The Tavistock and Portman NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

Tavistock and Portman NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

Name	Simon Young
Job Title	Director of Finance and Deputy Chief Executive
e-mail address	syoung@tavi-port.nhs.uk
Tel. no. for contact	020 8938 2468
Date	31 May 2013

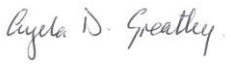
The attached Strategic Plan reflects the Trust's strategic and operational plans over the next three years, agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

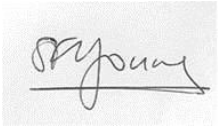
Name	Angela Greatley *(Chair)*

Signature 

Name	Dr Matthew Patrick *(Chief Executive)*

Signature 

Name	Simon Young *(Finance Director)*

Signature 

Strategic Context and Direction

The year 2012/13 has been shaped by two events: the publication of the Final Report of the Independent Inquiry into the terrible failures in the quality of care provided by Mid-Staffordshire NHS Foundation Trust by Robert Francis QC; and the lead-up to the full implementation of the Health and Social Care Act. The former has refocused the NHS on the profound importance of quality, safety, care and compassion, and the centrality of the patient/carer voice in securing these; the latter has encompassed the creation of new commissioning systems, structures and organisations, the separation of public health under the new body, Public Health England, and the overall leadership of the system moving to NHS England. All of this is set against the backdrop of continuing financial pressures on the NHS and significantly greater financial pressures on other public services.

At the heart of this Annual Plan is an absolute commitment to high quality patient centred care. This is achieved through a balance between delivering on our mission to help, to learn and to teach from our experience – working with other organisations to increase access to our clinical services, training and education – on the one hand; and on the other, delivering the levels of productivity that are required in the current very difficult climate.

We believe that our services remain amongst the best in the country, representing genuine and affordable excellence. This quality is reflected both in our feedback from patients and students, and in continued support from commissioners for clinical services and for training and education.

The Trust's income has grown from £24.7m in 2007/08 to £36.2m in 2012/13; an increase of 46% over 5 years, or 8% per annum compound growth, in a period when the tariffs for NHS services have increased very little, and more recently have reduced. This represents the "upside" projection made at the beginning of that period. With staff numbers increasing by 13% over the same period, from 367 wte to 416 wte, the growth has allowed the Trust to increase both our contribution and our productivity.

Growth remains a key component of the plan because we believe that our distinctive approach to mental health and wellbeing represents an important contribution that we wish to extend. In addition, growth offsets inevitable losses in other areas of income; it provides flexibility in relation to staff employment; and it offers the potential for improving profitability in relation to our activity, with the aim of controlling the level of savings that we need to make each year as a Trust and supporting core NHS provision. In extending our contribution we aim to build from our areas of existing strength. These include not only areas of clinical and training excellence, but also the Trust's capacity to work in a responsive manner with a diverse range of partners and local communities.

A notable example of growth has been achieved in 2013/14, with the Trust taking on responsibility for the National Unit leading the Family Nurse Partnership:

> The Family Nurse Partnership
>
> The Family Nurse Partnership (FNP) is a preventive programme for vulnerable first time young mothers. It is a clinical, public health programme, offering intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two.

FNP is based on a model from the USA, and was first piloted in England in 2007. By 2012, there were 74 teams offering FNP in over half the local areas in England. The programme is led and overseen by a National Unit which has been within the Department of Health.

In 2012, the Secretary of State agreed that this implementation function should no longer sit within DH. DH therefore invited tenders for a partner organisation to take on the National Unit and lead the future delivery of the programme. This includes the training programme and the support of all existing sites. The Trust – in partnership with Impetus and the Dartington Social Research Unit – bid successfully for this role.

The government has set targets for the continuing expansion of the programme. The National Unit is responsible for ensuring that new sites have the capacity to deliver FNP; and for the ongoing quality of delivery. It is the responsibility of the NHS Commissioning Board (until 2015, when this should pass to local authorities) to increase the places by commissioning providers.

The Trust and its voluntary sector partners have taken on responsibility for the programme with effect from 1 April. It is being managed as a new service line within CAMHS, with the Programme Director reporting to the CAMHS Director. The value of the contract in 2013/14 (including the elements provided by our partners) is £3.8m, adding just over 10% to the Trust's overall size.

There is an increasing view that acquisitions and mergers, or competition alone, are unlikely to resolve the pressing difficulties of local health economies, or to substantially enhance service quality and patient experience. We think that innovative solutions are more likely to come through greater emphasis being placed on creative partnerships, and a more systemic network approach to care pathway creation and management. As a Trust we actively seek relationships with innovative providers from across a wide range of sectors. We view working in partnership and working as part of a larger system as essential if the quality of patient services is not to suffer in economically stringent times.

We think that improved value within healthcare will only be delivered through such a systemic approach and through the routine articulation and measurement of outcomes that matter to patients against the cost of care pathway delivery. Defining and understanding outcomes is not easy within mental health, but what is clear is that we need to work closely with service users, mix patient determined outcomes with more traditional clinical outcome measures, increase transparency, and create a sense of shared ownership in which the measurement of outcomes is valued and owned by both service users and professionals.

The Trust's quality priorities for 2013/14 therefore focus on measuring and improving outcomes; increasing access to service information; and further development of our patient and public involvement.

Significant levels of productivity improvement and cost reduction are required in the current environment of financial constraint. The Trust's productivity programme in 2012 achieved savings of £3.1m, while protecting the quality of our work. These savings have been implemented during 2012/13, and are a major factor in enabling us to set a budget which meets our financial targets for 2013/14 without the need for further savings in-year.

In the autumn of 2013, however, we will be working on a further productivity programme to meet the continuing national requirement for efficiency savings in future years. In so doing we will work closely with our staff, with patients and students, with new commissioning structures and with other providers in the development and delivery of high quality training, education and clinical services. In addition we will engage actively with new elements of the NHS system, including Academic Health Science Networks and Strategic Clinical Networks. Our Chief Executive, Dr Matthew Patrick, is NHS England lead for the London mental health Strategic Clinical Network.

These are exceptionally difficult and challenging times. We believe, however, that through working with others and focusing on our core purpose of public benefit we can continue to make a contribution that is both relevant and substantial.

While continued growth remains an important component of this plan, it is also important that our economic planning is not reliant upon it.

The Trust's Commissioners

The primary local commissioners of the Trust's patient services are in North, East and West London and comprise both health and local authorities. The Trust is seen as a valuable component of the local health economy by many commissioners. The position of the Trust in each area is different, depending on local need. In some areas the Trust provides a very significant service, for example in Camden where the Trust is the main provider of CAMHS, and in City and Hackney where the Trust provides a Primary Care based Psychological Therapy Service targeting complex cases and people with medically unexplained symptoms. In others the Trust provides a choice for patients and referrers for CAMHS or Adult Psychological therapies. A number of other commissioners have chosen to use their contract for more specific specialist service components, to complement their existing local provision. While the healthcare environment is becoming more competitive, the Trust aims to maintain contracts by ensuring that services are responsive to and fit with local requirements, offering value for money, excellent outcomes and excellent patient experience. The Trust aims to work closely with patients, with new commissioning structures and with other providers in the development and delivery of high quality services.

Innovation is one of the Trust's core strengths, often expressed through partnership work with other organisations from different sectors. The Trust aims to build on this approach in developing and delivering relevant and contemporary services that are responsive to need within local communities.

The difficult economic situation, both outside of and within health, is leading to an increase in service reconfigurations and tendering opportunities as local commissioners seek to use competition as a means of delivering improved value to local populations (with value defined as better outcomes at lower cost). Consequently, after a period of relative quiescence, we are now seeing more opportunities for the Trust to bid for new business, a trend which we expect to continue. Of course the other side of this situation is the increased likelihood that existing Trust services may also be re-tendered. The Trust has worked hard to ensure it is well placed to respond to these opportunities and threats, having invested over the past three years in the establishment of excellent clinical leadership and a robust commercial directorate.

Clinical Strategy

The Trust is committed to the implementation of evidence based practice, i.e. the use of models of intervention which have been shown to be effective by research studies, particularly randomised controlled trials. At the same time, the development of 'practice based evidence' – evidence derived from patients' and clinicians' more individual experience of what works – will be important in examining and demonstrating the effectiveness of some models for specific patient groups. These groups may often be those for whom NICE guidance is unavailable or where NICE recommended interventions have previously proved insufficiently helpful.

We are also committed to the measurement of clinical outcomes and to ensuring that this information is made publicly available. As a Trust we provide a wide range of interventions, ensuring that patients have appropriate choice. Such choice, we believe, will be supported when the outcomes associated with differing interventions are published regularly via our website. As we develop more fine grained analyses of our data we aim to publish outcomes and patient satisfaction in relation to conditions, Payment by Results clusters and modes of intervention.

Ensuring the quality of our clinical services, consultation services and training and education services remains high remains a primary concern for the Trust. This means ensuring adequate staffing levels, levels of training and experience and supervision. This is an area constantly under review as our services grow in some areas and come under pressure in others. Health economic analysis is important in ensuring that our services continue to improve value in terms of improved outcomes that matter to patients, within a fixed funding environment.

The maintenance and growth of all services is dependent upon up to date knowledge of external drivers and knowledge and sensitivity to the diverse markets for our services. Effective implementation of Payment by Results (for over 18s) will be central to the maintenance of clinical contracts for the Complex Needs Service.

There is an increasing recognition that attention needs to be paid to the interface between physical and mental health, an area in which the Trust has real strength; and an increasing emphasis on integrated care, involving not only the integration of physical and mental health, but the integration of social care and health care, and the integration of primary care and secondary care; all areas in which the Trust is active in developing and delivering services.

Growth plans also focus on several other areas where the Trust has significant expertise and where there are opportunities for further development: early years; maltreated children; education; psychological therapies for complex difficulties; digital approaches to mental health; primary care mental health; and capacity building in the wider health and social care workforce. In each of these areas the Trust is offering and developing specific products and models of working.

In Child and Adolescent services (CAMHS), in geographic areas where the Trust provides only a specialist part of the care pathway currently we will seek to widen our reach through partnerships with other organisations. In Camden, where we already provide the majority of the care pathway, a significant development is the introduction during 2013/14 of the Children and Young People's IAPT approach:

Children and Young People's Improving Access to Psychological Therapies

The first wave of pilot services for Children and Young People's Improved Access to Psychological Therapies (CYP IAPT) started in 2012. The Trust has been involved in training for this first wave, not directly in delivery.

The Trust, together with voluntary sector partners, has been successful in a bid for a second wave pilot for Camden which started in January 2013, initially with ten clinicians.

The CYP IAPT project aims to work with existing Child and Adolescent Mental Health Services (CAMHS) in the NHS, voluntary sector and other settings to improve services to children and young people. Unlike the Adult IAPT project, it is not an additional stand-alone service; it aims to transform existing services and to make them more consistent.

At the heart of the project is a vision of using routine patient reported routine outcome measurement to improve the quality and experience of services. CYP IAPT services are required to collect a specific goal-based measure from the patient or carer at each session.

Information systems and technology are being provided so that these measures can be collected; and also so that each session can be videoed for supervision purposes.

Education & Training

Over the next three years we are aiming to develop our strong training portfolio, increasing the range of academically-validated postgraduate courses and continuing professional development programmes we provide, as well as our professional qualifying courses. In particular we are investing in the development of e- and blended distance learning. Our intention is that our training and education should be as widely and as easily accessible as we can make it in support of quality in health and social care provision.

As for the whole organisation, one major focus remains the delivery of productivity savings within education and training, while maintaining and improving both the quantity and quality of activity.

To take these aims forward, the priorities for the coming period are

- E-learning Strategy to be revised by June 2013.
- Portfolio review to be completed by September/October 2013.
- International strategy to be developed by October 2013.
- Overall Learning and Teaching Strategy to be finalised, after full consultation with staff, by March 2014.
- Student relationship management strategy to be developed by March 2014.

The Trust's financial projections include the introduction in 2015/16 (year 3 of this plan) of new courses – likely to be aimed at the international market – delivering a margin which would contribute £0.4m to our efficiency target for that year.

Clinical Quality: Risks, Governance and Priorities

The Trust Board reviews and monitors risks to quality and safety via the Clinical Quality, Safety and Governance Committee (CQSGC). A number of work streams report to the CQSGC. Responsibility for each work stream is delegated to a named individual who may be supported and advised by work groups or committees that they chair.

The Medical Director chairs the CQSGC and leads and oversees a number of work streams falling under its remit. This committee has strong NED and Governor representation, and the CEO is a member of the committee.

Risk management is overseen by the Corporate Governance and Risk Work Stream (led by the Director of Corporate Governance) and a Patient Safety and Clinical Risk Work Stream is led by an Associate Medical Director. Both leads sit on the CQSGC and report to the CQSGC on their work streams. Clinical quality and effectiveness is reported to the CQSGC from the Clinical Outcomes and Clinical Audit work streams, responsibility for which is held by an Associate Medical Director. Information Governance is the responsibility of the SIRO (Finance Director/Deputy CEO), who also reports to the CQSGC.

During 2012/13, we have continued to develop our dedicated outcome monitoring system, to collect a wide range of additional measures and also to be more directly accessible to clinicians. The product is sufficiently advanced to be attracting commercial interest from other neighbouring organisations.

The Trust's PPI lead holds responsibility for patient experience and reports on activity relating to the remit of that committee.

Responsibility for Quality Accounts is held by a Quality Accounts Lead, accountable to the Trust Director. The Quality Accounts Lead is a member of the CQSGC.

The Trust Director sits on the CQSGC, representing the professional link with the Trust Clinics Committee, and holds responsibility for professional engagement and accountability (in line with the Francis Report recommendations).

Key elements of the work undertaken within work streams also report to the Management committee in advance of reporting elsewhere. Metrics include: SUIs, patient survey and other PPI data, complaints, CQC reporting/compliance, NHSLA compliance and compliance with contractual requirements and progress on CQUIN targets and Quality Accounts.

No specific areas of concern about poor performance in the area of quality and safety have been identified in the last year.

The Trust's quality priorities for 2013/14 focus on measuring and improving outcomes; increasing access to service information; and further development of our patient and public involvement. These objectives are published in more detail in our 2012/13 Quality Report, and have been based on wide consultation with stakeholders over the last year.

Productivity & Efficiency

As noted in the opening section of this Plan, during 2013/14 we will be working on a further productivity programme to meet the continuing national requirement for efficiency savings in future years.

In line with Monitor projections, we estimate that the requirement for this Trust will be for savings of around 4.2% in 2014/15 and slightly less, 3.6%, in the following year. As in 2012, this will necessitate the review of all staffing and non-pay costs, to identify and implement changes in working practice which can bring down costs while maintaining and developing the quality of our work. We expect the staff savings to come through a combination of slightly reduced numbers and also the continued introduction of some posts at slightly lower pay bands.

Any surplus generated by growth will contribute to the targets. More significantly, achieving growth can facilitate the redeployment of staff from existing services. We aim to avoid redundancies by a combination of this redeployment and the natural pattern of retirements and leavers. Where possible, opportunities for such changes are being taken during 2013/14, in advance of the need for savings.

As in 2012, the productivity programme will cover all directorates and will be developed in full consultation with clinical and non-clinical staff. Quality impact assessments for the proposed changes will be presented by the responsible directors to the Board before the changes are approved.

Financial & Infrastructure Strategy

The Board of Directors was able to approve an income and expenditure budget for 2013/14 with a surplus of £150k and with reserves for contingencies (£355k) and investment (£170k). As always, there are some risks to this budget, but thanks to the 2012 productivity programme it is not dependent on identifying any further savings during the year. The Board expects to achieve the budgeted surplus and also to maintain liquidity, so as to retain a Financial Risk Rating of at least 3 (on the current basis).

The annual efficiency targets of 4.2% and 3.6% are expected to require some £3.0m savings over years 2 and 3 of the Plan. The Trust's financial projections allow for some income loss through activity reductions; but also for modest increases, especially in year 3. This represents a conservative projection based on achievement over the past five years, and our development plans aim for more significant growth.

Allowing for all these factors, we project productivity savings targets of £1.6m in 2014/15 and £1.0m in 2015/16. In 2015/16, some of these savings should be delivered through redeployment. This will also be done as far as possible in 2014/15, but as there may be a need for a net reduction in staffing and costs, we aim to make changes sooner, where opportunities arise during the current year.

The Trust plans capital expenditure to continue improvements to the Tavistock Centre and the Portman Clinic. A more significant project has also been approved, to build an extension to the Tavistock Centre and then to dispose of the Trust's third property. After review by the Monitor Assessment Team in February and March 2013, the Board has recently confirmed approval of this project:

Gloucester House Day Unit

The current building housing the Gloucester House Day Unit at 33 Daleham Gardens is not purpose-built, and is difficult and costly to maintain. The last Ofsted report noted that the service should be moved to better accommodation prior to the next visit.

The Board of Directors has approved a proposal to build a new block at the back of the Tavistock Centre, which will provide modern facilities for the Day Unit and will also provide new seminar rooms. The Trust expects to receive formal confirmation of planning permission for the proposed building shortly. The estimated cost of the whole building is £3.35m. The sale of 33 Daleham Gardens is expected to raise a significantly higher sum to fund the project; with a bridging loan to allow the Day Unit to remain there until the new facility is ready.

The proposal includes an assessment of the market for this service, and an action plan for continuing work with commissioners (local authority and health) in order to secure the future of the unit.

While preparations for this project continue, an alternative is currently being explored. The Board will consider this in September. If the current decision is confirmed, the timetable is that tenders will be invited in September; building should start in November/ December; and the new building should be ready for occupation by September 2014.

The Trust's cash balance of £3.2m at 31 March 2013 included some short term and non-recurrent items, and this balance is expected to reduce to £0.9m by 31 December, and to remain at that level during 2014. Our liquidity, as measured by the current Monitor metric, is projected to remain satisfactory. The cash balance is projected to increase after the sale of 33 Daleham Gardens and repayment of the bridging loan.

Significant development of the Trust's information systems and technology are planned during the next three years, not primarily through capital expenditure.

The nationally-funded contract for our patient records system, RiO, is due to expire in October 2015. In a consortium of Trusts, we started the process for procuring a replacement in 2012. A project team has been established with the aim of taking this opportunity to move from a purely administrative system to an integrated system, fully accessible by clinicians and holding all records including outcome measures. The business case should be presented to the Board in summer 2013, and a contract for the new system – and for hosting it – during 2014, for implementation before the current contract expires.

More immediately, the Trust's own outcome monitoring system has been enhanced, as noted in the Quality section above, to capture additional measures (including the goal-based measures for CYP IAPT) and to be more directly accessible to clinicians. We aim for significantly wider use of the system during 2013/14.