NHS
Birmingham
Community Healthcare
NHS Foundation Trust

Annual Report

2020-21

Best Care
Healthy Communities

Birmingham Community Healthcare NHS Foundation Trust

Annual Report and Accounts 2020/21

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

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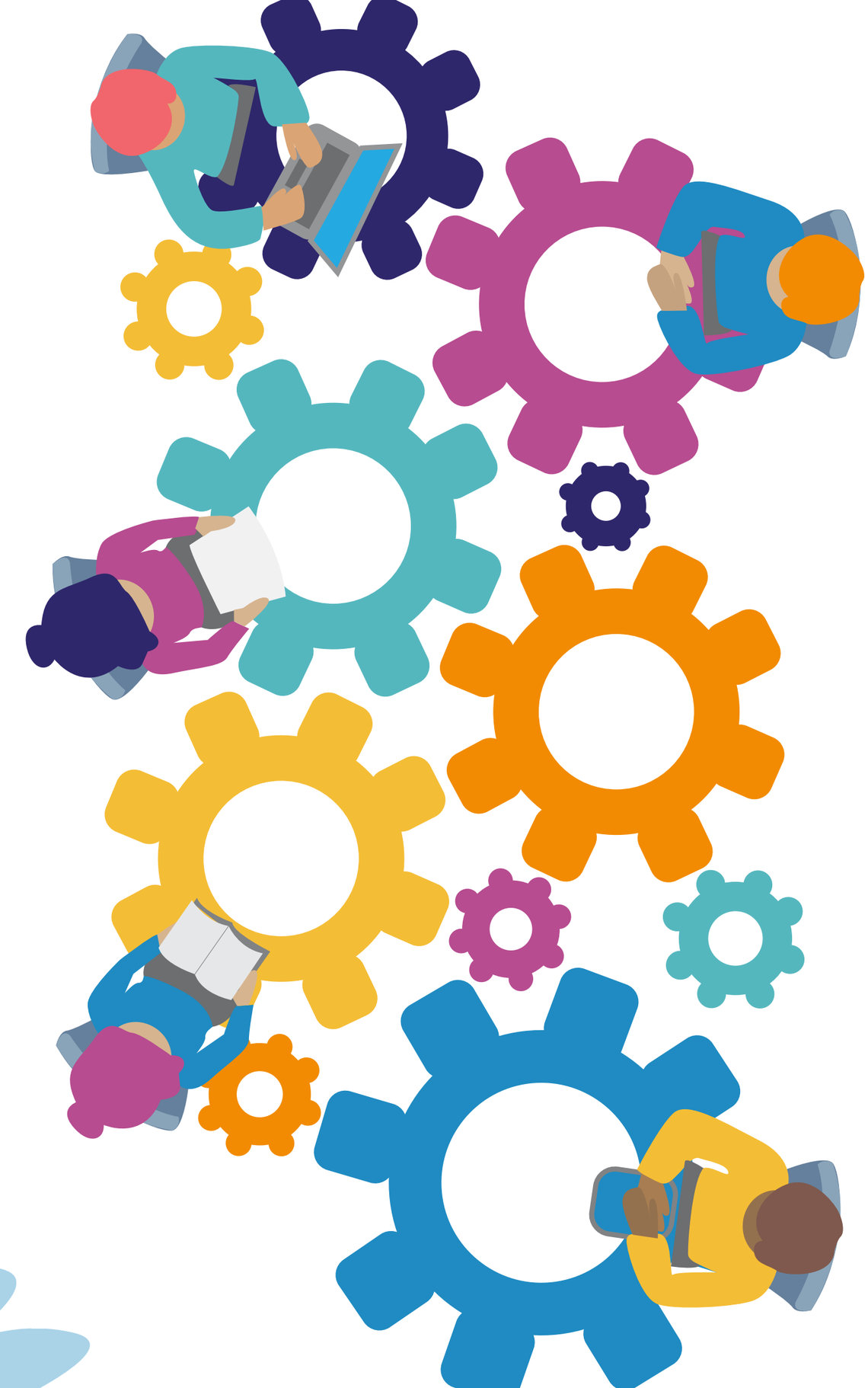
Content



Message from Dr Barry Henley, Trust Chair

Our Annual Report provides us the opportunity to present how our organisation has played its part in helping respond to the greatest public health crisis to face our society in living memory.

The commitment demonstrated by our colleagues in all parts of the health and social care sector - together with the wider community response - has been truly extraordinary, and should rightly be recognised and applauded. At the same time our thoughts are with all those who have lost loved ones - family, friends, colleagues - during the pandemic.

The Board of Birmingham Community Healthcare NHS Foundation Trust (BCHC) places on record its thanks and gratitude to all who have been involved in our response to COVID-19. Whether delivering care at the frontline or working in areas which support that activity, whether redeployed or required to work remotely, our colleagues have displayed outstanding compassion, incredible dedication, and great adaptability. My fellow directors and I are extremely proud of the Trust's response and of all those who have played a part. Colleagues have taken on so many new challenges - working in personal protective equipment (PPE) in unfamiliar settings; controlling outbreaks in hospitals and care homes; inventing new ways for families to keep in touch with their loved ones in hospital, and so much more.

"Our colleagues have displayed outstanding compassion, incredible dedication, and great adaptability"

Our thanks extend to all those in our partner organisations - NHS, local authority, third sector and private healthcare - with whom we have worked closely in what has been a true and effective integrated style, to cope with the crisis.

From great adversity we have certainly adapted many of the things we do, and have learned much that we can take forward with us. Increasing use of technology to improve the ways we operate and the deeper embedding of integrated working are two positive outcomes which we will seek to harness into the future.

"Increasing use of technology to improve the ways we operate and the deeper embedding of integrated working are two positive outcomes"

I hope that we can maintain innovations such as these as lasting improvement legacies from the challenges of this pandemic.

Alongside, we have been determined to keep focus on our core services and activity. Attention must now be on the continuing recovery of some of our services which were unavoidably disrupted and on working to reduce backlogs and waiting lists. In working to our vision of 'Best Care: Healthy Communities', we will continue to do all we can, together with our health and social care partners, to help our communities achieve strong recoveries and healthier futures.

Working together in partnership is vital to our chances of success at every level - in caring for those who need our services and in helping improve the health of our communities.

To this end I am proud of the way in which BCHC is playing its part within the wider health

"I am proud of the way in which BCHC is playing its part within the wider health and social care system"

and social care system, and as a core member of the two Integrated Care Systems in which we are a full partner – namely Birmingham & Solihull and the Black Country.

I would like to thank all of my fellow Board members for their commitment and support through the year in review, and for their important contributions to the Trust's response to the pandemic and our planning for the future. Their concern for the wellbeing of our staff and patients and service users has been outstanding.

Members of our Council of Governors have also been an important part of our response and my thanks go to each of them. Following Governor elections in early 2021, I would like to thank those who are no longer serving for their commitment to this voluntary role whilst in post, and also to welcome our newly elected members. Full details of our Board members and Council of Governors can be found within the Directors Report (Section 2.1) and Corporate Governance Report (Section 2.4) in this report.

Thank you for your interest in our Annual Report and for your ongoing support for our Trust.

Dr Barry Henley
Chair
Birmingham Community Healthcare NHS Foundation Trust

Message from Richard Kirby the Chief Executive Officer

Our Annual Report for 2020/21 reflects the most challenging year yet for the wider NHS and for all those individual organisations within it, such as our own Birmingham Community Healthcare NHS Foundation Trust (BCHC).

The COVID-19 pandemic has challenged us in ways that we have not encountered before - stretching our operational systems, putting our support systems to the sternest test and pressuring the resilience and determination of our colleagues.

Everyone in BCHC has been affected by COVID-19 in the last 12 months both professionally and personally often in very profound ways that it will take us time to come to terms with. Right at the start of this Annual Report however I would like to say a huge 'thank you' to everyone - all of our BCHC colleagues, and people in our communities and our partner organisations, for their compassion and commitment as we have responded to the coronavirus pandemic.

"I would like to say a huge 'thank you' to everyone – all of our BCHC colleagues, people in our communities and our partner organisations"

Time and again our colleagues have demonstrated our values - Caring, Open, Respectful, Responsible and Inclusive (CORRI) - in practice in caring for our patients and service users. We genuinely could not have asked for more from our teams.

At a time of real adversity, we have also seen great adaptability and innovation. At its peak over 1,000 BCHC colleagues were redeployed into roles different from their usual and expected work, while others adapted quickly to the challenges of remote working. From the midst of great challenge we have created adaptations which we will turn into 'business as usual' features, including increased use of virtual consultations, a range of new services (such as our enhanced care home teams, discharge to assess pathways and early intervention community teams and health facilitation teams for people with a learning disability) and effectively integrating more elements of services with health and social care partners.

Our initial response focused on keeping our patients and service users safe and well cared for, and playing our part in the wider response from the health and social care system. Many of our services were temporarily suspended so that we could focus on COVID-19 requirements – such as supporting the safe and early discharge of patients from acute care, supporting care homes and mobilising swabbing teams, and all whilst still ensuring we provided our 'normal' services for those most in need. Alongside all of this we have played our part in the vaccination programme working with GPs to vaccinate housebound older people and delivering the vaccine to our workforce.

As I write, it looks increasingly likely that we are out of the worst of the pandemic. It is however important to recognise that we still face some significant challenges as we look ahead: COVID-19 has not gone away and it is important we restore services safely; services that were stood-down during the pandemic now face major backlogs (Dental, Children's and Specialist Rehabilitation for example) and other services are only now beginning to see the impact of the pandemic on wider health and wellbeing as referrals increase. Working with system partners we still have a big job to do in the year ahead.

Towards the end of the year in review we were able to begin planning for the next phase, into 2021/22, in which we hold ambition for a sustained recovery throughout our services and our communities; one based on our 'Best Care: Healthy Communities' vision and rooted in our values.

We have never felt a greater sense of the need to support our colleagues and get it right for our patients; and, while accepting that challenge, to seize the opportunity to cement new ways of working into a sustained recovery.

As we look to the year ahead we have recommitted to our "Best Care: Healthy Communities" vision and our CORRI values. To enable us to continue to bring this vision to life and embed our values we have identified the following priorities on which to focus as we move through 2021/22:

- **COVID-19 response, restoring services and staying COVID-19 safe.**
- **Support colleague health and wellbeing and develop compassionate and inclusive leaders.**
- **"Home First" service transformation for older people.**
- **See through our Children's improvement journey.**
- **Deliver increasingly digitally-enabled care.**
- **Play our part in tackling inequalities and their impact on health.**

In tackling these priorities we will be making the most of the learning we have acquired through the past year. This means, for example, we shall see much greater use of virtual consultations with patients, whether telephone triage or Attend Anywhere for consultations where this is appropriate. We will also be "baking in" the integrated approach to working with partners in health and social care that we have developed through the pandemic, especially in intermediate care and Early Intervention services.

Also, in line with our vision and values, we have made a commitment to "Healthy Communities" and to being a 'Truly Inclusive Organisation'. The experience of the pandemic has brought into stark relief the impact of divisions within our society and also reinforced the importance of our commitments and work on inclusion and equality – both within the Trust and on tackling the impact of inequalities in the communities we serve.

Our Annual Report for 2020/21 stands as testament to the most challenging year we have faced, and it is thanks to the incredible commitment of our colleagues and partners that we have been able to deliver so much for our patients, service users and communities.

"Thanks to the incredible commitment of our colleagues and partners that we have been able to deliver so much"

Richard Kirby
Chief Executive Officer
Birmingham Community Healthcare NHS Foundation Trust

Part 1 - Annual Report

1. Performance Report

2. Accountability Report

1. Performance Report

The purpose of the Performance Report is to provide a fair, balanced and understandable analysis of Birmingham Community Healthcare NHS Foundation Trusts' performance during the period April 2020 to March 2021. The Report is prepared in accordance with the requirements of sections 414A, 414C and 414D of the Companies Act 2006.

1.1. Overview

The purpose of this overview is to provide the reader with sufficient information to gain an understanding of Birmingham Community Healthcare NHS Foundation Trust, our purpose, the key risks to the achievement of our objectives and how we have performed during financial year 2020/21.

Birmingham Community Healthcare NHS Foundation Trust was formally authorised as a Foundation Trust on 1 April 2016. We are one of the largest specialist providers of community health services in the NHS with over 4,500 colleagues and an annual turnover of £328.075 million in 2020/21. We deliver services to the 1.2 million residents of Birmingham, as well as some services in the Black Country and the wider West Midlands from five main clinical divisions:

- Adult Community Services - including community nursing and therapy services, Early Intervention intermediate care teams and specialist community services for people with a long-term condition;
- Adult Specialist and Rehabilitation Services - including 300 intermediate care beds, regional rehabilitation services and prison healthcare;
- Children and Families - including universal and specialist community children's services for Birmingham;
- Learning Disabilities - services for adults with learning disabilities in Birmingham;
- Dental - tertiary and secondary dental services at the Birmingham Dental Hospital and community dental services for Birmingham, Sandwell, Dudley and Walsall.

Birmingham Community Healthcare NHS Foundation Trust operates from over 300 sites across Birmingham and the West Midlands providing care for people throughout their lives from the new-born and their families to the frail elderly and their carers. The services we provide are diverse; from healthy lifestyle services that support people to feel well to the most complex healthcare for those with highly specialist needs. We provide care in people's homes and also in clinics and inpatient units across the city. All of this is delivered with a commitment to integrated, personalised care to meet the needs of our diverse local communities.

We have a strong track record of providing safe, high quality care. Over the past year we continued to monitor feedback from our patients, on average 98% of our patients each month, who provided us with feedback, have told us they would recommend the care we provide to their family and friends. Nearly 80% of colleagues were satisfied with the quality of care they give to patients/ service users and over 88% of colleagues felt their role makes a difference to patients and service users.

Birmingham Community Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional, therefore we have to operate our services in line with the instructions outlined by CQC within the Section 31 Notice. The CQC inspected the organisation in 2020 and we were rated 'Requires Improvement' overall and rated 'outstanding' for caring across our services. Five of the six services were rated 'good' whilst the sixth; Children and Young People services received a rating of 'requires improvement'. This is an improved rating from the previous inspection, initiated in 2018 and completed in 2019 whereby the service was rated 'inadequate'. BCHC has continued to improve this service since being issued a Section 29A Warning Notice in 2018 and Section 31 Notice in 2019. Working in close partnership with stakeholders including CQC, Birmingham and Solihull Clinical Commissioning Group and Birmingham City Council has been a pivotal aspect of this achievement.

Since 2018, detailed action plans have been developed, consulted and executed to enable the continued improvement of the services provided to Children and Young People within the community of Birmingham. Whilst the plan is not yet complete, a significant amount of progress has been made, leading to a formal application having been submitted for the review of the Section 31 Notice and imposed conditions. This will enable the remaining plans to increase health visitor capacity, retention and reduction in caseload to form a part of the 2021/22 business strategy. BCHC anticipate full establishment in this service by end of calendar year 2022.

During January and February 2020, the CQC undertook a Well-Led Inspection and an inspection of a number of core services including End of Life Care, Children and Young People's Services, Adult Community and Specialist Services and Learning Disability Services. The Trusts' CQC Inspection Report was published on 27 May 2020 and the outcome of the inspection can be seen in the ratings grid on the next page.

In summary, the Trust remains

- 'Requires Improvement' overall,
- 30 out of 36 services rated as 'Good' or 'Outstanding',
- Rated overall 'Outstanding' for Caring, and
- 5 of our 6 core services are rated 'Good', and our children's services rating has improved to 'Requires Improvement'.
- Our one remaining 'Inadequate' rating (in the responsive domain for children's services) applies to long waiting times for specialist children's services (including neuro-developmental assessments), which, with the support of our Commissioners, we are making progress to address.

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Apr 2020	Good → ← Apr 2020	Outstanding ↑ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement → ← Apr 2020	Requires improvement → ← Apr 2020

Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good → ← Apr 2020	Good → ← Apr 2020	Outstanding ↑ Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020
Community health services for children and young people	Requires improvement ↑ Apr 2020	Requires improvement → ← Apr 2020	Good → ← Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↑ Apr 2020	Inadequate ↑ Apr 2020
Community health inpatient services	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good → ← Apr 2020	Good → ← Apr 2020	Outstanding → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020
Community dental services	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014
Learning disabilities services	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020

Our full CQC report can be accessed via the following link: *https://www.cqc.org.uk/provider/RYW*

Our Vision and Values

During 2018/19, we developed a new vision, set of values and strategic objectives which were co-produced with our local population, colleagues from across the organisation and partner organisations.

These were also informed by the Care Quality Commission (CQC) Local System Reviews, the CQC Core Service Inspection (2018) of our Trust, the Independent Equality & Diversity Review (commissioned by the Trust) and the Independent Well-Led Review undertaken by Deloitte (commissioned by the Trust). We also carefully considered the views of our system partners, Birmingham and Solihull Sustainability and Transformation Partnership (BSol STP) and Black Country and West Birmingham Sustainability and Transformation Partnership (BC STP) as well as our regulator, NHS Improvement.

Our vision, values and strategy were approved at the Trust Board in October 2018 and set out what matters most to us as a specialist provider of community healthcare.

Our Vision

Best Care
Healthy Communities

Our vision for the future is to provide the Best Care possible for the people who need our services and to enable them, and the whole local population, to live healthy lives within Healthy Communities.

This vision is rooted in the communities we serve and is reflected in our approach to the delivery of community services based on Birmingham's five localities and the provision of specialist care services across the wider West Midlands area. It commits us to working closely with our local partners and is directly linked to the vision of the two local Sustainability and Transformation Partnerships (STPs) that we are members of.

Live healthy
Live happy
Birmingham and Solihull

Healthier Futures
Black Country and West Birmingham

BCHC is a partner within both the Birmingham and Solihull (BSol) Sustainability and Transformation Partnership (STP) and the Black Country and West Birmingham STP (BCWB). The NHS Long Term Plan confirmed that all parts of England would be served by an integrated care system or ICS from April 2021. Both BSol and BCWB STP have been approved to become ICSs by NHS England and Improvement and so were formally established on 1 April 2021. NHS England and NHS Improvement has asked the Government and Parliament to establish ICSs in law and to remove legal barriers to integrated care for patients and communities.

Both ICSs are working with the populations they serve to develop their priorities for the future as well as the governance and financial frameworks that will underpin decision making. More details are available through: https://www.england.nhs.uk/integratedcare/what-is-integrated-care/birmingham-and-solihull/ and https://www.healthierfutures.co.uk/about-us.

Our Values

Our values were developed through an extensive colleague-led engagement process during 2018.

Our values guide all our actions, the decisions we make and the way that we behave as we seek to deliver our vision and our leadership behaviours.

Our Strategic Objectives

Based on our "Best Care: Healthy Communities" vision, our strategy for 2018-2022, is to deliver high quality, holistic community health services, across our local ICS footprints and the wider West Midlands.

Agreed by the Trust Board in October 2018, our strategy sets out four strategic objectives that describe the big things we need to achieve to bring our vision to life:-

- **Delivering safe, high quality care** - working with the people we care for, their families and our partners to deliver the best possible outcomes and experience.
- **Creating a great place to work** - creating a great place to work and learn, enabling our colleagues to be the best that they can be.
- **Providing integrated care in communities** - working with our partners across the NHS, mental health, primary care, local government, social care, and the voluntary sector to support people to live healthily in their communities.
- **Making good use of resources** - getting the best from our people, technology, information, estates and money.

We also agreed key milestones that act as a series of stepping stones to get us to where we need to be by 2022 - the year in which Birmingham will be in the international spotlight as host of the Commonwealth Games. These key milestones form our 'Fit for 2022 Improvement Programme' and are closely monitored within the organisation. The Fit for 2022 Improvement Programme includes actions to progress our four strategic objectives and responds to external reviews and recommendations such as the Equality Diversity and Human Rights Independent Review (2018), the Well-Led Independent Review (2018 and 2019) and the CQC Inspection (2018, 2019 and 2020).

Further information is available via our intranet:

http://www.bhamcommunity.nhs.uk/about-us/board-of-directors/meetings-and-papers/

Progress against Our Strategic Objectives in 2020/21

Last year was the second year of our Fit for 2022 Improvement programme. As we set out the things we wanted to achieve in 2020/21, we were very mindful that we were also responding to a global pandemic and so our ambitions for what we could deliver in 2020/21 had to reflect this. The role of our Clinical Council and Divisional Leadership in supporting the Board to reset its priorities during 2020/21 is described in the section on our response to the COVID-19 pandemic.

Despite the significant challenged the NHS has faced during 2020/21 we have still managed to make good progress against our Fit for 2022 Improvement programme.

The table below summarises our progress during 2020/21.

Strategic Objective	2020/21 Delivery Priority	Progress during 2020/21
Ensure that the Trust responds effectively to the coronavirus pandemic keeping our patients safe, playing our part in the system response and supporting our colleagues.		
Safe, High Quality Care	Embed quality improvement by implementing 'BCHC Improving 2gether'	• The BCHC Improving 2gether Strategy was approved by Trust Board in July 2020 and launched in October 2020. • A network of Quality Improvement (QI) buddies has been established to support colleagues. • An Improving 2gether Forum has been launched to supporting shared learning across the organisation. • There is a bespoke QI training module within the Trust-wide INSPIRE leadership programme - Leadership for Quality Improvement. • One cohort has now completed their Quality Service Improvement and Redesign (QSIR) training in full.
	Improve our services for children by delivering the Birmingham Forward Steps service model and reducing waiting times for specialist services.	• We continue to work with our partners to deliver the Birmingham Forward Steps model. • There has been an improvement in performance of mandated visits • Virtual Consultations has been key to ensuring children could still be seen during the pandemic.

Strategic Objective	2020-21 Delivery Priority	Progress during 2020/21
Great Place to Work	Embed a leadership culture based on our values through delivery of a Leadership Development Programme for over 600 line managers	• INSPIRE'; a virtual leadership course, commenced in September 2020. 157 colleagues have now attended the course; operational pressures have impacted the original trajectory so this has been revised. • A Line Management Induction course has been developed for new starters.
	Ensure our staffing is safe and sustainable through work in recruitment, retention and health and wellbeing.	• A health and wellbeing plan has been developed specifically in relation to the additional pressures staff experienced due to COVID-19. There have been a range of sessions offered including both face to face and virtual sessions to ensure accessibility for all. Bespoke support packages were also created for some areas. • Webinars have been delivered to support colleagues' emotional, psychological, mental and general wellbeing. • Hear for You' was launched in November 2020, which is a dedicated focus on engagement and wellbeing. • The Trust has introduced a number of mechanisms to ensure staff are able to raise concerns. Freedom to Speak up champions have been offering drop in clinics across BCHC sites. • An e-Roster implementation plan has been developed; this will be executed over coming months.
	See through our commitment to become a truly inclusive organisation by addressing issues of race equality.	• The Trust has a Truly Inclusive Action plan in place. • The reverse mentoring programme has been introduced and colleagues from across the Organisations have been encouraged to put themselves forward to support the initiative. Reverse mentors have been recruited. • A Service Equality working group has been established and an Anti-Racism campaign has been launched. The Board has made a pledge to eradicate racism. • Cultural ambassadors have been recruited from across the Organisations and are all now trained to support the Trusts Disciplinary process and support decision making following the initial fact-find stage. • Inclusive Recruitment Guide - Recruiting Fairly has been published on the intranet and incorporated into recruitment and selection training.

Strategic Objective	2020-21 Delivery Priority	Progress during 2020/21
Integrated Care in Communities	Deliver our "Home First" service model for older people through Early Intervention intermediate care teams and integrated neighbourhood teams	• Enhanced Support to Care Homes has been provided throughout the COVID-19 Pandemic. • Early Intervention Community Teams have been expanded. • Integrated hub set up to coordinate referrals and from acute and community step down routes and maintain patient flow across the system. • Improved length of stay which has supported pressures across the system.
	Build a strong and sustainable community offer through our alliances with partners in mental health primary care and social care	• A programme of work has been set up, alongside partners to develop our integrated neighbourhoods approach. • Joint work programmes were identified between BCHC and Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). • Service Level Agreement (SLAs) in place with Primary Care in relation to Additional Roles Reimbursement scheme.
Making Good Use of Resources	Agree and make progress with a road map to electronic patient records across the organisation	• There is a robust Electronic Patient Record (EPR) programme in place which includes Electronic Prescribing and Medicines Administration (EPMA), Electronic Observations and Patient Flow, Patient Portal, Inpatients EPR Enablement and Health Information Exchange.
	Deliver our financial plan and develop our longer-term financial strategy based on a programme of operational productivity and delivering value through our services	• Productivity workstream has commenced seeking to identify areas of key efficiencies. • The financial plan was not delivered as planned, however significant savings were identified during the last financial year.

COVID-19 Pandemic Response

As the COVID-19 pandemic started to develop, during March 2020 the Trust commenced formal mobilisation of COVID-19 Response actions which included a review of clinical interventions delivered by all services, prioritising these in order to ensure that critical to life services were maintained and that all available resource could be utilised in supporting a number of new services which were mobilised to support COVID-19 response and/or services where additional capacity was urgently required e.g. bedded units.

As the pressures created by the first wave of COVID-19 pandemic started to decrease the Trust, in line with National Guidance, developed a Restoration and Recovery plan which detailed how the ongoing pressures created by the pandemic should be balanced with the need to restore normal service provision and start to recover the increase in waiting times, most notably in Dental services.

BCHC 2020/21 winter plan was based on the general assumption that any winter surge of increased COVID-19 cases would not exceed the level and pressures caused during the first wave. Unfortunately the 2nd and 3rd waves saw higher levels of infection both nationally and locally, resulting in BCHC moving back to a '1st wave response' with redeployment increasing in order that additional capacity could once again be created across the System. Through the impact of national lockdown restrictions, coupled with the COVID-19 vaccination programme, the Trust has been able to develop a plan for COVID-19 recovery for 2021/22.

Our Annual Governance Statement in section 2.4 provides more details on how we responded to the pandemic with the impact on our performance described in the context of our performance in our performance analysis in section 1.2.

Performance report overview and disclosure of risks

As a result of the COVID-19 pandemic, the Trust has had to review current services to support the delivery of the national response from the NHS. This has seen a reduction in the delivery of some services, whilst other essential services continuing to be delivered with adaptions to ensure safety for staff and patients. This includes the delivery of remote services where this is possible. Significant numbers of staff have been redeployed and new services have been set up such as community swabbing, and, more recently, the vaccination for house bound community patients. We have also adopted the use of many of our bedded units and opened new wards in order to support the local care system.

The impact of the COVID-19 pandemic on our performance reported throughout the year is detailed within the performance analysis section (Section1.2). Our Annual Governance Statement (Section 2.4) describes our approach to managing the risks faced during this period.

Equality, Diversity and Human Rights Summary

Throughout the year the Trust has maintained its commitment to become a Truly Inclusive Organisation, to tackle racism and discrimination and to create a culture where equality and diversity are genuinely respected and valued.

The Trust Board approved the 'Becoming a Truly Inclusive Organisation Action Plan' at its public meeting in September 2020 following receipt of the 2020 NHS Workforce Race Equality Standard (WRES) Report.

It is clear that the COVID-19 has had a significant impact on the capacity to deliver against a number of Fit for 2022 programmes of work.

In spite of challenges of the pandemic a continued focus has been maintained on the Equality, Diversity and Inclusive agenda resulting in good progress being made in a number of areas:

- Roll-out of new Disciplinary Policy to embed the principles of 'Just Culture'
- Completion of the review and revision of the End to End Recruitment process and development of the 'Recognising and Realising Potential Programme'.
- Introduction of Cultural Ambassadors
- Development of Equality, Diversity and Human Rights (EDHR) Key Performance Indicators (KPIs)
- Equality, Diversity and Inclusion (EDI) Data Reports
- Black and Minority Ethnics (BME) Risk Assessments
- Emotional and Spiritual Support to BME colleagues during COVID-19
- Inspire Leadership
- Divisional Inclusive Organisations

Further detail is provided within our Staff Report in Section 2.3 of our Accountability Report.

Financial summary and performance

The table below illustrates our key financial metrics for 2020/21 and the previous two financial years.

	2020/21	2019/20	2018/19
Surplus/(Deficit) £000s	(2,635)	(11,028)	1,850
Closing cash position £000s	43,663	32,289	39,432
Capital expenditure £000s	9,889	6,156	6,198
Use of Resources Rating	N/A*	1	1

*The 'use of resources' rating is not currently required to be reported to NHS Improvement

On 17 March 2020 NHS England and Improvement suspended the national operational planning process for 2020/21 and put in place temporary payment arrangements, which were at that time intended to cover the first four months of the year. These featured block payments based on the previous financial year and a recovery arrangement for those costs directly associated with the response to COVID-19.

In April 2020 BCHC's Board approved a financial plan for 2020/21, which set a requirement for a surplus of £1.0m. This was the result of the usual financial planning work which had taken place in the last quarter of the previous financial year, and was based upon the delivery of an £8.0m Cost Improvement Plan (CIP). In the weeks that followed, as the technical details of the new payment arrangements emerged, the Trust reduced its financial plan to a breakeven requirement (in line with new national requirements) and put in place specific reporting arrangements and controls in relation to COVID-19 expenditure.

As the year progressed, the new national payment arrangements were extended until the end of September. In relation to October onwards a separate planning process was undertaken at a Birmingham and Solihull STP level, and BCHC's Board approved its element of the plan – which was for the Trust to deliver a breakeven position at the year end.

At the end of March 2021, the Trust reported surplus of £0.2m on an adjusted financial performance basis (which excludes the impact of impairments in relation to our estate, and consumables donated by the Department of Health and Social Care). After these items the Trusts' final accounts position records a deficit of £2.6 million as outlined in the table above.

The Trust's CIP schemes were developed ahead of the financial year through a well-established gateway process, which includes clinical scrutiny of each scheme, and these were embedded in operational budgets from the beginning of the financial year. Against the £8.0m target in the financial plan we ended the year with delivery of £6.0m, which was due to the impact of the COVID-19 pandemic. Some schemes were dependent on the delivery of additional income, which were hampered by the block income arrangements, while others slipped due to the operational issues. However it should be noted that, in the context of COVID-19, the delivery of efficiencies of 1.8% in 2020/21 is a commendable performance.

Our Annual Governance Statement in Section 2.4 describes the controls and monitoring arrangements in place for the Trust's financial performance. All financial areas of the 2020/21 internal audit plan received a rating of 'significant' assurance.

Going concern disclosure

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Impact of charitable donations

£251k was spent by Birmingham Community Healthcare Charity on items, services and projects for the benefit of patients and colleagues across the Trust during 2020/21 financial year, an increase of £168k compared to 19/20 (£83k spent during 2019/20).

A large portion of funds were spent on patients and colleagues in response to the COVID-19 crisis including self-care items to enhance wellbeing, home comforts and entertainment items for inpatients and bereavement items such as memory boxes and refurbishment of the Dandelion bereavement suite. Items not directly relating to COVID-19 include a Cuddle bed to support patients and their families at end of life and communication aids and sensory equipment for patients within both our rehabilitation services and learning disabilities services.

1.2 Performance Analysis 2020/21

How we Measure Performance

Performance in the Trust is reported each month through Balanced Scorecards. The scorecards report Key Performance Indicators (KPIs) at Trust and Divisional levels. These reports are supported by disaggregated performance and activity information at Team and Business Unit levels via the 1Vision platform. Each KPI has an executive lead with responsibility for performance in that area and the overall executive lead for Performance is the Chief Financial Officer.

During the COVID-19 pandemic many of the routine governance meetings have been stood down with Divisions and services focussed on immediate response to the crisis. Some indicators of performance such as use of Agency staff have been less of an immediate priority than under normal circumstances, whilst others such as monitoring of clinical quality outcomes have remained as important as ever.

Development of the Balanced Scorecards

The Performance Team led an annual review of scorecards with Executive and Divisional leads to ensure that Key Performance Indicators (KPIs) and associated targets are relevant and that the definitions of individual measures are clearly defined. Whilst this review took place as normal in Quarter 3 (Q3) the current intention is to introduce scorecard changes from July 2021 effectively treating Q1 as a continuation of the previous year and in the meantime maintaining targets and priorities from 20/21.

Structure of the Balanced Scorecard

Scorecards are developed in four key domains. These are:

Safe, High Quality Care

Integrated Care in Communities

A Great Place to Work

Making Good Use of Resources.

A ‘Balanced Scorecard Explainer’ catalogue is updated each year and provides more detail on the technical definition of each KPI.

Key Performance Indicators

The Trust aims to develop KPIs which are supported by robust data quality and which are clearly defined and understood by services. The Performance Team developed a ‘sandbox’ approach for 2020/21 which allowed us to scope, test and report performance for newer or experimental KPIs before reporting on the Trust and Divisional scorecards. This approach allowed flexibility and focus on areas of development whilst allowing time for data quality improvement work and reviews of processes to take place.

Table 1.2a: Key Performance Indicators at Trust level (measures)

Strategic Objective	Key Performance Indicators (KPIs) for 2020/21
Safe, High Quality Care	• Patient Safety Thermometer (harm-free care - NEW HARMS ONLY) • Patient Safety Thermometer (new and old harms) • Essential care indicators community nursing (aggregated measure) • Essential care indicators inpatients (aggregated measure) • Essential Care indicators - Early Intervention • Essential Care Indicators - Dental Services • Essential Care Indicators - combined Learning Disabilities (LD) inpatient and community • Essential Care Indicators - Health Visiting • Friends and Family test • Infection Prevention Control Audit • Falls with severe injury or death (cumulative) • Pressure ulcers - community • Pressure ulcers - inpatients • Total Number of Preventable Inpatient Deaths (1 month in arrears) • Number of never events • Safe staffing - Inpatients • Safe Staffing - Community Nursing • Falls with Harm per 1,000 Occupied bed days (OBDs) • Number of Serious Incidents • Health Visitor Whole Time Equivalent (WTE) in post average caseload • Written Complaints rate (per 100 WTE Staff) • Average Response Time to Complaints • WHO Surgical Checklist compliance
Integrated Care in Communities	• 18 week pathway consultant led services (incomplete pathways) • Zero tolerance Referral To Treatment (RTT) waits over 52 weeks • Open Referrals over 52 weeks with no contact • Open pathways with more than 52 weeks since last contact • Health Visitor antenatal contacts as % of referrals received • Health Visitors - New Birth Contact • Health Visitors - 6 to 8 reviews • Health Visitors - 12 month review • Health Visitors - 2.5 year review • Total Delayed Transfer days as % of OBDs • Delayed transfer days as % of OBDs - NHS reasons • Emergency Re-admission rates • SPA Call Management - Average Wait Time

A Great Place to Work	• Mandatory Training Compliance (Core Skills) • Percentage of vacancies • % sickness absence • % staff appraised (12 month rolling average) • Average length of time to recruit in days (date advertised to offer) • Agency as a percentage of WTE • Bank as a percentage of WTE • WRES - Relative likelihood BME staff entering formal disciplinary • WRES - % of staff at bands 8A+ who are BME (excluding Medical & Dental) • 5 of Workforce Demographics collected (added in year) • Staff Friends & Family - % that would recommend this organisation as a place to work • Staff Friends & Family - % that would recommend this organisation if they needed care or treatment
Making Good use of Resources	• DNA rates (clinical appointments) • Agency spend - Year to Date (YTD) Total (cumulative) (£000) • Net income and expenditure (£000) • Cost Improvement Plans - in month delivery against plans • Cash balance (£m) • Capital programme - % achievement of plan • Contractual - RAP/financial penalty or Activity Management Plan • % compliance with CQUINS (forecast) • Un-outcomed activity in year

Impact of COVID-19 pandemic on Performance Reporting

KPI performance across a whole range of indicators and services was unsurprisingly affected hugely by the ongoing COVID-19 pandemic and the sections which follow will outline some of the impact on individual areas. However it is important to note that the COVID-19 pandemic also affected the normal reporting of a number of KPIs as follows

- Following national guidance the 'Friends and Family test' reporting whether patients would recommend the service they had received to friends and family was paused from Q4 2019/20 until January 2021; largely due to concerns about the infection risk of collecting the results, although from 1 April 2020 the Trust continued to collect feedback albeit in lower numbers through COVID-19 secure means. In line with our governance light process to maintain oversight, this data has been reported within the quarterly Patient Experience Reports to our Quality and Safety Committee and in turn to the Board. Nationally the old style friends and family test had been amended from the 1st April 2020 and now incorporates the Trust's internal measure asking patients to report their experience on a scale from 'very good' to 'very poor'. The Trust will report this single measure going forwards and plans are underway to reinstate the audit with increased use of Attend Anywhere and text message reporting whilst also allowing patients to use more traditional pen and paper updates.
- The staff 'Friends and Family' test was also paused in line with the national reports. However as the NHS staff survey was carried out in Q3 reporting of this quarterly measure commences from March 2021.
- All forms of contractual reporting and performance management were suspended for the duration of the pandemic and so measures reporting the number of contractual KPI breaches (with and without remedial action plans or financial penalties) and updates on progress with CQUINs schemes have not reported this year.
- Dental Essential Care audits were not carried out from April to August 2020 as the service paused nearly all work and staff were redeployed to other areas of priority
- Whilst Methicillin-resistant Staphylococcus Aureus (MRSA) and Venous thromboembolisms (VTE) screening continued to be carried out on admission the results were not audited and reported for several months during the early stages of the pandemic.

Performance Management in Divisions

As a result of the COVID-19 pandemic recovery plans for breaches have not been requested as normal. This is due partly to the challenges of forecasting during an ongoing crisis and also as a result of significant disruption to divisions including redeployment of many staff, the move to virtual governance meetings and suspension at times of all but the most essential meetings.

However the performance team have continued to collate and send out divisional scorecards as normal and support the Board and Board Committees that continued to meet and maintain oversight. The full set of divisional reports produced included Statistical Process Control (SPC) reports which highlighted where performance has varied from the normal range to a degree which is statistically significant; identifying areas for further investigation in a timely manner and maintaining oversight during a challenging period.

Performance Management at Trust Level

The Performance Management Executive (PME) is chaired by the Chief Finance Officer and has continued to meet each month albeit in virtual format to review scorecards, offer support and seek assurance from divisional senior management teams relating to areas of concern. The Quality and Performance report has continued to be produced each month to keep the Board informed of developing performance and continues to be made available to the public on the Trust intranet.

Our Performance during 2020/21

Safe, High Quality Care Domain

Overall the Safe, High Quality Care Domain has maintained strong performance despite the challenges of the year. In particular we are proud to report:

- Our Patient Safety Thermometer which following a pause at the start of the pandemic has resumed and continued to report over 99% of patients free of new harms each month.
- The maintenance and development of Essential Care Indicators across a range of services
- There were 9 Falls in the year in which a patient sustained a severe harm. This is the same number as we reported for 2019/20 despite the additional pressure which the inpatients staff were under this year
- No preventable in-patient deaths
- Maintenance of infection control standards and particularly no instances of Trust developed (avoidable) cases of Clostridium difficile (C.diff), Methicillin-resistant Staphylococcus aureus (MRSA) or Escherichia coli (E.Coli).

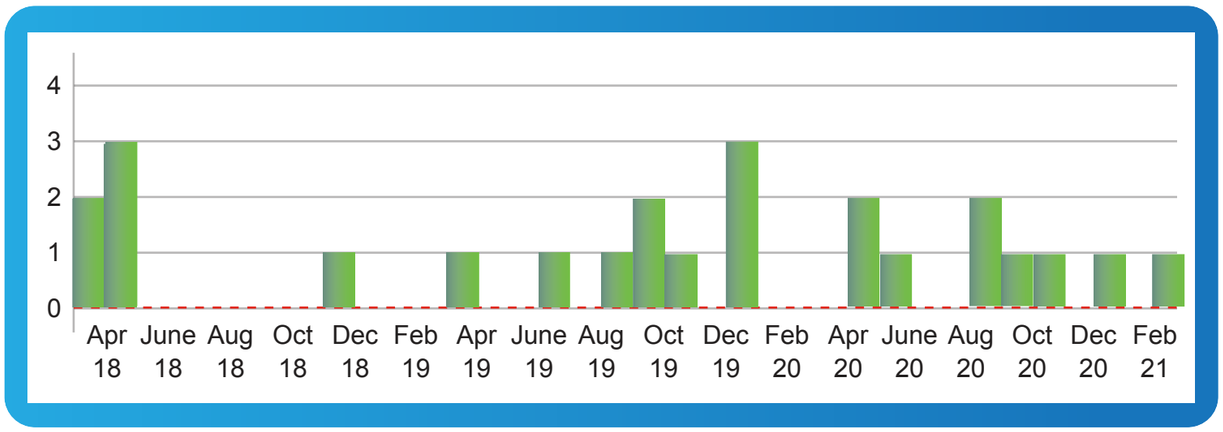
Performance in this domain is overseen by Quality and Safety Committee.

Falls with severe harm

In 2019/20 the Trust was able to maintain a very low rate of falls in which a severe harm was reported with an end year position of 9 such falls. This followed a significant reduction of falls in the summer of 2018 and so maintaining this improvement was one of the key challenges anticipated for 2020/21.

It is therefore positive to be able to report that the total number of falls where a patient sustained a severe harm (such as a broken or fractured bone) was kept at 9 falls this year meaning we have managed to maintain the improvements of last year.

Graph 1.1: BCHC Falls with severe injury or death



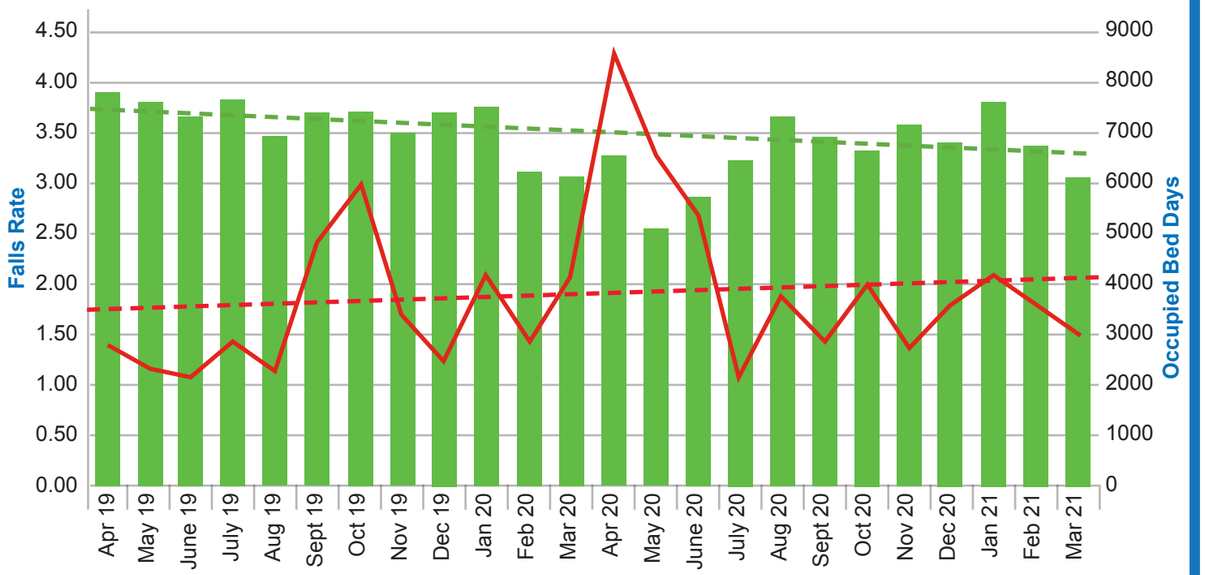
All falls with harm

The Trust continues to carefully monitor falls in our in-patient units. In addition to the number of severe harms we also report the rate or likelihood of a patient experiencing a fall resulting in any sort of harm. This is reported as the number or likelihood of experiencing a fall with any harm for every 1,000 days a patient spends in one of our beds.

As shown in the graph below the rate of falls with harm increased at the start of the pandemic and in April spiked to nearly twice the normal rate. In that month we reported 28 falls with some harm resulting in a rate of 4.28 falls for every 1,000 bed days. This increase took place at a time of maximum disruption when wards were experiencing high numbers of staff sick or shielding and were adapting to new 'COVID-secure' practices. The need to urgently free up bed space in acute hospitals also meant that more acutely ill patients were discharged into the care of the Trust which is likely to have been a factor in the increased falls.

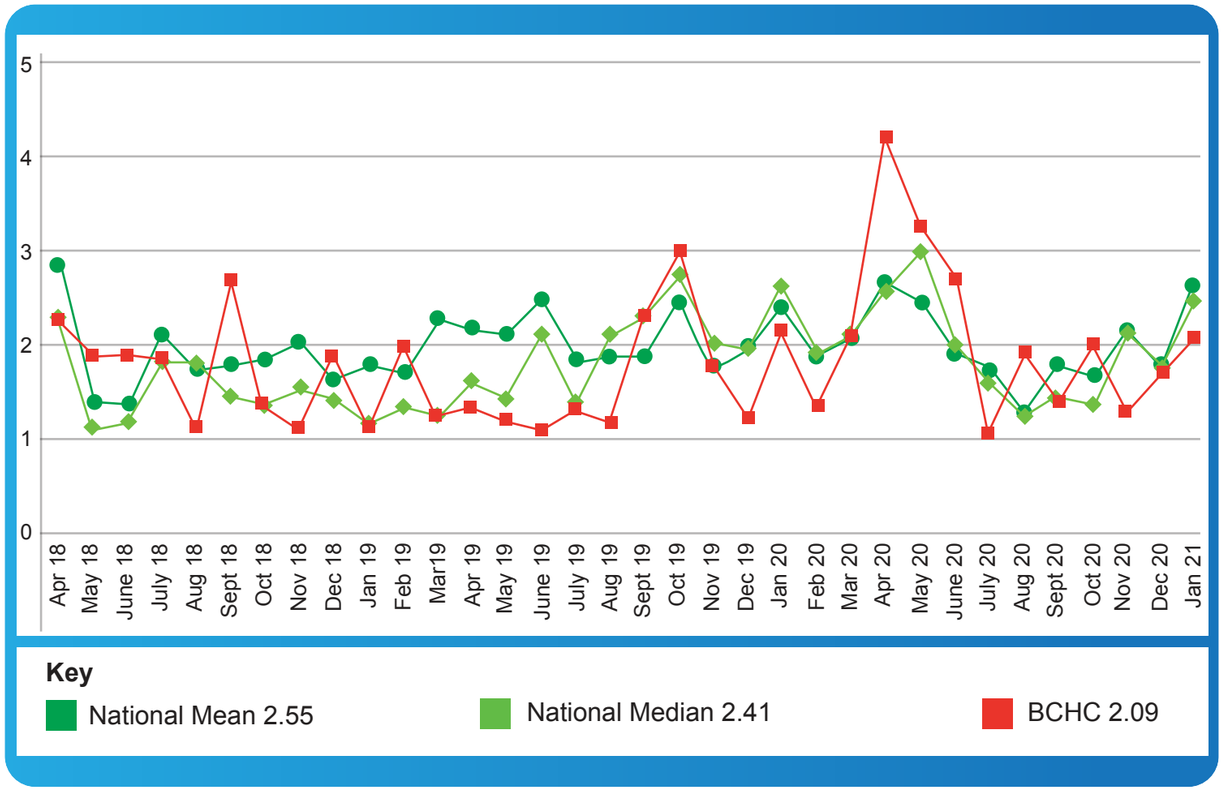
However the wards were able to adapt to the new circumstances and by July falls with harm had returned to more normal levels of between one and two per 1,000 bed days.

Graph 1.2: Falls with harm per 1,000 Occupied Bed Days



A comparison of rates of falls with harm with other Community Trusts highlights a similar increase in falls at the start of the pandemic although the Trust (shown in red) appears to have experienced a greater increase than average. It is therefore positive to report that the return to more normal levels of falls again puts the Trust at or below the average for all falls with harm which gives us assurance that our wards are comparable to other community Trusts.

Graph 1.3: Rate of Falls with Harm per 1,000 Occupied Bed Days



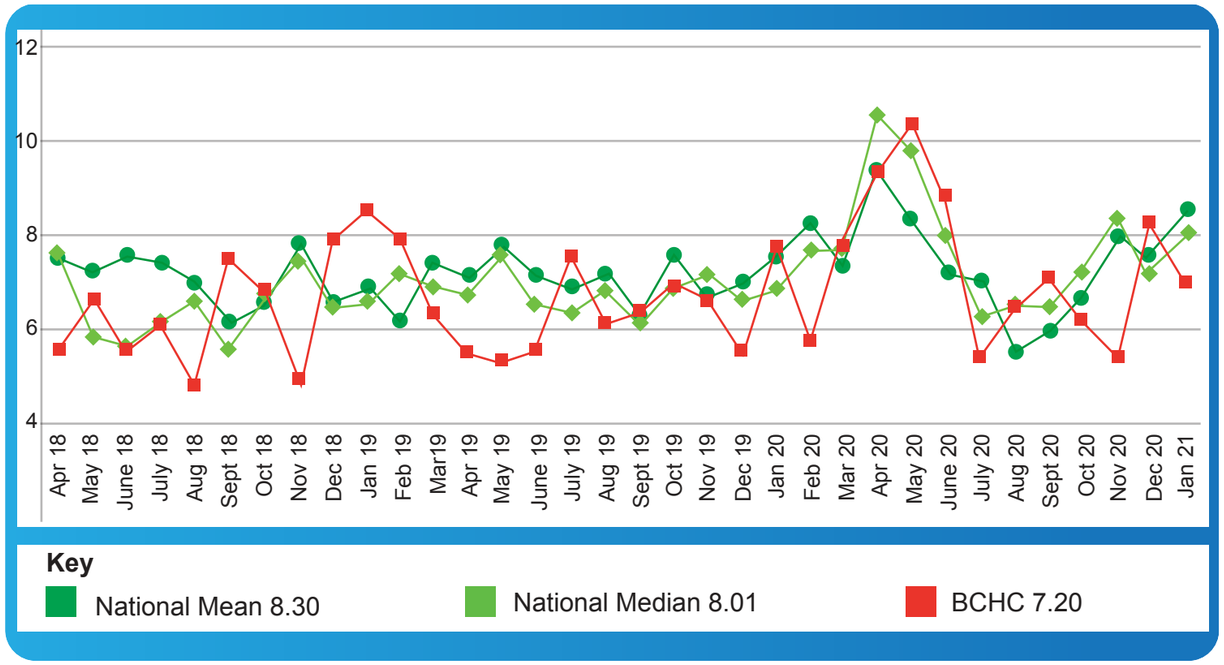
Source: NHS Benchmarking Network

The Trust seeks to identify learning from all falls resulting in a severe harm and conducts detailed root cause analyses into every event.

All Falls

The rate of all falls, including slips and trips, in which no harm was sustained is also monitored and compared to national benchmarks for other community trusts. As shown in the graph below this shows a similar picture to the graph above with the increase in falls at the start of the pandemic across community hospitals again clearly visible.

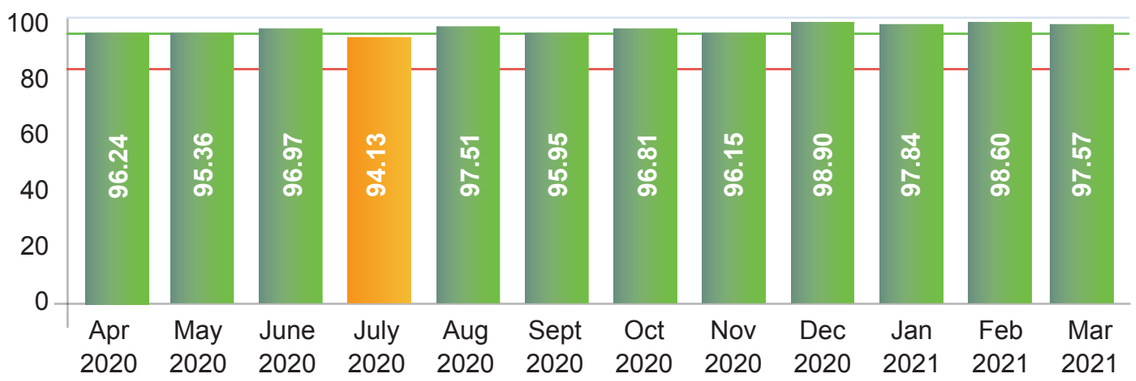
Graph 1.4: Rate of all Falls per 1,000 Occupied Bed Days



Source: NHS Benchmarking Network

The target for the rate of falls with harm will be reviewed at the end of Q1 2021/22 and compared with national benchmarks so that we can continue to give assurance that our wards are safe. Essential care indicators continue to report falls risk assessments to give additional assurance that patients are being individually assessed and managed on personalised pathways and performance in this area has been generally strong throughout the year.

Graph 1.5: Essential Care Indicators, Falls Assessment, Adult and Specialist Rehabilitation Services

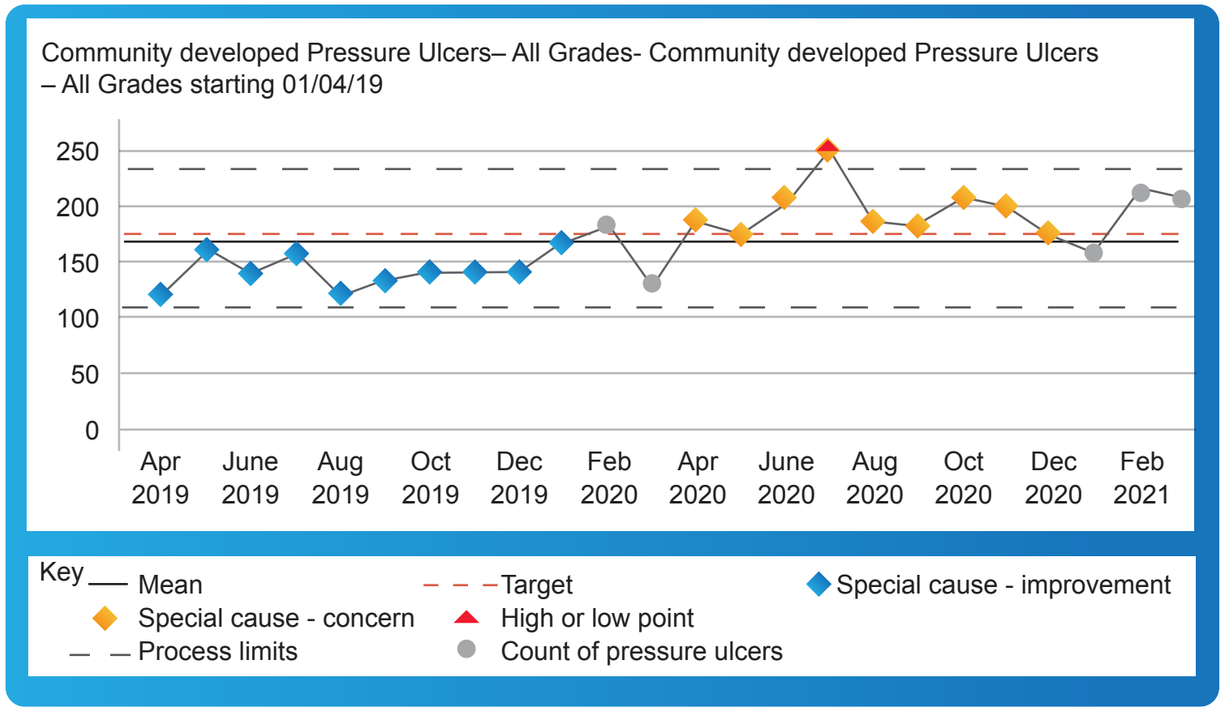


Pressure Ulcers

Preventing patients from developing pressure ulcers is a key focus of both community and inpatient teams.

At the start of 2019 we showed an increase in the number of pressure ulcers reported although this was expected due to changes in the definition of reportable pressure ulcers meaning that smaller pressure ulcers and those classed as ‘’unavoidable’ due for example to patient non engagement with advice were included in figures for the first time. Both Community and Inpatient services have shown an increase compared to this new baseline on the total number of pressure ulcers developed in our care during 2020/21.

Graph 1.6: All Community Pressure

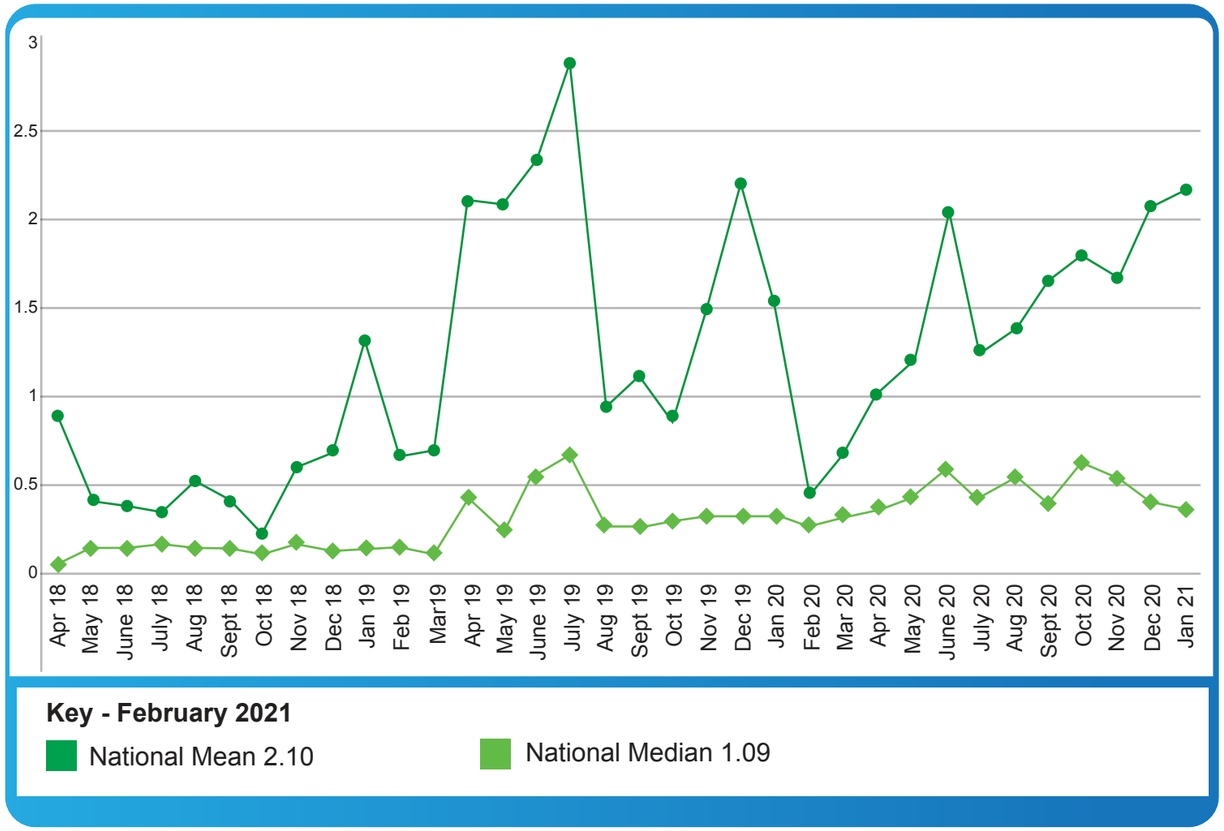


As shown in the chart above the number of pressure ulcers reported each month in the community increased sharply from April to July at which point we reported 249 community developed pressure ulcers, the highest monthly total since the start of the new reporting rules. The position then improved during late summer and autumn whilst still remaining higher than usual and continues to be monitored carefully for further deterioration.

This increase coincided with the first lockdown and was a time when community teams like the inpatient areas were struggling with high absence due to sickness and shielding. Rules on discharge from hospital beds were also relaxed nationally to free up acute capacity and this led to an increase in the acuity of patients in the community. It is also likely that the reduction in access to other support services and activities will have had a detrimental effect on the patients.

This increase in pressure ulcers is apparent in national data with Benchmarking showing increasing rates throughout 2020 depicted in Graph 1.7.

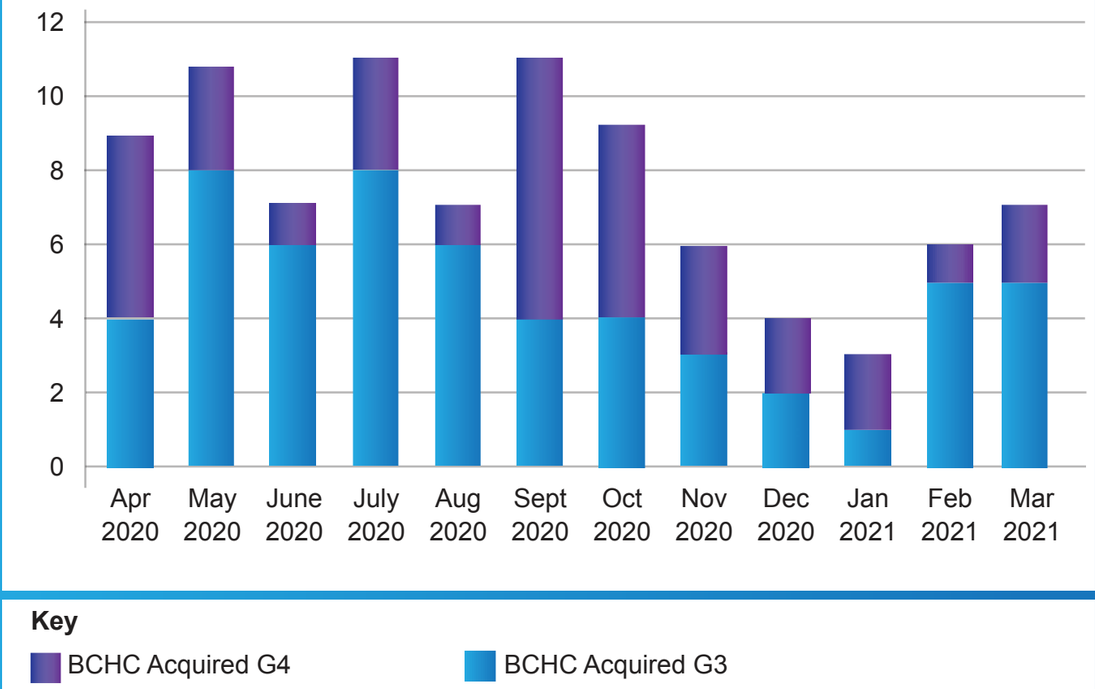
Graph 1.7: Rate of New Grade 2, 3 and 4 Pressure Ulcers acquired whilst under care of the provider in a Community setting per 1,000 patients (on caseload)



Source: NHS Benchmarking Network

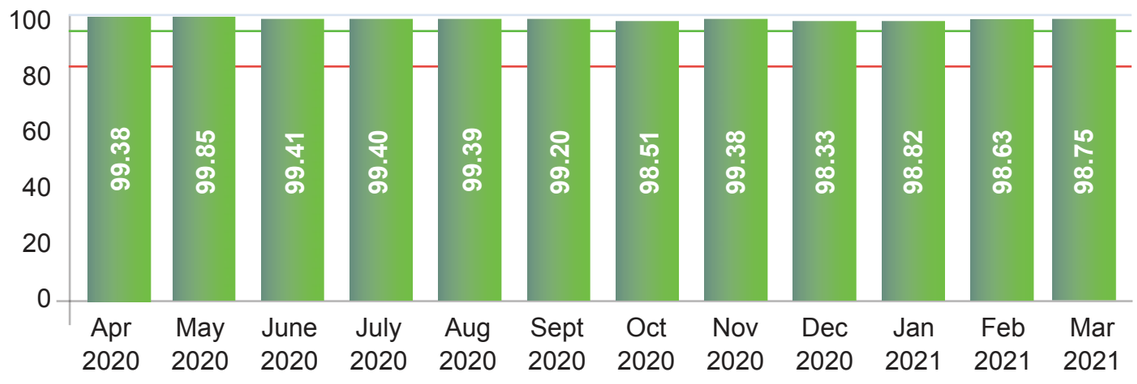
It is important to note that the majority of these are early stage pressure ulcers or moisture lesions and that the service have been successful in preventing deterioration of these into more serious grade 3 or 4 ulcers, which are considered serious incidents. Out of a total of 1,730 Community pressure ulcers in the year which patients of the Trust developed just 91 or 5.26% developed into those higher grade ulcers as shown in the graph below

Graph 1.8: Community Grade 3/ Grade 4 Pressure Ulcers by month

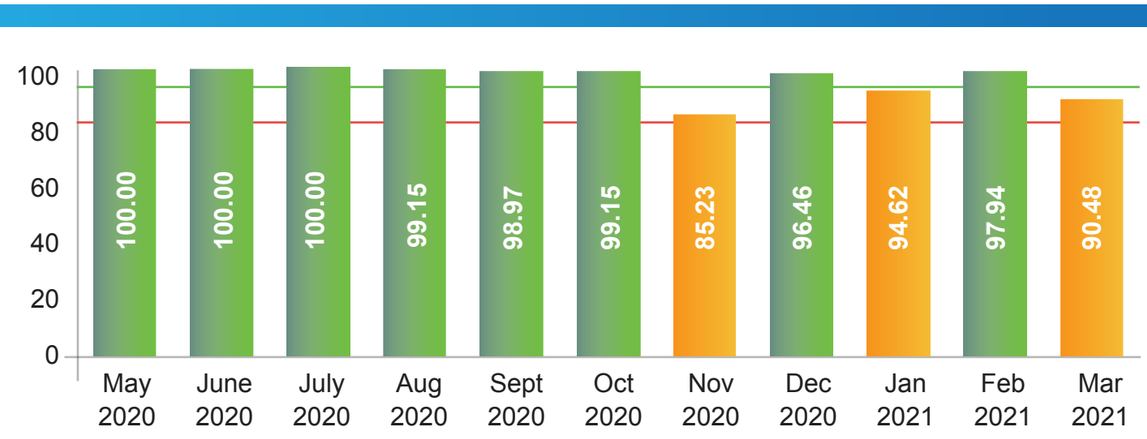


The community team have recorded Essential Care Indicators relating to Tissue Viability (Graph 1.9) throughout the pandemic reporting audits from across each community nursing team each month and therefore giving good assurance that the teams have managed to deliver the basic skin inspections and care plans our patients require. This year has also seen the launch of new Essential Care Indicators for the Early Intervention service which has a key role to play in assessing and helping to stabilise new patients in the community following crisis or discharge from acute settings. Prevention of pressure ulcers is audited and reported each month since May and with small dips visible on the graph (Graph 1.10) has maintained good or very good performance throughout the year with the audit now reporting on patients across the city.

Graph 1.9: Essential Care Indicators, Tissue Viability, Community Nursing



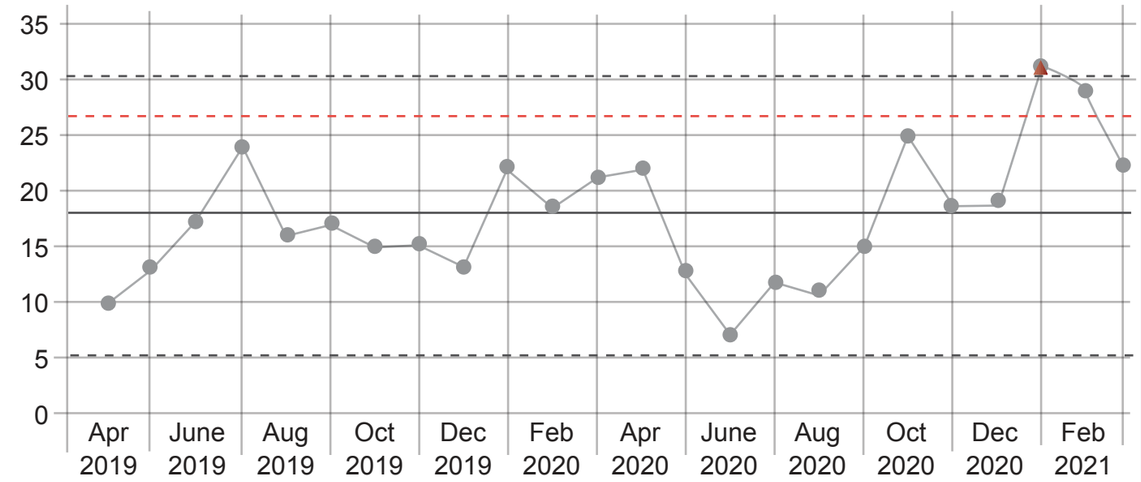
Graph 1.10: Essential Care Indicators, Pressure Ulcer Prevention, Early Intervention Teams



Our in-patient areas report a similar pattern of increased pressure ulcers compared to the baseline set in 2019/20 although for our inpatient areas this increase started in the summer with the first lockdown reporting a lower level of pressure ulcers than during the winter. However rates have increased since summer and in January we reported 31 pressure ulcers, the highest level since the start of the new reporting methodology.

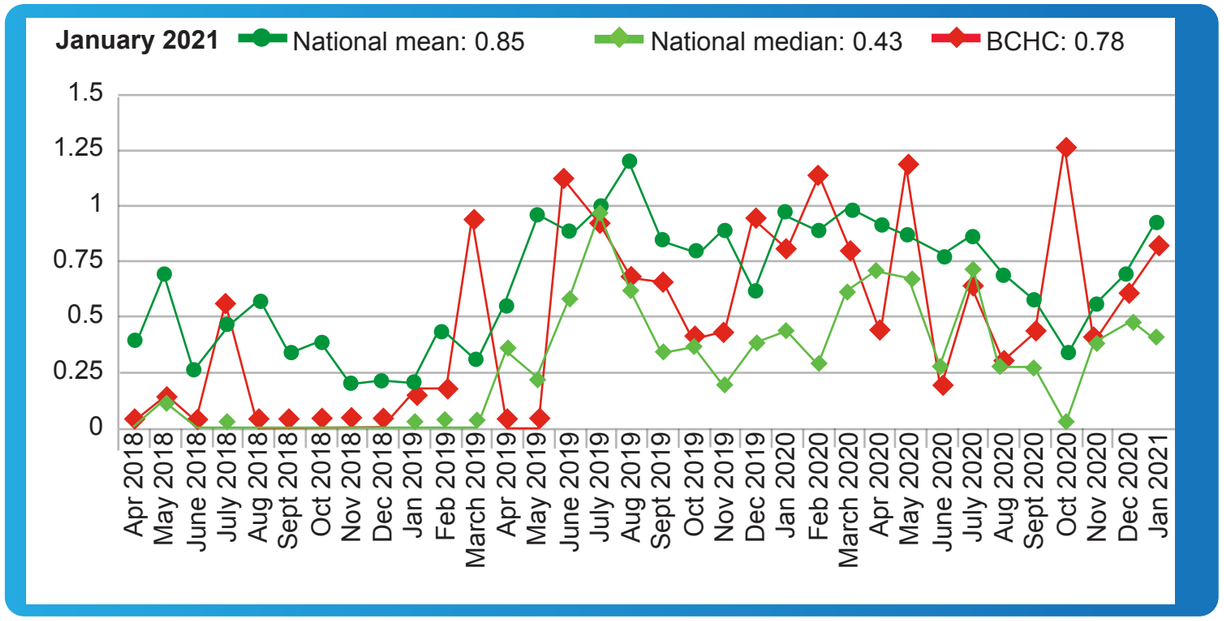
Graph 1.11: All in-patient Pressure Ulcers

Inpatient Developed Pressure Ulcers - All Grades-Inpatients starting 01/04/19



Inpatient services have faced some of the same issues as community teams, in particular staff absence due to sickness and shielding and increased acuity of patients being admitted. These factors may have contributed to the increase in pressure ulcers reported. As shown in the graph below the rate of Pressure ulcers being developed in the Trust during the pandemic was similar to or slightly lower than average for community Trusts over the same period although with some months of where the rate did increase significantly above normal.

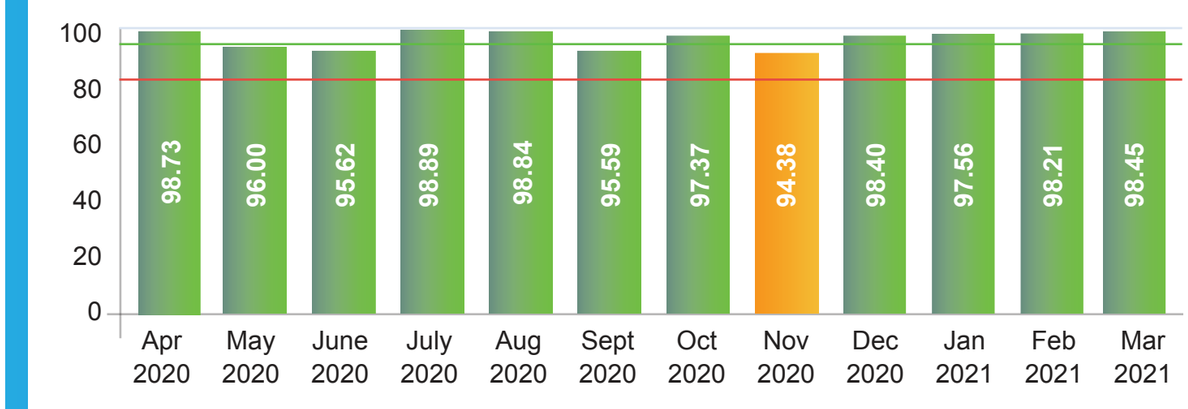
Graph 1.12: Rate of New Grade 2, 3 and 4 Pressure Ulcers acquired whilst under care of the provider in a Community Hospital setting per 1,000 occupied bed days



The inpatient areas also note success in early identification of pressure ulcers and in preventing early stage moisture lesions and pressure ulcers from deteriorating into the more serious grade 3 and 4 ulcers. Out of the 122 pressure ulcers developed in our inpatient areas just 3 (or 2.46%) were of this more serious level.

The wards have also continued to report Essential Care Indicators each month and those specific to Tissue Viability are shown below – again demonstrating an ability to ensure that patients are receiving regular skin checks and that care plans are being implemented and refreshed when circumstances change.

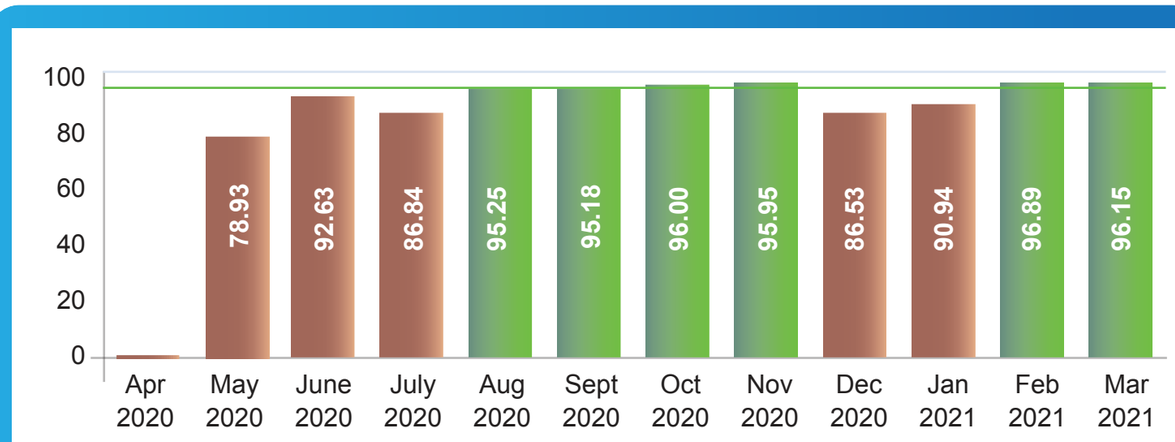
Graph 1.13: Essential Care Indicators, Tissue Viability, Adult and Specialist Rehabilitation Services (ASR)



Two other areas of mandated checks on admission relate to VTE and MRSA for patients.

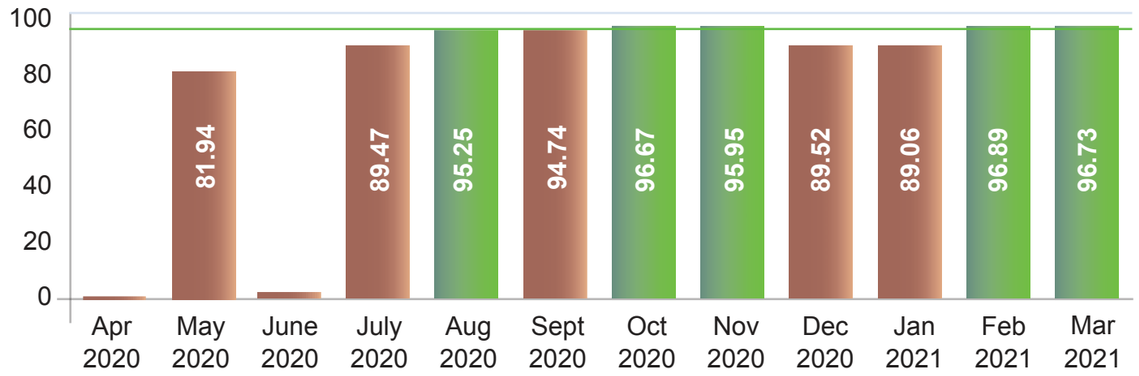
Venous Thromboembolisms (VTEs) are blood clots which form in veins and can then spread to other areas forming dangerous blockages. VTEs are a key risk for immobilised and especially post-surgery patients. As a result we are required to risk assess all adults who are admitted to our in-patients for VTE within 24 hours of their using the criteria in the National VTE Risk Assessment Tool. Where patients are found to be at high risk of developing VTEs we can then take appropriate measures to reduce this risk such as medication and use of compression stockings.

Graph 1.14: Percentage of patients assessed for VTE within 24 hours of admission



Methicillin-resistant Staphylococcus Aureus (MRSA) refers to a group bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans and can spread easily. As a result all patients have to be screened for MRSA on admission and where infection is found patients will be treated and steps put in place to ensure that the infection does not spread to other patients.

Graph 1.15: Percentage of patients assessed for MRSA within 24 hours of admission



As shown in the graphs above (Graph 1.14 and 1.15) performance for screening patients for VTE and MRSA on admission has been mixed this year. In the initial few months of the pandemic neither audits were carried out due to lack of capacity to audit notes, however the assessments continued to take place. When audits resumed it was apparent that there had been a reduction in the levels of assessments taking place within the target timeframe. The reasons for this are varied but will largely relate to increased activity in the initial stages of the pandemic and high turnover of staff with increased use of agency and redeployed staff who will have been less familiar with some processes. It is also possible that in many cases the audits may have taken place but not have been recorded on patient notes for the reasons outlined above, again due to the high turnover of staff.

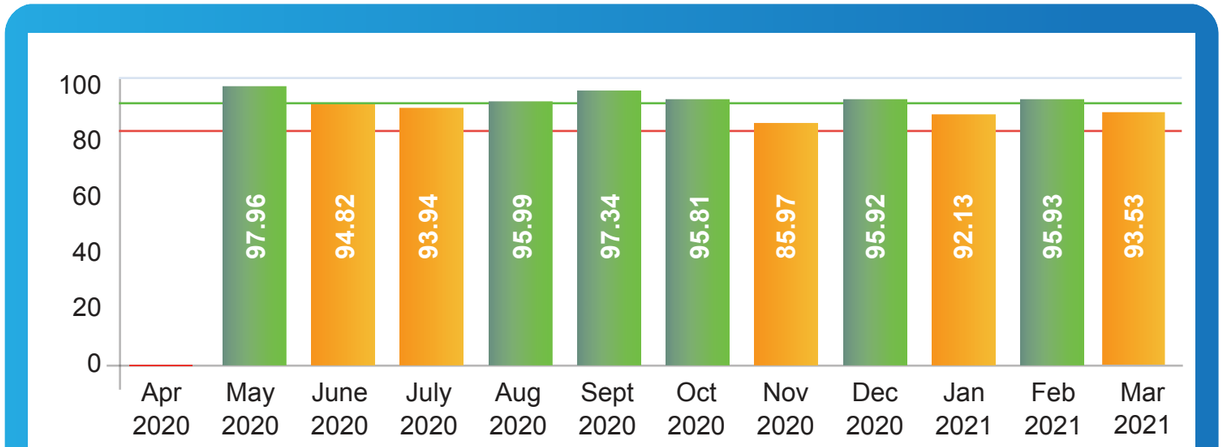
However it is positive to note, that outside of the two main waves of COVID-19, the wards have managed to maintain high level of consistence with the audits and as we approached the end of the year were returning to normal performance. Each month the number of assessments reported has been between over 200 and some months over 300 reflecting the increased activity on inpatient units this year and giving us assurance that the assessment is reporting a representative position covering most admissions.

Essential Care Indicators

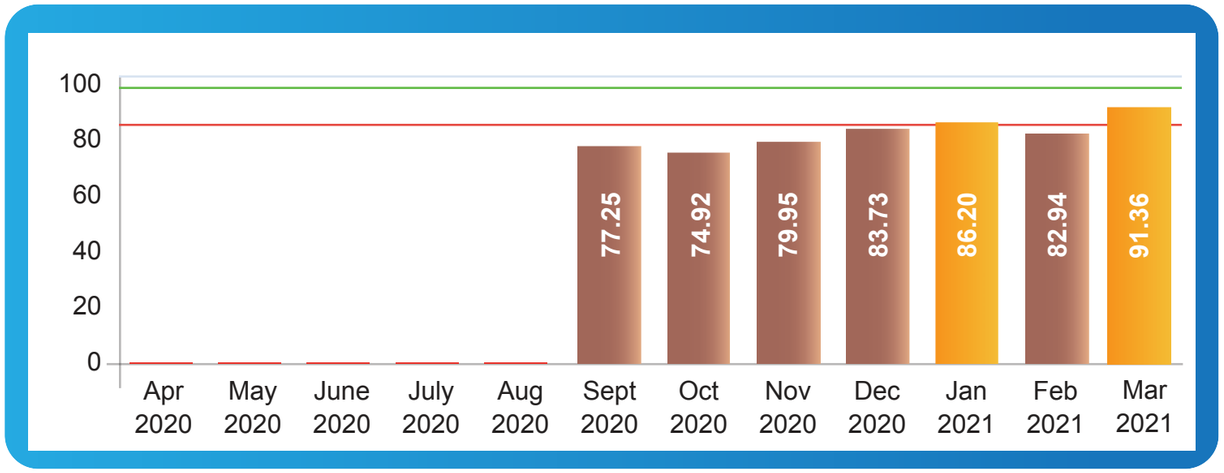
Essential Care indicators are a safety assessment tool developed within the Trust to report the results of team level audits into the basics of care delivery. The questions assessed vary depending on the particular service but could include review of nutrition and hydration status recording, checks to avoid patients developing pressure ulcers or falls risk assessments. All of the audits can be broken down by topic or team allowing services to get a regular update and highlight of any areas of requiring further attention.

This year we added new Essential Care indicators for Early Intervention Community services (Graph 1.16) and began work to substantially review and refresh the audits for children's Health Visitor Services (Graph 1.20). These are in addition to the existing and established audits which cover Dental Services (Graph 1.17), Community Nursing (Graph 1.18), adult in-patient services (Graph 1.19) and Learning Disability Services (Graph 1.21).

Graph 1.16: Early Intervention Essential Care Indicators



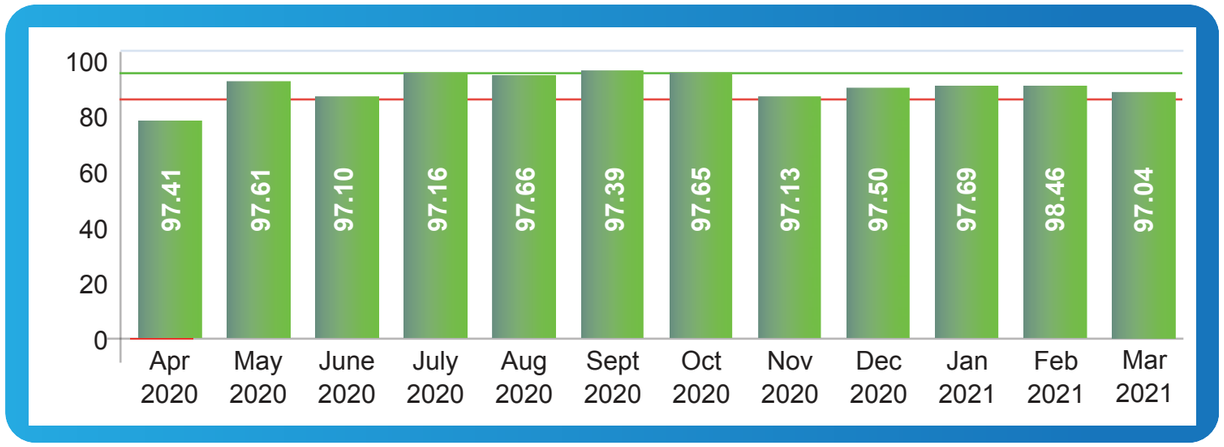
Graph 1.17: Dental Services Essential Care Indicators



Dental Service ECIs were launched in pilot form in June 2019 before a wider roll out across the service in the following months. The audits were developed in part as a response to never events reported in 18/19 and include assessments of quality of information where patients are referred for clinical imaging.

During the first months of the COVID-19 pandemic nearly all activity at the Dental Hospital ceased with only emergency contacts taking place and many of the clinical and support staff redeployed to alternative roles across the Trust. From Autumn the Hospital again began treating reduced numbers of patients under strict COVID-19 secure processes and restarted the Essential Care Assessments. Since then there has been a steady improvement in performance although still short of the target. The main areas of shortfall have related to imaging and discharge planning. The service has also continued to roll the audits out to new areas for example from February including assessments of the Endodontics service. The addition of new services generally results in a reduction in reported performance in the initial months as time is needed to understand and act on the results. There are plans to roll out the audit to Community Paediatrics next.

Graph 1.18: Community Nursing Essential Care Indicators

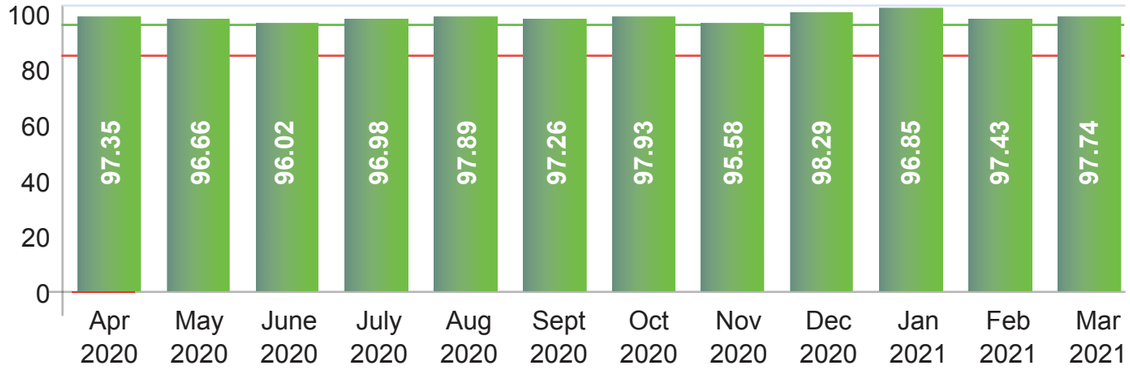


Community Nursing ECIs show a very stable position reporting over 97% compliance throughout the whole year and with all 37 Community Nursing Teams contributing to the audit which assesses the following areas

- Falls Assessment
- Medication Assessment
- Hydration Criteria
- Nutritional Criteria
- Pain Assessment
- Palliative Care
- Patient Observations
- Pressure Ulcer Prevention
- Wound Management

These reports give assurance that community nursing team are managing to carry out key assessments despite the challenge of delivering community nursing during a pandemic.

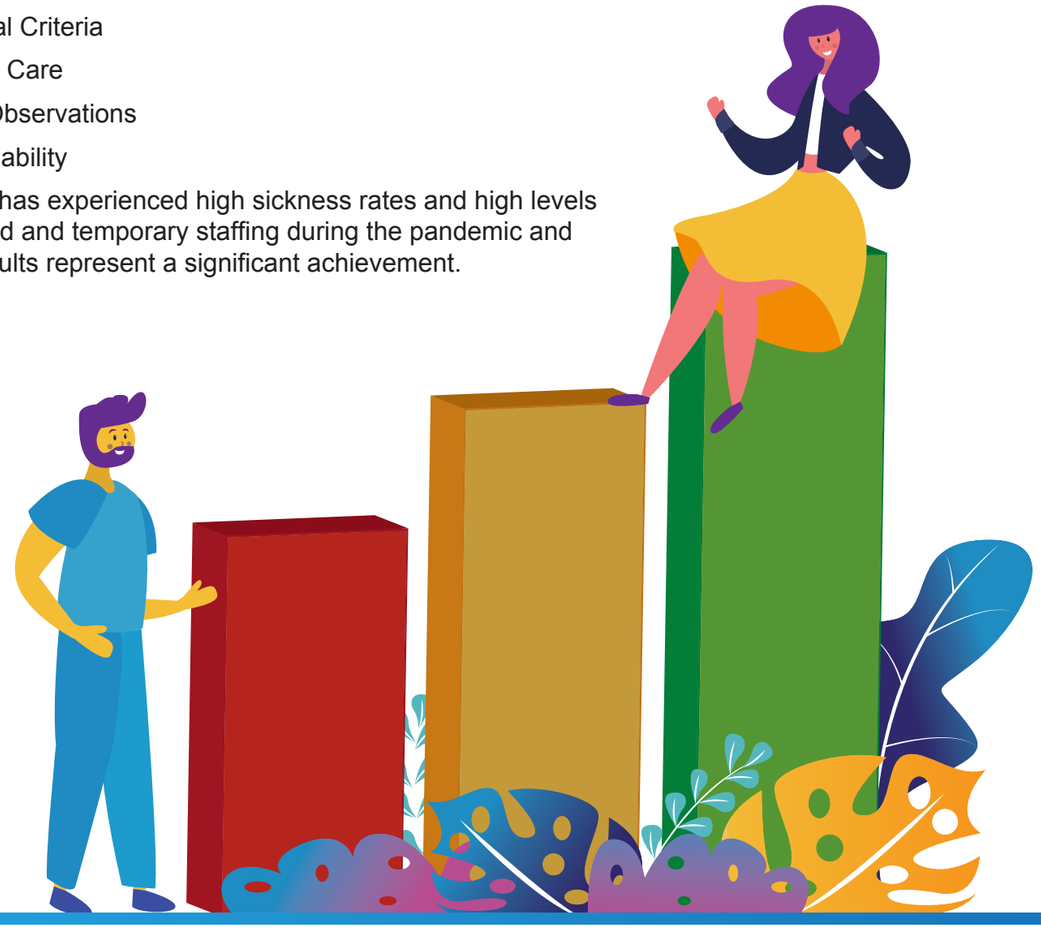
Graph 1.19: Adult In-Patients Essential Care Indicators



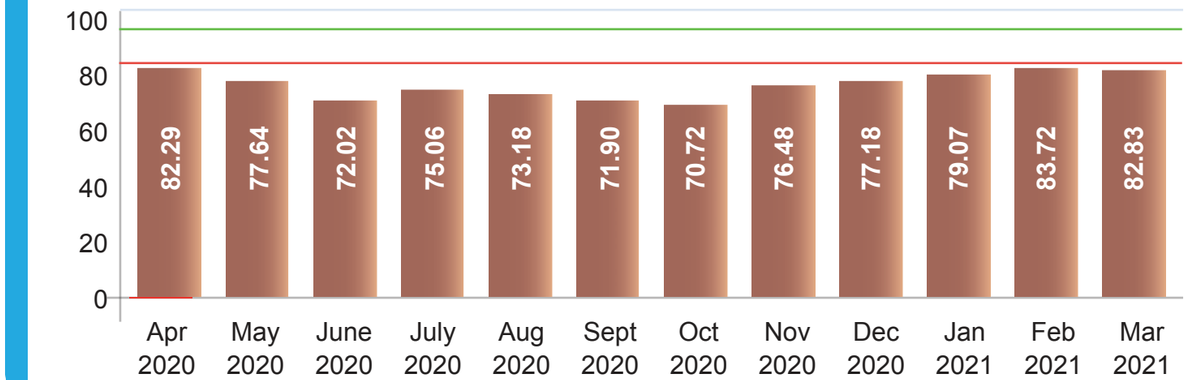
Adult in-patient ECIs show a very stable position throughout the whole year with at least 95% compliance reported each month. Records are audited each month in the following areas

- Admission Documentation
- Falls Assessment
- General / Environmental
- Hydration Criteria
- Medicines Management
- Nutritional Criteria
- Palliative Care
- Patient Observations
- Tissue Viability

The service has experienced high sickness rates and high levels of redeployed and temporary staffing during the pandemic and so these results represent a significant achievement.

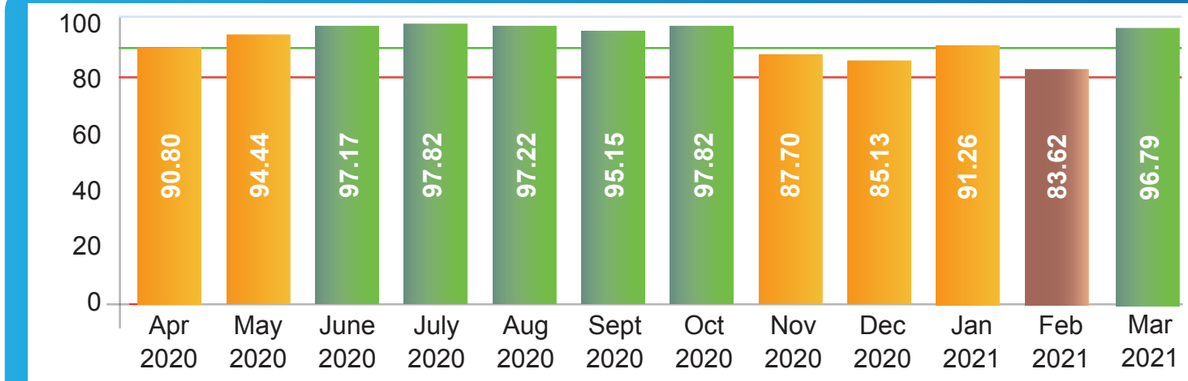


Graph 1.20: Health Visitors Essential Care Indicators



The Children & Families Division's Health Visiting Service has continued to report its own set of Essential Care Indicators (ECIs) and has continued to report breaches each month of the year. However this audit differs from the other ECIs and has been largely based on the Division's delivery of Health Visitor mandated contacts, with other elements such as patient satisfaction paused during the pandemic. As such the performance has mirrored the underperformance shown in those metrics. Whilst a review and refresh of the audit was paused during 2020/21 due to competing priorities this work has now recommenced and a fully updated set of audit questions is awaiting sign off from Quality and Safety Executive before being added to the overall ECI programme. More detail on the performance of our Health Visiting Service is detailed in the sections that follow.

Graph 1.21: Learning Disability Services Essential Care Indicators - Community

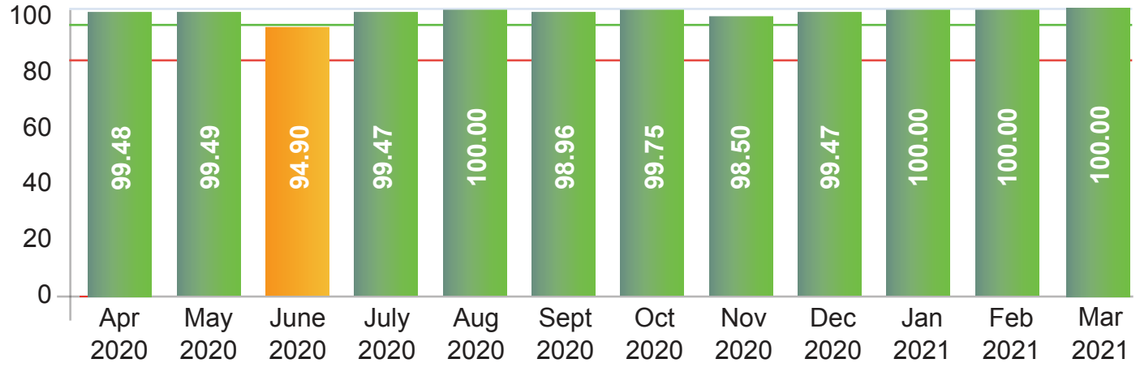


The Learning Disability Community Services report generally good performance throughout the year for their community indicators although the numbers of patients surveyed each month are generally lower than in other areas and are therefore more likely to fluctuate. The Service has also faced a challenging year with both clinical and management staff redeployed during the pandemic. Where breaches have been reported these have generally related to up to date information regarding general Health Promotion and overall clinical pathways and care plans.

Topics covered in the audit are:

- Core Assessment
- Communication Criteria
- Medicines Management
- Nutritional Criteria
- Promotion of Health
- Pathway Indicators

Graph 1.22: Learning Disability Services Essential Care Indicators - Inpatients



The Learning Disabilities (LD) Services have also continued to monitor Essential Care Indicators relating to service users in residential facilities and have reported generally very stable performance throughout the year. The number of service users is again relatively low compared to other ECI audits and the service have maintained performance despite practical challenges caused by the pandemic.

Topics covered in the LD inpatient audit are:

- Communication Criteria
- Falls Assessment
- Environmental Assessment
- Medicines Management
- Mental Health
- Nutritional Criteria
- Patient Observations
- Promotion of Health
- Record Keeping Status
- Safety Indicator Criteria
- Tissue Viability

Health Visitors WTE in post

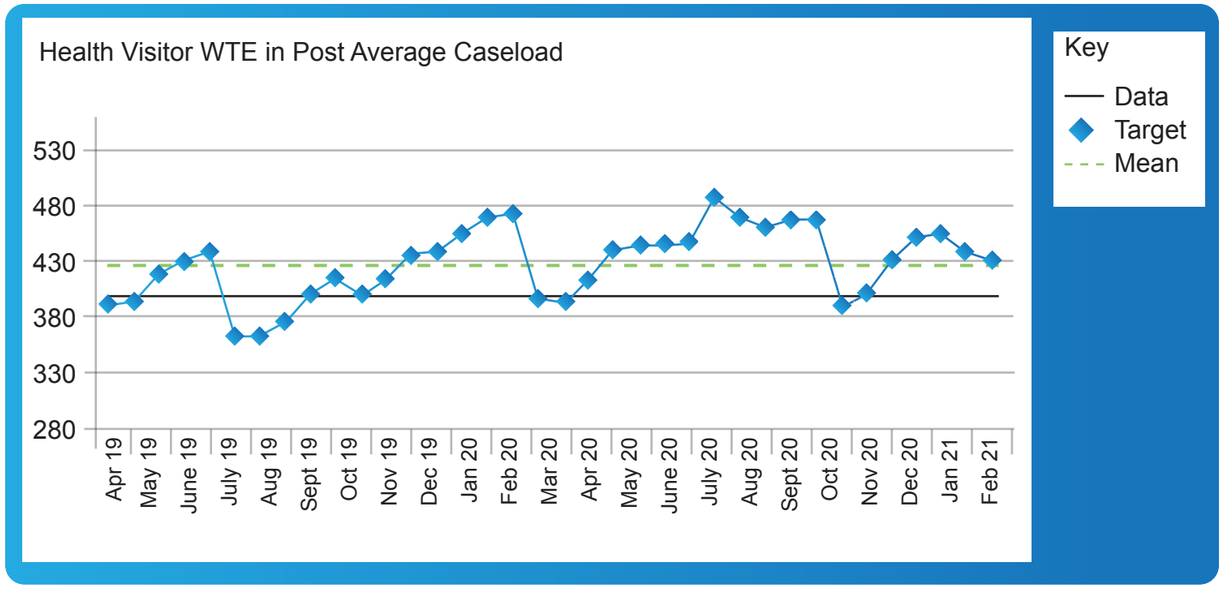
A key challenge for the Trust this year has been the need to improve performance in the health visiting service as identified in our CQC assessment visit. A key marker of capacity is how many children each Health Visitor is responsible for and so we have developed a KPI reporting the average caseload per health visitor. The target was set at 350 children for each WTE health visitor based on some national guidance suggesting this is a 'safe' level. However it is worth noting that the national guidance does not define the acuity of the children or other aspects of how vacancies and temporary staff should be counted, meaning that comparisons with other providers of health visiting services should be treated with caution.

A capacity tool has been developed to support the service in managing demand across the city and this gives detailed information to team managers on the number of patients and their complexity both within teams and also allocated to individual staff. This tool takes into account sickness absence and use of temporary staff as well as allocating some clinical time for Team Leaders and Practice Teachers in addition to the Band 6 Health Visitor roles who carry the majority of the caseload.

As shown in the graph below (Graph 1.23) the caseload tool described above shows health visitors have had on average more than 350 children on their caseload throughout the year. An annual incremental increase is noted in the caseload starting from September when children who start school are moved to the School Nursing caseload, following which new births continue to be added to the Health Visitors.

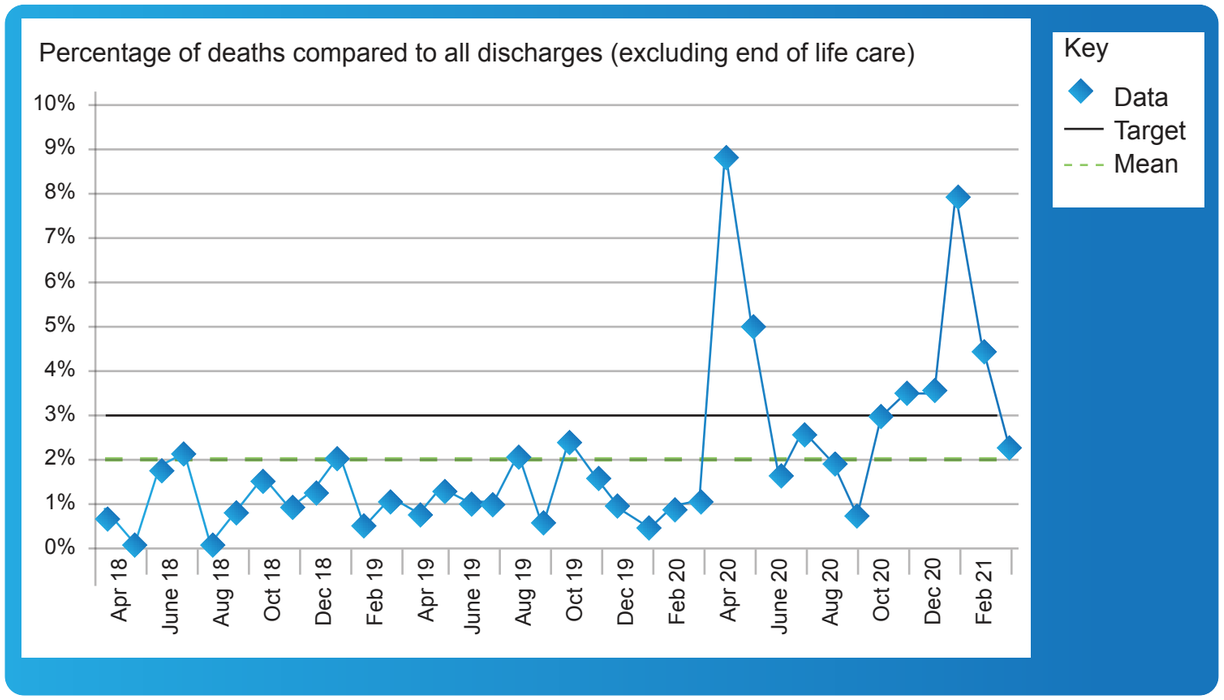
Despite the recruitment challenges posed by the pandemic the service have continued to develop their approach including categorising caseload into different bands to ensure that support is focussed on the most vulnerable children with the highest levels of need. Many of the children shown on the overall caseload will not require any additional support from Health Visiting services after their 2.5 year checks, although they remain able to access support should they wish to.

Graph 1.23: Health Visitors Average Caseload

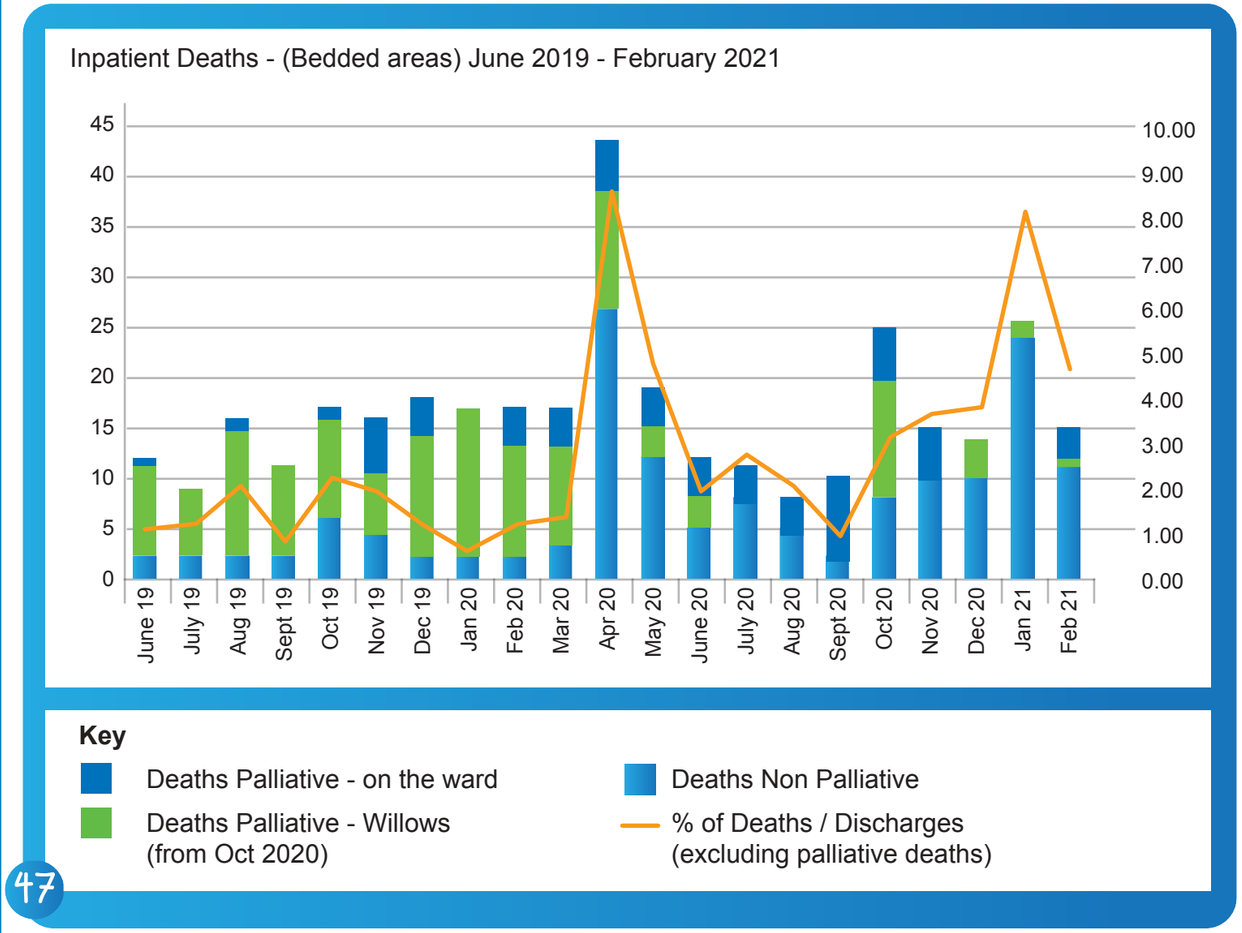


Avoidable Deaths

Graph 1.24: Percentage of Deaths to Discharges



Graph 1.25: Inpatient Deaths



The Trust continues to report the ratio of Deaths to Discharges as well as conducting mortality reviews into deaths to assess whether there were any factors in the patient's care which could have contributed to their death.

As shown in (Graph 1.25) this involves reporting every inpatient death and indicating which patients were receiving palliative (end of life) care. All non-palliative deaths as well as any palliative patients on a mainstream ward are subject to a full case note review to determine to what extent 'problems in care' contributed the death. To provide additional assurance five randomly selected palliative deaths are also reviewed each month. The rate of deaths to discharges is also reported each month to ensure that any unusual peaks in deaths would be identified and investigated.

It is clear from the charts above that both the ratio of deaths to discharges and the absolute number of deaths both increased during the pandemic. The impact of the first main wave is clearly visible in April when 27 non-palliative deaths were recorded on the wards and then again in January during the second main wave when we reported 24. The reason for the increased mortality is primarily the changes to discharge rules which meant that patients were discharged from acute hospitals to our care when they were more unwell than would normally be the case. Whilst this has presented particular challenges to the staff on the inpatient wards it is positive to report that none of the mortality reviews have identified any avoidable deaths.

Integrated Care in Communities

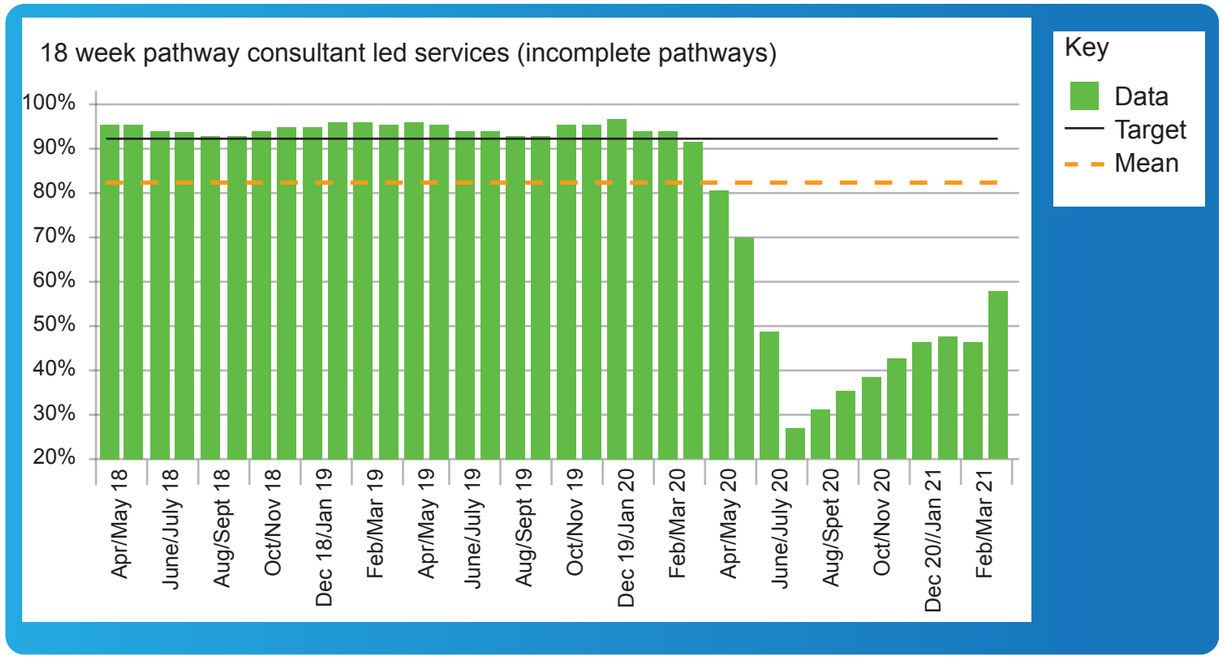
The Integrated Care in Communities domain reports on the way in which the Trust supports community based partnership working by keeping patients safely at home for as long as possible with community care and support, and by helping acute trusts to safely discharge patients with appropriate community care or admission to a community bed. Performance in this domain is overseen by the Finance and Performance Committee.

This year the domain has reported on some areas of particular challenge and the impact of the COVID-19 pandemic in increasing patient waits is very clear.

In particular we report

- A decrease in the percentage of patient on consultant led (RTT) pathways who receive their first treatment within 18 weeks of referral
- An increase (from zero) in the number of patients on those 18 week RTT pathways who have waited more than 52 weeks from referral
- Increasing numbers of all patients (on both consultant and non-consultant led pathways) who have waited more than 52 weeks from referral without being seen
- Increasing numbers of patients who have started treatment but who have waited more than 52 weeks since last contact with the Trust (often for follow up assessments)
- Pressure on our health visiting services who nevertheless show improvements in the delivery of mandated contacts with children
- A significant improvement in the rate of Delayed Discharges of patients who are medically fit for discharge but who are still in hospital due to problems arranging for safe discharge.

Graph 1.26: Whole Trust 18 week RTT Incomplete Pathways (patients waiting for treatment)

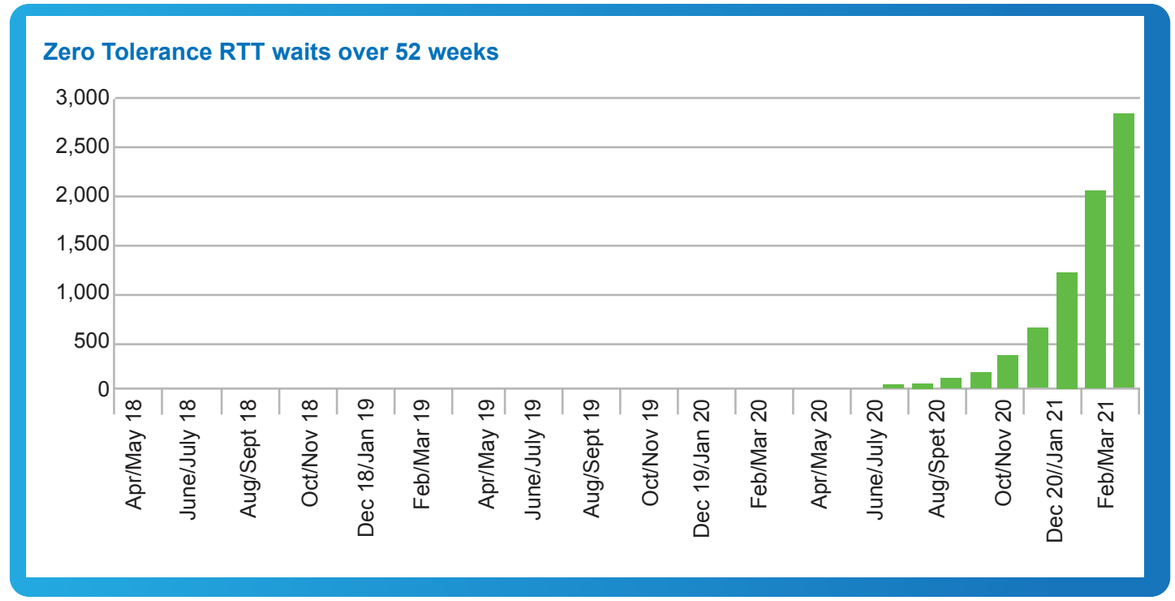


As shown in the graph above (Graph 1.26) throughout previous years the majority of patients waiting for treatment on consultant led pathways have been seen within 18 weeks of their referral. The nationally set target is 92% and we had achieved this consistently until March 2020 when many patients had their appointments cancelled due to risk of COVID-19 infection leading to unavoidable increases in their waits for treatment. The percentage of RTT patients waiting less than 18 weeks then fell each month until July when we reported just 26.78 of patients on consultant led pathways with waits of less than 18 weeks. This figure represented 7,112 patients waiting over 18 weeks from a total of 9,713 patients on RTT pathways.

Since then performance has improved although it is still far below targets. At the end of the year we report 5,777 patients waiting over 18 weeks from a total consultant led waiting list of 13,316 patients.

Along with these waits over 18 weeks the Trust also monitors patients on consultant led RTT pathways who have waited over 52 weeks from referral without commencing treatment. As shown in the graph below we had not reported any breaches of this target until March when 3 patients reported waits over 52 weeks. This total has increased each month and we end the year with 2,817 RTT waits over 52 weeks, a figure which may increase into the new financial year.

Graph 1.27: Zero Tolerance RTT waits over 52 weeks



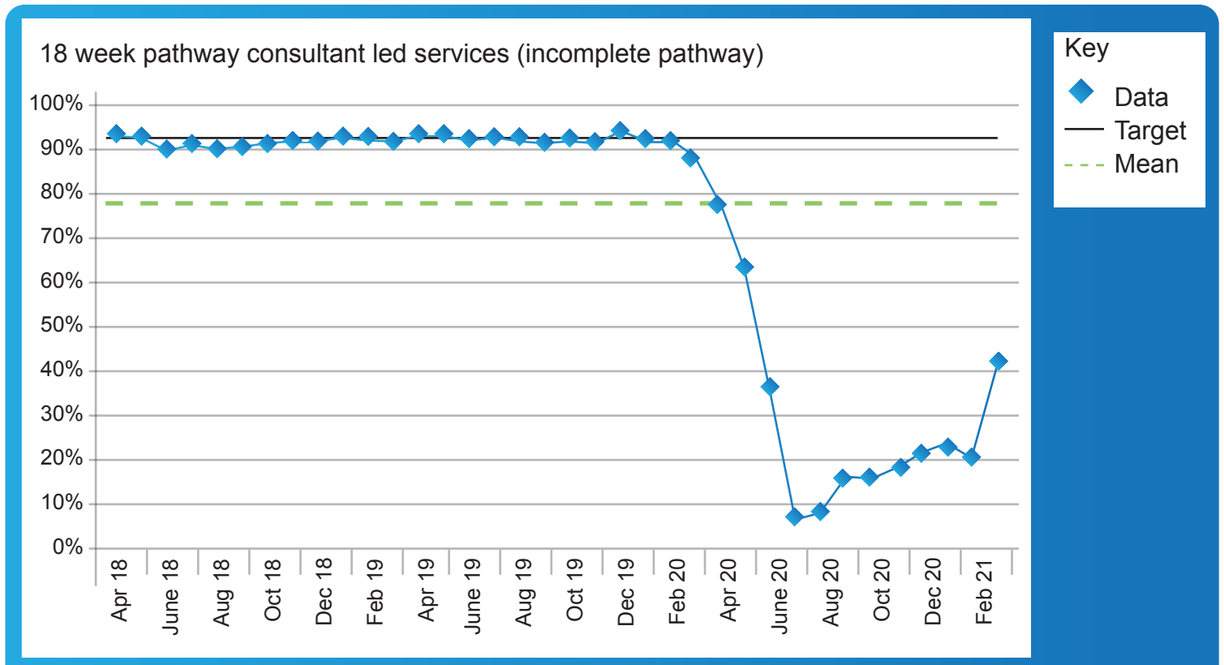
The reasons for these increases in waits have been challenging to manage. Some services were paused to all but the most urgent referrals at the start of the pandemic with staff redeployed to other roles leading to inevitable increases in waits. Other services have continued to operate but with much reduced capacity due to the need to establish COVID-19 secure practices which could include reduced capacity for patients to wait and a requirement for clinical rooms to be left vacant for airing following some procedures. Patients have also asked to delay treatment due to concern about COVID-19 safety and in some cases due to a need to shield. However referrals in many areas were also reduced at early stages of the pandemic.

Services have now begun offering non face to face (or virtual) appointments by video call or telephone and this has led to an ability to carry out more appointments as the year has developed.

The Dental Hospital carry out a significant number of the Trust's consultant led pathways and have been most affected by increased waiting lists with most of their services paused in the early months of the pandemic and many clinical and other staff redeployed to alternative roles. Of the 13,316 patients waiting for treatment on RTT pathways at the end of the year 9,788 are patients at the Dental Hospital.

As shown below (Graph 1.28) the Dental Hospital service had been able to achieve the 92% standard throughout the previous years until patient cancellations in March 2020 caused additional waits for patients. Performance was worst in July 2020 when just 7.75% of the Consultant led caseload had waits of less than 18 weeks. This represented 539 patients from a waiting list of 6,954. With adoption of COVID secure practices the service has been able to improve this situation albeit still operating with reduced capacity. At the end of the year waits have improved so that 42.98% of the patients waiting for first treatment on RTT pathways are less than 18 weeks. This represents 4,207 out of 9,788 patients.

Graph 1.28: Dental Service 18 week RTT Incomplete Pathways (patients waiting for treatment)



RTT consultant led waits over 52 weeks have continued to rise throughout the year and the majority of the Trust's patients who are in this group are patients at the Dental Hospital. At the end of March all but 11 of the Trust's patients over 52 weeks on RTT pathways were at the Dental Hospital.

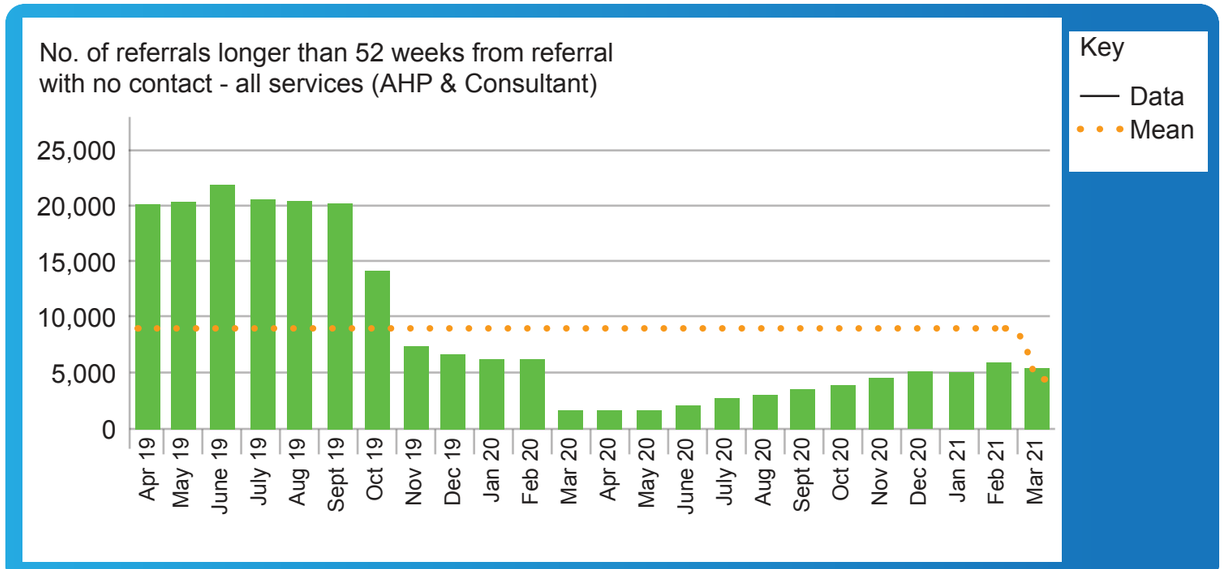
In addition to the national focus on consultant-led pathways, many of our patients are being treated on non-consultant led pathways. In 2019/20 services across the Trust had focussed on all patient waits from initial referral to first treatment (Graph 1.29) and also looked at reasons why patients who have already began treatment have not been seen for 52 weeks or longer. (Graph 1.30)

As shown in the graphs below we had shown great success in reducing waits over 52 weeks in the previous year.

Partly this was due to resolving data quality issues with the Trust developing live information systems and individualised processes and Standard Operating Procedures to support individual services in managing their waits and removing patients who were no longer waiting for treatment. However this work was significantly challenged by the pandemic as already detailed with services across the Trust paused and only able to respond to the most urgent needs.

Waits for first treatment have increased steadily throughout the year from a low of 1,788 in March 2020 to a high of 6,149 in February. It is therefore positive to report an improvement in the figures with March's unseen caseload dropping to 5,481 as services recommence a full service offering and develop new ways of delivering COVID secure appointments including increasing use of virtual contacts.

Graph 1.29: Total number of patients waiting longer than 52 weeks from referral with no contact



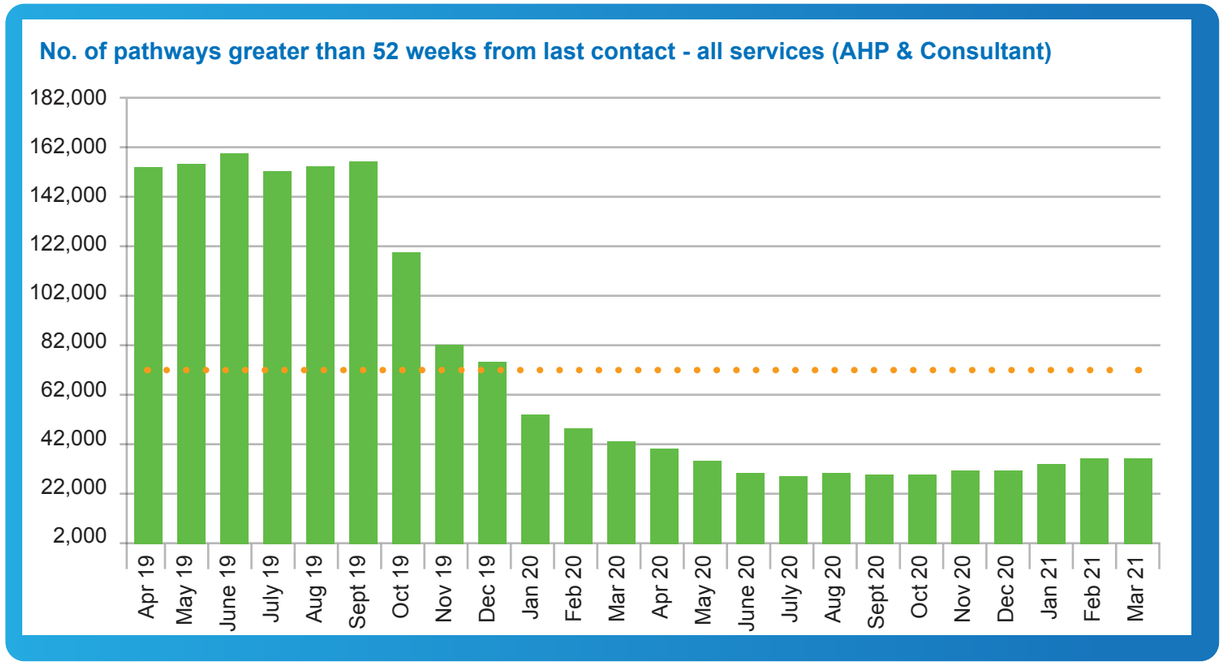
As shown in the table below the majority of patients waiting over 52 weeks for first contact following referral are at the Dental Hospital. However other services including particularly Children & Families have high waits for a range of services including some therapies such as Speech & Language therapy and also for support on Neuro Development services.

A key focus of work this year has been the development of clinical reviews to assess which patients are at risk of harm if they continue to wait for treatment, combined with processes to ensure these patients are prioritised for treatment. Services are now calling high priority patients for treatment; however as a result of this other patients will continue to experience unavoidably long waits into the new financial year.

52 week referrals Divisional Breakdown (M12)					
Trust	**AC**	**ASR**	**C&F**	**DS**	**LD**
5,481	51	419	1,865	3,145	1

Waits over 52 weeks for patients who have already been treated but form active caseload have increased in a similar way to waits for first treatment throughout the year. As shown in the graph below following significant reductions in the previous year waits began increasing again last year and we end the year with 35,015 patients who are on active caseloads but have had no contact for 52 weeks or longer.

Graph 1.30: Total number of patients waiting longer than 52 weeks since last contact



As shown in the table below patients in this category are more evenly spread throughout the Trust with Adult Specialist Rehabilitation services, Children and Families and Dental services all reporting over 10,000 patients of this category.

52 week referrals Divisional Breakdown (M12)					
Trust	**AC**	**ASR**	**C&F**	**DS**	**LD**
35,015	802	12,761	10,060	11,390	2

The same process of clinical review to assess risk of harm is also being applied to these patients. However it is important to note that some of these patients may have chosen to delay continuation of treatment or follow up appointments as they need to shield or have other concerns about treatment at the current time. The lists also include patients who have equipment or long term conditions which do not require regular contact. Providing these patients know how to access support should they need it then long periods between contacts are not necessarily an issue and further work is taking place to categorise these patients who are on Patient Initiated Follow Up pathways.

Health Visitors Mandatory Contacts

Health Visiting services have a number of nationally mandated and reportable contacts which they make to all children within their area of responsibility. The contacts start with meeting a new baby within 14 days of birth and then take place at 6-8 weeks, 12 months and 2.5 years. Health Visiting services have been challenged for some time with high caseload figures which have been impacted by vacancies and problems with recruiting to key posts.

However the services have continued to operate throughout the pandemic and so it is positive to report that despite challenging conditions and increased staff sickness a recent improvement in the levels of children and families receiving these mandated contacts has begun to be reported.

Table 1.31: Health Visitor Mandated Contacts

Month	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021
Health HV Mandated Visits - New Birth Contact	95%	97%	97%	97%	98%	96%	97%	96%	98%	97%	98%	96%
Health HV Mandated Visits - 6 to 8 Week Contact	76%	78%	81%	84%	81%	79%	83%	81%	83%	81%	91%	90%
Health HV Mandated Visits - 12 Month Review	42%	42%	37%	44%	44%	39%	45%	47%	54%	57%	70%	68%
Health HV Mandated Visits - 2 and a Half Year Review	57%	53%	55%	53%	51%	44%	44%	51%	50%	51%	60%	63%

The service has prioritised visits to new babies within 14 days of birth and has reported at least 95% of these delivered within that target throughout the year. Visits to babies at 6-8 weeks have dropped as low as 76% in April 2020 and so it is very positive to end the year reporting over 90% delivery for two consecutive months. Reviews at 12 months and 2.5 years also show an improving position as we end the year.

A key challenge for the service has been recruiting sufficient staff to cope with increasing need from a growing population. Health Visitors are a staff group which are difficult to recruit to and so the service have been running ongoing recruitment campaigns as well as working closely with universities to attract new recruits to the Trust.

A further area of activity has been working with the commissioners to redesign services in order to focus care on the most vulnerable children whilst using support from children's centres and other staff groups to provide support and access to other parents. Whilst caseloads remain higher than is ideal it is important to note that the majority of children are classed as 'universal' and whilst support remains available to them their families are very unlikely to contact Health Visiting services following their 2.5 year reviews.

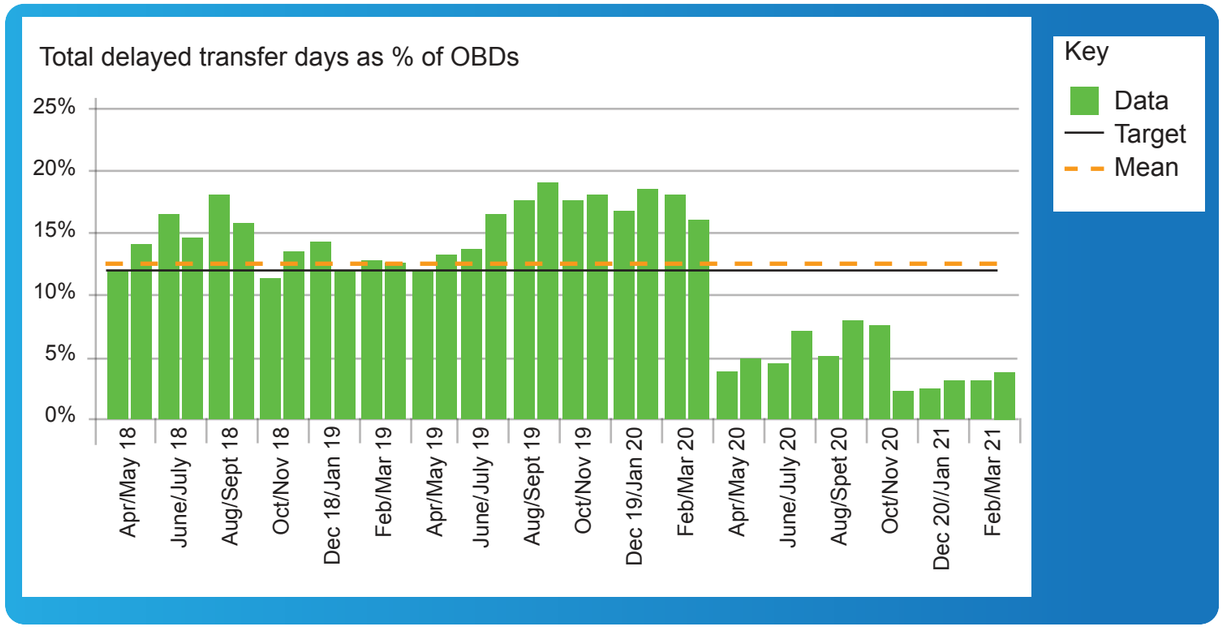
We also recognise that parents may delay or decline initial contacts and so it is worth noting that additional assessments to those reported are made slightly outside of the target timescales which nevertheless provide care and support as defined. Maintaining and building on the improvements showing at the end of year and ensuring that staff skill mix and caseload handling is designed in a manner which provides the most effective possible support to children and their families will remain a key focus of activity in the new financial year.

Delayed Transfers of Care

As shown in the graph below (Graph 1.32) the Trust has continued to report the extent to which our inpatient beds are occupied by patients who whilst medically fit for discharge are unable to leave for some other reason. These delays reduce our capacity to support discharges from acute hospitals as well as admit community patients who need rapid assessment.

The graph highlights a significant change at the start of the year when we reconfigured our beds to support the wider NHS system in its COVID-19 response in order to ensure that acute Trusts had as much capacity as possible to respond to the surge in admissions. New national guidance on discharge criteria were issued and the Trust set up a Discharge Hub to liaise closely with system partners including Social Workers and Local Authority and private nursing homes to ensure avoidance of unnecessary delays. Throughout 2019/20 the Trust provided over 1,000 bed days each month to patients who were medically fit for discharge, this has reduced significantly and in the last quarter of this year was at or below 200 days per month.

Graph 1.32: Delayed Transfers of Care (as a % of Bed Days)



The impact of new guidelines on discharge, the development of the Discharge Hub with full time discharge facilitation roles and increased working with system partners are all key reasons for the improvements noted.

A Great Place to Work Domain

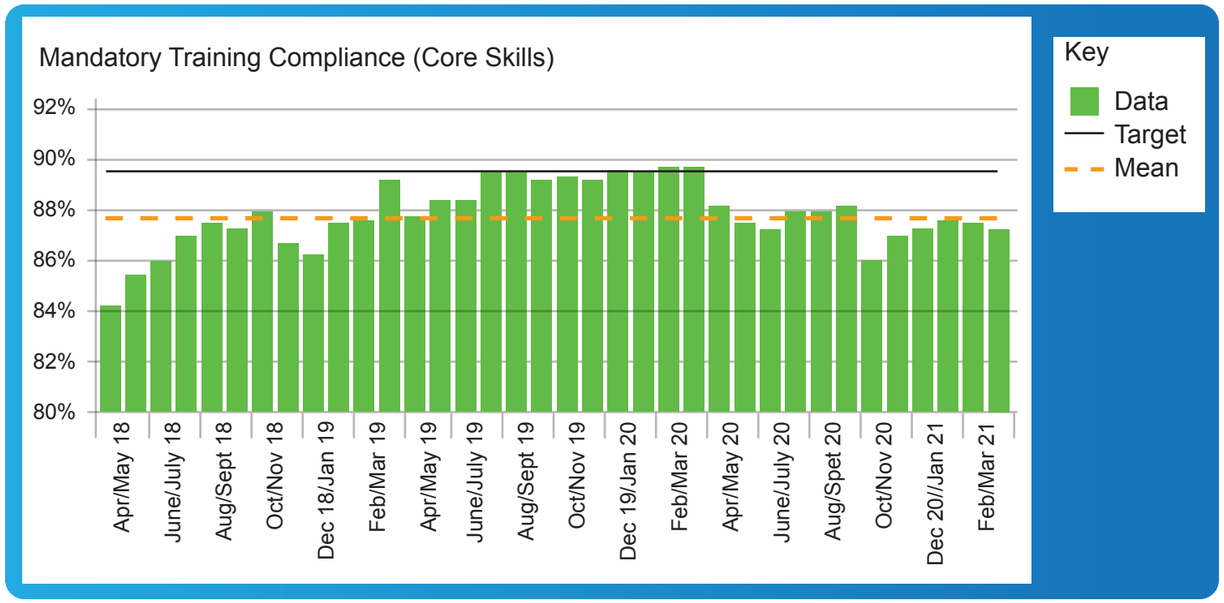
The 'Great Place to Work' domain reports key measures of staff experience and support. Some of our most persistent challenges remain within this domain with many services reporting a combination of increasing numbers of more acutely ill patients, combined with vacancies and challenges recruiting new staff.

In particular the 'Great Place to Work' domain highlights

- A minor but persistent under performance against mandatory training targets
- Underperformance against targets to ensure all staff have at least an annual personal development review (appraisal)
- An improving vacancy rate throughout the year
- A sickness rate which has been volatile throughout the year but shows recent signs of improvement
- An improvement in the disparity between the application of formal disciplinary policies to white staff and those from Black and Minority Ethnic communities (BME).

Performance in this domain is overseen by the Workforce and Organisational Development Committee.

Graph 1.33: Mandatory Training % compliance



As shown in the graph above (Graph 1.33) the Trust has spent much of the year performing slightly below its target that staff should have on average 90% of their total required mandatory training. Performance has been stable in this area varying by just 2% throughout the year with a low of 86.05% and a high of 88.12%.

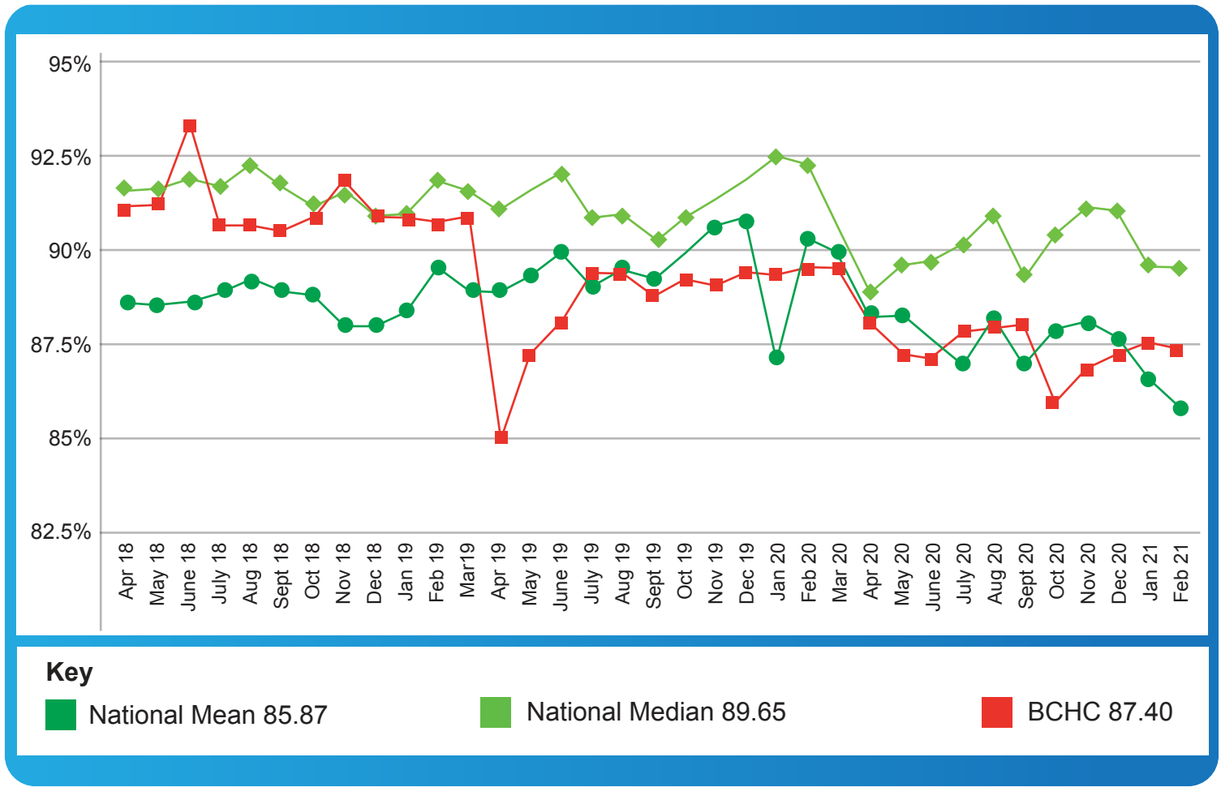
Delivery of Mandatory training has been significantly affected by the COVID-19 pandemic. Staff have been shielding or working in areas with high sickness rates meaning that it is difficult for them to attend training. In many cases staff have been redeployed with day to day management from new teams which may have different mandated training to their substantive roles. The pandemic has also meant that classroom based training was initially halted and whilst it has restarted for courses which need to be face to face (such as some manual handling, resuscitation and site specific fire) capacity is much reduced.

The online portal continues to operate and much training has now shifted on-line with individual policy leads reviewing learning from this exercise to ensure that in the future we provide virtual training where this is safe and appropriate. The Learning and Development team have continued working closely with divisional general managers to ensure detailed breakdowns of training and gaps in compliance are available to managers.

Although based on national guidance, Trusts set their own mandatory training requirements in co-ordination with commissioners. As a result it is difficult to benchmark between different organisations. However as shown in the graph below comparisons with other Community Trusts suggest that BCHC has remained at or close to the National Mean average as far as delivery of training.

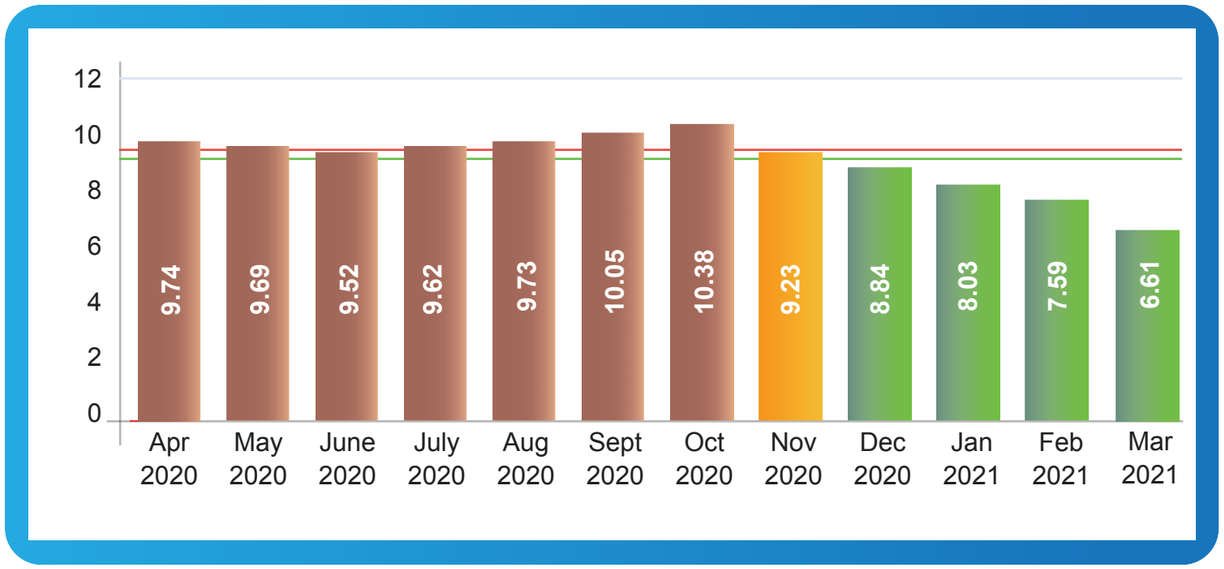
As staff return to their substantive roles from redeployments or in some cases shielding delivery of PDRs and individual reviews of mandatory training remain a key focus of work.

Graph 1.34: Benchmarking of Mandatory Training Compliance



https://members.nhsbenchmarking.nhs.uk/project/29/toolkit?a=960&b=991

Graph 1.35: Vacancies



Vacancies have remained higher than the 9% target throughout the first half of the year (as shown in Graph 1.35). However the latter months show a steadily improving position and we end the year with a vacancy rate of 6.61% which represents around 315 whole time equivalent vacancies. However it has also to be noted that some services do continue to face significant challenges when recruiting to qualified specialist roles.

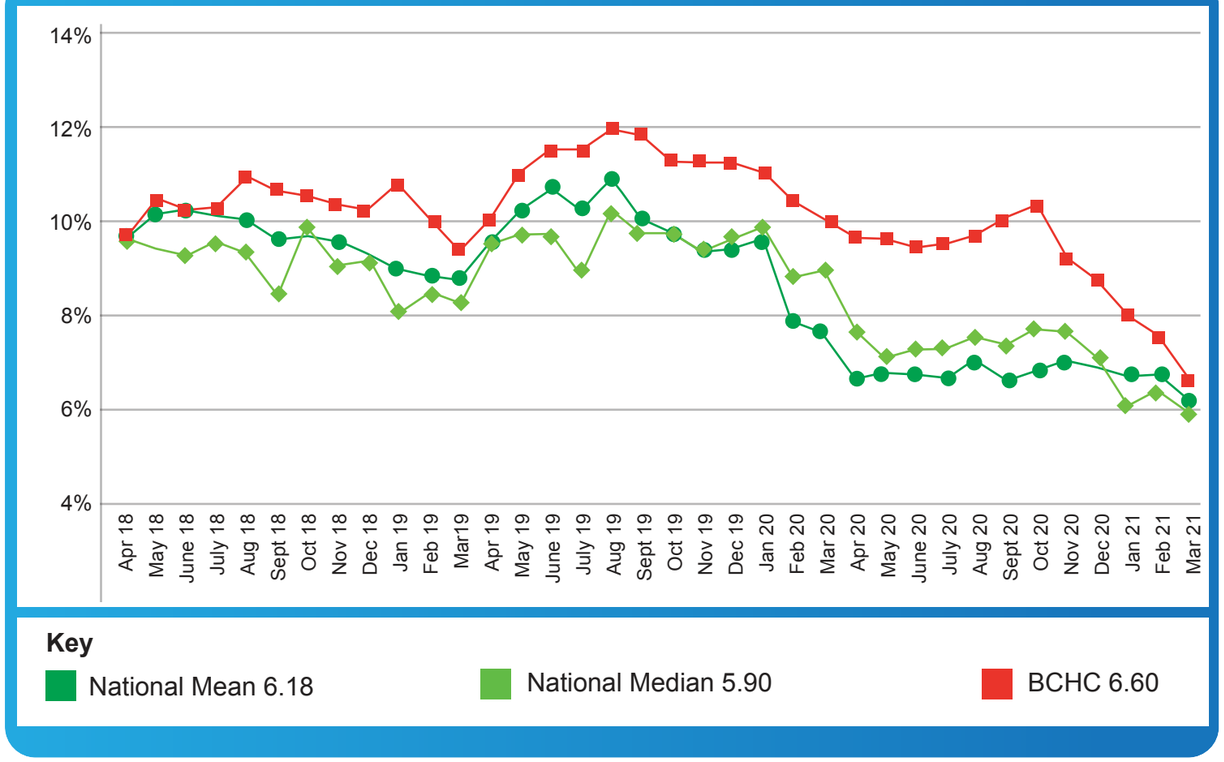
The pandemic has presented both challenges and opportunities with many staff given the chance to work in different areas and a large number of temporary posts created in for example immunisation and swabbing teams to meet the changing circumstances.

Regular monthly recruitment open days have continued throughout the period despite the challenges of operating under COVID secure rules.

Services have also continued to link with universities and apprenticeship programmes and in some areas have been able to offer temporary roles to students whose courses have been paused during stages of the pandemic.

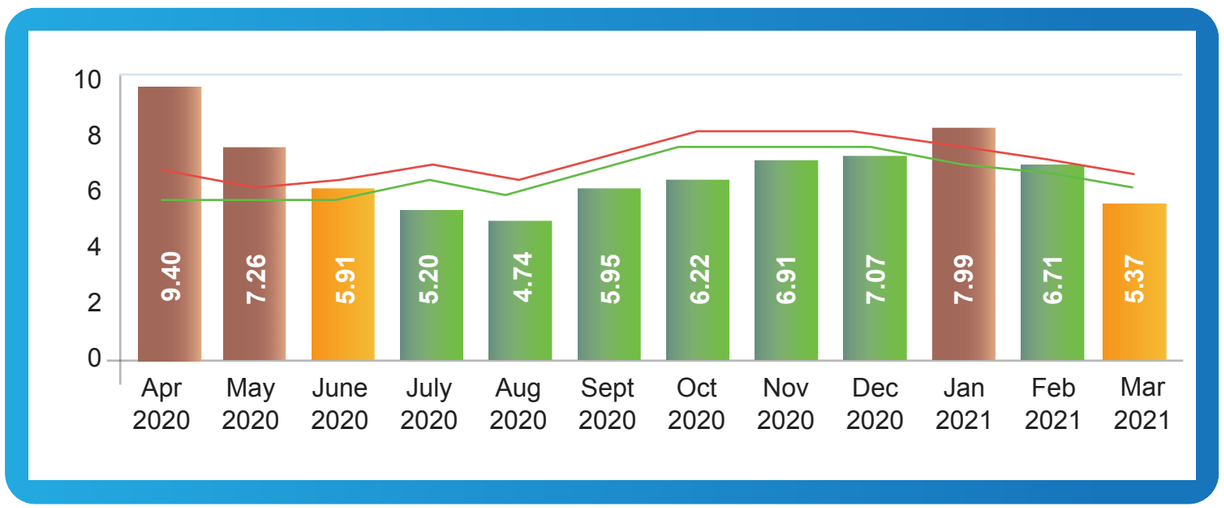
Benchmarking against other community services as shown in Graph 1.36, shows the Trust with historically higher than average levels of vacancy over recent years. However the improving position since October takes us very close to the average in February at 7.6% against 7.26%. Budgets and staffing allocation will be reviewed in the new financial year with some services continuing to work in substantially changed ways and so it is unclear how we will compare to benchmarks going forwards.

Graph 1.36:



https://members.nhsbenchmarking.nhs.uk/project/29/toolkit?a=960&b=994

Graph 1.37: Staff Sickness Rate

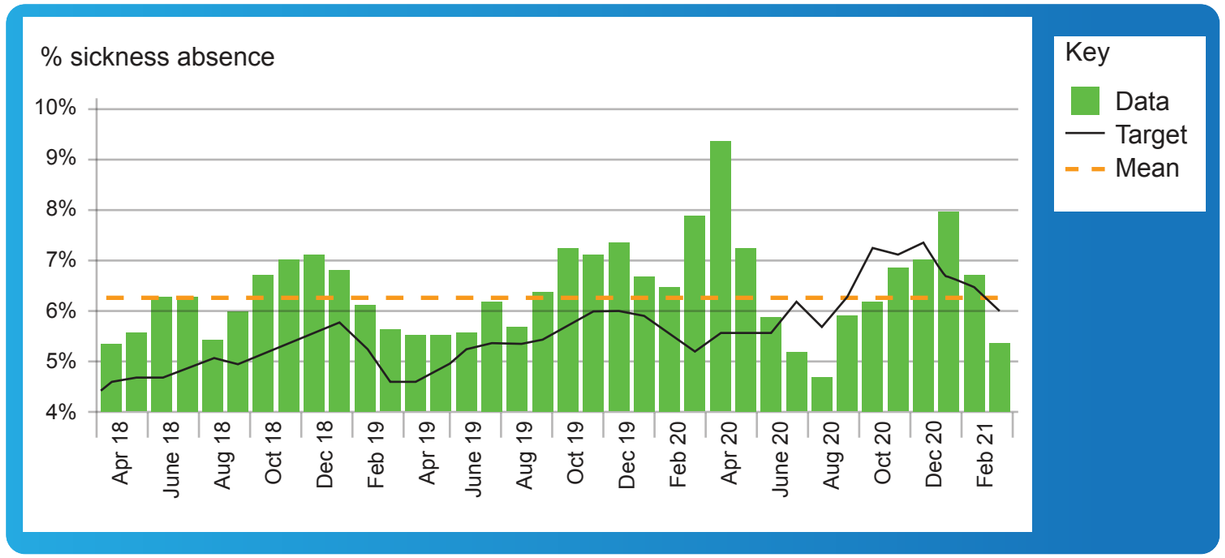


Staff sickness has shown considerable movement during the year. The 9.4% absence reported in April 2020 represents the highest level of sickness we have ever reported. However during the summer months and at year end we show lower sickness and report an improving position compared to this time last year.

All Divisions end the year achieving their individual sickness targets and all divisions show reductions in the rate of long-term sickness which indicates that some of the improvements may be sustainable.

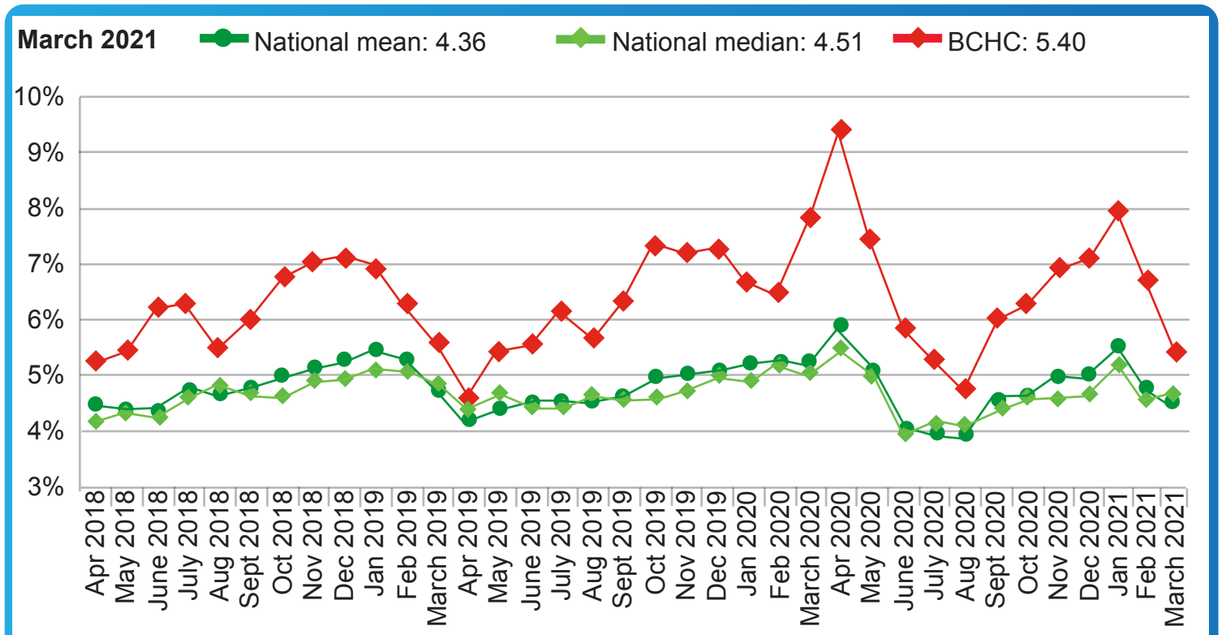
Reasons for increased sickness include staff with COVID-19 and those experiencing anxiety related to changing work processes and redeployments. There have also been increasing numbers of staff waiting for scans, surgery or therapies before they can return to work who have experienced delays in accessing care. Maintaining contact with staff has been harder than usual but ongoing welfare calls have taken place and staff have had full access to Team Prevent and Care First support. The Trust has provided individualised Risk Assessments to all staff in order to support their welfare during this period. Other initiatives include a Health and Wellbeing Programme with a specific focus on Mental Health and the introduction of the Mental Health First Aid training and Staff Resilience Programme.

Graph 1.38: Sickness absence long term trends



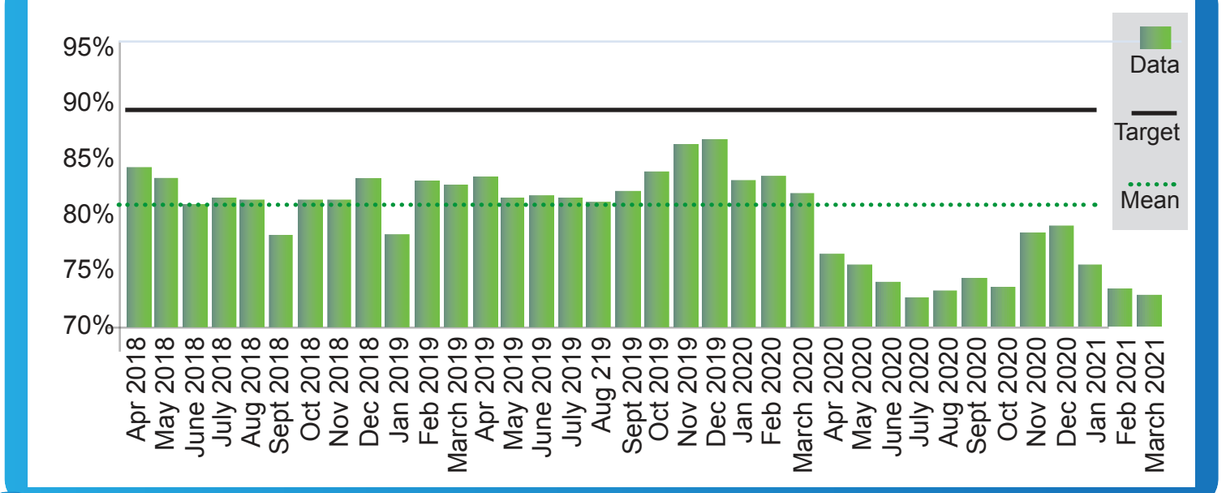
Despite these improvements NHS Benchmarking against community trusts shows a six month average sickness rate of 5.0% in February 2021. The Trust compares unfavourably to this with an average of 6.7%. The graph below highlights that whilst we have mirrored national trends during the year we have had higher than average spikes in sickness and at our best have still had higher sickness than average suggesting this remains an area at which BCHC does less well than peers.

Graph 1.39: Sickness absence Benchmarking



https://members.nhsbenchmarking.nhs.uk/project/29/toolkit?a=960&b=990

Graph 1.40: Staff Appraisal (PDR) Rate



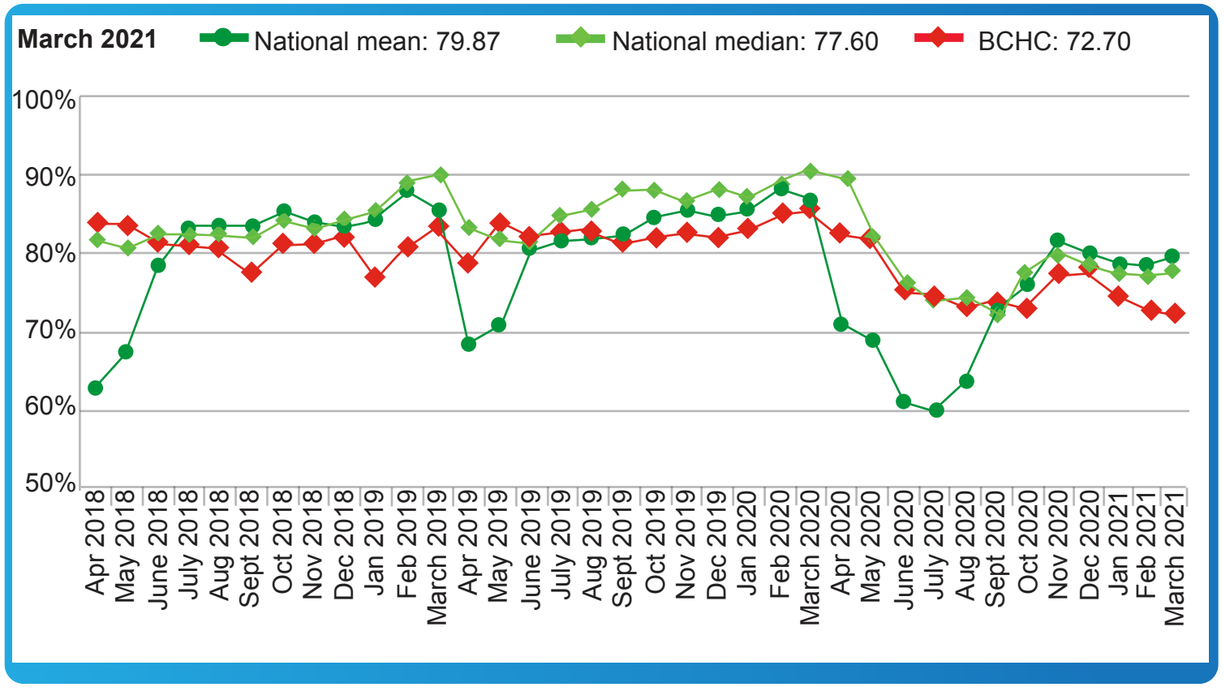
Throughout the year services across the Trust have not achieved the target that at least 95% of staff should have an appraisal or Personal Development Review (PDR) at least every 12 months (Graph 1.40). This underperformance is reported across all divisions and represents a decline on performance in previous years as shown in the graph 1.40.

A key challenge this year has been the significant number of staff and managers who have been redeployed to other roles. Whilst substantive managers remain responsible for PDRs there have been practical challenges to carrying these out with staff who they do not manage on a day to day basis. Additionally challenges of sickness absence and remote working have meant it is difficult for staff and managers to arrange meetings. Following national guidance in relation to Medical Revalidation and Appraisal, PDRs for Medical staff have not been required during COVID-19. As a result of this guidance and in communication with medics groups, the data has been amended to exclude this group of staff from reporting although this has a minimal effect on the data due to the relatively low numbers of staff involved.

Benchmarking against other community trusts as shown in the chart below shows BCHC at or near the mean average for much of the pandemic with a less sharp deterioration throughout the summer however improvements appear to be lagging behind national trends in recent months suggesting that this is an area where the Trust will need to carry out additional work into the new year to regain lost ground.

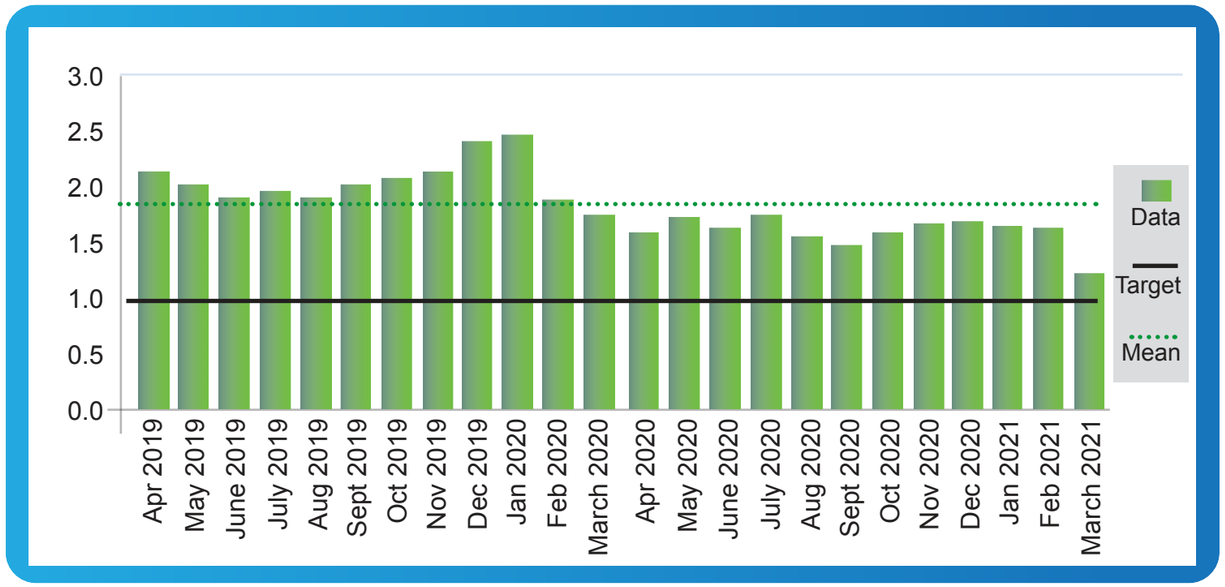
As staff return from redeployments or from shielding ensuring they are given a supporting PDR with the opportunity to discuss their changed circumstances is a priority for the Trust and so we hope to see performance improve in the new financial year. However issues with overwork and significant levels of annual leave carried over remain and so there may be areas which struggle to deliver full PDRs.

Graph 1.41: Staff Appraisal (PDR) Rate Benchmarking



https://members.nhsbenchmarking.nhs.uk/project/29/toolkit?a=960&b=992

Graph 1.42: WRES Relative likelihood of BME Staff entering formal disciplinary



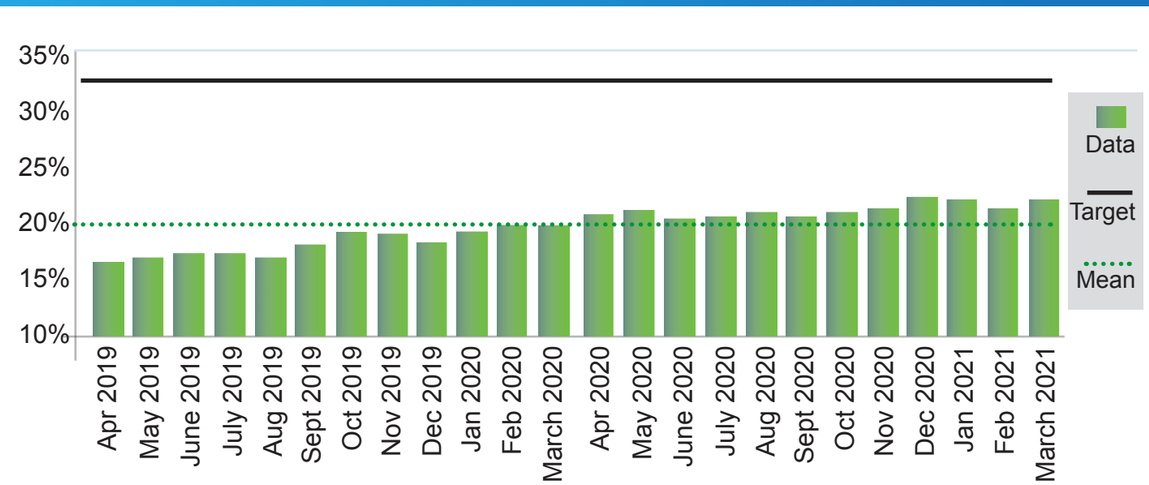
Throughout the year we have continued to report several KPIs from the Workforce Race Equality Scheme (WRES) toolkit on scorecards. The first of these is shown above as Graph 1.42 and reports that at the end of the year across the Trust black and minority ethnic (BME) staff are around 1.24 times as likely as their white colleagues to be subject to formal disciplinary processes.

Whilst this performance is lower than the parity which we would expect to see it does represent an improving position on the previous year's performance. The levels of disciplinary hearing for both white and BME staff have reduced over the last two years as the Trust seeks to give Investigation Teams time to seek mediated outcomes in preference to formal processes along with monitoring and reporting data at team levels.

However the position is still unequal and reflects some of the issues raised in the staff survey where colleagues are asked if they see the Trust as an equitable employer.

The Equality, Diversity and Human Rights (EDHR) Steering Group has been established and meets monthly as a forum to discuss and progress actions relating to equality and staff support networks have continued virtually during the pandemic. A new disciplinary policy is being launched in the new financial year which will include Cultural Ambassador support for all relevant cases and changes to the roles of commissioning and investigating managers. The new policy will be supported by refreshed training for Investigation teams.

Graph 1.43: Percentage of staff at Band 8A+ who are BME



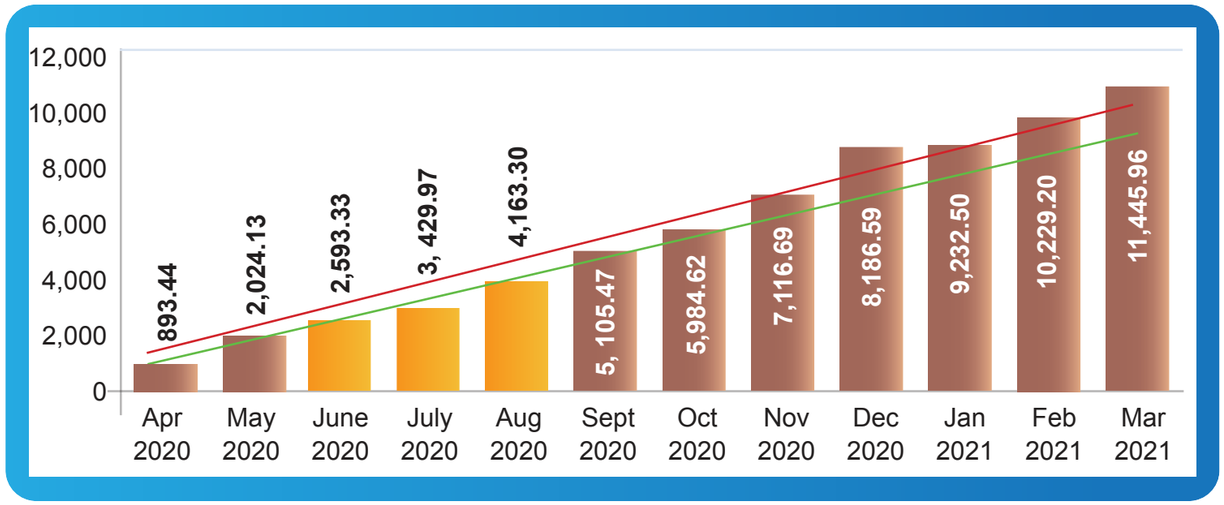
The second KPI selected from the WRES toolkit compares the percentage of senior staff who are of BME backgrounds with the overall workforce (Graph 1.43). Data has been provided to individual divisional senior management teams and targets are based on the overall percentage of staff employed in the Trust who are BME. Currently this is around 33% of all staff with the end of year position showing 22.57% of senior managers are BME.

The reasons for this discrepancy are complex however the pattern reported is consistent with data from Staff Survey where BME staff in the Trust report lower confidence that we recruit and promote fairly.

In response to the data the Trust has made changes to recruitment processes including the guarantee of panels which are both ethnically and gender diverse for senior roles. Services have also been given longer term targets to improve diversity in senior roles over a five year period and this will continue to be monitored.

A Great Place to Work Domain

Graph 1.44: Cumulative Agency Spend



Agency expenditure has continued to exceed the NHSE/I cap throughout the year, and at the year end the Trust has spent a total of £11.4 million on Agency staffing. This total is £2.3 million greater than the target and £1.3m higher than last year's final position.

A large portion of this spend has been driven by the COVID-19 pandemic with the Adult inpatient services in particular spending significant additional money on Agency to cope with increased referrals of more than usually ill patients onto the wards whilst dealing with high levels of sickness due to COVID-19 and shielding rules.

However no adjustment to the target has been made by NHSE/I to take the events of last year into account. Both Bank and Agency have increased although Bank staffing is insufficient to meet the increased needs of the past year.

There have also been increased instances where the services have had to request 'off framework' and therefore more expensive agencies in order to address staff shortages with little notice.

Sustainable Development Plan

During 2020/21, the Trust has continued with its commitment in delivering and improving on its environmental and energy reduction programme despite the COVID-19 pandemic, however this has slowed progress.

The LED lighting upgrade program has continued throughout the year and is near completion. The Trust continues with its life cycle programme to replace outdated energy systems with modern fuel efficient units that contribute to the NHS national target of carbon free net zero by 2040. The upgrade of the building energy management system has given the Trust better control of its energy systems to ensure maximum efficiency is now achieved at all of its freehold properties.

Additional sub metering continues to be installed to all utilities. The meters are connected to an energy module on the building energy management system and will provide improved reporting and analytics on usage, helping to identify areas with high or erratic consumption issues.

The Trust is also working with its local suppliers and contractors to minimise its carbon footprint and its impact on the environment. The Trust has a sustainability development strategy (2020/21) that demonstrates the Trust's commitment to carbon reduction through a range of practical but ambitious measures, sharing of good practice, active engagement and support of its staff.

The Trust has also submitted a number of building related energy projects for capital investment to support the NHS national decarbonisation target.

The Trust will continue to use the NHS Sustainable Development Unit's 'Carbon Reduction Strategy' as both the target and benchmark in the reduction of carbon emissions and sustainable development.

As a Community Trust with a geographical presence across the Birmingham area, the Estates team have leased fully electric vehicles to use for Trust business. These vehicles are being trialled and if successful the Trust will continue to lease electric vehicles as current leases expire. These vehicles will not only reduce the carbon footprint but also support the Birmingham Clean Air Zones being introduced in June 2021.

All Trust energy and waste usage/metrics are reported and identified within the Department of Health's annual Estates Return and Information Collection (ERIC) return.

Disclosure on equality of service delivery to different groups

Our Approach to Ensuring Equality in the Provision of Services

At the Trust Annual General Meeting (AGM) and Annual Members Meeting held in back September 2019, we made a public pledge to

- Have a new Trust Engagement Strategy by March 2020 and be clear about how we will start to build long-term relationships with our local communities
- Improve the quality of data that we collect
- Share our first Annual Service Equality Report, telling you how we have done

We said there were four key things that as an organisation we want to become great at doing

- Ensuring our services are designed and delivered to meet the health needs of local communities
- Helping people to access our services
- Ensuring people have positive experiences of our services
- Helping people who have multiple care needs to move through different services smoothly

This section of our annual report is our first Service Equality Report.

A New Trust Community Engagement Strategy

During 2020, we started to build the foundations of our Trust-wide approach to service equality. The Trust Board approved a revised Community Engagement Strategy in September 2020, https://www.bhamcommunity.nhs.uk/about-us/publications/engagement-strategy/. In developing this, we did a lot of engagement work with local community leaders and representatives to ensure that the strategy and the associated toolkit for Trust staff was focused on the things that really mattered to our local communities.

A New Service Equality Working Group

We established a Service Equality subgroup of the Trust Equality, Diversity and Human Rights (EDHR) Steering Group chaired by the Chief Executive Officer. The Service Equality Working Group was established in June 2020 and meets monthly, chaired by the Director for Strategy and Partnerships. Its purpose is to lead the Trust's work on Elements One and Two of the NHS Equality Delivery System (EDS2). These are:

1. **Better Health Outcomes For All and**
2. **Improved Patient Access and Experience.**

The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty. The Trust Board approved the EDS2 assessment for 2020 in January 2021. The full statement can be viewed here https://www.bhamcommunity.nhs.uk/about-us/corporate-information/equality-diversity-and-human-rights/equality-diversity-and-human-rights-documents/

Improving Data Quality and Monitoring our Performance

During 2020/21, the EDHR Steering Group commissioned the further development of the EDHR dashboard. This work has been led by the Trust's Head of Equality, Diversity & Human Rights with the Performance Team and includes patient admissions, patient contacts, patient referrals and patient mortality, by specialty.

The dashboard is an interactive tool which enables clinical service leads to see who is accessing their services with reference to the nine protected characteristics. It is intended to promote a culture of curiosity; to prompt probing questions to inform further analysis and future actions.

We have also made progress in recording data capture; recording of ethnicity has risen to 85.3% complete from 75% in 2019 and recording of religion and belief has gone from 2% in 2019 to 20.4% in 2020. There is obviously still more work to do, particularly for recording of disability where the clinical system does not enable this to be captured currently, but it is encouraging that we have made progress with recording of protected characteristic during 2020.

Protected Characteristic	Ability to record on RiO clinical system	Capture Rate
Age	Yes	100%
Disability	No	0%
Ethnicity	Yes	85.3%
Gender	Yes	100%
Gender reassignment	No	0%
Marital status	Yes	38.4%
Pregnancy and maternity	Yes	unconfirmed
Religion and belief	Yes	20.4%
Sexual orientation	No	0%

Supporting our Work to Address Health Inequalities

Easy access to service-level data mapped to protected characteristics of patients and service users will enable us to identify current gaps in service provision and inform the part we need to play in reducing variations in health outcomes within the local health and care system. This could include identifying specific groups who may be unaware of or unable to access existing services, potentially because these are not provided in a culturally appropriate way or are not at accessible venues.

The EDHR dashboard has been discussed by our Clinical Council, chaired by the Medical Director, and a number of areas of potential future work to improve the equality of our services were identified.

During 2021, each of our five Clinical Divisions will be supported to identify specific areas for action in relation to service equality, including service 'deep dives' that will lead to engagement with patients, services users, families, carer and the wider community, to support delivery of our strategic priority to be a truly inclusive organisation.

Customer Satisfaction Scores

We have continued to listen to feedback from patients with Friends and Family Test (FFT). We have continued to listen to feedback from patients with Friends and Family Test (FFT) scores indicating a high level of satisfaction by respondents.

Whilst nationally the reporting of Trust-wide Friends and Family Test (FFT) responses was paused during Quarter 4 2019/2020 until January 2021, we continued to collect feedback albeit in lower numbers. It is also important to note that the Trust previously asked the national FFT question and an additional question about how the person would rate the service they received.

It is particularly pleasing to report these high levels despite the pressures facing the NHS during the COVID-19 Pandemic over this last year and the scores are a testament to the professionalism and commitment all staff.

The new FFT question was introduced nationally from 1 April 2020, which now asks about the experience of the patient / carer, "Thinking about the service you have received today, please tell us overall how was your experience" rated as Very good/ Good / Neither good nor bad /Poor / Very poor/ Don't know. This replaces the previous two questions rating likelihood to recommend and rating of service. In line with our governance light process to maintain oversight, the following data has been reported within the quarterly Patient Experience Reports to our Quality and Safety Committee and in turn to the Board.

Family and Friends Test Results for 2020/21

Month	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
%	97	97	96	95	98	98	98	99	100	99	98	100

During the period of 1 April 2020 to 31 March 2021 a total of 3,180 actual Friends and Family Test responses were received and in addition the Trust sought to collected demographic information in relation to these responses. The provision of this information was not mandatory, therefore the number of returns vary as depicted in the summary of demographic information collected for the year.

The demographic information collected related to age, sex, gender reassignment, disability, ethnicity, religion and belief, sexual orientation, pregnancy, whether had a baby in the last 12 months and marriage and civil partnership.

A total number of 1,373 responders shared their age range with us, as depicted in the table below:

Age range of FFT respondents during 2020/21

Under 16	16-17	18-20	21-24	25-29	30-44	45-59	60-64	65-74	75-84	85-89	90 and over
48	7	10	21	29	98	216	131	232	333	152	90

When we asked about whether the individual had a disability, 1,115 people responded; of which 366 confirmed they had, 447 said they did not and 302 preferred not to say.

A total of 1,366 respondents shared their ethnicity, as detailed in the following table:

Ethnicity of FFT respondents during 2020/21

White		Black or Black British		Asian or Asian British	
British	1004	African	18	Indian	46
Irish	43	Caribbean	45	Asian British	0
White other:		Black British	0	Pakistani	76
Greek/ Greek Cypriot	2	Other (please specify)	24	Bangladeshi	12
Turkish	0	**Mixed**		East African Asian	0
Turkish/ Cypriot	0	White and Black African	4	Other (please specify)	5
Gypsy / Roma	1	White and Black Caribbean	10	**Chinese or other ethnic group:**	
Irish Traveller	0	White and Asian	5	Chinese	2
Other (please specify)	67	Other (please specify)	2	Any other ethnic background (please specify)	0

When asked information on their religion and belief a total number of 1,272 responses where received as follows:

Religion and Belief of FFT respondents during 2020/21

Christian	725	**No religion**	148
Buddhist	50	**Jewish**	1
Rastafarian	1	**Sikh**	15
Muslim	104	**Prefer not to say**	110
Hindu	28	**Other (please specify)**	90

A total of 1,529 told us about their sex, with 524 identifying as male, 707 as female, 4 as other and 294 preferred not to say. We received 1,302 responses in relation to gender reassignment; of which 13 confirmed yes, 900 said no and 389 preferred not to say.

A total number of 1,385 responders told us about their sexual orientation with the breakdown as follows:

Sexual orientation of FFT respondents during 2020/21

Heterosexual	963
Bisexual	45
Gay	6
Lesbian	2
Prefer Not To Say	369

When we asked about whether the individual was pregnant, 1117 people responded; of which 10 confirmed they were, 1107 said they were not and no one preferred not the say. Three individuals confirmed they had had a baby in the last 12 months with the remaining 760 confirming that they had not; totally 763 responses for this question.

When asked about marriage and civil partnership status 1,376 people responded, with the breakdown in responses as follows:

Marriage and civil partnership status of FFT respondents during 2020/21

Single	301	**Separated**	31
Married	461	**Divorced**	60
Co-habiting	55	**Widowed**	319
Civil Partnership	6	**Prefer not to say**	141

This was the first year the Trust has collected demographic data related to those returning the Friends and Family Test feedback on our services. Whilst the collection of this data is not a national requirement, the Trust had chosen to introduce this data collection to support our work around service equality.

The data has indicated the need for further exploration to understand the reasons why a large numbers of respondents prefer not to share their demographic information. This initiative has provided us with some baseline data that will direct our work in the coming year; including the correlation of the data against specific services to identify any service inequalities.

Engagement Activities

During 2020/21, the Trust Engagement Manager has worked with over 50 community and voluntary sector organisations and over 20 faith centres from Synagogues, Hindu Temples, Gurdwaras, Mosques, Churches and community centres connecting BCHC to the people who support or use services and also those who have yet to receive our services.

As the pandemic transformed the delivery of care, thousands of appointments were delivered by video conference. A major piece of engagement to assess how this may have impacted or led to inequalities was undertaken; resulting in the Trust receiving feedback on over 4,000 people's experiences of using video conferencing to access their healthcare appointments.

Alongside the Chief Information Officer, the Trust Engagement Manager and members of the local community co-designed a community engagement forum with community representatives, patients and carers. The forum provided learning about the amount of travel time that video appointments had saved, the costs of parking and petrol savings to individuals and the "through the looking glass" window it had given children's occupational therapists into the 'sensory play time' in the family home. BCHC also led the regional conversation around digital poverty with patients already trialling a sound booth video pod which enables individuals who do not own a laptop or smart device (phone/tablet) to have a digital healthcare appointment.

Each week the Trust worked alongside the cities grass roots community organisations and for many months worked closely alongside researchers from Birmingham Voluntary Sector Council (BVSC), Nishkam Centre, BAPS Hindu Temple and members of other groups to map assets and break down barriers between statutory and community services.

The Engagement Manager worked with Neighbourhood Network schemes to identify gaps where the NHS had not connected to particular groups and new friendships were formed. One example is the Active Wellbeing Society whose work transformed the lives of individuals struggling with the pandemic through mutual aid. Working with the team of networks, which sprung up across the city during the pandemic to clean the city's parks, collect rubbish, delivering food to vulnerable people or setting up street based WhatsApp groups, rallied together to offer BCHC patients and service users support within their own homes.

Each week the Trust has worked with a citizen involvement team on over 20 projects that involved the co-design of services. From the Early Intervention Community Teams, the emerging Stroke Pathway, the transition to adult services, hundreds of members of the community contributed their ideas, thoughts and feelings to services within the BCHC.

A highlight of the year was a special connecting community's radio show where the Trust Engagement Manager featured in a programme on faith, health and engagement on Unity FM.

Modern Slavery Act 2015

Birmingham Community Healthcare NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

Our Modern Slavery and human trafficking statement can be accessed via: http://www.bhamcommunity.nhs.uk/about-us/corporate-information/equality-diversity-and-human-rights/modern-slavery/

Signed on behalf of the Board:

Richard Kirby
Chief Executive
25 May 2021

Ian Woodall
Chief Finance Officer
Date: 25 May 2021

2. Accountability Report

The Accountability Report has been compiled in accordance with the requirements of sections 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and section 418(5) and (6) do not apply to NHS Foundation Trusts) as inserted by SI 2013 (1970) and Regulation 10 and Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008.

All individuals have been informed in advance of the intention to disclose information about them, invited to see what is intended to be published, and notified of their right to object under Article 21 of the General Data Protection Regulation (GDPR).

2.1. The Directors Report

According to paragraph 18A of Schedule 7 of the National Health Service Act 2006 (NHS Act 2006) (as inserted by the Health and Social Care Act (HSCA) 2012) the duty of the board, and each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public. Furthermore the Foundation Trust (FT) Code states that 'every NHS Foundation Trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS Foundation Trust'.

Birmingham Community Healthcare NHS Foundation Trust operates a unitary board structure which consists of both Executive Directors and Non-Executive Directors (NEDs) under the leadership of the Trust Chair. In a unitary board, all directors are collectively and corporately accountable for the organisational performance. A key strength of unitary boards is the opportunity provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

As at 31 March 2021, in line with our Trust Constitution, the Board of Directors comprised a total of 11 voting members, with 3 non-voting* directors in attendance. A recruitment process is in progress to appoint to our one voting NED vacancy.

Voting Members:

- Dr Barry Henley, Trust Chair and Non-Executive Director
- Professor David Sallah, Vice Chair, Senior Independent Director and Non-Executive Director
- Salma Ali, Chair of the Finance and Performance Committee and Non-Executive Director
- Jenny Belza, Chair of Audit Committee (Interim) and Non-Executive Director
- Jacynth Ivey, Chair of Workforce and Organisational Development Committee and Non-Executive Director
- Richard Kirby, Chief Executive Officer
- Chris Holt, Chief Operating Officer
- Marcia Perry, Chief of Nursing and Therapies
- Dr Doug Simkiss, Medical Director
- Ian Woodall, Chief Finance Officer

Non-voting* directors in attendance:

- Michelle Alli, Director of Corporate Governance*
- Dr Suzanne Cleary, Director of Strategy and Partnerships*
- David Holmes, Director of Workforce and Organisational Development*

Birmingham Community Healthcare NHS Foundation Trust operates a Fit and Proper Persons Requirement (FPPR) process for all directors on appointment and on an annual basis. The Trust also operates a code of conduct that builds on the values of the NHS foundation trust and reflects high standards of probity and responsibility.

The organisation ensures succession planning is in place for the Board of Directors. During 2020/21, there have been a number of promotions and departures; specifically in relation to the Non-Executive Team. The organisation, through its Council of Governors, is required to ensure for Non-Executive Directors hold a maximum tenure. The purpose of this requirement is to ensure a refresh of the independency of the challenge by the Non-Executive Directors within the Board of Directors. This has resulted in a recruitment drive currently underway to seek skilled Non-Executive Director that will complement the skills of existing Board members.

The changes to the Board of Directors within financial year 2020/21 are detailed as follows:

- Ian Woodall was appointed substantively as Chief Finance Officer on 9 June 2020;
- Professor David Sallah was appointed as Vice Chair by Council of Governors; commencing on 1 October 2020;
- Jerry Gould, Vice Chair, Chair of Finance and Performance Committee and Non-Executive Director stepped down on 31 September 2020 in line with the requirements for Non-Executive Directors to hold a maximum tenure;
- Dr Doug Simkiss, Medical Director, was appointed as Deputy Chief Executive on 1 January 2021;
- Sukhbinder Heer, Chair of Audit Committee and Non-Executive Director stepped down on 5 February 2021; the Council of Governors are currently recruiting to this vacancy; and
- Jenny Belza, Non-Executive Director, was re-appointed by the Council of Governors for further 3 year tenure commencing on 1 April 2021 and appointed to the role of Chair of Audit Committee on an interim basis from 8 February 2021.

We congratulate Board members on their new appointments during the year and express our sincere gratitude to those who have left us during 2020/21 for their commitment to BCHC and those we serve.

Attendance at the Board, Committees of the Board and the Council of Governors

The following table details attendance rates for individual directors at the Board, Board Committee meetings and Council of Governors. Please note that attendance is only displayed for those directors who are identified on the terms of reference as actual members. Where directors were only eligible to attend some of the meetings within the financial year (due to commencement of a new post, maternity leave or other reasons), the number of eligible meetings is displayed in brackets adjacent to the number of meetings attended.

Name/Committee	Trust Board	Audit Committee	Quality and Safety Committee	Finance and Performance Committee	Mental Health Legislation Committee	Workforce and Organisational Development Committee	Nomination and Remuneration Committee	Council of Governors
Meetings held in 2020/21	9	7	9	9	3	9	3	4
Salma Ali	9	6	-	9	-	6	3	1
Michelle Alli	9	7	5	-	3	6	1(1)	3
Jenny Belza	9	1(1)	8	8	-	6	3	4
Suzanne Cleary	9	-	-	8	-	8	-	3(3)
Jerry Gould	5 (5)	5(5)	-	5(5)	-	2(5)	1(1)	2(2)
Sukhbinder Heer	8	6(6)	-	5(8)	-	-	3	3(3)
Barry Henley	9	-	-	-	3	2(2)	3	3
David Holmes	9	-	-	-	-	9	3	3(3)
Chris Holt	9	-	1	7	-	-	-	3(3)
Jacynth Ivey	7	-	8	-	3	8	3	3
Richard Kirby	9	-	8	9	3	9	2(2)	4
Marcia Perry	8	-	9	-	3	-	-	2(2)
David Sallah	9	6	9	-	3	-	3	3
Doug Simkiss	9	-	9	7	3	-	-	-
Ian Woodall	9	6	-	8	-	-	-	1(1)

Board of Directors and Council of Governors: Declaration of Interests

Birmingham Community Healthcare NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by directors and governors which may conflict with their management responsibilities. The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors and Governors, which is available for inspection on application to the Company Secretary or via http://www.bhamcommunity.nhs.uk/about-us/board-of-directors/meetings-and-papers/.

HM Treasury Compliance

Birmingham Community Healthcare NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Details of Political Donations

Birmingham Community Healthcare NHS Foundation Trust has not made any political donations during 2020/21.

Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code in dealing with suppliers of goods and services and the table below sets out our performance in 2020/21.

Compliance with Better Payment Practice Code during 2020/21

Better Payment Practice Code - Measure of Compliance	2020/21	
	Number	£000
Total Non-NHS trade invoices paid in the year	47,161	142,784
Total Non-NHS trade invoices paid within target	43,253	132,607
Percentage of Non-NHS trade invoices paid within target	91.7%	92.9%
Total NHS trade invoices paid in the year	1,807	28,089
Total NHS trade invoices paid within target	1,585	22,346
Percentage of NHS trade invoices paid within target	87.7%	79.6%
The Better Payment Practice Code requires all Trusts to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.		

Prompt Payment Code

The Trust has signed up to the prompt payment code administered by the Chartered Institute of Credit Management.

Disclosures relating to NHS Improvement's Well Led Framework

Our Annual Governance Statement (Section 2.4) describes the Trust's approach to ensuring it remained well led; particularly during the pandemic.

Statement as to Disclosure to Auditors

Each individual who was a director at the time at which this report was prepared and subsequently approved can declare so far as they are aware, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

The Director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trusts' auditor is aware of that information.

Members of the Board of Directors have made such enquiries of his/her fellow directors and of the Trust's auditors for that purpose and taken such steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill and diligence.

Income Disclosures as Required by Section 43(2A) of the NHS Act 2006

In accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the income that Birmingham Community Healthcare NHS Foundation Trust received during 2020/21 for provision of goods and services for the purposes of the health service in England was greater than its income for the provision of goods and services for any other purpose.

Signed on behalf of the Board:

Richard Kirby
Chief Executive
Date: 25 May 2021

2.2. Remuneration Report

The Remuneration Report has been compiled in accordance with Section 420 to 422 of the Companies Act 2006, Regulation 11, Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410), Parts 2 and 4 of Schedule 8 of the Regulations and the NHS Foundation Trust Code of Governance. All individuals have been informed in advance of the intention to disclose information about them, invited to see what is intended to be published, and notified of their right to object under Article 21 of the General Data Protection Regulation (GDPR).

Annual Statement on Remuneration

The membership of the Nomination and Remuneration Committee comprises all Non-Executive Directors including the Trust Board Chair; the Chief Executive and Director of Workforce and Organisational Development are invited to attend the Committee as and when required. The purpose of the Nomination and Remuneration Committee is to make recommendations to the Board of Directors in relation to the appointment and remuneration of the Chief Executive, Executive Directors and other senior managers reporting directly to the Chief Executive. Furthermore the Committee reviews and makes recommendations in regard to the Board's skill mix and balance; taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise that are required within the Board to meet them. The Committee is also responsible for ensuring that adequate Executive succession planning arrangements are in place. The Committee has not employed the services of external advisors in executing its duties in year and has not incurred any fees in this respect.

The committee met on three occasions during 2020/21 to discuss the following:

- The approach to Annual Pay Increase for Very Senior Managers (VSM)
- The appointment of a Deputy Chief Executive
- The appointment of the Chief Finance Officer

Senior Manager Remuneration Policy

The Nomination and Remuneration Sub-Committee of the Trust Board is responsible for determining the pay and terms of conditions of employment for Executive Directors and for any senior managers not subject to national Agenda for Change Terms and Conditions.

It is the policy of the Trust that all senior managers will be employed on national Agenda for Change conditions, with the exception of those designated as members of the Executive Team.

The 2020/21 Nomination and Remuneration Committee considered and accepted the NHS England / I guidance on annual pay increase for NHS VSM Senior Managers and applied the recommended increase of 1% for Executive Directors with effect from 1 April, 2020.

The committee also considered NHSE/I recommendations for pay increases for VSMs with effect from 1 April, 2019. In light of national guidance a non-consolidated pay increase of 2.09% was agreed.

In 2020/21, the Council of Governors considered the remuneration and terms and conditions of the Trust Board Chair and Non-Executive Directors in line with the NHS England/Improvement guidance to align the terms and conditions of NHS Trust and NHS Foundation Trust Board Chair and Non-Executive Directors. The national recommendations were accepted and would be applied to future appointments.

Barry Henley

Chair, Nomination and Remuneration Committee

Date: 25 May 2021

Annual Report on Remuneration

Equality Reporting

The Trust has an Equality and Diversity and Human Rights Policy which sets out the Trusts commitment to eliminating all forms of unfair / unequal treatment and discrimination at work.

In addition, the decision of pay increases is taken in the light of NHS England and NHS Improvement (NHSE/I) national recommendations and are equally applied to all individuals.

Remuneration Report Tables

Board Members Remuneration during 2020/21 respective to their terms of office

Name and Job Title	Salary (bands of £5k)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5k)	Long term performance pay and bonuses (bands of £5k)	All pension related benefits (bands of £2,500)**	Other (bands of £5k)	Total pay (bands of £5k)
Salma Ali Non-Executive Director	10-15	0	0	0	0	0	10-15
Michelle Alli Director of Corporate Governance	105-110	0	0	0	25.0-27.5	0	130-135
Jenny Belza Non-Executive Director	10-15	600	0	0	0	0	10-15
Suzanne Cleary Director of Strategy and Partnerships	110-115	0	0	0	30.0-32.5	0	140-145
Jeremy Gould Non-Executive Director (for period of 1 April to 30 September 2020)	5-10	300	0	0	0	0	5-10
Sukhbinder Heer Non-Executive Director (for period of 1 April 2020 to 5 February 2021)	10-15	0	0	0	0	0	10-15
Barry Henley Trust Chair	45-50	0	0	0	0	0	45-50
David Holmes Director of Workforce & Organisation Development	115-120	0	0	0	12.5-15.0	0	125-130
Christopher Holt Chief Operating Officer	125-130	0	0	0	20.0-22.5	0	150-155
Jacynth Ivey Non-Executive Director	10-15	0	0	0	0	0	10-15
Richard Kirby Chief Executive	170-175	0	0	0	25.0-27.5	0	195-200
Marcia Perry Chief of Nursing & Therapies	125-130	0	0	0	0	0	125-130
David Sallah Non-Executive Director	10-15	0	0	0	0	0	10-15
Doug Simkiss* Medical Director	195-200	0	0	0	60.0-62.5	10-15	275-280
Ian Woodall Chief Finance Officer	120-125	0	0	0	22.5-25.0	5-10	150-155

*Included in the Medical Directors' Remuneration is £60k-£65k in respect of clinical duties.
**Pension related benefits are the benefits accruing to senior managers from their membership of the NHS Pension Scheme.

These figures have been subject to audit.

The Trust's Policy takes due regard to advice in relation to the scrutiny of salaries. Executive salaries, including those above £142,500, and have been subject to external pay benchmarking and NHSE/I guidance. The national recommendations were accepted and would be applied to future appointments. The Nomination and Remuneration Committee considered and accepted the NHSE/I guidance on annual pay increase for NHS VSM Senior Managers and applied the recommended increase of 1% for Executive Directors with effect from 1 April, 2020.

Remuneration Report Tables

Board Members Remuneration during 2019/20 respective to their terms of office

Name and Job Title	Salary (bands of £5k)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5k)	Long term performance pay and bonuses (bands of £5k)	All pension related benefits (bands of £2,500)**	Other (bands of £5k)	Total pay (bands of £5k)
Salma Ali Non-Executive Director	0-5	0	0	0	0	0	0-5
Michelle Alli Director of Corporate Governance	90-95	0	0	0	27.5-30.0	0	120-125
Jenny Belza Non-Executive Director	10-15	1300	0	0	0	0	10-15
Suzanne Cleary Director of Strategy and Partnerships	90-95	0	0	0	***	0	90-95
Andrew Dayani Medical Director	5-10	0	0	0	0	0	5-10
Gilbert George Director of Corporate Governance (Interim)	60-65	0	0	0	***	0	60-65
Jeremy Gould Non-Executive Director	10-15	1600	0	0	0	0	15-20
Sukhbinder Heer Non-Executive Director	10-15	0	0	0	0	0	10-15
Barry Henley Chair (June 2019 – current)	35-40	0	0	0	0	0	35-40
David Holmes Director of Workforce & Organisation Development	110-115	400	0	0	50-52.5	0	160-165
Christopher Holt Chief Operating Officer	105-110	0	0	0	27.5-30	0	135-140
Jacynth Ivey Non-Executive Director	10-15	0	0	0	0	0	10-15
Richard Kirby Chief Executive	165-170	0	0	0	37.5-40	0	205-210
Marcia Perry Director of Nursing & Therapies	125-130	400	0	0	287.5-290	0	415-420
David Sallah Non-Executive Director	10-15	0	0	0	0	0	10-15
Doug Simkiss Medical Director*	190-195	0	0	0	157.5-160	10-15	365-370
Tom Storrow Chair (Retired May 2019)	5-10	500	0	0	0	0	5-10
Joanne Thurston Chief Operating Officer	5-10	0	0	0	0	0	5-10
Ian Woodall Chief Finance Officer	115-120	6800	0	0	90-92.5	0	215-220

*Included in the Medical Directors' Remuneration is £60k-£65k in respect of clinical duties.

**Pension related benefits are the benefits accruing to senior managers from their membership of the NHS Pension Scheme.

***Opening position for 31 March 2019 figures are not available.

These figures have been subject to audit.

Fair Pay Multiples

As an NHS Foundation Trust we are required to disclose the relationship between the remuneration of the highest-paid Director in the Trust and the median remuneration of the Trust's workforce.

The banded remuneration of the highest paid director in Birmingham Community Healthcare NHS Foundation Trust in financial year 2020/21 was £212,500 (£207,500 in 2019/20). This was 7.1 times (7.2 times in 2019/20*) the median remuneration of the workforce, which was £29,834 (£28,785 in 2019/20). In 2020/21 the number of staff in the sample was 5,081 compared with 4,871 in 2019/20.

In 2020/21, no employee received remuneration in excess of the highest-paid director, which reflected the same position for 2019/20.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Compensation on Early Retirement or for Loss of Office

No exit packages or severance payments have been made to any very senior managers or past or present Executive Directors.

Payments to Past Directors

No payments have been made to any past very senior managers or Executive Directors.

Annual report on Remuneration

Salary and Pension Benefits of Senior Managers

Pension Benefits for Senior Managers during 2020/21

Name and Job Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021 (£'000)	Real increase in Cash Equivalent Transfer Value (£'000)	Cash Equivalent Transfer Value at 31 March 2020 (£'000)	Employer's contribution to stakeholder pension (£'000)
Michelle Alli Director of Corporate Governance	0-2.5	0	5-10	0	99	10	75	0
Suzanne Cleary Director of Strategy & Partnerships	0-2.5	0-2.5	30-35	55-60	481	22	444	0
David Holmes Director of Human Resources	0-2.5	0	50-55	70-75	850	24	811	0
Christopher Holt Chief Operating Officer	0-2.5	0	20-25	0	283	11	254	0
Richard Kirby Chief Executive	2.5-5	0	60-65	125-130	1,025	23	977	0
Marcia Perry Chief of Nursing & Therapies	0-2.5	0-2.5	50-55	155-160	1,132	21	1,093	0
Douglas Simkiss Medical Director	2.5-5	0-2.5	90-95	245-250	2,083	87	1,968	0
Ian Woodall Chief Finance Officer	0-2.5	0	35-40	75-80	602	18	567	0

Director Expenses

Directors expenses for 2020/21 in comparison to 2019/20 can be viewed in the remuneration tables featured above.

Governor Expenses

Governors are unpaid and volunteer part-time on behalf of the Trust that they represent. The Trust has a procedure in place under which Governors may be reimbursed for legitimate travel expenses in the course of their duties as Governors of Birmingham Community Healthcare NHS Foundation Trust. Nineteen of the twenty-three Governors who comprise the Council of Governors are eligible to claim expenses, as the Trust does not reimburse Partner Governors.

In 2019/20, eight Governors made claims under this process of an aggregate sum of £1,430.33. During the period of 2020/2021, no Governors made claims. The lack of expenditure was due to no travel costs being incurred to attend governor meetings, activities or training events in line with the COVID-19 secure guidance. During 2020/21 all Governor activities were held virtually.

Richard Kirby
Chief Executive
Date: 25 May 2021

2.3. Staff Report

The following tables provide a year-end position in relation composition of the Trust's Employees.

Table: Numbers and the Composition of all staff and senior managers employed at the end of 2020/21

Number of employees	All staff*			Senior Managers **		
Division	Female	Male	Grand Total	Female	Male	Grand Total
Adult and Specialist Rehabilitation Services	980	201	1,181	10	3	13
Adults Community Services	953	103	1,056	8	0	8
Children & Families Division	1,176	83	1,259	13	3	16
Corporate Division	531	228	759	30	30	60
Dental Services	520	109	629	3	2	5
Learning Disabilities Division	204	56	260	2	1	3

All data for Primary Assignments only
*total staff numbers - including senior managers
** Senior Managers at 8b and above excluding Clinical Leads.

The average number of staff that we employed in 2020/21 by category is set out below:

Table: Average staff numbers by category employed during 2020/21

Staff category	Permanently employed number	Other number (FTC and Bank/agency)	2020/21 Total Number	2019/20 Total Number	2018/19 Total Number
Medical and dental	110	78	189	190	185
Ambulance Staff	0	0	0	0	0
Administration and estates	1,060	285	1,345	1,288	1,196
Healthcare assistants and other support staff	838	204	1,042	976	981
Nursing, midwifery and health visiting staff	1,211	142	1,353	1,340	1,263
Nursing, midwifery and health visiting learners	10	41	51	40	144
Scientific, therapeutic and technical staff	741	37	777	749	721
Healthcare Science staff	5	0	5	7	6
Social Care staff	0	0	0	0	0
Other	0	1	0	0	1
Total Average Numbers	**3,974**	**788**	**4,763**	**4,589**	**4,496**
Of which Number of Employees (WTE) engaged on Capital Projects	4	1	5	5	0

The figures above and overleaf have been subject to audit.

Table: Permanent and Other Staff Costs during 2020/21

	Permanently employed total	Other total	2020/21 Total £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	161,058	0	161,058	150,562	143,546
Social security costs	15,238	0	15,238	14,232	13,505
Apprenticeship Levy	769	0	769	720	688
Employers contribution to NHS Pension	27,589	0	27,589	25,886	17,449
Pension cost - other	76	0	76	-	15
Other post-employment benefits	0	0	0	-	-
Other employment benefits	0	0	0	-	-
Termination Benefits	0	0	0	-	-
Temporary staff - agency/contract staff	0	11,446	11,446	10,150	9,399
Total Gross Staff costs	**204,730**	**11,446**	**216,176**	**201,550**	**184,602**
Recoveries in respect of seconded staff	(182)	0	(182)	(287)	(111)
Total Staff Costs	**204,548**	**11,446**	**215,994**	**201,263**	**184,491**
Costs Capitalised as part of assets	112	0	112	62	-

* Employer pension contributions in 2020/21 include £8,372k paid by NHS England.

Staff turnover

The staff turnover report is available through the following link.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Diversity and inclusion policies, initiatives and longer term ambitions

At the outset of the COVID-19 Pandemic the Trust recognised the disproportionate impact of COVID-19 on specific groups and committed to support BME colleagues through a range of interventions including:

- Listening and engagement events through BME Staff Network Pandemic
- Publication of data reports assessing the impact of Flu and COVID-19 workforce interventions on BME colleagues
- Establishment of an active risk assessment process
- Launch of an Anti-Racism Campaign
- Emotion and spiritual support through Emotional Survival Strategy Sessions

In spite of COVID-19 the Trust has maintained an absolute commitment to develop its equality, diversity and inclusion capability through its Becoming a Truly Inclusive Organisation Action Plan.

Whilst capacity has been severely stretched excellent progress has been made during the year in revising employment processes including the development of a new disciplinary process, re-launching the Cultural Ambassadors Programme and progressing the review of recruitment and selection procedures.

Developments have also been made in our ‘Recognising and Supporting Potential’ and Widening Participation strategies in preparation for 2021/22 launch.

During the year the scope of equality and diversity monitoring and reporting with the Quality and Performance Report (see below) has been extended and targets and trajectories have been developed for each Clinical Division.

Embedding the commitment towards inclusion was also supported through a series of ‘Inclusive Organisation Conversations’ with the Chief Executive Equality leads and Divisional Senior Leadership Teams.

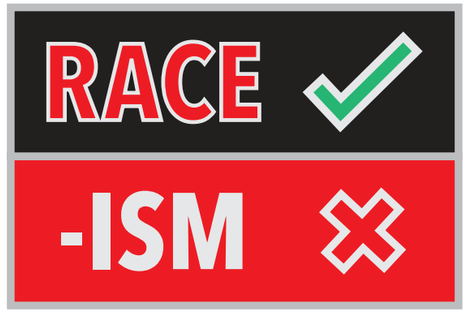
The importance of developing cultural competence throughout the organisation has been recognised and the Executive Team have participated in the ‘Leading Beyond Cultural Boundaries’ in preparation for the Reverse Mentoring Programme in 2021/22 and this is an essential element of the line managers leadership programme ‘Inspire’.

Another important step in the Trusts journey is the establishment of Equality Staff Networks. This year a commitment has been made to supporting Network Leads with allocated time and a budget, development and sponsorship. A Staff Network Coordinator will be appointed in 2021/22.

In addition to the workforce activities undertaken progress has been made in relation to Service Equality, particularly focussing on the development of service equality, data and monitoring.

Work has also commenced to develop a BCHC vision for addressing health inequalities and the Trust, through the Chief Executive Officer, is also taking a lead role in the Integrated Care System in the development of the health inequalities agenda.

Whilst it is acknowledged that there is still much work to do the Trusts progress was recognised in being shortlisted for the HSJ Award for Equality and Diversity 'NHS Workplace Race Equality Award'

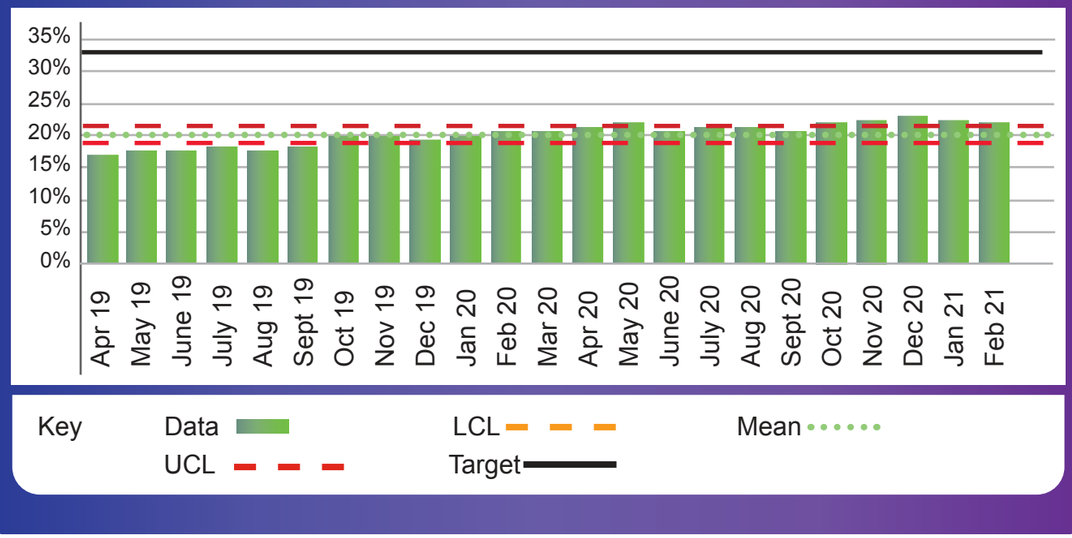


The Trust monitors through its Quality and Performance Report two WRES indicators in relation to likelihood of BME staff entering the formal disciplinary process and the percentage of BME staff at Band 8a and above.

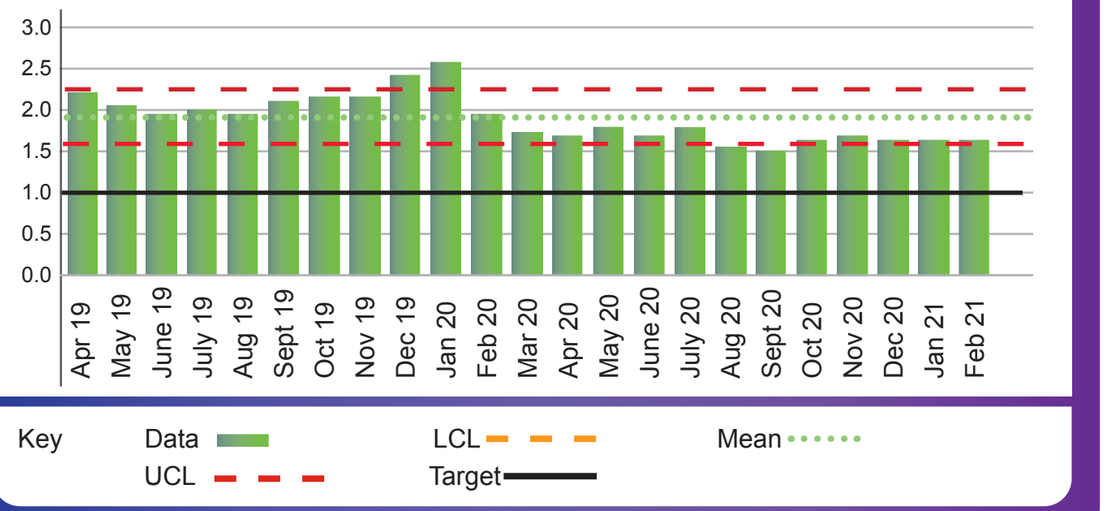
More detail regarding these key performance indicators is included within our performance analysis section in relation to our Great Place to Work strategic objective.

The WRES Report for 2020 is set out below which shows that whilst improvements have been made, the experience of BME colleagues is less favourable than white colleagues.

WRES - % of staff at bands 8a+ who are BME (exc Medical and Dental)



Relative likelihood BME staff entering formal disciplinary



Disabled Persons

The Disability and Neurodiversity Network launched in the Trust in 2018. The Executive Sponsor is Ian Woodall, Chief Finance Officer and the Non-Executive Sponsor is David Sallah.

The Network was built on a partnership with colleagues from Birmingham & Solihull Mental Health Trust, to bring deeper insight into the experiences of colleagues living with visible and invisible disabilities and the measures required to make BCHC a Great Place to Work for all our people.

Engagement with the Estates Team has opened up a line of dialogue where the needs, views and experiences of people living with disabilities can be systematically reflected in the physical spaces across the Trust.

The WDES Report showed that Disabled staff were not treated less favourably in terms of being appointed from shortlisting when compared to non-Disabled staff and there was no available data to confirm the position in relation to entering into formal employment processes.

However, in terms of the National Staff Survey indicators, the experience of Disabled staff was less favourable than non-Disabled staff in all matters covered by the WDES Report i.e. in relation to harassment, bullying or abuse, equal opportunities, feeling pressure to come to work and work being valued.

This was a disappointing result and highlights that the Trust must continue to address the experience of Disabled staff in the organisation.

The 2020 Staff Survey shows a deterioration of scores for staff with a long term condition / illness in relation to experiencing Bullying, Harassment and Abuse from managers, feeling pressure to come to work despite not feeling well enough and reporting Bullying, Harassment and Abuse.

Scores that improved were related to staff experiencing Bullying, Harassment and Abuse from patients, and from colleagues, staff believing that the organisation provides equal opportunities, the extent to which the Trust values their work and staff saying that the Trust has made adequate adjustments for them to carry out their work.

Table: Data supplied by the Survey Coordination Centre for the WDES metrics

		Trust 2019	Trust 2020
Percentage of staff experiencing HBA from patients, relatives or public in the last 12 months	LTC or illness	29.5%	**26.3%**
	No LTC or illness	23.3%	**20.7%**
Percentage of staff experiencing HBA from managers in the last 12 months	LTC or illness	20.1%	**22.5%**
	No LTC or illness	10.4%	**10.0%**
Percentage of staff experiencing HBA from other colleagues in the last 12 months	LTC or illness	30.0%	**28.1%**
	No LTC or illness	16.8%	**15.2%**
Percentage of staff who said that the last time they experienced HBA they or a colleague reported it	LTC or illness	55.4%	**51.8%**
	No LTC or illness	54.8%	**51.8%**
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	LTC or illness	66.4%	**67.8%**
	No LTC or illness	80.6%	**79.9%**
Percentage of staff who felt pressure from manager to come to work despite not feeling well enough to perform their duties	LTC or illness	24.6%	**28.3%**
	No LTC or illness	18.3%	**21.8%**
Percentage of staff satisfied with the extent to which the organisation values their work	LTC or illness	33.1%	**35.0%**
	No LTC or illness	49.9%	**48.6%**
Percentage of staff saying their employer has made adequate adjustments for them to carry out their work	LTC or illness	76.1%	**76.9%**
	No LTC or illness	76.9%	**81.5%**
Staff engagement score	LTC or illness	6.6%	**6.4%**
	No LTC or illness	7.1%	**7.1%**

Gender Pay Gap

The Trust's 2020 Gender Pay Gap report can be found here: https://gender-pay-gap.service.gov.uk/Employer/ZgMLryMp

The 2021 Gender Pay Gap Report will be published in 2021/22.

Sickness Absence

The Trust's sickness absence data published by NHS Digital can be found here:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff absence has been severely affected due to COVID-19 which has resulted in some of the highest sickness rates experienced by the Trust during the peaks of the pandemic. Sickness absence rates rose to over 9% in April 2020 and 7.60% in January 2021. The sickness absence related to COVID-19 equated to 3.17% and 2.13%, respectively.

However, for the seven months from July to December 2020 sickness rates were below the target and were better than previous years.

The sickness rate for March 2021 was just under 5.4% against the March target of 6.08%

It should be noted that the Trust ended the year with a rolling 12 month average sickness absence rate of 6.56%.

Chart 2.3.1: Trust actual sickness against target 2020/21

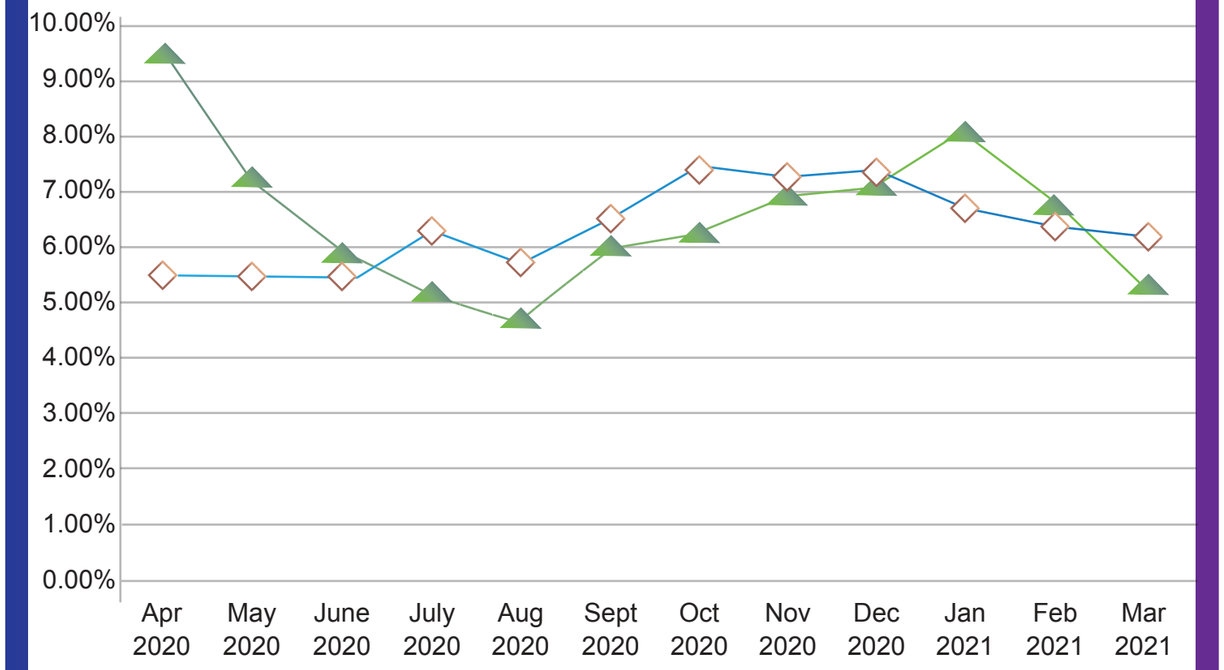
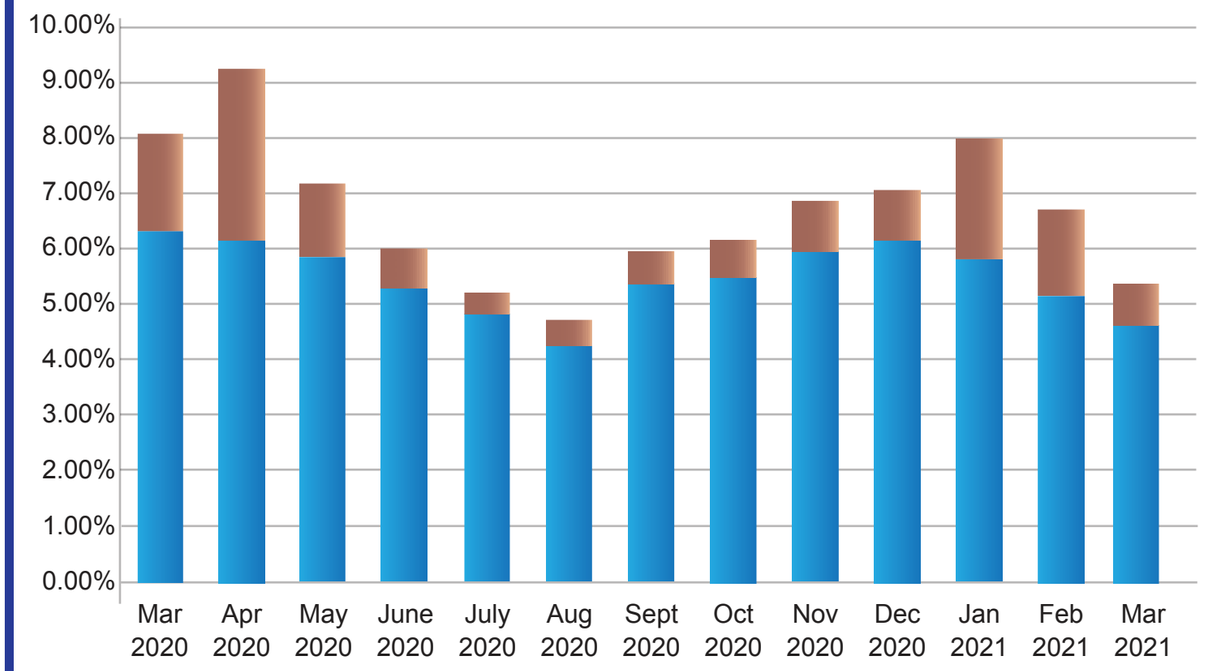


Chart 2.3.2: COVID-19 versus Non-COVID-19 related sickness 2020/21



	Mar 2020	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
covid%	1.86	3.17	1.30	0.65	0.45	0.40	0.54	0.67	0.92	1.02	2.13	1.62	0.76
non covid%	6.20	6.10	5.89	5.33	4.72	4.35	5.41	5.55	5.99	6.05	5.86	5.09	4.64

HR support has been provided to both individuals and their line managers in managing absence through this challenging time conducting wellbeing meetings and return to work discussions virtually wherever possible.

Long-term absence throughout the year has accounted for approximately two thirds of absence and the delay in treatment and cancelled operations has adversely affected return to work.

The Trust has provided a comprehensive health and wellbeing package to support colleagues through COVID-19, branded as 'Hear for You'.

This has included provision for colleagues to stay safe through vaccination programmes and a range of interventions for supporting healthy lifestyles and a package of flexible working provisions.

'Hear for You' also brings together a number of more specific psychological and mental wellbeing interventions including Occupational Health, Employee Assistance Programme and helplines.

Staff were also supported by a comprehensive Risk Assessment process based on an initial self-assessment which then provided for either a Health Risk Assessment or BME specific individual risk assessment. The Trust also established a COVID-19 Secure Workplace Assessment where managers and staff were able to access the support of Occupational Health. The Trust was able to report 98% coverage with individual risk assessments.

Exit Packages and Severance Payments

The exit packages and severance payments are available in the annual accounts as part of note 7 and have been subject to audit.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the organisation has agreed early retirements, the additional costs are met by the organisation and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS pension's scheme and are not included in the table.

Reporting of other Compensation Schemes - Exit Packages 2020/21

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s
Less than £10,000	0	0	1	7	1	7	0	0
£10,000 - £25,000	2	34	0	0	2	34	0	0
£25,001 - £50,000	5	196	0	0	5	196	0	0
£50,001 - £100,000	1	69	0	0	1	69	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**8**	**299**	**1**	**7**	**8**	**306**	**0**	**0**

Table FS4: Other Exit Packages 2020-21

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of Exit Package Agreements	Total value of agreements	Number of Exit Package Agreements	Total value of agreements
	2020/21	2020/21	2019/20	2019/20
	No.	£000	No.	£000
Voluntary redundancies including early retirement contractual costs	0	0	22	701
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	7	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severance payments)*	0	0	0	0
Total**	**1**	**7**	**22**	**701**
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Off Payroll Engagements

The following table outlines all off-payroll engagements as at 31 March 2021 for more than £245 per day.

Number of existing engagements as at 31 March 2021	
Of which, the number that have existed are:	3
for less than one year at time of reporting	3
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	0

The table below outlines all off-payroll appointments engaged at any point between 1 April 2020 and 31 March 2021, for more than £245 per day.

Number of off-payroll workers engaged between 1 April 2020 and 31 March 2021	
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	3
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	3
Of which: Number of engagements that saw a change to IR35 status following the consistency review	3
Number of engagement where the status was disputed under provisions in the off-payroll legislation	3
Of which: number of engagements that saw a change to IR35 status following review	3

The table below outlines any off-payroll engagements of Board Members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	Exceptional circumstances leading to these engagements	0
		Length of time each engagement lasted	
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0		

Policies Applied and Actions Taken During the Year

During the year the Trust developed a comprehensive workforce response to the COVID-19 pandemic. This included a significant programme of internal redeployment, recruitment of temporary staff including volunteers and a range of local policies to support the workforce.

A package of support mechanisms and practical benefits were developed as part of the Hear for You Programme.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on the 1 April 2017. These regulations place a legislative requirement on relevant public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of facility time within their organisation Information can be found on our website via: https://www.bhamcommunity.nhs.uk/

Expenditure on Consultancy

The Trust spent £1,209k on consultancy during 2020/21 compared to £1,575k during 2019/20.

Countering Fraud and Corruption

Our Local Anti-Fraud Service is provided by our Internal Audit Service and we have an annual plan of work that is compliant with the Secretary of State's directions. This is aimed at preventing and detecting fraud and ensuring that we take action where necessary.

Modern Slavery Act 2015

Birmingham Community Healthcare NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

Our Modern Slavery and human trafficking statement can be accessed via: http://www.bhamcommunity.nhs.uk/about-us/corporate-information/equality-diversity-and-human-rights/modern-slavery/

NHS Staff Survey Results 2020

Staff engagement

Until March 2019, BCHC used the Listening into Action (LiA) for a period of 18 months as the main method of staff engagement, with the ambition to replace this with an alternative engagement strategy including the internal launch of the BCHC Quality Improvement 'Improving 2gether'. Due to responding to the pandemic situation the 'Hear for You' colleague support brand was developed and formed the brand for staff engagement with the offer under the 'bubble' of Listening to You.

Staying safe

- PPE
- Risk assessments
- Flu vaccinations
- Home working support

Listening to you

- Trust Talk with CEO
- Covid email address
- FTSU Guardians
- Weekly leaders brief

When times get tough

- Care First EAP
- Team Prevent
- Bereavement support
- NHS National Helpline

Looking after yourself

- Advice on health lifestyles
- Care First webinars
- BME Events & webinars
- Free apps

Support for all

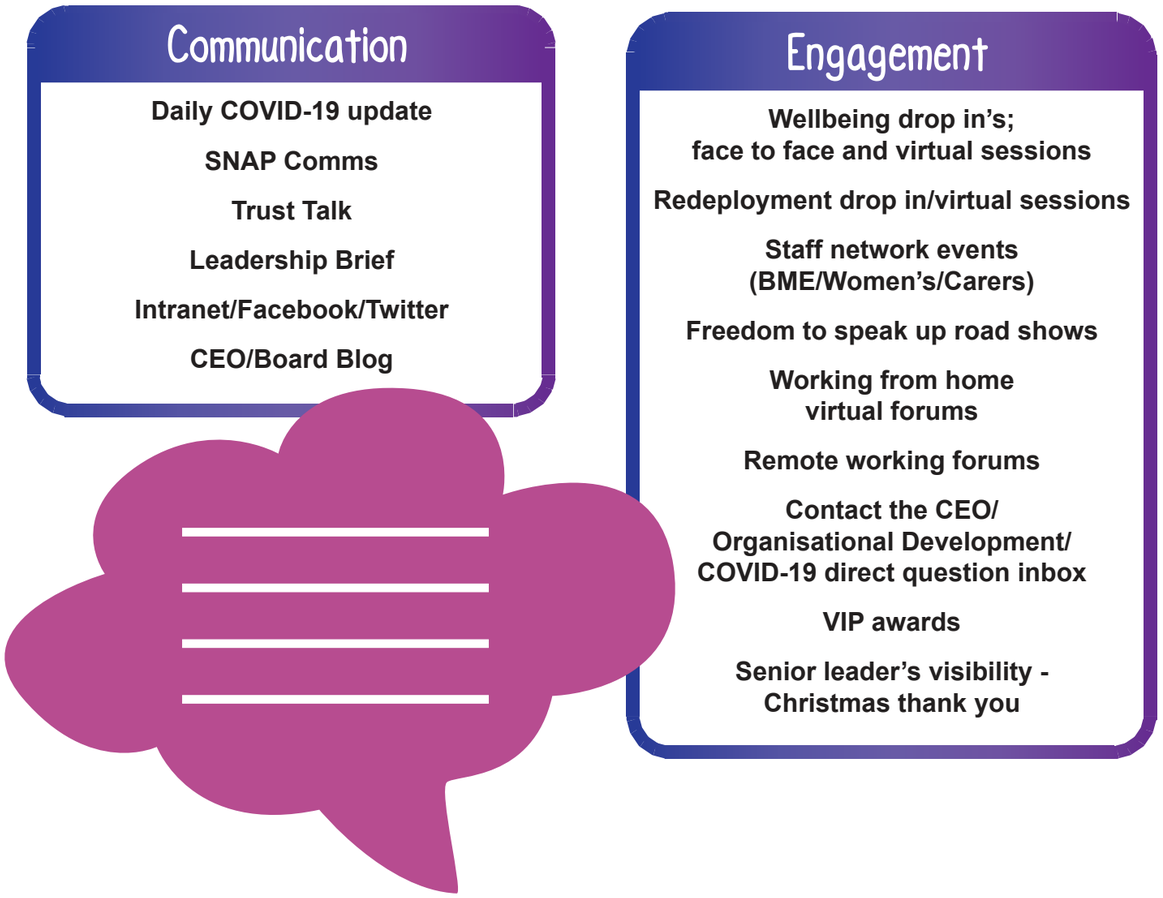
- HWB drop-ins
- Staff Networks
- Staff Side
- Outdoor seating provision

Flexible Support (Contractual stuff)

- Additional carers leave
- NHS Staff benefits
- Financial hardship support
- Free car parking on NHS sites

An element of the Quality Improvement 'Improving 2gether' commenced in the form of a half day module within the INSPIRE leadership programme. Over 800 colleagues are expected to undertake INSPIRE of which 157 have currently completed, with a trajectory for full completion by March 2022.

The core mechanism for BCHC staff engagement has been via a suite of formal and informal communication and engagement mechanisms responding proactively to the environment colleagues find themselves in and inevitably with a focus on COVID-19. The diagram below outlines those activities from March 2020 to March 2021.



NHS staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

In the midst of a global pandemic, the Trust was delighted to receive what was the largest number of completed surveys with over 2000 colleagues having their say, with a response rate to the 2020/21 survey of 43% (2019/20: 41%).

Results in comparison to previous years across the themes

The 2020 NHS staff survey covered 10 themes with a further measurement of Staff Engagement across three sub-sections of Theme 10. Additionally due to the pandemic colleagues were asked new questions about their experience and lessons learnt from COVID-19 pandemic.

Scores for each theme together with that of the Community Trust survey benchmarking group are presented in the table below.

Table: Trust NHS Staff Survey results compared to Benchmarking Group over the last three years

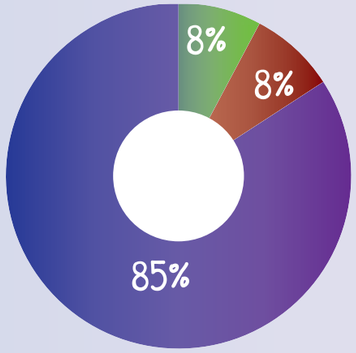
	2020		2019		2018	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.8	9.4	8.9	9.4	8.8	9.3
Health and wellbeing	6.0	6.3	5.9	6.0	5.6	5.9
Immediate managers	7.0	7.2	6.9	7.2	6.7	7.0
Morale	6.1	6.5	6.0	6.3	5.7	6.2
Quality of appraisals	No longer a theme	No longer a theme	5.3	5.8	5.0	5.6
Quality of care	7.5	7.5	7.5	7.4	7.3	7.3
Safe environment - bullying and harassment	8.2	8.5	8.1	8.4	8.0	8.4
Safe environment - violence	9.6	9.7	9.6	9.7	9.6	9.7
Safety culture	6.8	7.1	6.8	7.0	6.6	7.0
Staff engagement	6.9	7.3	7.0	7.2	6.7	7.1
Team Working	6.6	6.9	6.7	7.0	6.5	New theme introduced in 2019, therefore no data for 2018.

The key headlines from the 2020 NHS staff survey results for were:

- BCHC has maintained the progress we have made in 2019, despite the unprecedented challenges we faced, although there is room for improvement as we are below our national comparator group scores.
- The priorities as result of the 2019 staff survey, that the Trust began to implement, remain the priority areas from this year's survey, as detailed later in this section.
- BCHC remains lower than its comparators in all themes except high Quality of Care.

The overall results show that, BCHC scores have not significantly improved or declined since 2019 despite COVID-19 having a profound effect on our entire workforce.

Figure: Question local (BCHC) changes from 2019 to 2020:



6 (8%) Questions(s) scored significantly better than 2019

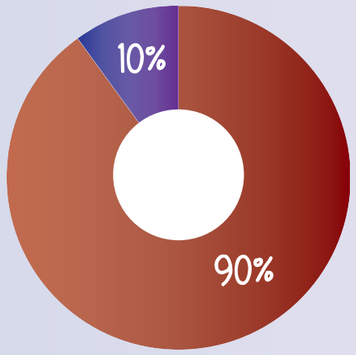
6 (8%) Questions(s) scored significantly worse than 2019

66 (85%) Questions(s) showed no significant change in relation to the 2019 scores

There have been no significant changes in any of 10 thematic areas for BCHC since 2019.

BCHC is benchmarked against 15 comparator Community Trusts. Nine of the BCHC theme scores for 2020 remain significantly below the comparator score which is a repetitive result to previous years.

Figure: Themed Results changes from 2019 to 2020



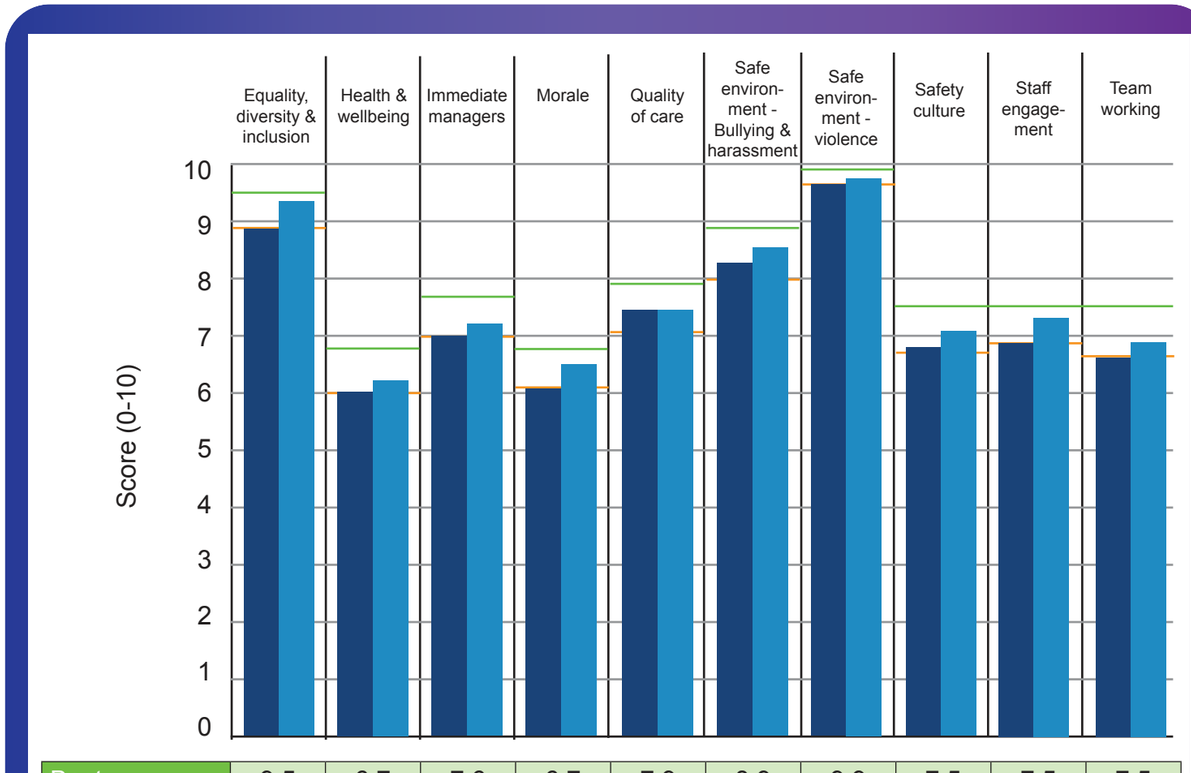
0 (0%) Theme(s) scored significantly better than the sector

9 (90%) Theme(s) scored significantly worse than the sector

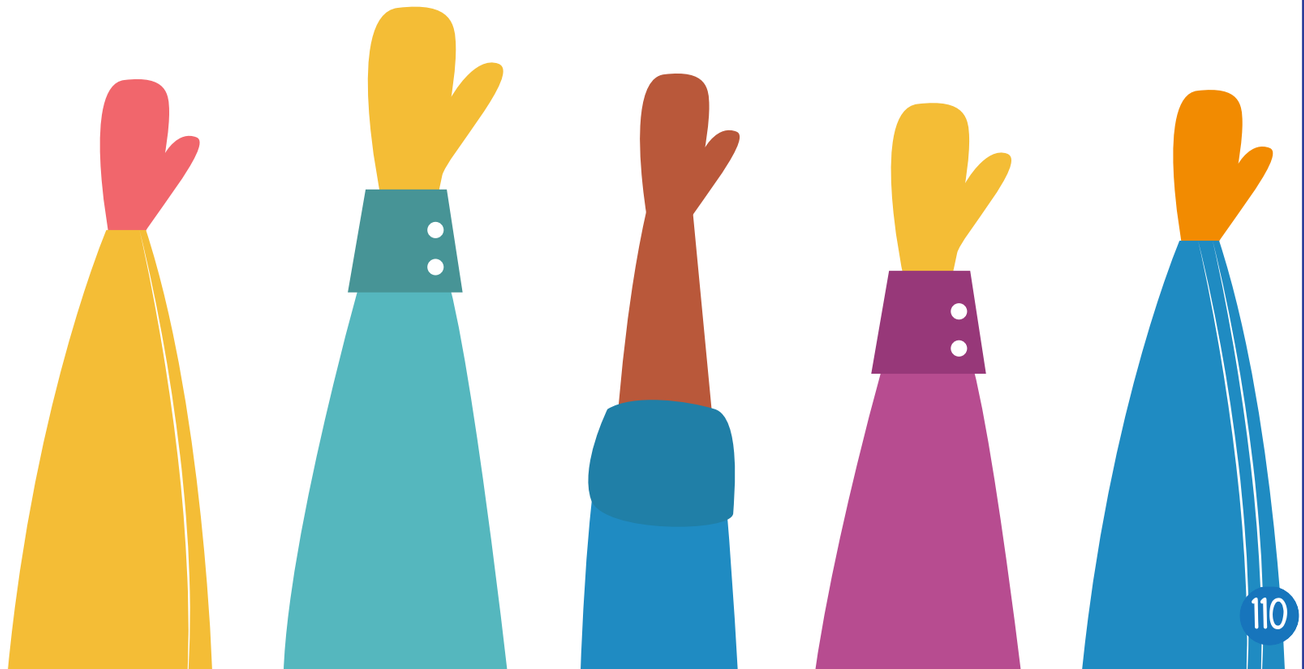
1 (10%) Theme(s) showed no significance in relation to the sector average

Specific COVID-19 pandemic response themes saw those working from home reporting the best scores against the 10 themes.

The worst scores overall are for those shielding or working in a COVID-19 specific area with the lowest themed results being for Health and Wellbeing for those on COVID-19 specific areas.



	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	6.7	7.6	6.7	7.9	8.9	9.9	7.5	7.5	7.5
Your org	8.8	6.0	7.0	6.1	7.5	8.2	9.6	6.8	6.9	6.6
Median	9.4	6.3	7.2	6.5	7.5	8.5	9.7	7.1	7.3	6.9
Worst	8.8	6.0	7.0	6.1	7.1	8.0	9.6	6.7	6.9	6.6
Response	2,017	2,025	2,023	2,019	1,724	2,006	2,013	2,028	2,026	1,979



We have seen improvement in 6 (8%) question(s) since 2019.
The largest improvements have been in the following questions:

Q4e. I am able to meet all the conflicting demands on my time at work +5%

Q4f. I have adequate materials, supplies and equipment to do my work +3%

Q4g. There are enough staff at this organisation for me to do my job properly +5%

Q11a. Does your organisation take positive action on health and well-being? +4%

Q11d. In the last three months have you ever come to work despite not feeling well enough to perform your duties? -9%

Q16c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again +4%

We have seen deterioration in 6 (8%) questions since 2019:

Q3a. I always know what my work responsibilities are -4%

Q5g. How satisfied are you with level of pay -4%

Q9d. Senior managers act on staff feedback -4%

Q11b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? +5%

Q11c. During the last 12 months have you felt unwell as a result of work related stress? +4%

Q11e. Have you felt pressure from your manager to come to work? +4%

We have 66 (85%) question(s) which have shown no significant movements since 2019 or comparisons could not be drawn.

The results of the 2020 Staff Survey have been shared with senior leaders through Management Board, Workforce and Organisational Development and with a particular focus on the equality and diversity findings, through the Equality, Diversity and Human Rights (EDHR) Steering Group.

Feedback has also been shared more generally through corporate communications and staff briefings. The staff engagement programme planned for Quarter 1 will ensure that staff views on the Staff Survey findings and solutions will be sought and further considered. Lessons learnt and good practice from comparative Community Trusts will also be identified.

An important element of the Trust's next steps is working with Directorate Teams to understand the specific survey findings and to develop an appropriate local response.

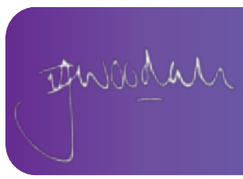
Areas for Improvement:

The Trust response to the Staff Survey is summarised in five areas for action:

- Developing our Line Managers: All line managers will take part in the Inspire Leadership Programme. Following the partial 'hold' during COVID-19 the programme will recommence in Quarter 1 on a fortnightly basis, reverting to a weekly programme from July 2021. The Inspire Programme is key to the ongoing development of leaders throughout the organisation.
- Equality, Diversity and Inclusion: The Trust will deliver the commitments made in the Truly Inclusive Organisation Action Plan. This will include:
  - Roll-out of new Disciplinary Policy and Cultural Ambassadors to embed the principles of Just Culture
  - Completion of the review and revision of the End to End Recruitment Process and development of the 'recognising and realising potential' Programme
  - Re-launch of the Anti-Racism Campaign
  - Commitment to building cultural competence throughout the Inspire Leadership Programme and Reverse Mentoring
  - Actively supporting Equality Staff Networks and engagement
  - Embedding EDI within Divisional priorities and objectives
- Health and Wellbeing: The Trust will develop the 'Hear for You' support package available to all staff and will introduce Health and Wellbeing Conversations and Passport during Quarter 1. The range of interventions to support healthy lifestyles, mental health and wellbeing and add on benefits to staff will be further developed
- Reducing Bullying and Harassment: A 'Zero Tolerance' approach to bullying and harassment will be further developed and support available for staff who are subject to abuse and violence will be enhanced.
- Supporting Colleagues to Speak Up: The role of the Freedom to Speak up Guardian and Champions will continue to be developed and a culture of openness embedded throughout the Trust.

Each of these themes are consistent with the Trust's Fit for 2022 plans and strategic objective to become a 'Great Place to Work'. These actions will be monitored through the Trust Board Fit for 2022 Quarterly Performance Report.

Richard Kirby
Chief Executive
Date: 25 May 2021



Ian Woodall
Chief Finance Officer
Date: 25 May 2021

2.4. Corporate Governance Report

Disclosures set out in the NHS Foundation Trust Code of Governance

Birmingham Community Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance (July 2014) reflects the principles of the UK Corporate Governance Code 2012 and aims to promote best governance practice. Whilst the NHS Foundation Trust Code of Governance is a guidance document, it requires that Foundations Trusts disclose any deviation from it; providing a reason for deviation from the Code and explanation as to how alternative arrangements meet the requirements of the Code.

The Board of Directors implements the Code of Governance through a number of key governance documents and policies which include:

- The Trust Constitution
- Standing Orders and Standing Financial Instructions
- Scheme of Delegation and Matters Reserved to the Board
- Code of Conduct - Board of Directors and Council of Governors
- Gifts, Hospitality and Commercial Sponsorship Policy
- Annual Plan
- The Board Committee Governance Structure

The Board of Directors

The Board of Directors is responsible for establishing the strategy of the Trust and for the operation of the Trust's business; ensuring compliance with the Trust's Constitution, NHS Improvement's Provider License, statutory requirements and contractual obligations.

Details of the composition of the Board of Directors are set out in Section 2.1 of the Annual Report with details of the Board Committee arrangements and attendance by individual Directors. Details of Director Terms of Office and remuneration are outlined in Sections 2.1 and 2.2 of the Annual Report respectively.

The Council of Governors

The Council of Governors represents the interests of those we serve and partner organisations and has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors; providing and gaining feedback on the Trust's performance to the stakeholder organisations and members. The Chair of the Council of Governors is also the Chair of the Board of Directors and is responsible for the performance of Non-Executive Directors.

The senior independent director is a non-executive director appointed by the Board of Directors, in consultation with the Council of Governors, with a role to supports the Trust Chair and serves as an intermediary for the other directors when necessary. The Senior Independent Director (SID) is also available to members of the foundation trust and to governors if they have concerns

The Council of Governors receive the Trust's Annual Report and Accounts and has responsibility for conducting an Annual Members meeting.

Members of the Council of Governors and the Constituencies they represent are included within this report.

Information and Evaluation

The Board of Directors has in place a programme of patient stories at each meeting of the Board of Directors in which it regularly receives direct feedback from patients, service users and carers. In addition the Board of Directors and the Quality and Safety Committee receive a quarterly patient experience report.

The Board of Directors undertakes an annual review of the performance and committee Terms of Reference in order to inform future information requirements and governance arrangements and to establish an annual Cycle of Business. Individual members of the Board participate in appraisal processes, the outcome of which is reported to the Executive Remuneration Committee or Council of Governors as appropriate.

Review of the Effectiveness of the Trust's System on Internal Controls

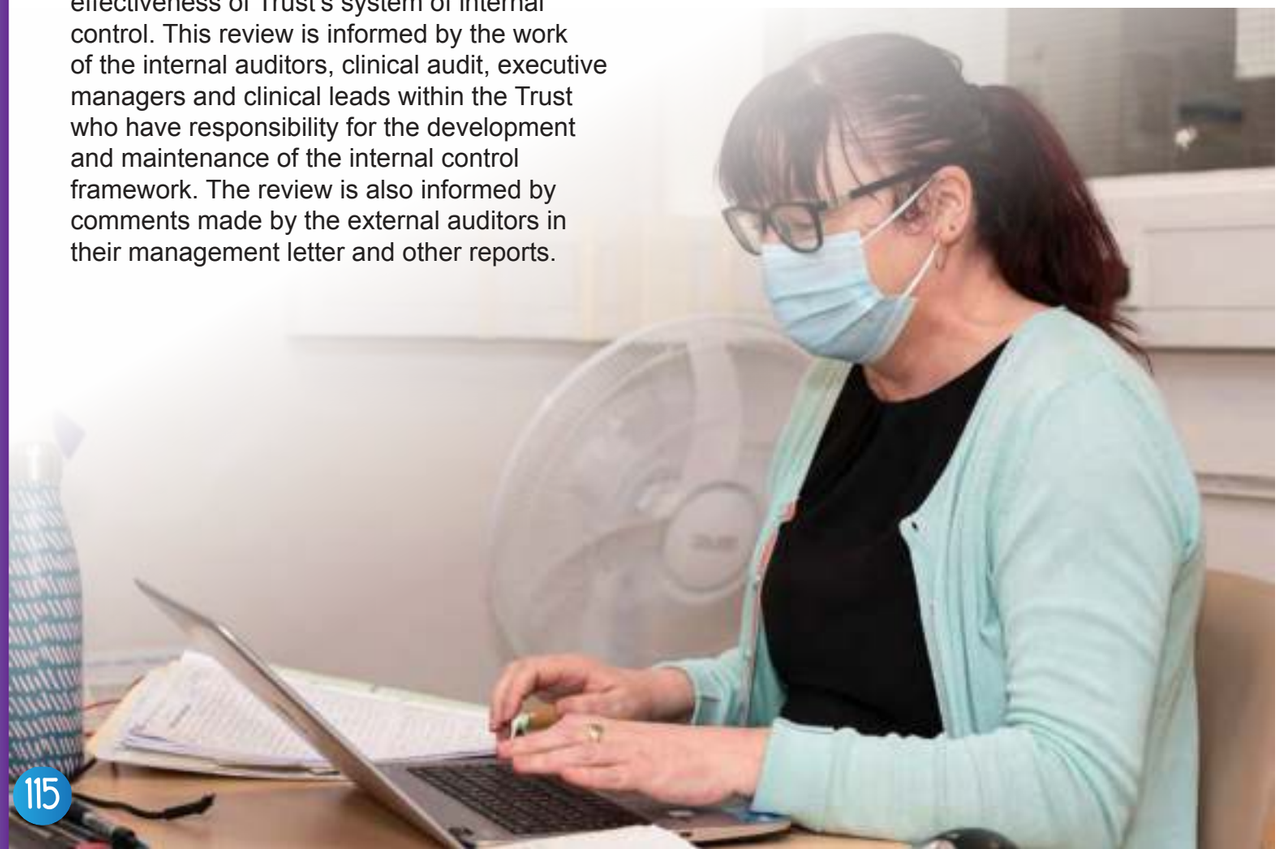
The Chief Executive as the Accounting Officer has a responsibility for reviewing the effectiveness of Trust's system of internal control. This review is informed by the work of the internal auditors, clinical audit, executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. The review is also informed by comments made by the external auditors in their management letter and other reports.

The Board's assessment of the effectiveness of the organisation's system of internal control during the year is supported by the Head of Internal Audit Opinion for 2020/21, which states that "Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk."

Areas of weakness relate to aspects of the health and safety arrangements, operating effectiveness of risk management and business continuity. A plan to address weaknesses identified and ensure continuous improvement of the system is in place. Further details are provided within the Trust's Annual Governance Statement, in Section 2.4.

Compliance with the Code

The Trust has been compliant with the NHS Foundation Trust Code of Governance throughout the year.



Information Governance (IG)

In 2020/21 the Trust's Information Governance (IG) team developed a work programme in line with the Trust's information risk organisational priorities reporting into the Information Governance Steering Group (IGSG). The IGSG is responsible for providing assurance that the Trust is compliant with all relevant legislation and guidance regarding information governance and security, and in particular for delivering the Trust's annual Data Security and Protection Toolkit (DSPT) submission. Due to the COVID-19 pandemic, the Trust's 2019/20 DSPT submission was delayed for 6 months to September 2020. At the point of submission, a number of evidence items were incomplete, and the Trust was assigned "Standards Not Met - Plan Agreed" for 2019/20. The Trust submitted a required improvement plan in October 2020, setting out the steps to deliver the outstanding requirements.

Key achievements over the last 12 months include the introduction of an information asset register platform so that the Trust can identify and track all its information assets and the suppliers used to process those assets. Alongside this the platform enables a central portal to be used for Data Protection Impact Assessments, a key requirement of the GDPR. The team has also delivered a new IG training package across the Trust to ensure that staff are fully equipped to identify any threats to data security and ensure that personal data is appropriately protected.

The Trust has handled 372 IG incidents in 2020/21; of these, 23 were reported via the DSPT online reporting tool where it was considered that a specific data breach had occurred; of these, three were considered to be reportable to the Information Commissioner's Office (ICO) as a notifiable incident, in line with the reporting obligations in the GDPR to report any data incidents which may present an adverse risk to the rights and freedoms of the individual(s) affected. Following internal measures having been taken to respond to these incidents the ICO considered that no further action was required and no enforcement action was taken against the Trust in each case.

Membership

Our public membership remains open to all residents of the wider West Midlands region who are aged 16 or above. Our staff membership is open to all staff who are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months. Our members and governors support the BCHC to be locally accountable to those we serve.

Our membership of around 13,000 public and staff members is represented by 13 elected public governors and 6 elected staff governors, who are joined by 4 appointed partner governors and the Trust's Chair to comprise our Council of Governors.

The principal role of the Council of Governors is to hold the Board of Directors to account for the performance of the Trust through the Non-Executive Directors and to represent the interests of our members and the communities we serve.

In line with the staggered governor terms of office that concluded on 31 March 2021, we opened Governor Elections in January 2021 with election results being declared on 26 March 2021. These elections offer our members the opportunity to stand to be elected to public and staff governor roles; with the nominations reflecting our diverse membership.

Table: The Governors of BCHC during 2020/21

Governor Name	Date Appointed/ Finished	Duration of Appointment	Role Title	Constituency Representing
Christopher Vaughan	07.10.16/ 31.03.19 Re-elected 01.04.19/ 31.03.21 Re-elected 01.04.21	3 years	Public Governor Chair of Nominations and Remuneration Committee for Non-Executive Directors	Centre & West Birmingham
Jill Jesson	15.12.16/ 31.03.19 Re-elected 01.04.19	3 years	Public Governor	Centre & West Birmingham
Graham Green	31.01.13*/ 31.03.19 Re-elected 01.04.19	3 years	Public Governor	Centre & West Birmingham
Steve Keating	06.12.2019/ 20.01.21	2 years	Public Governor Vice Chair of Governor Membership and Communications Group	Centre & West Birmingham
Sheila Try	21.11.14*/ 31.03.19 Re-elected 01.04.19	3 years	Public Governor Vice Chair of Patient Experience Group	North & East Birmingham
Joanne Benjamin-Lewis	07.10.16 Re-elected 01.04.19	3 years	Public Governor	North & East Birmingham
Roger Leek	31.01.13*/ 31.03.19 Re-elected 01.04.19/ 31.03.2021 Re-elected 01.04.2021	3 years	Public Governor	North & East Birmingham
Leky Parveen	06.12.2019/ 31.03.2021	2 years	Public Governor Chair of Governor Membership and Communications Group	North & East Birmingham
Frances Young	31.03.13*/ 31.03.19 Re-elected 01.04.19/ 31.03.2021	3 years	Public Governor Chair of Patient Experience Group	South Birmingham
Jane Hill	31.01.13*/ 31.03.19 Re-elected 01.04.19	3 years	Public Governor	South Birmingham
Peter Rookes	31.03.19/31.03.2021 Re-elected 01.04.2021	3 years	Public Governor	South Birmingham
Peter Mayer	31.01.13*/ 31.03.19 Re-elected 01.04.09/ 31.03.2021 Re-elected 01.04.2021	3 years	Lead & Public Governor	South Birmingham
Sue Durrant	31.01.13*/ 13.02.19 Re-elected 01.04.19 to represent WM	3 years	Public Governor Vice Chair of Nominations and Remuneration Committee for Non-Executive Directors	West Midlands
Jean Dipple	21.11.14*/ 31.03.19 Re-elected 01.04.19/ 31.03.2021	3 years	Staff Governor	Healthcare Assistant & Support Staff
Vicky Danyluk	31.03.19/ 31.03.2021 Re-elected 01.04.2021	3 years	Staff Governor	Healthcare Assistant & Support Staff
Lurieteen Miller	01.04.19	3 years	Staff Governor	Medical, Dental & Nursing Staff
Carroll Johnson-Chapman	01.04.19 / 31.03.2021	3 years	Staff Governor	Medical, Dental & Nursing Staff
John Frazer	01.04.19 / 31.01.2021	3 years	Staff Governor	Other Staff
Ronnie Meechan-Rogers	Interim 13.12.16 Partner Governor appointment confirmed 29.1.18 / 30.04.2021	3 years	Partner Governor	University of Birmingham
Mick Brown	01.04.2020	3 years	Partner Governor	Birmingham City Council
Stephanie Bloxham	01.11.18	3 years	Partner Governor	Birmingham Voluntary Services Council (BVSC)

*Governors who had been original elected in shadow form prior to the Trust being licenced as a NHS Foundation Trust on the 1 April 2016.

The Council of Governors has remained active in their role during 2020/21 and has formally met four times during the period virtually in public; receiving appropriate information to enable them to discharge their statutory responsibilities. Governors have paid particular focus on the organisational response to the pandemic, especially in relation to staff vaccinations, the stepping down and recovery of services and staff well-being and risk assessments throughout the pandemic. In addition Governors have maintained a focus on the progress to support our Children's Services.

An informal Governor led discussion group, chaired by the Lead Governor, has met six times during the year to support the triangulation of information from individual Governor activities. The group also provides a forum for Governors to seek further information to support informed debates, development of a consensus of views and identify additional development needs. This year it played a particular role in connecting with each other.

Whilst the national restrictions of the pandemic hindered some of the usual Governors activities they continued to observation of both Public and Private Board meetings and its sub-committees virtually in order to witness the performance of the Non-Executive Directors and Board of Directors at work.

Due to the pace of change the Governors held regular virtual briefing sessions with the Trust Chair and Chief Executive to ensure they remained connected to the decisions of the Trust; in relation to the pandemic in terms of our response to support our patients, our colleagues and the wider system including care homes and the development of the local Integrated Care System.

Prior to the pandemic Governors had been provided with electronic devices which supported them to move seamlessly to virtual meeting platforms. Governors also utilised the opportunities to participate in a number of local virtual forums to stay connected with our communities and also provided direct advice to the Trust around spirituality support for patients, carers, families and staff.

Our annual governor development programme, to support Governors with the knowledge and skills to deliver their roles, aligns to our governor competencies framework and is shaped by governors and their annual effectiveness review. The 2020/21 development programme utilised the increased accessibility for governors to assess virtual training opportunities linked to their role and wider conversations around the move to integrated care systems. Governors actively participate in the Governwell programme and the virtual governor workshops to promote learning from others.

A priority for 2021/22 will be to continue to support Governors with knowledge around the developing local system landscape of service delivery and local accountability in light of the new NHS White Paper.

The Council of Governors utilised its Nominations and Remuneration Sub-Committee for Non-Executive Directors to lead a review of the terms and conditions for Chairs and Non-Executive Directors in line with the national guidance to align these between NHS Trusts and NHS Foundation Trusts. The review resulted in a slight adjustment to the annual remuneration for new Non-Executive appointees and as part of the re-appointment process for existing NEDs and Trust Chair. The Council of Governors approved the combined remuneration for the roles of Vice Chair and Senor Independent Director in accordance with the national guidance to only remunerate two enhanced NED roles; the second being Chair of Audit Committee. The Council of Governors also appointed David Sallah to succeed Jerry Gould, who finished his tenure in year, as the Vice Chair.

Following a process led by the Nominations and Remuneration Committee for NEDs, the Council of Governors approved the re-appointment of Jenny Belza as Non-Executive Director for a further 3 year tenure to commence on 1 April 2021.

During 2020/21, the Board and the Council of Governors made no amendments to the Trust Constitution.

In year, we utilised our Governor Elections to refresh and maintain a representative membership. The Trust utilised new opportunities to engage with new audiences to ensure we had representative candidates of the communities we serve standing in our Governor elections. The Trust is not seeking to grow its membership; although every opportunity will be taken to embed membership into Trust activities to ensure membership remains reflective of the communities we serve.

Table: Overview of Public Membership (as of 31 March 2021)

Public Constituency	Electoral Wards	Number of Governors	Membership size
South Birmingham	Allens Cross, Bartley Green, Billesley, Bournbrook & Selly Park, Bournville & Cotteridge, Brandwood & King's Heath, Druids Heath & Monyhull, Edgbaston, Frankley Great Park, Hall Green North, Hall Green South, Harborne, Highter's Heath, King's Norton North, King's Norton South, Longbridge & West Heath, Moseley, Northfield, Quinton, Rubery & Rednal, Stirchley, Weoley & Selly Oak	4	2,203
Centre & West Birmingham	Aston, Balsall Heath West, Bordesley Green, Bordesley & Highgate, Birchfield, Handsworth, Handsworth Wood, Holyhead, Kingstanding, Newtown, Ladywood, Lozell, Nechells, North Edgbaston, Oscott, Perry Bar, Small Heath, Soho & Jewellery Quarter, Sparkbrook & Balsall Heath East, Sparkhill	4	1,865
Birmingham East & North	Acocks Green, Alum Rock, Bromford & Hodge Hill, Castle Vale, Erdington, Garretts Green, Glebe Farm & Tile Cross, Gravelly Hill, Heartlands, Perry Common, Pype Hayes, Shard End, Sheldon, South Yardley, Stockland Green, Sutton Four Oaks, Sutton Mere Green, Sutton Reddicap, Sutton Roughley, Sutton Trinity, Sutton Vesey, Sutton Walmley & Minworth, Sutton Wylde Green, Tyseley & Hay Mills, Ward End, Yardley East, Yardley West & Stechford	4	2,738
West Midlands Region	Herefordshire, Shropshire, Staffordshire, Warwickshire, Worcestershire, West Midlands (excluding Birmingham)	1	1,858

Our Annual Members Meeting had to move to a virtual forum and the increase in number of attendees was welcomed. This increase attendance was mirrored at our Governor Awareness Session and our Patient Experience Group, providing learning that virtual engagement is an additional accessible tool available to support face to face engagement for the future.

In year, public governors sought to building on existing virtual opportunities where local communities come together, which was mirrored by staff governors as they embed themselves into staff forums and Clinical Council, to hear the views of those they represent.

Membership engagement in year had a strong focus on the role of governor to support the diversity of members who stood in our governor elections and updating our members around service changes and the pandemic. We remain thankful to our members who continue to provide us feedback through our Patient Experience Group, chaired by Public Governor Frances Young, and by responding to our emails seeking their views. We are also grateful to Frances, who stepped down from her Governor role on 31 March 2021, for her leadership to develop an informative forum. Frances will be succeeded by Sheila Try, Public Governor as Chair of the Patient Experience Group.

Working closely alongside different community groups has helped connect BCHC Governors and Membership team to new residents who wanted to get involved. We had a range of community volunteers including new friends from the Active Wellbeing Society and individuals co-designing with the Trust's public engagement manager who stood in our January elections. We are delighted that this work has seen an increase in representation and inclusion that will help us to ensure our council of governors truly represent the communities BCHC serves.

The engagement between public governors and members continues to be an area for further development during 2021/22. In support, the Council of Governors has a sub-committee with a focus on membership engagement and communication; chaired by a public governor. In year the Trust has also refreshed its overarching community engagement strategy, which will inform a refresh of the membership strategy and seek to embed governors further into the engagement activities of the Trust.

If you are currently not a member of our Trust and would like to join us to influence what we do or to learn more about the services we provide please either contact the membership team or complete the online form that is available at:

http://www.bhamcommunity.nhs.uk/about-us/membership/

If you are interested in the role of governor, we would welcome the opportunity to discuss this further with you. Please contact the membership team for more information.

Your Governors are keen to hear your views please contact them and the membership office by phone on 0121 466 7023 or email bchc.membership@nhs.net

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

This segmentation information is the Trust's position as at 31 March 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. The use of resources scores were not required to be reported to NHSE/I during 2020/21 due the national guidance in place to support the response to the pandemic.

Statement of the Chief Executive's responsibilities as the Accounting Officer of Birmingham Community Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Birmingham Community Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Birmingham Community Healthcare NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Richard Kirby
Chief Executive Officer
Date: 25 May 2021

Annual Governance Statement 2020/21

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Birmingham Community Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Birmingham Community Healthcare NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust commissioned an independent external contractor to undertake a developmental review of leadership and governance using the Well Led Framework[1] in 2018/19.

Following the review, the Trust took the opportunity to strengthen its risk management arrangements by undertaking a refresh of the Risk Management Strategy (and associated documentation), establishing an executive level risk management committee (chaired by an executive director) and refreshing the governance structure to ensure it supported the timely escalation of risks. The Risk Management Strategy was approved by the Trust Board in June 2019 and clearly outlines roles and responsibilities for the management of risk.

In line with the Best Care: Healthy Communities Strategy, the Trust has four strategic objectives; Safe High Quality Care, Great Place to Work, Integrated Care in Communities and Making Good Use of Resources. Each strategic objective is aligned to a committee of the Board. The Quality and Safety Committee oversees Safe, High Quality Care. The Finance and Performance Committee oversees Integrated Care in Communities and Good Use of Resources. The Workforce and Organisational Development Committee oversees Great Place to Work. Each committee oversees delivery of the respective Fit for 2022 Improvement Programme workstream for their strategic objective(s) and has a responsibility to fully consider both the significant operational risks (risks scoring 15 and above on the corporate risk register) and strategic risks (which collectively form the Board Assurance Framework (BAF)) which relate to the delivery of their respective strategic objectives.

Following the declaration of a Level 4 National Incident in response to the COVID-19 pandemic and in light of the publication received from NHSE/I in March 2020, the executive team considered the arrangements in place within the organisation for the management of risk. Given the unprecedented situation, it was acknowledged that the organisation required a dynamic, responsive and agile approach to managing the risks associated with the pandemic; it was also acknowledged that this approach should be aligned with the Trusts' Risk Management Strategy and managed via the Datix risk management system.

The COVID-19 risk log was introduced in April 2020 and was identified as the mechanism by which the Executive Team would maintain strategic oversight of the impact of the pandemic on all risks including those newly arising.

For the purpose of fulfilling its legal duty for ensuring there are mechanisms in place for on-going monitoring and review of risk, the Board should note that the following steps are in place in relation to the management of risk during the COVID-19 pandemic:

- Weekly operational oversight of any risks arising or impacted by the COVID-19 pandemic via the Trust COVID response meeting;
- Weekly strategic oversight of the impact of the pandemic on all risks including those newly arising via the Executive Team meeting;
- Monthly review of all risks rated as 15 and over via the Risk Management Executive (RME) as part of the established Risk Management Process, this will include the approval of new risks, risk recommended for closure, risks reviewed;
- Monthly notification to Assurance Committees of the Board of all relevant risks via the Executive Lead COVID-19 updates featured on the monthly agendas as a standing item; and
- Bi-monthly assurance reporting to the Audit Committee.

The following diagram outlines the roles and accountability for risk management within the Trust Governance Structure

	In receipt of...	Accountability for...
Audit committee	• Corporate Risk Register • Board Assurance Framework • Risk Dashboard	• Seeking assurance on behalf of the Board that the processes in place for risk management are fit for purpose
Board	• Board Assurance Framework • Corporate Risk Register (noting)	• Seeking assurance through committees that risk is being managed effectively at the Trust
Committees	• Board Assurance Framework (relevant risks) • Movement log/CRR (relevant risks)	• Seeking assurance on behalf of the Board that strategic risks are appropriately managed. • Line of sight of risks scoring 15+ (relevant risks)
Risk Management Executive	• Corporate Risk Register • Movement Log • Risk Dashboard • Board Assurance Framework	• Scrutiny and challenge of risks scoring 15+ • Holding divisions to account for timely and appropriate management of risk • Recommending risks for addition to BAF
Divisional Management Board	• 12+ Risk Register • Movement log (Divisional) • Risk Dashboard (Divisional)	• Scrutiny and challenge of risks scoring 12+ • Approval of risks scoring 12 and above for inclusion on risk register within 6 weeks of identification
Divisional Quality Governance and Risk Committee	• Divisional Risk Register (all risks) • Risk Dashboard (Divisional)	• Scrutiny and challenge of divisional risks • Approval of risks scoring 1 to 10 for inclusion on risk register within 6 weeks of identification

[1]NHSE/I Guidance for Foundation Trusts, June 2017

The Risk Management Strategy clearly outlines the roles and responsibilities of the Chief Executive in ensuring there is a sound system of internal control in place which is designed to identify and prioritise risks, to evaluate the likelihood of those risks being realised (and the impact should they be realised), and to manage them efficiently, effectively and economically. However all executive directors have a role in the management and oversight of risk as follows:

- The Director of Corporate Governance is responsible for ensuring there are clear risk management policies, procedures and governance frameworks in place designed to identify and prioritise risks, and to evaluate the likelihood of those risks being realised (and the impact should they be realised);
- The Medical Director and Chief of Nursing and Therapies have joint responsibility for all aspects of clinical quality governance and associated clinical quality risk;
- The Chief Finance Officer is responsible for all aspects of financial governance and associated financial risk; and
- All Executive Directors have responsibility for governance and risk in relation to their respective portfolios.

The majority of risk management training is provided to colleagues in order that they are able to undertake their specific role and responsibilities e.g. risk and incident management.

However, other risk management related training forms part of mandatory training i.e. Health and Safety, Fire Safety, Manual Handling. Training is provided throughout the Trust using a range of techniques including face to face, team specific and eLearning platforms, including the Moodle virtual campus which can be accessed from any computer. Access to training has been tailored through the development of training videos and fully utilising access to Microsoft Teams to reach colleagues across the Trust and in all locations.

The Trust ensures that its range of training programmes effectively raise the profile and understanding of risk identification, assessment and management, and clearly demonstrates to all colleagues across the Trust, how their routine and consistent application of risk management processes will serve as a key enabler to ensuring continuous improvement in the quality of care delivered. This standard applies whether the corresponding training is specific to risk (including therefore, the Trust's mandatory risk management training module), or whether it is principally dedicated to other subjects or specialisms that would nevertheless benefit from supporting coverage of risk such as Health and Safety training or the use of Display Screens.

This commitment to increasing all colleagues' awareness of their personal responsibilities for risk management is enhanced by a proactive and on-going programme of communications across the Trust that seek to reinforce appreciation for the value and significance of risk management outcomes; this is supported through corporate newsletters, updated information on the intranet and through meeting teams within their own workplace.

Specialist risk management training has been delivered across the organisation in a range of settings and using a variety of methodologies, albeit with clear focus upon self-service training which will enable colleagues to access the information and support that they need, where and when it is most convenient and appropriate to them.

More specifically, an overview of risk management systems and processes is included within the induction programme that is mandatory for all new Trust colleagues.

Furthermore, in order to augment the Trust's risk management training programmes and to provide additional or supplemental advice and support on all issues related to risk, detailed guidance materials and resources are maintained on the Trust intranet.

The Trust ensures that its risk management training is appropriate to fulfil the personal development needs of all colleagues. This is equally applicable whether the training is being provided to frontline colleagues within operational teams who need to understand how to identify, report and escalate operational risks within their services, or whether the training is more specialist and therefore targeted at meeting the needs of those Trust colleagues with specific role-based responsibility for risk management, such as the Head of Information Governance and the Head of Risk Management.

However, it is important to recognise that the delivery of mandatory training has been significantly affected by the COVID-19 pandemic. A combination of shielding, sickness and redeployment has made releasing staff challenging. The pandemic has also meant that face to face training was initially halted and whilst it has restarted for subjects which need to be delivered face to face (such as manual handling, resuscitation and site specific fire), due to the COVID-19 secure arrangements that need to be in place, capacity is much reduced.

The risk and control framework

The Risk Management Strategy was refreshed and approved by the Trust Board in 2019. The Trust has an effective risk management strategy in place; significant progress has been made in the implementation of the strategy but one of the objectives related to the implementation of service level risk registers has been impacted by the COVID-19 pandemic.

Following a number of actions, risk management is rightfully recognised by the Trust as a key enabler to ensuring continuous improvement in the quality of delivered care.

The Trust maintains a number of formal processes and systems by which it seeks to manage both strategic and operational risk. These include:

- Trust policies and procedures
- Risk registers that are maintained electronically via the Datix software system and that capture all risks (both clinical and non-clinical), together with a Board Assurance Framework that identifies strategic risks
- The appointment of key individuals to oversee risk processes on behalf of the Trust, including the Director of Corporate Governance, Head of Risk Management and Emergency Planning, the Risk Management Team and Divisional/Service Governance Leads
- A number of key forums with specific responsibilities for relevant aspects of risk, which include the Trust Board and the Board Committees.

The Trust comprises five clinical Divisions and a number of corporate Directorates, all of which have risk registers which feed into the organisation wide risk register.

Risk assessments are proactively encouraged as a normal function of day to day activity, as we believe that risk should influence strategic planning and corporate objective setting.

All risks are recorded on a Trust-wide electronic system and are rated using a standardised methodology for quantifying risks; this assesses the consequence of the risk and the likelihood of it arising and arrives at an overall risk score.

Once identified, risks are assessed in terms of the controls and assurances that are in place to manage them, and actions are developed to manage any gaps in these. For some areas of risk, the mitigating action reduces the consequence and likelihood of risk; however some residual risk may still remain that requires managing.

In line with our Risk Management Strategy, identified risks are scored using the National Patient Safety Agency (NPSA) matrix and the risk register is regularly monitored at both divisional and corporate level.

The level of risk that the Trust is prepared to accept, before action is deemed necessary to reduce it, is defined as the Trust 'Risk appetite'. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings. The Board has agreed and maintains the risk appetite of the Trust, and reviews this in line with national and organisational change and the Orange Book: Management of Risk - Principles and Concepts (HM Treasury, 2013).

Divisions within the organisation have Quality and Safety Committees that oversee the performance information. Items are escalated to Divisional Management Boards for assurance on quality, safety and risk issues and mitigation. A quarterly Quality and Governance report is presented by each division to the Trust Quality and Safety Executive for assurance.

The Trust Quality and Safety Executive is chaired by the Medical Director and receives reports from a number of specialist groups that such as Safeguarding Children's Committee, Safeguarding Adult's Committee, Infection Prevention and Control Committee, Mortality Review and Deteriorating Patient Committee, Serious Incident Panel, Clinical Effectiveness Committee, Medicines Management Committee, Resuscitation Committee, Medical Device Management Committee, Safety Express Committee, Falls Steering Group and Research Steering Group.

The Trust Quality and Safety Committee is an assurance committee of the Board and is chaired by a Non-Executive Director where members of the executive team such as the Medical Director and Chief of Nursing and Therapies provide assurance on issues of quality governance included in the Safe, High Quality Care strategic objective of BCHC. This relates closely to the work of the Clinical Safety Committee and the Safe, High Quality care elements of the Risk Management Committee. This committee also conducts deep dives into the work of the clinical divisions and corporate services with a clinical function seeking assurance on quality and safety issues, the clinical risks in that division and the mitigations in place.

In January 2019, the Trust Board seminar agreed the following risk appetite descriptors and rating for each of the Trust Strategic Objectives. The risk appetite has been subject to review, the latest of which occurred in February 2021.

Safe, High Quality Care

- Risk Appetite level - Averse (3)
- Preference for ultra-safe delivery options that have a low degree of inherent risk and only limited reward potential. Prepared to expend significant time and resource to mitigate risks in this area to a minimal level.

A Great Place to Work,

Integrated Care in Communities and

Making Good Use of Resources

- Risk Appetite level - Moderate (8)
- Willing to consider all potential delivery options and choose based on delivering an acceptable level of reward (and Value for Money). Prepared to accept that risks are likely to occur in the pursuit of our objectives in this area and that we will need to tolerate risks up to a rating of 'high' to realise potential rewards.

Board Assurance Framework (BAF)

The tables below provide a summary of the risks to the delivery of the Trust's strategic priorities which form the Board Assurance Framework as at 31 March 2021. The Board Assurance Framework is reviewed quarterly at the Assurance Committees and quarterly at the Trust Board. However the Assurance Committees were stood down in December 2020 and February 2021, as were the respective meetings of the Trust Board in January and March 2021.

The Trust Board last received a Board Assurance Framework Update in February 2021 whereby it approved the proposal that an exercise is undertaken with board members to identify future strategic risks (those relating to the delivery of the organisation's strategic objectives) and compile the Board Assurance Framework.

The strategic risks developed by board members collectively will be aligned to our strategic objectives.

The Trust Board will approve the Board Assurance Framework 2021/22 in July 2021; this could be subject to change depending upon the submission timelines prescribed nationally for approval of the Annual Plan.

The Board Assurance Framework (BAF) as at 31 March 2021

BAF19/13: If we do not recruit and retain staff and develop a workforce with the right skills to deliver our strategy due to inadequate workforce planning and an ineffective recruitment and retention strategy we may fail to attract and retain the most capable and ambitious staff and deliver our Fit for 2022 Strategy.

20 (L4xC5)

BAF19/4: Failure to embed an inclusive culture consistent with our values and deliver good practice in equality due to a lack of commitment to the equality and diversity as a core part of everything we do may result in missed opportunities to utilise the talents of our diverse workforce, low morale in the workforce and poorer quality of care for the diverse communities of our city.

16 (L4xC4)

BAF19/3: A failure to deliver the improvements required by CQC and OFSTED in Children's services could result in poor outcomes for children and young people.

16 (L4xC4)

BAF19/8: If we are unable to transform our digital capability due to the cost and difficulty of effectively implementing change, we risk impacting on patient care and foregoing efficiency opportunities.

15 (L3xC5)

BAF19/9: If we are unable to maintain sustainable contractual margins, develop and deliver efficiency gains due to market pressure and a lack of opportunity and/or capability, we risk damaging our financial sustainability.

15 (L3xC5)

BAF19/2: If we do not deliver safe high quality care we will not meet stakeholder including regulators' requirements. This could lead to poor clinical care, potential loss of reputation and income.

12 (L4xC3)

BAF19/16: If we fail to engage with and build strong partnerships externally or to foster relationships and failure to align our priorities to those of our partners and the wider system due to a lack of leadership capability, may result in us being unable to secure contracts, sustain our services over the longer term and ultimately deliver integrated services for our community.

12 (L4xC3)

BAF19/5: If we do not improve staff health and wellbeing due to a failure of leadership at all levels to fully recognise and respond to the impact that mental and physical wellbeing can have on staff and a lack of investment this may result in higher sickness absence, poor staff morale and higher turnover which will have an adverse effect on the delivery of our strategic objective.

12 (L4xC3)

BAF19/18: If we fail to engage with primary care networks, there is a risk that we will not fully benefit from the primary medical and community services funding guarantee set out in the NHS Long Term Plan, in particular, community health crisis response, providing enhanced health in care homes, first contact physiotherapy and implementing 'anticipatory care' for complex patients at risk of unwarranted health outcomes.

12 (L3xC4)

BAF19/15: If we fail to implement a clear strategic direction for research and innovation due to lack of commitment and/or resources, we will lose and/or fail to attract research activity and income and the ability to contribute to evidence based care.

12 (L3xC4)

BAF19/19: If we do not change and redesign our services quickly enough to demonstrate the effectiveness of our model to partners and stakeholders we will be unable to retain key contracts which will result in us being unable to deliver our older people model.

12 (L4xC3)

BAF19/14: If Commissioners reduce funding for services or fail to increase funding to meet increasing demands, we may be unable to provide a safe, high quality service and/or to meet service demands.

12 (L3xC4)

BAF19/12: If we are unable to ensure an estate that complements our clinical and enabling strategies due to technical and commercial constraints, we risk impacting on delivery of our strategic work programme.

9 (L3xC3)

BAF19/21: Failure to develop a strong partnership with BSMHT will reduce the chances to bring together mental and physical community health services affecting our ability to provide the best care to our patients and service users.

9 (L3xC3)

BAF19/17: If we are unable to provide equity of access and/or quality across the entire geography and population we serve or fail to successfully implement our locality model due to recruit challenges in some areas, this may result in inequality of provision.

9 (L3xC3)

BAF19/6: If we do not embed our vision and values in behaviours and leadership style we will not deliver our objective of Making BCHC a Great Place to Work, nor delivering a high quality service.

8 (L2xC4)

BAF19/11: If we are not able to mitigate emerging risks relating to EU exit due to lack of visibility of the true risk and /or availability of mitigations, we risk impacting on accessibility of services and quality of patient care.

8 (L2xC4)

BAF19/1: Failure to implement and embed an effective Trust wide improvement methodology programme due to lack of engagement and empowerment with all colleagues and a systematic approach to improve culture modelled by our leaders may result in the quality of our services not improving to support delivery of our 2022 strategic plan.

8 (L2xC4)

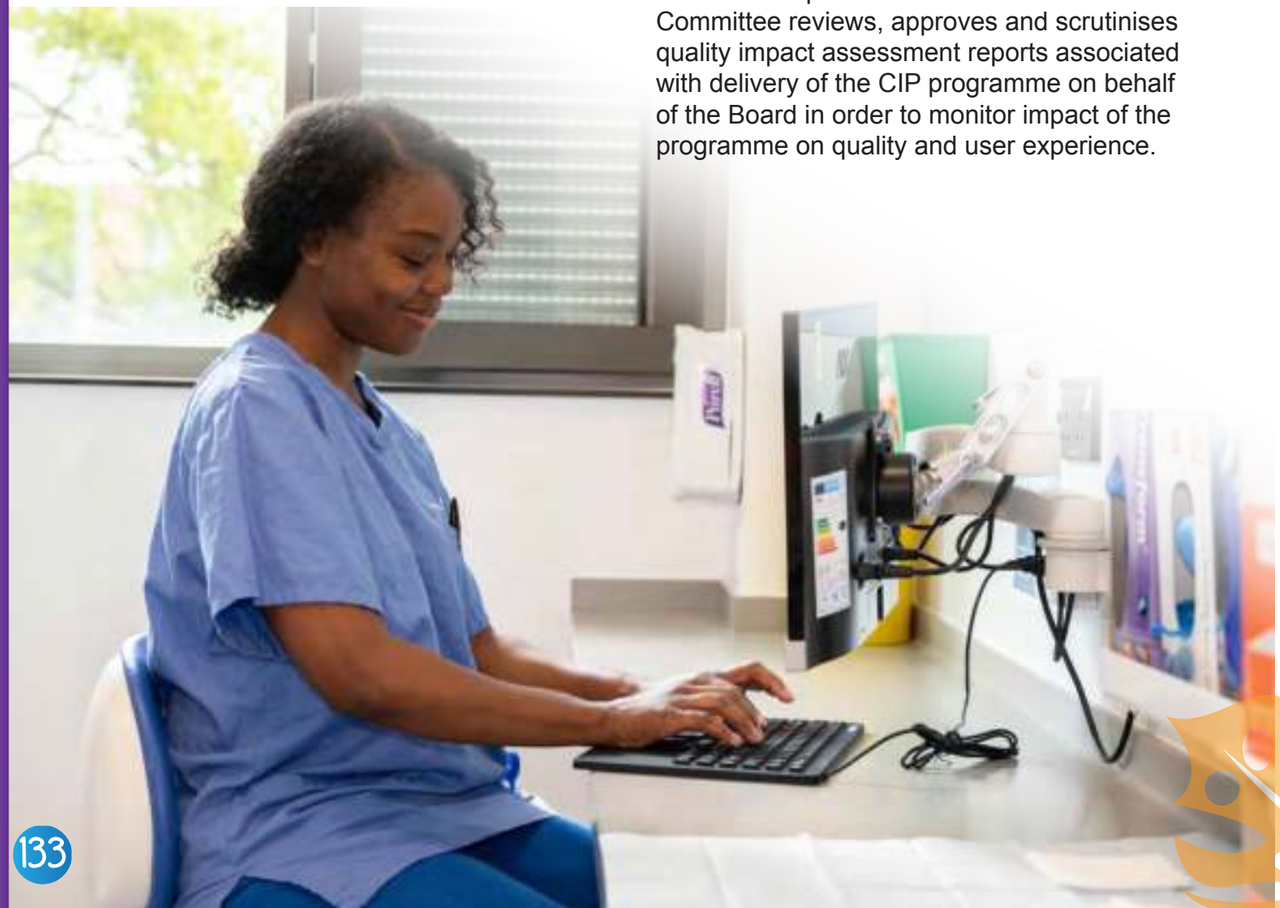
BAF19/20: If we don't have sufficient Commissioning Expertise in Learning Disability Services, we may be unable to demonstrate our system leadership model and consequently may be unable to realise the benefits of being a commissioner of other LD services

6 (L2xC3)

All Trust Board members support a proactive approach to risk management within the organisation. The Board reviews the Risk Register in full on an annual basis at the start of the financial year and subsequently reviews new risks, removed risks and all high level risks on a quarterly basis. The Board also receives an Annual Risk Management Report which provides assurance that the Risk Management Strategy is being implemented.

The Trust Board has overall responsibility for the management of risk across the organisation. Its specific duties include:

- Setting the risk appetite for the organisation;
- Ensuring an effective system of internal control including risk management;
- Receiving the Board Assurance Framework quarterly, and advising on mitigations and actions as appropriate; and
- Receiving assurance reports from all Board Committees with regard to risks, internal control and assurance.



The Board has up to date access to information on the Trust Risk Register through reporting arrangements from the committees described below.

Information on significant risks, the magnitude of those risks, options for risk prevention or control and progress made in achieving control are agreed and approved at the Quality and Safety Committee, the Workforce and Organisational Development Committee and the Finance and Performance Committee, all of which are committees of the Board and have delegated responsibility for ensuring that effective risk management and assurance processes exist throughout the Trust on behalf of the Board.

The Committees do this at every meeting to govern the performance of the Risk Management Executive and Clinical Safety Executive through a process of receiving escalation reports and reviewing performance against key indicators.

The Board committees provide monthly reports to the Board relating to achievements and areas of concern and also provide an annual assurance report to the Audit Committee. The Committee reviews, approves and scrutinises quality impact assessment reports associated with delivery of the CIP programme on behalf of the Board in order to monitor impact of the programme on quality and user experience.

Detailed scrutiny of compliance with CQC standards is undertaken by the Quality & Safety Executive. Additionally, a programme of internal inspection is operated and routinely reports to the Quality and Safety Committee providing assurance of ongoing compliance.

The Risk Management Executive (RME) ensures that all risk management activity is co-ordinated across the Trust. The RME provides support to Divisional and Corporate Service Directors and advises the committees of the Trust Board of the on-going risk profile of the Trust, the trends in risks and priorities for action.

All High Level Risks graded 15 and above are reviewed at every meeting of the Risk Management Executive.

The Trust Risk Management Operational Development Group reviews all risks rated below 15 at each meeting. The Chair is responsible for analysing trends/hotspots to identify mechanisms which can reduce the level of reported risks/incidents. Assurance is obtained from local governance groups that they are effectively managing and investigating risks/incidents.

The Board of Directors reviews and approves a Corporate Governance Statement (FT4) on an annual basis, as required under its license conditions, and is assured of its validity through the leadership, governance, performance, risk management and escalation processes that it employs and which are described in this Annual Governance Statement.

Patients, carers, members, public (and other stakeholders including staff) help to identify risks that may be impacting on them through patient feedback channels such as surveys, friends and family test, customer services (PALS) and complaints. The Trust actively engages and consults with communities, community groups, Healthwatch and other representative organisations for major service changes and developments and proactively encourages Members' and Governors' participation and involvement in the work of governance and other committees including Quality & Safety Executive, Patient Experience Group, Research and Innovation which review relevant risks and their management.

Incident Management

During the reporting period, a total of 10,742 incidents were reported; 124 were classified as Serious Incidents (SIs) including 1 Never Event.

The 124 Serious Incidents can be detailed as follows:

- Grade 3 Pressure Ulcer x 56
- Grade 4 Pressure Ulcer x 40
- HCAI/Infection Control x 15 (14 of which COVID Related)
- Inappropriate handling of a child x 1
- Potential Treatment Delay x 1
- Slip trips and falls x 9
- Sub-optimal care of the deteriorating patient x 1
- Surgical/invasive procedure incident (Never Event - Dental) x 1

All new and on-going serious incidents and those where root cause analysis investigations have been completed and lessons learned are reported to the Quality and Safety Executive every month.

Workforce Safeguards

The Trust has established a committee of the Trust Board to oversee the People and Workforce Strategies.

The Trust develops a workforce plan as part of its Annual Plan contribution which is integrated with service and financial planning. This plan is submitted to the Trust Board as part of the approval process for the Annual Plan.

There is an increasing priority given to workforce planning at an Integrated Care System (ICS) level and the Trust is an integral partner in this.

The Trust has a well-established process for the overview and scrutiny of safe staffing levels through monthly reports to the QSC. These indicators appear on the Trust scorecard and are reviewed at Divisional and Trust Board level on a monthly basis.

Escalation processes are in place to identify supply gaps and risks. The Trust undertakes regular safe staffing establishment reviews to ensure that workforce capacity meets service demands.

Workforce Risks and Safe Staffing Risks are registered on the Trust's Risk Management system and are defined under the Trust's Great Place to Work Strategic Objective. These Risks are monitored through the RME and Board Committee structure.

The Trust has a well-established governance system for assessing the quality impact of transformation and productivity changes through the Gateway system. The impact on quality and workforce are assessed through specific assessment tools and a senior workforce lead oversees the impact of service changes at the various stages of the process. The Trust is developing its quality impact analysis approach to include a wider consideration of equality impact during 2021/22.

The Trust has continued to roll out its programme to extend e-Job Planning and e-Rostering within clinical services.

The Trust has identified that a key priority for 2021/22 will be to review and revise existing workforce plans and to build on the workforce development workstreams put in place during the COVID-19 Pandemic e.g. New Opportunities Programme. There is a commitment to developing a plan to identify the potential for new roles and the greater use of Apprenticeships and the extension of advanced practice.

The Trust has recently approved the Allied Health Professionals Strategy and will be receiving the Nursing Workforce Strategy for approval in June 2021.

The Trust has developed a comprehensive set of Great Place to Work Key Performance Indicators which are monitored and managed through the Trust's Performance framework. These indicators cover issues such as Sickness Absence, Turnover, Vacancies, compliance with PDR/ Mandatory Training, Disciplinary, Casework and WRES. These KPIs feature in the Quality and Performance Report which is presented on a monthly basis to the Trust Board and its Committees.

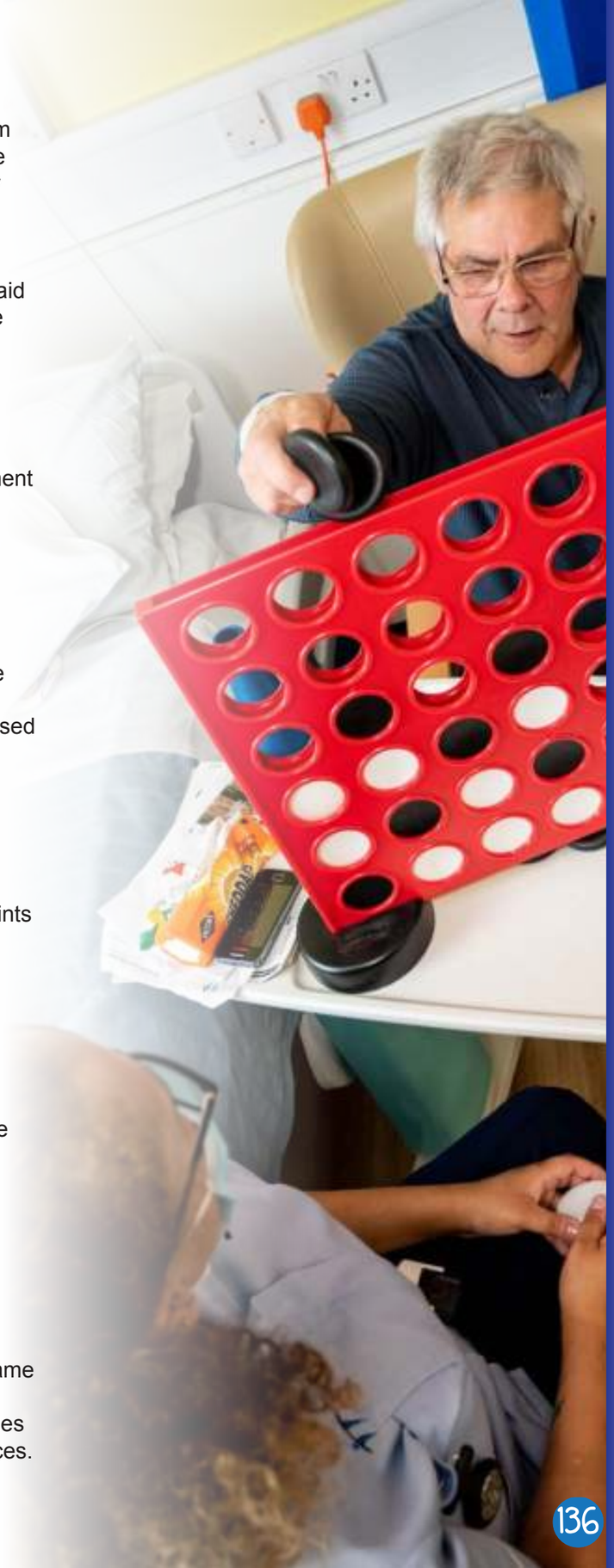
A RAG rating system flags areas of concerns and requires Recovery Plan and exception reporting.

Safe Staffing Process Overview

COVID-19 has had an unprecedented impact on all areas of the NHS and Birmingham experienced some of the greatest challenges nationally. In relation to safe staffing, a clear focus and governance oversight was maintained and indeed enhanced through the year. The Trust continued to meet the requirements and reporting arrangements as required by the National Quality Board 2016 guidance. In addition attention has been paid to the four key elements as set out within 'Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing' (October 2018). Chapter 6 'Responding to unplanned workforce challenges' has been key through the pandemic. There was an unprecedented need to open additional beds, expand community services at pace and redeploy, at peak, over 1,000 colleagues in order to maintain safe staffing. As set out in monthly reporting, safe staffing was maintained whilst experiencing some of the greatest challenges ever and requiring daily oversight and senior leadership. In addition colleagues were deployed to support the wider system response to the COVID-19 Pandemic. The pandemic has led to a need to create new roles, new ways of working and the ability to safely redeploy colleagues from their normal areas of work in order to support safe patient care. Through this we have paid careful attention to chapter 5. Governance considerations: redesigning roles and skill mix and quality impact assessments were completed. We continue to report safe staffing arrangement within the Learning Disability and Dental Divisions; these colleagues played a key role in redeployment and supporting critical service provision.

Inpatients

All inpatient units within the Adult and Specialist Rehabilitation (ASR) Division and Learning Disabilities Division continue to use the Allocate E-Roster system, this ensures any staffing shortfalls are recognised and appropriate support is arranged in a timely manner through the use of bank or agency staffing. Within the ASR division there is a daily conference call, chaired by one of the Matrons to review the day's staffing and to look ahead at the next 72 hours for any potential hotspots and at points this was increased to twice daily through the pandemic. This enabled the effective deployment of colleagues and the ability to respond to rapidly changing situations (such as needing to change a ward designation to an outbreak ward). A daily assessment of patient dependency is completed, where clinically appropriate the Shelford Safer Nursing Care Tool (SNCT) is used alongside the clinical judgement of the Senior Sisters. The Safe staffing reporting is also triangulated with quality measures including incidents, Safety Thermometer, complaints and essential care indicators (ECIs) and other metrics e.g. vacancies. To support safe staffing during the pandemic ward managers became fully clinical and were also supported by the matrons and a range of other colleagues from across divisions and corporate services.



Community (District Nursing)

Again through the pandemic teams required support from redeployed colleagues and experienced increased demand as other services paused face to face activity. The Early Intervention Care Teams rapidly expanded at unprecedented pace in order to respond to the requirements to support system flow and enable all patients who could be cared for to be cared for at home. Induction and training plans and supervision was put in place to ensure support for all redeployed colleagues and to support oversight of safe care. The Adult Community Service (ACS) division's nursing teams utilise Rio to plan patient visits and build an individual schedule using the Care in Focus electronic capacity and allocation (CIF tool). A clear set of actions are put in place if any capacity issues are identified and there is a daily escalation management process in place overseen by Matrons who assist the teams to resolve their issues locally or escalate further on their behalf. The safe caseload information is viewed alongside quality measures such as ECIs, safety thermometer and Early Warning Alerts and monitored through the Quality and Safety Committee.

Birmingham Forward Steps (Health Visiting)

Recognising the needs of children and families and the risks identified through lockdown the trust maintained its health visiting service and did not redeploy any colleagues through the pandemic. Colleagues from other parts of children's services were redeployed to support and maintain the health visiting service.

Within Health Visiting there is an allocation tool which provides team leaders and managers with an indication of the work allocated and the resource available to complete it.

Over the year there has been a major focus on developing the tool and data in order to ensure that there is clear oversight of the most vulnerable children and delivery of the five mandated visits. There is also a daily risk assessment matrix to support teams in identifying any risk and supporting the escalation of issues.

The Children and Families Division quality and performance data is reviewed monthly through the Children's Health Improvement Group and Quality and Safety Committee.

Learning Disability

Through the pandemic Kingswood 9 was maintained as the open bedded unit and short breaks were suspended. Safe staffing was maintained on the unit and this is monitored through the SNCT in line with all bedded areas. There were no safety of quality issues identified during this time. The division undertook a process of Quality Impact Assessments and service redesign through this time. Numbers of colleagues were redeployed to support critical service areas and the division established new ways of working to support individuals with Learning Disability such as the in reach model to local hospitals.

Dental Services

In line with national guidance the majority of dental services were suspended during the pandemic with critical service being maintained. The division continues to restore dental services and this has been complex given the nature and volume of types of procedures undertaken with dental services. Safe staffing has been maintained but has been challenging due to the revised rotas to support aerosol generating procedures. The division are actively looking at alternative recruitment routes to support nursing vacancies and requirements.

Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Birmingham Community Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional, therefore we have to operate our services in line with the instructions outlined by CQC within the Section 31 Notice. The CQC inspected the organisation in 2020 and we were rated 'Requires Improvement' overall and rated 'outstanding' for caring across our services. Five of the six services were rated 'good' whilst the sixth; Children and Young People services received a rating of 'requires improvement'. This is an improved rating from the previous inspection, initiated in 2018 and completed in 2019 whereby the service was rated 'inadequate'. BCHC has continued to improve this service since being issued a Section 29A Warning Notice in 2018 and Section 31 Notice in 2019. Working in close partnership with stakeholders including CQC, Birmingham and Solihull Clinical Commissioning Group and Birmingham City Council has been a pivotal aspect of this achievement.

Since 2018, detailed action plans have been developed, consulted and executed to enable the continued improvement of the services provided to Children and Young People within the community of Birmingham.

Whilst the plan is not yet complete, a significant amount of progress has been made, leading to a formal application having been submitted for the review of the Section 31 Notice and imposed conditions. This will enable the remaining plans to increase health visitor capacity, retention and reduction in caseload to form a part of the 2021/22 business strategy. BCHC anticipate full establishment in this service by end of calendar year 2022.

During January and February 2020, the CQC undertook a Well-Led Inspection and an inspection of a number of core services including End of Life Care, Children and Young People's Services, Adult Community and Specialist Services and Learning Disability Services. The Trusts' CQC Inspection Report was published on 27 May 2020 and the outcome of the inspection can be seen in the ratings grid below.

In summary, the Trust remains

- 'Requires Improvement' overall,
- 30 out of 36 services rated as 'Good' or 'Outstanding',
- Rated overall 'Outstanding' for Caring, and
- 5 of our 6 core services are rated 'Good', and our children's services rating has improved to 'Requires Improvement'.
- Our one remaining 'Inadequate' rating (in the responsive domain for children's services) applies to long waiting times for specialist children's services (including neuro-developmental assessments), which, with the support of our Commissioners, we are making progress to address.

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Apr 2020	Good → ← Apr 2020	Outstanding ↑ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement → ← Apr 2020	Requires improvement → ← Apr 2020

Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good → ← Apr 2020	Good → ← Apr 2020	Outstanding ↑ Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020
Community health services for children and young people	Requires improvement ↑ Apr 2020	Requires improvement → ← Apr 2020	Good → ← Apr 2020	Inadequate ↓ Apr 2020	Inadequate ↑ Apr 2020	Inadequate ↑ Apr 2020
Community health inpatient services	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good → ← Apr 2020	Good → ← Apr 2020	Outstanding → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020
Community dental services	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014
Learning disabilities services	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020

Our full CQC report can be accessed via the following link: *https://www.cqc.org.uk/provider/RYW*

Register of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. During 2020/21, a number of small gifts were given to staff across the organisation as part of appreciation of the NHS, these were small in value and have not been recorded on the gifts register.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

Summary Financial Position

On 17 March 2020 NHS England and Improvement suspended the national operational planning process for 2020/21 and put in place temporary payment arrangements, which were at that time intended to cover the first four months of the year. These featured block payments based on the previous financial year and a recovery arrangement for those costs directly associated with the response to COVID-19.

In April 2020 BCHC's Board approved a financial plan for 2020/21, which set a requirement for a surplus of £1.0m. This was the result of the usual financial planning work which had taken place in the last quarter of the previous financial year, and was based upon the delivery of an £8.0m Cost Improvement Plan (CIP). In the weeks that followed, as the technical details of the new payment arrangements emerged, the Trust reduced its financial plan to a breakeven requirement (in line with new national requirements) and put in place specific reporting arrangements and controls in relation to COVID-19 expenditure.

As the year progressed, the new national payment arrangements were extended until the end of September. In relation to October onwards a separate planning process was undertaken at a Birmingham and Solihull STP level, and BCHC's Board approved its element of the plan – which was for the Trust to deliver a breakeven position at the year end.

At the end of March we reported surplus of £0.2m, which was ultimately revised downwards to a deficit of £2.5m following a number of impairments in relation to our estate.

The Trust's CIP schemes were developed ahead of the financial year through a well-established gateway process, which includes clinical scrutiny of each scheme, and these were embedded in operational budgets from the beginning of the financial year. Against the £8.0m target in the financial plan we ended the year with delivery of £6.0m, which was due to the impact of the COVID-19 pandemic. Some schemes were dependent on the delivery of additional income, which were hampered by the block income arrangements, while others slipped due to the operational issues. However it should be noted that, in the context of COVID-19, the delivery of efficiencies of 1.8% in 2020/21 is a commendable performance.

Controls and Monitoring Arrangements

The Trust's financial performance is reported to the Trust Board on a monthly basis and is reviewed in detail by the Finance and Performance Committee. Through a suite of standard reports all key financial metrics are reviewed, and where variances from plan exist they are scrutinised and challenged appropriately.

The Trust's financial position is also reported on a monthly basis to NHS England and Improvement, which monitor's in-year performance against plans and provides further scrutiny on the position.

Our internal audit plan is refreshed each year, and in the development of the plan the consideration of economy, efficiency and effectiveness is applied across all audit areas. Internal audit findings are reviewed by the Executive Team and the Audit Committee, and any recommendations resulting from each audit are tracked at each meeting of the committee. The Audit Committee reports to the Trust Board following each meeting through a regular escalation report.

All financial areas of the 2020/21 internal audit plan received a rating of 'significant' assurance.

Information Governance Leadership and Governance

Birmingham Community Healthcare NHS FT is committed to ensuring that information governance and cyber security risk management are integral parts of the BCHC risk strategy. Management of information risk within BCHC rests with the Information Governance Steering Group (IGSG), chaired by the Chief Finance Officer in his position as Senior Information Risk Owner (SIRO).

In 2020/21 the IGSG developed a work programme in line with the Trust's information risk organisational priorities meeting on a bi-monthly basis. IGSG reports into the Trust's Digital Transformation Executive (DTE), the body with oversight of the Trust's digital transformation agenda. IGSG was also attended by the Trust's Caldicott Guardian and the Data Protection Officer (DPO). The IGSG was responsible for providing assurance that the Trust is compliant with all relevant legislation and guidance regarding information governance and security, and in particular for delivering the Trust's annual Data Security and Protection Toolkit submission.

Data Security and Protection Toolkit

The introduction of the GDPR and revised Data Protection Act 2018 chimed with the publication of a new version of the IG toolkit, known as the Data Security and Protection Toolkit (DSPT). Normally submitted at the end of each financial year, the DSPT is a submission made by any health or social care organisation (and any supplier of health or social care services) to NHS Digital, which is designed to demonstrate that the submitting organisation's data protection and cyber security practices meet a minimum set of standards essentially equivalent to the requirements of the GDPR. Since the introduction of the current DSPT the Trust's submission has been led by the Trust's DPO and Head of IG, who is responsible for collating and publishing the Trust's DSPT submission each year.

Due to COVID-19, the Trust's 2019/20 submission was delayed for 6 months to September 2020. At the point of submission, a number of evidence items were incomplete, and the Trust was required to submit an improvement plan setting out those areas where it had not achieved the relevant standard and the steps to be taken to deliver the outstanding requirements.

In tandem with delivering the 2019/20 improvement plan the Trust has also been working to complete the requirements of the 2020/21 toolkit. The date for submission of the current year's toolkit has been postponed to 30 June 2021, at the time of writing work is continuing at pace to achieve the toolkit requirements, as well as the outstanding requirements of the 2019/20 DSPT improvement plan. Particular work is being directed to our digital estate and ensuring that our Trust digital systems are robust enough to minimise the risk of cyber attack and ensuring that patient data is appropriately protected. Our progress to date will be audited during April 2021 with the Trust's submission to be signed off by DTE in June 2021.

IG team activities

(i) Information Asset Register - OneTrust

The introduction of the GDPR mandated the use of Data Protection Impact Assessments and an information asset register detailing how the organisation processes all the personal data it handles both internally and by any third party suppliers. To support this significant piece of work the Trust has introduced a bespoke software platform to capture all its information assets and DPIAs undertaken on suppliers in one place. This has enabled the Trust to deliver the central requirements of the GDPR – to identify how it is using any personal data in its possession and to be able to be accountable for the use of that personal data in a clear and transparent way. As part of the workplan significant steps have been taken to build up the asset register over the course of the year to identify all data assets and to provide a central portal to enable the completion of the relevant data privacy assessments. Colleagues and suppliers alike have noted the ease of use and clarity of requests when completing the questionnaire and the use of the platform has become central to the Trust's procurement processes.

(ii) Training and information governance awareness

A significant piece of work over the year has been to introduce the IG Handbook for staff. This document has been put together as a first port of call for any IG queries staff may have before any more detailed queries are taken up with the IG team. The document is a readable and accessible resource for staff to use and feedback to date has been extremely positive.

Additionally we have also introduced a new online training package for staff to complete as part of their annual data protection mandatory training. The Trust had previously used e-Learning for Healthcare's Data Security Awareness module and has sought to shift away from the format of this product to a more interactive, engaging and communication module delivering up to date data protection and cyber security training relevant to BCHC staff in practice. Introduction of the new module is also designed to support the Trust in achieving the 95% training target within the DSPT. Monitoring of IG training uptake is carried out by the Learning and Development Team who reported uptake results to the IG Team on a monthly basis. The Trust IG team has also undertaken ad hoc training sessions throughout the year to bolster staff awareness and understanding of how to deal with IG issues in practice.

Data breach incidents

The Trust has handled 372 IG incidents in 2020/21; of these, 23 were reported via the DSPT online reporting tool where it was considered that a specific data breach had occurred; of these, three were considered to be reportable to the Information Commissioner's Office (ICO) as a notifiable incident, in line with the reporting obligations in the GDPR to report any data incidents which may present an adverse risk to the rights and freedoms of the individual(s) affected.
In summary:

Case 1: a nurse on one of our in-patient units appended the wrong medication chart to the records of a patient being transferred out to an acute hospital, which resulted in the patient receiving the wrong medication within acute care. The error was identified and the correct chart was obtained for the records. The Trust put in place further measures to undertake a second check on records leaving the Trust estate with a transferred patient. In light of the measures put in place the ICO took no further action in this case.

Case 2: a report was made to the ICO concerning letters received by families of Trust child patients making allegations against a clinician employed by the Trust. The services received by the families concerned were delivered by another local Trust. An ongoing investigation is being undertaken across both Trusts. The ICO confirmed that they would be taking no further action in this case.

Case 3: The Trust undertook a mass mailing campaign sending letters to parents of children within the Trust's preschool services that their care was being transferred to the Trust's health visiting services. 57 letters out of 19,000 sent out were wrongly sent to the parents of deceased children due to human error. The ICO confirmed in their response that receipt of the letters did not constitute a data breach and consequently did not require any further action to be taken.

Data Quality and Governance

The quality of our data is measured against multiple criteria including the accuracy, completeness, consistency, relevance and timeliness. The Information Team monitor the quality of our data against these criteria through both manual and automated validation methods as well as by working with external stakeholders to address areas where the Trust is considered to be an outlier. The quality of the data within our Performance Framework is governed at both the Divisional and Trust levels with monitoring of performance undertaken using Statistical Process Control (SPC) charts and Balanced Scorecards.

Data Quality of Referral to Treatment (RTT) information featured as part of the internal audit plan for 2020/21, which was approved by the Audit Committee. In concluding their work in this area, our internal auditors provided a level of 'significant assurance'. The overall quality of our data has improved (in terms of improved scores on the Data Quality Maturity Index) as part of the delivery of the Information Strategy with a new data model and with an enhanced and robust infrastructure with clear and transparent audit capabilities, active monitoring and automated data quality alerts.

The extensive programme of work undertaken in 2019/20 regarding data quality improvement with a particular focus on waiting times, clinical prioritisation and reassessment put the Trust in a strong position to respond safely and effectively to the challenges of COVID-19. All services had completed the validation of Unseen referrals with continued monitoring and performance being managed by the waiting times and activity monthly meeting. This ensures the ongoing accuracy of our online Patient Tracking List (PTL) data. Work continues in light of COVID-19 following changes to service delivery (i.e. use of telemedicine) and changes to Standard Operating Procedure (SOP) to develop the PTL to provide additional, high quality, information including Clinical Prioritisation and Patient Demographic data such as deprivation and ethnicity.

The Impact of COVID-19 and Our Response

In a letter from NHSE&I dated 17 March 2020, NHS Trusts were asked, in response to the growing COVID-19 pandemic, to redirect staff and resources to – Free up maximum resource for Inpatient and critical care capacity, prepare for, and respond to, the anticipated large numbers of COVID-19 patients who would need respiratory support.

This was supplemented by a further letter dated 19 March 2020, which highlighted the following priorities during the pandemic:

- Teams should support home discharge today of patients from acute and community beds, as mandated in the new guidance for Hospital Discharge Service Requirements, and ensure patients cared for at home receive urgent care when they need it;
- By default, use digital technology to provide advice and support to patients wherever possible;
- Prioritise support for high-risk individuals who will be advised to self-isolate for 12 weeks; and
- Apply the principle of mutual aid with health and social care partners, as decided through your local resilience forum.

The Trust's initial response to COVID-19 had to address some significant issues, which at their peak saw >700 colleagues absent from work; >1,000 staff redeployed and 516 clinical interventions either reduced or stopped. The response also included the strengthening of a number of existing services (such as inpatient bed capacity, District Nursing and EICT) as well as new services such as a Care Home Team, Discharge Hub and a Swabbing Team.

To address these issues, a full review of all services was undertaken to determine whether a service needed to be maintained, could be reduced or could be stopped altogether. To support the decision making, all 800 clinical interventions (as a sub-set of services) were reviewed and classed as:

- Critical to life maintenance (118 interventions)
- Essential to quality of life (259 interventions)
- Prevention and wellbeing (423 interventions)

A total of 106 Quality / Service Impact Assessments were undertaken by teams which assessed which services/interventions could be stepped down and the actions to be undertaken to assess the impact whilst also mitigating against risks to patients / service users. BCHC then used the outcome of these pieces of work to inform a baseline service provision level during peak COVID-19 pressures.

As the national response moved into restoration, some services were identified as a priority for restoration and from mid-June 2020, organisations were asked to commence the planning for the broader Recovery of clinical services, whilst maintaining a COVID-19 response.

The primary challenge to restoring services was the availability of the workforce. As the Trust moved into the Recovery phase, this was calculated as being approximately 400 WTE. The next stage was to determine, with the workforce available, the services that could be restored and the clinical priority in doing so. The Trust Clinical Council provided oversight of this process.

The Trust's recovery plan, signed off at the July Trust Board, looked at the backlog of demand (and clinical priority) that had been created as a result of COVID-19. These waits were in 13 (of 65) services and teams built this into their recovery planning, and the use of virtual / remote consultations was considered as a key part to this by teams. The most significant impact and increase in waiting times was to services within the Dental Division. There was also a clear reminder for teams to apply the Clinical Harms policy for any patients where there was a concern as a result of them having to wait.

There has remained a key focus on supporting our colleagues across the Trust throughout the COVID-19 pandemic, primarily those who are most at risk of the effects of COVID-19, specifically Black and Minority Ethnic (BME) colleagues and those with underlying health conditions or protected characteristics. The Trust ensured all appropriate staff risk assessments were offered, undertaken and actions taken as appropriate by the July 2020.

On the 31 July 2020, NHS England published their expectations for NHS Providers from 1 August 2020 onwards as part of the phase three response to COVID-19 Recovery.

In anticipation of potential increases in COVID-19 during the winter period, the Trust Board approved the Wave 2 Response Plan at its meeting on 4 November 2020. The response aimed to deliver four key objectives:

1. **Deliver the Trust's three service priorities:**
   - COVID-19: keep our patients safe and support the system;
   - Non-COVID19 emergency care: keep our patients safe through winter;
   - Planned care: continue to provide planned care and tackle backlogs for as long as possible in the light of the need to deliver (a) and (b).
2. **Ensure that all our services operate in a way that is COVID-secure;**
3. **Support our colleagues to maintain health and wellbeing through Wave 2; and**
4. **Build inclusion and equality into all we do as we respond to Wave 2.**

A number of steps were taken in order that additional workforce could be secured to support the Trust in meeting the objectives set in the Winter/2nd Surge Plan as well as the Trust once again redeploying staff into critical service areas.

On 20 November 2020, routine COVID-19 testing for patient-facing colleagues as part of the national testing programme was launched across the Trust. This has continued throughout the rest of 2020/21 and continues to be a key component of keeping our staff and patients safe.

As part of the 2nd wave planning process key assumptions from the Trust Recovery plan were revisited as were the initial Quality Impact Assessments. These were used to inform the 2nd wave/winter plan and Service Provision planning for the winter of 20/21.

On the 23 December 2020 NHSE/I corresponded with all NHS Trusts, Commissioners and Primary Care Providers outlining Operational Priorities for winter and 2020/21. Then in response to increasing cases of COVID-19 on the 4 January 2021 the Prime Minister announced another national lockdown. Both of these developments significantly challenged a number of the assumptions within the original 2nd Wave/ Winter plan. The Board therefore decided in early January to move the Trust back to a "Wave 1 style" COVID-19 response with just three priorities:

- Caring for COVID-19 patients, meeting emergency demand and keeping high risk people on caseloads safe;
- Supporting the health and wellbeing of our colleagues;
- Delivering the COVID19 vaccination programme.

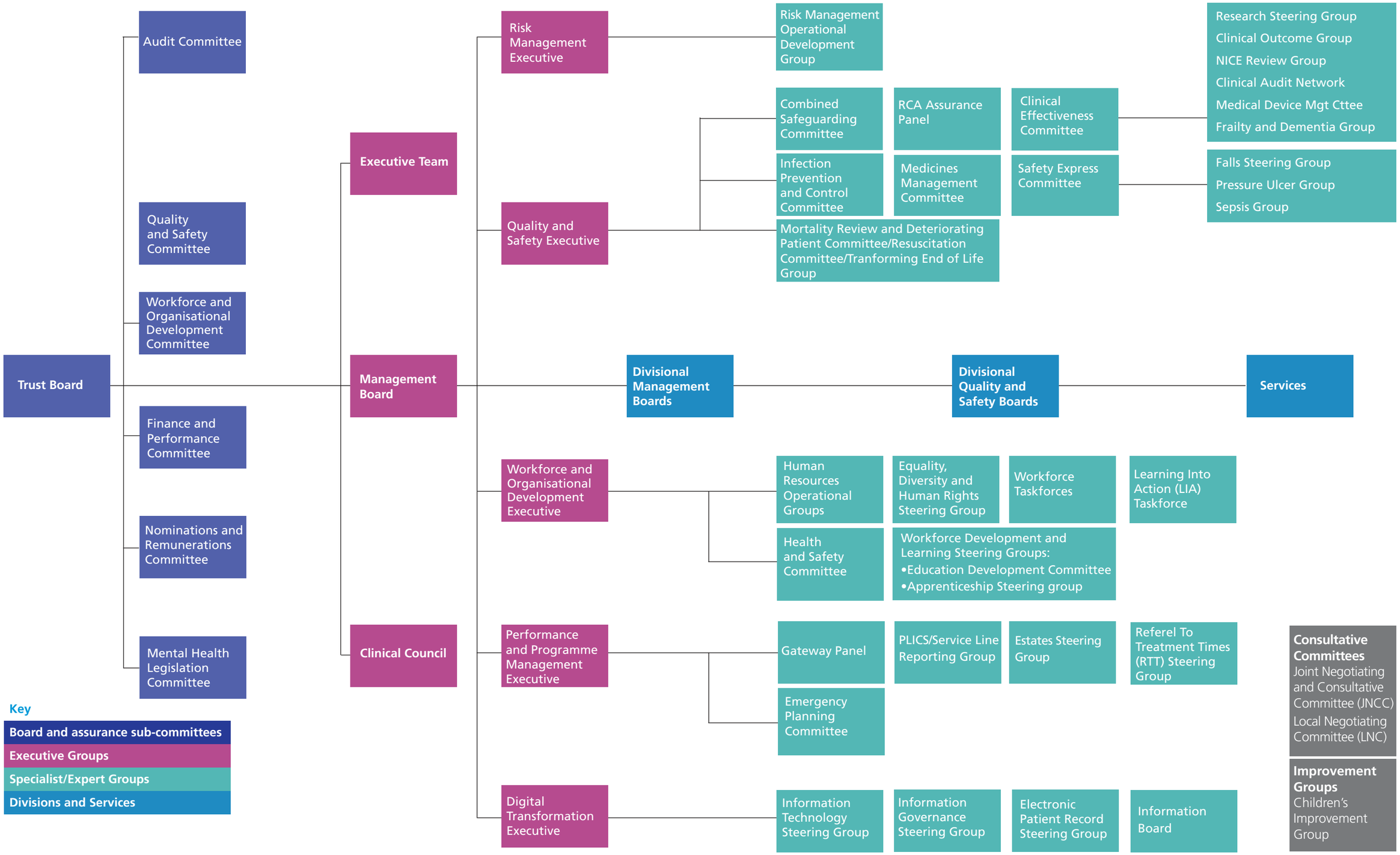
Through the combination of national lockdown restrictions and the increased percentage of the population receiving the COVID-19 vaccination, there was a significant decrease in the number of COVID-19 positive patients in both the community and being hospitalised throughout late February and March. The Trust therefore took the approach that Quarter One of 2021/22 would be a transitional quarter, moving from our full-scale emergency response to a more stable model of care in which we restore the full range of our services.

Our priorities for Quarter One include:

- Ensuring we stay COVID-safe for our colleagues and our patients;
- Supporting the health and wellbeing of our colleagues through an opportunity to recover from the last 12 months, maintaining our "Hear for You" support and progressing our commitment to be a Truly Inclusive Organisation;
- Service restoration including sustaining new services (e.g. discharge to assess pathways and long-COVID-19 assessments), restoring services and beginning to tackle backlogs especially in Dental, Specialist Rehabilitation and Children's services;
- Planning for the rest of the year and the second half of our Fit for 2022 Improvement Programme including engaging colleagues through a series of "Big Conversation" style events.

The Governance Structure

The following diagram illustrates the governance structure in place within the organisation.



Governance Arrangements during the COVID-19 Pandemic

On 28 March 2020, NHS England & NHS Improvement (NHSE/I) wrote to all NHS Foundation Trusts about 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic'. In response to this publication, a review of our governance arrangements was undertaken; the outcome of this review was approved by the Audit Committee on 21 April 2020 and subsequently the Trust Board on 6 May 2020; with a clear mandate to the Audit Committee to maintain oversight of these arrangements.

The following provides a summary of the principles that were approved by the Trust Board on 6 May 2020:

- **Trust Board and Assurance Committees (including Council of Governors):** Maintenance of the existing schedule of dates as previously notified and approved by the Board. The Public Session of the Trust Board was to remain accessible to the public via Cisco WebEx Meetings and details were advertised on the Trust's website. The Assurance Committees of the Board (i.e. Quality & Safety Committee, Finance & Performance Committee, Workforce & Organisational Development Committee et al) would operate in a streamlined approach, with focussed agendas, of approximately one hour held via Cisco WebEx Meetings. With effect from 23 March 2020, all Divisional attendance was cancelled and the proposal was that would continue until the end of June 2020 when a review will take place.
- **Executive Groups:** Maintenance of the existing schedule of dates as previously notified. The Executive Groups would operate in a streamlined approach, with focussed agendas, of approximately one hour held via Cisco WebEx Meetings. For example:
  - **Executive Team** - Weekly meetings were held with a focus on strategic oversight of our COVID-19 response.
  - **Clinical Council** - Frequency was increased from once a month to weekly to ensure enhanced clinical oversight of our COVID-19 response.
  - **Management Board** - A shortened meeting, with focussed agenda, of approximately one hour held via Cisco WebEx Meetings; re-focused as necessary on emerging issues with COVID-19.
  - **Programme and Performance Management Executive, Digital Transformation Executive and Risk Management Executive** - A shortened meeting, with focussed agenda, of approximately one hour held via Cisco WebEx Meetings. Time slots were agreed for division/directorate representatives to join the virtual meeting to present their division/directorate specific information and be subject to check and challenge as necessary. Meetings were refocused where appropriate for example the Digital Transformation Executive (DTE) focussed on IT requirements in light of COVID-19.
  - **Specialist/expert groups:** Maintenance of the existing schedule of dates as previously notified. The Specialist/expert groups operated in a streamlined approach, with focussed agendas, of approximately one hour held via Cisco WebEx Meetings.

All virtual meetings were conducted in line with the rules of engagement that had been developed internally and benchmarked against national guidance. We would continue to review and monitor the situation and remain agile in making further changes where necessary. The Audit Committee maintained oversight of these arrangements.

On 6 July 2020, NHSE/I further wrote to all NHS Foundation Trusts about 'Stepping back up of key reporting and management functions'. In response to this publication, a number of Recovery Governance Principles were developed and noted at the Audit Committee on the 18 August 2020; the Recovery Governance Principles were escalated to the Board on 2 September 2020 and can be summarised as follows:

- Maintenance of the existing schedule of committee and Board dates, as previously approved by the Board for 2020/21;
- Maintenance of virtual committee meetings through a sustainable virtual platform; this will be held under review in line with COVID-19 safe practices;
- Retention of a limited number of CISCO WebEx licences to support the Trust Board, Board Committees and Council of Governors;
- Virtual meetings have been extended from one hour to 90 minutes in line with the recovery of routine reporting;
- Committee discussion will remain focused on key business through maintenance of streamlined agendas and supporting papers and maintenance of the process of advance notification of queries in relation to minutes, action logs and papers for noting to support Committees to deliver its duties across all items;
- The streamlining of agendas will continue to be supported and approved by non-executive directors, in their capacity as chair, in association with respective executive directors;
- A five working day publication deadline for papers to support advance notification of items;
- Re-introduction of Committee Divisional deep dives and Divisional attendance during quarter 3 of 2020/21; and
- The Audit Committee will maintain oversight and review the arrangements.

On 4 November 2020, the Trust Board approved the organisation's response to the second wave of the COVID-19 Pandemic and the plan for the winter period. During this challenging period Birmingham Community Healthcare NHS Foundation Trust (BCHC) remained committed to supporting our leaders and colleagues to support the prioritisation of workload to ensure it is focused on doing what is necessary to manage the response to the COVID-19 pandemic and winter pressures.

Therefore a further review of the organisation's governance arrangements was undertaken to ensure we continued to have sound systems of governance in place to maintain oversight of the quality and safety of our healthcare provision, the health and well-being of our colleagues and our finances alongside our COVID-19 and winter response.

We continued to review and monitor the situation and remained agile in making further changes where necessary. The Audit Committee continued to maintain oversight of these arrangements.

The Principles of Governance during COVID-19 Wave 2 and Winter were noted by the Board on 2 December 2020 and can be summarised as follows:

- The stepping down of the December Board Committees and January Board meeting previously outlined in the approved 2020/21 schedule of committee and Board dates;
- Maintenance of Board Committee meetings during January 2021 with a respective Board meeting held in February;
- Commitment to undertake a review prior to the February 2021 Board meeting regarding whether there would be a need to hold Board Committees in February and the respective Board meeting in March; with the exception of the Audit Committee;
- Establishment of dedicated Non-Executive Director Briefing Sessions in month to facilitate operational escalation and maintenance of Board oversight during the months that Board Committees are stepped down;
- Maintenance of the Board Development Session in December; moving to a virtual model of delivery in line with COVID safe practice;
- Maintenance of the Council of Governors meeting in December; supplemented by a specific Governor Briefing on COVID-19 wave 2 and winter response.
- Maintenance of virtual committee meetings through a sustainable virtual platform; this will be held under review in line with COVID-19 safe practices;
- Retention of a limited number of CISCO WebEx licences to support the Trust Board, Board Committees and Council of Governors;
- Virtual meetings will continue to be extended to 90 minutes in line with the recovery of routine reporting;
- Committee discussion will remain focused on key business through maintenance of streamlined agendas and supporting papers and maintenance of the process of advance notification of queries in relation to minutes, action log and papers for noting to support Committee to deliver its duties across all items;

- The streamlining of agendas will continue to be supported and approved by Non-Executive Directors, in their capacity as Chair, in association with respective Executive Directors;
- Re-introduction of Committee Divisional deep dives and Divisional attendance during Quarter 1 of 2021/22; and
- The Audit Committee will maintain oversight and review the arrangements.

On 25 March 2021, the NHS announced that the national incident level for the COVID-19 response had been reduced from level 4 to level 3. As we moved into quarter one of 2021/22, it had become necessary to review our governance arrangements and develop a committee schedule and set of principles that met both legal and best practice requirements, and demonstrated learning from the 'Governance Light' model operating during the pandemic alongside remaining COVID secure in line with Government guidance.

The governance arrangements and key governance principles for 2021/22 were approved by the Trust Board on 5 April 2021 and can be summarised as follows:

The Board and committees of the Board

- Retain all monthly meetings, with the exception of Board Committees in August and December and respective Trust Board meetings in September 2021 and January 2022.
- The proposal is for a move to the MS Teams platform for the Trust Board and committees.

Executive Groups

- Reinstate the full schedule of dates.
- Operate meetings in line with the key governance principles.

Specialist/expert groups

- Reinstate the full schedule of dates.
- Operate meetings in line with the key governance principles.

Key Governance Principles:

- Operate all meetings virtually until the end of quarter 1 (2021/22) when the approach will be reviewed in line with Government guidance.
- Retain all monthly meetings, with the exception of Board Committees in August and December and respective meetings of the Board of Directors;
- Consider standing down all Executive Groups and Specialist/expert groups meeting in August and December 2021;
- Review the Cycle of Business to support streamlined and appropriately focus of agendas;
- Review of membership of all meetings to ensure they continue to support good governance and increase challenge;
- Ensure there is a schedule of pre-meets in place between relevant leads and Committee Chairs;
- Maintain the discipline gained from virtual meetings to support meeting lengths of no more than an hour and a half;
- Limit the length of reports with a focus on providing assurance (associated training can be provided to report authors);
- Reports taken as read with presentations focussed on highlighting exception, risk and mitigations;
- Cease the practice of 'greyed out' items and include a section entitled 'for information' on agendas where necessary;
- Seek to re-introduce Divisional Deep Dives at Board Committees in quarter 3;
- Implementation a cycle of Committee observations (committees of the Board only) by Trust Chair and CEO to support NED and Executive appraisals respectively;
- Dedicated quarterly board development days, with the flexibility to access some sessions following monthly Board meetings in quick succession to ensure that progress is built-on/momentum is not lost; and Seek the support of colleagues to re-introduce NED triangulation activities within the Trust when safe to do so and in line with COVID secure arrangements.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Quality & Safety Committee, the Finance & Performance Committee, the Workforce & Organisational Development Committee and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There are a number of mechanisms by which the Trust ensures the effectiveness of its systems of internal control. They include but are not limited to:

- Our “Best Care: Healthy Communities” vision, our CORRI values (Caring, Open, Responsible, Respectful and Inclusive) and our Fit for 2022 improvement programme;
- Four strategic objectives clearly aligned to the committees with defined responsibilities for the management of risk (corporate and BAF);
- A defined governance structure that facilitates prompt escalation of risks; the structure is supported by a clear approach to escalation reporting between specialist/expert groups, executive groups, committees and the Trust Board;
- Cycles of business in place for both the Trust Board and committees which maintain a robust approach to receipt of reports on quality, performance and finance, including a number of specialist areas such as the SIRO annual report and Freedom to Speak Up Guardian Reports;
- The Audit Committee oversee a robust programme of internal audits including progress against recommendations arising as a result of the audits.

The Board’s assessment of the effectiveness of the organisation’s system of internal control is supported by the annual Head of internal Audit Opinion. The overall opinion is that:

‘Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.’

Issues that I have highlighted in the narrative of my opinion:

- The Trust has an effective Assurance Framework;
- Whilst a number of reviews received Significant Assurance, a number received Moderate Assurance: Health and Safety arrangements, Business Continuity and Risk Management - operating effectiveness; and
- The Trust needs to maintain its focus on outstanding actions to ensure it continues its good record of effective implementation of agreed actions.

‘I have not identified any Significant Internal Control Issues (as defined by HM Treasury) that must be reported within your Annual Governance Statement.’

‘I would suggest that consideration is given to reflecting on the COVID19 response and maintenance of core controls during the pandemic in the Annual Governance Statement.’

The Audit Committee has overseen a programme of internal audits, the details are as follows:

Significant Assurance	• Financial Governance during Covid-19 • Risk Management - system design • Payroll • Financial systems • Data Quality (18 week RTT)
Moderate Assurance	• Health and Safety arrangements • Business continuity • Risk Management - operating effectiveness

Details of the reviews where we did not receive significant assurance have been set out below:

Health and Safety arrangements

- The perceived lack of capacity within Divisions to support the Health and Safety agenda should be addressed;
- Risk assessments should be completed and updated as a matter of urgency;
- A Health and Safety Inspection timetable should be developed.
- Root Cause Analysis should be completed for all Staff Health and Safety RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) events.

Business Continuity

- Due to the absence of a clear process setting out how decisions and actions were to be recorded, it is not possible to give assurance that actions were not overlooked and implemented on a timely basis and decisions taken appropriately.
- The risk log should highlight timescales for key actions and to allow slippage to be monitored.

Risk Management - Operating Effectiveness

- The Trust should ensure the triangulation of information between external assurance and the Corporate Risk Register to ensure consistency.
- Guidance should be reiterated in relation to Datix information requirements and the completion of escalation reports.

Conclusion

In conclusion, I am confident that our systems of internal control have continued to operate effectively and no significant internal control issues have been identified by this review. This is in the context of an extremely challenging year in which we responded to the COVID19 pandemic by seeking to keep our patients safe, supporting the health and wellbeing of our colleagues and play our full part in the system response to the pressures we have faced.

Richard Kirby
Chief Executive
Date: 25 May 2021

Part 2 - Quality Report

Section 1
Quality Overview

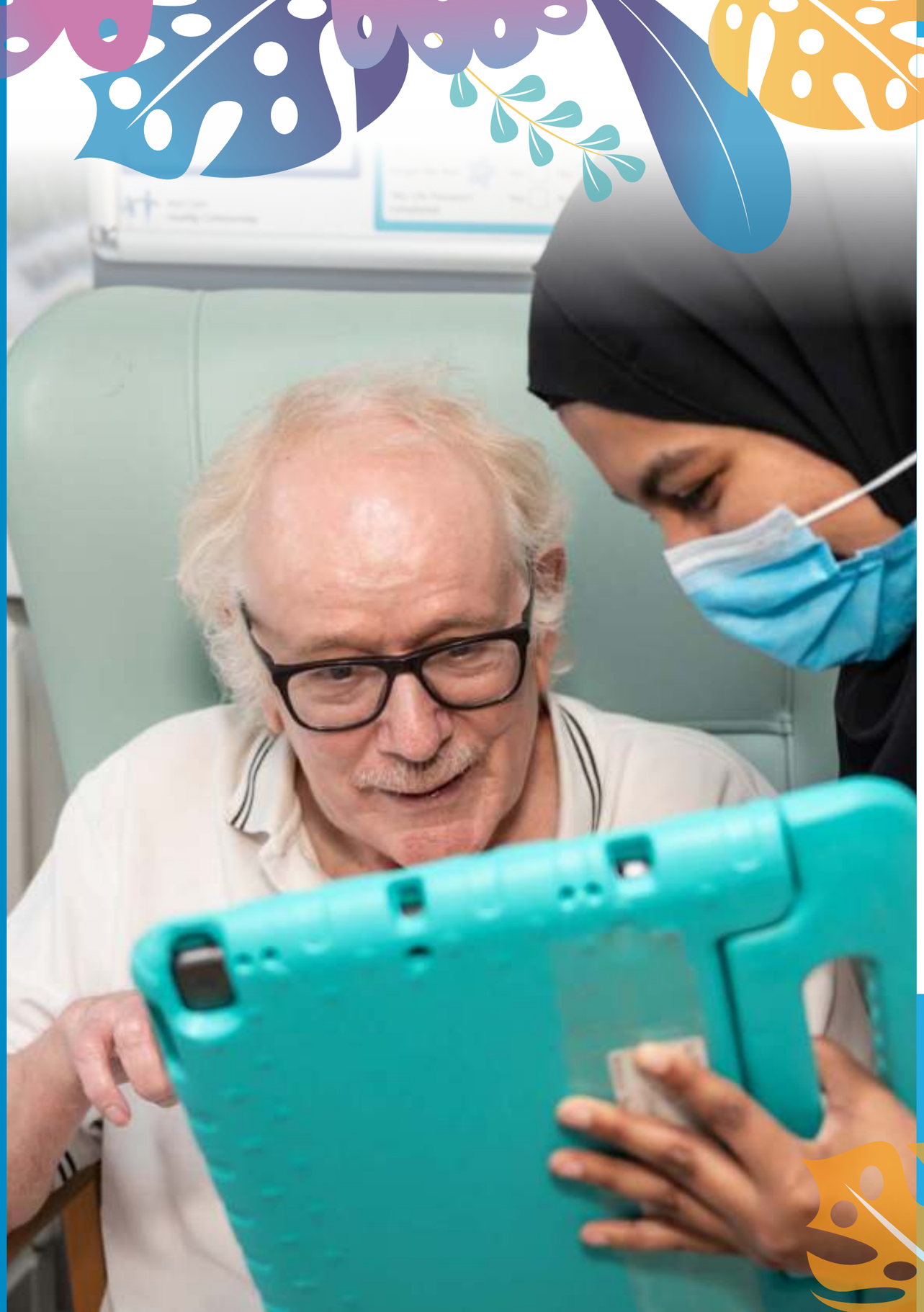
Section 2
Our Quality Priorities and Statements of Assurance

Section 3
Review of Quality Performance

Section 4
Achievement Stories

Section 5
Appendices

Quality Report
2020-21



Section 1

Quality Overview

Statement of Quality from the Chief Executive

The year 2020/21 was one that was dominated by the challenge of the COVID-19 pandemic.

The scale of the pandemic and its impact on everyone who works for BCHC and all those we are here to serve was truly unprecedented. The commitment we made two years ago to our “Best Care: Healthy Communities” vision and our Trust values – Caring, Open, Respectful, Responsible and Inclusive – have felt more important than ever as teams and colleagues across the trust responded to the virus alongside our partners in the health and social care system.

Right at the start of this Quality Report, I want to recognise that everyone in BCHC has been affected by COVID-19 in the last 12 months both professionally and personally often in very profound ways that it will take time to come to terms with. I would like to say a huge ‘thank you’ to everyone - all of our BCHC colleagues, people in our communities and our partner organisations, for their compassion and commitment as we have responded to the coronavirus pandemic.

Time and again our colleagues have demonstrated our values - Caring, Open, Respectful, Responsible and Inclusive - in practice in caring for our patients and service users. We genuinely could not have asked for more from our teams.

We have continued to keep our commitment to provide Safe, High Quality Care at the heart of our response to the pandemic and our work over the last 12 months. In practice this has meant ensuring that we do all we can to keep our most vulnerable patients and service users safe through this period. For example through delivering new services to support older people through care home teams, Early Intervention Community Teams and discharge to assess pathways, supporting people with a learning disability admitted to acute hospital and working with GPs to deliver COVID-19 vaccination to housebound older people.

Alongside this we have worked hard to support the health and wellbeing of our colleagues so that they can do their best for our patients - our “Hear for You” programme has brought together a range of practical support at a difficult time.

Looking forward there will be important to lessons to learn from the last 12 months. As I write it look increasingly likely that we are out of the worst of the pandemic. It is however important to recognise that we still face some significant challenges as we look ahead: COVID-19 has not gone away and it is important we restore services safely; services that were stood-down during the pandemic now face major backlogs (Dental, Children’s and specialist rehabilitation for example) and other services are only now beginning to see the impact of the pandemic on wider health and wellbeing as referrals increase. Working with system partners we still have a big job to do in the year ahead.

Most importantly however as we look to the year ahead is the importance of inclusion and equality. The experience of the last 12 months has thrown the impact of discrimination and inequality in our society into stark relief. Ensuring that we build on our existing commitment to make BCHC a truly inclusive organisation and that we begin to turn our “healthy communities” vision into a set of practice steps that we can deliver for the people we serve will therefore be essential elements of the legacy of the last 12 months as we look forward to the year ahead.

Richard Kirby

Chief Executive Officer

About our services

Birmingham Community Healthcare (BCHC) NHS Trust provides high quality accessible and responsive community and specialist NHS services across Birmingham and the West Midlands. At the end of 2020-21 BCHC employed 5144 staff (4453.69 Full Time Equivalents).

We deliver community-based healthcare to people of all ages across Birmingham, covering a population of approximately 1.1 million people and a geographical area of 103 square miles (268 square km). These services are delivered in a variety of settings including patient’s homes, primary care premises and community inpatient facilities.

We also deliver a range of specialist services for a population of approximately 5 million people in the wider West Midlands region, including Warwickshire, Staffordshire, Worcestershire, Shropshire and Herefordshire. These services include Specialist Rehabilitation and a purpose-built Dental Hospital that provides undergraduate teaching and postgraduate dental training, secondary and tertiary specialist dental care.

BCHC has five clinical divisions providing services to patients:

Adult Community Services (ACS)

The ACS division offers a broad range of services to individuals living in Birmingham. The aim of the service is to provide high quality person centred care and enhance an individual’s quality of life. This may be achieved through preventing admissions to hospital, providing care at home, supporting and facilitating discharge to an individual’s home environment and/or supporting in an emergency. It is important that patients and their carers feel reassured and empowered by the service we provide and that they are actively involved the care we offer, promoting choice and dignity.

Adult and Specialist Rehabilitation (ASR)

Specialist rehabilitation services are mainly provided at two sites - West Midlands Rehabilitation Centre and at Moseley Hall Hospital. A wide range of services are provided for people living in all parts of the West Midlands to assist them in managing disabilities. The comprehensive range of services is for people with physical, cognitive, emotional and social disabilities. All services are provided by teams of clinical professionals and support staff who aim to provide personalised, integrated services that best meet the needs of individual patients and their carers.

Children and Families (C&F)

The C&F division brings together all the specialist community services for children and young people across Birmingham and offers a co-ordinated approach for child healthcare.

Dental Services

Birmingham Dental Hospital (BDH), in partnership with the University of Birmingham School of Dentistry, provides a range of dental services for people in the West Midlands, training and development of the dental workforce and an extensive research programme. Community Dental Services provides a range of specialist dental services across Birmingham, Dudley, Sandwell and Walsall.

Learning Disability (LD)

The LD division works across Birmingham, in which 23,800 (2.3 per cent of the 1.1 million population) have a learning disability. Teams provide healthcare for people with learning disabilities living in the community. The service aims to provide high quality care through multidisciplinary working and close collaboration with other agencies.

Our objectives

Safe High Quality Care

Working with the people we care for, their families and our partners to deliver the best possible outcomes and experience.

A Great Place to Work

We are committed to creating a great place to work and learn, enabling our colleagues to be the best that they can be.

Making Good Use of Resources

We are committed to getting the best from our people, technology, information, estate and money.

Integrated Care in Communities

We will work with our partners to support people to live healthy in their communities.

Our values

Our values have been developed through an extensive colleague-led engagement process where over 600 colleagues voted for the themes they believe support the achievement of our new vision and strategy. From these responses our stakeholder reference group, with representation from across the organisation (Clinicians, Managers, Administration Forum, Staff Side and BME network), selected our values.

…treating people with kindness, respect and compassion…

… it's about having integrity, with staff allowed the space to be honest with each other and the people who use our services...

… respect for autonomy, dignity, feelings, choices and preferences forms the basis for any successful clinical and working relationship…

… thinking about how our actions affect others, being dependable and honouring our commitments…

… it's about a sense of belonging - feeling valued for who we are…listening to one another and trying hard to understand the other person's point of view...

Our vision

Best Care
Healthy Communities

BCHC exists to provide the Best Care possible to support the people who use our services, many of whom are among the most vulnerable in our society, to live healthy in Healthy Communities. This is directly linked to the Birmingham and Solihull STP vision: “Live Healthy: Live Happy”.









Board Level Assurance

Examples of Trust Board level Assurance on Quality

Board assurance framework	Trust strategic risks are reviewed quarterly.
Care Quality Commission compliance update	Quarterly assessments are undertaken to review and ensure on-going compliance.
Integrated quality performance report and cost improvement programmes	Both national and local quality metrics are reviewed on a monthly basis. Update on the quality priorities and top risks to quality.
Quality and Safety Committee	Trust Board sub-committee which reports monthly on quality and risk issues.
Quality impact assessment	Assessment carried out on all strategic intentions.
Quality Report	Annual Quality Report provides an overview of the delivery of quality for the previous 12 months, and the quality priorities for the following year.
Ward to Board	Board members receive a range of qualitative and quantitative quality information in order to enable them to triangulate the messages contained in board papers with observations and interactions with patients, staff and stakeholders. Patients are also invited to share their stories directly to the Board.

Statement from Director of Nursing and Therapies

It is certainly feels true to say that time goes more quickly as you age.

As I sat to write this statement I realised that this is now my third Quality Account here at BCHC and twelve months has passed in a moment and been like no other in my 35 years of nursing. The last year has been an incredibly challenging year as we have worked to maintain and develop new services in order to respond to the COVID-19 pandemic. I start with a thank you to all colleagues who have worked tirelessly through this time and we have asked much of them. I take pride in the way individuals and teams have responded to requests and the work to maintain services and patient care. COVID-19 has impacted on everyone in different ways and each person has a powerful work and personal narrative through the last year. I am very mindful that through this time colleagues have lost family members and patients have died and we paused on the first national Memorial Day to remember them

Whilst the last year has been challenging it has also been a positive time of development in relation to Quality, Safety and Patient Experience. It was very clear that the response to the pandemic would require a whole systems response with all partners across BSOL coming together to agree plans. As part of our response and contribution a number of new services were established and included

- The care home support team
- The community testing team
- The COVID-19 immunisation response team
- The Personal Protective Equipment Team (PPE)

Each of these teams has played a significant role in providing safe and effective care for the communities who live in Birmingham including some of our most vulnerable residents. We were also pleased that through these teams we were able to support partner agencies in maintaining safe service provision during the pandemic across a wide range of service areas.

These new teams have worked to set up new services in very short time frames and have worked tirelessly to meet rising demand and daily challenges

Patient experience has remained at the heart of our work. At board level it was positive that the patient story remained at the heart of each board meeting and we were pleased to welcome patients who joined us virtually through this time. This has enabled the board to maintain focus on the quality of services and to continue to directly hear the voice of patients

We have had to work in new and innovative ways. Visiting was ceased in inpatient settings during the pandemic and for many patients our teams were often the only physical contact or visitor within the home. The teams worked to develop ways in which families could maintain contact with patients whilst in hospital. Initiatives included letters to loved ones, ipads to support virtual contact and the new role that of the family liaison officer (FLO). The FLO's worked daily to ensure that families were kept up to date and could have meaningful contact with their loved one. The BCHC charity also supported with comfort packs and additional resources to occupy patients when families were unable to visit. Through this time we maintained covid secure visiting for patients who were end of life, had learning disability or where there was an identified need.

We continued to develop and work with partners in relation to End of Life Care and ensuring we could support patients who wished to be cared for at home. The role of locality support lead nurses for end of life care was introduced. More nurses completed end of life care training and verification of death training to support continuity of care for families at this most difficult time

Maintaining a focus on safety has been paramount through this time and again required a different approach. We have all worked to adjust to undertaking meetings on Teams and virtual platforms.

This has enabled us to continue governance and oversight and key committees have continued to meet and maintain core functions. In addition streamlined reporting around quality, safety and patient, experience has been maintained and all national reporting requirements were met. Work with regulators such as the Care Quality Commission has continued and has included thematic reviews of IPC arrangements and specifically with healthcare at HMP Birmingham. Feedback has been positive in relation to both these reviews. We have also contributed to a CQC consultation process in relation to mortality reviews. Our work in relation to developing Covid Secure environments, core IPC standards and covid safe ways of working has rapidly become business as normal and an area of daily focus. Key action areas in relation to patient safety have remained firmly in focus and had included maintaining progress and further developing out falls prevention work and reducing the incidence of pressure ulcers.

Maintaining and setting up new services has required at the height of the pandemic redeploying over 1000 staff from their normal roles. This particularly impacted on colleagues in dental and learning disability services and parts of children's services. Additional wards were opened, EICT expanded rapidly and in reach services to support acute hospital settings were quickly set up. Numbers of colleagues also went to work and support within acute hospital settings to support critical care provision. A number of services were stepped down or reduced in order to maintain and expand core services. This work was supported by the clinical council and a process of Quality Impact Assessments and Equality Impact Assessments. The Medical Director has continued to support and develop the clinical harms review process alongside this. This work was carefully reviewed each week by the Executive Team with regular additional review points through the Quality and Safety Committee and with senior leaders alongside regular all colleague briefings.

Safe staffing has been challenging through this time but has been maintained with support from senior clinicians, redeployed collagues and bank/agency where available. The health and wellbeing of colleagues has been a key priority through this time.

A specific and enhanced health and wellbeing offer was launched and the team worked daily to promote and enable colleagues to access support. In addition a clinical supervision app was launched and we continued Schwartz rounds although held virtually.

2021 saw the publication of our first AHP Strategy an important milestone. The strategy sets out a vision and direction and the important contribution that AHP's make to service delivery and patient care each day. The work is led by our Director of AHP's and supported but the AHP Clinical Council. I very much look forward to the development and delivery of the strategy and continuing to maximise the contribution of AHP colleagues. The strategy sets out some important achievements that services are already making such as use of digital technology to support patient care, the use of e job planning to support care and the examples of embedding research in practice. A number of teams have also presented their work and service developments within the BCHC Clinical Council which has met weekly over the last year. We are currently developing the first Nursing Strategy to sit alongside this

The year ahead will require an on-going focus on COVID-19 secure ways of working and restoring our services. We will continue to ensure we are working with national and local guidance in best practice in doing this. This is balanced carefully alongside supporting colleagues to restore and recognising the impact that the last year has had for both the communities we serve and our colleagues providing care and services each day.

Marcia Perry
Director of Nursing and Therapies,

Statement from Medical Director

As I look back at what I wrote for the Quality Report a year ago, so much changed in the care we have provided during the year.

The SARS-CoV-2 pandemic was clearly the dominant issue of the year and I am very grateful to all BCHC staff who have worked tirelessly to support safe care and maintain quality. Many staff worked outside of their usual practice which was very challenging for some and colleagues, line managers and the Hear for You support are all important as we recover from this traumatic year.

The BCHC Clinical Council has become the senior clinical voice in the organisation; made up of divisional clinical leadership and professional clinical leadership, it met weekly through the pandemic and supported our operational colleagues as we reduced or stopped some services to redeploy staff to other COVID related activities. As services were restored in the autumn and again in the spring of 2021, the Clinical Council has guided decisions.

We developed a clinical prioritisation process to bring clinical insights as we address patients and service users waiting for care and we have supported the development of the Long COVID rehabilitation service as it has developed. As I write the Council is hearing from different professional groups describe how they can assist as we emerge from the pandemic and I think an overarching clinical workforce strategy will emerge from these discussions. In addition the Trust has participated in a number of local and national Research and Innovation Projects linked to COVID-19.

The Clinical Council has initiated another group this year, the Improving 2Gether Forum. The first meeting was in December 2020 and we have now had five monthly meetings. The aim is to learn from each other as part of the BCHC Improving 2Gether Quality Improvement approach; it could be a clinical audit, a piece of research, an innovation, a service evaluation, learning from an incident or a quality improvement project.

The format is simple, three presentations of 15 minutes with five minutes for questions. The sessions are open to all on MS Teams and the presentations are recorded so staff can watch or re-watch the sessions from the link at the Improving 2Gether Forum webpage.

All the talks have been inspiring and the cross divisional and inter-professional discussions that it stimulates are very encouraging to me.

Another significant change over this last year has been in our digital innovation. I was really proud that we managed our best ever clinical engagement with the Electronic Prescribing and Medicine Administration system procurement in January, I know it was demanding but we will have made a clinical informed decision. Through the pandemic BCHC has adapted to remote consultations and video conferencing has been taken up extremely well by some services and some patients. We continue to review feedback including data on use by patients' with protected characteristics. The BCHC team led the procurement of a video consultations system on behalf of trusts across the region.

This has been one of the most difficult years of my professional career but I am really grateful to BCHC colleagues for their care, some examples of which you will read in this Quality Report.

Dr Doug Simkiss
Medical Director

Governor's Statements

Lead Governor - Peter Mayer

What a strange year where the ability to communicate virtually has ensured the Council has been kept informed. We have been amazed at the dedication of all our staff in delivering high quality essential services throughout the COVID-19 imposed crisis and the rapidity with which innovations have been implemented. It has though been a difficult time for services which have had to be curtailed to maintain capacity for our pandemic response and to allow deployment of staff to support this.

Not only has our Board had to manage these processes but also work in government imposed system wide changes as outlined in a new NHS white paper. We have seen excellent partnership approaches where BCHC has often been the lead organisation.

I was referred for Dental surgery at the beginning of lock down and was rapidly treated when re-referred by NHS111 when my problem deteriorated within a very COVID safe approach.

I do hope that those who are reluctant to be vaccinated are now coming forward to protect our patients, local communities and themselves.

Chair of Patient Experience Group - Frances Young

Maintaining the usual quality services has clearly been a challenge during this year with the extra pressures of the pandemic. Nevertheless the Trust has gone out of its way to remain accountable to Governors, and through online meetings the Patient Experience Group has been assured of the continuing commitment of the Trust to high quality care. Besides its usual attention to the gathered data and formal reports the Group has received some useful presentations, including one on End of Life Care. As Chair of the Group I am pleased to see the current drive towards developing further emotional, spiritual and chaplaincy support for staff and patients, especially for those at end of life. I wish everyone all the best as I retire from the Governing Council and hand over the chairing of the Patient Experience Group.

Key Moments in 2020-21

The first lockdown in the UK **extended**

First donation to BCHC Charity from **NHS Charities Together**

April 2020

NHS CHARITIES TOGETHER

FLO (Family Liaison Officer) **role established**

April 2020

Lifting lockdown - return to the workplace

May 2020

June 2020

Phased **re-opening of schools** and Non-essential shops in England

Relaxing of restrictions and **2m social distancing** rule

June 2020

Restoration of **Critical Services**

COVDENT Study

Launch of extra **bereavement/end of life resources**

July 2020

Staff Risk Assessment

COVID secure premises

UK's first **local lockdown** comes into force

August 2020

Eat Out to **Help Out**

Eat Out TO HELP OUT

Lockdown restrictions **eased** further

Transition to **Adult Services webpage**

'Rule of **six**'

September 2020

October 2020

A new **three-tier system** of COVID-19 restrictions starts in England

Value In Practice Awards

Second national **lockdown**

November 2020

Second lockdown **ends**

First BCHC vaccinations given

December 2020

January 2021

England enters **third national lockdown**

February 2021

Launch of **Winter Activity Packs for patients and Wellbeing Kits for staff**

Return to school for primary and secondary school students in England

BCHC Charity turns 5!

March 2021

Values in Practice (ViP) Awards

373 VIP winners

During the most challenging times in NHS history, there has been such a huge outpouring of support and gratitude for the NHS, that the Trust's 'Values in Practice' (VIP) colleague awards took a slightly different form in order to recognise the commitment.

Designed to recognise great work in line with the Trust values – caring, open, respectful, responsible and inclusive - the awards are normally narrowed down to just a few finalists in each of the five categories. However, in 2020 so many members of the public and colleagues wanted to nominate their 'COVID-19 stars', that the Board felt that to do these nominations justice, a different approach was needed.

There were so many high quality nominations and so many amazing examples of our values in practice that demonstrated compassion and commitment amid such great challenges, that it was clear everyone nominated truly deserved to be recognised as a "winner".

Therefore, this year, instead of a panel of judges choosing a small number of winners and finalists, every team and individual nominated received a VIP Award and certificate, presented by leadership and executive teams. That's 373 worthy winners!

The Board congratulated all our winners, thanking each for their outstanding dedication and consistent demonstration of our 'CORRI' values during the COVID-19 response.

COVID-19

BCHC planning for the COVID-19 Pandemic commenced formally on 13 February 2020, with a planning meeting convened by the Medical Director and Director of Nursing and Therapies. A number of work streams were discussed and initial planning put in place.

a. Initial clinical response actions included the management of patients arriving on a clinical site, management of patients with suspected or confirmed COVID-19, patient assurance leaflets and a clinical triage process. Furthermore, in relation to Personal Protective Equipment (PPE), it was clear that BCHC needed to monitor stock levels of PPE, medical devices, clinical consumables, receipt and issue processes needed to be clear, there was a need for visibility of stock levels and a daily sitrep of stock status was necessary.

b. An Incident Management Team and associated Command and Control (C2) was established, with an Incident Coordination Centre (ICC) established at Priestley Wharf operating 8am – 8pm 7 days a week, with dedicated phone lines and email address.

c. In relation to Business Continuity arrangements, the key drivers were: the identification of business critical services, planning arrangements to support & maintain service provision (at reducing staffing levels), assessing and tracking the impact of reduced / stopping activity, determining critical service offerings for an emerging situation and the need to avoid face-to-face consultations/meetings.

d. Establishment of an internally developed Sitrep and Data collection methodology to collect information on critical issues.

e. Suspension of routine Trustwide meetings and an agreement of 'Governance Light' to ensure the Trust Board and Sub-Committees were informed of key actions and assured of the BCHC response.

f. Weekly briefings by the Chief Executive to senior managers setting out local and national position, and BCHC response.

The Initial Trust's initial response to COVID-19 had to address some significant issues, which at the peak saw >700 colleagues absent from work; >1,200 staff redeployed and 516 clinical interventions either reduced or stopped. There was also the impact of having to care for >70 COVID +ve patients and establish and run new services across a whole range of areas.

To support the initial COVID outbreak, the system focus was on protecting acute critical care and inpatient capacity. The Trust responded by strengthening a number of existing services (such as inpatient bed capacity, District Nursing and EICT) as well as new services such as a Care Home Team, Discharge Hub and the Swabbing Team.

There was also a significant impact on the workforce in terms of COVID-related absences. This impact therefore necessitated the need to consider the services which could be provided.

To address these issues, a full review of all services was undertaken to determine whether a service needed to be maintained, could be reduced or could be stopped altogether. To support the decision making, all 800 clinical interventions (as a sub-set of services) were classed as:

- **Critical to life maintenance (118 interventions)**
- **Essential to quality of life (259 interventions)**
- **Prevention and wellbeing (423 interventions)**

A total of 106 Quality / Service Impact Assessments were undertaken by teams and which assessed the services to step down and the actions to be undertaken to assess the impact and mitigate against any risk to patients / service users. It was considered that the mitigations were for a period of approx. 3 months

COVID-19 has presented a number of specific issues, which have required a response from across the Trust. This response has been to support system partners, the local population, as well as supporting our own colleagues. The tables below summarise a number of ways BCHC responded to COVID-19 related challenges.

COVID-issue	How we responded…
Create acute capacity	Creation of a Complex Discharge Hub and Acute Interface team to support flow out of Acute hospitals
	Additional beds opened across two wards to support discharge from acute
	Additional resource deployed to Early Intervention Community Team to take patients home
Increased risk in care homes	Established Care Home Team, support to care homes, swabbing team to ensure residents tested
Increased community rehabilitation	The establishment of a COVID recovery pathway to support increased prevalence of COVID related community care
Increased EOL need	An enhanced EOL Care Pathway to support increased need for EOL care
Avoid hospital diagnostics	Establishment of Phlebotomy team to support out-of-hospital diagnostics for vulnerable patients
Availability of PPE	PPE Team established to support teams in defining PPE needs, source stock and distribute to teams
Risk to vulnerable colleagues	Establishment of risk assessment for vulnerable colleagues and support them in shielding and working in low-risk areas
Risk to BME colleagues	Creation of a BME risk assessment to agree actions to reduce risk exposure to COVID
Need to undertake Testing	Testing has been determined as a key response and the establishment of drive thro facilities, staff testing teams and antibody testing team
No local dental services	With the suspension of community dental services, we have established an Urgent Dental Centre to provide urgent dental services across the Midlands
Support to colleagues	A suite of support packages for staff including free parking, food pantry's, free refreshments and food, overtime provisions, "Hear for You" support programme, etc.

As the national response moved into Restoration, additional 'critical services' needed to be restored and from mid June 2020, organisations were asked to commence the planning for the broader Recovery of clinical services, whilst maintaining a COVID-19 response.

The primary challenge to restoring services was the availability of the workforce. This availability was, in the first instance, impacted by the new services that have been put in place as a result of the BCHC response. As we moved into the Recovery phase, this was calculated as being ~400 WTE. (In conjunction with this, there remained approx. 300 colleagues absent from work due to COVID, of which around 150 were not available to work).

The next stage was to determine, with the workforce available, the services that can be restored and the clinical priority in doing so. The Clinical Council provided oversight of this process.

The restart looked at the backlog of demand (and clinical priority) that had been created as a result of COVID-19, and this showed that, as a result of the reduction in referrals, the overall number of new patients waiting to be seen was approx. 3,700 fewer than at the outset of COVID. However, this reduction was at the 'front-end' of the waiting slots (with ~12k fewer waits at 0-11 weeks). In contrast there had been a 'bulge' in waits further down in the 15 to 29 week waits (~9k) as a result of reduced service provision. These waits were in 13 (of 65) services and teams built this into their recovery planning, and the use of virtual / remote consultations was considered as a key part to this by teams. There was also a clear reminder for teams to apply the Clinical Harms policy for any patients where there was a concern as a result of them having to wait.

A key feature in all divisional plans was the importance of adhering to strong IPC guidelines at all times, ensuring the usage of the correct PPE and taking great care around all aspects of hand hygiene, good monitoring of standards and appropriate and ongoing training and education. Also a suite of 'clear and simple' Recovery SOPs were developed to support teams in new ways of working.

To compliment this, all of our clinical and non-clinical estate was reviewed for COVID-secure accreditation in order to keep colleagues and patient safe in the delivery and receipt of care.

In terms of clinical divisions, all services were reviewed as to their own 'recovery' and when services could begin to restart and from July onwards, 75/100 services (75%) were delivering a progressively enhanced service (some close to or at full capacity) with 100% of services expected to be delivered by October 2020.

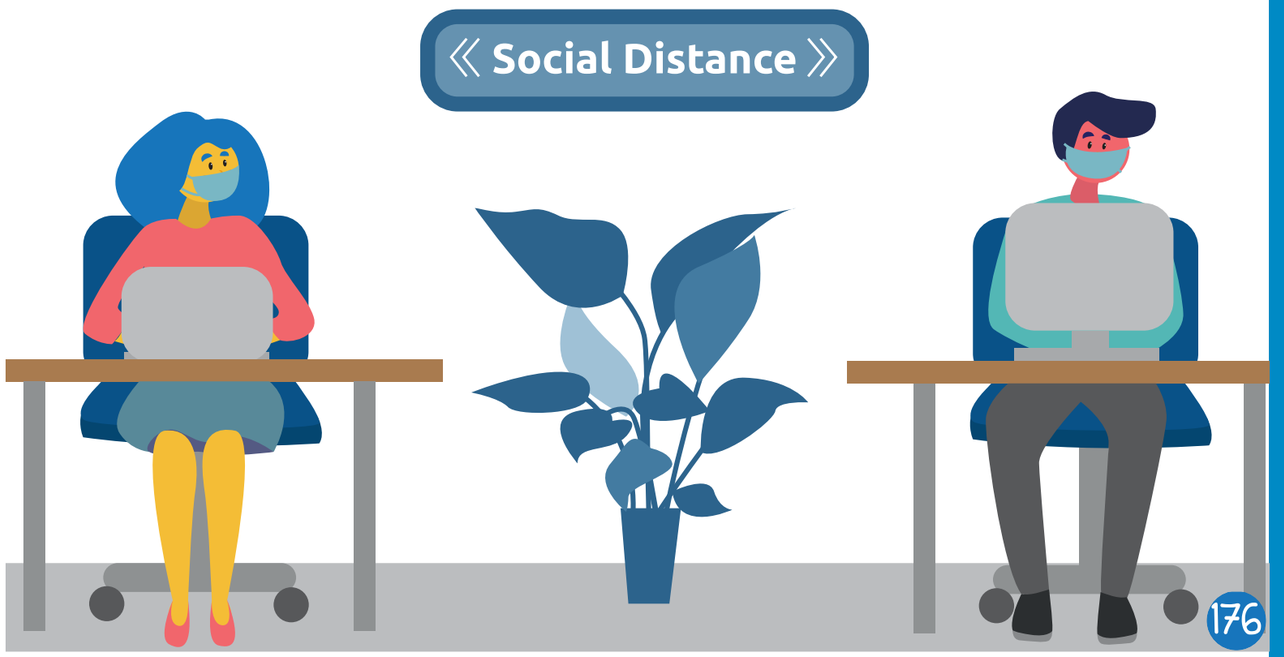
There remained a key focus on supporting our colleagues, primarily those who are most at risk of the effects of COVID, specifically BME colleagues and those with underlying health conditions or protected characteristics. The Trust committed to ensuring all appropriate risk assessments were offered and undertaken and actions take as appropriate by the end July 2020.

The financial environment remains very fluid and we continue to work with sector and regional colleagues to respond to any changes. One such request was for all organisations to submit forecast costs for the impact of COVID, which we supported to anticipate in greater detail the future impact with greater clarity.

Overall, a significant amount of work had been undertaken by BCHC to respond to the COVID 19 pandemic and there remains some key challenges as we recovered services, not least the relaxation of social-distancing guidelines in wider society. However, as a result of the contribution and hard work of colleagues we believe we had a plan that begins the process of getting services back, whilst retaining our overall COVID-response.

As a result of the impact of the Second Wave, which started in September 2020 and continued through to January 2021, BCHC developed four pieces of work for Wave 2 and Winter until March 2021. This included:

- most importantly, the support we will provide to colleagues, over the next six months including PPE, flu vaccinations, updating risk assessments and Care First, as well as other initiatives;
- our service and capacity plans so we can balance caring for COVID-19 and non-COVID-19 patients through this period;
- our approach to ensuring we have the workforce to support our plans, keeping redeployment to the minimum necessary to stay safe;
- a quality and equality analysis so we can identify and mitigate risks as a result of the decisions we are taking.



Section 2

Our Quality Priorities and Statements of Assurance

Looking Forward... 2021-22

Our priorities for improving quality

The requirements for Quality Reports stipulate that organisations must agree at least three priorities for improvement and link into the three quality domains:

Patient Safety

Clinical Effectiveness

Patient Experience

During 2017-18, BCHC engaged and listened to stakeholders and colleagues to support the development of it's new strategy, which provided meaningful and valuable feedback to support the development of the Fit of 2022 Improvement Programme. The programme includes actions to progress each of the four strategic objectives and responds to external reviews and recommendations. Since the programme's launch the Trust has developed a series of strategies and plans to envisage a number of agendas. These include:

- **Informatics Strategy** - using data to provide care and treatment more efficiently;
- **Digital Strategy** - using IT to improve patient access to their own information and appointments;
- **Patient Safety plan** - assurance that we are providing safe high quality care, and learning when we don't;
- **Increasing Patient and Public Engagement** - working with individuals and groups to ensure that the care we provide meets the needs of Birmingham.

The proposed Quality Priorities this year are designed to highlight what BCHC is doing for our patient population, improving access to care, while continuously learning and improving:

- Ensuring we investigate patient's deaths and improve care where we could have done better;
- Bring down patient waiting times while ensuring they are safe;
- Provide a portal for patient's to review the care they have received, access more information about their condition and book appointments;
- Reach out to patients and work with them to improve access and model care delivery.

The Quality Priorities chosen are from a group of projects highlighted during the development of the 2021-22 annual plan in March 2021. They provide clear examples to staff, patients and the public how we are keeping them safe and informed alongside Improving Quality 2Gether, the Trust Quality Improvement programme.

The Proposed Quality Priorities for 2021-22 are:

Monitoring Patient Mortality

Quarterly Breakdown	
Q1	Develop a new Case note review platform using Datix to support learning from case note review process
Q2	Testing of new platform with clinical staff from Adult Specialist Rehabilitation Division
Q3	Using the new platform to help to learn from case note reviews and embed process to implement learning from themes
Q4	Learning Disabilities Mortality Review (LeDer) programme - to ensure that LD reviews are Trust wide under safety culture • Learning from Excellence and Appreciative Inquiry - tools for Quality Improvement. • Safety Huddles - Trust wide and standardised approach
Executive lead	
Dr Doug Simkiss, Medical Director	

Implementation of the Community Engagement Strategy

Quarterly Breakdown	
Q1	Re-launch the Learning Disability Services Service User Group online
Q2	Develop networks with faith communities to nurture relationships at a grassroots level
Q3	Develop a training programme for Associate Director, Divisional Director and Board around consultation and engagement.
Q4	Develop a plan on a page for each division to enhance understanding and embed engagement activities.
Executive lead	
Marcia Perry, Director of Nursing and Therapies	

Implementation of a Patient Portal

Quarterly Breakdown	
Q1	Selection of a suitable Patient Portal provider Information Security Assessment Questionnaire and Data Protection Impact Assessment to undertaken
Q2	Phase 1 Integration with current Electronic Patient Record (EPR) Provider Allow Patients to manage appointments online
Q3	Focus on user adoption of service Integration of current questionnaires and patient assessment forms with provider and with Informatics
Q4	Phase 2 Integration with EPR provider User access to first tranche of own clinical information
Executive lead	
Chris Holt, Chief Operating Officer	

Prevention of Clinical Harms due to delays in Treatment

Quarterly Breakdown	
Q1	Divisions (Services) begin to define processes for prioritising referrals for treatment, with clear trigger points based on time elapsed (wait) and other relevant factors in terms of preventing the risk of Clinical Harm through undertaking timely Clinical Referral Triage and Clinical Re-assessments. This will include developments to RiO in order to appropriately capture data to enable accurate reporting.
Q2	Continued expansion of the Q1 aim with basic monthly performance and operational data available to Services via OneVision.
Q3	Completion of the Q1 aim, with all active services. Enhanced reporting via OneVision with the increase in the use of automation where possible (i.e. timely alerts, breach reports). Performance reviewed monthly as part of the Waiting Times and Activity Group. Reporting data for divisions as part of quarterly report to CEC and QSE. Sandbox development of a Performance Scorecard Key Performance indicators (KPI)(s).
Q4	Revision of Prevention of Clinical Harms Policy. Introduction of approved KPI(s) onto Divisional and Trust Scorecards.
Executive lead	
Dr Doug Simkiss, Medical Director	

Looking back 2020-21

Met | Partially Met | Not Met

Quality priority 1 - Improvements in Children's Services

Goals	
Run a parent workshop for Attention Deficit Hyperactivity Disorder (ADHD)	👍
Have a Child Development Centre (CDC) Advice Line	👍
Develop a Transition web page on BCHC website	👍

Achievements

First "Virtual Attention Deficit Hyperactivity Disorder (ADHD) Information Workshop for Parents" for families who's child has had a recent diagnosis of ADHD or was already under regular follow up with the ADHD service and parents just wished to learn more about the disorder.

The Child Development Centre (CDC) advice line opened in April 2020 for all families who had been referred to the CDC due to their children having additional needs.

The new Transition to adult service webpage launched on the BCHC website making the transition to adult services easier - The BCHC Transition web page https://www.bhamcommunity.nhs.uk/patients-public/children-and-young-people/transition/

Improvements

ADHD Information Workshop for Parents resulted in improved management of children with ADHD and gave parents/carers opportunity to ask questions around this disorder, which they greatly appreciated.

CDC advice line established so families can now leave a message and the team call families back within 48 hours and offer practical everyday advice.

Accessible information on Transition for young people and families.

Ongoing work

Further ADHD Information workshops are planned throughout the year

Transition web page will be regularly updated

Quality priority 2 - Roll out of the Electronic Patient Record (EPR)

Goals	
The EPR will be a patient centred record that provides clinical staff with immediate access to patient clinical information at the point of care.	👍
Support the implementation of EPR with trust wide standards for the recording of clinical data, enabling improved information flow within the organisation and reducing the use of unstructured progress notes.	👍
No matter where they are, staff can access and input into EPR using a variety of hardware including smartphones, tablets, and laptops.	👍

Achievements

Implementation and optimisation of Phase 1 of Total Mobile is providing more clinicians with EPR access at the point of care.

Your Care Connected provides health care professionals with access to patient's records within GP systems, enabling safe, high quality care, clinical effectiveness, and improved patient safety.

Improvements

Introduction of virtual patient consultations using Attend Anywhere has allowed clinicians to continue delivering patient care during the pandemic.

Ongoing work

Development of BCHC Core Record ensuring clinical data is entered once in one IT system and shared across a regional resource.

Implementation of EPR for Moseley Hall Hospital ward 5 as a proof of concept ahead of implementation across all In Patient units

Outstanding actions

Initiation of electronic prescribing & medicines administration project on completion of procurement exercise and awaiting Trust Board approval. This will support better clinical effectiveness and patient safety.

Moving forward

Approval has been granted for the implementation of a patient portal, electronic observations and patient flow management, all of which will contribute to the ticked objectives.

Quality priority 3 - Delivery of the Early Intervention programme

Goals

To deliver integrated care and support early discharge from a bed in the acute or community setting and embed home first ethos

To support people become more independent in their own homes

Prevent people from getting admitted into hospital unnecessarily and look after them in their own home

Achievements

300 staff from seven different health and social care organisations, and a private sector domiciliary care provider, successfully joined forces for the first time, to launch the new Early Intervention Community Team.

During the pandemic kept the system going as well maintaining high performance levels.

Introduced the government's Discharge to Assess guidance.

Improvements

Working together as a collaborative

Overcoming barriers between Health and social care

77,000 acute bed days saved annually

3650 admissions avoided annually

6 hours per week ongoing care reduced on average

26% more likely to go home when leaving non acute beds instead of in long term placement/care.

Ongoing work

To review and evaluate the service

Continuous Improvement cycle

Service review a year after launch and pandemic

Build upon staff and citizen feedback

Outstanding actions

To start to look at readmission and reasons

Reduce paperwork and duplication by using iPads

Ensure capacity and demand visibility.

Moving forward

Expand the Community teams to be able to respond to urgent crisis 2 hour response

Work with West Midlands Ambulance Service and use technology.

Have one IT system

Quality priority 4 - Embed Quality Improvement methodology

Goals - Designing and embedding a BCHC improvement approach to create an organisation capable of continuously improving.

Develop a co-designed BCHC improvement approach, including a range of behaviours and tools, to promote a culture where everybody can participate in improvements in quality.

Develop a learning framework to promote the BCHC improvement approach within and across clinical divisions and corporate directorates to enable all colleagues to identify and act on opportunities to improve quality.

Establish a means to evaluate the impact of the co-ordinated BCHC improvement approach, with a baseline and progress against this reported to the Quality and Safety Committee.

Devise a means for colleagues to keep informed about the on-going BCHC improvement approach, how they can learn more, get involved and increase Trust-wide capability and capacity in quality and safety improvement.

Achievements

Over the past 12 months, BCHC has seen a number of changes in the way we approach quality improvement in the Trust.

Successfully designed and started to embed BCHC Improving 2Gether approach to help create an organisation capable of continuously improving.

Improving 2Gether strategy approved by the Trust Board in July 2020 and outlines four key ambitions and a framework to report progress against.

More details on the BCHC Improving 2Gether can be found on page 287

Outstanding actions

Plans are in place to implement Quality Improvement Huddles across the Trust.

Quality priority 5 - Building Highly Effective teams supported by a leadership development offer

Goals

To develop and deliver a Leadership programme for all those colleague for line BCHC Leaders. Leaders are colleagues within BCHC who have responsibility for the line management of a team of one or more colleagues, or who has a professional leadership role within a service or services	
The implementation plan was reduced to support the operation impact of Covid; thus the frequency of the programme reduced from weekly to monthly for a period of time. However on line leadership development modules were accessible at all times should colleagues wish to continue self-directed leadership development.	
Additionally a new 'Line Manager' Induction programme has commenced and is delivered quarterly for new line managers to BCHC or those who have been promoted to line management positions who are not planned to undertake INSPIRE.	
The 360 feedback process has commenced as an element of the leadership offer. All of the Executive Team have undertaken this and received feedback. Some Management Board and senior colleagues have also started this process. As from Q2 there will be a roll out plan for the remainder of the senior leaders (approx 200 in total).	

Achievements

The INSPIRE leadership programme has been developed with the intention of supporting leaders across BCHC in enabling a compassionate and inclusive culture driving the ambition of best place to work.

To date 10 cohorts comprising of 157 colleagues from all divisions have completed the 2 day INSPIRE programme. The Chief Executive opens each of these events for the first hour and discusses the importance of the leader's role and impact on teams and individuals.

A robust evaluation of cohorts 1 – 10 has been conducted to identify the impact and validity of the programme. Of the 157 colleagues, 63 (40%) were successfully engaged in providing feedback.

- 84% of the respondents stated that INSPIRE had a positive impact on their working practice
- 92% stated that INSPIRE has been beneficial to them as a leader

To date 2 New line manager induction programme have been undertaken. The Chief Executive opens these events for the first hour and discusses the Trusts ambitions and importance of leaders on teams.

Improvements

As a result of the INSPIRE pre-course evaluation and the robust evaluation, a further third day will be undertaken with all cohorts to provide the reflective space to review and further embed the cultural change and behaviours.

Additionally a 6 and 12 month touch point to focus on the impact of inclusivity, compassion and patient care as a result of INSPIRE will occur in the format of self-directed action / network sets.

Ongoing work

Cohorts 11 onwards will continue in mixed cohorts on a virtual basis, flexible in its frequency as COVID-19 continues until all leaders have undertaken the programme. Continual review and monitoring of the programme will continue.

Roll out plans for the 360 feedback offer will be prepared for Q2 and will apply to the approximately 200 senior leaders in the Trust.

Outstanding actions

Initially INSPIRE intended to be delivered weekly with cohorts of 20 which so would be completed in 8 months for all BCHC leaders. The trajectory is fluid in regards to timeline to support both service needs and the balanced wellbeing of BCHC colleagues.

Moving forward

Cohorts 11 continue on the basis of a weekly trajectory.

The development of the third recall day for cohorts 1-10 is underway and for cohorts 11 onwards this will be planned as part of the participants' cohort.

Quality priority 6 - Safe Sustainable Staffing

Goals

Colleague health and wellbeing - ‘Hear for You’ branding	👍
Roll-out of e-Rostering and Job Planning	👉
Develop and launch the ‘New Opportunities’ programme	👍

Achievements

The Trust has faced a momentous challenge in being able to maintain safe staffing levels during COVID-19.

The demand for an effective and urgent clinical response to the Pandemic, the introduction of a range of non-clinical services to support the wider health and social care system and a workforce impacted by the consequences of the virus, has meant maintaining and sustaining safe staffing levels has been a major achievement.

This has only been made possible through an extensive redeployment and retraining programme, flexibility in working practices and processes and a number of workforce development programmes
to recruit adequately skilled and competent staff into the workforce.

Whilst targeting its effort and capacity on the specific response to COVID-19 the Trust has made good progress in a number of its commitments under the safe and sustainable work programme.

Improvements

Colleague health and wellbeing has been a major part of the COVID-19 response and a range of interventions have been brought together under the ‘Hear for You’ branding.

As well as the health, wellbeing and COVID-19 safety elements of the response the programme of support has included a number of practical and contractual provisions to help colleagues during this period. The Trust has actively engaged with colleagues to listen and respond to concerns.

The Trust has further developed its support to staff being able to raise concerns in a safe and timely way through the Freedom to Speak up Guardian (FTSU). A number of Speak Up Champions have been appointed, a series of open engagement sessions with Executive Directors were organised and regular FTSU reports and themes were raised at Trust Board level.

The roll-out of e-Rostering and Job Planning has continued during the year albeit at a considerably slower pace than planned due to the obvious workforce capacity challenges.

A number of longer term ambitions to support sustainable staffing have admittedly been affected by development capacity.

However, initial work to develop the ‘Employment Offer’ has commenced and a platform has been established to develop on-boarding and work experience in 2020/21.

The Recruitment Team have worked collaboratively with nursing and therapy and Divisional colleagues to successfully develop and launch the ‘New Opportunities’ programme to recruit, train and support trainee unqualified nursing support roles with future plans to extend the scheme. The Trust has worked to support the ‘Bring back staff’ national campaign, the ‘step down’ programme for final year nursing students to take up paid nursing roles and other nursing students to undertake bank unqualified nursing roles through expressions of interest and collaborative working with local universities.

Ongoing work

Work to develop long-term workforce planning will be progressed early in 2021/22.

Statements of Assurance from the Board of Directors

This section contains statutory statements concerning the quality of services provided by Birmingham Community Healthcare NHS Foundation Trust. These are common to all trust Quality Reports and can be used to compare us with other organisations. Our Board is ultimately responsible for the delivery and quality of services delivered throughout the organisation. It is therefore also responsible for the accuracy of information that is presented within our Quality Report.

Richard Kirby
Chief Executive Officer

Chris Holt
Chief Operating Officer

Marcia Perry
Director of Nursing and Therapies

Ian Woodall
Chief Finance Officer

Michelle Alli
Director of Corporate Governance

Dr Doug Simkiss
Medical Director

Dr Suzanne Cleary
Director of Strategy and Partnerships

David Holmes
Workforce and Organisational Development Director

Dr Barry Henley
Chair

Jerry Gould
Non-Executive Director

Professor David Sallah
Non-Executive Director

Jacynth Ivey
Non-Executive Director

Sukhbinder Heer
Non-Executive Director

Jenny Belza
Non-Executive Director

Salma Ali
Non-Executive Director

BCHC Board changes

In September 2020, Jerry Gould and in February 2021, Sukhbinder Heer stepped down from the Board. We would like to thank both Jerry and Sukhbinder for their contribution through their years on the BCHC Board and wish them well for the future.

Review of services

During 2020/21 the Birmingham Community Healthcare NHS Foundation Trust provided and/or subcontracted 100 health related services.

However, the COVID-19 pandemic resulted in some of our services operating at a reduced level during the year in order to respond appropriately to the significant challenges the NHS and Social Care Services faced. In addition these 100 services, several new services were implemented specifically in response to COVID-19 such as Outbreak Testing, a PPE Team, support to Care Homes, a Discharge Hub and a COVID-19 Rehabilitation service to name but a few.

Birmingham Community Healthcare NHS Foundation Trust has reviewed all of the data available to them on the quality of care in 100 of these relevant health services, each of which had a Service Impact Assessment as part of the COVID-19 response. The income generated by the relevant health services reviewed in 2020/21 represents 88.58%* of the total income generated from the provision of relevant health service by the Birmingham Community Healthcare NHS Foundation Trust for 2020/21.

** the % of income is a forecast figure from M11 as the ledger for 2020/21 has not yet closed.*

Participation in Clinical Audit

During 2020-21, 6 national clinical audits and 0 national confidential enquiry covered NHS services that Birmingham Community Healthcare NHS Foundation Trust provides.

During that period Birmingham Community Healthcare NHS Foundation Trust participated in 100 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Birmingham Community Healthcare NHS Foundation Trust was eligible to participate in during 2020-21 are as follows:

- Falls and Fragility Fractures Audit Programme (FFFAP)
- Learning Disabilities Mortality Review Programme (LeDeR)
- National Asthma and Chronic Obstructive Pulmonary Disease (COPD) audit programme
- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
- National Diabetes Audit – Adults National Foot-care Audit
- Sentinel Stroke National Audit programme (SSNAP)

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- National Diabetes Audit – Adults National Foot-care Audit
- Sentinel Stroke National Audit programme (SSNAP)

The national clinical audits and national confidential enquiries that Birmingham Community Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2020, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

*% - Number of cases submitted by Birmingham Community Healthcare NHS Foundation Trust expressed as a % of the number of registered cases required by the terms of the audit or enquiry

Title	Participated	%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	N/A See Appendix 1
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) audit programme.	Yes	100% 56 cases submitted
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Rolling data collection Total Patients registered 12 (10 in cohort 1 and 2 in cohort 2).
National Diabetes Audit - Adults National Foot-care Audit	Yes	N/A Rolling data collection No min ascertainment required for this audit.
Sentinel Stroke National Audit programme (SSNAP)	Yes	90+% case ascertainment 46 cases included in audit. Band A for case ascertainment maintained over the last 2 quarters at a time when participation was non mandatory.

A full list of clinical audits and confidential enquiries can be found in Appendix 1.

Please note in addition to this BCHC participates in a number of national audits which are not commissioned as part of the NCAPOP/NCEPOD national audit programmes.

Participation in Clinical Research

The number of people receiving relevant health services provided or sub-contracted by BCHC in 2020-21 that were recruited during this period to participate in National Institute for Health Research (NIHR) Portfolio Research* approved by a research ethics committee was over 1755.

**Portfolio Research refers to the projects funded or adopted by the NIHR through open competition.*

National Clinical Audits

The reports of 0 national clinical audits were reviewed by the provider in 2020-21 and Birmingham Community Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Case study published 2019/2020 NACAP Audit Report

The pulmonary rehabilitation (PR) National Asthma and COPD Audit Programme (NACAP), is a continuous clinical audit with a biennial (in alternate years) organisational

Audit component, launched in March 2019 in England, Scotland and Wales. All services who treat patients for chronic obstructive pulmonary disease (COPD) are eligible to participate. The audit captures the process of treatment in patients who are treated by, and the structure and resources of, PR services.

A quality standard that is reported is the process of recording clinical outcomes for exercise capacity.

Actions Taken:

The Incremental shuttle walk test (ISWT)

The patient is asked to walk around two cones (10 metres) in time to a set of auditory beeps played. Initially, the walking speed is very slow, but each minute the required walking speed progressively increases. The patient walks for as long as they can until they are either too breathless or can no longer keep up with the beeps, at which time the test ends.

The number of shuttles is recorded. Each shuttle represents a distance of ten metres

The results of the ISWT can be used to prescribe the intensity of walking training.

Ensuring that a practice walk test is conducted before recording an outcome will ensure:

- that patients understand what the test involves so reduces the risk of patients setting off to quickly, or not reacting to the beep in time; whilst ensuring that outcomes are reliable
- exercise is accurately prescribed and safe high quality care is achieved.

Key Successes:

Case study published Dec 2020 NACP Report.

Results:

Only 60.6% of patients nationally were completing a practice ISWT

100% of BCHC patients had a practice walk test.

National Audit of Care at End Of Life

Audit Aim:

During the ongoing COVID-19 pandemic in 2020, the National Audit was stood down however the division made the decision to continue with the audit with the aim of continuing to improve End of Life Care.

Action Taken:

The audit therefore utilised the 2019 National Audit of Care at the End of Life (NACEL) case note review tool which measured criteria against the National Institute for Health and Care Excellence (NICE) QS144 'Care of dying adults in the last days of life' and the Five priorities for care of the dying person (2014). The focus was on documentation of recognition of dying and individual care planning at the end of life.

Use of the NACEL case note review tool enabled direct comparison to be made with the Trust's 2019 results and was completed locally in the absence of the national audit during 2020.

The audit was a retrospective case note review of patients who died in any of the Trust inpatient wards during May and June 2020. A total of 28 sets of patient notes were reviewed. Deaths which were classed as 'sudden deaths' were excluded from the audit.

Overall identified:

- Recognition of dying - There was evidence of discussion with patients' families in 96% of notes. This was an improvement on the 2019 result of 73%.
- 14% of patients had their preferred place of death documented and there was very little documented evidence that patients had participated in advance care planning discussions
- 86% of patients had a documented individualised plan of care, an increase on the 2019 figure of 65%
- There was evidence of involvement of the family in discussing the plan of care in 88% of notes, an increase on the 2019 figure of 73%
- Documentation of assessment of physical symptoms – While there is evidence of sustained improvement in recording of some of these symptoms, there was a decrease on the 2019 figures for mouth care and bowel function
- Documentation of non-physical symptoms continues to be infrequent with assessment of spiritual needs and practical/support needs
- There is a significant increase in the documentation of review of the benefit of starting or stopping identified interventions compared with the 2019 audit results
- While 81% of patients had anticipatory medication prescribed, there was documented discussion with patient's families about the use of these drugs in less than half of the notes (46%)
- 52% of patients had an indication for use of their anticipatory medication included within the prescription, an increase on the 2019 figure of 30%
- There was a good level of documented evidence that patients' nutrition and hydration status was addressed daily. Discussion with patients and families about the risks and benefits of nutrition and hydration options was, however, infrequently recorded.

Key Successes:

Identified improvement in documentation included:

- Recognition of dying – this included earlier recognition and documentation of this alongside evidence of discussion with the family
- Individual care planning - documentation of an individualised plan of care for an increased number of patients with evidence of involvement of families in discussions about the plan of care
- Review of the benefit of starting or stopping identified interventions e.g. routine recording of observations or routine blood tests.

Key Areas Requiring Improvement:

Areas to address:

- Recording of patient wishes for care at the end of life
- Improvement in the recording of discussions with both patients and families
- Documentation of assessment of non-physical symptoms – particularly in relation to the assessment of spiritual care and practical support needs
- Documentation of assessment of identified physical symptoms e.g. agitation and mouth care
- Recording of indication for use of anticipatory medication

Actions taken following the audit:

- Findings from the audit directly informed End of Life training requirements for staff
- Review and further development of the End of Life Care Plan to ensure it captures all key areas identified in the audit
- Review of audit results alongside themes identified from structured judgment reviews

Changes to Practice:

- Revised End of Life Care Plan to be introduced across all inpatient wards

Future Plans:

- Roll out revised end of life care plan across all inpatient wards with an agreed training plan
- Participation in the 2021 NACEL to measure improvement over the past year

Sentinel Stroke National Audit Programme (SSNAP)

Audit Aim:

Reports reviewed:

- SSNAP Seventh Annual Report 2020 examines the findings of data collected during 5 years from April 2019-March 2020.
- Site specific SSNAP reports generated by SSNAP for BCHC during 2019-20

SSNAP requires all services admitting patients with stroke to complete a minimum data set for all patients. The core data set includes acute care, inpatient rehabilitation, early supported discharge, community follow up and six month reviews.

- BCHC has been submitting data for its inpatient service since January 2014 and receives site specific quarterly reports on clinical care of patients with stroke.
- Early Supported Discharge (ESD), Community Stroke Team (CST) and Birmingham Neuro-Rehabilitation Team (BNRT) (community follow up provider) are submitting data for SSNAP with the aim of generating frequent reports. All teams are submitting data and where there are enough cases completed BCHC are receiving reports every 6 months.

Key messages and improvements over time 2020/21

Following review of the national reports and local data our key improvements have been

- Provision of therapy services (Occupational Therapy achieved A in last quarter for inpt care, Physiotherapy maintained a B last quarter) and increased diversity in referral source.
- ESD and BNRT receive six monthly reports, inpatients are quarterly.
- During the covid pandemic, community stroke services at BCHC have seen a significant increase inpatient referrals. Despite the increase, case ascertainment in the audit has maintained above 90% compared to a national average of 79%.
- Inpatient assessment of cognition of patients discharge has been 93.5% compared to a national average of 77%.
- The inpatient service continued to screen mood at 5% higher than national average.
- For ESD and CST, contact time with therapists per session is slightly above national average.
- The % of patients staying in their own home after discharge from community stroke services is higher than the national average.

Actions taken

Following review of national report a paper was submitted to Divisional Quality and Safety Board February 2020 and the following actions have been taken within context of COVID-19:

- Review of stroke rehabilitation care pathway with support at Executive Team level
- Multi-sector engagement to put forward a bid to be a national pilot site for integrated community rehabilitation model in January 2020. This collaboration provides a platform moving forward to further develop the stroke pathway across the Clinical Commissioning Group (CCG) area. Shortlisted for National Teams to consider.
- Appointed project support manager to deliver local changes within current contract to improve access to rehab and follow up work from regional Early Supported Discharge project.
- Executive level support for development of Stroke Programme Board.
- Continue to maintain close links with Stroke Association which includes volunteers and commissioned family support service.
- BCHC representative chairs regional community group linking to national SSNAP workshops delivered at regional level, aim to increase engagement with audits.
- Evaluating impact of use of new technologies/remote working to support patient care within current context.

UK Parkinsons Audit National Parkinsons Disease Audit

Service level benchmarked reports received and reviewed February 2020
2019 UK Parkinsons Audit national report published July 2020

Key messages and improvements over time 2020/21

Elderly Care

Actions being taken

The elderly care outpatient clinic has been stood down over the last 12 months due to impact of the COVID-19 pandemic. In turn the model of service delivery which has evolved and adapted to provide a telephone consultation service from March 2020 with occasional home visit where clinically required to continue to meet patient needs.

Physiotherapy and Occupational Therapy

While it is recognised staff redeployment has had an impact during 2021, greater use of virtual appointments to support patient care has contributed to an increase in the number of contacts able to be made by the service.

Actions being taken

Consider appropriate training courses for Occupational Therapists and Physiotherapists in the service as part of restoration.

Signposting to appropriate website support and advice available to patients including literature available re Lasting Power of Attorney.

National Chronic Obstructive Pulmonary Disease Audit (COPD)

The publication of the national report published July 2020 (interim) and December 2020 (final)

National Quality Improvement Plan to improve waiting times

Guidelines state that 100% patients should be seen within 90 days of referral. Only 58% of services achieved this, nationally.

BCHC achieved 60%

Actions taken:

1. Incorporate a process of monitoring waiting lists - BCHC use 1vision and RIO waiting/ triage lists.
2. Have a list of patients wiling to attend at short notice - BCHC allow for direct access referrals
3. Ensure classes run at full capacity and are rolling programmes

National Quality Improvement Plan to ensure objective outcomes are performed within recommended standards.

practice walk prior to recording incremental shuttle walk test (ISWT)

BCHC achieved 100%. Only 41% of patients completed this nationally.

Actions taken

- BCHC were asked to present a case study- published in final report.

National Quality Improvement Plan to ensure 70% of patients enrolled for treatment receive and discharge assessment.

BCHC achieved 76%

Action taken:

- discharge assessments to be performed when a patient has completed 75% of programme (where needed) to reduce the risk of drop out/ DNA at final appointment.

Other actions taken to support service delivery for audit outcomes.

- BCHC have completed on line self-assessment for the Pulmonary Rehabilitation Accreditation scheme (Royal College of Physicians) site visits due in May 2021
- All service Standard Operational Plan (SOP), Risk assessments and policies have been updated.
- Collaborative work with Secondary care trusts and BSol Clinical Commissioning Group has produced a standardised operational plan.
- A Pulmonary Rehabilitation service online resource bank, including videos and useful information has been launched.
- Virtual Pulmonary Rehabilitation classes have been implemented to support the most vulnerable and those patients that are able and have consented to virtual treatment. Article published in Chartered Society of Physiotherapy magazine January 2021.
- Mailshot completed with regular communications made to all patients on waiting lists for reassurance, guidance and information regarding services and COVID-19 restrictions.
- Extended Pulmonary Rehabilitation classes are being introduced to restore Pulmonary Rehabilitation face-to-face classes and tackle waiting lists.
- Support staff have gained specific qualifications in rehabilitating patients with chronic lung conditions.

National Confidential Inquiry into Suicide and Homicide: Annual Report

Following a report to Clinical Effectiveness Committee the Trust revised the Suicide Prevention Policy which was ratified in October 2019.

Work is on-going with divisions to revise the training and guidance available to support staff in the event they are approached by patients or colleagues who may be considered vulnerable or at risk.

The Trust recognised the impact of the pandemic on staff wellbeing and instigated a programme call “Hear for You” which provided links to a number of support networks including the Employee Assistance Programme. This service can provide counselling, support and advice 24 hours a day, 365 days a year. The service can help with information, advice and articles about staff health online, around the home and at work.

BCHC plays an active role supporting the processes of Domestic Homicide Reviews and Safeguarding Adult Reviews in order to identify lessons which can be learnt to try to avoid similar issues occurring in the future. Additionally the Trust are mindful of responsibilities to staff and patients where Domestic Abuse is of concern. Domestic Abuse is a category of abuse noted in the Care Act (2014) which sadly, on occasion, has led to a domestic homicide.

Learning Disabilities Mortality Review Programme (LeDeR)

LEDER is a national audit into deaths of patients who have a learning disability (LD).

They had 14 deaths reported during this period and 6 were COVID-19 related. All 14 deaths were reported to LeDeR and Multi- Agencies Reviews continue to be carried out. The key themes that are identified continue to be around issues of coordinated care especially where an individual is diagnosed with both Mental Health and LD, annual health checks, Heath Facilitation (HF) primary services, multi-agency communication, recognition and management of pain, correct application of MCA, etc.

- The Division has developed a Mortality SOP/ Screening tool.
- Will be signing up to The Birmingham and Solihull (BSOL) Strategic Plan to support action the themes as one of the key stakeholder.
- Attend and contribute to the Multi Agency Reviews
- Work around HF supporting acute services to continue to monitor progress to minimise premature death and provide patients, family and carers the right support.
- The Grab and Go documents are proving to be useful when implemented alongside hospital passports.
- EOL champions identified and Matrons linking in with regional EOL network.
- Promotion of COVID-19 and flu vaccination with 100% of all patients in our bedded area vaccinated and majority staff within LD Services vaccinated.
- Staff have received LeDeR training and patients have COVID-19 care plans linked to their physical health deterioration care plan.
- Staff have also been trained in the use of NEWS 2

National Diabetes Audit – Footcare audit

The aim of the audit is to capture number of new diabetic foot referrals referred into podiatry each year, how quickly the patients are seen for assessment and the outcome over 12 weeks.

Overall identified:

- Annually numbers collated, higher number of referrals received however may be attributable to increased awareness and prompt recognition by the team. Most patients are being seen within 1-13 days from referral. Main results not yet published for this year however indicate positive results when compared to previous years.

Key Successes:

The service is able to:

- Assess numbers of wounds with healed outcomes in 12 weeks
- Assess success in treatments for more complex patients and more complicated wounds
- Use data for service outcomes
- Utilise this data as part of the national diabetes audit to inform on outcomes with links for complications, medications, ulcerations, amputations and death.

Key Concerns:

- Some home visits not captured and recorded in audit
- Some new wound referrals not appointed timely due to caseload demand and capacity issues.

Local Clinical Audits

The reports of 147 local clinical audits were reviewed by the provider in 2019-20 and Birmingham Community Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Dental Services Division

Audit on the appropriateness of remote antibiotic prescribing during COVID-19 pandemic at the Birmingham Dental Hospital, UK.

Overall identified: 1st cycle: 74% of cases met Scottish Dental Clinical Effectiveness Programme (SDCEP) guidelines. The correct antibiotics, dose and duration were prescribed. 95% of antibiotics prescriptions were indicated.

100% antibiotics prescriptions were given at the recommended dose.

90% of antibiotics prescriptions were given for the recommended duration.

3% of patients had repeat prescriptions of antibiotics issued by the Dental Hospital.

19% of patients made further contact and had further telephone consultations. Twelve of those were seen face to face and had interventional treatment.

2nd cycle: 88% of cases met SDCEP guidelines. The correct antibiotics, dose and duration were prescribed. 100% of antibiotics prescriptions were indicated.

100% antibiotics prescriptions were given at the recommended dose.

88% of antibiotics were given for the recommended duration.

1 patient had a repeat prescription form issued by the Dental Hospital.

8 patients made further contact and had further telephone consultations. Three of those were seen face to face and had interventional treatment.

Key Successes:

The results of the 2nd cycle show a dramatic improvement in prescribing behaviours. There has been an improvement from 74% to 88% meeting SDCEP guidelines. All antibiotics prescriptions were indicated and all given at the recommended dose. However, there was no improvement in prescribing for the correct duration, with all 12 prescriptions given for five days instead of three to treat pericoronitis. Diligent prescribing continues as demonstrated by low numbers of repeat prescriptions.

Key Concerns:

The target of 95% has not been met and there are still some improvements to be made.

Adult and Specialist Rehabilitation Services Division

The Storm On Our Shores: Contribution Of Specialist Rehabilitation To Acute Care During The COVID-19 Pandemic

Inpatient Neurological Rehabilitation Unit (INRU) is a 34 bedded level 1 unit managed by Birmingham Community Healthcare NHS Foundation Trust with requirement to respond to system surge and rapid discharges from acute trusts.

We reviewed challenges, opportunities for service development and innovation that occurred during COVID-19 pandemic.

Overall identified:

When compared 2020 & 2019, there were more patient admission; comparable level of needs - PCAT and complexity - RCS; reduced period between referral to admission days; significant average gain in FIM / FAM and reduction in length of stay days.

	2020	2019
Patient Admission	35	29
PCAT	33.5	32.8
RCS	16.5	15.3
Referral to Admission	12.10	33.5
FIM / FAM	45.5	31.9
Length of Stay (days)	59.4	77.2

Overall INRU performance improved in comparison to similar period in 2019 despite facing challenges including high rate of staff sickness, increased staff work load from higher demand providing adequate nutritional support via alternate feeding plan, maintaining effective communication with families during visiting restriction period, higher rate of medical instability and neurosurgical complications, greater rate of staff absence and managing uncertainty and emotional loads on staff, patients and family .

There were changes to the workforce through the redeployment of the staff from outpatient and community services including the use of community paediatric SLT team and community specialist rehabilitation team. Despite being inexperienced with complexity and specialist input required in adult services, redeployed staff integrated and supported within MDT setting immediately. INRU revised multidisciplinary process, introducing daily huddles to provide safe patient care and support staff. Virtual communication was established with patients and families.

Community nutrition team assisted nursing staff with alternative feeding plans. Community medical team including rehabilitation medicine consultants and specialist trainees based on community were redeployed to inpatient setting and provided extended hours support to the multidisciplinary team. These innovations enabled us to extend our services to include seven day therapy, additional tracheostomy care beds, provision of out-of-hours therapy service and medical cover to provide safe, effective and timely care to severely disabled and complex patients.

Patient flow was enhanced by the allocated COVID-19 support fund to access community placements via trust discharge hub, and integrated care delivery by NHS and social care systems.

Key Successes:

Sufficient diversity of professions and disciplines, suitable leadership and team dynamics, and supportive organisation are important enablers to provide such an efficient cohesive care. Multidisciplinary team (MDT) approach in INRU enabled professionals and practitioners from different backgrounds to communicate better about each other's roles and responsibilities; they shared identity and purpose that encouraged team members. MDTs approach led to better communication and trust between team members and more holistic and person-centred practice. This approached resulted in resources being used more efficiently through greater productivity. Professionals and practitioners were less isolated which improved morale and reduced stress and emotional loads during highly exceptional circumstances.

The true value of rehabilitation services revealed during the pandemic, specialist rehabilitation services were utilised exceeding routine practice to reduce pressure off acute services. This was achieved by effective compassionate leadership within the service supported by the Trust at the time of greatest uncertainty.

Key Concerns:

While INRU has benefitted from input from the redeployed staff, it is important to maintain the skillsets within INRU when their redeployment is over.

Audit Aim:

West Midlands Rehabilitation Centre (WMRC) provides comprehensive Intrathecal Baclofen (ITB) service at regional level with catchment of 5 million.

WMRC has established collaboration with neurosurgeons from acute trusts for surgical intervention. With the grip of COVID-19 pandemic, elective surgeries and outpatient clinics came to a halt. We wanted to reflect on how we sustained ITB clinic which is a critical life maintenance service

Overall identified:

All patients had pumps refilled before alarm date. All established patients who were due for pump revision had operation.

When compared activities:

	2019	2020	Changes in %
New Referrals	14	11	4%
New Assessments	12	9	25%
ITB bolus test	4	3	25%
Pump/Catheter	11	11	10%

There were 6 new pump implantations and 1 catheter test in 2019 but none were possible in 2020 due to pressure on theatre slots.

Key Successes:

ITB clinics are unique in that face-to-face patient treatment is needed without delay because of risk of baclofen withdrawal and damage to delivery system. The transport service suspended to all but was agreed to continue for ITB patients. Due to redeployment and infection control guidance, a new clinic schedule was devised which consisted of one regular full day multidisciplinary clinic/ week and twice monthly half day clinics, supplemented with telephone reviews and domiciliary visits.

Once we highlighted risk of Baclofen withdrawal, a revision pathway was identified. The patients were triaged into cold and hot pathways depending on their ability to self-isolate for surgery. One patient who was frail had ITB therapy weaned off. Patients who have end of service of pump in 2020 were enlisted chronologically.

We collaborated closely with surgical colleagues to ensure that revisions were done in time. Despite the unprecedented circumstances, innovative effort has been made to sustain the ITB service safely.

Key Concerns:

While we are maintaining the core ITB pathway, the implementation of the new pump is not possible due to the pandemic.

Actions taken following the audit:

The risk to patients waiting for their first pump will be mitigated by liaising with their spasticity teams.

Enhancing patient care: Innovative MDT Spasticity clinic with Rehabilitation medicine consultant, Upper limb surgeon and Specialist physiotherapist.

Audit Aim:

The West Midlands Rehabilitation Centre (WMRC) is piloting a joint MDT clinic to provide a one stop shop approach of comprehensive assessment and management for patients who may potentially need early surgical intervention.

This study is to improve referral and delivery pathway for patients with upper limb spasticity related issues who may benefit from early surgical intervention and also to evaluate the outcome of such an innovative clinical approach. The MDT comprises a rehabilitation medicine consultant, upper limb surgeon and a specialist physiotherapist

Overall identified:

The management advice were:

BoNT	14
Surgery	6
Orthotics	6
Functional electrical simulation	2
Wheel chair referral patients	1

Among 44 patients, 41 patients were able to be contacted by phone to gather patient satisfaction with clinical outcome. PROM suggested that majority (38 patients) were satisfied apart from 1(surgery) and 1(BoNT). 1(BoNT) felt equivocal outcome.

Key Successes:

This approach is effective in providing one stop shop assessment and treatment plan for patients. It offers unique opportunity for the patient to get shared multidisciplinary advice from the experienced clinicians in a single clinic contact.

It reduces multiple appointments in different hospitals, shortens waiting times for further surgical and non-surgical interventions and improves overall patient experience.

Key Concerns:

We would like to address the lack of information regarding type of surgical interventions the patients had and improve on the ArmA score documentation.

Changes to Practice:

We would like to observe the long-term reverberations of the interventions which would provide references for decision making in similar cases and offer early surgical intervention in appropriate cases.

Future Plans:

A proforma is going to be designed and implemented to facilitate collection and evaluation of the data. There is further work in progress to streamline the referral to the clinic, the delivery of this pathway and collection of evidence.

Learning Disability Services Division

Service evaluation: Evaluating the impact of the 'maintenance team' on service users and staff in community learning disability services during the COVID-19 outbreak.

Aim:

To seek to identify and explore issues that staff have experienced following the change to the existing service model ('Maintenance Team') due to the COVID-19 outbreak

To explore how changing to this model has impacted on the care provided to service users

Overall identified:

Method

- Exploring Staff Experiences of staff who made 4-weekly 'maintenance calls' to check lower-risk client wellbeing
- Semi-structured interviews with 5 members of the maintenance team exploring their experiences

Results

- Exploring Staff Experiences
- 3 primary themes (12 sub-themes)
- Positive: Ability to 'make a difference' to clients, support from team members, development of skills, working from home
- Negative: Technology issues, lack of face-to-face contact with colleagues, lack of face-to-face contact with clients, feeling unsure of new role, working from home

Key Successes:

Small % of clients required escalation; this was done successfully – majority able to be supported effectively (in the short term) via maintenance team

Key Concerns:

- Use of client database - not always clear which clients were allocated to maintenance team / when they were allocated; some service users not contacted within 4 weeks
- Ability to access client RiO files as RiO case notes not always clear
- Technological difficulties with interviews

Actions taken following service evaluation:

- Training and leaflets for those working from home, deal with laptop malfunction and other IT issues
- Flexible modes of working such as office days, visiting clients and working from home
- Able to keep more of existing caseload: hold on to patients previously on caseload instead of being given new patients
- Repeat evaluation in one year

Changes to Practice:

Service evaluation disseminated to peers and lesson learn to improve service delivery

Future Plans:

- Action to be discussed at the operational meeting and appropriate action to be taken.

Monitoring Children on Medications

Children and Families Services Division

for Attention Deficit Disorders

Medications routinely used for children with ADHD can lead to side effects such as appetite suppression, poor growth and cardiovascular side effects. Due to this, regular follow up is required along with blood pressure (BP), heart rate, height and weight monitoring.

As a consequence of lockdown due to COVID-19 there has been a change in the process of prescription requesting. It was suspected that the NICE guidelines for appropriate monitoring of children on ADHD medications is frequently not being met & that there were a number of children who had not had recent monitoring of parameters. This was a new audit to establish current practice and comparison with the standard set by the NICE guideline.

Actions could then be implemented to improve the follow up of these children before re-auditing to assess improvement. Monitoring children more closely will reduce the risk of adverse outcomes secondary to ADHD medications.

Overall identified:

40 cases were included in this audit

- Currently the follow up of children on medications for ADHD for their height, weight and blood pressure is inadequate. This is likely to have been worsened by lockdown and the reduction in face-to-face clinical contacts.
- Only small number (10%) where BP result was interpreted.
- Small sample and therefore not able to interpret current management of hypertension in children on stimulants, but there was one child with BP above 95th centile with no actions documented.

Key Successes:

Started BP, height and weight face-to-face clinics during lockdown

Key Concerns:

Monitoring of children on medications for ADHD not as per standard (NICE guidelines)

Actions taken following the audit:

Presented in trust CPD meeting to remind clinicians about requirement for monitoring.

Blood pressure charts printed and displayed in clinic rooms for quick assessment of blood pressure and to act as reminder to clinicians.

BP, height and weight face-to-face clinics started during lockdown.

Future Plans:

To re audit after face-to-face clinics reinstated.

Audit of Rejected Prescriptions within Community Paediatrics

Community Paediatrics became aware high levels of prescriptions were being returned by Pharmacies for re-writing. The service reviewed reasons prescriptions were rejected with an aim to reduce this occurring.

Overall identified:

During a 4 month period 17 prescriptions were returned to one of the service bases.

There are many reasons why prescriptions were returned by pharmacists and families including:

- Child's date of birth missing
- For controlled drugs the quantity was not specified in words and figures
- Incorrect demographics
- Wrong formulation being prescribed
- Parents wanting a different formulation

Key Successes:

Identified issues around prescribing were addressed, resulting in a reduction in returned prescriptions.

The reminder for staff around good prescribing practice has improved prescribing quality, which will in turn have reduced work load of dealing with rejected prescriptions for admin staff and prescribers. Also reduced stress for families.

Key Concerns:

17 prescriptions were returned during a 4 month period. The GMC and NICE guidelines on good prescribing practice were not consistently being followed.

Actions taken following the audit:

A summary of the findings and a single page prompt sheet were shared with prescribers.

A new prescription request sheet was introduced by the admin team to capture more information from families who are requesting prescriptions.

A further audit was subsequently undertaken and during the 4 month period only 2 prescriptions were returned.

Changes to Practice:

The prompt sheet is now available as a visual aid for prescribers to have in their office, in addition to the induction training junior doctors receive.

Admin staff taking requests for prescriptions use the new prescription request sheet which helps ensure collection of the formulation of medication the families are seeking (liquid v tablets) to reduce returned prescriptions.

Audit of frequency of use of positioning/ standing equipment by classroom staff

Audit Aim:

The aim was to get factual information as to how frequently children are using their equipment when compared to the recommended frequency in their physiotherapy programme. When children use their equipment they experience many benefits including improving motor skills, maintaining bone density and improved participation in class activities. It appeared that the children were not using Standers and other equipment as frequently as was recommended by their physiotherapists. It was hoped the audit would identify barriers to use, enable the staff to understand why and how the equipment should be used and identify how to target training of classroom staff more effectively to increase the usage of equipment.

It was hoped the results of the audit would enable the physiotherapy team to work more effectively with classroom staff for the benefit of the children.

Overall identified:

Before the standard was rolled out, classes were asked to estimate how frequently each child stood. Data recording frequency of standing was audited in the first half of the summer term of 2018. The audit results showed that overall approximately 20% of the expected number of stands took place over the 6 week period.

Key Successes:

3 out of the 6 classes had started to show an increase in recorded stands by the end of the audit period. Classes reported some of the reasons for children not using their standers, which included:

- Staffing shortages in the classrooms
- Time constraints
- Storage of standers
- Standers need to be safe and easy to use for teaching staff

This information will enable more effective interaction with classroom staff to enable the barriers to be overcome.

Key Concerns:

20% of expected standing was a very low result. One class didn't record any standing episodes and one class's numbers decreased over the recording period. Actions taken following the audit: Training of primary, secondary and sixth form classes, and new staff. Incentives for classes e.g. certificates for best class

Future Plans:

Repeat audit to see if there has been an improvement in the frequency of use of standing equipment and to identify further actions to continue improvement.

Adult Community Services

Comfort Care Box Audit

The overall aim of this audit is to identify if all staff within District Nursing teams know about comfort care boxes. The comfort care boxes contain items that staff have access to within a patient's home to support responsive end of life care.

Key Successes:

Review of the audit results has identified both areas of good practice and where there is scope for improvement.

Areas of good practice include:

- 94% of team members are aware of comfort care boxes.
- 97% clean and restock comfort care boxes after they are returned.

Key Concerns:

Improvement areas focus on two key elements:

- Amount of comfort care boxes within each team across BCHC.
- Processes in place for recording where the boxes are and the contents.

Actions taken following the audit:

1. To apply to charitable funds for 2 way monitoring and communication devices, that can be added to the comfort care boxes.
2. To relaunch comfort care boxes/contents lists and re-audit in 6 months ensuring an additional question is included around the use of Green "I am clean" stickers following the return of the boxes.

Changes to Practice:

- The contents list needs to be updated; to include codes for shampoo caps and disposable bed pans.
- To launch mouth care training with the support of dental colleges within teams and standardize mouth care equipment within the boxes.
- The use of continence products and pressure relief being used appropriately within each team.

Future Plans:

- Review number of comfort care boxes within each team to ensure all EOL patients/staff across BCHC have equal access to a box.
- Implement processes for:
  - recording where the boxes are
  - when they are returned
  - a contents list for each box.

Community nursing kit bag audit

The overall aim of this audit is to identify if all staff in District Nursing teams are aware of which items should be included as part of the content of their clinical nursing bags. These items are needed for nursing staff to be able to carry out their clinical tasks in the patient's home.

A total of 15 audits were carried out in the team consisting of both registered and non-registered staff.

11 of the bags that were audited carried the laminated lists. All staff were aware of the lists which were also kept in the office.

Key Successes:

Examples of good practice identified during the audit are:

- All staff carried tympanic thermometer and sheaths, omron fully automatic blood pressure machine, abbott blood glucose machine and pulse oximeter
- Anaphylaxis shock packs were carried and all in date
- Clinell wipes were carried by all staff for cleaning equipment between patients
- All staff carried sepsis and hydration laminates

Key Concerns:

Areas for imporvement:

- Ensuring staff carry all items listed on the portable equipment lists relevant to their role
- Enusring all staff carry pressure relieving prevention equipment, to initiate pressure ulcer prevention immediately at point of assessment
- Ensure staff check if all observation equipment has been callibrated
- Ensuring staff are aware to check expiry dates for urinalysis test strips

Actions taken following the audit:

Pen torch and stethescope to be added for all staff trained in verification of death.

Future plans:

Repeat the audit.

Please note a number of local clinical audits for the 2020-21 reporting period had data collection which spanned quarter 4 (Jan - March 2021) and quarter 1 of the 2021 - 22 reporting period (Apr - June 2021). The Trust anticipates the reports associated with these audits will be completed during Quarter 1 2021-22 following data verification and analysis.

Commissioning for Quality and Innovation (CQUIN): 2020-21

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.

CQUINs require service providers to evidence continuous improvement and enable commissioners to reward excellence by linking a proportion of income to the achievement of quality improvement goals.

From April 2019, CQUIN schemes are of one-year duration in line with the rest of NHS England's contracts.

The NHS standard contract and Specialised service contracts apportion a percentage of the applicable contract value to the CQUIN scheme, payment of which is dependent upon the achievement of specific targets and/or milestones.

There have been no CQUIN's for the year 2020-21 due to COVID-19.

Care Quality Commission (CQC) Registration

Birmingham Community Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional. Birmingham Community Healthcare NHS Foundation Trust has the following conditions on registration to operate services in line with the instructions outlined by CQC within the Section 31 Notice.

The Care Quality Commission (has/has not) taken enforcement action against Birmingham Community Healthcare NHS Foundation Trust during 2020-21.

The CQC inspected the organisation in 2020 and we were rated “Requires Improvement” overall. Five of the six services were rated ‘good’ whilst the sixth; Children and young people services received a rating of ‘requires improvement’. This is an improved rating from the previous inspection, initiated in 2018 and completed in 2019 whereby the service was rated ‘inadequate’. BCHC has continued to improve this service since being issued a Section 29A Warning Notice in 2018 and Section 31 Notice in 2019. Working in close partnership with stakeholders including CQC, CCG and Birmingham City Council has been a pivotal aspect of this achievement.

Since 2018, detailed action plans have been developed, consulted and executed to enable the continued improvement of the services provided to Children and Young People within the community of Birmingham.

Whilst the plan is not yet complete, a significant amount of progress has been made, leading to a formal application having been submitted for the review of the Section 31 and imposed conditions.

This will enable the remaining plans to increase health visitor capacity, retention and reduction in caseload to form a part of the 2021/22 business strategy. BCHC anticipate full establishment in this service by end of calendar year 2022.

During January and February 2020, the CQC undertook a Well-Led Inspection and an inspection of a number of core services including End of Life Care, Children and Young People’s Services, Adult Community and Specialist Services and Learning Disability Services. The Trusts’ CQC Inspection Report was published on 27th May 2020 and the outcome of the inspection can be seen in the ratings grid below.

In summary, the Trust remains Requires Improvement overall with 30 out of 36 services rated as Good or Outstanding. We have been rated overall Outstanding for Caring. 5 of our 6 core services are rated Good, and our children’s services rating has improved to Requires Improvement. Our one remaining Inadequate rating (in the responsive domain for children’s services) applies to long waiting times for specialist children’s services (including neuro-developmental assessments), which it is recognised we are working to address.

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Apr 2020	Good → ← Apr 2020	Outstanding ↑ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement → ← Apr 2020	Requires improvement → ← Apr 2020

Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2020	Good Apr 2020	Outstanding Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Community health services for children and young people	Requires improvement ↑ Apr 2020	Requires improvement Apr 2020	Good → ← Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↑ Apr 2020	Inadequate ↑ Apr 2020
Community health inpatient services	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good → ← Apr 2020	Good → ← Apr 2020	Outstanding → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020
Community dental services	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014	Good Sept 2014
Learning disabilities services	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020	Good → ← Apr 2020

Our full CQC report can be accessed via the following link: *https://www.cqc.org.uk/provider/RYW*

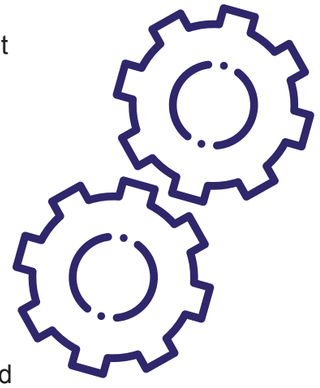
Safe, High Quality Care

- A Quality Improvement (QI) Strategy 2020-2022: BCHC Improving Together has been developed and was approved by Trust Board in July 2020. The Improving 2Gether Forum was launched in December 2020, the forum has provided an opportunity to bring together the Clinical Governance and Quality Improvement Teams to develop a co-ordinated approach to supporting shared learning across the organisation.
- The Children's and Families Division have developed an 11 point plan which encompasses all of the focus areas for improvements across Children's services. Progress against this plan is monitored monthly, by the Children's Health Improvement Group (CHIG).
- The leadership structure at the C and F division has been amended with new roles to strengthen the divisional leadership. The Triumvirate continue to be visible to teams undertaking visits to bases to hear staff's lived experience and support unblocking any daily issues they may be experiencing.
- There have been various work streams developed to support the recruitment and retention of the Health Visitor workforce.
- A Health Visitors Council has commenced.
- The Data Quality Lead, safety huddles, monthly updates and tutorials embed data quality procedures and processes across the health visiting teams. This is evident via the significant improvement of the data on our key areas, which is monitored at clinical data quality meetings.
- Introduction of specialist Health Visiting roles for children in temporary accommodation continues to work well.
- Agile working has progressed in Health Visiting and this has been mostly due to COVID-19. "Attend anywhere" enables video appointments and this is been piloted across a couple of districts. SMS messaging has been introduced to remind parents of appointments and this has also reduced DNA's, The specialist TA Health Visitor are having an impact. One example is that in partnership with Children's Centres and family action they have set up a food club in a hotel for families to access and for families in neighbouring TA. Additionally they have received funding to purchase slow cookers enabling families in hotel rooms to cook for themselves.
- The introduction of virtual breast feeding lounges and increased access to antenatal mums and new births has supported an increase in breast feeding engagement and figures.

A Great Place to Work

- A suite of communication channels were undertaken to provide colleagues with various ways to have two way communications. The weekly Thursday Senior Leadership brief is well attended, which replace the previous 'team talk'. Slides are shared following the session to be further cascaded across teams ensuring one consistent message. A variety of 'hot topics' engagement sessions have been undertaken that include working from home, lessons learnt and redeployment.
- The Trust has introduced a number of mechanisms to ensure staff are able to raise concerns this includes an email address for staff suggestions. This enables staff and colleagues across the organisation to email any concerns or suggestions directly to the Chief Executive. Freedom to Speak up champions have been offering drop in clinics across BCHC sites which also encourages staff to utilise the email feedback process.
- An anti-racism campaign has been launched and a Service Equality working group established.
- Over 400 VIP awards have been presented across the Trust by line managers, leaders and executives providing opportunities for colleagues to engage and chat. Pictures have been shared on social media.
- Recognising the increased impact of the pandemic on BAME staff, the Trust identified five commitments to support colleagues. All five commitments were met and there continues to be an emotional and spiritual support package in place for BAME members of staff.
- Proposal for Reverse Monitoring has been approved at Executive Team, the model is to be implemented over the next few months
- The INSPIRE Leadership Course commenced mid-September, this was slightly later than planned however changes had to be made to the course to ensure that the course can be delivered virtually.

Making Good Use of Resources



- Digital Transformation has been a key focus for the Organisation Work has been progressed around developing an Electronic Patient Record (EPR) commencing with Adult Inpatient units and Adult District Nursing Teams. Moving to EPR will ensure that records are in a accessible form at all locations to support clinical decision making and reduce risks associated with transporting records.
- Work has also progressed on development of Electronic Prescribing; a project manager has also been recruited to this project and official communication has been received from NHS Digital confirming approval of a funding bid to support this work.
- We are continuing to implement virtual consultations utilising 'Attend Anywhere' software.
  69 services are currently using the system and the numbers of consultations are continuing to grow and remain a key focus to support COVID-19 recovery.

Integrated Care in Communities

- A new Engagement Strategy for Patients, Service Users and Communities has been developed. This was approved by Trust Board in September 2020. The community elements of this strategy will be driven forward by the newly appointed Associate Director of Community Engagement and Partnerships. This post will focus on the delivery of the community elements of the Engagement Strategy.
- In July 2020, an engagement toolkit 'What Matters to You' was published on the Trust Intranet page for colleagues to access and utilise.
- Working with BSoL CCG we have developed a Medical Examiner role to learn from deaths in community and primary care settings. A member of staff has been identified to pick up this role from April 21.

Well Led

- The Board commissioned GGI to undertake an initial piece of assessment work around the Board Development Programme. GGI have now provided a draft report which is currently being reviewed by the Chair and the Chief Executive.
- The Board is currently starting a procurement process through which we will be commissioning an independent party to support in the production of a Board Development Programme.
- There is now a bespoke leadership programme in place for Health Visiting teams. Feedback from the first phase of staff has been sought. Weekly divisional leadership meetings have been developed for Children's Community Services to strengthen the governance systems and processes in place. This will ensure that risks and issues are identified and resolved more effectively.
- A full review of the end to end Freedom of Information (FOI) process has been led by the Data Protection Officer (DPO) in conjunction with the Information Governance Team. Following this review, a Standard Operating Procedure (SOP) has been developed and implemented; the SOP represents a streamlined process to facilitate improved response times. The DPO has briefed the Information Governance Team and the SOP has been made available to all colleagues on the intranet.

Information Governance (IG)

Information Governance is the way by which the NHS handles all organisational information, but particularly personal and sensitive information about patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, ethically, confidentially, securely, efficiently and effectively, in order to deliver the best possible care.

As a result of the pandemic the deadline for submission of the Trust's Data Security and Protection Toolkit (DSPT) for 2019-20 was extended by 6 months to 30 September 2020. Following its submission the Trust was assigned the status "Standards Not Met - Plan Agreed" and was required to submit an Improvement Plan setting out how it would meet the required standards in those areas where the relevant assertion had not been met. Broadly, these consisted of meeting the mandatory training requirement of 95% of all staff having undertaken data protection training and a number of areas relating to the Trust's digital agenda, including patching of unsupported systems and undertaking penetration testing. An update to that Improvement Plan was submitted in February 2021 and the Trust continues to make progress against that Improvement Plan, in line with its strategic aim to make good use of Trust resources.

Alongside delivery of that Improvement Plan the Trust has also been working towards delivering the 2020-21 DSPT, a baseline submission (an unpublished interim submission) was made in February 2021, the Trust is working towards a final submission date for its 2020-21 DSPT of 30 June 2021.

Clinical Coding

Clinical Coding is "the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention into a coded format" which is nationally and internationally recognised.

Birmingham Community Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020-21.

Data Quality

Data quality is the assessment of the data fitness to serve its intended purpose in a given context and its typically quantified by factors such as accuracy, completeness, reliability, relevance and how up to date it is. Good quality information is a fundamental requirement for the Trust to conduct its business efficiently and effectively.

This applies in all areas of activity including the delivery of care to service users, service management, contract and performance management, corporate governance, internal and external accountability and communication. This commitment includes governance, policy, process, training and monitoring. Data Quality is the responsibility of all staff who record information whether on paper or by electronic means. Staff have a responsibility to take care and ensure that the data is accurate, as complete as possible and up to date.

Birmingham Community Healthcare NHS Foundation Trust will be taking the following actions to improve data quality.

- We will increase the focus on standardisation for the use of system hierarchies across Trust systems
- We will monitor this standardisation process and output through Trust data warehouse technologies and reporting
- Continue to implement online Trust approved web forms and applications that enable capturing of data in controlled and validated ways
- Ensure all Trust systems continue to have adequate and readily available training that promotes standards and meet user requirements, leading to a more consistent user knowledge and behaviour, resulting in an overall improvement in data quality
- Continue with Trust data quality initiatives to ensure standards are adhered to and systems are continuously validated and aligned to operating procedures
- Automation of all possible manual tasks through technology, leading to reduction in manual data entry errors, resulting in an overall improvement in data quality
- Ensure information is accessible daily on the Trust's dashboard portal, to highlight and aid correction of any data quality issues
- Promote the Trust's 2020 data quality policy

These actions are underpinned by the Data and Information Strategy 2019-22, the annual information programme plan and governed by the Trust's information board

Learning from deaths

Division	Adult and Specialist Rehab	HMP Birmingham	Adult Community Services	Learning Disabilities	Children and Families
No. of deaths	210	7	17	67	104

During 2020-21, 405 of Birmingham Community Healthcare NHS Foundation Trust patients died, in accordance within the scope of the Learning from Deaths Policy, and which were reported through the Learning from Deaths programme and the data presented to the Mortality and Deteriorating Patients Committee. This comprised the following number of deaths which occurred in each quarter of that reporting period:

119 in the first quarter

72 in the second quarter

105 in the third quarter

109 in the fourth quarter

By 31/03/2021, 200 case record reviews/investigations had been carried out in relation to 209 of the 405 deaths. In 200 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

74 in the first quarter

29 in the second quarter

51 in the third quarter

46 in the fourth quarter

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

0 0% for the first quarter

0 0% for the second quarter

0 0% for the third quarter

0 0% for the fourth quarter

These numbers are exact using the Trigger Tool Case Note Review method applying the Hogan and Black scale.

(Reference; Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study, Helen Hogan, Frances Healey, Graham Neale, Richard Thomson, Charles Vincent, Nick Black. BMJ Qual Saf 2012;21:737-747).

Learning

The learning is identified from the screening and case record reviews undertaken of the deaths "in scope" in accordance with the Trust policy on identifying, reporting, investigating and learning from deaths in care. Reports are presented every quarter to the Trust Board.

The Trust supported the resources to implement the Child Death Review process and the ongoing commitment to the Adults programme to comply with the CQC Learning from Deaths national guidance. For 2020 -21 Adults Specialist and Rehabilitation Division, Learning Disabilities, Adults Community and Children and Families Division have identified key themes for learning and improvement some of which are from gaps in practice and also includes good practice.

Themes leading to improvement include as follows:

1. Cases have identified management of hydration, including prescribing, management of fluids and fluid balance monitoring. This is included in training and awareness sessions including the doctor's induction programme.
2. Teaching programmes have been developed and delivered to address constipation assessments and bowel care management.
3. The Learning Disability service has developed Standard Operating Procedures for visiting to support family and friends visiting their units with Advanced Life Care Plans and ReSPECT forms for their units in an easy to read format. They have instigated virtual ward rounds supported by GP and Matron and also have established 10 End of Life Champions in the division.
4. Learning across the care pathway for End of Life Care in children and adults services to encompass a system wide partnership improving palliative care across Birmingham. For Children, this included working closely with Acorns Hospice with some good examples of cases. Working well with St Marys Hospice and John Taylor Hospice on virtual training packages for adults community, care homes and inpatients; Teaching sessions have also been delivered to consultants and senior clinicians in inpatients by the QEHB Lead Consultant on End of Life and Palliative Care.
5. Verification of death training has also been a part of the improvement work for community, Learning disabilities and care homes. Development of a 24 hour community nursing services model is underway to support the night service to be experienced in the verification of death and end of life care. Patient Safety has worked with Legal Services and the Clinical Lead Consultant to develop new guidance for inpatients to support the accuracy and cause of death recorded on death certification and referral to the Coroners.
6. Bereavement support is a key improvement in the Learning from Deaths plan with memory boxes purchased for children and adults; refurbishment of the bereavement room at Moseley Hall Hospital and "Dandelion bags" for families for personal belongings.
7. Spiritual care was noted with a range of support required for patients and their families. The Director of Nursing and Therapies is leading a Trust wide improvement programme and this has been welcomed by staff to support their patients.
8. Opportunities taken with redeployment of staff have also meant that dental staff working with the inpatient teams to develop a work programme around "Mouth Care Matters" and raising awareness, better care planning and use of resources has improved this for patients.

9. The Child Death Review process supported the need for two palliative care posts within the palliative care team to be made permanent. This was successfully achieved.
10. The Child Death Review Process has identified good communication with the Children's Acute Palliative Care and Complex Care Teams and that this has been as a consequence of the joint palliative care consultant post for BCHC and the Children's Hospital. It has also been noted through the Child Death review process excellent communication between secondary, tertiary, community pharmacy, Acorns Hospice and the Palliative Care team, good symptom control for end of life care.

5 case record reviews and 5 investigations completed after 31/03/2020 which related to deaths which took place before 31/03/2020. These reviews were undertaken in the month of April 2020 and wholly related to patient deaths that occurred in March 2020.

0 representing 0% of the patient deaths before 31/03/2020 are judged to be more likely than not to have been due to problems in the care provided to the patient. This number is exact using the Trigger Tool Case Note Review method applying the Hogan and Black scale.

0 representing 0% of the patient deaths during 2019-20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

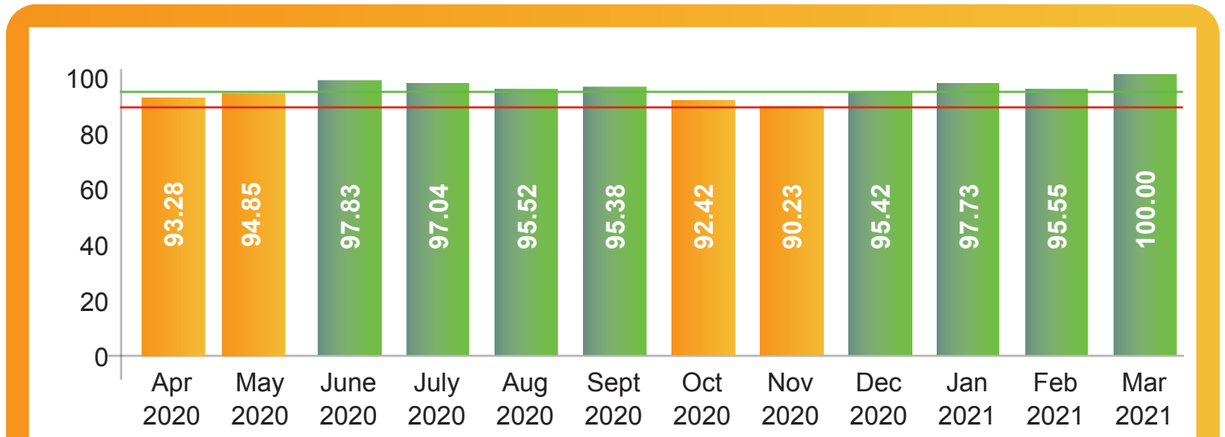
Care Programme Approach

Indicator: the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

The Care Programme Approach (CPA) is a partnership working model used in secondary mental health and learning disability services to co-ordinate care, treatment and support for people with complex needs, relating to their mental health or learning disabilities. The Learning Disabilities Division monitor two indicators relating to this model. The first are patients who should receive a follow up consultation within 7 days of discharge from an inpatient facility and it is positive to report full achievement of this target.

Last year the service report full compliance with the seven day target. However in 2020/21 activity was lower than usual due to the impact of the coronavirus pandemic. As a result the annual total is based on just one patient who was discharged in October 2020 and who was seen for a follow up appointment within the seven day window.

The second measure relates to people who are living in the community on a Care Programme Approach and who should receive a formal review at least annually. The service delivers around 135 reviews each month and performance in 2020/21 is shown in the graph below.



Whilst the pandemic may have caused some challenges with reaching individuals it is nevertheless positive to report over between 90% and 100% of contacts taking place each month.

BCHC considers that this data is as described as the number of referrals to BCHC during 2020-21 was only 1, therefore the volume was low and the service have been able to prioritise seeing these patients.

Emergency readmissions within 30 days of discharge

Indicator: the percentage of patients aged: (i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Readmission rates were a nationally mandated measure to monitor the safety of patient discharges and to ensure that in particular acute Trusts were not discharging patients earlier than is safe. The NHS Standard Contract for 21/22 states that Trusts and Commissioners should work together to 'avoid circumstances and transfers and/or discharges likely to lead to emergency readmissions' but sets no particular standard. Meanwhile NHS Digital are reviewing an experimental measure to monitor all emergency admissions which take place within 30 days of any discharge from hospital although they have paused this review during the pandemic.

(https://digital.nhs.uk/data-and-information/publications/statistical/ccg-outcomes-indicator-set/october-2020/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-ccg/3-2-emergency-readmissions-within-30-days-of-discharge-from-hospital)

In the absence of a national mandate the Trust continues to monitor situations in which patients are readmitted to one of our own beds within 30 days of discharge from our care.

2020/21 30 day emergency readmissions (BCHC only)

Original discharge month	30 day emergency readmissions	Total discharges	% 30 day emergency readmissions
Apr-20	7	287	2.4%
May-20	11	255	4.3%
Jun-20	5	304	1.6%
Jul-20	7	305	2.3%
Aug-20	4	263	1.5%
Sep-20	6	260	2.3%
Oct-20	4	260	1.5%
Nov-20	5	278	1.8%
Dec-20	4	265	1.5%
Jan-21	2	274	0.7%
Feb-21	3	239	1.3%

As shown in the table above throughout the year a very low level of patients have been readmitted suggesting that discharge has been carried out safely. However an increase in the levels of readmissions is noted at the start of the year during a time when community Trusts including BCHC were given new guidelines relaxing discharge criteria in order to free up space in acute hospitals managing the first wave of the pandemic.

It is also important to note that readmission to a community trust within 30 days is not necessarily a reflection of poor discharge practices and that in most emergency situations admission would be to an acute Trust and would therefore not register against this definition.

NHS Number and General Medical Practice Code Validity

Birmingham Community Healthcare NHS Foundation Trust submitted records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

These are 2020/21 figures (to date):

% with valid NHS number

	Inpatients	Outpatients
Numerator	3271	204307
Denominator	3334	204578
Percentage	98.1%	99.9%

% with valid GP practice code

	Inpatients	Outpatients
Numerator	3265	200672
Denominator	3334	204578
Percentage	97.9%	98.1%

Medical Revalidation

Revalidation is a process by which clinical staff demonstrates to the Trust and their professional body that they are up to date, fit to practice and complying with the relevant professional standards.

In the 2020-21, revalidation and appraisal was put on hold. The new Responsible Officer (RO), leading on revalidation for medical and dental staff is Dr Doug Simkiss.

Staff Survey 2020

The National Staff Survey was undertaken by our contractor Quality Health for a total of 121 NHS organisations between September and December 2020.

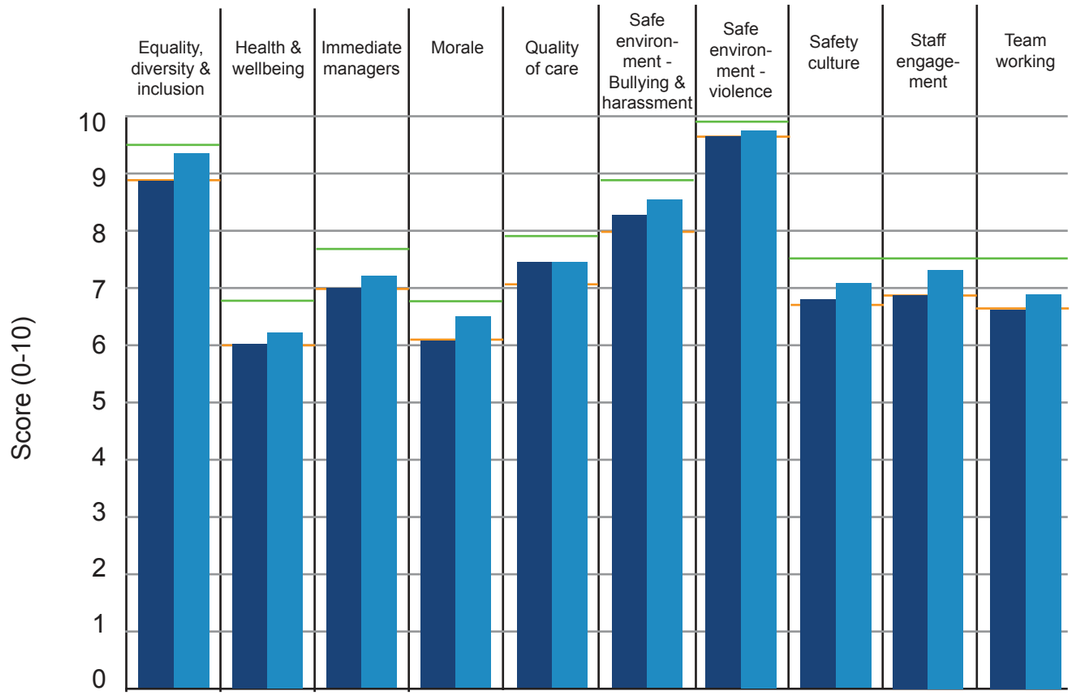
The annual Staff Survey 2020 questionnaires were sent to **4,738** eligible colleagues at BCHC through both online and paper surveys.

Each staff member could only receive one type of questionnaire.

Colleagues selected to participate online were sent an email invitation directly to their work email address inviting them to securely log into the online questionnaire portal and provide their responses. Colleagues selected to complete paper questionnaires received these through our organisation's internal post.

From the usable sample, **2,036** questionnaires were returned yielding a response rate of **43%.**

BCHC theme score



Best	9.5	6.7	7.6	6.7	7.9	8.9	9.9	7.5	7.5	7.5
Your org	8.8	6.0	7.0	6.1	7.5	8.2	9.6	6.8	6.9	6.6
Median	9.4	6.3	7.2	6.5	7.5	8.5	9.7	7.1	7.3	6.9
Worst	8.8	6.0	7.0	6.1	7.1	8.0	9.6	6.7	6.9	6.6
Response	2,017	2,025	2,023	2,019	1,724	2,006	2,013	2,028	2,026	1,979

Staff Survey 2020 Results

Overall our scores have remained broadly the same.

The results are broken down into 10 themes. Our scores across the 10 themes show no significant difference in relation to the 2019 score. No further comparisons could be drawn.

Whilst it is positive to note no significant deterioration has occurred, the Trust remains below average for comparator organisations in 9 of the 10 themes.

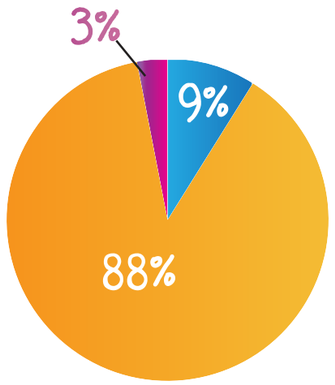
The table below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the comparator organisations* scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity and inclusion	**8.9**	1813	**8.8**	2017	Not significant
Health and wellbeing	**5.9**	1820	**6.0**	2025	Not significant
Immediate managers	**6.9**	1826	**7.0**	2023	Not significant
Morale	**6.0**	1798	**6.1**	2019	Not significant
Quality of care	**7.5**	1540	**7.5**	1724	Not significant
Safe environment - Bullying and harassment	**8.1**	1789	**8.2**	2006	Not significant
Safe environment - violence	**9.6**	1797	**9.6**	2013	Not significant
Safety culture	**6.8**	1820	**6.8**	2028	Not significant
Staff engagement	**7.0**	1834	**6.9**	2026	Not significant
Team working	**6.7**	1796	**6.6**	1979	Not significant

**The comparator group is made up of 15 community trusts BCHC are benchmarked against nationally.*

Headline finding - Question Benchmarking



2 (3%) question(s) scored significantly better than the sector*

69 (88%) question(s) scored significantly worse than the sector

7 (9%) question(s) showed no significance in relation to the sector average or comparisons could not be drawn

**The sector score is also the comparator score.*
It is the national average score for community trusts.

Some of the areas where the Trust saw significant improvements are:

- Q4e. I am able to meet all the conflicting demands on my time at work (+5%)
- Q4f. I have adequate materials, supplies and equipment to do my work (+3%)
- Q4g. There are enough staff at this organisation for me to do my job properly. (+5%)
- Q11a. Does your organisation take positive action on health and well-being? (+4%)
- Q11d. In the last three months have you ever come to work despite not feeling well enough to perform your duties? (lower the score the better -9%)
- Q16c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (+4%)

Areas of concern with a focus on improvement:

- Q3a. I always know what my work responsibilities are (-4%)
- Q5g. How satisfied are you with level of pay (-4%)
- Q9d. Senior managers act on staff feedback (-4%)
- Q11b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? (+5%)
- Q11c. During the last 12 months have you felt unwell as a result of work related stress? (+4%)
- Q11e. Have you felt pressure from your manager to come to work? (+4%)

Key Priority Areas For Action

The Trust has therefore prioritised the endorsed 5 themes from 2019 to be taken forward in 2021 in response to the results:

1. Immediate Managers
2. Equality, Diversity and Inclusion
3. Health and Wellbeing
4. Safety Culture
5. Safe Environment - Bullying and Harassment

Each of these themes are consistent with the Trust's Fit for 2022 plans and strategic objective to become a 'Great Place to Work'.

Venous thromboembolism (VTE)

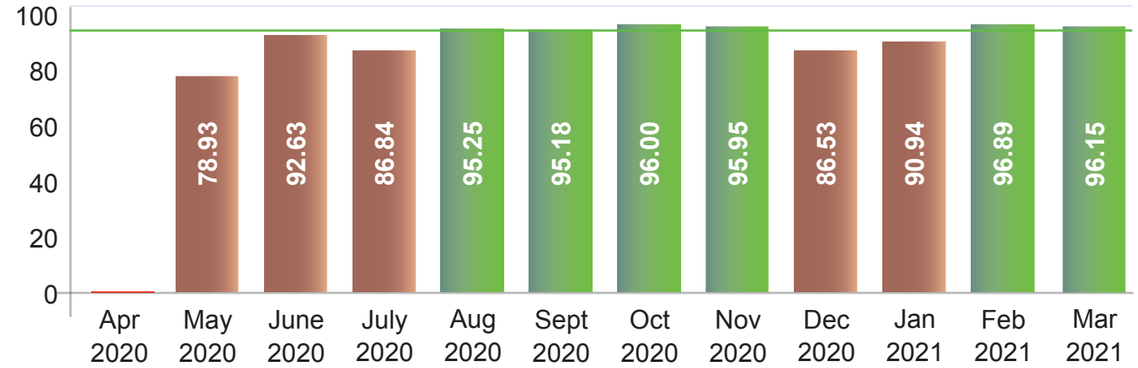
Venous thromboembolisms (VTEs) are blood clots which form in veins and can then spread to other areas forming dangerous blockages.

VTEs are a key risk for immobilised and especially post surgery patients. As a result we are required to risk assess all adults who are admitted to our in-patients for VTE within 24 hours of their admission using the criteria in the National VTE Risk Assessment Tool. Where patients are found to be at high risk of developing VTEs we can then take appropriate measures to reduce this risk such as medication and use of compression stockings.

Indicator: the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Percentage of patients assessed for VTE within 24 hours of admission

Percentage of patients assessed for VTE within 24 hours of admission



Clostridium Difficile

Indicator: the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

The Trust had 4 cases of Clostridium difficile infections in 2020-21. All cases have a detailed root cause analysis completed which is reviewed by the commissioners. Each case reviewed in 2020-21 has been classed as unavoidable. This means that there was nothing the Trust could have done to prevent these cases. Birmingham Community Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: Data is received from specimen laboratories directly.

This data is also checked through a national database by commissioners monthly. Birmingham Community Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and therefore improve the quality of its services, by ensuring that when a case of Clostridium difficile occurs on a ward an Enhanced Clostridium difficile audit is completed by the Infection, Prevention and Control Team every week until the unit achieves a compliance score of 95% or above for 3 consecutive audits- this is to thus ensuring good practice is imbedded into the unit. The tool also gives us greater quality assurance of the prevention and control of infection in the unit.

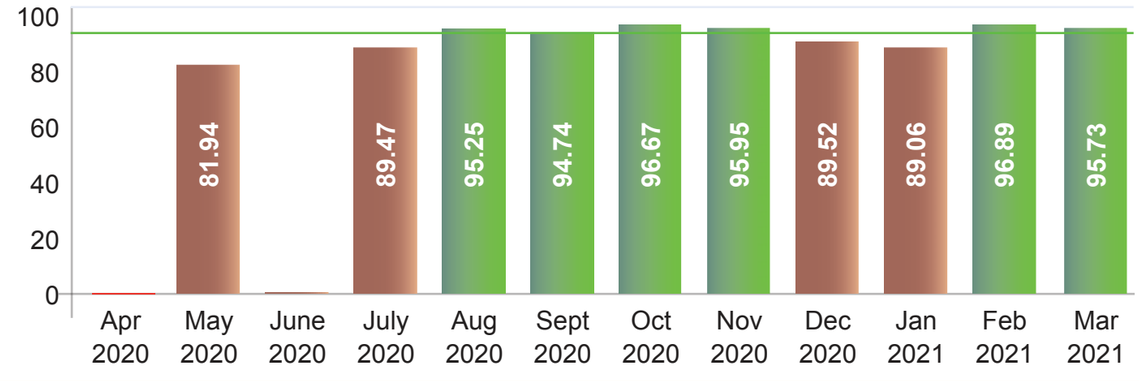
Where a clinical area does not achieve 3 consecutive scores of 95% within 6 weeks of the audits commencing this is escalated to the Lead Matron.

Methicillin-resistant Staphylococcus Aureus (MRSA)

Methicillin-resistant Staphylococcus Aureus (MRSA) refers to a group bacteria that are genetically distinct from other strains of Staphylococcus aureus.

MRSA is responsible for several difficult-to-treat infections in humans and can spread easily. As a result all patients have to be screened for MRSA on admission and where infection is found patients will be treated and steps put in place to ensure that the infection does not spread to other patients.

Percentage of patients assessed for MRSA within 24 hours of admission

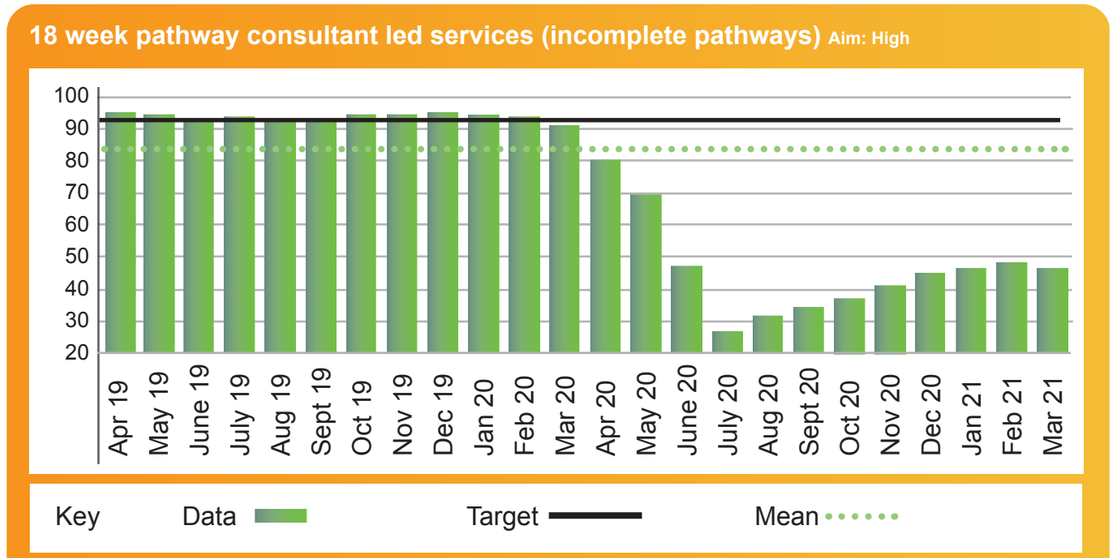


As shown in the graphs above performance for screening patients for VTE and MRSA on admission has been mixed this year. In the initial few months of the pandemic neither audits were carried out due to lack of capacity to audit notes (however the assessments continued to take place). When audits resumed it is apparent that there had been a reduction in the levels of assessments taking place within the target timeframe. The reasons for this are varied but will largely relate to increased activity in the initial stages of the pandemic and high turnover of staff with increased use of agency and redeployed staff who will have been less familiar with some processes. It is also possible that in many cases the audits may have taken place but not have been recorded on patient notes for the reasons outlined above, again due to the high turnover of staff. However it is positive to note that outside of the two main waves of COVID-19 the wards have managed to maintain high level of consistence with the audits and as we approach the end of the year are returning to normal performance. Each month the number of assessments reported has been between over 200 and some months over 300 reflecting the increased activity on inpatient units this year and giving us assurance that the assessment is reporting a representative position covering most admissions.

Incomplete Pathways

Incomplete pathways represent those patients who have been referred on to consultant led referral to treatment (RTT) pathways, but whose treatment had not yet started at the end of the reporting period. The incomplete waiting time standard was introduced in 2012 and states that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways.

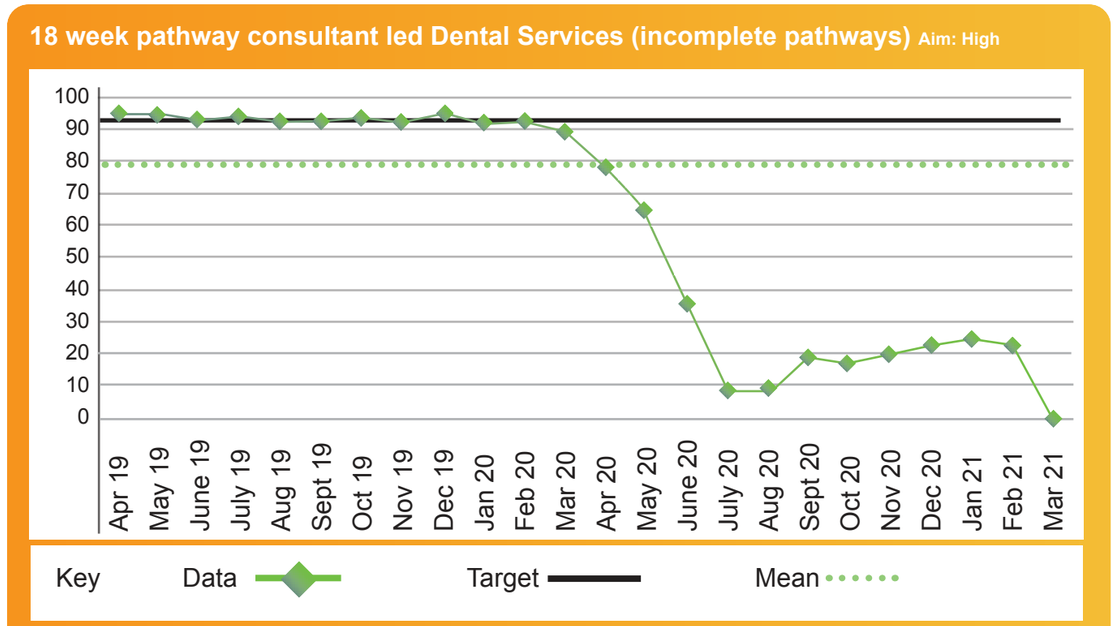
Whole Trust 18 week RTT Incomplete Pathways (patients waiting for treatment)



As shown in the graph above throughout previous years the majority of patients waiting for treatment on consultant led pathways have been seen within 18 weeks of their referral. The nationally set target is 92% and we had achieved this consistently until March 2020 when many patients had their appointments cancelled due to risk of COVID-19 infection leading to unavoidable increases in their waits for treatment. The percentage of RTT patients waiting less than 18 weeks then fell each month until July when we reported just 26.78 of patients on consultant led pathways with waits of less than 18 weeks. This figure represented 7,112 patients waiting over 18 weeks from a total of 9,713 patients on RTT pathways.

Since then performance has improved although it is still far below targets. At the end of the year we report 5,777 patients waiting over 18 weeks from a total consultant led waiting list of 13,316 patients.

Dental Service 18 week RTT Incomplete Pathways (patients waiting for treatment)



RTT consultant led waits over 52 weeks have continued to rise throughout the year and the majority of the Trust's patients who are in this group are patients at the Dental Hospital. At the end of March all but 11 of the Trust's patients over 52 weeks on RTT pathways were at the Dental Hospital.

In addition to the national focus on consultant-led pathways, many of our patients are being treated on non-consultant led pathways. In 2019/20 services across the Trust had focussed on all patient waits from initial referral to first treatment and also looked at reasons why patients who have already began treatment have not been seen for 52 weeks or longer.

We had shown great success in reducing waits over 52 weeks in the previous year. Partly this was due to resolving data quality issues with the Trust developing live information systems and individualised processes and Standard Operating Procedures to support individual services in managing their waits and removing patients who were no longer waiting for treatment. However this work was significantly challenged by the pandemic with services across the Trust paused and only able to respond to the most urgent needs.

Waits for first treatment have increased steadily throughout the year from a low of 1,788 in March 2020 to a high of 6,149 in February 2021. It is therefore positive to report an improvement in the figures with March's unseen caseload dropping to 5,481 as services recommence a full service offering and develop new ways of delivering COVID secure appointments including increasing use of virtual contacts.

Patient Safety Incidents

An incident is any event which has given rise to actual harm or injury or damage to/loss of property. This definition includes patient or client injury, fire, theft, vandalism, assault and employee accident. It also includes incidents resulting from negligent acts, deliberate or unforeseen.

Indicator: The number and, where available, rate of patient safety incidents reported within the Trust during 2020/21, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Year	Total Incidents	Severe	Death	Total	%
2020/21	10849	69	110	179	1/6
2019/20	10809	42	106	148	1.4
2018/19	8343	25	49	74	0.88
2017/18	7450	45	41	86	1.15
2016/17	7044			26	0.4

The Trust continues to report all patient deaths in compliance with the National Quality Board 'National Guidance on Learning from Deaths' March 2017, which was reinforced by the findings of the Care Quality Commission (CQC) report Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. Previously all in-patient deaths were subject to review, however, all patient deaths notified to or noted by BCHC are also reported. This included community patients with a Learning Disability, or older adults who were visited by the Adult Community Services District Nursing teams, or children under the caseload of the Children and Families Division, even if the death was not linked to BCHC care. The data above includes incidents reported under these criteria and accounts for all incidents recorded as 'deaths'.

There have been no deaths reported which have been reported as a Serious Incident.

Birmingham Community Healthcare NHS Foundation Trust considers that this data is as described because the Trust has a single incident reporting system (Datix) which can be accessed by all staff. Each incident is assigned a 'handler' who manages the incident to ensure that all information is accurate.

Birmingham Community Healthcare NHS Foundation Trust continues to introduce initiatives to ensure that the quality of its services remains high and that we learn from incidents.

It is important, however, to emphasise that incident reporting is encouraged to ensure that the Trust is open and transparent.

Reported Incidents

All incident data correct at 30/04/2021

During the period 1 April 2020 and 31 March 2021 a total of 10849 incidents have been reported.

Incident by type

Incident Type	Total 2020/21	Total 2019/20	Total 2018/19
Information Governance	**353**	322	315
Fire Safety	**30**	41	28
Infrastructure	**394**	383	320
Medication, Medical Gas, Medication Delivery System	**751**	872	776
Patient Incident*	**7846**	7368	5357
Security	**364**	366	365
Staff, Visitor, Contractor Incident	**1111**	1457	1182
Total	**10849**	10809	8343

**Changes to include the reporting of Deep Tissue Injury/Moisture Associated Skin Damage as incidents*

Top 3 Incidents

Top 3 Incidents	Incident by type	2020/21	2019/20	2018/19
Patient Incident	Care delivery (inc. pressure ulcers)	4919	3872	2115
	Admission, transfer, discharge, access to services	597	832	649
	Slips, trips, falls	633	633	751
Staff, visitor, contractor incident	Violence, abuse, assault	534	573	411
	Staffing issues	229	443	330
	Contact injury	81	89	82
Medication	Administration	430	474	383
	Prescribing	106	120	119
	Storage	31	114	82

Serious Incidents

The Trust reported 146 Serious Incidents in 2020/21, of which a total of 23 were reclassified, leaving a total number of 123. This compares to a total of 105 Serious Incidents being reported during 2019/20. The reported Serious Incidents for 2020/21 have been summarised below:

Type	Total
Alleged abuse of child patient by staff	1
Category 3 Pressure Ulcer	56
Category 4 Pressure Ulcer	40
HCAI/Infection Control	15
Slips trips and falls	9
Sub-optimal care of the deteriorating patient (NG Tube incident)	1
Surgical/invasive procedure incident meeting SI criteria – (Never Event)	1
Total	**123**

14 of 15 HCAI Serious Incidents were Ward closures due to COVID-19.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

During the period 2020/21, the Trust reported One Never Event in the Dental Division - Wrong Site Surgery - Wrong tooth Extraction. Moving forward to 21/22 - Wrong tooth extractions will not meet the criteria for a Never Event.

Patient and Service User Experience

We have continued to listen to feedback from patients with Friends and Family Test (FFT) scores indicating a high level of satisfaction by respondents.

The reporting of Trust-wide Friends and Family Test (FFT) responses was paused during Quarter 4 2019/ 2020, in line with national guidance, despite this we continued to collect feedback albeit in lower numbers. It is also important to note that the Trust previously asked the national FFT question and an additional question about how the person would rate the service they received.

It is particularly pleasing to report these high levels despite the pressures facing the NHS during the COVID pandemic over this last year and the scores are a testament to the professionalism and commitment all staff.

A new FFT question was introduced nationally from 1st April 2020, which now asks about the experience of the patient / carer, “Thinking about the service you have received today, please tell us overall how was your experience” rated as Very good/ Good / Neither good nor bad /Poor / Very poor/ Don’t know. This replaces the previous two questions rating likelihood to recommend and rating of service.

Friends and Family Test

month	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2012	March 2021
%	97	97	96	95	98	98	98	99	100	99	98	100

Feedback from patients using Attend Anywhere virtual consultations

As part of the Trust’s response to COVID-19, to keep patients and colleagues as safe as possible, a digital first strategy has been implemented including a remote consultation/appointment offer (by phone or video) prior to face to face consultation.

This has the benefit of providing a service to patients whilst managing the risk of transmission of the virus. Feedback is collected from patients at the end of their consultation.

A patient/service user experience question was added over the summer period and was rated using the new FFT descriptors:

- very good
- good
- neither good nor bad
- poor
- very poor.

month	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2012	March 2021
%	100	96	98	95	94	96	97	94	95	95

Complaints

Top 5 Complaints

1. Lack of care and support
2. Manner and attitude
3. Delay as a result of staff action
4. No contact from the service
5. Awaiting assessment

Number of Complaints by Division

Division	Number of Complaints
Adult Specialist Rehabilitation	46
Adult Community Services	40
Children and Families	35
Dental	24
Learning Disability	7
Corporate	2
Nursing and Therapies	1
Trust Total	**155**

Total Activity by per 100 WTE staff

	2020-21	2019-20
Total WTE	53,449.50	48,299.25
Number of Complaints	155	234
Complaints per 100 WTE staff	0.29	0.48

Actions and lessons learned from complaints:

Trust Value: Caring

Concerns were raised by a patient's son in regard to the care his mother received from the Early Intervention Community Team (EICT) during her admission to the Kenrick Centre. Issues raised included catheter care, manual handling and personal care. The issues raised were discussed with the team at length, with staff required to participate in refresher training on catheter care by end December 2020, and two members of the team asked to undertake a reflective account of the patient's care. The team has also offered to meet with the patient and her family, in an attempt to restore confidence and rebuild the relationship; providing the family with the opportunity to discuss their experiences and consider the patient's care and support needs going forward.

Trust Value: Inclusive

Concerns were raised by a family in respect of their child's package of care provided by the Complex Care Service, with the suggestion that the refusal of the service to provide 50% of the child's school package within the home environment was due to discrimination and direct abuse of her personal health budgets. Assurances were offered within the complaint response that this was not the case and, following liaison with the commissioners of the service, it was explained that the school care package was there to provide children with complex health needs access to education and therefore hours were not automatically given at home in the event that the child no longer attended school. It was acknowledged that a formal discussion with the complex care team, commissioners and the family, at the time of reducing the child's school hours and costings being reassessed, would have helped significantly. It was also agreed that the service's 'Agreement to Care' standard operating procedure would be updated, to include information about what would occur should a child's hours at school change. In addition, the commissioners have developed a parent information leaflet which includes information on school attendance and is now available for families.

Trust Value: Respectful

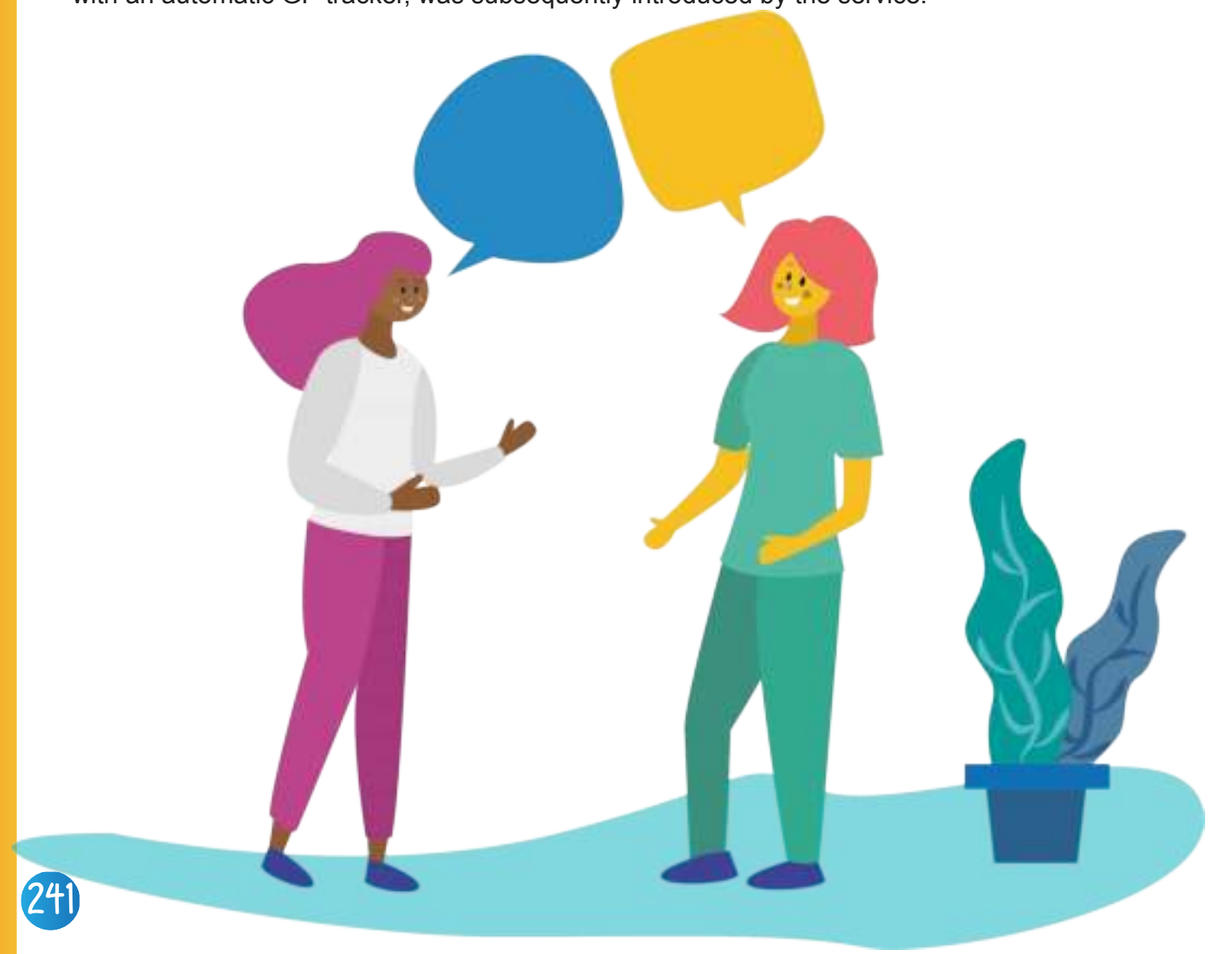
Concerns were raised by a family in regard to the actions of a Community Paediatrician during a child's appointment, specifically, comments made about the detail within a report from a clinician in Poland. The investigation identified that the report was much briefer and in a very different format to those previously experienced by the clinician, and this had given rise to confusion as to whether the report was based on observation only (via an initial assessment) or a confirmed diagnosis following full assessment. The service acknowledged that this should have been clearly explained to the family, to avoid them feeling that the report was being dismissed, and communication training is being arranged for the Community Paediatrician.

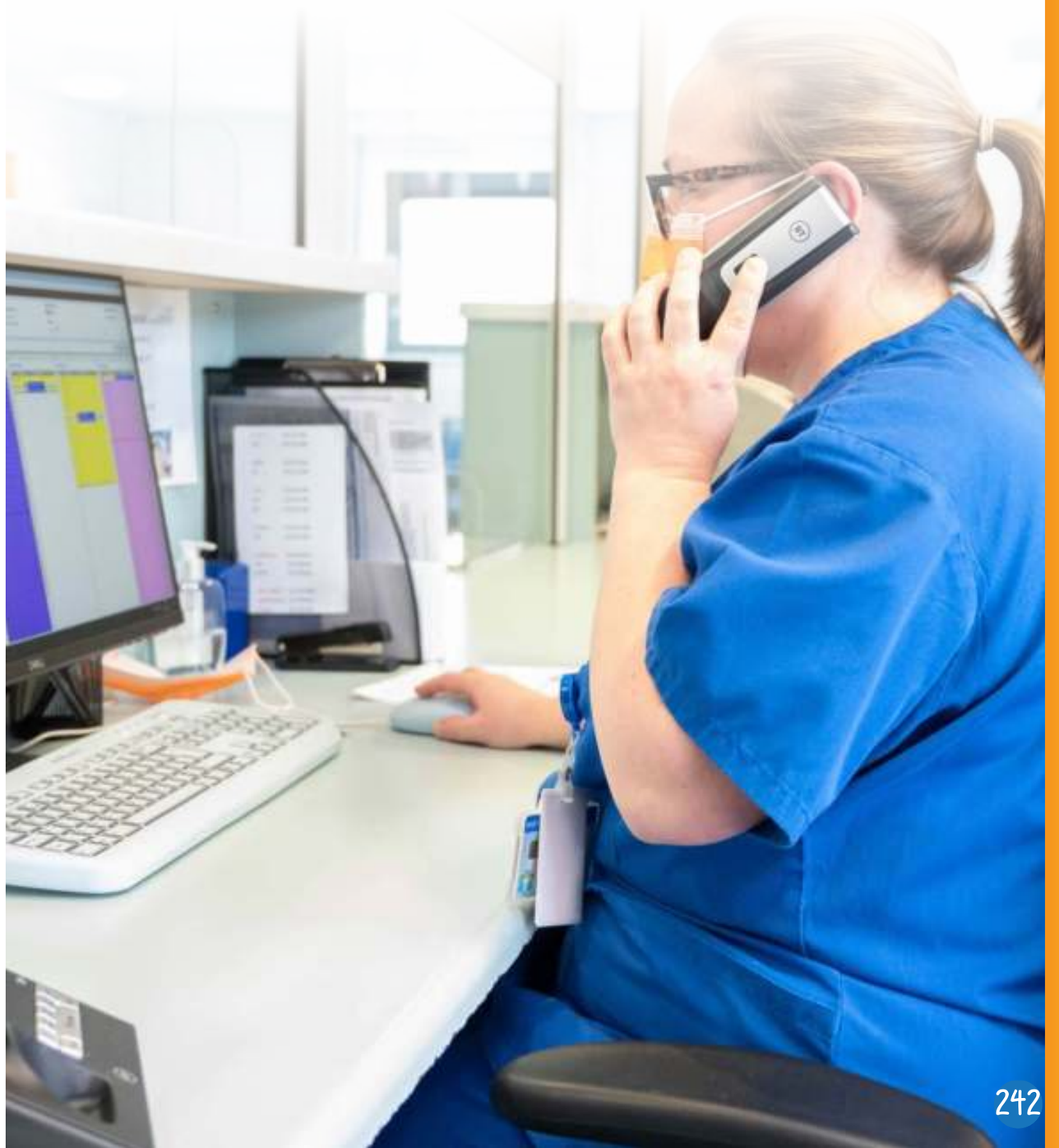
Trust Value: Open

Upon investigation of a complaint concerning the rejection of a referral to Birmingham Dental Hospital, it was confirmed that the referral from a General Dental Practitioner (GDP) had been submitted via an incorrect channel and a request for resubmission had therefore been made by the hospital. It was noted that ordinarily, the patient would not be notified of the request for resubmission, which would leave them unaware of the emerging situation with their referral. The complaint highlighted the importance of patients receiving a copy of referral rejection letters, and it was agreed to build this into the referral process. The Division committed to reinforcing the requirement during team meetings and via the Dental Services Lessons Learned bulletin, urging administrative teams to be vigilant in cross checking that all patient correspondence has been sent in a timely manner.

Trust Value: Responsible

It was identified during a complaint investigation that a child with an out of area General Practitioner (GP) had been incorrectly placed on the waiting list for speech and language therapy (SLT), resulting in the child waiting for over 12 months for therapy and then being discharged at the point of initial assessment. On being alerted to the error, the service liaised with the appropriate SLT team in a different area, to fast-track the child's appointment, and a financial gesture of good-will was offered by the Trust. A full review of children on the SLT waiting list was also conducted, to ensure the GP details for each child were correct, and a new electronic triage system, with an automatic GP tracker, was subsequently introduced by the service.





Section 3

Review of Quality Performance

Quality Indicators

Indicator	Target 2020-21	End of year position 2020-21	End of year position 2019-20
Number of Meticillin-resistant Staphylococcus aureus (MRSA) new bacteraemia cases	0	0	0
Number of Clostridium difficile avoidable cases	4	0	0
Number of falls resulting in severe injury or death	13	9	9
All Community Pressure Ulcers (monthly Target)	175	207	126
All Inpatient Pressure Ulcers (monthly target)	27	22	21
Number of Serious Incidents (cumulative)	na	143	112
Number of Never Events	0	0	0
Patient NHS Safety Thermometer (Harm FREE Care - new and old harms)	95%	98.73%	98.84%
Patient NHS Safety Thermometer (HarmFREE Care - New Harms only)	95%	99.64%	99.82%
Essential Care Indicators - Inpatients (aggregated measure)	95%	97.74%	98.40%
Essential Care Indicators - community (aggregated measure)	95%	97.04%	97.97%
Essential Care Indicators - Learning Disability Inpatients	95%	100%	98.80%
Essential Care Indicators – Learning Disability Community	95%	96.79%	97.67%
Percentage of Venous Thromboembolism (VTE) risk assessment on admission	95%	91.65%	95.16%
Written Complaints Rate (per 100 WTE Staff)	NA	0.31	0.57
Percentage of staff appraised (within 12 months)	90%	72.69%	83.74%
Percentage of sickness absence	5.21%	5.37%	7.88%
Safe staffing	90% - 110%	101.66%	109.37%
Mandatory Training Compliance	90%	87.15%	89.59%
Environmental Cleanliness	95%	95.69%	93.50%

Smallwood Library

Smallwood Library supporting Trust strategic objectives

Smallwood Library provides quality library services to all staff, students and volunteers working across BCHC. The library services not only support Trust values, but also our Strategic Objectives.

During the last year we have worked hard to re-configure services to meet the needs of colleagues working through the pandemic, and ensure that services are accessible in as many ways as possible.

The new Library Outcomes Framework, which should have been submitted in April 2020 was delayed due to the pandemic and will be submitted in September 2021 as agreed nationally.

"I asked them (the Library) to look for guidance around the retention of syringe drivers after the death of a patient. I think it's very efficient, very effective. It gave me the answers quickly when we were trying to move things along and it enabled the interim Chief Pharmacist to start drawing up guidelines for the Trust - Associate Director of Clinical Governance, BCHC."

- Develop and maintain a knowledge database of Trust publications to share learning and prevent duplication.
- Providing the evidence for services and individuals to provide the most up-to-date effective care.
- Enable individuals to be kept up-to-date in their areas of interest.
- Ensure that policies are supported by current relevant evidence, and that they are available on theTtrust intranet.

"Just wanted to give a huge thank you to @smallwoodlib @bhamcommunity helping me to find the supporting evidence for training project resulted in a #2ndprize @Clinell @ipswestmidlands"

"Concise. It highlighted a risk to training that was acted upon immediately."

- Run a monthly virtual book group to support staff wellbeing.
- Provide the knowledge and information that colleagues need to develop both personally and professionally.
- Offer library access to 24/7 so that colleagues can access a quiet place to work no matter their working hours.
- Offer a health and wellbeing collection, reminiscence collection, CDs and DVDs, fiction and materials to support to staff networks.

"The Library is a hub where I can access a lot of material quickly and it saved our service some money in that we didn't each have to go out and buy resources to look at or to study. There might also be resources where we only need a chapter in a book but we can access that book on a short loan via electronic resource through the Library so it saves us from having to buy resources which might only be partially applicable to our team – Senior Applied Psychologist, BCHC."

- Work collaboratively with other healthcare libraries locally and nationally to make joint purchasing decisions to increase value for money
- Ensure that library services are accessible to all colleagues via email, phone and post, no matter where they are based
- Encourage the use of nationally purchased resources to ensure return on investment

"I requested articles because of the piece of research we were undertaking and it was a confirmation of what others were saying. It confirmed other research findings. Sometimes I think that the Library service don't really realise, dare I say this, how helpful you are, how meaningful your contribution to research and adding to the field of knowledge, to all of the fields of knowledge because our research not only contributed to nurses knowledge but to doctors, microbiologists, and scientists knowledge" - IPCNS & Decontamination Lead, BCHC.

- Enable use of healthcare libraries across Birmingham and Solihull as part of joint working arrangements
- Work jointly with local library colleagues to provide support to local networks including STPs and the Birmingham Care Alliance
- Contribute to the shared purchase of resources for the benefit of all partners

Duty of Candour

We include openness as one of our values, and remain committed to having open and honest communication with patients, carers and people with parental responsibility when things have gone wrong or something unexpected has happened during care and treatment.

We aim to show care and concern during these conversations and correspondence, explaining things in a way that can be easily understood and answering questions and concerns to ensure you are fully informed. This is known as the Duty of Candour (DOC) and applies when there has been unintended or unexpected severe or moderate harm or prolonged psychological harm to the service user or even death.

We have processes in place to give assurance of BCHC compliance with the duty, including processes within Datix which means that relevant incidents cannot be closed without all aspects of DOC considered and fulfilled.

There is also a monthly audit of compliance with our legal and contractual duty, which is reported through governance committees, ensuring that BCHC are communicating openly and honestly with patients who are impacted when things have gone wrong. The audit helps us to understand and make necessary improvements to the quality and timeliness of letters sent to patients.

We ask patients and carers to provide feedback on our approach to duty of candour, and this helps us to make further improvements to both the process and the quality of correspondence with patients. A recent example of feedback includes a concern from a bereaved relative who found the letter and the report from the investigation into an earlier incident to contradict each other. Further exploration and discussion with the relative allowed us to reflect on how the letter was constructed and how the introduction of doubt into the letter created unnecessary confusion and further upset which could have been avoided.

Advice and Liaison Service
(Formerly Customer Service)

The Advice and Liaison Service team supports BCHC in listening to patients, service users and carers to assist in improving services for patients.

It provides confidential impartial advice and support to patients and staff, helping to sort out concerns or queries people have about their care and treatment. The team also help enquirers navigate the services provided by the Trust and signpost them to appropriate points of contact within the Trust. The Advice and Liaison Service is part of the wider patient experience team for the Trust.

When concerns are raised with the Advice and Liaison Service, a member of the team will work with the service to resolve the issue wherever possible. Where themes and trends emerge, these are escalated to the Associate Director of Patient Experience.

	Q1	Q2	Q3	Q4	Total 2019 /20	Total 2020/21
Adult community	224	168	141	166	766	699
ASR	65	71	63	78	575	277
Children's and Families Division	45	82	79	85	474	291
Dental Services	40	49	53	35	363	177
Learning Disability	1	6	5	7	18	19
Other	37	24	20	61	151	142
Totals	**412**	**400**	**361**	**432**	**2347**	**1605**

During COVID pandemic we have continued to support clinical services by responding to patient, carer, public and colleague enquiries, working with up to date service information and understanding of service provision and challenges. This ensures that we are able to respond to enquirers' queries, concerns and issues in a timely manner and in turn maintain close working relationships with our clinical colleagues.

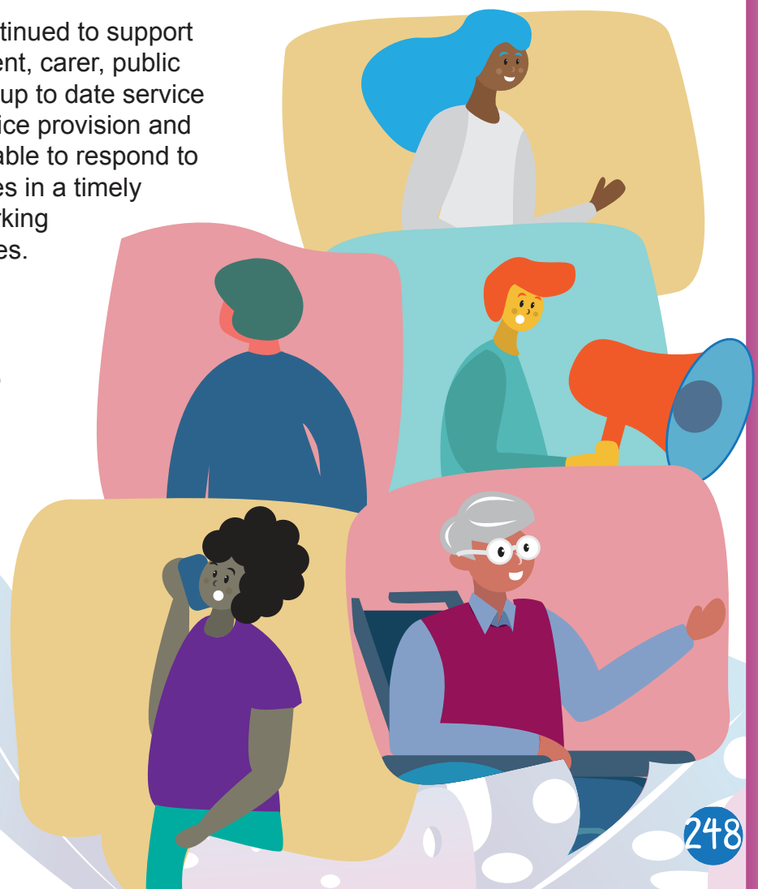
Contact Advice and Liaison Service Team

Telephone: Freephone 0800 917 2855

Text: 07540702477

Email: contact.bchc@nhs.net

You can write to us at:
Moseley Hall Hospital,
Alcester Road,
Moseley, Birmingham,
B13 8JL

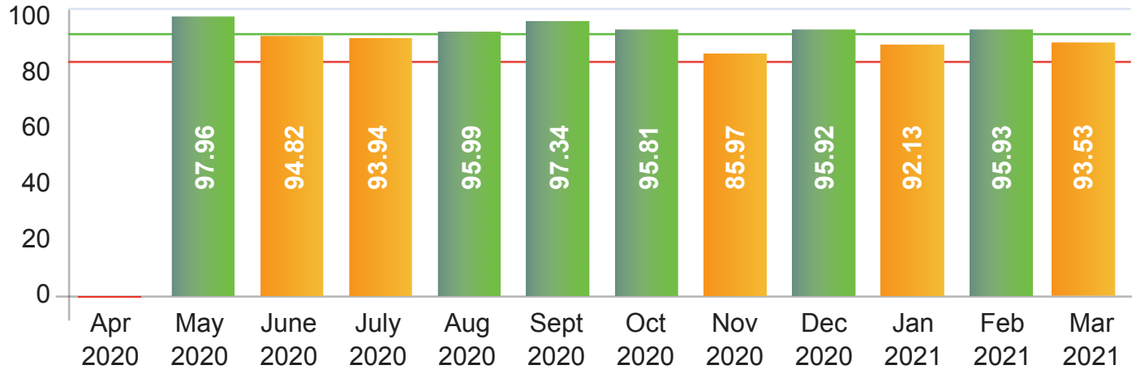


Essential Care Indicators

Essential Care Indicators (ECI) are a safety assessment tool developed within the Trust to report the results of team level audits into the basics of care delivery.

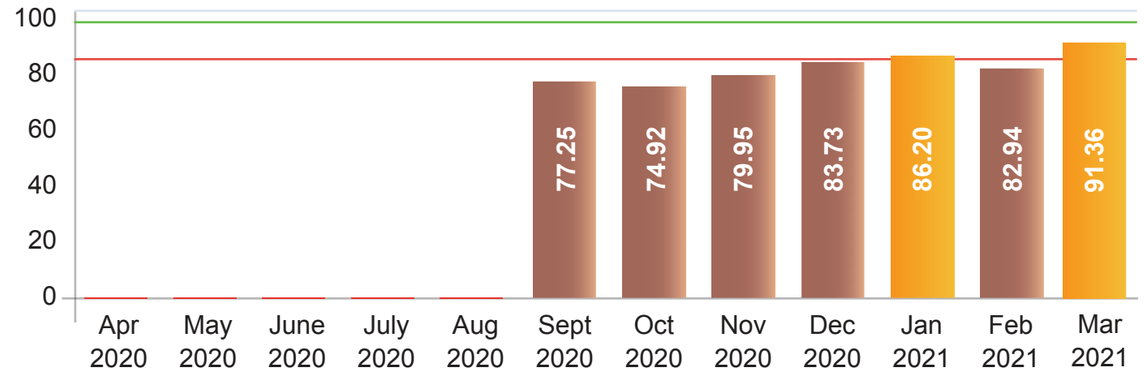
The questions assessed vary depending on the particular service but could include review of nutrition and hydration status recording, checks to avoid patients developing pressure ulcers or falls risk assessments. All of the audits can be broken down by topic or team allowing services to get a regular update and highlight of any areas of requiring further attention.

Early intervention Essential Care Indicators



In 2020-21 a new Essential Care Indicator was added for Early Intervention services as well as work to substantially review and refresh the audits for children's Health Visitor Services. These are in addition to the existing and established audits which cover Community Nursing, adult in-patient services, Learning Disability Services and Dental Services.

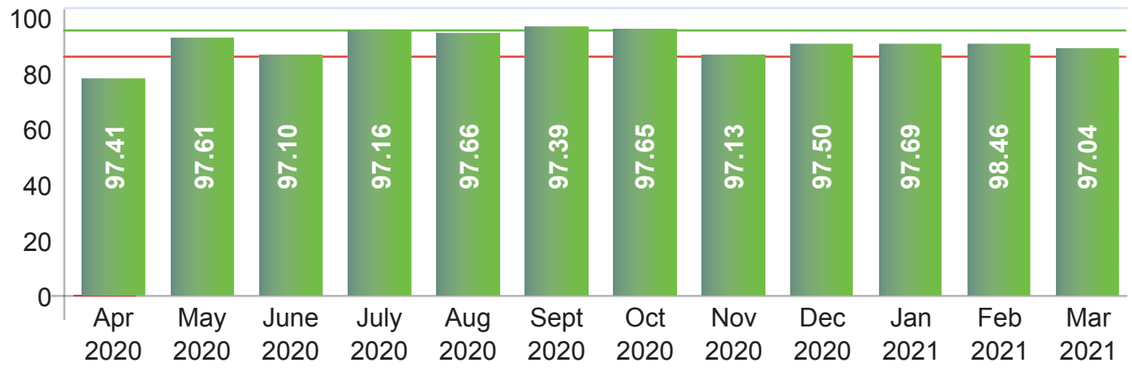
Dental Services Essential Care Indicators



Dental Service ECIs were launched in pilot form in June 2019 before a wider roll out across the service in the following months. The audits were developed in part as a response to never events reported in 18/19 and include assessments of quality of information where patients are referred for clinical imaging.

During the first months of the covid pandemic nearly all activity at the Dental Hospital ceased with only emergency contacts taking place and many of the clinical and support staff redeployed to alternative roles across the Trust. From Autumn the Hospital again began treating reduced numbers of patients under strict covid secure processes and restarted the Essential Care Assessments. Since then there has been a steady improvement in performance although still short of the target. The main areas of shortfall have related to imaging and discharge planning. The service have also continued to roll the audits out to new areas for example from February including assessments of the Endodontics. The addition of new services generally results in a reduction in reported performance in the initial months as time is needed to understand and act on the results. There are plans to roll out the audit to Community Paediatrics next.

Community Nursing Essential Care Indicators

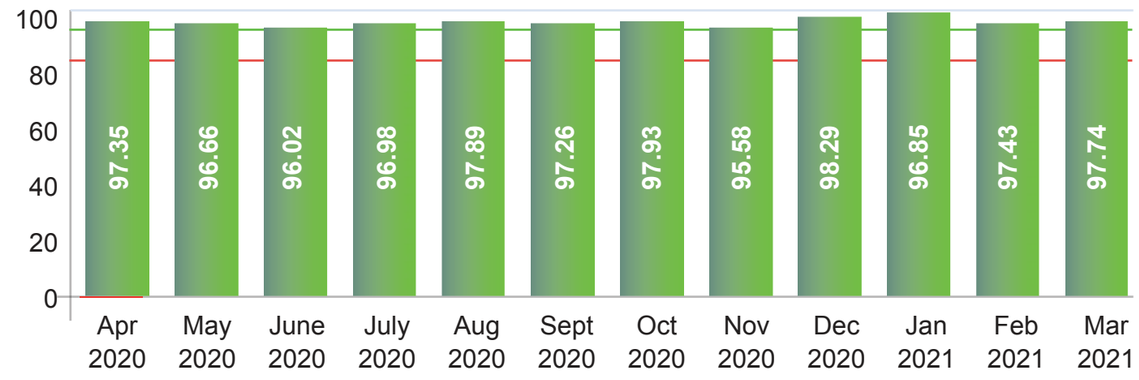


Community Nursing ECIs show a very stable position reporting over 97% compliance throughout the whole year and with all 37 Community Nursing Teams contributing to the audit which assesses the following areas:

- Falls Assessment
- Medication Assessment
- Hydration Criteria
- Nutritional Criteria
- Pain Assessment
- Palliative Care
- Patient Observations
- Pressure Ulcer Prevention
- Wound Management

These reports give assurance that community nursing team are managing to carry out key assessments despite the challenge of delivering community nursing during a pandemic.

Adults In-Patients Essential Care Indicators

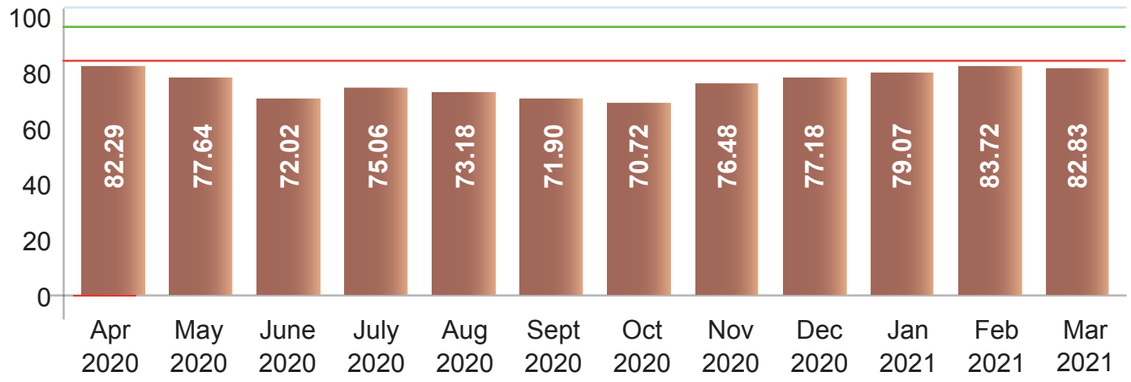


Adult in-patient ECIs show a very stable position throughout the whole year with at least 95% compliance reported each month. Records are audited each month in the following areas:

- Admission Documentation
- Falls Assessment
- General / Environmental
- Hydration Criteria
- Medicines Management
- Nutritional Criteria
- Palliative Care
- Patient Observations
- Tissue Viability

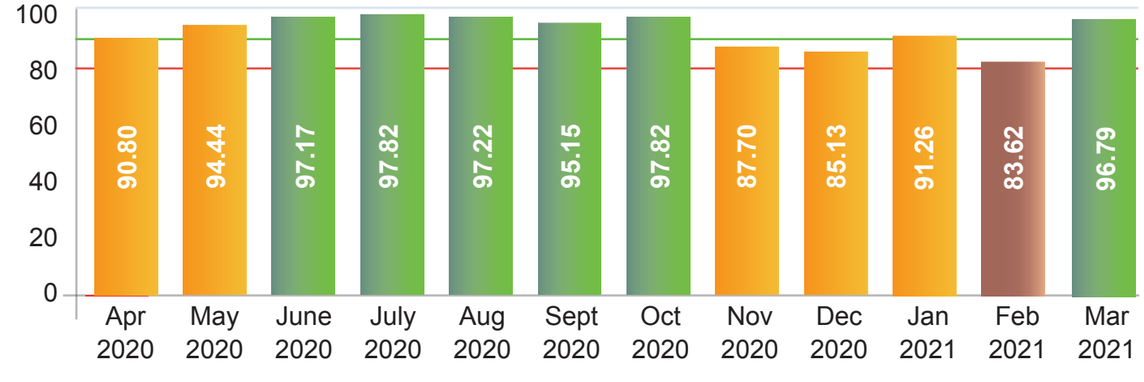
The service have experienced high sickness rates and high levels of redeployed and temporary staffing during the pandemic and so these results represent a significant achievement.

Health Visitors Essential Care Indicators



The Children & Families Division's Health Visiting Service has continued to report its own set of Essential Care indicators and has continued to report breaches each month of the year. However this audit differs from the other ECIs and has been largely based on the Division's delivery of Health Visitor mandated contacts with other elements such as patient satisfaction paused during the pandemic. As such the performance has mirrored the underperformance shown in those metrics. Whilst a review and refresh of the audit was paused during 20/21 due to competing priorities this work has now recommenced and a fully updated set of audit questions is awaiting sign off from Quality and Safety Executive before being added to the overall ECI programme.

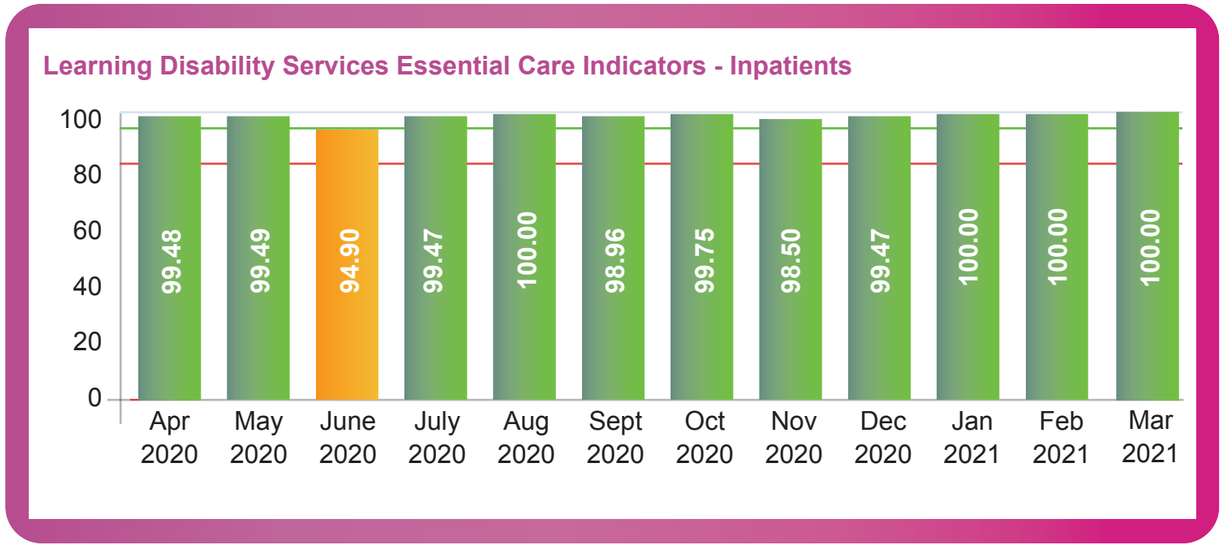
Learning Disability Services Essential Care Indicators - Community



The Learning Disability Services report generally good performance throughout the year for their community indicators although the numbers of patients surveyed each month are generally lower than in other areas and are therefore more likely to fluctuate. The Service have also faced a challenging year with both clinical and management staff redeployed during the pandemic. Where breaches have been reported these have generally related to up to date information regarding general Health Promotion and overall clinical pathways and care plans.

Topics covered in the audit are

- Core Assessment
- Communication Criteria
- Medicines Management
- Nutritional Criteria
- Promotion of Health
- Pathway Indicators



The learning disabilities service have also continued to monitor Essential Care Indicators relating to service users in residential facilities and have reported generally very stable performance throughout the year. The number of service users is again relatively low compared to other ECI audits and the service have maintained performance despite practical challenges caused by the pandemic.

Topics covered in the LD inpatient audit are:

- Communication Criteria
- Falls Assessment
- Environmental Assessment
- Medicines Management
- Mental Health
- Nutritional Criteria
- Patient Observations
- Promotion of Health
- Record Keeping Status
- Safety Indicator Criteria
- Tissue Viability

Same Sex Accommodation

BCHC is committed to providing same sex accommodation for every patient in order to help safeguard their privacy and dignity when they are often at their most vulnerable.

ASR Division is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We have the necessary facilities, resources and values to ensure that patients who are admitted to our hospitals will only share the ward bay with members of the same sex and that same-sex toilets and bathrooms will be close to their bed area.

Sharing of facilities with members of the opposite sex will only happen if clinically necessary to meet patients' needs, (for example, where patients need specialist equipment such as the provision of specialist bathroom facilities which cannot be designated as single sex) or when patients actively choose to share.

This achievement is regularly monitored and should our care fall short of the required standard there is an escalation and reporting process in place.

ASR are proud to report, that even with the increased service pressures during the COVID-19 pandemic, there have been no breaches of the standards during 2020/2021. We are committed to ensuring that this continues in order to provide our patients receive the best possible experience of care within our organisation.

Safety Thermometer

For 9 years BCHC has collected NHS Classic Safety Thermometer survey data in an effort to reduce avoidable harm in relation to four common harms, detailed below, experienced by patients.

Even though the NHS Classic Safety Thermometer survey ceased to be collected nationally at the end of March 2020, the implementation of Safety Express and continuance of collecting the data within the Trust as a measurement tool has again work well this year as one of the Trust's patient safety objectives and a quality priority. Due to COVID-19 and associated pressures, data collection was paused from April until July 2020 to avoid placing undue pressure on teams throughout the height of the pandemic. Once data collection resumed in August, support was provided by the Safety Thermometer Programme Manager in adopting a 'light' approach to data collection where teams had capacity to do so, and where teams did not, they were not pursued to complete the data collection to allow them to prioritise the care of their patients.

The Trust's ambition of delivering 95% HarmFREE Care measured by the NHS Classic Safety Thermometer has been exceeded throughout the year and our objective is to eliminate avoidable harm and protect patients from four common conditions which are:

- Pressure Ulcers
- Harm from Falls
- Catheter associated Urinary Tract Infections (CaUTIs)
- New Venous Thromboembolism (blood clots: VTE/DVT/PE).

We said that we would continue to measure and monitor delivery of this objective. Table 1 below, illustrates that the Trust has achieved this and has exceeded 95% HarmFREE Care for all patient harms whether they are old harms or new harms. Old harms being those the patient experienced before coming into our care, and new harms being those the patient has experienced during our care. Table 1 further illustrates that 0.48% of patients surveyed over the course of the year experienced a new harm, as 99.52% of our patients were HarmFREE. This information is collected on a set day every month as a snapshot in time and shows a slight reduction in improvement over the year compared with last year.

Table 1

2020/21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trust Overall
All Patient Harms - HarmFREE Care					97.27	97.87	98.40	97.98	97.35	98.59	98.26	98.53	**98.01**
New Patient Harms - HarmFREE Care					99.27	99.52	99.61	99.57	99.40	99.75	99.63	99.48	**99.52**

Table 2 shows the sample size for 2020-21 and is split by divisions. The percentage of HarmFREE Care (All) is the prevalence and is measured once a month. The overall Trust achievement for the year is 98.01% HarmFREE.

For the Children and Families Division the sample is restricted to the community nursing teams and the inpatient respite beds. Although no longer collected nationally, the requirements to complete the NHS Classic Safety Thermometer survey remain the same within the Trust. The NHS Safety Thermometer Programme Manager supports teams to ensure that we achieve as full a data collection as possible. Due to COVID-19 and associated pressures, however, the approach as described above has been taken through this year. The Trust has sampled 16,534 patients this year and 16,205 were free of the four common harms.

Table 2

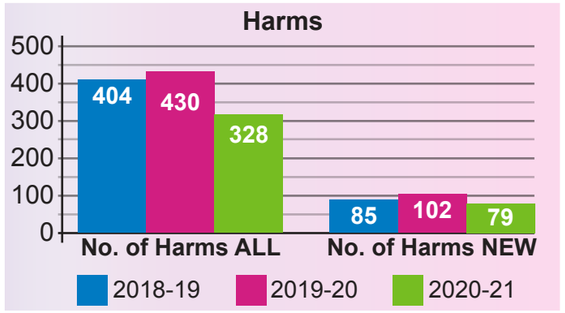
2020/21 - Target 95%	HarmFREE	Number Sampled	% HarmFREE Care (All)
Trust-wide (Total)	**16205**	**16534**	**98.01**
Adult Community Services Division (Total)	**13956**	**14164**	**98.53**
- District Nursing	12800	12987	98.56
- Early Intervention	1156	1177	98.22
Adult Specialist Rehabilitation Division (Total)	**1982**	**2103**	**94.25**
- Inpatients	1556	1677	92.78
- Prison	426	426	100.00
- Children and Families	231	231	100.00
- Learning Disabilities	36	36	100.00

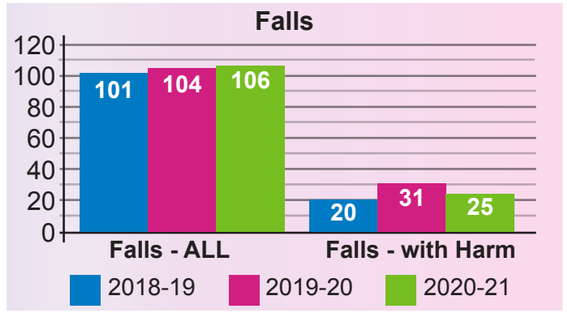
Table 3

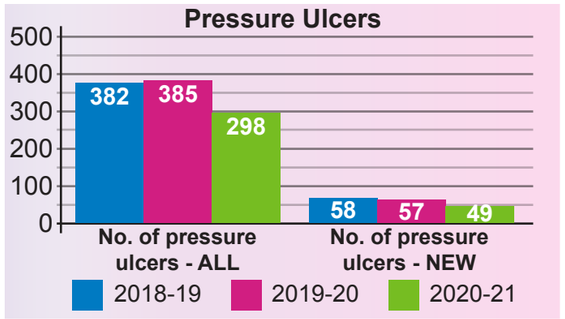
Table 3 below demonstrates NHS Classic Safety Thermometer annual Trust results for the last three years.

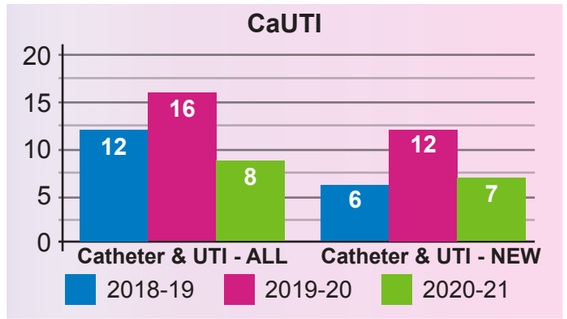
Trust-wide HarmFREE Care (All Harms) - Target 95%	% HarmFREE Care
2018/19	98.40
2019/20	98.28
2020/21	98.01

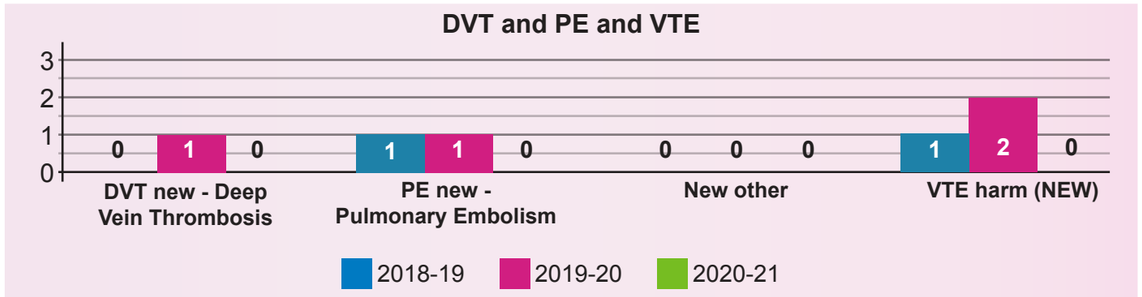
Over the last nine years there has been significant reduction in avoidable harm relating to the four common harms. Between April and July 2020, data collection of the NHS Classic Safety Thermometer was paused, therefore, for 2020-21, the below tables illustrate harms data collected from August 2020 to March 2021.











PLACE 2020

Patient Led Assessments of the Care Environments (PLACE)

The PLACE assessments provide a frame work for assessing the quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The annual appraisal of the non-clinical aspects of the NHS is undertaken by teams which consist of staff and members of the public (known as patient assessors who make up 50 percent of the team). Therefore in view of COVID-19 pandemic and the Government guidelines on social distancing, NHS Digital recommended that a formal PLACE assessment was suspended.

22 March 2021

A BCHC PLACE working group discussed Patient Led Assessments of the Care Environment and agreed the following;

- The Trust will commence a PLACE-Lite for 2021.
- The PLACE team will consist of BCHC staff and the use of external patient representation will be on hold due to COVID restrictions.
- BCHC teams will consist of IPC, Clinical, Patient Experience and Estates and Facilities.
- Each area will be assessed by two people.

26 March 2021

Correspondence was sent by NHS Digital encouraging Trusts to undertake local assessments when possible, using the PLACE-Lite module.

Several changes have been made to the PLACE-lite module to reflect feedback received from first use of the 2019 question set (created in response to the national review). The most important change is that the flow of the questions on the system now matches that on the assessment forms (also updated). We have also made some other changes to improve the user experience.

Improving Sickness Absence Levels

Staff absence has been severely affected due to COVID-19 which has resulted in some of the highest sickness rates experienced by the Trust during the peaks of the Pandemic. Sickness absence rates rose to over 9% in April 2020 and 7.60% in January, 2021. The sickness absence related to COVID-19 equated to 3.17% and 2.13% respectively.

However, for the 7 months from July to December 2020 sickness rates were below the target and were better than previous years.

The sickness rate for March was just under 5.4% against the March target of 6.08%

It should be noted that the Trust ended the year with a rolling 12 month average sickness absence rate of 6.56%.

Chart 1: Trust actual sickness against target 2020/21

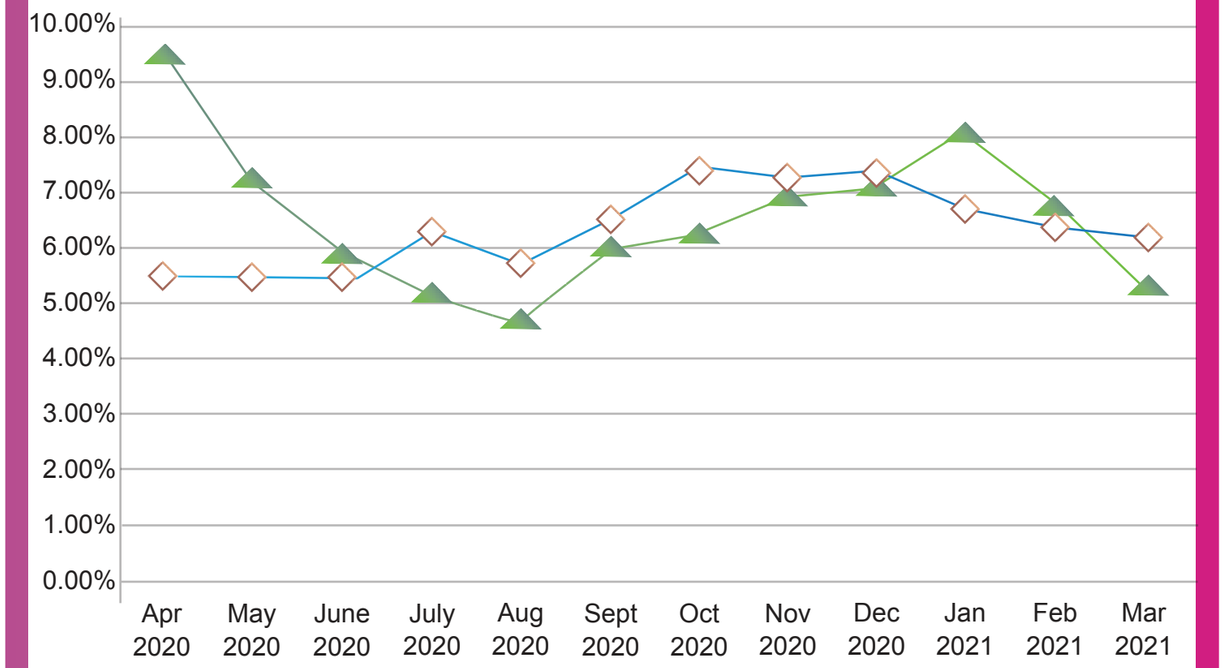
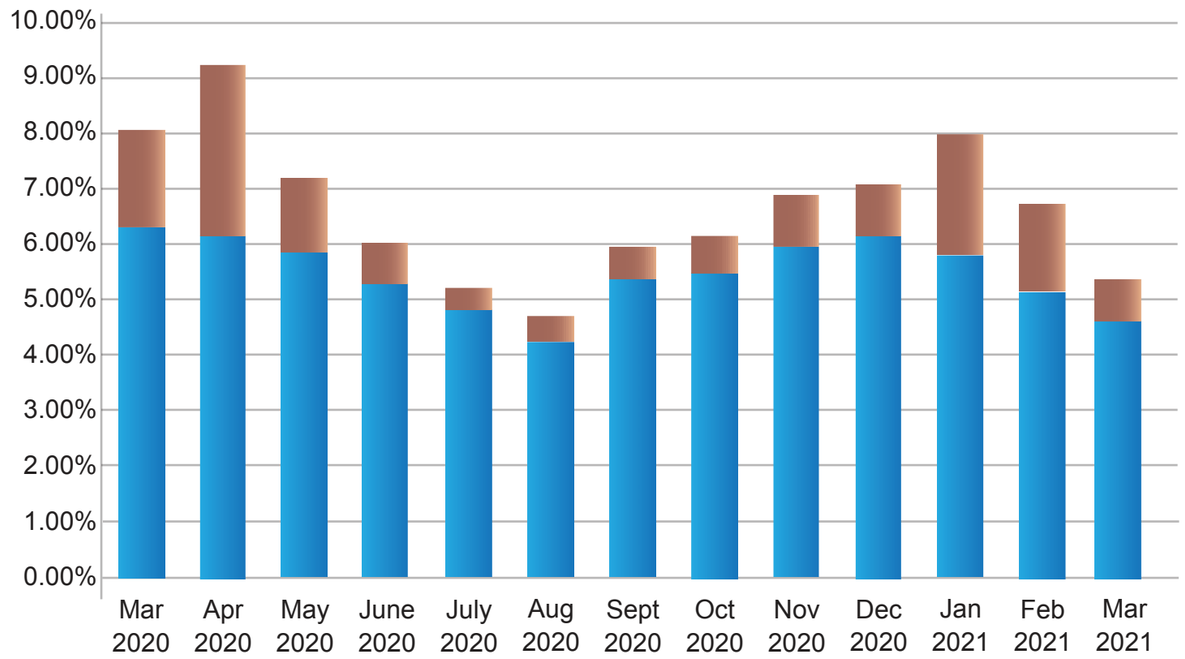


Chart 2: Covid vs non covid related sickness 2020/21



	Mar 2020	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
covid%	1.86	3.17	1.30	0.65	0.45	0.40	0.54	0.67	0.92	1.02	2.13	1.62	0.76
non covid%	6.20	6.10	5.89	5.33	4.72	4.35	5.41	5.55	5.99	6.05	5.86	5.09	4.64

HR support has been provided to both individuals and their line managers in managing absence through this challenging time conducting wellbeing meetings and return to work discussions virtually wherever possible.

Long-term absence throughout the year has accounted for approximately two thirds of absence and the delay in treatment and cancelled operations has adversely affected return to work.

The Trust has provided a comprehensive health and wellbeing package to support colleagues through COVID-19, branded as ‘Hear for You’.

This has included provision for colleagues to stay safe through vaccination programmes and a range of interventions for supporting healthy lifestyles and a package of flexible working provisions.

‘Hear for You’ also brings together a number of more specific psychological and mental wellbeing interventions including Occupational Health, Employee Assistance Programme and helplines.

Staff were also supported by a comprehensive Risk Assessment process based on an initial self-assessment which then provided for either a Health Risk Assessment or BME specific individual risk assessment. The Trust also established a COVID-19 Secure Workplace Assessment where managers and staff were able to access the support of Occupational Health. The Trust was able to report 98% coverage with individual risk assessments.

National Institute for Health and Care Excellence (NICE)

NICE Implementation Programme - working together to evidence care

The National Institute for Health and Care Excellence (NICE) has continued it's work during the pandemic to produce evidence based guidance for clinical services. Alongside the guidance it was already developing NICE produced 24 rapid guidelines to support teams who were treating patients with COVID-19.

The Trust has continued to review the guidance as it comes out to prevent a backlog; the Nice Review Group (NRG) has met virtually to consider where the information might be relevant throughout the pandemic. Where possible services have continued to appraise applicable guidance and submit their assessment of compliance to the NRG and the Clinical Effectiveness Committee. The directions from NICE allow services to review their current provision of care, make changes where needed to improve with an action plan, use the standards for audit purposes, and utilise the specifications in negotiations with commissioners.

Assessments of published NICE guidances are completed and presented as part of the Trust Knowledge Database range from Clinical Decision Making and Mental Capacity to Pressure Ulcers, from Air pollution and Outdoor air quality to Cerebral Palsy in Adults, from Patient Group Directions for medicines to Chronic Obstructive Airways Disease. The guidance helps confirm and strengthen policy and clinical pathways. This year that has included work to refresh guidance on the treatment of Sepsis, and prompted audits on antibiotic prescribing and Attention Deficit Hyperactivity Disorder.

In addition the Trust has been able to utilise the NICE guidance on the Treatment of Long COVID to work with colleagues from acute hospitals and general practice to establish a pathway for the care of patients in Birmingham. The presence of national guidelines helps to define the needs of the service and standardise care across the NHS.

Fiona Adair, lead the NICE programme since 2015 and helped establish an effective and robust process for managing the flow of guidance. The Trust would like to acknowledge her contribution now that she has moved to a new role in the organisation.

The programme will continue to ensure that NICE guidance supports evidence based Safe, High Quality Care in 2021 for both patient support using technology, to care and treatment of acute and long term illness.

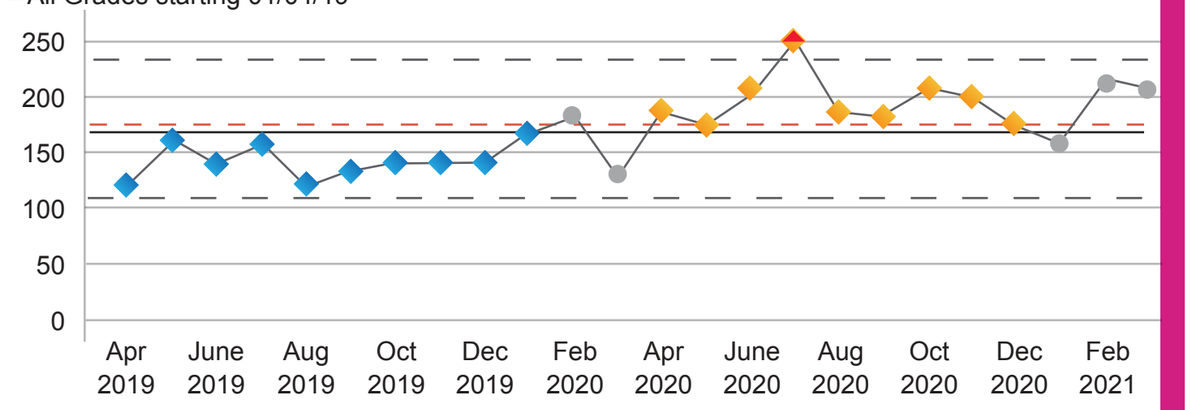
Pressure Ulcers

Preventing patients from developing pressure ulcers is a key focus of both community and inpatient teams.

At the start of 2019 we showed an increase in the number of pressure ulcers reported although this was expected due to changes in the definition of reportable pressure ulcers meaning that smaller pressure ulcers and those classed as ''unavoidable' due for example to patient non engagement with advice were included in figures for the first time. Both Community and Inpatient services have shown an increase compared to this new baseline on the total number of pressure ulcers developed in our care during 2020-21.

All Community Pressure

Community developed Pressure Ulcers– All Grades- Community developed Pressure Ulcers – All Grades starting 01/04/19



Key
Mean
Target
Special cause - improvement
Special cause - concern
High or low point
Process limits
Count of pressure ulcers

The number of pressure ulcers reported each month in the community increased sharply from April to July at which point we reported 249 community developed pressure ulcers, the highest monthly total since the start of the new reporting rules. The position then improved during later summer and autumn whilst still remaining higher than usual and will continue to be monitored carefully for further deterioration.

This increase coincided with the first lockdown and was a time when community teams like the inpatient areas were struggling with high absence due to sickness and shielding. Rules on discharge from hospital beds were also relaxed nationally to free up acute capacity and this led to an increase in the acuity of patients in the community. It is also likely that the reduction in access to other support services and activities will have had a detrimental effect on the patients.

This increase in pressure ulcers is apparent in national data with Benchmarking showing increasing rates throughout 2020. The national data also shows the increase based on changed reporting requirements in April 2019 and a further steep increase in winter 2019/20 which was not experienced in BCHC.

Infection Prevention and Control

The strategic and operational aim of the Infection Prevention and Control Team (IPCT) is to increase organisational focus and collaborative working to effectively maintain standards to ensure BCHC meet the 10 criteria presented in the Health and Social Care Act 2008 (amended in 2015) Code of Practice on the Prevention and Control of Infections and Related Guidance.

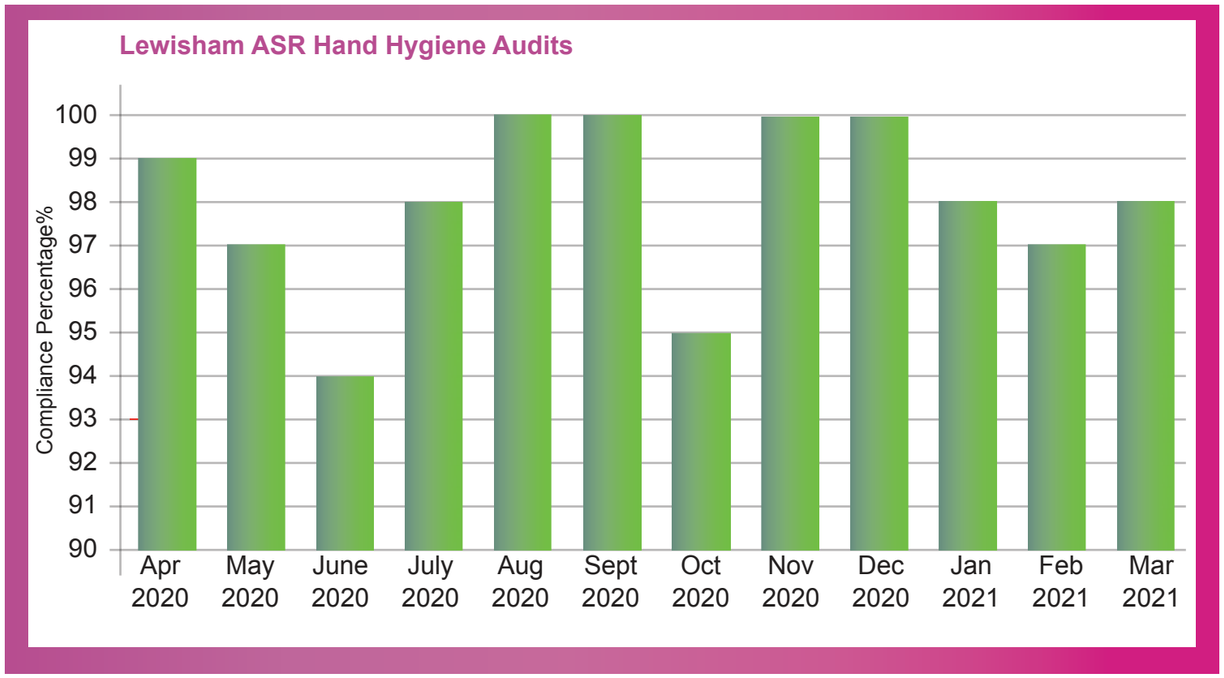
The objective is to engage staff at all levels, through effective leadership, in order to develop and embed a culture that supports infection prevention and control across the organisation.

Hand decontamination is a fundamental principle in preventing the spread of healthcare associated infections; in reality 'hand washing' is the single most effective measure to prevent cross infection. This message has become even more essential as a key part of the prevention strategy for COVID-19. Hand hygiene audits (the Lewisham tool) have continued across the Trust's inpatient areas and a compliance target agreed at 90%.

The Trust has achieved compliance each month during 2020-21. The audit involved the IPCT observing practice in each inpatient area every month. The advantage of this approach is that the IPCT can provide ad-hoc training to staff if non-compliance is observed and real time feedback given to those involved.

Audits have been completed in line with the annual audit programme. The IPCT audit clinical areas using national tools to enable bench marking against other departments and organisations.

In 2020-21 clinical practice observational audits pertaining to Urinary Catheter Care and Peripheral Venous Device Care Bundles were carried out by ward based link workers or IPC Champions redeployed to the IPCT during COVID-19 Pandemic. These audits are designed to highlight areas for improvement for clinical teams and teams consistently achieved compliance in year, thus demonstrating the high level of Infection Prevention and Control standards within the inpatient units.



Infection Prevention and Control Compliance Audit

During 2020-21 the IPC Compliance audit, which included auditing of both the environment and practice standards, was further embedded across all divisions via smart survey as detailed in the table below.

Division	Apr 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Adult Community Services	96	95	95	98	97	97	98	98	97	98	99	99
Adult Specialist Rehabilitation	96	95	97	97	97	98	99	98	98	95	95	98
Children and Families	100	99	98	97	99	99	98	98	98	98	99	99
Dental	97	99	97	96	100	98	100	98	99	99	100	98
Learning Disabilities	100	97	97	96	95	96	100	89	95	100	100	100

Adult Community Services (ACS) Division

Common themes resulting from audit and challenges for the Trust moving forward into 2021-22 are around:

- Lack of storage;
- Decontamination of patient equipment.

These areas are being addressed locally within the relevant clinical services.

Action taken:

- The service worked closely with the IPCT to raise awareness of Trust policy and standards and this work forms part of the divisional IPC Action Plan which is monitored via the ACS Clinical Effectiveness Committee (CEC)
- Teams failing two consecutive monthly audits will be required to complete an action plan which will be presented at CEC by the Team Leader or Service Lead.
- Failing sites will also be escalated for spot checks as part of the COVID secure site checks
- There is a plan to undertake the audits via a peer system in the coming month's but it is recognised that it is not appropriate to be moving staff between teams unless a clinical need is identified. This will provide further assurance of the accuracy for completion of the survey.

Adult and Specialist Rehabilitation (ASR) Division IPC Compliance Audit

Common themes resulting from audit and challenges for the Trust moving forward into 2021-22 are around:

- Issues pertaining to the overall Environment and old Estate;
- Decontamination of patient equipment;
- Lack of Storage and resulting in items being stored on the floor;
- Cleanliness issues.

These areas are being addressed locally within the relevant clinical services.

Action taken:

- Capital works programme to refurbish wards at Moseley Hall Hospital, Perry Tree Centre and Ann Marie Howes;
- Regular inpatient visits by IPCT to support the wards to improve IPC practice;
- Cleaning issues escalated to Facilities team.

Dental IPC Compliance Audit

Common themes resulting from the audit and challenges for the Trust moving forward into 2021-22 is detailed below:

- Lack of storage which necessitated items being stored on the floor in store rooms and issues pertaining to the overall Environment and old Estate;
- Cleanliness issues.

These areas are being addressed locally within the relevant clinical services.

Action taken:

- Cleanliness issues escalated via locality and addressed following audit.
- Capital works are proposed for Brace Street Dental Department and Central Clinic at Dudley.

Learning Disability IPC Compliance Audit

Common themes resulting from the audit and challenges for the Trust moving forward into 2021-22 is detailed below:

- Assurance Process not being in place to identify if equipment is clean and ready to use;
- Surfaces cluttered;
- Items stored on the floor;
- Staff not aware of the process to follow if blood or body fluid spillage occurs; this issue was addressed at the time of the audit with the staff concerned; this was not highlighted as a reoccurring issue.
- IPC not an Agenda item at team meetings. This issue was addressed at the time of the audit with the team concerned; this was not highlighted as a reoccurring issue.

These areas are being addressed locally within the relevant clinical services.

Children and Families IPC Audits

Themes and trends from the audits identified:

- Lack of storage space;
- Environmental Cleanliness

Action taken:

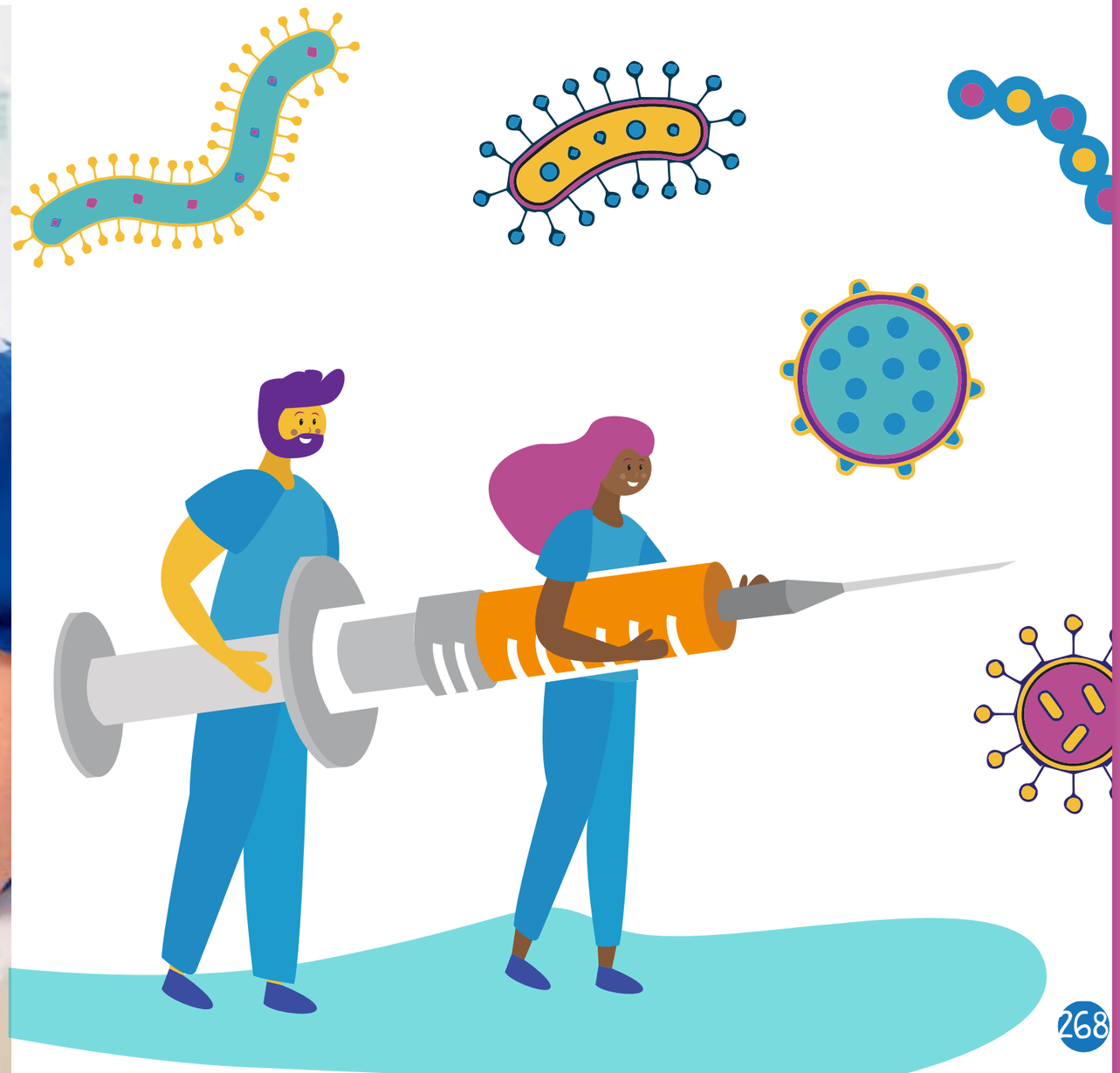
- These areas are being addressed locally within the relevant clinical services.
- IPC issues are included on the Divisional Clinical Effectiveness & Audit Group, Senior Management Team and Quality Safety Board agendas, with escalation to Divisional Management Board if there are barriers to improvement.

Flu

The impact of flu on frail and vulnerable people in communities, care homes and in hospitals can be fatal.

Immunisation against flu should form part of the organisation's policy for the prevention of transmission of flu to protect patients, residents, service users, staff and visitors. The campaign to ensure frontline clinical staff had the flu vaccines showed a final uptake of 71.2%. There were 79 active Peer Vaccinators (29 of these were new this year), and over 2500 vaccines were given by peer vaccinators across the Trust. This has enabled greater access to vaccination for clinical teams.

Front-line health and social care workers have a duty of care to protect their patients and service users from infection; this includes getting vaccinated against flu.



Equality and Diversity (Incl. WRES)

At the outset of the COVID-19 Pandemic the Trust recognised the disproportionate impact of COVID-19 on specific groups and committed to support BME colleagues through a range of interventions including:

- Listening and engagement events through BME Staff Network
- Publication of data assessing the impact of Flu and COVID-19 workforce interventions on BME colleagues
- Establishment of an active risk assessment process
- Launch of an Anti-Racism Campaign
- Emotion and spiritual support through Emotional Survival Strategy Sessions

Inspite of COVID-19 the Trust has maintained an absolute commitment to develop its equality, diversity and inclusion capability through its Becoming a Truly Inclusive Organisation Action Plan.

Whilst capacity has been severely stretched excellent progress has been made during the year in revising employment processes including the development of a new disciplinary process, re-launching the Cultural Ambassadors Programme and progressing the review of recruitment and selection procedures.

Developments have also been made in our 'Recognising and Supporting Potential' and Widening Participation strategies in preparation for 2021/22 launch.

During the year the scope of equality and diversity monitoring and reporting with the Quality and Performance Report (see below) has been extended and targets and trajectories have been developed for each Clinical Division. Embedding the commitment towards inclusion was also supported through a series of 'Inclusive Organisation Conversations' with the Chief Executive Equality leads and Divisional Senior Leadership Teams.

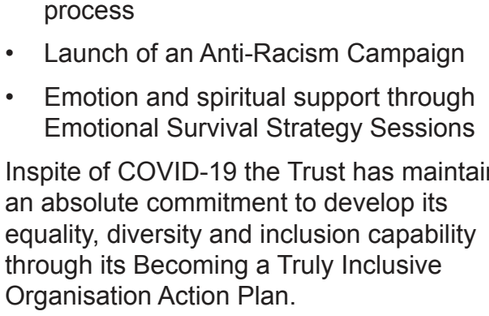
The importance of developing cultural competence throughout the organisation has been recognised and the Executive Team have participated in the 'Leading Beyond Cultural Boundaries' in preparation for the Reverse Mentoring Programme in 2021/22 and this is an essential element of the line managers leadership programme 'Inspire'.

Another important step in the Trust's journey is the establishment of Equality Staff Networks. This year a commitment has been made to supporting Network Leads with allocated time and a budget, development and sponsorship. A Staff Network Coordinator will be appointed in 2021/22.

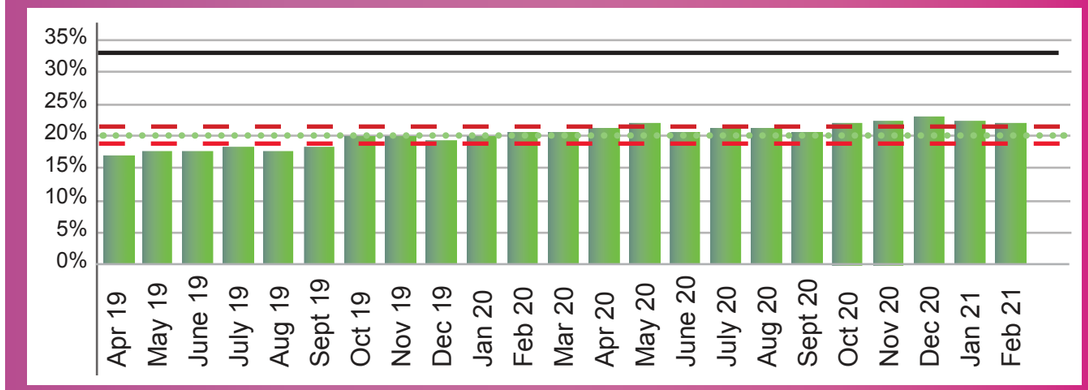
In addition to the workforce activities undertaken progress has been made in relation to Service Equality, particularly focussing on the development of service equality, data and monitoring.

Work has also commenced to develop a BCHC vision for addressing health inequalities and the Trust, through the Chief Executive Officer, is also taking a lead role in the Integrated Care System in the development of the health inequalities agenda.

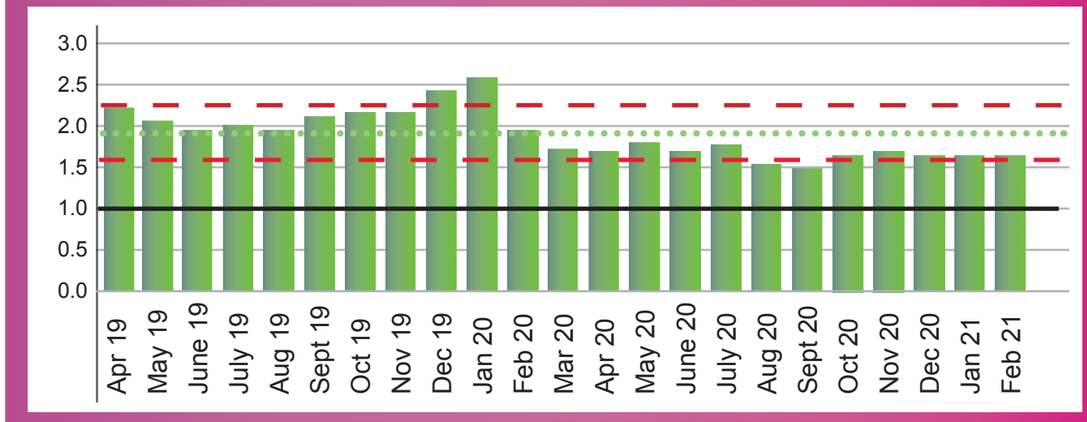
Whilst it is acknowledged that there is still much work to do the Trusts progress was recognised in being shortlisted for the HSJ Award for Equality and Diversity 'NHS Workplace Race Equality Award'



WRES - % of staff at bands 8a+ who are BME (exc Medical and Dental)



Relative likelihood BME staff entering formal disciplinary



Improvements in Children's Services

April 2020

The Child Development Centre (CDC) advice line opened in April 2020 for all families who had been referred to the CDC due to their children having additional needs. Families are now able to leave a message and the team call families back within 48 hours and offer practical everyday advice. The phone line is currently provided by a mixture of professionals including speech and language therapy, clinical psychology and nursery nurses. They can respond to messages in a number of languages including English, Punjabi, Urdu and Mirpuri.

This has been very much welcomed by families where children are on waiting lists for assessments. Many of these families not only have medical needs but also social needs and they have found the advice line very helpful in also not only addressing these needs but signposting them to other appropriate services for support.

11 June 2020

The ADHD (Attention Deficit Hyperactivity Disorder) Community Paediatric Team invited parents and carers to the first "Virtual ADHD Information Workshop for Parents" for families whose child had had a recent diagnosis of ADHD or was already under regular follow up with the ADHD service and parents just wished to learn more about the disorder.

Using Microsoft Teams parents were able to join community paediatricians, Dr Roy and Dr Dasgupta and an Educational psychologist to present on the following:

- Medical background on ADHD.
- Other conditions seen with ADHD.
- Non medications options for ADHD management
- Medication used in ADHD
- School's role in supporting children with ADHD and advice regarding internet use in children.
- Tips for behavioural management for ADHD.
- Resources for further information on ADHD

A panel session was held afterwards to answer any questions the families had. Several more workshops have been delivered and the feedback from the families has been very positive:

"It's been a really informative afternoon - thank you"

"Good range of information and balance of medical and practical information"

"I thought the presentation was excellent."

September 2020

In September 2020 the new Transition to adult service webpage was launched on the BCHC website. The web page has information to help families with the process of preparing, planning and moving from children's to adult services. This includes deciding which services are best for them and where they can receive that care and support.

The page links to the different services that are available - providing useful contacts and information to support them through transition. This includes information on the Young Adults Rehabilitation Service and Adults Learning Disabilities Service and how both services can be accessed. There is also an easy read poster using symbols on the web page so young people with learning disabilities can gain better understanding in the transition process and what transition means for them.

The web page can be accessed through the BCHC Trust webpage under the section Children and Families Services.

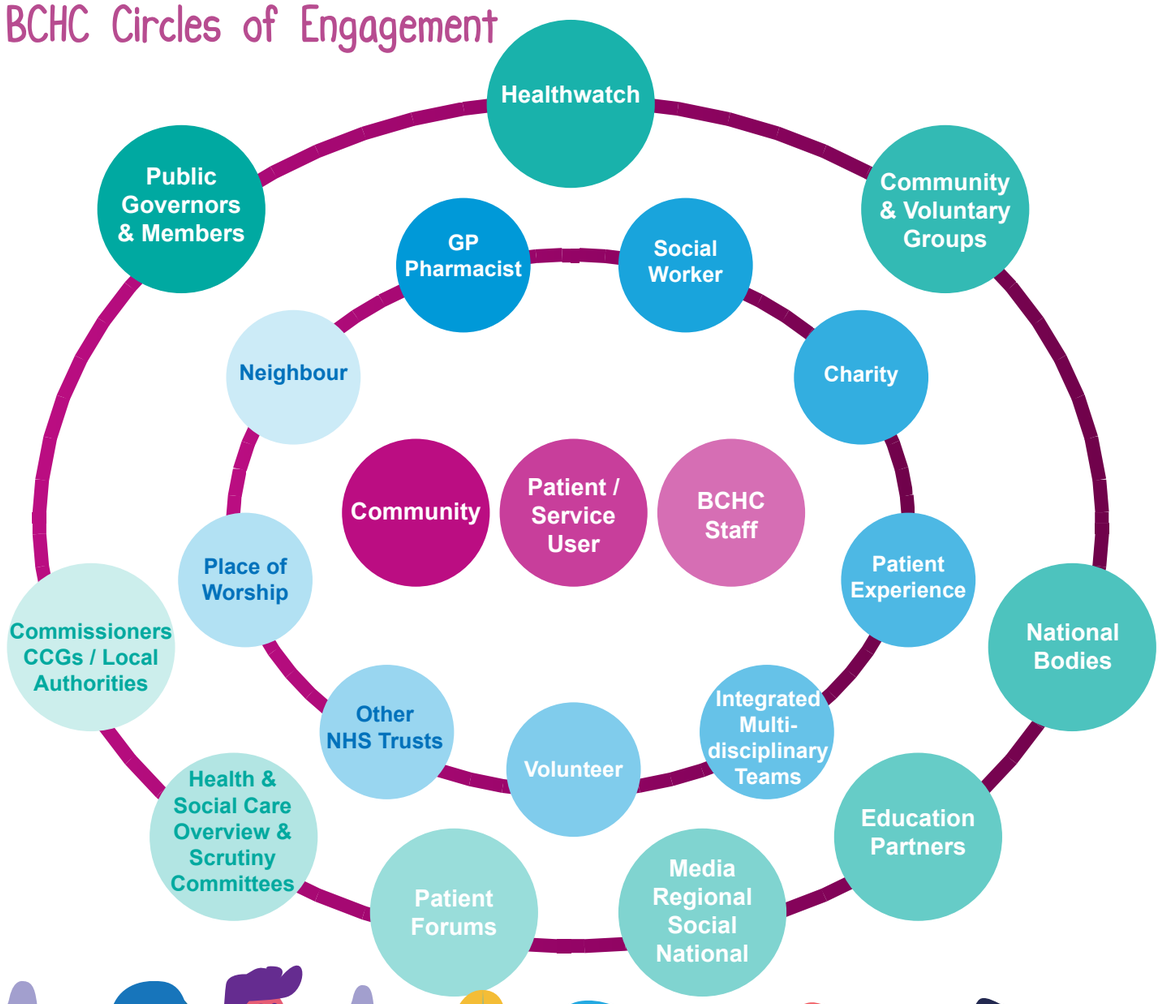
A 2 ½ year old little boy in the care of the palliative nursing team receiving end of life care had a wish to see a fire engine and fire fighters. The little boy's life was drawing to a close so very quickly staff contacted West Midlands Fire Service to see if they could make his wish come true despite the COVID situation. Within an hour of the call being made the fire engine and fire fighters arrived at the family home and some special memories were made that the family can treasure for evermore. This is a fantastic example of how services are working together to support children and families to ensure end of life care continues to be child and family focused even during exceptional times.

A child in their final stages of life required an infusion as part of their palliative care. This type of infusion had never been done before in Birmingham in a home setting. The palliative care team's determination to support every child's and families choice of place of death resulted in them providing the support and care required facilitating the infusion at home. They worked closely with the cardiology department at Birmingham Children's Hospital and through an integrated team approach successfully coordinated care that meant this young child could go home. In doing this they enabled the child to spend his final days at home with family to whom he was able to say his final goodbyes rather than in hospital. Both the cardiology team and child's family were very grateful for the support they received by the Palliative Care Team during this difficult time.

Public Engagement

As a Trust, BCHC have a duty to engage and involve service users at all levels of service change. We are committed to providing inclusive opportunities for services to get involved.

BCHC Circles of Engagement



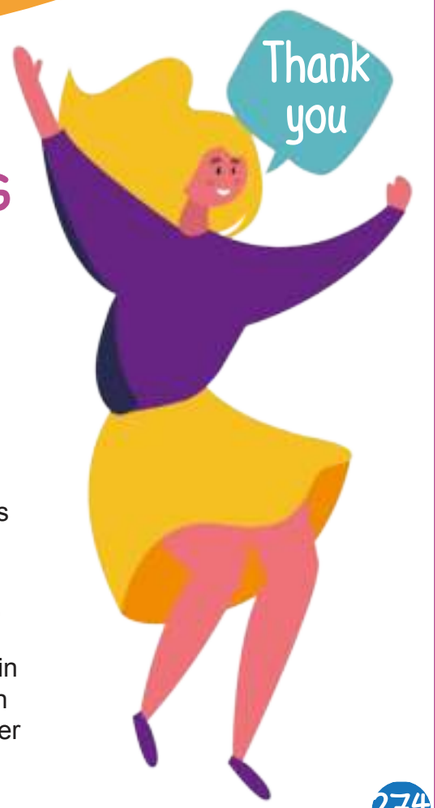
We have recently completed the development of the Community Engagement Strategy. This strategy involved a wide range of internal and external individuals, including clinical and non-clinical staff, community organisations and patients and families who use our services.

Engagement Cycle

Thank you to our communities

BCHC have recently completed the development of the Community Engagement Strategy. This strategy involved a wide range of internal and external individuals, including clinical and non-clinical staff, community organisations and patients and families who use our services.

Throughout the pandemic, BCHC's Engagement Manager has been working collaboratively with the citizen involvement team at Birmingham City Council and the patient experience teams across University Hospitals Birmingham (UHB) in co-design of services. During this time he has been working closely with Healthwatch Birmingham and a range of grass roots community organisations, and neighbourhood network schemes breaking down barriers to engagement and sowing seeds to ensure BCHC has a voice within the communities we serve, and also creates opportunities to listen to the views of citizens and communities as we restore and recover following events of the past twelve months.



Early Intervention Programme

The early intervention programme was developed between health and social care partners across the city with the aim of transforming the lives of thousands of people with complex needs for years to come.

What is Early Intervention?

Early Intervention (EI) provides urgent assessment, treatment and care to people; as well as a range of integrated services that promote recovery and independence.

Staff Engagement

Birmingham's approach to the challenges was to establish an evidence-based, frontline-led plan that engaged staff at all levels and across all partner organisations. This involved interviews and case reviews with hundreds of frontline staff. A team of partner-wide 28 practitioners then developed a set of recommendations about what needed to change and where.

This was the first time that teams across the Birmingham system had come together in this way and breaking down cultural and organisational barriers, myth busting and building trust formed an important part of these sessions.

The next stage was to trial new ways of working before implementing them on a wider scale and additional MDT's of cross partner practitioners were established to deliver the programme.

To provide senior and corporate support, forums were put in place with senior representatives from all partners and all areas including governance, informatics, data, estates and services and primary care engagement through three representative GP's.

Citizen and Patient Engagement

Early Intervention was established on the basis of citizen engagement to develop the Birmingham Better Care Fund and discussions with citizens' forums established by Birmingham City Council (BCC). Citizen feedback said:

- I want to tell my story only once
- I only want to be assessed once as far as possible
- I want to be in control and plan my care together with professionals who understand my culture and are non-judgemental
- If I receive support at home I want as few strangers as possible entering my home
- I want help, not barriers, for me to get the support I need
- I don't want to go into hospital unless I need to

The principles of Early Intervention were developed in response to citizen feedback.

- One integrated model across the entire system.
- Person must be at the centre of everything we do
- To support an older person's life not simply deliver a service.
- To ensure each person receives the right care, at the right time, in the right place,
- People should have to tell their story as few times as possible.
- Staff to champion the 'home first' ethos.

What our health and social care system says...

"EI makes the difference between older people not just surviving but thriving n their own home"

Graeme Betts, Director of Adult Social Care, Birmingham City Council

"The use that this new model of care is being put to, to help us to get through COID-19 is invaluable"

Richard Kirby, Chief Executive of BCHC

"We will get to a point where mental and physical health are integrated"

Waheed Saleem, Non-executive Director of Birmingham and Solihull Mental Health Trust

"This service delivers on the ambition to support older people to live in their own homes independently for as long as possible"

Paul Jennings, Chief Executive of Birmingham and Solihull CCO

"The H&WB England Board is incredibly impressed with outcomes being achieved by EI for older people in the city"

Andy Cave, Chief Executive Officer of Healthwatch Birmingham

Section 4

Achievement Stories

Demonstrating Quality

This past year the SARS-CoV-2 virus evolved, moving from animals to people and then creating different variants some of which are more infectious.

BCHC has evolved this year, to meet the needs in treating COVID-19 and non-COVID-19 patients and supporting its staff. As the saying goes “when the going gets tough” and BCHC responded to the challenge.

The Trust recognised the need to maintain assurance on the quality of care throughout the pandemic and while many groups were stepped down through the “governance light” programme, the senior committees continued to meet and monitor service delivery. This included working with commissioners and national guidance to assess the impact of stopping some care pathways, balancing the risk to staff and patients of catching COVID-19 against the clinical need to treat their condition. The Trust recognised the importance of keeping patients and the public updated and this stimulated a review of the information we make available on the internet, and of the plans to implement a patient portal next year. (Page 180).

The painful necessity of stopping families visiting our wards led to the creation of Family Liaison Officers to facilitate communication between patients and their loved ones. That gave a number of corporate colleagues the chance to leave their laptops and work with clinical staff and patients on the wards. This also gave them all a very special perspective on the work the Trust does and the difference we can make (Page 279).

We continued to work on making the care we deliver more efficient and effective, as we undertook a clinical audits (Page 191), developed a wider range of clinical outcomes, assessed our pathways against NICE guidance, (Page 268) and extended the implementation of our electronic patient record RIO. The latter will improve our ability to share information between clinical staff, and collect data on how effective we have been in improving the lives of our patients. In 2021-22 we are implementing and Electronic Prescribing and Medicines Administration system, which will improved the effectiveness and safety of our management of medication.

I would like to take this opportunity to thank Frances Young, who is stepping down as a governor, for her work with both the BCHC Quality Committee (QSE) and even more influentially with the Transforming End of Life Steering Group where she continues to provide valuable insight.

BCHC staff have been adaptable and resourceful in countering the impact of COVID-19 and will I am sure will be equally enterprising in tending to those patients who are now on waiting lists. We have continued to provide Safe High Quality Care to our patients, and this report highlights some of the many examples of that.

Colin Graham,

Associate Director
of Clinical Governance

Family Liaison Officer (FLO)

The Family Liaison Officer (FLO) role was launched at the beginning of April 2020, on in-patient units within the Adult Specialist Rehabilitation Division.

The role provided an essential link between patients and their families / loved ones, at times when COVID-19 restrictions were in place preventing in-person visiting. FLO's were assigned to each ward / unit and maintained a service over a 7-day week.

The role of the Family Liaison Officer

- Patient's named contact telephoned on a regular basis (daily wherever possible), in order to collate and deliver messages between patients and their families and arrange telephone and video calls with their loved ones
- Daily contact with patients to talk about their experience, and to ask whether they have any messages they would like to be passed to their loved ones
- Co-ordinate laundry deliveries to and from relatives, and other personal items patients may require to make their stay more comfortable
- Delivery of `Letters to Loved Ones' to patients (received via the BCHC 'LettersToLovedOnes' email address)
- Use of iPads for patients and families to be able to Skype and Face Time each other
- Use of iPads and laptops to play pre-recorded messages and songs from families to patients
- Liaise with ward staff to arrange follow up calls with families to discuss clinical queries
- Updating patients' My Life Passports
- Enabling patients to watch DVD's and listen to radio and / or music

FLO roles were filled by redeployed colleagues from non-essential clinical services and from corporate support services

Provision of this service has improved patients' experience and wellbeing by maintaining a line of communication during their time in hospital, and has helped to enable ward based clinical staff to focus on direct patient care.

The relationship between the Family Liaison Officer and patients was often brief but produced some lasting memories for both. One FLO listened as a patient reminisced about his experiences in the Royal Navy, where he had travelled and the ships he had served on. Later the FLO found a picture of one of the ship's company from around that time, showed it to the patient, who was able to spot himself in the photo (which he had never seen before). Another patient with a lifelong love of music, composed a piece for Macbeth on napkins, and had three Health Care Assistants acting the part of the witches, while they tapped out the score on their chairs as they cackled along. He then turned to the FLO and suggested that "a couple more rehearsals like that and we will be ready to open".

Feedback from the FLOs, ward staff, patient and relatives is vast and all very positive

- 'Lovely to hear from you, and please thank the person who is printing these out and bringing them to you to either read or to be read to. It's a very clever idea at a really difficult time'.
- 'Thank you that means so much. It is so hard not being able to see him or talk to him. So thank you for that'.
- A patient's daughter really appreciated daily updates about her mother and commented that it 'made such a difference to how (they) all coped with the situation'.
- 'The FLOs have become part of the team. It would be great if this role can continue after Covid. This role has become very important with regards to communication and wellbeing'.
- 'We had a lady who was very poorly and was being transferred to an acute hospital. Her granddaughters were unsure if they would see their grandmother again, so we were able to use the iPads to facetime them and they could talk to the patient who did open her eyes at the sound of their voices. It felt that they were saying their goodbyes.'

Letters to Loved Ones

This email service was launched at the beginning of April 2020, promoted on the BCHC website and through social media. The account is managed by the Patient Experience Team 7-days a week, each email is acknowledged personally and forwarded to ward receptionists who operationally support the service by arranging for messages and pictures to be printed, laminated (to provide a wipe clean surface) and then delivered to the patient. Whenever requested a return message is sent to the family member.

COVDENT

A triumph of team working & collaboration

The SARS-COV-2 pandemic swept across the world in early 2020 in a manner that appeared indiscriminate.

However, we now realise the risk of infection was far higher in certain vulnerable groups of society and other high-exposure risk groups such as frontline healthcare workers. Dental care professionals (DCPs) are a group of essential care workers who received scant attention, despite being frontline clinicians managing pain and infection, and operating routinely within 1 metre of the aero-digestive tract and undertaking high risk aerosol generating procedures (AGPs). For this reason, dental practices across the world closed down in March 2020 and in many countries did not re-open until June/July 2020, when level 3 personal protective equipment (PPE) was in sufficient supply to enable resumption of AGPs for those in need of urgent dental care.

Seroepidemiological studies of healthcare workers have been critical in determining occupational risk of exposure to the SARS-COV-2 virus and informing on immunity to re-infection in high-exposure cohorts. Such studies have guided public health planning, the design of healthcare services, and associated infection prevention protocols to mitigate risk and maintain essential care services during the pandemic. However, there have been no dedicated seroprevalence studies of DCPs in general dental practice or hospital practice settings. Therefore, in collaboration with colleagues in the Clinical Immunology Service at UHBFT, specifically Dr Adrian Shields, Prof Alex Richter and Dr Sian Faustini, Thomas Dietrich and I set out to undertake the largest longitudinal cohort (COVDENT) of DCPs in the world, to assess their risk, and to monitor with time antibody levels in blood serum and saliva to SARS-COV-2. The emergence of the new variants and immunization during the second wave coincided with us being able to shed light on longevity of effective antibody levels and the efficacy of the vaccines.

The study had to be set up rapidly to enable a start on the 8th June 2020, with phase-1 completed on 3rd July 2020. During this time UK DCPs had ceased work on 25th March 2020 and the majority had not returned at the time of baseline examination, allowing us to examine COVID-19 exposure risk prior to the implementation of PHE guidance on infection prevention control and level 3 PPE. This would have been impossible without the tremendous work of Chris Burt and her team in R&I, alongside the support of Richard Kirby, Doug Simkiss and David Pearson, and David Adams and Phil Lumley from the University's College of Medical and Dental Sciences. Thomas Dietrich programmed a smart tool called "RedCap" that automated a lot of our processes and a team of secretaries (Marie Jones, Erika Malone, Kate Ward), my daughter Jess Chapple and our trials co-ordinator Yvonne Simaloi worked night and day contacting the 1716 DCPs who expressed an interest. Eddie Crouch our Local Dental Committee Chair (now BDA President) also helped promote the study……huge team effort.

1513 volunteers were seen between 8th June and 3rd July 2020 for baseline blood and saliva sample collection. Our nursing team were amazing as always, especially Jo Crumpler, Jacqui Rees, Keeley Bramley, Joanne Whitehouse, Amanda Stokes, Harpreet Dhami and Sahikha Begum and our hygienists Joanna Rooney and Amneet Sidhu. In truth, they did the lion's share of the venepuncture. We also involved Lecturer's Annika Kroeger, Josefine Hirschfeld, Praveen Sharma and DCTs Raza Jaffery, Sylwia Nowak, Samantha Gee. And of course the laboratory teams, Helen Wright our only NHS research technician was key, as of course were the Clinical Immunology Laboratory Team……huge team effort.

A summary of the baseline results is below:

- 16.3% tested +ve against a West Midlands background population prevalence of 6-7%
- The elevated risk was the same for Dental Surgeons, Hygienists/Therapists, Dental Nurses, but Dental Reception staff were no more at risk than the general public (6.3%)
- Current smoking was associated with a lower seroprevalence compared to never-smokers or ex-smokers (7.6% vs 16.4% vs 17.6%). This is likely due to complex reasons (thicker sputim, reduced blood supply to the mouth and various molecular processes), BUT smokers who develop COVID-19 do badly – so this is not a reason to start smoking!
- Ethnicity was a significant risk factor for baseline seropositivity, with higher exposure observed in individuals of Black ethnicity (35.0%), compared to those of Asian (18.8%) and white ethnicity (14.3%).

Phase-2 involved recalling the 246 volunteers who tested positive for COVID-19 antibodies to the spike protein of the virus between 21st September to 6th October to analyse any change in their serology. 217 returned for sampling and the figure shows what happened to their antibody levels. 70% retained antibodies at 3-months, which was about 6-months after they were likely to have been infected. Those that lost antibody responses had low levels in the first place (probably due to mild exposure to SARS-COV-2).

Phase-3 involved recalling as many of the original 1513 volunteers as we could and between 11th January and 4th February 2021 we re-bled 944 volunteers from across the Midlands. These were long evenings where sometimes over 120 arrived in a single night. The need for social distancing, staggering of appointments and waiting room management was very important, and a “WhatsApp” link between our nurse by the hospital entrance and the R4 clinic made that possible. The key findings from this phase were:

- 94 new PCR +ve infections were reported on RedCap
- The infection risk in those who were seronegative at baseline was 9.6% verses 2.8% for those who were seropositive. Our assay measures simultaneously 3 antibodies to the spike glycoprotein of the virus, IgG, IgM and IgA and so it is highly sensitive and specific. The main protective antibody however is IgG and we also measured that separately.
- There were no new infections in volunteers who had a detectable IgG response at baseline, demonstrating that natural exposure to SARS-COV-2 that generates an IgG response is protective against re-infection about 9 months later.
- We were also able to estimate for the first time the minimum level of anti-SARS-CoV-2 spike glycoprotein IgG antibodies necessary to confer 6 months protection from infection up to 6-months, using a new WHO standard serum.
- Of those who were seronegative at baseline the risk of PCR-proven infection in the 6-months between baseline and Jan/Feb 2021 was 11.7%. Compare that with an increase of 12.3% seroprevalence across the West Midlands. This implies but does not prove yet, that the new infection prevention control measures and FFP3 masks may have resulted in new cases of SARS-COV-2 in DCPs being no higher than the general population, despite their return to work and to AGPs from June/July 2021.
- 70% of volunteers had received a single dose of the Pfizer vaccine and 5% the Astra Zenica vaccine.
- Vaccination of those who had prior exposure to COVID-19 led to a more rapid and greater total antibody response, indicating the boosting of immunological memory.
- Of those not exposed to the SARS-COV-2 virus, 98% antibody positivity was achieved amongst vaccine recipients sampled at least 12 days after immunization.

Conclusions

This was a very important and huge undertaking that demonstrated BCHCTs ability to respond rapidly to a key research need, but requiring the strong endorsement of the Chief Exec and Medical Director, as well as the Pro-VC/ College Head to ensure all doors opened in time for it to happen. The R&I team were key and the whole study represented a massive team effort from all staff groups. It was huge fun and very rewarding and we leave you with 3 key messages:

1. The highest performing Trust’s do lots of research like this.
2. The words “can’t do” uttered only once can stop a study like this happening, but it still requires thousands of “yes we will help” responses to make it happen.
3. Please get your jab, if this does not convince you that you will get protection from this potentially deadly virus, then please do it to protect your families and the vulnerable you come into contact with.

Learning Lessons

Dental division launches oral health training for community nursing teams.

A new e-learning oral health teaching module was launched within the Trust. The training need was identified by dentists during redeployment to community nurse settings. All patient facing staff have a unique opportunity to support oral health, to improve patients ‘quality of life, whilst maintaining function and dignity. Whilst Mouth Care Matters initiatives have been promoted in community hospitals, dentists found that many colleagues have never received any oral health training. This e-learning project aims to improve the oral health related quality of life amongst BCHC patients. Whilst staff are not expected to diagnose and manage oral conditions independently, early identification and onward referral are imperative to facilitate early diagnosis of oral diseases, including oral cancer. It is essential for dental teams to collaborate with other health care professionals to provide holistic patient care.

Waste

The Trust Waste Group has been re-named and will be known as Trust Waste and Sustainability Steering Group as a response to Listening in Action Events to include waste, plastic and re-cycling.

Learning from Excellence

Learning from Excellence (LfE) is a positive reporting system that enables staff to be recognised and appreciated for their good work in a structured, inclusive process.

In order to support staff in building resilience with balance, we must not forget that we produce excellent work on a daily basis, but in the main, this is accepted as the norm and moved on from. Learning from Excellence introduces and provides a balance, thus enabling us to recognise and acknowledge when things work well, encourage repetition and reflection of this positive outcome and to perpetuate learning to improve our safety culture.

The LfE monthly group meeting has been stood down during 2020-21 due the impact of COVID-19 and subsequent pressures, however, the LfE process, as described below, has continued throughout to enable acknowledgement of the challenging period we have worked through and recognition of the staff involved.

On receipt of all the nominations, they are reviewed for exceptional practice and some are recommended to be taken forward as an Appreciative Inquiry (AI). The AI is a change process focusing on strengths rather than weaknesses and encourages active and effective staff participation for shared, wider learning.

Below are examples of nomination that might be considered for an AI.

“I have nominated XXXX following this feedback received from the mother of a child she has been working with: ‘’Just wanted to email you to say thank you for everything you have helped with regarding XXXX. During lockdown we had occupational therapy through video call; this was an absolute God send as we couldn’t meet in person at clinic due to Covid lockdown. Although it may at first seem impossible to get the right help and support through video call, I can honestly say it has been amazing. XXXX really built a rapport with you and she enjoyed the sessions.

The exercises and targets you set her really worked because we practised all week before our next appointment and XXXX couldn’t wait to show you how hard she had worked and that she was progressing hugely. Thanks to this hard work by us all. XXXX met her targets and can now tie her own shoe laces and has a technique to combat small buttons. We honestly as parents cannot thank you and your service enough for the help, advice and support you have given us throughout this extremely difficult time the world is going through. You are honestly our angel and you have given our daughter the skills to help her through the hard issues she faces on a regular basis. We cannot praise this service enough and hope it brings the help and support needed for so many families like ours.’’

“XXXX has clearly had a profound and positive impact for this child and family and has represented the OT service so very well. This feedback also demonstrates that good outcomes can be achieved through virtual contacts for the right children, which is reassuring. Thank you, XXXX!”

“While working as an HCA on the male side of Ward 6 XXXX was helping to care for a clever, articulate and mobile patient, who suffers from dementia, and has very little awareness of his surroundings. He had spent the evening composing music to go with Shakespeare’s Macbeth, and wanted to rehearse the opening scene involving the three witches. XXXX joined with two of her colleagues (who are also nominated) engaged with the patient, following his conducting and making “music” and “cackling” as directed. The patient was delighted with their efforts, and assured me that with a couple more rehearsals like that we would be ready to open.

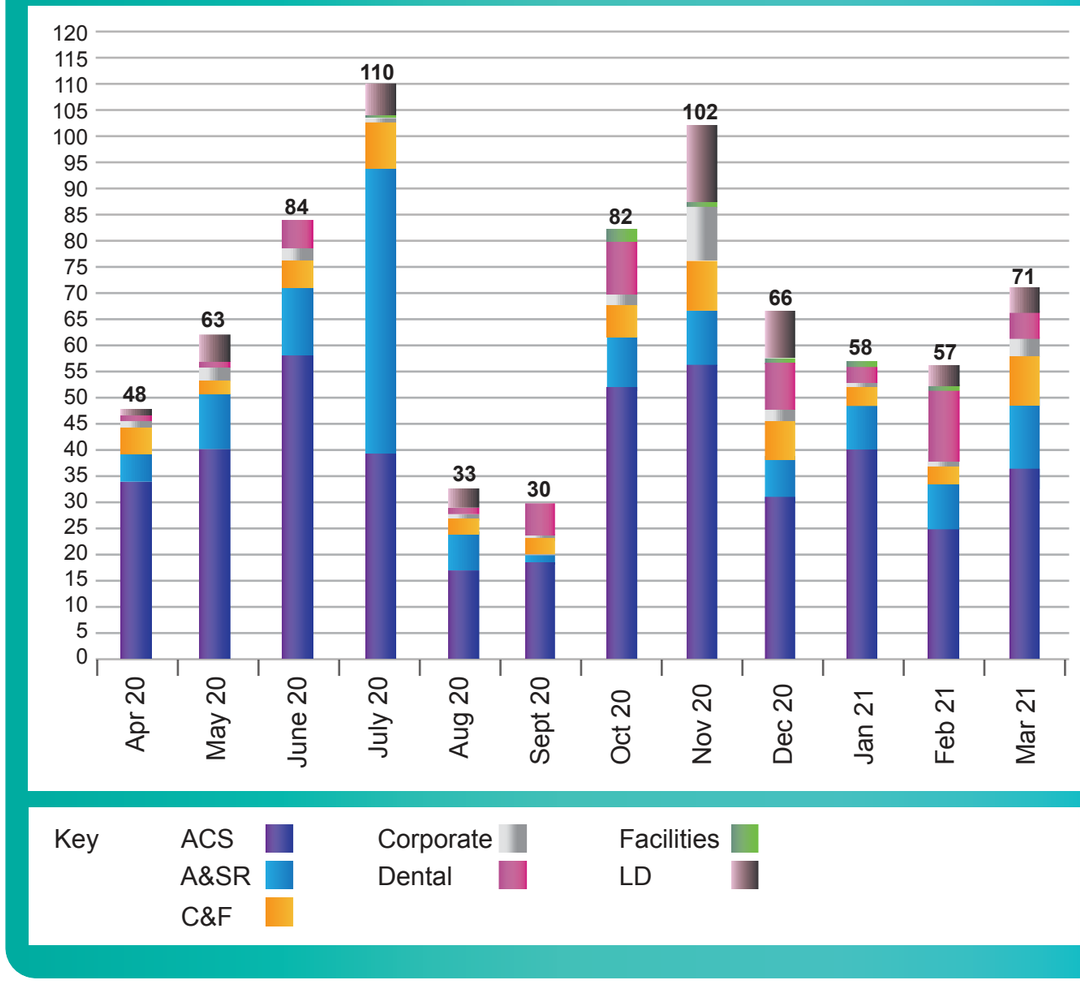
XXXX recognised the value of engaging with a patient on a level that meant something to them, and put them at their ease. This not necessarily clinical work, but has a real clinical benefit for an agitated patient.”

“XXXX and her colleague, XXXX XXXX, deliver SLT to the Youth Offending Service in Birmingham, through training and support to the staff and intervention for the young people. This is a relatively new BCHC Plus (traded) service, for a group of young people with whom the SLT service has long known it could have a significant impact, and we are proud to have gained this contract. Feedback has been really positive - the example below gives a flavour of how XXXX‘s input has changed the life of one young man: ‘’thank you for the attached report.

I have compiled my pre-diagnostic report and awaiting a 1:1 telephone review with XXXX this Friday at 4pm. I will perhaps be helping him with some sleep hygiene and possible short-term sleep medicines. He should receive his ASC diagnosis in the next two weeks. Thank you again for advocating for their engagement with my service. Please forward this onto your line manager as without your advocacy they would have been closed for non-engagement’’ Thank you to XXXX and XXXX for their excellent work”.

Both the nominator and the nominee(s) achieve a sense of appreciation from the nomination, which does not go unrecognised itself by the senior leaders who frequently respond direct to the nominee(s) with their thanks and comments of support.

LfE Nominations between April 2020- March 2021



BCHC Improving 2Gether

Over the past 12 months, BCHC has seen a number of changes in the way we approach quality improvement in the Trust.

Progressing on from our quality priority goals we set ourselves last year, we have successfully designed and started to embed our BCHC Improving 2Gether approach to help create an organisation capable of continuously improving. Our Improving 2Gether strategy was approved by the Trust Board in July 2020 and outlines four key ambitions and has given us a framework for which we are proud to report progress against.

- **Building capacity and capability**

  BCHC has maintained their status to teach Quality Service Improvement Redesign (QSIR) on site by having 3 QSIR Associates who are accredited to deliver the training

  Our first cohort of QSIR practitioners started in February 2020. Due to the COVID-19 restrictions, the first cohort of QSIR practitioners was forced to defer. Fortunately, this did not hinder their ability to start their improvement projects and training will resume in 2021.

- **Promoting visible inspirational leadership**

  A Leadership in Quality Improvement (QI) module has been incorporated into the INSPIRE leadership programme. The session provides an introduction to QI behaviours within the organisation.

The first session took place in September 2020 and will continue throughout 2021.

- **A culture of continuous quality improvement**

The launch of the new BCHC Improving 2Gether branding and approach took place in October 2020. The launch included dedicated QI pages on the staff intranet that includes QI tools, resources and sign posting to QI 'Buddies' across the organisation.

Colleagues are supported through various channels. A support network for QI Buddies has been established to support colleagues and to strengthen the local support available to colleagues in their areas. Many of these QI buddies had previously completed our internal Patient Safety Ambassadors programme

Through the QI Steering Group and Quality Safety Executive, clinical divisions and corporate functions are encouraged to review their own data and proactively identify areas for improvement with support from the QI Team

Since its inception, there has been some focussed Trust wide projects that has used the improvement methodology to bring about improvement.

- **Celebrating, learning and sharing**

Highlights

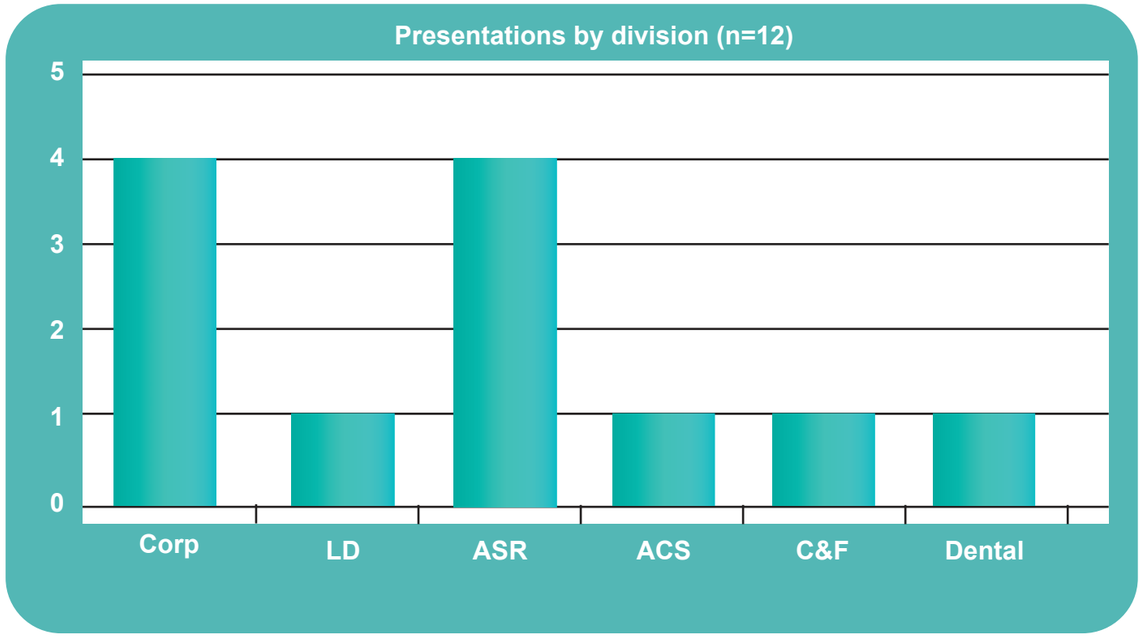
- Forum has its own branding
- Between Dec 20 – March 21, there has been four sessions
- Over 100 colleagues in attendance
- Range of topics - Including Physiotherapy, Dietetics, Safeguarding, Infection Prevention & Control, Dentistry, Community paediatrics
- Positive and useful feedback

  "Another great session!"

  "inspiring"

  "Publicise more"
- Already seeing some benefits with joined up working with potential of publication

The BCHC Improving 2Gether Forum is explicitly linked to our quality improvement approach BCHC Improving 2gether. It is a sharing and learning event held virtually held monthly and open to all staff. Colleagues can hear about some of the truly amazing initiatives other colleagues are doing to improve the safety and quality of care we provide.



As BCHC Improving 2Gether evolves, we will continue to build on best practice and use data and intelligence from all sources, including complaints, compliments and patient experience feedback; patient outcome measures and our communities needs to ensure we are continuously improving.

Through 2021, we are looking forward to building on the work we have completed, in particular expanding our training programmes and commencing the roll out of regular quality improvement huddles across the organisation

Clinical Effectiveness events

Children & Families Division

The Children & Families Division held 2 virtual Clinical Effectiveness events in July 2020 and February 2021.

There was a maximum attendance of 47 staff from many different services across the Division. The Clinical Effectiveness events help towards sharing best practice and improvement projects across the Division supporting quality improvement. These events also support staff development.

There were a number of areas of focus for the two events including safeguarding of children, which has been highlighted as a significant problem during the pandemic, the links between health and schools in improving learning for children and the advances in technology which support the access of patients and parents to care and advice, but reduce the need for travel and exposure to infection."

NETWORKS

Menopause Awareness Events in October and November 2020.

The events were brought about through a need raised by regular visitors to the Virtual Drop-in Coffee Morning the network runs weekly on a Thursday morning, 11am-12pm.

The Menopause Awareness Event consisted of 2 subtopics – the first was an informative conversation and the second focused on the workplace. Both interactive and engaging webinars were led by 2 local GPs and included an afternoon session followed by an evening one.

"I didn't realise how early menopause could start effecting a woman – I had never heard of perimenopause before this session!" said one attendee.

The sessions were not only well attended by BCHC staff but also their family members and partners, some of whom had been finding it difficult to have the "conversation" with their GP or loved ones.

"I knew I was going through the change but I only thought symptoms went as far as hot flushes – hearing all the mental and physical effects of going through this change was enlightening. It was a relief that I could associate some of the symptoms I was having to this, rather than worry it was something else!" said an employee's sister, who attended the first session.

The initial sessions were followed up with another 2 sessions on 18th November 2020 to discuss Menopause in the Workplace – highlighting the need for managers to be a lot more aware of the needs of their staff during this time. This included women's role in the workplace, symptom impact, and how managers/colleagues can support. Again, a session was held in the afternoon and another in the evening to allow as much accessibility as possible.

These events were attended by both men and women and the network lead received a very positive response from all. "As a network we are proud of the start we've made and are now directing the Trust towards adopting a menopause policy, which does not yet exist within BCHC" explained current network lead Carolyn Fielding.

LGBT Network

A staff Network to make BCHC a great place to work for its Lesbian, Gay, Bisexual and transgendered employees and workers

BCHC formed an LGBT+ Network in 2019 and encouraged staff who identified as Lesbian, Gay, Bisexual and Transgendered and their allies to join together to make BCHC a great place to work for employees and workers who identified as LGBT+. The aims of the network are to:

1. To work towards achieving equality and inclusion in terms of shaping and influencing the improvement of policies, procedures, practices, recruitment, retention, working lives and career development of Lesbian, Gay, Bisexual and Transgendered (LGBT) + employees of Birmingham Community Healthcare NHS Foundation Trust to ensure that all are treated fairly.
2. Raise the profile of LGBT+ staff and offer support, advice and guidance to LGBT+ employees of BCHC in a totally confidential manner.
3. Work towards improving relations between BCHC and the LGBT+ communities.
4. To work towards creating an improved working environment to enable LGBT+ employees to feel more comfortable at work and be able to achieve their aspirations and potential.

Actions taken:

Since early 2019 the network has held regular meetings to create a confidential and safe space for colleagues to discuss issues affecting LGBT employees and workers to implement a culture change in the organisation.

The network has identified that gender recording for the Trust via ESR is not accurate for today's gender identities and has escalated a concern to the National ESR team. The network wishes to see the terms Non-Binary and transgender to be added which would allow the Trust to measure the number of these employees better in the organisation for workforce planning.

The network has highlighted that the current Equality and Diversity e-learning package does not explore in detail LGBT terminology including Homophobia, Biphobia and Transphobia. The network is campaigning for an updated learning package to reflect these and to raise awareness of LGBT people in the organisation. This has been escalated to Learning and Development and the EDHR Steering Group.

Key Successes:

The network is thrilled to have an Executive Sponsor, Doug Simkiss Medical Director and Non-Executive Sponsor Barry Henley Trust Chair. The Executives continuously highlight to the Trust Board LGBT+ issues to ensure that BCHC is a truly inclusive organisation.

The network is chaired by Jonathan Cassidy, Senior HR Business Partner and William Hopkins, PA to Head of Specialist Services.

The network held its first LGBT History month event in February 2020 which was a huge success with support from West Midlands Police and Birmingham Health and Wellbeing Centre.

The network has built strong relationships with key stakeholders; Birmingham LGBT Health and Wellbeing Centre and West Midlands Police.

The network is part of the West Midlands NHS consortium of LGBT Networks and took part in a very successful 2021 LGBT History Month Conference in March 2021.

Representatives from the network regularly attend Trust EDHR Steering Group to give updates and campaign for changes to make BCHC a great place to work for its LGBT employees.

In 2020 the Network had a stand at the Trust Leadership Conference to raise awareness of the network to Senior Leaders.

The network has its own web page and dedicated email account to communicate with its members, allies and the wider Trust. There are 186 colleagues from the Trust on the mailing list for the network across a number of Divisions and staff groups.

Results:

The network was allocated a budget of £5k from the Trust to assist with expenditure including Birmingham Pride.

The network has been recognised by Trust EDHR Steering Group and has received support from Richard Kirby, Chief Executive and David Holmes, Director of Workforce.

The network has purchased 4,000 rainbow badges for colleagues who wish to wear these. The Rainbow badge is a symbol of inclusion and LGBT+ equality.

The network wishes to engage more with staff going forward to have a presence as part of the Trust Induction. The future goal of the network is to make BCHC an employer of choice for LGBT people and to build a stronger relationship with the Stonewall charity.

Research and Innovation

COVID-19 Challenges and Opportunities: The onset of COVID-19 led to a significant increase in related research and innovation activity requiring additional staff to provide support. The COVID-19 surveillance study conducted in schools created the opportunity to collaborate with Primary Care and Clinical Research Nurses representing a new way of working that will be embraced in the future. The increased demand of research and innovation during COVID-19 is an opportunity to raise our profile and awareness within the organisation.

Innovation Champions: In line with the renewed R&I strategy and the ambition to have Innovation Champions in divisions, the R&I team identified technology-loving research-orientated colleagues to fulfil this role and support the team with various innovation initiatives.

ORCHA Digital Health Tools: BCHC has deployed a digital health app library for citizens of Birmingham that will allow clinicians to recommend appropriate and safe apps of high quality to their clients.

Attend Anywhere Support: The R&I Team designed and deployed the patient and clinician surveys for evaluation of the attend anywhere virtual consultations. Data was reported back to the services and to the Trust board which included the friends & family test and protected characteristics data.

CHART (Community Healthcare Alliance of Research Trusts): CHART is a national initiative led by BCHC, which continues to grow and have an impact. The CHART working group have led a number of national online events where Community Trusts and other organisations providing out of hospital care shared experiences and ideas on for e.g COVID-19 research, vaccine trials and creative collaborations across organisations to support research amidst the challenge of staff depletion due to re-deployment.

Awards: Involvement in COVID-19 research has strengthened research collaboration and partnerships both within the Trust and externally with academic institutions and the local clinical research network. In recognition of this work a Paediatric Consultant and the R&I Team received BCHC Values in Practice Awards. The R&I Team was also Highly Commended for Collaboration in Research by the NIHR Clinical Research Network West Midlands as part of their Annual Partner Awards.

Research and Innovation

R&I activity during COVID: Most innovation and research projects were placed on hold whilst we understood the process of undertaking trials and pilots with Covid in and amongst us. Below is a list of some of the activities that continued including projects that R&I have played a vital role in supporting the government's strategy to tackle COVID-19.

Project summary	Principal Investigator / Study lead
SIREN Study: A Public Health England research project which aims to understand whether prior infection with COVID-19 protects against future infection with the same virus. For this study participants agreed to be tested for the virus and antibodies and provide data regularly over 12 months.	April Hawkins, Deputy Director for Nursing and Therapies
Clinical Characterisation Protocol for Severe Emerging Infection: This research involves collecting symptom and outcome information from records of patients diagnosed with COVID-19.	Dr Joanna Garstang, Consultant Community Paediatrician
COVID-19 enhanced surveillance on schools in England: This is a programme of work managed by Public Health England to test local school staff and children for the virus and antibodies and collect data on their health and illness.	
COCO-COVDENT: This is an observational study to examine the correlates of humoral, cellular and molecular immunity against SARS-CoV-2 in convalescent health care workers with a focus on dentistry staff.	Professor Iain Chapple and Prof Thomas Dietrich, School of Dentistry, University of Birmingham
A suite of studies that capture healthcare workers experiences during the pandemic and inform the development of supports services: **Psychological impact of COVID-19** – pandemic and experience: An international survey. **The COVID-19 Resilience Project:** Studying the impact of COVID-19 on the NHS workforce to guide trauma-informed and psychologically-informed support provision. **UK-REACH:** United Kingdom Research Study into Ethnicity And COVID-19 outcomes in Healthcare workers	Dr Sunny Kalsy-Lillico, Trust Head of Psychology and Psychological Therapies
Virtual Consultations: Innovation team have been supporting the Digital team in the selection and deployment of the virtual consultation software, called Attend Anywhere. An evaluation framework was designed to assess impact of this new mode of service delivery on both patients/service users and our services/staff members	Hamid Zolfagharinia, Innovation Manager and Clinical Scientist
RIQI (Research and Innovation into Quality Improvement) **Review:** A RIQI report was produced to compare available Surveying solutions and it recommended that Smart Survey was the company to use based upon their security, functionality and cost.	
Patient Portal: Digital and R&I teams developed the requirements for a patient portal and demo's were from various suppliers. A supplier of choice has been selected and the portal will be commissioned in the next financial year.	Hamid Zolfagharinia, Innovation Manager and Clinical Scientist & Bolaji Akinwale
DoMore: Developing an intervention to reduce sedentary behaviour in non-ambulant young people with long-term disabilities.	Marilyn Bradbury
Snacktivity: To promote physical activity and reduce future risk of disease in the population. The Podiatry service have been informing and testing the recruitment strategy, the Snacktivity intervention and training material in preparation for the feasibility study due to open in the spring of 2021.	BCHC R&I Sponsored NIHR Funded Research
Trauma-AID: Trauma-AID: Eye movement desensitisation and reprocessing (EMDR) for symptoms of post-traumatic stress disorder (PTSD) in adults with intellectual disabilities. The protocol has undergone major amendments to make it COVID secure and is now ready to open at several sites across the country imminently.	

New for 2021/22

The strategic activities of the R&I team will be achieve through the Clinical Digital Innovation Forum and the Research and Innovation Forums launched 18 months and 8 months ago respectively. Strategic objectives previously set were paused during COVID-19 and will be reported next year.

Chief Clinical Information Officers (CCIOs)

Andrea Grace

As we enter the second year of having Chief Clinical Information Officers (CCIOs) in BCHC, the role of a CCIO to improve the links between clinical staff and Information Technology (IT) teams has continued.

Over the past 12 months they have developed and built on links across the organisation which has enabled them to contribute to digital leadership and facilitate the implementation and adoption of new technologies.

A key challenge has been the implementation of a remote consultation solution in response to the COVID-19 pandemic, as well as supporting other aspects of the BCHC response such as COVID data reporting and the development of trust wide coding solutions to support services to accurately record their new ways of working and monitor the risks of extended waiting times for our service users.

In addition to their role in the COVID response they have continued to support multiple projects within the trust that are dependent on the successful implementation of information system solutions, some ongoing and some new. The procurement process for our Electronic Prescribing and Medicines Administration (ePMA) has continued to progress, as has the journey towards the procurement of a Patient Portal and the transition to implementation of electronic patient records (EPR) in our inpatient units as well as the overarching development of the EPR core record; standardising Care/Intervention plans across services. The ability of clinical services to evidence the impact of their interventions to our commissioners is key and significant progress has been made to incorporate a simplified measure within the Care/Intervention plans across the Trust, which will support this requirement.

Jon Higham

A key focus for both CCIO's has been ensuring the approach taken across the Trust remains patient cantered and supports the patient's journey within our organisation - the emphasis remains on the creation of a single source of truth with data shared appropriately between relevant professionals, information entered being pulled into clinical letters, reducing the need for duplication and unnecessary data capture.

This too has taken on new meaning as we move forward with a regional shared care record ensuring the needs of our clinicians and service users are meet within the solution.

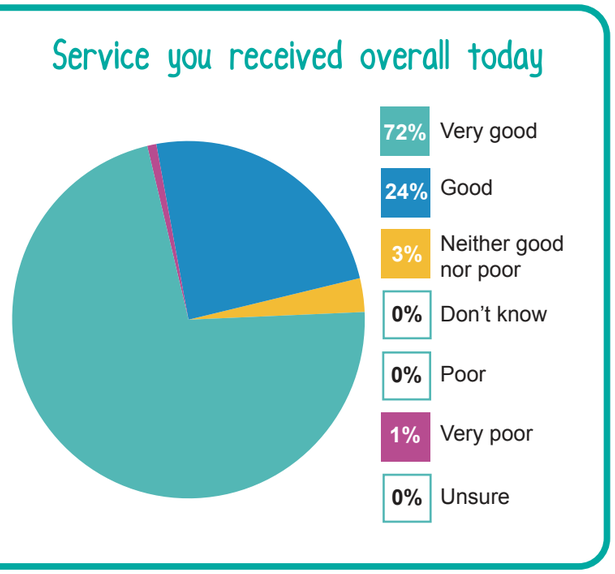
Over the next 12 months their focus will remain on the expanded roll-out of the "patient centred" EPR core record. Whilst providing on-going support to the many digital projects that are already underway, they will continue to improve the links between clinicians and informatics colleagues, supporting future projects as they arise. The benefit of having the CCIO roles within the organisation has been firmly established and they are keen that the Trust continues to profit from the improved clinical engagement that has resulted from the introduction of their roles within the organisation.

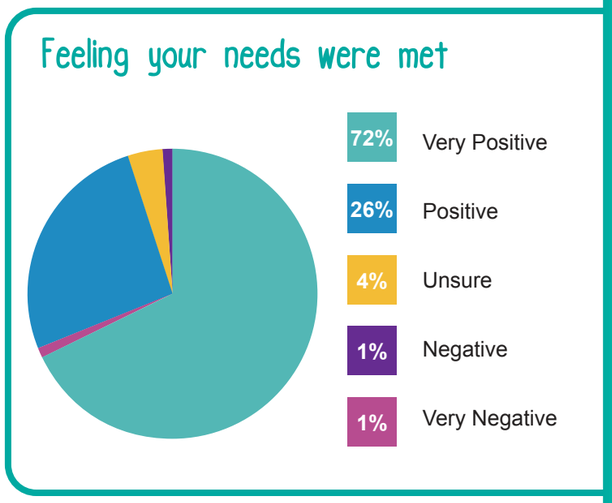
Remote Consultation

The COVID pandemic and the first national lockdown meant that there was an urgent need to expand the delivery of telephone consultations and to introduce video consultation in the Trust to help maintain our clinical services whilst maintaining a COVID secure estate.

Our clinical services quickly up scaled telephone consultations during March 2020 whilst Digital Technology Services explored options for the provision of video consultation. After trialling several video consultation platforms we opted for the national offer of the Attend Anywhere video consultation platform. We first trialled this with the Children's and Families Speech and Language Therapy Service and then rolled out further to all suitable clinical services in the Trust. In July 2020 we also introduced Microsoft Teams for group and large MDT consultations. As we had to urgently move to delivering our services remotely a major focus over the last year has been developing the supporting governance and guidance to enable our clinicians to provide remote consultations safely and to feel supported in delivering this change.

We are now delivering around 1000 video consultations a week which is around 5% of all contacts and around 20% of our contacts are delivered by telephone. We have received very positive feedback from around 1400 service users who were seen by video consultation.





This transformation has been a team effort with contributions from across corporate services and the clinical divisions. We have recently led a Midlands regional procurement of Attend Anywhere, involving 20 NHS Trusts, for 2021/22 and this has achieved considerable financial savings for the region and ensured continuity of service. There remains a significant opportunity to expand our use of remote consultation, particularly in managing long waits as a result of the impacts of the pandemic. We anticipate that remote consultation will continue to play an important role in the way that we deliver services in the future and the next phase of the deployment will focus on co-design with service users and the wider public of our future provision of these technologies. An area of concern is that of digital poverty and digital literacy limiting some service user's access to these technologies and this will be a major focus of our work during the next year. We have already engaged STP partners in planning how we will mitigate these issues and we are currently trialling a video consultation pod at Priestley Wharf for use by patients across the region as well as by Trust staff.

BCHC Charity

Supporting Staff & Patient Wellbeing

Thanks to the incredible show of support from fundraisers, donors, local business and NHS Charities Together, BCHC Charity has been able to fund all sorts of items and initiatives across the Trust to help patients, service users and colleagues throughout the COVID-19 crisis.

The focus throughout the pandemic has been on boosting colleague morale and wellbeing by funding projects that encourage BCHC colleagues to take breaks, look after themselves and relax, as well as supporting patients with entertainment, activities and home comforts. In February 2021, the Charity launched Winter Wellbeing Staffroom Kits which contained an array of items to help boost colleague wellbeing, such as; lunch bags to encourage staff to take breaks and ensure they are well nourished, hand cream to ease the dry skin caused by frequent hand washing, scented candles to promote relaxation after a shift, eye masks to aid with sleep, and more. Zara Mahmood of the Inclusion Team in the Central Booking Service was very happy to receive a kit for the team. “They have given us a real boost in these dark times”, she said. “It’s so uplifting to see these little things that can help, especially the activity book, as I love doing puzzles.”

For inpatients, it quickly became clear that lack of visitation from families, friends and carers due to COVID restrictions caused two large issues; boredom and increased anxiety, and a lack of basic dignities such as having spare clothing or extra toiletries.

“The packs will make lockdown life that bit easier.”

BCHC Charity worked closely with matrons and ward staff to help provide entertainment items such as TVs, DVD players and DVDs, CD players and CDs, board games, books and audio books, jigsaws, and more. In December, Winter Entertainment Kits containing festive films, winter novels and a snow scene jigsaw to help spreads some festive cheer. In February 2021, the charity provided over 320 Winter Activity Packs across the inpatient units in the Trust. The packs contained colouring books and pencils to help ease anxiety, puzzle books to relieve boredom, playing cards for entertainment, and more. The charity also provided pyjamas, loungewear and travel toiletry kits in lieu of items usually brought in by family and friends.

At the start of the lockdown period, the LD Division approached the charity with ideas on how to help support patients with learning disabilities to adjust to the sudden change in their routine and lack of access to their usual community activities. We worked together to create ‘Stay At Home’ activity packs to help relieve boredom, provide distraction and promote positive behaviours during this challenging time.

The packs contained arts and crafts supplies, games, gardening tools and seeds, colouring books, puzzles and much more. Simone Bettam of the LD Intensive Support Team said “These packs were delivered to adults with learning disabilities who were struggling with the change to their day-to-day routine. The packs will make lockdown life that bit easier.”

Providing Comfort in End of Life Care

Experiencing a loss is always devastating, but the visitation restrictions due to COVID-19 have made this even more difficult for families and their loved ones. Thanks to incredibly kind donations, BCHC Charity have funded several initiatives to help patients and their loved ones accessing end of life care.

Our Bereavement Memory Boxes are a lovely way for families to celebrate the life of their loved ones, containing remembrance items such as memory candles and seeds to grow a forget-me-not plant. There is an inset on the lid to display a treasured photograph, and they are large enough that further personal trinkets and items can be added to create a box of wonderful memories. Sarah Turner, one of the Trust’s Enhanced Care Assistants, prepared a box for the son of a gentleman who passed away at West Heath Hospital. As well as the remembrance items funded by the charity, Sarah placed the gentleman’s glasses and watch inside, much to the appreciation of the son. “The son was very emotional when he was given the box”, says Sarah. “He said it was a really lovely thing to receive, as he hadn’t expected to receive anything from the hospital.” Colleagues are also adding their own personal touches, such as signing condolence cards, to let families know how much they cared for their loved ones during their time under BCHC care.

Local artist Hannah Clark designed bespoke framed superhero prints, 100 of which were provided as Christmas gifts to families accessing our Community Children's Nurses and Children's Palliative Care teams as a means to brighten the children's day and provide a lasting keepsake for families.

The Charity Team also worked closely with Anne Pemberton of the Patient Experience Team and Ruth Denton of the Palliative Care Team to refurbish the bereavement room at Moseley Hall to create a more inviting and tranquil space for reflection and meditation. The newly named Dandelion Room has been thoroughly redone, having been painted a more peaceful and relaxing shade of silver, with new flooring, seating and furniture, and a beautiful dandelion mural. Bereaved families now have a more private setting to take the time to process prognosis or bereavement, with hot drink facilities and bereavement resources available.

Granting wishes at the West Midlands Rehab Centre!

Thanks to an amazing fundraising effort from Jeevan's Legacy, the paediatric fitting room at the West Midlands Rehabilitation Centre has been treated to a £10,500 makeover! Jeevan's Legacy was established by Cathy Dhanda in memory of her son Jeevan who died in August 2014 aged just 18. One of Jeevan's dreams had been to set up a children's charity which led his family to establish Jeevan's Legacy.

The room was transformed by local interior designer Nikki Shaw, who took on the exciting challenge of creating a space that is practical and functional, as well as inviting and suitable for children of all ages. The fitting room has now been enhanced with new furniture, technology, storage solutions and décor, and has become a space which families accessing the service can enjoy during their appointments.

Senior Occupational Therapist Sue Barlow said; "The room is not only very functional, but it is a bright cheerful space that is a pleasure to work in. The families who attend have all commented positively on the transformation, and the new toys are being well used therapeutically. The whole team and patients are delighted and we thank Cathy and Nikki very much".

Nikki was so taken by the team, she decided to make-over the staffroom at the centre for free, to say thank you to all the people she met whilst working on the fitting room project. "Everyone made me feel so warmly welcomed and it was fascinating to learn about the roles of the staff who do such a valuable job caring for patients and their families every day", she said.

"Not only that, but the fact that so many staff went to help in other departments and hospitals during the height of the COVID pandemic.

I have the utmost respect for everyone working for and with the NHS to protect and save the lives of so many people in the UK."

Jos Van Mulken, Service Lead for Specialist Orthotics, Prosthetics and Amputee Rehabilitation said: "It has been brilliant working with Nikki in transforming the paediatric fitting room at the centre. It was such a lovely surprise when Nikki offered to redecorate the staff room as a token of appreciation to all NHS staff. The room is now a relaxing space to retreat to following busy clinics. Colleagues are using this room a lot more which is a pleasure to see. Thank you so much Nikki."

Children accessing the centre also benefited from an incredibly kind three-part donation from construction company John Sisk & Son and their client Moda; first came a donation of beautiful handcrafted wooden toys made by the apprentice carpenters at the company's workshop in Dublin, then a donation of 70 individual toys to be given out as Christmas gifts thanks to a successful toy drive at the company's Birmingham office, and finally a monetary donation to help BCHC Charity continue to make a difference at the centre. Tony Brooks, Managing Director at Moda, said; "With the extreme challenges faced by so many this year, it is a true pleasure to be able to bring some Christmas joy to children in Birmingham, our newest home. At Moda, we work hard for the communities we live in… we're proud to give back to the community as we look ahead to everything we can bring to the city."

Birmingham Community Healthcare Charity

Supporting Team BCHC

Over £440,000 raised in 20/21 to support patients, service users and colleagues

759 bereavement support items

1,905 toiletry kits and individual toiletries for inpatients

35,960 items to support colleague health and wellbeing

7,334 activity items and 683 entertainment items

1,069 items of clothing and sleepwear

If you would like to find out more about BCHC Charity, what we do, or how to fundraise or make a donation, please contact the Charity Team on 0121 466 7314 or via email to bchc.Charity@nhs.net.

Safeguarding

Who's in Charge?

In 2011 BCHC Safeguarding nurses conceived the Who's In Charge?™ slogan in response to concerns that growing numbers of babies and children are put at risk of harm because of the way parents and carers consume alcohol at home. A set of training and interactive materials were created to help health visitors and other professionals prompt discussion and reflection about parental use of alcohol and the risks that present.

This resulted in a series of films being produced by a film campaign team, comprising of the BCHC Safeguarding Named Nurse and Communications team, a local film producer and the Designated Doctor for Child Death. The campaign was supported by Birmingham Safeguarding Children's Partnership (BSCP). The film campaign was launched in national Alcohol Awareness Week on 6 November 2020. To date it has reached across city, regional and national safeguarding partnership networks and, as a public health safeguarding message, has spread using online and social media strategy.

Actions taken:

- Five two minute films were produced with story lines representing true life scenarios that are commonly seen in relation to the safety of children.
- The team wanted to concentrate on the danger of sleeping on a sofa or a bed with a baby when the adult has been consuming alcohol this being a recurrent theme of national and local child death & safeguarding reviews.
- The films were designed to have a generic public health appeal that any parent or carer could identify with.
- Following a presentation to the BSCP the campaign was formally adopted for the city and a campaign task group was formed.
- The BCHC communications team worked as part of the campaign group using their individual skills and expertise to steer and monitor the progress of the campaign via external web based communications networks and on social media.
- The task group met frequently to agree a launch date and strategies based on social media outcomes.

Key Successes:

'The 'Who's in Charge?' Campaign (films and images) have been presented at professional safeguarding and partnership events locally and nationally and are being used in their training and their social and online media sites.

- Working in close partnership with BSCP the safe sleeping films and messages connected with sofa sleeping and bed sharing have been shared across city, regional and national partnership networks
- The original campaign images and message were picked up by the British Armed Forces in Germany and Belgium for use at community health venues and regional A&E departments used them in Christmas campaigns.
- Social media was the key to spreading the films and 'Who's in Charge?' message. Having access to that expertise within the BCHC communications team enabled the campaign team to monitor, target and amend their approach to maximise the reach and potential of the message.
- There was evidence of online and social media conversation about the message which had been designed to influence parental behaviour and save lives.
- By analysing the social media behaviours the team were able to work with the film producer to provide shortened one minute versions to increase the viewings.

Results:

- The Who's in Charge online message has been seen 1,117,972 times
- The films have been played 888,731
- The campaign task group have been commissioned to make a film connected with another national baby safeguarding message….the work goes on.

Safe and Well Checks

West Midlands Fire Service called a Serious Incident Review following the passing of an old lady with mobility concerns as the result of a house fire. She had taken to sleeping next to the gas fire which presented a fire risk as it was surrounded by personal items and knitting equipment including wool.

A Serious Incident Review is a multiagency review linked to the Fire and Rescue Services Act 2004. It looks at learning and sharing lessons which may come from a serious incident where there has been loss of life or significant harm. From this tragedy BCHC and West Midlands Fire Service linked together to promote steps to try to avoid similar issues in the future.

Actions taken: Recognition that Safe and Well checks, supported by West Midlands Fire Service, are an important part of prevention activity. They provide advice and awareness on safety at home, with a particular focus on those most vulnerable. BCHC staff are in a unique position visiting individuals and families in their own homes and may pick up on concerns or worries for which a Safe and Well check is vital as it involves much more than just fitting smoke detectors.

The Safe and Well check can include looking at:

- smoking, alcohol, medication and drugs
- mental health, dementia
- mobility including slips, trips and falls
- hoarding
- loneliness and social isolation
- healthy eating and lifestyles
- home security
- road safety

Key Successes:

BCHC and West Midlands Fire Service planned and delivered a number of awareness sessions which were well attended by BCHC staff which raised the profile of Safe and Well visits. Having this tool in a practitioner's toolkit is helpful in terms of supporting our community
and this was the aim of the awareness sessions.

Results:

Increased awareness of fire risk and the role of partnership working to address concerns. It highlighted the role of West Midlands Fire Service and BCHC working together to protect those vulnerable to risk.

Homelessness, we all have a role to play

A young man, sadly passed away aged 31 on the streets of Birmingham back in 2019. He had been homeless and died tragically young. His death is subject to a Safeguarding Adults Review from which lessons will be identified for agencies across the city of Birmingham and beyond. His death, widely reported in the media, has opened the eyes of many to the plight homelessness delivers and the recognition that we all need to do more to address the issues which cause this tragedy.

The Safeguarding Team recognised that we need to better understand the lived experiences of those impacted by homelessness and with this in mind supported a team member to embark on a training programme to develop understanding and awareness of the issues faced by those impacted by homelessness. In addition the Homelessness Reduction Act 2017 introduced a duty on public bodies in England including the NHS to refer consenting people they think may be homeless or threatened with homelessness within 56 days to a Local Housing Authority. The team focussed on raising awareness of this Act and our role to support the Act. Furthermore it was recognised that awareness raising is important and an eLearning package was developed by Safeguarding Adults Practitioner Cathy Knox.

Cathy recognised the importance of BCHC staff being able to identify factors which may lead to an individual being homeless so that we can recognise the role we all play in homelessness prevention right through to action to address the concern when an individual reports that he/she is homeless.

The development of a Homelessness Training package available for all staff at BCHC via eLearning at Moodle. Secondly, a commitment to share our eLearning with partner agencies recognising the challenges this issue presents to society no matter what agency you come from. Thirdly membership of two multiagency forums which look at partnership working to address the issues of homelessness. One forum is enriched by people with lived experience of homelessness with a desire to ensure healthcare is accessible and respectful to those no matter what background an individual comes from.

The outcome is increased awareness of Homelessness and the role we can play to address concerns. We recognise that this young man's death is a tragedy for all of us and any small or big steps we can take to prevent this issue are important to consider. Dr Doug Simkiss, Medical Director and Caldicott Guardian, also facilitated awareness raising of the issues of homelessness across Birmingham for children and adults at the Improving 2gether forum held on the 24th of February 2021. The presenters included Nikola Demetrius, Specialist Health Visitor for Homeless Families and Liz Webster Associate Director of Nursing who highlighted the impact of this issue on individuals and families both adults and children.

Domestic Abuse, We can prevent it

Sadly, Domestic Abuse is an issue faced by people across the city, this includes BCHC patients, staff, women, children and men. BCHC notes that nobody should live in fear of violence or abuse. To do so is a violation of human rights. Domestic abuse may not be limited to partner on partner abuse and is not an issue limited to younger people, but any person, any age, any gender can experience domestic abuse including in a situation where an individual is cared for in a relationship such as a mother being cared for by a son as seen in a Safeguarding Adults Review recently.

Tackling domestic abuse must become everyone's business. BCHC recognised the Birmingham Domestic Abuse Prevention Strategy 2018-2023 and our role to play in this strategy. Much focus was aimed at having a robust Domestic Abuse policy in place so that staff are clear on actions to take when faced with this issue. Additionally much work has progressed with the realisation that sadly domestic abuse can impact on not only members of the Birmingham community and Patients of BCHC but also staff who may work for BCHC.

It was important that BCHC support the Birmingham Community Safety Partnership and Birmingham Safeguarding Adults Board through the work of Domestic Homicide Reviews and Safeguarding Adults Reviews which are statuatory functions which focus on learning to aid better understanding and awareness in this area as well as ensuring any response to domestic abuse is robust when the issues arise.

The development of a Domestic Abuse training package available for BCHC which aids raising awareness, understanding and embeds a realisation that we all have a role to play in its prevention. Secondly the development of policy to aid staff in managing issues presented. Thirdly raising awareness of the DASH assessment and MARAC process which has been shared though Safeguarding Newsletter, e-bulliten and with a link to the BCHC website so that those working with patients or managing staff can take on board how these processes may aid the safe management of concerns.

The DASH assessment is the Domestic Abuse, Stalking and Honour Based Violence assessment while MARAC stands for Multi-Agency Risk Assessment Conference.

Awareness that this issue impacts on many however we all have a role to play to support patients, citizens of Birmingham and BCHC Staff as Domestic Abuse can impact on anyone. The results focus on the fact that whether you are a nurse visiting a patients home, or a Human Resource manager supporting staff or a clinician on an inpatient unit we can all do something to address this issue.

Safeguarding and Prevent training figures

	Compliant	Required	%
Safeguarding Adults Level 1	4333	4589	94.42%
Safeguarding Adults Level 2	3107	3277	94.81%
Safeguarding Adults Level 3	129	147	87.76%
Safeguarding Adults Level 4	3	3	100%
Safeguarding Adults Level 5	1	1	100%
Safeguarding Adults Higher Levels	3240	3428	95%

BCHC Christmas Message

Along with the rest of the world, BCHC Paediatric Physiotherapy have been on quite a journey over the last year -here it is in song!!

https://youtu.be/vKGehQr3qG0

Dementia-Friendly Dolls Provide Therapeutic Boost

The therapeutic use of lifelike dolls for people with dementia has been gaining traction over recent years, as research shows that dolls or soft toy animals can provide much-needed benefits.

The dolls can enhance a patient's level of engagement by giving them something to nurture, or a renewed sense of purpose. They may also inspire pleasant reminiscence of a time when the patient had young children. Some patients living with dementia find that they simply get enjoyment from holding or being with the doll as a form of comfort. There is evidence to suggest that the use of dolls can be particularly helpful to those with enhanced dementia, improving their wellbeing and ability to communicate, as well as often times leading to an increase in activity levels.

Kelly Ellis, Enhanced Care Team Lead, approached the charity to trial therapy dolls within the Adults & Specialist Rehabilitation Division. The idea was to introduce dolls to patients that staff felt would appreciate having something to nurture, in a bid to improve their wellbeing during their time under BCHC care.

A trial of dolls was funded by BCHC Charity in July 2019, and the results have been fantastic. The project has had a number of positive outcomes including having a calming effect when anxious or upset, agitated or not sleeping. For example, a patient at Willow House was calling out for her children so the Enhanced Care Team asked the patient's family if they would agree to use of a therapy doll. They were grateful; a family member explained that the patient had previously worked in a children's nursery and took to the doll immediately. The doll became a constant companion to the patient; they would change the doll's clothes, walk about and sleep with it and a calming effect was noted. The doll left with the patient when they were discharged.

Thanks to kind donations and fundraising for BCHC Charity, following the success of this trial, further dolls will be provided by the charity to continue this therapeutic process.

Marion Darby with two of the therapy dolls

Section 5

Heading

Assurance Process

In order to assure ourselves that the information presented is accurate, and that the services described and the priorities for improvement are representative of BCHC, the Trust Board designated the Director of Nursing and Therapies to lead the process of developing the Quality Report for 2020-21.

The Director of Nursing and Therapies ensured through the Clinical Quality Assurance Programme Manager that BCHC's main stakeholders were given the opportunity to comment and provide an objective view around the content of this Quality Report and the goals it set itself for improvement for the coming year.

External influence has included the Council of Governors, Healthwatch and our Commissioners in order to ensure that the Quality Report presents a balanced view of the quality of care delivered by BCHC.

The Trust has shared a draft Quality Report 2020-21 with our commissioners through NHS Birmingham and Solihull Clinical Commissioning Group (co-ordinating commissioner), Healthwatch Birmingham and Birmingham Health and Social Care Overview and Scrutiny Committee.

Their responses can be found on the following pages.

Consultation with staff and some Public Governors took place through BCHC committee structures and staff forums which included open access 'page turning' sessions via teleconferencing whereby attendees were given the opportunity and time to talk through and comment on the content of the Quality Report. The whole process has been overseen by the Quality and Safety Executive.

Progress was reported to a number of executive led committees before its final approval. External assurance work on quality reports was not mandated this year and no limited assurance opinions are to be issued in 2020-21.

Clinical Commissioning Group (CCG)

Birmingham Community Healthcare NHS Trust
Quality Account 2020/21

Statement of Assurance from NHS Birmingham and Solihull CCG

May 2021

1.1 Birmingham and Solihull Clinical Commissioning Group (CCG) as coordinating commissioner for Birmingham Community Healthcare NHS Trust (BCHC), welcomes the opportunity to provide this statement for inclusion in the Trusts 2020/21 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 7th May 2021 and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that BCHC provides. The range of services described and priorities for improvement are representative based on the information that is available to us. The report demonstrates the progress made by the Trust against the 2020/21 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2021/22.

1.4 It was reassuring to see how during the SARS-CoV-2 pandemic BCHC recognised the need to maintain assurance on the quality of care delivered and that senior committees continued to meet and monitor service delivery. Throughout this period, Patient Experience remained at the heart of the work undertaken by the Trust and a patient story remained as a focus at the Board meetings.

1.5 The information provided around Equality Diversity and Inclusion demonstrates the Trust's commitment to workforce inclusion and improving the experience of staff. In spite of COVID-19 BCHC has maintained this commitment through its Becoming a Truly Inclusive Organisation Action Plan, the launch of an anti-racism campaign, and the establishment of a Service Equality working group. Commissioners welcome the identified work streams to develop a BCHC vision for addressing health inequalities and appointment of a Staff Network Coordinator in 2021/22.

1.6 Both Community and Inpatient services have shown an increase in numbers of pressure ulcers developed in their care during 2020. This increase in pressure ulcers is also apparent in national data. The information presented demonstrates how BCHC are monitoring trends and benchmarking against national data. As commissioners, we continue to work closely with the Trust to regularly review progress in implementing its quality improvement initiatives to reduce the incidence of pressure ulcers.

1.7 It was encouraging to see that BCHC Children & Families Division held two Virtual Clinical Effectiveness events in July 2020 and February 2021. We note the focus on areas highlighted as safeguarding of children, and the links between health in schools and improving learning for children, which had both been highlighted as a significant problem during the pandemic. Commissioners recognise the value of such events in helping towards sharing best practice and improvement projects across the Division and supporting staff development.

1.8 The CCG recognises the importance of the introduction of The Family Liaison Officer (FLO) role which was launched at the beginning of April 2020 and the Letters to Loved Ones service managed by the Patient Experience Team which provided an essential link between patients and their families / loved ones at times when COVID-19 restrictions were in place preventing in-person visiting. Commissioners are interested in future development of the FLO role and encourage BCHC to share case studies across our region to highlight lessons learned in contributing to the improvement of services.

1.9 The quality priorities for 2021/22 reflect areas where improvement is required. The CCG is supportive of the priority to increase Patient and Public Engagement, working with individuals and groups to ensure that the care they provide meets the needs of Birmingham and will continue to work with BCHC over the next year in the delivery of this and all of the ambitions set out in this account.

1.10 The CCG welcomes the inclusion of a Learning from Deaths section in the 2020/21 Quality Account and is encouraged by the learning across the care pathway for End of Life Care in children and adults services to encompass a system wide partnership improving palliative care across Birmingham. Commissioners support the identified priorities to embed quality improvements in the recording of patient wishes for care at the end of life and recording of indication for use of anticipatory and will continue to work with BCHC over the next year in the delivery of this and all of the ambitions set out in this account.

1.11 The section on Participation in Clinical Audit is well presented and clearly provides the reader with details of the Trust's performance. It was positive to see the number of clinical audits that were undertaken in 2019-20. The detail in the report gives further assurance regarding actions taken and changes to practice as a result of this work . In response to the National Confidential Inquiry into Suicide and Homicide: Annual Report, the CCG is pleased to note ongoing work in relation to the Suicide Prevention Policy training and guidance available to support staff in the event they are approached by patients or colleagues .

1.12 It is encouraging to see how the BCHC Clinical Council has become the senior clinical voice in the organisation and have, in conjunction with the CCG and NHS Improvement developed a clinical prioritisation process to bring clinical insights as we address patients and service users waiting for care. The CCG acknowledges the positive work undertaken to date and supports the Trust's 2021/22 quality priority to bring down patient waiting times while ensuring they are safe.

1.13 As commissioners, we have worked closely with BCHC over the course of 2020/21, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2021/22.

PAUL JENNINGS
CHIEF EXECUTIVE OFFICER
BSOL CCG

Health and overview scrutiny committee (HOSC)

Response to BCHC Quality Report 2020-21

The Birmingham Health and Social Care O&S Committee (HOSC) recognises the challenges faced by the Trust over the past 12 months to maintain services whilst coping with the extra demands resulting from the Covid-19 pandemic.

The committee would like to put on record its sincere gratitude to the staff who have worked tirelessly to meet the needs of the people of Birmingham.

The committee is also aware of the challenges that lie ahead in order to restore services and to clear backlogs. Nevertheless, we are pleased to note and applaud some of the new and innovative ways of working that have been introduced as a consequence of the pandemic including the introduction of Family Liaison Officers to enable families to maintain contacts with patients in hospital. Also, the 4 new teams that have been established to provide safe and effective care across services city-wide.

Specifically looking at the Quality Priorities for 2020-21, the committee is pleased to see that all 3 goals for Priority 1 improving children's services have been met. It also recognises that although Priority 3 has been partially met that it was imperative to deliver the Early Intervention Programme in order to discharge patients from hospital to free up beds for Covid-19 patients otherwise the acute sector would have been overwhelmed. The committee welcomes the development of the New Opportunities Programme under Priority 4 and work that is being undertaken to ensure sustainable staffing levels Trust-wide. Finally, it is encouraging to see that 2 out of 3 goals under Priority 6 - Safe Sustainable Staffing have been met especially in a year where Covid-19 has had a significant impact on the health and wellbeing of NHS staff.

The committee notes that the outcome of your 2020 CQC inspection rating which has improved from 'inadequate' to 'requires improvement' but has serious concerns that the rating for community health services for children and young people 'requires improvement' in 5 out of 6 categories. In our Scrutiny work programme we have resolved to pay closer attention to this area of the Trust's role in the coming year and look forward to working constructively with you to assist in developing further improvements.

It is also concerning that there has been a further significant increase in incidents reported relating to care delivery (including pressure ulcers), which we have previously highlighted, where the figure has more than doubled since 2018/19. Also, of concern, is the performance in Health Visitor Essential Care where there is a clear need for improvement.

However, in summary, notwithstanding these latter observations, it is very encouraging to see, overall, there are many positive examples of success and plans for continuing improvement including: -

- The decision to continue with the Audit of Care at End of Life and the improvements in documenting recognition and care planning at end of life.
- The National Diabetes Audit – Footcare.
- Despite there being 405 deaths within the Trust following a review/investigation of case records that no deaths were due to problems with care provided.
- The low levels of emergency readmissions within 30 days of discharge.
- That there was no significant change in the results of your Staff Survey other than an increase in the number of responses.
- Recognition that staff sickness levels have been affected by Covid-19 but also note that the 12-month average sickness absence rate of 6.56% is an improvement on 2019/20 which was 7.88%.

In relation to the proposed Quality Priorities 2021-22, it is encouraging to see the emphasis on enhancing patient and public engagement. In particular, we welcome the re-launch of the Learning Disability Services Service User Group online. This will be potentially valuable in our own work on the development of a revised day opportunities strategy across the City. Similarly, the implementation of the Patient Portal is an important and much-needed modernisation in technology and a strengthening in the extent of patient and service user empowerment, transparency and shared care management. We believe these will add significant value to the quality of the relationship between the Trust and service users.

The committee looks forward to its continuing relationship with the Trust and the positive outcomes that can be achieved for the people of Birmingham through partnership working.

Councillor Rob Pocock

Chair Birmingham Health and Social Care O&S Committee

Healthwatch

Statement from Healthwatch Birmingham on Birmingham Community Healthcare NHS Foundation Trust Quality Account 2020/21.

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Birmingham Community Healthcare NHS Foundation Trust. As we give our comments to the Quality Accounts 2020-21, we would like to first thank the Trust's staff for their hard work throughout the pandemic and their commitment to the Trusts vision and values. Indeed, feedback from service users has highlighted the commitment and hard work of the staff at BCHC:

Really quick service, staff were fantastic and really welcoming. Very COVID secure (March 2021)

I am the daughter of a resident at Perry Trees Care Centre. I would just like to say a very big thank you to the manager and all his staff for all the hard work, care and compassion they show to not only my mum but all the residents. We understand how difficult and challenging these times are and would just like to pass on our appreciation and gratitude to everyone involved at Perry Trees. It's so comforting to know we can phone and speak to a member of staff or to Mum and get updates on her wellbeing. The manager and his staff are amazing and a credit to Perry Trees (April, 2020).

Patient and Public Involvement

We are pleased to see that patient experience has remained at the heart of the Trust's work. We note that patient stories are still leading board meetings enabling the Trust to maintain focus on the quality of services.

The development of a new Engagement Strategy for Patients, Service Users and Communities is welcome. Equally that the Trust has appointed a new Associate Director of Community Engagement and Partnerships that will oversee the community elements of the engagement strategy. We look forward to working with the Trust on the implementation of the engagement strategy.

Without in-depth knowledge of the engagement strategy, we would like to urge the Trust to ensure that the strategy has the overall objective of using 'patient and public insight, experience and involvement to identify, understand and address the potential consequences of service improvement, design and development on health inequalities and barriers to improvements in health outcomes (including increasing independence and preventing worsening ill-health)'. This will enable the Trust to meet its two public sector legislative duties of involving patients and the public; and addressing inequality. This will also complement the Trust's commitments to inclusion and equality as it starts to put the 'healthy communities' vision into practice. We would like to see in the 2021/22 Quality Accounts how the Trust has used the engagement strategy to identify and engage with deprived communities, ethnic minority communities, inclusion health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population.

Key to achieving the above will be how well the Trust is collecting data and using public health data to understand the community it serves. We believe that this should be a critical part of the Trust's focus on data quality. The Trust should consider linking the Data and Information Strategy 2019 -22 to its commitment to address health inequalities and make sure that the Trust is collecting demographic data, how accurate this is, how it's being used and so on.

The creation of the Engagement toolkit 'what matters to you' demonstrates the importance that the Trust places on the use of patient experience. We would like to read in the 2021-22 Quality Accounts how many members of staff have been trained in the use of the toolkit, the extent of the roll out across the trust and examples of the impact of using the toolkit.

In our comments to the 2018/19 Quality Accounts, we asked the Trust to demonstrate to patients how their feedback is used to make changes or improvements so that patients and the public know they are valued in the decision-making process. We are pleased to see examples throughout the Quality Account of the use of service user experiences and actions taken as a result.

Equality and Diversity

The unequal impact of Covid-19 on people with a disability and Black, Asian and Ethnic Minority groups has further highlighted the important role of health and social care organisations in promoting equality for everyone. We are pleased to see the Trust is making a commitment to inclusion and equality with a focus on discrimination and inequality. We believe that this focus is ever more important as the Trust works to restore services. It will be important for the Trust to understand the various experiences of discrimination that lead to health inequality and use this to inform restoration of services.

We note all the work being done to address equality and diversity issues within the Trust. We are pleased that, in addition to the workforce activities undertaken, progress has been made in relation to service equality. We welcome the work that has commenced to develop a BCHC vision for addressing health inequalities as well as the leading role the Trust is taking to drive the health inequalities agenda at the Integrated Care System level. Healthwatch Birmingham recently shared our 'Health Inequalities: Somali people's experiences of health and social care services in Birmingham' with the Trust. We would like to know how the findings of this report are informing the Trust's health inequalities work; how the Trust is improving its knowledge about the issues facing minority ethnic groups, improving engagement with ethnic minority groups, and how it is designing and delivering services in a manner that addresses issues of discrimination and stigma.

Healthwatch Birmingham is keen to support the Trust in developing this vision. We would also like to know how the health inequalities work and the work under the community engagement strategy complement each other.

Use of technology to deliver services

We note the use of new and innovative approaches (e.g. use of ipads, letters) in ensuring that patients in inpatient settings kept in touch with families during the pandemic. We also note the use of digital approaches to consultations. We believe that, in theory, the use of technology for citizens to enhance their use of health and care services is a good thing. However, the experiences we hear demonstrate that use of virtual consultations, video or telephone calls have the real potential to lead to health inequality. As the Trust rightly identifies, issues of poverty are quite significant in impacting use of technology. For people with sensory disabilities, use of technology can be both enabling and a barrier to accessing service. On the other hand, NHS Digital observes that one in ten people in England lacks basic digital skills and nearly six million people have never used the internet. Therefore, the number of people digitally excluded is significant and needs to be taken into account when making the decision to continue with virtual approaches. The Trust should aim to ensure that varied ways which include the use of technology are offered to all individuals.

Although we are pleased to see that the Trust continues to collect service user feedback in order to understand satisfaction with the use of virtual approaches, we believe that this is inadequate. This approach does not take into account those groups that face such considerable barriers that they do not access the Trust's services. We would like to read about the work the Trust has done to understand the community it serves in regards to these new approaches, digital capability, who the new approaches will affect, how it will affect them and alternative methods for those excluded.

Regarding the roll out of the Electronic Patient Record (EPR), we welcome this as it has a positive impact on outcomes, and reducing variability in care and support. We hear regularly from service users how important this is to them and how important it is for people to not have to repeat themselves. We note that this priority was partially achieved. We would like to read progress on this in the 2021/22 Quality Account.

Care Quality Commission (CQC) 2020

We note that the Trust continues to face challenges within Children and Young People Services and that a recent CQC inspection rated the service 'requires improvement'. Although this is an improvement on the previous rating of 'inadequate', the experiences we hear from service users demonstrate that more work is indeed required. Healthwatch Birmingham has been getting feedback about the poor performance of Children Services over the past year. The concerns around waiting times and assessments outlined in the Quality Account match the experiences we have heard from service users. We note that actions to address these areas are still in progress and we would like to read about the impact of these actions on waiting times for specialist children's services and neuro-developmental assessments in the 2021/22 Quality Account. We look forward to improved feedback as the Trust makes progress in this service.

Clinical Council and Improving 2Gether Forum

Healthwatch Birmingham would like to commend the Trust for the work that the Clinical Council is doing to support services and also for commissioning the 2Gether Forum to aid learning across the Trust. We are pleased to see examples of learning (from complaints, audits, incidents, patient experience, research innovation) informing the activities of the Forum.

We note that the Clinical Council has become key to decision making within the Trust. We would like to see patient's involvement within the Council. For instance, we note that the Council is currently hearing from different professional groups, the outcome of which will inform an initial workforce strategy. We believe hearing from service users will also be useful to the Trust. One key finding of our study on health inequalities was the lack of diversity of health and social care staff within communities, with a high concentration of ethnic minority groups.

LEDER (Learning Disabilities Mortality Review)

We welcome that reviews are or have been carried out in all deaths reported to LEDER. We note that key issues identified are around coordinated care especially where there is a dual diagnosis (mental health and learning disability), annual health checks, multi-agency communication, recognition and management of pain. We note some of the changes already made and we welcome that the Trust will be signing up to The BSOL Strategic Plan to support action the themes as one of the key stakeholders. We would like to read in the 2021/22 Quality Accounts what has been done to change services as a result of the reviews completed. This should include an understanding of the barriers that are faced by ethnic minority groups.

Quality Indicators

Healthwatch Birmingham is pleased to see that the Trust has performed above average for most of the quality indicators, with the exception of serious incidents, pressure ulcers, staff appraisals, VTE and mandatory staff training. We would like to see in the 2021/22 Quality Account actions taken to address the issues identified such as health promotion, overall clinical pathways, care plans and avoidable harm.

Conclusion

Healthwatch is pleased to see the Trust develop a Homelessness Training package available for all staff at BCHC, via eLearning, in order to increase awareness of Homelessness. We also note the development of a Domestic Abuse training package available for BCHC which has helped raise awareness, and embed the staffs' role in prevention.

Andy Cave, CEO
Healthwatch Birmingham

Statement of Directors responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance

Detailed requirements for quality reports 2020/21

- The content of the quality report is not inconsistent with internal and external sources of information including: –

  - Board minutes and papers for the period April 2020 to March 2021

  - papers relating to quality reported to the board over the period April 2020 to March 2021

  - feedback from commissioners dated 21st May 2021

  - feedback from governors dated April 2021

  - feedback from local Healthwatch organisations dated 28/05/2021

  feedback from overview and scrutiny committee dated 24/05/2021

  - the Trust's complaints report published under Regulation 18 of the Local Authority

  Social Services and NHS Complaints Regulations 2009, dated 2nd September 2020

  - the 2020 national staff survey dated 11th March 2021

  - the Head of Internal Audit's annual opinion of the trust's control environment dated 4th May 2021

  - CQC inspection report dated 27th May 2020

- the quality report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Dr Barry Henley
Chairman
Date: 25th May 2021

Richard Kirby
Chief Executive Officer
Date: 25th May 2021

Appendix 1

Full list of clinical audits and confidential enquiries

Title	Participated	%
Audits BCHC completed data collection for in 2020-21		
Falls and Fragility Fractures Audit Programme (FFFAP) Hosted by: Royal College of Physicians	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR) Hosted by: University of Bristol/Norah Fry Centre for Disability Studies	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) audit programme (NACAP). Hosted by: Royal College of Physicians	Yes	100% 56 cases submitted
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) Hosted by: Royal College of Paediatrics and Child Health (RCPCH)	Yes	Rolling data collection Total Patients registered 12 (10 in cohort 1 and 2 in cohort 2).
National Diabetes Audit – Adults National Foot-care Audit Hosted by: HSCIC	Yes	No min ascertainment required for this audit.
Sentinel Stroke National Audit programme (SSNAP) Hosted by: Kings College London	Yes	90+% case ascertainment 46 cases included in audit. Band A for case ascertainment maintained over the last 2 quarters at a time when participation was non mandatory.
Audits BCHC was not eligible to participate in		
Antenatal and newborn national audit protocol 2019-22 Hosted by: Public Health England	No	N/A
BAUS Urology Audits Hosted by: British Association of Urological Surgeons	No	N/A
British Spine Registry Hosted by: Amplitude Clinical Services Ltd	No	N/A
Case Mix Programme (CMP) Hosted by: Intensive Care National Audit & Research Centre (ICNARC)	No	N/A
Child Health Clinical Outcome Review Programme Hosted by: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No	N/A
Cleft Registry and Audit Network (CRANE) Hosted by: Royal College of Surgeons	No	N/A
Elective Surgery (National PROMs Programme) Hosted by: NHS Digital	No	N/A
Emergency Medicine QIPs Hosted by: Royal College of Emergency Medicine	No	N/A

Title	Participated	%
Inflammatory Bowel Disease (IBD) Audit Hosted by: IBD Registry	No	N/A
Mandatory Surveillance of HCAI Hosted by: Public Health England	No	N/A
Maternal and Newborn Infant Clinical Outcome Review Programme Hosted by: University of Oxford/MBRACE-UK collaborative	No	N/A
Medical and Surgical Clinical Outcome Review Programme Hosted by: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No	N/A
Mental Health Clinical outcome Review Programme Hosted by: University of Manchester/NCISH	No	N/A
National Audit of Breast Cancer in Older People (NABCOP) Hosted by: Royal College of Surgeons (RCS)	No	N/A
National Audit of Cardiac Rehabilitation Hosted by: University of York	No	N/A
National Audit of Care at the End of Life Hosted by: NHS Benchmarking Network	No	National decision to cancel audit this year.
National Audit of Dementia (NAD) Hosted by: Royal College of Psychiatrists (RCPsych)	No	N/A
National Audit of Pulmonary Hypertension Hosted by: NHS Digital	No	N/A
National Bariatric Surgery Register Hosted by: British Obesity and Metabolic Surgery Society	No	N/A
National Cardiac Arrest Audit (NCAA) Hosted by: Intensive Care National Audit and Research Centre (ICNARC)/Resuscitation Council UK	No	N/A
National Cardiac Audit Programme (NCAP) Hosted by: Barts Health NHS Trust/National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A
National Clinical Audit of Anxiety & Depression (NCAAD) Hosted by: Royal College of Psychiatrists (RCPsych)	No	N/A
National Clinical Audit of Psychosis (NCAP) Hosted by: Royal College of Psychiatrists (RCPsych)	No	N/A
National Comparative Audit of Blood Transfusion programme – 2020 Audit of the management of perioperative paediatric anaemia. Hosted by: NHS Blood and Transplant	No	N/A
National Early Inflammatory Arthritis Audit (NEIAA) Hosted by: British Society of Rheumatology (BSR)	No	N/A
National Emergency Laparotomy Audit (NELA) Hosted by: Royal College of Anaesthetists (RCoA)	No	N/A
National Gastro-intestinal Cancer Programme Hosted by: NHS Digital	No	N/A
National Joint Registry Hosted by: Healthcare Quality Improvement Partnership	No	N/A
National Lung Cancer Audit (NLCA) Hosted by: Royal College of Physicians	No	N/A

Title	Participated	%
National Maternity and Perinatal Audit Hosted by: Royal College of Obstetrics and Gynaecology (RCOG)	No	N/A
National Neonatal Audit Programme (NNAP) Hosted by: Royal College of Paediatrics and Child Health (RCPCH)	No	N/A
National Ophthalmology Database Audit Hosted by: The Royal College of Ophthalmologists	No	N/A
National Paediatric Diabetes Audit (NPDA) Hosted by: Royal College of Paediatrics and Child Health (RCPCH)	No	N/A
National Prostrate Cancer Audit (NPCA) Hosted by: Royal College of Surgeons (RCS)	No	N/A
National Vascular Registry Hosted by: Royal College of Surgeons (RCS)	No	N/A
Neurosurgical National Audit Programme Hosted by: Society of British Neurosurgeons	No	N/A
NHS provider interventions with suspected/confirmed carbapenemase producing Gram negative colonisations/ infections. Hosted by: Public Health England	No	N/A
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry. Hosted by: University of Warwick	No	N/A
Paediatric Intensive Care Audit (PiCANet) Hosted by: University of Leeds/University of Leicester	No	N/A
Perioperative Quality Improvement Programme (PQIP) Hosted by: Royal College of Anaesthetists	No	N/A
Prescribing Observatory for Mental Health UK (POMH-UK) Hosted by: Royal College of Psychiatrists	No	N/A
Serious Hazards of Transfusion Scheme (SHOT) Hosted by: Serious Hazards of Transfusion (SHOT)	No	N/A
Society for Acute Medicine Benchmarking Audit Hosted by: Society for Acute Medicine	No	N/A
Surgical Site Infection Surveillance Hosted by: Public Health England	No	N/A
The Trauma Audit & Research Network (TARN) Hosted by: The Trauma Audit & Research Network (TARN)	No	N/A
UK Cystic Fibrosis Registry Hosted by: Cystic Fibrosis Trust	No	N/A
UK Registry of Endocrine and Thyroid Surgery Hosted by: British Association of Endocrine and Thyroid Surgery (BAETS)	No	N/A
UK Renal Registry National Acute Kidney Injury Programme Hosted by: UK Renal Registry	No	N/A

Membership application

We want you to join us as a member and help shape our services

General information

We will keep any information we hold about you confidential in accordance with the General Data Protection Regulations. By law we have to keep basic information about you as a member.

Please tick this box if you are happy for your name and constituency to be available to the public through the Foundation Trust Register of Members ☐

PLEASE ENTER IN BLOCK CAPITALS

About you

1. Title: ..... Gender: Male ☐ Female ☐ Other

First name: ..... Middle name: .....

Last name: .....

Date Of Birth: (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Please note that you must be aged at least 16 to become a member. If you are younger than this, but still wish to be involved, please contact us

Full address: .....

.....

Postcode: .....

Email: .....

Telephone ..... Mobile .....

Contacting you

2. We would prefer to contact you by email, if possible, as it reduces our costs and enables us to communicate more often.

Please select the way in which we can contact you: (tick as appropriate)

☐ E-Mail (preferred method)

☐ Post

Note: If you would prefer to be contacted by post, we will need to share your name and address with a third party to enable printing and postage to you.

3. Please let us know of any requirements that would assist us to communicate with you?

.....

.....

.....

4. Are you registered disabled? Yes ☐ No ☐

5. How did you hear about becoming a member of the Foundation Trust (e.g. by post, telephone, events, etc)? .....

.....

.....

We have a statutory duty to try to ensure our membership is representative of the community we serve. We would like to know details of your ethnic background, but would point out that it is optional for you to provide this information.

6. How would you describe your ethnic origin (please tick as appropriate)?

- ☐ White/British
- ☐ White/Irish
- ☐ White/Other
- ☐ Asian or Asian British/Pakistani
- ☐ Asian or Asian British/Indian
- ☐ Asian or Asian British/Bangladeshi
- ☐ Asian or Asian British/ Any other Asian background
- ☐ Black or black British/Caribbean
- ☐ Black or Black British/African
- ☐ Black or Black British/African
- ☐ Black or Black British/ Any other Black background
- ☐ Mixed White/Black African
- ☐ Mixed White/Black Caribbean
- ☐ Mixed White and Asian
- ☐ Mixed Any other mixed background
- ☐ Chinese
- ☐ Do not wish to disclose
- ☐ Any other ethnic group (please specify)

.....

Section 2: Level of Involvement

7. How would you like to be involved with the NHS Foundation Trust at the current time? (please tick as appropriate)

- ☐ Keep in Touch (receive our annual newsletter, invite to annual members meeting and election information)
- ☐ Receive Opportunities about Getting Involved (receive monthly email newsletter and any additional email communications to self-choose the opportunities that interest you, in addition to 'Keep in Touch' information)

8. Do you have any areas of interest related to the services we provide? (please tick as appropriate)

- ☐ Adult Services
- ☐ Children's Services
- ☐ Dental Services
- ☐ Learning Disability Services
- ☐ Rehabilitation Services
- ☐ Other (please specify)
- ☐ Volunteering
- ☐ Our Trust Charity Volunteering

9. We value the experiences of our members. Please can you let us know if you are any of the following: (tick as appropriate)

- ☐ Patient/Service User
- ☐ Carer
- ☐ Partner Organisation
- ☐ Other: (please specify) .....
- ☐ Trust Volunteer

10. Would you consider standing to be elected as a Governor to join our Council of Governors?

☐ Yes ☐ No

Section 3. Declaration

I would like to become a member of the Foundation Trust and agree to the processing of my information for this purpose.

Signature ..... Date .....

Please return your form to: FREEPOST RSUJ-TESZ-BHSH, Membership, Birmingham Community Healthcare NHS Foundation Trust, 3 Priestley Wharf, 20 Holt Street, Birmingham B7 4BN or email to ft@bhamcommunity.nhs.uk

Find out more and our online form at www.bhamcommunity.nhs.uk/membership or email ft@bhamcommunity.nhs.uk or call 0121 466 7023

If you would like to request a copy of this document in an alternative format, or have any other queries about its content, please contact the Birmingham Community Healthcare NHS Foundation Trust Communications team at:

Communications team:
3 Priestley Wharf
20 Holt Street
Birmingham Science Park
Aston, Birmingham
B7 4BN

Tel: 0121 466 7281

Email info@bhamcommunity.nhs.uk

Or follow us on Twitter @bhamcommunity

The report is also available at www.bhamcommunity.nhs.uk

Or you can speak to a Patient Experience Officer in our Customer Services team on tel: 0800 917 2855

How to provide feedback

If you would like to provide feedback on the Quality Report you can do this by:

Tel 0121 466 7069

Email bchc.clinical.governance@nhs.net

Address Quality Report, Clinical Governance Department
3 Priestley Wharf
20 Holt Street
Birmingham Science Park
Aston, Birmingham, B7 4BN

Acknowledgements

We would like to thank Clinical Photography and Graphic Design and all members of staff, public members and users of our services who have contributed towards this Quality Report.

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Fiona Waide	Head of Corporate Governance
Frances Young	Chair of Patient Experience Forum and Governor
David Disley-Jones	Communications Manager

Other Language

If you would like this document in another format including audio, large print, Braille or translated, please contact Communication Team on: 0121 466 7281.

Inclusive

إذا أردت هذه الوثيقة بشكل آخر بما في ذلك النسخ الصوتية أوالطبعة الكبيرة أو نسخة البريل أو نسخة مترجمة فعليك الاتصال بفريق الاتصالات على : 0121 466 7281

که تاسي دغه سند په يوه بله بڼه غواړئ د ډرغ، غټو ټکو، برايل (درندولپاره ځانګړی ليک) او يا د ترجمي په شمول تر لاسه کړئ، نو د مکالمي له ډلي سره په دغه شمېره 01214667281 اړيکه ونيسئ.

اگر آپ یہ دستاویز اور طرز میں حاصل کرنا چاہتے ہیں جس میں آڈیو، بڑی چھپائی، بریل یعنی ابھرے ہوئے حروف یا ترجمہ شامل ہے تو براہ کرم کمیونی کیشنز ٹیم **Communications Team** سے **0121 466 7281** پر رابطہ کریں۔

যদি এই তথ্যপত্র আপনি অন্য কোনো নমুনায় যেমন ক্যাসেটে রেকর্ড করে, মোটা অক্ষরে, ব্রেইলে (অক্ষলিপি৩) বা বাংলায় অনুবাদ চান, তবে দয়া করে কমিউনিক্যাশন টিমের সহগে যোগাযোগ করুন: 0121 466 7281

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ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਕਿਸੇ ਦੂਜੇ ਤਰੀਕੇ, ਜਿਵੇਂ ਕਿ ਸੁਣਨ ਵਾਲੇ ਤਰੀਕੇ, ਵੱਡੀ ਛਪਾਈ ਵਿਚ, ਬ੍ਰੇਲ ਵਿਚ ਜਾਂ ਅਨੁਵਾਦ ਵਿਚ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰ ਕੇ ਕਮਯੂਨਿਕੇਸ਼ਨ ਟੀਮ ਨੂੰ ਇਸ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ : **0121 466 7281**

Dacă doriți acest document într-un alt format, inclusiv audio, tipărit cu litere mari, Braille sau tradus, vă rugăm să contactați Echipa de comunicații la 0121 466 7281.

Haddii aad rabto in aad dukumeentigan ku hesho nuskhad kale sida dhegeysi, far waaweyn, farta Braille ee dadka indhaha la' ama turjumaad, fadlan Kooxda Isgaarsiinta (Communications Team) kala soo xiriir lambarka: 0121 466 7281

Independent Auditor's Report including certificate

Independent Auditor's report to the Council of Governors and Board of Directors of Birmingham Community Healthcare NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Birmingham Community Healthcare NHS Foundation Trust (the 'Foundation Trust'):

- give a true and fair view of the state of the Foundation Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 33.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers;
- the table of pay multiples;
- the exit packages; and
- the table of pension benefits of senior managers.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Foundation Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Foundation Trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the Foundation Trust and its control environment, and reviewed the Foundation Trust's documentation of its policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the Foundation Trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the Foundation Trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018, relevant employment legislation and clinical standards.

We discussed among the audit engagement team, including relevant internal specialists such as IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address it, are described below:

- Recognition of NHS clinical revenue. We evaluated the recognition of income through the period, including year-end cut-off, and evaluated the results of the agreement of balances exercise. In doing so, we assessed the appropriateness of judgements made and the nature of provisions for disputes and the basis for the position adopted.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the Foundation Trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the Foundation Trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the Foundation Trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the Foundation Trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the Foundation Trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report
This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Birmingham Community Healthcare NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Mohammed Ramzan, CPFA (Key Audit Partner)
For and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United kingdom
11 June 2021

Audit certificate issued subsequent to opinion on financial statements

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2021 issued on 11 June 2021, we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 11 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2021 issued on 11 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Birmingham Community Healthcare NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mohammed Ramzan, CPFA (Key Audit Partner)
For and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
27 August 2021

Part 3: Annual Accounts and Financial Statements

The Financial Statements to Annual Accounts 2020/21

1. Foreword to the Accounts

These accounts for the financial year ending 31st March 2021 have been prepared by Birmingham Community Healthcare NHS Foundation Trust in line with Department of Health and Social Care Group Accounting Manual 2020/21 and in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

2. Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

By order of the Board

Signature

Richard Kirby
Chief Executive Officer
Date: 25 May 2021

Ian Woodall
Chief Finance Officer
Date: 25 May 2021

3. How is our Financial Performance Assessed?

The Trust reports 'Adjusted Financial Performance' to NHS Improvement, which is calculated on a different basis from the reported deficit. The Trust agreed an adjusted financial performance of a £0.127 million surplus for 2020/21 and achieved a surplus of £0.197 million against this plan, a favourable variance of £0.070 million.

4. Efficiency Savings

In 2020/21 efficiency savings of £6.067 million were delivered against a plan of £8.025 million. This shortfall is due to the impact of COVID-19 on the trust's ability to deliver its cost improvement programme (CIP).

5. Where our Money Comes From

The majority of our income comes from the provision of patient care which totals £288.1m. The remainder of £40.0m comes from other activities such as Education, Training and Research, but also includes COVID-19 reimbursement and top-up funding of £14.2m.

6. How we Spend our Money

In the financial year 2019/20 we spent £327.6m. The largest proportion of this expenditure was on the salaries and wages that we pay our staff, which totaled £212.9m.

Further details on our expenditure can be found in the Income and Expenditure section of the Financial Statements section of this report.

7. Capital Investment

In 2020/21 we invested £9.9m on purchases through the capital programme, most of which was funded from our own cash resources, and was in respect of:

- the improvement and maintenance of our buildings (£5.9m)
- investment in IT hardware and software (£3.3m)
- the replacement of clinical equipment and furniture (£0.7m)

8. International Financial Reporting Standards (IFRS)

These Accounts have been prepared in accordance with International Financial Reporting Standards.

9. Income and Expenditure Accounts

The financial statements are set out in this section of the report. It should be noted however, that that these financial statements might not contain sufficient information for a full understanding of the entity's financial position and performance, and a full set of accounts can be obtained from Ian Woodall, Chief Finance Officer at Trust Headquarters.

10. Financial Statements

10.1. Statement of Comprehensive Income for Year Ended 31 March 2021

		2020-21	2019-2020
	NOTE	£000	£000s
Operating income from patient care activities	3	288,088	277,860
Other operating income	4	39,987	25,223
Operating expenses	6, 8	(327,596)	(310,357)
Operating surplus (deficit) from continuing operations		**479**	**(7,274)**
Finance income	11	8	259
Finance expenses	12	(2,652)	(2,625)
PDC dividends payable		(343)	(1,388)
Net finance costs		**(2,987)**	**(3,754)**
Other gains	13	**1**	**-**
Deficit for the year		**(2,507)**	**(11,028)**
Other Comprehensive Income			
Will not be reclassified to income and expenditure:			
Impairments	7	(584)	(16,183)
Revaluations	16	156	461
Total comprehensive income/(expense) for the period		**(2,935)**	**(26,750)**

10.2. Statement of Financial Position as at 31 March 2021

	NOTE	31 March 2021 £000s	31 March 2020 £000s
Non-current assets			
Intangible assets	14	1,699	912
Property, plant and equipment	15	78,133	81,774
Receivables	18	2,174	71
Total non-current assets		**82,006**	**82,757**
Current assets			
Inventories	17	2,657	256
Receivables	18	11,736	17,581
Non-current assets for sale and assets in disposal groups	19	359	-
Cash and cash equivalents	20	43,663	32,289
Total current assets		**58,415**	**50,126**
Current liabilities			
Trade and other payables	21	(37,015)	(29,827)
Borrowings	23	(938)	(977)
Provisions	25	(2,778)	(2,727)
Other liabilities	22	(1,622)	(225)
Total current liabilities		**(42,353)**	**(33,757)**
Total assets less current liabilities		**98,068**	**99,127**
Non-current liabilities			
Borrowings	23	(28,086)	(29,020)
Provisions	25	(102)	(115)
Total non-current liabilities		**(28,188)**	**(29,135)**
Total assets employed		**69,880**	**69,992**
Financed by			
Public dividend capital		10,040	7,217
Revaluation reserve		7,174	7,872
Income and expenditure reserve		52,666	54,903
Total taxpayers equity		**69,880**	**69,992**

The notes on pages 347 to 392 form part of these accounts.

Signed:

Chief Executive / Accounting Officer
Date: 25 May 2021

10.3. Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2021

	Public Dividend capital £000s	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**7,217**	**7,872**	**54,903**	**69,992**
Deficit for the year	-	-	(2,507)	**(2,507)**
Other transfers between reserves	-	(266)	266	**-**
Impairments	-	(584)	-	**(584)**
Revaluations	-	156	-	**156**
Transfer to retained earnings on disposal of assets	-	(4)	4	**-**
Public dividend capital received	2,823	-	-	**2,823**
Taxpayers' and others' equity at 31 March 2021	**10,040**	**7,174**	**52,666**	**69,880**

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2020

	Public Dividend capital £000s	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**7,191**	**23,758**	**65,767**	**96,716**
Deficit for the year	-	-	(11,028)	**(11,028)**
Other transfers between reserves	-	(164)	164	**-**
Impairments	-	(16,183)	-	**(16,183)**
Revaluations	-	461	-	**461**
Public dividend capital received	26	-	-	**26**
Taxpayers' and others' equity at 31 March 2021	**7,216**	**7,872**	**54,903**	**69,992**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

10.4. Statement of cash flows for the year ended 31 March 2021

	NOTE	2020/21 £000s	2019/20 £000s
Cash flows from operating activities			
Operating surplus / (deficit)		479	(7,274)
Non-cash income and expense:			
Depreciation and amortisation	6.1	5,441	6,073
Net impairments	7	4,955	15,128
Decrease / (increase) in receivables and other assets		5,361	(3,391)
Increase in inventories		(2,401)	(14)
Increase / (decrease) in payables and other liabilities		7,855	(4,000)
Increase / (decrease) in provisions		38	(1,717)
Other movements in operating cashflows		1	-
Net cash generated from / (used in) operating activities		**21,728**	**4,806**
Cash flows from investing activities			
Interest received		8	259
Purchase of intangible assets		(869)	(247)
Purchase of property, plant and equipment and investment property		(8,820)	(6,636)
Sales of property, plant and equipment and investment property		1	-
Net cash generated from / (used in) investing activities		**(9,680)**	**(6,624)**
Cash flows from financing activities			
Public dividend capital received		2,823	26
Capital element of finance lease rental payments		(131)	(122)
Capital element of LIFT payments		(843)	(747)
Other interest		(10)	(12)
Interest paid on finance lease liabilities		(42)	(50)
Interest paid on LIFT obligations		(2,600)	(2,563)
PDC dividend refunded / (paid)		128	(1,856)
Net cash flows used in financing activities		**(675)**	**(5,324)**
Increase (decrease) in cash and cash equivalents		**11,373**	**(7,143)**
Cash and cash equivalents at 1 April - brought forward		**32,289**	**39,432**
Cash and cash equivalents at 31 March	**20.1**	**43,663**	**32,289**

10.5. Late Payment of Commercial Debts (interest) Act 1998

The Trust incurred less than £1,000 of charges for the late payment of commercial debts in 2020/21.

10.6. Fees and Charges

The Trust has complied with all applicable Treasury Guidance on setting charges for information. Costs have not exceeded £1 million.

10.7. Difference Between the Carrying Amount and Market Value Interest in Land and Buildings

No properties were sold in 2020/21.

10.8. Pension Liability

An indication of how pension liabilities are treated in the Accounts and a reference to the statements of the relevant pension scheme can be found in Note 9 of the Annual Accounts of the Trust.

10.9. Related Parties

During the year, none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with Birmingham Community Healthcare NHS Foundation Trust other than those shown in the table below. The figures disclosed in the table below are transactions between the organisation and the related party listed in the table, rather than transactions with the individual Board members.

Details of related party transactions with individuals are as follows:

Table FS1: 2020/21 Related Party Transactions

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
Dr Barry Henley - Chair				
Birmingham City University (Associate)	58,408	490	2,196	0
Aston University (Member of Business Advisory Council)	56,032	0	56,032	0
Professor David Sallah - Non Executive Director				
University of Wolverhampton (Emeritus Professor)	5,263	0	0	0
St Andrew's Healthcare (Non-Executive Director/Trustee)	0	4,111	0	2,277
Jenny Belza - Non Executive Director				
Royal College of Nursing (Member)	5,500	0	0	0
University College Birmingham (Governor)	0	0	0	0
Salma Ali - Non Executive Director				
St Mary's Hospice (Trustee)	12,098	0	0	0
David Holmes - Director of Human Resource				
Healthcare People Management Association (Deputy National President)	695	0	0	0

The Department of Health is regarded as a related party. During the year Birmingham Community Healthcare NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department, including:

- Birmingham and Solihull Mental Health NHS Foundation Trust
- Midland Partnership NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- NHS Birmingham and Solihull Clinical Commissioning Group
- NHS Sandwell and West Birmingham Clinical Commissioning Group
- NHS England
- NHS Property Services Limited
- Community Health Partnerships

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Health Education England and Birmingham City Council.

The Trust hosts a charity, registered with the Charities Commission, registration number 1069427. The total value of transactions by the Trust on behalf of the charity was £264k, of which £84k was due from the Charity at the year-end.

10.10. Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code in dealing with suppliers of goods and services and the table below sets out our performance in 2020/21.

Compliance with Better Payment Practice Code during 2020/21

Better Payment Practice Code: Measure of Compliance	2020/21	
	Number	£000
Total Non-NHS trade invoices paid in the year	47,161	142,784
Total Non-NHS trade invoices paid within target	43,253	132,607
Percentage of Non-NHS trade invoices paid within target	91.7%	92.9%
Total NHS trade invoices paid in the year	1,807	28,089
Total NHS trade invoices paid within target	1,585	22,346
Percentage of NHS trade invoices paid within target	87.7%	79.6%
The Better Payment Practice Code requires all Trusts to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.		

10.11. Prompt Payment Code

The Trust has signed up to the prompt payment code administered by the Chartered Institute of Credit Management.

10.12. External Auditors' Remuneration

Deloitte were appointed as the Trust's External Auditors for 2020/21. Our audit cost in respect of statutory services for the year was £59,580, including VAT. In addition, we were charged £18,000, including VAT, for audit work to inform Deloitte's 'Value for Money' opinion. No additional amounts were paid to the external auditor.

10.13. Sickness Absence Data

The sickness absence data is discussed within Staff Report.

Table FS4: Other Exit Packages 2020-21

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of Exit Package agreements	Total value of agreements	Number of Exit Package agreements	Total value of agreements
	2020/21	2020/21	2019/20	2019/20
	No.	£000	No.	£000
Voluntary redundancies including early retirement contractual costs	0	0	22	701
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	7		
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severance payments)*	0	0	0	0
Total**	**1**	**7**	**22**	**701**
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

10.14. HM Treasury Compliance

Birmingham Community Healthcare NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

10.15. Details of Political Donations

Birmingham Community Healthcare NHS Foundation Trust has not made any political donations during 2020/21.

10.16. Other Income

As required by section 43(3A) of the NHS Act 2006, an NHS foundation trust must provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England. All 'other' income received by Birmingham Community Healthcare NHS Foundation Trust during 2020/21 was in relation to services provided to NHS patients and their families.

11. Trust Accounts Consolidation (TAC) Schedules for Birmingham Community Healthcare NHS Foundation Trust

11.1. Finance Director Certificate

1. I certify that the TAC schedules have been compiled and are in accordance with:

- the financial records maintained by the NHS foundation trust
- accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
- the template accounting policies for NHS foundation trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Foundation Trust

Ian Woodall
Chief Finance Officer
Date: 25 May 2021

11.2. Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the foundation trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Chief Finance Officer above.

Richard Kirby
Chief Executive Officer
Date: 25 May 2021

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected.

The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The vast majority of the trust's income is earned under block contracts with commissioners, ie contracts that do not vary directly with activity performed. As a result, the relevant performance obligation is the provision of services throughout the year, rather than the delivery of units of activity. Income is invoiced and recognised on a monthly basis, with payment usually made by commissioners around the 15th of the same month.

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the trust accrued income relating to activity delivered in that year. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

NHS injury cost recovery scheme

The trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset. This allowance is currently set at 22.43% by DHSC.

Note 1.4 Expenditure on employee benefits
Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the trust of participating in a scheme is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment
Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either:
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Items forming part of the initial equipping and setting-up cost of a new building, ward or unit are capitalised irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Freehold land, assets under construction or development, and assets held for sale are not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability.

Subsequently, the assets are accounted for as property, plant and equipment as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset.
The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	25
Buildings, excluding dwellings	3	81
Plant & machinery	5	26
Transport equipment	7	8
Information technology	4	8
Furniture & fittings	5	15

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset.
The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	5
Software licences	2	5

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21, the trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value at 31 March 2021 for the transaction based on the cost of acquisition by the Department.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses using a provisions matrix.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Finncial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts- and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Corporation tax

As an NHS foundation trust established under section 30 of the National Health Service Act 2006, the trust is exempted from corporation tax under sections 985 and 986 of the Corporation Tax Act 2010.

Note 1.17 Third party assets

Assets belonging to third parties in which the trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM .

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust is currently working to determine the impact of this implementation of this standard. The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

From 1 April 2022, the principles of IFRS 16 will also be applied to the trust's PFI liabilities where future payments are linked to RPI. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

In addition, IFRS 17 (insurance contracts, applicable for accounting periods beginning on or after 1 January 2023) is also issued but not yet adopted. This is not expected to have a significant impact on the trust.

Note 1.21 Critical judgements in applying accounting policies and sources of estimation uncertainty

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revisions affects both current and future periods.

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are details below:

Valuation of dental hospital - critical judgement

In line with IAS 17, the trust's LIFT-funded dental hospital is valued on the basis of the present value of the minimum lease payments. As the lease payment is rolled up within the unitary charge, a notional rent has been calculated by 'decapitalising' the depreciated replacement cost valuation using the trust's weighted average cost of capital. The resulting lease payments have then been discounted at a rate of 5.5%, based on advice from the trust's independent external valuers.

Modern equivalent asset valuation of property - key source of estimation uncertainty

As detailed in note 16, the trust's independent valuer has provided the trust with a valuation of land and building assets (providing a fair value and a remaining useful life). The significant estimation being the specialised buildings, which are valued at depreciated replacement value using a modern equivalent asset methodology. Future revaluations of the trust's property may result in further material changes to the carrying values of non-current assets.

Useful economic lives of property - key source of estimation uncertainty

The trust's buildings and equipment are depreciated over their remaining useful economic lives as described in accounting policy 1.6. Management assesses the useful economic life of an asset when it is brought in to use and periodically reviews these for reasonableness.

Lives are based on physical lives of each class are based on similar assets with lives for the trust's buildings advised by an independent expert.

Provisions - key source of estimation uncertainty

Provisions (as set out in note 25) have been made for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

Note 2 Operating Segments

Birmingham Community Healthcare NHS Foundation Trust provides a range of hospital, community-based, and specialist services to residents of Birmingham and the wider West Midlands. The trust operates a divisional structure, with five clinical divisions sitting alongside a corporate division, which includes estates. Expenditure incurred by each division is reported to the trust board, as the chief operating decision maker, on a monthly basis. The year-end position reported to the board is shown below.

Capital charges, impairments and finance income and expenditure are currently held within the corporate division. Assets and liabilties are not reported by division.

2020/21	Adult Community Services	Adult and Specialist Rehabilitation	Learning Disabilities	Dental	Children and Families	Corporate (including estates)	Total
Income	56,930	85,020	17,553	41,699	76,724	50,148	328,074
Pay	(41,602)	(51,604)	(11,355)	(22,879)	(43,796)	(44,774)	(216,010)
Non-pay	(6,164)	(12,416)	(661)	(5,322)	(22,995)	(50,724)	(98,282)
Other*	-	-	-	-	-	(16,289)	(16,289)
Surplus/ (Deficit)	**9,164**	**21,000**	**5,537**	**13,498**	**9,933**	**(61,639)**	**(2,507)**

2019/20	Adult Community Services	Adult and Specialist Rehabilitation	Learning Disabilities	Dental	Children and Families	Corporate (including estates)	Total
Income	57,611	84,760	17,373	42,531	74,558	26,250	303,083
Pay	(39,516)	(47,715)	(11,782)	(23,546)	(41,499)	(37,270)	(201,328)
Non-pay	(6,398)	(14,397)	(871)	(7,117)	(23,450)	(35,606)	(87,839)
Other*	-	-	-	-	-	(24,944)	(24,944)
Surplus/ (Deficit)	**11,697**	**22,648**	**4,720**	**11,868**	**9,609**	**(71,570)**	**(11,028)**

* Other expenditure includes capital charges, impairments and net finance costs.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)

	2020/21 £000	2019/20 £000
Mental health services		
Block contract / system envelope income*	17,387	17,277
Community services		
Block contract / system envelope income*	216,334	207,266
Income from other sources (eg local authorities)	45,995	45,443
All services		
Additional pension contribution central funding**	8,372	7,874
Total income from activities	**288,088**	**277,860**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2020/21 £000	2019/2020 £000
Income from patient care activities received from:		
NHS England	71,075	66,414
Clinical commissioning groups	171,018	166,004
Department of Health and Social Care	127	19
Other NHS providers	5,610	5,916
Local authorities	38,043	38,219
Injury cost recovery scheme	345	637
Non NHS: other	1,870	651
Total income from activities	**288,088**	**277,860**

Note 4 Other operating income

	2020/21		
	Contract income £000	Non-contract income £000	Total £000
Research and development	1,069	-	1,069
Education and training	16,644	322	16,966
Non-patient care services to other bodies	171	-	171
Provider sustainability fund (2019/20 only)	-	-	-
Reimbursement and top up funding	14,180		14,180
Charitable and other contributions to expenditure	-	5,170	5,170
Other income	2,431	-	2,431
Total other operating income	**34,495**	**5,492**	**39,987**

	2019/20		
	Contract income £000	Non-contract income £000	Total £000
Research and development	889	-	889
Education and training	18,079	-	18,079
Non-patient care services to other bodies	470		470
Provider sustainability fund (PSF)	2,479		2,479
Charitable and other contributions to expenditure		4	4
Other income	3,302	-	3,302
Total other operating income	**25,219**	**4**	**25,223**

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	80,811	81,082
Income from services not designated as commissioner requested services	207,277	196,778
Total	**288,088**	**277,860**

Note 6 Operating expenses

	2020-21	2019-20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,822	-
Purchase of healthcare from non-NHS and non-DHSC bodies	199	-
Staff and executive directors costs	212,934	199,475
Remuneration of non-executive directors	128	127
Supplies and services - clinical (excluding drugs costs)	41,271	36,083
Supplies and services - general	3,331	3,350
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	10,584	10,442
Inventories written down	1,559	-
Consultancy costs	1,209	1,575
Establishment	3,649	3,835
Premises	16,306	13,332
Transport (including patient travel)	2,219	2,382
Depreciation on property, plant and equipment	5,131	5,756
Amortisation on intangible assets	310	317
Net impairments	4,955	15,128
Movement in credit loss allowance: contract receivables / contract assets	(205)	528
Movement in accrual for untaken annual leave	3,778	345
Change in provisions discount rate	13	-
Audit fees payable to the external auditor		
audit services- statutory audit	72	60
other auditor remuneration (external auditor only)	-	11
Internal audit costs	76	83
Clinical negligence	949	737
Legal fees	326	451
Insurance	81	78
Research and development	791	426
Education and training	3,973	3,254
Rentals under operating leases	7,118	7,988
Charges to operating expenditure for LIFT scheme	751	732
Car parking & security	673	345
Other services, eg external payroll	316	283
Other	3,277	3,234
Total	**327,596**	**310,357**

The Trust's response to the Covid-19 pandemic has contributed to a significant change in some of the expenditure categories set out above, most notable in staff costs and clnical supplies and services.

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	11
Total	**-**	**11**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,955	15,128
Total net impairments charged to operating surplus / deficit	**4,955**	**15,128**
Impairments charged to the revaluation reserve	584	16,183
Total net impairments	**5,539**	**31,311**

Note 8 Employee benefits

	2020/21	2019/2020
	£000	£000
Salaries and wages	161,058	150,562
Social security costs	15,238	14,232
Apprenticeship levy	769	720
Employer's contributions to NHS pensions	27,589	25,886
Pension cost - other	76	-
Temporary staff (including agency)	11,446	10,150
Total gross staff costs	**216,176**	**201,550**
Recoveries in respect of seconded staff	(182)	(287)
Total staff costs	**215,994**	**201,263**
Of which		
Costs capitalised as part of assets	**112**	**62**

Note 8.1 Retirements due to ill-health

During 2020/21 there were 7 early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £292k (£0k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/p are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allow direction of the Secretary of State for Health and Social Care in England and Wales. They are not desig a way that would enable NHS bodies to identify their share of the underlying scheme assets and liability each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of p each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ material would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the p formal valuations shall be four years, with approximate assessments in intervening years”. An outline of

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous period in conjunction with updated membership and financial data for the current reporting period, and i providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relev interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the sc into account recent demographic experience), and to recommend contribution rates payable by employ employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap the following the 2012 valuation. In January 2019, the Government announced a pause to the cost control e 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling rela McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the will be included in this process. HMT valuation directions will set out the technical detail of how the cost be included in the valuation process. The Government has also confirmed that the Government Actuary cost control mechanism (as was originally announced in 2018). The review will assess whether the cost mechanism is working in line with original government objectives and reported to Government in April 2 findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap made in time for the completion of the 2020 actuarial valuations.

Note 10 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where Birmingham Community Healthcare NHS Foundation Trust is the lessee.

The trust's operating leases relate to the rental of space in buildings owned by third parties in order to provide healthcare in community settings and administration bases for staff. The notes below also include operating leases relating to vehicles used by staff in the course of their duties.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	7,118	7,988
Total	7,118	7,988

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
• not later than one year	5,871	8,442
• later than one year and not later than five years	20,505	27,591
• later than five years	17,401	23,948
Total	43,777	59,981

Extensions to the current leases with NHS Property Services are currently being negotiated for properties under their management, and the disclosure above reflects the trust's intended period of occupation.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	8	259
Total finance income	**8**	**259**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20 total	2018/19 total
	£000	£000
Interest expense:		
Finance leases	42	50
Interest on late payment of commercial debt	-	2
Main finance costs on PFI and LIFT schemes obligations	2,016	2,069
Contingent finance costs on PFI and LIFT scheme obligations	584	494
Total interest expense	**2,642**	**2,615**
Other finance costs	10	10
Total finance costs	**2,652**	**2,625**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	2

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	1	-
Total gains / (losses) on disposal of assets	1	-

Note 14.1 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**1,341**	**534**	**-**	**1,875**
Additions	301	-	770	**1,071**
Reclassifications	-	-	26	**26**
Valuation / Gross cost at 31 March 2021	**1,642**	**534**	**796**	**2,972**
Amortisation at 1 April 2020 - brought forward	**644**	**319**	**-**	**963**
Provided during the year	203	107	-	**310**
Amortisation at 31 March 2021	**847**	**426**	**-**	**1,273**
Net book value at 31 March 2021	**795**	**108**	**796**	**1,699**
Net book value at 1 April 2020	**697**	**215**	**-**	**912**

Note 14.2 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**1,051**	**534**	**-**	**1,585**
Additions	290	-	-	**290**
Valuation / Gross cost at 31 March 2020	**1,341**	**534**	**-**	**1,875**
Amortisation at 1 April 2019 - brought forward	**434**	**212**	**-**	**646**
Provided during the year	210	107	-	**317**
Amortisation at 31 March 2020	**644**	**319**	**-**	**963**
Net book value at 31 March 2020	**697**	**215**	**-**	**912**
Net book value at 1 April 2019	**617**	**322**	**-**	**939**

Note 15 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**9,188**	**63,545**	**971**	**10,101**	**191**	**17,754**	**507**	**102,257**
Additions	**-**	**3,955**	**385**	**665**	**-**	**2,253**	**-**	**7,258**
Impairments	-	(1,159)	-	-	-	-	-	**(1,159)**
Reversals of impairments	27	548	-	-	-	-	-	**575**
Revaluations	91	(6,680)	-	-	-	-	-	**(6,589)**
Reclassifications	-	-	(431)	-	-	405	-	**(26)**
Transfers to assets held for sale	(144)	(216)	-	-	-	-	-	**(360)**
Disposals	-	-	-	(207)	(36)	(15)	-	**(258)**
Valuation/gross cost at 31 March 2021	**9,162**	**59,993**	**925**	**10,559**	**155**	**20,397**	**507**	**101,698**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**995**	**-**	**5,750**	**147**	**13,287**	**304**	**20,483**
Provided during the year	66	2,505	-	743	20	1,760	37	**5,131**
Impairments	-	7,019	499	-	-	-	-	**7,518**
Reversals of impairments	-	(2,563)	-	-	-	-	-	**(2,563)**
Revaluations	(66)	(6,679)	-	-	-	-	-	**(6,745)**
Transfers to assets held for sale	-	(1)	-	-	-	-	-	**(1)**
Disposals	-	-	-	(207)	(36)	(15)	-	**(258)**
Accumulated depreciation at 31 March 2021	**-**	**1,276**	**499**	**6,286**	**131**	**15,032**	**341**	**23,565**
Net book value at 31 March 2021	**9,162**	**58,717**	**426**	**4,273**	**24**	**5,365**	**166**	**78,133**
Net book value at 1 April 2020	**9,188**	**62,550**	**971**	**4,351**	**44**	**4,467**	**203**	**81,774**

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**25,156**	**76,623**	**409**	**9,884**	**191**	**16,915**	**476**	**129,654**
Additions	-	4,218	691	88	-	839	31	**5,867**
Impairments	(8,091)	(8,551)	-	-	-	-	-	**(16,642)**
Reversals of impairments	40	419	-	-	-	-	-	**459**
Revaluations	(7,917)	(9,164)	-	-	-	-	-	**(17,081)**
Reclassifications	-	-	(129)	129	-	-	-	**-**
Valuation/gross cost at 31 March 2020	**9,188**	**63,545**	**971**	**10,101**	**191**	**17,754**	**507**	**102,257**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**486**	**-**	**5,015**	**127**	**11,260**	**253**	**17,141**
Provided during the year	64	2,859	-	735	20	2,027	51	**5,756**
Impairments	7,874	9,642	-	-	-	-	-	**17,516**
Reversals of impairments	(11)	(2,377)	-	-	-	-	-	**(2,388)**
Revaluations	(7,927)	(9,615)	-	-	-	-	-	**(17,542)**
Accumulated depreciation at 31 March 2020	**-**	**995**	**-**	**5,750**	**147**	**13,287**	**304**	**20,483**
Net book value at 31 March 2020	**9,188**	**62,550**	**971**	**4,351**	**44**	**4,467**	**203**	**81,774**
Net book value at 1 April 2019	**25,156**	**76,137**	**409**	**4,869**	**64**	**5,655**	**223**	**112,513**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned -purchased	7,821	37,534	426	4,273	24	5,365	166	**55,609**
Finance leased	-	238	-	-	-	-	-	**238**
On-SoFP LIFT contract	1,341	20,945	-	-	-	-	-	**22,286**
NBV total at 31 March 2021	**9,162**	**58,717**	**426**	**4,273**	**24**	**5,365**	**166**	**78,133**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned -purchased	7,809	39,142	971	4,351	44	4,467	203	**56,987**
Finance leased	-	668	-	-	-	-	-	**668**
On-SoFP LIFT contract	1,379	22,740	-	-	-	-	-	**24,119**
NBV total at 31 March 2020	**9,188**	**62,550**	**971**	**4,351**	**44**	**4,467**	**203**	**81,774**

Note 16 Revaluations of property, plant and equipment

Land and buildings are restated at current cost using professional valuations at five-yearly intervals in accordance with IAS 16. Between five-yearly valuations, interim valuations are undertaken on an annual basis to ensure the accounts reflect the fair value of land and buildings. A full valuation of the trust's land and buildings was undertaken by DTZ Debenham Tie Leung Limited (trading as Cushman and Wakefield), an independent valuer, as at 31 March 2020, which has been updated via a desktop exercise as at 31 March 2021.

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards (the "Red Book") insofar as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury.

The Existing Use Value of the trust's properties has been primarily derived using the depreciated replacement cost (DRC) approach, because the specialised nature of the assets means that there are no market transactions of this type of asset, except as part of a business or entity.

The DRC approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same service potential as the existing asset. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery. With external support, the trust has applied the modern equivalent approach to all relevant freehold land and building assets from 1 April 2019.

The valuation of the trust's 20 year interest in the dental hospital as at 31 March 2021 has been derived using a DRC approach because the specialist nature of the asset means that there are rarely market transactions of dental hospitals, other than as part of a business or operating entity. With respect to both the land and building, the notional rent payable by the trust, has been determined from the DRC valuation using the trust's weighted average cost of capital. Over the 20 year period of the trust's interest in the property, the annual rental has been discounted at a rate of 5.5% to reflect the net present value, which represents the existing use value.

Note 17 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	93	90
Consumables	2,564	166
Total inventories	**2,657**	**256**

In response to the Covid-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the trust received £5,170k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income.

Inventories recognised in expenses for the year were £1,616k (2019/20: £242k). Write-down of inventories recognised as expenses for the year were £1,559k (2019/20: £0k).

Note 18 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	8,439	15,533
Allowance for impaired contract receivables	(659)	(867)
Prepayments (non-LIFT)	3,274	1,873
PDC dividend receivable	107	578
VAT receivable	412	387
Other receivables	163	76
Total current receivables	**11,736**	**17,581**
Non-current		
LIFT lifecycle prepayments	2,090	-
Other recievables	84	71
Total non-current receivables	**2,174**	**71**
Of which receivables from NHS and DHSC group bodies:		
Current	3,643	12,464
Non-current	84	71

The Trust has, for the first time, recognised a prepayment relating to the lifecycle capital expenditure associated with the dental hospital, reflecting the amount by which contractual payments made exceed the capital works performed by the LIFT company. This information has not been made available by the LIFT company in previous years.

Note 18.2 Allowances for credit losses

	2020/21 Contract receivables and contract assets	2019/20 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**867**	**346**
New allowances arising	101	600
Changes in existing allowances	230	(15)
Reversals of allowances	(536)	(57)
Utilisation of allowances (write offs)	(3)	(7)
Allowances as at 31 Mar 2021	**659**	**867**

Note 18.3 Exposure to credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. In line with IFRS 9, the trust has used historical credit loss experience to determine appropriate provision rates for each age category of non-NHS receivables. No provision is made against NHS receivables as such amounts are not expected to be irrecoverable.

Note 19 Non-current assets held for sale and assets in disposal groups

	2020/21	2019/20
	£000	£000
NBV of non-current assets for sale at 1 April	**-**	**-**
Assets classified as available for sale in the year	359	-
NBV of non-current assets for sale at 31 March	**359**	**-**

During 2020/21, the trust approved the disposal of part of the Hobmoor Road site, comprising two bungalows and the associated land. The properties are being actively marketed and the sale is expected to complete in the final quarter of 2021/22.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**32,289**	**39,432**
Net change in year	11,374	(7,143)
At 31 March	**43,663**	**32,289**
Broken down into:		
Cash at commercial banks and in hand	7	9
Cash with the Government Banking Service	43,656	32,280
Total cash and cash equivalents as in SoFP	**43,663**	**32,289**
Total cash and cash equivalents as in SoCF	**43,663**	**32,289**

Note 20.2 Third party assets held by the trust

Birmingham Community Healthcare NHS Foundation Trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	101	-
Monies on deposit	1	1
Total third party assets	**102**	**1**

Note 21 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	7,797	5,969
Capital payables	2,520	1,790
Accruals	19,361	15,363
Social security costs	2,592	2,479
Other taxes payable	1,662	1,423
Other payables	3,083	2,803
Total current trade and other payables	**37,015**	**29,827**
Of which payables from NHS and DHSC group bodies:		
Current	1,992	5,457
Non-current	-	-

The trust had no non-current payables at 31 March 2021.

Note 22 Other liabilities

	31 March 2021	1 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	1,622	225
Total other current liabilities	**1,622**	**225**

The COVID-19 pandemic has had an impact on the trust's ability to deliver some types of activity (both patient-related and non-patient-related) for which additional funding has been received, most notably £661k from Birmingham and Solihull CCG in relation to neuro-developmental pathway activity. This income has therefore been deferred.

Note 23 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Obligations under finance leases	140	131
Obligations under LIFT contract	798	846
Total current borrowings	**938**	**977**
Non-current		
Obligations under finance leases	312	452
Obligations under LIFT contract	27,774	28,568
Total non-current borrowings	**28,086**	**29,020**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Finance leases	LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2020	**583**	**29,414**	**29,997**
Cash movements:			
Financing cash flows - payments and receipts of principal	(131)	(843)	**(974)**
Financing cash flows - payments of interest	(42)	(2,016)	**(2,058)**
Non-cash movements:			
Additions	-	1	**1**
Application of effective interest rate	42	2,016	**2,058**
Carrying value at 31 March 2021	**452**	**28,572**	**29,024**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Finance leases	LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2019	**705**	**30,161**	**30,866**
Cash movements:			
Financing cash flows - payments and receipts of principal	(122)	(747)	**(869)**
Financing cash flows - payments of interest	(50)	(2,069)	**(2,119)**
Non-cash movements:			
Application of effective interest rate	50	2,069	**2,119**
Carrying value at 31 March 2020	**583**	**29,414**	**29,997**

Note 24 Finance leases

Obligations under finance leases where the trust is the lessee.

	31 March 2021	31 March 2020
	£000	£000
Gross lease liabilities	**518**	**691**
Of which liabilities are due		
not later than one year	173	173
later than one year and not later than five years	345	518
later than five years	-	-
Finance charges allocated to future periods	(66)	(108)
Net lease liabilities	**452**	**583**
Of which payable:		
not later than one year	140	131
later than one year and not later than five years	312	452
later than five years	-	-

Note 25 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2020	**391**	**597**	**1,854**	**2,842**
Change in the discount rate	-	-	13	13
Arising during the year	37	299	864	1,200
Utilised during the year	(12)	(265)	(88)	(365)
Reversed unused	**(51)**	(336)	(423)	(810)
At 31 March 2021	**365**	**295**	**2,220**	**2,880**
Expected timing of cash flows:				
- not later than one year;	365	295	2,118	2,778
- later than one year and not later than five years;	-	-	18	18
- later than five years	-	-	84	84
Total	**365**	**295**	**2,220**	**2,880**

Legal claims relate to the public liability and injury benefit claims as informed by NHS Resolution, as well as ongoing employment tribunals. The values provided for are based on current legal advice, although there remains uncertainty over the timing and value of the settlement in each case.

The redundancy provisions relate to the trust's ongoing programme of service transformation. While all affected staff have been consulted before the 31 March 2021, the exact timing of the potential redundancies remains uncertain.

Other provisions include potential claims for dilapidations on the exit of leases (£780k) and a potential VAT payment due to HMRC (£1,240k), for which the timing of the payment is uncertain and value represents management's best estimate of the liability. Other provisions also include provisions for pay protection costs based on restructurings during previous years (£56k), back pay costs, for which the amount payable depends on the staff in post at the time of the payment (£60k), and an amount set aside to meet clinical pension tax obligations (£84k) which will be incurred at some point in the future.

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £1,271k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Birmingham Community Healthcare NHS Foundation Trust (31 March 2020: £1,233k).

Note 26 Contingent liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(34)	(20)
Net value of contingent liabilities	**(34)**	**(20)**

The outcomes of legal claims managed by NHS Resolution are, by their nature, uncertain and NHS Resolution advise of an amount that should be recognised by the trust as a contingent liability pending more certainty over the outcome of the claims.

Note 27 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	20,015	20,257
Intangible assets	115	-
Total	**20,130**	**20,257**

Note 28 On-SoFP LIFT arrangements

The trust opened its new dental hospital in April 2016, which had a capital value of £32.4 million. The contract started on 5 February 2016 and is due to end on 3 July 2040, and results in a unitary payment that is indexed each year in line with RPI inflation.

Under IFRIC 12 the assets of the scheme are treated as assets of the trust as the substance of the scheme is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges.

Note 28.1 On-SoFP LIFT arrangement obligations

The following obligations in respect of the LIFT arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross LIFT liabilities	**52,445**	**55,298**
Of which liabilities are due		
not later than one year;	2,756	2,862
later than one year and not later than five years	10,824	10,894
later than five years	38,865	41,542
Finance charges allocated to future periods	(23,873)	(25,884)
Net LIFT obligation	**28,572**	**29,414**
not later than one year	798	846
later than one year and not later than five years	3,602	3,434
later than five years	24,172	25,134

Note 28.2 Total on-SoFP LIFT commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the LIFT arrangement	**118,799**	**124,894**
Of which payments are due:		
not later than one year	4,878	4,811
later than one year and not later than five years	20,764	20,476
later than five years	93,157	99,607

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**4,812**	**4,695**
Consisting of:		
- Interest charge	2,016	2,069
- Repayment of statement of financial position obligation	846	748
- Service element and other charges to operating expenditure	751	732
- Capital lifecycle maintenance	85	652
- Contingent rent	584	494
- Addition to lifecycle prepayment	530	-
Total amount paid to service concession operator	**4,812**	**4,695**

Note 29 Financial instruments

Note 29.1 Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the trust has with commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities, rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within the parameters defined formally within the trust's standing financial instructions and treasury management policy. The trust's treasury activity is also subject to review by the trust's internal auditor. There are no significant changes in either the trust's exposure to risk or its policies and procedures for managing that risk since the previous period.

Currency risk:

The trust is principally a domestic organisation with transactions, assets and liabilities ordinarily being in the UK and sterling based. The trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Interest rate risk:

The trust's borrowings (see note 23.1) are in the form of a fixed-interest LIFT agreement and finance lease, although repayments on the former are indexed in line with RPI. The trust therefore has low exposure to interest rate fluctuations.

Credit risk:

The majority of the trust's revenue comes from contracts with other public sector bodies, therefore the trust has low exposure to credit risk. The most significant exposure as at 31 March 2021 relates to receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk:

The majority of the trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The trust funded the majority of its capital expenditure in 2020/21 from depreciation. The trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

	Held at amortised cost
	£000
Carrying values of financial assets as at 31 March 2021	
Trade and other receivables excluding non financial assets	8,027
Cash and cash equivalents at bank and in hand	43,663
Total at 31 March 2021	**51,690**

	Held at amortised cost
	£000
Carrying values of financial assets as at 31 March 2020	
Trade and other receivables excluding non financial assets	14,814
Cash and cash equivalents at bank and in hand	32,289
Total at 31 March 2020	**47,103**

	Held at amortised cost
	£000
Carrying values of financial liabilities as at 31 March 2021	
Obligations under finance leases	452
Obligations under LIFT contracts	28,572
Trade and other payables excluding non-financial liabilities	28,351
Total at 31 March 2021	**57,375**

	Held at amortised cost
	£000
Carrying values of financial liabilities as at 31 March 2020	
Obligations under finance leases	583
Obligations under LIFT contracts	29,414
Trade and other payables excluding non-financial liabilities	25,925
Total at 31 March 2020	**55,922**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	31,280	28,960
In more than one year but not more than five years	11,169	11,412
In more than five years	38,865	41,542
Total	**81,314**	**81,914**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30 Losses and special payments

	2020/2021		2019/2020	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	number	£000	number	£000
Losses				
Cash losses	1	-	1	0
Bad debts and claims abandoned	16	30	14	13
Stores losses and damage to property	1	-	1	6
Total losses	**18**	**30**	**16**	**19**
Special payments				
Ex-gratia payments	19	23	26	68
Total special payments	**19**	**23**	**26**	**68**
Total losses and special payments	**37**	**53**	**42**	**87**

Note 31 Related parties

During the year, the trust has entered in to several transactions with entities at which our senior managers also have a role. A summary of the transactions, which are with the entity in question, not our senior managers themselves, is shown below:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party
Dr Barry Henley - Chair	58,408	490	2,196	-
Birmingham City University (Associate)	56,032	-	56,032	-
Aston University (Member of Business Advisory Council)				
David Holmes - HR Director	-	-	-	-
Healthcare People Management Association	695	-	-	-
(HPMA) (Deputy National President)				
Professor David Sallah - Non-Executive	5,263	-	-	-
University of Wolverhampton (Emeritus Professor)	-	4,111	-	2,277
St Andrew's Healthcare (Non-Executive Director Trustee)				
Jenny Belza - Non-Executive	5,500	-	-	-
Royal College of Nursing (Member)	-	-	-	-
University College Birmingham (Governor)				
Salma Ali - Non-Executive	12,098	-	-	-
St Mary's Hospice (Trustee)				

At 31 March 2021 there were no allowances for doubtful debts associated with related parties, and no debt with related parties was written off during the year.

The Department of Health is regarded as a related party. During the year, Birmingham Community Healthcare NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These organisations include:

- Birmingham and Solihull Mental Health NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- Midlands Partnership NHS Foundation Trust
- NHS Birmingham and Solihull CCG
- South Warwickshire NHS Foundation Trust
- NHS Property Services
- University Hospitals Birmingham NHS Foundation Trust
- Community Health Partnerships
- NHS Sandwell and West Birmingham CCG
- NHS England

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Health Education England and Birmingham City Council.

The trust hosts a charity, registered with the Charities Commission, registration number 1069427. The total value of transactions by the trust on behalf of the charity was £328,702, of which £84,281 was due from the charity at the year- end.

Note 32 Related parties 2019/20

During the year, the trust has entered in to several transactions with entities at which our senior managers also have a role. A summary of the transactions, which are with the entity in question, not our senior managers themselves, is shown below.

Directors	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party
Dr Barry Henley - Chair Birmingham City University (Associate) Aston University (Member of Business Advisory Council)	155,189 3,300	1,415 -	2,266 9,800	475 -
David Holmes - HR Director Healthcare People Management Association (HPMA) (Deputy National President)	1,057	-	-	-
Professor David Sallah - Non-Executive University of Wolverhampton (Emeritus Professor)	60,226	-	-	-
Jenny Belza - Non-Executive Royal College of Nursing (Member) University College Birmingham (Governor)	1,870 5,050	-	-	-
Salma Ali - Non-Executive St Mary's Hospice (Trustee)	14,154	1,050	3,475	2,115

At 31 March 2019 the only provision for doubtful debts associated with a related party is £118 set aside for a debt relating to Birmingham City University. No debts relating to related parties were written off in year.

- The Department of Health is regarded as a related party. During the year, Birmingham Community Healthcare NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These organisations include:
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Midlands Partnership NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- NHS Birmingham and Solihull CCG
- NHS Sandwell and West Birmingham CCG
- NHS Property Services
- Community Health Partnerships
- NHS England

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Health Education England and Birmingham City Council.

The trust hosts a charity, registered with the Charities Commission, registration number 1069427. The total value of transactions by the trust on behalf of the charity was £178,331, of which £15,528 was due from the charity at the year-end.

Note 33 Events after the reporting date

There have be no events after the reporting date requiring disclosure.