

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–3.30pm
Tuesday 26th November 2013

Board Room,
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 26th November 2013, 14.00 – 15.30,

Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Ms Angela Greatley, Trust Chair		Verbal	
2.	Apologies for absence and declarations of interest Ms Angela Greatley, Trust Chair	To note	Verbal	
3.	Minutes of the previous meeting Ms Angela Greatley, Trust Chair	To approve	Enc.	p.2
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Enc.	p.8
REPORTS & FINANCE				
5.	Trust Chair's Report Non-Executive Directors as appropriate	To approve	Enc.	p.9
6.	Acting Chief Executive's Report Mr Simon Young, Acting Chief Executive	To note	Enc.	p.13
7.	Finance & Performance Report Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.18
CORPORATE GOVERNANCE				
8.	Charitable Funds Annual Report and Accounts 2012–13 Mr Simon Young, Acting Chief Executive	To approve	Enc.	p.29
QUALITY & GOVERNANCE				

9.	Clinical Quality, Safety and Governance Report, Quarter 2, 2013-14 Dr Rob Senior, Medical Director	To note	Enc.	p.44
10.	Education and Training Report Mr Malcolm Allen, Dean of Postgraduate Studies	To note	Enc.	p.77
11.	Gender Identity Development Service report Dr Polly Carmichael, GIDS Director	To note	Enc.	p.103
CONCLUSION				
12.	Any Other Business		Verbal	
13.	Notice of Future Meetings <ul style="list-style-type: none"> • Thursday 5th December 2013: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre • Tuesday 28th January 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre 		Verbal	

Board of Directors

Meeting Minutes (Part One)
2.00pm–3.30pm, Tuesday 29th October 2013

Present:			
Ms Angela Greatley Trust Chair	Mr Malcolm Allen Dean	Mr Martin Bostock Non- Executive Director (Senior Independent Director)	Dr Rita Harris CAMHS Director
Mr Altaf Kara Non-Executive Director	Ms Louise Lyon Trust Director	Dr Ian McPherson Non-Executive Director	Ms Joyce Moseley Non-Executive Director
Dr Rob Senior Medical Director	Richard Strang Non-Executive Director (Deputy Trust Chair)	Mr Simon Young Acting Chief Executive	
Attendees:			
Ms Georgia Denegri, Interim Trust Secretary (minutes)	Mr Carl Doherty Deputy Director of Finance (item 7a)		
Apologies:			
Ms Lis Jones Director of Nursing			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Ms Denegri to amend the minutes of the previous meeting.	GD	Immed
2	6	Ms Denegri to recirculate the details for the Directors' Conference on 13 th November.	GD	Immed

1. Trust Chair's Opening Remarks

Ms Greatley welcomed all to the meeting and particularly Mr Simon Young to his first Board meeting as Acting Chief Executive.

2. Apologies for Absence

Ms Lis Jones, Director of Nursing.

3. Minutes of the Previous Meeting

API

The minutes were approved as a correct record of the meeting subject to the following amendments:

- Page 4, second paragraph, first sentence: Replace TCS with TC.
- Page 4, Item 8, last paragraph, first sentence: Amend to read: Ms Moseley reported that the CQSG minutes did not accurately reflect the concern some committee members had expressed about the low number of clinicians who were using the outcome monitoring system.
- Page 5, Item 9, penultimate paragraph: Amend to read: Mr Bostock queried whether there was a risk that external consultants were creating products independently of management.

4. Matters Arising

- Action point 1: The minutes of the previous meeting had been amended.
- Action point 2: Mr Young reported that information on Monitor's new rating system was included in the Governance Statement under Item 8 of the agenda.
- Action Point 3: Mr Allen's report in November will include retention figures.
- With regard to minute 8, page 5, first paragraph, Mr Kara reported that the Audit Committee had completed its ongoing discussion on each workstream recommendation.

The Board considered the Outstanding Action Part 1 schedule and noted the progress updates and completed actions.

5. Trust Chair's and Non-Executive Directors' Reports

Ms Greatley reported that the Chief Executive's recruitment campaign had been her main focus. She further reported that she attended the Foundation Trust Network conference which had been interesting. There were presentations on CQC's new inspection regime and reports on its current focus on acute trusts where concerns about patient safety had been raised. As a result, the applications for FT status of the aspirant Mental Health and Community Trusts in the pipeline would be considerably delayed.

Ms Greatly further stated that this was the last meeting Mr Kara and Mr Strang were attending as Non-Executive Directors. Ms Greatly acknowledged the enormous contribution each one had made to the work of the Board and the passion and care each demonstrated about the work of the trust. All Board members echoed the comments of the Chair and thanked Mr Kara and Mr Strang for their valuable contribution.

The Board NOTED the Chair's report.

6. Chief Executive's Report

Mr Young introduced his report and informed that there had been an error in the dates of Dr Patrick's appointments (at paragraph 1.2). Dr Patrick had been Trust Director from 2005 to 2008 and was appointed Chief Executive in 2008.

Mr Young further highlighted the Joint meeting of the Board of Directors and Council of Governors held on 28 October 2013, which had been attended by seven governors. Unfortunately due to the severe weather conditions, only two non-executives had been able to attend. Mr Young thanked the Executive Directors for their presentations which generated good debate and exchange of strategic thinking, followed by discussion in small groups on how governors can hold the non-executives and the Board to account.

Mr Bostock emphasised how positive the meeting had been. He had the opportunity to work more closely and exchange ideas with five governors in the small groups' session which he found helpful and constructive.

Mr Bostock further commended this year's Annual General Meeting which he felt had been a particularly successful event. All Board members agreed and asked that their thanks to the Communications and the Family Nurse Partnership teams who organised the meeting are recorded formally in the Board minutes.

Finally, Mr Young reminded the Board that the conference on the strategic plan review was scheduled on the 13th November and the executive was planning the event. Members asked that the details of the venue and arrangements for the day are re-circulated.

AP2

The Board NOTED the Acting Chief Executive's report.

7. Finance & Performance Report

Mr Doherty introduced the report and highlighted that £1,143k was reported before restructuring, which was £816k above the revised budget surplus of £327k. The income from consultancy and clinical had fallen below expectations, but this had been offset by underspends across most services mainly due to vacancies. The current forecast for the year was a surplus of £712k.

The Trust maintained a strong cash position with a cash balance of £3,357k as at 30 September, which was above plan due to the size of the surplus. Cash balances were expected to be lower by the end of the financial year yet still above plan.

In response to a query, Mr Young briefed the Board on the new rating system to be implemented from the following quarter and the assumptions with regard to the liquidity ratio.

The Board further discussed the income and expenditure relating to training and the implications of the reported e-learning vacancies. Mr Allen commented that the issue should be considered as strategic rather than financial and a more detailed discussion could be held at the following meeting when the Board will have a full report on education and training.

The Board NOTED the report.

8. Governance Statement Quarter 2

Mr Young introduced the report and linked the information to the earlier discussion on the new rating system. He reported that it was anticipated that the Trust will remain profitable over the next year. Using the figures of the Annual Plan, the Debt Service Cover was expected to remain above the threshold of 2.5, at 4, throughout the Plan. The liquidity rating was expected to stay at least to 3 and even if it fell to 2, the Board would still be able to make the finance declaration. Therefore, Mr Young

recommended that the Board approved the declaration.

With regard to the governance declaration, all targets and indicators were being met and plans were sufficient to ensure that they continued to be met. The Management Team had considered all risks and agreed that there were not any issues of concern so it could recommend to the Board to approve the declaration.

Mr Strang reported that the Audit Committee had agreed an internal audit into the process for compiling the governance statement to assure the Board as opposed to non-executive directors being expected to approve it in good faith for the management team.

The Board APPROVED the Governance Statement for Quarter 2.

9. Audit Committee Annual Report 2012–13

Mr Strang introduced the report and noted that all issues included had been reported previously to the Board during the course of the year.

The report offered the opportunity to the Board to reflect on the way the trust's governance arrangements were working, the improvements made to CQSG and the assurance framework, as well as the effective working relationships between non-executive and executive directors.

Mr Strang and Mr Kara commented on how much they had enjoyed their role and added that the change in the membership of the Audit Committee offers the opportunity that their successors can look at all systems and processes afresh and instigate further improvements.

The new Committee membership will be appointed at the November Board meeting.

The Board NOTED the report.

10 Quality Report 2013–14 – Quarter 2

Ms Lyon introduced the report and noted that the data had already been presented to the Clinical Quality Review Group with Commissioners.

The Board discussed in depth the development of measures and collection of accurate data. While many of the trust's indicators were good (e.g. DNA rates, waiting times, etc), further consideration was being given to improve performance.

The Board NOTED the Quality Report 2013-14, Quarter 2.

11 Any other business

The Chair noted that a review of Committee membership will be discussed at the November meeting.

12 Notice of Future Meetings

The Board noted its future meetings.

The meeting concluded at 3.15pm.

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
2	Nov-12	12. Ageing Population T+P Contribution to Care	Lis Jones to report back to a future meeting on the outcome of the discussions in relation to care for older people.	Lis Jones	Jan-14	
3	Mar-13	8. Finance and Performance Report	Mr Young to include an additional column in next year's budget report to show the final outturn	Simon Young	Apr-14	
4	Mar-13	12. Equalities Report	Mr Allen to circulate a copy of the sexual orientation statement to the board in due course	Malcolm Allen	When available	It will be incorporated in the report to the Board in November 2013.
6	Sep-13	9. Education & Training report	Mr Allen to report on retention figures	Malcolm Allen	Nov-13	On the agenda.

Board of Directors : November 2013

Item : 5

Title : Chair's Report

Purpose:

To seek approval for non-executive key roles on the Board of Directors

- Deputy Chair
- Chair and Membership of Audit Committee
- Chair of Business Development Committee
- Remuneration Committee membership
- Senior Independent Director

This report focuses on the following areas:

Corporate Governance

For : Approval

From : Angela Greatley, Chair

Following the recent changes of non-executive directors, I would like to propose the following appointments:

Deputy Chair of the Trust

Following Richard Strang leaving the Board, I should like to propose Dr. Ian McPherson to serve as Deputy Chair of the Board of Directors, for a period of three years. Ian was recently re-appointed as a non-executive director for his second term of office. Ian joined the Trust as an NED after a distinguished career as a clinician and in the Department of Health. He retains his membership of the Equalities Committee.

Chair of Audit Committee

Following the successful recruitment process for a non-executive director to serve as the Chair of the Audit Committee, I am pleased to propose David Holt to take on the chairmanship for a period of three years. David's appointment was supported at the Council of Governors' meeting in September 2013 and I am pleased to report that, even before he took up appointment, David has been visiting the Trust and meeting staff.

Membership of the Audit Committee

I should like to propose Joyce Moseley as a new member of the audit committee. It was agreed earlier this year that a CQSG member should join the Audit Committee to maintain and develop the important links between the two committees. Joyce has made a considerable contribution to the development of the work of CQSG and I am pleased that she has agreed to join the Audit Committee for the coming year.

Chair of the Business Development Committee

Following the successful recruitment process for non-executive directors we were pleased to appoint Ms. Caroline Rivett as a non-executive director with particular experience of and interest in business development matters. I should like to propose that Caroline take on the chairmanship of the Business Development & Investment Committee for a period of three years. Caroline has already begun to

make links in the Trust and participated in the recent CEO appointment process.

Remuneration Committee

I confirm all non-executive directors as members of the Remuneration committee: Angela Greatley (Chair), Martin Bostock, David Holt, Ian McPherson, Joyce Moseley and Caroline Rivett.

Senior Independent director

I confirm that Martin Bostock remains as Senior Independent director.

Recommendation:

The Board of Directors is asked to approve with immediate effect:

1. The appointment of Dr Ian McPherson as Deputy Chair of the Trust Board for a period of three years.
2. The appointment of Mr David Holt as Chair of the Audit Committee for a period of three years.
3. The appointment of Ms Joyce Moseley as member of the Audit Committee.
4. The appointment of Ms Caroline Rivett as Chair of the Business Development & Investment Committee for a period of three years.
5. The membership of the Remuneration Committee comprising all non-executive directors: Ms Angela Greatley (Chair), Mr Martin Bostock, Mr David Holt, Dr Ian McPherson, Ms Joyce Moseley and Ms Caroline Rivett.
6. The continuation of the appointment of Mr Martin Bostock as the Senior Independent Director.

Angela Greatley
Chair
November 2013

Board of Directors : November 2013

Item : 6

Title : Acting Chief Executive's report

Summary :

Our latest patient feedback results are excellent.

Our Primary Care Psychotherapy Consultation Service in City and Hackney has this month won a Royal College of Psychiatrists team of the year award:



The report covers these results and other developments in the Trust and the wider world.

For : Discussion

From : Acting Chief Executive

Acting Chief Executive's report

1. Patient feedback

- 1.1 We have just had the quarter 2 results for the experience of service questionnaire (ESQ). The overall figures for the Trust, based on 217 responses, are shown in the table below.
- 1.2 This table has been sent to all staff, with a covering e-mail noting that these results are our best ever and we can feel pleased and proud that we achieve such positive feedback about our services.

Question Number	Question / Statement	All Results 2012/13 & 2013/14 (18 months) (Total: 1116)	2012/13 Qtr 2 (Total: 200)	2013/14 Qtr 2 (Total: 217)
1	I feel that the people who saw me listened to me	95%	96%	97%
2	It was easy to talk to the people who saw me	86%	85%	88%
3	I was treated well by the people who saw me	96%	99%	97%
4	My views and worries were taken seriously	94%	95%	95%
5	I feel the people here know how to help me	84%	87%	86%
6	Were you given enough explanation about the help available here? / The written information I received about the Trust before I first attended was helpful	81%	83%	80%
7	I feel that the people who have seen me are working together to help me	91%	92%	91%
8	The facilities here are comfortable	83%	79%	83%
9	The appointments are usually at a convenient time	78%	74%	81%
10	It is quite easy to get to the place where the appointments are	82%	77%	80%
11	If a friend of family member needed this sort of help, I would suggest to them to come here	89%	88%	91%
12	Options for my care were discussed with me	88%	90%	90%
13	I felt involved with important decisions about my care/treatment	91%	94%	92%
14	I was satisfied with how quickly I was seen	71%	67%	82%
15	Overall the help I have received here is good	93%	94%	97%

2. Team of the year

- 2.1 I am very pleased to report that our Primary Care Psychotherapy Consultation Service in City and Hackney is the joint winner of the Royal College of Psychiatrists team of the year award for non-age specific services.¹



- 2.2 The team also recently won the British Psychoanalytic Council's Award for Innovative Excellence.
- 2.3 The service was started in 2009 at the instigation of the GPs in Hackney; and since then we have continued to develop it to meet the needs that they have identified for their patients.
- 2.4 A service evaluation has recently been carried out by the Centre for Mental Health, and their full report is due to be published in February.

3. Strategic and operational planning in the NHS

- 3.1 The Trust has received a letter issued jointly by NHS England, Monitor, the Trust Development Authority and the Local Government Association, dated 4 November.

¹ <http://www.rcpsych.ac.uk/mediacentre/pressreleases2013/rcpsychawards2013.aspx>

- 3.2 The letter stresses the need for “all parties – CCGs, foundation and non-foundation trusts” – to “develop and implement bold and transformative long-term strategies and plans for their services.”
- 3.3 Foundation Trusts will be required to submit their strategic plans to Monitor in June 2014, covering 5 years (rather than 3, as previously).
- 3.4 Before this, on 4 April, all parties are required to submit a two-year operational plan. The bodies who have issued this letter will then carry out an assurance process, reconciling the financial and activity figures so as to ensure that the plans are aligned. This is a greater central intervention in planning than in previous years.
- 3.5 CCGs are to agree whether to form larger planning units for the purpose of joint working with the main providers on their patch.
- 3.6 Contracts are to be signed by 28 February. If this is achieved (unlike the current year, where many contracts in the NHS were not finalised six months into the year), it will assist with alignment for year 1. It is not clear how alignment for year 2 is to be achieved.
- 3.7 Full guidance, template and tools are to be issued before Christmas. This will also include confirmation of the efficiency target and tariff deflation for 2014/15; and indicative targets and deflators for the following years.
- 3.8 The final CQUIN scheme for 2014/15 is also to be published in December.

4. The Trust’s Strategic Planning

- 4.1 Two very useful meetings have taken place in the last month: the joint meeting of the Board of Directors and the Council of Governors on 28 October; and the day conference of the Board of Directors and the Trust’s senior management on 13 November.
- 4.2 These discussions are informing the work of the Management Committee on our plans for continuing development of quality, effectiveness, productivity and growth for all the Trust’s services and activities.
- 4.3 Enhancements to our Informatics and IT, and to our facilities, will be key to these plans. Proposals and options are being discussed at this meeting and last month’s.
- 4.4 The good financial performance in the current year is enabling us to fund some additional short-term resources to support these developments.

5. The Care Quality Commission

- 5.1 Professor Mike Richards, the CQC Chief Inspector of Hospitals, came to the recent meeting of London Mental Health Chief Executives. We had a very positive discussion of his plans to work with mental health and community services. (His title, however, is not expected to change to reflect this wider remit.)
- 5.2 The new regime of inspections, with larger and more senior teams, has started. Three trusts spoke of their positive experiences of these inspections at the Foundation Trust Network Chief Executives and Chairs meeting last week.
- 5.3 The CQC has an active communication strategy. See for example <http://www.cqc.org.uk/public/our-blogs>

Simon Young
Acting Chief Executive
18 November 2013

Board of Directors : November 2013

Item : 7

Title : Finance and Performance Report

Summary:

After seven months a surplus of £1,161k is reported before restructuring, £853k above the revised budget surplus of £308k. Income from consultancy and clinical has fallen below expectations, but this has been offset by underspends across most services mainly due to vacancies.

The current forecast for the year is a surplus of £702k.

The service line report is provided in Appendix C.

The cash balance at 31 October was £6,906k which is above plan due to the size of the surplus. Cash balances are expected to be lower by the end of the financial year yet still above plan.

This report has been reviewed by the Management Committee on 14 November.

For : Information

From : Deputy Director of Finance

1. **External Assessments**

1.1 **Monitor**

1.1.1 We expect the Trust to receive a Financial Risk Rating (which still applies for quarter 2) of 4.

1.1.2 The CoSRR is expected to be 4 both cumulatively and year to date at the end of September. The quarter 3 and 4 forecast is to maintain the total cumulative rating of 4. As the surplus is forecast to reduce, the Debt Service Cover metric for the separate quarters 3 and 4 are expected to be lower; but our rating is based on the cumulative metrics.

2. **Finance**

2.1 **Income and Expenditure 2013/14**

2.1.1 After October the trust is reporting a surplus of £1,161k before restructuring costs, £853k above budget. Income is £765k below budget, and expenditure £1,635k below budget.

2.1.2 The main issues behind the cumulative income shortfall of £765k are low activity for TC Consultancy which is now £203k below target, SAAMHS Clinical is £174k below target largely due to the delayed Portman London Probation Service (PLPS) and BWW. SAAMHS Consultancy is £10k below target due to Portman. As we are yet to have confirmation of the Learning Disability income for NCL there is in-month adverse variance for Clinical Central Income of £64k.

2.1.3 Appendices A and B show that significant savings have been achieved by month 7, exceeding the target, though some of these may be non-recurrent.

2.1.4 There is also shortfall in clinical income in CAMHS as the Day Unit is £65k below budget due to low pupil numbers. These main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.5 For an externally funded Finance project, the £38k under spend to date (within the Finance line) is matched by a £38k adverse variance on other income, since the funding is released in line with costs.

2.1.6 The key financial priorities remain to achieve income budgets; and to identify and implement the additional savings required for future years.

2.2 **Forecast Outturn**

2.2.1 The forecast surplus before restructuring of £702k is £552k above budget. FNP is £387k under spent after October but expect to utilise this by the end of the financial year, GIDU also expect to use the majority of their under spend.

2.2.2 The Clinical income forecast is £188k below budget mainly due to the Day Unit in CAMHS (forecast £148k below target) and the delayed start to the Portman London Probation Service (forecast £90k below) in SAAMHS. The majority of the Consultancy forecast shortfall of £236k is due to TC, although they do expect to have an improved performance against target in the second half of the year. The

Training income forecast is discussed in 3.1

2.2.3 The forecast allows for the remaining investment reserve of £147k to be fully utilised (which was allocated in August); and also for the remaining contingency reserve of £131k to be needed. There has also been some additional investment for improving the environment added to the Estates forecast.

2.3 **Cash Flow (Appendix D)**

2.3.1 The actual cash balance at 31 October was £6,906k which is an increase of £3,549k in month and is £3,698k above plan. The increase is due to the payment in advance of the Training Contract as well as £1,349k payment due from the National College of Teaching and Leadership (formerly CWDC). Salaries are lower than plan due to vacancies across the trust and the under spend on non-pay has reduced expected payments to suppliers. Capital expenditure is below plan following the decision to defer the Day Unit project. The year-to-date receipts and payments are summarised in the table below.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	3,176	3,176	0
Operational income received			
NHS (excl SHA)	10,053	8,928	1,125
General debtors (incl LAs)	4,763	5,242	(479)
SHA for Training	9,197	8,145	1,052
Students and sponsors	1,357	1,725	(368)
Other	352	126	226
	<u>25,722</u>	<u>24,166</u>	<u>1,556</u>
Operational expenditure payments			
Salaries (net)	(8,932)	(9,815)	883
Tax, NI and Pension	(6,711)	(6,817)	106
Suppliers	(5,390)	(6,404)	1,014
	<u>(21,033)</u>	<u>(23,036)</u>	<u>2,003</u>
Capital Expenditure	(393)	(512)	119
Interest Income	5	3	2
Payments from provisions	0	(11)	11
PDC Dividend Payments	(571)	(578)	7
Closing cash balance	<u>6,906</u>	<u>3,208</u>	<u>3,698</u>

2.4 **Better Payment Practice Code**

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During October we achieved 91% (by number) for all invoices and the cumulative total for the year was 88%.

3. **Training**

3.1 The income for the month was close to budget. The academic year 13/14 income is projected at £3.1m, £25k below academic year Plan. Further details is provided in a separate Training paper to the Board.

3.2 The October year to date income is analysed as follows

3.2.1 Contractual income £11k adverse mainly as a result of Child Psychotherapy analysis claims being lower than plan

3.2.2 Non-contractual income £125k below Plan due to a deferral of FNP income of £211k. E & T income is otherwise £86k above Plan. This is largely reflective of the favourable fee income variance £103k (due to late invoicing) and HEFCE variance £31k from AY12/13. This also reflects £27k of income from the HENCEL investment to set against project expenditure. The adverse variance to date on E-learning income (£86k below Plan) and the current adverse position on LCPPD and Short course income (£40k due to deferred activity) is offset against the favourable fee and HEFCE variances.

3.3 Expenditure; Visiting lecturer spend is £109k below plan for E-learning offset by a current overspend on course lecturers by £29k.

3.4 Forecast Non-contractual income is projected at £136k above Plan, including £235k of the total unplanned £385k HENCEL estimated to be against activity this financial year. The otherwise adverse variance of £99k is due to shortfall of £173k in the E-learning activity. CAMHS and SAAMHS short courses are expected to exceed target by £20k.

3.4.1 Much of the reduction of planned E-learning activity and income will be mitigated by the £148k underspend on VLs for development and backfill for E-learning. Expenditure is expected to be slightly above target by the end of the financial year, currently forecast at an overspend of £14k.

4. Patient Services

4.1 Activity and Income

4.1.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN[†] targets agreed with commissioners; achievement of these is reviewed on a quarterly basis.

4.1.2 Variances in other elements of clinical income, both positive and negative, are shown in the table below.

4.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £205k to £196k. £64k of the total budget is to replace the contract with Waltham Forest. After October actual income is £18k above budget but the forecast is expected to reduce to £6k above budget.

[†] Commissioning for Quality and Innovation

4.1.4 Court report income (which is budgeted at £113k for the year, of which £50k is for the Portman) has delivered just £11k up to October. The fall in demand is unlikely to recover and as a result the target for 2014/15 will have to be greatly reduced or removed altogether. An alternative source of income must be sought or costs reduced to mitigate the loss.

4.1.5 Day Unit was £65k below target after month 7. There are currently down to 6 pupils and the budget was set at 11. The service is currently reviewing potential alternatives which would be more appealing to commissioners.

4.1.6 Project income is forecast to be £77k above plan for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	7,166	7,075	-1.3%	-155	-30	GIDU credit note
Cost and vol variances	108	108	0.0%	0	0	
NPAs	114	132	15.9%	31	6	
Projects and other	920	801		-	77	Income matched to costs, so variance is largely offset.
Day Unit	488	423	-13.4%	-115	-148	
FDAC 2nd phase	302	319	5.6%	29	0	Income matched to costs, so variance is largely offset.
Court report	66	11	-83.5%	-94	-93	
Total	9,164	8,869		-304	-188	

5. **Consultancy**

5.1 TC income was £84k in October and is £405k cumulatively, significantly down compared to last year's £647k at this stage, and £203k below budget. However, the expenditure budget is currently £99k under spent, reflecting the staffing model. TC have also earned some of the CPPD income included in Education and Training which is £25k below target. As noted above, TC are forecasting an improvement in the second half of the year and expect to reduce the shortfall to £168k.

5.2 Departmental consultancy is £126k below budget after seven months. The majority of the shortfall is within SAMHS £98k of which is due to the Portman which is expected to improve. Actions to recover the shortfall will be required to deliver against plan.

Carl Doherty
Deputy Director of Finance
12 November 2013

**THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14**

	Oct-13				CUMULATIVE			FULL YEAR 2013-14		
	BUDGET	ACTUAL	VARIANCE		BUDGET	ACTUAL	VARIANCE	REVISED	FORECAST	BUDGET
	£000'S	£000'S	£000'S	£000'S	£000'S	£000'S	£000'S	BUDGET	OUTTURN	VARIANCE
INCOME										
1 CLINICAL	1,339	1,257	(82)	9,164	8,869	(294)	15,838	15,650	(188)	
2 TRAINING	1,638	1,660	22	12,848	12,712	(136)	21,197	21,325	128	
3 CONSULTANCY	124	118	(6)	951	622	(329)	1,564	1,335	(229)	
4 RESEARCH	12	(4)	(15)	98	145	47	211	263	53	
5 OTHER	64	71	8	445	392	(53)	1,063	1,037	(26)	
TOTAL INCOME	3,176	3,102	(74)	23,506	22,741	(765)	39,873	39,610	(264)	
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6 CLINICAL DIRECTORATES	1,600	1,464	136	11,043	9,845	1,198	19,050	18,478	571	
7 OTHER TRAINING COSTS	822	860	(38)	6,848	6,661	187	11,130	11,044	86	
8 OTHER CONSULTANCY COSTS	78	59	18	543	444	99	931	781	150	
9 CENTRAL FUNCTIONS	608	618	(10)	4,128	4,050	78	7,376	7,338	38	
10 TOTAL RESERVES	7	0	7	72	0	72	271	271	0	
TOTAL EXPENDITURE	3,114	3,001	113	22,635	21,000	1,635	38,757	37,913	845	
EBITDA	62	101	40	871	1,741	870	1,116	1,697	581	
ADD:-										
11 BANK INTEREST RECEIVED	0	1	(0)	3	5	(2)	5	9	4	
LESS:-										
12 DEPRECIATION & AMORTISATION	46	47	(1)	321	340	(19)	550	582	32	
13 FINANCE COSTS	0	0	0	0	0	0	0	1	1	
14 DIVIDEND	35	35	0	246	246	0	421	421	(0)	
SURPLUS BEFORE RESTRUCTURING COSTS	(19)	20	38	308	1,161	853	150	702	552	
15 RESTRUCTURING COSTS	0	4	(4)	0	30	(30)	0	30	(30)	
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(19)	16	34	308	1,131	824	150	672	522	
EBITDA AS % OF INCOME	1.9%	3.3%		3.7%	7.7%		2.8%	4.3%		

APPENDIX A

THE TAVISTOCK AND PORTMAN NHS TRUST											APPENDIX B
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14											
All figures £000											
	Oct-13			CUMULATIVE			FULL YEAR 2013-14				
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	REVISED BUDGET VARIANCE	
INCOME											
1	CENTRAL CLINICAL INCOME	610	546	(64)	4,082	4,023	(59)	6,247	7,131	7,262	130
2	CAMHS CLINICAL INCOME	344	327	(17)	2,387	2,326	(61)	4,033	4,121	3,895	(226)
3	SAAMHS CLINICAL INCOME	385	384	(1)	2,694	2,520	(174)	4,358	4,586	4,494	(92)
4	NHS LONDON TRAINING CONTRACT	605	606	1	4,232	4,232	0	7,254	7,254	7,254	0
5	CHILD PSYCHOTHERAPY TRAINEES	179	188	9	1,253	1,215	(39)	2,188	2,148	2,082	(66)
6	JUNIOR MEDICAL STAFF	94	87	(7)	657	665	8	1,130	1,126	1,139	14
7	POSTGRADUATE MED & DENTL EDUC	7	6	(1)	49	69	20	76	84	118	34
8	DET TRAINING FEES & ACADEMIC INCOME	54	55	1	1,775	1,782	7	1,324	2,201	2,357	156
9	CAMHS TRAINING FEES & ACADEMIC INCOME	541	545	4	3,801	3,713	(88)	7,541	6,506	6,715	210
10	SAAMHS TRAINING FEES & ACADEMIC INCOME	138	149	11	895	876	(19)	1,426	1,584	1,406	(179)
11	TC TRAINING FEES & ACADEMIC INCOME	21	26	4	187	162	(25)	293	293	253	(41)
12	TC INCOME	87	84	(3)	608	405	(203)	1,004	1,042	873	(168)
13	CONSULTANCY INCOME CAMHS	9	7	(2)	68	49	(19)	107	107	103	(3)
14	CONSULTANCY INCOME SAAMHS	28	27	(1)	275	168	(107)	337	416	358	(58)
15	R&D	12	(4)	(15)	98	145	47	128	211	263	53
16	OTHER INCOME	64	71	8	445	392	(53)	964	1,063	1,037	(26)
	TOTAL INCOME	3,176	3,102	(74)	23,506	22,741	(765)	38,411	39,873	39,610	(264)
EXPENDITURE											
17	COMPLEX NEEDS	284	272	11	2,104	1,924	180	3,432	3,513	3,333	180
18	PORTMAN CLINIC	127	102	26	891	674	217	1,527	1,527	1,246	281
19	GENDER IDENTITY	96	102	(6)	671	531	140	1,115	1,151	1,123	27
20	BIG WHITE WALL & DEV PSYCHOTHERAPY UNIT	18	17	1	131	133	(2)	247	221	228	(7)
21	NON CAMDEN CAMHS	346	302	44	2,399	2,348	52	4,023	4,147	4,193	(45)
22	CAMDEN CAMHS	399	373	26	2,603	2,421	182	3,684	4,596	4,456	140
23	CHILD & FAMILY GENERAL	43	36	7	234	192	42	449	449	471	(23)
24	FAMILY NURSE PARTNERSHIP	287	260	27	2,010	1,623	387	0	3,446	3,429	17
25	JUNIOR MEDICAL STAFF	84	88	(4)	587	559	28	1,052	1,006	958	49
26	NHS LONDON FUNDED CP TRAINEES	179	194	(15)	1,253	1,222	31	2,189	2,148	2,094	54
27	TAVISTOCK SESSIONAL CP TRAINEES	3	3	(1)	20	18	2	34	34	30	4
28	FLEXIBLE TRAINEE DOCTORS & PGMDE	32	25	8	227	232	(5)	388	389	397	(8)
29	EDUCATION & TRAINING	189	183	6	2,664	2,591	73	4,042	3,779	3,876	(97)
30	VISITING LECTURER FEES	135	138	(3)	699	619	80	1,179	1,374	1,256	118
31	CAMHS EDUCATION & TRAINING	122	142	(19)	855	865	(10)	4,868	1,466	1,482	(16)
32	SAAMHS EDUCATION & TRAINING	78	87	(9)	544	555	(11)	843	933	950	(17)
33	TC EDUCATION & TRAINING	0	0	0	0	1	(1)	0	0	1	(1)
34	TC	78	59	18	543	444	99	893	931	781	150
35	R&D	15	12	2	95	78	17	183	169	134	34
36	ESTATES DEPT	174	219	(45)	1,218	1,269	(51)	2,053	2,088	2,151	(63)
37	FINANCE, ICT & INFOMATICS	165	164	1	1,153	1,111	42	1,944	2,276	2,301	(25)
38	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	83	68	15	572	538	35	977	989	922	67
39	COMMERCIAL DIRECTORATE	70	56	13	432	408	24	646	772	700	72
40	HUMAN RESOURCES	69	58	11	411	387	24	622	670	669	1
41	CLINICAL GOVERNANCE	39	52	(13)	287	293	(6)	451	480	520	(40)
42	PROJECTS CONTRIBUTION	(6)	(10)	4	(40)	(35)	(5)	(69)	(69)	(60)	(9)
43	DEPRECIATION & AMORTISATION	46	47	(1)	321	340	(19)	550	550	582	(32)
44	IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0	0	0	0
45	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0	0	0	0
46	INVESTMENT RESERVE	0	0	0	0	0	0	170	147	147	0
47	CENTRAL RESERVES	7	0	7	72	0	72	350	124	124	0
	TOTAL EXPENDITURE	3,160	3,050	110	22,956	21,339	1,616	37,845	39,307	38,496	811
	OPERATING SURPLUS/(DEFICIT)	16	52	37	550	1,401	851	566	566	1,114	548
48	INTEREST RECEIVABLE	0	1	0	3	5	2	5	5	9	4
49	DIVIDEND ON PDC	(35)	(35)	0	(246)	(246)	0	(421)	(421)	(421)	(0)
	SURPLUS/(DEFICIT)	(19)	18	37	308	1,161	853	150	150	702	552
50	RESTRUCTURING COSTS	0	4	(4)	0	30	(30)	0	0	30	(30)
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(19)	14	33	308	1,131	824	150	672	581	

Appendix C

SLR Report M7 2013-14	Trust Total Budget M7 2013-14 £000	Actuals M7 2013-14 £000	SAMHS Budget M7 2013-14 £000	Actuals M7 2013-14 £000	CAMHS Budget M7 2013-14 £000	Actuals M7 2013-14 £000	Appendix C
Clinical Income	9,338	9,030	3,787	3,616	5,551	5,415	
Training course fees and other acad income	7,061	6,883	1,692	1,634	5,369	5,249	
National Training Contract	4,232	4,232	1,599	1,599	2,633	2,633	
Total Training Income	11,293	11,115	3,291	3,233	8,002	7,882	
Consultancy Income	792	477	780	479	12	-2	
Research and Other Income (incl Interest)	132	177	51	67	81	110	
Total Income	21,554	20,799	7,909	7,394	13,645	13,405	
Clinical Directorates and Consultancy	12,881	11,583	4,799	4,173	8,082	7,410	
Other Training Costs (in DET budget)	2,762	2,610	772	684	1,990	1,926	
Research Costs	181	171	64	61	117	110	
Accommodation	1,473	1,537	702	732	771	804	
Total Direct Costs	17,297	15,901	6,338	5,650	10,959	10,251	
Contribution	4,257	4,898	1,571	1,744	2,686	3,154	
Central Overheads (excl Buildings)	6,120	5,719	2,206	2,057	3,913	3,662	
Central Income	2,170	1,982	746	671	1,424	1,311	
Surplus (deficit)	308	1,161	110	358	197	803	
SURPLUS as % of income	1.4%	5.6%	1.4%	4.8%	1.4%	6.0%	
CONTRIBUTION as % of income	19.8%	23.6%	19.9%	23.6%	19.7%	23.5%	

APPENDIX D													
2013/14 Plan													
	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Operating cash balance	3,176	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	3,540	2,648	3,176
Operational income received													
NHS (excl SHA)	315	1,942	1,380	1,421	1,314	1,283	1,273	1,315	1,283	1,274	1,314	1,283	15,397
General debtors (incl LAs)	1,073	403	556	562	459	1,618	571	483	480	829	565	482	8,081
SHA for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
Operational expenditure payments	4,298	2,655	2,183	4,668	1,934	3,198	5,229	2,208	1,960	5,438	2,140	1,962	37,875
Salaries (net)	(1,427)	(1,527)	(1,453)	(1,427)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(16,450)
Tax, NI and Pension	(932)	(981)	(981)	(981)	(981)	(981)	(980)	(981)	(981)	(981)	(981)	(981)	(11,722)
Suppliers	(847)	(988)	(1,074)	(874)	(723)	(799)	(1,099)	(1,174)	(724)	(723)	(725)	(723)	(10,473)
	(3,206)	(3,496)	(3,508)	(3,282)	(3,031)	(3,107)	(3,406)	(3,482)	(3,032)	(3,031)	(3,033)	(3,031)	(38,645)
Capital Expenditure	0	0	(100)	(72)	0	(340)	0	0	(530)	0	0	(1,275)	(2,317)
Loan	0	0	0	0	0	200	0	0	600	0	0	900	1,700
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	(367)	0	0	0	0	(211)	0	0	0	0	0	(210)	(788)
Closing cash balance	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	3,540	2,648	995	995
2013/14 Actual/Forecast													
Operating cash balance	3,176	3,786	2,141	1,291	3,871	4,707	3,357	6,906	5,232	3,632	5,568	4,377	3,176
Operational income received													
NHS (excl SHA)	572	1,065	1,296	2,227	2,639	965	1,289	1,315	1,283	1,274	1,314	1,283	16,522
General debtors (incl LAs)	861	433	274	393	741	293	1,768	483	480	829	565	482	7,602
SHA for Training	2,465	17	199	2,669	154	105	3,588	142	79	2,567	143	79	12,208
Students and sponsors	291	108	86	134	90	344	304	250	100	750	100	100	2,657
Other	39	30	54	50	65	77	37	18	18	18	18	18	442
Operational expenditure payments	4,228	1,653	1,909	5,473	3,689	1,784	6,986	2,208	1,960	5,438	2,140	1,962	39,431
Salaries (net)	(1,329)	(1,308)	(1,274)	(1,296)	(1,218)	(1,212)	(1,295)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(15,567)
Tax, NI and Pension	(932)	(998)	(981)	(953)	(976)	(931)	(940)	(981)	(981)	(981)	(981)	(981)	(11,616)
Suppliers	(968)	(962)	(463)	(570)	(618)	(678)	(1,131)	(1,574)	(1,124)	(1,123)	(1,025)	(923)	(11,159)
	(3,229)	(3,268)	(2,718)	(2,819)	(2,812)	(2,821)	(3,366)	(3,882)	(3,432)	(3,431)	(3,333)	(3,231)	(38,342)
Capital Expenditure	(24)	(31)	(42)	(74)	(42)	(109)	(71)	0	(130)	(70)	0	(175)	(768)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	1	1	1	0	1	1	0	0	1	0	1	0	7
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	(366)	0	0	0	0	(205)	0	0	0	0	0	(210)	(781)
Closing cash balance	3,786	2,141	1,291	3,871	4,707	3,357	6,906	5,232	3,632	5,568	4,377	2,723	2,723

Tavistock and Portman Charitable Fund Annual Report and Accounts 2012/13

CHARITABLE FUND
ANNUAL REPORT OF THE TRUSTEE
2012/13

1. Reference and Administrative details

The Tavistock and Portman Charitable Fund was established by a Declaration of Trust dated 4 September 1995, to contain all the funds held on trust by the Tavistock and Portman NHS Trust (since 1 November 2006, an NHS Foundation Trust).

Its objects cover any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the Tavistock and Portman Clinics.

Two legacies are registered as separate charities under the “umbrella” of the Charitable Fund, and are included in its accounts.

Correspondence should be addressed to:

Trust Secretary
Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London NW3 5BA

Independent Examiner:

HW Fisher and Company
The Fisher Organisation
Acre House
11-15 William Road
London NW1 3ER

Bankers:

National Westminster Bank plc
3rd Floor
Argyll House
246 Regent Street
London W1R 6PB

Charity registration no. 1049530

2. Structure, Governance and Management

The Tavistock and Portman NHS Foundation Trust is Trustee of the Charitable Fund. The Trust's Board of Directors has appointed a Charitable Fund Committee, whose main duties as listed in its terms of reference are:

- To agree and recommend to the Board a strategic policy for utilising the assets of the Fund in pursuit of its stated purposes; and to review that policy at least every three years.
- To consider and approve any proposals for expenditure above £20,000 from the Fund, except where these relate to external grants awarded for specific purposes.
- To agree and recommend to the Board an investment policy for the Fund; and to review that policy at least every three years.
- To review the financial statements of the Fund annually, and more frequently if appropriate.

The Directors of the NHS Foundation Trust during 2012/13 were as follows:

Chairman

Ms Angela Greatley *

Non-Executive Directors

Mr Altaf Kara

Mr. Martin Bostock

Ms. Joyce Moseley

Mr Richard Strang

Dr Ian McPherson

Executive Directors

Dr Matthew Patrick – Chief Executive *

Ms Lis Jones – Nurse Director

Mr Malcolm Allen – Dean of Postgraduate Studies

Dr Robert Senior – Medical Director

Ms Louise Lyon – Trust Director

Dr Rita Harris – CAMHS Director

Mr Simon Young – Director of Finance *

* indicates the members of the Board's Charitable Fund Committee.

The Trust Chair and the Non-Executive Directors are appointed by the Council of Governors of the NHS Foundation Trust.

The Chief Executive is appointed by the Trust Chair and the Non-Executive Directors. The other Executive Directors are appointed by the Trust Chair, the Non-Executive Directors and the Chief Executive.

3. Objectives and Activities

In pursuit of the objects set out on page 3, the main activities of the Fund in 2012/13 were research relating to the Clinics' services; the Tavistock Society of Psychotherapists; and smaller projects for the welfare of patients, staff and trainees.

4. Achievements and Performance

The Fund does not actively raise funds at present, but will continue to manage grants, donations and legacies towards the important objectives of the Trust, especially its research projects.

5. Financial Review 2012/13 *(2011/12 figures in brackets for comparison)*

Income was £215,000 (2011/12 £78,000), and expenditure £133,000 (£161,000).

No new investments were made during the year.

Overall, funds increased by £82,000 in 2012/13, compared to a £83,000 decrease in 2011/12. The Fund's current policy is not to hold significant general reserves, since the commitments to projects do not exceed the funds specifically held for those projects. The total value of the Fund at 31 March 2013 was £375,000, being £322,000 in restricted funds and £53,000 in unrestricted funds.

The Fund was very pleased to receive a significant legacy "to the Tavistock Clinic" from the estate of the late Miss Margaret Pritchard. Miss Pritchard died in January 2000, and it is distressing that her executors took more than 12 years to resolve a difficulty caused initially by their own drafting of Miss Pritchard's will, and to fulfil her intentions. The Committee is now considering the best way of allocating this generous bequest.

The independent examiner HW Fisher and Company has carried out an examination on the 2012/13 accounts, of which copies can be obtained from the address on page 2.

6. Plans for Future Periods

The Charitable Fund committee has been pleased to be able to help fund a significant outcome research project at the Tavistock Clinic over several years from two generous legacies. The committee welcomes further donations or legacies, which are likely to be directed towards this or similar projects as part of the Trust's future research strategy.

External grants and the Tavistock Society of Psychotherapists' funds will continue to be used for their intended purposes.

Signed:

Chair

Acting Chief Executive

Date

Date

Tavistock and Portman Charitable Fund

Accounts for the year ended

31 March 2013

Statement of Financial Activities for the year ended 31 March 2013

	Note	Unrestricted Funds £000	Restricted Funds £000	2012-13 Total Funds £000	2011-12 Total Funds £000
Incoming resources					
Incoming resources from generated funds					
Legacies	2.1	0	127	0	0
Total Incoming resources from generated funds		<u>0</u>	<u>127</u>	<u>127</u>	<u>0</u>
Operating Activities					
Charitable activities		<u>18</u>	<u>70</u>	<u>88</u>	<u>78</u>
Total Operating Activities		<u>18</u>	<u>70</u>	<u>88</u>	<u>78</u>
Total incoming resources		<u>18</u>	<u>197</u>	<u>215</u>	<u>78</u>
Resources expended					
Charitable expenditure	3.1	20	103	123	153
Governance	3.2	<u>3</u>	<u>7</u>	<u>10</u>	<u>8</u>
Total resources expended		<u>23</u>	<u>110</u>	<u>133</u>	<u>161</u>
Net incoming/(outgoing) resources before Transfers		(5)	87	82	(83)
Gross transfer between funds		0	0	0	0
Net incoming/(outgoing) resources		(5)	87	82	(83)
Fund balances brought forward at 31 March 2012		58	235	293	376
Fund balances carried forward at 31 March 2013		<u>53</u>	<u>322</u>	<u>375</u>	<u>293</u>

Balance Sheet as at 31 March 2013

	Notes	Unrestricted Funds £000	Restricted Funds £000	Total at 31 March 2013 £000	Total at 31 March 2012 £000
Current Assets					
Debtors: Amount falling due					
within one year:	5.1	20	34	54	33
over one year:	5.2	2	0	2	0
Cash at bank and in hand		32	318	350	349
Total Current Assets		<u>54</u>	<u>352</u>	<u>406</u>	<u>349</u>
Creditors: Amounts falling due					
within one year	6.1	1	30	31	89
Net Current Assets		<u>53</u>	<u>322</u>	<u>375</u>	<u>260</u>
Total Assets less Current Liabilities		<u>53</u>	<u>322</u>	<u>375</u>	<u>260</u>
Total Net Assets		<u>53</u>	<u>322</u>	<u>375</u>	<u>260</u>
Funds of the Charity					
Income Funds:					
Restricted	7.2	0	322	322	235
Unrestricted		53	0	53	58
Total Funds		<u>53</u>	<u>322</u>	<u>375</u>	<u>293</u>

The notes at pages 3 to 9 form part of this account.
All the above results are derived from continuing operations

Approved and authorised for issue by the Board on and signed on its behalf by

Signed:

Date:

Notes to the Account

Accounting Policies **1**

1.1 Accounting Convention

The financial statements have been prepared under the historic cost convention and in accordance with applicable United Kingdom accounting standards and the Statement of Recommended Practice "Accounting and Reporting by Charities" issued by the Charities Commissioners in 2005.

1.2 Incoming Resources

- a) All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:
 - i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
 - ii) certainty - when there is reasonable certainty that the incoming resource will be received;
 - iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

b) Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

1.3 Resources Expended

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

The Fund's main expenditure is on research and other activities in furtherance of its objectives. As shown in the Statement of Financial Activities on page 1, a small amount is spent on administration and there has been to date no expenditure on fundraising.

Governance costs include a charge of £5,000 from the Tavistock and Portman NHS Foundation Trust.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds.

1.5 Pooling Scheme

An official pooling scheme is operated for investments relating to the following funds:

Tavistock and Portman Charitable Fund
Dean Legacy
Shaw Legacy

The Scheme was registered with the Charity Commission on 17 March 1998.

Material Legacies received by category	2 2.1	Amount received in aggregate 2013 £000	Amount received in aggregate 2012 £000
The Charitable Fund gratefully acknowledges receipt of the following Legacies:-			
	The Margaret Pritchard Legacy	127	0
	Total	127	0

Details of Resources Expended - Other	4 4.1	Unrestricted Funds	Restricted Funds	Total 2013 Funds £000	Total 2012 Funds £000
Other:		£000	£000		
Staff welfare and amenities		13	40	53	51
Research		7	63	70	102
Governance		3	7	10	8
		<u>23</u>	<u>110</u>	<u>133</u>	<u>161</u>

No staff are employed directly by the Charitable Fund. Instead, they are employed by the Tavistock and Portman NHS Foundation Trust and this is reimbursed as shown in note 10.

Analysis of Governance Costs	4.2	Unrestricted Funds	Restricted Funds	Total 2013 Funds £000	Total 2012 Funds £000
Independent examiner's fee		£ 0	£000 1	1	2
Legal and Professional fees		3	6	9	6
		<u>3</u>	<u>7</u>	<u>10</u>	<u>8</u>

TAVISTOCK AND PORTMAN CHARITABLE FUND ACCOUNTS - 2012/13

		31 March 2013	31 March 2012
Analysis of Debtors	5		
	5.1	£000	£000
		Amounts falling due within one year:	
		Other debtors	29
		Total debtors falling due within one year	29
	5.2	Amounts falling due over one year:	
		Other debtors	4
		Total debtors falling due after more than one year	4
		Total debtors	33
	<hr/>		
Analysis of Creditors	6		
	6.1	£000	£000
		Amounts falling due within one year:	
		Other creditors	74
		Accruals	15
		Total creditors falling due within one year	89
		Total creditors	89

Analysis of Funds 7

7.1 Endowment Funds

There are no endowment funds held.

7.2 Restricted Funds	Balance 31 March 2012 £000	Incoming Resources £000	Resources Expended £000	Transfers £000	Gains and Losses £000	Balance 31 March 2013 £000
Material funds						
Margaret Pritchard Legacy	0	127	0	0	0	127
Tavistock Soc. of Psychotherapists	45	27	-22	0	0	50
Suicide in adolescents	64	14	-41	0	0	37
Shaw Legacy	24	-2	-1	0	0	21
Hosp and Hosp Drs Research	18	-1	-1	0	0	16
Families with Precarious	14	0	-0	0	0	14
Journal for Social Work Practice	20	0	-6	0	0	14
Family Therapy &	9	0	0	0	0	9
The Unconscious at Work	7	0	-0	0	0	7
Others (24 funds)	34	31	-38	0	0	27
Total	235	196	-109	0	0	322

Details of material funds - restricted funds

7.3 Name of fund

Description of the nature and purpose of each fund

Shaw Legacy

Purposes connected with the Tavistock Clinic, namely for research and grants for students.

Common Investment Fund

Has no funds of its own. Exists as a vehicle for the pooling scheme, to allow the Charitable Fund, the Dean Legacy and the Shaw Legacy to act jointly in investing their funds (ref. Section 24 of the Charities Act 1993).

Margaret Pritchard Legacy

This is a legacy "to the Tavistock Clinic" from the estate of the late Miss Margaret Pritchard. The Committee is now considering the best way of allocating this generous bequest.

Contingencies 8 The Directors of the Tavistock and Portman NHS Foundation Trust are not aware of any material contingent liabilities relating to the Charitable Fund.

Commitments, Liabilities and Provisions 9 There were no commitments under capital expenditure contracts or under charitable projects at the balance sheet date.

Trustee and Connected Persons Transactions 10
10.1

Details of transactions with trustees or connected persons

The Charitable Fund reimburses the Tavistock and Portman NHS Trust for staff and other expenses borne on its account.

2012-13		2011-12	
Total charge for the year	Balance due to the Trust at 31 March	Total charge for the year	Balance due to the Trust at 31 March
£000	£000	£000	£000
(0)	(2)	61	74

No trustee received any remuneration during the year and there were no other expenses reimbursed to any trustee other than those shown above.

No staff are employed directly by the Charitable Fund. Instead, they are employed by the Tavistock and Portman NHS Foundation Trust and this is reimbursed as above.

10.2 Trustee Indemnity Insurance

The Charitable Fund provided no indemnity insurance cover during the year.

Loans or Guarantees Secured against assets of the charity 11

There were no loans or guarantees secured against assets of the charity.

Connected Organisations 12

There were no transactions with connected bodies, except as disclosed in note 10.1 above.

Related party transactions 13

Related party transactions

The Charitable Fund has made revenue payments to the Tavistock and Portman NHS Foundation Trust which is the sole trustee of the Fund. Details are given in note 10.1 above.

Board of Directors : November 2013

Item : 9

Title : CQSG Report, Q2, 2013/14

Purpose:

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report is based on assurance scrutinised by the following Committees:

- Management Committee
- Clinical Quality, Safety, and Governance Committee

The assurance to these committees was based on evidence scrutinised by the work stream leads. The RAG ratings have been fine tuned in line with guidance from the Audit Committee.

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Patient / User Safety

- Risk
- Finance
- Productivity
- Communications

For : Discussion

From : Rob Senior, CQSG Chair

CQSG Report, Q2, 2013/14

1. Introduction

- 1.1 The overview summary of areas already considered by the CQSG is set out in Appendix 1; the Board of Directors is reminded that ratings are not given in the same way as for the Risk Register.
- 1.2 The focus in this narrative is on areas of concern and interest to which the board should pay particular attention; it is not simply an amplification of red and amber rated elements.

2. Findings

- 2.1 Appendix 1 sets out the detail by reporting line, the expected rating in column on the right of the table may change over that reporting period. The ratings are based on the following:

	Overall Opinion Level	Effectiveness	System Adequacy	Control Application
Positive Opinions	Substantial Assurance	Targets have been met or exceeded.	Robust framework of controls ensures objectives are likely to be achieved.	Controls are applied continuously or with minor lapses.

	Adequate Assurance	Targets have been closely missed or there are appropriate reasons as to why they have not been met.	Sufficient framework of key controls for objectives to be achieved but, control framework could be stronger.	Controls are applied but with some lapses.
Negative Opinion	Limited Assurance	Targets have not been met and no reasons are given as to why.	Risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

2.2 Having considered and discussed the reports, the committee set the level of assurance as demonstrated; this is recorded below.

2.3 Corporate Governance and Risk ■

2.3.1 Substantial assurance was demonstrated

2.3.2 All areas green

2.3.3 The committee commended work on the Ampthill site

2.3.4 The committee pleased to note training performance

2.4 Clinical Outcomes ■

2.4.1 Adequate assurance was demonstrated

2.4.2 Development work has finished for the present; the focus is now on delivery

2.4.3 Clinical engagement is an issue that is being tackled on a number of fronts; the committee directed that sanctions apply to non-compliers as with mandatory training

2.4.4 The SAMHS Director is addressing low clinical engagement levels in SAMHS, especially at the Portman

2.4.5 The committee looked for greater assurance on data quality from Q3

2.5 Clinical Audit ■

2.5.1 Adequate assurance was demonstrated

2.5.2 The committee directed that timescales be added to reporting lines where action plans were mentioned

2.6 Patient Safety and Clinical Risk

2.6.1 Substantial assurance was demonstrated

2.6.2 A process to eliminate discrepancies on child protection arrangement records in different record systems has been implemented

2.6.3 The committee directed that a report on the relevant implications of recent reports, eg the Berwick Report, be generated and considered by clinical management

2.7 Quality Reports

2.7.1 Adequate assurance was demonstrated

2.7.2 The setting of 2013/14 KPIs was still not complete at the end of this quarter for reasons beyond the Trust's control; operationally this was unhelpful

2.7.3 The Trust is considering a cost-benefit analysis of compliance with smoking cessation targets

2.8 Patient and public involvement

2.8.1 Substantial assurance was demonstrated

2.9 Information Governance

2.9.1 The committee requested that the work stream report was constructed in a clearer format for the next committee.

2.9.2 Performance was not uniform; it was not possible to predict levels of compliance at the end of Q4 as some assurance was not supplied by the respective assurance leads

2.9.3 The breadth of externally imposed demands in this complex area was noted; the committee directed that in future reports focus on areas of highest uncertainty

3. Conclusion

3.1 This report gives a comprehensive overview and summary of the level of assurance demonstrated to the CQSG.

Appendix 1

Corporate Governance and Risk Work stream							Predicted position for end of Q4
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks		
To maintain CQC registration without qualification	G	G	G	G	The latest risk profile published by the CQC shows no areas of concern.		
To maintain a green governance rating with Monitor	G	G	G	G	Monitor's rating of the Trust remains green.		
To maintain a highly effective workforce	G	G	G	G	All targets achieved or exceeded.		
Estates and Facilities	G	A	G	G	All estates projects were completed on schedule.		

infrastructure improvements and CQC and NHSLA compliance							
Managing responses to recommendations and requirements of external bodies	G	G	G	G	G	Schedule up to date; no deadlines missed.	
Maintain compliance with current NHSLA rating	G	G	G	G	G	Maintaining compliance with current system requirements.	
Non-clinical incident reports	G	G	G	G	G	Monitoring via work streams working well.	
Specific case reports (serious incidents / SUIs)	G	A	G	G	G	No issues to report.	
Central alert broadcast advice	G	G	G	G	G	No issues to report.	

Operational Risk Register	G	G	G	G	G	No issues to report.	
Relocation of Day Unit	G	G	G			This is on hold pending further consideration by the Board of Directors of the options for the Tavistock site and of the revised day unit business case	
CGR IG compliance	A	G	G	G	G	Targets part completed, full completion on schedule.	

Clinical Outcomes Work Stream						
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4
Local ownership of outcome monitoring	A	A	A	A	Support is being provided from the Clinical Governance Office where clinical teams are struggling.	
Functionality of reports	A				Reporting line discontinued	
Robust plans are in place for quality data collection	A				Reporting line discontinued	
OM tracking system pilot		G			Reporting line discontinued	

training						
Processes for data collection are robust.		A	A	A	New group to support this work established and running; clinical directorate management support essential.	

Clinical Audit work stream						Predicted position for end of Q4
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	
Development of Clinical Audit Process	A				Reporting line discontinued	
NICE compliance	G	G	A	A	A gap analysis is to be produced in Q3 following publication of national guidance.	
Confidential inquiries	G	G			Reporting line discontinued	
Completion of annual case note audit	A				Reporting line discontinued	
CA IG compliance	A	A			Reporting line transferred to IG report	

National audit requirements	G	G	G	G	Only one data collection exercise applies; this is being undertaken.
Compliance with plan	A	A	A	A	Work is underway to embed audit as part of clinical practice at team level
Audit register	G	G	G	G	No issues to report.
Clinical audit for medical revalidation	G				Reporting line discontinued
NICE quality standards			A		Reporting line discontinued



Patient Safety and Clinical Risk Work stream						
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4
Clinical incidents	A	G	G	G	No 9+ rated incidents; only 4 clinical incidents reported for Q2.	
Specific case reports (serious incidents / SUIs)	A	A	G	G	No outstanding Sis.	
Hospital acquired infection	G	G	G	G	'flu vaccination campaign underway	
New Clinical claims	G	G	G	G	None.	
Complaints responses	G	G	G	G	2 clinical complaints were made in Q2, 1 remained open from Q1.	

Quality reports work stream						Predicted position for end of Q4
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	
Quality report section of the AR is produced to a high standard	G	G			Reporting line discontinued	
Arrangements to deliver CQUIN are fit for purpose	A	A			Reporting line discontinued	
That data to be collected has been	G	G			Reporting line discontinued	

2013/14	Arrangements in place to report on CQUIN's and KPI's for SAAMHS	A	A	Trust's position on smoking cessation target to be agreed.
	Arrangements in place to report on CQUIN's and KPI's for CAMHS	A	A	work to be undertaken to ensure data flows for the late agreed targets
	Meeting Quality Priorities listed below at **	G	G	Priority 1 and 2 targets are not reported until Q3 as involve time delay between first and second outcome monitoring form
	Meeting quality reporting requirements of CCG	G	G	Arrangements have been agreed with commissioner; reports will be scrutinised by the Management Committee prior to external submission

Quality report Recommendations from 2012-13		A	A	Rolling audits of waiting time and DNA data on going which continue to show issues with data quality; guidance has been issued to staff.
Preparation for Quality Report 2013-14		-	-	

PPI work stream							Predicted position for end of Q4
Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks		
CQC compliance	G	G	G	G	Liaison activity is on-going; no gaps in delivery of work apparent.		
Providing assurance that the Trust adheres to all PPI related policies and procedures	G	G	G	G	Departmental PPI leads promote procedures to teams		
Discussing PPI issues arising from PALS, complaints or other forms of PPI input and making recommendations		G	G	G	See PPI minutes for details of discussions		

Providing a forum of PPI related matters	G				Reporting line discontinued	
Discussing the findings of the experience of service questionnaire and ensure delivery of action plans	G	G	G	G	Findings and action plans considered quarterly.	
Ensuring the involvement of patients in service improvement	G	G			Reporting line discontinued	
To improve the patient experience of diverse groups	G	G			Reporting line discontinued	
To hold 3 meetings with stakeholders	G				Reporting line discontinued	

To ensure 3 issues identified at stakeholder meetings were addressed by March 2014	G	G	G	G	An action plans has been agreed	
					Reporting line discontinued	
To increase membership by 10%	G				Reporting line discontinued	
To develop a BME engagement strategy	G				Reporting line discontinued	
To hold 3 patient forums	G	G	G	G	Scheduled	
To increase presence in social media	G				Reporting line discontinued	
To promote choice through information provision and produce 5	G				Reporting line discontinued	

leaflets on modalities							
To audit accessibility of modality leaflets		G	G	More leaflets are to follow.			
To produce 3 further leaflets on modalities		G		Reporting line discontinued			
To produce further 4 leaflets on modalities			G	Reporting line discontinued			
That PPI IG requirements are completed	A	G		Reporting line transferred to IG report [see 203]			
Ensure that quality is continually improved through the development of patients centred services and		G	G	5 public members are members of the PPI Committee.			

within the organisation's culture [with QR lead and others]						
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Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
101 Governance Overview	G	G	G	G	A strong area for the Trust.	
105 Policy overview	R	G	R	R	IT Manager to complete Mobile Device Procedure review.	
110 Contractor compliance	G	G	A	R	The Commercial Directorate needs to provide evidence of compliance with the contracts procedure. Evidence for all other directorates in place.	
111 Employee contract compliance	G	G	G	G	The use of national terms and conditions saves the Trust from the expense of developing its own compliance regime.	
112 IG training	R	G	A	A	Performance has dropped significantly since this time last year; there is much to be done before the December deadline.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
200 Data protection compliance	R	G	A	R	<p>An audit by the ICO identified some areas of weakness; the Trust is working through the recommendations, the following is outstanding:</p> <ul style="list-style-type: none"> • Adoption of risk assessment on home working (SIRO) • Inclusion of legally required clauses in a contract (Commercial Director) • Monitoring of mobile device maintenance records to be made (Finance Director) 	
201 Confidentiality compliance	A	G	A	A	A revised Code of Confidentiality is awaited from the Caldicott Guardian.	
202 lawful basis and objections respected				G	This was previously reported in conjunction with 203 but has been split for ease of monitoring. New guidance was issued by the Governance Manager thus achieving compliance.	
203 service users are aware of the uses to which their data is put	A	G	A	A	Evidence of compliance from PPI Lead is awaited: the Governors gave feedback on the respective patient leaflet which is due for review following the review and re-approval of the respective procedure. Staff are due a reminder of this guidance.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
205 Access request compliance	G	G	G	G	The Trust receives very few requests.	
206 Confidentiality audit compliance	R	G	A	G	Progress is being made for all sensitive data compliance.	
207 Sharing protocol compliance	G	G	G	A	This is covered in contracts, though as most partners are NHS the Trust can be assured we are all working to the same high standards unlike the private sector. However, more work to ensure good contract management is indicated (see also 210).	
209 processing outside UK	G	G	A	A	A check has been undertaken to identify any transfers that were not known: FNP identified a transfer previously unreported and information on this is awaited.	
210 New systems compliance	R	G	R	R	Commercial Directorate is to complete development of a protocol setting out how compliance will be incorporated into due diligence and implementation processes; this has been added to the Trust risk register. (A protocol agreed earlier was considered impractical.)	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
300 Information security skills compliance	A	G	G	A	An audit is underway in non-clinical areas.	
301 Risk assessment of Information Assets	A	G	A	A	As part of the further development for 2013/14, additional training is to be undertaken by all IAOs and IAAs; also, FNP assets need to be assessed.	
302 Incident Reports	G	G	G	G	A revised procedure is being put in place to meet external requirements.	
303 Registration Authority compliance	A	G	G	G	This relates to the issue of 'smart cards' for access to patient data systems; the system is running well.	
304 RA monitoring compliance	A	G	G	G	This relates to the issue of 'smart cards' for access to patient data systems; the system is running well.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
305 access control compliance	A	G	G	G	Access to Trust systems is multi-layered.	
307 Risk management	A	G	R	R	Risk assessments are awaited from FNP, a new activity from April. The work stream also reviews all risks directly and indirectly related to IG, one of which relates to a complaint raised externally to the ICO relating to DET for which the resolution has not yet been finalised and implemented.	
308 Data mapping	R	G	A	G	All know assets have been mapped, the MC have confirmed that there are no missing assets and that the register is accurate.	
309 Business continuity assurance	A	G	A	A	FNP assets are to be assessed.	
310 Disruption preparation assurance	A	G	A	A	Staff are reminded what to do in the event of an emergency; this is also the subject of a risk assessment for all assets; FNP assets are to be assessed.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
311 Protection of IAs	A	G	A	A	A comprehensive programme of assessment is monitored and reported to the IG work stream; FNP assets are to be assessed.	
313 Network assurance	A	G	G	G	Access to Trust systems is multi-layered.	
314 Teleworking assurance	A	G	G	G	Access to Trust systems is multi-layered.	
323 Protection of IA assurance	A	G	G	G	A comprehensive programme of assessment is monitored and reported to the IG work stream.	
324 Pseudonymisation assurance	A	G	G	G	A comprehensive programme of assessment is monitored and reported to the IG work stream.	
400 IG quality, skills and experience assurance	A	G	G	G	A review of an external archive is underway. A reorganisation of the Trust's basement archive was completed. Extra capacity is needed to cope with more and thicker patient files and this is being arranged for completion by year-end.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
401 NHS number assurance	A	G	G	G	This is partly obsolete as 'RiO' only functions with NHS numbers, though the Trust needs to ensure that this is in place for non-RiO systems.	
402 Accuracy of data input	A	G	A	R	The new arrangements are yet to deliver evidence of compliance with this requirement.	
404 Audit assurance	G	G	A	G	This complements 206 and is managed by the Governance and Risk Adviser with support from the Clinical Governance Office and Governance Manager.	
406 Monitoring paper records assurance	G	G	G	G	Tracking records is well managed; spot checks have been introduced.	
501 Data definitions compliance assurance	A	G	G	G	This is rather obsolete as 'RiO' only functions with national definitions; nevertheless the task to 'prove' compliance exists!	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
502 External data feedback reports	A	G	A	A	Such data is limited, work to improve assurance is underway with the Clinical Governance Manager and the Governance Manager and the new Clinical Information Management Group is the forum for facilitating evidential submissions.	
504 Benchmark reports	A	G	A	A	Such data is limited, work to improve assurance is underway with the Clinical Governance Manager and the Governance Manager and the new Clinical Information Management Group is the forum for facilitating evidential submissions.	
506 Service user data accuracy validation	A	G	A	A	The Clinical Governance Manager has set up monitoring in conjunction with the Acting Informatics Manager; the new Clinical Information Management Group is the forum for facilitating evidential submissions.	
507 Data completeness validation	A	G	A	A	The Clinical Governance Manager has set up monitoring in conjunction with the Acting Informatics Manager; the new Clinical Information Management Group is the forum for facilitating evidential submissions.	
508 Clinical data input validation	A	G	G	G	This is limited as the question is not tailored to the Trust.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
514 Clinical coding audit validation				A	A meeting has been convened to establish an effective approach to the provision of evidence.	
516 Clinical coding training programme assurance				A	A meeting has been convened to establish an effective approach to the provision of evidence.	
601 Corporate record management assurance	G	G	A	G	An audit by the ICO identified some areas of weakness but found no serious matters; the Trust is working through the recommendations.	
603 FOI compliance assurance	A	G	G	A	The FOI Manager needs to attend a pan-London FOI expert group session in lieu of training.	

Task	Q3	Q4	Q1	Q2	Action plan for amber and red risks	Predicted position for end of Q4, 2014
604 Records lifecycle management assurance	G	G	A	G	An audit by the ICO identified some areas of weakness but found no serious matters; the Trust is working through the recommendations.	

Board of Directors : November 2013

Item : 10

Title: Education and Training Report

Purpose:

To report on the recruitment and admissions position for the academic year 2013–14, and the finance and performance position for the financial year. To present the recommendations of the portfolio review and an action plan for their implementation.

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Discussion

From : Malcolm Allen, Dean of Postgraduate Studies

Education and Training report

November 2013

1. INTRODUCTION

1.1 This report has three main sections:

- A. Recruitment and admissions for the academic year (AY) 2013–14 and their implications for the financial and performance position for the financial year (FY) 2013–14;
- B. Strategic transformation and the portfolio review;
- C. Other relevant developments.

1.2 The recommendations of the portfolio review are also bound up with the proposals for spending the special one-off grant of £385k from Higher Education North Central and East London (HENCEL) to enhance the work of the NHS national Training Contract (Extending our Reach).

1.3 The action plan flowing from the portfolio review also takes into account the recommendations of the recent internal audit out of which has come a draft Annual Operating Plan which sets out systematic key performance indicators (KPIs) for education and training activity across the Trust.

A. RECRUITMENT AND ADMISSIONS FOR AY 2013/14

2. Long/ degree-level courses

- 2.1 The results for the current academic year are pretty healthy. Total enrolments are 1147 against a target of 1047, i.e. above target by 100 enrolments or 9.6%. See **Appendix 1**.
- 2.2 Year 1 recruitment is especially strong. An ambitious target of 563 Year 1 enrolments was set, an increase of 27% on last year's actual enrolments. There are 557 enrolments this academic year (6 short of target) but still a healthy 25% increase on last year.
- 2.3 Year 2 plus recruitment is also in excess of target by 13.4% though relatively cautious targets were set for this. This is because of the low Year 1 recruitment figures from the years prior to 2012–13 which have been washing through and impacting upon total enrolment figures in later years.
- 2.4 AY 13/14 fee income is projected at £3.09m, almost on target (£15k below). This is broken down by service line as follows:

- **CAMHS £1.96k (£161k above AY target)**

CAMHS has exceeded its Year 1 recruitment target by 61 students, largely due to two new commissioned systemic courses which attracted 54 students. In addition, good recruitment on two courses contributed significantly to the favourable variance: PG Certificate/Diploma in Applied Systemic Theory (£44k above plan) and PG Certificate/Diploma/ MA in Emotional Factors in Learning and Teaching (£10k above plan). However, some courses did not reaching target: Therapeutic Communication with Children (£30k below plan); Early Years Development: Infant Mental Health (£20k below plan). PG Diploma/MA Psychoanalytic Observational Studies and PG Certificate in Child, Adolescent and Family Mental Well-being were given ambitious recruitment targets (20% increase) which was met by the former and fell short in the latter case by 5%.

Students progressing (Year 2 plus) are 76 above plan (plus an additional 37 students on a pending 'P' status that are likely to convert to enrolled). There are, therefore, favourable fee income variances related to progressing students on a number of courses: PG Certificate

in Child, Adolescent and Family Mental Well-being is above plan by £50k and PG Diploma/MA Psychoanalytic Observational Studies by £64k. Other courses with fees above plan are Professional Doctorate in Systemic Psychotherapy (£21k above plan) and Professional Doctorate and Clinical Training in Child and Adolescent Psychotherapy (£33k above Plan). However, the Professional Doctorate in Child and Educational Psychology is below plan by £18k.

- **TC £143k (£21k below AY target)**

Overall, the two TC courses netted a variance of two students below target; 5 below target for Year 1 compensated by 3 students above target for Year 2 plus. Recruitment for the Professional Doctorate in Consultation and the Organisation (16 students) was above last year (11 students), but fell short of the target of 20.

- **SAAMHS £987k (£155k below AY target)**

Overall, SAAMHS recruitment was 62 below target. Two SAAMHS courses were above plan for Year 1 recruitment: Introduction to Counselling and Psychotherapy (5 above plan) and PG Diploma/MA Foundation Course in Psychodynamic Psychotherapy (4 above plan). The latter course also did well for Year 2 plus progression (16 above plan).

However, ambitious targets set for the Social Work cluster (12 below plan for Year 1 recruitment; 22 below plan for Year 2 plus progression) and the Clinical Qualification in Psychodynamic Psychotherapy group (25 below plan) has resulted in adverse variances of £82k and £89k respectively.

The current variance reflects the fact that the start of Understanding Trauma – Principles and Practice (target of 14 students and £19k fee income) has been postponed to January 2014, subject to recruitment (5 applications to date). PG Certificate/Diploma/MA in Psychodynamic Approaches to Working with Adolescents is not running this academic year due to poor recruitment (recruitment target of 10 and fee income target of £23k). The cluster lead redirected a number of applicants to other Trust courses. The MA in Social Work has also recruited 20%

below Plan (32 against a target of 40) due to a cap on social work bursaries.

2.5 In terms of its translation into the financial year, total full year estimated income for fees from long courses together with HEFCE funding is £106k above target, though there is also an £18k adverse variance for LCPPD fees.

2.6 All in all, our long courses are holding up very well and this is before the impact of the portfolio review. This may be attributable to the following factors:

- A focus on expanding numbers for our more successful courses, e.g. PG Certificate in Child, Adolescent and Family Mental Well-being ('picking winners');
- The strides that continue to be made by our marketing operation;
- Some improvement in our methods and processes for student relationship management from the point of enquiry onwards (though with a huge amount still to do).

3. Short courses, conferences and events

3.1 Our general short/ CPD courses have broadly stayed at last years' level with an estimated 729 participants compared to 716. There has been more growth in the area of customised courses with 132 participants compared to 47 last year. Taken together, there is an overall 12.3% increase in participants on last year. See **Appendix 2**.

3.2 Conferences have had a healthier year than last year, increasing the number of conferences from 8 to 13 and delegate numbers from 432 to 712 (65%).

3.3 Financially, total estimated full year income for short courses and conferences together is £450k, £21k above target, and £83k above last year's income (22.8%).

3.4 Despite this success, the general sense within the Education and Training Executive is that this area, along with the constraints of the

external environment, has been impacted by the reduction in staff over the last two years. The generation of short courses and conferences has traditionally happened in people's 'spare time', a direct result of people's enthusiasm and interest over and above their existing commitments. It is this developmental capacity that has been significantly eroded during this time.

4. E-learning

- 4.1 The estimated income from our e-learning products is £81k, a clear increase from last year's £24k. Whilst this is significantly short of target by £173k, the net income and expenditure figure is mitigated by savings in e-learning related expenditure of £164k, giving a net adverse variance of £9k. **See Appendix 3.**
- 4.2 In terms of the product we now have, the biggest shortfall on target was for our one e-learning long course, Introduction to Counselling and Psychotherapy. Here a highly ambitious target of 40 was set. In fact we achieved 19 enrolments, short on target but still double our recruitment figures for last year, the first year of the course.
- 4.3 A recent report from the external examiner on the first year's cohort stated that he was 'very impressed with the integration of theory and practice and by the level of the work seen, especially the way in which students integrated psychodynamic language' and finished by praising the work and overall saying that he was very impressed. The feedback from students has also been highly positive.
- 4.4 The small portfolio of e-learning short courses has been performing well against target numbers. Therefore, the income shortfall has been a combination of an over-ambitious target for the Introduction to Counselling and Psychotherapy course and a slower pace for the introduction of new courses, with the commensurate favourable variance in expenditure.
- 4.5 What these figures demonstrate is that e- and blended learning have not been taken to scale in the way that had been hoped. But the figures

absolutely demonstrate the real potential for our e-learning products, especially if we can significantly increase our market intelligence in this area, shape an informed product development strategy and gain access to new markets.

- 4.6 The Higher Education Academy (HEA) Associates' recommendation that we shift the emphasis from a discrete, independent 'e- and blended learning strategy' to a more integrated and embedded 'technology-enhanced learning strategy' chimes with the most recent thinking of the Education and Training Executive. There will still be a place for identifiable on-line product, but e-learning will now take its place as an alternative delivery platform within a broader spectrum of flexible learning opportunities.

B. STRATEGIC TRANSFORMATION AND THE PORTFOLIO REVIEW

5. Key findings of the portfolio review

- 5.1 As previously reported, the Education & Training Executive appointed Higher Education Academy (HEA) Associates as our external consultants to work with us on the detail of the portfolio review. We have now received their final report and recommendations. There are 54 specific recommendations ranked high, medium or low. We are currently working through these and they form the subject of a special awayday on 19 November.
- 5.2 Key to the success of the implementation of the recommendations is the adoption of the concept of the 'learner experience'. This approach looks at the learning experience provided through the eyes of a student. By taking this approach the trust widens its responsibility from looking after its students from enrolment to qualification to considering all types of potential student, where they come from, how they come to consider the Trust, investigate it as a potential provider, enrolment, retention, qualification through to active alumni involvement.

5.3 This will also require a cultural shift in the organisation. Higher education in the UK is experiencing unprecedented changes, challenging traditional approaches to learning and teaching and putting students firmly in the driving seat. Institutions have been catapulted into a landscape where they must compete at home and abroad for students on distinctiveness, value for money and cost; while grappling with a more diverse student base, new modes of delivery and rising expectations about learning, teaching and employment.

6. Internationalisation

6.1 Complementing this approach the HEA recommends that the Trust also adopts a non-deficit approach to its international students. All students should be treated equally with a focus on facilitating the interaction between student cohorts rather than the needs of the individual student groups. Also, internationalisation should be embedded into learning and teaching policy and processes across the Trust and not just on those courses aimed at International student cohorts.

6.2 There should be a focus on the core offer for students; that which is routinely provided for all students rather than compensatory, bespoke services provided for particular groups of students. If the core offer is appropriately designed to ensure the success of a diverse student body, the need for additional services is minimised. As the quality of education is a core concern for all higher education professionals, it follows that all staff should be invested in and contribute towards internationalisation. A successful internationalised institution is arguably one that seeks to change its culture, going beyond the quality and content of what is taught and how, to nurture the quality of the ethos, whereby intercultural and global perspectives are valued, and staff and students sense of belonging is fostered.

7. Action plan and project plan

- 7.1 The Education & Training Executive has been considering the detailed recommendations and will have done so in more detail at its planned awayday on 19 November. It will also combine this with the programme of projects to enhance the impact of the National Training Contract funded by HENCEL (Extending our Reach).
- 7.2 On the basis of discussions to date and the work done on Extending our Reach, I have produced a draft action plan to give an indication of the broad programme of work that the E&T Executive will be undertaking over the coming months (see **Appendix 4**). It is proposed that following the work of the awayday, this action plan is finalised and brought back to the Board of Directors in January 2014. This will then be the benchmark document that will allow the board to monitor the progress of the implementation of the portfolio review and hold the E&T Executive as well as the delivery service lines of CAMHS and SAAMHS to account.

8. Annual Operating Plan and KPIs

- 8.1 Coming out of the internal audit, we have begun work on a draft Annual Operating Plan with a set of key performance indicators (KPIs) (see **Appendix 5**). This is different from the above action plan in that this will form our regular on-going framework against which the board can monitor our performance. However, over the next year especially there is a degree of overlap between the two documents.

C. OTHER RELEVANT DEVELOPMENTS

9. Work on sexual orientation

- 9.1 There is an Outstanding Action that refers to a 'copy of the sexual orientation statement'. This is something of a misnomer in that it emerged out of a report from the Equalities Committee which was a proposal for a letter not a statement. The Equalities Committee had discussed the proposal that all staff involved in teaching and/or supervision should be written to stating the trust's commitment to

equalities for lesbian, gay, bi-sexual and transgender people within education and training, and asking them to assure themselves that they were comfortable with that perspective and that any contribution to teaching, discussion and assessment would be consonant with that. This was in the light of a legacy of certain negative attitudes to homosexuality within sections of the psychotherapeutic community that had in the not too distant past been supported within the trust and elsewhere. A letter was in fact drafted and discussed.

- 9.2 The proposed (draft) letter was agreed as a recommendation but subject to further discussion and consultation beyond the Equalities Committee (e.g. at the Education & Training Executive, Clinics Committee). One of the unresolved issues, amongst others, was who the letter might be sent to. The proposal for the letter was discussed at the Education and Training Executive. The Executive fully supports the Equalities Committee's work in this area and is committed to move this agenda forward in a purposeful way. However, it also considered that simply to send out a letter outside of any wider context or linked set of initiatives was not the best way of achieving these important shared objectives. Therefore, the Executive agreed to develop a set of proposals to make progress in this area, but to hold for the moment the sending of a letter.
- 9.3 A recent discussion at Clinics Committee supported the Education and Training Executive's approach on this. The committee also recommended that we commission some work from a relevant external agency (e.g. Stonewall, PACE) to help us move forward on this issue, as well as on race and ethnicity (obviously with a different agency).

Malcolm Allen
Dean of Postgraduate Studies
November 2013

ANNUAL PLAN 13/14

ICS

Student number and training income summary

	Actual AY12/13	Budget AY13/14	Forecast AY13/14	Variance AY13/14	Actual FY12/13	Budget FY13/14	Forecast FY13/14	Variance FY13/14
Students enrolled - Year 1	14	24	19	-5				
Students enrolled - Total	53	49	47	-2				
Associate Centres	0		0					
Fee Income (incl. Associate Centres)	£115,150	£163,556	£142,820	£-20,736	£137,535	£142,887	£131,991	£-10,896
Commissioned Income	£0	£0	£0	£0	£0	£0	£0	£0
LCPPD	£95,502	£57,946	£20,580	£-37,366	£98,754	£63,982	£77,429	£-3,969
HEFCE	£31,950	£33,300	£23,500	£-9,800	£31,965	£31,988	£30,152	£-1,836
Short courses					£9,400	£36,921	£13,000	£-23,921
Total	£242,602	£254,802	£186,900	£-67,902	£277,654	£293,194	£252,572	£-40,622

ANNUAL PLAN 13/14

SAAMHS

Student number and training income summary

	Actual AY12/13	Budget AY13/14	Forecast AY13/14	Variance AY13/14	Actual FY12/13	Budget FY13/14	Forecast FY13/14	Variance FY13/14
Students enrolled - Year 1	195	273	211	-62				
Students enrolled - Total	394	458	385	-73				
Associate Centres	26		18					
Fee Income (incl. Associate Centres)	£990,639	£1,142,663	£987,413	-£155,250	£917,566	£1,050,918	£989,996	-£60,922
Commissioned Income	£0	£0	£0	£0	£0	£0	£0	£0
LCPPD	£102,429	£86,841	£73,371	-£13,470	£75,246	£95,887	£102,895	£1,091
HEFCE	£120,756	£106,953	£97,677	-£9,276	£124,798	£112,704	£111,141	-£1,563
Short courses					£102,850	£110,000	£135,919	£25,919
Total	£1,213,824	£1,336,457	£1,158,461	-£177,996	£1,220,460	£1,375,426	£1,339,951	-£35,475

ANNUAL PLAN 13/14		CAMHS							
Student number and training income summary		Actual AY12/13	Budget AY13/14	Forecast AY13/14	Variance AY13/14	Actual FY12/13	Budget FY13/14	Forecast FY13/14	Variance FY13/14
Students enrolled - Year 1		235	266	327	61				
Students enrolled - Total		603	540	715	175				
Associate Centres		221		218					
Fee Income (incl. Associate Centres)		£1,474,836	£1,464,310	£1,624,962	£160,652	£1,430,497	£1,438,315	£1,599,744	£161,429
Commissioned Income		£385,539	£335,518	£335,518	£0	£351,997	£361,858	£361,383	-£475
LCPPD		£32,527	£19,677	£41,816	£22,139	£39,381	£21,727	£37,383	£17,639
HEFCE	c/f of FY12/13	£523,420	£467,526	£435,562	-£31,964	£519,547	£490,869	£510,956	£20,087
Short courses						£232,059	£231,000	£259,309	£28,309
Total		£2,416,322	£2,287,031	£2,437,858	£150,827	£2,573,481	£2,541,786	£2,768,775	£226,989

ANNUAL PLAN 13/14		Non-Service Line							
Student number and training income summary		Actual AY12/13	Budget AY13/14	Forecast AY13/14	Variance AY13/14	Actual FY12/13	Budget FY13/14	Forecast FY13/14	Variance FY13/14
Students enrolled - Year 1									
Students enrolled - Total Associate Centres									
Fee Income (incl. Associate Centres)		£0	£0	£0	£0	£0	£0	£0	£0
Commissioned Income		£0	£0	£0	£0	£0	£0	£0	£0
LCPPD		£44,897	£55,819	£92,633	£36,814	£25,283	£61,633	£40,948	-£32,562
HEFCE		£0	£0	£0	£0	£0	£0	£0	£0
Short courses						£21,758	£51,000	£41,334	-£9,666
Total		£44,897	£55,819	£92,633	£36,814	£47,041	£124,510	£82,282	-£42,228

ANNUAL PLAN 13/14		Total							
Student number and training income summary		Actual AY12/13	Budget AY13/14	Forecast AY13/14	Variance AY13/14	Actual FY12/13	Budget FY13/14	Forecast FY13/14	Variance FY13/14
Students enrolled - Year 1		444	563	557	-6				
Students enrolled - Total		1050	1047	1147	100				
Associate Centres		247		236					
Fee Income (incl. Associate Centres)		£2,580,625	£2,770,529	£2,755,195	-£15,334	£2,485,598	£2,632,120	£2,721,731	£89,611
Commissioned Income		£385,539	£335,518	£335,518	£0	£351,997	£361,858	£361,383	-£475
LCPPD		£275,355	£220,283	£228,400	-£3,414	£238,664	£243,229	£258,655	-£17,801
HEFCE	c/f of FY12/13	£676,126	£607,779	£556,739	-£51,040	£0	£33,227	£652,249	£16,688
Short courses						£676,310	£635,561	£652,249	£16,688
						£366,067	£428,921	£449,562	£20,641
Total		£3,917,645	£3,934,109	£3,875,852	-£69,788	£4,118,636	£4,334,916	£4,443,580	£108,664

CPD & Conference Income and Student nos combined

Service Line	FY11-12	FY11-12	FY11-12	Student nos	
	Budget	Actual	Variance	FY11-12 Actual	FY 12-13 Budget
Non-SL	-102,800	-8,059	94,741		0
ADOL/SAAMHS	-100,000	-118,481	-18,481	620	-120,000
ADULT	-50,000	-66,627	-16,627	465	-72,800
PORTMAN	-36,000	-24,773	11,227	52	-36,000
TCS	-36,921	-36,428	493	32	-36,921
C&F	-140,000	-267,615	-127,615	1216	-280,000
Room hire	0	-9,166	-9,166		0
Total Conference	-465,721	-531,149	-65,428	2385	-545,721

Financial		Student nos	Student nos			
FY12-13 Actual	FY12-13 Variance	FY12-13 Actual	FY 13-14 Budget	FY13-14 Forecast	FY13-14 Variance	FY13-14 Forecast
-8,313	-8,313		-51,000	-30,729	20,271	115
-62,142	57,858	287	-110,000	-135,919	-25,919	724
-30,506	42,294	198	0	0	0	
-10,202	25,798	29	0	0	0	
-9,400	27,521	13	-36,921	-13,000	23,921	23
-232,059	47,941	668	-231,000	-259,309	-28,309	734
-13,445	-13,445		0	-10,605	-10,605	
-366,067	179,654	1195	-428,921	-449,562	-20,641	1,596

E-learning income and expenditure for the financial year 13-14			
	Budget	Forecast	Variance
Income	£253,922	£80,666	-£173,256
Expenditure:			
Core staff	£210,533	£181,101	-£29,432
E-cpd/course development and delivery	£194,933	£46,733	-£148,200
Non-pay	£9,000	£22,000	£13,000
	£414,466	£249,834	-£164,632
Net E-learning position	-£160,544	-£169,168	-£8,624

Task	Completion date	Progress made
OVERARCHING		
Receive HEA associate's final report & recommendations	Oct 2013	Done
Translate into E&T proposals, overall action plan and specific project plans	end Nov 2013 for action plan; end Dec 2013 for project plans	Exec discussions plus Awayday planned for 19 Oct; appoint project management specialist to map projects
PORTFOLIO/ CURRICULUM CHANGES		
Agree specific changes to curriculum for 2014/15: <ul style="list-style-type: none"> • Drop courses • Re-configure courses • New courses 	29 Nov 2013	Discussions taking place
Detailed work on 2014/15 curriculum changes <ul style="list-style-type: none"> • Identify staff to do this 	End May 2014	Some staff identified, e.g. for D24
Map the learner journey and develop how this should look in the future	End February 2014 ??	
Develop new frameworks of provision/clusters/ detailed modularisation/re-worked curriculum	End July 2014	
REGIONAL DEVELOPMENT		
Associate Centres review	1 May 2014 ?	Associate centres informed; brief written; criteria formulated
Regional development review	End July 2014	Brief being worked on
VIABILITY/COSTINGS		
Agree viability criteria for courses	End December 2013	Have drafted outline criteria
Develop and embed financial costings systems across the trust	17 April 2014 (Easter)	
MARKETING		
Commission exercise on detailed workforce mapping	End March 2014	Possible contractors identified, e.g. Binleys
Key messaging/ copywriting	17 April 2014 (Easter)	Discussions with Comms team & Martin Bostock
Work with new Marketing Officer towards enhanced marketing strategy	17 April 2014 (Easter)	Working with Rachel Surtees on JD for post

BUSINESS PROCESSES AND SYSTEMS		
Overhaul business processes and systems: <ul style="list-style-type: none"> • Embed student-focused processes • Re-focus DET structures • New IM&T (inc. CRM system) • Redefine interface with academic staff 	17 April 2014 (Easter) ??	Appoint external consultants ??
Procure videoconferencing/ streaming equipment	End March 2014	

Goal	Objectives	Actions	KPIs/Outcomes	Targets
		<p>1.3 Ensure students experience a high-quality education by: <i>access to fully articulated, integrated and comprehensive courses;</i> <i>engaging students in active and autonomous learning;</i> using technology to support learning; <i>enhancing the efficiency and quality of student services;</i> <i>assessing student outcomes, establishing a culture of reflection towards pedagogy and curriculum to improve student learning</i></p>	<p>Course evaluation</p>	
			<p>Student Satisfaction surveys</p>	
			<p>Student Satisfaction with facilities</p>	
		<p>1.4 Involve the student in the creation and transfer of knowledge through research-intensive courses, research opportunities, related employment, joint student-staff activities</p>	<p># of doctoral course completions ratio of students to supervisors</p>	

Goal	Objectives	Actions	KPIs/Outcomes	Targets
		1.5 Enhance the student experience by improving: <i>student engagement in day-to-day running of T&P;</i> Student database that supports positive relationships with students from recruitment to alumni status; <i>learning communities that connect staff and students together.</i>	% of courses with Student Representative # of international student ambassadors	
			# of students active alumnae	
	To achieve a shared culture that promotes shared learning and experience and strives for outstanding performance	2.1 Improve the structure of decision-making, promote core values and build and promote inter-disciplinary working. 2.2 Improve processes that enable students, tutors and administrators to evaluate teaching effectiveness. 2.3 Improve processes that enable students, tutors and administrators to evaluate administrative effectiveness. 2.4 Staff access professional development opportunities and budget	# of new courses/modules developed % of REP delivered on time Average response time to enquiries # of staff with Teaching qualification % of staff participating in Prof Development	

Goal	Objectives	Actions	KPIs/Outcomes	Targets
		2.5 Foster links with HEI partners to increase research links and opportunities		
	Encourage institutional research	Research conducted collaboratively across disciplines	# projects initiated annually	
			# projects cross-discipline	
			# of articles published, conferences	
Provide viable academic courses	Courses are relevant to market needs	attract increased LCPD commissions	# of contract value increases	
		attract increased student numbers through marketing strategy and plans	# of enquiries	
		Attract increased international students through marketing strategy and plans.	% conversion of enquiries to applications	
		increase greater links with HEI partners and professional organisations	% conversion of applications to enrolments	
			% graduates in employment	
			Accreditation from Professional Bodies	
	Courses are sustainable	Develop FEC model	Staff student ratio	
			% margin	
			Student debtor status	

Goal	Objectives	Actions	KPIs/Outcomes	Targets
Effective resources management and future expansion	Allocate and manage resources that improve organisational processes	Undertake annual planning to identify improvements including cost reduction, revenue generation and quality enhancement Conduct 5 yearly holistic reviews Develop, fund and execute marketing strategies and plans, domestically and internationally	Ratio of expenditure against income Enrolment increase	
	Generate non-traditional revenue streams	Develop business development working groups.	# of new income generators % of new income vs traditional income	
	Establish new courses	Initiate new courses based on evaluation of full business case including market research assessing market demand and need.	# of courses validated	
	Expand the infrastructure to meet growing needs	Establish sufficient quality premises and equipment Review place of online learning	# of elearning materials generated annually % of blended learning in programme delivery % of staff undertaken e-learning training	

Indicators for DET Learners

Indicators	Measurement	Targets
1. Newly enrolled students	% of new enrolment to leavers/graduating % graduating rates % of actual vs target enrolment % of re-enrolment	
2. Retention rates	% of student non-continuation	
3. Student satisfaction	% of completed questionnaires % of high satisfaction scores	
4. Course profitability	% of courses operating at 20>% margin	
Academic staff development activities	% with T&L award # publications, seminars, conferences, workshops	

Board of Directors : November 2013

Item :

Title : Gender Identity Development Service Report

Summary:

This report provides a description of the Gender Identity Development Service and outlines current projects and plans for the future.

This report focuses on the following areas:

- Service Description
- Patient / User Experience
- Current Projects and Future Plans
 - Development of Leeds Second Centre
 - Revised Service Protocol
 - Surveillance Study of Incidence
 - Research Projects

For : Discussion

From : GIDS Director, Dr Polly Carmichael

Gender Identity Development Service Report

1. Introduction/Service Description

- 1.1 The Gender Identity Development Service (GIDS) is a national highly specialist service. The service was designated as a National Service and commissioned by the National Specialised Commissioning Group (NSCG) in April 2009 and is staffed by a multi-disciplinary team. The team consists of a child and adolescent psychiatrist, clinical psychologists, social workers and child and adolescent psychotherapists.
- 1.2 In the reorganisation of the NHS in April 2013 the NSCG ceased and the contract is now held by the NHS England specialist commissioners. They are advised by the Multi-systems disorders Clinical Reference Group in Child and Maternal Health in which the service is located. The Director of the service is a member of the Multi-systems disorders clinical reference group and is convening and chairing a sub-group to review the service specifications.
- 1.3 We see children and adolescents (up to the age of 18) and their families who are experiencing difficulties in the development of gender identity. Typically, these young people are unhappy about their biological sex and wish to belong to the other one. Some may be boys who feel or believe they are girls and vice versa. The onset of puberty is commonly associated with an escalation of distress and an increased risk of self harming behaviours.
- 1.4 The Service also offers counselling to children with a transsexual parent. Assessment and advice are provided to the Courts at their request. Court reports usually result in referral to the GIDS which is covered by our contract.
- 1.5 Referrals to the service have increased year on year as follows:
 - 1.5.1 2007/08 – 64 referrals
 - 1.5.2 2008/09 – 85 referrals
 - 1.5.3 2009/10 – 97 referrals
 - 1.5.4 2010/11 – 139 referrals
 - 1.5.5 2011/12 – 208 referrals
 - 1.5.6 2012/13 – 314 referrals
 - 1.5.7 2013/4 – 570 (predicted)

See Appendix 1 for further details about referrals.

The rapid increase in referrals is a particular challenge and we are hoping to use over performance to employ new staff to manage the number of referrals in a timely and safe way. Due to retirement, voluntary redundancy, one member of staff moving to another post in the trust, maternity leave and the Leeds development we already have a number of new staff in the team. The

senior staff have implemented new management structures and supervision groups to ensure that all team members receive appropriate support.

- 1.6 The GIDS follows the values and principles of the Tavistock and Portman NHS Foundation Trust. The Service understands Gender Identity Disorder (GID) within the context of a psychological, biological, developmental and social framework.
- 1.7 In line with the Tavistock and Portman NHS Trust's Mission principles we aim:
 - 1.7.1 To conduct research to increase the evidence base in the area of gender identity and inform service developments.
 - 1.7.2 To ensure that our service reaches out to a group of children, adolescents and their families who are socially disadvantaged and often experience discrimination and stigma.
 - 1.7.3 To take a leading role in influencing policy on the management of GID in children and adolescents: locally, nationally and internationally.
- 1.8 The GIDS follows and contributes to international and national guidelines on the management of GID in children and adolescents. Namely we follow the Royal College of Psychiatrists Guidelines on the Management of GID (1998) and the Statement of Management of Children and Adolescents with GID issues by the British Society of Paediatric Endocrinology and Diabetes (BSPED, 2010).
- 1.9 The GIDS offers comprehensive and interdisciplinary assessment and treatment of children and adolescents with GID. The Service recognises that GID can be an extremely distressing condition, for those who present with it, their families and those around them. We endeavour to help young people and their families cope.
- 1.10 We require local CAMHS teams to remain involved in referred cases and regularly convene local network meetings at the young persons local CAMHS or school. Many of the young people we work with have significant difficulties and the meetings are used to discuss these as well as the management of issues associated with gender identity development and agree roles.
- 1.11 We regularly run groups in London and Leeds for adolescents and parents. In 2013 we piloted a family day attended by young people referred to the service, their parents and carers and siblings. This proved successful and further such days are planned. We also co-run a group for adolescents in the evening hosted by Gendered Intelligence, a charitable organisation that works with Gender Variant adolescents.
- 1.12 Transition to adult gender services when appropriate is problematic due to long waiting lists and inconsistent assessment protocols in adult services. We are actively addressing this with our commissioners and the adult gender

Clinical Reference Group and are working to improve transition pathways. A new transition clinic for complex cases has been developed in association with the Charing Cross adult gender service which will take place at the Tavistock with GIDS clinicians and a clinician from Charing Cross.

1.13 The GIDS team at the Tavistock work closely with Paediatric Endocrine colleagues at University College London Hospital (UCLH) and these services are commissioned by us through a Service Level Agreement. Following a detailed assessment and a period of therapeutic work, a referral may be considered for a selected number of cases to the Paediatric Endocrinology Liaison Clinic.

1.14 We offer two types of endocrine liaison clinics:

1.14.1 The Early Intervention Clinic is offered as part of the research on the evaluation of early pubertal suppression in a carefully selected group of adolescents with GID. The clinic is held 10 times a year and is open to carefully selected young adolescents aged between aged 12 and 14 years. Under the research protocol this is currently only offered in London. It is envisaged that it will also run in Leeds when intake for the research study ends in April 2013.

1.14.2 Standard clinics for adolescents aged 15 – 18 years.

1.15 After a series of physical tests young people may be prescribed hormone blockers. This intervention is believed to be completely reversible. The blockers produce a state of hormonal neutrality. The pausing of physical development associated with puberty aims to reduce distress associated with this and so facilitates reflection and further exploration of the young person's gender identity. Such interventions are considered as part of an overall treatment plan offered by the Gender Identity Development Service and other therapeutic treatment/consultation and psychological monitoring remain ongoing. When possible the GIDS clinicians attend the endocrinology liaison clinics with their patients.

2 Patient / User Experience

2.1 In February 2010 the GIDS introduced a service evaluation questionnaire to gather feedback and service user views. The questionnaire we use is the Commission for Health Improvement's Evaluation of Service Questionnaire (CHI-ESQ).

2.2 In general the feedback has been very positive. We have used the feedback to support service developments. The main area of dissatisfaction relates to getting to appointments. This is understandable given that we are a national service and appointments take place in London. The Leeds Second Centre Project (see section 3 below) will hopefully improve feedback in this area.

2.3 The second area with relatively poorer feedback relates to information given about the service we provide. We used this to secure QIDIS funding to develop our patient information.

2.4 Please see appendix 2 for the full report of results for 2012/13.

Current Projects and Future Plans:

3 Service Review and Leeds Second Centre Project

3.1 In the original service specification submitted to the NSCG in the application for national designation and funding, the GIDS committed to developing a second centre in the North of England to improve equity of access to services for patients who do not live within easy reach of London.

3.2 The NSCG originally specified that the Tavistock GIDS would implement the setting up of the second service, but that it would subsequently become a separate autonomous service. However following discussion with the NSCG commissioner and medical advisor last year it was agreed that the second centre would be set up and subsequently remain part of the Tavistock GIDS.

3.3 Following these discussions with the NSCG commissioning team, as well as the GID Service Director and the Trust's Contracting and Business Development team, it became clear that an overall service review and development plan was required in order to fully meet the national dimension of this contract.

3.4 A service review was completed in 2011 and we put an implementation plan in place, which included the development of the second centre. We increased staff resources in the London base to manage the rising number of referrals and, re-visited London accommodation requirements accordingly. The Service Level Agreement with UCLH was revised to increase the number of Paediatric Endocrinology Liaison Clinics. During this process of change and development we remain committed to service user and stakeholder engagement and, for example, regularly meet with representatives from a long standing support group primarily representing parent's views - Mermaids.

3.5 A detailed analysis of the activity data of the service in 2010 revealed three potentially geographically driven differences in service delivery:

3.5.1 The service receives more referrals from the South than from the North

3.5.2 The mean number of appointments is higher for referrals from the South than from the North

- 3.5.3 The proportional break down of referrals by age is different in the South than in the North, referrals in the north being an older mean age.
- 3.6 The main method to address these differences and provide equity of access and service provision to the national service was to establish a second centre in the North of England. We aim to raise awareness of the needs of young people with GID in the North and so decrease their isolation. To promote an integrated service across the two centres we reviewed and updating our service delivery model to include the second centre (see section 4, Service Protocol).
- 3.7 Leeds was identified as the preferred location for a second base. Leeds affords excellent transport links, committed and interested paediatric endocrinologists with some experience of working with this group of patients, established links with CAMHS services with some experience of working with GID and an established adult gender service. The choice of Leeds was supported by a survey we conducted with service users in the North.
- 3.8 We identified two potential premises in Leeds and presented these options to the Trust Management Committee on September 8th 2011. Unfortunately one premises proved to be unsuitable and the other too costly. We resumed our search and finally found a suitable premises and signed a lease in April 2013. The premises was refurbished and opened in July 2013.
- 3.9 In the meantime we employed a full time clinician in Leeds in February 2012. She worked in temporary accommodation until the permanent base was completed. In 2013 two further clinicians were appointed to the Leeds team.
- 3.10 The Leeds based clinicians joined the London staff for inductions and training and joined the London based clinicians on existing cases to facilitate a smooth transition for existing service users. New cases are now allocated to either base depending on location and patient choice. The team is working hard to keep the two teams integrated and the Leeds clinicians join the GIDS London team meeting on a weekly basis using Skype.
- 3.11 The entire service is managed by the current Service Director and referrals and administration continue to be facilitated through the London base. Now the Leeds centre is established we have employed a Leeds based administrator to support the Leeds based clinicians. The strategic plan is that the GIDS will remain an integrated service, offering the same input to all service users across two bases.

3.12 Following lengthy negotiations we contracted with Leeds General Infirmary (LGI) to provide Paediatric Endocrinology Liaison clinics so that patients from the North would not have to travel to London to attend Liaison Clinics at UCLH. Two Consultant Paediatric Endocrinologists have joined the team. There were meetings with our UCLH Paediatricians to ensure that both of those services offer the same input and one of the UCLH clinicians regularly attends the Leeds clinic to support the development of a consistent and high quality service. The clinics started in 2013.

3.13 Approximately 130 families been seen in Leeds so far, including 2 for Children with a transgendered parent. Currently 110 families on Leeds caseload

4 Service Protocol

4.1 The last service protocol was approved by the Trust's management committee in April 2007. Since this time there have been a number of major developments, including the national designation and centralised commissioning, as well as a new research project offering early hormonal intervention in younger adolescents.

4.2 As such the protocol has been updated to reflect the current work of the service.

5 Surveillance Study of Incidence

5.1 There are no epidemiological studies to provide data on the incidence of gender identity disorder in children and adolescents in the UK. The 1998 survey of Gender Dysphoria conducted in Scotland is commonly cited, and estimates a prevalence of people who had presented with Gender Dysphoria to be 8 per 100,000 people aged 16 years and over. These figures are based on historic data and represent only those adult individuals who sought sex reassignment surgery.

5.2 Extrapolating from the available data to estimate incidence and prevalence in children and adolescents in the UK is therefore not meaningful. For this reason we are in the process of conducting a surveillance study of gender identity disorder in children and adolescents. The study has been approved by the British Paediatric Surveillance Unit and the Child and Adolescent Psychiatry Surveillance System and was presented to an Ethics Committee in September 2011.

5.3 The study commenced in 2011. All Consultant Paediatricians and Child and Adolescent Psychiatrists were asked to periodically report any incidences of presentations of gender identity disorder. The collection of new incidences ended this year and follow up questionnaires will be sent out to gather more information over the next two years. Once the study is complete we will have an idea of the prevalence of gender identity disorder in children and adolescents in the UK and outcomes at one & two years including persistence/desistence of gender dysphoria, referrals, treatment and co-morbidities.

5.4 The early intervention research project started in April 2011. It involves giving Gonadotropin-releasing hormone analogue (or hormone blockers) to a carefully selected group of young people with gender dysphoria aged 12–14 years. In order to be considered for this research project the young people must have completed an assessment at the Gender Identity Development Service and have their key worker/s's support regarding this treatment, have a diagnosis of gender dysphoria, be in early puberty and have their parents' support regarding the blocker treatment. In order to be eligible the young people have to fulfil a number of psychological and medical criteria (e.g. regarding BMI and BMD etc).

5.5 Thus far 35 people have been seen in the early intervention clinic (16 natal females and 19 natal males) and none has been excluded from the research project based on psychological or medical criteria. Thus, all the young people who have expressed a wish to be included in the research project have been able to. In the GIDS we currently have 81 open cases on our caseload aged between 12–14 years which provides an indication of the proportion of our cases have requested this treatment.

5.6 Thus far 23 participants have started on the blockers (12 natal females and 11 natal males). None of the participants have decided to stop taking the blockers and 6 people (4 natal females and 2 natal males) have started on cross-sex hormones after turning 16. Blocker treatment was delayed for 4 people due to them not having started puberty and for 4 people due to low bone mineral density. One person did not go ahead with the blocker treatment as one parent did not consent to the treatment.

6 Research

6.1 The Gender Identity Development Research Unit (GIDRU) is a collaborative development between the Gender Identity Development Service and the Department of Psychology at University College London.

6.2 Current and Recent Research Projects include:

- 6.2.1 Early pubertal suppression in a carefully selected group of adolescents with Gender Identity Disorder (has received ethical approval and is sponsored by UCL). In progress. The main aim of the present study is to evaluate the psychological, social and physical benefits and risks involved in blocking sex hormone production in biological girls and boys with Gender Identity Disorder in the early stages of puberty.
- 6.2.2 Empathising and systemising in adolescents with Gender Identity Disorder (in collaboration with the Autism Research Centre, Cambridge University). This investigation aims at identifying potential factors contributing to rigidity or fluidity in gender identity development. In other words, looking at factors involved in the persistence or desistance of the atypical gender identity organisation. Paper to be presented at the Royal College of Psychiatrists Faculty of Child and Adolescent Psychiatry Annual Conference and at the WPATH biannual conference in Atlanta (USA) in September 2011.
- 6.2.3 Experiences of parenting an adolescent with gender identity issues. Paper to be presented at the WPATH conference in Atlanta in September 2011.
- 6.2.4 Experiences of parenting a child with gender identity issues.
- 6.2.5 Evaluation of a short-term group for adolescents with GID.
- 6.2.6 An audit of self-harm in young people attending the GIDS.

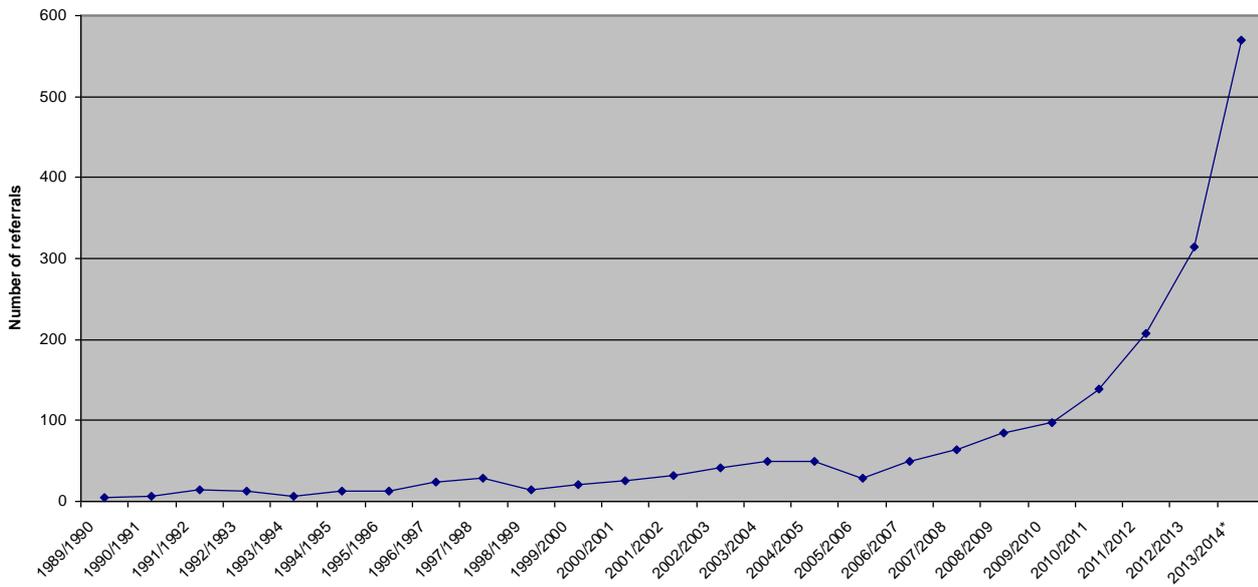
7 Consultation, Teaching & Training

- 7.1.1 In 2011 we offered a day conference in the Tavistock. This was well attended and received. In November 2013 we ran a similar day in Leeds to raise awareness of Gender Dysphoria in the North and 'launch' the Leeds base. The event received very positive feedback.
- 7.1.2 Members of the team regularly travel to Belfast to provide clinical consultations to a developing gender service. The Belfast service are following the GIDS model and this year have been joined by an endocrinologist who will provide physical intervention when appropriate.

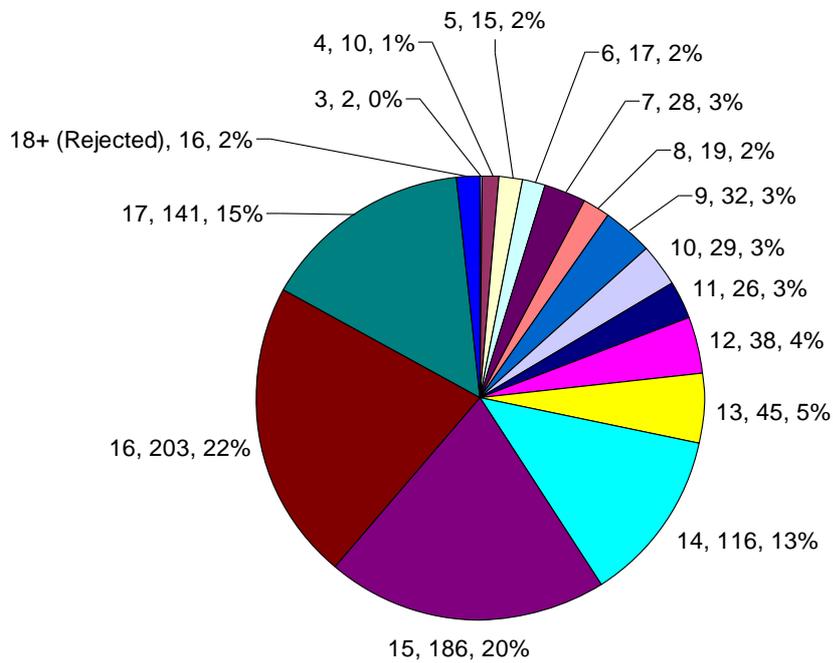
Dr Polly Carmichael
November 2013

Appendix 1

How our referrals have increased over the years

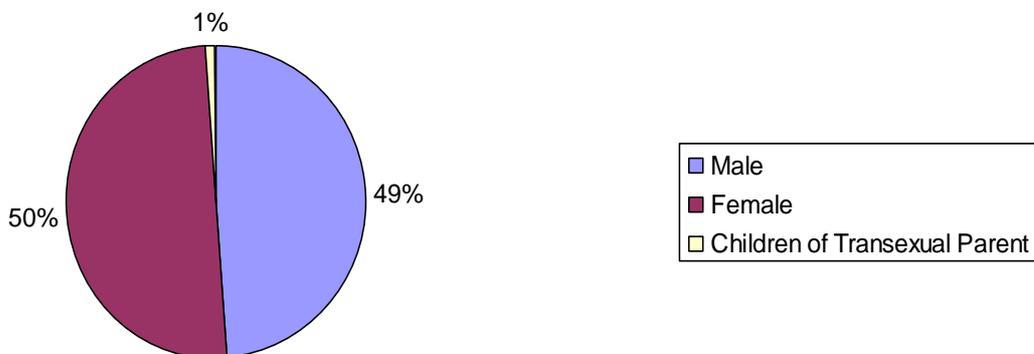


Proportion of Age at Referral from 1st April 2009



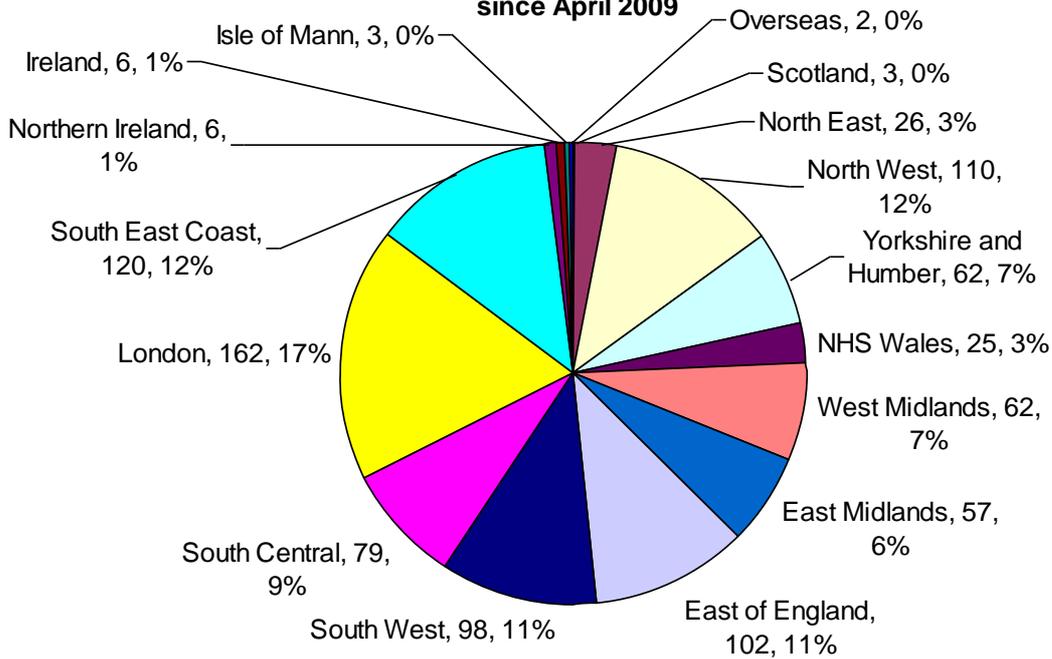
Who is referred to the service?

Overall Ratio of Natal Males to Females and Children of a Transsexual Parent referred to the service between April 2009 and February 2012



Where do these referrals come from?

Breakdown of where referrals have come from (by Strategic Health Authority) since April 2009



Service Evaluation Forms 2012-13

Research Analysis and Summary

Q1. I feel that the people who had seen my child/who saw me listened to me				
	Certainly true	Partly true	Not true	Don't know
Young person	83.9% (^12.5%)	16.1%	0%	0%
Parent	93.1% (^7.9%)	6.9%	0%	0%
Q2. It was easy to talk to people who have seen my child/who saw me				
	Certainly true	Partly true	Not true	Don't know
Young person	58.1% (-3.1%)	38.7%	3.2%	0%
Parent	89.3% (^18.9%)	10.7%	0%	0%
Q3. I was treated well by the people who have seen my child/who saw me				
	Certainly true	Partly true	Not true	Don't know
Young person	87.1% (^13.6)	12.9%	0%	0%
Parent	92.9% (^7.7%)	7.1%	0%	0%
Q4. My views and worries were taken seriously				
	Certainly true	Partly true	Not true	Don't know
Young person	74.2% (^0.7%)	16.1%	3.2%	6.5%
Parent	85.7% (^2.4%)	14.3%	0%	0%
Q5. I feel the people here know how to help with the problem I came here for				
	Certainly true	Partly true	Not true	Don't know
Young person	64.5% (^13.5%)	29%	3.2%	3.2%
Parent	85.7% (^14%)	14.3%	0%	0%
Q6. I have been given enough explanation about the help available here				
	Certainly true	Partly true	Not true	Don't know
Young person	67.7% (^8.5%)	29%	3.2%	0%
Parent	78.6% (^21.2%)	21.4%	0%	0%
Q7. I feel that the people who have seen my child/me are working together to help with the problems				
	Certainly true	Partly true	Not true	Don't know
Young person	67.7% (^4.4%)	19.4%	9.7%	3.2%
Parent	82.1% (^9.9%)	10.7%	3.6%	3.6%

Q8. The facilities here are comfortable				
	Certainly true	Partly true	Not true	Don't know
Young person	67.7% (^8.5%)	25.8%	6.5%	0%
Parent	67.9% (-0.6%)	28.6%	3.6%	0%
Q9. The appointments are usually at a convenient time				
	Certainly true	Partly true	Not true	Don't know
Young person	45.2% (^10.5%)	38.7%	16.1%	0%
Parent	39.3% (-1.4%)	53.6%	7.1%	0%
Q10. It is quite easy to get to the place where the appointments are				
	Certainly true	Partly true	Not true	Don't know
Young person	22.6% (-14.1%)	45.2%	32.3%	0%
Parent	32.1% (-4.9%)	42.9%	25%	0%
Q11. If a friend needed similar help I would recommend that he/she come here				
	Certainly true	Partly true	Not true	Don't know
Young person	80.6% (^5.1%)	12.9%	0%	6.5%
Parent	82.1% (^4.3%)	14.3%	3.6%	0%
Q12. Overall, the help I have received here is good				
	Certainly true	Partly true	Not true	Don't know
Young person	80.6% (^9.2%)	16.1%	0%	3.2%
Parent	92.9% (^13.3%)	7.1%	0%	0%

N= 59

(^ # %) = Percentage increase from the previous financial year (2011-12)

(- # %) = Percentage decrease from the previous financial year (2011-12)

What was really good about your care?

Being listened to/ able to talk to someone

- “Our viewpoints are listened to and respected. Helpful advice given to follow/try. Always listens to feedback from advice given. Flexible with meetings i.e. parents alone or with child”
- “I was listened to”
- “The length of time being listened to. Caring about the young person”
- “Really listened and cared”
- “You listened and I felt my daughter was listened to”
- “Very easy to talk to and listens to what I have to say”
- “Having people listen and advise us and give us the information we need”
- “They listened and tried to help”
- “People listened and were very understanding”
- “I was listened to and appropriate action has been taken”
- “Having people to listen and advise”
- “The man listened to me and answered all my questions, also the people in the reception were very kind and chatty”
- “Listened to our worries”
- “I have someone to talk to”
- “Child is given time to talk about any concerns/ worries that they might have. Staff have time to talk with GIDS staff about concerns.”
- “I was listened to and was very happy with the care I was given”
- “I think it was really good that they listen to me, and that something can be done to help me”

Being understood and accepted

- “That no matter what I say I will be understood”
- “A feel of acceptance”
- “Our views were taken seriously, we felt easy to express ourselves and felt we were taken seriously and were listened to. The help and understanding was very good, so thank you all so much. Overall a great service...”
- “Being understood and taken seriously”

The Process

- “It’s a step in the right direction”
- “The people I saw explained the process clearly. I found the appointments beneficial to progress further in my process.”
- “I feel the Tavistock Clinic provided a stepping stone towards the ultimate result which is required for my Grandson to lead a comfortable and happy life when Gender Reassignment is attained. I realise this is a necessary process until he reaches 18 years old.”

Relaxed Tone of Sessions

- “The people I spoke to were not patronising or condescending. The time with them didn’t feel like an interrogation either”
- “Everyone is very caring and sympathetic to my child and wants what’s best for her”
- “I also feel comfortable when I am able to express myself... I enjoy talking to my counsellor about these kinds of things”
- “I could relax and felt I could say anything that was on my mind”
- “Meetings are relaxed and I feel my child’s views are taken into account. There is no pressure on my child to answer questions if he does not want to”
- “The clinician put us at ease and explained everything very clearly; we all felt at ease”
- “How everyone is welcoming, friendly and put you at ease. I just wish appointments could be longer sometimes!”
- “Everyone was nice”
- “Was a friendly, caring place. Was a good experience and a lot of care I felt from my mother and staff also”
- “Helpfulness & caring attitude of counsellors”
- “I felt comfortable talking and being honest”
- “The staff without question were courteous and helpful. The man who saw our child very quickly built a rapport with us which helps enormously”

Information & Knowledge

- “Explained everything to me... It was perfect”
- “It’s regular and we got to choose our appointments and the people have lots of information and knowledge.”
- “Now I understand more”
- “We have been signposted to other services such as Gendered Intelligence to support our child”
- “Quite thorough, steps taken to help are very good”
- “The Tavistock is the only place to deal with my child’s needs at this moment in time due to her age. They listened and have provided us with the care we have needed and still need in the future”
- “The people understand what they are talking about and are able to give educated care.”
- “The fact that the NHS actually provides this service. Helped me establish better relationship with my child. Being seen by experts. We had only seen a junior trainee doctor in CAMHS who had very little knowledge and didn’t seem to hear what I was saying.”
- “Talking to people who are well aware of the problems and difficulties we do and may face.”

Flexibility/ Dealing with problems

- “The way things were dealt with in general”
- “On our last visit there was an appointment mixup. But it was sorted out and someone else saw us”
- “It has not been too long between appointments”
- “Prompt action was taken for crisis intervention and following up call”

Was there anything you didn't like or anything that needs improving?

The Wait

- “I feel as though as someone in their late teens I should have been referred more quickly to UCLH”
- “We had to wait a few months to be seen, there is a long wait to see the paediatric endocrinologist”
- “I was just annoyed I have to wait a very long time before anything can be done”
- “Waiting list to be seen at Charing Cross for hormone blockers is too long to wait (but not your fault)”

Clearer Pathway/ Information of Services

- “More information about what the process is from referral through to medical intervention: What are the aims? What do the team need to assess and how do they achieve that? How do they make a decision for early intervention? We just turned up for appointments with little understanding of what was going to happen or how the process progresses. Some paperwork showing this would have been and would still be useful.”
- “The knowledge of the adult experiences- operations”
- “We would have appreciated clearer/fuller info about the pathway post 18.”
- “Things are not completely explained from the beginning”
- “When we asked questions about treatments we could hope for in the future, there seemed to be quite a lot of false information given and this led to disappointment and frustration i.e. time scales for being seen at Charing Cross Hospital, we were told waiting time for Tavistock Adult Service which is not what we asked therefore this gave us the wrong impression.”
- “I'd like to know when it can all start happening because I'd like the blockers ASAP!”
- “I felt like my parents were given more information than I was on how I could be helped and information such as why puberty blockers are given before cross-hormones was not given to me which did not aid with my frustration at the pace of the service. GPs should be more aware of the services that can be offered so that more people can receive specialised help. I myself could have benefitted by a referral almost a year earlier.”

Aims/ Directions of sessions

- “Although we had plenty of information about the care pathway, there were times when I wondered what we had gained by attending an appointment. That might be understanding the difference between physical medical care and psychological therapies I guess.”
- “Counsellors unclear about aims of sessions. Counsellors also jumped to conclusions about my feelings then disbelieved me when I rejected their ideas”

- “I feel it should be more about me and my case and less about other things... so my mother can accept something she never will”
- “I felt that the two consultants who worked with us didn’t always seem to make us feel completely comfortable: there were many pauses and quite long silences that I felt I had to speak to make conversation flow! I felt my Grandson was not given reassurances about GID in many ways.”
- Practitioner did not know much about related services or alternatives – relied too much on the assumption that I would do my own research of information. Asked what I would like out of the service though did not give specific detail on what could be offered before asking this question.
- I didn’t feel that the 2 people I saw worked together and weren’t well organised. A lot of the time I would be left in awkward silences that made me feel uncomfortable.”
- The people I saw need to listen less to my parents and more to me. They also need to be less condescending and not treat me like a child. They also were rude and need to stay focussed on the topic of HELPING ME not anything else
- There were times when I expressed a certain view about topics that were brought up and I felt as if my view wasn’t valid or understood
- A lot of false information was given during my appointments which were back tracked on and left me feeling extremely upset and disappointed when I left. I was often left feeling extremely upset and disappointed when I left. I was often left feeling messed about, not taken seriously and 1 of the 2 workers seemed to constantly disbelieve what I was saying.”

Location

- “We live in Bath- London is a long way away- trains are expensive
- “I didn’t like the location, due to traffic. However, this can’t really be helped”
- It’s a shame that there is nothing closer to home, and everything takes such a long time
- “Nothing about the service, but overall it would help if there were more local services around the country as we have to travel quite far for appointments.
- “In general the only downfall is that I have to travel to London from Manchester for my appointments, there should be more of these services all over the country”
- “Travelling from the North West to London - too far for a 1 hour appointment. There should be more resources available to children under 18 across the country”
- Many of us come from far away. It is a long way to come for a 1 ½ hour session.
- “The distance is an unavoidable issue”

More support

- “I think it is very unfair that the hospital will pay for any fare that has to be paid by parents if you do not work. I am a single mum with 4 jobs and struggle to find the train fare, food and drink while we are in London.”

- “More support for families with young children with gender identity (i.e. under 10 years old)

Facilities

- “This letter being addressed to the previous female gender and not the present male. I have changed name by deed poll and will notify clinic again to get it changed”
- “A canteen”
- “It would be nice to be offered a cup of tea and a drink, having travelled quite a way”
- “The vending machine in the waiting room has been broken for months. One time the receptionist asked my name about 5 times and gave me really weird looks”
- “Perhaps more child friendly material in the waiting room would be better as children can be nervous before appointments and this may prove a good distraction”
- “No, I thought the clinic was amazing just the way it was”

Time of appointments

- I had requested Friday³, as it was my day off. Although the first appointment was a Friday, I was then informed our clinician did not usually work on Friday³. This meant I had to take days off work to attend. Very disappointed that the Support Group is run on a Wednesday when most adults are at work. Already we have to take time off to come for clinic appointments for this and additionally CAMHS for our children. I work in the NHS and we put on support meetings for patients and partners either in the evenings or on a Saturday. As staff, we do give up our Saturday and get time off in lieu, but we do this to reduce time people have to take off work. We had been advised it would be on a Saturday. Even then, we were told it was for 1 ½ hours.

Greater awareness of the Service by GP’s and other professionals

- “We are grateful to have a specialist Transgender Service available to us. GP³ need to be more aware of this service. We would have benefitted from a referral many months before when we attended the GP surgery and saw a different GP.”
- “No, the only thing we would like is to have been aware of the problem at a younger age so our child could have been put on hormone blockers as soon as possible”

Other comments

- “Thank you for everything you do to help us. We are so fortunate to have such an amazing place to go for support.”
 - “The overall service is very good. I feel my child is totally supported”
 - “Excellent service, everyone is very friendly and helpful”
 - “No the service was great”
 - “We are just generally relieved that the service exists and it is friendly, welcoming and the staff knowledgeable. This gives us confidence in the service”
-
- “The receptionist should have appointments booked under “Alfred” not my birth name to avoid embarrassment. I should also not be misgendered by ANYONE at the clinic as that’s transphobia and makes the person misgendering me a bigoted asshole who shouldn’t be working at the clinic.”
 - “The benefits of a session sometimes didn’t show themselves until much later. Coming from the South West, it was difficult to access the extra support groups and was also quite costly e.g. train £103 per trip to London. We therefore tried to make the most out of our trips. I’m sure many people would struggle with this cost.”
 - Always dealt with in a calm professional manner by staff

BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 26th November 2013, 14.00 – 15.30,

Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES

1. Chair's Opening Remarks Ms Angela Greatley, Trust Chair		Verbal	
2. Apologies for absence and declarations of interest Ms Angela Greatley, Trust Chair	To note	Verbal	
3. Minutes of the previous meeting Ms Angela Greatley, Trust Chair	To approve	Enc.	p.2
4. Matters arising Ms Angela Greatley, Trust Chair	To note	Enc.	p.8

REPORTS & FINANCE

5. Trust Chair's Report Non-Executive Directors as appropriate	To approve	Enc.	p.9
6. Acting Chief Executive's Report Mr Simon Young, Acting Chief Executive	To note	Enc.	p.13
7. Finance & Performance Report Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.18

CORPORATE GOVERNANCE

8. Charitable Funds Annual Report and Accounts 2012-13 Mr Simon Young, Acting Chief Executive	To approve	Enc.	p.29
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QUALITY & GOVERNANCE

9. Clinical Quality, Safety and Governance Report, Quarter 2, 2013-14 Dr Rob Senior, Medical Director	To note	Enc.	p.44
10. Education and Training Report Mr Malcolm Allen, Dean of Postgraduate Studies	To note	Enc.	p.77
11. Gender Identity Development Service report Dr Polly Carmichael, GIDS Director	To note	Enc.	p.103
CONCLUSION			
12. Any Other Business		Verbal	
13. Notice of Future Meetings <ul style="list-style-type: none"> • Thursday 5th December 2013: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre • Tuesday 28th January 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre 		Verbal	