Avon and Wiltshire Mental Health Partnership NHS Trust

Meeting	Trust Board
Date of meeting	30 May 2019
Agenda item	
Provided for	Assurance

Title of report	2018/19 Annual Objectives - Q4 Update
Report author	Associate Director, Planning and Development
Report sponsor	Rachel Clark, Director of Strategy

Executive summary of key issues

This report is submitted to Trust Board for assurance and to note. It provides a summary of progress in Quarter 4 towards the Trust's 2018/19 Annual Objectives and notes the direction of travel during the year.

The scorecard attached to this report provides a more detailed picture of the position against the desired outcomes and process measures during Quarters 1-4.

Summary of performance
Overall, performance in Q4 has been similar to Q3. Whilst more improvements were made in several areas, performance has also deteriorated in a few key indicators. The main headlines are summarised below under the Trust's three strategic principles.

We will support our service users and carers

- Violent incidents increased during 2018/19 by 20% over the 2017/18 baseline, despite the delivery of the Safewards programme. This remains a priority for 2019/20 **(Red).**
- 92% of service users have received a follow up appointment within three days of hospital discharge, a target achieved since Q2 **(Green).**
- 93% of staff completed the Suicide Prevention training and 83% of service users had a Preventing Suicide risk assessment by the end of 2018. Take up of this training has been consistent since it was launched **(Green)**.
- Q4 saw a significant increase in NEWS assessments reported on RiO. The Physical Health team is now preparing for the implementation of NEWS2 **(Amber).**
- Medication errors have reduced by 32% since 2017/18 and the 75% reduction in blank boxes target was exceeded in the 4 wards audited **(Green)**.

We will engage our staff

- The Trust spent £14.534m on Agency staff by the end of the year, significantly exceeding our £6.4m agency cap. This overspend grew significantly in year. Deep dive reports identifying the reasons for expenditure in year have been provided to Finance and Planning Committee. The Agency Reduction Project will continue in 2019/20 with a range of priorities agreed that aim to reduce reliance on costly non-framework agency and increase bank staff numbers **(Red).**

- Steady progress was made during 2018/19 towards reducing vacancies and staff turnover, by 0.6% and 1.3% respectively. This work continues in 2019/20 as part of the Workforce Programme **(Amber).**

- The results of the 2018 Staff Survey were reported in the Q3 update. Actions planned for 2019/20 to improve staff wellbeing include support for staff if they feel bullied or harassed, making sure that they have the tools to do the job and strengthening and promoting communication channels with senior managers **(Amber).**

- Trustwide and local initiatives also planned in 2019/20 to raise awareness of the health and wellbeing initiatives, and ensure that these opportunities address what staff themselves believe will make a difference. The 2018 Staff Survey results indicate that staff health and wellbeing remains is a priority for the year ahead **(Amber).**

We will be sustainable

- 10% reduction in the use of inpatient beds for adult acute patients target has not been achieved. Bed pressures remain acute with Out of Trust (OOT) placements continuing to exceed the 10 bed OOT target. New, centralised, bed management arrangements and flow rules introduced **(Red).**

- Over the last year demand for inpatient services has continued to rise. As part of the Service Delivery and Improvement Plan (SDIP) we are working with CCG colleagues to understand the drivers of the demand and ways in which we can positively reduce length of stay when clinically appropriate **(Red).**

- Overall the Trust financial position at the end of Q4 was a deficit of £1m against a final plan of £2.635m. The 2018/19 control total was achieved which ensured that the Trust attracted a further £1.2m of Provider Sustainability Funding (PSF). This is a significant improvement on previous year's performance, demonstrating the impact of improved grip and control and financial rigour across the organisation **(Green).**

- The £12.1m efficiency savings required were delivered in full in year. It is noteworthy however that £4.85m of these savings were non-recurrent, demonstrating that greater progress needs to be made in 2019/20 to deliver sustainable savings **(Green).**

Implications for 2019/20 planning

The major issues for 2019/20 are those that arose in or before 2018/19. Although significant progress has been made with many 2018/19 objectives, there is a need to ensure that the workstreams to achieve them continue to receive focused attention and resourcing in 2019/20. Outcomes and Key Performance Indicators and milestones are being signed off with delivery leads for the following programmes:

- CQC and other regulatory improvements
- Embedding a culture of quality improvement
- Getting the basics right
- Clinical systems
- Workforce programme
- Operational Effectiveness
- Continuous Financial Improvement.

These programmes reflect priorities identified through both delivery of 2018/19 annual objectives and also changes that must be made if the Trust is to achieve required improvements in clinical service provision (as evidenced through the CQC report).

Recommendation	Trust Board is requested to review and note the contents of this covering paper, slides and scorecard.	
Previously Considered by	N/A	
Corporate risk or Board Assurance Framework		
Which Strategic objectives does this papers progress or challenge?	**We will support our service users and carers**	X
	We will engage our staff	X
	We will be sustainable	X

2018/19 Annual Objectives – Q4

Area of review	Key Highlights	YTD Rating	Year end Rating	Change
We will support our service users and carers	• Violent incidents increased by about 20% since the 2017/18 baseline, despite the delivery of the Safewards programme. • 93% of staff completed the Suicide Prevention training and 83% of service users had a Preventing Suicide risk assessment by the end of 2018. • 92% of service users were followed up within 3 days of discharge. • 79% of service users had a NEWS assessment within 24 hours of admission. • 86% of eligible patients had a NEWS assessment weekly during their inpatient stay. • 89% of patients on participating Older Adult wards had an initial pressure ulcer risk assessment, almost achieving the 90% target. • Medication errors have reduced by 32% since 2017/18 and the 75% reduction in blank boxes target was exceeded in the 4 wards audited. Performance against this strategic principle overall is rated as Amber due to the number of violent incidents on wards despite the continued good performance following up with service users after discharge from hospital and the progress made towards the desired Physical Health outcomes. Further progress expected in 2019/20.			

Area of review	Key Highlights	YTD Rating	Year end Rating	Change
We will engage our staff	• Agency expenditure at the end of the year was £14.534m despite a wide range of Trustwide and LDU initiatives to reduce agency spend and improve recruitment and retention. This is £8.134m higher than the Trust agency cap for the year and an increase in expenditure of £3.607m over 2017/18 levels. • The Trust staff turnover rate in March (rolling average) was 13% against a baseline of 13.6% in April 2018, progress but well short of the 2% target. • The total number of vacancies was reduced by 1.3% by March 2019, reflecting steady progress throughout the 2018/19 year. • A detailed programme of work has been developed to improve staff wellbeing and staff survey results in 2019. This includes measures to support staff if they feel bullied or harassed, making sure that staff have the tools to do their job and strengthening and promoting communication channels with managers. • Trustwide and local initiatives also planned to raise awareness of the many health and wellbeing initiatives and activities available, and ensure that these opportunities address what staff themselves think will make a difference. Recent performance against this strategic principle rated as Red because of the growing agency spend. It should also be recognised that the trust now has identified and begun to implement a detailed programme of work to improve staff wellbeing and recruitment and retention.			

Area of review	Key Highlights	YTD Rating	Year end Rating	Change
We will be sustainable	• 10% reduction in use of inpatient beds has not and will not be achieved. Bed pressures remain acute. Original bed management project has closed and new, centralised, bed management arrangements and flow rules introduced. • Unable to establish the impact of the introduction of 'packaged' community services because the team have been unable to identify baseline positions. The target was a 25% reduction in community length of stay. Caseload audit completed, project is now being rolled out across the Trust. • Out of Trust bed use has not been reduced to the level of target, no more than 10 Out of Trust beds commissioned. • Overall Trust financial position at the end of Q4 was a deficit of £1m against a final plan of £2.635m. The control total was achieved and an additional £1.6m of Provider Sustainability Funding brought the final outturn position down to a deficit of £1m. The underlying deficit before PSF was £3.875. • The £12.1m efficiency savings required were delivered in full by the end of the year. However £4.85m of these savings were non-recurring. Grip and control schemes will need to be maintained in 2019/20 in order to maintain financial control. Performance against this strategic principle is rated as Amber due to the achievement of the financial control total and the efficiency savings despite not delivering recurrent savings or reducing the use of resources. The same challenges will be faced in 2019/20.			

AWP Annual Objectives 2018-2019

Q4 Update

Principle	Objective	Activities to support delivery	Theme	Outcome Measure	Process Measure	Balance Measure	Q1 Milestone Against Outcome Measure	Q1 Milestone against Process Measure	Q2 Milestone Against Outcome Measure	Q2 Outcome Measure - RAG Score and narrative	Q2 Milestone against Process Measure	Q2 Process Measure - RAG score and narrative	Q3 Milestone Against Outcome Measure	Q3 Outcome measure - RAG Score and narrative	Q3 Milestone against Process Measure	Q3 Process measure - RAG score and narrative	Q4 Outcome measure RAG score and narrative	Q4 Process measure RAG score and narrative
1. We will support our service users and carers	We will improve the quality of our care by focussing on patient safety	1. All Teams and services will be rated as "good" for the CQC safety domain. 2. Safety Programme: *Sign up to safety *Safe Wards *Suicide Prevention Strategy *Physical Health Actions (CQUINS) *Medicines Administration	Patient Safety	30% reduction in violent incidents on inpatient wards. Ongoing program of support for implementation of Safewards.	Review uptake of safewards. RRP steering group, strategy and lead appointed.	Safewards plan to RRP with baseline agreed and implemented	Base line established.	Steering group set up. Six core strategies audit undertaken. Process to appoint RRP lead in place.	Agree indiviual reduction targets for each ward.	757 incidents of violence in Q2 – this is an 18.8% increase from the Q4 baseline. N&Q are in the process of agreeing individual targets for each ward through the RRP programme.	Steering group up and running. Strategy developed based on audit findings. Safewards training and coaching model developed.	Monthly Reducing Restrictive Practice Board meetings up and running. Recruitment of a lead professional for this work is underway.		736 incidents of violence reported in Q3. An increase of 15.5% from the Q4 17/18 baseline, 3.3% lower than Q2.	Safewards program delivered. Recruitment of a lead professional for this work is underway.	Safewards program fully implemented across Trust, including a Safewards Forum. Monthly RRP Board meetings up and running.	20% increase since 2018/19 baseline.	
				75% uptake in staff flu vaccination (CQUIN)	Number of staff trained to deliver vaccine		Hold learning event to review successes and challenges from last year	Agree package and begin delivery of training to ensure adedqaute number of vaccinators	Develop implementation plan	Implementation plan agreed and commenced.	All identified staff vaccinators to have recived training	All staff that have volunteered to be vaccinators have received training.	40% of staff vaccinated	50% of staff have received the flu vaccination		All staff that have volunteered to be vaccinators have received training.	52% of staff vaccinated	
			Suicide Prevention -	90% of staff trained (MLE e-learning)	None identified	Compliance of other stat/man training courses	50% staff trained		60 % staff trained	Stat Man training report has been developed by L&D and shows the Trustwide position at 88%			80% staff trained	87% staff trained		Stat Man training report developed by L&D	93% staff trained.	
				90% of SU receive a follow up appt within 3 days of discharge from hospital	Understand current performance. Work with Ops to model 3 day follow up implications.	Agree model and capacity.	Establish baseline performance	Developement of model in line with evaluation of baseline data	30% SU followed up in 3 days	Reporting established on IQ and shows a compliance of 90.8%. N&Q will be undertaking a quality audit of the contacts following discharge in Q3.	Establishment of the model within clinical practice	Model established within clinical practice. N&Q to commence an audit in Q3.	60% SU followed up in 3 days	Reporting established on IQ and shows 94.1% compliance		Model established within clinical practice. Discussions about what a good follow up looks like are taking place. Audit not commenced due to capacity.	92% of people have received follow up within 72 hours of discharge	Further work is being completed in 2019/20 to review the quality of the follow up.
				90% of service users will have a documented Preventing Suicide risk assessment that meets the requirements of the NPSA toolkit	Completion of update to RiO pages.		Review performance based on last years improvement work	Agree draft format of updated RiO pages	75% SU have a good quality Risk assesment	Delay in amending the IQ records management audit due to limitations with the system (small window opportunity to amend the audit questions) and IT capacity. A plan is in place to commence the records audit on 05/12/18, audit results will be included in the Q3 update.	Begin buiding of updated risk pages within RiO	Specification produced, delay in updating the risk pages within RiO due to IT capacity	85% of service users have a quality risk assesment	Audit commenced in Nov 2018, which shows 83% of service users had a good quality risk assessment in Nov and Dec 18.	Full implementation of new pages	New risk pages within RiO have been built and are currently being tested by users. The go live date of these pages depends on feedback from the testing phase.	83% of service users have had a documented Preventing Suicide risk assessment.	Further work is being undertaken this year to continue to make progress through the suicide prevention workstream.
			Physical Health	90% of eligible SU have an annual physical health check	Training compliance Compliance with correct recording guidelines		60% service users have an annual physical health check	Review audit performance from last year and develop clear improvement plan. Updating of clinical pathways 90% training compliance	75% of service users have an annual physical health check completed and recorded	Reporting for physical health checks based on the updates to RiO will be completed by the end of October and monthly data will be included in the quality dashboard for	Maintained training compliance at 90%	89% of target staff have completed the cardio metabolic e-learning training.	90% of service users have an annual physical health check recorded	Reporting for physical health checks based on the updates to RiO completed in December, therefore, data for Q3 is unavailable.	Maintained training compliance at 90%	Awaiting overall compliance figure from Learning & Development	The national audit undertaken in 2018/19 is yet to be published.	
				90% of patients have a NEWS recorded within 24 hours of admission	Training compliance. Effective evidenced based policy		Establish baseline performance	Review policy and guidelines	50% compliance	6 monthly audits have commenced on all inpatient wards – each ward is required to audit 5 service users who have been with them for the longest period (where relevant), if the ward had less than 5 service users, then all service users are audited. 100% of wards engaged in the July audit, which shows 72% of service	Make amendments to policy required and publish	Care of the Deteriorating Patient Policy, including tools to support clinicians	75% compliance	There has been no formal audit data collection in Q3, this is due to the physical health team focusing on work to prepare for the implementation of the NEWS2 project across the Trust.		Work to scope NEWS2 project, draft a work plan to support its implementation across the Trust ongoing. The implementation date for NEWS2 is the first week of April 2019	79% of service users have had a NEWS recorded within 24 hours of admission	This work will continue with the roll out of NEWS2 in 2019/20
				90% of eligible patients will have a NEWS recorded weekly during IP admission	Training compliance. Effective evidenced based policy		Establish baseline performance	Review policy and guidelines	50% compliance	6 monthly audits have commenced on all inpatient wards. 100% of wards engaged in the July audit, which shows 79% of service users had NEWS undertaken within the last 7 days.	Make amendments to policy required and publish	Care of the Deteriorating Patient Policy, including tools to support clinicians	75% compliance	There has been no formal audit data collection in Q3, this is due to the physical health team focusing on work to prepare for the implementation of the NEWS2 project across the Trust.		Work to scope NEWS2 project, draft a work plan to support its implementation across the Trust ongoing. The implementation date for NEWS2 is the first week of April 2019	86% of eligible patients have had a NEWS recorded weekly during IP admission.	This work will continue with the roll out of NEWS2 2019/20
				90% of patients admitted to older adults ward will have a pressure ulcer risk assessment and nutrition screen	Review and publish updated policy. Staff Training		Develop an audit tool and process for data collection. Review baseline position from audit in Q4. Develop improvement plan with ward staff	Publish updated pressure ulcer policy with standard risk assesment tool	30% compliance	Reporting on completion for MUST tool is being developed by BIU and planned for the end of October. A quality audit of pressure ulcer screening has been delayed due to capacity within the team and planned Q3/Q4 update.	Delivery of actions within improvement plan	Improvement plan to developed with each ward	60% compliance	6 monthly audits commenced on all inpatient wards – 14/17 wards participated, which shows 87% of service users had an initial pressure ulcer risk assessment, on track with trajectory to reach 90% by the end of March.	Delivery of actions within improvement plan	Improvement plan in development following most recent audit	89% of older adults received a nutrition screen and pressure ulcer assessment following admission to our inpatient wards.	
			Medicines Optimisation	75% reduction in blank boxes				Review work undertaken with teams and understand lack of imapct. Develop revised improvement plan based on small pilot undertaken this year	25% reduction	Ceased Trustwide reporting to focus on piloting an audit on four inpatient wards. Audit results are currently being analysed and will be included in the Q3 update.	Delivery of actions within improvement plan	Audit results are currently being analysed - improvement plan to be developed following this.	50% reduction	Trustwide reporting ceased to focus on piloting an audit on 4 inpatient wards. Pilot results analysed and improvement plan developed	Delivery of actions within improvement plan	Improvement plan being implemented. Once actions embedded, a re-audit will take place on the 4 pilot wards, with the aim of rolling out Trustwide.	Medication errors - a 32% reduction in errors in 2018/19 compared with 2017/18. Blank boxes - 75% reduction target exceeded on the 4 audited wards.	Blank boxes - Initiative will be rolled out across other wards this year.

Principle	Objective	Programmes and Activities to Support Delivery	Theme	Outcome Measure	Process Measure	Balance Measure	Q1 Milestone Against Outcome Measure	Q1 Milestone against Process Measure	Q2 Milestone Against Outcome Measure	RAG Score and narrative	Q2 Milestone against Process Measure		Q3 Milestone Against Outcome Measure	Q3 Outcome measures RAG Score and narrative	Q3 Milestone against Process Measure	Q3 Process measures RAG Score and narrative	Q4 Outcome measure RAG score and narrative	Q4 Process measure RAG score and narrative
2. We will engage our staff	We will attract and retain great staff to support and provide safe and effective care	*Recruitment & Retention Strategy *LiA *Leadership Forum *Retention Support Programme *Link Directors *Mgrs Toolkit refresh *Bullying & Harrassment Advisors *Health & Wellbeing Programme *Improve comms via social media	Staff Engagement	Reduce agency use in line with mandated agency cap (£6.4m)	1. Establish Bank & Agency Task and Finish Groups in each LDU (April/May 18) 2. Implementation of Turnaround Task Force to support LDU in gaining grip and control 3. Alignment of Bank & Agency plans with recruitment and retention strategy initiatives/plan 4. Alignment and refinement of B&A plans alongside the process of capacity and demand modelling of new models of care and implementation of Safer Staffing	Failure to achieve £1M reduction in Bank and Agency Spend 2018/19 (FIP Scheme 8)	End of Quarter milestones: 1. Q1 Reduction in Bank and Agency spend compared to 17/18 Q4 position	1. All LDU T&F Groups established. All LDU's have Q. trajectories agreed for the year: recruitment to (nursing, medical & admin) vacancies rates; incremental reductions in bank & agency spend; retention initiatives. 2. Bank office support functions have 18/19 workplans in place to support operational services to deliver trajectories; aligned to recruitment and retention strategy activities 3. Cost Reduction Steering Group (DoF Chair) operational, providing robust monitoring and assurance function of LDU's expenditure	1. Q2 Reduction in Bank and Agency spend compared to 18/19 Q1 position; aligned to trajectory profiles at locality level	To be on track to deliver the originally anticipated agency reduction of £1.2m, agency expenditure would have to be £4.686m. Trust expenditure was £7.037m - a gap of £2.169m	1. Turnaround Task Force interventions (if applied) added value 2. Monthly Cost Reduction Steering Group Exception Reports 3. Delivery of Retention Plan milestones in line with B&A LDU planning timeframes	Financial turnaround programme implemented with Secure, Bristol and Wiltshire being monitored through this process. Revised agency project in development, led by COO, with a focus on LDU trajectories.	1. Q3 Reduction in Bank and Agency spend compared to 18/19 Q2 position; aligned to trajectory profiles at locality level 2. 0.5% decrease in turnover rate against 31/3/18	As at end of Q3, in order to be on track to deliver the originally anticipated agency reduction of £1.2m, trust agency expenditure would have needed to have been £7.302m. As at the end of Q3, actual expenditure on agency was £10.786m – a gap of £3.484m. Hotspots in Quarter 3 include Qualified Nurses and Admin in Bristol, BaNES and CAMHS, and Medical agency usage.	1. Turnaround Task Force interventions (if applied) added value 2. Monthly Cost Reduction Steering Group Exception Reports	To be confimed	In order to deliver the originally anticipated agency reduction of £1.2m, year end agency expenditure would have needed to be £9.736m. Final year end actual expenditure was £14.534m, a gap of £4.798m.	Final agency expenditure for 2018/19 ended up at £14.534m - £8.134m higher than the trust agency cap for the year and an increase in expenditure of £3.607m over 2017/18 levels.
				2 percentage point reduction in staff turnover by 31.03.19	Create a more engaging communications culture to reduce frustrations	Do managers have the time and skills to dedicate to this?	Turnover reduced by 0.5%	Review communications channels and create a new tone of voice	Turnover reduced by 1.0%	Rolling turnover rate at April 2018 was 13.6%. Turnover rate at September 2018 was 13.1% demonstrating a 0.5% reduction in turnover rate which is less than planned.	Upgrade ourspace and introduce line manager team brief channel		Ourspace upgrade planned for Quarter 4	0.5% decrease in turnover rate against 31/3/18	Turnover was 13.6% at 31 March 2018. At 31 December 2018 it was 13.3, a reduction of 0.3%.	Report on progress made - you said, we did with focus on LiA and staff survey groups		Staff turnover was 13% in March 2019. Lowest in Secure (10%), N Somerset (11%), BaNES and S Glos (12%). Highest in Specialised (20%) and in Bristol (16%)	Staff turnover has reduced from 13.6% in April 2018 to 13% in March 2019. Reported to Board via Recruitment and Renetion project and the Executive Committee. Over 2018/19 Secure Services has seen turnover drop from 15 to 10%. Bristol has seen staff turnover increase from 12 to 16% over the same time period. Work has commenced with Bristol and Swindon to try to reduce turnover which has mostly been driven by levels of acuity. Specialised turnover increase has at least in part been driven by the short contracting periods for many services. Many staff chose to move on rather than risk being TUPE'd to another provider if the contract is lost.
					Deliver NHSI Retention Plan	Retention payments / costs will remain in line with figures agreed through retention plan.	Turnover reduced by 0.5%	Initial project plan linked to NHSI retention project completed by end of Q1	Turnover reduced by 1.0%	Rolling turnover rate at April 2018 was 13.6%. Turnover rate at September 2018 was 13.1% demonstrating a 0.5% reduction in turnover rate which is less than planned.	Delivery of milestones in agreed project plan for the quarter			0.5% decrease in turnover rate against 31/3/18	Turnover was 13.6% in March 2018. In December 2018 it was 13.3, a reduction of 0.3%. This is, however, an increase of 0.2% since September 2018.	Delivery of milestones in agreed project plan for the quarter			
				2 percentage point reduction in vacancy rate by 31.03.19	Create a tone of voice that can be used to write more compelling recruitment collateral and content		Vacancy rate reduced by 0.5%	Audit current activty, set objectives, identify tactics, create content plan and agree evaluation	Vacancy rate reduced by 1.0%	Vacancies for Q1 were 16.2% of establishment. Vacancies for Q2 were 15.0% of establishment.	Pilot 'new look' material	Recruitment information in production with revised adverts and documentation	0.5% decrease in vacancy rate	Vacancy rate was 16.0% at 31 March 2018. At 31 December 2018 it was 14.7%, an improvement of 1.3%	Roll-out approach to remainder of recruitment		The target was a challenging one but we have achieved a reduction of 1.3% since April 2018. Vacancy rate was 15.1% in March 2019. Lowest in CAMHS and S Glos (8%). Highest in Wiltshire (22%) and Secure Services (21%)	Ongoing work to increase attraction and recruitment as well as retention. This includes the improvement of AWP collateral to take to external recruitment events, the improvement of the process and associated documents that are used to recruit and a change of selection process that is more inclusive and value based.
					Deliver NHSI Retention Plan - as above. **Will have impact on vacancy rate as well.**	As above: Retention payments / costs will remain in line with figures agreed via retention plan.	Vacancy rate reduced by 0.5%	As above: Initial project plan linked to NHSI retention project completed by end of Q1	Vacancy rate reduced by 1.0%	Vacancies for Q1 were 16.2% of establishment. Vacancies for Q2 were 15.0% of establishment.	As above: Delivery of milestones in agreed project plan for the quarter			As above 0.5% decrease in turnover rate against 31/3/18	Turnover was 13.6% at 31 March 2018. At 31 December 2018 it was 13.3, a reduction of 0.3%.	As above: Delivery of milestones in agreed project plan for the quarter			

				3% improvement in staff survey questions in 3 priority areas – Bullying & Harrassment; Resources to do my job; communication with senior managers, plus staff engagement score.	*Run a campaign that supports managers to be more effective communicators. * Train anti-bullying and harrassment champions. * Clarity around resources required for roles.	*May be confused with or overshadow LiA action groups. *Delivery of operational requirements at same time as addressing staff engagement may be beyond capacity / capability of some managers.	*None until Q4 *None until Q3 *None until Q4	*Review communications training, tools and resources available to staff and draw up senior manager visibility programme * Completion of training of anti-bullying and harassment champions (LiA). * Divisions complete their review of Staff Survey responses and identify resource gaps	*None until Q4 *None until Q3 *None until Q4	Not applicable until Q3 and Q4	*Create a suite of resources dedicated to helping managers be effective communicators and launch senior manager visibility programme. * Divisions link to corporate depts to align resources to roles / close resource gaps. *Communicate changes made as a result,		*None until Q4 *Improved Staff Survey response rate *None until Q4	85% not experienced bullying, harassment or abuse from managers (86% in 2017/18) 45% had adequate materials, supplies and equipment to do job (42% in 2017/18) 31% said that communciations between senior managers and staff is effective (was 34% in 2017/18) 52% of staff responded to survey (was 51% in 2017/18)	*Launch toolkit and run a temperature to check on progress being made. *Evaluate improvements in response rate and celebrate where appropriate.		Actions taken to help us work better together: a) **Bullying and Harassment** • 40 Prevention of Bullying and Harassment Champions now work across the Trust. • Rachael Redman is our interim Freedom to Speak up Guardian, available to report concerns and to promote an open and transparent culture. • The new Prevention of Bullying and Harassment page is live on Ourspace, detailing all support and resources available. b) **Adequate materials, supplies and equipment to do my job**. Localities have been encouraged to review such practical considerations with their teams. In addition to this IT improvements had been happening across the Trust including (to date): • The introduction and roll out of Skype for Business; 3146 staff have access so far • Upgrading 98% of PC's and 85% of laptops to Windows 10 • Upgrading 1555 PCs and 417 laptops to date • Local network printers being replaced by new Canon multifunction devices across the organisation c) **Improving communication with senior leaders.** • More staff experience groups, peer forums, and new huddles were started. • The Trustwide Staff Experience Group continues chaired by the Chief Executive. • LiA events continue across the Trust, hosted by the Chief Executive and Executive team. • Link Directors are in place for all localities – this includes one Non-Executive and one Executive Director. • Transformation bulletins are published weekly. • Some localities have started newsletters to share local developments.
				5% Improvement in staff survey questions relating to staff health and wellbeing measures (CQUIN)	Raise awareness of health and wellbeing initiatives and activities	n/a	None until Q4 (Staff Survey results not published until Q4)	Board agreement of wellbeing outcomes, including physical and mental health support for staff.	None until Q4	Not applicable until Q4	* Employee Relations team provides skills development to managers to support improved attendance *Campaign to raise staff awareness of health and wellbeing resources that are available to them.	Employee Relations Team continues to provide skills development to managers.	None until Q4	18% of staff believe that the organisation definitely takes positive action on health and wellbeing (24% in 2017/18)	* Employee Relations team continues to provide skills development to managers to support improved attendance *Continue staff awareness campaign.		A major Trustwide priority for 2019/20. • Wellbeing Crowdfixing event happened in April • Localities encouraged to discuss with their teams way to improve health and wellbeing in their areas e.g. investigating what health and wellbeing looks like to them, what can be done to improve this with e.g. local running groups, Pilates or yoga classes etc. • Currently recruiting for new Health and Wellbeing Lead. • New Occupational Health contract re-tender happening
				Social Media (target to be defined)	A new social media strategy that positions AWP as an employer of choice, a service provider that supports service users and carers, sustainable and positive about the future	Needs a policy that fully supports the strategy and mitigates as much risk as possible		Audit current activty, set objectives, identify tactics, create content plan and agree evaluation		Communications and engagement strategy (incl. social media) developed and being approved through appropriate governance structures	Pilot social media initiatives	Pilot initiatives to commence as part of implementation of Communications and Engagement Strategy		Three year Communications and Engagement Strategy agreed in 2018. Trust's Social Media Policy also written, ratified and on Ourspace.	Roll-out remainder of proposed activity	A Social Media Plan may be developed to support the Communications and Engagement Strategy.		
Principle	**Objective**	**Programmes and Activities to Support Delivery**	**Theme**	**Outcome Measure**	**Process Measure**	**Balance Measure**	**Q1 Milestone Against Outcome Measure**	**Q1 Milestone against Process Measure**	**Q2 Milestone Against Outcome Measure**	**RAG Score and narrative**	**Q2 Milestone against Process Measure**		**Q3 Milestone Against Outcome Measure**	**Q3 Outcomes RAG, score and narrative**	**Q3 Milestone against Process Measure**	**Q3 Process RAG, score and narrative**	**Q4 Outcome measure RAG score and narrative**	**Q4 Process measure RAG score and narrative**	
3. We will be sustainable	We will transform our services to meet increased demand safely and sustainably.	*Implement revised PCLS model *Launch ACUs *Develop and roll out Standard Care & Discharge packages *Trustwide Bed Management service *Implement New Care Models	Clinical / Operational Sustainability Measures	10% reduction in use of inpatient beds	Introduction of "flow rules" throughout the Trust.	The "flow rules" are likely to lead to complaints as patients will not go to the ward of their choice. This is an accepted conseqence. The balance measure is therefore no increase in complaints (outside of convenience / preference) as a result of the new rules.	Evaluate impact of South Gloucestershire pilot on flow.	Evaluate the clinical impact of expanded pilot.	10% reduction in use of inpatient beds	Occupied bed days for reduced by 5% (c. 1500 Occupied Bed Days) against the same period 2017/18. Whilst this reduction is positive, reduction in overall beds has driven c. 50% of the total reduction.	Flow rules in place across the Trust.		Bed Management project that this target derived from has closed.	OBDs during this quarter totalled 41, 894, 1% less than same quarter last year. Bed pressures remain acute and this Outcome has not and will not be achieved.	Centralised bed management service.	New bed management arrangements introduced	Bed capacity exceeded	New flow rules introduced	
				25% reduction in community LoS for "packaged" services for teams included in roll out this year.	All relevant team caseloads to be 'cleansed' using audit tool before roll-out	There are no adverse incidents involving patients removed from caseloads.	Complete training gap analysis	Develop audit tool	25% reduction in community LoS for "packaged" services for teams included in roll out this year.	Audit tool developed and rolled out, however it is not yet clear whether changes to programmes has resulted in a reduction in community LoS.	Test audit tool with pilot teams.	Achieved - pilot completed and roll out of audit tool underway.	25% reduction in community LoS for "packaged" services for teams included in roll out this year.	Unable to establish baseline position to measure change.	Roll out tool.	Audit completed. Project plan in place.	Project not yet in a position to measure change	Caseload audit completed.	

				Out of area use will not exceed 10 commissioned beds	Introduction of "flow rules" throughout the Trust.	The "flow rules" are likely to lead to complaints as patients will not go to the (perhaps private) ward of their choice. This is an accepted conseqence. The balance measure is therefore no increase in complaints (outside of convenience / preference) as a result of the new rules.	Evaluate impact of South Gloucestershire pilot on flow.	Evaluate the clinical impact of expanded pilot.	Out of area use will not exceed 10 commissioned beds	Not achieved. Out of Trust bed use was 16.2 April to Sept 17/18, out of Trust bed use for the same period in 18/19 was 16.6.	Expand pilot across BNSSG.	Achieved - roll out across BNSSG complete (and BSW). Trustwide flow rules agreed.	Out of area use will not exceed 10 commissioned beds	Not achieved.	Agree Trust-wide "flow rules"	New bed management arrangements introduced	OOT numbers exceed this	New flow rules introduced
		*Mgrs action to remain within budget *Delivery of CIP Programme	Financial Sustainability Measures	Planned vs Actual Expenditure	Monthly delivery of budgeted position	Quality of services is not compromised / delivery of key contracted KPIs is maintained	Delivery of budgeted position	Delivery of budgeted position	Delivery of budgeted position	Financial position £1.878m against a budgeted position of £1.888m deficit	Delivery of budgeted position		Delivery of budgeted position	Overall Trust financial position at the end of Q3 was a deficit of £2.253m against revised plan of £2.259m.	Delivery of budgeted position		Overall Trust financial at the end of Q4 was a deficit of £1m against a final plan of £2.635m	The control total was achieved and an additional £1.6m of Provider Sustainability funding brought the final outturn position for the year down to a deficit of £1m. The underlying deficit before PSF was £3.875m.
				Planned vs Actual CIP Delivery	Monthly delivery of CIP Programme	Quality of services is not compromised / delivery of key contracted KPIs is maintained	Delivery of planned CIP £	Delivery of planned CIP £ / Project Progress	Delivery of planned CIP £	CIP delivery on target with delivery of £5.469m however this is only being achieved through including non-recurrent cost savings.	Delivery of planned CIP £ / Project Progress	Slippage on a number of schemes which is being mitigated through a number of non-recurrent means, as well as deploying planning mitigations held in reserce.	Delivery of planned CIP £	Although CIP delivery at th	Delivery of planned CIP £ / Project Progress		Full delivery of the £12.1m efficiency requirement was delivered in year. However, a significant amount (£4.85m) of the savings were non-recurrent in nature.	Grip and control schemes will need to be maintained moving into 19/20 in order to maintain financial control.