Board of Directors (Part I)

Schedule	Wednesday 31 March 2021, 9:00 AM — 12:30 PM BST
Venue	Via Microsoft Teams
Organiser	Sharan Madeley

Agenda

TEAM Story: Women's Services

Agenda

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1. Opening Administration, Welcome, Apologies & Declarations of Interest

2. Minutes of the previous meeting

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3. Matters Arising

4. Chair's Report

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5. Chief Executive's Report

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6. Non-Executive Overview: Trust Values

7. Integrated Quality Committee Chair Report

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8. Serious Incidents Report (to update if required)

9. People Committee Chair Report

10. Staff Survey

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11. Finance, Performance & Productivity Committee Chair Report

12. Integrated Performance Report

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13. Finance Report

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14. Trust Strategy Launch

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15. New Care Models: Eating Disorders

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16. Development of new Board Assurance Framework

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17. Questions from Governors

18. Any Other Business

19. Snapshot Review of Board Performance

20. 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

21. Date & Time of Next Meeting: 28th April 2021

AGENDA
BOARD OF DIRECTORS MEETING
WEDNESDAY 31st MARCH 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

TEAM Story: Women's Services

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Welcome, apologies and declarations of interest	*Chair*	09:30	-	-
2.	Minutes of the previous meeting		09:35	A	
3.	Matters Arising/Action Log		09:40	A	Assurance
4.	Chair's Report		09:45	V	Assurance
5.	Chief Executive's Report	*CEO*	09:50	A	Assurance
6.	Non-Executive Overview: Trust Values	*L. Cullen*	10:05	V	Assurance
QUALITY					
7.	Integrated Quality Committee Chair Report	*W. Saleem*	10:20	A	Assurance
8.	Serious Incidents Report *(to update if required)*	*S. Hartley*	10:30	V	Assurance
PEOPLE					
9.	People Committee Chair Report	*J. Warmington*	11:00	To follow	Assurance
10.	Staff Survey	*P. Nyarumbu*	11:05	A	Approval
SUSTAINABILITY					
11.	Finance, Performance & Productivity Committee Chair Report	*R. Beale*	11:15	To follow	Assurance
12.	Integrated Performance Report	*D. Tomlinson*	11:20	A	Assurance
13.	Finance Report	*D. Tomlinson*	11:30	A	Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
14.	Trust Strategy Launch	*P. Nyarumbu*	11:40	A	
15.	New Care Model: Eating Disorders	*P. Nyarumbu*	11:50	A	
	GOVERNANCE & RISK				
16.	Development of new Board Assurance Framework	*D. Tomlinson*	*12:00*	*A*	*Assurance*
17.	Questions from Governors	*Chair*	*12:10*	*V*	*Assurance*
18.	Any Other Business *(at the discretion of the Chair)*	*Chair*	*12:20*	*V*	-
19.	**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*		*V*	-
20.	**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.				
21.	**Date & Time of Next Meeting** • 09:00am • 28th April 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

compassionate

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Meeting	BOARD OF DIRECTORS
Agenda item	4
Paper title	CHAIR'S REPORT
Date	31st March 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 cores purpose.

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.

1.2 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.

1.3 Thank you to all BSMHFT staff who continue to step up to great during the Covid-19 pandemic

2. MEETINGS

2.1 The key internal meetings I have been involved with during the month are detailed below:

- Dr Renarta Rowe, Deputy Medical Director for Quality and Safety, introductory meeting
- Stephanie Crow, Head if Learning and Development, introductory meeting
- Kuldeep Singh, Quality Improvement Lead, introductory meeting
- Tasnim Kiddy, Associate Director of Performance and Information, introductory meeting
- Governor training with NHS Providers
- Shane Bray, Managing Director of SSL, introductory meeting
- Reducing Restrictive Practice Collaborative, launch event

3. PARTNERSHIPS

3.1 Some of the external activities I have been involved in since the last Board meeting include:

- BSoL ICS Board meeting
- Midlands Regional Talent Board
- Midlands STaR Board
- University of Helsinki research team regarding research and innovation
- Dr Andrew Coward, Kings Norton Surgery, regarding the role of trauma in health inequalities
- Mike Bell, Chair of Croydon Health Services NHS Trust and Barking Havering and Redbridge NHS Trust, regarding SW London ICS approach to health inequalities
- BAME Chair-CEO Network anti-racism discussion with NHSEI Director of People, Prerana Issar

4. NHS OPERATIONAL PLANNING

The 2021/22 priorities and operational planning guidance has been published which sets the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. The full guidance can be found Here

5. PEOPLE

5.1 Non Executive Director

Board Members will be aware that Joy Warmington's term of office comes to an end at the end of April 2021. The Nomination & Remuneration Committee has agreed to extend Joy's term of office until the end of June 2021 to assist with continuity whilst a replacement Non-Executive Director is recruited. This process will commence early April.

6. BOARD DEVELOPMENT

6.1 We are completing a detailed Board Development Programme for the next 12 months and the Board will be having further discussions later in the Board meeting.

DANIELLE OUM
CHAIR

Meeting	**Board of Directors**
Agenda item	**6**
Paper title	**Chief Executive's Report**
Date	31st March 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 continues to be written in the main in the context of the COVID-19 pandemic and our response to decreasing numbers of COVID-19 positive cases and easement of lockdown restrictions. The key aim of my report is to provide the Board with an overall summary of our collective response to these pandemic related matters and key areas of interest for the Board in relation to 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
Inclusive

CHIEF EXECUTIVE'S REPORT

1. CURRENT PANDEMIC SITUATION

At the time of writing I am pleased to report that the Trust has no in-patients being cared for with COVID-19 and we have 4 wards remaining in outbreak management conditions. We have a staff absence rate of 9.4% of which 43% is COVID-19 related.

2. COVID-19 SERVICES UPDATES

2.1 Supply Chain

SSL are supporting the NHS System via the CCG, right across all Primary Care Health Centres and GP Surgeries through the establishment of COVID-19 Vaccination sites. They continue to give logistical and vehicular support by providing mobile vehicles to deliver COVID vaccinations across Birmingham and Solihull faith buildings, homeless support services, sex workers support services and other specific groups in partnership with UHB and the CCG.

2.2 Clinical and Ethical Group

The group will in April review all the guidelines and policy changes implemented during the pandemic, to ascertain which of these should be amalgamated into existing guidelines and policies as we emerge from the current situation.

2.3 Communications

During the past month the Trust have continued their focus on COVID-19 communications and engagement, in particular internal communications, engagement and messaging around vaccination. This includes a range of collateral, including a dedicated vaccine section on Connect (the Intranet), which is regularly updated, Connect banners and screensavers, films, shared colleague stories/case studies and social media activity.

A Listen Up Live event focussing on the COVID-19 vaccination was held on 4th March. The Trust have been working closely with the Organisational Development Department to progress a programme of engagement to help colleagues to have supportive conversations at a local level within their teams and with peers. We hope that this will help to support those colleagues who have not yet taken the vaccine and those who do not have ready access to Trust wide and online channels. An engagement toolkit has been developed and is being used to assist colleagues with this activity.

2.4 Nursing

I'm pleased to report that our Infection Control team continue to see a reduction in positive cases and outbreaks. We currently have no inpatients who are Covid-19 positive and have 2 outbreaks which are very well controlled and due to finish in the next week. We have completed a themed analysis of the outbreaks and a full review of the Infection, Prevention and Control Board Assurance Framework which has identified some key learning points and actions for us to continue to implement; for example, the need to refresh Covid-19 secure risk assessments, the importance of floor walking and supporting colleagues with PPE.

They are also constantly reviewing and updating our guidelines as national protocols change, for example on visiting and testing and these are then updated to reflect where we are in the pandemic.

Once again, our third year Student Nurses have joined us as employees and we have been fortunate in that, over 60 third year students have taking up this option with us.

We are also supporting a larger number of student nurses coming out into clinical practice placements, as courses move from theoretical to practical components. We have been able to accommodate all students who require clinical placements which has been a phenomenal task for our Practice Placement Team.

2.5 Workforce

This month the Remote Working Task Group recommended a hybrid model of working post pandemic, which will be determined locally taking into account service needs and that of individual colleagues and their circumstances. This option is being worked through with input from different stakeholders to develop principles which would support a framework to allow consistency of decision-making to ensure safety of services and safeguard the wellbeing of colleagues wherever they are located.

The Redeployment Group have been looking at innovative ways to access more workforce capacity during the pandemic. Options are being explored to engage more directly with the local community to promote the career opportunities available in mental health and also to demystify and simplify the application process. The first of such events is being held week commencing 22 March 2021.

Work by the Wellbeing Group on the pilot around reflection/take time out spaces in areas across the Trust, is making good progress. These areas will have resources such as hot drinks, access to self-help and will also have rotas where volunteers and colleagues trained in psychological first aid will be able to support individuals who access the facilities at the start, during and end of shifts. Materials have been ordered to support these spaces and the first of these is scheduled to be open after the Easter break.

2.6 Clinical Services

Services continue to manage both COVID-19 and demand pressures well. The demand surge work is being progressed by service and we are actively looking at our recruitment plan to support both our transforming services plan and demand surge predictions.

3. INTERNAL UPDATES

3.1 Chief Nursing Officer for England recognises exceptional BSMHFT nurses

Ruth May, the Chief Nursing Officer (CNO) for the NHS in England, joined our matrons this month for a meeting via Microsoft Teams and presented a number of our fabulous nurses with CNO awards. The awards were launched in 2019 to recognise the outstanding contributions of nurses, with two categories for these awards: Silver awards that recognise major contributions to patients and the profession and Gold awards that recognise lifetime achievements for nurses and midwives.

I am so pleased to report that our Deputy Director of Nursing, Natalie Willetts, Head of Safeguarding, Cath Evans and Zalika Geohaghon, our Senior Infection Prevention and Control Nurse Specialist, received Silver awards.
These exceptional nurses have all shown unswerving commitment and compassion to service users, carers and colleagues, particularly during the COVID-19 pandemic. A Gold award was presented to Sue Hartley, Executive Director of Nursing who has recently retired from the Trust after a 40 year nursing career. This is great recognition of the nursing profession in BSMHFT and, as a nurse myself, I am hugely proud of the work of these amazing colleagues

3.2 Executive Director of Quality and Safety (Chief Nurse)
We welcomed this month Sarah Bloomfield to the team in an interim capacity to this role. I have also now restarted the recruitment process to the substantive role.

4. LOCAL ISSUES

4.1 Birmingham City Council

Birmingham City Council has started an engagement programme with the city's Business Improvement Districts (BIDs) to help retail and hospitality reopen safely following the Government's phased reopening of lockdown. The Council report that discussions are being held with emergency services, local residents as well as other partner organisations and authorities, to ensure that the measures the Council implements are COVID safe and work for everybody as the city comes out of lockdown.

4.2. Integrated Care System (ICS)

As part of The Birmingham and Solihull ICS we have during this month continued to consider how we develop our key areas of work and respond to the recent white paper. Discussions on the ICS Board, ICS Partnership, Strategic Commissioning and setting in place of a Provider Partnership have progressed.

The People Board have agreed a set of joint ares of ICS focused work resulting from the NHS Provider. Staff Survey results and the WRES report..

5. NATIONAL ISSUES

5.1 Reforming the Mental Health Act

The Mental Health Network of the NHS Confederation has provided a summary of the government's white paper proposing changes to improve the Mental Health Act. The full document can be found Here

5.2 Money & Mental Health Policy Institute

A report from the Money and Mental Health Policy Institute considers the inter-relationship between income and mental health and well-being. In recognition of the complexity of the area and diverse possible solutions, the Mental Health and Income Commission was established.

The Commissioners were chosen for their expertise in representing businesses and workers, for their knowledge across mental health, social security and work, and their insights into how to achieve meaningful change, from a political level through to implementation. The full report can be found Here

5.3 Covid Support for BME NHS staff following a Covid-19 risk assessment

This briefing from the NHS Confederation considers the type of support available to black and minority ethnic staff following a Covid-19 risk assessment. The paper has been developed in partnership with the Chief Nursing Officer's Nursing and Midwifery BME Action Plan Steering Group and can be found Here.

5.4 Young people's mental health Young people's well-being

This study from the Education Policy Unit and The Prince's Trust considers young people's wellbeing and emotional mental health focusing on drivers in childhood and adolescence. Further reading is available Here

5.5 NHS England: COVID Treatment developed in the NHS

NHS England has reported this week that Dexamethasone, an inexpensive and widely available steroid, has saved around one million lives worldwide since its discovery as an effective treatment for COVID-19 in a clinical trial in the NHS. New figures, published, show that use of the drug has so far saved 22,000 lives in the UK and an estimated one million worldwide.

Since the RECOVERY trial, led by University of Oxford scientists and involving tens of thousands of patients and 175 NHS hospitals, announced the results just nine months ago, dexamethasone has been used to treat millions of seriously unwell patients with COVID. The RECOVERY researchers found that dexamethasone cut the risk of death by a third for COVID patients on ventilators and for those on oxygen it cut deaths by almost a fifth.

Previously used for a wide range of ailments, including allergies and skin conditions, the drug is now being used around the globe to improve survival in patients with COVID who need oxygen or ventilation. The NHS moved quickly to use the breakthrough research in hospital settings. Dexamethasone was made available to patients on hospital wards in England just hours after the results were announced in June.

5.6 Regulatory Lessons to be learnt from the pandemic

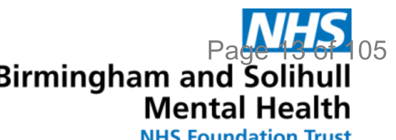
A new report by NHS Providers on trusts' experience of NHS regulation highlights strengths and weaknesses in the approaches taken by Care Quality Commission (CQC) and NHS England and NHS Improvement in response to the COVID-19 pandemic.

Reconsidering the approach to regulation concludes that both organisations implemented welcome changes in response to the onset of the pandemic, scaling back their activity to allow trusts to concentrate their full efforts on patient care.

CQC paused all routine inspections and provider information requests and concentrated its activities on areas of critical risk and safety. NHS England and NHS Improvement also suspended its core oversight activities, continuing those which were deemed essential for monitoring the pandemic. This leaner approach enabled health and care organisations to work together, delivering care in new and innovative ways.

However, during the second wave many trusts felt that reporting requirements and other regulatory activity increased disproportionately, indicating "a perception that the regulators do not necessarily have a strong enough understanding of the impact of COVID-19 pressures". The survey found that 60% of respondents felt CQC's scaled back approach helped them focus on managing COVID-19, but the comments received – both positive and negative – suggest that regulatory activity in the second wave "created a greater sense of pressures at the frontline than it did during the first wave".

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE



Meeting	BOARD OF DIRECTORS
Agenda item	7
Paper title	INTEGRATED QUALITY COMMITTEE CHAIR REPORT
Date	31st March 2021
Author	Waheed Saleem
Executive sponsor	Waheed Saleem

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

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

Reason for consideration
To provide the Council 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
Our values
Committed Compassionate Inclusive

REPORT FROM THE IQC COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

1.1 Draft Quality Strategic Risks: Board Assurance Framework

The draft Quality Strategic Risks for Board Assurance Framework were presented by AHH Ltd. The risks linked to IQC were discussed.

There was some NED Challenge around how health inequalities could be threaded through the BAF and all the Committees. We were informed that the draft risks will go to FPP and People Committee before Board in March. Then each risk will be worked through and the controls and mitigations to be presented at the April Committee's and Board.

Chairs assurance comments:
I and the Nursing and Governance Department leads, pre-committee worked through the BAF risks with AHH and aligned these with the quality goals. Further work will be undertaken and consideration on ensuring health inequalities are captured. The work is progressing well and the final BAF will be presented to Board in April after which the Committee will monitor and report on these to the Board. Agenda items will be linked to the BAF risks.

1.2 Hot Topics

The Committee received an update on the challenges to quality and safety, in meeting the trajectory and steps being taken to support a zero Out of Area (OoA) position by June 2021. The details of the plans for the introduction of an Intensive Rehab Community Team to be shared with the members.

Chairs assurance comments:
This is a significant ask for the Trust, there were some challenge on what an inappropriate OoA placement meant and it is important that we didn't just chase the target, but ensure we are doing this in the best interest of the patient.

1.3 CQC Section 31 Escalation and Forecast Report

We received the updated action plans and the individual action plans from the Acute and ICCR services. We were given assurance of the accountability structures in the delivery of the actions and management of the gaps.

There was a robust discussion on the assurance on the forecast position for the delivery of the improvement plans and the NED's challenged the Trust as to whether the action deadline for the roll out of the en-suite door alarms could be trimmed

The report to IQC in April is to include the narrative around 'so what and what difference has this made'.

Chairs assurance comments:
The committee rightly challenged the Executive on reviewing the deadline for the en-suite door alarms roll out to see if this can be bought forward, as I am concerned about the potential risks that this poses. We also raised issues of other ligature points for example vents, room doors, etc and how to mitigate against this.

I was assured that Acute services will be introducing a real time dashboard for staffing levels. Although we can make physical changes, the real difference will be made through ensuring sufficient staff on all wards, effective risk assessments, excellent care planning and ensuring a therapeutic environment, with consistent service delivery across all our services. I do not think we are there yet, but a plan is in place.

The ICCR presented on the key issues from the CQC visit, these are issues that have been discussed numerous times and yet we still have challenges; lone working, care planning and case loads. Although we had updates on how these are being dealt with and the strong commitment from leaders, I am not fully assured until substantial improvements can be evidenced.

The other issues of the intercom at Zinnia, cleaning schedules and keys left in the drug cupboard should not happen as these are basic issues, assurances were given these were dealt with!

We asked about accountability throughout the organization, we were provided with an update on the process, however, we need to test this on the ground and it will be helpful when we are able to do visits to test this with front line staff.

We have a long way to go to evidence sustained improvement in quality and safety, as such the Trust carry's risk, which I am glad are acknowledged by the leadership. The question in my mind is if we are implementing the change quick enough and what else can we be doing?

1.4 COVID-19 Thematic Review

The Associate Director of Governance presented the report detailing the impact that COVID-19 has had on the Trust in the patient and staff safety and care domain. The NED's requested that the demographic data presented had further detail and narrative to help gain a better understanding of the context.

Chairs assurance comments:
A comprehensive report was presented, however, it is important that the actions are owned and implemented, we were assured this will be picked up through existing governance structures. An update will be requested on implementation at a future meeting.

1.5 Health, Safety and Security Quarterly Report

IQC received the report from the Associate Director of Governance giving an update of the activities of the health, safety, fire and security portfolio since the last report in December.

Chairs assurance comments:
The significant issues were picked up under other agenda items.

1.6 Capital Prioritisation Report

The Associate Director of Finance presented the report as IQC needed to have sight of the risk based prioritised list, arising from a range of health and safety risk assessments to be included in the capital programme.

We were informed that FPP would be recommending to Board to approve £3.4m of pre-commitments which include the door alarms as raised by this committee.

IQC accepted and recognised the requested of the prioritisation plan and asked that it was noted that that the identified ligature risks carry equal weight of importance within the future decisions.

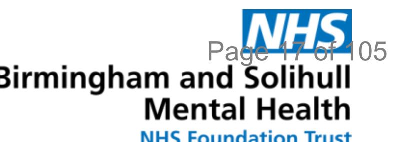
The Trust capital allocation had not been made, therefore it was difficult to agree the definitive plan.

Chairs assurance comments:
It was agreed that a separate meeting will be held with the Chair of IQC, FPP, People, DoF, DoN, ADoF and ADoG, to agree the prioritisation for the capital plan over and above the pre-commitment and this be presented to the Committees and Board in April.

1.7 Quality Dashboard

We received an update on progress from the Associate Director of Governance who confirmed the report includes the national benchmarking data.

Chairs assurance comments:
We receive this as a regular agenda item which details the quality metrics as of the end of February with run charts and commentary on each indicator.



Meeting	**BOARD OF DIRECTORS**
Agenda item	**10**
Paper title	**NHS STAFF SURVEY RESULTS**
Date	31 March 2021
Author	John Travers, Internal Communications and Engagement Lead
Executive sponsor	Patrick Nyarumbu, Director of Strategy, People and Partnerships

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

Executive summary & Recommendations:

This paper shares the results of the annual NHS Staff Survey and provides assurance that its unrivalled assessment of our people's experience is being used to inform our work to make BSMHFT the best place to work.

1,860 colleagues completed the NHS Staff Survey this year: giving us more answers than ever before to help improve the way we work together.

Overall, we have made some improvement in many areas, with more work to do to bring us up the national average in others.

We recommend the Board notes the results and the ongoing work which will continue to be scrutinised at People Committee.

Reason for consideration:

For awareness and assurance.

Previous consideration of report by:

People Committee.

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

PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users

Financial Implications *(detail any financial implications)*
No immediate implications.
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
No new risks.
Equality impact assessments:
NA
Engagement *(detail any engagement with staff/service users)*
Results have been published and shared with all staff using the Trust's internal communications channels. A significant programme of engagement with senior leaders, operational teams, professional groups, staff networks, staff side, relevant themed meetings and fora and individual team managers is underway. This includes through our Team Culture Deep Dive programme which is using a Quality Improvement approach to help team managers engage with their teams to improve teamworking and employee experience.

NHS STAFF SURVEY RESULTS

1. Situation

1.1. Our full NHS Staff Survey Report is presented with some initial analysis and an explanation of what we are doing as a result.

1.2. This paper provides information to our Board colleagues, an opportunity to ask further questions and to gain assurance that these results inform our ongoing work appropriately.

2. Background

2.1. The NHS national staff survey is an annual employee survey asked of all NHS staff between September and November. The reports are published the following March and are attached to this paper.
2.2. The survey measures employee experience through a large set of established questions that explore ten key themes such as employee engagement, bullying and harassment, teamworking and management.
2.3. The survey is a complex but rich source of insight to leaders and managers in our Trust to inform the development of their approach.
2.4. The detailed reports attached have been published and communicated within the Trust already.

3. Assessment

3.1. All ten major themes have shown some improvement compared with last year. We have improved to the national average on questions regarding immediate managers, morale and quality of care. The rating of managers has improved for three years in a row now.

3.2. We still perform below average on the majority of major themes compared with similar trusts with 7 out of 10 theme scores numerically below average compared to other trusts of our type.

3.3. At a question level we maintained or improved our scores on 47 questions, there was no significant change in 42 questions and just 1 question worsened this year.

3.4. A significant deficit remains in our employee’s experience of equality, diversity and inclusion and bullying/violence where only small improvements have been made.

3.5. A smaller deficit remains in safety culture, health and wellbeing and teamworking despite some very good progress year on year. This is particularly notable with regard to questions around safety where all six measures of safety culture have improved with 4 of those statistically significant improvements.

3.6. All nine employee engagement scores improved but we remain below average numerically.

3.7. One stand-out result with regard to a specific question is the overall increase in people feeling senior manager communication with staff is effective. This has gone up by 8.4% as against a 1.3% national increase and is now at an average. This could be attributed to initiatives such as Listen Up Live which was introduced to improve our staff engagement with senior managers.

3.8. Every individual comment made in the survey by a colleague has been read and themed to allow learning. Many of the comments focus on the need to build trust for more flexible working and to strengthen teamworking, particularly between occupational groups.

3.9. The Trust has been progressing work on embedding the Just Culture principles as part of the People Plan. Control measures and assurance required in relation to our response to the staff survey has been built into the People Plan and this will be shared with the Board in April 2021. We will also be developing a system approach to some of the actions and this will be led through the ICS People Board.

4. Recommendation

4.1. We ask the Board to note the results and the resulting engagement work to ensure lessons are learned from our progress and where ground still needs to be made.

5. Appendix

5.1. Three documents already published which give further details of the staff survey results are attached. These are: -
NHS_staff_survey_2020_RXT_summary.pdf - summary of results and themes
NHS_staff_survey_2020_RXT_full.pdf – theme results and question by question results.
NHS_staff_survey_2020_RXT_directorate.pdf – theme results at a directorate level.
Initial Staff Survey results Board presentation.pptx – summary presentation.

John Travers
Internal Communications and Engagement Lead
23 March 2021

NHS Staff Survey 2020 results

An analysis

Background

- Annual survey: September – November 2020
- All permanent staff invited to take part
- 1860 colleagues responded (2019: 1782)
- Trust Response rate: 47% (2019: 49%)
- National median response rate: 49%

Key messages from 2020 initial analysis

- Below average performance on majority of major themes compared with similar trusts but better than in the past.
- All themes have shown some improvement compared with last year – nine out of ten significantly so.
- Still an overall deficit in Equality, Diversity and Inclusion, bullying, safety culture, health and wellbeing and teamworking.
- Variation across different departments/directorates, professional groups and demographics of our workforce (age, disability and ethnic background).

Consistent change

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.3**	1715	**8.5**	1799	↑
Health & wellbeing	**5.8**	1733	**6.1**	1806	↑
Immediate managers †	**7.1**	1739	**7.3**	1813	↑
Morale	**6.1**	1685	**6.4**	1786	↑
Quality of care	**7.3**	1514	**7.5**	1557	↑
Safe environment - Bullying & harassment	**7.4**	1703	**7.7**	1725	↑
Safe environment - Violence	**9.1**	1706	**9.2**	1789	Not significant
Safety culture	**6.4**	1708	**6.6**	1796	↑
Staff engagement	**6.9**	1768	**7.1**	1830	↑
Team working	**6.5**	1747	**6.7**	1811	↑

2020 NHS Staff Survey Results > Theme results > Overview

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	8.5	6.1	7.3	6.4	7.5	7.7	9.2	6.6	7.1	6.7
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,799	1,806	1,813	1,786	1,557	1,725	1,789	1,796	1,830	1,811

Score (0-10)

Key themes v national results

- EDI remains below average especially re progression.
- Health and Wellbeing improved markedly towards average.
- Immediate Managers improving marginally to the average.
- Teamwork improved marginally but below average.
- Morale steady overall but respect a continued concern.
- Care quality ratings all moving to the average.
- Bullying and harassment very poor but some improvement
- Significant improvements in safety culture to build on but below average.
- Solid improvements on staff engagement.

Summary position: question level data

Comparison with 2019

- Significant increase compared to 2019 results - **40 questions**
- No significant change in score compared to 2019 results - **35 questions**
- Scores remained the same compared to 2019 results - **7 questions**
- Decrease in score compared to last year - **1 question**
- Significantly worse compared to last year - **0 questions**
- New questions added this year - **3 questions**

Comparison with Picker average

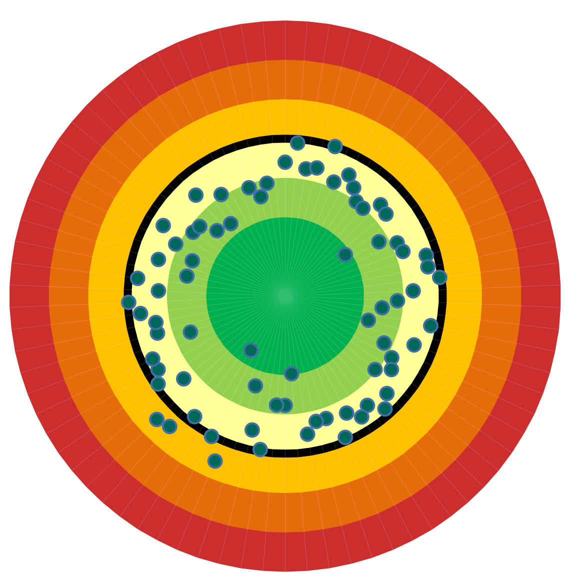
- Significantly better on 10 questions
- No significant difference on 40 questions
- Significantly worse on 28 questions

Advocacy/ Friends & Family questions

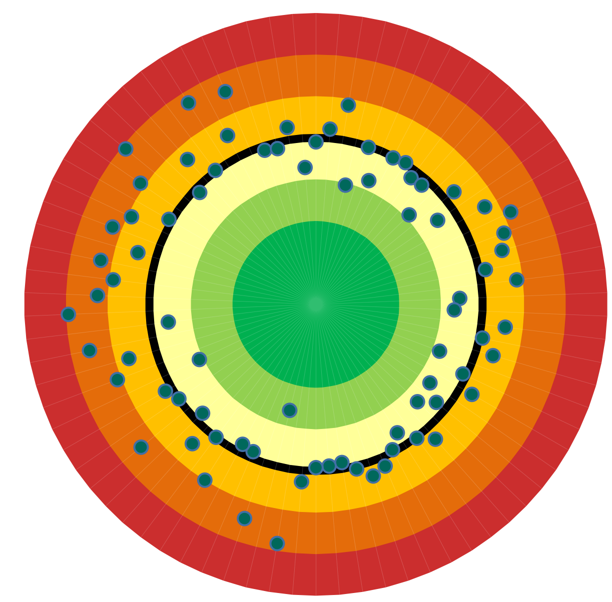
66%	Q18c. Would recommend organisation as place to work
60%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
80%	Q18a. Care of patients/service users is organisation's top priority

Summary

Current scores vs. historical scores



Current scores vs. similar organisations



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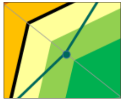
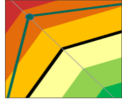


This score is considerably better than the comparison score



This score is considerably worse than the comparison score

Birmingham and Solihull Mental Health NHS Foundation Trust

Summary Trust position from Picker report

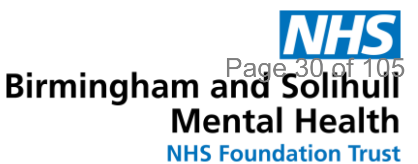
	Top 5 scores (compared to average)
42%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
94%	Q12d. Last experience of physical violence reported
88%	Q3a. Always know what work responsibilities are
51%	Q4e. Able to meet conflicting demands on my time at work
28%	Q6a. I have realistic time pressures

	Bottom 5 scores (compared to average)
75%	Q14. Organisation acts fairly: career progression
56%	Q17c. Would feel confident that organisation would address concerns about unsafe clinical practice
68%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
60%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
61%	Q18f. Feel safe to speak up about anything that concerns me in this organisation.

	Most improved from last survey
50%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
41%	Q4g. Enough staff at organisation to do my job properly
48%	Q9b. Communication between senior management and staff is effective
65%	Q5h. Satisfied with opportunities for flexible working patterns
66%	Q18c. Would recommend organisation as place to work

	Least improved from last survey
73%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
7%	Q11g. Not put myself under pressure to come to work when not feeling well enough
79%	Q11f. Not felt pressure from colleagues to come to work when not feeling well enough
57%	Q11c. In last 12 months, have not felt unwell due to work related stress
91%	Q3b. Feel trusted to do my job

*Only scores which are higher/lower than the average/historic scores are shown.



Interesting outliers

- Communication and engagement by senior managers
- Large increase in people saying we have enough staff
- Large increase in people having opportunity to use skills
- People feel more valued
- More flexible working
- Making a difference to patients
- Demographic discrimination falls everywhere bar ethnic background
- Fair treatment on incidents and taking action improving but not speaking up
- Closed the gap on thinking about leaving

Demographics

- People with a disability are less disengaged than in the past and feel more valued than before.
- Colleagues who are Black or Asian remain discriminated against.
- Engagement and multiple ethnic background.
- Gay or Lesbian colleagues are relatively engaged.

Occupational groups

- Administrative and clerical generally most positive.
- HCAs don’t feel involved enough in decision making.
- Medical colleagues more valued and involved than in the past but clear concerns about care and safety to speak up.

Conclusion

- More detailed analysis supplied
- We are supporting team managers and other groups within the Trust to make use of the rich data available.
- We are working to make sure we align with three ICS priorities of which teamworking seems most relevant.
- As the paper explains, progress will be overseen through direction from People Committee.
- Any questions?

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	12
Paper title	INTEGRATED PERFORMANCE REPORT
Date	31st March 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:

The People domain has seen the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Position has improved a little in February but remains of concern across the board · Sustainability has been artificially improved by national funding decisions in first six months but is currently overperforming against the mid-year forecast .

Quality scores have improved substantially as a result of highincident reporting being considered a positive · Performance remains strong, though Out of Area bed days are a serious concern and metrics introduced earlier in year where performance standards are still under review

Reason for consideration:

To assure the Board of Trust delivery against its key performance indicators and priorities

Previous consideration of report by:

Performance Delivery Group

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)*

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

INTEGRATED PERFORMANCE REPORT

Performance in February 2021

Services and performance continue to be impacted adversely by COVID-19 and this is expected to continue for some time to come.

People (adversely) and Sustainability (positively and artificially) are both significantly impacted by COVID-19. Scores in the People domain are of particular concern.

The Trust is reviewing the performance metrics it currently uses to ensure they remain appropriate given the Strategy refresh. There will be changes to these in 2021/22.

Overall – 71% (up from 70% in month)

- Overall score fluctuated between 77% and 82% between 2016 and 2020 but has been significantly impacted over the last year due to the pandemic. In January it was 70%, the lowest level in the entire reporting period (59 months since Apr-16). It is little changed in month. Score will be constrained by financial issues when the current national funding approach reverts to normal
- People and Sustainability scores are significantly and artificially impacted by COVID, although the discontinuation of top up funding will expose the underlying issues in Sustainability
- Performance scores are impacted by the inclusion of the new KPIs pending agreement on the standards to be used and have dipped over the last two months
- The underlying financial position is of significant concern although immediate concerns and risks were mitigated by national funding decisions relating to COVID-19
- Out of Area bed days continue to be problematic but were improving. The figure has worsened in February

Quality – 83% (up from 81% in month)

- Position now reflects high incident reporting as a positive outcome
- We continue to show general incident reporting levels above the median with levels of harm well below that typically experienced at national levels (18% harm locally versus 39% nationally).
- Reduction in incidents of physical assault on staff and patients has been sustained below the median. The National Staff Survey shows a slight improvement in our score around incidents of violence on staff moving to 9.2 against a national average of 9.5. Our safety culture score in the survey has increased to 6.6 against a national average of 6.9 and our quality of care score has increased to 7.5 which is representative of the national average
- Count of prone restraints has reduced in month but this is on lower occupied bed days, i.e. rate has increased. Our nationally benchmarked position for prone restraint per 10,000 occupied bed days is 44 in adult acute care against a national mean of 20 and median of 14
- **Key concerns: Inpatient falls, assaults on patients and staff**

Performance – 72% (down from 76% in month)

- The overall score has been adversely impacted by introduction of new KPIs and decisions to be taken regarding performance standards for these
- Of the continuing metrics, the Out of Area Patient performance remains the main concern, and it has deteriorated in month

- IAPT patients seen within 6 weeks of referral has considerably worsened over last two months and reflects large number of staff vacancies (14%)
- The % of service users on CPA having a formal review in the last 12 months remains a worry. Performance standards not yet agreed
- New referrals not seen within 3 months are down to 2,363
- Eating disorders routine appointment is low - represents 4 out of 5 service users, no underlying issues
- All other measures apart from BAF are achieving target or better
- Data Quality Maturity Index has sustained improvement and remains one of best in the country
- **Key concerns: Out of Area, IAPT seen in 6 weeks, CPA 12 month review and new referrals not seen in 3 months**

People – 49% (up from 45% in month)

- The People domain has seen the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Scores in the month have improved across several metrics but remain of concern across the board
- **Return to work interviews** improved at 57% but at very low level historically
- **Fundamental training** at 89%, the lowest level since Jun-16
- **Appraisals** at 78%, lowest level since May-19
- **Sickness** improved at 6.5%, but 3rd worst level since Apr-16
- **Shift Fill Rate** at 80%, second worst level in the entire reporting period
- Work progressing on review of metrics and data quality to ensure we are presenting most relevant items of performance. Changes anticipated in 2021/22
- **Key concerns: Return to work interviews, fundamental training, shift fill rates, appraisal rates and sickness**

Sustainability – 80% (unchanged from last month)

- Surplus/Deficit is now being assessed against mid-year plan and last month position has improved because of this
- The underlying financial position remains a serious concern, although immediate risks are mitigated in short term by national funding decisions relating to COVID-19
- Monthly deficits have been better than mid-year forecast for last 3 months
- IG held down by poor IG training compliance from temporary staff
- **Key concerns: CIP under achievement impacting adversely on Operating Surplus, Cash and CapEx**

Other matters

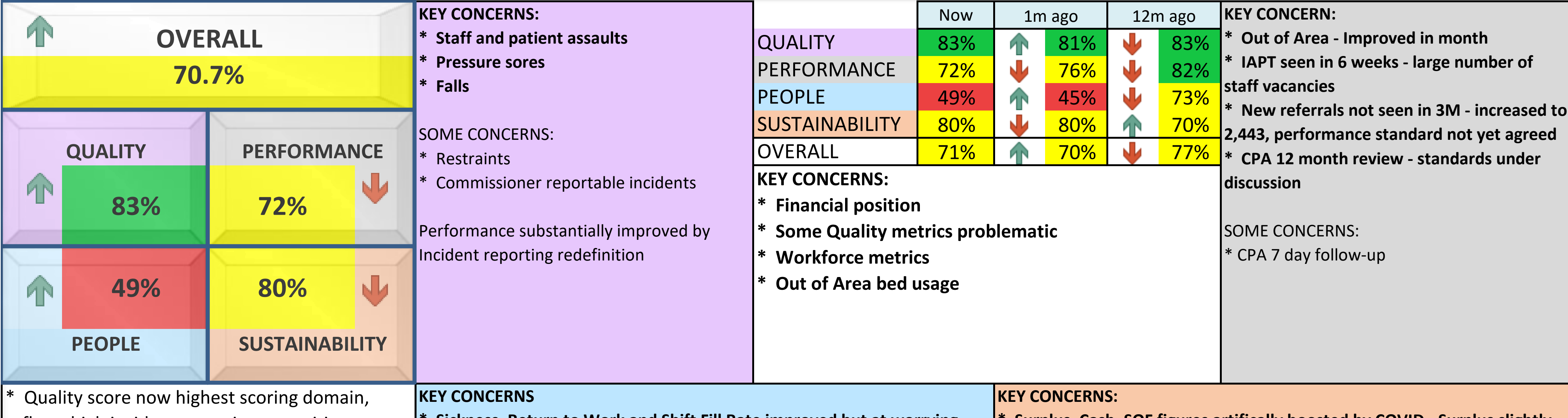
COVID 19 – Details are provided in other reports

Staff Survey – Responses being reviewed and benchmarking information awaited

INTEGRATED PERFORMANCE DASHBOARD

Overall Performance @ Feb-21

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



KEY CONCERNS:
* **Staff and patient assaults**
* **Pressure sores**
* **Falls**

SOME CONCERNS:
* Restraints
* Commissioner reportable incidents

Performance substantially improved by Incident reporting redefinition

	Now		1m ago		12m ago
QUALITY	83%	↑	81%	↓	83%
PERFORMANCE	72%	↓	76%	↓	82%
PEOPLE	49%	↑	45%	↓	73%
SUSTAINABILITY	80%	↓	80%	↑	70%
OVERALL	71%	↑	70%	↓	77%

KEY CONCERNS:
* **Financial position**
* **Some Quality metrics problematic**
* **Workforce metrics**
* **Out of Area bed usage**

KEY CONCERN:
* **Out of Area - Improved in month**
* **IAPT seen in 6 weeks - large number of staff vacancies**
* **New referrals not seen in 3M - increased to 2,443, performance standard not yet agreed**
* **CPA 12 month review - standards under discussion**

SOME CONCERNS:
* CPA 7 day follow-up

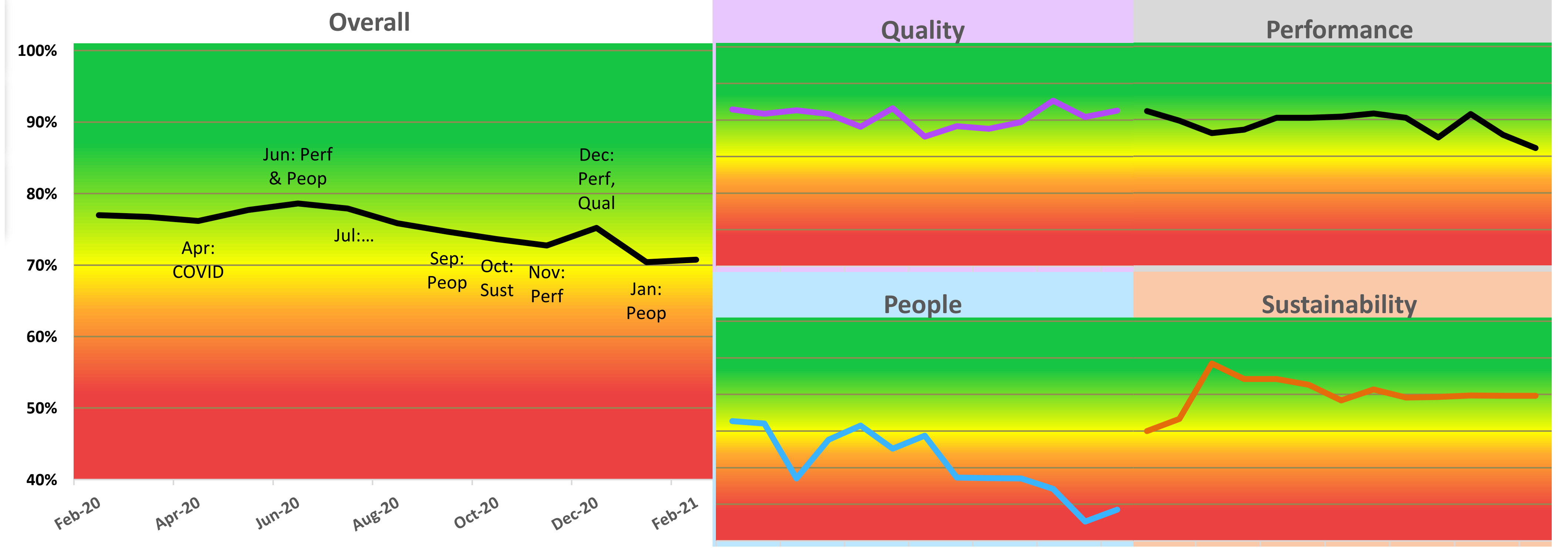
* Quality score now highest scoring domain, reflects high incident reporting as positive outcome
* Performance dipping - issues with staffing and new metrics
* People improved a little but significant under performance across the board
* Sustainability artificially improved, but impacted by removal of top up income

KEY CONCERNS
* **Sickness, Return to Work and Shift Fill Rate improved but at worrying levels**
* **Appraisals at lowest level since May-18**
* **Fundamental training at lowest level since Jun-16**
* **Appraisals at lowest level since May-19**

SOME CONCERNS
* **Vacancies improved for second successive month**

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**

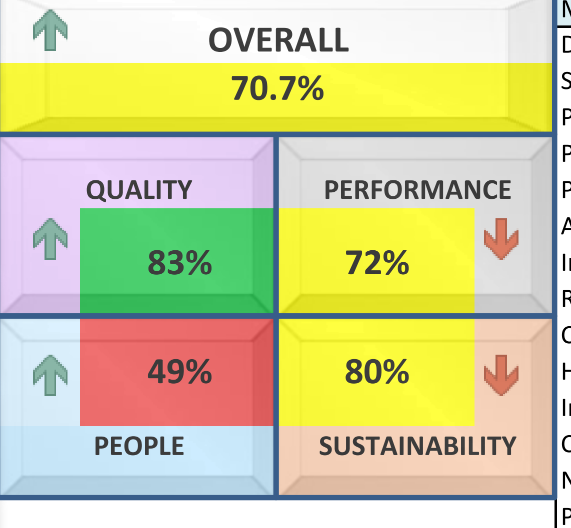
SOME CONCERNS: IG held down by poor compliance by temporary staff



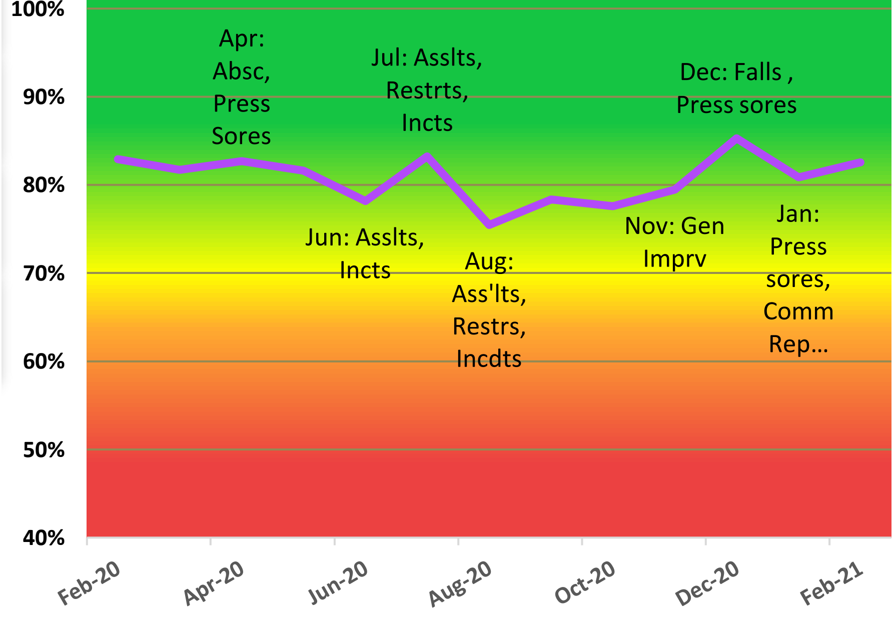
INTEGRATED PERFORMANCE DASHBOARD

Quality @ Feb-21

NHS Birmingham and Solihull Mental Health NHS Foundation Trust



Metric	Actual	Comparator		Now		1m ago		12m ago	4y Trend	Reference
Duty of Candour	0	Target	0.5	100%	→	100%	→	100%		DoC oversight
Staff assaults/ 1000 OBD	4.7	Target	0	53%	↓	59%	↑	48%		Assaults on staff
Patient assaults/ 1000 OBD	2.4	Target	0	53%	↓	75%	↓	53%		Assaults on patients
Prone restraints/ 1000 OBD	5.2	Target	0	65%	↓	67%	↓	76%		Prone restraints
Physical restraints/ 1000 OBD	12.4	Target	8	78%	↓	89%	↓	100%		Physical restraints
Abscon. and Fail to Return	6	Target	0	93%	→	93%	↑	62%		Fails to Return summary
Incidents resulting in harm	18.0%	Target	0	100%	→	100%	→	100%		Incidents result. in harm
Reported incidents	1,724	Target	1,800	92%	↓	100%	↓	93%		Incidents reported
Comm report incidents	4	Target	0	73%	↑	13%	↑	53%		Summary of CR incidents
Homicides in month	0	Target	0	100%	→	100%	→	100%		Homicide analysis
Inpatient suicides	0	Target	0	100%	→	100%	→	100%		Inpatient suicides
Comm'ty suicides	0	Target	0.5	100%	↑	99%	↑	96%		Community suicides
Never events	0	Target	0	100%	→	100%	→	100%		Never events
Pressure sores (weighted)	2	Target	0	60%	↑	40%	↓	100%		Pressure sores
Inpatient falls/ 1000 OBD	2	Target	0	62%	↓	65%	↑	55%		Inpatient falls
Falls resulting in serious harm	0	Target	0	100%	→	100%	→	100%		Serious harm falls
Qual BAF Score	7	5x5 matrix		74%	→	74%	→	74%		BAF Summary
QUALITY				83%	↑	81%	↓	83%		



Headlines

KEY CONCERNS:
*** Staff and patient assaults**
*** Pressure sores**
*** Falls**

SOME CONCERNS:
* Restraints
* Commissioner reportable incidents

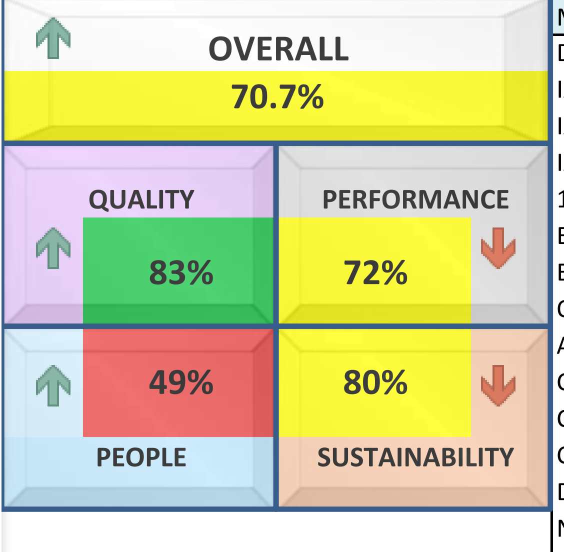
NO CONCERNS:
All other metrics on or close to target

NB The scoring of the Incidents reported metric has been changed to reflect the fact that reporting is 'good' and demonstrates a reporting culture.

INTEGRATED PERFORMANCE DASHBOARD

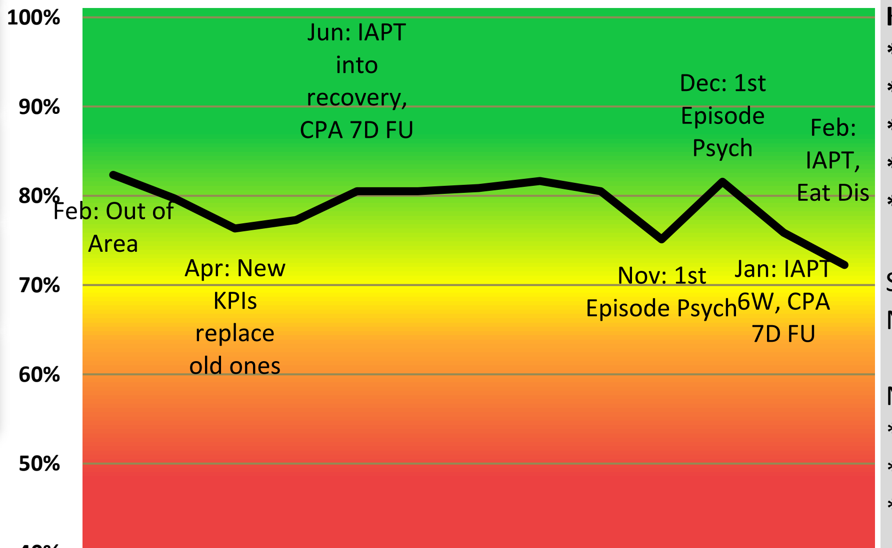
Performance @ Feb-21

Birmingham and Solihull Mental Health NHS Foundation Trust



Metric	Actual	Comparator		Now		1m ago		12m ago	4y Trend	Reference
Data Quality Matur. Index	98%	Target	95%	100%	→	100%	→	100%		DQMI summary
IAPT seen in 6 weeks	58%	Target	75%	0%	↓	35%	↓	100%		IAPT <6 weeks
IAPT seen in 18 weeks	100%	Target	95%	100%	→	100%	→	100%		IAPT <18 weeks
IAPT into recovery	54%	Target	50%	100%	→	100%	→	100%		IAPT moving to recovery
1st episode psychosis	100%	Target	60%	100%	→	100%	→	100%		1st Episode psychosis
Eating disorders urgent	100%	Target	95%	100%	→	100%	→	100%		Eating disorders urg.
Eating disorders routine	80%	Target	95%	57%	↓	100%	↓	100%		Eating disorders rout.
Out of Area Bed Days	1,027	Target	46	0%	→	0%	→	0%		OAP bed days
Admissions gatekept HTT	97%	Target	95%	100%	→	100%	↑	87%		Gatekept admissions
CPA 7 day FU	98%	Target	95%	100%	↑	73%	↑	91%		7 day follow up
CPA 3 day FU	88%	Target	80%	100%	→	100%	→	100%		3 day follow up
CPA 12m Review	86%	Target	95%	43%	↓	50%	↓	78%		12 month review
DTOC %	6%	Target	8%	100%	→	100%	↑	55%		DTOC
New Referrals not seen in 3m	2,363	Target	1,000	32%	↑	28%	↓	37%		New refer not seen
Perf BAF Score	13	5x5 matrix		52%	→	52%	→	52%		BAF Summary
PERFORMANCE				72%	↓	76%	↓	82%		

Performance



Headlines

KEY CONCERN:

* **Out of Area - deteriorated in month**
* **IAPT seen in 6 weeks - large number of staff vacancies**
* **New referrals not seen in 3M - reduced to 2,363, performance standard not yet agreed**
* **CPA 12 month review - standards under discussion**
* **Eating Disorders - represents 4 out of 5 service users, no underlying issues**

SOME CONCERNS

None

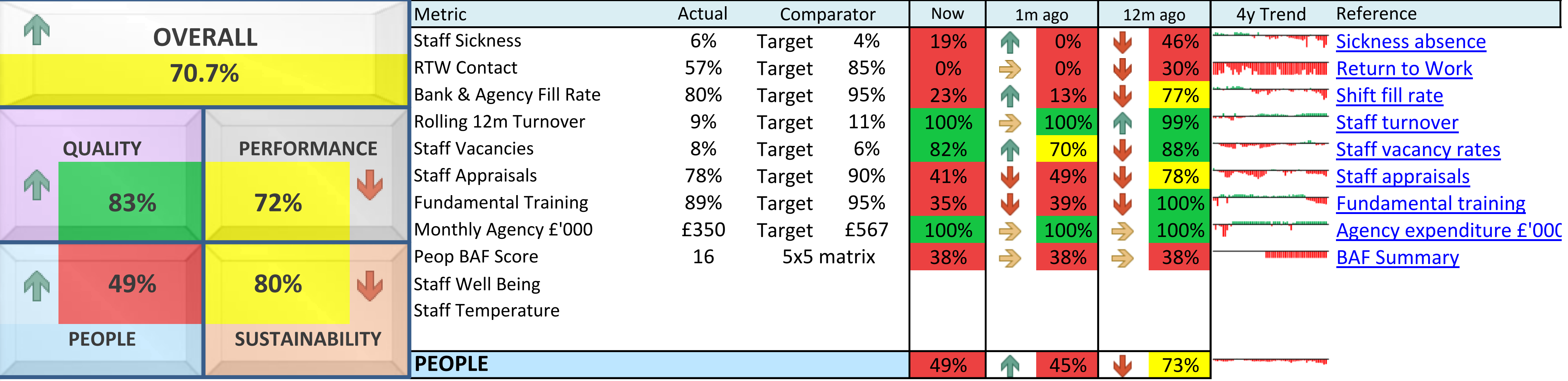
NO CONCERNS

* DQMI score has sustained improvement and in top 7 nationally
* All other metrics are on or close to target
* BAF scores/risks based on new definitions, 2 risks in Performance domain

INTEGRATED PERFORMANCE DASHBOARD

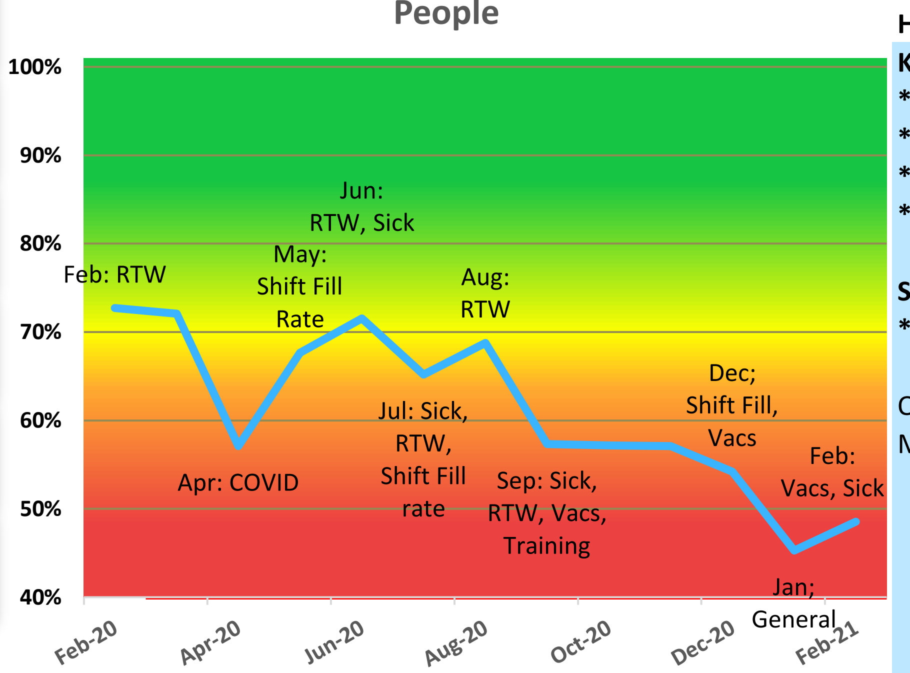
People @ Feb-21

Birmingham and Solihull Mental Health NHS Foundation Trust



OVERALL	
70.7%	
QUALITY 83%	PERFORMANCE 72%
PEOPLE 49%	SUSTAINABILITY 80%

Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
Staff Sickness	6%	Target	4%	19%	0%	46%		Sickness absence
RTW Contact	57%	Target	85%	0%	0%	30%		Return to Work
Bank & Agency Fill Rate	80%	Target	95%	23%	13%	77%		Shift fill rate
Rolling 12m Turnover	9%	Target	11%	100%	100%	99%		Staff turnover
Staff Vacancies	8%	Target	6%	82%	70%	88%		Staff vacancy rates
Staff Appraisals	78%	Target	90%	41%	49%	78%		Staff appraisals
Fundamental Training	89%	Target	95%	35%	39%	100%		Fundamental training
Monthly Agency £'000	£350	Target	£567	100%	100%	100%		Agency expenditure £'00C
Peop BAF Score	16	5x5 matrix		38%	38%	38%		BAF Summary
Staff Well Being								
Staff Temperature								
PEOPLE				49%	45%	73%		



Headlines

KEY CONCERNS

* **Sickness, Return to Work and Shift Fill Rate improved but at worrying levels**
* **Appraisals at lowest level since May-18**
* **Fundamental training at lowest level since Jun-16**
* **Appraisals at lowest level since May-19**

SOME CONCERNS

* **Vacancies improved for second successive month**

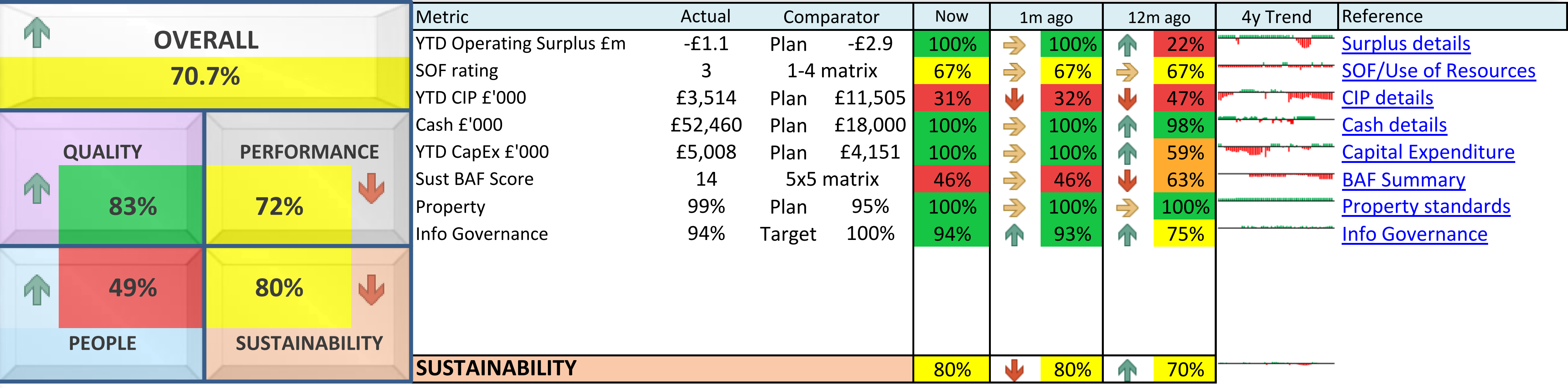
OTHER

Metrics/data quality under review to ensure most relevant items of performance reported

INTEGRATED PERFORMANCE DASHBOARD

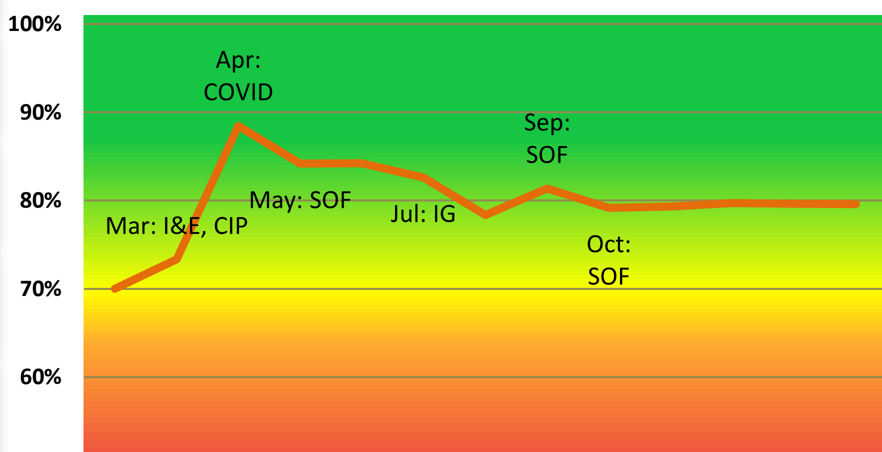
Sustainability @ Feb-21

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



OVERALL 70.7%		
QUALITY 83%	PERFORMANCE 72%	
PEOPLE 49%	SUSTAINABILITY 80%	

Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
YTD Operating Surplus £m	-£1.1	Plan	-£2.9	100%	100%	22%		Surplus details
SOF rating	3	1-4 matrix		67%	67%	67%		SOF/Use of Resources
YTD CIP £'000	£3,514	Plan	£11,505	31%	32%	47%		CIP details
Cash £'000	£52,460	Plan	£18,000	100%	100%	98%		Cash details
YTD CapEx £'000	£5,008	Plan	£4,151	100%	100%	59%		Capital Expenditure
Sust BAF Score	14	5x5 matrix		46%	46%	63%		BAF Summary
Property	99%	Plan	95%	100%	100%	100%		Property standards
Info Governance	94%	Target	100%	94%	93%	75%		Info Governance
SUSTAINABILITY				80%	80%	70%		



Headlines

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

NO CONCERNS

* BAF score reflects revised strategic risks (4 in Sustainability domain) including financial position at score of 25

Latest Board Assurance Framework

TOP RISKS (Impact * Likelihood)

BAF2012: Failure of medium to long term financial sustainability - 25
BAF2001: Unable to maintain acceptable levels of care - 16
BAF2007: Unable to recruit staff – 16
BAF 2015 - Risk of pandemic - 16

MOVEMENTS
BAF2013 - closed

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**13**
Paper title	**MONTH 11 2021 FINANCE REPORT**
Date	31/03/2021
Author	Emma Ellis, Head of Finance and Contracts
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

Month 11 Finance Report: The month 11 2020/21 consolidated Group position is a deficit of £1.1m YTD, £1.8m better than phase 3 financial projection. Notification of £1.3m additional income from NHSE received in month 11, as part of arrangements to assist providers in managing cash positions. Consequently, the forecast outturn has improved by £1.3m to a deficit of £1m.

Notification of £0.6m additional funding in March in relation to annual leave accrual movement could further improve the outturn to £0.4m deficit. The financial position is considered robust enough to recommended that the going concern basis of accounting be used for the preparation of year end accounts.
Capital expenditure is £5mYTD, £0.4m ahead of plan. Additional capital funding received in month 11 of £1.8m for the Birmingham and Solihull shared care record. Full year forecast capital expenditure is £9m.

Reason for consideration:

Assurance on the year to date financial position and forecast outturn.

Previous consideration of report by:

Trust FPP – 24th March 2021
Executive Team – 22nd March 2021
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.

Finance Report

Financial Performance:

1st April 2020 to 28th February 2021

Month 11 year to date position ahead of phase 3 projection

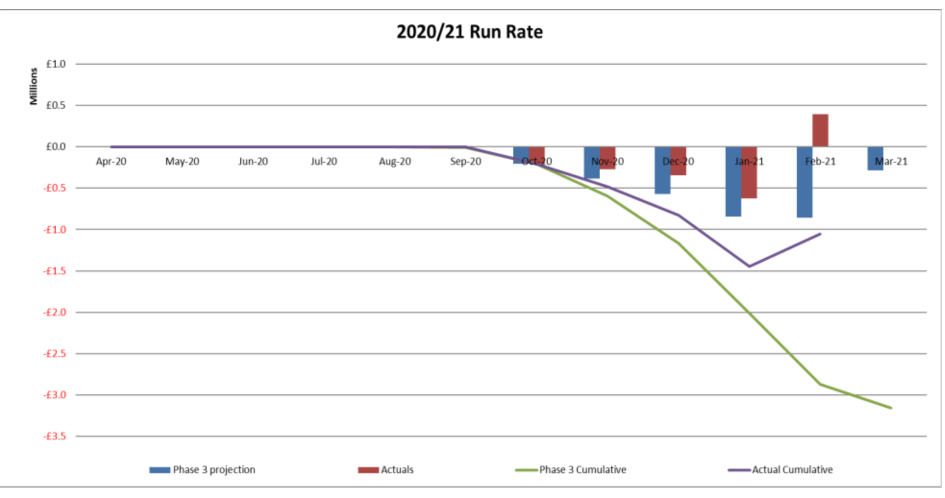
The month 11 2020/21 consolidated Group position is a deficit of £1.1m. This is £1.8m better than the year to date phase 3 financial projection, submitted to NHSEI on 22/10/20. The month 11 position of £0.4m surplus is an improvement of £1m compared to month 10. This is predominantly due to additional income of £1.1m received from NHSE in month 11 as described below.

2020/21 Forecast

In the month 11 financial return as submitted to NHSEI, the forecast outturn has improved by £1.3m, to a projected deficit of £1m. This is due to notification on 16/2/21 that we would receive additional income from NHSE as part of arrangements to assist providers in managing cash positions. An interim payment of £1.3m has been received (5/6ths recognised in month 11: £1.1m). This payment is subject to final review and there could be further adjustment closer to year end.

On 12/3/21 we were notified of £606k interim funding to be received in month 12 in relation to the annual leave accrual. This is currently calculated at 80% of the forecast annual leave accrual movement. The final value and treatment will be confirmed closer to year end. This has not been included in the month 11 forecast.

For further detail on forecast movement compared to phase 3 projection of £3.1m deficit, see page 3.



Group Summary	Original Plan	Phase 3 Projection	YTD Position		
			Phase 3 Projection	Actual	Variance
	£'m	£'m	£'m	£'m	£'m
Income					
Healthcare Income	250.4	250.4	229.5	223.3	(6.2)
Other Income	13.8	23.0	20.5	37.4	16.9
Total Income	**264.2**	**273.5**	**250.1**	**260.7**	**10.7**
Expenditure					
Pay	(201.8)	(204.5)	(186.7)	(192.4)	(5.7)
Other Non Pay Expenditure	(31.4)	(37.2)	(33.8)	(39.7)	(5.9)
Drugs	(5.9)	(6.9)	(6.3)	(5.8)	0.5
Clinical Supplies	(0.8)	(0.5)	(0.5)	(0.6)	(0.2)
PFI	(10.2)	(8.8)	(7.9)	(9.2)	(1.3)
Unallocated Budget	(3.7)	(3.7)	(3.4)	-	3.4
EBITDA	**10.4**	**12.0**	**11.5**	**13.0**	**1.5**
Capital Financing					
Depreciation	(7.0)	(7.1)	(6.6)	(6.3)	0.3
PDC Dividend	(2.8)	(2.3)	(2.6)	(2.5)	0.1
Finance Lease	(4.4)	(4.4)	(4.0)	(4.0)	0.0
Loan Interest Payable	(1.3)	(1.4)	(1.3)	(1.2)	0.0
Loan Interest Receivable	0.1	0.0	0.0	(0.0)	(0.0)
Surplus / (Deficit)	**(5.0)**	**(3.1)**	**(2.9)**	**(1.1)**	**1.8**

2021/22 Planning

We are currently awaiting operational planning guidance for 2021/22. Current indications are that this will be released following the public meeting of the NHSEI Board scheduled for 25/3/21. The planning requirement is expected to be for the first half year, with the final six months plan to be developed later in the year. Plans are expected to be built at system level following a similar process to that used for phase 3 planning (second half year of 2020/21).

We continue to work as a system to develop our planning approach and in mid February, BSOL STP submitted a run rate return to NHSEI, outlining key assumptions and pressures that will impact on 2021/22 expected outturn. For further detail, see page 4.

2020/21 Forecast

2020/21 Forecast Outturn

£ Millions

£2
£0
-£2
-£4

Phase 3 projection (M7-12): -3.1
Benefit from additional allocations: 0.5
System contingency released: 0.3
M10 Forecast per NHSEI return: -2.3
M7-12 financial regime additional income: 1.3
M11 Forecast per NHSEI return: -1.0
Annual leave accrual funding: 0.6
M12 Forecast projection (incl A/L funding): -0.4

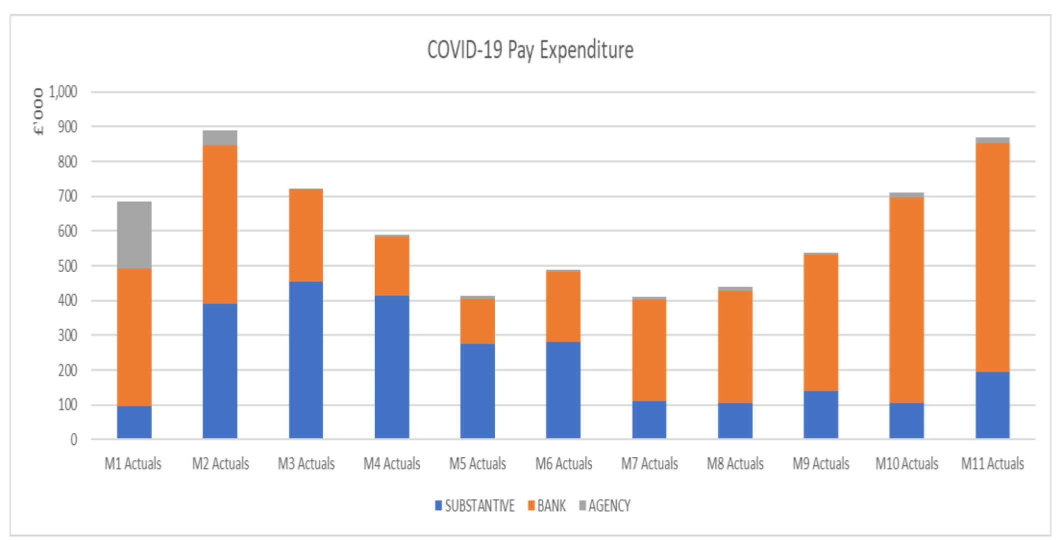
The phase 3 projection as submitted to NHSEI in October 2021 was a deficit of £3.1m. The waterfall chart above summarises the key factors contributing to improvements in the forecast position:

£3.1m deficit to £1m deficit forecast as per month 11 NHSEI financial return:

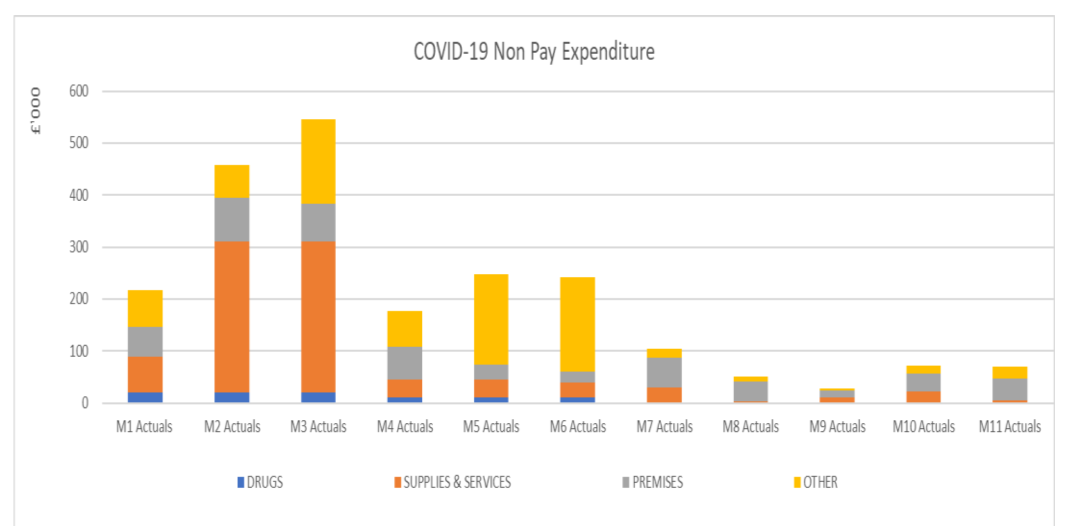
- £0.5m improvement (as reported in month 8 NHSEI return) to recognise benefit from additional allocations following agreement across the STP.
- £0.3m improvement (as reported in month 10 NHSEI return) due to an STP-wide agreement to release system contingency, centrally held by BSOL CCG.
- £1.3m improvement (as reported in month 11 NHSEI return) due to additional income from NHSE as part of arrangements to assist providers in managing cash positions. It should be noted that this is subject to final review and there could be further adjustment closer to year end.

On 12/3/21 we were notified of £606k interim funding to be received in month 12 in relation to the annual leave accrual, currently calculated at 80% of the forecast annual leave accrual movement. The final value and treatment will be confirmed closer to year end. As requested, this has not been included in the month 11 financial return, but would result in the forecast outturn improving to £0.4m deficit.

COVID-19 Revenue Expenditure



COVID EXPENDITURE	Q1 Actuals £'000	Q2 Actuals £'000	Q3 Actuals £'000	M10 Actuals £'000	M11 Actuals £'000	TOTAL M11 YTD £'000
SUBSTANTIVE	939	972	356	104	195	2,566
BANK	1,117	500	1,006	591	657	3,871
AGENCY	239	23	25	14	17	318
PAY TOTAL	**2,296**	**1,495**	**1,387**	**710**	**869**	**6,755**
DRUGS	62	31	0	0	0	93
SUPPLIES & SERVICES	647	98	43	21	5	814
PREMISES	217	113	108	35	42	514
OTHER	296	424	33	16	23	792
NON PAY TOTAL	**1,221**	**667**	**184**	**72**	**70**	**2,214**
TOTAL	**3,517**	**2,162**	**1,571**	**781**	**939**	**8,969**

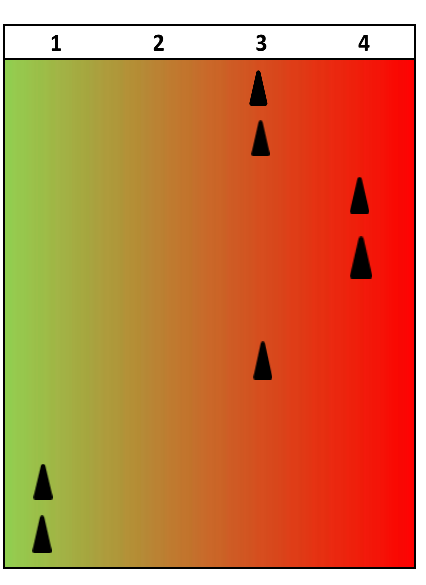


As at month 11, £9m COVID-19 expenditure has been incurred; £6.8m pay and £2.2m non pay.

- Under the financial regime for months 1 to 6, COVID expenditure was offset by retrospective top up income.
- Under the updated financial regime for the second half of the year, COVID expenditure is expected to be covered via system funding allocation.
- Month 11 expenditure is £159k higher than month 10, due to pay expenditure, both substantive and temporary staffing.

Trust Use of Resources rating: 3

Single Oversight Framework (without Overrides)		
Single Oversight Framework (After Overrides)		
Financial Sustainability	Liquidity Ratio	
	Capital Servicing Capacity	
Financial Efficiency	I&E margin (%)	
Financial Controls	Distance from Financial Plan	
	Agency Spend	



Month 11 Single Oversight Framework (SOF) rating is 3 (after overrides).

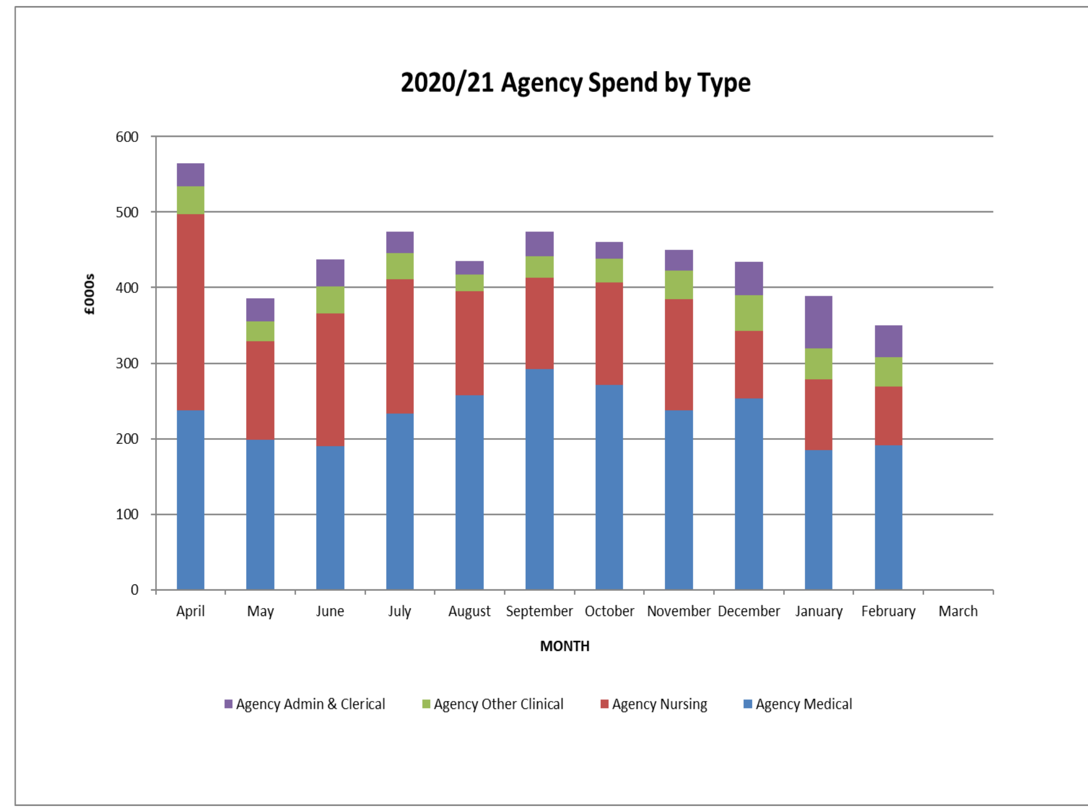
- Month 11 Liquidity rating is 4.
- Month 11 Capital servicing score is 4.
- Month 11 I&E Margin Rating is 3. This is better than plan due to the COVID-19 financial regime resulting in a break even position for months 1 to 6.
- Month 11 Agency spend is scored at 1 as expenditure is below the NHSEI ceiling.

Single Oversight Framework Risk Rating	**Month 11 2020/21**	**Original Plan (£5m deficit) 2020/21**	**Phase 3 Projection (£3.1m deficit) 2020/21**
	Risk Rating	**Risk Rating**	**Risk Rating**
Liquidity (Current Assets and Current Liabilities less inventories and assets held for sale / Operating Expenditure x No of days in financial year to date)	4	4	4
Capital servicing (EBITDA for year to date / capital servicing costs)	4	4	4
I&E Margin %	3	4	4
Distance from Financial Plan	1	1	1
Agency Spend	1	1	1
Rounded Average	**3**	**3**	**3**
Single Oversight Framework (without Overrides)	**3**	**3**	**3**
Single Oversight Framework (After Overrides)	**3**	**3**	**3**

Agency expenditure remains below ceiling

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	20/21Total
Agency Spend (£000s)	564	386	438	474	435	474	460	450	434	389	350	0	4,854
NHSEI Ceiling (£000s)	608	628	608	628	628	608	628	608	628	628	567	628	7,395
Net (£000s)	**44**	**242**	**170**	**154**	**193**	**133**	**168**	**158**	**194**	**239**	**218**		**1,913**

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	20/21Total
Agency Medical	237	198	190	233	257	292	271	238	253	185	191	0	2,545
Agency Nursing	260	130	175	178	138	121	136	147	90	94	78	0	1,548
Agency Other Clinical	36	26	36	34	22	28	32	37	47	41	39	0	379
Agency Admin & Clerical	30	31	37	29	17	33	22	28	44	70	41	0	382
Agency Spend (£000s)	**564**	**386**	**438**	**474**	**435**	**474**	**460**	**450**	**434**	**389**	**350**	**0**	**4,854**



The Total NHSI agency expenditure ceiling for 2020/21 is £7.4m.

Agency spend decreased from £389k in January to £350k in February, continuing a steady decrease of agency spend since September 2020. February spend was £125k less than agency spend in September 2020. Year to date expenditure is £4.9m; this is £1.9m below the NHSEI year to date ceiling.

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

- There was rapid, substantial recruitment to the bank in Q1 in response to Covid-19. Outstanding issues with the provision of AVERTS training has delayed start dates however, as training is completed, more individuals have started on the bank in Q4 with risk assessments for an earlier start undertaken where possible.
- In response to the increasing staffing pressures, weekly bank recruitment has been undertaken throughout Q4 to assist with again rapidly increasing the availability of bank staff; guidance has been produced detailing if an individual is waiting to complete AVERTS training, where they can work dependent on other training they may have completed e.g., MAPA.
- In response to significant staffing pressures, HCA over-recruitment has been stood back up for Q4 with the first round of recruitment taking place in February and a second round planned for March. The Trust has accessed national winter pressure funding in relation to this.
- To reduce staffing pressures and agency reliance, those who have recently retired were contacted in January to ask whether they were able to return and assist the Trust in any capacity. Those who have responded are being deployed through the Trust redeployment process.
- Work continues with operational areas to convert long term agency into substantive offers of employment Trust-wide and 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.
- The Trust continues to run its COVID-19 staff testing, internal track and trace and outbreak processes to ensure the staffing impact of COVID-19 is minimised as much as possible to help prevent heavy reliance on agency workers as staffing pressures increase due to winter and the impact of rising COVID-19 infection levels.
- The Trust's Redeployment group continues to meet with the frequency of the meeting being increased back to once a week with additional urgent meetings where needed to review deployment of staff, including clinical and non-clinical Corporate staff, to reduce workforce gaps and release clinical capacity on wards.

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - Draft 31-Mar-20 £m's	NHSI Plan YTD 28-Feb-21 £m's	Actual YTD 28-Feb-21 £m's	NHSI Plan Forecast 31-Mar-21 £m's
Non-Current Assets				
Property, plant and equipment	180.6	178.2	179.3	178.1
Prepayments PFI	1.5	1.5	2.6	1.5
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	-	-	(0.0)	-
Deferred Tax Asset	(0.3)	(0.3)	(0.0)	(0.3)
Total Non-Current Assets	181.7	179.4	181.8	179.2
Current assets				
Inventories	0.4	0.4	0.4	0.4
Trade and Other Receivables	17.4	17.4	7.4	17.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	14.0	11.6	52.5	10.4
Total Curent Assets	31.8	29.4	60.3	28.3
Current liabilities				
Trade and other payables	(24.2)	(25.4)	(29.2)	(24.2)
Tax payable	(4.1)	(4.1)	(4.4)	(4.1)
Loan and Borrowings	(2.7)	(2.7)	(2.6)	(2.7)
Finance Lease, current	-	-	-	-
Provisions	(0.6)	(0.6)	(0.7)	(0.6)
Deferred income	(7.3)	(7.3)	(35.5)	(7.3)
Total Current Liabilities	(38.9)	(40.0)	(72.4)	(38.9)
Non-current liabilities				
Loan and Borrowings	(31.7)	(29.5)	(29.5)	(29.5)
PFI lease	(50.9)	(49.4)	(49.4)	(49.3)
Finance Lease, non current	-	-	0.0	-
Provisions	(2.1)	(2.1)	(1.8)	(2.1)
Total non-current liabilities	(84.7)	(81.1)	(80.8)	(81.0)
Total assets employed	89.9	87.7	88.9	87.7
Financed by (taxpayers' equity)				
Public Dividend Capital	106.7	106.7	106.7	106.7
Revaluation reserve	24.6	24.6	24.6	24.6
Income and expenditure reserve	(41.4)	(43.6)	(42.4)	(43.6)
Total taxpayers' equity	89.9	87.7	88.9	87.7

SOFP Highlights

The Group cash position at the end of February 2021 is £52.5m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 9 to 10.

Current Assets & Current Liabilities

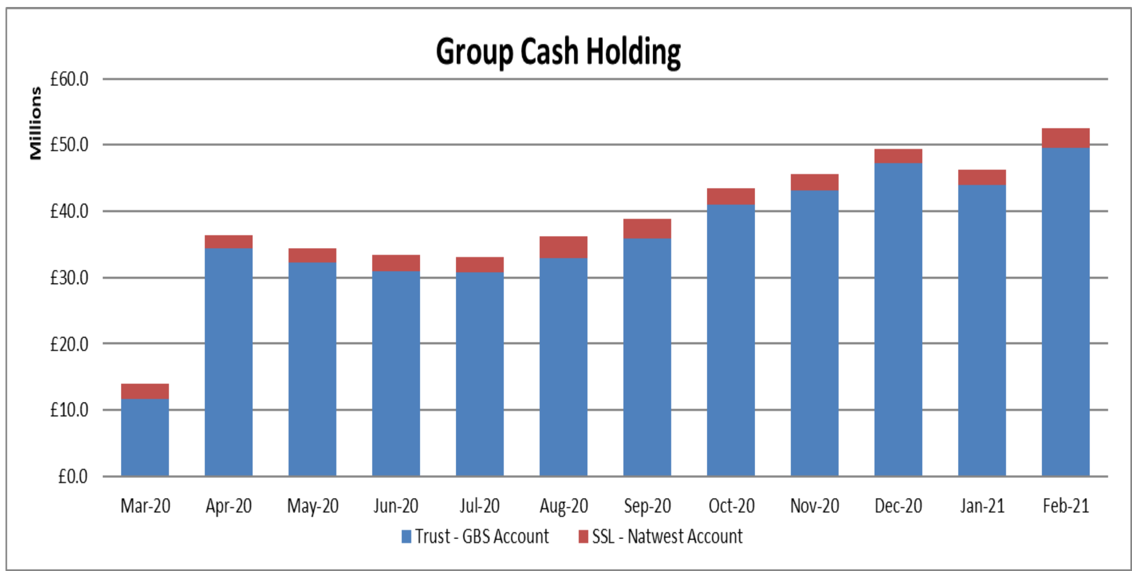
Ratios

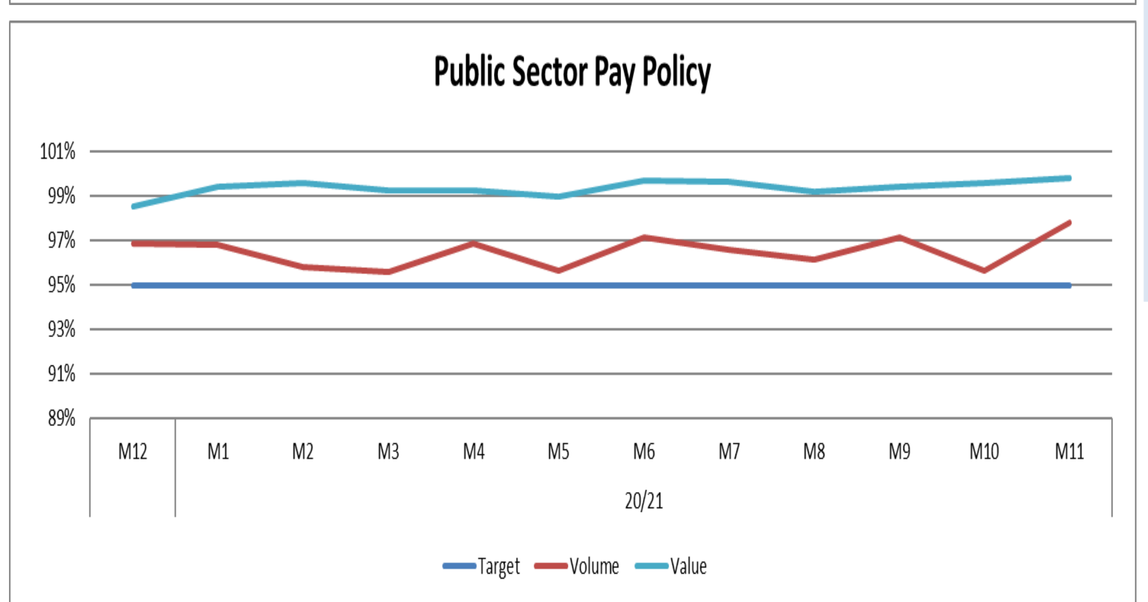
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	60.3
Current Liabilities	-72.4
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 February 2021 is £52.5m.

Under the current financial regime, the majority of our NHS contracts are being paid on a block basis. These payments are being made in advance, resulting in the cash position being significantly higher than plan. Block payments in advance equate to approx. £21m of the current cash balance.

In order to ensure the prompt flow of cash during the pandemic, NHSEI have instructed that we must aim to pay all supplier invoices within seven days of receipt of goods and services.

The block income arrangement is expected to continue (but not paid in advance) into 2021/22 for Q1 and potentially for Q2.

Better Payments

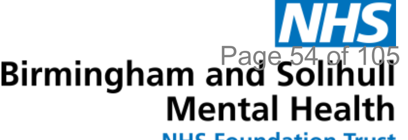
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

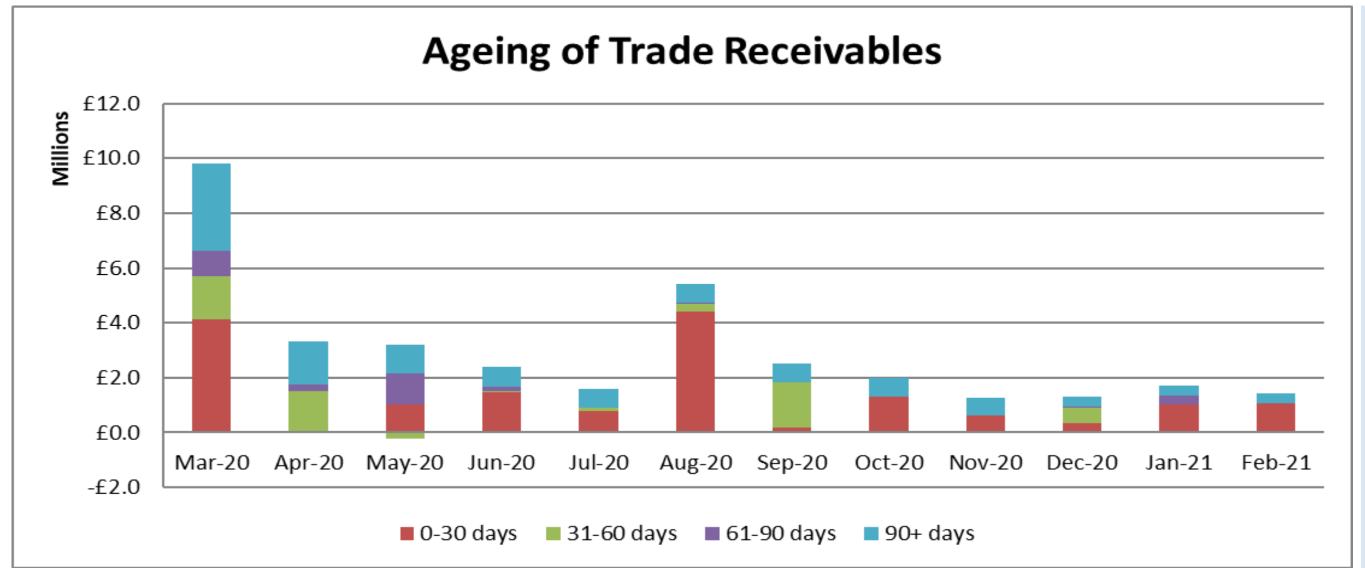
Performance against target is 99% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	100%	✓	100%	✓
Non - NHS Creditors within 30 Days	98%	✓	100%	✓

Trust Receivables and Payables





Ageing of Payables

Millions

£8.0 £7.0 £6.0 £5.0 £4.0 £3.0 £2.0 £1.0 £0.0

Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21

0-30 days 31-60 days 61-90 days 90+ days

Trade Receivables

The overall receivables position has reduced significantly during the year to date, mainly due to provider to provider arrangements under the COVID-19 financial regime. 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 90 days**-consists of outstanding NCA balances from 6 NHS bodies- less than £16k.

Trade Payables

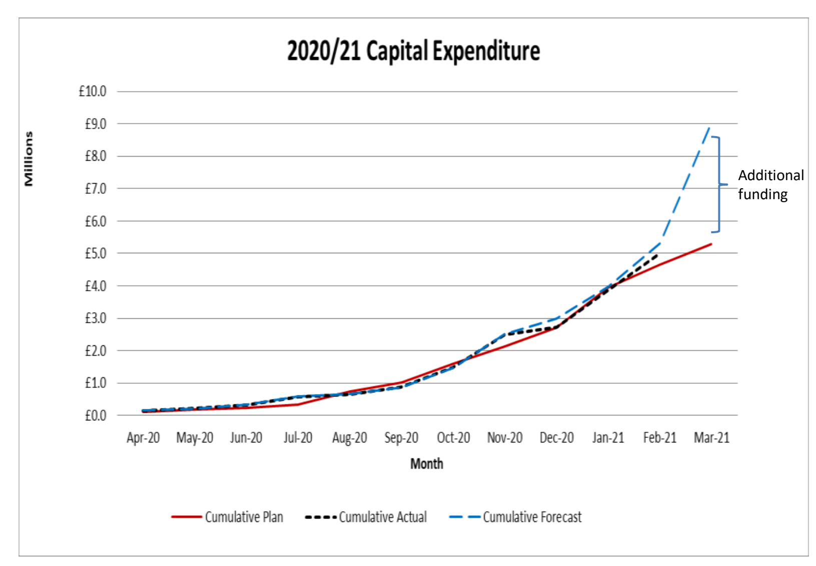
Payables greater than 90 days:

- Birmingham Community £1m – Invoices are not in line with provider to provider arrangements (in query). These have been resolved in March 2021 (hence the increase in 0-30 days as the correction invoices form part of this).

- Non-NHS Suppliers (45+) £1.3m – accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in March 2021.

Month 11 YTD Capital expenditure ahead of YTD plan, capital forecast increase

	2020/21 Capital			
	Annual	Year to date		
	Plan	Plan	Actual	Variance to plan
	£m	£m	£m	£m
Major Projects	0.58	0.47	0.55	-0.08
Minor schemes	1.22	1.00	0.69	0.31
Statutory Standards and Backlog Maintenance (SSBM)	0.97	0.79	0.69	0.10
Estates Total	**2.77**	**2.26**	**1.93**	**0.33**
ICT Total	**1.92**	**1.89**	**2.31**	**-0.42**
Original Plan	**4.69**	**4.15**	**4.24**	**-0.09**
CIR bid	0.61	0.51	0.770	-0.26
Plan submitted 27/7/20	**5.30**	**4.66**	**5.0**	**-0.35**



Month 11 YTD Capital Expenditure

Capital expenditure at month 11 is £5m, this is £0.4m ahead of year to date plan as submitted to NHSEI.

Capital forecast increase:

The capital forecast increased by £2.3m in month 11 to reflect the following:

- £1.8m Birmingham & Solihull Shared care record – funding approved February 2021 from two provider digitisation funding sources: £1m Local Health and Care Record (LHCR) programme and £0.8m Health Service Lead Investment (HSLI) programme.

- £0.5m STP agreed transfer of capital envelope – in February 2021, it was indicated that an STP partner would underspend their capital envelope by £0.5m, we identified that we could utilise this for additional ICT capital to start to redress the pressure on ICT equipment as a result of the pandemic. This expenditure will be funded internally.

	Original Plan		Forecast M10	Forecast M11	Forecast movement
	£'000		£'000	£'000	£'000
Internal funding:					
BAU (Estates & ICT)	4.69		4.69	4.69	0.00
STP agreed transfer of envelope	0.00		0.00	0.50	0.50
Total internally funded schemes	**4.69**		**4.69**	**5.19**	**0.50**
External funding:					
Critical Infrastructure Risk funding	0.61		1.60	1.60	0.00
COVID - ICT	0.00		0.14	0.14	0.00
MH Remote working fund- ICT	0.00		0.29	0.29	0.00
Shared care record	0.00		0.00	1.82	1.82
Total externally funded schemes	**0.61**		**2.03**	**3.85**	**1.82**
TOTAL	**5.30**		**6.72**	**9.03**	**2.32**

2021/22 and long term Capital Plan

We are still awaiting notification from NHSEI of the 2021/22 capital envelope. As the list of currently identified capital schemes for 2021/22 is significantly greater than the anticipated envelope, work is continuing on the capital prioritisation process, with discussions held at Trust Operational Management Team and Trust Health and Safety Committee in February and March 2021.

Across the STP work is commencing to review long term capital plans and capital prioritisation across the system.

2020/21 Service Area Breakdown

Directorate	Original Plan £'m	Phase 3 Projection £'m	YTD Phase 3 Projection £'m	YTD Actual £'m	YTD Variance £'m
Operating Income	0.3	0.3	0.3	0.3	(0.0)
Pay	(36.5)	(36.5)	(33.5)	(33.6)	(0.1)
Non Pay	(3.0)	(3.0)	(2.8)	(2.9)	(0.1)
Acute and Urgent Care Services	**(39.2)**	**(39.2)**	**(36.0)**	**(36.1)**	**(0.2)**
Operating Income	0.1	0.1	0.1	1.0	0.9
Pay	(42.4)	(42.4)	(38.9)	(35.7)	3.2
Non Pay	(8.7)	(8.7)	(7.9)	(7.6)	0.4
ICCR	**(51.0)**	**(51.0)**	**(46.7)**	**(42.3)**	**4.4**
Operating Income	2.2	2.2	2.0	2.1	0.1
Pay	(37.3)	(37.3)	(34.2)	(33.7)	0.5
Non Pay	(3.2)	(3.2)	(3.0)	(2.6)	0.4
Specialities Services	**(38.3)**	**(38.3)**	**(35.1)**	**(34.1)**	**1.0**
Operating Income	0.8	0.8	0.7	1.5	0.8
Pay	(47.7)	(47.7)	(43.8)	(43.9)	(0.1)
Non Pay	(7.8)	(7.8)	(7.1)	(6.5)	0.6
Secure Serv & Offender Health	**(54.7)**	**(54.7)**	**(50.2)**	**(48.9)**	**1.3**
Activity Income (HCI)	250.4	250.4	229.5	223.3	(6.2)
Operating Income	11.0	11.0	10.1	12.0	1.9
Pay	(30.1)	(30.1)	(28.0)	(31.3)	(3.3)
Non Pay	(39.3)	(39.3)	(36.0)	(45.8)	(9.7)
Capital Financing	(10.8)	(10.8)	(9.9)	(9.6)	0.3
Unallocated Budgets	(3.7)	(3.7)	(3.4)	-	3.4
COVID-19	-	1.8	2.1	11.1	9.0
Corporate and Trustwide	**177.6**	**179.4**	**164.5**	**159.8**	**(4.7)**
Operating Income	21.3	21.3	19.5	22.1	2.6
Pay	(8.0)	(8.0)	(7.4)	(7.8)	(0.4)
Non Pay	(8.0)	(8.0)	(7.3)	(8.9)	(1.5)
Capital Financing	(5.9)	(5.9)	(5.4)	(6.2)	(0.8)
Summerhill Services Ltd	**(0.6)**	**(0.6)**	**(0.6)**	**(0.8)**	**(0.2)**
Capital Financing	1.3	1.3	1.2	1.4	0.2
Consolidation Adjustments	**1.3**	**1.3**	**1.2**	**1.4**	**0.2**
Consolidated Position Total	**(5.0)**	**(3.1)**	**(2.9)**	**(1.1)**	**1.8**

- All COVID-19 expenditure and planning assumptions, including the break even financial regime for months 1 to 6 have been included in Corporate and Trustwide. The service area narrative below is therefore, based on actuals compared to original plan (£5m deficit).

- **Acute and Urgent Care – £152k overspend at month 11.** Inpatient overspend of £1.4m mainly due to pay (high levels of observations and seclusions). Urgent Care underspend of £1.2m, mainly pay – core 24 vacancies.

- **ICCR – £4.4m underspend at month 11.** £3.2m is attributable to pay, this mainly relates to delays in recruitment against long term plan due to the pandemic. Other income (mainly HEE) of £0.9m is offset by expenditure.

- **Specialities – £1m underspend at month 11.** £504k relates to pay. This is mainly attributable to continuation of vacancies in Birmingham Healthy Minds £861k and Specialties £361k. Overspend in Older People pay £805k is mainly due to significant temporary staffing spend. Non pay is £395k underspent due to reduction in expenditure as a result of lockdown.

- **Secure & Offender Health – £1.3m underspend at month 11.** Other income over performance of £814k mainly due to specialling. Non pay is £588k underspent as a result of reduced expenditure due to lockdown.

- **Corporate & Trustwide - £4.7m adverse variance.** Healthcare income underperformance mainly due to long term plan growth investment. Non pay adverse, mainly due to underachievement of planned savings and out of area expenditure.

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	14
Paper title	OUR FIVE YEAR TRUST STRATEGY
Date	31 March 2021
Author	Abi Broderick, Head of Planning and 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:

Following approval of the Trust Five Year Strategy at September 2020 Trust Board, this paper sets out the plans for launching our strategy and an outline of our Strategy Implementation Framework.

Our strategy was very much developed through engagement and co-production with our staff, service users and carers as we wanted it to reflect what people felt were the important things we needed to focus on so it was real to them. Since the content of the Trust Strategy was approved by Trust Board in September we have been preparing for the launch of the strategy and making sure we have a robust implementation framework in place.

We want the launch of our Trust strategy to build on the ethos we created during the strategy refresh exercise and so the purpose of our launch is to:
Launch our strategy and values in a meaningful way to reach as many people as possible.
Make the strategy and values real to colleagues so they understand and take personal responsibility for the role they have to play in delivery.

The strategy will be launched on Thursday 8 April at Listen Up Live, which will be followed by a six-week internal and external campaign to promote the components of our strategy. As well as central materials and resources describing and promoting the strategy, fundamental to the success of really embedding the strategy will be cascade by senior leaders and managers and engagement with their teams to define their contribution to delivery of the strategy.

The Strategy Implementation Framework sets out how we will deliver, monitor and report against the ambitions set out in the strategy.

Reason for consideration:

Trust Board are asked to note i) the plans for the strategy launch and ii) the outline Strategy Implementation Framework

Previous consideration of report by:

The plan for the Trust Strategy Launch has been considered by:

- Executive Team – 8 March 2021
- Senior Leaders Forum – 22 March 2021

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

Select Strategic Priority

This report relates to all four of the Trust's strategic priorities:

- Clinical Services
- Quality
- People
- Sustainability

Financial Implications *(detail any financial implications)*

No specific financial implications associated with the strategy launch to highlight to Trust Board.

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

Not specifically around the strategy launch.

Equality impact assessments:

Inclusivity and reducing inequalities is a core principle running through our Trust strategy in line with our Trust values. Our strategy materials have been tested, including with our Staff Network Chairs, to ensure they reflect inclusivity and are accessible. Our strategy launch plan has considered how we can promote the strategy and engage with all staff groups using a range of channels, and key messages will include our ambitions around equality, diversity and inclusion.

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

The Trust strategy was developed through comprehensive engagement with staff, service users, carers and partners. Our launch plan builds on this engagement.

Our Trust Five Year Strategy

Update for Trust Board

31 March 2021

1. Purpose of paper

Following approval of the Trust Five Year Strategy at September 2020 Trust Board, this paper sets out the plans for launching our strategy and an outline of our Strategy Implementation Framework.

The final Trust Year Strategy document can be found in Appendix 1.

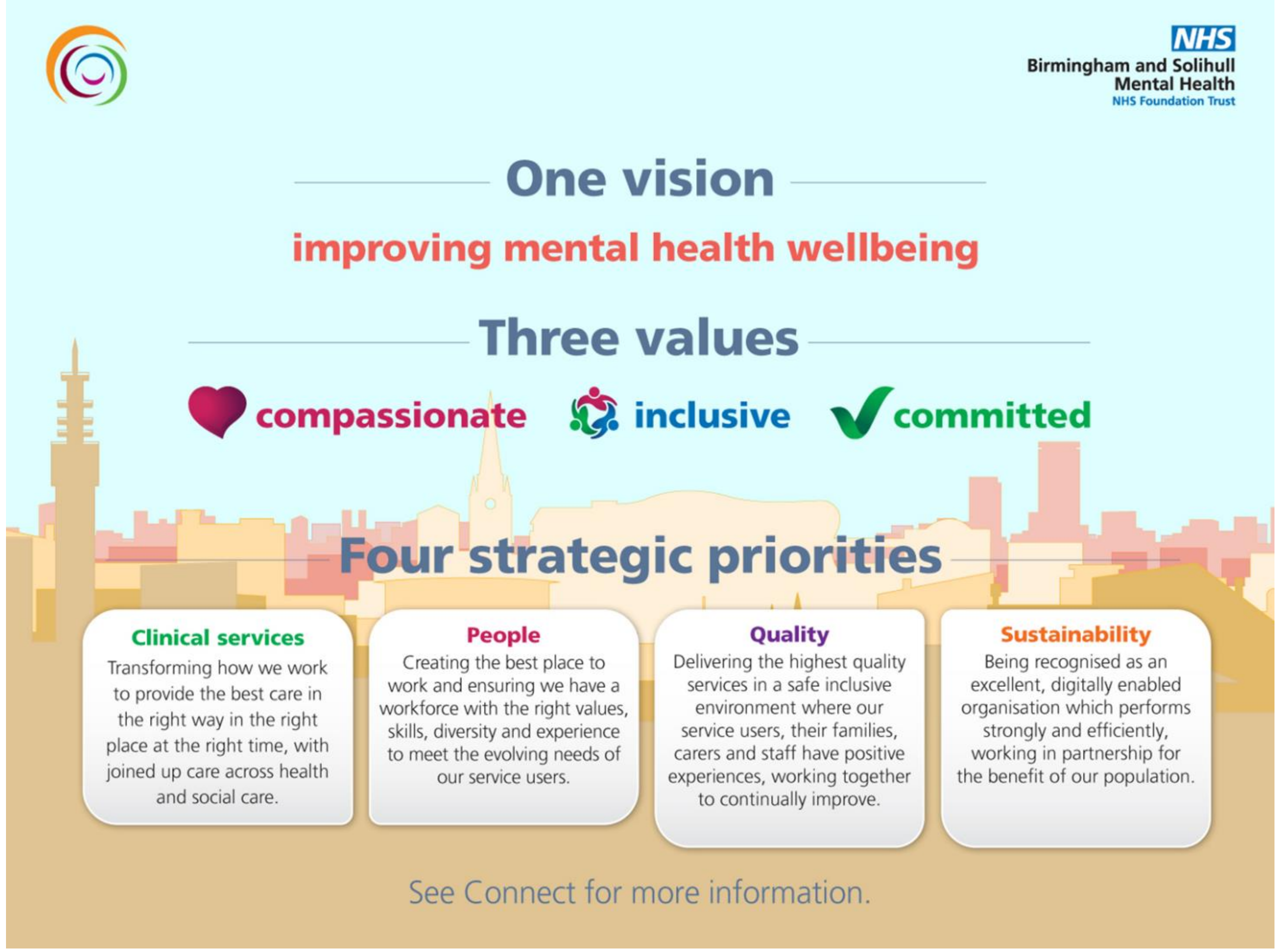
2. Background

When we started refreshing our Trust strategy in Autumn 2019, we were clear from the outset that we wanted our strategy to be co-produced so it was real and meaningful to our colleagues, reflected what is important for our service users, families and carers, and was aligned to the plans and aspirations of our partners.

We carried out one of the largest engagement exercises we have ever carried out, over a period of ten months and using a variety of mechanisms to find out what people thought was important to them and what they thought should be included in the strategy.

Phase 1: Help us brew up our strategy	**November 2019 – February 2020**
Our engagement started with a widespread campaign to get people's views on what the 'ingredients' of our strategy should be, asking people to take a few moments out of their day and have a cup of tea to reflect on what was important to them. We asked about our four priorities of clinical services, people, quality and sustainability, as well as what our values and behaviours should be.	
Phase 2: Learning from COVID-19	**May – July 2020**
When the COVID-19 pandemic hit us in March, we had to very quickly adapt our ways of working so that we could continue to provide our services in a safe way. We decided to spend some time evaluating these changes and asking our staff, service users and carers what their experience of these changes had been and what we should stop, continue and improve. This helped inform how COVID-19 would impact our future strategy.	
Phase 3: Taste our brew	**August – September 2020**
We wanted to finish our engagement with a campaign to test the contents of our strategy before taking it to Trust Board for approval. This asked people whether they felt we had heard what they had told us, whether we were focussing on the right areas and how they thought the strategy would make a difference to them.	

The themes from the engagement were triangulated with the ambitions set out in national and local strategies and plans, as well as our key internal drivers, to determine our refreshed values and what the areas of focus will be for each of our four strategic priorities.



Since September Trust Board when the content of the Trust Strategy was formally approved we have:

- Been awarded the Trust's first Recovery for All Quality Mark, for demonstrating the principles of recovery and coproduction through the strategy development.
- Finalised the branding and design of the strategy and supporting materials, taking account the feedback received from Trust Board.
- Developed a comprehensive plan for launching our strategy internally and externally, making sure we took account of where the Trust's focus was in relation to our COVID-19 response when deciding the timeline.
- Commenced developing supporting documents for all of the four strategic priorities, articulating in more detail what the ambitions and aims are for each of the priorities, as well as defining the specific goals, objectives and plans for Year 1 of the Strategy 2021/22.
- Reviewed arrangements for delivering, monitoring and reporting the ambitions set out in the Strategy.

3. Strategy Launch Plan

We want the launch of our Trust strategy to build on the ethos we created during the strategy refresh exercise and so the purpose of our launch is to:

- Launch our strategy and values in a meaningful way to reach as many people as possible.
- Make the strategy and values real to colleagues so they understand and take personal responsibility for the role they have to play in delivery.

The strategy will be launched on Thursday 8 April at Listen Up Live, which will be followed by a six-week internal and external campaign to promote the components of our strategy.

<table>
<tr><th>Date</th><th colspan="2">Activity</th></tr>
<tr><td>8 April</td><td colspan="2">• Strategy officially launched at the start of Listen Up Live describing why it is important, what colleagues can expect to see during the launch and what resources are available.

• Information about the strategy live on Connect, the external website and social media. Signposting through screensavers/ banners on Connect.

• Letter sent to all colleagues about the new strategy.

• Engagement pack circulated to all senior leaders and managers.</td></tr>
<tr><td>Week 1 –
w/c 12 April</td><td colspan="2">• Email to all colleagues, explaining what resources are available and socialising the strategy.

• Packs distributed to all Trust sites containing strategy documents, posters, pull up banners for reception areas, z-cards, promotional pens showing our values.

• Special edition of Connected, our colleague e-newsletter, focussed on the strategy.

• Stakeholder communications.

• Service user and user communications.

• Social media campaign.</td></tr>
<tr><td>Week 2 –
w/c 19 April</td><td>• Focus on values and behaviours, including promoting the everyday behaviours guide</td><td rowspan="5">Describing the different elements of our strategy and what they mean for colleagues, service users, carers, partners etc.

Using a range of mechanisms including case studies, pen portraits, vox pops etc.</td></tr>
<tr><td>Week 3 –
w/c 26 April</td><td>• Focus on Quality</td></tr>
<tr><td>Week 4 –
w/c 3 May</td><td>• Focus on People</td></tr>
<tr><td>Week 5 –
w/c 10 May</td><td>• Focus on Clinical Services</td></tr>
<tr><td>Week 1 –
w/c 17 May</td><td>• Focus on Sustainability</td></tr>
</table>

The principles of our strategy launch are:

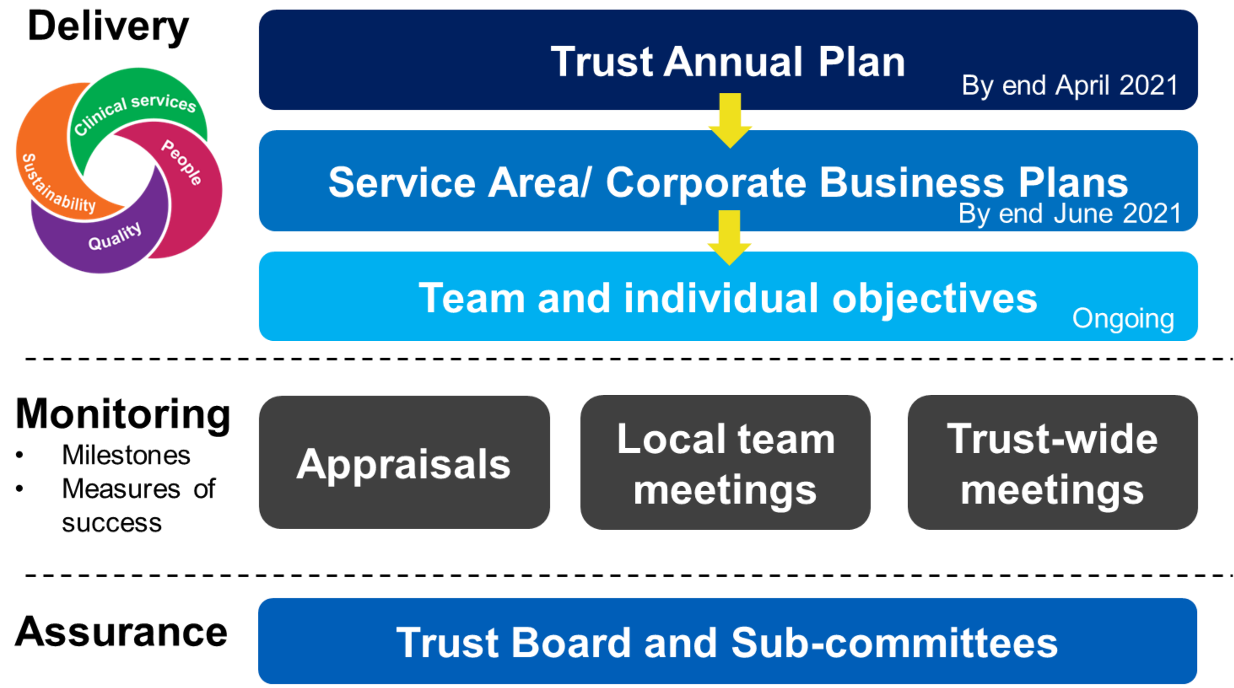
- ✓ The key message of the campaign will be that this is 'everyone's' strategy – it reflects what people told us was important for our Trust to focus on, and everyone has a role, however big or small, to play in helping us deliver the strategy.
- ✓ The launch will be supported by a range of central communication materials using multi-channels e.g. documents, posters, screensavers, videos, a letter to colleagues, website, intranet, social media etc.
- ✓ Cascade and engagement throughout the organisation by senior leaders and managers is crucial for all colleagues to be able to really understand what the strategy is and what it means for themselves and their teams. We want to reach all colleagues and conversation is the best way to do this, particularly for those colleagues who not regularly log onto a computer or have time to read information online. An engagement pack will be available for managers to use to support and stimulate team discussions and think about what their contributions are across the four strategic priorities.
- ✓ We will bring the strategy to life through stories, quotes and videos from our colleagues, service users and carers.
- ✓ We will use non-technical and simple language so everyone can easily understand what a strategy is and why it is important.

4. Strategy Implementation Framework

2021/22 will be the first full year of implementation against our five year strategy. We have reviewed the framework for the delivering, monitoring and reporting the ambitions set out in the Strategy, making sure that this incorporates:

- Ensuring we have clear plans for what we need to do to deliver the strategy that can be used to prioritise our resources and programmes of work.
- The cascade of objectives and monitoring through the organisation on an individual level, a team/service level, and a Trust level – so delivery of our strategy becomes everyone's business.
- How we know we are delivering the strategy and making a difference – defining measures of success such as KPIs, outcome measures and qualitative feedback as well as monitoring against delivery milestones.

The diagram below shows our Strategy Implementation Framework.

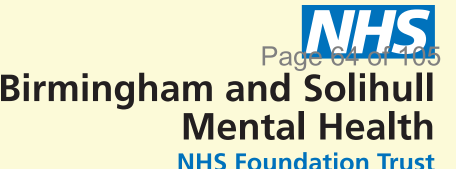


5. Next Steps

Strategy launch will commence	8 April 2021
Confirm governance arrangements for the monitoring and assurance of the strategy	By end April 2021
Supporting documents for each of the four strategic priorities will be finalised and brought to Trust Board	Trust Board April 2021
Draft Annual Plan for 2021/22	TBC – but anticipated draft for end April and final version approved by Trust Board end of May 2021
Development of service area/corporate plans and alignment of PMO and QI activity	During Quarter 1 April-June 2021
Develop integrated reporting of progress against the strategy	By end September 2021

6. Conclusion

Trust Board are asked to note i) the plans for the strategy launch and ii) the outline Strategy Implementation Framework.



Our Trust Five Year Strategy

compassionate

inclusive

January 2021

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Welcome to our new Trust strategy

One vision
Improving mental health wellbeing

Three values
Compassionate
Inclusive
Committed

Four strategic priorities
Clinical services
People
Quality
Sustainability

Welcome to our new Trust strategy which sets out our direction of travel, ambitions and priorities for the next five years.

This strategy has been co-produced with our staff, our service users, families and carers and our partners to make sure we truly have a common vision and shared values for the future.

Like others across the NHS we are facing increasing challenges every day – such as increasing demand for our services, demographic change through a growing and ageing population, a shortage in workforce supply and financial constraints. We know that there is more we need to do to make our Trust a compassionate and inclusive place to work, a place where we can all be the best version of ourselves irrespective of our identity and background and where we feel safe to speak up and learn from things that go wrong. This year has been one of the most difficult years ever for the NHS as we have had to respond to the COVID-19 pandemic, which fundamentally changed the way we had to work.

Yet, this is also an exciting time for us as we respond to these challenges.

We are breaking down barriers by collaborating and working in partnership in ways we have never done before, across systems, across sectors and across organisations, to transform how we deliver care together, improve outcomes and meet the needs of our population in a truly integrated way.

As a Trust we are on a real journey of improvement, as implementation of our quality improvement approach gains momentum and starts to underpin more and more of what we do.

Our refreshed values as well as our new leadership framework will be a key enabler in embedding a 'just' culture of inclusion, compassion and safety and helping us tackle discrimination so that everyone has equal opportunities to thrive.

The technological opportunities now available to us are vast. Over the past six months through the pandemic we have shown that we can quickly implement new digital approaches which have enabled us to work in a more flexible, agile and productive way and for many enabled better work-life balance. We want to hold onto many of these changes we have made and go further, transforming how we work and becoming more sustainable for the future.

We believe our strategy will give us the direction and focus to make our Trust a better place to work, make sure our service users are at the heart of what we do, and improve the quality of care we provide. It will also enable us to provide increasingly integrated care with others and tackle the very evident health inequalities in many of the communities we serve.

Roísìn Fallon-Williams
Chief Executive

Danielle Oum
Chair

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About us

We provide a wide range of mental healthcare services for the residents of Birmingham and Solihull, as well as some specialist regional and national services to communities in the West Midlands and beyond.

Our population is culturally diverse, characterised in places by high levels of deprivation, low earnings and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

We pride ourselves on our wide range of local and regional partnerships across the NHS, voluntary and charitable sector, local government, education and private sector to make sure we have integrated services and pathways to meet the needs of the people that we serve.

We are committed to being a learning organisation and have collaborative partnerships with our local universities and academic institutions to help us provide high quality evidence based care through education and research. We provide medical, nursing and psychology training and we have a regional, national and international reputation for both research and innovation.

Our Trust

We provide care for c71,000 service users (2019/20)

c4,000 staff

12,475 members (at 31 March 2020)

c700 inpatient beds

40+ sites – inpatient and community

c£260m income (2020/21)

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About us

Our services

- Acute and Urgent Care
- Integrated Community Care and Recovery
- Specialties
- Secure Care and Offender Health

Our population

1.3 million population in Birmingham and Solihull.

42% of Birmingham residents identify with a non-white ethnic group.

100+ languages spoken in Birmingham.

Homelessness rate in Birmingham more than three times the England average.

Unemployment rate in Birmingham 2.5 times higher than the England average.

We are both young and ageing: Birmingham is the youngest core city in Europe, with almost half our population under 30.
Solihull has an ageing population with 21% over 65.

46% of our population live in 10% of most deprived areas in England.

1 in 3 children live in poverty.

Nationally 1 in 4 will have mental health problems.

compassionate inclusive committed

How we have developed the strategy

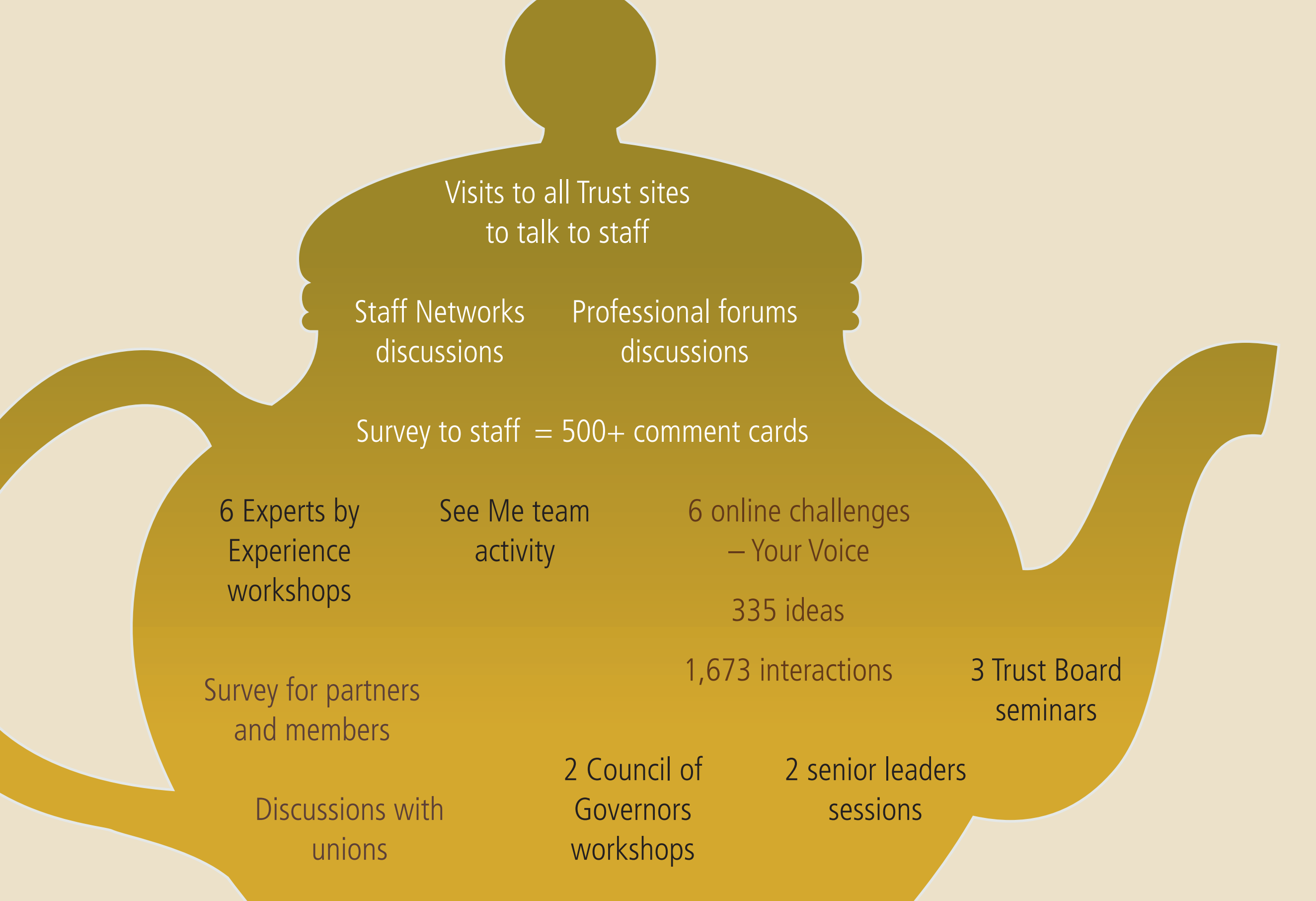
Co-production at the heart

It is important to us that our strategy is real and meaningful to our staff, reflects what is important for our service users, families and carers, and is aligned to the plans and aspirations of our partners.

We carried out one of the largest engagement exercises we have ever carried out, over a period of ten months and using a variety of mechanisms, to ask what values we wanted to live by, what our key areas of focus should be, and what we needed to change by 2025.

Throughout this document we have represented some of what was said to us in speech bubbles so you can see how we have responded.

We had so much energy and enthusiasm throughout all of our engagement and we are hugely grateful to everyone who participated for their views and for helping shape our future direction.



Phase 1: **Help us brew up our strategy**

November 2019 – February 2020

Our engagement started with a widespread campaign to get people's views on what the 'ingredients' of our strategy should be, asking people to take a few moments out of their day and have a cup of tea to reflect on what was important to them. We asked about our four priorities of clinical services, people, quality and sustainability, as well as what our values and behaviours should be.

The strategy has been awarded the Trust's Recovery for All Quality Mark, for demonstrating the principles of recovery and co-production with service users and carers.

How we have developed the strategy

Phase 2: **Learning from COVID-19**

May – July 2020

When the COVID-19 pandemic hit us in March, we had to very quickly adapt our ways of working so that we could continue to provide our services in a safe way. We decided to spend some time evaluating these changes and asking our staff, service users and carers what their experience of these changes had been and what we should stop, continue and improve. This helped inform how COVID-19 would impact our future strategy.

Online survey, focus groups and one-to-one interviews with service users and carers

Sharing learning with partners

45 workshops with staff

Triangulation with data

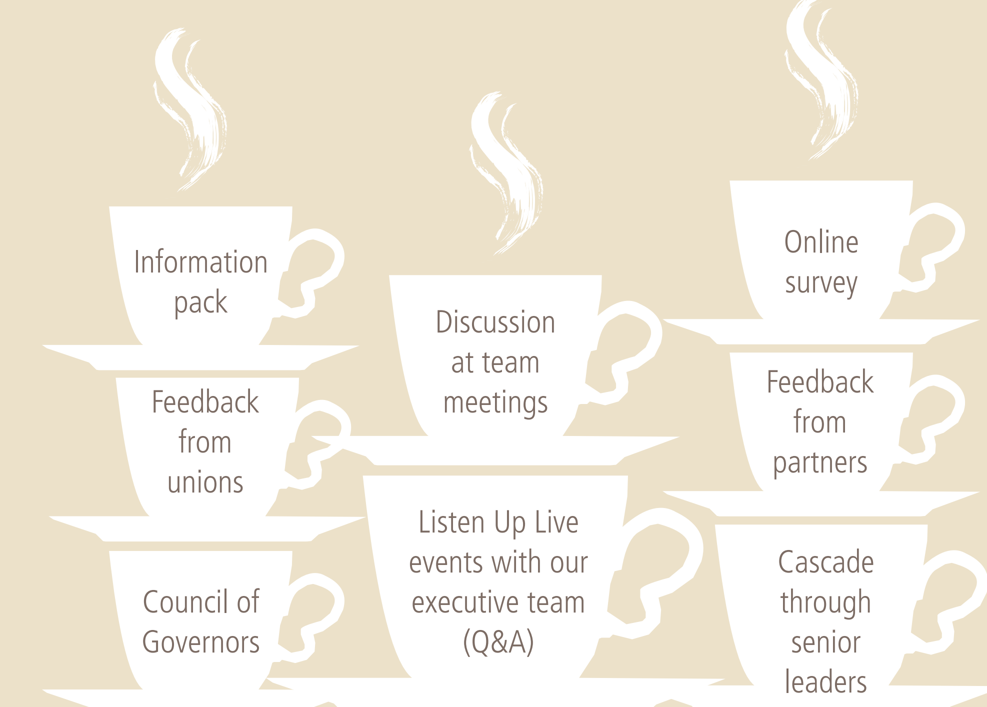
Online feedback

Staff reflection tools

Phase 3: **Taste our brew**

August – September 2020

We wanted to finish our engagement with a campaign to test the contents of our strategy before taking it to Trust Board for approval. This asked people whether they felt we had heard what they had told us, whether we were focussing on the right areas and how they thought the strategy would make a difference to them.



compassionate

What we heard

We had so much brilliant feedback and it has all been really useful to help inform our strategy. The messages coming from our different stakeholders were broadly consistent and some clear themes emerged which we have summarised here. This, and all of the detailed feedback we received, has been taken into consideration in developing our strategy.

It's really clear that this strategy has been widely co-produced.

Our service users, carers and staff will have real ownership of the strategy because of how it's been developed.

It's great that the strategy team listened and then came back again to check with us.

Clinical services

- Demand for our services is high and our staffing levels don't meet this.
- Our care needs to be truly tailored to service users' needs, whether they are medical, social or emotional.
- We need more joined up working across our services – both in planning and delivery of care.
- We can't work on our own – we need effective pathways with GPs, third sector, social care etc.
- We should focus on clinical effectiveness and how we know our service users are getting better.
- A recovery approach should be taken throughout the service user journey.

Quality

- We need to be better at giving feedback on things that we do well.
- Service user co-production needs to be through all processes and activities.
- We shouldn't make staff feel they have done something wrong if there is a serious incident.
- Let's encourage staff to share ideas and empower them to become involved in change.
- The Quality Improvement approach is good and needs to be embedded in everything we do.

People

- An inclusive and compassionate work environment is essential.
- We need solutions to our workforce gaps and supply issues.
- Improve retention through a positive staff experience.
- We need to be able to tackle behaviours not in line with our values.
- More flexibility, career development and progression opportunities are needed.
- How can we work better as effective teams.

Sustainability

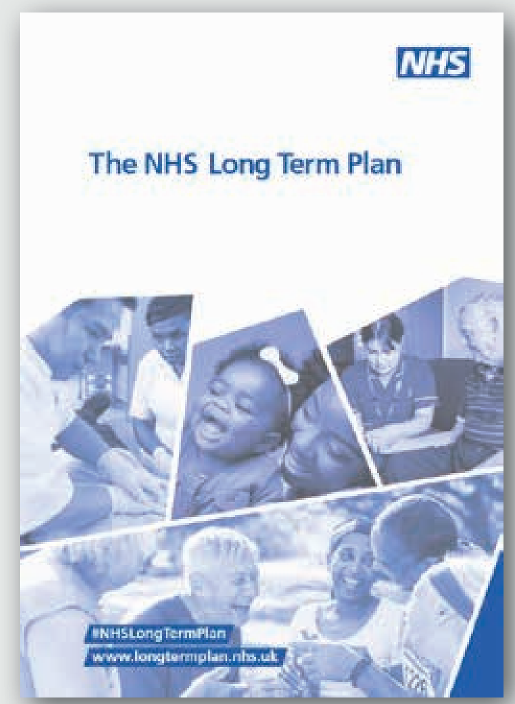
- We need to take a more focussed approach to making savings.
- Our buildings should be fit for purpose.
- Can we have more IT solutions to enable different ways of doing things.
- Closer working with commissioners and partners to improve pathways.
- A greater emphasis on the environment.

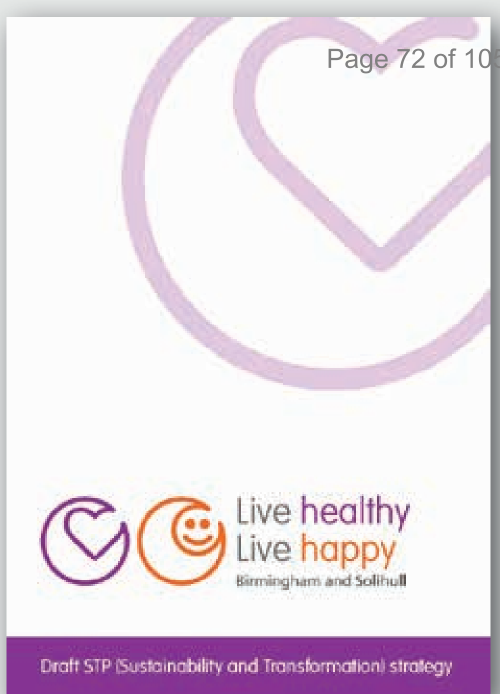
Learning from COVID-19

- New technology was embraced and really helped us work differently.
- It's important to consider service user choice and clinical need when embedding different modes of contact e.g. telephone, video, face to face.
- Staff feel trusted to work more flexibly with a more person-centred culture for both service users and staff.
- We have had a can-do culture shift, where local services feel empowered to make changes as bureaucracy barriers reduced.
- There are concerns of burnout due to impact on services and acuity, and divisions in teams from impact of shielding, redeployments. Staff wellbeing is key going forwards.

External influences

In developing our strategy, we have made sure that it aligns with the national direction of travel for the NHS as well as our local system plans and programmes of work.





The NHS Long Term Plan was published by NHS England in 2019 and sets out the priorities for healthcare over the next 10 years to improve quality of care and outcomes, based on the experiences of patients and staff.

The NHS People Plan was published by NHS England in 2020 and describes practical actions to look after our people, belonging in the NHS, delivering care through new ways of working, and growing for the future.

The Birmingham and Solihull Sustainability Transformation Partnership brings together local health and social care organisations to manage the health of our population collectively, and deliver better health and care within the resources available to us through joint planning and programmes of work.

We also deliver services in West Birmingham who are part of the Black Country and West Birmingham STP.

Our values

Our values are our guide to how we treat ourselves, one another, our service users, families and carers, and our partners.

Our values were developed by listening to feedback about what people wanted to see and experience when working for us, with us or accessing our services.

Compassionate

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

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Valuing all voices so we all feel we belong.

Committed

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

Our values 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.

Our values will only make a difference when we each let them guide our own thoughts, feelings, decisions, attitudes and actions. The more we demonstrate our values through our work, the more likely others are to experience our values when working with us.

Our everyday and detailed behaviours describe what our values look like in practice. They give us a shared language to help bridge the wide range of specialties and roles in our Trust.

Our vision

Our vision describes what we want to achieve – our aspiration for the future. Our vision is at the heart of everything we do and every decision that we make.

Our vision is simple:

improving mental health wellbeing

We believe we will need to work in four key ways to achieve this vision, and so these are themes running through our strategy:

Driving change

Leading the way and encouraging collaboration across systems to develop joined up, integrated mental health services for our population.

Working together

Co-producing our strategies and plans with our people, our partners and our service users, families and carers.

Continuous improvement

Continually seeking to question, improve, learn and innovate through our practices, our research and our developments.

Reducing inequalities

Working in a way that tackles discrimination, addresses stigma, and encourages equality for all.

compassionate inclusive

Our priorities

Our priorities set out what we will do to deliver our vision and live our values. They support us to stay focussed on what is important to us and make sure we are using our resources to do the right things.

We have four strategic priorities:

Improving mental health wellbeing

Clinical services

Transforming how we work 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.

People

Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.

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.

Sustainability

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

Over the following pages we have set out what the areas of focus will be over the next five years to achieve each of these priorities and there will be a separate supporting strategy for each priority. These strategies have been developed alongside one another to make sure they are aligned and joined up, and we have considered the impact on each other and the dependencies between them. For example, the quality, people and sustainability strategies will all have a focus on ensuring that we are able to achieve the transformation we want to see in our clinical services.

Clinical services

Transforming how we work 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.

Better interfaces between Trust services – too many barriers

We can't work on our own – we need effective pathways with others

Care tailored more to individual needs

Stop repeating assessments and re-triaging

I want to feel listened to and my views taken seriously

A recovery focus from the beginning

Leader in mental health

- Smooth interfaces and transitions between our own services.
- Transforming integrated pathways and services with primary care, acute trusts, police, social care, housing, and community, voluntary and independent sectors to manage demand across the system and improve outcomes.
- Developing an Integrated Care System for mental health across Birmingham and Solihull.
- Influencing decisions on the level of funding coming into mental health services to meet growing need.
- Challenging inequities between mental health and physical health.
- Being an advocate for mental health and influencing partners across the system to address health inequalities and causes of mental illness, such as poverty, debt, homelessness, gambling and unemployment.
- Provider Collaboratives across secure care (Reach Out), eating disorders, veterans, children and young people, and perinatal services.
- Refreshed model of healthcare in HMP Birmingham to meet changing needs.
- Recognising and celebrating our wide range of services.

Recovery focussed

- Delivering personalised care:
  - Empowering service users to manage their own recovery, supporting them to have choice, control and self-management of their care
  - More effective, personalised care planning
  - Shared decision-making with service users
  - Considering the use of personal health budgets for all service users
  - Signposting to social prescribing where appropriate.
- A recovery approach from assessment and throughout the service user journey.
- Equipping our staff with the skills to deliver truly recovery focussed care.
- A family and carer pathway.
- More peer support workers and experts by experience roles.
- Supporting service users with employment through links with Individual Placement Schemes (IPS).
- A wide range of recovery opportunities, through our Recovery College for All and links with community and voluntary sector organisations.
- Using recovery outcomes measures.

Clinical services

Transforming how we work 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.

Links for housing and benefits advice

Services close to where people live

What community organisations are out there?

Clearer communication with GPs

Rooted in communities

- Reducing inequalities through targeted work with over and under-represented groups.
- A culturally competent workforce with culturally sensitive services and interventions, removing barriers to access and experience.
- Tackling stigma across our communities.
- Transforming how we work in the community to be more place based, integrated in neighbourhoods with primary care, social care and the community and voluntary sector in an all age model that dissolves barriers between providers and manages demand and need effectively.
- Rolling out and integrating our models of Primary Care Liaison and multidisciplinary working.
- Reducing out of area placements and providing personalised care in the least restrictive setting:
  - By improving service user flow and length of stay in acute care
  - Through our Reach Out strategy for secure care services across the West Midlands
  - By transforming rehabilitation services.
- Expanding access to perinatal community services.

Prevention and early intervention

- Working collaboratively with NHS, statutory, community and voluntary sector partners to deliver an integrated urgent care pathway across Birmingham and Solihull, including alternatives to admission for those in crisis.
- Enhancing mental health support to care homes.
- Integrated model of intermediate care / early intervention for older people, enabling people to be cared for at home and reducing time in hospital.
- Developing a 0–25 Children and Young People's model in Solihull.
- Widening our Birmingham Healthy Minds offer.
- Increasing awareness of veteran mental health and enhancing services for veterans through our Complex Treatment Service and new High Intensity Service.
- Developing services in partnership for rough sleepers.

Prevention matters just as much as treatment

More support early so people don't end up sectioned

compassionate

Clinical services

Transforming how we work 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.

Clinically effective

- A 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.
- Trauma informed care.
- Increased psychological formulations and a range of interventions.
- Consistent model of multidisciplinary working with effective multidisciplinary leadership.
- Meeting national standards (e.g. early intervention and psychiatric liaison).
- Needs based pathways, for example personality disorder, neurodevelopmental.
- Clear models of care for our service users who have both mental health and substance misuse needs, including clear pathways with partner providers and collaborative care planning.
- Consistently using NICE guidance, evidence based interventions, and a range of outcome measures, informed by research.

Changing how we work

- New roles and workforce models.
- Building on COVID-19 learning, enhancing use of technology to support transformation.
- Using Quality Improvement to ensure efficient and effective processes, for example to help manage demand, bed utilisation and service user flow effectively.
- Using data to drive decisions and transformation.
- Using our proposed new build developments for Reaside and Highcroft as opportunities to work in a different way.

More effective MDT working

More choice over therapies

Think about the service users' holistic needs

More direct time with service users

Using IT more to do things differently

More peer support workers

Can we use volunteers?

People

Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.

Shaping our future workforce

Attract and retain diverse talent

- A strong employer brand which connects with our values and culture.
- A diverse workforce reflective of our population and service users.
- Values based approach to recruitment.
- Encouraging recruitment of those with lived experience.
- A positive new starter experience.
- Our people feel supported, valued, and engaged and are advocates of our Trust.
- A co-designed total reward and recognition offer.

High performing workforce

- Upskilling and developing our people to meet the evolving needs of our service users and carers.
- Credible and convincing route inclusive maps for career development.
- Clear measurable objectives for all, linked to our strategy, values and behaviours.
- Positive approach to performance management to maximise potential for all our people.
- Having the right leaders with the right capabilities, developed through a supportive leadership framework.
- Multidisciplinary leadership approach.

Flexible and transformative workforce models

- Flexible working that balances home and work life, building on COVID-19 learning.
- Thinking differently about our workforce models and what skills we need.
- Using our creativity and experiences to work collaboratively to enhance service user experience and recovery.
- Innovative new roles and ways of working.
- Working with our partners to improve workforce supply and address gaps.

We need to try new ways

How do I progress?

BAME, LGBT+ and disabled staff under-represented

More multidisciplinary working

Rotating staff around so they get new experiences

Destigmatise mental health

Get rid of the nine-to-five mentality

compassionate inclusive committed

People

Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users.

Support staff with disabilities stay in work

Tech-savvy workforce

Systems as an enabler not a burden

Staff need to feel like they matter

Not a blame culture

Challenge poor behaviour

Transforming our culture and staff experience

Inclusion

- A step change in our approach to equality and inclusion, valuing the experience of our diverse workforce.
- A zero-tolerance approach to discriminatory and bullying behaviours.
- Championing and role modelling inclusion.
- Embedding inclusion in appraisals.

Safety to speak up and share learning

- Making it safe to speak up and raise concerns or challenge behaviours.
- A culture of trust, empowering the sharing of ideas and learning.
- Shared accountability when things go wrong.

Compassion and wellbeing

- Role modelling behaviours in line with our values.
- An enhanced wellbeing offer, incorporating learning from COVID-19, which includes recovery focussed support, enhanced mental health and psychological support, physical health, social and financial wellbeing.
- Everyone feeling involved and listened to in decision-making.

Modernising our people practice

Integrated people practice

- Working in an integrated way to support our leaders.
- Putting our people at the centre of our processes by considering their psychological and emotional impact.
- Getting the basics right with our data, processes and systems.

Evidence based people practice

- Making sure systems hold accurate and credible workforce data.
- Using data and analytics to truly understand the needs of our people and improve staff experience.

Digitally enabled workforce

- Using digital solutions to streamline or automate people processes.
- Supporting our workforce to use technology.

compassionate inclusive

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.

Improving service user experience

- Co-production with experts by experience is business as usual.
- Increasing the number of experts by experience who work with us.
- A strong voice and shared decision-making with service users, families and carers about their treatment and care.
- Develop a Patient Safety Partner role for service users on our Patient Safety groups to give service users equality of voice and empowerment to speak up and contribute to changes that we make.
- Developing 'Always Events' to ensure a positive service user experience.
- Increasing the range of meaningful activities on our wards.
- Delivering our Family and Carer Involvement and Engagement Strategy.
- Delivering our Recovery for All Strategy.

Preventing harm

- Working with Patient Safety Collaboratives to share learning.
- A new Suicide Prevention Strategy.
- Improving quality of clinical handover (both within teams and between services) and multidisciplinary approaches.
- Think Family, Safeguarding and Infection Control are part of everyday practice.
- Improving physical health alongside mental health.
- Reducing incidents of violence and aggression.
- Always using least restrictive practice approaches.
- Clinical Risk Assessment and Management training.

Peer support is so valuable

Service users' needs to be connected to their care plans

More service user activities – crafts, life skills, sports, music

Improve handovers when service users are transferred to another service

Take positive risks

Think Family throughout the service user journey

Restraint as a last resort

Doing better with physical health checks

compassionate inclusive

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.

More supervision and reflective practice

More peer review and audit

More clinical practice with compassion

A Patient Safety culture

- High quality, meaningful clinical supervision in place routinely.
- Post incident and psychological support for staff.
- Improving how we learn from excellence and celebrate and recognise great practice.
- Embed a just and fair culture in our incident processes to identify system improvements rather than individual blame.
- We will have a strong and embedded approach to learning from incidents and serious incidents to improve practice, systems and care for service users that is wholly inclusive.
- Improving service user, family and carer experience of serious incidents and complaints.

Empower staff to share ideas and make changes

Sharing good practice – too much silo working

More support to staff following an incident

Quality assurance

- A robust Quality Assurance Framework, assuring us of quality at all levels.
- Individuals are empowered to make changes to improve care and improve equity.
- Increasing numbers trained in and using quality improvement.
- Developing our own Care Quality Commission (CQC) Peer Review processes.
- The differing tiers of our quality improvement training equitably represent the diversity of our staff and experts by experience.
- Using data, including equality data, to understand and drive actions and decisions.

Using our time more effectively

- Using digital technology to drive improvements in quality and safety.
- Using quality improvement to work more productively and efficiently.
- Increasing clinical time to care.
- Using evidence based practice supported by research as a routine way to inform transformation of care and services.

Sustainability

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

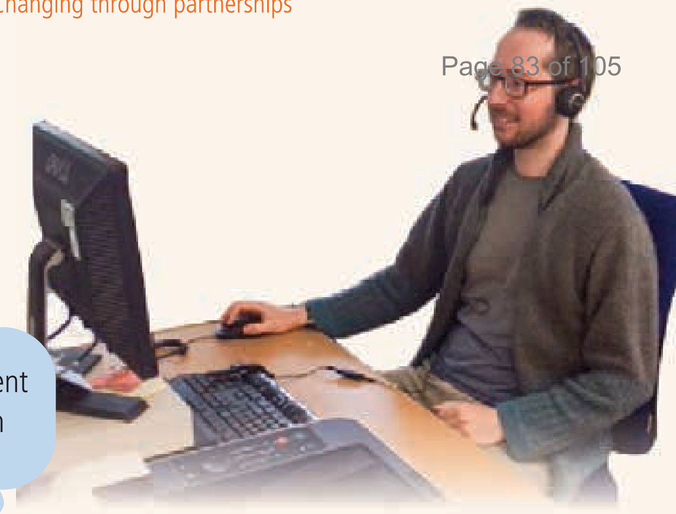
Using IT more to assist the work we do

Accuracy of data is important

What digital solutions are out there?

More video-conferencing

Short term investment for long term gain



Balancing the books

- Spending less than we earn.
- Generating cash to invest in facilities, technology and services.
- A workforce that is financially aware with the right information and training to support them.
- Reducing non-pay spend, limiting the impact on our services.
- A framework for delivering recurrent savings over the lifetime of the strategy, recognising the opportunity that innovation, prevention and partnerships will make in delivering this.
- Financial improvement plans where needed.
- Managing financial risks and rewards with partners.
- Improving the way we price services to produce sustainable outcomes, especially incorporating new and innovative technological ways of delivering service.
- Clearly communicate our financial position, the implications and how resources are used.

Be open about how much resources are available

Honest conversations with CCGs

Staff at all levels to have awareness of our budgets

Transforming with digital

- 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.

Sustainability

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

Caring for the environment

- Greater focus on recycling and our wider environmental responsibilities, including our existing commitment to reduce the use of single-use plastics.
- A procurement strategy that ensures that minimising waste is a key element, releasing funds for investment in key priorities.
- Reducing emissions by building on the changes in how we have reduced travel during COVID-19, a green vehicle strategy, and responding to the impact of the Birmingham Clean Air Zone.
- Developing renewable energy solutions by investing in new technology during all developments of buildings and facilities, aiming to become a leader in providing mental health facilities utilising renewable energy.

Good governance

- Well-developed corporate and clinical governance structures.
- Clear and robust governance processes to fulfil Reach Out and other Provider Collaborative Lead Provider functions.
- A clear Corporate Social Responsibility offer to benefit our communities, including stimulating social value through our supply chain and workforce.
- Internal and external communications that support good governance and promote our reputation, for example through our intranet, social media and external website.

Reduce waste and increase recycling

We spend too much time travelling and it's not green

We waste too much food

More flexibility to work from home

Need to be better at saving energy – heating, lights, computers left on

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Sustainability

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

Partner with other local organisations so we don't duplicate initiatives

Tap into the local voluntary services better

It's hard to get partners on our systems and training

Changing through partnerships

- Removing barriers to working in partnership, reviewing and refreshing our Partnership Strategy and providing a framework to provide clear guidance on how best to take advantage of all opportunities.
- Strategic alliances, formal partnerships and provider collaboratives to improve services, pathways and service user outcomes, share expertise and spread best practice, for example:
  - Birmingham Care Alliance with Birmingham Community Healthcare NHS Foundation Trust
  - Joint working with Birmingham Women's and Children's NHS Foundation Trust
  - MERIT partnership with the mental health trusts across the West Midlands
  - Reach Out provider collaborative, and lead provider, for adult secure care
  - A range of partnerships with the community and voluntary sector.
- Establishing an Integrated Care System for Mental Health in Birmingham and Solihull with a model that will help us to manage demand, improve safety and clinical outcomes, and ensure that we can provide sustainable services.
- Working with our partners in the Black Country and West Birmingham STP, ensuring that mental health services for West Birmingham are integral to Integrated Care System plans.
- Developing capabilities and capacity to fulfil our new commissioning responsibilities.

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How we will implement our strategy

Now that we have approved our new strategy, it is important that we have robust mechanisms in place to bring this to life and make sure that everyone is aware of the strategy and the part they and their teams have to play in its delivery.

Our strategic framework

We will have a clear framework in place to describe how we will implement our strategy, routinely monitor our progress and assure our Trust Board and our Council of Governors that we are on the right track.

The strategy has been awarded the Trust's Recovery for All Quality Mark, for demonstrating the principles of recovery and co-production with service users and carers.

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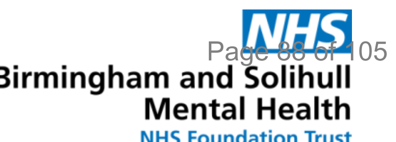
Ref: COM0088A-012021 • Review date: January 2026



Meeting	BOARD OF DIRECTORS
Agenda item	15
Paper title	EATING DISORDERS PROVIDER COLLABORATIVE
Date	31 March 2021
Author	Abi Broderick, Head of Planning and 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:

The report sets out the proposed arrangements for the Eating Disorders Provider Collaborative. Trust Board are being asked to consider the contents of this paper and give approval that we go live with the provider collaborative arrangements from 1 April 2021The Trust is a core partner in the Eating Disorders Provider Collaborative.

The Eating Disorders Provider Collaborative business case sets out the case for change and clinical, governance and financial models.

The proposed timeframe is that the Eating Disorders provider collaborative will go live from 1 April 2021. MPFT as the lead provider for the collaborative will hold commissioning responsibility and this means from this date:

- Our contract to provide services will be with MPFT as lead provider rather than NHS England.
- A partnership agreement will be in place defining how the partnership will work and how decisions will be made.
- A financial risk and gain share will be in place.
- We will continue implementing our clinical model for eating disorders in line with the business case.

The clinical model has been co-produced through a series of workshops held with clinicians across both inpatient and community eating disorder services across the West Midlands. It has also been informed by engagement with service users, carers and families, data about patient flows and activity, and the strategic ambitions set out in the NHS Long Term Plan. The clinical model describes a number of objectives which will bring improvements to inpatient and community pathways, service user experience, service user outcomes and sharing of expertise and knowledge across the West Midlands.

This will also result in reduced out of area placements and lower lengths of stay across the West Midlands.

We have carried out due diligence over the clinical model and operational impact, governance arrangements including the partnership agreement, and the financial model. We are satisfied that there are no significant risks to the Trust.

Reason for consideration:

Trust Board is asked to formally give approval that we:

- Proceed to go live as a core partner in the West Midlands Eating Disorders Provider Collaborative from 1 April 2021.
- Sign the Partnership Agreement.

Previous consideration of report by:

Integrated Quality Committee – 17 February 2021
Finance, Performance and Productivity Committee – 17 February 2021
Trust Board – 24 February 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)*

The total budget for the West Midlands eating disorders Provider Collaborative is £11.7m. Of this budget the Trust's core contract value is c£2.5m. A risk and gain share will be in place among the three NHS providers based on % of total contract value, although reserves within the Provider Collaborative exist that aim to mitigate any risk.

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

None

Equality impact assessments:

An Equality Impact Assessment has been carried out by MPFT as part of the development of the Adult Eating Disorders Business Case. No negative impacts were identified.

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

The clinical model has been co-produced through a series of workshops held with clinicians across both inpatient and community eating disorder services across the West Midlands and informed by engagement with service users, carers and families.

Provider Collaboratives – Adult Eating Disorders

Trust Board 31 March 2021

1. Background

From April 2020 NHS England and NHS Improvement are enabling local service providers to join together under NHS-led Provider Collaboratives who will be responsible for managing the budget and patient pathway for specialised mental health, learning disability and autism care for people who need it in their local area, covering adult low and medium secure, CAMHS tier 4 and adult eating disorder services.

The Provider Collaboratives model is based on what were formerly known as New Care Model (NCM) pilots. These pilots were launched in 2016/17 and trialled new ways of working across mental health providers. Their aim was to empower local systems, including people with lived experience, their families, carers and clinicians, to work collaboratively to support people who use specialised mental health services, with a view to reducing the number of people who were cared for out of area and creating the services their population needed through local re-investment. The success of NCM pilots in repatriating out-of-area patients, reducing bed days and reinvesting efficiencies in local community mental health services resulted in a decision to transition to a permanent model and to expand service coverage. NCM pilots covered adult secure mental health, CAMHS and adult eating disorder services: both adult and child and adolescent coverage has now been expanded to include learning disability and autism services. This approach is now being rolled out nationally as the Provider Collaborative Programme - Mental Health, Learning Disability and Autism.

Under the arrangement NHS-led Provider Collaboratives will hold a budget for a particular geographically-based population that they are responsible for. To begin with, Provider Collaboratives will deliver Child and Adolescent Mental Health services (CAMHS), Adult Low and Medium Secure services and Adult Eating Disorder Services, and lead providers will be responsible for the relevant budgets for these specialised services.

The Trust is a core partner in three Provider Collaboratives in the West Midlands – Reach Out (adult secure care), Eating Disorders and CAMHS Tier 4.

2. Purpose of the paper

This paper considers the Eating Disorders Provider Collaborative which is due to go live from 1st April 2021 in terms of the Collaborative being formally responsible for the budget and contracts for services.

We have carried out internal due diligence considering the clinical model, operational impact, governance arrangements, financial arrangements and risk, contractual implications and quality assurance.

Trust Board are being asked to consider the contents of this paper and give approval that we go live with the Provider Collaborative arrangements from 1 April 2021.

3. West Midlands Eating Disorders Provider Collaborative

Name of Collaborative	West Midlands Eating Disorders Provider Collaborative
Lead provider	Midlands Partnership NHS Foundation Trust (MPFT)
Core partners	Voting/part of risk and gain share: • MPFT • BSMHFT • Coventry and Warwickshire Partnership NHS Trust Non-voting/ not part of the risk and gain share: • Priory Group • Elysium
Total Provider Collaborative budget	£11.7m
BSMHFT contract value	£2.5m
Status	Go live 1 April 2021 (operating in shadow form since April 2020)

The Eating Disorders Provider Collaborative business case sets out the case for change and clinical, governance and financial models. ***The business case can be found in the Reading Room (commercial in confidence).***

The proposed timeframe is that the Eating Disorders Provider Collaborative will go live from 1 April 2021. MPFT as the lead provider for the collaborative will hold commissioning responsibility and this means from this date:

- Our contract to provide services will be with MPFT as lead provider rather than NHS England.
- A partnership agreement will be in place defining how the partnership will work and how decisions will be made.
- A financial risk and gain share will be in place.
- We will continue implementing our clinical model for eating disorders in line with the business case.

4. Clinical model

BSMHFT services in scope in this Provider Collaborative are:

- 10 eating disorder inpatient beds
- Eating disorder community outpatient services
- Eating disorder day services

The clinical model described in the business case has been co-produced through a series of workshops held with clinicians across both inpatient and community eating disorder services across the West Midlands. It has also been informed by engagement with service users, carers and families, data about patient flows and activity, and the strategic ambitions set out in the NHS Long Term Plan.

The business case describes a number of issues as a case for change and more collaborative working, the key one being the disjointed commissioning and service design across inpatient and community pathways in the region which has led to:

- Varied levels of provision of community outpatient provision across the West Midlands leading to inequalities in care.
- Differences in the range of eating disorders treated across providers.
- Challenges for community providers in accessing inpatient beds.
- Delays in access to care, with some patients having to travel long distances (and out of area) to access treatment.

The Provider Collaborative aims to address these through the following key objectives and actions:

Objective of the new clinical model	**How we will do this**
Consistent equitable access to the same level and standard of service across the region in relation to community and inpatient service with a preventative focus in terms of admissions where clinically appropriate	Consistent approach to inpatient referral criteria and weekly referral meetings
A reduction in both out of area placements and in length of stay within the inpatient service	Centralised bed management and single point of access
An improved, joined up system approach to the care and treatment of adults with eating disorders across the health system and wider services, resulting in improved patient outcomes and experience and improved transitions from CAMHS services	Geographic alignment between inpatient and community providers
A comprehensive pathway across inpatient and community services	New clinical liaison role (1 post per inpatient unit)
Opportunities for service user, families and carers central to be shaping the future development of services	Development of peer support roles
Opportunities to grow day care services across the West Midlands	Explore potential to develop new day care services

Before we came together as a Provider Collaborative, eating disorders services in the West Midlands tended to operate in silos. Over the last twelve months we have seen increased joint working across our inpatient clinical teams and our clinicians say this has been extremely beneficial and has resulted in:

- Joined up decision making about referrals and admissions through a weekly referral meeting.
- Sharing knowledge and expertise, e.g. in complex case discussions.
- More agile use of beds, for example, patient transfers to other units to support patient preference and treatment recovery.
- No new out of area placements during 2020/21
- Shared training resources.
- Shared learning and approaches to care during the pandemic.

Conclusion

Through our due diligence of the clinical and operational impact on BSMHFT of the proposed changes, we are satisfied that there are no significant risks to the quality of care we provide, service user outcomes, bed occupancy or length of stay.

5. Governance arrangements

Governance structure

The provider collaborative will be governed by an Eating Disorders Provider Collaborative Board. This Board will drive the delivery of the clinical and business model. The first formal meeting took place on 8 March 2021 and our Trust representative is the Associate Director of Operations for Specialities. Underneath the Board will be a number of sub-groups which the Trust will be represented on:

- Eating Disorders Delivery Group – overview of service delivery
- Eating Disorders Scrutiny Group – overview of clinical delivery including quality, incidents and risks.
- Eating Disorders Clinical Reference Group – forum for discussions about best practice, service developments and new initiatives
- Eating Disorders Service User Group – experts by experience group who will advise and support the Provider Collaborative in its developments and delivery.

The Eating Disorders Provider Collaborative Board will feed into the West Midlands Provider Collaborative Board which has oversight of the strategic direction of all specialist services providers in the region.

Internally we will report progress with the Provider Collaborative developments and any risks through our Transformation Board.

Partnership agreement

A Partnership Agreement will be in place to set out how the partnership will work, key roles and responsibilities, decision making and dispute resolution. This is based on the national template. This has been reviewed by our legal, contracts and financial teams. ***A copy can be found in the Reading Room (commercial in confidence).***

Contract for services

MPFT as lead provider will hold a contract with NHS England for West Midlands eating disorders services and will in turn hold sub-contracts with each of the providers which includes BSMHFT. We have not yet received our contract and contract offer for 2021/22 due to the national delays in confirming the financial framework but meetings are taking place before the end of March with MPFT to discuss further.

The proposal is that there is a central commissioning hub for the West Midlands across all of the Provider Collaboratives to prevent unnecessarily duplication and enable consistency of approach and economies of scale.

Information sharing

An Information Sharing Agreement will be in place setting out how and in what circumstances we will share information across the Provider Collaborative. This has been reviewed by our information governance team and a Data Privacy Impact Assessment competed.

Quality assurance

Quality assurance is a key function of the lead provider so will be MPFT's responsibility. A Quality Assurance and Improvement Framework will be in place across the Provider Collaborative. This has been produced by MPFT and we are currently reviewing it from a contractual and operational perspective.

Conclusion

Through our due diligence of the governance of the Provider Collaborative we are satisfied that governance structures are robust and the agreements and contracts that will be in place are fit for purpose and pose no significant risks to the Trust.

6. Financial model

The total budget for the West Midlands eating disorders Provider Collaborative is £11.7m and MPFT have carried out due diligence over the activity data and financial allocations to ensure this financial baseline is correct. Of this budget the Trust's core contract value is c£2.5m.

We have carried out internal due diligence and checks over the financial model prepared by MPFT which assumes:

- Implementation of the clinical model will continue to reduce the cost of out of area placements over the next four years.
- Inpatient activity for MPFT, BSMHFT and CWPT will be paid at contracted occupancy rates.
- Funding for community services across MPFT, BSMHFT and CWPT will remain the same subject to inflationary uplifts.
- Investment in community teams will primarily be done through the Transforming Community Mental Health monies in the first instance, however this will be kept under review.
- New roles to support the clinical model delivery – e.g. clinical liaison, peer support, case manager.
- Investment in infrastructure posts employed by MPFT to support the Provider Collaborative.

A risk and gain share agreement will be in place between the three NHS providers based on % of total contract value. Scenario modelling has shown that the maximum downside risk exposure for BSMHFT based on a 35% share of contract value will be £85,000, although reserves within the Provider Collaborative exist that aim to mitigate this risk.

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Conclusion

Through our financial due diligence we are satisfied that there are no significant financial risks from the proposed financial model or risk and gain share. It should be highlighted that we have not yet received a contract offer for 2021/22 due to the delays in confirmation of the national financial framework but we do not anticipate any significant risks around this.

5. Recommendation

As summarised above our due diligence has not identified any significant risks.

Trust Board is asked to formally give approval that we:

- Proceed to go live as a core partner in the West Midlands Eating Disorders Provider Collaborative from 1 April 2021.
- Sign the Partnership Agreement.

Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	16
Paper title	DEVELOPMENT OF NEW BOARD ASSURANCE FRAMEWORK
Date	31st March 2021
Author	Andrew Hughes, ANHH Consulting Alex Rickard, ANHH Consulting
Sponsor	Sharan Madeley, Company Secretary

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, summarising activities and key events

Previous consideration of report by:

Not applicable.

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

Select Strategic Priority

The Board Assurance Framework will provide assurance against all of the strategic risks associated with the delivery of the Trust Strategy.

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)

This report is identifying the new risks associated with the delivery of the strategy and will form the Board Assurance Framework for 2021/2022

Equality impact assessments:

Not applicable for this report

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

Engagement with staff has been through preparation meetings with the Executive Lead and Non Executive Director for each Board Committee.

REPORT TO THE BOARD OF DIRECTORS, 30 MARCH 2021
DEVELOPMENT OF A NEW BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

In September 2020, the Board of Directors ("**Board**") agreed a new Trust Strategy. The Strategy sets out the direction of travel, ambitions and priorities for the next five years, based on four strategic priorities:

- Clinical services
- People
- Quality
- Sustainability.

The Board has a critical role to focus on the risks that may compromise the achievement of those strategic priorities. The Board Assurance Framework ("**BAF**") is the means by which the Board will hold itself to account, i.e., the main tool to discharge responsibility for internal control.

This Report describes the process that has been followed to develop a draft BAF and the next steps that will be followed to populate it more fully.

The Board is asked to consider the recommendations made in the final section.

2. METHODOLOGY

The BAF is just one element of a much wider interdependent process of governance development led by the Company Secretary, including:

- Refresh of the Terms of Reference for the Board Committees
- Review and refresh of the Risk Management Policy
- Training in the preparation and production of Board and Committee papers
- Creation and implementation of new cover sheets and other templates
- Introduction of Committee Assurance Reports and Hot Topics Reports
- Development of a programme for a Non-Executive Development Plan
- Consideration of lessons to be learned for governance from COVID-19.

The Board will receive a detailed report about the totality of initiatives in April 2021.

This work has been supported by ANHH Consulting. The detailed and inclusive process that has been followed is shown at Appendix One.

Three of the strategic priorities align neatly with the three functional Board Committees:

- People (People)
- Quality (IQC)
- Sustainability (FPP).

The fourth priority, Clinical Services, has cross-over between Committees, with various elements sitting in different forums. The nineteen Strategy headings have been consolidated into sixteen strategic risks, split by Committee:

- People (5)
- Quality (7)
- Sustainability (4).

Each Committee will hold responsibility for its elements of the BAF, and Terms of Reference and membership will adapt to reflect those responsibilities.

3. BAF ENTRIES FOR THE PEOPLE COMMITTEE

The Committee has determined that it has a **Significant** risk appetite:

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 positive change.

The Committee recommends the following risks.

Transforming our culture

The Trust fails to develop an inclusive and compassionate working environment, resulting in:

- poorer quality patient service
- increased levels of sickness absence
- reduced productivity
- failure to attract talent
- unacceptable staff turnover
- increased recruitment costs
- demotivated workforce
- increased legal costs
- absence of a values-led culture
- increased regulatory scrutiny, intervention, and enforcement action

High performing workforce

The Trust fails to deliver its ambition to transform the culture and develop the right capabilities in staff by sponsoring, implementing, supporting and monitoring a multidisciplinary values-based leadership framework, resulting in:

- unhealthy and poor leadership
- an underperforming workforce
- sustained patterns of inequalities and discrimination
- unacceptable staff turnover
- non-compliant behaviours
- Employee Relations cases
- poor staff retention

Communication, inclusion, and wellbeing

The Trust fails to effectively communicate and engage with its workforce through a dynamic, sustainable internal communication plan, resulting in:

- a lack of inclusion
- diminished knowledge and education to make and take the right decisions
- reduced productivity
- confusion
- fear of safety to speak up
- poor employer brand
- non-compliant behaviours

Modernising our people practice

The Trust fails to demonstrate an equitable and holistic approach to reward and develop all employees, which reflects and represents the communities served by the Trust, resulting in:

- a poor employer brand
- compensation costs
- unacceptable staff turnover
- increased regulatory scrutiny, intervention, and enforcement action

Flexible and transformative workforce models

The Trust fails to look holistically at flexible and transformative workforce models used across all services, resulting in:

- a failure to take opportunities where positive gains are possible
- drastic inefficiencies
- unacceptable patient care
- a failure to address inequalities
- unacceptable staff turnover
- missed opportunities for cost improvement

4. BAF ENTRIES FOR THE INTEGRATED QUALITY COMMITTEE

The Committee has determined that it has an **Open** risk appetite:

We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.

The Committee recommends the following risks.

Improving service user experience

The Trust fails to co-produce with all people who use its services including their families, resulting in:

- a reduction in quality of care
- service users not being empowered
- services that do not reflect the needs of service users and carers

- service provision that is not recovery focussed
- increased regulatory scrutiny, intervention, and enforcement action

Preventing harm

The Trust fails to focus on the reduction and prevention of patient harm, resulting in:

- unacceptable variations in care
- continued inequality in health status and outcomes
- unwarranted incidents
- less safe care
- increased regulatory scrutiny, intervention, and enforcement action

A Patient Safety culture

The Trust fails to be a self-learning organisation that embeds patient safety culture, resulting in:

- a culture where staff feel unable to speak up safely and with confidence
- unacceptable variations in care
- a failure to develop pathways of care within the Integrated Care System
- increased regulatory scrutiny, intervention, and enforcement action

Quality Assurance

The Trust fails to be a self-learning organisation that embeds quality assurance, resulting in:

- insufficient understanding and sharing of excellence in its own systems and processes
- lack of awareness of the impact of sub-standard services
- variations in standards between services and partnerships
- demotivated staff
- increased regulatory scrutiny, intervention, and enforcement action

Leader in mental health

The Trust fails to lead and take accountability for the development of system-wide approaches to care and multi-disciplinary approaches, and to exploit its status and position to advocate for mental health services and service users, resulting in:

- inferior and poor care
- detrimental impact for service users
- higher critical caseloads
- missed income opportunities
- missed positive brand awareness opportunities
- unexploited research and innovation opportunities
- breakdown in critical relationships with key partners

Prevention and early intervention

The Trust fails to prevent and contain a major public health outbreak, resulting in:

- death and compromised duty of care for staff's health and wellbeing
- fundamental breakdown of service provided for service users
- fundamental breakdown of the network of collaborative work with partners
- disintegration of trust by the public and staff

Clinically effective

The Trust fails to respond to service users' holistic needs, resulting in:

- increased mental health and physical health morbidity
- potential increased mortality
- unacceptable patient experience
- missed opportunities for cost improvement
- a demotivated workforce
- missed opportunities for cost improvement

5. BAF ENTRIES FOR THE FPP COMMITTEE

The Committee has determined that it has **significant** risk appetite:

We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.

The Committee recommends the following risks.

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:

- missed income opportunities
- an inability to support the System's medium to long term financial viability
- reductions in service provision
- continued inequalities in health status and outcomes
- unacceptable pathways of care
- inability to invest in improvement
- increased regulatory scrutiny, intervention, and enforcement action
- a breakdown in critical relationships with key partners

Transforming with Digital

The Trust fails to focus on the digital agenda and to harness the benefits of digital improvements, resulting in:

- less-than-optimal data security and sharing
- not addressing cybersecurity threats
- inefficiencies and ineffectiveness in critical processes
- ineffective care
- unacceptable care for service users

Caring for the environment

The Trust fails to behave as a socially responsible organisation, resulting in:

- poor waste management
- unnecessary journeys
- higher than necessary energy costs
- failure to hit zero emissions targets
- damage to reputation and public trust

The Trust fails to manage the safety and quality of its therapeutic environment, resulting in:

- increased maintenance costs
- health and safety executive scrutiny
- failure to meet statutory standards
- patient harm and increased untoward incidents related to the environment
- increased regulatory scrutiny, intervention, and enforcement action
- damage to reputation and public trust

6. NEXT STEPS

During April, work will continue to populate the **Controls** and **Assurances** associated with the strategic risks:

- The mitigations that will be put in place to manage the risks
- The measures that will be used to demonstrate the effectiveness of those mitigations.

Controls and Assurances will be provided for each of the bullet points in the risks.

The fully populated BAF will be submitted for consideration at the April Board meeting.

The framework will then inform the forward plan and cycle of business for each Committee and will form the basis of the 2021/22 Statement of Internal Control and the Head of Internal Audit's Opinion.

Each Committee will be asked to provide initial, residual, and target risk scores.

7. RECOMMENDATIONS

The Board is asked to:

- **NOTE FOR ASSURANCE** the process that has been used to develop the Board Assurance Framework

- **APPROVE** the three Risk Appetites

- **APPROVE** the strategic risks

- **APPROVE** the assignment of strategic risks by Committee
- **NOTE FOR ASSURANCE** the next steps in the development process
- **RECEIVE** the fully populated BAF at the April Board meeting

APPENDIX ONE
Process to Develop the Board Assurance Framework

Board Development Day 22.02.21

- The Board reaffirms its role in the delivery of the strategy and the purpose of the BAF
- Facilitated by ANHH Consulting

Co-create new strategic risks with each committee

- ANHH Consulting meets Chair and Lead Executive of the People, Quality and Sustainability Committees
- Discussion at the March Committee meetings

ANHH documents & revises strategic risks by committee

- ANHH Consulting ensures consistency and read acrossall committees, reflecting 2020–2025 Strategy

Revised strategic risks submitted to March Board

- Company Secretary presents to Board the final draft strategic risks, and agree next steps for assurances and controls

Controls and Assurances finalized

- ANHH Consulting work with People, Quality and Sustainability Committees tofinalisecontrols and assurances
- ANHH Consulting finalisesdocumentation of BAF

BAF agreed at April Board

- Company Secretary presents the final BAF for Board sign off

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	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 a positive chan.