Operational Plan Document for 2014-16

Birmingham and Solihull Mental Health NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

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The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	SUE DAVIS

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	JOHN SHORT

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	SANDRA BETNEY

Signature

1.2 Executive Summary

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care to a local population of over a million spread over 172 square miles. We are one of the largest mental health foundation trusts in the country. We also provide specialist services for people who live further afield.

We have developed a balanced approach to our business planning consisting of four domains derived from our corporate strategy:

- People
- Quality
- Stakeholder
- Sustainability

Our operational plan captures the short and medium term challenges we face.

The **short term challenges** we face are very much similar to our peer group, these include :

- Increasing Demand

  Adult inpatient occupancy levels.
  Demand on specialist services such as Assertive Outreach as well as Community Mental Health services.

- Financial Challenge

  There is increasing pressure across the health economy to meet affordability gap which is estimated to reach £30b by 2020/21.
  Stretching cost improvement programme of 5% for the next 2 years.
  Transformational Service Integration programme as a key driver for change and cost improvement.

  NHS England's Moratorium on investments has impacted on our established business case assumptions for expansion of Womens' Medium Secure Service development and the Womens' Low secure service.

- External Environment/ Commissioner priorities

  Re-designing care pathways across traditional boundaries:

Quality plan

Our business plans place quality at the centre of everything we do underpinned by our corporate strategy to :

"Continuously improve quality by putting patients at the heart of everything the Trust does to deliver excellence. Measured by consistency of outcomes, clinical outcomes /effectiveness, Safety outcomes, and patient and carer experience".

We measure quality through high level goals across of experience and effectiveness and safety.

Experience and Effectiveness

•Our service users are always treated with dignity and respect

•We continuously use feedback to improve outcomes and experience

•There is no Care Plan about me without me, evidenced by Care Programme Approach

•Our services deliver equality of outcomes for diverse needs

Safety

•We provide service users with a safe environment of care

•We continuously learn from incidents and any recurring themes demonstrating improved patient safety

•We have a supportive culture, people raise concerns about poor quality or unsafe care, and we act on them

Our Integrated Quality Committee which has a clear programme of work which includes:

- Quarterly themed review of Serious incident recommendations
- Progress against the Trust Quality Strategy and updates against the Quality Governance framework
- Themes from external reviews and internal quality assessments
- Regular team to Board monitoring report
- Performance report and benchmarking reviews of services
- HR dashboard
- Key risks identified in Trust Risk registers

We have placed significant emphasis on learning from the Francis report, reflected through our Quality Governance processes by:

- •Increasing the visibility of Board members
- •Developing robust real time feedback systems from service users
- •Reinforcing requirements for incident reporting and raising concerns
- •Strengthening the reporting and review of complaints to the Trust Board
- •Communicating learning from serious incidents
- •Involving staff as part of the listening into action initiative

We have promoted open reporting:

- •A 'Dear John' system has been introduced to allow staff to raise any quality concerns directly to the Chief Executive.
- •A process for anonymised reporting of incidents has also been introduced

We are working on introducing defined minimum staffing levels for all its inpatient units.

Capacity requirements

We are expecting that our bed capacity to remain broadly static over the next two years with the exception of our business case for Womens' medium and low secure.

Bed Numbers	2013/14	2014/15	2015/16
Bed Numbers - Adult - (excluding High/Medium/Low Secure)	347	350	350
Bed Numbers - Adult - Medium Secure	211	217	217
Bed Numbers - Adult - Low Secure	14	30	30
Bed Numbers - CAMHS	26	26	26
Bed Numbers - Older People	116	116	116
Total Bed Numbers	714	739	739

To meet the operational capacity efficiency and productivity requirements the Trust is embarking on a major programme of re-design through a transformational Service Integration Programme.

This will help us to achieve improvements over the next two years by focusing on the areas that through a consultation process patients, carers and staff have told us will really make a difference to the quality of care we provide.

As of December 2013 our workforce was made up of 4,114 staff. Nearly 30% of staff are over the age of 50. We recognise the need to attract applications from a younger age group and we will be looking to build on our past apprenticeship scheme with a particular focus on BME representation.

SIP transformation includes emergence of a flexible and reflective workforce. Further future changes to workforce include

- Corporate function review
- Commissioning/de-commissioning services
- In-patient bed review

Financial plan

To meet these challenges we have robust financial plans which are prepared on a consolidated basis, including the wholly owned subsidiary, Summerhill Supplies Limited, which is now fully operational, providing a fully managed service lease for the Tamarind forensic site and pharmacy dispensing services. We plan to generate small surplus in over the next two years.

	Annual Plan 2014/15 £000s	Annual Plan 2015/16 £000s
Healthcare Income	233,469	249,960
Other Income	14,668	14,718
Total Income	**248,136**	**264,678**
Pay Costs	(180,873)	(175,088)
Drug Costs	(7,697)	(7,629)
Clinical Supplies and Services	(90)	(90)
Other Costs (excl Dep'n)	(34,781)	(54,604)
PFI Specific Costs	(7,210)	(6,871)
EBITDA £'000	**17,485**	**20,396**
EBITDA Margin %	7.0%	7.7%
Capital Financing	**(15,219)**	**(16,161)**
Surplus / (Deficit) before impairment	**2,266**	**4,235**
Surplus / (Deficit) Margin %	0.9%	1.6%
Savings Target Assumed in year	**13,524**	**11,647**

Financial Sustainability

Our Continuity of Service ratings for the next two year period are shown below. The ratings remain at a score of 3 overall for each of the next two years. This is dependent on delivery of the surplus in each year, and the associated savings for each year in order to fully fund the capital programme. A detailed upside and downside risk evaluation against the financial assumptions has been undertaken and presented in our Operational plan.

	Forecast 2014/15	Forecast 2015/16
	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
Capital servicing (EBITDA for year to date / capital servicing costs)	2	2
Rounded average	**3**	**3**

Conclusion

Despite the challenges ahead outlined in detail in our Operational Plan we have assured ourselves that we have robust clinical, transformational and financial plans in place to continue delivering our goal of 'excellence in care' for our local population and continue to work toward our strategic purpose of 'Improving Mental Health and Well being' for our service users in a meaningful and sustainable manner.

1.3 Operational Plan

1.3.1 Operational Plan

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care a local population serving a culturally and socially-diverse population of over a million spread over 172 square miles. We are one of the largest mental health foundation trusts in the country. We also provide services for people who live further afield because of some of the specialised services we provide.

Our catchment population is ethnically diverse and 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 have four domains for our objectives to ensure that we have a balanced approach to business planning. Each of these has two themes; under which we have set high level goals. These have been translated by service into detailed business plan goals. The domains, themes and high level goals are shown below:

Domain: People

Theme: Leadership and Development

•We have the right management and clinical leadership capacity & capability

•We have highly visible leadership

Theme: Staffing

•We have the right number and diversity of staff to deliver services

•Our staff have the required skills

Domain: Quality

Theme: Experience and Effectiveness

•Our service users are always treated with dignity and respect

•We continuously use feedback to improve outcomes and experience

•There is no Care Plan about me without me, evidenced by Care Programme Approach

•Our services deliver equality of outcomes for diverse needs

Theme: Safety

•We provide service users with a safe environment of care

•We continuously learn from incidents and any recurring themes demonstrating improved patient safety

•We have a supportive culture, people raise concerns about poor quality or unsafe care, and we act on them

Domain: Stakeholder

Theme: Reputation

•Service users, carers and staff are happy to recommend us as a place to receive care and a place to work

Theme: Engagement

•We make the Trust a smaller place by excellent staff engagement ; you say we listen

•Services are responsive to and reflective of their local communities

Domain: Sustainability

Theme: Finance

•Services are self-sustainable; delivering full cost recovery & margin

•We save now to invest for our services in the future

Theme: Development

•Services are designed for optimum delivery & value for money

•We search continuously to identify new opportunities to develop services

Our business plans place quality at the heart of everything we do, see our quality goals. Business plan performance is reviewed by service area quarterly and these reviews and performance against a balance scorecard is reported to Trust Board.

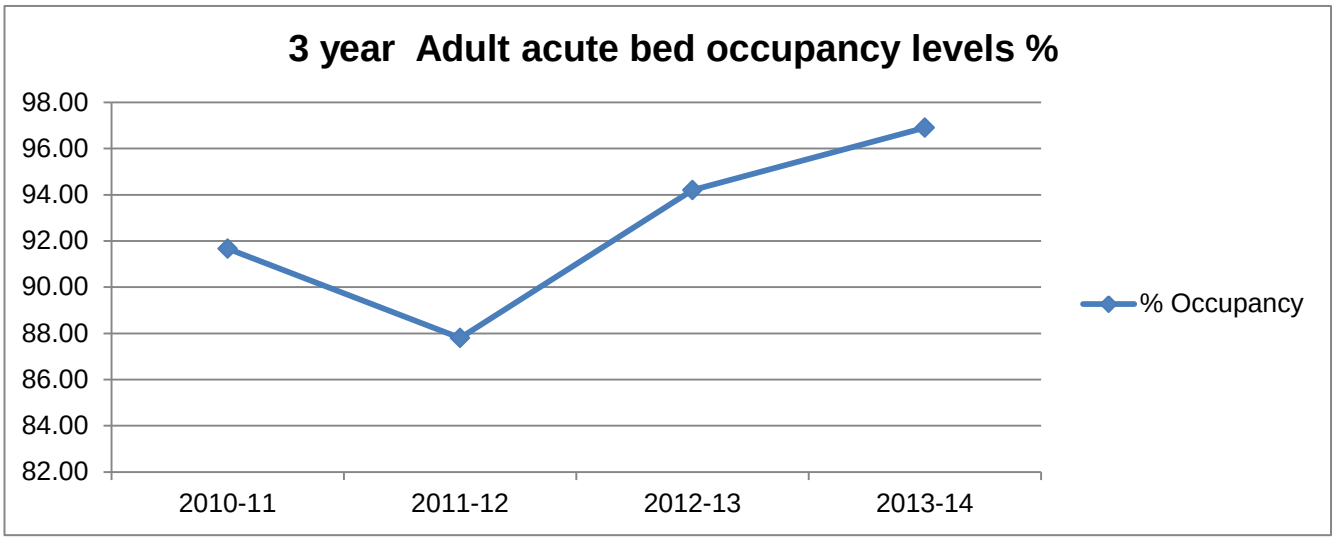
1.3.2 Short term challenges

The short term challenges that we face reflect similar challenges with our peer Trusts nationally[1]. These include:

Increased Demand

We have seen unprecedented demand for services, especially adult acute mental health inpatient services. Our occupancy levels have been near 97% in year and averaged over 90% the last three years. This trend is in line with that reported nationally. Our local CCG commissioners are increasing their activity and expenditure for out of area placements. Couples with this increase overall demand, the activity of the inpatients admitted appears to be increasing if measured by the use of the Mental Health Act.

Graph1: Acute Bed Occupancy levels



1. McNicholl, A. Community Care. October 2013. “NHS has shut more than 1,700 beds in two years”

Whilst there is specific focus is on adult acute inpatients bed shortage there is also an underlying increase in the caseload for community care. We experience demand on specialist services such as Assertive Outreach as well as Community Mental Health services.

Meeting the national IAPT target of 15% numbers in treatment for Birmingham by 31st March 2015 will be a shared challenge with local commissioners. Achieving such targets in a complex inner city like Birmingham was highlighted in the recently published “Closing the Gap" 2014. We continue to highlight the divergence between achieving numbers in treatment with the aspirational target of 50% moving to recovery target.

Financial challenge

There is increasing pressure across the health economy to meet affordability gap. Nationally NHS struggles to meet the £20billion challenge at the end of the 2015 it is forecast that future year the net efficiency requirements are going to increase across the health economy. NHS England’s 5 year business plan, Putting patients first, predicts there will be a £30billion funding gap by 2020/21.

We have set ourselves a stretching cost improvement programme of 5% for the next 2 years. We have invested in developing a dedicated programme management office to oversee the delivery of CIPs within a robust governance framework.

Fundamental changes in the way we deliver services will be required to meet the financial challenge. We have a wide-ranging transformational Service Integration programme as a key driver for change and cost improvement, see section 1.3.4.

NHS England’s moratorium on service development is challenging especially where our business cases were based on their predecessor’s strategy of providing treatment close to home. This includes the business case assumptions for expansion of Womens’ Medium Secure Service development and

Womens' Low secure service.

NHS England's financial position has impacted on Medium Secure Forensic Outreach. We are in discussions with commissioners regarding derogation from the draft national service specification due to funding constraints. We have included the reduced funding and consequently reduced expenditure in our financial model. This means a significant transition project for forensic medium secure services in 14/15.

Birmingham City Council White Paper

Budget cuts planned at £840m over next 7 years, within Birmingham City Council will have an impact particularly in relation to delayed discharges and bed blocking due to inadequate follow on social care provision. As a direct result of rationalising the social worker workforce within Birmingham the local council initially planned to withdraw social workers from our assertive outreach services. After highlighting the clinical risk through clinical quality equality impact assessment shared with commissioners we have secured recurrent funding for these integral posts.

External Environment

There are a number of commissioner plans that will impact in the short term. Those highlighted already include:

- NHS England Moratorium
- IAPT- Challenge to meet targets and expand services with limited if any investments

Commissioners are re-designing care pathways across traditional boundaries in an attempt to release wider health economy efficiencies. This involves large scale competitive tendering processes which absorb significant corporate and clinical resource and create significant uncertainty for staff and service users. Conversely they provide an opportunity for us to grow and develop further partnerships.

- Better Care Fund.

  We share a commitment to develop a viable health and social care system which more appropriately responds to the needs of individuals who are vulnerable.

  The programmes focus upon an aspiration to maximise the opportunities for providing quality care including mental health in a variety of community based settings, with a focus on preventative and proactive care, only admitting to a hospital bed when it is the right thing to do so. This means avoiding non qualified admissions and discharging people from acute care at the optimum time into more appropriate alternatives.

  We are a member of both Birmingham Integration Partnership Board and Integrated Care and Support Solihull, therefore influential in developing the delivery plans. As an organisation we are supportive of these plans and they are in line with our own strategy. However we are clear that we continue to have a duty to respond to the need that presents to us and our own plans reflect this mitigation.

- There has been national focus on the quality of service provision across the NHS following the Francis, Winterbourne View and Berwick reviews. During 2013, we commissioned an external review of our quality governance assurance framework by KPMG to inform our 3 year quality strategy. Our response to the national reviews is outlined below and in Appendix C.

- We have confirmed to commissioners that we meet the standards for mental health on 7 day working through our RAID service. We support the national commitment to seven day working review outlined in “Everyone counts: Planning for Patients”.

- From April 2014, adults with mental health will be given the right to choose which provider and consultant or mental health professional will be in charge of their care when they attend their first outpatient appointment.

- Nationally Mental Health is more frequently referenced than in previous years for example in 7 day working but guidance to commissioners (and providers) is often less specific and rarely funded as was seen in the assumptions made in relation to Francis recommendations in national tariff deflator. Against this national context we will continue to raise the profile of mental health to achieve parity of esteem both in mental healthcare provision and in parity of physical health outcomes for those with mental health issues. We are working hard to ensure that mental health has parity of esteem both locally, for example in Better Care, and nationally, for example in discussions about the contribution of mental health services to urgent care capacity as evidenced by our RAID service.

Our Estate

We have reviewed our estate for its ability to support the delivery of safe, consistent care. We have produced a draft estates strategy for the period 2014-19.

A key objective of the revised strategy is to support the re-design of services and the development of new ways of working.

Emerging priorities to be addressed are:

- Relocation of three standalone inpatient units.
- A development which will allow services to be relocated from a site unsuitable for mental health provision
- Development to address shortfalls associated with two inpatient units
- Development of two new Community Hubs
- New ways of working for IAPT services workers

1.3.3 Quality plans

National/local commissioning priorities

The local commissioner strategy Better Mental Health for Birmingham: An overarching strategic direction for Mental Health Services for adults 2011-2016 was published which set out the strategic aims for the City.

These include the following key strategic objectives derived from the mental health strategy, No Health Without Mental Health (2012) and the Trust responses are outlined below.

Table 1. Better Mental Health for Birmingham 2011-2016 key objectives and local response

Strategic Objective	Commissioner's local objective	Trust strategic programme response
More people will have good mental health	Improved working across statutory providers	Service Integration Programme, RAID, IAPT
More people with mental health will recover	Redesign of CMHT/IAPT and PD services	Service Integration Programme, IAPT
More people with mental health will have good physical health	Expansion of IAPT including long term conditions and further development of mental health liaison in hospital	Physical health strategy, RAID
More people will have a positive experience of care and support	Increase choice of care at home, prevent avoidable inpatient stays, use of personal health budgets	Service Integration Programme .RAID, Participate in commissioner panel for non- acute inpatients
Fewer people will suffer avoidable harm	Fewer hospital admissions as a result of self-harm	Service Integration Programme , RAID, Time to change

The recent publication of Closing the Gap: priorities for essential change in mental health, builds on the mental health strategy, No Health Without Mental Health (2012) and provides 25 key priorities.

See Appendix A for local Joint Commissioning response the priorities defined in the publication.

Everyone counts: planning for patients 2014/15 to 2018/19 details NHS England's key expectations for commissioners:

The national priorities for mental health include**:**

- 7 day working
- Introduction of FFT for Mental Health provider
- Improvement against the NHS Safety Thermometer, particularly pressure sores;
- Improving diagnosis in mental health – providers will be rewarded for better assessing and treating the mental and physical needs of their service users.
- More integration with social care – cooperation with Local Authorities on Better Care Fund planning, see above.

Key challenges faced by local commissioners over and above that already set out include:

•Capacity management.

A shortage of appropriate adult inpatient mental health beds nationally. This is reflected locally with the increase in number of out of area placements due to lack of local capacity within the city for patients with complex mental health needs. The commissioner is reviewing of use of beds, length of stay and discharge arrangement across the local health economy.

•Primary Care and Community Mental Health Services

Commissioners plan to consider how service delivery can be restructured to maximise mental health wellbeing at the primary care level. A primary care hub pilot and a review of IAPT service provision. Plans will be complete in 2014 with re-designed services starting June 2015.

•ADHD

There is recognition that the service has capacity issues due to increased demand.

•Older Adults

The Dementia Strategy for Birmingham and Solihull 2013-16, 'Give me something to Believe in' is now undergoing formal consultation prior to launch in May 2014. Focusing on community support to reduce admissions to acute hospitals and premature entry to care homes. Subject to the Better Care Fund applications, this portfolio will be form part of the integration programme.

Quality goals

Our quality goals, developed through the business planning process , are underpinned by our corporate strategy to :

Quality

Safety

Q5. We provide service users with a safe environment of care

"Service Manager to link with corporate Estates Department to discuss and outline key requirements for a building for the Specialist Psychotherapies Service (SPS) by 30.6.2014 and make arrangements for SPS to be allocated an appropriate building fit for purpose within period February 2014 – December 2014"

Solihull and Youth

Q6. We continuously learn from incidents and any recurring themes demonstrating improved patient safety

"Develop and extend guidelines for managing inpatient clinical risk including new strategies 1) flexible observations 2) use of seclusion as required. Manual and trainings strategy to be agreed at local governance and built in to training programme"

Secure, Specialties and Health Offender

Q7. We have a supportive culture, people raise concerns about poor quality or unsafe care, and we act on them

"Feedback and learning derived from concerns raised by staff from the service area (via LiA, Dear John etc.) will be shared in the IQ meetings on a quarterly basis, along with any specific actions implemented"

Central South and MHSOP

The above shows some examples of quality goals, see Appendix D for the full list of quality goals

Outline of existing quality concerns and solutions

Quality concerns have been identified through**:**

- Quality Support Team – A peer review process against a range of Trust standards.
- CQC Mental Health act visit – undertaken by individual inpatient service and also around particular themes.
- Deanery visits
- Integrated Quality Committee

Quality support team visits over the year have highlighted the top areas of concerns from individual services as follows:

Top Areas of quality concern

10 Standards with the Lowest Levels of Compliance by Percentage	
Annual Physical health assessment take place for those open to services more than 12 months. #	43.2%
Evidence of how the manager records that all new staff (including Bank Staff) complete local Induction	41.5%
Evidence that environmental risk assessment is up to date and valid	38.8%
There is evidence in the Integrated Care Record that the nature, purpose and likely effects of the medication has been explained to the patient #	33.3%
The team ensures that nutritional assessments are routinely carried out #	31.9%
The team ensures that care plans are regularly reviewed and updated with the involvement of service users #	30.2%
Copy of the Assessment of Capacity to Consent to Treatment Form 2 is Attached to the T2 or T3	27.6%
Evidence that the team ensures service users receive copies of their care plan, rights and choices available #	26.3%
The team ensures MDT input into all care plans #	26.3%

Actions from these visits are addressed through local action plans and reviewed by our compliance department. We use further visits to ensure improvements have been made.

Those concerns identified with a (#) reflect areas which are a priority for improvement, in relation to care planning and Care Programme Approach, our main Quality Account and Business Plan goal**.**

CQC Mental Health Act visits identified

- Assessing Capacity and s58 practices (prescriptions and administrations are legal)

  Action: This has been of concern over a number of years, we have achieved significant improvement in ensuring that appropriate local practices are followed. A quarterly audit is undertaken led by our Lead Nurses ensures any errors are identified and addressed.

- Care Plans

  Action: The CQC have identified in their reports examples of high quality practice, however this has not always been consistent across all services. The CPA working group and quality audit of care records is driving improvement.

- S17, this is low risk issue, e.g. old forms not scored through and low staffing levels impacting on leave.

  Action: This has been addressed through lead clinical staff to ensure awareness of best practice.

In addition CQC Themed Review into Seclusion and Long Term Segregation highlighted:

- Different terms for practices which may include seclusion, such as seclusion; de-escalation and extra-care.
- Patient involvement prior to, during and after episodes of seclusion
- Compliance with the Code for patients who are in seclusion who wish to contact their legal representative
- Ensuring that records clearly demonstrate the justification for continued seclusion

In response we have updated the seclusion policy and training to address the areas.

A peer review visit from the Deanery raised a concern that trainee doctors did not always feel full involved in local Clinical Governance activities. As a result a range of actions have been taken to address this which include:

- Ensuring attendance by a junior doctor to local clinical governance committees**.**
- Receiving a feedback report from junior doctors to our clinical governance committee.
- Improving co-ordination of our clinical audit programme to ensure that trainee doctors receive better feedback from audit activity.
- Improvements at induction at raising clinical governance activities such as incident reporting and clinical audit.

The Integrated Quality Committee highlighted an increase in the number of serious incidents reported

(50% over past two years). These are closely monitored and reflect national trends in relation to unexpected deaths.

Our reporting to Integrated Quality Committee also included information governance breaches.

Risk of non-compliance with information governance arrangements leading to significant patient identifiable data loss reflected by the number of incidents reported to the Information Commissioner. We have invited an audit from the Information Commissioner in April 2014.

Actions include the following:

- Introduced email 'gate' software for emails leaving the organisation
- Local IG training for 'high risk' departments
- Posters and computer standby awareness campaign
- Reminder in Monthly newsletter Update of information governance policies

Key quality risks inherent in plan:

Table 3: Key risks inherent in quality plan

Inherent Risks	Mitigation
Staffing recruitment to vacancies and provision of temporary cover	Staffing review and development of robust HR monitoring dashboard.
Variability of service standards	Improvements to service monitoring eg development of a 'my clinical dashboard' Quality support team visits to identify potential areas of significant deficit.
Overall co-ordination of care management processes has been identified as a key risk and the Trust has reviewed and revised processes to strengthen our approach and how this is monitored	Care management project group to oversee improvement. Quality audit programme to review all areas. Routine feedback to local service areas.
Ensuring compliance with CQC regulations, particularly in relation to safeguarding arrangements	Quality support team visits to identify potential areas of significant deficit. Policy compliance.
The risk of major service reconfiguration due to commissioning intentions and challenges to continue to provide competitive and high quality services	Close working with commissioners and other health and social care partners.
Reputational/ media risks arising from greater openness and transparency.	Increased understanding of issues identified
Impact of wider health / social care economy on Trust services – particularly in relation to social care support.	Close working with other health / social care partners.

Overview of how our board derives assurances on the quality of its services

Our Board established an Integrated Quality Committee which provides assurance to the Board on the effectiveness of quality and safety across all services. The committee has a clear programme of work including the following reports:

- Quarterly themed review of Serious incident recommendations.
- Progress against the Trust Quality Strategy and Quality Governance Assurance Framework.
- Themes from external reviews and internal quality assessments.
- Regular team to Board monitoring report
- Performance report, service profile and benchmarking reviews of services
- HR dashboard
- Key risks identified in Trust Risk registers

Each service area has a monthly Service Area Integrated Quality Committee chaired by their Clinical Director, to support and co-ordinate effective clinical governance arrangements and to demonstrate high standards and a commitment to service improvement.

Improvements in quality are overseen by the Integrated Quality Committee through the Operational Clinical Governance structure.

The role of the Clinical Governance Sub-committee which reports to the Integrated Quality Committee and is jointly chaired by the Medical and Nursing Directors includes:

- A systematic and co-ordinated approach to the provision of good quality clinical care
- Continuous improvement of clinical services
- Assessment and management of patient safety and risks

The Clinical Governance committee has nine subcommittees that report quarterly against defined work programmes.
The Audit committee reviews the effectiveness of our systems of integrated governance, risk management and internal control.

The Mental Health Legislation committee ensures we meet the requirements of all relevant mental health legislation.

The Board monitors quality at each meeting including Quality Goals, Quality account priorities and serious incidents. A service user and carer experience report reviews complaints received, trends in issues identified and learning the report also includes feedback and data from our Real Time feedback monitoring system which monitors service user and carer views across the organisation

The Trust has continued to apply Monitor's Quality Governance Assurance Framework which contributed to the development and implementation of the Trust's Quality Strategy.

In order to further support progress, in February 2013 we commissioned a review of compliance against Monitor's Quality Governance Framework using a limited version of standard methodology adopted for aspirant Foundation Trusts. The review was commissioned for internal purposes to enable continuous improvement to services and embed quality. A further review conducted by in July 2013 identified a significant improvement and reduced the score to 6. The report reinforced actions being undertaken to move towards a score below 4, the expected standard for aspirant Trusts.

Progress on this work is reviewed through the Integrated Quality Committee and reported to Trust Board.

In response to the Francis report we have promoted open reporting across the Trust and ensure that Trust Board members regularly visit service areas to get direct feedback from staff and service users.

•A 'Dear John' system has been introduced to allow staff to raise any quality concerns directly to the Chief Executive.
•A process for anonymised reporting of incidents has also been introduced.

What the quality plans means for our workforce

Our Quality Plan provides a clear focus and ensures that work is supported which leads to improvements in patient experience. This also improves staff satisfaction. Ultimately quality improvements leads to a positive cycle of improvement which includes:

- Greater sharing of expertise
- Improved scope for development and wider learning
- Improved reputation and opportunities for service development

We are proud to deliver services that meet our diverse communities. Our community engagement team are working with the national Time to Change project to tackle stigma. We recognise the importance to patient access and care that our staff to be reflective of our community we have developed the following objective in our business plan "We have the right number and diversity of staff to deliver services". We aim to deliver national and international leadership in this area.

Our staff survey results tell us that staff feel satisfied with the quality of patient care they are able to deliver and overall staff engagement. Areas to improve on include; bullying and harassment from patients, relatives or the public; physical violence from other staff and discrimination at work. We will develop meaningful action plans aims to address these concerns.

The Listening into Action (LiA) events provided a forum for open discussion and feedback. In total over 400 staff participated and 12 teams completed implementation. As a result we are now a LiA Beacon programme for 2014/15.

We value research and innovation as a driver for up clinical effectiveness. We have a national and international reputation for its research, enjoying strong academic links with the universities of Birmingham and Warwick, and hosting the Heart of England Mental Health Research Network Hub. Other examples of innovation include our pilot Street triage service with West Midlands Police and Ambulance Service; nationally recognised Rapid Assessment, Interface and Discharge in our local hospitals and suicide prevention pilots with British Transport police.

Trusts responses to Francis, Berwick and Keogh

We have placed significant emphasis on learning from the Francis report, reflected through our Quality Governance processes.

Our Board has sought to ensure recommendations were not used as a 'tick box' but that the Board effectively embraces the themes and challenges which the report identifies. In August 2013, the Board received and reviewed an assurance summary against the key recommendations of the following reports:

Francis Inquiry: report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013).
Berwick report': Improving the Safety of Patients in England (Aug 2013)
Keogh report: Review into the quality of care and treatment provided by 14 hospital trusts in England: (July 2013)

Following discussion by the Trust Board the assurance summary has been further updated in December 2013 and also reviewed against the Government response to the Francis report ('Hard Trusts').

The Trust has taken significant steps over the past year to tackle the themes of the Francis report. These include:

- Increasing the visibility of Board members
- Developing robust real time feedback systems from service users
- Reinforcing requirements for incident reporting and raising concerns
- Strengthening the reporting and review of complaints to the Trust Board
- Communicating learning from serious incidents
- Involving staff as part of the listening into action initiative

We are working on introducing defined minimum staffing levels for all its inpatient units.

The key risks identified relate to:

- Ensuring the provision of adequate levels of staffing to maintain a safe service
- Failure to address identified variations of quality across services.
- Failure to adequately learn from feedback and incident lessons
- Poor data quality leads to not addressing issues in a prompt way.

Further detail can be found in Appendix C.

• Risks of the plan

The risks associate with delivering our strategic ambitions is outlined below.

STRATEGIC AMBITION: Continuously improving quality by putting patients at the heart of everything the Trust does to deliver excellence. This will be measured by; Consistency of outcomes Clinical outcomes & effectiveness Safety outcomes Patient and carer experience

Risk of Non compliance	• CQC Non compliance • Trust reputation (eg Patient Survey) • Loss of contracts • Failure to win new business • Lack of acute inpatient beds, leading to riskier management in community or out of area placement	• Failure to comply with Monitor Quality Governance framework • Increase in litigation costs / complaints / non valued adding activity • Failure to deliver CPA requirements
Key Controls	• CPA action group (E) • PMO – Transformation process (A, H(part)) • Identifying minimum staffing	• Eclipse incident reporting (monitoring) (G) • Associate Director of Recovery (F)

	levels	
Committee review	• Integrated Quality Committee • Programme Management Board (Quality Impact of major projects)	• Learning against SI recommendations
Positive assurance	• Improvements recorded in patient survey • Board Quality Reports • ICR (Completeness audit results) • Daily review of bed state • Audit on staffing levels	• Incident reporting levels (NRLS benchmarking) • Review of Quality Goals in Business Plan/ Balanced Scorecard • Progress on Quality Strategy reported to IQC

STRATEGIC AMBITION: Achieve long-term financial stability by: Being top quartile for productivity. Consolidation and protection of current business. Growth by acquisition or merger FRR of 4, discipline and rigour

Risk of Non compliance	• Increased focus on finance detracts from focus on Quality • Short term savings required to bring financial balance back • Long term viability threatened by decreasing margins • Reduced Monitor risk rating leads to increased regulatory activity	• Rising cost pressures, e.g. dementia drugs • Inability to maintain bed occupancy • Reduction in education and training monies • Inaccurate data
Key Controls	• Business Development	• Project Management of savings plans
Committee review	• Planning and Development Committee • Integrated Quality Committee • Programme Management Board	
Positive assurance	• Current Surplus • Savings plans for future years • Finance report (October)	

STRATEGIC AMBITION: 3. Develop strong, effective, credible, sustainable relationships with

key stakeholders, building the Trust's reputation

Risk of Non compliance	• Loss of contracts • Not becoming integral part of local health economy • Specific contracts at risk of non renewal or underperformance x 3	• Impact of changes to local commissioning groups
Key Controls	• Clinical Quality review group • Individual relationships	• Contract management structure
Committee review	• Integrated Quality and Primary Care Board	
Positive assurance	• GP Engagement • Customer Relationship Management Tool	

STRATEGIC AMBITION: To have a workforce that is innovative, empowered, engaged, fairly rewarded and motivated to deliver the strategic ambitions of the Trust. Evidenced in the staff survey feedback

Risk of Non compliance	• Failure to recruit adequately trained staff • Litigation • Risk of non compliance with CQC registration caused by insufficient staff	• Low staff morale • Disruption caused by immature operational structure
Key Controls	• E rostering • HR recruitment processes	
Committee review	• Integrated Quality Committee (Quarterly report)	
Positive assurance	• Staff survey results • Improved staff retention rates	• Pulse surveys • Workforce report

Operational requirements and capacity

Table 4: Activity, Team and Bed profile across next three years

		Actual for	**Plan for**	**Plan for**

Activity summary	Currency measure	Year ending 31-Mar-14	Year ending 31-Mar-1	Year ending 31 Mar-16
Activity – Mental Health				
Adult - (excluding High/Medium/Low Secure)	OBDs	122,394	123,497	123,497
Adult - Medium Secure	OBDs	64,355	66,434	66,434
Adult - Low Secure	OBDs	4,896	10,413	10,413
CAMHS	OBDs	6,946	6,946	6,946
Older People	OBDs	41,722	41,260	41,260
Other A	Adult Contacts/attend ances	1,082,864	1,082,864	1,082,864
Other B	Older Adult contacts/attenda nces	166,830	166,830	166,830
Resources – Mental Health				
Early intervention teams	Teams	10	10	10
Crisis resolution teams	Teams	6	6	6
Assertive Outreach Teams	Teams	6	6	6
Wards/ treatment areas	Wards	51	52	52
No. of closed wards/ treatment areas	Wards	0	0	0
Hospitals/Sites owned or on PFI leases	Sites	58	58	58
Hospitals/Sites at which care given	Sites	74	74	74
Bed numbers				
Bed Numbers - Adult - (excluding High/Medium/Low Secure)	Beds	347	350	350
Bed Numbers - Adult - High Secure	Beds	0		
Bed Numbers - Adult - Medium Secure	Beds	211	217	217
Bed Numbers - Adult - Low Secure	Beds	14	30	30
Bed Numbers - CAMHS	Beds	26	26	26
Bed Numbers - Older People	Beds	116	116	116
No. of closed beds	Beds	0	0	0
Total Bed numbers	Beds	714	739	739

Physical Capacity

To meet our operational capacity efficiency and productivity requirements and in order to improve the quality of the service provided we are embarking on a major programme of re-design through a transformational Service Integration Programme.

This will help us to focus on the areas that through consultation patients, carers and staff have told us

will really make a difference to the quality of care we provide:

- Improving patient access to care.
- Improving patients' local access to care services and care closer to home.
- Increasing face-to-face contact time with patients.
- Patients reaching the right person at the right time.
- Patients having increased evidence based intervention and recovery focussed care.
- Patients having improved transition between services and out of services.
- Increasing support for patients from carers, families, friends, referrers and other organisations.

Work-streams are :

- Single Point of Access and out of hours crisis line
- Mobile working
- Increasing face to face contact time
- Team bases and satellite clinics- South, East and Central
- Team bases and satellite clinics- North, East and West
- Workforce realignment including flexible working for staff/increased access to services for
- patients
- Primary care liaison, discharge and rapid re-access

The deliverables for each project are summarised in Appendix B for detail.

Outcomes and benefits

Outputs, outcomes and benefits for patients reflected in the business plan detail SMART objectives.

Monitoring of the benefits will include :

- standard data monitoring in relation to defined metrics around effectiveness,
- satisfaction questionnaires for patients, carers, staff and referrers
- the use of patient stories

We use benefits mapping to understand the difference to the service before and after improvements have been implemented. The outcomes and benefits expected are:

Increased	**Reduced**	**Improved**
Patient, carer and referrer satisfaction	Administrative burden	Discharge plans, support and access back to services
Staff satisfaction with role clarity	Average journey length/times	Quality of referrals
Patients seen outside team base	Number of people referred to wrong team	Discharge processes
Patient seen quickly	Number of patients seen for more than three months	Access to evidence based interventions and recovery enabling support

Patient face to face contact		
People discharged who do not need support from specialist secondary care		

Workforce Capacity

Table 5: Workforce Age profile in 2013

Age Range	Headcount 2013	%Headcount 2103	2012 % Headcount
<20	3	0.1%	0.1%
20-29	588	14.3%	13.1%
30-39	1,058	25.7%	25.0%
40-49	1,266	30.8%	32.7%
50-59	978	23.8%	23.6%
60-64	173	4.2%	4.5%
>65	48	1.2%	1.0%
Grand Total	**4,114**	**100.0%**	**100.0%**

In December 2013 our workforce was made up of 4,114 staff, last year 3,989 an increase of 125 staff. The majority of staff are between 40 to 49, however there were increases in the 20 to 29 and 30 to 39 years categories. We recognise the need to attract applications from a younger age group and we are building on our past apprenticeship scheme with a focus on BME representation.

In the next 2 years our workforce will be re-modelled to meet the requirements of the SIP. These are:

- Increased skill mix to enable people with the higher level skill sets to complete most complex tasks and people with lower level skills sets to complete less complex tasks.
- Occupational Therapists no longer care coordinating but concentrating on providing occupational interventions to enable patients to move towards recovery and discharge from secondary care services.
- Reduced administration staff.
- Clarity of role through job plans for all clinicians.
- Flexible working hours for staff e.g. 10-6pm and extended opening hours for patients

Corporate review

Our plan is to deliver productivity gains across the corporate function. This will take the form of reviewing back office processes to determine most effective way of supporting operational services.

Commissioned/Decommissioned services

Our planning assumptions assume that we will broadly retain the same staffing levels in existing

Beds - Inpatient review

We have commissioned Internal Audit to undertake a review of inpatient bed capacity. The three main outcomes of the report are:

- Benchmarking data sets
  A series of data indicators to be developed to benchmark internal team performance such as admission, length of stay, discharge and delay transfer of care.
- Local Health Economy shortage
  An estimated 45 additional beds will be required to meet the current shortage of mental health inpatient beds. Work with commissioners to develop an invest to save scheme to meet this demand.
- Community alternative to inpatient beds
  An alternative to inpatient admission alternatives such as step down community beds an urgent care centres for mental health to be developed.

We are in early discussions with CCGs regarding bed capacity; there is a possibility of further investment to facilitate care closer to home. However because this expenditure is currently in commissioners out of area assumptions we have not modelled in our financial assumptions.

Key Risks

Increase in demand

Whilst there is demand increase in inpatient beds usage, this demand will need to be managed by commissioners. It will not have a direct impact on our services unless commissioner is willing to invest in additional bed capacity.

Our key risk is the projected demand in community services. We have outlined above that our SIP programme is designed to meet this demand through more productive ways of working described above.

1.3.5 Productivity, efficiency and CIPs

The CIP table below shows the planned schemes for 2014/15 and 2015/16, along with a RAG rating for the expected level of risk associated with the scheme is shown in Appendix E

Included in the Trust's CIP are schemes which relate to income generation and increased Trust surplus. These have been categorised and included in the table below.

Project Type	Savings included in Budget 2014/15 £	Risk £	Savings included in Budget 2015/16 £	Risk £
Cost Reduction - Identified schemes	8,855,422	978,398	5,788,529	1,678,208
Cost Reduction - Unidentified schemes	3,227,000	1,613,500	5,411,471	2,705,735
Revenue Generation - Certain	286,841		147,000	29,400
Revenue Generation - Identified	858,500	227,125	-	
Revenue Generation - Unidentified	300,000		300,000	150,000
Total	**13,527,763**	**2,819,023**	**11,647,000**	**4,563,343**

The CIP plan had originally been developed to deliver savings totalling £11m for 2014/15, however in order to fund the capital programme, savings for 2013/14 that have not been delivered, and income for some specialty services has decreased, the value of the savings requirement has increased. A breakdown of the savings requirement is shown below.

	2014/15 £m	2015/16 £m
CRES at 4%	8.78	8.25
Funded vs actual inflation	(1.11)	0.01
Cost Pressures	1.69	1.00
Strategic Investments	1.13	0.50
Income Reduction (net of cost savings)	1.71	0.00
Unachieved prior year savings	1.94	0.00
	14.14	9.75
Change in SSL profit	0.00	(0.08)
Surplus increase / (reduction)	(0.60)	1.97
	13.54	11.64

1.3.6 Supporting financial information

Revenue Plans

The financial plans are prepared on a consolidated basis, including the wholly owned subsidiary, Summerhill Supplies Limited, which is now fully operational, providing a fully managed service lease for the Tamarind forensic site and pharmacy dispensing services.

The plan for 2013/14 was a surplus of £1.5m. However, excluding non recurrent items such as impairment, reductions in income that have been assumed non recurrent and exit costs, the recurrent surplus is £4m.

The table below shows the summary Income and Expenditure budget for the next 2 year period.

	Annual Plan 2014/15 £000s	**Annual Plan 2015/16 £000s**
Healthcare Income	233,469	249,960
Other Income	14,668	14,718
Total Income	**248,136**	**264,678**
Pay Costs	(180,873)	(175,088)
Drug Costs	(7,697)	(7,629)
Clinical Supplies and Services	(90)	(90)
Other Costs (excl Dep'n)	(34,781)	(54,604)
PFI Specific Costs	(7,210)	(6,871)
EBITDA £'000	**17,485**	**20,396**
EBITDA Margin %	7.0%	7.7%
Capital Financing	**(15,219)**	**(16,161)**
Surplus / (Deficit) before impairment	**2,266**	**4,235**
Surplus / (Deficit) Margin %	0.9%	1.6%
Savings Target Assumed in year	**13,524**	**11,647**

Healthcare Income

The key assumptions in arriving at the income budgets for 2014/15 to 2015/16 are as follows:

- It is assumed that a net deflator of 1.5% applies to all healthcare income contracts with the exception of the prison contract. The same assumption is applied for future years. The deflator assumes CRES of 4% and inflation of 2.5%.
- Birmingham CCG's and NHS England have agreed a 1.5% net deflator, and partially funds the acute inpatient staffing requirement.

- CQUINS is assumed at 2.5% of contract value The financial plan assumes that CQUIN will be achieved at 95%for all contracts.

Birmingham, Sandwell and Solihull CCG Contracts

The agreed 14/15 contract is mainly block, with the exception of NAIPS, neurological services and IAPT services which will be on a cost and volume basis.

Sandwell and West Birmingham contracts which were historically cost and volume have been included in the baseline contract on the same basis as Birmingham and Solihull.

NHS England

This contract covers all specialised services including forensic adult, FCAMHS, deaf, mother and baby, eating disorder and CAMHS.

The Tamarind forensic inpatients service has increased in contracted value to reflect the full year effect of opening the unit, and the offer of a blended price to include specialling. The Tamarind Forensic Outreach service was not commissioned during 2013/14 and negotiations with NHS England have resulted in an offer.

For deaf, mother and baby and eating disorders, commissioners have offered a contract for 14/15 based on activity in 13/14. This has resulted in an increase for mother and baby and a decrease for deaf services due to low occupancy early in the year.

Forensic CAMHS activity for 13/14 has been used as a baseline and again this is resulting in a reduction in the contract value due to low occupancy in year. Management has been actively promoting the service and from April will be responsible for the gatekeeper role, which, it is hoped, will result in an increase in occupancy.

The CAMHS service in Japonica has experienced some clinical safety issues in early 13/14, when it opened, so although the contract reflects a full year, it is reduced significantly to the number of beds which is considered safe.

Other income

Other income is generally assumed to continue in line with 2013/14 levels, with the exception of the inclusion of income relating to Wolverhampton addictions service FP10 drugs, this was not included in the budget for 13/14, but was a delivered service. The cost is equal to the income.

New developments for 2015/16 onwards

There are various tender opportunities identified or planned for at present.

Expenditure

. Key assumptions:

- The Government have announced a national pay award of either a 1% inflationary increase on 1st April or an increment point for those not at the top of the scale. Budgets include the cost of increments of £1.6m for eligible staff, and pay inflation of £0.9m for those staff at the top of grade.
- Non pay inflation – varying increases have been applied across spend categories according to

expected contractual increases or latest market information, see the table below.

	Inflation rate %
Drugs	2.1%
Clinical Supplies	2.2%
Electric	7.0%
Gas	10.0%
Water	8.0%
Rates	5.6%
Non Pay Other	2.2%
PFI	3.2%
Total	

- Cost pressures of £2.6m, including £1.6m on drugs, have been funded as part of budget setting with budget owners across the Trust. Of the £2.6m, £1m has been funded from existing contingency budget, thus reducing the amount available to provide flexibility in year.
- Capital charges – Depreciation charges are expected to reduce by £0.2m following a full valuation and estimation of expected useful lives of building assets. PDC is expected to reduce by £0.2m for 2014/15, but increase year on year due to the capital programme, particularly around improvements to the Estate. Both of these reductions will contribute to savings for 14/15.
- Non recurrent budget of £1m has been included for 14/15. Some recurring costs are funded from this budget on a one off basis in order to provide time for alternative plans to be developed to reduce costs.
- Contingency budget of £1.6m to allow for risks around delivery of savings or under recovery of healthcare income.
- A budget of £1m has been included for strategic investments, which will be subject to business cases and strict criteria regarding invest to save. This will contribute to contingency if required. For this reason, no strategic investments will be released until the mid year financial position has been assessed.
- A review of Inpatient staffing levels has been completed. It is expected that this will be part funded via a reduction in the tariff deflator from 1.8% to 1.5%, which has been agreed with Birmingham Commissioners.
- Plans to reduce costs across the Youth service area are being put in place to mitigate the loss of income on FCAMHS and Japonica.

Capital Programme and Funding

The capital programme is designed to deliver assets to support the Trust's service and operational plans, over the next five years. It is aligned to the Estates Strategy, and has been developed alongside the 6 Facet survey and ICT development programme.

The table above shows that the funding available has an excess of £1m overall it is anticipated that as business cases are developed for these schemes, some cost reductions or a small amount of slippage will enable the full programme to be delivered

There is minimal risk of funding the capital programme over 2014/15 to 2016/17. The main risk on the capital programme arises in 2017/18, when the expected cost of the projects exceeds the funding available in year, however, the reverse is true in 2018/19 when there is an excess of funding available and this means that the programme is affordable overall. The spend on this capital programme is reliant on the delivery of the surplus each year and crucially on the delivery of savings to meet on-

going CRES requirements.

The Trust's 5 year Capital Programme and associated funding is shown in the table below

	14/15	15/16	*16/17*	*17/18*	*18/19*	*Total 5 years*
	£m	£m	*£m*	*£m*	*£m*	*£m*
SSBM	2.50	2.00	*2.00*	*1.50*	*1.50*	*9.50*
Minor schemes	1.50	1.50	*0.50*	*0.50*	*2.00*	*6.00*
Major Projects	1.80	6.48	*10.60*	*8.47*	*2.50*	*29.85*
Estates Total	**5.80**	**9.98**	***13.10***	***10.47***	***6.00***	***45.35***
ICT Projects	0.75	0.90	*0.46*	*0.47*	*0.48*	*3.07*
ICT Replacement	1.82	1.87	*1.90*	*1.89*	*1.98*	*9.47*
ICT Total	**2.57**	**2.77**	***2.36***	***2.37***	***2.47***	***12.54***
Total Spend	**8.37**	**12.74**	***15.46***	***12.84***	***8.47***	***57.89***

	14/15	15/16	16/17	17/18	18/19	Total 5 years
	£m	£m	£m	£m	£m	£m
Depreciation	6.92	7.64	8.50	8.80	9.44	41.31
Less PFI / loan	(3.79)	(3.79)	(3.79)	(3.79)	(3.79)	(18.96)
Prior year surplus	3.19	2.27	4.24	3.70	4.02	17.42
Cash Balance	1.50	5.50	3.00	0.00	0.00	10.00
Receipts	0.63	0.50	5.20	0.00	1.75	8.08
TOTAL FUNDING	**8.44**	**12.11**	**17.15**	**8.71**	**11.43**	**57.84**

Major schemes

There are 5 major schemes planned for delivery over the next five years as follows

1. Re-provision of standalone inpatient sites.
2. Highcroft Centralisation
3. Solihull re-provision
4. IAPT new ways of working
5. Development of Highcroft Site

Minor Schemes

For 2014/15, an initial list of schemes totalled £4.5m and was not affordable within the constraints of the funding for the capital programme. This list was considered by Associate and Clinical Directors for prioritisation. Principles were agreed regarding prioritisation in the following order

1. Projects already underway or committed to in 13/14 – this totalled £0.7m
2. Clinical / Associate Directors priority projects to ensure immediate safety issues were addressed
3. Invest to Save projects, in line with the financial strategy

The final list of schemes totals £1.5m for 2014/15. Further detail will be available at the Board meeting.

For 2015/16, several factors were considered for priority

1. Compliance / further safety issues as yet not known - £0.2m was set aside for this
2. Sustainability / Invest to save schemes - £0.2m was set aside for potential schemes that have not yet been identified
3. Prioritise PFI buildings as it takes considerable planning and agreement with PFI providers to deliver changes to these buildings.

Statutory Standards and Backlog Maintenance

A 6 facet survey has been conducted on the Trust's estate during the year, helping to inform where spending should be prioritised. This has resulted in a list of 90 projects which will be the subject of a business case to ensure the projects contribute to the Estates Strategy and the Trusts' strategic and operational goals.

ICT Development

There are a number of projects within the ICT development programme, including EPMA prescribing, Model Ward, Wi-Fi for wards/ Bring your own device for service users and Central Care Records. The ICT Development Projects plan totals £0.75m for 2014/15 and the projects will help the Trust to deliver cost effective services.

ICT Replacement Programme

The ICT replacement programme predominantly relates to Equipment Refresh at £1m per annum, which will ensure that the current computer, network, server and telecoms infrastructure is replaced based on predefined refresh cycles for each area of infrastructure. The programme also includes an allocation of £0.5m each year to allow clinicians to become a more mobile workforce in line with the requirements of SIP. The remaining £0.3m of the programme relates to wireless infrastructure, data growth storage and RiO system upgrade and development.

Capital Programme Funding

Funding for the capital programme has been considered alongside development of the 5 year revenue plan, savings plan and balance sheet. Funding includes £10m of cash balances, depreciation and prior years' surplus balances, plus use of receipts for sale of land/buildings. Funding for the capital programme is reliant upon sale of the land/buildings as set out in the table below:

Liquidity

Our liquidity ratio score remains a 4 for the 2014/15 and 2015/16

Financial Sustainability

Continuity of Service Rating

The Continuity of Service ratings for the five year period are shown below. The ratings remain at a score of 3 overall for each of the five years. This is dependent on delivery of the surplus in each year, and the associated savings for each year in order to fully fund the capital programme.

	Forecast 2014/15	Forecast 2015/16
	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
Capital servicing (EBITDA for year to date / capital servicing costs)	2	2
Rounded average	**3**	**3**

Other financial KPI's

Calculations for EBITDA as a % of income and Surplus as a % of income are included in the I&E Summary of this report. They are an indicator of the Trust's ability to generate a surplus of income over expenditure, and how much of the EBITDA is used for capital financing.

Risks and Opportunities

Downside Risks

Income Risks

- Neuropsychiatry – This is currently funded from CCG contracts, however commissioners have stated that they wish to transfer the contract to NHS England in 2015/16. However, this is not agreed and could result in a change in the contract.
- Japonica – on-going issues with patient profile may result in under performance against planned activity.
- Region wide cost per case income is budgeted at £0.9m and operates across a variety of services. This is not commissioned, and could under perform dependent on demand.
- Ardenleigh Women's medium secure - The expansion of the Ardenleigh facility provides space for an additional 6 beds for the Women's Medium Secure service. Although we have a contract with an agreed price, Commissioners have not agreed to fund additional activity. The Board has agreed the unit should be fitted out.
- Ardenleigh Low Secure – Provision was originally planned for 20 low secure women's beds in this facility, however Commissioners have not agreed to fund the activity. The Board has agreed to fit out the wards so that we can act quickly should a contract be agreed. The risk is quantified in the CIP schedule.

  Income risks could total £0.8m

Expenditure Risks

Inflation Sensitivity Analysis the risk to expenditure budgets of variances in inflation compared to the budgeted assumptions. The very worst case scenario is that all expenditure inflation is under estimated, but in reality, this is likely to be a combination of over and under estimates. The worst case

scenario is a 1% increase across all budgets, which would amount to £0.5m, the most likely scenario is £0.1m.

Women's low secure – costs of £3.1m will arise should the service be commissioned. Some costs will not be avoidable, such as the running costs of the building which could amount to £0.1m. Staff will not be recruited to this service until there is a clear commissioning intention.

Additional VAT on Contracted Out Services due to a late notification by HMRC could increase costs to the Trust by £0.7m from 2014/15.

Expenditure risks in 2014/15 could total £0.9m

There is an expected increase in Employer's contribution to pensions of 0.3% in 2015/16. This could amount to £0.39m.

Expenditure risks for 2015/16 could total £1.0m

The NHS Employers briefing report also identifies a further potential risk. The introduction of the Single Tier State Pension in April 2016 will coincide with the end of contracting – out arrangements for salary related pension schemes. This change will result in the removal of the National Insurance rebate for both employees and employers. The impact if this is likely to be a rise in costs in excess of 2% of the pensionable payroll (approximately £2.7m).

Savings Risks

Savings risks are included in the table in the CIP section of this report. All schemes are being managed using project management methods, and there are programme governance arrangements through a Programme Management Board which reports through the Trust Committee and Board structure. Progress against plans is reviewed regularly and remedial actions taken to get schemes on track.

Revenue Generation CIPs are divided into three categories, certain, identified and unidentified. The certain schemes are new contracts and will be delivered. The identified schemes relate to capacity within women's secure services which has not been commissioned. Unidentified schemes relates to contracts which are in as a the process of being tendered or are expected to be tendered in 2014/15.

The risks on savings could amount to £2.8m for 2014/15 and £4.6m for 2015/16.

For 2014/15, the potential risks outlined above could total £4.5m. Mitigation would be to utilise the £1.6m contingency budget and the strategic development fund of £1m, which will not be committed before the half year point. Should all risks arise, vacancies could be frozen with the exception of agreed inpatient staffing in order to provide one off savings for the balance of £1.9m.

For 2015/16, total risks could amount to £5.7m in the worst case. This would be mitigated by use of £1m of strategic development fund, £1.6m of contingency budget and vacancies could be frozen with the exception of agreed inpatient staffing in order to provide one off savings for the balance of £1.6m. It is expected that the risk of £0.39m arising on pension contributions would be funded through the inflation calculation.

<u>Upside Risks</u>

Additional demand on the Attention Deficit Hyperactivity Disorder service is being assessed by commissioners, with a view to increasing funding as a one off to deal with an increasing caseload, and reduce the existing waiting list. In 2015/16, this service will be included in the Birmingham under 25's Community Mental Health Service.

There has been a bid by City Council, CCGs and all NHS Trusts to NHS England in February to the Better Care Fund. The value of the BCF pooled budget in 14/15 will be £24.7m rising to £82.3m in 15/16 although how much of this will be available to the Trust is not yet known.

We are exploring with CCG commissioners an increase in bed capacity. If plans are delivered this will have an upside that at this stage is not quantified.