

Annual Report and Accounts 2010/11

This page has been intentionally left blank

Tavistock & Portman NHS Foundation Trust

Annual Report and Accounts 2010/11

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

This page has been intentionally left blank

Table of Contents

Trust Chair’s Statement	6
Chief Executive’s Statement	8
Introduction	10
Directors’ Report.....	12
Business Review	12
Operating and finance review.....	15
Statement as to disclosure to auditors.....	16
Going concern.....	16
Remuneration Report	17
The Remuneration Committee	17
Governance.....	19
Constitutional authority.....	19
Board of Governors.....	19
Board of Directors.....	23
Audit Committee.....	33
Non-Executive Director Nomination Committee.....	34
Membership.....	35
Quality Report.....	36
Independent Assurance Report to the Board of Governors of Tavistock and Portman NHS Foundation Trust on the Annual Quality Report	82
Staff survey	85
Regulatory ratings.....	89
Other disclosures	90
Responsibility for preparing the financial statements.....	95
Auditor’s opinion and certificate	97
Statement on internal control	99
Scope of responsibility.....	99
The purpose of the system of internal control	99
Capacity to handle risk.....	99
The risk and control framework.....	100
Review of economy, efficiency and effectiveness of the use of resources	101
Annual Quality Report	102
Review of effectiveness	102

Conclusion.....	104
The accounts	105
Foreword.....	105

Trust Chair's Statement

The Trust works hard to maintain a high level of performance, and rather than undertaking an annual snapshot, the Trust now collects evidence to show that it always meets the Care Quality Commission's standards. This required a change in the way the Board of Directors managed itself and its relationship with the Trust. In April, The Board agreed some important principles defining its approach to governance and systems, and re-structured its committees to reflect this approach.

The new structure is more streamlined and focusses on high level strategy. It is a further and important step towards a mature risk-enabled culture. My non-executive director colleagues look to receive either assurance that the Trust is delivering on its objectives, or where objectives are not yet met, plans are in place to meet them.

The new system has enabled the executive to focus on delivering high-quality care, training, consultancy, and reasearch, which they have done in an increasingly challenging financial climate. Our clinical results continue to be amongst the best in the country, as reflected in our patient survey and bycontinued support from the commissioners. I am sorry to lose our Dean, Trudy Klauber, who has delivered excellent results and has been a highly valued board member. Trudy retires from this role this year but will continue to contribute to the work of the Trust in a new role.

Our consultancy service has not performed to the level envisaged in 2006 in the Trust's 5 year plan. Some creative thinking began to ensure that consultancy, an important and integral part of the Trust's offering, is in a position to make a full contribution to the Trust. This work will conclude in 2011/12. Meanwhile, our research team has had some success in securing more work and we look forward to the results and the valuable addition to knowledge in the field of mental health that this will bring.


Other successes include an award of 'level 2' from the NHS Litigation Authority (the NHS's 'insurer'). This award means that the Trust is seen as a safe place, and the small reduction in premiums is a very welcome boost at this time –a good example of quality generating productivity.

Work to understand member's views remains a high priority. This is an important issue for the Board of Directors and we are supporting governors in their initiative to improve their working relationship with members. The Trust is not alone in finding this a challenge. Governors are well represented on key committees, but getting a clear message from our diverse membership has been harder to achieve. Directors and governors have also committed themselves to explore ways of working together to fulfil their respective, but complementary,

roles over the coming year. Our investment in communications and marketing should yield tangible results as activity is generated through greater awareness of what we do, both by our users and by those who pay for our services.

In November we welcomed Ian McPherson as a new non-executive director. Ian brings a wealth of knowledge and experience to the role, offering valuable perspectives and insights.

Finally I want to return to the need to achieve high-quality, responsive services in an ever more challenging financial climate. Money is tight, but this does present opportunities to work differently. The Trust has started from a position of strength and I have confidence that those who use or provide services will be in the best possible position for 2011/12.



Angela Greatley
Trust Chair
2nd June 2011

Chief Executive's Statement

The past year has again been a turbulent one, with the UK economy and level of public sector debt impacting on individuals, organisations and systems. As a provider of mental health services this remains of particular relevance, given the rise in mental health problems that is likely to ensue. At the same time, the government has flagged mental health as a key priority with the launch of a new mental health strategy seeking to place mental health on an equal footing with physical health. Meeting the needs of individuals and communities, however, has to be achieved against a background of significant constraint in public sector funding and the demands of large-scale structural reorganisation within the NHS.

Within this difficult context I believe that our clinical services continue to be amongst the best in the country, representing genuine and affordable excellence. This quality is reflected both in our feedback from patients and in continued support from commissioners. Whilst funding remains tight and looks set to become tighter, over the past year we have secured new business in a number of areas, including, for example, the innovative 'Big White Wall' project, an online support and wellbeing service. This service is now being delivered across increasingly wide geographical areas, and in pilot form to the armed forces, their families and to veterans. As a Trust we are also investing significantly in the development of e- and blended-learning technologies in support of our national role in training and education of the mental health and social care workforce. At the same time we are working to reduce our cost base and toward the end of 2010/11, along with many NHS organisations, we made an NHS voluntary redundancy scheme available to all staff.

Our students continue to give us excellent feedback and the Dean's success in working closely with education commissioners has ensured that the Trust continues to be valued as a high quality, responsive provider.

The current Dean, Trudy Klauber, has announced that she will be stepping down in the coming year. During her term we have seen education income rise steadily, and the number of students wanting to come here is a credit to Trudy and her team. I am pleased to say that Trudy will remain with us in a new role.

Our research team has also had some success in securing more R&D income and we look forward to the results of this work and the valuable addition to knowledge in the field of mental health that this will bring. The Trust has been very active in its engagement with its local Academic Health Science Centre, UCL Partners, and played a central role in the establishment of a mental health theme within UCLP. We will continue to develop this engagement over the course of the coming year, and see UCLP as key partner for the development and delivery of improved population mental health.

Work to understand members' views remains a high priority but getting a clear consensus from our ever-growing and diverse membership is hard to achieve. One of the benefits of being an FT is that it enables us to engage with our members and stakeholders in a way that adds value to the discussions that contribute to the plans of the Trust, but this doesn't just happen, it needs to be worked at. Over the past year we have employed a new member of our communications team to support governors in this essential task.

Another key development over the past year has been in the creation of an integrated system for ensuring that our services are safe and of high quality and that the Board of Directors has adequate assurance of this. This system brings together a number of different workstreams (including clinical outcomes, clinical audit, patient safety and clinical risk, corporate governance and risk, quality reports, and patient and public involvement) under a single Board committee: the Clinical Quality Safety and Governance Committee. Each workstream has a named lead who is accountable for delivery. Having the right processes in place to safeguard safety and quality is essential when systems are under stress, as indeed the NHS is.

These developments enabled us to achieve NHSLA (the NHS Litigation Authority) level 2 certification, a significant achievement in that it offers an independent view of the quality and robustness of the Trust's discharge of its governance procedures and policies. This is an excellent result for the Trust and sets us on the path for further improvements at the next assessment in 2014.

Over the coming year, the Trust will continue to work closely with service users, commissioners and other providers in the provision of high quality services to local residents, and to people from across the country for our specialised services. At the same time, we recognise that very significant levels of productivity improvement and efficiencies will be required in an environment of financial constraint. The Trust will aim to achieve these while protecting and developing the quality of our services.



Dr Matthew Patrick
Chief Executive
2nd June 2011

Introduction

History of the Trust

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

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

Principal Activities

The Trust is unusual in the balance of its activities. All of these, however, are closely integrated and share the same underlying values and philosophy. At heart, the Trust is rooted in clinical practice with all activities deriving from the experience of working with patients. The Trust is proud of its history of innovation and excellence, and seeks to build on this in the future. The Trust's two largest areas of activity are patient services, and education and training services:

- The Trust offers a broad range of generic and specialist outpatient mental health services to children, families and adolescents (CAMHS). CAMHS comprise the majority of the Trust's patient services. The Trust also offers a range of specialist and generic psychological therapy services to adults, including forensic services.
- The Trust provides a wide range of mental health education and training, offering 70 long courses locally, nationally and internationally, in addition to a new Continuing Professional Development (CPD) programme of short courses. The Trust enrolls in the region of 2000 students each year and has strong University partnerships.

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

- The Trust is active in research into the origins of mental health problems, models of social care, and research aimed at establishing the evidence base for its treatment methods. The Trust seeks to influence and develop new ideas by research, publication and participation in policy making.

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

Preparation of report and accounts

This Annual Report and Accounts has been prepared under direction issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Directors' Report

Business Review

The Trust in 2010/11

In 2010/11, the Trust continued to deliver a broad range of high-quality patient services, mental health education and training, research, and consultancy. These activities resulted in an overall increase of 5% in income in real terms, slightly less than the Trust's business plan. Income for patient services and for education and training both grew.

New clinical services which had started, or been taken on during the previous year, were developed further during 2010/11. These services and their contribution to better health are being fully evaluated.

During the year, the Trust remained fully involved in the development of the Mental Health Theme for UCL Partners (UCLP), our local Academic Health Science Centre. Membership of UCLP, and the partnership and development opportunities associated with this, are key elements of the Trust's strategy.

Throughout the year, the Trust has continued to promote equity of access and equality across the full range of its services. The minority ethnic profiles of the Trust's patient and student populations continue to broadly mirror the very diverse populations it serves.

The Trust continues to work closely with its Board of Governors and shares with its Governors a real commitment to ensuring that Members play a full and proper role in the further development of the organisation and its services to the benefit of all users of the Trust's services.

The Trust achieved a financial surplus of £90k in 2010/11, slightly below the Plan. In 2009/10, the surplus had been unusually high at £651k, mainly due to the contingency reserve not being needed in that year.

	2009/10 £000	2010/11 £000
Income		
Patient Services	13,422	14,159
Education & Training	14,912	15,360
Consultancy	1,162	910
Research	132	157
Other	671	1,799
Total income	30,299	32,385
Expenditure		
Pay	23,061	25,137
Non-pay	5,686	6,328
Total expenditure	28,747	31,465
EBITDA *	1,552	920
Depreciation, amortisation & impairments	-563	-511
Bank Interest	18	15
Other Finance Costs	-1	-1
Dividend (to the Department of Health)	-355	-333
Retained Surplus	651	90
EBITDA* as a % of income	5.4%	2.8%

Risks and uncertainties

The Trust, the NHS, and the public sector as a whole face substantial financial pressures. Commissioning structures are to change, and commissioners will continue to review services as they seek to ensure high quality and value of money. Efficiency savings targets were set at 4% for 2011/12 and are expected to remain at least at this level in future years.

The Trust has set out in its Annual Plan a course for improving productivity, engaging with commissioners and working in innovative ways to ensure that it continues to provide the high-quality services that its reputation is based upon.

The Trust acknowledges that constraints in public sector funding historically hit mental health services harder than acute services. To mitigate this, the Trust's Plan includes a contingency budget that should allow the Trust to continue to provide services should there be any shortfalls.

The Trust has in place an excellent assurance framework and risk register, which are reviewed regularly by the Board of Directors, and which highlight the risks facing the Trust. The two main risks were considered: the need for productivity savings in 2011/12 is particularly challenging and is being managed by a programme board reporting monthly to the Board of Directors; and the Trust's information technology recovery procedures are currently being revised and strengthened.

Analysis of development and performance

The Board of Governors has been actively involved in the development of the Trust's Annual Plan, shaping the overall direction of the Trust's services.

The Trust has recently reviewed its structures and systems around the delivery of quality, safety and governance, and the manner in which assurance in these areas is provided to both the Board of Directors and the Board of Governors. The Trust is now implementing a system of integrated delivery and governance around these areas which we believe will support our aim for continued improvement in these areas.

The Trust has also invested significantly in its service and business development teams and infrastructure.

The Trust aims to continually improve its services and facilities in support of improved patient and other user experience. Services continually improve as a result of feedback and findings from staff, patients and stakeholders, and also audit findings.

In 2010/11, the environmental improvement programme continued. Key developments have included:

- Relocation of the Monroe Service from inadequate accommodation to refurbished space in the Tavistock Centre
- Further refurbishment of toilet facilities
- A rolling programme of facilities upgrades to individual rooms and public areas
- A programme to improve the lighting throughout the Tavistock Centre
- Completion of the second phase of the signage project
- Work began to replace the old, inefficient boilers
- Upgraded facilities for conferences

The Trust has continued to invest significantly in communications activity, in part due to feedback from patients and users about the information systems in place. The Communications Committee has been working on a range of communication activities such as the new Trust website, a website for primary school children in conjunction with the Patient and Public Involvement

Committee, internal communications, the rolling out of the new corporate style, and other web-based communications functioning.

The Trust at the end of 2010/11

The Trust achieved Level Two of the NHS Litigation Authority (NHSLA) requirements during 2010/11, with a score of 46/50.

The Trust once again achieved a very low did not attend (DNA) rate of 10%. The average in London mental health trusts is 15% for CAMHS and 12% for adult psychotherapy.

The environmental context

The Care Quality Commission has registered the Trust without conditions.

The Trust also performed well against its internal performance indicators, except targets set for induction and mandatory training. The Trust's annual staff survey was one the most positive it has received.

The Trust aims to make a positive contribution to public mental health through its emphasis on early years interventions and preventative work. These contributions include, for example, the location of clinical practitioners in a variety of community settings including primary and secondary schools. The Trust made a number of positive contributions to the development of the new mental health strategy *No Health Without Mental Health*. Flowing from this, the Trust has been continued to develop and roll out its on-line Wellbeing Service, in partnership with the Big White Wall. This is work that we will be actively pursuing over the coming year.

Operating and finance review

The audited Accounts for 2010/11 are attached to this Report.

The Trust again achieved all its statutory financial duties. Earnings before interest, tax, depreciation and amortisation were £920,000 (compared to £1,552,000 in 2009/10 accounts); and after allowing for depreciation, interest and dividends, the Trust had a retained surplus of £90,000 (£651,000 in 2009/10). The surplus and the dividend together represent a 3% return on the assets employed (7.6% in 2009/10).

The cash balance at 31 March 2011 was £4,712,000 (up from £3,648,000 at 31 March 2010; cash forecasts indicate that the balance will reduce but remain positive throughout 2011/12. The Foundation Trust has a loan facility of £2.0m in place, but no borrowing was necessary in the period.

The Trust expects its Financial Risk Rating issued by Monitor to be at level 3, based on the 2010/11 Accounts and to remain at this level based on the 2011 Annual Plan.

Based on the Trust's Annual Plan, and the risk assessments contained therein, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operation for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the Accounts.

Capital expenditure totalled £355,000, less than Plan due to the deferral of one project. The Plan for the next three years allows for capital expenditure averaging £400,000 per year on improvements to the Trust's facilities, under the estates strategy; and a further £200,000 per year on IT equipment.

Details of all remuneration to each senior manager of the Trust are given in Note 32 to the Accounts.

As far as the Directors are aware, there is no relevant information of which the Auditors are unaware. The Directors have taken all steps they ought to have taken to make themselves aware of relevant information and to establish that the Auditors are also aware of that information. The Directors are not aware of any events that have arisen since the end of the year which have affected or may significantly affect the operations of the Trust.

Statement as to disclosure to auditors

Each individual director has confirmed that as far as they are aware, there is no relevant audit information of which the auditor is unaware; and, that each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Going concern

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

Remuneration Report

The Remuneration Committee

Membership and attendance

Name	Apr 2010	Feb 2011
Martin Bostock	Y	Y
Altaf Kara	Y	Y
Joyce Moseley	Y	Y
Emma Satyamurti	Y	N/a
Mr Richard Strang	Y	Y
Angela Greatley	Y	Y
Ian McPherson	N/a	Y

Advice received

The Director of Human Resources provided advice to the committee.

Remuneration Policy

Senior managers are normally employed on permanent contracts. Those who are medical consultants are remunerated under the 2003 Consultants Contract. Non-medical senior managers are remunerated under Agenda for Change. Notice periods are in accordance with these national agreements, and there are no special provisions for termination periods.

All Trust staff, including Directors, are paid either on Agenda for Change terms and conditions or on a medical consultants scale, both of which are determined by the NHS nationally. The pay of the CEO was reviewed at the end of May 2010; in the economic climate no increase, other than the contractual increment already agreed, was made at that time.

The salaries of senior managers are shown in note 32 to the accounts.



Matthew Patrick
Chief Executive
2nd June 2011

Governance

Constitutional authority

The Board of Directors is responsible for the governance, planning, and management of the Trust's activities. It meets on a monthly basis (with the exception of August and December) and authorises all the key decisions regarding the Trust's business. It operates according to the values and standards of conduct of the NHS. These include the Nolan principles (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). The Board of Directors delegates the day-to-day running of the organisation to the Chief Executive and the Management Committee, which includes the executive directors. The Board of Directors works closely with the Board of Governors.

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

Board of Governors

Composition

Public Governors:

Camden

- Ms Jennie Bird
Elected November 2006. Re-elected November 2009. Term of office ends October 2012
- Ms Mary Burd
Elected November 2009. Term of office ends October 2012

- Mr Adam Elliott
Elected November 2009. Term of office ends October 2012

Rest of London

- Dr Robin Anderson
Elected November 2006. Re-elected November 2009. Term of office ends October 2012
- Ms Stephanie Cooper
Elected December 2006. Re-elected November 2009. Term of office ends October 2012
- Ms Sara Godfrey
Elected November 2009. Term of office ends October 2012
- Dr Caroline Lindsey
Elected November 2006. Re-elected November 2009. Term of office ends October 2012
- Ms Carole Stone
Elected November 2009. Term of office ends October 2012
- Mr John Wilkes
Elected November 2006. Re-elected November 2009. Term of office ends October 2012

Rest of England & Wales

- Ms Chrissie Kimmons
Elected November 2006. Re-elected November 2009. Term of office ends October 2012
- Ms Jan McHugh
Elected November 2009. Term of office ends October 2012

Staff Governors:

Administrative & Technical

- Mrs Amanda Hawke
Elected November 2006. Re-elected November 2009. Term of office ends October 2012

Clinical, Academic, Senior

- Mr Jonathan Bradley
Elected November 2009. Term of office ends October 2012

Representatives of Recognised Staff Organisations and Trade Unions

- Mr Robin Bonner
Elected November 2006. Re-elected November 2009. Term of office ends October 2012

Stakeholder Governors:

Non-Statutory Sector (As appointed by Voluntary Action Camden; includes voluntary sector)

- Ms Simone Hensby
Appointed November 2006. Re-appointed November 2009. Term of office ends October 2012

University of Essex (A key education partner)

- Dr Aulay Mackenzie
Appointed November 2006. Re-appointed November 2009. Term of office ends October 2012

University of East London (A key education partner)

- Professor Steve Trevillion
Appointed November 2009. Term of office ends October 2012

Primary Care Trusts (As appointed by Camden PCT)

- Mr John Carrier
Appointed November 2006. Re-appointed November 2009. Term of office ends October 2012

Local Authorities (As appointed by the London Borough of Camden)

- Councillor Pat Callaghan
Appointed June 2010. Term of office ends October 2012.

Specialist Commissioning (As appointed by London Strategic Health Authority as an interim arrangement prior to new arrangements being in place)

- Vacant

Attendance

Name	May 2010	Sep 2010	Dec 2010	Feb 2011
A. Greatley*	✓	✓	✓	✓
J. Wilkes	✓	✓	✓	✓
J. Bird	x	✓	✓	✓
M. Burd	✓	✓	✓	✓
A. Elliott	x		x	✓
R. Anderson	✓	✓	x	✓
C. Lindsey	x	x	x	x
C. Stone	✓	✓	x	✓
C. Kimmons	✓	✓	x	x
J. McHugh	✓	✓	✓	✓
J. Bradley	✓	x	✓	x
A. Hawke	✓	✓	✓	✓
R. Bonner	✓	✓	✓	✓
J. Carrier	x	x	x	x
P. Callaghan	N/a	✓	x	x
S. Hensby	x	x	x	✓
A. Mackenzie	✓	x	✓	x
S. Trevellion	x	✓	x	x
S.Cooper	✓	x	✓	✓
S. Godfrey	✓	x	x	✓

*Chair

Register of governors' interests

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

latest version can be found on the Trust's website and is available on request via the Trust Secretary's office.

Understanding the views of members and governors

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

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

The Trust holds a number of consultations with governors, and encourages governor involvement in a number of different areas of the Trust's work, in particular through involvement in committees.

The Members' Newsletter is the primary vehicle for communication with members, and the Trust encourages governors to write articles for this. The Members' Newsletter Editorial Group has a governor representative. Each newsletter aims to feature public governors to introduce members to their governors. Governors are encouraged to attend the Annual General Meeting, which is a major event to which members are invited each year. Governors are also encouraged to develop their own ways of engaging with their members.

Board of Directors

Composition

Non-Executive Directors

Ms Angela Greatley, Trust Chair

Appointed November 2009. Term of office ends October 2012

Selected relevant experience:

- Formerly Chief Executive of The Sainsbury Centre for Mental Health a research and development charity
- Previously Fellow in Mental Health at The King's Fund
- Experience of working in the NHS in a variety of managerial roles and as a director of commissioning
- Previous experience as a non-executive board member at a neighbouring mental health trust and before that as a board member of a large further education college
- Spent time as a Trustee of 'Mental Health Media' (now part of Mind) and is currently a non-executive board member of 'Headstrong' the Irish National Youth Mental Health Centre
- Served as an elected member of a London local authority in the 1970s and early 1980s.

Qualifications:

- Read Social Administration at the London School of Economics & Political Science
- Completed the Athena women's development programme sponsored by the Department of Health
- F.R.S.A.

The Chair has no significant commitments outside the Trust.

Mr Martin Bostock, Senior Independent Director

Appointed November 2008. Term of office ends October 2011

Selected relevant experience

- Trustee, The Citizenship Foundation (2007 – present)
- Chairman, Nelson Bostock Communications, a leading public relations agency (1987 – present)
- Head of Press and Publicity, London Borough of Hackney (1984-87)
- Senior roles in a number of commercial PR agencies (1977-84)
- A year with VSO, teaching in Thailand (1971-72)

Qualifications

- BA (Hons), English and Drama, University of Hull

Mr Altaf Kara, Non-Executive Director

Appointed November 2007. Reappointed November 2010. Term of office ends October 2013.

Selected relevant experience

- Director, Healthcare Practice, Ernst & Young (present)
- Managing Director, Alvarez and Marsal (2005-06)
- Independent Management Consultant (2003-04)
- Partner, Accenture, London (1995-2002)

Qualifications

- BA, Engineering, Cambridge University
- Postgraduate, Production Engineering, Cambridge University
- MBA INSEAD, France

Ms Joyce Moseley, Non-Executive Director

Appointed January 2009. Term of office ends December 2012

Selected relevant experience

- Chief Executive of Catch22 (1999 – present)
- Director of Social Services, London Borough of Hackney (1991-97)
- Member of the Youth Justice Board (1998-2004)
- Trustee (1997-2011), Patron (2011- present) The Who Cares? Trust (1997 – present)
- Chair, HTC Group (social enterprise) (2011 – present)
- OBE in 2007 for services to youth justice

Qualifications

- BSc (Hon), Sociology, University of London (Bedford College)
- Certificate of Qualification in Social Work (CQSW), University of London (Bedford College)
- MSc, Social Research, Surrey University

- Strategy and Leadership, Ashridge Business School

Mr Richard Strang, Deputy Trust Chair, Chair of Audit Committee

Appointed August 2006. Reappointed July 2010. Term of office ends October 2013.

Selected relevant experience

- Governor and Chair of Finance Committee, Sherborne Girls (2008 – present)
- Corporate Finance Consultant (2004 – present)
- Senior Managing Director at Bear Stearns (Head of European M&A) (1998-2004)
- Corporate Finance at Morgan Grenfell (Deutsche Bank) (1978-97) (Director 1986-97)
- Non-Executive Director, Morgan Grenfell, Australia (1988-91)
- Seconded to Gleacher Morgan Grenfell in New York (1990-92)
- Seconded to British Rail Investments (1980-81)
- Accountant with Peat Marwick Mitchell (KPMG) (1971-78)

Qualifications

- MA, Politics, Philosophy & Economics, Oxford University
- Fellow of the Institute of Chartered Accountants of England and Wales.

Dr Ian McPherson, Non-Executive Director

Appointed November 2010. Term of office ends October 2013

Selected relevant experience

- Chief Executive, Mental Health Providers Forum (2011 – present)
- Director, National Mental Health Development Unit (2009-2011)
- Director, National Institute for Mental Health in England (2002-2009)
- Director of Mental Health, Worcestershire Mental Health Partnership Trust (1999- 2002)
- Director of Mental Health, North Warwickshire NHS Trust (1989-1999)

- Head of Adult Mental Health Clinical Psychology, North Warwickshire Health Authority (1985-1989)
- Course Director/ Lecturer, Clinical Psychology Programme, University of Birmingham (1978-1985)

Qualifications

- Fellow of the British Psychological Society
- Chartered Clinical Psychologist
- PhD in Psychology, University of Birmingham
- MSc in Clinical Psychology, University of Birmingham
- MA (Hons) in Psychology, University of Glasgow

Executive Directors

No executive director holds any non-executive position elsewhere.

Dr Matthew Patrick, Chief Executive

In post since March 2008

Selected relevant experience

- Trust Director, Tavistock & Portman NHS Foundation Trust (2005-08)
- Consultant Psychiatrist in Psychotherapy, Adult Department, Tavistock and Portman Trust (1996 – present)
- Wellcome Trust Advanced Training Fellow, Tavistock and Portman NHS Trust (1993-99)
- Lecturer in Developmental Psychopathology, Academic Department of Psychiatry, University College London (1991-99)
- MRC Training Fellow, Tavistock Clinic (1990-93)

Qualifications

- MB BS, Royal London Hospital, London University
- BSc (Hons), Physiology, London University
- MRCPsych, London
- Fellow of the Institute of Psycho-Analysis (FIPA)
- Training and Supervising Analyst for the British Psycho-Analytical Society

Ms Trudy Klauber, Dean of Postgraduate Studies

In post since September 2004

Selected relevant experience

- Qualified Teacher (1971), Various roles in three secondary Comprehensive Schools, Catford Country, Willesden High and The Camden School for Girls – Head of Department, Head of Year, Head of House, School Counsellor (1969-82)
- Child Psychotherapist, Bromley, Kent, Tavistock Clinic, Child & Family Department (Development post with Autism Team)
- Consultant Child and Adolescent Psychotherapist, Donald Winnicott Centre
- Director, Donald Winnicott Centre, Hackney (1994-96)
- Head, Child Psychotherapy, Child & Family Department, Tavistock Clinic (2002-04)
- Organising Tutor of the PG Dip/MA in Psychoanalytic Observational Studies (largest course in the Trust) (1998-2004)
- Teaches and supervises regularly in Florence, and occasionally in France and in the USA (1987 – present)

Qualifications

- BA (Hons), Geography with Anthropology, Bedford College, London University
- MACP Member of the Association of Child Psychotherapists
- Formerly Full Member of the British Association of Psychotherapists
- Member of the Tavistock Society of Psychotherapists – Child and Adolescent and Adult divisions.

Ms Louise Lyon, Trust Director

In post since March 2008

Selected relevant experience

- Clinical Director, Adolescent Directorate, Tavistock & Portman NHS Foundation Trust (2007-08)
- Trust Head of Psychology, Tavistock & Portman NHS Foundation Trust (2004-06)

- Deputy Trust Clinical Governance Lead, Tavistock & Portman NHS Foundation Trust (2001-06)
- Consultant Clinical Psychologist, Adolescent Department, Tavistock & Portman NHS Foundation Trust (1996 – present)
- Consultant Clinical Psychologist, SW Kensington and Chelsea Mental Health Centre (1988-99)

Qualifications

- BA (Hons), Psychology, University of Durham
- Chartered Clinical Psychologist
- Member of the Institute of Psychoanalysis

Dr Rob Senior, Medical Director

In post since December 2006

Selected relevant experience

- Senior Research Fellow, University College London
- Honorary Consultant Child and Adolescent psychiatrist, Tavistock Clinic and Royal Free Hospital
- Trust Named Doctor for Child Protection
- Systemic psychotherapist

Qualifications

- MRCPsych, London
- MB BS, London University
- MSc, Family Therapy, Birkbeck College / IFT
- BA (Cantab), History and Philosophy of Science
- MHA Section 12 Approved

Mr Simon Young, Finance Director

In post since April 1996

Selected relevant experience

- Trained as a management accountant in manufacturing industry
- Worked for the National Can Corporation (1981-1987) and for Glaxo (1987-1991)

- Director of Finance at the London Ambulance Service (1991-1996)

Qualifications

- BA, Mathematics, University of York
- MSc, Mathematics, Cambridge University
- Fellow of the Chartered Institute of Management Accountants

Ms Lis Jones, Director of Nursing

In post since September 2010

Selected relevant experience:

- Director of Nursing & Mental Health Care of Older People's Services, Camden & Islington NHS Foundation Trust, (2002 – 2009).
- Nurse Advisor, Department of Health, Mental Health Branch, (2001-2003).
- Head of Mental Health Nursing, Camden & Islington NHS Foundation Trust (predecessor organisations - 1999-2002).
- Community Mental Health Team Manager, Bloomsbury & Islington (1989-1995).
- Community Mental Health Nurse, Bloomsbury Health Authority (1984-1988).

Qualifications

- B.A. Hons, Social Policy & Administration (in Welsh), University College of North Wales, Bangor, 1976.
- SRN (State Registered Nurse) St. George's Hospital, London 1979.
- RMN (Registered Mental Nurse) Maudsley Hospital, London 1982.
- Post Graduate Diploma in Psychodynamic Counselling, Goldsmith College, 1992.

Attendance

Name	Apr 2010	May 2010	May 2010 (E)	Jun 2010	Jul 2010	Sep 2010	Oct 2010	Nov 2010	Jan 2011	Feb 2011	Mar 2011
M. Bostock	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
J. Moseley	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
A. Greatley*	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
A. Kara	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
R. Strang	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
I. McPherson	na	na	na	na	na	na	na	✓	✓	✓	✓
L. Lyon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M. Patrick	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
T. Klauber	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
S. Young	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
R. Senior	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
L. Jones	na	na	na	na	na	✓	✓	✓	✓	✓	✓

*Chair

Balance, completeness, and appropriateness of membership

The Board of Directors was comprised of six Executive and six Non-Executive Directors, including a Non-Executive Trust Chair. Of the six Executive Directors, only five were voting members. One of the Executive Directors was the Finance Director. Two of the current Executive Directors were registered medical practitioners; one of the Executive Directors was a registered nurse (this Executive Director was a non-voting Director); one was a child and adolescent psychotherapist; and one clinical psychologist. All members of the Board of Directors had joint responsibility for every decision of the Board of Directors regardless of their individual skill or status. All members had responsibility to constructively challenge the decisions of the Board and helped to develop proposals on strategy.

The expertise of Non-Executive Directors included finance, management consultancy, public relations and communications, and public policy. This mix of expertise was reviewed on the retirement of Ms Emma Satyamurti. Discussions led to agreement that legal expertise was valuable but not essential and the new mix of expertise was found to be satisfactory.

Performance evaluation

Developing robust governance arrangements was a key work stream in the preparation to becoming an FT and much useful development was undertaken as a result; however, as the Francis Report (2010) made clear, relying on the development of governance systems to achieve FT status would not in itself generate assurance arrangements that stand up to scrutiny in an increasingly challenging regulatory regime. The challenge was to develop a system that delivers quality of service and outcomes together with assurance and management of risk. Such a system needed to assist the Board of Directors in its corporate collective responsibility, whilst maintaining accountability to members, the public, the regulators, and commissioners.

Important principles of governance were established as a result. The Board's committees are connected to the Board only, they are not part of the chain of management; their function is to provide assurance directly to the Board, not to manage the work of the Trust. Board committees can also function to support the work of the executive through providing leadership and direction and coordination. In addition, board committees are a forum to scrutinise outcomes, advise senior staff how standards might be improved, and provide assurance to the Board on these matters. It is individuals, not committees, that are accountable for the delivery of work. Terms of reference were amended to ensure that this was reflected in the language used in the duties section.

All committees of the Board of Directors completed a self-evaluation which was considered and adopted by the Board; no changes were found necessary as a result of these reviews and the Board accepted that the committees had discharged their duties as set. Having completed a year under the new approach, the Board is (at the time of writing) undergoing a review of performance under the revised arrangements.

Register of directors' interests

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

Register is available on the Trust's website and on request via the Trust Secretary's office.

Audit Committee

Composition and attendance

Name	May 2010	September 2010	November 2010	January 2011	March 2011
A. Kara	✓	✓	x	✓	✓
E. Satyamurti	✓	✓	N/A	N/A	N/A
R. Strang*	✓	✓	✓	✓	✓
Dr Ian McPherson	N/A	N/A	✓	✓	✓

* Committee Chair

All members of the committee are non-executive directors. The Finance Director, Mr Simon Young, is normally in attendance at meetings of the Audit Committee. In addition, representatives from External Audit, Internal Audit and Local Counter Fraud Specialist are also present.

The committee's work in 2010/11

In 2010/2011 the Audit Committee reviewed the work of the Internal and External Auditors, counter fraud, financial systems and reporting, assurance processes, including risk management and clinical governance, and various corporate governance matters.

Much of the Committee's time has been spent on reports from Internal Auditors and on the annual external reporting of the Trust. These reports are essential to provide assurance to the Trust and to outside stakeholders that financial management is robust and that sound corporate governance procedures are in place. The Committee has continued to develop its focus on risk management and corporate governance processes in accordance with guidance from Monitor and has reviewed the operation of the new Clinical Quality, Safety and Governance Committee.

The Committee is satisfied that there is an effective internal audit function and a counter fraud function established by management that meets mandatory

NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Executive and the Board of Directors.

The Committee has reviewed the work and the reports of the Internal Auditors and of the External Auditors and is satisfied with the findings and with management’s responses. The External Auditors have examined the Quality Accounts and given a limited assurance opinion on the content of the quality report and on the selected performance indicators reported therein. In addition to auditing the financial accounts as usual. The counter-fraud plan and the work of the Local Counter Fraud Specialist have been reviewed to ensure that the Trust continues to develop its programme of deterrence, prevention and detection.

The Committee has reviewed the process of other significant assurance functions and is satisfied that they can be relied on to provide the necessary information to management and to the Board of Directors regarding the Assurance Framework and corporate governance. The Committee has received positive assurance from management on the overall arrangements for corporate governance, risk management and internal control and is satisfied that there is an effective system of integrated corporate governance, risk management and internal control across all the Trust’s activities. The Committee is satisfied with the Statement on Internal Control.

Non-Executive Director Nomination Committee

Composition and attendance

Name	May 2010	August 2010
M. Burd	✓	✓
C. Kimmons	✓	✓
J. Carrier	✓	✓
J. Bradley	x	x
A. Greatley*	✓	✓
M. Bostock	✓	✓
S. Young	✓	✓
S. Thomas**	✓	✓

*Committee Chair

** Adviser

The work of the committee in 2010/11

The committee met to approve the process of nomination, and the re-nomination of Altaf Kara and Richard Strang in May. It met again in September to interview candidates before recommending the appointment of Ian McPherson in August.

Membership

Eligibility and constituencies

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

Three classes of Public Constituency were set according to the volume of clinical activity: *Camden* (in which the Trust has its geographical base and is the borough to which the Trust provides more services than any other single borough) has three seats; the *Rest of London* (to which the Trust delivers the majority of services) has six seats; and the *Rest of England and Wales* (to which the Trust delivers a higher proportion of specialist services) has two seats. The number of seats in the Camden constituency was reduced for the 2009 elections, and the Rest of England and Wales constituency gained an additional seat, to reflect the distribution of the Trust's services.

The Trust is mindful of the need to ensure that our membership grows and continues to be representative. The Trust writes to all new patients, three months after their first appointment, inviting them to become Members. All current students and staff are Members unless they opt out of membership.

Membership strategy

The objectives were to:

- Develop the opportunities for patients/public to get involved with the work of the trust through voluntary work
- Encourage patients' views through members' contribution to the members newsletter
- Increase the number of relevant small scale surveys on issues meaningful to patients, such as the environment
- Increase the number of events that patients and local public can attend and contribute to

- Increase numbers of younger members and the input of younger members by developing aspects of the membership that will be of interest to young people such linking with schools and local youth groups
- Increase the number of Trust committees to which governors contribute.

The Trust promoted membership to the local voluntary organisations network (Voluntary Action Camden) as a way of trying to ensure a representative membership.

Membership statistics

Constituency	Members at 31.3.11
Public	4810
Staff	722

Contacting governors

Members can contact Governors and Directors via the Trust Secretary in the first instance.

Quality Report

Part 1 : statement on quality from the Chief Executive

The Trust is proud of its record for the provision of high quality mental health services. In previous years the Healthcare Commission awarded the Trust the highest rating of excellent for the quality of our clinical services. Under the Care Quality Commission regulation the Trust has achieved registration without conditions. In March 2011, the Trust achieved NHSLA Level 2 Risk Assessment. This is a significant achievement for the Trust as it is the first time it has been assessed at this level. We have valued the opportunity provided by the Quality Report to work closely with patients, the public, our staff, the Board of Governors, the Board of Directors, our commissioners and other stakeholders in our efforts to ensure that we continue to provide the highest quality services and innovative ways of improving mental well-being.

Building on our achievements from last year, where we introduced a quality programme which was strongly supported by senior management and the Board of Directors and locally owned in each clinical service line, this year we have implemented an integrated system of Clinical Quality, Safety and

Governance (CQSG). The CQSG Committee includes the following work streams: *Patient Safety and Clinical Risk; Corporate Governance and Risk; Clinical Outcomes and Clinical Audit; Patient and Public Involvement* and the *Quality* work streams. The CQSG Committee, which is clinically focused and clinically led, meets quarterly and provides assurance to the Board of Directors and ensures that the work streams deliver on their objectives. Each service line within the Trust continues to produce an annual report to the Board of Directors which includes financial, performance, clinical quality, and staffing data.

The majority of the national indicators proposed for mental health do not apply to our Trust because we provide specialist out-patient services and few indicators have yet been developed which apply either to CAMHS or adult psychological therapies. However, we are committed to finding ways of evaluating and demonstrating the quality of the services we offer whenever possible through the use of national measures, which allow us to benchmark our services. The implementation of our new electronic Patient Administration System (PAS), RiO, has also enabled us to improve our data collection. In addition, this year through the use of the CQUINs (Commissioning for Quality and Innovation) Framework, in conjunction with our commissioners we have agreed indicators (goals) aimed at encouraging innovative practice and improving the quality of services we provide.

Over the past year we have made significant progress on the five areas we identified as priorities. Overall we have increased return rates within our Outcome Monitoring Programme; our redesigned website has been launched and the initial feedback has been very positive from patients and students, and we are awaiting the results of our survey to be undertaken in the Summer; we maintain a rolling programme of refurbishments; we are involved in on-going consultation with patients, carers, Governors and our Non-Executive Directors on the quality of our services through the Patient Public Involvement (PPI) Committee, and we have provided additional training to support staff.

We continue to work to improve outcome monitoring return rates across all clinical services and this year have piloted a number of new outcome measures for use with specific patient groups. We continue to explore ways of improving the communication with our patients and facilitating engagement in services, through the use of telephone surveys and text messaging.

We believe that well-trained, well-supported staff are essential to delivering high quality services. In the past year we have added a number of courses to our Staff Training Prospectus, including workload management and stress awareness. In addition, the findings from the 2010 National NHS Staff Survey indicate that the Trust is rated very highly by the staff.

We are also pleased to report other innovations and achievements during the year, including the launching of a new Young Person's Drug Advisory Service (YPDAS) in Barnet; the implementation of our online wellbeing service, delivered in partnership with Big White Wall, which was short-listed for a

number of prestigious awards and successful in winning the Guardian Public Sector Transformation Award; and achieving a short-listing of the Family Drug and Alcohol Court Service (FDAC) in the MJ (Municipal Journal) Local Government Achievement Awards.

In summary, the Trust is fully committed to the quality agenda and to the areas of patient experience, clinical effectiveness and safety that comprise it. We intend to continue to work closely with all of our stakeholders in order to ensure that we deliver on our commitments.

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 the information contained in this report is accurate.



Dr Matthew Patrick,
Chief Executive
2nd June 2011

Quality Initiatives

The Trust is committed to providing services of the very highest quality and safety. It recognises the patient experience as a key indicator of quality, and the importance of creating a clear role for patients, the public, Governors, Members and the Board of Directors alongside staff in contributing to driving up quality standards. Over the past year, the Trust has implemented the following quality initiatives:

- Established an integrated approach to providing assurance to the Board of Directors on Quality, Safety and Patient and Public Involvement with the establishment of the Clinical Quality, Safety and Governance Committee (CQSG), with work streams reporting on quality and safety issues spanning the Trusts services
- Developed a data validation process to support reported data items in this report, to provide assurance to the Board of Directors on the quality of data. The establishment of a Framework for Data Quality and Procedures has been a key area of development for improving data validation and the assurances over the data quality during the course of the year. A Data Validation Form

has been developed for use with each data entry in the Quality Report. This Form specifies the Lead responsible for providing evidence and assurance, concerning the accuracy and the completeness of data as appropriate, along with identifying gaps, risks and an action plan as required, with the Lead responsible for signing off this form. This data is summarised in a Data Assurance Overview document, which has been presented to the Board of Directors

- Undertaken a series of stakeholder consultations involving patient and public representatives and a Non-Executive Director, and to which Governors have been invited. These meetings have focused on patient experience and both the process of providing information to patients on the psychological therapies offered by the Trust, and facilitating patients making informed decisions about their treatment
- Established a Clinical Quality Forum open to clinical and administrative staff, to identify and share examples of good clinical practice across the Trust and for the purpose of identifying key factors contributing to effective clinical practice, especially in complex cases
- Appointed a Quality Standards and Reports Lead, who leads the Quality work stream reporting to the CQSG Committee and is a member of the Trust Patient and Public Involvement (PPI) Committee and Pan-London PPI Mental Health Forum. This role also involves liaising with staff and relevant stakeholders including commissioners to agree the quality priorities for next year and the Quality indicators for the CQUINs (Commission for Quality and Innovation) scheme for 2011/12
- Appointed a staff member with specific responsibility for promoting and developing Trust and Governor links with the Trust's Members and improving patient experience
- Participated as a key member of the Pan-London Patient and Public Mental Health Forum, which represents ten mental health trusts across London. The PPI Mental Health Forum, which meets regularly, has a remit to ensure that the involvement of service users, carers and the wider community forms an integral part of mental health services in London, and to share good practice

Introduction to parts 2, 3, and 4

Part 2 gives an overview of our achievements in relation to the priorities which we set last year in the areas of clinical outcome monitoring, access to clinical services and healthcare information, improvements to the built environment and facilities, patient and public involvement, and maintaining a high quality and effective workforce. We then outline our priorities for 2011/12 and the measures and processes we plan to use to monitor our progress. Part 2

concludes with statements of assurance from the Board and reports on a range of areas as required by Monitor.

Part 3 offers us the opportunity to demonstrate the quality of our service through a range of quantitative and qualitative measures covering the domains of patient safety, clinical effectiveness, and patient experience. Overall this section demonstrates maintenance and improvement of clinical quality over the year and highlights areas for further work.

Part 4 covers feedback from stakeholders and we are grateful for their constructive responses.

Part 2 : priorities for improvement and statements of assurance from the Board of Directors

Priorities for Improvement

The following section describes our progress and achievements against the targets set for each quality priority for 2010/11.

1 Clinical Outcome Monitoring

Outcome Monitoring (OM) in “talking therapies” is used as a way of evaluating the effectiveness of the therapeutic intervention. For some patients, their engagement with a service may consist of their attending relatively few appointments, limited to the assessment phase, whereas for other patients, they will progress to the treatment phase and complete a course of therapy. Typically, the patient is asked to complete a pre-assessment questionnaire. The therapist may also complete a questionnaire during the assessment phase. At the end of the assessment, the patient will be required to complete a post-assessment questionnaire, as will the therapist. The patient is also requested to complete a questionnaire at the end of treatment. It is recognised by mental health trusts that it is difficult to continue to engage patients in the process of completing and returning questionnaires, especially as the patient moves towards the end of treatment. The lower rate of returns reported by the Trust at treatment end are similar to other trusts offering talking therapies.

Although the implementation of RiO in November 2010 has led to an overall improvement in our data collection, RiO was not designed to include a tracking function for use with outcome monitoring, specifically to indicate when the OM questionnaires have been sent to and received back from patients, which our previous Patient Administration System, Care Notes, enabled us to do. As a consequence, gathering the OM data for Quarters Three and Four has required an extensive cross-checking process for every patient in each service. Because of

the time taken to collect the OM data, there was insufficient time to interrogate fully the data for inclusion in this Report, nor to ensure that we have captured all of the required OM data. Therefore, for the purpose of this Quality Report we have made the decision to focus our reporting on the Quarters One and Two OM data.

However, being able to demonstrate clinical effectiveness for our psychotherapeutic interventions is a priority for the Trust. As part of this process we need to be able to provide adequate assurances over the data we report. In order to take this forward, we have developed an action plan to improve our data collection, collation and reporting systems. This will be delivered in 2 phases: Phase one will involve establishing a system to deliver an effective, efficient and accurate tracking process for requesting and receiving questionnaires and forms completed by the patient, parent or carer, teacher, clinician and others, as required. Phase two will aim to ensure that all the OM and patient data inputted into the Trust Data Warehouse is fully accessible to Informatics team for the generation of reports, which can be used by OM staff to interrogate and analyse the data collected. The results generated should enable clinicians to identify clinical changes with patients, help inform treatment, and determine the effectiveness of clinical interventions. Improving outcome monitoring data is an important component of improving clinical outcomes for patients. This is a Trust priority and therefore additional resources have been identified to improve the outcome monitoring service.

1.1: CAMHS (Children and Adolescent Mental Health Service) Outcome Monitoring Programme

Clinical Outcome Monitoring	
1.1 CAMHS (Child and Adolescent Mental Health Service) Outcome Monitoring Programme:	
Targets for 2010/11	Progress
1.1.1. To increase the return rates for CAMHS to 60% and above.	1.1.1. This has been achieved for the SDQ and C-GAS for the combined data for Q1 and Q2, 2010/11.
1.1.2. To implement the CORC (CAMHS Outcome Research Consortium) expanded protocol across all CAMHS services within the directorate for every new patient referred.	1.1.2. The expanded CORC protocol has been implemented.
1.1.3. To pilot the new outcome measures within the Learning and Complex Disabilities Service (LCDS), the Under Fives Service and the Fostering and Adoption Service.	1.1.3. LCDS are participating in a national programme to develop the CORE-LD (Clinical Outcomes for Routine Evaluation - Learning Disabilities). The Under 5's and Fostering and Adoption pilots are in progress.
1.1.4. To improve data collection in CAMHS across an agreed range of domains.	1.1.4. This had been achieved for all of the CAMHS services and teams by Q3 2010/11.

1.1.1 Following on from the achievements last year, the CORC (CAMHS Outcome Research Consortium) protocol has now been implemented across CAMHS, requiring services and teams to utilise the SDQ (Strengths and Difficulties Questionnaire), C-GAS (Children’s Global Assessment Scale), which provides a global rating of functioning covering a range of situations, e.g. school, home environment etc. and is completed by clinicians, and the GBM (Goal-Based Measure) as part of the routine CAMHS Outcome Monitoring Programme. This is in addition to the CHI-ESQ (Experience of Service Questionnaire), which is used to gather information about patient’s experience. An improvement in the patient return rates has been achieved for the SDQ and the C-GAS/PIR-GAS (Parent-Infant Relationship Global Assessment) compared to previous years. This increase in return rates has been particularly noticeable for the pre-assessment phase (with an increase to 65.3%) for young people and parents / carers where, rather than posting the pre-assessment SDQ forms, they are now handed to the young person and parent / carer to complete while in the waiting room prior to their appointment. This change in procedure has helped to improve patient / carer engagement. The return rate for the C-GAS/PIR-GAS was 62.3%. Further work is required to increase the return rates for the Goal-Based Measure, as the return rate was only 21%. For this reason, we have agreed that the collection of Time 1 and Time 2 data for the GBM will one of our CAMHS CQUINs indicators for 2011/12.

Outcome Monitoring Returns – CAMHS

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages			
				Pre-assessment	Post-assessment	6m	End of Treatment
Child and Family (including North and South Camden)	Self report SDQ	Young persons (Age 11 - 17)	2008/09	50%	N/A	27%	0%
			2009/10	21%	N/A	44%	0%
			2010/11 (Q1 & Q2)	65%	N/A	21%	3%
	Parent and Teacher SDQ	Parents / Carers and Teachers	2008/09	68%	N/A	40%	25%
			2009/10	41%	N/A	39%	29%
			2010/11 (Q1 & Q2)	66%	N/A	33%	19%
Child and Family (including North and South Camden)	CGAS (age 4 - 16)	Therapist	2008/09	N/A	64%	50%	78%
	PIR-GAS (under 4's)		2009/10	N/A	71%	51%	77%
			2010/11 (Q1 & Q2)	N/A	62%	57%	81%

1.1.2 The CORC (expanded) protocol is now used for every new patient referred to our CAMH services and teams.

1.1.3 The Learning and Complex Disabilities Services (LCDS) have been participating in a four year national programme to develop the CORE-LD. The priority for Phase one of the pilot was to ensure that the questionnaire covered all domains, while also assessing the readability and usability of the measure. Phase two ran from September 2008 to July 2010 and incorporated data gathering from clinical use. The LCDS contributed data from 14 patients to the study, which continues this year.

The *Under Fives Service* is currently piloting a series of outcome measures: The Goal-Based Measures, the PIR-GAS, and the CGAS, according to age, at Time 1 and 2. As there are no standard outcome measures for babies under 18 months, the Service is piloting the BCL (Behaviour Checklist) as an outcome measure. The PSI (Parenting Stress Index) is also included at Time 1 and 2. In addition, the Service has devised two forms: Parent Evaluation Form (Time 1 and 2), and the Clinician Evaluation Form (Time 1 and 2), which is hoped will provide more information about the intervention process, and its efficacy. The piloting of these measures is continuing.

The *Fostering and Adoption Service* are piloting the Assessment Checklist for Children (ACC, Tarren-Sweeney), and currently inputting the data into the Tarren-Sweeney database. But, further work is required in order to evaluate the results, before considering wider implementation.

1.1.4 The last target involved improving the data collection for CAMHS across a number of areas, in order to obtain the information required for the CAMHS dataset. This includes information such as the child / young person's presenting problem, and demographic data, such as GP, school etc., required for all of the children and young people attending CAMHS. This was obtained for the majority of children / young people by the end of Quarter Three in 2010/11.

In summary, for Quarters One and Two, there has been an improvement in the return rates for the majority of outcome measures, compared to previous years. We have been successful in rolling out the CORC protocol to all the relevant CAMH services and teams, and in gathering all the relevant information required for each patient attending our Service, and we have begun to pilot the use of new specialised outcome measures. The improvement in return rates indicates that the CAMHS, over the past year, has made some progress in improving the engagement of patients, their families and significant others in the process of thinking about the child or young person's difficulties, and their functioning in different situations.

"When the child psychologist visited my son's school, he was superb in helping them understand my sons' problems and prompting a SEN referral."

(Parent, Child and Family)

1.2: Adult Outcome Monitoring Programme

Clinical Outcome Monitoring	
1.2 Adult Outcome Monitoring Programme:	
Targets for 2010/11	Progress
1.2.1. To further increase the return rates of forms from patients in the Adult Department.	1.2.1. Return rates from patients have largely remained consistent with previous years.
1.2.2. The data from the new outcome measures currently being piloted within the Adult Brief Therapy Service will be evaluated.	1.2.2. Data from the PHQ-9, GAD-7 and the WASAS is being collected for 2 groups of patients within this Service.

1.2.1 The outcome measure used by the Adult Department is the CORE (Clinical Outcomes for Routine Evaluation) system. Although the return rates have remained consistently high over the past few years at the pre-assessment stage with return rates of over 90%, it was hoped that a change in the protocol would help to increase the return rates at the post-assessment stage where, rather than post the forms, clinicians hand the CORE forms to patients. However, the response rates in Quarters One and Two in 2010/11 have largely remained consistent with previous years, except for the end of treatment return rates which have dropped by 4% to 46.7%. It is believed that the reason for this slight decrease in return rates is due to data capturing difficulties resulting from the implementation of RiO in November 2010, and the transfer over from the previous Patient Administration System, Care Notes. As a consequence, any outcome monitoring forms distributed during Quarters One and Two in 2010/11, but returned after this period, may not have been captured as it was not possible to record these returned forms on RiO.

It was not possible this year to interrogate properly the OM date from the Adult Department for inclusion in this report. However, from reviewing the OM results from previous years, there appears to be a positive trend, when comparing the pre-assessment CORE scores to the end of treatment scores. There is an improvement in scores for a proportion of patients at the end of treatment, with a greater percentage of patients falling into the 'non-clinical' category on the CORE OM, compared with the pre-assessment phase.

Outcome Monitoring Returns – Adult

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages		
				Pre-assessment	Post-assessment	End of Treatment
Adult	CORE	Adult patients	2008/09	95%	56%	51%
			2009/10	100%	56%	51%
			2010/11 (Q1 & Q2)	97%	56%	47%
Adult	CORE Therapy Post Assessment Form	Therapist	2008/09	N/A	94%	92%
	CORE End of Therapy Form		2009/10	N/A	79%	86%
			2010/11 (Q1 & Q2)	N/A	83%	79%

1.2.2 In the Adult Brief Therapy Service, three new outcome measures: PHQ-9 (Patient Health Questionnaire - 9); GAD-7 (Generalised Anxiety Disorder - 7) and the WASAS (Work and Social Adjustment Scale) have been selected for use in evaluating this Service along with a client satisfaction questionnaire. These measures are currently being piloted in the Adult Department with Interpersonal Therapy (IPT) and Brief Psychotherapy with a small sample of patients to help evaluate these therapies and the benefits for patients presenting with anxiety and depression. Although the initial findings suggest that patients receiving these therapies are improving, the patient numbers are too small to allow for a meaningful analysis of the outcome data at this stage.

In summary, the return rates of the CORE outcome measure for the Adult Department have remained consistent with previous years, and three new outcome measures, along with a client satisfaction questionnaire are currently being piloted for possible use as part of the Brief Therapies Service.

“It was helpful to be able to talk about things that I had never mentioned to anyone before. And that gradually I was able to understand myself much more than I had before. ”

(Patient, Adult)

2: Access to clinical service and health care information for patients and the public

2. Access to Clinical Service and Health Care Information for Patients and Public	
Targets for 2010/11	Progress
2.1. In 2009 the Trust website was redesigned to ensure it provided the appropriate access to information. After the site has been live for a year a survey will be conducted through the Members' Newsletter to check that the site is functioning as it should.	2.1. This survey will be included in the Summer 2011 Members' Newsletter. The findings are not yet available for inclusion in this Report.
2.2. The Communications Team will prepare a series of downloadable leaflets on Life Issues which will offer information and advice in relation to common issues encountered across the life span. The series will be launched in 2010/11 and will make a contribution to promoting public health and well-being.	2.2. The leaflets were published in March 2011 and are available on the Trust Website.
2.3. Following a consultation with People First, the Trust will develop information leaflets suitable for people with learning disabilities and will make these available from 2010/11.	2.3. These leaflets have been produced and approved by People First.

2.1 We view the Trust's website as a key portal of access to, and a key route for, disseminating information about the Trust and its services. In 2008, a strategic decision was made to redesign the website to ensure that it was fit for purpose and, in response to feedback from patients, to ensure that the website was organised around the typical questions asked by patients (and our student users). The website has been completely revised and the new site was launched in July 2009.

Now that the site has been live for over a year, the Trust will conduct a further survey through a web-link which will be included in the Summer 2011 Members' Newsletter, and on the Trust Website to ensure that the site is functioning as it should. The findings will be reported in the 2011/12 Quality Report.

In October 2010, Camden's new children's emotional well-being website, Cam's Den, was launched. The project was led by the Trust's PPI and Communications Lead, supported by Camden PCT and Camden Local Authority, and included the involvement of other Trust staff.

2.2 The Communications Team has prepared a series of downloadable leaflets on Life Issues which offer information and advice in relation to common issues encountered across the life span. The series was launched in March 2011 and will make a contribution to promoting public health and well-being.

2.3 Following a consultation with People First, an advocacy group run for and by people with learning disabilities, the Trust has developed information leaflets suitable for people with learning disabilities.

In summary, in the time since the re-designed website went live, patients have been invited to provide feedback, which have led to further improvements. However a more comprehensive survey has been undertaken recently, and the findings will be included in the 2011/12 Quality Report. With the launch of Camden’s new children’s emotional well-being website in October 2010, and the development of information leaflets suitable for people with learning disabilities in addition to downloadable leaflets on Life Issues, the Trust is increasing its efforts to facilitate improved access for different patient groups and to provide information to promote emotional and mental well-being.

3: Improvements to the built environment and facilities

3. Improvements to the Built Environment and Facilities	
Targets for 2010/11	Progress
3.1. To conduct a survey of the improvements to the built environment and facilities.	3.1. A survey was undertaken and the findings are available.
3.2. To maintain a rolling programme of refurbishments, and plans for improvements to the use of the external spaces.	3.2. The refurbishments are ongoing.

3.1 In 2009, the Trust focused on the refurbishment of high traffic ground floor areas, responding to concerns that had been raised in previous patients’ surveys about the “tired” condition of the building. Such comments were far from universal, with many patients giving positive feedback about the ‘feel’ of the building and praise for the artwork.

During 2010/11, there were various other improvements made to the building, such as increased capacity of toilet facilities, including access to disabled toilet and shower facilities, installation of more efficient lighting and light sensors throughout many areas of the building and making seminar room doors acoustically and thermally efficient.

The 2010/11 Survey received both positive and negative feedback on the quality of the environment. Some individuals provided feedback that the trust “feels warm and welcoming”, but others feel it can be “too open and clinical”. We have had specific feedback about the new signs in the trust and how these have been appreciated. Surveys are planned on a yearly basis to ensure that regular feedback on the environment and facilities is obtained.

3.2 As the Patient and Public Involvement and Communications Lead is a member of the Trust’s Design Advisory Group, this ensures that there is a process in place for improving and maintaining the quality of the environment based on a range of views including patients, Governors, Members and staff on an on-going basis.

In summary, the Trust is engaged in obtaining on-going feedback from patients, Governors, Members and others regarding the physical environment and facilities, and taking forward various improvement programmes in response to the feedback received.

4: Patient and Public Involvement

The Trust places great importance on patient and public involvement and aims to elicit feedback from as wide a range of our service users as possible, including patients and their families, students and professionals who attend conferences and courses.

4. Patient and Public Involvement	
Targets for 2010/11	Progress
4.1. Complete a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee.	4.1. Two stakeholder consultations took place in 2010/11.
4.2. Complete and report on consultations involving patients and carers.	4.2. The PPI Committee have been consulted on RiO and various other issues.
4.3. Develop and evaluate more creative ways of obtaining feedback.	4.3. The PPI Psychology Assistant was appointed in March 2011 and will carry forward this initiative to 2011/12.

The Trust places great importance in patient and public involvement and aims to elicit feedback from as wide a range of our service users as possible, including patients and their families, students and professionals who attend conferences and courses.

The Patient and Public Involvement Committee consists of PPI Leads for all departments within the Trust, representatives from central services, training, education services and research. There are three patient and public involvement representatives from the patient / local public population as well as two Governors and a Non-Executive Director. There is a close link with the Communications Team to ensure that communications with patients and the public are optimised.

4.1 In liaison with the PPI Committee, the Trust Director, PPI and Communications Lead, and the Quality Standards and Reports Lead

completed Stakeholder Consultation meetings in September 2010 and March 2011, which included patient and public involvement representatives and a Non-Executive Director, and to which Governors were invited, in order to explore the ways the Trust could improve the quality of its clinical services. The three main issues discussed included: The need for patients to be provided with adequate information about the treatments / therapies offered by the service the patient attends, to facilitate patients making informed decisions about their treatment; the possibility of patients being offered a follow-up appointment, to help evaluate the outcome of treatment; and the different aspects of the patient experience from the time they walk into the building until the time they leave. It was agreed that the issues explored would be considered further by the Trust and the PPI Committee, and followed up at our subsequent Stakeholder Consultation meetings.

4.2 Over the past year, The Patient and Public Involvement Committee have been consulted about various initiatives, including patient information leaflets, updating the Trust website, developing a scheme to fund membership projects and also for feedback following the implementation of these initiatives. In addition, the PPI Team has obtained feedback from patients and carers on RiO.

4.3 The plan to develop more creative ways of obtaining feedback, including themed open meetings will be taken forward by the new PPI Psychology Assistant, who joined the Trust in March 2011.

In summary, over the past year the Trust has undertaken a series of stakeholder consultations around improving the quality of clinical services; the PPI Team has obtained feedback from patients and carers on RiO and other issues, and with the recruitment of the new PPI Psychology Assistant plans to develop more creative ways of obtaining feedback.

5: Maintaining a High Quality Effective Workforce

The Trust performed extremely well in the 2010 National NHS Staff Survey undertaken by the Care Quality Commission, and showed better than average scores for a large number of survey questions especially those relating to staff job satisfaction; staff recommending the Trust as a place to work and receive treatment; staff motivation; being able to use flexible work options, and the Trust's commitment to work-life balance. These were questions for which the Trust ranked in the top 20% of mental health/ learning disability trusts. On a less positive note, there was a decrease in the number of staff taking part in the survey compared with previous years, with the Trust having a response rate of 51% in 2010, compared with 57% in 2009, and 55% in 2008.

The sickness absence rates for staff for 2010/11 was low, at 1.4%, which can be regarded positively, and seen as being related to staff motivation and satisfaction at work.

5. Maintaining a High Quality, Effective Workforce	
Targets for 2010/11	Progress
5.1. To put in place a range of measures to reduce work related stress.	5.1. Training has been provided to staff on time and workload management, along with stress awareness training and briefing sessions.
5.2. To maintain a well-trained, flexible and creative workforce through providing personal development plans, supporting Continuing Professional Development and continuing to support workshops aimed at enhancing clinical learning and development.	5.2. A comprehensive action plan was developed in response to the Annual Staff Survey 2009, where many of the actions identified have been completed, and other actions are in the process of being completed.

5.1 During 2010/11, the range of training provided to staff was expanded to include the provision of time and workload management, stress awareness training and briefing sessions to staff. The feedback has been largely positive, with scores ranging from 6-9, for the “Managing Pressure Positively” workshop for staff responding to the question: ‘From a scale of 1 to 10 how confident and motivated do you feel in taking these steps with 10 being very motivated and confident?’ This has been reflected in the 2010 Staff Survey, with fewer staff (17%) reporting work-related stress compared to 26% in 2009. While the number of staff reporting that they work extra hours has increased from 75% in 2009 to 83% in 2010, the number of staff reporting job satisfaction has remained high at 3.94 (with a score of 5 indicating that staff are satisfied with their jobs), which is reasonably consistent with the figure of 3.98 obtained for 2009, with the Trust ranking in the “best” 20% of trusts, when compared to trusts of a similar type. However, there has been a slight decrease in the number of staff saying that they would recommend the Trust as a place to work or receive treatment, from 4.30 in 2009 to 4.14 in 2010. Although, the Trust still ranks in the “best” 20% of similar trusts for this finding, the reasons for this warrant further exploration.

5.2 The Trust is committed to maintaining a well-trained and flexible workforce. The Trust performed well on the 2010 Staff Survey for the section of the survey related to staff training and the support provided from the line management structure for staff, with the Trust ranking in the top 20% of mental health/learning disability trusts for four out of a total of six questions, and “better than average” for the remaining questions covering this area. In the past year, as part of the comprehensive action plan developed in response to the 2009 Staff Survey, and further developed in 2010, the Trust has provided appraisal training for managers, providing an extended Management Development Program for middle and senior managers and training in improving

communication. The use of Personal Development Plans (PDPs), which in 2010/11 were completed for 82% of staff, has contributed to the identification of training needs for the majority of staff and enabled the Trust to establish a coherent training programme for 2010/11, which is relevant to the needs of its staff group.

Staff Survey Feedback

	2008	2009	2010
Percentage of staff working extra hours	84%	75%	83%
Well-structured appraisals received	34%	49%	46%
Work-related stress	46%	26%	17%
Job satisfaction	-	3.98*	3.94*
Recommend the Trust as a place to work and receive treatment	-	4.30*	4.14*

*Scale is from 1-5. 1 is a low score and 5 is a high positive score.

In summary, the Trust has provided staff with time and workload management and stress awareness training and briefing sessions, which has helped to reduce work-related stress reported by staff. In addition, a Management Development Program has been put in place for middle and senior managers, along with training for conducting appraisals and improving communication.

Quality Priorities for 2011/12

It is clear from the span and the number of quality priorities achieved for 2010/11, that the Trust is both committed to quality improvement at every level of service delivery, and for all Trust staff to be involved in its quality improvement initiatives.

Feedback from patients has been essential for the process of selecting quality priorities for 2011/12, where patient surveys, information from the Experience of Service Questionnaire completed with patients, feedback from the PPI Team, and consultation with stakeholders (PPI representatives), Non-Executive Directors and Governors has been an important part of the process for thinking about the priorities for the year ahead. Furthermore, in selecting our priorities for next year, we have been actively involved in seeking contributions from our Board of Directors, the Board of Governors, commissioners, LINKs, staff and members as part of this process and when agreeing CQUIN targets for 2011/12. Liberating the NHS: Greater Choice, Greater Control (DH, 2010), with its focus on patient experience, choice and outcomes has been important for determining our direction of travel. In addition, the recent MIND et al survey, 'We Need to Talk: Getting the Right Therapy at the Right Time' (MIND, 2010) has pointed to the enhanced perceived helpfulness of treatments where choice was available.

In response to the feedback we have received over the year to our 2010 Quality Report, we have decided to refine our priorities for 2011/12. However, this does not mean that the priorities identified in previous years for quality

improvement will be dropped. For example, while improvement to the built environment and facilities had been identified as a priority for 2009/10 and 2010/11, it is clear that there are now structures and systems in place to oversee the plans for on-going maintenance and improvements to the building and facilities. For this reason, we have decided not to include 'Improvements to the built environment and facilities' as a priority for 2011/12.

Targets for 2011/12

1: Outcome Monitoring (Clinical Outcomes)

Rationale

We recognise that demonstrating clinical effectiveness is a priority. In 2010/11 we managed to achieve reasonable return rates for the questionnaires we used for outcome monitoring, particularly at initial stages (Time 1) of assessment and treatment. Our next 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. However, as we are in the process of improving our Trust outcome monitoring system, as described previously, we first need to have an opportunity to test the new OM system, to ensure that it allows us to derive the necessary data for analysis. For this reason, for 2011/12 we also plan to confine our reporting on outcome monitoring to two of our services, CAMHS and the Adult Department.

For CAMHS we have decided to continue to use the Goal-Based Measure (GBM) as one of our priorities for next year, with a target to achieve a return rate of 60% for Time 1 and Time 2 for the GBM for CAMHS. This has also been agreed as one of our 2011/12 CAMHS CQUINs indicators with our commissioners. Our reason for continuing with this OM is because of the importance that patients, clinicians and our commissioners place on patient reported outcomes, as they represent a "measure of *what the service user wants to achieve*" [Goal Based Outcomes (GBOs), Some Useful Information: CORC website]. Essentially, they are the goals identified by the child/young person/family/carers, rather than 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 (Time 2). In addition, they enable the service to measure the effectiveness of interventions across a range of services, in a variety of settings with different patient groups.

We have also set a target of achieving a return rate of 60% for Time 1 and 2, for the CORE OM, for patients attending the Adult Department who have completed their assessment between April 2011 and January 2012. This will enable us to obtain robust data, which is essential for starting to consider the effectiveness of treatments provided to the patients attending this service.

Targets

Outcome Monitoring
CAMHS (Child and Adolescent Mental Health Service):
Target for 2011/12
1.To achieve a return rate of 60% for the Goal-based Measure for Time 1 and Time 2 (for those patients who completed the GBM at Time 1)
Adult Department
Target for 2011/12
2. To achieve a return rate of 60% for the CORE for Time 1 and Time 2 (for those patients who completed the CORE at Time 1)

Monitoring Process

- Quarterly measurement of return rates for OM forms using a newly developed OM tracking system to track the sent and received OM forms
- Monitoring of progress towards achieving target by OM Lead, who will take remedial actions, where required, to ensure that targets are met.
- Quarterly progress report to be completed by OM Lead and submitted to Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors
- Quarterly review of progress reports by Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors

2: Access to Clinical Services and Health Care Information for Patients and Public

Rationale

We are awaiting feedback from the survey to be included in the Summer 2011 Members' Newsletter, along with the feedback on the downloadable leaflets on Life issues from the Trust Website. This feedback will be included in the 2011/12 Quality Report.

As we know from the MIND et al survey (MIND, 2010), individuals who have been provided with 'full and informed choice' were more likely to feel that their therapy was effective. We already provide information to patients outlining the benefits and risks of therapy, but it is clear from the Trust's Annual Patient Survey, our PPI Committee and Stakeholder's meetings that patients wish to have more detailed information, to facilitate patients making informed decisions about their treatment.

For this reason, for 2011/12 we plan to develop leaflets for specific treatment modalities, which can be provided to patients, but also to provide this information via the Trust website. We will seek feedback from patients and Members to ensure that the links to this information is clearly accessible. For 2011/12 aim to achieve the following targets:

Targets

Access to Clinical Services and Health Care Information for Patients and Public
Targets for 2011/12
1. To increase the number of leaflets about specific treatment modalities from 0 to at least 5 leaflets by February 2012
2. To ensure that links to this information are clearly accessible through the website by February 2012

Monitoring Process

- PPI Lead to initiate and oversee the process for developing these leaflets
- Monitoring of progress towards achieving target by PPI Lead, who will take remedial actions, where required, to ensure that targets are met.
- For Trust Communications Specialist to seek feedback from patients and members on the accessibility of this information via the Trust website
- Quarterly progress report to be completed by PPI Lead and submitted to PPI Committee, Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors
- Quarterly review of progress reports by PPI Committee, Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors

3: Patient and Public Involvement

Rationale

Feedback from patients as part of our Annual Patient Survey is extremely important in order for us to know where services need improving and what patients find valuable. In addition, we greatly value the feedback we have received from the two consultation meetings with Stakeholders (PPI representative), Non-Executive Directors and Governors this year, along with the feedback from the PPI Committee, where this feedback has contributed to the targets we have set for 2011/12 for our Priority 2 described previously. Therefore, we plan to continue with our stakeholders meetings, increasing the frequency of these meetings and to extend the use of the Experience of Service Questionnaire (adapted version) to the Adult Department, which is also one of

our CQUINs targets. Now that we have a PPI Psychology Assistant in post, we plan to take forward our plans to develop and evaluate more creative ways of obtaining feedback.

This will include holding at least 3 patient information/discussion groups over the course of the year and to trial a patient forum. Although we greatly value the feedback from patients provided through the Annual Survey, we aim to increase the opportunities for obtaining real-time feedback from patients, carers and other stakeholders, to use to improve the quality of our clinical services. We hope that the targets for 2011/12 namely, the patient discussion groups, patient forum, increased frequency of stakeholders meetings and feedback from the patient satisfaction questionnaires, used in the Adult Department, along with CAMHS and the Adolescent Department will help us achieve this aim.

The PPI Committee are keen to develop relationships between governors and members of the foundation trust, and patient and public involvement. This will be a key priority for work over the coming year. We aim to do this by promoting service user involvement within the organisation, where children and young people attending the Child and Family Department will be encouraged to become members. In addition, in response to feedback from Camden LINKs to our 2009/10 Quality Report, we plan to improve our engagement with local black and minority ethnic (BME) groups, by establishing contact with VAC (Voluntary Action Camden) and other BME community groups based in Camden.

Finally, in order to improve our accessibility and to provide opportunities for a greater range of individuals to access information about the clinical services provided by the Trust we plan to increase our presence on social media websites. The targets for 2011/12 have all been derived from patient feedback to the patient survey, our contact with Camden LINKs, and other patient feedback mechanisms. They have been agreed with the PPI Committee which has both governor and external PPI representatives. For 2011/12 we aim to achieve the following targets:

Targets

Patient and Public Involvement
Targets for 2011/12
1. To have held at least 3 stakeholder quality meetings by February 2012
2. To increase the membership numbers by 10% by March 2012.
3. To develop a clear strategy around BME engagement by February 2012
4. To trial a patient forum and to hold at least 3 patient information / discussion groups by February 2012
5. To increase our presence on at least one of the social media websites by February 2012

Monitoring Process

- Maintain minutes from the stakeholder quality meetings, to ensure that recommendations are actioned
- Maintain monthly records of the number of members
- Patient and Member feedback
- Monitoring of progress towards achieving target by PPI Lead, who will take remedial actions, where required, to ensure that targets are met.
- Quarterly progress report to be completed by PPI Lead and submitted to PPI Committee, Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors
- Quarterly review of progress reports by PPI Committee, Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors

4: Maintaining a High Quality Effective Workforce

Rationale

Staff training is a high priority for the Trust, to ensure that patients are treated safely and effectively and in order to maintain and improve our standards of care. We are pleased that in response to our 2010 patient survey 70 % of patients indicated that they “were listened to and treated with respect and dignity”. In addition, we have achieved a good record of attendance for the Level 3 training for Safeguarding of Children, but clearly recognise that we need to improve on the levels of attendance for the Mandatory training/INSET Day, Trust-wide Induction and for the number of staff completing local inductions and have action plans in place to help achieve these improvements. However, in consideration of the importance of mandatory training, and staff being properly inducted to the Trust, we have decided to include this as a priority for 2011/12, with the following targets:

Targets

Maintaining a High Quality Effective Workforce
Targets for 2011/12
1. For 75% or more of Trust staff to have attended the mandatory training/INSET day once every 2 years, as required
2. For 75% or more staff joining the Trust to have attended Trust-wide Induction
3. For 75% or more staff joining the Trust to have completed their Local Induction

Monitoring Process

- Staff database in order to keep track of new starters and leavers

- Attendance records for the mandatory training, INSET day and trust-wide induction
- Completion records for the local inductions
- Monitoring of progress towards achieving target by HR Director, will take remedial actions, where required, to ensure that targets are met.
- Quarterly progress report to be completed by HR Director and submitted to Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors
- Quarterly review of progress reports by Clinical Quality, Safety and Governance Committee (CQSG), and Board of Directors

Statements of Assurance from the Board

During 2010/11 The Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted four NHS services.

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

The income generated by the NHS services reviewed in 2010/11 represents 97% of the total income generated from the provision of NHS services by The Tavistock and Portman NHS Foundation Trust for 2010/11.

Participation in Clinical Audits and National Confidential Enquiries

During 2010/11 one national clinical audit and two national confidential enquiries covered NHS services that The Tavistock and Portman NHS Foundation Trust provides.

During 2010/11, The Tavistock and Portman NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

- The National Audit of Psychological Therapies for Depression and Anxiety
- Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH)

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in during 2010/11 are as follows:

- The National Audit of Psychological Therapies for Depression and Anxiety
- Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH)

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- The National Audit of Psychological Therapies for Depression and Anxiety
100%
- Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH) 100%

The report of one national clinical audit was reviewed by the provider in 2010/11 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. No actions to be taken until the results are nationally reported in October 2011.

The reports of twelve local clinical audits were reviewed by the provider in 2010/11 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Clinical audit needs to be more embedded within each of the Trust directorates and support will be given to departmental clinical governance leads in providing basic clinical audit training.
- In order to enhance the process of dissemination of clinical audit findings and recommendations a regular Trust-wide clinical audit forum will be established
- Further work on the electronic database will be undertaken
- Continue participation in relevant National Clinical Audits
- Consultation with PPI Committee to facilitate developing service user involvement in the clinical audit programme.
- Review the implementation and monitoring of the Clinical Audit Policy.
- A Number of key Trust-wide audit topic priorities have been identified and are being actioned.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 73.

The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust's income in 2010/11 was conditional upon 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 NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at <http://www.tavistockandportman.nhs.uk/performanceandachievements>

The total financial value for 2010/11 was £119,000 and the Trust expects to receive £109,480.

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 2010/11.

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

Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2010/11 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 2010/11 was 100% at level 2 or above for all key requirements and was graded green for key requirements.

The Tavistock and Portman NHS Foundation Trust will be taking the following actions to improve data quality:

- Completing and implementing a new policy on data quality which has been drafted with expert advice from the Trust’s External Auditors; and
- Build on and improve the validation and sign off procedure introduced during 2010/11 for all data entries in this report.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3 : other information

Quality of Care Overview: Performance against selected indicators

The quality metrics that we have selected to measure the performance of The Tavistock and Portman NHS Foundation Trust are incorporated within the three quality domains of patient safety, clinical effectiveness and patient experience. These indicators include those reported in the 2009/10 Quality Report along with metrics that reflect our quality priorities for both 2010/11 and 2011/12. In addition, we have highlighted other indicators outside of our priorities that the Trust is keen to monitor and improve.

Patient Safety Indicators

NHS Litigation Authority Level

Indicator	2008/09	2009/10	2010/11
NHS Litigation Authority Level	-	Level 1 achieved (Feb 2009)	Level 2 achieved (March 2011)

In March 2011, the NHS Litigation Authority (NHSLA) awarded the Trust a Level 2 for demonstrating compliance with its policies and procedures covering all aspects of risk management. This assessment is valid for three years.

Patient Safety Incidents

Indicator	2008/09	2009/10	2010/11
Incidents*:			
All reported incidents	187	264	325
Patient Safety Incidents	Not reported	53	54

* Please note that in the 2009/10 Quality Report, due to a data definition error, the number of incidents reported related to 'all incidents' and not 'patient safety' incidents. This error has been corrected in the table above.

In this report, the Trust has taken the definition of 'patient safety incident' to be an incident reportable to the National Patient Safety Agency (NPSA) database National Reporting and Learning System (NRLS).

The Trust has a very low 'patient safety incident' rate due to the nature of its patient services. The vast majority of the reportable incidents have occurred in the Trust's Specialist Children's Day Unit, a school for children with emotional difficulties and challenging behaviour.

Prior to April 2009, the Trust, in consultation with the NPSA, did not add any 'patient safety' incidents to the NRLS. Following a discussion with the NPSA in mid-2009 it was agreed that the Trust would begin to upload incidents. The NPSA requested that all 'pupil to pupil' violent behaviour and patient accident incidents were uploaded and these make up almost all the incidents uploaded since April 2009.

The total reported incidents (both clinical and non-clinical) rose in both 2009/10 and 2010/11 which is considered to be as a result of a general increase in awareness of incident reporting across the Trust, rather than any change in the type or rate of incidents being experienced.

In 2010/11, the Trust has not had an incident that has rated more than 8 on the Trust risk matrix, i.e. all incidents have been rated as suitable for no further action or for local review only, and none have triggered an investigation under the Trust's serious investigation procedure.

The Trust continues to promote incident reporting at the Trust-wide Induction, INSET and other risk training events.

Monitoring of Adult Safeguards

Indicator	2008/09	2009/10	2010/11
Monitoring of Adult Safeguard Alerts	Not reported	2	4

The importance of safeguarding vulnerable adults, by identifying and reporting those adults who might be at risk of physical or psychological abuse, has been highlighted to staff in the Trust. This has been through the implementation of various education and awareness initiatives, including mandatory training provided at the Trust INSET day and team meeting presentations, which promote the Trusts policy and procedure for Safeguarding Adults. In addition, the Trust has formally appointed a senior clinical member of staff as Vulnerable Adults Adviser.

Electronic Recording of Children in Need

The Trust has introduced RiO as a Patient Administration System. Within RiO it has not been possible to establish an electronic recording system for 'children in need'. We are investigating alternative solutions.

Attendance at Trust-wide Induction Days and Local Induction

Indicator	2008/09	2009/10	2010/11
Attendance at Trust Wide Induction Days	66%	85%	64%
Completion of Local Induction	Not reported	Not reported	39%

As Trust turnover is low we provide Trust-wide induction three times per year, where all new starter staff are expected to attend. However, in light of poorer attendance this year, compared to 2009, an action plan to improve attendance has been implemented. This includes individual invitations to attend the induction day and the potential sanctions if non-attendance is identified as deliberate.

At a recent NHSLA assessment the Trust was unable to demonstrate adequate evidence of completion of local induction. Evidence relies on managers returning a form to Human Resources to show that local induction has been undertaken, for each new starter. The Trust has developed an action plan to address the low reporting rates.

Attendance at Mandatory Training

Indicator	2008/09	2009/10	2010/11
Attendance at Mandatory Training***	Not reported	Unable to provide a comparative figure because of a different reporting system	64%

*** Staff are expected to attend training every 2 years. In order to achieve this 100% attendance is expected over a 2 year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at year end.

The Trust provides its main mandatory training update via its In-Service Education and Training (INSET) day, which staff are required to attend every two years. At the INSET day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality and Caldicott guidance, equality and diversity, information governance, safeguarding children level one, safeguarding adults and fire safety.

All staff are expected to attend mandatory training every two years and in light of poorer attendance this year, an action plan to improve attendance has been implemented. This includes invitations sent to all staff who are required to attend, notification sent to line managers and the potential for sanctions if non-attendance is identified as deliberate. In addition, attendance is also raised and discussed in staff appraisals. In the context of the findings from the 2010 staff survey, which indicates that overall staff engagement is good, the attendance at mandatory training events and inductions in 2010 was not as good as expected. While the staff survey shows staff to be working longer hours, it appears that there is not adequate recognition amongst staff of the importance of attending mandatory training and induction events. For this reason, it has been agreed that local induction, along with mandatory training and the Trust-wide Induction will be included as quality indicators under Priority 4 for 2011/12.

Safeguarding of Children

Indicator	2008/09	2009/10	2010/11
Safeguarding of Children - Level 3 Training	Not reported	94%	88%

The Trust has made it mandatory for all staff from CAMHS and the Adolescent Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years, and their attendance is monitored. By year end, 88% of staff requiring Level 3 training had attended this training. Another training session is scheduled to take place in June 2011 and for additional staff to attend.

Infection Control

Although the Trust has no in-patient beds and does not provide the types of services which are associated with higher risks of infection, such as those provided by acute hospitals, we nevertheless take steps to maintain high standards on cleanliness in all parts of the building, and to reduce the risk of infections, as follows:

- We have a policy in place regarding infection control
- All staff are informed of the policy during INSET, Induction and mandatory training days
- We have placed alcohol hand rubs on all floors near lifts/doorways
- We have installed hazard waste spill kits in areas of likely/possible occurrence
- The Health and Safety Manager and Trust Risk Advisor are on email alerts list from Department of Health in relation to infection control
- A poster campaign regarding washing hands is included in all toilets and kitchenettes
- Annual flu injections are arranged for staff with the Royal Free Hospital

Family Drug and Alcohol Court (FDAC)

The Family Drug and Alcohol Court (FDAC) is an intensive multi-agency parent-child intervention program. The FDAC improves outcomes for children with substance misusing parents. The Service builds on the parent's desire to overcome their problems and have their children returned. An initial assessment (completed within a week of the families entering the program) allows workers to agree (with the families and safeguarding, treatment and other agencies) a 'fair test' of the parent's capacity to make appropriate changes in a timeframe compatible with the child's needs. Parents are given the best possible support to generate the evidence the safeguarding agencies need. The Family Court then lends its authority to a highly coordinated, time-limited, intensive therapeutic intervention. The aim is to improve children's chances of remaining safe and thriving in their parents' care while making alternative plans as soon as possible for the families that fail.

FDAC successfully uses parent mentors and the 'Strengthening Families Banishing Violence Program' (intensive multiple-family-therapy for individuals and couples with a history of discord and violence).

Case example

P, 25, was a drug addict living in a hostel in Camden, North London, with her children of 5 and 2. She was pregnant with her third. "I knew I was expecting but I blocked it out," she recalls. "I didn't want to know about it — I had no family and was living with a former partner." She gave birth in the hostel toilet. Social services were contacted and her children taken away. Luckily, Camden is one of the sponsoring boroughs for the FDAC scheme and she was referred. She was placed in a special mother-and-baby unit and helped to become abstinent. After three months, she was reunited with her older two children in a parenting unit where she could be helped and monitored. Now, she is housed in her own flat with all three children in another borough and reunited with her family after many years. She came out of FDAC two months ago. "I have been clean for 18 months. It's really successful: they guide you all the way and help you through it. And the judge is lovely — a really good judge — he always praised me. That gives you strength to keep going."

Gibb, F. "The Family Drug and Alcohol Court: saving families and money" The Times November 26, 2009

Clinical Effectiveness Indicators

Monitor Number of Staff with Personal Development Plans (PDPs)

Indicator	2008/09	2009/10	2010/11
Monitor number of staff with Personal Development Plans	92%	93%	82%

Through appraisal and the agreement of Personal Development Plans 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.

The number of staff with PDPs in 2010/11 was 82% which is a decrease on the 93% achieved in 2009/10 and lower than the target return rate of 90%. However, the staff group who have not completed a PDP in 2010 include those staff who are on a career break, sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

Range of Psychological Therapies

Over the years, the Trust has increased the range of psychological therapies available, which enables us to offer treatment to a greater range of patients, and also offer a greater choice of treatments to all of our patients. We have established expertise in systemic psychotherapy and psychoanalytical psychotherapy and continue to support staff development and innovative applications of these models.

Over the last year we have continued to strengthen our capacity to offer a range of interventions through a staff training and supervision programme. Examples of developments include, support for training in Interpersonal Therapy (IPT) through which a number of staff across the Trust have completed practitioner level training and a smaller number have achieved supervisor status. We continue to offer specialist supervision and training in Cognitive Behaviour Therapy (CBT) for CAMHS staff and specialist supervision and training for CBT for Post Traumatic Stress Disorder for the adult and adolescent trauma service. An increasing number of staff have been trained in Eye Movement Desensitisation and Reprocessing (EMDR) for children with post traumatic stress disorders. In addition, a group of staff have been trained in Dynamic Interpersonal Therapy (DIT), now recognised as an approved treatment within the Improving Access to Psychological Therapies Programme. This innovative therapy was developed by a member of our staff in partnership with colleagues at the Anna Freud Centre, London. We continue to develop our work in a range of other models including, Family and Schools Together (FAST), Relationship Development Intervention (RDI) and Mentalisation Based Therapy (MBT).

During the past year, there has been the opportunity to embed the increased range of therapeutic approaches, though this remains work in progress. Leading on from this, our priority for next year will be to train staff to increase their capacity to identify treatment choices, including a range of psychological therapies, for patients and to present the range of treatment options clearly so that patients are confident that they have been offered choices where appropriate.

"I was able to talk about things, sometimes very painful things, without fear. It was a relief and it allowed me to realise how important the type of treatment (talking) was and how relieved and how changed I am as a result of it. Even my friends noticed it"
(Patient, Adult)

Addressing Complexity in Primary Care

"The Primary Care Psychotherapy Consultation Service (PCPCS) came into existence in August 2009. Commissioned by the City and Hackney Primary Care Trust from the Adult Department of the Tavistock and Portman NHS Foundation Trust, the service was established with three primary objectives in mind: providing a direct clinical service to patients; supporting GP practices and surgery staff in the management of complex cases; and providing training to all practice staff working with this group of patients."

"An innovative feature of the PCPCS is that not only do we provide a clinical service, but we also work alongside the GP to support and develop their work with their patients."

"The service is designed to bring secondary care experience into primary care to help narrow the gap in the stepped care model in a way that ensures that patients have access to the support they need, when and where they need it"

Excerpts from HCPJ (*Healthcare Counselling and Psychotherapy Journal*) January 2011

What GPs found helpful...

"I've been very impressed with your service to date, and hope it can continue." [North Hackney consortium]

"Joint consult has made a real difference to my understanding of the patient's presentation, and then to my relationship with the patient, I feel much better able to help him." [North Hackney consortium]

For GPs working alongside PCPCS clinicians...

"Enhanced my ability to hold vulnerable patient"

"Thoughtful attendance to patient's needs"

"Sharing of the burden"

What patients found helpful...

"Helping to contextualise the pain"

"Talking through my beliefs and thoughts made them clearer and easier to see for what they are".

Outcome Monitoring Returns – Child and Family

See earlier section on CAMHS Outcome Monitoring.

Outcome Monitoring Returns – Adolescent

Outcome Monitoring Returns – Adolescent

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages						
				Pre-assessment	Post-assessment	6m	12m	18m	24m	End of Treatment
Adolescent	YASR / YSR	Young persons (age 12 - 30)	2008/09	87%	21%	14%	15%	21%	12%	14%
			2009/10	98%	18%	13%	13%	22%	11%	10%
			2010/11 (Q1 & Q2)	95%	15%	16%	12%	31%	12%	10%
	CBCL / YABCL	Significant other	2008/09	83%	15%	16%	15%	17%	10%	11%
			2009/10	95%	14%	14%	11%	18%	8%	4%
			2010/11 (Q1 & Q2)	84%	17%	16%	8%	25%	12%	9%
Adolescent	YABCL (over 18) CBCL (under 18)	Therapist	2008/09	N/A	36%	39%	38%	36%	28%	49%
			2009/10	N/A	29%	35%	31%	33%	28%	32%
			2010/11 (Q1 & Q2)	N/A	44%	36%	46%	28%	21%	37%

As indicated in the 2009/10 Quality Report, the Adolescent Department planned to introduce some new outcome monitoring measures in order to encourage more young people to provide feedback on their mental well-being and increase the rate of returns.

As part of this process, the Adolescent Department sought feedback from young people on a variety of outcome measures, presented to different groups of adolescents over the course of a series of focus groups.

On the basis of this feedback, since January 2011 the Adolescent Department has been implementing CORE OM (Clinical Outcomes for Routine Evaluation), with young people aged 18 and over and using the SDQ (Strengths and Difficulties Questionnaire), with young people up to the age of 18, as recommended by CORC.

However, because of the difficulties encountered with outcome monitoring for Quarter Three and Four we have decided to focus our report on considering the data for Quarters One and Two.

The return rates recorded for Quarters One and Two for young people completing the outcome measures was roughly in line with previous years. However, for therapists there was seen to be a slight improvement in the completion of forms at the post-assessment phase. This is thought to be as a consequence of the Adolescent Outcome Monitoring Team working closely with clinicians to encourage them to complete and return the outcome monitoring forms.

**“I had plenty of say in decisions. I was asked, rather than told”
(Patient, Young Person)**

Outcome Monitoring Returns – Adult

See earlier section on Adult Outcome Monitoring.

Outcome Monitoring Returns – Portman

Outcome Monitoring Returns – Portman

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages		
				Pre-assessment	Post-assessment	End of Treatment
Portman	CORE	Adult patients	2008/09	73%	46%	19%
			2009/10	73%	38%	13%
			2010/11 (Q1 & Q2)	60%	54%	17%
Portman	CORE Therapy Post Assessment Form	Therapist	2008/09	N/A	77%	17%
	CORE End of Therapy Form		2009/10	N/A	44%	0%
			2010/11 (Q1 & Q2)	N/A	60%	20%

The Portman Clinic is a specialist NHS outpatient psychotherapy clinic offering treatment for adults, adolescents and children with problems of criminality, violence, sexual deviation and anti-social personality disorder. It has a national catchment area. Direct and indirect patient services offered by the Clinic include assessment for psychotherapeutic treatment (individual, group, couple and family); extended assessment and psychodynamic formulation to inform the patient’s local service based treatment programme. In addition, the Clinic provides consultation and advice to the professional network involved with the patient; risk assessment reports; reports to criminal or family courts, tribunals and inquiries; and consultancy and supervision to individuals, teams and institutions.

Although there are limitations to using the CORE as a measure of outcome for a forensic population receiving psychotherapeutic treatment, there was seen to be a noticeable improvement, at least for Quarters One and Two in 2010/11 for the completion of CORE forms by patients and clinicians at the post-assessment stage, when compared to the 2009/10 return rates.

However, clinicians at the Portman Clinic have been interested in finding an outcome measure which they consider more relevant for their patient group. For this reason, as part of the 2010/11 CQUINs framework, the Portman has

been piloting the use of the Shedler-Western Assessment Procedure (SWAP) with adults. The return rate achieved for was 100% for the thirty-five patients included in this CQUINs indicator at the end of Quarter Four in 2010/11, which supports the decision to identify an outcome measure which is better suited to this group of patients.

**“I realised that it was myself that was keeping me stuck in a destructive cycle. It has changed my life.”
(Patient, Portman, Clinic)**

Patient Experience Indicators

Complaints Received

Indicator	2008/09	2009/10	2010/11
Complaints received	8	10	10

In 2010/11, a total of 10 formal complaints were received. These were all managed in line with the Trusts complaints policy. Out of the ten formal complaints received by the Trust during the year, three of these were upheld. The actions arising from the investigations have included: patients and parents being invited to meet with the relevant Clinical Director to discuss the issues arising from the complaint and the actions to be taken by the Trust; case discussion with teams, identifying learning points; the retrieval of information from a third party; support for the staff involved in the complaint (via supervision from a more senior colleague) and for the lessons learnt from complaints to be incorporated in the mandatory trainings for staff, including safeguarding training, the Trust induction and the INSET training for all Trust staff.

In 2010/11, no complaints were referred by patients to the Ombudsman.

Patient Feedback

Indicator	2008/09	2009/10	2010/11
Patients who would recommend the Trust	73%	69%	71%
Patients rating care 'excellent' / 'very good' / 'good'	73%	70%	65%
Patients who felt they were listened to and treated with respect and dignity	Different criteria used so unable to compare	73%	70%
Patients rated the Trust's facilities as very good or good	Different criteria used so unable to compare	82%	79%

The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the CQC from using the NHS patient Survey, with the recognition that the nature of the services provided by the Trust differs to other mental health trusts. For example, the Trust does not provide in-patient treatment. Consequently, some of the questions in the NHS Survey are not relevant to our patients. As part of the 2010 Trust Survey, 675 surveys were sent out and 118 returned, which represents a response rate of 17.5%, compared to 18.2% in 2009. There was an increase in the number of surveys completed by respondents from the Portman (10% in 2010, 9% in 2009, 7% in 2008) and the Adolescent Department (16% in 2010, 14% in 2009, 4% in 2008). The number of surveys completed by respondents from the Adult Department was similar to recent years (32% in 2010, 35% in 2009, 34% in 2008) and we continue to seek ways to improve on this, while there was a decrease in the number of surveys completed by respondents from the Child and Family Department (30% in 2010, 33% in 2009, 37% in 2008).

Overall the results of the patient survey are positive. The qualitative comments provide very useful information from patients which Clinical Directors have scrutinised in order to improve services. The majority of our targets for next year's PPI work are directly related to the feedback received through this and other mechanisms. The other routes we obtain feedback from patients are; small scale surveys and audits (such as the Children's Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer, informal feedback to clinicians and administrators that is sent to the PPI Lead and complaints. We continue to seek ways to improve upon the return rates to our main survey.

DNA Rates

Indicator	2008/09	2009/10	2010/11
Trust Wide			
First Attendances	9.5%	8.6%	10.5%
Subsequent Appointments	10.4%	11.0%	10.4%
Adolescent			
First Attendances	Not reported	9.7%	10.1%
Subsequent Appointments	Not reported	17.5%	17.0%
Adult			
First Attendances	Not reported	8.5%	7.3%
Subsequent Appointments	Not reported	9.0%	8.6%
Child and Family			
First Attendances	Not reported	9.2%	10.0%
Subsequent Appointments	Not reported	9.8%	7.4%
LCDS			
First Attendances	Not reported	2.8%	3.2%
Subsequent Appointments	Not reported	8.9%	4.3%
North Camden CAMHS			
First Attendances	Not reported	9.0%	11.9%
Subsequent Appointments	Not reported	11.1%	12.0%
Portman			
First Attendances	Not reported	7.0%	9.1%
Subsequent Appointments	Not reported	9.6%	10.1%
South Camden CAMHS			
First Attendances	Not reported	12.8%	17.3%
Subsequent Appointments	Not reported	15.0%	13.7%

Compared with other mental health trusts, where the DNA (Did Not Attend) rate is reported at around 14%, the Trust-wide DNA rate for patients in 2010/11 [which also include the DNA rates for the Gender Identity Disorder Service (GIDS), a National Service, and the Tavistock Haringey Service (THS), a locally commissioned service] is below average. However, the Trust-wide DNA rates for first attendances has increased from 2009/10 to 2010/11, but yet does not exceed the 11% upper limit, which is the quality standard outlined in our patient services contracts. In addition, the DNA rate for 2010/11 for subsequent attends has decreased. As DNA rates can be regarded as a proxy indicator of patient's satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively.

The 2010/11 DNA rates for most of the departments are below 11%, with the exception of the South and North Camden CAMHS teams and the Adolescent Department. Children, young people and families from Camden attending the child and adolescent services provided by the Tavistock constitute a particularly deprived group (see section on Access to Services). It is recognised that patients from deprived backgrounds experience greater difficulties accessing mental health services, even when services are provided in community settings, as is the case for the South CAMHS Team.

The DNA rates for the Adolescent Department are not unexpected, as ambivalence amongst adolescents about attending and engaging with mental health services is characteristic of this patient group, but where the DNA rates for the Adolescent Department compare favourably with other similar adolescent teams/services. Notwithstanding this, in circumstances where it is deemed clinically appropriate, the Team Administrator, or clinician will text the young person to remind them of their appointment.

Waiting Times

Indicator	2010/11
Trust Wide - Number of patients waiting for first treatment appointment for + 11 weeks	139
Internal Causes	90
External Causes	49
Trust Wide - Percentage of patients waiting for first treatment appointment for + 11 weeks	9.0%
Internal Causes	5.8%
External Causes	3.2%

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment by the same therapist where possible. This system on the whole helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral. However, during 2011/12 139 (9.0%) patients had to wait for longer than eleven weeks. There were both factors external to the Trust and internal to the Trust which contributed to these delays. However, in the Gender Identity Disorder Service (GIDS), there was a rapid increase in referrals during the year with a lag in increased resources being made available which led to an overall increase in the number of patients in the Trust having to wait longer than eleven weeks to be seen. It is hoped that an increase in funding provided by commissioners for this Service and the establishment of a satellite service in Leeds, which will

improve the accessibility for patients and carers living in the North of England, will lead to some reduction in the length of time that patients have to wait to be seen.

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, actions to be taken to prevent recurrence.

Access to Services

Analysis of Camden patients in 2010/11 using postcodes to find the Index of Multiple Deprivation (IMD 2007) for each patient's locality (with the assistance of the NHS Camden Health Intelligence unit), has shown that 53% of our patients are in the 40% most deprived section of the borough's population, whereas only 29% come from the least deprived 40%. For our child and adolescent services, the difference is even more pronounced, with 69% of patients coming from the most deprived 40%, and only 17% from the least deprived. Similar results are obtained using the Income Deprivation Affecting Children Index (IDACI).

The Trust has a Single Equalities Scheme (SES), and produces an SES Annual Report, which includes information in relation to access and equalities issues.

Complexity and Learning Difficulties

Patients referred to our **Learning and Complex Disability Service (LCDS)** at the Tavistock Centre have complex problems in multiple areas which may include educational, social, occupational, family, mental and physical health. These complex cases have usually already received a great deal of input from local services but continue to have significant problems, indicating the need for specialist work.

LCDS is able to complement and support local provision by:

- Seeing patients presenting with high levels of complexity, when local services are unable to meet their needs
- Offering psychodynamic assessments for people with learning difficulties and developmental disorders when they are not available locally
- Offering a service to patients across the age span, for whom continuity of service is particularly important and not always available locally, especially for the transition stage between child and adult services
- Seeing patients who do not fit local eligibility criteria

Case example

Brian is a 13 year old boy with a learning difficulty and in foster care. He had been previously seen in individual psychotherapy in the local, well resourced CAMHS and attended a local special school. However he had begun to present with sexually harmful behaviour and the local team referred him to LCDS for more specialist assessment.

Our assessment involved a professionals meeting, sessions for the boy and his carer and a school visit for observation. We worked with the professional network to help them recognised that he had probably been sexually abused and to clarify his risk of current and future harmful behaviour. We recommended further specialist work and made recommendations concerning safeguarding and educational provision.

Performance against Key National Priorities

The first four mental health indicators set out in Appendix B to the Compliance Framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as the Trust does not provide services to which the indicators would apply.

The Trust has collected all the information deemed necessary, but taken the decision not to collect marital status, which has also been removed from requirements in the Compliance Framework for 2011/12. Feedback from clinicians has indicated that in many cases this question is irrelevant and/or unnecessarily intrusive for patients. In addition, the Trust does not believe that this information is something which demonstrates the quality of the service.

The Trust complies with requirements regarding access to healthcare for people with a learning disability.

Annex : statements from stakeholders

Comments from Camden Primary Care Trust

Our Lead Commissioner reviewed our Draft Quality Report and commented that it was a very interesting and thorough document.

She indicated that she looked forward to hearing the outcome of the survey on access to clinical services and health care information (priority 2) and would be interested to hear the outcome of any further exploration into the reasons for the decrease in the number of staff saying that they would recommend the Trust as a place to work or receive treatment (priority 5).

She noted that the DNA rates cited for the North and South Community CAMHS Teams were higher than for other service areas, at over 11%, and that she would be interested to explore this further with the CAMHS Director and Service Lead Manager.

Comments from Camden Local Involvement Network (LINKs)

We welcome the quality report and we support the Trust's openness. The Trust is keen to identify opportunities for improvements and acknowledges the importance of data; it rightly values the perspective of both patients and staff. We would however make the following comments.

Patients' feedback via LINKs

Patients rate their experience of therapy as good, very good or excellent in 65% of cases; this means that in 35% of cases the service is rated poor or very poor. Moreover, the trend is worsening. It does seem that there is space for improvement, and the Trust may wish to adopt a strategy to do that. Separate reporting of poor, good, very good and excellent ratings may also help. The Trust may also consider seeking feedback from other agencies, such as GPs or schools, besides patients.

Trust Response: It is the Trust's ambition to improve patients' experience of therapy and it is matter of concern that 35% of respondents rated the service as poor. We recognise the importance of using a variety of ways to receive feedback, beyond the Patient Survey and for this reason we use the experience of service questionnaires with patients in CAMHS and the Adolescent Department, along with parents and teachers, and the questionnaire has been extended to the Adult Department this year. We also receive feedback on patient and service users experience from the PPI (Patient and Public Involvement) Committee and stakeholders meetings

(which include patient representatives); from the PALS officer, and informal feedback to clinicians & administrators that is sent to the PPI Lead and from complaints. In addition, the feedback we receive from schools and GPs concerning specific patients contributes to the treatment/therapy provided to patients.

The Trust values this constructive feedback which, combined with the main findings from the Survey, is forwarded to each department/service to form part of the departmental/service plan for the coming year. Regarding the Patient Survey, the very nature of our work will mean that there will always be a percentage of people who are unhappy with their experience of therapy, as this reflects their presenting difficulties. In addition, it is recognised that generally people do not complete surveys unless they have something particular to say, which has the effect of distorting feedback to the extremes. That is, the feedback tends to be skewed towards both positive and negative responses, as opposed to the more neutral feedback. However, we continue to explore other methods of getting feedback in order to counter this effect. The Patient Survey also includes a section which enables patients to comment freely on any other issues.

Outcome monitoring feedback via LINKs

We support the Trust's endeavour to increase patients' return rate to questionnaires. Yet the response rate is low even for therapists (57-81%) and the trend is only slowly improving. If members of staff themselves are not fully motivated in monitoring outcomes, it will be difficult to convince patients and carers to do so. If questionnaires are overly time-consuming, they could perhaps be simplified. Any valid reason for therapists' reluctance to monitor outcomes should be investigated, addressed and if necessary reported. There are hand-held electronic devices for responding to questionnaires that are particularly appealing to young people as well as saving labour, and they should perhaps be investigated.

Trust Response: We are keen to identify new outcome measures which feel more relevant and meaningful both to patients and clinicians. However, we acknowledge that this is an area which needs significant further work. The Trust is currently undertaking a complete overhaul of the Trust outcome monitoring system, led by the Assistant Medical Director. During the year, using focus groups, the Adolescent Department sought feedback from young people on a variety of outcome measures/forms. On the basis of this feedback, since January 2011 the Adolescent Department has changed to using shorter forms, with patients and therapists. However, services also need to be responsive to the requirements of our commissioners, specifically their expectations that we

will use measures used by other mental health trusts. For example, during the past year, as part of the CQUINs (Commissioning for Quality and Innovation scheme) targets agreed with commissioners, CAMHS has extended the CORC (CAMHS Outcome Research Consortium) protocol to all teams in CAMHS. We are also committed to exploring new methods for making it easier for patients to return outcome measures. For example, in the Adolescent Department we involve administrative staff and clinicians in handing these forms directly to patients, send text messages to patients, to request that they contact us to arrange to provide feedback, as well as posting forms to patients.

Feedback on range of therapies from LINKs

We welcome the Trust's efforts to widen the range of available therapies, but there should also be a strategy to market those therapies among users and GPs or other referrers.

Trust Response: We plan to increase the availability of information to potential patients and referrers outlining the range of treatments available.

Complaints analysis feedback from LINKs

The trust could perhaps indicate how many complaints were upheld out of the 10 received during the year. If any of the complaints led to service improvements, this could also be reported, as long as to do so would not reveal any confidential information.

Trust Response: We agree with this point, and we have now covered this in the Complaints section above.

Waiting times feedback from LINKs

Internal factors were responsible for 90 patients having to wait longer than 11 weeks for their first appointment. The Trust should indicate how it intends to reduce this figure.

Trust Response: These figures have been revised in the Quality Report to include the waiting time figures from the Gender Identity Disorder Service (GIDS), along with the Vulnerable Children and Developmental Service lines. As indicated, there was a rapid increase in referrals to GIDS during the year with a lag in increased resources being made available which led to an overall increase in the number of patients in the Trust

having to wait longer than eleven weeks to be seen. However, it is expected that an increase in funding provided by commissioners for this Service and the establishment of a satellite service in Leeds, which will improve the accessibility for patients and carers living in the North of England, will lead to a significant reduction in the length of time that patients have to wait to be seen.

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, actions to be taken to prevent recurrence.

The Trust makes every effort to ensure that patients are seen in a timely manner, and for some teams the actions taken to reduce patients having to wait for longer than eleven weeks for their first appointment includes bringing cases to the weekly team meeting until they are allocated and contacting clinicians directly to check their availability to see new patients.

Ethnic minorities comments from LINKs

The Trust could provide some ethnic analysis of its patient body to ensure that its services are properly targeted at all ethnic groups. The Trust could indicate whether any provision is made to facilitate access to services by non-English-speaking patients.

Trust Response: The ethnic profile of patients broadly reflects our catchment population. The diversity of our patient and student population is increasing e.g. growth from 12-15% for BME students in the past four years. We are reaching more patients from black and minority ethnic groups by locating CAMHS in Local Authority services and in the community (e.g. safeguarding, youth offending service, schools). The percentage of BME patients in these services is 51% compared to 28% at the CAMHS in our main bases. We have developed services for specific ethnic communities, including the Somali, Congolese and Bangladeshi residents of Camden and in dedicated refugee services. In addition, within our Adolescent and Adults departments we have a Trauma Service which includes refugees and patients seeking asylum. As a consequence, the Trust routinely use interpreters when engaging in clinical and consultation work with non-English speaking patients.

Comments from Camden Overview and Scrutiny Committees

We invited feedback from the Camden Overview and Scrutiny Committees on our Draft Quality Report. We will plan to up-date this section in due course, once this feedback has been received.

Comments from the Board of Governors

The Draft Quality Report was discussed at the Board of Governors meeting in February 2011. The Trust Director explained that the Trust's Quality Report and Accounts would be focusing on access to information for patients; patient experience; and outcomes. One of the Governors queried why patient experience and outcomes were separate priorities. The Medical Director explained that whilst there was much overlap, the methodology for both of these was very different, and highlighted the difference between clinical outcomes and patient-determined outcomes. Two governors commended giving outcomes such a high priority. One of the Governors expressed concern at removing staff training from the list. The Trust Director explained that whilst the physical environment and staff training were no longer explicit priorities in the Trust's Quality Report and Accounts, work to improve these aspects was still continuing. Following discussion of the feedback from this Board of Governors meeting, the Trust made the decision to include the targets of increasing staff attendance at the mandatory training/INSET day, Trust-wide and local inductions as a Quality Priority (Maintaining a High Quality Workforce) for 2011/12. The Trust considers this priority important for ensuring that patients are treated safely and effectively and in order to improve and maintain standards of care.

Annex: Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor 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 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 2010-11;
- 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 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011
- Feedback from the commissioners dated 6/05/2011
- Feedback from governors dated 3/02/2011
- Feedback from LINKs dated 23/05/2011

The Trust does not provide an annual complaints report, because of the very small number of complaints and the risk of complainants being identified.

- The Head of Internal Audit's annual opinion over the trust's control environment dated 1/6/11.
- CQC quality and risk profiles dated monthly from September 2010 until, and including, April 2011
- the Quality Report presents a balanced picture of the NHS Foundation trust's performance over the period covered;
- the performance information in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and the reporting of 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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



Angela Greatley
Chair
2nd June 2011



Matthew Patrick
Chief Executive
2nd June 2011

Independent Assurance Report to the Board of Governors of Tavistock and Portman NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Tavistock and Portman NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Tavistock and Portman NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

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 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor") and dated 31 March 2011.

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 content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011;
- Feedback from the Commissioners dated 6/05/2011;
- Feedback from LINKS dated 23/05/2011;

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
- The 2010 national staff survey;
- The Draft Head of Internal Audit's annual opinion over the Trust's control environment dated 1/06/2011; and
- CQC quality and risk profiles dated April 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Tavistock and Portman NHS Foundation Trust as a body, to assist the Board of Governors in reporting Tavistock and Portman NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Tavistock and Portman NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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:

- Making enquiries of management;
- 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 less 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

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual dated 31 March 2011.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP

Chartered Accountants

London

Date: 6 June 2011

Staff survey

Commentary

Over the past year, the Trust has ensured that staff have felt engaged with and taken ownership of the annual survey process through the use of various communication techniques. These include continually updating staff on changes implemented across the Trust from feedback received in previous surveys, as well as regular promotional material such as e-mails and bulletins from the CEO and Directors on progress in areas where the Trust did not perform so well and needed to improve. These notifications not only highlighted action plans but also provided staff with encouragement and support with completing the 2010 survey. All this was essential in ensuring that the benefits of completing the survey remained in the forefront of staff thinking, throughout the year.

A detailed analysis of the 2010 survey and action plans for improvement, focussing on areas where it has been identified the Trust can do better, will be provided to the Board of Directors for approval. These plans will include improvement targets as well as timescales. Senior Managers, with responsibility for taking actions forward, will be identified and regular updates on targets will be provided to the Board of Directors throughout the year.

Communication in form of newsletters, briefings and e-mail notifications will be provided to staff showing areas where the Trust has done well and where it needs to improve. Staff will also be provided with regular updates on progress at staff meetings.

Summary of performance

Last year there was a slight reduction in the number of staff taking part in the survey as compared with previous years. The Trust's response rate of 51% was lower than the national response rate of 54% and lower than The Trust's response rate in 2009, which was 57%. This year's results also show improvements in areas that were identified as not so good in 2009.

A number of areas where the Trust scored better this year than in 2009 include:

- a reduction in the number of staff witnessing potentially harmful errors, near misses or incidents
- a reduction in the number of staff experiencing work-related stress
- a reduction in the number of staff stating their intention to leave their job
- a better score for the impact of health and wellbeing on ability to perform work or daily activities.

- an increase in the number of staff reporting that they feel motivated at work.

However, some areas have not improved since 2009 and these include:

- an increase in the number of staff working extra hours
- A reduction in the number of staff receiving equalities training in the past 12 months.
- a decrease in the number of staff stating that they feel there are good opportunities to develop their potential at work
- a reduction in the number of staff stating that they believe the trust provides equal opportunities for career progression.

The Trust's top four ranking scores were in:

- health and wellbeing
- low numbers of staff witnessing harmful errors, near misses and incidents
- staff reporting good communication between senior management and staff
- staff using flexible working options.

However, the Trust's bottom four scores were in:

- staff working extra hours
- staff receiving health and safety training
- staff believing the Trust provides equal opportunities for career progression
- staff receiving equality and diversity training.

The summary of the Trust's results are shown in the tables below with comparisons made against 2009 results. The accompanying notes summarise the main areas of concern, as well as planned activities, to secure improvements.

2010 Staff Survey Findings – Response Rate

	2009/10		2010/11		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	57%	55%	51%	54%	Decrease 6%

2010 Staff Survey Findings – Top 4 Ranking Scores

	2009/10		2010/11		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Top 4 Ranking Scores					
Impact of Health and wellbeing on work performance	1.46	1.62	1.39	1.62	decrease 0.07 (ranking 1-5)
% of staff witnessing potential harmful errors, near misses or incidents in last month	18%	29%	7%	28%	Decrease 11%
% of staff reporting good communication between senior management and staff	56%	29%	62%	31%	Increase 6%
% of staff using flexible working options	87%	72%	89%	67%	Increase 2%

2010 Staff Survey Findings – Bottom 4 Ranking Scores

	2009/10		2010/11		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Bottom 4 Ranking Scores					
% working extra hours	75%	63%	83%	65%	Increase 8%
% receiving health and safety training in last 12 months	59%	75%	58%	80%	Decrease 1%
% believing the Trust provides equal opportunities for career progression	94%	90%	79%	89%	Decrease 15%
% having equalities and diversity training in last 12 months	52%	42%	38%	47%	Decrease 14%

Priorities and targets for 2011/12

The key priority areas for the Trust 2011/12 are as follows:

- increasing the Trust's staff survey response rate
- addressing issues relating to staff working additional hours
- continuing to implement measures to improve attendance at mandatory training events
- providing targeted equalities and health and safety updates and information to staff
- analysing data and processes relating to staff promotion and progression.

To ensure that these future priorities are properly measured, the following will take place:

- a manager will be nominated to manage each action plan priority area

- regular reports will be provided to the Board of Directors and Management Committee showing whether deadlines and timescales have been met and areas where further work will be required
- 2010 survey results will be compared against 2009 outcomes to see whether action undertaken has secured desired improvements, further measures may need to be taken where improvements have not been realised.
- managers and directors will be encouraged to discuss the survey content and outcomes in team meetings, committees and at other team events to ensure staff continue to understand the benefits of completing the survey.

Regulatory ratings

Monitor's risk ratings

Monitor assigns each NHS foundation trust a risk rating for governance, finance and the provision of mandatory goods and services (as defined in their Terms of Authorisation).

Financial Risk Rating

Financial Risk Ratings are allocated using a scorecard which compares key financial metrics consistently across all foundation trusts. The rating reflects the likelihood of a financial breach of an NHS foundation trust's Terms of Authorisation. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the highest.

Governance Risk Rating

A green risk rating indicates that a foundation trust's governance arrangements comply with its Terms of Authorisation; an amber risk rating reflects that concerns exist about one or more aspects of governance; and a red risk rating indicates that there are concerns that a trust is, or may be, in significant breach of its Terms of Authorisation.

2009/10	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	3	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green

2010/11	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Green	Green

Summary of Performance

The Trust has worked hard to achieve and maintain good ratings. Performance in all areas has been high and maintained at this rate. The governance rating has also been at the highest rating consistently since the Trust received its licence, with no concerns over governance raised by Monitor. The Financial Risk Rating was at level 3 throughout 2010/11 risk. There were no formal interventions.

Analysis of Ratings

Monitor no longer issues a “mandatory services” rating; this is now included in the Governance Risk rating, which has remained Green throughout 2010/11.

In its Annual Plan, the Trust budgeted to maintain a Financial Risk Rating of 3, again opting for prudence in light of the tough economic climate facing the NHS. This target rating was achieved in each quarter of the year. The planned surplus was achieved, unlike 2009/10, when the surplus was significantly higher than planned and the rating was consequently higher.

Other disclosures

Communicating with employees

This work is extensive and includes capturing discussion as part of the objective setting, appraisal, and CPD processes; emails to all staff on key topics, situation updates from the Chief Executive; open meetings with the Chief Executive; open meetings with the boards; meetings with trades’ union representatives; engagement with staff governors; and essential and useful information provided through the Trusts’s intranet. The following consultation took place:

- staff in C&F on service design took
- improving the access to outside space.

Equal opportunities for employees

In line with the Equalities Act 2010, our employment policies including recruitment and equal opportunities have been updated to reflect the legislative intent around the various protected characteristics including Disability.

In relation to staff disability, progress has been made under the Single Equality Scheme to create an environment where the Trust and disabled employees are able to engage in a meaningful way throughout their employment cycle. The Trust successfully completed the annual validation and compliance requirements for the use of the "Two Ticks" symbol by Job Centre Plus. As part of the wider engagement with staff who have disclosed their disability, annual meetings will be organised by the HR Manager to discuss any emergent access and support needs. (This will be over and above any meeting with Human Resources or the line manager throughout the year and have been completed for this year). A Trust wide campaign has also been launched to encourage staff who may not have disclosed their disability, for various reasons, to feel able to do so in a confidential manner. Disability Access Audits are conducted to evaluate building access & reports are taken to the Clinical Quality, safety and Governance committee. HR Manager is the designated Trust Disability Officer as part of the commitment under the Single Equality Scheme. As on 2nd February 2011, 12 members of staff have disclosed their disability. The figure reported in the Single Equality Scheme was 9.

Staff have been made aware of the current support systems, facilities & provisions for reasonable adjustment via email, at the INSET day, Trust wide Single Equality Scheme – update event & through the relevant employment policy, including "Equal opportunities" briefing sessions.

As reported in the Staff survey 2009,

- The Trust was listed as above average for the numbers of staff having equalities training, (definition of which included training on the awareness of age, disability, gender, race, sexual orientation and religion). The Trusts score of 52% was higher than the average (median) for other mental health Trusts, reported as 42%.
- Specifically in relation to disability as an equality strand, 77% of disabled staff reported that the Trust has made adequate adjustments to enable them to carry out their work. The Average (median) for mental health trusts was reported as 75%. (Question 41b – appearing under background details & applicable for those having a long standing illness, health problem or disability and if adjustments felt necessary were made).

We hope the initiatives and current support systems in place will influence staff to further engage with the Trust in a confidential manner and feel able to disclose their disability. It is hoped this approach will enable staff to realise the

range of support systems available to them and for the Trust to enhance the functional experience of the disabled staff whilst at work.

Health and safety

The Trust holds bi-annual In-Service Education and Training (INSET) days, to ensure attendance by all staff (held in April and September). It is mandatory for all Trust staff to attend one of the INSET days in a two year period, proving that mandatory training can be delivered successfully in a large organised event.

The Trust also runs annual specific Clinical and Health & Safety mandatory training programmes. These are monitored by the Medical Director and the Health and Safety Manager respectively, and are overseen by the Training and Development Manager.

The Trust has a robust Health and Safety Policy, which is subject to regular review, available to all staff via the Trust's Intranet.

Countering fraud and corruption

The Trust is proactive in countering fraud and corruption. The Trust has a policy on fraud and corruption, which is available to all staff via the Trust's Intranet. The Trust also has a Local Counter Fraud Specialist, who undertakes reviews and holds annual fraud awareness days at the Trust.

The Trust took part in the 2010/11 National Fraud Initiative. So far, the matching reports provided by the Audit Commission have not on this occasion led to any fraud at the Trust being identified.

Better payment practice performance

Performance is detailed in Note 31 to the Accounts.

Consultations with the public

A consultation was held with People First, the advocacy group on access for people with learning disabilities.

Planned consultations:

- a consultation with young people in local schools about what they would like to gain from membership of the trust
- a consultation about the trust website focusing on the changes made to it in 2009/10.

Consultation with local groups and organisations including an overview and scrutiny committee of local authorities

We have consulted with our Local LINKs as set out in our quality report. We have also worked with the Overview and Scrutiny Committee.

Any other public and patient involvement activities

There is an on-going programme of PPI activity which this year has included:

Regular surveys and audits across groups such as users of CAMHS or the whole trust or service areas such as the young people's drug and alcohol services in Barnet

- The young people's drug and alcohol service have been putting together information films in conjunction with local young people and service users
- We ran a 'bid for better' scheme where members were able to bid for small sums of money for service improvements. This year money was given to purchase play equipment for the children's waiting room and information books for patients
- The PPI team including user reps are involved in writing all patient information material the trust produces
- We launched a children's emotional well-being website; www.camsden.co.uk which was developed in conjunction with local school children and child service users.

Management costs

Management costs were £2.97m in the year, equivalent to 9.2% of income.

Pension liabilities

No liabilities due to retirement on health grounds were incurred. Financial information on pensions is set out in the accounts.

Sickness absence

Staff absence due to sickness was 3.48%.

Cost allocation and charging

The Trust has complied with cost allocation and charging requirements set out in HM Treasury guidance.

Serious untoward incidents

There were no such incidents in 2010/11.

Responsibility for preparing the financial statements

The NHS Act 2006 states that the chief executive is the accounting officer of the 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements; 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 Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Chief Executive
2nd June 2011

Auditor's opinion and certificate

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

We have audited the financial statements of Tavistock and Portman NHS Foundation Trust for the year ended 31 March 2011 on pages 106 to 158. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Governors of Tavistock and Portman NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, 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 Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on pages 95 to 96 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Tavistock and Portman NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' 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

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Statement on Internal Control does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Statement on Internal Control or that risks are satisfactorily addressed by internal controls.

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 Audit Code for NHS Foundation Trusts issued by Monitor.

Ross Tudor
Ross Tudor for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London

June 2011

Statement on internal control

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 Tavistock and Portman NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive, I hold overall responsibility for risk management, the Risk Register, and the Assurance Framework. The Medical Director is responsible for the management of clinical risk, has the overall responsibility for clinical governance, and chairs the Clinical Quality, Safety, and Governance Committee. The Director of Finance is responsible for identifying risks to strategic objectives in the Risk Register. The Director of Corporate Governance and Facilities is responsible for non-clinical risk and provides a central resource of information and advice on all risk management. The Director of Corporate Governance and Facilities also leads and co-ordinates the assessment of progress on each of the standards set by the NHS Litigation Authority.

Strategic and operational risks are covered by a comprehensive Risk Register. The Trust's Management Committee agrees and implements the necessary actions, which are included in the reports to the Board of Directors (see below). The Trust's "risk appetite" is determined by agreeing for each register entry an assessment of whether the remaining risk – after taking account of the actions taken and planned – is tolerated or not.

Through induction courses, the annual staff training day and other training events, staff are trained in managing the clinical and non-clinical risks relevant to their posts.

The Director of Finance is responsible for maintaining an effective system of internal financial control and for providing financial information to enable the Trust's management and Board to manage financial risk.

The Director of Corporate Governance and Facilities leads the Trust's action plans towards achieving compliance with the CQC's essential standards; monitors progress; and reports to the Board of Directors via the Clinical Quality, Safety, and Governance Committee.

The Dean of Postgraduate Studies is responsible for leading the Trust's management and delivery of training programmes, and any risks arising from this area of Trust activity. The Dean of Postgraduate Studies leads the Trust's annual contract negotiations with the Department of Health through the Strategic Health Authority.

The risk and control framework

Information Governance and Data Security

The suite of information governance policies was reviewed and updated as required. A new structure and reporting arrangements were put in place to enhance the provision of assurance to the Board of Directors. New procedures were introduced to manage data risks related to the RiO patient data computer management system. The Trust enhanced management of information assets and the support to information asset owners. Over 95% of staff completed information governance training.

At 31 March 2011, the Trust has declared that it has reached at least level 2 against all the key criteria of the Information Governance toolkit issued for the NHS.

Equality

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

Care Quality Commission

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

Climate change

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Pension scheme

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.

Risk management

Risk management is embedded in Trust management and is integral to the development of policies and procedures, as well as in practice reinforced by training at all levels.

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

The Trust identifies cost savings to meet NHS efficiency targets as part of the annual budget process, and during the year. Savings programmes cover pay and non-pay costs, and include the benefits of improved procurement. The costs of services are compared to their income and benchmarked against other organisations where appropriate. The Board of Directors approves the budget

and reviews the financial position monthly. The Audit Committee receives reports from Internal Audit on the Trust's financial controls.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. 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 Quality Report Work Stream and the Clinical Quality, Safety, and Governance Committee of the Board of Directors (chaired by the Medical Director). Staff follow the procedures previously approved by the Board, and these were enhanced by the development and introduction of a new Quality Procedure. A senior member of clinical staff is the Quality Lead and terms of reference for this work stream were agreed by the committee. The Quality Lead does not line manage those people supplying evidence for this report; the lead facilitates its production and takes an impartial view of submissions and progress. Data is drawn from the Trust's clinical systems, especially RiO, these findings have been reviewed extensively at Board level, including governors serving on the Clinical Quality, Safety, and Governance Committee.

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, and the executive managers 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, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Board Reporting

Neither the Audit Committee nor the Board of Directors has identified any significant control weaknesses which could prejudice the Trust's services or service users; its strategic objectives; its reputation; or its financial stability.

Strategic risks are identified by management and the Board as part of preparing the Annual Plan. The Plan is developed in consultation with our Board of Governors, who represent the public; Trust staff; and key stakeholders. The Plan document itself includes the key risks; and the formal Strategic Risk Register, which tabulates the risks, the actions being taken to manage them, who is taking these actions, and who is monitoring them, is presented and approved at the same time. Every two to three months, the Board of Directors receives an update on the high-level risks and the action being taken on them. An update will be given immediately in the event of a major change or new risk. Operational risks are identified and included in the Risk Register, which is presented in full to the Board of Directors annually; assurance that risks are being managed is received by the Clinical Quality, Safety, and Governance Committee.

The Corporate Governance and Risk Lead assesses evidence of effective risk management of non-clinical risks, and the Patient Safety and Clinical Risk Lead assesses clinical risks, both report to the Clinical Quality, Safety, and Governance Committee, which reports assurance to the Board of Directors.

The Board of Directors receives minutes and reports from the Clinical Quality, Safety, and Governance Committee and the Audit Committee.

Committee Structure

The Clinical Quality, Safety, and Governance Committee's role is to provide the Board of Directors with assurance of effective risk management within the Trust.

Health and safety issues are covered by the Corporate Governance and Risk work group which reports to the Clinical Quality, Safety, and Governance Committee.

The Audit Committee reviews the establishment and maintenance of an effective system of internal control and risk management. This covers all areas of the Trust's activities, in conjunction with the Committees mentioned above,

as well as our core financial systems and procedures and our counter-fraud controls. The Audit Committee reviews all reports from the External Auditors, the Internal Auditors, and the Local Counter-Fraud Specialist. The Annual Report of the Internal Auditors provides the Audit Committee with assurance that the Trust's system of internal control is sound.

Independent Assurance

As noted elsewhere in this statement, independent assurance has been provided principally by our External and Internal Auditors, and by the NHS Litigation Authority. The Trust has developed and implemented action plans in response to the recommendations of each of these bodies.

Internal Audit has reported to the Board of Directors that "Based on the work undertaken in 2010/11, significant assurance can be given that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are being applied consistently."

Stakeholder Involvement

The Trust's Raising Concerns at Work policy encourages staff to be aware of risks and to report them so that action can be taken.

Participation in risk management is part of the Trust's overall strategy for patient and public involvement. Two governors serve on the Clinical Quality, Safety, and Governance Committee.

The Board of Governors appoints the Trust's External Auditors and reviews, with the Board of Directors, the performance of the Trust, including any risk of breach of the Terms of Authorisation.

Conclusion

No significant internal control issues have been identified.



Dr Matthew Patrick
Chief Executive
2nd June 2011

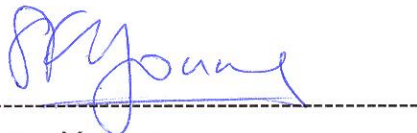
The accounts

Foreword

These accounts have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 Act.



Matthew Patrick
Chief Executive
2nd June 2011



Simon Young
Director of Finance
2nd June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

		2010/11	2009/10
	note	£000	£000
Operating income from continuing operations	2.1	32385	30300
Operating expenses of continuing operations	3.1	-31976	-29311
OPERATING SURPLUS		409	989
FINANCE COSTS			
Finance income	5.0	15	18
Finance expense - financial liabilities	6.1	0	0
Finance expense - unwinding of discount on provisions		-1	-1
PDC dividends payable		-333	-355
NET FINANCE COSTS		-319	-338
Share of profit / (loss) of associates and joint ventures accounted for using the equity method		0	0
Corporation tax expense		0	0
Surplus from Continuing Operations		90	651
Surplus / (deficit) of discontinued operations and the gain / (loss) on disposal of discontinued operations		0	0
SURPLUS FOR THE YEAR		90	651
Other comprehensive income			
Revaluation gains / (losses) and impairment losses on property, plant and equipment		0	0
Other recognised gains and losses		0	0
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		90	651
Prior period adjustments		0	0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		90	651
		2010/11	2009/10
		£000	£000
Note: Allocation of profits for period			
(a) surplus for the period attributable to			
(i) minority interest and		0	0
(ii) owners of the parent		90	651
TOTAL		90	651
(b) total comprehensive income for the period attributable to			
(i) minority interest and		0	0
(ii) owners of the parent		90	651
TOTAL		90	651

STATEMENT OF FINANCIAL POSITION

	note	31 Mar 2011 £000	31 Mar 2010 £000
Non-current assets			
Intangible assets	8.1	111	117
Property, plant and equipment	9.1	12603	12753
Total non-current assets		12714	12870
Current assets			
Inventories	13.1	1	2
Trade and other receivables	14.1	2422	2801
Other financial assets	29	0	0
Non-current assets for sale and assets in disposal groups	10.1	0	0
Cash and cash equivalents		4712	3648
Total current assets		7135	6451
Current liabilities			
Trade and other payables	15.1	-2031	-2203
Borrowings	17	0	0
Other financial liabilities		0	0
Provisions	21	-51	-103
Tax payable	15.1	-558	-593
Other liabilities	16	-3469	-2771
Liabilities in disposal groups		0	0
Total current liabilities		-6109	-5670
Total assets less current liabilities		13740	13651
Non-current liabilities			
Other financial liabilities		0	0
Provisions	21	-60	-61
Total non-current liabilities			
Total assets employed		13680	13590
Equity			
Public dividend capital		3403	3403
Revaluation reserve	22	7840	8022
Income and expenditure reserve		2437	2165
Total taxpayers' equity		13680	13590

These accounts were approved by the Board on
and signed on its behalf by



CEO

3 June 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	note	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers's Equity at 1 April 2010		13590	3403	8022	2165
Surplus for the year		90			90
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve		0		-182	182
Taxpayers's Equity at 31 March 2011		<u>13680</u>	<u>3403</u>	<u>7840</u>	<u>2437</u>
Taxpayers's Equity at 1 April 2009 as previously stated		13303	3403	8208	1692
Restatement to International Financial Reporting Standards		-364			-364
		<u>0</u>			
Taxpayers's Equity at 1 April 2009 restated		12939	3403	8208	1328
Surplus for the year		651			651
Revaluation gains / (losses) and impairment losses on property, plant and equipment		0			
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve		0		-186	186
Taxpayers's Equity at 31 March 2010		<u>13590</u>	<u>3403</u>	<u>8022</u>	<u>2165</u>

STATEMENT OF CASH FLOWS

	2010/11 £000	2009/10 £000
Cash flow from operating activities		
Operating surplus from continuing operations	409	989
Operating surplus of discontinued operations	0	
Operating surplus / (deficit)	409	989
Non-cash income and expense		
Depreciation and amortisation	511	473
Impairments	0	90
(Increase)/Decrease in Trade and Other Receivables	461	693
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	1	11
Increase/(Decrease) in Trade and Other Payables	-205	160
Increase/(Decrease) in Other Liabilities	663	-187
Increase/(Decrease) in Provisions	-53	-270
Tax (paid)/received		0
Movements in operating cash flow of discontinued operations		0
Other movements in operating cash flows		0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	1787	1959
Cash flow from investing activities		
Interest received	15	18
Purchase of financial assets	-2801	-3001
Sales of financial assets	2801	3001
Purchase of intangible assets	-26	-71
Purchase of property, plant and equipment	-297	-511
Net cash generated from/(used in) investing activities	-308	-564
Cash flow from financing activities		
Public dividend capital received	0	0
Public dividend capital repaid	0	0
Interest paid		0
PDC dividend paid	-415	-386
Cash flows from/(used in) other financing activities	0	0
Net cash generated from/(used in) financing activities	-415	-386
Increase/(decrease) in cash and cash equivalents	1064	1009
Cash and cash equivalents at 1 April 2010	3648	2639
Cash and cash equivalents at 31 March 2011	4712	3648

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Accounting and Reporting Manual (FTARM) which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.2 Acquisitions and Discontinued Operations

Activities are considered to be "discontinued" where they meet all of the following conditions:-

- a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;
- b. if a termination, the former activities have ceased permanently;
- c. the sale or termination has a material effect on the nature and focus of the Tavistock and Portman NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the Tavistock and Portman NHS Foundation Trust's continuing operations; and
- d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

Activities are considered to be "acquired" whether or not they are acquired from outside the public sector.

1.3 Income recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable.

The main source of income for the trust is contracts from commissioners in respect of healthcare services, and from NHS London for training services.

Income is recognised in the period in which services are provided. There are two main sources of income where amounts are receivable in advance of the services being provided, and that income is deferred:-

Tuition fees in respect of training courses are normally payable for an academic year from September to August. Income is recognised based on the number weeks of tuition and training that have been delivered up to the date of the accounts. Income receivable in respect of tuition and training services to be delivered after the date of the accounts is deferred.

Income is recognised from contributions receivable towards the funding of projects and new developments as expenditure on those projects and new developments is incurred. Amounts receivable in excess of expenditure incurred is deferred unless no further expenditure is required.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.4 Expenditure on Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments 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 direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers 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.

Teachers' Pension Scheme

Some current employees are covered by the provisions of the Teachers' Pensions Scheme (England and Wales). The scheme is an unfunded, defined benefit scheme that covers teachers and schools and other educational establishments. As a consequence it is not possible for the Tavistock and Portman NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme under IAS19.

1.5 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.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.6 Property, Plant and Equipment

Recognition

Property, plant and equipment is recognised 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; and

it individually has a cost of at least £5,000; or

it forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

it forms part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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 economic lives.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.6 Property, Plant and Equipment

Measurement

Valuation

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

All assets are measured subsequently at fair value.

Property assets are valued by independent valuers, primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value.

The last full valuation was carried out in April 2008.

In the light of the fall in the property market during the six months to 31st March 2009, a further interim valuation was also undertaken as at 31st March 2009.

The property valuations assume no biological or asbestos hazards, and that although a higher value might be achieved if some of the properties were redeveloped for residential use, the local authority's desire to retain community and health premises would mean a valuation for continuing existing use is more appropriate.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation, or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.6 Property, Plant and Equipment

Measurement

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 are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation

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 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 FT ARM, impairments that are due to a loss of economic benefits 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.

Other impairments are treated as revaluation losses. Reversals of "other impairments" are treated as revaluation gains.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.6 Property, Plant and Equipment

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; and

the sale must be highly probable, ie

- 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 and the assets are not revalued, except where the "fair value less costs to sell" falls below the carrying amount. Assets are derecognised when all material sale contract conditions have been met.

Protected assets

Under the terms of the authorisation of the Tavistock and Portman NHS Foundation Trust, certain patient services and training activities are defined as "mandatory services", and the land and building needed for the purpose of providing these mandatory services are "protected assets". The Tavistock and Portman NHS Foundation Trust may not dispose of any protected assets without the approval of the regulator. Protected assets may therefore not be used as security for loans.

After authorisation in November 2006, the Trust determined that the Tavistock Centre and the Portman Clinic are protected assets; and all other assets are not protected. This information is recorded on the asset register.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.7 Intangible fixed assets

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.

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 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 or property, plant and equipment. Software which is not integral to the operation of hardware eg application software, is capitalised as an intangible asset where expenditure of at least £5,000 is incurred.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.7 Intangible fixed assets

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 fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where , and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and therefore are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item "other comprehensive income". 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value on a First In, First Out method. The Trust's stocks are all consumables, with no overheads included and no long term contracts.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.9 Financial Instruments

Recognition

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

Derecognition

All financial assets are derecognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and Measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are categorised as other financial liabilities.

Financial Instruments at "fair value through income and expenditure"

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.9 Financial Instruments

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 Tavistock and Portman NHS Foundation Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transaction 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.

Other financial liabilities

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

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

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.9 Financial Instruments

Impairment of Financial Assets

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

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

An asset's carrying value is only written down directly when it is certain that the lower value is the only amount recoverable. When it is still possible the full amount will be recovered, the asset is treated as impaired.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.9 Financial Instruments

Market Risk, Credit Risk and Liquidity Risk of Financial Instruments

There are three types of risk associated with financial instruments: market risk, credit risk and liquidity risk.

Market risk is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices. This could be interest rate risk, currency risk or any other price risk. All of the Tavistock and Portman NHS Foundation Trust's financial instruments are denominated in sterling, and so there is no currency risk. The Tavistock and Portman NHS Foundation Trust's cash and cash equivalents, £4,712,000 at 31 March 2011 (£3,648,000 at 31 March 2010) receive a very low rate of interest, in line with market rates. If interest rates rise in the future, the Tavistock and Portman NHS Foundation Trust will seek to place term deposits to benefit from higher rates. The Tavistock and Portman NHS Foundation Trust has no interest-bearing liabilities and so a rise in interest rates carries no risk of added expenditure in the future. There are no other price risks to the Tavistock and Portman NHS Foundation Trust's financial instruments.

Credit risk is the risk that a counterparty to a financial instrument will cause financial loss to the Tavistock and Portman NHS Foundation Trust by failing to discharge an obligation. The Tavistock and Portman NHS Foundation Trust's receivables, particularly trade and NHS receivables, worth £2,299,000 at 31 March 2011 (£2,653,000 at 31 March 2010) carry a risk that the counterparty will not pay. For this reason the Tavistock and Portman NHS Foundation Trust accounts for some of these assets as impaired, please see note 14.

Liquidity risk is the risk that the Tavistock and Portman NHS Foundation Trust will encounter difficulties meeting obligations associated with financial liabilities. The Tavistock and Portman NHS Foundation Trust has, at 31 March 2011 £6,169,000 (£5,731,000 at 31 March 2010) of liabilities. Excluding deferred income, where there is no further obligation to pay cash, and non current provisions, leaves liabilities of £2,640,000 (£2,899,000 at 31 March 2010) payable in the short term. With readily available cash and cash equivalents of £4,712,000 (£3,648,000 at 31 March 2010) the Tavistock and Portman NHS Foundation Trust is able to fulfil its obligations as they fall due and faces little liquidity risk. To safeguard against liquidity risk, cash flow is reported monthly to the Board.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.10 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Tavistock and Portman NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Operating lease incentives received are added to the lease rental and charged to operating expenses over the life of the lease.

Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.11 Provisions

The Tavistock and Portman NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Tavistock and Portman NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Tavistock and Portman NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Tavistock and Portman NHS Foundation Trust is disclosed at note 21.

Non-clinical risk pooling

The Tavistock and Portman NHS Foundation 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 the NHS Litigation Authority and in return receives assistance with the costs of claim arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

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 for 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.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.13 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 Trust.

HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS32.

A charge, reflecting the forecast cost of capital used by the Tavistock and Portman NHS Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Tavistock and Portman NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held within the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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 of the audit of the annual accounts. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.14 Value Added Tax

Most of the activities of the Tavistock and Portman NHS Foundation 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.

1.15 Corporation Tax

The Tavistock and Portman NHS Foundation Trust has no corporation tax liability because its activities are public sector healthcare and education.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.16 Foreign Exchange

The functional and presentational currencies of the Tavistock and Portman NHS Foundation Trust are sterling.

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

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

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

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

1.17 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.18 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Tavistock and Portman NHS Foundation Trust's cash book. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "other income" and "finance costs" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.19 Critical Accounting Estimates and Judgments

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 judgments 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 judgment 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. Operating costs include an estimate for the annual leave earned but not taken at the year-end date. Accounting for receivables necessarily involves judgment when assessing levels of impairment.

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.20 Accounting Standards that have been issued by not yet adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

IFRS 7 Financial instruments: Disclosure (amendment) - transfers of financial assets	effective 2012/13
IFRS 9 Financial instruments: Financial Assets: Financial Liabilities	uncertain
IAS 12 Income Taxes amendment	effective 2012/13
IAS 24 (Revised) Related Party Disclosures	2011/12
Annual improvements 2010	2011/12
IFRIC 14 amendment	2011/12
IFRIC 19 Extinguishing financial liabilities with equity instruments	2011/12

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

NOTES TO THE ACCOUNTS

2.1 Operating Income (by classification)

	2010/11 Total £000	2009/10 Total £000
Income from Activities		
Cost and volume contract income	2723	2601
Block contract income	5620	5495
Other clinical income from mandatory services		0
Other non-protected clinical income	5816	5326
Total Income from Activities	<u>14159</u>	<u>13422</u>
Other operating income		
Research and development	157	132
Education and training	15360	14912
Charitable and other contributions to expenditure	63	19
Non-patient care services to other bodies		0
Other see also note 2.4	2646	1815
Total other operating income	<u>18226</u>	<u>16878</u>
TOTAL OPERATING INCOME	<u><u>32385</u></u>	<u><u>30300</u></u>

2.2 Private patient income

	2010/11 £000	2009/10 £000	Base Year £000
Private patient income	0	0	0
Total patient related income	14159	13422	9170
Proportion (as percentage)	0.00%	0.00%	0.00%

Section 44 of the NHS Act 2006 requires that private patient income as a proportion of total patient related income should not exceed a cap. Under the Health Act 2009 this cap is now increased to at least 1.5% for all mental health foundation trusts.

As a result of a judicial review in 2009, the definition of private patient income has been widened. Under this new definition, however, the Tavistock and Portman NHS Foundation Trust's private patient income remains nil.

2.3 Operating Lease Income

	2010/11 Total £000	2009/10 Total £000
Operating Lease Income		
Rents recognised as income in the period	22	85
TOTAL	<u>22</u>	<u>85</u>
Future minimum lease receipts due		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years	0	0
TOTAL	<u><u>0</u></u>	<u><u>0</u></u>

NOTES TO THE ACCOUNTS

2.4 Operating income (by type)

	2010/11	2009/10
	Total	Total
	£000	£000
Income from Activities		
NHS Foundation Trusts	92	156
NHS Trusts	90	76
Strategic Health Authorities	1261	1062
Primary Care Trusts	8708	8356
Local Authorities	3064	2584
Department of Health - other	67	33
Non NHS other *	877	1155
Total Income from Activities	14159	13422
Other operating income		
Research and development	157	132
Education and training	15360	14912
Charitable and other contributions to expenditure	63	19
Non-patient care services to other bodies		0
Other **	2646	1815
Total other operating income	18226	16878
TOTAL OPERATING INCOME	32385	30300

* Analysis of Income from Activities: Non NHS - other

	2010/11	2009/10
	Total	Total
	£000	£000
Ministry of Defence	0	0
Other government departments and agencies	0	0
Other	877	1155
Total	877	1155

** Analysis of Other Operating Income: Other

	2010/11	2009/10
	Total	Total
	£000	£000
Car parking	40	25
Consultancy	910	1162
Clinical excellence awards	116	142
Property rentals	22	85
Other	1558	401
Total	2646	1815

NOTES TO THE ACCOUNTS

2.4 Operating income (by type) (continued)

Mandatory and Non-Mandatory Services Income	2010/11 Total £000	2009/10 Total £000
Cost and volume contract income	2723	2601
Block contract income	5620	5495
Other clinical income from mandatory services		0
Total income from mandatory patient services	8343	8096
Court report assessment work	231	513
Mednet income	313	288
Other non protected clinical income	5272	4525
Total income from patient services	14159	13422

Note 3.1 OPERATING EXPENSES (by type)

	2010/11	2009/10
	£000	£000
Employee expenses - Executive directors	686	642
Employee expenses - Non-executive directors	75	71
Employee expenses - staff	24376	22348
Drug costs		2
Supplies and services - clinical (excluding drug costs)	181	183
Supplies and services - general	81	73
Establishment	529	614
Transport	4	7
Premises	1473	1278
Increase / (decrease) in bad debt provision	19	10
Depreciation on property, plant and equipment	478	444
Amortisation on intangible assets	33	29
Impairments of property, plant and equipment	0	90
Audit fees		
audit fees - statutory audit	63	57
audit services - regulatory reporting		0
Other auditors remuneration		
further assurance services	1	0
other services		0
Clinical negligence	136	124
Legal fees	43	38
Consultancy costs	235	304
External lecturers and seminar leaders	1341	1193
Training, courses and conferences	307	362
Patient travel	50	41
Redundancy	28	0
Hospitality	17	18
Publishing		4
Insurance	57	52
Interpreting service	35	24
Internal audit	14	31
Payroll	22	28
Occupational health	18	17
Professional charges	484	355
Educational external contracts	870	430
Other services	13	16
Losses, ex gratia and special payments	-69	30
Other	376	396
TOTAL	31976	29311

Note 3.2 Arrangements containing an operating lease

	2010/11 £000	2009/10 £000
Minimum lease payments	99	96
Contingent rents	0	0
Less sublease payments received	0	0
TOTAL	99	96

	31 Mar 2011 £000	31 Mar 2010 £000
Future minimum lease payments due:		
- not later than one year;	51	96
- later than one year and not later than five years;	8	47
- later than five years.		0
TOTAL	59	143

Note 3.3 Limitation on auditor's liability

The limitation on the external auditor's liability to the Tavistock and Portman NHS Foundation Trust for the external audit service provided is £1 million (2009/10 £1 million).

Note 3.4 The Late Payment of Commercial Debts (interest) Act 1998

No interest or compensation was paid under this legislation.

NOTES TO THE ACCOUNTS

4.1 Employee Expenses

	2010/11	2010/11	2010/11	2009/10
	Total	Permanent	Other	Total
	£000	£000	£000	£000
Salaries and wages	19927	13551	6376	18037
Social security costs	1831	1244	587	1650
Pension costs - defined contribution plans	0	0	0	0
Employer contributions to NHS Pensions	2464	1674	790	2221
Pensions costs - other contributions	26	26		28
Termination benefits	58		58	11
Agency / contract staff	784		784	1055
TOTAL	25090	16495	8595	23002

The termination benefits included above are one redundancy and one other agreement, each costing less than £50,000. In 2009/10, there was just one agreement.

4.2 Average number of employees (WTE basis)

	2010/11	2010/11	2010/11	2009/10
	Total	Permanent	Other	Total
	Number	Number	Number	Number
Medical and dental	40	16	24	41
Ambulance staff	0			0
Administration and estates	159	135	24	157
Healthcare assistants and other support staff	0			0
Nursing, midwifery and health visiting staff	12	7	5	9
Nursing, midwifery and health visiting learners	0			0
Scientific, therapeutic and technical staff	165	80	85	146
Social care staff	23	20	3	24
Bank and agency staff	26		26	16
Other	5	4	1	4
TOTAL	430	262	168	397

NOTES TO THE ACCOUNTS

4.3 Employee benefits

	2010/11	2009/10
	£000	£000
Value of holiday pay accrued (included in note 15) at 1 April 2010	400	364
Value of holiday pay accrued (included in note 3.1)	<u>-108</u>	<u>36</u>
Value of holiday pay accrued (included in note 15) at 31 March 2011	<u><u>292</u></u>	<u><u>400</u></u>

The employee benefits shown above are the value to the Trust of holiday pay accrued at the balance sheet date and to be taken at a later date. There are no other non-pay benefits provided to staff.

4.4 Early Retirements due to Ill Health

During the year ended 31 March 2011, and also the year ended 31 March 2010, there were no retirements from the Trust on the grounds of ill health.

4.5 Management Costs

Management costs were £3.0 million in the year (2009/10 £2.7 million), equivalent to
9.2% (2009/10 £8.8% of income)

NOTES TO THE ACCOUNTS

Note 5 Finance income

	2010/11 £000	2009/10 £000
Interest on loans and receivables	0	7
Interest on available for sale financial assets	0	0
interest on held-to-maturity financial assets	15	11
Other gains (investment properties)	0	0
Available for sale financial assets and liabilities held at fair value through income and expenditure account		
- fair value gains	0	0
- fair value losses	0	0
Net gains / (losses) on available for sale financial assets through income and expenditure	0	0
Other		
TOTAL	15	18

No interest has been earned on any impaired financial assets.

Note 6.1 Finance costs - interest expense

There has been no interest payable during the year ended 31 March 2011 (to 31 March 2010, £nil)

Note 6.2 Impairment of assets (Property, Plant and Equipment and Intangibles)

In the year ended 31 March 2011 there have been no impairments of property, plant, equipment nor intangible assets.

In the year ended 31 March 2010, assets under construction worth £90,000 were abandoned.

Note 7 Segmental Reporting

The Tavistock and Portman NHS Foundation Trust's work has operating segments as follows:-

	Operating expenditure 2010/11 £000	Dividends and unwinding discount 2010/11 £000
Adult Department Services, including training and research	5357	66
Portman Clinic Services, including training and research	2083	22
Adolescent Services, including training and research	4468	63
Tavistock Consultancy Services, including training	1042	8
Children's Services, including training and research	19026	175
Total	31976	334

Assets and liabilities are not reported on a segmental basis.

NOTES TO THE ACCOUNTS

Note 8.1 Intangible assets

	Total £000	Software licences purchased £000
Gross cost at 1 April 2010	195	195
Additions - purchased	27	27
Gross cost at 31 March 2011	<u>222</u>	<u>222</u>
Amortisation at 1 April 2010	78	78
Provided during the year	33	33
Amortisation at 31 March 2011	<u>111</u>	<u>111</u>
Net book value of purchased intangible assets at 1 April 2010	117	117
Net book value of donated intangible assets at 1 April 2010		
Net book value of total intangible assets at 1 April 2010	<u>117</u>	<u>117</u>
Net book value of purchased intangible assets at 31 March 2011	111	111
Net book value of donated intangible assets at 31 March 2011		
Net book value of total intangible assets at 31 March 2011	<u>111</u>	<u>111</u>

Note 8.2 Intangible assets acquired by government grant

There are no intangible assets acquired by government grant.

Note 8.3 Economic life of intangible assets

Intangible assets - purchased

Software

Minimum life (years)	Maximum life (years)
5	5

NOTES TO THE ACCOUNTS**Note 8.4 Intangible assets 2009/10**

	Total £000	Software licences purchased £000
Gross cost at 1 April 2009	127	127
Additions - purchased	68	68
Gross cost at 31 March 2010	<u>195</u>	<u>195</u>
Amortisation at 1 April 2009	49	49
Provided during the year	29	29
Amortisation at 31 March 2010	<u>78</u>	<u>78</u>
Net book value of purchased intangible assets at 1 April 2009	78	78
Net book value of donated intangible assets at 1 April 2009		
Net book value of total intangible assets at 1 April 2009	<u>78</u>	<u>78</u>
Net book value of purchased intangible assets at 31 March 2010	117	117
Net book value of donated intangible assets at 31 March 2010		
Net book value of total intangible assets at 31 March 2010	<u>117</u>	<u>117</u>

NOTES TO THE ACCOUNTS

Note 9.1 Property, plant and equipment 2010/11

	Total £000	Land £000	Buildings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Cost or valuation at 1 April 2010	14611	3495	9926	90	206	811	83
Additions - purchased	328	0	118	13		197	
Additions - donated	0						
Reclassifications	0						
Cost or valuation at 31 March 2011	14939	3495	10044	103	206	1008	83
Accumulated depreciation at 1 April 2010	1858	0	1073	90	145	492	58
Provided during the year	478		314	0	36	122	6
Impairments recognised as operating expenses	0						
Accumulated depreciation at 31 March 2011	2336	0	1387	90	181	614	64
Net book value							
Net book value of purchased tangible assets at 1 April 2010	12753	3495	8853	0	61	319	25
Net book value of donated tangible assets at 1 April 2010	0	0	0	0	0	0	0
Net book value of owned tangible assets at 1 April 2010	12753	3495	8853	0	61	319	25
Net book value							
Net book value of purchased tangible assets at 31 March 2011	12603	3495	8657	13	25	394	19
Net book value of donated tangible assets at 31 March 2011	0	0	0	0	0	0	0
Net book value of owned tangible assets at 31 March 2011	12603	3495	8657	13	25	394	19

Note 9.2 Analysis of property, plant and equipment 2010/11

	Total £000	Land £000	Buildings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Net book value							
Net book value of protected assets at 31 March 2011	11070	2995	8075				
Net book value of unprotected assets at 31 March 2011	1533	500	582	13	25	394	19
Total at 31 March 2011	12603	3495	8657	13	25	394	19

NOTES TO THE ACCOUNTS

Note 9.3 Property, plant and equipment 2009/10

	Total £000	Land £000	Buildings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Cost or valuation at 1 April 2009	14182	3495	9524	158	201	737	67
Additions - purchased	429		72	262	5	74	16
Additions - donated	0						
Reclassifications	0		330	-330			
Cost or valuation at 31 March 2010	14611	3495	9926	90	206	811	83
Accumulated depreciation at 1 April 2009	1324	0	779	0	108	383	54
Provided during the year	444		294		37	109	4
Impairments recognised as operating expenses	90			90			
Accumulated depreciation at 31 March 2010	1858	0	1073	90	145	492	58
Net book value							
Net book value of owned tangible assets at 1 April 2009	12858	3495	8745	158	93	354	13
Net book value of purchased tangible assets at 1 April 2009	12858	3495	8745	158	93	354	13
Net book value of donated tangible assets at 1 April 2009	0	0	0	0	0	0	0
Net book value at 1 April 2009	12858	3495	8745	158	93	354	13
Net book value							
Net book value of owned tangible assets at 31 March 2010	12753	3495	8853	0	61	319	25
Net book value of purchased tangible assets at 31 March 2010	12753	3495	8853	0	61	319	25
Net book value of donated tangible assets at 31 March 2010	0	0	0	0	0	0	0
Net book value at 31 March 2010	12753	3495	8853	0	61	319	25

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. The last asset valuations were undertaken in 2004 as the prospective valuation date of 1 April 2005. The revaluation undertaken at that date was accounted for on 31 March 2005. The last full valuation was also carried out as at 1 April 2008.

In the light of the fall in the property market during the six months to 31 March 2009, a further interim valuation was also undertaken as at 31 March 2009.

Note 9.4 Analysis of property, plant and equipment 2009/10

	Total £000	Land £000	Buildings £000	Assets under Construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Net book value							
Net book value of protected assets at 31 March 2010	11244	2995	8249	0	0	0	0
Net book value of unprotected assets at 31 March 2010	1509	500	604	0	61	319	25
Total at 31 March 2010	12753	3495	8853	0	61	319	25

NOTES TO THE ACCOUNTS

Note 9.5 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	5	50
Plant and machinery	5	5
Information technology	3	8
Furniture and fittings	5	5

Of the totals at 31 March 2011, none related to land or buildings treated as modern equivalent assets nor valued using an alternative site method nor valued at open market value. It is likely that open market value would be higher than the values used here which reflect continuing use as clinics.

No assets were held under finance leases and hire purchase contracts at the balance sheet date.

No depreciation was charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts in the year.

Plant and equipment are valued at cost depreciated over useful life.

10.1 Non-current assets for sale and assets in disposal groups 2010/11

There were no non-current assets for sale nor assets in disposal groups at 31 March 2010 nor 31 March 2011.

NOTES TO THE ACCOUNTS

Note 11.1 Investments

The Trust does not hold any non-current asset investments (31st March 2010: £nil)

Note 12.1 Investments in associate (and jointly controlled operations)

The Trust does not hold any investments in associates nor in jointly controlled operations (31st March 2010: £nil)

Note 13.1 Inventories

	31 March 2011 £000	31 March 2010 £000
Materials	1	2
Work in progress		
Finished goods		
Inventories carried at fair value less costs to sell		
Total inventories	<u>1</u>	<u>2</u>

Note 13.2 Inventories recognised in expenses

	2010/11 £000	2009/10 £000
Inventories recognised in expenses	0	0
Write-down of inventories recognised as an expense	1	3
Reversal of any write down of inventories resulting in a reduction of recognised expenses		
Total inventories recognised in expenses	<u>1</u>	<u>3</u>

NOTES TO THE ACCOUNTS

Note 14.1 Trade receivables and other receivables

	Total 31 Mar 11 £000	Total 31 Mar 10 £000
Current		
NHS receivables	513	731
Other receivables with related parties	537	0
Provision for impaired receivables	-383	-364
Prepayments	182	139
Accrued income	211	342
PDC dividend receivable	113	31
Other receivables	1249	1922
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	2422	2801

There are no non-current trade or other receivables

All of the above trade and other receivables are financial assets apart from the prepayments.

NHS receivables have a very low credit risk, mainly because NHS debtors are government-backed, and also because NHS organisations correspond about balances outstanding at the year-end. Accrued income comes from different sources other than NHS and government, so its credit risk is a little higher. The other receivables are mostly other trade debtors for court report or consultancy work, or students for training, so again these carry a slightly higher risk than do NHS receivables.

Note 14.2 Provision for Impairment of Receivables

	Total 31 Mar 11 £000	Total 31 Mar 10 £000
At 1 April 2010	364	348
Increase in provision	243	275
Amounts utilised		
Provision for impaired receivables		
Prepayments		
Accrued income		
PDC receivable		
Unused amounts reversed	-224	-259
At 31 March 2011	383	364

Note 14.3 Analysis of impaired receivables

	Total 31 Mar 11 £000	Total 31 Mar 10 £000
Ageing of impaired receivables		
Up to three months	4	78
In three to six months	146	106
Over six months	233	180
Total	383	364

Note 14.4 Analysis of non impaired receivables

	Total 31 Mar 11 £000	Total 31 Mar 10 £000
Ageing of non-impaired receivables past their due date		
Up to three months	926	1540
In three to six months	472	417
Over six months	66	96
Total	1464	2053

Note 14.5 Finance lease receivables

There are no finance lease receivables

NOTES TO THE ACCOUNTS

Note 15.1 Trade and other payables

	31 Mar 2011 £000	31 Mar 2010 £000
Current		
Receipts in advance	0	0
NHS payables	445	380
Amounts due to other related parties	110	45
Trade payables - capital	27	0
Other trade payables	241	261
Other payables	605	633
Accruals	1161	1477
TOTAL CURRENT TRADE AND OTHER PAYABLES	<u>2589</u>	<u>2796</u>

There are no non-current trade and other payables.

Note 15.2 Early retirements detail included in NHS payables above

	31 Mar 2011 £000	31 Mar 2011 number	31 Mar 2010 £000	31 Mar 2010 number
to buy out the liability for early retirements over 5 years	0		0	
number of cases involved		0		0

Note 15.3 Outstanding pension contributions included in NHS payables above

	31 Mar 2011 £000	31 Mar 2010 £000
Outstanding pension contributions for current staff	329	309

Note 16 Other liabilities

	31 Mar 2011 £000	31 Mar 2010 £000	1 April 2009 £000
Current	0		
Deferred income	3469	2771	3054
Deferred government grant			
Net Pension Scheme liability			
TOTAL OTHER CURRENT LIABILITIES	<u>3469</u>	<u>2771</u>	<u>3054</u>

There are no non current liabilities for deferred income, deferred government grant nor deferred net pension scheme liability.

NOTES TO THE ACCOUNTS

Note 17 Borrowings

The Trust has no current nor non-current borrowings (31st March 2010: £nil)

Note 18 Prudential Borrowing Limit

The Tavistock and Portman NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long-term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation trusts Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent regulator of foundation trusts.

In 2010/11 these limits totalled £6.3 million (2009/10 £6.7 million), comprising maximum cumulative long-term borrowing of £4.3 million and approved working capital facility of £2.0 million. The Trust did not borrow during 2010/11 or 2009/10.

	2010/11 actual	2010/11 approved plan	2009/10 actual	2009/10 approved plan
Dividend cover ratio	2.8	2.4	4.4	2.3
Debt service cost as a percentage of revenue	0%	0%	0%	0%

The Trust has a working capital facility of £2.0million, which is within its approved limit. The Trust had not drawn down any of this facility at 31 March 2011 (or at 31 March 2010).

The Interest Cover and the Debt Service Cover ratios are not shown in the table above, because the Trust has had no debt in either year.

Note 19 Finance lease obligations

There were no finance lease obligations in 2010/11 (or in the year ended 31 March 2010).

Note 20 PFI obligations (on Statement of Financial Position)

There were no private finance obligations in 2010/11 (or in the year ended 31 March 2010).

NOTES TO THE ACCOUNTS

Note 21 Provisions for Liabilities and Charges

	Current		Non-current	
	31 March 2011	31 March 2010	31 March 2011	31 March 2010
	£000	£000	£000	£000
Pensions relating to former directors	0	0	0	0
Pensions relating to former staff	6	6	60	61
Other legal claims	45	97	0	0
Other	0	0	0	0
Total	51	103	60	61

The movements on these provisions are shown below:

	Total £000	Pensions - former directors £000	Pensions - other staff £000	Legal Claims £000	Other £000
At 1 April 2010	164	0	67	97	0
Change in the discount rate	1		1	0	
Arising during the year	39			39	
Utilised during the year	-28		-3	-25	
Reversed unused	-66			-66	
Unwinding of discount	1		1	0	
At 31 March 2011	111	0	66	45	0
Expected timing of cash flows:					
- not later than one year	51		6	45	
- later than one year and not later than five years	25		25		
- later than five years	35		35		
Total	111	0	66	45	0

Legal claims concern employers' liability matters.

£ nil (31.3.2010: £nil) is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust.

NOTES TO THE ACCOUNTS

Note 22 Revaluation reserve

	Total revaluation reserve £000	Revaluation reserve - intangibles £000	Revaluation reserve - property, plant and equipment £000
Revaluation reserve at 1 April 2010	8022	0	8022
Revaluation gains / losses and impairment losses on intangible assets	0	0	0
Revaluation gains / losses and impairment losses on property, plant and equipment	0	0	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-182	0	-182
Revaluation reserve at 31 March 2011	7840	0	7840
Revaluation reserve at 1 April 2009	8208	0	8208
Revaluation gains / losses and impairment losses on intangible assets	0	0	0
Revaluation gains / losses and impairment losses on property, plant and equipment	0	0	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-186	0	-186
Revaluation reserve at 31 March 2010	8022	0	8022

NOTES TO THE ACCOUNTS

Note 23 Cash and cash equivalents

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
At 1 April 2010	3648	2639
Net change in year	1064	1009
At 31 March 2011	4712	3648
Broken down into		
Cash at commercial banks and in hand	212	22
Cash with the Government Banking Service	4500	3626
Other current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	4712	3648
Bank overdraft	0	
Cash and cash equivalents as in Statement of Cash Flows	4712	3648

There are no third party assets held by the Tavistock and Portman NHS Foundation Trust (31 March 2010: £nil)

Note 24.1 Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2011 were £170,000 (31 March 2010: £nil)

Note 24.2 Events after the reporting period

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

Note 25 Contingent Assets and Liabilities

At 31.3.2011, there were two employer's liability litigation cases outstanding against the Trust (at 31.3.2010: three cases).

The gross possible liability of the Trust for all these cases in aggregate is £45,000 (31.3.2010: £22,500 for three cases), £45,000 (31.3.2010: £20,000) of which is provided for in these accounts.

One of these cases was outstanding at both 31st March 2011 and at 31 March 2010, when the gross possible liability was £2,500, of which £2,500 was provided in the accounts. The other two cases outstanding at 31st March 2010 are no longer outstanding at 31st March 2011. A new case also arose during the year 2010/11.

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 which have occurred but have not yet been reported.

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

NOTES TO THE ACCOUNTS

Note 26 Related Party Transactions

The Tavistock and Portman NHS Foundation Trust is a body corporate authorised by Monitor, the regulator of NHS Foundation Trusts.

Dr Robert Senior is employed by University College London. In 2010/11, the Trust paid University College London £448,941 (2009/10 £105,852) and University College London paid the Trust £6,944 (2009/10: £nil) for various education and research activities

Dr Robert Senior also has a research collaboration with the Anna Freud Centre. The Trust pays the Anna Freud Centre £40,236 (2009/10 £46624) and the Anna Freud Centre pays the Trust £3,325 (2009/10 £8,691) for various education and research activities.

Key management personnel have received employment benefits as detailed below.

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Key management personnel compensation for short-term employee benefits ie pay	1098	1447
Key management personnel compensation for post employment benefits ie pensions	128	192
Key management personnel compensation for other long term benefits		0
Key management personnel compensation for termination benefits		0
Key management personnel compensation for share based payment	0	0
Key management personnel compensation in total	<u>1226</u>	<u>1639</u>

Apart from this, none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions during the period with the Tavistock and Portman NHS Foundation Trust.

NOTES TO THE ACCOUNTS

Note 26 Related Party Transactions continued

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

	Total income for the year ended 31 March 2011	Total charge for the year ended 31 March 2011	Debtor/ (creditor) as at 31 March 2011	Total income for the year ended 31 March 2010	Total charge for the year ended 31 March 2010	Debtor/ (creditor) as at 31 March 2010
	£000	£000	£000	£000	£000	£000
Department of Health	90	333	138	126	355	16
London Strategic Health Authority	12322	3	247	11547	3	25
Barnet Primary Care Trust	423	0	-23	424	0	0
Camden Primary Care Trust	4774	31	19	4655	6	31
Haringey Teaching Primary Care Trust	426	0	-46	475	0	-7
Hillingdon Primary Care Trust	0	0	0	1260	0	-1
Islington Primary Care Trust	329	0	-18	478	14	54
Westminster Primary Care Trust	215	0	7	192	0	-13

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. In particular, HM Revenue and Customs receives payments of Pay As You Earn income tax and National Insurance as shown below:

	Total income for the year ended 31 March 2011	Total charge for the year ended 31 March 2011	Debtor/ (creditor) as at 31 March 2011	Total income for the year ended 31 March 2010	Total charge for the year ended 31 March 2010	Debtor/ (creditor) as at 31 March 2010
HM Revenue and Customs for Pay As You Earn income tax and National Insurance (included in staff costs)	0	6892	-558	0	6224	-553

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:

	Total recharge for the year ended 31 March 2011	Debtor/ (creditor) as at 31 March 2011	Total recharge for the year ended 31 March 2010	Debtor/ (creditor) as at 31 March 2010
	£000	£000	£000	£000
Tavistock and Portman Charitable Fund	92	67	0	2
Tavistock Clinic Foundation	7	19	0	26

The accounts for these two charities are published separately.

During 2010/11, the Trust entered into an agreement with National Shared Business Services to provide certain accounting processes. The Trust paid £37,200 (2009/10 £nil) for these services.

NOTES TO THE ACCOUNTS

Note 27.1 Financial Assets by Category

	Total £000	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available for sale £000
Assets as per Statement of Financial Position					
Trade and other receivables excluding non financial assets (at 31 March 2011)	2127	2127	0	0	0
Other Investments (at 31 March 2011)	0		0	0	0
Other Financial Assets (at 31 March 2011)	0		0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2011)	4712	4712	0	0	0
Total at 31 March 2011	6839	6839	0	0	0
Trade and other receivables excluding non financial assets (at 31 March 2010)	2631	2631	0	0	0
Other Investments (at 31 March 2010)	0	0	0	0	0
Other Financial Assets (at 31 March 2010)	0	0	0	0	0
Cash and cash equivalents at bank and in hand (at 31 March 2010)	3648	3648	0	0	0
Total at 31 March 2010	6279	6279	0	0	0

NOTES TO THE ACCOUNTS

Note 27.2 Financial Liabilities by Category

	Total £000	Other financial liabilities £000	Liabilities at fair value through the I&E £000
Liabilities as per Statement of Financial Position			
Borrowings excluding finance lease and PFI liabilities (at 31 March 2011)	0		0
Trade and other payables excluding non financial liabilities (at 31 March 2011)	2031	2031	0
Other financial liabilities (at 31 March 2011)	0		0
Provisions under contract (at 31 March 2011)	0	0	0
Total at 31 March 2011	2031	2031	0
Borrowings excluding finance lease and PFI liabilities (at 31 March 2010)	0		0
Trade and other payables excluding non financial liabilities (at 31 March 2010)	2203	2203	0
Other financial liabilities (at 31 March 2010)	0		0
Provisions under contract (at 31 March 2010)	0	0	0
Total at 31 March 2010	2203	2203	0

NOTES TO THE ACCOUNTS

Note 27.3 Fair values of financial assets at 31 March 2011

	Book Value £000	Fair Value £000
Non current trade and other receivables excluding non financial assets		0
Other investments		0
Other	6839	6839
Total at 31 March 2011	6839	6839

Note 27.4 Fair values of financial liabilities at 31 March 2011

	Book Value	Fair Value £000
Non current trade and other payables excluding non financial liabilities		
Provisions under contract		
Loans		
Other	2031	2031
Total at 31 March 2011	2031	2031

NOTES TO THE ACCOUNTS**Note 28.1 Losses and Special Payments**

	2010/11	2010/11	2009/10	2009/10
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
LOSSES				
Losses of cash due to overpayment of salaries etc.			1	4
Losses of cash due to other causes			0	0
TOTAL LOSSES	0	0	1	4
SPECIAL PAYMENTS				
Compensation under legal obligation	2	40	2	15
Ex gratia payments in respect of personal injury, with advice			1	8
TOTAL SPECIAL PAYMENTS	2	40	3	23

None of the above cases exceeded £100,000 during 2010/11 or 2009/10.

Note: the total costs included in this note are on a cash basis and will not reconcile to the amounts included in the accounts which are prepared on an accruals basis.

Note 28.2 Recovered Losses

There were no compensation payments received or other losses recovered during 2010/11 or 2009/10.

NOTES TO THE ACCOUNTS

Note 29 Other Financial Assets

	31 March 2011 £000	31 March 2010 £000
Non-current		
Derivatives and embedded derivatives held at "fair value through income and expenditure"		0
Available for sale financial assets		
Held to maturity investments		
Loan and receivables	0	0
Total	<u>0</u>	<u>0</u>

Current

Derivatives and embedded derivatives held at "fair value through income and expenditure"		0
Available for sale financial assets		
Held to maturity investments		
Loan and receivables	0	0
Total	<u>0</u>	<u>0</u>

Note 30 Other Financial Liabilities

	31 March 2011 £000	31 March 2010 £000
Non-current		
Derivatives and embedded derivatives held at "fair value through income and expenditure"		0
Other financial liabilities	0	0
Total	<u>0</u>	<u>0</u>

Current

Derivatives and embedded derivatives held at "fair value through income and expenditure"		0
Other financial liabilities	0	0
Total	<u>0</u>	<u>0</u>

NOTES TO THE ACCOUNTS

Note 31 Better Payment Practice Code

	Number of bills paid Number	Number of bills paid within 30 days Number	% of bills paid within 30 days %	Value of bills paid £000	Value of bills paid within 30 days £000	% of bills paid within 30 days %
Year ended 31 March 2011	5,442	4,886	90%	6,270	5,930	95%
Year ended 31 March 2010	5,023	4,476	89%	5,947	5,547	93%

This is lower than the target of 95% set by the Better Payment Practice Code.

NOTES TO THE ACCOUNTS

Note 32 Directors' and Senior Managers' Remuneration

Name		2010/11 Salary (bands of £5,000)	2009/10 Salary (bands of £5,000)
Bostock, M.	Non Executive Director	5-10	5-10
Brimblecombe, NR	Nurse Director until 31 January 2010	0	5-10
Greatley, A	Chair from 1 November 2009	25-30	10-15
Harris, R	Director of Child and Family Directorate	100-105	95-100
Jones, E	Nurse Director from 6 September 2010	10-15	0
Kara, AA	Non Executive Director	5-10	5-10
Kennedy, E	Director of Research and Development from 1 November 2009	85-90	90-95
Key, P	Director of Corporate Governance and Facilities	90-95	85-90
Klauber, T	Dean of Postgraduate Studies	100-105	95-100
Lyon, L	Trust Director	95-100	80-85
McPherson, I	Non Executive Director from 1 November 2010	0-5	0
Moseley, J	Non Executive Director	5-10	5-10
Patrick, MPH	Chief Executive	140-145	135-140
Satyamurti, E	Non Executive Director until 31 October 2010	5-10	5-10
Selbie, N	Chair until 31 October 2009	0	15-20
Senior, R	Medical Director	100-105	75-80
Smith, J	Director of Performance	90-95	110-115
Strang, R	Non Executive Director	10-15	10-15
Thomas, S	Director of Human Resources	90-95	85-90
Young, S	Director of Finance	100-105	100-105

NOTES TO THE ACCOUNTS

Note 32 Directors' and Senior Managers' Remuneration continued

Name		Pension at age 60		Lump sum at age 60		Cash equivalent transfer value		
		Total accrued		Total accrued		at 31 March 2011	at 31 March 2010	Real increase since 31 March 2010
		lump sum at 31 March 2011	Real increase since 31 March 2010	lump sum at 31 March 2011	Real increase since 31 March 2010			
		Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £2,500	£000	£000	£000
Brimblecombe, NR	Nurse Director until 31 January 2010 Director of Child and Family	n/a	n/a	n/a	n/a	n/a	607	n/a
Harris, R	Directorate of Research and Development from 1 November 2009	50-55	5-7.5	150-155	15-17.5	1095	1045	50
Kennedy, E	Director of Corporate Governance and Facilities Dean of Postgraduate Studies	10-15	0-2.5	30-35	2.5-5	130	139	-9
Key, P	Trust Director	25-30	2.5-5	80-85	7.5-10	604	574	30
Klauber, T		40-45	5-7.5	130-135	15-17.5	0	0	0
Lyon, L		40-45	5-7.5	130-135	15-17.5	942	876	66
Patrick, MPH	Chief Executive Director of Performance Director of Human Resources	50-55	10-12.5	160-165	32.5-35	914	809	105
Smith, J	Director of Finance	25-30	n/a	80-85	n/a	397	n/a	n/a
Thomas, S		25-30	2.5-5	80-85	7.5-10	507	500	7
Young, S		25-30	2.5-5	75-80	7.5-10	607	579	28
		Value £'000S						
Directors' remuneration		669						
Employer contributions to pension schemes		92						
Total number of directors to whom benefits are accruing under		Number						
- money purchase schemes		0						
- defined benefit schemes		6						