Board of Directors (Part I)

Schedule	Wednesday 28 July 2021, 9:00 AM — 12:30 PM BST
Venue	Via Microsoft Teams
Organiser	Daniel Conway

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
WEDNESDAY 28th July 2021 VIA VIDEO-CONFERENCING

Purpose and Ambition
The Board is accountable to the public and stakeholders; to formulate the Trust's strategy; ensure accountability; and to shape the culture of the organisation. The Board delegates authority to Board Committees to discharge its duties effectively and these committees escalate items to the Board, where Board decision making and direction is required.

Values
The Board will ensure that all its decisions are taken in line with the Values of the Trust: Compassion, Inclusive and Committed

Ardenleigh inpatient Service User Story 9:30 start for this item

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Declarations of interest	*Chair*		-	-
2.	Minutes of the previous meeting held on the June 2021			A	Approval
3.	Matters Arising/Action Log			A	Assurance
4.	Chair's Report			A	Assurance
5.	Chief Executive's Report	*CEO*		A	Assurance
6.	Board Overview: Trust Values			V	Assurance
QUALITY					
7.	Integrated Quality Committee Chair Report	*W. Saleem*		A	Assurance
8.	Mental Health Legislation Committee Chair Report	*P. Gayle*		A	Assurance
9.	Medical Directorate Escalation Report - Annual Organisational Audit	*H. Grant*		A	Assurance
PEOPLE					
10.	People Committee Chair Report	*P. Gayle*		A	Assurance
SUSTAINABILITY					
14.	Finance, Performance & Productivity Committee Chair Report	*R. Beale*		A	Assurance
15.	Integrated Performance Report	*D. Tomlinson*		A	Assurance
16.	Finance Report	*D. Tomlinson*		A	Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
17.	Medium and Low Secure Facilities (Reaside) Strategic Outline Case	*D. Tomlinson*		A	Assurance
18.	Audit Committee Chair Report	*G. Hunjan*		A	Assurance
19.	Charitable Funds Committee Chair Report	*L. Cullen*		A	Assurance
GOVERNANCE & RISK					
20.	BAF	*D. Tomlinson*		*A*	*Approval*
21.	Reach Out Governance	*D. Tomlinson*		A	Assurance
22.	BSOL Mental Health Provider Collaborative	*P. Nyarumbu*		A	Assurance
22.	Questions from Governors and Public (***see procedure below***)	*Chair*		*V*	*Assurance*
23.	Any Other Business *(at the discretion of the Chair)* • Thank you and goodbye to Waheed Saleem	*Chair*			-
24.	**SNAPSHOT REVIEW OF BOARD PERFORMANCE** **Were items appropriate?** **Were timings appropriate?** **Are there any items for inclusion on the action log?** **Are there any items to be disseminated across the Trust?** **Were the papers, clear, concise and aided decision making?**	*Chair*			-
25.	**RESOLUTION** The Board is asked to approve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
26.	**Date & Time of Next Meeting** • 09:00am • September 2021			*Chair*	

A – Attachment ***V - Verbal*** ***Pr - Presentation***

At the Chair's discretion, there will be an opportunity for Governors and other visitors to ask questions on agenda items at the end of the meeting

Procedure for questions from the public at board meetings

The Board meetings are held in public rather than being public meetings: this means that the public are very welcome to attend but cannot take part. Nevertheless the Chair is happy to conduct a short question session at the conclusion of each board meeting held in public to respond to questions which have been raised by the public or members of staff at the meeting.

Questions

Members of the public, staff and governors are permitted to ask questions at meetings of the Board of Directors.

The Chair will invite questions at the end of the meeting.

Relevance of questions

Every question must relate to the items received or considered by the Board of Directors at the meeting.

Questions should not refer to or require discussion of confidential information, including personal information about any individual.

The Chair may interrupt to stop a question being asked where it is not relevant to the matters at the meeting or it discloses confidential information.

Notice requirements

There is no need for notice to be given to ask a question at the meeting. However, members of the public are encouraged to give notice of their question to the Trust Secretary by 12 noon on the working day before the meeting to enable a full response to be prepared.

Limitations on numbers of questions or time allowed

No member of the public may ask more than one question at any meeting unless the Chair allows otherwise.

There are no limits to the questions for Governors.

The time allowed for questions by the public and governors is limited. The Chair may curtail the time available for questions at his discretion.

Response to questions

Where possible a response to a question asked will be given at the meeting and recorded in the minutes. Where this is not possible a written response will be provided within ten working days, with the response being reported to the next meeting for information. If a question has been asked previously, the Chair may refer to the response recorded in the minutes rather than repeating the response.

SERVICE USER STORY (To begin at 9:30)

1. Opening Administration: Apologies for absence: Declarations of Interest

2. Minutes of the previous meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING HELD Wednesday 30th June VIA VIDEO CONFERENCING, MICROSOFT TEAMS

PRESENT:	Ms D Oum	-	Chair
	Prof R Beale	-	Non-Executive Director
	Ms S Bloomfield	-	Director of Quality & Safety *(Chief Nursing Officer)*
	Dr L Cullen	-	Non-Executive Director
	Mrs V Devlin	-	Executive Director of Operations
	Mrs R Fallon-Williams	-	Chief Executive
	Mr P Gayle	-	Non-Executive Director
	Dr H Grant	-	Executive Medical Director
	Mrs G Hunjan	-	Non-Executive Director
	Mr P Nyanrumbu	-	Director of Strategy, People & Partnerships
	Mr W Saleem	-	Non-Executive Director
	Ms J Warmington	-	Non-Executive Director
	Mr D Tomlinson	-	Executive Director of Finance

IN ATTENDANCE:

	Mr D Conway	-	Deputy Company Secretary

GOVERNORS OBSERVING:

	Mrs M Johnson	-	Carer Governor
	Mrs H Kench	-	Public Governor
	Mr M Mirza	-	Service User Governor
	Mr J Travers	-	Staff Governor

1. STAFF STORY

The Board received a detailed presentation from Stephen Harrison, Aiysha Majid and Jake Berry. They all work in the IT Department of the Trust and detailed how the pandemic has impacted on their roles and their educations. They also demonstrated how they had consistently stayed true to our value of Compassion even when faced with individuals they were supporting whose behaviours were not.

R. Beale thanked them for their honesty in their presentation.

M Mirza thanked them for their gratitude as a Service User Governor for the difference they make to the Trust.

S. Bloomfield stated that this was brilliant to hear, and I really enjoyed your story. She wanted to talk about how everybody who works in this Trust contributes to patient safety.

She added that through all of the work you did over and above during the pandemic have prevented harm occurring to our staff and to our patients.

P. Gayle wanted to echo what my other colleagues have said. You have done a phenomenal job. He asked how you feel we as a Board and senior leaders could support you even more going forward.

The Team felt that getting the recognition that we are today really pushes us and gives us a bit of inspiration to work as hard as we do. They added it has been nice to be able to voice what has happened.

G. Hunjan wanted to say to all three members a big thank you for coming across to the Board and sharing your story. She asked the Trust held a series of seminars where colleagues and team members were invited to share their experiences regarding what happened when COVID became more prevalent, were you involved with any of those sessions. They confirmed that they were invited but never took part.

The CEO wanted to particularly echo the point about the P. Gayle made about our values and the two extremes of how our values are not being demonstrated in the organisation. Given the fact that you were experiencing people who were showing completely unacceptable behaviour, yet you stay true to our values and compassionate. We must continue to make a commitment to you to ensure that we continue to give the message that it was unacceptable.

The Chair concluded by saying thank you for coming and sharing your story, so openly. The Board really appreciate you putting in the work in to bring it to life for us. It will influence how we work together as a Board.

2. OPENING ADMINISTRATION

There were no apologies for absence.

There were no declarations of interest relevant to items on the agenda.

3. MINUTES FROM THE PREVIOUS MEETING & ACTION LOG

The minutes of the meetings held on the 28th May 2021 were approved as true and accurate records of the meetings.

4. CHAIR'S REPORT

The Chair's report providing an overview of key activities undertaken that month was received and noted by the Board. She highlighted that the advert for the recruitment or Non-Executive Director was live and interviews would be taking place next week.

5. CHIEF EXECUTIVE'S REPORT

The CEO wanted to add some updates and emphasise a couple of areas in her report. In terms of where our current position around COVID-19, she wanted to let the Board know

that we do have a number of individual patients in three service areas who are COVID positive, it was looking as though they were all community acquired and it was not known yet if it was a situation of an outbreak. She commended our clinical staff for how they were managing this situation.

The Board were informed that at the moment, about 78% of our permanent staff have had the vaccine. There have been a couple of deep dives into particular areas where the take up is lower, for example, in Acute and Urgent Care and we have seen based on some of the different actions over 10% increase in the uptake in that Directorate. The deep dives would continue over the coming weeks around some of our approaches, including entries on a risk register actions to mitigate so that if we end up in a situation where we have another wave, we are clear about how those services are going to manage and what actions are going to be taken

She raised the Memorial Garden at Uffculme that was opened last week. This was a real demonstration of how collaborative work and support across our charity, the organisation, our service users, Governors, and a community organisation can bring to fruition something meaningful for all of us. As a consequence of discussions that we had on Friday with colleagues from Reaside and Aredenleigh they are considering how they provide something in their local facility, given particularly the restrictions on both service users, and staffing in order to be able to go to Uffculme versus to be able to have something more local there.

Individual directorates are taking forward quite a bit of work now on equality, diversity and inclusion. Every senior leader, has now had an opportunity to take part in a three session development around our anti-racist leadership and how that can show up in the organisation. The Trust are asking everybody now to think about what this would mean and the commitment you will make into your area of your working.

Work continues around the Integral Integrated Care System. She added that the new Health Secretary may have a slightly different view about timeframes and some of the elements of the Bill.
P. Nyanrumbu will be leading a much larger session for us across all the elements of the integrated care system that are pertinent to us as a Board next month.

Finally, she wanted to remind us all that the NHS is 73, this month and wanted to take the opportunity to think about our thank you's and invite everybody to put forward their thank you's to individuals in the organisation that we work with.

H Grant thanked the CEO for profiling the academy this was really exciting and was one of the biggest in the country. The Trust had built a real supportive infrastructure, which was not just about teaching this was also about trainees happy competing with good experience. She added that these are senior trainees who are stepping out of training by taking a year out for development. This will add further to their career when they are applying for jobs.

P. Gayle felt that this was fantastic news and he was proud of this academy as we are going to be a beacon. He wanted to congratulate everybody that had been involved in getting this off the ground

P. Gayle further raised the issue that clinical activities continue to rise during the month, and the acuity remains at a high level. High acuity often means dealing with other patients or service users, who may present more complex and challenging issues. In order to ensure we provide high quality care, are we confident that we do have the right people in place with the skills to deal with to deal with this.

The CEO stated that the Board are aware that we have some gaps in our workforce and there was a lot of transformational work going on that is enticing people into new exciting areas of work. We are looking to see how we can mitigate that and how can we make the experience and the desire to working on inpatient settings, as attractive. Work continues around thinking about how we over recruit into roles that we know that are easily or more easily recruitable than, for example, band five nurses might be at this moment in time.

She added that she was hopeful to be able to tackle it from a number of angles and we needed to think quite differently about how we get the expertise and skills and also thinking about how the senior team operate. Also a number of new patients that have been never known to us before are hitting us with much higher acuity level, as opposed to coming through a pathway of care or being dealt with at earliest stages. She gave some reassurance that we are talking to other areas of the country, just to make sure that we are not an unknown or an anomaly in all of that and it was quite clear that our colleagues elsewhere in the country are experiencing exactly the same kind of profiling that she described.

P. Gayle further raised the issue of referrals increasing to older adult mental health teams and do we know why that is.

The CEO was not fully sure why at the moment. Once the referrals have been addressed this could be looked at in more detail.

V Devlin stated that the trust know that people are presenting and acuity and complexity is high. To help this was are putting services around early intervention and prevention. One of our pieces of work was to create a crisis house working in partnership with FTB, under the third sector.

6. EXECUTIVE OVERVIEW TRUST VALUES: P Nyanrumbu EXECUTIVE DIRECTOR

The Board received an update from P Nyanrumbu, Executive Director, on how he had seen the values of the Trust being demonstrated through the month.

7. QUALITY

7.1 Integrated Quality Committee Chair's Assurance Report

Mr Saleem presented the report from the Committee highlighting that the Committee received the latest response to the CQC against the action plan, which is being progressed. The Committee would continue to have oversight of the implementation of the action plan, however, as previously stated it is important that the improvements are embedded across the trust and a safety and quality culture exists in a consistent manner, and more work is needed in this regard.

In regards to the Ligature Review update the members were provided an update on the work that was being undertaken on procedural and relational actions that are being considered to reduce ligature risks. A full report would be presented to the July committee. The Committee asked that this report includes the details on how the changes will make a difference, how they will be embedded and become part of the standard operating procedure of the trust and ensure that these are consistently implemented across the trust.

Health, Safety and Security Quarterly Report was discussed and noted that the potential additional responsibilities to the Trust as part of the Fire Safety Act, although further clarity will be required as further guidance is issued

The Committee was pleased to note the robust system and processes in place on investigation and sharing the learning from SI's. Further work is being undertaken to embed the learning across the Trust.

The Chair raised in regards to the Ligature Risk Review the approach to building a quality and safety culture with co-production. She added that the Trust was interested in increasing service user voice and the input of carers, adding that IQC would seek assurance regarding progress on this.

S. Bloomfield stated that this needs to be business as usual. This is seen a lot through QI work and needs to be into our governance processes as an automatic question that we ask.

She added that she was contacted yesterday about funding available for improving our ward environments for learning disabled people and people with ASD. It was really encouraging that we did not have to ask for that to be put into the bid. Ultimately this relies on us all to push back when things are not good enough.

She has asked the team to send us a monthly patient experience report through to IQC.

6.2 <u>The Quality Account 2020/21</u>

The Board were presented with the Quality Account 2020/21 for approval following a recommendation from IQC.

S. Bloomfield raised the stakeholder comments for this year. Historically, we have struggled to get a full set of stakeholder comments and feedback and we certainly struggled to get them all the time. This year, thanks to the hard work of my team and the emphasis placed on the importance of this. We have got full set of statements back. If you look at the Healthwatch statements, there has been some lovely feedback in there for us, but there's also some really good challenge about

things they would expect to see, for example, health inequalities, that they did not see as much as they wanted to.

She added that we have made some changes to our Quality Account based on the feedback.

The Chair stated that it was good to see stakeholders being so engaged. She commended the team for the work on this and asked the Board for approval.

Decision: The approved the Quality Account 2020/21

6.3 Serious Incident Report

S. Bloomfield presented the report and highlighted that the executives had some discussion together health inequalities of late and it was helpful that the author of this report has started to include some of those in the terms of clinical characteristics and social characteristics in the report.

She added that we need to improve our reporting by religion. Not all the religions that the communities we serve are currently on the system to be flagged and she found it interesting that we break Christianity down into denominations but not in the other religions.

In terms of the themes, there are no surprises. It was great to be able to recognise excellence in practice, even in difficult situations. We will be writing out to recipients of learning from Excellence Awards.

7. PEOPLE

7.1 People Committee Chair's Assurance Report

The committee received an update on the final narrative and numerical submissions and that plan was successfully submitted on the 3rd June. And as a committee, we noted the critical organisational systems and actions plus the risks to the delivery of the workforce plans.

The committee continue to receive assurance in relation to the delivery of the plan through the committee subgroups, which are now established, We received assurance that this newly formed subgroup was focusing on the key areas of concern, and workforce KPIs to feed back their findings to the People Committee. This group highlighted the vacancy fill rates and the bank and agency fill rates, which were of concern and highlighted the fact that it was acknowledged that the Trust was responded to the increase in service needs, resulting in expansion of services and creating more vacancies.

The Committee highlighted that the organisation should be more ambitious in regards to the ICS people aim to have 100 entry level jobs pledge. We thought it was not ambitious at all. This ambition will be reviewed, particularly from a trust perspective and further steps will be reported and monitored.

The meeting discussed the pseudo anonymization clinical records for patients who also trust staff and we had a very lengthy debate about this. The Committee did approve the recommended approach of pseudo anonymization of clinical records for patients.

The Committee received a report outlining the organisation's disparity ratio. A Race Disparity Ratio is the difference in proportion of Ethnic Minority colleagues at various AfC bands in a Trust, compared to the proportion of White colleagues at those bands. Racial 'disparity ratios' have been created for each trust to root out discriminatory practice in NHS systems.

The Chair stated that once those structures are fully embedded, that was going to be a really rich source of information up through to the board

The Chair sought the lead executive's feeling on the scale of the People challenge, where progress felt as though it was being made and their sense of where there may be challenges along the way.

P Nyanrumbu stated that this was quite ambitious and innovative. However, the challenge will be with our system colleagues, not just ourselves as an organisation where some of the opportunities to work across the system in partnership will be really critical for us. The other area, which he wanted to highlight was around the reliance on temporary staffing as he did not feel that this was sustainable. The Trust have to really start to think about our offer of flexible working within the organisation and getting the grip on why people are choosing to go on temporary staffing rather than fill some of our vacancy within the organisation.

V. Devlin stated that feedback from our bank staff was that they like the flexibility that having a permanent contract does not give them that. There has been conversations around flexible bank contracts of maybe 15 hours, where you can move and work around. We also need to look at how we can have more apprenticeships from the local communities.

The Chair stated that it was her ambition for the Trust as far as possible, to encourage and support people from the local community to access meaningful careers with prospects in our Trust.

P. Gayle asked if bank staff that consistently take up regular shifts on a weekly basis, that go beyond 13 weeks, then technically should they be offered substantive contracts under law.

The Trust are having those conversations with individuals. However, we cannot just automatically switch people to a contract.

The Chair asked sought clarity regarding the additionality of the ICS Bank staff list.

P Nyanrumbu stated that this was really about flexible redeployment of staff. We have been looking at developing a memorandum of understanding of how we become more flexible. So, for example, if you want to open up the vaccination centre, how do we ensure that we can navigate our way around the system and be able to, to redirect some of our workforce across the system.

7.2 Freedom to Speak Up Report

S. Bloomfield presented the report highlighting the work undertaken by the guardians. She stated that the Trust were seeing an increase in issues being raised with the guardians, which is exactly what we wanted. It should be expected to see further increases over the coming months or quarters.

She further highlighted the need to support operational leaders to understand what the role of Freedom To Speak was and what is was not..

National Guardian's office index did state the Trust was one of the 10 most improved trusts. But we cannot rest on our laurels we have a lot more work to do.

W. Saleem stated that it was great that people are raising concerns, but the proof of the pudding was how the Trust are dealing with outcomes. He had some concerns about the why one case was still open since November and asked for some assurance that the systems are in place to ensure that things are being dealt with in an appropriate and timely manner. S. Bloomfield confirmed that the case has been dealt with correctly and systems are in place for the management of cases.

S. Bloomfield confirmed that the roles will be going out shortly for a permanent post and a plan would be coming back for agreement. Once the Champions are in place we may need even more resource if cases go up.

The CEO stated that the attention was always that we would have permanent roles and the plan always was to do that review work with the input of the temporary guardians but we had not determined what they would look like.

The CEO questioned around the survey work that was done. Staff are still reluctant to raise issues because they feel they are going to be repercussions for them. As more people come forward, where how we are we dealing with them in a way that was satisfactory to the person that raised the concern. Also, how do we use that information to get the message out into the organisation and give more people the confidence to feel psychologically safe around raising their concerns.

S. Bloomfield felt that the champions network was going to be critically important about how we encourage and support people to come forward to do that. These champions, being out in the areas where staff are providing the direct care, and in our back office functions and talking very positively about our freedom to speak up service and should often encourage staff to access it.

HG made a point about the need to triangulate all the different sources of information. The Guardian of Safe Working has a particular remit that within the medical trainees and we are seeing very similar issues come through. She questioned whether there are opportunities for how they might work together in terms of triangulation.

ACTION: S. Bloomfield and H. Grant to discuss mapping out a triangulated assurance report for The Guardian of Safe Working and FTSU

The Chair asked that the Guardians are thanked for their work in this area.

8. SUSTAINABILITY

8.1 Finance, Performance & Productivity Committee Chair Report

G. Hunjan advised the Board that key items from the meeting are on todays agenda.

8.2 Integrated Performance Report – including cycle of business

D. Tomlinson highlighted the performance in May. He stated that there was nothing new to report in terms of trends. The key issue was around Out of Area Bed Use as it stalled in terms of the numbers in May, there was a plan to reduce that going forward.

We have talked to representatives of the three committees to make sure going forward we are providing the full level of detail insight and intelligence that was helpful. Under the option, the Committees and Board would review intelligence and insight at weeks 7 and 8, e.g., at the end of July for May outputs.

The principal benefit of this approach was that there would be time to create that important triangulation through PDG and to discuss the 'so what?' at other governance forums. Whilst it would be later that the assurance forums receive evidence, that evidence would be fully analysed and triangulated, making it more likely to drive insightful discussion and decisions.

DECISION: The Board approved the move to reporting at weeks 7 and 8 from August 2021, with the caveats of external reporting milestones, and the benefits of other governance techniques.

8.4 Finance Report

D. Tomlinson highlighted the capital situation, the total capital plan was £9.6m. On 28 May 2021,the Trust submitted a bid as part of the system capital prioritisation process to access funding from the system capital investment fund (SCIF). The panel had recommended an award that would result in a £0.6m increase to the capital envelope. This was subject to formal sign off by system Chief Executive Officers on 25 June 2021.

The overall position at both ICS, and Trust level was for the first half year, with a for a deficit plan for £1.6 million. A change plan would be submitted, along with the rest of the ICS to have an overall breakeven plan as an ICS and as an organisation. To achieve that we have got an underspend against the income, by exploring what we can do in terms of carrying some of that income forward.

The Chair stated that was a a potential shifrt of emphasis happening in the NHS, with the likelihood of an increased focus on finance.

D. Tomlinson agreed and stated that it felt like it was moving back towards business as usual in terms of focus on the financials. There is a view from the centre, that BSoL as a system was very prudent. The general principle here was we put in what we know we can deliver, and then talk about opportunities as opposed to other people putting ambitious plans in and then talk about the risks.

W. Saleem sought to understand the level of confidence around the plan, that, given the initial plan for the Trust was for a deficit and then the revised plan was breakeven in terms of the system and also giventhe significant challenges that the Trust faced as an organisation.

D. Tomlinson commented that all organisations have got significant degree of flexibility. At the tail end of last year, the NHS at the centre was telling all organisations to really build up their balance sheet. So that they have the flexibility going forward, and everyone took this opportunity. In addition, there was a significant chunk of additional monitoring to the system around elective recovery. For this Trust in this year between the new money coming through developments, and the actual staffing and against this. We know that at this stage we are £1.3m better than the plan, or £800,000 surplus. He felt pretty confident this would be achieved.

P. Gayle asked to what extent Cost Improvement Programmes had been rolled out across the Trust to different directories.

D. Tomlinson stated that this had been discussed at Executive level and during this challenging time we do not want to put pressure on the services. The plan was to look at the following areas:

- Transport
- Temporary Staffing
- Transformation of Out of Area Patients
- E Rostering

8.5 Highcroft and Reaside Stakeholder Engagement

D. Tomlinson detailed the paper on the stakeholder management and communications and engagement plan. This was taken through the finance committee last week. The plan that sets out the communication and engagement objectives and describes how the Trust would work together to communicate and engage by identifying target audiences, key messages and appropriate channels. Details of the proposed timetable of activities designed to deliver these objectives were shared.

W. Saleem questioned in terms of engagement, what is the outcome, what are the Trust trying to achieve with this engagement and will this be developed and implemented. He added in terms of the design process and the need to safety and quality input these need to come through IQC for discussion.

D. Tomlinson confirmed that the quality and safety agenda was entirely driven by the clinical teams locally. There has been a lot of engagement over the last three years on this. The service areas have leads on this too.

He added if we implemented the design of safety elements now for a building in 3 years it would be out of date very quickly, so we need to make sure these are managed carefully.

ACTION: Medium and Low Secure Facilities (Reaside) Strategic Outline Case to IQC in July 2021

9.1 Reach Out Governance Architecture

D. Tomlinson updated the final proposals will be going through Committee's and reported to Board in July 2021.

9.2 Questions from Governors and Public

J. Travers raised the Highcroft and Reaside Stakeholder Engagement and commented that staff engagement at Highcroft always brings up the provision of hot food on site. Can we ensure that this will be taken into account.

D. Tomlinson confirmed that the plans will include this provision.

J Travers asked for assurance of the overall effectiveness of the apprenticeship scheme.

P Nyanrumbu stated that at the last People Committee the meeting had the details of the outcomes of the last 110 apprentices that came through the Trust and it was agreed that this would be a regular report for oversight. The Committee also agreed that the pledge of 100 new apprentices into the Trust should be review as it was not felt to be ambitious enough.

M. Mirza questioned why in the Board Blog last month the details of the service user story was not included and the members of the public questions.

D. Tomlinson stated that this was due to potential confidentiality reasons as a discussion with the individual before production was not possible. In regards to the members of the public questions there was still further work to be done to address the quires and these were being managed outside of the Board process.

9.2 Snapshot Review of Board Performance

V. Devlin reflected that the team was really warm and open to suggestions especially on the staff story.

Individuals were open to challenges and we look to seek assurance more and more each month.

R. Beale felt that the meeting was feeling more effective and a team effort.

10. RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC & MEMBERS OF THE PRESS

DECISION: ***It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted***.

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS: ACTION LOG JULY 2021

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
Part II Agenda 24th February 2021	Reach-Out Final Business Case for Reach-Out to be presented to the public May Board meeting.	D. Tomlinson	May 2021		NHSE have moved implementation date to October. Update reports provided to FPP and IQC in May, final business case will now be taken to Board in August/September.
Part I Agenda Wednesday 28TH June 2021	Freedom to Speak Up Report S. Bloomfield and H. Grant to discuss mapping out a triangulated assurance report for The Guardian of Safe Working and FTSU	S. Bloomfield and H. Grant	Sept 2021		
Part I Agenda Wednesday 28TH June 2021	Highcroft and Reaside Stakeholder Engagement Medium and Low Secure Facilities (Reaside) Strategic Outline Case to IQC in July 2021	D. Tomlinson	July 2021		On the Agenda

RAG KEY

Overdue
Resolved
Not Due

4. Chair's Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	28 July 2021
Author	Danielle Oum, Chair
Executive sponsor	Danielle Oum, Chair

This paper is for (tick as appropriate):		
☐ Action	☐ Discussion	☒ Assurance

Executive summary & Recommendations:
The report is presented to Board members to highlight key areas of involvement during the month and to report on key local and system wide issues.
Reason for consideration:
Chair's report for information and accountability, an overview of key events and areas of focus
Previous consideration of report by:
Not applicable.
Strategic priorities (which strategic priority is the report providing assurance on)
Select Strategic Priority
Financial Implications *(detail any financial implications)*
Not applicable for this report
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Not applicable for this report
Equality impact assessments:
Not applicable for this report
Engagement *(detail any engagement with staff/service users)*
Engagement this month has been through introductory meetings with staff across the Trust.

CHAIR'S REPORT TO THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 Our vision is simple in that we are here to "*Improve mental health wellbeing*". I deliberately open with this statement, grounding this report in our core purpose.

1.2 Our values of compassion, Inclusive and Committed describe our core ethics and principles. They help guide our culture by inspiring people's best efforts and constraining unwanted actions that do not align with our values.

1.3 I am pleased to offer a brief report to the Board giving an overview of my key areas of focus since the last Board meeting with my intention to provide a regular update at each Board meeting. It has been a busy period, and I will limit this report to focus on just a few aspects of activity.

2. CLINICAL SERVICES

2.1 I attended the Lay Mangers meeting where I heard discussions about the workload associated with the Mental Health Act and some of the challenges of maintaining the accessibility of the Mental Health Act panels throughout the pandemic. I was able to reflect on how the team work together cohesively with the needs of our service users being at the heart of decisions being made.

3. PEOPLE

3.1 I enjoyed meeting Jaskiern Kaur, Head of Equality, Diversity and Inclusion, and learn more about the support available for staff and key areas of focus over the coming months.

4. QUALITY

4.1 I was pleased to be able to participate in the interview panels for the BSol ICS Non- Executive Director Inequalities lead. The role will chair the Inequalities Board to drive down inequity of access, experience and outcomes across the health and care system.

5. SUSTAINABILITY

5.1 I was pleased to meet Shane Bray, Managing Director of Summerhill Supplies Limited, discuss challenges and opportunities for SSL as well as the planned developments across the sites.

5.2 I attended the Bsol ICS transition committee to gain a greater understanding of the work underway within the programme workstreams.

6. COUNCIL OF GOVERNORS

6.1 Recruitment of Non-Executive Director
The Non-Executive Director recruitment process is now complete, and two candidates have been successfully appointment.

DANIELLE OUM
CHAIR

5. Chief Executive's Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE'S REPORT**
Date	28 July 2021
Author	Roisin Fallon-Williams
Executive sponsor	Roisin Fallon Williams

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

My report to the Board this month provides context of the on going COVID-19 pandemic and our response to increasing cases and the further easement of lockdown restrictions. It also provides information on focused work of relevance to the Board, in relation to our Trust strategy, local and national reports and emerging issues.

Reason for consideration

To provide the Board of Directors with an overview of key internal, systemwide and national issues.

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability. Quality. Clinical Services. People

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
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CHIEF EXECUTIVE'S REPORT

1. CURRENT PANDEMIC SITUATION

All Infection Prevention Control measures remain in place, and we currently have no patients with Covid 19 in our inpatient services. Whilst we have recently had a small number of isolated cases these have all been community acquired following community leave and have effectively been managed and no further spread has occurred. We are following the national guidance and all of the measures such as PPE, social distancing and managed visiting remain in place at this time to minimise the risk of infections entering and being spread within our services.

Following the national guidance, we are currently finalising our process which will enable staff who have been contacted by test and trace to return to work where clinically essential, balancing the risk of low staffing levels and the risk of infection.

2. PEOPLE

Staffing Levels

Absences across services are increasing in particular in relation to COVID-19, including for reasons of isolation following contact from Test and Trace. In some services this is posing increased risks which we are monitoring daily and taking actions to mitigate as far as is possible. Work on this includes revision of priorotisation, review of staff movements and flow processes and payment regimes.

Wellbeing

Staff Wellbeing remains a key focus of our work and at this time we are ensuring communication of all our offers and options is increased.

The working group responsible for wellbeing are also continuing to look at how we extend our 'Take Time' spaces throughout the Trust and how we further develop our framework for wellbeing conversations, we anticipate that Health Education England will be releasing an e-learning package to support training of managers to have wellbeing conversations and that this will inform our own future work.

Birmingham and Solihull (BSoL) Mental Health System Transformation Board

The **BSOL Mental Health System Transformation Board** has been created to replace a similar Committee which was previously stood down due to COVID-19.

The Board will remember that we agreed that the Clinical Commissioning Group, Birmingham Women's and Children's Trust and ourselves would work collaboratively through the BSOL Mental Health System Transformation Board to oversee the design, development and implementation of our collaborative workplans to meet the mental health NHS Long Term Plan deliverables for Birmingham and Solihull.

To support the Transformation Board an **ICS Mental Health Workforce Delivery Sub-**

Group has been formed and a scoping meeting took place on 15th July 2021.

The role/aim of the group is to move the associated workforce plans to implementation phase, monitoring progress, identifying risks and escalation to the Transformation Board. The focus of the sub-groups work includes -

- Recruitment/ Attraction – events/ social media/ incentives
- New Roles
- Existing Staff Development
- Staff experience & retention
- International Recruitment
- New Ways of Working

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Work has begun on building a clear and robust EDI approach including a clear governance structure. The intention behind this being to bring together all the existing work programmes and build in a clear route of engagement and ownership for future proposals. Becoming an anti-racist – anti discriminatory organisation is a key element of that approach, work within this space is currently underway for example in addition to our sessions as a Board, all senior Leaders across the Trust have been engaged to take part in series of Anti-Racism learning spaces.

A working group is currently being put together to explore the 'next steps' in further roll out of this approach, engagement has begun to ensure that group is inclusive by design.

In addition Patrick Nyarumbu, Jaskiern Kaur and myself have met with a member of the NHS Horizons team to discuss how we design and enact our approach in relation to Social Movement principles and we will bring back more on this to the Board in coming months.

In the meantime, if we are truly to step into active anti-racism, we must realise the importance of responsiveness, this most recently has been evident in relation to recent footballing events. We continue to show our active approach in response to discrimination and support colleagues to speak out and trust that racism and discrimination will be actively challenged.

4. CLINICAL SERVICES

Secure Care and Offender Health

Plans are in place to enhance staff engagement across Reaside/Hillis Lodge. These include Freedom to Speak up Guardian drop in sessions so that staff can raise concerns if needed and Staff Side (Unions) drop in clinics are planned over the summer.

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Team updates:

Newbridge House

- The Quality Improvement (QI) project surveys have shown a significant improvement in how staff feel about the team working better together
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- A Distress Tolerance Group is just being delivered in a way that supports greater access to service users receiving home treatment.
- Early Intervention Service (EIS) training across Home Treatment Teams (HTT) is now much improved at 84%.
- There has been further improvement in the use of Skyguard across HTT with plans in place to work with teams with the lowest usage.

Specialties

Our services are working collaboratively with system partners and colleagues in Integrated Community Care and Recovery (ICCR) to develop and implement community transformation plans. A key focus will be the development of an all age model and how this will be implemented across services.

Referrals to the older adult community mental health teams are increasing. Waiting lists are being reviewed and fixed term contracts are in place to support capacity.

There is ongoing work to look at the Memory Assessment Service pathway to support reductions in the waiting list. This has included work with our IT Analysts to develop an algorithm to assist managing the waiting list. We have also received funds from NHS England/Improvement (NHSE/I) to support the surge in referrals and we are recruiting to 12 month fixed term posts which are now being advertised.

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All ICCR teams are aware that the status quo will remain in respect of Covid safe practices. Teams will continue to work in a flexible fashion offering hybrid models of care using both virtual and face to face practices. All ICCR Managers have been advised to ensure all staff groups have the offer of flexible patterns of work including working from home on a rota basis to ensure fairness across services.

Meetings are being held with each team in ICCR by the Associate Director and Clinical Service Manager to engage in conversations around the trust strategy and staff survey. Teams have been very interactive and appreciative of these meetings to date and have given interesting feedback on issues that concern them. ICCR leads will look towards following up on these issues and feeding back the actions we have been able to take in a ‘you said, we did’ manner.

Implementation of the community transformation continues. The Governance structure is in place and local Implementation groups are well underway and well represented. Posts have been advertised and interviews are planned. Presentations were delivered to the Midland's wide NHSE Transformation webinar By Elaine Murray, Derek Tobin and Renu Bophal-Padiair, which was well received

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6. SUSTAINABILITY

The Board will receive later in the meeting our financial report. We will also have opportunity to consider the development of the Integrated Care System and Provider Collaboratives in our Part II meeting later today.

7. OTHER MATTERS

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ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE'S REPORT**
Date	28 July 2021
Author	Roisin Fallon-Williams
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This paper is for: ***[tick as appropriate]***		
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Paper previous consideration

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ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Board Overview: Trust Values

QUALITY

7. Integrated Quality Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7**
Paper title	**INTEGRATED QUALITY COMMITTEE CHAIR REPORT**
Date	
Author	Waheed Saleem, Chair of IQC
Board sponsor	Waheed Saleem, Chair of IQC

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration

To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Quality

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

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REPORT FROM THE IQC COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

1.1 CQC Update

Executive Director of Quality and Safety (Chief Nurse) presented the report on the latest submission to the Care Quality Commission as part of our section 31 monitoring regime. She added The CQC have confirmed that we have now been 'de-escalated' from weekly monitoring. Monthly reporting will however continue for the foreseeable future.

Chair's assurance comments:

Although progress is being made against the action plan, there is still someway to go on ensuring high quality and safety is systematic across the organisation. The new care planning process is undergoing a quality review as we are not assured that this is embedded across the organisation, as some staff have raised concerns about the rapid rollout of the standards and are unsure about expectations. MDT standards are not consistency applied and required further changes. Further review on the quality and consistency of safety huddles will also be required. The Committee asked for a comprehensive report at the next meeting detailing the journey over the last 6 months, and the future actions. It was also agreed to merge the CQC update report with the ligature risk assurance report.

1.2 Medium and Low Secure Facilities (Reaside) Strategic Outline Case

The Director of Finance presented the paper informing the meeting that this had been approved by the Secure Care management team, the Inpatient Developments Programme Board and the Capital Review Group. He asked the Committee to review and endorse the SOC for approval by the Board.

Chair's assurance comments:
The Committee was assured about the process of ensuring quality and safety requirements will form part of the business planning process, with the Outline Business Case and Final Business Case to come to IQC for sign off. The DoN and MD will provide further input into the development of the plans.

1.3 Reach Out Governance

IQC were informed that the paper sets out the governance arrangements for the Provider Collaborative (PC) which will replace the current Reach Out arrangements in October. This covers governance within the PC to BSMHFT as the Lead Provider and upwards to NHSE.

Chair's assurance comments:
The Committee endorsed the proposed governance arrangements. It was agreed that further conversation will be held with the DoN and MD about the commissioner/provider split and how this will be managed. The development of the ICS was also discussed and as further guidance emerges this will be taken into consideration.

1.4 A Safety Review of our Acute Inpatient Wards

The Director of Nursing and Associate Director of Governance presented the outcomes of the safety review undertaken on the acute inpatient wards. A number of recommendations were made for procedural and relational activities to reduce the risk of ligature related suicides with outcome measures.

Chair's assurance comments:
The report set out several actions that will be implemented to improve safety on inpatient wards, encompassing environmental, relational and procedural actions. Assurance reports will be presented to the IQC and progress against the outcomes measures. We can develop the best plans and the most innovative ideas, however, 'the proof of the pudding' is in the systematic implementation of the actions across the inpatient wards and the actual reduction of risk. There is a long way to go to be assured on this. There has also been numerous previous initiatives and actions which have not resulted in the outcomes we hoped for, therefore it is important that these are implemented and people are held to account for the implementation with appropriate oversight and governance. We owe it to our patients to do whatever we can to keep them safe whilst they are under our care, I am not sure we can put our hand on our hearts and say we do!

1.5 QI Update

The Committee received a presentation on the QI projects, some of which were impacted due to Covid. One page summaries of the projects will be distributed to Committee members.

Chair's assurance comments
The Committee were keen to hear how the QI process is helping towards the quality and safety agenda. It was agreed that at the October committee, the QI team will bring along project leads and Expert by Experience workers to provide an update on specific projects.

1.6 BAF

Andrew Hughes from AHNN Ltd who are supporting the Trust on the refresh of the BAF presented with the proposed final version and agree a Committee narrative before presentation at Board this month.

Chair's assurance comments:
In our pre meeting we reviewed the risk scores, controls and assurances which was presented to the committee for approval. Quarterly updates will be presented to the Committee.

1.7 Integrated Performance Report

Key performance indicators and priorities for Quality were presented and discussed.

Chair's assurance comments:
It was noted that informal patients who left the wards were counted as absconding, it was agreed to review this data collection methodology.

1.8 Integrated Quality Report for Q1 2020-2021

The Associate Director of Governance highlighted to IQC the themes that have arose over Q1.

Chair's assurance comments:

The new format of reporting was welcomed as it proved a better overview against indicators.

1.9 Review Of Quality Metrics 2021-22

The Committee agreed to defer this agenda item to the next meeting.

Chair's assurance comments:

8. Mental Health Legislation Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**8**
Paper title	**MENTAL HEALTH LEGISLATION COMMITTEE**
Date	28th July 2021
Author	Phil Gayle
Executive sponsor	Phil Gayle

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

To provide the Board of Directors with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration

To provide assurance to the Board of Directors.

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

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REPORT FROM THE MHL COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Mental Health Legislation Committee met on the 21st July 2021 with a summary of the key discussions being detailed below:

1.1 INTEGRATED REPORT (COMPLAINTS, INCIDENTS, CQC)

Overall, there was a decrease of 25% in MHA incidents reported for quarter 1 with the biggest reduction being in unlawful detentions following in the bedding in of the new regulations; the most reported category of incident was Section 17 Recording. There was 1 CQC MHA visit awaiting the report. There were no MHA Complaints received Q1

Chair's assurance comments:
The committee felt assured due to the decrease in MHA incidents reported for quarter 1.

1.2 MHL COMPLIANCE

There were 2 areas noted as a deficit across the trust, MCA assessments on admission and the RC not providing the patient with SOAD feedback. This has been addressed with all medics, reminding of their CoP responsibilities. Consent to treatment was raised as a particular concern at Reaside consistently over the quarter. The reasons given were limited consultant and SPR input due to Covid isolations but they were in the process of working through the deficits highlighted by the audit

1.3 MHA DATA

Louise / Hilary /Dinesh and Jas Kaur to meet and discuss how the MHA data systematically collated in line with data across the organisation.

Chair's assurance comments:
The committee had some assurance that the data for the quarter showed no unusual activity and reflected the usual trends the committee are aware of.

1.4 CTO PROJECT / SERVICE EVALUATION

A large project / service evaluation around CTO inequity has started. It is an unprecedented piece of work, underpinned by the literature review demonstrating we are starting where many other pieces of research have concluded. The committee will be kept appraised of the progress and presented with the conclusions

Chair's assurance comments
Given this is a long-standing concern for the committee and the Trust, it was recognised that no other Trust had undertaken a comprehensive detailed piece of work to produce what lies behind the CTO inequality at their Trust. The committee felt assured of the thorough process being taken by the group to present in October their findings and conclusions around CTO inequality.

1.5 LIBERTY PROTECTION SAFEGUARDS IMPLEMENTATION PLAN

The implementation plan was received by the committee. The committee was informed there has been a delay in the publication of the regulations and the Code of Practice which was due April 2021. This is now expected August 2021.

1.6 COVID PROCEDURES - LEAVE & VISITING

The Committee received updated guidance on Covid procedures, leave and visiting and this was noted by the committee.

Chair's assurance comments
The committee noted that the procedures may need to be received elsewhere rather than MHLC due to the revised governance reporting arrangements.

1.7 LEGAL REPORT

Report noted by the committee. No PFDs received this quarter

1.8 DELAYS IN CQC SOAD PROVISION

Committee were informed of an FOI submitted to the CQC from the Trust re SOAD timescales due to the lengthy delays being experienced by the Trust. Our timely SOAD requests are monitored by the CQC on MHA inspections.

Chair's assurance comments
The committee were informed that the Trust are experiencing the reciprocal impact of the delays in CQC SOAD provision. Therefore, the impact on treatment of patients whilst waiting for the legal authority to do so is a major concern.

1.9 **TERMS OF REFERENCE AND REVIEW OF COMMITTEE EFFECTIVENESS**
Discussed appropriateness of the membership of those external to the Trust as they sit on the JSOG where all multi-agency policies are formulated and agreed

9. Medical Directorate Escalation Report - Annual Organisational Audit

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**Medical Directorate Report**
Date	28th July 2021
Author	Kerry Rowley, Medical Directorate Non-Clinical Manager
Executive sponsor	Dr Hilary Grant, Executive Medical Director

This paper is for: ***[tick as appropriate]***		
☒ Action	☐ Discussion	☒ Assurance

Executive summary

The report is presented to Board members to update on the following work streams within the Medical Directorate:

- Medical appraisal.
- Medical job planning.
- Effective clinical governance for the medical profession.
- BSMHFT teaching academy.

Reason for consideration

The Board is requested to note the content of this report, receive assurance and approve the signing of the Annual Board Report and Statement of Compliance (Annex D) provided as appendix 1.

Paper previous consideration

Not applicable to this report.

Strategic objectives

Identify the strategic objectives that the paper impacts upon.

- Sustainability.
- Quality.
- Clinical Services.
- People

Financial implications

Not applicable to this report.

Risks

Not applicable to this report.

Equality impact

Not applicable to this report.

Our values

- Committed
- Compassionate
- Inclusive

MEDICAL DIRECTORATE REPORT

1. Medical Appraisal:

The Appraisal and Revalidation Committee's remit is to provide assurance to the Board that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is undertaking its statutory responsibilities to ensure that all doctors with a designated body connection to the organisation can be successfully revalidated, as well as supporting the decision-making process for revalidation recommendations in complex cases.

The Committee provides support and advice to the Medical Director in the exercising of their duties as the Responsible Officer in relation to the process of medical appraisal and revalidation.

This report provides an update for the work undertaken by the Medical Directorate and Appraisal and Revalidation Committee during the 2020/2021 appraisal period.

The members of the Appraisal and Revalidation Committee for 2020/2021 were:

- Executive Medical Director (Chair).
- Deputy Medical Director (Professional Practice, Legal and Transformation).
- Associate Medical Director (Medical Education).
- Medical Directorate Non Clinical Manager.
- Senior Medical Appraisal Auditor.
- Appraisal and Revalidation Administrator.

Medical appraisal and revalidation was suspended for some doctors between 6th March 2020 and 31st March 2021 to free up clinical time to manage the Covid-19 emergency situation. However as appraisal is a supportive mechanism, BSMHFT encouraged all doctors to continue participating in their appraisal process so long as they could meet remotely with their appraiser or use social distancing. However, for those who wished to defer their appraisal they would be supported to do so according to GMC (General Medical Council) guidelines.

NHSE/I (NHS England/Improvement) have undertaken significant work with colleagues across the profession and the UK to review the format of appraisal in light of the pandemic. With partners and stakeholders in the Academy of Medical Royal Colleges, the GMC and the British Medical Association (BMA), it has been agreed to implement a rebalanced approach that focuses on the doctors' professional development and wellbeing and simplifies expectations around supporting information and pre-appraisal paperwork.

Medical Appraisal was fully reinstated within the Trust in April 2021, recognising the exceptional stresses that the Covid-19 pandemic has placed on healthcare workers and the need for the provision of a flexible opportunity for a confidential professional discussion as part of supporting professional development and well-being, with preparation being straightforward and proportionate.

Further local suspensions of appraisal activity may be necessary in the face of local outbreaks and it has been encouraged by NHS England / NHS Improvement that these decisions be made locally; also that flexibility and understanding be shown to individual doctors by postponing or approving the missing of an appraisal as necessary.

For the period of 1st April 2020 and 31st March 2021, 192 out of 198 doctors (97.0%) with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust completed their 2020/21 appraisal.

Six doctors were identified as having an approved incomplete or missed appraisal for the 2020/2021 appraisal period for the following reasons:

- Covid-19 related x 1 doctor
- Long term sick leave x 2 doctors
- Maternity leave x 2 doctors
- Sabbatical leave x 1 doctor

Out of the 192 doctors who completed their 2020/21 appraisal, 142 doctors (74.0%) completed their appraisal on time with 50 doctors (26.0%) submitting deferral requests to formally request approval by the Responsible Officer for them to complete their appraisals outside of the agreed timeframe. Reasons given are as follows:

- Covid-19 related x 5 doctors
- Sickness x 5 doctors
- Appraiser availability x 6 doctors
- Maternity leave x 2 doctors
- Capacity issues x 6 doctors
- Insufficient supporting evidence x 8 doctors
- Personal circumstances x 3 doctors
- System issue x 1 doctor

Following the recruitment of an additional 4 appraisers, the Trust retains 36 appraisers to conduct medical appraisals as part of their job plans, the number of which is sufficient and meets the NHSE (NHS England) Framework of Quality Assurance for Responsible Officers and Revalidation – Core Standards. Additionally we have recruited a further 2 Medical Appraisal Auditors following 1 auditor standing down.

In response to the Covid-19 pandemic, the GMC extended the revalidation due dates for those doctors who were due to revalidate between 6th March 2020 and 31st March 2021 meaning that no doctors were revalidated during this time. Revalidation recommenced as business as usual from 1st April 2021.

NHSE/I have confirmed that the 2020/2021 Annual Organisational Audit (AOA) End of Year Questionnaire has been stood down. We are still required to submit Annex D – Annual board report and Statement of Compliance (attached as appendix 1).

Our organisation continues to demonstrate improvement in the management and quality of medical appraisals, having achieved the following this past year:

- Undertaken further review of involvement by Trust Expert by Experience in the medical appraisal process.
- Shortly prior to the Covid–19 outbreak, face to face appraisee training was provided by Miad Healthcare.
- In light of the Covid-19 pandemic, we provided virtual refresher training to all existing appraisers to support the rebalanced approach for medical appraisal.
- Recruited a small number of additional appraisers and provided new appraiser training which incorporated the changes to medical appraisal.
- All doctors with a designated body connection to BSMHFT were notified of the revised appraisal approach and were supported through their appraisal process.
- Appraiser Peer Support Sessions were held remotely and attended by our appraisers and Trust Expert by Experience.
- Recruited 2 additional Medical Appraisal Auditors.
- The Trust's Medical Appraisal policy has been reviewed and is currently out for consultation.

- Introduced a check of doctors indemnity insurance.
- Established a robust processes for dissemination of Responsible Officer and Appraisal Network Information (ROAN) sheets.
- At the request of GMC have introduced a process for informing the GMC ELA (Employment Liaison Advisor) of doctors who have not had an appraisal for over one year without an agreed deferral or other reason.
- Established mechanisms for triangulation of learning from deaths into medical appraisal.

Future Plans:

- Implement reciprocal organisational peer review.
- Implement appraiser 1-1 feedback sessions.
- Further review the inclusion of Trust Expert by Experience within the Medical Appraisal process – namely within the audit process.
- Undertake a review of the 'Caring for Doctors, Caring for Patients' document, reviewing factors which impact on the mental health and wellbeing of doctors.
- Implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

2. Medical Job Planning:

E-JobPlan, part of Allocate Software's HealthMedics Optima, is designed to help facilitate the process of job planning as set out by the national consultant contract, allowing users to populate, review and sign off of job plans all in one place. The system provides organisations with the facility to manage and report on current and historic information at an individual, departmental or organisational level, presenting a valuable opportunity to maximise efficiency through increased transparency.

E-JobPlan provides consistency in the format of job plans, accurate calculations for PAs (programme activities) and on call work including prospective cover, and the ability to reflect the most complex work patterns through the combination of annualised and timetabled activities.

Electronic medical job planning has been in situ within the Trust since February 2015 and is now a mandatory annual process in which the doctor whose job plan is being reviewed has a formal planned structured meeting to agree individual programmes of work that contribute to the overall delivery of services. This meeting requires a partnership approach and should take place with all relevant clinical manager(s) for assurance that planned activities align with strategic objectives.

The review of PA allocations above 10 per week is a key part of the job planning process and in all cases, medical staff should not be paid more than 13.5 PA's as agreed by the Trust Remuneration Committee. In exceptional circumstances where there is a requirement to undertake more than 13.5 Programmed Activities this will need to be considered and approved by the Director of Operations and the Executive Medical Director and comply with the requirements of the European Working Time Directive in relation to completion of an opt out form and relevant risk assessment that needs to be undertaken in line with the Trust Working Time Regulations Guidelines.

The last round commenced as planned; however due to the Covid-19 pandemic, a decision was made to extend the completion deadline. This decision was made to give medical staff more time to complete job plans and identified amendments following Clinical Director review panels and to support doctors to make job plans more effective for their own wellbeing, development and patient care. This round closed in December 2020.

The current round commenced in January 2021 and requires medical staff to complete their own

prospective job plans for 1st April 2021 to 31st March 2022.

This is really important and needs to reflect the amount of work that our medical colleagues are doing for the Trust – both direct clinical care and supporting professional activities. We recognise that it has been an extremely busy time and this may feel like an additional task at a time of pressure, but it is only with this additional information that we can start to make progress towards job plans that reflect the work done, needed and very much valued.

It is recognised that the current Covid-19 pandemic continues to impact on the completion of prospective job plans. A final request has been circulated to doctors requesting for them to ensure that their job plans are fully completed by 30th July 2021. Following this, any job plans remaining in discussion on 13th August 2021 will automatically be forwarded by the Medical Directorate to clinical leads and clinical directors for review and sign off.

Any doctor declining to participate in the process without reasonable cause may affect:

- Annual pay progression.
- Application for new and/or renewal of clinical excellence awards (consultants) and
- May be subject to investigation and discliplinary action.
- Appraisal – a current job plan must be in place prior to an appraisal taking place unless this is beyond the doctors control.

For job plans whereby it has not been possible to agree activity content, then Trust policy will be followed in accordance with mediation and appeals as stipulated in the Consultant Contract 2003 and Terms & Conditions of Service for Associate Specialists (2008) and Specialty Doctors (2008).

In line with the Trust policy which has been recently reviewed and ratified, the Medical Directorate are required to annually report to Trust board the number of doctors who have undergone the Trust's e-JobPlan process.

Please find the position below as of 19th July 2021 which relates to the current round.

Service Area	Total Number of Job Plans for Completion	Total Number of Job Plans Remaining in Discussion	Total Number of Job Plans with Doctor for Agreement Following Amendment	Total Number of Completed Job Plans Awaiting First Sign Off	Total Number of Completed Job Plans Awaiting Second and Final Sign Off	Total Number of Job Plans Fully Signed Off
Acute Care	**26**	8	1	9	8	0
Urgent Care	**15**	13	0	2	0	0
PCDS	**50**	9	1	1	4	35
ICCR	**60**	26	0	23	5	6
Secure Care & Offender Health	**32**	7	9	1	2	13
Exec Director – Medical Locality *Review and Sign off by Service Area Clinical	**5**	2	0	3	0	0

Leads and Clinical Directors*						

3. Effective Clinical Governance for the Medical Profession:

The General Medical Council previously circulated a handbook *'Effective Clinical Governance for the Medical Profession'* to all organisations which employ, contract or oversee the practice of doctors in the UK. In the majority of cases these organisations will also be designated bodies. The handbook is also relevant for healthcare providers in the crown dependencies and Suitable Persons.

In particular, the handbook is designed for those individuals or groups of individuals who play an important leadership role in delivering and assuring the quality of clinical governance processes for doctors.

The handbook aims to provide boards with a description of the core principles underpinning effective clinical governance for doctors focussing particularly on responsibilities outlined in the Responsible Officer (RO) Regulations. In doing so it acts as a resource to support organisations in evaluating the effectiveness of their local arrangements including:

- Leadership, delivery and quality of clinical governance for doctors.
- Medical Revalidation.
- Identifying and responding to concerns about doctors.
- Pre-employment checks for doctors.

Responsibilities for and delivery of various aspects of clinical governance for doctors are different across the UK, sectors and type of organisation. They are also dependent on whether an organisation acts at a national or local level. For this reason the handbook requires a certain level of interpretation by organisations to ensure that benefits are maximised. It is also used in conjunction with other relevant clinical governance guidance.

There is no specific requirement to report against the handbook but we considered it useful to undertake a gap analysis against the standards.

Following input from key stakeholders, a self assessment has been completed, identifying where we are meeting outcomes, with areas identified on where further work is required as an organisation. We plan to continue our work with internal stakeholders to devise action plans to further scope and strengthen the following areas where needed:

- The provision of development and training opportunities for Trust Board members where necessary to support the oversight of clinical governance arrangements for doctors.

- How our organisation identifies clinical governance information about doctors.

- How our organisation demonstrates its commitment to the delivery of effective governance.

- How BSMHFT works with local patient groups to promote awareness of revalidation processes and how are they promoted locally.

- Assurance that BSMHFT has a clear view of risks associated with clinical governance systems for doctors.

- What quality assurance activity does BSMHFT undertake to assess the robustness of its clinical governance processes for doctors.

- How does BSMHFT assure itself that clinical governance processes generate accurate, timely and reliable data to support continuous monitoring.

- What areas for learning and improvement has our organisation identified from the triangulation of outputs from different clinical governance processes.

4. BSMHFT Teaching Academy:

The vision of BSMHFT Teaching Academy is to inspire medical students through innovative and enthusiastic teaching, to challenge their preconceptions about mental illness and to promote recruitment into psychiatry through quality placements, excellence in teaching and further enrichment activities such as careers events and summer schools. The Academy's vision is also to nurture and develop medical educators within BSMHFT from Foundation Year up to Consultant level. This year we will be hosting 4th year medical students from both Birmingham and Aston Medical Schools. This makes BSMHFT one of the largest providers of clinical psychiatry experience for medical students in the UK.

Over the past year it became increasingly difficult to identify clinical placements for medical students. This was due to a combination of factors - increased absences due to Covid-19, consultants retiring/leaving the Trust and others asking for a break from hosting students due to the challenges posed by an increased move to remote working during lockdown. Given the current climate, in order to meet the challenge of increased student numbers and realise our vision of becoming a pioneering centre of educational excellence, we have made a number of structural changes to the Academy.

New Academy Appointments:

SATus (Senior Academy Tutors)

We have appointed 10 BSMHFT Senior Academy tutors, Consultants and SAS (Specialty & Associate Specialty) doctors who demonstrate commitment and passion for undergraduate teaching to take on additional teaching responsibilities and gain honorary lecturer status at the universities. Each will have responsibility for a firm of 8-10 medical students in, or near their place of work ('hub'). The role of each SATu is to ensure the students in their firm have a rich and diverse clinical experience during their psychiatry placement. They will be responsible for signposting students to (and arranging taster days in) different psychiatry specialities within their hub. They will provide information and support and oversee local teaching.

CTFs (Clinical Teaching Fellows):

In line with Teaching Academies across the country, we have appointed 3 CTFs to start in August 2021. They will develop new teaching resources and lead on quality improvement projects. They will work on curriculum change and development of new assessments (MCQ/OSCE – multiple choice questions / objective structured clinical examination) and help us develop simulation training which is one of the most effective teaching methods.

Academy Tutors and Teachers:

The new Academy structure provides teaching experience for psychiatric trainees at each stage of their training with educational career progression. Senior trainees with an interest in medical education can apply for the role of Academy Tutor (ATu) and core trainees for the role of Academy Teacher (AT).

Challenges Ahead:

This year Health Education England (HEE) has requested an accountability report from all trusts in England to account for how the teaching money is spent. We have completed our report and await the response from HEE. As the Academy grows we need to ensure that our wider Trust systems can evolve to keep pace with the growth.

5. Conclusion

The Board is requested to note the content of this report, receive assurance and **approve** the signing of the Annual Board report and Statement of Compliance provided as appendix 1.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

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Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Birmingham and Solihull Mental Health NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   The 2020/2021 Annual Organisational Audit (AOA) End of Year Questionnaire has been stood down. We are still required to submit Annex D – Annual board report and Statement of Compliance.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   A Responsible Officer is in situ and is in compliance with the regulations.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes/~~No~~ [delete as applicable]

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   There is robust monthly monitoring of all licensed practioners with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust which is further enhanced by the triangulation of information at the pre-employment check stage.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   The Medical Appraisal policy has recently been reviewed and is currently out for consultation. The policy has been updated and incorporates the revised approach for Medical Appraisal.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

It was anticipated that a reciprocal organisational peer review would be arranged in 2020/2021; however we have been unsuccessful in agreeing this with our MERIT partners.

We have recently identified an alternative organisation that is willing to participate in a reciprocal arrangement.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Robust processes are currently in place to identify locum and short term workers within the organisation. Annual appraisal is provided to those doctors with a designated body connection to BSMHFT, in addition to regular 1-1 meetings, Regular Management Supervision meetings, provision of fundamental and other relevant training and access to governance activities and meetings.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

A mechanism for the transfer of information relating to complaints, SI's and learning from deaths has been established which ensures that all doctors have access to this information for the purpose of medical appraisal.

We also provided appraisee training which was supported by an external provider and was very well attended.

Refresher training for existing appraisers and new appraiser training for new appraisers was provided and updated on the revised approach for appraisal.

We are planning to implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

n/a

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The Medical Appraisal policy has recently been reviewed and is currently out for consultation. The policy has been updated and incorporates the revised approach for Medical Appraisal.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust retains 36 appraisers to conduct medical appraisals as part of their job plans, the number of which is sufficient and meets the NHSE (NHS England) Framework of Quality Assurance for Responsible Officers and Revalidation – Core Standards.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

In light of the Covid -19 pandemic, we provided virtual refresher training to all existing appraisers to support the rebalanced approach for medical appraisal.

Recruited a small number of additional appraisers and provided new appraiser training which incorporated the changes to medical appraisal.

Appraiser Peer Support Sessions were held remotely and attended by our appraisers and Trust Expert by Experience.

Recruited 2 additional Medical Appraisal Auditors.

The Trusts Medical Appraisal policy has been reviewed and is currently out for consultation.

There are plans in place to implement appraiser 1-1 feedback sessions.

Further review the inclusion of Trust Expert by Experience within the Medical Appraisal process – namely within the audit process.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

We have an established Appraisal and Revalidation Committees remit is to provide assurance to the Board that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is undertaking its statutory responsibilities to ensure that all doctors with a designated body connection to the organisation can be successfully revalidated, as well as supporting the decision making process for revalidation recommendations in complex cases.

In addition we have recently been able to identify another organisation with a view to implementing a reciprocal organisational peer review arrangement and plan to undertake further review of the involvement by Trust Expert by Experience (lay persons) in the medical appraisal process.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

In response to the Covid -19 pandemic, the GMC extended the revalidation due dates for those doctors who were due to revalidate between 6th March 2020 and 31st March 2021 meaning that no doctors were revalidated during this 2020/2021 appraisal year. Revalidation recommenced as BAU from 1st April 2021.

Additionally we have timely processes to address FTP concerns and follow the MHPS process.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All positive revalidation submissions are made immediately following the Trusts Revalidation Committee meeting, with doctors being notified in writing the same day. Conversations relating to deferrals or non-engagement are held with the doctor prior to any submission being made. Additionally there is a process in place to notify the GMC Liaision Officer prior to revalidation for any doctors where non-engagement is a concern. There are currently no concerns with engagement.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Trust currently have an Appraisal and Revalidation Committee in situ which links into clinical governance via the Executive Medical Director/Responsible Officer.

A benchmarking exercise has been undertaken, benchmarking our governance and performance against 'The Effective Clinical Governance for the Medical Profession' document. We continue to develop an action plan to address identified actions following completion of the benchmarking exercise.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust has established links for the sharing of information between the Investigation, Complaints, Learning from Deaths and HR teams. The Trust also has in situ a Decision Making Group and follows the MHPS process. The Trusts Medical Appraisal policy is also in the process of being reviewed.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The organisation follows the MHPS which is underpinned by policy.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

The Human Resources Department report into People Committee and Board. The Medical Director, Deputy Medical Director and Human

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Resources representative have regular meetings with the GMC Liaison Officer to discuss current and potential concerns.

We use the MHPS Framework to identify and the Decision Making Group to address required actions.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

A robust method for the use of Medical Practice Information Transfer Forms (MPIT) is in use within the Trust,

We are also in the process of scoping a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

We have benchmarked our governance and performance against 'The Effective Clinical Governance for the Medical Profession document' and continue to develop an action plan to address identified actions following completion of the benchmarking exercise.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The use of robust documentation to enhance the sharing of information between teams continues to work successfully.

Section 6 – Summary of comments, and overall conclusion

Medical appraisal and revalidation was suspended for some doctors between

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6th March 2020 and 31st March 2021 to free up clinical time to manage the COVID-19 emergency situation. However as appraisal is a supportive mechanism, BSMHFT encouraged all doctors to continue participating in their appraisal process so long as they could meet remotely with their appraiser or use social distancing. However, for those who wished to defer their appraisal they would be supported to do so according to GMC guidelines..

Medical Appraisal was fully reinstated within the Trust in April 2021, recognising the exceptional stresses that the COVID-19 pandemic has placed on healthcare workers and the need for the provision of a flexible opportunity for a confidential professional discussion as part of supporting professional development and well-being, with preparation being straightforward and proportionate.

Further local suspensions of appraisal activity may be necessary in the face of local outbreaks and it has been encouraged by NHS England / NHS Improvement that these decisions be made locally; also that flexibility and understanding be shown to individual doctors by postponing or approving the missing of an appraisal as necessary.

For the period of 1st April 2020 and 31st March 2021, 192 out of 198 doctors (97.0%) with a prescribed connection to Birmingham and Solihull Mental Health NHS Foundation Trust completed their 2020/21 appraisal.

Six doctors were identified as having an approved incomplete or missed appraisal for the 2020/2021 appraisal period for the following reasons:

- Covid related x 1 doctor
- Long term sick leave x 2 doctors
- Maternity leave x 2 doctors
- Sabbatical leave x 1 doctor

Out of the 192 doctors who completed their 2020/21 appraisal, 142 doctors (74.0%) completed their appraisal on time with 50 doctors (26.0%) submitting deferral requests to formally request approval by the Responsible Officer for them to complete their appraisals outside of the agreed timeframe. Reasons given are as follows:

- Covid related x 5 doctors
- Sickness x 5 doctors
- Appraiser availability x 6 doctors
- Maternity leave x 2 doctors
- Capacity issues x 6 doctors
- Insufficient supporting evidence x 8 doctors
- Personal circumstances x 3 doctors
- System issue x 1 doctor

Following the recruitment of an additional 4 appraisers, the Trust retains 36 appraisers to conduct medical appraisals as part of their job plans, the number of which is sufficient and meets the NHSE (NHS England)

Framework of Quality Assurance for Responsible Officers and Revalidation – Core Standards. Additionally we have recruited a further 2 Medical Appraisal Auditors following 1 auditor standing down.

In response to the Covid -19 pandemic, the GMC extended the revalidation due dates for those doctors who were due to revalidate between 6th March 2020 and 31st March 2021 meaning that no doctors were revalidated during this time. Revalidation recommenced as BAU from 1st April 2021.

Our organisation continues to demonstrate improvement in the management and quality of medical appraisals, having achieved the following this past year:

- Undertaken further review of involvement by Trust Expert by Experience in the medical appraisal process.
- Shortly prior to the Covid – 19 outbreak, face to face appraisee training was provided by Miad Healthcare.
- In light of the Covid -19 pandemic, we provided virtual refresher training to all existing appraisers to support the rebalanced approach for medical appraisal.
- Recruited a small number of additional appraisers and provided new appraiser training which incorporated the changes to medical appraisal.
- All doctors with a designated body connection to BSMHFT were notified of the revised appraisal approach and were supported through their appraisal process.
- Appraiser Peer Support Sessions were held remotely and attended by our appraisers and Trust Expert by Experience.
- Recruited 2 additional Medical Appraisal Auditors.
- The Trusts Medical Appraisal policy has been reviewed and is currently out for consultation.
- Introduced a check of doctors indemnity insurance
- Established a robust processes for dissemination of Responsible Officer and Appraisal Network Information (ROAN) sheets
- At the request of GMC have introduced a process for informing the GMC ELA of doctors who have not had an appraisal for over one year without an agreed deferral or other reason.
- Established mechanisms for triangulation of learning from deaths into medical appraisal.

Future Plans:

- Implement reciprocal organisational peer review.
- Implement appraiser 1-1 feedback sessions
- Further review the inclusion of Trust Expert by Experience within the

Medical Appraisal process – namely within the audit process.

- Implement organisational peer review.
- Undertake a review of the 'Caring for Doctors, Caring for Patients' document, reviewing factors which impact on the mental health and wellbeing of doctors.
- Implement a process for an annual Responsible Officer to Responsible Officer communication relating to private providers and SIs (serious incidents), complaints, mortality case note reviews and disciplinary.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

PEOPLE

10. People Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	
Paper title	PEOPLE COMMITTEE
Date	28 July 2021
Author	Patrick Nyarumbu
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, people and Partnerships

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary
To provide the Board of Directors with an update relating to the people committee.

Reason for consideration
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. People
Financial implications
Not applicable for this report
Risks
No specific risk is being highlighted to the Board regarding the contents of the report
Equality impact
Not applicable for this report
Our values
Committed Compassionate Inclusive

ISSUES TO RAISE WITH THE BOARD

The People Committee met on 22 July 2021 and an exception report has been developed to update the Board.

The committee would like to bring the following areas of discussion to the attention of the Board:

1 SHAPING THE FUTURE WORKFORCE

1.1 Shaping Our Future Workforce Sub group

The committee received any update from the sub group.

Key highlights included:

- Work is underway to complete the guidance and policy on remote working. This work is also being aligned to the guidance relating to flexible working which comes into effect from the 13th September 2021. The guidance provides greater opportunities to widen access to flexible working for staff
- The group is supporting the work being progressed to increase the number of opportunities available for entry level jobs.
- A temporary staffing project group has been established to progress work in reducing organisational reliance on temporary staffing. The committee will continue to receive assurance on progress.

Chair's assurance comments:

The subgroup has met for the second time since its inception in June and is progressing the actions within the implementation plan. The committee will continue to maintain delivery oversight. In relation to the group supporting the work to increase the number of opportunities available for entry level jobs, the committee were partly assured as the analysis so far highlighted that further work is required to review our staffing establishments and create opportunities for entry level roles.

2. TRANSFORMING OUR CULTURE AND STAFF EXPERIENCE

2.1 Transforming Our Culture and Staff Experience sub group

The committee received an update on the work of the sub-group.

Key highlights included:

- The committee was pleased to see that work is progressing to deep dive into data relating to incidents of assaults or harassment of staff by protected characteristics.
- The group approved the pay progression policy which has been refreshed to align with national policy changes
- The committee agreed that the disciplinary policy will be shared with Board members as the timeline for approval is not aligned with committee dates. The committee however received the quarterly details regarding current disciplinary cases and the ethnicity and disability breakdown of the cases. The table below shows a breakdown of this data for the past 7 quarters.

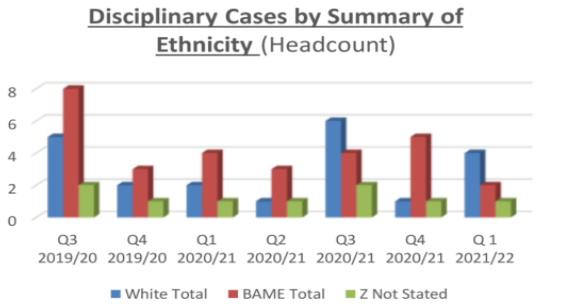
Trust Ethnicity Profile (as at June 2021)

Ethnicity Group	Headcount	%
BME	1488	36.39%
White	2101	51.38%
Not Stated	500	12.23%
Total	4089	100.00%

Disciplinary Cases

7 new disciplinary cases started in Q1 2021/22 of which 2 related to BAME staff (28.57%).

Quarter & Year	White Total	BAME Total	Z Not Stated	Grand Total	BAME %
Q3 2019/20	5	8	2	15	53.33%
Q4 2019/20	2	3	1	6	50.00%
Q1 2020/21	2	4	1	7	57.14%
Q2 2020/21	1	3	1	5	60.00%
Q3 2020/21	6	4	2	12	33.33%
Q4 2020/21	1	5	1	7	71.43%
Q 1 2021/22	4	2	1	7	28.57%
Grand Total	**17**	**27**	**8**	**52**	**51.92%**



There were no disciplinary cases involving colleagues with a disability in Q1

Quarter & Year	Disabled	Not Disabled	Not Declared	Grand Total	Disabled %
Q3 2019/20		7	8	15	
Q4 2019/20		4	2	6	
Q1 2020/21		6	1	7	
Q2 2020/21		5		5	
Q3 2020/21	2	8	2	12	16.67%
Q4 2020/21		7		7	
Q 1 2021/22		7		7	
Grand Total	**2**	**44**	**13**	**59**	**3.39%**

Chair's assurance comments:

With regards to the deep dive into data relating to incidents of assaults or harassment of staff by protected characteristics, the committees' views were that further work was needed to communicate widely with staff to ensure such incidents are recorded to be assured. The working group will be taking this forward.

The committee received the quarterly details regarding current disciplinary cases including the ethnicity and disability breakdown. The graphs highlight that while the data shows improvement in this area, there is still work to be done to demonstrate continued sustainability to provide the Board with full assurance of this.

3. MODERNISING OUR PEOPLE PRACTICE

3.1 Key Performance Indicators (KPIs)

The committee received assurance on actions being taken to address concerns around People KPIs aligned to the Trust's People Strategic Priority. The report generated significant discussion and the committee welcomed the level of detail provided.

Chair's assurance comments:
The committee felt that further work needed to be undertaken to strengthen assurance on actions, specifically improvement in the rate of exit interviews, return to work interviews and fundamental training targets. The committee received a detailed pack on quarterly measures as outlined in the People Strategic Implementation Plan. We noted that there are still gaps in some of the quarterly KPIs and work is being done to set the baselines as these KPIs are new within the plan. The committee requested a clear time frame for the development of this dataset.

4. COMMITTEE GOVERNANCE

4.1 ICS People Board update

The committee was updated regarding the ICS People Board. A workforce summit was held this month in place of the Board to explore and agree further opportunities to support the workforce challenges across the system. As a system we have already made a commitment to increase the number of apprenticeships and volunteers. Further short to medium term priorities were explored to respond to the workforce pressures across the system.

Chair's assurance comments
The Committee were assured that it will continue to receive update reports on agreed priorities and actions being taken by the ICS People Board.

4.2 Board Assurance Framework

The BAF was discussed by the committee and approved.

4.3 Term of Reference

The TOR were discussed and approved pending addition of the safer staffing element to the TOR. This action has now been completed.

Birmingham and Solihull Mental Health NHS Foundation Trust

PEOPLE COMMITTEE

TERMS OF REFERENCE

Trust Values: Compassion/Inclusion//Commitment

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1. Values

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future.
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Committee is constituted as a standing committee of the Board and is authorised by the Board to investigate any activity within its Term of Reference. It is authorised to seek any information it requires from any employee and contractors as directed to co-operate with any request made by the Committee or the Board.

2.2 The Committee is authorised by the Board to instruct professional advisors and require the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee is authorised to obtain internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 To ensure and provide assurance on behalf of the Board that the People Strategic Priority of the Trust's Strategy (2020) and people related issues of the Strategic Priorities of the Trust strategy (2020) is being delivered to all staff groups in line with the Trust values:

The Committee will take responsibility and delivery of aims set out within the People Strategic Priority as below:

- Shaping Our Future Workforce including
    - Attract and Retain Diverse Talent
    - High-Performing Workforce
    - Flexible &Transformative Workforce Models
- Transforming Our Culture including
    - Inclusion, Equality and diversity
    - Safety to Speak Up and Share Learning
    - Compassion and Wellbeing
- Modernising our People Practice including
    - Integrated People Practice
    - Evidence-Based People Practice
    - Digitally –Enabled Workforce

The Committee will be supported by two sub-groups to provide reports to the People Committee to this effect.

The following sub-committees will be chaired by professional leads outside of the People function:

- Shaping the Future Workforce Sub Committee
- Transforming Our Culture and Staff Experience Sub Committee

3.2 To assure focus and delivery of wellbeing and inclusion where staff are the top priority to support a happy workforce.

3.3 The People Strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care.

3.4 Processes are, and the right culture is, in place to support optimum employee performance to enable the delivery of the People Strategy and business plans aligned with the Trust's values.

3.5 To assure The Trust is meeting its legal and regulatory duties in relation to staff, volunteers and peers by experience.

3.6 The committee will ensure that there are appropriate governance arrangements in place to receive assurance that clinical staffing levels are safe and in the case of inpatient areas reviewed twice yearly. Also that risks to quality and safety in relation to safe staffing levels are identified and mitigated.

3.7 To review and advise any human resource risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way.

3.8 To lead on monitoring of controls and assurance related to the 'People' sections of the Board Assurance Framework.

4. RESPONSIBILITIES AND DUTIES

4.1 Developing and advising the Board on the People Strategic Priorities including any leadership and organisational development interventions, actions to improve inclusion, equality and diversity necessary to deliver the Trust's strategy, incorporating external best practice and professional advice.

4.2 Overseeing delivery of the People Strategic Priorities on behalf of the Board against agreed plans, a range of workforce metrics, indicators and targets.

4.3 Providing appropriate reports to the Board on the above indicating assurances received, decisions made, and matters escalated that require consideration by the Board.

4.4 Monitoring the development of the future workforce, through an effective workforce plan that includes workforce supply, new roles, learning and organisational development.

4.5 Ensure the there is sufficient leadership and management capacity and capability within the Trust to deliver the Trust's strategy.

4.6 Ensuring that the voice of staff and volunteers is heard, via staff networks, staff surveys and other appropriate mechanisms, and that this acted upon in line with the strategic vision and values and to ensure compliance with requirements relating to Freedom to Speak Up and Whistleblowing.

4.7 Maintaining oversight and assure the Trust's equality, diversity and inclusion agenda is being delivered

4.8 Ensuring the Trust has a suitable policy framework and leadership development framework to deliver the People Strategic Priorities, ensuring alignment with the NHS People Plan and relevant regulatory requirements such as NHS Improvement workforce standards and CQC.

4.9 Oversee the development and implementation of initiatives to maintain the organization as an undergraduate and postgraduate learning provider.

4.10 Oversee and influence key relationships with educational partners to maximise benefit of these relationships to the Trust.

4.11 Review national and local strategies and reports from external bodies such as CQC, NHS E/NHS I, HEE & NHS Employers, identifying the implications for, and actions required by the Trust.

4.12 Ensure there are ongoing arrangements for reviewing the regulatory requirements relating to staff, such as NHSE/NHS I and CQC standards such as Well-Led. Ensure that appropriate strategies and plans are developed, implemented and sustained to meet these requirements.

4.13 Maintain oversight of its associated sub-groups through receipt of regular update reports and metrics.

4.14 Receive bi-annual reports from the Joint Negotiation and Consultative Committee and the Joint Local Negotiation and Consultative Committee for discussion and assurance.

4.15 Receive Review the People Risk Register and relevant risks from the Board Assurance Framework to review assurance on risk mitigation and controls including any gaps in control.

4.16 Assess any risks within the workforce portfolio brought to the attention of the Committee and identify those that are significant for escalating to IQC, FFP and Board as appropriate

4.17 Maintain oversight of Remumeration and Reward, ensuring and assuring alignment to relevant Employee and Worker legislation

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

- Chair – Non Executive Director
- Deputy Chair - Non-Executive Director
- Non-Executive Director
- Executive Director of Quality and Safety (Chief Nurse)
- Medical Director
- Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In Attendance

5.2 The following will be standing attendees of the Committee:

- Deputy Director of Nursing
- Deputy Director of Finance
- Associate Director for Allied Health Professions and Recovery
- Chief Psychologist
- Deputy Director of People and Organisational Development
- Chief Pharmacist

5.3 Other members of the Board can attend meetings if they indicate to the Chair of the People Committee, in advance, of their intention to do so.

5.4 Other members of staff may attend to present papers or to contribute to the staff story

5.5 Other parties may be invited to present papers from time to time.

5.6 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.7 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.8 Members should make every effort to be present at all Committee meetings.

5.9 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 3 Committee members, one of which must be a Non-Executive Director and one must be an Executive Director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All members must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 The meeting will be closed and not open to the public.

8.2 Meetings will be held monthly. Members will agree the meeting dates annually in advance.

8.3 The agenda of every Committee meeting will include as standing items a review of how effectively it has discharged its business and how effective the Committee has role modelled the values of the Trust through its decision making.

9. ADMINISTRATION

9.1 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.2 The Committee shall report to the Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

9.3 The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference.

9.4 The agenda for each meeting will be agreed by the Executive Director of Strategy, People & Partnerships and the People Committee Chair. The agenda, minutes and papers will be issued 5 calendar days before the meetings and any issues with the agenda must be raised with the People Committee Chair within 2 working days.

9.5 An action list and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.6 Any issues with the action list or minutes will be raised within 7 calendar days of issue.

10. REPORTING AND LINKS TO OTHER COMMITTEES

10.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance was received through papers and oral testimony.

10.2 The Committee will report to the Integrated Quality Committee on matters that are likely to affect workforce resourcing, education and learning to enable triangulation with clinical outcome and patient care indicators.

10.3 The Committee will report to Finance Productivity and Performance Committee on matters that are likely to affect expenditure on the Workforce and quarterly on the work of the Workforce Intelligence and Systems as they relate to pay.

10.4 The Committee will provide exception reports to the Audit Committee.

10.5 The Committee will provide reports as requested to the remaining committees.

10.6 Operational delivery of the Committee's work plan will be overseen by the Director of Strategy, People & Partnerships via day-to-day oversight of the HR, OD and Learning and Development functions.

10.7 The Committee will review its effectiveness on an annual basis, reporting the outcome of the review to the Board.

10.8 The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors at the next scheduled meeting.

Revised: July 2021

Approved: TBC

Review: July 2022

SUSTAINABILITY

11. Finance, Performance & Productivity Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	
Author	Russell Beale - Non-Executive Director
Executive sponsor	

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary
The Reaside and Highcroft Stakeholder Engagement plans over the next few months were discussed and agreed *The ongoing work of the BAF was reviewed.* *The financial plan for the Trust and the resultant changes from system-wide working were reviewed and agreed.* *The proposal for greater detailed reports as part of the Integrated Performance Report were agreed.*

Reason for consideration
Paper previous consideration
Not Applicable
Strategic objectives
Identify the strategic objectives that the paper impacts upon. Sustainability
Financial implications
Not applicable for this report
Risks
Financial risk relating to Reach Out provision is significant: management, mitigation and governance is still being worked on.
Equality impact
Reach Out programme assists us helping all sectors of the community.
Our values
Committed Compassionate Inclusive

REPORT FROM THE FPP COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Finance, Performance & Productivity Committee met on the 21st July 2021 with a summary of the key discussions being detailed below:

1.1 Medium and Low Secure Facilities (Reaside) Strategic Outline Case

The Director of Finance presented the paper informing the meeting that this had been approved by the Secure Care management team, the Inpatient Developments Programme Board and the Capital Review Group. He asked the Committee to review and endorse the SOC for approval by the Board.

Chair's assurance comments: Much more detail than usual in a SOC but this means it is easier to move forwards, and the committee thanked all concerned for their efforts. It's an important and necessary move, and whilst there are start-up costs that we take on at-risk, the benefits are clear. We explored the case from both a positive and a negative perspective and were well assured that all relevant concerns have been taken into account at this stage, and we fully endorse the case.

1.2 BAF

Andrew Hughes from AHNN Ltd who are supporting the Trust on the refresh of the BAF presented with the proposed final version and agree a Committee narrative before presentation at Board this month.

Chair's assurance comments: The BAF has been under discussion for a while and has evolved into a much more understandable and appropriate form. We are happy with the current document, but noted that we will need more details about the assurances and controls for the different metrics in due course (and reasonably soon) in order to be able to effectively manage the risks identified. We also noted that some of the targets are long-term ones, and so we may also want to have ways to identify shorter-term targets and goals for some of these risks, as it will not be feasible to do everything at once.
:

1.3 Financial Position and including Capital Update

FPP were informed that the month 3 2021/22 consolidated Group position was a surplus of £2.6m year to date. This was mainly due to non-recurrent slippage on recruitment against new investment. The financial plan for the first half of 2021/22 (H1) was re-submitted on 22 June 2021. The six-month outturn plan was now a break even position compared to £1.6m deficit as per the original submission. Actual performance will be monitored against the break even plan from month 3 onwards.

The Month 3 year to date Group capital expenditure is £0.5m, this was in line with plan. The total capital plan has increased by £0.7m to £10.3m. This was due to an agreed allocation of the BSOL system capital investment fund (SCIF) following a bid to the system to prioritise expenditure for en-suite door sets. This increased envelope was an allowance to increase capital expenditure but will be internally funded.

The month 3 Group cash position is £27.8m as at the end of June 2021, this was in line with plan and is consistent with the cash position held since block payments

in advance ceased in February 2021.

Chair's assurance comments: A clearer format of report especially including the overall Trust position (with SSL). Pressures are noted, but the current good position of the trust is good. Assurances on actions taken to address agency/bank spend were presented well. There are no particular new causes for concern over issues with C-19 pressures on funding

1.4 ICS Shared Services

FPP were given details of the key issues and potential benefits and suggest a way forward for the ICS and how to assess the potential for greater sharing of non-clinical services between local NHS organisations to improve value for money.

Chair's assurance comments: The report was discussed, and whilst it presents some opportunities for cost savings, the ethos behind the analysis was questioned – shared services should be about what we can do better together, not just financial cost savings. The report was criticized for this, meeting with minimal approval from the committee members. There has also been little consideration given to the negative aspects of combining services such as loss of corporate knowledge, and no mention made of the historical attempts to combine things, and so it is not clear that appropriate lessons have been learned, noted and applied this time round. We concluded that it is right to look at shared services (in a positive manner) but that the current approach is too consultancy-focused, lacks detailed knowledge of past issues, and doesn't really advance the case particularly well. We therefore are content to support the direction of travel but question the need for consultants, the basic ethos, and so need to see more specifics to help move things forwards effectively.

1.5 Reach Out Governance

The Committee were given details of the governance arrangements for the Provider Collaborative (PC) which will replace the current Reach Out arrangements in October. This covers governance within the PC to BSMHFT as the Lead Provider and upwards to NHSE.

Chair's assurance comments: A thorough and clear discussion of the principles and approaches to governance that underly this structure were explored, as was the scope for its evolution along with the flexibility to provide authority and autonomy in a distributed fashion. All were agreed this met the standards of accountability, separation of roles, and appropriate flexibility.

Integrated Performance Report

The Director of Finance gave assurance on the delivery against its key performance indicators and priorities and seek support for recommended improvements.

Chair's assurance comments: The newer format of the report is clearer and easier to interpret, which is a great benefit and aids assurance. The areas detailed above were well discussed and some assurances and some concerns were noted. We decided to give this item a more in-depth look at the next meeting as I felt we'd not spent enough time on this in the recent past, but at present we are content that there is sufficient awareness of key issues and we are reasonably assured that actions are in place to keep on top of them

Terms of Reference

The Director of Finance gave an overview the ToR and of the proposed change of the Committee name to the Sustainability Committee seeking approval

Chair's assurance comments: 'Sustainability' has strong connotations of maintaining an onward status quo, rather than capturing the dynamic change and improvement that we want to see. It also has environment-specific overtones which taint perspectives. Whilst we recognize we use 'sustainability' in the strategy there was impetus to consider whether the committee should have a slightly more appropriate name, and we will spend time next meeting discussing it. The terms of reference in general are mostly the same, and were endorsed.

Hot Topics

Chair's assurance comments: The meeting review found that we had concluded some significant matters of importance, had given some serious attention to the risks and benefits of the SOC, BAF, and shared services. We noted the wide contribution from execs and non-execs across all the topics, it being a meeting that really benefitted from all the people attending contributing throughout the meeting. It was felt to be positive, with appropriate discussion, challenge, support and assurances given as needed

Birmingham and Solihull Mental Health NHS Foundation Trust

SUSTAINABILITY COMMITTEE

TERMS OF REFERENCE

1. VALUES

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Sustainability Committee is constituted as a Standing Committee of the Board of Directors. Its constitution and terms of reference are as set out below, subject to amendment by the Board of Directors.

2.2 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise as it considers necessary.

2.3 The Committee is authorised to carry out any function within its terms of reference.

3. PURPOSE

3.1 The primary purpose of the Committee is to provide assurance on finance, performance and productivity systems and processes and to approve any business cases in line with the SFI's and scheme of delegation.

3.2 To seek any and all explanations and information it requires from any employee or contractor of the Trust to achieve the Committee's purpose

3.3 To ensure and assure on behalf of the Board that the Sustainability stream of the Trust's Strategy (2020) is being delivered:

- Balancing the books
- Transforming with digital
- Caring for the environment
- Good governance
- Changing through partnerships

3.4 To lead on monitoring of controls and assurance related to the "Sustainability" sections of the Board Assurance Framework.

4. DUTIES

4.1 To receive assurance regarding the Trust's medium- and long-term financial strategy and financial health, including consideration and endorsement of financial plans and budgets for approval by the Board.

4.2 To approve business cases in line with authority limits defined by the scheme of delegation or to make a recommendation to the Board for matters reserved to Board. The Committee will expect assurance that there has been full and proper consideration of the quality implications of any business case coming to the Committee for approval or review.

4.3 To consider savings targets and plans and endorse them for approval by the Board, including assurance of progress against the cost improvement programme.

4.4 To consider the Trust's approach to tax.

4.5 To approve and keep under review the Trust's investment strategy and policy.

4.6 To receive regular reports and insights regarding organisational performance in a form determined by the Committee, including external benchmark information as an aid to improving overall performance and productivity of the Trust.

4.7 To review relevant high-level risks and escalate to Quality & Safety Committee (Q&S) and Audit Committee as appropriate in order to ensure these are properly reflected in the Board Assurance Framework.

4.8 To scrutinise and challenge financial information and service redesign plans and ensure that any potential impact on quality is fed back to Q&S.

4.9 To seek assurance regarding the strategic direction and operational delivery of the digital agenda, its impact on users and plans for sustaining it.

4.10 Where there are any concerns regarding finance, planning, performance and productivity, the committee is authorised to seek assurance that the concerns have been investigated, corrective action taken and lessons learnt.

4.11 To review and advise on the Trust's strategic business development and planning approach, including strategic intentions. This includes consideration of any relevant, significant business development proposals.

4.12 To approve policies appropriate to the work of the Committee, as defined by the Policy for Management of Policies.

4.13 To review and discuss the R & D strategy prior to approval by the Board.

To oversee, promote and provide assurance that the research and innovation work of the Trust is positively impacting on services.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 The membership of the Committee will be:

Chair - Non-Executive Director

- Deputy Chair - Non-Executive Director
- Non-Executive Director
- Executive Director of Finance
- Executive Director of Strategy, People & Partnerships
- Executive Director of Operations

In attendance

5.2 The following will be standing attendees of the Committee

- Deputy Director of Finance
- Company Secretary

5.3 All members have one vote. In the event of votes being equal the Chair of the Committee has a casting vote.

5.4 In the absence of the Chair of the Committee, the Deputy Chair will chair the meeting.

5.5 Other members of the Board can attend meetings if they indicate to the Chair of Committee, in advance, of their intention to do so.

5.6 Where members are unable to make the meeting, they are entitled, and, in the case of Executive Directors, expected to nominate a deputy to attend on their behalf. These attendees will not assume temporary voting rights.

5.7 Members are expected to make every effort to be present at all Committee meetings.

5.8 Meeting attendance will be reviewed by the Committee Chair annually.

6. QUORACY

6.1 The meeting will be considered quorate with 3 Committee members, including one non-executive director and one executive director. These cannot be deputies attending on behalf of substantive members.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 Meetings will be held at least 8 times per year.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 The Executive Director of Finance will be responsible for updating the Committee's cycle of business, with input from the Executive Director of Operations, for agreement with the Chair of the Committee.

9.4 The Executive Director of Finance will agree a draft agenda with the Committee Chair and it will be circulated 7 calendar days before the meeting.

9.5 Any issues with the agenda must be raised with the Committee chair within 4 working days.

9.6 All reports and papers must be submitted 7 calendar days before the meeting.

9.7 The agenda, minutes and papers will be issued 6 calendar days before the meetings.

9.8 An action list and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.9 Any issues with the action list or minutes will be raised within 7 calendar days of issue

10. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

10.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

10.2 The Committee will receive regular reports from the Research and Innovation Committee which will formally report into it and will receive regular exception reports from OMT covering issues emerging which are relevant to the remit of SC, including development of tenders and business cases.

10.3 The Committee will provide exception reports to the Audit Committee as the lead committee for governance.

10.4 The Committee will receive exception reports from Q&S on concerns which have been raised about potential impact on quality of financial plans. Conversely, exception reports will be reported to Q&S on issues the committee needs to draw to its attention about the impact on quality from issues emerging from discussions.

10.5 Overlap between Q&S, PC and SC business will be provided through an attendee at Q&S meetings providing a verbal update to SC. Attendees at Q&S, PC and SC will ensure the need for an integrated approach so that impact issues are not lost, and papers to committees will need to indicate where there is a potential impact on quality or the people agenda.

10.6 The Committee will review their effectiveness on an annual basis, reporting the outcome of the review to the Board of Directors.

10.7 The Committee Chair will present to the Council of Governors annually a report on the work of the Committee. The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors at the next scheduled meeting.

Date Reviewed: July 2021

Approved by the Board:

Date of Review:

12. Integrated Performance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**All Committees and Board**
Agenda item	**15**
Paper title	**Integrated Performance Report**
Date	21/7/2021
Author	Richard Sollars, Deputy Director of Finance Dawn Clift, Associate Director of Governance Lizzie Prior, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

This paper is for (tick as appropriate):		
☐ Action	☒ Discussion	☒ Assurance

Executive summary & Recommendations:

We are critically reviewing our performance management and reporting approaches as we begin to move forward with the new Trust Strategy. We will retain the positive intentions of the existing approach and enhance the process in a number of respects.

The key issues for consideration by the Committees on which they need to provide assurance the Board are as follows:

- IQC - Staff and patient assaults, prone restraints, commissioner reportable incidents, falls
- FPP – Out of area bed use, financial position and CIP
- People - Return to work interviews, fundamental training, appraisal rates and sickness. Also the divergence in performance between different teams

The Board and Committees have approved changes to reporting cycles which we will move to from January 2022. We will continue to report the overall Trust position and overall performance to the first meeting following the month in question but supplement this with a triangulated, more detailed thematic review to provide more insights and intelligence into what's happened, the consequences and planned improvements

Reason for consideration:

To assure the Board of Trust delivery against its key performance indicators and priorities and seek support for recommended improvements.

Previous consideration of report by:

Executive Team and Performance Delivery Group

Strategic priorities (which strategic priority is the report providing assurance on)

Clinical Services, Quality, People and Sustainability

Financial Implications *(detail any financial implications)*
None
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
N/A
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Ongoing performance monitoring via Performance Delivery Group

Integrated Performance Report

Context

As has been outlined in previous discussions at Committee and Board meetings, we are critically reviewing our performance management and reporting approaches as we begin to move forward with the new Trust Strategy to ensure that:

- We focus on the priorities and key outcomes associated with the Strategy
- We develop our Board Assurance Framework to understand the strategic and emerging risks relating to the Strategy and the world around us
- We provide the right information at the right level of detail in the right format that helps us transparently explain what has happened and the implications and identify the action required to improve outcomes

We will retain the positive intentions of the existing approach:

- Balanced review of performance in the round rather than concentrating on one factor at the expense of others
- Use of graphics to make it easy to understand trends and distinguish between random variation and underlying issues
- Allow drill down from top level or average information to identify the underpinning detail

We will enhance the process in a number of respects:

- Improve the robustness of performance review by the Executive Team and performance Delivery Group
- Provide greater insight and intelligence to the Committees to allow them to better understand key performance issues and improve the level of assurance they provide to the Board
- Improve the integration and structure of data in different Trust systems to improve accuracy and integrity

The Board and Committees have approved changes to reporting cycles which we will move to from January 2022. We will continue to report the overall Trust position and overall performance to the first meeting following the month in question but supplement this with a triangulated, more detailed thematic review to provide more insights and intelligence into what's happened, the consequences and planned improvements. As an example, in September the Board would receive aggregate performance information regarding August supplemented by a more detailed analysis of July's performance.

Performance in June 2021

The key performance issues facing us as a Trust have changed little over the last six months:

- **Out of Area Bed Use** – Some process improvements have helped us address underlying issues, but the impact of COVID-19 and the closure of beds has significantly impaired our ability to eliminate use of out of area beds. There have been good reductions over the last three months, but the figure is at 566 occupied bed days for June (18.9 patients)
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. While this has deteriorated as a result of COVID, the divergence between individual teams is of concern:
- **Financial position and CIP** – Financial control totals have only just been set for 2021/22 and we are still developing plans. We have thus yet to identify savings, but are currently performing better than plan as a result of delays in recruitment against additional funding for new services

Quality

- The reported level of physical assaults on service users has continued to reduce though this may be down to under reporting
- Assaults on staff are up but remain below median levels
- Levels of prone restraint (10.6 per 1000 OBD) at lowest level since Ma4-20
- Failures to return reduced on the high level seen in May-21
- The overall rate of falls has remained below the median but has risen four months in succession while absconsions have remained above median for lats three months
- **Key concerns: Staff and patient assaults, prone restraints, commissioner reportable incidents, falls**

Performance

- The level of Out of Area Patients remains the main concern. The national requirement was for this to be eliminated by April, but this has been renegotiated as being by July. April has seen the figure significantly reduced at 566 occupied bed days (18.9 patients), the lowest level since Aug-18
- IAPT patients seen within 6 weeks of referral has fallen nine months in succession to 34%, the lowest position in entire reporting period (63 weeks since Apr-16). It reflects large number of staff vacancies (17%)
- The % of service users on CPA having a formal review in the last 12 months remains a worry at 89%
- New referrals not seen within 3 months are of concern but have reduced in month to 2,167, the lowest level since Jan-20
- On the large majority of targets, the Trust achieves target or better on an ongoing basis
- **Key concerns: Out of Area, IAPT seen in 6 weeks, CPA 12 month review and new referrals not seen in 3 months**

People

- The People domain continues to show the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Scores are of concern across the board
- Return to Work interviews have remained around or below 60% for last 10 months and show no signs of improvement - individual departments/teams vary between Psychology (13%) and Birmingham Healthy Minds (95%)
- Fundamental training at 91.1% is at its highest level since May-20 but remains below the 95% standard with temporary staffing a particular issue (59% for IG training) - varies between Medical directorate (77%) and Offender Health (97%)

- Shift Fill is at 86.3%, the lowest level since Feb-21, against a standard of 95% - the main issue is Secure (78%), which has the highest number of requested shifts (4,381 out of a total of 13,649
- Appraisals slightly down at 82.5% and still significantly below pre-COVID levels and target - varies between Psychology (50%) and Liaison & Diversion (100%)
- Sickness increased to 6.0%, the highest figure since Feb-21 and remain much higher than target (3.9%) – varies between Medical directorate (1.3%) and Home Treatment (12.3%)
- Rolling 12 month turnover and agency expenditure continue to be better than plan
- **Key concerns: Return to work interviews, fundamental training, appraisal rates and sickness**

Sustainability

- The financial result for June is better than plan with a surplus in month of £1.7m against a planned breakeven, as a result of delays in recruitment against additional funding for new services. Savings plans are yet to be set for 2021/22. No savings have been identified as yet
- Cash, performance against the capital expenditure plan and property standards remain well above target
- **Key concerns: CIP under achievement impacting adversely on Operating Surplus, uncertainty regarding national financial ask**

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

* Performance: IAPT seen in 6 weeks worsen
* People: Continues to be adversely affected by COVID
* Quality: reported incidents

Division: A: All

A: All

June-2021

Performance

CPA 7 day FU	93.8%
CPA with Formal Review last 12 mths	88.6% ↓
Data Quality Maturity Index (DQMI)	98.5% ↑
Delayed Transfer Bed Days	997
Delayed Transfer, percent of bed days	6.4%
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0%
IAPT into recovery	55.5% ↑
IAPT seen in 18 weeks	97.1% ↓
IAPT seen in 6 weeks	34.3% ↓
Out of Area Bed Days	566
Referrals over 3 mths with no contact	2167 ↓

People

Bank & Agency Fill Rate	86.3%
Fundamental Training	78.0% ↓
Rolling 12m Turnover	9.5% ↑
Staff Appraisals	82.5% ↓
Staff Sickness	6.0% ↓
Staff Vacancies	10.0% ↓

Quality

Absconsions and Failures to Return	22 ↑
Commissioner reportable incidents	2
Community suicides	0
Duty of Candour	0
Falls resulting in harm	1
Homicides	0
Incidents resulting in harm	12.4% ↑
Inpatient suicides	0
Never Events	0
Patient Assaults / 1000 OBD	1.9 ↗
Pressure Scores	1
Prone restraints/ 1000 OBD	2.7
Reported incidents	1956 ↓
Staff Assaults / 1000 OBD	4.8

Sustainability

CAP Ex	£88k
Cash	£27,830k ↑
CIP	£0k ↓
Info Governance	92.5%
Monthly Agency	£462k ↑
Operating Surplus	-£1,776k ↓
Property	98.5% ↑
SOF rating	2 ↓

	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

compassionate inclusive committed

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
CPA 7 day FU	95.00	89.6%	96.2%	95.8%	95.1%	94.7%	93.8%
CPA with Formal Review last 12 mths	95.00	87.5%	86.4%	88.1%	88.3%	88.5%	88.6% ↓
Data Quality Maturity Index (DQMI)	95.00	98.2%	98.3%	98.2%	98.2%	98.6%	98.5% ↑
Delayed Transfer Bed Days		888	852	825	797	922	997
Delayed Transfer, percent of bed days		5.7%	6.3%	5.2%	5.1%	5.7%	6.4%
Eating disorders routine	95.00	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%
Eating disorders urgent	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%
IAPT into recovery	50.00	56.9%	54.3%	55.5%	59.2%	55.1%	55.5% ↑
IAPT seen in 18 weeks	95.00	100.0%	99.8%	100.0%	99.2%	94.7%	97.1% ↓
IAPT seen in 6 weeks	75.00	65.2%	57.7%	45.1%	41.8%	36.7%	34.3% ↓
Out of Area Bed Days		895	1027	1029	643	664	566
Referrals over 3 mths with no contact		2443	2363	2292	2227	2256	2167 ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* **IAPT seen in 18 weeks and IAPT seen in 6 weeks**
* **New referrals not seen in 3M - down to 2,167 performance standard not yet agreed**
* **CPA 12 month review - standards under discussion**

SOME CONCERNS

* None

	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | **PEOPLE** | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Staff Vacancies	6.00	9.6%	8.2%	7.9%	8.2%	9.5%	10.0% ↓
Staff Sickness	4.28	7.9%	6.5%	5.3%	5.3%	5.3%	6.0% ↓
Staff Appraisals	90.00	79.7%	78.1%	80.8%	80.8%	82.6%	82.5% ↓
Rolling 12m Turnover	11.00	9.2%	9.2%	8.9%	8.9%	9.2%	9.5% ↑
Fundamental Training	95.00	90.9%	90.4%	90.7%	91.3%	92.0%	78.0% ↓
Bank & Agency Fill Rate	95.00	77.4%	86.5%	88.6%	89.3%	88.8%	86.3%

Top Line Commentary (Trust level)

KEY CONCERNS

* Fundamental training at lowest level
* Sickness rate is increasing
* Appraisals remain very low

	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | **QUALITY** | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Absconsions and Failures to Return	0.00	6	6	7	15	25	22 ↑
Commissioner reportable incidents	0.00	14	4	10	5	6	2
Community suicides	0.00	1	0	1	0	0	0
Duty of Candour	0.00	0	0	0	0	0	0
Falls resulting in harm	0.00	0	0	1	0	0	1
Homicides	0.00	0	0	0	0	0	0
Incidents resulting in harm	0.00	19.8%	17.8%	16.7%	16.8%	16.2%	12.4% ↑
Inpatient suicides	0.00	0	0	0	0	0	0
Never Events	0.00	0	0	0	0	0	0
Patient Assaults / 1000 OBD	0.00	1.3	2.4	2.8	2.1	2.0	1.9 ↗
Pressure Scores	0.00	2	2	4	1	0	1
Prone restraints/ 1000 OBD	0.00	4.9	5.1	5.8	4.6	4.5	2.7
Reported incidents	0.00	1959	1796	1945	1812	1912	1956 ↓
Staff Assaults / 1000 OBD	0.00	4.3	4.7	4.5	3.4	4.2	4.8

Top Line Commentary (Trust level)

KEY CONCERNS:

* **Reported incidents**

SOME CONCERNS:

* Absconsions and failures to return

NO CONCERNS:

All other metrics on or close to target

	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | **SUSTAINABILITY**

Division

A: All

A: All

Measure	Latest Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
CAP Ex		£1,119k	£1,160k	£3,693k	£55k	£334k	£88k
Cash	27,986,330.87	£46,346k	£52,460k	£28,803k	£28,160k	£28,642k	£27,830k ↑
CIP		£319k	£319k	£319k	£0k	£0k	£0k ↓
Info Governance	100.00	93.3%	93.8%	91.7%	80.1%	88.6%	92.5%
Monthly Agency		£389k	£350k	£478k	£405k	£366k	£462k ↑
Operating Surplus		£625k	-£396k	£707k	£315k	-£1,116k	-£1,776k ↓
Property	95.00	98.5%	98.5%	98.5%	98.5%	98.5%	98.5% ↑
SOF rating	3.00	3	3	3	3	3	2 ↓

Top Line Commentary (Trust level)

KEY CONCERNS:

*** Surplus, Cash, SOF figures artifically boosted by COVID - Surplus slightly better on mid-year forecast**

*** Removal of top-up funding exposes underlying performance**

*** CIP will be an issue when national funding regime returns to normal**

*** SOF remains at 'normal' position**

SOME CONCERNS: IG held down by poor compliance by temporary staff

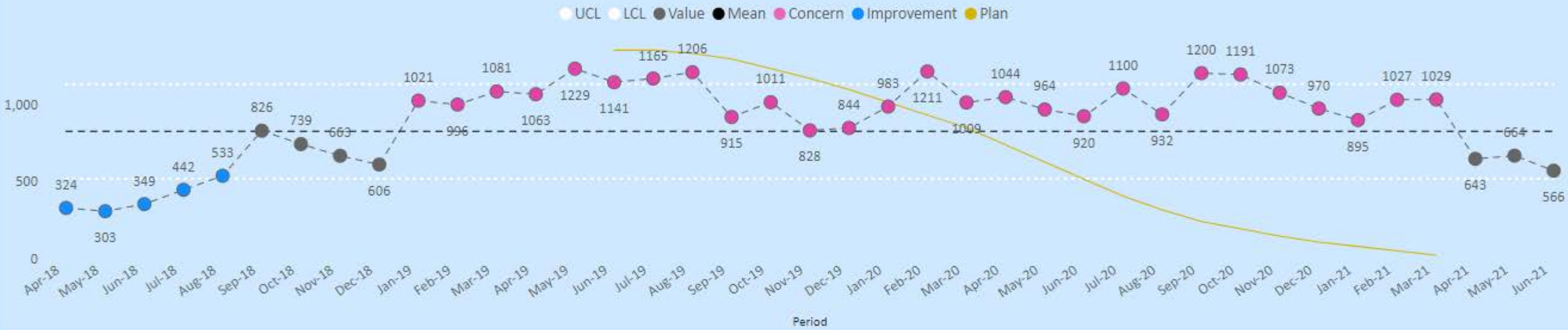
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

Divisions

Statistical Process Control (SPC)



Break down by Division (with pink background where target not met)

Division	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
A: All	895	1027	1029	643	664	566
B: Acute and Urgent Care	895	1027	1029	643	664	566

Commentary

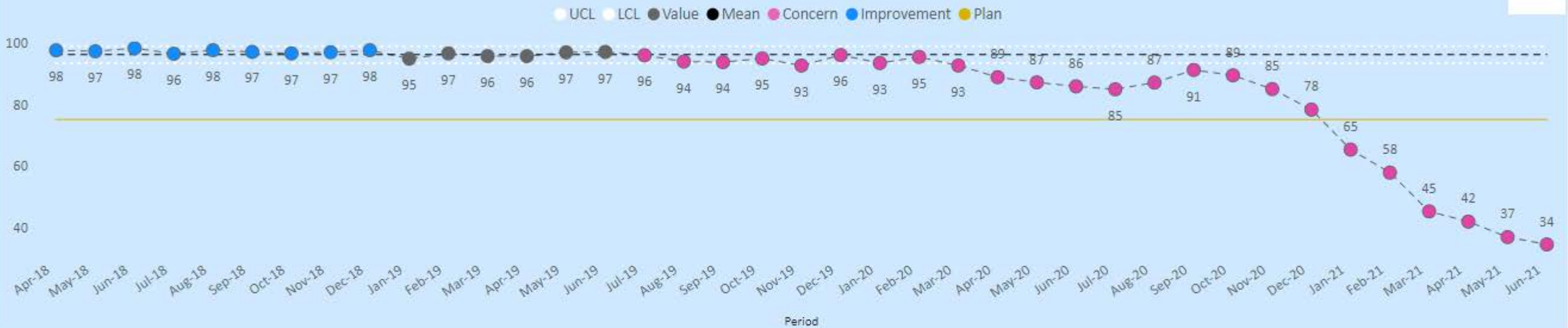
The impact of COVID saw a peak in out of area OBDs in September 2020 to 1200. However, despite the ongoing pressures, key areas of the out of area implementation plan were being implemented and a reducing trend was observed from November 2020 through to January 2021, with out of area OBDs at 864. Although an increase in OBDs was observed in February and March (1027 OBDs), the numbers remained below the peak in September 2020. In April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the last 16 months. This has been sustained in May and June with a decrease in June to 566 days. There were a total of 13 new out of area placements in June, remaining lower than the beginning of the year.
A revised target has been agreed with NHSE/I to reduce OOA bed usage to zero by the end of quarter 2, although internally we are working to achieve and maintain this target from July 2021.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

Divisions

Statistical Process Control (SPC)



Break down by Division (with pink background where target not met)

Division	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
A: All	65.2%	57.7%	45.1%	41.8%	36.7%	34.3%
E: Specialties	65.2%	57.7%	45.1%	41.8%	36.7%	34.3%

Commentary

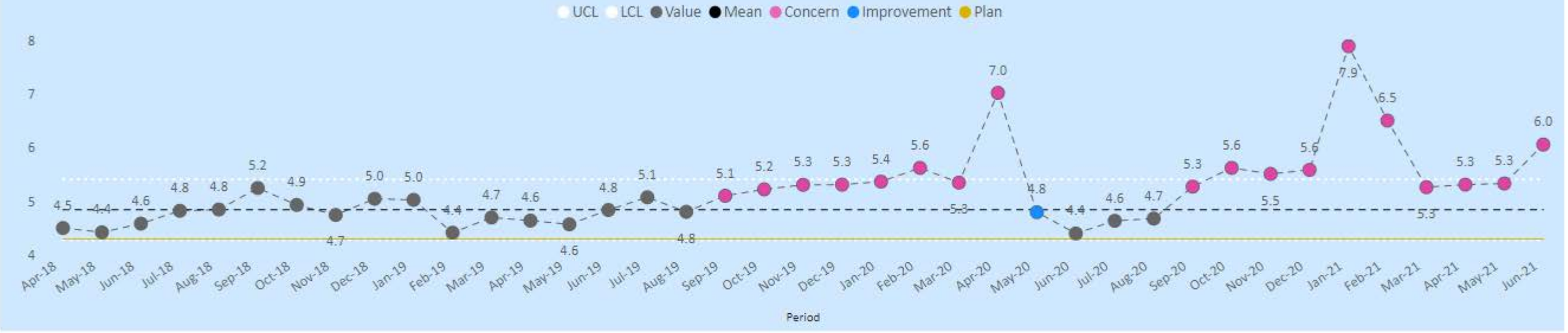
Consistently meet and exceed the national target of 75% although there has been a notable impact of COVID-19 on performance. Pre C-19 compliance was consistently at 95% and has been on a reducing trend since March 2020 with the exception of August and September 2020 which saw an improvement. Performance has continued to reduce and is now below the 75% target at 34.59% and outside control limits.
The service has a large number of vacancies which are difficult to recruit to and additional sickness which has made it difficult to offer appointments in a timely way. The service is working hard to address this.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

Divisions

Statistical Process Control (SPC)



Break down by Division (with pink background where target not met)

Division	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
A: All	7.9%	6.5%	5.3%	5.3%	5.3%	6.0%
B: Acute and Urgent Care	8.9%	8.9%	6.0%	7.0%	8.0%	8.2%
C: ICCR	7.6%	7.4%	6.3%	5.6%	5.3%	5.6%
D: Secure Serv & Offender Health	11.6%	6.9%	6.0%	6.5%	6.2%	7.1%
E: Specialties	7.3%	6.5%	5.5%	4.9%	4.5%	5.9%
F: Corporate	2.9%	2.7%	2.1%	2.2%	2.7%	3.3%

Commentary

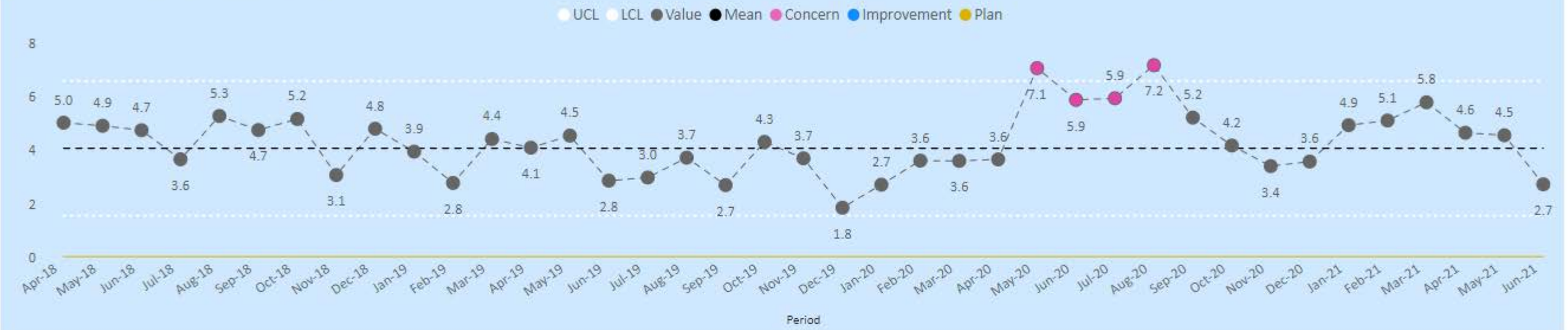
(Blank)

Birmingham and Solihull Mental Health NHS Foundation Trust

Prone restraints/ 1000 OBD

Divisions

Statistical Process Control (SPC)



Break down by Division (with pink background where target not met)

Division	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
A: All	4.9	5.1	5.8	4.6	4.5	2.7
B: Acute and Urgent Care	8.8	8.3	10.1	10.3	7.7	4.9
C: ICCR	0.7	0.8	0.7	0.7	0.4	0.7
D: Secure Serv & Offender Health	4.1	5.3	5.7	2.1	4.6	2.0
E: Specialties	1.2	0.9	0.4	1.1	0.7	1.1

Commentary

There have been 51 reported incidents of prone restraint for the month of June a reduction of 36 on the previous month.

Birmingham and Solihull Mental Health NHS Foundation Trust

CIP

Divisions

Statistical Process Control (SPC)

Break down by Division (with pink background where target not met)

Division	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
A: All	£319k	£319k	£319k	£0k	£0k	£0k

Commentary

There are no CIP plans yet developed for 21/22

13. Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**Finance Report**
Paper title	**Month 3 2021/22 Finance Report**
Date	28/07/2021
Author	Emma Ellis, Head of Finance & Contracts
Executive sponsor	David Tomlinson, Executive Director of Finance

This paper is for (tick as appropriate):		
☐ Action	☒ Discussion	☒ Assurance

Executive summary & Recommendations:

Revenue position
The month 3 2021/22 consolidated Group position is a surplus of £2.6m year to date. This is mainly due to non-recurrent slippage on recruitment against new investment. The financial plan for the first half of 2021/22 (H1) was re-submitted on 22 June 2021. The six-month outturn plan is now a break even position compared to £1.6m deficit as per the original submission. Actual performance will be monitored against the break even plan from month 3 onwards.

Capital position
Month 3 year to date Group capital expenditure is £0.5m, this is in line with plan. The total capital plan has increased by £0.7m to £10.3m. This is due to an agreed allocation of the BSOL system capital investment fund (SCIF) following a bid to the system to prioritise expenditure for en-suite door sets. This increased envelope is an allowance to increase capital expenditure but will be internally funded.

Cash position
The month 3 Group cash position is £27.8m as at the end of June 2021, this is in line with plan and is consistent with the cash position held since block payments in advance ceased in February 2021.

Reason for consideration:

Update on month 3 financial position.

Previous consideration of report by:
Regular briefing on financial position with FPP chair.
Strategic priorities (which strategic priority is the report providing assurance on)
SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population
Financial Implications *(detail any financial implications)*
Group financial position

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Linked to existing BAF2_0012
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Ongoing financial briefings via Operational Management Team and Sustainability Board.

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2021 to 30th June 2021

Month 3 financial position

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Group Summary	H1 Budget *Revised June '21 NHSEI submission* £'000	YTD Position Budget £'000	YTD Position Actual £'000	YTD Position Variance £'000
Income				
Healthcare Income	143,980	71,985	72,361	375
Other Income	7,502	3,755	4,395	640
Total Income	**151,482**	**75,741**	**76,756**	**1,015**
Expenditure				
Pay	(109,400)	(54,700)	(54,511)	189
Other Non Pay Expenditure	(21,949)	(10,954)	(11,233)	(279)
Drugs	(2,959)	(1,480)	(1,591)	(111)
Clinical Supplies	(570)	(285)	(149)	136
PFI	(5,198)	(2,599)	(2,578)	21
Unallocated Budgets	(3,263)	(1,629)	-	1,629
EBITDA	**8,142**	**4,094**	**6,694**	**2,601**
Capital Financing				
Depreciation	(4,042)	(2,021)	(2,050)	(29)
PDC Dividend	(1,182)	(591)	(589)	2
Finance Lease	(2,183)	(1,092)	(1,090)	2
Loan Interest Payable	(631)	(318)	(318)	(0)
Loan Interest Receivable	49	24	0	(24)
Surplus / (Deficit) before taxation	**152**	**96**	**2,647**	**2,551**
Profit/ (Loss) on Disposal	40	-	-	-
Taxation	(192)	(96)	(96)	-
Surplus / (Deficit)	**0**	**0**	**2,551**	**2,551**

Month 3 2021/22 Group Financial Position

The month 3 2021/22 consolidated Group financial position is £2.6m surplus year to date. This is mainly due to non-recurrent slippage on recruitment against new investment.

H1 Plan re-submission

The financial plan for the first half of 2021/22 (H1) was re-submitted on 22 June 2021, with a planned break even outturn compared to £1.6m deficit as per the original submission. Actual performance will be monitored against the break even plan from month 3 onwards.

H2 Plan – early indications

The H2 (October 2021 - March 2022) settlement is expected to be agreed In September 2021. It is anticipated that H1 system envelopes will be the start point for H2 envelopes with the continuation of block income arrangements, funding for any agreed pay settlement and increased target for waste reduction (efficiency).

NHS System Oversight Framework 2021/22

NHS System Oversight Framework 2021/22
On 24 June 2021, NHSEI issued the NHS System Oversight Framework for 2021/22, replacing the NHS Oversight Framework for 2019/20.

The framework describes NHSEI's approach to oversight for 2021/22 as one that reinforces system-led delivery of integrated care. It applies to all Integrated Care Systems (ICSs), Clinical Commissioning Groups (CCGs), NHS trusts and foundations trusts.

A single set of oversight metrics will be used to flag potential issues and prompt further investigation of support needs. The metrics align to the five national themes of the System Oversight Framework, which reflect the ambitions of the NHS Long Term Plan as follows:

System Oversight Framework national themes
- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- People
- Leadership and capability
- Finance and use of resources

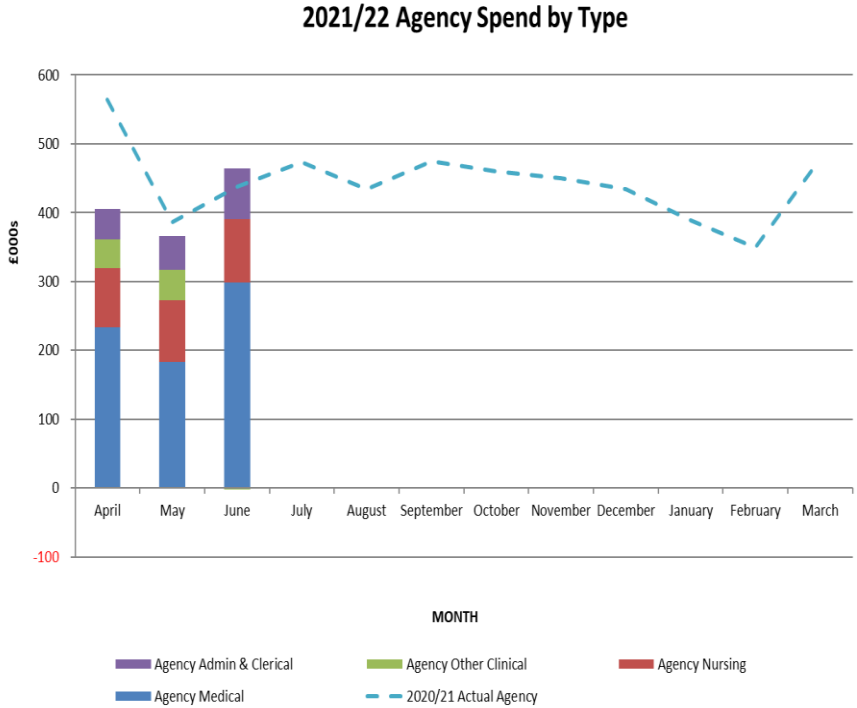
The 2021/22 metrics for the finance and use of resources oversight theme are shown below. The focus is on the achievement of financial balance.

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Finance and use of resources	The NHS will return to financial balance: NHS in overall financial balance each year	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Agency expenditure

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 YTD Total
Agency Spend (£000s)	405	366	462									1,234
NHSEI Ceiling (£000s)	501	501	501									1503
Net (£000s)	**96**	**135**	**39**									**270**

Agency Medical	234	183	298									714
Agency Nursing	86	91	92									269
Agency Other Clinical	42	44	(2)									84
Agency Admin & Clerical	44	49	74									166
Agency Spend (£000s)	**405**	**366**	**462**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,234**



Agency spend for June 2021 was £462k; this is £96k more than last month and £24k more than agency spend in June 2020, however is below the NHSEI monthly target. The increase is mainly due to 115k increase in medical agency spend. Year to date expenditure is £1.2m; this is £270k below the estimated NHSEI year to date ceiling.

Agency controls are in place to ensure that spend remains below target:

- Rapid, substantial recruitment to the bank took place in 2020/21 in response to Covid-19 which has greatly increased bank capacity and reduced reliance on agency. Bank recruitment continues to take place in 2021/22.
- There are a number of bank staff currently unable to work in areas which require AVERTS due to an under-resource in AVERTS training capacity however, as more individuals complete their training, bank capacity is increasing. Two core skills trainers that can deliver ELS, AVERTS and CRAM have been recruited and will start in August 2021 (one permanent and one FTC) which will increase training capacity. Guidance has been produced on where and how staff can work dependent on previous training whilst they are awaiting AVERTS training and those who have completed alternative restraint reduction courses are fast tracked on to one day AVERTS updates where appropriate.
- In response to significant staffing pressures, HCA over-recruitment was stood back up for Q4 of 2020/21 – the HCA over-recruitment initiative has reduced HCA agency spend.
- Work continues with operational areas to convert long term agency into substantive offers of employment Trust-wide.
- Recruitment plans continue to be developed and reviewed with each service to address clinical vacancies and recruit to additional posts identified through the Long Term Plan expansion requirements and the 2021/22 Spending Review Funding.
- The Workforce Transformation workstream continues to focus on upskilling our current workforce, additional workforce supply, new roles and new ways of working and retention to address high levels of substantive vacancies and reduce reliance on agency.
- Following the pilot of MHOST in 2020/21, work is continuing to roll out a bi-annual establishment review process Trust-wide.
- The Trust continues to run processes to ensure the staffing impact of COVID-19 is minimised as much as possible to help prevent heavy reliance on agency workers. A review of the staffing impact of long covid has been undertaken.
- The newly formed Workforce Initiatives Group (previously the Redeployment Group) is meeting weekly to respond to urgent workforce pressures and recruitment blockers that arise and to progress initiatives to drive up workforce supply and availability.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - Draft 31-Mar-21 £m's	NHSI Plan YTD 30-Jun-21 £m's	Actual YTD 30-Jun-21 £m's	NHSI Plan Forecast 31-Mar-22 £m's
Non-Current Assets				
Property, plant and equipment	186.5	180.2	184.9	183.2
Prepayments PFI	1.6	1.4	1.7	1.4
Finance Lease Receivable	-	-	(0.0)	-
Finance Lease Assets	-	-	(0.0)	-
Deferred Tax Asset	0.1	(0.0)	0.1	(0.0)
Total Non-Current Assets	188.1	181.6	186.7	184.5
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	9.7	7.4	17.0	7.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	28.0	27.8	19.8
Total Curent Assets	38.9	35.8	45.1	27.6
Current liabilities				
Trade and other payables	(29.4)	(28.6)	(30.8)	(28.0)
Tax payable	(4.4)	(4.4)	(4.2)	(4.4)
Loan and Borrowings	(2.7)	(2.7)	(2.4)	(2.7)
Finance Lease, current	-	-	-	-
Provisions	(1.2)	(0.7)	(1.2)	(0.7)
Deferred income	(13.2)	(11.2)	(16.1)	(11.2)
Total Current Liabilities	(50.9)	(47.7)	(54.6)	(47.1)
Non-current liabilities				
Loan and Borrowings	(29.5)	(28.4)	(28.4)	(27.3)
PFI lease	(49.3)	(48.9)	(48.9)	(47.7)
Finance Lease, non current	-	-	0.0	-
Provisions	(2.4)	(1.8)	(2.4)	(1.8)
Total non-current liabilities	(81.3)	(79.2)	(79.7)	(76.9)
Total assets employed	94.9	90.5	97.4	88.1
Financed by (taxpayers' equity)				
Public Dividend Capital	110.5	110.5	110.5	110.5
Revaluation reserve	27.5	24.6	27.5	24.6
Income and expenditure reserve	(43.1)	(44.7)	(40.6)	(47.0)
Total taxpayers' equity	94.9	90.5	97.4	88.1

SOFP Highlights

The Group cash position at the end of June 2021 is £27.8m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 6 to 7.

Current Assets & Current Liabilities

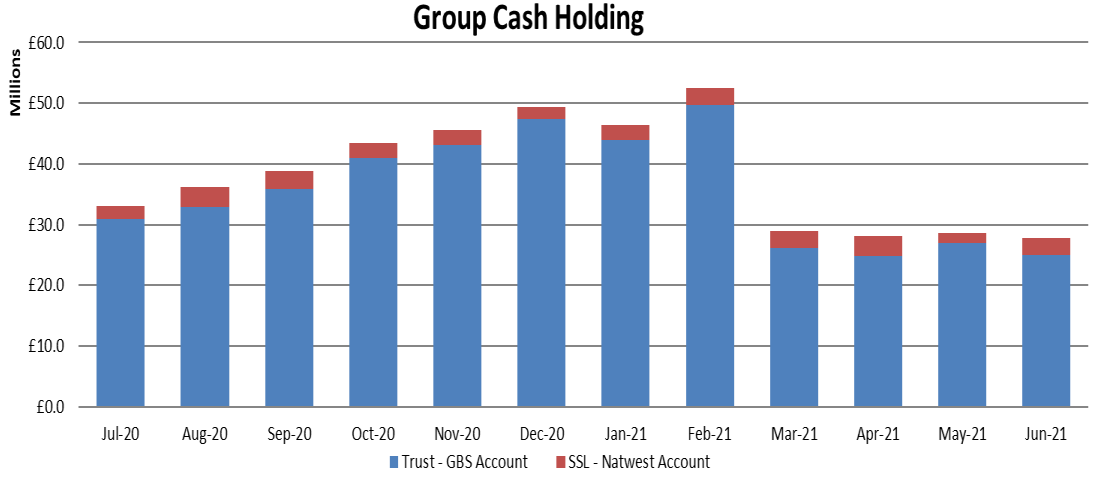
Ratios

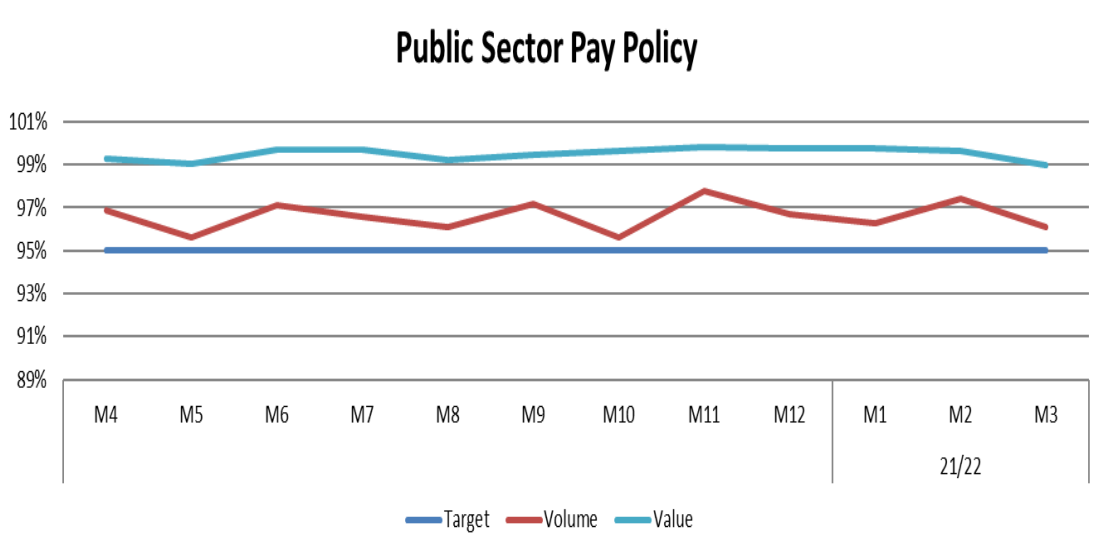
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	45.1
Current Liabilities	-54.6
Ratio	0.8

Current Assets to Current Liabilities cover is 0.8:1 this shows the number of times short-term liabilities are covered.

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of June 2021 is £27.8m.

As per last financial year the financial regime introduced as a result of the pandemic will continue for at least the first half of 2021/22, where the majority of our NHS contracts are paid on a block basis. Last year the payments were made in advance to bolster cash positions, this arrangement ceased in month 12, hence the reduction in cash balance from February 2021 to current position.

Better Payments

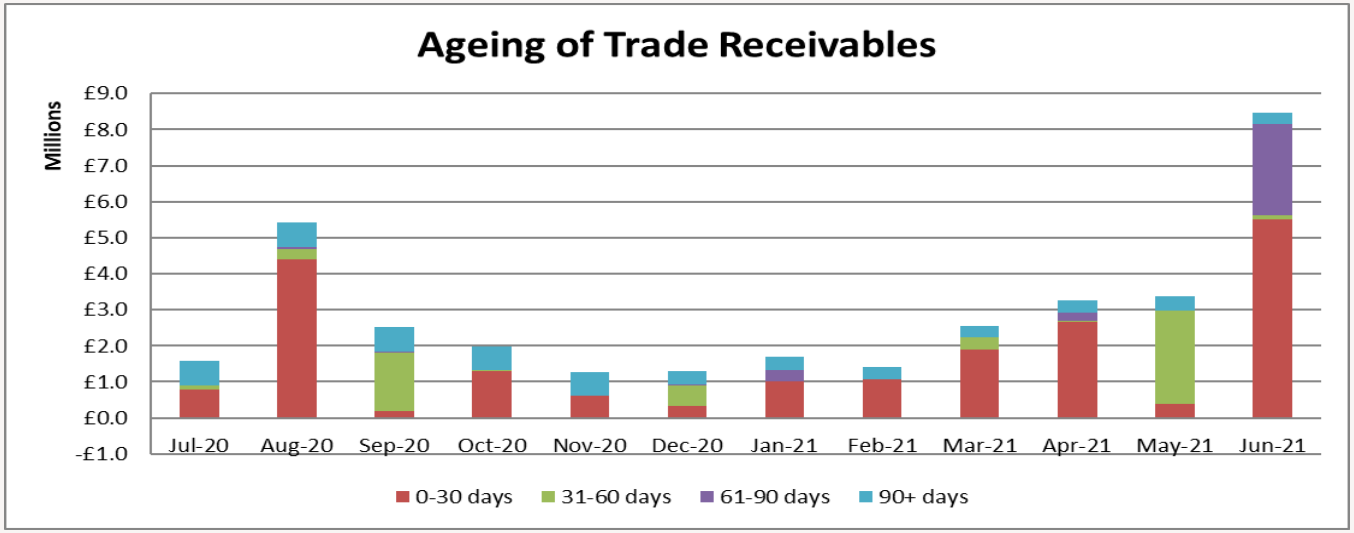
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

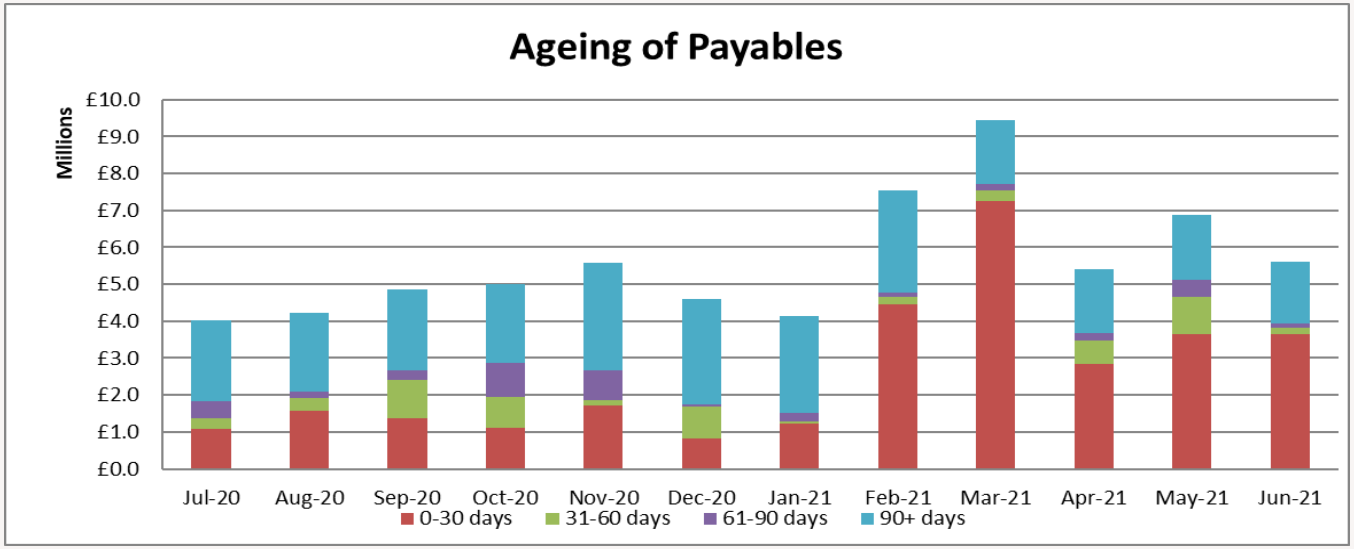
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	97%	✓	100%	✓
Non - NHS Creditors within 30 Days	96%	✓	99%	✓

Trust Receivables and Payables





Trade Receivables

The overall receivables position reduced significantly last financial year mainly due to provider to provider arrangements under the COVID-19 financial regime. This is to continue for the first half of 2021/22. The focus is to maintain this position as far as possible and escalate to management, STP and other partners where necessary for urgent and prompt resolution.

Receivables :

- **Over 30 days & 0ver 60 days**-mainly intercompany. To be settled in July 2021
- **Over 90 days**-consists of outstanding NCA balances from 1 NHS body which has been settled in July 2021.

Trade Payables

Payables greater than 90 days:

- NHS Property Services £344k– Awaiting lease agreement to be finalised to enable/facilitate payment. The Estates Dept are working with NHS Property to resolve this matter.

- Non-NHS Suppliers (43+) £1.2m – accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in July 2021.

Month 3 YTD Capital expenditure in line with plan

	original plan	Forecast post SCIF panel	Variance to original plan
STP ENVELOPE ALLOCATION - CFO agreement 7/4/21	**£'m**	**£'m**	**£'m**
System approved spend	6.7	6.7	0.0
Bids against SCIF (door sets) - to be approved by system	1.4	2.0	-0.6
STP agreed adjustment	-0.1	0.0	-0.1
Capital envelope excluding PFI Capital (IFRIC12)	**8.0**	**8.7**	**-0.7**
Plus PFI Capital (IFRIC 12)	1.2	1.2	0.0
Plus planned disposal - NBV	0.4	0.4	0.0
Adjusted gross capital envelope - submitted to NHSEI 12/4/21	**9.6**	**10.3**	**-0.7**

Capital schemes	Total 2021/22	Approval
	£'m	
Pre committed - major schemes b/f - Urgent Care Centre	1.2	
Pre committed - minor schemes b/f	0.3	
Pre committed - Ardenleigh Women's seclusion suite	0.5	
Pre committed Acute en suite door sets (CQC plan) - SCIF envelope	1.4	Approved by System CEOs June 21 (total SCIF award £2m)
Total Pre committed plans (Approved by Board March 21)	**3.4**	Approved by Board March 2021
Additional en suite door setc (b/f from 22/23) - SCIF envelope	**0.6**	Approved by System CEOs June 21 (total SCIF award £2m)
Statutory Standards and Backlog Maintenance	**1.5**	Approved by Committee Chairs April 2021
ICT	**0.8**	Approved by Committee Chairs April 2021
Newington refurbishment	**0.5**	Approved by IQC May 2021
Risk Assessments	**3.4**	Prioritisation details to be approved
Contingency	0.1	
TOTAL	**10.3**	

Month 3 Group Capital expenditure

Month 3 year to date Group capital expenditure was £0.5m as per plan.

Capital plan

The 2021/22 capital plan as submitted to NHSEI on 12 April 2021, was £9.6m. This included use of £1.4m capital envelope for en-suite door sets from the System Capital Investment Fund (SCIF).

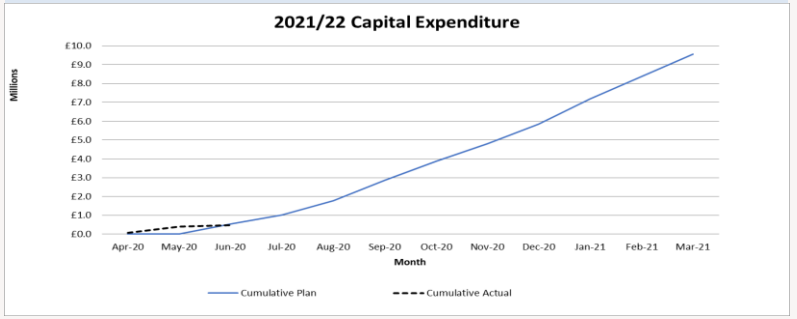
The SCIF was created for system priorities based on 15% of the total system capital envelope. In June 2021, a panel reviewed all SCIF bid submissions and BSMHFT was awarded £2m, increasing the available capital envelope by £0.6m. The envelope was further increased as an agreed adjustment of £0.1m that was applied in the April system capital planning round was removed. Therefore, the total capital envelope has increased by £0.7m to £10.3m. This increased envelope is an allowance to increase capital expenditure but will be internally funded.

Risk Assessment works

£3.4m has been allocated to risk assessment work in the capital plan. Further to briefs managed by the Risk Management Team, the SSL Team have produced an estimated programme of risk related works, totalling £1.9m for 2021/22 (with a further £1.3m for 2022/23).

Mental Health Capital Data Collection

In preparation for the next comprehensive spending review, NHSEI launched a Mental Health capital data collection on 9 June 2021 to establish a high level understanding of the scale of potential investment required. The submission was based around 6 potential estates programmes and digital infrastructure. The BSMHFT capital cost identified as submitted to NHSEI on 25 June 2021 totalled £239m.



14. Medium and Low Secure Facilities (Reaside) Strategic Outline Case

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**17**
Paper title	**Medium and Low Secure Facilities (Reaside) Strategic Outline Case**
Date	28 July 2021
Author	Various managers
Executive sponsor	Dave Tomlinson – Director of Finance

This paper is for (tick as appropriate):		
☒ Action	☐ Discussion	☐ Assurance

Executive summary & Recommendations:

The reprovision of the services at Reaside has been an ambition of the Trust for many years and was included, along with Highcroft, in the Estates Strategy approved in 2017. These projects are recognised as priorities in our Trust Strategy, and figure in the top five such schemes in the Birmingham and Solihull Estate Strategy.

The Strategic Outline Case (SOC) is now complete and the development has been led by the Secure Care management team with appropriate support from corporate functions and specialist external organisations. There has been a high level of clinical involvement as part of the process.

The SOC has been approved by the Secure Care management team, the Inpatient Developments Programme Board and the Capital Review Group. It also requires approval by FPP and the Board and has been provided for comment to IQC. Because of the value involved (£91m), this scheme requires Treasury and Department of Health review and approval and the SOC will be formally submitted when approved internally. Relevant authorities are well aware of the scheme and are waiting for the submission, although it might be the late autumn before we receive approval, because of the comprehensive spending review.

Assuming support, we will move on to development of the Outline Business Case and Full Business Case. The full detail of clinical model, staffing and final design including digital arrangements will be finalised at that stage, although it should be noted that some of the detailed work carried out to prepare the SOC would normally be carried out at a later stage.

The preferred option is Option A, a New Build adjacent to the existing Reaside site to include the capacity currently proved at the adjacent Hillis Lodge.

Key milestones:

- SOC approval (external) – November 2021
- OBC approval (external) – September 2022
- FBC approval (external) – June 2023
- Start on site – December 2023
- Construction completion – June 2026
- Operational date – August 2026
- The SOC was considered and endorsed by IQC and FPP in July 2021

Reason for consideration:

The Board is asked to:

- APPROVE the strategic fit within the context of BSMHFT;
- APPROVE the identification of the preferred way forward;
- APPROVE the commercial viability and feasibility of the programme;
- NOTE the anticipated financial impact assessment on BSMHFT's financial standing;
- APPROVE the planned capital investment of £90.8m including VAT; and
- APPROVE the Strategic Outline Business Case and progression to development of the Outline Business Case.

Previous consideration of report by:

- Secure Care senior management team
- Inpatient Developments Programme Board
- Capital Review Group
- IQC and FPP in July 2021

Strategic priorities (which strategic priority is the report providing assurance on)

SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population

Financial Implications *(detail any financial implications)*

Capital costs of £91m, to be funded by Public Dividend Capital.
Affordable within the Trust's overall financial position

Board Assurance Framework Risks:
(detail any new risks associated with the delivery of the strategic priorities)

No new risks associated with report.

Equality impact assessments:

N/a

Engagement *(detail any engagement with staff/service users)*

Relevant clinical teams, service users and stakeholders

Birmingham and Solihull Mental Health NHS Foundation Trust

Medium and Low Secure Facilities

Strategic Outline Case

FINAL

8 July 2021

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3-B	CIA model
3-C	OB capital cost forms and cashflow
4-A	NOT USED
4-B	Drawings / Layouts
4-C	Design Quality Indicator toolkit report
4-D	BREEAM Pre-Assessment
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1.0 EXECUTIVE SUMMARY

1.1 Introduction

This Strategic Outline Case (SOC) is in support of the investment new medium and low secure facilities at Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). This project will enable the development of suitable and sustainable accommodation in order to deliver modern models of care in the most appropriate setting.

The OBC is based on the Five Case Model, which is the format recommended as best practice by HM Treasury.

The planned investment, and the revenue implications associated with it, is supported at a system level by the commissioners, Reach Out, and the Integrated Care System and letters of support can be found at Appendix 1-A.

This SOC is compliant with NHS England / Improvement (NHSE/I) fundamental assessment criteria, the completed checklist for which is included at Appendix 1-B.

1.2 Strategic Case

The Strategic Case provides a summary account of BSMHFT in terms of clinical services delivered and sets the baseline position and strategic direction of the Trust. The new build will align with the Trust's strategic direction to provide sustainable medium and low secure services. In addition it is fully compliant with the strategic and estates objectives of the Birmingham and Solihull Integrated Care System (ICS).

The Trust's Five Year Strategy identifies the need for strategic change following assessment of the clinical and financial position in a base case scenario. This need is reflected in the key drivers for change for the project which are summarised as:

- Enabling the delivery of modern models of care
- Providing sufficient appropriate and compliant medium and low secure services in North Birmingham to meet current and future demand for services
- Improve patient pathways

In response to these drivers for change the following project objectives, and associated benefits, have been agreed:

No.	Investment Objective	Main Benefits
IO 1	To develop a whole-systems approach, reducing gaps in service and delayed transfers of care in current national and local provision and to deliver the Inpatient aspect of the Reach Out Model of Care by 2024/25	Reduced delays in Transfers of Care through improved patient flow with access to wider range of interventions and bed modelling.
		Improved NHS system working through the development of the Reach Out Model of Care and associated improvements in referrals and bed management.
IO 2	To provide a therapeutic and rehabilitative environment that ensures wards are configured in-line with national secure/environmental standards and to provide appropriate space for sports and leisure activities for patients at the opening of the facility.	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system
		To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to CQC.
		Reduction in patient LoS through improved quality of care, additional space for wider ranges of interventions and better flow through the system
		To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to the Royal College of Psychiatrists Quality Forensic Network Scores
IO 3	To provide services in a 21st Century healthcare facility which addresses existing backlog maintenance liabilities and provides a fit-for purpose environment for patient recovery at the opening of the new facility.	Reduction in major infection control incidents leading to HCAI through improved environment.
		Improved security and quality of care outcomes through introduction of modern technology - key/door management, improved access to digital technology with infrastructure in place to support.
IO 4	To ensure that the estate meets both current and future bed demand and capacity requirements and reduces the requirement for out of area placements over the next 10-15 years	Reduced travel time requirement for carers, family and friends to visit OOA patients through repatriation of existing OOA placements and increased bed provision.
		Reduction in Out Of Area (OOA) placements through repatriations of existing OOA patients and reduced need to seek future OOA placements with increased bed capacity in area.
IO 5	To provide an environment that improves the privacy, safety and dignity for patients reducing the risk and impact of serious incidents and to improve staff satisfaction, experience and effectiveness from the opening of the new facility.	Reduction in annual Trust cost of Recruitment through scheme intervention.
		Reduction in patient on patient incidents reported through the Trust's safeguarding system for incident reporting.
		Reduction in patient on staff incidents reported through the Trust's safeguarding system for incident reporting.
		Reduction in incidents resulting in self-harm and patient behaviour reported through the Trust's safeguarding system for incident reporting.
		Reduction in incidents resulting in damage, theft or loss of property reported through the Trust's safeguarding system for incident reporting.
		Reduction in Trust Agency/Bank spend.
		Reduction in sickness absence associated with violence and aggression and injury at work as a result of the environment, and burnout, by providing an environment that enhances the safe offer of a wider range of interventions to manage violence and aggression.
		Improve the wellbeing of staff by facilitating a working environment that is safe and supports their wellbeing outcomes through improved physical and psychological safety.

1.3 Economic Case

Based on the case for change and the agreed project objectives, the critical success factors (CSFs) for the project are shown in the figure following. The CSFs that have been developed for this scheme are in line with the CSFs suggested by the HM Treasury guidance.

The options considered in this case were considered against these CSFs.

CSF	Description
Strategic fit and business needs	How well the option: • meets the agreed spending objectives, related business needs and service requirements, • provides holistic fit and synergy with other strategies, programmes and projects
Potential value for money	How well the option: • Maximises the return on the required spend (benefits optimisation) in terms of economy, efficiency and effectiveness from both the perspective of the organisation and wider society. • Minimises associated risks.
Potential achievability	How well the option: • Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change, and • matches the level of available skills required for successful delivery.
Supplier capacity and capability	How well the option: • Matches the ability of the service providers to deliver the required level of services and business functionality, and • is likely to be attractive to the supply side.
Potential affordability	How well the option: • Meets the sourcing policy of the organisation and likely availability of funding, and • Matches other funding constraints.

A long list of options was identified using the Options Framework within the HM Treasury 'Green Book' (covering scope, solution, delivery, implementation and funding). The options framework provides a structured approach to identifying and filtering a broad range of options for delivering programmes of work or individual projects.

The outcome of the options generation and appraisal workshop was a shortlist of options as shown below.

Short-List Options
Business As Usual
Option 1 – Do Minimum
Option 2 (Option A) – New Build at Reaside to Include Hillis Lodge
Option 3 (Option B) – Part New Build, Part Refurbishment at Reaside to Include Hillis Lodge Beds
Option 4 (Option C) - New Build on Site Adjacent to Tamarind to Include Hillis Lodge

The figure following summarises the planned benefits, categorised as cash-releasing, non-cash-releasing, societal and non-monetisable. The benefits shown following link with the benefits realisation plan, included in the Management Case.

Ref.	Benefit Name	Benefit Description
CRB1	Reduction in Recruitment Costs	Reduction in annual Trust cost of Recruitment through scheme intervention.
NCRB1	Reduction in Incidents - Patient on Patient	Reduction in patient on patient incidents reported through the Trust's safeguarding system for incident reporting.
NCRB2	Reduction in Incidents - Patient on Staff	Reduction in patient on staff incidents reported through the Trust's safeguarding system for incident reporting.
NCRB3	Reduction in Incidents - Self Harm and Patient Behaviour	Reduction in incidents resulting in self-harm and patient behaviour reported through the Trust's safeguarding system for incident reporting.
NCRB4	Reduction in Incidents - Property Theft, Loss of Damage	Reduction in incidents resulting in damage, theft or loss of property reported through the Trust's safeguarding system for incident reporting.
NCRB5	Reduction in Healthcare Acquired Infection (HCAI)	Reduction in major infection control incidents leading to HCAI through improved environment.
NCRB6	Reduction In Agency/Bank Spend	Reduction in Trust Agency/Bank spend.
NCRB7	Reduction in Staff Sickness	Reduction in sickness absence associated with violence and aggression and injury at work as a result of the environment, and burnout, by providing an environment that enhances the safe offer of a wider range of interventions to manage violence and aggression.
NCRB8	Reduction in Patient Length of Stay	Reduction in patient LoS through improved quality of care, additional space for wider ranges of interventions and better flow through the system
NCRB9	Reduction in Out of Area Placements	Reduction in Out Of Area (OOA) placements through repatriations of existing OOA patients and reduced need to seek future OOA placements with increased bed capacity in area.
NCRB10	Reduction in Delays in Transfer of Care	Reduced delays in Transfers of Care through improved patient flow with access to wider range of interventions and bed modelling.
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year (QALY) score	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system
SB2	Reduction in Travel Times Saving	Reduced travel time requirement for carers, family and friends to visit OOA patients through repatriation of existing OOA placements & increased bed provision.
UB1	Improvement In Trust Performance - CQC Ratings	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to CQC.
UB2	Improvement in Trust performance - National Standards for Mental Health	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures premises are fit for purpose, thereby improving Trust performance in regards to National Standards for Mental Health
UB3	Improvement in Trust Performance - Royal College of Psychiatrists Quality Forensic Network Scores	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to the Royal College of Psychiatrists Quality Forensic Network Scores
UB4	Improvement in Staff/Patient Experience and Satisfaction	Improve the wellbeing of staff by facilitating a working environment that is safe and supports their wellbeing outcomes through improved physical and psychological safety.
UB5	Improved STP/ICS Partnership Working	Improved NHS system working through the development of the Reach Out Model of Care and associated improvements in referrals and bed management.
UB6	Introduction of Technology	Improved security and quality of care outcomes through introduction of modern technology - key/door management, improved access to digital technology with infrastructure in place to support.

Key:
CRB – Cash Releasing Benefit
NCRB – Non- Cash Releasing Benefit
SB – Societal Benefit
UB – Unquantifiable Benefit

The figures following present the key economic appraisal outputs based on the assumptions and inputs described above, expressed as Benefit / Cost Ratios.

Economic Impact in NPV terms including societal present costs	BAU £000	Do-Minimum £000	Option 2 (option A) £000	Option 3 (option B) £000	Option 4 (option C) £000
NPV of Capital (including optimism bias, Lifecycle + Opportunity Costs)	(20,685)	(34,265)	(72,920)	(63,851)	(82,032)
NPV of Revenue (including Transitional costs)	(878,528)	(900,871)	(801,964)	(819,103)	(782,469)
NPV of Risk	**(57,478)**	**(26,996)**	**(2,230)**	**(1,780)**	**(40,339)**
NPV Total	**(956,691)**	**(962,132)**	**(877,114)**	**(884,734)**	**(904,840)**
Incremental Capital (Cost) NPV	-	(14,171)	(52,826)	(43,757)	(61,939)
Incremental Revenue Benefit NPV	-	-	78,003	60,864	97,499
Incremental Risk NPV	-	30,482	55,248	55,698	17,139
Incremental Benefit NPV	-	-	167,551	88,751	167,456
Net Present Social Value (NPSV)	-	**(5,442)**	**247,128**	**160,708**	**219,307**
Benefit/Cost Ratio	-	**0.85**	**5.55**	**4.56**	**4.46**
Economic Ranking of Options	5th	4th	1st	2nd	3rd

This economic analysis indicates that:

- All options have the potential to show a positive Benefit / Cost Ratio (BCR) compared to BAU; and
- Option 2 (option A) is the preferred option, with a BCR of 5.55.

On the basis of the BCR the Option 2 (option A) provides better value.

A summary of the capital costs of this option are shown following, with a planned outturn cost of £90.8m (rounded figures used).

Capital Cost Elements	Option 1 (option A)
Departmental Works Costs	£45.5m
On-Costs	£5m
Location Adjustment	Inc
Fees	£8.8m
Non-Works	£0m
Equipment	£6.8m
Planning Contingencies (20%)	£10.1m
Optimism Bias (15%)	£11.7m
Total Capital Cost excluding inflation	£88.0m
Inflation (3% p.a.)	£2.7m
Total Capital Cost	£90.8m

1.4 Commercial Case

On completion the new facility will deliver the following scope:

- New Build MSU and LSU adjacent to the existing Reaside MSU, as new accommodation to replace existing Reaside MSU and Hillis Lodge LSU
- Demolition of existing Reaside MSU upon full transfer of services to new Reaside building
- Reallocation of Hillis Lodge building to alterative mental health facility (to be determined but any changes to the Hillis Lodge facility are outside of the scope of this SOC)

The new building will provide 123 beds in the following configuration:

- 36 male combined medium secure acute and PICU beds (3x12 bed wards)
- 54 male medium secure rehabilitation beds (3x18 bed wards)
- 15 male complex communications beds (1x15 bed ward)
- 18 male low secure beds (1x 18 bed ward)

The designs for the development primarily follow the HBN guidance and currently assume no derogations. The Trust is targeting a BREEAM rating of 'Excellent' (based on BREEAM 2018), with a current targeted score of 74.77%.

The Trust has appraised a range of procurement routes and concluded that a traditional procurement route for the appointment of the design team and contractor is the most appropriate. The procurement route will be aligned to the Contract Strategy with the appropriate forms of contract. The type of contract will be agreed with the design team and be comprised of traditional with supplemental contractor specialist design e.g. *JCT Standard Building Design with sub-contractor's design Conditions 2016.*

Following a meeting with the Local Authority town planners, there is support in principle of the plans along the line shown in this SOC.

The overall planned increase in staffing is 53.79 WTE (against 2020/21 WTE figures) which will be a one off increase at year 1.

The proposals contained within this OBC are fully compliant with the Trust's Health Informatics Strategy and is underpinned and fully aligned with NHSX and NHS Digital requirements.

1.5 Financial Case

The total capital value of the preferred option is £90.8m and financial impact assessments have been made on this basis. The financial case details the Statement of Comprehensive Income (SOCI), Statement of Financial Position (SOFP) and cashflow for the preferred option in comparison to the BAU option, plus it details the expenditure changes between the two scenarios.

The SOCI for the preferred option showing the SOCI at Years 1, 5 and 10 year is shown below.

£0	21/22	25/26	30/31
	Year 1	Year 5	Year 10
Operating income from patient care activities	(271,910,947)	(279,603,695)	(304,039,847)
Other operating income	(11,319,201)	(11,319,201)	(11,319,201)
Operating expenses	280,358,261	287,525,274	312,693,585
Operating surplus/deficit from continuing operations	**(2,871,888)**	**(3,397,622)**	**(2,665,463)**
Finance income	(97,020)	(97,950)	(97,949)
Finance expenses	5,605,082	5,740,229	5,598,128
PDC Dividends payable	2,416,281	5,737,448	5,793,492
Net finance costs	**7,924,343**	**11,379,727**	**11,293,670**
Gains on disposal of assets			
Losses arising from transfers by absorption			
Corporation tax expense			
Surplus/Deficit for the year from continuing operations			
Surplus/Deficit for the year	**5,052,455**	**7,982,105**	**8,628,207**
Other comprehensive (expense)/income			
Will not be reclassified to income and expenditure:			
Revaluation losses on property, plant and equipment			
Revaluation gains on property, plant and equipment			
Total comprehensive expense for the year			

The SOFP showing the preferred option at Years 1, 5 and 10 is shown in the following figure.

	21/22	25/26	30/31
	Year 1	Year 5	Year 10
Total Non-Current Assets	**£187,149,497**	**£259,852,394**	**£233,293,552**
Total Current Assets	**£25,679,031**	**-£4,721,276**	**-£39,260,451**
Total Current Liabilities	**-£47,115,382**	**-£47,115,382**	**-£47,115,382**
Total assets less current liabilities	**£165,713,146**	**£208,015,736**	**£146,917,720**
Total Non-Current Liabilities	**-£76,892,598**	**-£60,974,659**	**-£42,250,098**
Total assets employed	**£88,820,548**	**£147,041,077**	**£104,667,622**
Financed by			
Public dividend capital	**£113,126,929**	**£198,256,563**	**£199,581,207**
Revaluation reserve	**£24,633,353**	**£24,633,353**	**£24,633,353**
Income and expenditure reserve	**-£48,939,734**	**-£75,848,839**	**-£119,546,938**
Total taxpayers' equity	**£88,820,548**	**£147,041,077**	**£104,667,622**

The cashflow statement showing the cashflow for the preferred option for years 1, 5 and 10 is shown in the table following.

	21/22	25/26	30/31
	Year 1	Year 5	Year 10
Cash flows from operating activities			
Surplus / (Deficit) from Operations	**£2,871,888**	**£3,397,622**	**£2,665,463**
Depreciation and amortisation, total	**£8,083,820**	**£8,315,389**	**£9,495,598**
Total Cash Flow from Operating Activities	**£10,955,708**	**£11,713,012**	**£12,161,061**
Cash flows from investing activities			
Capital Expenditure	**-£12,191,000**	**-£32,528,629**	**-£3,830,000**
Proceeds from Disposal of PPE	**£400,000**	**£0**	**£0**
Interest Received	**£97,020**	**£97,950**	**£97,949**
Total Cash Flow from Investing Activities	**-£11,693,980**	**-£32,430,679**	**-£3,732,051**
Cash flows from financing activities			
Capital Repayment of Loans	**-£2,182,560**	**-£2,182,560**	**-£2,182,560**
Capital Repayment of PFI	**-£1,566,555**	**-£1,573,290**	**-£1,884,556**
Capital Repayment of Finance Leases	**£0**	**£0**	**£0**
Interest Repayment of Loans	**-£1,270,721**	**-£913,802**	**-£469,011**
Interest Repayment of PFI	**-£4,366,296**	**-£4,468,690**	**-£4,771,379**
Interest Repayment of Finance Leases	**£0**	**£0**	**£0**
PDC Dividends paid	**-£2,416,281**	**-£5,737,448**	**-£5,793,492**
PDC Receivable	**£2,600,000**	**£27,777,629**	**£0**
Other Cash Flows from Financing Activities	**£31,935**	**-£357,737**	**-£357,738**
Net cash flows generated from financing activities	**-£9,170,478**	**£12,544,102**	**-£15,458,736**
Increase in cash and cash equivalents	**-£9,908,750**	**-£8,173,565**	**-£7,029,725**
Cash & cash equivalents at 1 April - b/f	**£27,774,372**	**-£4,229,937**	**-£39,721,425**
Cash and cash equivalents at 31 March	**£17,865,622**	**-£12,403,502**	**-£46,751,150**

The overall investment has been assessed as being affordable to the Trust.

1.6 Management Case

A clear and robust governance structure has been agreed for the delivery of the Reaside and Hillis Lodge re-provision project. The programme is overseen by the Reaside and Highcroft Project Board, which is accountable to the BSMHFT Executive. Reporting to the Reaside and Highcroft Project Board is the Reaside & Hillis Lodge Delivery Group and relevant workstream groups.

The structure of the programme has been developed to follow the principles set out in the NHS Capital Investment Manual and the HM Treasury Green Book, supported by PRINCE2 project management principles.

The Senior Responsible Owner (SRO) and Programme Sponsor is David Tomlinson, Executive Director of Finance, BSMHFT.

The table below summarises the key milestones for the successful planning and delivery for the new Reaside MSU and Hillis Lodge LSU. This shows construction commences in December 2023 with a completion by summer 2026.

Programme Stage	Completion Date
SOC approval (external)	November 2021
OBC approval (external)	September 2022
FBC approval (external)	June 2023
Start on site	December 2023
Construction completion	June 2026
Operational date	August 2026

The Trust's approach to risk management in accordance with its internal assurance framework is designed to ensure that the risks associated with the project are systemically identified, appraised and action plans developed for effective reduction, elimination and mitigation.

A planning contingency of £10.1m including VAT has been included within the OB capital cost forms and as such form part of the capital budget for the project. The figure included is based on 20% of the works cost. A sum of £11.7 including VAT has been included for optimism bias, which equates to 15%. The Risk Potential Assessment has been completed and concluded the programme is Medium Risk. At this time the Trust does not intend to undertake an external assurance review but will keep this decision under review.

BSMHFT is committed to a process of meaningful stakeholder engagement and communication. It has established formal and informal channels adapting its communications and engagement as far as possible to the methods and frequency preferred by stakeholders. The intention is to continue to maintain significant engagement with key stakeholders. A range of engagement activities have been undertaken, and more are planned during the OBC and FBC development and construction works.

A benefits realisation plan (BRP) has been developed with the aim of providing an evidence base to support the intended health, quality and other identified benefits, where that evidence exists, and to quantify the benefits, wherever possible, to ensure that they can be measured and demonstrated over time. This will be further developed during OBC and FBC to ensure all benefits have been identified.

1.7 Conclusion and Recommendations

Conclusion

This Strategic Outline Business Case document provides a compelling case for the investment in the redevelopment of medium and low secure services. This SOC demonstrates:

- The strategic need for change in line with national, local and organisational drivers;

- The proposed delivery model and scope of the project, together with projected demand and capacity analysis;
- The preferred commercial strategy, comprising procurement and contract;
- The capital and revenue consequences of the options set in the context of an affordability analysis (based on a capital expenditure of £90.8m); and
- Detailed plans for the governance and management of the implementation of the project.

Recommendations

The Strategic Outline Business Case is being presented to the Trust Board in July 2021 with a request to:

- APPROVE the strategic fit within the context of BSMHFT;
- APPROVE the identification of the preferred way forward;
- APPROVE the commercial viability and feasibility of the programme;
- NOTE the anticipated financial impact assessment on BSMHFT's financial standing;
- APPROVE the planned capital investment of £90.8m including VAT; and
- APPROVE the Strategic Outline Business Case and progression to development of the Outline Business Case.

2.0 STRATEGIC CASE

2.1 Introduction

The Strategic Case articulates the case for change, setting it in both the national, regional and local context and confirms that the Trust's proposals for the redevelopment of Reaside Medium Secure Unit (MSU) and Hillis Lodge Low Secure Unit (LSU) are fully aligned with Trust, STP/ICS, DHSC and Government policies and plans.

This section of the Strategic Outline Case also sets out the scope of the project, investment objectives plus the associated benefits, risks, constraints and dependencies that have been identified at this stage.

The structure of this Chapter follows the guidance set out in the HM Treasury Green Book.

PART A: Strategic Context

2.2 National Context

The national policy context against which this project has been developed consists primarily of the NHS Long Term Plan and the DHSC Five Year Forward View for Mental Health. Figure 2-1 provides a summary of the broader national strategic direction.

Figure 2-1: National Strategic Direction Alignment with SOC Proposals

NHS 'Long Term Plan' (2019)	The overriding aim of the NHS Long Term Plan (LTP) is to redesign patient care to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment. The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the overall NHS budget. It requires a more proactive and preventative approach to reduce the long term impact of people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services. Leaders across the system are tasked to take decisive steps to break down the barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer and improve outcomes.
Mental Health Taskforce 'The Five Year Forward View for Mental Health' (2016)	'The Five Year Forward View for Mental Health' (FYFVMH) sets out the national vision for health and social care services, the start of a ten year journey for NHS mental health transformation. It acknowledges the chronic underinvestment in mental health across the NHS in recent years and requires efficiencies made through achieving better value for money to be re-invested to meet the significant unmet mental health needs of people to improve their experiences and outcomes. The recommendations include the need to treat people in the least restrictive setting, as close to home as possible and, in doing so, seek to address existing fragmented pathways in care.
Mental Health Taskforce 'The Five Year Forward View for Mental Health – One Year On' (2017)	A report on the progress made against the FYFVMH. In relation to secure adult mental health services the report notes that NHSE has carried out the first national audit of mental health secure services at individual and service levels.

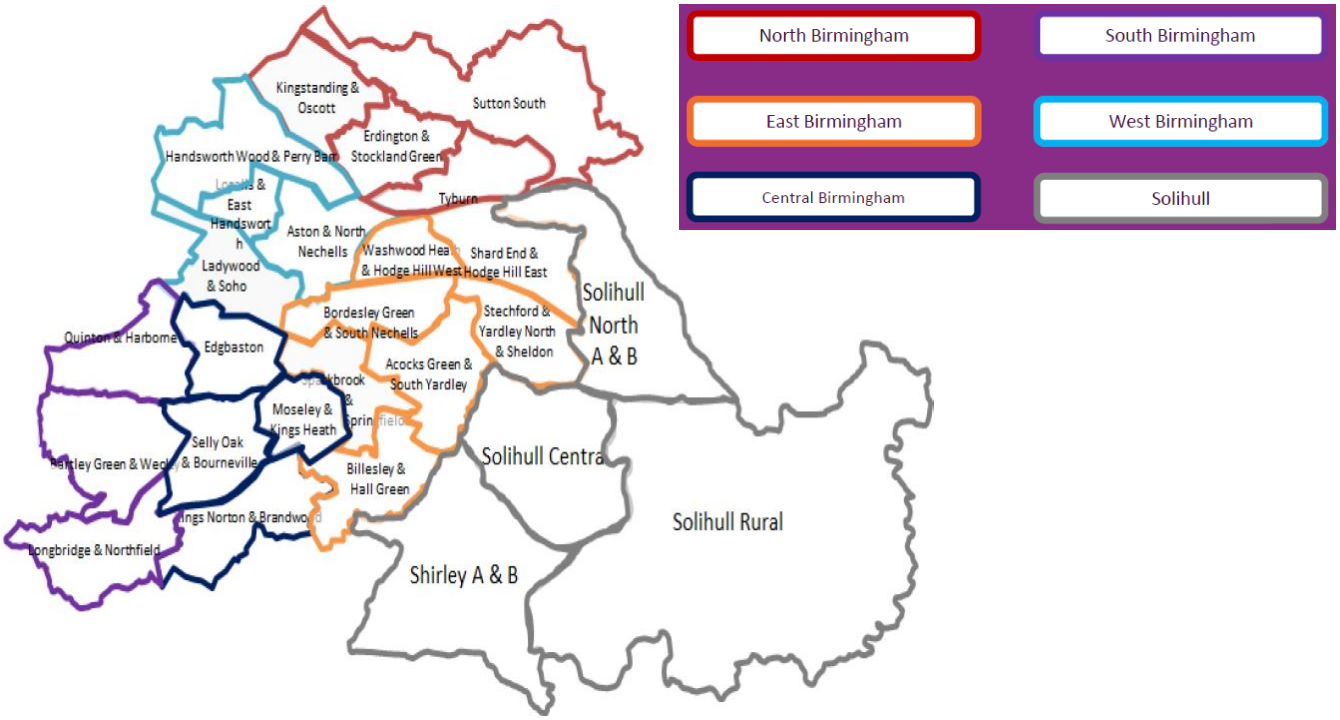
NHS England 'Mental Health Implementation Plan 2019/20 – 2023/24'	The 'NHS Mental Health Implementation Plan' summarises the FYFVMH and LTP ambitions to deliver against STP/ICS-level plans to eliminate all inappropriate adult acute out of area placements by 2020-21 (FYFV) and to improve the therapeutic offer from inpatient mental health services through increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital by 2023/4 (in line with LTP ambition).
Quality Network for Forensic Mental Health Services 'Standards for Forensic Mental Health Services: Low and Medium Secure Care' (2017)	Standards for patient safety, patient experience and clinical effectiveness relating to the provision of low and medium secure facilities, including reference to the Royal College of Psychiatrists standards for these facilities.
Royal College of Psychiatrists – Standards for Forensic Mental Health Services: Low and Medium Secure Care (2019)	Standards for patient safety, patient experience and clinical effectiveness relating to the provision of low and medium secure facilities. The standards were developed in consultation with member services of the Quality Network for Forensic Mental Health Services
'Pathways to unlocking secure mental health care', National Mental Health Development Unit (2011)	The report examines the extent to which pathways into and through secure mental health services can be improved through the different security levels and ensure a better flow between prison and secure services.
CQC Health and Social Care Act 2008: Regulation 15	The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located.
CQC: 'State of Care 2019/20'	This report is an annual assessment of health and social care in England. Key point of relevance to this case is the need to maintain a safe environment including managing the need to socially distance or isolate people

2.3 Regional Context

Birmingham and Solihull STP

The Birmingham and Solihull Sustainability and Transformation Partnership (STP) (intended to become an Integrated Care System (ICS) in 2021) is a collaboration of public NHS and council social care commissioners and providers across Birmingham and Solihull working together with partners in the voluntary, community and independent sectors to manage the health and care needs of the population and provide high quality, sustainable care for the future. The STP/ICS provides services to a population of 1.3 million. The STP/ICS comprises of two local authorities (Solihull Metropolitan Borough Council and much of Birmingham City Council) and as such represents two places and six localities of c. 250,000 population (Figure 2-2).

Figure 2-2: STP/ICS Footprint



The Birmingham and Solihull STP/ICS s a collaboration of public NHS and council social care commissioners and providers across Birmingham and Solihull working together with partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of the population within available resources and provide high quality, sustainable care for the future.

Both Birmingham and Solihull have stark inequalities in terms of health and wealth. In Birmingham, 440,000 people, or 46% of the population, live in the 10% of most deprived areas in England, which accounts for some very poor health outcomes. The city has a level of homelessness that is more than three times the national average; long-term unemployment is two-and-a-half times higher; one in three children live in poverty; and one in four people live with a mental health condition that started in childhood. There are notable mental health inequalities - one in ten mothers suffer mental health problems in the first years after giving birth and, as time progresses, this has an impact on both mothers and young people. Referrals for young people's mental health service increase by 45% between 2015/16 and 2018/19. There is also a high proportion of Employment Support Allowance claims for people with mental health conditions and only 6% of people on the Serious Mental Illness register are currently employed. With regards to the STP/ICS workforce it is noted that there are areas of significant workforce pressure, including all mental healthcare professionals. In addition the STP/ICS faces challenges of an ageing workforce, as 17% of the workforce is aged 55 and over.

Birmingham and Solihull are refreshing work to identify both the service model and recurrent capacity required for mental health services. This will include ensuring patients are far less likely to be placed out of area, building on work undertaken earlier with BSMHFT and Forward Thinking Birmingham at Birmingham Women and Children NHS Foundation Trust, on changes required to models of care to impact this and wider issues and the opening of additional bed capacity. The work is likely to require

significant capital investment to support an expansion of beds and this has been prioritised in the STP estates plan. NHS Birmingham and Solihull CCG currently incurs £4m of expenditure on acute out-of-area placements for adult mental healthcare, including secure services, and has been working with BSMHFT to reinvest in local capacity to support the reduction in this spend. Further work is being scoped to reduce the out of area costs for the 18 to 25-year population.

BSMHFT continues to use the opportunities afforded as a mental health Global Digital Exemplar to explore new technology to deliver improved patient care, alongside plans within MERIT and the STP.

There is recognition at an STP/ICS level that the following are key drivers for change:

- Ageing society, which leads to the need for high quality sustainable health and care
- A shifting burden of disease, which leads to the promotion of health and wellbeing and the continuous improvement of the quality of care
- Technological advances, including the need to maximise efficiency of service delivery

In response to the NHS LTP, the STP/ICS has developed a regional Long Term Plan (2019). The STP/ICS vision is: '*helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible*'. To deliver this vision the STP/ICS has five aspirations:

1. Independence and resilience: to provide an enabling role allowing people to take responsibility for their health and wellbeing
2. Equity, equality and inclusion: reducing the gap between health and wellbeing between the most and least advantages
3. Integration and simplification: integration of services around pathways on a system-wide basis
4. Promoting prosperity – improving health and life outcomes
5. Social value – using the collective system to deliver social and economic benefits

As an output of these aspirations, the STP/ICS has identified its priorities, as shown at Figure 2-3.

Figure 2-3: STP/ICS Priorities

All STP/ICS partners have agreed a set of collective priority transformation schemes that will deliver the components of a system designed to meet the challenges set out in the NHS LTP.

With regards to mental health services the STP/ICS has targets to achieve:

- The length of stay for mental health patients will be reduced by approximately 10%
- To reduce out of area placements
- To increase year on year spending on mental health
- An increase in occupational therapists and other professionals on wards to assist in delivering a more therapeutic environment

The STP/ICS issued its draft Estates Strategy in July 2018 and supplemented with a 'checkpoint' update issued to NHSE/I in July 2019. The Estates Strategy supports the overall system strategy which aims to continue to deliver specialist services at scale, concentrated in a fewer number of places.

The estates vision for STP/ICS mental health services is to '*provide a safe, compliant and fit-for-purpose environment for those with mental health illnesses is imperative for the delivery of better care quality, improved patient experience and the opportunity to improve on their mental health wellbeing. This will support the reduction of out of area placements by ensuring we have the capacity and infrastructure in place to enable access to care and treatment locally*'.

Key aims for the STP/ICS planned estate include:

- Reduction in the amount of non-clinical space
- Reduction in total estate running costs
- Reduction in the amount of unoccupied space
- To have plans in place to eradicate all high risk backlog maintenance
- Reduce void space in community accommodation
- Implement principles of agile working

The STP/ICS recognises the estate from which services are delivered is a core enabler, together with digital innovation, which is fundamental for a sustainable system. The 2018 Estates Strategy articulated the STP/ICS's comprehensive approach i.e. utilising smart investment in the estate, in support of service transformation, whilst increasing efficiency and addressing the poor quality of the estate.

Linked to the key service strategy theme 2. Adulthood and Work (see Figure 2-3 for definition), the agreed implications for future estate includes the need to 'develop efficient mental health sites', specifically to:

- Reduce stigma around mental health and improve access through early intervention services
- An integrated, co-located, all age urgent care offer that combines places of safety, bed management and psychiatric decision suite

- Reconfiguration of mental health provision and development of recovery-based approaches within psychologically informed environments, where any building is being upgraded
- Commit to the delivery of the Transforming Care Programme by 2020, to support people with autism and/or learning disabilities to be as close to home as possible, in the least restrictive environment

The STP/ICS used a formal assessment process to support the prioritisation of capital schemes based on three broad criteria relating to service transformation; current estate issues which are detrimental to patient and staff safety including functional suitability; and financial alignment with the STP/ICS plan. The output of this process is that the redevelopment of Reaside is the fourth highest priority scheme for the STP/ICS, which is full support of key service strategy theme number 2. This priority mirrors the Trust's proposals and is the subject of this SOC.

The 2019 Estates Strategy 'Checkpoint' noted that BSMHFT has two business cases in production for estate reconfiguration in direct response to STP/ICS priorities and in full alignment with one its key estates priorities, including this SOC. The STP/ICS notes that these planned developments are supported by commissioning strategies, address significant backlog maintenance issues and meet patient compliance and quality standards. The STP/ICS service strategy and the STP/ICS Estates Strategy support the need for capital investment at Reaside, as articulated in this Strategic Outline Case.

2.4 Birmingham and Solihull Mental Health NHS Foundation Trust Organisational Overview

Overview

Birmingham and Solihull Mental Health NHS Foundation Trust provides a comprehensive mental healthcare service for residents of Birmingham and Solihull, and a range of specialist mental health services to communities across the West Midlands and beyond. The Trust operates from over 40 sites, serves a culturally and socially diverse population of 1.3 million spread over 172 square miles, has an income of more than £240m and a dedicated workforce of around 4,000 staff. It covers a range of local and regional services and partnerships covering inpatient, community and specialist mental healthcare.

The Trust provides a range of inpatient, community and specialist mental health services for service users from the age of 16 and over in Birmingham and for all ages in Solihull. These services are split into four key areas:

- Acute and urgent care
- Integrated community care and recovery
- Specialties
- Secure care and offender health

The most recent CQC assessment of the Trust (undertaken in 2019) rated it as 'Requires Improvement' overall, albeit two of the five categories were individually rated as 'Good' (Figure 2-4).

Figure 2-4: CQC Rating

Vision and Strategic Direction

The Trust's Five Year Strategy outlines how the Trust will provide the best care in the right way in the right place at the right time, with joined up care across health and social care.

The Trust's strategic vision is *'improving mental health wellbeing by making a positive difference to people's lives'.*

There are six strategic ambitions that directly relate to how the Trust will achieve its vision, as shown below. These strategic ambitions have driven the specific investment objectives that have been identified for the project (see Section 2.8):

1. We will put service users first and provide the right care, closer to home, whenever it's needed
2. We will listen to and work alongside service users, carers, staff and stakeholders
3. We will champion mental health wellbeing and support people in their recovery
4. We will attract, develop and support an exceptional and valued workforce
5. We will drive research, innovation and technology to enhance care
6. We will work in partnership with others to achieve the best outcomes for local people

The organisational ambitions for clinical services include:

- Being a leader in mental through our Reach Out provider collaborative
- Being recovery focussed
- Reducing out of area placements and providing personalised care in the least restrictive setting
- Having a model that considers all the needs of the service user: their mental, physical and social wellbeing; and wraps around the service user, working in partnership across professions and across other organisations to meet those needs
- Using our development at Reaside as an opportunity to work in a different way

- Using strategic alliances, formal partnerships and provider collaboratives to improve services, pathways and service user outcomes, share expertise and spread best practice.

The map at Figure 2-5 shows the geographical location between the Trust and its ICS health partners.

Figure 2-5: Trust Location within STP/ICS Geography

Reach Out is a partnership between the three providers of secure inpatient care in the West Midlands: Birmingham and Solihull Mental Health NHS Foundation Trust, Midlands Partnership Foundation Trust and St Andrew's Healthcare. Alongside NHS England, Reach Out's aim is to improve the delivery of forensic mental health care across a wide geography, including beyond the ICS boundary. Reach Out was part of wave 1 of the 'new care models' selected by NHS England to improve the experience of service users by providing care closer to home, in the least restrictive setting possible.

In April 2017, there were over 550 adult men and women receiving care in medium and low secure mental health hospitals in the West Midlands, of whom a third were being cared for outside of the region. Working collaboratively across the partnership, through streamlining processes and care pathways and focusing on providing appropriate care in the community, Reach Out has reduced the number of patients in hospital and significantly reduced the proportion of people receiving inpatient care out of the West Midlands.

Alongside this the community forensic service, called FIRST, has helped service users to stay in the community and to facilitate earlier discharge from inpatient care. Investment has been made to enhance services locally, including providing services in local courts, and Reach Out has worked collaboratively with key stakeholders such as housing providers to ensure local community needs are better met. Reach Out has been working to redesign services in the West Midlands with a strong focus on co-production and service user engagement. This has enabled a reduction in the length of time that service users stay in hospital and improve service user experience according to their needs.

Population and Demography

The catchment population of BSMHFT is ethnically diverse and characterised by high levels of deprivation, low earning and unemployment. As a result of these factors, there is a higher need for access to health services, including mental health. Figure 2-6 summarises key demographic statistics for the Trust's population.

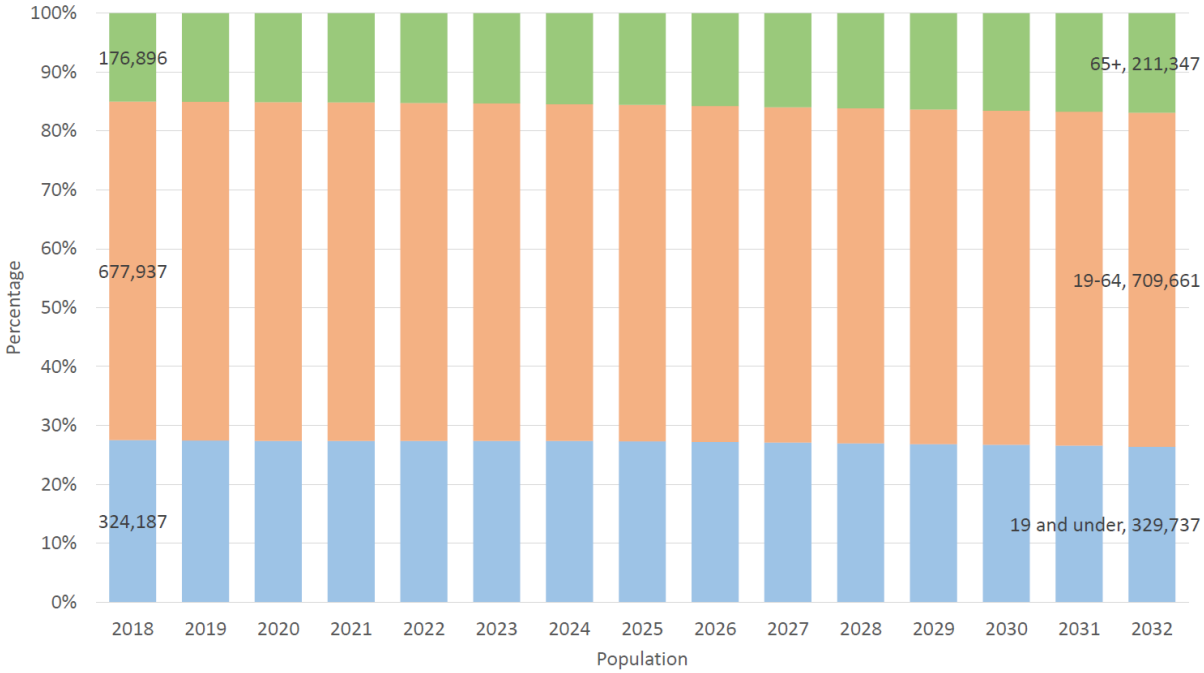
Figure 2-6: Trust Demographics

Category	Demographic Profile
Age	• Birmingham is the youngest core city in Europe, with 46% of our population under 30 • Solihull has an ageing population with 19% over 65
Ethnicity	• 42% of Birmingham residents identify with a non-white ethnic group • 11% of Solihull residents identify with a non-white ethnic group, although this percentage is growing year on year
Deprivation	• 46% of our population live in the bottom 10% most deprived areas in England • 1 in 3 children live in poverty
Life expectancy	• Solihull has a gap in life expectancy of 10.3 years for males and 10.5 years for females • Birmingham has a gap in life expectancy between the most deprived and least deprived areas of 7.4 years for males and 4.9 years for females
Homelessness	• Birmingham has a homelessness level more than three times the England average
Unemployment	• Birmingham has a long term unemployment rate around 2.5 times higher than the England average

There is a growing population, which is both ageing and young in Birmingham and ageing in Solihull (Figure 2-7). Birmingham's population is expected to increase significantly over the next 10 years with the largest projected increase in age brackets 65-84 and 85+.

ONS data (as documented for NHS Birmingham and Solihull CCG) shows a marginal increase in the 19 and under age group in the period to 2032 (1.7% growth). The number of adults of working age is expected to increase by c. 32,000 or 4.8%. The greatest anticipated percentage growth rate and actual growth is in the 65+ age band which over the geographical area as a whole is expected to increase by c. 34,500 people which equates to a growth rate of over 19% in the period.

Figure 2-7: Population Growth 2018-2032



Clinical Strategic Direction

The Trust has an ambition to transform clinical services in order to provide the best care in the right way in the right place at the right time, with joined up care across health and social care. This is aligned with the Reach Out model as identified above. This ambition, as it aligns with the services detailed in this SOC, focuses on:

- **The Trust being a leader in mental health.** Transforming integrated pathways and services across health, care, public sector, voluntary and independent sectors to manage demand across the system, improve outcomes and reduce inequalities.
- **Recovery-focussed**. A recovery approach from assessment throughout the service user journey.
- **Rooted in communities**. Reducing out of area placements and providing personalised care in the least restrictive setting.
- **Prevention and early intervention**. Increase early support collaboratively with NHS, statutory, community and voluntary sector partners to treat people as soon as possible.
- **Clinical effective**. A needs-lead model that considers all of the needs of the service user: their mental, physical and social wellbeing; and wraps around the service user, working in partnership across professions and across other organisations to meet those needs.
- **Changing how the Trust itself works**. Within this dimension, the Trust notes that it will use the new Reaside facility, amongst other key developments, to work in a different way.

Estates Profile and Strategic Direction

The Trust has a Board-approved Estates and Facilities Strategy 2019-2024. The priorities for estate investment and development have been based on the Trust's Clinical Services Strategy. The Estates vision for the Trust is:

> *'An estate which efficiently, effectively and economically supports the delivery of safe, high quality services and addresses the Trust's service, business and financial strategies and plans'.*

The priorities for 2019-2024 are:

1. Re-provision of standalone inpatient sites and utilisation of existing Trust estate to accommodate the inpatient adult acute services, including development of the Highcroft Site (currently part of a separate SOC being developed)
2. Hillis Lodge re-provision
3. Replacement of Reaside (Medium Secure Unit) Forensic Facility

An integral part of the Estates Strategy is the planned reduction of carbon usage. The overall NHS commitment is to be Carbon Net Zero by 2040 with interim targets at 2030. SSL on behalf of the Trust are developing an action plan that will help to address some of the very many challenges and modal shift that a net zero commitment will inevitably lead to, this will include for instance:

- Greening the fleet – Moving to an all-electric fleet and potentially providing access for staff / public electric vehicle charging points.
- Decarbonizing the heat supply – Removing the need for natural gas use and instead making use of newer technologies such as air source heat pumps (where the electricity is already from decarbonised sources)
- Developing the Trust Estate Including the new Highcroft and Reaside projects (for example) to be low carbon, energy efficient (with onsite renewable energy and low / zero carbon heat) and exemplars of best practice in terms of resource efficiency.
- Procuring - Controlling what is procured and making the best and most informed decisions.

SSL on behalf of the Trust is updating its Sustainable Development Management Plan (SDMP). This Management Plan and associated Action Plan brings together all current Government plans (and equivalent – Green Plans / Carbon Net Zero etc) along with the previous BSMHFT strategies and plans (Climate Change Adaption Plan, Sustainable Development Plan etc) into one inclusive document with clear appendices describing each of the political / social or economic drivers and then a joined-up Action plan to focus attention and deliverables.

Key aims in the SDMP are to:

- invest in renewable and decarbonised energy – using whole life costs to drive decision making and procurement processes.

- reduce omissions aiming for that aspirational Zero (net) Carbon status. Focussing on key areas that the Trust can influence such as staff behaviour, procurement, buildings, vehicles and journeys and energy consumption

Specifically with regards to the Trust's provision of low and medium secure services, BSMHFT provides inpatient forensic/secure services from 227 beds across hospital sites at:

- Reaside (medium secure male services) (**the subject of this SOC**);
- Ardenleigh (medium/low secure Adult Women's secure services and FCAMHS/low secure CAMHS);
- Tamarind Centre (medium secure male services); and
- Hillis Lodge (low secure male services) (**the subject of this SOC**).

The male adult services predominantly cover the following geographical areas:

- Birmingham
- Coventry
- Warwickshire
- Worcestershire
- Black Country (excluding Wolverhampton)
- Herefordshire

The current service is configured over the Reaside and Hills Lodge sites as shown at Figure 2-8.

Figure 2-8: Reaside and Hillis Lodge Current Configuration

Facility	Bed Number
Reaside	
Two acute wards	14 beds (Avon) & 13 (Blythe) beds
One psychiatric intensive care unit (PICU)	Severn Ward - 8 beds
Three rehabilitation wards	Kennett ward – 14 beds Trent ward – 14 beds Swift ward – 15 beds
One functionalised ward for complex communications needs (including autism)	Dove ward - 14 beds
Hillis Lodge	
One low secure ward	15 beds

Reaside and Hillis Lodge forming a key component of this segment as the services currently provide 21% of the total medium and low West Midlands capacity and 35% of the total West Midlands medium secure capacity.

Premises Assurance Model

The Trust has, ever since PAM was first released, completed it in partnership across the organisation and used the self-assessment tool to help to identify any potential gaps in compliance or assurance, and / or any areas where improvements are necessary. The strategic aim being to be able to use PAM to help to demonstrate as necessary that the buildings, services and facilities have a level of assurance and compliance necessary to sustain for an environment that is safe to work in and be cared for within. Using the PAM tool to help benchmark standards with a view to continuous improvements. The PAM self-assessment is not undertaken on a building specific basis and as such Reaside is included within the overall assessment.

The Trust (led by SSL Estates and Facilities) has an offline version of the Self-Assessment that can be shared as necessary and is awaiting at this time the completion of the online 'portal' based version before re-examining the organisations assurance / compliance self-assessment.

In particular it should be noted that SSL Senior management have found the tool particularly useful in asking difficult questions and in trying to identify gaps in assurance and improvements necessary.

People Strategy

The people who work with and for the Trust are a fundamental resource to the successful delivery of services. The Trust aims to create the best place to work and ensure it has a workforce with the right values, skills, diversity and experience to meet the evolving needs of its service users. The Trust's strategy to shaping its future workforce is:

- To attract and retain a diverse talent
- To develop a high performing workforce
- To have flexible and transformative workforce models
- To transform the culture and staff experience
- To modernise the Trust's people practice

Part B: The Case for Change

2.5 Existing Arrangements

Current Medium and Low Secure Services

Reaside is a medium secure facility currently located in Rubery, Birmingham. It became operational in 1987 and increased total bed provision to 92 plus a seclusion room in 2010. An additional seclusion room was built in 2018/19.

Hillis Lodge was originally commissioned in 2001 as a 14 beds long stay low secure service, intended to provide step down care for a cohort of patients who no longer required the physical and procedural

security of a medium secure service, but who, because of their long term risk profile and chronic mental illness, were thought to require long term care in a structured environment with high relational security.

The Reaside Medium Secure service currently comprises four medium-secure rehabilitation wards, two medium-secure acute wards and an associated psychiatric Intensive Care Unit. Hillis Lodge Low Secure wards is a standalone facility, which increased its capacity to 15 beds in 2019/20.

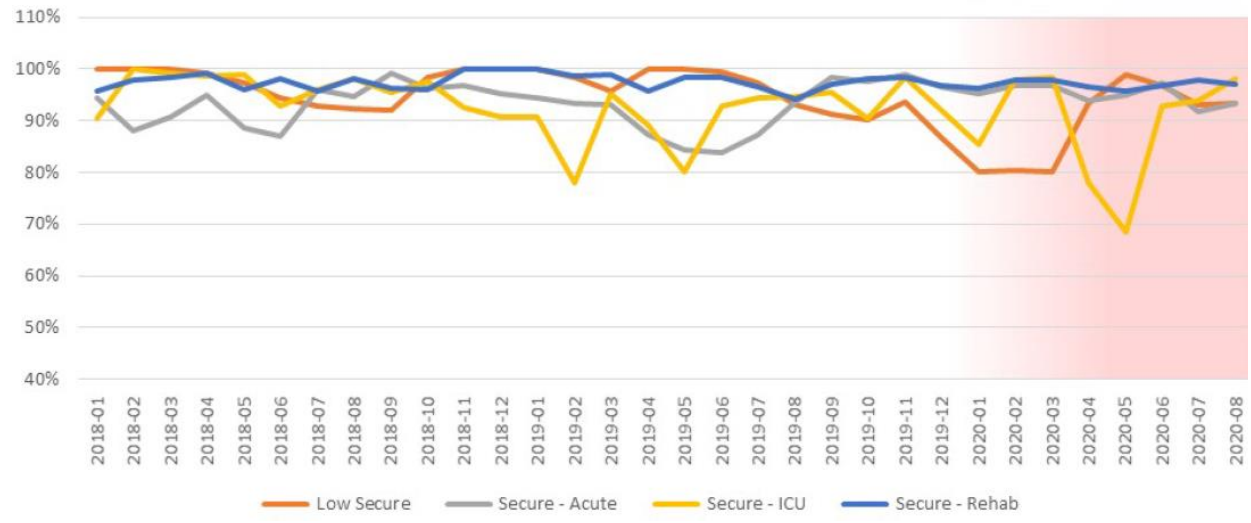
Summary of Historic and Current Activity

Reaside provides 92 male medium secure beds; this is 21% of the total West Midlands low and medium secure capacity; 35% of total West Midlands male medium secure capacity and 51% of male medium secure capacity within BSMHFT. Reaside forms a key component of the Reach Out partnership new care model. This model builds on existing specialist forensic outreach services and joins together secure care and step down providers, third sector organisations and statutory partners e.g. Criminal Justice System and Social Services across the whole of the West Midlands.

The West Midlands has the biggest shortfall of capacity to demand in the country with 35% of patients needing to be sent out of area.

There are currently a total of 15 low secure, 27 acute, 57 rehabilitation and 8 PICU beds all for male cohorts within scope of the proposed service change. This provides for a maximum of 5,475 occupied bed days of low secure capacity, 9,855 occupied bed days of acute capacity, 20,805 days of rehabilitation capacity and 2,920 days of PICU capacity when running at 100% occupancy. Average utilisation on the medium secure acute, rehabilitation and low secure wards ranges from 95% to 97% occupancy respectively with the PICU operating at 90% occupancy. Figure 2-9 shows the monthly bed utilisation from which it is clear that, notwithstanding the impact of COVID, there is no significant trend in utilisation and the wards are running consistently at capacity.

Figure 2-9: Current Position of Bed Utilisation by Month (2018-2020)



A current census on the use of out of area placements suggests that there are 11 service users in medium-secure beds and 24 service users in low secure beds. Figure 2-10 shows that there is a marked reduction in the use of out of area placements that has been relatively consistent for both medium and

low secure services from around August 2019. This has reduced the reliance on third parties for low secure services from a peak of 35 placements at any given point down to around 22 placements currently. Likewise, for medium secure services this reduction is from a peak of 30 placements in January 2019 down to 16 placements currently. Analysis undertaken by the Trust has identified that it is likely that around 8 beds of rehabilitation excess demand and 2 beds of low secure excess demand can be repatriated with the remainder having a valid clinical or operational reason for requiring a spell at a third party service.

Figure 2-10: Analysis of Out of Area Placements

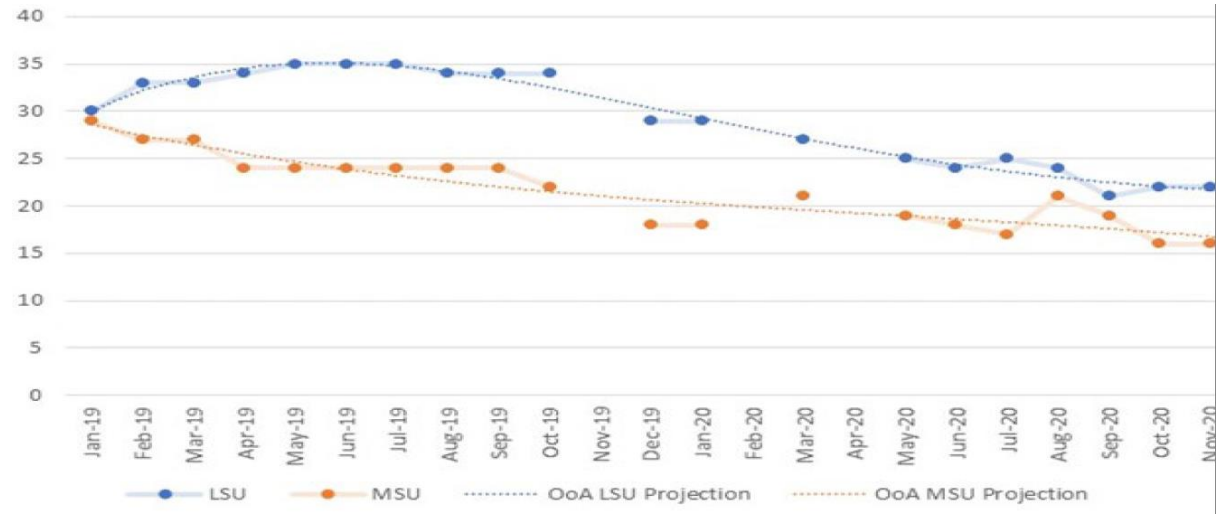


Figure 2-11 shows the average median length of stay (across both Reaside and Hillis Lodge plus OOA placements) for the patients in a bed at the end of each financial year. Years are shown from 2016/17 to 2020/21. In summary there is a trend that shows there is an increase median length of stay at all three settings since 2019.

Figure 2-11: Median Length of Stay

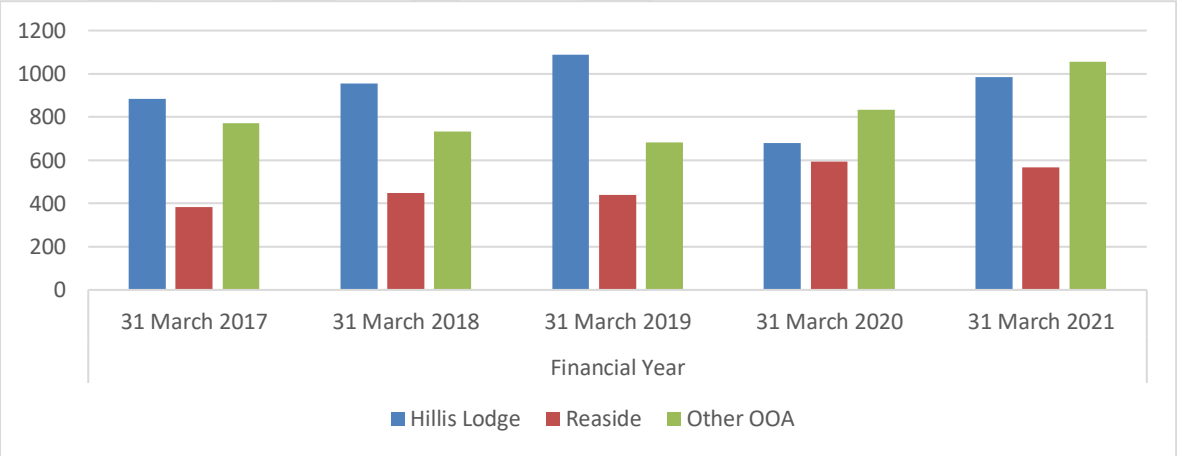
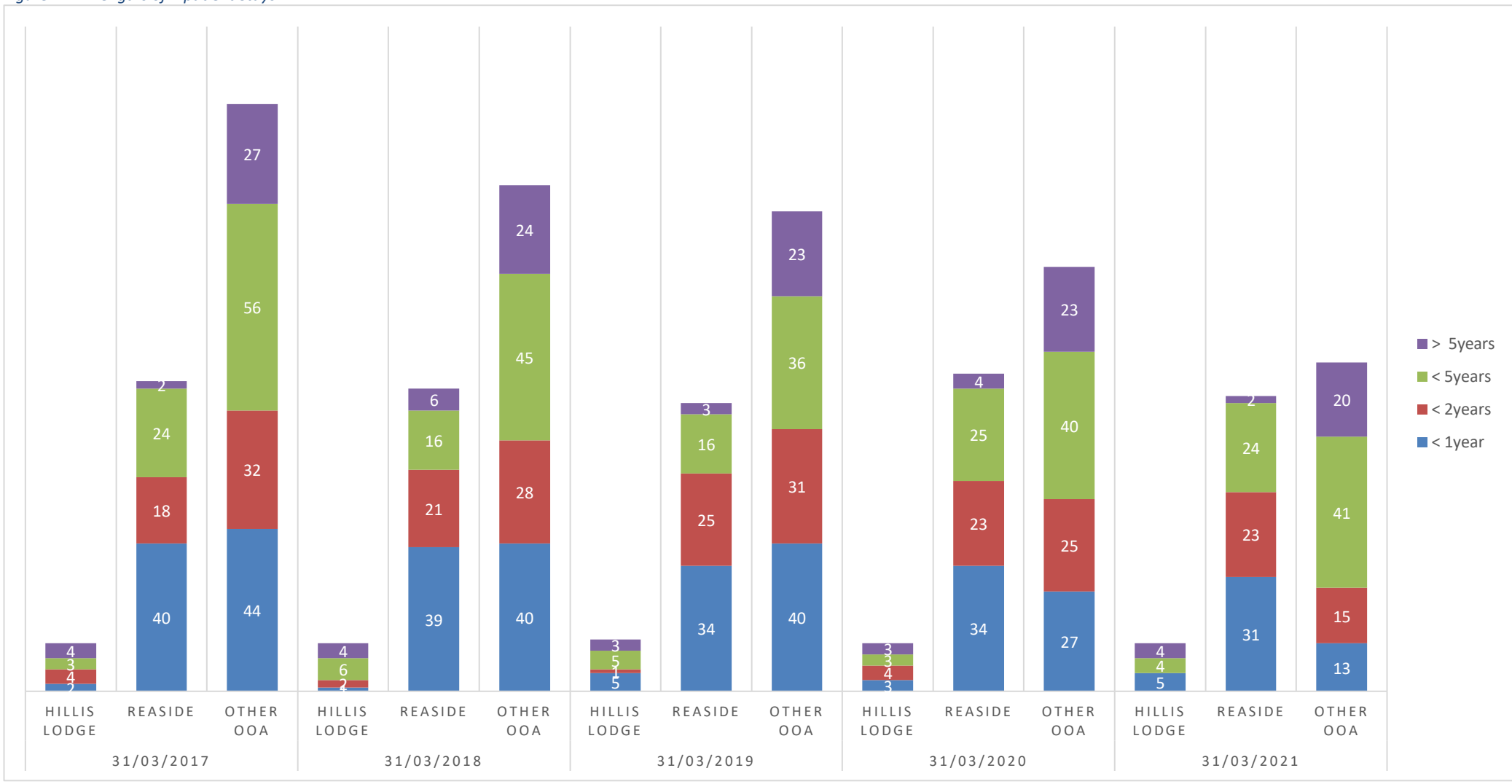


Figure 2-12 shows the make up on the inpatient population across Hillis Lodge, Reaside and in OOA placements. There has been a large decrease in the OOA population over the time period from 2017, with an increasing proportion of patients with stays over 5 years. The proportion of shorter stay patients has decreased slightly over the period.

Birmingham and Solihull Mental Health NHS Foundation Trust

Figure 2-12: Lengths of Inpatient Stays



The Reaside MSU Replacement and Hillis Lodge LSU Re-provision and Highcroft Redevelopment schemes were identified as three of the service priorities (of which the Highcroft redevelopment is the subject of a separate SOC) set out in the BSMHFT Estates and Facilities Strategy 2019-24, approved by the Board May 2017.

Figures 2-13 and 2-14 show the current site plans for Reaside and Hillis Lodge.

Figure 2-13: Reaside Site Plan

Figure 2-14: Hillis Lodge Site Plan

A review of Reaside was completed as part of the Tamarind Full Business Case (FBC) in March 2010. Reaside became operational in 1987 and in 2010 provided 92 beds plus a seclusion room. During the period 2005-2018 over £3.9m was invested in the facility to improve the general environment, upgrade the security fencing, refurbish specific areas within the clinic, creating additional day area space, toilet and shower facilities, and a seclusion room on the most environmentally challenging and limiting ward. While these investments upgraded the Reaside facility, the Reaside facility does not fully meet the DHSC's HBN 00–03 – Clinical and Clinical Support Spaces guidance, particularly for security and dignity.

The Trust's ERIC return for 2019/20 identified the estate performance of Reaside and Hillis Lodge. Key metrics are included at Figure 2-15.

Figure 2-15: Key Estate Metrics 2019/20

Area	Reaside	Hillis Lodge
Gross internal floor area	7,084m2	1,117m2
Land owned area	3.57 hectares	0.98 hectares
Clinical space	5,934m2	750m2
Non-clinical space	1,150m2	367m2
Single rooms with en-suite	0	0
Single rooms without en-suite	92	15
Not functionally suitable – occupied floor area	30%	20%
Age of premises	1985-1994	1985-1994

Whilst the Trust's two other secure units (Tamarind and Ardenleigh) largely meet current accommodation standards the existing accommodation at Reaside (commissioned in 1987) and Hillis Lodge (commissioned in 2001) is not conducive to the delivery of modern mental health inpatient services and does not meet modern accommodation standards. Secure care provision has moved from a containment model of care when the current buildings were constructed to a therapeutic model where the support of the patient in their recovery is central. The current buildings hinder the expansion of the types of therapeutic intervention that can be provided. The main current environmental shortfalls at Reaside and Hillis Lodge include:

- No en-suites in any bedrooms.
- A number of wards at Reaside only have two shower rooms and one bathroom to accommodate 14 patients, and do not meet the recommended patient / bathroom ratio of one bathroom/shower rooms for every three patients. The showers on these wards have a particularly high level of use and often suffer with drainage issues.
- The majority of wards at Reaside for not have a fully wheelchair accessible bathroom.
- Four of the seven wards at Reaside have spaces defined as Quiet Rooms, however these rooms do not meet design standards for de-escalation rooms.
- Bedroom sizes are below the minimum as required by DHSC being typically 11-12m^2 against a minimum standard of 15m^2
- Inadequate day space on inpatient ward areas and limited visiting areas for family and friends.
- Four wards on first floor at Reaside which forms part of the external secure perimeter, with restricted access to external space.
- Inadequate seclusion rooms and interview/therapy space on wards.
- Poor sight lines to adjacent patient areas on the wards at Reaside.
- Poor levels of natural light in the ward corridors and elsewhere.
- Reaside has insufficient dining space on wards.
- The nurse call facility within each bedroom has been obsolete for a number of years and has been decommissioned, which does not comply with DHSC guidance.
- Restricted access to external space.
- The mechanical and electrical services are generally in poor condition, having exceeded their projected serviceable life. The installations are at an increased risk of major failure and major capital expenditure is required to replace a significant amount of mechanical and electrical installations (source: Condition Report 2020).
- Hillis Lodge is a stand-alone site.

The current facility does not meet HBN 00-03 Clinical and Clinical Support Spaces standard for physical environment for security and dignity. A Condition Survey for Reaside was commissioned in 2020; the summary from this report notes:

'….. due to the age of the building and building services, the majority of the major items of mechanical plant and electrical systems have reached the end of their operational life expectancy and will require replacement within the next five years.

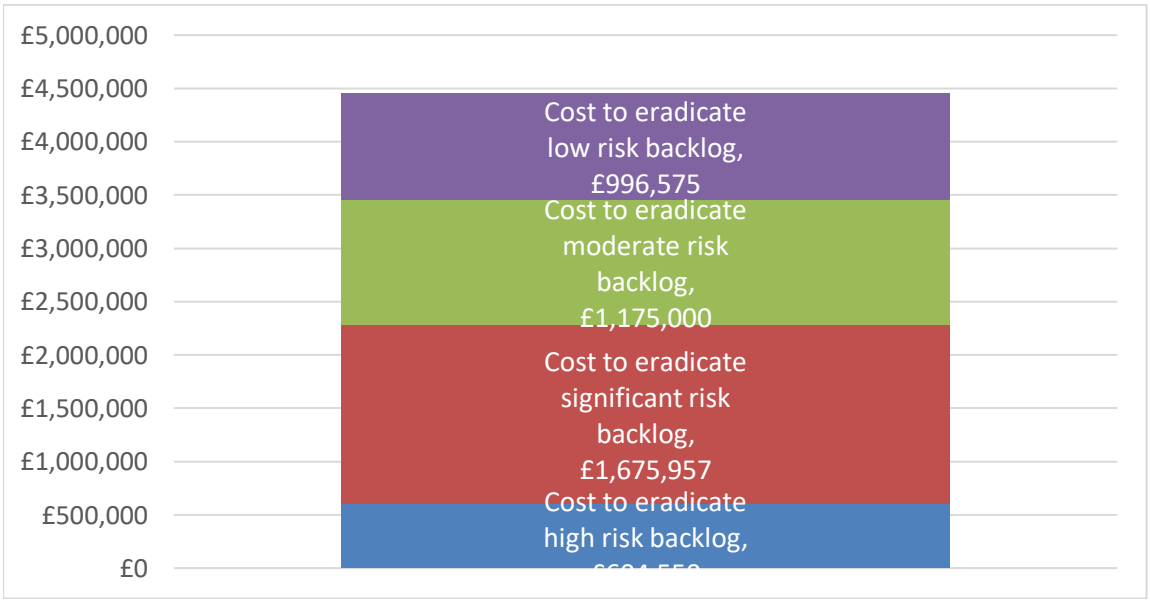
The cost of replacing the mechanical plant and electrical systems is estimated at over £3 million. This is part of an overall total backlog and premises costs of almost £4.7 million over the next five years.

This report also identifies a number of areas where the building does not comply with current design guidance for Adult Medium Secure Services. Most notable is the absence of bedroom en-suite facility, and the relatively high number of patients per bathroom/shower room on the wards. Even with a large investment it will not be possible to provide bedroom en-suites within the existing building footprint without seriously impacting the function and capacity of the service'

A Condition Survey for Hillis Lodge (June 2020) noted that, whilst the fabric and mechanical and electrical installations were generally acceptable, the survey did note that a number of the mechanical and electrical systems were approaching the end of their life and showing signs of deterioration.

The backlog maintenance is as reported in 2020/21 for Reaside and Hillis Lodge is shown at Figure 2-16. This shows a combined backlog maintenance liability for the two premises of £4.45m, of which £0.6m relates to high risk backlog and £1.7m relates to significant backlog maintenance. The combined risk-adjusted backlog maintenance figure is £1.4m. Within the overall figure, the largest backlog cost items are at Reaside and include the replacement of the steam boilers and associated works (£2.0 million), the replacement of the electrical switchgear etc. (£400,000), and the replacement of the alarm systems (£1.1 million).

Figure 2-16: Reaside and Hillis Lodge Backlog Maintenance Liability



At present, throughout Reaside there is an absence of dedicated therapeutic space which severely inhibits the ability to consistently deliver a full range of individual and group interventions. While

occupational and vocational activities can be accommodated in the workshop and the therapy kitchen areas, there is no provision for psychological or speech and language therapy. The centrality of these interventions to an individual's recovery, progress and their future safety is universally recognised. The lack of space and associated ease of access to appropriate intervention at the right time severely impedes service user progression. It can result in unnecessarily extended lengths of stay.

For those service users who are at an early point in the admission and who don't have leave from the ward, the situation is worse. The small, crowded wards can limit the ability of staff to provide therapeutic interventions. The wards do not have dedicated therapy space reducing the ability to provide intensive 1-1 psychological interventions due to lack of privacy and the need for confidentiality. Often the mix of new admissions and more settled patients on the wards can disrupt the recovery process for some, with the lack of space at times leading to crowding and increasing risks within the clinical environment.

The Quality Network for Forensic Mental Health Services, in their '*Aggregated Report: LSU Cycle 6 2017-2019*', benchmarked 112 low secure units across UK and Ireland against a number of criteria, within the key domains of patient safety, patient experience, clinical effectiveness and governance. In support of the deficiencies in the estate identified above, this report identified that whilst 81% of providers fully met the environmental and facilities standards, BSMHFT's low secure facilities at Hillis Lodge were significantly below average (Figure 2-17), with only c. 60% of the criteria fully met. The Quality Network for Forensic Mental Health Services also undertook an assessment of medium secure units, published in their '*Aggregated Report: MSU Cycle 6 2017-2019'* (Figure 2-18). This showed that, whilst there were areas of better estates and facilities, Reaside was still only able to achieve c. 80% of the estates and facilities requirements in full.

Figure 2-17: Hillis Lodge Assessment by The Quality Network for Forensic Mental Health Services

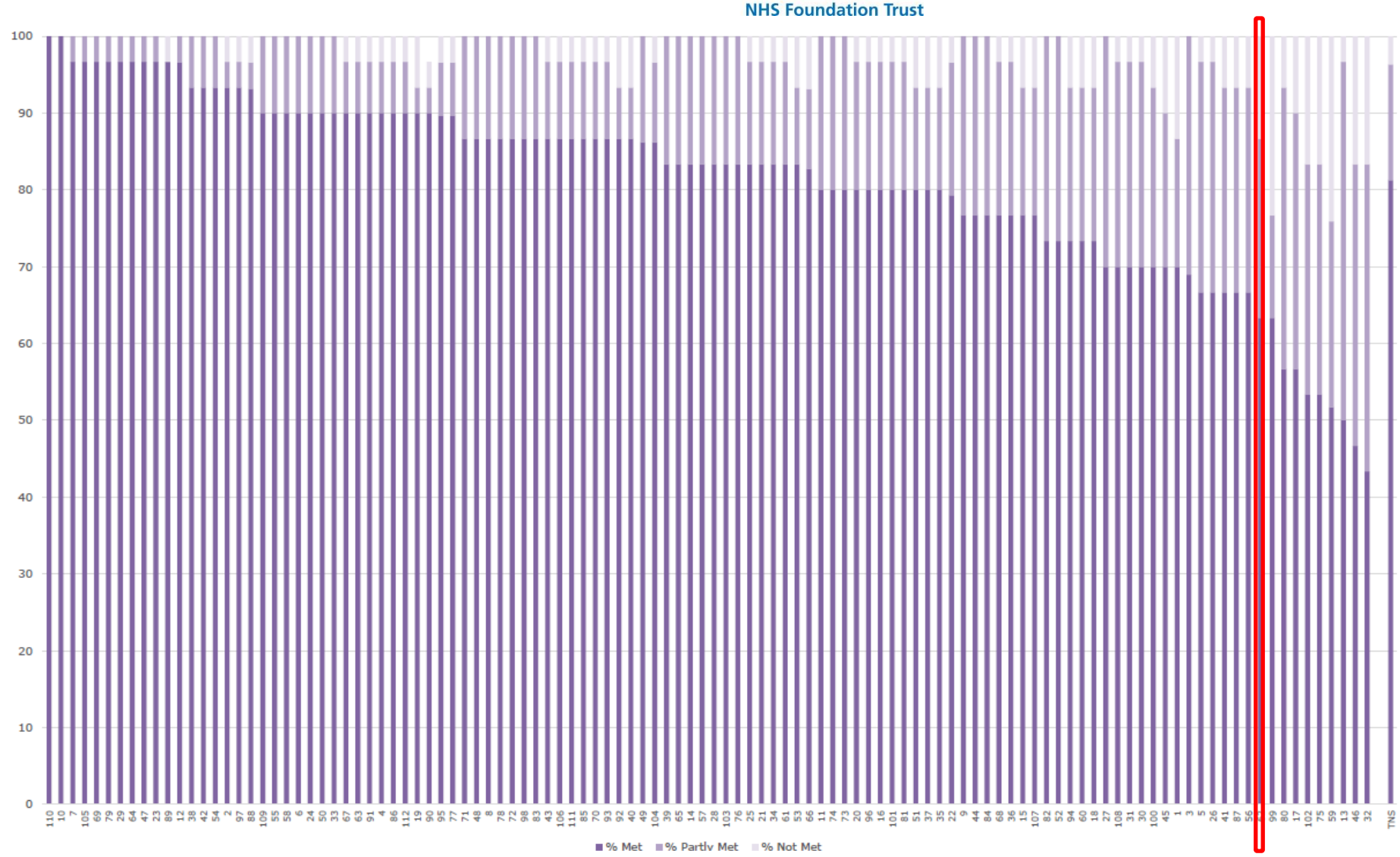


Figure 2-18: Reaside Assessment by The Quality Network for Forensic Mental Health Services

Specific areas for improvement that The Quality Network for Forensic Mental Health Services noted in their reviews included:

- The standard for at least one bathroom / shower room for every three patients is not met
- There are not consistently clear lines of sight to enable staff members to view patients.
- There is limited ability for patients to control the temperatures in their rooms.

- De-escalation rooms are to be created / identified.

Due to the development of required standards for low secure units, a significant upgrading of the external perimeter and entrance at Hillis Lodge was necessary. This was completed in 2020 at a cost of £0.5m. Nonetheless, Hillis Lodge remains a small, relatively isolated unit (it is approximately 1 miles from Reaside MSU). This continues to compromise its ability to manage the levels of clinical risk that most low secure hospitals would expect to be able to manage safely. This excludes some patients, who would otherwise benefit from the clinical service provided. Over the years, while still providing relatively slow stream rehabilitation, Hillis Lodge has become more dynamic than originally envisaged and successfully discharges patients into less restrictive, community based settings. For a small but important minority of patients who require an intermediate stage, Hillis Lodge provides a viable pathway from medium secure care to community living.

BSMHFT owns the freehold to both sites.

The clinical drivers for change which impact on the accommodation and environment can be summarised as:

- Creating a more psychologically informed environment – trauma informed and enabling
- Improving the understanding of the sensory processing difficulties experienced by many patients and designing a building and service to support this
- Increasing the understanding of the complexity of patients' needs and having an environment to support their recovery
- Reducing restrictive interventions with an environment that supports the delivery of trauma informed care
- Accommodation for FIRST team is close to therapeutic spaces, allowing shared use of therapeutic facilities, and reducing boundaries between in-patient care and community living
- Co-location of multidisciplinary teams with the care environments to facilitate whole team approaches to care planning and delivery
- Improved patient satisfaction with the care environment; facilities, cleanliness, supporting access to interventions
- Improved staff satisfaction with the care environment; security, privacy, dignity, infection control, access to interventions
- Improved access to a range of physical health interventions on and off wards;
- Immediate access to external space
- Improved community focus and integration within the care model and building design.
- Future proofing the investment by having a building that is designed to reduce inequalities and be responsive to changing patient and commissioning needs.

2.6 Future Inpatient Model of Care

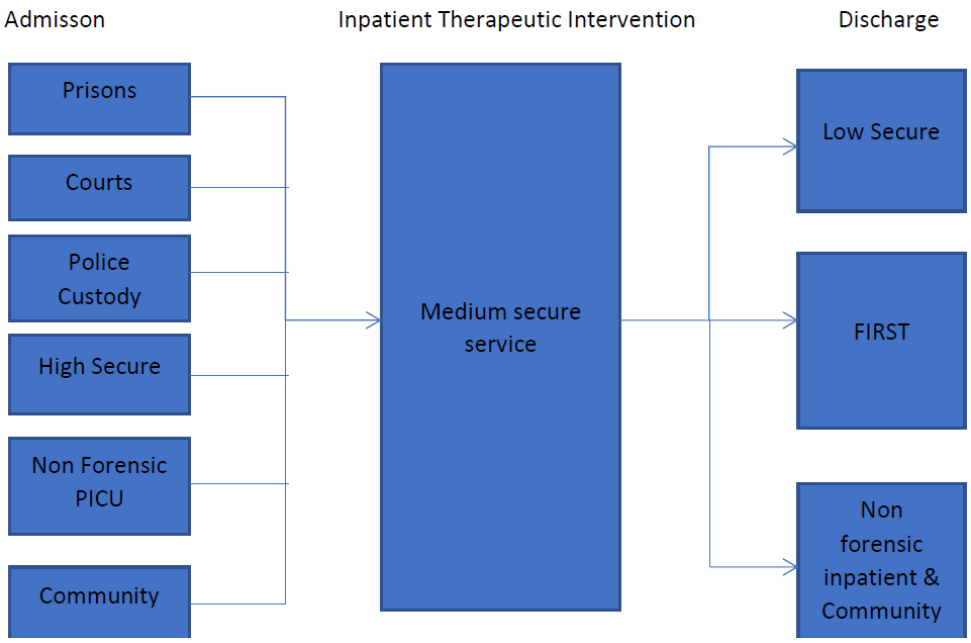
Admission and Discharge Pathways

The majority of admissions in the male medium secure service come from prisons or courts within the West Midlands region. Other admissions are received from non-forensic psychiatric intensive care wards, police custody settings, Ashworth - the local high secure facility or from the community via the forensic intensive recovery support teams (FIRST).

Once a decision to admit has been made, the service user will be admitted to the most suitable ward. As interventions are introduced and the service user's condition improves, the service user will transition to dicharge, with all service user treatment plans being individualised and based on their particular needs .

The vast majority of service users are discharged for onward care in the community setting, under the care of the FIRST team. Service users may also be discharged to a low secure inpatient facility, a non-forensic inpatient/community service or return to prison (see Figure 2-19).

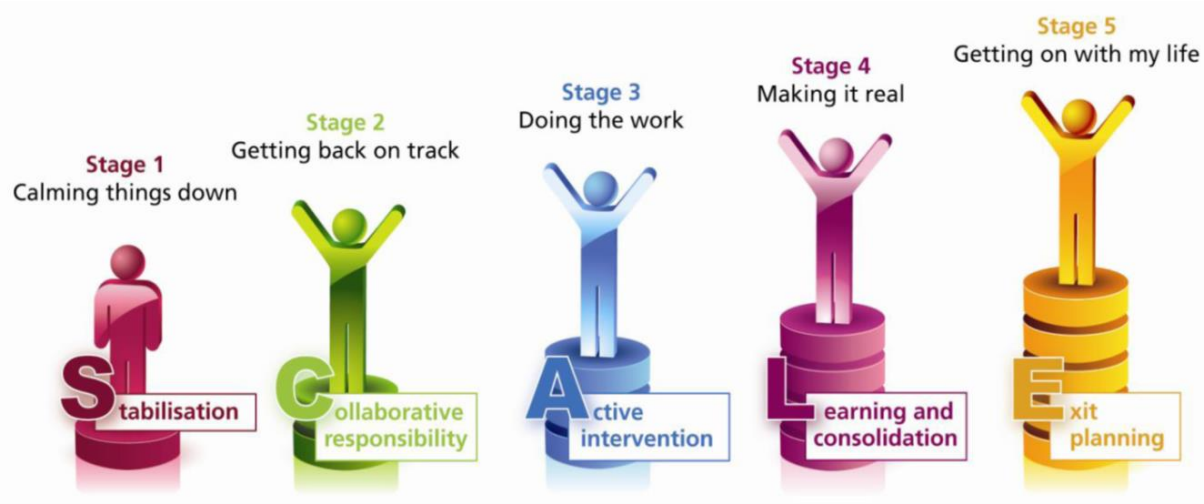
Figure 2-19: Admissions and Discharge Pathways



Inpatient Clinical Model

The Trust has a well-defined five-stage clinical model for inpatient services – the SCALE model (see Figure 2-20).

Figure 2-20: SCALE Model of Care



Service users admitted to secure services can be in crisis and many feel uncertain about their future. This can result in service users being unable to take full control of their mental health and wellbeing. At this stage secure services will ensure the safety of all service users and support them in regaining control of their life.	At this stage services users are assisted in developing a joint understanding of where they are in their lives, where they want and can go, and how to get there. These conversations are tailored to each individual with the aim of developing a joint understanding. The work also enables each service user to get to know their clinical team and how they can access help and support.	By this stage each service user has an agreed treatment plan which supports them in actively completing the necessary work to achieve their goals. The pace of the work is matched to the capabilities of each service user. The hard work is acknowledged via the care programme approach (CPA) and where applicable via reports to the Ministry of Justice and Mental Health Act tribunals.	Each service user demonstrates their progress by developing a safe lifestyle, which includes increasing freedoms and autonomy. This stage focuses on service users making personal choices in terms of their values, interests and preferences.	This stage focuses on the transition between hospital and community life. This is a time of increasing opportunity for service users to develop a safe life outside of hospital, whilst acknowledging restrictions that may be imposed by the Ministry of Justice.

The SCALE clinical model is built on local expertise and knowledge, whilst considering national drivers, and aims to:

- Reduce length of stay
- Enable care closer to home
- Provide Trauma informed approaches to care
- Meet the sensory needs of patients
- Reducing restrictive interventions and practices.
- Reducing inequalities

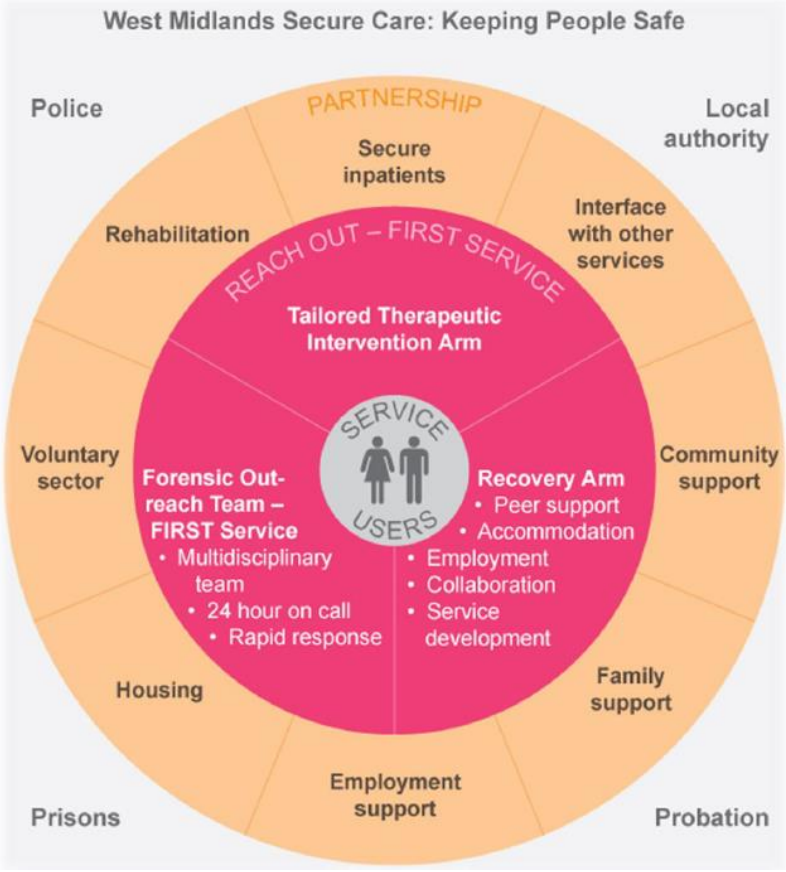
The model is functional in endeavouring to describe the key components of care required to support service users in their recovery and seeks to identify the interventions that focus on ensuring a successful care journey for service users. The model acknowledges that the entire care system has to work as a whole and always make the best use of the resources and expertise.

Appendix 2-A further discusses how the SCALE model concept is used as a descriptor of the service user's journey.

System Partnership across the West Midlands – The Reach Out Model

The new care model as noted at Section 2.4 – Reach Out - builds on existing specialist forensic outreach services and joins together secure care and step down providers, third sector organisations and statutory partners (e.g. Criminal Justice System and Social Services) across the whole of the West Midlands. Figure 2-21 shows this model and highlights the three key components of forensic outreach, recovery focus and therapeutic interventions.

Figure 2-21: System Wide Reach Out Model



Reach Out is delivered by BSMHFT as the lead provider in partnership with Midlands Partnership Foundation Trust and St Andrews Healthcare. The commissioning of secure mental health services for the West Midlands via the Reach Out Partnership is one of the first 'accountable care' models in the

country, going from strength to strength since it was established in 2017. This includes bringing large numbers of out of area patients back into local care.

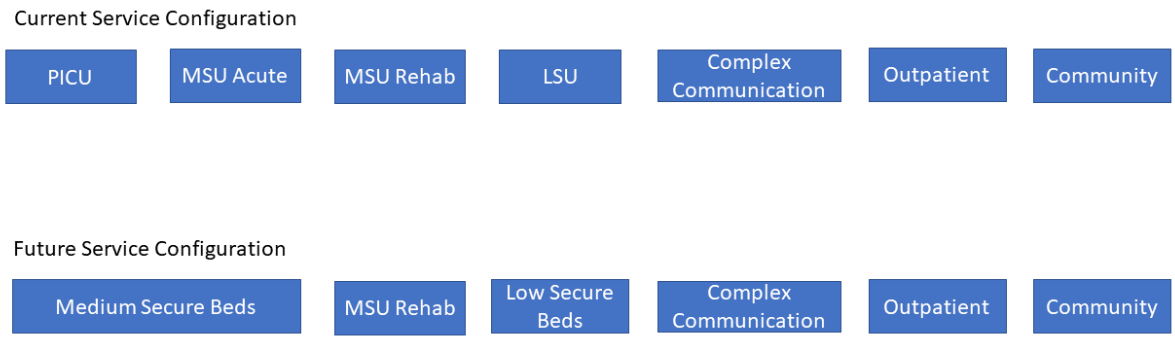
There is still much to do in this respect, however, and the planned development and expansion of services at Reaside in Birmingham and St George's Hospital in Stafford are key enablers of the strategic plan, allowing the repatriation of many more out of area patients. There are still around 70 patients who receive their inpatient care many miles away from their local services and the expansion of local services are acutely needed. BSMHFT plans are also focusing on the current mix of patients, understanding future demand and the learning from 'blended service' models to understand how local capacity can be best utilised with the aim of substantially reducing transitions and improving patient experience by offering care and support in the most effective setting. The aims of the Reach Out Model are:

- For care to be provided in services as close to home as possible; in the least restrictive environment;
- To prevent avoidable admissions and re-admissions when in crisis and
- Improve community integration via meaningful activity, daily living skills, housing, work and education.

The Future Service Configuration

The proposed bed model provides for continuity of care for most patients throughout their inpatient treatment including discharge into the community, while also ensuring cohesive working relationships between ward based staff and clinical teams. Figure 2-22 summarises the future service configuration, in comparison to the existing configuration.

Figure 2-22: Current and Future Service Configuration



Appendix 2-A provides further detail on the planned model of care.

2.7 Future Demand and Capacity Modelling

Overview

For the purposes of detailed the future capacity requirements for the Reaside and Hillis Lodge project, the Trust engaged to services of HA Partnerships, healthcare planners. The detailed demand and capacity report is included at Appendix 2-B.

The current utilisation of local beds is between 95% for and 97% medium secure acute, rehabilitation and low secure bed bases. Occupancy within the PICU is approximately 90%. This is causing a requirement to utilise third parties to provide additional capacity to support the demand for bed admissions.

Out of area placements have been reducing consistently for both medium secure services and the low secure service. Use of third party medium secure beds has reduced form a peak of 35 placements at any point in time in April 2019 to 22 in November 2020 and from 30 to 16 in the low secure service over the same period. The Trust has identified that 9-10 further beds will be able to be repatriated with the remainder having a reasonable need to be in a third party bed.

Aligned to the use of out of area placements is the use of waiting lists. These have been analysed for each of the services and, as with the out of area placements, the waiting lists have been reducing since 2018 and are projected to have a minimal impact on the capacity requirements with 3 beds of capacity being identified for the medium secure bed base, none for the low secure bed base and a single bed for the PICU bed base.

Prisoner population growth has been assessed and variances between the 2019 ONS projections and the 2020 ONS projections is material with a change in trend from significant increase over time to a marginal decrease. As such it has been assumed that the actual position will be somewhat static and thus prisoner population growth has been discounted in this model.

Finally, the clinical model proposed for the future is to aggregate medium secure acute and PICU beds together to make a more flexible pool of beds for those service user cohorts. This has been assumed within the proposed capacity models.

Current and Projected Population

ONS data predictions for demographic growth for the predominant CCG (Birmingham and Solihull) have been reviewed to establish the potential for organic (population) based service growth (Figure 2-23). It is worthy of note that the adult working age population growth is marginally behind the overall population growth. Demographic growth has also been reviewed as part of the modelling of future capacity requirements with a 2.5% working age adult population growth prediction included to the point the wards are assumed to open and an overage 0.33% population growth each year thereafter based on ONS models. For completeness the weighted average population for all major referring CCGs has been tested to ensure there is no significant variance.

Figure 2-23: Population Growth Projections

	2019		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Demographic Growth (%)	0%		2.50%	0.27%	0.27%	0.33%	0.19%	0.34%	0.34%	0.25%	0.36%	0.49%

Demand and Capacity Plans

Consensus has been provided from the operational team that for the purposes of efficient and safe staffing 12 bed wards are the preferred model across the combined acute and PICU service, with 18 bed wards for the rehabilitation and low secure services and 15 beds for complex communications.

It is worthy of note that this excludes seclusion suites which are not classed as a routine bed for the purpose of this work.

Within this capacity modelling work the bed occupancy has been assumed to remain at the current level of c96.5% in line with the expected operational model.

All of the scenarios have been planned on that basis and are inclusive of population growth to 2032, repatriation of out of area placements as appropriate and management of waiting lists.

The cumulative modelled bed requirement for the Reaside service is 125 beds which, when configured in the ward structures described previously, would generate an as built facility of 123 beds. The composition of which would be:

- 36 male combined medium secure acute and PICU beds (3x12 bed wards)
- 54 male medium secure rehabilitation beds (3x18 bed wards)
- 15 male complex communications beds (1x15 bed ward)
- 18 male low secure beds (1x 18 bed ward)

The plans developed for the scheme are based on these accommodation requirements.

The demand and capacity model, including the assumptions made in developing the future capacity requirements, is included at Appendix 2-B.

2.8 Project Investment Objectives

The project investment objectives associated with this SOC are shown at Figure 2-24. The measures associated with the project objectives have been used as the basis of the economic appraisal in the Economic Case, and the benefits realisation plan identified in the Management Case. The project investment objectives are based on the need for the Reaside and Hillis Lodge project to significantly contribute to meetings the overall ICS, Reach Out commissioning requirements and organisational objectives.

Figure 2-24: Investment Objectives

Investment Objective 1	To develop a whole-systems approach, reducing gaps in service and delayed transfers of care in current national and local provision and to deliver the Inpatient aspect of the Reach Out Model of Care by 2024/25
Definition	Provide a service that delivers the inpatient aspect of the Reach Out partnership model, with a spectrum of services for men with mental illness who offend and non-offenders with challenging behaviour who require secure care and to provide step down care as part of a network of specialist mental health services, integrated within a spectrum of local mental health services within the region.

Investment Objective 2	To provide a therapeutic and rehabilitative environment that ensures wards are configured in-line with national secure/environmental standards and to provide appropriate space for sports and leisure activities for patients at the opening of the facility.
Definition	Meet or exceed the standards set out in the national standards for secure services and environmental standards and provide a therapeutic and rehabilitation environment for men some of whom require longer-term placements. To provide an environment that promotes recovery, and is sensory and trauma informed throughout the pathway.

Investment Objective 3	To provide services in a 21st Century healthcare facility which addresses existing backlog maintenance liabilities and provides a fit-for purpose environment for patient recovery at the opening of the new facility.
Definition	To address all backlog maintenance liabilities of the existing Reaside estate which is in parts over 60 years old and ensure that the new facility meets or exceeds environmental/sustainability standards, considers ecology and vacates existing wards that are no longer fit-for purpose.

Investment Objective 4	To ensure that the estate meets both current and future bed demand and capacity requirements and reduces the requirement for out of area placements over the next 10-15 years
Definition	To increase the Trust's capacity to repatriate out of area placements and ensure services are provided closer to home to increase accessibility for patients, family and visitors and reduce bed waiting lists. To ensure the design includes latest technology to aid recovery and service delivery and facilitate improved use of modern technology to deliver a safe environment.

Investment Objective 5	To provide an environment that improves the privacy, safety and dignity for patients reducing the risk and impact of serious incidents and to improve staff satisfaction, experience and effectiveness from the opening of the new facility.
Definition	Include en-suite facilities and space for patient privacy in communal areas to deliver a healing environment to aid recovery, enable safer observations and reduce the risk of patient harm through seclusion/de-escalation areas. To provide facilities which aid recruitment and staff retention and environment that is designed to be a place where staff are happy to work and enable flexibility and innovation in the way services are delivered. To ensure services are designed to be inclusive and focussed on reducing inequalities, considering gender, ethnicity, age group, sexuality, disability, physical health and therapeutic need.

2.9 Business Needs

This section identifies the 'business gap' in relation to overall existing arrangements i.e. the difference between 'where we want to be' (as suggested by the Investment Objectives) and 'where we are now' (in terms of existing arrangements for the service). This highlights the problems, difficulties and inadequacies associated with the status quo. Figure 2-25 outlines the existing arrangements and describes the problems with these existing arrangements in order to identify business need.

Figure 2-25: Business Needs

Investment Objective 1 - Geography	To develop a whole-systems approach, reducing gaps in service and delayed transfers of care in current national and local provision and to deliver the Inpatient aspect of the Reach Out Model of Care by 2024/25
Existing Arrangements	BSMHFT, STP/ICS and the Reach Out recognise the levels of clinically unsuitable out of area placements which are not necessarily conducive to minimising lengths of stay, do not offer a continuum of service and are comparatively expensive in relation to in-region provision.
Business Need	- Reduction in clinically unsuitable out of area placements - Co-location of medium and low secure units to assist in delivering a continuum of care

Investment Objective 2 - Therapeutic Environment	To provide a therapeutic and rehabilitative environment that ensures wards are configured in-line with national secure/environmental standards and to provide appropriate space for sports and leisure activities for patients at the opening of the facility.
Existing Arrangements	Reaside is particular does not offer a therapeutic environment in line with best practice. The environment focusses on containment of patients. Access to outside space, especially for the four wards currently located on the first floor, is very limited.
Business Need	- Improved access to outside space - Enable patients to be treated (where appropriate) in area in order to better access other mental health services when their level of secure placement (e.g. medium or low secure) changes

Investment Objective 3 – Estate Suitability	To provide services in a 21st Century healthcare facility which addresses existing backlog maintenance liabilities and provides a fit-for purpose environment for patient recovery at the opening of the new facility.
Existing Arrangements	Reaside is over 30 years old and the limitations of the estate infrastructure are not conducive to delivering modern standards of secure care. Backlog maintenance for Reaside and Hillis Lodge combined is c. £4.5m. Six facet surveys identify that a significant proportion (30% for Reaside and 20% for Hillis Lodge) is functionally unsuitable for purpose. To improve the performance of the estate.
Business Need	• Reduce backlog maintenance liabilities • Improve performance against the six facets, including functional suitability • To act as a key enabler to the implementation of the digital strategy • To assist in the delivery of the Trust's sustainability agenda

Investment Objective 4 – Demand / Future Proofing	To ensure that the estate meets both current and future bed demand and capacity requirements and reduces the requirement for out of area placements over the next 10-15 years
Existing Arrangements	The lack of capacity within the medium secure environment in area impacts on out of area placements and waiting lists.
Business Need	• To provide additional medium secure capacity within the BSMHFT system to meet future projected need • Improve accessibility for patients, visitors and family • Reduce waiting times for medium and low secure services

Investment Objective 5 – Patient / Staff experience	To provide an environment that improves the privacy, safety and dignity for patients reducing the risk and impact of serious incidents and to improve staff satisfaction, experience and effectiveness from the opening of the new facility.
Existing Arrangements	None of the bedrooms at either Reaside or Hillis Lodge have en-suite facilities. The settings do not significantly contribute to therapeutic services and therefore serious incidents occur.
Business Need	• To improve staff recruitment and retention rates • To improve staff satisfaction • Reduce the number of serious incidents in Reaside & Hillis Lodge settings

2.10 Potential Scope

The potential scope for the programme has been developed based on the investment objectives and business needs identified at Section 2.8. The scope has been assessed against a continuum of need ranging from minimum to maximum (Figure 2-26).

Figure 2-26: Potential Scope

	Minimum	Intermediate 1	Intermediate 2	Intermediate 3	Maximum
Potential Scope	Refurbish existing premises to achieve Condition B	Part new build and part refurbishment of existing Reaside MSU (excluding Hillis Lodge)	Part new build and part refurbishment of existing Reaside MSU (including Hillis Lodge)	Part new build and part refurbishment of existing Reaside MSU (including Hillis Lodge)	New build to replace Reaside MSU and Hillis Lodge LSU
Key Service Requirement	Sized to meet current needs	New build sized to meet current needs	New build sized to meet current needs	Sized to meet current and projected future needs	Sized to meet current and projected future needs

This business case will take forward the maximum scope which is to provide fit for purpose inpatient accommodation for adults with mental health concerns that require low or medium secure services, sized to meet current and projected future demand.

2.11 Benefits Planning

Based on the investment objectives and the agreed scope of works, benefits have been identified as categorised as follows:

- CRB – cash-releasing benefits (e.g. avoided costs)
- Non CRB – non cash-releasing benefits (e.g. staff time saved)
- SB – societal benefits (e.g. achievement of targets)
- UB – unmonetisable benefits (e.g. improvement in staff morale)

Figure 2-27 shows the main categorised benefits against each investment objective and the planned beneficiary of the benefit.

Figure 2-27: Investment Objectives and Benefits Plans

No.	Investment Objective	Main Benefits
IO 1	To develop a whole-systems approach, reducing gaps in service and delayed transfers of care in current national and local provision and to deliver the Inpatient aspect of the Reach Out Model of Care by 2024/25	Reduced delays in Transfers of Care through improved patient flow with access to wider range of interventions and bed modelling.
		Improved NHS system working through the development of the Reach Out Model of Care and associated improvements in referrals and bed management.
IO 2	To provide a therapeutic and rehabilitative environment that ensures wards are configured in-line with national secure/environmental standards and to provide appropriate space for sports and leisure activities for patients at the opening of the facility.	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system
		To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to CQC.
		Reduction in patient LoS through improved quality of care, additional space for wider ranges of interventions and better flow through the system
		To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to the Royal College of Psychiatrists Quality Forensic Network Scores
IO 3	To provide services in a 21st Century healthcare facility which addresses existing backlog maintenance liabilities and provides a fit-for purpose environment for patient recovery at the opening of the new facility.	Reduction in major infection control incidents leading to HCAI through improved environment.
		Improved security and quality of care outcomes through introduction of modern technology - key/door management, improved access to digital technology with infrastructure in place to support.
IO 4	To ensure that the estate meets both current and future bed demand and capacity requirements and reduces the requirement for out of area placements over the next 10-15 years	Reduced travel time requirement for carers, family and friends to visit OOA patients through repatriation of existing OOA placements and increased bed provision.
		Reduction in Out Of Area (OOA) placements through repatriations of existing OOA patients and reduced need to seek future OOA placements with increased bed capacity in area.
IO 5	To provide an environment that improves the privacy, safety and dignity for patients reducing the risk and impact of serious incidents and to improve staff satisfaction, experience and effectiveness from the opening of the new facility.	Reduction in annual Trust cost of Recruitment through scheme intervention.
		Reduction in patient on patient incidents reported through the Trust's safeguarding system for incident reporting.
		Reduction in patient on staff incidents reported through the Trust's safeguarding system for incident reporting.
		Reduction in incidents resulting in self-harm and patient behaviour reported through the Trust's safeguarding system for incident reporting.
		Reduction in incidents resulting in damage, theft or loss of property reported through the Trust's safeguarding system for incident reporting.
		Reduction in Trust Agency/Bank spend.
		Reduction in sickness absence associated with violence and aggression and injury at work as a result of the environment, and burnout, by providing an environment that enhances the safe offer of a wider range of interventions to manage violence and aggression.
		Improve the wellbeing of staff by facilitating a working environment that is safe and supports their wellbeing outcomes through improved physical and psychological safety.

2.12 Strategic Project Risks

The strategic risks associated with the planned investment, plus the management actions to assist in their mitigation, are shown at Figure 2-28.

Figure 2-28: Key Project Risks

Risk Heading (there is a risk of)	Description and Consequence	Management Action
Project Management		
Insufficient resources in BSMH/SSL to properly manage the project. contractors and design team caused by limited resource	Potential delay to programme caused by lack of resources	Early market testing and quantity surveyor to give regular updates on current market demand, pricing and demand. Split contractors across developments (Reaside and other Trust investment projects), although supply chain and sub contractors may be the same.
Approvals		
Failure or delay to obtain relevant approvals (OBC, Full Business Case, planning approvals)	Delay or termination of the programme.	• High visibility scheme. • External stakeholders (NHSE/I et al) aware of programme. • BAU/Minimum options would be a default position.
Financial		
Potential cost overrun	Cost overrun meaning that the project becomes unaffordable	• Ongoing cost planning with cost advisor • Appropriate calculation of optimism bias and planning contingency
Failure to achieve conditions placed on the receiving of PDC capital funds.	Unacceptable conditions may delay the overall programme delivery.	Ongoing liaison with NHSE/I
External		
External policy changes (e.g. Government removes funding on offer.)	No alternative funding source identified. Programme delays or termination.	Ongoing liaison with NHSE/I

2.13 Project Constraints, Dependencies and Interdependencies

As with all planned capital investments the programme is subject to potential constraints which have been identified and reviewed throughout the development of the proposals. The constraints and dependencies of the proposed development are laid out in Figure 2-29.

Figure 2-29: Assumptions, Constraints and Dependencies

Element	How this is being managed	Constraint	Dependency	Assumption
Capital funding availability	• Early engagement with NHSE/I • Project is identified as an STP/ICS priority	✓		
Timescales and expectations around business case approvals	• Early engagement with NHSE/I	✓		
Site constraints	• Site masterplanning • Engagement of healthcare planner to appraise future accommodation requirements		✓	
The project is reliant on planning permission in order to progress the scheme.	• Initial discussions have taken place with planners who are, in principle, supportive.	✓		
Revenue costs to demonstrate financial viability to progress the project.	• Engagement with Trust finance team			✓
Success of the project is dependent on the budget being adequate to support the design and build of the new development and the project being delivered within the agreed cost envelope.	• Establish of workstream groups which report to the Programme Board			✓
The project is reliant on the capacity to deliver a major capital scheme and will need to manage clinical, management, estates and facilities and corporate support services availability.	• Identification of resource capacity requirements for OBC and FBC		✓	
The project will need to ensure staff have the capability and the right skills needed to ensure the workforce can operationalise the new model of care.	• Early engagement with Trust HR lead		✓	
The project will require the support of key stakeholders, including Reach Out and the ICS.	• Ongoing liaison with ICS. • The scheme is one of the highest priority schemes for the ICS.	✓		
The project will align to the Trust Strategy and four strategic priorities.	• Development of robust business cases aligning the scheme with national, regional and local priorities			✓

2.14 Equality Impact Assessment

Promoting equality and addressing health inequalities are at the heart of Trust values. Throughout the development of the project, the Trust has given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

Furthermore the Trust, via the Reach Out model, have given regard to the need to reduce inequalities between patients with access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

An Equality Impact Assessment (EIA) has been undertaken for the scheme (which can be found at Appendix 2-C). There are not considered to be any needs or barriers which could affect people with the above protected characteristics, and the likely impact of the scheme is considered low. The EIA is reviewed monthly and reported to the Strategy and Transformation Management Board. It is an iterative process and will be fully considered during the design phase to ensure any health inequalities and the 9 protected characteristics are fully considered.

2.15 Chapter Appendices

Appendix Number	Appendix Title
2-A	Model of Care
2-B	Demand and capacity planning
2-C	Equality Impact Assessment

3.0 ECONOMIC CASE

3.1 Critical Success Factors

Based on the case for change, as outlined in the Strategic Case, and the agreed project objectives (see Figure 2.8), the critical success factors (CSFs) for the project are shown at Figure 3-1. The options considered in this case have been considered against these CSFs.

Figure 3-1: Critical Success Factors

CSF	Description
Strategic fit and business needs	How well the option: • meets the agreed spending objectives, related business needs and service requirements, • provides holistic fit and synergy with other strategies, programmes and projects
Potential value for money	How well the option: • Maximises the return on the required spend (benefits optimisation) in terms of economy, efficiency and effectiveness from both the perspective of the organisation and wider society. • Minimises associated risks.
Potential achievability	How well the option: • Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change, and • matches the level of available skills required for successful delivery.
Supplier capacity and capability	How well the option: • Matches the ability of the service providers to deliver the required level of services and business functionality, and • is likely to be attractive to the supply side.
Potential affordability	How well the option: • Meets the sourcing policy of the organisation and likely availability of funding, and • Matches other funding constraints.

3.2 Options Development

An Options development session took place with key management, estates and clinical stakeholders at the Trust and the session focused on development of the long-List of scheme options. The session was carried out in line with HM Treasury guidance in developing the long-list of potential options for the SOC Re-Provision scheme in line with the key dimensions of the HM Treasury Options Framework, as outlined at Figure 3-2.

Figure 3-2: HM Treasury Guidance for Options Development Framework

Key Dimensions	Brief Description
Scoping Options	The "**what**", in terms of the potential coverage of the project. Potential scopes are driven by business needs, service requirements and the scale of organisational change required to improve service capabilities. Examples include coverage in terms of: business functions, levels of service, geography, population, user base and other parts of the business.
Service Solution	The "**how**" in terms of delivering the "preferred" scope for the project. Potential service solutions are driven by available technologies, recognised best practice and what the market place can deliver. These solutions provide the potential "**products"** (inputs and outputs) and as such the enabling work streams and key activities required.
Service Delivery	The "**who**" in terms of delivering the "preferred" scope and service solution for the project. Potential options for service delivery are driven by available resources, competencies and capabilities - both internal and external to the organisation. Examples include: in-house provision, outsourcing, alliances and strategic partners.
Implementation	The "**when**" in terms of delivering the "preferred" scope, solution and service delivery arrangements for the project. Potential implementation options are driven by deadlines, milestones, dependencies (between outputs), economies of scale, benefit realisation and risk management. The optimal option provides the critical path for delivery of the agreed products and activities and the basis for the project plan. Options for implementation include: piloting, modular delivery, big bang and phasing (tranches).
Funding	The "**funding**" required for delivering the "preferred" scope, solution, service delivery and implementation path for the project. Potential funding options are driven by the availability and opportunity cost of public funding, value for money and the characteristics of the project. Potential funding options include the public or private capital, the generation of alternative revenue streams, operating and financial leases, and mixed market arrangements.

The focus of the session was the development of the service scope element, and was successful in generating seven options, in addition to Business As Usual and Do Minimum benchmarking options. The options developed are outlined in Figure 3-3. The long list of options is detailed against the five options dimensions in Figure 3-4.

Figure 3-3: Options Scope

Option	Scope
BAU	No capital investment over and above capital programme. Requirement for BAU position to effectively become Do-Minimum at year 10 in appraisal to meet space requirements and guidance
Do Minimum	Refurb conversion to existing Reaside to achieve Condition B and provision of en-suites (results in loss of 1/3rd of existing beds)
Option 1.0	New Build on Reaside site to include Hillis Lodge beds
Option 2.0	Part new build (all clinical services), part refurbish existing buildings (for non-clinical use) on Reaside site. To include re-provision of Hillis Lodge
Option 3.0	New Build on the site adjacent to the Tamarind site. To include re-provision of Hillis Lodge on the Newbridge House site
Option 4.0	New build on a new site
Option 5.0	New build at Ardenleigh
Option 6.0	New Build Reaside, Hillis Lodge remains as is.

Figure 3-4: Long List of Options

Option	CIAM Option Ref	Service Scope	Service Solution	Service Delivery	Implementation
BAU	**Option 0 – BAU**	No capital investment over and above capital programme. Requirement for BAU position to effectively become Do-Minimum at year 10 in appraisal to meet space requirements and guidance	n/a	n/a	n/a
Do – Minimum	**Option 1 – Do-Minimum**	Refurb conversion to existing Reaside to achieve Condition B and provision of en-suites (results in loss of 1/3rd of existing beds)	Following the completion of the condition survey, works to be undertaken to replace or improve engineering services, etc., to extend the life of the building. Building will remain 'non-compliant' in other aspects of design and layout against current DoH MSU guidance.	No changes to existing workforce	To lessen impact on Service Users and Staff, works would be undertaken on differing elements of engineering services in a planned and phased manner over a number of months. This would reduce overall disturbance to occupants and enable the building to function in a normal manner whilst the works were being completed.
Option 1	**Option A**	New Build on Reaside site to include Hillis Lodge beds (123 beds)	State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds). All compliant with the latest DoH MSU guidance, with en-suite bedrooms, increased day space, a variety of therapy facilities and external grounds and gardens.	Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff 16 additional beds OOA	New-build would be on Trust-owned land adjacent to the existing Reaside facility (but outside the secure perimeter) and would be constructed and commissioned in a single phase by the Contractor. The Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside. The existing Reaside building would then be demolished in a second phase enabling the resulting land area to be landscaped and secured for potential Service User use.
Option 2	**Option B**	Part new build (all clinical services), part refurbish existing buildings (for non-clinical use) on Reaside site. To include re-provision of Hillis Lodge	In-patient facilities would be state-of-the-art new-build, all compliant with the latest DoH MSU guidance, with en-suite bedrooms, increased day space, a variety of therapy facilities and external grounds and gardens. The existing Reaside building would be upgraded, refurbished and linked to the new facilities enabling its use for non-clinical services (ie; admin, FM, team base, etc.)	Reconfigured Workforce to include Hillis Lodge staff	New-build would be constructed and commissioned in the first phase by the Contractor on Trust-owned land adjacent to existing Reaside facility. The Service Users and a number of Staff would move across into the new in-patient facility in a phased, controlled manner, enabling partial vacation of the existing Reaside. The second phase would be the works within the existing building which would be undertaken in an area-by-area basis, requiring staff to be decanted around the building as the work was undertaken until completion, re-commissioned and ready for use.
Option 3	**Option C**	New Build on the site adjacent to the Tamarind site. To include re-provision of Hillis Lodge on the Newbridge House site	State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds).	Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff	New-build would be on Trust-owned land adjacent to the existing Tamarind facility (but outside the secure perimeter) and would be constructed and commissioned in a single phase by the Contractor. The Reaside Service Users and Staff would move across into

Option	CIAM Option Ref	Service Scope	Service Solution	Service Delivery	Implementation
			All compliant with the latest DoH MSU guidance, with en-suite bedrooms, increased day space, a variety of therapy facilities and external grounds and gardens. Potential issues with local residents and planning permission as was the experience when Tamarind was built. Additionally, Trust would prefer the additional beds to remain in or around the current location in the South of the city.	16 additional beds OOA	the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside. The future use of the existing Reaside would need to be decided upon by the Trust (either development for another mental health service or sale for housing development).
Option 4	-	New build on a new site	2.3 State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds). Fully compliant with the latest DHSC MSU guidance with provision of en-suite bedrooms, increased day-space, a variety of therapy facilities and external grounds and gardens.	Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff 16 additional beds OOA	.3 New-build would be on Trust-owned land primarily adjacent to the existing Reaside facility with some elements within the secure perimeter and would be constructed and commissioned in a single phase by the Contractor. The Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside and Hillis Lodge. The existing Reaside building would then be demolished in a second phase enabling the resulting land area to be landscaped and secured for potential Service User use.
Option 5	-	New build at Ardenleigh	2.3 State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds). Fully compliant with the latest DHSC MSU guidance with provision of en-suite bedrooms, increased day-space, a variety of therapy facilities and external grounds and gardens.	Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff 16 additional beds OOA	.3 New-build would be on Trust-owned land primarily adjacent to the existing Reaside facility with some elements within the secure perimeter and would be constructed and commissioned in a single phase by the Contractor. The Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside and Hillis Lodge. The existing Reaside building would then be demolished in a second phase enabling the resulting land area to be landscaped and secured for potential Service User use.

Option	CIAM Option Ref	Service Scope	Service Solution	Service Delivery	Implementation
Option 6	-	New Build Reaside, Hillis Lodge remains as is	State-of-the-art new-build facility replacing the 92 Reaside MSU beds. Fully compliant with the latest DHSC MSU guidance with provision of en-suite bedrooms, increased day-space, a variety of therapy facilities and external grounds and gardens.	Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff 16 additional beds OOA	New-build Reaside would be on Trust-owned land primarily adjacent to the existing Reaside facility with some elements within the secure perimeter and would be constructed and commissioned in a single phase by the Contractor. The Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside. The existing Reaside building would then be demolished in a second phase enabling the resulting land area to be landscaped and secured for potential Service User use.

A SWOT analysis of all options has been completed and included at Appendix 3-A.

3.3 Options Appraisal Analysis

Figure 3-5 sets out the Options Appraisal Analysis in accordance with the HM Treasury described process, designed to identify the Preferred Way Forward and Carried Forward elements.

Figure 3-5: Options Development Framework

Key Dimensions	BAU	Do Minimum	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
1. Scope	1.1 No changes to existing services or ways of working. BAU becomes Do-minimum at Year 10 in appraisal.	1.2 Refurb conversion of existing Reaside Provision of en-suite facilities. To bring current facilities to condition B. Engineering services in existing buildings. Replace boiler plants, pipework and general engineering plant. Results in loss of 1/3rd of existing bed numbers.	1.3 New Build on Reaside site to include Hillis Lodge beds	1.4 Part new build (all clinical services), part refurbish existing buildings (for non-clinical use) on Reaside site. To include re-provision of Hillis Lodge	1.5 New Build on the site adjacent to the Tamarind site. To include re-provision of Hillis Lodge on the Newbridge House site	1.6 New build on a new site	1.7 New build at Ardenleigh	1.8 New Build Reaside, Hillis Lodge remains as is
	Carry Forward	Carry Forward	Preferred	Carry Forward	Carry Forward	Discount	Discount	Discount
2. Service Solution	2.1 No Changes until year 10 in appraisal, at which point service solution becomes 2.2	2.2 To enable the provision of en-suites to all bedrooms, every third bedroom would become two en-suites, thus overall bed numbers would be reduced by a third. The resulting	2.3 State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds).	2.4 In-patient facilities would be state-of-the-art new-build, all compliant with the latest DHSC MSU guidance, with en-suite bedrooms, increased day space, a variety of therapy facilities and	2.5 State-of-the-art new-build facility replacing the 92 Reaside MSU beds and the 15 Hillis Lodge LSU beds plus additional beds for out-of-area placements (Total 123 beds).	2.3	2.3	2.3 Minus reprovision of Hillis Lodge Beds

		reduction in income would not be acceptable to the Trust.	Fully compliant with the latest DHSC MSU guidance with provision of en-suite bedrooms, increased day-space, a variety of therapy facilities and external grounds and gardens.	external grounds and gardens. The existing Reaside building would be upgraded to 123 beds, refurbished and linked to the new facilities enabling its use for non-clinical services (ie; admin, FM, team base, etc.)	All compliant with the latest DHSC MSU guidance, with en-suite bedrooms, increased day space, a variety of therapy facilities and external grounds and gardens. Potential issues with local residents and planning permission as was the experience when Tamarind was built. Trust would prefer additional beds to remain in proximity to the current location in the South of the city.			
	Carry Forward	Carry Forward	Preferred	Carry Forward	Carry Forward			
3. Service Delivery	3.1 No changes to workforce	3.1	3.3 Reconfigured Workforce to include Hillis Lodge staff, increased workforce to staff 16 additional beds	3.3	3.3	3.3	3.3	3.3
	Carry Forward		Preferred					
4. Service Implementation	4.1 N/A until year 10 in appraisal at which point BAU service implementation becomes 4.2	4.2 To lessen impact on Service Users and Staff, works would be undertaken on a ward-by-ward basis, with the likelihood of reducing the overall occupied bed numbers whilst the works are completed, enabling some decanting/movement of Service Users out	4.3 New-build would be on Trust-owned land primarily adjacent to the existing Reaside facility with some elements within the secure perimeter and would be constructed and commissioned in	4.4 New-build would be constructed and commissioned in the first phase by the Contractor on Trust-owned land adjacent to existing Reaside facility. The Service Users and a number of Staff would move across into the	4.5 New-build would be on Trust-owned land adjacent to the existing Tamarind facility (but outside the secure perimeter) and would be constructed and commissioned in a single phase by the Contractor.	4.3	4.3	4.3 Minus inclusion of Hillis Lodge Beds

		of areas of work for a period of time. External drainage works would be implemented on a continuous basis to suit the programme.	a single phase by the Contractor. The Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside and Hillis Lodge. The existing Reaside building would then be demolished in a second phase enabling the resulting land area to be landscaped and secured for potential Service User use.	new in-patient facility in a phased, controlled manner, enabling partial vacation of the existing Reaside. The second phase would be the works within the existing building which would be undertaken in an area-by-area basis, requiring staff to be decanted around the building as the work are undertaken until completion, re-commissioned and ready for use.	The Reaside Service Users and Staff would move across into the new facility in a phased, controlled manner, enabling full vacation of the existing Reaside and Hillis Lodge. The future use of the existing Reaside and Hillis Lodge would need to be decided upon by the Trust (either development for another mental health service or sale for housing development).			
	N/A	Carry Forward	Preferred	Carry Forward	Carry Forward			
5. Funding	5.1 Ongoing service and estate delivery costs until year 10 in appraisal when BAU becomes 5.2	5.2 HM Treasury Capital Funding	5.2	5.2	5.2	5.2	5.2	5.2
	N/A	Preferred						

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3.4 Identification of Preferred Way Forward

A summary of the options appraisal analysis is shown at Figure 3-6.

Figure 3-6: Summary of Options Appraisal

Key Dimensions	BAU	Do Minimum	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
1. Service Scope	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.1
2. Service Solution	2.1	2.2	2.3	2.4	2.5	2.6	2.3	2.3	2.1
3. Service Delivery	3.1	3.1	3.3	3.4	3.3	3.3	3.3	3.3	3.1
4. Implementation	4.1	4.2	4.3	4.4	4.5	4.6	4.3	4.3	4.1
5. Funding	N/A	5.2	5.2	5.2	5.2	5.2	5.2	5.2	N/A

The preferred way forward, and those options which have been carried forward, are shown at Figure 3-7.

Figure 3-7: Preferred Way Forward

Preferred Way Forward		Carry Forward	
1. Service Scope	Option 1	**1. Service Scope**	BAU, Do Minimum, Option 2 & Option 3
2. Service Solution	Option 1	**2. Service Solution**	BAU, Do Minimum, Option 2 & Option 3
3. Service Delivery	Option 1	**3. Service Delivery**	BAU, Do Minimum, Option 2 & Option 3
4. Implementation	Option 1	**4. Implementation**	BAU, Do Minimum, Option 2 & Option 3
5. Funding	Option 2, 3, 4, 5, 6, 7 (5.2)	**5. Funding**	N/A

3.5 Short-List to CIAM – Options Naming Protocol

In order to differentiate the Short-List of appraised options to feed into the Comprehensive Investment Appraisal Model (CIAM), an alternative naming protocol was adopted, necessitated by the need to reflect the requirement within the CIAM to provide the naming protocol for Do Minimum as Option 1. Lettering of options has therefore been adopted to avoid confusion (Figure 3-8).

Figure 3-8: Shortlist Options Naming Protocol

Long-List Options Development Naming Protocol	Short-List to CIAM Options Naming Protocol
Business As Usual	Business As Usual
Do – Minimum	Option 1 – Do Minimum
Option 1 – New Build at Reaside to Include Hillis Lodge	Option 2 – Option A – New Build at Reaside to Include Hillis Lodge
Option 2 - Part New Build, Part Refurb at Reaside to Include Hillis Lodge	Option 3 – Option B – Part New Build, Part Refurbishment at Reaside to Include Hillis Lodge Beds
Option 3 - New Build on Site Adjacent to Tamarind to Include Hillis Lodge	Option 4 – Option C - New Build on Site Adjacent to Tamarind to Include Hillis Lodge

3.6 Economic Assessment Summary

Process

The economic appraisal of the short-listed options follows HM Treasury Green Book guidance and is underpinned by the Comprehensive Investment Appraisal (CIA) model. Key assumptions are:

- Covers an appraisal period of 60 years and uses a discount rate of 3.5%;
- Costs, benefits and risks are expressed in real prices at 2020/21 levels;
- VAT, planning contingency and transfer payments are excluded from cash flows.

CIA model inputs are described in the sections that follow.

An electronic version of the CIA model is available at Appendix 3-B.

Capital Costs

The capital costs have been developed by the Trust's advisors and are summarised at Figure 3-9 (may not fully calculate due to rounding) (full OB capital cost forms are at Appendix 3-C). Figure 3-9 provides a summary of the cost breakdown, at the required PUBSEC reporting index of 250, but total costs at outturn prices (assessed at mid-contract PUBSEC index levels) and includes a percentage increase for inflation.

Figure 3-9: Capital Cost of Schemes including VAT

Capital Cost Elements	Do Minimum	Option A	Option B	Option C
Departmental Works Costs	£21.6m	£45.5m	£39.1m	£47.3m
On-Costs	£0m	£5m	£2.5m	£12.8m
Location Adjustment	Inc	Inc	Inc	Inc
Fees	£4.3m	£8.8m	£7.5m	£10.2m
Non-Works	£0m	£0m	£0m	£0
Equipment	£0m	£6.8m	£6.2m	£7.1m
Planning Contingencies (20%)	£4.3m	£10.1m	£8.3m	£12.0m
Optimism Bias (15%)	£4.6m	£11.7m	£9.8m	£13.7m
Total Capital Cost excluding inflation	£34.9m	£88.0m	£73.5m	£103.1m
Inflation (3% p.a.)	£1m	£2.7m	£2.2m	£3.2m
Total Capital Cost	£35.9m	£90.8m	£75.7m	£106.3m

Key assumptions are:

- For the development options, Departmental Works Costs are based on the Healthcare Premises Cost Guides (HPCGs) applied to the areas derived from the 1:200 drawings prepared by the Architect;
- On-costs are based on the site layout drawings and any known conditions such as site levels, plant/services age and capacity, and other constraints;

- Professional fees are included all options and cover design team fees and charges, surveys etc. The internal project team cost has been included in accordance with the internal resource team details at Appendix 6-B;
- Non-works costs are included;
- Equipment costs are included;
- Optimism Bias has been assessed in line with HM Treasury requirements. Optimism bias calculations for each option are shown at Appendix 3-B;
- Planning contingencies are excluded.

Lifecycle Costs

Lifecycle costs for building and engineering works have been assessed and are based on standard NHS replacement profiles, those being:

- All structural components - 60 years
- General fabric - 50 years
- Mechanical and electrical services – 25 years
- Internal finishes – 10 years

The lifecycle timescales and approach to revaluation will be reviewed at OBC and FBC.

Opportunity Costs

Opportunity costs are assumed to be zero under all the short-listed options except the BAU position.

Revenue Cost Baseline

The baseline revenue costs within the economic model have been extracted from the Trust's 2020/21 budget report.

Assessment Financial Benefits

The proposed redevelopment of Reaside MSU and Hillis Lodge LSU is expected to deliver a wide range of benefits, including cash-releasing benefits. Figure 3-10 summarises the planned benefits, categorised as cash-releasing, non cash-releasing, societal and non-monetisable. Also see Section 6.7 for the benefits realisation plan.

Figure 3-10: Benefits Plan

Ref.	Benefit Name	Benefit Description
CRB1	Reduction in Recruitment Costs	Reduction in annual Trust cost of Recruitment through scheme intervention.
NCRB1	Reduction in Incidents - Patient on Patient	Reduction in patient on patient incidents reported through the Trust's safeguarding system for incident reporting.
NCRB2	Reduction in Incidents - Patient on Staff	Reduction in patient on staff incidents reported through the Trust's safeguarding system for incident reporting.
NCRB3	Reduction in Incidents - Self Harm and Patient Behaviour	Reduction in incidents resulting in self-harm and patient behaviour reported through the Trust's safeguarding system for incident reporting.
NCRB4	Reduction in Incidents - Property Theft, Loss of Damage	Reduction in incidents resulting in damage, theft or loss of property reported through the Trust's safeguarding system for incident reporting.
NCRB5	Reduction in Healthcare Acquired Infection (HCAI)	Reduction in major infection control incidents leading to HCAI through improved environment.
NCRB6	Reduction In Agency/Bank Spend	Reduction in Trust Agency/Bank spend.
NCRB7	Reduction in Staff Sickness	Reduction in sickness absence associated with violence and aggression and injury at work as a result of the environment, and burnout, by providing an environment that enhances the safe offer of a wider range of interventions to manage violence and aggression.
NCRB8	Reduction in Patient Length of Stay	Reduction in patient LoS through improved quality of care, additional space for wider ranges of interventions and better flow through the system
NCRB9	Reduction in Out of Area Placements	Reduction in Out Of Area (OOA) placements through repatriations of existing OOA patients and reduced need to seek future OOA placements with increased bed capacity in area.
NCRB10	Reduction in Delays in Transfer of Care	Reduced delays in Transfers of Care through improved patient flow with access to wider range of interventions and bed modelling.
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year (QALY) score	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system
SB2	Reduction in Travel Times Saving	Reduced travel time requirement for carers, family and friends to visit OOA patients through repatriation of existing OOA placements & increased bed provision.
UB1	Improvement In Trust Performance - CQC Ratings	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to CQC.
UB2	Improvement in Trust performance - National Standards for Mental Health	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures premises are fit for purpose, thereby improving Trust performance in regards to National Standards for Mental Health
UB3	Improvement in Trust Performance - Royal College of Psychiatrists Quality Forensic Network Scores	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to the Royal College of Psychiatrists Quality Forensic Network Scores
UB4	Improvement in Staff/Patient Experience and Satisfaction	Improve the wellbeing of staff by facilitating a working environment that is safe and supports their wellbeing outcomes through improved physical and psychological safety.
UB5	Improved STP/ICS Partnership Working	Improved NHS system working through the development of the Reach Out Model of Care and associated improvements in referrals and bed management.
UB6	Introduction of Technology	Improved security and quality of care outcomes through introduction of modern technology - key/door management, improved access to digital technology with infrastructure in place to support.

Key:
CRB – Cash Releasing Benefit
NCRB – Non- Cash Releasing Benefit
SB – Societal Benefit
UB – Unquantifiable Benefit

Summary Impact of Benefits

Figure 3-11 summarises the financial impact of the benefits for each option over the same 60 year period as the costs (see the CIAM at Appendix 3-B).

Figure 3-11: Summary Impact of Benefits

Summary (Discounted) - £000	Business as Usual	Do-Minimum	Option A - New Build Reaside	Option B - New Build/Refurb	Option C - New Build Tamarind
Cash releasing benefits	£0.00	£0.00	£94,887	£47,432	£0.00
Non-cash releasing benefits	£0.00	£0.00	£151,089,038	£75,544,454	£151,089,038
Societal benefits	£0.00	£0.00	£16,367,363	£13,159,218	£16,367,363
Total benefits	**£0.00**	**£0.00**	**£167,551,290**	**£88,751,105**	**£167,456,402**
Rank	**5th**	**5th**	**1st**	**2nd**	**3rd**

Risks

An analysis of risk has been undertaken including design, construction, performance, operating, revenue and technology and other costs.

The judgements made to assess the differential impact of risk under each of the short-listed options reflect the balance of refurbishment and new build that each contain. Option B provides the lowest risk with Option A a minimal difference. The BAU position has the highest risk profile, primarily due the estates issues (lack of clinical suitability of existing wards & site, requirement to meet HBN compliance would mean a reduction in bed numbers and loss of bed days needed to allow for refurbishment conversion).

3.7 Economic Appraisal

Figure 3-12 presents a summary of the key outputs of the economic appraisal based on the assumptions and inputs described above, expressed as Net Present Values (NPV) (see Appendix 3-B).

This economic analysis indicates that:

- All options have the potential to show a positive Benefit / Cost Ratio (BCR) compared to BAU; and
- Option A is the preferred option, with a BCR of 5.55.

On the basis of the BCR the Option A provides better value.

The outputs of the CIA model are included at Appendix 3-B.

Figure 3-12: Economic Appraisal of Options

Economic Impact in NPV terms including societal present costs	BAU £000	Do-Minimum £000	Option A £000	Option B £000	Option C £000
NPV of Capital (including optimism bias, Lifecycle + Opportunity Costs)	(20,685)	(34,265)	(72,920)	(63,851)	(82,032)
NPV of Revenue (including Transitional costs)	(878,528)	(900,871)	(801,964)	(819,103)	(782,469)
NPV of Risk	**(57,478)**	**(26,996)**	**(2,230)**	**(1,780)**	**(40,339)**
NPV Total	**(956,691)**	**(962,132)**	**(877,114)**	**(884,734)**	**(904,840)**
Incremental Capital (Cost) NPV	-	(14,171)	(52,826)	(43,757)	(61,939)
Incremental Revenue Benefit NPV	-	-	78,003	60,864	97,499
Incremental Risk NPV	-	30,482	55,248	55,698	17,139
Incremental Benefit NPV	-	-	167,551	88,751	167,456
Net Present Social Value (NPSV)	-	**(5,442)**	**247,128**	**160,708**	**219,307**
Benefit/Cost Ratio	-	**0.85**	**5.55**	**4.56**	**4.46**
Economic Ranking of Options	5th	4th	1st	2nd	3rd

3.8 Economic Sensitivity Testing

Sensitivity testing has been undertaken to assess the extent to which the key cost drivers would have to change differentially between options in order to switch economic preference.

Figure 3-13 shows the impact on the BCR of (a) a reduction in the % realisation of benefits and (b) deferred realisation of benefits. This shows that, in comparison to all other options, in all circumstances Option A remains the option with the highest comparative BCR. Should the realisation of benefits fall below 75%, Option A would not meet the required 4:1 ratio of benefits to costs.

Figure 3-13: Economic Sensitivity

BCR	Option 0 - Business as Usual	Option 1 - Do-Minimum	Option 2 - Option A - New Build Reaside	Option 3 - Option B - Part New Build Part Refurb	Option 4 - Option C - New Build Tamarind
100% Benefits	0.00	0.85	5.55	4.56	4.46
95% Benefits	0.00	0.00	4.30	3.14	3.97
75% Benefits	0.00	0.00	2.26	1.66	2.09
50% Benefits	0.00	0.00	2.26	1.66	2.09
25% Benefits	0.00	0.00	1.13	0.83	1.05
25% Reduction BAU Risk/Cost for Refurb Conversion	0.00	0.00	3.59	2.52	3.42
Deferred Benefit Realisation to year 6 (4Y post construction)	0.00	0.00	4.34	3.19	4.02
Deferred Benefit Realisation to year 6 (4Y post construction)	0.00	0.00	4.17	3.08	3.88

This confirms that Option A ranks highest.

3.9 Preferred Option

The outputs of the qualitative and economic appraisals confirms that Option A is clearly preferred.

3.10 Chapter Appendices

Appendix Number	Appendix Title
3-A	Options development and appraisal (including SWOT analysis)
3-B	CIA model
3-C	OB capital cost forms and cashflow

4.0 COMMERCIAL CASE

4.1 Clinical Quality

Since the inception of the project, improvements in clinical quality have been a key driving factor supporting the delivery of the organisational strategy and is fully aligned to the STP/ICS clinical and estates strategies and commissioning intentions.

The development of the optimum estates solution, based on the agreed model of care as summarised at Section 2.6, has had the consistent and integral input from executive clinical leaders and frontline clinical and non-clinical staff. This will continue throughout the development of the OBC and FBC, and will increasingly incorporate feedback and input from patient groups.

Clinical quality aspects have informed and been integral to the project through the following means:

- Processes:
    - Appointment of a healthcare planner to lead on the development of the model of care (Section 2.6) and demand and capacity planning (Section 2.7)
    - A schedule of accommodation has been developed based on the agreed model of care and demand and capacity plan (see Sections 2.6 and 2.7)
    - Development of a clinical user group structure (Section 6.1) to inform and develop the estates solution
    - Alignment with key estates guidance e.g. HBNs and HTMs (Section 4.3)
    - Establishment of procurement routes which will enable ongoing stakeholder engagement throughout the design and implementation phases (Sections 4.4)
- Design:
    - Clear evidence and future plans for sustained stakeholder involvement in design development (Section 6.1)
    - Outline designs based on established patient need, as defined in the model of care (Section 2.6)
    - Appropriateness of designs appraised against privacy and dignity, security, accessibility requirements (Section 4.3)
- Suitability for purpose:
    - Supporting delivery of the identified patient benefits (Section 6.7)
    - Alignment with the workforce plan which will deliver the agreed model of care (Section 4.8)
    - Affordability of the estates solution (Section 5.14)
    - Consistency with the model of care (Section 2.6)

- Quality of estate solution, as supported by an initial design assessment and executive leader support to the plans (Section 4.3)

4.2 Scope of Required Services

Scope of Services

The preferred option is Option A New Build on Reaside site to include Hillis Lodge beds comprising the following scope of works:

- New Build MSU and LSU adjacent to the existing Reaside MSU, as new accommodation to replace existing Reaside MSU and Hillis Lodge LSU
- Demolition of existing Reaside MSU upon full transfer of services to new Reaside building. Following demolition an external exercise will be constructed.
- Reallocation of Hillis Lodge building to alterative mental health facility (to be determined but any changes to the Hillis Lodge facility are outside of the scope of this SOC)

Exclusions from Scope of Services

The following elements are excluded from the scope of works:

- any works to Hillis Lodge LSU once vacated

4.3 Scheme Description – Preferred Site

Site Description

The proposed site (highlighted in blue at Figure 4-1) is adjacent to the existing Reaside site and approximately 1 mile from the existing Hillis Lodge site. The proposals indicate that the site will be re-developed as a single-phase project with the new buildings able to be constructed before the existing buildings on the Reaside site are demolished. Following demolition the external exercise area for service users will be created on part of the site of the existing Reaside. The financial cost estimates and project timescales are based on this assumption.

Figure 4-1: Proposed Site

Accommodation Requirements

The accommodation requirements for the project reflect the demand and capacity modelling work outlined at Section 2.7 and the need to deliver safe, high quality and fit for purpose facilities as emphasised in the investment objectives. Figure 4-2 summarises the estimated accommodation requirement for the project (Appendix 4-B provides detailed accommodation schedule).

Figure 4-2: Accommodation Requirements

Suite	Ward / Department	QTY	New Build Area m²
A	Reception	1	120.35
B	Unit Administration	1	149.13
C	Visitor Accommodation & Tribunal Suite	1	251.19
D	Outpatients	1	110.00
E	Meeting/Training Centre	1	271.70
F	Secure Vehicle Airlock	1	251.00
G	Estates Base	1	197.78
H	Staff Welfare	1	183.22
I	Hotel Services	1	513.00
J	Office Accommodation	1	777.28
L	12 Bed MSU (ICU)	1	637.00
M	12 Bed MSU (ICU)	1	606.00
N	12 Bed MSU (ICU)	1	639.00
O	18 Bed MSU	1	779.00
P	15 Bed MSU	1	677.00
Q	18 Bed MSU	1	720.00
R	18 Bed MSU	1	769.00
S	18 Bed LSU	1	820.00
T	Community	1	306.00
U	TEA 1 - Shared Services.	1	458.44
V	TEA 2 - Sports/Recreation	1	436.00
W	TEA 3 - Therapy	1	350.80
		Total:	**10022.11**
		Circulation and Support Accomodation:	**1114.00**
		Department Total:	**11136.11**

As noted, the Trust has used the relevant HBNs as the baseline for its draft schedules of accommodation. At this stage no derogations from HBN / HTM guidance is anticipated. However, should this be necessary as the design develops, this will be documented and appraised using the new NHSE/I guidance, with an aim of assessing the derogations reported, the reasons behind these and the risk and mitigation that the Trust's advisors (in-house and external) consider appropriate to ensure user safety.

Design, Design Principles, and Design Standards

The designs standards that have been used as the baseline for the development of the plans are shown at Figure 4-3.

Figure 4-3: Design Standards

HBN / HTM Reference	Title
Department of Health	Environmental Design Guide – Adult Medium Secure Services
HBN 00-01	General Design Guidance for Healthcare Buildings
HTM 00	Policies and Principles of Healthcare Engineering

Design Buro, architect, has developed a 1:1000 drawing, based on the agree model of care and demand and capacity requirements as set out in the Strategic Case. The plan for Reaside and Hillis Lodge is included at Figure 4-4 (Appendix 4-B provides further detail).

Figure 4-4: Drawings

Layout Acceptance

The plans for the scheme have been developed in conjunction with key stakeholders involved in the project with the aim of establishing:

- Footprint works on site available
- Indicative overall area for the project. Key because capital costs and Estates and Facilities revenue costs have been established from this value
- Support for town planning application via Pre-Application and/or Outline Planning Applications
- Shows all stakeholders including the Trust, Clinicians, Staff, Service Users, etc. and other members of the Project Team the development direction of the project
- Allows buy-in and ownership of all parties with operational consideration for big accommodation 'building blocks' such as ward configurations

- Allows early development of Room Data Sheets, Schedules of Accommodation, etc
- Formulates the strategic approach to the premises development including a site Development Control Plan

The layouts will be further developed and sign off against relationships of rooms, size, location, shape, etc at OBC stage. This will be achieved through detailed design workshops with the appointed Architects and Engineers, key Clinicians, Trust advisors (Risk Management, Infection Control, Fire Safety, Security, etc).

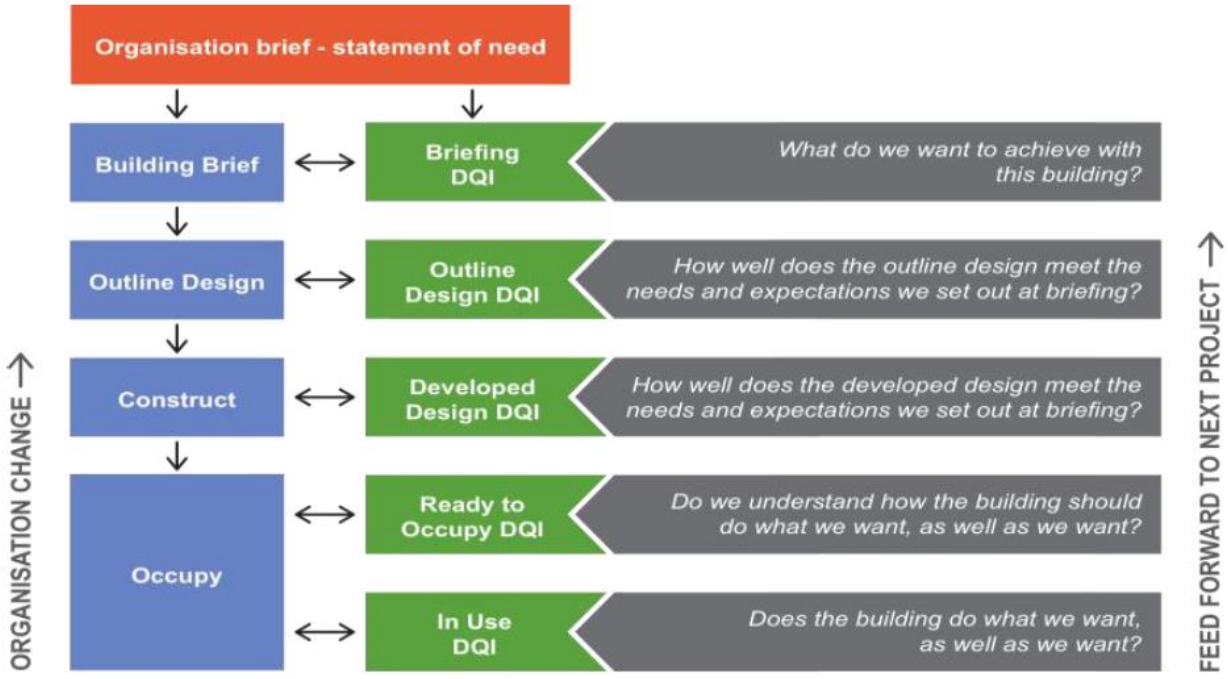
Design Quality and Review

The Trust is using the Construction Industry Council Design Quality Indicator for Health (DQIfH2) tool, updated in September 2020, as the basis for appraising the quality of the design of its new facilities. The DQIfH2 appraisal is an inclusive process that establishes a briefing record as a platform from which stakeholders can agree common goals, interrogate designs, and demand excellence from contractors and suppliers.

The DQIfH2 tool and the questionnaire have been updated to perform better with the latest NHSE/I requirements. DQIfH2 is now designed to become the vehicle for not only design appraisal but also staged review of other NHS estates assurances processes covering impact on the procurement process at an early stage e.g. Carbon Reduction and Sustainability, Infection Prevention & Control, Fire Safety, Planning, Budget, Travel Plan etc.

There are five DQIfH2 Stages, as shown are Figure 4-5.

Figure 4-5: DQIfH2 Process



The first 'briefing' stage assessment for the project was undertaken by the project team, lead clinicians at a 2 day workshop held in June 2021. The report, including matters to be considered as the project progresses, are shown in the DQIfH2 report at Appendix 4-C.

The next DQI workshop will be held during OBC development.

Sustainable Development

BSMHFT has a Board-approved Sustainable Development – Environmental Strategy (2007-2020) in which the Trust commits to the principles of Sustainable Development and will progressively integrate these principles into its daily activities. Through its work with the DHSC, NHSE/I, other Government departments and the resident population, the Trust will seek to increase awareness of Sustainable Development and to ensure that wherever possible, activities support the achievement of sustainable development objectives and support the improvement of health and well-being. The proposed development meets the DHSC's Energy and Sustainability targets as part of BSMHFT's overall commitment to achieving these.

The Trust's Sustainable Development Management Plan (SDMP) describes how the Trust / SSL will embrace and embed Sustainable Development principles alongside the delivery of quality healthcare. Investment is needed in greener technologies, renewable energy and in ensuring that staff and contractors have the ability and knowledge necessary to support and lead positive changes.

The SDMP brings together all current Government plans (and equivalent – Green Plans/ Net Zero Carbon (NZC) etc)) along with the previous BSMHFT strategies and plans (Climate Change Adaption Plan, Sustainable Development Plan etc) into one inclusive document with clear appendices describing each of the political / social or economic drivers and then a joined-up action plan to help focus attention and deliverables. This plan is available in draft format as are current documents as mentioned. This plan applies to the Trust as a whole, with any new development at Reaside being included or indeed being the opportunity to set best practice standards in not only the development but also when operational.

The Trust's performance against core sustainability components sees the Trust achieving a cumulative decrease of 18% in carbon usage against their 2007/08 baseline.

The Trust has engaged the services of a BREEAM assessor, and is targeting a BREEAM rating of 'Excellent' (based on BREEAM 2018), with a current targeted score of 74.77%. The BREEAM assessment is based on information obtained at a pre-construction assessment workshop on 24/05/21. A copy of the summary BREEAM Pre-Construction Assessment can be found at Appendix 4-D.

Further BREEAM assessments will be undertaken at the end of each further design stage. The Programme Team, design team and contractors will work to ensure that all targeted credits are realised during the detailed design and construction phases.

The digital implications on this project are confirmed as being in line with DHSC and NHSX policy.

The Government Construction Strategy has the ultimate aim of reducing the cost of government construction projects through increased efficiency. The strategy sets out ambitions for smarter procurement, fairer payment, improving digital skills, reducing carbon emission, and increasing client capability. Other targets were to improve investment in research and innovation and to confirm the

government's commitment to the Building Information Modelling (BIM). Appendix 4-E sets out further detail on the national strategy.

In developing proposals for the Reaside and Hillis Lodge development, BSMHFT will seek to demonstrate a commitment to the aims of this policy by the following actions:

- Use of BIM Level 2;
- Adoption of government soft landings approach to construction, using the five key stages:
    - inception and briefing – ensuring that the Trust's needs and required outcomes are clearly defined.
    - design development and review – reviewing comparable projects and assessing proposals in relation to facilities management and patients, staff, families and carers.
    - pre-handover – ensuring operators properly understand systems before occupation.
    - initial aftercare – stationing a soft landings team on site to receive feedback, fine tune systems and ensure proper operation.
    - extended after care and post completion review – outstanding issues are resolved, and evaluations are fed-back for changes to the working environment and for future projects.
- Digital and data capability. Digital technologies and collaboration have the potential to bring significant improvements in productivity and effectiveness. BIM is key here and the strategy seeks to build on the BIM Level 2 journey with increasing maturity towards Level 3. Data-driven decision making can bring significant improvements around costing and carbon impact and offset.
- Skills and the supply chain. New ways of working require new skills and abilities. Codifying these requirements and delivering the supporting frameworks and standards can help those working in construction really deliver. The publication of the National Infrastructure Delivery Plan 2016-21 is also designed to give certainty and surety of what the industry can expect from its biggest client. Use of competitive tendering (contractor, external advisors and design team) in accordance with standing financial instructions. These instructions operate within the requirements of OJEU, both for the OBC stage and for the FBC development; and
- Proposed use of the Trust's Procurement Department for all Trust-commissioned appointments and market testing and procurement of new equipment
- A whole-life approach to construction. Driving reductions in whole life cost and carbon is crucial to realising the benefits of increasing collaboration and data-driven decision making. By measuring carbon accurately at delivery and operational stages of a project better decisions can be made. Embedding sustainability at the design stage is also key to getting best results and will contribute to the Trust's action in further reducing their carbon footprint.

Modern Methods of Construction

The Trust is committed to maximising the application of Modern Methods of Construction on its project and to complying with Government policy in this respect. The Design Team has considered the use of modular build / off-site construction methods as part of the alternative construction methodologies, as a means to deliver time and cost savings as well as whole life cost benefits and in use costs.

The core information required by NHSE/I on the use of MMC for the project is set out in Figure 4-6.

At this SOC stage, the Trust's expectation of the total estimated outturn cost, excluding enabling works, VAT and inflation, of the project that may potentially be attributed to MMC are shown at Figure 4-7. The assumptions made in the development of MMC analysis at this SOC stage will be further tested and developed at OBC stage.

Figure 4-6: Modern Methods of Construction Information

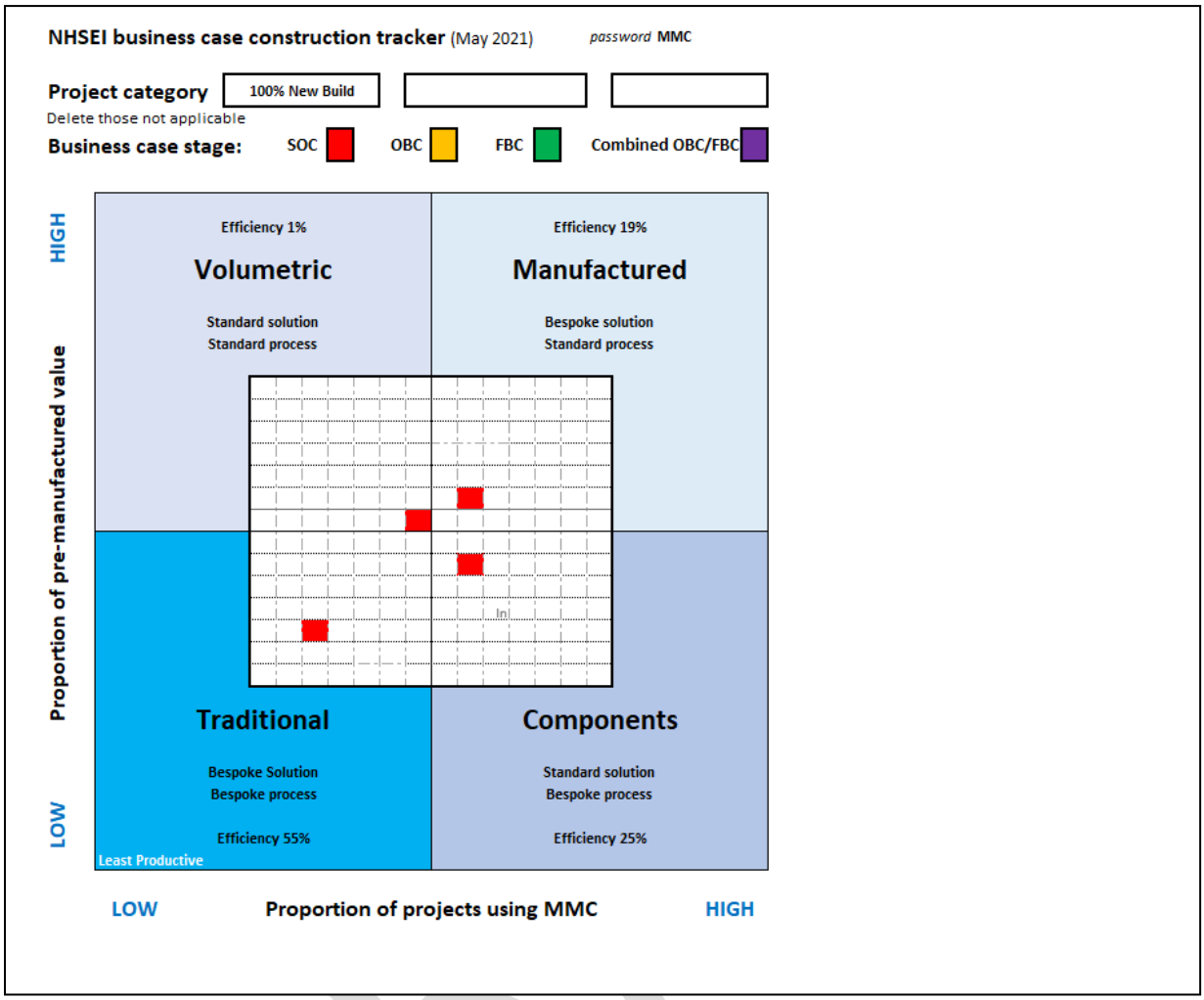
#	Heading		Requirement
1	**New build GIA/m2**		11,164m2
1a	**Major refurbishment GIA/m2 (<90% > 65% of new build project average cost £m2/GIA)**		
1b	**Other refurbishment GIA/m2 (<65% of new build project average cost £m2/GIA)**		
	Total project GIA/m2		**11,164m2**
2	**New build total estimated outturn cost excluding VAT and inflation**		£42,173,226
2a	**Major refurbishment total estimated outturn cost excluding VAT and inflation**		
2b	**Other refurbishment estimated outturn cost excluding VAT and inflation**		
	Total project estimated outturn cost excluding VAT		**£42,173,226**
3	**Which of the following is the trust currently considering and for how much of the total project GIA/m2 and estimated outturn cost excluding VAT and inflation?**		[redacted]
3a	**Volumetric**		£237,628
3b	**Manufactured**		£7,815,310
3c	**Component**		£10,490,998
3d	**Traditional**		£23,629,290
4	**What is the likely option <u>or</u> what is the agreed option for procuring these works? The business case will require additional details in the *Commercial Case* as described the NHSEI Business Case Checklist** https://improvement.nhs.uk/documents/459/NHSI_Capital_Regime_Investment_Annex_1_-_V5_final.docx		[redacted]
4a	**Pre-tendered framework:**	Details in brief	
4b	**Other procurement process**:	Details in brief	
5	**Are the current designs considered to be standardised / repeatable**		Yes/~~No~~
5b	**If 'Yes' to # 5 provide details of which other NHS organisations have used these designs and when**	The Bedrooms and Ensuites are based on the P22 repeatable rooms and used in the following completed facilities: • Ardenleigh Medium Secure Unit for BSMHFT • Tamarind Medium Secure Unit for BSMHFT • Heartlands Psychiatric Intensive Care Unit • Brookhaven for Worcestershire Health and Care NHS Trust • Juniper Older Adult Unit, Moseley, BSMHFT	
5c	**If 'No' to # 5 provide details why 'MMC' options are not being considered and where in the business case there is evidence to support this**	Details in brief	

Figure 4-7: Modern Methods of Construction Cost by Category

Category	Category as % of cost	Main Works	Volumetric	Manufactured	Component/ Standardisation	Traditional
Demolition and Alteration Works	2.00%	£843,465	£0	£0	£0	£843,465
Foundations	3.00%	£1,265,197	£0	£0	£253,039	£1,012,157
Frame	0.50%	£210,866	£189,780	£0	£0	£21,087
Upper Floors	0.01%	£4,217	£0	£2,952	£0	£1,265
Roofing Works	3.00%	£1,265,197	£0	£632,598	£189,780	£442,819
Stairs	0.03%	£12,652	£0	£7,591	£0	£5,061
External Walls	3.00%	£1,265,197	£0	£506,079	£0	£759,118
External Doors & Windows	4.00%	£1,686,929	£0	£0	£1,686,929	£0
Internal Walls	3.00%	£1,265,197	£0	£189,780	£379,559	£695,858
Internal Doors	3.50%	£1,476,063	£0	£0	£1,180,850	£295,213
Wall Finishes	1.00%	£421,732	£0	£0	£147,606	£274,126
Floor Finishes	1.00%	£421,732	£0	£0	£168,693	£253,039
Ceiling Finishes	1.00%	£421,732	£0	£0	£63,260	£358,472
Fittings	2.50%	£1,054,331	£0	£0	£632,598	£421,732
Sanitary Fittings	3.00%	£1,265,197	£0	£0	£759,118	£506,079
M&E Installations	33.00%	£13,917,165	£0	£4,871,008	£2,087,575	£6,958,582
BWIC	1.50%	£632,598	£0	£31,630	£31,630	£569,339
External Works	10.00%	£4,217,323	£0	£0	£632,598	£3,584,724
Drainage Works	1.96%	£826,595	£0	£0	£165,319	£661,276
Preliminary Costs	14.00%	£5,904,252	£23,722	£780,205	£1,047,319	£4,053,005
Price and Design Risk	6.00%	£2,530,394	£12,810	£421,311	£565,552	£1,530,720
Inflation	3.00%	£1,265,197	£11,316	£372,158	£499,571	£382,152
Works Cost	100.00%	**£42,173,226**	**£237,628**	**£7,815,310**	**£10,490,998**	**£23,629,290**
Total % of MMC			**44%**			**56%**

The tracker at Figure 4-8, completed in accordance with the NHSE/I guidance, shows the projected proportionate use of MMC on the project.

Figure 4-8: Modern Methods of Construction Tracker



4.4 Procurement and Contract Strategy

Summerhill Services Limited (SSL) is a wholly owned company of BSMHFT. SSL delivers hard and soft Facilities Management (FM), pharmacy services and other support services to over 50 sites including Reaside and Hillis Lodge. SSL will be responsible for the procurement and delivery activities associated with developing the preferred option.

Construction

The traditional method tends to be used where the client has knowledge and experience of delivering such projects. A Design & Build/ProCure 22 Framework is considered to be for clients who may not have the experience, capacity and capability to manage the project. A Design and Build procurement approach assumes that the contractor is experienced in delivering the construction and can use this experience to improve the project delivery.

However, designing and specifying the construction of a secure mental health facility requires specialist knowledge. The specification is not only crucial to the construction but also the ongoing clinical delivery after the construction has finished. The Trust cannot transfer the clinical risk associated with building

safety features such as anti-ligature and anti-barricade requirements and the risks associated with potential patient damage to the building fabric.

The Trust Technical project team has significant experience working in Mental Health environments managing major capital schemes and delivering the Estates and Facilities thereafter. The team will develop the facility with the Design Team and thereafter manage the FM moving forward.

Therefore, the Trust has decided to use the Traditional procurement route for the appointment of the design team and contractor to construct the building. There will be elements of Contractor Specialist design work such as the building envelope, roof construction, drainage systems, and energy centre this approach will get the best out of the latest technology and have a sound footing of what works in a mental health setting. The Trust will use the evaluation criteria of a Design and Build procurement route to ensure the appointed contractor can support the Trust in the construction so that it not purely about constructing a building to the Trust's specification.

The traditional procurement route aligns the ongoing clinical and operational risk with the construction risk.

The Procurement Route will be aligned to the Contract Strategy with the appropriate forms of contract. The type of contract will be agreed with the design team and be comprised of traditional with supplemental contractor specialist design e.g. *JCT Standard Building Design with sub-contractor's design Conditions 2016.*

The appropriate amendments to the standard form will also be made to take into account; contract terms, insurances, payment processes, retention, defects liability periods, treatment of latent defects, etc.

Advisors

BSMHFT propose to utilise the NHS Shared Business Services (SBS) 'Construction Consultancy Services' procurement framework agreement, which provides Estates, Facilities and Capital teams a compliant route to market for the provision of Consultancy Services from a wide-range of specialisms, utilising both Small & Medium Enterprises (SMEs) and national providers, to deliver either a single service or provide a 'one-stop shop' for a range of services. Through this route providers will be asked to commit to developing projects utilising Building Information Modelling (BIM) Level 2 across the range of Consultancy Services, dovetailing with the Government's Soft Landings (GSL) agenda to help deliver added value and meet the Government's target of BIM being used in all public sector construction contracts.

The Trust anticipates procuring a range of specialist advisors to support the development of the OBC, including:

- Architect;
- MEP Engineer;
- Structural & Civil Engineer;
- Principal Designer;

- Landscape Designer;
- BREEAM Assessor
- Sustainability Advisor;
- Ecology Advisor;
- Fire Engineer;
- Healthcare Planner;
- Cost Advisor;
- Project/Programme Manager(s); and
- Business Case Author.

The resource schedule for the delivery of the scheme up to, and including, FBC stage is shown at Appendix 6-B.

4.5 Digital Strategy

The Trust's digital ambitions are clearly set out in the Trust's Five Year Plan, which will be used to assist in the transformation of clinical services. These are:

- As a Global Digital Exemplar and highest scoring mental health trust on the Digital Maturity scale, continuing to implement innovative technologies to transform the care we provide, how we make decisions and enable new ways of working.
- Building on the opportunities from our rapid roll out of new ways of using digital solutions and technology during COVID-19, being brave to try new developments and remove barriers.
- Taking part in new digital research, adopting digital forms of service delivery underpinned by research and service evaluation.
- Shared care records and systems.
- Quality, safety and security of data and information flows.
- Business intelligence and data driving decisions and change.
- A workforce skilled in using new technologies.
- Making sure we consider the impact of technological developments on our service users and their recovery.
- Develop a technology roadmap following the publication of the Trust Strategy to determine how we implement the opportunities identified

4.6 Town Planning

A meeting was held with the Local Authority town planners in March 2021 to review the Trust ambitions for the redevelopment of Reaside and Hillis Lodge. In principle, the Local Authority is supportive as shown below, subject to a pre-application and full town planning application process.

> *'Many thanks for our recent virtual meeting [where you] outlined the emerging proposals at the Reaside Medium Secure Unit and the Highcroft Acute Psychiatric Unit. As discussed both sites are existing sites where you are seeking to expand and improve the quality of mental health services to the community. have no objections in principle to what we have seen so far and officers are keen to work with yourselves and your consultants to develop these proposals further and as discussed suggest that you submit formal Pre-Applications for both projects (the attached link sets out the information that would be required.'*

4.7 Legal Implications

Other than the procurement process of contractor and advisors as described at Section 4.4, there are no legal implications in relation to this scheme. There are no acquisitions or disposals associated with the scheme.

4.8 Workforce Planning

Workforce Strategy

The NHS Interim People Plan (June 2019) set a vision for how people working in the NHS will be supported to deliver the care required, and identifies the actions national bodies will take to help them. This includes people in different professions working in different ways; promoting positive cultures and building a pipeline of compassionate and engaging leaders; making the NHS an agile, inclusive and modern employer; transforming the way the entire workforce works together; enabling people to have less linear careers; and using technology to automate tasks and to organise and deliver services more efficiently. BSMHFT has developed a workforce strategy for the project, which is fully in alignment with the NHS Interim People Plan.

Staffing Implications of New Unit

The staffing implications for the new unit, in comparison to the 2020/21 baseline position, is shown at Figure 4-9.

Figure 4-9: Workforce Requirements

Current Budget 20/21	Medical	Reception / Security	OT	Psychology	Pharmacy	Mgmt. Report	Admin	New	Severn	Blythe	Avon	Dove	Swift	Trent	Kennett	Hillis Lodge	Total
Existing WTE	11.43	15.00	16.33	11.50	11.65	9.33	15.82		39.75	29.65	31.53	23.16	22.17	21.80	22.9	26.60	**308.66**
New WTE	13.33	15.00	20.23	16.00	12.95	20.83	16.33	32.96	32.96	32.96	32.96	28.96	28.96	28.96	0.00	29.06	**362.45**
Difference WTE	1.90	0.00	3.90	4.50	1.30	11.50	0.51	32.96	-6.79	3.31	1.43	5.80	6.79	7.16	-22.94	2.46	**53.79**

Recruitment Plans

The communication campaign will use various mediums to recruit staff to the new units which is likely to include:

- Better use of social media/twitter/facebook to raise awareness of opportunities and not just be reliant on NHS Jobs
- Promote career routes from HCA through the Trainee Nurse Associate routes.
- Reach out to community groups via social media/You Tube remove stigma around mental health and make them aware of the various career opportunities and different types of jobs within the NHS
    - A day in the life of video from staff from different profession/roles about what it's like to work for the Trust, these could be used in reach outs to Universities and outreach into the communities.
    - Open days
    - Career Fairs at Universities and colleges
    - Community engagement to focus on HCA development roles ie B2 to B3 development target specific under-represented groups.
    - Block recruitment days ie interviews, and checking ID/documents at the same time to reduce timescales.

TUPE and Consultation

There are no TUPE or formal consultation processes required. In accordance with Trust workforce principles and guidance the Trust will consult with staff regarding the planned change. The Stakeholder Communications and Engagement Strategy (Section 6.9) provides further information.

4.9 Risk Allocation Matrix

Figure 4-10 includes the agreed risk allocation matrix identifying key risk categories and their allocation to the Trust or the contractor / supplier, or if it is a shared risk. This risk category apportionment is reflected in the risk register (see Section 6.6).

Figure 4-10: Risk Allocation Matrix

Risk Category	Trust Risk	Contractor Risk	Shared Risk
Design	✓		
Brief	✓		
Financial	✓		
Logistics		✓	
M&E			✓
Management			✓
Operational	✓		
Planning	✓		
Programme			✓
Quality		✓	

4.10 Chapter Appendices

Appendix Number	Appendix Title
4-A	NOT USED
4-B	Drawings / Layouts
4-C	Design Quality Indicator toolkit report
4-D	BREEAM Pre-Assessment
4-E	Government Construction Strategy compliance

5.0 FINANCIAL CASE

5.1 Financial Assumptions

The financial and efficiency assumptions assumed in the development of the proposed investment are shown at Figure 5-1.

Figure 5-1: Financial Assumptions

Assumption	Description
Revenue – Base Year	Costings were based on staffing options supplied by the service. Costed on 20/21 pay rates done at mid-point, with Oct as increment date. For Non-Pay have used actual spend & pro-rated up based on increased beds. Income is based on current OBD rate. Both have been uplifted by 2% per year. SSL have used the ERIC return & new build floor space to calculate the E&F charge. For 'Option A' 2% inflation has been applied each year to all costs.
Revaluation of the Asset Value	Revaluation of the asset hasn't been modelled in the case.
VAT	Not included in the Economic Case but included in the Financial Case as part of the affordability assessment. VAT recovery has been assumed at 0% at this stage (other than on professional fees) as no analysis on VAT Treatment of the scheme has yet been undertaken and no advice has been sought as yet.
Workforce	The workforce model has been developed by Trust operational service leads and costed by the Finance Manager
Inflation	Inflation Assumptions used in the case are as follows: Tariff Inflation of 2.50% offset by CRES of 1.10% Pay inflation applied at 2.0% Drugs Cost inflation applied at 0.6% Non-Pay inflation applied at 1.80%
Depreciation	Depreciation is calculated over the useful economic life of the asset and charged to Income and expenditure on a straight line basis. The asset life used for the building In this case is 66 years.
Impairments	Impairments have not been modelled in the Financial Case
Covid / pandemic modelling	Covid / pandemic has not been modelled in the Financial Case
CIP/QIPP	No increase/decrease in CIP/QIPP assumptions have been included in this case in order to show full impact on SOCI of Preferred Option.

5.2 Summary of Normalised Financial Performance

The historical financial statements, namely Statement of Comprehensive Income (SoCI) and Statement of Financial Position (SoFP) of the Trust are shown at Figures 5-2 and 5-3.

Figure 5-2: Summary of Historic SoCI

Statement of Comprehensive Income	YE 31/3/20 £000	YE 31/3/19 £000
Operating Revenue	263,991	247,413
Operating Expenditure	(261,379)	(244,544)
Operating surplus / (deficit) from continuing operations	**1,815**	**3,340**
Net finance costs	(8,273)	(8,401)
Surplus / (deficit) for the year from continuing operations	**(6,759)**	**(5,204)**
Surplus / (deficit) for the year	**(6,759)**	**(5,204)**
Other comprehensive income (expense)	**(481)**	**(7,058)**
Total comprehensive income (expense) for the year	**(7,240)**	**(12,262)**

Figure 5-3: Summary of Historic SoFP

Statement of Financial Position	31/03/2020		31/03/2019	
	Group	Trust	Group	Trust
	£'000			£'000
Non-Current Assets	182,223	182,930	171,029	167,025
Current Assets	31,894	32,495	31,551	32,964
Current Liabilities	(39,395)	(33,077)	(39,193)	(33,059)
Non-Current Liabilities	(84,780)	(88,069)	(84,758)	(89,183)
Total Assets Employed	**89,942**	**94,279**	**78,629**	**77,747**
Financed By:				
PDC / Other	106,682	103,779	106,682	103,779
Revaluation reserve	24,636	25,117	4,459	1,871
I&E reserve	(41,376)	(34,617)	(32,512)	(27,903)
Total Taxpayers Equity	**89,942**	**94,279**	**78,629**	**77,747**

5.3 Capital Requirements

The capital requirement for the scheme is £90.8m. The summary OB Capital Cost forms for the scheme showing the costs and contingencies included in the capital cost calculations and showing the overall capital costs of the scheme is included at Section 3.6. The funding sources to meet this capital requirement are discussed below.

Planning contingency has been included at 20% and optimism bias calculations are at 15%.

The profile of capital spend is shown at Figure 5-4.

Figure 5-4: Capital Cashflow

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Spend Profile	£3,324,794	£14,125,542	£20,557,093	£23,042,791	£28,417,449	£1,324,644	£90,792,313

5.4 Sources and Application of Funds

The total capital value of the preferred option is £90.8m allowing for VAT at 20%. It is assumed that the full investment will be funded via PDC.

Figure 5-5 provides a summary of the sources and application of capital funds (inclusive of VAT) for the project including a cashflow of anticipated expenditure.

Figure 5-5: Sources and Application of Funds

CAPITAL	21/22	22/23	23/24	24/25	25/26	27/27	Total
Funding Source							
Public Dividend Capital	**£3,324,794**	**£14,125,542**	**£20,557,093**	**£23,042,791**	**£28,417,449**	**£1,324,644**	**£90,792,313**
Total	**£3,324,794**	**£14,125,542**	**£20,557,093**	**£23,042,791**	**£28,417,449**	**£1,324,644**	**£90,792,313**
Application of Funding							
Build costs per OB/FB Forms	-	-	£13,457,093	£17,942,791	£17,942,791	£1,265,196	£50,607,871
Equipment	-	-	-	-	£6,832,301	-	£6,832,301
Professional fees	£1,324,794	£5,529,762	£700,000	£700,000	£500,000	£59,448	£8,814,004
Planning Contingency	£1,000,000	£4,000,000	£2,500,000	£1,500,000	£1,121,574	-	£10,121,574
Optimism Bias	£1,000,000	£4,500,000	£3,000,000	£2,000,000	£1,220,783	£0	£11,720,783
Inflation	-	£95,780	£900,000	£900,000	£800,000		£2,695,780
Total	**£3,324,794**	**£14,125,542**	**£20,557,093**	**£23,042,791**	**£28,417,449**	**£1,324,644**	**£90,792,313**
Source *less* Application	**0**	**0**	**0**	**0**	**0**		**0**

5.5 CDEL Impact

The CDEL appraisal of the planned investment is shown at Figure 5-6.

Figure 5-6: CDEL Impact

CDEL	21/22	22/23	23/24	24/25	25/26	26/27	Total
Gross Capex (approval value)	£3,324,794	£14,125,542	£20,557,093	£23,042,791	£28,417,449	£1,324,644	£90,792,313
Less NBV of Disposals	-	-	-	-	-	-	-
Less Grants and Donations (must be in the same financial year as the capex)	-	-	-	-	-	-	-
CDEL	£3,324,794	£14,125,542	£20,557,093	£23,042,791	£28,417,449	£1,324,644	£90,792,313

5.6 Forecast Impact on Statement of Comprehensive Income

The SOCI showing the projected 10 year SOCI for the BAU option is shown at Figure 5-7 and for the preferred option is shown at Figure 5-8. The incremental difference between the two positions is shown at Figure 5-9.

Figure 5-7: SOCI Position – BAU Option

£0	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Operating income from patient care activities		(271,910,947)	(268,229,073)	(271,968,020)	(275,759,317)	(279,603,695)	(286,421,888)	(290,415,538)	(294,465,099)	(298,571,353)	(302,735,096)
Other operating income		(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)
Operating expenses		280,358,261	276,047,689	279,691,210	283,446,654	287,525,274	294,616,303	298,622,719	302,463,054	306,491,680	316,838,850
Operating surplus/deficit from continuing operations		**(2,871,888)**	**(3,500,585)**	**(3,596,011)**	**(3,631,864)**	**(3,397,622)**	**(3,124,786)**	**(3,112,020)**	**(3,321,246)**	**(3,398,874)**	**2,784,553**
Finance income		(97,020)	(97,950)	(97,949)	(97,950)	(97,950)	(97,949)	(97,950)	(97,950)	(97,949)	(97,949)
Finance expenses		5,605,082	6,033,289	6,045,769	6,030,553	5,740,229	5,432,795	5,413,149	5,610,736	5,665,075	5,598,128
PDC Dividends payable		2,363,826	2,565,245	2,648,194	2,699,270	2,755,347	2,789,945	2,808,510	2,832,200	2,867,920	4,045,265
Net finance costs		**7,871,888**	**8,500,584**	**8,596,013**	**8,631,873**	**8,397,626**	**8,124,790**	**8,123,709**	**8,344,986**	**8,435,045**	**9,545,443**
Gains on disposal of assets											
Losses arising from transfers by absorption											
Corporation tax expense											
Surplus/Deficit for the year from continuing operations											
Surplus/Deficit for the year		**5,000,000**	**4,999,999**	**5,000,002**	**5,000,009**	**5,000,004**	**5,000,004**	**5,011,689**	**5,023,740**	**5,036,171**	**12,329,996**
Other comprehensive (expense)/income											
Will not be reclassified to income and expenditure:											
Revaluation losses on property, plant and equipment											
Revaluation gains on property, plant and equipment											
Total comprehensive expense for the year											

Figure 5-8: SOCI Position – Preferred Option

£0	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Operating income from patient care activities		(271,910,947)	(268,229,073)	(271,968,020)	(275,759,317)	(279,603,695)	(287,656,063)	(291,666,991)	(295,734,071)	(299,858,089)	(304,039,847)
Other operating income		(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)	(11,319,201)
Operating expenses		280,358,261	276,047,689	279,691,210	283,446,654	287,525,274	296,554,782	300,575,692	304,431,102	308,475,157	312,693,585
Operating surplus/deficit from continuing operations		**(2,871,888)**	**(3,500,585)**	**(3,596,011)**	**(3,631,864)**	**(3,397,622)**	**(2,420,482)**	**(2,410,500)**	**(2,622,170)**	**(2,702,133)**	**(2,665,463)**
Finance income		(97,020)	(97,950)	(97,949)	(97,950)	(97,950)	(97,949)	(97,950)	(97,950)	(97,949)	(97,949)
Finance expenses		5,605,082	6,033,289	6,045,769	6,030,553	5,740,229	5,432,795	5,413,149	5,610,736	5,665,075	5,598,128
PDC Dividends payable		2,416,281	3,100,192	3,881,070	4,727,254	5,737,448	5,859,593	5,833,914	5,810,684	5,799,502	5,793,492
Net finance costs		**7,924,343**	**9,035,531**	**9,828,889**	**10,659,857**	**11,379,727**	**11,194,438**	**11,149,113**	**11,323,470**	**11,366,627**	**11,293,670**
Gains on disposal of assets											
Losses arising from transfers by absorption											
Corporation tax expense											
Surplus/Deficit for the year from continuing operations											
Surplus/Deficit for the year		**5,052,455**	**5,534,946**	**6,232,878**	**7,027,993**	**7,982,105**	**8,773,956**	**8,738,613**	**8,701,300**	**8,664,494**	**8,628,207**
Other comprehensive (expense)/income											
Will not be reclassified to income and expenditure:											
Revaluation losses on property, plant and equipment											
Revaluation gains on property, plant and equipment											
Total comprehensive expense for the year											

Figure 5-9: SOCI Position – Incremental Difference

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Operating income from patient care activities		0	0	0	0	0	1,234,175	1,251,453	1,268,972	1,286,736	1,304,751
Other operating income		0	0	0	0	0	0	0	0	0	0
Operating expenses		0	0	0	0	0	(1,938,479)	(1,952,973)	(1,968,048)	(1,983,477)	4,145,265
Operating surplus/deficit from continuing operations		**0**	**0**	**0**	**0**	**0**	**(704,304)**	**(701,520)**	**(699,076)**	**(696,741)**	**5,450,016**
Finance income		0	0	0	0	0	0	0	0	0	0
Finance expenses		0	0	0	0	0	0	0	0	0	0
PDC Dividends payable		(52,455)	(534,947)	(1,232,876)	(2,027,984)	(2,982,101)	(3,069,648)	(3,025,404)	(2,978,484)	(2,931,582)	(1,748,227)
Net finance costs		**(52,455)**	**(534,947)**	**(1,232,876)**	**(2,027,984)**	**(2,982,101)**	**(3,069,648)**	**(3,025,404)**	**(2,978,484)**	**(2,931,582)**	**(1,748,227)**
Gains on disposal of assets		0	0	0	0	0	0	0	0	0	0
Losses arising from transfers by absorption		0	0	0	0	0	0	0	0	0	0
Corporation tax expense		0	0	0	0	0	0	0	0	0	0
Surplus/Deficit for the year from continuing operations		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Surplus/Deficit for the year		**(52,455)**	**(534,947)**	**(1,232,876)**	**(2,027,984)**	**(2,982,101)**	**(3,773,952)**	**(3,726,924)**	**(3,677,560)**	**(3,628,323)**	**3,701,789**
Other comprehensive (expense)/income											
Will not be reclassified to income and expenditure:											
Revaluation losses on property, plant and equipment											
Revaluation gains on property, plant and equipment											
Total comprehensive expense for the year											

5.7 Forecast Impact on Statement of Financial Position

The SOFP showing the projected 10 year SOFP for the BAU option is shown at Figure 5-10 and for the preferred option is shown at Figure 5-11. Figure 5-12 provides the incremental difference in the two positions.

Figure 5-10: SOFP Position – BAU Option

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current assets											
Property, plant and equipment		£143,414,600	£145,099,223	£143,349,926	£141,650,995	£139,609,069	£136,759,755	£133,645,439	£130,489,559	£127,372,611	£159,277,131
Finance Lease - Right of Use Asset		-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0
Intangible Assets		£2,120,719	£289,807	-£879,698	-£1,539,359	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601
On balance sheet PFI		£37,674,691	£36,528,470	£35,382,248	£34,236,027	£33,089,805	£31,943,584	£30,797,362	£29,651,140	£28,504,919	£27,358,697
Prepayments PFI		£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854
Finance Lease Receivable		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Deferred Tax Asset		-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368
Total Non-Current Assets		£184,549,497	£183,256,986	£179,191,962	£175,687,149	£172,122,760	£168,127,224	£163,866,686	£159,564,585	£155,301,415	£186,059,713
Current Assets											
Inventories		£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995
Trade and Other Receivables		£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413
Cash and Cash Equivalents		£17,918,078	£10,262,552	£5,219,614	-£478,349	-£5,704,321	-£10,086,819	-£14,310,358	-£18,913,972	-£23,762,566	-£35,663,548
Assets Held for Sale		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Current Assets		£25,731,486	£18,075,960	£13,033,022	£7,335,059	£2,109,087	-£2,273,411	-£6,496,950	-£11,100,564	-£15,949,158	-£27,850,140
Current Liabilities											
Trade and Other Payables		-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490
Tax payable		-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799
Loan and Borrowings		-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248
Provisions		-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860
Deferred income		-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986
Total Current Liabilities		-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382
Total assets less current liabilities		£163,165,601	£154,217,564	£145,109,602	£135,906,827	£127,116,465	£118,738,431	£110,254,354	£101,348,639	£92,236,875	£111,094,191

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current liabilities											
Loan and Borrowings - Current		-£27,324,040	-£25,141,480	-£22,958,920	-£20,776,360	-£18,593,800	-£16,411,240	-£14,228,680	-£12,046,120	-£9,863,560	-£7,681,000
Loan and Borrowings - New		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PFI lease		-£47,749,448	-£46,015,093	-£44,121,905	-£42,135,039	-£40,561,749	-£39,401,994	-£38,149,133	-£36,487,978	-£34,634,544	-£32,749,988
Finance Lease Liability - Right of Use Asset		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Provisions		-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110
Total Non-Current Liabilities		-£76,892,598	-£72,975,683	-£68,899,936	-£64,730,509	-£60,974,659	-£57,632,344	-£54,196,923	-£50,353,208	-£46,317,214	-£42,250,098
Total assets employed		£86,273,003	£81,241,881	£76,209,666	£71,176,318	£66,141,806	£61,106,087	£56,057,431	£50,995,431	£45,919,661	£68,844,093
Financed by											
Public dividend capital		£110,526,929	£110,526,929	£110,526,929	£110,526,929	£110,526,929	£110,526,929	£110,526,929	£110,526,929	£110,526,929	£145,822,343
Revaluation reserve		£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353
Income and expenditure reserve		-£48,887,279	-£53,918,401	-£58,950,615	-£63,983,964	-£69,018,476	-£74,054,195	-£79,102,850	-£84,164,850	-£89,240,621	-£101,611,603
Total taxpayers' equity		£86,273,003	£81,241,881	£76,209,666	£71,176,318	£66,141,806	£61,106,087	£56,057,431	£50,995,431	£45,919,661	£68,844,093

Figure 5-11: SOFP Position – Preferred Option

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current assets											
Property, plant and equipment		£146,014,600	£161,451,344	£180,259,140	£201,603,000	£227,338,703	£224,464,726	£220,001,331	£215,496,374	£211,030,347	£206,510,970
Finance Lease - Right of Use Asset		-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0	-£0
Intangible Assets		£2,120,719	£289,807	-£879,698	-£1,539,359	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601	-£1,915,601
On balance sheet PFI		£37,674,691	£36,528,470	£35,382,248	£34,236,027	£33,089,805	£31,943,584	£30,797,362	£29,651,140	£28,504,919	£27,358,697
Prepayments PFI		£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854	£1,359,854
Finance Lease Receivable		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Deferred Tax Asset		-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368	-£20,368
Total Non-Current Assets		£187,149,497	£199,609,107	£216,101,176	£235,639,154	£259,852,394	£255,832,195	£250,222,578	£244,571,399	£238,959,151	£233,293,552
Current Assets											
Inventories		£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995	£387,995
Trade and Other Receivables		£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413	£7,425,413
Cash and Cash Equivalents		£17,865,623	£9,675,150	£3,399,336	-£4,326,611	-£12,534,684	-£19,341,827	-£25,943,212	-£32,875,308	-£40,003,148	-£47,073,859
Assets Held for Sale		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Current Assets		£25,679,031	£17,488,558	£11,212,744	£3,486,797	-£4,721,276	-£11,528,419	-£18,129,804	-£25,061,900	-£32,189,739	-£39,260,451
Current Liabilities											
Trade and Other Payables		-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490	-£28,030,490
Tax payable		-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799	-£4,445,799
Loan and Borrowings		-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248	-£2,714,248
Provisions		-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860	-£722,860
Deferred income		-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986	-£11,201,986
Total Current Liabilities		-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382	-£47,115,382
Total assets less current liabilities		£165,713,146	£169,982,283	£180,198,538	£192,010,570	£208,015,736	£197,188,394	£184,977,393	£172,394,117	£159,654,030	£146,917,720

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current liabilities											
Loan and Borrowings - Current		-£27,324,040	-£25,141,480	-£22,958,920	-£20,776,360	-£18,593,800	-£16,411,240	-£14,228,680	-£12,046,120	-£9,863,560	-£7,681,000
Loan and Borrowings - New		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PFI lease		-£47,749,448	-£46,015,093	-£44,121,905	-£42,135,039	-£40,561,749	-£39,401,994	-£38,149,133	-£36,487,978	-£34,634,544	-£32,749,988
Finance Lease Liability - Right of Use Asset		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Provisions		-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110	-£1,819,110
Total Non-Current Liabilities		-£76,892,598	-£72,975,683	-£68,899,936	-£64,730,509	-£60,974,659	-£57,632,344	-£54,196,923	-£50,353,208	-£46,317,214	-£42,250,098
Total assets employed		£88,820,548	£97,006,600	£111,298,602	£127,280,061	£147,041,077	£139,556,049	£130,780,470	£122,040,910	£113,336,816	£104,667,622
Financed by											
Public dividend capital		£113,126,929	£126,879,050	£147,436,143	£170,478,934	£198,256,563	£199,581,207	£199,581,207	£199,581,207	£199,581,207	£199,581,207
Revaluation reserve		£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353	£24,633,353
Income and expenditure reserve		-£48,939,734	-£54,505,803	-£60,770,893	-£67,832,226	-£75,848,839	-£84,658,510	-£93,434,090	############	-£110,877,744	-£119,546,938
Total taxpayers' equity		£88,820,548	£97,006,600	£111,298,602	£127,280,061	£147,041,077	£139,556,049	£130,780,470	£122,040,910	£113,336,816	£104,667,622

Figure 5-12: SOFP Position – Incremental Difference

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current assets											
Property, plant and equipment		-£2,600,000	-£16,352,121	-£36,909,214	-£59,952,005	-£87,729,634	-£87,704,971	-£86,355,892	-£85,006,814	-£83,657,736	-£47,233,839
Finance Lease - Right of Use Asset		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Intangible Assets		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
On balance sheet PFI		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Prepayments PFI		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Finance Lease Receivable		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Deferred Tax Asset		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Non-Current Assets		-£2,600,000	-£16,352,121	-£36,909,214	-£59,952,005	-£87,729,634	-£87,704,971	-£86,355,892	-£85,006,814	-£83,657,736	-£47,233,839
Current Assets											
Inventories		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Trade and Other Receivables		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Cash and Cash Equivalents		£52,455	£587,402	£1,820,278	£3,848,262	£6,830,363	£9,255,008	£11,632,854	£13,961,336	£16,240,581	£11,410,310
Assets Held for Sale		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Current Assets		£52,455	£587,402	£1,820,278	£3,848,262	£6,830,363	£9,255,008	£11,632,854	£13,961,336	£16,240,581	£11,410,310
Current Liabilities											
Trade and Other Payables		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Tax payable		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Loan and Borrowings		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Provisions		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Deferred income		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Current Liabilities		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total assets less current liabilities		-£2,547,545	-£15,764,719	-£35,088,936	-£56,103,743	-£80,899,271	-£78,449,963	-£74,723,038	-£71,045,478	-£67,417,155	-£35,823,529

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Non-current liabilities											
Loan and Borrowings - Current		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Loan and Borrowings - New		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PFI lease		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Finance Lease Liability - Right of Use Asset		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Provisions		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Non-Current Liabilities		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total assets employed		-£2,547,545	-£15,764,719	-£35,088,936	-£56,103,743	-£80,899,271	-£78,449,963	-£74,723,038	-£71,045,478	-£67,417,155	-£35,823,529
Financed by											
Public dividend capital		-£2,600,000	-£16,352,121	-£36,909,214	-£59,952,005	-£87,729,634	-£89,054,278	-£89,054,278	-£89,054,278	-£89,054,278	-£53,758,864
Revaluation reserve		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income and expenditure reserve		£52,455	£587,402	£1,820,278	£3,848,262	£6,830,363	£10,604,315	£14,331,240	£18,008,800	£21,637,123	£17,935,335
Total taxpayers' equity		-£2,547,545	-£15,764,719	-£35,088,936	-£56,103,743	-£80,899,271	-£78,449,963	-£74,723,038	-£71,045,478	-£67,417,155	-£35,823,529

5.8 Forecast Impact on Cashflow

The cashflow statement showing the projected 10 year cashflow is shown at Figure 5-13 for the BAU option and for the preferred option is shown at Figure 5-14. Figure 5-15 provides the incremental cashflow difference.

Figure 5-13: Cashflow Position – BAU Option

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Cash flows from operating activities											
Surplus / (Deficit) from Operations		£2,871,888	£3,500,585	£3,596,011	£3,631,864	£3,397,622	£3,124,786	£3,112,020	£3,321,246	£3,398,874	-£2,784,553
Depreciation and amortisation, total		£8,083,820	£8,612,511	£8,435,024	£8,255,813	£8,315,389	£7,825,536	£8,090,538	£8,132,101	£8,093,170	£8,367,116
Total Cash Flow from Operating Activities		£10,955,708	£12,113,096	£12,031,035	£11,887,677	£11,713,012	£10,950,322	£11,202,558	£11,453,347	£11,492,044	£5,582,564
Cash flows from investing activities											
Capital Expenditure		-£9,591,000	-£7,320,000	-£4,370,000	-£4,751,000	-£4,751,000	-£3,830,000	-£3,830,000	-£3,830,000	-£3,830,000	-£39,125,415
Proceeds from Disposal of PPE		£400,000	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Received		£97,020	£97,950	£97,949	£97,950	£97,950	£97,949	£97,950	£97,950	£97,949	£97,949
Total Cash Flow from Investing Activities		-£9,093,980	-£7,222,050	-£4,272,051	-£4,653,050	-£4,653,050	-£3,732,051	-£3,732,050	-£3,732,050	-£3,732,051	-£39,027,465
Cash flows from financing activities											
Capital Repayment of Loans		-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560
Capital Repayment of PFI		-£1,566,555	-£1,734,355	-£1,893,188	-£1,986,867	-£1,573,290	-£1,159,755	-£1,252,861	-£1,661,155	-£1,853,434	-£1,884,556
Capital Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Repayment of Loans		-£1,270,721	-£1,186,026	-£1,090,625	-£1,005,395	-£913,802	-£825,513	-£736,472	-£650,636	-£558,177	-£469,011
Interest Repayment of PFI		-£4,366,296	-£4,489,525	-£4,596,089	-£4,668,739	-£4,468,690	-£4,249,544	-£4,315,441	-£4,605,862	-£4,749,160	-£4,771,379
Interest Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PDC Dividends paid		-£2,363,826	-£2,565,245	-£2,648,194	-£2,699,270	-£2,755,347	-£2,789,945	-£2,808,510	-£2,832,200	-£2,867,920	-£4,045,265
PDC Receivable		£0	£0	£0	£0	£0	£0	£0	£0	£0	£35,295,415
Other Cash Flows from Financing Activities		£31,935	-£357,738	-£359,054	-£356,420	-£357,737	-£357,738	-£361,236	-£354,238	-£357,737	-£357,738
Net cash flows generated from financing activities		-£11,718,023	-£12,515,450	-£12,769,710	-£12,899,250	-£12,251,426	-£11,565,055	-£11,657,080	-£12,286,651	-£12,568,988	£21,584,905
Increase in cash and cash equivalents		-£9,856,295	-£7,624,403	-£5,010,726	-£5,664,623	-£5,191,464	-£4,346,783	-£4,186,572	-£4,565,355	-£4,808,995	-£11,859,996
Cash & cash equivalents at 1 April - b/f		£27,774,372	£17,918,077	£10,293,674	£5,282,948	-£381,675	-£5,573,139	-£9,919,922	-£14,106,495	-£18,671,849	-£23,480,844
Cash and cash equivalents at 31 March		£17,918,077	£10,293,674	£5,282,948	-£381,675	-£5,573,139	-£9,919,922	-£14,106,495	-£18,671,849	-£23,480,844	-£35,340,840

Figure 5-14: Cashflow Position – Preferred Option

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Cash flows from operating activities											
Surplus / (Deficit) from Operations		£2,871,888	£3,500,585	£3,596,011	£3,631,864	£3,397,622	£2,420,482	£2,410,500	£2,622,170	£2,702,133	£2,665,463
Depreciation and amortisation, total		£8,083,820	£8,612,511	£8,435,024	£8,255,813	£8,315,389	£9,174,843	£9,439,616	£9,481,179	£9,442,248	£9,495,598
Total Cash Flow from Operating Activities		£10,955,708	£12,113,096	£12,031,035	£11,887,677	£11,713,012	£11,595,325	£11,850,116	£12,103,349	£12,144,381	£12,161,061
Cash flows from investing activities											
Capital Expenditure		-£12,191,000	-£21,072,121	-£24,927,093	-£27,793,791	-£32,528,629	-£5,154,644	-£3,830,000	-£3,830,000	-£3,830,000	-£3,830,000
Proceeds from Disposal of PPE		£400,000	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Received		£97,020	£97,950	£97,949	£97,950	£97,950	£97,949	£97,950	£97,950	£97,949	£97,949
Total Cash Flow from Investing Activities		-£11,693,980	-£20,974,171	-£24,829,144	-£27,695,841	-£32,430,679	-£5,056,695	-£3,732,050	-£3,732,050	-£3,732,051	-£3,732,051
Cash flows from financing activities											
Capital Repayment of Loans		-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560	-£2,182,560
Capital Repayment of PFI		-£1,566,555	-£1,734,355	-£1,893,188	-£1,986,867	-£1,573,290	-£1,159,755	-£1,252,861	-£1,661,155	-£1,853,434	-£1,884,556
Capital Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Repayment of Loans		-£1,270,721	-£1,186,026	-£1,090,625	-£1,005,395	-£913,802	-£825,513	-£736,472	-£650,636	-£558,177	-£469,011
Interest Repayment of PFI		-£4,366,296	-£4,489,525	-£4,596,089	-£4,668,739	-£4,468,690	-£4,249,544	-£4,315,441	-£4,605,862	-£4,749,160	-£4,771,379
Interest Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PDC Dividends paid		-£2,416,281	-£3,100,192	-£3,881,070	-£4,727,254	-£5,737,448	-£5,859,593	-£5,833,914	-£5,810,684	-£5,799,502	-£5,793,492
PDC Receivable		£2,600,000	£13,752,121	£20,557,093	£23,042,791	£27,777,629	£1,324,644	£0	£0	£0	£0
Other Cash Flows from Financing Activities		£31,935	-£357,738	-£359,054	-£356,420	-£357,737	-£357,738	-£361,236	-£354,238	-£357,737	-£357,738
Net cash flows generated from financing activities		-£9,170,478	£701,724	£6,554,507	£8,115,557	£12,544,102	-£13,310,059	-£14,682,484	-£15,265,135	-£15,500,570	-£15,458,736
Increase in cash and cash equivalents		-£9,908,750	-£8,159,350	-£6,243,602	-£7,692,607	-£8,173,565	-£6,771,428	-£6,564,418	-£6,893,837	-£7,088,240	-£7,029,725
Cash & cash equivalents at 1 April - b/f		£27,774,372	£17,865,622	£9,706,272	£3,462,670	-£4,229,937	-£12,403,502	-£19,174,930	-£25,739,349	-£32,633,185	-£39,721,425
Cash and cash equivalents at 31 March		£17,865,622	£9,706,272	£3,462,670	-£4,229,937	-£12,403,502	-£19,174,930	-£25,739,349	-£32,633,185	-£39,721,425	-£46,751,150

Figure 5-15: Cashflow Position – Incremental Position

	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Cash flows from operating activities											
Surplus / (Deficit) from Operations		£0	£0	-£0	£0	£0	£704,304	£701,520	£699,076	£696,741	-£5,450,016
Depreciation and amortisation, total		£0	£0	£0	£0	£0	-£1,349,307	-£1,349,078	-£1,349,078	-£1,349,078	-£1,128,482
Total Cash Flow from Operating Activities		£0	£0	-£0	£0	£0	-£645,003	-£647,558	-£650,002	-£652,337	-£6,578,498
Cash flows from investing activities		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Capital Expenditure		£2,600,000	£13,752,121	£20,557,093	£23,042,791	£27,777,629	£1,324,644	£0	£0	£0	-£35,295,415
Proceeds from Disposal of PPE		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Received		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Cash Flow from Investing Activities		£2,600,000	£13,752,121	£20,557,093	£23,042,791	£27,777,629	£1,324,644	£0	£0	£0	-£35,295,415
Cash flows from financing activities		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Capital Repayment of Loans		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Capital Repayment of PFI		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Capital Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Repayment of Loans		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Repayment of PFI		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Interest Repayment of Finance Leases		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
PDC Dividends paid		£52,455	£534,947	£1,232,876	£2,027,984	£2,982,101	£3,069,648	£3,025,404	£2,978,484	£2,931,582	£1,748,227
PDC Receivable		-£2,600,000	-£13,752,121	-£20,557,093	-£23,042,791	-£27,777,629	-£1,324,644	£0	£0	£0	£35,295,415
Other Cash Flows from Financing Activities		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Net cash flows generated from financing activities		-£2,547,545	-£13,217,174	-£19,324,217	-£21,014,807	-£24,795,528	£1,745,004	£3,025,404	£2,978,484	£2,931,582	£37,043,642
Increase in cash and cash equivalents		£52,455	£534,947	£1,232,876	£2,027,984	£2,982,101	£2,424,645	£2,377,846	£2,328,482	£2,279,245	-£4,830,271
Cash & cash equivalents at 1 April - b/f		£0	£52,455	£587,402	£1,820,278	£3,848,262	£6,830,363	£9,255,008	£11,632,854	£13,961,336	£16,240,581
Cash and cash equivalents at 31 March		£52,455	£587,402	£1,820,278	£3,848,262	£6,830,363	£9,255,008	£11,632,854	£13,961,336	£16,240,581	£11,410,310

5.9 Reduction in Backlog Maintenance Liabilities

The backlog maintenance is as reported in 2019/20 for Reaside and Hillis Lodge is a combined backlog maintenance liability for the two premises of £4.3m, of which £1.2m relates to significant backlog maintenance. The combined risk-adjusted backlog maintenance figure is £1.4m. Through the implementation of the preferred option this backlog maintenance liability will be reduced by £4.3m.

5.10 Procurement Costs

Procurement costs associated with both the construction and equipping elements of the scheme are included in the overall fees structure and shown at OB4 of the capital cost forms (Appendix 3-C).

5.11 VAT Treatment

No VAT recovery has been assumed at this stage with the exception of professional fees. This assumption will be tested further at OBC stage.

5.12 Financial Risks

The financial risks with the greatest potential financial impact, as identified and costed in the CIAM, are summarised in Figure 5-16, together with mitigating actions.

Figure 5-16: Financial Risks and Mitigating Actions

Financial Risks	Mitigating Actions
Failure to translate design could lead to facilities not being fit for purpose	Detailed design drawings to be developed in conjunction with BSMH clinical/management/estates colleagues to minimise the risk to design and will be completed at OBC stage. Multiple engagement sessions planned to mitigate the risk further.
Continuing development of design could lead to facilities not being fit for purpose	Sign-off of by clinical/management staff of key spaces, SoA, 1:50 and detailed drawings to be agreed at key milestones to mitigate risk. Multiple engagement sessions planned with key stakeholders.
Failure to build to brief could cause delays, additional cost and design not supported by users.	Full BSMH involvement in design and early consideration of procurement process.
Incorrect cost estimates leading to increase in capital costs	Programme Team and estates work stream group to ensure designs are cost led to ensure budgets are achieved. Rigorous cost planning required throughout the healthcare planning/design planning period. Work in regard to capital costs and affordability are managed through the estates work stream group with clear accountability to the Programme Team and Programme Board. Capital costing work is started early in the process in order to identify any potential issues.
Legislative / regulatory change e.g. Brexit impact, Covid impact, market suitability	Early market testing and quantity surveyor to give regular updates on current market demand, pricing and any potential legislative change.

5.13 Sensitivity Analysis

A sensitivity analysis has been undertaken and included within the CIAM (see Appendix 3-B).

5.14 Overall Affordability Assessment

The Trust operate at an increasing, albeit manageable deficit as a result of this development for years 0-6 at which point the new building goes live and despite additional operating expenses associated with

the new build, commissioner support for the additional bed capacity means additional income. Years 7-9 the Deficit is gradually reduced as the Trust's PDC dividends payable liability begins to decrease incrementally. Whilst CIP and QIPP are not modelled in the Finance Case in order to demonstrate the full effect of the investment on the Income and Expenditure statements of the preferred option, the assumption behind the modelling is that the deficit from years 1-9 would, in application, be partially offset by CIP/QIPP initiatives which will be developed and outlined in greater detail as part of the OBC process. At year 10, the Trust turn a surplus of c.£3.6million compared to what would exist as the BAU option due to the removal of the need for the refurb conversion and OOA provision and the additional income provided by commissioners. From year 10 onwards the Trust continue to operate with a modest surplus when compared against the BAU position thus demonstrating the long term affordability of the preferred option. This assessment is supported by the significant incremental revenue cost reduction demonstrated within the CIAM in terms of comparison between the Preferred Option and the BAU position.

6.0 MANAGEMENT CASE

6.1 Project Governance Structure

A clear and robust governance structure has been agreed for the delivery of the Reaside and Hillis Lodge re-provision project. The programme is overseen by the Reaside and Highcroft Project Board, which is accountable to the BSMHFT Executive. Reporting to the Reaside and Highcroft Project Board is the Reaside & Hillis Lodge Delivery Group and relevant workstream groups. Figure 6-1 shows the governance structure of the Reaside and Hillis Lodge Project.

Reaside and Highcroft Project Board

The Reaside and Highcroft Project Board has decision-making and programme assurance responsibility and is accountable to the BSMHFT Executive and is subject to regular scrutiny and review through reporting. It is responsible for the successful delivery of both the Reaside and Hillis Lodge project and the Highcroft Project (the latter of which is outside of the scope of this SOC). The Reaside and Highcroft Project Board will be informed of ongoing strategic guidance from the BSMHFT Executive. The Reaside and Highcroft Project Board represents the higher level interests of the Trust, users and suppliers within the project and has overall responsibility for strategic planning, service quality and the operational and financial performance of the programme. It is therefore responsible for the investment of financial and human resources.

The Reaside and Highcroft Project Board's responsibilities are to:

1. To review, approve and monitor the project brief, Project Initiation Document and Business Case
2. To review and approve project healthchecks at each stage of the project
3. To review and approve any major deviation from agreed plans via Exception Reports and or Business Change Requests
4. To ensure that necessary resources are committed to the project.
5. To arbitrate on any conflicts within the project
6. To review and monitor risks and issues that are escalated for attention ensuring risks are effectively mitigated and the planned actions are having the desired effect
7. To negotiate a solution to any problems between the project and external bodies
8. To judge whether constraints of time, budget and resources are reasonable

The Reaside & Hillis Lodge Project Board is chaired by Dave Tomlinson, Executive Director Finance for BSMHFT. The full membership of the Project Board is shown at Figure 6-2; Terms of Reference for the Project Board can be found at Appendix 6-A.

Figure 6-1: Programme Governance Structure

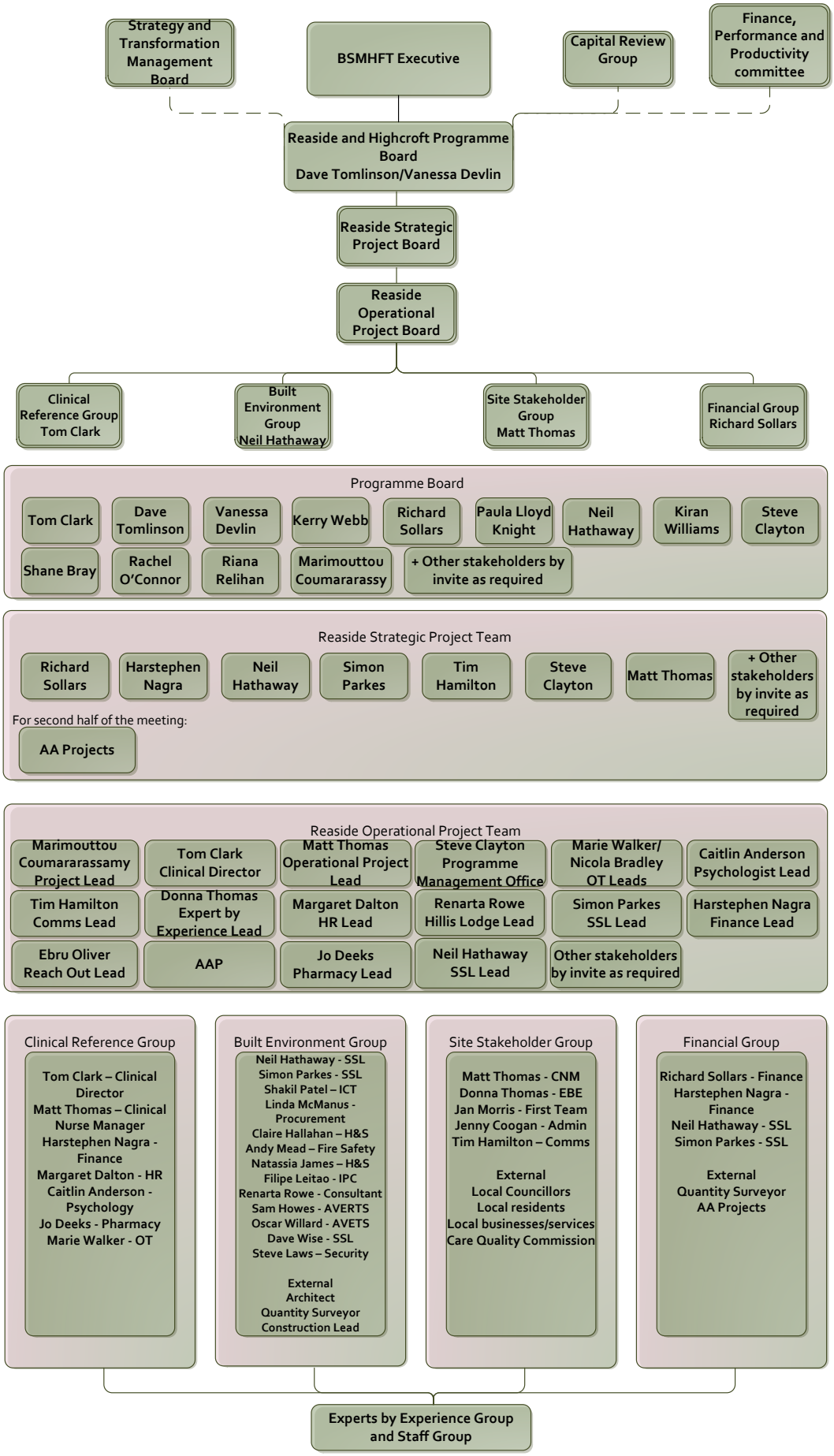


Figure 6-2: Reaside & Highcroft Project Board Membership

Name	Role / Department	Organisation
Dave Tomlinson (SRO)	Executive Director of Finance	BSMHFT
Vanessa Devlin	Executive Director of Operations	BSMHFT
Peter Wilson	Project Lead	BSMHFT
Richard Sollars	Deputy Director of Finance	BSMHFT
Paula Lloyd-Knight	Associate Director of Operations Acute and Urgent Care	BSMHFT
Marimouttou Coumararassy	Associated Director of Operations Secure Services / Offender Health	BSMHFT
Kiran Williams	Strategic Estates Lead – Birmingham & Solihull	NHSE/I – Commercial Directorate
Shane Bray	Managing Director	Summerhill Services Ltd
Rachel O'Connor	Assistant CEO, BSoL ICS	BSMHFT
Riana Relihan	Regional Delivery Director (Midlands)	NHSE/I – Commercial Directorate
Kerry Webb	Clinical Director Adult Acute	BSMHFT
Tom Clark	Clinical Director Secure Services / Offender Health	BSMHFT
Neil Hathaway	Director of Operations	Summerhill Services Ltd
Steve Clayton	Programme Manager	BSMHFT

Reaside & Hillis Lodge Project Delivery Group

The Reaside and Hillis Lodge Project Delivery Group is responsible for the successful delivery of the Reaside and Hillis Lodge project and reports directly to the Project Board. The Reaside and Hillis Lodge Project Delivery Group's responsibilities are to:

- ensure the scheme delivery to meet all critical delivery objectives including time, cost and quality
- manage the Procurement Structure and Contract Strategies
- agree the Project Plans and key critical path milestone dates and ensure the project stays within the agreed delivery timeline
- agree key activity sign-off and delivery
- ensure capital costs remain within the agreed parameters in this SOC
- oversee the risk register and issues log and escalate where advised.

Membership of the Reaside and Hillis Lodge Project Delivery Group is detailed at Figure 6-3.

Figure 6-3: Delivery Group Membership

Name	Organisation	Role
Tom Clark	BSMHFT	Clinical Director
Matt Thomas	BSMHFT	Operational Project Lead
Marimouttou Coumararassy	BSMHFT	Project Lead
Margaret Dalton	BSMHFT	HR Lead
Steve Clayton	BSMHFT	Programme Management Office
Marie Walker / Nicola Bradley	BSMHFT	Occupational Therapist Lead
Caitlin Anderson	BSMHFT	Psychologist Lead
Tim Hamilton	BSMHFT	Communications Lead
Donna Thomas	BSMHFT	Expert by Experience Lead
Margaret Dalton	BSMHFT	HR Lead
Renarta Rowe	BSMHFT	Hillis Lodge Lead
Simon Parkes	Summerhill Services Ltd	Estates Lead
Harstephen Nagra	BSMHFT	Finance Lead
Ebru Oliver	BSMHFT	Reach Out Lead
Jo Deeks	BSMHFT	Pharmacy Lead
Neil Hathaway	Summerhill Services Ltd	Estates Lead

Workstream Groups

The Delivery Group is responsible for implementing the work stream group packages:

- **Built Environment Group** – focus on design and build of the project including: ensuring project build adherence to current standards (fire regulations and security requirements), ordering equipment, signing off plans and delivery of model plans that support the delivery of the building.
- **Clinical Reference Group** – tasked with reviewing current clinical model to ensure that it is fit for purpose for the new building. Review operational policies to ensure fidelity to the model.
- **Stakeholder Group** – ensure that those affected by the changes are communicated with (internally within the Trust, External partners, local community).
- **Financial Group** – oversee the project spend, confirm capital and revenue implications and provide due diligence and financial assurance.

Throughout the various groups and at different stages within the project lifecycle the following groups will be incorporated:

- **Expert By Experience Group –** Establish consistent patient and carer representation at meetings. Ensure there is an engagement plan for the wider patient and carer group affected by the project. Identify appropriate engagement with the built environment group and the Clinical Reference group.
- **Staff Group** - Establish consistent staff representation at meetings. Ensure there is an engagement plan for the wider staff group affected by the project. Identify appropriate engagement with the built environment group and the Clinical Reference group.

6.2 Project Management Methodology and Arrangements

Robust project management arrangements are in place to drive programme and project delivery.

The structure of the programme has been developed to follow the principles set out in the NHS Capital Investment Manual and the HM Treasury Green Book, supported by PRINCE2 project management principles.

All project management and consultancy services, and project management methodology are as set out in the NHS Shared Business Services framework - Construction Consultancy Services upon which all delivery services have been secured.

6.3 Project Team Roles & Responsibilities

Key Project Roles

The Senior Responsible Owner (SRO) and Programme Sponsor is David Tomlinson, Executive Director of Finance, BSMHFT.

David joined the Trust as Executive Director of Finance in April 2017. David brings 20 years' experience as a Director of Finance in the NHS, the vast majority of which has been with large mental health providers. He plays a key role in advising the Board on issues around the Trust's fiscal performance, information governance and estates. David's experience includes 12 years as Director of Finance at Lancashire Care NHS Foundation Trust where he established the Trust as a £100m turnover provider by bringing together services from seven organisations, led the acquisition of a number of services and established a commercial and property management joint venture that delivered savings of £1m per annum. He has experience in both the private and public sector and during his career has been responsible for a broad portfolio of services in large and complex organisations.

The project SRO is accountable for the success of the programme ensuring that the outcomes meet declared objectives and deliver benefits. The SRO will ensure that the programme maintains business focus in a changing healthcare context and that risks are managed effectively. The key roles and responsibilities of the SRO are to:

- Take responsibility for the information contained in the Project Workbook
- Provide input into the development of the Project Brief, business case and Project Initiation Document (P.I.D)
- Secure funding from the appropriate Trust committee for the project
- Present the business case/P.I.D/Project Brief at meetings to committees and boards as appropriate
- Ensure that there is a coherent project team structure and logical set of plans
- Authorise expenditure and proposed tolerances
- Ensure that risks and issues are validated
- Approve the Programme report

- Approve the project plan
- Take responsibility for use of resources and authorise corrective action where necessary
- Liaise with the PMO Lead to assure the overall direction and integrity of the project
- Liaise with the finance lead to ensure costs and savings are captured and monitored accordingly
- Ensure that the benefits have been realised by holding a review and forward the results of the review to the programme board
- To actively participate and input in the formal project closure process, as directed by the PMO lead

6.4 Use of External Advisors

External Programme Roles

Delivery of the preferred option will require the appointment of direct external appointments to support the internal Programme Team. The key appointments include the external Project Manager, Cost Advisor, Architect, Health Planner and other Construction / Engineering disciplines.

Current appointments are as shown at Figure 6-4.

Figure 6-4: SOC External Advisors

Name	Project Role
AA Projects	Business Case Consultant Healthcare Planner
Design Buro	Architect DQI Assessor
RSK	BREEAM Advisor

Costs of Project Implementation

The costs associated with internal fees and contractor fees are included in the OB forms, which are included at Appendix 3-C.

The total fees are calculated at £8.8m or 20.9% (excluding inflation beyond the reporting index PUBSEC 250) and include the following:

- Contractor management
- Architectural, interior design, healthcare planning, M&E, structural design fees
- BREEAM Consultant fees
- Business case author fees
- Project management fees

- Cost management fees
- CDM Co-ordinator fees
- Survey fees
- Internal fees (see Appendix 6-B for a complete list)

6.5 Project Delivery Programme

Figure 6-5 summarises the key milestones for the successful planning and delivery for the Reaside and Hillis Lodge project. The programme provides a more detailed milestone delivery (Appendix 6-C). This shows an anticipated operational date of 2026.

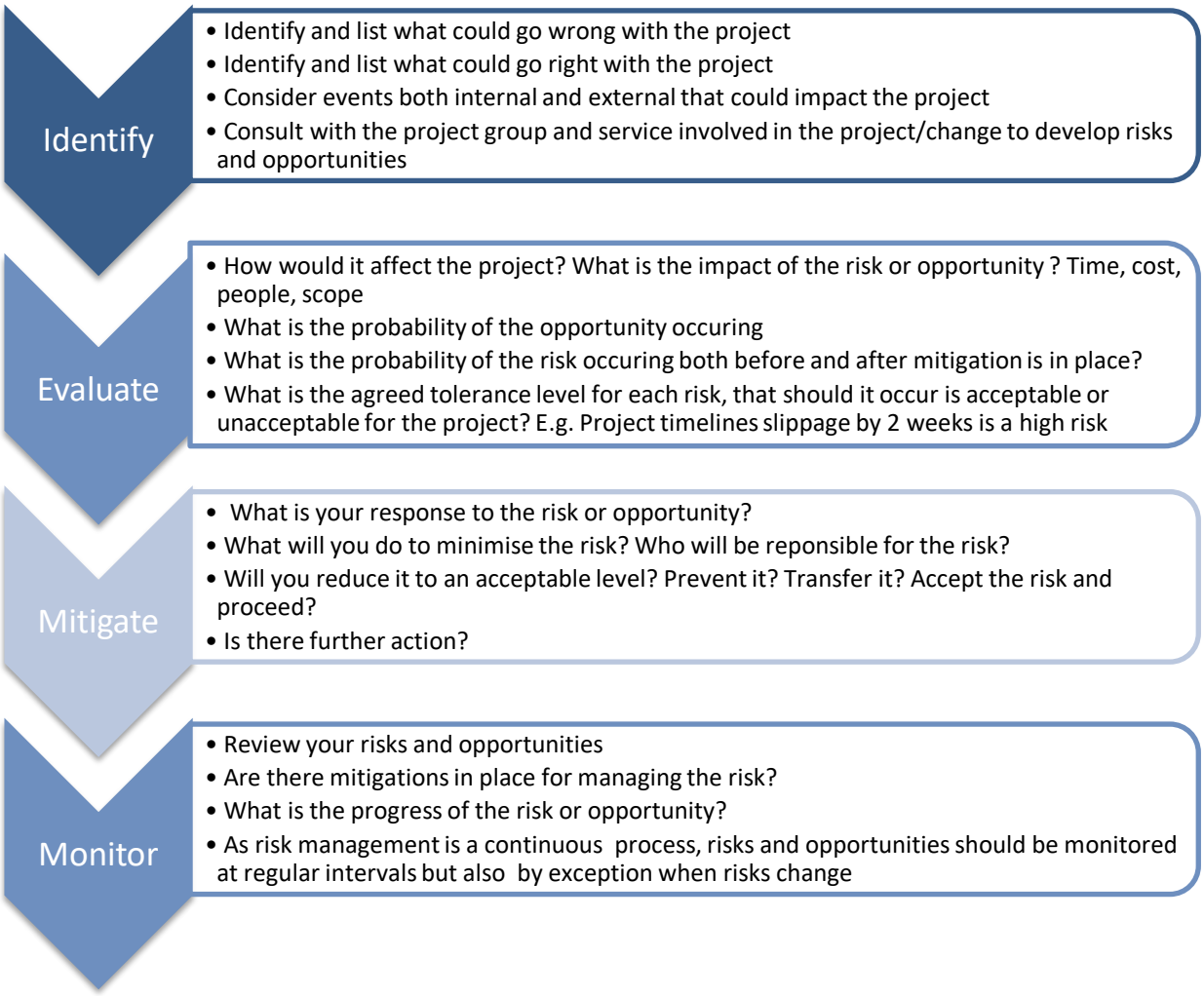
Figure 6-5: Summary Programme

Programme Stage	Completion Date
SOC approval (external)	November 2021
OBC approval (external)	September 2022
FBC approval (external)	June 2023
Start on site	December 2023
Construction completion	June 2026
Operational date	August 2026

6.6 Risk Management Strategy

Risk management for the project will enable the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of negative effects or to maximize the realization of opportunities. For risk management to be effective risks need to be identified, assessed and controlled and the process needs to be visible, repeatable and consistent. It is the role and responsibility of the project group to ensure that risks and issues are highlighted and raised through the project lead and Senior Responsible Owner. The process for identifying and managing a risk or opportunity is illustrated at Figure 6-6.

Figure 6-6: Risk Identification Process



The risk mitigation process as a means to reduce either the probability or consequences of a threat is described in full at Appendix 6-D, as is the scoring matrix. Depending on the residual score higher level risks will be escalated in line with the escalation policy detailed at Appendix 6-D.

Risk Profile Assessment

All significant public sector projects are required to complete the Health Gateway Review assurance process of detailed peer review and assessment at key stages or gateways. The requirement to register a project for formal review is based upon an initial Risk Potential Assessment (RPA). The RPA has been completed at a project level (see Appendix 6-E). This shows that the project is rated as a Medium risk. The project will be subject to agreed internal assurance processes. The project will not be subject to a separate RPA process. At this stage the senior stakeholders have agreed there is no requirement for an external assurance review but this decision will be further revisited at OBC stage.

High Level Risks

A risk register has been developed for the project. The current higher rated risks are summarised in Figure 6-7.

A copy of the risk register is included at Appendix 6-F. This will be subject to regular risk workshops.

Figure 6-7: Higher Rated Risks

Ref	Risk Description	Rating	Mitigation
7	Insufficient contractor tenders for the project caused by size of project, current market, Covid-19, BREXIT impact leads to delay to construction and increased costs.	12	Early market testing and quantity surveyor to give regular updates on current market demand, pricing and demand. Split contractors across developments (Reaside and Higcroft), although supply chain and sub contractors may be the same.
8	There is a risk that external economic conditions change leading to increased cost through government policy and/ or changes to law, VAT, commodity price change, inflation, BREXIT etc.	12	Maintain awareness of external economic factors and alert team to any potential issues. Options to mitigate any cost increases to be explored, including: minimising the tax costs associated with the scheme; liaising with NHSI on responsibility for any inflation liability.
12	Insufficient resources in BSMH/SSL to properly manage the projects.	12	Resourcing levels and requirements will be continually monitored throughout the duration of the programme to ensure early warning is made to Programme Boad in regard to any potential resourcing issues. Resource needs for project lifecycle are being collated which will give the Trust a clear idea of resource and capacity.
18	Other Trust initiatives which could adversely impact on the project.	12	A clear governance structure and protocols have been put in place to ensure that Trust initiatives are identified and communicated in a timely manner and other Trust initiatives have already been identified and will be monitored for any potential effect they may have. Identify workstreams and ensure resources to support. Escalation to board for decision.
21	There is a risk to the Trust finances and reputation if the Trust fund the project(s) without STP (Sustainability and Transformation Partnership) funding.	12	This cannot currently be mitigated against until it is known how the project will be funded and whether the STP (Sustainability and Transformation Partnership) funding has been secured or is still available. This is likely to be at 2021 at the earliest.
26	There is a risk that the construction company get into financial difficulties.	12	A thorough due diligence process will be completed as part of the procurement process to mitigate this and ensure the contractor has sufficient insurance policies.
31	There is a risk that the capital figure submitted to NHS E/I will be used and the Trust held to this figure	12	Design costs, optimism bias, contingency, inflation, VAT, etc have all been added to the capital figure in order to add a degree of tolerance. The costs are summarised on the Cost Summary forms submitted to NHS E/I.
32	There is a risk with the Reaside development that any time pressures will increase the cost of keeping the current building operational due to the age and condition of the current provision.	12	Review business contingency plans for current Reaside provision. Place measures in place such as back-up generators, back-up hot water system boilers, critical spares, and continue servicing and maintaining all aspects of the premises including building and engineering components.
34	There is a risk that any external awarding of funds may include a caveat around meeting specific timescales.	16	At present this risk will need to be accepted until the Trust know whether this will be the case. If required timescales will be reviewed and where necessary, appropriate and agreed timelines could be amended.
36	There is a risk that external influences may require the Trust to go down the P22 procurement route.	12	The decision and rationale for the chosen route will be articulated with the business case and any decision will be approved at programme board.
38	There is a risk around the transition from the current Reaside building to the new development.	12	Transition planning and associated timescales and phasing will be captured within the transition plan. Patient moves will be clinically led and planned.

6.7 Benefits Realisation Planning

Benefits Planning

Benefits planning and realisation is being developed in accordance with NHSE/I requirements.

The Benefits Realisation Strategy will provide an evidence base to support the intended health, quality, financial and other identified benefits, where that evidence exists, and to quantify the benefits, wherever possible, to ensure that they can be measured and demonstrated over time. The Benefits Realisation Plan (BRP) will include detailed benefits which will be realised as a result of the acute programme implementation. The BRP will detail:

- Key deliverables required to secure the benefit
- Performance measure
- Baseline and Baseline date
- Target outcome
- Data source
- Officer responsible for ensuring benefits are realised
- Benefits measurement timescale
- Risks to benefit delivery
- Benefit dependency

The communication and use of this strategy will help ensure that there is a shared understanding across the project team, workstreams and stakeholders of the process of benefits management and realisation in relation to:

- The approach to benefits planning, which includes how benefits are identified, defined, measured, recorded and prioritised
- The functions, roles and responsibilities of those involved in benefits planning and benefit realisation
- When and how reviews and assessments concerned with measuring benefit realisation will be carried out, and who is to be involved
- Measurement methods and steps that will be used to monitor and assess the realisation of benefits
- The tool(s), system(s) and source(s) of information that may be used to enable benefit measurement
- The use and definition of any benefits management terminology that is specific to the Project.

The realisation of benefits will in most cases continue beyond project closure and into benefits realisation. The management activities for outstanding/incomplete benefits will transfer from the

Programme Management Office to the Benefit Owner and be accountable to the Associate Director or appropriate manager of the service area where the benefit will be delivered. This process is captured in the Programme Management Office Closure Report.

The benefit owner will remain with the benefit and be responsible for the continual reporting of benefit performance information for the purpose of monthly Business Plan Return reports and service area quarterly planning and performance reviews.

A summary of the benefits that will be realised as a consequence of this redevelopment project are set out in Figure 6-8. The assumptions relating to these benefits and their data sources are included in the CIA model at Appendix 3-B. This will be further developed as part of the development of the OBC.

Figure 6-8: Benefits Summary

Ref.	Benefit Name	Benefit Description	IO Ref.	Calculation of benefit	Equivalent Annual Benefit £'000
CRB1	Reduction in Recruitment Costs	Reduction in annual Trust cost of recruitment through scheme intervention.	IO5 – To improve environment	Average annual Staff turnover for 2019/20 - 2020/21 = 28 leavers. Assuming an annual reduction of 5% through scheme intervention, staff turnover would be reduced by 1.4. Assuming an average cost of recruitment at £3,000 per staff = an annual saving of £4,231. Option A realises full benefit and Option B realises 50%. Due to known issues with recruitment at the Tamarind site, should this option be pursued it is estimated that staff turnover would increase. As a result no benefit is realised on this option.	£3,617
NCRB 1	Reduction in Incidents - Patient on Patient	Reduction in patient on patient incidents reported through the Trust's safeguarding system for incident reporting.	IO5 – To improve environment	Average annual number of patient on patient incidents from 2019-2021 = 38 Incidents. Average cost of incident from ELFT study (Benefit Source Ref. 3.0) reported at £3,399. Cost built up from medication, legal, response team costs etc. Assumed total annual incident reduction of 10% for Option A resulting in 3.8 less incidents per year at a cost saving of £12,916. Option A and Option C realise 100% of Benefit, Option B realises 50%.	£12,916
NCRB 2	Reduction in Incidents - Patient on Staff	Reduction in patient on staff incidents reported through the Trust's safeguarding system for incident reporting.	IO5 – To improve environment	Average annual number of patient on staff incidents from 2019-2021 = 133 Incidents. Average cost of incident from ELFT study (Benefit Source Ref. 3.0) reported at £3,399. Cost built up from medication, legal, response team costs etc. Assumed total annual incident reduction of 10% for Option A resulting in 13.3 less incidents per year at a cost saving of £45,207. Option A and Option C realise 100% of Benefit, Option B realises 50%.	£45,207
NCRB 3	Reduction in Incidents - Self Harm and Patient Behaviour	Reduction in incidents resulting in self-harm and patient behaviour reported through the Trust's safeguarding system for incident reporting.	IO5 – To improve environment	Average annual number of self harm and patient behaviour incidents from 2019-2021 = 51 Incidents. Average cost of incident from ELFT study (Benefit Source Ref. 3.0) reported at £3,399. Cost built up from medication, legal, response team costs etc. Assumed total annual incident reduction of 10% for Option A resulting in 5.1 less incidents per year at a cost saving of £17,165. Option A and Option C realise 100% of Benefit, Option B realises 50%.	£17,165
NCRB 4	Reduction in Incidents - Property Theft, Loss of Damage	Reduction in incidents resulting in damage, theft or loss of property reported through the Trust's safeguarding system for incident reporting.	IO5 – To improve environment	Average annual number of incidents resulting in property theft, loss or damage from 2019-2021 = 27 Incidents. Average cost of incident from ELFT study (Benefit Source Ref. 3.0) reported at £3,399. Cost built up from medication, legal, response team costs etc. Assumed total annual incident reduction of 10% for Option A resulting in 2.7 less incidents per year at a cost saving of £9,007. Option A and Option C realise 100% of Benefit, Option B realises 50%.	£9,007
NCRB 5	Reduction in Healthcare Acquired Infection (HCAI)	Reduction in major infection control incidents leading to HCAI through improved environment.	IO3 - To provide services in a 21st Century healthcare facility	3 Major Infection Control incidents occurred between 2016-2018, 2 Scabies, 1 Flu resulting in the closure of 3 wards (Scabies 1 - 14 bed ward - 2 week closure (Scabies 2 - 13 bed ward - 2 week closure (Flu 1 - 14 bed ward - 1 week closure))). Multiplying bed numbers by average occupancy and closure length = 455 bed days lost at a cost of c£225,000 (£495 ref bed day cost for medium secure). Additional staffing/cleaning cost for this period equates to 9 FTE for full closure period at £20 hourly rate = c.£50,000 total cost. Assuming a 50% reduction in incidents due to scheme intervention, total bi-annual saving of = £137,826. Option A and C realise 100%, Option B realises 50%.	£68,913

Ref.	Benefit Name	Benefit Description	IO Ref.	Calculation of benefit	Equivalent Annual Benefit £'000
NCRB 6	Reduction In Agency/Bank Spend	Reduction in Trust Agency/Bank spend.	IO5 – To improve environment	Average annual bank/agency filled shifts for 2019/20 - 20/21 = 10,096. Applying a blended hourly rate for Bank at £20.94 and Agency at £19.23 and assuming an average shift length of 7 hours, total annual cost of Agency/Bank = £1,584,696. Assuming a reduction in required bank/agency filled shifts of 3.5% for years 1-3 post construction for Option A and 7% thereafter, at an annual saving of c.£55,000 years 1-3 and c.£110,000 thereafter. Option A and Option C realise full benefit and Option B realises 50%.	£55,464
NCRB 7	Reduction in Staff Sickness	Reduction in sickness absence associated with violence and aggression and injury at work as a result of the environment, and burnout, by providing an environment that enhances the safe offer of a wider range of interventions to manage violence and aggression.	IO5 – To improve environment	Total average annual FTE days lost to staff sickness for 2019/20 - 2020/21 = 7736. Assuming an average day length of 7.5 hours, the average annual lost hours to staff sickness = 58,021. Using a blended hourly rate for Trust staff at £20 the total cost of staff sickness to the trust = c.£1,100,000. Assuming a reduction of 3.5% in total staff sickness for years 1-3 and 7% thereafter, at an annual saving of c.£40,000 Y1-3 and c. £80,000 thereafter. Options A and C realise full benefit and Option B realises 50%.	£40,614
NCRB 8	Reduction in Patient Length of Stay	Reduction in patient LoS through improved quality of care, additional space for wider ranges of interventions and better flow through the system	IO2 - To provide a therapeutic and rehabilitative environment in-line with national secure/environmental standards.	Average LoS for Hillis and Reaside between 2017-2021 = 702.1 days (918.3 Hillis, 485.9 reaside). Assuming a 15% reduction in LoS through scheme intervention results in an LoS reduction of 105.3 days per patient. 105.3 multiplied by total bed numbers of 123 post construction = total bi-annual LoS reduction of 12,953 days or an annual LoS reduction of 6,476.8 days. From a care hour perspective, this equates to 155,444 annual care hours that could be redirected to "new" patients that would otherwise have been spent on the BAU patient LoS. Using a blended hourly rate for staff bandings 2-9 and including a blended rate for shifts with enhancements of £26.66 per hour = a total annual care-hour saving of £4,143,613.47. Option A and C realise full benefit, Option B realises 50%.	£4,143,613
NCRB 9	Reduction in Out of Area Placements	Reduction in Out Of Area (OOA) placements through repatriations of existing OOA patients and reduced need to seek future OOA placements with increased bed capacity in area.	IO4 - Meets demand and capacity requirements and reduces the requirement for Out Of Area placements.	Annual Length of Stay for OOA Placements between 2017-2021=861 days. Average number of annual placements in the same period = 15.4. Assuming a reduction of 15% in terms of OOA Length of Stay through not having to seek OOA placements and through repatriation of existing OOA placements results in a saving of 122.5 patient bed days. Using a cautious reference cost for OOA bed days at £600 multiplied by 122.5 patient bed days = c.£73,485 per patient. Multiplied by the average annual OOA placements at 15.4 = Bi-Annual saving of c. £1,131,669. Option A and C realise full benefit, Option B realises 50%. Post year 10 in Appraisal, the Trust are required to place an additional 46 patients OOA. Using the same methodology as above, this increases the benefit of the preferred option to 46 patients multiplied by average LoS of 816.5 days multiplied by £600 reference bed day cost for a total cost of c.£30million, assuming a 15% reduction in LoS through scheme intervention results in an annual cost saving of £4,511,979 applied bi-annually from years 10-60. Options A and C realise full benefit, Option B realises 50%.	£565,834
NCRB 10	Reduction in Delays in Transfer of Care	Reduced delays in Transfers of Care through improved patient flow with access to wider range of interventions and bed modeling.	IO1 - To develop a whole-systems approach, reducing gaps in service and	Average Length of Stay for Reaside and Hillis Lodge Patients between 2017-2021 = 485.9 days (Reaside) 918.3 days (Hillis Lodge) and 816 (OOA). Assuming 4.7% of total bed days are attributable to Delays in Transfer of Care (DiTC), the total bi-annual LoS attributable to DiTC = 104.4 days (43.2 Hillis, 22.8 Reaside, 38.4 OOA). Applying reference costs for medium/low/OOA bed days (£497 & £395 & £600) and multiplying by bed occupancy between 2017-2021 (14.58 Hillis, 87.95 Reaside, 15.4 OOA (Reaside catchment areas only OOA)) = Total Bi-Annual cost of DiTC of c. £1,601,397 (c.£1m	£240,209

Ref.	Benefit Name	Benefit Description	IO Ref.	Calculation of benefit	Equivalent Annual Benefit £'000
			delayed transfers of care	Reaside, c.£200,000 Hillis c.£354,000 OOA). Assuming a reduction in DiTC of 15% = total saving of c.£240,000. Option A and Option C realise full benefit, Option B realises 50%. From year 10 in the appraisal, the Trust are required to place an additional 46 patients OOA. At this point the same methodology as above is used, only bed day occupancy for OOA is increased resulting in an annual increase in cost for DiTC for OOA placements from £354,000 to c.£1.41m, assuming the 15% reduction remains this increases the benefit from year 10 from £240,000 to £399,048	
SB1	Reduced Time for patient attainment of Improvement in Quality Adjusted Life Year (QALY) score	Increased speed of attainment of improved QALY scores through improved quality of care, additional space for wider ranges of interventions and better flow through the system	IO2 - To provide a therapeutic and rehabilitative environment in-line with national secure/environm ental standards.	Health of the Nation Outcomes Score (HoNOS) questionnaires have been assessed for 3 patients on admission and discharge from Reaside which ranks 7 security scales and 12 other scales 0-4 for a total HoNOS score of 76. The average improvement of the three patients between admission and discharge equates to a QALY improvement of 0.27 (P1 = 0.37, P2=0.24, P3=0.21). With a QALY score of 1 equating to an annual value of £60,000, the 0.27 improvement equates to a full year value QALY of £16,315. Applying the LoS benefit methodology assuming a 15% reduction in LoS per patient (104.7 days/0.29 years) results in the QALY improvement being realised 0.29 years earlier post scheme intervention. Multiplying the 0.29year improvement in attainment of QALY by the full improvement value £16,315 results in a QALY value per patient per year of £4,652. Multiplying this value by the increased bed capacity at Reaside of 123 results in an annual QALY benefit of £572,197.42. Option A and C realise full value benefit Option B realises 75%.	£489,261
SB2	Reduction in Travel Times Saving	Reduced travel time requirement for carers, family and friends to visit OOA patients through repatriation of existing OOA placements and increased bed provision.	IO4 - Meets demand and capacity requirements and reduces the requirement for Out Of Area placements.	Utilising the DfT Transport Analysis Guidance methodology, four cost data points have been identified for quantification of this benefit; cost of Travel time per vehicle, cost of travel time per vehicle, fuel and electricity prices and components and non-fuel resource vehicle operating costs. An average of the 42 placements in terms of distance and time has been used year 10 onwards to assess average distance for additional distance of OOA placement for the 46 further OOA placements made under the BAU option at this point. Assuming each OOA placement is visited twice a month/24 times a year the total travel time has been used to calculate the four cost data points and adjusted year on year to reflect inflation etc In order to reasonably reflect the fact that delivery of the scheme does not completely remove the requirement for travel for visitation (although it significantly reduces it) and accounting for the fact that in area placements are likely to result in more visitations due to closer proximity, 80% of the total cost has been used as the benefit of Option A, B & C.	£134,768
UB1	Improvement In Trust Performance - CQC Ratings	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to CQC.	IO2 - To provide a therapeutic and rehabilitative environment in-line with national secure/environm ental standards	N/A	0
UB2	Improvement in Trust performance - National	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose,	IO2 - To provide a therapeutic and rehabilitative environment in-	N/A	0

Ref.	Benefit Name	Benefit Description	IO Ref.	Calculation of benefit	Equivalent Annual Benefit £'000
	Standards for Mental Health	thereby improving Trust performance in regards to National Standards for Mental Health	line with national secure/environm ental standards		
UB3	Improvement in Trust Performance - Royal College of Psychiatrists Quality Forensic Network Scores	To improve the safe and effective care delivered to patients that reduces restrictive practices and ensures that premises are fit for purpose, thereby improving Trust performance in regards to the Royal College of Psychiatrists Quality Forensic Network Scores	IO2 - To provide a therapeutic and rehabilitative environment in-line with national secure/environm ental standards	N/A	0
UB4	Improvement in Staff/Patient Experience and Satisfaction	Improve the wellbeing of staff by facilitating a working environment that is safe and supports their wellbeing outcomes through improved physical and psychological safety.	IO5 – To improve environment	N/A	0
UB5	Improved STP/ICS Partnership Working	Improved NHS system working through the development of the Reach Out Model of Care and associated improvements in referrals and bed management.	IO1 - To develop a whole-systems approach, reducing gaps in service and delayed transfers of care	N/A	0
UB6	Introduction of Technology	Improved security and quality of care outcomes through introduction of modern technology - key/door management, improved access to digital technology with infrastructure in place to support.	IO3 - To provide services in a 21st Century healthcare facility	N/A	0

6.8 Outline Arrangements for Change Management and Contract Management

This project will adhere with the PMO change management process for Business Change Requests. The process provides a framework and mechanism for enabling consideration to be given to proposals for change to project scope.

The PMO will take responsibility for reviewing Business Change requests and advising on where further information may be required. The Strategy and Transformation Management Board will take responsibility for reviewing and approving Business Change Requests. Any deviation to the Trust's processes will be reported via an exception report that will be tabled for review and approval at the Strategy and Transformation Management Board.

Change management will be managed through a tiered approach:

- Where the Trust requests a change to the scope or a significant variation to specification which has a cost impact, the Steering Group will seek assurance, where possible, that the additional costs can be offset by value engineering.
- Where the Trust requests a change to scope or significant variation to specification that will add additional cost to the project, a Business Change Request (BCR) will be used as the mechanism for seeking approval for the change from the Strategy and Transformation Management Board. This can be escalated directly to the Executive Director of Finance for timely approval.

Where there is an emergent variation to specification where works cannot proceed until the issue is resolved, these project controls mandate that the project team have authority to progress the necessary work. Where the cost for these works are within the project budget the Steering Group will be notified in line with contract variation process. Where the cost for these works will add additional cost the Executive Director of Finance will make a decision and the Business Change Request will be completed retrospectively and shared with the Executive team.

Where a formal Business Change Request is raised and approved, the financial profile will be refreshed in the Business Case and Project Initiation Document to reflect the cost implication.

Contract Management

The contract management strategies employed will include the appointment of a Principal Contractor and subsequent works package contractors under the procurement processes described above using the Joint Contracts Tribunal (JCT) suite of contracts (on the assumption that the Trust proceeds with a traditional form of procurement; this assumption will be further tested at OBC stage). The contracts will be up to date of all NHS amendments, contractors' insurance obligations, sectional completion clauses, retention provisions and liquidated and ascertained damage implications.

The PMO will be responsible for the contract management of specialist external advisors.

Interdependencies Management

This project will follow the PMO Interdependencies management process. This will require that dependencies between projects under the remit of the Strategy and Transformation Management Board are mapped out, tracked, managed and reported upon to the Strategy and Transformation Management Board. Other known interdependencies that fall outside of the remit of projects under the Strategy and Transformation Management Board be referenced in the Project Initiation Document and project workbook and will be included in the report to the Strategy and Transformation Management Board.

6.9 Stakeholder Engagement and Communications Strategy

A Stakeholder Engagement and Communications Strategy has been produced for the project (see Appendix 6-G) which sets out the communication and engagement objectives and describes how the Trust will work together to communicate and engage by identifying target audiences, key messages and appropriate channels. It also describes the resources required to deliver the strategy and how the Trust will manage the communications and engagement risks.

Communications and Engagement Objectives

The Trust's communications and engagement objectives are:

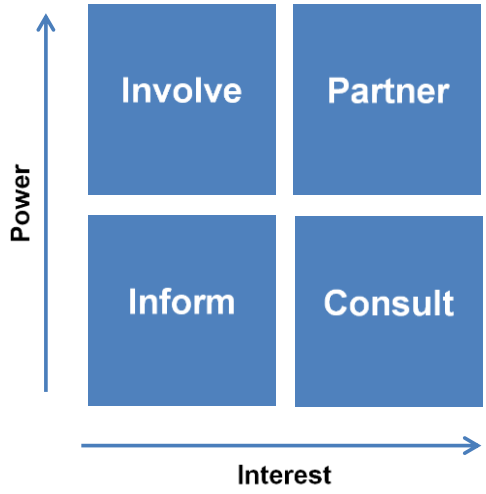
- To ensure that staff at Reaside, Hillis Lodge and the wider Secure Care and Offender Health service area are fully engaged with and able to participate in the development of the Reaside site.
- To provide a realistic timeline and reassurance of the Trust's commitment to this development, to address a degree of scepticism amongst staff following a number of previous 'false starts'.
- To inform all Trust staff about key developments and benefits.
- To ensure that all stakeholders are appropriately and regularly involved, engaged and informed about the work we are doing, the case for change and the benefits that will be realised through the development of Reaside. This will work on the principle of 'no surprises'.
- To work with our patient engagement team and Reaside management to build meaningful and two way communication and engagement with service users, carers to ensure that they have a genuine opportunity to influence the planning, development, design, production and evaluation of services.
- To ensure that equality, diversity and inclusion is considered and promoted in all communications and engagement activities, given the inequalities present in secure care settings and over-representation of BAME service users, and the Trust's commitment to improve equality, diversity and inclusion for service users, carers and staff.
- To ensure that the public, particularly local residents and communities, are informed and engaged about the development and have opportunities to provide feedback.

- To promote the development, both locally and nationally, as a state of the art facility that will have a positive impact on quality of care and service user recovery and rehabilitation, and in doing so grow and enhance the reputation of the unit, the Trust and Reach Out.
- To promote Reaside as a great place to work with a positive staff experience and a wide range of career development opportunities.
- To support the Reach Out partnership through joint communication and engagement and promotion of the partnership, its objectives and achievements, through our communications and engagement activity.

In line with external advice received it is noted that the Trust's Executive Director of Finance has confirmed that, following discussions with legal advisors, NHS England and the ICS, there is no requirement for a formal public consultation for this project. This Communications and Engagement Strategy has been established on this basis. There remains a need to evidence appropriate levels of communications and engagement with all relevant audiences, in line with best practice.

Stakeholder mapping will allow the Trust to determine the appropriate messages, timing, channels and resources to communicate and engage with each audience, broadly segmented as shown at Figure 6-9.

Figure 6-9: Stakeholder Influence Mapping



- **Partner – high power, interested:** requires individually tailored communications. It is important that their involvement is encouraged throughout the programme as a good relationship with them is essential to the successful recognition and positioning of the programme.
- **Involve – high power, less interested:** It will be beneficial to provide this group with general information on a regular basis as it is possible that the interest of stakeholders within the group could grow as the programme progresses.
- **Consult – low power, interested:** whilst not considered high power, without involvement from this group the successful delivery of the project is at risk. It is

therefore important that this group feel their opinions, concerns and ideas are heard and understood.

- **Inform – low power, less interested:** Whilst not essential to the success of the programme, this group will be extremely valuable in enabling access to a wide range of further stakeholders. They should therefore be kept informed and use of existing mass communications channels is often the best method to update this group on key developments.

A high level stakeholder map for the Reaside development is at Figure 6-10. This will be further developed and reviewed with the involvement of the Delivery Group.

Figure 6-10: Stakeholder Map

Involve	Partner
• Secure care staff more widely • Governors • Senior leaders • Birmingham and Solihull and other West Midlands STPs • Local healthcare partners • Local MPs and councillors • Third sector partners • Criminal justice system partners • Local residents and neighbouring organisations and businesses	• Reaside and Hillis Lodge staff • Reaside and Hillis Lodge service users, carers and families • Executive Team • Board members • Reach Out partners • NHS England/Improvement • Health and Wellbeing Board • Health Overview and Scrutiny Committee • Local authority planners
Inform	**Consult**
• Foundation Trust members • Wider staff in Reach Out partner organisatons • Other Trust stakeholders • Local and national media	• Schools • Colleges • Community organisations • Trade media

Power

Interest

Appendix 6-G summarises the key messages of communications and the channels of communication appropriate to each stakeholder group.

6.10 Business Continuity Planning

The Delivery Group recognises the need to adequately plan to ensure business continuity during the development and delivery processes for the new facility. Appendix 6-H includes a draft business continuity plan which will be further developed during OBC and FBC stages.

6.11 Post Completion Review / Project Evaluation Planning

BSMHFT is committed to the full evaluation of all major schemes and projects through a formal evaluation methodology in line with the requirements of NHSE/I's Post Project Evaluation (PPE) guidance.

The Programme Team will complete an NHSE/I-format PPE report c. 12 months of scheme completion. The evaluation will also encompass the evaluation of the scheme whilst in construction.

The objective is to prepare a report which assesses how well and effectively the scheme was managed during the initial operation of the new facility.

In line with the guidance the programme will be evaluated against the investment objectives set out in this SOC and the processes involved in the programme delivery. In summary:

- Lessons will be captured throughout a project lifecycle and published and declared at project completion (to inform subsequent projects on a rolling basis);
- Formal evaluation of alignment with business case and user expectations will be completed within twelve months of project completion;
- An annual declaration of cumulative activity and evaluations will be declared to the Programme Board; and
- A final consolidated PPE will be produced and published at Programme Closure.

The aim of the PPE is to:

- Improve the design, organisation, implementation and strategic management of other projects.
- Ascertain whether the project has been running smoothly so that corrective action can be taken if necessary.
- Promote organisational learning to improve current and future performance.
- Avoid repeating costly mistakes.
- Improve decision-making and resource allocation (e.g. by adopting more effective project management arrangements).
- Improve accountability by demonstrating to internal and external parties that resources have been used efficiently and effectively.
- Demonstrate acceptable outcomes and/or management action, thus making it easier to obtain extra resources to develop healthcare services.

In addition a Post Completion Report will be completed, using NHSE/I format, within 6 months of practical completion of the new facility. The process will be over seen by the Programme Management Team.

The lessons learnt will be of benefit to:

- The Trust – in using this knowledge for future projects including capital schemes.
- Other key local stakeholders – to inform their approaches to future major projects.

The programme will be evaluated using the following topics:

- Revisiting the strategic context

- Investment decision
- Procurement
- Project management and implementation
- Organisational impact and change management
- Outcome and impact
- Lessons for future projects
- Post-occupancy evaluation
- Approvers' input
- External support

These investigations will focus on three groups:

- Patients / Service Users / Clinical Users – for their views on the design of individual projects met their clinical needs and to confirm that Project Plans ensured minimum disruption to clinical services;
- Programme and Project Teams – for their views on the overall project from planning through the building phase and ultimately to commissioning and handover.
- Service commissioners and approvers – for their views as to the delivery of their stated commissioning requirements.

The assessment and views of the above groups will be sought using appropriate methodologies. The project evaluation process will set in place a framework within which the BRP can be tested to identify which of the identified benefits associated with the programme have been achieved and which have not as well as any additional benefits not yet identified.

The Evaluation Teams have not been confirmed but will have full representation from Estates, Facilities, Finance, Operations, Clinical Teams, patients, staff and users, as well as the contractor team and other relevant external advisors.

6.12 Chapter Appendices

Appendix Number	Appendix Title
6-A	Reaside & Highcroft Project Board Terms of Reference
6-B	Internal resource
6-C	Programme
6-D	Risk Strategy
6-E	Risk Potential Assessment (RPA)
6-F	Risk Register
6-G	Communications and Engagement Strategy
6-H	Business Continuity Plan

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

This Strategic Outline Business Case document provides a compelling case for the investment in the redevelopment of medium and low secure services. This SOC demonstrates:

- The strategic need for change in line with national, local and organisational drivers;
- The proposed delivery model and scope of the project, together with projected demand and capacity analysis;
- The preferred commercial strategy, comprising procurement and contract;
- The capital and revenue consequences of the options set in the context of an affordability analysis (based on a capital expenditure of £90.8m); and
- Detailed plans for the governance and management of the implementation of the project.

7.2 Recommendations

The Strategic Outline Business Case is being presented to the Trust Board in July 2021 with a request to:

- APPROVE the strategic fit within the context of BSMHFT;
- APPROVE the identification of the preferred way forward;
- APPROVE the commercial viability and feasibility of the programme;
- NOTE the anticipated financial impact assessment on BSMHFT's financial standing;
- APPROVE the planned capital investment of £90.8m including VAT; and
- APPROVE the Strategic Outline Business Case and progression to development of the Outline Business Case.

8.0 GLOSSARY OF TERMS

Acronym	Full Title
BAU	Business as usual
BCR	Benefit Cost Ratio
BRP	Benefits Realisation Plan
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIAM	Comprehensive Investment Appraisal Model
CQC	Care Quality Commission
CRB	Cash Releasing Benefit
CSF	Critical Success Factor
DHSC	Department of Health and Social Care
DQIfH2	Design Quality Indicator for Health 2
EIA	Equality Impact Assessment
FBC	Full Business Case
FIRST	Forensic Intensive Recovery Support Team
FM	Facilities Management
FT	Foundation Trust
FY	Financial Year
HBN	Health Building Notes
HTM	Health Technical Memorandum
HWB	Health and Wellbeing Board
ICS	Integrated Care System
LOS	Length of Stay
LSU	Low Secure Unit
LTP	Long Term Plan
MMC	Modern Methods of Construction
MSU	Medium Secure Unit
NCRB	Non Cash Releasing Benefit
NHS	National Health Service
NHSE/I	National Health Service England & Improvement
NPV	Net Present Value
NZC	Net Zero Carbon
OBC	Outline Business Case
ONS	Office for National Statistics
PD	Programme Director
PICU	Psychiatric Intensive Care Unit
PMO	Programme Management Office
PPE	Post Project Evaluation

Acronym	Full Title
QIPP	Quality, innovation, productivity and prevention
SCALE	Trust's model of care
SDMP	Sustainable Development Management Plan
SOC	Strategic Outline Case
SRO	Senior Responsible Owner
SSL	Summerhill Services Ltd
STP	Sustainability and Transformation Plan
SWOT	Strengths, Weaknesses, Opportunities, Threats
VFM	Value for Money

15. Audit Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**AUDIT COMMITTEE**
Date	28th July 2021
Author	Gianjeet Hunjan
Executive sponsor	Gianjeet Hunjan

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

To provide the Board of Directors with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration

To provide assurance to the Board of Directors.

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

REPORT FROM THE AUDIT COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Audit Committee met on the 22nd July 2021 with a summary of the key discussions being detailed below:

1.1 Internal Audit Report

The Committee received the internal audit progress against the Annual Plan for 2021-22 and an update on the outstanding 2020/21 reviews.

The details of completed reviews for 2020/21 were discussed and they are:

- DSP Toolkit
- Patient Experience – New Friends and Family Test
- Capital Prioritisation Final Report
- Project Oversight – IHI Final Reports
- ESR Workforce Processes

TIAA confirmed their Head of Internal Audit opinion as previously advised to the Committee stood in that for the areas reviewed in the year, the Trust has reasonable and effective risk management, control and governance processes in place.

In terms of 2021/22, TIAA confirmed their Quarter 1 reviews had started. However, the job planning review had been deferred to Quarter 4 following discussions with management colleagues.

Chair's assurance comments:

The Committee discussed the reviews in detail and were assured that compliance with the processes in place at a particular point in time had been met although the processes themselves needed to be strengthened which in the case of capital prioritisation had already been actioned.

The Committee agreed the process for cross-Committee working would be considered by the Executive Director of Finance together with the Audit Chair in particular how best to provide feedback to the referring Committee following audit reviews.

The Committee noted and sought assurance on the deferral of planned audits particularly as these had been previously agreed by all stakeholders.

1.2 Counter Fraud Progress Report and confirmation of submission outcome

TIAA confirmed the outcome of the Counter Fraud Annual Assessment which was an overall Green rating. The work to strengthen the 2 amber and 1 red areas has commenced and would continue throughout the year.

The Committee considered the details of the activities carried out against the agreed Counter Fraud work plan since the last Audit Committee, for the Trust in line with the new Government Functional Standards as set out by the NHS Counter Fraud Authority (NHSCFA).

Chair's assurance comments:

The Committee noted and were assured of the on-going work undertaken by Counter Fraud Team.

1.3 External Audit update and Technical Updates including VFM opinion

The Committee received an overview regarding the following areas:

- Audit of the financial statements
- Commentary on VFM arrangements
- Other reporting responsibilities

The Committee was advised that the work in relation to VFM had been completed. There were no matters that needed to be brought to the Committee's attention and the audit certificate would be issued shortly.

Chair's assurance comments:

The Committee was assured that the Annual Accounts processes for 2020/21 had been almost completed.

1.3 **Audit Committee Self Assessment/Improvement Plan**

The Committee was verbally informed of the plan to carry out the self-assessment for this year.

Chair's assurance comments

It is best practice to assess the effectiveness of Committee working and this will continue.

1.6 Board Assurance Framework (BAF)

The Committee was presented with the Quarter 1 new strategic risks aligning to the new Trust Strategy. This commenced with a Board Development session in January and continued with Committee Chairs and Lead Executives agreeing the strategic risks, the controls and mitigations over the last few months. This had been presented and agreed at the July 2021 Committee meetings with the Quarter 1 position for 2021/2022 being presented to the Board of Directors in July 2021.

Chair's assurance comments:

The Committee heard about the processes in developing the BAF and will receive future updates.

1.7 Review of Audit Committee Terms of Reference

The Committee received and discussed the Audit Committee Terms of Reference. With a few minor amendments, they were agreed and would be presented to the Board for agreement.

Attached with this report.

Chair's assurance comments:

The Committee agreed the Term of Reference

1.8 Internal Audit Contract

The Committee was advised the existing internal audit contract will come to an end on 31 March 2022. In line with best practice, the service will be tendered using the agreed NHs framework. The detailed plan was being developed and would be shared with Committee Members in advance of the next Audit Committee meeting.

Chair's assurance comments:

The Committee supported this approach.

Birmingham and Solihull Mental Health NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

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1. VALUES

The Committee will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve and grow together

2. AUTHORITY

2.1 The Audit Committee is constituted as a Standing Committee of the Board of Directors. Its constitution and terms of reference are as set out below, subject to amendment by the Board of Directors.

2.2 The Committee is a Non-Executive Committee of the Board of Directors, with no executive powers, other than those specifically delegated in the Terms of Reference.

2.3 The Committee is delegated and authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- Recommend the annual accounts and report (including the Quality Account and Charitable Funds Accounts) to the Board for approval

3. PURPOSE

3.1 The primary purpose of the Committee is to provide assurance on the overall arrangements for governance, risk management and internal control to the Board of Directors.

4. DUTIES

4.1 Governance, Risk Management and Internal Control

4.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives.

4.3 The Committee will scrutinise the Board Assurance Framework (BAF) to provide the Board with assurance that the BAF is valid and suitable for the Trust's requirements. Specifically, the Audit Committee will:

- Ensure that there is an appropriate spread of strategic risks. This should be done once a year
- Assure itself that the process undertaken by management to populate the BAF is appropriate. This could be carried out on the Committee's behalf by the Internal Auditors to terms of reference agreed by the Committee
- Monitor the implementation of action plans that have been drawn up to cover gaps in controls, assurances, and reports to management
- Consider the audit needs of the organisation in terms of sources of assurance, and that there is a plan for these assurances to be received
- Review the results of assurances and the implications these have on the achievement of the Trust's strategic objectives

4.4 The Committee will review the adequacy of:

- All risks and controls related to disclosure statements (in particular the declarations of compliance with the CQC regulations and requirements for the Annual Report and Accounts and the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to approval by the Board

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the NHS Counter Fraud Authority

4.5 The Committee will ensure and assure on behalf of the Board that:

- The Trust has an appropriate and up-to-date Risk Policy
- The Risk Policy is being adhered to, in that risks are being identified, described, scored, managed, and addressed appropriately
- There is a transparent and effective method for the escalation of risks upwards within the Trust
- The higher scoring risks as collated into a single Corporate Risk Register, which is visible to the Board
- The Board Assurance Framework is a live document that reflects the controls and assurances needed to ensure and assure management of the risks associated with delivery of the Trust's Strategy

4.6 In carrying out its work the Committee will primarily utilise the work of Internal Audit, External Audit and other independent assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it

4.7 The committee will have delegated authority from the Board to receive and approve changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.8 Internal Audit

4.9 The Committee shall ensure that there is an effective internal audit function appointed in line with the scheme of delegation and that it meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation dismissal; as well as agreeing the adequacy of the procurement process
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation including those identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit

4.10 External Audit

4.11 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, in order for a recommendation to go to the Council of Governors', whose role it is to appoint the external auditors
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including receipt of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Consider any non-audit work to ensure external audit retain independence

4.12 Other Assurance Functions

4.13 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arms-length Bodies or appropriate regulators/inspectors.

4.14 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee, and any Risk Management committees that are established, as well as receiving or seeking assurances as appropriate, from the other board sub committees.

4.15 In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

5. MEMBERSHIP AND ATTENDANCE

Members

5.1 All members of the Committee will be independent Non-Executive Directors. At least one member will have a formally recognised accountancy qualification. The Senior Independent Director of the Board of Directors will not be Chair of the Committee.

5.2 The membership of the Committee will be:

Chair - Non-Executive Director

- Deputy Chair - Non-Executive Director
- Non-Executive Director
- At least two other non-Executive Directors

In attendance

5.3 The following will be standing attendees of the Committee

- Executive Director of Finance
- Company Secretary

5.4 Invitations for attendance of others will be issued by the Chair of the Committee in line with the requirements of the agenda.

5.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. Other Non-Executive Directors who are not members of the committee may attend with the agreement of the Chair of the committee. The Chair of the Board will not be a member of the Committee but may be in attendance.

5.6 All members will have one vote. In the event of votes being equal the Chair of the committee will have the casting vote.

5.7 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. At least once a year the Committee should meet privately with the External and Internal Auditors.

6. QUORACY

6.1 A quorum shall be two members of the Committee.

7. DECLARATION OF INTERESTS

7.1 All attendees must declare any actual or potential conflicts of interest in advance. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

8. MEETINGS

8.1 Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

8.2 Meeting dates will be agreed annually in advance by the members of the Committee.

8.3 The agenda of every Committee meeting will include as a standing item a review of how effectively it has discharged its business.

9. ADMINISTRATION

9.1 The meeting will be closed and not open to the public.

9.2 The Company Secretary will ensure there is appropriate secretarial and administrative support to the Committee.

9.3 An Action List and minutes will be compiled during the meeting and circulated within 7 calendar days of the end of the meeting.

9.4 Any issues with the Action List or minutes will be raised within 7 calendar days of issue.

9.5 The Company Secretary will agree a draft agenda with the Committee chair and it will be circulated 7 calendar days before the meeting.

9.6 Any issues with the agenda must be raised with the Committee chair within 4 working days.

9.7 All final committee reports must be submitted 7 calendar days before the meeting.

9.8 The agenda, minutes and all reports will be issued 6 calendar days before the meetings

10. REPORTING AND RELATIONSHIP WITH OTHER COMMITTEES

10.1 The Committee Chair will provide a Committee Assurance Report for the next meeting of the Board. This will describe the major issues that were discussed by the Committee, and the level of assurance that was received through papers and oral testimony.

10.2 The committee will review their effectiveness on an annual basis, reporting the outcome of the review to Trust Board.

10.3 The Committee Chair will present to the Council of Governors annually a report on the work of the committee. The Committee Assurance Report(s) will be presented by the Committee Chair to the Council of Governors at the next scheduled meeting.

Date Reviewed: July 2021

Approved by the Board:

Date of Review:

16. Charitable Funds Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**19**
Paper title	**CHARITABLE FUNDS COMMITTEE**
Date	28th July 2021
Author	Linda Cullen
Executive sponsor	Linda Cullen

This paper is for: ***[tick as appropriate]***		
☐ Action	☐ Discussion	☒ Assurance

Executive summary

To provide the Board of Directors with a summary of issues and Chairs assurance relating to the remit of the Committee

Reason for consideration

To provide assurance to the Board of Directors.

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report

Risks

No specific risk is being highlighted to the Board regarding the contents of the report

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

REPORT FROM THE AUDIT COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Charitable Funds Committee met on the 21st July 2021 with a summary of the key discussions being detailed below:

1.1 Fundraising Update

The Committee received the Fundraising Update and noted the details of current activity being impacted by Covid.

Caring Minds continues to operate on a largely voluntary basis thanks to the generous efforts of colleagues within the Trust.

The 4000 Club continues to be a steady source of income and is administered by the Communications and Marketing team.

Opportunities to support and commit to the Commonwealth Games was discussed in detail and it was agreed this should be a key focus for the Trust.

Partnership working opportunities will be explored and considered for moving forward.

Chair's assurance comments: *We were pleased to note the ongoing fundraising activity in the charity despite the restrictions of the pandemic and that funds continue to be spent on staff and patient well-being across the trust. Various opportunities to increase the charity's profile, increase messaging about mental health within our communities and expanding the reach of the charity including working in partnership with others were explored by the committee. An example of this is the upcoming Commonwealth games and the increased public awareness of mental health and sport and how we could capitalise on this might be taken forward by Patrick and John*

1.2 Fund Balances and Financial Analysis

The position of the Charity as at 31st March 2021. There has not been much financial activity bar the 4000 lottery income for 2021 to date.

Chair's assurance comments: *The charity funds are in a stable position and we are making a good return on the investments and investing ethically. Due to limited opportunities for fundraising activities during the pandemic most of the income has come from NHS Charities Together ie. Captain Tom et al*

1.3 Approval of the 2019/20 Annual Report & Accounts

The Committee received the annual report and accounts and noted the extension to formally submit to 30 September 2021.
The Committee were assured the external examiner has reviewed the annual reports and accounts and has no concerns to raise.

Chair's assurance comments: *The committee recommends to the Board to approve the Annual report and accounts*

1.4 Caring Minds Review and Future

The Committee received the independent Caring Minds Review and noted the recommendations. All members agreed to the recommendations which will be presented to Trust Board for approval in September.

Chair's assurance comments

Following conversations with the UHB group of charities during the pandemic whilst working together to allocate funds, UHB Charities agreed to support us in carrying out this review . It is an inclusive and thorough look at Caring Minds as a charity and how it can help to deliver even better care in the Trust and be a focal point within the organisation for staff , families and service users . We had a very rich discussion and agreed that a discussion paper will be brought to Board in September to consider the future strategy for Caring minds and the potential benefits of investing and supporting the charity to grow .

GOVERNANCE & RISK

17. BAF

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**20**
Paper title	**Draft Strategic Risks:**
Date	28th July 2021
Author	Daniel Conway, Acting Company Secretary Andrew Hughes & Alex Rickard – ANHH Consulting
Executive sponsor	Dave Tomlinson – Director of Finance

This paper is for (tick as appropriate):		
☒ Action	☒ Discussion	☐ Assurance

Executive summary & Recommendations:

At the Board Development Session on the 22nd February 2021, the Board of Directors had discussions regarding the role of the Board Assurance Framework ensuring there was a focus on the risks that may compromise the achievement of the Strategic objectives. The Board discussed how the risks associated with the priorities would report into the Board Committees.

Following the session, meetings were then held with the Chair of Committees and the Lead Executive to further work on the draft wording for the strategic risks.

The Committee is therefore presented with the draft wording for the risks aligned to IQC.

All Committees reviewed their own risks at the March meetings and a report will then be presented to the Board of Directors on the 31st March 2021 to formally agree the overarching strategic risks which could impact on the delivery of the Trust Strategy.

Following the Board meeting in March, further work was then be undertaken to ensure the controls, assurances and gaps are identified for each risk.

Work was carried out over May and June and ANHH has proposed initial and target scores for each of the risks. The initial risk score is a view (from an inevitably less than fully informed perspective) of how the risk scores 'now'. The target risk score is a suggestion as to where the Trust might reasonably expect to be, with appropriate controls, within a year's time.

Since the last meeting, key Committee members and ANHH have met to review the scores and to provide a high-level statement of status against each risk. This Report describes that approach and highlights key issues.

The Board is asked to consider the recommendations made in the final section.

Reason for consideration:

The Board is asked to:

- **RECEIVE** the BAF and **UNDERSTAND** that it is now a live document
- **APPROVE** the renaming of Committees:
    - FPP becomes **Sustainability**
    - IQC becomes **Quality, Safety and Experience**
- **NOTE** the scoring process and the resultant risk universe
- **DISCUSS and ACTION** those issues identified in Section 5
- **NOTE** the next steps

Previous consideration of report by:

Not applicable

Strategic priorities (which strategic priority is the report providing assurance on)

QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve

Financial Implications *(detail any financial implications)*

No financial implications associated with this

Board Assurance Framework Risks:
(detail any new risks associated with the delivery of the strategic priorities)

N/A. This report is focusing on the development of a new Board Assurance Framework for 2021.

Equality impact assessments:

N/A

Engagement *(detail any engagement with staff/service users)*

The new full Board Assurance Framework was presented to the sub-committee's in July.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

DEVELOPMENT OF A NEW BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION and PURPOSE

The Board of Directors has a critical role to focus on any risks that may compromise the achievement of the Trust's strategic priorities.

The Board Assurance Framework ("**BAF**") is the means by which the Board holds itself to account, i.e., the main tool to discharge responsibility for internal control.

The process to develop a new BAF has continued over several months. The Board has held a developmental workshop; Committees have co-produced controls and assurances; risk descriptions have iterated; and, as reported at the June Committee meetings, ANHH Consulting ("**ANHH**") proposed residual and target scores for consideration.

Since the last meeting, key Committee members and ANHH have met to review the scores and to provide a high-level statement of status against each risk. This Report describes that approach and highlights key issues.

The Board is asked to consider the recommendations made in the final section.

2. THE BOARD ASSURANCE FRAMEWORK

The BAF is now a live and working document. It remains a **work in progress**, with further attention needed on controls and assurances, and gaps within them, but the working group discussions have highlighted how useful a tool it will be to manage the work of Committees and Board priorities.

The BAF is deliberately outside of ECLIPSE so that it remains separate to other risks. It will be held and co-ordinated by the Company Secretariat with the respective Executive Owners charged with providing clarity on progress on a quarterly basis.

The BAF is attached to this Report. It is an excel workbook with three worksheets, one for each of the functional Committees.

The format of the Framework can be summarised as follows:

- At the head of each worksheet, a summary of:
  - Strategic Priority taken from the Trust's Strategy
  - Executive Owner
  - Assurance Committee (People; Quality, Safety and Executive; Sustainability)
  - Risk Appetite(s), as agreed by the responsible Committee
- Unique identifier (Column A)

- Risk description (Columns B and C):
  - Focus (taken from the Trust Strategy)
  - Risk description (*The Trust fails… resulting in*)
  - Impact (given as a series of bullet points)
- Controls (Column D)
- Assurances (Column E)
- Residual Risk Score (Columns F G H). A risk would usually have an inherent or initial risk score but, since these are all new risks, it is appropriate to have only a residual score after the controls already in place
- Target Risk Score (Columns I J K)
- Q1 2021/22 update on risk status (Column L). For this first update, the statement is principally an explanation of the rationale for the two risk scores.

3. RISK SCORING

The working groups used a consistent risk scoring system that aligns to the Trust's Risk Policy (April 2021, Version 16, Appendix 1, pg16-19).

LIKELIHOOD

1. **Rare**
   Not expected to occur in the current or next year
2. **Unlikely**
   Unlikely to occur during the current or next year
3. **Possible**
   Could easily occur during the current or next year
4. **Likely**
   Will probably occur during the current or next year
5. **Almost certain**
   Definitely will occur during the current or next year

CONSEQUENCE

1. **Negligible**
   No impact on health; or negligible financial loss (<£10K) that can be restored; or small reduction of reputation in the short run; no violation of law
2. **Minor**
   No direct impact on health or a minor temporary impact; or finanical loss that can be restored (between £10K and £100K); less serious violation of law that results in a warning or command; or small reduction in reputation

3. **Moderate**
   Reduced health; or a large financial loss that cannot be restored (between £100K and £500K); violation of law that results in minor penalty or fine; or serious loss of reputation that will influence trust and respect for a long time

4. **Major**
   Permanent reduction of health; or a large economic loss that cannot be restored (between £500K and £2M); or serious loss of reputation; violation of law that results in significant penalty or fine; or serious loss of reputation that will influence trust and respect for a long time

5. **Catastrophic**
   Death; considerable economic loss that cannot be restored (>£2M); serious loss of reputation that permanently influences life, health, sustainabilty and viability; serious violation of law that results in potential or actual imprisonment; serious loss or reputation that is devastating for trust and respect

The Committee working groups agreed some key principles for scoring:

- Consequence score would remain constant (unless specifically argued) as a change in consequence of a risk is likely to mean that the risk definition no longer applies
- Likelihood score would change with reference to the perceived impact of the controls in place
- Target risk score would be the long-term aim, with in-year statements of trajectory to this target.

4. RISK UNIVERSE

The pattern of the BAF's risk profile is shown in the two tables below.

ANHH recommends that this dashboard be positioned in front of any discussion about the Trust's strategy or investment decision-making.

It should be the dashboard via which the Trust can visualise the challenges to delivery of the Trust Strategy.

It would typically be expected that target risk scores would be in the green zone but the nature of strategic risks means that they will always exist – money, staffing, quality.

A shift in scores can be glacial in timeline, certainly when measured against a typical operational risk.

Table One: Residual Risk Score

LIKELIHOOD						
	Almost Certain	5	10	15	20	25
	Likely	4	8	12 P4	16 S2, P2, P3, QSE4, QSE7	20 S1, S4, QSE6
	Possible	3	6	9 QSE1	12 P1, P5, QSE2, QSE3, QSE5	15
	Unlikely	2	4	6 S3	8	10
	Rare	1	2	3	4	5
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

Table Two: Target Risk Score

LIKELIHOOD						
	Almost Certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	16
	Unlikely	2	4	6 P1, P3, P4, QSE1	8 S2, P2, P5, QSE4, QSE5, QSE7	10 S1, QSE6
	Rare	1	2	3 S3	4 QSE2, QSE3	5 S4
		Insignificant	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

5. POINTS TO NOTE BY ASSURANCE COMMITTEE

People

- The consequence score for P1 and P3 have been reduced to reflect the change of scale that would arise from a single service rather than Trust-wide impact

Quality, Safety and Experience

- The target likelihood scores for QSE2 and QSE3 have been reduced to 1 (“rare”) to reflect the link between those risks and the core business of the Trust

Sustainability

- Separate Risk Appetites have been defined for “Finance, Governance and Environment” and “Digital and Partnerships”

6. NEXT STEPS

The BAF is now a live document, which must remain dynamic and must be kept up-to-date.

The responsible Committees will provide status updates to inform the Board's discussions at the end of each quarter.

7. RECOMMENDATIONS

The Board of Directors is asked to:

- **RECEIVE** the BAF and **UNDERSTAND** that it is now a live document
- **APPROVE** the renaming of Committees:
    - FPP becomes **Sustainability**
    - IQC becomes **Quality, Safety and Experience**
- **NOTE** the scoring process and the resultant risk universe
- **DISCUSS and ACTION** those issues identified in Section 5
- **NOTE** the next steps

Strategic Priority People
Executive Owner Director of Strategy, People and Partnerships
Assurance Committee People
Risk Appetite Significant: We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positve change.

	Risk Description	Controls	Assurances	Residual Risk Score			Target Risk Score			Update - Q1, 2021/22
				L	C	Total	L	C	Total	
P1	**Focus: Transforming our culture**									
	The Trust fails to develop an inclusive and compassionate working environment, resulting in:			3	4	12	2	3	6	The Trust's position current position is not bad but more work is needed. The target consequence score should reduce to reflect how the risk would shift over time from a whole-Trust issue to pockets of poorer performance, i.e., it becomes an issue of scale.
	- poorer quality patient service									
	- reduced productivity									
	- increased recruitment costs									
	- increased legal costs									
	- increased regulatory scrutiny, intervention and enforcement action									
	- increased levels of sickness absence	Integrated Dashboard (monthly)	% sickness rate							
	- unacceptable workforce retention	Integrated Dashboard (monthly) People Committee Slide Deck (quarterly)	% Employee Turnover Annual % of staff in post > 2 years Waterfall forecast report							
	- failure to attract talent	Integrated Dashboard (monthly) People Committee Slide Deck (monthly)	% of live vacant roles Time from vacancy approval to offer % of BAME staff successful in being appointed to internal roles % of BAME staff likely to be appointed into roles from shortlisting % of disabled staff successful in being appointed to internal roles % of disabled staff likely to be appointed into roles from shortlisting Workforce demand and supply waterfall (staff group and service)							
	demotivated workforce	Integrated Dashboard (monthly) People Committee Slidedeck (quarterly)	% Fundamental Training completion % Appraisal completion rates % of staff who have accessed clinical supervision in the last 12 months % of staff who have accessed leadership and management training modules in the last 12 months % of staff with a clear PDP agreed with their manager % of staff who have team related objectives % of return to work meetings undertaken within 7 days							
	absence of value-led culture									
P2	**Focus: High performing workforce**									
	The Trust fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multidisciplinary values-based leadership framework developing the right capabilities, resulting in:			4	4	16	2	4	8	This will take time to address, and will never reach a "rare" likelihood rating. Cultural change will be protracted and a constant theme. The aim for this year, as measured by the Staff Survey, will be to reduce the likelihood score to a 3.
	- an unhealthy and poor leadership	Annual Staff Survery People committee Slide Deck (quarterly)	Staff Engagement Score Number of staff accessing: Occupational health referrals Psychology and wellbeing support Physiotherapy support Post incident support Other support from occupational health Psychological first aid support N = Health promotion and wellbeing sessions delivered N = Health promotion and wellbeing sessions attended Feedback on quarterly sessions							
	- an underperforming workforce	Integrated Dashboard (monthly)	% overall sickness rate							
	- sustained patterns of inequality and discrimination	People Committee Slide Deck (quarterly)	% of BAME staff in a role of 8A or above % of BAME staff entering disciplinary processes % of disabled staff entering formal capability processes compared to all other staff							
	- high turnover	Integrated Dashboard (monthly)	% employee turnover							
	- non-compliant behaviours	People Committee Slide Deck (quarterly)	Total number of disciplinary cases Total number of grievances Total number of dignity at work cases Total number of whistleblowing cases Total number of FTSU cases Feedback from exit interviews Emplovee lifecvcle feedback							
	- Employee Relations cases	People Committee Slide Deck (quarterly)	Total number of disciplinary cases Total number of grievances Total number of dignity at work cases Total number of whistleblowing cases Total number of FTSU cases Feedback from exit interviews Emplovee lifecvcle feedback							
P3	**Focus: Communication, inclusion and wellbeing**									
	The Trust fails to engage effectively with its workforce through a dynamic, sustainable internal and external communication plan, resulting in:			4	4	16	2	3	6	As with PC1, the Committee believes that the scale of the issue will be limited and isolated in the future, meaning that a reduced consequence score is recommended. The results of the Staff Survey drive public and professional reputation and perception. Equality, Diversity and Inclusion will be a vital component of the Trust's response.
	- diminished knowledge and education to make and take the right decisions	People Committee Slide Deck (quarterly)	N of development sessions attended: Schwartz rounds TRIM sessions Balint groups							
	- reduced productivity									
	- confusion									
	- fear of safety to speak up									
	- poor employer brand	People Committee Slide Deck (quarterly) Annual Staff Survey	% of Staff Friends and Family Test results % of sickness due to anxiety, stress and depression % of sickness due to musculoskeletal reasons n/10 Staff Engagement Score							
	- non-compliant behaviours									
P4	**Focus: Modernising our people practice**									
	The Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and represent the communities served by the Trust, resulting in:			4	3	12	2	3	6	The Trust's Policies on this issue need to be clear and fully implemented. This will take time to address as recruitment from harder to reach communities, that represent the population served, is a challenge.
	- a poor employer brand									
	- compensation costs									
	- unacceptable staff turnover									
	- increased regulatory scrutiny, intervention and enforcement action									
P5	**Focus: Flexible. transformative workforce models**									
	The Trust fails to look holistically at flexible and transformative workforce models used across all services, resulting in:			3	4	12	2	4	8	The Risk Policy's thresholds for finanical consequence are driving a consequence rating of 4. Another risk that will take cultural change to address.
	- a failure to take opportunities where positive gains are possible									
	- inefficiencies	Integrated Dashboard (quarterly) People Committee Slide Deck (quarterly)	% Bank fill rate % Agency fill rate % of rostas presented 6 weeks in advance							
	- unacceptable patient care									
	- a failure to address inequalities									
	- decreased staff retention	People Committee Slide Deck (quarterly)	Staff Experience survey (recruitment induction)							
	- missed opportunities for cost improvement									

Strategic Priorities Quality and Clinical Services
Executive Owner Executive Director of Quality and Safety (Chief Nurse)
Assurance Committee Quality, Safety and Experience Committee
Risk Appetite Open: We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.

	Risk Description		Controls	Assurances	Residual Risk Score L	Residual Risk Score C	Residual Risk Score Total	Target Risk Score L	Target Risk Score C	Target Risk Score Total	Update - Q1, 2021/22
QSE1	**Focus**	**Improving service user experience**									
	The Trust fails to co-produce with all people who use its services including their families, resulting in:				3	3	9	2	3	6	The Trust is making strides with co-production and involvement but with more still to do. Several EBEs are now active members of our QI programmes. During Q1 the co-production kitemark was awarded to our EBE QI Training Scheme and QI Branding. During Q2 we will establish a Patient Experience and Engagment Advisory Group with strong EBE membership in response to the findings of the quality governance review The use of Patient Stories will continue and be extended where possible to ensure that the voice of the service user is heard and learned from.
	- a reduction in quality care		Experts by experience in QI Patient stories at Board	Complaints levels and themes PALS levels and themes Percentage of dissatisfied complainants Family and Friends Test scores National Community MH survey scores and benchmarking Postings on Patient Opinion/NHS Choices							
	- service users not being empowered										
	- services that do not reflect the needs of service users and carers		Peer Support Workers								
	- service provision that is not recovery focused		Recovery College Third sector partnership working								
	- increased regulatory scrutiny, intervention and enforcement action			CQC Caring and Safety domain ratings							
QSE2	**Focus**	**Preventing harm**									
	The Trust fails to focus on the reduction and prevention of patient harm, resulting in:				3	4	12	1	4	4	The aim must be to ensure, long term, that the likelihood of the risk occuring is rare.
	- variations in care		Incident Reporting Policy								
	- unwarranted incidents										
	- less safe care		Quality Improvement Programme Health and Safety Programme Ligature Risks Reduction Policy Fire Policy Quality Governance Structure Quality Improvement Collaboratives Patient Safety Collaboratives Safety Huddles MDT Working Patient Safety Advisory Grouop System Oversight Group Intergrated Quality Committee Clinical Governance Committee Thematic Reviews Learning Lessons Approach Serious Incident Reviews Mortality Case Note Reviews Patient Safety Specialist Role Medicines Safety Officer Role Serious Incident Report Intergrated Performance Dashboard Clinical Audit Programme	NRLS Benchmarking reports on harm levels and incident reporting National Confidential Inquiry Benchmarked levels for suicide and homicide National benchmarking for Restrictive Practice Environmental Risk Assessments Ligature Risk Assessment Fire Risk Assessments Security Risk Assessments						
	- increased regulatory scrutiny, intervention and enforcement action		Section 31 CQC Improvement Plan	CQC Safety Domain rating							
QSE3	**Focus**	**A patient safety culture**									
	The Trust fails to be a self-learning organisation that embeds patient safety culture, resulting in:				3	4	12	1	4	4	The aim must be to ensure, long term, that the likelihood of the risk occurring is rare.
	a culture where staff feel unable to speak up safely and with confidence		Freedom to Speak Up Guardian for Safe Working	Board reporting on Freedome to Speak Up							
	variations in care		Quality Improvement Programmes System Oversight Group Learning lessons approach Learning from Excellence	National staff survey metrics for safety culture Incident reporting levels							
	a failure to develop pathways of care within the Intergrated Care System										
	increased regulatory scurtiny, intervention and enforcement action			CQC Well Led rating							
QSE4	**Focus**	**Quality Assurance**									
	The Trust fails to be a self-learning organisation that embeds quality assurance, resulting in:				4	4	16	2	4	8	The use of high quality data to create intelligence and insight will be vital to an improvement in quality assurance and reduction in score for this risk.
	- insufficient understanding and sharing of excellence in its own systems and processes		External Peer Reviews								
	- lack of awareness of the impact of sub-standard services		Learning from Excellence	Service Accreditations for quality							
	- variations in standards between services and partnerships		System oversight Group Patient Safety Bulletin Quality Improvement Programme								
	- demotivated staff										
	- increased regulatory scrutiny, intervention and enforcement action			CQC Insight Report CQC rating							
QSE5	**Focus**	**Leader in mental health**									
	The Trust fails to lead and take accountability for the development of system-wide approaches to care, and to exploit its status and position to advocate for mental health services and service users, resulting in:				3	4	12	2	4	8	The Trust's role as system leader will develop through initiatives such as provider collaboratives. The strategy depends on greater and closer working with other providers, the third sector, and statutory agencies. This has a clear overalap with S1 and the focus on system and partnership.
	- inferior and poor care		Quality Improvement Programme Ligature Risk Reduction Policy Quality Governance Structure Quality Improvement Collaboratives Patient Safety Collaboratives Safety Huddles MDT working Patient Safety Advisory Group Integrated Quality Committee Clinical Governance Committee Thematic Reviews Learning Lessons Approach Patient Safety Specialist Role Integrated Performance Dashboard Clinical Audit Programme	NRLS Benchmarking reports on harm levels and incident reporting National Confidential Inquiry Benchmarked levels for suicide and homicide National benchmarking for Restrictive Practice Environmental Risk Assessments Ligature Risk Assessments							
	- detrimental impact for service users										
	- higher critical caseloads		Quality Improvement Programme Quality Governance Structure MDT working Learning Lessons Approach Mortality Case Note Reviews Serious Incident Report Intergrated Performance Dashboard Clinical Audit Programme	Caseload numbers per professional Length of time on caseload, linked to recovery focussed targets Partnership agreements							
	- missed income opportunities		Internal reports on financial position of the STP and Trust Bidding process embedded in SFIs CFO and FD system meetings influencing the system, and then the system influencing upwards	STP funding low MH share of that too low MH Investment Standard met with fair share to adult services Successful bid processes System financial target met (control total)							
	- limited brand awareness		Friends and Family Test Patient Survey Staff Survey	N = applicants for job							
	- unexploited research and innovation opportunities		Research database Annual R&I report R&I included in Annual Quality Report	No of patients recruited national research programmes No of patients recruited to local research programmes Research income (NIHR) Research income Isuppliers)							
	- breakdown in critical relationships with key partners		Stakeholder Map and Management Plan								
QSE6	**Focus**	**Major public health incident**									
	The Trust fails to prevent and contain a major public health outbreak, resulting in:				4	5	20	2	5	10	COVID continues to demonstrate that the likelihood of this risk is weekly and that the consequence can be fatal. This drives a high residual score, even after initial controls and assurances.
	death and uncompromised duty of care for staff's health and wellbeing		Business Continuity Plan Major Incident Emergency Preparedness, Resilience and Response (EPRR) Gold and Silver Command	Independent annual assessment against the 68 NHS Core Standards for EPRR							
	fundamental breakdown of service provided for service users										

	findamental breakdown of the network of collaborative work with partners										
QSE7	**Focus**	**Clinically effective**									
	The Trust fails to respond to service users' holistic needs, resulting in:			4	4	16	2	4	8	Parity of esteem remains a challenge. This risk links well with the advocacy role described in QSE5. The conseqence rating is driven by the implications for health and cost.
	- increased mental health and physical health morbidity	Physical Health Strategy and Policy								
	- potential increased mental and physical ill health	Learning from Deaths Policy Learning from Deaths Group Mortality Case Note Reviews	Mortality Reports to the Trust Board							
	- unacceptable patient experience	NICE compliance QSIS compliance for specialised services	Clinical Audit Programme							
	- missed opportunities for cost improvement	Clincial Effectiveness Advisory Group	GIRFT status CQUIN attainment							
	- a demotivated workforce									

Strategic Priority	Sustainability	
Executive Owner	Executive Director Finance	
Assurance Committee	Sustainability	
Risk Appetite	Finance, Governance and Environment	Open: We are willing to consider all potential delivery options and choose whilst alos providing an acceptable level of reward
	Digital and Partnerships	Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Risk Description		Controls	Assurances	Residual Risk Score			Target Risk Score			Update - Q1, 2021/22
				L	C	Total	L	C	Total	
S1	**Focus** **System finances and partnership working**									
	The Trust fails in its responsibilities as a partner, and does not structure and resource itself properly to take advantage of new contractual mechanisms, resulting in:			4	5	**20**	2	5	**10**	The consequence would be >£2m, which delivers a consequence score of 5. Significant work is continuing to prepare the Trust for its new responsibilities as Lead Provider for Reach Out (secure care) from 1st October 2021. This will establish clear principles and a governance process that should allow the likelihood score to reduce during this finanical year.
	- an inability to support the system's medium to long term financial viability	Internal reports on financial position of the STP and Trust bidding process embedded in SFIs CFO and FD system meetings Influencing the system, and then the system influencing upwards	Mental Health investment standard met with fair share to adult services Successful bid processes System financial target met (control total)							
	- reductions in service provision as a result of insufficient funding									
	- continued inequalities in health status and outcomes									
	- inability to invest in improvement									
	- increased regulatory scrutiny, intervention, and enforcement action		CQC rating							
	- a breakdown in critical relationships with key partners									
S2	**Focus** **Transforming with Digital**									
	The Trust fails to focus on the digital agenda and to harness the benefits of digital improvements, resulting in:			4	4	**16**	2	4	**8**	The Trust has much work to do to enable it fullly to realise the benefits of technology, although it is a Digital Exemplar. The risk consequence of 4 reflects how important technology will be to the delivery of the most effective care. This links to S1 as partners will need to be part of the efforts. The Board of Directors needs to own the ambition.
	- less than optimal data security and sharing	System Failures Report	Digital Maturity Index							
	- not addressing cyber security threats	General ICT Report	GDPR Compliance - Annual Data Protection Reporting Downtime Core resolution time							
	- inefficiences and ineffectiveness in critical processes	Sustainability Strategy - Digital metrics Digital Executive Group	Customer Satisfaction scores Help Desk Reporting							
	- unacceptable care for service users									
SC3	**Focus** **Caring for the environment**									
	The Trust fails to behave as a socially responsible organisation, resulting in:			2	3	**6**	1	3	**3**	The Trust performs well in this area. The challenge will come if or when the Government's targets become a statutory requirement. Aligned to S1, the Trust should aim to be an influencer in the system.
	- poor waste management	Annual Sustabability Report								
	- unnecessary journeys	Strategic Estates Board (ICS)	Green transport targets							
	- higher than necessary energy costs	Birmingham Clean Air Zone								
	- failure to hit zero emissions targets									
	- damage to reputation and public trust									
S4	**Focus** **Caring for the environment**									
	The Trust fails to manage the safety and quality of its therapeutic environment, resulting in:			4	5	**20**	1	5	**5**	The consequence of weaknesses in the environment has sadly been shown to be fatal, so that domain score can only be 5. Capital expenditure will be needed to enhance physical security. The solution cannot just be a financial one, so the continuing work on relational and procedural security and mitigations must continue. The aim must be for incidents to be rare.
	- increased maintenance costs	Capital Prioritisation Process	Balance of risk - safety vs quality							
	- Health and Safety Executive scrutiny	Customer Satisfaction (TBC)	PLACE scores Help Desk metrics							
	- failure to meet statutory standards	SLL Service Agreement Forum	Contract KPIs							
	- patient harm and increased untoward incidents related to the environment	Capital Programme Patient Safety Report (IQC)	Risk Assessments							
	- increased regulatory scrutiny, intervention, and enforcement action	CQC well-led and unannounced visits	CQC Rating Conditions on Licence							
	- damage to reputation and public trust									

18. Reach Out Governance

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**Trust Board**
Agenda item	**21**
Paper title	**Reach Out Governance Architecture**
Date	28/7/2021
Author	ANHH Consulting Ebru Oliver, Associate Director, Reach Out
Executive sponsor	David Tomlinson, Executive Director of Finance

This paper is for (tick as appropriate):		
☐ Action	☒ Discussion	☒ Assurance

Executive summary & Recommendations:

As reported to the Board in June, we need to formalise governance arrangements for the Provider Collaborative (PC) which will replace the current Reach Out arrangements in October. This covers governance within the PC to BSMHFT as the Lead Provider and upwards to NHSE.

At the June meeting it was agreed to hold a meeting between representative Executives and Non-Executives to review proposals to offer some assurance when the matters are considered formally this month at Committees and the Board. There was unanimous support for the proposals attached.

The Reach Out Provider Collaborative has established governance arrangements, which were developed prior to clarification of the lead provider role and will need to change to reflect contractual arrangements between NHSE/I and BSMHFT as the Lead Provider from 1st October.

The governance architecture needs to be reinforced by some key principles:

- Clarification of responsibilities for the shaping of decisions:
    - Decision-forming: clarifying what part of the architecture will set the context and drive strategic thinking, with some decision-making powers
    - Decision-making: clarifying what part of the architecture will do the heavy lifting needed to make judgements and recommendations
    - Decision-taking: confirming the accountable and responsible forum.
- Confirmation of responsibility for assurance
- Clarity in nomenclature, i.e., only one Board, Sub-Committees reporting to Committees, Sub-Groups reporting to Groups, etc.
- Clarity in authority and delegated powers, remit, membership, and attendance

The attached report:

- Clarifies the governance principles that will underpin the future

- Explains the governance architecture that will apply from 1st October. This incorporates separate arrangements for adult secure care and LDA secure care services
- Defines the activities that need to be undertaken before 1st October

The report was considered and endorsed by the IQC and FPP at their meetings in July.

The Board is asked to:

- **APPROVE** the governance principles to underpin the PC governance architecture
- **NOTE FOR UNDERSTANDING** the work programme for the next three months
- **RECEIVE** a further update at its September meeting

Reason for consideration:

Approval of arrangements can only be provided by the Board

Previous consideration of report by:

Reach Out Programme Board, Partner organisations, Executive and non-Executive representatives

Strategic priorities (which strategic priority is the report providing assurance on)

Clinical Services, Quality, People and Sustainability

Financial Implications *(detail any financial implications)*

Total commissioning budget of £138m, which includes the Secure provider budget

Board Assurance Framework Risks:
(detail any new risks associated with the delivery of the strategic priorities)

N/A

Equality impact assessments:

N/A

Engagement *(detail any engagement with staff/service users)*

Ongoing performance monitoring via Performance Delivery Group

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

REACH OUT PROVIDER COLLABORATIVE BOARD

REACH OUT GOVERNANCE ARCHITECTURE

1. INTRODUCTION and PURPOSE

The new arrangements from 1st October 2021 will require clarity in governance within the Provider Collaborative, to BSMHFT as the Lead Provider, and upwards to NHSE.

The Report serves to:

- Clarify the governance principles that will underpin the future
- Explain the governance architecture that will apply from 1st October. This incorporates separate arrangements for adult secure care and LDA secure care services
- Define the activities that need to be undertaken before 1st October

The Board is asked to consider the recommendations at the end of the Report.

2. GOVERNANCE PRINCIPLES

The Reach Out Provider Collaborative has established governance arrangements, which were developed prior to clarification of the lead provider role and will need to change to reflect contractual arrangements between NHSE/I and BSMHFT as the Lead Provider from 1st October.

The governance architecture needs to be reinforced by some key principles:

- Clarification of responsibilities for the shaping of decisions:
    - Decision-forming: clarifying what part of the architecture will set the context and drive strategic thinking, with some decision-making powers
    - Decision-making: clarifying what part of the architecture will do the heavy lifting needed to make judgements and recommendations
    - Decision-taking: confirming the accountable and responsible forum.
- Confirmation of responsibility for assurance
- Clarity in nomenclature, i.e., only one Board, Sub-Committees reporting to Committees, Sub-Groups reporting to Groups, etc.
- Clarity in authority and delegated powers, remit, membership, and attendance.

3. ARRANGEMENTS FROM 1ST OCTOBER 2021

Figure One above shows the suggested governance structure for Reach Out.

Figure One: Governance Architecture from 1st October 2021

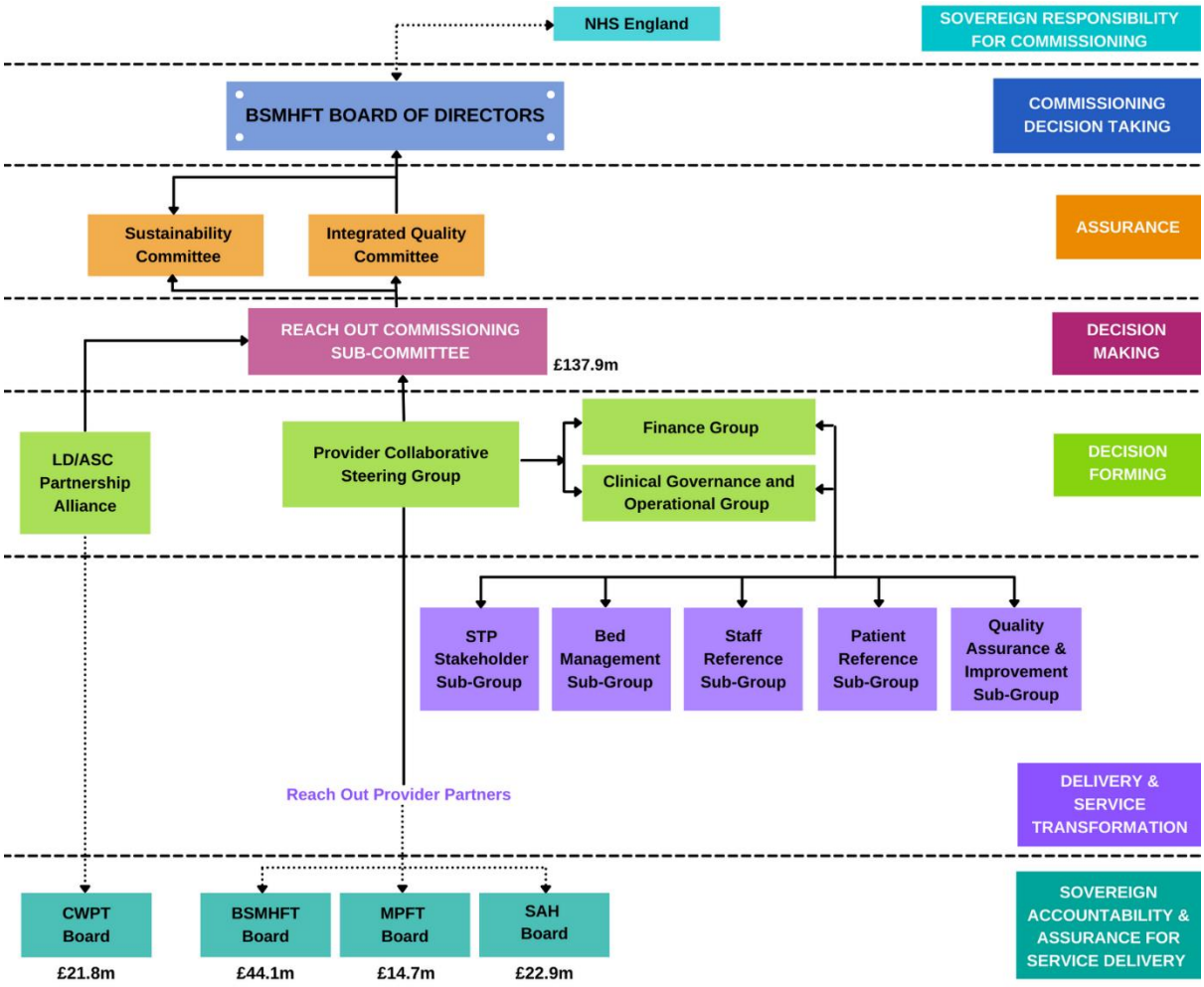

Figure One is best read **from the bottom up**.

Sovereign accountability and assurance for service delivery

Each provider organisation will remain responsible for its own quality, safety and contractual performance.

Decision forming

The **Provider Collaborative Steering Group** (PCSG) is the proposed new name for the existing Provider Collaborative Board. There are two **Groups** that will report into it, and these will address and monitor Finance, Contracting and Commissioning, and

Clinical Goverance and Operational Delivery. There are five **Sub-Groups** at the level of delivery and service transformation.

The BSMHFT Board of Directors will agree an annual business plan formulated by the PCSG. The PCSG will have powers to operate, and to make and take selected decisions within those parameters. The PCSG's role as decision-former is critical as it will ensure that decisions are informed by the clinical experts and service users.

It will be the PCSG that identifies service gaps, formulates clinical and operational solutions, and ensures improvement in service quality, patient experience and outcomes whilst maintaining financial sustainability.

Decision making

The PCSG will report into a new **Reach Out Commissioning Sub-Committee** that will be established by the BSMHFT Board**.**

The Sub-Committee is a decision-making forum, with specific delegated powers from the Board of Directors.

Assurance

The Sub-Committee will report into the **Integrated Quality and Sustainability (FPP) Committees**, for assurance on the key contractual headings of quality, finance and performance.

Decision taking

The two Committees report into the **Board of Directors**.

The Board will approve a budget and plan for the year, which will be managed by the Sub-Committee and PCSG within their delegated powers. The Board will address any in-year issues that would adversely impact on delivery.

Sovereign responsibility for commissioning

NHS England retains sovereign responsibility for commissioning.

4. LDA SECURE CARE

Introduction

There is agreement that Coventry and Warwickshire Partnership NHS Trust (CWPT) should provide leadership on commissioning, financial management and quality of services for people with LDA across the West Midlands.

BSMHFT is the lead provider for Reach Out; CWPT is the lead partner for LDA.

This lead partner role should encompass:

- Developing in co-production the clinical model for secure services
- Overseeing financial management of LDA secure care, including risk and gain share arrangements
- Leading on pathway funding panels
- Giving expert advice and leadership on the commissioning and quality oversight of all Learning Disability and Autism partners
- Providing quality assurance on LDA to the Commissioning Sub Committee via the Clinical Programme Director.

Other inpatient providers in the Alliance are Black Country Health Care NHS FT and MPFT. There are also community providers and discussions continue regarding the scope of the Alliance.

CWPT's proposed governance arrangements

CWPT has developed governance proposals that encompass:

- An LDA Partnership Alliance Executive Board, with executive membership from each provider, including community providers, to be chaired by CWPT's CEO. BSMHFT, as the Reach Out Lead Provider, will be a member of the Board
- CWPT to be a member of the Provider Collaborative Board ("Steering Group" as this paper proposes) as the Chair of the lead partner representing the LDA Partnership Alliance
- An LDA Partnership Alliance Steering Group with clinical leadership from all providers
- Four Sub-Groups mirroring Reach Out governance (safety and quality, finance and commissioning, experts by experience, health inequalities), which are yet to be established
- Five Task and Finish Groups (clinical pathway development x2; referral, assessment and bed management; patient voice; communications), which are already active and may change as the Alliance forms and norms.

These proposals were presented at a high level to the Provider Collaborative Board on 24th June 2021.

Suggested amendments to CWPT's proposals

The nomenclature of "Board" should be changed, in line with adult mental health secure care.

The architecture of steering group, sub-groups, and task and finish groups aligns well with what is proposed to sit under the Provider Collaborative Steering Group, as shown in Figure One.

Figure One also shows a different approach to how LDA secure care might interface with Reach Out. CWPT proposes its membership of the Provider Collaborative Steering Group. Instead, BSMHFT proposes that LDA secure care reports directly into the Commissioning Sub-Committee.

These are suggestions that are being discussed with CWPT and NHS England.

5. PRINCIPAL ACTIONS IN THE NEXT THREE MONTHS

The programme plan to 1st October 2021 has the following principal activities.

July

- Evolution of the governance architecture, particularly for LDA secure care
- Amendments to Terms of Reference for existing governance forums to reflect their new responsibilities (Reach Out Steering Group, Groups and Sub-Groups; LDA secure care forums; Board of Directors; FPP and IQC)
- Drafting of Terms of Reference for the new Commissioning Sub-Committee
- Risk Workshop with the Reach Out partners.

August

- Development of the Reach Out Risk Register
- Development of the LDA governance arrangements
- Formal adoption of governance arrangements by the Provider Collaborative
- Inaugural meeting of the Reach Out Commissioning Sub-Committee.

September

- Second meeting of the Reach Out Commissioning Sub-Committee
- First assurance reporting to the BSMHFT Board Committees

6. RECOMMENDATIONS

The Board is asked to:

- **APPROVE** the governance principles to underpin the PC governance architecture
- **NOTE FOR UNDERSTANDING** the work programme for the next three months
- **RECEIVE** a further update at its August meeting

19. BSOL Mental Health Provider Collaborative

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Trust Board
Agenda item	22
Paper title	**BSOL Mental Health Provider Collaborative – Proposed Approach to Integration and Collaboration**
Date	28 July 2021
Author	Abi Broderick, Head of Strategy, Planning and Business Development
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships

This paper is for (tick as appropriate):		
☒ Action	☐ Discussion	☒ Assurance

Executive summary & Recommendations:

In September 2021 the Boards of BSMHFT, Birmingham Women's and Children's NHS Foundation Trust and Birmingham and Solihull CCG committed that we would start to work together to scope and develop a plan for moving towards an integrated care system approach for mental health across Birmingham and Solihull. It was agreed this would be driven by the principles of reducing and managing demand, improving access, improving safety, achieving better outcomes, and delivering better value for money. A sixth principle of reducing inequalities was subsequently added to reflect Birmingham and Solihull system priorities.

The *NHS Long Term Plan* and the government white paper *Integration and Innovation: Working Together to Improve Health and Social Care for All* both signal a shift away from competition towards more collaborative and integrated health and social care systems. Integrated Care Systems (ICS) need to be in place from 1 April 2022 and locally an ICS has been formed to oversee health and care services for Birmingham and Solihull. Provider Collaboratives will form one of the key elements of an ICS's future structure. This means several organisations coming together to make collective decisions about the design and delivery of health and care services around the needs of a particular group of people (for example, people in a geographical area or people with a shared need).

This proposal sets out our aspiration and vision for the Mental Health Provider Collaborative for Birmingham and Solihull. It is a joint proposal, developed by representatives across the three organisations and informed by engagement with staff members, third sector partners, local authorities and experts by experience. It outlines

an ambitious set of commitments for future working, which we believe are necessary to better make a difference for the population and communities we serve.

The BSOL Mental Health Provider Collaborative aims to improve mental health, biological, psychological and social outcomes. For the Collaborative to achieve these aims it will be critical that partnerships are developed beyond NHS funded mental health services into local authorities and the third sector.

The proposal sets out:

- The six guiding principles and how our programme of work will help us make positive change in these areas.
- The drivers and case for a move towards greater integration and partnership for mental health.
- Options for our collaboration and partnership.
- The proposed programme of work to design and deliver a Provider Collaborative.
- Commitments about how we want to work in a more integrated way in the future and what we want to do across:
    - Cross cutting themes that run through everything we do: health inequalities; place; co-production; and third sector partnerships
    - Workstreams that focus our effort: quality, safety and outcomes; people culture and leadership; finance, contracting and governance; and service/pathway transformation.
    - System enablers that support our work: digital; estates.
- Actions and next steps.
- Challenges and mitigations.

The BSol Mental Health Provider Collaborative Programme Board oversees this programme of work. They endorsed this proposal on 8th July 2021 and approved progression to Trust Boards and CCG Governing Body in July/August 2021.

This proposal has been developed in parallel to the development of the BSOL ICS and fully reflects the ambitions for greater integration and partnership as well as being cognisant of the high-level direction of travel for ICS governance. As the infrastructure and governance arrangements for the ICS emerge we will need to make sure the design of our Provider Collaborative is fully aligned. We also need to make sure there is a strong mental health voice across the ICS in all its place-based partnerships and care programmes. When we have proposals for how the governance, contractual and financial frameworks will work for our Mental Health Provider Collaborative, these will be brought back to Trust Boards and CCG Governing Body for consideration and approval.

Reason for consideration:

Trust Board are asked to note the contents of the proposal and **approve:**

- The guiding principles, commitments and next steps for each of the proposed workstreams.
- To mandate the Programme Board to oversee phase 3 of the programme in line

with timeframes set out.

Previous consideration of report by:

- Mental Health Provider Collaborative Steering Group - 2 July 2021
- Mental Health Provider Collaborative Programme Board – 8 July 2021
- Executive Team – 12 July 2021

Strategic priorities (which strategic priority is the report providing assurance on)

This report relates to all four of the Trust's strategic priorities:

- Clinical Services
- Quality
- People
- Sustainability

Financial Implications *(detail any financial implications)*

1) The Finance and Contracting workstream will be responsible to designing the financial framework for the Provider Collaborative, aligned to both the principles and commitments outlined in this proposal but also the mechanics of the ICS and any formal delegated authority in relation to financial responsibilities. At a minimum this will include openness and transparency about financial spend, as well as joint prioritisation and decision making across the Provider Collaborative.

2) A key next step is for the Steering Group to consider the resourcing of the programme going forwards: this is likely to require a programme lead per organisation and project support as well as a potential joint budget for programme delivery (for example external advice, support for experts by experience, communications and engagement activities etc.).

Board Assurance Framework Risks:
(detail any new risks associated with the delivery of the strategic priorities)

No new risks for the BAF associated with report.

Equality impact assessments:

Reducing inequalities is one of our guiding principles and a key theme running through the proposal. This proposal sets out our aspirations and vision for the future, and as plans get articulated further in Phase 3 onwards, equality impact assessments will be carried out as part of the programme governance where necessary.

Engagement *(detail any engagement with staff/service users)*

The proposal includes a case for change which summarises the key themes that staff, service users, families and carers have told us need to be improved to make mental health care better. For BSMHFT, this includes some of the key themes that came out of the Trust strategy engagement activities.

The BSOL Co-production Steering Group, which includes expert by experience representatives of all ages, were involved in the writing of the co-production chapter

and articulating the commitments for the future.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH PROVIDER COLLABORATIVE: OUR PROPOSED APPROACH TO INTEGRATION AND PARTNERSHIP V.1

NHS
Birmingham Women's and Children's
NHS Foundation Trust

By your side

NHS
Birmingham and Solihull
Clinical Commissioning Group

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Live healthy
Live happy
Birmingham and Solihull

Contents

-

What service users, families, carers and staff have told us they feel and want to see

Executive Summary

This document sets out a proposed approach to establishing a Birmingham and Solihull Mental Health Provider Collaborative. *The NHS Long Term Plan* and the government white paper *Integration and Innovation: Working Together to Improve Health and Social Care for All* both signal a shift away from competition towards more collaborative and integrated health and social care systems.

Provider Collaboratives will form one of the key elements of future structure of health and social care services. They are made up of several organisations coming together to make collective decisions about the design and delivery of health and care services around the needs of a particular group of people (for example, people in a geographical area or people with a shared need). All NHS Trusts will be expected to be part of one or more provider collaboratives that will provide services to the population of an Integrated Care System (ICS). NHS England has already stated that all parts of England will be part of an ICS by April 2021. Locally an ICS has been formed to organise health services for Birmingham and Solihull.

Rising to the challenge of the Covid19 Pandemic has required us to work more closely together across CCGs, mental health providers in the NHS and Third Sector; with people who use services, their families and communities, and with our colleagues in primary care, acute hospitals, local authorities, the police and the Independent Sector.

Our six guiding principles are simple;

- **reduce health inequalities,**
- **prevent mental ill-health and manage demand,**
- **improve access,**
- **achieve better outcomes,**
- **keep people safe**
- **deliver better value.**

Whilst a move towards integration is signalled in national policy, **we are developing the Birmingham and Solihull Mental Health Provider Collaborative because we think that we will be better able to achieve our ambitions for the people we serve by working more closely together.**

Our Collaborative will not only design and deliver services but will have an important role to play in advocating for parity in respect of mental health within the wider ICS. This might include influencing decisions around investment, physical health care pathways and the design of care environments amongst other things.

Traditionally, business cases present a series of appraised options. Here however, we are reflecting back to partners a realistic picture of ‘where we are now’, ‘how we want to work together’ and ‘who we want to work with’. This picture has been derived

from our conversations and engagement with partners through the production of this proposal.

The proposed approach set out here assumes that partnership will be at the level of co-ordination of services, with some examples of joint-management of services or functions where this makes sense.

Currently, we anticipate the Birmingham and Solihull Mental Health Provider Collaborative including Birmingham and Solihull Mental Health Foundation Trust (and its partners), Forward Thinking Birmingham (and its partners), and a range of Third Sector Organisations. The Collaborative will work closely with local authority children and adult social care, public health and other commissioned providers (for example, providers of drug and alcohol services)

Purpose and Scope

This document is intended to do the following:

- Set out the drivers for a move to greater integration and partnership in the form of a Birmingham and Solihull Mental Health Provider Collaborative
- Describe the options for our collaboration and partnership
- Describe the programme of work to design and deliver a Provider Collaborative
- Propose a series of 'commitments' across a range of themes which will be key to unlocking the benefits of collaboration.
- Set out how action across these themes supports our guiding principles and results in meaningful improvement for people who use services, their carers and families.
- Summarise our ambitious programme to transform mental health pathways and services.
- Make recommendations for next steps that the Programme Board and Governing Bodies will be asked to endorse

The BSOL Mental Health Provider Collaborative is being established in the first instance to improve provision of NHS funded mental health services. It is important to note that as such it's work represents a part, and not the whole, of the activity needed to improve the mental health and wellbeing of the population. Such work includes population level prevention and public mental health activity. The Provider Collaborative and our programme of transformation must therefore be seen in the context of a wider programme of work delivered by local authorities, other public and voluntary sector organisations, employers and local communities. Whilst, it is not in the scope of this proposal to attempt to describe in detail how the Provider Collaborative will interface with this wider work we can anticipate this occurring at regional, Integrated Care System (ICS), place and neighbourhood levels.

Clinical Case for Change

The clinical case for change is fundamental to the whole programme of change set out in this proposal. Service users, families, carers and those involved in the delivery of care, want to be in a system that is effective, responsive, safe integrated and importantly helps people achieve meaningful recovery. More than ever our

system must reduce rather than reinforce health inequalities. Experiences of those using and delivering services have for many years reflected care that is disjointed, difficult to access in a timely fashion, complex in its delivery, and separated from other aspects of need or support. Feedback on the need to improve services, and those delivering services with passion and commitment has resulted in significant transformation in some areas - but there is much more to be achieved. Data and service user stories reflect that our population does not receive mental health support that is in parity with their other needs, that does not take account of their ethnicity, financial circumstances, learning disability and autism, social situation and is not inclusive – those who are living in the most difficult circumstances find it the most difficult to access the help that they need. The impact of Covid19 on mental health has resulted in a further imperative to improve care delivery: the number of people suffering mental health problems has increased, in a system that was already unable to meet demand; public perception and media reporting of mental health has increased in a way that has brought mental health into the limelight and removed some of the associated stigma; resources for mental health provision have increased/will increase. The pandemic allowed and even mandated working across traditional boundaries, with an escalation in transformational delivery of care.

The way that mental health care is delivered must change. Firstly, we need to do more as a whole system to address the social determinants of poor mental health and prevent people becoming ill. Secondly, when people need support, the care we provide must be good enough. When care and support is not good enough the impact is felt as devastating personal experiences for those using services, for staff who are unhappy with the care they are able to deliver, and across the system with an increase in the need for expensive escalation and prolonged care and complex interactions with multiple services.

Building on work that has already happened, and is happening now, this proposal is directed at answering the demands of users and staff to truly transform the system in which they live and work in partnership and focussed on delivering experiences of care to our service users, families and carers of which we can be proud.

Programme Overview

The programme of work proposed in this document is a holistic one. This is because to realise the full benefits of collaboration and partnership we need to think about how we work together across a range of themes and priorities.

The programme structure is based on a ‘theory of change’ model. The actions necessary to support the guiding principles are organised as follows:

Cross Cutting Themes that run through everything we do:

- **Health Inequalities,**
- **Place,**
- **Coproduction,**
- **Third Sector Partnerships**

Workstreams that focus our effort:

- **Quality, Safety and Outcomes**
- **People, Culture and Leadership**
- **Finance, Contracting and Governance**
- **Our Programme of Transformation**

System Enablers that support our work:

- **Digital**
- **Estates**

The Programme is overseen by the Birmingham and Solihull Mental Health Provider Collaborative Programme Board. The Board is supported by a Steering Group who coordinate the work of a joint Programme Team compromising staff from Birmingham and Solihull CCG (BSol CCG), Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) and Forward Thinking Birmingham (FTB) at Birmingham Women's and Children's Hospital Foundation Trust (BWCH).

The Programme is organised across four phases. This document represents the output of PHASE TWO:

- PHASE ONE: Existing Collaboration [to date]
- PHASE TWO: Describing Our Approach [May-July 2021]
- PHASE THREE A: Preparation [August 2021 – March 2022]
- PHASE THREE B: Pre-implementation [August 2021 – March 2022]
- PHASE FOUR: Implementation [April 2022]
- PHASE FIVE: Learning and Growing [April 2022 onwards]

Quality, Safety and Outcomes

High quality, safe and effective care means delivering care that is experienced by service users, families and carers, and staff in a way that reflects being cared for, and providing care, expertly and safely. It means working with service users and families and carers, and staff, to reduce avoidable harm. It means providing care that is effective and connected across the service user's life. It means that quality,

safety and outcomes are part of a continuously learning system, with every member of staff being able to effect improvements in care delivery, and every service user, family and carer having agency to impact on improvements in the way that care is delivered.

When we focus on the experiences of users to drive the way that we deliver care that is safe and high quality, it looks more 'messy', and difficult to draw straight lines between the care we are delivering and measures of effectiveness and efficiency, often because we are measuring with too narrow a focus, over too short a timeframe, and the wrong things….

Our proposed commitments are to:

1. Be integrated in the measurement and sharing of data and information
2. Set a culture of openness and honest in the way we deliver safe and high quality care
3. Focus on service users, families and carers and staff to drive the way we deliver safe, quality care
4. Design recovery-based outcomes across the system
5. Ensure that data and technology support continuous learning in pathway and care delivery, and that service users, families and carers are integral to and interactive with the flow of data and information through the system

People, Culture and Leadership

Our workforce is our biggest asset and so investing in and developing our people is going to be critical if we are to stand by our principles.

Responding to the Covid19 pandemic has shone a spotlight on the amazing people that work with the NHS and our partners at every level. However, we know that the pandemic has also taken its toll on people's health and wellbeing. We need to take this into account as we progress the recovery of our system and its ongoing transformation. For staff to build compassionate and person-centred relationships with service users and families our organisations also need to be places where that same compassion is present in the way we make decisions and work together.

Working as a partner in the Birmingham and Solihull NHS People Plan, we propose commitments in the following areas:

- Addressing workforce challenges around recruitment, retention and wellbeing
- Promoting and embracing diversity in our workforce so that it is fully reflective the communities we serve and is inclusive of those with lived experience.
- Stopping discrimination and bullying and establishing a culture of compassion and compassionate leadership that fosters trust
- Empowering staff, giving them the agency to improve quality and safety
- Contributing to economic development through our role as anchor organisations *('anchor organisations' are large, typically non-profit, public*

sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve)[1]

Finance, Contracting and Governance

We are clear that for our provider collaborative to be successful, we want to create a partnership ethos that promotes inclusivity and equality across partners with openness, transparency and collaborative decision making. We commit to developing governance, contractual and financial frameworks that enable and support this partnership ethos. We recognise that decisions will be taken for the ICS as a whole about what provider collaboratives look like, their legal form and their specific responsibilities, but we are keen to influence this where we can and design our governance, contractual and financial frameworks in a way that both align to the ICS and give us the best chance in meeting our core principles. Our proposed commitments include:

- A collective approach to making the best of the Birmingham and Solihull financial envelope, jointly prioritising and making decisions about resources, re-balancing resource, and managing cost pressures.
- Transparent and clear reporting of actual spend against our plans.
- Developing short, medium and long-term financial planning.
- Understanding of resources at a place and sub-place level to support local planning and delivery of services.
- Shifting our contract monitoring towards collective strategic measures and outcomes.
- Developing a contract framework that is fair and transparent and does not penalise smaller organisations with the level of bureaucracy.

Place

People live in a place, neighbourhood and community and this is where care should be centred and where preventative work will take place. Place-based working is a key element of the integration agenda as set out in the NHS Long Term Plan and White Paper[2][3]. Place-based partnership have a critical role in understanding need and shaping the way that services are provided to reflect their local communities. Central to this way of working is the act of joining up and coordinating services to prevent illness and meet people's needs. This is particularly important where people have multiple and complex needs. Often, many professionals and organisations are working with one service user, but because their work isn't joined up its impact is reduced, and in some cases services can be experienced as 'part of the problem' by the person themselves[4].

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[1] https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

[2] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/nhs-organisations-focus-on-population-health/

[3] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

[4] Cottam, H. (2018) *Radical Help: How We Can Remake the Relationship Between Us and Revolutionise the Welfare State*: Virago

We are already doing excellent work ‘at place’ in some areas but we can do much more. Our proposed commitments include:

- Working with emerging place-based partnerships and ensuring local voices inform decision making
- Transforming the way we work with primary care and primary care networks
- Working more closely with local Third Sector Organisations
- Contributing to broader strategies to prevent poor mental health by addressing health inequalities and social determinants.

Co-production

Put simply, we will not be adhering to the principles of the Birmingham and Solihull Mental Health Provider Collaborative if we do not coproduce more of our work more effectively. Why? Co-production recognises that people with ‘lived experience’ of a condition, or need, are best-placed to shape the care and support that would be most helpful to them in the context of their own life. By failing to coproduce we miss the critical insight gained through lived-experience that can meaningfully prevent illness, improve access, increase safety, achieve outcomes and reduce inequality. Where power is genuinely shared, discussions are more grounded in reality and the ‘person’ is more likely to be placed at the centre of people’s thinking, planning and provision.[5]

We want to ensure that service users, their carers, families and communities are coproducing the design, delivery, governance and quality assurance of provision. Our proposed commitments to co-production reflect this:

- Working as equal partners
- Supporting and valuing co-production in practical ways
- Ensuring co-production practice is inclusive
- Growing, developing and valuing the lived experience workforce

Health Inequalities

Addressing health inequalities is a priority for the Birmingham and Solihull Integrated Care System. The diversity of our community is an enormous asset culturally, socially and economically. However, areas of significant local inequality have a dramatic impact on the health and wellbeing of the population.

Inequalities remain deep rooted in our society. This not a problem for those affected to address, it’s for all of us and organisations and individuals to stand up and take responsibility. In responding to the events of the past year such as the impact of Covid19 and Black Lives Matter, and what we already know about the inequalities in our society and our health and care system, we will take up the challenge to tackle inequalities of all kinds that are experienced by colleagues and people we support.

Our proposed commitments include:

- Supporting the ICS’s work in this area

[5] https://coalitionforpersonalisedcare.org.uk/wp-content/uploads/2020/10/C4CC-Co-production-Model.pdf

- Ensuring our programmes of work are explicit in demonstrating how they will contribute to reducing health inequalities and effectively monitoring this
- Working closely with local communities and making better use of data to inform our work
- Zero tolerance of discrimination

Partnering with the Third Sector

The Third Sector is expert in providing support and thinking that is whole-person, whole-family and whole-community focused[6]. This holistic approach is rooted in the history and culture of many local organisations founded by people with lived experience of the issues they now respond to. This culture can be seen in contrast to that of the NHS and public sector which has often treated individual aspects of people's needs in isolation. As we seek to work in a more person-centred way we are fortunate to be able to draw on the wealth of experience that the Third Sector has in this regard. Although we are working increasingly closely and effectively with local Third Sector Organisations there is more we can do to fully realise the benefit of partnership and to support a thriving and sustainable sector. We propose commitment to:

- Strengthening the role of the Third Sector in the leadership and governance of our system
- Embracing the Third Sector as equal partners in service delivery and in helping to address barriers to this
- Drawing on the experience and insight of the sector in designing and developing services
- Exploring how local networks of Third Sector Organisations can be effectively linked with mental health services in each Primary Care Network and aligning with Neighbourhood Networks (Birmingham) and Thriving Communities Programme (Solihull)

System Enablers: Estates and Digital

As the Birmingham and Solihull ICS develops, organisations are already progressing collaborative on programmes of work to ensure that our estate and our digital infrastructure support and enable improved health outcomes.

We will work to influence the emerging ICS estates and digital strategies to help ensure that there is parity with other health and care needs for people accessing mental health support and facilitate more effective ways of working for staff.

Transformation Programme

The Birmingham and Solihull Mental Health Strategic Outcomes Framework (embedded at **Appendix Three**) sets out our programme of transformation. At the heart of our transformation is the intention to work 'upstream' to prevent poor mental health and respond quickly when people need support to avoid the problem becoming a crisis. Doing this requires us to work as a system with local authorities, the Third Sector, Police, the Ambulance Service, the Criminal Justice System, schools and colleges, faith groups, communities, families and people who use

[6] https://vcsereview.org.uk/

services. This reflects both the nationally determined components of the NHS Long Term Plan and a number of local priorities – such as improving access to support for autism and ADHD. In addition, Local Transformation Plans for Children and Young People's Mental Health set out further detail of our objectives for 0 to 25 year olds. Separate plans are in place for Birmingham and Solihull. Our programme of transformation covers the following areas:

- Transformation of community mental health services, including expansion of the mental health workforce in primary care
- Children and Young Peoples' Mental Health (0-25)
- Perinatal Mental Health
- Older Adults Mental Health
- Rehabilitation and Recovery
- Urgent and Crisis Care
- Suicide Prevention
- Neurodevelopmental

Challenges

It is easy to find consensus around visions and principles but inevitably making collaboration work is not straightforward and will require sustained commitment over time. Challenges may include:

- Building and maintaining levels of trust and confidence in the endeavour
- Agreeing the detail of financial, contractual and governance arrangements
- Maintaining pace and momentum without leaving people behind
- Answering the 'so what' question and making the Provider Collaborative meaningful and relevant to staff, stakeholders and people who use services
- Ensuring our work in mental health is aligned with and complementary to the development of the wider Integrated Care System

In addition to the workstreams set out above the programme will need to take steps to respond to these challenges positively and constructively.

Conclusion and Recommendations

This document describes the vision for a Mental Health Provider Collaborative for Birmingham and Solihull, explaining how we want to work in a more integrated way and how this will support and enhance delivery of our six guiding principles.

Our proposals are fully cognisant with the ongoing and emerging work taking place across Birmingham and Solihull ICS to define governance models and a framework for strategic commissioning. As we carry on designing our governance framework in more detail, we will ensure this reflects and is aligned with the ICS direction of travel. We hope however, that by articulating our commitments to provider collaboration in mental health that we can share these with the wider ICS and influence the future direction of travel for provider collaboratives.

Throughout the document we have described our next steps in relation to each workstream. A key immediate priority will be for us to define what leadership and resource is needed to move us into the next phase of our planning and

implementation. Our commitments are ambitious but necessary and we mustn't underestimate the time and focus that needs to be given to this to be successful.

Following endorsement of this proposal by the Programme Board, we aim to take this through organisational governing bodies/boards by the end of September 2021.

The Birmingham and Solihull Mental Health Provider Collaborative Programme Board is asked to:

- ✓ Endorse the guiding principles, commitments and other content of the proposal
- ✓ Recommend that organisational governing bodies receive and approve the proposal
- ✓ Subject to governing body approval, initiate and resource, via the Steering Group, a project to implement Phase Three of the Programme and progress the delivery of the 'next steps' set out in the proposal.

Introduction

Supporting the mental health of our population in Birmingham and Solihull is at present delivered through a number of statutory and non-statutory bodies, with a range of organisational maturity, formality, and disparity in terms of inclusivity and geography. The way in which support is provided, and interfaces, is varied – with the experience of clients who encounter services acutely reflective of all aspects of this variation.

Organisations/Groups/Partners involved in Mental Health Support (Not Exhaustive)	
Service Users and Families	
NHS Mental Health Services	Children and Adults
Acute Care NHS Services	Children and Adults including Urgent and Emergency Care Pathways
Primary Care	
Community NHS Services	
Ambulance Services	
Third Sector Organisations	
Local Authority Services	Social Care
	Police
	Special Educational Needs and Disabilities (SEND)
	Healthwatch
	Health & Wellbeing Boards
Employment Organisations and Services	
Educational Organisations and Services	
Autism Spectrum Disorder & Learning Disability services	
Independent Sector	

Need for mental health support exceeds provision in many parts of the system. This is both a reflection of continuing shortage of provision and increasing demand – with the latter being exacerbated through people's experiences during the current Covid19 pandemic.[7]

NHS care provision is moving increasingly towards a system-based approach with integration of services between a range of providers, with mental health being prioritised for this approach. In addition, two significant national programmes are already in place to improve mental health service provision – the Long Term Plan (LTP)[8] and the Mental Health Investment Standards (MHIS)[9].

The Birmingham and Solihull Strategic Outcomes Framework for Mental Health **(Appendix Three)** sets out a 'direction of travel' for mental health services across

[7] https://www.nationalhealthexecutive.com/articles/home-group-mental-health-crisis
[8] https://www.longtermplan.nhs.uk/areas-of-work/mental-health/
[9] https://www.england.nhs.uk/publication/mental-health-investment-standard-mhis-categories-of-mental-health-expenditure/

Birmingham and Solihull. The document describes key approaches to meeting people's needs from prevention through early intervention to admissions to hospital and rehabilitation. It is important to note that what is set in the Framework represents a part, and not the whole, of the work necessary to reduce the burden of poor mental health across the population.

The work that has already occurred across Birmingham and Solihull working towards improved integration, and more seamless care for service users and their families and carers is an important basis on which formalisation of integration can occur. Previous imperatives to improve integration, access, communication, early help, have resulted in development of better pathways and communication through closer working with Third Sector organisations, primary care and local authorities. Increasing focus on the lived experience of service users and their families and carers has helped us better understand what quality looks like[10]. However, case studies, service user and family and carer experiences, and staff feedback, all continue to show that there are still poor experiences of receiving and delivering care, often with silo working characterised by poor communication and planning, so that consistent delivery of person-centred recovery-based care remains an aspiration. In addition, the ambition to engage fully with Third Sector and community service provision to improve early interventions at a local level and support and prevent escalation of need has been a stated strategic aim across all service delivery agencies for many years – and whilst there are some successes in this area, there is plenty more to be achieved for the benefit of service users, families, carers and the entire system.

In 2020 the Birmingham and Solihull Sustainability and Transformation Partnership (STP) responded to NHS England's requirement that all parts of England be part of an Integrated Care System (ICS) by April 2021. The Birmingham and Solihull Integrated Care System was formally approved by NHSE in December 2020.

In parallel with the STP's application to form an ICS, Birmingham and Solihull Clinical Commissioning Group (BSol CCG), Forward Thinking Birmingham - Birmingham Women's and Children's Hospital Foundation Trust (FTB-BWC) and Birmingham and Solihull Mental Health Foundation Trust began working on a project to form a provider collaborative to deliver mental health services to the people of Birmingham and Solihull. The project has been adjusted over time to take into account the changing landscape of commissioning, and the need to redeploy staff to roles supporting the Covid19 response. As the pressure due to the Covid19 pandemic has eased, resources have been redeployed to support this work.

Provider Collaboratives are a key building block of Integrated Care Systems and will be involved in both designing and delivering services, as well as making decisions about how resources are allocated and how care is delivered flexibly to meet the needs of local populations[11].

[10] http://wrap.warwick.ac.uk/100545/7/WRAP-impact-process-evaluation-report-Birchwood-2018.pdf; https://onlinelibrary.wiley.com/doi/10.1111/eip.13009
[11] https://www.kingsfund.org.uk/publications/next-steps-towards-integrated-care

The reorganisation of commissioning and contracting from CCG based systems to that of an ICS is in progress. Whilst there is emerging guidance around the structure and governance of the ICS, at this stage of the developments are not yet at a level of clarity that allows a good understanding of how this will be organised and interface with provider collaboratives. There is a significant and appropriate focus on strengthening the Place-based care that has been developed over the last few years – how this will fit into the new structure is again as yet unclear.

Despite a lack of clarity around some of the organisational, structural, and governance elements, this proposal will:

1. Use the 6 guiding principles (below) as challenges to collaborate in ways that make a real difference
2. Focus on ensuring that the Birmingham and Solihull Mental Health Provider Collaborative partners sign up to principles of working across key areas including Quality, Safety & Outcomes, People, Culture and Leadership, Finance, Contracting and Governance
3. Keep Place, Health Inequalities, Co-production and Third Sector Partnerships at the centre of the proposal and continuing work
4. Ensure that enablers such as Digital and Estates are key partners (interface with ICS workstreams)
5. Describe the commitments that will underpin the design of the details of partnership working within the Collaborative, with Place, and with the ICS and that will form the ongoing working groups for the Collaborative

Principles

We have six guiding principles for our mental health provider collaborative that set out how we want to make a difference. Throughout this document, we have used the principles to focus outputs for each of the workstreams to make sure we can demonstrate positive change from collaboration and integration.

Clinical Case for Change

Context and data to inform the Clinical Case for Change has been drawn form a wide range of sources, including user feedback (both personal stories and from organisation systems), Healthwatch and other bodies involved in collecting data and information on mental health service provision and experience, previous reports on transformational change, The Kings Fund, local and national reporting and publications, and information published in relation to mental health experience and provision impacted by the Covid19 pandemic.[12]

[12] https://www.theguardian.com/commentisfree/2021/mar/29/conversation-mental-health-psychiatric-language-seriously-ill; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975891/covid-19-mental-health-and-wellbeing-recovery-action-plan-easy-read.pdf; https://www.kingsfund.org.uk/publications/covid-19-road-renewal-health-and-care

User Experience

There is an overwhelming wealth of data, reports and feedback which tell us that the experience of mental health service users, their carers and families does not always meet the standard that they, or we as providers, feel is good enough. Whilst there are improvements in many areas, there are some key themes in the user experience that should underpin transformation and development of services.

1. **Fragmentation and continuity of care**:
   Services are often fragmented with a lack of continuity, which often means our service users do not receive the holistic support and joined up care they need.
2. **Thresholds for accessing support:** restrictive thresholds and criteria for accepting people into our services can make it difficult to get the right help at the right time and can lead to people 'falling between the gaps'.
3. **Complexity of pathways:** our pathways and services are complex and difficult to navigate, both within and across organisations.
4. **Repetition of information:** people tell us they are frustrated having to tell their stories multiple times and repeat the same information to different professionals and teams
5. **Lack of agency and control:** our service users, families and carers want to be involved in decisions about their care and care planning, able to make informed choices about a range of treatment options.
6. **Recovery at the heart:** our service users want their care to be focussed on recovery from the beginning of their journey through services, supporting them to flourish in whichever way is important to them and empowering them to manage their own mental health on a day-to-day basis.
7. **Poor transition:** moving between different services can be difficult and many service users describe a poor experience of transition
8. **Timeliness of intervention/support**: at times and for some services, waits for assessment or treatment can be long with little or no support offered in the interim.
9. **Integration and access to physical health support:** people with mental ill health often also experience poor physical health. Despite this, services are not always integrated, a person's mental and physical health are not routinely considered at the same time, and at times there is a lack of access to physical health support needs.
10. **Care that considers holistic needs:** service users want to experience care and support for physical health, mental health and social needs that is truly joined up through multi-agency and multi-disciplinary assessment, care planning and delivery of services.
11. **Better support for families and carers:** making sure families and carers are recognised, supported, informed, listened to and connected to the care and treatment of the person they support.

Demand/Supply Imbalance

Over recent years there has been an increase in the number of people who experience a diagnosable mental health condition. We have also seen an increase in the levels of acuity of people accessing mental health services, while complexity is increasing as more people have multiple co-morbid health conditions.

Capacity in our services is sometimes not enough to meet current levels of demand which is shown by:

- Individuals frequently placed ‘out of area’ when they need inpatient beds.
- Longer lengths of stay on wards.
- Delayed discharges from mental health services.
- Caseloads in our teams above best practice levels making early and effective intervention difficult to achieve.
- Long waits for some services such as community services, psychological therapies, and assessments for neurodevelopmental conditions.
- Staff reporting that they at times feel stressed and overwhelmed with trying to manage demand.

We know as well that due to population growth and the impact of the Covid19 pandemic, the number of people who will need to access mental health services in the future will rise:

- Experiences during the pandemic have had, and will continue to have, a significant impact on mental health for children and young people, adults, and older adults.
- Living with health concerns, restrictions and isolation, loss of coping mechanisms and support networks, change in economic circumstances, bereavement or experiencing the direct impact of Covid19 at work, are all expected to have a detrimental impact on mental health.
- Many staff across the health and social care system are experiencing these negative impacts of Covid19, added to the relentless pressure on services over more than a year with the risk of high levels of stress and burnout. This presents issues for staff health and wellbeing and workforce capacity.

Inequity and Lack of Inclusion

While the focus on mental health services is greater than a few years ago, years of under-investment in mental health means that services are not on an equal footing with physical health services, and that there is unmet and growing need in our communities. In addition, the Covid19 pandemic has held a mirror up to the scale and impact of inequalities in the area we serve. Examples of the inequities include:

1. Longstanding ‘poor relation’ of mental health services when compared with physical health services
2. Mental health seen as an ‘issue’ that interferes with delivery of physical health support e.g. in Emergency and Urgent Care pathways, ambulance and police, in inpatient wards designated for physical health support rather than mental health support, in health care workers who see mental health issues as a nuisance and burden on them and of taking them away from supporting what they *should* be doing – e.g. supporting physical ill health needs of service users and families.
3. Lack of parity of physical and mental health needs also mean that those with mental health issues experience poor physical healthcare
4. Experience of mental health care access and support is disparate in different sectors of the local population including ethnicity, learning disability and autism, and the complexities associated with poverty and social circumstances.

5. We know that some people from marginalised groups or with protected characteristics are less likely to access our mental health services. We also know that in some services, we have over representation from Black, Asian and minority ethnic (BAME) communities, for example, Black people are more likely than White British people to be detained under the Mental Health Act.
6. Wider causes of inequalities and mental ill health include poverty, unemployment, poor education, gambling and housing issues.

Policy and Mental Health

Drivers for provision of health care have long prioritised physical health and separated the provision of mental and physical healthcare. With a national context of increasing understanding of the need to improve provision for mental health, and mental health now having reached the giddy heights of national prioritisation, the scene is set for real and sustainable improvement in service provision. Clear national policy drivers have been set, which include the NHS Long Term Plan for Mental Health and the Mental Health Investment Standards – resulting in an ability for local prioritisation and funding streams to deliver fundamental change to the quality of mental health services.

The Covid19 pandemic has resulted in a spotlight on mental health and in some quarters may have reduced the stigma that has traditionally dogged the ability for mental health to have parity of esteem with physical health. This has been reflected in a rise in media interest and a more responsible and sensitive approach to reporting of mental health issues. A public narrative has been supported by those working in healthcare and other frontline services being prepared to share their experiences of the impact of Covid19 on their mental health. 'Recovery from Covid19' policy prioritises mental health alongside the traditional priorities of emergency, urgent and elective care.[13]

This convergence of public opinion and experience with national policy has resulted in a unique opportunity to bring mental health provision into all conversations about health, rather than as an 'add-on'.

The framework for this opportunity began with the Five Year Forward View for Mental Health[1415], continues with the Long Term Plan[16] and Mental Health Investment Standards, and is supported most recently by the Covid19 Mental Health and Wellbeing Recovery Action Plan and supporting planning guidance, and the transition to integration afforded by the creation of ICS's.

Alongside the prioritisation of improvement of mental health service provision is the re-organisation of service provision as networks of integrated care provision across

[13] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan
[14] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan
[15] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[16] https://www.longtermplan.nhs.uk/areas-of-work/mental-health/

service providers rather than individual contracting of services, and a focus on Place and personalised care. The pressures of Covid19 have resulted in a natural need to work across traditional boundaries, and to accelerate alternative forms of care provision – supporting the work already taking place under the Transformation Programmes and LTP. The establishment of Integrated Care Systems to provide the strategic framework for care delivery across an STP footprint, and the formation of Provider Collaboratives for the delivery of these strategic outcomes is the foundation for this project.

A powerful way of improving services and support is to work in equal partnership with the people who use services, families and staff to deliver services that use their priorities as drivers for pathways of care. When we do this, the focus is on integrating care and support service delivery and reducing silo service delivery. Integrating, even within single organisations, can be complex – so integrating across and between organisations is even more of a challenge. Despite the complexities we have many examples of where integrated delivery has provided improved experience of care, improved experience for the staff delivering care, with improved outcomes for users, families, staff and organisation. When this bottom-up approach is used, with 'top down enabling', not only is there service improvement, but there is more likely to be agility of service response to feedback and external forces (eg Covid19) because of the strength of the human relationships within these systems, supported by enabling structures.

The NHS Long Term Plan, place-based partnerships, provider collaboratives and localisation of care delivery, and therefore this project to increase integration in BSol Mental Health provision, are facilitated by the statutory changes that are currently being implemented.

This project then will embed the principles of integrating for benefit – for users and their families, staff and organisations, with the development of the human relationships at all levels of the system underpinning a strong operational Case for Change and reflecting the statutory requirements in commissioning and contracting as a Provider Collaborative.

Options for Collaboration & Partnership

Partnership can come in a range of forms. Crucially, who you partner with and how you work together will depend on, amongst other things, the nature of the task in hand and the context in which partnership is taking place. The diagram below shows partnerships varying in both their breadth (the range and number of partners) and their depth (the closeness of the relationship)[17].

Traditionally, business cases present a series of appraised options. In this case however, we are reflecting back to partners a realistic picture of 'where we are now',

[17] https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/we-have-to-stop-meeting-like-this-PP13.pdf

‘how we want to work together’ and ‘who we want to work with’. This picture has been derived from our conversations and engagement with partners through the production of this proposal.

As described in the section on governance below, the arrangements for future contracting between the ICS and provider collaboratives is not yet clear. As these plans become more fully formed our partnership may need to adapt in response.

The breadth and depth of the relationships within the BSol Mental Health Provider Collaborative may shift over time as we continue to be guided by our principles.

Breadth: Currently, we anticipate the Birmingham and Solihull Mental Health Provider Collaborative including Birmingham and Solihull Mental Health Foundation Trust, Forward Thinking Birmingham (and its partners) and a range of Third Sector Organisations. The Collaborative will work closely with local authority children and adult social care, public health and other commissioned providers (for example, providers of drug and alcohol services)

Depth: The proposed approach set out here assumes that partnership will be at the level of co-ordination of services, with some examples of joint-management of services or functions where this makes sense. In the governance section below we propose that as part of the establishment of the Collaborative we develop a governance framework which would set out the terms of our partnerships in more detail.

There are no plans to establish a partnership organisation or seek a formal merger at this time. As the contractual arrangements for provider collaboratives are confirmed it will be necessary to reach agreement as regards any necessary contractual relationships between members of the Collaborative.

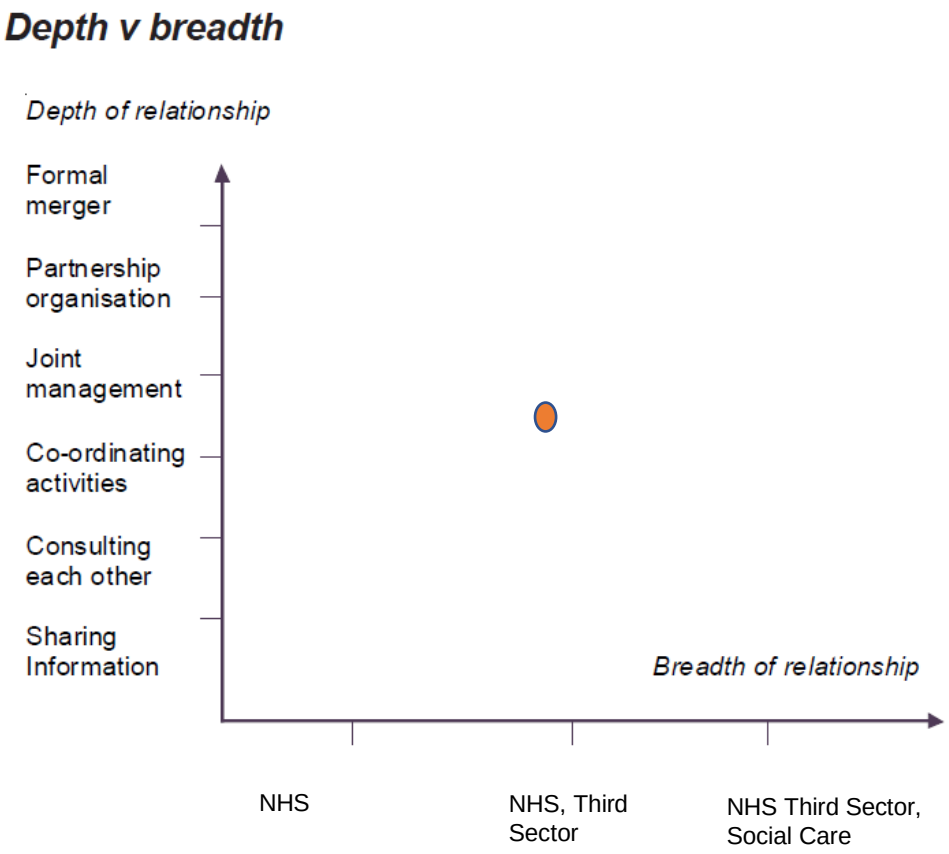


Figure 1: adapted from Glasby, J. (2012)

Programme Overview

Our guiding principles are simple... reduce health inequalities, manage demand and prevent mental ill-health, improve access, achieve better outcomes, keep people safe and deliver better value. We are developing the Birmingham and Solihull Mental Health Provider Collaborative because we think that we will be better able to operate in line with our principles by working more closely together.

The programme of work proposed in this document is a holistic one. This is because to realise the full benefits of collaboration and partnership we need to think about how we work together across a range of themes, priorities and organisations. Where we are weak in particular areas this will undermine our efforts elsewhere. For example, we might design integrated pathways of care delivered by co-located teams – but if we fail to collaborate around workforce, recruitment and culture we won't fully staff our service or effectively enable our people to work as one.

In developing this proposal, we were set the challenge of articulating how working collaboratively would enable us to achieve our improvement principles. Each of the thematic sections below begins with a table showing how the principles will be met.

Programme Structure

The programme structure is based on a 'theory of change' model. The actions necessary to support our guiding principles are organised as follows:

Cross Cutting Themes that run through everything we do:

- **Health Inequalities,**
- **Place,**
- **Coproduction,**
- **Third Sector Partnerships**

Workstreams that focus our effort:

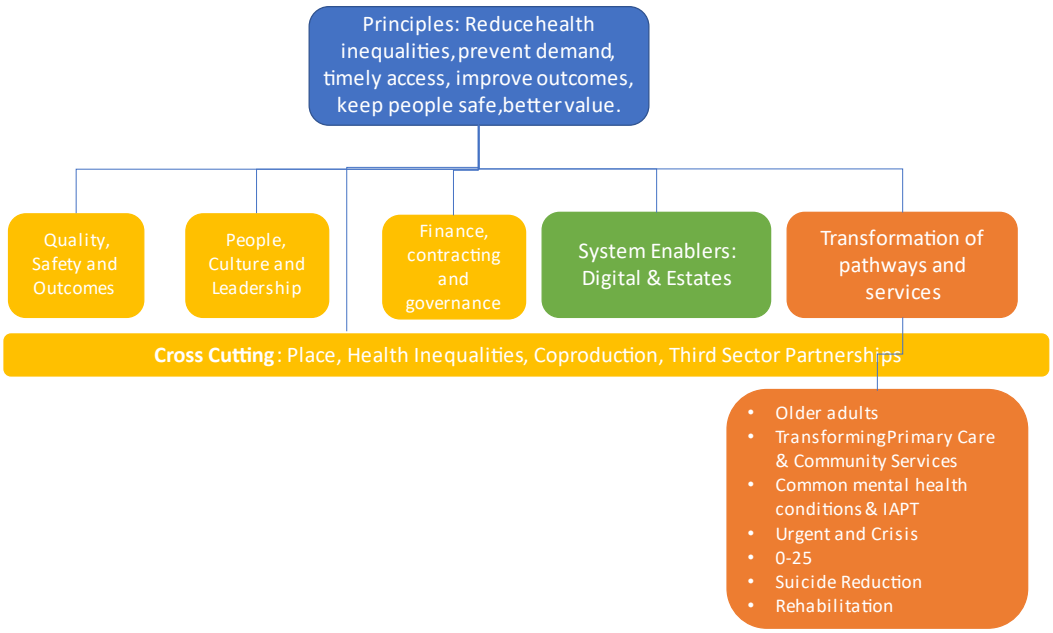
- **Quality, Safety and Outcomes**
- **People, Culture and Leadership**
- **Finance, Contracting and Governance**
- **Our Programme of Transformation**

System Enablers that support our work:

- **Digital**
- **Estates**

In parallel with the Provider Collaborative Programme our BSol Mental Health Transformation Programme is shown also. This reflects the interdependency of these programmes of change in achieving our improvement principles.

Figure 2: BSOL Mental Health Provider Collaborative Programme Structure



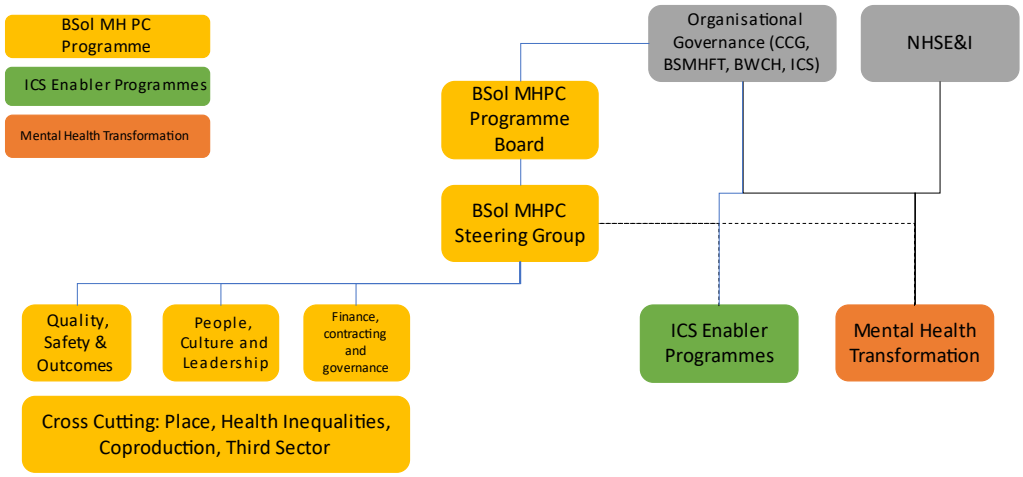
Programme Approach and Governance (Figure 2)

The Programme is overseen by the Birmingham and Solihull Provider Collaborative Programme Board. The Programme Board is responsible for overseeing the design, development and establishment of a BSol Mental Health Provider Collaborative (MHPC) with the intention of enabling positive change for service users, staff and communities.

A Steering Group was established to oversee the work of the Programme Team and the development and production of the proposal document.

The Programme Team led work with partners and stakeholders through groups reflecting the workstreams and cross-cutting themes and via engagement with other existing fora. Where possible the content and commitments set out were developed iteratively through this engagement. As such it is hoped that the document is reflects a collective view of the work that will make the most difference in enabling collaboration, change and improvement. A list of engagement activity is included in **Appendix One**

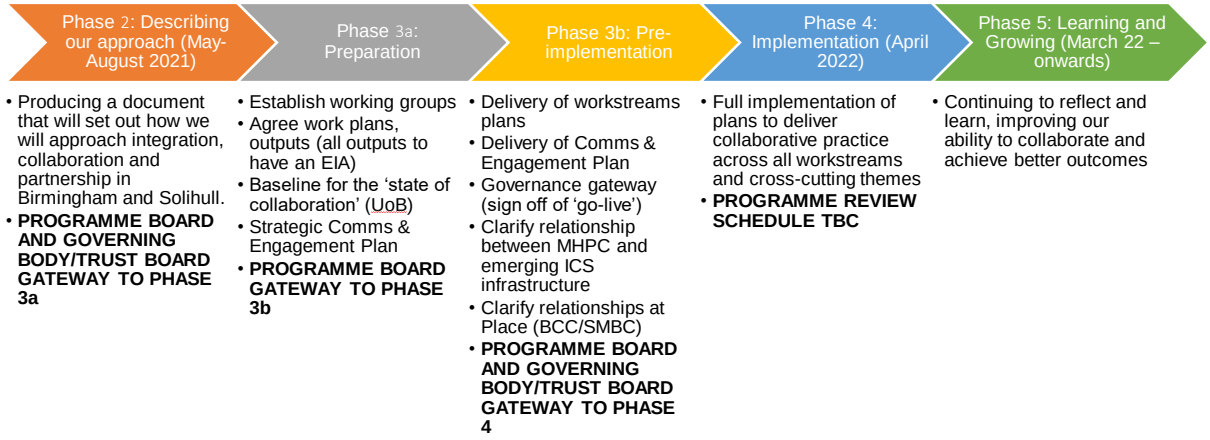
Figure 3: Programme Governance Structure



Programme Phases and Next Steps (Figure 3)

This proposal document is the output of Phase 2 of the Programme (see Figure 3, below). Subject to partner's agreement to the approach set out here, Phase 3 takes the necessary next steps in progressing the more detailed work to deliver the commitments set out below and to monitor their impact.

Figure 4: BSoL Mental Health Provider Collaborative Programme Phases and Next Steps



Our Proposed Commitments

Developing our ability to collaborate effectively to improve mental health outcomes will take time. This document does not describe the detail of how the BSol Mental Health Provider Collaborative will function. These details will require continued engagement and will form Phase 3 of this programme of work. It should be noted that at the time of writing systems are awaiting further national guidance in respect of legislative changes, locally partners are continuing to work towards an agreement around local ICS arrangements.

The sections below provide background and context in relation to each of the workstreams and cross-cutting themes within the programme. Each section illustrates how the theme will meet the principles. We then list a number of proposed 'commitments', developed through discussion with stakeholders, that we recommend the Provider Collaborative adopt. The commitments are intended to provide the foundations for collaborative working across key areas - delivering next steps will require making true collaboration a reality and setting up working groups to deliver against the commitments. In addition, the commitments will act as a touchstone for all partners to return to and against which we can collectively hold ourselves to account.

Quality, Safety and Outcomes

Quality & Safety, and Outcomes Groups and individuals who worked on this proposal included wide ranging participation that reflected experience and expertise across a range of providers, users, service delivery staff, and localities. Place, health inequalities, inclusion and diversity were fundamental to the design and discussion of these sections – co-production of commitments and next steps were treated as mandatory to the process.

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Measuring demand across all services; improving support in most appropriate level of care; joining up service delivery; reducing duplication	Safety, quality, and outcomes delivering service user driving recovery care plans that are locally fir for purpose; outcomes designed in partnership with service users that reflect person's protected characteristics and ensure disparity is addressed	Continuous improvement embedded through quality, safety and outcomes improving local, place based, early support, and delivering recovery based outcomes intervention early in the service user journey	Effective measurement, with system wide understanding of interfaces and impact across the service user's life, truly personalised recovery based outcomes designed care pathways, continuously learning systems of care delivery.	Improved levels of reporting of lower level incidents; widespread use of Learning from Excellence (LfE); shared information around potential areas of risk and early intervention; development of system oversight (eg MH System Oversight Group)	Recovery based care pathways and planning; early intervention through use of quality, safety and outcomes information to drive earlier support, and integrated service provision across the service user's life and health experience

Table 1: How a focus on Quality, Safety and Outcomes supports our guiding principles

Quality and Safety

High quality, safe and effective care means delivering care that is experienced by service users, families and carers, and staff in a way that reflects being cared for, and providing care, expertly and safely. It means working with service users and families and carers, and staff, to reduce avoidable harm. It means providing care that is effective and connected across the service user's life. It means that quality, safety and outcomes are part of a continuously learning system, with every member of staff being able to effect improvements in care delivery, and every service user, family and carer having agency to impact on improvements in the way that care is delivered.

To achieve this across the BSol Mental Health Provider Collaborative will require substantial changes to the way in which Q&S and Outcomes are managed across not only health care organisations, but also non-health. Whatever the structure and governance framework for Provider Collaboratives, and their interface with the ICS and Place, in order to impact meaningfully on the experience and quality of service delivery and safety, the level of information sharing and openness across the system must be significantly improved. This will engender anxieties in some parts of the system. There is however already an important move at least within health and commissioning organisations, to share, and to use a wider forum to improve services in response to serious incidents and an emerging culture of openness in the system, with senior leadership role models at key strategic positions. This alongside the

commitment of experts by experience in the system, who have been fundamental in creating this proposal, and who continue to challenge us to put them at the front and centre of transformational change, is an exciting and effective platform for a real shift in care delivery.

Our commitments for Quality & Safety:

- ✓ We will use the existing BSol, BSMHFT and FTB work and strategy on Quality & Safety to underpin the BSol Mental Health Provider Collaborative Quality and Safety Strategy
- ✓ Oversight structure and function across the BSol MH Provider Collaborative will include experts by experience at all levels, with clear roles and responsibilities, training and remuneration
- ✓ Policies, procedures, and standards will be unified wherever possible across the Collaborative, will include clear escalation, and take into account the BSol Mental Health Provider Collaborative as well as individual organisations and partners
- ✓ An open, honest, and transparent culture for Quality and Safety will be role modelled across the BSol Mental Health Provider Collaborative and within partner organisations, and will include high volume reporting of low threshold incidences as this evidences system safety
- ✓ We will improve agency of frontline staff to improve care/avoid future incidents in all disciplines and at all levels, including non-clinical staff, with a clear accountability and responsibility/just culture/system improvement culture
- ✓ We will embed Learning from Excellence in the reporting system and culture (see reference 18)
- ✓ Quality matrices and reporting will be aligned and agreed across the BSol Mental Health Provider Collaborative with clear line of sight into how measures and initiatives are reflective of improvement for service users and their families and carers, and for staff
- ✓ Quality monitoring and assurance will meet mandatory, statutory and compliance requirements across the BSol Mental Health Provider Collaborative
- ✓ We will focus on working collaboratively around quality monitoring and assurance to learn from experience and deliver positive, impactful and lasting change
- ✓ We will work to set up systems for collection and analysis of feedback across the BSol Mental Health Provider Collaborative
- ✓ Quality Improvement principles will underpin service change delivered through Quality & Safety and Outcomes
- ✓ We will align existing reporting systems and consider a BSol Mental Health Provider Collaborative - wide reporting system
- ✓ We will use Human Factors Training across the system
- ✓ Significant incidents, critical reports from external agencies, and from users, families and other organisations, will be responded to with openness, honesty and transparency, with a focus on learning and improvement
- ✓ Information flow should inform the leadership and culture in an open and transparent manner so that there is clear evidence of transformational culture and leadership in response to the service users and families and carers and the communities in which they live.

[18] https://learningfromexcellence.com/

Current State

Quality management and safe practice processes are present in each organisation of the partnership in various forms and are a normal part of the structure and function of delivering care, receive high levels of scrutiny and focus, and are mandated for compliance with external monitoring.

Previous transformational change, research both locally and in wider geographical and healthcare context, and reporting of serious incidents reflects recuring themes of lack of communication and 'joined up' working between different parts of the same organisation, and between different organisations. Quality and safety therefore in the BSol Mental Health Provider Collaborative must be founded on collaboration, sharing, communication and openness, and a continuous breaking down of traditional boundaries and silo working.

Groups and individuals within organisations with a responsibly and passion for Q&S are working together in various fora across the system to improve the way that Q&S is managed in a more system-based approach. These include the Quality Governance Service User Safety Hub (BSMHFT/FTB/CCG) and the Multiagency Quality Oversight Group.

Other agencies connected to service user and family pathways, and integral to delivering safe high-quality services include physical health, police, social services, housing, education, employment, third sector, local communities are not currently clearly embedded in a multiagency structure, except in response to serious incidents or externally mandated reviews.

Mandatory, Statutory and Compliance These are items that are required to be measured by service providers. In Mental Health delivery services these include (not exhaustive)	
Mental Health Services Dataset[19]	
Care Quality Commission compliance measures[20]	
Commissioning requirements	Bsol Mental Health Strategic Commissioning Outcomes Framework
	Mental Health Investment Standards
	CQUINs
Other service providers will have their own requirements. Understanding the information mandated in these areas that will enhance the experience of care that service users, families and their	Housing
	Social Services
	Education
	Employment
	Physical Health Services

[19] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

[20] https://www.cqc.org.uk/guidance-providers/mental-health-services/how-we-regulate-mental-health-services

carers receive, as well as ensuring compliance across the system is needed. Having sight of data from all organisations ensures that services are collecting and meeting standards, but also enables analysis of the data collected across the system to have early flags of concern, and to understand where services/system can improve.	Third Sector Organisations
	Substance misuse services
	Police

Next Steps for this Workstream

Working Group/Task & Finish Group to be set up to continue the work of the current groups in to deliver:

- Design a collaborative and inclusive system of Quality and Safety and Outcomes oversight, with measurement, data gathering, interpretation and feedback across partners, quality improvement embedded, and clear governance structure and lines of responsibility
- Consider setting up a 'hub and spoke' model to ensure that the 'Hub' sees information from organisations and system-wide, and local 'spokes' ensure Place-based coproduction and community partnership to enhance local relevance
- System quality and safety principles to be embraced by all partners, with the ability for local place-based additions and amendments to ensure that principles are locally appropriate and effective
- Feed into the ICS and other working groups to design and enhance digital and technology systems, working across the system to maximise the collection and use of data and information to improve service quality and safety, and to bring value directly to the service users and families and carers through integration of service user and family and carer information into their care pathway.
- Digital/Technology Working Group across BSol to embrace wider care record innovation and invest in integrated systems to join up care delivery across the system not just in (mental) healthcare records.
- Embed LfE across the system
- Provide Human Factors training across the system
- Provide Quality Improvement training across the system
- Ensure explicit role modelling and champions of open and transparent Q&S practice

Outcomes

Introduction

Measuring the success of services delivered is fundamentally important. If integration of mental health services across Birmingham and Solihull is to be successful – ergo if it is to deliver the intention of improving the state of mental health service delivery and the experience of the service users and families within that service, then it is crucial that there is measurement and relatable improvement. The difficulties of measuring outcomes are well documented even in more simple services – it is therefore no surprise that multidisciplinary discussions around measuring outcomes across integration mental health services in BSol have explored how to successfully measure success of service delivery in such complexity. This then is the multidisciplinary co-produced description of the ways in which the Birmingham and Solihull Mental Health Provider Collaborative are asked to ensure that the services delivered are effective and continuously improving.

Clinical outcomes are key. However, outcomes that focus on the contexts for service users and families and recovery are increasingly understood to be required in order for the intentions of service delivery to achieve real and meaningful improvements for service users.

In addition, although outcomes relating to health service delivery are crucial, collaboration across the system to include the wider aspects of service users and families where they come into contact with those delivering mental health support requires an understanding of those contacts and their impact on the 'health' of all of the services delivered and their interaction with each other that relate to the mental health of service users and families. [21]

[2121] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf

Our commitments for Outcomes:

- ✓ We will design outcomes that can be used as a baseline across all (eg 10 localities) but will support adaptation/addition reflective of and applicable to Place
- ✓ Coproduction will be embedded throughout
- ✓ Performance of the BSol Mental Health Provider Collaborative will be measured against outcomes that are 1. Operationally meaningful; 2. Required for compliance; 3. Reflective of user and family experience; 4. Reflective of staff experience; 5. Enable improvement
- ✓ The BSol Mental Health Strategic Outcomes Framework will be utilised but will be reviewed within an appropriate timeframe and adapted to support the principles of the collaborative
- ✓ Outcomes which are self-determined are complex to define and measure, but are fundamental and will be explicit about recovery
- ✓ User experience will be used as evidence of the health and effectiveness of the system
- ✓ User derived outcomes will be developed across the system with coproduction and continuous learning to ensure these are of value to the users of services
- ✓ Measurement will ensure that strategic and other outcome measures can be continuously viewed for evidence of improvement or early warning of concerns
- ✓ Place will be considered as vital to the delivery and measurement of outcomes within local populations
- ✓ Information which describes the effectiveness of the system and outcomes will be shared transparently by the collaborative with the wider system, including across partners, stakeholders, users and their families

Clinician Reported Outcome Measures (CROMS)

There are current systems in use across the BSol region, in different services, for different age groups – but the use of these is patchy and unintegrated. HoNOS[22] may have some significant benefits as a system-wide CROM – but essentially further developments should ensure that system-wide information collected is easy to collect, shared across the system, and results in not only the ability to inform mandated reporting, but most important is of utility to informing care pathway delivery and clinical care, with an ability to provide information that results in a continually improving delivery of care.

Service user Reported Outcome Measures (PROMS) & Service user (and Family & Carers) Reported Experience Measures (PREMS)

[22] https://www.healthylondon.org/resource/mental-health-in-integrated-care-systems/outcome-measures/honos/

For service users and their families and carers, recovery is at the heart of the outcomes wished for. Rather than these being clinically imposed recovery imperatives, recovery needs to be personal – and therefore to include an ability to foster hope and self-determination, with housing, education, employment, relationships, inclusion and equality, physical health and societal contribution being some of the important personally directed meaningful goals that may be included. Many of the PROMS/PREMS used currently struggle to bridge the gap between traditional service delivery and an ability to be truly service user focussed – this requires transformation of our beliefs around what our roles are within the pathways of a service user and their mental health. Technology is likely to be key to ensuring that PROMS/PREMS are inclusive, reflective of the service user and family and carer experience and local care delivered in the communities in which they live, and of the breadth of life experience – not just mental health services.

Potential PROMS/PREMS in use or could be used: DIALOG[23]; INSPIRE/Brief INSPIRE[24]; Family&Friends Test[25]

Staff Reported Satisfaction and Experience Measures

Michael West's work on the relationship between how staff wellbeing and improved outcomes for service users is compelling and is not a difficult concept with which to align our thinking[26]. Ensuring this is embedded within organisations and across a wider collaborative system needs to be a certainty for mental health service provision across BSol to be able to achieve the aspirations set out in this proposal. This will require an understanding at all levels of the culture and leadership of compassion that underpins true staff wellbeing. Michael West describes compassionate leadership as: *'Compassionate leadership creates the conditions where the collective good – the needs of service users and communities and staff wellbeing and development – are prioritised over individual agendas, regardless of status, aggression, or undermining. Such leadership creates the conditions where it is possible to identify and challenge inappropriate use of power, hierarchy or control over resources that are inconsistent with the values and vision of our health services.'*[27]

[23] https://dialog.elft.nhs.uk/DIALOG-scale
[24] https://www.researchintorecovery.com/measures/inspire/
[25] https://www.england.nhs.uk/fft/
[26] https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf
[27] https://www.kingsfund.org.uk/blog/2019/05/five-myths-compassionate-leadership; https://www.kingsfund.org.uk/blog/2020/03/covid-19-crisis-compassionate-leadership

Next Steps for this Workstream

Working Group/Task & Finish Group to design

1. CROMS as far as possible to be aligned across the system
2. PROMS/PREMS that are recovery focussed and service user and family and carer driven
3. Interface with those delivering digital/technological innovation across the system to ensure that design of these systems is coproduced and of value to service users, families and carers, and staff
4. Development of measures that reflect staff experience (in addition to the National Staff Survey) be taken on by the Workforce Task and Finish Group of the Collaborative
5. Embedding Compassionate Leadership is taken on by the Culture and Leadership Task and Finish Group of the Collaborative

Digital Systems and Technology to Support Quality, Safety & Outcomes

In order for quality and safety to be integrated across the system, and for continuous learning to be embedded, there will need to be a step change in the digital platform and associated technology and workforce that supports this. Current measurement and data gathering is patchy, labour intensive and too far removed from the delivery of services and service user and family and carer experience and care delivery to be able to generate improvement in services and care pathways that are of value to staff and service users and their families and carers. In addition, the ability to access the richness of information from the whole of the service user and family experience that reflects connectedness with their daily lives (such as where their experience touches other services including housing, employment, education, social services, police and physical health) such that true measures of recovery can be embedded and be of value are lacking. Improving the digital and technological aspects of the system will reduce the work related to measurement and data gathering, and at the same time will increase the value to everyone in the system of the measurement and data that is collected, no matter which outcome and other measures are chosen. This inherently improves the quality and safety across the entire system.

There is discussion across the system to use RIO™[28] across some of the mental health organisations in BSol. Whilst this would be a useful improvement in joined up healthcare records across mental health service delivery organisations, if this does not include additional functionality (which is available in additional products from the same organisation) then this will become of limited utility in terms of truly stepping away from 'silo' care delivery – for instance the ability to see how and where a service user's life interfaces with offender services, substance misuse, housing, social care, homelessness services, education, community support groups, physical health services, employment is all possible within such a system, but requires

[28] https://www.servelec.co.uk/product-range/rio-epr-system/#:~:text=Rio%20is%20a%20future%2Dproof,of%20patients%20in%20your%20care.

commitment to invest in more than simply digital mental health care records across organisations.

Currently there are individuals within organisations who are working with partners across the system to centralise information gathering with a view to using this information to enhance system wide knowledge and ability to improve services. There are individuals within organisations who can demonstrate the disparity between service provision and public health data. The ICS is working on digital and technology to support integration of information and systems. Bringing all of these experts and enthusiasts together is emerging as a structural aim – ensuring that this results in the step change in collaborative information access, sharing and interpretation is vital.

Finance, Contracting and Governance:

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Longer term financial planning to ensure services can meet and manage demand. Collective decisions about the re-balancing of resources, for example, investment into more preventative interventions and initiatives.	Making sure resources are allocated to reducing inequalities. Understanding resources at a locality level and aligning to population need through place partnerships. Collectively holding ourselves to account in achieving real change.	Longer-term, outcome-focused contracts within the Provider Collaborative making it easier to shift resource to where it's needed most and ensure a focus on transformation.	Making the shift to outcome-based contracts that enable organisations to work in a more creative, agile and flexible way.	A collaborative approach to contract and quality monitoring supports transparency and aids improvement.	Achieving best value by collaborative prioritisation and allocation of resources; potentially sharing some functions where this makes sense.

Table 2: How Finance, Contracting and Governance support our guiding principles

Governance

BSOL ICS is developing a strategic commissioning approach based on a number of defined 'care programmes', at both system and place level, each of which will have a provider collaborative to deliver the outcomes for the care programme. At the time of writing, the proposal is for the following care programmes:

System wide care programmes					
Maternity	Children's (acute/ secondary)	Mental health (all age)	Planned and managed care	Urgent and emergency care	Community care (including learning disability and autism)
Place care programmes • Based on geography • Based on population grouping e.g. older people					

We are pleased that mental health will be one of the system wide care programmes and designing a governance framework for the mental health provider collaborative as a core programme fits with the proposals within the document.

We will also need to consider the wider implications for mental health:

- Place based partnerships will be responsible for planning integrated physical, mental and social care across localities and populations.
- All of the system care programmes will have relationships with mental health and this is important for truly integrated care and parity of esteem between mental and physical health. For example, links between perinatal mental health and the maternity care programme, and psychiatric liaison and the urgent and emergency care programme.

Through our governance framework we will need to make sure that our mental health provider collaborative has oversight, representation and ensures join up of all mental health related aspects across care programmes, including identification and management of resources.

An ICS working group is currently considering the nature of the provider collaboratives, considering the best legal, governance and leadership arrangements, and this group is due to make recommendations to the ICS Chief Executives in July. Following the publication of the ICS Design Framework by NHS England in June we are also awaiting further guidance about provider collaboratives to be published.

Although developing the 'form' of the provider collaboratives may not be within our gift to determine, we can make commitments about how we want our provider collaborative to operate and how we want the partners within the provider collaborative to work together.

Our commitments for Governance:

- ✓ We will create a governance framework that supports a partnership ethos based on:
    1. A common purpose
    2. Equality across partners
    3. Openness and transparency
    4. Collaborative decision making
    5. Valuing everyone's contribution
- ✓ We recognise the vital role NHS providers, primary care, third sector, local authority and independent sector all have a part to play in delivering our mental health aims for Birmingham and Solihull and will create structures within our governance framework where all partners are represented and have a voice.
- ✓ We promise to have co-production with people with lived experience across everything that we do. It is important that our plans and decision making takes account of people's access, experience and outcomes and what is important at a locality level.

Finance and contracting

Currently funding flows through Birmingham and Solihull CCG, who hold contracts with individual organisations to deliver services for the population. Of the total planned mental health spend in 2021/22, approximately 70% is with NHS providers and 30% is with non-NHS providers which includes the third sector and independent sector.

Over the past 15 months we have seen more collaborative approaches to managing and making decisions about financial resources, particularly to respond effectively to the pandemic and recovery of services, as well as submission of system planning returns and delivery of the NHS Long Term Plan. Due to the national regime during the pandemic there have been simpler approaches to contracting and payment, predominately through block mechanisms. There has been a spirit of openness and transparency across organisations. These are all positive building blocks to our mental health provider collaborative and we want to continue and enhance this joined up way of working.

There are things that we know we can improve. Sometimes our contracts and the way the specifications are designed is overly rigid and prevents agile and flexible developments and innovation to improve services. We can be very transactional in how we monitor our performance, with more focus on metrics and counting activity rather than outcomes. Sometimes it is not clear how we have prioritised where resources will go and how they will be used.

Similarly to the design of the form of the provider collaborative, working groups within the ICS are considering what the ICS financial and contractual frameworks should

be. We don’t yet know what delegated responsibilities for financial resources will be passed to provider collaboratives, if any. We don’t yet know what the preferred

contractual form for the provider collaboratives will be - the Design Framework published by NHS England states that for services delivered through provider collaboratives, ICS NHS bodies could either i) contract with and pay providers individually or ii) contract with and pay a lead provider acting on behalf of a provider collaborative, who would then hold sub-contracts with the providers.

Our aim is for our finance and contracting frameworks to be an enabler and supporter rather than a barrier to what we want to achieve in our provider collaborative. We can make broad commitments about what we want this to look like and the principles we want to adopt as a provider collaborative. When we know more about the direction of travel of ICS frameworks and infrastructure, we can refine exactly what these will look like in practice.

Our commitments, Finance:

- ✓ We will have a single BSOL mental health financial envelope that everyone understands, and which includes all mental health budgets whether NHS, 3rd sector, local authority or independent sector.
- ✓ We will develop a collective approach to making the best of the BSOL £ and:
  - Prioritisation and making decisions about resource allocation and investment
  - Re-balancing resource where necessary
  - Making sure we have adequate resource for system transformation and reducing inequalities
  - Achieving cost savings and value for money
  - Managing cost pressures
  - Sharing financial risks and gains

  (all subject to the ICS NHS body's financial framework and principles of financial governance).
- ✓ We commit to transparent and clear reporting of spend against the financial envelope.
- ✓ We will identify resources at a locality level to support place-based planning and delivery of services.
- ✓ We will combine short, medium and long-term financial planning.
- ✓ We will align to the ICS principles of financial governance.
- ✓ We will advocate a mental health voice, connecting with and influencing the wider ICS financial planning and system allocation of financial resources.
- ✓ We will make sure our framework connects with NHS England and specialised services Provider Collaboratives.
- ✓ We will bring 'fresh air' into what we are doing using benchmarking and best evidence.

Our commitments: Contracting

- ✓ We will design a contractual framework aligned to the overarching ICS body's plans, but which will also enable and support our ethos of partnership working and the purpose and function of the provider collaborative.
- ✓ We will make sure we support and encourage contracts with smaller organisations, with a fair and transparent way of working, simpler frameworks and reduced bureaucracy.
- ✓ We will shift our contract monitoring towards collective strategic measures and outcomes.
- ✓ We will take a collaborative approach to quality assurance and monitoring
- ✓ We will have mechanisms to resolve differences between they turn into a formal disagreement
- ✓ We will have clear links to the ICS assurance and oversight framework

Next steps for the workstream:

Short term (ongoing now):

- Map current contracts – what contracts are in place and when do they end
- Assess potential options for contractual frameworks
- Map financial envelope – by provider, by recurrent/non-recurrent, by baseline vs transformation

Medium term (as ICS plans become clearer about the legal and governance frameworks for provider collaboratives):

- Define provider collaborative and partnership members, and roles and responsibilities
- Develop provider collaborative principles of collaboration, governance framework and proposed partnership model
- Develop principles of a financial framework
- Develop contractual framework for NHS and non NHS providers
- Identify what resource is needed to support provider collaborative arrangements

People, Culture and Leadership

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Working in partnership with Third Sector Organisations specialist in community-based preventative and recovery work	Make a step change in our approach to equality and inclusion, valuing the experience of our diverse workforce, including those with lived experience	Build a healthy, happy and sustainable workforce increasing our capacity to meet people's needs. Introducing 'new roles' will help improve access by addressing shortage in supply of staff	Work toward a more distributed leadership where staff are empowered to work in ways which best meet the needs of the people they serve.	Establish an open and compassionate culture where take shared responsibility when things go wrong and learn collectively from mistakes	Reduce the cost of bank and agency staffing through improved recruitment, retention and reduced sickness

Table 3: How People, Culture and Leadership support our guiding principles

The Birmingham and Solihull People Plan for 2020/21 outlines the ambition that we have to ensure our health and care organisations have a progressive and supported workforce to transform and deliver health and care for our local population. Working collectively on an equal footing across health and care provides opportunities to deliver with ambition and for change at scale.

Our workforce is our biggest asset and so investing in and developing our people is going to be critical if we are to achieve our aims.

Responding to the Covid19 pandemic has shone a spotlight on the amazing people that work with the NHS and our partners at every level. However, we know that this has also taken its toll on people's health and wellbeing. We need to take this into account as we progress the recovery of our system and its ongoing transformation. For staff to build compassionate and person-centred relationships with service users and families our organisations also need to be places where that same compassion is present in the way we make decisions and work together.

> *Sustaining the NHS as a culture of high-quality compassionate care requires compassionate leadership at every level and in interactions between all parts of the system – from national leaders to local teams. Compassionate leadership in practice means leaders listening with fascination to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and then taking action to help or support them[29].*

Poor integration of provision is bad for service users but also affects staff at all levels. The ease in how we are able to work together around people greatly impacts how we experience our work, our job satisfaction and in being able to give more time to care for those who need it the most.

Staff in our organisations are already at the forefront of integrated working and there are many examples of the innovative work that they have been able to achieve in, and in spite of, current organisational structures. We want to remove more barriers to let people work in the way that they already know makes the most sense for local people and services. It is important to us that staff feel visible, valued and able to work flexibly in the way that enables them to provide high quality, compassionate and safe care.

The Birmingham and Solihull People Plan has already set out a practical programme to support and develop the workforce which mirrors the key themes of the National NHS People Plan. The themes are:

Looking after our people – providing high quality health and wellbeing support for all

Belonging – addressing the discrimination that some staff face

[29] https://www.kingsfund.org.uk/blog/2019/05/five-myths-compassionate-leadership

New ways of working – capturing transformation and innovations driven by our workforce and increasing flexible working opportunities

Growing for the future – addressing future workforce availability, through recruitment, training and retaining our current and future workforce increasing apprenticeships and Bring Back Staff.

Addressing workforce challenges in Mental Health

In addition to playing our role in the wider system People Plan we are committed to addressing specific challenges in relation to the mental health workforce. A Joint Mental Health Workforce Group has been established and has already begun to develop shared plans across our organisations, our actions include:

- Increased community engagement work and targeted recruitment in local areas to increase workforce supply and the diversity of the Mental Health workforce. This includes cultural work to build a culturally competent workforce.
- Ongoing development of entry roles into care including apprenticeships and other widening participation approaches with clear career development pathways, including moving from admin roles in the NHS into clinical careers. This will include looking to fully utilise the Apprenticeship Levy for new and existing staff.
- Encouragement of lived experience and building the support and framework to enable successful development of Mental Health Peer Support roles.
- Refreshed system-wide recruitment and onboarding strategies to ensure we reach a wide audience and are attractive to individuals looking for work, ensuring candidates are aware of the benefits and flexibility on offer. This will include looking at opportunities to work together across the ICS to attract talent into Birmingham and Solihull.
- Exploration of international recruitment options, particularly for medics and nursing.
- The development of robust retention plans in collaboration across the ICS with a system-wide strategy. This includes work with existing staff nearing retirement to understand how we best retain them and support them at work/encourage them to return to the NHS.
- Continued work on skill mix, new roles, pathway redesign and new ways of working, particularly where there are significant staffing challenges in terms of supply e.g., mental health nurses. This includes the implementation and/or expansion of new roles such as care navigators, physician associates, non-medical prescribers and peer support workers.
- Continued system-wide engagement in pathway redesign to utilise the available mental health workforce across the system and sectors.
- Increased digitalisation in response to Covid19 but also capitalising on opportunities to increase workforce capacity through new ways of working.
- Maximise the use of systems such as e-rostering to ensure effective deployment of staff.

- Further expansion of the mental health temporary staffing bank (already expanded significantly in 2020/21) to respond to staffing gaps, particularly in relation to future Covid19 infection waves and absence spikes. Includes system-wide work to introduce an ICS wide bank and reservist model.
- Utilisation of the Covid19 vaccinator workforce for those wishing to have an NHS career.
- System-wide health and wellbeing work to aid with the retention of staff and the prevention of higher levels of sickness absence including the development of wellbeing hubs and wellbeing spaces within workplaces.
- Work with Primary Care Network (PCN) Clinical Directors to agree mental health practitioner role requirements and recruit into posts. Roles will be joint funded through PCN Additional Role Reimbursement Scheme and Spending Review funding and will align with the expansion of the community-based mental health workforce.

In addition to the above we want to work more closely with local Third Sector Organisations. There is a huge benefit to staff being exposed to the different cultural contexts in both the Public and Third Sector and being able to draw on the best of both in their practice and approach. Furthermore, the Third Sector is well placed to bring people from a wide range of backgrounds into the workforce, particularly through organisations embedded in local communities. We have begun to explore initiatives including:

- Apprenticeship routes into mental health roles through Third Sector organisations providing a bespoke course in working with people with varied mental health conditions alongside core academic qualifications.

- A partnership between the NHS and the Third Sector offering individuals a clear, defined pathway through Third Sector organisations into mental health nurse training. This is based on an approach previously on developed by between BSMHFT and Birmingham Mind.

Our Commitments to People, Culture and Leadership:

We will:

- ✓ Make a step change in our approach to equality and inclusion, valuing the experience of our diverse workforce.
- ✓ Take a zero-tolerance approach to discriminatory and bullying behaviours making it safe to speak up and raise concerns or challenge behaviours.
- ✓ Establish a culture of trust, empowering the sharing of ideas and learning.
- ✓ Take shared accountability when things go wrong.
- ✓ Role modelling behaviours in line with our values.
- ✓ Establish an enhanced wellbeing offer, incorporating learning from Covid19, which includes recovery focussed support, enhanced mental health and psychological support, physical health, social and financial wellbeing.
- ✓ Work toward a more distributed leadership where staff are empowered to work in ways which best meet the needs of the people they serve
- ✓ Demonstrate our collective role as ‘anchor organisations’ and contribute to our local economy through creating sustainable employment.

Next Steps for the Workstream:

Short Term:

- Review and widen the membership of the BSol Mental Health Workforce Group to include Primary Care, Third Sector and local authority representation.
- Progress recruitment to key expansion roles with a particular focus on Mental Health Practitioner roles in Primary Care Networks
- Develop and implement staff retention plans

Medium Term

- Through the BSol Mental Health Workforce Group, develop a shared plan to deliver the commitments set out above.

Place

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Understanding patterns of demand within communities, working with local partners to meet need at the earliest opportunity	Focusing on the most pressing health inequalities in each place to achieve the biggest impact	Delivering support as close to people's homes and places of work as possible. Addressing pockets of digital poverty	Working with local areas to achieve shared outcomes that make a real difference to people's lives	Working as part of joined up local teams, reducing gaps between services and appropriately sharing information between trusted colleagues	Reducing duplication between health, social care and the Third Sector by better aligning our offers

Table 4: How place supports our guiding principles

> *"A simple proposition lies at the heart of place-based care: that we blur institutional boundaries across a location to provide integrated care for individuals, families and communities [and] start to deliver on the long-held promise of joining up health and social care for a population … with the ultimate aim to improve the public's health and reduce health inequalities."*[30]

Place-based working is a key element of the integration agenda as set out in the NHS Long Term Plan and White Paper[3132]. Central to this way of working is the act of joining up and coordinating services around people's needs. This is particularly important where people have multiple and complex needs. Often, many professionals and organisations are working with a person, but because their work isn't joined up its impact is reduced, indeed, in some cases services can be experienced as 'part of the problem' by the person themselves[33].

In addition to delivery of services The Kings Fund have identified other key functions of place-based working (see Figure 4)[34].

[30] https://publichealthmatters.blog.gov.uk/2016/03/17/the-journey-to-place-based-health/
[31] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/nhs-organisations-focus-on-population-health/
[32] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all
[33] Cottam, H. (2018) *Radical Help: How We Can Remake the Relationship Between Us and Revolutionise the Welfare State*: Virago
[34] https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems

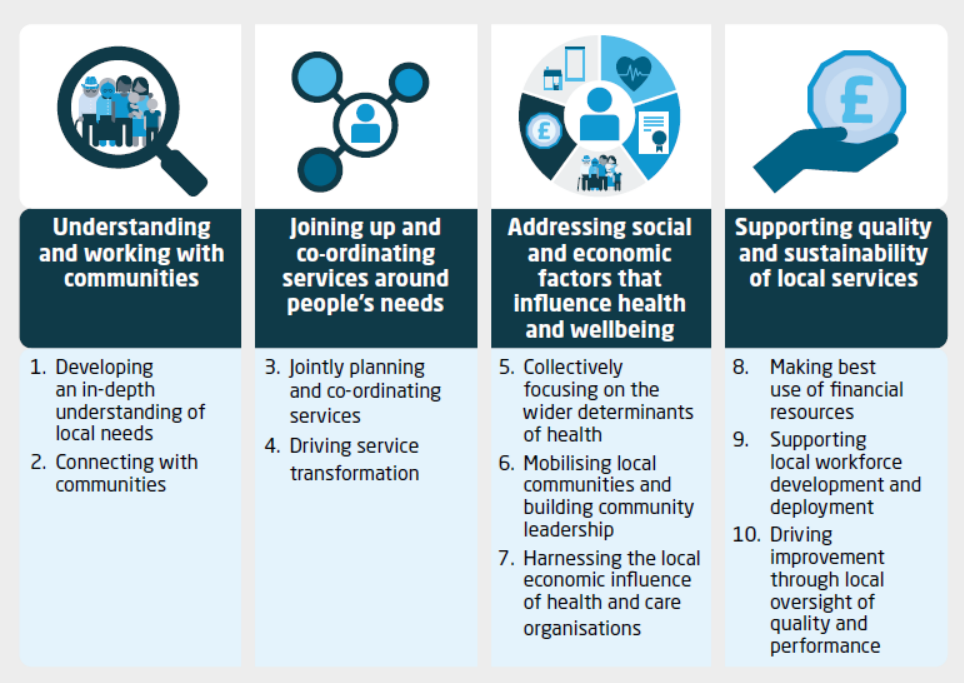


Figure 5: Key Functions of Place-Based Working

In mental health we are already working 'at place' in a range of ways (see box below). We now want to do this more comprehensively and consistently to truly realise the benefits of this way of working. Importantly, this is not about creating change for its own sake, rather the aim is to enable local areas to determine what's working well and what changes are required.

Primary Care Liaison and 'East Hub' Multi-Disciplinary Team (MDT)

Over the past two years BSMHFT, Forward Thinking Birmingham, Birmingham Mind and Solihull Mind have worked with a number of Primary Care Networks and individual GP practices to trial more integrated ways of providing community-based mental health support. Mental Health Practitioners have worked as part of the practice team to support the assessment and care of people with mental health needs. In other areas, senior medics have participated in regular MDTs with GPs to discuss individual service users and to plan care collectively.

Community Development Workers

The Birmingham Mind Community Development Worker Service (CDWs), work with communities across Birmingham to promote discussion around mental health and wellbeing through various training, workshops and activity sessions. Focusing on working with all communities groups and leaders; they work to increase knowledge of mental health and wellbeing, encourage greater self-awareness and self-management as well as to increase community engagement and cohesion citywide.

Solar

Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands work together to provide emotional wellbeing and mental health services for children and young people in Solihull. They provide multi-disciplinary assessment and treatment of children and young people with mental health or severe emotional and behavioural difficulties. Solar has worked closely with the Solihull Children and Young People's Mental Health Transformation Board to shape services in the area.

Solihull Mental Health 'Pod'

A new initiative, the 'Pod' brings together key local agencies in Solihull to develop a shared understanding of, and shared solutions to, challenges within the local mental health system. The group will also support the refresh of the Solihull Mental Health Strategy, helping to better align measures to address social determinants of poor mental health alongside service provision.

Mental Health In Schools

Solar and Forward Thinking Birmingham have worked with a range of partners to develop new approaches to improving the way that children and young people's mental health is supported in schools.

Talking Therapies

Psychological therapists have, for a number of years, provided CBT and other therapies from general practice and other community venues. Psychological therapists have, for a number of years, provided Cognitive Behavioural Therapy and other therapies from general practice and other community venues. As we improve the quality of our data we have been able to identify the neighbourhoods where lower numbers of people access support. In response Living Well Consortium have targeted support to Hall Green, an area with particularly low uptake.

Figure 6: Examples of Place-Based Working

At the time of writing arrangements for place-based partnerships across Birmingham

and Solihull are still being developed. However, as a mental health system we are committed to working with the structures and approaches that emerge and to ensure that mental health is a core aspect of place-based care and support.

Our commitments to Solihull and Birmingham's distinct localities:

Our commitments reflect not only an intention to join-up services locally, but also ambitions in relation to some of the other functions described above. We will:

- Work in alongside Place-Based Partnerships and Integrated Care Partnerships in Birmingham and Solihull to ensure that mental health is joined up with other provision locally.
- Transform primary care and community mental health services to align with localities and Primary Care Networks where we will work as part of integrated teams
- Deliver services and make decisions as close to local communities as possible – that means that the majority of people will get the support they need close to their home. Where it make sense to provide a service across the whole of Birmingham and Solihull we will make sure care is connected back to a person's local team.
- Work closely with schools, colleges and universities to join-up support for children and young people
- Ensure that all of our key decision making boards and our transformation workstreams have representatives from Birmingham and Solihull, and from primary care
- Take a more collaborative and transparent approach to quality monitoring, assurance and improvement where we work with local partners to understand and respond to quality & safety issues.
- Continue to develop partnerships with local voluntary and community sector organisations drawing on their expertise, skills and experience of working in and with communities *(See Section on Third Sector Organisations)*
- Work closely with local authorities and voluntary and community sector organisations transform aftercare and rehabilitation
- Work with local Children's Services to better meet the needs of Children in Care and for care experienced young people
- Work with the wider Integrated Care System to develop population health management capacity to better understand the demography, patterns of need, issues of inequity and requirements of distinct communities. We will use this to inform our work and measure those outcomes that are most important and meaningful to people.
- Work alongside Health and Wellbeing Boards, The Birmingham Creating a Mentally Healthy City Forum and the Solihull Together Board to drive a shift towards prevention and to address the social determinants of ill health.

Next Steps for the Workstream:

- Continue to progress the transformation of community mental health services and the development of place-based delivery of care in partnership with Primary Care Networks
- Fully scope emerging plans for place-based partnerships across Birmingham and Solihull working
- Support the development of a Solihull Mental Health Strategy through the Solihull Mental Health 'Pod'

Co-production

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Work with EBE to understand what is most effective in keeping people well	Engage communities to design support which is culturally meaningful and reflects the reality of people's lives	Better understand people's preferences around accessing services and support	Measure the outcomes that are most important to people using services and their families	Work with people and families as equal partners in the positive management of risk	Delivering more person-centred and culturally appropriate support helps us 'get it right first time'

Table 5: How co-production supports our guiding principles

This section has been produced collaboratively with the input of the BSol Mental Health Co-production Steering Group. It is recognised that often consultative and participatory activity that has been is led by organisations and driven by their agendas is wrongly termed 'co-production'.

Members of the Co-production Steering Group were involved in the drafting of the commitments and have reviewed and commented on the section. Two members of the Group have provided summary definitions of Co-production which reinforce the some of the specific requirements that need to be in place for true co-production to be achieved.

Co-production is a term that is increasingly being used but not everyone understands what true co-production really is. Co-production is when services are developed with the direct input from the service users themselves. Some people believe that asking for "feedback" or for opinions of service users is co-production but this is actually participation rather than true co-production. In order for something to be truly co-produced, the service users need to be involved through the whole process of the development of a new service; from the very beginning.

We are currently improving and increasing the amount of services that are truly co-produced, but more needs to be done. The Birmingham and Solihull CCG's Co-production Steering Group is making these changes and leading the way towards true co-production. The group has already been instrumental in the development of new services in our local area with more projects in the works. The group has worked with Birmingham Mind, Birmingham and Solihull Mental Health NHS Foundation Trust and other organisations to create services that are now available.

Co-production is vital for developing and creating new services or improving old ones in the future. It is important that co-production is not thought of as an after thought or just a box that needs ticking. By hearing from service users and people with lived experience, a service can have real insight into what it's like to use these services. Hearing those real life experiences and stories can ensure that positive changes are made for the betterment of all.

Imogen, Co-production Steering Group (2021)

Years ago, there were already people treated in psychiatry who met together to express their opinions about the services they were receiving, and to ask for changes. There were also projects set up and managed by people who had their own mental health needs; projects whose purpose was to help and support others with similar issues. But it took some time before something called service user involvement was set up within statutory and voluntary mental health services.

The idea of co-production was introduced later. To begin with, it was evaluation of existing services, and suggestions about how they could be improved – needless to say, that can't really be seen as co-producing, simply as advising. But more recently there have been projects that are closer to genuine co-production – projects designed by people who have their own experience of mental health issues, and who then have paid roles in delivering the service they have designed.

Continued below…

However: NHS Trusts are managed and staffed by people who are paid a salary for the job they have been recruited for – and this recruitment is based on their qualifications and their previous working experience. Nowadays there are some fairly low-level jobs given to people who have used the services – but it is still rare for a senior job to be given to someone who is known to have a lived experience of mental health issues. They would have to have the appropriate work qualifications to be hired – and of course this can be achieved by some people who have had episodes of being mentally unwell. But until recently, people with their own mental health issues who worked in mental health services – unless they were in a service user involvement role -- would be unlikely to share these experiences with service users, or with other workers -- or with their employer.

It is vitally important for us to develop co-production further, and to find more ways of including people with lived experience in the structure of the NHS mental health services. It is worth thinking about making some alterations to the job structure, so that jobs for people with lived experience can be created at higher levels. At the same time, there are lived-experience participants who could not take on a regular paid job – unfortunately, permitted payment for those who receive State benefits is very small. Co-production needs to be open to lived-experience participants in as fair a way as possible -- whether they are "employable" or not – but we must remember that our employment system always gives more power to those who are paid than to those who volunteer for a gratuity. At present, this is bound to affect the influence on co-production of those who do not receive a salary.

Barbara, Co-production Steering Group (2021)

Co-production means working in equal partnership with people who use health and care services, their families, carers and communities and is a vital component of the design, development, delivery and evaluation of services. We can also think about co-production more broadly in terms of the way we work with staff and other stakeholders.

Put simply, we will not be adhering to the principles of the Birmingham and Solihull Mental Health Provider Collaborative if we do not co-produce more of our work more effectively. Why? Co-production is the feedback that is necessary to enable provider and commissioners to focus on what works and recognise what does not. It recognises that people with 'lived experience' of a condition, or need, are best-placed to shape the care and support that would be most helpful to them in the context of their own life. By failing to co-produce we miss the critical insight that can meaningfully prevent illness, improve access, increase safety, achieve outcomes and reduce inequality. Where power is genuinely shared, discussions are more

grounded in reality and the 'person' is more likely to be placed at the centre of people's thinking, planning and provision.[35]

Co-production, is fundamentally about relationships. Whenever and wherever there is true power-sharing co-production is happening. Our challenge is to ensure that power is shared equitably much more often in all that we do. The following are just four examples of where co-production can take place:

- **Governance:** People with lived experience with equal say on decision making boards
- **Design:** People with lived experience co-designing pathways and services
- **Delivery:** People with lived experience in the mental health workforce
- **Quality Assurance:** People with lived experience monitoring the quality of services

For co-production to work at all, experts by experience have to be given an equal voice at all stages of a process and not seen as a 'rubber stamp' at the end. For their voice to be heard effectively they will need support and training to enable them to contribute effectively in meetings and other for a. It also needs to be recognised that if people commit to a project then the project has to commit to the people and if this is a significant amount of work then people should be paid for their time.

[35] https://coalitionforpersonalisedcare.org.uk/wp-content/uploads/2020/10/C4CC-Co-production-Model.pdf

With the participation of the BSOL Mental Health Co-production Steering Group we have developed the following commitments to improve the quality, quantity and impact of co-production.

Our Commitments to Co-production:

We will:

- ✓ Ensure that co-production means equal power and equal voice
- ✓ Support experts by experience through:
  - Training and development support to enable people to participate equally
  - Payment in some circumstances
  - Using plain, jargon-free language and producing clear information
- ✓ Promote a culture that values co-production through the way we talk about it and the way we do it.
- ✓ Celebrate, share and learn from examples of effective co-production locally, nationally and internationally. Explore ways of joining together the various co-production groups and resources within the Birmingham and Solihull Mental Health Provider Collaborative
- ✓ Ensure that co-production is inclusive and that the diversity of the people that live in Birmingham and Solihull is reflected
- ✓ Ensure that people can participate in a range of ways that suit their preferences and circumstances
- ✓ Support the ongoing development of people with lived experience in the mental health workforce
- ✓ Make time for co-production. Recognise that genuine coproduction might mean things take longer.
- ✓ Be flexible, create opportunities for co-production to evolve and develop over time. We will learn together through our successes and mistakes.

Members of the Birmingham and Solihull Co-production Steering Group felt it was important to reflect the fact that there are already excellent examples of good practice in co-production, and other forms of participation happening locally (some of these are listed below). These examples are proof that good co-production is possible when the right culture and approach is adopted.

- Think4Brum (T4B) is the youth advisory group for Forward Thinking Birmingham (FTB), our 0-25s mental health service. T4B gives young people, an opportunity to get directly involved in FTB, by helping to shape the design and delivery of our services. T4B provides support and as well as offering training opportunities and the chance to get involved in lots of different activities. Recently, T4B co-developed ‘WellBeing Passports’ which were launched in March 2021. The aim of the Wellbeing Passport is to get the service user and health professional on the same page and improve communication. The passports are intended tomake the experience easier for service users who will no longer need to repeat their mental or physical health

journey every time they see a new health professional. These bespoke journals are designed to empower patients to manage their own health and wellbeing.

- The Community Development Worker service, delivered by Birmingham Mind and the CCG Joint Commissioning Team provide excellent support to members of the Co-production Steering Group ensuring that are well prepared for meetings, understand the agenda, are involved in the meetings and have a chance to ask questions.
- Peer Support Workers in Forensic Mental Health have been supported by Shelter. They are now well respected in their roles and are a valued part of the team.
- There has been excellent work co-producing the delivery of Nurse Associate Training with experts by experiences
- A number of engagement workshops were held to ensure that the perspectives of experts by experience were well reflected in the refresh of the Birmingham and Solihull Mental Health Foundation Trust Strategy. The sessions were so popular more had to be organised.

Next Steps for the Workstream:

- Review existing co-production initiatives across the provider collaborative, identifying good practice and areas for improvement
- Identify collective resource to progress co-production
- Co-produce a plan to achieve the commitments set out above through the Co-production Steering Group

Health Inequalities

Demand	Access	Outcomes	Safety	Value
Working as part of the wider system to address the social determinants of ill health.	Focusing on communities with low uptake of services to help people access support more quickly	Measuring and holding ourselves to collective account for achieving meaningful improvement	Addressing disparities in the safety of people from different backgrounds	Realising the social and economic benefit of closing the health gap

Table 6: How a focus on health inequalities supports our guiding principles

Addressing health inequalities is a priority for the Birmingham and Solihull ICS. The diversity of our community is an enormous asset culturally, socially and economically. However, areas of significant local inequality have a dramatic impact the health and wellbeing of the population.

- **Poverty**: 40% of Birmingham and 12% of Solihull residents live on bottom decile on the Index of Multiple Deprivation.
- **Diversity**: 40% of Birmingham and 11% of Solihull residents are from Black and Ethnic Minority backgrounds. There is a large LGTBQ+ community with increasing numbers of people opening identifying in this way.
- **Youth**: Birmingham is the youngest local authority in the country with high levels of infant mortality and children living in poverty.
- **Mortality**: Both local authorities have a 9 year gap in life expectancy at birth between highest and lowest areas. Rises to 17 year gap for healthy life expectancy.
- **Physical Health**: Cancer, circulatory disease and respiratory diseases account for majority of the gap within the councils.
- **Covid19**:. Birmingham has seen 8.865 cases per 100k population; Solihull is lower at 6,773 (England average of 6,840). Case rates in both local authorities have been highest in the areas of highest deprivation and poorest underlying health which are also the areas hardest hit by the economic impact of lockdown.

The disparities highlighted above have an impact on the mental health and wellbeing of our communities. For example:

- Children and adults living in the lowest 20% income bracket in Great Britain are two to three times more likely to develop mental health problems than those in the highest[36]
- In addition to black and ethnic minority communities being at comparatively higher risk of poor mental health, evidence suggests that inequalities persist in relation to mental health access, treatment and outcomes[37]
- Rates of depression and anxiety are higher amongst the LGBTQ+ community that the general population. Rates are higher still where people are women, from black or Asian communities and have experienced hate crime.[38]
- In some mental health services we have over representation from Black, Asian and minority ethnic (BAME) communities, for example, Black people are four times more likely than White British people to be detained under the Mental Health Act[39].

[36] Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). Fair society, healthy lives: Strategic review of health inequalities in England post 2010. Retrieved from instituteofhealthequity.org/projects/ fair-society-healthy-lives-the-marmot-review [Accessed 07/11/16].
[37] https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf
[38] https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf
[39] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

- The mental health of children and young people has declined over time, inequalities associated with ethnicity, gender, sexuality, family circumstances and poverty exacerbate this.
- When co-morbid mental health conditions interact with long-term physical conditions peoples' outcomes are often poorer resulting in a lower quality of life[40]
- Older adults are less likely to access support for mental health issues like depression and anxiety.[41]
- The physical, social and economic impacts of the Covid19 pandemic appears to have increased rates of stress and anxiety, in addition restrictions may be increasing loneliness and depression. Alcohol and drug use has increased in places and concerns exist for people working in front-line roles and those experiencing the effect of 'long-covid'[42].

We know that many people experience discrimination and inequality in relation to multiple-facets of their lives and identities (ethnicity, gender, age, sexuality etc). This is sometimes referred to as 'intersectionality'. This means that we cannot make assumptions about a person's experience without understanding them as a whole person. Intersectionality can be a helpful lens through which to approach and understand the experience of discrimination and inequality and one which can inform both policy and practice[43].

The Birmingham and Solihull ICS has established a Health Inequalities Programme spanning nine workstreams. The ICS has set out its commitment to "*reduce inequalities in health and wellbeing across our diverse communities in Birmingham and Solihull. . . .We want to promote inclusive communities, reducing social isolation, as well as valuing mental health equally with physical health.".* This is supported by the following statement of purpose… *"to contribute to improving the health and wellbeing of the people of Birmingham and Solihull by putting action to tackle inequalities and the impact of inequalities on health at the heart of the work of the ICS."*

The work is underpinned by the following principles:

- Reducing health inequalities and workforce inequalities is mainstream activity that is core to and not peripheral to the work of the NHS.
- Interventions to address inequalities must be evidence-based with meaningful prospects for measurable success.

[40] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

[41] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2

[42] https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/publications-and-technical-guidance/mental-health-and-covid-19

[43] https://www.ted.com/talks/kimberle_crenshaw_the_urgency_of_intersectionality

In addition, both Birmingham and Solihull, as places, have strategic approaches to tackling health inequalities. In Birmingham, the Creating a City Without Inequality Programme has been established. In Solihull, a goal of the Health and Wellbeing Strategy (2019-2023) is to *improve the lives of those with the worst health, fastest.*

Inequalities remain deep rooted in our society. This not a problem for those affected to address, it's for all of us and organisations and individuals to stand up and take responsibility. In responding to the events of the past year such as the impact of Covid19 and Black Lives Matter, and what we already know about the inequalities in our society and our health and care system, we will take up the challenge to tackle inequalities of all kinds that are experienced by colleagues and people we support.

Our commitments to reducing health inequalities

We will:

- Proactively support the ICS's commitment, purpose and principles in tackling health inequalities and work as a partner in progressing this.
- Explore intersectionality as a lens to understand discrimination and inequality and to inform policy and practice.
- Work with local authorities to achieve the health inequality goals in each place
- Ensure that all programmes of work (transformational, enabling, quality improvement) are explicit in identifying how they will contribute to addressing health inequalities
- Through our workforce programme take active steps to ensure that the diversity of our workforce is visible in decision-making; is seen as an asset; and that our staff are increasingly culturally competent.
- Work with communities and experts by experience and make better use of data to more effectively identify, understand, prioritise and monitor our actions to transform services and tackle health inequalities
- Develop explicit and time-bound plans to make a demonstrable difference to health inequalities and be open and transparent in sharing the results.
- Mitigate against digital exclusion, ensuring that use of new technology does not disadvantage some groups.
- Support, participate in and keep up to date with current national and local research into inequalities and mental health, including use of population health data and benchmarking.
- Undertaking targeted work with over and under-represented groups.
- Work alongside partner organisations to tackle discrimination and address stigma across our communities, improving the public perception of mental health.

Next Steps for the Workstream:

- Meet with the BSol ICS Health Inequalities Team and identify shared objectives in relation to mental health
- Scope existing fora within the BSol Mental Health System where work is being progressed
- Agree governance arrangements within the provider collaborative in relation to the oversight and monitoring of action to reduce health inequalities

Partnering with the Third Sector

Demand	Reduce HI	Access	Outcomes	Safety	Value
Working in partnership with Third Sector Organisations specialist in community-based preventative and recovery work	Make a step change in our approach to equality and inclusion, valuing the experience of our diverse workforce.	Build a healthy, happy and sustainable workforce increasing our capacity to meet people's needs	Work toward a more distributed leadership where staff are empowered to work in ways which best meet the needs of the people they serve	Establish an open and compassionate culture where take shared responsibility when things go wrong and learn collectively from mistakes	Reduce the cost of bank and agency staffing through improved recruitment, retention and reduced sickness

Table 7: How partnership with the Third Sector supports our guiding principles

The 'Third Sector' is an umbrella term for organisations which are neither public nor private-sector. This includes voluntary and community organisations (registered charities, associations, self-help groups and community groups), social enterprises, mutuals and cooperatives. Third Sector Organisations are generally independent of government, are 'values driven' and reinvest surpluses in achieving their goals. The sector spans large national and international organisations to small and medium sized locally based organisations and then to organisations that may compromise a small number of voluntary staff.

There are a range of benefits that the public sector can gain from working with Third Sector Organisations including:

- Understanding of the needs of service users and diverse communities that the public sector needs to address;
- Closeness to the people that the public sector wants to reach;
- Ability to deliver outcomes that the public sector finds it hard to deliver on its own;
- Innovation in developing solutions; and
- Performance in delivering services.[44]

The Third Sector is expert in providing support and thinking that is whole-person, whole-family and whole-community[45]. This holistic approach is rooted in the history and culture of many organisations founded by people with lived-experience of the issues they now respond to. This culture can be seen in contrast to that of the NHS and public sector which has often treated individual aspects of people's needs in isolation. As we seek to work in a more person-centred way we are fortunate to be able to draw on the wealth of experience that the Third Sector has in this regard.

Birmingham and Solihull has a strong and diverse Third Sector, which includes many organisations whose mission addresses mental health issues either directly or indirectly. The sector comprises a broad range of organisations from very small organisations deeply rooted in specific communities, to medium sized locally based and larger organisations with a national profile. All have a role to play.

In 2020/21 Birmingham and Solihull CCG, BSMHFT and BWCH commissioned a range of services from Third Sector Organisations to the value of £13,249m (see figure six below). Indeed, the sector has been part of the fabric of mental health provision for many years both through commissioned provision and through services developed and funded via a range of other means.

The Children's Society, Open Door Counselling, Acacia, Ashram, Change Brief Therapy, Creative Support, Birmingham Mind, Solihull Mind, Birmingham Women's Aid, Common Unity, Forward For Life, Living Well Consortium (including Our Roots, Citizen Coaching, MyTime, Womens Consortium, Health Exchange, Anawim, Spring to Life, Sport 4 Life, Newman College) , Future Housing, Home Group, Pattigift, Cruse Bereavement, Marie Curie, Edwards Trust, Solihull Bereavement Counselling Service, Beyond the Horizon, Servol, Shaw Trust, Barnardo's, Autism West Midlands, Better Pathways, The Alzheimer's Society, Relate, Citizens Advice Bureau, St Martin's Centre for Health and Healing, Karis Neighbourhood Scheme, Approachable Parenting, Action on Postpartum Psychosis.

Figure 7: Third Sector Organisations with NHS mental health funding in Birmingham and Solihull

In recent years, the NHS in Birmingham and Solihull has worked more closely with Third Sector Organisations to provide some services in a more integrated way. A

[44] Successful Commissioning Toolkit: How to secure value for money through better financial relationships with third sector organisations (2010) National Audit Office https://www.nao.org.uk/successful-commissioning/
[45] https://vcsereview.org.uk/

number of examples are included in the box below and help describe how closer working with the Third Sector can help achieve the aims of the Mental Health Provider Collaborative.

By ensuring that the local Third Sector is a key partner in our Mental Health Provider Collaborative we have a great opportunity to enable people and communities to benefit from the best of both sectors. Where we collaborate effectively, that benefit is likely to be amplified.

Partnership between the Third and Public Sector Organisations can focus on a range of different areas and aspects of system working. *(Figure 7, below)*

To ensure that people and communities gain the most benefit from Third and Public Sector partnership it will be important that our collaboration draws on all of these forms. Through our existing relationships and engagement with Third Sector Organisations we know that there are a range of barriers and related enablers that support partnership.

Barriers include:

- Organisations may have limited capacity to attend multiple partnership meetings
- Previous poor experience of partnership which may have reduced trust and faith
- Tendering and procurement exercises which place organisations in competition with each other and may be onerous for small and medium sized organisations
- Funding is often time-limited making long term planning difficult
- Some requirements of NHS contracts can be difficult to achieve for small organisations
- Turnover of staff where public sector terms and conditions are preferrable
- Difficulty for individual organisations to be heard and visible
- The cultures of public and Third Sector organisations can be quite different, staff in both sectors may need time and support to understand and value these differences and find ways of working effectively together

Figure 8: Different Areas of Focus for Partnerships with Third Sector Organisations

Our Commitments to Partnership with the Third Sector

Leadership and Governance

- ✓ Ensure a strong presence and voice from local Third Sector Organisations
- ✓ Value the cultural differences between public and Third Sector Organisations drawing on both to offer the most benefit to our staff and the people we support
- ✓ Establish the Birmingham and Solihull Mental Health Third Sector Forum as a formal subgroup of the BSOL Mental Health Provider Collaborative Programme Board to act as a reference group and two-way channel of communication between the Provider Collaborative and the Sector.
- ✓ Work with the Forum to develop a formal partnership agreement
- ✓ Invite two representatives from the Forum to become full members of both the Provider Collaborative Programme Board and the Mental Health System Transformation Board.
- ✓ Work with the Forum to support the development of members to ensure that representatives are able to contribute equally and with confidence in board settings.

Service Delivery

- ✓ Work with the Forum to develop approaches to the 'selection' of organisations as delivery partners which are transparent, limit workload and do not disenfranchise smaller organisations. This could include a provider framework contract; small-grants programme; contracting with a consortium
- ✓ Develop a shared view on when and where Third Sector Organisations are best placed to deliver services
- ✓ Adopt a measured approach to contracting which ensures requirements are manageable whilst remaining robust
- ✓ Work with the Forum to propose a target for the level of financial resource that we aim to invest in Third Sector provision over an agreed period of time
- ✓ Explore the role of Living Well Consortium as infrastructure organisation to support the participation of smaller providers. Work in partnership to support the Sector's sustainability and development
- ✓ Support all contracted Third Sector Organisations to submit data through the National Mental Health Service Dataset making it easier to evaluate the impact of the Sector's work

Design and Development

- ✓ Work with the Forum to support the design and development of new pathways and services, drawing on the Sector's insight and experience and ensuring this contribution is credited

Local Networks

- ✓ Explore how mental health system work can align with Neighbourhood Networks (Birmingham) and Thriving Communities Programme (Solihull)
- ✓ Explore how local networks of Third Sector Organisations can be effectively linked with mental health services in each Primary Care Network
- ✓ Support the development of and improvement of existing commissioned Third Sector provision

Next Steps for the Workstream:

- Agree a revised terms of reference for the BSol Mental Health Third Sector Forum to include the development of a partnership agreement between the Sector and the BSol Mental Health Consortium
- Ensure that the Third Sector Forum is represented in key groups and board
- Support Third Sector Organisations to consistently submit data to the National Mental Health Service Data Set
- Develop existing relationships with Neighbourhood Networks (Birmingham) and Thriving Communities Programme (Solihull)

System Enablers: Estates and Digital

As the Birmingham and Solihull Integrated Care System develops, organisations are already progressing collaborative on programmes of work to ensure that our estate and our digital infrastructure support and enable improved health outcomes.

In the area of **estates** there is an ambition to develop an integrated estates plan designed to facilitate the way we will deliver care and support in the future. This is likely to include highly specialist regional centres; place and locality-based centres for standard procedures and diagnostics; integrated community-based locations making care easy to access; and the facilitation of staff working as part of embedded services in primary care, schools and other settings.

We will work to influence the emerging estates strategy to help ensure that settings reflect the needs of people accessing mental health support and are conducive to good mental health and wellbeing for those who use and work there.

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Working across the wider ICS estate to ensure that settings support both physical and mental health outcomes.	Thinking creatively about how and where our staff deliver services that do not reproduce inequality	Estate which facilities easy local access to joined-up provision which fits around the way people live their lives	Environments which are trauma informed and are conducive to achieving therapeutic outcomes	Continuing to address issues associated with environmental safety on wards and in other settings	Making best use of the available estate, co-locating where appropriate.

Table 8: How estates supports our guiding principles

The Covid19 Pandemic has resulted in a huge acceleration in the use of **digital technology** to provide care. We know that some members of our community are not well served by this change due to digital poverty and other reasons that make digital access problematic. There is more work to do to ensure that such groups are not disadvantaged as a result of this. Nevertheless, for many digital technology has provided convenient and discreet ways of accessing support and in general advances have been welcomed by the public. Technology has also enabled staff to work more flexibly and efficiently and enabling people to achieve a better work-life balance – although we are all still learning how to manage the new challenges that this can bring. Finally, digital also promises further benefits in terms of improving the sharing of information and supporting quick and effective diagnosis and clinician to clinician dialogue.

We will engage fully with the ICS digital programme ensuring that advances help to reduce the separation of mental and physical health rather than reinforce this. Further, we will seek to bring forward a single service user information system across the BSol Mental Health Provider Collaborative, evaluate the costs and benefits of recent digital progress and explore where technology can provide solutions to challenges and help achieve better outcomes.

Demand	Reduce Health Inequalities	Access	Outcomes	Safety	Value
Building on the success of digital access to support self-care	Working together to address digital poverty	Enabling more timely access through digital offers that reach beyond 9-5.	Developing digital solutions to enable staff and people using services to track recovery and measure the outcomes most important to them	Step change in accessing service user information across organisations and services, reducing the need for people to re-tell their story	Reducing the need for estate where digital solutions exist. Reducing travel time and environmental impact

Table 9: How digital supports our guiding principles

Next Steps for the Workstream:

- Assess the future estates and digital needs of BSol Mental Health Provider Collaborative
- Ensure the Collaborative is fully engaged with ICS enabler programmes and speaks with a single voice

Our Programme of Transformation

Working more effectively and closely together through the BSol Mental Health Provider Collaborative will be a key enabler of our efforts to transform the way that mental health services are provided. However, we cannot wait until our Collaborative is fully formed to begin our transformation journey. Indeed, we have already made significant progress in a number of areas.

Our Transformation Programme adopts an all-age approach and is underpinned by a set of strategic aims which support the broader focus on economic growth, a clean, green environment and thriving education and cultural sectors described in the Live Healthy, Live Happy Plan. Tackling the challenge of mental ill health requires us to work as a system to prevent poor mental health and maintain people's wellbeing; protect those who we know are most vulnerable; provide safe and effective treatment to manage people's conditions when help is needed and share a will to support meaningful recovery. Given the anticipated rise in demand for mental health support following Covid19 our focus on intervening as early as possible as part of a preventative approach will be even more critical to help ensure that services are not overwhelmed.

The Birmingham and Solihull Mental Health Strategic Outcomes Framework (embedded at **Appendix Three**) sets out our programme of transformation. This reflects both the nationally determined components of the NHS Long Term Plan and a number of local priorities – such as improving access to support for autism and ADHD. In addition, Local Transformation Plans for Children and Young Peoples Mental Health set out further detail of our objectives for 0 to 25 year olds. Separate plans are in place for Birmingham and Solihull. The areas of work within the Transformation Programme are set out below. The Transformation Programme is overseen by a joint Transformation Board chaired by the BSMHFT Executive Director for Strategy, People and Partnership. The programme's governance is set out in Table 10 below. A list of the key deliverables in each area is included in **Appendix Two.**

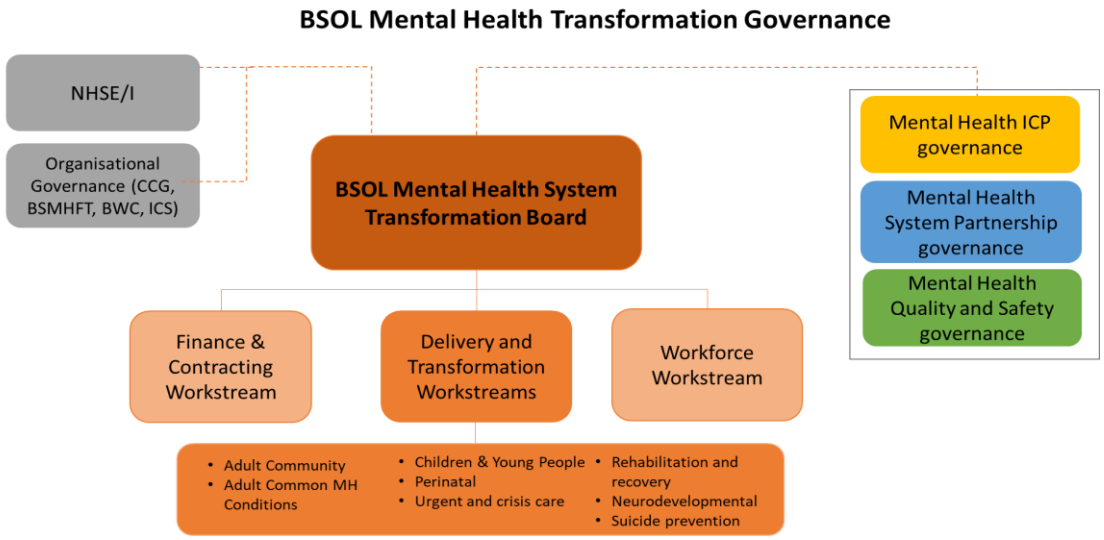


Table 10: BSol Mental Health Transformation Programme Governance

Challenges

The table below summarises a number of the key challenges that the BSOL Mental Health Provider Collaborative may need to respond to in its development and delivery.

Challenge	Proposed responses
Collaboration can be difficult! Success is influenced by factors including levels of trust, 'faith', approach to conflict, communication.	- Undertake baseline assessment in respect of 'success factors' (supported by Health Services Management Centre) - Agree actions to address areas of weakness and maintain strengths
Agreement to a model of governance for the MHPC, including decision making, contractual and financial frameworks	- Learning from other provider collaboratives/collaborations - Alignment to national guidance - Adopting principle of form following function - Further organisational approval prior to 'go-live'
Maintaining sufficient pace and momentum as collaboration is critical to transformation.	- Dedicate ample capacity to deliver programme - Progress through organisational governance during summer - Set ambitious but achievable timeline for Phase 3a (Workstreams plans in draft for Prog Board Sept 2021)

Making the Programme relevant and meaningful to staff and stakeholders	- Strategic communication and engagement to support collaboration, focus on what this will mean for people's day to day work?
Interface with emerging ICS infrastructure including, ICO, Provider Collaborative, Place-based partnerships	- Exploratory engagement with BCC/SMBC re place interface in phase 3a - Ongoing and proactive influencing of emerging system-wide development to ensure this supports the ambitions of the MHPC

Conclusion and recommendations

This document describes the vision for a Mental Health Provider Collaborative for Birmingham and Solihull, explaining how we want to work in a more integrated way and how this will support and enhance delivery of our six guiding principles.

Our proposals are fully cognisant with the ongoing and emerging work taking place across Birmingham and Solihull ICS to define governance models and a framework for strategic commissioning. As we carry on designing our governance framework in more detail, we will ensure this reflects and is aligned with the ICS direction of travel. We hope however, that by articulating our commitments to provider collaboration in mental health that we can share these with the wider ICS and influence the future direction of travel for provider collaboratives.

Throughout the document we have described our next steps in relation to each workstream. A key immediate priority will be for us to define what leadership and resource is needed to move us into the next phase of our planning and implementation. Our commitments are ambitious but necessary and we mustn't underestimate the time and focus that needs to be given to this to be successful.

Following endorsement of this proposal by the Programme Board, we aim to take this through organisational governing bodies/boards by the end of September 2021.

The Birmingham and Solihull Mental Health Provider Collaborative Programme Board is asked to:

- ✓ Endorse the guiding principles, commitments and other content of the proposal
- ✓ Recommend that organisational governing bodies receive and approve the proposal
- ✓ Subject to governing body approval, initiate and resource, via the Steering Group, a project to implement Phase Three of the Programme and progress the delivery of the 'next steps' set out in the proposal.

Appendices

Appendix One: List of Engagement Activity

Workstream/Theme	Engagement
Quality, Safety and Outcomes	BSol Working Group and Programme Board Members including experts by experience, expertise in: research, policy, data protection and management, informatics, data collection, business change management and transformation, public health, clinical care (multidisciplinary), patient and staff engagement, commissioning from a wide range of organisations including: FTB (BWCH); BSMHFT; BSol CCG; Birmingham Children's Trust (BCT); Birmingham City Council; Sandwell and West Birmingham CCG; Healthwatch; Midlands & Lancashire CSU.
People, Leadership and Culture	BSol Mental Health Workforce Group (representation from BSMHFT, BSol CCG, BWCH, BSol ICS Workforce Leads, Health Education England). Additional Input from Living Well Consortium and Birmingham Mind
Finance, Contracting and Governance	BSol Finance, Contracting and Governance Workstream Group - representation to date from BSMHFT, BWCH and BSol CCG Finance and Contracting leads and a lived experience representative (please note future meetings will be expanded to include 3rd sector and local authority representatives). Sessions with the BSoL Mental Health Third Sector Forum also examined elements of service delivery which included finance and contractual arrangements.
Place	Solihull Mental Health Pod (including SMBC, Primary Care, Solihull Mind, BSMHFT, BSol CCG, West Midlands Police)
Co-production	Birmingham and Solihull Co-production Steering Group (facilitated by Birmingham Mind Community Development Worker Service and BSol CCG)
Health Inequalities	Birmingham and Solihull ICS Health Inequalities Lead
Partnering with Third Sector Organisations	Birmingham and Solihull Mental Health Third Sector Forum (including, Birmingham Mind, Change Brief Therapy, Cruse Bereavement, Relate, Karis Neighbourhood Scheme, Pattigift, Forward for Life, Common Unity, Acacia)

Appendix Two: Transformation Programme Deliverables

The following lists the national deliverables for mental health set out in the NHS Long Term plan and additionally in the Spending Review 2020. Where deliverable are locally, rather than nationally, derived this is shown as [LOCAL] beside the deliverable

Adult Community (including Older Adults)
• Continue expansion and transformation of community services to ensure that in 2021/22, at least 126,000 adults and older adults with SMI can access new and integrated models of primary and community mental health, increasing to 370,000 adults and older adults per year by 2023/24 (including adult eating disorder, personality disorders and rehab pathways) • Maintain targets of 60% of service users requiring Early Intervention for Psychosis (EIP) receiving NICE concordant care within two weeks, and at least 70% graded at level three in terms of NICE concordance by the end of 2021/22. Expand current provision to include care and support for all-ages (including 35+) and people experiencing At-Risk Mental State (ARMS), in line with EIP commissioning guidance. • Ensure 32,000 people have access to Individual Placement and Support (IPS) services through delivery against ICS trajectories, in line with fidelity of model • Deliver annual physical health checks to at least 302,000 people with SMI nationally in line with set trajectories. • Deliver on submitted and approved transformation proposals, investing all allocated CCG baseline funding and transformation funding • From April 2021, GPs will be incentivised via QOF to complete all six elements of the annual physical health checks for people with SMI • Maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care. • Memory assessment services to enhance working practices to support recovery of the dementia diagnosis rate and access to pre and post diagnostic support.

ADDITIONAL SPENDING REVIEW DELIVERABLES

- Embed mental health practitioner roles in each PCN by 2021/22
- Expand the peer support workforce and non-clinical workforce to support community MH services
- Accelerate transformation across eating disorder pathways, with a focus on early intervention models and close working with voluntary and community sector partners
- Commission VCS-led outreach services to address inequalities amongst underserved SMI populations, including BAME communities, LGBTQIA+ communities
- Deliver tailored outreach and engagement for people with SMI, increasing access to physical health checks (to meet existing commitments) and ensuring uptake of flu and Covid19 vaccinations, in every ICS.
- Additional investment to address rising backlog of appointments in Memory assessment services, supporting services to achieve the existing dementia diagnosis commitment

Urgent Care and Crisis

- By 2020/21 35% coverage of 24/7 crisis provision for Children and Young People which combines crisis assessment, brief response and intensive home treatment functions
- 100% STP coverage of Liaison Mental Health teams meeting the needs of all ages
- Flexible Ambition by 2023/24: Improve mental health response provided by the ambulance service
- 50% of Liaison Mental Health Teams achieving 'core 24' standard
- 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21
- Flexible Ambition by 2023/24: Improve mental health response provided by the ambulance service
- Flexible Ambition by 2023/24: Invest in crisis alternatives
- Flexible Ambition by 2023/24: Access via NHS 111 to urgent mental health care
- 50% of Liaison Mental Health Teams achieving 'core 24' standard
- Eliminate OAPs for adult acute care

ADDITIONAL SPENDING REVIEW DELIVERABLES

- Continue investment in post-discharge support using new additional discharge funding, with the aim of reducing length of stay in mental health wards, reducing 6 and 12-hour waits for mental health service users in A&E (from attendance to departure) as well as reducing inappropriate OAPs.
- Sustain and enhance 24/7 open access, urgent mental health helplines for all ages in 2021/22
- Additional funding to deliver existing commitment that all CRHTTs achieve and maintain best practice models of care

Common Mental Health and Improving Access to Psychological Therapies (IAPT)

- By 2020/21 A total of 1.5m adults and older adults accessing treatment nationally
- Every CCG has an IAPT-Long Term Conditions (LTC) service in place
- [LOCAL} Network of VCS led counselling and wellbeing support
- Maintain the IAPT RTT rates (75% RTT within 6 weeks; and 95% RTT within 18 weeks)
- Maintain the IAPT recovery rate (50%)

ADDITIONAL SPENDING REVIEW DELIVERABLES:

- Funding direct to providers via Health Education England to increase the capacity of the IAPT workforce by 200-300 new High Intensity trainees across Cognitive Behavioural Therapy and other therapeutic modalities.
- Funding distributed fair shares to CCGs to increase capacity and efficiency of IAPT services, by expanding workforce, improving retention and introducing productivity initiatives.

Objectives of investment include

- supporting existing staff through retention and wellbeing initiatives
- supporting recovery of access and outcomes for groups disproportionately impacted by Covid19, including ethnic minority communities, older adults, students
- ensuring rapid access for frontline NHS and social care staff referred from Mental Health and Wellbeing hubs
- supporting integration and joint working with long-covid assessment clinics and treatment pathways, e.g. via recruitment of BABCP accredited clinical health psychologists

Children and Young People's Mental Health (0-25 years)

- Comprehensive 0-25 support offer across all STPs/ICS by 2023/24
- Mental Health Support Teams (MHSTs) to cover between a quarter and fifth of the country by 2023/24
- By 2020/21 70,000 additional Children and Young People aged under 18 accessing NHS-funded services [Five Year Forward View commitment] 73,000 additional Children and Young People aged 0 - 25 accessing NHS-funded services [LTP commitment]
- Achievement and maintenance of 95% Children and Young People Eating Disorder waiting time standard from 2020/21 (start NICE concordant treatment within 1 week if urgent and within 4 weeks if non-urgent)
- Delivery of the Early Intervention in Psychosis standard: - Achieve 60% Early Intervention in Psychosis (EIP) Activity Standard by 2020/21
- Delivery of the Early Intervention in Psychosis standard: - Achieve 60% Level 3 EIP NICE- Concordance by 2020/21
- Joint agency Local Transformation Plans aligned to STP plans are in place and refreshed annually to 2020/21
- [LOCAL] Review and align policies to ensure equitable and effective mental health support for children in care

ADDITIONAL SPENDING REVIEW DELIVERABLES:

- INCREASED ACCESS - In addition to the LTP requirement, ensure 22,500 children and young people aged 0-25 access NHS funded community MH services. The total access requirement in 2021/22 is therefore 186,500
- Sustain 24/7 crisis lines established in response to Covid19

Perinatal

- By 2020/21 At least 47,000 women in total accessing specialist community Perinatal Mental Health (PMH) services
- Flexible Ambition by 2023/24: Specialist community care from pre-conception to 24 months
- Flexible Ambition by 2023/24: Implementing assessment of partners
- Flexible ambition by 2023/24: Maternal Mental Health Services (formerly Maternity Outreach Clinics)

Multi-agency Suicide Prevention Groups

- Targeted investment to areas in line with the activity and actions agreed in local suicide prevention plans.
- 40% of STPs providing suicide bereavement support services

Rehabilitation

- [LOCAL] Reduction in out of area and total High Dependency Unit beds
- [LOCAL] Intensive Community Rehabilitation Teams
- [LOCAL] Improve access to independent accommodation and housing

Neurodevelopmental
• Reduce waiting times across all-age neurodevelopmental provision • Increase pre and post diagnostic support • Establish an integrated all-age pathway

Appendix Three: Birmingham and Solihull Strategic Commissioning Outcomes Framework

BSOL Mental Health Strategic Commission

Appendix Four: Definition of Terms

Additional Role Reimbursement Scheme (ARRS)	The Additional Roles Reimbursement Scheme entitles Primary Care Networks to access funding to support recruitment across a range of reimbursable roles – mental health practitioners, clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics
Anchor Organisation	The term anchor institutions refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities. Health.org
Co-production	Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

	Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches. Coalition for Personalised Care
Expert by Experience (EBE)	An expert by experience is a person with direct experience of health or social care services either as a service user, carer, family member or friend. Experts by experience play an important role in co-production by drawing on their own experience to inform service design, delivery and monitoring.
Integrated Care Pathway (ICP) or Place-based Partnership	ICP can stand for Integrated Care Providers, which bring together primary, secondary, community and other health and social care services under a single contract. The intention is to focus on population health by designing and delivering all health and care services for the local community within an agreed budget. NHS Providers 2021
Integrated Care System (ICS)	ICSs are partnerships that bring together providers and commissioners of NHS services, across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population *- Kings Fund, 2020*

Lived Experience	Personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people. It may also refer to knowledge of people gained from direct face-to-face interaction rather than through a technological medium. - *Oxford Reference, 2021*
NHS Long Term-Plan	The NHS LTP (formerly known as the 10-year plan) was published setting out key ambitions for the service over the next 10 years - *Kings Fund, 2020*
NHS England and NHS Improvement	NHS E/I is a non-departmental body in England, responsible for overseeing the NHS' foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
Place	Most health and care services need to be planned, designed and delivered on a smaller geographic footprint and population size than the ICS. This means that within each ICS there are several smaller planning footprints – termed “places” – where health and care organisations come together to improve service user pathways and deliver more joined up care. In the context of ICSs, broadly speaking, a “place” is intended to be an area with a population size of between 250,000 and 500,000 which is meaningful for the local community and organisations serving it. For some it will align with council boundaries, while for others it will reflect the flow of service users into a hospital.

	NHS Providers 2021
Primary Care Network	Primary care networks (PCNs) enable general practices to work together at scale leading to coordinated approaches around locality practices - including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to service users and to more easily integrate with the wider health and care system.
Provider Collaborative	A provider collaborative is made up of several organisations coming together to make collective decisions about the design and delivery of health and care services. Providers can form collaboratives for different groups of people for example: • people in a particular 'place' (e.g. Solihull, Birmingham) • people with a particular set of needs or conditions (e.g. mental health, maternity) people with a particular set of characteristics (e.g. older adults, children and young people)
Sustainability and Transformation Partnership (STP)	STP stands for Sustainability and Transformation Partnership. These are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve.

	STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities. They have been making simple, practical improvements like making it easier to see a GP, speeding up cancer diagnosis and offering help faster to people with mental ill health In some area, STPs have evolved to become 'integrated care systems', a new form of even closer collaboration between the NHS and local councils. The NHS Long Term Plan set out the aim that every part of England will be covered by an integrated care system by 2021, replacing STPs but building on their good work to date.
System of Care / Whole System	A system of care is the people, organisations and institutions that prevent illness and deliver care. The 'whole system' comprises of service users and their carers, the individual teams delivering care, the community of organisations providing integrated care to its population and the environmental context set by policy, regulation and social-economic factors Institute for Innovation and Improvement
Transformation (transformational change)	A change that brings about an entirely new way of doing something (e.g. a new way of providing a service). Transformational change is often brought about because of a shift in what is considered possible or

	necessary. Transformation can result in a different way of organising things, culture or level of performance. Based on Kings Fund 2018

Appendix Five: Accompanying Slide Pack

These slide present a summarised version of the proposal document.

Birmingham and Solihull Mental Health

20. Questions from Governors and Public

21. Any Other Business (at the discretion of the Chair)

22. Snap shot review of Board Performance

23. RESOLUTION: To exclude members of the public from the remainder of the meeting due to the confidential nature of the business to be transacted

Matters arising from previous meeting