Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Operational Plan 2017-19

For Publication

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1. Introduction

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care serving a culturally and socially diverse population of 1.3 million people spread over 172 square miles. We are one of the largest mental health foundation trusts. We provide specialised services for people. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings and unemployment.

This is an exciting time for our Trust as we are at the forefront of developing new partnerships and alliances to improve quality and consistency of care across organisational and geographical boundaries. We are refreshing our Trust strategy to make sure our ambitions and priorities are focussed in the right place.

With our three partner mental health trusts in the Black Country, Dudley and Walsall, and Coventry and Warwickshire, we were successful in becoming one of the 50 'vanguards' that are developing new care models. Our unique Mental Health Alliance for Excellence, Resilience, Innovation and Training (**MERIT**) is focussing on improving the consistency and efficiency of crisis care and reducing risk across our populations, promoting a recovery culture, developing a more flexible workforce and enabling better sharing of information across our organisations.

We are involved in the Solihull Emergency and Urgent Care and Care Connected Now vanguards.

Our '**Reach Out'** partnership with South Staffordshire and Shropshire Healthcare NHS Foundation Trust and St Andrew's Healthcare is one of four bids to pilot the management of tertiary budgets for secure adult mental health services and develop a new and innovative model of care. Our accountable care partnership will be responsible for system management and commissioning decisions for West Midlands service users from 1 April 2017. Our clinical model will introduce a more personalised intensive outreach service and provide comprehensive and responsive support in the community. This will focus on aiding recovery, enabling earlier discharge, reducing the likelihood of readmission to hospital; allowing care to be provided in the least restrictive setting as close to home as possible. As well as clinical care, the new service will enhance practical support such as accommodation, community activities, social networks and employment advice with a range of effective use partnerships. Also in relation to management of tertiary care budgets we are working with Birmingham Children's Hospital to develop a model for **Tier 4 CAMHS** and expect to submit a bid for the next wave of applications in 2017.

Partnership working is also at the heart of the development of our **'New Dawn'** model of care, which is enabling our services to be completely transformed and based on needs and values, with recovery and service user experience at their heart. The model will ensure that we not only meet the clinical needs of those who use our services, but also work in partnership to help them with their recovery and wellbeing in the wider community, including support for physical health needs and social issues such as employment and housing. Implementation will be completed during 2017/18.

In January 2016 our pioneering **RAIDplus** initiative was named an NHS 'Test Bed'. This innovative partnership will provide service users and clinicians with digital tools to support the management of conditions in the community and identify early warning signs of mental health crisis.

We have aspirations to be a paperless organisation by 2020 and this aligns to our Paperless Strategy that has just been approved for development of a full Electronic Document management system and our invitation to submit an application to NHS England in January 2017 to become a Mental Health Digital Exemplar.

This plan covers the two year period from 2017-2019, however we face a number of longer term challenges that we will need to address to ensure clinical and financial sustainability in the future. These include the cost of some of our PFI buildings and suitability of some of the environments, Birmingham City Council funding pressures and in particular reduction of social workers, risks to our critical mass linked to part to our savings requirements, and risks to our capacity to deliver the Mental Health Five Year Forward View due to unconfirmed STP mental health funding.

2. Sustainability and Transformation Plans (STPs)

Our organisation is in the Birmingham and Solihull STP footprint. We also provide services in West Birmingham which is in the Black Country STP. There has been little cross working between the STPs to ensure consistency. This section describes the Birmingham and Solihull STP.

We have a population that is changing and facing a number of challenges: nearly half live in some of the poorest areas of the country, people are more likely to have a mental health problem and the population is becoming more diverse. If we do not change anything in the way we deliver care we will have a system financial gap of £721m in five years. Our STP has three strategic objectives, each of which has a number of areas of work underneath them. A mapping exercise is establishing how mental health fits into each work theme and the consequent implications for our organisation.

Strategic objective	How this fits with our Operational Plan
Creating efficient organisations and infrastructure	We have provided information about our infrastructure to the STP for discussion. Our Estates strategy contains a programme of rationalisation to make sure we are making the best use of our buildings and estates. We have carried out benchmarking of our corporate services and corporate services are part of CIPs.
Transformed primary, social and community care "Community Care First" (CCF)	The CCF ambition is to deliver primary care at scale which should enhance our ability to concentrate on the provision of specialist mental health care. We are represented on the Programme Board to ensure mental health is embedded in the work plan.
Fit for future secondary and tertiary services	This is the main objective that will impact us. One of the system programmes to deliver this objective is 'Mental Health', described in more detail below

Mental Health Programme – the main focus for mental health is on ensuring care is provided in the least restrictive setting to ensure that capacity is better aligned to resources. This will be enabled by the following areas of work:

- ***System capacity modelling:*** this has been independently procured and will be completed by April 2017; commissioners will see where investment on mental health services needs to be concentrated and where additional investment is needed.
- ***MERIT shared bed management function for 18+ years:*** as well as improving the utilisation of bed capacity across the MERIT partnership, this will enable us to answer some of the questions that the system capacity modelling exercise will produce.
- ***Reach Out*** accountable care partnership for low and medium secure services
- ***Alternatives to admission for children and young people ****
- ***Review of complex care packages for children and young people ****
- ***Reviewing and improving systems of care*:*** areas of focus are personality disorder, complex trauma, neurodevelopmental conditions and eating disorders.

***** These are being scoped and once completed we will work through the implications for our services and our partnership working with Forward Thinking Birmingham who deliver children's and young people's services in Birmingham.

We have had MERIT funding of £1.75m confirmed for 2017/18 and this is built into our financial plan. We have not built into any activity, finance or workforce assumptions for Reach Out. We have submitted a business case for Reach Out to NHS England but we still need substantial due diligence over the financial budget transferring, quality of data and contractual arrangements and our plans will be amended as these develop.

There is an underpinning principle in our STP that a recovery focus will reduce reliance on the health and care system therefore a second transformational area will involve embedding recovery, employment and training. One focus for us will be on the developing relationships with an accredited Individual Placement Scheme (IPS).

The STP has an ambition to improve the management of long term conditions and it is crucial that mental health is part of these plans so that we can manage demand.

3. Activity planning

3.1 Capacity and demand – as part of our New Dawn work, modelling was carried out of our inpatient/community capacity and this informs our activity. Services have been planned to meet expected demand at agreed levels of bed occupancy in accordance with the agreed models of care developed alongside commissioners. In 2016/17 we have piloted the use of the Clinical Utilisation Review tool to track demand for our beds and test for appropriateness of placements and this will be rolled out across further in 2017/18.

One of the MERIT goals is to implement a shared bed management function across trusts to give us enhanced responsiveness over how we manage our bed resources and flexibility of how we deal with risk and need. This is expected to reduce out of area and in particular long distance placements, as well as have a positive impact on A&E breaches due to shortage of beds. We have developed a draft bed management policy but this is not yet agreed by all four organisations which is a key milestone to meeting this objective.

We have a continued focus on understanding Delayed Transfers of Care and these are monitored at a weekly Executive led performance meeting. Particular pressure areas for us are our older adult beds due to factors including lack of social care, lack of suitable nursing/residential placements and funding issues.

We currently have Rapid Assessment, Intervention and Discharge (RAID) services operating in all of the acute hospitals in Birmingham and Solihull. These are contracted by a combination of the acute trusts and the local CCGs. Acute trust colleagues may not be in a position to continue funding this. Stopping or reducing the service will place increased demand on the system, both on acute and mental health services and this represents a significant risk.

3.2 Waiting times – we are working to implement Referral to Treatment for mental health outlined in the Five Year Forward View before they come into effect. In 2017/18 our focus will be on community eating disorder services, psychological therapies for common mental health disorders (IAPT) and early intervention in psychosis and we are currently developing clinical, operational and reporting plans for these pathways. We are also engaging with NHS Improvement and NHS England about the definitions, particularly for the psychosis target.

3.3 Contracts – we have agreed all of our contracts with local CCGs and NHS England with no outstanding issues impacting on our plan. It has been agreed to review capacity and need for our Non Acute Inpatients services over the next three months which may result in an income variation to contract. We are pleased that our Birmingham commissioners have made a commitment in our contract to achieving parity of esteem for mental health. They have confirmed that funding streams for mental health investment will potentially be available to support reports of rising levels of acuity in community and inpatients and will work with us to understand the drivers and impact in clinical teams. The system capacity modelling referred to in section 2 will analyse caseload numbers, increases in demand and compliance with standards set out in the Five Year Forward View and the West Midlands Mental Health Commission priorities to consider balance of investment across commissioners.

4. Quality planning

4.1 Approach to quality governance – We have a clear, well recognised governance system from the frontline to Board. Each service area has a Clinical Governance Group chaired by a Clinical Director and attended by a range of key multi-professional representatives. Meetings include review of incidents, serious incidents, complaints, clinical audit outcomes, patient experience feedback and risk registers. There is a focus on lessons learnt and triangulation of issues arising from these meetings. These groups report to the Trustwide Clinical Governance Committee (CGC), chaired by the Director of Nursing; Clinical Directors participate in discussions about Trustwide issues and escalate service risks/positive performance. Sub-committees report into the CGC, including Safeguarding, Infection Control, Clinical Risk Management and Physical Health. The CGC reports to our Board's Integrated Quality Committee (IQC); which oversees quality, safety, effectiveness and experience. A monthly report assures the IQC of key issues and agree resolutions. Our Director of Nursing and Medical Director have executive accountability for quality and safety outcomes, advising the Board on the progress of quality improvement goals, effectiveness of improvement plans and risks to safety and quality. A monthly report on the performance of our quality improvement goals is presented to the public Trust Board.

Our governance approach includes assurance that the Association of Medical Royal Colleges' guidance on the responsible consultant has been taken into account and implemented in the organisation. Clinical leadership is provided across services via the relevant Clinical Director who has responsibility for:

- Ensuring a patient's entire stay in hospital is coordinated
- Ensuring that every patient and those close to them know who has overall responsibility for their care
- Ensuring that responsibility is transferred to another consultant or clinician when appropriate

Our latest CQC rating was good and we have no CQC concerns or enforcement notices. We continue to build upon our rating, and are working with our MERIT partners to implement a robust programme of compliance reviews and methodology for mock CQC inspections across our services, ensuring that best practice is shared and enabling greater learning, insight, experience and objectivity in high quality safe care and areas for improvement. We will work together to develop a pool of expert investigating officers who can be deployed across our organisations to provide objectivity and subject matter expertise in serious incident investigations. Our clinical quality team are undertaking a gap analysis taking us from good to outstanding; action plans will be integrated into our business plans. We have received notification of a CQC inspection in March 2017.

During 2017/18, we will continue to develop our culture of openness, learning and safety, through the delivery of a range of learning events arising from integrated governance intelligence. Our innovative approach uses multiple engagement mechanisms to improve capability and build capacity for ongoing quality improvement and change. This includes:

- Lessons learnt lunches, podcasts and bulletins
- Bi-annual quality and safety debates
- Continuous quality improvement plans for each site
- Service user stories
- Quality goal campaigns
- Subject Matter Expert training for delivering regulatory outcomes
- Quality impact assessments
- Thematic reviews to drill down into the root causes of sub-optimal quality outcome

We are learning from Human Factors Analysis to support our investigation methodology in areas such as mortality and serious incidents. In 2017/18 we will be implementing a patient safety culture tool to further determine improvements.

We will promote the role of the Freedom to Speak Up Guardian throughout the Trust and ensure that this individual is visible and accessible to our colleagues. We will include Freedom to Speak Up within our core induction programme and proactively remind staff of their ability to access this as one of many opportunities to speak up safely.

Key quality risks:

Risk	**Mitigations**
Demand outweighing capacity for inpatient beds	Through New Dawn we have developed demand and capacity plans which cross reference with our estates and workforce plans and commissioning intentions; the STP modelling will also inform future plans and investment; MERIT working on shared bed management.
Failure to recruit to establishment levels, resulting in high use of agency staffing across both the medical and nursing workforce	Medical, psychology and nursing workforce plans; recruitment initiatives through MERIT
Recent CQC report highlighted inconsistency of reporting and investigations of deaths across the NHS. Whilst we have made good strides in this area there is some learning for the Trust	Establishment of the Mortality Surveillance Group; Mortality Masterclass planned for February 2017 to train clinicians in mortality case note review

4.2 Approach to quality improvement – During 2017/18 we will continue to focus on creating safe, high quality services for our service users and carers through our quality goals:

Experience and effectiveness

- We have a recovery focus in everything that we do and service users are fully engaged in the plan for their care and recovery and have opportunities to participate in the wider Trust and community
- Families and carers have a positive experience and feel involved in and supported by our services
- We are a leader in implementing and embedding new models of care, such as New Dawn, MERIT, Reach Out and RAIDplus, ensuring that the right services are provided in the right place at the right time for our service users
- 50% of people experiencing first episode psychosis have access to treatment within two weeks

- 75% of people with relevant conditions access talking therapies within six weeks and 95% within eighteen weeks
- We work jointly with commissioners, local authorities and the third sector to make sustainable improvements in the number of delayed transfers of care and out of area placements
- Our service users get the help and advice they need about their physical health
- We have a clear plan to reduce inequalities of access and outcomes for service users from protected groups underpinned by robust measurement
- We embed a culture of research and innovation to help staff work to best practice using the latest evidence and ensure service users are given the opportunity to participate in high quality research

Safety

- Our service users have reduced mortality through coproduced crisis plans and learning from reviews, and we have reduced the number of suicides
- We have implemented our Positive and Proactive Care Strategy and have an environment that is as safe as possible for everyone with reduced incidents of restraint, seclusion and physical assault
- We have a strong approach to the management of leave for detained service users with reduced absconsions
- We have reduced the number of incidents resulting in harm to our service users
- All service users are encouraged to identify a carer or family member and we proactively include them in care planning

Our quality priorities link strongly with STP priorities. Our work on suicide prevention and crisis care will assist in preventing mental health crises and managing them better when they do. Our work on urgent care pathways and bed management through MERIT will also assist in the delivery of this STP priority. The strong focus that we give to recovery through recovery peer support workers and our highly successful Recovery College supports the STP priority to help people with mental health problems to recover back into everyday life. Our smoke free policy and commitment to both mental and physical health will continue to be a strong focus throughout the year building on the successes that we have seen to date in 2016/17. Such work supports the STP priority to protect those who are most vulnerable from the adverse effects of mental health problems including management of the relationship between mental and physical health.

Our plans in relation to **local and national initiatives** set out in the Planning Guidance include:

National clinical audits - We recognise the importance of participation and learning from clinical audit to inform improved practice and care delivery. We will participate in audits to support the National Confidential Inquiry to support learning from suicide, homicide and sudden unexpected deaths. We will also participate in all other required national audits per the Prescribing Observatory for Mental health in support of NICE compliance. We will give particular focus within our locally determined audit programme to Positive and Proactive Care, Care Planning, Clinical Risk Assessment, Crisis Planning and Physical Health.
Seven day hospital services – We have self-assessed against the four priority standards and where they are applicable to our mental health services we are confident that we meet requirements.
Safe staffing - Our medical workforce plan went to our IQC in December and psychology workforce plan will go in March. In line with guidance we submit a monthly safer staffing report to NHS England and ward staffing levels are reviewed every six months in accordance with guidelines. Our current review will assess whether numbers on shift, including qualified nurses are adequate and staff have the right skills, that there are effective procedures for bringing in necessary additional staff, that staff know the service users and are familiar with ward procedures, provide an indication of where any 'hot spots' are and consider workforce planning. The resulting action plan will be taken forwards in 2017.

Mental health standards (EIP and IAPT) – we are developing clinical, operational and reporting plans for pathways to meet the standards and Referral to Treat waiting times

Mortality and lessons learned - We continue to review avoidable deaths of our services:

- Our Mortality Surveillance Group scrutinises and objectively reviews the deaths of all detained service users and community suicides through detailed case note review and associated learning. This includes service user and carer representation to supplement our existing arrangements of involving them in reviewing our serious incidents. We have also expanded this approach to complaints review and learning.
- Presentation of quarterly reports to the Trust Board on mortality levels including the identification of any avoidable deaths and associated learning, resulting in the development of a mortality reduction plan
- Implementation of our Suicide Prevention Strategy and training programme

In response to lessons learned in homicide and serious incident reviews a priority for us is the support we provide to carers and families. Each service user must have an identified carer or family member documented in our care records system and we will carry out an assessment of each carer or family member to identify any support needed and how they can be engaged in care planning

Infection control and prevention - We have an excellent record of good infection control. Throughout 2017/18 we will continue to adhere to our infection control policies to reduce risk of infection prevalence across our services.

Falls and pressure ulcers - We have appointed a Specialist Nurse in Physical Health who will be working as an integrated part of our quality team to both reduce the number of falls occurring in the Trust and to eliminate serious harm arising from patients falling in our care. We will continue to implement our Falls Policy and deliver our Falls Training. We will equally continue in our improvement journey to reduce the development of pressure ulcers across out Trust. Learning events will take place throughout the year to ensure best practice adherence.

Patient experience - we will further improve our established process for quality improvement by engaging staff, commissioners, service users and carers in securing feedback about the quality of services provided, including patient experience. This will include a triangulated approach to feedback to identify key themes for learning including (but not limited to):

- Family and Friends Test Feedback
- Complaints and PALS intelligence
- Incident reporting
- Clinical Audit outcomes
- Mortality data and case note review
- National and local benchmarking
- Compliance visits
- Feedback from CQC visits
- Feedback from Commissioner visits
- Analysis of risk registers/ mitigations

National CQUINs - are in the process of being agreed and include:

- Establishment of recovery colleges for Medium and Low Secure patients
- Development, implementation and evaluation of a framework to reduce restrictive practices within adult low and medium secure services
- Discharge and resettlement – reduction in average length of stay in specialist services
- To improve transitions to adult care from children's and young peoples services
- Improvement of staff health and wellbeing
- Healthy food for NHS staff, visitors and patients
- Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff
- Cardio metabolic assessment and treatment for patients with psychoses
- Collaboration with primary care clinicians
- Improving services for people with mental health needs who present to A&E
- Preventing ill health by risky behaviours – tobacco and alcohol

Some of our **local quality improvement plans** include:

Dementia Care - Through New Dawn we will have ageless and co-located integrated community teams providing specialist care for people with mental health problems at any age which will include service users with co-morbidity of dementia. This will include using the Community Enablement Recovery Team (CERT) approach to supporting people to stay at home, avoiding unnecessary

admissions. Care Home Liaison will work closely with CERT and inpatient services so that unnecessary admissions from care homes are avoided.
Psychological Interventions - We are in the process of developing an enhanced psychological interventions pathway delivered directly into primary care, and offering a range of psychotherapeutic interventions for people with more complex needs than would currently be met within IAPT services.
Personality Disorder - We are undertaking a substantial review of the system of care for service users experiencing psychological complexity or diagnosed with personality disorder, to ensure we provide a more consistent and evidence-based care pathway for this group of service users. Our service user experts by experience are working closely with us as well as GP and commissioners.
Quality outcomes reporting - We will further develop our internal reporting on quality outcomes at 'service area' level through the development of integrated quality intelligence reporting so that all service areas understand their own quality and safety outcomes as well as their contribution to the overall Trust position. This will be reported through local service area Clinical Governance Committees, feeding into the Trust wide Clinical Governance Structure. This is an area which features in our improvement plan for the CQC Well Led Domain.
Research and Innovation - as well as continuing to engage our clinicians to deliver (and develop) high quality research, we will focus on further developing a suite of technological services to support mental health prevention, working in partnership with other providers and the West Midlands CLAHRC and West Midlands AHSN. We will also establish the Institute of Crisis Care in collaboration with Aston University.

4.3 Quality impact assessment process – Our Programme Management Office ensures that Clinical, Quality and Equality Impact Assessments (CQEIA) are undertaken for all new proposed projects and service changes. All projects must be assessed for impact as part of the initial scoping and continuously maintained and monitored throughout the project lifecycle. The impact assessment highlights both benefits and risks to enable an analysis of the impact of the change, providing assurance on the quality impact. When weighing up the change, careful consideration is given to the outcomes of the impact assessment, the weighting of the benefits and risks against each other and against the financial cost/benefit; where possible the overall impact should be neutral or positive. Clinical teams are engaged in the project/change and have sight of all Impact assessments to enable wider discussion. All new and amended impact assessments are escalated to the Programme Management Board for approval by the Director for Nursing and the Medical Director. The Trust Board monitors savings projects through the Finance, Performance and Productivity Committee and receives assurance from the Director of Nursing and the Medical Director that CQEIAs have been completed and signed off via Programme Management Board (PMB). The PMB escalate any quality risks in terms of pathways, teams and services via the IQC if appropriate to their resolution.

4.4 Triangulation of indicators – The integrated quality report pulls together a range of quality and safety indicators to demonstrate trends in performance. Each indicator is supported by an escalation sheet detailing the rationale for any underperformance or heightened risk. The content of the escalation gives a high level picture of performance. Our business planning process measures performance against goals in the four domains of quality, people, stakeholder and sustainability. At a Trust level we report a balanced scorecard to Trust Board on a quarterly basis. On a Service Area level this is monitored through Planning and Performance Review meetings which discuss business planning goals across the four domains alongside quality improvement, contractual, operational and financial performance.

5. Workforce planning

Our workforce plan ensures there is a competent and qualified workforce to meet our service users and carers needs. The Health Education England Recipe for Workforce Planning Tool has been

used to develop our workforce plan. Our plan sits under our People Plan to address the main workforce risks/gaps to our People goals for 2017/18 which are:

Leadership and development	Staffing
• We have the right management and clinical leadership capacity and capability • We have highly visible leadership and engagement with front line staff • We have a clear measurable strategy for the support and development of all clinical and non-clinical staff in both general and specific clinical skills • We have an agreed approach to aligning our values, behaviour and culture which is understood and utilised by all staff	• We have the right number of staff to deliver services, including people with lived experience • The diversity of our staff reflects the community we work within • Our staff have the required skills • We work to reduce usage of agency and bank staff and implement the new National Workforce Plan • Our approach to recruitment, retention, widening participation and staff wellbeing means we are the employer of choice for new and existing staff and sickness absence is reduced

The workforce plan is signed off at our Finance and Performance Committee to ensure operational and financial alignment, and will be reviewed by Health Education England. Workforce plans for each service area are reviewed annually with Professional Leads/ Associate Directors to align ambitions with clinical requirements and business plan objectives and considered at our Workforce Sub Committee and Integrated Quality Committee (IQC) as part of the People Plan to assess performance against the plan and ensure robust governance.

The table below shows our planned workforce numbers:

WTE	2016/17	2017/18	2018/19
Medical	225.5	216.1	216.1
Nursing	1,152.8	1,153.8	1,138.5
Scientific, therapeutic and technical	451.0	488.9	488.9
Support to clinical staff	915.1	875.2	863.3
Infrastructure support	964.6	960.0	945.5
Bank – clinical and non-clinical	371.1	371.1	371.1
Agency – clinical and non-clinical	117.2	117.2	117.2
Total workforce	**4,197.3**	**4,182.2**	**4,140.6**

5.1 Service Re-Design and New Roles – Our New Dawn model has a number of key workforce ambitions linked to the delivery of the local clinical strategy and commissioning intentions:

- Ward-based consultant roles and on site presence in acute settings
- Delegation of some service provision to third sector providers
- AHPs built into the skill mix of ward and team complements
- Expansion of psycho-therapeutic interventions across pathways

Although some of these are pathway specific, the service model aims to enhance the skill mix and increase integration between teams and pathways to improve service user and carer experience. Enablers of increased experience, effectiveness and safety include:

- Working hours will be re-aligned for seven day working
- Clear job planning for all staff groups (including non-medical)
- Maximising the talent we have through learning and development programmes
- Further adoption of the recovery approach

- Introduction of new technology - increasing efficiency and enabling staff work flexibly

A number of new roles have been introduced to support registered clinical staff to deliver higher quality care and enhance service user experience, and we will expand these in 2017/18. Roles include apprentices, assistant practitioners, associate nurses, volunteers, peer support workers and physician associates. They will ensure we have a fit for purpose workforce, bringing new talent into the organisation, nurturing existing employees competencies, developing a flexible workforce and supporting staff with clinical skills to use these more efficiently. These have been established in line with the Cavendish Report, the Lampard Review, Shape of Caring Review and Talent for Care.

The apprenticeship levy provides opportunities to grow our own talent and progress staff through apprenticeships. We will review existing band 2/3 vacancies to convert many to apprenticeships, targeting areas with high agency spend. We will continue to work with Professional Leads on career pathways and progression including the implementation of degree apprenticeships. We will explore the potential of becoming an Employer-Provider; delivering our own apprenticeship training funded through the digital voucher system.

Through clearer and sustainable career progression routes we will reduce turnover and reliance on agency and bank usage. We shall increase clinical expertise to create a more flexible, responsive and competent workforce.

5.2 Proactive Partnership – Evidence shows where staff report that they are engaged and valued they deliver better quality care and this shows highly engaged employees:

- Are healthier and happier
- Have lower sickness absence
- Contribute to lower staff turnover
- Delivery high quality care
- Have fewer accidents
- Make better use of resources
- Are more likely to think creatively and innovate
- Are more likely to intervene to raise concerns

Our ProActive Partnership seeks to empower teams in making engagement part of business as usual and delivering improvements in line with the business plan.

5.3 e-Rostering and Agency Usage – Significant work has been undertaken to reduce agency spend. A weekly Executive performance management group has been established to control agency expenditure and reports to the Executive team. We have agreed KPI's in relation to e-rostering practice with mechanisms in place to monitor them as part of our programme. All rosters are approved eight weeks in advance to enable a forward view on rosters and proportion of staff unavailability, unfilled shifts and unused contracted hours.

5.4 Workforce Risks – The implementation of New Dawn, our People Plan and our agency reduction initiatives while maintaining safe staffing levels will address the following risks:

- Vacancies - compounded by high staff turnover
- Unrepresentative workforce
- Redundancies associated with restructuring
- Impact of removal of bursaries - Nursing and AHP Training
- Overreliance on agency workers

Workforce risks and issues are reviewed weekly with the Chief Operating Officer, Associate Directors of Operations, HR and Professional Leads and are also formally escalated to the Workforce Subcommittee which reports in the Integrated Quality Committee

5.5 Plans for new Workforce Initiatives and Five Year Forward View –

Reach Out – the main workforce implication is developing the enhanced outreach team which will lower costs through an increased rate of safe discharge from inpatient facilities. It will be a comprehensive multi-disciplinary team including consultant psychiatrists, psychologists, advanced nurse practitioners, community psychiatric nurses, district nurses, occupational therapists, support workers, peer support workers and social workers.

MERIT – we are working across MERIT to develop plans for a more flexible workforce across the West Midlands as well as looking at joint recruitment and training initiatives.

Recovery strategy – our recovery college will continue to take shape during 2017/18 and provides a platform for co-designed and co-produced learning supporting genuine cultural change. Our recovery e-learning package supports all staff in their understanding of the recovery approach.

HEE Workforce development programme – we are leading on a workforce development programme funded by Health Education England (West Midlands), which will enhance our excellent urgent and crisis care. The funding will assist in the review, revision and delivery of innovative training programmes, and enable further collaboration with other mental health trusts and local universities that will support urgent care staff to deliver the very best care to people who are experiencing a mental health crisis.

Community Perinatal Services – we have been successful in a bid as part of the Five Year Forward View to develop a community perinatal service pilot over the next three years. In 2017/18 we will be developing a multi-disciplinary team to offer psychological and therapeutic support and interventions, nursing capacity, and psychiatry and medication, with input from allied health professionals e.g. occupational therapists and nursery nurses.

5.6 Retention initiatives – We work to attract and retain the best talent and develop staff through positive and fair learning and development interventions and access to promotional opportunity. We will target the causes of turnover in high turnover teams and are reviewing our Retire and Return arrangements to promote opportunities for staff to return to work following retirement. We are developing our talent management and succession planning strategy to increase internal opportunities for promotion to retain key talent.

We have committed to improving the health and wellbeing of our staff by ensuring access to services to support health and well-being, encourage healthy lifestyle and help reduce absence. Our Health and Wellbeing group is responsible for developing and implementing a Health and Wellbeing Strategy. As part of this, we have a newly commissioned fully integrated occupational health, neuro musculoskeletal (physiotherapy) and employee psychological support and therapies service which gives staff access to innovative health and well-being solutions.

Through ProActive Partnership we have implemented a number of initiatives in response to staff feedback to improve employee engagement and promote retention. This includes early intervention for conflict management through mediation, development and delivery of a series of workshops to provide a safe environment for staff to have challenging conversations, Listen Up Events where staff feel safe to share concerns with our Executive Team, and promotion of low tolerance for violence and aggression in the workplace.

6. Approach to financial planning

6.1 Financial forecasts and modelling – We have financial plans which are prepared on a consolidated basis and incorporate the financial effects of strategic and operational planning, including the wholly owned subsidiary, Summerhill Supplies Limited which provides a fully managed service lease for the Tamarind forensic site and pharmacy dispensing services (this will be extended by 2017/18 to include Ardenleigh and Juniper). We plan to generate a surplus over each of the next four years, however it is an incredibly challenging context given the high level of savings required and with a number of high risks described in detail later on.

Budget Principles – Our budget setting process is based upon an established set of principles of budget delegation: responsibility, ownership, flexibility, control and clinical, quality and equality assessment. These principles set out that budgets should be managed by a responsible person who has the most control over how the resources will be deployed. Whilst there is flexibility to move budgets between budget lines, any changes that could have an impact on service users or staff are subject to Clinical Quality and Equality impact assessments to ensure that they do not have a negative impact on quality or equality.

Financial challenge –There is increasing pressure across the health economy to meet the affordability gap. Nationally NHS England predicts there will be a £30billion funding gap by 2020/21. It is forecast that the net tariff deflator will be 2% year on year for the planning period and this is reflected in the Birmingham & Solihull STP. Recognising the financial context of the NHS and the control total set by NHSI we have set ourselves a stretching cost improvement programme of 6.0% of revenue for 2017/18 and 4.4% for 2018/19. Our Programme Management Office oversees the delivery of all programmes and projects within the Trust within a robust governance framework. Fundamental changes in the way we deliver services will be required to meet the design of services and the associated financial challenge. Savings have been set as budgetary savings (which all areas are required to make) and productivity or sustainability savings dependent on the assessment of the service area. We are working collaboratively with partners to explore more effective ways of working and this is reflected in our Vanguard programmes, Reach Out and RAIDPlus.

Income & Expenditure – We give consideration to the key factors which influence the operational environment and the constraints which we operate in. These factors, along the requirement to maintain a healthy financial position on liquidity and capital service cover influence the amount of surplus and the savings we are required to make. Our control total requires a £2m surplus in 2017/18. The table below shows the summary Income and Expenditure plan.

Consolidated I&E Summary	2017/18 £000	2018/19 £000
Healthcare Income	210,557	210,766
Other Income	18,583	14,793
Total Income	**229,140**	**225,559**
Pay Costs	(168,996)	(165,285)
Drug Costs	(5,251)	(5,372)
Clinical supplies & Services	(219)	(224)
Other Non-Pay	(26,947)	(25,030)
PFI specific costs	(8,447)	(8,691)
Total Expenditure	**(209,860)**	**(204,603)**
EBITDA	**19,280**	**20,956**
EBITDA %	**8.4%**	**9.3%**
Capital Financing	(17,256)	(18,242)
Surplus / (Deficit) Total	**2,024**	**2,714**
Surplus Margin %	**0.9%**	**1.2%**
Savings Requirement	13,645	9,944
Savings as % of Income	6.0%	4.4%

Key Assumptions

- Tariff inflator will apply to all healthcare income contracts with the exception of the prison. The CRES deflator is 2% for 2017/18 and inflation at 2.1%, which includes the uplift relating to the Apprenticeship Levy. NHSI have published indicative figures for tariff deflator for future years, which have been used as part of the STP process
- CQUINs are assumed to be 2.5% of contract value, with 0.5% set aside in line with STP guidance. Our plan assumes that CQUINs will be achieved at 95%
- We have set an initial savings target for 2017/18 of £13.6m and £9.9m for 2018/19
- Details of the pay deal to be announced have been assumed to be consistent with previous years at an average of 1%. Budgets include the cost of increments £1.6m, the newly introduced apprenticeship levy £0.8m and pay inflation £1.7m. An uplift of £0.1m has been included for the Living wage foundations revised calculations pending a Board decision
- Non pay inflation – varying increases have been applied across spend categories.
- Cost pressures of £0.75m have been assumed in budget setting.
- The Trust have received notification of the CNST premium for next year, which is an increase of 40% (the maximum increase). NHSI have indicated that they will not be changing control totals to reflect this pressure as they do not consider it to be material
- A healthcare income shortfall budget of £0.95m allows for risks around under recovery of healthcare income
- A recurrent strategic investment budget of £0.95m will be subject to invest to save business cases
- The HCI shortfall and strategic investment will not be released until all savings have been planned

Financial Sustainability – For 2017/18 the newly introduced Single Oversight Framework (SOF) replaces the Financial Sustainability Risk Ratings. The SOF values are shown below. Savings requirements for each financial year have been calculated to include an uplift to maintain liquidity, capital service and I&E margin levels to maintain financial sustainability.

Finance and use of resources metrics	2017/18	2018/19
Capital service capacity	3.00	2.00
Liquidity	2.00	1.00
I&E margin	2.00	1.00
Distance from financial plan	1.00	1.00
Agency spend	1.00	1.00
Finance and use of resources score	2.00	1.00

6.2 Efficiency savings for 2017/18

The CIP table below shows the planned recurrent schemes for 2017/18.

£m	Total	Acute Urgent Care	Community & Recovery	Primary Care, Dementia, Specialties	Secure Care & Offender Health	Corporate
1% budget setting	1.6	0.3	0.5	0.2	0.1	0.5
3% productivity	4.7	1.0	1.5	0.6	0.2	1.4
6% sustainability	3.2	-	-	0.5	2.7	-
Total	**9.5**	**1.4**	**1.9**	**1.3**	**3.0**	**1.9**
Apprenticeship levy	0.8					0.8
STF	1.5					1.5
Total plans	**11.8**	**1.4**	**1.9**	**1.3**	**3.0**	**4.2**
Target plans	**13.6**					
Current shortfall	**1.8**					

The Board is considering the actions necessary to deal with the savings gap.

Lord Carter's provider productivity work programme – *Operational Productivity and Performance in English NHS Acute Hospitals: unwarranted variations,* estimates that about 8,500 acute beds are "blocked" each day in the acute sector, costing NHS providers around £900m per year. Operating RAID and Psychiatric Decision Unit, we work with our acute partners to alleviate system pressure. We have implemented e–rostering to ensure productivity and efficiency is at the heart of our operational plans.

EPMA system – We are delivering an integrated Electronic Prescribing and Medicines Administration (EPMA) system to replace existing paper based processes for prescribing and administering medication. Accessible to all clinicians involved in medicines management in conjunction with RiO, it allows pharmacy to review, verify and dispense the prescription prior to administration. EPMA will deliver patient safety benefits as prescriptions will be actively checked against allergies and the removal of the paper medication charts will reduce errors in medication type and dose.

Agency rules – We are fully compliant with the use of all staffing groups being under the set cap rates. The Trusts agency ceiling for the next 2 years has been set at £8.1m/year. Tight controls are in place over the approval of the use of agency and this has resulted in spend reduction from 2015/16 to 2016/17.

Procurement – Our Standing Financial Instructions set out the competition requirements for the contracting of goods and services. Our procurement strategy sets out our aims of using National and Regional frameworks where possible before tendering as a single Trust. This strategy has delivered in line with its original objectives and is being refreshed. In addition, we have a wholly owned subsidiary company that dispenses outpatient prescriptions with the ability to reclaim

VAT. This will be extended to home treatment team dispensing and possibly discharge medicines in the near future.

6.3 Capital planning – Our capital programme is designed to deliver assets to support our plans over the next five years. It is aligned to the Estates Strategy, and has been developed alongside the 6 Facet survey and ICT development programme. It is affordable within the context of a realistic savings plan, whilst still delivering the outcomes in terms of suitable, well maintained premises.

Capital programme	2017/18 £m	2018/19 £m
Major schemes	3.71	5.22
Minor schemes	1.50	1.00
Statutory Standards and Backlog Maintenance	1.50	1.00
Estates investment	**6.71**	**7.22**
ICT strategic investment	**3.21**	**2.04**
Total capital plan	**9.92**	**9.26**
Funded by:		
Depreciation	7.90	8.58
Available depreciation	5.37	5.62
Available cash	4.55	0.89
Receipts	-	2.75
Total funding	**9.92**	**9.26**

Major Schemes – The major schemes programme, over the next 5 years comprises:

- Reduce standalone wards and enhance Highcroft site
- Hillis Lodge low secure unit re-provision.
- Rehabilitation review
- Review of older people services and premises
- Reaside medium secure re-provision.

The major schemes programme will be managed through the business case process to ensure value for money and contribute to service and operational strategies and clinical models within our New Dawn transformation project.

Minor Schemes – A long list of minor works schemes has been developed. The order of the works will be subject to operational prioritisation within the financial envelope for each financial year and subject to business case approval.

Statutory Standards and Backlog Maintenance – A 6 facet survey informs spending priorities.

ICT Strategy and Replacement Programme – We recognise that technology offers the potential for improved quality of service with the efficiency savings and have a clinically focused ICT. The ICT replacement programme predominantly relates to equipment refresh, mobile working and network infrastructure growth. The asset lives of all equipment were reviewed and extended in 2014/15.

Capital Programme Funding – Capital programme has been considered alongside development of the revenue plan, savings plan and balance sheet. Funding includes cash balances, depreciation, prior years' surplus balances and use of sale receipts. Funding for the capital programme is reliant upon the delivery of the revenue.

6 Membership and elections

6.1 Governors elections – In 2016/17 our Lead Governor, a service user, has been re-elected unopposed for a further three year term. There were contested elections for clinical (non-medical) and non-clinical staff governors. Having had no nominations for 'rest of England and Wales' service user and public governor positions, a co-option was agreed for the former role, and will be

considered for the latter if a suitable person is identified. In 2017/18 we will hold elections for 1 medical staff governor, 4 public governors and 1 stakeholder governor when their terms lapse.

6.2 Training and development – we have introduced annual skills audits to assess Governors knowledge, understanding and competence in a range of areas to inform our training and development plan. The key areas of focus are strategic planning, role of the governor, engaging with and representing their constituencies, holding the board to account, communications and marketing, finance in the NHS, the wider Health Economy and the Trust and its services. Training is provided to our Governors through a combination of dedicated in-house sessions (some with Trust Board), conferences and workshops such as those held by NHS Providers, or by the local health economy within the West Midlands.

6.3 Engagement between governors, members and the public – we regularly promote and encourage attendance by our governors and members at community engagement and awareness raising events. Examples have included: events to seek views on our New Dawn Plans, seminar for the Somali community, celebration of Nursing event, World Mental Health/homelessness day, Arts All Over The Place festival, BEDLAM Festival of Divine Madness, launch of dementia DVD for Asian communities, Positive Mental Health Group Christmas parties, university open days/welcome fairs, awareness days for a range of issues including disability and diabetes and membership seminars across our communities.

6.4 Membership strategy – Our refreshed Membership Engagement and Governor Involvement Strategy was approved by its Council in September 2015. This outlines our vision for membership, objectives, current membership details, methods that will be used to build an effective, responsive and representative member body and ways in which the governors will be trained, involved and supported. Overall there we have a good mix of ages, gender and individuals from different ethnic minorities. There are some areas where further work is required to increase the representation and we are constantly looking for opportunities to engage with our communities. We have a well-developed programme around community engagement and equality and diversity and the work around membership has dovetailed with this which has enabled interaction with a wide range of hard to reach groups and targeted events. The key areas of under representation we are seeking to address are i) 17-19 age groups (both men and women), ii) males under 30 and iii) males over 60. To remedy this we have exciting projects in place with University of Birmingham, Birmingham City University and with ExtraCare Charitable Trust who support older people in Retirement Villages and Housing Schemes.