Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Annual Operating Plan 2016/17

Contents

1. Introduction

1.1 Context

There will be challenges ahead for the NHS and for our local health economies, with a constrained financial settlement, rising customer expectation, increasing demand, requirements for increased productivity and an absolute focus on quality. Our operational plan reflects both the opportunities and the challenges that 2016-17 brings and shows how AWP NHS Trust will address them.

Throughout 2015/16, AWP, ('the Trust'), has continued the developmental journey: improving processes, governance, engagement and service quality. We have delivered sustainable change and improvement, which is reflected and built upon in this plan. Improvement is a continual process, and so throughout 2016/17 we will continue to improve service quality, consistency in delivery, service user experience and staff wellbeing. We will define and deliver an improved acute care pathway in each locality and will further reduce out of area placements. We will support and develop our workforce: prioritise staff engagement, deliver a broad and locality-focused programme of organisational development, standardise supervision and improve appraisal quality. Through continued implementation of the Trust's strategy we will reduce bullying and harassment and will raise staff confidence in speaking out. We will consolidate our financial position through the Trust's financial strategy, with early budget setting, a clear cost improvement programme and meaningful quality impact assessments.

1.2 The Future of Mental Health Services

Across the health community the demand for mental health services is growing, as is the population in the South West. There is shared recognition of the need for:

- greater alignment and co-working between providers of physical and mental health services
- a renewed emphasis on alternatives to admission and improved community support to reduce the need for admission and to reduce length of stay
- improved mental health estate and strategic co-location with key partners
- increased use of technology for staff and service users

We will work closely with our stakeholders (commissioners, patients and carers, AWP staff and partner organisations) to develop services which meet the needs of our populations. The Executive team has begun a series of discussions with commissioner Accountable Officers in which we are describing the potential future state for specialist mental health provision across our geography; this is reflected in our Clinical Strategy, the driving strategy for our Trust.

1.3 Objective Setting

The Trust Board has taken an inclusive and consultative approach to our Annual Objectives for 2016/17 and these have been developed to reflect:

Our purpose:

To provide the highest quality mental healthcare to support recovery and hope

Our vision:

We will be the first choice for service users.
We will be widely recognised as the best mental healthcare employer in the country.
We will be a highly established learning, teaching and research organisation.
We will be rated as 'excellent' by regulators and described as excellent by commissioners
We will be a strong partner and a system leader that ensures best quality, best value and coherence across complex pathways of care.
We plan to grow – consolidate, integrate and expand

Our Strategic Objectives:

Consolidate provides the building blocks on which the success of our Trust rests. 'Being Brilliant at the Basics' will be a frequently heard statement as, helped by feedback from for example 'the friends and family test', we review what we do well, identify what needs to be better and deliver more and constantly improving recovery-focused services.

Integrate requires us to work more effectively in partnership, internally and externally, connecting fully with the local health communities we serve and forging positive, dynamic relationships with our staff, commissioners, GPs, service users and carers, as well as those in the voluntary and social care sectors.

Expand will be fundamental to the viability of the Trust, developing first a portfolio of quality, specialist services which meets the needs of commissioners locally and in areas outside our traditional heartland.

Our Strategic Priorities:

We will deliver the best care
We will support and develop our staff
We will continually improve what we do
We will use our resources wisely
We will be future focused

Throughout March 2016, local and corporate directorates have defined actions to deliver the objectives. Risks to delivery of the annual objectives will be reflected in the Board Assurance Framework and dashboards and progress will be reviewed monthly. We will communicate finalised annual objectives widely through April 2016.

The Trust's Strategic Priorities, and annual objective themes are based around our motto: You matter, we care:

Strategic Priority	Annual Objective 2016/17	Risk to achievement
About delivering the best care	We will have reduced levels of variation in our interventions and service standards across all care pathways system wide.	If service users are not treated as equal partners in the creation of consistent care standards and care pathways – then co-production will be delayed and the achievement of the objective will suffer.
About our staff	Together we will produce a co-created staff charter to support increased levels of engagement and experience amongst our staff.	If we do not maximise the levels of engagement within our workforce, then we will not have the opportunity for staff to feel part of 'the solution' and to identify poor practice and become change agents. The Charter will therefore be unsuccessful as a tool

		for staff engagement and improvement for the cultural change programme: 'One Trust'
About continually improving what we do	We will do all we can to improve the physical health of our service user population working with our system partners.	If we cannot maximise the opportunities to work with our public health, voluntary, and third sector partners within the system, who specialise in preventative aspects of healthcare; then we may lose opportunities to improve physical healthcare for our population.
About using our resources wisely	We will achieve financial balance.	If we do not retain our current business and achieve new business in line with our strategic plan, then we may not achieve our financial targets.
About the future	Within our two local regions, we will accurately reflect the priorities for mental heath and define these within our local Sustainable Transformation Plans.	If sufficient resources are not available to support our contribution to the STP work in both local areas, then the value of the planning work will not be derived and the prioritisation of mental health will not be achieved.

1.4 Contracting Arrangements

In previous years the Trust has had two key contracts, one with NHS England for the secure service and one with all the other main CCGS. For 2016/17 the Trust will have four key contracts:

NHS England (secure services);
Swindon (Mental health provision to Swindon);
North Somerset (Mental health services to North Somerset); and
Bristol, Banes, South Gloucestershire and Wiltshire (Mental health services to these areas.)

All CQUINs have been agreed both national and local, with the exception of one Swindon local CQUIN, whereby further discussions are being held.

Due to the separation of the contracts and previous contracts being block based much work has been completed in year to understand the degree of cross subsidisation across the contracts. Given this and the fact NHS England have only made their contract offer at the end of March, contract discussions are not yet concluded, although the Trust expects to conclude all contracts without arbitration by the deadline.

1.5 Impact of CQC inspection in 2016

The Trust is preparing for the comprehensive CQC inspection in Q1 16/17 and is working closely with commissioners, NHS Trust Development Authority (TDA) and NHS England (NHS E) in preparation. We will address actions and requirements arising through 'business as usual' processes and will address system-wide actions through the TDA/NHSE chaired Quality Improvement Group.

2. Approach to activity planning

2.1 Working with Commissioners

In 2015-16, the Trust has worked closely with each CCG to agree a financial envelope that reflects the fully absorbed cost of providing care to their population. The 'resource mapping' exercise has confirmed that some CCGs have historically provided more funding than the cost of services, and some CCGs have underfunded, i.e. the cost of service is more than the contractual income in place. This has been a key factor in agreeing 2016/17 contracts as overfunding CCGs are proposing to withdraw funds but underfunding CCGs do not wish to increase investment. The Trust has put forward a contract proposal that does not leave either provider or commissioner with a significant financial risk; this is currently being discussed with our Commissioners.

The demand and capacity modelling for the Trust is in its infancy as we have been working with our Commissioners to develop a payment mechanism that moves away from block contracting to an outcomes-based payment. Whilst this is not yet finalised, the nationally proposed 'episodic' approach (rather than capitation) is likely to be agreed, using the 'care cluster day' as the unit of currency. This move is subject to further national guidance, given the wide variation in cluster day prices between providers. In this context, the Trust is developing tailored demand and capacity plans by CCG, which will take into consideration the proposed changes to the financial envelope.

In the absence of detailed demand and capacity modelling, for the 2016/17 plan activity modelling has been based on the activity levels for 2015/16; this is deemed to be a realistic model on the basis that the month on month volumes of activity were very similar. We will work with our Commissioners in 2016/17 to develop our demand and capacity modelling.

2.2 Managing capacity for inpatient care

As part of the care cluster pathway, some service users will require hospital care. CCGs do not commission hospital beds, rather, activity plans agree a level of 'inpatient days'. In 2015-16, demand for admission exceeded capacity and so AWP block purchased additional capacity from private providers in order to reduce the negative impact of admission to distant units for service users and families. This enables the Trust to maintain oversight of care quality and to maximise cost efficiency.

In 2016-17, we will further improve the care pathway and so close the gap between demand and capacity. We are working with stakeholders and within the Trust to:

- Agree alternatives to admission, working closely with non-statutory agencies, increased use of Crisis Houses and Street Triage
- Increase liaison and community capacity
- Maximise efficient use of current bed base through standardised expectations for admission

We seek to reduce to zero the use of private provision where appropriate services exist within AWP. However, clinical need may necessitate remote admission under circumstances of high activity or where specialist provision is required.

2.3 Productivity work

The Trust is working with an external organisation (Meridian) to look at its productivity, i.e. more for less. This work is currently underway in the Trust's Wiltshire locality. Initial scoping suggests that improvements in productivity can be made in the coming year which will result in increased efficiency and quality. We will realise improvements that will ease workforce pressures, specifically the use of nursing agency staff in Wiltshire, by end Q1 16/17.
Milestone – Q1: reduce nursing agency in Wiltshire community teams by 20% from 15/16 levels

The Trust will use the Wiltshire productivity model and will apply it in our other 7 delivery units over the next 18 months. The programme is as follows:
Milestone – Q2: scoping assessments in further 3 delivery units
Milestone – Q3: scoping assessments in further 3 delivery units; implementation in 3 delivery units
Milestone – Q4: scoping assessment in final delivery unit; implementation in 3 delivery units
Milestone – Q1 2017: implementation in final delivery unit

2.4 Impact of new access and waiting time standards for mental health services

New mental health access standards have been set for 2016/17. The Trust will work with our CCGs to meet these standards and where expanded provision is required in specialist areas, such as perinatal psychiatry, the Trust is working to ensure that services are developed to meet the national and contractual timetables.

The Trust will fully meet the access standards for patients presenting with first episode psychosis by the end of Q3. There is a challenge to train all Early Intervention (EI) staff in NICE accredited interventions, specifically CBTp (for psychosis), IPS (Individual Placement and Support), and Family Interventions.
Milestone – Q1: develop programme for EI staff to train in NICE accredited treatments and commence training
Milestone – Q2: >50% of people assessed by EI teams will commence treatment with the EI team within 2 weeks of referral for possible first episode psychosis. 25% will receive NICE concordant packages.
Milestone – Q3: >50% of people assessed by EI teams will commence treatment with a NICE approved care package within 2 weeks of referral for possible first episode psychosis.

The second mental health access standard requires 75% of people with a common mental health condition, referred to IAPT, to be treated within 6 weeks. The Trust provides varying models of IAPT services across our CCG areas which reflect historic commissioner priorities. The Trust will use the Sustainability and Transformation Plan (STP) mechanism to work with Accountable Officers to standardise the IAPT model in order to provide best practice intervention and outcomes. The Trust recognises the key nature of this intervention pathway in improving population health and resilience and has set a stretch target of 80% of people treated within 6 weeks of referral by the end of Q4.
Where IAPT services are commissioned to a nationally approved model:
Milestone – Q1: 75% of people with common mental health conditions referred to IAPT will be treated within 6 weeks
Milestone – Q4: 80% of people with common mental health conditions referred to IAPT will be treated within 6 weeks

2.5 Delayed Transfers of Care (DTOC)

Delayed transfers of care (DToC) have varied over the last two years, exceeding 9% at times. DToC varies by CCG geography, and may also reflect national cuts to social care budgets. This impacts on the Trust's ability to manage bed capacity, especially with regard to Older Adults and service users requiring psychiatric intensive care (PICU).

The Trust is working with Accountable Officers and with mental health commissioners to create the right acute care pathway for service users, to address specific, local causes of DToC and to address demand as detailed in earlier paragraphs. The STP mechanism is key to accelerating system responsiveness and efficiency and will be the main route for improvement.

3. Approach to quality planning

3.1 Context

The Care Quality Commission is the regulator responsible for ensuring delivery of quality services within the NHS and as such we answer to them for the quality of services we provide. The Trust made the decision to focus quality delivery on the parameters set by the CQC. The Trust uses five main quality themes to ensure our services are:

- Safe;
- Effective;
- Caring;
- Responsive; and
- Well Led

The Trust uses the mantra that everyone is part of the solution therefore we include everyone in setting the solutions for problems they've defined. We do not use a traditional quality improvement plan; we base all our quality improvements on the standards we set for each of the quality themes and set the task list against each of the standards. This allows us to incorporate CQC inspection recommendations into our business as usual practice. As an example if the CQC were to visit and find a number of issues relating to one of the themes requiring a number of actions to be completed we would be able to map that on to our quality standards development and put the actions onto the task list we would also then check that issue against the rest of the organisation practice and develop further tasks should they be required.

To achieve our vision we are continually developing, measuring and monitoring our standards and actions these include:

- Redesigning our separate services into a robust and effective Clinical Executive Directorate integrating Nursing and Medical Director portfolios and responsibilities into one focused directorate co-led by the Nursing and Medical Directors.
- Restructure several clinical and quality corporate departments into one functioning structure that identifies ownership, responsibilities and accountability to support locality services. The new structure will be responsible for setting the standards, holding services to account to deliver against the standards and will step in, when required, to improve services/systems to enable practice to meet the standards.
- Triangulate priorities; this means a joined up coordination of annual objectives, quality account, clinical audit, key performance indicators, quality, locality and profession specific work plans all have the 'golden thread' that holds and pulls them in the same direction with the same outcomes.
- Identify named leads for whole functions and ensure delivery against those functions.

- Provide the most up to date, relevant information to clinical services so they can adapt their practice to best evidence.
- Bring together governance under one service
- Bring together risk under one service
- Bring together coroner functions under one service

The Trust has developed a mechanism, the Trust IQ system, to measure and monitor quality. The system is the primary mechanism for monitoring quality and ensuring quality information is readily available across the Trust in an integrated, open and transparent way. The system provides information from ward to board on matters of quality. One key purpose of the system is to act as an early warning system to all levels of management to focus actions, support and development to improve quality.

The Trust dashboard metrics are structured under the CQC 5 domains of quality. There are currently 88 metrics in use in the IQ system and these continue to be developed to further expand the directory available.

In terms of monitoring and assurance the clinical executive prepares a monthly report to the Trust board and the Commissioner quality review meeting which provides a monthly update on performance against the key indicators included within the Trusts mental health contract. The trend at Trust level is reported, with further information provided by exception, for those indicators that are below target. Where this is the case additional data is provided to show the differing performances between localities. The dashboard can then be reported by team, local delivery unit and the Trust level. This information is used as the basis for our performance reviews within each locality.

We have sign up to safety initiatives in place and report progress through the clinical executive briefing given to the Quality and Standards committee on a monthly basis.

Our annual quality objectives are delivered in conjunction with our quality account which is triangulated through our clinical strategy.

The named executive lead for quality improvement and governance is Andrew Dean: Director of Nursing

3.2 Our top three quality priorities

The Trust is structured for its operational delivery into eight services; six are geographically structured and two are service line structured. Quality improvement has been led at a local level with each delivery unit deciding on what quality was and on what improvement needed, the top three priorities in 16/17 for the Trust are:

- Standardisation of practice across the organization
- Consistent articulation/delivery of our standards from every member of staff across the organisation
- Service user and carer involvement at all levels.

The clinical executive is defining the standards for all local delivery units to achieve. This is being delivered by a cross organisation group from within the Integrated Governance Group meeting. Once the standard has been set the Quality Forum, which is a trustwide forum and has between 80 to 150 people per meeting, define the measures procedures and practices that makes the standard and then roll it out to all practice areas across the organisation. We carry out regular trustwide audits on areas such as medicines management, care planning, risk assessing, safeguarding and decision-making. We are starting a monthly performance meeting for all local delivery units in April. We are standardising

formats such as patient information booklets and standardising practice through the development of the standards.

We have a monthly Chief Executive briefing that goes out to all staff with executive support in key locations to answer questions. We have a clinical executive set of newsletters from both nursing and medical directors. We have several forums which are trustwide to ensure the messages are given and received. A subgroup is producing a rollout of information guidance so all local delivery units give the message in the same way at the same time using the same message. We have set up trustwide service user and carer forums which are fed by locality service user and carer involvement/groups/meetings these two groups are currently devising and writing the service user and carer strategies for the organisation and are supported by the clinical executive.

3.3 Current concerns

In December 2015 the Care Quality Commission made an unannounced visit to Bristol community services after receiving a number of concerns regarding those services. As a result of that inspection a Section 29A warning notice was issued on 31 December 2015 requiring the Trust to make significant improvements to the following areas:

- Care and treatment was not always provided in a timely way
- There was a lack of safe care and treatment
- There was a lack of governance systems in place to manage the quality and effectiveness of the service
- Staff providing care to patients did not always have the competence or experience to provide care safely
- Staff did not always take steps to safeguard patients from abuse
- The premises and equipment were not suitable at Brookland Hall and the Greenway Centre.
- The Trust was required to undertake the following actions by 1 February 2016:
- An immediate review of the services' waiting lists and case load ensuring all patients are allocated to a care coordinator
- Develop a system to ensure all referrals are tracked and followed up to ensure patients are not forgotten.

The CQC returned on 17 February 2016 and confirmed we had complied with the specified requirements for improvement by 1 February:

- An effective system was in place to monitor referrals.
- The waiting list had been addressed
- A skill-mix review had been agreed with commissioners to ensure there are enough qualified staff to assess and manage patients
- The Bristol governance structure had been revised
- A safeguarding tracking system had been implemented and training had commenced.

Further actions required to achieve CQC compliance have been undertaken to achieve our second set of actions required to be complete by 16 May so the CQC can assess our compliance when they undertake the comprehensive inspection commencing 17 May 2016:

- A caseload / skill-mix review, this was completed in March, with recommendations presented to the Executive Team for consideration in April 2016.
- Training in safeguarding has been provided to 191 Bristol staff to date. The target for training has been set at 90% of staff (191 staff).
- The first of the Central and East Assessment and Recovery Team staff groups moved to new accommodation at Stokes Croft on 1 April, with the second staff group to follow. Additional clinical space has already been provided at a General Practice.

The North estates review was completed on 30 March. Recommendations will be presented to the Executive Team for consideration in April 2016.

3.4 Our Top three quality risks

The trust is going through a significant change process that cannot be underestimated both in terms of the improvement can achieve versus the inherent risks such change in focus practice and culture can bring. The three biggest risks to achieving our quality objectives are:

- That there is no organisational identity or coordination;
- That staff are not feeling 'part of the solution' and are therefore not identifying poor practice; and that;
- Service users and carers are not treated as equal partners.

We have described how we will improve quality we have described some of the measures we've already put in place. The quality and risk priorities are closely aligned so that the mitigations will address both these priorities. We will continuously monitor our achievements to make sure the key risks don't crystallise and lead to quality problems. Further mitigations in addition to those identified in quality are:

- Meetings restructure – to ensure clear standardisation and co-ordination of Trust priorities and risk
- Development of performance indicators that reflect the domains of quality – we are aware that clinicians can become comfortable with certain performance indicators and therefore it is important to revise and update these to ensure a changing focus on each quality domain
- Development of our standards – this is done in collaboration with clinicians and service users/carers to ensure bottom-up solutions ensuring better engagement to focus on our quality and risk challenges. Service users and careers will be important partners in this process ensuring experienced based design in our service standards and practice. We will ensure that these standards and learning are shared with all clinical areas.
- Make all staff part of the solution through new IGG, quality forum, trust wide meetings, development of quality directors within senior management structure. New understanding of the organization by all through CEO video briefing, profession newsletters, quality forum identification of trust wide issues and solution focused activities rolled out by leaders consistently across the organization.
- Resetting board sub-committee function to assurance based inquiry.

3.5 Seven day services

The Trust is committed to achieving parity between mental health and physical health within our own services as well as working to influence the wider healthcare community to achieve this objective. The aspiration for Seven Day Services supports parity of esteem. We recognise that the aspirations to match physical health services for emergency care standards, as set out in Lord Crisp's review, are welcome yet recognise the disparity of funding for emergency care between physical and mental health care. We have set out plans to achieve affordable progress in emergency mental health care and Seven Day Services during 2016-2017 and will work with the system to develop services through the mechanism of the STP, bringing to play the increased funding to Liaison and Crisis care, and using the CCG % uplift required for mental health investment if given.

The arrangements for 7 day services are set out in the commissioning contract in the service development improvement plan (SDIP) on the following page:

	Milestones	Timescales	Expected Benefit	Consequence of Achievement/ Breach
7 day service	The Trust will use the NHSIQ Seven Day Service Self-Assessment Tool to understand their position in relation to preparing for the introduction of seven day services. http://www.nhsiq.nhs.uk/8622.aspx	Self-assessment completed in Q1. To scope and agree an improvement plan with Commissioners by the end of Q4	Preparedness for the delivery of 7 day service standards applicable to mental health services.	Subject to GC9 (*Contract Management*)

3.6 Overview of how the Board derives assurance on the quality of services and patient safety

The Trust's Quality Governance Framework is being revised to increase integrated quality improvement and learning, ward to board and board to ward, and to facilitate effective staff engagement using a multidisciplinary approach. The key fora that have recently been implemented are described below:

- Integrated Governance Group: (IGG): Cross-trust representation, discussion and AWP executive and director level quality governance oversight
- Quality Forum: Quality Improvement and Shared Learning Forum
- CQC Programme Board: Sharing Learning through Engagement
- QI: Monitoring Improvement in Outcomes and Risks

The Trust has established Board Assurance Committees (with explicit terms of reference and membership) and advisory groups. Additionally Trust management groups are established, and have been added to in 2015/16 to facilitate the provision of management assurance. These arrangements have been reviewed through 2015/16 to ensure compliance with best practice and alignment with the quality objectives set out above and this process will be completed by end of March 2016.

The Trust Board has a clear reporting line from its Assurance Committees via Committee Chair reporting, and established horizontal reporting arrangements between Committees in place. In addition, the Audit and Risk Committee and Quality and Standards Committee share membership to ensure good cross working. In 2016/17, with the addition of two new Non-Executive Directors and an Associate Non-Executive Director, the Board Development Plan will reflect additional development for the Board, focused on ensuring that the Board maintains and grows its effectiveness in the areas of Board Committee reporting and ward to board escalation.

The Trust Board receives a monthly quality and performance report, which includes detailed information arising from the Trust's IQ system detailing performance against key quality indicators. During the last year, each Board meeting has been prefaced with a clinical quality or safety presentation focusing on services delivered in the locality in which the Board is convened, to share actions that have been taken to improve quality.

In addition, Board members take an active role in the Trust through Quality Improvement Visits to each of our services, providing an opportunity to discuss patient experience, safety and effectiveness concerns with staff, patients and carers. During 2015/16 the Trust has reviewed and strengthened its quality improvement processes to include a wider range of inspection-style visits and reviews to test quality and safety locally.

3.7 Well led

The Trust is currently preparing to undertake a readiness review with another Trust supported by the TDA. In addition, an independent reviewer will be working with the Trust to validate the robustness of the evidence base against the well led framework. The outcome of the reviews will inform the strategy going forward.

3.8 Quality Impact Assessment Process

The Trust has developed quality impact assessment guidance which supports the implementation of the Trust Quality Impact Assessment Policy. The Policy itself is an essential part of continuous quality improvement and is part of the learning from the Francis Report. One key aim of the Policy is to embed quality impact assessments into the culture of the organisation when it approaches change.

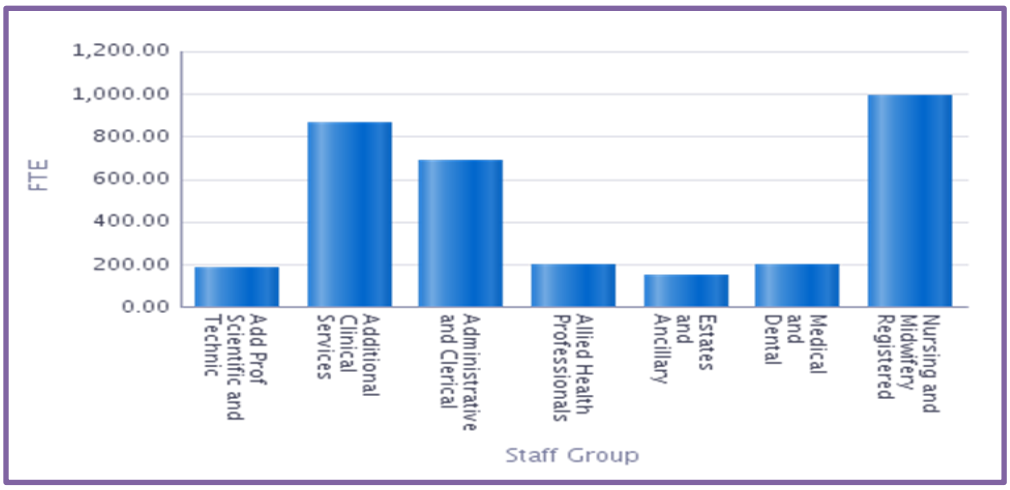
The Trust policy ensures that quality impact assessments are undertaken for all significant cost improvement schemes, skill mix reviews, service change and service development proposals and plans. For 2016/17 the role of the Programme Management Office has been extended to include Transformation with the appointment of a new Head of Programme Management and Transformation. The office supports the locality delivery units developing CIPs and also provides strategic leadership to the Trust's key transformation and service change programmes. If a decision not to complete a quality impact assessment is taken it must be ratified by the Executive Lead and reported to the Trust Directors Team.

The Trust's Executive Lead for Quality, Director of Nursing Andrew Dean, is responsible for ensuring that quality impact assessments are received by the clinical executive directors. The Director of Nursing is responsible for ensuring that quality impact assessments are received by the Quality and Standards Committee for Board scrutiny and assurance purposes. The QIA scoring is based on the Trust's risk matrix scoring system. The score will therefore reflect the potential risk to quality. The process and scoring is outlined in detail in the Trust Risk Management Policy.

4. Approach to workforce planning

4.1 Context

AWP currently has 3277.45 WTE staff as of 31 March 2016, with a headcount of 3787 staff. The following shows the staffing by staff group.



Staff information produced in line with NHS standard national staff reporting categories.

4.2 Workforce impact of developments in 2015/16

During 2015/16 there have been a number of developments which have impacted on our staff both positively and negatively; these include:

Positive:

- National commitment to parity of care for those with physical and mental health conditions reinforces wider commitment to improving mental health services
- Health and wellbeing programmes
- Development of Team of the Month Award and continuation of Staff Awards and Lifetime Service Awards
- Improved access to benefits for all NHS staff
- Learning & development programmes to build clinical and managerial confidence & competence.

Negative:

- Continued recruitment challenges as a result of increased demand for nurses across the NHS to meet safer staffing levels and the requirements from CQC.
- Increased turnover as staff affected by major service change move roles for job security
- Uncertainty about future pay and pensions alongside challenges to the government via professional bodies and unions has continued to impact on staff engagement at all levels.
- The transition of Bristol services impacted on a large group of staff and also on patient experience and the effects of this transition continue to be felt in teams working in this changed environment.

4.3 Workforce experience & engagement

AWP values its staff and recognises they are fundamental to delivering high quality mental healthcare that promotes recovery and hope; commitment to staff is reflected in our strategic priorities.

Despite intensive efforts to improve staff experience through the Organisational Development Programme, 2015 Staff Survey Results remain, in large part, less positive that the Board would wish to see. In is important to note, however, that in some areas, the Staff Survey did demonstrate improvements, and these gains are recognised and celebrated.

Staff survey results have been fully scrutinised by the Executive Team, the Strategic Workforce Group and Trust Board. Locality Directors are developing plans to focus on local plans to address the issues in their areas.

The Board has chosen to focus as demonstrated in the draft 2016/17 annual objectives themes, on the following areas:

- Respectful treatment of colleagues and team members
- Recruitment and retention
- Quality supervision and appraisal

Actions to achieve positive change and performance indicators to measure improvement have been approved and form the basis for monitoring across the organisation and reporting to Board on a monthly basis.

Regular Workforce Development meetings with each Locality considered workforce data, staff survey feedback and service priorities for 2016/17. Bespoke Locality Workforce Development Plans that support strategic objectives have been developed in each area.

Trust wide actions led by Corporate Teams provide programmes and coordinated action to support improvement in other areas of the staff survey. Key actions to note are as follows:

- Recruitment and Retention Strategy
- Increased development and training opportunities for all staff groups; apprenticeships are a key priority.
- Team-based Working Programme to continue with reviews of the benefits that the initial programme in 2015/16 have brought
- Improved communication (internal and external)
- Leadership Development Programmes to support aspiring and current leaders

4.4 Plans for 2016/17

Workforce plans for the year 2016/17 identify opportunities for efficiencies within services and wider Trust systems. These will be reviewed regularly at Board level to assess achievement and impact on clinical quality.

The following priorities will affect staff groups across all localities:

- Continued staff recruitment programme for nursing in response to vacancies, safer staffing and CQC requirements.
- Improving engagement and retention across the organisation through team and professional development
- Improved rostering to ensure that staffing levels are appropriate and meet the needs of service users with increased use of the e-rostering system
- Health and wellbeing support to ensure that staff remain healthy and are supported to increase their resilience to challenging working situations.
- Bespoke workforce development plans that address specific needs of local workforce including a focus on apprenticeships
- Skill mix development reviews underway across a number of acute pathway developments; this is in response to supporting improved access and increased overall demand.

Our workforce plans reflect proposed service developments as well as Cost Improvement Programmes. Where posts that become available through turnover or skill mix reviews move to a lower band, these are reflected in the costings and do not affect the WTE.

Additionally on 1st April 2016 the Trust will welcome approximately 175 whole time equivalent staff (250 headcount) staff as part of a TUPE transfer of CAMHS services from North Bristol Trust for an initial 12 month period with the intention that the Trust retains this service on an ongoing basis.

4.5 Governance of workforce plans

The Workforce programme is overseen by a new Strategic Workforce Group, chaired by the Director of Nursing, attended by the Medical Director and locality management teams. The group directs Trustwide programmes to meet workforce objectives; it is accountable to the Executive Team for oversight and delivery of the workforce plans for each LDU and the Trust, and provides management assurance to the Quality and Standards Committee, and via this Committee, to the Board.

Individual Locality Delivery Unit workforce plans are developed by locality clinical leadership teams, supported by corporate departments with detailed staffing and activity data, and are reviewed and signed off by the Strategic Workforce Group. Quality Impact Assessments and which support change programmes are signed off by the Nursing and Medical Directors in order to assure quality and safety metrics.

The Trust's Quality Information System presents key staffing metrics alongside quality/performance indicators to allow services to assess the possible relationship between the two. This includes a range of workforce, operational and key waiting time metrics

4.6 Trust-wide workforce plans

Turnover

The Trust retains its commitment to limiting redundancies as far as possible and will seek to ensure that opportunities across all services are fully explored where there is a potential for redundancies.

Where staff turnover (currently 17.08%) creates vacancies, these roles are reviewed within the service to ensure they are filled by the most appropriately skilled staff. 16.3% of the Trust's workforce is aged over 55; the Trust recognises both the potential impact of this on the availability of appropriately skilled and qualified staff and the opportunities for service change that this provides. The organisation is carrying out work to understand in more detail plans within teams to ensure succession planning and resilience.

4.7 Specific staff group plans

Nursing

The Trust employs 988 qualified nurses (Mar 2016) with the grouping forming 30.1% of the total workforce. The Trust is continuing to address its vacancy issues through significant recruitment programmes, recognising that turnover is likely to remain an issue in the early part of the 2016/17 year while retention and recruitment programmes continue.

Commissioned service developments to meet specialist needs in the year 15/16 included street triage and A&E Liaison and these arrangements will continue into 16/17, offering role development opportunities for existing staff. System efficiencies will create increased capacity for patient contact.

The TUPE transfer of the CAMHS service from North Bristol NHS Trust will approximately 47 WTE nurses from mental health, paediatric general and Learning Disability backgrounds to the service, enabling the Trust to provide improved clinical quality across service transitions for those in the care of CAMHS. This will also offer existing and transferring staff learning and development opportunities not previously available.

Increased demand for qualified nursing staff has been shared via Health Education England's Workforce Demand templates.

Allied health professionals & scientific, therapeutic and technical
AWP employs 389 staff in this group which total 11.9% of the workforce. The workforce plans developed, demonstrate broadly consistent WTE numbers throughout 2015/16. This group will also receive approximately 60 WTE new staff within the CAMHS TUPE.

Skill mix reviews will continue during 2016/17 as turnover opportunities provide and these will ensure that staff have the most appropriate skills and are paid at the appropriate band for the work that the role requires.

Additional clinical services (unregistered staff, providing clinical support to registered practitioners, including health care assistants and technicians)
This is the second largest staff group in the organisation with 865 WTE staff, 26.4% of the workforce. The revised safer staffing models will have a significant impact on this group although this will be achieved through the provision of development opportunities via higher apprenticeships, turnover and ongoing work-based programmes to increase skills. This staff group will see the development of the apprenticeship role to prepare individuals for the future role of healthcare assistants. The Care Certificate will support increased skills and accountability.

Administrative and clerical
This group includes all staff who hold an administrative role, corporate staff and those providing administrative support to clinicians. It should be noted that the workforce template captures administrative support staff working directly with clinicians in the group 'Other Clinical Support Staff'.

The Trust will continue to review these roles, developing staff where appropriate to ensure maximum efficiencies both in supporting clinical staff and in corporate departments.

Medical
AWP currently employs 198 Medical staff. This includes those junior doctors who have fixed term contracts with AWP. AWP will implement the rostering of medical staff during 2016/17 to ensure that we make the most effective use of this highly skilled resource through effective planning of leave and availability in order to reduce reliance on agency and locum workers, thereby improving the quality of care. The Medical Decision Making Group, has been responsible for significant improvements in the monitoring of revalidation issues as well as issues relating to performance. The focus on quality and efficiency will continue in 16/17.

4.8 Bank and temporary staffing

AWP will retain its in house temporary staffing bank and will extend this to cover all professions within 2016/17. Bank usage increased significantly to meet demand and the Executive team are closely sighted on the clinical and quality issues that result from increased temporary staffing usage. The Trust introduced weekly bank pay for staff during 15/16, and as a result has recruited a number of new workers to the bank.

AWP recognises that recruitment and retention programmes will not provide an immediate solution to current vacancies and workforce plans recognise the need for continued use of the bank resource throughout the year. The safer staffing modelling will impact on the demand for both registered and unregistered workers and the implications of this will be kept under review through the Strategic Workforce Group.

4.9 Sickness absence

Sickness absence levels within the Trust remained broadly consistent throughout 2015/16, benchmarking well against other MH and LD Trust nationally. There is ongoing health and wellbeing work in the organisation to support improved health maintenance and recovery.

4.10 Rostering of staff

E-rostering is in place across all relevant services. Oversight and focus on good practice principles delivered through monthly 'roster challenge' meetings chaired by the Director of Nursing with all ward managers and modern matrons. This is supported by key metrics in the Trust's Quality Information System (timeliness of rostering, over / under used hours, allocation of annual leave and usage rates across weekends).

As referred to above, e-rostering will be extended to all medical staff during 16/17. Effective rostering, supported by local management oversight, has been shown to reduce the reliance on both bank and agency during 15/16 and this learning will be shared and implemented throughout the organisation in 16/17.

4.11 Recruitment and retention of staff

In 2014-15, reduced staff availability led to a number of temporary closures of beds in year. 2015-16 saw fewer difficulties in recruiting staff to permanent posts and the Trust was able to reopen beds in Secure services, PICU, North Somerset and Callington Road Hospital. Nevertheless there remains some difficulty retaining staff in some roles and locations. This largely reflects the national picture for mental health nursing and medical recruitment. We are currently undertaking a deep dive review of staff retention and retention of staff through improved staff engagement and wellbeing is a key area of focus for us in 2016-17.
Milestone –Q3: improve staff turnover to 15 %
Milestone – Q4: improve staff turnover to 12 %

5. Approach to financial planning

5.1 Financial forecasts and modelling

Assumptions

The forecast plan for 2016-17 has been developed in line with the activity and workforce modelling and takes into account the key objectives and priorities for the Trust. All the models and the narrative have been reviewed by the Trust to ensure consistency with regards to modelling and setting assumptions.

The following assumptions are mindful of the need to ensure the NHS returns to aggregate financial balance:

- Current income envelope being discussed with main commissioners, including tariff of 1.1% increase along with funding support for safer staffing levels. Contract dialogue should be concluded by end of April, noting that NHSE contract offer was received in the last week of March.
- Net gain of new income relating to:
    - Learning Difficulties provision in Wiltshire
    - CAMHS Tier 4 provision
    - Children's Community Mental Health Services Tier 3 community provision for Bristol and South Gloucestershire

This has led to a net increase in income of close to £10m above income levels at Month 10 2015/16.Expenditure has been calculated taking into account:

- Increase in pay and prices as defined nationally at 3.3% including the additional costs associated with NI and pension changes
- Changes in service provision as detailed above
- CIP £6.1m
- Surplus of £50k
- Removal of non-recurrent expenditure.

	2015-16 Forecast m10 £'000	2016-17 Current Plan £'000
Income		
CCG main contracts (including Swindon PCT, Secure and LD)	163,992	176,396
CQUIN @ 2.5%	3,096	3,779
Total contract income	167,088	180,175
0		
Other CCG income	10,674	9,089
Other Health income (including MPET and R&D)	8,891	7,799
LA income (including S75 and SDAS)	9,940	9,670
Total Income	**196,592**	**206,733**
Expenditure		
Pay	(144,450)	(148,472)
Drugs	(3,499)	(3,211)
Clinical Supplies & Services	(1,338)	(1,392)
Sub-contracted Healthcare and OOA	(9,501)	(7,825)
Utilities, maintenance and Provider SLAs	(3,136)	(3,747)
PFI Operating Costs	(1,399)	(1,393)
Other Non-Pay	(16,487)	(15,307)
Other Non-Pay (Hotel Services)	(2,228)	(1,999)
New Developments	0	(12,594)
CQUIN expenditure	0	(1,453)
Patient Care Fund	0	0
Trust Contingency Reserve	0	0
	(182,038)	(197,393)
Savings Plans Required - To be posted to ledger in period 1		6,136
Other adjustments		
Depreciation	(5,403)	(6,151)
Public Dividend Capital	(3,304)	(2,988)
PFI Interest & Contingent Rent	(5,846)	(6,296)
Interest paid and received	0	10
Total Expenditure after depreciation & interest	**(196,592)**	**(206,683)**
Total operating surplus @ 1%	**0**	**50**

5.2 Service priorities & financial investment

The achievement of the agreed financial position for 16/17 will be enabled through a range of workstreams across the Trust supported by enhanced finance systems and a new format for Board reporting. These include:

- Delivering income and expenditure surpluses that ensure sustainability but with the ability to invest in redesigning clinical services and to enable our health economies to operate efficiently in the future. Savings plans for both 16/17 and 17/18 are being progressed and supported by a dedicated PMO function. This will ensure that AWP can manage the national financial challenges within the NHS.
- Implementation of the Estates Strategy to rationalise our estate, ensure our environment is in line with the requirements of our Clinical Strategy and maximise the disposal programme to invest in updated facilities and infrastructure.
- Deliver consistently high financial performance metrics for our liquidity and capital debt positions.
- Focussing on productivity within community mental health teams following initial work undertaken in Wiltshire in 2015-16
- AWP currently has a reference cost index (RCI) of 128 and is actively renewing its cost base and productivity to identify where this can be rationalised and improved for 2016/17.

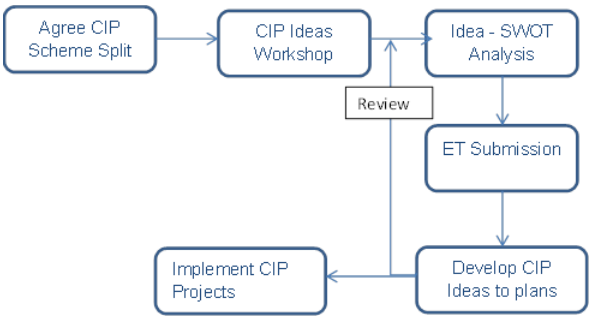
5.3 Key risks to achieving the financial strategy & mitigations

Efficiency & productivity

The achievement of cost improvement programmes (CIP) is one of the Trust's annual objectives; in 2015/16 the Trust delivered significant CIP of £6.56m, but some schemes did not deliver the level of savings anticipated . The Trust has adopted a Programme Management approach to CIP. To build on the success to date, the robust reporting and governance framework put in place to support CIP for 2015/16 will be expanded in 2016/17 to include CIP, Cost Reduction, Commissioning for Quality and Innovation (CQUIN), and large scale Build and Change programmes.

Cost improvement programme planning process

In previous years the Trust has adopted a more centralist approach to identifying CIPs; the current programme has matured into a dual approach where locally driven schemes make up £5.1m and trustwide schemes contribute the remaining £1m. The planning round commenced early January to identify potential schemes and will undergo multiple iterations prior to final sign off by Executive Leads. The overall process from identification to mobilisation of the CIP program is as below



5.4 2016/17 Cost Improvement Plans

The Trust has developed plans around 3 broad themes People, Places and Assets, which are then aligned to service priorities and financial targets. All CIP schemes are recurrent with non-recurrent.

The categorisation of plans into fully developed and 'in progress' is based on the current phase of scheme delivery. For reporting purposes, only when a scheme is actually in delivery will plans be turned to fully developed. This grading is linked to the NHS Trust Development Agency grading system and is a snapshot of the current position. These grading categories will change as programmes transition into delivery. A detailed delivery plan for each scheme retained and tracked by the Programme Management Office and progress is monitored by the Future Focus Programme Board monthly.

Efficiency Programme	Status: Fully Developed, Plans in Progress, Opportunity or Unidentified	Recurring (R) or non-recurring (NR)	Category: Pay (Skill Mix), Pay (WTE reduction) , Non Pay and Income	Risk Rating High (H), Medium (M), or Low (L) (If Unidentified must be high risk)	Total 2014/15
	(mc 01)	(mc 02)	(mc 03)	(mc 04)	(mc05)
					£000s
Description of scheme					
Cost Improvement program					
Southmead Telephone SLA	Fully developed	R	Pull through from 15/16	L	20
Estates Rationalisation - Blackberry Centre PDC and Dep	Fully developed	R	Pull through from 15/16	L	54
Memory drugs	Fully developed	R	Pull through from 15/16	L	60
Aripripazole	Fully developed	R	Pull through from 15/16	L	17
Salary Sacrifice	Fully developed	R	Pull through from 15/16	L	60
Local savings scheme	Plans in Progress	R	Pay (Skill Mix)	M	5,100
Local savings scheme	Plans in Progress	R	Non Pay and income	M	500
Local savings scheme	Plans in Progress	R	Non Pay – Hotel Services	M	325
Total CIP					6,136

Governance of programmes
The management of CIP across AWP is led through the Programme and Transformation Management Office (PMO), which works closely with individuals, delivery units and corporate services to support the identification and development of efficiency savings. The PMO's administrative support includes plan conformance tracking, management of work products, resources administration, and physical and technical environment support.

Framework:
The PMO ensures governance to achieve the necessary linkage, oversight, and control of the programs. This governance element, depending on the scale of the scheme, includes:

- Organisational structures: Each CIP themes will include a program steering committee;
- Roles: The program structure will include the executive sponsor, a steering committee member, the PMO manager, and project / program managers.
- Mechanisms: Provide guidance and direction, with respect to decisions and specifications.

Program execution and tracking strategy:
The Trust has a monthly Future Focus Programme Board (FFPB) which tracks all CIP, CQUIN, Cost Reduction and Large Scale Projects across the Trust. The FFPB is chaired by Director of Operations and is attended by all Executive Directors, Project and Programme Delivery Leads/Owners. All plans are monitored and reported through the FFPB which is accountable for delivery management and reports directly to the Trust Executive Team (ET) and through the Executive Director of Resources to Finance & Planning Committee (F&P). Supplementary reports are provided to Quality and Standards Committee as appropriate.

The Future Finance Programme Board has the following key functions:

- Provide Executive overview and control of the Trust Cost Improvement Programme (CIP), Cost Reduction Programme (CRP), Commissioning for Quality and Innovation Programme (CQUIN), and Large-scale Projects as directed by the ET
- Monitor and direct Trust programme activity
- Ensure all benefits are maximised
- Ensure that work strand interdependencies are identified and managed
- Ensure effective communication amongst key stakeholders of progress against Trust wide projects and the programme as a whole
- Provide an opportunity for escalation of issues for resolution
- Enable new ideas to be generated and agreed rapidly at an Executive level

The responsibilities of the Future Finance Programme Board are:

- Ensure that the quality of service delivery is not adversely affected by the Cost Improvement Programme and that it is developed in an integrated and systematic way at all levels across the organisation
- Ensure that the interfaces between projects and work strands are identified and maximised. Identify issues and delays that require escalation and action accordingly;
- Ensure effective communication amongst key stakeholders of progress against Trust wide projects and the programme as a whole, encouraging members to identify opportunities for further savings
- Scrutinise the Cost Improvement Programme and identify corporate risks that would undermine the achievement of the Trust's plans and seek firm assurance that these risks are robustly managed

Programme key performance indicators
In order to provide the FFPB with a wider view of the impact of the Trust Efficiency Programme; work strand groups have 'soft' Key Performance Indicators as a measure of behavioural change and delivery in addition to financial indicators. At least one of these indicators is a measure of quality where the change directly affects a clinical service.

Programme project control
Each work strand within the Trust wide themes has an identified Executive Lead/Project Owner, Operational Delivery Lead/Project Manager and a Clinical Lead where the Delivery Lead is not a clinician. Within each Delivery Unit and Corporate Department, a CIP workbook is used to collate project supporting documents. Each workbook includes a Project Initiation Document, Work Plan, Quality Impact assessment, a Stakeholder Matrix as a minimum along with other supporting project documentation to record performance. Project issues are tracked using an online tool and managed centrally by the PMO. Project risks are held centrally by the PMO with service risks being reported and managed via delivery unit's operational risk register.

Programme quality impact assessment
All individual and overarching plans are Impact Assessed at the local level by Clinical Directors and then given final approval through the monthly Directors of Medicine and Nursing review panel. The whole CIP plan is impact assessed.

Programme reporting
All reporting of CIP is by exception in order to promote proportional project management and efficient working practices across the Trust. Larger Projects and Programmes are directly supported by the Trust Programme Management Office in order to maintain overarching visibility of emerging threats to the Trust Strategy.

Lord Carter provider productivity work programme
The Lord Carter review focused predominately on acute trusts and whilst there is much overlap and good practice that mental health providers can implement there are areas which offer minimal scope for savings.

The Trust developed a high level briefing paper that detailed where the Trust could implement the proposals. The key areas identified resulted in Agency reduction (covered within Agency sub section), Estates and Procurement. The Trust will continue to further implement the proposals where appropriate and applicable to a mental health trust.

5.5 Agency rules

Annual ceiling for the maximum use of nursing agency staff
There are still significant nursing vacancies in the organisation. This means there are always significant gaps requiring bank and agency to meet need. Since the introduction of the annual ceiling for nursing agency use, AWP have increased bank recruitment and the way in which it recruits to the bank. Additionally the introduction of weekly pay for bank work has increased the number of substantive registered nurses who also hold bank posts by 6% since September 2015.

Mandatory use of frameworks

AWP bank has changed processes when trying to fill gaps with temporary workers. Once all bank workers and overtime has been exhausted, the bank then try all framework agencies before taking this back again to the wards and only as a last resort does the shift then go out to non framework agencies and in these circumstances only an Executive Director can authorise.

Also the approval process for agency authorisation has changed and there is now a requirement for a Managing Director to agree this before agency is sought.

Hourly capped rate for nursing

AWP has written to all of its framework agencies as per instruction from TDA/Monitor requesting confirmation that they will be supplying at capped rates. Those unable to achieve thishave been moved further down the list of agencies to contact but would still be contacted before those which are non-framework. The second price caps which came into force in February have been more difficult for agencies to achieve and several have responded with the ability to provide capped rates for some shifts/staff types but not all. Those identified as most difficult to comply with are day shifts for registered staff.

Procurement

Currently the Trust has a finance and procurement system that ensures that all expenditure against purchase orders is signed off at both budget holder and a higher level. This ensures that items purchased are from approved suppliers and at NHS discounted rates/framework contracts where appropriate.

Where possible the Trust has an approved items catalogue. These items are either tendered or framework based items and represent best value for money, patient safety and appropriateness of item. The Trust has focused on standardisation of labelled commodities this year including, domestic supplies, catering, and stationery and will continue to roll this work in the following year using the published Atlas of Variation as a benchmark to set products and costings. The Trust will be reporting against the top 100 list but are aware that we do not commonly purchase many of the items on the list.

To further aid potential saving opportunities the Trust will work more closely with neighbouring trusts to investigate if bulk buying discounts benefit either party, and will investigate working with partners external to the NHS.

As a Trust buying predominantly services over products there will be focused attention of the standardisation of services. This will be conducted by initially restricting the number of suppliers used and working with jointly with operational staff to clearly define the services required

5.6 Capital planning

Our capital plan for 2016/17 is part of a rolling three year plan and reflects the current 5 year LTFM and Estates and IM&T Strategies which were updated during 2015/16.

The Trust runs an Investment Planning Group with clinical and operational representation that prioritises projects against our Clinical strategy for recommendation to the Trust Board.

The plan and any subsequent changes are subject to scrutiny and sign up at our Operational Senior Management Team meeting and all clinical estates implications are ratified by the Director of Nursing through a Design Authority Group Meeting.

The current plan is as follows for 2016/17.

Capital Programme for 2016-17	IT Plan £'000	Current Plan £'000
Source of Funds		
Depreciation		6,151
Self-funding for Daisy		1,615
Loan received for Hillview 15-16 Spend		767
Hillview land transfer		160
Loan for Hillview		8,355
Planned Disposal of Assets to be reinvested		2,325
		19,373
Application of Funds		
Bristol South Gloucester DU Accomodation (inc. reprov. Bybrook Lodge)		300
Bristol Weston Ward		450
Service redesign - Bristol Lot 2 - Second Step		1,619
CQC Anti-Ligature works		2,250
Core and Server Infrastructure (IT)	687	
Desktops and laptops replacement (IT)	500	
Electronic Patient Records Procurement (IT)	606	
Sharepoint Upgrade Trust Systems	224	
Wireless sites - 20 sites (IT)	150	
Medical Devices		100
Southmead Water System Re-engineering		400
Section 136 Review		315
Otsuka Implementation Service		750
Wiltshire Daisy Centre		1,615
BANES - Hillview rebuild project		9,322
Lifecycle maintenance		250
Capital feasibility		100
Operational Investment		47
		19,685
Currently over committed		**312**

6. Link to STPs

To date we do not have any fully developed Sustainability and Transformation Plans for any of our CCGs areas however we are involved in their strategic planning meetings and are assessing the impact of this on the commissioning intentions we have received so far.

We will span two areas – Bristol, North Somerset and South Gloucestershire (BNSSG) and B&NES, Swindon and Wiltshire (South Central)

We have held two joint accountable officer meeting for our current CCGS in January and April to discuss how AWP's footprint could be best used within these plans as we do not want to be introducing inefficiency in the local health systems.

The commissioning intentions that we have received so far for 2016/17 from our CCG commissioners have generally indicated continued growth and development in a number of key areas;
we have not yet received formal commissioning intentions from Bristol or Swindon CCGs. The following tables sets out the position of all of the CCG's to date:

Bristol CCG:	Bristol have issued commissioning intentions for the healthcare community in line with the Bristol Mental Health Redesign principles.
B&NES CCG	Implementation of B&NES Mental health Crisis Concordat, rebuild of mental health in-patient unit, alignment of mental and social care services, review of Special Patient notes usage and Specialist Accommodation Pathway.
North Somerset CCG	Individual contract being agreed for 16/17. Negotiations progressing well, with locally co-developed Service Specifications agreed and the CCG having clear plans to utilise CQUIN funds to pump prime service improvement initiatives in the Locality, using CQUIN money to fund additional posts. No further investment identified, with the caveat that were additional funds to be released by NHSE with regard to new Early Intervention targets, these would be made available to AWP.
Swindon CCG	Individual contract for next year. No reduction in bed base and want ability to continue to be part of a risk pool to use entire AWP bed capacity, no additional investment.
Wiltshire CCG	Commissioning intentions identify the continued development of existing intentions. Whilst most of the intentions are funded by existing resource there is expected additional money dedicated via the Daisy development, but a slight reduction in the IAPT agreement. Plans also in development to enable reductions related to overfunding.
South Gloucestershire CCG	Commissioning intentions have been received and focus on CHL continued investment, IST later life provision, and increased funding to EI service to meet NICE guidelines and continued investment in Adult and PICU beds.
NHS England	Still awaiting intentions but meeting to discuss CQUINS and draft service changes and proposals for 16/17

6.1 Risks of 2016/17 commissioning intentions and resource mapping

AWP recognises that there are risks, financial and non financial, associated with the delivery of the 2016/17 commissioning intentions. These risks are related to a range of reasons including:

- Growth in short term and AQP type contracts for specialised and other services focused on improving access to local mental health services
- Recognised need and continued growth in the integration and partnerships between mental health, physical health and social care
- Continued growth in integration of services, across health and social care
- Impact of continued financial position of NHS England on specialist commissioning
- Risk share arrangements on high cost beds and out of area placements leave AWP unduly exposed to risk
- Resource mapping leaves AWP unduly exposed to financial risk of circa £1.7m.

The mitigation of these risks is based around continuing to work with commissioners, especially the Accountable Officers, to provide collaborative solutions where possible. Additionally a proposal to appropriately balance the risks between commissioners and AWP on the impact of inpatient beds and the implications of resource mapping has been put forward. This will be concluded by late April.

6.2 Other factors

It is known that there are a number of other factors which will impact on the strategic response from AWP throughout 2016/17. These include changes to local and regional health services, as well as national developments.

- Impact on delayed transfers of care due to factors relating to social care services
- Overall increase in emergency and urgent healthcare and its impact on mental health services
- Impact of changes to Weston Area Health Trust - Impact for AWP as based on site of Weston General Hospital as well as part of the integrated health and social care service in North Somerset. Expected to be from late 2016.
- Emerging competitors to AWP business from acute/community and ambulance service sector

6.3 Planned growth in 2016/17

It is clear that the demand for mental health services is growing and developing. This is due to a number of reasons including increasing incidence and diagnosis, as well as improved knowledge and understanding

Children's Community Health Partnership with BCH & Sirona for Bristol, South Gloucestershire and North Somerset (1YR)	£8.5m
Tier 4 CAMHS for Bristol and South Gloucestershire	£2.1m
Offender Health with BCH for Bristol CCG	£4m
Daisy Unit	£1.6m

6.4 Tender activities in 2016/17

We are involved in the following tenders and bids for services which will start from 1st April 2017.

Children's Community Health Partnership with BCH & Sirona for Bristol, South Gloucestershire and North Somerset (Ongoing)	£11.5m
B&NES Your Care Your Way	£6m
North Somerset – Working on a transformation programme to avoid full procurement	£15m
Secure Services	£26m
Drug & Alcohol Services	£10m
Eating Disorder Services	£8m
Perinatal Mental Health Services	£4m