Tavistock & Portman NHS Foundation Trust

Annual Report and Accounts 2016/17

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

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Annual Report 2016/17

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Foreword to the Report

This is my second Foreword to the Annual Report as Trust Chair. It is a great privilege to be leading the organisation through such an exciting and challenging time in mental health.

As this report demonstrates the scope and reach of the work of the Tavistock and Portman clinics continues to grow. During the year the Trust secured an overall and across the board Good rating from the Care Quality Commission (CQC) and a similar rating for our education and training from the Quality Assurance Agency for Higher Education (QAA). The CQC particularly praised the care and compassion of our staff.

The work of our clinicians and the experience of young people in our gender identity services were the subject of a BAFTA nominated Channel 4 documentary series called Kids on the Edge. The series also showcased the work of our school Gloucester House and of our child and adolescent mental health services.

The Trust's leadership in gender identity saw a further growth of the children and young people's service and a successful bid to take on the running of the adult service at Charing Cross. We hope this speciality in gender will further develop and will enable us to improve the transitions young people make into the adult services.

Our strong relationships with the London Borough of Camden and Camden CCG have led to sustained investment in our children and young people's (CYP) services. The Trust continues to provide leadership to develop and deliver the Thrive CYP mental health model. Our schools based work in Camden recently attracted the positive attention of the Health and Education Parliamentary Select Committees.

Both our adult and Portman Clinic services continue to offer high quality therapeutic care. The Camden based Team around the Practice has established itself as a vital part of the primary care offer in the borough.

The Trust works closely with the Ministry of Justice and Public Health England to deliver support for the Family Drug and Alcohol Court Service and recently celebrated the 10th Anniversary of the Family Nurse Partnership.

Our chief executive and senior clinicians have played a critical part in developing the North Central London sustainability and transformation plan (STP) mental health plan. However, the scale of the financial challenge facing the NHS and north central London in particular has taken its toll on the resources available to deliver the plan in full.

As a leading educator of psychological therapists and child and adolescent psychotherapists the Trust has worked closely with Health Education England to develop a mental health workforce development collaborative. We have also established a National Workforce Skills Development Unit to support workforce development to deliver the Five Year Forward View for Mental Health.

During 2016/17 the Trust took a careful look at its future estate requirements resulting in the Board and Council of Governors endorsing plans to relocate within the London Borough of Camden to a new purpose built home. We hope to be able to make the move around the time that the Tavistock Clinic celebrates the centenary of its foundation.

Finally, I want to thank the staff of the Trust for their hard work and dedication and express my appreciation to our commissioners and many stakeholders. 2016/17 has been a busy and eventful year and all the signs are that will continue in 2017/18.

Rt Hon Prof Paul Burstow

Trust Chair

Performance Report

Overview

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

Statement from CEO providing perspective on performance

2016/7 has been a busy year for the Trust with a significant growth in both patients and students supported at the Trust. Despite this the Trust has been able to maintain high standards in both patient care and teaching and education, a position which has been confirmed by external regulators CQC and QAA. As a result of large increases in demand the Trust has seen an increase in waiting times for some of its services and action is in hand to address this.

The Trust is continuing to develop its work. From 1st April 2017 the Trust has taken over responsibility for the Charing Cross Adult Gender Identity Clinic making it the biggest centre of expertise for gender work in the UK.

Despite wider external pressures the Trust continues to perform well financially and has delivered a surplus (including STF Funding) of £1.327m in 2016/7.

The Trust has maintained a positive public profile. In the autumn of 2016 it featured in “Kids on the Edge” a documentary programme on Channel 4 which covered a number of aspects of its work with children and young people.

Statement of purpose and activities of the Trust.

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

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

- offers a wide range of generic and specialist outpatient mental health services to children, families, adolescents (CAMHS) and to adults. Whilst CAMHS comprise the majority of the Trust's patient services, through our Adult and Forensic Services (AFS) the Trust also offers a range of specialist and generic applied psychological therapy services to adults, including forensic services. Many of our services are now located in community or primary care settings.
- provides a wide range of mental health education and training, offering 14 taught postgraduate courses, 6 professional doctorates and 12 Trust certified programmes with a range of professional and clinical accreditations. In addition there is a dynamic programme of short courses for Continuing Professional Development (CPD) and career development. Courses are offered locally, nationally and internationally. The Trust enrols in excess of 2000 students each year and has strong University partnerships.

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

- is active in research into the origins of mental health problems, models of social care, and research aimed at establishing the evidence base for its treatment methods. The Trust seeks to influence and develop new ideas by research, publication and participation in policy making. During 2016/17 it has been successful in winning a NIHR Programme Grant to research effective interventions in relation to conduct disorder.
- provides an extensive programme of organisational and management consultancy to the NHS, the public, commercial, and industrial sectors.

The Trust is well known for its original and influential work in this field.

Brief history of the Trust and statutory background

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

Key issues and risks that could affect delivery on objectives

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

The Trust is fully engaged in the development of the Sustainability and Transformation Plan in North Central London.

The national contract between the Trust and Health Education England (HEE) to provide education and training has been under review, and a new contract agreed. The Trust will need to extend the reach of our training and education work, both geographically and to broader areas of the workforce. Plans are in place to achieve this through partnership with a range of NHS trusts across the country who will be working together and sharing expertise to form a workforce skills development unit. This is an exciting opportunity, but the continuation of our contract depends on good implementation of our plans and following through on changes to our portfolio to better align it to HEE's priorities. Plans for growth in the Trust are central to our strategic vision, and these include continued growth in student numbers. A lot of work has been done over the past year and we are confident that we can reach our higher target in the coming year.

A new Student Information System (SITS) has been purchased and is in the process of implementation. SITS will make a significant contribution to improving the quality and efficiency of our administration process.

The Trust is proud of its reputation for clinical quality and of the “Good” rating it received from CQC last year across all the areas of its work which they inspected. It is not complacent, however, in relation to the need to work hard to maintain and develop quality and to address waiting time pressures in some services.

The Trust is expected to deliver significant efficiency savings across many of its clinical contracts. We are determined that such pressures should neither impact negatively on waiting times, nor on quality of service delivered.

From April 2017 we have taken over, as an interim provider, the Charing Cross Gender Identity Clinic (GIC). This is the largest of the national seven Gender Identity services, with a current patient group of nearly 6000 patients. Due to the volume of demand the GIC has been facing challenges in struggling to meet the national 18 week wait time, and will continue to do so as referral numbers continue to rise. We are working closely with the service to review all processes in order to make improvements to productivity where ever possible.

NHS England is currently in the process of reviewing the service specifications for Gender Services, with the aim to standardize treatment pathways across the country and we will be working with the service to prepare for the new specifications.

Our Children’s Gender Identity development service (GIDS) has been going from strength to strength, with a doubling of staff numbers in both London and Leeds. This follows the increase in contract value from NHS England which takes account of the very significant increase in numbers of referrals over the last 18 months. We are also in the process of developing outreach clinics to improve accessibility. The waiting time is now decreasing.

This year we had a very positive independent evaluation of Family Drug and Alcohol Court (FDAC), which demonstrated that for every pound spent on the service, an additional £2.30 is saved to the public purse. We are looking at ways of ensuring the service is sustainable for the longer term. This is likely to be through Social Investment Bonds, and we are working closely with the DfE and partners to develop this model.

Our Relocation project, for which the Outline Business Case was approved in September 2015, continues to be a significant part of the Trust’s work programme. This is a major endeavour for the Trust, and its successful implementation underpins our strategic objectives. A review conducted in 2016 of the assumptions and costs involved allowed the Board and Council

of Governors to reaffirm the decision to relocate, and work will continue to agree heads of terms for a new site and to prepare a Full Business Case for the move.

Going Concern disclosure

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

Performance Analysis

The Trust regularly assesses performance. Some of the Trust's key performance indicators are outlined below. At Board level, in 2016-17 performance has primarily been reviewed and assessed by regular reports to our Trust Board which include trend data where appropriate, as indicated below.

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

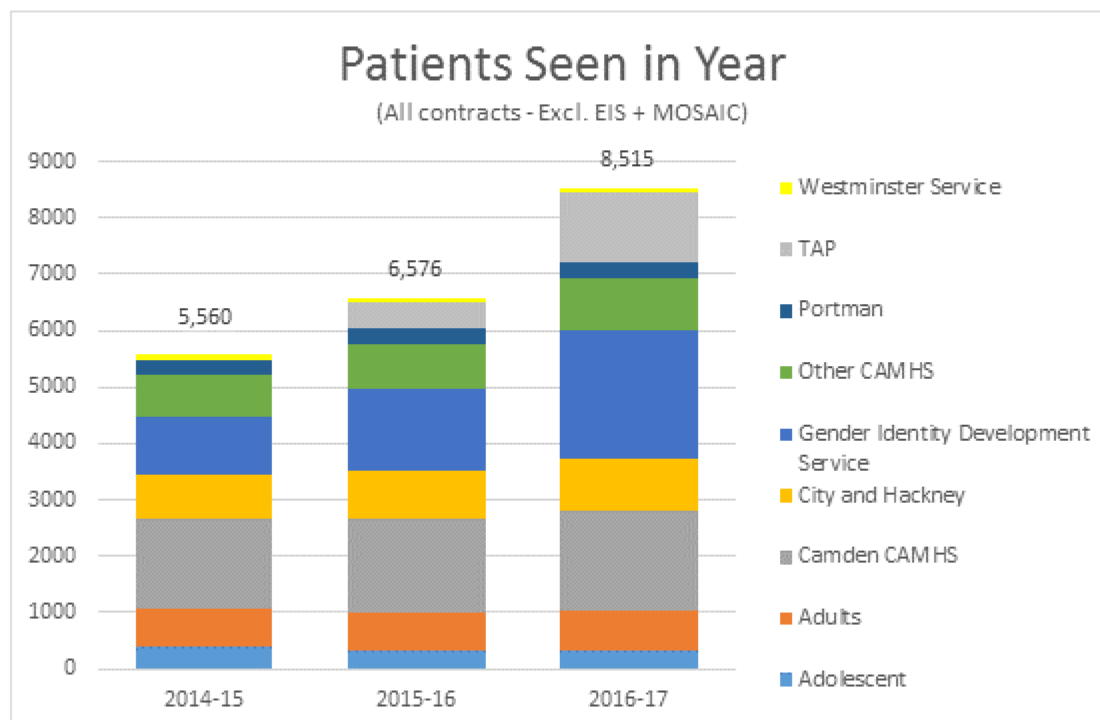
In 2015/16 the Trust developed a more integrated system for performance management, which utilises a number of dashboards. These provide the Trust with visual presentation of performance, which identify trends, illustrates where further interrogation and attention is needed and enables total visibility of the whole system instantly. These were regularly used by the Trust Board in 2016/17 to review and assess performance.

The Trust monitors the outcomes of care being delivered to patients. An overview of quality indicators for 2016/17 can be found in the Quality

Report along with full details on our compliance against the quality priorities we agreed for 2016/17. We are pleased to have met the majority of our priorities by the end of March 2017.
The Board of Directors receives a quarterly report on Quality, where performance against our Key Performance Indicators, CQUIN and Quality Indicator targets is presented. The measures examined include waiting times, DNA rates, staffing measures such as sickness rates, clinical outcome measures, and measures of complaints, incidents and safeguarding.

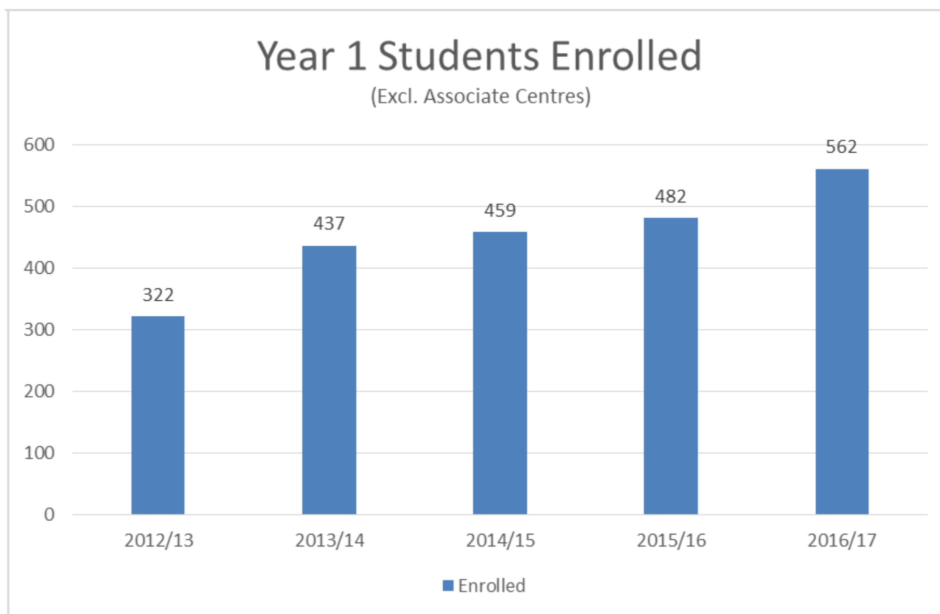
Key Areas of Performance

Trust Reach



The Trust continues to see an increase in patient numbers year on year, in accordance with our strategy for growth across services. Much of the growth has come from our nationally commissioned Gender Identity Development Service (GIDS), where demand continues to rise.
In addition, other newly established services like the Camden Team around the Practice (TAP) have contributed to this increase, with 4800 attended appointments in TAP’s first 18 months of operation.

We are in our second year of CAMHS transformation, and we have received some additional funding in order to increase the access services in Camden. We have invested in developing a telephone triage process, to speed up ensuring children and families are able to access the most helpful service as quickly as possible. We aim to increase access to an additional 30% of the population who are likely to need a CAMHS intervention by 2020 in line with the recommendations of the Five Year Forward View (5YFV), and we are already a significant way towards this target.



The Trust has also seen a significant increase in 2016/17 academic year in the number of students enrolled on its courses.

Staff Engagement

Staff sickness		Staff appraised	
1.69%	4.1%	99%	100%
Q4 Trust	Benchmark (16/17) – all NHS Trusts	2015/16	2016/17
Source: TPNHSFT HR		Source: TPNHSFT HR	

Staff motivation at work

MORALE

Staff sickness	
1.7%	4.1%
Trust	Benchmark (15/16) - all NHS Trusts

Source: TPNHSFT HR

Staff motivation at work	
Trust 2014/15 Score	3.91
Trust 2015/16 Score	3.99
Trust 2016/17 Score	3.87
MH Trust 2016/17 Average	3.91

Source: NHS Staff Survey

Staff recommend Trust as place to work	
66%	78%
Q3	Q4
National Average Q3	56%

Source: TPNHSFT HR

Disclosure and Barring Service Compliance	
% of staff with a compliant DBS Check	96%

Source: TPNHSFT HR

TRAINING

Staff appraised	
99%	100%
2015/16	2016/17

Source: TPNHSFT HR

Staff opinion on quality of appraisals	
Trust 2015/16 Score	3.05
Trust 2016/17 Score	3.05
MH Trust 2016/17 Average	3.15

Source: NHS Staff Survey

Mandatory training: % staff	
85%	94%
Q3	Q4

Source: TPNHSFT HR

Staff opinion of training	
Trust 2015/16 Score	3.97
Trust 2016/17 Score	4.01
MH Trust 2016/17 Average	4.06

Source: NHS Staff Survey

MANAGEMENT

Support from immediate managers	
Trust 2014/15 Score	4.01
Trust 2015/16 Score	3.95
Trust 2016/17 Score	3.85
MH Trust 2016/17 Average	3.88

Source: NHS Staff Survey

% staff reporting good comms between senior mgmt and staff	
Trust 2014/15 Score	43%
Trust 2015/16 Score	46%
Trust 2016/17 Score	45%
MH Trust 2016/17 Average	35%

Source: NHS Staff Survey

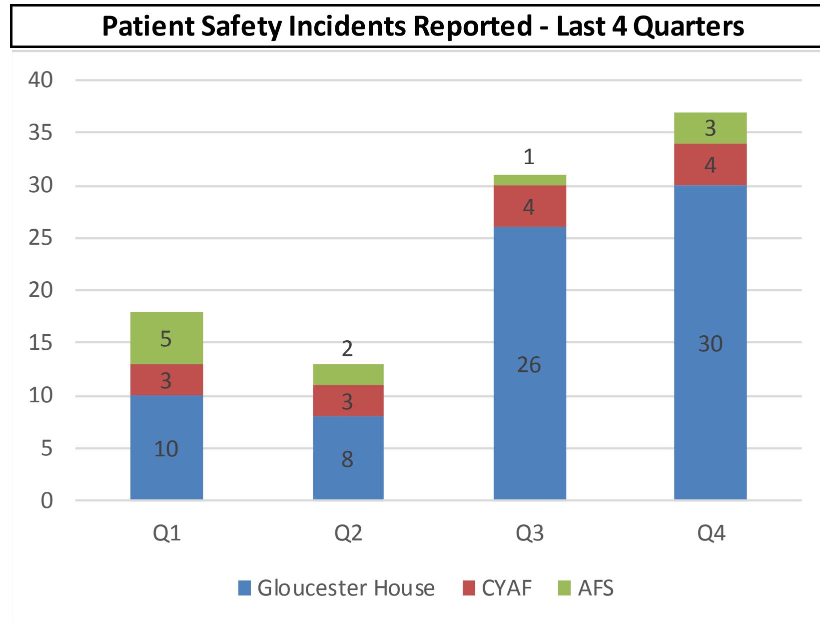
Recognition and value of staff by managers and the organisation	
Trust 2015/16 Score	3.92
Trust 2016/17 Score	3.61
MH Trust 2016/17 Average	3.56

Source: NHS Staff Survey

The NHS staff survey showed that our staff were committed and would recommend the Trust both as a place to work, and also as a place for

treatment and it was pleasing to receive a high engagement score. Sickness absence remains low compared to other mental health trusts. Further details can be found in the staffing chapter of this report.

Patient Safety



Source: TPNHSFT HR

% staff experiencing harassment
Trust 2016 Score
Trust 2015 Score
National MH Average 2016
Best MH Score 2016

% staff witnessing potentially har
misses or incidents in las
Trust 2016 Score
Trust 2015 Score
National MH Average 2016
Best MH Score 2016

Source: 2016 National Staff Survey - TPNHSFT

Safeguarding aler

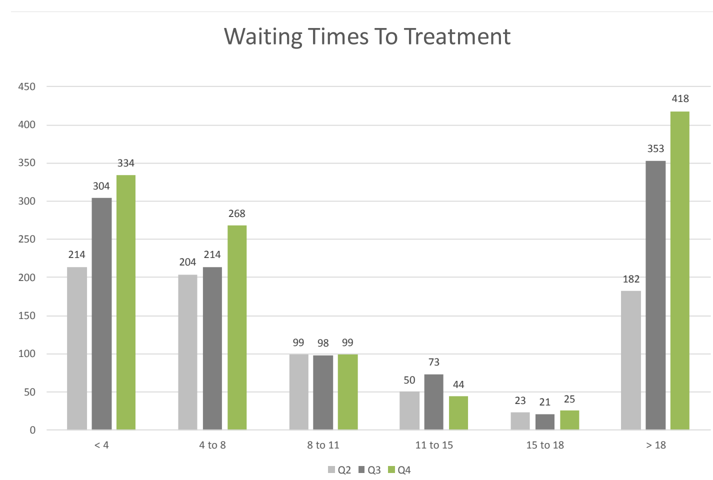
The Board encourages an open and transparent culture throughout the Trust, and feels the learning that can be taken from incidents is one of the best ways to improve the quality of our services. Gloucester House has completed its first full year with a third class, with referrals continuing to rise. The higher number of children has led to an increase in the number of incidents but numbers are lower per child than they have been in the past. All Serious Incidents are reported to the Board and the full investigation reports are considered by the Clinical Quality Safety and Governance Committee which provides assurance to the Board about the adequacy of the investigation and the associated action plan to address any lessons learned. The lessons learned from both incidents and complaints are shared with the relevant team, and also at induction and mandatory training events and via the quarterly Quality News, an internal communication to all staff. A Trust-wide 'learning from incidents' event is planned for later in the year.

Outcomes

The Trust monitors the outcomes of care being delivered to patients. An overview of quality indicators for 2016/17 can be found in the Quality Report along with full details on our compliance against the quality priorities we agreed for 2016/17. We are pleased to have met the majority of our priorities by the end of March 2017. We missed our targets for the collection rate of the Goal based Measure for children although achieved the target for 80% of those completing the measure showing improvement. For adults, 64% of patients completing measures showed improvement, missing the challenging target of 70% showing improvement on the measure. For the coming year we have identified two quality improvement priorities focussed on outcome measures in order to improve in this area.

Our DNA rate for patient first appointments remained at 10%. Our Experience of Service Questionnaires showed that 93% of patients rated the overall help they had received as good and 90% would recommend the Trust to others.

Service Responsiveness



(All contracts. Excl. First Step, MOSAIC, TAP and EIS)

Q2 2016-17 = 772 First Attendances
Q3 2016-17 = 1,063 First Attendances
Q4 2016-17 = 1,188 First Attendances

		15-16	2016-17			
		Q4	Q1	Q2	Q3	Q4
ESQ	Views and worries were taken seriously (Q4)	94%	93%	93%	94%	94%
	Involved in important decisions about my care (Q13)	87%	86%	87%	86%	86%
Data Collection	ESQ Scores Collected	74%	63%	72%	73%	78%

NB: ESQ report run on 12.04.17 (All contracts. Excl. MOSAIC, TAP and EIS)

	2016-17			
	Q1	Q2	Q3	Q4
No. of Complaints	12	6	13	11

Overall the Trust has seen an increased number of patients. In many services, patients are seen within our waiting time targets and in some services well before the target date. Waiting times for first appointments remained an area of concern in the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) and the under 18's Gender Identity Development Service (GIDS). Over the year, we have seen a

significant improvement in waiting times in PCPCS due to greater clarity about general intake criteria, improved intake processes and full administrative staffing. In GIDS, we are beginning to see the positive impact of increased staffing as patients who have been waiting are being seen for their first appointments. This is contributing to the high figure on the bar chart for those seen after 18 weeks.

We are pleased that even with the increased numbers of patients we are seeing, patients continue to feel that their concerns and worries are taken seriously and that they are involved in important decisions about their care.

Whilst the numbers remain small, we have seen an increase in complaints over the last year. In general we are pleased that patients feel that they can raise concerns with us and provide us with opportunities for improvement where possible. We continue to look carefully at all complaints, formal and informal, to establish whether they point to persistent problems within our services.

Education and Training

Training and education are key to the work of the Trust, and our student numbers continue to rise year by year. We have restructured our professional support services to create a dedicated student recruitment team to support prospective applicants with studying at the Trust. This team also actively facilitates engagement with faculty through the delivery of open days and bespoke marketing material. This year it also helped design and roll out the new student information management system, MyTap.

In our Education and Training services a key measure of performance has been the student survey. In 2015/16 a single survey was offered to both taught and research students on long courses. A branched structure was applied to the questions to allow students to be able to give answers relevant to their type of programme. The overall positive satisfaction response was 90% which is above comparable results from the sector. Some of our findings are shown later in the section.

Our external examiners continue to comment on the high standard of the work prepared by our students and quality and detail of the feedback which they receive from teaching staff.

The Trust continues to work at engaging and involving students in contributing to our thinking through key committees including Academic

Quality and Learning and Teaching. All course committees have student members and we have operated a Student Experience Committee as well as Dean's Forums open to all.

In summary the Trust continues to perform well and above average in many areas. We are seeing more patients and training more students than ever before.

Satisfied with Learning and Teaching		I feel better prepared for my future career		Overall satisfaction for taught courses	
Benchmark	T&P	Benchmark	T&P	Benchmark	T&P
82%	91%	78%	89%	83%	88%

In our Directorate of Training and Education, student satisfaction is high across the board. In 2016 we achieved the following results in the student survey:

- 91% of students were satisfied with the quality of learning and teaching
- 97% agreed that their course is intellectually stimulating
- 92% of doctoral students agreed that their academic supervisor(s) provide feedback that helps direct my research activities.

There are some issues that were flagged by the survey particularly in relation to some aspects of student support.

The Trust was visited for a week by assessors from the Quality Assurance Authority (QAA), the regulatory body for Higher Education in April 2016. They conducted a detailed analysis of how the Trust manages:

- The setting and maintenance of academic standards
- The quality of student learning opportunities
- The enhancement of student learning opportunities.

The assessors reported that the Trust meets national standards for higher education providers in each of these areas. In addition they identified four areas of good practice around:

- The integration of academic study with clinical practice
- Online access to library and study skills resources
- Equivalence of assessment marking across all national centres
- The strategic promotion and support of technology enhance learning.

Recommendations for future developments were made in a further four areas around feedback to students, external examiners and national centres, annual course monitoring and information to applicants.
This year the Trust also unveiled a new alumni function. Two events have so far taken place specifically aimed at our past graduates. They were very well received. This activity will help us foster a sense of community practice amongst those who have trained with us.

Financial Performance

	2016/17 £'000	2016/17 £'000	2015/16 £'000
	Excluding STF	Per Accounts	
Income			
Patient Services	25,508	25,508	22,581
Education and Training	20,995	20,995	20,519
Consultancy	459	459	656
Research	488	488	283
Sustainability and Transformational Fund income	–	1,309	–
Other	1,358	1,358	1,217
Total	48,808	50,117	45,256
Expenditure			
Pay	(32,600)	(32,600)	(29,845)
Non-Pay	(14,058)	(14,046)	(13,066)
Total	(46,658)	(46,658)	(42,911)
EBITDA before restructuring costs	**2,150**	**3,459**	**2,345**
Depreciation and amortisation	(748)	(748)	(768)
Bank interest	10	10	11
Other finance costs	(1)	(1)	(1)
Dividend to the Dept. of Health	(571)	(571)	(484)
Retained surplus before restructuring costs	840	2,149	1,103
Restructuring costs	(336)	(336)	(773)
Impairment of fixed assets	(76)	(76)	(93)
Loss on disposal of fixed assets	(62)	(62)	0
Retained surplus	366	1,675	237
EBITDA (before restructuring costs) as a percentage of income	4.4%	6.9%	5.2%

At £50,117k, income for 2016/17 was up by 10.7% compared with the prior year. Income for 2016/17 includes £1,309k from the Sustainability and

Transformation Fund ("STF"). Nil for 2015/16. Excluding STF monies, income increased by 7.9%.

Operating costs increased by 8.7% meaning that EBITDA (as a percentage of income) increased from 5.2% to 6.9%. Excluding STF monies, EBITDA margin decreased to 4.4%.

Surplus, before restructuring costs, increased (compared with the prior year) by 94.8% to £2,149k and represents a margin (on income) of 4.3% or 1.7% if STF monies are excluded.

The Trust's Control Total for 2016/17 was £800k (including STF core allocation monies of £500k). The Trust actually achieved a Control Total of £1,813k (of which £1,309k was STF monies). The following table reconciles the retained surplus to the Control Total:

	£'000
Retained surplus	1,675
Add back:	
- Impairment of fixed assets	76
- Loss on disposal of Fixed Assets	62
Control Total achieved	1,813
Control Total required	800
Surplus over required Control Total	1,013

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

Media Work

The Tavistock and Portman NHS Foundation Trust collaborated with Century Films in the production of a documentary series relating to its work with children and young people Kids on the Edge which aired in November and December 2016.
We have received filming requests in the past, but a combination of factors made this the right opportunity and Century Films and Channel 4 the right partners. We felt it was important that we have an active voice in the current debate about mental health, and highlight the expertise of our world renowned experts. Consultation with our patients revealed an eagerness to 'tell their stories' and help defeat mental health stigma by providing examples and inspiration for people living with mental health issues who have not yet felt able to seek help.
The producers from Century Films demonstrated care, compassion, and a willingness to spend considerable time familiarising themselves with the Trust and our ethos before beginning filming.
We were also pleased with Channel 4's desire to push beyond a superficial treatment of mental health issues and delve into the complexity of providing mental health treatment for young people.
The series aired Wednesday nights on Channel 4 at 10pm, and total viewership for the series was nearly 2.5 million.
We facilitated interviews with nearly all major UK newspapers including a cover article in the Times Sunday magazine, cover of the Observer magazine, online media including Huffington Post, The Pool, and Guardian Social Network, and interviews with writers from Reuters, Time Magazine, and the New Statesman, and another cover feature in Children and Young People.
We have also had opportunity to hold background briefings with influential journalists, including Helen Lewis, writing for the New Statesman, Janice Turner, features editor of the Times, and Sarah Ditum, also of the New Statesman. We also formed relationships with Lin Taylor writing for Reuters, Tim Adams of the Observer, and Derren Hayes, editor of Children and Young People Now.
We analysed 65 pieces of media coverage mentioning the Tavistock and Portman NHS Foundation Trust and the documentary project, during the period of September through to start of December, and 33 pieces of coverage in the preceding 3 month period from July through to September.

Environmental Performance

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

The Trust's priorities are to:

- Create secure waste compound for the storage use of WEE items and office furniture for recycling.
- Investment in energy reduction lighting in all office refurbishments.
- Continue to promote culture of change for waste and energy

The Tavistock main site is poorly insulated and as a consequence this makes the structure hard to heat efficiently. Its layout and lighting design can also lead to poor visibility within the office environment.

Over the course of 2016/17 we have initiated a programme for the replacement of all the old florescent lighting in office upgrades and communal areas to LED efficient lighting.

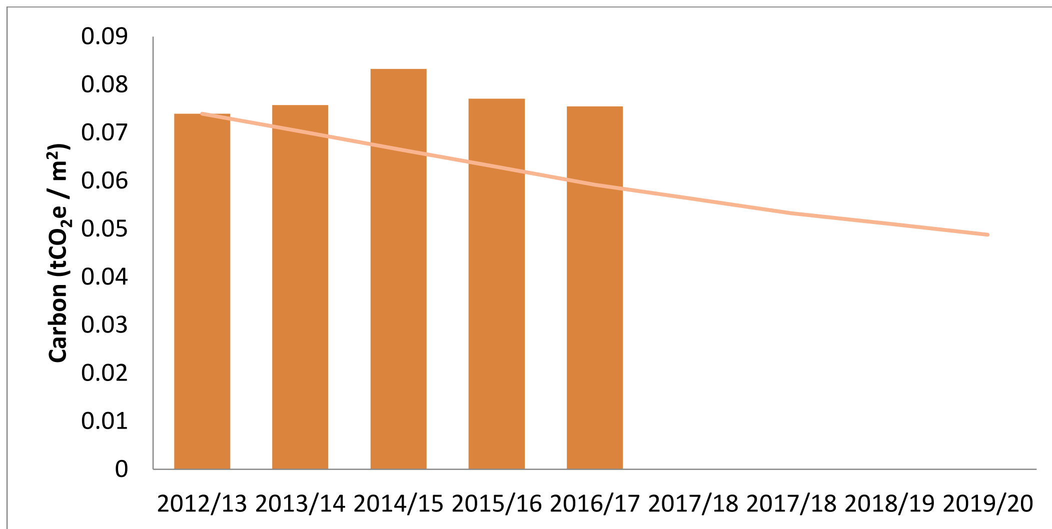
We have better managed our energy consumption due to the improvements made to the Building management system (BMS), despite a prolonged winter season and an increase in both building use and staff numbers.

The Trust's environmental impact is proportional to the number of people it employs and the floor space of the Trust's buildings. The table below shows how floor space increased from 2014/15 to 2015/16 but has remained unchanged since, the number of staff have remained broadly similar. The increase in floor space was due to a large two story expansion at The Tavistock Centre.

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

This data has been used to normalise our direct emissions and compare progress against our target of 34% (Brown line) reduction by 2019/20. It can

be seen from the figure below that the Trust's primary emissions have broadly stayed flat when the organisation is normalised by floor space. The percentage reduction against the base year is shown above the corresponding bar.



The Trust is still working towards a figure of zero waste to landfill and hopes to achieve the NHS target of zero paper use by 2018 .The Trust has recognised the importance of placement and the utilisation of recycling bins. Additional green food waste bins are to be introduced to help with segregation of food waste for improved data collection. Cycle and motor cycle spaces are covered and additional secure cycle area is to be put in the underground car park.

Our priorities and targets for the future

- To send 0% waste to landfill
- Nominated paperless office space by 2018
- Build on current Trust Cycle Strategy
- Continued commitment to energy reduction and car use

Progress on priorities:

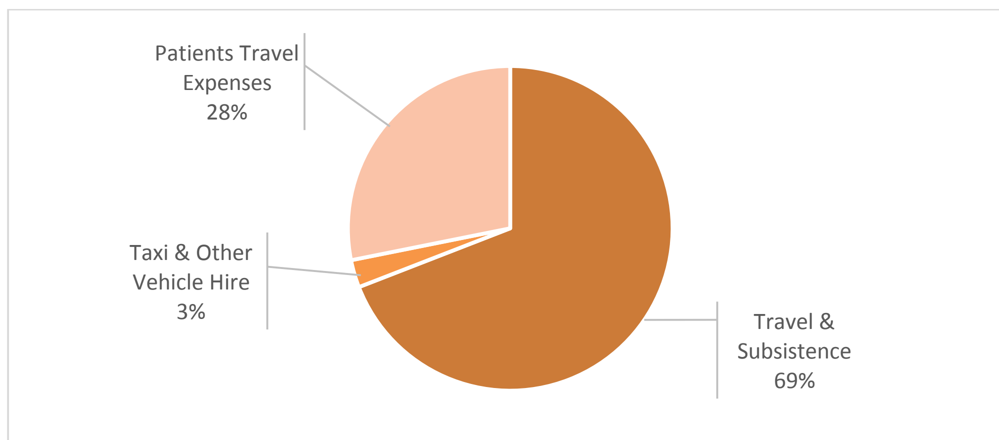
The Trust has reduced the percentage of waste to landfill during the GIDS office refurbishment. This was achieved by retaining a lot of the redundant office equipment for reuse within the trust and only disposing of those items damaged beyond repair. The Trust has reinforced a culture of behaviour change within departments and the use of paper trying to achieve the NHS target of zero paper use by 2018.

The Trust has embedded cycle use with staff, students and visitors. We have introduced covered parking spaces for cycle and motor cycle users. We are initiating secure motor cycle and bike space in the underground car park by 2017.
BMS has increased the control of the Trust's heating system. We have put in place a maintenance programme to continually monitor the control valves and pumps to aid efficiency in the delivery of the heating. A programme of new LED lighting with movement and light sensor control is to be implemented 2017.
Car use as a means of travel to the Trust by staff has been reduced again in 2016/17. Within the last 12 months we have reduced the number of car users by allocating more parking areas for visiting lecturers. We are currently reviewing the Trust car parking policy to encourage users to seek alternative means of getting to the trust. A vehicle recognition system is to be introduced to better monitor the car park for nominated drivers and avoid misuse.
We can improve local air quality and improve the health of our community by promoting active / non-carbon intense travel – for our staff, patients and public that use our services. We also support a culture of active travel to improve staff wellbeing and reduce sickness; an example of this is providing secure cycling storage for employees. Our impact from travel is shown as shown in table below.

Category	Mode	2013/14	2014/15	2015/16	2016/17
Visitor Travel	tCO_2e	114	130	154	154
Business Travel	tCO_2e	145	219	253	262
Staff commute	tCO_2e	160	169	168	168

Staff commuting impact is estimated from total number of staff on site and average distances travelled from National Travel Survey figures. The Trust is aiming to improve its knowledge of lengths and type of staff commuting in the next year as we recognise that the national survey does not accurately reflect our staff commutes profile given our London location. This will enable the Trust to better model emissions due to staff commuting and implement

programs to reduce the environmental impact of staff commuting. Our business travel impact has been estimated from the Trust spend profile. Whilst we understand how our travel spend is split as shown below, we do not understand the carbon impact of each of the areas and we plan to improve our understanding of this in the coming year to develop mitigation strategies.



Social and Community Work

2016/2017 has seen a large increase in the active involvement of patients, carers and the public in our day to day service. Last year the aim was to increase the amount of engagement work and include more teams at local level working in the community as well as those based in the Tavistock Centre. The aim was to find ways of working in areas where active patient and carer involvement is not straightforward for clinical reasons. Over this year we have connected with many of these teams and services to share the overall aims of Patient and Public Involvement.
Clinical teams are now working with the involvement team to develop our next steps. This collaboration has been strengthened through the successful project to involve patients and carers more closely in staff recruitment. We now include a patient, carer or family member on all clinical interviews where the team requests this. With over one panel a week, the plan has seen the involvement team forge positive relationships between staff and service users in a non-clinical setting.
Patients and carers are also represented at key meetings to review the quality of our clinical services such as the Quality Stakeholder Group, and

the Clinical Quality Review Group, our regular meeting with our commissioners to review the quality and safety of our clinical services

With this development in relationships the established patient groups are developing, and more are being created. The former Adult Reference Group, changed their name to Getting Together: This was service user lead designing their own branding bringing both reflective and proactive advice and guidance to the Trust on how the patient journey feels and providing feedback on upcoming suggestions for the Trust's development.

The young people's group, now firmly established as the 'Pizza Session' is running with high energy and interaction from the young people, siblings and some parents who have become part of the fun – normally at the call of the young people. It is a fully interactive group with ideas coming from all kinds of teams across CYAF services. It is generously sponsored by Franco Manca Pizza in Belsize Park and the Trust and young people extend their gratitude. This year there has been an ongoing art project, where many of our young people have created work that will be on display outside Swiss Cottage Tube station until 2019. There has been interest in developing mental health apps for mobile phones in conjunction with the Anna Freud Centre. There has also been a film screening for the CYAF services at a private screening room in Camden, where younger CYAF patients and their families watched Pixar's Inside Out, a film about emotions, giving the young people a chance to talk with some of our psychiatrists about feelings and dealing with them. The Trust is grateful to Digital Cinema Media for their sponsorship.

There has been a small but active group of parents who have been meeting to establish a parents' support group. This work is being supported by the involvement team, it has yet to find a perfect time as different families across the services have such different schedules and appointment times.

Our Adult Primary Care services, Team Around the Practice (TAP) in Camden, and Primary Care Psychotherapy Consultation Service (PCPCS) in City and Hackney are well underway in expanding their user involvement groups, requested and led by patients with the support of the involvement team. Adult Primary Care Services mounted a well-received exhibition of photography hosted in the Tavistock Library wing this year with great service user attendance. The exhibition is moving to a location in Hackney to provide easier access for some service users.

The Patient and Public Involvement Team has been glad to re-commence and host, in collaboration with many other trusts, the Pan London Mental Health Forum. There are lots of Involvement groups we can work with around London, but as many deal with physical health issues they are not always the right platform for us to discuss the needs of our particular demographic – outpatient mental health. This forum was well attended and we will now host it on a quarterly basis, moving forward with involvement of service users for improvement of mental health services.

This year the Bid for better panel awarded money to the following projects for improved patient experience:

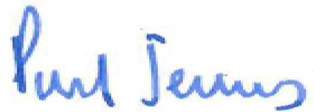
- Portman clinic young people's waiting room
- Refugee team Recipes of Life
- Family Drug and Alcohol Court patient library
- Primary Care Psychotherapy Consultation Service Photography group
- African Physical Training Organization computers for deaf and mute service users
- Peoples center 4 change music project

We look forward to hearing feedback from patients on these projects and hope that as with many other groups, the initial group develops and becomes an established involvement activity.

The plan to embed Experience of Service Questionnaire (ESQ) and Family and Friends (FFT) test feedback into teams has developed well this year. The involvement team now work directly with team leaders and team assistant psychologists to get the written feedback into team meetings and commissioner meetings. There have been many improvements that arise from service user feedback, from teams thinking about how they can improve the waiting room experience, down to swapping a staff room for a clinical room to better accommodate a baby buggy. The feedback has been useful for improvements where possible, but also helpful for us to identify problems we cannot change in the short term such as aspects of our physical locations. This is challenging for many patients, but we are able to feed back that we understand the problem and can offer additional support where possible, particularly passing this information on to the relocation team who can think about a future Trust location, the possible amenities and aesthetics.

The Patient and Public involvement team continue to work closely with NHS England to provide monthly feedback on the Friends and Family Test, the percentage rate remains steady with an average of 91%-92% per month would recommend us. We have been looking into the processes for the cascading of the ESQ/FFT and hope to improve and streamline this as a quality improvement measure over the next year. Over the last year the PPI team have been extending their work to include the Department of Education and Training (DET). Patients are increasingly involved in selection of candidates for some of our courses and in direct training delivery. The work is at an early stage but has been well received by DET.

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

Signed 

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

Accountability Report

Directors' Report

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

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

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

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

The Trust's intention is to continue to improve productivity, engage with commissioners and local organisations, and work in innovative ways to ensure that it continues to provide the high-quality services that its reputation is based upon. The overall strategy is for measured growth to enable our services to be available more widely.

In the current period of austerity, we believe that growth is still possible and will be achieved through close collaboration with commissioners and

partners to re-shape services and trainings, building on the models we have developed.

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

We completed optimisation of a new patient record system in late 2016, in order to give us an opportunity to radically change the way we work, moving from largely paper-based records to holding all records on the system, providing clinicians with ready access to information to support care. There is still work to be done to allow us to take full advantage of the opportunities it affords us, but improvements in the quality and accessibility of data on our clinical work is already apparent. We are also developing our strategies for technology-enhanced learning and for the use of digital technology in our clinical services. We have begun a project to review our use of our current buildings and assess our future needs and the options available to best meet them.

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

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

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

quality improvement strategy, developed in collaboration with staff across the Trust. Whilst the Trust is drawing on established quality improvement methodologies we are actively taking up the challenge to develop a quality improvement programme which is congruent with our established psychoanalytic/ systemic, contextually aware approach to understanding mental health.

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

This year our Equalities Committee focused on BAME inclusion, mental health in the workplace, and sexual orientation. Across the year, the CEO and Chair have held a series of meetings with BAME staff to understand better BAME staff experience of working in the Trust and of processes of discrimination which may have limited career progression. The Workforce Race Equality Standard set out some initiatives to address inequality of opportunity, for example including a trained observer on all recruitment panels for positions at 8a and above. Building on staff feedback, the HR directorate have set up a career development and mentoring programme, launched in March 2017. The Board gave strong support to the development of a Trust wide strategy to address BAME inequality in our staff group and in access to and delivery of our education and training programmes. The development of the strategy is led by the Equalities Committee and a draft strategy will be presented to the June Board 2017. Initiatives around mental health included raising the profile of our Staff Consultation Service, training mental health first aiders and planning two events for staff to look at what support we offer staff. For our focus on sexual orientation we continued to work with Stonewall to review our training and education provision in relation to LGBT issues. The Committee has led on extending the collection of data on protected characteristics across our patients, staff and students. With more extensive data we can explore questions of equity of access and suitability of provision for those with protected characteristics.

The Trust regards consultation with staff as essential to our work, and works hard to keep staff informed of issues of concern to them. Measures include

our Joint Staff Consultative Committee, the newly introduced Leadership Group conferences, frequent meetings between staff and directors, monthly email newsletters from the CEO, emailed summaries of each Board meeting circulated to staff, and feedback on the results of the staff survey. Communications address issues such as the financial situation of the Trust and wider NHS, cultural issues such as our approach to the Duty of Candour or our work supporting staff, as well as more local team or clinical issues. These measures are in place to encourage the involvement of staff with the aims and performance of the Trust.

The Trust has policies in place to ensure that all directors, staff and governors observe the Trust's values and accepted standards of behaviour in public life. All directors and governors meet the 'fit and proper' person test as described in the Trust's licence as issued by Monitor (now known as NHS Improvement).

The Trust has in place a Board Assurance Framework and Risk Register which highlight the key risks facing the Trust. These are reviewed on a regular basis by the Board of Directors. Three key risks currently facing the Trust are: management capacity; achieving productivity savings; generating income growth. In terms of management capacity, the Trust is seeking, where possible to pool resources with other organisations. More critically, the Trust regularly reviews its strategic plan to review pressures and resolve tensions over priorities. In terms of efficiencies, the Trust has annual targets and regular reviews to ensure these are met. Generating income growth is, perhaps, the largest challenge facing the Trust. A review of the mechanisms and resources dedicated to this aspect of the Trust's activities is in the process of being undertaken in order to increase the Trust's capacity in this area.

Quality is central to the Trust's strategy and directors focus consistently on key aspects of providing safe, effective care and positive patient and carer experience. The Annual Report, including the Quality Report, Annual Governance Statement and Board Assurance Framework explains in further detail the Trust's arrangements for the governance of service quality. These arrangements ensure that services meet the best possible standards. Directors are provided with high quality information which is robustly examined to determine whether standards are being maintained. Where there are indications that we may fall short of standards, remedial action plans are devised, implemented and reported upon. The Trust has a formal

quality governance structure which is formally linked to the Board through the Clinical Quality Safety and Governance Committee chaired by the Medical Director. The Trust is compliant with Monitor's quality governance framework. The Board receives quarterly quality and performance reports, service line reports, and patients present their stories to the Board. Board members have the opportunity to examine service quality in more detail through membership of relevant committees and work streams and a programme of visits to clinical services

A full list of the name of the directors can be found in the Governance section of this report. The register of the interests of directors and governors is published on our website, www.tavistockandportman.uk/about-us

As far as the directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

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

It is the responsibility of the directors of the Tavistock and Portman NHS Foundation Trust to prepare the annual report and accounts, and we consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Foundation Trust's performance, business model and strategy.

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

In 2016/17, the Trust's total income from the provision of goods and services for the purposes of the health service in England was 81% of the total income (2015/16, 73%). A further 13% of income was received from local authorities, and 3% from other central government bodies (2015/16, 16% and 8% respectively). The remaining 3% with bodies external to government (2015/16 3%) was used to ensure the sustainability of the organisation and had no adverse effect on the provision of healthcare.

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

Better Payment Practice Code

The Trust has a target of 95% being paid within the agreed terms. The Trust paid 90% of the number of invoices within the target and 92% of the total value of invoices was paid within target.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

Remuneration Report

Annual Statement on Remuneration

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

The Executive Appointment and Remuneration Committee met four times: to consider the recruitment and remuneration of the Deputy CEO and Director of Finance; to consider the remuneration and recruitment of the Nursing Director; to ratify the decision of the Clinical Excellence Awards Committee; and to conduct the annual review of remuneration of the executive directors of the Trust.

Senior Managers' Remuneration Policy

Senior managers are normally employed on permanent contracts. Those who are medical consultants are remunerated under the 2003 Consultants Contract. Non-medical senior managers are generally remunerated under Agenda for Change, with the exception of the Chief Executive, the Deputy Chief Executive and Director of Finance, and the Director of Education, who are paid on spot salaries. Notice periods are in accordance with national agreements, and there are no special provisions for termination periods, payments for loss of office or service contract obligations.

All Trust staff, including Directors, are generally paid either on Agenda for Change terms and conditions or on a medical consultant's scale, both of which are determined by the NHS nationally. Salaries are set in accordance with the rules of the Agenda for Change payscales and employees are not consulted on these. Where Directors and Non-Executive Directors are not paid through the Agenda for Change system their remuneration is set following a review of the salaries of the other members of the board of directors, and comparisons to the remuneration of similar roles across the NHS. The Trust does not currently consult with employees in setting the senior managers' remuneration. In looking at benchmarking comparisons for

remunerations, comparisons are drawn from a range of Mental Health Foundation Trusts, and separately from a number of trusts with comparable turnovers, in order to establish what the average remuneration is across the sector.
The intention of the Foundation Trust in the next financial year is to maintain the current system of remuneration, which does not include any performance based awards, and in which changes to Agenda for Change salaries and issues of fairness are always taken into consideration in determining directors' remuneration.

Annual Report on Remuneration

Service Contracts for Senior Managers

	Date of commencement	**Unexpired term**	**Details of notice period.**
Professor Paul Burstow	November 2015	One year Eight months	Three months
Professor Dinesh Bhugra	November 2014	Six months	Three months
Ms Helen Farrow	November 2016	Two years Six months	Three months
Ms Jane Gizbert	November 2014	Six months	Three months
Mr David Holt	Reappointed November 2016 (second term)	Two years Six months	Three months
Ms Edna Murphy	November 2014	Six months	Three months
Ms Chris Caldwell	November 2016	No term of office	Six months
Dr Sally Hodges	November 2015	No term of office	Six months
Mr Paul Jenkins	February 2014	No term of office	Six months
Ms Louise Lyon	March 2008	No term of office	Six months
Mr Terry Noys	October 2016	No term of office	Six months
Mr Brian Rock	January 2015	No term of office	Six months
Dr Rob Senior	December 2006	No term of office	Six months
Dr Julian Stern	February 2017	No term of office	Six months

Remuneration Committee – Composition & Attendance

Composition & Attendance at Remuneration Committee Meetings 2016/17

	April 2016	May 2016	Nov 2016	Mar 2017
Paul Burstow (Chair)	✓	✓	✓	✓
Paul Jenkins	✓	✓	✓	x
David Holt	✓	✓	✓	✓
Ian McPherson	✓	x	n/a	n/a
Jane Gizbert	✓	✓	✓	✓
Edna Murphy	✓	✓	✓	✓
Dinesh Bhugra	x	✓	✓	✓
Helen Farrow	n/a	n/a	✓	✓

The Director of Human Resources provided advice to the Committee.

Payments for Loss of Office

There were no payments made to individuals defined as senior managers within the NHS for loss of office in 2016/17, however, there is a provision in the accounts for a payment to be made in 2017/18.

Payments to Past Senior Managers

There were no payments made to past senior managers in 2016/17.

Remuneration of Senior Managers

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

Single Total Figure Remuneration of Senior Managers

Name	Title	Salary and fees £000, bands of £5k	Taxable Benefits £s, to the nearest £100	Annual performance-related bonuses £000, bands of £5k	Long-term performance-related bonuses £000, bands of £5k	Pension-related benefits £000, bands of £2.5k
Jenkins, P	Chief Executive	150-155	0	0-5	0-5	60-62.5
Noys, T	Deputy Chief Executive and Director of Finance	45-50	0	0-5	0-5	17.5-20
Senior, R	Medical Director	140-145	0	0-5	0-5	107.5-110
Hodges, S	Children, Young Adults and Families Director (CYAF)	105-110	0	0-5	0-5	112.5-115
Stern, J	Adult and Forensic Services Director (AFS)	135-140	0	0-5	0-5	105-107.5
Lyon, L	Director of Quality and Patient Experience	85-90	0	0-5	0-5	0-2.5
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	105-110	0	0-5	0-5	42.5-45
Caldwell, C	Director of Nursing	40-45	0	0-5	0-5	85-87.5
Young, S	Deputy Chief Executive and Director of Finance	45-50	0	0-5	0-5	0-2.5
Smith, J	Commercial Director	75-80	0	0-5	0-5	0-2.5

Avery, T	Director of Information Management & Technology	25-30	0	0-5	0-5	(7.5)-(10)
de Sousa, C	Director of Human Resources	75-80	0	0-5	0-5	27.5-30
Thomas, L	Director of Marketing & Communications	70-75	0	0-5	0-5	57.5-60
Wyndham Lewis, D	Director of Information Management & Technology	115-120	0	0-5	0-5	n/a
Jones, E	Director of Nursing	30-35	0	0-5	0-5	0-2.5
Paul, Burstow	Chairman	35-40	0	0-5	0-5	n/a
Helen, Farrow	Non-Executive Director	0-5	0	0-5	0-5	n/a
Jane, Gizbert	Non-Executive Director	5-10	0	0-5	0-5	n/a
David, Holt	Non-Executive Director	10-15	0	0-5	0-5	n/a
Edna, Murphy	Non-Executive Director	5-10	0	0-5	0-5	n/a
Dinesh, Bhugra	Non-Executive Director	5-10	0	0-5	0-5	n/a

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

The median salary of the Trust's staff is £27,500 (£31,402 in 2015/16). The midpoint of the highest paid director is £150,000 (£150,000 in 2015/16), which gives a ratio of 5.45 (4.78 in 2015/16) times median pay of the Trust's staff.

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

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

Travel and subsistence expenses totalling £1,882 were reimbursed to three directors, out of 15 in total, and expenses totalling £5,140 were reimbursed to six of the 19 governors. By comparison in 2015/165 travel and subsistence expenses totalling £793 were reimbursed to three governors during the year, out of 31 governors in total; and £3,213 reimbursed to eight directors, out of 14 in total.

Two members of staff are paid more than £142,500 pa. They are the Chief Executive and Medical Director. Their salaries were agreed by the Remuneration Committee when they were recruited to the role or at the annual salary review. The annual salary review involved benchmarking salaries across similar Foundation Trusts within the NHS, and salaries within the Trust being set at the level judged necessary to attract and retain the required calibre of applicant, whilst providing value for money for the Trust.

Pensions Benefits

Name	Title	Real Increase in Pension at Pension age (bands of £2500)	Real Increase in pension lump sum at Pension age (bands of £2500)	Total accrued pension at pension age 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016
Jenkins, P	Chief Executive	5.0-7.5	0-2.5	35-40	80-85	829	83	746
Noys, T	Deputy Chief Executive and Director of Finance	0-2.5	0-2.5	0-5	0-5	11	5	0

Senior, R	Medical Director	5.0–7.5	12.5–15.0	50–55	160–165	0	0	0
Hodges, S	Children, Young Adults and Families Director (CYAF)	5.0–7.5	12.5–15.0	25–30	75–80	418	90	328
Stern, J	Adult and Forensic Services Director (AFS)	5.0–7.5	12.5–15.0	65–70	200–205	1539	140	1398
Lyon, L	Director of Quality and Patient Experience	0–2.5	0–2.5	0–5	0–5	0	0	0
Rock, B	Director of Education and Training and Dean of Postgraduate Studies	5.0–7.5	0–2.5	20–25	55–60	395	36	359
Jones, E	Director of Nursing	0–2.5	0–2.5	0–5	0–5	0	0	0
Caldwell, C	Director of Nursing	5.0–7.5	0–2.5	20–25	0–5	290	54	236
Young, S	Deputy Chief Executive and Director of Finance	0–2.5	0–2.5	0–5	0–5	0	0	0
Smith, J	Commercial Director	2.5–5.0	0–2.5	35–40	105–110	689	12	677
Avery, T	Director of Information Management & Technology	2.5–5.0	0–2.5	15–20	40–45	237	10	208
de Sousa, C	Director of Human Resources	2.5–5.0	2.5–5.0	10–15	20–25	104	19	85
Thomas, L	Director of Marketing & Communications	2.5–5.0	0–2.5	0–5	0–5	20	10	10
Wyndham Lewis, D	Director of Information Management & Technology	0–2.5	0–2.5	0–5	0–5	0	0	0

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

Staff Report

Our staff are pivotal to our success in delivering excellence in care, education, training and research. We have a rich mix of staff and wealth of experience which contributes to our continuing development as specialist mental health and education provider.
In 2016/17 we formalised our organisational development and people strategy which focuses on the skills, behaviours and the unique role that our staff will play to position our organisation in the wider and ever changing healthcare environment.

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

Our workforce make up

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

Staff costs					
			2016/17		**2015/16**
	Permanent £000	**Other £000**	**Total £000**		**Total £000**
Salaries and wages	25,717	155	**25,872**		23,859
Social security costs	2,824	-	**2,824**		2,216
Employer's contributions to NHS pensions	3,086	-	**3,086**		2,875
Pension cost - other	-	-	**-**		29
Termination benefits	336	-	**336**		773
Temporary staff	-	732	**732**		784
Total gross staff costs	**31,963**	**887**	**32,850**		**30,536**
Recoveries in respect of seconded staff	-	-	**-**		-
Total staff costs	**31,963**	**887**	**32,850**		**30,536**
Of which					
Costs capitalised as part of assets	-	-	**-**		-

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

Average number of employees (WTE basis)					
			2016/17		2015/16
	Permanent Number	Other Number	Total Number		Total Number
Medical and dental	42	-	**42**		39
Administration and estates	227	-	**227**		196
Nursing, midwifery and health visiting staff	24	-	**24**		21
Scientific, therapeutic and technical staff	270	-	**270**		189
Social care staff	-	-	**-**		24
Agency and contract staff	-	11	**11**		22
Bank staff	-	49	**49**		35
Other	-	-	**-**		5
Total average numbers	**563**	**60**	**623**		**531**
Of which:					
Number of employees (WTE) engaged on capital projects	-	-	**-**		5

Gender analysis

Gender	Directors	Other senior managers	All other staff
Female	6	2	478
Male	8	2	152

Sickness absence information

Sickness absence measure	Q1	Q2	Q3	Q4
Sickness absence rate (%) average per month	1.85	1.44	1.37	1.40
Sickness absence rate (%) twelve month rolling average	1.63	1.67	1.69	1.70

Policy, partnership, diversity and inclusion

Our human resources policies are all within date and have undergone an appropriate review process. We have a number of policies which set out the Trust's commitment to providing equal and fair access to service, employment and training. We confirmed our commitment to diversity and inclusion through our equality delivery system and workforce race equality standard submissions.
Diversity and inclusion are an integral part to our work and continued successes over the years. We have, for some time, had an established equal opportunities policy which is up to date and confirms our commitment to understanding, meeting and working with our diverse staff, students and service users. We bring our diversity and inclusion work to life through a range of methods and we have a long established equality, diversity and inclusion committee which brings together the different strands of our work.
In 2016/17 we complied with our statutory requirements and published our workforce race equality standard submission; an integrated equality and diversity report; and, set our four year diversity and inclusions meeting the specific duties set out in the public sector equality duty.
We have excellent working relationships with our trade union colleagues and collaborate on many work programmes. This approach has been longstanding and we continue to develop our working arrangements so that we can respond to change quickly and ensure that staff are supported.

Sharing information and consulting with our staff

The chief executive and other directors host open meetings every month, to which all staff are invited, to ensure that staff are kept informed of developments and have an opportunity to raise any issues or concerns.
This is complemented by monthly briefings to all staff following each Trust board meeting, a daily email bulletin which was launched in 2017 and a wide range of printed newsletters.
Our staff governors have, at various points throughout the year, convened meetings to allow staff to share their experiences of working in the organisation and to ensure that their views are represented at the council of governors.

Staff experience and engagement

The NHS Staff Survey took place between September and December 2016. For a second year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.
This year the survey was sent to 556 staff and 321 responded giving a final response rate of 58%, a 12% increase from the previous year.
Out of the 32 key finding areas 29 have not changed compared to previous years, 2 have got worse and 1 has got better.
The following areas are our top result areas:

- We have a higher than average engagement score (4th best compared to mental health trusts and 21st best when compared to all NHS provider organisations);
- Our staff would recommend the organisation as a place to work and be treated (best mental health trust and 18th best compared to all provider organisations);
- A higher proportion of staff are happy with the opportunities to work flexibly, this was a concern area last year;
- Communication between senior management and staff is better;
- Fewer staff experience bullying, harassment, violence or aggression from service users or their relatives;
- Whilst staff witness incidents the number is smaller than our peer group.

There are some less positive findings, some which are consistent with previous years and are also with feedback we have been receiving through less formal mechanisms:

- The number of staff working additional hours continues to be a challenge;
- The level of work place stress has increased;
- That there is less resources and support;
- Staff feel, less so, that their role makes a difference to service users and that they do not receive recognition from their managers;
- That when staff feel they have been bullied or harassed by managers or colleagues they have not reported this;

- That bullying and discrimination amongst our BME staff has increased since the previous survey; and
- That a lower than average number of staff reported errors, near misses or incidents.

This year we have seen some changes in our best and less positive areas. We have also received results at both directorate and service line level which will help us to understand where we need to focus our attention and give support.

The NHS staff survey – 2016

In March we received the results from the most recent NHS staff survey. The findings were positive in most parts and placed us in the upper quartile for staff engagement. There are still a number of areas where we need to improve and actions that need to follow. The table below details the key actions and where they will be managed through.

Improvement Area	Method of Managing Actions	Responsible	Timescale
Bullying and harassment	Review the methods of raising concerns and draw on best practice from other organisations. Develop a confidential mechanism to raise concerns with action following	Chair, chief executive, director of HR and freedom to speak up Guardian	Q1 Q2-3
Staff working extra hours and workplace stress	Implement reducing the burden initiative Ensure that there is adequate coverage of reflective practice groups like Thinking Space, coffee mornings and other initiatives.	Director of technology and transformation Director of HR	Q1-4 Q2

Improvement Area	Method of Managing Actions	Responsible	Timescale
	Continue to implement the living well programme	Director of HR & director of quality and Patient experience	Q1-4
Incident reporting and learning from lessons	Implement an electronic system for reporting incidents Review existing arrangements for incident management and how lessons learned are communicated	Director of quality and patient experience	Q4
Quality of appraisal discussions	Review the revised appraisal process	Director of HR	Q2
Teams with concern areas arising from the staff survey	Commission a bespoke and focused organisational development programme for middle managers across the organisation.	Director of HR	Q2
Diversity and inclusion	Develop and implement a comprehensive workforce race equality strategy	Director of quality and patient experience	Q2

Health and wellbeing

Throughout the year we have increased our focus on health and wellbeing and taken a number of steps to implement a range of programmes that aim to support our staff to make healthy life style choices.
During the year we hosted two health and wellbeing promotion days each having in excess of a hundred attendees. Both involved promotional stands but also ways for staff to contribute to what is working well and what they

would like to see more of. As a result of our programme of work we now offer or have launched:

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

In addition to all of the above we have a number of other channels which staff seek support, when needed, these include through our HR team; our internal staff consultation service; the occupational health service which is provided by the Royal Free London NHS Foundation Trust; and our confidential 24/7 bullying helpline provided by CareFirst. We are conscious that we have multiple channels and we will be working throughout the coming year to publicise and help signpost staff should they wish to share things that concern them.

Expenditure on consultancy

The total consultancy expenditure for 2016/17 was £824k (£266k in 2015/16). This includes £40k (£32k in 2015/16) for Internal Audit.

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months:

No. of existing engagements as of 31st March 2017	3
Of which:	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	–
No. that have existed for between two and three years at time of reporting.	–

No. that have existed for between three and four years at time of reporting.	–
No. that have existed for four or more years at time of reporting.	–

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and lasted longer than 6 months:	
The number of new engagements, or those that reached six months in duration, during the time period	1
Number of these engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	–
No. for whom assurance has been requested	1
Of which...	
No. for whom assurance has been received	1
No. for whom assurance has not been received	–
No. that have been terminated as a result of assurance not being received.	–

Exit Packages

The number and make-up of the exit packages agreed during 2016/17 are detailed in the table below.
There were a total of seven redundancies in 2016/17 as a result of productivity savings to benefit the Trust in future financial periods compared to 18 exit packages in 2015/16.

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

Reporting of compensation schemes – exit packages 2015/16				
Exit package cost band (including any special payment element)				
	Number of compulsory redundancies	Number of other departures agreed		Total number of exit packages
<£10,000	–	3		3
£10,001 – £25,000	1	5		6
£25,001 – 50,000	–	3		3
£50,001 – £100,000	1	2		3
£100,001 – £150,000	1	1		2
£150,001 – £200,000	1	–		1
>£200,000	–	–		–
Total number of exit packages by type	4	14		18

Total resource cost (£)	£356,000	£417,000		**£773,000**
Exit packages: other (non-compulsory) departure payments				
	2016/17		**2015/16**	
	Payments agreed, Number	**Total value of agreements, £000**	**Payments agreed, Number**	**Total value of agreements, £000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	14	417
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	**14**	**417**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment	-	-	-	-

value was more than 12 months of their annual salary				

High paid off payroll arrangements

There were no high paid off payroll arrangements.

Governance Disclosures

Constitutional Authority

The Board of Directors is responsible for the governance, planning, and management of the Trust's activities. It 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 Team, which includes the executive directors. The Board of Directors works closely with the Council of Governors.

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

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

Council of Governors

Composition & Attendance

Composition & Attendance at Council of Governors Meetings 2016/17

Name	Type	June 2016	Sept 2016	Dec 2016	Feb 2017	Mar 2017
Natalie Baron	Public	✓	✓	×	✓	×
David Bell	Staff	✓	✓	✓	✓	✓
Christine Bury	Staff	✓	✓	✓	✓	✓
Thomas Das	Stakeholder	✓	✓	✓	✓	✓
Sue Dowd	Stakeholder	×	✓	×	✓	×
Derek Draper	Public	✓	×	✓	✓	×
Craig Griffiths	Public	✓	✓	✓	✓	✓
Angela Haselton	Staff	✓	✓	✓	✓	✓
Jo Jackson	Stakeholder	✓	×	✓	×	×
Anthony Levy	Public	✓	×	×	✓	×
Claire-Louise Leyland	Stakeholder	✓	×	✓	✓	✓
Helen Masterton*	Stakeholder	×	×	n/a	n/a	n/a
Marilyn Miller	Public	✓	✓	×	×	✓
Richard Murray	Public	✓	✓	×	✓	×
Camilla Nicholls*	Public	✓	✓	n/a	n/a	n/a
Edna O'Shaghnessy	Public	×	✓	×	✓	×
Samuel Takunda	Public	×	✓	✓	×	×
George Wilkinson	Public	✓	✓	✓	✓	✓
Kimberley Wilson	Public	×	✓	✓	✓	×

*Helen Masterton resigned in December 2016.

*Camilla Nicholls resigned in September 2016

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

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

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

The Council of Governors seeks to maintain a positive relationship with the Board and is able to raise concerns in an appropriate and effective manner. The Council of Governors periodically assesses its collective performance and communicates to the public, members and other stakeholders how it has discharged its responsibilities.
The process for managing the removal from the Council of Governors of any governor is set out in the Trust's constitution.

Constituencies

Public Constituency: The Trust has three classes within the Public Constituency, which are set according to the volume of clinical activity: Camden, for residents of the London Borough of Camden (in which the Trust has its geographical base and is the borough to which the Trust provides more services than any other single borough) has three seats; the Rest of London, for residents of all London Boroughs excluding Camden, has six seats; and the rest of England and Wales, for all residents outside of London, has two seats. All governors in this constituency are elected.
Staff Constituency: The Trust has three classes within the Staff Constituency, with two set to represent staff according to their job type and grade – Administrative and Technical, which includes staff paid on Agenda for Change bands 1 to 6, and Clinical, Academic and Senior, which includes staff paid on Agenda for Change bands 7 and above (or equivalent). The third class within the Staff Constituency is for Representatives of Recognised Staff Organisations and Trade Unions. All staff members who fall into that category are not eligible to be members of either of the other classes. All governors in this constitution are elected.
Stakeholder Governors: These are Governors who are appointed, rather than elected, from within organisations with whom the Trust has a relationship. The National Health Service Act 2006 requires that the Council of Governors has Stakeholder Governors from Clinical Commissioning Groups for which the Trust provides goods or services (the Trust has a Stakeholder Governor from Camden CCG), a Local Authority within the Trust's Public Constituency (the Trust has a Stakeholder Governor from Camden Local Authority), and any organisations that the Trust considers partnership organisations (the Trust has Stakeholder Governors from Voluntary Action Camden, the University of East London and the University of Essex).

When the Health and Social Care Act 2012 abolished Primary Care Trusts we replaced the PCT Governor Stakeholder by approaching Camden's Clinical Commissioning Group and inviting them to nominate representatives. Two representatives were appointed initially, but one representative had to withdraw, and the CCG was unable to nominate a replacement. Therefore in October 2014 our constitution was changed to allow for a Stakeholder Governor from another commissioning body to be appointed, however this role has not yet been filled.

Elections

There were no elections held in 2016/17.

Register of Governors' Interests

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

Understanding the views of members and Governors

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

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

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

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

The Members' Newsletter is the primary vehicle for communication with members, and the Trust encourages Governors to write articles for this. 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. The Trust's forward plan, priorities and strategy are published on the Trust's website, and the opinion of the members is sought both through the newsletters and via contact details provided on the website. Governors are also encouraged to develop their own ways of engaging with their members.

Roles and Responsibilities of the Governors

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

Governors have two main responsibilities: holding the Board of Directors to account for the running of the Trust (statutory responsibilities), and representing members. Governors are also responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. Governors will have the power to request that directors attend a meeting to obtain information about their Trust's performance and that of its directors.

Statutory Responsibilities

Governors have several statutory responsibilities. These are:

- Appointing the Trust Chair and the Non-Executive Directors
- Appointing the Trust's External Auditors
- Approving the appointment of the Chief Executive
- Deciding the pay and terms of office of the Trust Chair and the Non-Executive Directors
- Agreeing the process for evaluating the performance of the Trust Chair and Non-Executive Directors
- Ensuring the Trust operates in accordance with the Terms of Authorisation
- Holding the Non-Executive Directors to account for the performance of the Trust
- Approving "significant transactions"

- Approving applications by the Trust to enter into a merger, acquisition, separation or dissolution
- Ensuring that the earning of any private patient income will not significantly interfere with the Trust's primary purpose or the performance of its functions and must notify the board of their decision on this
- Approving any increase of more than 5% in private income in any financial year
- Where an amendment is proposed to the constitution in relation to the powers or duties of the council, at least one governor must attend the next annual members' meeting and present the proposal.

Representing Members

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

Board of Directors
Composition & Attendance
Non-Executive Directors

- ***Professor Paul Burstow, Trust Chair***
  Appointed November 2015. Term of office ends in October 2018.
  - Professor of Health and Social Care, City University London
  - Professor of Mental Health Policy, University of Birmingham
  - Formerly Member of Parliament from 1997 to 2015, served on the Health, Select and Public Accounts Committees
  - Formerly Minister of State, Department of Health between 2010 and 2012 (leading the development of the 'No Health Without Mental Health' strategy
  - Formerly Councillor of London Borough of Sutton
  - Formerly First Campaigns Officer and Chief Executive Office, Association of Liberal Democrat Councillors
  - Director, Indy Associates Limited

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

- ***Ms Helen Farrow, Non-Executive Director***
  Appointed November 2016. Term of office ends October 2019.
  - Experience in Investment Management
  - Formerly Director at Ignis Asset Management
  - Formerly Non-Executive Director at Royal National Orthopaedic Hospital
  - Formerly Vice Chair of the Board at Royal National Orthopaedic Hospital
  - Formerly Chair of Finance and Performance Committee at Royal National Orthopaedic Hospital

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

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

- *Dr Ian McPherson, Deputy Trust Chair*

  Appointed November 2010 and was re-appointed in October 2013 His term of office ended in October 2016.
  - Chair, Improving Health and Wellbeing UK
  - Non-Executive Director, Mental Health Division, Care UK
  - Trustee/Director, Centre for Mental Health
  - Formerly Chief Executive now Trustee/Director, Mental Health Providers Forum
  - Formerly Director, National Mental Health Development Unit
  - Formerly Director, National Institute for Mental Health in England
  - Formerly Director of Mental Health, Worcestershire Mental Health Partnership Trust
  - Formerly Director of Mental Health, North Warwickshire NHS Trust
  - Formerly Head of Adult Mental Health Clinical Psychology, North Warwickshire NHS Trust
  - Formerly Course Director / Lecturer in Clinical Psychology Programme, University of Birmingham
  - OBE in 2012 for Services to Mental Health

- *Ms Edna Murphy, Non-Executive Director*

  Appointed in November 2014. Term of office ends in October 2017.
  - Experience in Research Management and Education in the University Sector
  - Manages the Faculty of Medical Sciences at University College London – from 1 June 2017 will be Bursar, St Edmund's College Cambridge
  - Former Magistrate, Cambridge and Peterborough bench
  - Previously Executive Director of the Joint Research Office, Imperial College Academic Health Science Centre
  - Previously held various Senior Management roles, University of Cambridge and the Cambridge High Tech Sector, 6th form Governor

Executive Directors

- ***Dr Chris Caldwell, Nurse Director***
  Appointed November 2016
  - Formerly Dean of Healthcare Professions at Health Education England since 2013.
  - 20 years' experience in NHS, higher education and health policy
  - Formerly Deputy Director of Education and Assistant Chief Nurse at Great Ormond Street Hospital
  - Programme Manager at the Department of Health
  - Programme Director at the Royal College of Nursing
  - Registered children's nurse

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

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

- ***Ms Louise Lyon, Director of Quality and Patient Experience***
  Appointed March 2008.
  - Consultant Clinical Psychologist, The Tavistock & Portman NHS Foundation Trust
  - Member of British Psychoanalytical Society
  - Formerly Director of Quality and Patient Experience, Adult and Forensic Services
  - Formerly Trust Director
  - Formerly Clinical Director of Adolescent Directorate, The Tavistock & Portman NHS Foundation Trust
  - Formerly Head of Psychology, The Tavistock & Portman NHS Foundation Trust
  - Formerly Deputy Trust Clinical Governance Lead, The Tavistock & Portman NHS Foundation Trust
  - Formerly Consultant Clinical Psychologist, SW Kensington & Chelsea Mental Health Centre

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

- ***Mr Brian Rock, Director of Education and Training and Dean***
  Appointed January 2015.
  - Qualified as Clinical Psychologist
  - Formerly at Goldstone Commission
  - Formerly Director of The Children's Inquiry Trust NGO
  - Experience in the NHS since 1996
  - Formerly Consultant Clinical Psychologist, The Tavistock & Portman NHS Foundation Trust

- Involved in setting up The Tavistock and Portman NHS Foundation Trust award winning City and Hackney Psychotherapy Consultation Service
- Involved in developing and delivering training and consultation to GPs and primary care staff
- Member of the British Psychoanalytical Society
- MBA from Henley Business School

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

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

- ***Mr Simon Young, Finance Director & Deputy Chief Executive***
  Appointed Finance Director April 1996, and as Deputy Chief Executive in October 2011. Mr Young left the Trust in October 2016
  - Formerly Director of Finance at London Ambulance Service
  - Formerly at Glaxo
  - Formerly at National Can Corporation
  - Formerly Management Accountant in manufacturing industry

Composition & Attendance at Board of Directors Meetings 2016/17

Director Name	Apr 16	May 16	June 16	July 16	Sept 16	Oct 16	Nov 16	Jan 17	Feb 17	Mar 17
Dinesh Bhugra	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Farrow*	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓
Paul Burstow	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓
Chris Caldwell*	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓
Jane Gizbert	✓	✓	✓	✗	✗	✓	✓	✓	✗	✓
Sally Hodges	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Holt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Jenkins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lis Jones	✓	✓	✓	✓	✓	✓	✗	n/a	n/a	n/a
Louise Lyon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian McPherson	✓	✗	✓	✓	✓	✓	✗	✗	✗	n/a
Edna Murphy	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Terry Noys*	n/a	n/a	n/a	n/a	n/a	n/a	✓	✗	✓	✓
Brian Rock	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rob Senior	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Julian Stern*	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Simon Young	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a

* Ms Lis Jones stepped down, and Ms Chris Caldwell took the role of Nursing Director on the Board in November 2016.
* Mr Simon Young stepped down in 2016, and Mr Terry Noys took the role of Director of Finance and Deputy Chief Executive in November 2016.
* Dr Julian Stern was appointed to the board in 2015 in an interim role, and made the substantive Director of Adult and Forensic Services in 2016.
* Ms Helen Farrow commenced joined the Board as a Non-Executive Director in November 2016.

Independence of Non-Executive Directors

The Trust considers all directors to be independent.

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

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

Balance, completeness, and appropriateness of membership

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

Our executive directors come from a mixture of clinical and non-clinical backgrounds: two of our current executive directors is a registered medical practitioner, one is a registered nurse, one is a child and adolescent psychotherapist, one a clinical psychologist and one is a psychoanalyst.

The expertise of the Non-Executive Directors includes finance, management consultancy, public relations, marketing, communications, business development, commercial property, research management, healthcare management and public policy. The mix of expertise is reviewed each time a new appointment is to be made.

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

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

Performance evaluation

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

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

Register of Directors' Interests

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

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

Audit Committee

Composition & Attendance

Composition & Attendance at Audit Committee Meetings 2016/17

Member Name	17 May 2017	24 Nov 2017	17 Jan 2017	21 Mar 2017
David Holt (Chair)	✓	✓	✓	✓
Edna Murphy	✓	✓	X	✓
Ian McPherson	x	n/a	n/a	n/a
Helen Farrow	n/a	n/a	✓	✓

Mr David Holt and Ms Edna Murphy served on the Audit Committee throughout the year. Mr Holt was the Chair of the Audit Committee throughout the year.
Mr Ian McPherson left the Board and the Audit Committee on 31 October 2016.
Ms Helen Farrow was appointed to the Audit Committee on 29 November 2016 (having been appointed to the Board of the Trust on 1 November 2016).

All members of the Committee are Non-Executive Directors. Representatives from External Audit, Internal Audit and Local Counter Fraud Specialist are normally present at meetings of the Committee. The Director of Finance and the Chief Executive are also normally in attendance and other members of the management team attend as appropriate, to discuss specific agenda items. The Chair of the Clinical Quality, Safety and Governance Committee and the Chair of the Trust each attend at least once per year.
Subsequent to an Audit Committee meeting, minutes are provided to the Trust Board and at each Trust Board meeting the Chair of the Audit Committee is invited to share any concerns or issues with the Board.

The Audit Committee's Work 2016/17

During 2016/17, the Audit Committee reviewed the work and the reports of the Internal Auditors, the External Auditors, and the Local Counter Fraud Specialist. This work covered the Trust's financial and reporting systems; assurance processes, including risk management and clinical governance; and a number of corporate governance and compliance matters.
Through its work the Audit Committee has undertaken a review of the effectiveness of the Trust's system of internal control on behalf of the Board.
Internal Audit work during the year has covered a range of internal controls and potential risks, notably: Risk Management and the Business Assurance Framework, Information Governance, Data Quality, Key Financial Controls (notably around debtors), Procurement and the Care Notes system.
The Trust seeks to use its limited Internal Audit resources to focus on areas of potential weakness. Partly driven by this targeted approach, four of the five assurance reviews carried out (around Procurement, Data Quality, Care Notes and Debtors) produced a 'partial assurance' outcome, whilst the other (on the Board Assurance Framework and Risk Management) resulted in a

'reasonable assurance' conclusion. An advisory audit was also undertaken on Information Governance.

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

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

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

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

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

In addition to auditing the financial accounts, 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.

The Trust's external auditors are Deloitte LLP, who were appointed in 2015 (following a competitive tender process) for a five year period (starting in 2015/16), renewable on an annual basis – subject to satisfactory performance. The Audit Committee having reviewed the performance of Deloitte LLP during 2015/16 – on the basis of cost/value for money, independence and professional expertise – recommended their reappointment for 2016/17. This decision was ratified by the Council of

Governors. The audit fee for 2016/17 was £47,500 plus VAT. Deloitte LLP did not provide any non-audit services to the Trust during 2016/17.

The Trust carries significant non-NHS related debt and the Audit Committee, therefore, receives a report on debtors at each of its meetings. Data quality is a key issue for the Trust and significant effort has gone into addressing identified weaknesses in this area. Similarly, there were concerns around Information Governance in the first part of the year for which the Audit Committee received - and subsequently monitored - action plans to successfully address these concerns. By the year end all of the issues raised around Information Governance and the main concerns impacting data quality had been resolved.

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

The Audit Committee has reviewed the processes of other significant assurance functions e.g. reports from the Care Quality Commission and the Quality Assurance Agency for Higher Education and is satisfied that they can be relied upon to provide the necessary information to management and to the Board of Directors regarding the Assurance Framework and corporate governance. The Audit Committee has received positive assurance from management on the overall arrangements for corporate governance, risk management and internal control and is satisfied that there is an effective system of integrated corporate governance, risk management and internal control across all the Trust's activities. The Audit Committee has reviewed and confirmed the basis of the revaluation in March 2017 of the Trust's land and buildings.

The Audit Committee has continued to develop its focus on Risk Management and corporate governance processes in accordance with guidance from NHS Improvement and others. This has included in-depth reviews and presentations by management to the committee of a number of significant risks on the Strategic Risk Register. The Trust's Risk Strategy, Policy and Procedures have been reviewed and updated during the year and were approved by the Board at its meeting of 28 March 2017. In line with Internal Audit recommendations, the Trust's Business Assurance Framework

has been updated and the Board was provided with formal training, in terms of both managing risk and on local counter fraud, during the period.

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

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

Non-Executive Director Appointment Committee

Composition & Attendance

Member Name	May 2016	September 2016
Paul Burstow (Chair)	✓	✓
Paul Jenkins	✓	✓
David Bell	✓	✓
Dinesh Bhugra	✓	✓
George Wilkinson	✓	✓
Lars Fischer/Marilyn Miller	X	✓

The Non-Executive Director Appointment Committee is a committee of the Council of Governors. It is chaired by the Trust Chair, and there are three Governor members, one Non-Executive Director member, and one Executive Director member, ensuring that appointments are Governor led, but incorporate the views of the Board of Directors on the skills, qualifications and experience required for each position. The Director of Human Resources, Mr Craig De Sousa, attends the meetings in an advisory role.

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

The Committee met twice over the course of the year, to consider the re-appointment of Mr David Holt, whose first term of office was due to end in October 2016, and to plan the recruitment to replace Dr Ian McPherson, whose final term ended on 31st October 2016. Ms Helen Farrow was appointed in November 2016 as the new Non-Executive Director on the

Board, and the appointment was confirmed by the Council of Governors at their meeting in September 2016.

Non-Executive Director Remuneration Committee

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

Executive Director Nomination and Remuneration Committee

Composition & Attendance

Member Name	April 2016	May 2016	November 2016	March 2017
Paul Burstow (Chair)	✓	✓	✓	✓
Dinesh Bhugra	X	✓	✓	✓
Helen Farrow	n/a	n/a	✓	✓
Jane Gizbert	✓	✓	✓	✓
David Holt	✓	✓	✓	✓
Ian McPherson	✓	✓	n/a	n/a
Edna Murphy	✓	✓	✓	✓

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

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

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

Membership

Eligibility and Constituencies

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

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

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

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

Membership Statistics

Membership Statistics 2016/17

Constituency	31 March 2016	31 March 2017
Public	6788	6012
Staff	658	666

Membership Strategy

Our strategy for membership has five main aims:

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

- Involving members in decision making processes including recruitment interviews

A Governors' working group was set up in the year to look at improving membership engagement, and to facilitate ways for governors to communicate better with the Trust's membership.

Contact Procedures for Members

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

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.
The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

The Trust is in segment one.
This segmentation information is the Trust's position as at 24th March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

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

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

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

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

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts

comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

Annual Governance Statement

Scope of Responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Tavistock and Portman NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Capacity to handle risk

As Chief Executive, I hold overall responsibility for risk management, the Operational 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 which provides the Board of Directors with assurance of effective (non-financial) risk management within the Trust.

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

The Corporate Governance and Risk Workstream Lead assesses evidence of effective risk management of non-clinical risks, and the Patient Safety and

Clinical Risk Workstream Lead assesses effective management of clinical risks. They monitor the respective elements of the Operational Risk Register. Both report to the CQSG.

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

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

The Associate Director of Quality and Governance is responsible for non-clinical risk and provides a central resource of expertise and advice on all non-financial risk management. The Associate Director leads and coordinates the Trust's compliance with risk management standards set by the NHS Litigation Authority (NHSLA) and adopted by the Trust.

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

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

Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken throughout

their area of responsibility and that any necessary remedial action is carried out.

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

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

The Risk and Control Framework

Risk management is embedded in the Trust's management and is integral to the development of policies and procedures, service planning and any change to patterns of service delivery and is reinforced by training at all levels.

Strategic and operational risks are covered by Trust-wide Risk Registers.

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

Operational Risks

Operational risks are identified throughout the year and included in the Operational Risk Register, which is presented in full to the Board of Directors annually. In addition, significant operational risks are reported to the Board of Directors every quarter by the CQSG, based on assurance reports it has itself received on corporate governance and risk; clinical outcomes; clinical audit; patient safety and clinical risk; quality reporting; and information governance. In addition, the Board of Directors receives reports from the Training and Education Programme Board.

Strategic Risks

Strategic risks are agreed by management and the Board of Directors as part of preparing the Annual Plan. The Plan is developed in consultation with our Council of Governors, who represent the public; Trust staff; and other key stakeholders. The Plan document itself includes key risks. The Strategic Risk Register (Business Assurance Framework), which tabulates the risks, the actions being taken to manage them, risk lead and monitoring arrangement is presented and approved at the same time (as the Plan). 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. Risks to compliance with the governance condition of our Foundation Trust licence are mitigated through regular reviews of the performance of board committees, annual review of the responsibilities of directors and subcommittees, and clear and regular reporting by the executive to the Board of Directors.

The current Business Assurance Framework has 13 identified risks, of which two are classified as ‘Red’. These are the risks associated with a lack of sufficient management capacity to achieve the goals of the organisation and the adverse impact of the changes to the National Training Contract (NTC). The risk of a lack of sufficient management capacity is being managed by use of the strategic plan to focus priorities and quarterly review of the plan at the Strategic and Commercial Committee to review pressures and any tensions over priorities. The risk of the adverse impact of the changes to the NTC have been mitigated by active engagement with Health Education England and agreement to spread the reduction in funding over four years, as well as actively creating partnerships with organisations across the country to increase both geographic access to our courses as well as access from a wider cross section of the health workforce.

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

Governance

The governance framework for the Trust is set out in its Constitution and further supported by a suite of policies including the Scheme of Delegation and individual committee terms of reference. The work covered by these committees, their membership and attendance records are included in other

sections of this annual report. There are no areas where the Trust does not comply with the Foundation Trust Code of Governance and compliance has been highlighted in the relevant sections of this annual report.

The Trust's Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of internal control and risk management. This covers all areas of the Trust's activities, in conjunction with the CQSG, as well as the Trust's core financial systems and procedures and counter-fraud controls. The Audit Committee reviews all reports from the External Auditors, the Internal Auditors, and the Local Counter-Fraud Specialist. The Annual Report of the Internal Auditors provides the Audit Committee with assurance on the extent to which the Trust's system of internal control is sound.

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

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

Pension membership

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

Equality and diversity

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

Carbon reduction

The Foundation Trust has undertaken risk assessments 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.

Raising Concerns at Work

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, and training is given to all staff on the Duty of Candour, Whistleblowing, and the importance of incident reporting as part of the mandatory INSET events which all staff attend. A Freedom to Speak-Up Guardian was appointed in October 2015, and has worked to support staff who have concerns as well as to promote a culture of transparency and openness within the Trust.

Care Quality Commission Inspection

During January 2016, the Care Quality Commission (CQC) conducted an announced inspection of the Trust, rating the Trust as 'good' overall, but with 'requires improvement' in the rating for the safety domain.

At the end of 2016 the CQC conducted a further inspection of the Trust, focussed on adult and forensic services, and concluded that we had successfully delivered our "must do" actions from our original inspection. They also revised their ratings for the safety domain for our specialist psychological services from "requires improvement" to "good". As a result the overall rating for the Trust for this domain also moves from "requires improvement" to "good".

The Foundation Trust is fully compliant with the registration requirements of the CQC.

Quality Assurance Agency Inspection

In the first part of the year the Quality Assurance Agency (QAA) conducted an inspection of the Trust's higher education provision. Reporting in April, the QAA rated the Trust as 'meets' expectations in all of its judgements (this being the highest rating awarded by the QAA).

Information Governance

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

During the year the Trust undertook a review of its IG policies and procedures. As a result some areas for improvement were identified, particularly around Secondary Use of data. These improvements were successfully implemented during the year, which we were able to report as part of the Trust's IG Toolkit submission. The Trust has declared that it has attained 81% against all the key criteria of the IG toolkit issued for mental health trusts. Although the Trust attained Level Three, the highest, for the majority of the requirements, it did not attain level two or more for all of them.

Training in IG remains a priority for the Trust with 99% of staff completing their IG training during the year.

There was one information governance near-miss during the year, involving a potential ransomware attack on a Trust device that, on initial reporting, was thought to reach the Serious Incident Requiring Reporting threshold. The case was logged on the incident reporting tool available via the Information Governance Toolkit. Following investigation it was confirmed that there was no impact to the near miss and a SIRI score of 0 calculated within the reporting tool. Given this score the near miss was not escalated to the ICO or NHS Digital for action. The incident was closed.

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

For 2015/16 the Trust met its financial Control Total, as it also did for 2015/16. The Trust's financial performance includes only a 1% variation to its agency cap. In achieving this financial result, the Trust saw an increased number of patients and enrolled an increased number of students. The Trust also dealt with a much higher level of Freedom of Information requests. Details of these outcomes are shown elsewhere within this Annual Report.

The Trust identifies cost savings to meet NHS efficiency targets as part of the annual budget process, and during the year. Savings programmes cover pay

and non-pay costs, and include the benefits of improved procurement. The costs of services are compared to their income and benchmarked against other organisations where appropriate. The Board of Directors approves the budget and reviews the financial position monthly. The Audit Committee receives reports from Internal Audit on the Trust's financial controls.
The effectiveness of services is monitored by the Board of Directors through scrutiny of the quarterly quality report, and the monthly detailed reports from individual clinical Service Lines, and education and training Portfolios. Both internal and external audit also consider value for money as part of their work and both are required, as part of their annual audit, to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. Neither has reported that the Trust has failings in this respect.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports, which incorporate the above legal requirements, in the *NHS Foundation Trust Annual Reporting Manual*.
The work to produce the Quality Report has been supported and scrutinised through the Executive Management Team. The Director of Quality and Patient Experience does not line manage those people supplying evidence for this Report; but facilitates its production and takes an impartial view of submissions and progress. Data is drawn from the Trust's clinical systems, especially CareNotes. This information has been reviewed extensively at Board level, including Governors serving on the CQSG.
Due to the nature of its patient services (where we provide psychological therapies and do not undertake any physical interventions, and are an out-patient service only), the Trust is not required to collect elective waiting time data using the national definition. However, the Trust reports on the waiting times to assessment and adheres to the same data validation assurance process for this waiting time data as used for the other data reported in the Quality Report. On occasions there are administrative errors which can pose a risk to the quality of this data. However, the Trust tries to ensure that

these administrative errors are kept to a minimum, via quarterly audits, data cleansing and by providing training and feedback to administrative staff.

Waiting times from referral to first appointment was selected by the Trust for auditing by our External Auditors in 2016/17 and progress has been made during the year in validating data across all services.

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

An update on the quality priorities selected for 2016/17 are included within the Annual Quality Report. Progress has been made in all areas although there have been IT challenges in developing the dashboard for 'real time' patient and team level data to improve services. The agreed outcome monitoring targets were not fully met and this work will continue in more detail during 2017/18.

Review of effectiveness

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

Independent assurance has been provided principally by our External and Internal Auditors, and by the CQC and Quality Assurance Agency. The Trust has developed and implemented action plans in response to the recommendations of each of these bodies.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The opinion is that that "In general the organisation has an adequate and

effective framework for risk management and governance. However, there are weaknesses in certain parts of the framework of internal control such that it could be, or could become, inadequate and ineffective. These weaknesses relate to the reviews of CareNotes, data quality, student debtors (key financial controls), procurement and benefits realisation of CareNotes."

Given its limited, Internal Audit resources, the Trust seeks to focus internal audit on areas of potential weakness. This has resulted in the majority of the audits carried out resulting in a rating of 'partial assurance' and so leading to the opinion noted above. (Further details are provided in the Audit Committee Report above.) The Audit Committee has paid close attention to the issues raised by Internal Audit and is satisfied with the responses of management to the issues raised by Internal Audit and time-bound action plans for improvements are in place to address any outstanding weaknesses.

Notwithstanding the above, the view of the Audit Committee, taking into account all relevant information (such as that of the inspections of the CQC and QAA and progress against implementing actions recommended by internal audit and others), is that an effective system of internal control has been in place in The Tavistock and Portman NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Conclusion

The Board of Directors is fully committed to continuous improvement of its governance arrangements to ensure that systems are in place that ensure risks are correctly identified and managed and that serious incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action so that the patients, students, service users, staff and other stakeholders of the Trust can be confident in the quality of the service we deliver and the effective, economic and efficient use of resources.

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

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

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

I present this Accountability Report.

Signed

Paul Jenkins, Chief Executive and Accounting Officer

23 May 2017

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

Opinion on financial statements of The Tavistock and Portman NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements that we have audited comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Taxpayers' Equity;
- the Statement of Cash Flows;
- the Accounting Policies and other information; and
- the related notes 1 to 28.

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

Certificate

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

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: • Recognition of NHS revenue • Management override of controls • Accounting for Capital Expenditure In 2016/17, we included management override of controls as a key risk, as it had one of the greatest effect the allocation of resources in the audit. In 2015/16, we identified a separate key risk in respect of property valuations which we have considered as part of our management override of controls risk in the current year as there have been no significant changes to the Trust's estate in the year, nor the valuation methodology or assumptions applied in the valuation.
Materiality	The materiality that we used in the current year was £950,000 which was determined on the basis of approximately 2% of the Trust's total revenue recognised in the year to 2016/17.
Scoping	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the senior statutory auditor.
Significant changes in our approach	Other than the changes to key risks as described above, there have been no significant changes in our approach to the audit in 2016/17 compared to 2015/16.

Going concern

We have reviewed the Accounting Officer's statement contained within the Statement of the chief executive's responsibilities as the accounting officer of Tavistock and Portman NHS Foundation Trust on page 70, the going concern disclosure within the Performance Report at page 6 and the going concern disclosure in note 1 of the financial statements on page 96 that the Trust is a going concern.

We confirm that:

- **we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and**
- **we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.**

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

NHS revenue recognition	
Risk description	In 2015/16 we referred to our presumed fraud risk related to revenue recognition as the 'recoverability of NHS receivables'. In 2016/17, we have focused the risk on whether NHS revenue that is unsettled at the year-end (and therefore is a receivable), is valid, accurate and valued appropriately. In 2016/17, this revenue includes new funding from the Trust referred to as Sustainability and Transformation Funding (STF). As described in note 1.20 Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to: • the judgements taken in evaluating Commissioning for Quality and Innovation ("CQUIN") income; • the judgemental nature of provisions for disputes with commissioners; and • the Sustainability and Transformation Funding (STF) which is dependent on the Trust meeting certain financial performance targets and therefore recognition of this funding is affected by other accounting estimates. Details of the Trust's income, including £25.5m of Commissioner Requested Services and £1.3m of Sustainability and Transformation Funding (STF), are shown in note 3 and note 4 to the financial statements. NHS debtors are shown in note 17 to the financial statements. The Trust earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.
How the scope of our audit responded to the risk	We evaluated the design and implementation of key controls for recording and reporting contract income. Where we identify significant management estimates, for example with respect to CQUIN income accrued, that involve judgement in respect of recognition of unsettled revenue, we assessed the design and implementation of the Trust's controls around the preparation and review of those estimates. In particular, we have considered the Trust's performance against its control total and the management estimates that impact that performance (see further details on other accounting estimates in the management override of controls risk below), and therefore the eligibility of the Trust in recognising the STF funding. We have reviewed the Trust's correspondence with NHS Improvement, regarding the STF, to validate the amounts of STF recognised in the Financial Statements. We have held discussions with the finance team and contracts team and understand that there are no unresolved commissioner challenges. We have challenged and corroborated management's explanation through procedures such as review of minutes and where relevant, we have also consider the Trust's history of settling similar matters. We have selected a sample of unsettled NHS revenue at year-end and sought evidence that cash has been received post year-end, where cash has not been received post year-end we have sought further evidence to support the validity and accuracy of the unsettled amounts. We have selected a sample of differences between the amounts that the Trust reports as receivable from commissioners, and the amounts that commissioners report that they owe the Trust, in the agreement of balances ("mismatch") report. For this sample, we have sought explanations from management for the variances together with documentary evidence to corroborate those explanations.

Key observations	We did not identify any material misstatements through our procedures in respect of this risk, and we considered the estimates made by the Trust to be within an acceptable range.

Management override of controls

Risk description	We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.20 of the Financial Statements. This is due to the increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The Trust has been allocated £1.3m of the Sustainability and Transformation Fund, contingent on achieving financial targets each year, equivalent to a "control total" for the year of a surplus (adjusted for certain items) of £0.1m. NHS Improvement has allocated funding for a "bonus" to organisations that exceed their control total, including offering trusts £1 of additional funding for each £1 above the control total. This creates an incentive for reporting financial results that exceed the control total of £0.8m. The Trust's reported results show a surplus of £1.7m. Details regarding the amount of STF funding received by the Trust, and the associated control total, are set out in note 4 of the Financial Statements and page 16 of the Performance Report. All NHS Trusts and Foundation Trusts were requested by NHS Improvement in 2016 to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, bad debt provisions, property valuations, and useful economic lives of assets. The Trust had a desk-top valuation of its estate performed as at 31 March 2017 and that the value of the Trust's estate was impaired by £2.2m, from £19.5m in 2016 to £17.6m in 2017, largely as a result of functional and economic obsolescence. Details of this impairment are included in note 15.1 of the financial statements. There is an incentive for the Trust to reduce its asset values because the Public Dividend Capital payment that the Trust pays to the Department of Health is calculated as a function of the Trust's asset values. Therefore there is a cash benefit to reducing the value of the Trust's estate. For this reason, there is a risk that the judgements involved in deriving the valuation of the Trust's estate could be manipulated.
How the scope of our audit responded to the risk	**Manipulation of accounting estimates** Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates, including in respect of NHS revenue and provisions and property valuations, focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. In respect of the valuation of the Trust's estate, we integrated an internal property valuation specialist within our team to challenge management's assumptions and methodology for the valuation. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were

	in accordance with accounting requirements and were appropriate in the circumstances of the Trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements.
Key observations	We did not identify any material misstatements through our procedures in respect of this risk, and we considered the estimates made by the Trust to be within an acceptable range.
Accounting for capital expenditure	
Risk description	The Trust's capital spend on Property Plant and Equipment was £1.5m in 2016/17. This is shown in note 15.1 of the Financial Statements. The Trust is undergoing a significant capital programme over a 4 year period, including the proposed relocation of the Trust's facilities, and spend on the Family Nurse Partnership and Education and Training IT systems. During 2016/17 the Trust incurred costs on the implementation of a new student record system called SITS which was not in operation at 31 March 2017. Determining whether expenditure should be capitalised under International Financial Reporting Standards, and when to commence depreciation, can involve significant judgement in identifying when an asset is ready for use. In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down. As a result of the history of error in capitalisation in the previous year, this continues to be a key risk in the current year.
How the scope of our audit responded to the risk	We evaluated the design and implementation of key controls in place around the capitalisation of costs. We have tested spending on a sample basis to confirm whether it complies with the relevant accounting requirements and whether the depreciation rates adopted are appropriate. We discussed the relocation project with management and noted that no costs have been incurred on the project in the current year.
Key observations	We did not identify any material misstatements through our procedures in respect of this risk.

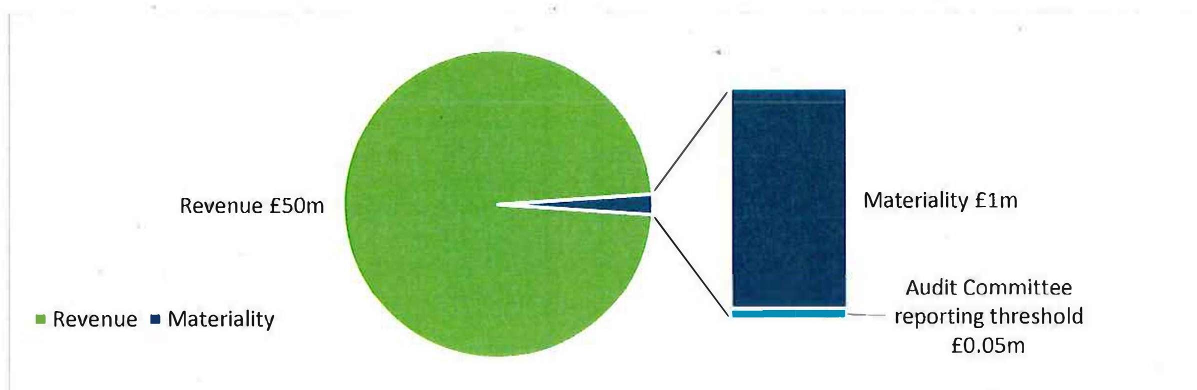
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

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

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

Materiality	£1m (2015/16: £0.9m)
Basis for determining materiality	Approximately 2% of revenue (2015/16: 2% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £47,000 (2016/17: £45,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices directly by the audit engagement team, led by the senior statutory auditor.

The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

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

In our opinion:

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

Matters on which we are required to report by exception

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

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

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

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

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

We have nothing to report in respect of these matters.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We confirm that we have not identified any such inconsistencies or misleading statements.

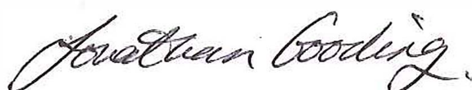
Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

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

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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.



Jonathan Gooding FCA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St. Albans, United Kingdom

24 May 2017

Tavistock and Portman NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

Tavistock and Portman NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Tavistock and Portman NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Paul Jenkins
Chief Executive Officer
23 May 2017

Statement of Comprehensive Income

	Note	2016/17	2015/16	Restated 2015/16
		£000	£000	£000
Operating income from patient care activities	3	25,508	22,581	22,581
Other operating income	4	24,609	22,675	22,675
Total operating income from continuing operations		**50,117**	**45,256**	**45,256**
Operating expenses	5, 7	(47,817)	(44,545)	(44,452)
Operating surplus from continuing operations		**2,300**	**711**	**804**
Finance income	10	10	11	11
Finance expenses	11	(1)	(1)	(1)
PDC dividends payable		(571)	(484)	(484)
Net finance costs		**(562)**	**(474)**	**(474)**
Losses of disposal of non-current assets	12	(62)	-	(93)
Surplus/(deficit) for the year from continuing operations		**1,676**	**237**	**237**
Surplus for the year		**1,676**	**237**	**237**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	6	(2,103)	-	-
Revaluations	16	414	5,452	5,452
Total Other comprehensive (expense)/ income		(1,689)	5,452	5,452
Total comprehensive (expense)/income for the period		**(13)**	**5,689**	**5,689**

Losses on disposal of non-current assets is now disclosed seperately on the face of the Statement of Comprehensive Income.

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000
Non-current assets				Restated
Intangible assets	14	191	110	110
Property, plant and equipment	15	19,709	20,734	20,734
Total non-current assets		**19,900**	**20,844**	**20,844**
Current assets				
Trade and other receivables	17	7,714	8,657	6,271
Cash and cash equivalents	18	2,152	3,355	3,355
Total current assets		**9,866**	**12,012**	**9,626**
Current liabilities				
Trade and other payables	19	(5,659)	(6,293)	(6,293)
Other liabilities	20	(3,010)	(5,659)	(3,273)
Provisions	21	(253)	(71)	(71)
Total current liabilities		**(8,922)**	**(12,023)**	**(9,637)**
Total assets less current liabilities		**20,844**	**20,833**	**20,833**
Non-current liabilities				
Provisions	21	(82)	(58)	(58)
Total non-current liabilities		**(82)**	**(58)**	**(58)**
Total assets employed		**20,762**	**20,775**	**20,775**
Financed by				
Public dividend capital		3,474	3,474	3,474
Revaluation reserve		12,263	14,126	14,126
Income and expenditure reserve		5,025	3,175	3,175
Total taxpayers' equity		**20,762**	**20,775**	**20,775**

The notes on pages 96 to 125 form part of these accounts.

The Trade and other receivables and other liabilities balances were overstated by £2,386k. This was as aresult of the Quarter 1 2016/17 income from NHS England being billed and deferred in March 2015/16.

Signed …………………………………………….

Paul Jenkins
Chief Executive Officer
23 May 2017

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

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

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**3,474**	**8,763**	**2,849**	**15,086**
Surplus for the year	-	-	237	**237**
Other transfers between reserves	-	(89)	89	**-**
Revaluations	-	5,452	-	**5,452**
Taxpayers' and others' equity at 31 March 2016	**3,474**	**14,126**	**3,175**	**20,775**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus		2,300	804
Non-cash income and expense:			
Depreciation and amortisation	5.1	748	768
Net impairments	6	76	224
(Increase)/decrease in receivables and other assets		(1,434)	(3,204)
Increase/(decrease) in payables and other liabilities		(1,090)	3,968
Increase in provisions		206	5
Net cash generated from operating activities		**806**	**2,565**
Cash flows from investing activities			
Interest received		10	11
Purchase of intangible assets		(126)	(93)
Purchase of property, plant, equipment and investment property		(1,269)	(1,475)
Net cash used in investing activities		**(1,385)**	**(1,557)**
Cash flows from financing activities			
PDC dividend paid		(624)	(414)
Net cash used in financing activities		**(624)**	**(414)**
Increase/(decrease) in cash and cash equivalents		**(1,203)**	**594**
Cash and cash equivalents at 1 April		**3,355**	**2,761**
Cash and cash equivalents at 31 March	18.1	**2,152**	**3,355**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow 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.

Going concern

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

Note 1.1 Interests in other entities

The Trust has no interest in other entities.

Note 1.2 Income

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

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

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

Note 1.3 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

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The latest actuarial valuation has been carried out at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 1.4 Expenditure on other goods and services

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

Note 1.5 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

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

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5 (Note 16).

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

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

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

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

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

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

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

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable 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. Assets are de-recognised when all material sale contract conditions have been met.

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

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

Recognition
Property, plant and equipment is capitalised where:

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

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

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

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

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

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

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

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

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

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

Note 1.5 Property, plant and equipment (continued)

De-recognition
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. Assets are de-recognised when all material sale contract conditions have been met.

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

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

Useful economic lives of property, plant and equipment

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

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

Note 1.6 Intangible 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 as intangible assets.

Expenditure on research is not capitalised.

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

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

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

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

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

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

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

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

	Min life Years	Max life Years
Intangible assets - internally generated		
Information technology	5	5
Software	5	5

Note 1.7 Revenue government and other grants

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

Note 1.8 Inventories

The Trust has no inventories.

Note 1.9 Financial instruments and financial liabilities

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

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

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

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

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

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's receivables are set out in Note 17. The trust has no loans in its assets.
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

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

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

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

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

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

Note 1.10 Leases

Finance leases
The Trust has no Finance Leases.

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 rentals 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.

Note 1.11 Provisions

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

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 21.1 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling
The 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 claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12 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 IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.13 Value added tax

Most of the activities of the 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.

Note 1.14 Corporation tax

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

Note 1.15 Foreign exchange

The functional and presentational currencies of the Trust are pounds sterling.

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

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

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

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

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

Note 1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are required to be disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM* when such amounts exist. For the year ended 31 March 2017, the Trust did not hold any third party assets.

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

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses. For the year ended 31 March 2017 the Trust did not report any losses or special payments.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

The following table presents a list of recently issued accounting standards and amendments which have not yet been adopted within the FReM, and are therefore not applicable to DH group accounts in 2016-17.

Standards issued or amended but not yet adopted in FReM

Standard
IFRS 9 Financial Instruments Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts Not yet EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
IFRS 15 Revenue from Contracts with Customers Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

* The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.

Note 1.20 Critical accounting estimates and judgements

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. The total current valuation, as shown in note 15, is £19,785,000, (2015/2016, £20,734,000). The impairment of fixed assets as a result of the valuation was £2,103K charged to the revaluation reserve and £76k charged to operating expenses.

- Operating costs disclosed within note 5 include an estimate of £288,000 for the annual leave earned but not taken at the year-end date, as shown in note 5 (2015/16, £314,000)

- Accounting for receivables necessarily involves judgment when assessing levels of impairment. A provision of £306,000 has been made - see note 17.1. (2015/16, £322,000)

Note 1.21 Contingent liabilities

Contingent liabilities are not recognised, but are disclosed in note 22 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

Note 2 Operating Segments

2016/17

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

This table does not include the Trust's restructuring cost of £336k

2015/16

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	Dividends
Adult Services and forensic services	8,101	7,985	116	88
Children, Young People and Families Services	20,383	20,018	365	218
Education & Training, research	16,772	15,775	997	175
Total	45,256	43,778	1,478	481

This table does not include the Trust's restructuring cost of £773k

2015/16 (Restated)

All figures £000	Operating income	Operating expenses	Operating Surplus before Restructuring	Dividends
Adult Services and forensic services	8,101	7,985	116	88
Children, Young People and Families Services	20,383	20,018	365	221
Education & Training, research	16,772	15,775	997	175
Total	45,256	43,778	1,478	484

The operating segment note has been restated to reflect the the reported dividend payable (£484k)

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17	2015/16
	£000	£000
Block contract income	16,467	12,935
Other clinical income	9,041	9,646
Total income from activities	**25,508**	**22,581**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17	2015/16
	£000	£000
CCGs and NHS England	20,452	16,145
Local authorities	3,368	3,596
Department of Health	2	-
Other NHS foundation trusts	162	318
NHS trusts	129	117
NHS other	194	84
Non NHS: other	1,201	2,321
Total income from activities	**25,508**	**22,581**
Of which:		
Related to continuing operations	25,508	22,581

Note 3.3 Income from activities arising from commissioner requested services

	2016/17	2015/16
	£000	£000
Commissioner related income	25,508	22,581
Non Commissioner related income	24,609	22,675
Total	**50,117**	**45,256**

Note 4 Other operating income

	2016/17	2015/16
	£000	£000
Research and development	488	283
Education and training	21,454	21,175
Sustainability and Transformation Fund income	1,309	-
Other income*	1,358	1,217
Total other operating income	**24,609**	**22,675**
Of which:		
Related to continuing operations	24,551	22,675

**Education and Training*

Increases in the number of students attending short course and long course training was offset by a reduction of £290k in the Family Nurse Partnership (FNP) contract, a reduction of £159k in Tavistock Consulting Services and a reduction of £141k in Higher Education Funding Council of England (HEFCE) income.

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

The Trust was awarded £1,309k Sustainability and Transformation Fund income as a result of meeting its targets.

***Other income

The bulk of other income relates to HMRC VAT rebate of £351k, I-thrive project income £256k, Clinical Excellence Awards £92k, Transforming services £63k, salary recharges £56k and miscellaneous income totalling £540k.

Note 5.1 Operating expenses

	2016/17	2015/16	2015/16
	£000	£000	£000
			Restated
Employee expenses - executive directors	1,128	894	894
Remuneration of non-executive directors	86	82	82
Employee expenses - staff	31,386	29,642	28,869
Supplies and services - clinical	414	316	316
Supplies and services - general	129	134	134
Establishment	891	893	893
Transport	11	5	5
Premises	3,121	2,947	2,947
Increase/(decrease) in provision for impairment of receivables	2	(307)	(307)
Increase/(decrease) in other provisions	213	-	-
Rentals under operating leases	-	120	120
Depreciation on property, plant and equipment	703	733	733
Amortisation on intangible assets	45	35	35
Net impairments	76	224	224
Audit fees payable to the external auditor			
audit services- statutory audit	52	58	53
other - quality accounts	5		5
Clinical negligence	26	-	30
Legal fees	56	35	35
Consultancy costs	824	266	266
Internal audit costs	40	32	32
Training, courses and conferences	904	1,069	1,069
Patient travel	121	103	103
Restructuring	336	-	773
Hospitality	33	33	33
Insurance	33	45	45
Losses on disposal of non-current assets	-	93	-
Other services, eg external payroll	1,964	2,033	2,033
Grossing up consortium arrangements	4	170	170
Other	5,214	4,890	4,860
Total	**47,817**	**44,545**	**44,452**
Of which:			
Related to continuing operations	47,817	44,545	44,452
Related to discontinued operations	-	-	-

The table above has been restated to reflect restructuring payments of £733k in 2015/16 which were previously disclosed under employee expenses - staff now disclosed separately under restructuring. Clinical negligence costs £30k were not disclosed separately in 2015/16. They were included as part of Other.

Losses on disposal of non-current assets is now disclosed on the face of the Statement of Comprehensive Income.

Note 5.2 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2015/16: £1m).

Note 6 Impairment of assets

	Note	2016/17	2015/16
		£000	£000
Net impairments charged to operating surplus resulting from:			
Abandonment of assets in course of construction	15.2	-	224
Changes in market price - Impairments charged to operating expenses	15.1	76	-
Total net impairments charged to operating surplus		**76**	**224**
Impairments charged to the revaluation reserve	15.1	2,103	-
Total net impairments		**2,179**	**224**

Note 7 Employee benefits

	2016/17	2015/16
	Total	Total
	£000	£000
Salaries and wages	**25,869**	23,859
Social security costs	**2,824**	2,216
Employer's contributions to NHS pensions	**3,089**	2,875
Pension cost - other	**-**	29
Termination benefits	**336**	773
Temporary staff (including agency)	**732**	784
Total gross staff costs	**32,850**	**30,536**

Note 7.1 Retirements due to ill-health

During 2016/17 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £24k (£0k in 2015/16).

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

Note 8 Pension costs

The Trust paid NHS pension agency £3,086k (£2,875k in 2015/16) and the National Employment Savings Scheme (NEST) £3k in 2016/17

Note 9 Operating leases

Note 9.1 Tavistock and Portman NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Tavistock and Portman NHS Foundation Trust FT is the lessee.

	2016/17	2015/16
	£000	£000
Operating lease expense		
Minimum lease payments	-	120
Total	**-**	**120**

	31 March 2017	31 March 2016
	£000	£000
Future minimum lease payments due:		
- not later than one year;	-	130
Total	**-**	**130**

The Trust acquired the Garden Wing. Therefore there are no operating lease commitments.

Note 10 Finance income

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

	2016/17	2015/16
	£000	£000
Interest on bank accounts	10	11
Total	**10**	**11**

Note 11 Finance expenditure

The Trust had unwinding of discount expenditure of £1k in 2016/17, (£1k in 2015/16).

Note 12 Losses on disposal of non-current assets

	2016/17	2015/16
	£000	£000
Loss on disposal of non-current assets	(62)	(93)
Net Loss on disposal of non-current assets	**(62)**	**(93)**

Note 13 Discontinued operations

The Trust has no discontinued activities.

Note 14.1 Intangible assets - 2016/17

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

Note 14.2 Intangible assets - 2015/16

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015	**360**	**-**	**360**
Additions	93	-	**93**
Valuation/gross cost at 31 March 2016	**453**	**-**	**453**
Amortisation at 1 April 2015	**308**	**-**	**308**
Provided during the year	35	-	**35**
Amortisation at 31 March 2016	**343**	**-**	**343**
Net book value at 31 March 2016	**110**	**-**	**110**
Net book value at 1 April 2015	**52**	**-**	**52**

Note 15.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**8,801**	**10,703**	**112**	**214**	**2,599**	**157**	**22,586**
Additions	-	345	648	-	512	-	**1,505**
Impairments charged to operating expenses	-	(76)	-	-	-	-	**(76)**
Impairments charged to the revaluation reserve	-	(2,103)	-	-	-	-	**(2,103)**
Reclassifications	-	-	9	-	(9)	-	**-**
Disposals / derecognition	-	(62)	-	-	-	-	**(62)**
Valuation/gross cost at 31 March 2017	**8,801**	**8,807**	**769**	**214**	**3,102**	**157**	**21,850**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**-**	**-**	**209**	**1,539**	**104**	**1,852**
Provided during the year	-	414	-	2	272	15	**703**
Revaluations	-	(414)	-	-	-	-	**(414)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**211**	**1,811**	**119**	**2,141**
Net book value at 31 March 2017	**8,801**	**8,807**	**769**	**3**	**1,291**	**38**	**19,709**
Net book value at 1 April 2016	**8,801**	**10,703**	**112**	**5**	**1,060**	**53**	**20,734**

Note 15.2 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	**5,690**	**8,401**	**412**	**214**	**2,145**	**151**	**17,013**
Additions	-	1,003	(0)	-	547	6	**1,556**
Impairments	-	-	(224)	-	-	-	**(224)**
Reclassifications	-	76	(76)	-	-	-	**-**
Revaluations	3,111	1,224	-	-	-	-	**4,335**
Disposals / derecognition	-	-	-	-	(93)	-	**(93)**
Valuation/gross cost at 31 March 2016	**8,801**	**10,703**	**112**	**214**	**2,599**	**157**	**22,586**
Accumulated depreciation at 1 April 2015	**-**	**672**	**-**	**205**	**1,271**	**88**	**2,236**
Provided during the year	-	445	-	4	268	16	**733**
Revaluations	-	(1,117)	-	-	-	-	**(1,117)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**209**	**1,539**	**104**	**1,852**
Net book value at 31 March 2016	**8,801**	**10,703**	**112**	**5**	**1,060**	**53**	**20,735**
Net book value at 1 April 2015	**5,690**	**7,729**	**412**	**8**	**874**	**63**	**14,776**

Note 15.3 Property, plant and equipment financing - 2016/17

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

Note 15.4 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016							
Owned	8,801	10,703	112	5	1,060	53	**20,734**
NBV total at 31 March 2016	**8,801**	**10,703**	**112**	**5**	**1,060**	**53**	**20,734**

Note 16 Revaluations of property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 every five years. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Asset valuations were undertaken in this financial year with the prospective valuation date of 31 March 2017. The revaluation undertaken at this date was accounted for on 31 March 2017. In 2016/17 a 'desktop valuation' was performed outside of this cycle of 5 year full valuations.

The impairment of fixed assets as a result of the valuation was £2,103K charged to the revaluation reserve and £76k charged to operating expenses.

Note 17 Trade receivables and other receivables

	31 March 2017	31 March 2016	Restated 31 March 2016
	£000	£000	£000
Current			
Trade receivables due from NHS bodies	2,343	4,820	2,438
Other receivables due from related parties	3,325	1,599	3,470
Provision for impaired receivables	(306)	(322)	(322)
Prepayments (non-PFI)	679	411	411
Accrued income	1,419	228	136
PDC dividend receivable	9	-	-
VAT receivable	117	26	26
Other receivables	128	1,895	112
Total current trade and other receivables	**7,714**	**8,657**	**6,271**

Trade receivables and other receivables has been restated due to miss-classification of trade receivables in Other Receivables and Accrued income in 2015/16.

The first quarter's income due from NHS England and totalling £2,386k for the year ended 31 March 2017 was billed and deferred in the last quarter of Financial Year 31 March 2016. Hence the amounts disclosed as "Trade receivables due from NHS bodies should have been £2,438k.

Note 17.1 Provision for impairment of receivables

	2016/17	2015/16
	£000	£000
At 1 April	**322**	**629**
Increase in provision	2	109
Amounts utilised	(18)	-
Unused amounts reversed	-	(416)
At 31 March	**306**	**322**

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

Note 17.2 Analysis of financial assets

	31 March 2017	31 March 2016	31 March 2016
	Trade and other receivables	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	£000	£000	£000
0 - 30 days	-	67	67
30-60 Days	-	10	10
60-90 days	-	-	-
90- 180 days	18	95	95
Over 180 days	288	150	150
Total	**306**	**322**	**322**
			Restated
Ageing of non-impaired financial assets past their due date			
0 - 30 days	1,938	5,831	3,445
30-60 Days	341	289	289
60-90 days	89	40	40
90- 180 days	1,030	1,219	1,219
Over 180 days	232	527	527
Total	**3,630**	**7,906**	**5,520**

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

Note 18.1 Cash and cash equivalents movements

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

	2016/17	2015/16
	£000	£000
At 1 April	**3,355**	**2,761**
Net change in year	(1,203)	594
At 31 March	**2,152**	**3,355**
Broken down into:		
Cash at commercial banks and in hand	111	54
Cash with the Government Banking Service	2,041	3,301
Total cash and cash equivalents as in SoFP	**2,152**	**3,355**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**2,152**	**3,355**

Note 18.2 Third party assets held by the NHS foundation trust

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

Note 19.1 Trade and other payables

	31 March 2017	31 March 2016
	£000	£000
Current		
NHS trade payables	163	346
Amounts due to other related parties	628	553
Other trade payables	-	708
Capital payables	317	81
Social security costs	782	707
Other payables	480	286
Accruals	3,289	3,568
PDC dividend payable	-	44
Total current trade and other payables	**5,659**	**6,293**

Note 20 Other liabilities

	31 March 2017	31 March 2016	31 March 2016
	£000	£000	£000
Current			**Restated**
Other deferred income	3,010	5,659	3,273
Total other current liabilities	**3,010**	**5,659**	**3,273**

The first quarter's income due from NHS England and totalling £2,386k for the year ended 31 March 2017 was billed and deferred in the last quarter of FY 31 March 2016. Hence the retated disclosure

Note 21 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other legal claims	Re-structurings	Total
	£000	£000	£000	£000
At 1 April 2016	**64**	**65**	**-**	**129**
Arising during the year	35	7	175	**217**
Utilised during the year	(7)	-	-	**(7)**
Reversed unused	(4)	-	-	**(4)**
Unwinding of discount	1	-	-	**1**
At 31 March 2017	**89**	**72**	**175**	**336**
Expected timing of cash flows:				
- not later than one year;	6	72	175	**253**
- later than one year and not later than five years;	26	-	-	**26**
- later than five years.	56	-	-	**56**
Total	**89**	**72**	**175**	**336**

Note 21.1 Clinical negligence liabilities

At 31 March 2017, £8k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Tavistock and Portman NHS Foundation Trust (31 March 2016: £0k).

Note 22 Contingent assets and liabilities

At 31 March 2017, there is one possible case of employer's liability litigation outstanding against the Trust (at 31 March 2016 there were four).

The gross possible liability of the Trust for all these cases in aggregate is £12k (31 March 2016 £65K).

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

There is no reliable statistical analysis available to estimate the potential liability for individual trusts in relation to incidents been reported which have occurred but have not yet been reported.
A national estimate for such potential liabilities in all NHS bodies, calculated on an actuarial basis, is included in the accounts of the NHS Litigation Authority.

Note 23 Financial instruments

Note 23.1 Financial risk management

Financial risk

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

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

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

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

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

The Trust follows procedures for receivables management, so as to ensure that payments are received promptly and risk is managed. A provision for impairment (see Note 17.1) is made, and is reviewed regularly.

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

Cash is held as far as possible with the Government Banking Service (see Note 18.1) at all times.

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

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

There are no other financial instruments held, other than the ones already disclosed in notes 23.2 and 23.3.

Note 23.2 Financial assets

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	5,490	**5,490**
Cash and cash equivalents at bank and in hand	2,152	**2,152**
Total at 31 March 2017	**7,642**	**7,642**

	Loans and receivables	Total	Restated Loans and receivables
	£000	£000	£000
Assets as per SoFP as at 31 March 2016			
Trade and other receivables excluding non financial assets	8,220	**8,220**	5698
Cash and cash equivalents at bank and in hand	3,355	**3,355**	3355
Total at 31 March 2016	**11,575**	**11,575**	**9,053**

Note 23.3 Financial liabilities

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

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2016		
Trade and other payables excluding non financial liabilities	5,583	**5,583**
Total at 31 March 2016	**5,583**	**5,583**

Note 23.4 Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	5,897	5,583
Total	**5,897**	**5,583**

Note 24 Related parties

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

Dr Robert Senior (Medical Director) has ongoing involvement with the University College London Hospitals NHS Foundation Trust. The Trust paid University College London Hospitals NHS Foundation Trust £258k (2015/16 £197K) and University College London Hospitals NHS Foundation Trust paid the Trust £39k (2015/16 Nill) for various education and research activities.

Dr Robert Senior has a research collaboration with the Anna Freud Centre. The Trust paid the Anna Freud Centre £336k in 2016/17 (£424k in 2015/16) for various education and research activities. Anna Freud Centre paid the Trust £125k in 2016/17 (£73k in 2015/16).

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

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

2016/17

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

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

2015/16

	Total income for the year ended 31 March 2017 £000	Total charge for the year ended 31 March 2017 £000	Debtor/ (creditor) as at 31 March 2017 £000
Public Health England	3,197	-	0
Health Education England	11,703	-	(284)
NHS England	4,484	4	(42)
Camden CCG	6,303	-	(3)
City & Hackney CCG	3,272	-	451
Homerton University Hospital NHS Foundation Trust	26	745	(343)

	Total income for the year ended 31 March 2017 £000	Total charge for the year ended 31 March 2017 £000	Debtor/ (creditor) as at 31 March 2017 £000
HM Revenue and Customs for Pay As You Earn income tax and National Insurance (included in staff costs)	-	2,216	(707)
NHS Pension Agency	-	2,875	-

The Trust is reimbursed by the Tavistock and Portman Charitable Fund and by the Tavistock Clinic Foundation for staff and other expenses borne on their account. For the Tavistock and Portman Charitable Fund the amount owed to the Trust is £6k and for the Tavistock Clinic Foundation the amount owed to the Trust is £1k.

During 2016/17, the Trust has an agreement with National Shared Business Services to provide certain accounting processes. The Trust paid £93,027 (2015/16 £88,435) for these services.

Note 25 Better Payment Practise Code

	Number of bills paid		% of bills	Value of bills paid		% of value
	Total	Paid within 30 days	paid within 30 days	Total	Paid within 30 days	paid within 30 days
	Number	Number	%	£000	£000	%
Year ended 31 March 2017	7,134	6,436	90%	23,417	21,609	92%
Year ended 31 March 2016	7,178	6,374	89%	13,373	12,199	91%

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

Note 26 Losses and special payments

There were no losses and special payments in 2016/17.

Note 27 Prior Period adjustments

Prior period adjustments are the following:-
Statement of Comprehensive Income
Statement of Financial Position
Operating Segments (Note 2)
Operating Expenses (Note 5.1)
Trade and other receivables (Note 17 and 17.2)
Other Liabilites - Deferred Income (Note 20)
Financial Assets (Note 23.2)

An explanation of the Prior Period Adjustments is highlighted within each note

Note 28 Events after the reporting date

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.

Tavistock and Portman NHS Foundation Trust

Quality Report for the year ended 31 March 2017

The Tavistock and Portman NHS

NHS Foundation Trust

Quality Report

2016/2017

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Introduction

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

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

It has a national role in providing mental health education and training, where its training programmes are closely integrated with clinical work and taught by experienced clinicians. One of its strategic objectives is to further extend its national reach and widen participation in its programmes. A key objective is to develop its equalities agenda and to work to increase the diversity of staff and trainees to better reflect and respond to the multi-cultural representation of the communities where the Trust provides services. A key to the effectiveness and high quality of its training programmes are its educational and research links with its university partners, the University of Essex, the University of East London, and the University of Middlesex.

Core Purpose

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

We make this contribution through:

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily.

- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and improving public understanding of mental health.

- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation.

- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies.

Part 1: Statement on Quality from the Chief Executive

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

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

In May 2016 we were pleased to receive an overall Good rating for our clinical services following a scheduled inspection by the Care Quality Commission (CQC) in January 2016 and follow up inspection in November 2016. The CQC required improvement in one area, Safety, in our adult specialist psychological therapy services and we immediately took action which included the introduction of patient crisis plans and the development of a separate children's waiting area. We also improved physical access to some of our facilities for wheelchair users.

The Trust also welcomed the Quality Assurance Agency for Higher Education (QAA) to review our education and training services in April 2016. We were highly satisfied that they reported we met national standards in all areas reviewed. In addition they identified four areas of good practice and made recommendations for further development in a further four.

Staff across our Trust are fully committed to improving the quality of our services and this is supported by our Clinical Quality Strategy, approved by the Board in January 2017. The strategy draws on the commitment and creativity of our staff and the growing collaborative work with our patients, carers and their families and other stakeholders. As part of the strategy we have identified quality champions across the organisation and are investing in training in specific quality improvement skills and techniques.

Some of the areas we have been focusing on include:

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

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

Whilst our patients continue to rate services 'good' we know that we still have work to do, particularly around improving waiting times in some of our services. We have in particular seen an increase in referrals to our very successful Gender Identity Development Service (GIDS) and City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) leading to waiting times remaining longer than we would wish. Progress has been made to address this issue but we will need to work to ensure it is maintained. Our recently introduced, team by team waiting times report keeps the Board and clinical teams alert to performance issues.

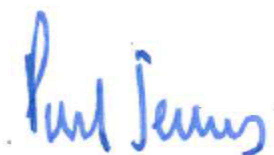
We also want to improve our use and understanding of patient outcome measures which give us information on how effective the treatments are that we offer. We recognise the link between physical and mental health, and over the past year have invested in developing physical health services across the organisation, and with external organisations. Again, this is early work and is continuing. We are also working to improve discharge information we provide to our GP partners so that the health care our patients receive is seamless across services.

We continue to have relatively small numbers of incidents and a good record on safeguarding with strong leadership from the Medical Director. Our staff consistently recommend the trust as a place to work or receive treatment but we know that we still have some work to do to address long hours of working.

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

You will find more details in the next section and throughout the report about our progress towards our priority areas as well as information relating to our wider quality programme. Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible. However, if there are any aspects on which you would like more information and explanation, please contact Marion Shipman (Associate Director Quality and Governance) at mshipman@tavi-port.nhs.uk, who will be delighted to help you.

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



Paul Jenkins
Chief Executive

Trust Achievements

We are proud to report that, in addition to our Quality Priorities, during the year 2016/17 we achieved the following:

- We are delighted to announce that the Care Quality Commission has given us an overall rating of 'Good' following the inspection in January 2016 and follow up visit in November. This is a significant and positive achievement for us. Our patients, their families and carers and our commissioners can have every confidence in the clinical services we deliver.

- The Trust has been working for some time to develop a system of dashboards that provide a visual representation of our performance. These came to the Board for the first time in April 2016, and were judged to be a valuable tool that will allow a more systematic and consistent system of performance management, from Board to team level.

- We have developed a Trust-wide clinical quality strategy, approved by the Board in January 2017. This sets out a systematic approach to continuously improving the quality of our services, building on our high quality care and making best use of our rich resource of clinical knowledge and experience. We are bringing staff, patients and other stakeholders together to design improvements in the care we provide. We have set up a quality task force, identified quality champions and embarked on a programme of staff training in key quality improvement methodologies.

- In January 2017 the Board of Directors confirmed the previous decision to support relocation as the preferred option for the Trust's estate. The decision was approved by the Council of Governors at its meeting in February. The Trust wishes to relocate to a site within the borough of Camden, hopefully by 2020/21. The project is expected to be self-funding, meaning that the proceeds of sales of existing assets will cover the purchase and development of a new site.

- Our Gender Identity Development Service (GIDS) renegotiated their contract which has increased their budget to better reflect the demand for the service. Following an extensive recruitment drive, a large new group of staff joined the service in 2016/17. We are pleased that GIDS London now has newly configured dedicated accommodation within the Tavistock Centre with its own reception and waiting area.

- The Gloucester House School service has grown over the last year. Following the revision of the service model, which made the service more affordable for local councils, occupancy rates have increased to the point that they were able to open a third class. This is a great achievement, and is testament to the hard work of everyone working in Gloucester House, and the support they have had more widely from the Trust.

- Gloucester House School, GIDS and Child and Adolescent Mental Health Services (CAMHS) work featured in the "Kids on the Edge" documentaries which were screened on Channel 4 during November/December 2016. The programmes, which attracted a total audience of 2.5 million followed two years of careful work with the production company, Century Films, to produce high quality television which provided an

appropriate platform for young people and their families to share their stories and the significant issues they are dealing with in their lives. In doing so we aimed to help inform public debate about those issues and hopefully to make it easier for others with the same experience to talk about things openly and seek help.

- The Board signed off the Trust Safety Improvement Plans for the Sign Up To Safety campaign. The campaign has provided a good opportunity to review our work and look for areas that could be improved. It has provided a framework for bringing together work that was already in hand so that there would not be too much additional burden for clinicians. Quality of care and patient safety are central to the Trust and the plan sets out clear organisation aims for improving the health outcomes of patients and provide equitable services.

- Over the last year we have held a series of meetings with Black, Asian and Minority Ethnic (BAME) staff from across the Trust to help us better understand the issues facing them in the workplace. The meetings have been well attended by a broad range staff from different parts and levels of the organisation.

Camden CAMHS

What is the service?

The Camden Transformation Team is an innovative multi agency team that was set up in 2012 in response to the national Troubled Families Programme. The team provides holistic help and support using a service model where a support workers engage with a family over a period of weeks or months. Rather than prescribing what the type of help is on offer, the team works to the priorities of the family which are often issues such as housing problems, debts, and getting into training or work. Once they have received help with these issues, they are usually ready to deal with other problems such as facing up to past trauma or getting help for adult and child mental health problems.

Who is the service for?

The service is for families facing multiple disadvantage who have had long term contact with a range of services but without significant benefit. They have usually learned over many generations not to trust or engage with professionals.

Most of the appointments take place in the community, in family homes or at local community centres.

Outcomes

Through developing trust and having (often for the first time) a positive experience of receiving professional help, many families have achieved a wide range of improved outcomes: such overcoming alcohol or substance misused, getting into employment, improved school attendance, improved academic attainment, improved family relationships.

Quotes

At a recent away day support workers came up with the following hashtags that they felt described their experience in the team and the work they do with families: #creativityexpected #buildtrusteverywhere #righttobewrong #attachmentbasedrelationships #equal

1.2 Overview of Quality Indicators 2016/17

The following table includes a summary of some of the Trust's quality priority achievements with the RAG status, along with the page number where the quality indicator and achievement are explained in greater detail.

Target	RAG	Annual Achievement	Page No
Child and Adolescent Mental Health Service Outcome Monitoring Programme			
For 80% of patients (attending CYAF who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Red	Not achieved	30
For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	Green	Achieved	30
Adult Outcome Monitoring Programme			
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.	Red	Not achieved	30
Patient and Public Involvement – 'Word of Mouth Project'			
Develop a plan for raising awareness and levels of engagement for service users	Green	Achieved	31
Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the project	Green	Achieved	31
Launch a Visual Straw Poll on awareness of the Living Well Programme	Green	Achieved	31
Patient involvement with physical healthcare – 'Living Well Programme'			
Consult with patients and carers on the scope and content of the Living Well Programme	Green	Achieved	32
Raise awareness of the Living Well Programme with patients and carers for self or clinical referral	Green	Achieved	32
Obtain feedback from programme participants and ensure that information is shared in PPI newsletters	Green	Achieved	32
Patient Safety Indicators			
Patient Safety Incidents	Green	114 Incidents	35
Child and Adult Safeguarding Alerts	Green	Achieved	36

Target	RAG	Annual Achievement	Page No
Maintaining a High Quality, Effective Workforce			
Attendance at Trust Wide Induction Days		85%	36
Completion of Local Induction		97%	37
Attendance at Mandatory INSET Training		100%	37
Safeguarding of Children & Adult – Level 1 Training Safeguarding of Adult – Level 2 Training Safeguarding of Children – Level 2 Training Safeguarding of Children – Level 3 Training		95% 88% 88% 94%	38
Clinical Effectiveness Indicators			
Monitor number of staff with PDPs		100%	40
Patient Experience Indicators			
Formal complaints received		Achieved	42
Patient Satisfaction			
Percentage of patients that rated the overall help they had received as good: Quarter 1 Quarter 2 Quarter 3 Quarter 4		Quarter 1: 93% Quarter 2: 91% Quarter 3: 92% Quarter 4: 94% 2016/17: 93%	43
Experience of Survey Questionnaire Results			
Number of Patients that would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment. Quarter 1 Quarter 2 Quarter 3 Quarter 4		Quarter 1: 90% Quarter 2: 92% Quarter3: 90% Quarter 4: 90% 2016/17: 90%	43
Did Not Attend Rates			
Trust Wide – First Attendances		Achieved	46
Trust Wide – Subsequent Appointments		Achieved	46

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

2.1 Our quality priorities for 2017/18

The priorities for 2017/18 which are set out in this report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

Patient Safety

Priority 1: Improve the physical health of patients receiving treatment
Priority 2. Improve the identification and management of high risk patients

Clinical Effectiveness

Priority 3: Embed meaningful use of outcome measures in services

Patient Experience

Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families

How we choose our priorities

In looking forward and setting our quality priority goals for 2017/18 we were keen to include issues which would make a real difference to the quality of care our patients receive. We undertook a wide consultation with a range of stakeholders, both internal and external over the last year. We have chosen those priorities which reflect the main messages from these consultations including focusing on reviewing the outcome measures that we use and reviewing how they are used in practice, continuing our focus on the physical health of our patients and looking further at how we identify and best manage patients at high risk of harm. The first three priorities build on earlier quality priorities.

Camden CCG (Clinical Commissioning Group, see Glossary) has played a key role in determining our priorities through review of the 2016/17 targets and detailed discussion to agree CQUIN targets for 2017/18.

Our Quality Stakeholders Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, Governor and non-executive director representatives along with members of the Patient and Public Involvement team, Associate Director Quality and Governance and is chaired by the Director of Quality and Patient Experience. The Governors Clinical Quality Group has also played a key role in helping us to think about some of our quality priorities for next year.

Patient Safety

Priority 1: Improve the physical health of patients receiving treatment:

This was a quality priority in 2016/17, and also one of our CQUINs (Commissioning for Quality and Innovation) targets. Whilst the 'Living Well' programme continues as a CQUIN for 2017/18 covering a number of public health issues including smoking, alcohol, drugs, healthy eating, and exercise and stress management we are keen to work with identified service 'physical health champions', and use innovative ways to communicate the messages to both staff, patients and carers. We will, in addition, be developing further the provision of individual support for staff and around smoking cessation and alcohol use. This priority continues to be one of the Trust's Sign up to Safety goals.

1.	Improve the physical health of patients receiving treatment
Targets for 2017/18 This priority continues but with new elements from last year	
1.	Further develop and deliver the 'Living Well' programme across Young Adult and Adult services
2.	Develop the physical health champions role across the Trust to support this priority
3.	Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver Very Brief Advice on smoking and alcohol
4.	Increase individual support for patients around physical health issues including smoking cessation and alcohol use

Measure Overview

We plan to use a number of different measures to evidence compliance with the targets including the development and dissemination of patient and staff information; development of a 'Living well' programme which is then evaluated by attendees; evidence on ongoing individual support for staff and patients; staff training to deliver Very Brief Advice for smoking and alcohol and ongoing monitoring to embed the use of physical health forms.

How we will collect the data for this target

Patients, carers and staff will be involved in further developing the 'Living Well' programme to be delivered during the year. Data will be collected on numbers recruited and feedback obtained from participants. Staff information will be provided to increase knowledge of the programme and provide training to deliver Very Brief Advice to patients on alcohol and smoking. This will be monitored from the physical health forms. Individual and self-referrals to the Physical Health Specialist Practitioner will continue, with use of the service monitored and evaluated at the end of the year.

Monitoring our Progress

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

Priority 2: Improve the Identification and Management of High Risk Patients

The highest priority of the Trust is the safety of patients seen in our services. For 2017/18 we plan to continue to roll out mandatory refresher training for all clinicians on clinical risk assessment and risk management. Clinicians must attend refresher training once every three years. Self-harm is particularly prevalent in some of the clinical populations that we assess and treat e.g. adolescents. We will be updating a number of relevant policies and procedures during 2017/18 to reflect the key elements of safer care in the context of being a provider of all age out -patient mental health services. An audit undertaken during 2016 showed there was further work to be done in respect of improving the recording of risk assessments and actions taken. This priority continues to be one of the Trust's Sign up to Safety goals.

2. Improve the identification and management of high risk patients
Target for 2017/18 This priority continues from last year but with updated elements
1. To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with the aim of achieving 80% attendance at the end of a 3 year training cycle
2. Update and disseminate relevant policies and procedures
3. Regular re-audit (twice yearly) with an increase in completion of risk assessment and risk management forms on Electronic Patient Record.
4. Use of relevant sections of *Safer Services: A Toolkit for Specialist Mental Health and Primary Care . 10 Key Elements to Improve Safety.* (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, February 2017).

Measure Overview

Trust wide induction for all new staff already includes an update on suicide and self-harm as does the twice yearly staff mandatory training INSET days. For all clinicians the Trust will provide regular mandatory refresher training on clinical risk assessment and risk management. All clinicians should attend one of these sessions at least once every three years.

How we will collect the data for this target

A number of tools will be used to assess progress. By the end of a 3-year training cycle we aim to have provided refresher training to 80% of clinicians. Clinician's knowledge of clinical risk assessment will be assessed via a specifically tailored survey tool sent 3 months after attendance at the training event. We will also monitor clinical practice by regular case notes audit of completion of the risk assessment form on the electronic patient record. Additionally we will use relevant quality/safety standards of the Safer Services Toolkit. A decision will be made on which two of the toolkit quality/safety standards will be used by the Trust. These will be audited in Q4.

Monitoring our Progress

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

Clinical Effectiveness

Priority 3: Embed meaningful use of outcome measures in services

We use various clinical outcome measures to evaluate how effective the interventions we provide are for our patients and carers. We know from data we currently collect that these are not always used consistently, may not indicate the outcomes which matter most in the lives of our patients and carers, or are best value, given the time commitment required to collect the information.

The aim of this priority is to ensure that the use of appropriate outcome measures becomes embedded in routine clinical practice and that the data is available in a timely way to clinicians and patients, and used to continually improve care at patient and service levels.

There are differences between the measures used by the Children, Young Adults and Families (CYAF) directorate and the Adult and Forensic Services (AFS) directorate, so these are addressed separately below. However, some common areas for improvement include how the measures are entered on to the patient information system and how they are used by clinicians, patients and teams to evaluate progress of treatment and review service delivery.

3. Embed meaningful use of outcome monitoring in services
Targets for 2017/18 This is a new priority
1. To liaise with the Patient and Public Involvement (PPI) team to gather information regarding patients' experiences of outcome measures. Findings will be utilised as part of an overall review of the appropriateness of currently used measures and how they are administered.
2. For outcome measures to be entered on to the patient information system within 1 week of completion and receipt by the Quality Team
3. Improve access to patient and team level data, to include a dashboard to provide 'real-time' data which is reviewed by clinicians and teams to improve services.

Measure Overview

Measures currently used are outlined below. Other outcome measures used will depend on a review of measures to be undertaken separately.

Children, Young Adults and Families (CYAF)

For the Children, Young Adults and Families (CYAF) directorate, we continue to use the Goal-Based Measure (GBM) this year. The GBM enables us to know what the patient wants to achieve (their goal or aim) and to focus on what is important to them. As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback. For CYAF, Time 1 refers to the initial assessment, where the patient and clinician complete the GBM together when they are seen for the first time. Then, the patient reviews

these goals again with their clinician after three months or, if earlier, at the end of therapy/treatment (Time 2), indicating whether or not they have shown improvement or achieved their goals. CYAF also use other measures to monitor progress, including the Strengths and Difficulties Questionnaire (SDQ), the Revised Children's Anxiety and Depression Scale (RCADS), and the Experience of Service Questionnaire (ESQ).

Adult and Forensic Services

Adult and forensic services will continue to administer the CORE Outcome Measure (CORE-OM) and the Experience of Service Questionnaire (ESQ). The CORE-OM is a client self-report questionnaire that is administered before, during and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: Subjective well-being; Problems/symptoms; Life functioning; Risk/harm.

Comparison of the scores offers a measure of 'outcome' (i.e. whether or not the client's level of distress has changed, and by how much).

The Experience of Service Questionnaire (ESQ, formerly CHI-ESQ) was developed by the then Commission for Health Improvement (now the Care Quality Commission) as a means of measuring service satisfaction. It consists of 12 items and three free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

At the Portman Clinic, an additional measure - the Shedler-Westen Assessment Procedure (SWAP), is administered at the beginning of treatment, at annual intervals thereafter, and after completion of treatment. The SWAP is a psychological instrument for personality assessment and clinical case formulation that is completed by the clinician. It is a well-validated instrument through empirical research. It has also been shown to be an effective method of demonstrating changes in personality functioning over time.

How we will collect the data for this target

Once the information from questionnaires is collected, it is entered onto the Trust patient information system (Carenotes). This allows us to determine the proportion of patients who have completed outcome measures and how quickly these are available to clinicians. Monthly audits will be undertaken to determine compliance with the standard, with information shared with administration teams. A review of the outcome measures currently in use including how widely they are used across the Trust, the evidence base for each and patient feedback on the experience of using the questionnaires will be used to inform decisions on any changes to the outcome measures being used.

Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream. The Clinical Governance Leads for Children Young Adult and Families and Adult and Forensic services will ensure that action plans are in place when expected levels of assurance are not achieved.

Patient Experience Involvement

Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families

We want to ensure that are services are responsive to patients with protected characteristics (see Glossary). Last year Healthwatch Camden highlighted the importance of looking at the needs of specific groups. Over the last year we have revised our Equalities Monitoring forms. In 2017/18 we plan to embed the collection of more complete data on demographics and protected characteristics of our service users using the revised forms. With more complete data, we can look at whether we are reaching all groups of patients and whether all groups of patients are equally well served. Where patients appear to be less well served, we will investigate further in consultation with service users to identify ways in which our services can be more effectively tailored to patient and carers needs and wishes.

4. Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families
Target for 2017/18 This is a new priority
1. Establish reference group(s) from staff, patients, and other stakeholders to develop and oversee the priority workplan
2. Embed use of revised equalities monitoring data collection forms which cover all relavant protected characteristics undertaking a baseline review of form completion and agreeing a measurable increase in compliance
3. Source and provide benchmarking data where possible to identify where there may be gaps in provision
4. Analyse quality metrics according to demographic profile and protected characteristics, mapping information to current service provision and agreeing an appropriate action plan

Measure Overview
Development of a systematic approach to analysing the quality of services.

How we will collect the data for this target

Data will be collected through the standard equality monitoring forms which every patient is invited to complete. Quarterly reports on data collection compliance will be provided to clinical directorates on service and team level data. Equalities data will be analysed and mapped to current service provision with an appropriate action plan.

Monitoring our Progress
We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee and the Board of Directors and the Clinical Quality Review Group

Complex Needs

What is the service?

Our adult complex needs teams provide a range of psychotherapies for those who need a specialised service. Our approach is based on a psychoanalytic perspective which understands mental health as involving the whole person, their life and their relationships. This service is open to Adults aged 23 and over.

Who is the service for?

Generally those who come to our service have been seen by counsellors or psychologists in the community (primary care), or in specialised mental health services. Most patients come with depression and anxiety. Many also have complications with their physical health. Relationships, isolation and work related problems are very common. Many wish to try to come to terms with early life and family relational experiences and difficulties.

Outcomes

Of the Experience of Service Questionnaire forms we received in 2015-16, 90% of patients responded that it was true' that they felt the service they received was good. 91% of patients surveyed also noted that they would recommend the Adult Department services to a friend or family member.

Quotes

"The therapist really helped me to open up and was honest."

"People were very nice and easy to talk to"

"Flexible with preferred time of appt. Being listened to."

"Feel of genuine care, not just obligation."

2.2 Statements of Assurance from the Board

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

A review of our services

During the reporting period 2016/17 the Tavistock and Portman NHS Foundation Trust provided and /or sub-contracted ten relevant health services.

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

The income generated by the relevant health services reviewed in 2016/17 represents 45% of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2016/17.

Participation in Clinical Audits and National Confidential Inquiries

During 2016/17 there were no relevant national clinical audits and one National Confidential Enquiry which covered relevant health services that the Tavistock and Portman NHS Foundation Trust provides.

During that period the Trust participated in 100% (1/1) National Confidential Eenquiries which it was eligible to participate in.

The National Confidential Enquires that the Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2016/17, are as follows:

- **National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.**
  We responded to three requests for information made by Manchester University for patients believed to be under the Trust's care. However, after further investigation, it was discovered that none of these patients were with the Trust and therefore no information was supplied.

The reports of nine local clinical audits were reviewed by the provider in 2016-17 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- **Identification and Management of Depression in Children & Young People**: Clinicians encouraged to document the severity of depression at assessment or treatment, and to complete more frequent and regular follow up sessions after any medications started to monitor side effects. Implementation of actions to be reaudited in Quarter 3.
- **Care Plans**: Clinicians reminded to discuss risks, benefits and alternatives with their patients, to document in the electronic Care Plan and to send a copy of the Care Plan to GPs. Report to be set up on the electronic patient system to enable administration

teams to follow up non completion of Care Plans with clinical staff (June 2017), re-audit to be undertaken in 2017.

- **Consent:** Improvement was shown in clinicians completing the consent area of the Assessment form; reaudit Q1 2017/18.
- **Safe & Timely Discharge**: Team Managers to circulate updated standardised discharge letter template to staff to use (October 2016); Informatics to amend electronic patient system to automate the upload of mandatory standards to the closing summary (July 2017).
- **Self-Harm & Suicidality:** Clinical risk training updated following audit and now delivered termly; all clinical staff and clinical trainees are required to attend clinical risk training; clinicians reminded to document these risks on the Assessment Form and to provide more detail in written notes area; identified audit issues to be included in the quality priority 2 for 2017/18 'identification and management of high risk patients'.
- **Timely Outcome Reporting**: Informatics send monthly reminders to Administration teams to follow up unoutcomed appointments (ongoing); Administration staff forward reminders to clinicians and team managers and follow up on outstanding information.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 33.

The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period is available electronically at https://tavistockandportman.nhs.uk/about-us/cquin/

The total financial value for the 2016/17 CQUIN was £471,587. The Tavistock and Portman NHS Foundation Trust have not received final confirmation from the commissioners of the CQUIN performance figure for 2016/17. (The Trust received £262,333 for the 2015/16 CQUIN).

Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

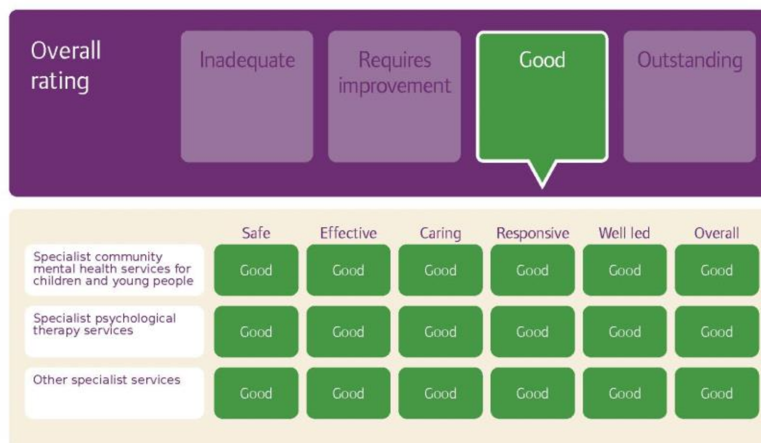
The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2016/17.

In January 2016 the Trust underwent a routine inspection by the Care Quality Commission (CQC) and a follow up inspection in November 2016. We continue to hold full registration with the CQC without restriction. The full report is available on the CQC website, www.cqc.org.uk. The Trust assessment of domain compliance is below:

Last rated
1 February 2017

Tavistock and Portman NHS Foundation Trust



	Safe	Effective	Caring	Responsive	Well led	Overall
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Specialist psychological therapy services	Good	Good	Good	Good	Good	Good
Other specialist services	Good	Good	Good	Good	Good	Good

Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2016/17 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 2016/17 was 81% and graded Red. This indicates that the Trust Information Governance Assessment Report was not met.

The Tavistock and Portman NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Information on the Quality of Data

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

- The Quality Team has continued to work with staff across the Trust to ensure effective processes and procedures are in place to meet our local and nationally agreed targets.

- The Quality Team developed Standard Operating Procedures for data collection, validation and reporting to support the quality of data.

- Weekly meetings with key Trust staff to address any data quality issues continue. Members of the Quality Team continue to meet with department managers on a monthly basis to review service/team performance in relation to CQUINs, KPIs and any locally-agreed targets and where data quality issues are identified they work with the service to deliver improvements.

- A monthly Clinical Data Validation Review Group was established during the year involving key Quality Team, Informatics, senior clinical and administration representation to support improvements in the quality of data.

- The Data Analysis and Reporting Committee (DARC), established in 2015/16 to look at clinical data in line with the Trust's overall strategic plans and to enable the Trust to benchmark services both internally and externally met twice in order to provide assurance to the Trust's Quality and Patient Experience Director and Trust Board met twice in 2016/17. This is a senior committee set up to meet biannually.

- With the trust settling in to the use of the electronic patient administration system, CareNotes, it has allowed the trust to easily capture the clinical and care data that is required. Mandatory CareNotes and Outcome Monitoring training has been a success and continues. This is essential to ensure good quality data is entered to enable robust reporting both internally and externally.

- The Trust has a Clinical Data Quality Management Proceedure which was updated in February 2017 to include an additional section around validation of data and checks on the completeness and accuracy of data. The Quality Team have also developed several Standard Operating Procedures to further ensure the veracity and timely capture of clinical and organisational data. An audit takes place for checking the accuracy of service user data as part of the Information Governance Toolkit and a Clinical Data Quality Review Group is established to analyse and critique data from the patient administration system, with clinical governance leads and administration lead, on a monthly basis.

- Monthly checks around missing data will continue to be run and disseminated by the Quality Team and Informatics department for services to resolve, in order to ensure a more complete and robust Mental Health Standard Data Set (MHSDS) return. These data items include missing demographic details such as ethnicity and employment status.

2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

As specified by NHS Improvement:

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS foundation Trust's indicators should be compared with:

- The national average for the same and
- NHS trusts and NHS foundation trusts with the highest and lowest for the same.

However, the majority of the indicators included in this section ("Reporting against core indicators") are not relevant to the Trust. The Trust is exempt from the National Patient Experience Survey for community mental health services. In respect of safety incidents, the Trust does not report enough incidents to receive a report.

Core Indicator No. 22 covers 'The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.'

The Tavistock and Portman NHS Foundation Trust considers this data is as described for the following reasons: the questions included in the Trust Experience of Service Questionnaire (ESQ) are used with patients seen in the Trust to obtain feedback on their experience of our services. This information cannot be directly compared with the questions derived from the National Patient Experience Survey for community mental health services however, we would score very positively for patient experience when compared to other mental health Trusts.

Quarterly breakdown of patients who rated help they had received from the Trust as 'good':

- 93% of patients in Quarter 1
- 91% of patients in Quarter 2
- 92% of patients in Quarter 3
- 94% of patients in Quarter 4

Also 90% of patients would recommend us to a friend or family number if they needed similar treatment. Patient satisfaction is reported elsewhere in the Quality Report on page 43.

Core Indicator No. 25 covers "The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death". The data for this indicator can be found elsewhere in the Quality Report on page 35.

The Tavistock and Portman NHS Foundation Trust considers that this data is as described for the following reasons: incidents reported reflect the lack of any physical interventions undertaken in the Trust and the organisation provides outpatient services only.

FDAC

What is the service?

The Family Drug and Alcohol Court helps families where children are put at risk by the substance misuse of their parents. The FDAC court provides an alternative to ordinary care proceedings. The focus is on solving the problems that lead Local Authorities to bring families to court. The parents have fortnightly reviews with a dedicated judge, and also has the support of a clinical team throughout the process. Parents are given a 'trial for change', offering them best chance of overcoming their problems within a timescale that is compatible with their children's needs.

At the heart of the FDAC team is the work of the social workers and substance misuse specialists. Where needed they can access specialist support from our Domestic Violence specialist, Adult Psychiatrist and Clinical Psychologist. Our Consultant Child and Adolescent Psychiatrist provides clinical leadership helping the team with formulation and decision making.

Who is the service for?

FDAC is a service for families who are in pre-proceedings or in care proceedings where the parents have difficulties with substance misuse among other issues.

Outcomes

FDAC has been evaluated on more than one occasion and the findings show that more families are reunified through FDAC, and not only this but a recent 5 year follow up study found that when comparing families reunified through FDAC and through ordinary care proceedings, FDAC families were less likely to breakdown in the future.

Of the 16 new cases taken on in 2016/17 in the London FDAC team, 8 have already concluded, in 4 cases the children remained with the family. In 1 case, the children were placed under a Special Guardianship Order with a family member. Three cases concluded with Care Orders for placement outside of the family.

Quotes

When asked what was most helpful about being in FDAC, one parent said "Being able to talk to my keyworker about any troubles I'm facing. I feel confident enough to express how I feel and not be judged. I can get the advice and help I need."

Part 3: Review of quality performance
Review of progress made against last year's priorities

This section contains information on the quality of services provided by The Tavistock and Portman NHS Foundation Trust during 2016/17, describing the Trust's progress against indicators selected by the Board in consultation with stakeholders.

3.1 Quality of Care Overview: Performance against selected indicators

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other Trusts. These indicators include those reported in the 2014/15 and 2015/16 Quality Reports along with metrics that reflect our quality priorities for 2016/17. Quality priorities four and five were measured in previous years and comparative data is provided.

In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve. Please note that data has been pulled at different times. Dates are included beneath individual tables.

The Trust Board, the Clinical Quality Safety and Governance Committee (CQSG), along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2016/17.

Please note performance against both the 'Risk Assessment Framework' and 'Single Oversight Framework' are not applicable to The Tavistock and Portman Foundation Trust due to the Trust providing outpatient services only.

Our quality priorities for 2016/17

Progress on achievement of our quality priorities for 2016/17 can be found in the following section.

Patient Safety

Priority 1: Improving the physical health of patients receiving treatment, part of the 'Living Well' programme
Priority 2: Identifying and managing issues of domestic abuse and violence
Priority 3: Self-harm and suicide

Clinical Effectiveness

Priority 4: Child and adolescent mental health service (CYAF) outcome monitoring programme
Priority 5: Young adult and adult outcome monitoring programme
Priority 6: Increase use of clinical audit and quality improvement methodologies across the Trust to support improvements in services

Patient Experience

Priority 7: Improve awareness and levels of engagement for service users: 'Word of Mouth' project
Priority 8: Patient involvement with physical healthcare within the 'Living Well' programme
Priority 9: ESQ data developments – integrating the use of ESQ data to improve services

2016/17 Quality Priorities summary

Meeting the targets for each of the 2016/17 quality priorities is covered in the following section. 'Green' denotes the targets have been met; 'amber' partly met and 'red', not met.

1. Improving the physical health of patients receiving treatment
1. Develop and deliver the 'Living Well' programme
2. Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver very brief advice on smoking and alcohol
3. Increase individual support for patients around physical health issues including smoking cessation and alcohol use
Performance in 2016/17
1. In consultation with patients, carers and staff we designed and delivered a six-week Living Well Group Programme to improve patient and carer physical health and wellbeing. We also provided a clinical service across the Trust covering individual referrals and treatment related to physical health for patients, carers and staff. We additionally established weekly staff lunchtime Mindfulness sessions.
2. We undertook to increase staff knowledge of physical health matters in running a 'Mind-body Lecture Series' and making Very Brief Advice (VBA) training available for all staff. We have recruited eight service level physical health champions to help support this work. We have gathered physical health resources which will be available on the Trust internet and intranet.
3. We established use of physical health assessments for all clients aged 14 and over and a referral process from across the trust to the Physical Health Specialist Practitioner to provide a one to one physical health service to clients with problems relating to: smoking, alcohol, diet and exercise, stress, sleep disturbance and substance misuse. This service has also been available to staff and carers.

2. Identifying and managing issues of domestic violence and abuse
1. 95% of team managers trained to use the CAADA-DASH assessment tool (competency)
2. 95% of eligible clinical staff to receive Level 2 & 3 domestic abuse and violence training.
Performance in 2016/17
1. (96%) 25/26 team managers or local safeguarding leads were trained by end of year. In addition, a further seven members of staff were trained (not included): FDAC Team and Patient Safety Lead
2. 94% by end of year trained to Level 3. All clinicians are required as from 1 January 2017 to complete Level 3 training.

3. Self-harm and suicide
1. To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with 80% attendance
2. To improve patient experience of clinical risk and safety in the Trust with 80% increase in attendee assessment score following training.
Performance in 2016/17
1. Mandatory risk assessment and risk management training events are held on a termly basis and all clinicians and clinical trainees are expected to attend once in a 3 year cycle. These trainings have been running on a regular basis for 3 years but are mandatory since April 2016. The format of the workshop has been adapted to reflect feedback from participants, to incorporate learning from incidents and to consider the commitment of the Trust to the Crisis Care Concordat to ensure that people of all ages who experience mental health crisis receive appropriate, timely and urgent care and support. As the requirement is attendance once every three years and 2016/17 was year 1 of the current cycle it will not be possible to report on the percentage attendance until later in the cycle. However, it is expected that more than 80% of clinicians will have completed this training by end of Year 3.
2. Feedback from participants at the risk assessment training is consistently high. One way of evaluating the impact of such training is to audit completion of risk assessment, risk management and crisis planning sections on the electronic patient record setting a baseline and re auditing biannually/annually depending on findings. This is a more robust way of determining change in practice than looking at an attendee assessment score following a training event. The patient safety lead has commissioned this audit which will be reported during Q2 2017/18. In February 2017 the CQC updated its overall rating for the Tavistock and Portman NHS Foundation Trust of good. Of particular note is the rating of good within the domain of safety for all Trust Services. At the last inspection in January 2016 the CQC rated specialist psychological therapy services as good in four of the five domains including caring, effective, responsive and well-led and rated safe as requires improvement. During the inspection of January 2017 the CQC found that the Trust had addressed the three issues leading to this rating and therefore changed the rating of safe to good. The issues from the November 2016 inspection were the use of crisis plans, risk assessments and management plans and having a separate waiting area for people under 18 at the Portman Clinic. During 2016/17 The Trust has also been part of the Sign up to Safety national initiative. The Trust focused on improving physical health of patients, improving clinician's knowledge of self-harm, suicide and domestic abuse and violence and improving awareness of the role of digital media on patient mental health.

4. Child, Adolescent and Young Adult Mental Health Service Outcome Monitoring Programme
1. For 80% of patients (attending CYAF) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).
2. For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).
3. Improve access to patient and team level data - developing a dashboard to provide 'real-time' data which is reviewed by teams to improve services.
Performance in 2016/17
1. Not achieved, 48%. – please see table below for annual comparison
2. Achieved, 80%. – please see table below for annual comparison
3. A project team has been established, trialling software solution in preparation for data warehouse redesign

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

GBM – Results			
	2014/2015	**2015/2016**	**2016/2017**
Target 1 – GBM completion	73%	59%	48%
Target 2 – GBM Improvement	75%	83%	80%

*Please see page 33 for commentary on GBM results.

5. Adult Outcome Monitoring Programme
1. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.
Performance in 2016/17
1. Not achieved, 64%. – Please see below for annual comparison

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

CORE – Results		
2014/2015	**2015/2016**	**2016/2017**
53%	71%	64%

*Please see page 34 for commentary on CORE results.

6. Clinical audit and quality improvement developments
1. Introduce the Quality Impact Assessment (QIA) Screening tool across the organisation and evidence use in each service line where indicated.
2. Evidence that each directorate actively engages in all of the four clinical audit priority areas, evidencing changes in practice in at least one.
Performance in 2016/17
1. The QIA tool was approved November 2015 by the Management Team. In 2016/17 the QIA tool was completed for the three services: CAMHS, Adult and Forensic services and Gender Identity Clinic.
2. Each directorate completed audits throughout the year to improve in the four Clinical Audit Priority areas. All audits have included action plans for improvement and change in at least one area within the given service.

7. 'Word of Mouth' project
1. Develop a plan for raising awareness and levels of engagement for service users
2. Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the project
3. Launch a Visual Straw Poll on awareness of the Living Well Programme
Performance in 2016/17
1. Over 2016/17 a word of mouth steering group began to run bi monthly. This group was identified primarily as a signposting forum to engage service users with other means of involvement. It was eventually disbanded as more value was seen in developing the engagement with service users attending the Adult reference Group, and the monthly Pizza and Chat. Within these groups more focused and detailed work was achieved for feedback to the trust and raising awareness within clinical teams to communicate directly with service users.
2. As well as continuation and strengthening of The Pizza and Chat group and the now self-renamed adult 'getting together' group, City and Hackney Primary Care Psychotherapy Consultation Service are establishing a service user lead group, and Camden Team Around the Practice have set up a monthly group supported by the PPI team.
3. The Visual Straw Poll ran and received over 100 responses.

8. Patient involvement with physical healthcare – 'Living Well Programme'
1. Consult with patients and carers on the scope and content of the Living Well Programme
2. Raise awareness of the Living Well Programme with patients and carers for self or clinical referral
3. Obtain feedback from programme participants and ensure that information is shared in PPI newsletters
Performance in 2016/17
1. Patient and Carer groups were consulted on the scope of the programme. General feedback was that it was detailed and thorough, although it did not appeal to the service users currently accessing involvement at the Tavistock Centre.
2. Posters and sign-up sheets were displayed around the trust throughout the year. Updates were provided in the Patient Public Involvement (PPI)quarterly newsletters
3. 80% of Trust members were happy with the physical health topics covered by the programme, 20% made recommendation on how this can be improved (as of 16.03.17)

9. ESQ data developments – integrating the use of ESQ data to improve services
1. Establish quarterly analysis of team level ESQ data
2. Disseminate the analysis to teams, discussing and agreeing actions as required
3. Establish regular feedback mechanisms for patients and staff
Performance in 2016/17
1. The PPI team provide team level data to services at quarterly intervals.
2. The PPI team is meeting with teams to discuss the qualitative feedback from the ESQ; teams have responded positively and are currently negotiating the best way to feedback actions to patients.
3. Feedback mechanisms are varied by service and team and are held by the Clinical Quality Patient Experience Workstream.

Clinical Outcome Monitoring

Child and Adolescent Mental Health Service (CAMHS)

Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2015/16	**2014/2015**	**2015/2016**	**2016/17**
1. For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	73%	59%	48%
2. For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	75%	83%	80%

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

Measure Overview

For our Child and Adolescent Mental Health Services (CAMHS), we have used the Goal-Based Measure again this year, building on the knowledge we have gained since 2012, with patients previously referred to CAMHS. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.

As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback. As a result, we set the targets as stated in the table above. These were agreed with our commissioners and were measured as one of our CQUIN targets for 2015/16 (see Glossary).

For CAMHS, Time 1 refers to the Pre-assessment stage, where the patient is given the Goal-Based Measure to complete with their clinician when they are seen for the first time, where the patient decides what would like to achieve. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2), indicating whether or not they have achieved their goal.

Targets and Achievements

1. This year the Trust target of 80% was not met for the return rate of forms for the Goal-Based Measure completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2. In year 2016/17 48% of patient with in the cohort met this target.

2. This year the target of 80% improvement in patients on the Goal Based Measure (GBM) from Time 1 to Time 2 was met, the trust achieved 80%; this is a pleasing result as this is important for demonstrating positive changes for patients. A Quality Improvement Project focusing the completeness and the quality of the GBMs completed will be undertaken in 2017.

Outcome Monitoring – Adult Service

Adult Outcome Monitoring Programme			
Targets for 2015/16	**2014/2015**	**2015/2016**	**2016/2017**
3. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.	53%	71%	64%

Source: CareNotes/Quality Team. All data is the annual percentage. Data received and calculated: 5 April 2017

Measure Overview

The outcome measure used by the Adult Services the CORE (Clinical Outcomes for Routine Evaluation system, see Glossary) was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure cover four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm. It is used widely by mental health and psychological therapies services in the UK, and it is sensitive to change. That is, where it is useful for capturing improvements in problems/symptoms over a certain period of time. We think in the future this should enable us to use this data for benchmarking purposes, for providing information on how our improvement rates for adult patients compares with other organisations and services using the CORE.

For the Adult Service, we used the CORE form again for the current year, building on the knowledge we have gained since 2012, with patients previously referred to the Adult Service. We set the following targets, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 2016/17.

Targets and Achievements

For the Adult Service, for Target 1, Time 1 refers to the Pre-assessment stage, where the patient is given the CORE form to complete before they are seen for the first time. Then, the patient is asked to complete this form again at the End of Treatment stage (Time 2).

Unfortunately we missed the target of 70% of patients who completed the CORE forms at Time 1 and Time 2 showing an improvement in their Total CORE score from the Pre-assessment to the End of Treatment stage. At the end of the financial year 2016/17 we achieved 64%. Whilst two thirds of our patients completing the measures showed improvement as a result of our psychological interventions we plan to look at the results in more detail to understand better what contributes to improvement on the CORE measure.

Patient Safety Indicators

Indicator	2014/2015	2015/2016	2016/17
Patient Safety Incidents	15	34	114

Source: Incident Database, Data received and calculated: 12 April 2017

Measure Overview

The Trust records all reported incidents in order to support the management of, monitoring and learning from all types of untoward incident. In addition, patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) for further monitoring and inter-Trust comparisons which promote understanding and learning. The NRLS definition of an incident that must be uploaded is as follows:

'A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.'

The Trust has a low rate of 'patient safety' incidents due to the nature of its patient services, (we provide psychological therapies, we do not undertake any physical interventions, and are an out-patient service only). There is no comparative NRLS data as the incidents reported by the Trust, whilst appropriate, are too few in number for meaningful comparisons.

We have robust processes in place to capture incidents, and staff are reminded of the importance of incident reporting at induction and mandatory training events. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on staff making the effort to report (often for this Trust very minor events). Whilst we continue to provide training to staff and there are various policies in place relating to incident reporting, there are ongoing efforts to remind staff to report all incidents.

Commencing in April 2016 the Trust took the opportunity with the NRLS Patient Safety Reporting Lead to review the types of incidents that would be classed as 'patient safety incidents' and therefore reported to the NRLS. It was confirmed that there were some incidents we should have been reporting but had not been. It was agreed that from 1 April 2016/17 we would report all of the following incidents – even if they do not happen on site. As is noted in the year on year numbers, by increasing the scope of the reportable incidents we are now reporting any and all incidents that 'caused harm' to patients including; Information Governance Incidents (relating to patient information), self-harm / attempted suicide (not previously reported as they were off site) and all Rapid Transfer incidents.

During 2016-17 the Trust had three suicides which were reported nationally. Serious Incident investigations were undertaken. Some lessons from across the investigations are similar:

- The importance of allocating an experienced clinician to patients with complex history;
- The importance of multidisciplinary case discussion of complex cases post assessment;
- Improving clinical risk assessment skills;
- Communications – internally with other clinicians and across other agencies, including clarity over the role of different agencies in a case and sharing of information where there is consent.

Being Open and Duty of Candour

Care organisations have a legal duty to act in an open and transparent way in relation to care provided to patients, with specific requirements when a patient safety incident has occurred. This 'duty of candour' has been met for such reported incidents. Where there is an incident with moderate to severe harm the duty of candour requirements are followed up with staff to ensure they are met. Fields have been added to the internal incident database to ensure records are accurately kept. Requirements are covered in all Trust induction and training (INSET) days. Information on compliance is also included within the Trust Quarterly Quality News.

Child and Adult Safeguarding Alerts

Indicator	2014/2015	2015/2016	2016/2017
Child Safeguarding Alerts	2	71	111
Adult Safeguarding Alerts	0	7	6

Source: Clinical Governance Report, Data received and calculated: 5 April 2017

Measure Overview

Trust staff have made one safeguarding enquiry to the local authority in Q4. Staff consultations regarding safeguarding issues continue to be raised at the rate of about one per week. Staff are thoughtful and increasingly aware of the ten adult safeguarding categories and the range of ways in which these can present. In-house level 2 and 3 adult safeguarding training is being developed and trialled. The new adult safeguarding policy has been launched. In 2016/17, 111 children and six adult safeguarding referrals were made.

The increase in children's safeguarding alerts reported numbers between 2014/2015 and 2015/2016 is due to the reporting system not being fully established until September 2014. Improved reporting and recording during 2016/17 saw a further increase in children's safeguarding alerts being reported.

Attendance at Trust-wide Induction Days

Indicator	2014/2015	2015/2016	2016/2017
Attendance at Trust Wide Induction Days	90%	85%	85%

Source: HR, Data received and calculated: 5 April 2017

Measure Overview

This measure monitors staff attendance at mandatory Trust-wide induction, which all new staff are required to attend, when they first join the Trust. The Trust schedules this induction event on a rolling basis to new staff at least three times a year. As part of this Induction, staff are provided with an introduction to the work of the Trust and the Trust's approach to risk management and incident reporting; health and safety; infection control, confidentiality and information governance; Caldicott principles; safeguarding of children and counter fraud awareness, to ensure that all new staff are able to provide a safe and good quality service to service users.

Targets and Achievements

12 members of staff joined the Trust after the last Trust-wide induction in February and are due to attend the next induction in May. The Trust will continue to monitor the attendance at mandatory training events, aiming to maintain a high level of attendance.

Local Induction

Indicator	2014/2015	2015/2016	2016/2017
Completion of Local Induction	98%	96%	97%

Source: HR, Data received and calculated: 5 April 2017

Measure Overview

The Trust provides all new staff with a local induction checklist in their first week of employment. This checklist needs to be completed within two weeks of commencing employment with line managers and a copy returned to Human Resources. This checklist is required by Human Resources to verify that the new staff member has completed their local induction.

This measure monitors the completion and return of the local induction checklist by new staff. The local induction process covers all local policies and procedures in place in individual service areas/directorates and ensures new staff are aware of all terms and conditions of employment, mandatory training requirements and arrangements in place locally that impact on working arrangements within the Trust.

Targets and Achievements

We are very pleased to report that we received 97% returned forms to show that the local induction had been completed by almost all staff joining the Trust in 2016/17.

It is important that all new staff undertake a local induction with the appropriate manager, in order to ensure that staff are aware of policies and procedures that apply locally within their service area/directorate, and so that staff newly recruited to the Trust are able to provide a relevant, safe and good quality service to patients.

Attendance at Mandatory INSET Training

Indicator	2014/2015	2015/2016	2016/2017
Attendance at Mandatory INSET Training*	98%	96%	100%

Source: HR, Data received and calculated: 5 April 2017

*Staff are expected to attend training every two years. In order to achieve this 100% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2017.

Measure Overview

This measure monitors staff attendance at mandatory INSET training. The Trust provides the main mandatory training through an In-Service Education and Training (INSET) day, which all staff are required to attend once every two years. During this training day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality, equality and diversity, information governance, PREVENT, safeguarding children and adults and fire safety.

Targets and Achievements

It is important that staff remain up to date with developments in each of these areas, to ensure that they are able to provide a safe and good quality service for service users. We can report that 100% of our staff who were required to attend INSET training had done so within the previous two years and that the attendance rate has improved further since last year.

Safeguarding of Children and Adults (Training)

Indicator	2014/2015	2015/2016	2016/2017
Safeguarding of Children & Adult – Level 1 Training*	97%	92%	95%
Safeguarding of Adults only – Level 2 Training	n/a	N=61	88%/ as of Q4 training was incorporated in level 3
Safeguarding of Children – Level 2 Training**	100%	96%	88%/ figures do not include Q4 as training for level 2 only was ceased
Safeguarding of Children – Level 3 Training**	94%	92%	94%

Source: Clinical Governance, Data received and calculated: 5 April 2017
*All staff receive Level 1 training as part of mandatory INSET training.
Please note: Adult Level 1 and Level 2 Safeguarding training introduced in 2015/16

Measure Overview

All staff receive Level 1 training as part of mandatory INSET training and must complete this training every 2 years.

All clinical staff, who are not in contact with children and young people and do not fulfil requirement for level 3, are required to attend Level 2 training. This training must be completed every 3 years. Further level 2 and 3 Adult safeguarding Training is being developed.

To ensure that as a Trust we are protecting children and young people who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in Child and Adolescent services and other clinical services working predominantly with children, young people and parents to receive Level 3 Safeguarding of Children training once every three years.

Targets and Achievements

The Trust places great importance on all staff receiving relevant safeguarding training and so we are very pleased that when compared with last year there has been an improvement in attendance for all three levels of Child Safeguarding training. By March 2017 95% of staff received Level 1 training and 88% of staff attended Level 2 training. In addition, 94% of staff requiring Level 3 training had attended this training.

Infection Control

Due to the types of treatment offered (talking therapies) this Trust is at very low risk of cross infection. All public areas are cleaned to a high standard by internal cleaning staff. Toilets and washrooms are stocked with soap and paper towels and we have alcohol hand gel available for staff and public use in public areas of the Trust (e.g. at the entrance to the lifts in the Tavistock Centre). Anti-bac wipes have been made available in all administration offices and Reception as an additional cleaning resource. Since April 2016 we have initiated processes for support services staff to clean communal area toys on a regular basis (quarterly) in sites managed by T&P Estates

The Trust organised on site access to flu vaccination for staff at the Tavistock Centre by Occupational Health Royal Free Hospital (RHF) staff through the flu campaign from October to February, they can also attend the walk in clinics at the RFH. Outreach and community staff are encouraged to make arrangements for their own Flu vaccines and report to HR. Update on personal responsibility for reducing the risk of cross infection is raised at induction and mandatory INSET training.

Clinical Effectiveness Indicators

Monitor number of staff with Personal Development Plans (PDPs)

Indicator	2014/2015	2015/2016	2016/2017
Monitor number of staff with Personal Development Plans	98%	99%	100%

Source: HR, Data received and calculated: 5 April 2017

Measure Overview

Through appraisal and the agreement of Personal Development Plans (PDP) we aim to support our staff to maintain and develop their skills. It also provides an opportunity for staff and their managers to identify ways for the staff member to develop new skills, so as to enable them to take on new roles within the organisation, as appropriate. A Personal Development Plan also provides evidence that an appraisal has taken place. In addition, the information gathered from this process helps to highlight staff requirements for training and is used to plan the Trust Staff Training Programme for the up-coming year.

The data collection period for Personal Development Plans has changed this year from January to March and now takes place from January to May each year. This has impacted our ability to report on the figures this quarter due to the transition process. We will be in a position to report on the appraisal statistics by the end of Q1 each year.

Regarding the statistics it is important to note that the staff group who have not completed a PDP include those staff who are on a career break or sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

Targets and Achievements

We are very pleased to report that 100% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the 31 March 2017 deadline. This is an improvement from last year's return rates.

Gender Identity Development Service
Kids on the Edge: The Gender Clinic documentary

What is the service?

The central aim of the service is to support the development of gender identity. We do this by exploring the nature and characteristics of the patient's gender identity. The aims of the service are to understand the nature of the obstacles or adverse factors in the development of gender identity, and to try minimise their negative influence.

Who is the service for?

The Tavistock's gender service is the country's only NHS-run gender clinic for children and young people with gender dysphoria – a profound distress caused by feeling they've been born into the wrong body. With transgender issues and stories rarely out of the news, the gender specialists have seen a 100% rise in referrals, but still understand very little about why children feel this way.

What was the documentary?

Following service user feedback the service took part in a Channel Four 3-part documentary series entitled "Kids on the Edge" about different services in the Tavistock. The one on the GIDS ("The Gender Clinic") involved two younger service users and their families. The documentary, which took two years to complete, aired in November 2016 and has received excellent feedback. This was an important opportunity to raise awareness in the context of a considered and balanced film.

Media impact

The series aired Wednesday nights on Channel 4 at 10pm in Nov-Dec 2016, and total viewership for the series was nearly 2.5 million. The Gender Clinic specific episode had 871,400 TV views and 51,535 on-demand views. The Trust facilitated interviews with nearly all major UK newspapers including a cover article in the Times Sunday magazine and the Observer magazine. Further to this, print media coverage in this time had a "reach" of 945 million and 45 articles were rated as positive about the trust or wider issues involving mental health, 15 were considered negative, and 5 pieces rates as neutral. The documentary led to increase in Trust website and social media traffic.

Patient Experience Indicators

Formal Complaints Received

Indicator	2014/2015	2015/2016	2016/2017
Formal Complaints received	14	27	39

Source: Clinical Governance. Data received and calculated: 05-04-17

Targets and Achievements

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 2016/17 remains relatively low at 39 although this represents a rise in complaints from previous years, 14 in 2014/15 and 27 in 2015/16. This is due to patients feeling more able to raise issues with us and an increase in patient numbers, particularly in GIDS.

36 of the formal complaints received relate to aspects of clinical care, appointment times and delays in referral, three complaints relate to corporate services.

The Trust policy states that a formal complaint any written complaint received from a patient or a representative of a patient. Although any informal complaint can be escalated to a formal complaint if on discussion the individual decides they decide for their concerns to be addressed formally.

In order to maintain confidentiality of the complainants, given the small numbers of complaints, the Trust does not provide the details of these complaints; however, a quarterly complaint summary is published on the Trust website. Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During the year three complaints were referred to the Health Service Complaints Ombudsman. One has not been taken forward and no failings were found for the Trust for the other two.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, a critical contribution to all of our service development. In addition, for 2016/17 the Trust has taken steps to ensure that all staff are fully aware of the different ways that patients can raise concerns and we have recently launched a short guidance note for staff to help them support their patients with raising concerns. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

Patient Satisfaction

Trustwide

Indicator*	Q1	Q2	Q3	Q4
	N (%)	N (%)	N (%)	N (%)
Patient rating of help received as good	264 (93)	239 (91)	246 (92)	202 (94)

* Yearly averages: 2016/17 = 93%; 2015/16 = 94%; 2014/15 = 92%; 2013/14 = 94%
Source: PPI, Data received and calculated: 4 April 2017

The Trust has been formally exempt from the NHS National Mental Health Patient Survey which is targeted at patients who have received inpatient care. For eleven years, up until 2011 we conducted our own annual patient survey which incorporated relevant questions from the national survey and questions developed by patients. However, the return rate for questionnaires was very low and in 2011 the Trust discontinued using its own survey and started to use feedback received from the Experience of Service Questionnaire (CHI-ESQ) to report on the quality of the patient experience on a quarterly basis. The ESQ was chosen because it was already being used as a core part of the Trust's outcome monitoring, and so we anticipated obtaining reasonable return rates to enable us to meaningfully interpret the feedback.

Targets and Achievements

Results from the Experience of Service Questionnaire found that 93% of patients in Quarter 1 (April to June 2016), 91% of patients in Quarter 2 (July to September 2016) 92% of patients in Quarter 3 (October to December 2016) and 94% of patients in Quarter 4 (January to March 2017) rated the help they had received from the Trust as 'good'. Our target for quarterly reporting is 92%; achieved in 3 out of the 4 quarters in 2016/17.

The Trust also takes part in the Friends and Family Test and reports as part of our Key Performance Indicator schedule on a quarterly basis. This allows us to see how many of our patients would recommend our service to a family or friend if the required similar treatment.

Experience of Survey Questionnaire: Friends Family Test only

Indicator*	Q1	Q2	Q3	Q4
Number of patients who would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment	216	260	222	195
Percentage of patients who would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment	90%	92%	90%	90%

*Please note that these figures are for London contracts only, data has been re-run for the year to capture all forms that may have been received by the trust after the quarter end.
*Yearly average of 90% 2016/17 **Source: PPI, Data received and calculated: 4 April 2017**

Targets and Achievements

It is pleasing to report that with an annual score of 90% we exceeded our quarterly target of 80% in every quarter throughout the financial year of 2016/17. This is a great way to measure the way people are feeling about the treatment or service that has been delivered to them from the Tavistock and Portman. Thematic analysis of the qualitative data is also collected, and patients are contacted if they feel as though they have had a negative experience in one of the trusts services.

We have met the target of 80% for the FFT indicator. However an audit identified a lack of adequate audit trail for our Experience of Service Questionnaire (ESQ) forms. We will address this by introducing new administrative procedures. These include ensuring all forms are scanned to the Quality Team stating patient ID and will be retained for 12 months. We also need to address the finding that some responses were recorded inaccurately, by introducing monthly audit of 20 ESQ and Outcome Monitoring forms to ensure they are entered correctly.

Physical Health: Living Well Programme

What is the programme?

In the past year we have developed and delivered a programme of initiatives related to improving physical health and wellbeing across both user, carer and staff groups. These included the introduction of formal patient physical health screening, a structured physical health programme, front line clinical service, mindfulness groups and increasing staff knowledge. We established use of physical health assessments for all patients aged 14 and over and a referral process from across the Trust to the Physical Health Specialist Nurse to provide both one to one and group physical health service to clients with problems relating to: smoking, alcohol, diet and exercise, stress, sleep disturbance and substance misuse.

Why did we do this?

Good mental health is associated with good physical health and there is evidence that links the two. We believe that physical health should be included within the holistic management of patients at the Trust and that improving the physical health and wellbeing of our staff is also important. The Trust chose this programme as one of its Quality Priorities for 2016/17 and it was also one of the Trust's Sign up to Safety projects. Additionally, it was a priority for our health commissioners.

Outcomes

A structure to support the delivery of physical health work across the organisation was set up during 2016/17. The Trust has two clinical physical health leads, one for the Children, Adult and Families service and one for the Adult and Forensic services. In addition the Trust appointed a Physical Health Specialist Nurse on 2 days per week to lead on developing and delivering the Living Well Programme. Service level physical health 'champions' have been supporting the work. We have developed an increased awareness of the importance of physical health across the Trust and will work with clinicians to further develop and embed a culture of integrated physical and mental health and wellbeing across the Trust.

By the end of quarter 3 over 60% of new patients aged 14 years and older had physical health assessments. One to one referrals to the PHSN have increased through the year, and weekly lunchtime staff mindfulness courses have been well attended.

Patient feedback comments to the Living Well Programme

"The group really helped me to reduce my alcohol use and my blood pressure went down. Now I can do more at the gym and eat healthier".

"By closing my kitchen/ bar earlier and developing new strategies for coping with stress, I reduced my alcohol use and my sleep pattern improved".

Did Not Attend Data

Indicator	2014/2015	2015/2016	2016/2017
Trust-wide Total			
First Attendance	7.8%	12.4%	10.0%
Subsequent Appointments	7.7%	8.6%	7.4%
Adolescent and Young Adult			
First Attendance	8.9%	18.3%	15.4%
Subsequent Appointments	14.8%	12.9%	8.5%
Adult			
First Attendance	8.5%	15.9%	11.6%
Subsequent Appointments	7.3%	7.4%	6.5%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)			
First Attendance	8.8%	10.8%	8.3%
Subsequent Appointments	7.1%	9.0%	7.7%
Other CAMHS (including Lifespan)			
First Attendance	3.8%	4.4%	6.4%
Subsequent Appointments	4.1%	4.7%	6.1%
City and Hackney			
First Attendance	n/a	19.7%	12.9%
Subsequent Appointments	n/a	13.8%	10.2%
Portman			
First Attendance	2.7%	11.0%	5.7%
Subsequent Appointments	8.3%	8.2%	7.0%
GIDS			
First Attendance	n/a	10.6%	10.7%
Subsequent Appointments	n/a	8.8%	7.4%
Westminster Service			
First Attendance	n/a	4.9%	1.5%
Subsequent Appointments	n/a	5.5%	12.7%

Please note n/a data was not reported on.
Source: CareNotes, Data received and calculated: 5 April 2017

Measure Overview

The Trust monitors the outcome of all patient appointments, specifically those appointments where the patient Did Not Attend (DNA) without informing us prior to their appointment. We consider this important, so that we can work to improve the engagement of patients, in addition to minimising where possible wasted NHS time.

Targets and Achievements

DNA rates have reduced in most services for first and subsequent attendances with an overall Trust decrease to 10% first attendance compared with 12.4% in 2015/16 and 7.4% subsequent appointments compared with 8.6% in 2015/16.

We believe that this has been as a consequence of the on-going and concerted efforts undertaken by all services to reduce the number of appointments patients fail to attend. For example, by offering a greater choice concerning times and location of appointments; emailing patients and

sending them text reminders for their appointments, or phoning patients ahead of appointments as required.

As DNA rates can be regarded as a proxy indicator of patient satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively. For example, for some patients not attending appointments can be a way of expressing their dissatisfaction with their treatment. However, it can also be the case, for those patients who have benefited from treatment that they feel there is less need to continue with their treatment, as is the case for some patients who stop taking their medication when they start to improve. However, this is only one of the indicators that we consider for patient satisfaction, which needs to be considered along with other feedback obtained from patients, described elsewhere in this report.

Waiting Time Breaches (Trustwide) – Target dependent on service

Number (%) of patients attending a first appointment 6, 8, 11 or 18 weeks after referral received and those who are still waiting for a first appointment as of the 31st March 2017

Service	Target	Internal Breach	External Breach	Total Breaches
Adolescent Service	<8 weeks (10%)	**33 (14.8%)**	14 (6.3%)	**47 (21%)**
Camden CAMHS	<8 weeks (10%)	**80 (5.6%)**	26 (1.8%)	**106 (7.3%)**
Other CAMHS	<8 weeks (10%)	**69 (14.3%)**	51 (10.6%)	**120 (24.8%)**
Westminster (Family Assessment Service)	<6 weeks (10%)	**15 (16.7%)**	20 (22.2%)	**35 (38.9%)**
Adult service	<11 weeks (5%)	**30 (5.2%)**	25 (4.4%)	**55 (9.6%)**
Portman	<11 weeks (10%)	**0 (0%)**	4 (2.9%)	**4 (2.9%)**
City and Hackney PCPCS	<18 weeks (10%)	**82 (7.0%)**	43 (3.7%)	**125 (10.7%)**
Gender Identity Service	<18 weeks (10%)	**2563(62.5%)**	38 (0.9%)	**2601 (63.4%)**

Source: Carenotes. Data received and calculated: 21 April 2017

Measure Overview

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially those who are close to our target time. The definition of this indicator is as follows:

To calculate the year-end indicator, the numerator and denominator at the end of each quarter, are added together, to arrive at year-end figure.

The numerator for the quarterly calculations is the sum of:
- number of referred patients who had attended a first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received; and
- number of referred patients still waiting for their first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received at the end of the quarter

The denominator for the quarterly calculations of the indicator is the sum of:
- Number of patients who attended a first appointment during the quarter
- Number of patients still waiting for an appointment at the end of the quarter

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment with the same therapist where possible. This system, on the whole, helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral.

Targets and achievements

To help address the breaches, at the end of each quarter a list is drawn up for each service of those patients who had to wait longer than the given target of weeks for their first appointment, together with reasons for this. The services where the breach has occurred are requested to develop an action plan to address the delay(s) and to help prevent further breaches.

Overall the Trust has seen an increased number of patients in 2016/17. In many services patients are seen within our waiting time targets. However in some services the number of breaches has exceeded the target. In services such as the Adolescent and Young Adult Service, this is due to scarce availability of the specialised resources required for complex patients seen in this service. In our Gender Identity Development Service this is due to the continued increase in the referral rate. We anticipate seeing an improvement in waiting times as additional resources have been made available and thirty new staff have joined the London base over the final quarters of 2016/17.

With regards to Other CAMHS, Lifespan team breaches are a mixture of both internal and external reasons, the first external reason for breaches is the patient group Lifespan work with can at times be hard to engage. Moreover the unspecific demographics of the service prove hard to secure funding within the 8-week target, as information from external services is needed to continue with the referral. This in turn impacts on our overall number of breaches.

Westminster Service (Family Assessment Service) has had unusually high number of referrals in the last three quarters which exceeds capacity and also exceeds targets for the year. This has means cases have had to wait for clinicians to become available to carry out the work. As the nature of the service is a multi-disciplinary team, some of the referrals state the need for adult or child psychiatric input. This usually has to be explored further by the service prior to allocating this very limited resource in the team. The service is under discussions with the commissioners and referring teams to devise solutions to these issues, including better referral gatekeeping by the service leads in the children's services.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) figures have improved greatly throughout the year due to improving the general intake criteria (better clarity and signposting for mental health services in City and Hackney area), intake processes (opt-in letter procedures and policies put in place) and staffing (fully staffed administration).

3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework/Risk assessment framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/or medical consultant led services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner Organisation code) apply to the Trust and in 2016/17 by achieving 97% data completeness for these mental health identifiers.

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

3.3 Reported Raising of Concerns: Whistleblowing

The Trust takes the issue of staff being able to raise concerns, 'whistleblowing' very seriously and appointed a clinician to the role of Freedom to Speak up Guardian in October 2015. This is in line with Francis Review recommendations. The Trust has in place a 'Raising Concerns and Whistleblowing procedure' and regular communications have gone to staff to make them aware of our Freedom to Speak up Guardian, her role and contact details. Meetings have also been held with groups of staff to raise awareness.

There were no formal clinical whistleblowing cases raised in 2016/17. There was one non-clinical matter raised. There were no whistleblowing cases in the previous year 2015/16. The Trust has had no members of staff coming forward and raising formal complaints about patient care, however, since being appointed, staff have felt able to make contact to discuss other issues in confidence. These have related in particular to staff feeling not listened to by managers and feeling bullied. This is sometimes seen as having an indirect impact on the quality of care given to patients and families. We are committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

Contact has been made with the National Whistleblowing Helpline and our Guardian now receives regular newsletter updates. She has also joined the NHS Employers, local Guardian hub, and her details are on the Freedom to Speak Up Guardian map. Links have also been made with the London Freedom to Speak Up Guardians and a new group for those based in Mental Health Trusts. The National Guardian's Office is now establishing itself and is arranging regular conferences and training events. The National Guardian visited the Trust in February 2017.

The Guardian will continue to keep the profile of the role in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness where staff are encouraged to speak up about patient safety, knowing that their concerns will be welcomed, taken seriously and responded to quickly.

3.4 Sign up to safety

The focus on quality of care and patient safety remains central to the Tavistock and Portman NHS Foundation Trust. The National Sign up to Safety Campaign's aim to deliver harm free care for every patient every time, halving avoidable harm in the NHS over the next three years is a commitment that the Trust fully supports. The Chief Executive signed up to the campaign on behalf of the Trust in October 2015. The actions the organisation would take in response to the five Sign up to Safety pledges within the National campaign can be found on our Trust website.

These commitments have led to the development of a Safety Improvement Plan which shows how we intend to reduce harm to patients over the next 3 years. This builds on and integrates with our Clinical Quality Strategy and Annual Quality Report. Our patient safety improvement plan focus on the following areas:

- Detection and management of e-safety risks in young people
- Improving the physical health of patients
- Improving domestic violence and abuse management
- Improving clinician knowledge of self-harm and suicide

The Trust has agreed a Clinical Quality Strategy to meet the local needs of our service users and believe that the core aims outlined in the Strategy will drive the Safety Improvement Plan. These are:

- Ensuring that all service users are safe and protected from avoidable harm and abuse;
- Providing services with care, treatment and support that achieves good outcomes and promotes good quality of life, based on best evidence;
- Organising services around the needs of the user – involving them and their carers in service design and delivery; and
- Supporting staff to maintain and develop their skills and working within clear and effective governance structures to deliver safe, effective, responsive, caring and well-led services.

3.5 Staff Survey

1. The 2016 survey

The NHS Staff Survey took place between September and December 2016. For a second year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.

This year the survey was sent to 556 staff and 321 responded giving a final response rate of 58%, a 12% increase from the previous year. A copy of the national report can be found here: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2016_RNK_full.pdf

2. Key messages from the survey

Out of the 32 key finding areas 29 have not changed compared to previous years, 2 have got worse and 1 has got better.

The following areas are our top result areas:

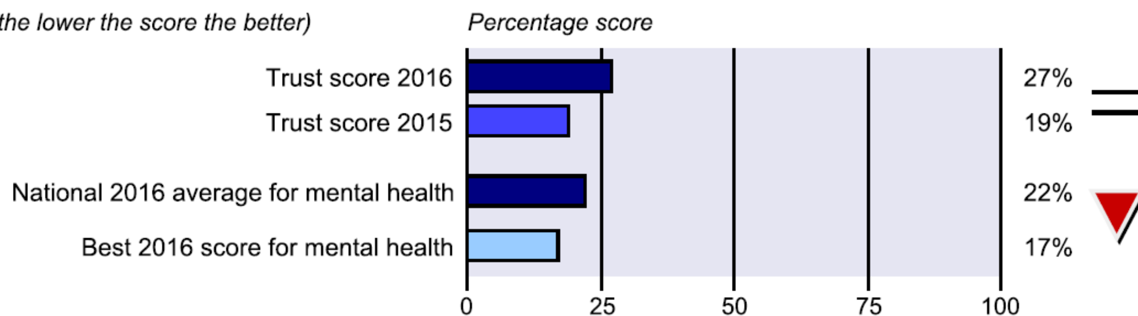
- We have a higher than average engagement score (4th best compared to mental health trusts and 21st best when compared to all NHS provider organisations);
- Our staff would recommend the organisation as a place to work and be treated (best mental health trust and 18th best compared to all provider organisations);
- A higher proportion of staff are happy with the opportunities to work flexibly, this was a concern area last year;
- Communication between senior management and staff is better;
- Fewer staff experience bullying, harassment, violence or aggression from service users or their relatives;
- Whilst staff witness incidents the number is smaller than our peer group.

There are some less positive findings, some which are consistent with previous years and are also with feedback we have been receiving through less formal mechanisms:

- The number of staff working additional hours continues to be a challenge;
- The level of work place stress has increased;
- That there are less resources and support;
- Staff feel, less strongly, that their role makes a difference to service users and that they do not receive recognition from their managers;
- That when staff feel they have been bullied or harassed by managers or colleagues they have not reported this;

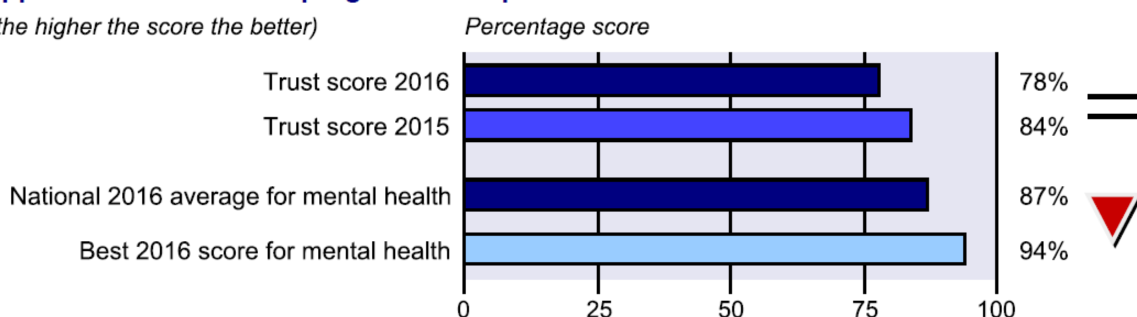
- That bullying and discrimination amongst our BAME staff has increased since the previous survey; and
- That a lower than average number of staff reported errors, near misses or incidents.

This year we have seen some changes in our best and less positive areas. We have also received results at both directorate and service line level which will help us to understand where we need to focus our attention and give support.



3. Responding to the workforce race equality standard (WRES)

During 2016/17 we published our WRES data and action plan and have started an ongoing programme of work to improve on areas where we need to focus more attention. The data last year did indicate that there had been some small changes in our workforce composition at more senior levels in the organisation which is positive, however, it is still early days and we have committed as an organisation to developing and implementing a race equality strategy.



4. Setting actions and tracking progress

The bottom-up action planning process that was followed last year proved to be successful and we will be repeating this process again. Our HR team will work collaboratively with service line managers and heads of service to discuss the results and agree how to best share the key messages and what support they will need to address the issues. This will then lead to local action plans being produced which inform a corporate plan.

Portman Service

What is the service?

We are a forensic psychotherapy out-patient clinic that offers psychoanalytic psychotherapy assessments and treatment to individuals presenting with problems of violence, criminality, antisocial behaviour and problematic sexual behaviours. We also provide risk assessments, teaching and consultations to forensic staff, teams and institutions within the NHS and Criminal Justice System and other services which work with forensic patients and offenders.

Because of the sensitive nature of the difficulties that our patients present with, we take issues of confidentiality very seriously whilst carefully assessing any risk posed towards self and others.

Who is the service for?

We offer treatment to children, adolescents and adults presenting with problematic violent, sexual or antisocial behaviours. We have a national catchment area and accept referrals from anywhere within England and Wales. Our referrals come from GPs, secondary mental health services, probation and other services within the Criminal Justice System, social services and voluntary agencies. We also accept self-referrals. Our treatments include individual, group and couple therapy, and when working with children and young adults, we offer support to their parents and carers as well.

Outcomes

Over 80% of our patients report a reduction in their problematic behaviours after six months of therapy.

Of the Experience of Patient Questionnaire (ESQ) forms returned in 2015-2016, 92% of patients reported that they had been treated well, 88% felt they had been listened to, and 95% felt they had worked well with their therapist.

Quotes from patients

"Without therapy I'd be dead or in prison - possibly both."

"I feel deeply grateful. Thank you for all your help and concern."

"The therapist who assessed me was very professional and competent."

Part 4: Annexes

4.1 Statements from Camden Clinical Commissioning Group (CCG), Governors, Camden Healthwatch, Overview and Scrutiny Committees (OSCs), and response from Trust.

Comments from Camden Clinical Commissioning Group (CCG)

NHS Camden Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Tavistock and Portman (T&P) NHS Foundation Trust on behalf of the population of Camden and associated commissioners. NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on T&P Trust's Quality Account.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in April 2017). We confirm that the document received complies with the required content as set out by the Department of Health or where the information is not yet available a place holder was inserted.

We observe that the document would benefit from a more logical flow and the use of language that is more accessible to the public, including: avoiding the use of acronyms without an explanation in full and the avoidance of NHS contractual language.
We note that some service information is dispersed throughout the report which would have benefited from being grouped together. This is a comment we also highlighted in the previous year's document and we were disappointed that the comments were not taken into consideration for this year's report.

We expect the Quality Account to have a clear narrative which tells the 'Trust story' over the last year including successes, areas for improvement and with reasons for choosing priority quality areas. We believe this would enable wider public accessibility and understanding of the quality of services being delivered by the Trust.

It would be helpful to have a clear rationale for the choice of priorities. We note that report identifies areas for improvement which have not been set as priorities for 2017-18. These include: the goal based measures priority which has been declining over the last 3 years, (goal based measures enable the Trust to identify what service-users want to achieve and focus on what is important to them), and the timeliness and completeness of communication to GPs which was identified as an area for strengthening in the Trust audit findings.

We also observe that some of the priorities identified by the Trust were in areas where they appear to be already strong or are aimed at improving internal processes rather than a focus on the quality of service being delivered.

There remain areas for improvement and as commissioners NHS Camden CCG will continue to work with T&P to monitor these areas, enabling improvement in the quality of services provided to patients. At the time of writing this statement Camden CCG cannot authenticate the achievement of 2016/17 CQUINs.

It is positive to note the Trust achieved a 'good' overall rating from the Care Quality Commission following their first and subsequent inspections in 2016.

We recognise the Trust have made improvements in data quality and its application over the last year. We envisage the Trust will continue to embed this further in 2017/18.

We are pleased to see the Trust have agreed their Clinical Quality Strategy and we fully endorse the core aims of the Strategy.

Trust Response:

The Trust welcomes comments on the Quality Report by our lead commissioners and looks forward to working closely on the implementation of our quality priorities and embedding the 'good' achievement from the Care Quality Commission inspection during the next year.

In response to commissioner feedback the initial Trust quality priorities selected were reviewed and strengthened. The focus of these is on improving the quality of services for our patients. We use various clinical outcome measures to evaluate how effective the interventions are for our patients and carers. In that respect we were disappointed with completion of the Goal Based Measure in the past year, having set ourselves a target of 80% and achieving 48%. To address staff engagement with using the measures, particularly when under pressure, the initial two outcome measure priorities proposed have been integrated, focusing on embedding the most appropriate measures within services. Our patients and carers will also be involved with us in this work.

Other priorities which form our 'business as usual' functions such as patient information and clinical audit and quality improvement developments have been removed from the priority list but will continue to be delivered. Information on how our priorities were identified and the rationale for the four quality priorities selected has been updated.

In respect of the document flow, this is strictly laid out in national guidance. However, we have taken the opportunity to review the language we have used so that this is more accessible to the public. In respect of the additional service information within the report this was not distinguished from the main Quality Accounts information in the draft report sent to commissioners to review. These vignettes are more clearly identified in later drafts, subsequently sent to our lead commissioners.

Comments from our Governors

Governors considered that the report provides a good and accurate reflection of the quality of the Trust's clinical services. Notwithstanding the constraints of the format, it is an excellent report. It is positive and sets out a clear way forward without avoiding some of the difficult questions. It is written in an accessible language and feedback on the use of acronyms has evidently been noted. More overt reference could be made throughout the report to the Care Quality Commission key domains, safe, effective, caring, responsive and well-led. Above all, the report demonstrates how seriously the Trust takes quality. The Governors appreciate the work of the quality team and the Trust's real commitment to quality.

Trust Response:

The Trust welcomes the feedback from the Governors to the draft Quality Accounts and appreciates the ongoing commitment to working closely with Trust staff to ensure the delivery of excellent quality services.

Joint statement by Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee

Overall
Patient and Public Involvement (PPI)
We were pleased to see the focus on Patient and Public Involvement (PPI) but would have liked more of a sense of learning from patients, relatives and local residents to improve services and outcomes – rather than just focusing on engaging with patients, relatives and local residents; and what success could look like as a result.

Working across the community
Collaborating with North Central London councils and local schools and organisations, listening to, learning from and contributing to improving the mental health of local residents. We were disappointed that there was no sense in the report that this is on the agenda of the Trust.

Specific comments

Part 1

- Positive to see CQC inspection has been successful and T&P have received a rating of 'good' overall.
- Excited to hear further details about proposed new site within Camden. Will it be the same site for supportive services and teaching services?
- Particularly impressed by the 'Sign Up To Safety' campaign. It would be interesting to see the outcomes of this project and what areas were marked for improvement.

Part 2.1 – priorities for improvement

- We welcome the priorities chosen.
- Priority 1 – it would be good to understand what ratio of staff the trust seeks to train in each directorate.
- Priority 3 – we particularly welcome the focus on meaningful outcome measures
- Priority 4 – we are pleased that our recommendation has been taken up. However no clear goal is set for the target rate of people providing monitoring information. We would like to see a measurable increase on current levels.

Part 3.1 –progress on priorities

- There are some pleasing positive results, such as the improvements in safety outlined under priority 3.
- Some results are concerning, particularly Priority 4 – disheartening outcomes here, we would like some commentary on what has caused the downfall in outcomes and how the trust plans to rectify the results and meet targets for 17/18.

Part 3.5 – Staff survey

We are pleased to see some positive outcomes from the survey. However, the negative outcomes could possibly have a serious impact on the delivery of services. We would like to see more about how the issues will be addressed.

Trust Response:

The Trust welcomes the response by Camden Healthwatch and Camden Health and Adult Social Care Scrutiny Committee. We can confirm that we are committed to learning from our patients, relative and local residents to improve services and outcomes.

In respect of 'working across the community' we are actively involved in work across the Sustainability and Transformation Plan (STP) community, which has a core purpose of improving the health of the community. Our CEO is the North Central London (NCL) STP Senior Officer for mental health which means he sits on the overall board for the STP, and both our clinical directors sit on the mental health steering group. We are also active members of the Camden Local Care Delivery board. Our work on reorganising CAMHS in Camden has had a key aim at improving population level mental health alongside wellbeing.

In our City and Hackney Primary Care Psychotherapy Consultation Service where we work within GP practices, we have set up specific projects to cater for 'hard to reach' or Black and Minority Ethnic (BME) groups. These projects are embedded within the service's local delivery model. They include the Horticultural Therapy Group (for Turkish speakers) and Community Photography Group. Such projects are also shared more widely including the production of a video involving three of the Turkish speaking service users in collaboration with a local GP, which will be used to recruit patients into the project. This was also recently shown at the National Medically Unexplained Symptoms (MUS) summit in Birmingham with excellent feedback. An exhibition of photographs was also held at the Trust and attended by service users and their families.

We can confirm that the proposed new Trust site will be the same for supportive and teaching services.

In respect of the quality priorities selected we welcome your feedback. For priority 1 we are currently developing a strategy for how best to provide staff with appropriate information and training on physical health issues across the organization. Our directorate clinical governance leads will be focusing on embedding meaningful outcome measures in priority 2 and regarding priority 4, improving the use of equalities information in our clinical services, we have amended the target and are committed, following a baseline review, to agree a measurable increase for the year.

Finally, in response to concerns about negative feedback from some of our staff survey results the issues, in particular relating to career advancement, working hours and stress, bullying and harassment experienced by staff have been acknowledged by the Board. In order to address identified issues an organisational development and people strategy has been developed with input from staff, students, service users and other stakeholders. This was initially received for discussion at the March 2017 Trust Board and approved at the April Trust Board.

4.2 Statement of directors' responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

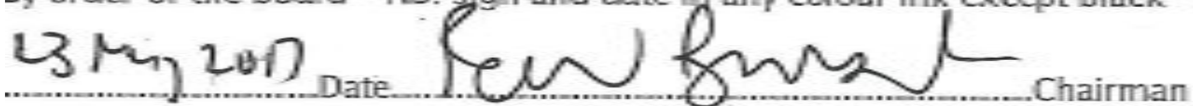
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to May 2017.
    - papers relating to Quality reported to the board over the period April 2016 to May 2017.
    - feedback from commissioners dated 2 May 2017.
    - feedback from governors dated May 2017.
    - feedback from local Healthwatch organisations dated 9 May 2017.
    - feedback from Overview and Scrutiny Committee dated 9 May 2017.
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2017 covering 2016/17, which was presented to the Board in April 2017.
    - The 2016 national staff survey, received by the Trust in 7 February 2017.
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 21 March 2017.
    - CQC inspection report dated 1 February 2017
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate.
    - This is with the exception of some degree of inaccuracy with Friends and Family test data
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
  - Lack of a robust audit trail for FFT data has led to some data incompleteness

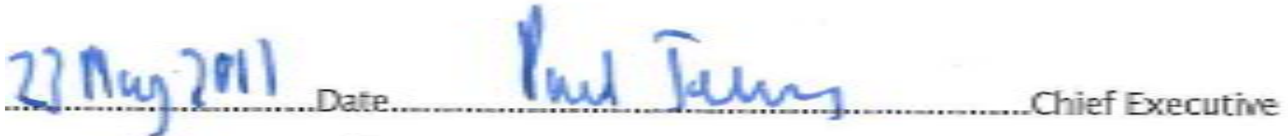
- The Quality Report has been prepared in accordance with NHS Improvment's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board – NB: sign and date in any colour ink except black



..............................Date...Chairman



..............................Date...Chief Executive

4.3 Independent Auditors Report

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

We have been engaged by the council of governors of The Tavistock and Portman NHS Foundation Trust to perform an independent assurance engagement in respect of The Tavistock and Portman NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Tavistock and Portman NHS Foundation Trust as a body, to assist the council of governors in reporting The Tavistock and Portman NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Tavistock and Portman NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period;
- number of delayed transfers of care per 100,000 population; and
- percentage admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

However, as the Trust does not provide inpatient services, the Quality Report does not include figures for any of these indicators. NHS Improvement guidance mandates that the Trust should choose two alternative indicators of its choice for testing, which have been selected as follows:

- The number of formal complaints received by the Trust during its reporting period; and
- Service users agreeing that they would recommend the Trust to their friends and family, calculated as those stating the statement is Certainly True (2 points) and Partly True (1 point) as a proportion of 2x the total number of responses received (Friends and Family Test).

We refer to these collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';

- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from the Commissioners dated 3 May 2017;
- feedback from the governors dated May 2017;
- feedback from local Healthwatch organisations, dated 9 May 2017;
- feedback from Overview and Scrutiny Committee, dated 9 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2017;
- the national staff survey dated 7 March 2017;
- Care Quality Commission Inspection report dated 1 February 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 21 March 2017; or
- any other information included in our review.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

The indicator measuring Service users agreeing that they would recommend the Trust to their friends and family, calculated as those stating the statement is Certainly True (2 points) and Partly True (1 point) as a proportion of 2 times the total number of responses received (Friends and Family Test), requires the Trust to accurately record the responses of all patients who have answered the question in the Trust's Experience of Service Questionnaires.

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

Our testing identified that the Trust does not always retain questionnaire responses received from service users. Therefore, documentation was not always available to evidence the accuracy of the responses stated in the population. For 23% of questionnaire responses tested, there was lack of an audit trail to allow us to conclude on the accuracy of the responses.

As a result there is a limitation upon the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting the Friends and Family Test.

In respect of the population used to calculate this indicator we found that, for 7% of questionnaire responses tested where documentation was available, the survey responses were not accurately recorded in the population, affecting the calculation of the published indicator.

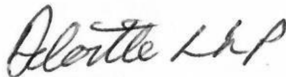
As a result of the issue identified, we have concluded that there are errors in the calculation of the indicator measuring Service users agreeing that they would recommend the Trust to their friends and family, calculated as those stating the statement is Certainly True (2 points) and Partly True (1 point) as a proportion of 2x the total number of responses received (Friends and Family Test), for the year ended 31 March 2017. We are unable to quantify the effect of these errors on the reported indicator.

The section on page 44 of the Trust's Quality Report summarises the actions the Trust is taking post year end to address the issues identified in relation to these issues.

Qualified conclusion

Based on the results of our procedures, except for the effects of matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.



Deloitte LLP
Chartered Accountants
St Albans
24 May 2017

Appendix – Glossary of Key Data Items

AFS- Adult and Forensic Services.

Black and Minority Ethnic (BAME) Groups Engagement - We plan to improve our engagement with local black and minority ethnic groups, by establishing contact with Voluntary Action Camden and other black and minority ethnic community groups based in Camden.

CCG (Clinical Commissioning Group) - CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31 March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

Care Quality Commission – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

CareNotes - This is the patient administration system using, which is a 'live system' for storing information electronically from patient records.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) - The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, and isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

Clinical Outcome Monitoring - In "talking therapies" is used as a way of evaluating the effectiveness of the therapeutic intervention and to demonstrate clinical effectiveness.

Clinical Outcomes for Routine Evaluation - The 34 items of the measure covers four dimensions, subjective well-being, problems/symptoms, life functioning and risk/harm.

Commission for Health Improvement Experience of Service Questionnaire - This captures patient views related to their experience of service.

CQUIN (Commissioning for Quality and Innovation payment framework) - This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

Complaints Received - This refers to formal complaints that are received by the Trust. These complaints are all managed in line with the Trust's complaints policy.

CYAF - Children, Young Adults and Families services.

Did Not Attend (DNA) Rates - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is a 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

The DNA Rate is based on the individual appointments attended. For example, if a family of three is due to attend an appointment but two, rather than three, family members attend, the appointment will still be marked as attended. However, for Group Therapy the attendance of each individual will be noted as they are counted as individual appointments.

DNA rates are important to the Trust as they can be regarded as a proxy indicator of patient's satisfaction with their care.

Family Nurse Partnership National Unit (FNP NU) - The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two. Fathers are also encouraged to be involved in the visits if mothers are happy for them to be. The programme aims to improve pregnancy outcomes, to improve child health and development and to improve the parents' economic self-sufficiency. It is underpinned by an internationally recognised evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing cost benefits.

Goal-Based Measure - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

Infection Control - This refers to the steps taken to maintain high standards of cleanliness in all parts of the building, and to reduce the risk of infections.

Information Governance - Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

Information Governance Assessment Report - The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorized access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

Information Governance Toolkit - Is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance included in the various Acts and presents them in one place as a set of information governance requirements.

INSET (In-Service Education and Training/Mandatory Training) - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

Key Performance Indicators (KPIs) –service indicators set either by commissioners or internally by the Trust Board.

LGBT - Lesbian, Gay, Bisexual, and Transgender community.

Local Induction - It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

Monitoring of Adult Safeguards - This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

National Clinical Audits - Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

National Confidential Enquiries - Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.

The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are "confidential" in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and coordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

NHS Litigation Authority (NHSLA) - The NHSLA is a not-for-profit part of the NHS. They manage negligence and other claims against the NHS in England on behalf of member organisations. They help resolve disputes fairly; share learning about risks and standards in the NHS and help improve safety for patients and staff. They are also responsible for advising the NHS on human rights case law and handling equal pay claims.

Participation in Clinical Research - The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

Patient Feedback - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

There are various other methods used to obtain feedback from patients, including small scale surveys and audits (such as the Children's Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer and informal feedback to clinicians and administrators.

Patient Forums/Discussion Groups – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

Patient Safety Incidents – This relates to incidents involving patient safety which are reportable to the National Reporting and Learning System (NRLS). Patient safety functions, including the NRLS system, previously delivered by NHS England were transferred with the national patient safety team to NHS Improvement on 1 April 2016.

Percentage Attendance – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

Periodic/Special Reviews - The **Care Quality Commission** conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

Personal Development Plans - Through appraisal and the agreement of a Personal Development Plan for each member of staff we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

Protected characteristics - These are defined in Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Quality Stakeholder Meetings - These include consultation meetings with stakeholders (Patient and Public Involvement representatives), Non-Executive Directors and a Governor, and the separate meeting with governors. The purpose of these meetings is to contribute to the process of setting quality priorities and to help improve other aspects of quality within the Trust.

Rapid Transfer Incidents- When a patient becomes acutely unwell they should be rapidly transferred from the Trust to a suitable healthcare setting for assessment and treatment; this will usually be by a local Accident and Emergency department.

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

Safeguarding of Children Level 3 - The Trust has made it mandatory for all clinical staff working in child and adolescent services and other clinical services working predominantly with children, young people and parents to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.) The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modelled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

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

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

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

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

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

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

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

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

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially beyond eleven weeks. A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, the actions to be taken to prevent recurrence.

The Tavistock and Portman NHS
NHS Foundation Trust