Total Figure Remuneration of Senior Managers

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k	Total Remuneration £000, bands of £5k
Jenkins, P	Chief Executive	150-155	0	0-5	0-5	0 – 2.5	150-170

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k	Total Remuneration £000, bands of £5k
Noys, T	Deputy Chief Executive and Director of Finance	120-125	0	0-5	0-5	N/A	120-135
Senior, R	Medical Director	140-145	0	0-5	0-5	57.5 - 60	200-215
Hodges, S	Children, Young Adults and Families Director (CYAF)	105-110	0	0-5	0-5	0 – 2.5	105-120
Stern, J	Adult and Forensic Services Director (AFS)	135-140	0	0-5	0-5	75 - 77.5	210-230
Lyon, L	Director of Quality and Patient Experience	65-70	0	0-5	0-5	N/A	65-80
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	105-110	0	0-5	0-5	0 – 2.5	105-120
Caldwell, C	Director of Nursing	105-110	0	0-5	0-5	N/A	105-120
Smith, J *	Commercial Director	35-40	0	0-5	0-5	0 – 2.5	35-50
de Sousa, C	Director of Human Resources	75-80	0	0-5	0-5	27.5-30	95-120
Thomas, L	Director of Marketing & Communications	70-75	0	0-5	0-5	N/A	70-80
Wyndham Lewis, D	Director of Information Management & Technology	115-120	0	0-5	0-5	N/A	115-130

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k	Total Remuneration £000, bands of £5k
Paul, Burstow	Chairman	35-40	0	0-5	0-5	N/A	35-50
Farrow, H	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-20
Gizbert, J	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-20
Holt, D	Non-Executive Director	10-15	0	0-5	0-5	N/A	10-25
Murphy, E *	Non-Executive Director	0-5	0	0-5	0-5	N/A	0-15
Bhugra, D	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-20
Colson, D *	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-20

Smith, J *	Commercial Director	Left Sep 2017 (redundancy pay 95k)
Murphy, E*	Non-Executive Director	Left Sep 2017
Colson, D *	Non-Executive Director	Joined Nov 2017

2016/17 – Single Total Figure Remuneration of Senior Managers

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k	Total Remuneration £000, bands of £5k
Jenkins, P	Chief Executive	150-155	0	0-5	0-5	60-62.5	210-230
Noys, T	Deputy Chief Executive and Director of Finance	45-50	0	0-5	0-5	17.5-20	65-80
Senior, R	Medical Director	140-145	0	0-5	0-5	107.5-110	250-265
Hodges, S	Children, Young Adults and Families Director (CYAF)	105-110	0	0-5	0-5	112.5-115	220-235
Stern, J	Adult and Forensic	135-140	0	0-5	0-5	105-107.5	240-260

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k	Total Remuneration £000, bands of £5k
	Services Director (AFS)						
Lyon, L	Director of Quality and Patient Experience	85-90	0	0-5	0-5	0-2.5	85-105
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	105-110	0	0-5	0-5	42.5-45	150-165
Caldwell, C	Director of Nursing	40-45	0	0-5	0-5	85-87.5	125-145
Young, S	Deputy Chief Executive and Director of Finance	45-50	0	0-5	0-5	0-2.5	45-65
Smith, J	Commercial Director	75-80	0	0-5	0-5	0-2.5	75-95
Avery, T	Director of Information Management & Technology	25-30	0	0-5	0-5	0	25-40
de Sousa, C	Director of Human Resources	75-80	0	0-5	0-5	27.5-30	105-120
Thomas, L	Director of Marketing & Communications	70-75	0	0-5	0-5	57.5-60	130-145
Wyndham Lewis, D	Director of Information Management & Technology	115-120	0	0-5	0-5	n/a	115-125
Jones, E	Director of Nursing	30-35	0	0-5	0-5	0-2.5	30-45
Paul, Burstow	Chairman	35-40	0	0-5	0-5	n/a	35-50
Helen, Farrow	Non-Executive Director	0-5	0	0-5	0-5	n/a	0-15
Jane, Gizbert	Non-Executive Director	5-10	0	0-5	0-5	n/a	5-20
David, Holt	Non-Executive Director	10-15	0	0-5	0-5	n/a	10-25
Edna, Murphy	Non-Executive Director	5-10	0	0-5	0-5	n/a	5-20
Dinesh, Bhugra	Non-Executive Director	5-10	0	0-5	0-5	n/a	5-20

No senior manager received any taxable benefits or a performance-related bonus.

The median salary of the Trust's staff is £25,397 (£27,500 - 2016/17). The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and cash equivalent transfer value of pensions.

The midpoint of the highest paid director is £153,000 (150,000 - 2016/17), which gives a ratio of 6.02 (5.45 - 2016/17) times median pay of the Trust's staff. Only those directors whose remuneration the trust is directly able to determine are included in this calculation. The shift in ration relates to growth across the organisation in the reporting year, most specifically the Charing Cross Gender Identity Clinic transferring in.

Two directors are paid an allowance for additional duties carried out. This is part of the salaries and fees disclosed in the table above. These directors are detailed in the table below along with the amount that they receive for these responsibilities.

Name and Title	Allowance £000, bands of £5k
Senior, R; Medical Director	15-20
Stern, J; Adult and Forensic Services Director	10-15

One member of staff is paid more than £150,000 per annum. They are the Chief Executive. The salary was agreed by the Executive Appointment and Remuneration Committee when the post holder was recruited to the role and has subsequently been reviewed annually. The annual salary review processes have involved benchmarking remuneration across similar Foundation Trusts within the NHS, and salaries within the Trust being set at the level judged necessary to attract and retain the required calibre of applicant, whilst providing value for money for the Trust.

2017/18 – Pensions Benefits

Name	Title	Real Increase in Pension at Pension age (bands of £2500)	Real Increase in pension lump sum at Pension age (bands of £2500)	Total accrued pension at pension age 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
Jenkins, P	Chief Executive	5.0-7.5	0-2.5	35-40	85-90	895	66	829	-
Noys, T	Deputy Chief Executive and Director of Finance	2.5-5.0	0-2.5	0-5	0-5	41	12	11	-
Senior, R	Medical Director	5.0-7.5	15-17.5	55-60	175-180	0	0	0	-
Hodges, S	Children, Young Adults and Families Director (CYAF)	5.0-7.5	0-2.5	25-30	75-80	472	54	418	-
Stern, J	Adult and Forensic Services Director (AFS)	5.0-7.5	12.5-15	75-80	200-205	1674	184	1490	-
Lyon, L	Director of Quality and Patient Experience	0-2.5	0-2.5	0-5	0-5	0	0	0	-
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	5.0-7.5	0-2.5	25-30	60-65	446	51	395	-
Caldwell, C	Director of Nursing	5.0-7.5	15-17.5	25-30	20-25	338	48	290	-
Smith, J*	Commercial Director	5.0-7.5	0-2.5	25-30	85-90	582	-107	689	-
de Sousa, C	Director of Human Resources	5.0-7.5	0-2.5	10-15	20-25	123	19	104	-
Thomas, L	Director of Marketing &	2.5-5.0	0-2.5	0-5	0-5	31	11	20	-

Name	Title	Real Increase in Pension at Pension age (bands of £2500)	Real Increase in pension lump sum at Pension age (bands of £2500)	Total accrued pension at pension age 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
	Communications								
Wyndham Lewis, D	Director of Information Management & Technology	0-2.5	0-2.5	0-5	0-5	0	0	0	-

Smith, J * Commercial Director Left Sep 2017 (redundancy pay £95k)

2016/17 – Pensions Benefits

Name	Title	Real Increase in Pension at Pension age (bands of £2500)	Real Increase in pension lump sum at Pension age (bands of £2500)	Total accrued pension at pension age 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
Jenkins, P	Chief Executive	5.0-7.5	0-2.5	35-40	80-85	829	83	746	-
Noys, T	Deputy Chief Executive and Director of Finance	0-2.5	0-2.5	0-5	0-5	11	5	0	-
Senior, R	Medical Director	5.0-7.5	12.5-15.0	50-55	160-165	0	0	0	-
Hodges, S	Children, Young Adults and Families Director (CYAF)	5.0-7.5	12.5-15.0	25-30	75-80	418	90	328	-
Stern, J	Adult and Forensic Services Director (AFS)	5.0-7.5	12.5-15.0	65-70	200-205	1539	140	1398	-
Lyon, L	Director of Quality and Patient Experience	0-2.5	0-2.5	0-5	0-5	0	0	0	-
Rock, B	Director of Education and Training and Dean of	5.0-7.5	0-2.5	20-25	55-60	395	36	359	-

Name	Title	Real Increase in Pension at Pension age (bands of £2500)	Real Increase in pension lump sum at Pension age (bands of £2500)	Total accrued pension at pension age 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
	Postgraduate Studies								
Jones, E	Director of Nursing	0-2.5	0-2.5	0-5	0-5	0	0	0	-
Caldwell, C	Director of Nursing	5.0-7.5	0-2.5	20-25	0-5	290	54	236	-
Young, S	Deputy Chief Executive and Director of Finance	0-2.5	0-2.5	0-5	0-5	0	0	0	-
Smith, J	Commercial Director	2.5-5.0	0-2.5	35-40	105-110	689	12	677	-
Avery, T	Director of Information Management & Technology	2.5-5.0	0-2.5	15-20	40-45	237	10	208	-
de Sousa, C	Director of Human Resources	2.5-5.0	2.5-5.0	10-15	20-25	104	19	85	-
Thomas, L	Director of Marketing & Communications	2.5-5.0	0-2.5	0-5	0-5	20	10	10	-
Wyndham Lewis, D	Director of Information Management & Technology	0-2.5	0-2.5	0-5	0-5	0	0	0	-

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

Staff Report

Our staff are pivotal to our success in delivering excellence in care, education, training and research. We have a rich mix of staff and wealth of experience which contributes to our continuing development as specialist mental health and education provider.

In 2017/18 a significant amount of work has been undertaken to implement the organisational development and people strategy 2017 – 2020 and to consolidate a number of workforce programmes from the previous financial year.

This section of the annual report sets out what we know about our staff and their experiences of working at the Trust.

Our workforce make up

The cost of our total employed workforce is made up as detailed in the table below.

Staff costs

			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	28,682	139	**28,821**	25,869
Social security costs	3,211	-	**3,211**	2,824
Apprenticeship levy	124	-	**124**	-
Employer's contributions to NHS pensions	3,580	-	**3,580**	3,089
Pension cost - other	5	-	**5**	-
Termination benefits	225	-	**225**	336
Temporary staff		574	**574**	732
Total gross staff costs	**35,827**	**713**	**36,540**	**32,850**
Recoveries in respect of seconded staff	-	-	**-**	-

Total staff costs	**35,827**	**713**	**36,540**	**32,850**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

Our staff numbers are made up as in the table below.

Average number of employees (WTE basis)

			2017/18	**2016/17**
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	43	-	**43**	41
Administration and estates	235	-	**235**	216
Nursing, midwifery and health visiting staff	25	-	**25**	24
Scientific, therapeutic and technical staff	254	-	**254**	223
Social care staff	26	-	**26**	27
Other	-	61	**61**	50
Total average numbers	**583**	**61**	**644**	**581**
Of which:				
Number of employees (WTE) engaged on capital projects	-	5	**5**	2

Gender analysis

Gender	Directors	Other senior managers	All other staff
Female	6	1	529
Male	7	2	181

Sickness absence information

Sickness absence measure	Q1	Q2	Q3	Q4
Sickness absence rate (%) average per month	1.03	1.52	1.63	1.66
Sickness absence rate (%) twelve month rolling average	1.50	1.41	1.44	1.29

Policy, partnership, diversity and inclusion

Our human resources policies are all within date and have undergone an appropriate review process. We have a number of policies which set out the Trust's commitment to providing equal and fair access to service, employment and training. We confirmed our commitment to diversity and inclusion through our annual diversity and inclusion report and have done further work to set a three year race equality strategy.

Diversity and inclusion are an integral part to our work and continued successes over the years. We have, for some time, had an established equal opportunities policy which is up to date and confirms our commitment to understanding, meeting and working with our diverse staff, students and service users. We bring our diversity and inclusion work to life through a range of methods and we have a long established equality, diversity and inclusion committee which has recently transitioned to become a board committee.

In 2017/18 we have fully complied with our statutory duties which include the publication of our public sector equality duty report; our workforce race equality standard; and more recently the gender pay gap report.

We have excellent working relationships with our trade union colleagues and collaborate on many work programmes. This approach has been longstanding and we continue to develop our working arrangements so that we can respond to change quickly and ensure that staff are supported. The table below fulfils our disclosure as per the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
6	5.35

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	0
1-50%	6
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	28,668
Provide the total pay bill	36,315,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.08%

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 8%

(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

Sharing information and consulting with our staff

The chief executive and other directors host open meetings every month, to which all staff are invited, to ensure that staff are kept informed of developments and have an opportunity to raise any issues or concerns.

In addition to the above the Trust's communications directorate successfully launched a new intranet in 2017 and have also implemented a daily email bulletin to keep staff informed of developments within our organisation.

Our staff governors have, at various points throughout the year, convened meetings to allow staff to share their experiences of working in the organisation and to ensure that their views are represented at the council of governors.

The results from the NHS staff survey have shown that our staff believe that communication between senior managers and staff is effective.

Staff experience and engagement

The NHS Staff Survey took place between October and December 2017. For a third year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.

In 2017 the Trust received, yet again, high response rates with 56.4% of those being survey submitting a questionnaire. This was a very slight decline from the previous year where 58% of staff responded.

A copy of the national report can be found here: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RNK_full.pdf

Highlights from the 2017 Survey

It is clear from our results that our staff take exceptional pride in the work that they do with a high proportion recommending the organisation as a place to work and to be treated. In addition to this we have an exceptionally high engagement score.

Having undertaken some extensive analysis of our survey results the Trust ranks as the best performing mental health and learning disability provider in 14 out of the 27 key findings areas.

Summarised below are our top five key result areas.

Key Finding	2017/18 Score	2016/17 Score	Increase / Decrease
Percentage of staff experiencing bullying harassment or abuse from patients	21%	24%	Decrease
Percentage of staff reporting good communication between senior management and staff	54%	46%	Decrease
Staff recommendation of the organisation as place to work or be treated	4.14	3.97	Increase
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	17%	16%	Increase
Percentage of staff satisfied with opportunities for flexible working patterns	74%	66%	Increase

Areas for improvement

Amongst our results there are a number where we need to do further work. Some are themes from previous years which we will continue to engage with staff and managers to address.

We are cognisant that whilst the report highlights a number of areas where we perform less well, we are also aware that there is a clear divergence of experience between black, Asian and minority ethnic (BAME) and white staff. The Trust has, in 2017, agreed a three year race equality strategy and an action plan to work to address a number of systemic issues in our organisation and

we hope that these efforts will result in positive changes over the coming years. In saying that change will happen over a longer period this reflects our view that cultural change does take time and requires continued visibility and action.

The chart below summarises the five areas where we perform less well compared to other organisations in our peer group.

Key Finding	2017/18 Score	2016/17 Score	Increase / Decrease
Percentage of staff working extra hours	83%	83%	Unchanged
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	73%	78%	Decrease
Staff satisfaction with the quality of work they can deliver	3.77	3.67	Decrease
Percentage of staff attending work in the last three months whilst feeling unwell due to pressure from manager, colleagues or themselves	56%	58%	Decrease
Percentage of staff feeling unwell due to work related stress in the last 12 months	43%	49%	Decrease

Improving our results

In 2016 we structured the staff survey data in a way that allowed us to report at Trust, directorate and service line level. We have done the same for 2017 and this has highlighted the services and teams where we need to give support and focused programmes of work.

Our service directors have, for another year, been tasked to discuss their results at a local level and then celebrate positive stories and co-design action plans that will address the concerns areas.

<u>Health and wellbeing</u>

Throughout the year we continued our focus on health and wellbeing and taken a number of steps to implement a range of programmes that aim to support our staff to make healthy life style choices.

Following a large amount of work in the previous financial year we continue to offer:

- Onsite chair massage
- Yoga sessions during and after work
- A cycle to work scheme
- A staff walking challenge
- Healthier eating options in our canteen
- Access to an NHS gym and fitness centre
- Fast track physiotherapy services

In addition to all of the above we have a number of other channels which staff seek support, when needed, these include through our HR team; our internal staff consultation service; the occupational health service which is provided by the Royal Free London NHS Foundation Trust; and our confidential 24/7 bullying helpline provided by CareFirst.

Countering Fraud and Corruption

The Trust's human resources directorate work closely with the contract counter fraud service both on a proactive and reactive basis. The organisation has the appropriate policies and procedures in place around handling alleged and suspected fraud.

In the last year a number of referrals have been made to the service to investigate.

In addition to the above the Trust ensures that all new starters received appropriate training through induction on the organisation's approach to managing suspected fraud and this is supplemented by in year promotional work undertaken by the contracted service supplier.

Expenditure on consultancy

The total consultancy expenditure for 2017/18 was £209k (£824k in 2016/17).

Off Payroll Engagements

The Trust has an appropriate temporary staffing procedure which covers the requisition and approval arrangements for all inside IR35 off payroll engagements.

For consultancy based services these may be commissioned by individual directorates with financial approval from the finance directorate.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months:	
No. of existing engagements as of 31st March 2018	3
Of which:	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	-
No. that have existed for between two and three years at time of reporting.	-
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. The arrangements disclosed above relate to consultancy services which fall outside of IR35.

For all new off-payroll new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £245 per day and lasted longer than 6 months:	
Of which:	
No. assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

There were no Board or senior official appointments engaged on an off payroll arrangement between 01 April 2017 and 31 March 2018.

Exit Packages

The number and make-up of the exit packages agreed during 2017/18 are detailed in the table below.

There were a total of 11 redundancies in 2017/18 as a result of productivity savings to benefit the Trust in future financial periods compared to seven exit packages in 2016/17.

Where other departures have been declared, these relate to individuals who have left the organisation and received contractual payments that they were entitled to (i.e. payments in lieu of notice).

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages

	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	4	-	**4**
£10,001 - £25,000	4	-	**4**
£25,001 - 50,000	2	-	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**11**	**-**	**11**
Total resource cost (£)	£225,000	£0	**£225,000**

High paid off payroll arrangements

There were no high paid off payroll arrangements.

Governance Disclosures

Constitutional Authority

The Board of Directors is responsible for the governance, planning, and management of the Trust's activities. It has met on a monthly basis (with the exception of August and December) and authorises all the key decisions regarding the Trust's business. As of January 2018, formal meetings of the Board of Directors are held every other month, with the alternate months being reserved for less formal Board Seminars. It operates according to the values and standards of conduct of the NHS. These include the Nolan principles (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). The Board of Directors delegates the day-to-day running of the organisation to the Chief Executive and the Management Team, which includes the executive directors. The Board of Directors works closely with the Council of Governors.

The Council of Governors is responsible for representing the interests and views of the Trust's members and partner organisations in the local health economy in the governance of the Trust. The Council of Governors also has a number of statutory duties, including responsibility for appointments to (and removal from) the positions of Non-Executive Director, Trust Chair, and the Trust's External Auditors, approval of the appointment of the Chief Executive, and the setting of remuneration of Non-Executive Directors and Trust Chair. The Council of Governors is responsible for holding the Board of Directors to account for the performance of the Trust. In order to facilitate this, the Chief Executive and Finance Director report to each meeting of the Council of Governors on the key issues regarding the delivery of the Trust's Annual Plan. Governors are required to act in the best interests of the Trust and are required to adhere to its values and code of conduct.

The Trust complies with the relevant principles and provisions of the Combined Code on Corporate Governance. The Tavistock and Portman NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Council of Governors

Composition & Attendance

Composition & Attendance at Council of Governors Meetings 2017/18

Name	Type	June 2017	Sept 2017	Dec 2017	Mar 2018
Natalie Baron	Public	✓	✓	✓	✓
David Bell	Staff	✓	✓	✓	×
Paul Burstow	Chair	✓	✓	✓	✓
Christine Bury	Staff	✓	✓	✓	✓
John Carrier	Camden	n/a	✓	✓	✓
Sue Dowd	Stakeholder	×	×	×	×
Derek Draper	Public	✓	✓	✓	✓
Angela Haselton	Staff	✓	×	✓	✓
Vasilios Ioakimidis* **	Stakeholder	n/a	×	×	×
Jo Jackson* **	Stakeholder	×	n/a	n/a	n/a
Celestine Keise	Camden	n/a	✓	✓	✓
Anthony Levy	Public	✓	×	✓	×
Claire-Louise Leyland	Stakeholder	✓	×	×	×
Marilyn Miller	Public	×	✓	✓	✓
Richard Murray**	Public	×	n/a	n/a	n/a
Edna O'Shaughnessy*	Public	✓	n/a	n/a	n/a
Michael Rustin	Public	n/a	✓	✓	×
Samuel Takunda	Public	×	✓	✓	×
George Wilkinson	Public	✓	×	✓	✓
Kimberley Wilson	Public	×	×	✓	×

*Edna O'Shaughnessy stepped down in July 2017

**Richard Murray lost his seat in the elections held in 2017

***Jo Jackson stepped down in August 2017 and was replaced by Vasilios Ioakimidis

All governors are appointed or elected for a three year term of office. The lead governor is Natalie Baron.

The Council of Governors meets at least four times a year. This is considered to be sufficiently regularly for it to discharge its duties. The composition and size of the Council of Governors is reviewed on a regular basis to ensure that it is not so large as to be unwieldy.

The Trust Chair chairs the Council of Governors. In addition, the Chief Executive and other executive directors and Non-Executive Directors have an open invitation to attend the Council of Governor meetings. The executive directors facilitate the provision of appropriate information to the Council of Governors.

The Council of Governors seeks to maintain a positive relationship with the Board and is able to raise concerns in an appropriate and effective manner. The Council of Governors periodically assesses its collective performance and communicates to the public, members and other stakeholders how it has discharged its responsibilities.

The process for managing the removal from the Council of Governors of any governor is set out in the Trust's constitution.

Constituencies

Public Constituency: The Trust has three classes within the Public Constituency, which are set according to the volume of clinical activity: Camden, for residents of the London Borough of Camden (in which the Trust has its geographical base and is the borough to which the Trust provides more services than any other single borough) has three seats; the Rest of London, for residents of all London Boroughs excluding Camden, has six seats; and the rest of England and Wales, for all residents outside of London, has two seats. All governors in this constituency are elected.

Staff Constituency: The Trust has three classes within the Staff Constituency, with two set to represent staff according to their job type and grade – Administrative and Technical, which includes staff paid on Agenda for Change bands 1 to 6, and Clinical, Academic and Senior, which includes staff paid on Agenda for Change bands 7 and above (or equivalent). The third class within the Staff Constituency is for Representatives of Recognised Staff Organisations and Trade Unions. All staff members who fall into that category are not eligible to be members of either of the other classes. All governors in this constitution are elected.

Stakeholder Governors: These are Governors who are appointed, rather than elected, from within organisations with whom the Trust has a relationship. The

National Health Service Act 2006 requires that the Council of Governors has Stakeholder Governors from Clinical Commissioning Groups for which the Trust provides goods or services (the Trust has a Stakeholder Governor from Camden CCG), a Local Authority within the Trust's Public Constituency (the Trust has a Stakeholder Governor from Camden Local Authority), and any organisations that the Trust considers partnership organisations (the Trust has Stakeholder Governors from Voluntary Action Camden, the University of East London and the University of Essex).

When the Health and Social Care Act 2012 abolished Primary Care Trusts we replaced the PCT Governor Stakeholder by approaching Camden's Clinical Commissioning Group and inviting them to nominate representatives. Two representatives were appointed initially, but one representative had to withdraw, and the CCG was unable to nominate a replacement. Therefore in October 2014 our constitution was changed to allow for a Stakeholder Governor from another commissioning body to be appointed.

Elections

There were elections held during 2017. This was to fill vacancies that resulted from governors stepping down during their terms of office. Elections were held to fill two vacancies in the Camden constituency and two vacancies in the Rest of London constituency. These were held according to the Model Election Rules, as per the Trust's constitution. All four vacancies were filled. The process was administered by Electoral Reform Services.

Register of Governors' Interests

The Trust requires all Governors to disclose details of company directorships or other material interests in companies or related parties held by Governors that are likely to do business or are possibly seeking to do business, with the Trust. These disclosures are entered on to the *Register of Governors' Interest,* which is published on the Trust's website.

Understanding the views of members and Governors

The Trust holds a number of open events that Governors and Members are invited to attend, including the Annual General Meeting. These events are opportunities for Governors and Members to meet with each other, and to

meet with Trust staff to express their views on certain topics including the Trust's objectives, priorities and strategy.

Meetings of both the Board of Directors and the Council of Governors are open to the public; meetings are well-publicised on the Trust's website. Members of the public are encouraged to attend meetings, which provide a useful opportunity to meet with directors and governors, and an opportunity to see the work of the boards in action. Non-Executive Directors, in particular the Senior Independent Director, are encouraged to attend meetings of the Council of Governors.

The Trust holds a number of consultations with Governors, and encourages Governor involvement in a number of different areas of the Trust's work. Governors formally provide to the Board views from the public on the Trust's forward plan. Governors are also involved in the Trust's committees, especially the Equalities Committee, the Clinical Quality, Safety and Governance Committee, and the Quality Stakeholders Group.

The Governors have not exercised their power under paragraph 10c of schedule 7 of the NHS Act 2006 to require one or more director to attend a governor meeting during the course of the year.

Governors are encouraged to attend the Annual General Meeting, which is a major event to which members are invited each year. The Trust's forward plan, priorities and strategy are published on the Trust's website, and the opinion of the members is sought both through Trust events and via contact details provided on the website. Governors are also encouraged to develop their own ways of engaging with their members.

Roles and Responsibilities of the Governors

Governors have an important role to play, although they are not responsible for the day-to-day running of the Trust.

Governors have two main responsibilities: holding the Board of Directors to account for the running of the Trust (statutory responsibilities), and representing members. Governors are also responsible for holding the Non-Executive Directors individually and collectively to account for the

performance of the Board of Directors. Governors will have the power to request that directors attend a meeting to obtain information about their Trust's performance and that of its directors.

Statutory Responsibilities

Governors have several statutory responsibilities. These are:

- Appointing the Trust Chair and the Non-Executive Directors
- Appointing the Trust's External Auditors
- Approving the appointment of the Chief Executive
- Deciding the pay and terms of office of the Trust Chair and the Non-Executive Directors
- Agreeing the process for evaluating the performance of the Trust Chair and Non-Executive Directors
- Ensuring the Trust operates in accordance with the Terms of Authorisation
- Holding the Non-Executive Directors to account for the performance of the Trust
- Approving "significant transactions"
- Approving applications by the Trust to enter into a merger, acquisition, separation or dissolution
- Ensuring that the earning of any private patient income will not significantly interfere with the Trust's primary purpose or the performance of its functions and must notify the board of their decision on this
- Approving any increase of more than 5% in private income in any financial year
- Where an amendment is proposed to the constitution in relation to the powers or duties of the council, at least one governor must attend the next annual members' meeting and present the proposal.

Representing Members

Governors face in two directions – they represent the interests of members to the Trust, and they also let members know what is happening at the Trust. Governors are our link between our members and the directors who make decisions about our services. They are responsible for representing the views of our members and partner organisations to the Board of Directors, and also responsible for feeding back information about the Trust and its performance.

Board of Directors
Composition & Attendance

Non-Executive Directors

- ***Professor Paul Burstow, Trust Chair***
  Appointed November 2015. Term of office ends in October 2018.
  - Chair, Social Care Institute for Excellence, 2017-present
  - Professor of Mental Health Policy, University of Birmingham (part-time) 2016-present
  - Managing Director, Indy Associates, 2015-present
  - Minister of State for Health, 2010-2012
  - Member of Parliament, 1997-2015
  - Chief Executive, ALDC, 1988-1997
  - Councillor, London Borough of Sutton, 1986-2002

Professor Dinesh Bhugra, Deputy Chair and Non-Executive Director
Appointed November 2014. Second term of office began in October 2017.
- Experience in Healthcare Management, Education and Business Development
- Emeritus Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, Kings College London
- President of World Psychiatric Association, September 2014
- Formerly President-elect of the World Psychiatric Association, Chair of the Mental Health Foundation from 2011 to 2014
- CBE in 2012 for Services to Psychiatry
- Director, DKB Consulting
- Secretary, Porism Limited
- Trustee, Care-IF
- Trustee, Sane
- President, Mental Health Foundation
- President, World Psychiatric Association

- ***Ms Helen Farrow, Non-Executive Director***
  Appointed November 2016. Term of office ends October 2019.
  - Experience in Investment Management

- Formerly Director at Ignis Asset Management
- Formerly Non-Executive Director at Royal National Orthopaedic Hospital
- Formerly Vice Chair of the Board at Royal National Orthopaedic Hospital
- Formerly Chair of Finance and Performance Committee at Royal National Orthopaedic Hospital

- ***Ms Jane Gizbert, Non-Executive Director***
  Appointed November 2014. Second term of office began in October 2017.
  - Experience in Marketing, Communications and Business Development
  - Director of Communications, National Institute for Health and Care Excellence since 2008
  - Formerly Head of Corporate Communications, Medical Research Council
  - Previously worked for International Planned Parenthood Federation

- ***Mr David Holt, Non-Executive Director, Senior Independent Director, Chair Audit Committee***
  Initially appointed November 2013. Term of office ended in October 2016. Reappointed for a second term which ends in October 2019.
  - Qualified Accountant (Chartered Institute of Management Accountants)
  - Non-Executive Director and Senior Independent Director, Whittington Health NHS Trust
  - Deputy Chairman, Ebbsfleet Development Corporation
  - Non-Executive Director, Planning Inspectorate
  - Non-Executive Board Member, Hanover Housing Association
  - Formerly Finance Director at Land Securities plc
  - Formerly Finance Director, Jaeger and Viyala Fashion Retail
  - Formerly Group Chief Auditor, Coats plc

- ***Ms Edna Murphy, Non-Executive Director***

Appointed in November 2014. Resigned and term ended at the end of September 2017.

- Experience in Research Management and Education in the University Sector
- Manages the Faculty of Medical Sciences at University College London – from 1 June 2017 will be Bursar, St Edmund's College Cambridge
- Former Magistrate, Cambridge and Peterborough bench
- Previously Executive Director of the Joint Research Office, Imperial College Academic Health Science Centre
- Previously held various Senior Management roles, University of Cambridge and the Cambridge High Tech Sector, 6th form Governor

- *Dr Deborah Colson, Non-Executive Director*

  Appointed in October 2017. Term of office ends in September 2020.
  - Formerly Chief Scientific Officer, Life Study
  - Experience in cross-disciplinary working in research organisations, higher education, and research funders
  - Experience in medical physics and research
  - Formerly Science Policy Consultant
  - Formerly Science Programme Officer for the Medical Research Council
  - Formerly Science Programme Manager for the Wellcome Trust
  - Formerly Non-Executive Director for the Wellcome Trust on the Diamond Synchrotron and the Structural Genomics Consortium

Executive Directors

- *Dr Chris Caldwell, Nurse Director*

  Appointed November 2016
  - Formerly Dean of Healthcare Professions at Health Education England since 2013.
  - 20 years' experience in NHS, higher education and health policy

- Formerly Deputy Director of Education and Assistant Chief Nurse at Great Ormond Street Hospital
- Programme Manager at the Department of Health
- Programme Director at the Royal College of Nursing
- Registered children's nurse

- ***Dr Sally Hodges, Director of Children, Young Adults and Families Services***
  Appointed in November 2015.
  - Consultant Clinical Psychologist specialising in Children and Young people with Learning and Developmental difficulties, The Tavistock and Portman NHS FT since 1996
  - Formerly Associate Clinical Director of Complex Needs in CYAF since 1996, The Tavistock and Portman NHS FT
  - Formerly Patient and Public Involvement (PPI) Lead, The Tavistock and Portman NHS FT
  - Leadership MSc from University of Birmingham and the NHS Leadership Academy

- ***Mr Paul Jenkins, Chief Executive***
  Appointed Chief Executive November 2013 and commenced in February 2014.
  - Formerly Chief Executive, Rethink Mental Illness
  - Formerly Director of Service Development, NHS Direct
  - Chair of Mental Health UK
  - Awarded an Order of the British Empire (OBE) for his role in setting up NHS Direct

- ***Ms Louise Lyon, Director of Quality and Patient Experience***
  Appointed March 2008.
  - Consultant Clinical Psychologist, The Tavistock & Portman NHS Foundation Trust
  - Member of British Psychoanalytical Society

- Formerly Director of Quality and Patient Experience, Adult and Forensic Services
- Formerly Trust Director
- Formerly Clinical Director of Adolescent Directorate, The Tavistock & Portman NHS Foundation Trust
- Formerly Head of Psychology, The Tavistock & Portman NHS Foundation Trust
- Formerly Deputy Trust Clinical Governance Lead, The Tavistock & Portman NHS Foundation Trust
- Formerly Consultant Clinical Psychologist, SW Kensington & Chelsea Mental Health Centre

- ***Mr Terry Noys, Deputy Chief Executive and Finance Director***
  Appointed in October 2016.
  - Chartered Accountant and Fellow of the Institute of Chartered Accountants of England and Wales
  - Held various Finance Director roles for stock exchange listed and private equity-backed groups and not-for-profit organisations
  - Previously Chief Operating Officer at St Mary's University
  - Previously Finance Director, The National Archives
  - Previously Finance Director, Hanover Housing
  - Previously Finance Director, Viridian

- ***Mr Brian Rock, Director of Education and Training and Dean***
  Appointed January 2015.
  - Qualified as Clinical Psychologist
  - Formerly at Goldstone Commission
  - Formerly Director of The Children's Inquiry Trust NGO
  - Experience in the NHS since 1996
  - Formerly Consultant Clinical Psychologist, The Tavistock & Portman NHS Foundation Trust
  - Involved in setting up The Tavistock and Portman NHS Foundation Trust award winning City and Hackney Psychotherapy Consultation Service
  - Involved in developing and delivering training and consultation to GPs and primary care staff
  - Member of the British Psychoanalytical Society

- MBA from Henley Business School

- *Dr Rob Senior, Medical Director*
  Appointed December 2006.
  - Senior Research Fellow, University College London
  - Consultant Child & Adolescent Psychiatrist, The Tavistock & Portman NHS Foundation Trust and Royal Free London NHS Foundation Trust
  - Trust Named Doctor for Child Protection
  - Systemic Psychotherapist

- *Dr Julian Stern, Adult Forensic Services Director*
  Appointed April 2016.
  - Previously Clinical and Academic Lead, and Consultant Psychiatrist in Psychotherapy in the Primary Care Psychotherapy and Consultation Service – City and Hackney, and in the Adult Complex Needs Team
  - Deputy Director (CQC) and Service Lead, Adult Complex Needs (2015-2016)
  - 2013 Winner (as part of PCPCS), Royal College of Psychiatrists Team of the Year award, and 2015 BMJ Mental Health team of the year.
  - 17 years' experience in developing and heading the Psychological Medicine Unit, St Mark's Hospital
  - Consultant Medical Psychotherapist
  - Interest in working psychotherapeutically with patients with physical symptoms and long term conditions
  - Co-editor of two text books 'Core Psychiatry' and 'Functional Gastrointestinal disorders: A Bio-psychosocial approach'
  - Published widely in medical, psychotherapy and psychotherapy and psychiatry journals

Composition & Attendance at Board of Directors Meetings 2017/18

Director Name	Apr 17	May 17	June 17	July 17	Sept 17	Oct 17	Nov 17	Jan 18	Feb 18	Mar 18
Dinesh Bhugra	✓	×	×	✓	✓	✓	✓	✓	✓	✓
Helen Farrow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Burstow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Caldwell	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Deborah Colson*	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	×
Jane Gizbert	✓	×	✓	×	✓	✓	✓	✓	✓	✓
Sally Hodges	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Holt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Jenkins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louise Lyon	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Edna Murphy**	✓	✓	×	✓	✓	n/a	n/a	n/a	n/a	n/a
Terry Noys	✓	✓	✓	✓	✓	×	✓	×	✓	✓
Brian Rock	✓	✓	✓	×	✓	✓	×	✓	✓	✓
Rob Senior	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Julian Stern	✓	✓	✓	✓	✓	✓	✓	×	✓	✓

*Deborah Colson started in post in October 2017 – attended meeting in September 2017 to observe

**Edna Murphy stepped down in September 2017

Independence of Non-Executive Directors

The Trust considers all its non-executive directors to be independent.

All non-executive directors are appointed for a three year period and ordinarily may serve a maximum of two terms of office. Appointments may be terminated during the term of office by the non-executive director resigning or the Council of Governors agreeing to end the appointment as set out in the Trust's constitution.

On occasion, and where appropriate, the Chair meets with just the Non-Executive Directors.

Balance, completeness, and appropriateness of membership

The Board of Directors is comprised of six Non-Executive Directors, including a non-executive Trust Chair, and eight executive directors, including our Chief Executive and our Deputy Chief Executive and Director of Finance. Of the eight executive directors only five are voting members; the Director of CYAF, the Director of AFS and the Nursing Director are non-voting members.

Our executive directors come from a mixture of clinical and non-clinical backgrounds: two of our current executive directors is a registered medical practitioner, one is a registered nurse, one is a child and adolescent psychotherapist, one a clinical psychologist and one is a psychoanalyst.
The expertise of the Non-Executive Directors includes finance, management consultancy, public relations, marketing, communications, business development, commercial property, research management, healthcare management, research and public policy. The mix of expertise is reviewed each time a new appointment is to be made.

All members of the Board of Directors had joint responsibility for every decision of the Board of Directors regardless of their individual skill or status. All members had responsibility to constructively challenge the decisions of the Board and helped to develop proposals on strategy.

The Board considers that the current directors ensure a balanced, complete and appropriate mix of skills to fulfil the requirements of the Foundation Trust. The Board and its committees are provided with sufficient resources and high quality information relevant to the decisions to be made.

Performance evaluation

The Trust evaluates the performance of its directors and committees. The chief executive appraises the executive directors using the standard Trust procedures. The Chair is appraised by the Senior Independent Director, following a process agreed by the Nominations Committee, which involves full 360 feedback both from within and from outside the Trust. The Non-Executive Directors are appraised by the Chair following a process agreed by the Nominations Committee. The outcomes of appraisals are used to determine individual and collective professional development programmes for directors relevant to their Board role.

The Board of Directors evaluates its own performance through quarterly scrutiny of the strategic plan by the Strategic and Commercial Committee and through completion of an annual Board evaluation questionnaire.

Register of Directors' Interests

The Trust requires all Directors to disclose details of company directorships or other material interests in companies or related parties held by Directors that are likely to do business or are possibly seeking to do business, with the Trust. These disclosures are entered on to the *Register of Directors' Interests*. This Register is published on the Trust's website.

The Trust has appropriate directors and officers insurance to cover the risk of legal action against its directors. Where appropriate, directors have access to independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors.

Audit Committee

Composition & Attendance

Composition & Attendance at Audit Committee Meetings 2017/18

Member Name	16 May 2017	10 Oct 2017	11 Jan 2018	08 Mar 2018
David Holt (Chair)	✓	✓	✓	✓
Edna Murphy	✓	n/a	n/a	n/a
Helen Farrow	✓	✓	✓	✓
Deborah Colson	n/a	n/a	×	✓

All members of the Committee are Non-Executive Directors. Representatives from External Audit, Internal Audit and Local Counter Fraud Specialist are normally present at meetings of the Committee. The Director of Finance and the Chief Executive are also normally in attendance and other members of the management team attend as appropriate, to discuss specific agenda items. The Chair of the Clinical Quality, Safety and Governance Committee and the Chair of the Trust each attend at least once per year.

Subsequent to an Audit Committee meeting, minutes are provided to the Trust Board and at each Trust Board meeting the Chair of the Audit Committee is invited to share any concerns or issues with the Board.

The Audit Committee's Work 2017/18

During 2017/18, the Audit Committee reviewed the work and the reports of the Internal Auditors, the External Auditors, and the Local Counter Fraud Specialist. This work covered the Trust's financial and reporting systems;

assurance processes, including risk management and clinical governance; and a number of corporate governance and compliance matters.

Through its work the Audit Committee has undertaken a review of the effectiveness of the Trust's system of internal control on behalf of the Board. Internal Audit work during the year has covered a range of internal controls and potential risks, notably: a review of the actions following on from the last CQC inspection in 2016, identifying and assessing any gaps that may exist in relation to cyber-attacks, a review of the pre-employment checks and recruitment process to ensure this is being consistently followed and responsibilities are clear, a review of the new student recruitment system in place, assessing the Board Assurance Framework and the processes to keep this up to date and operating as an effective tool on behalf of the Board, providing management with assurance on the robustness of the systems in place to support the key financial processes.

The Audit Committee is satisfied with the responses of management to the issues raised by Internal Audit and time-bound action plans for improvements are in place to address any outstanding weaknesses.

The Audit Committee is also satisfied that the Trust has an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Executive and the Board of Directors. The internal audit function is outsourced to RSM Risk Assurance Services LLP.

The work of the Local Counter Fraud Specialist and the counter-fraud plan have been reviewed to ensure that the Trust continues to develop its programme of deterrence, prevention and detection. There have been four investigations in the Trust during the year, none of which found any illegal or untoward behaviour by either the Trust or its staff.

The Audit Committee is satisfied with the processes and the conclusions of the work carried out by its Local Counter Fraud Specialist, a service which is outsourced to RSM Risk Assurance Services LLP.

External Audit work during the year has covered a range of potential risks most notably: the risk of fraud in revenue recognition, the risk of incorrectly categorizing expenditure as capital to meet the Trust's control total, the risk of management override of controls.

In addition to auditing the financial accounts, the External Auditors have examined the Quality Accounts and given a clean quality report opinion on the content of the Quality Report and on the selected performance indicators reported therein.

The Trust's external auditors are Deloitte LLP, who were appointed in 2015 (following a competitive tender process) for a five year period (starting in 2015/16), renewable on an annual basis – subject to satisfactory performance. The Audit Committee having reviewed the performance of Deloitte LLP during 2015/16 – on the basis of cost/value for money, independence and professional expertise – recommended their reappointment for 2016/17. This decision was ratified by the Council of Governors. The audit fee for 2017/18 was £48,800 plus VAT. Deloitte LLP did not provide any non-audit services to the Trust during 2017/18.

The Trust carries significant non-NHS related debt and the Audit Committee, therefore, receives a report on debtors at each of its meetings. Data quality is a key issue for the Trust and significant effort has gone into addressing identified weaknesses in this area.

In addition, the working relationship with both the Clinical Quality, Safety and Governance Committee and the Training and Education Programme Management Board has been effective in ensuring that the work of the three Committees is integrated and that the Audit Committee has appropriate oversight of the assurances provided to the Board by the other two Committees.

The Audit Committee has reviewed the processes of other significant assurance functions e.g. reports from the Care Quality Commission and the Quality Assurance Agency for Higher Education and is satisfied that they can be relied upon to provide the necessary information to management and to the Board of Directors regarding the Assurance Framework and corporate

governance. The Audit Committee has received positive assurance from management on the overall arrangements for corporate governance, risk management and internal control and is satisfied that there is an effective system of integrated corporate governance, risk management and internal control across all the Trust's activities.

The Audit Committee has continued to develop its focus on risk management, risk appetite and corporate governance processes in accordance with guidance from NHS Improvement and others. This has included in-depth reviews and presentations by management to the committee of a number of significant risks on the Strategic Risk Register.

The Audit Committee has reviewed the Annual Governance Statement, which is included in this report, and has confirmed to the Board of Directors that the wording of the Statement is consistent with the findings reported to the Audit Committee during the year.

The Audit Committee reviews the Trust's arrangements for whistle-blowing on a regular basis. The whistle-blowing arrangements enable staff and other individuals to raise, in confidence, concerns about possible improprieties in matters of control, clinical quality, patient safety or other matters.

Non-Executive Director Appointment Committee

Composition & Attendance

Member Name	April 2017	September 2017
Paul Burstow (Chair)	✓	✓
Paul Jenkins	✓	✓
David Bell	✓	✓
Dinesh Bhugra	✓	✓
George Wilkinson	✓	✓
Derek Draper	×	✓
Marilyn Miller	×	✓
Edna Murphy	✓	n/a

The Non-Executive Director Appointment Committee is a committee of the Council of Governors. It is chaired by the Trust Chair, and there are three Governor members, one Non-Executive Director member, and one Executive

Director member, ensuring that appointments are Governor led, but incorporate the views of the Board of Directors on the skills, qualifications and experience required for each position. The Director of Human Resources, Mr Craig de Sousa, attends the meetings in an advisory role.

The Council of Governors agreed the process for the appointment or reappointment of all Non-Executive Directors.

The Committee met twice over the course of the year, to consider the re-appointment of Prof Dinesh Bhugra and Ms Jane Gizbert, whose first terms of office was due to end in October 2017, and to plan the recruitment to replace Ms Edna Murphy, who stepped down as of September 2017. Dr Deborah Colson was appointed in September 2017 as the new Non-Executive Director on the Board, and the appointment was confirmed by the Council of Governors at their meeting in September 2017.

Non-Executive Director Remuneration Committee

The Non-Executive Director Remuneration Committee considers the level of pay based on external benchmarking to ensure that remuneration is sufficient to attract high calibre directors whilst achieving value for money for the Trust.

Committee Changes

In September 2017, the Council of Governors agreed to amalgamate the Non-Executive Director and Chair Appointment, Appraisal and Remuneration committees into one committee. This change was effected in order to bring the Trust into line with best practice and make the best use of Governors within the committee structure. This new Nominations Committee met once within the year, in March 2018, to discuss the appraisal of the Non-Executive Directors and consider the reappointment of the Trust Chair. Moving forwards, the committee will hold two standing meetings per year, with additional ad hoc meetings as required. Membership of the committee is as below.

Composition & Attendance

Member Name	March 2018
Paul Burstow (Chair)	✓
David Holt	✓
David Bell	x

Derek Draper	✓
George Wilkinson	✓

Executive Director Nomination and Remuneration Committee

Composition & Attendance

Member Name	May 2017	November 2017	January 2018
Paul Burstow (Chair)	✓	✓	✓
Dinesh Bhugra	x	✓	✓
Deborah Colson	n/a	✓	✓
Helen Farrow	✓	✓	✓
Jane Gizbert	x	✓	✓
David Holt	✓	✓	✓
Edna Murphy	✓	n/a	n/a

The Executive Director Nomination and Remuneration Committee is a committee of the Board. It is chaired by the Trust Chair and all Non-Executive Directors are members. The Director of Human Resources, Mr Craig de Sousa, attends the meetings in an advisory role. The Chief Executive, Mr Paul Jenkins, also attends to provide a view from the Executive Team.

The Committee sets the remuneration of executive directors to ensure that pay is reflective of the market and provides the Trust with value for money.

The above committees regularly consider the structure, size and composition of the Board to ensure that it is appropriate to discharge its responsibilities.

Membership

Eligibility and Constituencies

The Trust provides patient, training, consultancy, and research services. As mental ill health is still considered stigmatising, patients and carers are not required to disclose any connection with the Trust. Therefore one Public Constituency exists for all Members. As we provide national services, most of the population of England and Wales is eligible to join our membership.

Three classes of Public Constituency were set according to the volume of clinical activity: *Camden* (in which the Trust has its geographical base and is the borough to which the Trust provides more services than any other single borough) has three seats; the *Rest of London* (to which the Trust delivers the majority of services) has six seats; and the *Rest of England and Wales* (to which the Trust delivers a higher proportion of specialist services) has two seats.

The Trust is mindful of the need to ensure that our membership grows and continues to be representative. The Trust writes to all new patients, after their first appointment, inviting them to become members. Where membership in a constituency or demographic group is considered to be unrepresentative, the Trust will address this through its Membership Strategy.

All current students and staff are members of the staff constituency unless they opt out of membership.

Membership Statistics 2017/18

Constituency	31 March 2016	31 March 2017	31 March 2018
Public	6788	6012	6156
Staff	658	666	805

Membership Strategy

Our strategy for membership has five main aims:

- Ensure that members can contribute to Patient and Public Involvement activity through the PPI committee
- Develop stronger links with membership
- Increase members' contributions to the members' newsletter
- Increase numbers of younger users in the membership

- Involving members in decision making processes including recruitment interviews

Governors regularly consider how to improve membership engagement, and facilitate ways for governors to communicate better with the Trust's membership.

Contact Procedures for Members

Members can contact Governors and Directors via the Trust Secretary in the first instance, and details are published on our website.

NHS Improvement's Single Oversight Framework

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place.

Segmentation

The Trust is in segment one.

This segmentation information is the Trust's position as at 31st March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

2017/18

		2017/18 Q1 Score	2017/18 Q2 Score	2017/18 Q3 Score	2017/18 Q4 Score
Financial sustainability	Capital Service Capacity	1	1	1	1
	Liquidity	1	1	1	1
Financial efficiency	I&E Margin	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	1	1	1	1
Overall scoring		1	1	1	1

2016/17

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial sustainability	Capital Service Capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E Margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	2	2
Overall scoring		1	1

Statement of the chief executive's responsibilities as the accounting officer of The Tavistock and Portman NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Tavistock and Portman NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Tavistock and Portman NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in *the NHS Foundation Trust Accounting Officer Memorandum*.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Tavistock and Portman NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Tavistock and Portman NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive, I hold overall responsibility for risk management, the Operational Risk Register, and the Board Assurance Framework.

The Medical Director is responsible for the management of clinical risk, has the overall responsibility for clinical governance, and chairs the Clinical Quality, Safety, and Governance Committee which provides the Board of Directors with assurance of effective (non-financial) risk management within the Trust.

Health and safety assurance is provided via the Corporate Governance and Risk Workstream which reports to the Clinical Quality, Safety, and Governance Committee (CQSG).

The Corporate Governance and Risk Workstream Lead assesses evidence of effective risk management of non-clinical risks, and the Patient Safety and Clinical Risk Workstream Lead assesses effective management of clinical risks. They monitor the respective elements of the Operational Risk Register and both report to the CQSG.

The Executive Management Team is responsible for identifying risks to strategic objectives, whilst the Deputy Chief Executive and Finance Director is responsible for reporting on the management of these risks, using the Trust's Board Assurance Framework / Strategic Risk Register. He is also responsible for maintaining an effective system of internal financial control and for providing financial information to enable the Trust's management and Board of Directors to manage financial risk.

The Deputy Chief Executive is the Trust's Senior Information Risk Owner (SIRO).

The Associate Director of Quality and Governance is responsible for non-clinical risk and provides a central resource of expertise and advice on all non-financial risk management.

The Director of Quality and Patient Experience leads the Trust's rolling assurance programme of compliance with the Care Quality Commission's essential standards and reports to the Board of Directors via the CQSG if there is any risk of the Trust being non-compliant with any element of an Essential Standard. Assurances that the Trust is meeting Care Quality Commission requirements are reported via work streams of the CQSG as follows: The Clinical Quality and Patient Experience work stream provides assurances on key metrics with regards to the domains of 'Caring', 'Responsive' and 'Effective', and the Patient Safety and Clinical Risk work stream, on the domain of 'Safety'. Compliance for the 'Well-led' domain falls within the Corporate Governance and Risk work stream.

The Director of Education and Training and Dean of Postgraduate Studies is responsible for leading the Trust's management and delivery of training programmes, and risks arising from this area of Trust activity. The Director leads the Trust's annual contract negotiations for the provision of training services with Health Education England through the North Central and East London Local Education and Training Board.

Day to day management of risks is undertaken by operational managers who are charged with ensuring risk assessments are undertaken throughout their area of responsibility and that any necessary remedial action is carried out.

Risks are identified, inter alia, through third party inspections, complaints, comments and guidelines from external stakeholders, audits, reported incidents, benchmarking and risk assessments together with an assessment of the operating environment (both local and national).

Through mandatory induction courses, a biennial staff in-service training day and other training events, staff are trained in the recognition, reporting and management of clinical and non-clinical risks relevant to their posts. The risks are reviewed by workstreams of the CQSG, and the learning from good practice is shared with staff through the 'Quality News' newsletter and through directorate Clinical Governance leads.

The Risk and Control Framework

Risk management is embedded in the Trust's management and is integral to the development of policies and procedures with the use of equality impact assessments, service planning and any change to patterns of service delivery and is reinforced by training at all levels. Incident reporting is openly encouraged across the Trust and centrally managed. In May 2018 the Trust will have implemented an electronic risk management system to support the submission of incident information, particularly from satellite sites, and also provide a vehicle for reporting lessons learned, in real time, for all staff. Electronic risk assessments and risk register management will be implemented soon after.

Strategic and operational risks are covered by Trust-wide Risk Registers with both being updated during the year to include an identified 'target' risk –

representing the Trust's risk appetite. Each risk is assessed before and after mitigation and the 'current' score compared to the target. Where the net risk exceeds the target risk, a decision is then made whether or not that level of risk is tolerated or what further action is required.

An assessment of the Trust Risk Appetite against individual strategic aims and a Trust Risk Appetite statement was formally agreed by the Board of Directors in March 2018 and will inform 'target' risks going forward. This will be reviewed annually.

The Board of Directors reviews quarterly quality and performance information alongside financial and risk information for a comprehensive oversight of the Trust's performance.

Operational Risks

Operational risks are identified throughout the year and included in the Operational Risk Register. It was agreed in-year that this would be presented in full to the Board of Directors three times a year to be noted, with new significant risks reported by exception. In addition, significant operational risks are reported to the Board of Directors every quarter by the CQSG, based on assurance reports it has itself received on corporate governance and risk; patient safety and clinical risk; quality reporting; and information governance.

Strategic Risks

Strategic risks are agreed by management and the Board of Directors as part of preparing the Annual Plan. The Plan is developed in consultation with our Council of Governors, who represent the public; Trust staff; and other key stakeholders. The Plan document itself includes key risks. The Strategic Risk Register (Business Assurance Framework), which tabulates the risks, the actions being taken to manage them, risk lead and monitoring arrangement is presented and approved at the same time (as the Plan). Risks rated 15-25 are reviewed monthly by the Executive Management Team and four times a year, the Board of Directors receives an update on the strategic risks and actions being taken to reduce the level of risk.

Risks to compliance with the governance condition of our Foundation Trust licence are mitigated through regular reviews of the performance of board

committees, annual review of the responsibilities of directors and subcommittees, and clear and regular reporting by the Executive Management Team.

The current Business Assurance Framework has 14 identified risks, of which two are classified as 'Red'. These are the risk associated with the longer term sustainability of the Trust and the risk to being able to agree or fund relocation / redevelopment plans. The risk to the longer term sustainability of the Trust has been mitigated by establishing a new organisational focus on income generation; developing strategies for new markets and a response to the development of Integrated Care Systems in London. The second risk is mitigated in part by proactive negotiations with the vendor towards Heads of Terms and an ongoing updated review of costs and potential proceeds.

During the year, the Trust reviewed and updated its Risk Management Policy and Strategy and Risk Management Procedure. This included a 'refresh' of the Business Assurance Framework, incorporating recommendations made by Internal Audit

Governance

The governance framework for the Trust is set out in its Constitution and further supported by a suite of policies including the Scheme of Delegation and individual committee terms of reference. The work covered by these committees, their membership and attendance records are included in other sections of this annual report. There are no areas where the Trust does not comply with the Foundation Trust Code of Governance and compliance has been highlighted in the relevant sections of this annual report.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) and has a current rating of 'Good' across all CQC Domains published on 1 February 2017, following inspections in 2016.

The Trust's Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management. This covers all areas of the Trust's activities, in conjunction with the CQSG Committee, as well as the Trust's core financial systems and procedures and counter-fraud controls. The Audit Committee reviews all

reports from the External Auditors, the Internal Auditors, and the Local Counter-Fraud Specialist. The Annual Report of the Internal Auditors provides the Audit Committee with assurance on the extent to which the Trust's system of internal control is sound.

The Board of Directors receives minutes and/or reports from the Audit Committee at each of its meetings.

Participation in risk management is part of the Trust's overall strategy for patient and public involvement and two Governors serve on the CQSG Committee. The Council of Governors also appoints the Trust's External Auditors and reviews, with the Board of Directors, the performance of the Trust, including any risk of breach of the Trust's licence.

Pension membership

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

As a mental health trust, we know that inequality contributes to psychological difficulties for individuals and groups, and that multiple layers of inequality create marked differences in people's self-esteem, levels of hope and emotional wellbeing. The Trust is committed to the elimination of discrimination, harassment and victimisation in the delivery of all our services and seeks a culture that promotes equality and meets people's mental health needs. We launched our Race Equality Strategy 2017-2020 during the year and have in place a single equalities scheme, developed with staff, service users, specific communities and our members.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon reduction

The foundation trust has undertaken risk assessments in respect of carbon reduction and these are currently under consideration. The trust proposes to develop robust delivery plans to ensure full compliance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Raising Concerns at Work

The Trust's Raising Concerns and Whistleblowing procedure encourages staff to be aware of risks and to report them so that action can be taken, and training is given to all staff on the Duty of Candour, Whistleblowing, and the importance of incident reporting as part of induction and the mandatory INSET events which all staff attend. Our Freedom to Speak-Up Guardian continues to work to support staff who have concerns as well as to promote a culture of transparency and openness within the Trust.

Quality Assurance Agency Compliance

The Trust submitted an update to the action plan which was developed as a result of the Quality Assurance Agency Inspection (QAA) in 2016. A reviewer and facilitator visited the Trust in May 2017 to gather further information to that provided and the resulting report found that we were making satisfactory progress against our plan.

Information Governance and Data Security

Information Governance (IG) provides the framework for handling information in a secure and confidential manner. Covering the collection, storage and sharing of information, IG provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively. The Deputy Chief Executive and SIRO chairs an IG Workstream group which reports into the CQSG Committee.

While the Trust Information Governance Toolkit score remained high in 2016/17 a small number of areas dipped to level 1 and hence overall the Toolkit was not passed. During the 2017/18 year the Trust focussed its efforts on ensuring a minimum level 2 score in all IG Toolkit requirements to

ensure a pass on the toolkit as a whole. The Trust achieved a pass and an overall score of 90% again the Information Governance Toolkit 14.1.

IG Training was an area of key focus for the Trust, particularly given the absence for the majority of the year of the online materials previously provided by NHS Digital. Face to face training was commissioned to ensure our training compliance remained high throughout the year and until online training materials were again available.

There were four information governance incidents classed as serious during the year, one categorised as, 'loss of patient data' and three categorised as, 'confidential information leak'. Per Trust procedure, all were reported to the Strategic Executive Information System (STeIS). While all four were initially thought to reach the SIRI level 2 threshold and hence required STeIS and Information Governance Toolkit reporting, further investigation found that one reached SIRI level 1 only and so was handled through local procedures. The remaining three were correctly logged with the Information Governance Toolkit and escalated to the Information Commissioners Office (ICO). Following investigation the ICO found in each case that the Trust had taken appropriate actions and that no further formal action would be taken by the ICO.

In addition during the year the Trust was subject to a significant cyber-attack that affected many organisations across the country, WannaCry. The Trust responded well to this attack with all necessary security patches in place several months before the attack. The WannaCry ransomware was therefore unable to gain a foothold in the Trust. The combination of the Trust reactive response and technical controls ensured the Trust was not impacted by the attack.

The Trust also put in place plans to ensure readiness for the implementation of the General Data Protection Regulation in May 2018. Work on readiness and implementation will continue into the 2018/19 year overseen by the Information Governance Workstream.

Review of Economy, Efficiency, and Effectiveness of the Use of Resources

For 2017/18 the Trust met its financial Control Total, as it also did for 2016/17. The Trust's financial performance includes less than a 1% variation to its agency cap. In achieving this financial result, the Trust saw an increased number of patients and enrolled an increased number of students. The Trust also dealt with a much higher level of Freedom of Information requests. Details of these outcomes are shown elsewhere within this Annual Report.

The Trust identifies cost savings to meet NHS efficiency targets as part of the annual budget process, and during the year. Savings programmes cover pay and non-pay costs, and include the benefits of improved procurement. The costs of services are compared to their income and benchmarked against other organisations where appropriate. The Board of Directors approves the budget and reviews the financial position monthly. The Audit Committee receives reports from Internal Audit on the Trust's financial controls.

The effectiveness of services is monitored by the Board of Directors through scrutiny of the quarterly quality report, and the monthly detailed reports from individual clinical Service Lines, and education and training Portfolios. Both internal and external audit also consider value for money as part of their work and both are required, as part of their annual audit, to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. Neither has reported that the Trust has failings in this respect.

Well-Led Compliance

The Trust has undertaken an assessment of its compliance in line with the CQC's well-led key lines of enquiry to be clear on the organisation's strengths and areas where further work is needed. In the coming financial year the Trust will undergo a routine inspection from the national regulator and this will incorporate the new well-led inspection which will validate our self-assessment of compliance or identify areas where we need to do further work.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports, which incorporate the above legal requirements, in the *NHS Foundation Trust Annual Reporting Manual*.

The work to produce the Quality Report has been supported and scrutinised through the Executive Management Team. The Director of Quality and Patient Experience does not line manage those people supplying evidence for this Report, but facilitates its production and takes an impartial view of submissions and progress. Data is drawn from the Trust's clinical systems, especially CareNotes, and national data sources e.g. NHS Digital. This information has been reviewed extensively at Board level, including Governors serving on the CQSG Committee.

Due to the nature of our patient services (we provide psychological therapies, do not undertake any physical interventions, and are an out-patient service only), the Trust is not required to collect elective waiting time data using the national definition. However, the Trust reports on the waiting times from referral to first appointment (assessment) and following Internal Audit recommendations, a more in-depth process of validation has been put in place, working with teams a across the Trust, in order to provide greater assurance around this data. A data validation process is in place for all data reported in the Quality Report.

Significant work has been undertaken during 2017-18 to address the timely entry and subsequent coding of appointments and clinical note entry issues raised through other Internal Audit reviews. Actions continue to be taken with administrative and clinical staff to improve data quality including the development and implementation of relevant procedures, audits, data cleansing and by providing training and feedback. Work is ongoing to improve the functionality of the electronic patient record system and better integrate clinical and administrative functions.

Waiting times from referral to first appointment was selected by the Trust for auditing by our External Auditors in 2017/18 to provide further assurance about progress made during the year in validating data across services.

Issues identified in the Quality Report are reflected in the quality priorities set in the Annual Plan, which are monitored by the Board of Directors through the framework set out above.

An update on the four quality priorities selected for 2017/18 are included within the annual Quality Report. Progress has been made in all areas although none have been fully met. Work will continue on all priorities into 2018/19.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the CQSG and the Training and Education Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Independent assurance has been provided principally by our External and Internal Auditors, and by the CQC, the Quality Assurance Agency (QAA) for our Department of Education and Training and Ofsted for our school. Gloucester House day unit is a leading independent special school with a fully integrated specialist clinical team. The Ofsted inspection in November 2017 found the service Outstanding for 'personal development, behaviour and welfare' and Good for all other areas. The Trust has developed and implemented action plans in response to the recommendations of each of these bodies. In

particular the adult gender identity clinic (GIC) joined the Trust in April 2017 and worked hard to address issues identified in an earlier CQC inspection.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The opinion is that the Trust "has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

During the year, Internal Audit carried out reviews across 6 functional areas of the Trust with the following outcomes:

	2016/17	2017/18
Partial Assurance	4	2
Reasonable Assurance	1	4

The Audit Committee has paid close attention to the issues raised by Internal Audit and is satisfied with the responses of management to the issues raised by Internal Audit and that time-bound action plans for improvements are in place to address any outstanding weaknesses. The Audit Committee is pleased to note the improvement (over the prior year) in the Head of Internal Audit opinion. The view of the Audit Committee, taking into account progress against implementing actions recommended by internal audit, QAA and CQC, is that an effective system of internal control has been in place in The Tavistock and Portman NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Conclusion

The Board of Directors is fully committed to continuous improvement of its governance arrangements to ensure that systems are in place that ensure risks are correctly identified and managed and that serious incidents of non-

compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action so that the patients, students, service users, staff and other stakeholders of the Trust can be confident in the quality of the service we deliver and the effective, economic and efficient use of resources.

Through the scrutiny and systems of oversight noted above, the Board is able to assure itself of the validity of this statement on Corporate Governance.

My review confirms that, other than as mentioned above, the Trust has sound systems of internal control and that no significant internal control issues have been identified.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

I present this Accountability Report.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of The Tavistock and Portman NHS Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Equity;
- the Statement of Cash Flows; and
- the related notes 1 to 28.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • NHS revenue recognition • Capital expenditure These key audit matters are consistent with the prior year.
Materiality	The materiality that we used for the current year was £1,060k which was determined on the basis of approximately 2% of the foundation trust's total revenue recognised in the year to 2017/18.
Scoping	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the foundation trust's head offices directly by the audit engagement team, led by the senior statutory auditor.

Significant changes in our approach	There have been no significant changes in our approach to the audit in 2017/18 compared to 2016/17.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

NHS revenue recognition

Key audit matter description

As described in note 1.4, Accounting Policies and note 1.2 Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to:

- the judgemental nature of provisions for disputes with commissioners; and
- the Sustainability and Transformation Funding (STF) which is dependent on the foundation trust meeting certain financial performance targets and therefore recognition of this funding is affected by other accounting estimates.

Details of the foundation trust's NHS income, including £27.7m (2016/17: £25.5m) of Commissioner Requested Services, are shown in note 3 to the financial statements. NHS debtors are shown in note 19 to the financial statements. The Trust earnt £2,183k (2016/17: £1,309k) in STF funding which is included in note 4 to the financial statements.

The foundation trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.

How the scope of our audit responded to the key audit matter 	We evaluated the design and implementation of controls over recognition of NHS income. We considered the Trust's performance against its control total and the management estimates that impact that control total, and therefore the eligibility of the Trust to recognise the STF income. We have also reviewed the Trust's correspondence with NHSI, regarding the STF, to validate the amounts of STF recognised in the Financial Statements. We have held discussions with the finance team and contracts team to assess whether there are any unresolved commissioner challenges. We have challenged and corroborated management's explanation through procedures to test differences in the Trust's reported balances with those reported by other NHS bodies through the agreement of balances exercise. We have selected a sample of unsettled NHS debt at year-end and sought evidence that cash has been received post year-end. Where cash has not been received post year-end we have sought further evidence to support the validity and accuracy of the unsettled amounts, for example patient activity records. We have selected a sample of differences between the amounts that the Trust reports as receivable from commissioners, and the amounts that commissioners report that they owe the Trust, in the agreement of balances ("mismatch") report. For this sample, we have sought explanations from management for the variances together with documentary evidence to corroborate those explanations.
Key observations 	We did not identify any material misstatements through our procedures in respect of this key audit matter.
Capital expenditure	
Key audit matter description 	The Trust's capital spend on Property Plant and Equipment was £2.8m in 2017/18 (£1.5m in 2016/17). This is shown in note 15.1 of the Financial Statements. We note that the Trust is undergoing a significant capital programme over a 4 year period, including the proposed relocation of the Trust's facilities and spend on Education and Training IT systems. Determining whether expenditure should be capitalised under International Financial Reporting Standards, and when to commence depreciation, can involve judgement as to whether the nature of expenditure is capital in nature, and is directly attributable to bringing an asset into use. In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down.
How the scope of our audit responded to the key audit matter 	We have evaluated the design and implementation of key controls in place around the capitalisation of costs. We have tested spending on a sample basis to confirm whether it complies with the relevant accounting requirements and that the depreciation rates adopted are appropriate. We have reviewed management's schedule analysing the total costs of the relocation project between revenue and capital with supporting rationale for their treatment to inform budgeting and financial reporting decisions over the life of the project.

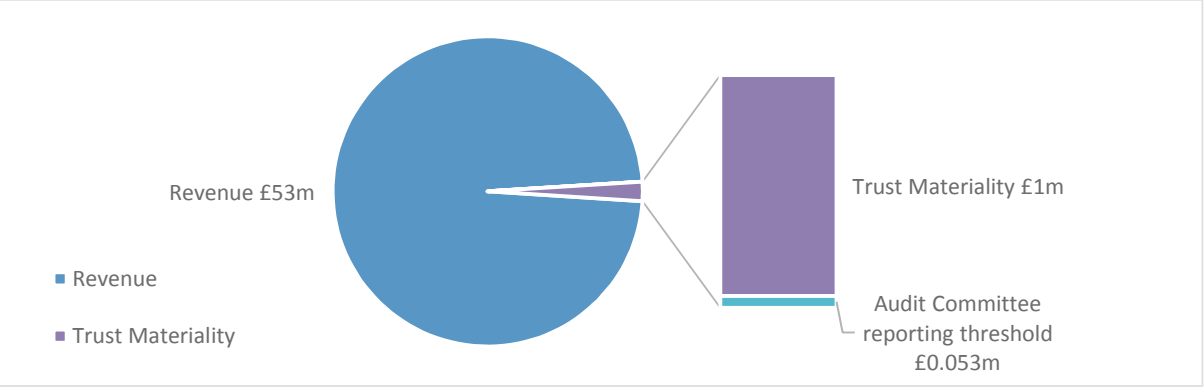
Key observations	We have not identified any material misstatements in relation to this key audit matter.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£1,060k (2017: £950k)
Basis for determining materiality	Approximately 2% of revenue (2017: 2% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £53,000 (2017: £47,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the senior statutory auditor. The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of The Tavistock and Portman NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St. Albans, United Kingdom
22 May 2018

Foreword to the accounts

Tavistock and Portman NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Tavistock and Portman NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Paul Jenkins**
Job title **Chief Executive Officer**
Date **23 May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	27,694	25,508
Other operating income	4	25,400	24,609
Operating expenses	5, 7	(49,706)	(47,817)
Operating surplus from continuing operations		**3,388**	**2,300**
Finance income	10	9	10
Finance expenses	11	(2)	(1)
PDC dividends payable		(595)	(571)
Net finance costs		**(588)**	**(562)**
Other gains / (losses)	12	-	(62)
Surplus / (deficit) for the year from continuing operations		**2,800**	**1,676**
Surplus for the year		**2,800**	**1,676**
Other comprehensive income/(expence)			
Will not be reclassified to income and expenditure:			
Impairments	6	(729)	(2,103)
Revaluations	17	729	414
Total comprehensive income / (expense) for the period		**2,800**	**(13)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	184	191
Property, plant and equipment	15	21,509	19,709
Total non-current assets		**21,693**	**19,900**
Current assets			
Trade and other receivables	19	8,865	7,714
Cash and cash equivalents	20	3,823	2,152
Total current assets		**12,688**	**9,866**
Current liabilities			
Trade and other payables	21	(5,873)	(5,659)
Provisions	24	(178)	(253)
Other liabilities	22	(3,618)	(3,010)
Total current liabilities		**(9,669)**	**(8,922)**
Total assets less current liabilities		**24,712**	**20,844**
Non-current liabilities			
Borrowings	23	(1,000)	-
Provisions	24	(151)	(82)
Total non-current liabilities		**(1,151)**	**(82)**
Total assets employed		**23,561**	**20,762**
Financed by			
Public dividend capital		3,474	3,474
Revaluation reserve		12,239	12,263
Income and expenditure reserve		7,848	5,025
Total taxpayers' equity		**23,561**	**20,762**

The notes on pages 114 - 154 form part of these accounts.

Signed .....

Name **Paul Jenkins**
Job title **Chief Executive Officer**
Date **23 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward		**3,474**	**12,263**	**5,024**	**20,761**
Surplus for the year		-	-	2,800	**2,800**
Other transfers between reserves		-	(24)	24	**-**
Impairments	6	-	(729)	-	**(729)**
Revaluations	15.1	-	729	-	**729**
Taxpayers' equity at 31 March 2018		**3,474**	**12,239**	**7,848**	**23,561**

Statement of Changes in Equity for the year ended 31 March 2017

		Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward		**3,474**	**14,126**	**3,175**	**20,775**
Surplus for the year		-	-	1,676	**1,676**
Other transfers between reserves		-	(174)	174	**-**
Impairments	6	-	(2,103)	-	**(2,103)**
Revaluations	15.2	-	414	-	**414**
Taxpayers' equity at 31 March 2017		**3,474**	**12,263**	**5,025**	**20,762**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus		3,388	2,300
Non-cash income and expense:			
Depreciation and amortisation	5	957	748
Net impairments	6	90	76
(Increase) / decrease in receivables and other assets		(1,153)	(1,434)
Increase / (decrease) in payables and other liabilities		1,137	(1,090)
Increase / (decrease) in provisions		(9)	206
Net cash generated from operating activities		**4,410**	**806**
Cash flows used in investing activities			
Interest received	10	9	10
Purchase of intangible assets		(55)	(126)
Purchase of property, plant, equipment and investment property		(3,102)	(1,269)
Net cash generated (used in) investing activities		**(3,148)**	**(1,385)**
Cash flows(used in) financing activities			
Movement on loans from the Department of Health and Social Care		1,000	-
PDC dividend paid		(591)	(624)
Net cash generated from / (used in) financing activities		**409**	**(624)**
Increase / (decrease) in cash and cash equivalents		**1,671**	**(1,203)**
Cash and cash equivalents at 1 April - brought forward		**2,152**	**3,355**
Cash and cash equivalents at 31 March	20	**3,823**	**2,152**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the financial statements.

Note 1.2 Critical judgements in applying accounting policies

There are no judgements other than those involving estimation that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Note 1.2.1 Sources of estimation uncertainty

The preparation of financial statements under IFRS requires the Trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors including expectations of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The main areas which require the exercise of judgement are in accounting for property, plant and equipment, accounting for untaken annual leave and in accounting for receivables.

- Property, plant and equipment includes the Tavistock Centre, Portman Clinic and the Day Unit, properties of high value whose accounting is subject to property market fluctuations. The total current valuation, as shown in note 15, is £21,509,000, (2016/2017, £19,709,000).

- Operating costs disclosed within note 5 (Staff and executive directors costs) include an estimate of £355,000 for the annual leave earned but not taken at the year-end date, as shown in note 5 (2016/17, £288,000).

- Accounting for receivables necessarily involves judgement when assessing levels of impairment. A provision of £309,000 has been made - see note 19 (2016/17, £306,000).

Note 1.3 Interests in other entities

The trust has no interests in other entities.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Asset valuations were undertaken in this financial year with the prospective valuation date of 31 March 2017. The revaluation undertaken at this date was accounted for on 31 March 2018. In 2017/18 a ‘desktop valuation’ was performed outside of this cycle of 5 year full valuations.

For all categories of PPE, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
The Trust has no PFI or Lift Schemes.

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	50
Plant & machinery	5	5
Information technology	5	5
Furniture & fittings	5	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Depreciation is on a straight line basis.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g.the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

SoftwareSoftware which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

For all categories of Intangible Assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	5
Software licences	5	5

Depreciation is on a straight line basis.

Note 1.9 Inventories
The Trust has no inventories.

Note 1.10 Investment Properties
The Trust has no investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivablesLoans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.The trust's receivables are set out in Note 19. The trust has no loans in its assets.Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Note 1.13 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 25 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

The Trust has no corporation tax liability to pay because its activities are within the public sector.

Note 1.18 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. For the year ended 31 March 2018 the Trust did not report any losses or special payments.

Note 1.23 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted
Following the release of the 2018/19 Department of Health and Social Care Group Accounting Manual in May 2018, the Trust is assessing the likely impact of IFRS 9 and IFRS 15 (and the adaptations included in the GAM).

Standards issued or amended but not yet adopted in FReM

IFRS 9 Financial Instruments

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from Contracts with Customers

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases

Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

Areas the Trust is reviewing include all Contract Income pathways (IFRS 15) and the approach to provisioning for non-NHS debtors (IFRS 9).

Note 1.25 The Tavistock and Portman Charitable Foundation Trust.

The Trust Board has considered both the size and nature of the charitable funds and taken the decision not to consolidate the Charitable Fund in the Annual Accounts at the 31st March 2018 on the grounds of materiality as permitted by the foundation trust annual reporting manual.

Note 2 Operating Segments

2017/18

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	Dividends
Adult Services and Forensic Services	6,358	5,832	526	69
Children, Young People and Families Services	28,811	27,249	1,562	324
Education & Training, Research	17,935	17,032	903	202
Total	53,104	50,113	2,991	595

This table does not include the Trust's restructuring cost of £192k which relate to contractual exit packages for staff.

2016/17

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	Dividends
Adult Services and Forensic Services	9,782	9,469	313	112
Children, Young People and Families Services	22,451	21,651	800	257
Education & Training, Research	17,884	16,997	840	202
Total	50,117	48,117	1,953	571

This table does not include the Trust's restructuring cost of £336k which relate to contractual exit packages for staff.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Block contract income	21,423	16,467
Other clinical income	6,271	9,041
Total income from activities	**27,694**	**25,508**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	11,403	6,481
Clinical commissioning groups	11,083	13,971
Department of Health and Social Care	-	2
Other NHS providers	311	291
NHS other	-	194
Local authorities	2,953	3,368
Non NHS: other	1,944	1,201
Total income from activities	**27,694**	**25,508**
Of which:		
Related to continuing operations	27,694	25,508

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	733	488
Education and training*	21,370	21,454
Sustainability and transformation fund income**	2,183	1,309
Other income***	1,114	1,358
Total other operating income	**25,400**	**24,609**
Of which:		
Related to continuing operations	25,400	24,609
Related to discontinued operations	-	-

**Education and Training*

Education and Training includes £10.3m (16/17 £9.5m) from Health Education England - funding training activity across the Trust. Tuition fees and related HEFCE grants total £4.9m (16/17 £4.5m), Family Nurse Partnership received £2.9m (16/17 £3.1m). The Conferences and Short Courses Unit received £0.9m (16/17 £0.7m), Tavistock Consulting received £0.5m (16/17 £0.6m), Child and Family projects received £0.4m, and the remaining £1.5m (16/17 £3.1m) was received across a range of departments across the Trust.

***Sustainability and Transformation Fund income (STF)*

The Trust was awarded £2,183k (16/17 £1,309k) Sustainability and Transformation Fund income as a result of meeting its targets.

***Other income

The bulk of other income relates to I-thrive project income £269k (16/17 £256k), project grants £175k, Clinical Excellence Awards £107k (16/17 £92k) , Phone Mast rental £70k, salary recharges £108k (16/17 £56k) and miscellaneous income totalling £385k (16/17 £603). The VAT rebate of £351k received in 16/17 was a non-recurring receipt.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	27,694	25,508
Income from services not designated as commissioner requested services	25,400	24,609
Total	**53,094**	**50,117**

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Staff and executive directors costs	36,315	32,514
Remuneration of non-executive directors	88	86
Supplies and services - clinical (excluding drugs costs)	785	414
Supplies and services - general	160	129
Consultancy costs	209	824
Establishment	1,039	891
Premises	3,184	3,121
Transport (including patient travel)	181	132
Depreciation on property, plant and equipment	895	703
Amortisation on intangible assets	62	45
Net impairments	90	76
Increase/(decrease) in provision for impairment of receivables	3	2
Increase/(decrease) in other provisions	-	213
audit services- statutory audit	55	52
other auditor remuneration (external auditor only)	-	5
Internal audit costs	36	40
Clinical negligence	30	26
Legal fees	3	56
Insurance	38	33
Research and development	425	-
Education and training	999	904
Redundancy	225	336
Hospitality	23	33
Grossing up consortium arrangements	-	4
Other services, eg external payroll	2,438	1,964
Other**	2,423	5,214
Total	**49,706**	**47,817**
Of which:		
Related to continuing operations	49,706	47,817
Related to discontinued operations	-	-

**Other expenditure includes subcontractor costs of £1.5m

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	Note	2017/18	2016/17
		£000	£000
Net impairments charged to operating surplus resulting from:			
Changes in market price	15	90	76
Total net impairments charged to operating surplus / deficit		**90**	**76**
Impairments charged to the revaluation reserve	15	729	2,103
Total net impairments		**819**	**2,179**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	28,821	25,869
Social security costs	3,211	2,824
Apprenticeship levy	124	-
Employer's contributions to NHS pensions	3,580	3,089
Pension cost - other*	5	-
Termination benefits	225	336
Temporary staff (including agency)	574	732
Total gross staff costs	**36,540**	**32,850**
Recoveries in respect of seconded staff	-	-
Total staff costs	**36,540**	**32,850**

*Pension cost - other relate to NEST contributions.

Note 7.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£24k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

The Trust paid NHS pension agency £3,580k (£3,086k in 2016/17) and the National Employment Savings Scheme (NEST) £5k in 2017/18 (£3k in 20016/17)

Note 9 Operating leases

The Trust has no operating lease commitments.

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	9	10
Total	**9**	**10**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Unwinding of discount on provisions	2	1
Total finance costs	**2**	**1**

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Losses on disposal of assets	-	(62)
Total losses on disposal of assets	-	(62)
Total other losses	**-**	**(62)**

Note 13 Discontinued operations

The Trust has no discontinued activities in current year or prior year.

Note 14.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	484	95	579
Additions	-	55	55
Gross cost at 31 March 2018	484	150	634
Amortisation at 1 April 2017 - brought forward	381	7	388
Provided during the year	36	26	62
Amortisation at 31 March 2018	417	33	450
Net book value at 31 March 2018	67	117	184
Net book value at 31 March 2017	103	88	191

Note 14.2 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	453	-	453
Valuation / gross cost at 1 April 2016 - restated	453	-	453
Additions	31	95	126
Valuation / gross cost at 31 March 2017	484	95	579
Amortisation at 1 April 2016 - as previously stated	343	-	343
Amortisation at 1 April 2016 - restated	343	-	343
Provided during the year	38	7	45
Amortisation at 31 March 2017	381	7	388
Net book value at 31 March 2017	103	88	191
Net book value at 31 March 2016	110	-	110

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	8,801	8,807	769	214	3,102	157	21,850
Additions	-	51	731	-	2,003	-	2,785
Impairments	-	(819)	-	-	-	-	(819)
Revaluations	399	-	-	-	-	-	399
Valuation/gross cost at 31 March 2018	9,200	8,039	1,500	214	5,105	157	24,215
Accumulated depreciation at 1 April 2017 - brought forward	-	0	-	211	1,811	119	2,141
Provided during the year	-	330	-	2	548	15	895
Revaluations	-	(330)	-	-	-	-	(330)
Accumulated depreciation at 31 March 2018	-	0	-	213	2,359	134	2,706
Net book value at 31 March 2018	9,200	8,039	1,500	1	2,746	23	21,509
Net book value at 31 March 2017	8,801	8,807	769	3	1,291	38	19,709

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	8,801	10,703	112	214	2,599	157	22,586
Additions	-	345	657	-	503	-	1,505
Impairments	-	(2,179)	-	-	-	-	(2,179)
Disposals / derecognition	-	(62)	-	-	-	-	(62)

Valuation/gross cost at 31 March 2017	8,801	8,807	769	214	3,102	157	21,850
Accumulated depreciation at 1 April 2016 - as previously stated	-	0	-	209	1,539	104	1,852
Provided during the year	-	414	-	2	272	15	703
Revaluations	-	(414)	-	-	-	-	(414)
Accumulated depreciation at 31 March 2017	-	0	-	211	1,811	119	2,141
Net book value at 31 March 2017	8,801	8,807	769	3	1,291	38	19,709
Net book value at 31 March 2016	8,801	10,703	112	5	1,060	53	20,734

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	9,200	8,039	1,500	1	2,746	23	21,509
NBV total at 31 March 2018	9,200	8,039	1,500	1	2,746	23	21,509

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017							
Owned - purchased	8,801	8,807	769	3	1,291	38	19,709
NBV total at 31 March 2017	8,801	8,807	769	3	1,291	38	19,709

Note 16 Donations of property, plant and equipment

The trust had no donations in current year or prior year.

Note 17 Revaluations of property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Asset valuations were undertaken in this financial year with the prospective valuation date of 31 March 2018. The revaluation undertaken at this date was accounted for on 31 March 2018. In 2017/18 a 'desktop valuation' was performed outside of this cycle of 5 year full valuations.

The impairment of fixed assets as a result of the valuation was £729k charged to the revaluation reserve and £90k charged to operating expenses.

PPE land was revalued up by £399k.

Note 18 Investment Property

The Trust has no Investment property.

Note 19 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	4,945	5,668
Accrued income	1,345	1,419
Provision for impaired receivables	(309)	(306)
Prepayments (non-PFI)	404	679
PDC dividend receivable	5	9
VAT receivable	-	117
*Other receivables	2,475	128
Total current trade and other receivables	**8,865**	**7,714**
Of which receivables from NHS and DHSC group bodies:		
Current	5,402	3,599
Non-current	-	-

*Other receivables includes STF funding of £2,183

Note 19.1 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April	**306**	**322**
Increase in provision	3	2
Amounts utilised	-	(18)
At 31 March	**309**	**306**

The Trust provides for debts more than a year old. In addition to debts more than a year a risk review is carried out to ensure its exposure is adequately mitigated.

Note 19.2 Credit quality of financial assets

	31 March 2018	31 March 2017	
	Trade and other receivables	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000
0 - 30 days	-	-	-
30-60 Days	-	-	-
60-90 days	-	-	-
90- 180 days	-	18	-
Over 180 days	309	288	-
Total	**309**	**306**	**-**
Ageing of non-impaired financial assets past their due date			
0 - 30 days	1,042	1,938	-
30-60 Days	242	341	-
60-90 days	866	89	-
90- 180 days	276	1,030	-
Over 180 days	301	232	-
Total	**2,727**	**3,630**	**-**

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations as disclosed in note 3 to note 4. Bad debt provisions are calculated based on the Trust's bad debt provision policy which considers the type of debtor, age of the outstanding debt and knowledge of specific balances. This addresses the risk for non-impaired debts not past their due date.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**2,152**	**3,355**
Net change in year	1,671	(1,203)
At 31 March	**3,823**	**2,152**
Broken down into:		
Cash at commercial banks and in hand	675	111
Cash with the Government Banking Service	3,148	2,041
Total cash and cash equivalents as in SoFP	**3,823**	**2,152**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,823**	**2,152**

Note 20.1 Third party assets held by the trust

Tavistock and Portman NHS Foundation Trust held no cash and cash equivalents in the current year or prior year which relate to monies held by the the Foundation Trust on behalf of patients or other parties.

Note 21 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	1,413	791
Capital payables	-	317
Accruals	3,099	3,289
Social security costs	740	782
VAT payables	44	-
Accrued interest on loans	2	-
Other payables	575	480
Total current trade and other payables	**5,873**	**5,659**
Of which payables from NHS and DHSC group bodies:		
Current	390	734

Note 22 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	3,618	3,010
Total other current liabilities	**3,618**	**3,010**

Note 23 Borrowings

	31 March 2018 £000	31 March 2017 £000
Non-current		
Loans from the Department of Health and Social Care	1,000	-
Total non-current borrowings	**1,000**	**-**

An ITFF bridging loan of £4m was issued to fund a project to relocate the Trust. The remainder of the loan will be drawndown in three instalments in 2018/19 (Q2/Q3/Q4)

The Loan shall be repaid from 18 August 2019 bi-annually at a percentage rate of 5.56% of the outstanding value till its completion on 18 February 2028.

Interest payable on the loan shall be paid at the National Loan Fund EIP rate of 0.20%

Note 24 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Total
	£000	£000	£000	£000
At 1 April 2017	**89**	**72**	**175**	**336**
Change in the discount rate	-	-	-	**-**
Arising during the year	5	-	138	**143**
Utilised during the year	(7)	-	(142)	**(149)**
Reversed unused	(3)	-	-	**(3)**
Unwinding of discount	2	-	-	**2**
At 31 March 2018	**86**	**72**	**171**	**329**
Expected timing of cash flows:				
- not later than one year;	7	-	171	**178**
- later than one year and not later than five years;	26	72	-	**98**
- later than five years.	53	-	-	**53**
Total	**86**	**72**	**171**	**329**

Note 24 Clinical negligence liabilities

At 31 March 2018, £8k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tavistock and Portman NHS Foundation Trust (31 March 2017: £8k).

Note 25 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	10	3
Gross value of contingent liabilities	**10**	**3**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**10**	**3**

At 31 March 2018, there is one possible case of employer's liability litigation outstanding against the Trust.

It is possible that clinical litigation claims could arise in the future due to incidents that have already occurred.

There is no reliable statistical analysis available to estimate the potential liability for individual trusts in relation to incidents been reported which have occurred but have not yet been reported.

A national estimate for such potential liabilities in all NHS bodies, calculated on an actuarial basis, is included in the accounts of the NHS Litigation Authority.

Note 26 Financial instruments

Note 26.1 Financial risk management

The Trust has no related financial risks associated within its financial instruments.

Financial risk

Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest rate risk
The majority of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest. Tavistock and Portman NHS Foundation Trust is not therefore exposed to significant interest-rate risk.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit risk
The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations as disclosed in note 3 to note 4. Bad debt provisions are calculated based on the Trust's bad debt provision policy which considers the type of debtor, age of the outstanding debt and knowledge of specific balances.

The Trust follows procedures for receivables management, so as to ensure that payments are received promptly and risk is managed. A provision for impairment (see Note 19.1) is made, and is reviewed regularly.

Liquidity risk
The Trust's net operating costs are incurred under annual service level agreements with local Clinical Commissioning Groups which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from retained surpluses and funds made available from Government under agreed borrowing limits. Tavistock and Portman NHS Foundation Trust is not therefore exposed to significant liquidity risk.

Cash is held as far as possible with the Government Banking Service (see Note 20) at all times.

The Trust also has in place a £1m working capital revolving loan facility for additional assurance. This is an NHS facility provided by the Department of Health that the Trust can draw down upon if required.

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost.

There are no other financial instruments held, other than the ones already disclosed in notes 26.2 and 26.3.

Note 26.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	1,000	**1,000**
Trade and other payables excluding non-financial liabilities	5,087	**5,087**
Total at 31 March 2018	**6,087**	**6,087**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Trade and other payables excluding non-financial liabilities	4,877	**4,877**
Total at 31 March 2017	**4,877**	**4,877**

Note 26.4 Fair values of financial assets and liabilities

Note 26.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	5,087	4,877
In more than five years	1,000	-
Total	**6,087**	**4,877**

Dr Robert Senior (Medical Director) has ongoing involvement with the University College London Hospitals NHS Foundation Trust. The Trust paid University College London Hospitals NHS Foundation Trust £9k (2016/17 £258k) and University College London Hospitals NHS Foundation Trust paid the Trust £13k (2016/17 £39k) for various education and research activities.

Dr Robert Senior has a research collaboration with the Anna Freud Centre. The Trust paid the Anna Freud Centre £167k (£336k in 2016/17) for various education and research activities. Anna Freud Centre paid the Trust £58k (£125k in 2016/17).

None of the above costs relates to remuneration for the individuals concerned.

The Department of Health is regarded as a related party. During the year the Tavistock and Portman NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department (controlling party). The significant entities are listed below:

2017/18

	Total income for the year ended 31 March 2018	Total charge for the year ended 31 March 2018	Debtor/ (creditor) as at 31 March 2018
	£000	£000	£000
Public Health England	2,678	-	-
Health Education England	11,580	-	515
NHS England	13,812	-	2,055
Camden CCG	7,404	-	250
City & Hackney CCG	1,169	-	25
Haringey CCG	1,056	-	274

	Total income for the year ended 31 March 2018	Total charge for the year ended 31 March 2018	Debtor/ (creditor) as at 31 March 2018

	£000	£000	£000
HM Revenue and Customs for Pay As You Earn income tax and National Insurance (included in staff costs)	-	3,211	(741)
NHS Pension Agency	-	3,580	(548)

2016/17

	Total income for the year ended 31 March 2017	Total charge for the year ended 31 March 2017	Debtor/ (creditor) as at 31 March 2017
	£000	£000	£000
Public Health England	2,828	-	0
Health Education England	12,046	-	112
NHS England	7,906	4	729
Camden CCG	7,443	-	373
City & Hackney CCG	4,388	-	1,396
Homerton University Hospital NHS Foundation Trust	28	1,272	(353)

	Total income for the year ended 31 March 2017	Total charge for the year ended 31 March 2017	Debtor/ (creditor) as at 31 March 2017
	£000	£000	£000
HM Revenue and Customs for Pay As You Earn income tax and National Insurance (included in staff costs)	-	2,824	(782)
NHS Pension Agency	-	3,089	(473)

The Trust is reimbursed by the Tavistock and Portman Charitable Fund and by the Tavistock Clinic Foundation for staff and other expenses borne on their account. For the Tavistock and Portman Charitable Fund the amount owed to the Trust is £1k and for the Tavistock Clinic Foundation the amount owed to the Trust is £0k.

During 2017/18, the Trust has an agreement with National Shared Business Services to provide certain accounting processes. The Trust paid £102,427 (2016/17 £93,027) for these services.

Note 28 Events after the reporting date

The Directors are not aware of any events that have arisen since the end of the year and to the date of this report which have affected or may significantly affect the operations and finances of the Trust.

Staff costs

	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	28,682	139	**28,821**	25,869
Social security costs	3,211	-	**3,211**	2,824
Apprenticeship levy	124	-	**124**	-
Employer's contributions to NHS pensions	3,580	-	**3,580**	3,089
Pension cost - other	5	-	**5**	-
Termination benefits	225	-	**225**	336
Temporary staff		574	**574**	732
Total gross staff costs	**35,827**	**713**	**36,540**	**32,850**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**35,827**	**713**	**36,540**	**32,850**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

Average number of employees (WTE basis)

	Permanent	Other	2017/18 Total	2016/17 Total
	Number	Number	Number	Number
Medical and dental	43	-	**43**	41
Administration and estates	235	-	**235**	216
Nursing, midwifery and health visiting staff	25	-	**25**	24
Scientific, therapeutic and technical staff	254	-	**254**	223
Social care staff	26	-	**26**	27
Other	-	61	**61**	50
Total average numbers	**583**	**61**	**644**	**581**
Of which:				
Number of employees (WTE) engaged on capital projects	-	5	**5**	2

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	4	-	**4**
£10,001 - £25,000	4	-	**4**
£25,001 - 50,000	2	-	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**

Total number of exit packages by type	**11**	**-**	**11**
Total resource cost (£)	£225,000	£0	**£225,000**

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,001 - £25,000	1	-	**1**
£25,001 - 50,000	3	-	**3**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**7**	**-**	**7**
Total resource cost (£)	£336,000	£0	**£336,000**

The Tavistock and Portman NHS Foundation Trust

Quality Accounts for the year ended 31 March 2017

NHS
The Tavistock and Portman
NHS Foundation Trust

Quality Accounts

Quality Report for The Tavistock and Portman NHS Foundation Trust 2017/18

Innovation in mind

Return rate - The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

Safeguarding of Children Level 3 - The Trust has made it mandatory for all clinical staff working in child and adolescent services and other clinical services working predominantly with children, young people and parents to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modelled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

Specific Treatment Modalities Leaflets - These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

TEL – Technology Enhanced Learning Team

Time 1 - Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.

Time 2 - Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.

Our goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post-assessment/treatment changes, and provide the necessary information for us to determine our clinical effectiveness.

Trust-wide Induction – This is a Trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear that they are required to attend this induction as part of their employment by the Trust.

Trust Membership - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

Waiting Times - The Trust has a policy that patients should not wait longer than 11 weeks for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient.

However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health Trust which provides psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental well-being. It has a national and international reputation based on excellence in service delivery, clinical innovation, and high-quality clinical training and workforce development.

The Trust provides specialist out-patient services, both on site and in many different community settings, offering assessment and treatment, and a full range of psychological therapies for patients of all ages. It also has a national remit for providing gender specific services for children and adults. In addition, in Camden it provides an integrated mental health and social care service for children and families. The Trust does not provide in-patient treatment, but has a specific expertise in providing assessment and therapy for complex cases including forensic cases. It offers expert court reporting services for individual and family cases.

It has a national role in providing mental health education and training, where its training programmes are closely integrated with clinical work and taught by experienced clinicians. One of the Trust strategic objectives has been to grow and develop our training and education services across the country, through local delivery and/or TEL blended learning and to produce plans for transnational developments. The Trust is working to increase the diversity of staff and trainees to better reflect and respond to the multi-cultural representation of the communities where the Trust provides services.

A key to the effectiveness and high quality of its training programmes are its educational and research links with its university partners, the University of Essex and the University of East London. Many of the Trust's programmes are also accredited by Professional Regulatory Bodies, including the Association of Child Psychotherapists (ACP), the Association for Family Therapy and Systemic Practice (AFT), the British Psychoanalytic Council (BPC), and the British Psychological Society.

Core Purpose

The Trust is committed to improving mental health and emotional well-being. We believe that high-quality mental health services should be available to all who need them. Our contribution is distinctive in the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the prevention and treatment of mental ill health.

We make this contribution through:

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily.
- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and improving public understanding of mental health.
- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation.
- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies.

Part 1: Statement on Quality from the Chief Executive

The annual quality report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders. The Board of Directors is ultimately responsible for ensuring that we continue to raise the bar on all our quality initiatives.

Our patients tell us that knowing that they will receive good treatment is the most important quality priority. This report sets out the ways in which we strive to provide that assurance to our patients, carers, commissioners and other stakeholders.

In February 2017 we were pleased to receive an overall Good rating for our clinical services following a scheduled inspection by the Care Quality Commission (CQC) in January 2016 and follow up inspection in November 2016. We look forward to welcoming the CQC in 2018 for a further scheduled inspection.

We were pleased to welcome the Charing Cross adult gender service (GIC) to our Trust in April 2017, taking on the interim stewardship. Prior to the service transferring to our Trust they underwent a CQC inspection and the resulting action plan has been monitored monthly by the CQC. We are pleased with the progress made and most actions are now completed.

The Trust also welcomed the Quality Assurance Agency for Higher Education (QAA) to review our education and training services in April 2016, followed up with a single review visit day in May 2017. We were highly satisfied to meet national standards in all areas reviewed. In addition the QAA identified four areas of good practice and made recommendations for further development in a further four which have now been addressed.

Staff across our Trust are fully committed to improving the quality of our services and this is supported by our Clinical Quality Strategy, approved by the Board in January 2017. The strategy draws on the commitment and creativity of our staff and the growing collaborative work with our patients, carers and their families and other stakeholders. As part of the strategy, and with Health Education funding, we appointed three part time Quality Improvement Leads to work with identified teams on specific projects. These are staff already working in the Trust with an understanding of many of the issues being raised.

We have also invested in training in specific quality improvement skills and techniques delivered by HAELO, an external provider with skills in this field. Over the winter 50 staff attended introductory training and our first cohort of 15 staff completed a three day intermediate course with more to be arranged for 2018/19. A smaller number of Trust staff are also undertaking more detailed external quality improvement training.

Some of the areas we have been focusing on include:

- The experience that our patients and students have when they visit us;
- The effectiveness of the wide variety of treatments our patients receive from us;
- The way we collect, protect and store information about our patients, and report and use information about the outcome of patients' treatment;
- The value we place on all our staff and their wellbeing, fostering leadership, innovation and personal accountability to deliver the best possible services;
- The way we communicate with all those who use or are interested in our services, to keep them informed and to take their views into account.

First and foremost we are pleased that most of our patients continue to rate the help they receive at the Trust as 'good', that they are treated well and listened to. We work closely with our patients including involving many on interview panels and listening to their stories at our Board of Directors' meetings. To continue to improve our services it is vital that we understand, in detail, how well we are providing services, and where we can improve. Over the last year the Trust has continued to provide teams and the Trust Board with detailed information about performance, and this work continues.

Whilst our patients continue to rate services 'good' we know that we still have work to do, particularly around improving waiting times in some of our services. We have in particular seen a continued increase in referrals to our very successful Gender Identity Development Service (GIDS) and our new Gender Identity Clinic (GIC) service for adults which joined the Trust in April 2017. This has led to waiting times remaining longer than we would wish. Internal administration processes have been reviewed and streamlined, and actions are being taken to provide information and support for those on the waiting lists. We continue to work closely with those who commission these services and will continue to explore ways in which we can bring about further improvements. We are also working on reducing the number of appointments patients do not attend, so that these can be utilised by those on the waiting list and have begun to introduce an appointment reminder system. Our team by team waiting times report continues to keep the Board and clinical teams alert to performance issues.

Our quality priorities over the past year have sought to embed the meaningful use of patient outcome measures in our services. We use these to give us information on how effective the treatments are that we offer. We recognise the link between physical and mental health, and have continued to invest in developing physical health services across the organisation, and with external organisations. We have prioritised the identification and management of high risk patients, continuing to develop the skills clinicians require to comprehensively assess patient risks, developing the Learning from Deaths policy and introducing Learning Events to learn lessons from serious incidents. Finally, we have sought to improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families.

We continue to have relatively small numbers of incidents including those which are serious, but are committed to learning lessons where possible. The Board receives reports in its public meetings on all serious incidents involving death. In addition we have a good record on safeguarding with strong leadership from the Medical Director. Our staff continue to recommend the trust as a place to work or receive treatment and we welcome a reduction in bullying and harassment issues. However, we know that there are areas we need to continue to work on. Our staff are committed to providing excellent quality of care and the national staff survey showed us that a significant number were dissatisfied with the quality of care they could provide.

We still have some work to do to address long hours of working and staff experience around fairness in promotion and development remains a concern particularly when we look at the divergent experience between White and Black, Asian and Minority Ethnic staff. Work to address this will continue to be a priority and reviewed by the Board.

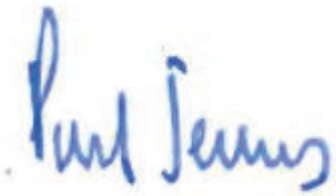
Over the last year the work of our Freedom to Speak up Guardian has continued to be well received in the Trust. The role is much appreciated and supports a culture of openness through providing an additional avenue for staff to raise concerns.

You will find more details in the next section and throughout the report about our progress towards our priority areas as well as information relating to our wider quality programme. Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible. However, if there are any aspects on which you would like more information and explanation, please contact

Marion Shipman (Associate Director Quality and Governance) at mshipman@tavi-port.nhs.uk, who will be delighted to help you.

There are a number of inherent limitations in the preparation of this Quality Report which may impact on the reliability or accuracy of the data reported. We have taken a number of actions to address data issues through the year which can be seen in section 2.2 of this report and have a major data quality project in progress which will be implemented through 2018/19.

I confirm that I have read this Quality Report which has been prepared on my behalf. I have ensured that, whenever possible, the report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge, within the data constraints outlined, the information contained in this report is accurate.



Paul Jenkins

Chief Executive

1.1 Trust Achievements

We are proud to report that, in addition to our Quality Priorities, during the year 2017/18 we achieved the following:

Our Technology Enhanced Learning (TEL) team were highly commended in the 2017 Learning Technologist of the Team Awards, competing against large TEL teams from major universities from the UK and abroad. The excellent work of our Camden adolescent intensive support service (CAISS), who support at risk young people, was also recognised with a nomination for the Nursing Times Awards 'team of the year' category. And our ground breaking Mentalisation Based Therapy project, which treats violent offenders with antisocial personality disorder, was shortlisted for the prestigious 2017 Health Service Journal awards, in the innovation in mental health category.

Our education and training offer continues to be a vital part of life at the Tavistock and Portman, and this year we saw a record number of first year students join the Trust. We thank all our tutors and visiting lecturers for their diligence and dedication to their students. This year we also established the National Workforce Skills Development Unit, a specialist team to look at provision of national training to support Health Education England to address the workforce requirements of the Five Year Forward View for Mental Health.

We welcomed the Charing Cross adult gender service to the Trust this year, taking on the interim stewardship of this service. Gender identity was the theme of our Annual General Meeting, with the highlight being a panel discussion involving staff and services users from the GIC and our Gender Identity Development Service for young people.

The Trust continues to enjoy a high national media profile contributing to the public discourse to help shape the future of mental health provision, and we're proud of the influence and reach of our Trust. Building on this. We have now agreed an External Affairs Strategy which we hope will add focus to this work going forward.

Our innovative Family Drug and Alcohol Courts continue to be a success story, helping vulnerable families reunite and supporting cessation of harmful substances, and it was pleasing to see this track record of success acknowledged with funding to expand the service to help more people in 2018, within London and across the UK.

We played host to Members of the Health and the Education Select Committees in March, joining with commissioners and service users to hold a special event at Regent High School. Regent High is one of the ten secondary schools and 43 primary schools where we run Child and Adolescent Mental Health services. It is heartening to see in the recent CAMHS Green Paper that this evidence has influenced plans and that the Government is taking seriously the need to improve access to support for children and young people's mental health. The opening of this consultation presents a vital opportunity for the Trust to draw on our expertise working with children and adolescents in education settings, and ensure the Government takes an evidence based approach to provision of CAMHS that best serves the needs of the community. We will continue to contribute to shaping future services for young people, and seek to improve public policy in line with our mission and values in key areas of Tavistock and Portman expertise.

Also in Camden, our Patient and Public Involvement department worked with Camden Council and the social enterprise Owls this year to set up problem solving booths, a bold community initiative to start discussion about mental health in public spaces. We've also partnered with Fitzrovia Youth in Action and Mind in Camden to support a new peer mentoring service for young people in Camden.

This year also marked the beginning of two important strategies to address change within the Trust. We launched our Race Equality Strategy for 2017-2020 in October this year, aiming to promote equality of opportunity across the organisation. The Strategy was developed through consultation with staff across the Trust and focusses on race equality in our workforce, setting out the actions required to tackle areas of concern in our current performance and promote diversity at all levels of our organisation and across all areas of our work. Also in October the Trust celebrated Black History Month with a series of events and activities for all staff to be involved in which included talks, poetry, food and art. Earlier in the year, we also launched the Organisational Development and People Strategy 2017-2020, which outlines the Trust's commitment to expanding the number of opportunities for growth and development. The publication of these strategies marks just the first step in changing the organisational culture of the Trust, and will act as a route map to guide us through the change.

A strategy was devised to plan and distribute materials to increase student engagement and to raise staff awareness. The response rate improved markedly on 2016/17 and was close to the historic rates generated by the paper based survey handed out in the classrooms.

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Patient and Public Involvement

Patient and Public Involvement (PPI) includes patients, family members, carers and the public in various aspects of work to help develop and improve the services we offer in a meaningful and informed manner. It is about empowering patients and the public to have a say. It is about professionals in the NHS listening and responding to the views of patients and the public.

"I can tell that the people here really do care and really are trying and that makes me believe in them more."
"It was an open space for my worries and concerns to be heard"
"Everyone is really kind"
"I felt that there was someone I could talk too especially at the beginning"
"I feel really listened to and empowered and it's great to feel that way."

'Frame of Mind' – A community photography exhibition

Frame of Mind brings together pictures from the community photography project run within two Tavistock adult services, **Team Around the Practice, Camden (TAP) and Primary Care Psychotherapy Consultation Service, City and Hackney (PCPCS).**

The 12-week project is for patients to engage in creating work that expresses feelings and gives an opportunity to reflect. Group members are lent cameras and each week a theme is chosen as a guide for members to then take photos in their own time and bring them back to the group to share and discuss.

The project is a celebration of how photography makes it possible to create images, harness the process of creativity and share the interest of promoting personal wellbeing. This exhibition is on display at Dalston CLR Library and spans the three floors.

It brings together a selection of photographs from the groups, some reflections from members about their pictures and the process of taking them. Photos from the exhibition are available to purchase by the public and the money is split between patients choice of charities.

New Peer Mentoring service for Young People in Camden

Fitzrovia Youth in Action (FYA), Mind in Camden and the Tavistock and Portman NHS Trust have formed a partnership to co-produce peer mentoring initiatives with a range of schools and youth clubs in Camden.

The programme will train young people as mentors to offer time-limited peer mentoring relationships to children and young people who are at least two years younger. Method, a design consultancy, will be working pro bono on the project to ensure that young people's voices are incorporated at all stages and influence the design and delivery.

Recipes of Life

In collaboration with the Made Up Collective organisation, a 'Recipes of Life' workshop was run this year at the Tavistock Centre Café. The 'Recipes of Life' workshop brought together unaccompanied young people from differing cultures for an evening of cooking cultural dishes and of sharing recipes, traditions and stories.

The young people brought recipes that meant something special to them to share their memories of their homeland.

As we cooked, ate and talked, we heard stories about how food was eaten and learned to cook different cultural dishes. The young people were able to perform and share their culture which was witnessed by other members of the group and in doing so were able to honour each other's cultures. A young male, aged 15 from Afghanistan said, "Today I have felt proud to be from Afghanistan and of my culture".

We heard stories about wisdom and love shared though cooking and acts of kindness. Conversations about holding onto and creating lasting bonds to their family members and countries of origin emerged. The young people spoke about the significance of cooking food that their families would have cooked and through cooking they felt they were able to hold onto significant people in their lives and what they have taught them. A young female, aged 17 from Ethiopia said, "It is the first time since arriving in this country that I have sat down to eat with so many people". She said that it was those around her that enabled her to maintain hope.

1.2 Overview of Quality Indicators 2017/18

The following table includes a summary of some of the Trust's quality priority achievements from the last year with the RAG status, along with the page number where the quality indicator and achievement are explained in greater detail. KEY= ↑ Improvement; ↔ Remained same; ↓ Worsened.

Target 17/18	RAG	Comparison to (16/17)	Annual Achievement 17/18	Page No
Child and Adolescent Mental Health Service Outcome Monitoring Programme				
For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2)		↑	Not achieved	40
For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals)		↓	Not achieved	40
Adult Outcome Monitoring Programme				
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients		↑	Achieved	41
Improve the physical health of patients receiving treatment				
Further develop and deliver the 'Living Well' programme across Young Adult and Adult services		n/a	Achieved	37
Develop the physical health champions role across the Trust to support this priority		n/a	Part achieved	
Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver Very Brief Advice on smoking and alcohol		n/a	Achieved	
Increase individual support for patients around physical health issues including smoking cessation and alcohol use		n/a	Achieved	
Improve the identification and management of high risk patients				
To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with the aim of achieving 80% attendance at the end of a 3 year training cycle		n/a	Part achieved	38
Update and disseminate relevant policies and procedures		n/a	Achieved	
Regular re-audit (twice yearly) with an increase in completion of risk assessment and risk management forms on Electronic Patient Record		n/a	Part achieved	
Use of relevant sections of Safer Services: A Toolkit for Specialist Mental Health and Primary Care. 10 Key Elements to Improve Safety		n/a	Achieved	

Embed meaningful use of outcome measures in services				
To liaise with the Patient and Public Involvement (PPI) team to gather information regarding patients' experiences of outcome measures. Findings will be utilised as part of an overall review of the appropriateness of currently used measures and how they are administered		n/a	Part achieved	39
For outcome measures to be entered on to the patient information system within 1 week of completion and receipt by the Quality Team		n/a	Achieved	
Improve access to patient and team level data, to include a dashboard to provide 'real-time' data which is reviewed by clinicians and teams to improve services		n/a	Part achieved	
Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families				
Establish reference group(s) from staff, patients, and other stakeholders to develop and oversee the priority work plan		n/a	Achieved	39
Embed use of revised equalities monitoring data collection forms which cover all relevant protected characteristics undertaking a baseline review of form completion and agreeing a measurable increase in compliance		n/a	Part achieved	
Source and provide benchmarking data where possible to identify where there may be gaps in provision		n/a	Achieved	
Analyse quality metrics according to demographic profile and protected characteristics, mapping information to current service provision and agreeing an appropriate action plan		n/a	Part achieved	
Patient Safety Indicators				
Patient Safety Incidents		↑	82 Incidents	42
Child and Adult Safeguarding Alerts		Children ↓ Adult ↔	Achieved	44
Maintaining a High Quality, Effective Workforce				
Attendance at Trust Wide Induction Days		↑	90%	45
Completion of Local Induction		↓	94%	45
Attendance at Mandatory INSET Training		↓	98%	46
Safeguarding of Children & Adult – Level 1 Training Safeguarding of Adult – Level 2 Training Safeguarding of Children – Level 2 Training Safeguarding of Children – Level 3 Training		↔	Part achieved	46

Maintaining a High Quality, Effective Workforce				
Monitor number of staff with PDPs		↓	99%	47
Patient Experience Indicators				
Formal complaints received (number)		↓	154	50
Percentage of patients that rated the overall help they had received as 'good': Quarter 1 Quarter 2 Quarter 3 Quarter 4		↑	Year Average: 99% Q1: 99% Q2: 99% Q3: 100% Q4: 100%	51
Maintaining a High Quality, Effective Workforce				
Number of Patients that would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment		↑	Average: 98%	52
Did Not Attend (DNA) Rates*				
Trust Wide – First Attendances		↓	Not achieved	54
Trust Wide – Subsequent Appointments		↓	Not achieved	

*DNA definition: Appointments where the patient Did Not Attend without informing us prior to their appointment. Note, full definitions can be found in section 3.1, Did Not Attend Data.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1 Our quality priorities for 2018/19

The priorities for 2018/19 which are set out in this report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: clinical effectiveness, patient experience and patient safety. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

Clinical Effectiveness

Priority 1: Provide effective sleep management information and support to patients and carers of those with sleep disorders

Priority 2: Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service

Clinical Effectiveness and Patient Experience

Priority 3: Improve patient and carer involvement in care planning in children, young adult and family services

Priority 4: Embed meaningful use of outcome measures in services

Patient Safety

Priority 5: Improve identification and management of high risk patients

How we chose our priorities

In looking forward and setting our quality priority goals for 2018/19 we were keen to include issues which would make a real difference to the quality of care our patients receive. We undertook a wide consultation with a range of stakeholders, both internal and external, including Camden CCG (Clinical Commissioning Group, see Glossary). We have chosen those priorities which reflect the main messages from these consultations including focusing on the meaningful use of outcome measures that we use, continuing our focus on the physical health of our patients, particularly on sleep issues and looking further at how we identify and best manage patients at high risk of harm. These build on earlier quality priorities. In addition will be looking at improving waiting time access to treatment in one of our adult services and improving patient and carer involvement in care planning in our children's services.

Our Quality Stakeholders Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, Governor and non-executive director representatives along with members of the Patient and Public Involvement team, Associate Director

Quality and Governance and is chaired by the Director of Quality and Patient Experience. The Governors Clinical Quality Group has also played a key role in helping us to think about some of our quality priorities for next year.

Quality Priorities 2018/19 Overview

Clinical Effectiveness

Priority 1: Provide effective sleep management information and support to patients and carers of those with sleep disorders

Physical Health in the form of the 'Living Well' programme was a quality priority in 2017/18, and also one of our Commissioning for Quality and Innovation (CQUIN) targets. Whilst the 'Living Well' programme continues as a CQUIN for 2018/19 covering a number of public health issues including smoking, alcohol, drugs, healthy eating, and exercise and stress management, we are keen to integrate physical health initiatives within our clinical service lines. We will, in addition, be developing further the provision of individual support for staff and around smoking cessation and alcohol use. This priority continues to be one of the Trust's Sign up to Safety goals. In the 2017/18, we increased provision of individual support for smoking and alcohol. We will now focus our efforts in maintaining this service as well as providing weight management, substance misuse, stress, mindfulness and behavioural sleep management interventions.

Provide effective sleep management information and support to patients and carers of those with sleep disorders
Targets for 2018/19 This is a new priority
1. Develop information guides on sleep hygiene with patient, carer and patient representative input
2. Provide sleep hygiene information to Trust practitioners and patients / carers
3. Work with parents and carers of children under the age of 13 years with sleep issues to support them in improving sleep

Measure Overview

Patients, carers and staff will be involved in further developing the 'Living Well' programme to be delivered during the year. Staff information will be provided to increase knowledge of the 'Living Well' programme and to deliver Very Brief Advice to patients on alcohol and smoking. An updated physical health form will be implemented to include questions on diet, exercise, and sleep.

Information guides on sleep hygiene will be developed using NICE recommended evidence based practice and published on the Trust's intranet for clinicians to download for patients, and on the Trust's internet site for general public. Two information guides will be written – one for those aged 13-17 and one for those aged 18+. These information guides will be disseminated to our patient feedback groups for feedback. Additional work will be conducted with parents and carers of children under the age of 13 who are experiencing issues with sleep. Clinicians across the Trust will be asked to identify patients who may benefit from some additional support around their sleep and parents/caregivers of these patients will be invited to take part in a group session on improving sleep for their child.

How we will collect the data for this target

We plan to use a number of different measures to evidence compliance with the targets.

Including the development and dissemination of patient and staff sleep hygiene information. Parents/caregivers invited to take part in a group session on improving sleep for their child will be asked to provide evaluation of the session on completion and then 6-weeks on from the intervention.

Further development of the 'Living Well' programme will be evaluated by attendees; data will be collected on numbers recruited and feedback obtained from participants. Individual and self-referrals to the Physical Health Specialist Practitioner will be monitored and evaluated at the end of the year.

Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality Patient Experience workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Physical Healthcare Specialist Practitioner for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved.

Priority 2: Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service

Our adult complex needs teams provide a range of psychotherapies for those who need a specialised service. Current waiting times from assessment to treatment within this service are approximately 12 months. There is a recognition that long delays between assessment and treatment may negatively impact on the mental health of patients, and result in patient dropout. As a result of the long waits, the Trust has decided to undertake some focused work as a Quality Priority in 2018/19. Some group and individual support is currently provided until treatment starts. There is evidence that brief interventions can be effective. Quarter 1 will be used to develop the new model of care, provide a baseline benchmark and confirm the target percentage reduction.

Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service
Targets for 2018/19 This is a new priority
1. Develop and pilot a new model of care
2. Reduce the number and % of patients waiting more than 9 months for treatment
3. Obtain feedback from service users about the new model

Measure Overview

We will develop and pilot an appropriate new model of care to begin to address these issues. This would be offered to patients who are assessed as likely to benefit from a brief intervention. A report will be built in order to assess the waiting time between final assessment appointment and first treatment appointment.

How we will collect the data for this target

The Lyndhurst service will deliver the new model of care and run the newly developed report on a monthly basis in order to analyse the waiting times between assessment end and treatment start. Service user and clinician feedback will be obtained. Qualitative data will be collected, validated and presented in monthly team meetings, assisted by the Quality Team.

Monitoring our Progress

A baseline will be taken at the beginning of 2018/19 and reported on a monthly basis in order to monitor the progress and efficiency of the new model of care. Once the new model of care is implemented, feedback from service users will be collected and analysed to make further improvements and recommendations. We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience workstream the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.

Clinical Effectiveness and Patient Experience

Priority 3: Improve patient and carer involvement in care planning in children, young adult and family services.

The Trust recognises the importance of involving patients and carers in treatment being proposed. The co-production of individual care plans are an important tool for this, completed at the assessment stage of care and regularly reviewed during treatment. Within children and young people services (CYP) patients and/or carers are involved in the development of care plans, and care plans are shared with patients and/or carers and referrers (including GPs). This priority aims to improve care plan completion rates, patient and/or carer involvement, the sharing of these to support cross agency working, and to further develop the plans. Quarter 1 will be used to provide a baseline benchmark, confirm the target percentage increase and agree the patients / cohort who require a careplan.

Improve patient and carer involvement in care planning in children, young adult and family services
Targets for 2018/19 This is a new priority
1. **Improve quality of patient and / or carer involvement in the development of care plans.**
2. **Increase the quality of data recorded of care plans shared with patients and referrers**
3. **Increase the percentage of care plans shared with patients and referrers**

Measure Overview

To identify who in the CYP services needs a care plan. The collection rates can then be analysed, validated and reported. It will then be possible to see how many patients and/or carers that require a care plan have it sent to them and the referrer. We are also interested in service user feedback on the development of care plans.

How we will collect the data for this target

Once the cohort has been accurately defined it can reported on a quarterly basis how many CYP have a care plan and the percentage of those shared with patients / carers and referrers. We will obtain patient and carer feedback about the development of care plans and use this to improve the quality of data recorded and undertake an audit to assess the quality of care plan recording.

Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience workstream the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Clinical Governance Leads for Children Young Adult and Families will ensure that action plans are in place when expected levels of assurance are not achieved. Reports will be run, validated and analysed on a quarterly basis to ensure the completion targets for 2018/19 are met.

Priority 4: Embed meaningful use of outcome measures in services

This quality priority has developed this year with a focus on Children's and Young Persons (CYP) outcome measures. The Goal Based Measure (GBM) and the Children's Global Assessment Scale (CGAS) are evidence based tools used in CYP to provide clinicians, patient and/or carers with feedback on the progress of treatment. It is paramount that the clinical services ensure completion rates of the outcome measures are high and also that opinions of patients on the outcome measures used in treatment are received well and are seen as helpful in aiding treatment. These current targets have been jointly defined, agreed and reported with the Camden commissioners.

Completion of Thrive categories on the patient electronic record system were not mandatory until the end of quarter 4 2017/18 but were completed by some staff. On the basis of the limited data using completed fields in 2017/18, 66% of children and young people with Thrive categories, 'getting help' and 'getting more help' had a Time 1 goal recorded for the Goal Based measure (GBM) and 55% had a Time 1 CGAS.

Again on the basis of limited data for Thrive categories in 2017/18 and in respect of closed cases or those open longer than 6 months, 67% had a paired Time 2 Goal Based measure and 62% a paired Time 2 CGAS.

Embed meaningful use of outcome measures in services
Target for 2018/19 This is an updated priority
1. 80% of children and young people with Thrive categories, 'getting help' and 'getting more help' have a Time 1 goal recorded for the Goal Based measure (GBM) and CGAS measure.
2. Obtain service user feedback on the use of outcome measures to feedback on progress.
3. 60% of closed cases or cases open longer than 6 months with Thrive categories, 'getting help' and 'getting more help' have a paired Time 2 Goal Based measure and Time 2 CGAS measure.
4. Develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress and opportunities for review.

Measure Overview

This priority has been updated from 2017/18 to focus on GBM, CGAS and the use of outcome measures. The GBM enables us to know what the patient wants to achieve (their goal or aim) and to focus on what is important to them. We are also continuing the use of CGAS, this is a numeric scale to rate the general functioning of CYP. Scores range from 1 to 100, with higher scores indicating better functioning.

Whilst both the outcome tools are based on evidence, we want to find out what patients think about their use, and whether they have found them helpful. For children young adults and families (CYAF) services, Time 1 refers to the initial assessment, where the patient and clinician complete the outcome measures together when they are seen for the first time. The patient then reviews these again with their clinician after three months or, if earlier, at the end of therapy/treatment (Time 2).

How we will collect the data for this target

Both outcome measures should be collected for those individuals with a Thrive category of 'getting help' or 'getting more help' with data to be obtained from the electronic patient record system for targets 1 and 3. Patient surveys and/or focus groups will be used to obtain user feedback and both patients and staff will be involved in the development of methods to more easily share timely outcome feedback.

Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream. The Clinical Governance Leads for Children Young Adult and Families will ensure that action plans are in place when expected levels of assurance are not achieved. Report will be run, validated and analysed on a quarterly basis to ensure the completion targets for 2018/19 are met.

Patient Safety

Priority 5: Improve identification and management of high risk patients

The highest priority of the Trust is the safety of patients seen in our services. For 2018/19 we plan to continue to roll out mandatory refresher training for all clinicians on clinical risk assessment and risk management. Clinicians must attend refresher training once every three years. Self-harm is particularly prevalent in some of the clinical populations that we assess and treat e.g. adolescents. We will be updating a number of relevant policies and procedures during 2018/19 to reflect the key elements of safer care in the context of being a provider of all age out -patient mental health services. A Suicide and Self harm audit undertaken during 2017 showed there was further work to be done in respect of improving the recording of risk assessments and actions taken. This priority continues to be one of the Trust's Sign up to Safety goals. Quarter 1 will be used to review risk assessments and crisis plans in the Adult and Forensic service, and confirm the baseline.

Improve identification and management of high risk patients
Target for 2018/19 This priority continues with elements from last year
1. Implement an electronic version of the Camden Adolescent Intensive Support Service (CAISS) crisis plan on the electronic patient record system (CareNotes)
2. Establish online clinical risk assessment training across the Trust and develop processes to ensure robust recording of training compliance procedures
3. Ensure 80% of crisis plans in Adult and Forensic services (AFS) have been reviewed / updated in the last six months
4. Launch Trust's suicide prevention plan and evidence implementation of the action plan

Measure Overview

This indicator includes a number of targets to improve the care of high risk patients. The CAISS service actively use crisis plans with their patient group. We would like implement this on CareNotes to improve access for clinicians involved in care of these patients and in AFS to improve the review and updating of crisis plans. Clinical risk assessment training is required by all clinicians every three years. We are looking to establish electronic training to supplement face to face training, and develop processes to robustly record training compliance.

How we will collect the data for this target

An electronic form will be created on CareNotes in order to collect crisis plans for CAISS as well as AFS. The Informatics Department will create a report in order to see what percentage of patients need a crisis plan, how many are recorded, and how many exceed the six month review period. Training for clinical risk assessments will be developed and compliance will be recorded on a quarterly basis.

Monitoring our Progress

We will monitor our progress on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Patient Experience Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for patient safety for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved. There will be an audit during Q4 of quality/safety standards.

Innovation in mind

The Tavistock and Portman NHS
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i-Thrive Programme

THRIVE is a new way of thinking about child and adolescent mental health services. It is needs-based, person-centred and ensures everyone involved in providing care works together in a co-ordinated way. The main ambition of THRIVE is to improve the care and treatment provided to children, young people and their families who experience mental health issues.

i-THRIVE is the implementation programme that supports sites to translate the principles of the THRIVE conceptual framework (Wolpert et al., 2016) into models of care that fit with the local context. i-THRIVE has been designed to enable provision of services that move towards delivery of a population health model for child mental health. It strives to ensure continuous quality improvement of services, drawing from evidence-based implementation science to ensure that children, young people and families get the best possible outcomes.

Quotes from clinicians

“Young person thanked me and sounded reassured”
“Young person said that he found it helpful talking on the phone - especially due to initial anxiety re talking face to face. He said that he preferred telephone consultation in the first instance.”

How is the model being implemented?

i-THRIVE is delivered through a partnership between the Anna Freud National Centre for Children and Families, the Tavistock and Portman NHS Foundation Trust, the Dartmouth Institute for Health Policy and Clinical Practice and UCLPartners.

The Team has ten national accelerator sites that form our Community of Practice. The i-THRIVE Team are working with each site to establish the key priorities they wish to focus on and to create a culture of shared learning. Camden is one of the ten accelerator sites. The four key priorities for Camden are ‘Getting Risk Support’, setting up ‘Getting Advice’ appointments, having robust systems of clinical oversight and review for cases in ‘Getting Help’ and ‘Getting More Help’, and embedding shared decision making across all of the needs-based groups.

2.2 Statements of Assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Tavistock and Portman NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

A review of our services

During the reporting period 2017/18 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 176 contracted services, across two Clinical Directorates, covering 76 teams.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to them on the quality of care in these 176 health services.

The income generated by the relevant health services reviewed in 2017/18 represents approximately (£30m) 60% of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2017/18.

Participation in Clinical Audits and National Confidential Inquiries

During 2017/18 there were no relevant national clinical audits nor national confidential enquiries which covered relevant health services that the Tavistock and Portman NHS Foundation Trust provides.

The reports of 12 local clinical audits were reviewed by the provider in 2017/18 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Referral-to-Treatment Pathway Audit: Retrospective audit to review patient pathway in Lifespan Team. Resulted in updating Patient Pathway and definitions of stages of treatment.

Safe & Timely Discharge Audit: Reviewed The Portman in Adult & Forensic Services to identify turn-around time between discharge date and discharge letter as well as letter content. Clinicians reminded of 2 week turn around deadline for discharge letters and of content to include. Carenotes to automatically populate letters for ease.

Care Plan Audit: This Q1 2017/18 audit compared to results from Q1 2016/17 audit. Improvement was shown in co-production (involving patient in treatment decisions) and primary care involvement (sending treatment plan to the GP). Further actions include continued reminders to continue involving patients & GPs.

Consent Audit: This Q1 2017/18 audit compared to results from Q2 2016/17 audit. Improvement was shown in clinicians obtaining and recording consent. However, multiple places to record consent on CareNotes, resulting in a review being undertaken to consolidate and make more consistent and then re-audit next year.

Suicide & Self Harm Audit: This Q1 2017/18 audit compared results from Q4 2015/16. The audit revealed that further improvements are required for the consistency and quality of identifying, recording and monitoring risks of suicide and self-harm. Further work to be done to educate clinicians on the appropriate protocols for medium- to high-risk patients.

Accommodation, Employment & Education Support Audit: This Q1 2017/18 audit served as a baseline service evaluation for how the Adolescent & Young Adult Service identifies patient needs for accommodation, employment and education support and also how any required support is provided. Identified that, while this need is noted by clinicians, it is not the role of the Trust to provide this kind of support but clinicians have role in liaising with other services. No re-audit necessary.

Safeguarding Supervision & NICE Guidance Audit: Audit of Children Young Adult & Family Services recorded use of NICE Guidance on Case Discussion Record Form identified need for improvement. Additionally, format and content of the Case Discussion Record Form to be edited and combined with Safeguarding Supervision to consolidate number of forms/boxes clinicians need to complete.

Clinical Notes & Supervision Audit: This audit compared Q2 vs. Q4 2017/18 data for Adult and Forensic Services to ensure clinical notes were completed after every session and that supervision was taking place. Identified a need to support clinicians in completing all required forms in a timely fashion. Also identified need for larger Supervision Audit across Trust.

Prescribing Audit: Reviewed Q1 & Q2 2017/18, identified need for policy updates which were completed before re-audit.

Prescribing Re-Audit: Reviewed Q3 2017/18, dramatic improvement and ease of audit due to new electronic report. Next steps include physically visiting all remote sites currently prescribing for the Trust.

Record Keeping Audit: This 2017/18 audit compared to 2016/17 showed improvement in requirements as outlined by the 'Health Records Management Procedure'.

Reducing the Burden – Quality Improvement Projects – Quality Portal: Advances made to implement quality improvement methodology across the Trust in 2017/18 with a view to continuing to embed this focus moving forward. New electronic system called the Quality Portal adopted and starting to be used across the Trust.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 63.

The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://tavistockandportman.nhs.uk/about-us/cquin/

The total possible financial value for the 2017/18 CQUIN was £582,594. The Tavistock and Portman NHS Foundation Trust have not received final confirmation from the commissioners of the CQUIN performance figure for 2017/18, however we will not receive the full amount as not all targets have been met. (The Trust received £485,855.61 for the 2016/17 CQUIN out of a total possible amount of £564,347).

Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2017/18.

The Tavistock and Portman NHS Foundation Trust have not participated in any special reviews or investigations by the CQC during 2017/18.

In January 2016 the Trust underwent a routine inspection by the Care Quality Commission (CQC), and a follow-up inspection in November 2016 with a rating of 'Good' across all assessed domains. The full report is available on the CQC website, www.cqc.org.uk. The Trust assessment of domain compliance is below:

Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 90% and was graded Green. This indicates that the Trust Information Governance Assessment Report was met. Whilst meeting his assessment internal reviews during the year identified some key issues with timely data entry by staff and a large data quality project is being implemented across the Trust during 2018/19 to support developments to further improve data quality.

The Tavistock and Portman NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

The Tavistock and Portman NHS Foundation Trust will be taking the following actions to improve data quality:

The Quality Team now has well established communication routes throughout the Trust, meeting with separate services on a weekly, monthly and quarterly basis. This includes the Adult Gender Identity Clinic. This is to review service/team performance in relation to CQUINs, KPIs and any locally-agreed targets and where data quality issues are identified they work with the service to deliver improvements.

Key performance target reports are taken to Adult and Forensic, Children and Young Person and Gender Services clinical governance meetings on a monthly basis.

The Quality Team has continued to work with staff across the Trust to ensure effective processes and procedures are in place to meet our local and nationally agreed targets.

The Trust has a Clinical Data Quality Management Procedure which was updated in February 2017 to include an additional section around validation of data and checks on the completeness and accuracy of data. The Quality Team have also developed several Standard Operating Procedures for data collection, validation and reporting to support the quality of data. An audit takes place for checking the accuracy of service user data as part of the Information Governance Toolkit and a Clinical Data Quality Review Group is established to analyse and critique data from the patient administration system, with clinical governance leads and administration lead, on a monthly basis.

The Clinical Data Quality Review Group continues to meet on a monthly basis involving the Quality Team, Informatics and senior clinical and administration representation to support improvements in the quality of data.

The Clinical Quality Patient Experience workstream meets quarterly, reporting into the Trust Quality Committee (Clinical Quality Safety and Governance Committee). It is responsible for monitoring all quality reports for submission both internally and externally and following up any data quality issues identified.

The Data Analysis and Reporting Committee (DARC) meets biannually to look at clinical data in line with the Trust's overall strategic plans, to enable the Trust to benchmark services both internally and externally. It met twice in 2017/18 in order to provide assurance to the Trust's Quality and Patient Experience Director and Trust Board.

The electronic patient administration system (CareNotes) allows the trust to easily capture the clinical and care data that is required. Mandatory CareNotes and Outcome Monitoring training has been a success and continues. This is essential to ensure good quality data is entered to enable robust reporting both internally and externally.

Monthly checks around missing data continue to be run and disseminated by the Quality Team and Informatics department for services to resolve, in order to ensure a more complete and robust Mental Health Standard Data Set (MHSDS) return. These data items include missing demographic details such as ethnicity and employment status.

- Internal auditors completed two audits relating to the quality of data in 2017-18, a Carenotes Audit and a Data Quality Audit. The first identified issues with the late entry of appointments. Direct feedback is provided to teams and the Health Records Management Procedure has been updated to include timescales for completion of patient records, including the adding of appointments. Information is then shared in the monthly Clinical Data Quality Review Group (CDQRG). This work is ongoing.
- External auditors undertook an audit on waiting times data within the Camden CAMHS service and a number of issues identified which are being addressed. These include:
- Some referrals were not dated on receipt in the Trust, leading to the lack of a robust audit trail for confirming waiting time information. This has been corrected and shared with all teams across the Trust;
- Monthly sample based audits of referrals were established in 2017, undertaken by the Quality Team. This followed an earlier external audit recommendation. The reaudit identified some

amendments were required to the Trust audit methodology and, following updating of the standard operating procedure, will continue;

- Late entry of appointments to the electronic patient record which impacts on the completeness and timeliness dimensions of data quality. The Quality Team will work with individual teams to address poor performance. Regular reporting continues to the Executive Management Team and monthly progress will be monitored in the Clinical Data Quality Review Group (CDQRG);
- Incorrect recording of referral received data in the electronic patient record in 7 cases and 2 cases with incorrect clock stops. Guidance and training were recommended. The Trust sending out validation breaches two weeks before the end of quarter and will follow up to ensure data has been corrected.
- The Data Quality Audit found issues with the timeliness of coding appointments. As a result of the poor compliance we liaised with lead administrators and directorate clinical governance leads and put in place reminders and local auditing processes to ensure the coding of appointments is recorded on a weekly basis. The system of reminders has led to a reduction in un-outcomed appointments. This information is then shared in the monthly Clinical Data Quality Review Group (CDQRG). The services with a high number of un-coded appointments work with the Quality Officer to rectify this to ensure that activity can be recorded accurately.

Learning from Deaths

During 2017/18, 10 of The Tavistock and Portman NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

2 in the first quarter;

7 in the second quarter (6 were reported as deaths due to natural causes/unknown cause);

1 in the third quarter;

0 in the fourth quarter.

By 31 March 2018 in 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

2 in the first quarter;

1 in the second quarter;

1 in the third quarter;

0 in the fourth quarter.

The deaths in the first two quarters were reported to the national serious incident database whilst the death in quarter 3 was led by another organisation as the patient had not been seen by this Trust for six months. In this case we provided information to the coroner. These serious incidents have been investigated using root cause analysis (RCA) methodology including case notes review. None of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. However, as a result of the investigations there have been a number of learning points/practice reminders which have been shared across the Trust. Please see these below.

A quarterly Mortality Review and Learning Lessons meeting is convened by the Medical Director.

Learning points:

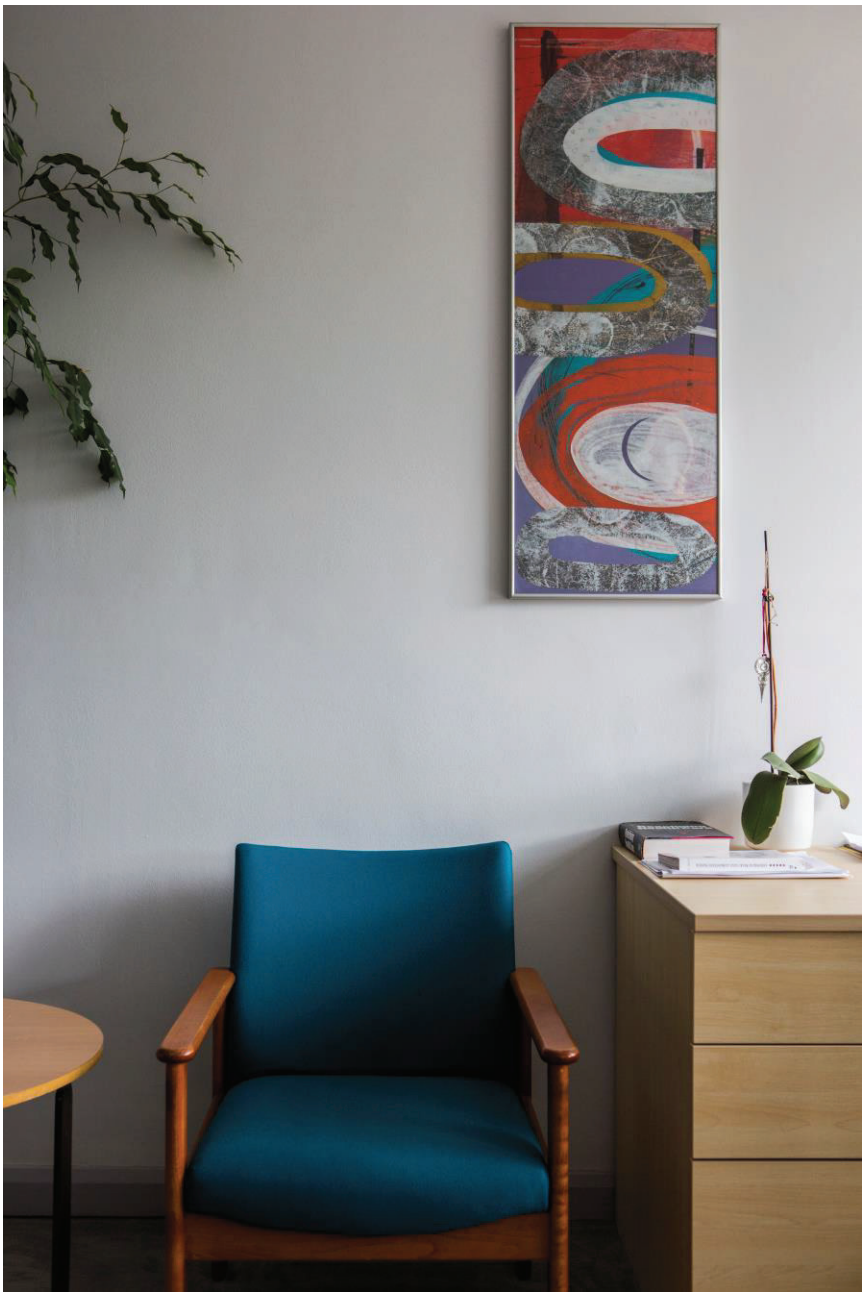
- Documenting risk assessment
- Use of crisis plans
- Documenting MDT discussion of complex casesEnsuring honorary clinicians have a formal link with a clinical team
- Seeing young people on their own at initial assessment
- Documenting supervision with senior staff
- Quarterly Mortality Review and Learning Lessons meetings to share information.
- Lessons learned shared at departmental clinical governance meetings and cascaded to clinical teams
- Clinical audits/reaudits of risk assessment and documentation
- Follow up of action plans in relation to each investigated death

The sharing of lessons learned from patient deaths has acted as a reminder to clinicians of the constant importance of documentation of risk and of having robust processes in place across teams for discussing complex cases and documenting such discussions. Governance processes around honorary clinicians have also been reviewed.

0 case record reviews and 0 investigations completed which related to deaths which took place before the start of the reporting period.

0 patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This has been estimated using RCA methodology and case note reviews.

0 of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.



2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

As specified by NHS Improvement:

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS foundation Trust's indicators should be compared with:

- The national average for the same and
- NHS trusts and NHS foundation trusts with the highest and lowest for the same.

However, the majority of the indicators included in this section ("Reporting against core indicators") are not relevant to the Trust. The Trust is exempt from the National Patient Experience Survey for community mental health services. In respect of safety incidents, the Trust does not report enough incidents to receive a report.

Core Indicator No. 22 covers 'The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.'

In 2017/18, 99% of patients who rated help they had received from the Trust as 'good'.

- 99% of patients in Quarter 1
- 99% of patients in Quarter 2
- 100% of patients in Quarter 3
- 100% of patients in Quarter 4

Furthermore, 98% of patients would recommend us to a friend or family number if they needed similar treatment. Patient satisfaction is reported elsewhere in the Quality Report on page 54.

The Tavistock and Portman NHS Foundation Trust considers this data is as described for the following reasons: the questions included in the Trust Experience of Service Questionnaire (ESQ) are used with patients seen in the Trust to obtain feedback on their experience of our services. This information cannot be directly compared with the questions derived from the National Patient Experience Survey for community mental health services however, we would score very positively for patient experience when compared to other mental health Trusts.

The Tavistock and Portman NHS Foundation Trust intends to improve waiting areas and clinical spaces, information provided about access to the trust and written information about clinical services. This has been identified as three key areas: Estates and trust accommodation, Access to sites and parking, Communication and Information. The Clinical Quality and Patient Experience work plan will evaluate the effectiveness of these improvements over the course of 2018/19.

Core Indicator No. 25 covers "The number and, where available, rate of patient safety incidents reported within the Trust during the 2017/18, and the number and percentage of such patient safety incidents that resulted in severe harm or death". The data for this indicator can be found elsewhere in the Quality Report on page 43.

The Tavistock and Portman NHS Foundation Trust considers that this data is as described for the following reasons: the organisation provides outpatient services only and the incidents reported reflect the lack of any physical interventions undertaken in the Trust. All clinical incidents are reviewed by the Associate Medical Director and considered in the quarterly Patient Safety Clinical Risk workstream which reports to the Trust Quality Committee. Non clinical incidents which deal with health and safety, information governance or information technology issues are managed by the relevant Trust leads for these areas and are considered in the quarterly Corporate Governance and Risk workstream.

The Tavistock and Portman NHS Foundation Trust has taken the following actions to improve this number and so the quality of its services:

- continuing to highlight incident issues and lessons learned at staff induction and mandatory training days;
- triangulating issues from reported incidents with those raised by patients via complaints and PALs;
- sharing incident information in the staff Quality News;
- establishing serious incident learning lessons events and;
- in May 2018 we will be implementing an online incident reporting system with access to 'live' incident information and the development of reports and dashboards during the year.

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Improvement

We launched our Trust Clinical Quality Strategy in January 2017 with the challenge to develop an approach to quality improvement in our clinical services which is tailored to our patients' needs. The past year the Trust has made significant progress in tackling this challenge.

The Trust chose a structured Quality Improvement (QI) methodology to help us to address issues that impact on the quality of our services. This relies on working together with our colleagues, patients and other stakeholders to make best use of our knowledge, experience, curiosity and creativity. For us, the challenge is to use the methodology in a way that recognises the distinctive psychological approaches we use at the Trust

What have we done?

The Trust is committed to increasing QI skills across the organisation and with Health Education England Funding, ran a series of QI courses to increase staff knowledge, understanding and skills over the winter.

These have been delivered by HAELO, an innovation and improvement science organisation with expertise in this field. Training included three one-day introductory courses and our first cohort for an intermediate course to develop staff skills. In total over 80 staff took part in the first round of training.

We also have members of staff involved with various external QI programmes to support the QI developments with greater expertise. There is a QI Group to oversee these developments across the Trust and support for those interested in QI through a Community of Practice.

Three QI Leads are working with Teams on the following pilot projects:

- Reducing DNAS for first appointments- Adult Complex Needs
- Improving ways of gaining feedback from patients- Camden Adolescent Intensive Support Service
- Improving uptake of lunch breaks to promote staff well -being- South Camden CAMHS

What's next?

We're developing QI resources available via our intranet and on our website and over time are looking to widen the groups of staff and patients involved in QI, ensuring the work is integrated across the Trust and making a positive difference.

More training and support for QI projects is planned, including developing in house capacity, pulling together a register of all those projects across the Trust and looking for ways to share the learning and work.

We are also working with staff to help reduce the burden of administration and reporting.

Feedback

Training has been well received. Feedback from a clinician on the intermediate course:

"Having a shared understanding of the methodology within the team…means that we can have conversations about identifying problems and beginning the process of designing potential solutions…I came away from the session energized and keen to put the training into practice…"

Part 3: Review of quality performance

Review of progress made against last year's priorities

This section contains information on the quality of services provided by The Tavistock and Portman NHS Foundation Trust during 2017/18, describing the Trust's progress against indicators selected by the Board in consultation with stakeholders.

3.1 Quality of Care Overview: Performance against selected indicators

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other Trusts. These indicators include those reported in the 2015/16 and 2016/17 Quality Reports along with metrics that reflect our quality priorities for 2017/18. Where possible comparative data is provided.

In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve. Please note that data has been pulled at different times. Dates are included beneath individual tables.

The Trust Board, the Clinical Quality Safety and Governance Committee (CQSG), along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2017/18.

The NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* was in place. The Trust is currently in segment one.

Our quality priorities for 2017/18

Progress on achievement of our quality priorities for 2017/18 can be found in the following section.

Patient Safety

Priority 1: Improve the physical health of patients receiving treatment

Priority 2: Improve the Identification and Management of High Risk Patients

Clinical Effectiveness

Priority 3: Embed meaningful use of outcome measures in services

Patient Experience

Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families

2017/18 Quality Priorities summary

Meeting the targets for each of the 2017/18 quality priorities is covered in the following section. 'Green' denotes the targets have been met; 'amber' partly met and 'red', not met.

PRIORITY 1: Improve the physical health of patients receiving treatment *(This priority continues but with new elements from last year)*
1. Further develop and deliver the 'Living Well' programme across Young Adult and Adult services
2. Develop the physical health champions role across the Trust to support this priority
3. Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver Very Brief Advice on smoking and alcohol
4. Increase individual support for patients around physical health issues including smoking cessation and alcohol use
Performance in 2017/18
1. The Living Well programme has been continued to be developed with the addition of sleep as a topic. A consultation was held with senior clinicians to get their views on implementing a targeted intervention to improve sleep within those aged 15+ across the Trust who met certain criteria. Overall, the proposition of this intervention was well received, with clinicians being keen for this intervention to be offered to their patient group. A pilot patient has completed the session on a 1:1 basis, however, it is hoped that from this point onwards, the sleep intervention will be run bi-annually for a 5 week period for those aged 15-17 and 18+.
2. A re-recruitment of physical health champions is currently underway
3. A continuation of meetings across the Trust with separate teams have been held to try and promote the benefits of improving your physical health alongside your mental health. The online training programme for Very Brief Advice continues to be accessible for all staff via the Trust's intranet.
4. Individual support for patients this quarter has been increased with a particular focus on sleep. The Trust's first behavioural sleep intervention session was launched as a pilot. Work has also continued on ensuring that the physical health service remains accessible to all, through promoting the physical health service in general to clinicians across the Trust. This has been done through attending meetings, sending information emails and placing text within the Trust's e-bulletin.

PRIORITY 2: Improve the identification and management of high risk patients *(This priority continues from last year but with updated elements)*
1. To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with the aim of achieving 80% attendance at the end of a 3 year training cycle
2. Update and disseminate relevant policies and procedures
3. Regular re-audit (twice yearly) with an increase in completion of risk assessment and risk management forms on Electronic Patient Record.
4. Use of relevant sections of *Safer Services: A Toolkit for Specialist Mental Health and Primary Care . 10 Key Elements to Improve Safety.* (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, February 2017).
Performance in 2017/18
1. We have provided training to ensure that clinical staff are fully aware of how to clinically manage clinical risk assessment and self-harm and suicide. We have provided several training sessions and workshops over the year 2017/18 to enable as many clinicians as possible to attend. We have not yet reached the required 80% of staff trained, but the training continues and has now been made mandatory, including the option to complete via e-learning, with a view to achieving the 80% training compliance by Q4 2018/19.
2. All relevant policies have been updated and disseminated including the Learning from Deaths policy which is available with all other policies on our intranet and website.
3. Clinical Audit Officer carried out an audit in September 2017 looking at data from Q2 to ensure that the risk of suicide and self-harm are being properly identified, recorded and monitored by clinicians in order to ensure the best possible care for the Trust patients. This will be re-audited this year to ensure there has been an increase in the completion of risk management forms on the Electronic Patient Record.
4. This year's focus has mainly been on the prevention of suicide and management of self-harm and we have used the relevant sections in the Safer Services toolkit in relation to ligature point audits.

PRIORITY 3: Embed meaningful use of outcome measures in services *(This is a new priority for 17/18)*
1. To liaise with the Patient and Public Involvement (PPI) team to gather information regarding patients' experiences of outcome measures. Findings will be utilised as part of an overall review of the appropriateness of currently used measures and how they are administered.
2. For outcome measures to be entered on to the patient information system within 1 week of completion and receipt by the Quality Team.
3. Improve access to patient and team level data, to include a dashboard to provide 'real-time' data which is reviewed by clinicians and teams to improve services.
Performance in 2017/18
1. Quality improvement (QI) leads have been recruited within the department and administration staff have completed QI training. QI leads and staff are currently working together to look at current outcome data. Patients will be involved in QI in 2018/19 to enable contribution in outcome measures.
2. As part of Reducing the Burden project outcome measures are being rationalised and the CareNotes assist system are being made simpler to navigate. Work is currently taking place on the programme of implementation. All measures received by the Quality Team are entered onto the patient information system within 1 week receipt.
3. A dashboard scoping exercise is currently taking place to allow a more convenient way for patients to complete OM forms, e.g. Online to increase return takes.

PRIORITY 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families *(This is a new priority for 17/18)*
1. Establish reference group(s) from staff, patients, and other stakeholders to develop and oversee the priority workplan
2. Embed use of revised equalities monitoring data collection forms which cover all relavant protected characteristics undertaking a baseline review of form completion and agreeing a measurable increase in compliance
3. Source and provide benchmarking data where possible to identify where there may be gaps in provision
4. Analyse quality metrics according to demographic profile and protected characteristics, mapping information to current service provision and agreeing an appropriate action plan
Performance in 2017/18
1. Quality Stakeholder group membership was extended to community groups. The group is now chaired by a revolving patient representative.
2. Collection of data is under review by the Quality Stakeholder Group and the Equalities Committee in order to increase quantity and quality for the particular demographic in Camden and other boroughs served by the Tavistock and Portman NHS Foundation Trust.
3. Detailed benchmarking data has been sourced and is available for London Borough of Camden.
4. This has not yet been fully achieved. Detailed data is provided to service lines but further work required to identify gaps and plans to address them. The Patient and Public Involvement team have addressed community groups to make links with over 18/19.

Child and Adolescent Mental Health Service (CAMHS)

Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2017/18	**2015/16**	**2016/17**	**2017/18**
1. For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	59%	48%	56%
2. For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	83%	80%	77%

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 10-4-18

Measure Overview

For our Child and Adolescent Mental Health Services (CAMHS), we have used the Goal-Based Measure again this year, building on the knowledge we have gained since 2012, with patients previously referred to CAMHS. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.

As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback. As a result, we set the targets as stated in the table above. These were agreed with our commissioners and were measured as one of our CQUIN targets for 2015/16 (see Glossary).

For CAMHS, Time 1 refers to the Pre-assessment stage, where the patient is given the Goal-Based Measure to complete with their clinician when they are seen for the first time, where the patient decides what would like to achieve. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2), indicating whether or not they have achieved their goal.

Targets and Achievements

This year the Trust target of 80% was not met for the return rate of forms for the Goal-Based Measure completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2. In year 2017/18 56% of patient with in the cohort met this target, this was an 8% increase on 2016/17.

This year the target of 80% improvement in patients on the Goal Based Measure (GBM) from Time 1 to Time 2 was also was not met, the trust achieved 77%. A quality improvement project is well under way to ensure that GBMs are being generated for the correct patients only and also how helpfully they will be generated. The Trust have worked with the commissioners to agree targets that will aid improvement with regards to collection rates in turn this will make our cohort larger for then analysing the improvement rates. With our percentages then being more representative of the patient group that we treat.

Outcome Monitoring – Adult Service

Adult Outcome Monitoring Programme			
Targets for 2017/18	**2015/2016**	**2016/2017**	**2017/18**
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.	71%	64%	76%

Source: CareNotes/Quality Team. All data is the annual percentage. Data received and calculated: 9-4-18

Measure Overview

The outcome measure used by the Adult Services the CORE (Clinical Outcomes for Routine Evaluation system, see Glossary) was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure cover four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm. It is used widely by mental health and psychological therapies services in the UK, and it is sensitive to change. That is, where it is useful for capturing improvements in problems/symptoms over a certain period of time. We think in the future this should enable us to use this data for benchmarking purposes, for providing information on how our improvement rates for adult patients compares with other organisations and services using the CORE.

For the Adult Service, we used the CORE form again for the current year, building on the knowledge we have gained since 2012, with patients previously referred to the Adult Service. We set the ambitious target, based on those set in previous years by the commissioners.

Targets and Achievements

For the Adult Service, for Target 1, Time 1 refers to the Pre-assessment stage, where the patient is given the CORE form to complete before they are seen for the first time. The patient is then asked to complete this form again at the End of Treatment stage (Time 2).

At the end of the financial year 76% of patients who completed the CORE forms at Time 1 and Time 2 showed an improvement in their Total CORE score from the Pre-assessment to the End of Treatment stage. This was against a target of 70%.

Patient Safety Indicators

Indicator	2015/16	2016/17	2017/18
Patient Safety Incidents	34	114	82

Source: Incident Database, Data received and calculated up to April 2017 – March 2018.

Reported Degree of Harm	England 2016/17 %	Tavistock & Portman NHS FT 2017/18 %
No Harm – Risk rating of consequence 'harm to patient'	73.1	29
Low	23.4	49
Moderate	2.9	13
Severe harm or death	0.54	9

Source: NaPSIR Commentary report – All Trusts in England, January – March 2017, patient safety incidents and Trust Incident Database full year 1 April 2017 – 31 March 2018

Our figures do not compare nationally because of the majority of incidents take place in Gloucester House Day Unit, a School for under 12's who harm each other and fall in play. Outside of the school the majority of incidents are Information Governance (minor data breaches), suicides, attempted suicides, rapid transfer to A&E and self-harm at home.

Measure Overview

The Trust records all reported incidents in order to support the management of, monitoring and learning from all types of untoward incident. In addition, patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) for further monitoring and inter-Trust comparisons which promote understanding and learning. The NRLS definition of an incident that must be uploaded is as follows:

'A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.'

The Trust has a low rate of 'patient safety' incidents due to the nature of its patient services, (we provide psychological therapies, we do not undertake any physical interventions, and are an out-patient service only). There is no directly comparative NRLS data as the incidents reported by the Trust, whilst appropriate, are too few in number for this. However, when we review the percentage of Trust reported incident categories for a longer period they are similar to those reported nationally. Please see table below. The majority of patient safety incidents outside of Gloucester House School, relate to information governance incidents. The Trust appointed a new Information Governance and Security Manager in November 2017 who has prioritised staff communications on these matters, encouraging staff to report such incidents.

Incident type	2016-17 TOTAL %	2017/18 TOTAL %
	ENGLAND	Tavistock & Portman NHS FT
Self-harming behaviour - **Suicide (Inc. attempted)**	27	33
Disruptive, aggressive behaviour (includes patient-to-patient)	17	18
Patient accident Slip/trip/ falls	16	22
Access, admission, transfer, discharge (including missing patient), **absconding, cancelled appointments**	10	8
Medication	9	0
Infrastructure (including staffing, facilities, environment)	7	0
Treatment, procedure	3	0
Documentation (including electronic & paper records, identification and drug charts)	2	0
Consent, communication, confidentiality, I**nformation Governance**	2	15
Implementation of care and ongoing monitoring / review	2	0
Patient abuse (by staff / third party), **Safeguarding**	1	4
Clinical assessment (including diagnosis, scans, tests, assessments)	0	0
Infection Control Incident	0	0
Medical device / equipment	0	0
Other	4	0
Total	**100**	**100%**

Note: the highlighted incident types show which national field our data is submitted under. Information is uploaded to NRLS via e-forms. T&P = Tavistock and Portman. GH = Gloucester House School. Please note that the national comparative data for England relates to mental health Trusts for 2016/17.

Targets and Achievements

We have robust processes in place to capture incidents, and staff are reminded of the importance of incident reporting at induction and mandatory training events. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on staff making the effort to report (often for this Trust very minor events). Whilst we continue to provide training to staff and there are various policies in place relating to incident reporting, there are ongoing efforts to remind staff to report all incidents. During the year the Trust published its 'Learning from Deaths' policy in November 2017 and has established regular staff events to review and learn lessons from patient death investigations.

During 2017-18 the Trust had three suspected suicides, four information governance incidents and one adult safeguarding incident which we reported nationally. Following initial investigation of the safeguarding incident it was confirmed as not being a serious incident and a de-escalation from the national reporting system has been requested. Full serious incident investigations were undertaken for the other incidents. Some lessons from across the investigations are similar:

- Need to improve communications with patients, GPs / referrers and relevant agencies;
- Improving clinical risk assessment skills;

- Group emails should be double checked before being sent out and software used to ensure information is sent securely;
- Court reports should be read by a senior member of the team before submission to Local Authority Legal Services Team

Being Open and Duty of Candour

Care organisations have a legal duty to act in an open and transparent way in relation to care provided to patients, with specific requirements when a patient safety incident has occurred. This 'duty of candour' has been met for such reported incidents.

Where there is an incident with moderate to severe harm the duty of candour requirements are followed up with staff to ensure they are met. Requirements are covered in all Trust induction and training (INSET) days.

Child and Adult Safeguarding Alerts

Indicator	2015/16	2016/17	2017/18
Child Safeguarding Alerts	71	111	239
Adult Safeguarding Alerts	7	6	6

Source: Clinical Governance Report, Data received and calculated: 9-4-18

Measure Overview

The incremental increase in child safeguarding alerts is causal to a number of variables: training regarding the importance of recognising, reporting and recording safeguarding and child protection concerns, an Electronic Patient Record system, IT and the role of the Patient Safety Officer in reinforcing compliance, the Safeguarding Team, who support, advise and escalate, finally, robust leadership emphasising and modelling the importance of children's safeguarding within the organisation.

Conversely, the adult safeguarding performance, as reflected by alerts, has been affected by 4 changes in the adult safeguarding role in as many years. However, the Trust expects to see an increase in adult alerts in 2018/2019 based on the provision of adult safeguarding training (100%) and a new adult safeguarding policy, both of which were expedited in 2017/2018.

Attendance at Trust-wide Induction Days

Indicator	2015/16	2016/17	2017/18
Attendance at Trust Wide Induction Days	85%	85%	90%

Source: HR, Data received and calculated: 9-4-18

Measure Overview

This measure monitors staff attendance at mandatory Trust-wide induction, which all new staff are required to attend, when they first join the Trust. The Trust schedules this induction event on a rolling basis to new staff at least three times a year. As part of this Induction, staff are provided with an introduction to the work of the Trust and the Trust's approach to risk management and incident reporting; health and safety; infection control, confidentiality and information governance; Caldicott principles; safeguarding of children and adults, PREVENT, equalities and counter fraud awareness, to ensure that all new staff are able to provide a safe and good quality service to service users.

Targets and Achievements

14 members of staff joined the Trust in the last quarter and 2 are due to attend the next induction in May. The Trust will continue to monitor the attendance at mandatory training events, aiming to maintain a high level of attendance.

Local Induction

Indicator	2015/16	2016/17	2017/18
Completion of Local Induction	96%	97%	94%

Source: HR, Data received and calculated: 9-4-18

Measure Overview

The Trust provides all new staff with a local induction checklist in their first week of employment. This checklist needs to be completed within two weeks of commencing employment with line managers and a copy returned to Human Resources. This checklist is required by Human Resources to verify that the new staff member has completed their local induction.

This measure monitors the completion and return of the local induction checklist by new staff. The local induction process covers all local policies and procedures in place in individual service areas/directorates and ensures new staff are aware of all terms and conditions of employment, mandatory training requirements and arrangements in place locally that impact on working arrangements within the Trust.

Targets and Achievements

We are very pleased to report that we received 94% returned forms to show that the local induction had been completed by almost all staff joining the Trust in 2017/18. It is important that all new staff undertake a local induction with the appropriate manager, in order to ensure that staff are aware of policies and procedures that apply locally within their service area/directorate, and so that staff newly recruited to the Trust are able to provide a relevant, safe and good quality service to patients.

Attendance at Mandatory INSET Training

Indicator	2015/16	2016/17	2017/18
Attendance at Mandatory INSET Training*	96%	100%	98%

Source: HR, Data received and calculated: 9-4-18

*Staff are expected to attend training every two years. In order to achieve this 98% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2018.

Measure Overview

This measure monitors staff attendance at mandatory INSET training. The Trust provides the main mandatory training through an In-Service Education and Training (INSET) day, which all staff are required to attend once every two years. During this training day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality, equalities, information governance, PREVENT, safeguarding children and adults and fire safety.

Targets and Achievements

It is important that staff remain up to date with developments in each of these areas, to ensure that they are able to provide a safe and good quality service for service users. We can report that 98% of our staff who were required to attend INSET training had done so within the previous two years and that the attendance rate has improved further since last year.

Safeguarding of Children and Adults (Training)

Indicator	2015/16	2016/17	2017/18
Safeguarding of Children & Adult – Level 1 Training*	92%	95%	95%
Safeguarding of Adults only – Level 2 Training	N=61	88% as of Q4 training was incorporated in level 3	35% as there has been no trainer for the past 8 months
Safeguarding of Children – Level 2 Training**	96%	88% figures do not include Q4 as training for level 2 only was ceased	Level 2 standalone training has ceased due to merging with Level 3 training
Safeguarding of Children – Level 3 Training**	92%	94%	96%

Source: Clinical Governance, Data received and calculated: 9-4-18

*All staff receive Level 1 training as part of mandatory INSET training.

Please note: Adult Level 1 and Level 2 Safeguarding training introduced in 2015/16

Measure Overview

All staff receive Level 1 training as part of mandatory INSET training and must complete this training every 2 years.

To ensure that as a Trust we are protecting children and young people who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in clinical services working predominantly with children, young people and parents to receive Level 3 Safeguarding of Children and Adults training once every three years.

Targets and Achievements

The Trust places great importance on all staff receiving relevant safeguarding training and so we are very pleased that when compared with last year there has been an improvement in attendance for all three levels of Child and Adults Safeguarding training. By March 2018, 95% of staff received Level 1 training and 96% of staff requiring Level 3 training had attended this training.

Infection Control

Due to the types of treatment offered (talking therapies) this Trust is at very low risk of cross infection. All public areas are cleaned to a high standard by internal cleaning staff. Toilets and washrooms are stocked with soap and paper towels and we have alcohol hand gel available for staff and public use in public areas of the Trust (e.g. at the entrance to the lifts in the Tavistock Centre). Anti-bac wipes have been made available in all administration offices and Reception as an additional cleaning resource. Since April 2016 we have initiated processes for support services staff to clean communal area toys on a regular basis (quarterly) in sites managed by T&P Estates.

The Trust organised on site access to flu vaccination for staff at the Tavistock Centre by Occupational Health Royal Free Hospital (RFH) staff through the flu campaign from October to February. Staff can also attend the walk in clinics at the RFH. Outreach and community staff are encouraged to make arrangements for their own Flu vaccines and report to HR. Update on personal responsibility for reducing the risk of cross infection is raised at induction and mandatory INSET training.

Clinical Effectiveness Indicators

Monitor number of staff with Personal Development Plans (PDPs)

Indicator	2015/16	2016/17	2017/18
Monitor number of staff with Personal Development Plans	99%	100%	99%

Source: HR, Data received and calculated: 9-4-18

Measure Overview

Through appraisal and the agreement of Personal Development Plans (PDP) we aim to support our staff to maintain and develop their skills. It also provides an opportunity for staff and their managers to identify ways for the staff member to develop new skills, so as to enable them to take on new roles within the organisation, as appropriate. A Personal Development Plan also provides evidence that an appraisal has taken place. In addition, the information gathered from this process helps to highlight staff requirements for training and is used to plan the Trust Staff Training Programme for the up-coming year.

The data collection period for Personal Development Plans takes place from May to July each year which impacts our ability to report on the figures at the end of quarter four. We will be in a position to report on appraisal statistics by the end of Q1 each year.

Regarding the statistics it is important to note that the staff group who have not completed a PDP include those staff who are on a career break or sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

Targets and Achievements

We are very pleased to report that 99% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the July deadline.

Staff Retention

Indicator 2017/18	Q1	Q2	Q3	Q4
Labour stability index	80.10%	78.74%	80.20%	80.5%

Source: HR, ESR Data
Note: Each Quarter's figure reflects the Labour Stability index over the previous 12 month period. The Q4 figure therefore represents the Labour Stability Index for the period 1/4/17 to 31/3/18.

Measure Overview

Staff retention often tends to focus on organisational turnover rates i.e. the number of leavers as a percentage of the entire workforce. This measure is crude in its nature, to understand retention more thorough it is prudent to look at both turnover and an organisation's stability index. The latter looks at the number of staff who leave within the first year of being employed by an organisation.

Stability index measuring is important as it can give an indication of where staff culture or organisational pressure is intense and as a result there is a lack of continuity within the workforce.

Targets and Achievements

The Trust has a higher than average rate of turnover, however, it is clear that those that leave the organisation have more than a year's service. Deeper analysis of this workforce metric has shown that whilst a high number chose to leave they normally do so after three years employment with the organisation.

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Gender Identity Clinic

The Gender Identity Clinic (GIC) is the largest and oldest gender clinic in the UK, dating back to 1966.

The service accepts referrals from all over the UK for people with issues related to gender. The GIC are a multi-disciplinary clinical team, including psychologists, psychiatrists, endocrinologists and speech and language therapists. The service provides holistic gender care, focusing on the biological/medical, psychological and social aspects of gender.

Staff ask all patients to fill in an anonymous form when they leave the clinic to provide feedback during the process of treatment in order to learn. At this point, the service feedback was almost exclusively positive, including statements such as, “Everything was perfect!”, “I really feel as if I made progress”, “Clinician listened to my personal story”, “Was nice to be able to talk to someone when needed”. “I feel really listened to and empowered and it’s great to feel that way.”

Who is the service for?

GIC provide treatment and support to a wide variety of adults who have issues in relation to gender.

Outcomes

The majority patients who attend the adult Gender Identity Clinic are keen to start the ‘official’ process of transitioning with hormones leading to eventual surgery as quickly as they can, for which the service are able to offer support and guidance.

However, this can be a complex and a lengthy process, which regularly includes individual counselling psychology, group therapy, and/or speech and language therapy.

For the majority of GIC patients, the experience is positive, culminating in them being able to live the lives that they have always wished for.

Patient Experience Indicators

Formal Complaints Received

Indicator	2015/16	2016/17	2017/18
Formal Complaints received	27	39	154

Source: Clinical Governance. Data received and calculated: 9-4-18

Targets and Achievements

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. The number of complaints received for 2017/18 has risen significantly from 39 the previous year to 154 of which 116 relate to complaints from the new Gender Identity Clinic service. The Trust took on the Gender Identity Clinic at Charing Cross from April 2017 and the service has a very large patient base.

149 of the formal complaints received relate to aspects of clinical care, appointment times and delays in referral, 4 complaints relate to corporate services. 7 complaints were received in the Adult and Forensic Directorate, 142 were received in the Children, Young Adults and Families Directorate (this includes the Gender Identity Clinic) and 4 were received in the Corporate Directorate.

Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During the year four complaints were referred to the Health Service Complaints Ombudsman and investigations are on-going. Of the complaints referred to the Ombudsman the previous year two were withdrawn and the others were not upheld.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, to ensure that improvements to our services are made we have instigated a more robust system of actions plans following upheld complaints.

During 2017/18 we have given presentations to staff both at Staff Induction Days and INSET days to ensure that staff are aware of the complaints procedure and how to advise patients who wish to make a complaint. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

Patient Satisfaction

Trustwide

Indicator*	Q1	Q2	Q3	Q4
Patient rating of help received as good	99%	99%	100%	100%

Please do note, the logic surrounding the calculation of the percentages changed in 2017/18 to improve data quality.

* Yearly averages: 2017/18= 99%; 2016/17 = 93%; 2015/16 = 94%; 2014/15 = 92%

Source: PPI, Data received and calculated: 9-4-18

Please note that the definition for this financial year has changed. The cohort previously included those who chose 'don't know' or 'had missing data', for data quality reasons we have now excluded these from our cohort and the definition from April 2017 is 'certainly true' + 'partly true'/'certainly true' + 'partly true' + 'not true'.

The Trust has been formally exempted from the NHS National Mental Health Patient Survey which is targeted at patients who have received inpatient care. For eleven years, up until 2011 we conducted our own annual patient survey which incorporated relevant questions from the national survey and questions developed by patients. However, the return rate for questionnaires was very low and in 2011 the Trust discontinued using its own survey and started to use feedback received from the Experience of Service Questionnaire (CHI-ESQ) to report on the quality of the patient experience on a quarterly basis. The ESQ was chosen because it was already being used as a core part of the Trust's outcome monitoring, and so we anticipated obtaining reasonable return rates to enable us to meaningfully interpret the feedback.

Targets and Achievements

Results from the Experience of Service Questionnaire found that 99% of patients in Quarter 1 (April to June 2016), 99% of patients in Quarter 2 (July to September 2016) 100% of patients in Quarter 3 (October to December 2016) and 100% of patients in Quarter 4 (January to March 2017) rated the help they had received from the Trust as 'good'. Our target for quarterly reporting is 92%; achieved in all 4 quarters.

The Trust also takes part in the Friends and Family Test and reports as part of our Key Performance Indicator schedule on a quarterly basis. This allows us to see how many of our patients would recommend our service to a family or friend if they required similar treatment.

Experience of Survey Questionnaire: Friends Family Test only

Indicator*	Q1	Q2	Q3	Q4
Percentage of patients who would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment	98%	97%	98%	99%

Please do note, the logic surrounding the calculation of the percentages changed in 2017/18 to improve data quality.
*Data has been re-run for the year to capture all forms that may have been received by the trust after the quarter end. Yearly average of 2017/18 = 98%; 2016/17 = 93%; 2015/16 = 94%.
Source: PPI, Data received and calculated: 9-4-18

Targets and Achievements

There has been a high level of achievement for positive patient feedback, significantly exceeding the target of 80% in every quarter throughout the financial year of 2017/18.

We can see from this that patients accessing treatment and completing an ESQ are satisfied with treatment. However work is being done to ensure we increase the quantity of Experience of Service questionnaires collected. This is being undertaken by the Trusts Quality Improvement leads in Adult and Forensic Services and Children Young Adults and Family services respectively with assistance from the Quality Team and the Patient and Public Involvement team.

The data also shows high levels of positive feedback for the FFT indicator. Last year data quality improvements were identified and actioned following an audit.

The Quality team now carries out a monthly audit of 20 ESQ forms to ensure they are entered correctly.

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Camden Adolescent Intensive Support Service (CAISS)

CAISS practitioners work intensively with families and young people for a period of time to help reduce crisis and risk taking behaviours. Through support and guidance, the goal is to help young people cope with difficult situations in future. This was a new service set up 1st April 2016.

“Patience and professionalism by all staff” (parent)
“The frequency of support and how quickly you can speak to someone is so great” (parent)
“Really understanding and really caring. I could see progress week on week. Keyworker was great at coming to us when I couldn’t get to the Tavistock” (young person)

Who is the service for?

CAISS is an intensive support service for young people (aged 11-18) and families in Camden who need significant extra support to help manage a deterioration in their emotional health.

Outcomes

Since CAISS was set up, young people of Camden are spending 48% less time in Psychiatric hospitals. The evidence shows us that an assertive approach within hospital wards has positive outcomes for the young people and families. Developing and/or continuing a therapeutic relationship with a member of the CAISS team whilst an inpatient enables young people and the multi-disciplinary/agency network around them to support safe, timely discharge into the community.

95% of young people were seen by CAISS either on the ward or in the community, within 24 hours of referral being received. The readmission data suggests that being seen in a timely manner reduces the chances of representing to an acute service and prevents unnecessary transfers to psychiatric units.

Did Not Attend Data

Indicator	2015/16	2016/17	2017/18
Trust-wide Total			
First Attendance	12.4%	10.0%	12.4%
Subsequent Appointments	8.6%	7.4%	9.8%
Adolescent and Young Adult			
First Attendance	18.3%	15.4%	13%
Subsequent Appointments	12.9%	8.5%	11%
Adult			
First Attendance	15.9%	11.6%	21%
Subsequent Appointments	7.4%	6.5%	9.4%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)			
First Attendance	10.8%	8.3%	9.3%
Subsequent Appointments	9.0%	7.7%	8.9%
Other CAMHS			
First Attendance	4.4%	6.4%	12.4%
Subsequent Appointments	4.7%	6.1%	8.2%
City and Hackney			
First Attendance	19.7%	12.9%	18.8%
Subsequent Appointments	13.8%	10.2%	11%
Portman			
First Attendance	11.0%	5.7%	5.6%
Subsequent Appointments	8.2%	7.0%	9.4%
GIDS			
First Attendance	10.6%	10.7%	11.6%
Subsequent Appointments	8.8%	7.4%	10.2%
GIC*			
First Attendance	n/a	n/a	12.4%
Subsequent Appointments	n/a	n/a	14.8%
Westminster Service			
First Attendance	4.9%	1.5%	8.3%
Subsequent Appointments	5.5%	12.7%	9%

*Service was taken on by the Trust from 1-4-17

Source: CareNotes, Data received and calculated: 9-4-18

Measure Overview

The Trust monitors the outcome of all patient appointments, specifically those appointments where the patient Did Not Attend (DNA) without informing us prior to their appointment. We consider this important, so that we can work to improve the engagement of patients, in addition to minimising where possible wasted NHS time.

Targets and Achievements

Unfortunately DNA rates increased for first attendances and subsequent/follow-up appointments compared with last year. Both first and subsequent appointments have risen by 2.4% in 2017/18.

The Trust continues to offer a greater choice concerning the times and location of appointment; emailing patients and sending them text reminders for their appointment, or phoning patients ahead of appointments as required. The Trust will be undertaking a more detailed review of DNA rates during the year to see if there is anything further we can do to lower these.

The definitions used for DNA's for percentages are as follows:

1st DNA(%)= Total 1st DNA / (Total First Attended + Total 1st DNA appointments)

Subsequent DNA(%)= Total sub DNA / (Total subsequent attended + Total subsequent DNA appointments)

Total DNA(%)= Total DNA / (Total Attended + Total DNA appointments)

Waiting Time Breaches (Trustwide) – Target dependent on service

Number (%) of patients attending a first appointment 6, 8, 11 or 18 weeks after referral received.

Service	Target	Total Breaches 17/18	Total accepted referrals waiting at the end of financial year 2017/18
Adolescent Service	<8 weeks (10%)for under 18 and <11 weeks for over 18	**19.2%**	**35**
Camden CAMHS	<8 weeks (10%)	**4.1%**	**109**
Other CAMHS	<8 weeks (10%)	**20.8%**	**57**
Westminster Family Assessment Service (FAS)	<6 weeks (10%)	**24.4%**	**9**
Adult service	<11 weeks (5%)	**13.4%**	**32**
Portman	<11 weeks (10%)	**2.0%**	**5**
City and Hackney PCPCS	<18 weeks (10%)	**2.4%**	**58**
Gender Identity Service (Under 18)	<18 weeks (10%)	**79.1%**	**1652**
Gender Identity Clinic (Over 18)	<18 weeks (10%)	**95.0%**	**1723**

Source: Carenotes. Data received and calculated: 6-4-18

Please note, the logic surrounding the calculation of the percentages changed in 2017/18 as requested by the contracting department and commissioners. As a result, we are unable to compare previous year's results. Increased waiting times have been due to a mix of reasons including patient choice, insufficient information at referral and staff availability. Other CAMHS waiting times have been reducing over the year. GIDS and GIC services have seen a significant increase in referrals over the past year. Further detail is included below. See Information on the Quality of Data within Section 2.2 Statements of Assurance from the Board for further information on waiting time data quality.

Measure Overview

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially those who are close to our target time. The definition of this indicator is as follows:

To calculate the year-end indicator, the numerator and denominator at the end of each quarter, are added together, to arrive at year-end figure.

The numerator for the quarterly calculations is the sum of:

- Number (*n*) of referred patients who had attended a first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received;

And

The denominator for the quarterly calculations of the indicator is the sum of:

- Number (*n*) of patients who attended a first appointment during the quarter

This definition has changed after feedback was given by clinicians and the external auditors. By discarding those who are still waiting treatment it allows us to see a more accurate representation of the number of breaches.

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment with the same therapist where possible. This system, on the whole, helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral.

Targets and achievements

To help address the breaches, at the end of each quarter a report is written and visible to board for each service of those patients who had to wait longer than the given target of weeks for their first appointment, together with reasons for this. The services where the breach has occurred are requested to develop an action plan to address the delay(s) and to help prevent further breaches.

Overall the Trust has seen an increased number of patients in 2017/18. In many services patients are seen within our waiting time targets of 10%, these include Camden CAMHS, Portman and City and Hackney PCPCS. However in some services the number of breaches has exceeded the target. In services such as the Adolescent and Young Adult Service, this is due to scarce availability of the specialised resources required for complex patients seen in this service.

In our Gender Identity Development Service (GIDS) and Gender Identity Clinic (GIC) this is due to the continued increase in the referral rate and specialist staff leaving the trust. To improve waiting times in

the Gender Identity Service for under 18 there are a number of projects underway which have been developed to improve access to the service and will potentially have a positive impact on the waiting list. Projects include more outreach clinics, assessment clinics, and group first appointments for carefully selected young people and Telemedicine. In addition we are working closely with Charing Cross Adult GIC to improve transfer from the GIDS to the adult GIC. Timely transfer of young people to adult services would reduce staff caseloads, which in turn creates space for new referrals to be picked up.

With regards to Other CAMHS, the unspecific demographics of the service prove hard to secure funding within the 8-week target, as information from external services is needed to continue with the referral. This in turn impacts on our overall number of breaches, however this has improved throughout the financial year and will hopefully continue through 2018/19.

Westminster Service (Family Assessment Service) has exceeded the 10% trust target, this is mainly due to external reasons with regards to the correct paperwork being received on time. And also to the nature of the service of having to wait until after the birth of babies (which may exceed the waiting time target).

3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/or medical consultant led services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner Organisation code, employment and accommodation status) are collected and monitored. For year 2017/18 Majority of the metrics are met with completion rate of 99%, for two metrics (Employment and accommodation status) underperforming are being worked with services for improvement.

The Trust complies with requirements regarding access to healthcare for people with a learning disability.

3.3 Reported Raising of Concerns: Whistleblowing

The Trust takes the issue of staff being able to raise concerns, or 'whistleblowing', very seriously and appointed a member of staff to the role of Freedom to Speak up Guardian in October 2015. This is in line with Francis Review recommendations. The Trust has in place a 'Raising Concerns and Whistleblowing procedure' and regular communications have gone to staff to make them aware of our Freedom to Speak up Guardian, her role and contact details. Meetings have been held with groups of staff to raise awareness and there are regular presentations at Inset days and updates sent out via the communications team.

There were no formal clinical whistleblowing cases raised in 2017/18 and the Trust has had no members of staff coming forward to raise formal complaints about patient care. Staff do however make contact to discuss other issues in confidence. These concerns have related in particular to staff feeling not listened to by managers and feeling bullied. During this year staff have also raised concerns about ethical matters of patient treatment. This is sometimes seen as having an indirect impact on the quality of care

given to patients and families. We are committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

Contact has been made with the National Whistleblowing Helpline and our Guardian now receives regular newsletter updates. She has also joined the NHS Employers, local Guardian hub, and her details are on the Freedom to Speak up Guardian map. Links have also been made with the London Freedom to Speak up Guardians and Guardians based in Mental Health Trusts. The National Guardian's Office is now well established itself and arranges regular conferences and training events. The National Guardian visited the Trust in February 2017. The Guardian also meets regularly with other staff in the Trust who hold responsibility for staff wellbeing such as the Staff side representative, HR Director, Board of Directors link and Director of Patient and Quality Experience alongside consulting with the CEO and Service Directors when issues are raised.

The Guardian will continue to keep the profile of the role in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness where staff are encouraged to speak up about patient safety, knowing that their concerns will be welcomed, taken seriously and responded to quickly.

3.4 Sign up to safety

The focus on quality of care and patient safety remains central to the Tavistock and Portman NHS Foundation Trust. The National Sign up to Safety Campaign is a national patient safety initiative that was launched in June 2014 to bring organisations together behind a common purpose of strengthening patient safety and making the NHS the safest healthcare system in the world. The Chief Executive signed up to the campaign on behalf of the Trust in October 2015. The actions the organisation would take in response to the five Sign up to Safety pledges within the National campaign can be found on our Trust website.

These commitments have led to the development of a Safety Improvement Plan which shows how we intend to reduce harm to patients over the next 3 years. This builds on and integrates with our Clinical Quality Strategy and Annual Quality Report. Our patient safety improvement plan during 2017/18 has focused on the areas below. Work will be undertaken during 2018/19 on the detection and management of e-safety risks in young people, as this links particularly with issues of self-harm and suicide.

- Improving the physical health of patients
- Improving clinician knowledge of self-harm and suicide
- Improving domestic violence and abuse management

The Trust has agreed a Clinical Quality Strategy to meet the local needs of our service users and believe that the core aims outlined in the Strategy will drive the Safety Improvement Plan. These are:

- Ensuring that all service users are safe and protected from avoidable harm and abuse;
- Providing services with care, treatment and support that achieves good outcomes and promotes good quality of life, based on best evidence;
- Organising services around the needs of the user – involving them and their carers in service design and delivery; and
- Supporting staff to maintain and develop their skills and working within clear and effective governance structures to deliver safe, effective, responsive, caring and well-led services.

Improving the physical health of patients

The programme of work is led by the Physical Health Specialist Practitioner (PHSP), a health psychologist, supported by two consultants, our physical health leads. This was a quality priority and also a CQUIN for 2017-18. Work has been undertaken to embed the use of physical health form assessments for all patients 13 years and above, with referrals to the PHSP for one to one support. The Living Well Programme was delivered with both clinician and self-referrals and covered smoking, drinking, substance use, healthy weight, exercise and mindfulness. This will continue to be developed in 2018-19 to include interventions relating to sleep issues and the physical health form will be revised to include sleep issues. A training programme for Trust staff was also developed highlighting the links between physical and mental health.

Improving clinician knowledge of self-harm and suicide

One of our aims for this priority is that by the end of a 3-year training cycle 80% of clinicians should have attended a refresher training on clinical risk assessment and risk management. Skills workshops have been run throughout the year and a simulation training event. An introduction to both is provided at the clinical induction event for new trainees and in Trust mandatory training (INSET) days. The target will be met by developing an e-learning module in 2018. The staff intranet resource page includes policies and procedures, NICE guidelines, links to National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Mental Capacity Act decision making pathway, suicide bereavement resources etc. Learning lessons events have been developed and delivered along with establishing mortality reviews. The Trust is signatory to the Zero Suicide Alliance http://zerosuicidealliance.com/ which provides a short online training on suicide prevention.

Improving domestic violence and abuse management

The named professional for safeguarding children organised a series of training events based on the Barnardo's Domestic Violence Risk Identification Matrix for assessing the risks to children from male to female domestic violence. This training has been delivered to Team managers and/ or representatives from teams during the year. At the end of March 2018, 4 events were held with a total of 23 attendees. Further work is ongoing during 2018-19.

3.5 Staff Survey

The NHS Staff Survey took place between October and December 2017. For a third year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.

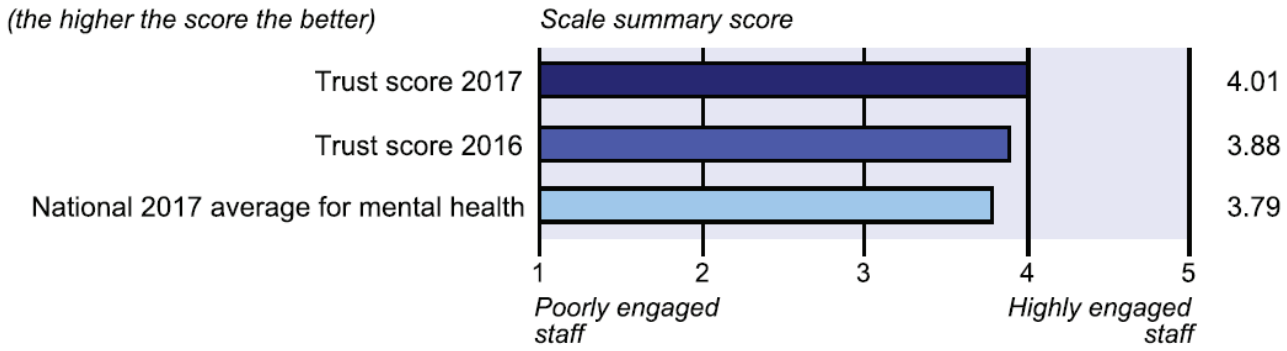
In 2017 the Trust received, yet again, high response rates with 56.4% of those being survey submitting a questionnaire. This was a very slight decline from the previous year where 58% of staff responded.

A copy of the national report can be found here:
http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RNK_full.pdf

Highlights from the 2017 Survey

It is clear from our results that our staff take exceptional pride in the work that they do with a high proportion recommending the organisation as a place to work and to be treated. In addition to this we have an exceptionally high engagement score.

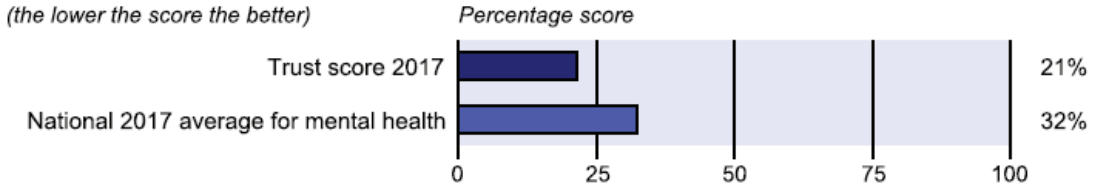
OVERALL STAFF ENGAGEMENT



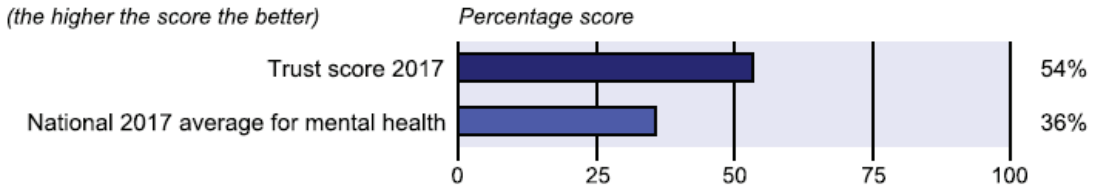
Having undertaken some extensive analysis of our survey results the Trust ranks as the best performing mental health and learning disability provider in 14 out of the 27 key findings areas.

Summarised below are our top five key result areas:

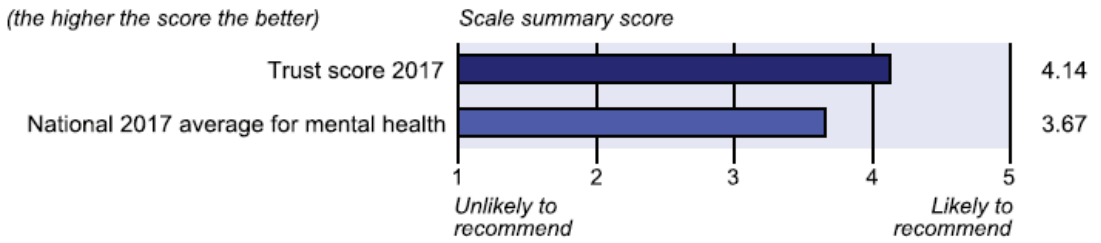
✓ **KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**



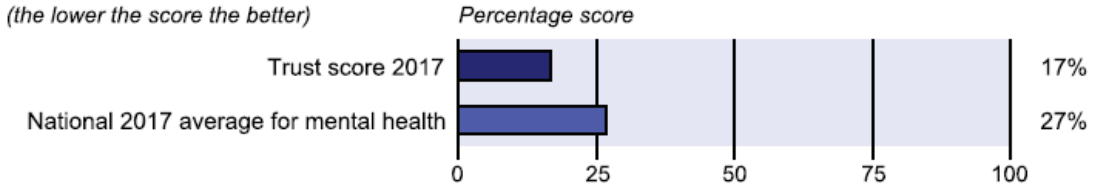
✓ **KF6. Percentage of staff reporting good communication between senior management and staff**



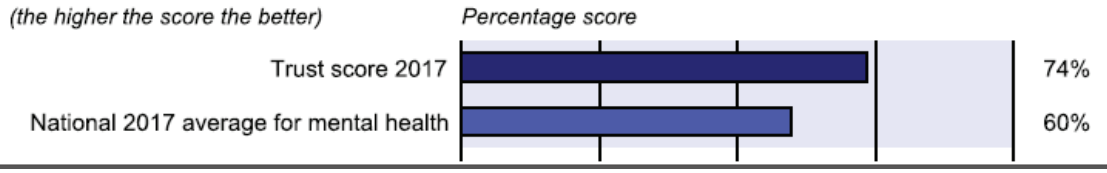
✓ **KF1. Staff recommendation of the organisation as a place to work or receive treatment**



✓ **KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**



✓ **KF15. Percentage of staff satisfied with the opportunities for flexible working patterns**



Areas for improvement

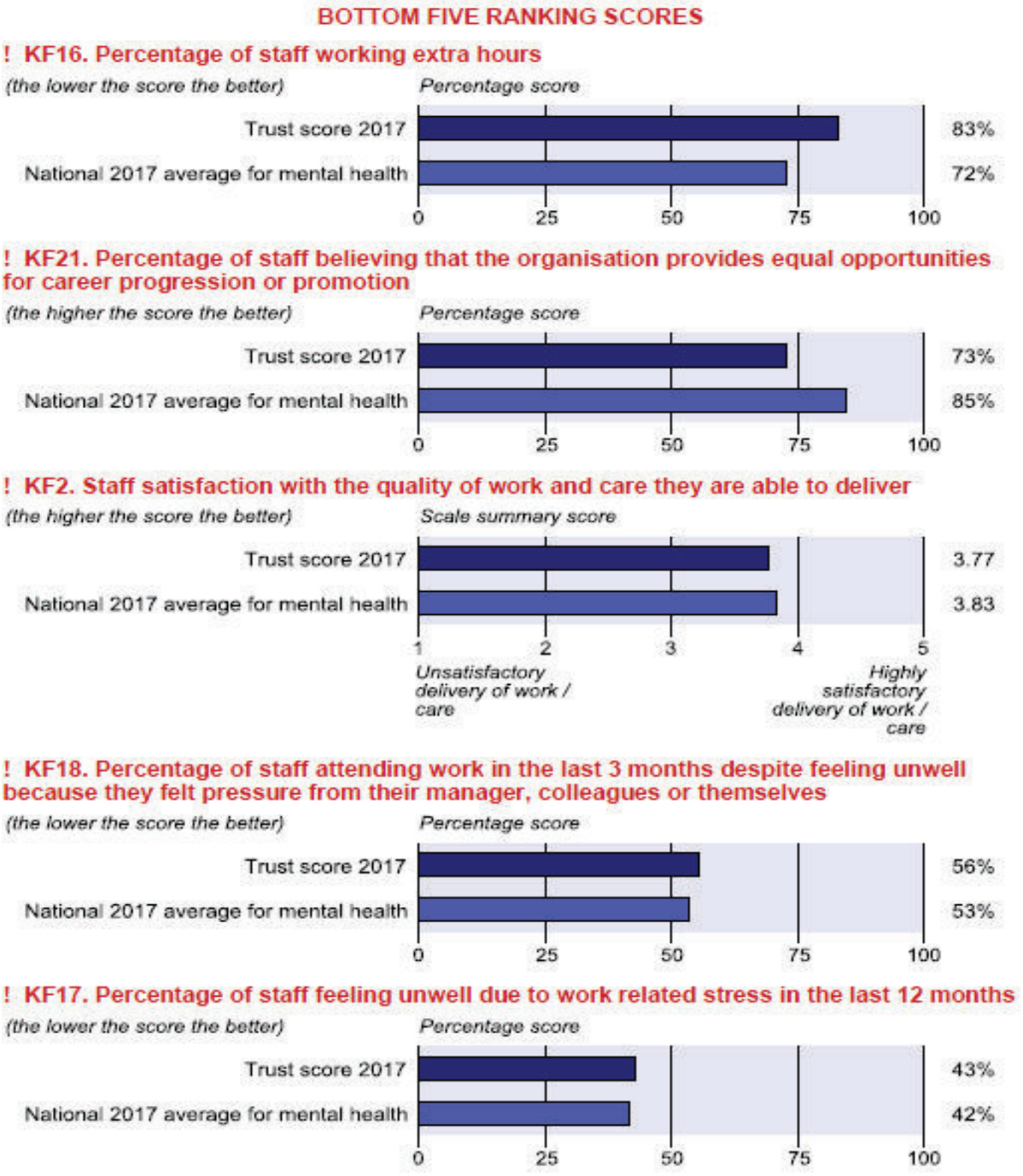
Amongst our results there are a number where we need to do further work. Some are themes from previous years which we will continue to engage with staff and managers to address.

We are cognisant that whilst the report highlights a number of areas where we perform less well, we are also aware that there is a clear divergence of experience between Black, Asian and Minority Ethnic (BAME) and white staff. The Trust has, in 2017, agreed a three year race equality strategy and an action plan to work to address a number of systemic issues in our organisation and we hope that these efforts will result in positive changes over the coming years. In saying that change will happen over a longer

period this reflects our view that cultural change does take time and requires continued visibility and action.

The Trust has developed a number of long term strategies which are designed to address our areas of concern. They are all long standing issues and ones which need a longer term approach to make change happen. Our strategies include our organisational development and people strategy 2017 – 2020; the race equality strategy 2017 – 2020; our reducing the burden programme; and our investment in quality improvement to name just a few.

The chart below summarises the five areas where we perform less well compared to other organisations in our peer group.



Improving our results

In 2016 we structured the staff survey data in a way that allowed us to report at Trust, directorate and service line level. We have done the same for 2017 and this has highlighted the services and teams where we need to give support and focused programmes of work.

Our service directors have, for another year, been tasked to discuss their results at a local level and then celebrate positive stories and co-design action plans that will address the concerns areas.

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Mentalization Based Treatment for violent offenders with Antisocial Personality Disorder Project – Portman

In 2014, the Portman Clinic received joint criminal justice/NHS England funding to roll out Mentalization Based Treatment services within the National Probation Service in 13 sites across England and Wales. The service offers 12 months of weekly group and monthly individual therapy for high-risk violent offenders with Antisocial Personality Disorder (ASPD).

Who is the service for?

Antisocial personality disorder is sometimes thought of as an uncommon or untreatable disorder. However, it is actually quite common. It is likely that at least half of UK prisoners meet the criteria for ASPD.

Individuals with ASPD often see the world as a hostile, 'dog eat dog' place, where other people are assumed to be a threat. Personal survival is only possible through diminishing, controlling or exploiting others and they may use both instrumental and explosive aggression to achieve these aims.

Mentalization Based Treatment (MBT) involves weekly group sessions and monthly individual sessions. MBT allows the opportunity to gain skills and practise mentalizing within a group setting.

The aim of MBT is to decrease the severity of violent and aggressive behaviours, improve the ability to manage stress, increase the ability to problem-solve within social situations and improve interpersonal relationships.

Outcomes

The services are now part of an randomised controlled trial (RCT) funded by the National Institute of Health Research, led by Professor Fonagy at UCL, the largest RCT to date evaluating treatment for ASPD.

As the anonymous reviewers of the bid for funding noted: “Findings are likely to be of international significance, with potentially enormous implications for how this condition is managed and treated”.

The role of service users or Experts by Experience has been critical to the success of the project. The Experts by Experience are ex-offenders with lived experience of personality disorder who have benefitted from treatment. They provide a crucial role in engaging offenders and preventing drop-out by participating in their assessment and treatment.

Co-commissioners report they “have been impressed with the project management and support to local sites offered by the Tavistock and Portman Clinic, and we have also welcomed the strong emphasis on service user involvement”.

The service was recently shortlisted for the prestigious HSJ awards, in the category ‘Innovation in Mental Health’.

Part 4: Annexes

4.1 Statements from Camden Clinical Commissioning Group (CCG), Governors and Camden Healthwatch and response from Trust.

Statement from Camden Clinical Commissioning Group (CCG)

NHS Camden Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Tavistock and Portman (T&P) NHS Foundation Trust on behalf of the population of Camden and associated commissioners. NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on T&P Trust's Quality Account.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in April 2018). We confirm that the document received complies with the required content as set out by the Department of Health or where the information is not yet available a place holder was inserted.

The CCG continues to meet with the Trust on a bi-monthly basis at its Clinical Quality Review Group meetings (CQRG) this forum is where the commissioners are provided with assurance regarding the quality of care and services provided by the Trust.

To ease the comprehension of this report for lay readers, we suggest that the Trust report on its progress against this year's quality priorities before describing those for next year, as an understanding of past performance will help the public place a narrative of future plans into context.

We are disappointed the Trust did not achieve some of the 2017/18 priorities, particularly the Child and Adolescent Mental Health Service Outcome Monitoring. It is envisaged the Trust make considerable improvement in 2018/19 in achieving goal based measures to further support patients to focus on what is important to them.

We would anticipate the Trust to improve their Did Not Attend rates in 2018/19 to enable timely appointments for their patients and optimise the use of NHS resources.

Commissioners are pleased to note the Trust are further prioritising Clinical Risk Assessment in 2018/19 by establishing an online training course for staff across the Trust. We are delighted the Trust have decided to further strengthen patient and carer involvement as a priority in the coming year.

The Trust have some work to do to relating to staff health and well-being, particularly to address long hours of working, and staff experience around fairness in promotion and development. The Trust have prioritised work to address this and we hope to receive progress against the improvement work required.

Camden CCG raised concerns with the Trust during the year regarding their processes relating to Serious Incident Management. A number of improvements have been made we hope the Trust will continue the hard work to improve systems and processes relating to Serious Incident Management.

At the time of writing this statement Camden CCG cannot authenticate the achievement of 2017/18 Commissioning for Quality and Innovation (CQUIN).

Commissioners are pleased with Trust compliance against the Workshop to Raise Awareness of Prevent training for staff and will continue to support this progress into 2018/19.

There remain areas for improvement and as commissioners NHS Camden CCG will continue to work with T&P to monitor these areas, enabling improvement in the quality of services provided to patients. We look forward to receiving detailed delivery plans (to be developed in Quarter 1, 2018/19) relating to the chosen priorities for 2018/19.

The CCG would like to continue to work collaboratively with the trust in agreeing, setting and monitoring of the quality issues and priorities during the coming year.

Trust Response:

The Trust welcomes comments on the Quality Report by our lead commissioners and looks forward to working closely on the implementation of our quality priorities during the next year.

In response to commissioner feedback we share the commissioner disappointment in not achieving some of our 2017/18 priorities, in particular the Child and Adolescent Mental Health Service Outcome Monitoring priority. We are reviewing how best to provide timely feedback to patients and staff in order to support improved patient outcomes.

We anticipate the use of telephone patient reminders across more services in 2018/19 will help improve DNA rates.

The Trust recognises that work is required to address issues raised by staff in the annual staff survey. Amongst our results there are a number of areas where we need to do further work including long hours of working and the clear divergence of experience between black, asian and minority ethnic (BAME) and white staff. The Trust is working with services and teams to address the former and in 2017, agreed a three year race equality strategy and an action plan to work to address a number of systemic issues in our organisation and we hope that these efforts will result in positive changes over the coming years.

We look forward to continuing to work collaboratively with our commissioner colleagues on quality issues and priorities during the coming year.

In respect of the positioning within this report of our progress against quality priorities for 2017/18 we have reviewed the NHS Improvement (NHSI) guidance and been advised not to amend the report for this year. We will however, raise this issue with NHSI to help inform 2018/19 reporting.

Statement from our Governors

The Council of Governors fully supports the initiatives and steps that the Trust continues to take to improve the quality of its services, and we note the commitment of the Trust's leadership and staff to its quality priorities.

In reviewing this Report, the Governors have also noted that the Trust is determined to avoid any complacency in its approach to quality. We are therefore pleased that as well as identifying the very welcome positives, the Report does not shy away from recognising those areas where the Trust still needs to improve, and sets out the actions the Trust needs to take as an organisation to address these.

Trust Response:

The Trust welcomes the feedback from the Governors to the draft Quality Accounts and appreciates the ongoing commitment to working closely with Trust staff to ensure the delivery of excellent quality services.

Statement by Camden Healthwatch

"Healthwatch Camden has taken part in the Trust's meetings for quality stakeholders, and we have been impressed with the openness and thoughtfulness of the Trust's senior representatives. The meetings are chaired by a service user representative, the importance the Trust places on user views and user experience.

We note good progress in many areas. We look forward to continuing our contact with the Trust."

Trust Response:

The Trust welcomes the response by Camden Healthwatch and looks forward to continued involvement as we develop the quality of our services.

Statement by Camden Health and Adult Social Care Scrutiny Committee

We have been informed that no statement will be received from the Camden Health and Adult Social Care Scrutiny Committee in time to be included in the final Quality Accounts. The Local Authority have confirmed that due to this being an election year, the Committee which would approve a statement to our Quality Accounts will not be formally appointed until late May, and not hold its first meeting until July.

A statement will be provided to the Trust following the July meeting, and published separately on our website.

4.2 Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to May 2018
    - papers relating to quality reported to the board over the period 1 April 2017 to 31 March 2018
    - feedback from commissioners dated 04/05/2018
    - feedback from governors dated 03/05/2018
    - feedback from local Healthwatch organisations dated 01/05/2018
    - feedback from Overview and Scrutiny Committee dated 26/04/2018
    - the trust's draft annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09/05/2018
    - the 2017 national staff survey, received by the Trust on 06/03/2018
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 15/05/2018
    - CQC inspection report dated 1 February 2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

.....Date.....23 May 2018.....Chairman

.....Date.....23 May 2018.....Chief Executive

4.3 Independent Auditors Report

Independent auditor's report to the council of governors of The Tavistock and Portman NHS Foundation Trust on the quality report

We have been engaged by the council of governors of The Tavistock and Portman NHS Foundation Trust to perform an independent assurance engagement in respect of The Tavistock and Portman NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Tavistock and Portman NHS Foundation Trust as a body, to assist the council of governors in reporting The Tavistock and Portman NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Tavistock and Portman NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care;
- number of bed days patients have spent inappropriately out of area;
- proportion of people who wait six weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period; and
- percentage of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

However, as the Trust does not provide inpatient services, the Quality Report does not include figures for any of these indicators. NHS Improvement guidance mandates that the Trust should choose two alternative indicators of its choice for testing, which have been selected as follows:

New Starters in the period less new starters who have left (leavers) the organisation during the period with less than 365 days of service as a proportion of new starters in the period (Labour Stability Index); and

Service users agreeing that they would recommend the Trust to their friends and family, calculated as those stating the statement is Certainly True and Partly True as a proportion of those stating the statement is Certainly True, Partly True and Not True (Friends and Family Test).

We refer to these collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from the Commissioners dated 4 May 2018;
- feedback from the governors dated 3 May 2018;
- feedback from local Healthwatch organisations, dated 1 May 2018;
- feedback from Overview and Scrutiny Committee, dated 26 April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 9 May 2018;
- the national staff survey dated 6 March 2018;
- Care Quality Commission Inspection report dated 1 February 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018; or
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
St Albans
22 May 2018

Appendix – Glossary of Key Data Items

AFS- Adult and Forensic Services.

Black and Minority Ethnic (BAME) Groups Engagement - We plan to improve our engagement with local black and minority ethnic groups, by establishing contact with Voluntary Action Camden and other black and minority ethnic community groups based in Camden.

CCG (Clinical Commissioning Group) - CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31 March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

Care Quality Commission – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

CareNotes - This is the patient administration system using, which is a 'live system' for storing information electronically from patient records.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) - The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, and isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

Clinical Outcome Monitoring - In "talking therapies" is used as a way of evaluating the effectiveness of the therapeutic intervention and to demonstrate clinical effectiveness.

Clinical Outcomes for Routine Evaluation - The 34 items of the measure covers four dimensions, subjective well-being, problems/symptoms, life functioning and risk/harm.

Commission for Health Improvement Experience of Service Questionnaire - This captures patient views related to their experience of service.

CQUIN (Commissioning for Quality and Innovation payment framework) - This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

CGAS - Children's Global Assessment Scale

Complaints Received - This refers to formal complaints that are received by the Trust. These complaints are all managed in line with the Trust's complaints policy.

CYAF - Children, Young Adults and Families services.

CORE - Clinical Outcomes in Routine Evaluation

Did Not Attend (DNA) Rates - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is a 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

The DNA Rate is based on the individual appointments attended. For example, if a family of three is due to attend an appointment but two, rather than three, family members attend, the appointment will still be marked as attended. However, for Group Therapy the attendance of each individual will be noted as they are counted as individual appointments.

DNA rates are important to the Trust as they can be regarded as a proxy indicator of patient's satisfaction with their care.

Family Nurse Partnership National Unit (FNP NU) - The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two. Fathers are also encouraged to be involved in the visits if mothers are happy for them to be. The programme aims to improve pregnancy outcomes, to improve child health and development and to improve the parents' economic self-sufficiency. It is underpinned by an internationally recognised evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing cost benefits.

Goal-Based Measure - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

Infection Control - This refers to the steps taken to maintain high standards of cleanliness in all parts of the building, and to reduce the risk of infections.

Information Governance - Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

Information Governance Assessment Report - The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorized access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

Information Governance Toolkit - Is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance included in the various Acts and presents them in one place as a set of information governance requirements.

INSET (In-Service Education and Training/Mandatory Training) - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

Key Performance Indicators (KPIs) –service indicators set either by commissioners or internally by the Trust Board.

LGBT - Lesbian, Gay, Bisexual, and Transgender community.

Local Induction - It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

Monitoring of Adult Safeguards - This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

National Clinical Audits - Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

National Confidential Enquiries - Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.

The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are “confidential” in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and coordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

NHS Litigation Authority (NHSLA) - The NHSLA is a not-for-profit part of the NHS. They manage negligence and other claims against the NHS in England on behalf of member organisations. They help resolve disputes fairly; share learning about risks and standards in the NHS and help improve safety for patients and staff. They are also responsible for advising the NHS on human rights case law and handling equal pay claims.

Participation in Clinical Research - The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

Patient Feedback - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

There are various other methods used to obtain feedback from patients, including small scale surveys and audits (such as the Children's Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer and informal feedback to clinicians and administrators.

Patient Forums/Discussion Groups – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

Patient Safety Incidents – This relates to incidents involving patient safety which are reportable to the National Reporting and Learning System (NRLS). Patient safety functions, including the NRLS system, previously delivered by NHS England were transferred with the national patient safety team to NHS Improvement on 1 April 2016.

Percentage Attendance – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

Periodic/Special Reviews - The **Care Quality Commission** conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

Personal Development Plans - Through appraisal and the agreement of a Personal Development Plan for each member of staff we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

Protected characteristics - These are defined in Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Quality Stakeholder Meetings - These include consultation meetings with stakeholders (Patient and Public Involvement representatives), Non-Executive Directors and a Governor, and the separate meeting with governors. The purpose of these meetings is to contribute to the process of setting quality priorities and to help improve other aspects of quality within the Trust.

Rapid Transfer Incidents- When a patient becomes acutely unwell they should be rapidly transferred from the Trust to a suitable healthcare setting for assessment and treatment; this will usually be by a local Accident and Emergency department.

Return rate - The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

Safeguarding of Children Level 3 - The Trust has made it mandatory for all clinical staff working in child and adolescent services and other clinical services working predominantly with children, young people and parents to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modelled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

Specific Treatment Modalities Leaflets - These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

TEL – Technology Enhanced Learning Team

Time 1 - Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.

Time 2 - Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.

Our goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post-assessment/treatment changes, and provide the necessary information for us to determine our clinical effectiveness.

Trust-wide Induction – This is a Trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear that they are required to attend this induction as part of their employment by the Trust.

Trust Membership - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

Waiting Times - The Trust has a policy that patients should not wait longer than 11 weeks for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient.

However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially beyond eleven weeks. A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, the actions to be taken to prevent recurrence.

NHS

The Tavistock and Portman

NHS Foundation Trust

Innovation in mind