BOARD OF DIRECTORS MEETING PART I

Schedule Wednesday 29 June 2022, 9:00 AM — 12:00 PM BST
Organiser Hannah Sullivan

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
09:00AM, WEDNESDAY 29th JUNE 2022 VIA VIDEO-CONFERENCING

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

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

09:00am - PATIENT STORY

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Apologies for absence & Declarations of interest	*Chair*	09.30	*(verbal)*	-
2.	2.1 Minutes of the previous meetings May 2021 2.2 June Extra-ordinary 2021		09.35	*(attached)* *(attached)*	Approval
3.	Matters Arising/Action Log		09.40	*(attached)*	Assurance
4.	Chair's Report		09.45	*(attached)*	Assurance
5.	Chief Executive's Report	*CEO*	09.50	*(attached)*	Assurance
6.	Board Overview: Trust Values	*G. Hunjan*	10:05	*(verbal)*	Assurance
7.	**QUALITY**				
7.1 7.2 7.3	QPES Chair's Assurance Report QPES Annual Report Quality Account	*L. Cullen* *L. Cullen* *S. Bloomfield*	10.15 10:25 10:30	*(attached)* *(attached)* *(attached)*	Assurance Assurance Approval
8.	**PEOPLE**				
8.1	People Committee Chair's Assurance	*P. Gayle*	10:40	*(attached)*	Assurance
9.	**SUSTAINABILITY**				
9..1	Finance, Performance & Productivity Committee Chair's Assurance Report	*R. Beale*	*10:45*	*(attached)*	Assurance
9.2	Integrated Performance Report	*D. Tomlinson*	*11:15*	*(attached)*	Assurance
9.3	Finance Report	*D. Tomlinson*	*11:30*	*(attached)*	Assurance/ Approval
9.4	Audit Committee Chair's Assurance Report	*G. Hunjan*	*11:40*	*(to follow)*	Assurance
10.	**GOVERNANCE & RISK**				
10.1	Questions from Governors and Public (***see procedure below***)	*Chair*	*11:45*	*(verbal)*	Assurance

10.2	Any Other Business *(at the discretion of the Chair)*	*Chair*	*11:50*	*(verbal)*	-
10.3	**FEEDBACK ON BOARD DISCUSSIONS**	*R. Beale*	*11:55*	*(verbal)*	-
10.4	**RESOLUTION** The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
11	**Date & Time of Next Meeting** • 09:00am 27th July 2022			*Chair*	

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

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

Procedure for questions from the public at board meetings

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

Questions

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

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

Relevance of questions

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

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

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

Notice requirements

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

Limitations on numbers of questions or time allowed

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

There are no limits to the questions for Governors.

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

Response to questions

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

1. Opening Administration:

Apologies for absence & Declarations of interest

2. Minutes of the previous meetings

2.1. Minutes of the May 2022 Meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	**BOARD OF DIRECTORS**
Date	**WEDNESDAY 25TH MAY 2022**
Location	**VIA MICROSOFT TEAMS**

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

Attendance	Name and Title		
Present	Danielle Oum	-	Chair
	Roisin Fallon-Williams	-	Chief Executive
	David Tomlinson	-	Director of Finance
	Sarah Bloomfield	-	Director of Quality and Safety *(Chief Nurse)*
	Vanessa Devlin	-	Director of Operations
	Hilary Grant	-	Medical Director
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	Russell Beale	-	Non Executive Director
	Linda Cullen	-	Non-Executive Director
	Philip Gayle	-	Non Executive Director
	Anne Baines	-	Non-Executive Director
	Winston Weir	-	Non Executive Director
In Attendance	Sharan Madeley	-	Company Secretary
	Jas Kaur	-	Head of Equality, Diversity & Inclusion *(item 11)*
	Neil Hathaway	-	SSL *(item 14)*
Observers	Maureen Johnson	-	Carer Governor
	Mustak Mirza	-	Service User Governor
	John Travers	-	Staff Governor
	Faheem Uddin	-	Service User Governor
Staff Story	Matt Brayshaw	-	Recovery Lead, Birmingham & Solihull Liaison & Diversion Team
	Ella Carman	-	Photographer and documentarist
Apologies	Gianjeet Hunjan	-	Non Executive Director

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** The Chair welcomed Governors who were observing the meeting, along with representatives of the public.	
2.	**STAFF STORY** Matt Brayshaw, Recovery Lead, Birmingham & Solihull Liaison & Diversion Team and Ella Carman, Photographer and documentarist attended the Board to provide the details of a project undertaken with the support of the Liaison and Diversion Team. The presentation was regarding Crisis and Resilience in the Community and the Board was provided with a range of photographs which told stories relating to service users and staff. The aim of the project was to hold an exhibition to showcase the photographs. There would be an eBook on Peer Mentors which was being produced which would include the photographs. The testimonies within the e-book were very detailed and the posters would include a specific quote from each individual. What came across clearly was that the service did so much and service users and staff had very positive things to say about the Liaison and Diversion Service. Ella explained how she had met Matt and the team and how the work commenced and for Ella it was a lifeline and it used her lived experience for socially engaged photography which she was very proud of. D. Oum thanked Ella and Matt for their presentation.	
3.	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 27th April 2022 were approved as a true and accurate record of the meeting.	
4.	**MATTERS ARISING / ACTION LOG** The action log was reviewed and noted. A. Baines queried if further information could be provided in relation to the data provided through the action log regarding outpatients' appointments to include further analysis. V. Devlin said the document provided an overview but a much more detail report was being produced to provide additional assurance on waiting times for patients which would be presented to a futyre Finance, Performance and Productivity Committee.	
5.	**CHAIR'S REPORT** The Board received an overview of the Chair's key areas of focus since the last Board meeting which was received and noted. It was noted that Non Executive Directors had commenced visits and these would be captured quarterly through the Chair's report/	

Agenda Item	Discussion	Action (Owner)
6.	**CHIEF EXECUTIVE'S REPORT** The Board received the Chief Executive's Report and noted that the Trust was moving towards living with COVID. The report detailed the work underway regarding recruitment within the Trust. The Board noted that further work was being undertaken on initiatives to assist staff with the cost-of-living crisis and the Chief Executive had personally made it clear to system partners that this work needed to progress at pace. It was expected that this would include two specific pieces of work which would include (a) looking how organisations could support the living wage and (b) review the list of areas of support available including food banks, transport and benefits. It was noted that it appeared that the NHSEI negotiations with the treasury had been successful in securing funding for systems in relation to inflation. There had been additional meetings regarding LDA collaborative and it was reported that work was commencing to bring people together again regarding the opportunities and priorities. The report included the detail of the draft Mental Health Bill which was highlighted in the Queens Speech. It was confirmed that the Trust had launched the Anti-Racism campaign, No Hate Zone, and staff were being asked to take the pledge, wear the badge and to make a difference. V. Devlin highlighted the work of the operational clinical services, and it was noted that there were no wards with COVID outbreaks. The service was focusing on recovery and a detailed paper was presented to the Finance, Performance & Resources Committee regarding the IAPT service with a 12-18 month recovery plan in place. The report was received and noted.	
6.	**BOARD OVERVIEW TRUST VALUES** The Chair provided reflections on seeing the Trust values in operation during the month and highlighted a visit to the team leaders of the First Service with Anne Baines and it was clear in the face of operational challenges that they were a very committed and compassionate team. On reflection, the nature of the service and providing forensic services in an outreach capacity was the embodiment of inclusion. This past month, the Chair and has held 1:1 conversations with Governors regarding how they can maximise the Governor role and what has been clear that this was a voluntary role and it was evident how committed Governors were to the work of the Trust. The Staff Story presented earlier in the meeting was a clear example of compassion and commitment regarding a project which was including people and was a great example of the values in operation.	
7.	**QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE CHAIR'S ASSURANCE REPORT** L. Cullen provided the assurance report from the Committee and highlighted the key areas of discissions from the last meeting.	

Agenda Item	Discussion	Action (Owner)
	This included an update on the CQC with the Director of Quality and Safety meeting with the new CQC inspector. The Annual Infection, Prevention and Control report was received and a lessons learned report would be presented to a future meeting of the Committee. The Committee reviewed the bi-annual Safeguarding Report and were appraised of the new integrated safeguarding system and how the standards would assist with assurance across the Trust. The Committee was briefed on the workplan of the safeguarding team. It was reported that compliance had been a challenge during the last 2 years and the Committee was impressed with how the team adapted during the pandemic. The PREVENT annual report was received and the Committee was assured regarding the level of training being undertaken. However, the Committee was informed that the threat level was high especially in Birmingham and in relation to the Commonwealth Games. The Committee had a discussion regarding that the highest threat level was from Islamic extremism and the challenge of how we approach PREVENT but not by impacting on the health and wellbeing of the communities. The Committee was presented with the anti-ligature deep dive and associated the challenges and the Committee was partly assured of the processes in place. The first quarterly report was received from the Mental Health Act Committee Sub Committee.	
8.	**INFECTION, PREVENTION & CONTROL ANNUAL REPORT** The Board received the Infection Prevention & Control Annual Report 2021-2022. In relation to compliance with the key performance indicators, the Trust has always been above the 95% threshold. The IPC team was working on supporting teams to ensure they could access the Hand Hygiene training. During thee year the IPC team had the support of an agency IPC nurse, which enabled the increase in the auditing program and the number of support visits performed. The IPC team undertook a total of 56 audits and 36 support visits during the financial year. In relation to COVID outbreaks, the Trust reported a total of 35 outbreaks which were widespread including some outbreaks in community settings. The report also detailed external visits which had been undertaken, food safety and water management. The Board received and noted the annual report.	
9.	**SAFEGUARDING BIENNIAL ASSURANCE REPORT** The Board received the Safeguarding Annual Report which provided an overview of safeguarding for the period, governance arrangements, integrated safeguarding service and training compliance.	

Agenda Item	Discussion	Action (Owner)
	It was reported that child poverty, knife crime and children in care were all outliers within Birmingham and Solihull. Domestic abuse has increased during the pandemic which was expected and there had been good resources within in the team to respond. Due to the impact of COVID, the conversations that the team have been engaged with were of a very high risk and intense and has had a significant impact on teams. Due to COVID, it had been challenging for the team to work together in an office environment and this had been felt by the team on a resilient level. The Mutli Agency Safeguarding Hub has had challenges regarding resources and there had been a significant number of system discussions taking place to address this. The training compliance was being addressed and from the report it detailed that Safeguarding for Children and Adults Level 3 had improved from 30% to 70%. However, it was the Level 3 training which was required for staff working with vulnerable children and adults**.** S. Bloomfield reported that it was disappointing there had been an increase in sexual abuse which was also on the radar. Cath Evans had retired and was an incredibly talented Safeguarding lead and the Trust was fortunate to have an Interim Safeguarding Lead in place. It was reported that the ICS needed to work together on the Safeguarding Structure and a report was commissioned by the CCG and the Chief Nurses were meeting to agree the system approach to Safeguarding. A supervision review of Safeguarding was being undertaken with a report being presented to QPES Committee. S. Bloomfield stated that in relation to “Person in a Position of Trust”, where Health and Social Care Staff may be referred into a process of concern regarding safeguarding. This was currently high on the agenda and being reviewed because the Trust was referring BAME staff through this process and a monthly report had been requested, broken down by ethnicity to understand the numbers of staff being referred. P. Nyarumbu said that Jas Kaur, Diversity Lead, should be linked into the work to review if there was bias or whether the referrals were genuine.	
10.	**PEOPLE COMMITTEE CHAIR’S ASSURANCE REPORT** The Board was informed that the Committee reviewed the key performance indicators and there had been a slight improvement in the vacancy rate. The Trust was addressing the challenges of addressing vacancies with many initiatives were being utilised. A job fair was being held to focus on the recruitment on registered nurses.	

Agenda Item	Discussion	Action (Owner)
	In relation to e-rostering, assurance could not be achieved in relation to rotas being agreed 6 weeks in advance and a detailed report would be received from the e-rostering Board and presented to the Committee at a future meeting. In relation to appraisals, the Committee were not fully assured that progress was being made although there had been a slight improvement the Trust target. A, Baines queried the target to ensure posts at 8a were recruited to, to reflect the communities served and asked if it was possible to undertake an analytical piece of work to see if a different approach was required to reach the target. P. Nyrarumbu said that there was more work to do regarding shifting the culture in the Trust adding that further analytic work would be discussed at the People Committee regarding embracing talent management and how the Trust was supporting colleagues' at band 5 and above to progress within the Trust. The work around talent management was critical to support colleagues with development programmes within the organisation. D. Oum asked the Chair of the Committee to ensure that the Committee was understanding the extent to which this was either an issue of staff needing development or them not being given the opportunities. R. Beale queried the position on overseas recruitment with S. Blommfield responding that the Trust had been successful in gaining national monies for international recruitment with the Trust seeking to bring 30 nurses into the organisation in the next 12 months who may need bespoke training on mental health. The Trust was cautiously optimistic and there was an issue of ensuring the support mechanisms were in place. R. Fallon-Williams added that the Trust had a fabulous HR trainee who has been undertaking a piece of work on international staff and was looking at learning from their experiences so this could be applied when specific recruitment campaigns commenced. H. Grant reported on the medial recruitment adding that the Trust was working with UHB and GMC regarding international recruitment. The Trust had been involved in the international medical training initiative who were welcomed into the Trust providing supportive information. In addition, the Trust was working with an international recruitment agency. H. Grant also informed the Board that the medical appraisal rates were at 98%. ***DECISION:*** ***The People Committee to gain understanding on the extent to which the lack of seniority in BAME colleagues could be addressed though targeted development of BAME colleagues and to what extent was the issue about addressing inequality within the recruitment and selection process***.	

Agenda Item	Discussion	Action (Owner)
11.	**REGULATORY REPORT ON EQUALITY DATA FOR THE WORKFORCE RACE AND DISABIILTY EQUALITY DATA AND GENDER PAY GAP** The Board received a report which detailed that NHS contracts required Trusts to publish Workforce Race and Disability Equality data in line with the Public Sector Equality Duty as well as the requirements set out in the NHS Standard Contract. The WRES and WDES reports were summarised via the slide deck presented to the Board as well as the full reports ratified through NHS England. The key message from the WRES was that the Trust did not show any positive indicators across the 9 stated, with the lowest indicator being Indicator 7: *Colleagues believing that the Trust offers equal opportunities for career progression* ranked in the lowest 6%. The key messages from the WDES were that the Trust was in the top 10% nationally for Metric 2: *Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff* and Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: patients/public.* It was important to note that the experience of disabled colleague was still considerably worse than non-disabled colleagues, so the experience of equity was not realised across even the top scoring metrics. The priorities for the WDES were Metric 10: Board disability representation; Metric 4a: Harassment, bullying or abuse from patients/public; Metric 5: Career Progression. The highlighted priorities across the WRES and WDES were embedded within People plan and these have recently been refreshed. D. Oum said that the report reemphasised the messages from the staff survey and we need to double efforts to be analytical and targeted. D. Oum asked if there were areas of focus that we have held off from addressing and now the data had been seen we would want to be more radical in addressing. P. Nyarumbu said that the area around career progression was a clear and positive action which was required and a focus on the wrap around support for colleagues. Jas Kaur added that this has been an area previously flagged by the staff network and this has evolved into a quality improvement approach regarding band 5 advancement. The traction and pace needed a careful considered approach and we were seeing traction on equality and the conversation was giving a great foundation on the positive action approach. S. Bloomfield reported that the corporate nursing leads were meeting to discuss what practically could be done within the profession and discussions would be held on the responsibility to make change and sponsor individuals to have opportunity and to step up with their career pathway and this work would be fed back through the People Committee. H. Grant stated that when people do progress, they unfortunately did not stay and the Trust needed to think carefully regarding the support available for staff. The report was received and noted.	
12.	**FINANCE, PERFORMANCE AND PRODUCTIVITY COMMITTEE CHAIR'S ASSURANCE REPORT** The Board received the Chair's Assurance report from the Finance,	

Agenda Item	Discussion	Action (Owner)
	Performance and Productivity Committee from the meeting held on the 18th May 2022. The Committee as informed that he month 1 Group position was a deficit of £0.2m, in line with plan. The position comprised of a £157k deficit for the Trust, a £22k deficit for Summerhill Services Limited (SSL) and a break-even position for the Reach Out Provider Collaborative. The final financial plan submitted to NHSEI by Birmingham and Solihull ICS was a deficit of £35.8m. This comprised a deficit plan of £2.7m for BSMHFT as submitted to NHSEI on 28/4/22. This was a £0.4m improvement to the proposed plan of £3.1m presented at month 12 FPP and was driven by a share of an increased efficiency requirement across the system. As previously requested by the Committee, the financial report now included breakdown regarding the segmented reporting of the Trust, Reach Out and SSL. R. Beale reported that capital issues discussed with the Committee being concerned regarding the process within the last 12 months and discussions were held regarding once this year's capital allocation had been resolved, the process would be reviewed. In terms of agency staff, the Committee reiterated the need for creative and imaginative solutions, especially flexibility, regarding recruitment and job roles. The report was received and noted.	
13.	**OUR TRUST FIVE YEAR STRATEGY UPDATE** The Board received an annual update detailing the achievements within 2021-2022, Year 1 of the Trust Five Year Strategy; the goals for 2022-2023 and a description of the Strategy Accountability Framework. It was noted that the Strategy was launched through a two-month multi-channel communications and engagement campaign aimed to launch the strategy in a meaningful way. Following approval of the Trust Strategy, the Board approved high level Trust goals for 2021/22 (Year 1 of the Strategy) for each of the four strategic priorities in May 2021. Reducing inequalities was a key priority for the Trust, ensuring the Trust was working in a way that tackled discrimination, racism, addresses stigma and encourages equality for all. This was a golden thread across all four of the strategic priorities, with each of the priorities having goals and plans around reducing inequalities. Board Members noted that despite the significant clinical and operational challenges the pandemic has presented over the past year, there had been a significant amount of progress in delivering the goals across all four strategic priorities, and colleagues were commended for these achievements. The majority of goals have been progressed forward and there had been a lot of positive achievements to report, putting the Trust in a good position for moving into Year 2 of the Strategy. The goals had been reviewed and reset moving into 2022/2023 for all four strategic priorities. T	

Agenda Item	Discussion	Action (Owner)
	Taking into account the key transformation programmes, the impact COVID has had and would continue to have on the workforce and demand for mental health services; the impact of the newly evolving BSOL Integrated Care system; the recent staff survey results and new local and national priorities and programmes of work. There was a clear and comprehensive Strategy Accountability Framework setting out the processes for the delivery, monitoring and reporting of the ambitions set out in the strategy. R. Beale said that the Board needed to understand how well the strategy was being embedded and queried whether the work needed to be done at meetings outside of the Board. P. Nyarumbu stated that part of the reason why the goals were taken through the Committees were to enable discussions and further work was needed to ensure people were fully engaged in the process. The Trust had Taste the Brew and other initiatives to engage staff with the strategy and through Board visits, members would be able to see if the strategy was understood as part of their assurance. V. Devlin added that in the report it included engagement with an example of how front line staff were agreeing their own goals and would hopefully see evidence of this through service visits. The Directorates all have their own objectives to deliver services and cross themes regarding working closely with other colleagues from directorates. **DECISION:** ***(a) The Board of Directors noted the progress made in 2021/22 in delivering the Trust Strategy*** ***(b) The Board of Directors approved the 2022/23 strategic goals for our four strategic priorities***	
14.	**SUSTAINABILITY STRAGETY: CARBON NET ZERO: OUR GREEN PLAN** The Board was informed that the Sustainability Development Strategy and Action Plan was developed late 2021 and submitted to Trust Executive Team. This has been further developed to the updated strategic Carbon Net Zero -Our Green Plan. Neil Hathaway explained that the new plan has been developed in conjunction with Environmental Consultants appointed by BSol ICO to ensure BSMHFT were in-line as an NHS System and consider NHSEI national agenda and key NHS National targets. The NHS has recently become the first National Health system to commit to become 'Carbon (Net) Zero' by adopting a multiyear plan with clear deliverables and milestones. The plan sees the NHS formally adopt two key targets, these being (a) For the NHS carbon footprint (emissions under its direct control) to be net zero by 2040 with an ambition for an interim 80% reduction being achieved by between 2028 and 2032, and (b) For the NHS Carbon footprint (emissions which also includes wider supply chain) to be net zero by 2045 with an ambition for an interim 80% reduction by between 2036 and 2039. Ultimately it was these future NHS National targets that would be disaggregated and agreed for each ICO and provider organisation.	

Agenda Item	Discussion	Action (Owner)
	BSMHFT, as an NHS provider, would need to work with such priorities and targets, progressing key actions as detailed in the plan which were all aimed at achieving the Trusts established objectives. The proposal was to bring a further update at the end of Quarter 3 for a progress report. D. Oum thanked Neil Hathaway for the work that has been undertaken and W. Weir thanked N. Hathaway and the team for the plan adding that in relation to Green Action Plans, it was important to consider creating a Sustainability Group across the Trust to ensure greater engagement. ***DECISION:*** ***The Board of Directors received and supported the proposals recommended in the Carbon Net Zero -Our Green Plan along with endorsing the Action Plan to ensure BSMHFT work towards its disaggregated targets and contribute to the NHS overall National position***.	
15.	**INTEGRATED PERFORMANCE REPORT** The Integrated Performance Report was received which detailed that new sets of metrics are being finalised for all domains following approval of the Trust Strategy. The key issues which had been considered by the Committees included the Out of area bed use, IAPT, CPA 12-month reviews, CPA 7-day follow up, new referrals not seen, financial position and CIP presented to the FPP Committee. In relation to the People Committee, the areas of vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness have been discussed. The Quality, Patient Experience and Safety Committee were presented with commissioner reportable incidents and ligature incidents. The report was received and noted.	
	FINANCE REPORT The finance report detailed the month 1 Group position which was a deficit of £0.2m, in line with plan. The position comprised a £157k deficit for the Trust, a £22k deficit for Summerhill Services Limited (SSL) and a break even position for the Reach Out Provider Collaborative. The final financial plan submitted to NHSEI by Birmingham and Solihull ICS was a deficit of £35.8m. This comprised a deficit plan of £2.7m for BSMHFT as submitted to NHSEI on 28/4/22. This was a £0.4m improvement to the proposed plan of £3.1m presented at month 12 FPP Committee and was driven by a share of an increased efficiency requirement across the system. Following system capital prioritisation discussions, a capital plan of £7.3m for BSMHFT was submitted to NHSEI on 28/4/22 for 2022/23 (£0.2m was subject to final system allocation). It was reported that the month 1 Group capital expenditure was £50k, which is £110k less than plan. The month 1 Group cash position is £54m.	

Agenda Item	Discussion	Action (Owner)
	The report was received and noted.	
16.	**MEETING FEEDBACK** V. Devlin provided feedback on the meeting stating that the Board was focused on the assurance aspects of the reports. The feedback on the WRES data was extremely important but difficult to hear. V. Devlin added that as Board Members, colleagues had acknowledged and embraced the feedback as Board Members. The feedback from Committee Chairs was detailed and informative. There had been a lot of work undertaken the strategy and challenges to the reports were undertaken in line with the Trust values.	
17.	**QUESTIONS FROM GOVERNORS AND PUBLIC** J. Travers highlighted the community hubs and in relation to the Community Transformation branding and referred to the on-going consultation queried what assurance did Board colleagues have regarding front line services being informed on these important developments. V. Devlin said that had understood from feedback that teams had been involved and the leaders felt very engaged. J. Travers said he was pleased to note Non Executive Directors seeking assurance on the Green Action Plan and it could be seen in the plan that further assurance was being sought on staff engagement.	
18.	**ANY OTHER BUSINESS** There was no further business raised.	
19.	**RESOLUTION** The Board asked that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.	
20.	**DATE & TIME OF NEXT MEETING** • 09:00am • 20th June 2022	

2.2. Minutes of the Extra-ordinary Board of Directors June 2022 Meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	**EXTRA-ORDINARY BOARD OF DIRECTORS**
Date	**MONDAY 20th JUNE 2022**
Location	**VIA MICROSOFT TEAMS**

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

Attendance	Name and Title		
Present	Danielle Oum	-	Chair
	Roisin Fallon-Williams	-	Chief Executive
	Sarah Bloomfield	-	Director of Quality and Safety *(Chief Nurse)*
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	Anne Baines	-	Non Executive Director
	Russell Beale	-	Non-Executive Director
	Linda Cullen	-	Non-Executive Director
	Philip Gayle	-	Non-Executive Director
	Gianjeet Hunjan	-	Non-Executive Director
	Anne Baines	-	Non-Executive Director
	Winston Weir	-	Non-Executive Director
In Attendance	Sharan Madeley	-	Company Secretary
	Richard Sollars	-	Deputy Director of Finance
	Jasmine Martin	-	Head of Financial Services
Apologies	Hilary Grant	-	Medical Director
	Vanessa Devlin	-	Executive Director of Operations
	Dave Tomlinson	-	Executive Director of Finance

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** The Chair welcomed Board Members to the meeting.	
2.	**ANNUAL REPORT AND ACCOUNTS 2021-2022** G. Hunjan, Chair of Audit Committee, provided an update for Board Members on three areas which included Counter Fraud, TIAA and Head of Internal Audit Opinion and the recommendations from Mazars, External Auditors.	

Agenda Item	Discussion	Action (Owner)
	It was reported that the Audit Committee met in April 2022 to review the draft annual accounts for 2021-2022 and then again June 2022. The Counter Fraud Assessment indicated that the Trust was compliant on 11 of the 12 functional standards and had therefore provided the Trust with a green rating. In relation to TIAA, Internal Auditors, they had concluded all of their internal audits and had published a number of their outstanding reports. All the substantial reports had been completed and therefore TIAA were able to issue their Head of Internal Audit Opinion, and this was assessed as "*reasonable assurance*" on the checks and balances within the Trust**.** It was reported that there were outstanding recommendations from the reports which would be picked up by the incoming internal auditors, RMS. The audits completed within the last Quarter included the BAF and Risk Assurance processes which was concluded as "*limited assurance."* Due to this outcome, the Annual Governance Statement was amended to reflect the comments of the Auditors and noted by the Audit Committee. All of TIA work undertaken resulted in a "*reasonable assurance*" opinion. It was reported that any audit reports not issued would be presented to the July Audit Committee meeting. Mazars have received the annual accounts in a timely fashion and have audited the accounts with extensive testing. The audits have concluded that that Mazars would be issuing the Trust with an unqualified opinion. Mazars said that whilst the Trust had been excellent in compiling the information for Mazars, it was not the same elsewhere in the economy and thanks were offered to the finance team for all their hard work**.** The Annual Accounts were submitted by the finance team and were reviewed by the Audit Committee. The conclusion of all the reports has resulted in the Audit Committee recommending to the Board of Directors that the Annual Report and Accounts could be approved for formal submission to NHSE/I by the 22nd June 2022. As Audit Chair, G. Hunjan, on behalf of the Audit Committee thanked the finance team, Company Secretary, internal auditors, external auditors and staff who were involved in compiling the documents. R. Sollars endorsed the comments made and added that the external auditors last week gave one of the best presentations on the accounts that had been seen by the Trust. There were no requests for adjustments which was an excellent position to be in. R. Sollars added that by the Board approving the Annual Report and Accounts 2021-2022, this allowed the Chairs and Chief Executive's signatures to be added electronically throughout the document. D. Oum said that it was an outstanding piece of work. The report also reflected the amount of work which had been undertaken by the Trust during the last 12 months. A Baines said that having no adjustment requests was amazing and showed the quality of the information provided.	

Agenda Item	Discussion	Action (Owner)
	W. Winston queried if a written report on the Head of Internal Audits Opinion was provided with G. Hunjan responding that the report had been received and was included within the Annual Governance Statement. Mazars reported that based on what they reviewed, they would be issuing an unqualified opinion. R. Sollars stated that Mazars now need to see the formal written minutes from the meeting today and they will then issue the formal letter that will be included within the report. S. Bloomfield stated that she didn't see the significant staffing risk reflected in the annual report and this was endorsed by the Board and would therefore provide a paragraph to be included before submission. ***DECISION:*** ***The Board of Directors received and approved the Draft Annual Report and Accounts for 2021-2022 subject to one additional inclusion within the text of the Annual Report relating to the staffing risk for the Trust.***	

Approved in Draft by the Chair: Danielle Oum, 11:45am, 20th June 2022

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS – JUNE ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
May 2022 Minute 10	People Committee Chair's Assurance Report The People Committee to gain understanding on the extent to which the lack of seniority in BAME colleagues could be addressed though targeted development of BAME colleagues and to what extent was the issue about addressing inequality within the recruitment and selection process.	P. Gayle	July 2022		

RAG KEY

Overdue
Resolved
Not Due

4. Chair’s Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	29 June 2022
Author	Danielle Oum, Chair
Executive sponsor	Danielle Oum, Chair

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

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

CHAIR'S REPORT TO THE BOARD OF DIRECTORS

1. INTRODUCTION

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

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

1.3 I am pleased to offer a brief report to the Board giving an overview of my key areas of focus since the last Board meeting with my intention to provide a regular update at each Board meeting.

2. CLINICAL SERVICES

2.1 I was pleased to be able to visit the team at William Booth Centre and learn more about the teams priorities and ambitions for the future.

2.2 A full schedule of site visits are now in place to enable members of the Trust Board and members of the Council of Governors to visit all sites over the coming months.

3. PEOPLE

3.1 As we move out of restrictions, I am making arrangements to meet individually with our Governors over the coming months to discuss their role, development, and engagement with the Trust. This will enable us to continue to strengthen the effectiveness of the relationship between Board and the Council of Governors.

3.2 I am pleased to confirm the schedule of dates for the 'Pull up a chair with the Chair' initiative have been agreed and will launch in early July 2022.

4. QUALITY

4.1 I was pleased to be able to chair the Extra ordinary Board of trustees and approve the annual accounts and annual report for 2022. It was a great opportunity to review the fantastic work over the past year and recognise the ongoing pressures we face as a Trust.

5. SUSTAINABILITY

5.1 I have scheduled the mid-year reviews for the newest members of the Non-Executive Team, Anne Baines and Winston Weir and was supported by members of the Council of Governors. It was a good opportunity to review the progress and priorities for the Non- Executive Directors.

5.2 The Non- Executive Director annual appraisals are being scheduled for the summer.

5.3 I am pleased to confirm the Governor elections are now live with applications being received. The closing date is 1 July 2022. I look forward to being able to appoint new members of the Governing Body of the coming months.

DANIELLE OUM
CHAIR

5. Chief Executive’s Report

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	29 June 2022
Author	Vanessa Devlin and Roisin Fallon-Williams
Executive sponsor	Roisin Fallon Williams

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

Executive summary

Our report to the Board this month provides context on our move to 'living with COVID 19' and. provides information on our areas of work focused on the future and other information of relevance to the Board, in relation to our Trust strategy, local and national reports and emerging issues.

Reason for consideration

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

Paper previous consideration

Not Applicable

Strategic objectives

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

Financial implications

Not applicable for this report

Risks

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

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

CHIEF EXECUTIVE and DIRECTOR of OPERATION'S REPORT

1 LIVING WITH COVID 19

There continues to be an increase in Community transmissions of Covid 19, with symptomatic cases also rising. This is impacting on acute physical health services with an increase in hospital cases, ITU cases remain at around 3%.This increases the risk of potential outbreaks within our ward settings and at the time of writing there are 2 outbreaks across our clinical areas.

New guidance has been received in relation to mask wearing across services, we are taking a phased approach to this and have removed the need for wearing masks in non-clinical setting. Mask wearing for Clinical areas remains in place whilst risk assessment and further considerations are given as to stepping this requirement down in a safe manner, our aim is to provide further updates by the end of June 2022.

We remain under increased scrutiny following a visit from NHSE/I IPC colleagues in February 2022 and a follow up visit is due to take place in the next few weeks to ensure that all appropriate actions and responses have been taken. There continues to be good engagement between the Trust and NHSE/I colleagues to ensure support and advice is sought to address continued concerns which have been observed through external outbreak meetings. The following actions are currently being undertaken by the Deputy DIPC:

- Review of response to outbreak processes, both internal and external
- Review of IPC team response and support to local areas
- Review of all Covid guidance in place to ensure it remains appropriate or to be stepped down in line with national standards
- Review of process and reporting for fit testing for Trust colleagues

1.1 Monkeypox

Cases of monkeypox are continuing to increase with over 700 cases in England, 17 currently in the Midlands region. Positive cases are now presenting much earlier in the disease process.

There are no current cases within the Trust and there is an escalation process in place for any suspected cases. Work continues in line with national guidance to strengthen practices in relation to Monkeypox.

The fit testing for FFP3 masks for colleagues continues within the Trust and increased sessions are being facilitated to help increase compliance rates.

2 PEOPLE

Our People Committee assurance report sets out for us the key areas of focus in recent weeks.

2.1 People Business Partnering Team

The Senior People Team has welcomed a new People Partner for ICCR Dawn Hall. Dawn joins us from BCHC and brings with her a wealth of experience gained across the NHS. We wish her the best whilst settling in. Gurpreet Bhamra, People Partner will be moving from ICCR to Acute and Secure Offender Health Care.

Anthony McCourt has joined the Team as Interim Head of Transformation. Anthony has worked with several NHS Trusts to improve workforce planning, International Recruitment and cost savings and we are excited to welcome him to the team.

A key focus for the People Team will be supporting the Divisions with their Long Term sickness recovery and retention action plans. Additionally, we are actively promoting and supporting the Health and Wellbeing Agenda within the Trust and are prioritising options to assist our colleagues struggling as a result of cost-of-living increases.

The Medical Workforce Team have been working with the Clinical Directors to finalise the new Specialist Grade Role which is awaiting approval by the Royal College of Psychiatrists. We welcome this role within the Trust as it gives more development opportunities to our medical workforce colleagues.

2.2 Temporary Staffing Solutions

The TSS team have developed a survey to engage our Temporary Workforce colleagues and Managers in a way that will aim to help us develop our service to be more inclusive, and with service user safety at our core. This will be developed into a series of workshops for clinical managers to better utilise the skills of our TSS workers.

2.3 Job Evaluation

We would like to thank Tara Conlan, Senior People Partner and Charlotte Anderton for arranging the recent NHS Professionals Job Evaluation Training.
As a result the Trust has 16 additional job evaluators ready to undertake the important duty of assessing new roles prior to advertising. We appreciate those who attended taking the time out to help us improve our services

2.4 Reservist job fair

The Recruitment Team supported the Reservist event held on the 21st May 2022, designed to recruit and retain the vaccination workforce who stepped in to help deliver Covid vaccinations during the pandemic.

Feedback was very positive as our colleagues were overwhelmed with applicants interested in learning more about the vital work undertaken in our Trust. We would like to thank all involved in attending this fabulous event.

2.5 Cost of Living Increases

The Board is aware that the current and forthcoming increases in the costs of living are impacting on many colleagues in a way that has never been the case in the past.
We have held a Listen Up Live Event to better understand the issues impacting our colleagues and will take actions from that to deliver meaningful support to all.

2.6 Organisational Development team

We currently have 166 individuals within the Trust who are accessing learning via apprenticeships, an increase of over 50 staff since 2020.

New in 2022 is the level 7 Apprenticeship Senior leads (with a master's qualification) regarding which we are working with two local universities. 16 colleagues have signed up to date, further cohorts will go live October 2022 and January 2023.

We are also working collaboratively with our NHS Nottingham and Nottinghamshire colleagues in relation to the Systems Thinking Practitioner level 7 Apprenticeship - (Midlands cohort) which commenced this month (June 2022) seeing our BSMHFT colleagues join colleagues in Nottingham.

In addition the Chartered Manager Degree (level 6 apprenticeship) will also commence in October, this will be delivered via Manchester University – BSMHFT were initially offered four places and we have successfully increased this and recruited eight Trust colleagues to undertake this.

2.7 Insight on Employee Experience

The Organisational Development (OD) team have continued their extensive work in supporting local teams in collating their staff survey data and supporting the leaders of these teams in developing their leadership responses. This has included comparative analysis and bespoke OD interventions being implemented as requested. At the same time briefings and follow ups with both our corporate and professional groups such as the Allied Health Professionals Advisory Committee and the Medical Advisory Committee have taken place and comments analysis is now underway.

The latest People Pulse survey was analysed and reported, it showed that colleagues continue to experience a challenged environment. There are nonetheless some minor signs in the results that teams are feeling more positive than in January. Many comments focused on the need for more visible leadership and improved communications as we emerge from the pandemic.

2.8 Recruitment and Resourcing

The Team have initiated and are taking part in a number of targeted activities in the coming weeks.

They are involved in a number of School events taking place over the coming weeks, designed to promote NHS careers and these are expected to reach over 700 young people, where we will promote all the roles we have to offer as a Trust/NHS.

We have planned an Apprenticeship recruitment event for 7th July 2022 at the Uffculme Centre; we will undertake recruitment to roles we have vacant on the day, which is aimed at supporting 16-30 year olds looking for careers within the NHS. BSMHFT is doing this as pat of our work in partnership with the Princes Trust.

A recruitment stall will be in place at the Birmingham and Solihull (BSOL) & Commonwealth Games Partnership event on the 21st July 2022.

Our work relating to the SEND virtual work experience event concludes on the 27th June 2022 this has seen us working with Mayfield School, promoting NHS careers via supported apprenticeships.

2.9 Reward and Recognition

The OD team visited operational sites over the bank holiday weekend to deliver a thank you poster for managers to use on NHS Thank You Day (which was on the bank holiday Sunday). The poster allowed managers to thank their teams and it was delivered in person with a thank you from the Trust along with a small jubilee themed thank you treat.

2.10 Enough is Enough

The Enough is Enough Campaign will launch on Monday 20th June 2022. The campaign will be split into 2 distinct areas:

Senior Leaders information pack

Part 1 of the information pack provides the necessary background information and process that has been approved by the People Committee in relation the Trust's commitment to permanently remove unacceptable behaviours of bullying, harassment, and discrimination.
Part 2 provides a flow chart to walk through the necessary steps of the process and set out accountability for leading and managing claims of bullying, harassment, and discrimination informally.

Colleague imagery and narrative

Our colleague campaign focusses on our ability to raise issues, the process is reliant on our senior leadership team to guide colleagues through the process. They are not expected to know the process but to be assured that they will be listened to in a non-judgmental way and supported to find a resolution to the issues they have raised.

2.11 Value based Appraisal

The new appraisal process related forms have been created and reporting requirements have been reviewed, this includes ensuring that data relating to the staff survey can be collated. Our aim is to launch our new values-based Appraisal the week beginning 1st August..

2.12 Corporate Induction

Our Quality Improvement methodology is being used to create a new Corporate Induction program that covers pre, during and post Induction experiences of colleagues and ensures it has a clear focus on wellbeing and our Trust values. The aim is to have our new corporate Induction in place by September 2022.

3 CLINICAL SERVICES

Our focus this month has continued to be on our priorities for the recovery and restoration strategy across all operational divisions. This includes, in part, the assessment and provision of safe environments for teams now expected to undertake more site based work and increases in face to face contact with service users.

Our data analysis of face to face contacts is now clearly indicating improvements across many services to levels of 60-70%.

Work also continues on our transformation and technological related plans to reduce patient waiting lists/times, and to always ensure patient preference.

Gaps in our workforce vacancies remain a concern and are highlighted in risk registers. Whilst a number of new and innovative methods of attracting staff are underway service wide, the immediate shortfall remains the topic of risk based discussions at all levels in the Trust.

3.1 Specialties

A new Clinical Nurse Manager is now in post,

In the Outpatients service the Administration team are continuing to closely monitor access to room usage as all rooms are now open for face-to-face appointments. A comprehensive office/ room review is due for completion at the end of July which will inform the divisions on going practice needs.

Birmingham Healthy Minds (BHM)

A rolling program of recruitment has been established to address vacancy levels which is a significant contributory factor to the services underperformance. The number of Cognitive Behavioural Therapist (CBT) trainees for year the 2022/2023 has now been confirmed by Heakth Education England (HEE) as work to increase face to face contacts is ongoing.

In conjunction with BSOL CCG and the Integrated Care System (ICS) digital team we are collectively developing a system for review and remote monitoring via virtual wards as well as mental health workstreams. It is hoped this will build on current working relationships and projects and to scope if there could be an opportunity for a remote monitoring pilot for

dementia patients or complex dementia patients in Acute Services.

We had submitted a proposal in partnership with BSoL CCG, for funding for a 12-month pilot to review the number of assessments for dementia undertaken in care homes - which in turn would improve the Dementia Diagnostic Rate (DDR).

The Health Education England (HEE) funded family intervention training continues to develop well and positive feedback continues to be received regarding this training. The division is looking to increase the cohort size by using affiliated trainers from across England to support the training.

3.2 Integrated Community Care and Recovery (ICCR)

The ICCR community transformation continues to go from strength to strength. The project team have received further congratulations from NHSE as they have recruited staff into their newly emerging primary care liaison teams. ICCR has already started to see the impact of the primary care teams within the South Birmingham Primary Care Liaison (PCL) team managing 94% of the 300 referrals received at the primary care level. With new funding they have been able to allocate new roles to secondary care CMHT teams, which include Occupational Therapists, support time & Recovery Workers, Psychologists, and Emotional Wellbeing Practitioners.

Transformation of rehabilitation services is progressing well; with further recruitment to the new rehabilitation team that will support the return of service users in out of area placements, in need of rehabilitation whilst also preventing the need to further place Service Users out of area. A Single sex complex care ward associated to this work, is on track to be available at the end of June 2022.

Two further funding bids are underway: One for drug and alcohol services and he second for the development of clinical services with innovative new treatments. Confirmation of the successful or otherwise award of these funds is expected in September 2022.

ICCR has welcomed significant investment from the Trust to refurbish the decommissioned Newington Centre. The project has been delivered on time with savings and feedback from colleagues and service users is positive.

Dame Yve Buckland, ICS Chair attended the Homeless Primary Care Service during the month. This resulted in the team being congratulated for the work they have completed towards improving their CQC rating.

Additional investment to enable the growth of a third Mental Health " in schools' team in Solihull has been granted.. The service has commenced an initiative involving the recruitment of young people to volunteer to be trained as support counsellors. This scheme is being evaluated with initial positive feedback from the young people in receipt of the service.

ICCR are also utilising new investment to offer a 18-25 year transition service and increased, preventative eating disorders offer to children and young people.

3.3 Secure Care & Offender Health

The Secure Care and Offender Health division are continuing with active recruitment in innovative ways. This month has seen changes to Reaside and Tamarinds leadership and nursing teams for Clinical Nurse Manager, Matron, Clinical Lead and Ward Manager posts.

HMP Birmingham Prison Tender has been awarded for a period of 7 (+2) years. This has been communicated with staff who have expressed their delight at the Trust succeeding in winning this tender.

The capacity within the psychology team is improving as staff are returning from maternity leave. There is also continued involvement in the Integrated Offender Health tender process.

The Occupational Therapy (OT) service are commencing the process of organisational change for current Physical Health Instructions within SCOH to transition to the AHP and Recovery Directorate in line with the structure as the rest of the Trust. Our 'FIRST OT' team are presenting at the Royal College of Occupational Therapists Conference week commencing 30th June regarding the transition programme they provide to service users within inpatient and community settings.

We are undertaking four new Arts Psychotherapies pilots across Secure and Offender Health Pathway, including the first music therapist posts (initially for 12 months). Positive feedback has been received from teams and service users as this means the service is operating at full staffing capacity.

Funding has been secured to facilitate two projects alongside the art therapy group. One will be based at the Uffculme and the second is a project developing psychological professionals in working with gender identity and variance. Both projects aim to increase knowledge and understanding, developing members capacity to self-care and break down barriers to engagement.

3.4 Acute and Urgent Care

The crisis house delivered in partnership with Future health & Care and Forward-Thinking Birmingham is now open and provides service users in crisis access to up to 7 days of intensive therapeutic support. The crisis house has onsite psychology support working along side future health care support workers with access to a nurse 24 hours a day. BSMHFT service users have access to a dedicated consultant whilst in the crisis house.

Acute and urgent care colleagues had several stalls at the recent recruitment event, PICU, Home treatment, and inpatient wards attracted interest from newly qualified staff to join their respective teams. A total of four appointments were made, one for Home Treatment and three for inpatient services. As all posts offered were to final year students, those appointed will commence in September or December 2022.

All inpatient wards received £100 to provide service users with cakes and decorations to celebrate the recent Queen's Platinum Jubilee.

It was reported that service users and colleagues enjoyed the celebrations and festivities.

4 SUSTAINABILITY

4.1 Funding

As I reported last month, the NHS in Birmingham and Solihull has received additional funding to take account of the higher than usual inflation at the moment. This has enabled all partners across the system to change the previous plan of deficits in this financial year into break even plans. All providers continue to experience significant pressures and we will be closely monitoring these as the year develops.

4.2 West Midlands Mental Health and Learning Disability and Autism Provider Collaborative Development

Since the last Board update in May, the Provider Collaborative CEOs have agreed a set of principles, and the aims and objectives of the Collaborative. Discussions have also been taking place to identify priority areas, as outlined below, for the Collaborative to work on together. The next step is to discuss and agree the function and priorities of the Collaborative with Trusts' Chairs in a workshop in July, and then widely share these with Trusts' Executive Teams to gain wider support and sign off before a formal Memorandum and Understanding is developed:

- *Mental Health and Learning Disability and Autism Population Modelling* Trusts have acknowledged the gap for a focused needs and demand analysis as a priority to help assist in modelling their capacity and reviewing financial baseline in light of post-Covid demand. It is also hoped that the completion of this work will assist further in identifying key programmes of work that can be undertaken at scale to minimise duplication of effort to develop sustainable solution and to enable more effective resource utilisation.
- *Children and Young People Service Pressures* - a better link with the CAMHS Provider Collaborative will be established to understand the gaps and opportunities in pathways/services and what can be addressed at place and ICS level, and what can be achieved across the Collaborative to build sustainable and connected systems.
- *PICU Capacity* - each system is significantly challenged therefore work will commence to ascertain current capacity and future demand to inform future planning and development of options that can be considered across the West Midlands footprint.
- *Addressing Health Inequalities* - commitment to work together to understand current and future challenges and identify best practices to disseminate and identify areas where joint work can be undertaken to address issues and improve experiences of patients.

In order to support the ambition of the Collaborative in establishing a Community of Practice and to enable mutual aid and identify areas where Trusts can collaborate, discussions are underway to establish networks of professions (Nursing, Medical, Finance, Operational and HR/OD). There is support from a significant number of Executive Team members to come together to share challenges and learn from and share their practice.

These forums will be part of the wider governance architecture of the Collaborative with clear focus points to ensure time and effort is put in place to yield clear benefits for each Trusts population.

Workforce

Psychological Therapies Supervisor Capacity Development- NHS England have provided three-year funding of £250k pa to the Collaborative to support innovation in supervision. Psychological Therapies Leads across the Trusts have been working together to agree an approach to scope and map current and future supervision needs in line with the new roles introduced, to develop a sustainable plan that will identify and address gaps in each Trust as well as commit the development of regional hub solutions to minimise shortfall in resources.

Clinical Support Worker (CSW) Roles Development- The Collaborative agreed in 2021/22 to receive c£850k funding from Health Education England (HEE) to support the retention of Clinical Support Workers. HEE have now also confirmed the availability of a second years funding to support regional and local developments. An initial workshop has been scheduled to take place on 29th June with Leads of Allied Health Professionals and Nursing from each Trust to determine an approach for

- developing and delivering a competency framework,
- developing a programme (recruitment, induction, and training) to increase retention and
- establishing the CSW role as the first step on a supported career pathway.

Staff Well Being Hubs- NHSE/I has funded staff mental health (SMH) hubs to provide rapid access to psychological and mental health assessment to staff working in health and social care across each ICS during the Covid-19 pandemic. Trusts have come together to support the update of the offer by establishing an ‘inter-hub referral transfer procedure’ for those staff who cannot access the available support in their own local Hub due to their connection with the hub or clinicians providing it. This procedure has worked very well, and the Leads are working together to further improve the support available for each other by developing a formal protocol.

Development of Regional Approach to Resource Allocation- NHSE/I and Health Education England have recently approached the Collaborative to offer funding for training programmes/resources (band 6 psychological therapies recruit to train, and approved clinician/responsible clinician training) through the Collaborative- The main rationale for this approach is for Trusts to review demand across the West Midlands system to provide support to each other by setting an approach to resource prioritisation, but also enable any shortfall in one provider to be reallocated to another. Initial discussions took place between the CEOs and professional leads who are in support of this in principle with acknowledgement that work would be needed to ensure a transparent and fair approach.

4.3 BSOL Mental Health, Learning Disability and Autism (MHLDA) Service Integrator Update

BSMHFT and partners continue to drive forward plans for the delivery of a BSOL Mental Health Service Integrator due to go live from 1 April 2023. This includes describing what the future working will look like and the governance structures that will be in place to oversee the mobilisation and delivery of the MHSI. Key deliverables to date include:

- Development of a MH SI Programme Plan
- Development and approval of the Heads of Terms Agreement which sets out a common purpose and ways of working between partners
- Drafted Governance arrangements linking into a MH SI Committee
- Establishment of a Communications & Engagement Task Force
- Continued engagement with the Third Sector Forum to develop options for future ways of working.
- Connecting with the Black Country MH Provider Collaborative lead to understand lessons learnt

Work within the Trust is progressing to understand the function/s required and which we will act on behalf of the collaborative to deliver both contracting and commissioning of sub-contracted services and facilitate the delivery of three-year Integrated Delivery Plans.

We have engaged in the development of the drafted Devolved Authority Assurance framework being led by KPMG on behalf of BSOL ICB. An initial draft of this framework has been circulated to partners to assist with preparations for undertaking the full assurance process due for completion in December 2022.

Current priorities include:

- Engagement and shaping of the Devolved Authority Assurance Process
- Development of a MH SI Partnership Agreement
- Development of a MH SI Risk Register which articulates mitigating actions
- Refining the drafted governance arrangements for the MH SI
- Engagement with Corporate Leads on the Trusts readiness to operate with regards to its lead provider responsibilities
- Engagement with staff over the development of the lead provider functions
- Continued engagement with the BSOL system on the connectivity of integrators with place and localities.

4.4 Birmingham and Solihull Integrated Care System (ICS) – Go Live

As Board colleagues are aware our ICS will go live on 1st July 2022 with this being marked with the holding of the first Board meeting.

The structures to support the system and the Board are now in place, including a number of Committees supported by ICB Non Executive

Directors and attended by Board members of system partner organisations. Our NED colleagues, Winston. Anne and Phil and are all attending a committee and I aim to be confirmed as one of the two provider CEOs members of the ICB.

5 QUALITY

Our Quality, Patient Experience and Safety Committee assurance report provides us with the key areas we have focused on in the last month and the work we are progressing in relation to this element of our strategy.

5.1 CQC Focused Inspection

The CQC undertook an unannounced focus inspection during this month on Meadowcroft Ward on the Mary Secole Site.
We completed a number of immediate actions following the inspector and await the final report from CQC colleagues.

5.2 Quality Improvement – Reducing Restrictive Practice (RRP) Collaborative – Celebration Event

Colleagues involved in the RRP Collaborative have enabled a number of improvements to be evidenced through this approach. The aim is to use these results and the celebration event on 1st July 2022 to inspire those not yet involved to do so.

6 NATIONAL ISSUES

The details below are drawn from a variety of sources, information published by NHS England/Improvement, Health Education England, NHS Providers, the NHS Confederation, and the Care Quality Commission (CQC)

6.1 Living with COVID-19

The Government has published a plan for Living with COVID: this is a 60-page document on living with the virus, which includes removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience. The plan sets out how it will continue to protect and support citizens by: enabling society and the economy to open up more quickly than many comparable countries; using vaccines; and supporting the National Health Service (NHS) and social care sector. It sets out how the Government will ensure resilience, maintaining contingency capabilities to deal with a range of possible scenarios.

COVID-19 Response: Living with COVID-19 - GOV.UK (www.gov.uk)

6.2 Health Education England

Next steps for integrating primary care: Fuller stocktake
'Health Education England has been pleased to support and contribute to this review working with NHSEI, ICS CEOs, and Primary Care colleagues. We welcome this essential report on Primary Care 'Next steps for integrating primary care: Fuller stocktake and have been working collaboratively across

the system for some time to ensure we are fully supporting Integrated Care Systems (ICS). We will be incorporating the findings of this report to help us and the wider system with future NHS workforce planning.

We recognise the need for more consistent and comprehensive training supervision and support the development of current and future medical and non-medical staff, including managers and administrative colleagues, it is vital they have adequate space for training, development, and space to consult with their patients. It is encouraging that all 42 ICS CEOs signed the covering letter, and we look forward to working with them to achieve local solutions

HEE reported last year that a record number of people started GP training in 2021/2, with the total intake reaching the landmark figure of 4,000 for the first time this year. There is more to be done and we will continue to work with NHS England, the BMA GPC, the Royal College of General Practitioners, and our other key stakeholder partners to ensure Primary Care has the workforce for now and the future to deliver first class care to patients in our communities.'

The full report can be found:
NHS England » Next steps for integrating primary care: Fuller stocktake report

6.3 The Messenger Review

The Messenger Review is a welcome spotlight on NHS leadership and management; a vital element in delivering quality care. It rightly recognises what leaders and managers across the health service are achieving in often incredibly challenging circumstances. It is the latest in a long line of leadership reviews in the NHS dating back over 40 years to the Griffiths review. The hope is that this review succeeds where its predecessors have had limited traction.

The review addresses many of the asks that our members fed back to the review team, including practical recommendations for more structure and consistency in leadership development; promotion of collaborative behaviours; and a greater commitment, backed by tangible action, to promoting equality, diversity and inclusion in leadership roles.

We particularly welcome plans to better support and incentivise leaders to take on the most challenged leadership roles in the NHS. If this support materialises, it will start to address what our members consistently highlighted to the review team: that too often, chief executives are not given the time, support and incentives they need to succeed in organisations that face the most severe systemic challenges. It is all too easy to remove a chief executive but fail to address the underlying systemic challenges that make some roles extremely difficult. Rather than endlessly removing these chief executives, we need to incentivise, support and reward them to take on roles where their leadership skills can be best used by the health and care system.

The review is the latest in a long line of reports that rightly acknowledges that we have much still to do to create a more diverse leadership in the NHS. However, the litmus test for the government and NHS will be whether we follow this through with tangible actions and changes to ensure this happens.

All too often, staff from ethnic minority backgrounds are still not being provided with the support they need to progress to leadership roles. We need to see a greater commitment to act on improving diversity in senior leadership, including making EDI a core aspect of the inspection regime.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Board Overview: Trust Values

7. QUALITY

7.1. Quality, Patient Experience & Safety Committee Chairs Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE**
Date	29 June 2022
Author	Dr L Cullen, Non-Executive Director, Chair
Executive sponsor	Mrs S Bloomfield – Executive Director of Quality and Safety (Chief Nurse)

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

Executive summary

The Quality Patient Experience & Safety committee met on the 22 June 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board of Directors.

The committee acknowledge the importance of addressing Health Inequalities and accepted the need to develop metrics / embed Health Inequality monitoring as part of the organisation's embedded practice.

The committee received a number of assurance reports in relation to learning from serious incidents, deaths. The committee wished to highlight the interim recommendations in response to the Joint Targeted Area Inspection. The committee noted that the CQC visit is likely to be in April and that further COVID-19 guidance would also be issued in April.

Reason for consideration

To demonstrate the effectiveness of the assurance process for the Trust's Quality and Safety Agenda and to escalate any key issues to the Board.

Strategic objectives

Quality

- Delivering the highest quality services in as safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve

Financial implications

Significant costs associated with delivery of high-quality services and addressing quality related risks.

Strategic Risks

- QSC1- The Trust fails to co-produce with people who uses its services
- QSC2 – The Trust fails to focus on reduction and prevention of patient harm
- QS2 – The Trust fails to be a self-learning organization that embeds patient safety culture
- QS4 – The Trust fails to be a self-learning organisation that embeds quality assurance

- QS5 – The Trust fails to lead and take accountability for the development of system wide approaches to care
- QS6 – The Trust fails to prevent and contain a public health outbreak
- QS7 – The Trust fails to take account of service users' holistic needs

Equality impact

Number of reports received by the committee analyses services along the lines of protected characteristics. The notes of the meeting reflect an increasing understanding of the equality/ inequality of services. One of the items include a discussion on how the committee addresses Health inequality

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Visit feedback

The core committee members visited the Juniper Centre prior to this month's committee meeting and met with teams from across each unit.
The committee agreed this was a positive way to ensure committee oversight of key priorities and pressures and enabled the committee to gain a greater understanding of the current demand on services.

Chair's assurance comments:
We agreed that this was a very useful exercise and that we would aim to hold committee meetings across other sites to enable visits to take place prior to the meeting

1.2 CQC Update

The Committee received an update on the activities related.

The salient points were noted as follows:

- We now have a revised programme of works for the installation of the en-suite door alarm systems in the south PFI based on the delays previously described. These works are now due to be completed by early August. Melissa en-suites are now completed.
- A total of 433 Safety Huddles were completed out of a possible 444 for the period.
- In terms of safer staffing, the Safer Staffing Lead Nurse continues to lead projects to implement agreed initiatives from the Safer Staffing Group. It is anticipated that we will start utilizing the MHOST tool in summer 2022.
- The monthly audits of MDT standards in Acute Care continue to take place and for this submission, we have seen an improvement in eight measures for the reporting period compared to the previous one and one has remained consistent. There is also reasonable compliance with the new measures that were introduced in April.
- The overall numbers of incidents of actual self-harm have reduced for the reporting period. Specifically, there has also been a decrease in the numbers of no anchor point incidents for the period.
- We reported two anchor point incidents for the period, which took place on Melissa and Tazzeta, both using the en-suite doors. Both service users and staff were provided with the necessary support and the incident was subject to a 72-hour review.
- The team continues to work with service areas to prepare for any upcoming inspections and this work includes our monthly CQC Steering Group and the wider roll out of the Peer Review programme.

The committee were appraised of a focused inspection – Meadowcroft June 13th – 14th 2022 and request for assurance regarding our processes and availability of

keys, fobs and alarms on the ward.

The committee were assured that we will not reduce our monitoring until we are confident with the level of compliance evidenced.

Following this visit S Bloomfield confirmed the divisional leadership team will meet weekly for at least the next 4 weeks to discuss audit and compliance information and ensure any issues are being acted upon.

Chair's assurance comments:
Committee was assured that the ongoing work in relation to the section 31 improvement plan remains on track. Committee noted that the recent focused inspection on Meadowcroft was in response to whistle blowing from several staff in the ward. Whilst we very pleased that this action was taken by staff, committee considered the need to consider boosting FTSU presence in areas of concern

1.3 Ockenden Report

The Committee received and noted the final report of the Ockenden review, published on 30th March 2022 which details the findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.

The report highlighted the key areas of concern and an initial benchmark against Trust processes. The committee noted further work will be undertaken through appropriate committee structures to give assurance that risk mitigation is in place

Chair's assurance comments:
We were provided with an excellent summary of the review which although focused on maternity services has many important learning points for all specialties. Committee discussed importance of continuing our work to improve engagement with service users and their family and carers and to strengthen their voice in all our pathways. The report also highlighted the importance of addressing health inequalities - very relevant to our services in mental health

1.4 Learning from Homicides and Suicides incl. NCI Annual Report

The committee received a detailed presentation on the NCISH Annual Report which was published in April 2022 which presents data from deaths occurring between 2009 and 2019 and provide an update on how we are progressing with the 10 Ways to Improve Safety.

The committee noted this year's report, though data is presented from deaths occurring between 2009 and 2019, most of the themed findings relate to groups that are likely to have been particularly vulnerable during the COVID-19 pandemic: patients with economic difficulties, those who have been victims of domestic violence, and those with comorbid physical illness.

The key messages and recommendations, surrounded:
- Clinical Risk
- Acute Care Services
- Economic Adversity
- Physical Illness
- Domestic Violence
- Suicide Prevention during COVID 19

The committee noted our Trust position against the NCI Safer Services Toolkit and our current nationally benchmarked position for suicide levels

Chair's assurance comments:

Committee noted the report .key messages continue to highlight the importance of clinical risk management within acute care inpatient and community services especially at points of transition. We understand that the clinical risk management training programme is being updated as this was impacted by the pandemic

We heard about a strong focus on alcohol as a risk factor and the ongoing working together with partners across the BSOL system. Greatest risk is in men with high rates of social adversity, isolation and unemployment and homelessness is also a key risk factor significantly linked to population public health concerns

1.5 Serious Incidents and Learning

The Committee received the Serious Incidents and Learning report and noted the salient points:

- 16 serious incidents have been reported to Commissioners during April 2022, which is a large increase above the median of 7, although this is primarily due to the number of infection outbreak/ward closures that were reported during the month.
- Serious Incident Framework these incidents will be investigated using these principles until we are instructed to transition to the Patient Safety Incident Response Framework (PSIRF) which is likely to be during Summer 2022 when work has been completed with the early adopters.
- 3 of these incidents related to the death of our service users in the community and 1 inpatient death. There were 8 infection outbreak/ward closure cases, 2 serious self-harm incidents and 2 cases related to the death of a service user's baby which highlighted safeguarding issues.
- The themes arising from Serious Incidents include record keeping, working in a trauma informed way and interfaces with internally and externally.
- There are currently 33 incidents in the review process, excluding infection control reviews. As the 60-day review deadline has been removed nationally due to COVID there are no breaches to report. The average time for completion of a review is currently 80 days which is due to a number of cases having been overdue as a result of delayed meetings with relevant staff or awaiting additional information from other agencies.

Chair's assurance comments:

Committee noted that recent increase in serious incidents is mainly caused by infection outbreaks and ward closures
We noted that over next year or so we will be moving from our existing serious incident framework to the new patient safety framework which will have a significant focus on embedding learning from incidents and will require considerable resource and change in approach and we were informed that these changes will be audited carefully through the changeover period

1.6 Learning from Deaths Report

The committee received the quarterly report for Learning from Deaths noting this provides evidence that our Learning from Deaths is firmly embedded as a priority across BSMHFT, ensuring full adherence to the National Quality Board Learning from Deaths Framework.

The committee noted this provides anonymised details of incidents that have been reviewed through this process, along with a summary of thematic learning identified during investigation into these cases, including our initial work exploring health inequalities, which is a central part of our strategic aims within the LfD group.

Within the last quarter, 14 cases have been reviewed; of these, 3 were serious incident reviews (SI reviews) and 11 were mortality case note reviews (MCNRs). None were considered to have involved an avoidable cause of death.

The committee were assured that quality governance systems are in place to ensure continuous monitoring and learning from deaths in accordance with BSMHFT policy.

Chair's assurance comments:
Committee was assured that we are following the Learning form Deaths framework and that we have systems in place in the trust to monitor and learn. Themes included COVID limiting face to face contact with patients and physical ill health prevention and monitoring in the community
Work is taking place to include health inequalities in the future analysis and benchmarking of data

1.7 Monthly Quality Report

The committee received the detailed report highlighting the following:

- During April there was a total number of 2026 incidents reported
- Daily staffing huddles are taking place to support teams in recognising and mitigating risks locally.
- 17% of our incidents reported during April resulted in a level of harm to patients. We remain below the national average for incidents resulting in harm to patients (39%) in accordance with the National Reporting and Learning System benchmark reporting and we also measure favorably in this area in the CQC Insight report.
- During April, 16 serious incidents were reported of which 13 occurred during the month, which is a significant rise, this is primarily due to the number of infection outbreaks that have occurred.
- In the 12 months preceding April 2022 17 confirmed through the inquest process.
- There were 2 suspected community suicides reported during April. There are 9 inquests scheduled to take place for those incidents reported as a suspected suicide, it should be noted that not all suspected suicides translate to confirmed suicides.
- During the month of April there was 1 suspected inpatient suicide
- There has been a reduction in the number of incidents reported during the month. 41 were reported incidents of prone restraint for the month of April, with acute care services reporting a decrease from 41 to 25. Of these 41 incidents, the majority last less than 5 minutes and 1 incident lasting 30 minutes.

- During the month of April 39 assaults were reported. Acute care has seen a reduction in recorded patient on patient assault. The majority of incidents reported across the Trust resulted in no harm.
- During April we have had 49 ligature incidents reported without an anchor point and 4 incidents with an anchor point
- Sadly, one service user has died, through an incident where it is suspected that she has used a towel to harm herself without an anchor point.

Chair's assurance comments:
Committee noted monthly quality report. Discussion took place about the quality priorities for the forthcoming year. Key areas included a focus on segregation and seclusion practice and use of QI processes. We also considered the importance of looking at more creative ways of capturing compliments and complaints

1.8 Health, Safety and Security Quarterly Report

The committee noted the Health, Safety and Security Quarterly Report and noted the salient points:

- The installation programme for the door monitoring alarm system is ongoing and all en-suites are now in place in Acute Wards in the North of the Trust. Bedroom door alarm systems have also been installed on George Ward and Larimar and enabling works have commenced on MSH, Ward 2.
- We have received the HSE's report following the reopening of the case into the death of our colleague at Reaside. We have completed the actions stated in the report however we are in dialogue with the HSE regarding one aspect of the content of the report as we do not agree with the finding. We have also had support from the CQC on our position and have now submitted a formal response back to the HSE on this.
- UV light machines have now been delivered to several sites across the Trust to support with improving air quality to prevent the spread of COVID19.
- The new vulnerability template for COVID19 has been agreed and the Staff Portal configured to record the completion of these. The form has now been launched for staff completion and recording on the system.
- There were 3 fire safety incidents of note – two involving service users setting fire to their mattresses resulting in significant smoke damage to their bedrooms. These incidents have been investigated with recommendations made.
- The new security concierge service has now been agreed and will be implemented in the near future albeit there is still some finance to agree.
- There has been positive use of the Management of Unacceptable Behaviour Policy, with twenty warnings being issued to service users and only two of these instances requiring further escalation.

Chair's assurance comments:
Committee noted the report and the key points as highlighted above. We were pleased to hear of the impact of the use of the management of acceptable behavior policy and that in majority of cases this had a positive impact and that in 2 the cases where escalation was required this resulted in a response form police and prosecution

1.9 Quality Account

Quality Account report provides an update about the quality of services offered by the Trust.

The report is required to be published annually and uploaded to the Trust website by 30 June.

The committee approved the Quality Account.

Chair's assurance comments:
Committee approved the quality account and thanked the authors for a very comprehensive and informative document

1.10 Integrated Performance Report

The committee received the Integrated Performance Report and noted the new sets of metrics are being finalised for all domains following approval of the Trust Strategy.
The key issues for consideration by the Committees on which they need to provide assurance to the Board are as follows:

- FPP – Out of area bed use, IAPT, CPA 12-month reviews, CPA 7-day follow up, new referrals not seen, financial position and CIP
- People – Vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness. Also, the divergence in performance between different teams
- QPES – Lligature incidents

Chair's assurance comments:
Throughout committee and as highlighted in the IPR report the impact of staffing levels across services remains a key risk

1.11 IPC Update

The committee was appraised of the Infection Prevention and Control update and noted the salient point as follows:

- Following repeated outbreaks on Mary Seacole Ward 1 and Cedar Ward, a supportive visit was undertaken from NHSE/I IPC colleagues
- Several recommendations have been made to improve and strengthen IPC standards and governance processes in relation to Covid outbreak areas
- National guidance continues to be updated and the Trust are aligning this to ensure appropriate guidance remains in place and outdated guidance is stepped down
- A comprehensive review of IPC standards and processes is underway and will continue to work towards making the recommended improvements
- Continued engagement and further visits with NHSE/I to be facilitated
- Letters received from NHSE/I and response letter are attached to this report for information

Chair's assurance comments:

Committee was partially assured and understand that a comprehensive review of IPC standards and processes are underway. Clear communication is currently planned to update all staff as to the recent changes in COVID guidance

1.12 Hot Topics

Throughout committee and as highlighted in the IPR report the impact of staffing levels across services remains a pressing issue

1.13 Annual report

The committee received the annual report for the committee.
The committee approved the annual report for submission to the Trust Board.

Chair's assurance comments:
'The Committee would like to assure the Board of Directors that the Committee has fulfilled its Terms of Reference during 2021/22. Throughout the year the Committee has monitored the impact of the pandemic on quality and gained assurance on how quality matters are considered and addressed. It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.'

LINDA CULLEN
NON-EXECUTIVE DIRECTOR

7.2. QPES Annual Report to the Board of Directors

Birmingham and Solihull Mental Health NHS Foundation Trust

ANNUAL REPORT QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE

APRIL 2021 – MARCH 2022

1. PERIOD COVERED BY THIS REPORT

This report covers the work of the Quality, Patient Experience & Safety (QPES) Committee for the financial year 1st April 2021 to 31st March 2022.

2. INTRODUCTION

The Quality, Patient Experience and Safety Committee has been formally established by the Board of Directors as one of its sub-committees. It is authorised to investigate and seek assurance on the effectiveness of the Trust's quality systems and processes and the quality of the services provided. This includes seeking assurance on the management of quality related risks at operational and strategic level. The Committee will monitor and report to the Board of Directors on the effectiveness of these systems and processes. With its key objectives being to seek assurance that:

- systems and processes are effective
- the quality of services provided is good and continuously improving
- the experience of people using Trust services is good and continuously improving.

3. PURPOSE

The Committee carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose and will:

- Be responsible for assuring on behalf of the Board that the Clinical Services and Quality streams of the Trust's Strategy (2020) are being delivered:

- To monitor and receive assurance on the delivery of the Quality Strategy for the Trust.

- Lead on monitoring of controls and assurances related to the 'Clinical Services' and 'Quality' sections of the Board Assurance Framework.

- Ensure and assure on behalf of the Board all matters relating to the administration within the Trust of statutory requirements relating to mental health legislation. These include the Mental Health Act (1983 and 2007 amended) and the Mental Capacity Act (2005).

- Receive assurance reports from the Reach Out Commissioning Sub-Committee. The Committee will ensure and assure on behalf of the Board the quality and safety aspects of the Adult Secure Care and Learning Disability & Autism Secure Care Provider Collaborative.

This report covers the work the Committee has undertaken at the meetings held during 2021/22. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

Secretariat support is provided by the Corporate Governance Team in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

4. ASSURANCE

The Committee receives assurance from the executive director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed. Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the organisation; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services; and talking to staff.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Quality, Patient Experience and Safety Committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the Committee or to commission further information where there was a lack of assurance (actual or perceived). These are:

The Committee reviews the BAF on a quarterly basis prior to it being presented to the Board of Directors.

REF	STRATEGIC RISKS	RISK APPETITE
QSC1	The Trust fails to co-produce with all people who use its services including their families	Open: We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.
QSC2	The Trust fails to focus on the reduction and prevention of patient harm	
QS3	The Trust fails to be a self-learning organisation that embeds patient safety culture	
QS4	The Trust fails to be a self-learning organisation that embeds quality assurance	
QS5	The Trust fails to lead and take accountability for the development of system-wide approaches to care, and to exploit its status and position to advocate for mental	
QS6	The Trust fails to prevent and contain a major public health outbreak	
QS7	The Trust fails to respond to service users' holistic needs	

5. TERMS OF REFERENCE FOR THE QUALITY COMMITTEE

In September 2021, the Terms of Reference for the Committee were approved by the members and approved by the Board of Directors in November 2021.

6. MEETINGS OF THE COMMITTEE

In 2021/22 the Committee met formally on 12 occasions. It should be noted that the committee continued to meet throughout the Coronavirus pandemic to discuss key quality issues. In 2021/22 all committee meetings were held virtually in order to comply with Government directions, which were included in the UK Coronavirus Act 2020. The dates on which the Committee has met during the year are as follows:

- 21st April 2021
- 19th May 2021
- 23rd June 2021
- 21 July 2021
- 24th August 2021
- 22 September 2021
- 20 October 2021
- 17 November 2021
- 22 December 2022
- 19 January 2022
- 23 February 2022
- 23 March 2022

The draft agenda for each meeting is presented to the Chair of the Committee, the Executive Director of Quality & Safety (Chief Nurse) by the Committee Secretariat.

In line with its Terms of Reference, paperwork for this meeting is circulated to members five calendar days prior to the meeting taking place. All actions pertaining to the meetings of the Committee are tracked on a cumulative action log and presented to each meeting by the Committee Secretariat for assurance with progress made.

7. MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the QPES Committee is made up of three non-executive directors; the Executive Director of Safety & Quality (Chief Nurse), the Medical Director and the Executive Director of Operations. The Committee is chaired by a non-executive director (NED), Dr Linda Cullen, (from April – July 2021 W. Saleem), Winston Weir and Phil Gayle are the other regular NED member of this Committee. Should the NED chair be unable to chair the meeting this role will fall to the Vice Chair of the Committee.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On this occasion, they are attendees and do not count towards to membership of the meetings as outlined in the Terms of Reference.

The table below shows attendance for substantive members of the committee for the meetings that took place during 2021/22.

Attendance at Quality Committee meetings by substantive members

Key:
✓ shows attendance
A Apologies received

NAME	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
L. Cullen	√	√	√	√	√	√	√	A	√	√	√	A
W. Saleem	√	√	√	√								
J. Warmington	√	√										
W. Weir						√	A	A	√	√	√	√
P. Gayle					A	√	√	√	A	A	A	√
S. Bloomfield	√	√	√	√	√	A	√	√	√	√	A	√
H. Grant	√	A	√	√	√	A	√	√	√	√	A	√
V. Devlin	√	√	√	√	A	√	√	√	√	√	√	√

Attendance at Quality Committee meetings by formal attendees

NAME	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
D. Oum	A	√	√	√	√		A	A	√	√	√	√
R. Fallon-Williams	√	√	√	√	√	√	√	√	√	√	√	√
G. Hunjan		√										
J. Kaur												√
C. Bell												√
R. Grant						√	√	√	√	√	√	√
D. Clift	√	√	√	√	√							
N. Rowe		√				√					√	
J. Clark				√			√				√	
K. Allen						√					√	
C. Wilson											√	
N. James							√				√	
N. Willetts		√				√					√	
F. Leitao							√					
J. Kenny-Herbert							√					
D. Tomlinson				√								
J. Romano				√								
S. Munbodh			√									
C. Evans			√									
P. Nyarumbu		√										

8. REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Committee makes an assurance and escalation report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the dates that the assurance and escalation reports were presented by the Chair of the Quality Committee to the Board of Directors meetings.

Date of meeting	Assurance and escalation report to Board by Chair
21st April 2021	28th April 2021
19th May 2021	26th May 2021
23rd June 2021	30th June 2021
21st July 2021	28th July 2021
24th August 2021	31st August 2021
22nd September 2021	29th September 2021
20th October 2021	27th October 2021
17th November 2021	24th November 2021
15th December 2021	No Board Meeting
19th January 2022	26th January 2022
16th February 2022	23rd February 2022
23rd March 2022	30th March 2022

9. THE WORK OF THE COMMITTEE DURING 2021/22

During 2021/22 the Chair of the QPES Committee confirmed that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all of these areas of work can be found in the minutes and papers of the Committee.

A high-level presentation of areas of work on which the Committee has received assurance and during 2021/22 are as follows:

Reports on:

- Monthly Quality Indicator Report
- Board Assurance Framework
- Corporate Risk Register Review
- Care Quality Commission Improvement Plan Progress
- Care Quality Commission Preparations for Well Led Inspection
- Joint Targeted Area (Safeguarding Children) Inspection
- Responding to COVID-19 – Outbreak Report & COVID-19 Isolation Guidance & System Surge Risk Log, Quality Monitoring Suring Surge and NHSE/I External Assurance Infection, Prevention & Control Team
- Safer Staffing
- Serious Incidents
- Trust Policy Update
- Board Patient Story Checklist

- Recovery for All Strategy Celebration
- Complaints: Current Review Quarter 3 Data 2021/2022
- Physical Health Committee Update
- Health Inequalities
- Health, Safety & Fire Quarterly Report
- Use of Force Act
- Learning from Deaths Report
- Integrated Quality Report including Quality and Patient Experience metrics
- Bed Capacity Planning
- REACH-Out Readiness to Proceed Assessment
- Medium and Low Secure Facilities (Reaside) Strategic Outline Case
- Reach-Out Governance
- A Safety Review of Acute Inpatient Wards
- Quality Improvement Update
- Regulation 28 Prevention of Future Deaths Response
- Ligature Review Update
- Quality Account
- Safeguarding Six Monthly Report
- Clinical Services Strategy
- Clinical Audit Plan
- People, Participation Experience and Recovery (PEAR)

10. CONCLUSION

The Chair of the Quality, Patient Experience and Safety Committee would like to assure the Board of Directors that the Committee has fulfilled its Terms of Reference during 2021/22. Throughout the year the Committee has monitored the impact of the pandemic on quality and gained assurance on how quality matters are considered and addressed. It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

DR LINDA CULLEN
Non-Executive Director and Chair of the Quality, Patient Experience and Safety Committee
June 2022

7.3. Quality Account

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7.3**
Meeting	**QUALITY ACCOUNT**
Date	29 June 2022
Author	Gill Mordain, - Associate Director of Governance
Executive sponsor	Sarah Bloomfield, Executive Director of Quality and Safety

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

Executive summary & Recommendations:

This Quality Account report provides an update about the quality of services offered by the Trust.

The report is required to be published annually and uploaded to the Trust website by 30 June.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided. The report outlines progress against priorities identified during 2021/22 and sets out agreed priorities for 2022/23.

The Committee is asked to approve the report for publication

Reason for consideration:

Statutory requirement for all NHS Providers.

Previous consideration of report by:

Clinical Governance Committee, Quality, Patient Experience and Safety Sub-Committee, stakeholder governance structures.

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

QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve

Financial Implications *(detail any financial implications)*

Not applicable for this report

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

Not applicable for this report
Equality impact assessments:
The Quality Account has been developed to enhance service delivery and equality of access and provision for all service users.
Engagement *(detail any engagement with staff/service users)*
Engagement has taken place with staff/service users and external partners.

Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY ACCOUNT REPORT

2021/2022 DRAFT

Contents

Quality Report

Part One

Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2021/22.

I want to begin by stating how immensely proud I am of all my colleagues who have continued to demonstrate their extraordinary resilience, compassion and flexibility to providing high quality care throughout such a hugely challenging time in their work and home lives. A time when we are deeply saddened to have lost patients/ service users, colleagues, loved ones and friends.

This Quality Account recognises the incredible work that has been delivered as well as setting out our commitment to continually improving the safety and quality of our services for our patients/ service users, their carers, their families and our community.

The impact of the pandemic has exposed the fragility of our society and we all know that this has had an uneven impact upon our own local communities and staff. Looking ahead it raises the question of how we ensure that a new geography of disadvantage does not emerge in the areas and communities served by our Trust as services are restored to pre pandemic levels and we respond appropriately to the challenges posed by different facets of vulnerability and inequality.

However, despite the challenges over the last year we have continued to drive change to address our unwavering priority to improve the mental health wellbeing for our populations and our colleagues. We are leading the way and encouraging collaborative working across systems building stronger alignment to improve care pathways and enhance socio economic strategies across Birmingham and Solihull to address the wider determinants of ill health. In doing this we are taking every opportunity to engage with our communities, to listen to them and work with them in more meaningful and different ways.

Through our reconfiguration and transformation programme we are taking the opportunity to secure much needed investment in our buildings and equipment, ensuring safer and more therapeutic environments for those that use our services. We have agreed a plan that will reshape our environments over the next year. This is inclusive of taking full advantage of the opportunities that technology offers us and to learn the lessons from the pandemic to design facilities which can be used flexibly.

We continue to drive continuous improvement. Our quality improvement framework outlines our commitment to learning, including from families and from the best nationally and globally, to continually improve patients/ service users'

outcomes. Despite the challenges we have faced we have seen progress to support our quality aims of:

· Improving patient safety by reducing harm

· Focussing on a positive patient experience

· Focusing on a positive patient culture

· Focussing on Quality Assurance

· Using our time more effectively.

Part of our Quality Improvement Programme involved a Reducing Restrictive Practices QI collaborative. This multi-disciplinary approach targeted inpatient services across our Trust and was supported by experts by experience. We have shown clear results in reducing rates of prone restraint (and restraint in general) and there has been a reduction in bedroom seclusion.

We have also seen reductions in other measures such as the use of rapid tranquilisation, where medication is used to reduce violent behaviour. However, we have not seen a significant reduction in the number of assaults reported and this continues to form one of our quality priorities into 2022-23.

Sadly, during the year 17 of our community service users died by suicide. This was tragic for the patients, their families and carers, our staff and fellow service users on the wards. I would like to take this opportunity to extend our sincere condolences to all who were affected by these most serious of incidents. Later in this report I speak about the learning that has arisen from these sad deaths and our ongoing commitment to preventing suicides in the communities that we serve, and in our inpatient wards.

We are continuing to drive improvements across all services and taking every opportunity available to embed a culture where we learn lessons from our practices and behaviours. Collectively working with all partners that use and work in our services we are identifying opportunities where we can improve our systems and processes. We are already seeing results with improved care. e.g., Throughout 2021-2022, we have seen the harm rate of patient safety incidents reported remaining low with the % of incidents resulting in harm remaining below the mean value and compared to other benchmarked mental health trusts.

Our aim is to embed a learning lessons approach as we introduce the new Patient Safety Incident Response Framework.

As I close this introduction, I reiterate my thanks and that of my fellow Board members, to our compassionate and committed staff, our service users, families

and carers, our stakeholders, our partners in the Integrated Care System and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2022/23.

I declare that to the best of my knowledge the information in this document is accurate.

Background

Once a year, every NHS Trust is required to produce a Quality Account Report. This report includes information about the services the Trust delivers, how well we deliver them and our plans for the following year.

Our aim in this Quality Account Report is to make sure that everyone who wants to know about what we do can access that information. All Quality Account Reports are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

What is NHS Choices?
NHS Choices is the UK's biggest health website. It provides information about symptoms conditions, medicines and treatment, NHS services and advice about how to live as well as possible at www.nhs.uk

What the Quality Report includes

- What we plan to do next year (2022/23), what our priorities are, and how we intend to address them.
- How we performed last year (2021/22), including where our services improved.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS trusts
- Stakeholder and external assurance statements.

Purpose and activities of our Trust

We provide comprehensive mental healthcare services for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond. We operate out of more than 40 sites and serve a culturally diverse population of 1.3 million spread out over 172 square miles. We have a dedicated workforce of around 4,000 staff and a range of local and regional partnerships, making us one of the most complex and specialist mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings, and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people form the most affected areas.

One vision

We have a vision to continually **improve mental health wellbeing** which is underpinned by three core values.

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

Compassionate	**Inclusive**	**Committed**
• Supporting recovery for all and maintaining hope for the future. • Being kind to ourselves and others. • Showing empathy for others and appreciating vulnerability in each of us	• Treating people fairly, with dignity and respect • Challenging all forms of discrimination • Valuing all voices so we all feel we belong	• Striving to deliver the best work and keeping service users at the heart. • Taking responsibility for our work and doing what we say we will. • Courage to question to help learn, improve and grow together

We continue to hold an ambition around the quality of care that we provide that we have developed in partnership with our experts by experience and our colleagues.

Our ambition
Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve.
Our aims • A focus on a positive service user experience • A focus on preventing harm • A focus on a positive safety culture • A focus on quality assurance • A focus on using our time more effectively

Part two: Priorities for Improvement and Statements of Assurance from the Board

- This section contains: Our priorities for improvement as agreed by the Board of Directors for 2022/23

- Progress made since publication of our 2020/21 quality report including performance against each of the 2021/22 quality priorities
- The monitoring, reporting and measurement approach to progressing achievement of our priorities
- A series of statements of assurance from the Board of Directors including:
- Participation in National and Local Clinical Audit Programmes
- Research
- Commissioning for Quality and Innovation 2022/22
- Registration with the Care Quality Commission
- Improving Data Quality
- Learning from Deaths
- Reporting against Core Indicators

2.1 Priorities for improvement during 2021/22

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to continuous quality improvement. This section of the report describes areas for improvement in the quality of our health service provision during 2022/23. In creating our quality priorities and goals, we have considered the aspirations in the NHS Long Term Plan; NHS England's Five Year Forward View for Mental Health and NHS Improvement Planning Guidance. We have also engaged with our workforce and our service users and Experts by Experience to ensure that these goals will support the delivery of our Quality Strategic Priority which reflects the local needs of our service users and staff as well as national needs.

Our overall priorities remain the same for 2022-23 in reflection of our multi-year journey to embed positive practice across these themes. The specific actions that support each of these have changed since last year, with some actions dropping to business as usual approaches where we have demonstrated success and others have remained with some slight adjustment to reflect the progressive journey we are taking.

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

What this means: We will reduce unwarranted variations and reduce harm across our services. We want to reduce the level of harm and suicide rate amongst our most vulnerable patients ensuring appropriate and consistent application of the Mental Health Act, good access to crisis care and effective community care pathways. We want to understand health inequalities or aspects of discrimination in our current delivery of mental health care so that we can improve and meet the needs of all of our service users.

During 2022/23 we will:

Preventing Harm	
Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards	Measure of success:- Reduced level of ligature incidents utlising an anchor point which result in moderate, severe or catastrophic harm to patients
To improve the physical health monitoring of patients in our care	Measures of Success:- To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission

Priority for Improvement 2: A Focus on a Positive Patient Experience

What this means: This aspect of our priorities puts a clear focus on delivering a high quality experience for service users, families and carers and largely focusses on ensuring that they have a powerful and equal voice in their own care, as well as helping to shape and influence future developments at the Trust to improve the patient experience. We have engaged groups of patients to help us to understand what they would like to see as priorities.

During 2022/23 we will:

Improving Patient Experience	
Improve the involvement of service users in MDT meetings and ensure that all service users have a copy of their care plan	Measures of success:- % of service users in receipt of their care plan

	Qualitative measure to be established through EBE group and reporting commenced
Improve the involvement of carers in service user care and recovery	Measures of success:- % of carer details on RIO
Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table	Measures of success: Number of patient safety partner roles established Feedback from patient safety partners on their experience

Priority for Improvement 3: A Focus on a Positive Patient Safety Culture

The link between workforce capacity, capability and safety has many factors, but workforce challenges clearly create pressures on the system. We must also recognise the importance of staff wellbeing to ensure a safe environment. This is becoming more and more important as we experience a significant increase in mental illness across our society which puts pressure on the services we provide. Many of our staff operate in a high risk environment and in the course of day-to-day work they could face traumatic or potentially traumatic situations. We want all of us to work in a way that keeps everyone safe. For this to happen we need to ensure that we treat each other equitably, well and have good working conditions.

During 2022/23 we will:

A Positive Patient Safety Culture	
Roll out Learning from Excellence across the Organisation to ensure systematic recognition of learning from excellent practice	Measures of Success:- Routine reporting of LFE submissions made in recognition of excellent practice

Strengthen the approach to confidence in incident reporting and learning from incidents resulting in an improved safety culture	Measures of Success:- Embed a standard approach to sharing lessons learned from incidents

Priority for Improvement 4: A Focus on Quality Assurance

What this means: Quality Assurance is a process to help us continually check that we are meeting the standards of quality of care that we owe to our service users, families, carers and staff. Our regulators such as the Care Quality Commission also hold us to account for delivering these standards. The process also offers us the basis for assessing whether or not we are continually improving care and can help us identify areas where we need to celebrate great practice as well as focussing on areas that need improving.

We aim to develop a quality assurance framework to underpin and assure us of the quality of our services and care on a continual basis.
We will do this with staff, service users, families and carers. This will help us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

During 2022/23 we will:

Improving Quality Assurance	
Roll out an internal quality assurance peer review scheme across the Trust involving staff and experts by experience	Measures of success:- Number of peer review visits completed

Priority for Improvement 5: A Focus on Using our Time More Effectively

What this means: We want to transform care using technology and quality improvement approaches to manage resources well without impacting on the quality of care we deliver. This includes improvements in patient flow and increasing clinical time to care.

By 2025:

We will have significantly reduced the amount of unwarranted variation, allowing us to focus on ensuring the right care and support is delivered for everyone at a consistently high standard. Unwarranted variation can be a sign of waste, missed opportunity and poor quality and can adversely affect outcomes, experience and resources.

During 2022/23 we will:

Using our Time More Effectively	
Implement a Community Care Planning Tool incorporating an outcome measure within our Community Services as an approach to improve the therapeutic effectiveness of service user interactions with our clinicians	Measures of success:- Determine the approach to needs assessment and care planning using a Patient Rated Outcome Measure.

2.1.2 Monitoring, Measuring and Reporting Progress on the Priorities

Monitoring measuring and reporting progress on the above priorities will take place through a quarterly report to the Quality Patient Experience and Safety Committee at Birmingham and Solihull Mental Health NHS Foundation Trust.

2.1.3 Progress Made since Publication of the 2020/21 Quality Report

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

Our measures of success relating to this priority were defined as:-

- Reduction in incidents of prone restraint
- Reduction in incidents of bedroom seclusion
- Reduction in incidents of assault on our inpatient wards
- Reduced level of ligature incidents utlising an anchor point which result in moderate, severe or catastrophic harm to patients
- Reduced level of harm attributable to patients and staff through incidents
- Ensure relevant blood tests and ECGs are performed prior to initiation of antipsychotic medication in all inpatient settings (to increase this by 100% over a three-year period)
- Ensure relevant blood tests and ECGS are performed for outpatients prior to the initiation of antipsychotic medication and annually thereafter for outpatients prescribed clozapine or depot antipsychotic medication (including Home Treatment Teams), increasing to 100% service users being offered this by the end of three years
- To ensure all episodes of Rapid Tranquilisation (RT) have appropriate physical health recording (as set out in the RT policy) by the end of the first year
- To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission by the end of the first year
- To increase the completion of the alcohol screening tool in our Home Treatment Teams with evidence of appropriate intervention against the March 2021 baseline level

Reducing Restrictive Practices

Part of our Quality Improvement Programme was the inclusion of a Reducing Restrictive Practices QI collaborative. This involved a multi-disciplinary approach to focused quality improvement activity in targeted inpatient services across Birmingham and Solihull Mental Health Foundation Trust including support from experts by experience. The collaborative has met regularly throughout 2021-22 to develop and implement a number of improvement cycles. The activity of the collaborative has shown clear results in reducing rates of prone restraint (and restraint in general) and considering normal variation there has been a reduction in bedroom seclusion also.

Figure 1 - rate of restraint (all types) per 1000 bed days

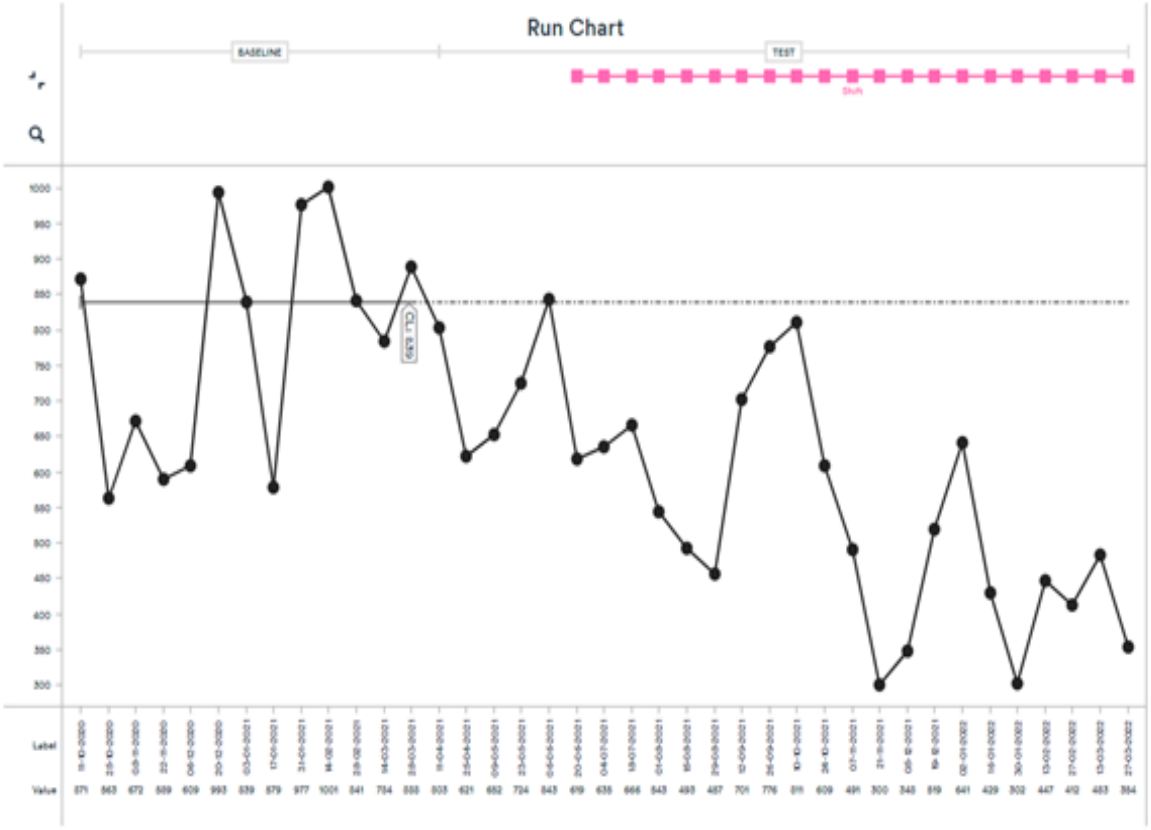


Figure 2 - rate of prone restraint per 1000 bed days

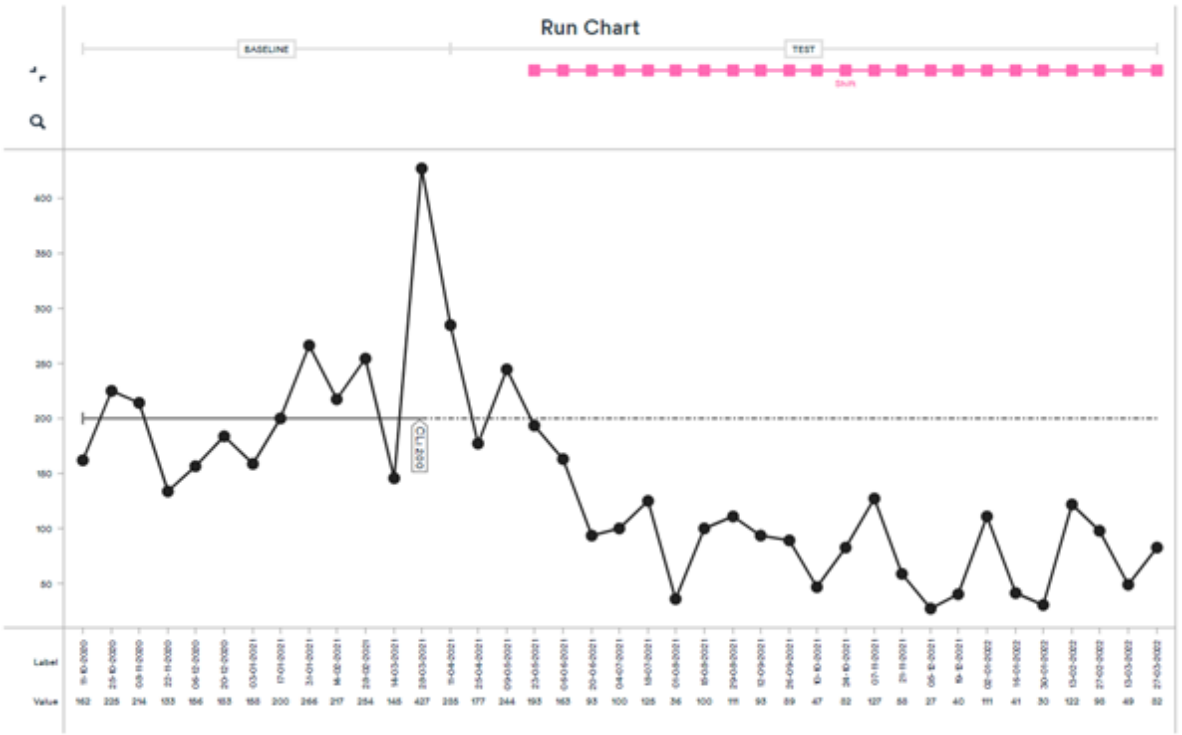
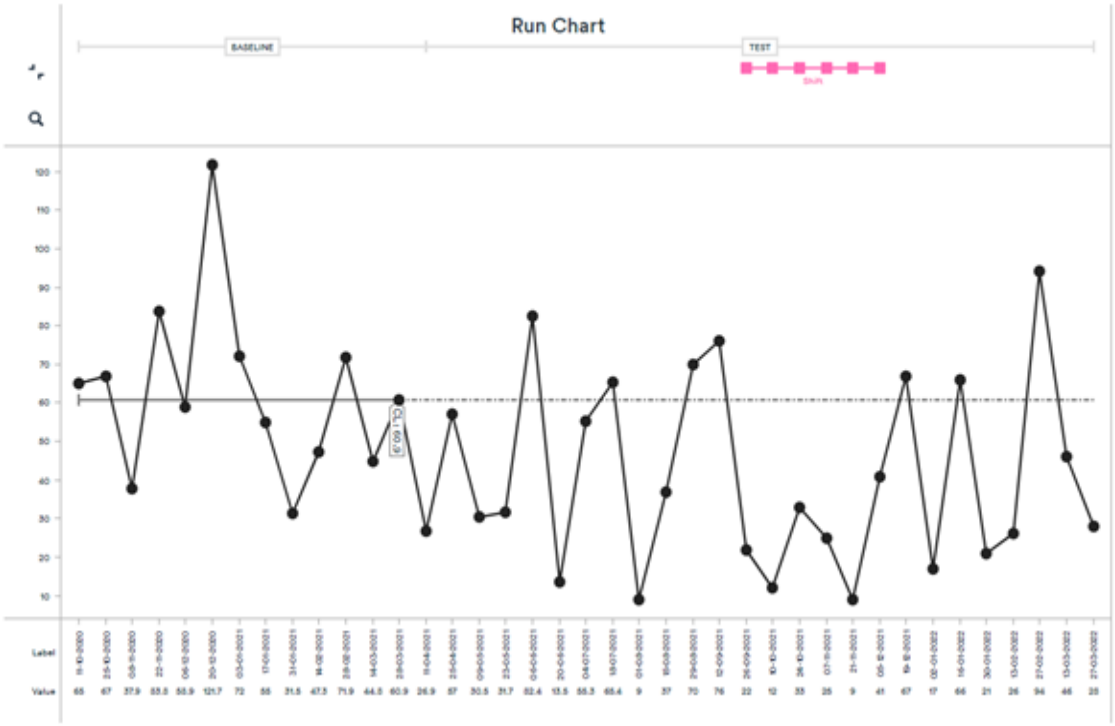
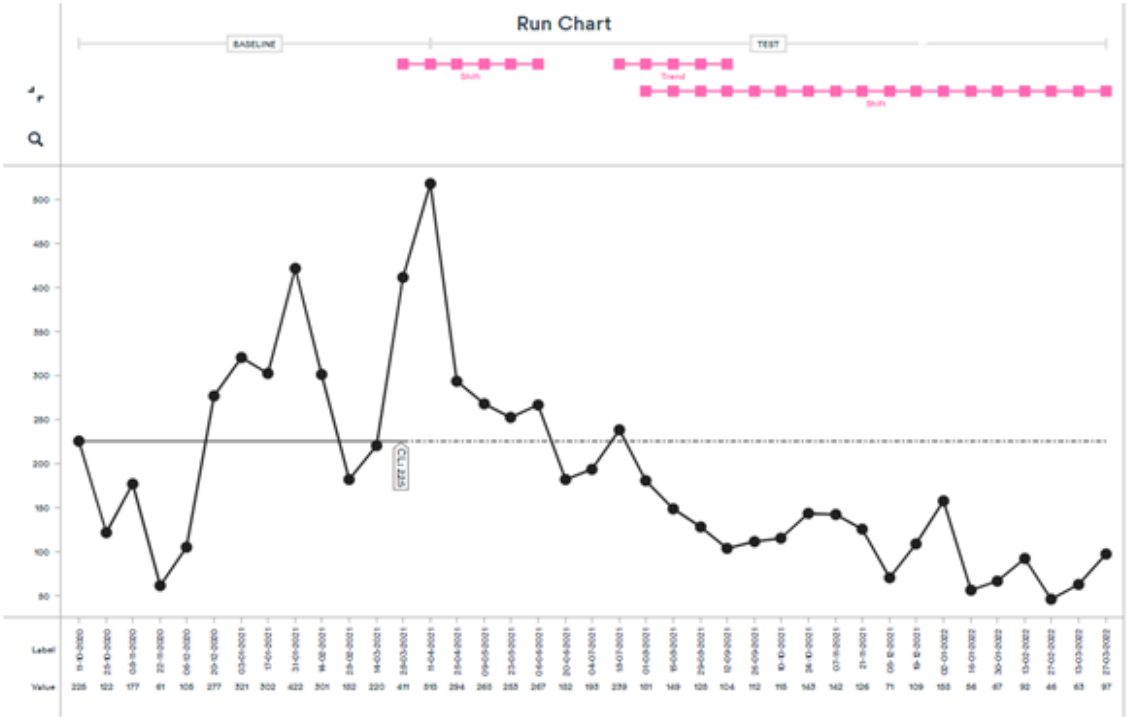


Figure 3 - rate of bedroom seclusion per 1000 bed days



During the work of the collaborative we have also seen reductions in other measures such as the use of rapid tranquilisation, where medication is used to reduce violent behaviour.

Figure 4 - rate of rapid tranquilisation per 1000 bed days



The collaborative continues its work to ensure that the gains delivered so far in reducing restraint, seclusion and rapid tranquilisation continue to offer benefits to patient care and experience.

During the year 2021-22 we have not seen a significant reduction in the number of assaults reported and this continues to form one of our quality priorities into 2022-23.

Reducing Harm from Anchor Point Ligatures

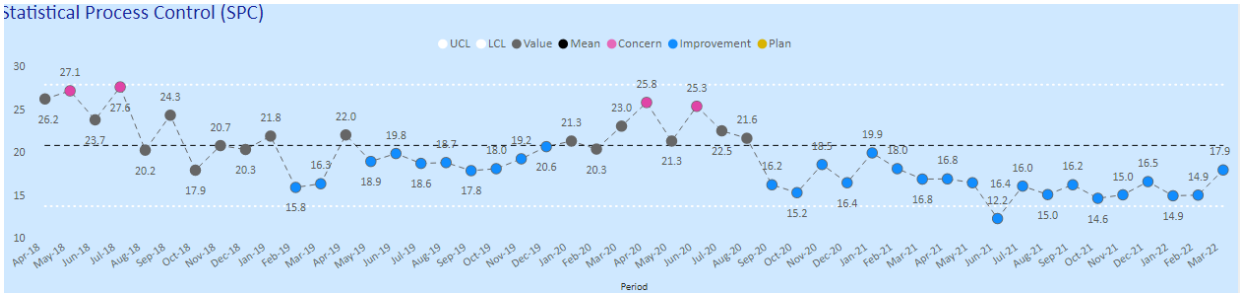
We have focused on a range of activity to reduce the frequency and impact of anchor point ligatures within our inpatient services. Activity has included the strengthening of risk assessment and care planning processes and regular monitoring of this to not only ensure that this is taking place but that service users are engaged with this and understand their care plan.

Alongside these relational measures we have also embarked on a multi-year capital investment programme to improve the safety of our clinical environments. This has included the fitting of en-suite door alarms and anti-barricade systems to reduce the risk of utilising doors as anchor points and increase the response time to emergency situations. The works completed in 2021-22 form part of a 3-5 year programme of works designed to improve the environmental safety of our inpatient settings. This means that this will continue to be a quality priority for us into 2022-23.

Reducing Harm

We have seen the harm rate of patient safety incidents reported remain low throughout 2021-22 with the % of incidents resulting in harm remaining below the mean value and compared to other benchmarked mental health trusts.

Figure 5 - % of incidents resulting in harm to patients



Monitoring of Physical Health

The Trust takes part in a range of National Audits and delivers local clinical audits in order to test compliance against a range of clinical and practice standards. This has included for 2021-22 the following:

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Physical Health in Mental Health Hospitals audit. We are awaiting the final published report from this audit and will review the outcome within our

Clinical Effectiveness Assurance Group, which will oversee the development and monitoring of any actions required.

- Risk to patient's physical health and monitoring the National Early Warning Score 2 (NEWS2) trigger system audit. We have demonstrated an improvement in compliance with physical checks within 24 hours of admission, the audit has shown:
    - 80.6% of the sample had the first set of observations completed within the first 24 hours of admission (as per policy). This is an improvement from last two audits which were 77% and 71.3%.
    - An additional 16.9% taken at soon as the service users mental health allowed, however this was after the 24 hours guideline.
    - 2.7% did not have a recorded physical health observation on the digital ward system. However, after reviewing these service users, most had been discharged within the 48 hours; therefore, not allowing the staff time within the admission period.
- Prescribing Observatory for Mental Health (POMH) 18b: Use of Clozapine audit. Actions we are taking to improve are:
    - Update our Clozapine initiation guidance
    - Develop Clozapine initiation checklist for clinicians
- National Clinical Audit of Psychosis (NCAP): Early Intervention Services audit. We scored 100% within the Clozapine treatment domain, with a physical health assessment rate of 96%.
- Rapid Tranquilisation audit: this forms part of our annual audit programme with the current audit cycle data collection complete awaiting the final analysis and report development. The outcome of this audit will be reviewed within our Clinical Effectiveness Assurance Group, which will oversee the development and monitoring of any actions required.
- The Home Treatment Service has included the routine screening for alcohol use within its assessment document within the electronic patient record (RIO) for all service users entering the service.

Priority for Improvement 2: A Focus on a Positive Patient Experience

What this means: This aspect of our priorities puts a clear focus on delivering a high quality experience for service users, families and carers and largely focusses on ensuring that they have a powerful and equal voice in their own care, as well as helping to shape and influence future developments at the Trust to improve the patient experience. We have engaged groups of patients to help us to understand what they would like to see as priorities.

During 2021/22 we set the following goals and detail our achievement below:-

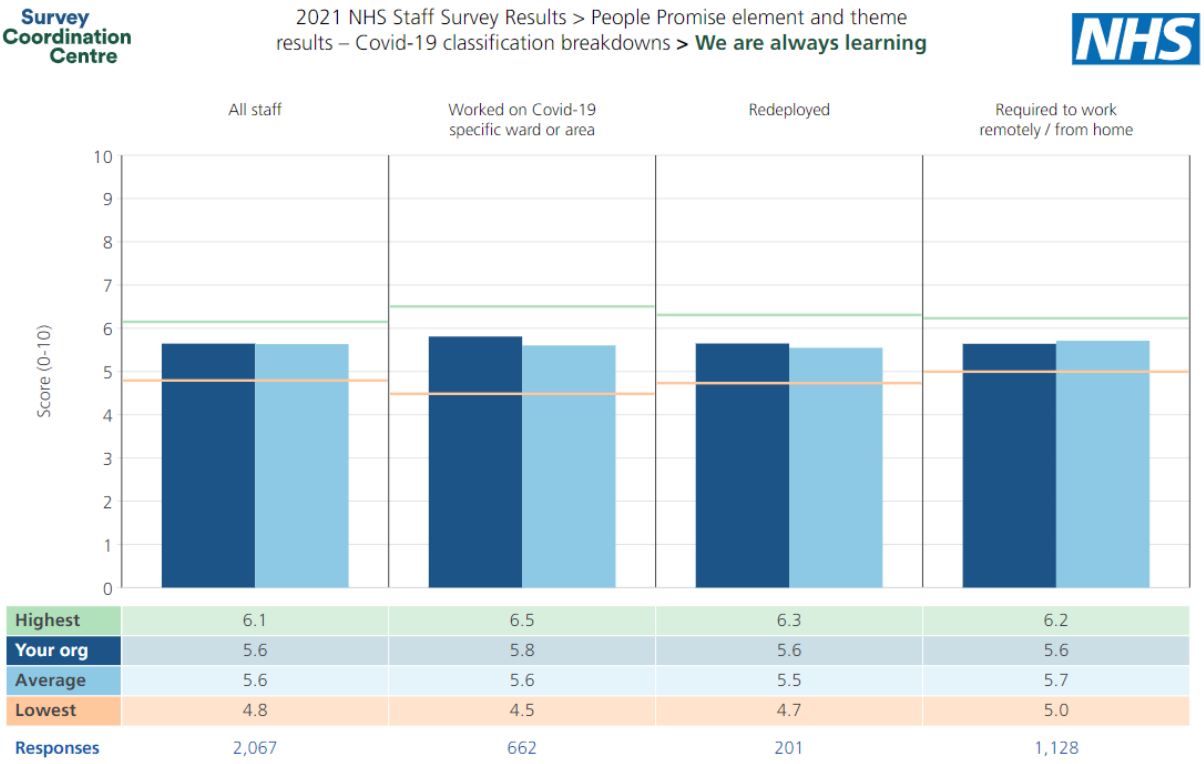
- % of service users attending their weekly MDT

    - Our monthly multi-disciplinary review audits have identified that in 2021-22 97% of service users in our inpatient services attended their weekly review meeting
- % of service users in receipt of their care plan
    - On average 68% of service users confirmed that they received a copy of their care plan in 2021-22.
    - We have a function on our electronic patient record system (RIO) that prints a summary of the key care plan information for service users. We recognise that measuring whether a service user has been given a copy of their care plan is only one measure of engagement and does not indicate whether the service user has been involved in its development and feels engaged with the plan itself. We therefore will introduce additional qualitative measures into our monthly MDT review audit to test this.
- Qualitative measure to be established through Experts by Experience group and reporting to commence against this measure from January 2022
    - The development of qualitative measures was delayed by our urgent response to the Covid-19 Omicron variant which required us to focus on covid outbreak management. The development of qualitative measures is now underway and will be completed in quarter 1 of 2022-23.
- % of carers registered on RIO
    - We have an established Family and Carer Pathway Collaborative Group which works to improve the way services engage families and carers in supporting the service user journey. The first step in this journey is to record the details of those carers that service users wish us to involve in their support. The proportion of carers recorded on our electronic patient record has remained static at 34% this year. The collaborative will continue to work to improve this position.
- % of carers with a completed carer engagement tool
    - The carer engagement tool is designed to work with carers to understand their role and support needs in caring for their loved one who is receiving services. Around a quarter of carers registered on our system have a carer engagement tool available on the system and of those who accepted the offer of this 89% have completed this. The collaborative will continue to roll this process out to more service users and their carers in 2022-23.
- Number of patient safety partner roles established and gain feedback from patient safety partners on their experience
    - The role of the patient safety partner has been a developing one over 2021-22 with role descriptors now in place and plans to recruit to this in quarter 1 of 2022-23. Once established and evaluation of their impact will be made.

Priority for Improvement 3: A Focus on a Positive Patient Safety Culture

Our measures of success relating to this priority were defined as:-

- Number of LFE submissions made in recognition of excellent practice
    - We have developed a mechanism for staff to record excellence in practice electronically. This is available through a simple electronic form for all staff. During the second half of the year this has gathered momentum with nearly 400 submissions being made. Excellence submissions are shared with the staff nominated and their line managers to recognise their actions. We are currently developing the mechanism to report excellence within quality reports so that in addition to learning from the times things go wrong we can learn from our successes also.
- Improvement in safety culture metrics in the national staff survey relating to incident reporting and learning from incidents



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home
Highest	6.1	6.5	6.3	6.2
Your org	5.6	5.8	5.6	5.6
Average	5.6	5.6	5.5	5.7
Lowest	4.8	4.5	4.7	5.0
Responses	2,067	662	201	1,128

We scored the same as the national average for learning in this year's staff survey. We recognise we have more work to do to ensure that staff feel truly engaged in developing a learning culture.

Interestingly staff who worked in covid specific areas or were redeployed were more likely to offer a positive score than those who worked from home.

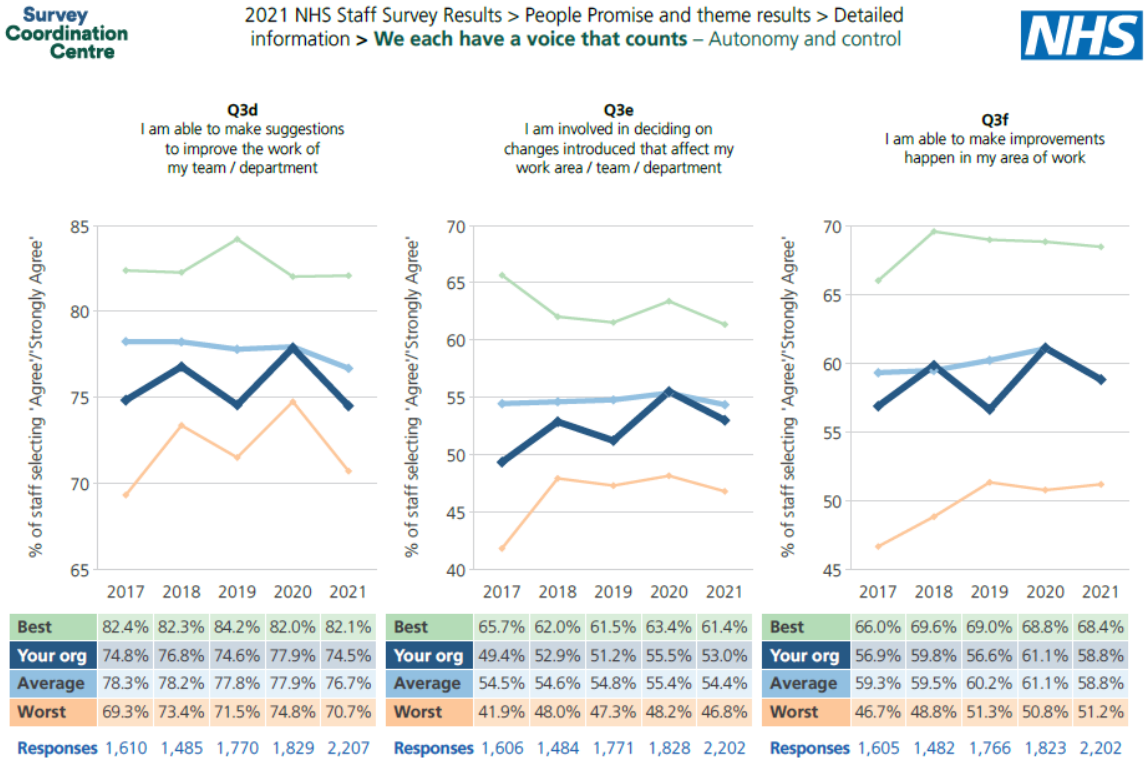
Priority for Improvement 4: A Focus on Quality Assurance

What this means: Quality Assurance is a process to help us continually check that we are meeting the standards of quality of care that we owe to our service users, families, carers and staff. Our regulators such as the Care Quality Commission also hold us to account for delivering these standards. The process also offers us the basis for assessing whether or not we are continually improving care and can help us identify areas where we need to celebrate great practice as well as focussing on areas that need improving.

We aim to develop a quality assurance framework to underpin and assure us of the quality of our services and care on a continual basis.
We will do this with staff, service users, families and carers. This will help us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

Our measures of success relating to this priority were defined as:-

- Number of peer review visits completed
- Improvement in national staff survey metrics relating to the 'Ability to Contribute to Improvements'
    - We recognise we have work to do to improve on staff reporting they are engaged in making changes; two of the three staff survey question responses have fallen below the national average this year:



We will work with staff to understand how we can improve their engagement in making positive changes in their work areas.

Priority for Improvement 5: A Focus on Using our Time More Effectively

Our measure of success relating to this priority was defined as:-

- Clinical outcomes associated with service user satisfaction levels with life domains and treatment aspects of their care
    - We recognise that delivering care through the pandemic period has been difficult and has affected outcomes for some of our service users. We have taken the results of the 2021 NHS community mental health survey and developed an action plan of improvement based on what it tells us. Some of the results from the survey are set out below:

Section	Focus	Score (of 10)	Benchmark to other MH Trusts
1	Health and Social Care Workers	6.5	About the same (as expected)
2	Organising Care	8.1	About the same
3	Planning Care	6.2	Somewhat worse than expected
4	Reviewing Care	6.7	About the same
5	Crisis Care	6.3	Worse than expected
6	Medicines	6.6	Somewhat worse than expected

7	NHS talking Therapies	7.4	About the same
8	Support and wellbeing	4.0	Worse than expected
9	Feedback	1.3	About the same
10	Overall View of Care & Services	6.7	About the same
11	Overall Experience	6.3	Somewhat worse than expected
12	Care During the Covid-19 Pandemic	6.3	About the same

Key:

2.2 Statements of Assurance from the Board

This section of the report includes a series of statements of assurance from the Board of Directors. The exact form of the statements is prescribed and specified by the 'quality account regulations' and as such the wording of these statements is statute and unable to be changed.

	Prescribed information	**Form of statement**
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2021/22 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT CAMHS Deaf Community Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention Forensic CAMHS Community Forensic CAMHS LOW SEC Forensic CAMHS MED SEC Forensic Outreach High Dependency Wards Home Treatment IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards Neuropsychiatry Older Adult Acute Ward Older Adult Community

		Memory Services OPIP (Older Adult Day Care) PICU Primary Care Prison Mental Health Care Rehab Ward Substance Misuse Services
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2021/22 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2021/22

2. Participation in National Clinical Audits and National Confidential Enquiries

	Prescribed Information	**Form of statement**
2	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	During 2021/2022, 7 national clinical audits and 3 national confidential enquiries covered relevant health services that Birmingham and Solihull Mental Health NHS Foundation Trust provides

2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2021/22 are as follows: • National Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health • POMH19b: Prescribing for depression in adult mental health services • POMH 14C: Alcohol Detoxification • POMH 1h & 3e: Prescribing high dose and combined antipsychotics • National audit of care at end of life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Audit of Dementia (NAD)- spotlight on Memory Assessment Services • National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2021/2022, are listed below: • National Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health • POMH19b: Prescribing for depression in adult mental health services • POMH 14C: Alcohol Detoxification • POMH 1h & 3e: Prescribing high dose and combined antipsychotics

		• National audit of care at end of life (NACEL) • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • National Audit of Dementia (NAD)- spotlight on Memory Assessment Services • National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).

2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during April 2021 to March 2022 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:-

Title of National Clinical Audit	Eligible	Participated	% *
National Clinical Audit of Psychosis (NCAP) Spotlight Audit in Physical health	Yes	Yes	100%
POMH19b: Prescribing for Depression in Adult Mental Health Services	Yes	Yes	100%
POMH 14C: Alcohol Detoxification	Yes	Yes	100%
POMH 1h & 3e: Prescribing High Dose and Combined antipsychotics	Yes	Underway- Delayed by provider	N/A
National audit of care at end of life (NACEL)	Yes	Yes	2- low numbers were expected
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	100%
National Audit of Dementia (NAD)- spotlight on Memory Assessment Services	Yes	Yes	100%

National Confidential Enquiry into Patient Outcomes and Death (NCEPOD): Physical Health in Mental Health Hospitals	Yes	Yes	8 case notes
National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health	Yes	Yes	Facilities questionnaire only
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Yes	Yes	100%

2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 17 national clinical audits were reviewed by the provider in 2021/22 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	

National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)

In September 2021, the Trust reviewed the findings of the 2020/21 National Clinical Audit of Psychosis re-audit. This audit focused on Service users with first episode psychosis receiving treatment from the Solihull Early Intervention in Psychosis service (EIS). The audit included a review of cognitive behavioural therapy (CBT) up take, family intervention uptake, education and employment programme up take and whether service users who had not responded adequately to or tolerated treatment with at least two antipsychotic drugs are offered clozapine. There were also two physical health related domains which were: Physical health annual review (smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol) and Physical health interventions (smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidaemia, Diabetes/high risk of diabetes and Hypertension).

Key success

- It is recognised that data was collected during a time of demand to move to digital interventions due to the COVID-19 restrictions. Despite this Solihull EIS were still able to maintain service delivery at a high level.
- EIS Solihull scored top performing in the CBTp, family interventions and supported employment programmes domains and has showed improvement across all of these domains since the previous audit.
- EIS Solihull scored 100% for the domain relating to clozapine treatment- this is an improvement from 88% in the previous audit.
- EIS Solihull has also improved significantly in the physical health assessment and interventions domain. They achieved 'Top Performing' compared to 'Needs Improvement' in the previous audit. Solihull EIS was the highest scoring team in the country achieve 96% in physical health assessments. A presentation around how we achieved this was given at the EIS conference in August and has been shared with the Trusts physical health committee.

- EIS scored above the national average for offered and accepted interventions for substance use, harmful alcohol use, weight/obesity and hypertension.

Key areas for improvement

- Overall Solihull EIS was scored as needs improvement by NCAP. This is due to scoring 'Needs Improvement' in the access and waiting time's domain and the outcome measures domain. Unfortunately, data for the access and waiting time domain was commissioning level data pulled from NHS digital. This data is combined with Forward Thinking Birmingham (FTB) which EIS Solihull has no control over.
- EIS Solihull scored needs improvement for not having an over 35's or ARMS service. However, since data was collected the over 35's aspect is now established and has been since the 4th Jan 2021 with the ARMs aspect being in development phase but is being hindered by recruitment issues and the identification of an organisation to deliver the CAARMS assessment training. This is being explored by NHSE as this is not just a local issue but a national one.

Key actions

- Share success of physical health instructor with the wider trust
- Escalate issue of using combined access and waiting times data to the NCAP network

POMH 18b: Use of clozapine

This is a re-audit of the use of Clozapine. Clozapine is a universally recommended treatment for the treatment of schizophrenia that has failed to respond to at least two standard antipsychotic medications. However, this antipsychotic medication is also associated with several potentially serious side effects. Therefore, it is essential that service users and/or carers are informed of both the potential benefits, and potential risks of Clozapine, prior to the initiation of treatment. The audit reviewed pre-treatment screening, off-label prescribing, monitoring in the first two weeks, assessment of side effects, impact of discharge from hospital and annual medication reviews. The outcome of this audit was reviewed by the Pharmacological Therapies Committee (PTC) in November 2021.

Key success

- The prevalence of off-label prescribing was very low
- There has been some improvement in documenting the early on-treatment monitoring of vital signs in patients prescribed clozapine.

Key areas for improvement

- 30% of sample as a documented discussion of potential benefits and side effects of clozapine prior to initiation.
- Clozapine treatment is associated with weight gain, an adverse lipid profile and the development of diabetes, but the relevant baseline measures were not documented for 50% of the sample.

Key actions

- The trust has updated the clozapine initiation guideline
- The trust has looked at developing a clozapine initiation checklist that is easily accessible to support clozapine initiation
- Ensure that the side-effect checklist which is already available, is available on RIO, and will form a part of the patient's clinical record, to ensure that each side effect is considered and the presence or absence is recorded

POMH Topic 20a: Improving the quality of valproate prescribing in adult mental health services

Reviewed by the Pharmacological Therapies Committee (PTC) in December 2021, this baseline audit looked at recording reasons for initiating valproate treatment, off label prescribing, pre-treatment physical health assessments, 3-month reviews, annual review and women of childbearing potential.

Key success

- Fewer women of childbearing potential now on valproate in our Trust
- Improved identification of eligibility for women of childbearing potential / completion of Prevent
- Improved performance in completing risk acknowledgement forms

Key areas for improvement

- Reason for prescription not consistently documented
- Where use was off-label, this was not consistently acknowledged in records
- Physical health checks within 3 months of commencing valproate not consistently recorded

Key actions

- Raise awareness with prescribers of the GMC duties of a doctor requirement when prescribing off label.
- Raise awareness with clinicians, that where they rely upon YCC results to inform prescribing, they should acknowledge this in progress notes

National Audit of Inpatient Falls (NAIF)

The National Audit of Inpatient Falls (NAIF) is a national clinical audit run by the Falls and Fragility Fracture Audit Programme (FFFAP) at the Royal College of Physicians. This audit measures compliance against national standards of best practice in reducing the risk of falls within acute care.

Key areas for improvement

- The full range of audit requirements are triggered by acute hospitals populating the hip fracture database. Once populated any BSMHFT patients who sustained a hip fracture in our care would be subject to this audit programme. During the audit period, we did not receive any requests for patient-based audits of care associated with BSMHFT.

Key actions

- There are internal learning processes for falls and hip fractures within the Trust. Due to this and the limited participation in this audit, the trust has agreed that we will no longer take part in this audit.

National Clinical Audit of Psychosis (NCAP) Spotlight Audit- Physical health

It is recognised that Life expectancy for adults with psychosis or schizophrenia could be between 15 and 20 years less than for people in the general population. This may be because people with psychosis or schizophrenia often have physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, that can be exacerbated by the use of antipsychotics.

This spotlight audit focused on two physical health related domains which were: Physical health annual review (smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol) and Physical health interventions (smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidaemia, Diabetes/high risk of diabetes and Hypertension) offered to people with psychosis seen by adult community mental health services.

Key success

- The trust performed above the national average when providing interventions for referring people to specialist alcohol and drugs services

Key areas for improvement

- There were issues identified during data cleaning with the data collection platform provider. Data were found to be missing from the majority of site's BMI (Q12), Glucose (Q14) and Cholesterol (Q15) screening responses, such that where sites had entered values, the data was not received by the server and was irretrievable.
- Physical health monitoring does not appear to be consistently recorded

Key actions

- Although it not always the trusts responsibility to conduct physical health assessments, it is within our remit to encourage service users to have them.

POMH 14C: Alcohol Detoxification

Many service users admitted to acute adult psychiatric wards have significant alcohol dependence and many may require medically assisted alcohol withdrawal. This re-audit reviews practice for alcohol detoxification conducted in acute psychiatric inpatient settings. The key indicators for this audit included: Alcohol detoxification of an inpatient should be informed by a documented assessment of drinking history, current daily alcohol intake, a physical examination, carried out on admission, blood tests relevant to the identification of alcohol related physical health problems, pharmacotherapy to treat withdrawal should be limited to a benzodiazepine, carbamazepine or clomethiazole and thiamine should be prescribed in acute alcohol withdrawal.

Key success

- Most of the sample received a liver function and renal function blood test.
- Most of the sample were referred to a more specialist alcohol service for support once they had alcohol detox as an inpatient.

Key areas for improvement

- The number of service users eligible to take part in this audit were low (n=11) as the trust does not record how many of our inpatients require alcohol detox.
- A detailed alcohol history is required to ensure the prescribed detoxification regimen adequately protects against potentially serious complications of acute alcohol withdrawal. The trust had a documented full alcohol drinking history for 60% of the sample.
- 65% had a physical exam- dropped from 80% in the previous audit
- The administration of thiamine during alcohol detoxification protects against the development of Wernicke's encephalopathy and permanent neurological damage in the form of Korsakoff's psychosis. There was no improvement on the assessment and treatment of symptoms of Wernicke's encephalopathy.
- Only 45% of the sample were prescribed only one benzodiazepine. This may partly reflect the use of different benzodiazepines for different indications, for example chlordiazepoxide to manage withdrawal symptoms and lorazepam to manage acute behavioural disturbance. It was also established that lorazepam is regularly prescribed on admission as PRN.

Key actions

- The trust has established a working group to review and promote the alcohol detox inpatient guideline which has been updated based on the finding of this audit.
- The working group will also review local alcohol detoxification prescribing protocols to ensure advice is given/safeguards are in place to reduce inadvertent co-prescribing/administration of multiple benzodiazepines to patients identified as drinkers on admission to hospital and will explore reasoning for prescribing Lorazepam on admission.
- The working group will also share benchmarked data with the local Commissioners, as a basis for constructive discussion regarding commissioned services for alcohol abuse.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

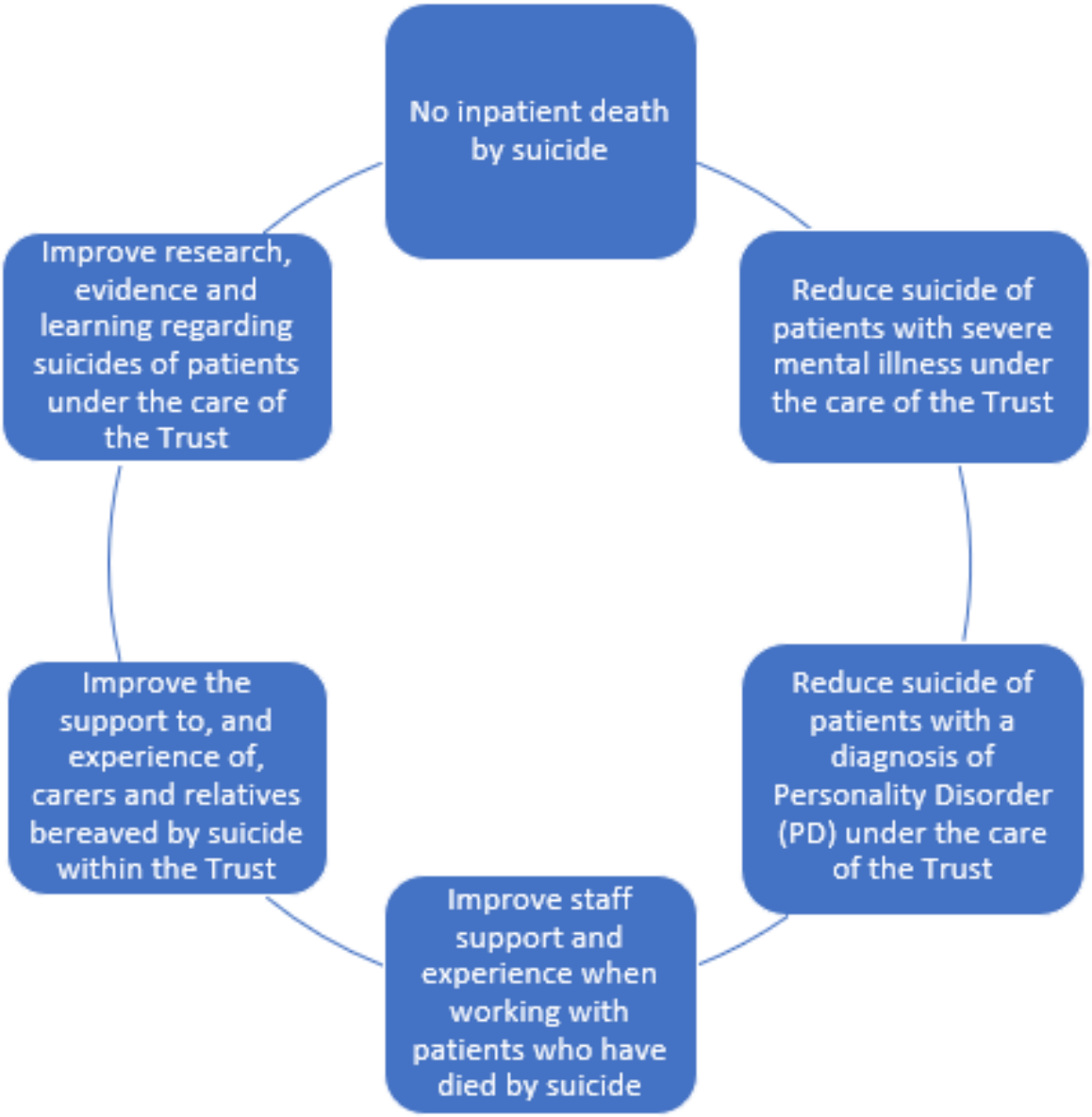
We have reviewed the 2019 NCISH report alongside a refresh of our suicide prevention strategy and will incorporate the learning from the national review and a review of local incidents to continue to improve the safety of our service users.

NCISH key messages are:

- Focus on established risk factors for suicide
- Increase in risk during leave and immediately post discharge from mental health hospitals (3 days)
- An increase in suicide amongst under 18s
- Economic adversity increases the risk of suicide

- Increase in suicide for people with physical health conditions, particularly involving chronic pain
- Understanding the risk factors for domestic violence
- Effects of the pandemic on isolation, anxiety and disruption to care may have contributed to suicides by mental health service users.

Our suicide prevention strategy has 6 strategic aims:



We are utilising the NCISH 10 ways to improve safety:

And work with Service Users to develop a Suicide Safety Plan:

2.7	The number of local under entry 2.5. clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 17 local clinical audits were reviewed by the provider in 2021/22 and Birmingham and Solihull Mental Health Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Clozapine assay re-audit

Last reviewed in September 2021, this audit is considered a key priority by the trust following the death of a patient on clozapine to prevent this ever happening again. The baseline audit assessed lower and higher clozapine assays. After the first audit there were less concerns with lower clozapine assays. This time round the focus was on assays that were above 600mg. The aim of the re-audit was to determine if we had made any improvement from the first audit.

There were 50 patients included in the re-audit.

Key success

- The reaudit indicated there has been improvement in trough levels, clinical indication, documentation on RIO and dose change due to assay

Key areas for improvement

- Further work to ensure the appropriate ordering of trough value assay samples
- Ensure assays are only requested when clinically indicated
- Results from assays are notified to the consultant as soon as possible and are acted on
- Documentation of any considerations or plans following an assay result
- Clear indications as to any changes made with doses following an assay
- Repeat bloods should be ordered after an appropriate period of stable dosing if needed

Key actions

- Pharmacy staff will review and report back on levels above 600mcg/L
- Update the Clozapine guideline based on the findings of this audit

PICU Prison Assessment Re-audit

This is an annual re-audit that looks at our compliance with the BSMHFT PICU Prison Assessment guideline.

Key successes

- Completed assessments were 71% compliant with standards which is an increase from 50% in the previous audit.

Key area for improvement

- There were slight delays between the patients referral date and their PICU assessment.
- It was unknown whether the decision was discussed during the MDT
- MDT's were not held within 2 working days of the assessment.

Key actions

- The new guideline has been ratified and is to be implanted

Staff to be trained in their roles and responsibilities

Solihull Safeguarding Children Board Multi-agency case audit

BSMHFT participates in an annual multi-agency case audit in Solihull. This audit considers cases that are directly related to any of the Solihull Local Safeguarding Children Partnership (LSCP) priorities. The focus of this audit is to explore the extent to which the voice of the child is heard by Birmingham and Solihull Mental Health NHS Foundation Trust during their work with children and families.

For this audit, BSMHFT selected cases from three tiers:

Tier 1 related to parents/carers who were known during the audit timescale to BSMHFT with either a less intense intervention level (such as 'care support' in community mental health teams) or for a brief interaction with the service (such as a single contact with liaison psychiatry in general hospital). From Tier 1, eleven service users were audited.

Tier 2 related to parents/carers who were known during the audit timescale to BSMHFT with more prolonged and regular contacts (such as 'Care Programme Approach' in community mental health teams or perinatal services) or through more intense crisis support (such as being under the care of a Home Treatment Team or receiving inpatient care on a psychiatric ward.) From Tier 2, six service users were audited.

Tier 3 related to children and young people who were known or had contact with the BSMHFT CAMHS Service in Solihull, 'SOLAR'. These individuals were known to one of the SOLAR services; either core

CAMHS, primary care, medical or crisis. It also included two service users who were referred to SOLAR and open for assessment. From Tier 3, eight service users were audited.

Key success

- There were some examples where evidence of Think Family was clear: children being considered, specific details being recorded and attempts to establish the voice of the child by observation, reflection or liaising with other professionals involved.
- SOLAR particularly displayed evidence of listening and responding to the child, adapting to their needs/wishes and advocating for their voice.

Key areas for improvement

- The main theme of the findings of this audit can be concluded as a lack of 'Think Family' consideration. 'Think Family' underpins establishing the voice of the child, especially for those professionals working with adults using mental health services as seen in the Tier 1 and 2 audits.
- There needs to be more joint up working between SOLAR and adult mental health teams where the child and parent are both open to BSMHFT.

Key actions

- Re-promote the children's and sibling's form to allow for a specific place where the identifying details of a child and family can be recorded, such as names and dates of birth.
- To add learning points into the SOLAR operational policy

Introduce the integrated safeguarding system which aims to better integrate safeguarding into clinical everyday practice and incorporate the voice of the child and think family.

Weight Management on Inpatient units

Obesity is an important cardiovascular risk factor contributing to the premature death of people with mental illness. On average, the life expectancy of those with a Serious Mental Illness is 15-20 years less than the rest of the population and this is mainly due to preventable physical illnesses. Both nationally and globally, the incidence of Obesity is increasing. BSMHFT has a comprehensive Physical Health Strategy aiming to turn the tide on the poor physical health outcomes of our service users. As part of the Strategy, we have committed to deliver a trust wide obesity action plan to ensure high quality interventions and support is accessible for Service Users.

This re-audit is part of the implementation plan laid out in the BSMHFT Weight management strategy. A total of 557 patient records were retrieved and analysed by service area.

Key success

- This audit indicated that there is some evidence of Trust improvement in supporting service users to maintain body weight during admission – during which there are a myriad of complex contributory effects including sedentary activity, medication side effects, reduced free food choices and eating as a pastime.
- A previous audit reported in 2017 in found weight gain in 80% of hospital admissions, with an average weight gain 7.06 kg. This audit shows improvement on this with just over 51% of service users gaining weight, with an average gain of 5.9kg.

Key actions

- Food services to be nutritionally balanced and offer clearly identified opportunities to choose healthier meal choices
- Staff to have access to local good quality training to feel confident and skilled at having supportive, non- judgemental conversations about weight gain.
- BMI > 30 to be documented as medical problem and regularly reviewed in the MDT meeting and care planned accordingly.

Risk to patient's physical health and monitoring the National Early Warning Score 2 (NEWS2) trigger system

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) uses the NEWS2 tracing and trigger system which is based on a simple scoring system in which a score is allocated to our routine observation of the six physiological measurements which can be taken – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.

The score is placed on the digital ward platform and is used by clinical staff to record vital signs, assign each a score and monitor people's physical condition where necessary. The total score lets the practitioner know if a patient is deteriorating, prompting them to take urgent action, to review the care of the patient and call for specialist help if necessary.

The NEWS2 has been shown to be a highly effective system for detecting service users at risk of clinical deterioration or death, prompting a timelier clinical response, with the aim of improving service user's outcomes in the trust. (NICE,2007 & Royal College of Physicans,2017). This scoring system is fundamental in the identifying and managing the deteriorating patient.

Key Success

- The audit identified that 80.6% of the sample had the first set of observations completed within the first 24 hours of admission (as per policy). This is an improvement from last two audits which were 77% and 71.3%.
- We then have an additional 16.9% taken at soon as the service users mental health allowed, however this was after the 24 hours guideline.

Key areas for improvement

- 2.7% did not have a recorded physical health observation on the digital ward system. However, after reviewing these service users, most had been discharged within the 48 hours; therefore, not allowing the staff time within the admission period.

Key actions

- The COVID pandemic has increased the monitoring of basic physical health observations and NEWS2 scores. We have better methods for quicker reporting and are now quicker at reviewing the service user's observation and are acutely aware when there is deterioration.

Staff training is available for all our staff, including face to face 'managing the deteriorating patient' (COVID-19) training ad-hoc training, eLearning and all the presentation and links on the COVID pages of our intranet.

Pharmacy/Medicines

(Inpatient controlled drugs, Inpatient Medicines Code Audit, Prescribing compliance with MHA forms, Antimicrobial prescribing and Hypnotics prescribing)

Across the course of the past year, the trust carried out several pharmacy and medicines related audits to assess various topics from inpatient controlled drugs, inpatient medicines code, compliance with mental health act forms, hypnotics and antimicrobial prescribing.

Key findings and actions

- Pharmacy staff have conducted an audit of safe and secure handling of drugs across 50 wards covering general adults, older adults, Steps to Recovery and secure care wards. For the 50

wards, there was 91% compliance with standards which is similar to previous audits.6 wards were fully compliant with the standards.

- Twelve wards had more than 10% non-compliance with safe and secure handling of medication standards. This is slightly higher than previous audits.
- Findings of the controlled Drugs audit have been discussed with senior ward staff and each ward has a specific ward action plan for improving compliance with standards.
- 91% of service users had Mental Health Act Consent to Treatment certificate in place to authorise their prescribed treatment for mental health disorders, representing a 1% improvement in practice compliance from 2020.
- Pharmacy services will work with staff on Inpatient wards to provide training on key safe and secure handling of medicines issues.
- Pharmacy staff will work intensely with those wards showing the greatest non-compliance with standards.
- The project to look at the procurement and installation of appropriate solutions for controlling the climate for storage of medicines to be resumed.
- Pharmacy will work with wards and estates to ensure that where medicines cabinets are non-compliant with BS2881 and are due to be replaced then suitable alternative cabinets that comply with the standard are procured.
- Where needed, pharmacy staff will provide additional controlled drugs training for staff to enable them to comply with all standards.
- The BSMHFT guideline on management of insomnia audit found that not all standards for hypnotic medication prescribing within the Steps to Recovery Service, Rosemary and Bergamot wards was being followed.
- Compliance with antimicrobial guidance is above the commissioner's target and this has been sustained.
- Clinical pharmacists will continue to work with medical staff to ensure that antimicrobial prescribing is appropriate and the outcomes are documented.

3. Research

	Prescribed Information	**Form of statement**
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by **Birmingham and Solihull Mental Health NHS Foundation Trust** in **2021-2022** that were recruited during that period to participate in research approved by a research ethics committee is **507**.

4. CQUIN

	Prescribed Information	Form of statement
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of BSMHFT income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the Covid Pandemic. CQUINS were suspended for the financial year and funding was through block contract payments determined nationally.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

5. CQC

	Prescribed Information	Form of statement
5	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional.
5.1	If the provider is required to register with CQC: (a)	

	whether at end of the reporting period the provider is: (i) registered with CQC with no conditions attached to registration (ii) registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional. BSMHFT has the following conditions on registration: **1.** The registered provider must take steps to address the ligature risks across all wards by 18 June 2021 **2.** By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. **3.** By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. **4.** Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. **5.** Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. Birmingham and Solihull Mental Health Foundation Trust make regular submissions and meets with the CQC to update it on progress against its actions relating to these conditions. The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2021 to 31 March 2022. Birmingham and Solihull Mental Health NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during 1 April 2021 to 31 March 2022.

	Prescribed Information	**Form of statement**
7	Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality

7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	Commission during 1 April 2021 to 31 March 2022.

8. Data Submission

	Prescribed Information	Form of statement
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

9. Information Governance

	Prescribed Information	Form of statement
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2021 / 2022 is not due to be submitted until the 30th June 2022 in line with national submission timescales relating to the Data Security and Protection Toolkit. The 2020/21 Data Security and Protection Toolkit attainment level for the Trust was 'standards not fully met – plan agreed.'

10. Payment by Results

	Prescribed Information	Form of statement
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	

11. Data Quality

	Prescribed Information	Form of statement
11	The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: • Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. • Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. • On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up-to-date. • Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using monitoring reports to identify and correct data errors. • A range of data quality audits covering all key reporting data sets, with special in-depth audits and corrective work if significant data quality problems are identified. • Maintaining work on completeness and validity of MHSDS submissions in relation to the Data Quality Maturity Index • Maintaining work on completeness and validity of the IAPT submissions and assessing the new experimental data set items added to the Data Quality Maturity Index • Active data quality support to operational services by service-aligned data analysts, bringing any data issues

		forward for attention and supporting and monitoring improvement actions

27 Learning from deaths

	Prescribed information	**Form of statement**
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2021-22 1503 of BSMHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 374 in the first quarter; 445 in the second quarter; 407 in the third quarter; 277 in the fourth quarter.
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31/03/2022, 13 case record reviews and 45 investigations have been carried out in relation to 1503 of the deaths included in item 27.1. In 1 case 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: 18 in the first quarter; 15 in the second quarter; 11 in the third quarter; 14 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	1 representing 0.07% 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: 1 representing 0.27% for the first quarter; 0 representing 0% for the second, third & fourth quarters. These numbers have been estimated using the [name, and brief explanation of the methods used in the case record review or investigation]

27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The death was investigated under our serious incident framework and improvements were identified in the regularity and quality of face to face named nurse time in order to understand the changes in their risk presentation, particularly in relation to the expression of suicidal thoughts.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	- There have been changes to the structure of the weekly multi-disciplinary reviews and ward rounds to make them more collaborative. Within the review; care plans, risk assessments, observation levels and leave prescriptions are all reviewed and updated on our electronic patient record (Rio) live in the meeting - Safety huddles have been incorporated into the normal daily routine of our inpatient wards; this is where a discussion is held focusing on the patients most at risk to develop a plan of action to manage and reduce any risks identified. These discussions and any relevant plans are formally recorded on shift coordination sheets. - Our Inpatient guidance is currently under review and should outline that when new expressions of suicidal ideation are made this should be escalated via a multi-disciplinary meeting, safety huddle discussion or to the on-call doctor for review

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	We monitor the delivery of multi-disciplinary reviews and safety huddles each month and have confirmed that these are now established and take place weekly and daily respectively. We are currently beginning a qualitative evaluation of these with the support of service users.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	27 case record reviews and 26 investigations completed after 31-03-2021 which related to deaths which took place before the start of the reporting period.

27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	6 representing 0.4 % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the final avoidability score of 3 or less.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item	7 representing 0.47 % of the patient deaths during 2020-21 & 2021-22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

The Trust is required to provide performance details against a core set of quality indicators that were part of a new mandatory reporting requirement in the Quality Accounts from 2013 with the data being supplied by NHS Digital as follows:

- The percentage of patients on Care Programme Approach who were followed up within 7 days of discharge from psychiatric inpatient care during the reporting period.
- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.
- Readmission to hospital within 28 days of discharge.
- Patient experience of community mental health services.
- Patient safety incidents.
- The Staff Friends and Family Test.

2.3.1 The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

The percentage of service users being treated under the Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:

This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a

member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2021-22	92.5%	*	*	*
2020-21	91.8%	*	*	*
2019-20*	94.7%	95.0%	100%	85.9%
2018-19	96.1%	95.7%	100%	82.8%

Data Source: Rio - our internal clinical information system

***** *No national comparator figures were collected or published for 2020-21 or 2021-22.*
*******Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year.*
Please note performance dipped sharply in March 2020 due to the impact of Covid-19

Our local methodology excludes three groups of service users where the exclusion is not explicitly defined in national guidance, as follows:

- People discharged to non-NHS psychiatric hospitals, because they continue to be under the direct 24-hour care of qualified mental healthcare staff.
- People discharged to an overseas address are excluded from the indicator due to the challenge of contacting people outside the United Kingdom.
- People discharged from our neurological investigations unit because their admissions do not relate to acute psychiatric illness.

- Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:
- A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
- Regular samples of records are compared with clinical progress notes to ensure that they are being correctly included or excluded from indicator calculations.

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by monitoring adherence to our Trust's policy on community follow-up of inpatient discharge, undertaking regular sample audits and feeding back results to clinical teams, and by ensuring oversight of this process is maintained through circulation

of daily reports to senior managers and review at regular divisional performance meetings.

Whilst the trust has taken these actions to improve the percentage completion, 2021/22 compliance was significantly impacted by Covid -19 in terms of the ability to make direct contact with service users, particularly for older adults discharged to nursing and residential care homes. During this period there was an increased level of contact by telephone instead of face-to-face visits and in some cases, contacts had to be made indirectly with care home staff where it was not possible to visit or talk to service users directly in this setting.

2.3.2 The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

This indicator identifies whether crisis resolution or home treatment teams had assessed people admitted to hospital and been involved in the decision to admit and, therefore, measures our success in ensuring that people are not admitted to hospital where they could be more appropriately cared for in their own home or another community location. As such, it is a measure of both quality of care and efficiency of resource use. National definitions exclude transfers from other hospitals, including A&E Departments, so the measure is looking at people admitted from their own homes or other community locations. Our local definitions would also consider admissions as having been 'gate-kept' where there was involvement from an assertive outreach or Psychiatric liaison, as these teams also provide a crisis resolution service and consider alternatives to admission as part of their assessments. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2021-22	95.4%	*	*	*
2020-21	97.5%	*	*	*
2019-20**	96.0%	97.9%	100%	91.9%
2018-19	97.1%	98.1%	100%	88.5%

Data Source: Rio - our internal clinical information system

***** *No national comparator figures were collected or published for 2020-21 or 2021-22.*
********Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year.*

Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

- A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
- Regular samples of records are compared with clinical progress notes to ensure that they are being counted correctly in indicator calculations.

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by ensuring oversight of this process is maintained through monthly review and targeted reports to senior managers.

2.3.3 Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:

(i) 0 to 15 and
(ii) 16 or over

which were readmissions within 28 days of discharge from a hospital which forms part of the Trust. There is no national indicator meeting exactly this definition. Trust data is based on all readmissions happening on the same day as a discharge from Trust inpatient services or any of the following 27 days.

This indicator measures quality of inpatient care, discharge arrangements and ongoing community support by identifying the extent to which service users discharged from hospital need to be readmitted within 4 weeks, our Trust's aim being to keep early readmissions to a minimum. National comparison figures are not available.

There is no national data available for comparison for this indicator.

	Age 0-15	Age 16+
2021-22	0.0%	5.3%
2020-21	0.0%	6.2%
2019-20	0.0%	5.8%
2018-19	0.0%	5.8%

Data source: Rio – our internal clinical information system

Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

- Admission and discharge dates, and service user dates of birth, are audited regularly as part of the Trust's routine data quality audit programme.
- Service user dates of birth are also subject to regular validation against information held on the NHS national Summary Care Record.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services, by ensuring oversight of this process is maintained by monthly reporting and review at regular divisional performance meetings.

2.3.4 Patient Experience of Community Mental Health Services

The Trust's mean 'Overall patient experience of community mental health services' indicator score (out of 10) as reported through the 2021 National Community Mental Health Service User Survey. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2021	6.5	6.9	7.7	6.0
2020	6.9	n/a	7.8	6.1
2019	6.9	n/a	7.7	5.8
2018	7.1	6.8	7.7	5.9
2017	7.4	7.3	8.1	6.4
2016	7.5	7.5	8.1	6.9
2015	7.3	7.5	8.2	6.8

Data source: National Community Mental Health Service User Survey 2021

Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

The survey is undertaken independently to the Trust by an external company in accordance with national survey requirements and the results are in line with our expectations.

2.3.5 Patient Safety Incidents

The number and rate of patient safety incidents reported within the Trust, and the number and percentage that resulted in severe harm or death.

Figures released by the National Reporting and Learning System (NRLS) are reported on a 6 monthly basis and are a reflection of harm levels caused by incidents reported during that data period. The quoted national figures are for all mental health trusts.

	Reported Patient Safety Incidents per 1000 bed days				Percentage of Patient Safety Incidents resulting in Severe Harm or Death			
	Trust	National Median	Highest National	Lowest National	Trust	National	Highest National	Lowest National
Apr 20 – Mar 21*	58	64	236	21	0.3%	1.0%	58.8%	0.0%
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 18 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%

**Note: NRLS reporting is annual for 2020-21 figures.*

	Patient Safety Incidents – Total Reported	Patient Safety Incidents per 1000 Bed days	Patient Safety Incidents resulting in Severe Harm or Death	% Patient Safety Incidents resulting in Severe Harm or Death
Oct 20 – Mar 21	6427	58	24	0.4%
Apr 20 – Sept 20	6588	58	23	0.3%
Oct 19 – Mar 20	5823	49	22	0.4%
Apr 19 – Sep 19	6188	51	31	0.5%
Oct 18 – Mar 19	5330	44	31	0.6%
Apr 18 – Sep 18	5233	44	22	0.4%

Data source: National Reporting and Learning System (NRLS)

Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

Data is submitted weekly to the National Reporting and Learning System (NRLS) from the Trust's incident reporting system (Eclipse). Any re-classification of incidents in relation to cause or harm flags up the incident locally and it is resubmitted to the NRLS; the new record overwrites the original to avoid duplication. The coding of incidents in relation to harm is based on guidance provided by NHS Improvement.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve this data, and so the quality of its services, by:

- Continuing to deliver incidents reporting training via incidents awareness sessions and Incident Manager training.
- Continue our approach to governance and incident reporting at the junior doctors marketplace, preceptorship training and at Student Experiential Learning Pathway sessions.

- Constantly evolve incident types to be reflective of incidents occurring in the Trust.
- Continuing to develop and promote the utilisation of the Black Hole, our innovative governance intelligence analytics portal, providing in-depth automated analysis of incidents data from ward to board.
- Improving the learning lessons framework and promote adoption through new practice guidance.
- Thematic reviews of incidents and reporting trends.

Part three – Other Information

In this section of the report we share other information relevant to the quality of the services we have provided during 2021/22 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

3.1.1 Safety

The three indicators selected for patient safety are:

- Serious Incidents
- Never Events

3.1.1.1 Serious Incidents

During 2021/22 we have completed much of the groundwork to move the investigation of our serious incidents in line with the NHS Patient Safety Incident Response Framework in preparation for the national roll out of this programme. We continue to work closely with partners across various agencies which support health and social care in Birmingham and Solihull to complete multi-agency reviews where it was evident that a patient involved in a serious incident was receiving care, support or advice from more than one agency. This enables us to take a system wide view on opportunities to improve how agencies can work together for the benefit of patients.

	2018/29	2019/20	2020/21	2021/22
Number of Serious Incidents Reported	91	78	96	82

3.1.1.2 Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been

implemented by all healthcare providers. We are pleased to report that the Trust has not reported any Never Events during 2021/22.

	2018/29	2019/20	2020/21	2021/22
Number of Never Events Reported	0	0	0	0

3.1.2 Patient Experience

The Trust identified the following key indicators for monitoring the quality of service user and carer experience. These were identified in the previous report and following review, they were still deemed to be a priority.

	2019/20	2020/21	2021/22
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	68%	59%	67%
Number of complaints	85	81	109
Timeliness of complaints	100%	100%	99.1%
% of dissatisfied complainants	18 returned (20%)	9 returned (11%)	9 returned (8%)
Number of referrals to the Ombudsman	2 0 accepted for re-investigation	2 0 accepted for re-investigation	2 0 accepted for re-investigation
FFT score	91%	94%*	79%

(National benchmark figure)

**please note that the 2020-2021 figure is reflective of the period January 2021 to end March 2021 as NHS England paused collection of the Family and Friends Test during the Covid Pandemic. Data source for the patient survey is the National Patient Survey Results, using national definitions, timeliness of complaints is our ECLIPSE reporting system for complaints and for CPA reviews is our KPI report on INSIGHT, our internal reporting system.*

It has been a challenging year as we seek to learn from service user experience in the midst of high system pressures. This is reflected in a sharp rise in complaints in 2021/2022 to 109 cases, an increase of 34% from the previous year. Despite this our dissatisfied complainants have remained at 9 cases, which is a reduction of 3% from the previous year. For the third year running, the PHSO have received 2 complaints from service users, neither of which they have accepted for reinvestigation. We failed to meet the agreed timescale for a single complaint which was shared with the complainant a day

late. We feel that our performance during 2021-22 demonstrates a positive record and improving picture of the way that we work with service users and their families to investigate their concerns and support their resolution. Work begun in 2020/21 on reviewing the carer experience of complaints was completed and will feed into the planned work for 2022/23 of a review of the Complaints Policy, including the establishment of an advisory panel of service users, carers, families, stakeholders and staff.

3.2. Performance against the relevant indicators and performance thresholds

The following indicators form part of the annexes to the NHS Oversight Framework and are required to be reported upon in this section of the report, unless they are referred to in section 2.

National mental health indicators

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2021/22	National Threshold	2021/22
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	93.8%
2	Improving access to psychological therapies (IAPT): * a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	52.1% 30.9% 84.2%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) **	n/a*	551*
4	Admissions to adult facilities of patients under 16 years old	n/a	0%

* The waiting times for IAPT have reduced below the national targets primarily due to factors outside the Trust's immediate control. Covid 19 has significantly impacted on the Trust's ability to maintain face to face appointments and contacts with service users, due to a significant reduction in the availability of physical space in primary care facilities where people were being seen for their appointments. Nationally a recognised shortage in the availability of appropriately qualified staff has added a further challenge along with

staff sickness due to Covid. A system wide forum has been established with the Birmingham and Solihull Clinical Commissioning Group and other partners to jointly develop plans to improve the position going forwards.

** Due to the impact of COVID-19 on the need for acute and urgent mental health services, it was recognised by NHSE/I that the national target to achieve 0 out of area placements by end March 2022 would not be possible.

In addition, please note that the average bed days per month for 2021/22 are based on the Standard Operating Protocol agreed with NHSE/1 to include 10 local acute private beds to be classified as 'appropriate placements' from the 1st of October 2022 and admissions to local PICU private beds from the 1st of January 2022. However as recognised by NHSE/I, these changes are not reflected in national MHSDS reporting and will continue to show as being ‘inappropriate’ placements due to MHSDS data constructs).

Annex 1: Stakeholder Statements

1.1 Healthwatch Birmingham and Healthwatch Solihull Statement

Statement from Healthwatch Birmingham and Healthwatch Solihull on Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2021/22

Healthwatch Birmingham and Healthwatch Solihull welcome the opportunity to provide our statement on the 2021/22 Quality Account for Birmingham and Solihull Mental Health NHS Foundation Trust. We welcome that the Trust has been clear in its assessment of its position, in particular the areas where it has performed well and areas needing further improvement. We acknowledge that Covid-19 continues to have a significant impact on the Trusts activities and on how the Trust delivers its services. We are however pleased to see that the Trust is using the learning from this period to design facilities which can be used flexibly.

We welcome plans to reshape the Trusts environment over the next year including taking full advantage of the opportunities that technology offers, both for the Trust and patients. The pandemic necessitated a change in how the Trust delivers its services. However, the pace of change was so fast so much so that in many cases patients, carers and the public were not taken along on the journey of change. We are pleased to see the Trust commit to continued engagement with service users, carers, and the public. We would like to read in the 2022/23 Quality Account how the Trust has engaged with service users, carers, and the public in reshaping how care is delivered. Including how engagement has informed and shaped the Trusts plans.

As noted in our statement to the 2020/21 Quality Account, Healthwatch Birmingham and Healthwatch Solihull would like to see varied methods of engaging and enabling access to health care. In theory, the use of technology for citizens to enhance their use of health and care services is a good thing, however, technology can be both an enabler and a barrier to accessing services. Thereby leading to variability in access and care, and health inequality. We would like to read in the 2022/23 Quality Account how the Trusts engagement strategy and inequalities work has informed the adoption of technology in the delivery of care.

We also ask that the Trust reconsiders the issues we raised in our statement to the 2020/21 Quality Account:

- Existing barriers such as language should not be ignored. It is therefore important that guides on how to access mental health services using digital technology are developed in various languages and accessible formats.
- The digital divide that exists among socio-economic classes in Birmingham and Solihull should be taken to account. People from lower socio-economic status often have reduced accessibility to digital technologies. In addition, due to lower household income, people from lower socio-economic status are likely not to have broadband, own a computer or smart phone or indeed afford credit for internet use on their phones.
- According to NHS Digital, 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 to account when considering transforming with digital. For instance, familiarity with modern technology for the elderly and those with language barriers is difficult. It is important that the Trust engages with various groups to ensure that their needs are met.

- It is important that the trust considers developing a digital communication strategy that identifies the diverse ways of engaging and delivering care using technology alongside the relevance of these for different service users.

Healthwatch Birmingham and Healthwatch Solihull agree with the priority goals for the Trust for 2022/23. We recognise many of the issues from our own engagement with the public. In particular improving access to crisis and community care in order to reduce unwarranted variations and harm across the service. We are also pleased to see a focus on understanding health inequalities or aspects of discrimination in the delivery of mental health care. We look forward to reading in the 2022-2023 Quality Accounts how the Trust has involved various stakeholders (including service users and carers) in developing and implementing this aspect of the patient safety priority.

We are pleased to also see continued focus on patient experience, especially on plans to improve the involvement of service users in MDT meetings; involvement of carers in service user care and recovery and ensuring an equal voice for service users at governance level. We look forward to reading in the 2022/23 Quality Accounts how insights from these involvement activities have informed care delivery and improved patient experience. Over the past year, Healthwatch Birmingham and Healthwatch Solihull have seen an increasing number of contacts from service users and carers concerned about access to mental health services. We have seen over the year a greater level of negative feedback for mental health services in the city, with no one leaving us a positive review in the last two quarters of the year. Of the experiences people told us about mental health services:

- For Quarter 4 (January – March 2022) - 94% were negative, and 6% neutral experiences.
- For Quarter 3 (October – December 2021) - 96% were negative with 4% were neutral.
- For Quarter 2 (July – October 2021) - 95% were negative, 3% positive, and 2% neutral: and
- For Quarter 1 (April – June 2021) - 73% were negative, 22% positive experiences, and 5% neutral.

Issues people have told us about have included:

- staff attitudes
- delays accessing the support they need from mental health services.
- lack of support or services from mental health teams
- lack of mental health support for people with a gender identity different from what they were assigned to at birth, either when accessing mental health services, or waiting for an appointment at a gender identity clinic
- being treated as an inpatient out of area, or difficulties visiting their relatives who are receiving inpatient care
- length of time it has taken to receive care following a crisis event such as a suicide attempt
- poor care from home treatment teams.

People have also told us about the effect on their mental health from delays to care and treatment. During the two quarters where we received some positive feedback, people told us about the following:

- mental health help for older people
- access to longer term treatment
- home visits
- supportive staff

Throughout the year, Healthwatch Birmingham and Healthwatch Solihull collect experiences and insights from the Trust's service users, carers, and members of the public. We believe that this is a valuable resource for the Trust that can complement the Trusts engagement activities and help inform or shape the delivery of the priority areas for 2022/23. We look forward to engaging with the Trust through our 'right to respond' program.

1.2 Birmingham and Solihull Clinical Commissioning Group Statement

NHS Birmingham and Solihull Clinical Commissioning Group, as co-ordinating commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for inclusion in the Trust's 2021/22 Quality Account.

A draft copy of the Quality Account was received by the CCG on 17th May 2022 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.

We acknowledge the significant ongoing challenges the Covid19 pandemic has presented throughout 2021/22 and the part the Trust has played in the mental health system response to these challenges. We recognise the impact of the sad loss of staff, service users, families and carers during the pandemic.

We note the Trust's ongoing work around five quality priorities and the Trust's continuing focus on improving outcomes and standards in these areas.

The Trust has kept the CCG regularly updated throughout 2021/22 on its ongoing programme of investment in buildings and equipment aimed at ensuring safer environments across the Trust. This is important work. Equally important is the development work around relational and procedural controls that the Trust has been undertaking, including a focus on multi-disciplinary team working, care planning, risk assessment, safety huddles, engagement with families, increased opportunity for meaningful activity, and the creation of therapeutic rather containing spaces.

The Trust has continued to report on a monthly basis to the Care Quality Commission in response to conditions placed on its registration. The CCG has been kept fully sighted on the response each month.

The work of the Reducing Restrictive Practices collaborative in reducing incidents of prone restraint is to be commended and it is good to see the harm rate of patient safety incidents remaining low compared to other benchmarked mental health trusts
The significant number of community suicides during 2021-22 is saddening.

We recognise there will be several wider societal and economic factors behind this picture, all of which have significant potential to impact on the mental health and wellbeing of our citizens. As a CCG we have continued to work with the Trust to ensure the completed reviews undertaken after each case have had a robust level of joint scrutiny.

The CCG has continued to work with the Trust in undertaking a series of joint themed reviews on areas identified from serious reported incidents. This work has continued to highlight that in a number of areas we require an integrated and consistent mental health system response, rather than single agency response, in order to improve outcomes for our citizens.

The move to an Integrated Care System will allow for a greater focus on mental health system issues. It is a time of tremendous opportunity for local partners to work closely together in order to deliver better outcomes for our citizens. Throughout 2021-22 the Trust has worked with the CCG to help shape and form the emerging systems for quality oversight and governance of mental health programme work. As these arrangements become embedded the Trust will maintain a key role both in service delivery but also in providing assurance to Birmingham and Solihull's Integrated Care Board on the effectiveness of our local mental health system.

1.3 Birmingham and Solihull Mental Health NHS Foundation Trust Council of Governors Statement

In opening this statement, we as the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust would like to formally give our thanks and pay tribute to all staff who have supported our service users, families, carers and each other throughout one of the most challenging periods in the history of the NHS. Their ongoing commitment to provide care in this most challenging period has been remarkable.

The covid pandemic has enabled an element of parity of esteem to be given to mental health due to the enormous impact that Covid 19 has had on the mental wellbeing of our population and as such we have seen demand for our services continue to increase due to economic climate changes, financial implications of loss/impact on employment, relationship breakdowns and pressures and bereavement. The pandemic has displayed and helped us all recognise the importance that our family, carer and social networks have on our ability to live our lives well.

We have recognised that the removal of some of these networks during heightened Covid restrictions may have contributed to an increased level of acuity and consequent serious incidents within the community of people we care for. This has placed more and more importance of the need for strong clinical risk assessments to be undertaken on an individualised basis. We are pleased to see that we recognise the importance of service

user, family, and carer engagement when we are discussing the care needs of individual patients in mental health care and the concerted efforts being made to ensure that improved engagement and 'voice' of patients, families and carers continues as a high priority. In relation to safety measures and reducing harm, we are pleased to see that our nationally benchmarked position for restrictive practice is largely improving, however we remain concerned that improvement is not trust wide. We hope that as the Reducing Restrictive Practice Quality Improvement Collaborative comes to an end change idea which are showing promising signs of delivering will be embedded across the organisation.

Despite the challenges that Covid has presented, we are pleased to see that the majority of the quality goals that we set for ourselves in 2021-2022 have been delivered. We would like to see a stronger focus on measures that demonstrated delivery of the Trust Quality Strategy and goals during 2022/23 inclusive of waiting times and out of area placements. We recognise the importance of ensuring a 'Just Culture' within the organisation so that staff feel safe to speak up about concerns relating to patient safety and feel confident that such concerns are constructively heard and addressed fairly and with a focus on positive change.

We recognise that we still have a journey of improvement ahead of us, it is, however, pleasing to see that we are moving in the right direction. We are supportive of the priorities laid out for 2022/23 and believe they provide an appropriate focus for the next 12 months. We would however in future years like to see more focus on transition points within care as we know that when our service users move from team to team this can result in increased risk and would like a greater focus on understanding if Covid has impacted on community suicides.

As the Council of Governors we would like to extend our apologies and condolences to all families affected by the suicide of loved ones this year. This must be an incredibly tragic time for all. We are supportive of the measures that the Trust is taking to invest in a safer physical inpatient environment through the installation of continuous pressure door sensors on all ensuite bathrooms in our acute inpatient wards. We are equally supportive of the measures to apply such alarms to bedroom doors of high-risk wards. We are pleased to see that we are also developing a 3-5 year capital investment programme to remove anchor points from our entire inpatient estate.

We recognise that improving the physical safety of our wards is only one part of managing safety and are pleased to see that we are increasing the level of therapeutic activities in our inpatient wards to aid the recovery of our service users and that teams are also engaging in daily safety huddles to ensure improved communication of safety issues and management plans. During the year, we have increased our involvement in research and were proud to present both nationally and internationally on the work of our LEAR group which focussed on the experience of lived experience practitioners.

We hope that this will further aid the development and importance of coproduction across the organisation. In concluding this statement, the Council of Governors would like to take the opportunity of thanking the Trust for their

proactive approach to seeking the views of Council throughout the course of 2020/21 and the opportunities that this has brought about for service improvement, enhanced safety and quality of care. We look forward to making even more progress in 2022-2023.

Council of Governors of BSMHFT

Annex 2: Statement of directors' responsibilities for the quality report

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 2021/22 and supporting guidance Detailed Requirements for Quality Reports 2019/20*

- *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 2021 to March 2022*
  - *Papers relating to quality reported to the Board over the period April 2021 to March 2022*
  - *Feedback from commissioners dated 17 June 2022*
  - *Feedback from Governors dated 17 June 2022*
  - *Feedback from local Healthwatch organisations dated* 15 June 2022
  - *The 2020 national patient survey*
  - *The 2020 national staff survey*
  - *CQC inspection report dated 1 April 2019 and subsequent enforcement notice dated December 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 and*
- *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

Roisin Fallon Williams
Chief Executive

Danielle Oum
Trust Chair

8. PEOPLE

8.1. People Committee Chair's Assurance Report

Meeting	**BOARD OF DIRECTORS**
Agenda item	**8.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**
Date	29th June 2022
Author	P. Gayle, Non-Executive Director (Chair of Committee)
Executive sponsor	P. Nyarumbu, Executive Director of Strategy, People & Partnerships

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

Executive summary

The People Committee met on the 22nd June 2022. The attached Assurance Report is provided by the Committee Chair for the attention of the Board.

Reason for consideration

To demonstrate the effectiveness of the assurance process for the Trust's People agenda and to escalate any key issues to the Board of Directors

Strategic objectives/ priorities

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

Financial implications

People are the Trust's largest area of expenditure.
The committee did not make any key decisions of a financial commitment

Risks

The key risk discussed with the Committee related to safer staffing and the shortage of registered nurses across the Trust.

Equality impact

Non specific.

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Quarterly Key Performance Indicators

The Committee received the quarterly report detailing the progress against the key performance indicators. The key messages included the fill rate for bank remained challenging and the Trust has been utilising several incentives to attract staff. The medical spend had increased and there were a number of recruitment drives underway. Appraisals rates had increased along with fundamental training which was due to intensive work being undertaken by HR staff. There had been a significant increase in performance regarding temporary staff completing IG training.

The sickness level had slightly increased compared to last month with two directorates being outliers and had recovery plans in place.

The Committee discussed flexible working and it was reported that the Trust was part of the national programme on flexible working with a cultural piece of work required to ensure managers saw flexible working as a valuable way to the delivery of services. Work was also underway within HR to ensure the data was captured across the Trust regarding how this was being addressed. It was reported that the Trust had changed the template for adverts to ensure flexible working was seen as an option for applicants.

Chair's Assurance Comments:
With regards to the vacancy fill rates the committee did receive reassurance that the focus is to continue utilising different initiatives to reduce vacancies, particularly the hard to recruit posts. The committee were updated on some of the actions on targeted work which have already taken place. However, although we were informed of the several activities used to address the Trust vacancies, the committee could not be assured that these were reducing our vacancy rates as we were informed the current data was not available for this meeting. Fill rates for Bank staff remain a challenge and several different incentives have been applied such as additional pay premium to encourage and attract people to work in the areas which are difficult to fill vacant shifts particularly for RMN.

In addition, the committee discussed the medical vacancy situation which remains quite challenging. The Committee was assured that there were no areas across our services without doctor cover, but due to agency usage, costs have been rising. The Committee were informed that the vacancy level within the Trust was aligned in all different speciality' areas across the Country and unfortunately this is problematic nationwide.

1.2 Integrated Performance Report

The Committee received the Integrated Performance Report and there were four key risks which included out of area, IAPT, Workforce and the financial plan.

Chair's Assurance Comments:
The Committee noted within the report that fundamental training and sickness there had been slight improvements across operational services within the last month which was encouraging.

1.3 Financial Wellbeing

A paper was received by the Committee on financial wellbeing provided assurance on the actions being taken regarding the increasing cost of living expenses for employees at the Trust. This included overtime payments, support for the cost of increasing fuel prices, fuel cards, childcare facilities, food banks and subsidised meals.

Chair's Assurance Comments:
The Committee welcomed this paper and were assured that the initiatives to address the Trusts supporting our employees in response to the cost-of-living expenses and the impact of this crisis on our staff were appropriate. The Committee discussed that pace was essential along with an effective communication plan to ensure staff understand how they may be placed in relation to the financial wellbeing areas.

1.4 Escalation from Safer Staffing Committee

The Committee received the escalation report from the Safer Staffing Sub Committee which had met in May and June. At the May meeting, the Sub Committee had a live demonstration of Safe Care. This would allow management teams to assess the staffing levels in real time and should be able to provide adequate opportunity to move staff around to support patient care. This was to be implemented in one pilot area with the view to be trust wide by October 2022. In addition, at the May meeting a paper was presented on medical workforce along with an update on acute workforce plans.

At the June meeting, the Sub Committee approved the Terms of Reference for the Sub Committee and were presented to the People Committee for formal approval. A report was presented regarding commencing the establishment reviews across 49 inpatient wards, this would use a combination of MHOST and Clinical Judgement. Funding has been ringfenced to support the highest clinical risk areas from the outcome of the reviews. The Safer Staffing Policy was discussed, and amendments made before it was circulated for consultation.

Chair's Assurance Comments:
The Committee were informed that the Safer Staffing Sub Committee stated significant concerns remain with regards to staffing and vacancies. The People Committee were asked to support the recommendations already approved at the safer staffing committee. All were approved although the recommendation to support an overarching plan for temporary service suspension/change if our staffing levels become critical to be included in the Safer Staffing Policy. The People Committee raised some concerns around the insertion of this statement in the policy as it was felt a Board discussion may need to be held regarding taking the decision to temporarily close services. However, this statement was approved in principle. The Committee approved the Terms of Reference for the SSC.

1.5 Safer Staffing Report

The Safer Staffing report was received, and it was noted that the work of the Safer Staffing Committee would be reviewing the long-term plans for the workforce. However, in relation to the short term, the Director of Nursing & Quality (Chief Nurse) reported that there was a significant concern regarding the risk being carried by the Trust in relation to the registered nursing (RN) workforce. The stark reality for the Trust was that if there was not enough registered nurse workforce, services may need to be stopped, then the Trust needed to be fully aware of when that threshold would be.

It was reported that there were several shifts working with one RN on duty and the Committee could not be fully assured that this could be fully mitigated, and the concerns were highlighted regarding the impact on quality and specifically on patient experience. It was reported that when establishment reviews had been undertaken then there would need to be a Board discussion and a requirement to invest in the registered workforce. The reviews would ensure unregistered nursing support however discussions would be required regarding how many beds could be safely staffed.

The Committee was briefed on the overseas recruitment drive which hoped to attract staff for 30 vacancies, but it would take between 6 – 12 months before the impact would be seen. The Committee would be kept fully briefed on the position and actions being taken.

.***Chair's Assurance Comments:***

The Committee were informed that there are significant concerns around the registered nursing workforce, limited numbers particularly in Acute and urgent care divisions. We were, informed assurance could not be given due to the risks highlighted around insufficient staffing which could not be fully mitigated. Staff are not always able to engage in therapeutic activities as the focus is about keeping service users/patients safe.

The Committee were informed that once the establishment reviews have been concluded, inevitable requests will be proposed and future consideration and discussion will need to be had on significant prioritization decisions, given the limited funding available.

1.6 Staff Survey Deep Dive

The Committee received a presentation on the staff survey results to provide assurance to the Committee on the development of the staff survey action plans**.** In addition, it described the corporate interventions that have or would be developed. The Committee was informed that through the Performance Delivery Group, Divisions and corporate teams would be held accountable for the delivery of the action. It was noted that there had been significant push back from pockets within the Trust questioning why there was a focus on discrimination and bullying and harassment.

Chair's Assurance Comments:

The Committee were pleased and assured that actions and plans are in place to address some of the key areas raised in the staff survey and we look forward to seeing improvements made in the future. There is further work around anti racism and bullying. The Committee were pleased to hear that a policy is currently being developed to address racism with clear actions that are planned, strategic and sustainable.

The Committee were informed the OD team have stated this is the first time within the Trust that they have seen high numbers of engaged managers who want to take ownership of improving staff experience within their teams which the Committee felt was encouraging. The Committee were informed that PN and his team will be holding the divisions and corporate teams accountable for delivery of the plans which is about local ownership. The Committee heard that we still have significant push back on pockets within the organisation on why the Trust is focusing on discrimination and bullying and harassment so there is still more work to do but we are heading in the right direction.

PHILIP GAYLE
NON-EXECUTIVE DIRECTOR
22nd June 2022

9. SUSTAINABILITY

9.1. Finance, Performance & Productivity Chair's Assurance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**9.1**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	29th June 2022
Author	R. Beale Non Executive Director (Chair of Committee)
Executive sponsor	D. Tomlinson, Executive Director of Finance

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

Executive summary
The FPP Committee met on the 22nd June 2022 The attached Assurance Report is provided by the Committee Chair for the attention of the Board.
Reason for consideration
To demonstrate the effectiveness of the assurance process for the Trust's sustainability agenda and to escalate any key issues to the Board of Directors
Strategic objectives/ priorities
Sustainability
Financial implications
Detailed within the report
Risks
Equality impact
Non specific.
Our values
Committed Compassionate Inclusive

CHAIR'S ASSURANCE REPORT FROM FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 Finance Performance

The month 2 finance report was received, and it was reported that the position was slightly behind plan as reported at month one and this included added pressures of electricity costs, with the position being £400k worse than plan.

In relation to national guidance, organisations had been asked to include in month 2, two months of an assumed pay award of 2% (yet to be approved nationally) which had been offset by additional funding discussed last month equating to £400k for the Trust. There were ongoing pressures around temporary staffing and in terms of the segmental element, this related to £18k deficit in SSL with Reach Out reporting a breakeven position.

At month 2 there was a significant increase relating to medial agency which was driven by significant increases in acute and emergency care and ICCR. This has resulted in a position which was £300k above this time last year.

In relation to capital spend, a relatively low spend was forecasted for month 1 at £100k. It was reported that there the Trust was waiting for notification on two new capital allocations, one for urgent and emergency care for mental Health only which would be £3m over 3 years for the system and national funding for a dedicated seclusion suite for child and adolescent mental health service.

The Committee was informed that the process for capital prioritisation was being amended as it was apparent that the way this had been previously implemented had led to delays. It was also noted that the Trust had to deal with the challenges of unrealistic expectations from the Centre when either funds were made available and had to be allocated and spent quickly or funds had to be allocated on very specific areas. The Committee was pleased to note that the Deputy Director of Finance was a member of the mental health group at the HFMA where lobbying could be undertaken on a national issue regarding the financial elements affecting mental health

The Committee did note that there was insufficient capital and that the Trust would be constrained as the system capital envelope was £70m.

Chair's Assurance Comments:
Agency costs, mostly medical, are substantial, and whilst we were assured that the relevant controls and checks on approving them are in place, we are not assured that we can improve the permanent staffing situation substantially in the short (or medium) term. We note that a start towards more innovative working is happening but are concerned that the ambition and scope is insufficient at present.

In addition, given inflation is substantially above 2%, there may be huge future pressures for cost-of-living increases which make the financial situation more challenging.

Capital prioritization needs to work more efficiently so that we can start programmes at the start of the year, ensure we are tacking the most pressing needs, and be in a position to respond to offers of funding from the centre, whether by showing it on our priority list, or discussing that list to divert the offer of funds. The DDF's role in helping shape those priorities and processes is helpful. We did not discuss the issues behind the current problems in prioritization and so will receive more information on the changes and how that will solve the problems in due course. Until that happens this is an area of risk for us.

1.2 Integrated Performance Report

The Committee was presented with the Integrated Performance Report discussed the presentation of the information being provided for assurance.

Discussions were held regarding the format and content of the report and being able to triangulate the information being presented. This included being more predictive regarding where the pressures were in the Trust. For example, addressing the pressures in the community to prevent patients coming in for emergency treatment. It was important to use the information to monitor areas and to escalate concerns.

The Committee agreed to raise three specific performance metrics with the Board which are (a) long waits in IAPT, (b) Referrals over 3 months with no contact where the figures in April 2021 were 2227 and were currently at 2636 in May 2022. and (c) CPA with formal review within the last 12 months with performance in this metric consistently declining over the last year and has been outside the control limits since July 2019. The Committee had requested the Associate Director of Operations to feedback to the services on these three specific areas where detailed assurance was required.

Chair's Assurance Comments: *The committee discussed the approach taken with the interactive dashboard, and whether it gave the information required regarding the causes of issues, the actions being taken, and the effects of those actions. We felt that the format was correct but that the narrative (the 'blue sheets') was not either up to date or detailed enough. We wanted to see specific plans for action, ways to measure the effectiveness and timescales, and progress against those plans. Thus we would then be able to asses which were on track to improve, and which needed more attention.*

The three areas identified are well off their targets, have been for a long time, and do not seem to be responding to current actions to improve them, and we feel that the board should have sight of these.

1.3 Recovery and Restoration with a focus on face-to-face appointments

The Committee received a report providing an update on the recovery status of face-to-face clinical interventions across all services in each

directorate. The data sets included the trends over the past quarter providing an indication of the future trajectory. The paper outlined the approach taken by each service to address the key challenges whilst acknowledging the recovery process would adopt a hybrid approach of working and not return to full face to face contact. There had been a discussion at the last Performance Delivery Group regarding the Trust approach and those of other organisations.

The Committee was assured that each clinical area were reviewing the ratio of face to face appointments based on patient and clinical need.

Chair's Assurance Comments:
This paper provided an update on how face to face contact was resuming, but the committee felt that there was overmuch attention on the return to things as they were rather than an assessment of the benefits and issues of remote working and approaches to provide the best of both worlds. There was no information on how digital working was being developed and promoted and integrated. We were assured that processes are in place to return to more normal forms of working, but are less confident that these are now the right ways for all service users and staff and did not see much evidence of a coordinated and structured approach to developing an integrated offering. Without this we cannot manage the increased demands with the limited resources we have: much more work on changing the culture to changing work practices is needed.

1.4 Trust Strategy: Sustainability Goals

As discussed at the May Board of Directors meeting, it was agreed that individual committees would consider the relevant elements of the Strategy and determine priorities and the appropriate means of monitoring these. Therefore, for the FPP Committee a report was received which elements of the goals regarding Clinical Services and the goals relating to Sustainability.

As reducing inequalities is a key priority for the Trust, the paper included inequalities-related goals.

The Committee discussed grouping and theming issues and prioritizing goals against the areas of the biggest risks and to simplify the messages. Comments on the overall structure of the goals would be reviewed.

Chair's Assurance Comments:
We are concerned that the large quantity of strategic goals makes identifying key issues hard, hence the grouping and thematic ideas. Given that we are embedded in the strategy and its documentation, and find it confusing and hard to follow, we feel that the majority of the organization will have a challenge relating to it and using it to shape their work and visions. We therefore have concerns that it is not going to be as effective as it might be because the messaging is not clear.

1.5 Reach Out Commissioning Sub Committee

A. Baines, chair of the Sub Committee, provided an update from the meeting held on the 9th June 2022. The Committee was informed that the Sub Committee had expressed frustration regarding NHSE/I still negotiating elements of the contract with partners which Reach Out was not in control off. However, the Sub Committee was partially reassured by officers that there was currently no great risk to the collaborative.

The Sub Committee had been joined by a Non-Executive Director from Coventry and Warwickshire who were the lead for Learning Disability & Autism (LDA) and there to ask the appropriate questions on the area of LDA.

The Associate Director for Reach-Out, Eddie O'Neil had undertaken a review on the delivery plan where it was reported that there had been progress within some areas and where there had been slippages this had been due to appointments into posts and the impact of COVID. The Committee was assured of the progress being made and there was a process in place to develop the action plan.

There was a good piece of work undertaken regarding leadership development within the Mental Health element Reach Out and it was clear from the report that the relevant staff had been able to take part in the discussions.

As a result of the engagement, an organisational development plan would be developed for Reach Out and a similar piece of work would be undertaken with LDA.

It was noted that there was management capacity issues for operational staff who were managing services day to day and were also required to contribute to the development of specific elements of services. Therefore, it was important to recognise that the ambitions may be compromised regarding what could realistically be achieved.

Chair's Assurance Comments:
We were assured by the report and noted the areas of concern. Issues of management capacity come back to staffing and need some further attention.

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RUSSELL BEALE
NON EXECUTIVE DIRECTOR
22nd June 2022

9.2. Integrated Performance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**INTEGRATED PERFORMANCE REPORT**
Date	29th June 2022
Author	Richard Sollars, Deputy Director of Finance Rob Grant, Interim Associate Director of Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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

- FPP – Out of area bed use, IAPT, CPA 12-month reviews, CPA 7-day follow up, new referrals not seen, financial position and CIP
- People – Vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness. Also the divergence in performance between different teams
- QPES – Ligature incidents

There was discussion at FPP regarding the fitness for purpose of the report and it was agreed that the approach used in directing the attention of the Committee to relevant areas of concern was good. There was, however, concern about a lack of transparency around improvement plans with no information regarding how the Trust is doing against improvement trajectories.

In addition, FPP agreed to escalate to the Board concerns regarding the following performance metrics, where no meaningful improvement is being achieved:

- Service users on CPA with a formal review in the last 12 months
- IAPT waiting times
- Out of Area bed days
- Referrals over 3 months old with no contact

Reason for consideration:

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

Previous consideration of report by:

Executive Team and Performance Delivery Group

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

Clinical Services, Quality, People and Sustainability

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

Integrated Performance Report

Context

New sets of metrics are being finalised for all four domains following approval of the Trust Strategy and will involve some transition.

We will move to new reporting cycles as previously agreed by the Board in the near future, though the exact date is unclear. We will continue to report the overall Trust position and overall performance to the first meeting following the month in question but supplement this with a triangulated, more detailed thematic review to provide more insights and intelligence into what's happened, the consequences and planned improvements. As an example, in September the Board would receive aggregate performance information regarding August supplemented by a more detailed analysis of July's performance.

The SPC-related charts are being updated in the days before the Committee meetings and can be accessed if you are on the Trust network via

http://wh-info-live/PowerBI_report/IntegratedDashboard.html - please copy and paste this link into your browser.

Charts and commentaries for key areas of under performance are attached as appendices

Performance in May 2022

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

- **Out of Area Bed Use** – Some process improvements have helped us address underlying issues, but the impact of COVID-19 and the closure of beds has significantly impaired our ability to eliminate use of out of area beds. April's figure is 14 patients
- **IAPT** – As discussed at FPP, there is a range of issues which require a system approach to resolve and additional investment
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. This has deteriorated as a result of COVID, but the overall divergence between individual teams has long been a concern:
- **Financial position and CIP** – Financial position for 2022/23 is adverse to plan

Quality

- Ligature incidents with no anchor point down from 49 to 31 – with anchor point 0
- **Key concerns: Ligature incidents**

Performance

- The level of Out of Area Patients remains a concern. The national requirement was for this to be eliminated by April, but this was renegotiated to September 22. The figure for May is 520 occupied bed days (16.7 patients), up from April 416 OBD (13.9). The elimination of acute bed days is anticipated in the next month or so, though PICU Out of Area stays will remain problematic

- IAPT patients seen within 6 weeks of referral has deteriorated to 30.1% and remains a real concern. This is being discussed across BSol to identify how to address underperformance. Performance for within 18 weeks is also problematic at 65.3%
- IAPT moving into recovery down from 52.6% to 47.5%
- CPA with formal review in last 12 months down to 84.9%, lowest level in four years
- CPA 7-day follow up down from 93.2% to 91.0%, 20% in Specialties and 25% in ICCR
- New referrals not seen within 3 months are of concern and up to 2,636
- **Key concerns: Out of Area, IAPT waiting times, CPA 12-month review, CPA 7-day follow up and new referrals not seen in 3 months**

People

- The People domain continues to show the most significant adverse impact from COVID-19, with staff availability and well-being at particular risk and requiring most focus. Scores are of concern across the board
- Vacancy information not yet available – being amended to allow for transformation
- Sickness levels have fallen from 6.6% to 6.1%. Variation: Corporate 3.4% v Secure 8.0%
- Appraisals down from 85.8% to 84.8% and still significantly below pre-COVID levels and target
- Fundamental training up from 91.8% to 92.9% and improvement seen in IG training. Little variation between directorates
- Bank and Agency fill up from 82.2% to 83.2%
- **Key concerns: Vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness**

Sustainability

- Financial position for the first two months is a deficit of £0.8m against a planned deficit of £0.4m, chiefly arising from the inclusion of an accrual for the pay award
- Capital expenditure for the first two months is £108k, £204k less than plan. An under spend on carry forward schemes is partly offset by backlog maintenance expenditure ahead of plan
- Information Governance position has fallen back to 81%, mainly because of serious IG incidents reported to the Information Commissioner's Office. Training of temporary staff has improved and is set to improve further
- Cash and property standards remain well above target

Integrated Performance Dashboard

BOARD OF DIRECTORS MEETING PART I

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: Out of Area is improving. IAPT remain key problems

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

May 2022

Performance

CPA 7 day FU	91.0% ↓
CPA with Formal Review last 12 mths	84.9% ↓
Data Quality Maturity Index (DQMI)	97.1% ↑
Delayed Transfer Bed Days	1161
Delayed Transfer, percent of bed days	7.3% ↘
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	47.5%
IAPT seen in 18 weeks	65.3% ↓
IAPT seen in 6 weeks	30.1% ↓
Out of Area Bed Days	520 ↑
Referrals over 3 mths with no contact	2636 ↓

People

Bank & Agency Fill Rate	83.2% ↓
Fundamental Training	92.9% ↓
Rolling 12m Turnover	10.2% ↑
Staff Appraisals	84.8%
Staff Sickness	6.1% ↓

Quality

Absconsions from inpatient units	8
Commissioner reportable incidents	2 ↑
Community confirmed suicides	0
Community suspected suicides	0
Failure to return	16 ↑
Incidents of self harm	167 ↑
Incidents resulting in harm (other)	12.5% ↑
Incidents resulting in harm (patients)	13.4% ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	31
Ligature with anchor point	0
Patient assaults	51
Patient ssaults / 1000 OBD	2.7

Sustainability

CAP Ex	£108k
Cash	£55,444k ↑
CIP	£0k
Info Governance	81.1%
Monthly Agency	£689k
Operating Surplus	£632k
Property	98.5% ↑
SOF rating	3

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

compassionate inclusive committed

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: Out of Area is improving. IAPT remain key problems

People: Continues to be adversely affected by COVID

Quality: Staff and Patient assaults

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

May 2022

Performance

CPA 7 day FU	91.0% ↓
CPA with Formal Review last 12 mths	84.9% ↓
Data Quality Maturity Index (DQMI)	97.1% ↑
Delayed Transfer Bed Days	1161
Delayed Transfer, percent of bed days	7.3% ↘
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	47.5%
IAPT seen in 18 weeks	65.3% ↓
IAPT seen in 6 weeks	30.1% ↓
Out of Area Bed Days	520 ↑
Referrals over 3 mths with no contact	2636 ↓

People

Bank & Agency Fill Rate	83.2% ↓
Fundamental Training	92.9% ↓
Rolling 12m Turnover	10.2% ↑
Staff Appraisals	84.8%
Staff Sickness	6.1% ↓

Quality

Incidents resulting in harm (patients)	13.4% ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	31
Ligature with anchor point	0
Patient assaults	51
Patient ssaults / 1000 OBD	2.7
Physical restraints	339
Physical restraints/ 1000 OBD	18.1
Prone restraints	43 ↑
Prone restraints/ 1000 OBD	2.3 ↑
Reported incidents	2353 ↑
Staff assaults	103
Staff assaults / 1000 OBD	5.5

Sustainability

CAP Ex	£108k
Cash	£55,444k ↑
CIP	£0k
Info Governance	81.1%
Monthly Agency	£689k
Operating Surplus	£632k
Property	98.5% ↑
SOF rating	3

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

compassionate inclusive committed

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
CPA 7 day FU	95.00	90.7%	94.4%	92.0%	93.5%	93.2%	91.0% ↓
CPA with Formal Review last 12 mths	95.00	87.1%	85.9%	86.3%	86.5%	85.2%	84.9% ↓
Data Quality Maturity Index (DQMI)	95.00	97.8%	97.8%	97.5%	97.1%	98.4%	97.1% ↑
Delayed Transfer Bed Days		1070	954	751	1001	1005	1161
Delayed Transfer, percent of bed days		6.9%	6.1%	5.2%	6.3%	6.5%	7.3% ↘
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Eating disorders urgent	95.00	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% ↑
IAPT into recovery	50.00	54.0%	47.2%	51.2%	49.9%	52.6%	47.5%
IAPT seen in 18 weeks	95.00	76.0%	70.2%	69.6%	64.9%	64.6%	65.3% ↓
IAPT seen in 6 weeks	75.00	29.5%	27.4%	26.8%	23.7%	33.7%	30.1% ↓
Out of Area Bed Days	279.00	583	553	332	270	416	520 ↑
Referrals over 3 mths with no contact		2611	2627	2641	2538	2577	2636 ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* Out of Area is improving
* IAPT
* CPA 12-month review
* New referrals not seen in 3 months

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

Integrated Performance Dashboard

BOARD OF DIRECTORS MEETING PART I

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Staff Vacancies		10.4 %	10.2 %	9.5%	8.0%		
Staff Sickness	4.28	6.6%	7.8%	6.3%	6.1%	6.6%	6.1% ↓
Staff Appraisals	90.00	81.2 %	81.6 %	83.4 %	84.7 %	85.8%	84.8%
Rolling 12m Turnover		9.6%	9.7%	9.7%	10.2 %	10.2%	10.2% ↑
Fundamental Training	95.00	93.3 %	92.7 %	91.9 %	91.6 %	91.8%	92.9% ↓
Bank & Agency Fill Rate		81.1 %	84.2 %	85.1 %	83.0 %	82.2%	83.2% ↓

Top Line Commentary (Trust level)

KEY CONCERNS

* Vacancies
* Shift fill rates
* Fundamental training
* Sickness
* Appraisal rates

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

Integrated Performance Dashboard

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	
Absconsions from inpatient units		3	2	2	5	3	8	
Commissioner reportable incidents		8	6	6	11	17	2	↑
Community confirmed suicides		0	1	0	0	0	0	
Community suspected suicides		0	1	3	3	3	0	
Failure to return		12	8	6	11	13	16	↑
Incidents of self harm		151	134	137	166	167	167	↑
Incidents resulting in harm (other)		13.8%	13.0%	14.1%	15.8%	16.7%	12.5%	↑
Incidents resulting in harm (patients)		16.5%	14.9%	15.1%	17.7%	17.4%	13.4%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	1	0	
Ligature no anchor point		42	30	37	49	49	31	
Ligature with anchor point		3	5	2	2	4	0	
Patient assaults		41	41	38	43	39	51	
Patient ssaults / 1000 OBD		2.2	2.2	2.2	2.3	2.1	2.7	

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
		%					
Incidents resulting in harm (patients)		16.5 %	14.9%	15.1%	17.7%	17.4%	13.4% ↑
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	0	0	1	0
Ligature no anchor point		42	30	37	49	49	31
Ligature with anchor point		3	5	2	2	4	0
Patient assaults		41	41	38	43	39	51
Patient ssaults / 1000 OBD		2.2	2.2	2.2	2.3	2.1	2.7
Physical restraints		214	193	207	223	196	339
Physical restraints/ 1000 OBD		11.4	10.2	12.1	11.9	10.8	18.1
Prone restraints		36	29	55	59	41	43 ↑
Prone restraints/ 1000 OBD		1.9	1.5	3.2	3.1	2.2	2.3 ↑
Reported incidents		2178	2008	2010	1979	2110	2353 ↑
Staff assaults		83	92	101	102	84	103
Staff assaults / 1000 OBD		4.4	4.9	5.9	5.4	4.6	5.5

Top Line Commentary (Trust level)

KEY CONCERNS

* Staff and patient assaults

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

Integrated Performance Dashboard

BOARD OF DIRECTORS MEETING PART I

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
CAP Ex		£766k	£220k	£3,614k	£4,088k	£49k	£108k
Cash		£52,956 k	£55,797k	£59,011k	£54,799k	£53,617k	£55,444k ↑
CIP		£374k	£374k	£374k	£374k	£0k	£0k
Info Governance		84.4%	87.4%	85.4%	89.5%	91.1%	81.1%
Monthly Agency		£575k	£507k	£800k	£551k	£520k	£689k
Operating Surplus		-£463k	-£681k	£456k	£3,406k	£157k	£632k
Property		98.5%	98.5%	98.5%	98.5%	98.5%	98.5% ↑
SOF rating		2	2	2	2	3	3

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

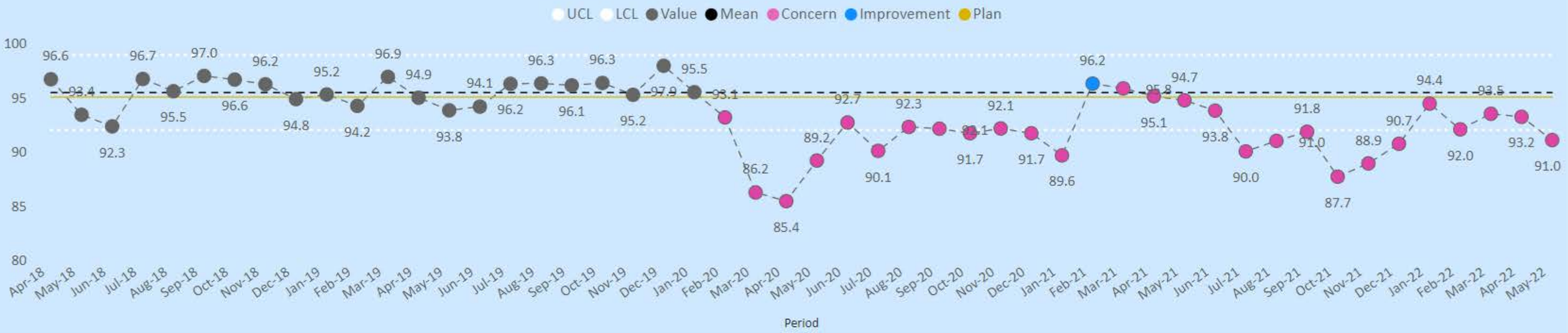
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

Divisions

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	90.7%	94.4%	92.0%	93.5%	93.2%	91.0%
B: Acute and Urgent Care	75.0%	84.6%	80.8%	51.9%	79.3%	65.8%
C: ICCR	75.0%	60.0%	57.1%	66.7%	40.0%	25.0%
D: Secure Serv & Offender Health	0.0%		100.0%	100.0%	50.0%	
E: Specialties	50.0%	66.7%	100.0%	50.0%	50.0%	20.0%

Commentary

National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 91.04% for May 2022, and is currently outside control limits.

This relates to 12 outstanding follow ups from 134 discharges in May of which, 3 patients were discharged to the care of FTB, 1 patient was discharged to the care of another trust, 1 patient absconded from the ward and was then arrested, 2 patients were discharged to a general hospital and contact was with staff only, and 1 patient cannot be located and has been reported as a missing patient to the police. 3 will be passes when data entry has been completed. Of the 12 exceptions 4 were acute adult, 3 were older adult, 2 were from ICCR and 3 from secure services.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

CPA 7 day FU

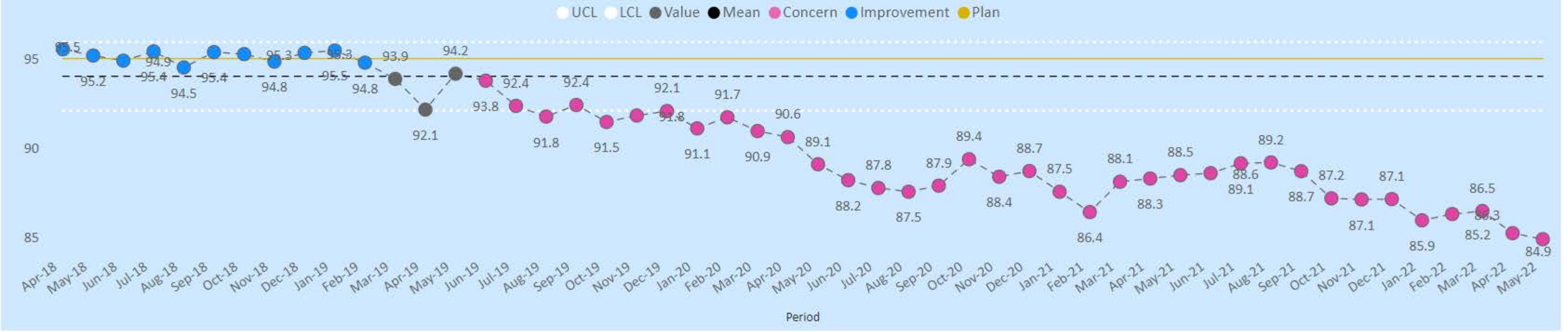
May - 2022

Question	Answers
A: What has happened?	National quality standard of 95% - compliance routinely maintained prior to the impact of COVID 19. Since March 2021, performance has been marginally below 95% and is at 91.04% for May 2022, and is currently outside control limits. This relates to 12 outstanding follow ups from 134 discharges in May of which, 3 patients were discharged to the care of FTB, 1 patient was discharged to the care of another trust, 1 patient absconded from the ward and was then arrested, 2 patients were discharged to a general hospital and contact was with staff only, and 1 patient cannot be located and has been reported as a missing patient to the police. 3 will be passes when data entry has been completed. Of the 12 exceptions 4 were acute adult, 3 were older adult, 2 were from ICCR and 3 from secure services.
B: Why has it happened?	Impact of COVID, operational pressures, staff sickness levels have impacted on this measure including ability to access care homes during the COVID period. Where service users have been discharged to other mental health services to undertake the follow up, this requires BSMHFT to check with them to see if this has taken place. During the last year we have not been asking services to undertake these checks as it is an additional burden on staff but this is now being lifted. completing data entry on rio would take performacne in May to 93.2%.
C: What are the implications and consequences?	Early follow up of patients post discharge prioritised by HTT in line with evidence based practise to reduce the risk of suicide or self harm. Service users are at a higher risk of suicide or self harm within the first 3-7 days of discharge and follow up is important to minimise this risk.
D: What are we doing about it?	Daily notifications of discharges are sent to the responsible team to alert them to plan follow up and this is monitored by the CSM for Home Treatment. Teams continue to require support from the information team regarding data entry on RIO. The addition of FTB data to the shared care record will also enable staff to check if patients have been followed up.
E: What do we expect to happen?	We expect 7 day follow up standard of 95% to be maintained with HTTs acting on the daily discharge notification received once the COVID restrictions are lifted.
F: How will we know when we have addressed issues?	Standard is being maintained with minimal or no input required from the information team to review data entry.

CPA with Formal Review last 12 mths

Divisions

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	87.1%	85.9%	86.3%	86.5%	85.2%	84.9%
B: Acute and Urgent Care	66.7%	0.0%	50.0%	0.0%	0.0%	10.0%
C: ICCR	85.4%	84.4%	84.4%	84.9%	84.3%	83.5%
D: Secure Serv & Offender Health	98.1%	97.5%	97.0%	97.1%	97.0%	97.3%
E: Specialties	71.7%	68.5%	70.8%	68.8%	69.5%	69.0%

Commentary

Performance has consistently declined over the last year and has been outside the control limits since July 2019. The rate was maintained at an average of 89% since April 2021 until October which declined to 87%. This was sustained until January 2022 which reduced to 86% and maintained until March 2022. April 2022 has reduced to 85% with May at 84.8%. Adult CMHT account for 54%, older adult CMHT for 4%, Secure for 14% and AOT for 22%.

CPA with Formal Review last 12 mths

May - 2022

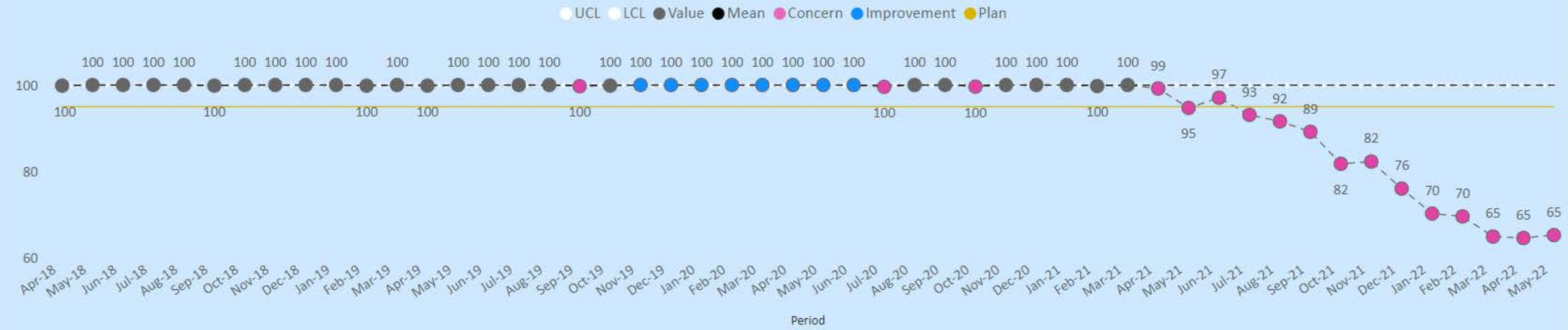
Question	Answers
A: What has happened?	Performance has consistently declined over the last year and has been outside the control limits since July 2019. The rate was maintained at an average of 89% since April 2021 until October which declined to 87%. This was sustained until January 2022 which reduced to 86% and maintained until March 2022. April 2022 has reduced to 85% with May at 84.8%. Adult CMHT account for 54%, older adult CMHT for 4%, Secure for 14% and AOT for 22%.
B: Why has it happened?	During the COVID period face to face contacts have reduced with staff using digital solutions such as AccuRx and telephone calls to conduct appointments. Meetings with multiple people cannot take place unless co-ordinated on teams and remains challenging at the moment.
C: What are the implications and consequences?	Carrying out as a minimum an annual CPA reviews is key to ensuring that the service user's care plan is updated to reflect changes in service users' needs, care and support requirements.
D: What are we doing about it?	Exception reports outlining service users coming up for their annual CPA review are available to all teams to enable proactive action in advance of the 12 months expiring. Work has taken place to address data quality issues in HTT, specialties and secure care. A further review of outstanding reviews took place in November 2021 and identified a number of CPA reviews which have taken place in external settings but not recorded on Rio. A plan to strategically review the CPA process including care plans has commenced with plans to introduce a new care plan in line with changes outlined in national guidance. Changes to the process in the community will be based on clinical models developed as part of the transformation work and in line with the NHSE statement on CPA. Services are developing plans to increase the number of face to face appointments.
E: What do we expect to happen?	Due to current circumstances and challenges to conduct appointments, the position is unlikely to improve.
F: How will we know when we have addressed issues?	Currently part of ongoing strategic service review discussions.

IAPT seen in 18 weeks

Divisions

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	76.0%	70.2%	69.6%	64.9%	64.6%	65.3%
E: Specialties	76.0%	70.2%	69.6%	64.9%	64.6%	65.3%

Commentary

Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 11 months. levels have been sustained in April and may at 65%. The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in a timely way. The majority of contact with service users remains via telephone and this is not always the most suitable form of contact and there is limited physical space in primary care to offer face to face appointments.

Detailed Commentary

IAPT seen in 18 weeks

May - 2022

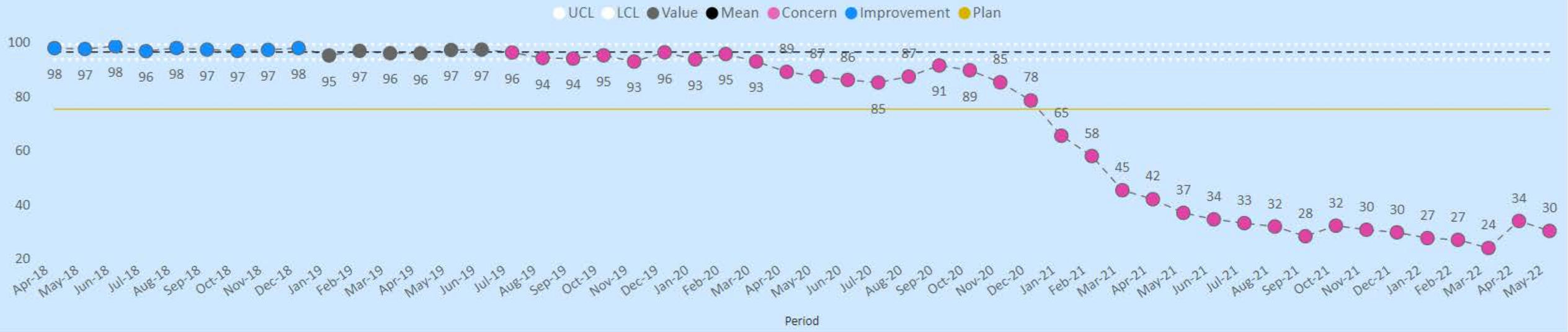
Question	Answers
A: What has happened?	Performance has been on a reducing trend for the last 12 months and has been below the 95% target for the last 11 months. levels have been sustained in April and may at 65%. The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in a timely way. The majority of contact with service users remains via telephone and this is not always the most suitable form of contact and there is limited physical space in primary care to offer face to face appointments.
B: Why has it happened?	Ability to see patients face to face has been impacted by Covid as access to GP surgeries and community facilities were stopped. Face to face contacts have increased in BHM premises but need to be undertaken in a COVID secure way and capacity is reduced in number. The service has a large number of vacancies with additional challenges around retention, with staff leaving to take further training or moving to posts which attract higher bandings elsewhere.
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Timely access to IAPT services aims to support service users in managing their anxiety and depression and to enable adoption of recovery/management strategies to improve long-term outcomes including reduced need for mental health services in the future.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. A number of strands of work have been identified both internal and external. Internally: a communications strategy to support increasing activity, HR support to help implement a preceptorship from band 6 to 7 and address recruitment issues and review of clinical space in order to recommence groups and face to face activity. Externally: A review of Long term conditions pathway, prioritising where additional investment can be focused and ongoing review through IAPT forum with regional IAPT team.
E: What do we expect to happen?	To slowly increase the face to face offer and increase capacity which will take time to implement.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 95% target

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 6 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	29.5%	27.4%	26.8%	23.7%	33.7%	30.1%
E: Specialties	29.5%	27.4%	26.8%	23.7%	33.7%	30.1%

Commentary

Performance has been on a reducing trend since March 2020 below the 75% target. April 2022 increased by 10% to 33.7% followed by a reduction in May to 30%.
The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in a timely way. The majority of contact with service users remains via telephone and this is not always the most suitable form of contact and there is limited physical space in primary care to offer face to face appointments.

Detailed Commentary

IAPT seen in 6 weeks

May - 2022

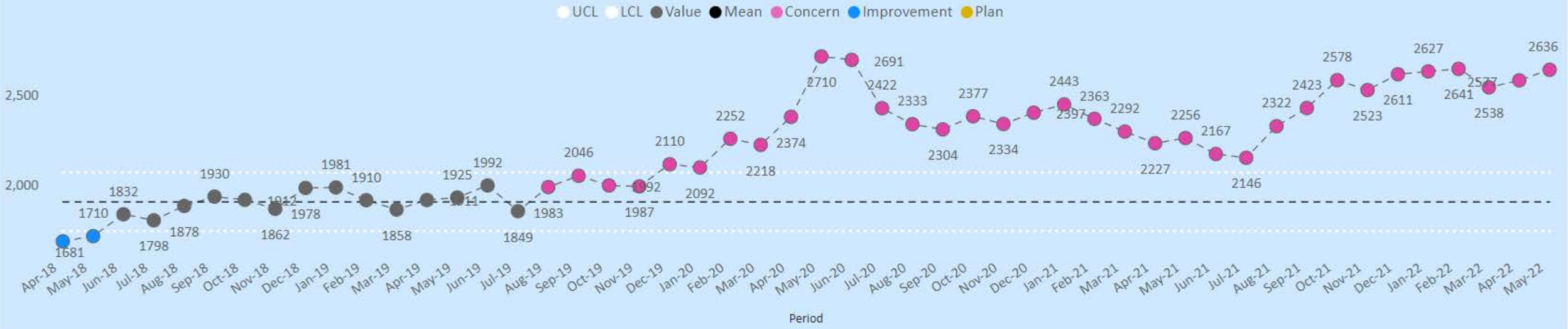
Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 below the 75% target. April 2022 increased by 10% to 33.7% followed by a reduction in May to 30%. The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in a timely way. The majority of contact with service users remains via telephone and this is not always the most suitable form of contact and there is limited physical space in primary care to offer face to face appointments.
B: Why has it happened?	Ability to see patients face to face has been impacted by Covid as access to GP surgeries and access to community facilities stopped. Face to face contacts have increased in BHM premises but need to be undertaken in a COVID secure way and capacity is therefore reduced in number. The service has a large number of vacancies with additional challenges around retention, with staff leaving to take further training or moving to posts which attract higher bandings elsewhere.
C: What are the implications and consequences?	In response to the COVID impact, NHSE/I and commissioners issued support recognising that performance in complying with national standards may be impacted and that performance would therefore be monitored from an assurance perspective during this time. Timely access to IAPT services aims to support service users in managing their anxiety and depression and to enable adoption of recovery/management strategies to improve long-term outcomes including reduced need for mental health services in the future.
D: What are we doing about it?	A system wide forum has been set up with the support from the national IAPT team which will bring together providers and the lead IAPT commissioner to work on an integrated approach to IAPT across BSol and to address how we can work together to address demand and capacity. A number of strands of work have been identified both internal and external. Internally: a communications strategy to support increasing activity, HR support to help implement a preceptorship from band 6 to 7 and address recruitment issues and review of clinical space in order to recommence groups and face to face activity. Externally: A review of Long term conditions pathway, prioritising where additional investment can be focused and ongoing review through IAPT forum with regional IAPT team.
E: What do we expect to happen?	To slowly increase the face to face offer and increase capacity which will take time to implement.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 75% target.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

Divisions

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	2611	2627	2641	2538	2577	2636
C: ICCR	870	910	898	949	980	1068
D: Secure Serv & Offender Health	64	75	88	93	84	86
E: Specialties	1571	1676	1643	1581	1457	1434

Commentary

The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular.
The number of patients who have not been seen after 3 months of referral at April 2021 was 2227. August onwards has shown a steep increase reaching 2578 in October which then fell slightly in November before increasing again to a peak of 2636 in May 2022. The number of referrals not seen within 3 months of referral have increased in all services with the exception of AOT and Specialties. It should be noted that changes have been made to the reporting to take into account alternative contact methods with service users e.g. telephone and video (introduced from April 2020) and this has been applied retrospectively. Neuropsychiatry service accounts for 29% and Adult CMHTs 30% of referrals open for over 3 months without a contact.

Referrals over 3 mths with no contact

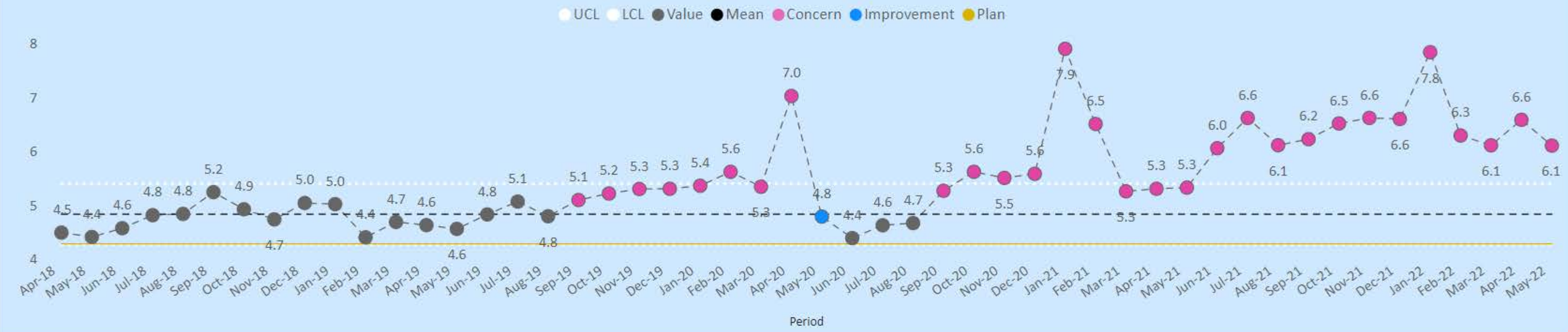
May - 2022

Question	Answers
A: What has happened?	The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular. The number of patients who have not been seen after 3 months of referral at April 2021 was 2227. August onwards has shown a steep increase reaching 2578 in October which then fell slightly in November before increasing again to a peak of 2636 in May 2022. The number of referrals not seen within 3 months of referral have increased in all services with the exception of AOT and Specialties. It should be noted that changes have been made to the reporting to take into account alternative contact methods with service users e.g. telephone and video (introduced from April 2020) and this has been applied retrospectively. Neuropsychiatry service accounts for 29% and Adult CMHTs 30% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts have reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. Based on available research, it is expected that the backlog of service users not seen or choosing not to access services during the Covid period together with new demand arising as a result of the impact from Covid -19 will result in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. 50% of older adult CMHT patients are being treated in care homes and contact with carers BUT not directly with service users due to Covid impact and these remain on the waiting list although care has commenced.
C: What are the implications and consequences?	This represents the number of referrals that have been open for more than 3 months without an appropriate contact being recorded and is indicative of the waiting time experienced by service users. Late data entry in outcoming appointments will impact on this measure.
D: What are we doing about it?	Reviewing patient flow and activities as part of strategic management of demand and capacity informed by service user need and staffing levels/skill mix to support. New ways of working and alternative methods of contact are being taken into account to manage the demand and services are drawing up plans to agree the appropriate level of face to face contact for each service. Face to face actitivy has continued to increase over the past few months.
E: What do we expect to happen?	This represents the number of referrals that have been open for more than 3 months without an appropriate contact being recorded and is indicative of the waiting time experienced by service users. Late data entry in outcoming appointments will impact on this measure.
F: How will we know when we have addressed issues?	Currently part of ongoing strategic service review discussions.

Staff Sickness

Divisions

Statistical Process Control (SPC)



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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	6.6%	7.8%	6.3%	6.1%	6.6%	6.1%
B: Acute and Urgent Care	8.1%	10.3%	6.9%	7.0%	7.7%	7.3%
C: ICCR	7.1%	7.4%	6.2%	5.1%	6.4%	5.9%
D: Secure Serv & Offender Health	7.6%	10.0%	8.1%	8.0%	8.7%	8.0%
E: Specialties	6.7%	6.6%	5.9%	5.9%	6.1%	5.7%
F: Corporate	3.1%	4.4%	3.5%	3.9%	3.3%	3.4%

Commentary

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Metric: Staff Sickness

What has happened?	Sickness absence saw a decrease in May to 6.09% from 6.58% in April 2022. Non-covid related sickness absence increased by 0.14% to 5.03% in May, whilst Covid-19 related sickness absence decreased to 1.06% in May from 1.69% in April. Short term sickness absence in May at 2.46% is an decrease of 0.55% from April of 3.01%. Long term sickness absence in May at 3.63% is a increase by 0.06% from 3.57% in April. 22 staff are absent due to long covid, of which 13 staff are absent over 12 months due to long covid. Overall sickness absence rates by division for April are as follows: Specialties – 5.76%; ICCR – 5.53%; Secure Services and Offender Health – 7.97%; Acute and Urgent Care – 7.22%, CEO office – 0%: Corporate Psychology – 3.57%; Exec Director – Medical – 3.58%; Exec Director – Nursing – 5.07%; Exec Director – Resources – 1.58%; Exec Director - Strategy People and Partnerships Locality – 3.57%.
Why has it happened?	Covid related sickness decreased in May. Covid-19. This will continue to be monitored and the potential impact of this on staffing levels. The top specified reasons for sickness absence in May were Anxiety/stress/depression/other psychiatric illnesses (accounting for 23.28% of all sickness absence which includes COVID-19); Cold, Cough, Flu - Influenza; other musculoskeletal problem; Other known causes - not elsewhere classified and Gastrointestinal problems;
What are implications and consequences?	Continuity of care for patients is affected and reliance on bank and agency staff increases. Lower staffing levels due to high sickness absence also has an impact on safe staffing levels, workload and health and wellbeing of staff. BAF Risk: Fails to develop an inclusive and compassionate working environment, resulting in increase levels of sickness. Fails to look holistically at flexible and transformative workforce models used across all services, resulting in a failure to take opportunities where positive gains are possible Fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multidisciplinary values-based leadership framework developing the right capabilities, resulting in an underperforming workforce
What are we doing about it?	• The People Partners/Senior People Partners are currently working with Divisional Associate Directors to create a sickness absence action/recovery plan for each of their service areas, working in conjunction with operational leads to reduce the sickness rates with a particular focus on LTS. Discussions are taking place to agree with the Divisional Associate Directors on the appropriate forum to confirm and challenge these recovery plans in a consistent manner across the organisation. These are yet to be agreed with the Divisional Associate Directors but will take precedence over the next month. • Sickness absence recovery plans have been created and will be presented to the divisions in June in respect of May's data. Where they will be presented has been agreed individually with each AD for an appropriate forum to confirm and challenge

Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

Divisions

Statistical Process Control (SPC)

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

Division	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
A: All	81.1%	84.2%	85.1%	83.0%	82.2%	83.2%
B: Acute and Urgent Care	81.4%	85.8%	84.4%	82.2%	82.1%	80.1%
C: ICCR	87.9%	94.0%	92.6%	87.4%	89.6%	92.1%
D: Secure Serv & Offender Health	73.2%	76.4%	76.8%	75.4%	71.4%	75.5%
E: Specialties	86.0%	86.1%	91.9%	86.2%	89.1%	87.9%
F: Corporate	95.4%	92.2%	95.8%	94.3%	96.2%	98.1%

Commentary

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Metric: Bank & Agency Fill Rate

What has happened?	The bank and agency fill rate increased to 83% in May from 82% in April. The bank fill rate remained relatively stable, as did the agency fill rate. The fill rate breakdown by division is as follows: ICCR – 92.7%; Specialties – 88%; Acute and Urgent Care – 81.4%; and Secure Services and Offender Health – 75.5%. The number of shifts requested in May increased by 1,477 compared to April. Bank filled 1,162 more shifts in May than April, and agency filled 253 more shifts. The breakdown of shifts requested by division is as follows: ICCR – 2,020; Specialties – 2,706; Secure Services and Offender Health – 4,953; and Acute and Urgent Care – 5,876.
Why has it happened?	17,084 temporary staffing shifts were requested in May. This is an increase of 1,477 from 15,607 in April. 14,223 shifts were filled in May (12,910 of these were bank). Despite an increase in shifts requested the fill rate has also increased. The main reasons for requested shifts in May were: Clinical Activity (5,797 shifts requested); Additional Work (4,004 shifts requested); Vacancies (2,446 shifts requested); Block booking (1,380 shifts requested) and sickness (1,185) . There has been an decrease in shifts requested for COVID-19 (551 in May from 973 in April).
What are implications and consequences?	Low fill rates resulting in unfilled shifts has an implication on safer staffing levels and the Trust's ability to deliver high quality patient care. Having less staff also has an impact on workload and staff health and wellbeing. BAF Risk: Fails to look holistically at flexible and transformative workforce models used across all services, resulting in inefficiencies
What are we doing about it?	• £5 enhancements as an incentive to fill shifts were offered to HCA's and RMN's at different times throughout the month of May to workers at Ardenleigh Wards, Cilantro and The Older Adults' Wards. • A bank and agency fill rate compared to £5 enhancements spreadsheet, with analysis, is provided for Senior Management each week in order for decisions to be made during Bronze/Silver meetings. • TSS leadership team held a fourth meeting to look at longer term strategic projects and improvements for the TSS function in terms of processes, health and wellbeing, training, and support for TSS workers. Action plans and meeting groups are in place for improvement of processes for Inductions, ADR's / RMS', clinical supervisions and Training Compliance, plus significant pastoral care support is now being offered to bank staff – which should, in turn, increase our ability to fill more shifts due to a more informed and productive workforce who feel more valued and appreciated. • A bank staff survey went live to ascertain and address satisfaction levels within the bank staff workforce. • Projects in conjunction with the Trust's Workforce Management Team / Bank staff Healthroster Management Team are being implemented in order to assist TSS Booking Co-Ordinators and bank staff with increasing the number of shifts filled. • Direct Engagement for Agency Staff meetings are on hold at the moment – prior to this and going forwards it will be a work in

9.3. Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**Board of Directors**
AGENDA ITEM	**12**
PAPER TITLE	**Month 2 2022/23 Finance Report**
DATE	29/6/2022
AUTHOR	Emma Ellis, Head of Finance & Contracts
EXECUTIVE SPONSOR	David Tomlinson, Executive Director of Finance

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

Equality & Diversity ***(all boxes MUST be completed)***	
Does this report reduce inequalities for our service users, staff and carers?	No
What data has been considered to understand the impact?	N/A

Executive summary & Recommendations:

Revenue position

The month 2 Group position is a deficit of £0.8m, this is £0.4m adverse to the year to date plan as submitted to NHSEI on 28/4/22. The position comprises an £866k deficit for the Trust, an £18k deficit for Summerhill Services Limited (SSL) and a break even position for the Reach Out Provider Collaborative. The month 2 Group position is a deterioration of £0.4m compared to month 1. This is mainly driven by a year to date 2% pay award accrual recognised in month 2, partly offset by an accrual for the year to date impact of 0.7% additional inflationary uplift as per latest national guidance.

2022/23 Planning

The financial plan submitted to NHSEI by Birmingham and Solihull ICS on 28/4/22 was a deficit of £36m. This comprised a deficit plan of £2.7m for BSMHFT. Following the allocation of additional national funding to deal with inflationary pressures, systems are required to submit a revised plan on 20/6/22.

The impact of the additional funding is that the proposed total system plan for 2022/23 has now improved to a break even plan. In line with fair share agreements, adjustments have been made to ensure that each organisation has a break even plan.

The 2022/23 capital plan of £7.3m remains unchanged from that submitted to NHSEI on 28/4/22.

Capital position
Month 2 Group capital expenditure is £108k, which is £204k less than year to date plan.

Cash position
The month 2 Group cash position is £55m.

Reason for consideration:

The Committee is asked to approve the revised 2022/23 break even financial plan, ahead of submission to NHSEI on 20/6/22.

Update on month 2 financial position.

Previous consideration of report by:

Regular briefing on financial position with FPP chair.

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

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

Financial Implications ***(detail any financial implications)***

Group financial position

Board Assurance Framework
(detail: (a) the strategic risk the report is providing assurance on or (b) any new risks being identified that is associated with the delivery of the strategic priorities

Linked to existing BAF2_0012

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

Ongoing financial briefings via Operational Management Team and Sustainability Board.

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2022 to 31st May 2022

Month 2
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Healthcare Income	293,205	48,868	48,749	(118)
Other Income	107,311	17,885	17,482	(403)
Total Income	**400,516**	**66,753**	**66,231**	**(522)**
Expenditure				
Pay	(236,738)	(39,456)	(38,817)	639
Other Non Pay Expenditure	(130,286)	(21,713)	(22,291)	(577)
Drugs	(5,956)	(993)	(1,087)	(94)
Clinical Supplies	(871)	(146)	(132)	14
PFI	(11,130)	(1,855)	(1,729)	127
EBITDA	**15,534**	**2,589**	**2,176**	**(413)**
Capital Financing				
Depreciation	(9,983)	(1,664)	(1,645)	18
PDC Dividend	(1,930)	(322)	(322)	-
Finance Lease	(4,845)	(808)	(809)	(1)
Loan Interest Payable	(1,154)	(186)	(199)	(13)
Loan Interest Receivable	97	10	63	54
Surplus / (Deficit) before taxation	**(2,281)**	**(380)**	**(736)**	**(356)**
Taxation	(380)	(63)	(64)	(1)
Surplus / (Deficit)	**(2,661)**	**(443)**	**(800)**	**(356)**

Month 2 2022/23 Group Financial Position

The month 2 consolidated Group position is a deficit of £0.8m year to date. This is £0.4m adverse to the year to date plan as submitted to NHSEI on 28/4/22.

The month 2 position is a deterioration of £0.4m compared to month 1. This is mainly driven by direction from NHSEI to accrue for a 2% pay award – year to date impact recognised in month 2 of £0.7m. This is partly offset by an accrual for increased income in line with additional 0.7% inflationary uplift as per latest national guidance – year to date impact recognised in month 2 of £0.3m.

The Trust month 2 position is a deficit of £866k year to date. Trust pay underspend is mainly driven by Service Development Fund (SDF) recruitment slippage. SDF income has been deferred to offset this.

The Group position includes an £18k deficit for our wholly owned subsidiary, Summerhill Services Limited (SSL) and a break even position for the Reach Out Provider Collaborative. For a segmental breakdown of the Group position, please see page 3.

2022/23 Financial plan

The 2022/23 Group financial plan as submitted to NHSEI on 28/4/22 was a deficit of £2.7m. Following the allocation of additional national funding, there is a requirement to submit an updated plan to NHSEI on 20/6/22. The proposed plan for the system and BSMHFT is break even, see page 10-11 for further detail.

Month 2 Group position
Segmental summary

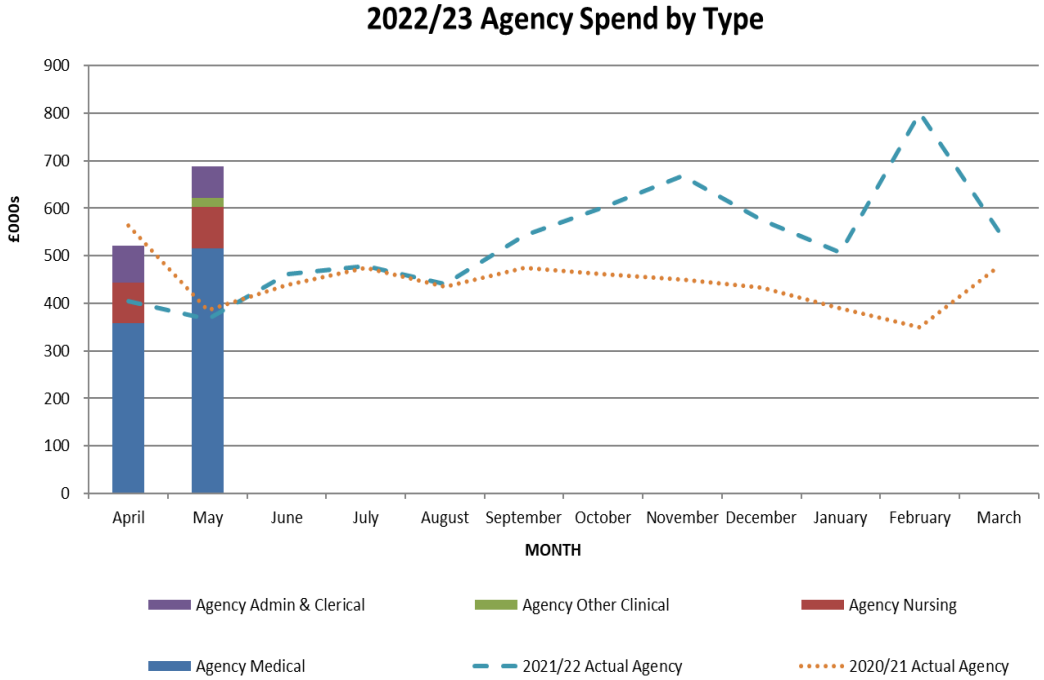
Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Trust	SSL	Reach Out	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual
	£'m	£'m	£'m	£'m	£'m
Income					
Healthcare Income	48,749	-	-	-	48,749
Other Income	3,917	4,247	22,719	(13,401)	17,482
Total Income	**52,666**	**4,247**	**22,719**	**(13,401)**	**66,231**
Expenditure					
Pay	(37,038)	(1,620)	(204)	45	(38,817)
Other Non Pay Expenditure	(11,399)	(1,077)	(22,515)	12,700	(22,291)
Drugs	(1,148)	(527)	-	587	(1,087)
Clinical Supplies	(132)	-	-	-	(132)
PFI	(1,729)	-	-	-	(1,729)
EBITDA	**1,221**	**1,023**	**(0)**	**(68)**	**2,176**
Capital Financing					
Depreciation	(1,177)	(556)	-	88	(1,645)
PDC Dividend	(322)	-	-	-	(322)
Finance Lease	(809)	(65)	-	65	(809)
Loan Interest Payable	(199)	(356)	-	356	(199)
Loan Interest Receivable	419	0	-	(356)	63
Surplus / (Deficit) before Taxation	**(866)**	**46**	**(0)**	**84**	**(736)**
Taxation	-	(64)	-	-	(64)
Surplus / (Deficit)	**(866)**	**(18)**	**(0)**	**84**	**(800)**

Agency expenditure increase in month 2

Birmingham and Solihull Mental Health NHS Foundation Trust

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	2022/23
Agency Spend (£'000)	520	689											1,209
NHSEI Ceiling (£'000)	616	616	616	616	616	616	616	616	616	616	616	616	7,395
Stretch target (£'000)	501	501	501	501	501	501	538	522	522	522	522	522	6,157
Variance to stretch target	(19)	(187)											(206)
Agency Medical	358	515											873
Agency Nursing	86	87											173
Agency Other Clinical	(1)	20											19
Agency Admin & Clerical	77	67											144
Agency Spend (£000s)	520	689											1,209



Month 2 agency expenditure is £689k. This is £73k above the anticipated NHSEI ceiling and £187k above the internal stretch target.

There has been a significant increase in medical agency expenditure in month 2 of £157k:

Acute and Urgent Care £93k – 3 new agency medics in month to cover vacancy, sickness and annual leave. One vacancy has recently been recruited to substantively.

ICCR £65k – medical agency to cover vacancies given unsuccessful recruitment rounds.

The total expenditure in May of £689k is £322k above that in May 2021 and £156k above the 2021/22 average.

The following agency controls are in place:

- We ceased paying the agency rate to cap on 7/2/22. Agency prices have increased to reflect changes in national insurance and living wage rates.
- Throughout May, 56 bank positions were recruited and filled, offsetting the need for some agency shifts.
- Due to the current staffing pressures, twice monthly adverts are continuing for bank nurses, HCAs and administrators to increase capacity.
- Opportunities around direct engagement continue to be explored.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - Audited 31-Mar-22 £m's	NHSI Plan YTD 31-May-22 £m's	Actual YTD 31-May-22 £m's	NHSI Plan Forecast 31-Mar-23 £m's
Non-Current Assets				
Property, plant and equipment	186.5	203.3	203.1	201.9
Prepayments PFI	1.6	1.3	1.5	1.3
Finance Lease Receivable	-	-	(0.0)	-
Finance Lease Assets	-	-	0.0	-
Deferred Tax Asset	0.1	0.1	0.1	0.1
Total Non-Current Assets	188.1	204.7	204.7	203.3
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	9.7	11.1	16.1	11.1
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	54.9	55.4	49.9
Total Curent Assets	38.9	66.4	71.9	61.5
Current liabilities				
Trade and other payables	(29.4)	(46.5)	(50.7)	(46.2)
Tax payable	(4.4)	(4.8)	(4.7)	(4.8)
Loan and Borrowings	(2.7)	(2.7)	(2.5)	(2.7)
Finance Lease, current	-	(1.0)	(1.0)	(1.0)
Provisions	(1.2)	(1.2)	(1.1)	(1.2)
Deferred income	(13.2)	(25.3)	(27.5)	(25.3)
Total Current Liabilities	(50.9)	(81.5)	(87.4)	(81.2)
Non-current liabilities				
Loan and Borrowings	(29.5)	(26.6)	(26.6)	(25.1)
PFI lease	(49.3)	(47.3)	(47.3)	(45.8)
Finance Lease, non current	-	(6.5)	(6.4)	(5.6)
Provisions	(2.4)	(4.3)	(4.3)	(4.3)
Total non-current liabilities	(81.3)	(84.7)	(84.6)	(80.9)
Total assets employed	94.9	104.9	104.6	102.7
Financed by (taxpayers' equity)				
Public Dividend Capital	110.5	113.0	113.0	113.0
Revaluation reserve	27.5	36.8	36.8	36.8
Income and expenditure reserve	(43.1)	(44.9)	(45.2)	(47.1)
Total taxpayers' equity	94.9	104.9	104.6	102.7

SOFP Highlights

The Group cash position at the end of May 2022 is £55.4m (this includes Reach Out).

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

Current Assets & Current Liabilities

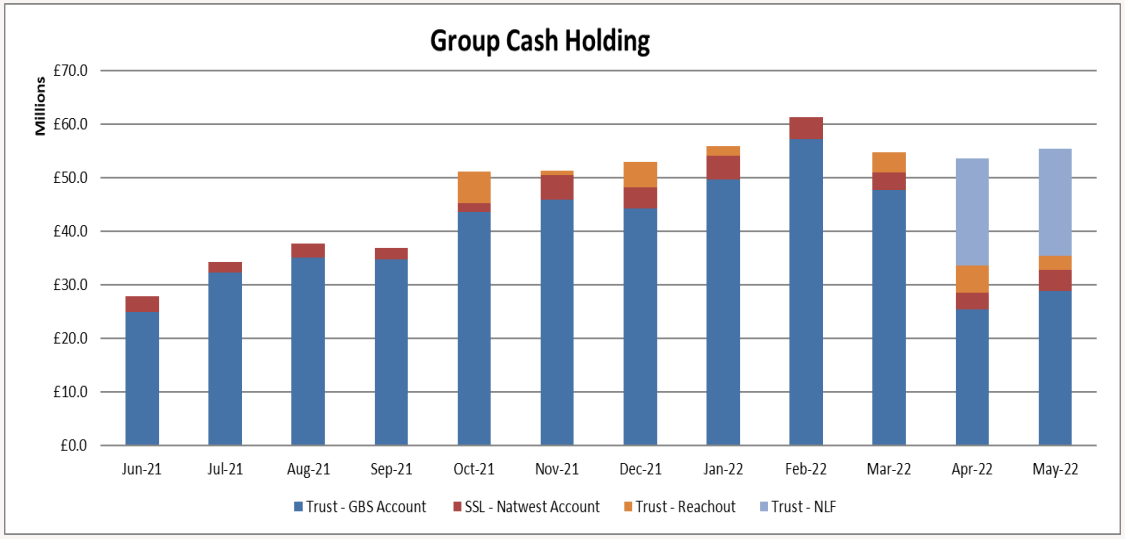
Ratios

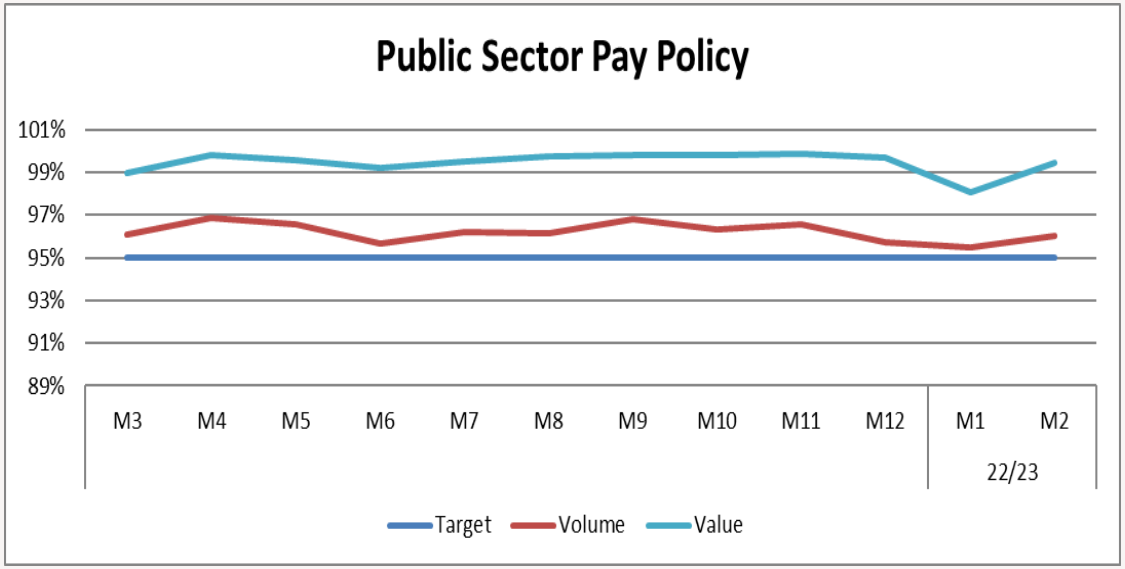
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	71.9
Current Liabilities	-87.4
Ratio	0.8

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of May 2022 is £55.4m.

In April 2022 we deposited £20m with the National Loan Fund (NLF) for 6 months, this is due to yield a return of £116k based on the interest rate at the time of placing the deposit.

Better Payments

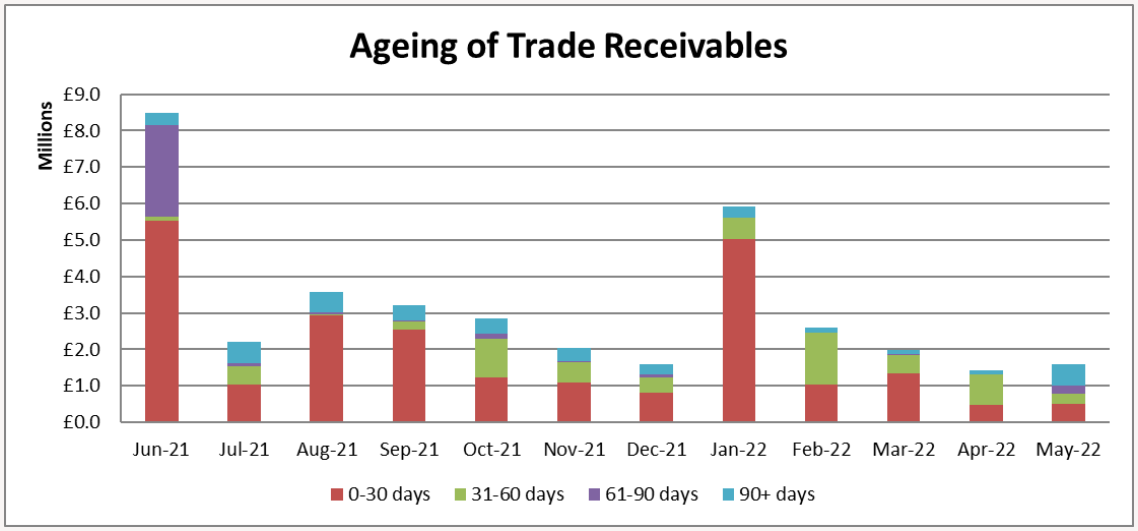
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

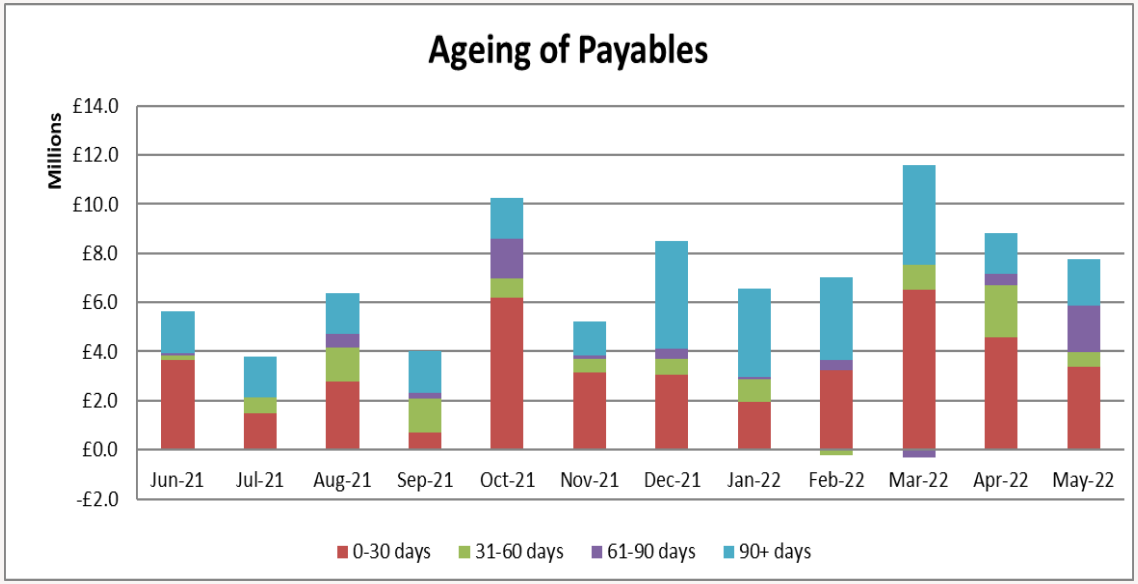
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables

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

Receivables :

- **0-30 days-** New overpayments £61k, South Warwickshire £376k at present no known disputes
- **31-60 days-** Significant decrease in balance due to movement of SSL £463k & BCC £126k into 61-90 days
- **61-90 days**-BCC £126K slow process of payment due to obtaining PO's, BWC £20k issue with PO, NHS Development £40k issue with SBS processing payment after credit note issued, Kingston Hospital NHS £29k issue externally due to setting us up on their system. All queries followed up regularly to resolve
- **Over 90 days -**Staff overpayments (on payment plans), £463k SSL (paid in June 2022)

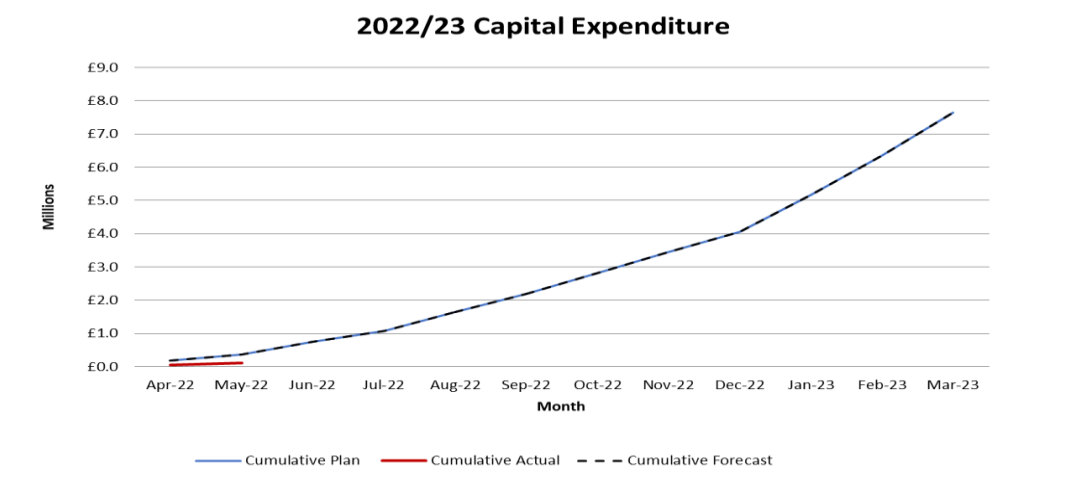
Trade Payables:

Over 90 days -

- NHS Property Services £521k– Awaiting lease agreement to be finalised to enable/facilitate payment. Estates colleagues are working with NHS Property Services to resolve this matter (DoF is aware of the position)
- Coventry & Warwick £240k-Reach Out invoice in query
- Non-NHS Suppliers (43+) £1.1m – mainly bed fees invoices in query, most accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in June 2022.

Capital Expenditure

Capital schemes	Annual Plan	YTD Plan	YTD Total Actual		YTD Variance to plan
		£'m	£'m		£'m
Approved Schemes:					
Ligature / Doorset Works Phase 1 & 2	**0.8**	**0.1**	**0.0**		**-0.1**
Ardenleigh Coral Seclusion Suite	**0.4**	**0.2**	**0.0**		**-0.2**
SSBM Works	**1.7**	**0.0**	**0.1**		**0.1**
ICT Projects	**0.8**	**0.0**	**0.0**		**0.0**
Plan TBC:					
Risk Assessment Works	**3.0**	**0.0**	**0.0**		**0.0**
Reaside Reprovision Business Case	**0.6**	**0.0**	**0.0**		**0.0**
Total	**7.3**	**0.3**	**0.1**		**-0.2**



2022/23 Group Capital Plan

The Group capital plan of £7.3m is based on £6.9m capital allocation as agreed by System Investment Committee, this includes a notional risk reserve allocation of £0.2m, to be confirmed. In addition, £0.4m capital expenditure will be funded from the planned disposal of Ross House.

£3.7m of the total planned expenditure relates to pre-commitments from prior year (for doorsets and Ardenleigh Coral Seclusion Suite) plus essential ICT and Statutory Standards and Backlog Maintenance (SSBM) works. Discussions around the balance of £3.6m continue, including with colleagues from SSL who are advising on what can be achieved during this financial year.

Month 2 Group Capital Expenditure

Month 2 Group capital expenditure is £108k which is £204k less than year to date plan. An underspend on carry-forward schemes was partly offset by SSBM expenditure ahead of plan.

Planned Asset Disposal

The disposal of Ross House is expected to be completed by the end of June 2022.

Birmingham and Solihull Mental Health NHS Foundation Trust

Financial Plan 2022/23

2022/23 Revenue Plan Update – Additional funding

The financial plan submitted to NHSEI by Birmingham and Solihull ICS on 28/4/22 was a deficit of £36m. This comprised a deficit plan of £2.7m for BSMHFT.

Additional funding – national allocations

Further funding to deal with inflationary pressures has been made available nationally, totalling £1.5 billion. Systems are expected to submit a revised balanced plan on 20/6/22, which has been signed off by the board and the national team, along with meeting a number of conditions of receipt of funding. Restrictions on funding will apply for any system with a deficit plan.

The additional system allocation is £36m, comprising the following:

- £13.8m Tariff cost uplift factor: 0.7% increase to the inflationary uplift to contracts/tariffs
- £8.6m Funding to cover broader commissioning pressures as a result of higher social care costs
- £3.8m Ambulance funding to cover fuel costs, 999 call handlers and specific service pressures
- £9.7m Regional discretionary allocations.

Conditions of receipt of funding

- Reflecting cost and productivity gains as a result of implementing the new IPC recommendations (and implementing new testing arrangements)
- Evidence of assessment against Key Lines of Enquiry (KLOEs)
- Commit to and reflect in plans, recurrent delivery of efficiencies from Q3
- Fully engage in national pay and non-pay savings initiatives to be launched in coming months
- Comply with controls on Bank, agency and consultancy spend
- Commission a report from internal audit covering the recent HfMA publication “Improving NHS financial sustainability: are you getting the basics right?”
- Systematically review excess inflation figures in plans

Impact of additional funding

The impact of the additional funding is that the proposed total system plan for 2022/23 has now improved to a break even plan. Adjustments have been made to ensure that each organisation has a break even plan. For an overview of the changes to the BSMHFT financial plan, see page 11.

BSMHFT 2022/23 Plan - Update

	£'m
BSMHFT plan per 28/4/22 submission	**-2.7**
0.7% Inflationary impact of out of system contracts	1.9
Boundary change adjustments	0.2
NHSE Growth on residual contracts	0.3
Share of additional funding allocations	
0.7% inflationary top up (Rec)	1.0
Other cost pressures top up (Rec)	0.6
Ambulance top up (Rec)	0.3
Discretionary funding (Non Rec)	0.7
Total share of additional funding allocations	**2.7**
Redistribution of resources to set break even plan	-2.3
BSMHFT proposed plan for 20/6/22 submission	**0**

Efficiency Plan 2022/23
The total efficiency target for 2022/23 remains unchanged at £10.9m (£7.8m recurrent and £3.1m non recurrent), this is an ambitious target and is considered a risk for delivery of the plan. Discussions are ongoing at Sustainability Board and Transformation Management Board around transformational opportunities and we are exploring options for generating further ideas.

Capital Plan 2022/23
The capital plan of £7.3m remains unchanged from that submitted to NHSEI on 28/4/22 (for further detail see page 8).

The financial plan submitted to NHSEI by Birmingham and Solihull ICS was a deficit of £36m. This comprised a deficit plan of £2.7m for BSMHFT as submitted to NHSEI on 28/4/22.

As a result of additional national funding allocations (see page 10), the proposed system plan has improved to a break even plan.

BSMHFT – changes to plan
The table opposite summarises the key adjustments that have been made to the BSMHFT plan since the submission to NHSEI on 28/4/22:

- The additional 0.7% inflation as per national guidance has been applied to out of system contracts, improving the plan by £1.9m.
- Final boundary change adjustments have resulted in a further £0.2m improvement.
- Updated contract offer from NHSE on 14/6/22 has improved the plan by £0.3m.
- The system additional funding allocation of £36m was distributed across each organisation on a fair share basis (based on total relevant expenditure). The BSMHFT 'fair share' being 7.4%, giving a total improvement of £2.7m.
- A final adjustment was made to redistribute resources across the system to ensure that all organisations have a break even plan where the system plan is break even.

9.4. Audit Committee Chair's Assurance Report

GOVERNANCE & RISK

10. Questions from Governors and Public (see procedure below)

11. Any Other Business (at the discretion of the Chair)

12. FEEDBACK ON BOARD DISCUSSIONS

13. RESOLUTION

The Board is asked to approve that representative of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.

14. Date & Time of Next Meeting

- 09:00am 27th July 2022