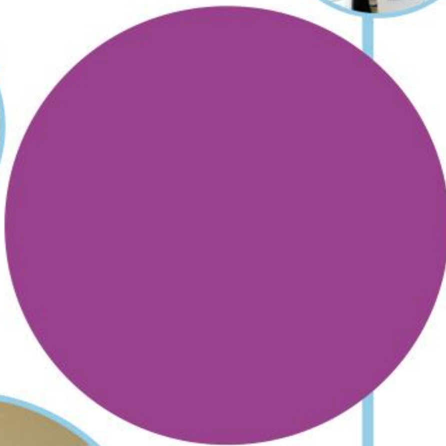
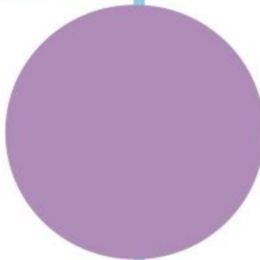
South Staffordshire and Shropshire Healthcare
NHS Foundation Trust





Operational Plan 2016/17

(Year ending 31st March 2017)

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SECTION ONE: Our approach to national drivers and their impacts on activity

National Drivers

Nationally there are a number of challenges within the healthcare system that are externally impacting on how the NHS plans and responds over the next five years. There are three key messages that have been introduced into the healthcare system, these include:

1. That the NHS needs to act urgently to tackle growing financial and operational pressures.
2. The need to press ahead with the NHS five year forward view (Forward View) and the new care models being pioneered by the vanguards. A particular emphasis is given on the need to strengthen primary care and out-of-hospital care, using the opportunities offered by the new voluntary contract announced by the Prime Minister at the Conservative Party Conference. NHS England is bolstering its team through the appointment of Arvind Madan from the Hurley Group in south London to provide leadership on this agenda of £1.1 billion.
3. That the NHS should avoid the distractions of the foundation trust pipeline and mergers and acquisitions and focus instead on using available funding to transform care. This would require organisations working in the same area to come together and bid for funding above their base allocations. Essentially, NHS England would be top slicing the NHS budget for 2016/17 in order to galvanise providers and commissioners to agree local transformation plans. Depending on the detail of how this works, it could represent a major change of direction for how resources are allocated within the NHS.

There are also a number of seminal documents that drive planning, these include:

The NHS Five Year Forward View (NHS5YFV): The NHS five year forward view, published in October 2014 by NHS England, sets out a positive vision for the future based around seven new models of care:

I. Multi-Specialty Community Providers: NHS five year forward view, GP group practices would expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out-of-hospital settings. Over time, these providers might take on delegated responsibility for managing NHS budgets (or combined health and social care).
II. Primary and Acute Care systems: Under this new care model outlined in the NHS five year forward view, primary and acute care systems (PACS) would provide list-based GP and hospital services, together with mental health and community care, in single NHS organisations for the first time. They could evolve in different ways, for example, by hospital trusts opening their own GP surgeries. Under some circumstances, PACS could become accountable for the whole health needs of a registered list of patients. This would resemble the accountable care organisation model that is emerging in the United States and elsewhere.
III. Urgent and emergency care networks: Under this new care model outlined in the NHS five year forward view, the urgent and emergency care system would be simplified to provide better integration between A&E departments and other services that provide and support urgent treatments. Changes include the development of hospital networks with access to specialist centres, new partnership options for smaller hospitals and greater use of pharmacists and out-of-hours GP services. There would be further freedoms for nurses, midwives and ambulance teams, and strengthened clinical triage and advice services to help patients navigate the whole system more successfully.

IV. Acute care collaborations: The NHS five year forward view proposes a new care model for smaller acute hospitals. These may include the formation of 'hospital chains' as operated in Germany and Scandinavia, or some services being offered by specialised providers on satellite sites. To complement these models, NHS England and Monitor will examine new approaches to medical staffing, and other ways for smaller hospitals to achieve sustainable cost structures.
V. Specialist care: The NHS five year forward view outlines that, where there is strong evidence for concentrating care in specialist centres (as in stroke or some cancer services), the NHS in England will seek to drive consolidation through a programme of three-year rolling reviews. The establishment of specialist centres for rare diseases will also be considered to improve the coordination of care for patients. As part of this new care model, specialised providers will be encouraged to develop networks of services over a wider area, integrating different organisations and services around patient need.
VI. Modern maternity services: The NHS five year forward view proposes a new care model for modern maternity services, stating that a review of future models for maternity units will recommend how best to sustain and develop maternity units across the NHS in England. NHS leaders have also pledged to make it easier for groups of midwives to set up their own NHS-funded midwifery services, and to ensure that tariff-based funding supports patient choices.
VII. Enhanced health in care homes: Under this new care model set out in the NHS five year forward view, the NHS will work in partnership with care home providers and local authority social services departments to develop new shared models of care and support, including medical reviews, medication reviews and rehabilitation services. These should build on work being done locally through the Better Care Fund and will draw on models that have been shown to improve quality of life, to reduce hospital bed use and to yield significant cost savings.

Transforming Mental Health

The government's mandate for achieving parity of esteem between physical and mental health has put the spotlight on mental health provision. Meeting the mental health needs of the UK's diverse population poses major challenges. In counties such as Staffordshire and Shropshire additional challenges of rurality also need to be met.

A number of key steps have been identified to support systemic implementation of this vision:

- Developing a process of collaborative commissioning to facilitate change
- Driving change through collective systems leadership
- Ensuring that service users and clinicians are at the core of provision
- Using contracting systems to support integration
- Building a public health approach to mental wellbeing
- Improving the availability of meaningful outcomes data
- Creating a new narrative for mental health

These steps reflect the strengths of individual stakeholder groups but also the importance of working collaboratively and adopting a shared agenda. Commissioners and providers are at the heart of this process, drawing together key organisations around the voice of service users, carers and clinicians in order to deliver improved outcomes.

Mental Health Taskforce Report (March 2015)

The independent Taskforce was set up in March 2015 by NHS England, the body responsible for the delivery of the NHS on behalf of Government. The Taskforce was asked to develop a five year strategy for mental health in England. It was chaired by Paul Farmer,

Mind CEO and the vice-chair was Jacqui Dyer, an expert by experience. The Taskforce comprised health and social care leaders, professional bodies, charities and experts by experience.

The recommendations span the NHS and other relevant cross-government departments, such as the Ministry of Justice and Department of Work and Pensions. To implement these, the Taskforce estimates an additional one billion per year is needed by 2020/21, which the NHS has committed to invest.

Key recommendations include:

- Secure care: better approaches to commissioning so that people do not stay longer than necessary in secure or other restrictive settings.
- Access to high-quality services close to home: ensuring that local community services are immediately available so that people experiencing a mental health crisis do not need to wait. If people need to use hospital services, they should not have to travel out of their area for the right care.
- Co-production: people living with mental illness and carers should be involved in the design and delivery of mental health services.
- Prescribing: new standards for health professionals who prescribe medication to improve the way they involve people in decisions about their treatment.
- Better carer engagement: health professionals should be trained to better involve carers. Services should also have to show evidence that that they effectively engage with carers as part of their inspections.
- Action on physical health: people with mental illness should get enhanced help with their physical health through better screening and lifestyle support.
- Research: calls for a 10 year strategy on mental health research, including details of the funding commitments to make this happen.

Transforming care for people with learning disabilities – Next Steps

The Government and leading organisations across the health and care system are committed to transforming care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services. Some progress has been made but much more needs to be done. Recognising this, NHS England commissioned Sir Stephen Bubb to produce a report on how to accelerate the transformation that people with learning disabilities and their families are looking for.

Following Sir Stephen's report, NHS England, the Department of Health, the Local Government Association, the Association of Directors of Adult Social Care, the Care Quality Commission and Health Education England, are confirming the commitment to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all our organisations.

Sir Stephen Bubb said in his report (Winterbourne View – Time for Change: transforming the commissioning of services for people with learning disabilities and/or autism (2014)):
"People with learning disabilities and/or autism and their families have an array of rights in law or Government policy - through human rights law, the Equalities Act, the NHS constitution, the Mental Health Act, the Care Act, the Mental Capacity Act, the UN Convention on the Rights of Persons with Disabilities, and so on… [but] the lived experience of people with learning disabilities and/or autism and their families is too often very different. Too often they feel powerless, their rights unclear, misunderstood or ignored."

Sir Stephen was supported by a steering group of representatives from the voluntary sector, the NHS and local government, individuals with learning disabilities and/or autism, and family members of people with learning disabilities and/or autism.

Over the course of its work, the group engaged with a range of stakeholders (from people with learning disabilities and/or autism and their families to commissioners, providers and academics).

Sir Stephen's report, published in November 2014, made a number of recommendations to organisations across the health and social care system, summarised below:

- To strengthen the rights of people with learning disabilities and their families
- To improve commissioning
- Closures of inpatient institutions
- Build capacity in community services

Activity and assumptions

Our activity assumptions and returns are underpinned by agreed planning assumptions and are aligned to commissioning intentions. These commissioning intentions form part of the annual contracting rounds which in turn help shape the assumptions within the directorate and divisional business plans.

The operational, contracting and finance teams work closely on gathering and analysing qualitative and quantitative evidence on the delivery of contracts and services on an ongoing basis as part of the routine monitoring. This is formalised through regular contract review meetings with commissioners where trends or changes in demand/capacity and resulting activity are reviewed.

During our planning assumptions the Trust recognised that the following factors applied to mental health and learning disabilities. Although national, these statistics demonstrate changes in provision and trends that are likely to continue into 2016/17. The Trust works closely with commissioners on the local impacts of these changes and will continue to help shape health economy wide STPs to ensure that parity of mental health remains key.

- 1,835,996 people were in contact with mental health and learning disability services at some point in the year. This means that 3,617 people per 100,000 of the population in England accessed mental health and learning disability services (approximately one person in 28).
- 5.7 per cent (103,840) of people in contact with mental health and learning disability services spent time in hospital during 2014/15. This is a decrease compared to 2013/14, when 6.0 per cent (105,270) of people in contact with mental health services spent time in hospital and is a continuation of the trend seen in earlier years.
- The Black or Black British group had the highest proportion of people who had spent time in hospital in the year, which meant that 12.7 people per 100 who were in contact with mental health and learning disability services from this ethnic group spent at least one night in hospital in the year. This is higher than the figure for any of the other ethnic groups and more than doubles the figure for the White ethnic group.
- Approximately one in five people aged 90 and over were in contact with mental health and learning disability services.
- NHS Bury Clinical Commissioning Group (CCG) had the highest standardised access rate to mental health and learning disability services at 9,350 people per 100,000 of the population and NHS South Gloucestershire CCG had the lowest at 2,080.
- Women who spend time in mental health hospitals were more likely to be detained than men. For every 100 female inpatients, there were 41.9 detentions, compared to 38.5 among male inpatients.
- People from the Black or Black British ethnic group were more likely than other ethnic groups to be detained, with 56.9 detentions per 100 inpatients.

Divisional business plans reflect both current and future demand and needs on the service. The Trust uses qualitative data to forecast demand activity and qualitative data on service fit and this is aligned with commissioner intent and feedback from service users and their carers. All of this data is used to evaluate our services. Service line reporting and management is effectively deployed throughout the Trust and an overview is maintained through the Finance and Performance committee.

Our current activity within our core contracts assumptions are stable and we continue to work with our commissioners to understand any areas of change including the new increased access targets around Early Intervention, Improving Access to Psychological Therapies (IAPT) and Child Adolescent Mental Health Services (CAMHS) transformation plans. The Trust has also been successful with a number of contracts that will start 1st April 2016 these activity assumptions are included within our baseline position.

We work in partnership with a number of other providers including the independent sector. We are planning to continue to work as a prime provider to a network of independent providers that support our ability to deliver complex care management such as long stay rehabilitation across our communities. Our plans are sufficient to deliver and achieve our recovery milestones and national targets and operational standards.

The Trust works closely with local commissioners to understand, plan and respond to demands and any seasonality on services on a regular basis. The Trust also, through its Contracting, Operational and Information departments, regularly model against existing and expected capacity and activity of existing contracts and new opportunities. The Trust prides itself on work undertaken prior to committing to the delivery of clinical services or the acquisition of new business by completing assessments or inputs needed against expected activity levels.

These assessments include:

- Quality and safety standards and compliance with regulatory standards
- Contractual compliance against key targets
- Physical capacity to maintain a safe and effective workforce
- Workforce and workforce development
- Information Technology and assistive technology
- Activity and Information requirements
- Physical locality including the estate and the operating environment
- Contractual and reputational risk

This analysis is also used to inform key operational risks and anticipated risks in areas of new business or contracts. The Trust has always demonstrated a positive appetite to risk including its commercial strategy and approach to growth.

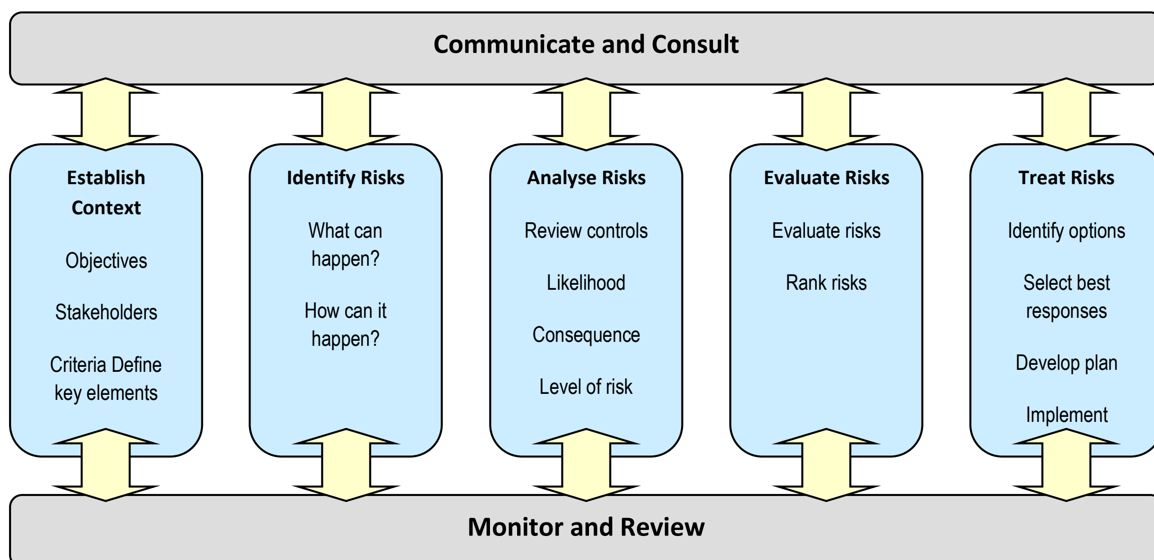
All growth in new business is reviewed on its return and impacts on our ability to continue to deliver in line with the above. The commercial strategy is focussed on our ability to develop new services in areas where we feel that we can make a positive difference and provide a high quality offer. The Trust is also conscious that changes to existing services are needed to continue to improve the service offer and be as efficient as possible. This is done in a number of ways but one area of strength includes our ability to respond to the current economic climate. The Trust is anticipating that there will be on-going pressure on levels of income but believes that changes being worked through based on the LEAN thinking will enable further cost reductions to be made in 2016/17 and the forthcoming years.

SECTION TWO: Our approach to quality planning

The quality standards for patient services as set out in the NHS Constitution and in the fundamental standards of quality and safety published by the Care Quality Commission (CQC) provide the framework by which the Trust defines its quality priorities and goals. Each year within the Quality Accounts we set out our quality priorities ensuring that we maintain a balanced focus on patient safety, clinical effectiveness and patient experience.

Our priorities are chosen following a process of review, consultation with key stakeholders, assessing the needs of the local population, and through listening to the views of service users and carers. In addition our quality improvement goals also consider both national and local commissioning priorities and recommendations from key national and local reviews.

Underpinning our annual improvement goals is the Trust's Quality Framework. The framework supports the delivery of the Trust Strategic Aim "Provide high quality recovery focused services". Any key risks that may have an impact on the delivery of our quality goals are detailed within the Board Assurance Framework. The process for the management of these risks is laid out within the Risk Strategy as summarised in the figure below.



The Trust is registered with the CQC. We fully meet the requirements of the CQC framework for clinical quality. The Trust is due to be been visited by the CQC under the new inspection regime in March 2016. However, their most recently published Intelligent Monitoring Report has indicated a rating of green (low risk).

Approach to quality improvement

Our Quality Improvement priorities for 2016/17 are chosen following a review of our current services, consulting with our key stakeholders and feedback from our Quality Improvement (QI) approach that utilises the Virginia Mason Production System[1] (VMPS). Our QI framework is aligned to our values and strategic direction. It explicitly puts staff, service users and carers at the heart of the system, ensuring that task and process redesign are critically analysed so that changes really can focus on measurable improvements. It allows

[1] https://www.virginiamason.org/VMPS

the different skills of all staff to be maximised in an organisation that believes that any task or existing form and function can be improved and should be challenged.

A large proportion of our QI work is in delivering Rapid Process Improvement Workshops (RPIWs) and in delivering these with teams where opportunities for improving services have been identified within directorate business plans. Our QI team provides resources, bespoke training, tools and the knowledge to enable teams to expedite changes to add value and remove waste, thereby creating capacity to provide a high-quality, recovery-focused environment for our service users.

Our long term aim is that decisions and responsibilities for improvement are handed to those best equipped for the task – the staff themselves. Key to the Virginia Mason Approach is the development of our Staff Charter which is an agreement between staff and the Trust on how we will ensure quality is central to service delivery. Staff need to believe that they will be authorised to make changes and it needs to be clear that senior staff will take a clearly structured and actively facilitative role to enable them to do so, breaking down any corporate barriers to change. Our Charter, highlighting five key behaviours (below) needed to demonstrate we live our values[2], was launched in 2014.

Our priorities are linked to the three quality domains of quality; safety, clinical effectiveness and service user experience, and are also aligned to the Commissioning for Quality and Innovation (CQUIN) scheme as agreed with our commissioners.

Consultation regarding the 2016/17 priorities is still to be finalised as the national CQUIN requirements for 2016/17 have yet to be published. These finalised goals will be published within the Trust's 2015/16 Quality Accounts.

Our approach to risk

The Trust promotes and deploys a positive risk culture. This encourages its employees to consistently use its risk management policies, Assurance Plan and Risk Register. These identify and control risks which may adversely affect the Trust's operational ability to meet its principle objectives and where possible, eliminate or transfer risks or reduce them to an acceptable and cost effective level.

The Trust Board has identified five strategic risks that are monitored and reviewed by a lead Executive Director and the appropriate Trust Board committee. Additionally these strategic risks are also reviewed by the Trust Board and Audit Committee. The five strategic risks are detailed below:

[2] http://www.sssft.nhs.uk/images/LOV/LivingOurValuesCharterA4.pdf

Risk No	Principal Risk	Key Controls
E18	The tightened economic environment has the potential to affect our ability to remain competitive when local economies require greater efficiencies	Competitive tendering processes in place that are monitored through Business Development & Investment Sub-Committee
E19	Reform and structural changes to the NHS creates a changing systems and political environment which creates the risk of not being able to effectively plan strategically with our partners over a longer period of time	Engagement in national forums such as Chief Executives and Monitor and Horizon scanning at Trust Board
E20	Increase in local and national competition, including a significant change in commissioning processes and scoring affects our ability to pursue new contracts	Co-ordinated robust approach to competitive tendering
P10	The increase in regulation and focus on quality and information may lead to a number of risks should controls not be in place and maintained. These include risks to: • Public confidence • Enforcement and legal actions • Our license • Reputation with commissioners	• Must do manual & Standard Operating Procedures in place • Training and awareness raising sessions in relation to requirements • Trust level governance process to ensure compliance with CQC registration regulations • Horizon scanning, networking and benchmarking • Trust and divisional governance structure and processes
R16	Failure to maintain and improve the morale of the Trust workforce. The risks include: • Increased sickness / Reduced productivity • Increased turnover / Challenges in recruiting	• Monthly HR Reports • Vacancy rates

Sign up to Safety priorities for 2016/17

The Trust Board has formally signed up to the five safety pledges. These pledges were reviewed in January 2016 by the Trust's Quality Governance Committee. The Trust will continue to strive towards the provision of harm free care by delivering on our action plan against the following priorities:

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. We will:
    - Publish our Safety Dashboard monthly on our website.
    - In consultation with stakeholders we will specifically (but not solely) focus on three indicators identified within our Quality Accounts.
    - Adopt the Medication Safety Thermometer in specific clinical areas to identify areas for focussed improvement.
    - Further reduce the impact of falls.
    - Build practice improvements in our services using RPIWs and Kaizen improvement events.
    - Using the Safety Thermometer maintain our "harm-free care" above 95%
    - Review the ways in which we engage with our service users.

2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from service users and carers and by constantly measuring and monitoring how safe our services are. We will:
   - Participate in patient safety research in conjunction with our research and development network.
   - Embed best practice in learning lessons from patient safety incidents.
   - Publish a regular learning lessons bulletin and make it available to all our staff.
   - Use feedback from our service users and carers to continually develop and improve services, using a range of sources including the Meridian patient experience real-time feedback tool, feedback and learning from PALS and complaints and the Service User and Carer Committee and its directorate and divisional sub groups.
   - Continue to review our incidents identifying recurring themes and share the learning through Thematic Reviews.
   - Share and spread the learning from improvement events via briefings, e-bulletins and websites.

3. **Honesty.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will:
   - Ensure Duty of Candour is effectively implemented.
   - Continue to develop the use of Patient Stories at Trust Board and throughout the organisation.
   - Share the findings of our serious incident investigations with our service users, their families and our commissioners.
   - Actively involve our commissioners and member governors in our regular service reviews.
   - Involve service users, carers and partners in improvement events, sharing with them the observations and data gathered from services looking to improve.

4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will:
   - Collaborate with Clinical Commissioning Groups (CCGs) to identified shared learning opportunities across the health economy (ie the collaborative learning forums)
   - Continue to engage with our local communities through groups such as Healthwatch and Overview and Scrutiny Committees to review the quality of our services
   - Work with our partners in primary care and other secondary care services to reduce harm.

5. **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. We will
   - Train our staff to ensure they are equipped to identify and manage risks.
   - Support staff to review incidents when they occur and look for ways to prevent re-occurrence.
   - Provide support to our staff to implement best practice in reducing incidents of absconding.
   - Support our staff to implement best practice in reducing harm from falls.
   - Provide our staff with training, resources, tools and support to undertake RPIWs and Kaizen events, and to sustain the improvements from such events in the long term.

Our Medical Director is the lead officer for the assurance required within the Association of Medical Royal Colleges' guidance on the responsible consultant. The Trust can confirm that this has been fully taken into account. We are also conscious of the need to work closely with commissioners on deploying seven day services including a primary focus on their need to increase the level of consultant cover and diagnostic services available in hospitals at weekends and improving access to out-of-hours care, by achieving better integration and redesign of 111/walk-in clinics/urgent care to enhance the patient offer. Progress towards the delivery of the above will be included within the economy Sustainability & Transformation Plan (STP) and organisational plans.

Quality impact assessment process (QIA)

The Trust has a well embedded QIA process and tool for identifying Cost Improvement Programme (CIP) schemes and assessing for their impact on patient safety, clinical outcomes and patient experience.

If the QIA tool is required to be completed for a scheme, then that proposal and associated QIA will also be subject to a Challenge Session. All schemes subject to this process are approved by the Director of Quality and Clinical Performance, the Medical Director and Director of Nursing/Chief Operating Officer.

Divisions are required to regularly monitor the impact of the schemes on quality and safety of care through collecting and reviewing the performance of these agreed measures at appropriate management meetings. If a scheme is identified as having an adverse risk to the quality and safety of care, then specific measures for monitoring the potential impact of a scheme should be identified and documented as part of the QIA process.

Triangulation of indicators

Twice a year, the Trust undertakes a series of performance reviews where by all directorates including some corporate areas are assessed and challenged against the Trust 'Must Do' areas and any other appropriate crosscutting issues. This includes triangulation of quality / risk, financial and workforce and key performance indicators. Performance reviews provide the Board with assurance that there is evidence that everything we are required to do, and have set ourselves as key objectives are being done. These reviews are carried out in June and December each year to tie in with evidence considered in relation to year end accounting and business planning processes.

SECTION THREE: Our approach to workforce planning

The Trust has an agreed workforce strategy that is aligned to the Trust's strategy. The Annual Workforce Plans are embedded in the directorate and divisional business plans and support our workforce returns.

The Trust has a robust approach to workforce planning with significant clinical engagement at all levels. All workforce planning activity at service and team level is carried out in conjunction with clinicians, which enables the teams to challenge and explore innovative ways to plan ahead. The approach being deployed at present is workforce planning through patient pathway mapping. This enables the teams to develop workforce models based on the patient journey and their feedback and identifying the appropriate skill mix to deliver the service model.

The workforce plans are built at operational level and then tested and shared through our Joint Staff Partnership with the Trade Unions and the directorate and divisional teams. These are then formally signed off through the Trust's governance processes, including Board approval. This annual workforce planning cycle includes sign off by the Chief Executive, Director of Nursing and Medical Director, prior to submission to Health Education England (West Midlands). The Plan is also subject to the Trust's ratification process through various committees.

In developing the Annual Workforce Plan, various stakeholders are engaged in the process in order to ensure a clear link to clinical strategy and local health and care system commissioning strategies. The plan takes into account the strategic and clinical direction of services and the plan is aligned to directorate business plans. These plans are then aligned to the team objectives and our priorities.

A key element of the assurance process of the workforce plan is identifying commissioning intentions and ensuring these are reflected within the plan. Face to face meetings are in place with lead commissioners to ensure that relevant commissioning intentions and strategic direction are embedded within the plan, which in turn leads to an assurance statement by commissioners. The Trust has gained full assurance through this process from commissioners and is the only Mental Health / Learning Disabilities Trust within the West Midlands to do so for the past two years.

We have aligned our workforce planning with that of our partners and will continue to work through development plans and the sustainability transformation plans to ensure longer term alignment. Our plans are mapped against staff and demand profiles outlined through patient need, commissioning intentions and contract monitors. We will continue to reduce our vacancy rates and the use of bank and agency by utilising our Nurse Bank.

We will continue to redesign our workforce, looking to develop new roles, broaden skills and competencies, as well as providing development opportunities. We are keen to promote Mental Health and Learning Disabilities as an excellent sector to work as well demonstrating with our partners that Staffordshire as a health economy has a lot of opportunities. We have been successful in our commitment to involve service user and carers in workforce development and recruitment.

We are also keen to explore new workforce opportunities to grow new roles and also provide opportunities through talent management. Some examples of this include:

- A real commitment to the employment of apprenticeships - with over 80 apprentices currently working within the sector.
- A real commitment to learning and development, from vocational places through to degree level opportunities.
- A real commitment to developing staff and living our values so that the organisation is a good place to work.
- A real commitment to the continued development of unique relationships with Universities including those overseas – e.g. the introduction of Physician Assistants into Psychiatry with a New York College (Wagner), Honorary contracts with the Military and the development of recovery colleges.

The Trust is actively involved in an economy workforce transformation programme that includes productivity schemes, leadership development and new ways to attract and retain staff. The development of STPs will also support joint planning for any new workforce initiatives, agreed with partners and funded specifically for 2016/17 as part of the Five Year Forward View. Any economy wide remodelling within clinical services that form part of these programmes will be integrated into our internal business plans and ensure the involvement of clinicians as well as corporate support services.

A key element of this programme of transformation is the development of a new model of care underpinned by re-developed patient pathways. The next phase of this programme is the development of the workforce plan and the skill mix within teams to align patient need with staffing requirements. The full impact on the workforce by staff group is to be determined; however, it is anticipated that there will be an increase in the deployment of new roles such as assistant and advanced practice. It is also likely that there will be training needs identified to deliver more generic roles and skills within existing staff groups.

The Trust also ensures that it effectively uses e-rostering. This has been effectively deployed and the monthly safe staffing metrics are analysed through the triangulation of quality and safety metrics with workforce indicators to identify areas of risk. This is reported monthly through our governance structures both internally to senior management and externally to commissioners. Action plans are developed to minimise any impact on safe staffing levels and these are monitored through Ward Managers' meetings. Six monthly establishment reviews are also undertaken. The safe staffing tool is also being deployed across community teams during the year.

The Trust has developed a range of recruitment and retention projects including an in-house nurse bank which has impacted positively with a reduction in the reliance and usage of agency staff. The Trust will continue to look at innovative ways to reduce spend in this area whilst ensuring that the quality of the workforce is improved. This is demonstrated within our workforce plan and supporting schedules which outline a number of realistic developments and redesign programmes leading to a reduction in spend on bank and agency and a greater utilisation of the substantive workforce. This will support us in effectively reporting and tackling any challenge of performance during the year.

The Trust is engaged with the Local Education and Training Board (LETB) workforce planning process and submits an Annual Workforce Plan that identifies the likely future supply requirements by professional group. The Trust is represented at Local Education and Training Council (LETC) meetings where supply issues are debated and education commissions agreed.

A robust process on the application and monitoring of quality impact assessments for all workforce CIPs. This has been implemented during previous financial years – including the completion of a 'Quality Impact Assessment Tool' and the introduction of the Quality Impact 'CIP Challenge Events'.

The Clinical Performance Development Team (with the involvement of three executive directors: the Chief Operating Officer/Director of Nursing; the Medical Director and the Director of Quality and Clinical Performance) have developed a process with regards to the arrangements for assessing, recording and monitoring risk(s) to quality posed by saving schemes (CIPs / QIPPs). This includes the criteria for deciding when the full QIA should be followed.

The quality impact assessment process is overseen by the Quality Governance Committee during the stages of planning, implementation and post implementation.

The Trust is acutely aware of the need to balance the new agency rules with the achievement of appropriate staffing levels. The Trust is currently working with agencies and frameworks to ensure agency/locum staff are procured under the cap rates from 1st April 2016.

The Trust has an established a Medacs mastervend arrangement for nursing staff that will ensure compliance with agency rules post April 2016. Work with medical supply agencies, via the framework, is underway and assurance has been received that the new rules will be complied with.

The Trust has robust systems in place to regularly review and address workforce risk areas. Areas of risk are reported monthly through the Trust Assurance Report to Trust Board. In addition, any areas of risk are highlighted through the Trust's Risk Register which is reviewed regularly. This is reported and managed through the Trust's governance and committee structures. Examples of previous risks that have been addressed include:

- Middle grade medic shortage – vacant posts converted to consultant level posts to ensure sufficient medical cover.
- Junior doctor rota cover and a large number of less than full time trainees – a locum hospital doctor post developed at St. George's and Redwoods sites to ensure cover across inpatient services.
- Band 5 nursing vacancies – alternative posts developed and created within establishments to ensure clinical cover, e.g. OT and Assistant Psychologist posts created as part of a skill mix review.

The Trust reviews the total staffing requirements (Full time equivalent staffing levels and skills mix) on a quarterly basis. The review includes strategic planning teams and the clinical and service-level staff. This is managed through a Project Management framework. An overview of all workforce requirements is regularly reported through Board and committees. Where large scale projects are required and capacity may be a risk, the Trust has a number of preferred partners with a proven track record of delivery. The Trust always ensures that projects of this scale report into the Trust Board and through an appropriate executive officer.

SECTION FOUR: Our approach to the emerging 'Sustainability and Transformation Plan' (STP)

The Trust's Strategy will align to the economy that we operate within and populations that we serve. Our priorities will focus on the Trust's contribution to the local health and well-being gap, the transformation agenda and working to address the finance and efficiency gap. The Trust is conscious that the prevention agenda requires a radical upgrade and is working with commissioners to ensure that the mental health and learning disabilities agenda retains strategic parity. The Trust is committed to improving mental health in line with the forthcoming taskforce report to ensure measurable progress towards parity of esteem.

The Trust is also committed to ensuring that people with a learning disability are also represented with parity within transformation plans. The Trust has excellent experience of working locally to ensure people are supported at home rather than in hospital.

Our planning assumptions contained within this plan and the supporting documents will form the first year of our five year strategy. This strategy will mirror the STP process. The Trust participates within three footprints; two "local" and one regional and national.

Footprint one: Staffordshire and Stoke-on-Trent

- Stafford and Surround CCG
- Cannock Chase CCG
- East Staffordshire CCG
- South East Staffordshire CCG
- Stoke on Trent CCG
- North Staffordshire CCG
- University Hospital North Midlands NHS Trust
- Burton Hospital NHS Foundation Trust
- Staffordshire & Stoke on Trent Partnership Trust
- Combined Healthcare NHS Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Stoke on Trent City Council / Staffordshire County Council

Footprint two: Shropshire and Telford and Wrekin Health and Social Care Economy

- Shropshire CCG / Telford and Wrekin CCG
- Shrewsbury and Telford Hospitals NHS Trust
- Shropshire Community Hospitals NHS Trust
- Robert Jones and Agnes Hunt NHS Foundation Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Shropshire County Council / Telford and Wrekin Council

Footprint three: Regional & National

These services include our more specialist services, some of which are national. These services include prisons, eating disorders, Ministry of Defence work and perinatal services. A number of these services have mixed commissioning from "local" commissioners and specialist services commissioning.

Transformation Programmes

Both of our local economies have plans in place to address the transformation agenda.

The Staffordshire and Stoke on Trent plan, called "Together We're Better" is bringing together all of the local providers included within its planning footprint, to address quality and efficiency gains required. The Trust is fully participating in this programme and represented at both operational and strategic level.

Shropshire and Telford and Wrekin have two programmes "Future Fit" (acute care modernisation) and "Community Fit" (community modernisation). The two plans are linked and are aimed at supporting a significant shift from the acute sector to enhanced community provision. The Trust is fully participating in this programme and leading on the Mental Health work streams.

Early thinking is that the work already undertaken within the Future Fit programme will underpin the development of the STP. It is key the next steps include the incorporation of the other pieces of work which are at different stages of development. In effect the STP will become an umbrella plan for the several pieces of work:

- Future Fit
- Community Future Fit
- Deficit Reduction Pan
- Primary Care Strategy
- Developing Rural Urgent Care services

This economy will produce one STP with the other pieces of work all feeding into it; Shropshire and Telford and Wrekin have stated that they do not want to lose the Future Fit work or the name, because it is recognised locally. Both of these programmes have timescales that are leading discussions around planned changes in planning assumptions. The two programmes are primarily acute care focussed; however, the Trust is aware that its involvement is key in shaping the local strategy for its local populations. Early strategic thinking includes a review of Psychiatric Intensive Care (PICU) capacity, Low Secure and Child and Adolescent Mental Health Services demand and provision. The Trust is not expecting any major change for 2016/17 to core services but will ensure that the following national drivers are incorporated within our strategy.

- Ensuring that mental health and learning disability retain parity of esteem
- The continued embedding of an open, learning and safety cultures
- The deployment of all quality standards and greater access to services
- The implementation of children and young people mental health strategies
- The implementation of local digital roadmaps
- The implementation of Multi-Specialism Community provider and Primary and Acute Care Systems including sustainable general practice solutions
- The transformation of urgent and emergency care
- The transformation of prevention programmes
- The implementation of combinatorial innovation
- Plans to reduce costs, improved demand growth and increased efficiency

SECTION FIVE: Our membership and elections

In 2015, the Trust held elections for 10 public/service user/carer and one staff governor seats, using both postal voting and online voting. All public/service user/carer seats were contested and all seats were filled. Regular communications were made with members in the months preceding the elections to generate interest. One to one and group meetings with the Company Secretary, Chair and Non-Executive Directors were offered to potential governors to initiate engagement and to ensure that potential candidates fully understand the role, its responsibilities and accountabilities.

In 2016, the Trust will commence elections for public/service user/carer and staff seats. The election campaign will commence late spring. A particular emphasis will be the use of social media to improve engagement with a wider audience, alongside written communications, invitations to Council of Governors' meetings, events, workshops and specifically designed "potential governor" workshops and meetings.

At present, governor recruitment is mainly focussed on: current membership, volunteers, current governor recommendations and engagement with members and the public and our service users and carers. At the point of being elected, governors are offered a comprehensive induction in addition to attending the Trust Induction. All governors are invited to be part of the internal governor development programme, where development sessions are held on a monthly basis. These development sessions are aligned to governors' statutory duties, in addition to any subjects which will assist in governors carrying out their role. The Trust also facilitates joint meetings/development sessions between governors and the Trust Board. Governors are also encouraged to attend external development opportunities such as those provided by NHS Providers.

The purpose of The Membership Strategy is to demonstrate how the Trust plans to grow and retain its membership base; but more importantly to plan and evidence meaningful engagement with a diverse range of members. At the heart of our approach is the need for the Trust to embrace its membership and focus on qualitative rather than quantitative membership levels and engagement. It outlines the approach that the Trust will take to ensure a coherent and consistent approach is taken with the vision and objectives of the Trust in the governance of the organisation.

The Trust and its Council of Governors regularly attend public and community events throughout the year within our different communities. Governors are also encouraged to facilitate constituency meetings (open public meetings) with local communities which have proved to be a successful method of engagement. Governors also attend events at local schools and other educational establishments to engage with the younger people within our communities. The Trust also encourages members and members of the public to attend Trust events such as the Annual Members Meeting, Annual General Meeting, Board Meetings, Council of Governors Meetings and other events such as a Service User and Carer Celebration Day.

These engagement activities are planned to continue with additional events in collaboration with our partners, service users and carers and governor members.