NHS

The Tavistock and Portman

NHS Foundation Trust

Annual report and accounts 2018/19

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The Tavistock and Portman NHS Foundation Trust

Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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1 Trust chair's statement

The Trust's Annual Report and Accounts for 2018/19 offer a snapshot of the life and work of the Tavistock and Portman. The year can best be summed up as one of rapid growth with a more than doubling in the numbers of people we support compared to four years ago.

Against a backdrop of increased pressure the Trust's staff have worked tirelessly to deliver excellence. This was recognised by the Care Quality Commission in its well-led inspection that awarded the Trust an outstanding for effectiveness and an overall good for what we do.

The past year has been one of important milestones and reflection on our history and our future. We marked 85 years of the Portman Clinic, its pioneering work and legacy and celebrated as it secured a new forensic CAMHS service placing the clinic at the forefront of tackling complex and contemporary issues.

Our thought and practice leadership in the field of child and adolescent mental health was recognised during the year with the award of 'trailblazer' status and funding to build on our longstanding schools based work.

The Trust also celebrated the 50th anniversary of our own school, Gloucester House. The school's pioneering therapeutic educational work with children was marked at a special conference.

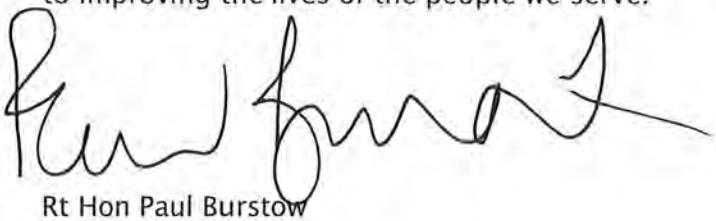
It is not just in the fields of children and young people's mental health that the Trust has a track record of innovation and impact. Our national workforce skills development unit, funded by Health Education England, has built on the Trust's traditions of organisational consulting to develop a framework for thinking and acting on the serious challenge of staff burnout. Focusing on creating psychologically safe working environments the goal is to help create resilient health care organisations.

A large part of what the Tavistock and Portman does is centred on education and training of the future clinical workforce, social workers and beyond. During the year we broke new ground playing host to two Chinese delegations of health care leaders. Although classroom based learning plays a big part in our trainings we are embracing the digital world too. This year we have taken the first steps in developing the platform for the Tavistock digital academy that will further extend

the reach of our psycho-social-developmental approach to mental health and wellbeing.

Looking ahead to 2019/20. We have the new NHS Long Term Plan. The welcome commitment to see funding for children and young people's mental health grow faster than overall funding increases for the NHS is welcome and long overdue recognition of the importance of tackling mental health problems at the earliest opportunity.

Finally, I want to thank the staff of the Trust for their dedication to their work and to improving the lives of the people we serve.



Rt Hon Paul Burstow
Trust Chair

2 Performance report

Annual performance statement from the chief executive

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

The quality of our services was formally recognised by Care Quality Commission this year, who rated our Trust as 'good', with 'outstanding' effectiveness, praising our skilled workforce, high-calibre board and innovative specialist services.

It was a particularly good result in the context of increasing demand for our services. In 2014/15 we had 5,560 services users. This year it more than doubled compared to four years ago, with 11,985 service users across the Trust, and to continue to deliver excellence as numbers increase so rapidly is a real credit to our staff, both clinical and on the administration and support side. We remain mindful that there a number of services which have longer than we would like wait times, however, work is being progressed to ensure this remains a focus for the Board and our operational services.

Our educational focus turned international this year as we signed a memorandum of understanding with the Beijing Huatong Guokang Foundation, China. On two occasions this year we played host to a delegation of Chinese visitors, looking to learn from our Trust and share their knowledge. We are excited by the possibilities ahead - we have much to learn from each other to better address global challenges in mental health care.

Around 400 people attended our annual graduation for students graduating from 20 programmes. One highlight was the award of an honorary doctorate to Dr Gail Lewis, an outstanding leader and scholar and who has engaged in various trainings at the Trust. Gail has made an outstanding contribution to developing an understanding of the links between mental health, racialisation, and racism. The student vote of thanks from Jill Comfort spoke of our 'extraordinary' commitment and input from everyone involved in their learning from faculty to professional staff.

For 50 years Gloucester House has pioneered therapeutic educational work with children, and we celebrated the anniversary of the school in 2018 with a special conference event, welcoming back former pupils, staff, and stakeholders connected to this very special place.

Another anniversary celebrated in 2018 was 85 years of our Portman Clinic, dubbed the UK's leading psychotherapy clinic in a recent magazine feature. We supported a special conference event with colleagues at the London Metropolitan Archive presenting historical material from the rich history of the clinic, and the history and future of the clinic was also the focus of the 2018 Trust annual general meeting.

As a Trust we're proud to be home to the Portman Clinic, not only for its pioneering history and psychoanalytic legacy, but also as it expands its expertise into new areas, including a new forensic CAMHS service. We also shared in nearly £4 million in government funding to support people with health conditions to manage their conditions at work through our new Add | Wellbeing programme.

We were also instrumental in the launch of the lighthouse, a new initiative which sees clinicians from the Tavistock and Portman working with University College London Hospitals NHS Foundation Trust and law enforcement in a single facility to support young people to recover from sexual abuse.

Workforce development was a focus for the Trust in 2018/19, including the practice supervisor development programme (PSDP), which aims to provide high-quality continuous professional development (CPD) to up to 700 social workers taking up their first role in which they are responsible for supporting and developing the practice of others.

Our national skills workforce development unit (NWSDU) was launched in 2017, and went from strength to strength in 2018/19, and launched a number of projects, including a workshop for the national mental health workforce development collaborative.

As part of the 'trailblazer' programme, NHS England awarded Camden Clinical Commissioning Group (CCG) funding for a collaboration between Camden Council, Camden CCG, and the Tavistock. This scheme is the pilot phase of the implementation of the Government's CAMHS Green Paper which the Trust alongside our Camden partners was able to input into based on the evidence of the longstanding work we have delivered in Camden schools.

Our outstanding individuals and teams received external recognition this year, including FDAC Project Manager, Beverley Barnett-Jones, recognised at the 2018 Queen's Birthday Honours, and our video-feedback intervention to promote positive parenting and sensitive discipline (VIPP-SD) project nominated in the children and young people now awards.

We supported the 2018 Hong Kong College of Psychiatrists Mental Health Congress, including a post conference workshop presented by Julian Stern and Joanne Stubley, and a pre-congress workshop presented by our non-executive director Dinesh Bhugra.

Nursing continued to be a vital area of our work, and we were pleased to welcome a new clinical professor in nursing, Professor Fiona Nolan, and see members of our outstanding nursing teams from CAISS and Gloucester House profiled in Mental Health Practice.

This year marked the first full year that the Charing Cross gender identity clinic (GIC) was under our auspices, and we were proud to have clinicians from the GIC contribute to new guidelines for speech and language therapists working with trans and gender-diverse people across the UK, published by the Royal College of Speech and Language Therapists.

An election was held to determine the latest additions to our council of governors. We were delighted to have such a strong field of candidates put themselves forward, and we look forward to working closely with our new and continuing governors as we enter a new year.

Paul Jenkins
Chief Executive

28 May 2019

Overview

This section of the annual report provides a short summary about our organisation, its history, our purpose and how we have performed against our strategic objectives and the risks to achieving these.

Our history

Our organisation was formed following both the Tavistock Clinic, founded in 1920, and the Portman Clinic, founded in 1933, being merged in to an NHS trust in 1994. We achieved authorisation as an NHS Foundation Trust in November 2006.

Our purpose

We are a specialist mental health trust with a focus on training and education alongside a full range of mental health services and psychological therapies for children and their families, young people and adults.

We are committed to improving mental health and emotional wellbeing, believing that high quality mental health services should be available for all who need them. We bring a distinctive contribution based on the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the promotion of health and the prevention and treatment of mental ill health

We contribute to the pool of ideas through our own research and development, but are also committed to bringing together the best ideas of the time, old and new, from inside and out, together with the most gifted and able professionals in our fields of endeavour. We aim to share our ideas and practice through as many routes as possible.

As a Trust we aim constantly to be evolving in nature and form in relation to the environment in which we work, to ensure that our contribution remains relevant.

How we operate

As an NHS foundation trust, we are accountable to Parliament and regulated by Monitor, operating under the name NHS Improvement. We are part of the NHS and must meet national standards and targets, but we have more financial freedom to retain surpluses and choose how we reinvest this money. Our governors and

members ensure that we are accountable and listen to the needs and views of our service users.

As a small specialist provider trust we have a number of roles in the health and care systems, these include:

- Providing health services to our local population in Camden;
- Delivering a number of specialist services which can be accessed by any individual across England;
- Providing education and training in a range of health and care subject areas, some commissioned by Health Education England; and
- Leading on research and innovation in both formally commissioned studies and locally driven innovation path finding.

To deliver all of the above we are structured in to two clinical directorates and a directorate of education and training which are all supported by a number of corporate support directorates.

Each year we develop and implement strategic objectives which set the direction for us to achieve our long term ambitions. In 2018/19 we set 17 objectives aligned to four thematic areas, these were:

- People;
- Services;
- Growth and development; and,
- Finance and governance.

Strategic and operational risks

The Trust has a robust approach for managing both its strategic and operational risks. The strategic risks to achieving the organisation's strategic objectives are captured on our board assurance framework and reported to the Board of Directors four times a year. We provide further information on our approach to risk management in the annual governance statement.

A number of operational risks have also been identified which have a high score and as such the Board should be sighted on. These include the risk that:

- Imposition of income reductions for the FNP National Unit will result in a decline in the services ability to meet its requirements.
- That ongoing delays to the procurement of a new information system for FNP will result in challenges in recording and reporting.
- That the FNP contract will cease after March 2020.
- The provision of power capacity and resilience to ground floor and level 5 data centres may impact on clinical and education service delivery.
- Lone working arrangements for estates and facilities staff and contractors may result in an incident.
- Limited levels of appropriately qualified staff for hard service may impact on the organisation's ability to remediate urgent issues.
- There is an elevated and increasing level of backlog maintenance.

Going concern disclosure

After making enquiries the directors have a reasonable expectation that the 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.

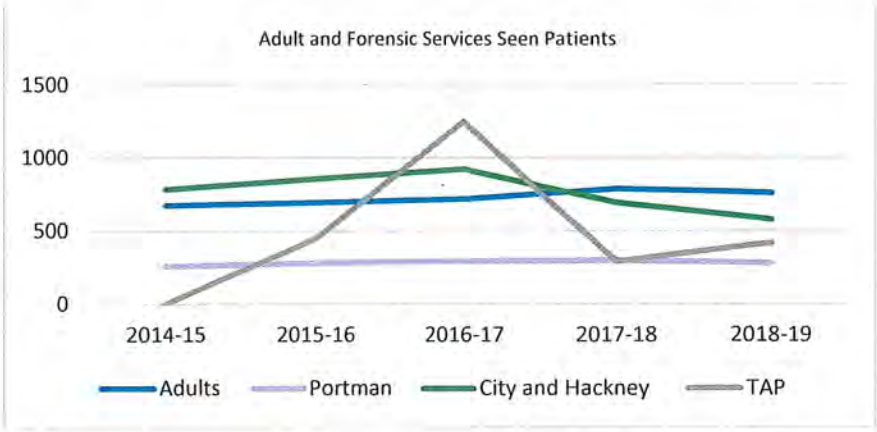
Performance analysis - clinical

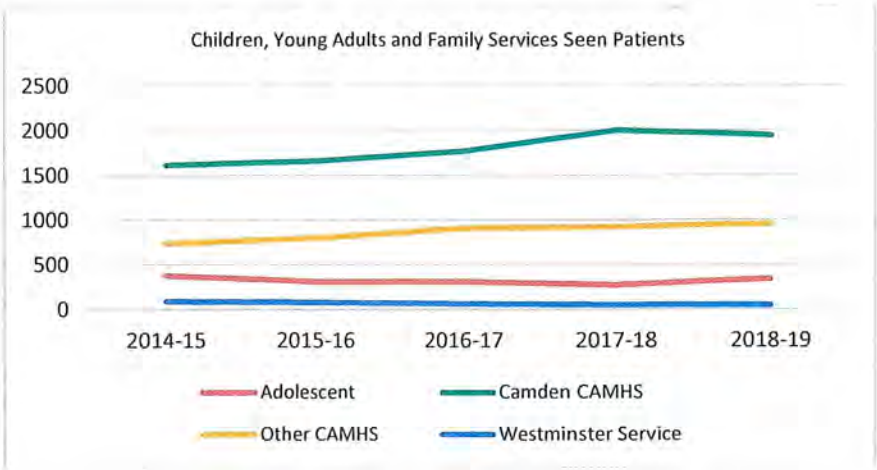
The Trust's performance is monitored against key national and local standards. In addition, our Board of Directors reviews progress against a range of internal and external metrics through our integrated quality dashboard report each quarter. This quarterly dashboard is considered alongside our operational risk register and board assurance framework at varying intervals to triangulate our performance and assessment of risk and uncertainty.

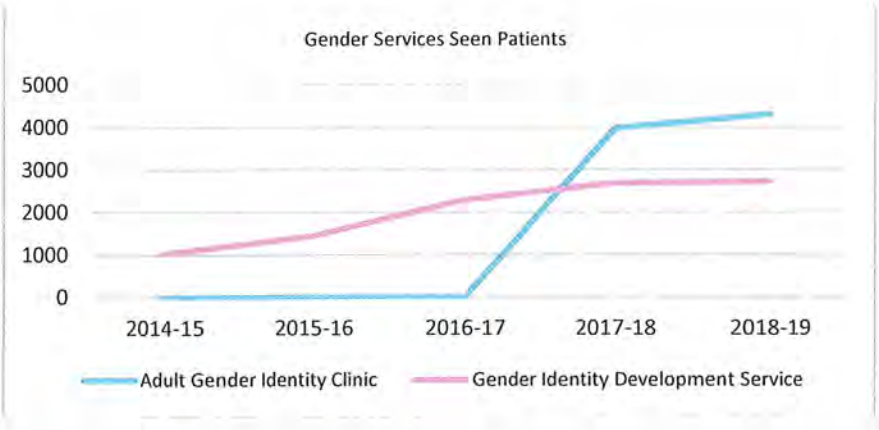
The following sections detail our organisation's key performance indicators and areas of performance.

Trust reach

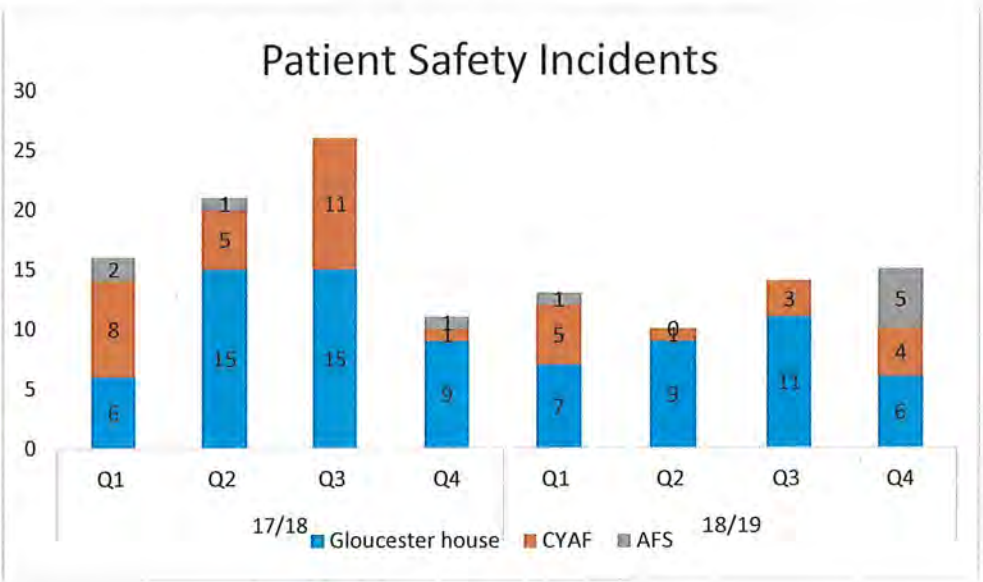
The Trust has seen a similar number of patients to last year (2017/18). As can be seen gender services and our primary care service team around the practice (TAP) have seen more patients in response to increased demand.







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.

An electronic incident reporting system was introduced during the year and this has seen a 26% increase in the number of incidents reported with the majority (95%) resulting in 'no' or 'low' harm. For the 5% which did result in other levels of harm these related to a number of serious incidents which we describe more fully in the quality report.

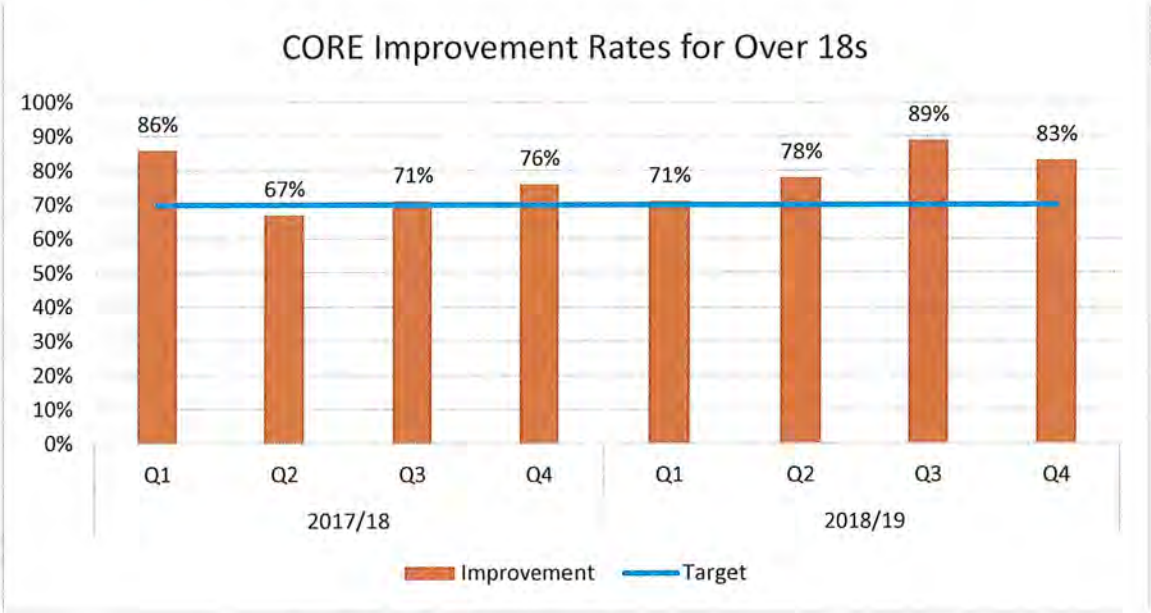
Gloucester House continues to report over half of the Trust's incidents (53%), this proportion has reduced from 64% last year owing to increased reporting across the Trust. Incidents at Gloucester House are due mainly to reporting of violence to staff and damage to property and all are discussed at the end of the school day with

senior staff. The 'patient safety incidents' section of the quality report provides more information on this area.

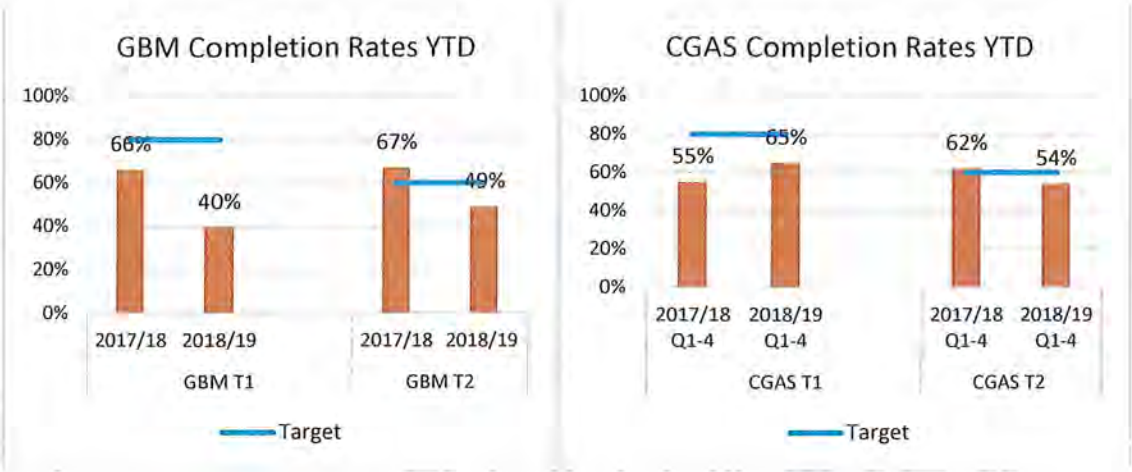
All serious incidents are reported to the Board and the full investigation reports are considered by the clinical, quality, safety and governance committee which provides assurance to the Board about the adequacy of the investigation and the associated action plan to address any lessons learned. The lessons learned from both incidents and complaints are shared with the relevant team, and also at induction and mandatory training events. Two Trust-wide 'learning from incidents' events have been held during the year.

Outcomes

The Trust monitors the outcomes of care being delivered to patients. An overview of our quality indicators for 2018/19 can be found in the quality report along with full details on our compliance against the quality priorities we agreed for 2018/19.



We met our target of 70% improvement rate for the Clinical Outcomes Routine Evaluation measure (CORE) by quarter 4 with 83% of patients who completed the measures displaying improvement after receiving treatment.



We did not meet the target to collect an initial time 1 (T1) goal based measure (GBM) score from all relevant patients in 2018/19 with 40% against a target of 80% but saw a slight increase in the collection of review scores paired GBM - time 2 (T2) by to 49%, when compared to the previous year.

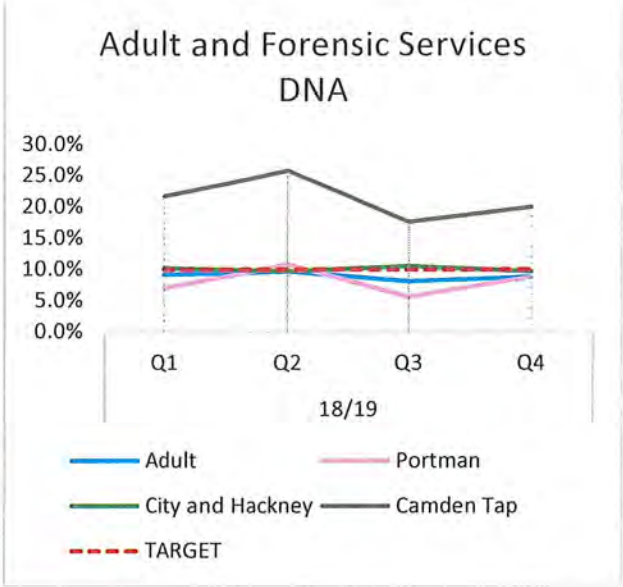
Initial completion of the children's global assessment scale (CGAS) was under the 80% target but was an increase on last year with only 65% of relevant patients completing this. However, of those who had completed the initial measure 54% completed the second review (paired CGAS).

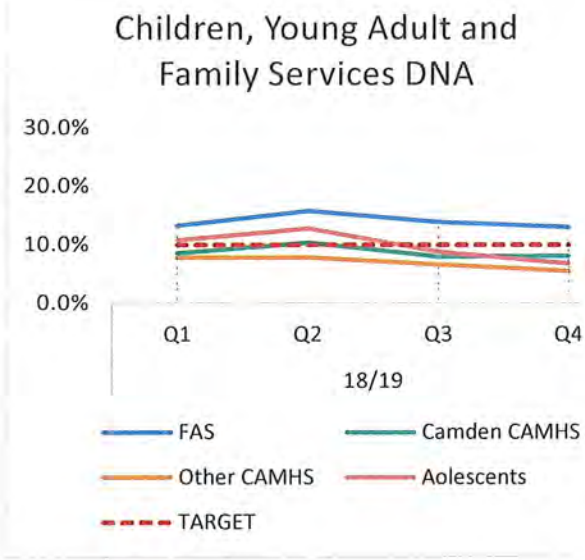
For 2019/20 the Trust will work across children's services to improve not just the completion of both GBM and CGAS measures but to ensure that data is in a format that can be easily shared with patients and carers. To provide timely feedback on their progress and opportunities for review. This is one of the Trust's quality priorities.

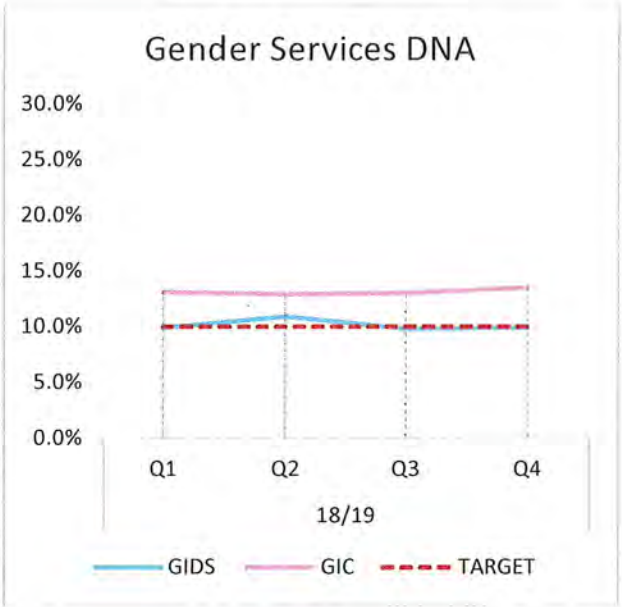
Service responsiveness

Our experience of service questionnaires showed that 98% of patients rated the overall help they had received as good and 98% would recommend the Trust to others.

Did not nttend (DNA) rates are expected to be no higher than 10%. The overall Trust rate at the end of March 2019 was 8.7%. The graphs below show an increase in rates for quarter 4 for the Portman Clinic, GIC and TAP services but all others are seeing a decrease. During the year we have invested in an SMS text reminders solution for patients in a number of our services to help reduce DNAs. This facility will be introduced to more services during 2019.


Adult and Forensic Services DNA
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Q1
Q2
Q3
Q4
18/19
Adult
Portman
City and Hackney
Camden Tap
TARGET

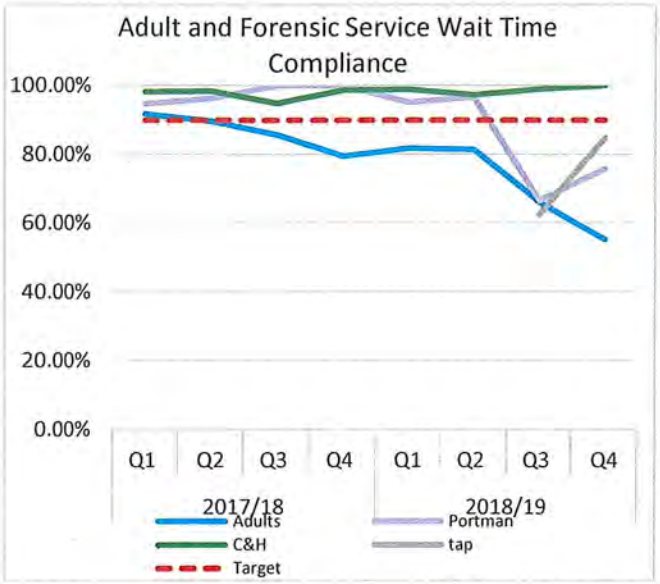

Children, Young Adult and Family Services DNA
30.0%
20.0%
10.0%
0.0%
Q1
Q2
Q3
Q4
18/19
FAS
Camden CAMHS
Other CAMHS
Aolescents
TARGET

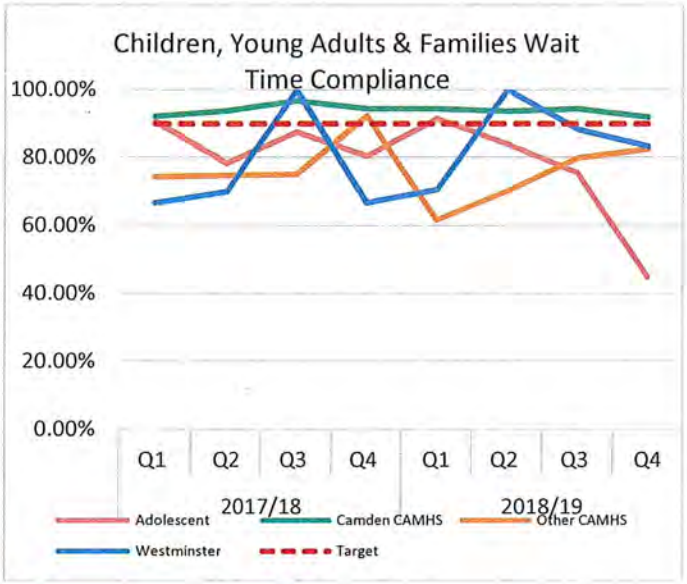

Gender Services DNA
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Q1
Q2
Q3
Q4
18/19
GIDS
GIC
TARGET

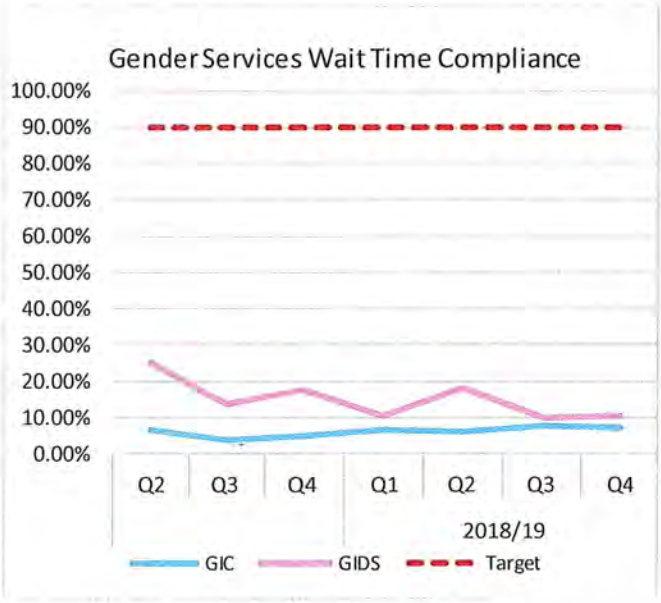
Waiting Times

In many services, patients are seen within our waiting time targets and in some services well before the target date. Waiting time targets vary between the various services.

The graphs below show compliance during this year and the previous year for the various services in respect of their particular waiting time requirements. 90% are meant to be seen within that time, which is the red dotted target line.



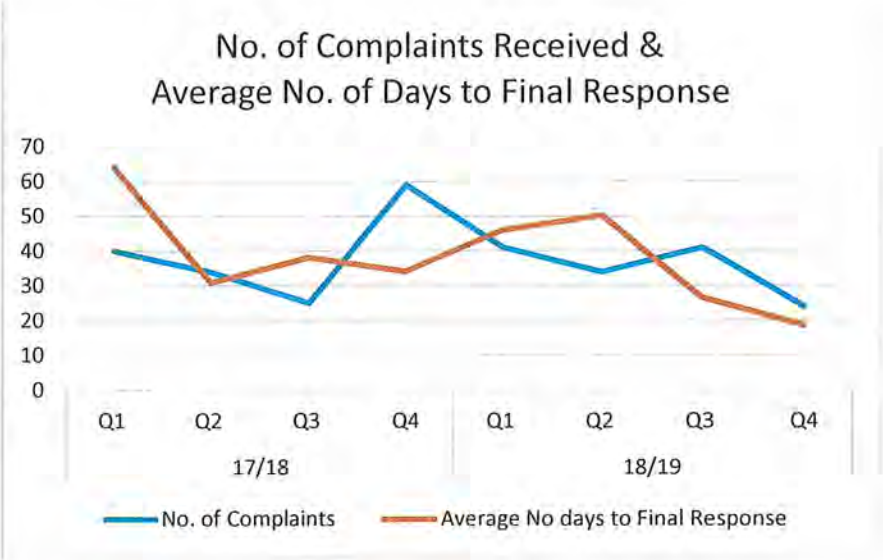




Over the year, we have seen a significant improvement in waiting times in TAP services and a steady increase in other CAMHS. We are pleased that even with the

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 two years, particularly in quarter four of 2017/18. These were due to a change in administrative processes at the Charing Cross gender identity clinic service. The decrease we have seen more recently in complaints was as a result of these administrative processes becoming established and improving the service for our patients. Action plans are in place for complaints where the outcome is 'upheld' or 'partially upheld'.

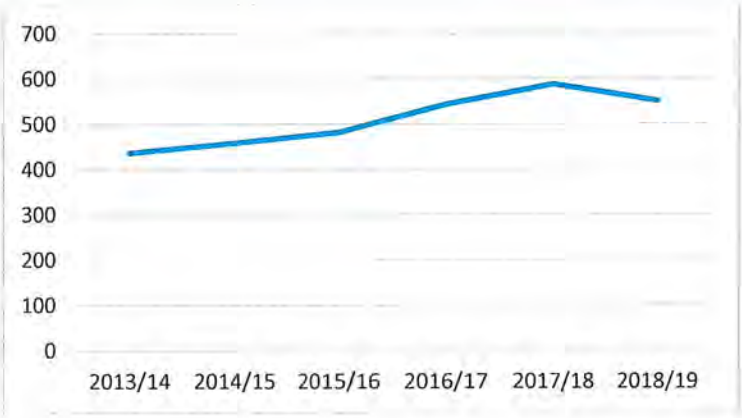
In general we are pleased that patients feel that they can raise concerns with us and provide us with opportunities to improve where possible. We continue to look carefully at all complaints, formal and informal, to establish whether they point to persistent problems within our services.

Performance analysis - 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.

Student numbers have remained strong despite challenging conditions across the postgraduate and non-university higher education sector. This year saw a small dip in new enrolments, however the number remains higher than the years preceding 2017/18. The Trust offers a unique portfolio of clinically led programmes offering students the opportunity to train under the guidance of practicing staff. Provision extends from introductory Trust Certificates through programmed pathways of increasingly specialised postgraduate courses leading to accreditation in a variety of professions.

Year 1 students enrolled (excluding national centres)						
Academic Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Number of Students	437	459	482	544	589	552



The implementation of the DET student information and management system (MyTap) has been completed and is driving process enhancement to improve productivity and efficiency. This will improve the service and communication to students as well as support for teaching staff. The system has already shown benefits with a marked improvement with managing assessment processes and providing information to exam boards. Ongoing work is focussed on the rapid production of data for stakeholders and partner organisations.

Work is continuing with the Trust's university partners. All students on taught programmes validated by University of East London (UEL) have now completed as

required by the teach-out. Doctoral students are continuing with UEL until 2024. The Trust is enhancing the partnership with the University of Essex who is now the validating body for all taught higher education students, apart from the Joint Qualifying Masters in Social Work with the University of East London. The first cohort of MA students have now completed and graduated and the first round of periodic course reviews are taking place in the Psychoanalytic Applied portfolio.

In addition to its long course provision, DET delivered over 100 continuing professional development (CPD) short courses. This portfolio included the development of bespoke training courses for the specialist perinatal mental health NHS workforce, national mental health and social welfare training for both public and private organisations, and a successful programme of visits for international healthcare providers keen to learn more about the Trust and its teaching and learning provision.

With the support of Health Education England, through the National Training Contract, we continue to focus on developing and delivering quality and relevant educational programmes that positively impact patient care and organisational capability. We strive to enhance our contribution to broader workforce issues, and our collaboration with the National Workforce Development Skills Unit has provided us with a rich opportunity to achieve this. In addition, the Trust's participation in the Mental Health Workforce Development Collaborative continues to create opportunities for genuine collaboration and joint working to deliver the best possible outcomes for workforce planning and development nationally.

Widening our geographical reach remains an ambition. In the aim of increasing efficiency and efficacy we have undertaken a review of our national centres. One of the outcomes of this review was a recommendation to establish a national centres steering group with the aim of facilitating more organisationally focused dialogue and the sharing of best practice, including possible synergies between the centres. We have taken significant steps in working towards making our educational provision more inclusive and accessible to a more diverse student group. We have appointed a DET Diversity Lead as well as increasing the number of CPD events for staff focusing on equalities and power issues in the learning process. We have also developed a library resource dedicated to diversity texts. There has recently been a Thinking Space event for DET staff focusing on supervision and race and we are planning some student events focusing on papers / lectures on diversity. The LGBTQi and BAME student groups continue to run.

The Trust has made significant headway in realising several of its supporting objectives to develop learning and teaching this academic year. Since its inception,

The Trust's accredited Advance Higher Education Fellowship Recognition Scheme has seen 11 staff members successfully achieve fellowship: one Associate Fellow; seven Fellows; and, three Senior Fellows. Following a constructive annual review with Advance HE, planning is underway for the next annual cycle of applications, with work continuing to embed the process institutionally and to further enhance the internal process. Following on from last year's successful launch of the Foundation programme in Learning & Teaching for the nursing discipline, relevant staff will be eligible to apply for Associate Fellowship of the Advance HE.

The Trust has offered its third year of learning and teaching CPD seminars for staff, to help develop their skills, and support them in applying for fellowship of the Advance HE. Uptake has increased this year and momentum is building. The 2019-20 programme of Learning and Teaching CPD will be launched at the fourth annual learning and teaching conference in June - learning from our learners. Expressions of interest were sought from students asking them to meet with the organisers of the Conference to think about possible themes for parallel sessions. This student input has been key in shaping the programme for this year. 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 Keynote presentation will be given jointly by Professor Dominic Micklewright, Dean of Partnerships, University of Essex, and Katie Argent, Portfolio Manager & Consultant Child and Adolescent Psychotherapist, Tavistock and Portman NHS Foundation Trust.

Our annual student survey is a key measure of performance for our education and training provision. The response rate has improved again to 59% giving confidence that the outcomes are reflective of our student population. Key indicators have remained in line with last year's survey and are in line with the national averages. Students continue to appreciate the content of Trust courses and the enthusiasm of staff. There was an improvement around the way in which issues around equalities and diversity are managed. Areas which require further work include aspects of assessment and feedback, communications and the research culture. These are being addressed through the appropriate committees which have drawn up action plans to implement improvements.

In November 2018, the Trust Board approved the initial phase of the Digital Academy project. This will be a key strategic initiative for the Trust, with the aim of developing an innovative set of online courses which reflect the key elements of our unique teaching model: learning through experiences, delivery by highly experienced clinician-trainers; and provision of a space for reflection.

The benefits of this teaching approach will be that it gives students the opportunity to learn from real experiences and translate new skills into everyday aspects of their work, at a pace and time that suits them, and with no restriction on location.

The Trust continues to be part of the review mechanism overseen by the QAA. Representatives will be visiting the Trust in April 2019 to meet with key staff and some students. The review by the QAA in 2018 had a successful outcome and affirmed that the Trust is continuing to make progress with the enhancement of its higher education programmes.

Performance analysis - financial

In 2018/19 the Trust has continued to deliver high quality services and deliver these within its financial resources.

	2018/19 £'000 Exc PSF	2017/18 £'000 Exc PSF	2018/19 £'000 Per Accounts	2017/18 £'000 Per Accounts
Income				
Clinical Services	30,127	27,694	30,127	27,694
Education and Training	22,741	21,370	22,741	21,370
Research	575	733	575	733
Other	654	1,114	654	1,114
PSF (Formerly STF)			2,225	2,183
Total	54,097	50,911	56,322	53,094
Expenditure				
Pay	(38,479)	(36,315)	(38,479)	(36,315)
Non-Pay	(13,286)	(12,344)	(13,286)	(12,344)
Total	(51,765)	(48,659)	(51,765)	(48,659)
EBITDA	2,332	2,252	4,557	4,435
Depreciation and amortisation	(1,228)	(957)	(1,228)	(957)
Bank interest	37	9	37	9
Other finance costs	(34)	(2)	(34)	(2)
Dividend to the DHSC	(616)	(595)	(616)	(595)
Retained surplus before impairment of fixed assets	491	707	2,716	2,890
Impairment of fixed assets	0	(90)	0	(90)
Retained surplus	491	617	2,716	2,800
EBITDA margin	4.3%	4.4%	8.1%	8.4%
Net surplus margin	0.9%	1.2%	4.8%	5.3%

Provider sustainability fund (PSF) income in the year was £2.2m (17/18-£2.2m). As this income is considered to be non-recurring and is not within the Trust's control, the rest of this commentary refers to income and expenditure excluding PSF income.

Income has increased by £3.2m (6.3%), whilst operating costs also increased by £3.1m (6.4%) driving an increase in EBITDA of £0.1m.

The increase in income is principally within clinical services (£2.4m, 8.8% annual increase) and, primarily, within the children, young adults and family services directorate, compensating for a smaller decline in adult forensic services.

Continuing increases in both of our gender services and the commencement of new services and projects, such as CAMHS trailblazers and child house, have driven an increase in revenue.

The decrease in income for adult forensic services is mainly the result of the reduction in the Camden team around the practice (TAP) contract, although this is offset, in part, by the start of the forensic CAMHS service.

Increases in education and training revenue (£1.4m - 6.4% annual increase) are driven by increases in grants from Health Education England. This has compensated for an ongoing reduction in the National Training Contract.

The £2.2m (6.0%) increase in pay-related costs reflects the 0.31% increase in staff numbers (from 644 to 646 full time equivalents); the Agenda for Change (3% in-year) pay award; and annual pay increments. The increase in staff numbers reflects, primarily, the expansion of services within the child, young adult and family services directorate and greater utilisation of administrative and clerical bank staff.

The cost of employing agency staff is up on the prior year - £866k (17/18 - £574k) and is also above the Trust's NHS Improvement agency ceiling. These costs represent 2% of the Trust's pay bill and have covered project roles or absences in key positions during ongoing restructuring.

Non-pay costs have increased by £942k (7.6%) which is the result of consultancy expenditure reflected, in particular, to the use of third parties to provide services for one-off projects and increased investment in estates.

Depreciation and amortisation have increased by £271k or 28% (17/18 - £957k) reflecting ongoing investment by the Trust in capital projects, notably the introduction of a scheduling solution (Oct 18), refreshing the Trust's network infrastructure (Jan 19) and the full year effect of the student information system (completed in Mid-17/18).

The Trust's control total for 2018/19 was £1,034k (including PSF monies of £703k). The Trust achieved a control total of £2,716k (of which £2,225k was PSF monies).

Performance analysis - sustainability and environment

The Tavistock and Portman NHS Foundation Trust is committed to meeting its targets for the Carbon Reduction Commitment for Public Sector Organisations. The Board is aware of the pressures within public sector organisations 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 2018/19 were to:

- Continue investment in energy reduction lighting in areas not already addressed;
- Maintain zero waste to landfill and investigate means of rebalancing towards recycling;
- 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; and,
- Continue with our commitment to energy reduction and reduced car use.

Over the course of 2018/19 the Trust continued with its programme to replace old florescent lighting with LED efficient lighting across more of our highest use areas.

General energy consumption remains low. This has been achieved, in part, from the more temperate conditions and due to system modifications made to hot water circulation and calorifier replacement. We have also trialled energy efficient systems that remove the need for kettles and water coolers.

Our environmental management results are categorised as:

ITEM	Procurement	Energy Performance	Water Consumption	Waste Management	Transport Management
CATEGORY	B	A(C)	B	B	C

It should be noted that whilst energy scores as grade A this is against the Estatecode calculation method, and when this is normalised for Tavistock and Portman (not a 24/7 unit) the score is C.

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 appropriate professional assessment of its environmental impact at end of year and this section is in line with those findings.

The Trust's environmental impact remains proportionate to both the number of people it employs and the floor space of the Trust's buildings.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Direct Emissions (tCO_2e)	510	725	643	630	620	613
Floor Space (m^2)	6,733	8,347	8,347	8,347	8,347	8,347
Number of Staff (FTE)	472	479	485	485	444	546

This data has been used to normalise our direct emissions and compare progress against our target of 34% reduction by the end of 2019/20. It can be seen from the figures above 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 has, therefore, continued work related to the placement and better utilisation of recycling bins. In addition, the Trust seeks to ensure that its contracts contain strong environmental clauses that support zero to landfill across the supply chain.

Regarding our effort to reduce car travel, through the promotion of other modes of commute, the Trust is looking to invest in rapid charging points for Electric Vehicles (EV) and has improved facilities for storage and drying of clothing for those choosing to cycle, walk, run etc.

For the 2019/20 year, the Trust intends to continue its 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, focusing on procurement processes;

- End of life asset replacement to most efficient units (boilers in smaller freeholds etc.);

- Continued commitment to energy reduction and reduced car use and the installation of rapid EV charging (subject to Government grant aid); and,

- Increased awareness of cultural choices that materially support the reduction in our carbon presence.

Social and community work

The Trust's patient and public involvement service is responsible for supporting the organisation to engage with those that use our services, their carers and other parties that have an interest in our work.

In the reporting period the Trust reviewed the service's strategy and re-affirmed its commitment to continuing with this important work area. Within that strategy review it is clear that our activities around communication, consultation, collaboration and co-design makes a significant difference to the care and services that our users and their families receive. This is evidenced through our outcome measures and positive feedback which we expand on in the quality report.

Anti-bribery

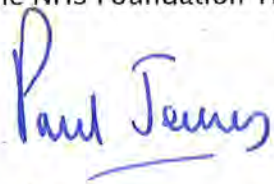
The Trust has in place an anti-fraud and bribery policy which was co-authored with the Trust's counter fraud service. The policy makes a Board level commitment to taking preventative and reactive steps to ensure that we have adequate and appropriate controls in place.

Human rights

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

Important events

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



Paul Jenkins
Chief executive and accounting officer

28 May 2019

3 Accountability report

The accountability report is made up of the following sections.

Within the accountability report the following sections or tables have been subject to external audit.

Directors' report

The Tavistock and Portman has performed well both operationally and financially during 2018/19 which was another busy and demanding year. Our staff continue to provide high levels of care and education and that is demonstrated through our performance in what has been a challenging financial context.

Delivering high quality care

We are a specialist mental health provider organisation with a wide range of services, our commitment to delivering high quality and safe care is described in our mission and values and demonstrated through strong operational performance and staff experience.

In 2018/19 we underwent a planned services and well-led inspection led by the Care Quality Commission. As a result the national regulator rated our services as good overall and upgraded our effectiveness rating to outstanding. This marked a very significant achievement and we are proud that the hard work and innovative practice of our clinical staff was recognised. We describe further in the annual governance statement our approach to maintaining the well-led standard requirements.

The NHS staff survey also gave us a number of positive indicators about the organisation's top priority being patient care and that people working at our Trust would advocate receiving treatment at our organisation to their friends and family.

Our local and national role

Whilst being one of the smallest provider organisations in the NHS we have extremely diverse contracting arrangements for the services we deliver. What makes us very different is that we are also a major provider of education and training providing courses and programmes ranging from short continuing professional development through to professional doctorates.

We provide a range of services to our local population in Camden, we are the largest children and young people services provider in the borough and we also are contracted to provide a range of adult specialist and primary care services locally.

Building on our rich history we are also fortunate to deliver a number of nationally commissioned specialist services which include our adult and children gender services and the Portman Clinic.

Commercial partnerships and ventures

The Trust continues to provide external consultancy services through our commercial trading division, Tavistock Consulting. The service was created in 1994 and sits within our directorate of education and training.

As a small organisation we have a range of partnership arrangements in place to support the delivery of clinical and education services. The Trust has an agreed protocol for establishing partnerships and retaining oversight of these through operational management.

North London Partners in Health and Care

Whilst being a specialist provider with a national role, we play an active part in our local sustainability and transformation partnership. Throughout the year we have actively contributed to footprint's work and our chief executive remains to be the senior responsible officer for the mental health workstream.

Our plans for our estate

For some years we have recognised that the Tavistock Centre is stretched to capacity and its design presents us with a number of challenges in a context where we wish to pursue growth both in our clinical services and our education and training endeavours.

We continue to actively explore the possibility of relocating to an alternative site within the London Borough of Camden, however, progress on this has been slower than hoped as the Trust seeks to deal with challenges surrounding affordability, notably land sale valuations and the impact that Brexit has had on construction costs.

Due to changes in market conditions, notably the valuation of the Trust's freehold properties, there currently exists a gap between the proposed costs (to complete relocation) and the capital receipts or income which the Trust has available to it. The Trust is undertaking a number of initiatives to close this funding gap. It is the

judgement of the Board of Directors that relocation of the Trust continues to be probable and, therefore, appropriate to continue to capitalise these costs. Should the expectations of the Board not be fulfilled, then the value of the said asset would need to be written off.

In order to find an answer to these affordability issues, in March 2019, at a joint meeting of our Board of Directors and Council of Governors, we made the decision to commence a process of competitive dialogue with commercial and not-for-profit providers to explore potential solutions. This programme of work will continue during the next financial year with a final decision about relocation in late 2020 or early 2021.

Board of directors

In 2018/19 members of the board of directors comprised of the following executive directors: chief executive, Paul Jenkins; deputy chief executive and finance director, Terry Noys; director of adult and forensic services, Julian Stern; director of children, young adults and family services, Sally Hodges; director of education and training / dean of postgraduate studies, Brian Rock; director of quality and patient experience, Louise Lyon; medical director, Rob Senior (until 31 July 2018); medical director, Dinesh Sinha (from 13 August 2018); and, director of nursing and system workforce development, Chris Caldwell.

And the following non-executive directors: Trust chair, Paul Burstow; Dinesh Bhugra, deputy chair; David Holt, senior independent director; and, non-executive Directors, Deborah Colson, Helen Farrow and Jane Gizbert.

Biographies for the board members can be found on page 73.

All of the members of our board of directors meet the standards set out in the fit and proper person requirement.

There was one declaration of interest from Jane Gizbert, non-executive director at the board of directors meeting on 27 November 2018 which could be deemed as a conflict of interest, as a result she refrained from debate on a matter concerning the Trust and the National Institute of Health Care Excellence. The Trust maintains a register of all interests that directors and governors hold and published this on the organisation's public website.

There have been no declarations of donations to political parties.

Performance evaluation is an integral component of our governance structures and is aligned to the NHS Improvement well-led framework. Each year the Board assesses its effectiveness during formal meetings and through developmental seminars. Each of the Board's standing committees conduct annual effectiveness reviews and the terms of reference are revisited, the outcomes of these reviews are reported to the Board of Directors when they have been concluded. Further details on our processes for performance evaluation, internal control and governance are detailed in the annual governance statement and the quality report.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditor, and members of the Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed on to the external auditors where appropriate.

Payment practice

Better payment practice code				
Measure of compliance	Year Ended 31 March 2018		Year ended 31 March 2019	
	Number	£000	Number	£000
Total bills paid in the year	6,557	23.2	6,255	22.6
– Of which were NHS invoices	227	1.8	232	1.4
– Of which were non-NHS invoices	6,350	21.4	6023	21.2
Total bills paid within target	5,782	21.6	5,000	20.1
– Of which were NHS invoices	156	1.3	152	0.9
– Of which were non-NHS invoices	5,626	20.3	4848	19.2
Percentage of bills paid within target	88%	93%	80%	89%
Percentage of NHS invoices paid within 30 days	69%	75%	66%	64%
Percentage of non-NHS invoices paid within 30 days	89%	95%	80%	91%

The Trust complies with the requirement of the better payment practice code to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance against the code is set out in the table above.

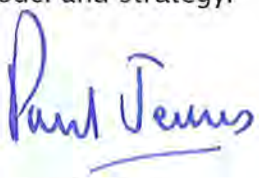
Statutory disclosures

The Trust meets the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for other purposes. For full details see Note 3.1 to the Annual Accounts.

Surpluses from other income that the Trust has received have been used to support the provision of goods and services for the purposes of the health service in England.

The directors confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury.

The directors are responsible for the preparation of the annual report and accounts. The directors also consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for service users, regulators and stakeholders to assess our performance, business model and strategy.



Paul Jenkins 28 May 2019

Chief executive and accounting officer

Remuneration report

Trust chair's annual statement on remuneration

As the chair of the executive appointments and remuneration committee (the committee), I am pleased to present our remuneration report for 2018/19.

There was one change to our Trust's remuneration policy for very senior managers in 2018/19, this was the introduction of performance related pay for two of our directors with a capped award level of £10,000.

Taking in to account the national pay settlement made to the NHS through the national terms and conditions of service and those that apply to the medical workforce, the committee approved that all senior managers within its remit should receive a cost of living increase consistent to those employed on the top of the Band 9 scale.

Having undertaken appropriate benchmarking using comprehensive data from NHS Providers, the committee agreed that there should be no further changes to executive director salaries or remuneration arrangements.

There was one change to the executive team during the year, Dr Robert Senior retired from his medical director position and was succeeded by Dr Dinesh Sinha who joined the Trust in August 2018 from East London NHS Foundation Trust.

Professor Paul Burstow 28 May 2019
Trust Chair and Chair of the
Executive Appointments and Remuneration Committee

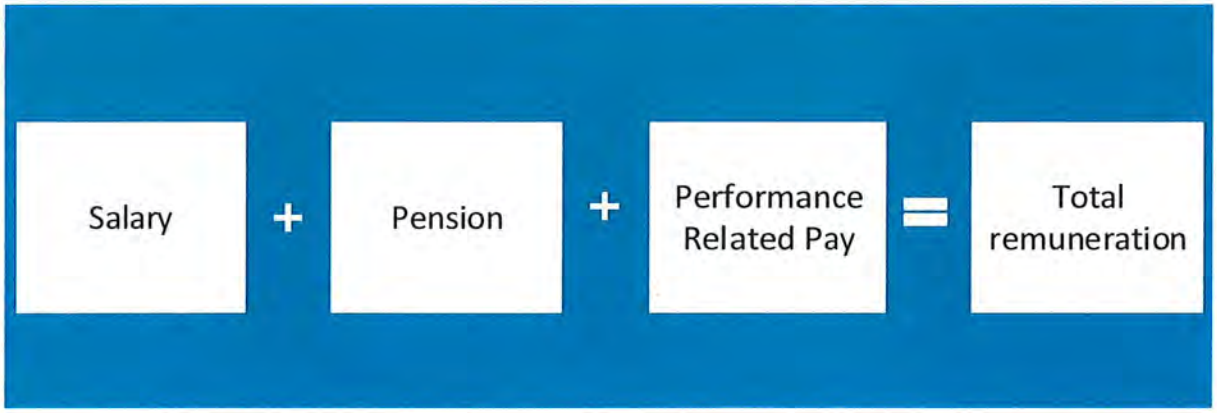
Remuneration policy report - 2018/19

Senior managers' remuneration policy

Remuneration for the Trust's most senior managers (executive directors who are members and regular attendees of the Board of Directors) is determined by the executive appointments and remuneration committee, which consists of the trust chair and all non-executive directors. Senior managers who do not attend the Board of Directors have their remuneration determined by the chief executive and deputy chief executive.

The executive appointments and remuneration committee is also responsible for ratifying any performance related pay scheme for all senior managers.

The total remuneration of each of the executive directors comprises of the following elements:



The Trust's remuneration policy for each of the elements above are outlined in the following table.

	Salary	Pension	Performance related pay
Purpose and link to strategy	To provide core reward for the role. Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.	-	Objectives are set for directors aligned to the Trust's strategic priorities. Payment against this scheme is dependent on achievement of objectives to a satisfactory standard.

	Salary	Pension	Performance related pay
Operation	When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Executive director salaries are inclusive of a High Cost Area Supplement. Salary increases typically take effect from 1 April each year.	Executive directors are eligible to receive pension and benefits which are applicable to all other staff. Pension arrangements are in accordance with the NHS Pension Scheme. There are no cash alternatives. The NHS Pension Scheme is made up of three parts. These are the 1995, 2008 and 2015 schemes. Newly appointed directors are enrolled in to the 2015 scheme, unless protection arrangements apply to them.	The scheme is operated for senior managers whose remuneration is set towards the lower end of benchmark ranges. Each senior manager is set a number of objectives through the annual appraisal process. Achievement of those objectives may result in a performance pay award being recommended.
Opportunity	There is no formal maximum limit, however salary increases will ordinarily be in line with increases for the wider NHS workforce (not including incremental progression increases) as recommended by the NHS Pay Review Body. Increases may be higher to reflect a change in the scope of an individual's role, responsibilities or experience. Where a new executive director has been appointed to the Board on a salary lower than the typical Trust level for such a role, the salary may be reviewed as the executive director becomes established in the role. Salary adjustments may also reflect wider external market conditions. Salary levels for 2018/19 are set out in the single total figure table in the annual report on remuneration.	Existing executive directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions . Details of the 2018/19 pension benefits of individual executive directors are available in the single total figure table in the annual report on remuneration. Total pension entitlement for each executive director is available in the total pension entitlement table.	For director's who are eligible for this scheme, the maximum earnable performance related pay is £10,000. The level of award is dependent on achievement of objectives. Payments awarded through this scheme are non-consolidated, non-pensionable and non-contractual.
Performance measures	The overall performance of the individual is considered when review salaries are undertaken. This is managed	There are no performance measures.	The overall performance of the individual is considered when review salaries are undertaken. This is managed

Salary	Pension	Performance related pay
through the annual appraisal process.		through the annual appraisal process. Examples of measurable objectives include factors such as achieved income growth, service developments or other measurable outputs. Performance pay awards are made on the basis of achievement of objectives (pro rated if some but not all objectives are achieved).

Salaries for senior managers are established and maintained taking the following factors in to account:

- The role;
- The individual's experience;
- Performance in post; and
- Benchmarking data from the NHS Providers annual salary survey.

Senior managers are employed on substantive, open ended contracts of employment and they are employees of the Trust. Their open ended contracts may be terminated by either party giving three months' notice.

The Trust's normal employment procedures apply to directors, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with the NHS redundancy terms for all staff.

There have been no circumstances in the financial year where senior manager remuneration has been withdrawn or withheld.

Differences between remuneration for senior managers and other staff

The key difference between the remuneration of executive directors and other staff is that salaries for senior staff are a fixed personal salary determined by conducting

cross market and skills benchmarking. All other staff are employed on terms and conditions determined nationally and which have a salary scale assigned to it.

Another difference is that senior managers' fixed salaries are inclusive of a high cost area supplement, ordinarily payable to staff based in inner London. All other staff receive this as a separate pay element.

The remuneration committee references national cost of living awards when considering its annual pay awards to directors.

The Trust does not consult with its wider workforce on senior manager remuneration.

Annual report on non-executive remuneration - 2018/19

The remuneration and expenses of the Trust chair and non-executive directors are determined by the Council of Governors' nominations committee. The committee takes account of guidance issued by NHS Providers when determining non-executive remuneration and expenses.

Remuneration of the non-executive directors comprises of the following fee elements.

The policy for determining the level of fee is described in the table below.

	Fee	Responsibility fees
Purpose and link to strategy	To provide core reward for the role.	The fee is applied to office holders who: - Chair the audit committee; and, - Act as the senior independent director.

	Fee	Responsibility fees
Operation	The fee levels are a set rate for all of the non-executive directors. There are two types of fee in operation, one for the Trust chair and another for the non-executive directors.	The Trust chair nominates office holders to fulfil the two roles where fees are applicable. The council of governors is responsible for ratifying the appointments.
Opportunity	The fees are reviewed annually by the nominations committee. These are set against the role requirements and not the office holder fulfilling the appointment.	The fees are reviewed annually by the nominations committee. These are set against the role requirements and not the office holder fulfilling the appointment.
Performance measures	There are no performance measures set against the fees.	There are no performance measures set against the fees.

Executive appointments and remuneration committee

The executive appointments and remuneration committee is responsible for determining the remuneration, terms and conditions of all board attending directors. The committee is chaired by the Trust chair and all non-executive directors are members.

Executive appointments and remuneration committee membership and attendance	
Member	Actual / possible
Paul Burstow	3/4
Dinesh Bhugra	3/4
David Holt	4/4
Deborah Colson	4/4
Helen Farrow	4/4
Jane Gizbert	4/4

Both Paul Jenkins, chief executive and Craig de Sousa, director of HR and corporate governance regularly attend committee meetings to provide advice or services that materially assist the committee in the operation of its functions.

Other individuals may also be invited to attend executive appointment and remuneration committee meetings during the year. Executive directors and other committee attendees are not involved in any decisions, and are not present at any discussions regarding their own remuneration.

Median remuneration and fair multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The remuneration of the highest paid director compared to the median remuneration of the workforce was as follows:

Median remuneration and fair pay multiple		
	31 March 2018	31 March 2019
Highest paid director's total remuneration	£153,000	£156,258
Median total remuneration	£25,397	£26,398
Remuneration ratio	6.02	5.92

The calculation is based on full-time equivalent staff working for the Trust on 31 March 2019. Where staff are part time, their salaries have been annualised for the purposes of the median ratio calculation.

Service contracts

The following table contains details of the service contracts in place during 2018/19 for senior managers:

Service contracts - senior managers			
Senior manager	Date of service appointment	Unexpired term	Notice period
Paul Jenkins	Feb 2014	Open ended	Three months
Terry Noys	Oct 2016	Open ended	Three months
Sally Hodges	Nov 2015	Open ended	Three months
Julian Stern	Feb 2017	Open ended	Three months
Brian Rock	Jan 2015	Open ended	Three months
Louise Lyon	Mar 2008	Open ended	Three months
Robert Senior	Dec 2006 - Jul 2018	Open ended	Three months
Dinesh Sinha	Aug 2018	Open ended	Three months
Christine Caldwell	Nov 2016	Open ended	Three months
Craig de Sousa	Feb 2016	Open ended	Three months
David Wyndham Lewis	Apr 2017	Open ended	Three months
Rachel Surtees	Mar 2018	Open ended	Three months
Laure Thomas	Feb 2015	Open ended	Three months

Service contracts - non-executive directors			
Senior manager	Date of service appointment	Unexpired term	Notice period
Paul Burstow	Oct 2015	Two years and six months	Three months
Dinesh Bhugra	Nov 2014	One year and seven months	Three months
David Holt	Nov 2013	One year and seven months	Three months
Deborah Colson	Oct 2017	One year and Six months	Three months
Helen Farrow	Nov 2016	Seven months	Three months
Jane Gizbert	Nov 2014	Expired 31 Mar 2019	Three months

Expenses

The following table outlines the details of travel and subsistence expenses claimed by our council of governor members and senior managers.

Expenses claims	2017/18		2018/19	
	Number claimed	Value	Number claimed	Value
Council of governors	3	£1,976	3	£1,650.50
Senior managers	5	£1,624	8	£4,186.10

Salary and benefits of senior managers

The following tables contain details on the salary and benefits of the Trust's senior managers in 2017/18 and 2018/19.

There was one senior manager in both 2017/18 and 2018/19 who received remuneration of greater than £150,000, this was the chief executive. The levels of remuneration were deemed to be appropriate for the post holder based on external benchmarking which evidences the reward package is within the lower quartile grouping of the NHS Providers annual remuneration survey.

In line with the Data Protection Act 2018, all members have been consulted and consented to the disclosure of this information.

The NHS Business Services Authority's Pensions Division is still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Single total remuneration figure 2017/18

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	150-155
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	200-205
Hodges, S	Children, Young Adults and Families Director (CYAF)	105-110	0	0-5	0-5	0 - 2.5	105-110
Stern, J	Adult and Forensic Services Director (AFS)	135-140	0	0-5	0-5	75 - 77.5	210-215
Lyon, L	Director of Quality and Patient Experience	65-70	0	0-5	0-5	N/A	65-70
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	105-110	0	0-5	0-5	0 - 2.5	105-110
Caldwell, C	Director of Nursing	105-110	0	0-5	0-5	N/A	105-110
Smith, J (until September 2017)	Commercial Director	35-40	0	0-5	0-5	0 - 2.5	35-4
de Sousa, C	Director of Human Resources	75-80	0	0-5	0-5	27.5-30	95-100
Thomas, L	Director of Marketing & Communications	70-75	0	0-5	0-5	N/A	70-75

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
Wyndham Lewis, D	Director of Information Management & Technology	115-120	0	0-5	0-5	N/A	115-120
Paul, Burstow	Chairman	35-40	0	0-5	0-5	N/A	35-40
Farrow, H	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-10
Gizbert, J	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-10
Holt, D	Non-Executive Director	10-15	0	0-5	0-5	N/A	10-15
Murphy, E (until September 2017)	Non-Executive Director	0-5	0	0-5	0-5	N/A	0-5
Bhugra, D	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-10
Colson, D (from October 2017)	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-10

* The medical director is employed on the consultant contract terms and conditions of service which equates to £128,000 per annum.

Single total remuneration figure 2018/19

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	155-160	0	0-5	0-5	222.5 - 225	375 - 380
Noys, T	Deputy Chief Executive and Director of Finance	120-125	0	0-5	0-5	27.5 - 30	150 - 155
Senior, R (until Jul 2018)	Medical Director	45 - 50	0	0-5	0-5	0	45 - 50
Sinha, D (from Aug 2018)	Medical Director	50 - 55	0	0-5	0-5	0	50 - 55
Hodges, S	Children, Young Adults and Families Director (CYAF)	105-110	0	0-5	0-5	15 - 17.5	125 -130
Stern, J	Adult and Forensic Services Director (AFS)	110 - 115	0	0-5	0-5	0	110 - 115
Lyon, L	Director of Quality and Patient Experience	65-70	0	0-5	0-5	0	65 - 70
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	105-110	0	0-5	0-5	22.5 - 25	130 - 135
Caldwell, C	Director of Nursing	105-110	0	0-5	0-5	22.5 - 25	130 - 135
Surtees, R	Director of Strategy	75-80	0	0-5	0-5	0	75 - 80
de Sousa, C	Director of Human Resources	85 - 90	0	0-5	0-5	37.5 - 40	120 - 125
Thomas, L	Associate Director of Marketing & Communications	75-80	0	0-5	0-5	17.5 - 20	95 - 100
Wyndham Lewis, D	Director of Information Management & Technology	110-115	0	0-5	0-5	25 - 27.5	135 - 140
Paul, Burstow	Chairman	35-40	0	0-5	0-5	N/A	35 - 40
Holt, D	Non-Executive Director	10-15	0	0-5	0-5	N/A	10 - 15

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
Farrow, H	Non-Executive Director	5-10	0	0-5	0-5	N/A	5 - 10
Gizbert, J	Non-Executive Director	5-10	0	0-5	0-5	N/A	5 - 10
Bhugra, D	Non-Executive Director	5-10	0	0-5	0-5	N/A	5 - 10
Colson, D	Non-Executive Director	5-10	0	0-5	0-5	N/A	5-10

* The medical director is employed on the consultant contract terms and conditions of service which equates to £83,000 (R Senior) and £68,000 (D Sinha) per annum.

** Current and prior year pensions data was not provided for D Sinha nor R Surtees by the NHS Business Services Authority's pensions divisions. As a result these have not been incorporate in to the calculation of their pension benefits.

*** R Senior achieved maximum scheme membership in 2017 and as a result there are no pension disclosures for this senior manager.

Salary and pension entitlement 2017/18

Name	Title	Real Increase in Pension at Pension age (bands of £2500) £000	Real Increase in pension lump sum at Pension age (bands of £2500) £000	Total accrued pension at pension age 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000
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 (until Sept 2017)	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

Name	Title	Real Increase in Pension at Pension age (bands of £2500) £000	Real Increase in pension lump sum at Pension age (bands of £2500) £000	Total accrued pension at pension age 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000
Thomas, L	Director of Marketing & Communications	2.5-5.0	0-2.5	0-5	0-5	31	11	20
Wyndham Lewis, D	Director of Information Management & Technology	0-2.5	0-2.5	0-5	0-5	0	0	0

Salary and pension entitlement 2018/19

Name	Title	Real Increase in Pension at Pension age (bands of £2500) £000	Real increase in pension lump sum at Pension age (bands of £2500) £000	Total accrued pension at pension age 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019(bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000
Jenkins, P	Chief Executive	10-12.5	22.5-25	50-55	110-115	922	115	1059
Noys, T	Deputy Chief Executive and Director of Finance	0-2.5	0	5-10	0-5	42	21	82
Senior, R (until Jul 2018)*	Medical Director	0	0	0-5	0-5	0	0	0
Hodges, S	Children, Young Adults and Families Director (CYAF)	0-2.5	0	30-35	75-80	486	64	566
Stern, J	Adult and Forensic Services Director (AFS)	0-2.5	0-2.5	70-75	220-225	1724	0	0
Lyon, L	Director of Quality and Patient Experience	0	0	0-5	0-5	0	0	0
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	0-2.5	0	25-30	60-65	459	66	540
Caldwell, C	Director of Nursing	0-2.5	0	25-30	20-25	348	57	421
de Sousa, C	Director of Human Resources	0-2.5	0-2.5	15-20	25-30	127	41	180
Thomas, L	Associate Director of Marketing & Communications	0-2.5	0	5-10	0-5	32	13	55
Wyndham Lewis, D	Director of Information Management & Technology	0-2.5	0	5-10	20-25	101	22	138
Surtees,R**	Director of Strategy	0	0	0-5	15-20	0	0	44
Sinha, D (from Aug 2018)**	Medical Director	0	0	25-30	65-70	0	0	466

* Dr Senior reached maximum scheme membership in 2017 and as a result there are no CETV, accrued pension nor lump sum disclosures for the current nor prior year.

** CETV disclosures were requested of the NHS Business Service Authority's, pensions division, prior year CETVs were provided but no prior year information was returned. Accrued pension and lump sum information was not provided either.

Payments for loss of office and past senior managers

In the prior year there was one payment for loss of office to a senior manager.

There were no payments for loss of office to any senior manager nor were there any payments to any past senior managers in this financial year.

Paul Jenkins
Chief executive and accounting officer

Staff report

Staff numbers and costs

The following tables presents an overview of our workforce composition.

Average FTE staff numbers	Permanent 2018/19 No.	Other 2018/19 No.	Total 2018/19 No.
Medical and dental	53	-	53
Administration and estates	262	-	262
Nursing, midwifery and health visiting staff	21	-	21
Scientific, therapeutic and technical staff	239	-	239
Social care staff	29	-	29
Other	-	42	42
Total average numbers	**604**	**42**	**646**

Headcount by sex				
Sex	**Directors**	**Other senior managers**	**All other staff**	**Total**
Female	4	4	579	**587**
Male	7	4	178	**189**

Staff costs	2017/18 Total £000s	Permanently employed 2018/19 Total £000s	Other 2018/19 Total £000s	2018/19 Total £000s
Salaries and wages	28,821	30,157	111	30,268
Social security costs	3,335	3,333	-	3,333
Apprenticeship levy	-	267	-	267
Pension cost - employer contributions to NHS pension scheme	3,580	3,740	-	3,740
Pension cost - other*	5	-	5	5
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	225	357	-	357
Temporary staff - external bank	-	-	-	-
Temporary staff - agency/contract staff	574	-	866	866
TOTAL GROSS STAFF COSTS	36,540	37,854	982	38,836

Sickness absence data	Q1	Q2	Q3	Q4
Sickness absence - average monthly data	1.92%	0.87%	1.69%	2.34%
Sickness absence - average 12 month period	1.64%	1.51%	1.49%	1.70%

Communication with staff

The Trust is committed to ensuring that all staff are informed and can contribute to key developments, performance and change across the organisation.

With a highly engaged workforce we place a lot of importance on communicating and consulting with our staff. Our methods of communicating included holding monthly open forum meetings where staff can meet with the chief executive, a regular email bulletin to all staff, a bi-monthly staff magazine and an extensive intranet where staff can find policies, procedures, guidance and online tools.

We work in partnership with our staff side representatives to ensure that employees' voices are heard. The joint staff consultative committee meets quarterly acting as an important forum for key developments affecting staff.

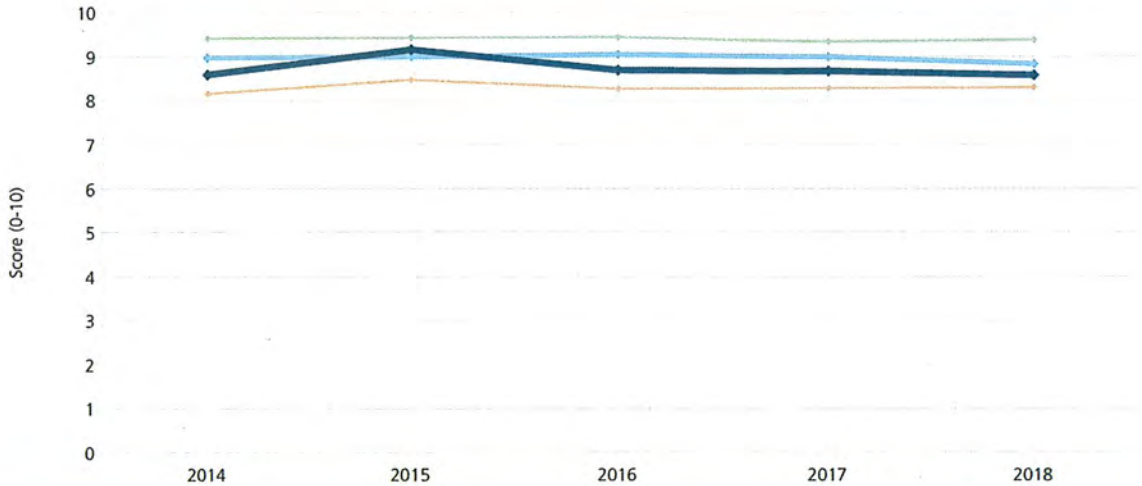
Staff survey

For a fourth year running we offered all staff employed by the Trust the chance to participate in the annual NHS staff survey. The national survey was conducted online and we received our highest ever response rate with 60% of eligible staff participating, this was an increase from the previous year when we achieved 56.4% participation.

Of the ten new survey theme areas, we ranked the best performing in two areas these being staff environment - violence and staff engagement.

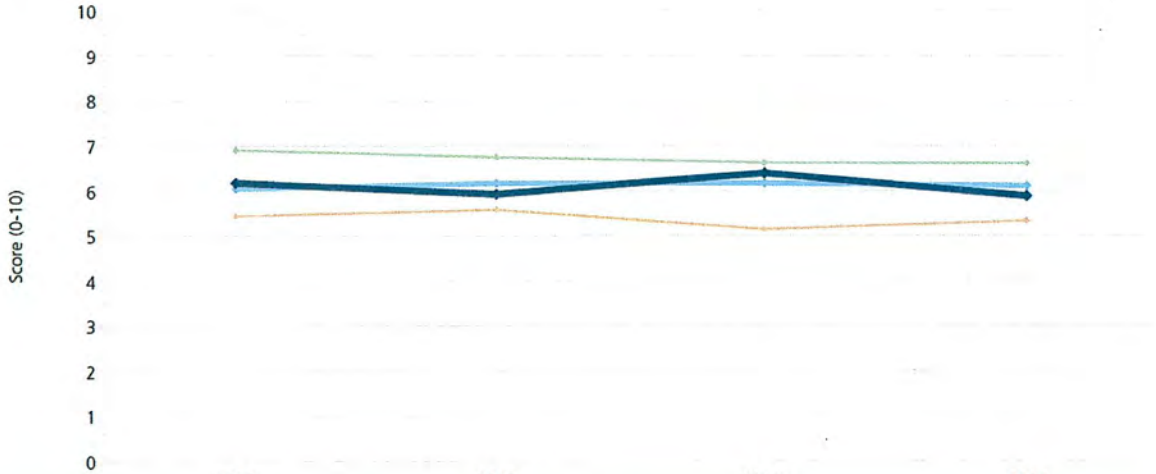
The charts below detail our staff experience data across the ten theme areas including data on the best performing, worst performing, average within our peer group and our results data.

Equality, diversity and inclusion



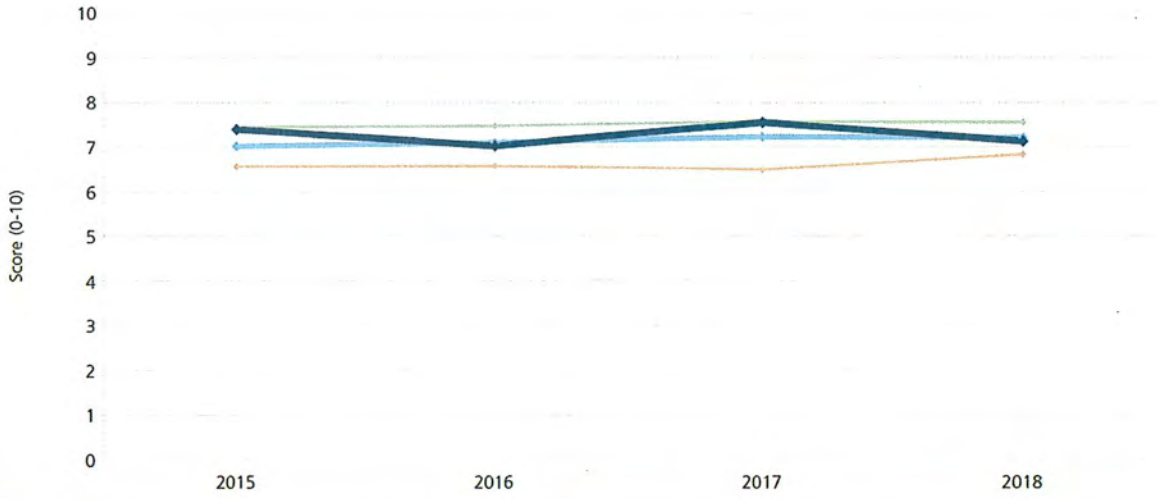
	2014	2015	2016	2017	2018
Best	9.4	9.4	9.4	9.3	9.4
Your org	8.6	9.2	8.7	8.7	8.6
Average	9.0	9.0	9.0	9.0	8.8
Worst	8.2	8.5	8.3	8.3	8.3
No. responses	199	253	307	341	382

Health and wellbeing



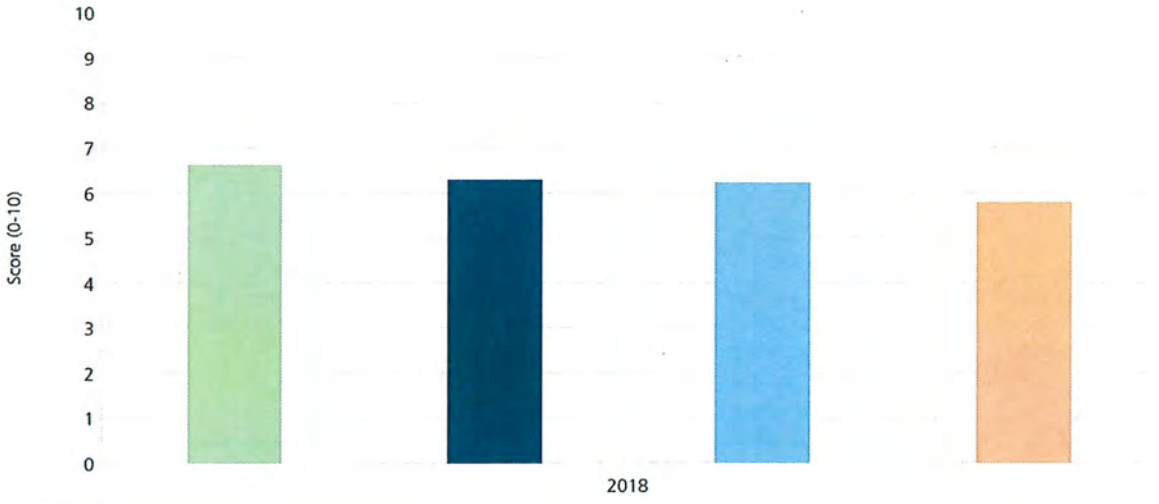
	2015	2016	2017	2018
Best	6.9	6.7	6.6	6.6
Your org	6.2	5.9	6.4	5.9
Average	6.0	6.2	6.2	6.1
Worst	5.4	5.6	5.2	5.3
No. responses	252	314	340	381

Immediate managers



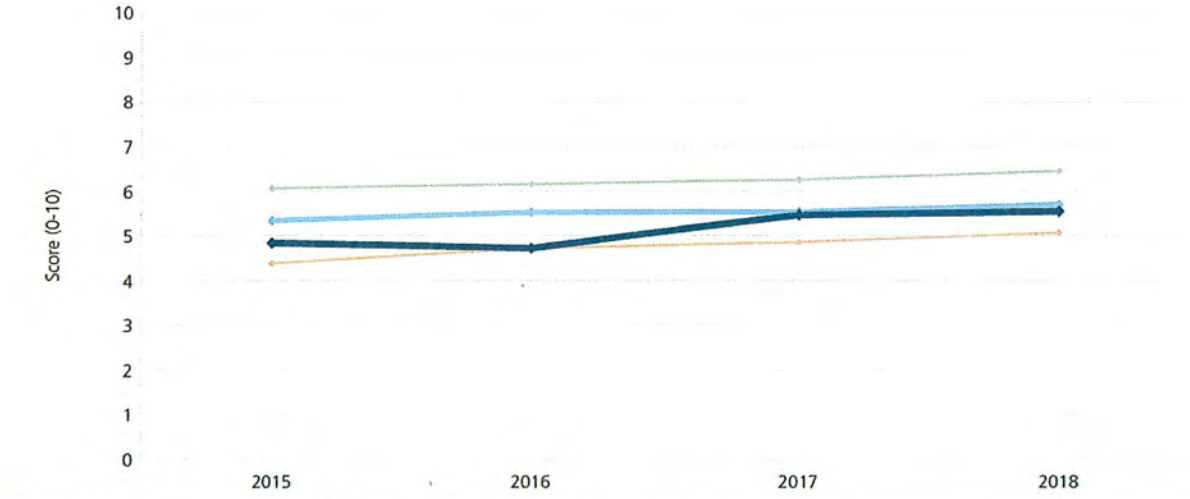
	2015	2016	2017	2018
Best	7.4	7.5	7.6	7.5
Your org	7.4	7.0	7.5	7.1
Average	7.0	7.1	7.2	7.2
Worst	6.6	6.6	6.5	6.8
No. responses	254	313	339	379

Morale



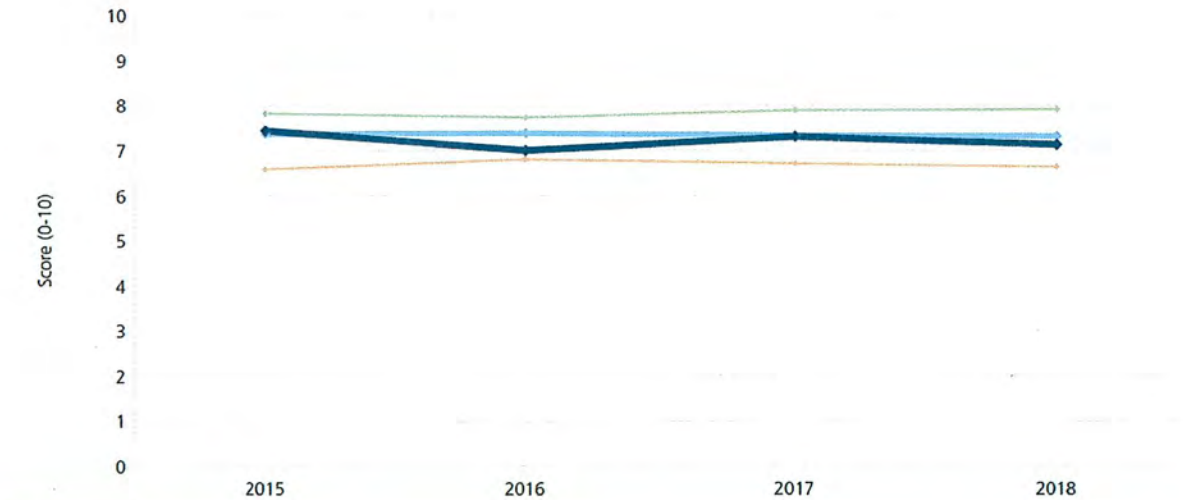
	2018
Best	6.6
Your org	6.3
Average	6.2
Worst	5.8
No. responses	379

Quality of appraisals



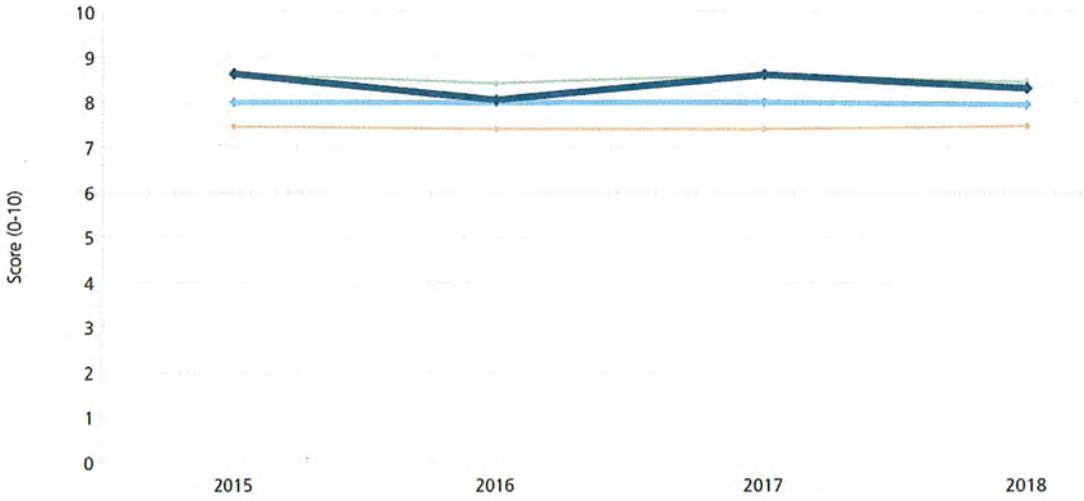
	2015	2016	2017	2018
Best	6.1	6.1	6.3	6.4
Your org	4.8	4.7	5.5	5.5
Average	5.3	5.5	5.5	5.7
Worst	4.4	4.7	4.9	5.1
No. responses	212	256	307	355

Quality of care



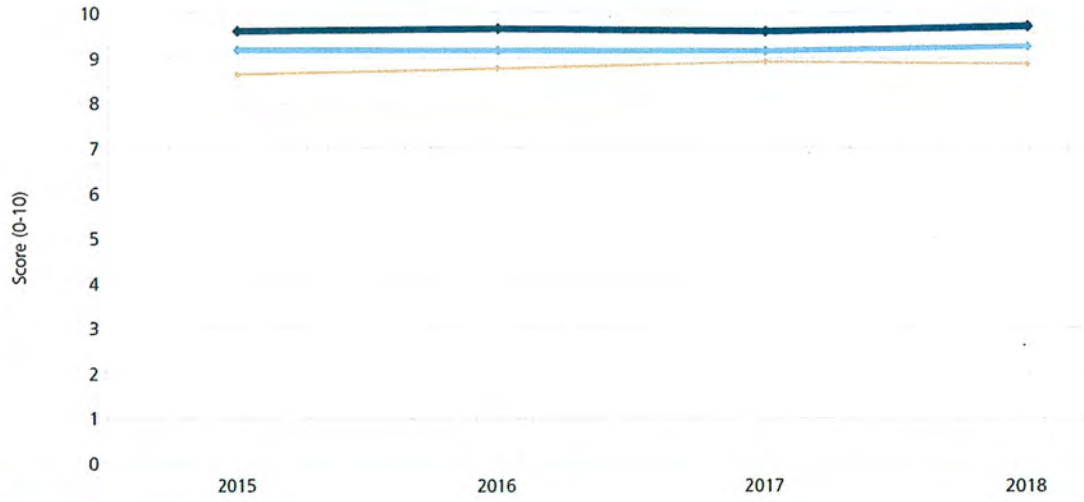
	2015	2016	2017	2018
Best	7.8	7.7	7.9	7.9
Your org	7.4	7.0	7.3	7.1
Average	7.4	7.4	7.3	7.3
Worst	6.6	6.8	6.7	6.6
No. responses	199	250	267	304

Safe environment - bullying and harassment



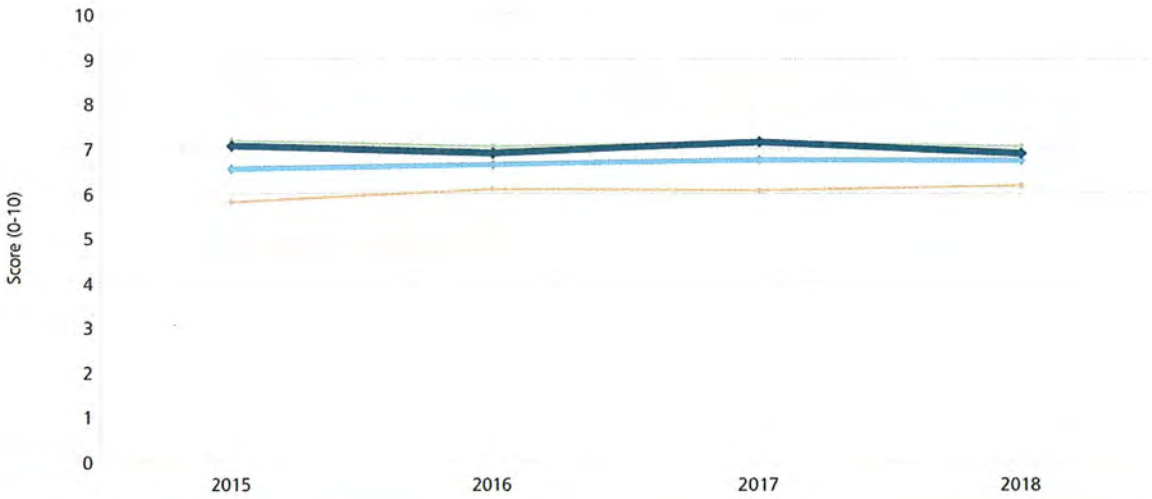
	2015	2016	2017	2018
Best	8.6	8.4	8.6	8.4
Your org	8.6	8.0	8.6	8.3
Average	8.0	8.0	8.0	7.9
Worst	7.5	7.4	7.4	7.5
No. responses	246	303	337	379

Safe environment - violence



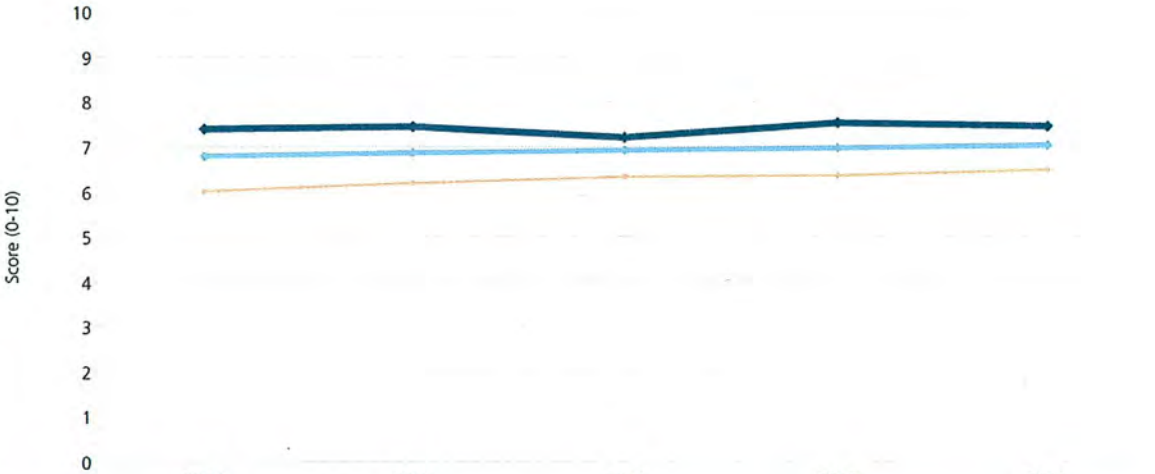
	2015	2016	2017	2018
Best	9.6	9.6	9.6	9.7
Your org	9.6	9.6	9.6	9.7
Average	9.2	9.2	9.2	9.3
Worst	8.6	8.8	8.9	8.9
No. responses	251	304	336	382

Safety culture



	2015	2016	2017	2018
Best	7.2	7.0	7.2	7.0
Your org	7.1	6.9	7.2	6.9
Average	6.5	6.6	6.7	6.7
Worst	5.8	6.1	6.1	6.2
No. responses	254	309	340	382

Engagement



	2014	2015	2016	2017	2018
Best	7.4	7.5	7.3	7.5	7.4
Your org	7.4	7.5	7.2	7.5	7.4
Average	6.8	6.9	6.9	7.0	7.0
Worst	6.0	6.2	6.3	6.4	6.5
No. responses	200	255	321	349	384

Our results are exceptionally positive and we are proud to have the highest level of engagement amongst mental health and learning disability trusts. We achieve this through having in place an organisational development and people strategy which

has driven improvements, an organisation that is rooted in reflective practice and a culture which promotes openness and transparency.

We recognise that we can always be doing more to improve. We have analysed our results and tasked our operational managers to engage with their staff and develop service specific action plans that will aim to addressing the issues reported.

Over the coming year we will be continuing to invest in developing and supporting middle managers across the organisation. We will also continue to implement the commitments made in our race equality strategy to improve the experience of our black, asian and minority ethnic staff.

Freedom to speak up guardian

Raising concerns is taken very seriously by our organisation. We appointed a freedom to speak up guardian in 2015, which was well ahead of the recommendations being a formal requirement for NHS provider organisations.

The current incumbent undertakes a number of activities to promote the purpose of the role which includes information from our various communications channels and giving presentations and talks at our mandatory training update days.

A number of directors also meet with the guardian to ensure that there is two way dialogue about what is presenting staff with concern and taking planned action to best address this.

We expand on this work further in the quality report.

Equality, diversity and inclusion

The Trust has constituted a standing committee of the board of directors to oversee and seek assurance on our equality, diversity and inclusion agenda. Throughout the year the committee has overseen a number of activities and programmes of work.

Our focus on improving the experience of black, asian and minority ethnic (BAME) staff remains a priority for the organisation and this year we have spent a lot of time thinking and developing actions how we will build on the work from the previous year.

Throughout the year we have been preparing for the introduction of the new national workforce disability equality standard which we will commence reporting on in 2019/20.

We refreshed our equality, diversity and inclusion policy in February 2019, affirming our commitment to making our organisation a place where unfavourable treatment and discrimination is tackled. This also includes our commitment to ensuring that those with disabilities are supported and that we seek to make reasonable adjustments. The policy also reflected important updates and guidance for support staff who chose to transition gender.

In March we published our second gender pay gap report nationally and fulfilled our statutory reporting requirements. This year we saw a small improvement in the gap for those receiving clinical excellence awards. The full details of our report can be found on our Trust website.

Safe working environment

Health and safety of our staff is of paramount importance and we continue to invest a lot of effort in this area, not just in terms of statutory duties but much more widely focusing on the mental health and wellbeing of our staff.

We have trained and have registered a number of mental health first aiders whose role is to provide staff with a contact point when they need to discuss what support is available to them. The individuals' details are held on our Trust intranet and staff can access support from the best placed person.

Trade union facility time

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 tables below fulfil our disclosure as per the Trade Union (Facility Time Publication Requirements) Regulations 2017.

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

Percentage of pay bill spent on facility time	*Figures*
Total cost of facility time	32,567
Total pay bill	38,601,000
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	
Total hours spent on trade union activities by relevant union officials during the relevant period	62.57
Total paid facility time hours	782.14
Total hours spent on paid tea paid trade union activities by relevant trade union officials (%)	8%

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

Occupational health and wellbeing

Throughout the year we continued our focus on health and wellbeing and have 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 years we continue to offer:

- Onsite chair massage
- Yoga sessions during and after work
- A cycle to work scheme
- A staff walking challenge
- Healthier food 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 through which staff seek support, when needed, these include through our HR team; our internal staff consultation service; the occupational health and wellbeing service which is provided by the Royal Free London NHS Foundation Trust; and, our confidential employee assistance programme provided by CareFirst.

Exit packages

During the last two financial years all exit packages paid to staff were the result of a compulsory redundancy. These all were made in line with the individual's terms and conditions of service.

2017/18 exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	4	-	4
£10,000 - £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	11	-	11
Total resource value (£000)	225	-	225

2018/19 exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	-	1
£10,000 - £25,000	2	-	2
£25,001 - £50,000	3	-	3
£50,001 - £100,000	1	-	1
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	0
>£200,000	-	-	0

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Total	8	0	8
Total resource cost (£000)	357	-	357

Countering fraud and corruption

The Trust's human resources directorate work closely with the 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 receive 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.

Agency staff

The Trust has a temporary staffing procedure which sets controls on how and when agency staff can be engaged within our organisation. Due to the organisation's specialist nature we have very little requirement for agency clinical staff.

In 2018/19 we exceeded the expenditure ceiling set by NHS Improvement by 27%.

Off-payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No Board member or senior officials with significant financial responsibility were engaged on an off-payroll basis in 2018/19.

The Trust has needed to engage a number of contractors to support fixed-term assignments in areas such as information technology and estate management on an off-payroll basis.

The number of contractors engaged is shown in the tables below where daily rates exceed £245 per day and the engagement has lasted longer than six months.

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the new rules. All the existing engagements outlined have been subject to an assessment and consequently no further assurance was sought.

High paid off-payroll engagements

During the reporting period there were no board members or senior officials, with significant financial responsibility, paid via off payroll arrangements.

The following tables outline all other off-payroll paid arrangements.

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:	
No. of existing engagements as of 31st March 2019	3
Of which:	
No. of new engagements	1
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

For all new off-payroll new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and lasted longer than 6 months:	
Of which:	
No. assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	3
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Expenditure on consultancy

The Trust's expenditure on consultancy in 2018/19 was £311,000. This was an increase from £209,000 in the previous year and the result of a number of one off projects and other service developments which have required short term consultative support.

Governance disclosures

Our governors play an important and active role in our work. We also benefit from a strong board of directors, whose wide-ranging experience underpins our continued success.

Council of governors

The council of governors continues to play a vital part in the work of the Trust, in 2018/19 we welcomed a number of new members following a round of elections. We also ratified the decision to create two new constituencies to broaden the reach of participation.

The council has a number of statutory duties including canvassing the opinions of members, appointing the Trust chair, non-executive directors as well as ratifying the appointment of the chief executive. The council holds non-executive directors to account individually and collectively for the performance of the board of directors. The council also receives the Trust's annual report and accounts and the auditor's report.

We actively involve our council members in a number of ways, including giving them attending rights to a number of our standing committees of the board and a number of operational groups. We also ensure that they are consulted and can contribute to our strategic objectives and plans which is achieved through information sharing and discussions within public and private council meetings.

This year, the council have approved the re-appointment for one of our non-executive directors through the nominations committee, chaired by the Trust chair.

The Tavistock and Portman NHS Foundation Trust constitution requires us to have 15 governors in total.

During the reporting period Anthony Levy held office as the lead governor until the end of his term of office. A successor was appointed at a general meeting of the Council in December 2018, George Wilkinson now fulfils this role.

Council attendance records - public governors		
Name	Elected from	Actual / possible attendance
John Carrier	Sep 2017	4 / 4
Celestine Keise	Sep 2017	4 / 4

Council attendance records – public governors		
Name	Elected from	Actual / possible attendance
Juliet Singer	Nov 2018	2 / 2
Kris Hutchison (until Mar 2019)	Sep 2017	0 / 4
Michael Rustin	Sep 2017	4 / 4
Salma Omokaro	Nov 2018	1 / 2
Noel Hess	Nov 2018	2 / 2
Julia Wall	Nov 2018	1 / 2
Marcus Evans (until Feb 2019)	Nov 2018	1/ 1
George Wilkinson	Nov 2015	3 / 4
Kimberley Wilson	Nov 2015	2 / 4
Anthony Levy (until Oct 2018)	Nov 2012	1 / 2
Natalie Baron (until Oct 2018)	Nov 2012	1 / 2
Derek Draper (until Oct 2018)	Nov 2015	1 / 2
Samuel Takunda (until Jun 2018)	Nov 2015	0 / 2
Marilyn Miller (until Sept 2018)	Nov 2015	1 / 2

Council attendance records – staff governors		
Name	Elected from	Actual / possible attendance
Angela Haselton (until Sep 2018)	Nov 2014	2 / 2
David Bell (until Sep 2018)	Nov 2015	2 / 2
Christine Bury (until Sep 2018)	May 2016	1 / 2
Jessica Anglin d'Christian	Nov 2018	2 / 2

Code of 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. It keeps its governance arrangements under regular review, including membership of board standing committees, their terms of reference and board performance assessments. 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.

Nominations committee

The nominations committee makes recommendations to the council of governors on the appointment, remuneration and appraisal of the Trust chair and non-executive directors.

This year, David Holt was re-appointed for a third and final term of office concluding in September 2020. As the Trust's audit committee chair and non-executive director providing oversight of the strategic future of the Tavistock Centre programme it was felt that it was important to give continuity and appoint a successor who can work alongside him for a year.

The Trust's constitution details the organisation's policy for non-executive director terms of office. A non-executive director may hold office for no more than seven years in total. The nominations committee's approach to awards of terms of office are ordinarily to offer an initial three year term of office which may be extended for a further term of three years, subject to satisfactory performance measured through the annual appraisal process for non-executive directors. The committee reserves the right to award a third and final term of office for one year if needed.

During the financial year a recruitment process for David Holt's successor commenced in January 2019. An executive search firm was not used initially as it was felt that the Trust would be able attract a suitable candidate using its internal resources.

All appointments for non-executive directors are made through a competitive recruitment process. The committee does not have a policy to appoint directly outside of open competition.

Members of the nominations committee	
Name	**Role**
Paul Burstow	Chair
David Holt	Senior Independent Director
David Bell (until September 2018)	Staff Governor
George Wilkinson	Public Governor
Derek Draper (until September 2018)	Public Governor
Marcus Evans (from October 2018 until February 2019)	Public Governor
Celestine Keise (from October 2018)	Public Governor
John Carrier (from March 2019)	Public Governor
Jessica Anglin d'Christian (from March 2019)	Staff Governor

*The nominations committee is serviced by Craig de Sousa, director of HR and corporate governance.

Our membership

The Tavistock and Portman NHS Foundation Trust's membership is an essential and valuable asset. It helps guide our work, decision making and adherence to the NHS values. It also provides one of the ways in which the Trust communicates with service users, the public and staff. There are five categories of members, two were newly established in 2018/19:

Public - any resident within England or Wales are eligible to register as members in this constituency. There are three sub-classes which are for members whose residence is within any ward within the London Borough of Camden, rest of London and rest of England and Wales.

Service users and service user carers - anyone who is aged 14 or over who has been a service user within the last five years. Carers who are not eligible to for other categories are also offered membership in this class.

Staff - employees whose contract means they can work for the Trust for at least a year.

Students - any individual enrolled on to a course or programme that is set to last three years or longer.

The table below sets out our membership data.

Constituency	31 March 2017	31 March 2018	31 March 2019
Public	6,012	6,156	6,406
Service user and service user carers	-	-	-
Staff	666	805	803
Students	-	-	-
Total	**6,678**	**6,961**	**7,209**

Members receive mailings and are invited to our annual members meeting, public meetings of the board of directors and council of governors and events. With the appointment of new council members, a small working group has been established to review and strengthen our approach to membership engagement.

The Trust does not have a membership strategy nor targets for recruiting members as the current membership data, excluding the new constituencies, is well above the minimum membership requirements set out in our constitution.

Should a member wish to get in contact with a council or board member details are provided on our public website on how to get in touch.

Board of directors

Our board of directors is made up of the Trust chair, five non-executive directors, five voting-executive directors and other directors who regularly attend. We have also engaged with NHS Improvement's non-executive training (NExT) programme

and we have hosted an associate non-executive director on the board. The board's role is to:

- Set out overall strategic direction.
- Monitor our performance against our strategic objectives.
- Provide effective financial stewardship.
- Ensure that the Trust provides high quality, effective patient and student focused services.
- Ensure high standards of corporate governance and personal conduct.
- Promote effective dialogue between the Trust and the communities we serve.

Membership is considered balanced, complete and appropriate. The Trust has appointed a senior independent director and this role is held by David Holt. The Trust considers all of its non-executive directors to be independent.

Every three to four years the Board commissions an external effectiveness review; one is due in 2019/20 and will be reported on in that year's annual report.

Board of directors attendance records		
Name	**Title**	**Actual / possible attendance**
Paul Burstow	Trust chair	5/6
Dinesh Bhugra	Vice chair	4/6
David Holt	Senior independent director	5/6
Deborah Colson	Non-executive director	6/6
Helen Farrow	Non-executive director	6/6
Jane Gizbert	Non-executive director	5/6
Rekha Elaswarapu	Associate non-executive director	3/3
Paul Jenkins	Chief executive	6/6
Terry Noys	Deputy chief executive / finance director	6/6
Julian Stern	Director of adult and forensic services	6/6
Sally Hodges	Director of children, young adults and family services	5/6
Robert Senior (until Jul 2018)	Medical director	2/2
Dinesh Sinha (from Aug 2018)	Medical director	4/4
Christine Caldwell	Director of nursing and system workforce development	6/6
Louise Lyon	Director of quality and patient experience	6/6

Board member profiles

Professor Paul Burstow
Trust chair

Paul Burstow joined us as Chair of the Trust in November 2015 and is currently serving his second term, due to end in October 2021.

Paul was previously a member of parliament from 1997 to 2015, where he served on the Health, Select and Public Accounts Committees, and worked cross party to secure debates and lobby Ministers on social care and health. From 2010 to 2012 he was the Minister of State for the Department of Health and led the development of the "No Health Without Mental Health" strategy.

Since leaving Parliament in 2015, Paul has developed a portfolio of non-executive leadership roles including Chair of the Social Care Institute for Excellence and Independent Chair of Hertfordshire and West Essex Sustainability and Transformation Partnership.

Professor Dinesh Bhugra
Vice chair

Dinesh Bhugra was appointed as a Non-Executive Director in November 2014. His term of office ends in October 2020. Professor Bhugra's background is in healthcare management, education and business development. Professor Bhugra is currently Professor Emeritus of Mental Health and Cultural Diversity at the Institute of Psychiatry, King's College London, and he took over as President of the World Psychiatric Association in September 2014. Previously he has been president-elect of the World Psychiatric Association, Chair of the Mental Health Foundation from 2011 to 2014, and President of the Royal College of Psychiatrists from 2008 to 2011.

He was awarded a CBE in the 2012 New Year's Honours for services to psychiatry.

David Holt
Senior independent director
Audit committee chair

David Holt was appointed as a non-executive Director in November 2013. He has experience of working across a wide range of sectors both in the UK and abroad, including spells at both Unilever and Coats Plc. Most recently, he was Finance Director of the retail division of Land Securities plc, which he left in 2014. He is currently a non-executive with Ebbsfleet Development Corporation, where he is Deputy Chairman and chair of the audit committee, Whittington Health, where he is Senior Independent Director and chairs the audit committee and the Planning Inspectorate, where he chairs the audit committee.

David is a qualified accountant (Chartered Institute of Management Accountants).

Dr Deborah Colson
Non-executive director

Deborah Colson joined the board as a Non-Executive Director in October 2017. Her term of office ends in September 2020. Dr Colson's background is in biomedical research and research management. Her last role was as Chief Scientific Officer on a child health study at the Institute of Child Health, University College London. Before that she worked as a freelance science policy advisor following nine years at the Wellcome Trust and seven years at the Medical Research Council.

Helen Farrow
Non-executive director

Helen Farrow joined the Trust in November 2016. Her professional experience is in investment management, focused on business development and client service, most recently as a director of Ignis Asset Management. She has five years of experience in the NHS as non-executive director at the Royal National Orthopaedic Hospital (RNOH), where she was vice-chair of the Board and chair of the finance and performance committee.

Jane Gizbert
Non-executive director

Jane Gizbert was appointed as a Non-Executive Director in November 2014. Her term of office ends in March 2019. Ms Gizbert's background is in marketing, communications and business development. Ms Gizbert is currently the Director of Communications at the National Institute for Health and Care Excellence, a post she has held since 2008. Before this she was Head of Corporate Communications with the Medical Research Council for 7 years, and has also worked for the International Planned Parenthood Federation.

Paul Jenkins
Chief executive

Paul joined us as Chief Executive in February 2014. He was previously the Chief Executive of Rethink Mental Illness, the leading national mental health membership charity working to help those affected by severe mental illness to recover and lead a better quality of life. He has an MBA from Manchester Business School and has over 20 years of experience in management and policy-making in the Central Government and the National Health Service (NHS).

Paul has previously served as Director of Service Development for NHS Direct. He has been involved in the implementation of a number of other major national government initiatives, including the Next Steps Programme and the 1993 Community Care Reforms. In 2002, he was awarded an Order of the British Empire (OBE) for his role in setting up NHS Direct.

Terry Noys
Deputy chief executive and director of finance

Terry Noys joined the Trust as Deputy Chief Executive and Director of Finance in November 2016, having previously worked for nearly five years for St. Mary's University, Twickenham (latterly as Chief Operating Officer). After qualifying as a Chartered Accountant (with PricewaterhouseCoopers), he spent six years in investment banking advising companies on strategy, mergers and acquisitions and fund raising before moving into commerce and industry, where he held finance

director roles for a number of stock exchange listed and private equity-backed groups. Terry then moved into the not for profit sector, holding finance director roles for, amongst others, Hanover Housing, Viridian and The National Archives. Terry is a Fellow of the Institute of Chartered Accountants of England & Wales.

Dr Sally Hodges

Director of children, young adults and family services

Sally Hodges was appointed as Director of CYAF in November 2015. Prior to taking up this role she was Associate Clinical Director of Complex Needs in CYAF, and the Patient and Public Involvement (PPI) lead for the Trust. Sally is a Consultant Clinical Psychologist, and has been working with the Trust since May 1996, specialising in children and young people with learning and developmental disabilities. She also holds a Leadership MSc from the University of Birmingham and the NHS Leadership Academy.

Dr Julian Stern

Director of adult and forensic services

Dr Julian Stern was appointed as Director of AFS in April 2016. Prior to this he was clinical and academic lead for our innovative Primary Care Psychotherapy and Consultation Service in City and Hackney, winner of the 2013 Royal College of Psychiatrists team of the year award. For 17 years until 2012, he developed and headed the unique Psychological Medicine unit at St Mark's Hospital, Harrow, a hospital for patients with gastrointestinal disorders. Julian is a Consultant Medical Psychotherapist. His particular interest is working psychotherapeutically in a medical setting. He has published widely in medical, psychotherapy and psychiatry journals and is co-editor of the popular textbook Core Psychiatry.

Brian Rock

Director of education and training / dean of postgraduate studies

Brian Rock took up his role as Director of Education & Training / Dean of Postgraduate Studies in January 2015. After qualifying as a clinical psychologist, before moving to London, Brian worked for the Goldstone Commission that was set up to examine political violence around the transition to democratic rule in 1994.

This led to him being appointed as the founding director of an NGO, The Children's Inquiry Trust. He has worked in the NHS since 1996 and was appointed as a Consultant Clinical Psychologist in 2004. Brian has worked in different roles in the organisation and has been involved in delivering training and supervision for a number of courses for the Trust and elsewhere. Since July 2009, Brian was involved in setting up and overseeing primary care services for the Trust, most notably with our award winning City & Hackney Psychotherapy Consultation Service. He has been involved in developing and delivering training and consultation to GPs and primary care staff.

Brian is a psychoanalyst and a member of the British Psychoanalytical Society. He also has an MBA from Henley Business School. Brian has published and presented widely on various topics related to mental health, Medically Unexplained Symptoms, and service development and service evaluation in primary care.

Louise Lyon
Director of quality and patient experience

Louise Lyon was appointed Trust Director in March 2008 and is now Director of Quality & Patient Experience. Prior to becoming Trust Director, she was the Clinical Director of the Adolescent Directorate here from 2007, and has been a Consultant Clinical Psychologist since 1996. Louise was a Consultant Clinical Psychologist at South West Kensington and Chelsea Mental Health Centre from 1988 until 1999.

Dr Dinesh Sinha
Medical director

Dinesh Sinha has significant experience in the health service having held board level and senior leadership roles, including within his most recent trust and clinical commissioning organisations (CCGs).

He was previously associate medical director, head of service and consultant psychiatrist in psychotherapy at East London NHS Foundation Trust. He has held roles on several CCG governing bodies and continues to be involved in commissioning of health services.

Dinesh is a fellow of the Royal College of Psychiatrists and holds an MBA from Lancaster University Management School. He brings senior leadership experience and strategic focus in the delivery of high quality services.

Dr Christine Caldwell
Director of nursing and system workforce development

Chris Caldwell is our Executive Director of Nursing, and also our executive lead for system workforce development, Director of the National Workforce Skills Development Unit, and the senior responsible officer for mental health workforce within North London Partners, North Central London's Sustainability Transformation Partnership.

Chris is concurrently the Programme Director for the CapitalNurse Programme, working across London for Health Education England (HEE), NHS England and NHS Improvement on a programme of collective action to build and sustain high quality nursing workforce across London

She is an adult and children's registered nurse and a nurse teacher. She has a Masters in Health Psychology and gained her Doctorate from Ashridge Business School focusing on transformational organisational change.

Board sub-committees

The board of directors delegates some of its oversight responsibilities to sub-committees where matters of assurance and quality can be explored in more detail.

Committee	Membership April 2018 - March 2019
Audit	David Holt (Chair), Deborah Colson, Helen Farrow.
Clinical, quality, safety and governance	Dinesh Sinha (Chair), Deborah Colson, Dinesh Bhugra, Paul Jenkins, Sally Hodges, Julian Stern
Charitable funds	Paul Burstow (Chair), Paul Jenkins, Terry Noys
Equality, diversity and inclusion	Dinesh Bhugra (Chair), Louise Lyon, Craig de Sousa
Executive appointments and remunerations	Paul Burstow (Chair), all non-executive directors
Strategic and commercial	Helen Farrow (Chair), David Holt, Paul Jenkins, Terry Noys, Julian Stern, Sally Hodges, Brian Rock, Christine Caldwell, Dinesh Sinha, Rachel Surtees
Training and education	Paul Burstow (Chair), Deborah Colson, Paul Jenkins, Brian Rock

Audit committee

The Board delegates certain of its duties and responsibilities and powers to the audit committee, so that these can receive suitably focussed attention. Principally, the purpose of the committee is to ensure, on behalf of the Board, that financial reporting, the external and internal audit processes and the systems of internal control and risk management are appropriate and effective across the activities of the Trust.

The committee fulfils its responsibilities by reviewing the work and the reports of the internal auditors, external auditors and the local counter fraud specialist. The committee also seeks assurances from senior managers and reviews other relevant reporting, such as that on reference costing and debtors.

During 2018/19, this work covered:

- The Trust's financial and reporting systems;
- The assurance processes, including risk management and clinical governance;
- A number of corporate governance and compliance matters, including audits on data quality and the general data protection requirement (GDPR).

The deputy chief executive / director of finance, together with the director of quality and patient experience, present the annual report and accounts to the audit committee, which reviews and scrutinises these, in particular, through questioning the external auditors and senior managers.

Composition & Attendance
The audit committee comprises of (at least) three non-executive directors, one of whom shall have recent and relevant financial experience.

The chair of the committee is appointed from these non-executive directors.

The Trust Chair may not sit on the audit committee.

The audit committee is quorate if at least two members (one of whom may be the chair of the committee) are in attendance.

The deputy chief executive / director of finance and representatives of the internal and external auditors and local counter fraud service usually attend each meeting.

The chief executive and other senior managers attend, by invitation only.

The chair of the clinical, quality, safety and governance (CQSG) committee and the Trust chair each usually attend at least once per year, again by invitation. During the year the medical director provided the committee with an annual review of the work of the CQSG committee and of other matters which fall within his areas of responsibility.

Attendance records – audit committee	
Member Name	**Possible / Actual Attendances**
David Holt (Chair)	4 / 4
Helen Farrow	4 / 4
Deborah Colson	4 / 4

All members served on the audit committee throughout the year. David Holt was the committee chair throughout the year.

Subsequent to an audit committee meeting, a note on the key issues addressed is 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 2018/19

Internal Audit

During the period, the Trust used the services of RSM Risk Assurance Services LLP ("RSM") to provide its internal audit function, such services being designed to conform to the Public Sector Internal Audit Standards. In setting the internal audit work plan for the year ahead, RSM (in conjunction with senior management and the audit committee) work within an overarching three year strategic plan and explicitly take into account the Business Assurance Framework of the Trust.

During the year under review, the internal audit function covered a range of internal controls and potential risks, notably:

- Risk Management and the Board Assurance Framework;
- Data Quality;

- Staff Appraisals;
- Key Financial Controls;
- Estates and Facilities; and
- Implementation of the new student records system.

The Trust seeks to use its, limited, internal audit resources to focus on areas of actual or potential weakness. A summary of the outcomes of these assurance reviews is as follows:

Audit opinion	2017/18	2018/19
Partial assurance	2	1
Reasonable assurance	4	4
Substantial assurance	-	1

In addition, two advisory audits were carried out, one on cyber security and the other on GDPR preparedness.

The audit committee is satisfied with the management responses regarding the issues raised by internal audit and time-bound action plans for improvements are in place to address any areas of outstanding weaknesses.
The 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.

During the financial year, the Trust put its internal audit out to competitive tender, the result of which was the re-appointment of RSM Tenon LLP for internal audit services.

Local Counter Fraud Service (LCFS)
The Trust also uses RSM Tenon to provide its LCFS. Each year the counter-fraud plan is reviewed to ensure that the Trust continues to develop its programme of deterrence, prevention and detection.

The audit committee is satisfied with the processes and the conclusions of the work carried out by LCFS.

There has been one investigation in the Trust during the year, which currently, is still ongoing.

During the year the Trust was subjected to a review and assessment by the NHS Counter Fraud Authority. The result of the assessment was in line with the expectations of the Trust. An agreed action plan has been put in place which is monitored by the audit committee.

During the financial year, the Trust put its LCFS out to competitive tender, the result of which was the re-appointment of RSM for these services.

External Audit

The Trust's external auditors are Deloitte LLP ("Deloitte"), who were appointed in 2015, following a competitive tender process. Deloitte were appointed to an annual contract, capable of being renewed for up to a maximum of five years.

As a foundation trust, the Council of Governors is responsible for appointing the external auditors. The audit committee therefore reviews the effectiveness of the external auditors on behalf of the Council. Having reviewed the performance of Deloitte during 2017/18 - on the basis of cost / value for money; independence; and professional expertise - the audit committee recommended their reappointment for 2018/19. This decision was ratified by the Council of Governors at its meeting in December 2018. The total cost of the external audit of the financial statements and quality report for 2018/19 is £51,000 (2017/18: £48,800) plus VAT. Deloitte did not provide any non-audit services to the Trust during 2018/19.

External audit work during the year covered a range of potential risks, most notably: validity and accuracy of NHS contract and sustainability transformation fund income recognised but not yet settled by commissioners; accounting for capital expenditure; and management override of controls. Work in these areas is fundamental to providing assurance to the Trust and to outside stakeholders that financial management is robust and that sound corporate governance procedures are in place.

As part of its work, the audit committee reviewed and confirmed the basis of the valuation of the Trust's land and buildings.

In addition to auditing the financial accounts, the external auditors have examined the quality accounts and given a qualified opinion on the content of the Quality Report and on the selected performance indicators reported therein. This qualified

opinion relates to a limitation of scope and small data inaccuracies identified in one of the audited indicators, namely disclosure and barring service checks.

Risk Management

The audit committee has continued to develop its focus on risk management 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 Business Assurance Framework / Strategic Risk Register. During the year the Trust continued to review and refine its approach and attitude towards risk management including (minor) revisions to its Risk Strategy, Policy and Procedures; an in-depth examination of the Trust's approach to risk appetite; regular reviews of the Trust's Business Assurance Framework / Strategic Risk Register; and, with assistance from RSM, further development of the Trust's use of assurance mapping. During the year, the Board of Directors have been provided with formal training on both managing risk and on local counter fraud.

The Trust is in the process of implementing new risk management software, in order that operational risks can be more efficiently tracked.

As part of its annual cycle, the audit committee undertakes a 'deep dive' of operational risks by interviewing one or more service line managers. During 2018/19, the committee met with the Director of the Family Nursing Partnership to understand how risk is managed at an operational level and to hear how operational risk management might be improved.

Regular subjects of review throughout the year have been tender waivers, aged debtors, data quality and GDPR. The committee has paid particular attention to the issue of data quality and, partly as a result of the committee's work, a review of health and safety and estates compliance was undertaken, leading to a new estates compliance work stream being established (reporting to the CQSG committee).

The audit committee gets a report at each of its meetings on any 'tender waivers', whether or not due to the use of framework agreements or for other reasons.

The Trust carries significant non-NHS related debt and the audit committee, therefore, receives a report on debtors at each of its meetings. It is pleasing to note that during the past year aged debtors (90+ day) have decreased significantly.

Data quality is also a key issue for the Trust and significant effort continues to go into addressing actual and potential identified weaknesses in this area. Also during the first part of the period, the audit committee kept close oversight of health and safety compliance matters (which are now overseen by the clinical quality, safety and governance committee). The audit committee has also received progress reports on the Trust's compliance with the recently introduced GDPR.

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. In addition, the working relationship with other relevant Board Committees - notably the clinical quality, safety and governance committee (CQSGC); the training and education committee (TEC); and the strategic and commercial committee (SCC) - 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 Committees. In this respect, the audit committee finds it helpful that two of its members sit on SCC and one of its members sits on CQSGC.

As part of its annual cycle of work, the committee has undertaken a self-assessment exercise which showed positive responses from both internal and external audit participants. However, as a result a number of minor changes to the committee's reporting processes will be trialed for the 2019/20 audit committee reporting cycle.

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.

Single oversight framework

NHS Improvement's single oversight framework provides a method for overseeing NHS trusts and identifying potential support needs. The framework looks at five themes:

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

Based on information from these themes, trusts are segmented from 1 to 4, where '4' reflects those in special measures and '1' reflects those with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it is found to be in breach, or suspected breach, of its licence.

Segmentation

NHS Improvement assigned a score of 1 to the Tavistock and Portman NHS Foundation Trust for month 12, 2018/19 performance.

Finance and use of resources

The finance score is based on five measures which are scored from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score.

From autumn 2017 a new 'use of resources' (UoR) assessment has been introduced to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. Under this framework, NHS Improvement will periodically undertake UoR assessments of providers. Currently, these new assessments have begun with non-specialist acute trusts with the aim of rolling out across the sector when more information is available. Therefore the Trust has yet to have a UoR assessment. Until a provider has undergone a UoR

assessment, NHS Improvement will use the finance score, alongside other evidence, of whether a provider is making optimal use of its resources, to identify potential support needs under this theme.

Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, our overall rating above is not the same as the overall finance score shown in the table below.

Metric	2017/18 Month 12 Score	2018/19 Month 12 Score
Capital service capacity	1	1
Liquidity	1	1
Income and expenditure margin	1	1
Distance from financial plan	1	1
Agency spend	1	3
Overall score	1	1

Agency expenditure

At the start of the financial year, NHS Improvement suggested that it would be appropriate for the Trust to spend no more than £683,000 on agency staff. During 2018/19, the Trust spent £866,000 on agency staff.

Statement of the chief executive's responsibilities as the accounting officer

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 and Social Care 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 and Social Care 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

- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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.

Paul Jenkins 28 May 2019

Chief executive and accounting officer

Annual governance statement 2018/19

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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has in place a risk management policy and strategy which clearly sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust.

Operational responsibility for the implementation of risk management has been delegated to executive and other named directors.

Risk management is a core component of the job descriptions of senior managers within the Trust. A range of risk management training is provided to staff and there are policies. All relevant risk policies are available to staff via the Trust intranet.

The Trust learns from good practice through a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, and performance management, continuing professional development, clinical audit and application of evidence based practice.

The risk and control framework

The risk management strategy and policy set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled. A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents. This framework includes the approach used to engage stakeholders on risks that impact them, this is current undertaken in conjunction with the Council of Governors.

To provide oversight and assurance the clinical, quality, safety and governance committee, a standing committee of the Board of Directors, is responsible for seeking assurance on the organisation's quality governance structures and systems of control. Within its remit it is an integrated governance forum that is responsible for seeking assurance on all matters of risk, safety, experience, data security and other corporate compliance requirements. We expand further about our approach to managing data risks in the information governance section of this chapter. The committee is also responsible for seeking assurance that the Trust's plans for complying with CQC regulatory requirements are delivered and where there are deficits that mitigating actions are in place.

The Board of Directors and Executive Management Team have undertaken a comprehensive process for assessing and agreeing the organisation's appetite for risk. This process was implemented following a Board development session to support the development of an appropriate internal framework to discuss, challenge and agree the level of risk which the Trust will accept.

Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level.

An incident panel has been established and is chaired by the Trust's medical director. Its purpose is to monitor the quality of investigation of serious incidents and progress in embedding subsequent learning.

Serious incidents and serious risks are reported to the Board of Directors either via the Trust's incident panel or the clinical, quality, safety and governance committee.

The board assurance framework supports the process for monitoring ongoing compliance with the requirements for registration set by the Care Quality Commission and sets out the principal risks to delivery of our corporate objectives. It identifies the assurances available to the Board of Directors in relation to achievement of the objectives and these are also mapped to key controls. The director with responsibility for managing and monitoring each risk is clearly identified.

During 2018/19 the board assurance framework was presented to the Board of Directors four times.

The Trust has not identified any risks to compliance with the NHS Foundation Trust condition 4 (FT governance).

The Board of Directors approves the quality priorities for the Trust. The priorities include a number of indicators agreed with stakeholders from our local community together with national indicators of quality.

The Board of Directors reviews a number of metrics and performance data through its quarterly quality dashboard report which is presented four times each year, after each quarter end.

The Board is satisfied that the Trust has adequate plans in place to respond to service user, staff and student surveys to support efforts to increase participation.

A range of methods have been put in place to ensure that the Trust complies with the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which are set out in the Care Quality Commission's five domains. Approaches include service visits, quality improvement projects, effective systems of supervision and regular team meetings.

Major risk in 2018/19

The key risks to delivering the Trust's strategic objectives are recorded in detail in the board assurance framework and monitored four times a year by the Board of Directors.

The Trust identified 12 risks which could impact on the delivery of the strategic objectives, these were:

- The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England

- The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.

- The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.

- The risk that the Trust fails to deliver affordable and appropriate Estates solutions with a negative impact on patient, staff and student experience.

- The risk that there is insufficient staff capacity with negative consequences in relation to quality of current activities or the ability to bid for and deliver future developments.

- The risk that issues with the quality use of data impact on decision making and the quality and effectiveness of the Trust's services.

- The risk that wider financial pressures in North Central London with consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives.

- The risk that the Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability.

- The risk that it is not possible to reconcile tension between demand and resources in respect of gender services with consequences for safety and patient experience.

- The risk that the pressure of reactive communications work means that the Trust lacks capacity to deliver the External Affairs Strategy, failing to raise its

external profile on the range of issues where it aims to influence public policy.

- The risk that the Trust fails to meet its regulatory responsibilities to CQC and QAA with negative consequences for our reputation and the quality of patient and student experience.

- The risk that the Trust fails to deliver its financial plan with negative consequences for the delivery of our Control Total and an impact on the quality of our services.

Against each of the strategic risks a responsible director is assigned to the risk who is tasked with identifying control measures to mitigate the risk, gaps in control measures and appropriate actions. It should be noted, however, a number of the risks relate to factors in the external environment which are outside of the Trust's control.

The executive management team review the risks identified on the board assurance framework and consider new and emerging issue which may impact on the delivery of the strategic objectives. Each year the framework is refreshed to reflect new objectives set and also provide a good opportunity to reflect on the current and emerging risks which should be captured, gaps in assurance and appropriate mitigations identified.

The Trust has regard for the CQC well-led framework and underwent a planned inspection in this domain area in 2018 achieving a good rating. The framework is applied routinely through operational management and the standard is reviewed regularly through our established systems of control and assurance.

Workforce Strategies

The Trust approved a three year organisational development and people strategy in April 2017 which covers our short, medium and long term systems for maintaining and developing a highly effective and skilled workforce. The Board is appraised twice yearly of progress being made against the strategy and also receives metric performance data via its quality dashboard every quarter. The strategy and reporting complies with the requirements of the 'Developing Workforce Safeguards' recommendations.

Compliance statements

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

A full description of the role of our Board of Directors, standing committees and governance structures are set out in the directors' report. This includes details about attendance and the systems of internal control.

For 2018/19 the Trust met its financial control total, as it also did for 2017/18. The Trust's financial performance includes 27% variation to its agency ceiling. 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 six times a year. 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 have reported that the Trust has failings in this respect.

Information governance

The Trust completed the annual self assessment against the Data Security and Protection Toolkit, the new tool which replaced the Information Governance toolkit. The Trust met the necessary standard for all ten National Data Guardian Standards, and confirmed and evidenced its compliance with all Assertions listed within the toolkit.

All staff receive data security training on the Trust's corporate induction and are required to refresh this training annually, through e-learning.

All information incidents are investigated, with near misses used as an opportunity to improve processes and reduce risks. In 2018/19 there was one incident classified as a 'level 2' serious incident requiring investigation which related to the disclosure of patient information in error. The Information Commissioner's Office closed the report with no further action required of the Trust.

The Trust has implemented the requirements set out in the General Data Protection Regulation (GDPR).

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 such as NHS Digital. This information has been reviewed extensively by the Board of Directors either directly or through its standing committees. The Council of Governors have also been consulted about its content. These steps assure the Board of Directors of the balance and data quality contained within the report.

Due to the nature of our patient services (we provide psychological therapies, do not undertake any physical interventions, and are an outpatient 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 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 the reporting year against the priorities set.

Complaints and disclosure and barring service checks were selected by the Trust for auditing by our external auditors in 2018/19 to provide further assurance. Of these two indicators, there were minor issues identified within the disclosure and barring service dataset and also a limitation of scope which has resulted in the qualification of this aspect of the report.

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 five quality priorities selected for 2018/19 are included within the annual Quality Report. Good progress has been made against these priorities.

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 NHS foundation 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 and the clinical, quality, safety and governance 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.

As a specialist provider Trust we are regulated by a number of agencies and arms-length bodies, the table below details our current compliance ratings:

Body	Last Inspected	Rating
Care Quality Commission	October 2018	**Overall - Good** Caring - Good Effective - Outstanding Responsive - Good Safe - Good Well-led - Good
Ofsted	November 2017	**Overall - Good** Leadership and management - Good Quality of teaching, learning and assessment - Good Personal development, behaviour and welfare - Outstanding Outcomes for pupils - Good
Quality Assurance Agency	June 2018	**Meets Expectations**

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, their 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:

Audit opinion	2018/19
Partial assurance	1
Reasonable assurance	4
Substantial assurance	1

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 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, Quality Assurance Agency for Higher Education and the Care Quality Commission, 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 2019 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 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 the Trust has sound systems of internal control and that no significant internal control issues have been identified.

Paul Jenkins 28 May 2019
Chief executive and accounting officer

I present this accountability report.

Paul Jenkins 28 May 2019
Chief executive and accounting officer

4 Quality report

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 a wide range of generic and specialist outpatient mental health services to children, young adults and families (CYAF) and to adults. 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 located in community or primary care settings 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.

The quality of services was formally recognised by the Care Quality Commission this year, who rated our Trust as 'good', with 'outstanding' effectiveness, praising our skilled workforce, high-calibre board, and innovative specialist services. It was a particularly good result in the context of increasing demand for our services. In 2014/15 we had 5560 service users. This year it more than doubled, with 11,985 service users across the Trust. To continue to deliver excellence as numbers increase so rapidly is a credit to our staff, both clinical and on the administration and support side.

The Trust is committed to improving the quality of our services, specifically patient outcomes, system performance and professional development, and have chosen to adopt the Institute of Healthcare Improvement (IHI) Model for improvement which is one type of quality improvement (QI) methodology. Please see the glossary for more information.

As part of our Clinical Quality Strategy we have continued to develop specific quality improvement skills for our staff, investing in training delivered by HAELO, an external provider with skills in this field and online training. Over the winter 28 staff attended introductory training and 14 completed a three day intermediate course. In addition, 17 staff completed the Institute for Health Improvement (IHI) Open School QI Training.

The Trust is working at sharing information about projects across the Trust. Our three part time Quality Improvement Leads have been working with identified teams on specific projects, and have established support groups for those wishing to use

this methodology to improve services. In July 2018 a Quality Event programme saw the presentation and discussion of five quality improvement projects. These are included in the list of some of the projects we have undertaken below:

- Adult and young adult confidentiality
- Lifespan team – review of pathways for those over 18 years with Autistic Spectrum Conditions
- North Camden CAMHS Did Not Attend (DNA) project
- Parent Group project – Camden Adolescent Intensive Support Service (CAISS)
- Experience of Service Questionnaire (ESQ) review – CAISS service
- Care plans – Family Mental Health service
- Goal based measures – South Camden CAMHS
- DNA's – Adult Forensic Service
- Dropout rate project – City and Hackney Primary Care Psychotherapy Service (PCPCS)

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 continue to 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. 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. A significant number of services across the Trust have rolled out text reminders to patients, which has been well received. Our team by team waiting times report continues to keep the Board and clinical teams alert to performance issues.

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 are committed to providing excellent quality of care. They 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.

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.
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

28 May 2019

Quality Improvement Project Vignette

Reducing overall waiting times for treatment in Adult Complex Needs

Introduction

There is a view that long delays between assessment and treatment may negatively impact on the mental health of patients. The initial patient assessment forms a clinical intervention and so, as with any psychotherapy, there is benefit in giving the patient time to process the experience. However, a waiting time in excess of two months would be considered less than ideal. Since November 2018, a Quality Improvement (QI) project aiming to reduce the waiting times for psychotherapy has been running in the Complex Needs department. The median waiting time from assessment to treatment on the generic units for the 18 month treatment pathway in June-November 2018 was 7.7 months. Our objective was to reduce this to a median of 6 months by the end of March 2019; a reduction of approximately 20%.

The Quality Improvement intervention

We decided to introduce a new brief intervention treatment model. This consisted of 16 weekly individual sessions for patients who were deemed able to use such a model. The intervention was to be offered immediately or very soon after assessment. There were 2 main reasons for selecting this model: (i) there is an evidence base supporting the efficacy of 16 session treatment (ii) this intervention is already offered elsewhere in the Trust and some clinicians working within the department already have experience in this area.

Evaluation of the intervention

In order to assess the impact of the intervention, we decided to measure the following:

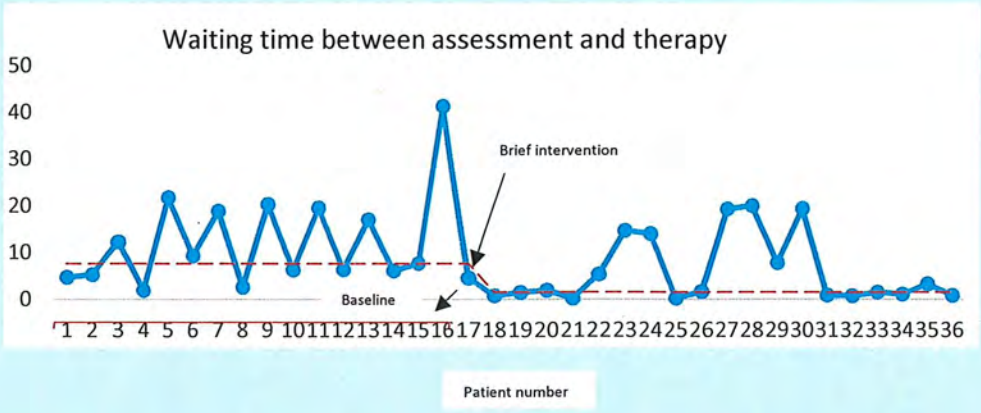
(i) Waiting time for patients allocated to the 18-month and 16-week treatment pathway within the generic units

(ii) Outcome measures - Core-10 and Work and social adjustment scale

(iii) Patient and clinician feedback

Preliminary Findings

The introduction of the brief therapy intervention significantly reduced the median waiting time within the generic units, from 7.7 months to 1.6 months, a reduction of nearly 80%. The median waiting time for 16-week treatment during this period was 0.75 months (approx. 3 weeks) and the median waiting time for 18-month treatment during this period was 5.36 months. There is therefore an early indication that the benefit of offering brief treatment within Complex needs is two-fold; firstly, patients rapidly access treatment on the 16-week treatment pathway and secondly, waiting times for patients on the 18-month treatment pathway are reduced. The waiting time data will need to be monitored and evaluated over a longer period of time however to establish a definite correlation. The chart below shows the baseline waiting time data from June 2018- Nov 2018 (patient 1-16) and then from November 2018-March 2019 (patient 17-26), when the brief treatment intervention was introduced:



As highlighted above, we will also be looking at outcome measure data and patient/clinician feedback, however as most of the brief treatments are still underway, this part of the QI project cannot be reported on yet.

Ellie Cavalli (QI lead, AFS), Andrew Williams (Head of Adult Complex Needs & Associate Director for QI, AFS), April '19

Part 2: Priorities for improvement and statements of assurance from the board

Our quality priorities for 2019/20

The priorities for 2019/20 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: patient safety, patient experience and clinical effectiveness. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

Patient Safety		
Priority 1	Improve identification and management of high risk patients	Builds on last year's Quality priority
Patient Experience		
Priority 2	Experience of Service Questionnaire Review	New priority
Clinical Effectiveness & Patient Experience		
Priority 3	Improve patient and carer involvement in care planning in children, young adult and family services.	Builds on last year's Quality priority
Clinical Effectiveness		
Priority 4	Provide effective sleep management information and support to adolescent patients and carers of those with sleep disorders (aged 14-18)	Builds on last year's Quality priority
Priority 5	Improve waiting time experience from end of assessment to first treatment session in the generic Adult Complex Needs service	New priority
Priority 6	Embed meaningful use of outcome measures in services	Builds on last year's Quality priority

How we chose our priorities

In looking forward and setting our quality priority goals for 2019/20 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, with staff and our Quality Advisory Group and external, including Camden Clinical Commissioning Group (CCG, 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 we will be looking at improving waiting time from end of assessment to first treatment session in the generic Adult Complex Needs service.

Our Quality Advisory Group has been actively involved in providing consultation on clinical quality priorities and indicators. This group includes patients 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. Our Governors also played a key role in helping us to think about some of our quality priorities for next year.

How will they be monitored to ensure achievement?
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. Each quality priority lead will ensure that action plans are in place when expected levels of assurance are not achieved

Patient safety

Priority 1: Improve identification and management of high risk patients

The highest priority of the Trust is the safety of patients seen in our services. For 2019/20 we plan to continue to run regular training updates on clinical risk assessment and risk management and to develop a "train the trainers" model to help other clinicians facilitate learning on risk assessment in their teams. This model will support existing learning programmes and activities that we currently deliver.

There will be a greater emphasis on assessment and management of self-harm as this is particularly prevalent in some of the clinical populations that we assess and treat e.g. adolescents. We will be updating several relevant policies and procedures during 2019/20 to reflect the key elements of safer care in the context of being a provider of all age out -patient mental health services. Audits of the recording of risk assessments and actions taken will be repeated during the year.

Improve identification and management of high risk patients
Targets for 2019/20 This priority continues with elements from last year
1. Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust.
2. Ensure all CYAF crisis plans have been regularly reviewed and updated. The frequency will need to be decided on a case by case basis but minimally once every 3 months.
3. Continue to audit recording of clinical risk assessments and actions taken

Measure overview

This indicator includes several targets to continue to improve the care of high-risk patients including the regular review and updating of crisis plans. Audits will be undertaken to ensure continuous improvement. All clinicians should regularly update their skills in clinical risk assessment. Regular face to face updates will continue and a new train the trainers' model will also be developed.

How we will collect the data for this target

The Informatics Department can create a report to determine the number of crisis plans in use. Information will also be provided via clinical audits. Compliance on clinical risk training will be monitored on team by team basis.

Patient experience

Priority 2: Standardise our experience of service questionnaire feedback forms in line with patient and staff feedback and test more streamlined ways of collecting information.

The PPI team is responsible for collating qualitative data from the ESQ and sharing this with team leads, as well as aiming to support teams where appropriate with implementing changes. This priority has been devised after careful consultation using feedback gleaned from service user groups and staff on the need for a briefer and more user friendly Questionnaire. The aim is to standardise this document and to increase ESQ return rates across the Trust, without losing what is unique to each service.

Standardise our Experience of Service Questionnaire feedback forms in line with patient and staff feedback and test more streamlined ways of collecting information
Targets for 2019/20 New priority
1. Further consultation with the Quality Advisory Group before completing and testing the new forms
2. Test streamlined forms in one service initially and review and evaluate effectiveness
3. Test streamlined forms in second service building on evaluation of first service
4. Evaluate and review second test and adjust with a view to rollout across the directorates

Measure overview

The suggested format for the new questionnaire is a postcard sized form with three questions followed by a free text box. This design is to be further consulted on and refined at the Quality Advisory Group with input from staff and patient representatives to the meeting. The first forms can then be piloted in an Adults or Children Young Adults and Families team.

The new ESQ can complement the follow up call system which has worked well in some services.

How we will collect the data for this target

We will review the figures for return rates from the first test and see if there is improvement for that service, as well as obtaining feedback from staff and service users on effectiveness and advice on any changes or modifications to be made. We will build on this and review and modify in the same way with the second test for the second team. Finally we will review all information in preparation for Trust wide rollout.

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 decision making regarding help and support interventions 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 these 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 in the development of care plans, and the sharing of these to support cross agency working. During 2018/19 the work for this priority focused on Family Mental Health services and particularly focused on increasing the percentage of care plans shared with patients and referrers. The start was delayed until January 2019 and is continuing. During 2019/20 we will be extending this work to Adolescent and Other CAMHS services.

Improve patient and carer involvement in care planning in Adolescent and Other CAMHS services
Targets for 2019/20 Development of 2018/19 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

Identify which CYP in the Adolescent and Other CAMHS services require a care plan. Analyse collection rates which are validated and reported to obtain a baseline and use quality improvement methodology to increase the percentage of plans shared with patients and referrers. We will also be seeking further service user feedback on their involvement in decision making regarding care plan development.

How we will collect the data for this target

The percentage of care plans shared with patients / carers and referrers will be measured quarterly along with a number of process measures for detail. We will obtain further patient and carer feedback on the content and process for providing

care plans and undertake a further audit to assess the quality of care plan recording.

Clinical effectiveness

Priority 4: Provide effective sleep management information and support to adolescent patients and carers of those with sleep disorders (aged 14-18)

Physical Health in the form of the provision of sleep management information and support for patients and carers with sleep disorders was a quality priority for 2018/19. It was also one of our Commissioning for Quality and Innovation (CQUIN) targets. During the past year the physical health service implemented behavioural sleep fully into the programme it now offers to its patients, providing information on sleep management and physical health matters to staff across the Trust and receiving patient referrals for sleep management. As a consequence we identified a more specific need for effective sleep management across our adolescent patient population which this priority seeks to address.

The 'Living Well' programme will continue in 2019/20 covering a number of public health issues including smoking, alcohol, drugs, healthy eating, and exercise and stress management. We continue to integrate physical health initiatives within our clinical service lines.

Provide effective sleep management information and support to adolescent patients and carers of those with sleep disorders (aged 14-18)
Targets for 2019/20 Development of the 2018/19 priority
1. Establish an adolescent only group for patients experiencing sleep difficulties (those aged 14 - 18)
2. Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input
3. Develop and disseminate information for clinicians on sleep in adolescence 4. Share sleep information more widely with other external agencies

Measure overview

Patients, carers and staff will be involved in further developing the sleep intervention programme to be delivered during the year. Staff information will be provided to increase knowledge of the programme and further support information will be developed for patients and parents. Formalised sleep assessments will be

implemented and patients offered appropriate written information for self-management or participation in a 5 session group programme.

Information guides on sleep hygiene (see Glossary for definition) have been 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 have been written - one for those aged 13-17 and one for those aged 18+. These information guides have been disseminated to our patient feedback groups for feedback.

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.

Priority 5: Improve waiting time experience from end of assessment to first treatment session in the generic Adult Complex Needs service

During 2018/19 a new short term model of treatment within the Adult Complex Needs service was implemented to meet particular needs. This has led to a welcome reduction in waiting times from assessment to treatment for some patients. The service was restructured in order to set up the new model, resulting in the movement of staff from the generic service to the new treatment model.

We wish to look more closely at what happens to patients when they are waiting for long periods between assessment and treatment in the generic Adult Complex Needs service. The current drop-out rate for patients waiting in this service is high. Since this was recognised, all those on the waiting list have been offered review appointments every 6-8 weeks. A weekly waiting list group has been piloted for up to 8 patients.

Improve waiting time experience from end of assessment to first treatment session in the generic Adult Complex Needs service
Targets for 2019/20 Development of 2018/19 priority
1. Reduce the number and % of patients dropping out between end of assessment and first treatment episode
2. Obtain feedback from service users on their experience of the gap period
3. Review reasons for drop out and patient experience to improve the service for both patients and staff

Measure overview

We will provide a baseline on targets identified for the period prior to the introduction of the short term model of treatment and use quality improvement methodology with the aim of reducing drop-out rates.

How we will collect the data for this target

In the case of patients who do not commence treatment when a vacancy becomes available, we will contact them and possibly their GP in order to gather information regarding the reasons for this (e.g. moved out of area, patient changed their mind about treatment). Feedback will also be obtained from clinicians who were involved with the patient.

Priority 6: Embed meaningful use of outcome measures in services

This quality priority focuses 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. Progress during the year 2018/19 was delayed owing to changes required in the electronic patient record. The focus has been on a single service, South Camden CAMHS, and on GBMs. During 2019/20 we will deliver this priority across both North and South Camden CAMHS services for both GBM and CGAS measures.

Embed meaningful use of outcome measures in CYAF services
Targets for 2019/20 This is an ongoing 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

We will continue to use quality improvement methodology to improve completion rates and involvement of patients for the GBM and CGAS. 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. The CGAS 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, in addition to improving completion rates 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

Small tests of change will be undertaken to identify improvements which can be adopted across the services. Data will be obtained from the electronic patient record system (CareNotes) to monitor these. 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.

Progress against priorities for 2018/19

The progress we have made in delivering our five quality priorities for last year are set out in the following tables.

How did we do against last year's priorities?

Patient safety

Our quality priorities	What success will look like	How did we do?
Improve the identification and management of high risk patients	- Implement an electronic version of the Camden Adolescent Intensive Support Service (CAISS) crisis plan on the electronic patient record system (CareNotes)	**We partially achieved this** A Focus group has been completed with young people and the Crisis plans have been updated in line with feedback from teams and focus group. Currently awaiting confirmation to be take forward change to electronic patient system (CareNotes).
	- Establish online clinical risk assessment training across the Trust and develop processes to ensure robust recording of training compliance procedures	**We partially achieved this** Online clinical risk presentation available with reporting. Face to face workshop continuing three times per year in CYAF. Patient safety lead visited teams to discuss risk assessment. Online training to be set against individual staff groups – this is to be aligned to North Central London work in 2019.
	- Ensure 80% of crisis plans in Adult and Forensic services have been reviewed / updated in the last six months	**We achieved this** All open cases in Adult Complex needs were looked between May – September 18 and clinicians were ask to update risk assessment/ crisis plans. 100% of cases were contacted and updated as a result. This has been audited recently and the compliance target met.
	- Launch Trust's suicide prevention plan and evidence implementation of the action plan	**We achieved this** The Trust's suicide prevention training event took place in March 2019 and the suicide prevention plan has been completed.

Effectiveness

Our quality priorities	What success will look like	How did we do?
Provide effective sleep management information and support to patients and carers of those	- Develop information guides on sleep hygiene with patient, carer and patient representative input - Provide sleep hygiene information to Trust practitioners and patients /Carers	**We achieved this** Through the PPI team patient and carer feedback was obtained and informed the draft of the sleep self-help guide for adults. This was approved and is now on the Trust internet and intranet. Sleep hygiene has continued to be promoted across the trust via staff induction, intranet and refresher training available. New staff are also

Our quality priorities	What success will look like	How did we do?
with sleep disorders	- Provide sleep hygiene information to Trust practitioners and patients /carers - Work with parents and carers of children under the age of 13 years with sleep issues to support them in improving sleep	being trained on sleep hygiene. A written guide has been developed to support parents and carers of children under the age of 13 and has been presented to the PPI forum for feedback.
Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service	- Develop and pilot a new model of care - Reduce the number and % of patients waiting more than 9 months for treatment - Obtain feedback from service users about the new model	**We partially achieved this** The brief intervention model is now in place for suitable patients to be offered the 16 session intervention. Since November 2018 seven clinicians have commenced the treatment. The median waiting time has reduced from 7.7 months to 1.6 months during the period of November 2018 - March 2019. For patients that are completing the treatment, a telephone interview will be conducted in order to obtain feedback. See vignette page 5 for more detail

Clinical effectiveness and patient experience

Our quality priorities	What success will look like	How did we do?
Embed meaningful use of outcome measures in services	- 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. - Obtain service user feedback on the use of outcome measures to feedback on progress - 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 - 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	**We partially achieved this** We adopted a quality improvement approach to improving GBM recording compliance. We started late due to IT changes and requirements to redraft the reports used in this priority and chose to restrict the work to the South Camden service and Time 1 Goal Based Measure (GBM) compliance. Time 2 GBM data will be reviewed in the May 2019. Obtaining service user feedback is going to be added to the QI project requirements for 2019/20. 'Patient view' on the electronic patient record system is now being used as a more effective way of sharing outcome data with patients. However, there are a few issues with graphs that will need to be fixed by informatics. Currently the return rate in South Camden is 50% for Time 1 GBM.

Our quality priorities	What success will look like	How did we do?
Improve patient and carer involvement in care planning in children, young adult and family services	- Improve quality of patient and / or carer involvement in the development of care plans. - Increase the quality of data recorded of care plans shared with patients and referrers - Increase the percentage of care plans shared with patients and referrers	**We partially achieved this** Two patient/carer Focus groups were held in February 2019 and feedback was obtained and evaluated which included the importance of co-creating care plans with patients and carers and sharing care plans across agencies. We have adopted a quality improvement methodology approach to help us increase the percentage of care plans shared with patients and referrers within the Family Mental Health Team. As part of the project we are in the process of improving the reporting structure.

Quality development vignette

Parent Group Report

The parent group was developed out of demand from the parents and carers of patients engaged in CAMHS, many stating in feedback forms that they would appreciate some enhanced programme of advice and guidance relating to managing their child's mental health at home. Through feedback it was determined that the best format for delivering this would be in a group, with a series of presentations about different aspects of caring for young people in the community delivered by clinicians from the CAISS team. This resulted in the setting up of a pilot programme.

The format of the group was open, meaning attendees and parent/carers could decide to opt in or out of different weeks' presentations at their own discretion. Thursday evenings from 18:00-19:30hrs was identified as the best time for working parents with the group running for 6 weeks. Invitations were sent directly to parents of CAISS children and CAISS nurses liaised with staff in the North and South locality CAMHS teams and the LAC team inviting them to refer patient to the group. Weekly measures and an adapted outcome form were used to give data on the participant's views on the group overall. The programme of presentations decided upon included:

1. Introduction to Mental Health
2. Risk: Self harm and suicide
3. Emotional self-regulation
4. Online lives and digital risk
5. Non-Violent Resistance
6. Healthy Living: sleep, diet & exercise, drugs and alcohol

Conclusion: Between 3-7 parents attended each group with feedback overwhelmingly positive. Parents valued practical advice above everything else and would often ask for practical advice about specific scenarios. They also found it valuable to be able to talk to other parents experiencing the same problems. All parents / carers who attended knew at least one of the leaders from clinical practice and it is acknowledged that this may have influenced the responses.
As a pilot study for the feasibility of future groups the groups were a success, showing these could be managed and undertaken by the CAISS team. Although further groups may be run using this model and the materials developed in this process, more consideration should be given to including the generic CAMHS teams more so that they can remember and feel confident to refer any suitable parents to the future groups.

Lessons Learned: Formal feedback on the six sessions was sought at the final session which was the least well attended. The final sessions used a different format to other sessions, with three different people presenting the session. This was least comfortable for presenters and more disjointed for participants. Earlier formal participant feedback would have been helpful and would incorporated into future programmes.
Clinical workloads presented challenges in completing presentations on time
Staff undertaking the sessions were not very experienced as group leaders and developed presentation skills through the process. The challenge was to translate nursing experience into practical, appropriate information for parents when none of the presenters were themselves parents.

Participant Feedback Comments on what they found useful

"Space to think about issues away from home with other parents/carers"
"This is really helpful, wish it had been available before."
"Talking to other parents."

Antonia Carding-Wright
Team Manager Camden Adolescent Intensive Support Service (CAISS)
& Head of CYAF Nursing Discipline

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 2018/19 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 191 contracted services, across two Clinical Directorates, covering 103 teams.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to them on the quality of care in these 191 health services.
The income generated by the relevant health services reviewed in 2018/19 represents approximately (£34.5m) 62.5% of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2018/19.

Participation in clinical audits and national confidential inquiries

National clinical audits and confidential inquiries

During 2018/19 there was one National Clinical Audit but no national confidential inquiries which covered relevant health services that the Tavistock and Portman provides. During that period the Tavistock and Portman participated in 100% of the national clinical audits that it was eligible to participate in.
The national clinical audits that Tavistock and Portman was eligible to participate in during 2018/19 are as follows:

National clinical audit on anxiety and depression (RC Psych)

This was the only national clinical audit that the Tavistock and Portman participated in and for which data collection was completed during 2018/19. One hundred percent of registered cases required by the terms of that audit or enquiry were submitted. The report of this national clinical audit is awaited. The Trust will review this once it is published and take action as required.

Local clinical audits

There were 12 local clinical audits undertaken during 2018-19 with three reports outstanding and two audits still in progress. The reports of 7 local clinical audits

were reviewed by the provider in 2018-19 and the Tavistock & Portman intends to take the following actions to improve the quality of healthcare provided:

1. **Non-binary patients referred into the GIC Speech and Language Therapy service**: the audit looked at those patients seeking voice exploration and modification in order to understand the needs of such patients. The audit found that patients require voice and communication therapy which is bespoke and that speech and recommended language therapists review their competence and skills to ensure these meet requirements, at the same time addressing any unconscious bias.

2. **Transition out of CAMHS at 18 years from NCCT**: Patients likely to transfer to adult services should have transition discussed 9 months before their 18th birthday. The audit found that discussions did not always take place and there was limited awareness of the Transition guidance. These audit findings and guidance information were shared with the teams and will be re-audited.

3. **Review of GP reasons for refusing to prescribe medications for transgender and non binary patients**: The audit resulted in implementing GP training for supporting patients and discussions with NHS England re the labelling of relevant medications for gender patients.

4. **Predictive factors for hypoactive sexual desire disorder (HSDD) in Transwomen**: The audit sought to compare transwomen with and without HSDD to examine if known predictive factors for the development of HSDD in natal females were present in transwomen with HSDD. The types of HRT used was also reviewed. The findings raise the possibility that preoperative hormone management may have an impact on postoperative libido function and support the use of more modern therapeutic hormone preparations in combination with Gonadotrophin Releasing Hormone analogues. The findings were discussed within the GIC service and will be presented at the World Professional Association Transgender Health (WRATH) conference.

5. **Prescription re-audit**: Reviewed Q3 2018/19. A number of discrepancies were identified in the handwritten prescription logbooks when compared with the electronic patient records (Carenotes). An update of the 'Medicines and Prescriptions Procedure' is to be provided and staff made aware of the updates.

6. **Consent audit:** Recommendations included the recording of consent in a single location on Carenotes which is being reviewed, and a discussion with teams underperforming in the recording of consent during treatment.

7. **Referral stamp audit:** The audit was undertaken to check compliance with the date referrals were received and information on Carenotes. This is an important validation audit as it underpins the accuracy of internal and external reports. Compliance has improved since the introduction of referral stamps and greater awareness within administration teams. Information is shared regularly with Administration managers.

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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 9.

The number is low as this refers to Trust patients recruited to research. For many of our studies we are recruiting patients from other NHS Trusts and Local Authorities.

The use of the CQUIN framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2018/19 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 2018/19 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 2018/19 CQUIN was £502,289, plus £200k performance risk share although not in the national guidance. The Tavistock and Portman NHS Foundation Trust have not received final confirmation from the commissioners of the CQUIN performance figure for 2018/19, however we will not receive the full amount as not all targets have been met. Data for the 'Staff improvement' CQUIN relating to Wellbeing, MSK and Stress was taken from the annual NHS staff survey. Whilst a significant amount of work has been done within

the Trust to improve staff health and wellbeing, and the Trust saw some improvement from previous survey data, this was not enough for the target to be met. The national Flu vaccinations CQUIN for frontline clinical staff was partially achieved at 61.5% against a target of 75%. This was a very challenging target given the Trust operates over a large number of sites, and has no on site Occupational Health service. The CQUIN relating to 'Transitions out of Children and Young Peoples Mental Health Services' was partially met, as not all discharge questionnaires were obtained from those in the cohort.

(The Trust received £564,347 for the 2017/18 CQUIN out of a total possible amount of £569,782.84).

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 2018/19.

The Tavistock and Portman NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2018/19.

In August and September 2018 the Trust underwent a routine and well-led inspection by the Care Quality Commission (CQC), with a rating of 'outstanding' for the 'Effective' domain, and 'good' for all other domains. The full report is available on the CQC website, www.cqc.org.uk. The Trust assessment of domain compliance is below.

Two large clinical services were selected for inspection: The adult Gender Identity Clinic and Camden Child and Adolescent Mental Health Services. The former was taken on by the Trust in April 2017 and came with a number of improvements required by CQC following a partial inspection in 2016.

We were rated as requiring improvement in the adult Gender Identity Services because of the long waiting times due to the high demand. The CQC required us to continue to work with Commissioners to further address this issue. Overall the ratings demonstrated our capacity to maintain and improve the quality of our services whilst at the same time managing a doubling of our patient numbers across the Trust since the previous inspection.

The CQC commended the Trust in a significant number of areas:

- Our strong values and ethos, based on strong clinical traditions made relevant for the current day

- High calibre Board, appropriately skilled, open and determined to make necessary changes to provide high quality care. The Trust has a clear and well-understood strategy and a linked clinical quality strategy

- Our strong academic and research links mean that patients have access to innovative treatments. Clinical innovation influenced the evidence base and clinical practice around mental health and well-being, one example being the CAMHS THRIVE model developed with other providers.

- High staff engagement, developed through improvements in communication, appraisals and access to leadership development opportunities

- Staff involved patients and those close to them in decisions about their care and treatment

- Feedback from patients showed high levels of satisfaction with care and treatment. The Trust has many examples of working with people who use services. Our patient and public involvement strategy is supported by PPI co-ordinators who facilitate a range of activities in the trust and with community colleagues and other stakeholders.

- The Trust is outward looking and active participants in the North Central London sustainability and transformation partnership, with executive members of the leadership team taking leadership roles. Staff worked closely with other organisations supporting people so they received co-ordinated care.

The CQC also outlined areas where the Trust should improve. The majority of these matched with issues the Trust had identified prior to inspection and work was in hand to address them. These issues included:

- Monitoring of quality and performance in service lines and further aligning and integrating cross trust governance systems

- Whilst it was acknowledged that the trust was working to implement a range of measures to improve career progression and address discrimination for black, Asian and minority ethnic staff (BAME) , some BAME staff felt that the measures had not yet positively affected their experience of working for the trust

- Responses to complaints were of high quality and showed empathy and willingness to apologise where necessary but significant delays in response had occurred in responding to Gender Identity Service complaints

- Work already in hand to improve health and safety, including fire safety needed to be completed and ongoing safety closely monitored

- People in the Gender Identity Service had long waits although it was acknowledged that the Trust had worked with Commissioners to try to increase funding.

The Trust has a comprehensive action plan to address these issues and an additional number of issues specific to clinical services inspected.

Information on the quality of data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2018/19 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 2018/19 was 97% 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 2018/19 by the Audit Commission.
The Tavistock and Portman NHS Foundation Trust will be taking the following actions to improve data quality:

Internal data processes
The Quality Team has well established communication routes throughout the Trust and continues to meet 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 improvement Key performance target reports are taken to Adult and Forensic, Children and Young Person and Gender Services clinical governance meetings on a monthly basis and the Quality Team continue 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 includes a 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 an established Clinical Data Quality Review Group (CDQRG) meets monthly to analyse and critique data from the patient administration system, with clinical governance leads and administration lead. It is proposed to expand the number of clinicians who attend this group for 2019/20.

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 to review information trends and ensure that actions are being taken to address identified issues.

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 has been agreed to increase the frequency of meetings to quarterly and to review the Terms of Reference alongside the review of Trust Governance arrangements.

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. MHSDS data issues are followed up in the monthly CDQRG meetings.

Trust developments

The Trust initiated the Reducing the Burden Project in 2017 as a response to clinician concerns about spending too much time on administrative tasks, especially since the introduction of Carenotes in 2015. Key changes to the Carenotes system were implemented in early 2019 and continue. These have included changes to form and a reduction of forms to reduce duplication, and general streamlining of notes within the patient record system.

Clinical data quality issues were identified through workshops over summer 2018. Few of the issues presented as 'data quality' were related to any errors with the Carenotes system itself. The root causes of most were found to be related to variation in practice between departments and clinicians or inconsistency in use over time. A Clinical Data Quality Improvement Project has been established to ensure that agreed short and long-term remediation plans are delivered.

Data Quality - audit by RSM

The Trust Internal Auditors, RSM, undertook a Data Quality Audit as part of the approved internal plan for the year 2018/19. The audit reviewed the processes for generating and validating key data used for reporting. This included a review of 'waiting times' and 'did not attend' (DNA) data. The conclusion was that there was 'reasonable assurance' (see Glossary for definition), that the controls in place were suitably designed and consistently applied. The auditor recognised subsequent work being undertaken as part of the Clinical Data Quality Improvement Project and recommended that going forward, the Trust should ensure that processes, capabilities and systems are sufficiently developed to support the use of data in managing Trust performance.

Learning from deaths

All unexpected patient deaths at the Trust are investigated under the Trust Procedure for the Investigation of Serious Incidents and an investigation team is appointed by the Medical Director.

The Trust's contractual Duty of Candour obligations are fulfilled with careful consideration of the needs of family members when suicide is the suspected cause of death. The Trust ensures that the deceased person's GP is aware of the death. This is undertaken by the relevant service director. In addition, the death is reported to other relevant organisations who may have an interest.

The Trust works jointly with other health care providers to review the care provided to people who are current or past patients.

During 2018/19, 11 of the Tavistock and Portman patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:	
Quarter 1	5
Quarter 2	5
Quarter 3	0
Quarter 4	1

By 31 March 2019 1 case record review and 5 investigations have been carried out in relation to 11 of the deaths above. In 1 case a death was subjected to both a case review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:	
Quarter 1	2
Quarter 2	0
Quarter 3	0
Quarter 4	3

All deaths of patients on the waiting list and/or where death was thought to be due to medical causes have been reviewed. Several inquest verdicts are pending. 0 cases representing 0% 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.

Four deaths were reported on the national serious incident system (STEIS) although one was requested to be de-escalated as it related to the death of one of our patients at another Trust.

Brief narrative:

- Patient likely to have died by suicide although inquest has not yet taken place. This death was investigated and reported under the Trust Serious Incident Investigation Procedure.

- Patient known to Gender Identity Clinic (GIC) - accidental death recorded at inquest.

- Patient died of a medical condition not related to their treatment at the Gender Identity Clinic.

- Patient known to GIC found dead at home by relative. No signs of foul play, suicide or accident. Inquest report awaited.

- Patient known to GIC, died in hospital following a fall at home.

- Former patient of GIC died. Inquest verdict was suicide.

- Patient known to GIC found dead at home. Inquest pending.

- Patient who had been referred to GIC but did not attend and was discharged, died from natural causes.

- GIC service alerted by a GP that a patient died in Australia in April 2018.
- Patient found dead by emergency services. Possible fatal overdose but inquest report awaited.
- Death from natural causes of patient on waiting list for adult services.

Actions taken in the reporting period:
An incident panel is convened monthly, chaired by the Medical Director. All deaths are discussed, and any reports reviewed.

A 'learning lessons' event is convened quarterly for Trust staff. Themes and best practice points from recent learning lessons events include the following:

- Risk assessment documentation
- Use of crisis plans
- Documenting multidisciplinary team discussion of complex cases
- Documenting supervision discussions.
- Suicide prevention
- Physical health monitoring
- Follow up of action plans in relation to each investigated death
- Supporting and involving families and carers
- Supporting staff after a patient suicide

0 case record reviews and 0 investigations completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.

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. In respect of patient safety incidents, the Trust does not report enough incidents to be included in the national report. Trust information over time is reported below. The Trust is exempt from the National Patient Experience Survey for community mental health services but undertakes a similar internal survey which is reported below.

Patient safety incidents (PSIs)

The number and rate of patient safety incidents reported within the Trust during 2018/19 are below. Our PSI numbers are too small for the national NRLS reports to provide comparative statistics.

During the past year we submitted 11/40 (27.5%) incidents to the National Reporting and Learning System (NRLS) that caused severe harm or death. Of the reported patient deaths seven were due to medical conditions not linked to Trust care and four were suspected suicide, with outstanding inquests.

Patient Safety Incidents	2015/16	2016/17	2017/18	2018/19
Total reported incidents	401	449	401	505
Patient Safety Incidents	34	114	82	40

Source: Quality Portal (QP), PSIs reported 1 March 2018 to 30 April 2019

*100% increase in children attending the school so increase of injuries e.g. slips and falls / harming each other

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. There is no nationally established and regulated

approach to the reporting and categorising of patient safety incidents, so different trusts may choose to apply different approaches and guidance when reporting, categorising and validating patient safety incidents.

The Tavistock and Portman NHS Foundation Trust considers that this data is as described for the following reasons:

- The organisation provides outpatient psychological therapy services only and no physical interventions;
- The majority of patient safety incidents reported resulted in no harm - 29/40 (72.5%);
- Deaths of all Trust patients, even if on a waiting list and not yet seen, are reported;
- The importance of incident reporting and learning is promoted across the trust in order to support the management, monitoring and learning from all types incidents. Staff are reminded at induction and mandatory training events and lessons are shared using a variety of methods;
- Data for this indicator is derived from the Quality Portal, our internal electronic patient safety software. This was introduced in July 2018 and we have seen a 26% increase in all incidents reported from 2017/18 to 2018/19;
- All clinical incidents are reviewed and action taken if required by the Patient Safety Lead (Associate Medical Director);
- The Trust Clinical Quality Safety and Governance Committee receives information on significant incidents from relevant reporting groups on a quarterly basis;
- There is a monthly Incident panel chaired by the Medical Director where all serious clinical and non-clinical incidents are shared and discussed;
- A 'learning lessons' event is convened quarterly.

Due to issues with administration processes the Trust experienced lengthy delays in reporting incidents to the National Reporting and Learning System during the year. As a result the Trust has reviewed the process for making regular monthly

submissions and tightened up on internal procedures which are being monitored in order to improve the timely submission of PSIs to the NRLS.

See the **learning from deaths** on page 128 for information on clinical incident lessons.

Patient experience

The Trust is exempt from the NHS National Mental Health Patient Survey which is targeted at patients who have received inpatient care and instead use an internal Experience of Service Questionnaire (ESQ) to report on the quality of the patient experience. In 2018/19, 98% of patients rated help they had received from the Trust as 'good'.

Indicator	Q1	Q2	Q3	Q4
Patient rating of help received as good	100%	97%	98%	98%

Please note, the logic surrounding the calculation of the percentages changed in 2017/18 to improve data quality.
* Yearly averages: 2018/19 = 98%; 2017/18= 99%; 2016/17 = 93%; 2015/16 = 94%; 2014/15 = 92%
Source: Quality Team, Data received and calculated: 9-4-19

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 has been clarified.
Numerator = 'certainly true' + 'partly true'
Denominator = certainly true' + 'partly true' + 'not true'.

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 completed by 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 ESQ is to be reviewed during 2019/20 to improve patient response rates and feedback to patients and staff on actions taken as a result of the feedback.

The Patient and Public Involvement (PPI) team oversaw the responses to the Experience of Service Questionnaire (ESQ) feedback during the year and has worked with the Quality and Patient Experience Directorate and Estates and Facilities to address issues identified in responses and through health and safety assessments. This has included improvements to Gloucester House water and fire safety, as well as responding to negative feedback about décor and access signage which has led to various fabric upgrades together with signage and decoration works.

The Main Tavistock centre has improved overall safety with the reduction of kettles in clinical spaces by installing constant hot water taps to eliminate potential hazards. The trust has also undergone an upgrade in the installation of LED lighting to ensure safety during darker winter hours.

The PPI team have supplied clinical teams and communication to improve written communication around issues such as access and parking. We now have a downloadable/printable page on our website called 'How to find the Tavistock Centre' with comprehensive map displays and guides to local public transport, parking and walking access. One of main areas of work this year was signposting around available parking access for patients who are not entitled to parking by teaming up with the online parking service 'Ringo' to allow patients to download a parking app which is convenient to patients who are not familiar with central London parking.

The PPI team are also working with the Director of Quality and Patient Experience and a service user representative on an Accessible Information Standards group. This included a walkthrough to assess the access and clarity of signage and access to space at the Tavistock Centre in November 2018. Feedback from this workstream is being undertaken by the Accessible Information Standards work group.

Part 3: Review of quality performance

Quality of care overview: performance against selected indicators

This section contains information on the quality of services provided by The Tavistock and Portman NHS Foundation Trust during 2018/19, describing the Trust's progress against indicators selected by the Board in consultation with patients.

This includes an overview of the quality of care offered by the Trust based on our performance in 2018/19 on a number of quality indicators selected by the board in consultation with internal and external stakeholders. At least three indicators for each of the three quality domains of patient safety, clinical effectiveness and patient experience are included. 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. Indicators include those reported in the past three years.
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 2018/19.

Single oversight framework (SOF)

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers, with the indicators acting as a trigger to detect possible governance issues and identify 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. The Trust is currently in segment one.

The data reviewed by NHSI as part of the SOF is presented quarterly to the Board. Quality of care information includes formal complaints, staff Friends and Family Test (FFT) findings and actions and patient safety incidents, reviewed alongside the Mental Health Services Data Set (MHSDS), and operational performance. The inclusion of Gender Identity Clinic (Charing Cross) services from April 2017 has had an ongoing impact for 2018/19 on some MHSDS metrics but these are improving. The service is now collecting data not previously routinely collected.

MHSDS Single Oversight Framework Indicators	Target (%)	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)
Valid NHS number	95%	98.6%	98.7%	98.9%	98.9
Valid Postcode	95%	99.7%	99.8%	99.8%	99.8
Valid Date of Birth	95%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.1%	99.2%	99.0%	99.0%
Valid Organisation code GP Practice	95%	98.2%	98.0%	98.1%	98.2%
Valid Gender	95%	99.8%	99.7%	99.4%	99.4%
Ethnicity	85%	78.4%	76.0%	75.8%	76.1%
Employment Status (for adults)	85%	43.4%	50.5%	51.6%	54.0%
Accommodation status (for adults)	85%	42.9%	49.9%	51.0%	53.2%
Overall finance and use of resources - NHSI risk rating segmentation		1	1	1	1

Patient safety

Patient Safety Incidents (PSIs)

This information is included under section 2.4.

Child and Adult Safeguarding Alerts

Indicator	2015/16	2016/17	2017/18	2018/19
Child Safeguarding Alerts	71	111	239	377
Adult Safeguarding Alerts	7	6	6	9

Source: Clinical Governance Report, Data received and calculated: 4-4-19
The incremental increase in child safeguarding alerts is due to improvements and enhancements in training on the importance of recognising, reporting and recording safeguarding and child protection concerns. Use of the Electronic Patient Record system and improved IT access to aid recording of such information and the role of the Patient Safety Officer in reinforcing compliance has been important. The Safeguarding Team provide support and advice to staff and will escalate issues as required. They provide 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 four 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.

Training 2018/19

Description	2017/18 Overall figures	Apr - June Quarter 1	July - Sept Quarter 2	Oct - Dec Quarter 3	Jan - Mar 2019 Quarter 4	2018/19 Overall figures
Mandatory Training Compliance INSET Attendance	88%	94%	94%	94%	94%	94%
Trust-wide Induction		96%	93%	95%	92%	92%
Local Induction Checklists Completed	94%	97%	96%	97%	98%	98%

Source: Electronic Staff Record, 11-4-19

Disclosure and Barring Service (DBS) compliance 2018/19

Description	2017/18 Overall figures	Apr - June Quarter 1	July - Sept Quarter 2	Oct - Dec Quarter 3	Jan - Mar 2019 Quarter 4	2018/19 Overall figures
DBS Compliance Checks Completed	97%	98%	97%	98%	98%	98%

Source: Electronic Staff Record, 11/04/2019

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions on more than four million people every year. The DBS is an executive non-departmental public body of the Home Office.

The Trust's Recruitment and Selection policy requires that all staff who handle patient or membership data, interact with patients or are a member of the Board,

have a Basic or Enhanced (dependent on their role) check every three years. The indicator measures compliance against this policy.

Sign up to safety

The focus on quality of care and patient safety remains central to the Tavistock and Portman NHS Foundation Trust. The five-year National Sign up to Safety Campaign was a national patient safety initiative 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 Trust signed up to the campaign in October 2015. The actions we chose to take led to the development of a Safety Improvement Plan which has been implemented over the past three years as a means to reduce harm to patients. The national campaign finished in March 2019 with around 98% of the NHS in England joining the campaign. There is a plan to share the most important points learnt across organisations until March 2020. Meanwhile, the new national patient safety strategy is due to be published in April 2019. Trust local improvement plans for 2019/20 will be required to include measurable outcomes for nationally agreed patient safety initiatives.
Our patient safety improvement plan during 2018/19 has focused on the areas below.

- Improving the physical health of patients
- Improving clinician knowledge of self-harm and suicide
- Improving domestic violence and abuse management

The Trust has an agreed Clinical Quality Strategy to meet the local needs of our service users and the core aims have driven 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 as well as 2018-19. Work has been undertaken to embed the use of the revised physical health form assessments for all patients 13 years and above, with referrals to the PHSP for one to one support, or, if appropriate, onward referrals into the community. The Living Well Service provides treatment for smoking, drinking, substance use, healthy weight, and sleep. 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

- "In house" e-learning module is being revised;
- Recent risk assessment and suicide prevention trainings;
- "Train the trainers" workshop events in development for Q1 and Q2 2019/2020;
- Discussion of relevant incidents at monthly incident panel;
- The Trust holds quarterly learning lessons events. There will be a focus going forward on specific themes including risk assessment, self-harm and suicide prevention;
- Yearly audit of case notes risk assessments.

Improving domestic violence and abuse management

Domestic violence and abuse is also part of the safeguarding level 3 training and the Barnardo's Metrics on domestic violence and abuse management have been incorporated into the Safeguarding and Risk under 18 form under the 'domestic violence/ abuse' risk section of the form as a guidance to help healthcare practitioners identify the level risk and record correctly. In addition, there are termly safeguarding children forums where team managers or representatives attend and

this issue is constantly addressed as well as any new updates in regulations and procedures.

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-bacterial wipes have been made available in all administration offices and Reception as an additional cleaning resource.

Since April 2016 we have initiated processes for estates and facilities staff to clean communal area toys on a regular basis on sites managed by the Trust Estates team. Further work has been undertaken in the past year to improve compliance with agreed toy cleaning procedures. The Infection Prevention and Control procedure was updated to include Toy cleaning schedules to be managed by Facility Staff on all trust properties and clinical staff have been supplied with wipes for any 'shared' toys in the their offices and family rooms.

The Trust organised on site access to flu vaccination for staff at the Tavistock Centre and a number of its associated satellites. The programme was delivered by the Royal Free London NHS Foundation Trust's Health at Work Centre's staff through the flu campaign from October to February. Staff were also able to attend walk in clinics at the Royal Free Hospital. Satellite and community staff are encouraged to make arrangements for their own flu vaccines and report this to our HR service. Staff are reminded of individual responsibilities for reducing the risk of cross infection at induction and mandatory INSET training.

Wipes and Spill Kits are available at all receptions in case of an accident. Trust staff working in the community are to be provided with individual hand sanitisers to reduce the risk of infection.

Patient experience

Formal complaints received

Indicator	2015/16	2016/17	2017/18	2018/19
Formal Complaints received	27	39	154	158

Source: Quality Portal (QP), 07-05-19

A formal complaint is defined as any written complaint received from a patient or a representative of the patient. A verbal complaint may be treated as a formal complaint if the complainant wishes their concerns to be treated formally. The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. Following the rise in complaints from 2016/17 to 2017/2018 which was due to the Trust's acquisition of the Charing Cross Gender Identity clinical complaints have remained at approximately the same level. For 2018/19 we received 158 complaints of which 102 related to the Gender Identity Clinic. The service receiving the next largest amount of complaints was the Gender Identity Development Service for those under 18 years of age, which received 27 complaints.

Formal Complaint Categories	1 April 2018 -31 March 2019
Access to Treatment or Drugs	20
Appointments	10
Clinical	34
Communications	30
Information Governance	5
Trust Administration	22
Values Behaviours	16
Waiting Times	21
Total	**158**

Source: Quality Portal (QP), 07-05-19

Eighteen complaints were received in the Adult and Forensic Directorate, 136 were received in the Children, Young Adults and Family Services Directorate (this includes the Gender Identity Clinic) and four 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 two complaints were referred to the Health Service Complaints Ombudsman. One of these is being investigated and the second one has concluded and was

partly upheld. A letter of apology has been sent to the complainant. Of the four complaints referred to the Ombudsman the previous year none were 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. Action plans following complaints will be reported to the Patient Safety and Clinical Risk meeting.

During 2018/19 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 and on the website.

Experience of survey questionnaire: friends and family test only

The Trust 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.

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%	98%

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 2018/19 = 97% 2017/18 = 98%; 2016/17 = 93%; 2015/16 = 94%.
Source: Quality Team, Data received and calculated: 5-4-19

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 2018/19.

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

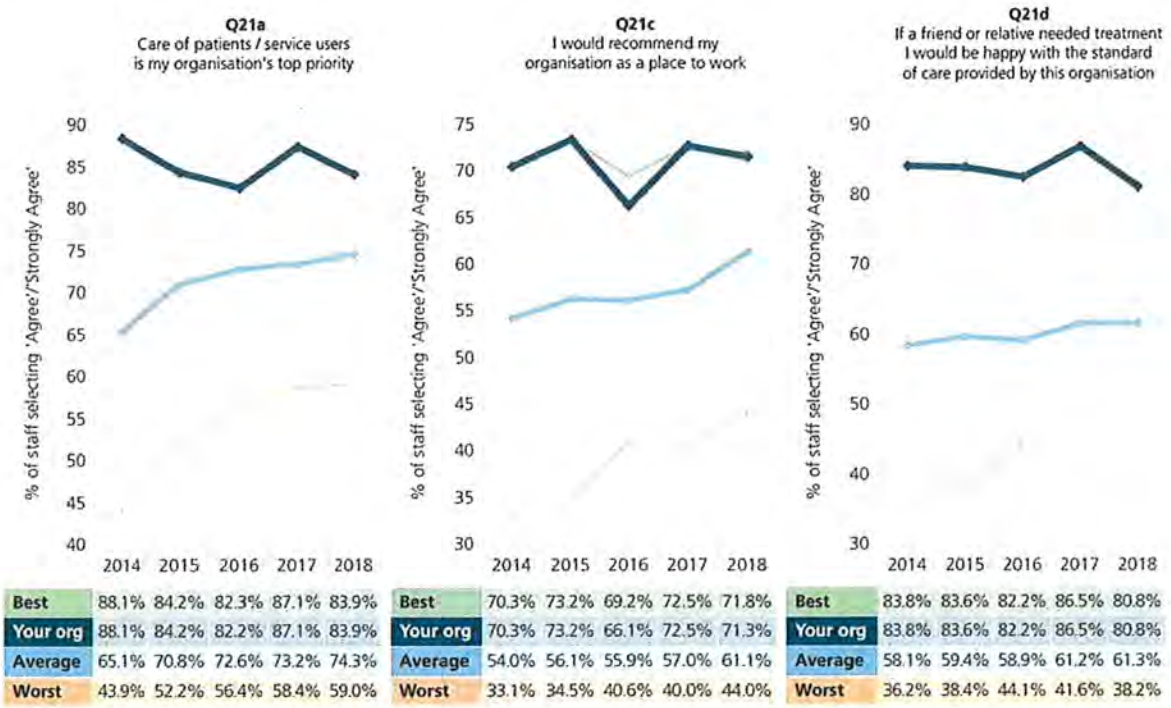
Children Young Adults and Family services respectively with assistance from the Quality Team and the Patient and Public Involvement team.

Patient satisfaction

This information is included under reporting against core indicators covered on page 130.

Clinical effectiveness

Staff Survey - quality of care provision



The NHS Staff Survey takes place every year between October and December. In 2018 the Trust received its highest response rate with 60% of eligible staff completing a survey. The survey gives us a richness of information about our staff experience and the quality of care they feel they are able to deliver.

In the most recent survey we learned that amongst our peer group we rank as the best mental health and learning disability provider Trust where staff believe care is our organisations top priority; the highest level of advocacy for receiving treatment at our organisation; and, the second best of staff recommending the organisation as a place to work.

These results are further confirmed in the positive care quality measures that we demonstrate through this quality report.

Outcome data (GBM/CORE)
Child and Adolescent Mental Health Service (CAMHS)

Child and Adolescent Mental Health Service Outcome Monitoring Programme Targets for 2018/19	2015/16	2016/17	2017/18	2018/19
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%	49%
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%	57%

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 9-4-19

For our Camden 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. This helps us to make adjustments to the way we work with the individual. The percentage of outcomes monitored has decreased for both Time 1 and Time 2 since 2017/18. This is to be addressed through our 'Embed meaningful use of outcome measures in CYAF services' Quality Priority 6 for 2019/20.

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 within the first two appointments, where the patient decides what they would like to achieve. 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.

Outcome monitoring - Adult Service

Adult Outcome Monitoring Programme Targets for 2018/19	2015/2016	2016/2017	2017/18	20/18/19
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%	83%

Source: CareNotes/Quality Team. All data is the annual percentage. Data received and calculated: 9-4-19

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 rate 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.

For the Adult Service which includes 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).

Did not attends (DNAs)

Indicator	2015/16	2016/17	2017/18	2018/19
Trust-wide Total				
First Attendance	12.4%	10.0%	12.4%	**11.8%**
Subsequent Appointments	8.6%	7.4%	9.8%	**8.3%**
Adolescent and Young Adult				
First Attendance	18.3%	15.4%	13%	**5.7%**
Subsequent Appointments	12.9%	8.5%	11%	**6.8%**
Adult				
First Attendance	15.9%	11.6%	21%	**22.6%**
Subsequent Appointments	7.4%	6.5%	9.4%	**8.4%**

Indicator	2015/16	2016/17	2017/18	2018/19
Camden Child and Adolescent Mental Health Service (Camden CAMHS)				
First Attendance	10.8%	8.3%	9.3%	6.9%
Subsequent Appointments	9.0%	7.7%	8.9%	8.1%
Other CAMHS				
First Attendance	4.4%	6.4%	12.4%	3.9%
Subsequent Appointments	4.7%	6.1%	8.2%	5.5%
City and Hackney				
First Attendance	19.7%	12.9%	18.8%	20.6%
Subsequent Appointments	13.8%	10.2%	11%	7.7%
Portman				
First Attendance	11.0%	5.7%	5.6%	13.1%
Subsequent Appointments	8.2%	7.0%	9.4%	8.7%
GIDS				
First Attendance	10.6%	10.7%	11.6%	13.8%
Subsequent Appointments	8.8%	7.4%	10.2%	9.4%
GIC*				
First Attendance	n/a	n/a	12.4%	13.4%
Subsequent Appointments	n/a	n/a	14.8%	13.5%
Westminster Service				
First Attendance	4.9%	1.5%	8.3%	0%
Subsequent Appointments	5.5%	12.7%	9%	14.2%

Source: CareNotes, *GIC Service was taken on by the Trust from 1-4-17 Data received and calculated: 5-4-19

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.

Taking in account patient numbers, there has been an overall decrease in DNA rates for both first attendances and subsequent/follow-up appointments compared with last year.

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.

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 (Trust wide) - Target dependent on service
Number (%) of patients attending a first appointment 6, 8, 11 or 18 weeks after

Service	Target	Total Breaches 2017/18	Total Breaches 2018/19	Total accepted referrals waiting at the end of financial year 2017/18 - 2018/19
Adolescent Service	<8 weeks (10%)for under 18 and <11 weeks for over 18	19.2%	21.70%	35 - 70
Camden CAMHS	<8 weeks (10%)	4.1%	7.09%	109 - 99
Other CAMHS	<8 weeks (10%)	20.8%	31.90%	57 -102
Westminster Family Assessment Service (FAS)	<6 weeks (10%)	24.4%	41.46%	9 -6
Adult service	<11 weeks (5%)	13.4%	27.39%	32 - 99
Portman	<11 weeks (10%)	2.0%	15.66%	5 - 5
City and Hackney PCPCS	<18 weeks (10%)	2.4%	1.57%	58 - 85
Gender Identity Development Service (Under 18)	<18 weeks (10%)	79.1%	87.57%	1652 - 2945
Gender Identity Clinic (Over 18)	<18 weeks (10%)	95.0%	94.14%	1723 - 3717

Source CareNotes. 18/19 Data received and calculated 5-4-19

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait. 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 definition is as follows:

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;

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

To help address the breaches, at the end of each quarter 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 2018/19. In many services patients are seen within our waiting time targets, these include Camden CAMHS and City and Hackney PCPCS. Increased waiting times have been due to a mix of reasons including insufficient referral information, delays in recruiting staff with specialised skills and staff sickness levels. All teams have action plans in place to increase compliance during the next financial year.

In our Gender Identity Development Service (GIDS) and Gender Identity Clinic (GIC) Service compliance with waiting times is due to the continued increase in the referral rates and shortage of staff. Both services are working on reducing the rates of patients not attending appointment (Did Not Attend) by the use of text reminders, and are working closely to improve transfer from the GIDS to the adult GIC service. Timely transfer of young people to adult services would reduce staff caseloads in GIDS which in turn will creates space for new referrals to be picked up. Additionally, the GIC service is receiving support from NHS England's Intensive Support Team to further understand the issues and develop solutions that are possible for improvement.

Reported raising of concerns: whistleblowing

The Trust takes the issue of staff being able to raise concerns, or 'whistleblowing', very seriously and appointed a freedom to speak up guardian (FSUG) in October 2015. This was in line with the 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 and of their role and contact details. Meetings have been held with groups of staff to raise awareness and there are regular presentations at mandatory training update days and updates sent out via the communications team.

There were two whistleblowing complaints raised in 2018/19 one related to a clinical service and was thoroughly investigated, with no immediate patient safety concerns identified. The other related to use of our Trust employment processes and was not upheld.

Our staff also contact the freedom to speak up guardian 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 can be seen as having an indirect impact on the quality of care given to patients and families. These concerns have usually been discussed more openly and sometimes resolved, but others need more ongoing follow up with both staff and senior managers.

The Trust is 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. Staff need to feel empowered to speak up in whatever way they feel comfortable with, even if this is anonymously or through staff other than the freedom to speak up guardian. This is something to be aimed for in all Trusts and needs a flexible approach; the pressures on staff working in different areas of the Trust constantly fluctuate and change and it is not always easy to anticipate and respond to perceived difficulties effectively. However, the Trust has a duty to try to learn from issues that are raised and to work together with staff and managers to improve communication.

The freedom to speak up guardian is in regular contact with the national whistleblowing helpline and receives regular newsletter updates. They have 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 and arranges regular conferences and training events. The freedom to speak up guardian also meets regularly with other staff in the Trust who hold responsibility for staff wellbeing, such as the staff side representatives, the HR and corporate governance director, the director of quality and patient and a link non-executive; alongside consulting with the chief executive, service directors and managers 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.

Staff rota information

The Trust appointed a Guardian of Safe Working Hours to coincide with the implementation of the new junior doctors' contract. Earlier in the financial year there were two vacancies on our rotation allocation from Health Education England (HEE). Following extensive work from our training programme director and working

collaboratively with the London regional team at HEE the Trust has reached the financial year end with no vacancies within our training allocations.

Part 4: Annexes

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 (CCCG) 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). 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 information was presented in a clearly structured format, making appropriate use of sections and headings, so that the information was *easy* to locate and *follow*.

The CCG continues to meet with the Trust on a bi-monthly basis at its Clinical Quality Review Group meetings (CQRG), where commissioners are provided with assurances regarding the quality of care and services provided by the Trust.

We are disappointed the Trust did not achieve some of the 2018/19 priorities, particularly the Child and Adolescent Mental Health Service Outcome Monitoring, which has not been achieved two years consecutively. It is envisaged the Trust make substantial improvements during 2019/20, in supporting achieving goal based measures to further support patients to focus on what is important to them.

Commissioners are pleased to note the Trust are building on last year's quality priority in improving identification and management of high risk patients, as patient safety is a key driver in providing quality services. We are delighted the Trust have decided to further strengthen and improve waiting time experience as a priority, which we hope will streamline systems and processes to reduce waiting times across all services provided by the Trust.

The Trust were rated as 'Good' by the Care Quality Commission, following their inspection in 2018. The Trust have developed an action plan for improving areas highlighted by the inspection and as commissioners we have discussed assurance at CQRG.

The Trust implemented new electronic patient safety software in July 2018, resulting in an increase in incident reporting. In addition, the Trust have established a monthly incident panel, where all incidents reported through this system are reviewed, which has resulted in improvements regarding the Trusts oversight and management of all incidents, including Serious Incidents.

The CCG are confident the Trust will continue with their current work to improve processes relating to Serious Incident Management and take actions to improve the timely submission of patient safety incidents to the National Learning and Reporting System.

We are cognisant that the Trust need to continue with their work to raise awareness of safeguarding within the Trust and in particular, to provide consistency within the adult safeguarding role in order to provide excellent quality of care to patients.

There remain areas for improvement and as commissioners NHS Camden CCG will continue to work with the Trust to monitor these areas, enabling improvement in the quality of services provided to patients. We look forward to hearing of progress against the Trust's chosen priorities and Quality Improvement initiatives throughout 2019/20.

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.

In response to commissioner feedback we are pleased with the work undertaken on the majority of our 2018/19 quality priorities during the year, in particular the work around a reduction in waiting times for patients within the Adult Complex Needs services, and the Risk Awareness actions. However, we share the commissioner disappointment in not achieving some these in full, in particular the Child and Adolescent Mental Health Service Outcome Monitoring priority. We anticipate that

we will see an improvement in patient outcome data during the coming year by working with staff and patients using quality improvement methods.

We acknowledge that further work is required to raise awareness of children and adult safeguarding within the Trust and are committed to ensuring actions are taken to provide excellent quality of care to patients.

We look forward to working collaboratively with our commissioner colleagues on quality issues and the implementation of our quality priorities during the coming year.

Statement from our Governors

The Council of Governors note that the Quality Report identifies the serious approach that the Trust takes with regards to these matters. It is clear that the organisation is a leader in its field and that it should remain committed to pursuing ongoing quality improvement. The Trust acknowledges it has further work to do and there is planned action to develop further.

Waiting times across the Trust's gender services are noted as being well above where the organisation would like to be performing, but the Council notes that there are clear plans in place to attempt to address these issues.

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 thanks the Trust for the opportunity to comment on your Quality Accounts. We were pleased to be involved in the Trust's discussions on quality during the year. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS means that we do not have the human resources to consider Quality Accounts in the detail that they deserve this year. We look forward to commenting in future years.

Trust Response:
We have welcomed the involvement of Camden Healthwatch in Trust discussions on quality during the year look forward to your continued involvement as we develop the quality of our services.

Statement by Chair of the London Borough of Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Alison Kelly, and they should not be understood as a response on behalf of the Committee.

Thank you for sharing your 2018/19 quality report for comment. The report is well written.

The Trust is to be congratulated on the 2018 CQC inspection results, in particular the rating of 'outstanding' for 'effectiveness', the overall progress made in 2018/19 and for the dedication of so many colleagues who ensured this happened.

The NHS staff survey is similarly positive – with a high response rate, and with the Trust rated by staff as the best mental health and learning disability provider.
The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do
The report makes clear that the organisation's overriding priorities are improving patient safety and experience, followed by improving clinical effectiveness, including reducing waiting times and embedding meaningful use of outcome measures in services.

2) Focussing on a common purpose, setting objectives, planning.
The Trust has six priorities, four of them carried forward from 2018/19. Targets are provided but can be less specific and measurable than ideal from a strategic perspective.

3) Working collaboratively
It was positive to learn about the Trust's work with the Parent Group. Many families would consider taking this work forward to be a priority for the Trust.
It would be helpful to include a list of the 20 largest contracts and sub-contractors covering the 103 teams at the Trust. It would also be helpful to have a better understanding of the main purchasers of services by name and their level of spend.
Mental health issues cannot be solved by the Trust alone. It would be helpful to know how the Trust works with local organisations to ensure the best outcomes for local people.

4) Acting in an open, transparent and accountable way – using inclusive language, understandable to all – in everything it does

The report, while being well written, can be difficult to navigate.
Priorities 1-6 for 2019/20 are explained in pages 6-12. It is unclear, however, where quality development on page 13 on developing a diagnostic pathway fits into the overall story. The same can be said of quality development on the patient group on page 16.

Progress against 2018/19 priorities is outlined in pages 14-15. However it is unclear how many priorities there were in 2018/19, except those brought forward to 2019/20. This included what progress has been made against Priority 3 listed on page 6 as a brought forward priority from 2018/19.

The findings of the local clinical audits, pages 17-18, could be linked to the 2018/19 and 2019/20 priorities and progress. As could the quality performance data presented on pages 27-37.

It would have been helpful to have had the resume of the report from the independent auditor included in the version sent across for comment.
We have reviewed quality reports which are similarly comprehensive but are easier to navigate. The versions that have been easiest to comment on appear to be more complete and less in a draft form. It might be helpful to share best practice across North Central London Partners.

We would like to finish by thanking the Trust for its commitment to high clinical standards and the best possible patient experience across the Trust.

Trust Response:
The Trust is grateful for the acknowledgement of our 2018 CQC inspection results and the positive staff survey results. We appreciate the feedback regarding the content of the report. Some of the questions raised are addressed in the full Annual Report of which the Quality Report is a part. Within the Quality Report we provide summaries of our progress on quality priorities but we would be pleased to provide our more detailed reports which demonstrate more fully the work undertaken over the year, building on progress in previous years. The document is set out in accordance with guidance but we will look to examples elsewhere to endeavour to provide a more readily comprehensible and navigable document next year. The 'Quality Development' information in section 2 are examples of work undertaken within the Trust to improve the quality of services during the year. In respect of progress against our quality priorities for 2018/19 we have amended the report so that it is clear there were five priorities.

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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*.
- 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 2018 to May 2019
    - papers relating to quality reported to the board over the period 1 April 2018 to 31 March 2019
    - feedback from commissioners dated 08 May 2019
    - feedback from governors dated 02 May 2019
    - feedback from local Healthwatch organisations dated 08 May 2019
    - feedback from Overview and Scrutiny Committee dated 03 May 2019

- the trust's complaints data published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28 May 2019

- the 2018 national staff survey 26 February 2019

- the Head of Internal Audit's annual opinion of the Trust's control environment dated 28 May 2019

- CQC inspection report dated 16 November 2018

- 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

RT Hon Paul Burstow
Trust chair

Paul Jenkins
Chief executive

28 May 2019

Independent auditor's report to the council of governors of The Tavistock & Portman NHS Foundation Trust on the quality report

We have been engaged by the council of governors of The Tavistock & Portman NHS Foundation Trust to perform an independent assurance engagement in respect of The Tavistock & Portman NHS Foundation Trust's quality report for the year ended 31 March 2019 (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 & Portman NHS Foundation Trust as a body, to assist the council of governors in reporting The Tavistock & 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 2019, 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 & 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 2019 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 choose two alternative indicators of its choice for testing, which have been selected as follows:

- number of formal complaints during the reporting period (Formal Complaints); and
- percentage of staff who are compliant with the Trust's Disclosure Barring Service (DBS) checks policy at the end of the reporting period (DBS Checks Compliance)

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 2018/19 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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from Commissioners, dated 8 May 2019;
- feedback from governors, dated April and May 2019;
- feedback from local Healthwatch organisations, dated 8 May 2019;
- feedback from Overview and Scrutiny Committee, dated 3 May 2019;
- the trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019;
- the latest national staff survey, dated 26 February 2019;
- Care Quality Commission inspection report, dated 16 November 2018;
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; and
- 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' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Tavistock & Portman NHS Foundation Trust'.

Basis for qualified conclusion

Percentage of staff who are compliant with the Trust's Disclosure Barring Service (DBS) checks policy at the end of the reporting period.

The "percentage of staff who are compliant with the Trust's Disclosure Barring Services (DBS) checks policy at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the compliance status of each staff member, in accordance with detailed requirements set out in the Trust's recruitment and selection policy. This is calculated as a percentage of the total number of staff who are compliant with the policy against the total number of staff who work at the Trust.

Our procedures included testing a risk based sample of 18 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 1 case of our sample of staff records tested, the DBS check required by the policy was not accurately recorded affecting the calculation of the published indicator;
- In 4 cases of our sample of staff records tested, the DBS check required by the policy was not accurately recorded, but did not affect the calculation of the published indicator; and
- In 1 case of our sample of staff records tested, the date of the most recent DBS check was not accurately recorded affecting the calculation of the published indicator

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of staff who are compliant with the Trust's Disclosure Barring Services (DBS) checks policy at the end of the reporting period" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

In addition, we identified:

- In 3 cases of our sample of staff records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting "percentage of staff who are compliant with the Trust's Disclosure Barring Services (DBS) checks policy at the end of the reporting period" indicator for the year ended 31 March 2019.

The "Information on the Quality of Data" section of the NHS Foundation Trust's Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 the detailed guidance; 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

Deloitte LLP
St Albans
28 May 2019

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.

CAMHS - Child and Adolescent Mental Health Services

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.

Data Security and Protection Toolkit (replacing the Information Governance Toolkit) - It is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardians' 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. It also draws together legal rules and central guidance included in the various Acts (GDPR, DPA18) and presents them in one place as a set of data security and protection assertions.

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 Improvement (NHSI) – NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. The organisation works with the Department of Health and Social Care.

NHS Resolution (formally the NHS Litigation Authority (NHSLA)) – The NHSLA changed its name to NHS Resolution in April 2017. It 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 surveys and audits, suggestions boxes, 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 Incident - 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. Such incidents are reportable to the National Reporting and Learning System (NRLS).

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 Advisory Group Meetings - These include consultation meetings with stakeholders including patients, commissioners, Non-Executive Directors, a Governor and Quality and Patient Experience directorate representatives. The purpose of these meetings is to contribute to the process of setting and reviewing quality priorities and indicators and to help improve other aspects of quality within the Trust.

Quality Improvement
Quality improvement (QI) is about improving patient (and population) outcomes, system performance and professional development. The Institute of Healthcare Improvement (IHI) Model for improvement (MFI) is one type of quality improvement (QI) methodology. More than a methodology, QI is about a change in behaviours, working together, change coming from bottom up, creative thinking and fundamentally, using measurement to guide improvement. The MFI consists of three questions which guide the course of a project namely: (i) What are we trying to accomplish? This guides the setting of the project aim and plan. (ii) How will we know that a change is an improvement? This concerns regular real time measurement, and (iii) What changes can we make that will result in improvement? This concerns the development of ideas to make improvement, and testing these.

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.

Reasonable Assurance – Terminology used by the Trust Internal Auditors (RSM) to provide their 'opinion' to any audit they undertake.

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'.

Sleep hygiene - Sleep hygiene is a variety of different practices and habits that are necessary to have good nighttime sleep quality and full daytime alertness.

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

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 an agreed time 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. This varies from 8 - 18 weeks depending on contract requirements. 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.

5 Annual accounts

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 2019 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 Taxpayers Equity;
- the Statement of Cash Flows; and
- the related notes 1 to 30.

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: • Recognition of NHS revenue • Accounting for capital expenditure These key audit matters are consistent with the prior year.
Materiality	The materiality that we used for the current year was £1,120k which was determined on the basis of 2% of the Foundation Trust's total revenue recognised in the 2018/19 financial year.
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 engagement partner.

Significant changes in our approach	There have been no significant changes in our approach to the audit in 2018/19 compared to 2017/18.

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.

Recognition of NHS revenue	
Key audit matter description	As described in note 1.2 and 1.4.1, 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 accounting for disputes with commissioners; and • the Provider Sustainability Fund (PSF) income, which is dependent on the Foundation Trust meeting certain financial performance targets and therefore recognition of this income is affected by other accounting estimates. Details of the Foundation Trust's income, including £30,127k (2017/18: £27,694k) of Commissioner Requested Services, are shown in note 4.1 to the financial statements. NHS debtors are shown in note 18 to the financial statements. The Foundation Trust earnt £2,225k (2017/18: £2,183k) of Provider Sustainability Fund (PSF) income, 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 have evaluated the design and implementation of controls over recognition of NHS income. We have considered the Foundation Trust's performance against it's control total and the management estimates that impact that control total, and the eligibility of the Foundation Trust to recognise PSF income. We have also reviewed the Foudnation Trust's correspondence with NHSI

	regarding PSF income, to validate the amount of PSF income reocgnised in the financial statements. We have held discussions with the finance 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 Foundation 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.
Key observations 	Based on the work performed we have concluded that the recognition of NHS revenue in the year is appropriate.
Accounting for capital expenditure	
Key audit matter description 	The Foundation Trust's capital spend on Property, Plant and Equipment was £2,053k in 2018/19 (£2,785k in 2017/18). This is shown in note 14 of the financial statements. We note that the Trust is undergoing a significant capital programme, which includes 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 significant judgement in identifying when an asset is ready for use and identifying whether spend 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. This is a potential misreporting fraud risk as there may be an incentive for the Foundation Trust to capitalise spend, in year, which does not meet the conditions for capitalisation to facilitate meeting its control total. The Foundation Trust has disclosed, in Note 1.2 of the financial statements, a critical judgement that its relocation to a site in Camden is probable and therefore continue to recognise approximately £1.4m of assets in relation to the project within property, plant and equipment.
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 discussed each project undertaken in the year with management and noted that overall all capital projects are capital in nature. We have discussed the relocation project with management, including the Head of Estates and Relocation Project Manager, and we have sample tested the costs incurred on the project in the current year to ensure that they comply with relevant accounting requirements. We have challenged management and the Board on its judgement regarding the probability of its relocation to a site in Camden, including

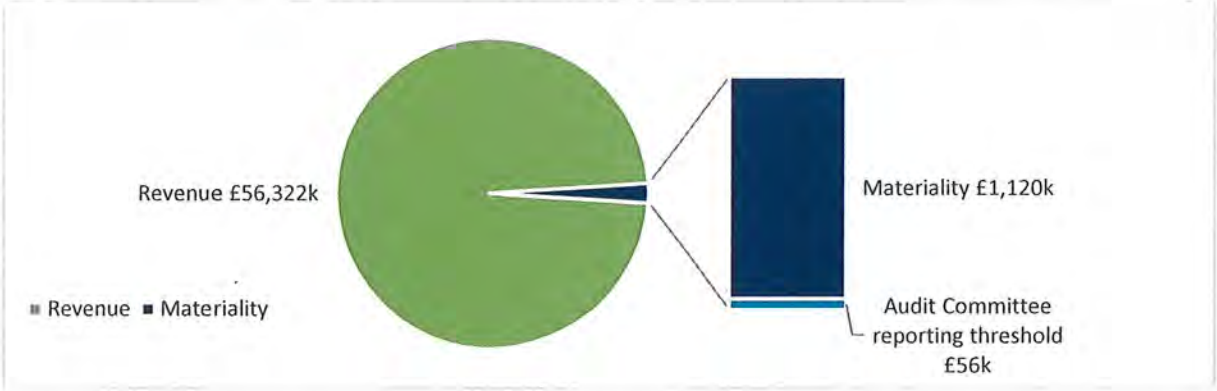
	with respect to the level of funding that would be required for the project.
Key observations	Based on the work performed we have concluded that the amount capitalised by the Trust in the year is not materially misstated. Whilst we agree that the relocation to a site in Camden remains probable, we consider this to be at the lower (less prudent) end of an acceptable range of probability.

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	£1,120k (2017/18: £1,060k)
Basis for determining materiality	2% of revenue (2017/18: 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 £56k (2017/18: £53k), 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
28 May 2019

Foreword to the accounts

Tavistock and Portman NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 & Accounting Officer**
Date	**28-May-19**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	30,127	27,694
Other operating income	4	26,195	25,400
Operating expenses	5, 7	(52,993)	(49,706)
Operating surplus from continuing operations		**3,329**	**3,388**
Finance income	10	37	9
Finance expenses	11	(34)	(2)
PDC dividends payable		(616)	(595)
Net finance costs		**(613)**	**(588)**
Surplus for the year from continuing operations		**2,716**	**2,800**
Surplus for the year		**2,716**	**2,800**
Other comprehensive income/(expense)			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(729)
Revaluations	16	471	729
Total other comprehensive income		**471**	**-**
Total comprehensive income for the period		**3,187**	**2,800**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	251	184
Property, plant and equipment	14	22,861	21,509
Total non-current assets		**23,112**	**21,693**
Current assets			
Receivables	18	9,812	8,865
Cash and cash equivalents	19	8,569	3,823
Total current assets		**18,381**	**12,688**
Current liabilities			
Trade and other payables	20	(7,895)	(5,873)
Borrowings	22	(448)	-
Provisions	24	(317)	(178)
Other liabilities	21	(2,388)	(3,618)
Total current liabilities		**(11,048)**	**(9,669)**
Total assets less current liabilities		**30,445**	**24,712**
Non-current liabilities			
Borrowings	22	(3,555)	(1,000)
Provisions	24	(142)	(151)
Total non-current liabilities		**(3,697)**	**(1,151)**
Total assets employed		**26,748**	**23,561**
Financed by			
Public dividend capital		3,474	3,474
Revaluation reserve		12,622	12,239
Income and expenditure reserve		10,652	7,848
Total taxpayers' equity		**26,748**	**23,561**

The notes on pages 183 to 234 form part of these accounts.

Paul Jenkins
Chief Executive and
Accounting Officer

Date **28 May 2019**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2019

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward		**3,474**	**12,239**	**7,848**	**23,561**
Surplus for the year		-	-	2,716	**2,716**
Other transfers between reserves		-	(88)	88	**-**
Revaluations	16	-	471	-	**471**
Taxpayers' equity at 31 March 2019		**3,474**	**12,622**	**10,652**	**26,748**

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

	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	-	(729)	-	**(729)**
Revaluations	-	729	-	**729**
Taxpayers' equity at 31 March 2018	**3,474**	**12,239**	**7,848**	**23,561**

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.

Other reserves
Where used, the trust should define what this reserve represents

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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		3,329	3,388
Non-cash income and expense:			
Depreciation and amortisation	5	1,228	957
Net impairments	6	-	90
(Increase) in receivables and other assets		(918)	(1,153)
Increase in payables and other liabilities		778	1,137
Increase / (decrease) in provisions		129	(9)
Net cash generated from operating activities		**4,546**	**4,410**
Cash flows from investing activities			
Interest received		37	9
Purchase of intangible assets		(123)	(55)
Purchase of property, plant, equipment and investment property		(2,053)	(3,102)
Net cash (used in) investing activities		**(2,139)**	**(3,148)**
Cash flows from financing activities			
Movement on loans from the Department of Health and Social Care		3,000	1,000
Interest on loans		(16)	-
PDC dividend (paid)		(645)	(591)
Net cash generated from financing activities		**2,339**	**409**
Increase in cash and cash equivalents		**4,746**	**1,671**
Cash and cash equivalents at 1 April - brought forward		**3,823**	**2,152**
Cash and cash equivalents at 31 March	19	**8,569**	**3,823**

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 2018/19 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 the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of land and buildings

Note 1.1.2 Going concern

These accounts have been prepare on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the Board of Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.2 Critical judgements in applying accounting policies

In Note 14 Property, Plant and Equipment, the Trust has recorded an Asset Under Construction with a value as at 31 Match 2019 of £1.4m. This asset represents the costs capitalised by the Trust in relation to its proposed relocation from its current sites in Swiss Cottage to a new site in Camden. Due to changes in market conditions (notably the valuation of the Trust's freehold properties) there currently exists a gap between the proposed costs (to complete relocation) and the capital receipts / income which the Trust has available to it. The Trust is undertaking a number of initiatives to close this funding gap. It is the judgement of the Board of Directors that relocation of the Trust continues to be probable and, therefore, appropriate to continue to capitalise these costs. Should the expectations of the Board not be fulfilled, then the value of the said asset would need to be written off.

Other than the above, 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 14, is £22,861,000, (2017/2018, £21,509,000) .

- Operating costs disclosed within note 5 (Staff and executive directors costs) include an estimate of £423,000 for the annual leave earned but not taken at the year-end date, as shown in note 5 (2017/18, £355,000).

- IFRS 9 has been adopted for 2018/19 with a resultant provision of £249,000 - see note 18 (2017/18, £309,000).

Note 1.3 Interests in other entities

The trust has no interests in other entities.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust recognises revenue in accordance with the agreement of balances exercise, and where contravention of this principle would invalidate the contract, the Trust has chosen to fully provide contract costs under IAS 37

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Where there are no explicit performance obligations governing recognition of Research Grant revenue, the Trust has chosen to recognise revenue in line with expenditure in accordance with the grant period.

Note 1.4.2 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 1.4.3 Other income

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.

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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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.

Land and buildings 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 2019. The revaluation undertaken at this date was accounted for on 31 March 2019.

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 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 lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful 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 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, eg, 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.

Software
Software which is integral to the operation of hardware, eg 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, eg 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 or IFRS 5.

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

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

Note 1.8.3 Useful economic life of intangible assets

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

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

Amortisation 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 assets and financial liabilities

Note 1.12.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.12.2 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.12.3 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 measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Loans and receivables
Loans 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 18. 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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.1 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.

Note 1.13.2 *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 24.1 but is not recognised in the trust's accounts.

Note 1.13.3 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 1.14.1 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 1.15.1 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 1.16.1 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 1.17.1 Corporation tax

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

Note 1.18.1 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 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 1.19.1 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 1.20.1 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 2019 the Trust had losses of £4k.

Note 1.21.1 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.22.1 Standards, amendments and interpretations in issue but not yet effective or adopted

The following table presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the *FReM*, and are therefore not applicable to DHSC group accounts in 2018-19.

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.
IFRS 17 *Insurance Contracts*	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the *FReM*: early adoption is not therefore permitted.

The Trust has no leases therefore no adoption is required.

Note 1.23 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 2019 on the grounds of materiality as permitted by the foundation trust annual reporting manual.

Note 2 Operating Segments
2018/19

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	PDC Dividends
Adult Services and Forensic Services	6,400	6,046	354	69
Children, Young People and Families Services	30,567	29,047	1,520	333
Education & Training, Research	19,392	18,550	842	214
Total	56,359	53,643	2,716	616

This table does not include the Trust's restructuring cost of £357k which relate to contractual exit packages for staff.

The Operating segments align to how services are structured and managed internally.

2017/18

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	PDC 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 £225k 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)	2018/19	2017/18
	£000	£000
Block contract income	22,515	21,423
Agenda for Change pay award central funding	510	-
Other clinical income	7,102	6,271
Total income from activities	**30,127**	**27,694**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	13,313	11,403
Clinical commissioning groups	10,019	11,083
Department of Health and Social Care	510	-
Other NHS providers	932	311
Local authorities	3,506	2,953
Non NHS: other	1,847	1,944
Total income from activities	**30,127**	**27,694**
Of which:		
Related to continuing operations	30,127	27,694

Note 3.3 Additional information on contract revenue (IFRS 15) recognised in the period	Total 2018/19
	£000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	2443

Note 3.4 Transaction price allocated to remaining performance obligations (i.e. revenue not recognised this year)

	Total 31 March 2019
	£000
Revenue from contracts entered into as at by the period end expected to be recognised:	
- within one year	2388

Note 3.5 Reconciliation of movements in contract liabilities recognised under IFRS 15	2018/19
	£000
- Opening deferred income	2443
- Released (performance conditions met)	(2,443)

- Arising (performance conditions note met)	2388
- Closing deferred income	2388

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	575	733
Education and training (excluding notional apprenticeship levy income)*	22,741	21,370
Provider sustainability fund income**	2,225	2,183
Other contract income***	654	1,114
Total other operating income	**26,195**	**25,400**
Of which:		
Related to continuing operations	26,195	25,400
Related to discontinued operations	-	-

**Education and Training*

Education and Training includes £11.9m (17/18 £10.3m) from Health Education England - funding training activity across the Trust. Tuition fees and related HEFCE grants total £5.5m (17/18 £4.9m), Family Nurse Partnership received £2.4m (17/18 £2.9m). The Conferences and Short Courses Unit received £1.2m (17/18 £0.9m), Tavistock Consulting received £0.5m (17/18 £0.5m), and the remaining £1.2m (17/18 £1.5m) was received across a range of departments across the Trust.

**Provider sustainability fund income (PSF) formerly disclosed as Sustainability and transformation fund income.(STF)

The Trust was awarded £2,225k (17/18 £2,183k) Provider sustainability income as a result of meeting its targets.

***Other contract income

Other contract income relates to I-thrive project income £105k (17/18 £269k), Clinical Excellence Awards £107k (17/18 £107k) and miscellaneous income totalling £328k (17/18 £385k).

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:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	30,127	27,694
Income from services not designated as commissioner requested services	26,195	25,400
Total	**56,322**	**53,094**

Note 5 Operating expenses

	2018/19	2017/18
	£000	£000
Staff and executive directors costs	38,479	36,315
Remuneration of non-executive directors	86	88
Supplies and services - clinical (excluding drugs costs)	688	785
Supplies and services - general	216	160
Consultancy costs	311	209
Establishment	921	1,039
Premises	3,537	3,184
Transport (including patient travel)	220	181
Depreciation on property, plant and equipment	1,172	895
Amortisation on intangible assets	56	62
Net impairments	-	90
Movement in credit loss allowance: all other receivables and investments	-	3
Change in provisions discount rate(s)	1	-
Audit fees payable to the external auditor		
audit services- statutory audit	53	51
audit services- Other related assurance services	7	4
Internal audit costs	37	36
Clinical negligence	25	30
Legal fees	212	3
Insurance	37	38
Research and development	300	425
Education and training	1,513	999
Redundancy	357	225
Hospitality	34	23
Losses, ex gratia & special payments	-	-
Other services, eg external payroll*	2,433	2,438
Other**	2,298	2,423
Total	**52,993**	**49,706**
Of which:		
Related to continuing operations	52,993	49,706

*Other services include lecture fees £1.7m / National QC fees £431k
**Other expenditure includes subcontractor costs of £1.8m (17/18 £1.5m)

Note 7 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	30,268	28,821
Social security costs	3,333	3,335
Apprenticeship levy	267	-
Employer's contributions to NHS pensions	3,740	3,580
Pension cost - other*	5	5
Termination benefits	357	225
Temporary staff (including agency)	866	574
Total gross staff costs	**38,836**	**36,540**
Recoveries in respect of seconded staff	-	-
Total staff costs	**38,836**	**36,540**

Note 7.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (£0k in 2017/18). The estimated additional pension liabilities of these ill-health retirements is £0k (£0k in 2017/18).

Note 8 Pension costs

The Trust paid NHS Pension Agency £3,740k (£3,580k in 2017/18) and the National Employment Savings Scheme (NEST) £5k in 2018/19 (£5k in 2017/18)

Note 9 Operating leases

The Trust has no operating lease commitments.

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 6 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	90
Total net impairments charged to operating surplus / deficit	**-**	**90**
Impairments charged to the revaluation reserve	-	729
Total net impairments	**-**	**819**

The Trust had no impairments resulting from changes in market price for 2018/19.

Note 10 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	37	9
Total finance income	**37**	**9**

Note 11 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	33	-
Total interest expense	**33**	**-**
Unwinding of discount on provisions	1	2
Total finance costs	**34**	**2**

Note 12 Discontinued operations

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

Note 13 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**484**	**150**	**-**	**634**
Additions	-	22	101	**123**
Valuation / gross cost at 31 March 2019	**484**	**172**	**101**	**757**
Amortisation at 1 April 2018 - brought forward	**417**	**33**	**-**	**450**
Provided during the year	26	30	-	**56**
Amortisation at 31 March 2019	**443**	**63**	**-**	**506**
Net book value at 31 March 2019	**41**	**109**	**101**	**251**
Net book value at 1 April 2018	**67**	**117**	**-**	**184**

Note 13.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought foward	**484**	**95**	**-**	**579**
Additions	-	55	-	**55**
Valuation / gross cost at 31 March 2018	**484**	**150**	**-**	**634**
Amortisation at 1 April 2017 - brought foward	**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 1 April 2017	**103**	**88**	**-**	**191**

Note 14 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**9,200**	**8,039**	**1,500**	**214**	**5,105**	**157**	**24,215**
Additions	-	200	1,011	-	842	-	**2,053**
Revaluations	79	90	-	-	-	-	**169**
Reclassifications	-	-	(645)	-	645	-	**-**
Valuation/gross cost at 31 March 2019	**9,279**	**8,329**	**1,866**	**214**	**6,592**	**157**	**26,437**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**0**	**-**	**213**	**2,359**	**134**	**2,706**
Provided during the year	-	302	-	1	854	15	**1,172**
Revaluations	-	(302)	-	-	-	-	**(302)**
Accumulated depreciation at 31 March 2019	**-**	**0**	**-**	**214**	**3,213**	**149**	**3,576**
Net book value at 31 March 2019	**9,279**	**8,329**	**1,866**	**(0)**	**3,379**	**8**	**22,861**
Net book value at 1 April 2018	**9,200**	**8,039**	**1,500**	**1**	**2,746**	**23**	**21,509**

Note 14.1 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 foward	**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 foward	**-**	**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 1 April 2017	**8,801**	**8,807**	**769**	**3**	**1,291**	**38**	**19,709**

Note 14.2 Property, plant and equipment financing - 2018/19

	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 2019							
Owned - purchased	9,279	8,329	1,866	(0)	3,379	8	**22,861**
NBV total at 31 March 2019	**9,279**	**8,329**	**1,866**	**(0)**	**3,379**	**8**	**22,861**

Note 14.3 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 Donations of property, plant and equipment

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

Note 16 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 2019. The revaluation undertaken at this date was accounted for on 31 March 2019. In 2018/19 a 'desktop valuation' was performed outside of this cycle of 5 year full valuations.

Land and buildings were revalued up by £471k.(17/18 £729k)

Note 17 Investment Property

The Trust has no Investment property.

Note 18 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	4,934	-
Trade receivables*	-	4,945
Accrued income*		1,345
Contract receivables: accrued income*	3,229	
Allowance for impaired contract receivables / assets*	(249)	-
Allowance for other impaired receivables	-	(309)
Prepayments (non-PFI)	604	404
PDC dividend receivable	34	5
VAT receivable	98	-
**Other receivables	1,162	2,475
Total current trade and other receivables	**9,812**	**8,865**
Of which receivables from NHS and DHSC group bodies:		
Current	5,034	5,402
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

*Contract receivables: accrued income includes PSF funding of £1,768k for 18/19

**Other receivables - includes STF of £2,183k for 17/18

Note 18.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		309
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	309	(309)
Allowances at start of period for new FTs	-	-
Utilisation of allowances (write offs)	(60)	-
Allowances as at 31 Mar 2019	**249**	**-**

Note 18.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	2017/18
	£000
At 1 April	**306**
Increase in provision	3
Amounts utilised	-
At 31 March	**309**

Note 19 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.

	2018/19	2017/18
	£000	£000
At 1 April	**3,823**	**2,152**
Net change in year	4,746	1,671
At 31 March	**8,569**	**3,823**
Broken down into:		
Cash at commercial banks and in hand	1,317	675
Cash with the Government Banking Service	7,252	3,148
Total cash and cash equivalents as in SoFP	**8,569**	**3,823**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**8,569**	**3,823**

Note 19.1 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 Foundation Trust on behalf of patients or other parties.

Note 20 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	1,197	1,413
Accruals	4,199	3,099
Social security costs	925	740
VAT payables	-	44
Accrued interest on loans*	-	2
Other payables	1,574	575
Total current trade and other payables	**7,895**	**5,873**
Of which payables from NHS and DHSC group bodies:		
Current	1,440	390
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 22. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 21 Other liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	2,388	3,618
Total other current liabilities	**2,388**	**3,618**

Note 22 Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from the Department of Health and Social Care	448	-
Total current borrowings	**448**	**-**
Non-current		
Loans from the Department of Health and Social Care	3,555	1,000
Total non-current borrowings	**3,555**	**1,000**

An ITFF bridging loan of £4m was issued to fund a project to relocate the Trust. The loan has been drawndown in full.(£3m in 18/19, £1m in 17/18)

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 0.95%

Note 23 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Total
	£000	£000
Carrying value at 1 April 2018	**1,000**	**1,000**
Financing cash flows - payments and receipts of principal	**3,000**	**3,000**
Financing cash flows - payments of interest	**(16)**	**(16)**
Non-cash movements:	**-**	**-**
Impact of implementing IFRS 9 on 1 April 2018	2	2
Carrying value at 31 March 2019	**3,986**	**3,986**

Note 24 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Re-structuring	Total
	£000	£000	£000	£000
At 1 April 2018	**86**	**72**	**171**	**329**
Change in the discount rate	1	-	-	**1**
Arising during the year	1	-	219	**220**
Utilised during the year	(7)	-	(80)	**(87)**
Reversed unused	(5)	-	-	**(5)**
Unwinding of discount	1	-	-	**1**
At 31 March 2019	**77**	**72**	**310**	**459**
Expected timing of cash flows:				
- not later than one year;	7	-	310	**317**
- later than one year and not later than five years;	-	72	-	**72**
- later than five years.	70	-	-	**70**
Total	**77**	**72**	**310**	**459**

	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 24.1 Clinical negligence liabilities

At 31 March 2019, £108k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tavistock and Portman NHS Foundation Trust (31 March 2018: £8k).

Note 25 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-	10
Gross value of contingent liabilities	-	10
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	-	10

At 31 March 2019, there where no cases 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 Resolution.

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 18.1) 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 19) at all times.

The Trust also has in place a £4m working capital revolving loan which has been drawn down in full.

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 26.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,163	-	-	**8,163**
Cash and cash equivalents at bank and in hand	8,569	-	-	**8,569**
Total at 31 March 2019	**16,732**	**-**	**-**	**16,732**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	7,155	-	-	-	**7,155**
Cash and cash equivalents at bank and in hand	3,823	-	-	-	**3,823**
Total at 31 March 2018	**10,978**	**-**	**-**	**-**	**10,978**

There are no differences in the classification basis as a result of IFRS 9

Note 26.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	4,003	-	**4,003**
Trade and other payables excluding non financial liabilities	5,396	-	**5,396**
Total at 31 March 2019	**9,399**	**-**	**9,399**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	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**

There are no differences in the classification basis as a result of IFRS 9

Note 26.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 26.5 Maturity of financial liabilities

	31 March 2019	**31 March 2018**
	£000	**£000**
In one year or less	5,844	5,087
In more than one year but not more than two years	445	-
In more than two years but not more than five years	1,331	-
In more than five years	1,779	1,000
Total	**9,399**	**6,087**

Note 27 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	2	4	-	-
Total losses	**2**	**4**	**-**	**-**

Note 28 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £2k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £56k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 28.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 29 Related parties

The Tavistock and Portman NHS Foundation Trust is a body corporate authorised by Monitor, the regulator of NHS Foundation Trusts.

The Trust has no positive disclosure of interests of senior manager related party transactions.

The Department of Health and Social Care 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:

2018/19

	Total income for the year ended 31 March 2019	Total charge for the year ended 31 March 2019	Debtor/ (creditor) as at 31 March 2019
	£000	£000	£000
Public Health England	2,278	-	-
Health Education England	11,902	-	270
NHS England	2,347	-	2,020
Camden CCG	6,468	-	(111)
City & Hackney CCG	1,087	-	111
Haringey CCG	1,102	-	207

	Total income for the year ended 31 March 2019	Total charge for the year ended 31 March 2019	Debtor/ (creditor) as at 31 March 2019
	£000	£000	£000
HM Revenue and Customs for Pay As You Earn income tax and National Insurance (included in staff costs)	-	3,600	(925)

NHS Pension Agency	-	3,740	(595)

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)

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 £91k.

During 2018/19, the Trust has an agreement with National Shared Business Services to provide certain accounting processes. The Trust paid £96,968 (2017/18 £102,427) for these services.

Note 30 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	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	30,157	111	**30,268**	28,821
Social security costs	3,333	-	**3,333**	3,459
Apprenticeship levy	267	-	**267**	(124)
Employer's contributions to NHS pensions	3,740	-	**3,740**	3,580
Pension cost - other	-	5	**5**	5
Termination benefits	357	-	**357**	225
Temporary staff	-	866	**866**	574
Total gross staff costs	**37,854**	**982**	**38,836**	**36,540**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**37,854**	**982**	**38,836**	**36,540**
Of which				

Average number of employees (WTE basis)

	Permanent	Other	2018/19 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	53	-	**53**	43
Administration and estates	262	-	**262**	235
Nursing, midwifery and health visiting staff	21	-	**21**	25
Scientific, therapeutic and technical staff	239	-	**239**	254
Social care staff	29	-	**29**	26
Other	-	42	**42**	61
Total average numbers	**604**	**42**	**646**	**644**
Of which:				
Number of employees (WTE) engaged on capital projects	-	5	**5**	5

Reporting of compensation schemes - exit packages 2018/19

	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**
£10,000 - £25,000	2	-	**2**
£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	**8**	-	**8**
Total cost (£)	£357,000	£0	**£357,000**

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**
£10,000 - £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 cost (£)	£225,000	£0	**£225,000**