Board of Directors: PART I

Schedule	Wednesday 25 May 2022, 9:00 AM — 12:30 PM BST
Organiser	Hannah Sullivan

Agenda

Agenda

14. Sustainability Strategy: Carbon Net Zero - Our Green Plan

15. Integrated Performance Report

16. Finance Report

GOVERNANCE & RISK

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

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

19. FEEDBACK ON BOARD DISCUSSIONS

20. 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.

21. Date & Time of Next Meeting
- 09:00am, 20th June 2022 (extra-ordinary)
- 09:00am 29th June 2022

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
09:00AM, WEDNESDAY 25th MAY 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

STAFF STORY
Matt Brayshaw, Recovery Lead, Birmingham & Solihull Liaison & Diversion team and Ella Carman, photographer and documentarist

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Apologies for absence & Declarations of interest	*Chair*	09.30	*(verbal)*	-
2.	Minutes of the previous meeting		09.35	*(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
QUALITY					
7.	Quality, Patient Experience & Safety Committee Chair's Assurance Report	*L. Cullen*	10.15	*(attached)*	Assurance
8.	Infection, Prevention & Control Annual Report	*S. Bloomfield*	10:25	*(attached)*	Assurance
9.	Safeguarding Annual Report	*S. Bloomfield*	10:35	*(attached)*	Assurance
PEOPLE					
10.	People Committee Chair's Assurance Report	*P. Gayle*	10:45	*(attached)*	Assurance
11.	Regulatory Report on equality data for the WRES, WDES and Gender Pay Gap	*P. Nyarumbu*	10:55	*(attached)*	Assurance
SUSTAINABILITY					
12.	Finance, Performance & Productivity Committee Chair's Assurance Report	*R. Beale*	*11:05*	*(to follow)*	Assurance

13.	Our Trust Five Year Strategy Update	*P. Nyarumbu*	*11:10*	*(attached)*	Assurance
14.	Sustainability Strategy: Carbon Net Zero – Our Green Plan	*D. Tomlinson*	*11:25*	*(attached)*	Assurance
15.	Integrated Performance Report	*D. Tomlinson*	*11:50*	*(attached)*	Assurance
16.	Finance Report	*D. Tomlinson*	*12:00*	*(attached)*	Assurance/ Approval
GOVERNANCE & RISK					
17.	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:20*	*(verbal)*	Assurance
18.	Any Other Business *(at the discretion of the Chair)*	*Chair*	*12:25*	*(verbal)*	-
19.	**FEEDBACK ON BOARD DISCUSSIONS**	*V. Devlin*	*12:30*	*(verbal)*	-
20.	**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.				
21.	**Date & Time of Next Meeting** • 09:00am, 20th June 2022 (extra-ordinary – Annual Accounts) • 09:00am 29th June 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING

Meeting	**BOARD OF DIRECTORS**
Date	**WEDNESDAY 27th APRIL 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
	Patrick Nyarumbu	-	Director of Strategy, People & Partnerships
	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
	Renarta Rowe	-	Representing Dr H Grant
	Sajid Muzaffar	-	Guardian of Safe Working Hours
	Shane Bray	-	Summerhill Services Ltd
Observers	Maureen Johnson	-	Carer Governor
	Mustak Mirza	-	Service User Governor
	Rajendra Harsh	-	Observer
	Rohan Manghra	-	Carer Governor
	John Travers	-	Staff Governor
	Gill Mordain	-	Associate Director of Quality Governance
Patient Story	Sandra Baker	-	Participation and Experience Manager
	Shay Bacon	-	Service User
Apologies	Hilary Grant	-	Medical Director

Minutes

Agenda Item	Discussion	Action (Owner)
1.	**OPENING ADMINISTRATION: DECLARATIONS OF INTEREST** The Chair welcomed Trust Governors who were observing the meeting, along with representatives of the public.	
2.	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 30th March 2022 were approved as a true and accurate record of the meeting.	
3.	**MATTERS ARISING / ACTION LOG** The action log was reviewed and noted.	
4.	**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. The Chair highlighted the Board development held last month which was the first session of the programme being held with NHS Providers.	
5.	**CHIEF EXECUTIVE'S REPORT** R. Fallon-Williams highlighted and acknowledged the hard work of colleagues across the Trust during the month. It was reported that the Infection Prevention and Control (IPC) team continued to provide proactive support and has now deployed a new COVID spot check audit tool to allow a more accurate reporting of the support visits done to the outbreak areas as part of recommendations given during the last visit of NHSE/I. The Trust was still seeing cases and all staff were thanked for their continued efforts and for remaining vigilant. As a Birmingham and Solihull system discussions had commenced on 'living with COVID' including the establishment of several key workstreams to consider our approach as government centrally established infrastructures were stood down, for example in relation to testing. It was expected that the national NHS would determine some requirements. However, it was also expected that areas would also be determined by the local system. It was confirmed that Summerhill Services Ltd would participate in the "I Can" Programme and that the system was reviewing the cost of living impact for colleagues including discussions taking place regarding support for individuals. Under sustainability, further partners have been asked to join the BSOL Mental Health Provider and there had been an emphasis in engaging with learning disability and autism partners and the approach would be signed off by the Provider Board. The urgent care system had been under significant pressure and work had been undertaken with acute partners to review the safest place for mental health patients with the data being reviewed on a daily basis.	

Agenda Item	Discussion	Action (Owner)
	It was the expectation that this would continue to ensure patients were treated in the appropriate environments. V. Devlin provided an overview on the work within operational clinical services adding that the focus of staff related to focusing on ensuring recovery within clinical services following the pandemic. It was noted that there had been changes to leadership and clinical directors within the operational portfolios. Mark Cox, Service Manager, had stepped into the Associate Director role with Derek Tobin retiring. In relation to system working, there was a focus on rehabilitation flow with patients in out of area beds and teams were reviewing how there could be appropriate step down for patients to ensure appropriate independent living. G. Hunjan queried lateral flow testing and the guidance being given to staff if they found themselves COVID-19 positive with the response that the Trust had continued to advise colleagues of the changes in guidance. In the last two weeks the national changes in wider society were different to the guidance being followed within public services. The leadership team was very much aware of the current guidance to support staff. In terms of access to testing, staff working in particular settings would continue to have access to lateral flow tests. Non-Executive colleagues raised the issue of the cost-of-living increases and the support being put in place for colleagues. R. Fallon-Williams reported that previously the Trust would have determined its own view and paid little attention in the context of sustainability beyond our organisation. However, the Trust was in a different now in relation to partnership working and therefore, this was being addressed through the People Board as a focused agenda item. The paper taken to the system group was reviewing a number of supportive arrangements with a communications plan and roadshows. The Chair congratulated the Early Intervention Service (EIS) Team Manager, Steve Harrison, who had received recognition in the Health service Journal for the fantastic work undertaken in developing the Solihull EIS team. The Service was meeting the majority of NHSE standards and in the coming year will develop an At Risk Mental State service (ARMS) which would enable the whole service to be fully compliant. *The report was received and noted.*	
6.	**BOARD OVERVIEW TRUST VALUES** D. Tomlinson provided a number of examples of seeing the Trust values in operation focusing on the members of staff who had been highlighted during the recent Trust Staff Awards. This included a senior occupational therapist at Rookery Gardens who assisted a service user who had been defrauded out of £95,000 by engaging with the police, the bank and solicitors achieving a positive outcome. Another example was David Reign, at Reaside, David who was seen as inclusive and non-judgmental, embedding the values daily and on a personal level actively encouraged staff to support LGBTQ+ patients. The Chair thanked D. Tomlinson for the overview.	

Agenda Item	Discussion	Action (Owner)
7.	**PATIENT STORY** Sandra Baker introduced Shay Bacon, to Board Members to present his experiences of services, and specifically regarding the prescribing of medication. Shay who was a very valuable member of the Experts by Experience Team. The Chair said that the story had been extremely illuminating as Board Members did not have a daily connection patients and service users who use the services of the Trust and it was extremely important to hear where improvements needed to be made. S. Bloomfield thanked Shay for providing so much to think about and a lot to reflect on and asked to come back for a personal conversation after the meeting. Shay had shared powerful and personal reflections and extremely articulate. There was a lot of learning and a sense from Shay of isolation which was not how it should be for patients. The learning included how Shay felt as a service user and the framework and guidance that was not provided in relation to the issue of prescription medication**.** S. Baker added that Shay did identify that as he had not made any demands and had felt that he had fallen between the gaps and therefore work was underway to ensure there was a personal statement and care plan in place which detailed his preferences if he became unwell in the future. Shay stated that there needed to be more publicity regarding the expert by experience role which would encourage service users to become more involved in shaping services in the Trust. S. Baker added that there were now four band 6 roles which had been appointed and attached to each Division who would concentrate on participation and experience and would have the See Me workers working with them. Therefore, there was a real push to encourage more experts by experience joining the Trust with a specific focus on co-production. The Chair said that it was vitally important to hear the voice of patients and service users and the extent to how this shaped policies and the Board wished to be kept upto date with the progress being made. The Chair said thanked Shay for sharing his experiences with the Board.	
8.	**QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE CHAIR'S ASSURANCE REPORT** The Committee raised concerns regarding the CQC Improvement Report and discussed the staffing levels on the Eden Unit. The Committee was informed staffing and acuity levels on this Unit have had an impact. Nevertheless, support was in place and an update to include timelines on improvements would be bought to the June 2022 Committee meeting for assurance. The preparations for CQC Well Led Inspection was continuing. The committee received a detailed presentation on Learning Disability and Autism and were pleased to note the successes in providing high quality services for people with LDA within the Trust. Work continued to widen the involvement of service users and staff and a steering group has been established to support the priorities of the work stream going forward The committee received the detailed report and noted the refreshed Trust Five Year Strategy was launched at the start of 2021/22.	

Agenda Item	Discussion	Action (Owner)
	The Committee felt this was a very good strategy but needed reassurance that we would see what the measures of success and the outcomes would be reflected in this document. The committee were assured good progress has been made in year one despite pressures faced in 2021/22 and despite significant operational challenges, staff are increasingly embracing service transformation. The committee were appraised of the areas of concern raised by NHSE/I following their visit to Mary Seacole and the Tamarind Centre 2 on 11 February 2022.There were no concerns with the Tamarind that were pointed out. Mary Seacole, they did raise concerns around COSH breach in relation to fridge temperatures as staff were still using paper recordings as this was not robust enough as we do have a centralized way of recording temperatures. A further visit has been scheduled for June 2022 The committee received an update on serious incidents and learning and was assured all incidents are within the mean and expected ranges. The committee were concerned that acuity remains challenging with high demand on PICU beds, and this has had an impact on out of area placements. The Committee acknowledged demand and capacity could also be a factor. The Committee was informed that on 19 April 2022 there was an inpatient suicide on Citrine, Ardenleigh with staff receiving support from Executive Directors and Senior Leaders. The escalation report from the Reach Out Commissioning Sub-Committee detailed that capacity issues remained a serious concern for all providers with medical vacancies remaining high with the impact on service delivery and keeping staff and service users safe being key concerns. The report was received and noted.	
10.	**PEOPLE COMMITTEE CHAIR'S ASSURANCE REPORT** The Board received the report from the People Committee which had met on the 20th April 2022. The Committee received an update on the workforce KIPs and the committee were pleased to see progress in the reduction of staff sickness absence as this was encouraging. With regards to return to work interviews (RTW) the committee were not assured that sufficient progress was being made as this remained an area of concern. However, the Committee was informed the People and Organisational Development Dept intended to review the RTW interview form to better align it to our Trust Values and develop Trust wide communications to re-emphasise the importance of RTW interviews. A report was received by the Committee which summarised a call to action on how the Trust would permanently reduce bullying, harassment and discrimination (particularly race discrimination) from the Trust and make the organisation a place where staff know that any of those behaviours were unacceptable. The Committee were pleased to see and agreed that the tone of the paper was entirely appropriate and a good challenge, and that the work now needed to be presented to the Directorates to ensure assurance could be provided regarding change being affected.	

Agenda Item	Discussion	Action (Owner)
	The Committee did feel the paper needed to be strengthened and include Freedom to Speak Up, as the committee felt this would also be an integral part of the document. The Committee was pleased to receive the quarterly report from the Freedom to Speak Up Guardian, Emma Randle with the Committee noting that cases had risen significantly during the last 12 months with a sustained increase across all staff groups. The People Committee also received a description of the increased staff resources that have been provided to the FTSU team, and how it would embed a "Champion FTSU model throughout the Trust. The Committee was informed that the Safer Staffing Committee (SSC) was still establishing itself and were pleased that the lead nurse is in place for SSC. The Chair thanked the Committee for their report.	
11.	**GUARDIAN OF SAFE WORKING HOURS** The Board was presented with the Guardian of Safe Working Hours report. Dr Muzaffar reported that all the exceptions during the quarter were regarding working hours and no educational exceptions were raised. There were no immediate safety concerns were raised and it was noted that there were several shift vacancies, but all were filled by locums. The report was received and noted.	
12.	**SUMMERHILL SERVICES LTD QUARTERLY REPORT** S. Bray attended the meeting to present the quarterly report from SSL The report summarisesd the performance and activities of SSL from April 2021 to March 2022. In addition, the reports details some of our plans, opportunities, and potential business developments for 2022/23. It was reported that COVID had caused significant operational challenges over the year for SSL services and the partners in PFI, with increased staff sickness and absences, ward isolations and increased demand on PPE. Over the year, SSL has continued to support the wider healthcare system and supported 23 COVID vaccine sites across Birmingham plus operating 4 mobile vaccination vehicles. During the year, SSL successfully maintained ALL SSL services and managed PFI partners across all sites. During the year, SSL saw increased revenue from external contracts and additional services with the Trust. This increased revenue ensured SSL delivered a financial performance ahead of budget. There were new national cleaning standards which the Trust would wish to achieve with additional resources being identified. Work was continuing on catering and looking at putting in new software for wards to order and covers off Natasha Law to ensure detailed ingredients for menus moving forward. New uniforms were now in place with SSL assisting the Trust with its uniform programme. It was noted that the old uniforms were being recycled and given to the British Heart Foundation for shredding. SLL would have its own Green plan and with the expansion regarding the use of electric vehicles.	

Agenda Item	Discussion	Action (Owner)
	D. Oum said it was very helpful to see the range of activities being undertaken and welcomed the update and the offer of services to the wider economy. G. Hunjan referred to the ICS Laundry and Customer Board and queried what the vision was for SSL in extending the reach across the system. S. Bray said that laundry and linen had been a challenge for the Trust and the greater region with a supplier outside of the region and was reviewing if the service could be provided internally and had liaised with partners throughout the ICS. At the moment it was cost prohibitive and were seeing how the costs could be addressed and within a couple of months would be submitting a proposal for the ICS. A Baines said ti was a very detailed report and queried what the risks were for the forward look for SSL. S. Bray stated that the risks were similar to the Trust with the major risk being ensuring the right people were in the right roles. In a very competitive market, SSL had to be an attractive employer by reviewing the offers for new staff, for example offering a trades allowance. One of the risks was the emerging ICS but this was also an opportunity. Ultimately, there was a risk for SSL that the ICS either did take on some of the back office services which may impact on the business and opportunities but this was seen more as a positive. A Baines raised the cost-of-living issue as this would be a key concern for staff. S. Bray responded stating that the SSL Board had discussed the issue and was struggling to find a solution. However, meetings had been held with Trust colleagues from a finance and HR and would work closely together with the Trust to look at solutions to support staff. W. Weir was impressed on recent visits to sites with SSL with the services being provided and queried sustainability and how SSL was working with the Trust to take issues forward to raise the standards to protect the environment. S. Bray replied that the Sustainability Plan was developed in conjunction with the Trust and was currently with the Executive Team and was to be presented to a future Board of Directors meeting. ***DECISION: The Board would be presented with the SSL Sustainability/Green Strategy at the May Board meeting.***	
13.	**AUDIT COMMITTEE CHAIR'S ASSURANCE REPORT** G. Hunjan presented the Chair's Assurance Report from the Audit Committee detailing that the discussion included reports from the Internal Audit reports and highlighted the list of internal audit recommendations which were outstanding. The Committee was assured that progress was being made regarding addressing outstanding internal audit recommendations. The new internal audit team, RMS, would address outstanding actions where the evidence needed to be reviewed.	

Agenda Item	Discussion	Action (Owner)
	It was reported that TIA had completed their annual plan and issued two reports in the last quarter one which provided significant assurance for planned maintenance and limited assurance in relation to e-rostering. The reviews in Quarter 4 had been issued to management and would not impact on the issuing of the Internal Audit Head of Opinion. The handover between TIAA and RMS would be a smooth process and Committee thanked TIAA for their work in supporting the Trust during the last five years.	
14.	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE CHAIR'S ASSURANCE REPORT** R. Beale, Chair of the Committee, reported that there had been a detailed discussion on the financial performance and the challenges. The Committee was informed of the work underway in relation to recruitment with the challenge of ensuring the workforce was viable with a review of the workforce underway to ensure a workforce fit for the future. The Committee discussed the challenges of cost savings and transformation and the need to review cost savings and to develop a pipeline for plans The Committee remained cautious as to the sustainability of the workforce issues, and remain in need of further assurance that the Trust was being being creative, flexible, and innovative to meet recruitment needs. The Committee was assured that the financial envelope for next year was probably deliverable, but that the following one would be much more challenging, and that there needed to be some substantial changes to practice to enable the Trust to make significant savings, The Committee received an update on the capital position for 2022 – 2023. The capital allocation was £5.7m and a notional £500,000 which was £200k less than in 2021/2022 which was a significant risk in relation to the requests from operational colleagues. The Committee stressed that the capital programme should be a continuous review process and divisions should have a list of capital plans which were continually being assessed and priorisited. The Director of Operations took an action to cascade to Divisions that this needed to be a priority with ownership and accountability. The Committee received a detailed report regarding progress against the achievement of the sustainability priorities within the Trust Five Year Strategy. There is much to be pleased about in making progress during such a challenging year, and many tasks are on track. However, the Committee was not assured that the digital aspects of the strategy were being progressed at sufficient pace, as it required time, headspace, and effort in order to achieve buy-in and progress. This was a considerable challenge to enable, but also a considerable risk to not delivering the objectives and the transformations needed.	
13.	**INTEGRATED PERFORMANCE REPORT** The Board was presented with the Integrated performance report with the key issues being discussed by Committee. This 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 being presented within the report to Finance, Performance & Resources Committee.	

Agenda Item	Discussion	Action (Owner)
	Vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness being presented to the People Committee and suspected community suicides under the remit of Quality, Patient Experience and Safety Committee. The report was received and noted.	
14.	**FINANCE REPORT** The 2021/22 consolidated Group outturn position was £1.3m surplus. This was a deterioration of £0.7m compared to the £2m surplus forecast. This was mainly driven by a prudent approach to year end accruals and £0.3m additional cost for out of area costs from West Birmingham identified in month 12. The position included a break even position for the Reach Out Provider Collaborative. It was reported that the 2022/2023 Priorities and Operational Planning Guidance was issued on 24 December 2021. The draft financial plan submitted to NHSEI by Birmingham and Solihull ICS on 17/3/22 was a deficit of £48m. This comprised a break even plan for BSMHFT. Work continued across the system to reduce the total deficit plan, ahead of the final plan submission on 28/4/22. A reduced deficit plan of £41m was agreed by system CFOs. Following agreement that all organisations should have a fair share of the total deficit, this resulted in a proposed revised plan of £3.1m deficit for the Trust. There was a further 2 weeks until the final plan was to be submitted to NHSEI and so additional adjustments may be required. Following system capital prioritisation discussions, a draft capital plan of £7.3m is proposed for 2022/23 (£0.2m is subject to final system allocation). The month 12 year to date Group capital expenditure was £11.5m, this was £1.3m more than original plan, mainly due to additional PDC funding for Shared Care Records (not in original plan). It was reported that the month 12 Group cash position was £55m	
15.	**USE OF THE TRUST SEAL** The Board was presented with the annual report from the Head of Legal, regarding the use of the Trust Seal. This is presented for information to the Board and was received and noted.	
16.	**MEETING FEEDBACK** R. Beale provided his reflections on the discussions, and it was very helpful to be grounded by the patient who spoke very powerful and from the heart. Adding that significant time had been spent on receiving reports from Committees and there could be further reflection on agenda items to take the opportunity to look beyond the next month and spend more time on the broader issues.	

Agenda Item	Discussion	Action (Owner)
	Gill Mordain, newly appointed Associate Director of Quality Governance, provided feedback stating it was useful to meet the Board and it was encouraging to see a Board working within the values of the Trust which was extremely important. There was challenge around the papers and solutions were being sought through the discussions.	
17.	**QUESTIONS FROM GOVERNORS AND PUBLIC** M. Mirza said thank you to R. Beale for the feedback on the meeting and thanked Hilary for being Medical Director and congratulated the new Medical Director for her appointment.	
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 • 25th May 2022	

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS – MAY ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
February 2022 Agenda item 10	Integrated Performance Report To report back on the processes in place for updating patients with their appointment details	V. Devlin	April 2022		An update from Divisions is attached to the log
April 2022 Agenda item 10	SSL Quarterly Report The Board would be presented with the SSL Sustainability/Green Strategy at the May Board meeting.	D. Tomlinson/S. Bray	May 2022		The item is on the agenda for the May meeting

RAG KEY

Overdue
Resolved
Not Due

Follow Up

Board of Directors Action

How are patients informed about their appointments?

Acute & Urgent Care

All acute adults on the bed waiting list under HTT will have regular contact with their HTT nurse, they are sometimes on the bed list because they have stopped engaging, but everyone on the bed list for inpatient adults are discussed daily at the bed meeting. waiting times are based on clinical need and bed availability. All patients in acute hospitals on the bed list have regular contact with LTP and have regular consultant reviews.

Secure & Offender Care

For forensic outreach teams, usually the professionals get in touch with the service users and arrange for an appointment, usually takes the form of telephone calls, letters and sometimes text messages depending on what suits best for our patients. The frequency of the visits depends on the risk and the care plan requirements. Our face to face appointments uptake is just above 75% for the month of Mar'22.

Specialities

This is ongoing work in relation to risk management and waiting times. In the older adult CMHT's team managers review the waiting lists and contact is made with service users and carers. Currently we also need to prioritise those most at risk. It is difficult to give an exact time when people will be seen as due to acuity in the team's we have seen lower rates of discharge particularly in the CMHT's.

For Memory assessment service waiting times are reviewed weekly and we are involved in system working to address waits. There are various factors as outlined in relation to informing people of when they will be seen. The teams are very much aware of this and managing this as best they can in liaison with service users and carers.

ICCR

We are currently examining data on waits in CMHTs services for assessment, treatment and follow up. All patients that are assessed and are waiting have access to the duty workers within the team should their situation deteriorate. The majority of patients are assessed within the 6 weeks wait time. Team Managers & Business support managers are reviewing data to cleanse, this is however challenging due to the capacity of individuals to regularly and consistently carry out this task. We are currently working through a programme of community transformation due for completion 2024, part of this work programme entails introducing a 4 week assessment to treatment standard which will negate the need to concern ourselves with long waits.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	25 May 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 FIRST team with Anne Baines, Non-Executive Director. It was a privilege to meet the team, to hear about the the work they do, their commitment to innovation and improvement as well as learning more about their ideas for addressing the challenges that can make their jobs harder than necessary.

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 was pleased to be able to Chair the AAC panel for recruiting a Consultant Psychiatrist in Reaside and Ardenleigh whereby we successfully recruited into post.

3.3 The Council of Governors took the opportunity to thank Maureen Johnson for her 12 years as a Governor as she sadly comes to the end of her term as a member of the Council.

3.4 The Council of Governors took the opportunity to thank Hazel Kench for her dedication and support over the years as a member of the Council.

4. QUALITY

4.1 I was pleased to be able to join the second development session with NHS Providers and the Trust Board where we had focused discussions regarding the impact of the pandemic and what the priorities are for our future together.

4.2 I chaired the Council of Governors meeting where we had the opportunity to receive updates on the upcoming Governor Elections.

5. SUSTAINABILITY

5.1 I completed mid-year reviews for members of the Non- Executive Team and was supported by members of the Council of Governors. It was a good opportunity to review the progress and priorities for the Non- Executives.

DANIELLE OUM
CHAIR

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT**
Date	25 May 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

My 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'S REPORT

1 LIVING WITH COVID 19

Across the country we have moved our approach to one designed to support us to live with COVID 19. In the Birmingham and Solihull system this has included a umber of changes to our guidance for example from a consistent requirement for mask wearing in all setting to a risk assessment approach to this in non clinical areas.

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 Senior People Partner for Acute and Urgent Care and Secure Offender Health Care division. Tajinder Ghai joins us from George Elliott Hospital and is already working hard to tackle several of the People Projects for this area. We are looking forward to welcoming a new People Partner in the same team and thank Laura Wright who has acted up into this role to give support and stability during the last few months.

A key focus for the People Team within Quarter 1 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. We have agreed an extension to the Occupational Health provision with our current provider PAM, and work is underway through collaboration with key partners across the trust to procure a new contract from 2023 onwards. We are mindful of the need to guarantee a service that reflects the equality and diversity needs of our workforce and this has been a big steer in the procurement process so far.

Turnover increased slightly to 10.4% in April from 10.2% in March 2022. Turnover has remained relatively stable over the last 12 months and the rate has been below the 11% Trust KPI target since April 2020. Turnover breakdown by division is as follows: ICCR – 9.6%; Specialties – 12.82%; Acute and Urgent Care – 8.67% and Secure Services and Offender Health – 11.69%. Turnover in Specialities and Secure Services is above the 11% Trust KPI. The People Partners are looking at our retention plans for professional groups, specifically Psychology and Occupational Therapists.

The Trust has completed participation in the "Flex for the Future" programme that is sponsored by NHS England and Improvement, and delivered by an organisation called Timewise. An action plan has been drawn up to start improving the flexible working offer

Sickness absence saw an increase in April to 6.6% from 6.1% in March

2022. Non-covid related sickness absence increased by 0.25% to 4.9% in April, whilst Covid-19 related sickness absence slightly increased to 1.7% in April from 1.5% in March. Short term sickness absence in April at 3.0% an increase of 0.5% from March of 2.5%. Long term sickness absence in April at 3.6% remained the same as in March.

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 over the coming month the appropriate forum to confirm and challenge these recovery plans in a consistent manner across the organisation.

Staff Survey

The People Team have been engaging to identify ways in which we can respond to the recent staff survey results. We have held several sessions as a Directorate to identify how we can identify, lead and implement on changes needed to make the Trust a better, safer place to work. We have had some innovative ideas emerging around future development opportunities and steward style leadership (i.e. managers work for their employees not the other way around). The team are actively working with staff in all roles to break down the results and make impactful changes to improve staff experience.

2.2 Organisational Development

A community of practice was established with Talent and OD colleagues across our Birmingham and Solihull system to determine how best to leverage Talent as part of the Integrated Care System (ICS) whilst embedding a vital network for supporting Systems Leadership. As well as this Leadership Development programme we will work towards supporting our leaders to become systemic thinkers and learn how to develop the new skills and post-heroic leadership required to successfully engage across systems.

We commenced our Trust Senior Leadership 12 month Leadership development programme with our partner Roffey Park in April. During this month we have also agreed a revised trajectory for our Trust leadership programme aimed at all of us that lead and manage others. The original trajectory we set has been impacted by COVID 19 absences and the significant workforce pressures we experienced over the last year. All Directorates have been asked to sign up to the revision and to the approach that we prioritise attendance based on our staff survey results.

2.3 Recruitment and Resourcing

Vacancy rates for March 2022 showed a decrease again to 8.1%.
Work to promote the perception of the Trust from our local communities and beyond so we can continue to attract applicants.

Targeted recruitment campaigns are underway for hard to recruit posts, which includes the use of various social media platforms to promote our vacancies, this includes sharing videos of staff sharing their experience of working in the Trust, as well as posts on LinkedIn and YouTube.

We are exploring how we can improve the benefits we offer as part of our attraction package, including a focus on flexible working and on specific wards only we will be offering a recruitment and retention premium.

On the 25th May, we are holding a jobs fair at the Uffculme Centee, specifically to attract nurses and occupational therapists. The focus is to attract retired nurses, nurses from other Trusts and students qualifying this year.

We will also be developing targeted attraction strategies for specific occupational groups and job roles where we have high vacancy rates for medical and dental staff, Occupational therapists and Very senior managers (VSM).

Reservist job fair

The Recruitment team have also been engaging with our clinical leads to ensure the Trust is well represented at the Reservist job fair on the 21th May at Millenium Point. This event focuses on retaining individuals who stepped up to provide covid vaccination support during the pandemic. We hope it will have a positive impact on recruitment.

2.4 I Can Programme

The ICS 'I Can' programme is now operational following a lengthy period of set up. To date over 100 individuals have joined the programme.

The Board will remember there was some questions in relation to the ability for Summerhill Services Limited (SSL) to be a partner in the programme, this has now been resolved and work is underway to enable SSL to join in.

We held a Listen Up Live in recent weeks that focused on this programme, how individual teams can access it as a talent pool and how ew can support family, friends and community members to access it.

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 like all our system colleagues have engaged in discussions with Trust colleagues on the practical things that may help ameliorate these to some extent. As a Birmingham and Solihull health and care system we have shared the emerging themes from this and through the working together of our Chief People Officers and Chief Finance Officer will pull together a proposed system plan of support for colleagues.

3 CLINICAL SERVICES

As we slowly emerge from the last covid Omicron wave, we can now see a reduction in wards closed to admissions and staff absences from work, and clinical services are now focusing on restoration and establishing future arrangements in clinical areas. This has commenced with a focused piece of work to increase our face-to-face contact with service users in our community teams working within a new blended hybrid model. The work was launched at our Performance Delivery Group (PDG) with, an expectation that divisions will work up plans via their local clinical governance group for present back to the PDG in May.

Our living with COVID plans also have a strong focus on how we manage demand across clinical areas, a key priority outlined in the clinical aspect of our strategy. This has taken on many forms with the key themes being:

- Transformation of services as outlined in the long-term plan of our crisis and urgent care pathways and community and rehabilitation services. Modelling of demand is enabling us to focus on pressure points, areas of need and gaps in service provision along with refining and developing new clinical pathways.
- Investment funding streams linked to our transformation, winter planning and mental health investment standards have enabled us to increase our workforce capacity offers from both our statutory services and beyond with our 3rd sector providers.
- A focus on early intervention and prevention as outlined again in our strategy to ensure we are supporting people at the earliest possible time avoiding a crisis episode following a deterioration in individuals mental health.
- Collaboration with our wider system partners including our local authority and voluntary sector colleagues is enabling us to widen our system mental health offer. This has been evident in our inclusion in the Ageing Well programme following the intensive diagnostic work by Newton Europe.
- A focus on managing our waiting lists and risk stratification of caseloads is also in place, ensuring that we are using all our available resources including both bed based and community provision.
- The consequences of Health inequalities is a significant risk and thus tackling these a priority throughout all the clinical services planning. Having access to local data is enabling the divisions to drill down and develop plans for tackling the inequalities

3.1 Specialties

Our Bi-Polar service has provided a second 5-day training to Community Mental Health Teams in Newcastle, Northumberland and Cumbria, who are embedding the BSMHFT model of Mood on Track programme into their community mental health offer. As leading experts, the service has also been asked to provide training on group interventions for Bipolar to several Health Education England funded courses at Universities across the UK.

There have been leadership changes in Barberry Specialty services with Caroline Clewer commencing as the Clinical Nurse Manager and Anna Rees as Interim Service Manager for perinatal community services.

Services across the specialties directorate area are working on recovery

plans to increase capacity for face-to-face contact, especially groups following new guidance for management of Covid risk. These recovery plans will enable an additional bed to open in our Neuro video telemetry department and Eating Disorder Day treatment is now increasing its activity.

Our dementia and frailty units have high levels of acuity on the wards and have experienced a number of service users requiring physical health care within general hospitals. This has increased the need for staff escorts and has highlighted challenges with reliable transport, the service is exploring alternative transport options. The two Covid outbreaks on Reservoir Court and Bergamot ceased mid-May. These restrictions had an impact on the availability of male beds and consequently had a negative impact on patient flow, which can now be addressed.

Bed availability has also been impacted by high numbers of Delayed Transfers of Care (DTOCS). We are currently working with our local authority colleagues to address gaps in social care input which has hindered the support in discharge processes.

A Recovery Action plan has commenced in Birmingham Healthy Minds (BHM), our Improving Access to Psychological (IAPT) service, this was presented to FPP committee last week. The plan focuses on steps to improve activity and achievement of KPIs following the impact of the pandemic and high vacancy rate. This plan aims to return BHM to an overachieving service within 12-18 months.

3.2 Integrated Community Care and Recovery (ICCR)

The leadership team are working closely with teams to support the quality assurance agenda including preparatory work for CQC inspections across all services. CQC preparation meetings have now evolved into quality assurance meetings led by our Head of Nursing.

NHSE/I gave high praise to BSols community transformation programme and leads at this month's touch point meeting. They have requested that we present to other systems to support their learning.

Transformation of rehabilitation is progressing with the initial Team Manager post out for advert. The National GIRFT (Get It Right First Time) conference was attended in London by leads and further guidance was gleaned and we were reassured that our model is in line with national requirements and expectations.

The work to complete the changes of our two High Dependency Units (HDU) in Solihull to single sex complex care units is still on track for completion by end of June. Expressions of interest will be reviewed re provision of HDU beds to support this reconfiguration. Work is ongoing to support the flow through our rehabilitation beds and to ensure we encourage appropriate referrals across the system.

The service is continuing work with system partners in Solihull and North Birmingham on the development of community hubs that will enable closer working with key partners. Two workshops have been attended so far and we have led the discussions on how mental health services will be delivered in the hubs. A wider programme of work around Birmingham

partnership working with a range of partners will be held mid May, BSMHFT leads will be in attendance to ensure the needs of those with mental health needs are included in any planning.

Addiction services Recovery near you & SIAS have received circa £450k each of new investment to develop services to meet the recommendations of the Dame Edna Black report. Service managers are working with teams to develop staffing models to enable recruitment to commence.

An official opening day of the SIAS new community addictions hub in Solihull will be held on 29th June. Invites will go out to all Board members and stakeholders to join this wonderful celebration. The staff and service users will be available to showcase their new community building full of bespoke therapeutic spaces and consulting rooms. We are delighted to announce that Dame Edna Black has kindly offered to attend to officially 'open' the new hub.

Adult community teams continue to experience high levels of activity and referrals, resulting in high caseloads and longer waits than we would wish. The service continues to manage waits using a multi-disciplinary team and risk stratification approach. As the community transformation plan moves forward, we will see an impact on activity being managed across both the primary and secondary care arms of the service, which will support us in meeting waiting time standards.

The directorate leads are continuing to meet with all teams to explore staff experience and how further improvements can be made to staff wellbeing at work. Teams have engaged well in these meetings and shared lots of ideas that will form a 'you said, we did' programme throughout the year. Teams are continuing to arrange 'away days' to ensure they have time out to reflect on their objectives and experiences over the past 12 months and to celebrate their achievements as a team.

Community Transformation Update

Funding and staffing model for community transformation has been confirmed and this will enable further recruitment and development of the model to progress. Work is ongoing with PCNs (Primary Care Networks) to establish their Additional Reimbursed Roles (ARRs) that will be employed jointly with BSMHFT & FTB. MIND is progressing recruitment to community recovery navigators to support the primary care offer.

We have stepped up engagement with our secondary care mental health teams and will be reconfiguring and recruiting to new roles to ensure the pressures within these teams are managed and supported. Primary care Mental health teams are now seeing patients in 4 areas (North, South, East and Solihull) West as our last hub will now start to recruit to enable the go live to plan.
Service users in this area are now able to access the Primary Care Mental Health teams directly via their GP, within South we have continued to trial self-referral, with East due to commence self-referrals trials at the end of Q1.

The programme has an established Voluntary Sector and Community Enterprise (VCSE) Partners Project Group, engagement with VCSE leads has continued, including input into the financial planning work and

developing the gap analysis for VCSE services in BSol. Further engagement has taken place recently with VCSE leads to consider options of collaborative working to enhance our diverse staffing offer to our service users and the communities we serve. To support collaborative working leads from both providers are working with partners including, VCSE, Local Authority and GP leads to finalise Information Sharing Protocols and Data Protection Impact Assessments to support the delivery of the pathway.

The advert for the divisions Equality Diversity Lead closed on 11th May with interviews scheduled for the beginning of June. This is a key role for the programme in ensuring our focus on tackling health inequalities and access to services for some of our key communities.

Considerable work has taken place over the last couple of months to develop the name and 'brand' of the new service. It was agreed through consultation with EBE's (Experts By Experience) from both providers, partners, VCSE colleagues and staff groups that the service name should reflect the service it delivers. The brand has also been agreed with ICS colleagues to ensure the colours, font and layout are all in keeping with the future ICS branding.
The title that has been agreed through this process is the Birmingham and Solihull Community Mental Health and Wellbeing Service.

3.3 Secure Care & Offender Health

Wards continue to experience registered nursing shortages across the men's and women's services and we are continuing with active recruitment in innovative ways. All Covid outbreaks have now ceased. There are changes to the Reaside leadership, with a new Clinical Service manager due to commending in post soon and changes to the Matron, Clinical Lead and Ward Manager posts as staff return from maternity leave.

We are pleased to announce the successful outcome and the award of the HMP Birmingham tender. The new contract will commence 1st November 2022. This will mark a rapid and considerable change in service as the Head of Healthcare and Deputy Head of Healthcare both move on to other roles/ventures. Dave Austin is taking over as the interim Head of Healthcare in June and the Deputy Head of Healthcare secondment is being advertised.

The psychology therapies service has successfully recruited to four Psychological Therapist roles (band 7) all of whom will take up their roles in September. Along with the welcomed return of maternity leaves over the forthcoming month, the directorate will experience a significant easing of psychological therapies staffing pressures.

The service is positively contributing to the development of our response to the Liaison and Diversion service re-tender process

The division celebrated International Nurses Day with cakes and vouchers being presented to all qualified and unqualified nursing professionals.

The leadership team are working closely with teams to support the quality assurance agenda including preparatory work for CQC inspections, this is across all services. In the last six weeks, the division had six visits from board members across Ardenleigh, Tamarind, Reaside and FIRST service lines.

3.4 Acute and Urgent Care

Preparation continues with the mobilisation plan for the opening of the Crisis House. The crisis house pilot evaluated extremely well and where clinically appropriate, prevented and diverted service users in crisis, who may have previously been admitted to a hospital inpatient environment. The crisis house is still on schedule to open in June.

The division celebrated International Nurses Day with cakes and vouchers being presented to each nurse and HCA across acute and urgent care. A number of senior leaders created video messages thanking our nurses for the amazing and outstanding work they do on a daily basis across the directorate.

The number of covid outbreaks increased again during April, staff have worked hard to contain wards to prevent spread, most ward isolations will be coming to an end during May.

The demand for inpatient acute care continues to be high as does the levels of acuity on the wards. Twice daily bed prioritisation meetings, which support clinical decision making for bed allocation continue and ensure all risks are taken into account and appropriate plans are put in place to support safe care.

4 SUSTAINABILITY

4.1 Funding

The Trust, along with many other NHS organisations, has been calling for additional funding to take account of the higher than usual inflation rates at the moment – this has led to increased costs in particular around our energy bills and contracts with PFI providers. Indications are that NHSE/I negotiations with the Treasury will result in more money being allocated to NHS providers to take account of these pressures and while the details are not yet confirmed, is likely to mean that we will be able to reduce the forecast deficit that we had initially reported.

4.2 West Midlands Mental Health and Learning Disability and Autism Provider

Collaborative Development Update

The MH/LDA Trusts across the West Midlands footprint continue working to review our focus as an establish regional Mental Health and Learning Disability and Autism Provider Collaborative. Recently a key appointment has been made to help progress the Trusts and CEOs intentions to revise and further fomalise the Collaborative working arrangements as well as leading on the mobilisation of the new a programme of work to support each Trust and ICS to deliver the Long-Term Plan and transform services at scale.

The aim of the Collaborative is for Trusts to work together on the greatest challenges to ensure high quality, sustainable mental health and learning disability services supporting local systems (ICSs) to improve population

health outcomes and reduce variation and address inequalities. Discussions are currently taking place with Trust CEOs and Executive Directors of Strategy to agree the revised collective aims and objectives of the Collaborative, and to identify the new priority areas to establish a delivery plan. This will be followed by further work to finalise and communicate the proposed governance model for Trust Boards to consider and determine links with wider local ICS/ICB governance frameworks. A meeting has been scheduled to take place on 30th June with Trust Chairs and CEOs to discuss the proposals and agree the next steps to disseminate the plans.

Whilst these new developments of the Collaborative are progressing, c£1m funds have been received from NHSE/I to support increase of supervision for psychological therapies and development of clinical support worker roles. Clinical colleagues are coming together to identify innovative ways of using this fund to achieve sustainable models across the region. More opportunities will be sought to work together to address workforce challenges across the region over the coming months, and to support this, networks are being created to facilitate these discussions.

4.3 <u>BSOL Mental Health, Learning Disability and Autism (MHLDA) Service Integrator Update</u>

Provider collaboratives described as ‘Service Integrators’ are at the heart of work within ICS’s to transform the care we provide for our citizens by driving integrated care pathways that improve outcomes and reduce inequalities. Across the Birmingham and Solihull ICS the MHLDA Service Integrator will be one of four large-scale collaboratives focussed on care programmes/pathways and having a delegated commissioning function.

The BSOL Integrated Care Body (ICB) Draft Operating Model has been developed to describe what future working will look like, what governance structures will be in place and the timelines for implementation. It is assumed that during 2022/23 Service Integrators will be readying themselves for ‘going live’ with formal delegated responsibilities from 1 April 2023. This will include developing an Integrated Delivery Plan setting out models of care, service and quality improvement plans, key delivery outcomes and investment expectations for workforce, estates and technology. The ICB is developing a Devolved Authority Assurance Process, which will have assessed each service integrator before 31 December 2022.

We continue to work with our partners to process the MHLDA Service Integrator, current priorities include:

- Developing a detailed programme plan, now timescales are more certain, along with a risk register and refreshed programme governance structures
- Defining the scope of the MHLDA Service Integrator
- Engagement with LDA partners, about how LDA and MH can be more integrated in the future and future plans for the Service Integrator
- Engagement with local authorities, ensuring they are involved in our planning and governance

- Engagement with the third sector, particularly around their representation in the collaborative and what this means for local organisations
- Drafting of Partnership, Risk Share and Data Sharing agreements

At our most recent programme board we also agreed to undertake more work to bring key groups of people together to ficus on the case for change, the opportunities and challenges this brings for service development and transformation to begin to determine our shared priorities.

We also continue to work with our colleagues across the BsoL system on the connectivity of integrators with place and localities.

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.

A number of new appointments have been made in the Directorate with individuals due to commence in role during May.

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 Ukraine

The government has confirmed that all Ukrainians arriving in England will be able to access NHS healthcare free of charge, including GP and nurse consultations, hospital services, and urgent care centres. The changes, which came into force on the 17 March 2022 will also cover any treatment that has taken place since the start of the Russian invasion. As part of the UK's offer to those Ukrainians coming to the UK, the government has committed to providing full access to a range of public services, including doctors, schools, and full local authority support. They will also be offered COVID-19 vaccines and medical screenings. The new legislative measures introduced will ensure Ukrainians who are in the UK lawfully can access the NHS on a similar basis as other UK residents

6.2 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)

6.3 Scope of COVID-19 Inquiry to be broadened

Following the consultation period into the COVID-19 Inquiry Terms of Reference, the Chair Baroness Hallett has completed an analysis of the responses received. On 12 May 2022 Baroness Hallett wrote to the Prime Minister and recommended that the scope of the Inquiry be reframed to put potential inequalities at its forefront; so that the investigation into any unequal impacts of the pandemic runs as a thread throughout the whole Inquiry. There are further proposed amendments which include a focus on the impact on the health, well-being and education of children and young people, and the wider mental health impact across the population. The final decision on the Terms of Reference rests with the Prime Minister, but the recommendations of Baroness Hallett are likely to be accepted.

In a letter to the Prime Minister, Baroness Hallett said: *"I believe these changes will ensure the Inquiry can best fulfil its purpose to examine the UK's preparedness and response to the COVID-19 pandemic and learn lessons for the future."*

6.4 Queen's Speech

The State Opening of Parliament took place on the 10th May with HRH The Prince of Wales delivering the Queen's Speech. The speech outlined the government's priorities for the year ahead, highlighting some of the 38 Bills that ministers intend to pass in the coming year. The key health announcement is the draft Mental Health Act Reform Bill which we expect to see published in the summer.

Draft Mental Health Act Reform Bill
The purpose of this draft Bill is to ensure patients suffering from mental health conditions have greater control over their treatment and receive the dignity and respect they deserve. It will also make it easier for people with learning disabilities and autism to be discharged from hospital.

The main elements of the draft Bill are:

- Amending the definition of mental disorder so that people can no longer be detained solely because they have a learning disability or because they are autistic.

- Changing the criteria needed to detain people, so that the Act is only used where strictly necessary: where the person is a genuine risk to their own safety or that of others, and where there is a clear therapeutic benefit.

- Giving patients better support, including offering everyone the option of an independent mental health advocate, and allowing patients to choose their own 'nominated person', rather than have a 'nearest relative' assigned for them.

- Introducing a 28-day time-limit for transfers from prison to hospital for acutely ill prisoners and ending the temporary use of prison for those awaiting assessment or treatment.

- Introducing a new form of supervised community discharge. This will allow the discharge of restricted patients into the community, with the necessary care and supervision to adequately and appropriately manage their risk.

- Increasing the frequency with which patients can make appeals to Tribunals on their detention and provide Tribunals with a power to recommend that aftercare services are put in place.

- Introducing a statutory care and treatment plan for all patients in detention. This will be written with the patient and will set out a clear pathway to discharge.

In January 2021, the Department of Health and Social Care published a white paper on Reforming the Mental Health Act. The paper set out reforms which build on recommendations made by an independent review in December 2018: Modernising the Mental Health Act: Increasing choice, reducing compulsion. The government consulted on the white paper's proposals from January to April 2021 and published a consultation response in July 2021.

6.5 Health Education England

NHS Providers have responded on behalf of Trusts regarding Health Education England's (HEE) budget which has just bene published. They have stated:

This long overdue announcement on HEE's budget will be welcomed by NHS trust leaders. The £500m increase, including an extra £160m to support training to support backlog recovery, is particularly welcome at a time when demands on the NHS are rising. But there are challenges ahead.

With dire warnings from the governor of the Bank of England yesterday, there is a very real risk that rising inflation depletes this – and the wider NHS – budget. And despite the best efforts of trusts and their frontline staff to bear down on care backlogs, concern remains about the NHS' recovery for the year ahead, with waiting lists expected to rise further as more people come forward for treatment that was delayed by the COVID-19 pandemic.

Trust leaders are committed to the training and developing their staff and they will of course, take seriously HEE's concerns over the potential impact of recovery targets on staff and students' education and training.

But the simple truth is that the NHS simply doesn't have enough staff at this point, and that significant, sustained action from government will be required to solve this issue. Trust leaders are working incredibly hard and innovating to cut waiting times, but pressures on our existing overstretched staff, and

persistent major workforce shortages, are preventing trusts from going even faster.

We have 110,000 vacancies in trusts alone, high levels of burnout and worrying numbers of staff resigning from the service. We can't keep asking the workforce to simply do more. There needs to be a long-term, fully funded workforce plan for the NHS to support HEE's work now and in the coming years."

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7**
Paper title	**CHAIR'S ASSURANCE REPORT FROM QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE**
Date	18 May 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 18 May 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 CQC Update

The Committee received an update on the activities related.

The salient points were noted as follows:

- Changes to the report to the CQC have been made in line with the requirements of the new Lead Inspector
- Safety huddles continue with high compliance
- Door alarms in North and Central are complete, delays noted for competition in the South. A plan is in place going forward. Risk noted.
- Damage to doors from service users has increased, Estates and Facilities are supporting the repairs
- Staffing issues continue, risk noted
- Therapeutic Observation Policy is nearly complete
- MHOST implementation delayed, national delays in training were noted, finance are supporting the process, noted as a priority risk
- Inspection date is yet to be confirmed, the Trust are not a high priority and remain transparent with reporting and escalating to the CQC
- The launch of the new 'Trigger Tool' will be confirmed
- CQC deck of cards have been sent to Board members in preparation

There were detailed discussions regarding the implementation and use of MHOST with the Committee acknowledging the need to be more creative in the interim. It was confirmed this is multifaceted and were assured the audit process for the establishment is robust and will be reported to People Committee for escalation to Board.

The Committee discussed concerns regarding the level of experience for some staff and the impact this can have service users and service delivery. It was agreed better understanding is required to understand the impact on health inequalities and use of restrictive practice.

Chair's assurance comments:
SB has had a useful first meeting with new lead inspector and reviewed and agreed format of reporting including SPC charts for ligature events as well as more of a focussed reporting on quality as well quantity of necessary actions. We understand that we are currently not high priority for forthcoming inspection and await a new trigger tool for inspection that CQC is currently developing

Committee was advice that Environmental works are completed in some areas ahead of schedule but in others are delayed due to delays in obtaining building supplies which is a national issue
There were detailed discussions regarding the implementation and use of MHOST with the Committee acknowledging that assessment of safe and effective establishment on the wards is multifaceted and will include for example what unregistered roles we can put in place to support across the day .Committee was also assured about the variety of activity that is ongoing to improve SU experience: acute wards now linked to community they serve (Better able to develop cultural local resources , increase knowledge about SUs needs),

Restrictive practice collaboration , seclusion review, analysis of protected characteristics.

1.2 Infection Prevention Annual Report

The Committee received and noted the Infection Prevention Annual Report and noted the salient points:

- Mary Seacole hot spot with the largest outbreaks throughout the pandemic
- FFP3 compliance issues noted, the Committee were assured staff are being held to account for low compliance with plans being completed for divisions
- Support mechanisms in place for supporting staff, purchase of smaller masks and device for fit test
- Food Safety Group established and will meet quarterly to address issues
- Flu uptake poor, low compliance nationally
- COVID themed review will be complete and received in the coming months

The Committee noted the risks for low compliance for use of FFP3 in the community highlighting the risk of TB. It was confirmed risks have been escalated with team managers and divisional teams.

Chair's assurance comments:
Committee were assured that COVID related learning and monitoring is continuing to take taking place and a themed review is to come to committee in coming months. For example, learning from a prolonged several months outbreak on Mary Seacole Ward has highlighted the need to balance urgency for admission from a MH risk perspective versus risk of prolonging outbreak and impact on subsequent patient experience e.g., Reduced Leave and more restrictions.
The committee were assured to hear that staff are being educated and held to account for infection control measures including need to consider other airborne transmissible infections such as TB in the community and that FFP3 masks have been improved to suit different users

1.3 Safeguarding Annual report

The committee received a detailed presentation on the Safeguarding Annual report for April 2020 to April 2022.

The focus on embedding safeguarding as a system link across all areas was confirmed with the Committee being assured standards, baseline and frameworks are a priority in line with shaping the culture for safeguarding across all organisational teams.

Safeguarding compliance for level 2 is above expected compliance, level 1 and 3 remain below compliance standards. The Committee were assured training options for face-to-face training has been reinstated alongside hybrid options. Links with BSoL Adults and Childrens Board are being strengthened and training offers through the partnerships are being promoted and included in compliance reporting for training.

A hot line for concerns to be raised has been implemented with a high number of calls relating to domestic abuse, escalations are made to the local authority.

Workplans are being developed with a focus for driving key areas forward.

The National Panel report has been received in draft and remains embargoed.

The team have reviewed the report for accuracy against the scoping and returned. Staff from the related services are being supported.
Issues relating to accessing safeguarding information remotely have been raised in relation to Street Triage were noted with assurance a 4G service to access records is being developed to enable this

Chair's assurance comments:
Committee welcome Jane Wilkinson, Interim Head of Guarding, who is joining us.
Committee reviewed Annual report of past 2 years. We were appraised of the focus and vision of an ISS integrated safeguarding system and the Standards and baseline framework to aid assurance.
As part of a commitment to Shape a robust safeguarding culture within our organisation Committee was given Assurance of the work plan of the safeguarding team (which has an increase in capacity) to be actively engaged with teams by, for example offering supervision, guidance, audit of staff attendance at safeguarding meetings as well as exploring data held in partner organisations re race, age, gender.
Learn in compliance has been a challenge over the past 2 years and committee were impressed by how staff have adapted to change during the pandemic, and the excellent safeguarding achievements that have been made.

1.4 Prevent Annual report

The Committee received the Prevent Annual report and noted the salient points:

- Compliance training is at 92%
- Solihull community has seen a change in residents with a large number of refugees from a range of countries, no concerns raised
- Birmingham and Solihull threat remains substantial
- Police priorities remain young people, online risk and need to increase mental health understanding and knowledge

There was a detailed discussion regarding the risks in relation to discrimination and need to manage the risk appropriately by understanding the balance and addressing health inequalities.

The Committee were assured Prevent in Place is active on secure wards in partnership with multiagency colleagues.

Escalation to Trust Board was agreed with a report to be bought to this month's Board meeting with a focus on what our offer to the community is.

Chair's assurance comments:
Committee was assured as to level of compliance training
However, we were informed that Threat level is substantial, particularly from Islamic extremism, and high-risk during Commonwealth games and HS2 protests Birmingham has received extra funding due to high need.
There was a detailed discussion regarding the risks in relation to discrimination and need to manage the risk appropriately by understanding the balance and addressing health inequalities We wish to escalate to Board to consider our strategy to address this, taking into account need for this approach not to alienate and impact on the wellbeing of these communities.

1.5 Ligature Deep Dive

The committee received a detailed overview of ligatures. This review was carried out in order to understand some of the factors associated with incidents involving a ligature without anchor point. Analysis of anchor point ligature incidents is completed through initial management review of each case due to the seriousness of potential outcome for these.

Whilst non anchor point ligature incidents by their nature have the potential to be lower risk due to the absence of body weight, they account for the vast majority of ligature incidents during this period 287 of the 302 overall ligature incidents (95%).

	Sept – Nov 21	**Dec 21 – Feb 22**
No. of incidents	160	127
No. of unique patients	51	33
No. of harm incidents	29	15
% of incidence of harm *(average harm rate for all incidents of all types during period = 15%)*	18%	12%
Highest no. of incidents per patient	18	56
% with more than 1 incident	43%	39%
% with 10 or more incidents	6%	9%

- From December 21 to February 22 56 incidents related to one service user
- No harm was recorded for the majority
- High number of white, British females with EUPD

The Committee noted the positive reductions and change in approach. This remains work in progress.

Chair's assurance comments:
Committee found the Ligature deep dive was highly informative and highlighted the complexity of working with patients with EUPD. We were partly assured by the work in progress, using the approach of Trauma informed practice leading to reduction in harm and reduction in incidents where applied. Although we were made aware of the variation in expertise and approach across teams.

1.6 Mental Health Legislation Quarterly Report

The committee received the detailed report highlighting the following:

- There were 954 detentions under the MHA in Quarter 4
- There were 85 incidents reported with the top category being AMHP related issues, although there was a reduction to 28 from 56 in Q3
- There were 2 CQC MHA visits and the key points raised for action were around blanket restrictions, care planning and a large number of issues raised around safety / ligature risks / environmental issues and use of bedrooms for seclusion
- There was no complaints data submitted for quarter 4
- 1 concern was received from Lay Managers from hearings about patients lacking capacity not having representation from a solicitor or an IMHA. Reponses received from service areas
- Quarter 4 saw 271 referrals, compared to 231 for the same time last year. Concerns were escalated and raised through JSOG. Multi-agency meetings have taken place and mitigations in place where possible to plan best practice

with the limited resources, but underlying causes are beyond the remit of these meetings and require further escalation. The police advised the trust at these meetings their Chief Constable intends to seek legal action as they say the Trust and the Local Authority are not meeting our legal obligations under the MHA

The Committee had a detailed discussion regarding the concerns raised by the Chief Constable and were assured the Trust have not acted unlawfully.

Chair's assurance comments:
Committee was assured by data that demonstrated that compliance with MHA legislation was generally good
For example, number of Appeals hearings have doubled in past year which is thought to be due to patients been given their rights more often
Committee had a detailed discussion about increase numbers of and delays in sec 136, which is a national trend. We were assured that trust is working in partnerships through JSOG
and that a newly created pathway for intoxication and an increase in AMPHs is likely to help. Also, that Urgent and acute care alongside Bed management is operating a robust risk assessment in practice as well as working together with FTB at a strategic level to address these issues.

1.7 Draft Quality Account

The committee was asked to receive the draft quality account.
It was confirmed the final version will be received in June 2022 for approval.

Chair's assurance comments:
Report was noted at committee and final version to come to committee in June.

1.5 Hot Topics

The committed noted the query from Trust Board:
G. Hunjan requested assurance that in light of a national media story regarding a child being stripped searched by the police, whilst unaccompanied, could assurance be provided that the policies within the Trust adhered to national guidelines.

DECISION: This would be escalated to the Quality, Patient Experience and Safety Committee.

It was confirmed the Trust do not strip search and any concerns in relation to actions taken the police will be challenged and escalated appropriately.

The Committee were appraised of:
- Escape from Ardenleigh, the service user returned safe and well.
- Inpatient death at Ardenleigh, suspected suicide
- 2 PFDs received, the Trust were unaware of one of these and the Legal Team are drafting a letter to the coroner.
- Next meeting will be face to face following a clinical visit

Chair's assurance comments:

Committee had a rich discussion as to how to incorporate ongoing issues of concern into dashboard including narrative and data and active consideration of high-risk issues such as how people issues affect quality

Committee agreed that next meeting would be face to face on a Trust site which has enough services for us to visit in small groups to gain further assurance as to quality of services

LINDA CULLEN
NON-EXECUTIVE DIRECTOR

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	8
PAPER TITLE	Infection Prevention & Control Annual Report 2021-2022
DATE	25.05.2022
AUTHOR	Filipe Leitao, Lead Nurse for Infection Prevention and Control
EXECUTIVE SPONSOR	Sarah Bloomfield, Executive Director of Quality and Safety

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?	

Executive summary & Recommendations:

1 - Compliance with Key Performance Indicators

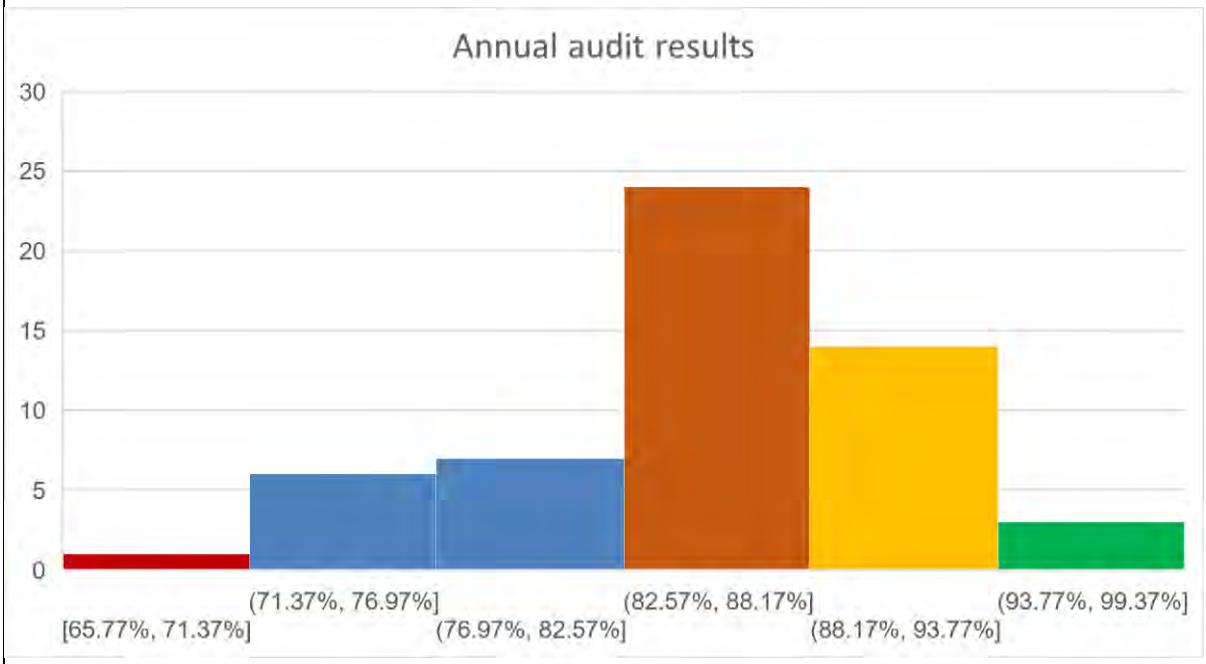
Standard	Progress
Compliance with national mandatory surveillance for bloodstream infection MSSA and E.coli.	*No cases reported*
Zero tolerance of MRSA bloodstream infection, minimise rates of *Clostridium difficile* (C. diff)	*Nil to report*
Completion of Root Cause Analysis (RCA)/Post Infection Review (PIR) and other significant HCAI's within set time scales.	*Clinical reviews were undertaken in line with trust risk management policy in response to outbreaks of infection.*
Compliance with Hand Hygiene Audit. 95% threshold	*The Trust has met its overall compliance of 95%.*
Compliance with Antibiotic Audit. 80% Threshold	*Quarterly reports on usage and recommendations/actions presented to IPPC by Chief Pharmacist*
Compliance with national cleaning standards/British Standards 95% threshold.	*The Trust has consistently met its overall compliance of 95% or above.*

The Trust has always been above the 95% threshold, but there still are several teams that do not have core hand hygiene trainers.
The IPC team is working on supporting the teams and ensure they can access the Hand Hygiene Training while new trainers are identified.
There are also some teams with lone workers were this is not possible, and the IPC teams has

been working towards ensuring those teams have up to date training on hand hygiene, but the auditing will not be possible since auditing is not easily feasible or will give us no assurances.

2 - IPC auditing program

During this year the IPC team had the support of an agency IPC nurse, allowing this way to increase 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.
The distribution scoring is as follows:

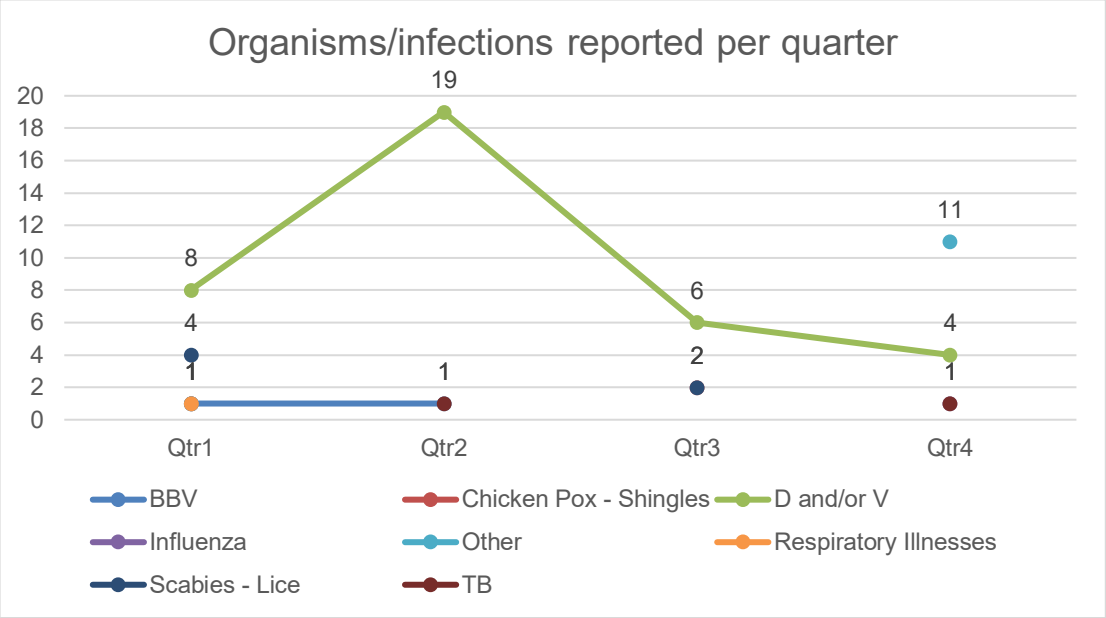


The majority of the audit sites have scores equal or superior to 82.57%, being the interval between 87.2% and 88.17% the highest group.

While IPC is happy that the results reflects the current trust situation, our aim is increasing the average score from 83% to above 90%. This is a complex goal to achieve due to the multitude of settings across the trust and its disperse nature. The engagement of all our staff is essential and this can only be achieved with the support of the local managers in moving the IPC agenda forward. Also, for the achievement of this goal, it is necessary that the IPC teams are not only given the support of human resources to audit but also have tools developed to be able to active monitor the local IPC situations, as for example an IT solution to aggregate results from local audits that can be monitored by IPC and help guiding us to identify areas of particular concern where we need to focus more our attention. Another aspect that will need reflection and strengthening going forward is establishing effective communication channels were IPC can easily send its messages across but also have useful feedback from staff working in patient facing roles. This is particularly complex in community teams, since in the current setting on what concerns to inpatient areas, The IPC team can quickly lease with the matrons for the areas.

3 - Surveillance of Alert Organisms and Outbreaks

We had a total of 64 reports of infection (excluding MRSA and COVID related)

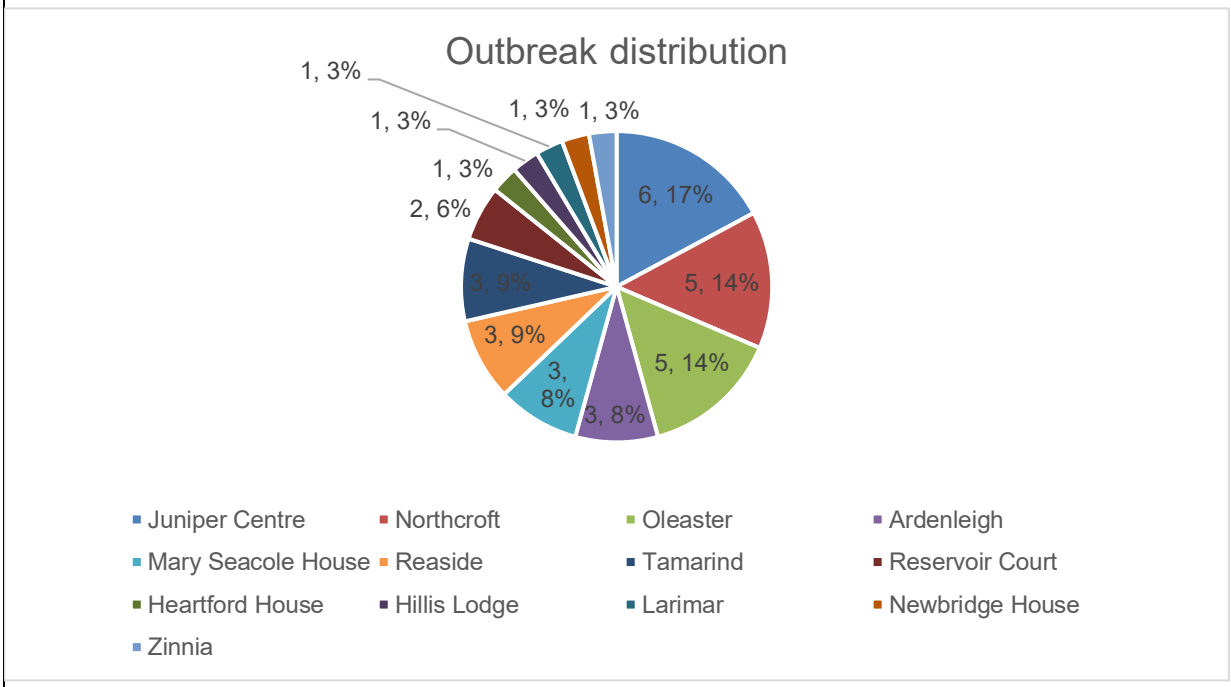


The most reported was D&V, nonetheless there are no reported outbreaks of D&V. The areas with highest number of cases were Chamomile (7), Reservoir Court (7) and Rosemary (6).

No Non-COVID related outbreaks declared

3.1 – COVID Outbreaks

We reported a total of 35 COVID outbreaks with the following distribution



The COVID outbreaks were widespread on the Trust, including some outbreaks in community settings (none of those had SU affected). There were 3 sites that seem to be more relevant. Juniper center by having the highest count of SU affected as part of an outbreak, Mary Seacole due to the length of the last outbreak there and Jasmine with communicating challenges with hearing impaired SU and staff.

The highest number of SU affected was in Q3.

All outbreaks were followed up with the local management area, DIPC, IPC team, microbiologist and external stakeholders invited to outbreak meetings (PHE, NHSi, CCG, Health protection team).
Due to the very high number of outbreaks, the Trust paused individual meetings per outbreak with external stakeholders (nonetheless, they were kept internally) and opted to do a weekly review meeting where all the outbreaks were discussed and assurances were given, as started during Q4 of previous year.
During the year, the Themes identified relating to the COVID Outbreaks were:

1. Delay on isolation due to lab reporting issues
2. SU meeting in communal areas
3. PPE Breaches
4. Staff not bare below the elbows
5. High dust
6. Air vents requiring cleaning
7. IPC board not up to date
8. Physical damage

3.2 - Mary Seacole House

The most complex and long outbreak was on Mary Seacole, involving MS1, MS2 and Meadowcroft initially and with the closure of MS2 and sustained control of Meadowcroft it continued in MS1. This outbreak was declared on 08/09/2021 and the last reported case was 15/01/2022 (approximately 22 weeks). This was particularly challenging to control due to not just some of the themes identified in other outbreaks but in particular because with the pressure for beds, it was never possible to fully close the ward to admissions, having the ward frequently admitted SU with positive cases. These cases should not have caused the prolongment of the outbreak by themselves, but the delays the Trust had during the year to obtain fast PCR results for both SU and staff, frequently caused positive newly admitted SU not being quickly identified as positive cases. Therefore, being able to roam the unit before any result was made available. The advice has always been to isolate on admission, but legally without symptoms or a positive result, forced isolation and mask enforcement was not an option. Also, not all SU were capable or willing to wear a mask and even when this was possible, an individual and global risk assessment was needed to ensure that the mask would cause no risk to other SUs.

4 - External visits

Due to the complex and prolonged outbreak, the IPC team invited the CCG IPC team to visit Mary Seacole and discuss the situation and arrangements in place. During the visit some environmental and PPE adherence aspects were identified, in line to which have been previously pointed by the IPC team. One of the most important was frequent PPE breach. To respond to this, the Human Resources Department (HR) was involved in the discussion and a letter was created to be given to frequent offenders explaining the possible disciplinary consequences of continuing not adhering to the Trust guidance, in parallel with a discussion with the staff member about what and why the compliant behavior was essential. The implementation of this document had very positive feedback significantly reducing the challenges around PPE compliance. All other findings were addressed in an action plan by the ward matron and monitored during informal support visits and weekly discussions both in the internal outbreak meeting as well as the meeting with external stakeholders.
By invite of the DIPC on the 11th of February 2022 PHE came to visit the ward (at this point the outbreak had already been closed).
The visits findings were:

- Fridge temperature monitoring not properly recorded on the paper form.
- COSHH breach due to bleach tablets found not locked
- Outbreak minutes for outbreak meeting with PHE and other external stakeholders had minimal information around the support visits performed.
- Trust external page outdated on what concerns to IPC information and DIPC statement not available

Due to the findings, the auditor opted to escalate the Trust to AMBER on the NHSi internal escalation matrix and recommend a new visit on the future.
The recommendations of the visit were:

- All visits/spot checks to be annotated and signed by an IP specialist.

- Strengthen the outbreak assurance governance process.

It is important to point that during the outbreak meetings with PHE, NHSEI, CCG and other external stakeholders, there was never reference to any concerns around the governance processes and the same was not referred during the CCG visit, nonetheless the IPC team developed an action plan with the following points:

Action
1 - Develop Outbreak tool General
2 - Develop Outbreak tool Covid
3 - Develop Community audit tool - Monthly local
4 - Update external web page
5 - Review training (IPC)
6 - Develop Spot checks form
7 - Algorithm for outbreak management updated
8 - Collate audit results in spreadsheet
9 - Discuss Fridge temp monitoring with pharmacy
10 - Program of audits
11 - Surveillance check
13 - Discuss internal pages for IPC - Intranet
14 - Book program of work meeting

5 - FFP3 respirators face fitting

During the year a face fitting program has been in place with currently 3 masks being used.

The Trust has the support of 2 external face fitters that perform mobile face fitting clinics on demand across the trust. Besides the efforts, the percentage of staff currently face fitted is under 50%.

This is a point of concern, not just for COVID exposure but other respiratory diseases like Flu, Tuberculosis, or any respiratory infection from unknown agent.

It is essential to work towards increase not just the overall percentage of staff face fitted but as much as possible to aim that most face fitted staff is able to use 2 different types of masks with the aim to increase resilience in case of future struggles of supply.

IPC advice – it is important that the Trust includes in its regular training a program of face fitting with a refresh at least every three years or before if needed.

Organize oversight of face fitting program, including record and monitoring of compliance

Include face fitting during induction

6- Incident Reporting

The most significant values are related to Possible transmission risk, this item incorporates a very wide range of issues like spit with risk of contact with the eyes to physical wounds with skin breach and would

require a broader analysis to understand that if it is related to increase in violence in our wards and the factors contributing for it.

Sum	Q					
Infectious incident	**1**	**2**	**3**	**4**	**Grand Total**	**Trend**
Blood Stream Infection (E-Coli, MMSA, MRSA…)	0	0	0	0	0	
Clinical Waste Management	4	5	4	4	17	
Incorrect Test Results (Specimens)	0	0	3	1	4	
MRSA Management	0	0	0	1	1	
Possible Transmission Risk	9	31	46	53	139	
Tests - Failure / Delay To Undertake	14	10	7	7	38	
Ward Closure Due To Infection Outbreak	0	2	11	5	18	
Wound Management (Resulting In Infection)	1	0	0	0	1	
Grand Total	**28**	**48**	**71**	**71**	**218**	

7 - Food Safety

At present, the Trust has no food expert, so the annual audit had to be externally sourced. It is recommended that the Trust contracts a permanent food safety expert to allow continuous monitoring and training of staff

On the next table we can see the summary of food related incidents eclipsed across the year. The number of reports is very low and have not seen increase across the year.

Count of Count	Q					
Food Safety	**1**	**2**	**3**	**4**	**Grand Total**	**Trend**
Food From Unapproved Supplier	1	1	1	1	4	
Foreign Body Identified In Food	1	1		1	3	
Inappropriate Storage Of Food	1	1	1	1	4	
Other Catering Issues	1	1	1	1	4	
Other Food Safety Issue	1	1	1	1	4	
Out Of Date Food	1	1	1	1	4	
Grand Total	**6**	**6**	**5**	**6**	**23**	

8 - Water Management

The WSG continues to respond to elevated Legionella counts identified in some of the water sampled in Trust buildings

At Reaside, an ORCA system for Legionella management continues operating, estates continue works to look at a future possibility of discontinuation of the ORCA system.

A similar ORCA system is being installed at Eden Unit

Where legionella counts are elevated, the outlets were temporarily closed as per policy, and remedial works done as needed.

When this is not possible, water filters are installed on the outlets, nonetheless this is dependent on risk assessment since the water filter have been identified as possible ligature points. It is important to mention that the use of water filters is never a long-term solution, but a way to reduce risk until a more permanent solution is put in place. Currently we have issues with elevated legionella counts in George ward, Forward/venture house, Eden Acute

9 - Capital Developments

The IPC team has worked with Estates and clinical staff to ensure that standards to meet the requirements of the document “IPC in the built environment” have been incorporated into refurbishments and works undertaken.

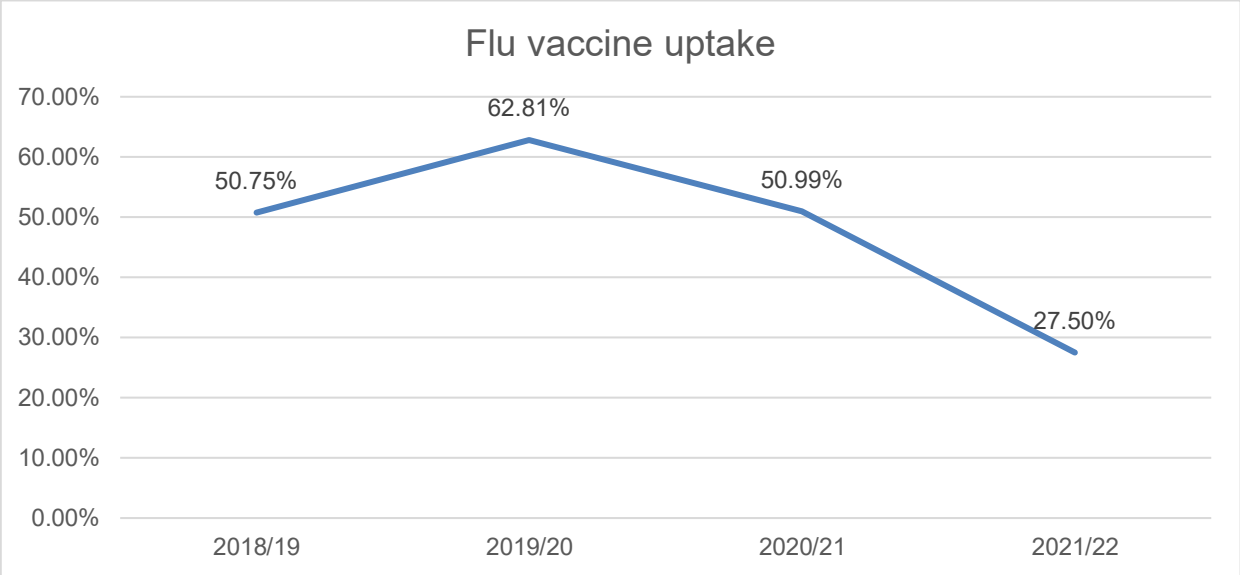
Place of safety has now concluded works, but not invited IPC to visit before opening. Some issues have been identified and are currently under discussion.

Newington finished construction works, IPC invited to walk around. Several fixtures still waiting to be installed and no furniture yet in place. No major issues identified. IPC will re-visit the unit.

10– Vaccination

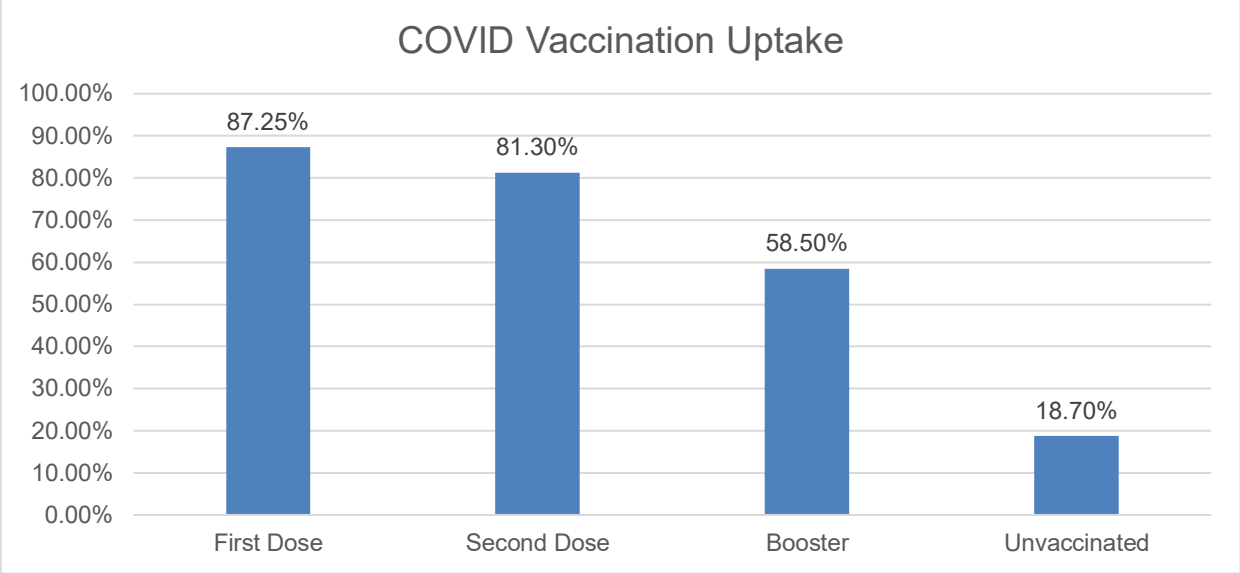
10.1 - Seasonal Influenza vaccination

The Trust final position following validation was submitted to Public Health England in March 2021. Our final staff flu vaccine uptake is 27.5%, a decrease of 23.49% compared to the 2020/21 final total of 50.99%, which represents a significant decrease.



10.2 – COVID Vaccination

The COVID staff vaccination has been more successful than the flu vaccination has ever been in the trust. The following table shows that we have around 81.3% of staff with 2 inoculations of COVID vaccine, in contrast with flu 27.5%.



From SU side we worked hard on making vaccine available to our SU. This is an ongoing and dynamic process, due to the constant rotation of service users on our wards and sometimes the level of acuity of our service users. Regardless, the IPC team worked with the matrons of all areas, to identify the needs for vaccination and set up a plan to cover all SU that accepted being vaccinated. We were this way able to increase our resilience and safety to COVID infections, but this is an ongoing process.

Reason for consideration:

IPC team proposes reflection/action on the following points

- Need to adopt electronic audits across the Trust
- IPC team needs integrated platform (e.g. ICNet)
- Subpar FFP3 fitting levels
- Face fitting program to be allocated to a team and needs dedicated admin support
- Discuss with labs through contract team the availability of rapid PCR testing
- Consider recruitment of food safety expert for the Trust
- COVID vaccination program for SU to be organized (depending on guidance)

Previous consideration of report by:

Infection Prevention Partnership Committee on 26/04/2022

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

Financial Implications *(detail any financial implications)*

- Funding needed for IPC integrated platform to be adopted (research needed on costs).
- ITC engagement and funding to for electronic audit system either through IT in house development or purchase of an electronic solution
- FFP3 fit testers already in place – use of fit testers is currently sub-optimal

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

Engagement ***(detail any engagement with staff/service users)***
Engagement needed with managers to ensure good communication between IPC and staff, also on what concerns to ownership of goals such as successful vaccination campaigns and face fitting.

Birmingham and Solihull Mental Health NHS Foundation Trust

Infection Prevention and Control

Annual Report 2021/22

Contents

Appendices

Tables

Executive Summary

The 2021/22 annual report outlines the Trust's continued commitment to minimising the risks of Healthcare Associated Infection (HCAI) on our services and to promote best practice in infection prevention and control, as well as the response to the COVID pandemic.

It details the activities undertaken by the Infection Prevention Partnership Committee (IPPC) and the Infection Prevention and Control team (IPCt) to lessen the risk of avoidable harm to service users and promote safe working practices for trust staff and the measures put in place to minimise the disruption of services due to COVID as well as keeping staff, service users, contractors, and visitors safe.

It demonstrates collaborative working to ensure that national initiatives are incorporated into trust policies, procedures, and guidance to inform best practice and to improve health outcomes for our service users and the wider community.

The Trust has continued to monitor compliance with regulatory requirements and is assured through the IPPC that services are safely and effectively managed through receipt of quarterly reports on audit, training, and surveillance of incidents and outbreaks of infection.

The report follows the format of the Health and Social Care Act (2008) Code of Practice of the prevention and control of infections and related Guidance (Department of Health 2015) to demonstrate our compliance with the criteria and recommendations for 2022-2023 work plan to strengthen assurance.

Introduction

The IPC team workload has had a substantial challenge during this reporting period, in particular, due to the ongoing COVID pandemic.

The Trust has a contract with Public Health England Laboratory, Birmingham, to provide expert infection prevention and control advice by a Consultant Medical Microbiologist, referred to as the Trust Infection Control Doctor.

This report sets out the activity undertaken by the IPC team and the Infection Prevention Partnership Committee under the Director for Infection Prevention and Control (DIPPC), who is the Executive Director of Nursing. The report is not exhaustive of all work undertaken, focusing on the main areas of progress against the annual plan of work and items of note by exception.

1. Compliance with The Health Act 2008 Code of Practice on the prevention and control of infections and related guidance

The table below sets out the actions taken by the Trust to evidence compliance with the code of practice and actions for 2021/22 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of Trust compliance	Recommendation/action for 2022-23 work plan
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• Director for Infection Prevention and Control • Infection Prevention Partnership Committee (IPPC). • Annual Programme of Work. • Annual Audit Programme • Annual Report to Trust Board. • Quarterly report to Clinical Governance Committee. • Risk Register review. • Training provision and • IPC champions programme • Policy review programme • Water Safety Group. • Trust Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist. • Access to microbiological testing • Seasonal Influenza Planning • COVID vaccination planning.	1. Development of an informatic tool for IPC audits (IPC team and monthly local audits) to ensure: - Single point of access. - Fast and consistent reporting. - Facilitate tool review. - Monitor compliance. 2. Revision of IPC audits and implementation of outbreak spot check audits COVID and non-COVID. 3. Acquire electronic system for management and record for IPC (e.g., ICnet®), including recording and management of outbreaks – Single point of access for IPC information.

2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	• Quarterly reports on cleanliness standards to IPPC • An annual programme of deep cleans • Annual PLACE inspection • Rapid Response team • Monitoring of contractors cleaning performance. • Cleaning Policy • Decontamination Policy. • Quarterly Dental Suite audits • Waste Management Policy • Access to Food Safety Advisor • Food Safety Policy • Water Safety Group • Control of Legionella Policy • IPC input to the built environment new build and refurbishment projects.	4. Auditing control of legionella policy requirements undertaken by the WSG. 5. Recruit food safety advisor or procure external service. 6. Recruit decontamination officer for the Trust 7. Develop a solution to centralise cleaning as well as local monthly IPC audit results with other IPC audits (as per point 1)
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	• Electronic prescribing. • Quarterly Antibiotic Audit Report. • Trust antimicrobial guidance document • Doctors' induction • Access to microbiological advice.	8. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice (Chief Pharmacist); 9. Include SEPSIS awareness training for IPC champions; 10. Ensure Trust Pharmacist antimicrobial use report is presented quarterly to IPC committee
4	Provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• IPC representation at Service User Experience Group • IPC notice boards • Hand washing notices. • BBV Screening secure care • Close work with comms to ensure adequate messages and information are available on internal and external sites – Currently reviewing internal and external pages	11. Provide information to be cascaded to clinical areas with relevant information displayed on the IPC boards at the clinical areas – Discuss processes to ensure information is successfully cascaded in the future 12. Regular meetings with matrons/managers for IPC update 13. Review internal and external web page and Discuss with Comms process to ensure the pages are curated and timely updated;

5	Ensure prompt identification of people who have or are at risk of developing infection so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people	• Electronic notification forms to the IPC team from RiO patient record. • Electronic pathology reports • Expert infection Control advice from the Trust IPCN's and contracted service of a Consultant Microbiologist. • Access to specialist TB service at Birmingham Chest Clinic. • BBV screening • Sepsis awareness of risk associated conditions such as pneumonia, urinary tract, and wound infections	14. Training of staff through IPC and Physical health to ensure early identification of at-risk patients and development of good strategy/care plan to prevent or address the situation. 15. Ensure that all inpatient areas have up to date cohorting plans if necessary as well as identified contingency measures in case of an outbreak; - 16. Ensure information given on training and link workers is cascaded to the team – Discuss processes to make this feasible. 17. Keep support from band 6 nurse to monitor RIO notification and lab results in a timely way and ensure the adequate advice is given and information cascaded within the team
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling the infection.	• IPC fundamental care e-learning for all staff on induction and updates. • Link worker training x3 per annum • Infection Control responsibilities included in job descriptions • Infection control training of contractors included in estates and facilities report to IPPC.	• Discuss Trust role in providing PPE and ensuring staff and contractors are supported to Doff, use, and Don PPE correctly. • Discuss update of local risk assessments to ensure staff are aware of national guidance and enable to take informed risk assessments while in workplace • Develop FFP3 face fitting program to cover majority of patient facing staff.
7	Provide or secure adequate isolation facilities.	• Ensuite bedrooms to most inpatient services. Dedicated toilet facilities made available in non-ensuite areas. • Management of Isolation Procedure in place and reviewed • COVID testing on admission and day 3, 5-7 and according to National guidance	18. Staff to return an electronic copy of the isolation checklist in accordance with isolation procedures. 19. IT development of a solution to capture and monitor isolation information/checklists (within the integrated solution proposed in point 1).
8	Secure adequate access to laboratory support as appropriate.	• Pathology services provided by Sandwell &West Birmingham Hospitals NHS Trust.	20. Due with the fast return of lab results for COVID, IPC advises to consider re-negotiation of service level and KPI with lab to ensure the service is provided in a consistent way. 21. Very small amount of rapid PCR testing available to the

			Trust. Consider negotiate quota increase with the lab.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	• Suite of procedures and policies aligned to the Trust Overarching Infection Prevention and Control Policy. • Annual plan of policy/procedure review in line with national standards and guidance and monitored through IPPC.	22. Policies/Procedures for review: • Management of Chickenpox & Shingles • Influenza • MRSA Procedure • Sharps Safety & Prevention, Management of Occupational Exposure to BBV • Outbreak of Infection management • Management of Tuberculosis
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	• Occupational Health provides vaccination at employment screening. • Flu Vaccination plan for employees. • Liaison with Birmingham Chest Clinic in response to staff exposure to TB. • Occupational Health activity reported to IPPC quarterly • Monitor COVID cases in staff – Manage advice/ support; Prevalence (HR).	23. Occupational Health to provide input to Seasonal Flu Planning. 24. Occupational Health to support staff testing for when outbreak declared (any outbreak – under discussion on contract testing) – IPC to be included on contract meetings for OC Health.

2. Compliance with Key Performance Indicators

Standard	Progress
Compliance with national mandatory surveillance for bloodstream infection MSSA and E.coli.	*No cases reported*
Zero tolerance of MRSA bloodstream infection, minimise rates of *Clostridium difficile* (C. diff)	*Nil to report*
Completion of Root Cause Analysis (RCA)/Post Infection Review (PIR) and other significant HCAI's within set time scales.	*Clinical reviews were undertaken in line with trust risk management policy in response to outbreaks of infection.*
Compliance with Hand Hygiene Audit. 95% threshold	*The Trust has met its overall compliance of 95%.*
Compliance with Antibiotic Audit. 80% Threshold	*Quarterly reports on usage and recommendations/actions presented to IPPC by Chief Pharmacist*
Compliance with national cleaning standards/British Standards 95% threshold.	*The Trust has consistently met its overall compliance of 95% or above.*

3. Training activity

3.1 Training delivered

Q1	Q2	Q3	Q4
The IPC Champions webinar was delivered on 10/06/21. Topics covered: testimony from IPC Champion (Fay O'Connor), reflection on a year with covid-19, questions around what's next, current IPC issues. The webinar was followed by the core hand hygiene training. Additional hand hygiene training was delivered on 20/05/21 and 05/05/21 (World Hand Hygiene Day).	None	The IPC Champions webinar was delivered on 11/11/21. Topics covered: IPC audits, flu, covid and vaccinations, revisiting the IPC Champion role - Back to Basics, working alongside the IPC team (Emma Latham), IPC quiz and a session from representative from NHS England & Improvement (Alison Heseltine). The webinar was followed by the core hand hygiene training. The IPC team facilitated three Q&A/Peer Support Sessions for Staff Vaccinators.	The IPC Champions webinar was delivered on 10/02/22, topics covered: IPC discussion, waste management (Neil Cross), hospital food review and listeria (Sue Ladkin) and overview of IPC pages on Connect. The webinar was followed by the core hand hygiene training. Additional hand hygiene training was delivered on 22/03/22.

3.2 Training attended

The IPC team continue to be an expert service to the Trust and have kept updated in their professional development as follows:

Q1	Q2	Q3	Q4
2/12/20 Transforming conversations – Building a Coaching Culture Mental Health and Covid-19 - Telling the Story in Mental Health Settings led by NHS England and NHS Improvement		Leadership Development for Infection Control Nurses working in Mental Health Settings programme by NHS England and NHS Improvement	Elizabeth Garrett Anderson Programme (started) by one of the team members Level 3 Award in Education and Training (PTLLS) delivered by Train Aid

4. Annual Audit and Inspection Programme

Audit/Inspection	Findings	Recommendations/Actions
IPC Standards	Due to work pressures during the year, related with the COVID pandemic, the IPC quarterly audits were not possible, and IPC relied in the monthly audits performed within the areas as well as spot checks. An agency IPC nurse has been recruited to ensure that IPC audits would still be performed as well as auditing outbreak sites as fast as possible and monitor action plans in place. This made possible audit and do support visits do all inpatient areas as can be seen in 4.3 In general, the IPC standards across the Trust have been improved.	Cascading findings to Matrons and link workers and request action plan – Discuss communication routes to ensure flow of information is optimum. Involve estates and facilities on the audits and action plans Monitoring improvements through inspections and actions in service area surveillance reports to IPPC IT to develop audit record tool for local IPC audits (monthly and outbreak) and so they can actively be monitored by IPC Develop and implementation of COVID and general outbreak spot check audit tool for both Community and inpatient setting – Upload to iAuditor® system
Dental Suite Checks	Dental suits have been closed during part of the year due to the COVID pandemic After ventilation review by H&S, the dental suits opened, but only on Tamarind AGP procedures can be performed, since Reaside clinic does not have ventilation systems to guarantee the recommended air exchanges.	HTM 01-05 requirements to be designed into any new build/ upgrade.
Hand Hygiene	The quarterly hand hygiene overall trust score met the Threshold of 95%.	Hand Hygiene audits are now to be submitted monthly and weekly during outbreaks Bare Below Elbows to be promoted across all staff groups and audits undertaken more widely in community services. Review lonely work teams and remove them from the hand hygiene audit lists and cross check they are up to date with hand hygiene training

Cleaning Standards	Annual PLACE inspections exceeded the National Average scores in all six categories. Trust KPI of 95% consistently surpassed.	Actions monitored through IPPC where standards fall below those required.
Antibiotic Use	Antimicrobial use across the Trust is low and reflects the fact that in our client group, whilst there are infection risks, the incidence of infection is low compared to many other healthcare settings. All mental health services, in keeping with national guidance, have a responsibility to use antimicrobials judiciously. Antimicrobial audits suggest that antimicrobials are primarily used in line with the antimicrobial prescribing guidance.	Medicines Management Committee to be informed of audit results and support the improvements and optimise the low usage level.
Sharps Safety	The annual audit was postponed due to COVID restrictions (as approved on the IPC committee), but monitoring was ensured through the sharp's injury reports. The number of incidents continued to reduce	Keep increasing awareness through link workers and matrons/managers. Re-in state audit on the new work program if COVID restrictions make it possible
Mattress Inspection	The annual mattress audit was postponed due to COVID restrictions as approved by the IPC committee. Discussed with matrons and link workers to increase awareness locally to ensure that monthly mattress audits were not missed.	Matrons to continue to report against mattress standards/replacements in quarterly reports to IPPC. All wards to ensure that correct mattresses for service need are ordered. Mattresses to be stored off the floor. Re-instate audit on the new work program if COVID restrictions make it possible
Food Safety	Completion of annual food safety audits by an independent food safety advisor. The audit did identify issues that had been picked up in the previous year's audits. This may suggest monthly kitchen inspections are not being undertaken/not undertaken correctly.	Food safety expert conducted audits across the Trust. Report by food safety expert can be seen attached. Matrons to keep updates on actions from inspections
Legionella Policy compliance	Water Safety Group (strategic and operational) in place	Development of integrated record and testing system that allows the follow up of the situation in the different buildings Annual report for water safety has been attached.

4.1 PLACE Scores

BSMHFT 2021 PLACE scores are included within Estates & Facilities IPC 2021-22 Annual Report – attached to this report.

4.2 Hand Hygiene

4.2.1 Inpatient

The table below provides average Hand Hygiene scores for 2021/22 Chore Hygiene trainer:

Trust-overall score:	**97.2**
Trust inpatients:	**97.4**
Community:	**97**

Table 1 - Hand Hygiene Scores for 2021/22

The Trust has always been above the 95% threshold, but there still are several teams that do not have Core Hand Hygiene Trainers:

Service Area	Site	Department
Solar & Specialist Community Services	Warstock Lane Health Centre	25Plus Adult ADHD Service
Dementia & Frailty	Little Bromwich	Admiral Nursing Service
Recovery	SIAS Services	Aquarious SIAS
Recovery	Recovery Near You, Pitt St	Aquarious Wolverhampton
Dementia & Frailty	Ashcroft	Ashcroft Inpatients
Primary Care & SPS	Little Bromwich	BHM Central
Dementia & Frailty	Little Bromwich	Care Home Liaison Team
Dementia & Frailty	Little Bromwich	CERTS
Barberry Specialties	Barberry Centre	Cilantro Day Treatment Service
Barberry Specialties	Barberry Centre	Eating Disorders Outpt Dept
Secure Care	Elliott House	Elliott House
Secure Care	Reaside - Community Building	Forensic Outreach Service FIRST
Recovery	Forward House	Forward House
Acute Care	Orsborn House	Handsworth HTT
Dementia & Frailty	Little Bromwich	Memory Assessment Service
Barberry Specialties	Barberry Centre	Mother & Baby Outpt Service
Acute Care	Mary Seacole	MSH Ward 2
Barberry Specialties	Barberry Centre	Neuropsychiatry Outpatients

Solar & Specialist Community Services	Barberry Centre	Perinatal Community East
Solar & Specialist Community Services	Maple Leaf Centre	Perinatal Community Solihull
Solar & Specialist Community Services	Birmingham Womens Hospital	Perinatal Community South
Solar & Specialist Community Services	Barberry Centre	Perinatal Community SWB
Recovery	Recovery Near You, Pitt Street	RNY Treatment Team
Integrated Community Care	John Black	Solihull HuB
Recovery	SIAS Services	Str8 Up
Recovery	SIAS Services	The Bridge
Acute Care	Oleaster	The Venue Activities
Recovery	SIAS Services	Welcome
Integrated Community Care	Zinnia Centre	Zinnia CMHT

Table 2 - Teams without Core Hand Hygiene Trainer

The IPC team is working on supporting the overmentioned teams and ensure they can access the Hand Hygiene Training while new trainers are identified.

There are also sometimes with lone workers were this is not possible, and the IPC teams has been working towards ensuring those teams have up to date training on hand hygiene, but the auditing will not be possible do to the fact they are single work teams and therefore auditing is not easily feasible or will give us any assurances.

4.2.2 Reasons for non-compliance

The main reasons for non-compliance with hand hygiene were:

- Staff member not bare below the elbows.
- Issues with hand hygiene technique.
- Use of false nails or nails varnish.
- Use of watches/bracelets/jewellery

All issues were addressed with reinforcement of training and surveillance. The most common issues are related to false nails/varnish and staff not being bare below the elbows.

The hand hygiene audits' frequency kept increased to monthly to ensure a higher level of assurance.

There have been challenges with the submission of hand hygiene audit results with some teams. This has been escalated.

Due to noncompliance with bare below the elbows during outbreak becoming a theme during outbreaks, Human Resources were involved in the discussion as well as temporary staff. A letter was developed for the Trust staff (cannot be used with temporary staff). This letter is to be offered to constant offender staff clarifying the expectation for them to be compliant with Trust guidance and explaining that the situation might need to be escalated through HR route. This has shown to be a very good deterrent and in general compliance has increased during outbreaks. Nonetheless when IPC do unannounced visits to the areas, it is still a frequent finding. IPC stresses the importance of having local managers actively monitoring compliance.

The auditing results report is generated in a format that makes the monitoring difficult. The IPC team is advising on the need for a solution with IT to centralise the information and allow easier monitoring of compliance by the teams (as mentioned on chapter 1).

4.3 IPC auditing program

During this year the IPC team had the support of an agency IPC nurse, allowing this way to increase 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 here, as seen on the next tables:

Site	Quarter	Score
Adams Hill	Q4	83.40%
Ashcroft	Q4	88.02%
Reaside - Trent	Q4	76%
Reservoir Court	Q4	84%
Ardenleigh - Tourmaline	Q4	80%
Blythe	Q4	
Oleaster - Caffra	Q1	84%
Oleaster - Melissa	Q1	84%
Meadowcroft	Q1	77%
Mary seacole 2	Q1	86%
Juniper - Sage	Q2	96%
Mary Seacole 1	Q2	93%
Mary s	Q2	95%
Caffra	Q3	88%
Tazetta	Q3	85%
George Ward	Q3	86%
Tazetta	Q3	85%
Melissa	Q3	89%
Japonica	Q3	88%
Magnolia	Q3	92%
Eden Acute	Q3	89%
Eden PICU	Q3	85%
Endeavour house	Q3	90%
Endeavour Court	Q3	91%
Reservoir Court	Q3	83%
Zinnia - Lavender	Q3	73%
Zinnia - Saffron	Q3	90%
Grove Avenue	Q3	83%
Newbridge House	Q3	83%
Little Bromwich	Q3	92%
Newbridge House – Peri natal	Q3	90%
Dan Mooney House	Q3	79%
Freshfields	Q3	95%
Hertford House	Q3	87%
Sycamore	Q3	81%
Hibiscus	Q3	73%
Acacia	Q3	83%
Laurel	Q3	82%
Lobelia	Q3	86%
Cedar	Q3	90%
Larimar	Q3	75%
Rookery Gardens	Q3	66%

Myrtle	Q3	87%
Forward House	Q3	81%
Tourmaline	Q3	88%
Coral	Q3	85%
Citrine	Q3	89%
Rosemary	Q3	84%
Bergamot	Q3	89%
Atlantic	Q3	84%
Pacific	Q3	85%
Osborne House	Q3	87%
Orchard House	Q3	90%
Handsworth & Ladywood HTT	Q3	80%
Aston CMHT	Q3	78%
Adriatic	Q3	73%

Table 3 - Audits undertaken by IPC team

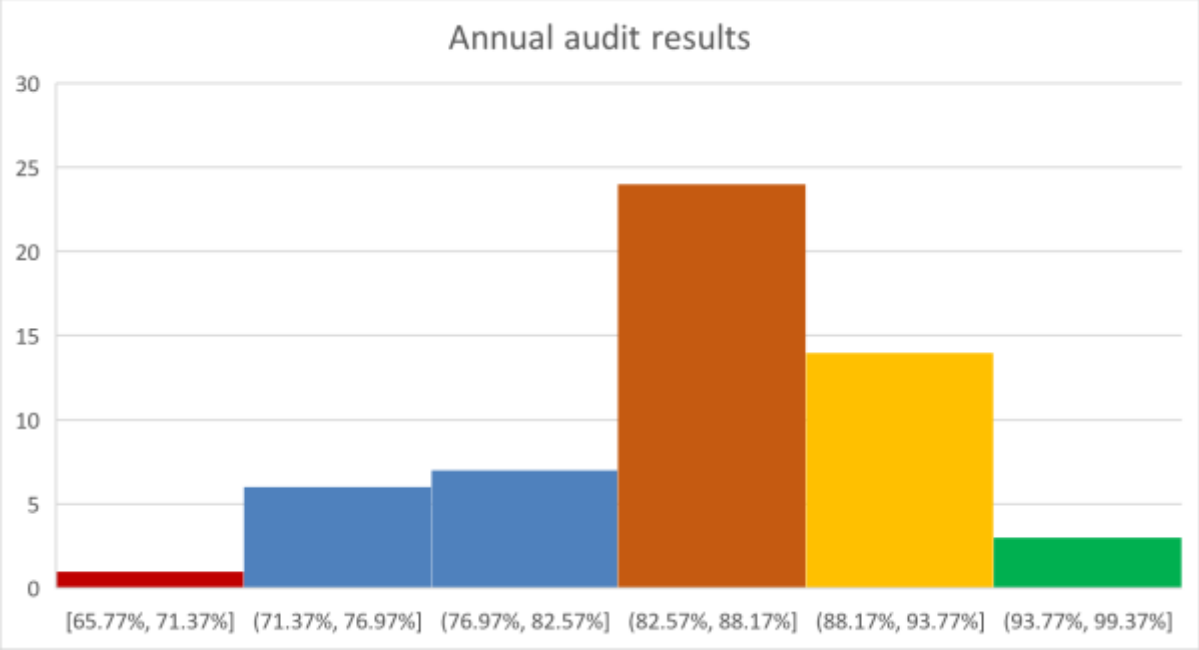
And the following support visits:

Support visits	Quarter
Larimar	Q1
Ardenleigh	Q1
Juniper Centre	Q1
Juniper Centre	Q1
Callum Lodge	Q1
Endeavour House	Q2
Juniper - Rosemary	Q2
Mary Seacole 1	Q3
Mary Seacole 2	Q3
Oleaster - Tazetta	Q3
Oleaster - Magnolia	Q3
Oleaster Japonica	Q3
Caffra	Q3
PDU Place of safety	Q3
ECT suite	Q3
Barberry - Chamomile	Q3
Cilantro	Q3
Neuropsychiatry	Q3
Tamarind	Q3
Reaside Clinic	Q3
Newbridge House	Q3
Little Bromwich	Q3
Zinnia - CMHT	Q3
Zinnia HT Sparks & Central	Q3
Zinnia Day Centre	Q3
Lavender	Q3
Saffron	Q3

Grove Avenue	Q3
Dan Mooney	Q3
David Bromley	Q3
Freshfields	Q3
Osborne House	Q3
Northcroft	Q3
Ardenleigh	Q3
Meadowcroft	Q4
Mary Seacole 1	Q4

Table 4 - Support visits undertaken by IPC team

When looking at the audit results distribution, we see the following histogram:



The majority of the audit sites have scores equal or superior to 82.57%, being the interval between 87.2% and 88.17% the highest group.

While IPC is happy that the results reflect the current trust situation, our aim is increasing the average score from 83% to above 90%. This is a complex goal to achieve due to the multitude of settings across the trust disperse nature. The engagement of all our staff is essential and this can only be achieved with the support of the local managers in moving the IPC agenda forward. Also, for the achievement of this goal, it is necessary that the IPC teams are not only given the support of human resources to audit but also have tools developed to be able to active monitor the local IPC situations, as for example an IT solution to aggregate results from local audits that can be monitored by IPC and help guiding us to identify areas of particular concern where we need to focus more our attention. Another aspect that will need reflection and strengthening going forward is establishing effective communication channels were IPC can easily send its messages across but also have useful feedback from staff working in patient facing roles. This is particularly complex in community teams, since in the current setting on what concerns to inpatient areas, The IPC team can quickly lease with the matrons for the areas.

5. External Inspections and Audit

The Trust was visited twice during the year, related to the prolonged COVID outbreak on Mary Seacole Ward. First visit with CCG and Second NHSi, both by Trust invite. The visits actions resulting from those are discussed on point 8.1.2 – External visits.

6. Surveillance of Alert Organisms and Outbreaks

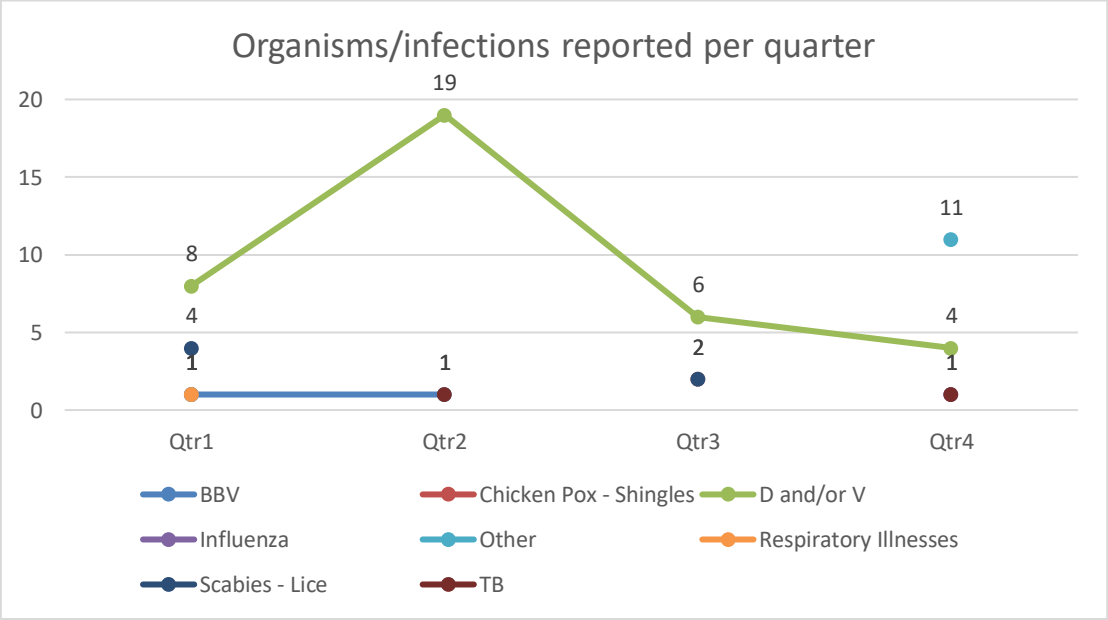
The IPC team have responded to numerous inquiries on the management of potential and actual infectious organisms; the following is a summary of the activity of individual cases and outbreaks.

6.1 Total number of organisms reported

We had a total of 64 reports of infection (excluding MRSA and COVID related).

Condition	Qtr1	Qtr2	Qtr3	Qtr4	Grand Total
Blood Borne Virus (BBV)	1	1			2
Chicken Pox - Shingles	1		2		3
D and/or V	8	19	6	4	37
Influenza				1	1
Other	1			11	12
Respiratory Illnesses	1				1
Scabies - Lice	4		2		6
Tuberculosis		1		1	2
Grand Total	16	21	10	17	64

Table 5- Infections/organisms reported by quarter

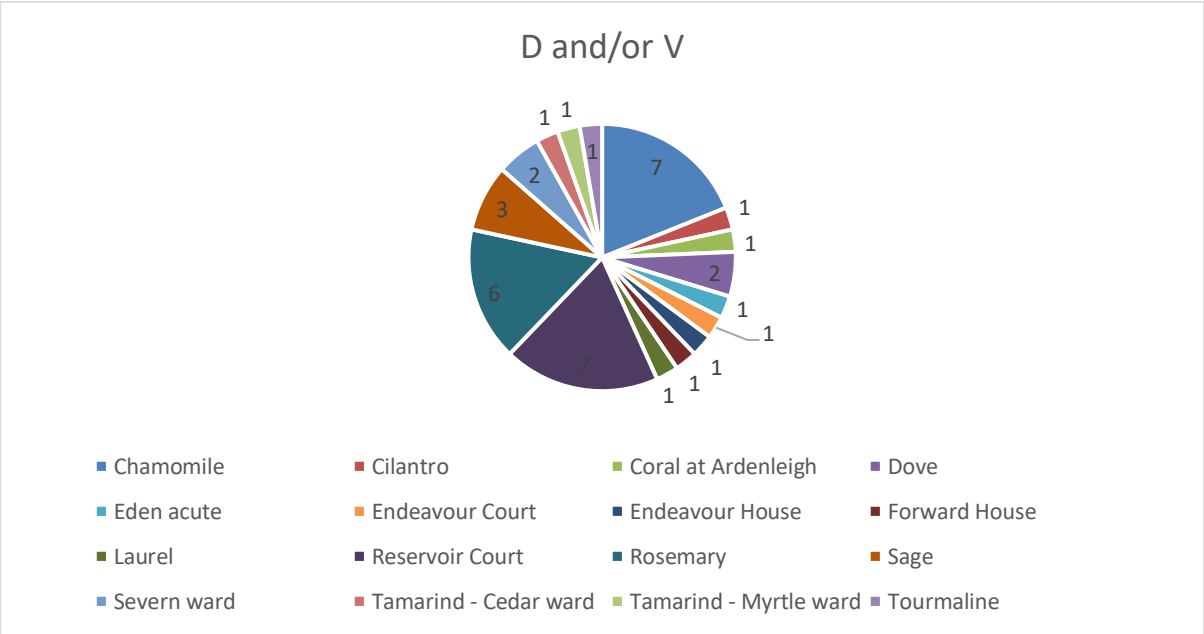


Graphic 1- Infections/organisms reported by quarter

The most reported was D&V, nonetheless there are no reported outbreaks of D&V. The areas with highest number of cases were Chamomile (7), Reservoir Court (7) and Rosemary (6) as we can see on the following table and graphic:

Area	Count
Chamomile	7
Reservoir Court	7
Rosemary	6
Sage	3
Dove	2
Severn ward	2
Cilantro	1
Coral at Ardenleigh	1
Eden acute	1
Endeavour Court	1
Endeavour House	1
Forward House	1
Laurel	1
Tamarind - Cedar ward	1
Tamarind - Myrtle ward	1
Tourmaline	1

Table 6 - D&V cases reported per area 2021/22



Graphic 2- D&V cases reported per area 2021/22

All Reported cases had IPC advice and follow up as needed.

6.2 Outbreaks (non-COVID)

No Non-COVID related outbreaks declared

6.3 MRSA Admission Screening

According to the Health and Social Care Act, the Trust continues to have management systems to ensure that MRSA colonisation is promptly identified. This includes screening patients admitted from other healthcare settings or have existing wounds or indwelling devices that could increase the risk to both the individual and other vulnerable patients of developing an MRSA infection. We had no patients MRSA colonised on admission.

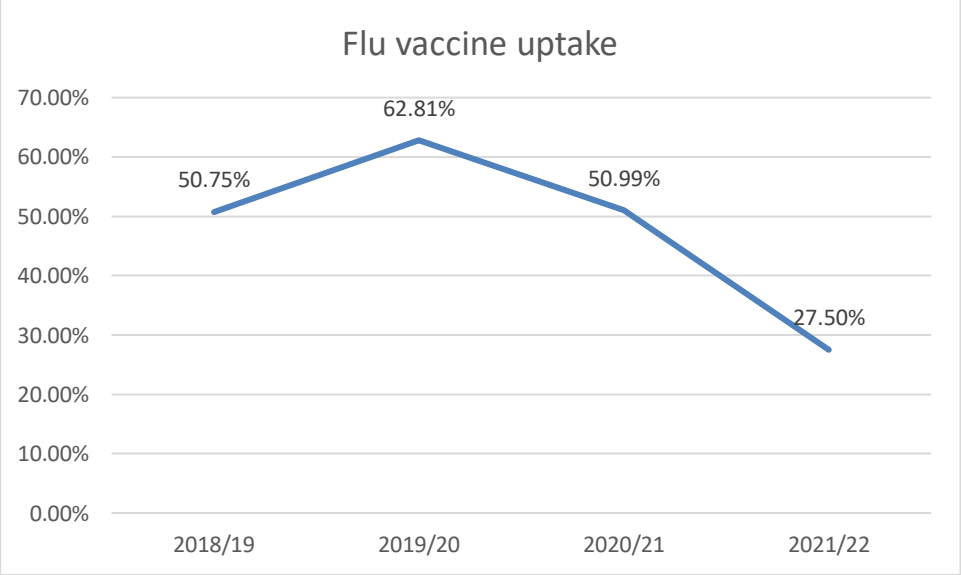
7. Staff Vaccination COVID and Flu

7.1 Seasonal Influenza vaccination

The Trust final position following validation was submitted to Public Health England in March 2021. Our final staff flu vaccine uptake is 27.5%, a decrease of 23.49% compared to the 2020/21 final total of 50.99%, which represents a significant decrease, as we can see in table 7 and graphic 3.

Year	Flu vaccine uptake
2018/19	50.75%
2019/20	62.81%
2020/21	50.99%
2021/22	27.5%

Table 7- Flu vaccine uptake since 2018/19



Graphic 3 - Flu vaccine uptake since 2018/19

Besides all the effort put into a successful flu campaign, it did not meet the intended success; this was another complex year with the COVID pandemic, which contributed to reducing the overall focus of staff on flu vaccination and consequent reduction in numbers. Also, the fact that on previous years the numbers of flu cases or very low or even non-existent on the Trust and community in general has contributed to reduce the staff interest in being vaccinated.

It is also important to refer that the focus on the COVID vaccine is likely to also have cannibalized the one in the flu vaccine.

The flu portal developed on the previous year was again used and made monitoring and reporting of flu vaccine uptake easier and more accurate than before its implementation and established a baseline to further electronic recording systems based on the same design concept, like the lateral flow test (LFT) result record.

For the new year 2022/23 it will be essential to refocus the Trust attention on increasing flu vaccination uptake, due to the risk of increased flu cases in a reality were face masks are mostly not used by the community and social distancing is no longer mandatory.

It will be important to reflect on future flu vaccination campaigns, the lessons learned during COVID vaccination, including on what concerns to the mandate of vaccines like it happened for the COVID vaccine (now retracted).

7.1.1 Actions taken to reach 100% uptake ambition

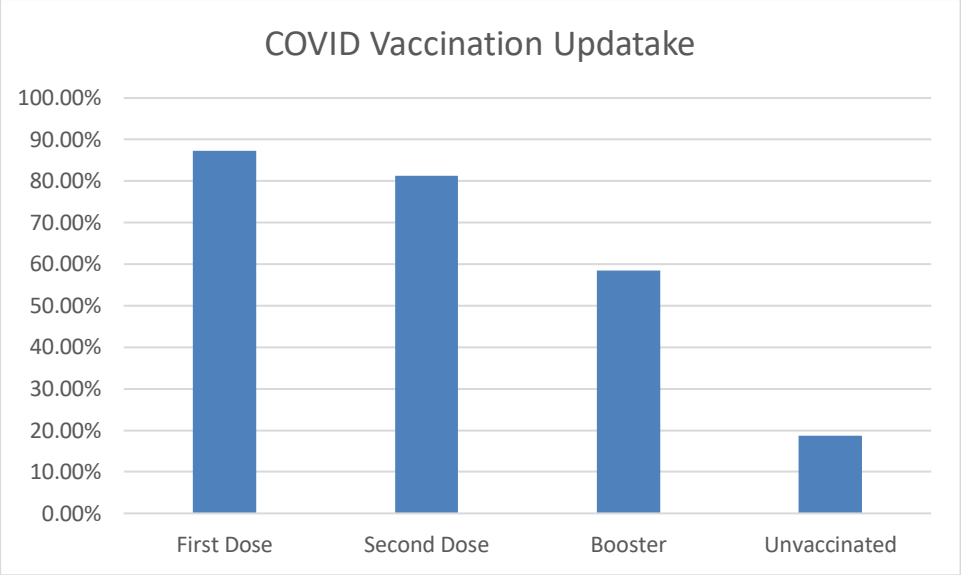
- Proactive communications and engagement programme in parallel with COVID vaccination
- Occupational Health Led Flu Clinics covering all, in repeated visits, deployed across the Trust. Roving clinics were not made to reduce staff mobility (peer vaccinators covered this role)
- Staff vaccinators deployed across the Trust across all locations to support the vaccination programme.
- Portal in place used for both peer vaccinators and Oc Health to ensure robust recording.
- Included in flu campaign training reminder of the risks of having a circulation of both flu and COVID
- Flu vouchers offered to staff who couldn't attend clinics.
- Weekly reminders issued to site contacts and flu leads regarding promoting flu clinics and ensuring staff attends clinics.
- IPC myth-busting intervention with several teams from community and inpatients.

7.2 COVID vaccination

The COVID staff vaccination has been more successful than the flu vaccination has ever been in the trust. The following table shows that we have around 81.3% of staff with 2 inoculations of COVID vaccine, in contrast with flu 27.5%.

First Dose	Second Dose	Booster	Unvaccinated
87.25%	81.30%	58.50%	18.70%

Table 8 - COVID vaccination



Graphic 4 - COVID vaccination

To achieve the current mark, it required constant reminders and the providing of information to all staff members. A work where local managers were heavily involved.

The fact that in Q3 we had the highest number of outbreaks during the pandemic also seems to have contributed to increase on the awareness about the need to be vaccinated and increased vaccination rates, since COVID vaccination scores were always scrutinized in outbreak meetings, work was put into allow staff to understand the impact higher rates of vaccination brought to the situation.

For some time, there was the expectation from the government that COVID vaccination would become mandatory. This might in some respects helped to boost the vaccination for COVID, nonetheless, the fact this was an imposed measure, and it was retracted might have an impact to future vaccination campaigns.

From SU side we worked hard on making vaccine available to our SU. This is an ongoing and dynamic process, due to the constant rotation of service users on our wards and sometimes the level of acuity of our service users. Regardless, the IPC team worked with the matrons of all areas, to identify the needs for vaccination and set up a plan to cover all SU that accepted being vaccinated. We were this way able to increase our resilience and safety to COVID infections, but this is an ongoing process as explained.

8. COVID-19

The first confirmed cases of COVID-19 in the UK were on 29th January 2020, followed by more cases on the 6th of February. The first suspected patient case recorded in BSMHT was on 2nd March 2020, before the scope of the current report.

The IPC team has supported the Trust and the emergency team planning since the beginning to ensure we were prepared to give an adequate response to the challenges ahead.

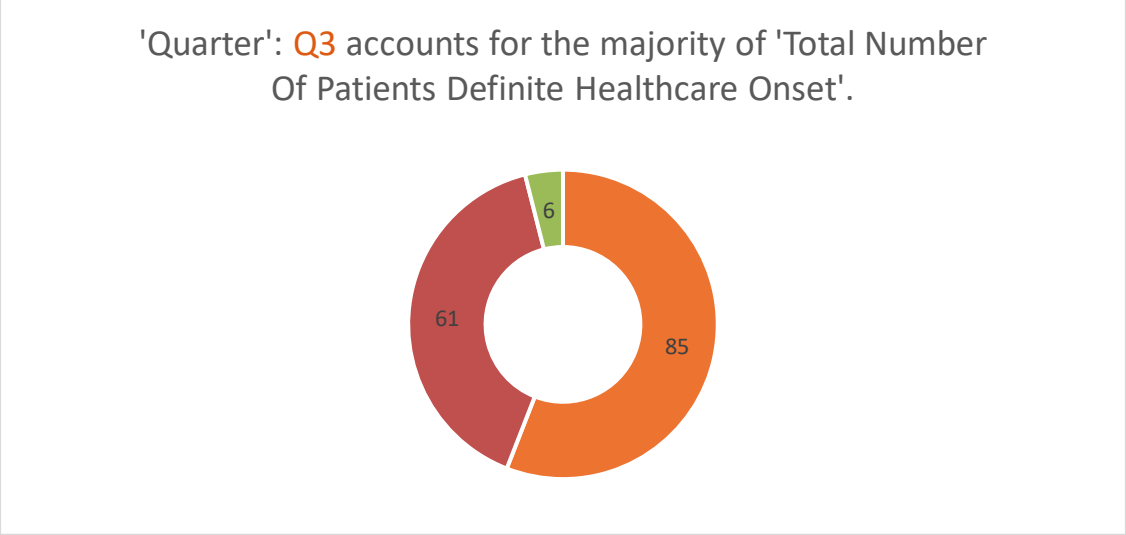
The IPC team was given the support of an extra staff members to cooperate with surveillance and local advice, freeing the team to provide specialised support to all Trust departments. Also, an agency IPC nurse was made available from Q2 to support the team, on the auditing process due to the unprecedented challenges brought by the COVID pandemic, in particular during Q3.

8.1 Reported outbreaks

We reported a total of 35 outbreaks:

No outbreaks have been reported during quarter 1

The highest number of SU affected was in Q3 as we can see in Graphic 5 (total 18 outbreaks):



Graphic 5- Q3 highest number of SU affected in outbreaks

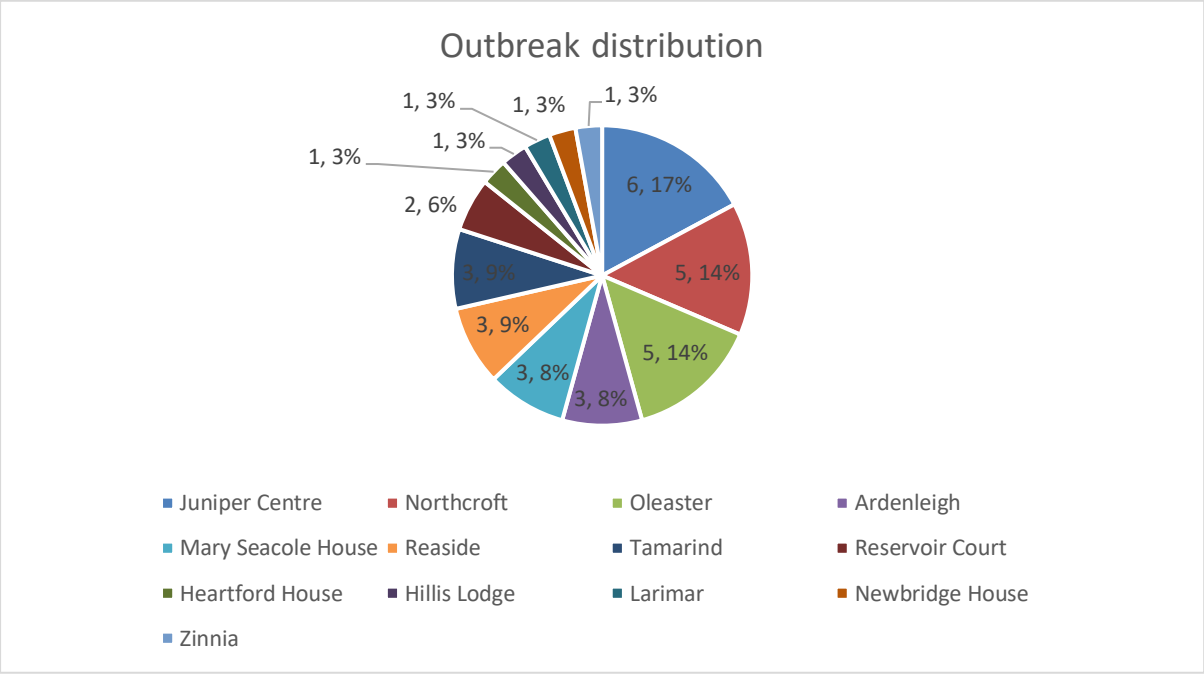
These findings come in line with what was the reality in the health economy at the moment, with particularly high rates of community transmission of COVID-1during Q3.

Table 4 illustrates the number of outbreaks per areas/quarter:

Per Quarter				
Site	Q2	Q3	Q4	Grand Total
Ardenleigh		1	2	3
Heartford House		1		1
Hillis Lodge			1	1
Juniper Centre	2	3	1	6
Larimar			1	1
Mary Seacole House		3		3
Newbridge House			1	1
Northcroft		3	2	5
Oleaster	1	2	2	5
Reaside		2	1	3
Reservoir Court		1	1	2
Tamarind		2	1	3
Zinnia			1	1
Grand Total	**3**	**18**	**14**	**35**

Table 9 - Reported outbreaks per quarter

The following pie chart shows how the outbreaks have been distributed across the Trust



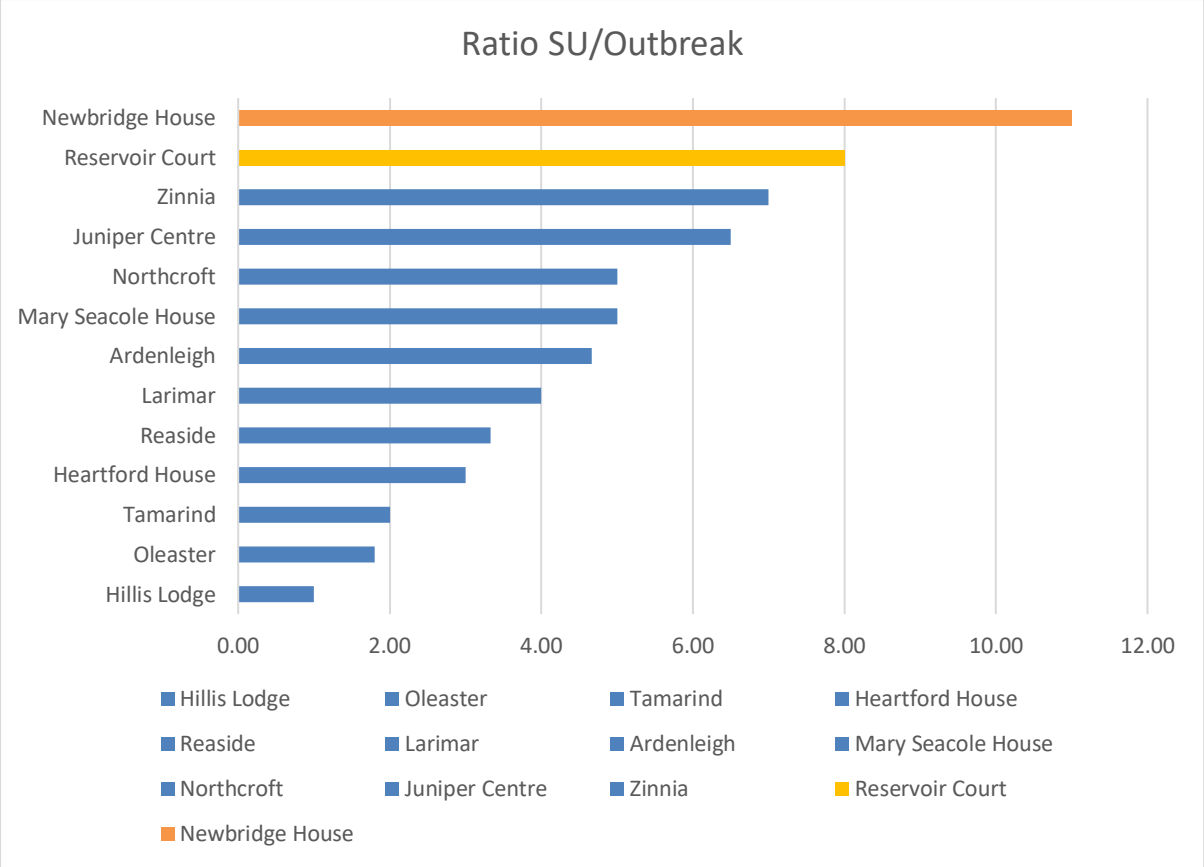
Graphic 6- Outbreak episodes annual distribution

The areas with highest percentage of outbreak episodes were Juniper centre followed by Oleaster and Northcroft.

But the highest Ratio Positive cases/number of outbreaks was in Newbridge House, followed by Reservoir Court as seen in the next Table and Graphic:

Site	Number Of Patients Tested Positive	Number of outbreaks	Ratio SU/Outbreak
Hillis Lodge	1	1	1.00
Oleaster	9	5	1.80
Tamarind	6	3	2.00
Heartford House	3	1	3.00
Reaside	10	3	3.33
Larimar	4	1	4.00
Ardenleigh	14	3	4.67
Mary Seacole House	15	3	5.00
Northcroft	25	5	5.00
Juniper Centre	39	6	6.50
Zinnia	7	1	7.00
Reservoir Court	16	2	8.00
Newbridge House	11	1	11.00

Table 10 - Ratio Positive cases/number of outbreaks

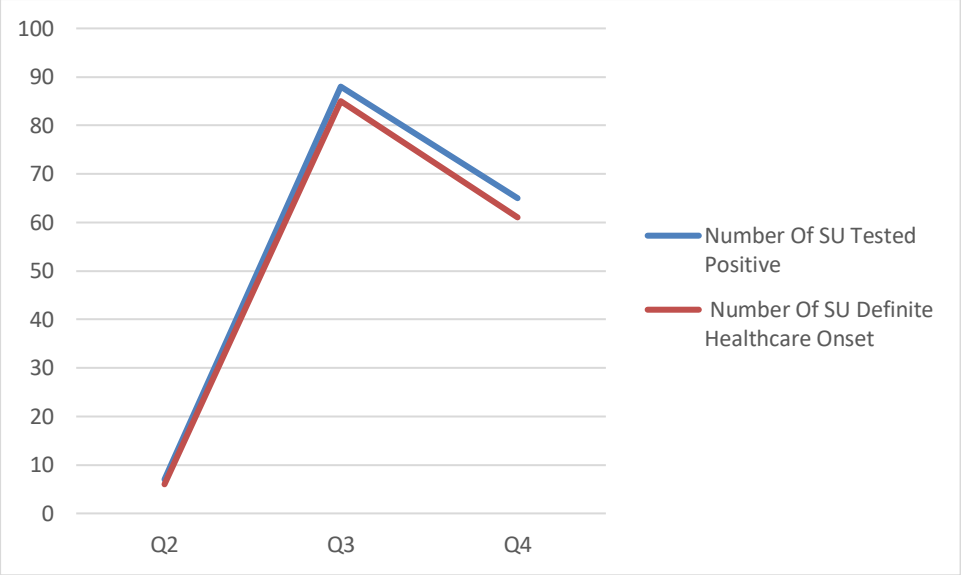


Graphic 7 - Ratio SU/COVID outbreaks

During the outbreaks, we reported a total of 152 SU affected with definite healthcare onset and a total of 160 SU as part of the outbreak as can be seen on the following table and graphic:

Quarter	Number Of SU Tested Positive	Number Of SU Definite Healthcare Onset
Q2	7	6
Q3	88	85
Q4	65	61
Grand Total	**160**	**152**

Table 11- Positive SU per quarter during outbreak



Graphic 8 - Positive SU per quarter during outbreak

8.1.1 COVID outbreaks per site and areas of concern

The COVID outbreaks were widespread on the Trust, including some outbreaks in community settings (none of those had SU affected). There were 3 sites that seem to be more relevant. Juniper centre by having the highest count of SU affected as part of an outbreak, Mary Seacole due to the length of the last outbreak there and Jasmine with communicating challenges with hearing impaired SU and staff.

The following chart shows the number of positive SU cases per site during the reported outbreaks (including not healthcare onset):

• Site	Number Of Patients Tested Positive
Ardenleigh	**14**
Ardenleigh low secure/ CAMHS	4
Ardenleigh: Citrine Ward	6
Tourmaline	4
Hertford House	**3**
Hertford House	3
Hillis Lodge	**1**
Hillis Lodge	1
Juniper Centre	**39**
Juniper - Sage	5
Juniper Bergamot ward	13
Juniper Centre - Rosemary Ward	11
Juniper Centre - Sage ward	3
Rosemary Ward	5

Sage Unit	2
Larimar	**4**
Larimar	4
Mary Seacole House	**15**
Mary Seacole Ward 1	1
Meadowcroft PICU	9
MS2	5
Newbridge House	**11**
Newbridge House	11
Northcroft	**25**
Eden PICU	8
Endeavour Court	4
Endeavour House	6
George Ward	7
Northcroft CMHT and BHM	0
Oleaster	**9**
Caffra	2
Oleaster - Caffra	3
Oleaster - Melissa Ward	2
Southwest & South East Home Treatment Team	0
Tazetta	2
Reaside	**10**
Reaside - Blythe	4
Reaside - Trent	4
Trent Ward - Reaside	2
Reservoir Court	**16**
Reservoir Court	16
Tamarind	**6**
Tamarind - Myrtle	1
Tamarind Centre - Sycamore Ward	3
Tamarind Sycamore ward	2
Zinnia	**7**
Saffron	7
Grand Total	**160**

Table 12 - Cumulative number of SU positive during outbreaks per site

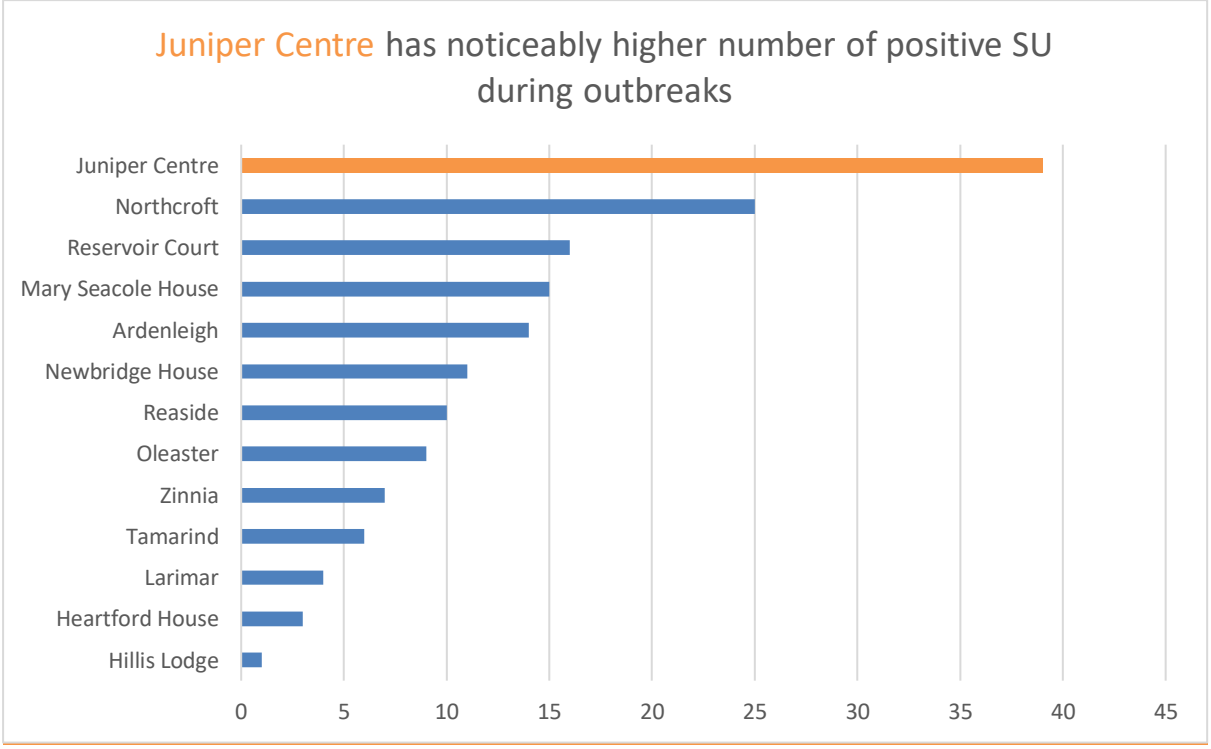
8.1.1.1 Dementia and Frailty - Juniper Centre

On a more detailed look we have identified that Juniper centre was the site with the highest number of affected SU, which comes in line with what was expected since it is the Trust area where we have the highest number of vulnerable SU do to their age and physical conditions.

The following table and graphic illustrate the findings:

Row Labels	Sum of Cumulative Number of Patients Tested Positive
Ardenleigh	14
Heartford House	3
Hillis Lodge	1
Juniper Centre	39
Larimar	4
Mary Seacole House	15
Newbridge House	11
Northcroft	25
Oleaster	9
Reaside	10
Reservoir Court	16
Tamarind	6
Zinnia	7
Grand Total	**160**

Table 13 - Total SU cases in oubreak per site



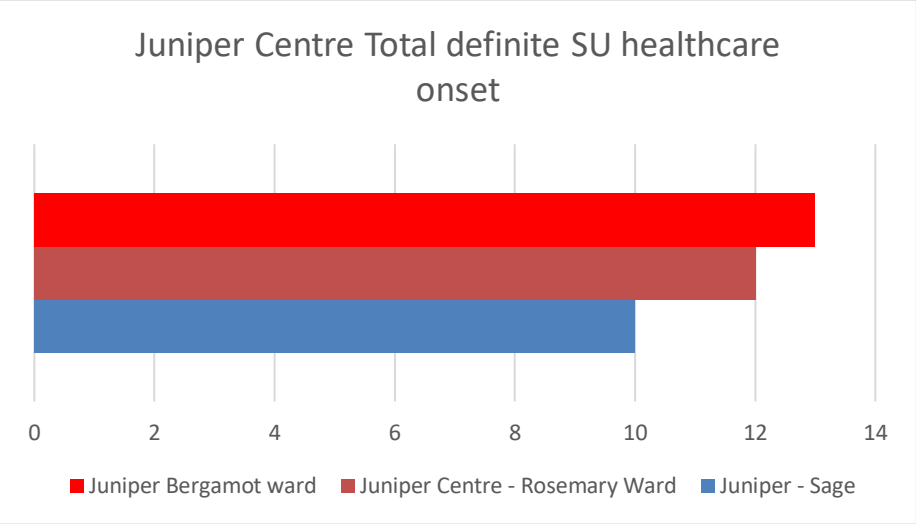
Graphic 9 - Total SU cases in outbreak per site

During the management of the pandemic, there was always given particular attention to the dementia and frailty (D&F) department, with the creation of admission and isolation suites and extended isolation periods due to COVID. During the year D&F had frequent support visits and audits to ensure the best IPC practices were in place and the IPC team worked particularly close with the department, that has been always very responsive and cooperative.

By looking at more detail into Juniper centre we identified that the highest count of cases was in Bergamot, followed by Rosemary and Sage:

Site	Total SU definite Healthcare Onset
Juniper - Sage	10
Juniper Centre - Rosemary Ward	12
Juniper Bergamot ward	13

Table 14 - Distribution of SU cases in Juniper Centre



Graphic 10 - Distribution of SU cases in Juniper Centre

No reason was identified for the differences but due to the size of the sample it is unlikely to be significant. When IPC conducted visits to the site, all of them had very high levels of compliance with required IPC standards and were very proactive and cooperative. Scored audits results can be seen on the next table:

Area	Score	Quarter
Juniper Centre - Sage Ward	96.42%	Q2
Rosemary	84.13%	Q3
Bergamot	89.39%	Q3
Rosemary	94.00%	Q4

Table 15- Juniper Centre IPC scored audits

The IPC team also performed several formal and informal support visits. The following table presents the formal support visits that have been performed:

Formal Support Visits	quarter	Done by
Juniper Centre	Q1	IPC
Juniper Centre	Q1	IPC
Juniper Centre	Q4	IPC
Juniper Centre	Q4	IPC
Juniper Centre	Q4	IPC
Rosemary	Q4	IPC

Table 16 - Formal Support visits to Juniper Centre

8.1.1.2 Mary Seacole House

The most complex and long outbreak was on Mary Seacole, involving MS1, MS2 and Meadowcroft initially and with the closure of MS2 and sustained control of Meadowcroft it continued in MS1. This outbreak was declared on 08/09/2021 and the last reported case was 15/01/2022 (approximately 22 weeks). This was particularly challenging to control due to not just some of the themes identified in other outbreaks but in particular because with the pressure for beds, it was never possible to fully close the ward to admissions, having the ward frequently admitted SU with positive cases. These cases should not have caused the prolongment of the outbreak by themselves, but the delays the Trust had during the year to obtain fast PCR results for both SU and staff, frequently caused positive newly admitted SU not being quickly identified as positive cases. Therefore, being able to roam the unit before any result was made available. The advice has always been to isolate on admission, but legally without symptoms or a positive result, forced isolation and mask enforcement was not an option. Also, not all SU were capable or willing to wear a mask and even when this was possible, an individual and global risk assessment was needed to ensure that the mask would cause no risk to other SUs.

8.1.1.3 The Barberry – Jasmine

Another area of significant complexity was Jasmine, where the service has SU with ear impairment and staff members. The service has the support of sign language interpreters as many SU struggles with reading and writing. It is a fact that British sign language heavily relies on lip reading.

Before any transparent solutions were available, the staff used the support of British sign language interpreters that would lower the masks while keeping a face shield at 2 or more meters. Also, a chat room was created with a Perspex screen in between the 2 seats so communication by gestures was made possible. Regardless of the efforts, it was always very challenging to achieve a balance between PPE adherence and the delivery of adequate and safe care, causing in some instances the need to breach PPE advice.

Besides the challenges there was only one outbreak recorded with the first case identified on the 05/01/2021 and therefore out of the scope of this report.

Two types of clear masks have been made available, nonetheless these masks brought with them some challenges, in particular condensation making the masks sometimes not comfortable for prolonged use (opinion varies).

The IPC team also proposed the use of masks in some therapy groups were face expression and lip reading was essential. The same kind of issues were reported; therefore, the masks are in use on several teams.

8.1.2 External visits

Due to the complex and prolonged outbreak, the IPC team invited the CCG IPC team to visit Mary Seacole and discuss the situation and arrangements in place. During the visit some environmental and PPE adherence aspects were identified, in line to which have been previously pointed by the IPC team. One of the most important was frequent PPE breach. To respond to this, the Human Resources Department (HR) was involved in the discussion and a letter was created to be given to frequent offenders explaining the possible disciplinary consequences of continuing not adhering to the Trust guidance, in parallel with a discussion with the staff member about what and why the compliant behaviour was essential. The implementation of this document had very positive feedback significantly reducing the challenges around PPE compliance. All other findings were addressed in an action plan

by the ward matron and monitored during informal support visits and weekly discussions both in the internal outbreak meeting as well as the meeting with external stakeholders.

By invite of the DIPC on the 11th of February 2022 PHE came to visit the ward (at this point the outbreak had already been closed).

The visits findings were:

- Fridge temperature monitoring not properly recorded on the paper form.
- COSHH breach due to bleach tablets found not locked
- Outbreak minutes for outbreak meeting with PHE and other external stakeholders had minimal information around the support visits performed.
- Trust external page outdated on what concerns to IPC information and DIPC statement not available

Due to the findings, the auditor opted to escalate the Trust to AMBER on the NHSi internal escalation matrix and recommend a new visit on the future.

The recommendations of the visit were:

- All visits/spot checks to be annotated and signed by an IP specialist.
- Strengthen the outbreak assurance governance process.

It is important to point that during the outbreak meetings with PHE, NHSEI, CCG and other external stakeholders, there was never reference to any concerns around the governance processes and the same was not referred during the CCG visit, nonetheless the IPC team developed an action plan with the following points:

Action
1 - Develop Outbreak tool General
2 - Develop Outbreak tool Covid
3 - Develop Community audit tool - Monthly local
4 - Update external web page
5 - Review training (IPC)
6 - Develop Spot checks form
7 - Algorithm for outbreak management updated
8 - Collate audit results in spreadsheet
9 - Discuss Fridge temp monitoring with pharmacy
10 - Program of audits
11 - Surveillance check
13 - Discuss internal pages for IPC - Intranet
14 - Book program of work meeting

Table 17 - Action points for IPC after NHSIE visit

At the moment this report is being produced points 1, 2, 3, 6 have been actioned and the tools are being tested on the IPC iAuditor platform. IPC has long requested a tool created by IT to allow monthly audits performed on the ward by the IPC champions or managers to be put in place, but at the moment of this report, this has not been made available.

On point 4, the page is being reviewed and restructured as well as point 5

Point 8 is in place and actively being monitored during the IPC internal meetings

Point 9 has been discussed with pharmacy, since all our fridges have central monitoring, and a SOP is in place to ensure the correct procedures are in place if the cold chain is broken. There have been identified some aspects of concern with the resilience of the SOP that are being addressed by the pharmacy with the aim of removing any paper records.

Point 10 – Is being developed a program of audit for the year (regular audits)

Point 11 – Surveillance document has been in place and procedures to ensure the information is recorded has been reviewed. IPC has advised that going forward it would be necessary the Trust to obtain a specialized IPC program to ensure the information is not stored in excel spreadsheets but in a properly functional database that would not just guarantee more accuracy of the information as well as a centralized way to not just record this information but also to monitor it and save IPC records, advice, and guidance as well as outbreak monitoring.

Point 13 is being worked, due to the fact there was a migration of the connect page to a new format.

Point 14 is presented in this report.

8.1.3 Outbreak surveillance

All outbreaks were followed up with the local management area, DIPC, IPC team, microbiologist and external stakeholders invited to outbreak meetings (PHE, NHSi, CCG, Health protection team).

Due to the very high number of outbreaks, the Trust paused individual meetings per outbreak with external stakeholders (nonetheless, they were kept internally) and opted to do a weekly review meeting where all the outbreaks were discussed and assurances were given, as started during Q4 of previous year.

During the year, the Themes identified relating to the COVID Outbreaks were:

1. Delay on isolation due to lab reporting issues
2. SU meeting in communal areas
3. PPE Breaches
4. Staff not bare below the elbows
5. High dust
6. Air vents requiring cleaning
7. IPC board not up to date
8. Physical damage

Point 1 was one of the more challenging points. Frequently the results for both staff and SU took a several days to be available.

On what concerns to staff PCR results there was the added complexity that there is not a robust system to ensure the results are made available 24/7 to the staff. Until the present moment all results are

received by the IPC team through email and then cascaded to the areas. Also, the information IPC receives most of the times do not identify were the staff member works. This adds even more delay to make the results available (sometimes already delayed by days from the lab).

Due to contractual limitations, occupation health service was never involved on staff testing for outbreak, which added extra demands on the local areas to arrange testing.

On what refers to the SU results, the frequent delays on having results, has been connected to the onset and prolonging of outbreaks, mainly because with no symptoms and a positive result the Trust is not legally able to isolate SUs. This allows positive admitted SUs to roam through the ward if they refuse to isolate and, in many cases, also without a mask due to not be possible for their safety or safety of the group or SU refusal to use it. Also, during outbreaks, the delays in obtaining results for the same reasons on not being able to quickly isolate positive cases is likely to have prolonged outbreaks and delayed breaking the chain of transmission.

On top of the concerns with the delays, the Trust has a very small number of rapid PCR tests available, IPC has already pointed to the need to have a reflection on the need to review not just the KPI with the laboratories but also review the availability of rapid PCR testing. Capacity to rapid test is essential going forward. Ideally IPC would advise to have point of care testing, but we are aware this is unlikely to be possible. Guidance from 30/03/2022 strongly reduces the reliance on PCR testing, focusing on faster lateral flow testing (LFT), nonetheless PCR remains to be used as main testing during outbreaks due to its sensitivity. At present moment IPC is adopting a double approach by testing SU with both LFT and PCR, allowing this way to quickly identify most of the positive cases with LFT and capture false negatives with PCR testing,

Point 2 – In many of our areas SU stay for long periods of time or may be too acutely unwell to be feasible to avoid congregations. This is a mental health organization, and therefore strongly relies on the interaction between human beings. IPC has advised to all inpatient areas to ensure high levels of cleanliness are kept, staff keeps using PPE at all times and an individual and global risk assessment is made for each SU to be able to offer him a mask (if not jeopardizing other SU safety). The result of the risk assessment and the SU adherence should be recorded on the care plan by the clinical team.

Point 3 and 4 – PPE breaches and staff not bare below the elbows has frequently been identified. HR team was involved on discussions around how to tackle this issue and a letter was produced to be delivered to constant offenders (only substantial staff), reminding them around the possible disciplinary proceedings going forward. The delivery of the letter is preceded by a conversation ensuring the staff member is fully aware of the Trust guidance and expectations on him/her.

Some areas (FCAMHS) developed a sticker system where compliant staff would be rewarded with a “champion” sticker if were able to keep the recommended standard/

Both approaches were seen to be very effective, significantly increasing the level of compliance.

The compliance with use of PPE is recorded in the daily spot checks performed by ward managers during outbreaks the findings are discussed during the meetings.

Point 5 and 6 – These aspects when detected were immediately escalated to the estates and facility team to ensure cleaning is at the expected level. High dust has been a frequent finding. The Estates and facility teams have frequently been involved during IPC visits in areas that have been felt as more problematic. Regardless the general cleanliness level of the Trust is very high as can be seen on the KPI consistently above de 95% mark. During outbreaks Estates and facilities were always very pro-active enabling adequate and fast response, even during the peak of the pandemic when their teams were also struggling with high levels of absenteeism due to COVID.

Point 7 – IPC boards have frequently been found out of date. This is checked in all IPC visits and escalated, also matrons and local managers are frequently reminded of the importance of updating the information. During IPC champions the team always stresses this message

Point 9 – Physical damage – Mostly related to wear and tear and planned upgrades/maintenance. Sometimes this has been challenging due to the pandemic, all measures have been taken to reduce risk of cross contaminations between contractors, staff and SU's. During outbreaks only essential work has been carried out. Estates and Facilities keep a log of all works undertaken and outstanding. IPC supported on the planning of this activities when contractors had to go to areas with known COVID cases.

At the moment this report is being produced, the Trust has already replied to the NHSi report and requests for new documentation has been made ahead of a revisit. The date has not been arranged yet and should fall around June.

8.2 COVID guidance

The COVID National Guidance had constant revisions, which made it very challenging to keep the team up to that with the changes and particularly the Trust staff. This issue was even more significant because most of the year (as in previous year), there was no specific guidance to mental health organisations. Not all the advice provided was applicable in this kind of organisation.

To ensure the guidance changes were quickly cascaded regular meetings between IPC and the deputy director of nursing were arranged (variable frequency depending on need) and weekly matrons meeting with IPC presence. This allowed us to cascade any changes, share learning and discuss challenges.

Training has been offered to the staff about COVID-19, symptoms, isolation measures, and a broader face-mask fitting program was put in place. At first, the IPC team and soon after supported by Health and Safety, Physical Health, and Professional Education teams.

Arrangements have been made with external face fitters to provide face fitting across the Trust. Currently the trust has 2 face fitters available and has 3 different types of FFP3 masks available.

The Trust has 5 powered hoods (one of them not usable due to screen been damaged). Two are currently located at Juniper Centre (one of those not operational), and the remaining at the ICT suite. The powered hoods have been prioritised to the ICT suite since most AGP procedures on the Trust are undertaken there. Regardless of this, any other department can request hoods, if necessary, except secure care where they are not to be used due to concerns the hood might be weaponised.

The IPC team established a narrow cooperation with procurement, ensuring that PPE available was always available in the desired quantity and try to support the recognition of the areas in need of specific equipment.

Continuous updated guidance has been issued to all professionals. To ensure this could be done optimally, communication channels were kept via the Deputy Director of Nursing and the COVID-19 department to ensure IPC messages could be cascaded effectively.

The Trust always followed national guidance as summarized in the next chart:

Setting	Disposable gloves	Disposable plastic apron	Fluid repellent surgical mask	Eye protection (Face visor/ eye goggles)	Hand hygiene	Bare below elbows
All staff inpatient settings (this includes any essential visiting staff who are required to access the area)	Single-use	Single-use	Single or sessional use.	Risk assessment - Single or sessional use.	After removal of PPE After all contact with patient/environment	At all times

Table 18 - National PPE advice

There were 3 exceptions regarding national guidance that were in place:

- Resus – FFP3 to be used during all stages – As per National Resus Team advice
- SALTS Assessment – FFP3 or powered hood used.
- Restrains – AS per risk assessment use of FFP3 with facemask or IIR with face mask.

8.2.1 FFP3 respirators face fitting

During the year a face fitting program has been in place with currently 3 masks being used.

The Trust has the support of 2 external face fitters that perform mobile face fitting clinics on demand across the trust. Besides the efforts, the percentage of staff currently face fitted is under 50% as can be seen on the next table:

Division	Requiring Mask Fit Test	Fit Tested	Not Fit Tested	% Fit Tested
⊞Acute And Urgent Care Services	634	271	363	42.7%
⊞Chief Executive Office	1	0	1	0.0%
⊞Exec Dir - Medical	76	16	60	21.1%
⊞Exec Dir - Nursing	56	20	36	35.7%
⊞ICCR	659	248	411	37.6%
⊞New Care Models	7	3	4	42.9%
⊞Secure Serv & Offender Health	814	421	393	51.7%
⊞Specialties	663	269	394	40.6%
⊞Strategy,people & Partnerships	9	0	9	0.0%
⊞Bank	1298	159	1139	12.2%
⊞Not Mapped	17	5	12	29.4%

Table 19 - Face Fitted staff

This is a point of concern, not just for COVID exposure but other respiratory diseases like Flu, Tuberculosis, or any respiratory infection from unknown agent.

It is essential to work towards increase not just the overall percentage of staff face fitted but as much as possible to aim that most face fitted staff is able to use 2 different types of masks with the aim to increase resilience in case of future struggles of supply.

IPC advice – it is important that the Trust includes in its regular training a program of face fitting with a refresh at least every three years or before if needed.

Organize oversight of face fitting program, including record and monitoring of compliance

Include face fitting during induction

9. Incident Reporting

The IPC team also keeps a database of infectious incidents to ensure that those affected are reported to Occupational Health and are properly followed up. Occupational Health reports numbers of staff injuries to IPPC.

The following table shows the reported incidents by quarter and correspondent trends.

The most significant values are related to Possible transmission risk, this particular item incorporates a very wide range of issues like spit with risk of contact with the eyes to physical wounds with skin breach and would require a broader analysis to understand that if it is related to increase in violence in our wards and the factors contributing for it.

The second most prevalent is Tests – Failure/Delay to undertake and has since seen a 50% reduction from Q1. This is sometimes related with challenges to get SU compliance on being tested and is an ongoing work.

Sum	Q					
Infectious incident	**1**	**2**	**3**	**4**	**Grand Total**	**Trend**
Blood Stream Infection (E-Coli, MMSA, MRSA…)	0	0	0	0	0	
Clinical Waste Management	4	5	4	4	17	
Incorrect Test Results (Specimens)	0	0	3	1	4	
MRSA Management	0	0	0	1	1	
Possible Transmission Risk	9	31	46	53	139	
Tests - Failure / Delay To Undertake	14	10	7	7	38	
Ward Closure Due To Infection Outbreak	0	2	11	5	18	
Wound Management (Resulting In Infection)	1	0	0	0	1	
Grand Total	**28**	**48**	**71**	**71**	**218**	

Table 20 - Infectious incidents per quarter

10. IPC Team Response to Alerts and Directives

The IPC team monitors all new alerts and directives released and after they are made available, the team works on ensuring the guidance is adapted to the Trust reality. This has been particularly evident during COVID since guidance for community and mental health settings has been scarce and the guidance was not always to apply in our reality. IPC led on discussions internally and externally to ensure best practice was always adopted.

The IPC team cascaded the information to the clinical areas and other areas of the Trust through the Deputy Director of Nurse, through regular matrons' meetings and IPC champions during the training sessions.
During IPC audits adherence to IPC guidance was monitored and when appropriate aspects of the guidance were incorporated on the auditing tools to ensure consistency.

11. Food Safety

Ward managers undertake quarterly food service audits and monthly activity kitchen audits. Findings are included in matrons service area reports to the IPPC, and checks are also included in IPCN inspections. Food safety advice and audit is provided externally.
At present, the Trust has no food expert, so the annual audit had to be externally sourced. It is recommended that the Trust contracts a permanent food safety expert to allow continuous monitoring and training of staff.
The Food Safety Report is attached to this document.
On the next table we can see the summary of food related incidents eclipsed across the year. The number of reports is very low and have not seen increase across the year.

Count of Count	Q					
Food Safety	1	2	3	4	Grand Total	Trend
Food From Unapproved Supplier	1	1	1	1	4	
Foreign Body Identified In Food	1	1		1	3	
Inappropriate Storage Of Food	1	1	1	1	4	
Other Catering Issues	1	1	1	1	4	
Other Food Safety Issue	1	1	1	1	4	
Out Of Date Food	1	1	1	1	4	
Grand Total	**6**	**6**	**5**	**6**	**23**	

Table 21 - Eclipsed food related incidents

12. Water Management

The water surveillance is made through the Water safety group (WSG).

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The WSG aims to ensure the safety of all water used by patients/residents, staff, and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water-related hazards, assesses risks, identifies, and monitors control measures and develops incident protocols.

12.1 Water Safety – Positive Legionella bacteria samples

Elevated cold-water temperatures can result in legionella bacterium present in water systems becoming active. Legionella pneumophila is a waterborne bacterium and is spread via exposure to aerosols of water containing the bacteria.

Legionnaire's diseases are severe pneumonia caused by exposure to Legionella pneumophila symptoms, including muscle aches, tiredness, headaches, dry cough, and fever.

The WSG continues to respond to elevated Legionella counts identified in some of the water sampled in Trust buildings

At Reaside, an ORCA system for Legionella management continues operating, estates continue works to look at a future possibility of discontinuation of the ORCA system.

A similar ORCA system is being installed at Eden Unit
Where legionella counts are elevated, the outlets were temporarily closed as per policy, and remedial works done as needed.
When this is not possible, water filters are installed on the outlets, nonetheless this is dependent on risk assessment since the water filter have been identified as possible ligature points. It is important to mention that the use of water filters is never a long-term solution, but a way to reduce risk until a more permanent solution is put in place. Currently we have issues with elevated legionella counts in George ward, Forward/venture house, Eden Acute.

Please refer to the attached WSG report for further details on Water Safety Management.

13. Cleaning Standards

The Estates and Facilities report details activities undertaken to promote and maintain standards required to meet the Code of Practice and other regulatory standards.

Of note were the consistently high cleaning scores reported to IPPC. Cleaning scores can be seen on estates report attached.

14. Capital Developments

The IPC team has worked with Estates and clinical staff to ensure that standards to meet the requirements of the document “IPC in the built environment” have been incorporated into refurbishments and works undertaken.

Place of safety has now concluded works, but not invited IPC to visit before opening. Some issues have been identified and are currently under discussion.

Newington finished construction works, IPC invited to walk around. Several fixtures still waiting to be installed and no furniture yet in place. No major issues identified. IPC will re-visit the unit after opening.

Infection Control Doctor – Annual Statement for April 2021 - March 2022
Dr Gemma Winzor. Consultant Microbiologist, UKHSA Laboratory, Birmingham

Overview

The Infection Prevention and Control Team (IPCT) have worked extremely hard this year. The workload has been very high and they are a small team. The planned main focus of 2021-2022 was restoration following the COVID-19 pandemic and to resume a full, proactive annual programme of work. However, on-going periods of high COVID-19 incidence have led to continued outbreaks amongst staff and service users across Birmingham and Solihull Mental Health Trust (BSMHT). In particular, managing COVID-19 outbreaks during winter 21/22 was extremely time and resource intensive. Lack of sufficient access to rapid molecular diagnostics led to delays in outbreak recognition and control.

The IPCT have a complex and varied skillset. They have worked closely with many sectors of the Trust in 2021/2022, including with estates to ensure water safety. This is challenging across such a geographically diverse trust with many building types of varying ages and uses. It is important that the IPCT are involved in capital investment and significant remedial works across the trust in order to ensure IPC risks are highlighted and managed appropriately from an early stage.

Staffing

The IPCT is small and has consisted of a lead Infection Prevention and Control Nurse (IPCN) at Band 8B, two IPCNs at Band 8A and 7 and an agency (locum) Band 7 Registered Nurse. The team is supported by a Band 4 part time member of staff and IPC are trying to recruit a Band 3 Administrator.

In order to proactively improve patient safety and provide more focus to an annual programme of work the team would benefit from a further substantive IPCN (of at least Band 6). Staffing shortage has been a long term issue for the IPCT and this has been highlighted further by the COVID-19 pandemic and the extremely high associated workload. Building and maintaining resilience within the IPCT should be a priority for the Trust.

Governance

Sarah Bloomfield (Chief Nursing Officer) is DIPC and has been chairing the IPCC. It is extremely important that the Lead IPCN can report directly to the DIPC, and this should continue. The IPCT need on-going engagement with the Trust Executive Board to ensure that IPC strategy can be implemented in all staff groups and across the organisation. The

IPCC continued remotely throughout the year and improvements have been made in the format and succinctness of the IPCC meetings.
This year BSMHT has experienced delays with reporting of COVID-19 molecular diagnostic results. At times, the Trust's access to rapid, molecular diagnostic testing was limited and insufficient to ensure timely diagnosis of COVID-19 or to permit safe admission or transfer of patients. The Trust needs to ensure that contracts for procurement of Microbiology and Virology laboratory diagnostics are robust and the KPIs are appropriate. The IPCT can assist with this and should be involved at appropriate stages of this process. Provision for staff testing, in addition to service user testing, must be considered.

COVID-19 Response & Influenza

During the last year, periods of high incidence of COVID-19 within the community (as restrictions have been lifted) have impacted on BSMHT. The IPC focus has shifted from the emergency planning phase to "living with COVID-19" and adapting healthcare delivery to minimise the impact of COVID-19. The trust has continued to suffer a high rate of outbreaks and ward closures; this had effects on service delivery and staffing. The Trust has experienced delays in outbreak recognition and management due to delays in accessing SAR-CoV-2 PCR results. To mitigate the risk posed by these delays, the IPCT devised a strategy to incorporate lateral flow testing into the BSMHT COVID-19 SOP, however limits to procurement of lateral flow tests have restricted the utility of this.

As in winter 2020/2021 the IPCT streamlined COVID-19 outbreak meetings to a weekly summary with external stakeholders. This worked well and allowed the IPCT to work more efficiently.

Spring 2022 has brought a rise in incidence of Influenza A within the community and NHS Trusts have also started to see outbreaks. Despite efforts of the IPCT, engagement with FIT testing amongst staff is very low across services within BSMHT. The IPCT are concerned about the Trust's current ability to manage an Influenza outbreak given the low numbers of FIT tested staff. We have particular concerns around clinical teams that care for high risk or vulnerable service users (i.e. homeless or the elderly and frail). Furthermore, access to timely molecular diagnostics are also crucial for Influenza control.

Water Management & Legionella

The new Water Safety Group structure of a Strategic Water Safety Group (SWSG) and an operational group has worked well. The SWSG continues to report to the IPCC quarterly. The IPC team and Consultant Microbiologist/Infection Control Doctor continued to attend the SWSG meetings quarterly whilst an IPCN is a member of the operational subgroup meetings

(held monthly). The BSMHT Water Safety Plan and Legionella Action Plan were reviewed, updated and ratified this year. Furthermore, BSMHT retained estate water risk assessments were reviewed and updated. Risk assessments for the North PFI are planned imminently. The Trust continues to source an external Water Safety expert (Authorised Engineer, Water Hygiene Centre).

Legionella species have continued to be detected and cause issues in some trust estates (e.g. Eden unit, Forward House). Infection Control have worked closely with Estates and external contractors to investigate and manage issues as they arise. Our aim has been to reduce the risk to service users and staff. Extensive remedial works (e.g. replacement of seized valves) and implementation of a copper and silver ionisation unit have been utilised to provide a long term solution to an ongoing issue within Eden unit.

Education/Training

The IPCT (with the exception of quarter 2) have provided a full programme of link worker training during this year, with good attendance.

Given the workload pressures, the IPCT have had little opportunity to access educational opportunities for their own continuing professional development (CPD). Support for IPCN CPD should be encouraged (e.g. attendance at IPC water safety courses, leadership and management).

Occupational Health

Occupational Health report to the IPCC, and this includes incidence of inoculation injuries (by type) and vaccination rates (Influenza and COVID-19). COVID-19 vaccination rates amongst staff could be improved significantly. Rates of staff and service user vaccination are reviewed during each COVID-19 outbreak; with rates of staff vaccination (two doses and booster) during a March 2022 outbreak being only 46.4%.

Antimicrobial Stewardship (AMS)

Given the workload pressures of COVID-19 and the small IPCT, little advancement has been made to increase the role of AMS within BSMHT. BSMHT are a relatively low user of antimicrobials and pharmacy regularly present antibiotic audits to IPCC. Generally, compliance with the local antibiotic policy is high (e.g. 90% in September 2021). However, education to raise awareness of antimicrobial resistance and a more in-depth review of the BSMHT use WHO's AWaRe category of antibiotics would be welcomed by the IPCT.

Food Safety Audit Report – Trust Food Production and Ward Kitchens (21/22)

Introduction

As SSL food manufacturing facilities continue to implement and comply with the Food Safety Standards, they are also required to conduct internal audits of their Foods Safety Management Systems. Meeting these requirements involves developing a strong internal audit program that utilises internal resources and auditors to perform internal audits. Lack of a properly designed or implemented internal audit program is one of the most common food hygiene non-conformances.

An internal audit is a complete review of the food safety system against HACCP standards. Internal audits are to be conducted by the company's own trained staff and involve more than just the inspection of the facility or verification of the Critical Control Points. The internal audit team should be multi-disciplinary, so that they can independently and objectively audit different departments, functions, and processes within the organisation. The internal auditor should understand the audit plan, schedule, procedure, documentation, and objective of the internal audit process, including the Trust inspection checklist and standard. Internal auditing involves a systematic, planned, independent and documented process for obtaining evidence to review and evaluate against pre-arranged standard requirements. There are many reasons a facility should conduct internal audits and some examples may include preparing for third party audits, satisfying program requirements, creating records of due diligence, driving continual improvement, identifying improvement opportunities, and verifying compliance to standard.

Key steps to conducting an Internal Audit consist of following the system Plan, Do, Check and Act. The PDCA cycle is a repetitive four stage cycle and is used for continuous improvement in many business processes.

Plan

Establish the objective or define the scope of the audit and create an annual schedule. Selecting and training of the internal auditors are also key components of the planning step. The planned audit route had to follow COVID regulations according to Government guidelines and Trust communications. All food production kitchen audits to be announced following the covid restrictions and the 2022 audit schedule to be emailed to Infection Prevention teams by March 2022. Food safety ward kitchen audits start date for 2021, 5/5/2021, end date 9/12/2021. This included Production kitchen audits to verify that a HACCP system is working across Ardenleigh, Barberry, Reaside, Tamarind and Zinnia. Food Safety audits to commence in 2022 on 25/1/2022, planned audit calendar attached as appendices (i). A new audit tool has been produced by Sue Ladkin for Trust ward kitchens and therapeutic kitchens (ADL), formatted as the food production audit tool so that a percentage score will identify any food safety hazards, the potential risks and recommended control measures to reduce any potential hazards (appendices ii).

Plan to review the Food Safety training courses for all Trust staff who manage food in line with changes to legislation e.g., Natasha's Law (introduced in Oct 2021) including online FSA food labelling training. This will include a TNA by Sue Ladkin and the Trust L&D team at Uffculme to review the induction Elearning L1 course.

Food Safety Policy review due date 2021, reviewer Sue Ladkin. Approved

Produce a Trust Allergen Policy by October 2021 author Sue Ladkin. Waiting Approval.

Plan to deliver Food Safety presentation on Listeria on IPCT Champions day in support of Trust IPCT. (Undertaken on 10/02/2022 by Sue Ladkin)

Trust Food Safety Group Meetings attend 28/1/2022. These are now in calendar for bimonthly meetings across 2022.

Do

Implement the plan or execute the process, which involves the collection of information for evaluation. Look for deviations in the implementation against the plan and check for appropriateness and completeness. This step involves utilising the Internal Audit Checklist Tool for assessment and includes conducting risk assessment of non-conformities according to standard classification of Critical, Major, and Minor Non-conformities. *This version was updated in March 2022 v4, to include the observation of safe handwashing methods due to COVID-19 and includes the questioning of staff allergen awareness at preparation, cooking, and service points. The updated version v4 also has changes to washing salads in a chlorine solution which has now changed to "wash salads, vegetables and fruits in cold running water". The Trust is also in the process of the removal of food waste macerators, so food waste observations that safe methods are being trialed at The Barberry are included (planning project start date 20/09/2021) (appendices iii)*

Check

This step includes writing the non-conformity report and assigning responsibility and deadlines for conducting root cause analysis and corrective action. The audit check included confirmation that CCPs (critical control points) are under control, reviewing any deviations and details of corrective actions taken, such as changes in food service at Trust sites where service users meals are being served at ward level not in dining areas. (Currently Reaside.) All ward level HACCP documentation checks to be verified, this will support due diligence and ensures the food safety management system is compliant.

Act

Follow-up with the corrective actions in the check step and verify that the corrective actions are effective and will prevent future re-occurrence. All inspections are reported with supporting evidence that the program audited either complies with or does not comply with the established Trust requirement or standards. All audit summary reports were sent to management within 24 hours of audit that included findings from observations and any recommended actions. Where any breaches in the Trust Food Safety policy, Food Safety Legislation are identified action will be

taken immediately by IPCT and SSL Facilities Management (all food safety hazards to be eclipsed)

Food Production Kitchen Audit % scores (yearly average from quarterly audits during 2021/2022)	
Ardenleigh	90%
Barberry	92%
B1 Bistro (Trust Headquarters)	N/A -closed during COVID
Reaside	94%
Tamarind	95%
Zinnia	96%
Some audits cancelled where sites in lockdown 2021/22. Uffculme not on audit remit as not an SSL property	All audits announced due to COVID regulations

The audit includes interviewing personnel and where relevant service users, but also reviews policy, procedures, and records; observations, and evaluations of all the collected information to confirm that established standards are being met. Once the Internal Audits have been concluded; the auditor will confirm the scope or area covered during the audit, detail non-conformities (where appropriate), assign responsibility and agree to corrective actions with deadlines. (Due to COVID restrictions and outbreaks, meetings and verification audits are pending).

- Manage internal audits as separate programs that include procedures, trend analysis, formal training, and cross department representation
- Ensure the internal audit is an official event and reports to be provided in a timely manner.
- Ensure internal auditors are objective and only collect evidence (including supporting photos) and facts.
- Internal Auditor to audit the system and not the person.

Internal audit non-conformity report must be written in a timely manner and provide routine updates to Senior Management.

All production sites given a minimum of seven days to take appropriate actions on any recommendations. All site managers given a verification audit date in advanced, as recommended by HSE. (No audits to be unannounced during post COVID). All previous EHO inspections of food production kitchens scores on the doors across SSL have been 5/5.) Check-It temperature control system in use in food productions sites and ward kitchens under SSL. (This is to be reviewed in 2022). Amey site audits finds HACCP is current, valid, and implemented.

No Trust food production sites have had an EHO visit during 2021.

Inspection Observations & Recommendations

ARDENLEIGH - Main production kitchen is lacking in storage space for dry goods items. Correct food storage is essential for a hygienic and efficient food business because the rate of food spoilage is affected by temperature, humidity, stock rotation practices and the integrity of packaging.

Main production kitchen requires refurbishment to include a cold food and raw food preparation area to prevent items such as salads and sandwich temperatures entering the danger zone. It is impractical to expect that chilled foods are kept below 5c when being prepared, however the area where high risk chilled food items are being prepared is in the main body of the food production kitchen, adjacent to deep fat fryers and grills.

Comprehensive Food Safety System

Allergens – observation of delivery of Kellogg's crunchy nut cornflakes to wards as part of cereal choice this, requires confirmation that this is an approved Trust cereal and has been risk assessed by clinical staff.

Therapy kitchen - (James Brindley) found in unhygienic conditions and HACCP documentation found incorrectly completed. All Trust staff that list food handling as part of their job (including HCAs) should be trained to Food Safety Level 2 and any staff that supervise or are training service users when preparing, cooking, and storing food should hold a Food Safety Level 3 Supervisors qualification. (Hillis Lodge have identified this and level 2 food safety training is booked for May 2022).

BARBERRY – Production kitchen has no major concerns in food production and is currently trialing the food waste project to recycle food and reduce food waste across the Trust, as food waste macerators are removed from sites.

Main observation food safety hazard, which was a serious HACCP concern, was the "free" sandwich bag delivery to all Trust sites. On inspection at Barberry reception sandwiches were stored in ideal temperatures (rear of reception) that promote the growth of pathogenic bacteria such as listeria which can survive in chilled temperatures of 8C. The egg mayonnaise sandwich found at 12.30am recorded at temperature of 19C this was reported immediately to IPCT. This is a kind and generous donation from the supplier, however if ready to eat high risk food items are not stored in safe conditions, they are highly dangerous to any vulnerable staff especially those who are pregnant. Recommend that this practice ceases and that donations of non-foods or low risk food items be risk assessed to identify any food safety hazards, and that control measures are in place prior to delivery.

REASIDE – Production kitchen found with sinks out of order in the cold preparation area, this has been ongoing throughout 2021/2022 and is still ongoing. Drains and sinks across this site are a continuing problem, the concerns about safe water have been reported to Estates.

HACCP - Currently all meals for service users are being served on wards, due to short staffing levels. This started in the first lockdown and is continuing as observed on 11/04/2022. Meals are selected from menus and are then sent in individual take away boxes, wrapped and taken to wards by porters. Having monitored the process I am

reassured that safe hot holding temperatures above 63c are being maintained. However, on all other aspects of safe food management, this practice is unacceptable in the long term and recommend business as usual is established where covid allows.

Tamarind – Main production area, no areas of food safety concerns. ADL kitchen found in unhygienic condition and items out of date. This was resolved on the day and rectified by Clinical teams.

Zinnia – Main production kitchen no food safety concerns. This site has had a rodent infestation which was reported in 2021. The food production site was closed until environmental controls were introduced and pests eradicated by the contractor. During kitchen closure all foods were prepared at Barberry and conveyed to Zinnia, following strict HACCP principles.

Summary:

All ward and food productions audits are sent to sites and Infection Prevention teams with photographic evidence to support the Food Safety of BSMHFT.

Recommendations:

All food handlers have a legal responsibility to make sure the food they prepare and serve is safe to consume. The role of any supervisor across the Trust is to help to establish, implement and communicate policies and procedures on supplier and customer specifications, delivery, storage, stock rotation, dating systems, cleaning, and temperature control. They should train staff to check deliveries and respond to anything unsatisfactory, for example signs of spoilage or damaged/contamination stock.

Managers have a duty to monitor staff as they carry out food handling procedures and carry out disciplinary and corrective actions if necessary. By checking, auditing, and reviewing the systems, and where appropriate, taking corrective actions food safety standards will be maintained.

The Independent Review of NHS Hospital Food (2020) summarises the main legislation related to food safety which Trusts must be aware of

The review recommendations states:

"The outbreak of listeriosis in 2019 has led to a thorough investigation of what happened and why. To help avoid a repeat episode, purchasers must have an effective mechanism in place to assure food safety within their supplier base and drive improvements where necessary to ensure all businesses supplying high -risk foods meet the highest standards.

a. *There must be open and speedy communication channels for food safety concerns between auditors, local authorities, Public Health England, Food Standards Agency, suppliers, and trusts, with appropriate governance structures to ensure concerns are acted upon swiftly.*
b. *Every Trust must have a nominated food safety specialist and named board member responsible for food service.*
c. *A mandated reporting procedure for food safety concerns for trusts and suppliers must be established, with penalties for not reporting issues.*
d. *Raise standards of food safety audits for high-risk food manufacturers, so that they give confidence that the legal and contractual requirements are being met.*
e. *Trust must recognise their obligations as food business operators and ensure effective compliance with robust food safety procedures in place at all levels, which must be understood, enacted, and verified."*

Going forward the review recommends:

a. *Set up an expert group of hospital caterers, dietitians and nurses, and input from infection prevention and control, and sustainability and health and well-being leads, to oversee hospital performance and progress against these recommendations, with suitable terms of reference.*
b. *The expert group to maintain momentum and provide support of hospital caterers, dietitians, and nurses.*

c. *The expert group to be responsible for propagating the core principles of good food service throughout the NHS.*
d. *The expert group to be funded and staffed.*
e. *The expert group to be accountable to the Secretary of State for Health and Social Care.*
f. *The expert group to publish a post-implementation review."*

All Trust staff currently complete the eLearning Food Safety training at induction (Reviewed by Sue Ladkin in2021 and approved by L&D)

For compliance and standardisation, the auditor recommends areas that require improvement include:

Training- CIEH Level 3 Intermediate in Food Safety for ward managers and all staff that prepare, cook, support, and supervise others.

CIEH Level 2 Foundation in Food handlers across the Trust for all staff that handle food and to complete the FSA online allergen training Food Standards Agency food allergy online training

Standardisation of service – Through an expert food safety group

Control of documentation

Testing methods – Food sampling for Listeria in pre prepared food items such as sandwiches and salads.

Documentation procedures – HACCP policy review 2022

Inspections & Audits: Review as part on ongoing due diligence when and where required

Actions on deviation

Comprehensive Food Safety System

Author Susan Ladkin SSL Facilities Training and Quality Compliance Manager (Estates & Facilities) V2

References

Report of the Independent Review of NHS Hospital Review, 2020

Hospital Caterers Association

Food Standards Agency

Chartered Institute of Environmental Health

Appendices sent as attachments.

Master Food Hygiene control tool 2022 v4

ADL Ward Food Safety Audit Master 2(

Managerial Efficacy Audit Dates - 2022.xls

SSL

Food Safety Report 2021/2022 Author: Sue Ladkin, SSL Quality Monitoring & Training Manger

ESTATES & FACILITIES INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2021-22

1. CORONAVIRUS (COVID) PANDEMIC

- **Estates & Facilities COVID Programme of Works 2021/2022**
  With collaborative support from Matrons, Ward Managers, and Estates Teams, Estates & Facilities continued to run a programme to assist in maintaining a safe environment for all staff, Service Users, and 3rd party visitors for example contractors across all sites by:

  - Enhanced Touchpoint Cleaning in accordance with the guidance provided by Infection Prevention & Control Team
  - Upgrading of additional areas which requires additional preventative measures such as screens.
  - Weekly Isolation Returns to capture any COVID related issues and communicate to all parties involved (Domestic Staff and Contractors)
  - Provided Post Infection cleans and deep clean of sites when requested by Infection Prevention & Control Team and Clinical Staff.

2. DOMESTIC & HOUSEKEEPING MANAGEMENT

- **Estates & Facilities**
  All "in-house" domestic services continue to be provided by SSL with the North PFI sites, B1 Trust HQ services being provided by a 3rd Party outsourced provision. This means that all E & F provision across the Trust is outsourced for 2021/2022 reporting period.

- **NHS E/I – Revised National Standards for Healthcare Cleanliness**
  After the successful pilot of the NHS E/I National Standards for Healthcare Cleanliness during 2018-19 the SSL Facilities Team and SSL PFI Contracts Management Team continued to work on the standards. With COVID 19, the implementation of these standards was delayed until April 2022 with Trusts given 6 months to implement the new standards. SSL are now in the process of revising the Trusts Cleaning Policy to align with the National Standards and will present the revised Trusts Cleaning Policy at the Q1 2022/2023 IPPC meeting in June 2022. A cleaning Standards Project Group was formed to implement this.

- **Trust Domestic and Housekeeping Operations Manual**
  Each operations manual contains Domestic and Housekeeping COSSH safety data documentation (in line with the Trust COSHH Policy), task-based risk assessments and method statements, task-based standard operating procedures, BICSc cleaning method statements, Trust Infection Prevention & Control policies and procedures, and operating instructions for departmental electrical equipment.

- **SSL Facilities Rapid Response Team**
  During 2021-22 BSMHFT Facilities Rapid Response Team continued to undertake a programme of COVID deep cleaning across Trust In-patient and Community units.

3. CLEANLINESS

- **Cleanliness Audit & Inspection Programme**

  During 2021-22 the programme of cleanliness inspections and audits was undertaken. Cleanliness scores and reports were provided to the Trust Infection Prevention & Control Team each month and the Trust Infection Prevention Partnership Committee each quarter. Due to the pandemic, monitoring was suspended during the lockdown/Ward Outbreaks with audits being conducted at supervisor level only, however if any concerns were raised a member of the monitoring team would attend the site and give assurances. The inspections were recommenced once COVID Restrictions had been lifted.

  The programme comprises 3 levels.

  - Level 1 Monitoring by Domestic Supervisors
  - Level 2 Trust-wide Management Audits
  - Level 3 'External' Audits. (External audits were restricted during COVID)

  Cleanliness scores were reported against the Trust's Commissioners KPI of 95% achievement of the Trust's thresholds against the National Specification for Cleanliness in the NHS.

  During 2020-21 the cleanliness scores throughout the Trust (BSMHFT, SSL and Amey Community Limited) averaged above 97% and were consistently and significantly above the thresholds set by the National Specification for Cleanliness in the NHS (i.e. 85% for High Risk areas such as in-patient units) and the Trust Overall Cleanliness Target of 81% as well as the Trust's Commissioners KPI of 95% of the Trust Overall Cleanliness Target of 81% (i.e. 77%).

  The thresholds will change with the adoption of the new Standards for Healthcare Cleanliness in 2022 this will be reflected in the New Cleaning Policy which is currently being drafted to present to the IPPC in June 2022.

  All special cleaning activity (including Isolation Cleaning, Post-Infection Cleaning and scheduled Deep Cleaning) was undertaken in compliance with the Trust Infection Prevention & Control Policy and was reported monthly to the Infection Prevention & Control Team and to the Infection Prevention Partnership Committee each quarter. The Trust's Deep Cleaning Programme is an integral element of the Trust Cleaning Policy and also responds to the "Deep Clean Good Practice Guidance" "From Deep Clean to Keep Clean" (DH October 2008) which specifically requires that "Strategic and operational cleaning plans should make provision for the organisation's on-going deep cleaning programme" (para 2.5). These programmes were affected by the Pandemic but were carried out were possible and Cleans during COVID were enhanced to ensure compliance was maintained.

Key Cleaning Performance Data for 2021-22

Quarter 1 1 April – 30 June 2021	Quarter 2 1 July – 30 September 2021	Quarter 3 1 October – 31 December 2021	Quarter 4 1 January – 31 March 2022

Trust Cleanliness Targets & Scores						
Trust Overall Cleanliness Target = 81% Trust Commissioners' Target (95% of Trust's Overall Target) = 77%						
	Trust Average	North PFI	BNHP	Community	Secure	Corporate
Quarter 1	97.19%	98.2%	93.37%	97.77%	98.17%	98.42%
Quarter 2	98.07%	98.68%	96.76%	98.36%	98.71%	97.84%
Quarter 3	97.65%	98.62%	95.21%	97.89%	98.67%	97.86%
Quarter 4	97.33%	97.75%	96.42%	97.82%	97.66%	97%

- **PLACE (Patient Led Assessments of the Care Environment)**
  The 2021 PLACE assessment programme was cancelled due to the Pandemic. With this cancelled SSL are in the process of conducting assurance visits (PLACE Lite) across all inpatient sites. These will be completed by Summer 2022 and outcomes are communicated with Key Stakeholders, informing them of any concerns.

- **Cleaning Quality Operational Group**
  The Cleaning Quality Operational Group (established in September 2015) was re-established in 2021 with new Terms of Reference and meets quarterly. It is led by Infection Prevention & Control and comprises of SSL Estates and Facilities Department, Matrons, and PFI Partner Amey Community Limited and reviews all issues (and implements actions) regarding cleanliness within the Trust. The Group reports into the Infection Prevention Partnership Committee.

- **Cleaning Policy**
  The aim of the Trust Cleaning Policy is to demonstrate compliance with the assessment criteria detailed in The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance" (DOH, July 2015) on the standards of cleanliness that facilitate the prevention and control of infections and improve the quality of health service provision by ensuring that all cleaning related risks are identified and managed. With the new National Standards for Cleanliness Being adopted (April 2022) the existing Trust Cleaning Policy will continue to be used until the New Policy (currently being Drafted by members of the SSL E & F Team) is adopted and will present the revised Trusts Cleaning Policy at the Q1 2022/2023 IPPC meeting in June 2022.

  The Trust Cleaning Policy incorporates the operational cleaning plans for all areas of the Trust.

  The policy requires delivery of common and consistent compliant cleaning practices cleanliness standards Trust-wide (whether delivered through the Trust's in-house, SS Providers).
  Compliance with the policy is monitored through the following.

- Estates & Facilities Cleanliness Audit & Inspection Programme
- Cleaning Quality Operational Group
- Estates & Facilities monthly reports to the Infection Prevention & Control Team and quarterly reports to the Infection Prevention Partnership Committee.

➢ **Cleanliness Training**

BSMHFT Facilities Department established an innovative accredited Training Hub now run by SSL at The Barberry which continues to provide education and training for SSL and Trust staff as well as external companies. The Facilities Training Hub provides dedicated education and builds awareness of the cleaning profession through accredited training in the "British Institute of Cleaning Science" (BICSc). Courses are delivered by SSL Facilities Team ranging from local induction training to higher level accredited training, whilst working alongside BSMHFT's Infection Prevention & Control Team and nursing colleagues. The Hub's syllabus also includes Level 2 in the Principles and Control of Infection in Healthcare Settings, Food Safety, Legionella and Water Safety and Biohazard Decontamination Training. During 2021-22, the Facilities Training Hub delivered FM training to Trust staff, SSL (Summerhill Services Limited) and PFI Partner Amey Community Limited

SSL Domestic Assistants and Rapid Response Teams hold a British Institute of Cleaning Science ("BICSc") Licence to Practice Card following training. BICSc Licence to Practice demonstrates the foundation units necessary for the Domestic Teams to perform their role safely and efficiently on wards and departments. SSL Catering Team was introduced onto the BICSc Licence to Practice training programme in 2018-19.

During 2021-22 SSL Domestic, Housekeeping and Catering Teams undertook Level 2 in the Principles and Control of Infections in Healthcare Settings when possible due to COVID restrictions. This course will continue to be provided during 2022-23 by the SSL Facilities Training & Compliance Manager

The Trust's PFI Partner (Amey Community Limited) has contracted with the Trust's Accredited Training Hub to provide BICS (British Institute of Cleaning Science) training to all of their Domestic Staff and Supervisors. The Trust's PFI Partner is also using the Training Hub to provide Level 2 Infection Prevention Awareness Training for their Domestic Assistants and Domestic Supervisors.

➢ **Computerised Cleanliness Monitoring System**

The Estates & Facilities Department operates a computerised cleanliness monitoring system "FM First" (based on the NHS Cleanliness Specification and updated for the New Standards for Cleanliness). This same system is used consistently across the Trust by, SSL and PFI Facilities Teams. The system generates cleaning scores and real time reports. It also provides automatic randomised scheduling to facilitate unannounced audits. This system will be updated in April 2022 in line with the new Cleaning Standards.

4. CATERING MANAGEMENT

- **Environmental Health Inspections**
  During 2021-22 Inspections by Birmingham City Council Environmental Health Officers were postponed or did not happen however SSL's Food Safety advisor carried out internal audits where possible.

- **SSL Kitchen Inspections and SSL Food Safety and Quality Audits on behalf of BSMHFT**
  During 2022-23 if COVID Restrictions allowed a programme of kitchen inspections and food safety and quality audits were undertaken once a quarter across the production kitchens with scores and reports provided to the Trust Infection Prevention Partnership Committee and the SSL/Trust Food Safety and Quality Group each quarter.

- **Allergy Awareness**
  With this legislation changing dramatically during 2021-22 additional training has been provided to SSL Catering and Housekeeping Teams, and also provided to the PFI Partner (Amey) who are responsible for the catering in the North part of the Trust.

- **Food Safety Training**
  The Trust food Safety Policy stated that all Housekeepers and Amey food service staff should be trained to Level 2 food Hygiene and food handlers to Level 1. However, with the recent problems with sandwiches throughout the NHS and the increase in food allergies we will be recommending that Food Safety level 2 training is given to all staff who prepare and serve food across the Trust as part of the Food Safety Report.

5. WASTE MANAGEMENT

- **Waste Contracts**
  The contract with the Violia for Domestic waste commenced 1st April 2020 and the Clinical Waste contract with Tradebe commenced 01 July 2020. These contracts were established for a period of 3 years with the option to extend on a +1 year and +1 year basis.

  These contracts for Domestic and Clinical Waste have continued to deliver an effective and compliant service during 2021-22 whilst at the same time keeping costs to a minimum. The 24/7 helpline and call logging process enabling queries to be logged, responded to and tracked more effectively and in doing so improving service standards has continued to be effective. Contract Review Meetings are held regularly with a focus at each meeting of dealing with any isolated problems and seeking further service efficiencies.

- **Duty of Care Audits**
  Duty of Care Audits by external experts of the Trust's various waste contractors continue to be carried out on an annual basis to ensure that the Trust's waste is managed effectively and compliantly from point of consignment to final disposal. In addition, SSL has worked very closely with the clinical waste contractor Tradebe to complete many pre-acceptance audits, ensuring that waste is effectively managed, segregated and consigned by BSMHFT. Where issues have been identified the findings have been shared accordingly.

- **Waste Management Policy**

The Trust's Waste Management Policy which was ratified in September 2021. This Policy places a clear responsibility on the producer of the waste (the ward / the team / the individual) to manage that waste compliantly and furthermore places a control responsibility on team / ward managers and equivalent who are custodians of healthcare within their sphere of influence to ensure that their staff manage waste safely and compliantly.

- **Waste Management Training**

  SSL's Estates and Facilities Department has supported clinical / healthcare colleagues by offering refresher training at their own sites this being to reduce the burden on clinical staff having to travel to 'training venues' to receive such on the job training.
  In addition, sharps management training was provided both by the Trust and its sharps supplier to the Trust's Infection Control Link Workers to allow them to disseminate best practice at their respective sites. This training will continue in 2022/23 under the terms of Infection Champions.

6. LAUNDRY & LINEN MANAGEMENT

- **Laundry & Linen Policy**

  The Trust Laundry & Linen Policy was due for review during 2021-22 and this was duly carried out. The review incorporated the Health Technical Memorandum (HTM) 01-04 "Decontamination of Linen for Health and Social Care" that has superseded the DOH Choices Framework for local Policy and Procedures (CFPP) 01-04 "Decontamination of Linen for Health and Social Care".
  The Policy has been amended to take this change into account and has been passed through the Infection Prevention and Control Committee and was presented to the Clinical Governance Committee and was duly passed and ratified and is now in place and on the Trust Intranet.

- **Laundry & Linen Contract**

  From 1 April 2020, the Supplier (Central Laundry) continued to provide a good level of service However during 2021-22. Central Laundry was bought by Ellis this caused a serious reduction in standards and Service despite weekly contract meetings conducted by SSL and PFI Partners with the supplier. Breach of Contract notices have been issued and there have been some improvements. SSL and PFI Partners are currently exploring alternatives to improve the service received which may include procuring a new contractor.

- **Duty of Care Audits**

  A Duty of Care Audits was undertaken of the Trust-wide Laundry and Linen supplier (Ellis during 2021 when they bought the business from Central Laundry). These were to the Coventry plant and the team observed the supplier's compliance with the service contract, the Trust's Laundry & Linen Policy, and Health Technical Memorandum (HTM) 01-04 "Decontamination of Linen for Health and Social Care". The Duty of Care visit also observed standards, quality systems, risk assessments and standard operating procedures as well as Laundry Staff Training Records to ensure compliance. Several concerns were raised at the

time of the visit and some of these continue despite monthly Contract meetings the meetings will continue until these concerns are resolved or a New contractor is appointed.

Capital/Revenue Schemes/Projects 2020-21 A full schedule of schemes and projects is available on request. The following schemes are highlighted as being particularly pertinent to Infection Prevention & Control;							
Location	**Description Of Scheme**		**Location**	**Description Of Scheme**		**Location**	**Description Of Scheme**
Oleaster	Creation of Place of Safety (PoS) and Psychiatric Decisions Unit (PDU)		Hillis Lodge	Flooring replacement		George Ward	Remedial works – Water Management Risk Assessment,
Ardenleigh	Coral Ward Seclusion Suite		Juniper Centre	Flooring and redecorations, improvements to internal fabric, fixtures and fittings		Little Bromwich Centre	Remedial works – Water Management Risk Assessment,
Newington Centre	Refurbishment to accommodate SIAS move from Middlewood House		Longbridge Centre	Replace heating and DHW boilers		Little Bromwich Centre	Hot and Cold Water System Distribution Works
Ardenleigh	Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Newington Centre	Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Newbridge House	Remedial works – Water Management Risk Assessment,
Dan Mooney House	Flooring replacement		Reaside	Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Newbridge House	Calorifiers - 1 x Andrews (Max Flow), 2 x state SBT 75
David Bromley House	Flooring replacement		Tamarind	Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Northcroft	Replacement Boilers
Hertford House	Upgrade Flats		Uffculme Centre	Flooring and redecorations. Improvements to internal fabric, fixtures and fittings		Northcroft	Replacement Boilers
Hertford House	Upgrade shower rooms		Eden ACUTE	Remedial works – Water Management Risk Assessment,		Small Heath Health Centre	Remedial works – Water Management Risk Assessment,
Hillis Lodge	Internal redecorations		Eden PICU	Remedial works – Water Management Risk Assessment,			

Summerhill Services

Annual Water Safety Report 2021/22
April 2022

- **Operational Water Management Group:**

  - This is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP. The aim of this group is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens and other risks such as scalding, chemical contamination and the risk of disruption to the water supply. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

  The following is a typical list of tasks assigned to the OWMG

  1. To work with and support the Infection Prevention and Control (IPC) team
  2. To ensure effective ownership of water quality management for all uses
  3. To determine the particular vulnerabilities of the at-risk population
  4. To review the risk assessments
  5. To ensure the WSP is kept under review including risk assessments and other associated documentation
  6. To ensure all tasks indicated by the risk assessments have been allocated and accepted
  7. To ensure new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required water standards
  8. To ensure maintenance and monitoring procedures are in place
  9. To review clinical and environmental monitoring data
  10. To agree and review remedial measures and actions, and ensure an action plan is in place, with agreed deadlines, to ensure any health risks pertaining to water quality and safety are addressed which may include balancing the risks related to water safety and other safety risks such as ligature risks
  11. To determine best use of available resources
  12. To be responsible for training and communication on water related issues
  13. To oversee water treatment with operational control monitoring and to provide an appropriate response to out-of-target parameters (that is, failure to dose or overdosing of the system)
  14. To oversee adequate supervision, training and competency of all staff
  15. To ensure surveillance of both clinical and environmental monitoring
  16. To review areas/rooms taken out of commission, to ensure adequate provisions are made for flushing/draining the water systems as appropriate

  Membership will include:

  1. Head of Facilities Management (SSL) – Chair
  2. Head of PFI
  3. Senior Estates Manager – North PFI

4. Senior Estates Manager – South PFI
5. Senior Facilities Manager - Community
6. Senior Facilities Manager – Secure
7. Senior Facilities Manager South PFI
8. Senior Infection Prevention and Control Nurse or nominated Person
9. Authorising Engineer
10. Capital projects representative
11. Sector Specific Nominated Contractors
12. Deputy Director of Nursing or nominated representative

Regular meeting will be held quarterly. Agenda items will include the following:

1. Review of previous minutes. - Chair
2. Review of Action Plan - Chair
3. Community update (by exception) - Senior Facilities Manager (community)
4. Secure update (by exception) - Senior Facilities Manager
5. North PFI update (by exception) - Senior Estates Manager (North PFI)
6. South PFI update (by exception) - Senior Estates Manager (South PFI)
7. Capital works update - Capital Team
8. Service Provider Update
9. AE update / comments / policy / audits - AE
10. AOB

Quorum - attendance to be no less than 40% of membership (Senior Infection Prevention and Control Nurse or Microbiologist/Infection Control Doctor must be present at all meetings). If the chair of the OWSG is unable to attend, the chair will nominate a deputy dependant on current ongoing issues.

- **Strategic Water Safety Group:**

The Committee comprises of but not limited to the below and is held on a quarterly basis:

1. Responsible Person (or Deputy Responsible Person)
2. Sector Specific Nominated Persons
3. BSMHFT's Infection Prevention and Control representative (where applicable)
4. BSMHFT's Nursing department representative
5. BSMHFT's Health and Safety Manager
6. External Independent AE
7. Consultant microbiologist
8. Trust / SSL Authorised Persons

Committee's responsibilities include:

1. Provide a forum of discussion and sharing of information pertaining to Legionella Management & Control and Safe Hot Water Management across the Trust.
2. The ratification of appointment of Responsible and Nominated persons.
3. The preparation of all relevant Documentation, Works Specifica Programmes, Policies etc. (may be prepared by the team or by others for
4. The ratification of all relevant Documentation, Works Specifications, PPM Programmes, Policies etc.

5. The monitoring and reporting upon the efficacy of all implemented PPM Programmes and all other relevant procedures.
6. The monitoring and reporting upon the efficacy of all contractors commissioned on Legionella related projects.
7. The monitoring and reporting upon the efficacy of all training Programmes implemented for associated staff.
8. The implementation of arrangements for managing an outbreak or suspected outbreak of Legionella.
9. The liaison between all other official bodies particularly in an outbreak situation.

Authorising Engineer:

SSL has appointed the Water Hygiene Centre to provide professional advice on water management issues.

The AE is an independent professional advisor whose primary role is to assist the Trust in managing the risks from exposure to legionella bacteria in water systems and also from other waterborne organisms associated with such systems such as pseudomonas and stenotrophomonas.

As a specialist, the AE will act as an independent professional advisor on water safety matters, and will work closely with both the Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG).

The role of the AE is to provide:

1. Advice to the appointed duty holders, responsible persons and their deputies on regulatory compliance, communication, management procedures, procurement etc
2. Make recommendations for the appointment of the RP[W], DRP[W]/AP[W]. Certificates of appointment will be issued detailing areas of responsibility and limitations.
3. Monitor the performance of employees and contractors with regards to their tasks in legionella management
4. Conduct regular compliance audits of single or multi-site facilities.
5. The AE will also become involved in developing staff training plans, reviewing commissioning works, construction design appraisals, mothballing of unused premises, and the development of specialist water safety policies and procedures etc.

The AE will also provide the following services:

1. Attend quarterly Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG) meetings.
2. Carry out annual audit of the Trust's control of legionella policy to ensure operational and management systems are in compliance with ACoP L8 and HTM 0[illegible] audit report indicating areas of non-compliance; recommend action improvements or amendments to policy and procedure documentatio[illegible]
3. Provide two half-day training sessions which include an update on the key principals of legionella risk management and associated legislation/codes of practice; two sessions to be targeted at trade maintenance staff, two at estates management staff; provide training workbooks and certificates of attendance for all delegates (BSMHFT Trust will provide the training venue and refreshments within the Birmingham locality)

4. Provide additional one day's refresher training for the Trust's infection control team
5. Provide on request ad hoc and technical expertise for all legionella risk management and other related matters via telephone, fax, letter or email; provide regular updates on any changes to legislation/codes of practice which may impact on the Trust legionella risk management system
6. Annual review of water safety plan.

- **Water Safety Plan**

The WSP has been developed in order to comply with the requirements of HTM 04-01: Safe Water in Healthcare Premises.

The purpose of the WSP is to assist with understanding and mitigating risks associated with waterborne hazards in distribution and supply systems, together with associated equipment. The WSP also provides a risk management approach to the safety of domestic hot and cold water and establishes good practice in local water usage, distribution and supply systems. The WSP will also identify potential water related hazards, consider practical aspects and detail appropriate control measures.

The content of the WSP includes management and governance arrangements, together with details of training, professional support, maintenance regimes and supporting documentation.

The water safety plan was updated in August 2021 with Appendix 10 (Legionella Sample Result Action Levels Flow Chart) reviewed and updated March 2022 so we have consistency in approach (see below).

Water safety plan 09.08.21.docx

Appendix 10 Rev A.docx

- **Legionellosis Management and control Policy**

Legionellosis Management and control Policy was reviewed, updated and ratified in September 2021 with the next anticipated review in 2024.

Legionellosis management and con

- **Training:**

Water Safety RP and AP Courses attended and completed across the SSL FM and PFI departments as per the below:

Water RP's

- Lee Gough – Head Of Facilities Management.
- John Mead - Senior Estates Manager – PFI South.
- Martin Germaney - Senior Estates Manager – PFI North
- Gary Stanton – Estates Contracts Officer

Lee Gough ILM.pdf | Martin Germany ILM.pdf | John Mead - Certificate.pdf | Gary Stanton RP Cert.pdf

Water AP's:

- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).

Dean Redmond AP Cert.pdf | Roy Bradley AP Cert.pdf

➢ **Risk Assessments:**

Retained Estate:

Legionella Risk assessments have been carried out at the below sites with action plans in place for the remedial works:

Ref	Property	Postal Address	Gross internal floor area (m2)	Date of Last Survey
1	Adams Hill	190 Adams Hill, Bartley Green, B32 3PJ	180	17/08/2021
2	Ardenleigh inc Thomas Telford and Training Centre	385 Kingsbury Road, Erdington, B24 9SA	8,598	20/07/2021
3	B1	Unit 1 B1, 50 Summer Hill Road, B1 3RB	3,039	29/07/2021
5	Dan Mooney House	1 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
6	David Bromley House	2-4 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
9	Grove Avenue	32 Grove Avenue, Moseley, Birmingham, B13 9RY	397	28/07/2021
10	Hertford House	29 Old Warwick Road, Olton, Solihull, B92 7JQ	484	27/07/2021
11	Hillis Lodge	Hollymoor Way, Northfield, B31 5HE	1,095	25/07/2021
12	Juniper Centre	Moseley Hall Hospital site, Alcester Road, Moseley, B13 8JL	5,246	29/07/2021
13	Longbridge Health & Community Centre	10 Park Way, Birmingham Great Park, Rubery, B45 9PL	1,414	17/08/2021
14	Lyndon Resource Centre	Hobs Meadow, Solihull, B92 8PW	888	27/07/2021
15	Maple Leaf Centre	2 Maple Leaf Drive, Marston Green B37 7JB	1,752	17/08/2021
18	Newington Resource Centre	Newington Road, Hamar Way, Marston Green, B37 7RW	850	16/03/2021
19	Orsborn House	55 Terrace Road, Handsworth, Birmingham, B19 1BP	1,659	18/08/2021
22	Rookery Gardens	385 Kingsbury Road, Erdington, B24 9SA	1,239	03/08/2021
23	Shenley Fields	15 Shenley Fields Drive, Northfield, B31 1XH	487	25/07/2021
24	Tamarind	165 Yardley Green Road, Bordesley Green, B9 5PU	8,261	29/07/2021
25	Uffculme Centre inc (Main Building, Tall Trees / Estates, Staff Support, Gate House	52 Queensbridge Road, Moseley, B13 8QY	2,166	20/09/2021
26	Uffculme site (Tall Trees)	52 Queensbridge Road, Moseley, B13 8QY	628	28/07/2021
27	Warstock Lane	Warstock Lane, Billesley, B14 4AP	577	28/07/2021

North PFI:

All WRA's are up-to-date and not due until November 2022.

South PFI:

Property	Address	Gross Area	Date of Last Survey
Barberry	25 Vincent Drive, Edgebaston, B15 2SY	8,913m2	
Oleaster	6 Mindlesohn Crescent, Edgebaston, B15 2SY	7,200m2	
Zinnia	100 Showell Green Lane, Sparkhill, B11 4HL	4,331m2	

➢ **Water Sampling Results and General Overview**

- Combined Sampling results are now collated into a single spreadsheet including actions taken (see below)

Combined Results.xlsx

- **Water Sampling Results and General Overview**

Reaside:

Throughout the year Reaside has only seen 2No positive results as per the below:

- Dove Ward 1171 WHB – Post – Hot – 07/07/2021 (25CFU's)
- Dove Ward 1171 WHB – Pre – Hot – 22/12/2021 (25CFU's)

On both occasions additional flushing was implemented and on the next round of sampling were all clear.

Reaside has also had widespread replacement of TMV's across the site over the past financial year and this shall continue into 22/23.

North PFI:

On the North PFI sites there have been numerous positive readings throughout the year but robust action plans have been put in place following the Action flow chart and discussions with the Strategic Water Safety Group.

The primary epicentre for positive results continues to be Eden Acute and Eden PICU, the estates team have a clear action plan which includes:

- Reviewing risk assessments and carrying out actions in a timely manner.
- Following the action flow chart including chlorination's, installing POU filters, reviewing flushing frequencies etc.
- Installing a new Copper and Silver Ionisation unit which went live in April 2022.
- Pipework is also going to be replaced in the coming financial year.

It must also be noted that Amey have changed their service provider from IWS to Severn Trent in the past month due to perceived service failures.

South PFI

Quarterly Reports below:

BNHP L8 Quarterly Report & Results (Ma… BNHP L8 Quarterly Report & Results (Aug… BNHP L8 Quarterly Report (Nov 21).docx BNHP L8 Quarterly Report (Feb 22).docx

Quarterly Sampling Results below:

BNHP L8 Results Tracker (Nov 21).xlsx

BNHP L8 Results Tracker (Feb 22).xlsx

- Awaiting commencement date for replacement of the CL02 systems across the South PFI sites as part of lifecycle replacement.

- The CLO2 system for Barberry has seen design amendments. This requirement was recognised during the preparation works for the replacement, thus seeing the design return to the drawing board and a delay being encountered. – Details forwarded to water AE for approval.

Capital (Major and Minor Projects of Note)

Location	Description of Works	Budget Cost £ (inc VAT @ 20%)
Acute & Urgent Care Wards	Replacement of patient bedroom en-suite doorsets with alarms (Phase One)	1,400,000.00
Acute & Urgent Care Wards	Replacement of patient bedroom en-suite doorsets with alarms (Phase One)	600,000.00
Acute & Urgent Care Wards	Replacement of patient bedroom en-suite doorsets with alarms (Phase One)	500,000.00
Acute & Urgent Care Wards	Replacement of patient bedroom en-suite doorsets with alarms (Phase Two)	1,900,000.00
Oleaster	Creation of Place of Safety (PoS) and Psychiatric Decisions Unit (PDU)	1,200,000.00
Ardenleigh	Coral Ward Seclusion Suite	150,000.00
Newington Centre	Refurbishment to accommodate SIAS move from Middlewood House	500,000.00

LEE GOUGH
Head Of Facilities Management

Birmingham and Solihull Mental Health
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B1 3RB

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Website: www.bsmhft.nhs.uk

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	Trust Board
Agenda item	9
Report title	Safeguarding Biennial Assurance Report 2020-22
Date	25 May 2022
Author	Catherine Evans and Jane Wilkinson
Executive sponsor	Sarah Bloomfield Chief Nurse

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

Executive summary & Recommendations:

Key Messages:
Safeguarding overview for the period
Governance arrangements
Integrated Safeguarding Service
Training compliance

Reason for consideration:

To Provide Assurance and Information

Previous consideration of report by:

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)*

none

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

This paper relates to the following BAF risks:

-

Equality impact assessments:

It has not been possible to include specific equality analysis data in this report. The development of specific analysis is planned.

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

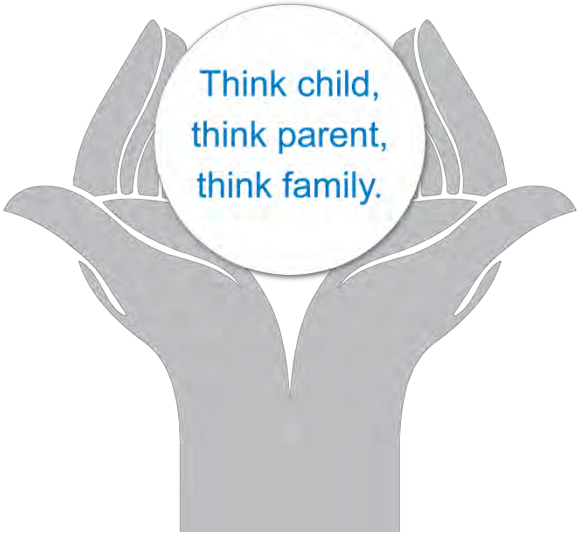
no

Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham & Solihull Mental Health NHS Foundation Trust

Safeguarding Biennial Assurance Report

April 2020 – March 2022



Cath Evans
Head of Safeguarding
March 2022

CONTENTS

1.0 INTRODUCTION

This Biennial Report is unusual as it covers a two-year reporting period and because it spans an episode when the safeguarding team were working in entirely new ways whilst under unprecedented pressure due to the Covid-19 Pandemic.

As a result, the safeguarding service alongside other areas have developed new ways of working and have delivered successes as set out in Appendix 1.

The report is divided into five sections:

- Context and Facts
- Safeguarding Arrangements
- Learning from Safeguarding Reviews
- Conclusions and Looking Forward

2.0 CONTEXT AND FACTS

Getting safeguarding right is a priority within Birmingham and Solihull Mental Health Foundation Trust (BSMHFT). BSMHFT operates in partnership with other essential services and will form part of the integrated care system in the future.

The following section illustrates some of the context which influences the organisation's approach to promoting a progressive safeguarding philosophy within all inpatient, community, and specialist mental healthcare teams.

BSMHFT has the privilege of serving a very ethnically diverse population. Birmingham specifically was described, in a survey by the Office of National Statistics (2017), as more diverse than London. The population is young and there are pockets of significant deprivation. Below are some facts which paint a picture of the complicated factors which impact on the mental health and emotional wellbeing of the residents of Birmingham and Solihull. They illustrate the likely physical health impacts and health inequalities that residents are subject to.

Relating to Children and Young People:

- Birmingham's Ladywood Constituency has the third highest level of child poverty in the UK among parliamentary constituencies, with 47% of children living in poverty. In Solihull, 6,789 children are living in poverty in the Meriden constituency (more than a quarter). In neighbouring areas of Solihull there are 4,009; a smaller number but still equivalent to one in five. (Loughborough University for the End Child Poverty Coalition, 2021)

- In Birmingham, there were 792 incidents of serious youth violence recorded in May 2021 - up 34% from the previous year with a monthly average of 590 incidents. The police force said that this spike was linked to the return of schools and colleges after lockdown. Since

2010, knife crime has risen faster in the West Midlands than anywhere else in the country. (West Midlands Police FOI, 2021)

- The current rate of children in care per 10,000 residents in Birmingham is 67.1, which is higher than the general rate for England which is 65. The number of children in care in Birmingham was 1,960 on 23 March 2020 which is above the funded budgetary requirements. (Birmingham Children's Trust FOI, 2021)

Relating to Families:

- There are 12,121 individual people living in temporary accommodation in Birmingham 6,480 of them are children.

- 1 in 5 - out of all the temporary accommodation offered by Birmingham City Council was in a B&B or hostel (end of March 2021).

(Data taken from Birmingham Fair Housing Campaign - Uncomfortable Home Truths – the People's Manifesto for Fair Housing in Birmingham, 2021)

Relating to Domestic Abuse:

- A total of 58,412 domestic abuse crimes were reported to West Midlands Police between the first day of lockdown on 23 March 2020 and 30 March 2021 - the day after restrictions eased.

- Over Christmas 2020, police in the West Midlands said they were called to 1,250 incidents of domestic abuse. The force said it was a 60% increase on the same period last year. Between Christmas Eve and 29 December 2020, West Midlands Police made 191 arrests, which it said accounted for almost 30% of the force's total arrests.

- The most recent Freedom of Information figures revealed 76% of the victims reporting abuse crimes were women and 24% were men. (WMP FOI request, 2021)

- Each year it is estimated that there are around 4,850 female victims of domestic abuse in Solihull, and 1,300 children and young people live in households in Solihull where domestic abuse occurs (Solihull Metropolitan Council data, 2021).

3.0 SAFEGUARDING ARRANGEMENTS

Required standards for safeguarding are outlined in law, by inspectorates and in contracts. Rather than list all of this within the report, details of all legislation and expectations are outlined in Appendix 2.

A core function of the corporate Safeguarding Team is to review safeguarding practice to monitor quality, effectiveness, and compliance to expected standards. The following are some methods we use to review how well we are doing:

- Information from advice line activity

- Eclipses (incidents and referrals)
- Serious incidents and external reviews
- Clinical work
- Supervision and reflective discussion
- Audit
- Learning and development activities including training compliance.

Safeguarding Priorities:

To support a culture of safeguarding within the organisation has adopted 3 priorities
These are:

- ★ "Back to Basics"
- ★ Responding to the findings from safeguarding reviews
- ★ Shaping the safeguarding culture in BSMHFT

These priorities were set prior to the Covid-19 pandemic (2019) and they were designed to encourage the universal embedding of safeguarding within all aspects of service delivery. Progression of these priorities was unfortunately delayed by the impact of the epidemic but is now being driven forward through reflective discussions, training and patient safety processes and support from the organisation.

To deliver the priorities the organisation has adopted an approach named Integrated Safeguarding System (ISS) and is designed it to fit with anticipated system wide safeguarding changes including the introduction of Integrated Care Systems. The model plans to improve training and practice development capacity and to build capacity for both the corporate Safeguarding Team and for all service areas. It provides tools to support competency/skills building, standards to assist outcome measurement and assurance, and outlines what activities are expected of staff regarding their duty to safeguard. To date we have used one early adopter site and we are in the process of encouraging self-adoption by interested teams which will be overseen by Heads of Nursing and Allied Health Professionals.

There are two primary elements to ISS:

- A suite of expected safeguarding standards *(Back to Basics)*
- A suite of behaviours descriptors *(Shaping Safeguarding Culture)*

Safeguarding Framework:

1. The Safeguarding Team will deliver an effective specialist service which clearly explains to staff their safeguarding roles and responsibilities and the standard of safeguarding practice expected by the organisation.
2. The Safeguarding Team will provide information to the organisation regarding standards of compliance to required statutory and mandatory safeguarding expectations.

3. Local governance forums will monitor safeguarding assurances and improvements requirements, and this will be reportable into the Trust's overall Clinical Governance Committee.
4. Safeguarding assurances will be monitored and governed by the Safeguarding Management Board on a quarterly basis. This board reports into the Quality, Patient Experience and Safety Committee.
5. The Safeguarding team will support the Birmingham and Solihull wide safeguarding partnerships by being active members of key safeguarding boards/ICS/ partnership bodies and systems/specialist sub-groups.
6. The Safeguarding Team will maintain and develop their specialist knowledge and expertise. This will be including the authorship, involvement and dissemination of lessons learned within child safeguarding practice reviews, safeguarding adult reviews, domestic homicide reviews and internal reviews.

Learning and Development:

Children and adult Safeguarding training is mandatory for all health staff regardless of role and compliance is monitored through contracts with the Birmingham and Solihull Clinical Commissioning Group (BSOL). The scope and level of training required is role dependant and determined by the intercollegiate document for adults and children.

The training offer has been refreshed and the organisation is now using the Health Education England generic eLearning for Safeguarding at level 2 and an internally written programme for level 3 which is bespoke for mental health which is face to face /online/ Webex offer.

Training is linked to the traffic light system and matching staff groups to training expectations and provides staff and their managers with the ability to monitor their requirements to meet trust expectations.

Compliance fell during the pandemic due to unprecedented public health pressures and the organisation is monitoring and supporting the gradual improvement that is now evident.

Steps which are now in place to continue this improvement include senior managers being alerted to attendance levels via a training report provided by learning and development and said managers' report improvements to the Safeguarding Management Board which seems to be starting to make a difference. Heads of Nursing and Allied Health Professionals now attend the board and account for training compliance and completion of actions from reviews.

Our most recent compliance figures are set out below.

Compliance figures for 2021/22:

Safeguarding Adults	Q1	Q2	Q3	Q4
Level 1 (eLearning)	95.6%	91.5%	92.6%	92.2%
Level 2 (eLearning)	87.9%	90.4%	92.7%	92.1%
Level 3 (virtual interactive)	N/A	39.5%	64.3%	71.8%
Domestic Abuse	N/A	39.5%	64.3%	71.8%

Safeguarding Children	Q1	Q2	Q3	Q4
Level 1 (eLearning)	95.5%	94.7%	95.1%	95.1%
Level 2 (eLearning)	85.3%	87.5%	92.0%	92.8%
Level 3 (virtual interactive	N/A	39.5%	71.1%	77.6%

Key:

	Indicates that compliancy is below the threshold set by the CCG
	Indicates that compliancy meets the threshold set by the CCG
Current CCG thresholds are: Level 1 – 95% Level 2 – 85% Level 3 – 85%	

Prevent

Please see attached Prevent Annual Report (appendix 3) for the BSMHFT Prevent activity.

Safeguarding Activity:

The Safeguarding Team provide advice to teams primarily via a dedicated telephone advice line. The activity for this function is provided from June 2020 until May 2022. Electronic records began for the advice line in June 2020.

For the year June 2020 – May 2021 (year 1) a total of 882 contacts logged
For the year June 2021 – May 2022 (year 2) a total of 1014 contacts logged.

Year 1	Year 2
Safeguarding adult calls 429 (48%) Safeguarding children calls 302 (34%)	Safeguarding adult calls 554 (54%) + 6% Safeguarding children calls 253 (24%) – 10%
Top 3 categories of abuse: Adults • Domestic abuse 220 (51% of adult calls) • Financial abuse 50 (11%) • Neglect 26 (6%)	Top 3 categories of abuse: Adults • Domestic abuse 242 (43% of adult calls) • Financial abuse 103(19%) • Sexual 37 (7%)

Children • Emotional abuse 83 (27% of children calls) • Neglect 75 (24%) • Domestic abuse 61 (20%)	Children • Emotional abuse 76 (30% of children calls)) • Sexual abuse75 (29%) • Physical abuse 44 (17%)

Year 1	**Year 2**
Top 3 calling Directorates (percentage of all calls): • Integrated Community Care 328 (37%) • Acute & Urgent Care 159 (18%) • Primary care &SPS 129 (14%)	Top 3 calling Directorates (percentage of all calls): • Integrated Community Care 319 (31%) • Acute & Urgent Care 209 (20%) • Primary Care & SPS 162 (16%)
Calls from services working with unborn and children: • Solar & Specialist Community Services 31 • Specialities (includes perinatal) 24	Calls from services working with unborn and children: • Solar & Specialist Community Services 53 • Specialities (includes perinatal) 20

Analysis of advice calls

There has been a small decrease in calls to the advice line in year 2 relating to safeguarding children. This is unusual considering the media interest and impact of the conclusion of the recent high profile safeguarding child abuse case and the conclusion of the associated court case. When high profile cases identify learning and agencies have been involved one would expect staff to have a renewed focus on safeguarding. The lifting of pandemic restrictions might have also suggested 'hidden harm' would have surfaced and safeguarding concerns to have increased. This activity has been evidenced externally through a sharp rise in the front door of children services and is seen in the sharp increase in the information provided by the safeguarding team who are based in MASH.

Domestic abuse has been the consistent highest cause of seeking advice. If children and adults domestic abuse calls are added together this is by far the biggest category of abuse staff seek advice on. Nationally there was a spike in domestic abuse during the pandemic lockdowns but the year 2 numbers remain high. Domestic abuse cuts across both adult and children queries. This fits with the known increase in domestic abuse prevalence in both Birmingham & Solihull, and the identification of concerns when lockdowns and restrictions were lifted.

The next highest contact for adults remains financial abuse in both years. Sexual abuse replaced neglect in year 2 as the third highest category of abuse. Sexual abuse can also be linked to domestic abuse and therefore may fit into this overall picture of violence against women.

Emotional abuse, as a category of abuse for children, has been the highest category of abuse listed for callers in both years. In year 2, sexual abuse and physical abuse have replaced domestic abuse and neglect in the list of top 3 categories. There is no explanation in this increase. However, the highest numbers for children nationally, on child protection plans is for the category of neglect. This may suggest our staff are either not considering neglect, as the main category of abuse, but are picking other categories of abuse as the issue they are calling about.

This might suggest further work is needed to help identify neglect as the mainstay of other coexisting types of abuse e.g. emotional abuse; domestic abuse.
Calls for safeguarding advice, from BSMHFT services working with unborn children and children are comparatively low. This may not represent a lack of safeguarding consideration but might reflect the support and supervision in these services means queries are dealt with 'in-house'. Perinatal services had their own safeguarding facilitator working within the service.

There were 24 calls relating to Person of a Position of Trust in year 1 and 40 in year 2. This indicates staff are considering this issue when there are concerns about BSMHFT staff working with children and vulnerable adults. These calls can also be related to concerns about our services users who are employed in positions of trust as well as concerns about staff in other agencies.

The safeguarding advice calls have a relatively high rate of calls which are not specifically about safeguarding (e.g. callers mistakenly consider a clinical management/information governance issue as a safeguarding concern) - 16% of all calls year 1 and 19% of calls year 2.

The Service Manager application used to record safeguarding advice calls is relatively new and there will be developments on the reporting function e.g highlighting the services who do not call for advice. The team will also use this data to help evaluate the impact of targeted work e.g. Integrated Safeguarding System, exploitation and self neglect. A reporting function that compares trends and themes across periods will also be requested.

The organisation contributes to the Multi Agency Risk Assessment Conference (MARAC) and additional resource has been sourced to meet the ongoing demand. A The organisation is supporting an independent review of MARAC commissioned by the BSOL Safeguarding Executive Group which will inform the health system about what safeguarding resources are needed in the impending ICS.

Pandemic Affect – Safeguarding Activity:

During the pandemic the safeguarding team took over the responsibility from operational teams to contribute to child protection review conferences which is a statutory obligation. The result, reported by Birmingham Children's Trust was an improvement in participation and better-quality reports. This is an identified area for development for clinical teams who should be contributing to adhere to "Working Together to Safeguard Children" (2018) expectations. The safeguarding team will be mentoring staff to build confidence in this area will encourage clinical teams to attend multi-agency training provided by the Birmingham and Solihull Children Partnerships to enhance their knowledge.

4.0 GOVERNANCE AND ACCOUNTABILITY:

Oversight, Governance and Assurance:

The Safeguarding Management Board provides assurance for safeguarding within the organisation. The board provides linkage to the patient safety workstream and clinical

effectiveness. This will be further strengthened in 2022/23 by the additional appointments of Heads of Nursing/AHP to bridge this gap. All these posts have now been appointed to and are actively supporting the safeguarding agenda within their divisions.

The board is supporting the implementation of additional quality measures to use across the governance structure which will then be reportable by local governance committees into the trust-wide Clinical Governance Committee monthly.

The safeguarding team will assemble a "community of good practice" to take safeguarding ISS incentives forwards which will start with membership comprised of the Heads of Nursing/AHP, our safeguarding practice facilitator, and the Chief Nurse (which may commute to deputy chief nurse once commenced in post).

The ISS will be the central tenet of our assurance framework supported by the project board and self-adoption by clinical teams. Assurance for implementation and delivery of ISS will be monitored by the Safeguarding Management Board

Development and Accountability:

During 2020-22 we have participated in an all-expected partnership audits such as the section 11 Children Act audit, self-evaluation of all-age exploitation practice, a "voice of the child" audit and many near miss activities. Items of learning have been incorporated into our work plans. We have numerous areas of opportunity to make improvements, for example, evaluation of what value and impact our work in MASH and MARAC has on our service users' experience and to support mental health staff and other colleagues. Our lead for quality and assurance will continue to develop and improve our audit opportunities and assurance measurements.

Working in Partnership:

The Safeguarding Team are committed to working in partnership with others. This is vital to grow an adequate and informed safeguarding culture and the team increased partnership participation during the pandemic. We are visible members of all Birmingham and Solihull safeguarding and domestic abuse forums. We also now have employed x 2 Mental Health Liaison Workers to broker better relationships between adult mental health services and children's social services in Birmingham (funded by Birmingham Children's Trust) and we have one Independent Domestic Abuse Advocate from Birmingham and Solihull Women's Aid working with us (and are recruiting 3 more).

5.0 LEARNING FROM SAFEGUARDING REVIEWS:

BSMHFT participate in internally and externally commissioned safeguarding related enquiries and investigations. The safeguarding team act as author for these reports and the Named Nurses and Head of Safeguarding track these reviews and outstanding actions with exception reports

being presented at Safeguarding Management Board. There are some common themes found within these reviews which include the need to implement a "Think Family" approach and to continue to highlight the issues regarding professional curiosity, self neglect and all age exploitation. To review the assimilated safeguarding related learning from reviews and audit findings we have developed and appointed to a new role; Lead for Safeguarding Quality and Assurance.

During this reporting period the organisation has supported the Joint Area Targeted Inspection (JTAI) and National Child Safeguarding Practice Review which was commissioned by Central Government following the sad death of 6yr old Arthur Labinjo –Hughes who was murdered by his step-mother. The organisation will consider the findings of these reviews and implement improvements using internal and external governance scrutiny to ensure lessons are learned.

In addition to the work, which we have done on external reviews, during this reporting period, the safeguarding team have supported our Patient Safety Team by participating in serious incident reporting and by formulating a "prompt sheet" of safeguarding considerations to use when writing serious incident reports or compiling terms of reference. This is also now being taken forward to influence safety huddles in home treatment teams with reference to how safeguarding can be linked to suicide prevention.

6.0 CONCLUSIONS AND LOOKING FORWARDS:

From 2020-22 the team have promoted the importance of safeguarding being a standard operating process in all aspect of service delivery and design. Our review of the corporate safeguarding function and its sustainability has been completed and the ISS has been developed to provide a viable way to promote universal safeguarding throughout the organisation with practical guidance and behaviours designed to influence our collective safeguarding philosophy.

The ISS builds safeguarding capacity throughout the Trust which incorporates learning and development needs, universal safeguarding accountability, quality improvement, clinical governance, and scrutiny functions. The learning and development aspect of the ISS will need continued investment, and this will require development of the training recording infrastructure to be practically applicable.

There is much to do to improve the embedding of learning from reviews to ensure safeguarding findings are acted upon and that service user outcomes, clinical effectiveness and quality is improved. This will need a systemic response with our Lead for Quality and Assurance, Associate Director for Clinical Governance and our Data Intelligence Team to draw this together into reportable material which should flow through the clinical governance system. An effective communication strategy is in place and will continue to need support from our communication colleagues to maintain the hard work put into the Safeguarding Hub over this reporting period.

There are some significant challenges ahead of us regarding safeguarding the citizens of Birmingham and Solihull whom we serve. BSMHFT will work with the ICS to provide safeguarding systems within the “health system "which will need to consider the post-pandemic recovery and will the impact of austerity and hardship for many of our service users. Our partnership challenges in MASH and MARAC remain and we need to continue to contribute to the development and reviews of these essential services.

Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. Please look at our Year in Summary for some examples of the work we have done (Appendix 1). There are a great number of committed staff who work impeccably to support and serve our service users and their families, and the safeguarding team would like to acknowledge them all. The impact of the pandemic has significantly shifted the focus of safeguarding in the last two years and all Trust Staff have adapted to this with equanimity and professionalism which is commendable.

Appendices

Appendix 1 is a separate document

Safeguarding Legislation and Expectations

The following legislation is applicable to safeguarding practice 2012-22:

- The Children Act (1989 and 2004)
- Safeguarding Vulnerable Groups Act 2006
- Children and Adoption Act 2006
- Children and Young Peoples Act 2008
- Protection of Freedoms Act 2012
- The Children and Families Act (2014)
- Crime and Policing Act 2014 (Forced Marriage)
- The Care Act (2014)
- Female Genital Mutilation (2003) amended by Serious Crime Act (2015)
- Serious Crime Act (2015, section 76 Coercion and Control)
- The Counter-terrorism and Security Act (2015): Schedule 6; Section 29 Prevent Duty Guidance for Health Services
- Violence against Women and Girls Strategy (2016)
- Children and Social Work Act (April 2017)

Below are the standards that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) must comply with:

Safeguarding Adults with Care and Support Needs:

- The Care Act 2014; particularly chapter 14;
- The Intercollegiate Document – Adult Roles and Competencies for Health Care Staff (20 August 2018).

Safeguarding Children and Young People:

- The Children Act 1989 and 2014; particularly section 11 (2004);
- Working Together to Safeguarding Children (2018);
- Intercollegiate document: Safeguarding Children and Young people: roles and competencies for health care staff (January 2019).

Both Adult and Children:

- Regulation 13 of the Care Quality Commission's Essential Standards - Its guidance and associated legislation;
- Care Quality Commission's, "Safeguarding People" (May 2017).

Prevent Annual report April 2021 to April 2022 for Trust Board

Author: Philippa King, Prevent Lead / Safeguarding Facilitator

Data:

BSMHFT records Prevent figures and these are securely saved in a database on a dedicated prevent drive. Data monitored includes the number of internal Prevent referrals to trust prevent and the number of those known to the trust referred to Prevent from other sources; outcomes, concern categories and the directorate from which those concerns arise.

This information is used to monitor trends, to identify any areas that may need specific prevent input and to ensure cases are closed and not left to drift.

This data is reported internally to the Safeguarding Management Board and externally to NHS England and Improvement and Commissioners.

Concerns:

We receive a breadth of prevent related concerns ranging from possible religious sect exploitation to generic expressions of desire to kill others. Some appear to be related to a person's mental state at that time. Please note that people under investigation for another crime are not managed under Prevent.

There are no real differences in Trust Prevent activity year on year.

Training figures:

As at 26/04/2022 are 92.8%

This figure is relatively static and we have never fallen below the 85% required by NHS England and Improvement. A refreshed online eLearning for health Prevent training is now available.

Information sharing:

West Midlands Police Counter terrorism unit provide quarterly updates for both Solihull and Birmingham and this information can be used to inform prevent activity within the trust.

The United Kingdom Threat level is currently substantial – an attack is highly likely. This was lowered from Severe in February 2021.

Birmingham Prevent Meetings:

The Prevent Coordinator attends the Birmingham Prevent Reference Group, Prevent Delivery Group, the Prevent strategy group and Birmingham Channel.

A new Prevent coordinator for Birmingham City Council has been appointed.

Solihull Prevent Meetings:

The Prevent Coordinator attends Solihull Protect, Prepare and Prevent Group and Solihull Channel.

A new Channel Coordinator for Solihull Borough Council has been appointed.

Both Local Authorities produce a Prevent Risk Assessment and Delivery Plan. BSMHFT contribute to this.

Independent Review of Prevent:

The Independent Review of Prevent, led by William Shawcross has been completed and its publication is eagerly anticipated.

Appointment:

The Home Office have appointed Regional Advisors in their Prevent Local Delivery and Communities (Homeland Security Group). Their role is to support and advise local Prevent partnerships regarding their delivery of the Prevent Duty with a particular emphasis on low priority areas.

Future Plans:

- Refresh the Prevent work plan
- Refresh the trust Prevent Strategy and Delivery plan
- Work with prevent partners to support their understanding of mental health concerns.
- Prioritise engagement around prevent with individual teams.

Birmingham and Solihull Mental Health NHS Foundation Trust

TRUST SAFEGUARDING TEAM

2021 - A YEAR IN SUMMARY

CONTENTS

STATEMENT

As Head of Safeguarding, I have had the privilege to work with and develop an amazingly committed team over the last 8 years. This report has been produced during a national lockdown so we have had to “work from home” – a totally new phenomenon, not without technical and psychological difficulties for a team which deals with abuse and neglect of vulnerable citizens as a norm.

To say the past year 2020-21 has been unusual and challenging because of the Covid-19 Pandemic, is an understatement. The impact this has had on our ability to safeguard our service users and support staff is documented within our annual report. However, we all wanted to celebrate what we have achieved by embracing our new and different circumstances in a positive way and this “year in summary” serves to illustrate some of the successes we have managed to achieve despite the difficulties we have faced.

I would like to thank the Safeguarding Team for their strength, ambition, sensitivity and dedication to improving the quality of safeguarding on behalf of the organisation over the past year. I would also like to acknowledge all the excellent Trust staff who “do the right thing” by Thinking Family and promoting a safeguarding culture in everything they do.

CATHERINE EVANS

Head of Safeguarding

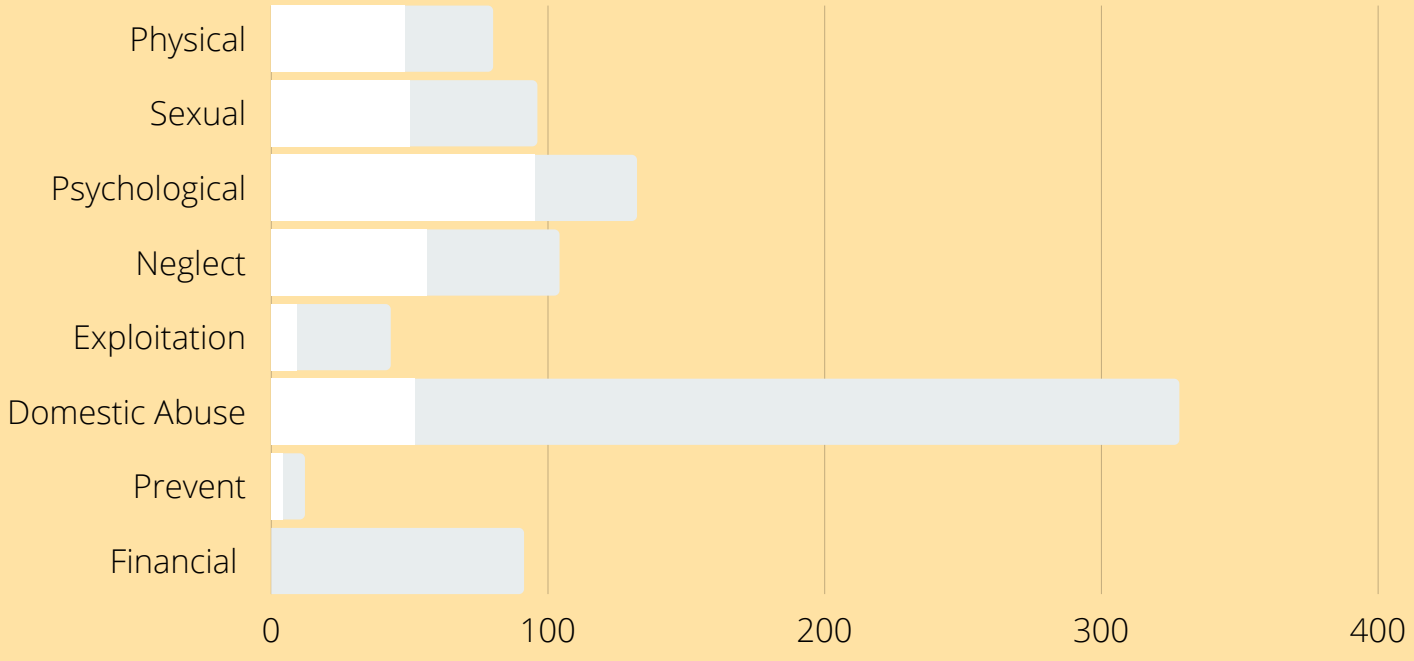
WE TOOK 970 ADVICE CALLS

If we look at the calls between November 2020 and 2021 we can see that domestic abuse is the main area of concern we were contacted about, more than double for the previous year . This could be due to the large increase in domestic abuse we have seen over the pandemic, and due to the complex nature of this form of abuse staff have been contacting our team for support.

We can see that the cases of exploitation we are contacted about are very low, we do not feel this is an accurate representation of adults and young people at risk of exploitation and this is an area we will be focussing on within the coming year.

We reflect on the previous year where we took 373 advice calls. Looking at the increase, this could reflect better identification of risks and an increase in safeguarding needs during the pandemic, however could also mean staff teams are not talking routinely about safeguarding within their MDT's and are instead replacing those important discussions with the Safeguarding advice line.

Below you can see in white the calls relating to children, and in grey relating to adults split into the main area of risk identified.



MULTI-AGENCY SAFEGUARDING HUB (MASH)

We have continued to provide Birmingham MASH with information to support their decision making and have liaised with those clinical teams where a service user is identified as a parent or caring role to children referred or open to children's services.

During 2021 we set up a similar provision within Solihull MASH. Alongside sharing information on adults known to BSMHFT services, checks are also carried out on the ILLY recording system for SIAS involvement and for the children listed within referrals who may be known to SOLAR.
So far in 2021 we have:

- Provided information for 3417 referrals into Birmingham & Solihull MASH
- Liaised with clinical teams for 971 service users identified as open to BSMHFT
- Attended and contributed to 139 strategy meetings

MULTI-AGENCY RISK ASSESSMENT CONFERNCE (MARAC)

We reviewed the way we shared information for Birmingham and Solihull MARAC's over 2021, due to the increase in high risk domestic abuse over the pandemic, Birmingham MARAC's were being held daily. Within each conference up to 20 individuals and families impacted by domestic abuse were being discussed.
We support teams with the MARAC process by;

- Sharing up to date, relevant information from our systems to inform the MARAC discussion
- Inform teams at the earliest opportunity, in order to influence risk assessments
- Document the outcomes and action planning onto RIO with a risk alert
- Support teams in attending professionals meetings
- Offering on-going advice and support to teams/clinicians where needed
- Challenging decisions where we feel this is needed in order to advocate on behalf of the person at risk of harm

TRAINING

Fantastic – complex information shared compassionately and sensitively

Despite my reservations about online training, this has got to be the best safeguarding training I've attended. Thank you very much, so practical and relevant to my role!

Covid halted face to face training, but that did not stop us innovating. We designed and delivered the following courses between November 2020 and November 2021.

79 L3 Safeguarding Adults Training webinars
106 L3 Safeguarding Children and Young People webinars.

This has meant that, despite social distancing restrictions, vitally important messages have been received and understood by staff, helping them to safeguard service users and their families.

The Level 1 Safeguarding e-Learning modules for children and for adults are completed by all Trust staff. The children's one has been rewritten and redesigned (publication is imminent) and the adults one will also be rewritten in the next year.

INTERGRATED SAFEGUARDING SYSTEM (ISS) PROJECT GOALS:

We have designed a new Integrated Safeguarding System.

It is designed to ensure we can provide assurance on the quality of safeguarding practice across the Trust. Focus - locally led responses to safeguarding issues.

Key features:

- A set of Safeguarding Behaviours - expected behaviours in key areas of safeguarding practice for clinical staff working at strategic level, operational management level and at ‘team member’ level. Aligned to Think Family principles.
- Safeguarding Standards - support local leaders and their staff to understand what good looks like for service users. Staff can use these Standards to inform and develop their safeguarding practice.
- Continued learning and development outside of mandatory training every 3 years.
- Local leaders will be encouraged to apply the ISS to support them to plan to address areas in need of development and to maintain the highest possible standards of safeguarding practice.

Early adopter sites have been establishing and refining ISS.

We will use the Safeguarding Standards and Behaviours as tools to apply when we look to assure safeguarding activity within the Trust.

ALL AGE EXPLOITATION STRATEGY

The sad death of a young woman in Birmingham (who was a Solihull resident) sparked the Rachel Safeguarding Adult Review (SAR) in 2019. Following on from the SAR, Solihull developed and launched the **Solihull All Age Exploitation Reduction Strategy 2020 – 2022**.

The strategy was mandated by Solihull Safeguarding Adults Board (SSAB), Solihull Local Safeguarding Children Partnership (LSCP), Safer Solihull Partnership and Solihull Health and Wellbeing Board (H&WBB). The strategy is delivered through the Solihull Exploitation Reduction Board.

As part of the implementation, BSMHFT, along with partner agencies, completed a self-assessment in April 2021.

This was taken as an opportunity to complete a self-assessment of our approach to recognising and responding to all-age exploitation across the Trust, not just Solihull services.

A work plan has been developed to address identified gaps and areas requiring improvement from the self-assessment. The overall aim will be to ensure **all operational staff understand all-age exploitation in its various forms, are able to recognise indicators of exploitation and know how to respond to concerns.**

Some actions have been taken to the BSMHFT Exploitation Reduction, Task and Finish Group to enable the embedding of an overall '**recognise, respond and record'** approach to exploitation within operational services. Senior Operational managers will ensure the approach is understood and implemented in everyday clinical practice.

A review of data will be completed in 2022 to ensure the organisation can adequately evidence and report on its activity. Assurance activities will be completed to evaluate the approach is embedded.

PREVENT

The Trust is a statutory organisation that must respond to the Prevent duty. When one of our service users is referred to Prevent, their needs may be discussed in a multi-disciplinary, multi-agency meeting called Channel. In 2021 we had around **50 service users** that had contact with trust prevent. This reflects an average year on year number.

In 2021 prevent was integrated into the safeguarding team. This integration will benifit from having a wider team of professionals who can bring their safeguarding expertise into prevent.

THE SAFEGUARDING HUB

Through the use of audit and feedback from you, we identified the need for a central resource of information for staff to easily access which holds a variety of documents aimed to help practitioners in their daily safeguarding practice and supporting them to meet their statutory duties.

This year we created the Safeguarding Hub - accessible via desktop's and connect, the hub is regularly updated with up to date relevant information. Your feedback so far has been positive, however we would encourage any further comments or suggestions for continued improvements.

RISK ASSESSMENTS & TOOLKITS

Links to our most used safeguarding risk assessments all in one place

MAKING REFERRALS

Practical guides and links to make referrals quickly and effectivley

LEARNING RESOURCES

Access to relevant training, webinars, videos, newsletters and other learning materials.

CATEGORIES OF ABUSE

A host of information about all of the different categories of abuse with examples and links for further reading

GUIDANCE

Guidance around specific topics all easy to find and download

SIGN-POSTING

Links to a large directory of services within Birmingham & Solihull

VIOLENCE AGAINST WOMEN AND GIRLS

This year, the extent to which violence against women and girls exists has been brought to the forefront of the nation's attention. We have seen reports to domestic abuse helplines increase in the context of COVID-19; we have read about tragic cases such as the deaths of Sarah Everard, Balvinder Gahir, Bibaa Henry, Julia James, Khloemae Loy, Nicole Smallman and Libby Squire.

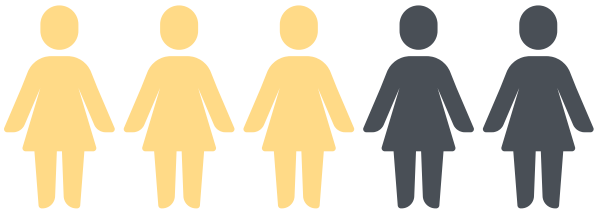
In response the government created a new strategy strengthened by the Domestic Abuse Act 2021 which aims to;

Prioritise prevention, support victims, pursuing perpetrators, strengthen the system and improve understanding.

We will be using this strategy to influence our decision making and service improvements. We will continue to act as an advocate and ally to women and girls.

DOMESTIC ABUSE ACT 2021

The Domestic Abuse Act is set to provide further protections to the millions of people who experience domestic abuse, as well as strengthen measures to tackle perpetrators. Detailed factsheets on each new measure are available on gov.uk



*3 women are killed every week by their current or former partners.

*On average

1 in 3

Women globally are subjected to physical/sexual violence in their lifetime.

EXTERNAL REVIEWS FOLLOWING A DEATH OR SERIOUS HARM:

1 SERIOUS ADULT REVIEW
1 SAFEGUARDING CHILDREN PRACTICE REVIEWS
5 DOMESTIC HOMICIDE REVIEWS

2020 Themes & Learning

During 2020-21 the safeguarding team have noted a theme emerging across external safeguarding reviews which reveals a clear link to the risks associated with **dual diagnosis** and specifically to **alcohol use**. We are currently working on the completion of 11 safeguarding reviews into deaths with strong links to substance misuse.
Break down of reviews:

4 Safeguarding Adult Reviews (all B'ham cases)
7 Domestic Homicide Reviews (4 B'ham &3 Solihull)

The individual reviews cover quite different situations but have all identified that we need to **improve substance misuse screening** within assessments and reviews. There is currently a quality goal in place 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."

The reviews associate risks related to reduced/fluctuating capacity when service users are intoxicated on both executive functioning and specific capacity, for example there is a **propensity for self-neglect**.
Acquired brain injury/damage/impaired cognitive function can be linked to excessive alcohol use due to injuries caused by accidents/acts of violence and because of diagnoses such as korsakoff's dementia.

There is a link between **problematic alcohol use and violence and aggression**. This relates to both the victim and perpetrator of violence. It also includes a link to suicide.

Learning from these reviews must be used to inform improvements to clinical intervention and service design within the transforming care agenda to reduce deaths /serious incidents associated with alcohol use.

GOOD PRACTICE

Over 2021 we have been in contact with a variety of practitioners working within different areas at different levels, but there are some that really stood out to us as demonstrating quality safeguarding practice within their work, we want to take the time to champion those people.
If you feel that someone has gone above and beyond to offer safeguarding support please let us know!

Ruth Buckerfield - Perinatal South
Ruth's contact and interventions were integral for a service user to feel able to safely end a relationship and take actions towards a non-molestation order. Throughout the support Ruth empowered the service user, and explored risks posed by the perpetrator of domestic abuse. This in turn provided other professionals an insight into this service users real lived experiences. Ruth provided her with a safe and non-judgmental place where she could speak freely.

CPN - Anonymous due to link to prevent
They attended Channel to discuss concerns and potential support for the service user, who was aware of the meeting and was in accord with the CPN attending. By working in partnership in this way, we were able to ensure that the voice of the service user was heard and the most appropriate support be made available. Prevent aims to minimise vulnerabilities to being drawn into extremism and this process was able to achieve this through interpretation, communication and collaborative work in this case.

Jed Jerwood and Laura Hambrook - Longbridge CMHT
Both of these team members ensured that during their regular contact with the service user they would routinely enquire about domestic abuse and relationships. This was integral as her partner at the time was perpetrating high risk domestic abuse towards her.

Alyson Coupe - Occupational Therapy Team
Alyson worked closely with the safeguarding team over a long period offering support and a guidance to a service user following incidents of high risk domestic abuse. She offered a non-judgmental considerate response and remains optimistic and persistent. Thankfully the perpetrator of domestic abuse has pled guilty to offences and will be sentenced.

EXTERNAL CONTRIBUTIONS

The Trust Safeguarding Team work within the trust, and as partners to other agencies externally in order to improve and sustain the safeguarding agenda over our locality. Throughout 2021 we have;

Committed to a full time member of our team within Solihull MASH, which has been well received and resulted in permanent funding for 1.5 staff.

Collaborated with Birmingham Childrens Trust which has developed into creating 3 new roles of 'Adult Mental Health Liaison Worker'. The purpose of this project is to build bridges between mental health and social care staff so that we can support families in a more positive and collaborative way.

Collaborated with specialist Domestic Violence/Abuse services, piloting the uses of IDVA's for the support of staff and service users which has resulted in extending this funding for 4x IDVA's.

Contributed towards the MARAC and ODOC governance committee, where concerns raised have lead to a regional review of MARAC.

During the pandemic Birmingham Children's Partnership initiated a Partnership Operational Group – although not officially part of the partnership we contributed throughout to highlight the vulnerabilities of families with parental mental ill health.

2022 PLANNING

What we have planned and how we will get there...

For 2022 we really want to improve our assurance and quality reporting. How are we going to do it? We are going to promote self-adoption of our integrated safeguarding system (ISS) to enable teams to check themselves against a set of basic standards and set up some local safeguarding quality goals. The ISS also presents clear expectations on staff roles and responsibilities which should help us model best practice in whatever role we hold. Our Heads of Nursing/Allied Health Professionals will be leading on this operationally to drive better quality safeguarding.

Our newly developed safeguarding role; Lead for Quality and Assurance will also be able to push us forward to create better data and reporting. We want this to help both local teams and the organisation to gauge their performance against requirements to help us become proactive rather than reactive when developing our safeguarding agenda.

2022 will also see Catherine Evans retiring from the Trust, during her time at the helm of the Safeguarding Team she has led on the transformation of the team itself and on the Trust's response to safeguarding concerns. She has been a fearless champion of ensuring that safeguarding sits at the heart of clinical practice within the Trust and has been a well-respected voice of calm, clarity and focus within the Trust and widely beyond.

Some words from our partners;
'I am still in shock that you're retiring!! I will have nothing but positive memories of you, you are a strong advocate for victims and passionate about ensuring we are all doing and giving our best to them and for them. I have no doubt that Yvonne will continue to carry that torch – as she already does – but your voice will be missed.'

'Thanks for all your support over the years Cath, centralising MARAC hasn't been without its hiccups and impact on the partnership, but I can honestly say Birmingham is in a far better space for our high risk victims, and you are a huge part of that.'

'Thanks for everything you have done Cath, we are sad that this is your last meeting. You are a safeguarding star!'

'You have been amazing, Cath ! A pleasure to work with and a Safeguarding role model.'

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**
Date	25th May 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 18th May 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 committee considered a variety of People related risks including but not exclusive to:

- The Trust does not develop an inclusive and compassionate working environment
- The Trust does not deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multidisciplinary values- based leadership framework developing the right capabilities
- The Trust does not engage effectively with its workforce through a dynamic, sustainable internal and external communication plan

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 Trust was seeing a slight improvement within the vacancy rate, however hot spots remained. It was reported that the Trust was working closely with system partners in relation to recruitment and workforce retention with job fairs being undertaken across the system.

The Committee was updated on the progress being made regarding the timely recruitment of staff and with the focus of the recruitment team the Committee should see an improvement within the next quarter.

It was reported that a target had been set of 90% relating to rotas being agreed six weeks in advance with a significant amount of work being required to achieve the target which was being monitored by the E-rostering Group.

The Committee had a detailed discussion regarding the requirements of bank staff undertaking mandatory training. It was noted that the Lead Nurse for TSS has commenced workshops with clinical bank staff in order to get their feedback on mandatory training.

In relation to staff at band 8a and above from a Black, Asian and Ethnic Minority background, the Trust is aiming to achieve 40% by 2028 with the Trust currently at 23.2% with further work to be undertaken.

There were currently 31 employment relations cases and there was 1 disciplinary case during the quarter.

Chair's Assurance Comments:
The committee received an update on our vacancies and we have seen a slight improvement. Different recruitment initiatives have been applied across the system, but the committee were informed this didn't provide assurance as a sustainable position as an organization, particularly not sufficiently making inroads to the ongoing shortage of qualified nursing staff.

The committee were informed that assurance could not be given around achieving our target of 90% rotas been agreed six weeks in advance. We were informed the e-rostering Programme Board did not meet last month; therefore, we will receive a more detailed response to the concerns raised at the next People Committee meeting.

With regards to appraisals the committee were not fully assured that we are making the progress we want to see. There has been a slight improvement in appraisals been undertaken but we are not achieving the targets we have set.

Fundamental training was a slight reduction due to availability of key trainers. Committee were informed we should see improvement in the areas where we have seen reduction in fundamental training next quarter due to additional capacity and resources to support uptake of the fundamental training.

Committee were informed that there is more we work we need to do to again assurance on progress with regards to BME Staff in roles at Band 8 and above. At the moment assurance could not be given to the committee that we have the actions and activities to get the Trust to the 40% we are aspiring to reach by 2028.

1.2 Report from Shaping Our Future Workforce Sub Committee

It was reported that draft Workforce Transformation Plans have been developed for Occupational Therapists and Psychologists and shared with the professional groups. There had been engagement with the professional groups in development of the plan and the subcommittee was assured that the retention actions outlined were robust and can deliver the expected outcomes.

The sub-committee were advised that plans were in place to develop a nursing workforce retention plan, working closely with the Safer Staffing Committee. A retention plan for medical workforce would be developed for the medical workforce during Q2. The sub-committee received assurance that these plans would be aligned with BSol retention planning. It was noted that the final version of retention plans for OT and Psychological professions would be presented to the June 2022 sub-committee.

The subcommittee received a report setting out the draft action plan that had been developed in conjunction with the NHSE/I "Flex for the Future" programme. BSMHFT has participated in this programme and acquired tools and techniques to enhance flexible working within the Trust. The Sub-committee were informed that a multi-disciplinary project team will be brought together to ensure that the Trust's approach to flexible working balances the needs of the Trust to provide as much flexible working opportunities as possible to staff, in a clear and transparent manner whilst balancing the operational needs of the service to provide high quality patient and service user care.

The subcommittee received a report relating to the refresh and launch of Trust retirement processes. The Retirement and Return policy has been ratified and promoted throughout the organization.

Chair's Assurance Comments:
The report from the Sub Committee provided assurance to the People Committee on the progress made within the People Strategy Implementation Plan that were reviewed at the Shaping Our Future Workforce Sub Committee on 9th May 2022. We commended the level of detail and the subcommittee clear approach to seeking assurance or stating why assurance was not available and when they were likely to see improvements.

1.3 ICS Update/Workforce Submissions

It was noted that draft workforce plans for BSMHFT and FTB were submitted to the national team via the HEE online portal on 28th April 2022. This was along with the final Operational Planning SDCS submission by finance. Data was still awaited from the non-NHS workforce and primary care which would be included in the final submission. The final MH Trust workforce submission is due on 28th May with the wider ICS submission due by 23rd June 2022.

The Chief People Officer Group met in April 2022, where there was unanimous agreement to develop a systemwide proposal to support staff due to the recent increases in the cost of living, due to receiving feedback that it is causing staff to experience a wide range of financial pressures. The interventions being considered include providing staff with support for clothing, financial advice, food, Government grant and tax relief, Health and Well Being and support with travel costs and frequency of payment of business and travel expenses.

Chair's Assurance Comments
Committee were pleased to hear The Chief People Officer Group had agreed to develop a systemwide proposal to support staff with regards to the cost-of-living financial pressures. The committee were informed that once a system wide offer has been agreed this will be reported back to the committee. We were also informed of the Community Transformation work being undertaken the committee asked if Third Sector organisations had been included in these discussions which they had. In the next quarter there will be workforce planning sessions with the four operational areas which will include the voluntary, third sector representation.

1.4 Transforming Our Culture and Staff Experience Sub Committee

The Sub-committee met on 7th April 2022 and 5th May 2022 with focused attention on review of the functioning of the Sub-Committee with the ratification of Members Support pack. The Anti-Racism Roadmap was reviewed and one of the areas discussed was an understanding of workforce equality in areas and have requested the triangulation of data through pulse surveys and freedom to speak up.

People's Policies were reviewed which included the Probation Policy, Appraisals & Development Policy and Duty Rostering Policy.

The Sub-Committee received an update on a proposed methodological change to the Team Culture Deep Dives given lessons learned from the first wave. The proposal is based on QI and OD learnings from Joy At Work that utilises a more holistic approach to cultural change and compassionate care in the workplace. Early methodological considerations have involved Staff Engagement and Psychology staff.

. The Sub-Committee received a high level anonymised extract from the report previously presented at People's Committee. There were 31 new cases in Q4 that raised issues around patient safety/quality, bullying and harassment and worker safety.

In terms of protected characteristics, data was provided on the bullying and harassment concerns from BAME colleagues. It was noted that colleagues identifying as LGBTQ+ rarely came forward with concerns. The Sub-Committee were also advised that the People Strategic Implementation Plan will have a more explicit workstream linked to speaking up to address concerns such as feedback following concerns raised. The Sub-Committee requested that the stakeholders for this should include professional and operational colleagues in addition to the identified representatives from the People's function.

The Sub-Committee were presented with NHS Flex for the Future programme. It was reiterated that this is wider than a flexible working policy and includes a staff benefits approach, that begins at the point of entry to the NHS. The Sub-committee appreciated that this was an ambitious programme of activities. The Sub-committee highlighted a risk of this programme not being joined up with relevant policies e.g. the Duty Rostering policy, Appraisal policy and Retire & Return approaches and the need to mitigate any inadvertent contradictions or disadvantage colleagues in different roles or stages of career.

Chair's Assurance Comments
The committee were informed the sub committee has now been operating since September 2021 and we are seeing positive changes with regards to reporting assurance /reassurance.

We discussed the anti-racism roadmap and the sub committee could not give assurance on the overall outputs as the organization is at the beginning of the is work determining measures of success. We were informed assurance could be given that the workstream lead is on track identifying support approaches and cultivating an organizational awareness of workforce inequality data.

Team Culture deep dive the committee were informed that assurance could not be given on this work as no formal proposal had been presented.

The Sub committee were assured that Freedom To Speak Up cases had increased and were assured that the development of the speaking up workstream within the People Plan was managed.

The committee were not assured on the workstream impact of actions with regards to activities. It was too early for the committee to determine assurance on impact as quarter 4 for example represents the first EDI triangulated workforce KPI covering clinical divisions.

The People Committee were disappointed to hear that assurance could not be given the policies presented to the subcommittee followed Trust values or a consistent route of engagement and consultation. The subcommittee will monitor the policies as they are presented over quarter 2 and quarter 3 to establish if there has been an impact.

1.5 WRES Report

The Committee received a presentation on the Workforce Race Quality Standard receiving an update on the specific indicators and expressing deep concern with the results presented.

The percentage of staff who believed that the trust provided equal opportunities for career progression or promotion was significantly lower for BME staff, 60.1%, than for White staff, 82.9%. In terms of the percentage of BME staff who believed that the trust provided equal opportunities for career progression or promotion, the Trust performed better than 6% of Trusts and worse than 94% of Trusts.

The percentage of staff who personally experienced discrimination from other staff in the last 12 months was significantly higher for BME staff, 18.9%, than for White staff, 8.8%.

The full report will be presented to the Board as a separate agenda item.

Chair's Assurance Comments
The committee were not assured sufficient work has progressed within this area, and it was quite disheartening to see the stark statistics that highlight the minimal improvements we have made. The committee are seeking more assurance of the work being done to boost representation groups at leadership level; as race equality is integral to every facet of the organisation and its functioning.

1.6 Enough is Enough: Accountability for Leading and Managing Information Claims of Bullying, Harassment and Discrimination

It was reported that the People and OD team had consulted with senior leadership within the Trust to receive feedback on the Enough is Enough paper that was presented to the People Committee in April 2022. The committee approved the process subject to ensuring that its effectively communicated across the organisation. The committee also agreed that we need to ensure that we continue to maximize on the use of our Freedom to Speak Up processes.

Chair's Assurance Comments:
The committee were supportive of the document and made a few comments regarding the flow chart content which was taken on board.

1.7 People Goals 2022/2023

The People Goals for 2021/2022 have been reviewed and deliverables that sit under the overarching goals have been reported to the People Committee via the People Strategy Implementation plan. The goals have now been refreshed and approved by the committee for 2022/2023.

PHILIP GAYLE
NON EXECUTIVE DIRECTOR
18th May 2022

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**WORKFORCE RACE EQUALITY STANDARD (WRES) & WORKFORCE DISABILITY EQUALITY STANDARD (WDES)**
Date	25th May 2022
Author	Jas Kaur, Head of Equality, Diversity & Inclusion
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships

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?	Yes
What data has been considered to understand the impact?	Demographic data for staff has been used to make the required calculations for this report

Executive summary & Recommendations:

NHS contracts require us to publish Workforce Race and Disability Equality data in line with our Public Sector Equality Duty as well as the requirements set out in the NHS Standard Contract. The WRES and WDES reports are summarised via the slide deck enclosed as well as the full reports ratified through NHS England.

Key message from the WRES is that we don't 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%.

Key messages from the WDES; we rank 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 is important to note that the experience of disabled colleague is still considerably worse than non-disabled colleagues, so the experience of equity is not realised across even the top scoring metrics.

Priorities for the WDES being Metric 10: Board disability representation; Metric 4a: Harassment, bullying or abuse from patients/public; Metric 5: Career Progression.
Highlighted priorities across the WRES and WDES are embedded within People plan, these have recently been refreshed.

Recommendations:

- Utilise WRES and WDES to increase understanding in the importance of accurate data and self-declaration.
- Socialise the WRES & WDES information across Divisions to enable informed decisions, awareness, and ownership.
- Encourage Divisions to explore their own internal data through Data with Dignity sessions
- Intentions are to reduce the disparity across the protected characteristics through informed decision making.
- Explore positive action approaches through intersections.

Reason for consideration:

Contractual, legal and in line with our intention of becoming a anti racist and anti-discriminatory organisation.

Previous consideration of report by:

This report is presented annually as contractually required.

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

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

Financial Implications *(detail any financial implications)*

Financial implications based on attraction and retention of workforce and organisational reputation.

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

- **P1: Transforming Culture:** The Trust fails to develop an inclusive and compassionate working environment, resulting in: poorer quality patient service, reduced productivity, increased recruitment costs, increased legal costs, increased regulatory scrutiny, intervention and enforcement action, increased levels of sickness absence, unacceptable workforce retention, failure to attract talent, demotivated workforce, absence of value-led culture.

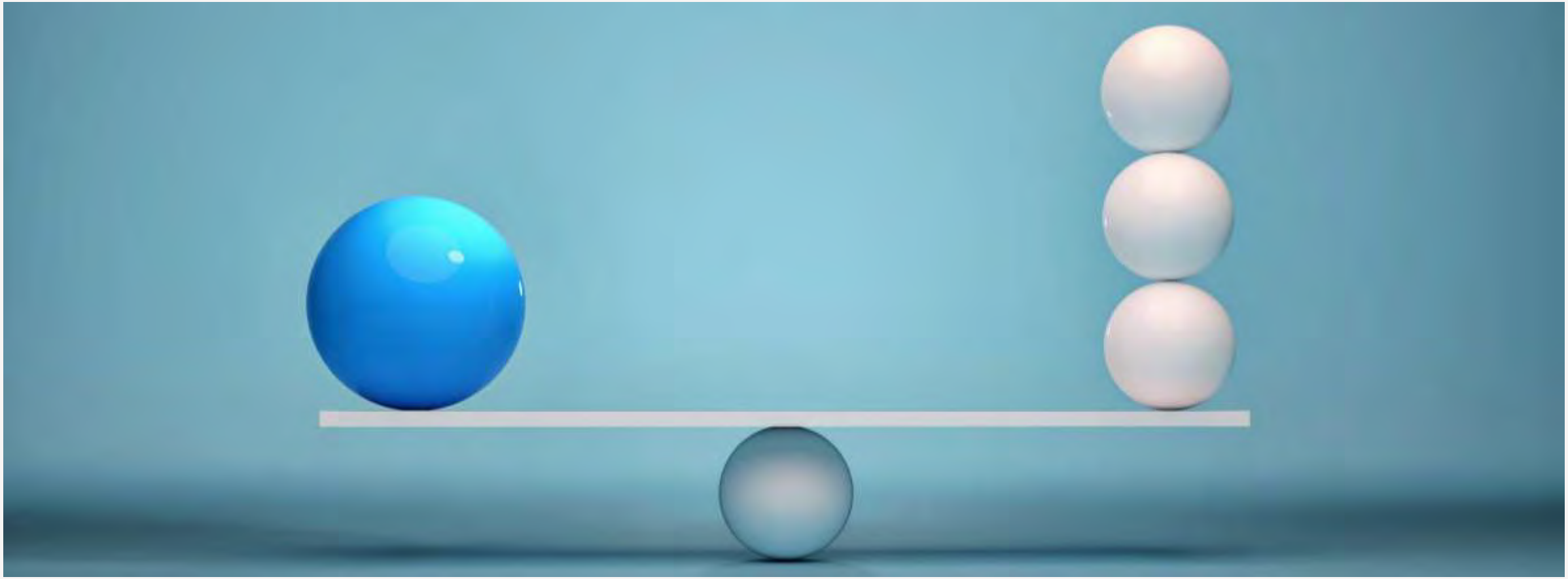
- **P2: High Performing Workforce:** The Trust fails to deliver its ambition to transform the culture and sponsor, implement, support, and monitor a multidisciplinary values-based leadership framework developing the right capabilities, resulting in an unhealthy and poor leadership, an underperforming workforce, sustained patterns of inequality and discrimination, high turnover, non-compliant behaviors, Employee Relations cases.

- **P3: Communication, inclusion and wellbeing**: The Trust fails to engage effectively with its workforce through a dynamic, sustainable internal and external communication plan, resulting in diminished knowledge and education to make and take the right decisions, reduced productivity, confusion, fear of safety to speak up, poor employer brand, non-compliant behaviors.

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

Birmingham and Solihull Mental Health NHS Foundation Trust

Value Me to Reduce Inequality
Workforce Race Equality Standard



Birmingham and Solihull Mental Health NHS Foundation Trust

Indicator number and description			Trust	Midlands	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band						
BME representation in the workforce overall			36.5%	21.6%	22.4%	
Pay band at which BME under-representation first occurs	**Non-clinical**	Band 4 and under	Band 3	Band 4	Band 3	
		Band 5 and over	Proportional	Band 8C	Band 8B	
	Clinical	Band 4 and under	Proportional	Band 3	Band 3	
		Band 5 and over	Band 6	Band 6	Band 6	
	Medical		Proportional	Consultant	Consultant	
Race disparity ratios	**Non-clinical**	Lower to middle	1.97	1.02	0.91	75%
		Middle to upper	0.75	1.43	1.39	26%
		Lower to upper	1.47	1.46	1.27	35%
	Clinical	Lower to middle	2.36	1.84	1.59	72%
		Middle to upper	1.78	1.23	1.36	60%
		Lower to upper	4.20	2.27	2.16	72%
Indicator 2: likelihood of appointment from shortlisting						
likelihood ratio White / BME			2.02	1.57	1.61	82%
Indicator 3: likelihood of entering formal disciplinary proceedings						
likelihood ratio BME / White			2.23	1.09	1.14	77%
Indicator 4: likelihood of undertaking non-mandatory training						
likelihood ratio White / BME			1.62	1.04	1.14	74%

Indicator number and description	Trust	Midlands	National	Percentile rank*
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months				
BME	36.7%	26.8%	28.9%	87%
White	31.1%	25.8%	25.9%	88%
Indicator 6: harassment, bullying or abuse from staff in last 12 months				
BME	32.4%	28.5%	28.8%	82%
White	25.9%	22.8%	23.2%	77%
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion				
BME	60.1%	69.5%	69.2%	94%
White	82.9%	87.8%	87.3%	89%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months				
BME	18.9%	16.9%	16.7%	80%
White	8.8%	5.9%	6.2%	91%
Indicator 9: BME representation on the board minus BME representation in the workforce				
Overall	-7.9%.	-7.7%.	-9.8%.	39%
Voting members	-7.9%.	-8.4%.	-10.0%.	37%
Executive members	-11.5%.	-12.1%.	-13.5%.	46%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator.

Areas for Improvement

A maximum of three high priority areas for improvement have been identified for the Trust. These are the areas from amongst the Trust's indicators with the worst percentile rankings against other Trusts (excluding indicator 4). For indicators 1 to 3 and 9, a further criterion is that the indicator is different from equality to a statistically significant degree. For indicators 5 to 8, performance must also be significantly worse than that for the other ethnic group.

High priority areas for improvement within the Trust (to a maximum of three):
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion amongst BME staff
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months against BME staff
Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff

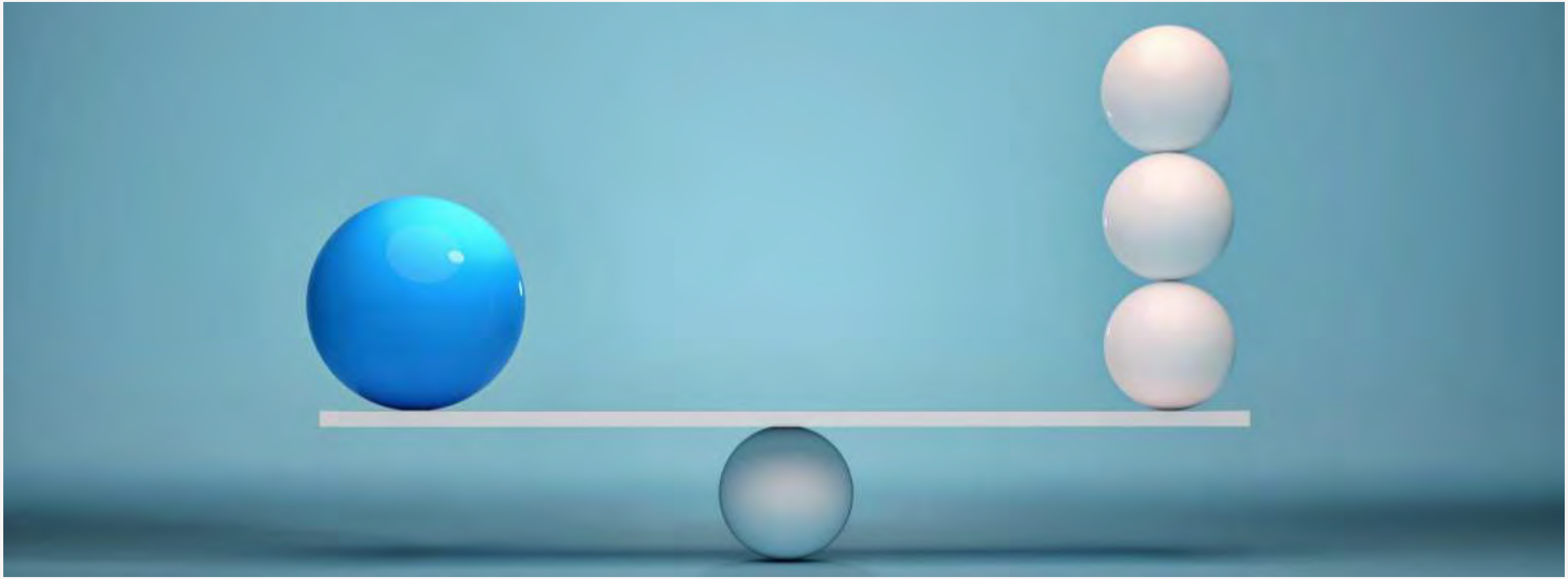
Areas of Best Performance

A maximum of three areas of best performance have been identified for the Trust. These are the areas from amongst the Trust's indicators with the best percentile rankings against other Trusts, and where the Trust performs in the best 10% of Trusts nationally (excluding indicator 4). For indicators 1 to 3 and 9, a further criterion is that the indicator is not different from equality to a statistically significant degree. For indicators 5 to 8, performance must also be similar to that for the other ethnic group.

Areas of best performance within the Trust (to a maximum of three):

Birmingham and Solihull Mental Health NHS Foundation Trust

Value Me to Reduce Inequality
Workforce Disability Equality Standard



Indicator number and discription		Trust	Midlands	Minimum	Maximum
Metric 1: Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce					
Declaration Rates	Overall	5.1%	3.7%	1.2%	10.0%
	Non-clincal	5.6%	4.3%	1.0%	13.1%
	Clinical	5.3%	3.8%	1.4%	9.9%
	Medical/Dental	0.8%	1.3%	0.0%	12.5%
Metric 2: Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff					
likelihood ratio non disabled/disabled		0.67	1.03	0	2.58
Metric 3: Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health)					
likelihood ratio non disabled/disabled		5.48	1.57	0	49.18
Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: patients/public					
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months	Disabled	40.60%	32%	20.60%	52.50%
	Non Disabled	30.40%			
Metric 4b:Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: harassment, bullying or abuse from managers					
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months	Disabled	17.80%	18.00%	9.60%	26.60%
	Non Disabled	12.50%			

Birmingham and Solihull Mental Health NHS Foundation Trust

Indicator number and discription		Trust	Midlands	Minimum	Maximum
Metric 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: harassment, bullying or abuse from colleagues					
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months	Disabled	27.50%	25.60%	15.40%	40.80%
	Non Disabled	20.50%			
Metric 4d: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: harassment, bullying or abuse -colleagues reporting lateset incident					
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months	Disabled	61.70%	51.20%	40.80%	66.10%
	Non Disabled	60.90%			
Metric 5: Career progression					
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled	71.70%	79.30%	65.90%	91.90%
	Non Disabled	76.50%			
Metric 6: Presenteesim					
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work,	Disabled	23.10%	31.70%	16.20%	54.60%
	Non Disabled	17.90%			
Metric 7: Feeling valued					
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	43.30%	39.60%	28.30%	54.60%
	Non Disabled	52.90%			

Indicator number and discription		Trust	Midlands	Minimum	Maximum
Metric 8: Workplace adjustments					
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		82.70%	77.10%	61.20%	88.40%
Metric 9a: Staff engagement					
The staff engagement score for Disabled staff, compared to non-disabled staff.	Disabled	6.78	6.65	5.79	7.28
	Non Disabled	7.16			
Metric 9b: Staff network					
Does the organisation have a staff network for disabilities		Yes			
Metric 10: Board representation					
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	Disabled	0%			
	Non Disabled	71.40%			
	Null/Unknown	28.60%			

Birmingham and Solihull Mental Health NHS Foundation Trust

Priority Areas

Priority 1	**Metric 10: Board disability representation**
Priority 2	**Metric 4a: Harassment, bullying or abuse from patients/public**
Priority 3	**Metric 5: Career Progression**

Birmingham and Solihull Mental Health NHS Foundation Trust

Strength Areas

Trusts were ranked according to their performance against each of the metrics. The following list shows the three highest-ranked metrics for each trust.

Strength 1	**Metric 2: Recruitment (Top 10% Nationally +ive)**
Strength 2	**Metric 4a: Reporting of harassment, bullying or abuse from patients/public (Top 10%Nationally +ive)**
Strength 3	**Metric 6: Presenteeism**

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**12**
Paper title	**CHAIR'S ASSURANCE REPORT FROM THE FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	25th May 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 18th May 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 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 is a £0.4m improvement to the proposed plan of £3.1m presented at month 12 FPP and is 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.

In respect of agency, the Trust was seeing a continued usage of high level of agency spend and in April this was higher than the average spend for the last financial year with the majority of the spend being medical agency. Therefore, the Agency Reduction Meetings were being reintroduced.

It was reported that the cash continued to be in a healthy position with £20m being deposited with the National Loan Fund.

The Committee expressed its previous concerns regarding the traction in developing prioritised capital plans with the Executive taking an action to review the timeframes and if required an interim decision-making process to be implemented and agreed to ensure capital bids could be progressed.

Chair's Assurance Comments: Capital issues discussed and out of meeting actions to be taken were agreed to progress things. We are concerned about how this process has not worked this year and once this year's allocation is resolved we need to review this. In terms of agency we reiterated the need for creative and imaginative solutions, especially flexibility, regarding recruitment and job roles.

1.2 Integrated Performance Report

The Committee deferred the Integrated Performance Report to the next meeting and would concentrate on the performance indicators which were below the national targets.

Chair's Assurance Comments: this was to be a priority item for this meeting but illness prevented us discussing it. We will review it in depth next time. We did note that some areas are starting to use it not only for reporting up to us but more actively in their management plans, which is encouraging.

1.3 Improving Access to Psychological Therapy (IAPT) Recovery Plan

The Committee received a detailed presentation on the key issues and challenges the service has been working to overcome in its delivery of commissioned IAPT activity and in improving performance against national KPIs indicators in 2021/2022.

The presentation outlined the approach being taken to address the key challenges and the key components of the IAPT Recovery Action Plan including the service's plan to return to a position of over-performance against targets in the next 12-18 months. The recovery plan had been agreed using West Midlands Network developing a 12–18-month plan to return the service to exceeding targets and be in a position to expand further next year. The project plan had been agreed and there was a weekly recovery project meeting.

The Trust was working closely with clinicians and there was assistance from the national team with V. Devlin chairing the IAPT Forum from a system perspective. There would also be a bi-monthly update to the FPP Committee.

Chair's Assurance Comments: Some good work detailed here, and a plan in place to attempt to catch up. We agreed 2-monthly reviews so we could monitor progress as it is too early to be assured these plans will work. We noted that our ambition needs to be mich higher – we do not just want to get back to where we were, but should be aiming to effectively service the population needs, and need to consider more ways to achieve that, including digital.

1.4 COVID Restoration Update

The Committee received a detailed verbal update regarding the work being undertaken to recover from COVID-19. Recovery had been discussed within the urgent care pathway, older adult services and within community and young person's transformation with the Board receiving an update on the . Community Transformation at the next Board meeting.

It was reported that the mental health investment funds which were being spent in operational areas.

A report was being prepared regarding the quality and clinical risks relating to people on the waiting list for services which would be presented in July.

It was reported that operational areas have been asked to pull together plans to increase face to face contacts with the national recommendation being a split of 60/40 (face to face & digital) but this was dependent on the service being provided.

The Committee agreed that from an ongoing assurance point of view it would be useful for an update on the progress being made on recovery to be included within future Integrated Performance dashboards.

Chair's Assurance Comments: Similar comments to 1.3

1.5 Digital Strategy Improvements & Assurance

A detailed report was presented on the areas of the Digital Strategy. It was noted that due to previous poor decisions being made across the NHS in relation to IT, a new Digital Technology Assessment Criteria was being introduced. The tool was designed to support the procurement and contract management of digital health solutions. It sets out criteria that suppliers should meet in relation to both legislation and good practice across five broad domains.

The ICB continued to develop the digital strategy. The shared care record across BSOL was led by the Trust and have the largest shared record in the country. All NHS organisations in BSOL are involved apart from Birmingham Women and Children's. It was also noted that we will also have the biggest social care record as linked to six councils.

The report included a significant number of internal updates which included developing the Microsoft 365 offering to the Trust, reviewing how the area of Robotic Process Automation could be developed further, a new programme of work regarding all aspects of paper and records of management and an update on the progress in developing internet media services for inpatients.

The Trust was also leading on the We lead Gov Roam project which allows any public sector workers to auto connect and to remote work from any site and not reliant on a Trust site and therefore allowed staff to hot desk across any site.

Chair's Assurance Comments: Lots more depth and detail here, with some good initiatives and progress. We discussed the need for a grander ambition again, and are considering how we can give front line staff space to articulate their needs to technical people who can address them.

1.6 CAMHS (Child and Adolescent Mental Health Services) Provider Collaborative

A report was received relating to the CAMHS Tier 4 Provider Collaborative which was due to go live on 1 July 2022. The lead provider was Birmingham Women's and Children's NHSFT and BSMHFT was a partner organisation with CAMHS low secure beds within scope. It was noted that key documents were in the process of being finalised with partners and would be taken through for approval to Board of Directors prior to go live which would include the business case and the partnership agreement.

It was reported that discussions were ongoing regarding the Risk and Gain Share Agreement. The report also included the most recent programme update. BWC were currently going through the final steps of the formal assurance process with NHS England and have their Final Assurance Panel

meeting w/c 13 June following which NHSE would make their final decision regarding the provider collaborative's state of readiness for July go live

Chair's Assurance Comments: We agreed that the direction of travel was appropriate and that we were currently content, but that without risk share agreements we could not agree anything binding as yet.

RUSSELL BEALE
NON EXECUTIVE DIRECTOR
18TH May 2022

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**13**
PAPER TITLE	**OUR TRUST FIVE YEAR STRATEGY - UPDATE**
DATE	25th May 2022
AUTHOR	Abi Broderick *Head of Strategy, Business Development and Planning*
EXECUTIVE SPONSOR	Patrick Nyarumbu *Executive Director of Strategy, People and Partnerships*

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?	Yes
What data has been considered to understand the impact?	Reducing inequalities is a theme that runs throughout our Trust Strategy and Strategic Priorities.

Executive summary & Recommendations:

Our refreshed Trust Five Year Strategy was launched at the start of 2021/22 and included 4 strategic priorities:

- Clinical Services
- Sustainability
- People
- Quality

This annual update paper to Trust Board contains:

- How our strategy launch went – **for information**
- What we achieved in 2021-22, Year 1 of our Strategy - **for information**
- Our 2022/23 Trust goals - **for approval**.
- A description of our Strategy Accountability Framework – **for assurance**

The Strategy was launched through a two month multi-channel communications and engagement campaign aimed to launch the strategy in a meaningful way and make the strategy and vakues real to colleagues so they understand and take personal eresponsiblity for the role they have to play in delivery.

Following approval of the Trust Strategy, the Trust 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 is a key priority for us, making sure we are working in a way that tackles discrimination, racism, addresses stigma and encourages equality for all. This is a golden thread across all four of our strategic priorities, with each of the priorities having goals and plans around reducing inequalities.

Despite the significant clinical and operational challenges the pandemic has presented to us over the past year, there has been a huge amount of progress in delivering our goals across all four strategic priorities, and colleagues should be commended for these achievements. The majority of our goals have been progressed forward and we have a lot of positive achievements to report, putting us in good stead for moving into Year 2 of the Strategy.

We have reviewed and reset the goals moving into 2022/23 for all four strategic priorities, taking into account our key transformation programmes, the impact COVID has had and will continue to have on our workforce and demand for mental health services, the impact of the newly evolving BSOL Integrated Care system, our recent staff survey results and new local and national priorities and programmes of work.

We have a clear and comprehensive Strategy Accountability Framework setting out our processes for the delivery, monitoring and reporting of the ambitions set out in the strategy.

Reason for consideration:

Trust Board are asked to:

- **Note** the progress made in 2021/22 in delivering our Trust Strategy
- **Approve** the 2022/23 strategic goals for our four strategic priorities.

Previous consideration of report by:

Reports containing the progress for 2021/22 and the 2022/23 goals have been reported in detail to the relevant Board Sub-Committee in March/April 2022:

- Clinical services priority – to QPES Committee and FPP Committee
- Quality priority – to QPES Committee
- People priority – to People Committee
- Sustainability priority – to FPP Committee

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

CLINICAL SERVICES: Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.
SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population
PEOPLE: Creating the best place to work and ensuring we have a workforce with the right values, skills, diversity and experience to meet the evolving needs of our service users
QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve

Financial Implications *(detail any financial implications)*

N/A

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

N/A

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

There was engagement with teams across service areas re the strategy launch, what it means to them and how they contribute to the achievement of the Trust goals. Service and corporate areas have been involved in updating and developing goals for 2022/23.

Our Trust Five Year Strategy - Update for Trust Board
25 May 2022

1. Purpose of paper

After significant engagement with our colleagues, service users and carers and partners, the new Trust Five Year Strategy was approved at September 2020 Trust Board and launched across the organisation from 1 April 2021.

This annual update paper to Trust Board contains:

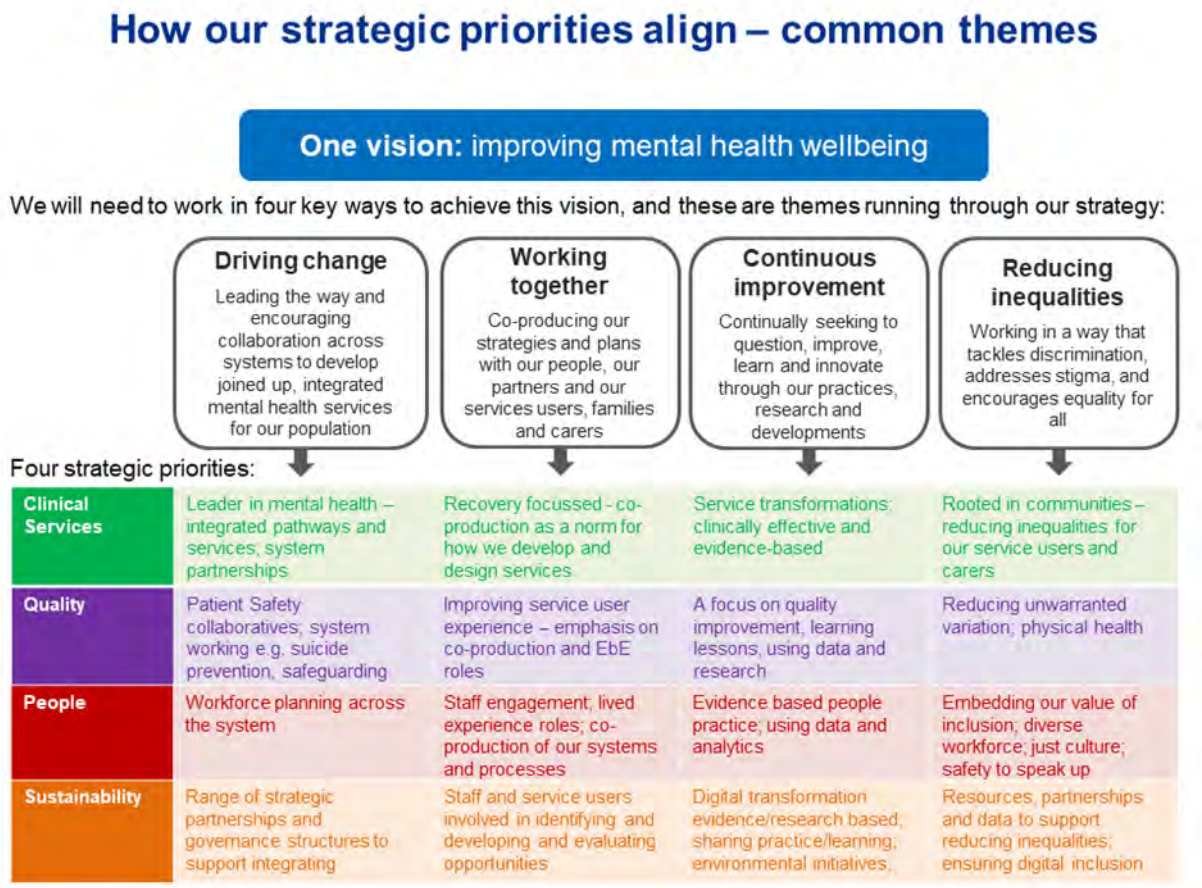
- How our strategy launch went – **for information**
- What we achieved in 2021-22, Year 1 of our Strategy - **for information**
- Our 2022/23 Trust goals - **for approval.**
- A description of our Strategy Accountability Framework – **for assurance**

2. Our Trust Strategy

Our Trust Strategy describes our **four strategic priorities** and provides a high-level overview of the key areas of focus.

Reducing inequalities is a key priority for us, making sure we are working in a way that tackles discrimination, racism, addresses stigma and encourages equality for all. This is a golden thread across all four of our strategic priorities, with each of the priorities having goals and plans around reducing inequalities. Throughout this document we have highlighted our reducing inequalities goals in blue.

Alignment has been key through our strategy development and implementation process as it is important that our strategic priorities are joined up, we have clear common themes running across all our strategic priorities and we are clear on what the key enablers were between the strategic priorities.



3. Strategy Launch

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

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

The key message of the campaign was that this is 'everyone's' strategy – it reflects what people told us was important for our Trust to focus on, and everyone has a role, however big or small, to play in helping us deliver the strategy.

Communications

We ran a two-month multi-channel internal and external communications campaign to promote the components of our strategy. This included:

- ✓ Listen Up Live with the CEO
- ✓ Letters and emails to all colleagues about the strategy
- ✓ Materials distributed to sites containing posters, pull up banners for reception areas, strategy documents, handy z-cards for colleagues and promotional pens
- ✓ Information about the strategy live on Connect, the external website and social media. Signposting through screensavers/ banners on Connect.
- ✓ Special edition of Connected, our colleague e-newsletter, focussed on the strategy
- ✓ A different focus each week to bring the strategy to life – we cycled through our values and each of our four strategic priorities with articles, stories, videos and quotes about what some of the key initiatives in our strategy were, and why they were important for colleagues, service users, carers and partners.
- ✓ Communications to our stakeholders about our refreshed strategy.

Engagement

Cascade and engagement throughout the organisation by senior leaders and managers has been crucial for all colleagues to be able to really understand what the strategy is and what it means for themselves and their teams.

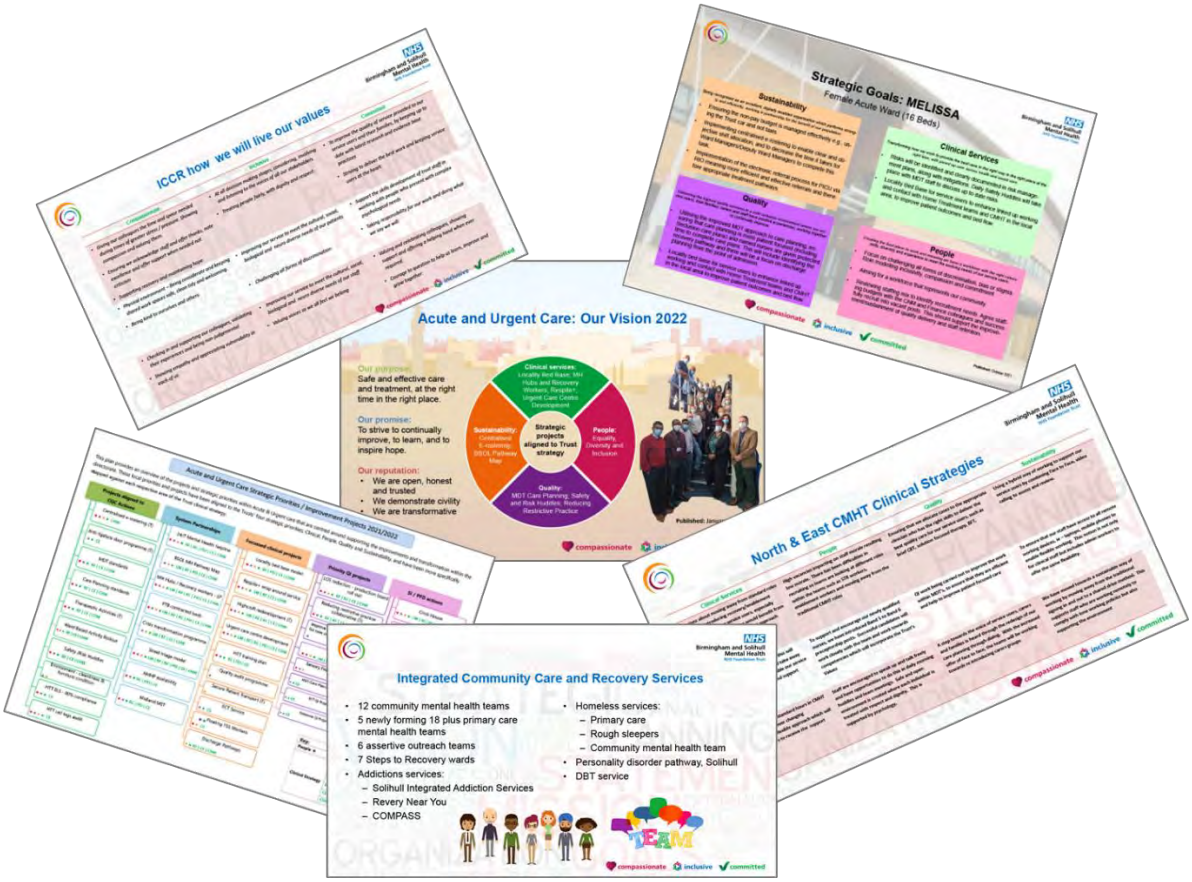
All leaders and managers were asked to support their teams to have some time out together to think about what they could do as a team to truly demonstrate each of our Trust values and help achieve our strategic priorities. An engagement pack was made available for managers to use to support and stimulate these team discussions.

We have had some fantastic examples of how local areas have really embraced this engagement with their teams, empowering local managers and teams to own plans and actions, and embedding strategy discussions and monitoring into their day-to-day business. Some examples of the outputs of this engagement include:

Acute and Urgent Care
✓ Away day for managers and leaders to agree the local vision for Acute and Urgent Care which has been turned into a poster for local sites ✓ Every team has created a poster setting out what they will do for each of our four strategic priorities, displayed on walls in team areas ✓ List of local strategic projects aligned to the strategy, centred around supporting the improvements and transformation within the service area, monitored through local service area meetings
ICCR
✓ Slide deck shared across the service area setting out: ▪ What services are in the service area ▪ The key priorities for each service, aligned to our four priorities

- How ICCR colleagues will live our values

✓ Clear objectives for managers aligned to the strategy, informing the agenda for local management meetings



4. Our achievements in Year 1 – 2021/22

In May 2021 the Trust Board approved our strategic goals for 2021/22 for each of our four priorities. Our strategic goals indicate what we want to achieve and where we will be focussing our efforts and resources so we can prioritise where needed.

The last two years have been a challenging time for the Trust, as for the wider NHS, as we have had to respond to the COVID19 pandemic. During 2021/22 - the first year of strategy of implementation - COVID19 has dominated our activities with our capacity and resource being prioritised to respond to staffing and service pressures. These additional pressures have meant that at times work on strategic programmes has had to stop and start during the year, with decisions taken about what was important to focus on.

Despite the significant clinical and operational challenges the pandemic has presented, there has been a huge amount of progress in delivering our goals across all four strategic priorities, and colleagues should be commended for these achievements. The majority of our goals have been progressed forward and we have a lot of positive achievements to report, putting us in good stead for moving into Year 2 of the Strategy.

As part of our routine monitoring and assurance framework, our progress for 2021/22 has been assessed against each of these goals and reported in detail to the relevant Board Sub-Committee in March/April 2022:

- Clinical services priority – to QPES Committee and FPP Committee
- Quality priority – to QPES Committee
- People priority – to People Committee
- Sustainability priority – to FPP Committee

The table below highlight some of our 2021/22 achievements:

(As previously referenced, reducing inequalities goals have been highlighted in blue).

Area of focus	What we have done
Clinical services	
Leader in mental health	✓ We have been visible as a national leader within the Synergi Pledge, sharing our focus areas and progress to date. We actively engaged in update events and meetings, have worked more strategically with community organisations and progressed workstreams including research and innovation, Reach Out, IAPT and reducing restrictive practices. ✓ A huge amount of work from clinical, operational and corporate colleagues was carried out to refresh our service, delivery, staffing and partnership models for HMP Birmingham and complete a high quality response to the tender – we were delighted to have found out in May 2022 that we have been successful in retaining our contract.
Recovery focussed	✓ There was a new provider of Individual Placement Support (IPS) services across BSOL and we have developed good relationships, with IPS workers embedded into our CMHTs and attending our multidisciplinary team meetings.
Rooted in communities	✓ Reducing inequalities data is now readily available via Insight to all colleagues within the Trust, and Data with Dignity sessions are being carried out across areas to highlight the data and develop approaches to using the data to inform improvements and developments and develop local reducing inequalities plans. ✓ Reach Out has carried out a deep dive into the current service user understanding and experience of inequalities across adult secure care. This learning will now be used to inform learning for colleagues so that we can work towards improving the experience of SU currently engaged in services. ✓ This has been Year 1 of the Community Transformation programme and a robust BSOL wide governance structure is in place, including all partners and experts by experience, with clear and comprehensive plans and timelines and a dedicated transformation team. Soft launch in the South and East locality commenced in February 2022, with go live in

Area of focus	What we have done
	April 2022. ✓ Birmingham received national funding to launch a new Maternal Mental Health service, including a psychological service for women experiencing loss and bereavement in their maternal journey.
Prevention and early intervention	✓ We have worked well with mental health partners across the system making significant improvements in the urgent care pathway. This includes: • Opening of the all-age Urgent Care Centre towards the end of the year, working in partnership with Forward Thinking Birmingham • Continued enhanced of the 24/7 mental health helpline, ensuring robust clinical support, with increased numbers accessing the helpline. • Development of a comprehensive map of services developed, with plans to develop this into an app in 2022/23. ✓ We have continued to play an active role with the Birmingham Integrated Partnership (older adults). We have reported particular achievements in year enhancing our Care Home Liaison Service and improving the support and integration between mental health services and local care homes.
Clinically effective	✓ The Solihull Early Intervention Service has implemented a number of developments to ensure it meets nationally mandated standards and has been commended in recent checkpoint meetings with NHSE/I. Developments include extension of the age range, IPS offer in place, and Severe Mental Illness (SMI) physical health checks being routinely undertaken.
Quality	
Preventing harm	✓ Comprehensive quality improvement programme delivered through the Reducing Restrictive Practice collaborative, with clear evidence of reduction in incidents of restraint and seclusion ✓ Safety huddles in place across the Trust, with clear quality assurance mechanisms and escalation processes ✓ Creation of an education programme for good management of Rapid Tranquilisation (RT) introduction of clinical educators on the ward leading to a significant reduction in number of RT episodes.
Improving patient experience	✓ Implementation of MDT standards across inpatient areas has led to audit reporting of 100% of service uses attending their weekly MDT meeting
A positive patient safety culture	✓ Increased number of internal Learning from Excellence submissions made in recognition of excellent practice

Area of focus	What we have done
Improving quality assurance	✓ Six internal peer reviews have been carried out with a further eleven scheduled for completion on the next two months.
Using our time more effectively	✓ Agreed Dialog+ in principle as the care planning approach moving forward, with roll out and implementation plans being built into the community transformation programme.
People	
Shaping our future workforce	✓ BSOL Mental Health Workforce Group established with partnership working in developing workforce plans ✓ Safer staffing steering group now established with establishment reviews regularly carried out and reported through safer staffing reports. ✓ Temporary and peripatetic recruitment model launched allowing peripatetic workers to work across a locality or hospital site or even a geographical area (focus mostly on HCA roles but will be used for nurses as well).
Transforming our culture and staff experience	✓ Organisational roadmap to being anti racist and anti-discriminatory has been approved by Trust Board. ✓ Launch of the Vivup application, giving colleagues access to a range of benefits such as savings schemes, lifestyle savings, support and wellbeing ✓ Completion of the Inclusion Advisor pilot and recommendations/ implementation plan for the future developed based on the RCN's tried and tested programme of Cultural Ambassadors. ✓ Just Culture pilot programme completed, now looking to expand using Quality improvement methodologies ✓ Continued support of our staff networks, including establishment of a new Women's Network ✓ Commissioning of Active Bystander training ✓ Development of resources on Incivility
Modernising our people practice	✓ Incorporated the learning from lived experience into the development and review of policies and procedures or action plans to ensure they are more people focused
Sustainability	
Transforming with digital	✓ Introduction of a range of new reporting tools such as the new Trust and Division-level Integrated Performance Dashboard (IPD) report, service user demographics/protected characteristic reports, enhanced Insight reporting based on local operational needs, and pharmacy core drug prescribing.
Caring for the environment	✓ Development of a Transport Strategy incorporated in the Trust's Sustainability Strategy and Action Plan.
Changing through partnerships	✓ Designing and implementing clear and robust governance processes that fulfil the Trust's Lead Provider responsibilities effectively for Reach Out ready for go live in October 2021. ✓ Continued to be embedded in local structures and plans for

Area of focus	What we have done
	determining the future direction of BSOL ICS and development of a provider collaborative/ service integrator for Mental Health. ✓ Continuing to play an active role and contribute to the delivery of 2021/22 workplans for the Eating Disorders and CAMHS Provider Collaboratives.
Good governance	✓ Completion of a Governance Improvement Action Plan.

5. Trust 2022/23 Goals

As part of our annual review of where we were against the 2021/22 priorities, we also considered what the priorities needed to be for 2022/23 and refreshed and reset priorities for Year 2 of the Strategy. Some particular considerations included:

- We have recognised that to deliver sustained change across Trust wide programmes, many goals will need to be in place over more than one year and therefore many of our 2021/22 goals will continue into 2022/23.
- We have to continue to deal with the legacy of the pandemic, in terms of embedding our learning from COVID, the impact COVID has had and will continue to have on increased demand for mental health services, and the impact COVID has had on the health and wellbeing of our workforce.
- Our recent staff survey demonstrates that we are not where we want to be in terms of the experience of our staff at work.
- We have some new and emerging local and national priorities and programmes of work going into 2022/23.
- The direction of travel of Birmingham and Solihull ICS and the impact this has now (or may have in the future) on our priorities and areas of focus.

Goals have been aligned to the areas of focus for each of our four strategic priorities. Indicative measures of success have been given for the goals, these will be refined and finalised as the monitoring and reporting arrangements for the Trust strategy are embedded.

As previously referenced, reducing inequalities goals have been highlighted in blue.

Our strategic goals are not static – as we review progress against the strategic goals during the year on a quarterly basis, we also review anything that may indicate these goals need to change e.g. new internal or external drivers or priorities such as the Birmingham ICS strategic plans.

2022/23 Goal	Measure of success
Quality Goals	
Preventing Harm	
Improve the safety of our acute inpatient wards by installing ligature alarm systems	Reduced level of ligature incidents utilising an anchor point which result in moderate,

2022/23 Goal	Measure of success
on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards	severe or catastrophic harm to patients
To improve the physical health monitoring of patients in our care	To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission
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	% of service users in receipt of their care plan Qualitative measure to be established through EBE group
Improve the involvement of carers in service user care and recovery	% 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	Number of patient safety partner roles established Feedback from patient safety partners on their experience
A Positive Patient Safety Culture	
Roll out Learning from Excellence across the organisation to ensure systematic recognition of learning from excellent practice	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	Embed a standard approach to sharing lessons learned from incidents
Improving Quality Assurance	
Pilot, evaluate and roll out an internal quality assurance peer review scheme across the Trust involving staff and experts by experience	Number of quality visits completed
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	Determine the approach to needs assessment and care planning using a Patient Rated Outcome Measure*.

2022/23 Goal	Measure of success
Clinical Services Goals	
Leader in mental health	
Make sure we have effective interfaces between our services, for example community services and acute/urgent care services, and secondary care and forensic services.	Pathway forums in place. Clear interfaces and pathways in place. Measures of effectiveness identified and being gathered.
Be a key partner in developing Place-based models for Birmingham (and its five localities) and Solihull and assessing how our services need to adapt to these new approaches.	Being part of place-based conversations about future arrangements and governance Impact assessment of what this means for our services
Work in partnerships with our acute, primary and community colleagues to make sure mental health and physical health services are embedded together.	Implementation plan for Physical Health Strategy across community transformation (clinical integration, working with primary care). Use our health inequality data and learning from the Learning from Deaths annual thematic review to influence system colleagues to address health inequalities for people with severe mental illness Working with NHSE/I regarding increasing physical health checks
Develop roadmap of how we proactively advocate for mental health across the system, identifying any gaps and future areas of focus.	Co-production with partners, staff and Experts by Experience about our areas of focus and roadmap to ensure that we have a clear understanding and plan of what this advocate role means for the Trust across the system.
Ensuring clinical engagement and clinically informed models is embedded throughout the BSOL Mental Health, Learning Disability and Autism Provider Collaborative governance.	Model for clinical engagement developed. Governance structure in place that is clinically led.
Work with partners to develop the clinical model for the West Midlands Perinatal Provider Collaborative	Partners and clinical leads identified for the provider collaborative. Clinical model developed, co-produced with partners, service users and carers.
Deliver on our commitments as an organisation signed up to the Synergi Pledge to reduce ethnic inequalities in	We are providing national leadership by making fundamental changes to reduce inequalities in access, experience and

2022/23 Goal	Measure of success
mental health.	outcomes, measuring the extent of inequalities and improvements, supporting research and policy development and working in partnership with local BAME communities, organisations and service users.
All provider collaboratives that the Trust is the lead provider for to have a clear focus on addressing inequalities, particularly race inequality, with a plan in place and clear milestones	Impact framework implemented. Positive practice shared.
Improve quality and utilisation of data including the recording of protected and other characteristics relevant to inclusion and inequalities, to inform improvements and developments.	Have a workplan in place to capture patient protected characteristics and experience data in a more systematic way.
Work as an ICS to access and triangulate a range of internal and external demographic and population data, including COVID-19 inequalities data, to identify and address inequalities and inform transformation plans.	We routinely use and break down data by protected characteristics and demographics to have a greater understanding of: • Local populations and their mental health needs. • Gaps in services/support. • Who is and is not accessing mental health services and their experiences. • The outcomes of mental health care for our population.
Successful mobilisation of the HMP Birmingham contract	Mobilisation plan activities and milestones met. TUPE in managed within timescales Staff and patient feedback. Staff retention rates.
Retain our Liaison and Diversion and Mental Health Treatment Requirement services that will be subject to tender during 2022/23 and successfully mobilise ready for the new contract to commence on 1 April 2023.	Partners identified/confirmed. Tender submitted. Successful tender outcome. Mobilisation plan activities and milestones met.
Recovery focused	
Refresh and launch the Recovery/Experts by Experience strategy	Coproduction of strategy with experts by expertise, colleagues and other partners

2022/23 Goal	Measure of success
	Approval of strategy Plan for launch and implementation
Increase opportunities for service user and families participation and engagement.	New participation team structure embedded in local areas
Expand employment opportunities for people using their lived experience.	Production of Expert by Experience guidance for staff Roles in place across all service areas Numbers of lived experience roles Number of services with lived experience roles How representative our peer workers are of our service user demographic
Service users and families being actively involved in clinical discussions, so care plans are unique and personalised, building on an individual's assets and what recovery means to them.	Patient feedback – bespoke surveys/ focus groups No of relevant complaints from families/ carers Launch of new recovery training package
Determine strategic position with the CCG for roll out and use of personal health budgets	% increase in number of personal health budgets
Review and refresh family and carer pathway, ensuring consistent ownership and application across all service areas	Review of pathway process completed % staff who have had family and carer pathway training % carers identified on RiO Carer groups re-established in service areas
Review effectiveness of Individual Placement Support, ensuring it is fully employed across all patches within BSOL.	Numbers in successful employment % increase in employment.
Deliver a programme with the Bedlam partnership of creative and physical activities across our services to support service users' recovery	Programme of activities across the year, across a range of premise and venues. Evaluation framework in place Increased confidence of arts organisations to work with our service users, carers and staff
Rooted in communities	
All service areas to have identified key	Patient population data analysis

2022/23 Goal	Measure of success
areas of inequality and have developed a strategic plan to address reducing these.	Staff data analysis Action plan in place for all service areas
Develop organisational competencies to provide culturally competent services in line with the Patient Carer Race Equality Framework.	Early examples of positive practice in improving BAME experience shared. Engagement programme rolled out. Steering group established including service users, carers, families and staff. Drawing on steering group expertise and engagement findings, draft a framework for testing.
Populate and promote use of a library of emerging positive practice within mental health services to advance service developments in line with the needs of our local populations	Having a well-populated library of positive practice guides and case studies to support advances in mental health equalities.
Implementation and monitoring of i) Accessible Information Standard ii) Sexual Orientation Standard	Accessible Information Standard - monitoring Sexual Orientation Monitoring Standard – pilot completed in two service areas.
Roll out community transformation across all geographical areas within the BSOL footprint, across young people, adult and older adult services.	Project plan timelines being followed. Teams in place Evaluation data being produced. Services aligned to localities and PCNs.
Re-design of the Forensic Intensive Recovery Support Team (FIRST) community services.	Co-produced FIRST team model after active engagement with staff and service users
Redesign the forensic women's pathway in co-production with staff and service users	Co-produced pathway design after active engagement with staff and service users
Progress the workplan for the transformation of rehabilitation services: Part a. Creation of intensive complex recovery community service with access to local supported tenancies to maintain service users in the least restrictive recovery focused manner Part b • HDU provision sourced and agreed within BSol footprint • Creation of gender specific complex	Part a. Service is in place and producing good recovery outcomes for service users & usage of OOH recovery & HDU provision has reduced Part b. Requirements scoped for HDU beds and ICS has agreed an appropriate way forward to procure

2022/23 Goal	Measure of success
care services within the Knowle Site • Secure appropriate accommodation flow across the system	
Increase and expand access to specialist perinatal mental health services and psychological therapies	Meet Long Term Plan ambitions: • Mental health assessments offered to fathers/partners. • 10% access target • Expanding provision to up to two years postnatal
Strategically and practically embed Asset Based Community Development (ABCD) and asset-based approaches in the way that we work, working with a range of community organisations	Commission and roll out ABCD training Determine desired aims, outputs and outcomes from the work
Work in collaboration with established and new PCREF partners to embed a community collaborative within existing governance structures	Community collaborative framework in place. Evaluation framework in place.
Prevention and early intervention	
Further development of the BSOL pathway map	Number of people funneled into alternatives to inpatient stays. Development of a web-based tool/app. Widen the map across community and urgent care.
Development of the psychiatric liaison clinical model, pathways and service at the new Midlands Metropolitan Hospital opening in 2022/23, working in partnership with Black Country Healthcare NHSFT and Local Authority	Agreement of clinical model. Partnership agreement with BCHFT. Transition to new service.
Implementation of mental health hubs and recovery workers in the acute hospitals.	Implementation of MH Hubs in Acute Hospitals Increased use of MH Hubs for LP patients, rather than patients remaining in A&E. Service user feedback on experience of MH Hubs. Support provided by Recovery Workers to divert patients from A&E.
Embed new service provision for Crisis Houses within existing pathways	Service user feedback.

2022/23 Goal	Measure of success
	Alternative admission to acute inpatient setting. Partnership working between FTB, BSMHT and Future HSC.
Deliver transformation plans for children and young people in Solihull, e.g.,18-25 service, LDA needs, mental health teams in schools, primary care liaison and eating disorder pathways	New roles recruited to and staff in place Positive feedback from young people. Friends and Family Test
Enhance eating disorder pathways for adults.	Workforce model confirmed and posts recruited to. Training of staff. Delivery of FREED and early intervention treatment packages. Evaluation framework in place.
Development of a clear BSOL wide IAPT offer (including use of digital) of which Birmingham Healthy Minds plays an integral part.	System wide strategic/ recovery plan developed. Expansion of service Numbers accessing IAPT services in line with trajectories. Waiting times reduced.
Strengthen our integrated Mental Health Older Adult offer across the BSOL Ageing Well System, with a particular focus on: • Implementing the mental health aspects of the early intervention 2021/22 work programme • Development of MDT working with system partners to support care homes. • Development of integrated model in Solihull and roll out plan (following Newton Europe diagnostic)	Reduction in length of stay on older adult inpatient wards. Qualitative feedback from care homes. Implementation plan for Solihull services and pathways.
Evaluate the rough sleepers service for effectiveness.	Evaluation and audit analysis.
Work with partners to develop the tender response for the Op Courage contract, ensuring joined up services and pathways across the region and with mainstream mental health services	Refreshed clinical model developed in partnership. A joined-up pathway through mental health services, including links with mainstream mental health services.

2022/23 Goal	Measure of success
	Expanded provision of specialist psychological therapies.
Review the current provision of Psychology-led services within acute hospital partnerships	Redefined model of service provision Establishment of quality review and assurance processes Clinically, professionally and operationally agreed service specification
Clinically effective	
Develop a consistent approach to the use of outcome measures across the organisation, with a core set of outcomes measures, and ensure we are using them to inform service delivery and improvement	Re-launch of HoNOS.in the Trust Roll out of Dialog Potential research into sensitivity of measures to cultural and language differences
Early Intervention Service will meet all national mandated CCQI Standards to include (list is not exhaustive) • Development of ARMS service.	ARMS service is in place: • Relevant staff have CAARMS training • Service open to new referrals for those who are at risk mental state EIS service is meeting all required CCQI standards
Continue the development and expansion of the personality disorder pathway in line with community transformation, embed the principles of structured clinical management (SCM) within community services.	SCM practitioners in place within the south community services. Personality disorder training prospectus available for all staff to select appropriate training for their needs. Development of a complex case panel to manage who is appropriate or not to access OOA specialist beds.
Improve our offer for service users who also have learning disabilities or autism needs.	Strategic review of what the Trust still needs to do to provide appropriate care to service users with LDA. Continuation of workstreams within the LDA Group: • Training • Physical environments • Documentation and recording • NICE guidance
Improve our offer for service users who also have substance misuse needs	Implementation plan monitored by the Task and Finish Group including: • Raising awareness of guidelines

2022/23 Goal	Measure of success
	• Training and learning events • Mapping existing services and pathways, and gaps • Raising awareness of existing pathways
Develop a trauma based therapeutic model for working with refugees	Co-produced evidence based therapeutic model Implementation plan for roll out Training for staff
New goal: Review of Care Programme Approach (CPA) across the Trust in line with NHS directive	Review of policy against NHS directive Implementation plan for each service area
Changing how we work	
Progress with the developments for Reaside re-provision and Highcroft redevelopment.	Reaside Development of Outline Business Case, (once funding confirmed) Highcroft Approval of Strategic Outline Care Development of Outline Business Case, (once funding confirmed)
Ensure clinicians play an integral role in developing a five-year roadmap for digital transformation across our clinical services by identifying problems and barriers that technology could overcome, ensuring that digital innovation is woven through all our transformation plans.	Clinicians are an integral part of the working/steering group established to identify digital improvements.
All services to develop comprehensive workforce plans	Workforce plans developed for each service area
People Goals	
Shaping our future workforce	
Embed a values based and inclusive approach to recruitment.	Analysis of vacancies Employee Turnover Stability index - % staff in post two years after commencement Workforce Demand and Supply Forecast Waterfall
Develop comprehensive on boarding programme to support new staff.	
Develop a Leadership Framework and Development programme.	
Implement a clear, credible route map to	

2022/23 Goal	Measure of success
support the progression and development of staff in entry level roles.	Fill Rates Fundamental Training % of staff who has accessed clinical supervision % of staff who has accessed Leadership and People Management Training Modules Completion and quality of appraisals and objectives
Development of transformation plans within the organisation that align with ICS development, system changes and predicted demand for the future.	Workforce plans for each area Coproduction of a system workforce plan with partners
Transforming our culture and staff experience	
The Trust is a Anti racist and Anti-discriminatory organisation	Anti Racist framework is co-produced, and we all understand what racist behavior is and is not. We utilise the framework to hold people to account and manage as appropriate. Anti Racist policy is co-produced. We utilise the policy to hold people to account and manage as appropriate. Bystander training is rolled out to 100 colleagues. Bystander training is evaluated. Bystander training is made available at regular intervals across the Trust PCREF competencies are understood and actively used in service delivery to ensure anti racist service delivery.
LGBTQ + Colleagues do not experience disproportionate Bullying and Harassment from colleagues, managers and service users	LGBTQ+ Colleagues know where and how to report discrimination. Staff survey shows no disproportionality Access to Freedom to Speak Up % of LGBT+ staff entering disciplinary processes More colleagues declaring sexual orientation on ESR
Black, Asian and Minority Ethnic colleagues believe that we provide equal opportunities for career progression or promotion.	Black, Asian and Minority Ethnic colleagues have equitable outcomes across recruitment process

2022/23 Goal	Measure of success
	% of BAME staff successful in being appointed to roles internally % of BAME staff likely to be appointed into roles from shortlisting Staff survey results
Black, Asian and Minority Ethnic colleagues do not experience disproportionate Bullying and Harassment from colleagues, managers and service users	Black, Asian and Minority Ethnic colleagues know where and how to report racism. % of BAME staff entering disciplinary processes Staff survey shows no disproportionality
Every colleague in the organisation has an annual appraisal. Embed the Culture Deep Dive framework. Embed a "Just Culture" and enable psychological safety and learning. Develop a toolkit, framework and training to enable behaviours which foster civility and compassion in the workplace. Develop a clear strategy to support staff to speak up. Strengthen and streamline the Trust Exit Interview process.	Employee Lifecycle Feedback % of staff accessing non-mandatory training and CPD Staff survey and Staff Friends and Family Test % of BAME, LGBT+ and Disabled staff entering disciplinary processes % of BAME, LGBT+ and Disabled staff successful in being appointed to roles internally %of BAME, LGBT+ and Disabled staff likely to be appointed into roles from shortlisting % of Disabled staff entering formal capability processes compared to all other staff Analysis of disciplinary cases Analysis of Grievances, Dignity at Work, Whistleblowing, FTSU and Capability cases Sickness absence rates and reasons
Have available a comprehensive and inclusive health and wellbeing offer that meets the needs of our diverse workforce	Offer is co-produced with representative pools of colleagues Colleagues from across the organisation utilise the offer Qualitative feedback on wellbeing interventions and their impact Number of staff accessing health and wellbeing support and how representative this is. Number of staff attending and/or number of

2022/23 Goal	Measure of success
	sessions for Schwartz Rounds, TRiM, Balint Groups, Psychological First Aid, Health promotion and wellbeing sessions
Improve our staff survey	Higher number of responses to survey Reduction in numbers reporting discrimination Reduction numbers reporting bullying Civility improvement
Modernising our people practice	
Review and streamline our job evaluation processes.	Time between a role being put forward for job evaluation and the banding being completed.
Complete implementation of the TSS stabilisation programme.	Completion of project plan and improvement in bank and agency fill rates.
Embed the principles of Just Culture in the management of all formal HR processes.	Completion of the review of all the HR processes. Staff survey scores around raising concerns.
Colleagues experience fair and equitable short- and long-term sickness management processes to address disproportionate application of capability process on colleagues with disabilities	Colleagues with disabilities not being overrepresented within the capability process % of Disabled staff entering formal capability processes compared to all other staff
HR process and process implementation are free from bias	Black, Asian and Minority Ethnic colleagues are not over-represented across HR processes
Embed the learning from COVID19	Agile working policy Embed hybrid model of working Embed flexible working
Sustainability Goals	
Transforming with digital	
Bring together clinicians, ICT, service users and carers to develop a clear strategy and five-year roadmap for how digital and technology will enable clinical services, quality and people transformations and developments.	Working/steering group established to identify digital improvements needed and confirm what is possible The roadmap focuses use of technology in key priority areas identified in our clinical services, quality and people strategic priorities.

2022/23 Goal	Measure of success
	Developments identified will reduce and not exacerbate inequalities. Roadmap developed, consulted on, circulated and understood.
Develop our business intelligence capability to improve the information and insights available for developing services and user experience.	Increased provision of Power BI analysis reports to support service level strategic priorities and other critical areas Implement next phases of Integrated Performance Dashboard (IPD) development plan, including drill-down to service-level and progressing phased plan to define and include revised domain metrics and service specific where possible.
Complete work to ensure digital skills development for all staff who need skills update.	Complete the work required to auto-register all personnel for the NHS DLS IT Skills Pathway.
Changing through partnerships	
Continue to work with local partners to develop the vision, approach and structure for the Birmingham and Solihull ICS	ICS fully operational from 1 July 2022.
Driving the development of the BSOL MHLDA provider collaborative aligned to the ICS and supporting our key tests of reducing inequalities, managing demand, improving access, experience and outcomes, improving safety, and achieving value for money, including lead provider governance and infrastructure and partnership governance.	Developing partnership arrangements, both in terms of governance and processes and partnership culture and values. Developing lead provider arrangements and assessing impact on the Trust, including commissioning, contracting and finance. Regular communications and engagement with staff and stakeholders. Provider collaborative has full responsibility from 1 April 2023.
Work in partnership with system partners to redesign and integrate pathways between secure care and secondary care services to ensure care is provided in the right setting, improving patient experience and outcomes, achieving greater system efficiency.	This goal and any milestones will be confirmed by the new Associate Director for Reach Out Commissioning.
Continue to play an active role to ensure readiness for the CAMHS provider collaborative to go live on 1 July 2022.	Agreement of partnership agreement, information sharing protocol and risk share agreement. Go live on 1 July 2022.
Develop our approach and play an active role in the perinatal provider collaborative in readiness for go live between 1 January and 1 April 2023.	Internal discussion to agree the Trust's approach. Discussions with the other West Midlands provider.

2022/23 Goal	Measure of success
	Go live between 1 January and 1 April 2023.
Review and refresh our Partnership Framework to support the delivery of our strategy across regional, local (place), and neighbourhood partnerships with the NHS, local authority, voluntary and community sector, and other statutory bodies.	The Partnership Framework is aligned to our strategic priorities, is widely circulated and understood and enables us to set subsequent goals and measures of success.
Caring for the environment	
Carry out a full review of data and information on waste tonnage and financial data and identify appropriate actions to reduce waste.	Trust review of data carried out supported by SSL and appropriate actions included in 2022/23 action plan.
Develop an options paper/ Business Case regarding installation of EV charging points for staff and visitors, to support a Trustwide Staff Charging Strategy (as per NHS Carbon Net Zero Strategy and Greening the NHS)	Enabling the Trust to have factual information to decide on the investment in installation of charging points. The Trust will have to view this in the round considering the management of vehicles on sites, the movement and vacating of the charging points, the recovery of payment for usage, etc. All within a Trustwide Staff Charging Strategy.
Site by site review about developing an 'opt-in' waste recycling provision (diverting waste from energy recovery to recycling as per waste management hierarchy (as per NHS Carbon Net Zero Strategy and Greening the NHS)).	Number of sites adopting the recycling provision.
To procure 100% of the directly purchased electricity from zero carbon supplies (as per NHS Carbon Net Zero Strategy)	Confirmation from Supplier that the Trust has achieved 100% zero carbon supply on electricity purchased.
To support the Trust on development and delivery of a Capital Programme for 2022/23 and deliver against each of the individual projects meeting time, cost and quality parameters within client requirements.	Achieve time, cost and quality parameters within client requirements on the overall Capital Programme.
Balancing the books	
Develop delivery plans and timescales for efficiency schemes following development of the PIDs and CQEIAs for these.	Delivery plans and timescales developed. Delivery of savings.
Formalise revenue and capital plans for the medium term.	Revenue and capital plans developed and formalised for 2023/24 and 2025/26.
Complete work to create and deliver a training financial training package across the organisation, including roles and responsibilities in procurement.	Develop one ‘refresher’ training course and review online learning options.
Develop a suite of reports to enable the organisation to understand the financial	Develop list of reports that finance would use via Power BI / Expand the use of service line reporting.

2022/23 Goal	Measure of success
position in detail, supplementing the existing budget reports.	Start using service line reporting in local FPPs. Develop finance reports based on information produced from PLICS system.
Good governance	
To undertake a skills analysis of the Board of Directors in relation to succession planning for 2022/2023	Successful recruitment to Non-Executive Director vacancies occurring within the next 12–18-month period
To undertake a full review of the Trust Constitution and Standing Orders incorporating any recommendations from forthcoming CQC Inspection	Ensuring clear processes are in place, approved by the Board of Directors and Council of Governors
To undertake a yearly self-assessment on all Board Committees on their effectiveness	Clear decision making in line with Committee responsibilities and aligned to risks on the Board Assurance Framework
To undertake a review of all groups reporting into Board Sub Committees with the explicit aim to rationalise the number and remove any duplication	Clear lines of responsibility and decision making of groups reporting into Board Committees.
Develop a clear Corporate Social Responsibility framework so the Trust is contributing positively to the lives of local people and the environment in which they live.	Finalising a baseline assessment with gaps/recommendations identified. Development of the CSR framework. Identify a lead or champion for CSR and social value.
Be an anchor organisation around procurement and employment, stimulating social value through our supply chain and a range of accessible and targeted employment opportunities, to improve the wellbeing of local people, reduce inequalities and contribute to the local economy.	Assess effectiveness, e.g. • How many more goods and services are sourced locally and from organisations that offer a living wage compared to previous years. • Analysis of new staff recruited by protected characteristics and demographic data. Identify future actions.

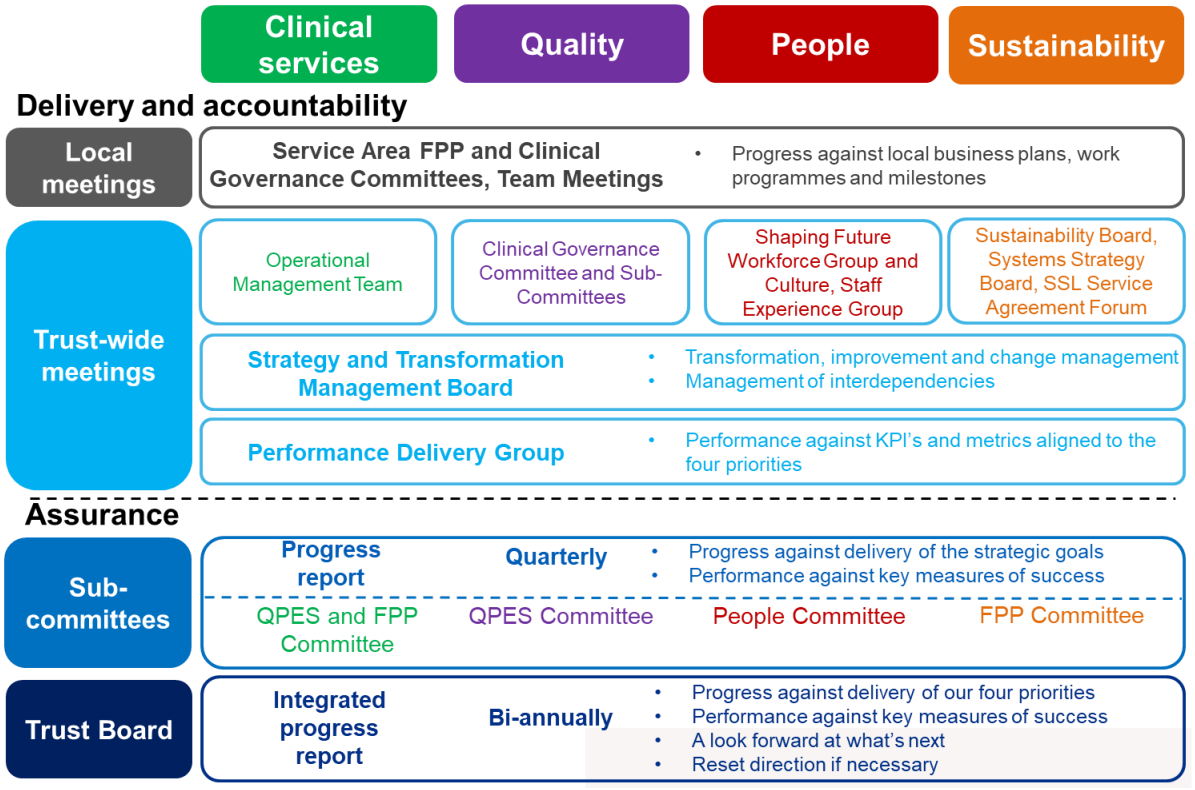
5. Strategy Accountability Framework

Our Strategy Accountability Framework sets out how we will ensure we have robust processes in place for the delivery, monitoring and reporting of the ambitions set out in the Strategy. This includes:

- Ensuring we have clear plans for what we need to do to deliver the strategy that can be used to prioritise our resources and programmes of work.

- The cascade of objectives and monitoring through the organisation on an individual level, a team/service level, and a Trust level – so delivery of our strategy becomes everyone's business and it is clear where accountability lies.
- How we know we are delivering the strategy and making a difference – defining measures of success such as KPIs, outcome measures and qualitative feedback as well as monitoring against delivery milestones.
- Clear routes for assurance to Trust Board and the Sub-committees.

The following diagrams show our Strategy Accountability Framework:



6. Conclusion

Trust Board are asked to:

- **Note** the progress made in 2021/22 in delivering our Trust Strategy
- **Approve** the 2022/23 strategic goals for our four strategic priorities.

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS**
AGENDA ITEM	**14**
PAPER TITLE	**SUSTAINABILITY STRATEGY - CARBON NET ZERO – OUR GREEN PLAN**
DATE	18 May 2022
AUTHOR	Neil Hathaway Director of Operations SSL Neil Cross Sustainability and Corporate Property Manager SSL
EXECUTIVE SPONSOR	Dave Tomlinson Executive Director of Finance Richard Sollars Associate 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?	

Executive summary & Recommendations:

Sustainability Development Strategy and Action Plan developed late 2021 and submitted to Trust Executive Team. This has been further developed to the updated strategic **Carbon Net Zero -Our Green Plan** document as attached.

The new plan has been developed in conjunction with Environmental Consultants appointed by BSol ICO to ensure BSMHFT are in-line as an NHS System and consider NHSEI national agenda's and key NHS National targets.

The Trust Board are asked to examine, accept, and support 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.

Reason for consideration:

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

- 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
- 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 is these future NHS National targets that will be disaggregated and agreed for each ICO and provider organization. BSMHFT as an NHS provider will need to work with such priorities and targets progressing key actions as detailed in the plan all aiming at achieving the Trusts established objectives.

Previous consideration of report by:

The Sustainability Development Strategy and Action Plan was developed late 2021. The new Plan has been prepared to reflect the developments under progress for 2022/2023.

- The increased net zero targeted work progressed for BSMHFT by SSL
- Reflect the BSol ICO position on Sustainability and their Green Plan
- Food waste recycling introduction at all sites with production kitchens and large patient/ staff food production quantities
- Movement of all electricity supply procured to net zero carbon for 2022/23
- Evolve through natural lifecycle on fleet vehicles replacing with hybrid/fully electric vehicles.
- Installation of fleet electric vehicle charging points strategically across the Trust and SSL estate.
- Achieve and maintain excellent waste management data, whereby less than 1% of all waste going to landfill
- Develop partnerships whereby we achieve free one week bus passes for all Trust/ SSL starters, plus looking to expand this partnership for further discounts for regular passengers

A further iteration of this Plan with; all national data target development, BSMHFT and SSL progress, national data sets re Carbon emissions available, etc. will be ready and submitted to Trust board during Q3 2022/23.

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)*

All initiatives will be cognisant of full financial implications. Initiatives such as food waste management, procurement of energy and utilities, overall waste management, fleet vehicular management will examine all investment and revenue implications. All such individual financial impacts will be progressed in partnership with Finance and Procurement and in line with Trust SFIs and SSL Scheme of Delegation.

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

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

From a strategic perspective - The Sustainability Development Strategy and Action Plan was developed late 2021 to give BSMHFT a start point and to align with NHSE/I requirements re 'Green Plan' or equivalent by Jan 22. The messages and challenges within the Carbon Net Zero – 'Our Green Plan' (attached) have been shared within the Trust with Exec / Non-Exec colleagues, Trade Unions and with other Trust and SSL colleagues. In addition, the Plan has been developed alongside the CCG / ICO – The Green Board and NHSEI Net Zero Carbon representatives. A further (enhanced) Plan will be developed by end Q3 2022/23 to allow for gap analysis, further operational engagement and to establish our full Scope 3 Carbon baseline.

NHS

Birmingham and Solihull
Mental Health NHS Foundation Trust

Carbon Net Zero – "Our Green Plan 2021 - 2026"

Prepared in partnership with

SSL+

Contents

Foreword

‘Our Green Plan’ represents a journey of how the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) will move towards Carbon Net Zero.

This document will embed Environmental and Sustainability principles further into our Business As Usual processes – aiming to create a Green currency and a new way of describing information, values or targets equivalent to that of financial.

This Green Plan has been written in two stages:

The First Stage reflects on our journey so far and our reasons to embark on it, including the premise for our targets and many of the interventions needed for us to reach them.

At this First Stage, the Plan deliberately avoids the setting of baseline and associated gap analysis due to Regional and National reports / instructions and data publications expected in summer 2022 that must be considered before finalising such important information and metrics.

At the Second Stage of this Plan, we expect further details and more in-depth targets in late 2022 / early 2023.Again, this will be subject to further Board approval.

An indispensable characteristic of each of these stages is Recognition. As this Plan will demonstrate, there are many challenges ahead. However, we all should pause and recognise the significant progress that the Trust has made to date, its’ Regional and National recognition and the many interventions already achieved, in progress and planned.

We hope that this plan has been written for BSMHFT in such a manner that it will be owned, developed, and delivered by all members of the Trust: Executives

Dave Tomlinson - Executive Director of Finance and Winston Weir - Non-Executive Director

Progress to date – recognising our achievements

- Won national HSJ in 2009 and Finalists again in 2010. Been recognised by NHSE/I for reporting
- Has Board level Executive Director and Non-Executive Director Leadership and strategic framework
- Has leadership and Management through SSL via the Corporate Property and Sustainability Manager and Operational Director
- Has been recognised previously for Sustainability reporting best practice
- Been improving processes over several years to inform medicine management and reduce Medicine wastage and excess stock
- Reflect the BSol ICO position on Sustainability and their Green Plan
- Food waste recycling introduction at all sites with production kitchens and large patient/ staff food production quantities
- Movement of all electricity supply procured to net zero carbon for 2022/23
- Evolve through natural lifecycle on fleet vehicles replacing with hybrid/fully electric vehicles.
- Installation of fleet electric vehicle charging points strategically across the Trust and SSL estate.
- Achieve and maintain excellent waste management data, whereby less than 1% of all waste going to landfill
- Develop partnerships whereby we achieve free one week bus passes for all Trust/ SSL starters, plus looking to expand this partnership for further discounts for regular passengers
- Installed Ground Source Heat Pumps
- Rationalised buildings to mitigated wasted space and promote efficiencies
- Already started to introduce electric / electric hybrid fleet vehicles and associated fleet charging points
- Normalised building improvements / capital and revenue schemes to include modern energy efficient and environmentally prudent components - such as LED lighting, heating and lighting controls and insulation
- Has already reduced its Carbon equivalent (scope 1 and 2 (aspects of) emissions) from 2008 baseline by in excess of 50%

Introduction

"*While the NHS is already a world leader in sustainability, as the biggest employer in this country and comprising nearly a tenth of the UK economy, we're both part of the problem and part of the solution.*

That's why we are mobilising our 1.3 million staff to take action for a greener NHS, and it's why we have worked with the world's leading experts to help set a practical, evidence-based and ambitious route map and date for the NHS to reach net zero."
Sir Simon Stevens, former NHS Chief Executive

A sustainable society is a thriving, inclusive society with cultural vitality, which uses its resources efficiently and sensibly, has a pleasant and healthy environment, which is treated responsibly and sensitively whilst meeting social needs.

For Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) this means continuing to provide the same high or a further enhanced standard of healthcare for all our service users whilst managing our resources better and minimising our negative impact on the environment.

Our climate is changing for the worse due to our actions and is threatening our quality of life by impacting our health, environment, economy, and society. We now know that the main cause of climate change is the emission of greenhouse gases, of which carbon dioxide (CO_2) and methane are the most significant.

We are all experiencing the impacts of climate change and Birmingham and Solihull will increasingly be affected by climate change resulting from previously emitted CO_2 and methane.

We must be prepared for this, with our four clear overarching priorities being:

- Sustainable production and consumption – working towards achieving more with less, reducing the inefficient use of resources and breaking the link between economic growth and environmental degradation.
- Natural resource protection and environmental enhancement – protecting and replacing the natural resources which we depend on.
- Sustainable communities – creating places where people want to live and work in, now and in the future.

- Climate change and energy – confronting the greatest threat by changing the way we use, procure, and generate energy.

The Trust has won and been finalists at several Health Service Journal awards for its approach to Sustainable Development. In addition, the Sustainability and Carbon reporting undertaken by Summerhill Services Ltd (SSL) on behalf of the Trust has been recognised nationally as an exemplar of best practice.

To continue the success of the work already done, the Trust already has plans and strategy in place that are being amalgamated into this single Green Plan and accompanying Area of Focus Action Plans to allow for joined up delivery and real outputs.

Executive Summary

BSMHFT is committed to the principles of Sustainable Development and will progressively integrate these principles into our daily activities.

Through our work with the Department of Health, NHSI/E, other Government departments and our communities we will seek to increase awareness of sustainability and to ensure that our activities support the achievement of sustainable development objectives wherever possible, whilst underpinning the improvement of health and well-being.

Investment will be needed in greener technologies, renewable energy, heat decarbonisation and in ensuring that staff and contractors have the ability and knowledge necessary to support and lead positive changes.

This Plan and Actions need to be owned by all within the Trust, with staff and contractors empowered to make and promote sustainable choices and changes.

It must be recognised that the 'big ticket' items do not always have the greatest impact. Instead, many quick wins at a team and site basis can make a huge impact on the Environmental efficiencies, Carbon emissions and the Sustainability of the Healthcare delivered by and within BSMHFT.

The Trust will need to balance its resources and prioritise accordingly. Patient wellbeing and safety will always come first when considering investment and budgets. Therefore, the organisation must recognise that interventions and ways of working that provide the right direction of travel must be developed without creating a strain on our resources.

This Plan places actions onto teams and individuals to lead and own, benchmark, and deliver real outputs. Although written by SSL on behalf of the Trust, this Plan is not SSL's and it is not SSL's remit to deliver it. However, SSL will help with Green Plan delivery such as within the Estates and Facilities, Travel and Transport, and Food and Nutrition areas of focus.

As per the BSMHFT 2007 Strategy, the ethos and practices of Sustainable Development in its many descriptors must be accepted and owned by all.

Birmingham & Solihull Mental Health NHS Foundation Trust in 2020/21

- Key Services:

In Patient, Specialist Services and Community mental health services

- Services Including:

Assertive outreach, Adult Acute, Crisis resolution, Child and Adolescent mental health (CAMHS), Community mental health, Day treatment, Early intervention, Eating disorders, Forensic mental health, forensic psychiatry, Homeless services, Memory, Neuro-psychology (CBT), Specialist Older Adult Services, Psychiatric, Perinatal mental health, support and recovery.

- Geography:

We provide mental health hospital and community care for the people of Birmingham and Solihull from our sites across the region and National Specialist Services.

- Number of operational Sites: 44
- Footprint of operational Sites: 89,000m2
- Number of Employees: 4,000+ employees
- Inpatient Beds: Circa 700 beds in use at any one time

Trust Key Resources & Baseline Data (Full scope 3 Carbon Data to be established)

- Building Energy: 32.8 million kWh or 32.8 GW
- Baseline year: 2019/20
- Waste arisings: 965.7 tonnes
- Water supplied: 96,896m3
- Procurement activity: £41,812,367
- Patient/visitor/commuting travel: 34,453,615 km

Organisational Vision

Vision & Objectives

- Embedding (continuing to embed) sustainability and low carbon principles into decisions made within BSMHFT and the services provided.
- Invest in renewable and decarbonised energy – using whole life costs to drive decision making and procurement processes. Putting a material value on doing the right thing and 'our' reputation.
- Reduce omissions aiming for that aspirational Zero (net) Carbon status – To support and embrace the NHS (net) Zero carbon commitment. Focussing on key areas that the Trust can influence such as Staff behaviour, Procurement, Buildings, Pharmaceuticals, Vehicles and Journeys and Energy consumption
- Procurement based on whole life cost and not purchase price!
- Ensure that sustainability, carbon mitigation (zero), energy and other environmental initiatives including 'greening of fleet' and 'green' methods of construction and operation are inclusive and embedded into such procurement and developments. Ensuring that lead contractors are tendered for and appointed based on 'best £' and 'quality' including environmental impact. Ensuring that BREEAM assessments are undertaken.
- Reduce waste and being more resource responsible (be that energy, time, products, processes)
- Positively influence providers, partners, suppliers, stakeholders, contractors
- Be the Trust of choice based on Sustainable Development credentials, being rightly recognised regionally and nationally re best practice.
- Empower Staff and contractors to make the right decisions and to take a controlled risk where needed to promote change
- Support and empower our service users to be more sustainable in the way they live their lives both within our care and when residing within the wider community

The Green Plan adds further environmental and social dimensions to the delivery of care, especially in terms of the widely accepted climate and ecological crisis.

Green Plan Vision

Net Zero: resource consumption and Greenhouse Gas (GHG) emission reductions that align with NHS net zero targets and mitigate against climate change.

Climate Resilience: adaptation strategies that strengthen the Trust's ability to maintain quality care and provide a basis for us to become a climate change resilient organisation.

Social Value: actions that influence the collective social wellbeing of patients, staff and surrounding community.

The Green Plan has nine Areas of Focus that appraise the Trust's status and set actions to be achieved within the next three years:

1. Workforce and Systems Leadership
2. Sustainable Models of Care
3. Digital Transformation
4. Travel and Transport
5. Estates and Facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation

Drivers for Change

BSMHFT is committed to deliver the NHS Long Term Plan, Standard Contract, and the recommendations in the Priorities and Operational Planning Guidance and '*Delivering a Net Zero NHS*' report, all of which have informed the Green Plan and shape the Trust's Vision.

The Trust will work through this plan to fulfil sustainable development requirements from the NHS (as shown in Figure 1) and other relevant legislation (as listed on the next page in Figure 2) that are aligned with the relevant United Nations (UN) Sustainable Development Goals (SDGs). This includes obligations to minimise adverse impacts on the environment and secure wider social, economic and environmental benefits for communities.

To explain these requirements further, there are two recent examples to draw from:

Carbon (Net) Zero

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:

- 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
- 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.

In setting these targets It should be recognised that the 'NHS' has already made considerable progress in reducing its footprint with an estimated achievement of a 62% reduction in emissions – well exceeding the 37% requirement for 2020 as outlined in the Climate Changes Act as delivered against a 1990 baseline.

Ultimately it is these future National targets that should be recognised by BSMHFT. Also, not clear at the time of drafting this Document how the data and Carbon % reduction will be disaggregated, recorded and reported and whether nationally any interim milestones will be set. Obviously BSMHFT as an NHS provider will need to work with such priorities and targets as they happen – with Actions as detailed in the plan all aiming at improving the Trusts position.

The Carbon (Net) Zero commitment includes many challenges for the NHS which have been paraphrased and included within the Action Plan appendix. The same also recognises that there will still be carbon associated with Travel / Waste / Energy and where this exists then part of the commitment includes the offsetting of such associated Carbon (financial investment in Carbon mitigation schemes such as planting tress / promotion and preservation of active swamplands. NHS Trusts will need to start to plan for and accrue for this commitment!

In October 2020, Delivering a "Net Zero National Health Service" was published which lays out the direction, scale and pace of change required to meet the challenge. It describes an iterative and adaptive approach, which will periodically review progress and aims to increase the level of ambition over time. The report identifies 8 interventions the NHS is required to implement in order to meet these targets:

1. Our care by developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.

2. Our medicines and supply chain by working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.
3. Our transport and travel by working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4. Our innovation by ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.
5. Our hospitals by supporting the construction of 40 new 'net zero hospitals' as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6. Our heating and lighting by completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7. Our adaptation efforts by building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.
8. Our values and our governance by supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

Greener NHS Programme

Supporting the Net Zero Carbon commitment being the Greener NHS Programme 2020/21 onwards. This Programme recognises that COVID-19 has led to resource's being 'taken off greener NHS work' and that challenges are faced by the Regions as a result of this. The Programme also recognises adversely that improvements have been experienced in climate change related issues, such as improved air quality due to reduced commuting and travel. NHS Trusts are encouraged to learn from their experiences of working as partnerships and collaborations to respond to COVID-19, and they are expected to incorporate benefits from COVID-19 into their own plans and into regional Greener NHS plans.

As with the Carbon (Net) Zero the challenges described within the Greener NHS Programme have been paraphrased and included within the Action Plan.

The Trust commits to review and participate in regional partnerships and strategies related to sustainable development wherever appropriate, in addition to our national commitments.

Priority	Link to our Green Plan
NHS Long Term Plan (LTP)	**2.18** Take action on healthy NHS premises. **2.21** Reduce air pollution from all sources. **2.24** Take a systematic approach to reduce health inequalities. **2.3** Improve preventative care. **2.37** Commission, partner with and champion local charities, social enterprises and community interest companies. **4.38** Make the NHS a consistently great place to work – promoting flexibility, wellbeing and career development. **4.42** Place respect, equality and diversity at the heart of workforce plans. **16** Play a wider role in influencing the shape of local communities. **17** Lead by example in sustainable development and in reducing use of natural resources and the carbon footprint of health and social care **18** Create social value in local communities as an anchor institution.
NHS Standard Contract 21/22 SC18	**18.1** Take all reasonable steps to minimise adverse impact on the environment. **18.2** Maintain and deliver a Green Plan, approved by the Governing Body, in accordance with Green Plan Guidance.
NHS Planning Guidance 21/22 PG	**C1** Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation
NHS Estates 'Net Zero' Carbon Delivery Plan NZCDP	**1.** Making every kWh count: Investing in no-regrets energy saving measures **2.** Preparing buildings for electricity-led heating: Upgrading building fabric **3.** Switching to non-fossil fuel heating: Investing in innovative new energy sources **4.** Increasing on-site renewables: Investing in on-site generation
NHS Greener NHS / Net Zero Plan	Net zero by **2040** for the NHS Carbon Footprint, with 80% reduction by 2028 to 2032. Net zero by **2045** for the NHS Carbon Footprint '*Plus*', with an ambition for an 80% reduction by 2036 to 2039.

Figure 1 NHS Environmental Drivers

Legislative Drivers	UK Guidance
Civil Contingencies Act 2004	National Policy and Planning Framework 2012
Climate Change Act 2008 (as amended)	Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013
Public Services (Social Values) Act 2012	Department for Environment, Food and Rural Affairs (DEFRA) Government Buying Standards for Sustainable Procurement 2016
Mandatory; those mandated within the NHS	The Stern Review 2006; the Economics of Climate Change
Standard Form Contract requirements	Health Protection Agency (HPA) Health Effects of Climate Change 2012
HM Treasury's Sustainability Reporting Framework	The National Adaptation Programme 2013; Making the country resilient to the changing climate
Public Health Outcomes Framework	Department of Environment, Food and Rural Affairs (DEFRA) 25 Year Plan
International	**Health Specific Requirements**
Intergovernmental Panel on Climate Change (IPCC) AR5 2013	Delivering a Net Zero National Health Service 2020 and Greener NHS guidance
UN Sustainable Development Goals (SDGs) 2016	Five Year Forward View 2014
World Health Organisation (WHO) toward environmentally sustainable health systems 2016	Sustainable Development Strategy for the Health and Social Care System 2014-2020
World Health Organisation (WHO) Health 2020	Adaptation Report for the Healthcare System 2015
The Global Climate and Health Alliance. Mitigation and Co-benefits of Climate Change	The Carter Review 2016
	National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012
	Health Technical Memoranda (HTM) and Health Building Notes (HBN)
	Sustainable Transformation Partnerships (STP) Plans

Figure 2 Legislative Drivers with UK Guidance

The UN Sustainable Development Goals

The Trust is working meaningfully towards the United Nations (UN) Sustainable Development Goals (SDGs) through the Green Plan, which have been aligned to relevant SDG targets.

The SDGs underpin a global action framework to 2030, adopted by every UN member country to address the biggest challenges facing humanity.

Each goal has targets and indicators to help nations and organisations prioritise and manage responses to key social, economic and environmental issues.

"The NHS belongs to all of us" *

The NHS and its people contribute to multiple SDGs through the delivery of its core functions, for example, target 3.8, to achieve universal health coverage.

Established on 5th July 1948, the UK's National Health Service is the world's first modern fully universal healthcare system, free at the point of use, and celebrating its 75th year in 2023.

* Constitution of NHS England

Linking the Green Plan to NHS Net Zero

Contributing to around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act.

Two clear and feasible net zero targets for NHS England are outlined in the 'Delivering a 'Net Zero' National Health Service' report (aka NHS Net Zero Report):

- **The NHS Carbon Footprint** for the emissions under direct *control*, net zero by **2040**
- **The NHS Carbon Footprint 'Plus'** for the emissions under *influence*, net zero by **2045**.

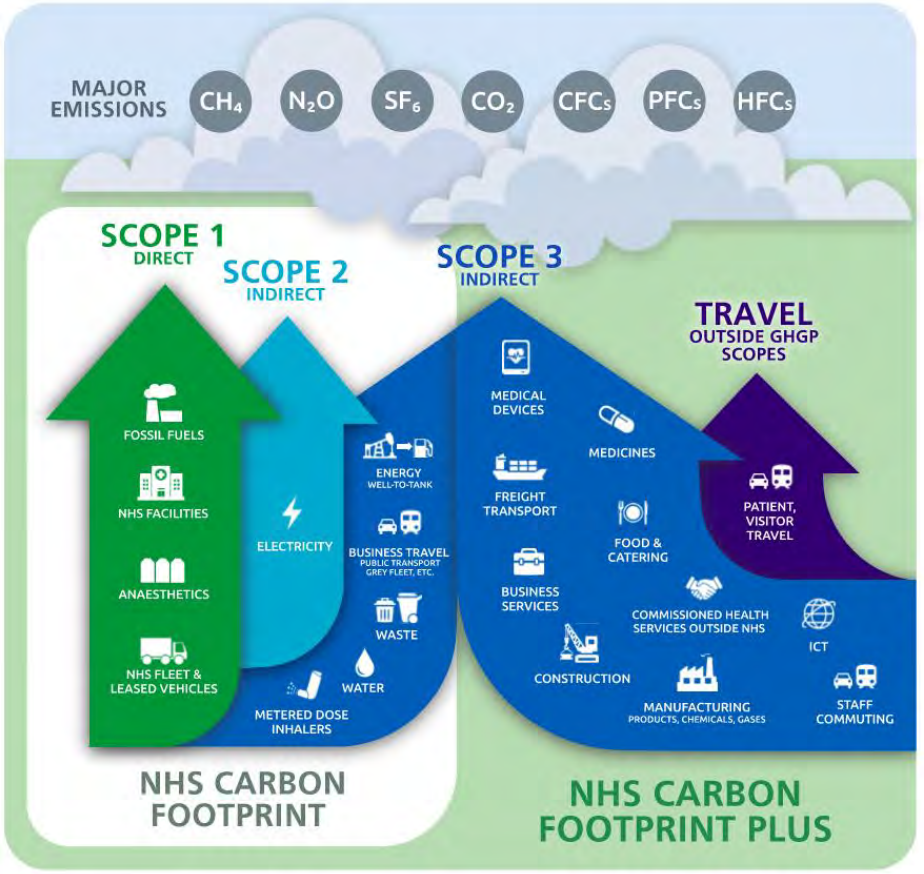
All NHS trusts are to align their Green Plans with NHS England's net zero ambitions. Those emissions have been calculated from all the sources listed in the NHS Net Zero Report should be reduced by approximately 4% year-on-year (akin to Science Based Targets) until each of the relevant target dates.

Greenhouse Gas Emissions

Greenhouse gas emissions are conventionally classified into one of three 'scopes', dependent on what the emission source is and the level of control an organisation has over the emission source. They are reported in 'tonnes of carbon dioxide equivalent' (t CO_2e).

The emission sources and their 'scopes' are shown in the infographic (Figure 3).

Figure 3 Greenhouse gas emission sources, and their 'scopes'



Data and methodology

The result of a GHG emission calculation varies in accuracy depending on the data set provided. The more accurate the data supplied, the more accurate the result, which will subsequently allow for better targeting of areas where improvements can be made.

BSMHFT's GHG emissions footprint has been calculated according to the GHG Protocol for Corporate Reporting and aligned with ISO 14064:1.

The Trust's carbon footprint has been calculated from 2018/19 to 2021/22 in terms of building energy and delivery of care, travel, and the supply chain, as per the categorisations in the NHS Net Zero report.

The Trust has used the following primary data:

- resource consumption (electricity, gas, water) data from utility bills
- waste arisings from data sets from waste contractors
- fleet vehicle fuel use from fuel reports/receipts
- business miles travelled (by car) from the expenses system
- published procurement spend

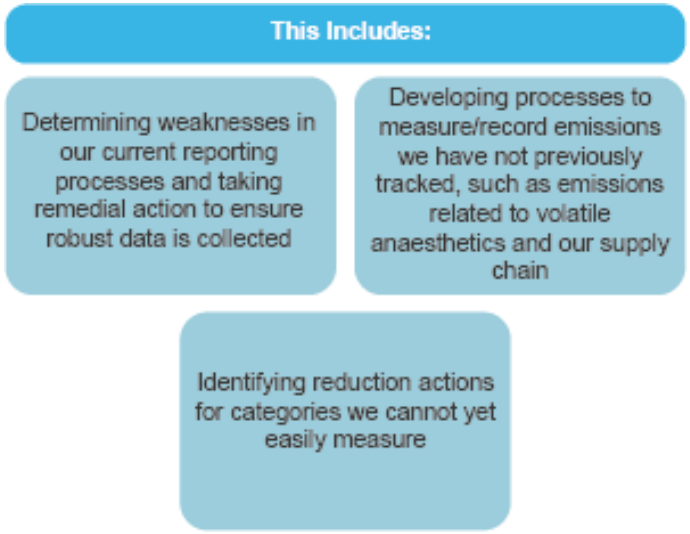
The Trust has used the NHS Health Outcomes of Travel Tool (HOTT) to estimate emissions from staff commuting, patient and visitor travel and published procurement expenditure to derive spend-based emission values for categories within our supply chain.

The Trust is using 2019/20 as the baseline year to set targets against as this is the last full financial year before the COVID-19 pandemic, allowing us to capture the impacts of the resulting negated travel and remote appointments in this Plan.

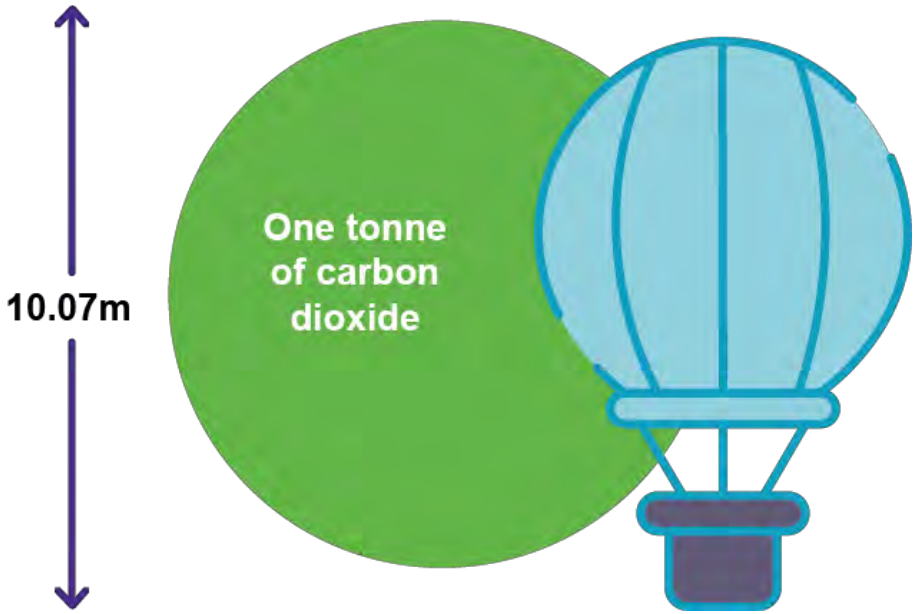
BSMHFT's Net Zero Ambitions

BSMHFT fully commits to reducing greenhouse gas emissions to Net Zero to prevent the worst impacts of climate change and meet NHS Net Zero commitments. This plan outlines high-level emissions reductions and enabling actions for each area of focus. This means BSMHFT needs to act now to reduce emissions from a variety of direct and indirect sources; from the estate to the delivery of care and beyond, each year from now until Net Zero is achieved.

The Trust is using this Green Plan to improve Net Zero-related data collation, carbon footprint and reporting capacity over time.



An emissions-reduction trajectory for each emission source has been given in each Area of Focus (if applicable) from 2021/22 until 2025/26. A series of actions in each Area of Focus has been listed to achieve these emission reductions. There will be residual emissions at both the 2040 and 2045 target dates, which will need to be 'offset' or sequestered (which is not in the scope of this Plan).



What does 1 tonne of carbon dioxide look like?

One tCO_2e can be visualised as a volume of gas the size of a hot air balloon – a sphere about 10 metres in diameter.

The average 3-bedroom semi-detached home in the Midlands emits around 1 tCO_2e per year from electricity consumption and almost 2 tCO_2e from the use of natural gas for heating and cooking.

The Current Position / Baseline

The Carbon Footprint for BSMHFT will be established in full and set using the 2019/20 financial year (this representing the last 'normal' year prior to the pandemic. This will be developed following data and metrics to be issued by NHSEI. An in-depth review of full scope 3 tCO_2e is also to be undertaken.

To meet the NHS Net Zero commitments, calculations, and metrics against the NHSEI requirements will be developed up to 2040/45

Areas of Focus Contents

The following ‘Areas of Focus’ give an overview of the Trust’s current performance/status, each including an Action Plan The Action Plans are lists of activities that the Trust will take to work towards and / or achieve our Green Plan goals by 2025/26. Individual actions are to be monitored and evaluated routinely, and progress status changed accordingly.

Indicative costs and emission reductions are given for each action. These are very high-level assumptions. A key is given below.

This Green Plan applies to all staff who work for or work within Birmingham and Solihull Mental Health Foundation Trust and its wholly owned subsidiary company, SSL. In addition, the principles of, and many actions within this plan should be shared and owned as necessary with approved contractors and when tendering for any works of any kind.

The Actions may have ‘target dates’ but the ethos, culture and behaviours that this Plan expects are for now and with immediate effect. In essence this Strategy and Action plan supports an approach of continuous improvement with ‘no’ end date; being sustainable, reducing carbon and protecting the environment can never be ‘ticked’ as completed.

Key:

Indicative Cost to achieve:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative Emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Workforce and System Leadership

The Trust will build the Green Plan into its strategic planning and governance, including clinical and operational policies and procedures to ensure sustainable development is a part of the Trust's daily work and how success is measured.

The Trust's board-level Net Zero lead will oversee the resourcing and delivery of this Green Plan. Action plans identified by this Green Plan will be reviewed in discussion with Finance and Capital Planning teams to identify suitable budgets. The Trust will seek to identify internal and third-party funding to support the roll-out of Green Plan actions.

This Green Plan is approved by the Trust Board and will be reviewed (and revised if necessary). These reviews and progress against the actions in the Green Plan will be submitted to the Coordinating Commissioner.

Partners and Stakeholders

Stakeholders and partners engagement will be paramount in ensuring change towards a more sustainable future. The need to be sustainable and reduce greenhouse gas emissions is a shared responsibility between our Trust and all whom the Trust (and SSL) work with. We have existing strategic alliances, formal partnerships and provider collaboratives to improve services, pathways and service user outcomes, shared expertise and spread of best practice. For example:

- Birmingham Care Alliance with Birmingham Community Healthcare NHS Foundation Trust
- Joint working with Birmingham Women's and Children's NHS Foundation Trust
- MERIT partnership with the mental health Trusts across the West Midlands
- Reach Out provider collaborative, and lead provider for adult secure care
- A range of partnerships with the community and voluntary sector

In addition to our existing partnerships, the Trust and SSL will need to work with the following:

- Staff and Service users
- Commissioners (CCG)
- Sustainability Transformation Partnership (to include Local Authorities and other NHS Trusts, Strategic Healthcare related organisations
- The Third Sector
- PFI partners
- Contractors / Suppliers / Supply chain
- Local people
- Regulators

Sustainability Groups

The Trust operates an open group with non-executive, executive, union and SSL membership.

NHS LTP 2.24, 17
NHS SC 13.9, 13.10, 18.2, 18
NHS NZ 4.2.3

13 CLIMATE ACTION

Target 13.2 Integrate climate change measures into policy and planning

Target 13.3 Build knowledge and capacity to meet climate change

No	BSMHFT Green Plan Actions	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	To develop a Sustainable Development Strategy and Action Plan that is Board Approved (Green Plan / Net Zero Plan)	21/22		£	✕	SSL/Trust	**SC** 18.2
02	To have an identified and recorded Board level Sponsor / Lead	21/22		£	✕	SSL/Trust	**SC** 18.2
03	Review and approve the plan at the Board level, monitoring delivery at Board meetings and relevant committees.	Ongoing		£	✕	Trust Board	**SC** 18.2
04	Nominate and empower a Climate Change Adaptation Lead and keep the Co-ordinating Commissioner informed at all times of the persons holding these positions.	22/23		£	✕	Trust Board	**LTP** 2.24,17 **SC** 18.2.2
05	Identify budgets for the delivery of each 'area of focus' and the Green Plan as a whole.	22/23		£		Trust Board	**LTP** 2.24,17
06	Streamline data collection processes and produce a comprehensive monthly data report with relevant Green Plan metrics	22/23		£		Estates and Facilities	**NZ** 3.1.1, 3.1.2
07	Produce an annual granular carbon account in line with HM Treasury's 'Public sector annual reports: sustainability reporting guidance', with the intention of widening its scope and data quality, when possible, along with an annual review of the progress against the Green Plan actions / emission reduction targets	22/23		£		Estates and Facilities	**SC** 18.3
08	Ensure staff are resourced to undertake Green Plan duties and nominate a lead person or department for each Green Plan area of focus to develop and coordinate action through the existing Sustainability Steering Group.	23/24		£		Trust Board	**LTP** 2.24,17
09	Ensure the Green Plan delivery is reflected in the corporate risk register.	23/24		£		Trust Board	**LTP** 2.24,17
10	Review procurement plan at board level to achieve a net zero supply chain. Fulfil the Trust's role as an anchor institution to achieve social value and wider benefits for communities, particularly for the Trust's care groups.	23/24		£		Trust Board	**LTP** 2.24,17
11	Identify and action ways to engage patients and community in Green Plan delivery, including links between health inequality and climate action.	23/24		£		HR	**LTP** 2.24,17
12	Identify internal and third-party funding to enable key Green Plan actions.	22/23		£		Estates and Facilities	**LTP** 2.24,17
13	Work in partnership with neighbouring NHS trusts and public authorities to enhance the delivery of the Green Plan and share best practice.	Ongoing		£		Trust Board	**LTP** 2.24,17
14	Ensure quarterly Greener NHS Data Collection uploads are made.	Ongoing		£	✕	Estates and Facilities	**NZ** 3.1.1, 3.1.2

Figure 4 Green Plan actions for system leadership

Workforce

All colleagues are needed for the Trust's Green Plan to be successful.

The NHS is the biggest employer in Europe and the world's largest employer of highly skilled professionals and the NHS Long Term Plan aims to ensure it is a rewarding and supportive place to work.

A 2018 national survey of NHS staff showed that 98% of those surveyed thought it was important that the health and care system works in a way that supports the environment, and BSMHFT will enable colleagues to lead the way to achieve a greener NHS.

However, the Trust's Green Plan needs to be embedded within its culture, with the recognition that people are at the core of the NHS. The Trust already has five sustainability champions, who act as environmentally conscious volunteers to embed the Green Agenda across our organisation. The Trust will empower staff to deliver this Green Plan at all levels of the organisation. To do this, the team will further utilise the Greener NHS "One Year On" Communications Toolkit, currently used for general messaging and press releases.

Key to workforce engagement is communications, and our Trust ensures that projects such as free public transport tasters and salary sacrifice schemes are posted on intranet and promoted through local fliers.

To achieve similar levels of engagement with the Green Plan going forward, there will be monthly intranet posts to expose our staff to the targets and achievements of the Green Plan. In addition, we will produce Green Plan posters to promote the Plan across our sites. These communications projects are being developed to ensure greater embedding of the green agenda across our activities.

NHS LTP 4.1, 4.3, 4.39, 4.42, 4.43, 4.7

NHS SC 13.1 through 13.10

NHS NZ 4.2, 4.2.1, 4.2.2

8 DECENT WORK AND ECONOMIC GROWTH

Target 8.5 Full employment and decent work with equal pay

13 CLIMATE ACTION

Target 13.3 Build knowledge and capacity to meet climate change

16 PEACE, JUSTICE AND STRONG INSTITUTIONS

Target 16.B Promote and enforce non-discriminatory laws and policies

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Establish a Sustainability Group and incorporate the Green Plan into its agenda.	22/23		£	✕	Estates and Facilities	**LTP** 4.1, 4.3, 4.39, 4.42 **SC** 13.1 to 13.10
02	Design and implement a Green Plan promotional campaign to encourage ongoing staff collaboration.	22/23		£	✕	People & OD	**N/A**
02	Building on current practice, review policies and processes against NHS aims for ensuring rewarding, flexible and supportive work, positive action on promoting equalities, including through the Workforce Race Equality Standard and new Workforce Disability Equality Standard, and regular reporting against the NHS Model Employer Strategy.	Ongoing		£	✕	People & OD	**LTP** 4.1, 4.3, 4.39, 4.42 **SC** 13.1 to 13.10
03	Further development of flexible working / homeworking. procedures / policies and resources that support, encourage and / or compensate staff for homeworking.	Ongoing		£		HR/ICT	N/A
04	Incorporate the Green Plan into the Essential Mandatory Training and Induction policies.	22/23		£		Education Services	**NZ** 4.2.1
05	Create Green Plan intranet pages for staff access and external webpages for other stakeholders; upload Green Plan content and progress updates accordingly.	22/23		£	✕	Sustainability Lead	**NZ** 4.2.1

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
06	Use the Green NHS 'ONE YEAR ON' Communications Toolkit and/or the 'Healthier Planet, Healthier People' Toolkit to create and share communications about the Green Plan.	Ongoing		£		Communications & Engagement	**NZ** 4.2.1
07	Encourage staff to actively participate in the Greener NHS community and other forums such as the Greener AHP Hub, Centre for Sustainable Healthcare and related workspaces on the FutureNHS platform.	22/23		£		Communications & Engagement	**NZ** 4.2.1
08	Consult, explore and action how clinical and non-clinical staff can best participate in the Green Plan delivery process, ensuring this is incorporated into workplans, work-time allocations, performance reviews, and collaborating with other trusts where appropriate.	22/23		£		Sustainability Lead	**NZ** 4.2, 4.2.1, 4.2.2, 4.3.3
09	Provide additional training related to this Green Plan to build capability in all staff, including on the link between climate change and health and practical actions that staff can take to help achieve net zero.	23/24		£		Training and Development	**NZ** 4.2.1
10	Work with suppliers to ensure that onsite workers are subject to the Real Living Wage, fair working practices and protections against discrimination.	23/24		£		Procurement & People & OD	**LTP** 4.1, 4.3, 4.39, 4.42

Figure 5 Green Plan actions for workforce

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Sustainable Models of Care

The NHS Long Term Plan updates the NHS service model, with a focus on preventative care in communities and tackling health inequalities, now and in the future. This has been linked to emissions reductions and greener activities.

BSMHFT delivers care from 46 sites across both regions, including inpatient, community and specialist mental health services. These services include rehabilitation, home treatment, community mental health services, assertive outreach, early intervention, inpatient services, day services and mental health wellbeing services.

The National Patient Safety Improvement Programmes and the Investment Impact Fund indicators (IIF) provide underpinning principles for sustainable models of care, such as preventative care interventions and reducing health inequalities. Staff training and empowerment, as detailed in the previous sections, are critical to enhancing sustainable models of care.

Adhering to the Getting it Right First Time programme (GIRFT) helps to avoid additional hospital bed days and patient and visitor travel to clinics, and their associated environmental impacts. Strong interagency partnership working enhances GIRFT, providing a better care package. A GIRFT report quarterly is produced quarterly and the Trust is in the process of strengthening the reporting process.

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Build on current efforts (GIRFT, National Safety Improvement Programme and CMPP) to reduce health inequalities and improve early intervention, linking this work to potential emissions reductions.	Ongoing		£		Trust Board and relevant clinical leads	**LTP** 2.26 **SC**13.9.118.4.2.1 **NZ** 4.1.3
02	Use the Embedding Public Health into Clinical Services Programme's toolkit and Sustainability in Quality Improvement (SusQI) Framework to ensure the best possible health outcomes with minimum financial and environmental costs, while adding positive social value at every opportunity.	Ongoing		£		Trust Board and relevant clinical leads	**LTP** 2.26 **SC**13.9.118.4.2.1 **NZ** 4.1.3
03	Continue to collaborate with other trusts and public authorities on the population's health.	Ongoing		£		Trust Board	**LTP** 1.53 **SC** 18.6 **NZ** 4.1.3
04	Appoint a Health Inequalities Lead to coordinate delivery of an updated Health Inequalities Action Plan.	22/23		£	✕	Trust Board	**LTP** 2.26 **SC** 13.9.2, 13.10 **NZ** 4.1.3
05	Follow Greener NHS guidance or support the development of GHG emissions reduction metrics linked with sustainable care actions, including establishing links between better health outcomes and reduction in emissions from avoided care and travel.	23/24		£	✕	Estates and Facilities	**SC** 18.4.2.1 **NZ** 4.1.1, 4.1.2
06	Work to engage suppliers related to sustainable care in relevant emissions reduction and health equalities activities.	23/24		£	✕	Procurement & service providers	**NZ** 4.1.3
07	Explore new ways of delivering care at or closer to home, meaning fewer patient journeys to hospitals.	Ongoing		£		Clinical divisions	**NZ** 4.1.1

Figure 6 Green Plan actions for Sustainable care models

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

✕ Not applicable

Digital Transformation

The NHS Long Term Plan commits all NHS bodies to focus on digital transformation by establishing a 'digital front door', enabling digital first care. The NHS App is one example of this, providing patients with a simple and secure way to access NHS services on their smartphone.

The NHS Planning Guidance requires that at least 25% of all clinically necessary outpatient appointments should be delivered remotely by telephone or video consultation. Streamlining and digitising administrative functions also reduces paper waste and expedites processes.

As a Global Digital Exemplar (GDE) Trust and as the highest scoring mental health trust on the Digital Maturity scale, BSMHFT strives to use digital care as a tool to promote inclusion and increase access to quality care across Birmingham and Solihull. We are committed to ensuring that digital services are tailored to meet the needs of the different specific care groups. The Government's Greening ICT and Digital Services Strategy 2020-2025 is also taken into consideration when looking at the improvement of the Trust's digital care services.

The 'What Good Looks Like' framework', designed to guide Trusts towards the successful integration of digital care systems, neatly summarises the Trust's position:

'The pandemic enabled us to achieve a level of digital transformation that might have otherwise taken several years. As we move into the recovery period, it is critical that we build on the progress we've made and ensure that all health and care providers have a strong foundation in digital practice'.

Digital Services

Since the beginning of the pandemic, the number of face-to-face, telephone and video consultations has increased significantly. However, there will always be a need for face-to-face appointments and consultations for some patient groups.

The COVID-19 pandemic has led to a blended working approach, especially for office-based staff – for example, a mixture of in office and home-based working. Many staff now work in an agile way, and the Trust is exploring how to embed this as a new sustainable way of working.

Microsoft Teams is used across the Trust. It has massively impacted the way staff groups communicate, with a knock-on effect on the use of space and resource efficiency across our estate.

To facilitate this transition, there has been a rollout of devices to allow for agile working which increases efficiency, reduces travel and the need for dedicated desk space.

The Trust has been driven towards the digitalisation of patient records in recent years, albeit with some inertia from some staff members. It will be important to communicate the importance of digitalisation to all our workforce to minimise this. Appointment and result letters have been digitised where possible, in addition to a complete digitalisation of expense claims. SMS messages are used for appointment reminders and 90-100% of community based and peripatetic workers such as district nurses have access to mobile digital services.

Going forwards, the Trust endeavours to build on the opportunities afforded from our rapid rollout of digital solutions and technology that occurred during the COVID-19 pandemic. This includes taking part in new digital research in order to adopt digital forms of service delivery which are underpinned by research and service evaluation. We also aim to develop share care records and systems and a technology roadmap to determine how we can implement opportunities identified in our Trust Strategy.

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	To increase capacity and ease of home working from a connectivity / ICT perspective	Ongoing		£		ICT	**PG** C1
02	Increase capacity and effectiveness of ICT and communications devices to allow for TEAMs / ZOOM and equivalent meetings, reducing reliance on buildings / space and travel	Ongoing		£		ICT	**PG** C1
03	Work with neighbouring Trusts and Birmingham and Solihull ICS to develop a shared care record.	22/23		£	✕	ICT	**PG C1**
04	Utilise our Global Digital Exemplar status to engage with digital research.	Ongoing		£	✕	ICT	**PG C1**
05	Ensure our staff are digitally literate by providing training sessions.	Ongoing		£	✕	ICT	**PG C1**
06	Develop a technology roadmap to determine how we can implement the opportunities identified in this plan and previous strategies.	22/23		£	✕	ICT & Sustainability manager	**PG C1**

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
07	Build on current practice and current online patient guidance, participate in delivery of the Long-Term Plan commitments for digital first primary care and an NHS digital front door, linking this to potential emissions reductions.	Ongoing		£	⊗	ICT	**LTP** 1.43, 1.44, 5 **NZ** 4.1.4
08	Follow NHS guidance on information collection, including any subsequent process for GHG emissions reduction metrics linked with digital-first care actions, such as the CSH's Carbon Calculator for Avoided Patient Travel	Ongoing		£	⊗	Sustainability manager & Infrastructure services.	**SC** 28
09	Offer more digital and remote appointments to staff and patients.	22/23		£		Care Groups	**PG** C1
10	Use the What Good Looks Like Framework, the Greening Government: ICT and Digital Services Strategy 2020-25 and The Technology Code of Practice as guides to ensure the Trust has robust ICT systems in place to deliver on digital transformation.	23/24		£		ICT	**NZ** 4.1.4
11	Build on current practice of engaging staff and care groups in digital care channels, meaning fewer patient journeys.	Ongoing		£		ICT	**NZ** 4.1.4 **PG** C1
12	Transfer paper-based systems such as prescribing, bed state, observations, ward state, referrals, and expense claims forms to a digital alternative.	23/24		£		ICT	**LTP** 1.43, 1.44, 5
13	Planned migration of data systems to cloud-based systems. Adoption of staff and patient portals. Continued cyclical replacement programme of IT hardware, including the provision of smart phones to all front-line staff.	23/24		£		ICT& Business & Value	**LTP** 1.43, 1.44, 5

Figure 7 Green Plan actions for digital transformation

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Travel and Transport

The Trust is committed to developing a Green Travel Plan, outlining the aims and objectives related to reducing congestion, single occupancy travel, and CO_2 emissions. It will explore how to promote active travel to staff and visitors. In addition, the Trust will produce site-specific plans to focus on the individual challenges of each hospital.

Emissions associated with the Trust's business travel could not be determined due to the current unavailability of business expense data. This will be amended in future carbon footprint reporting.

However, using the NHS' Health Outcomes Travel Tool (HOTT), most transport-related emissions (3,671 tCO_2e) can be linked to staff commuting and patient/visitor travel.

BSMHFT Fleet Vehicles

The Trust operates a fleet of 72 vehicles, which are used for a variety of purposes. These include non-emergency patient transport, PPE distribution, estates team usage, portering, facilities and general transport services. The Trust leases all of its official vehicles, meaning a modern fleet and circa 35% are hybrid or electric.

In 2019/20, these vehicles travelled in the region of 570,000 miles.

The new NHS Non-Emergency Patient Transport Services (NEPTS) target is to have:

- From 2023, **50%** of all fleet vehicles to be of the latest emissions standards, Ultra-low Emission Vehicles (ULEVs, such as plug-in electric hybrid), or Zero Emission Vehicles (ZEVs, such as electric cars)
- From 2025, **75%** of all fleet vehicles to be of the latest emissions standards, ULEVs or ZEVs
- From 2030, **100%** of all fleet vehicles to be ULEVs or ZEVs, including a minimum of 20% ZEVs

At present, ULEV and ZEV large vans are limited, though more will be coming onto the market.

ULEV and ZEV small vans and cars are becoming commonplace, with many options available.

BSMHFT needs to undertake a fleet review to see how the vans and large vans are being used, and whether suitable ULEVs and ZEVs are available. Additionally, the Trust must review the choice of company cars on offer and change the specifications to reflect the targets within the NEPTS.

If the Trust changed all of the fleet vehicles to ZEVs, based on 2019/20 data and using 100% renewable electricity, there would be a significant drop in emissions (emissions associated with electric vehicles are due to transmission and distribution losses in the national grid). This would result in total emissions

Aside from the electrification of transport, the Trust needs to reduce emissions from the fleet further by 2025/26, data and targets to be established. equating to just over xx tCO_2e per year.

Other Lease Vehicles

Staff have the option to lease personal vehicles through the NHS Fleet Solutions Salary Sacrifice Scheme.

Emissions from these vehicles (used for staff personal use) are outside of the scope of this report (although they do impact on emissions arising from commuting somewhat). However, as a Trust, the availability of vehicles on offer can be limited based on their engine size and emissions. Furthermore, the Trust can incentivise staff to choose Ultra Low Emission Vehicles (plugin hybrid cars) or Zero Emission Vehicles (electric cars).

Grey Fleet

The Trust has a 'grey fleet', which refers to employees' own vehicles and/or hire cars used for business purposes. As a Trust that provides care in the community, emissions associated with the grey fleet are sizeable.

BSMHFT reimburses staff and bank staff for the fuel used in line with their duties through an expenses system. However, the grey fleet emissions could not be determined due to the unavailability of expenses data. This will be amended in future carbon footprint reporting.

It is worth noting that in 2020/21, with the changed working styles affected by the pandemic, grey fleet mileage and therefore greenhouse gas emissions are projected to have fallen. Although mileage from business meetings and travel into offices fell, travel for care in the community continued. The changes in working practice associated with travel negation should continue to further greenhouse gas emission reduction.

As the electrification of transport continues, the emissions will reduce accordingly. This also brings forth the issue of providing additional electric vehicle charge points in the future.

Electric Vehicle Charging Infrastructure

At the time of writing, we are in the process of installing EV charging points at 10 of our sites, for use by Trust fleet vehicles only. We will look to invest in publicly accessible charging points going forward to further encourage EV uptake.

Business Travel (public transport)

The Trust also reimburses staff for business travel through the expenses system. However, these emissions cannot be determined at this time, as data is unavailable. This will be amended in future carbon footprint reporting.

Commuting, Visitor/Patient Travel

The Trust operates a salary sacrifice cycle to work scheme with cycle parking facilities available at most of our sites.

Increasing the number of cycle parking spaces, improving shower/changing facilities, and offering other incentives for active travel will be explored.

Public transport is widely available across the region, however our Trust has over 50 sites across Birmingham and Solihull and there are certain areas with less availability. Bus travel is promoted to staff through a scheme offering a week of free travel for all new starters in addition to a discounted scheme for all NHS staff through National Express; the portal through our intranet offers season tickets. Train travel is offered through salary sacrifice.

The previous travel survey was undertaken in 2014, and we endeavour to update this in our next Travel Plan. In lieu of any recent travel plan survey data, which will be collected annually going forward, the NHS HOTT Tool has been used to estimate the emissions associated with staff commuting and patient and visitor travel. The HOTT Tool uses national and regional datasets to generate figures for transport mode, distances, and emissions from a 2018 baseline and projections into the near future (shown in Figure 13).

However, these figures are indicative and need to be bolstered and verified by local travel plan survey data. Hence, the impacts of COVID-19, with less need for commuting, do not fully feature in the results (the sequentially lower emissions are attributed to improvements in vehicle efficiencies and electrification of transport).

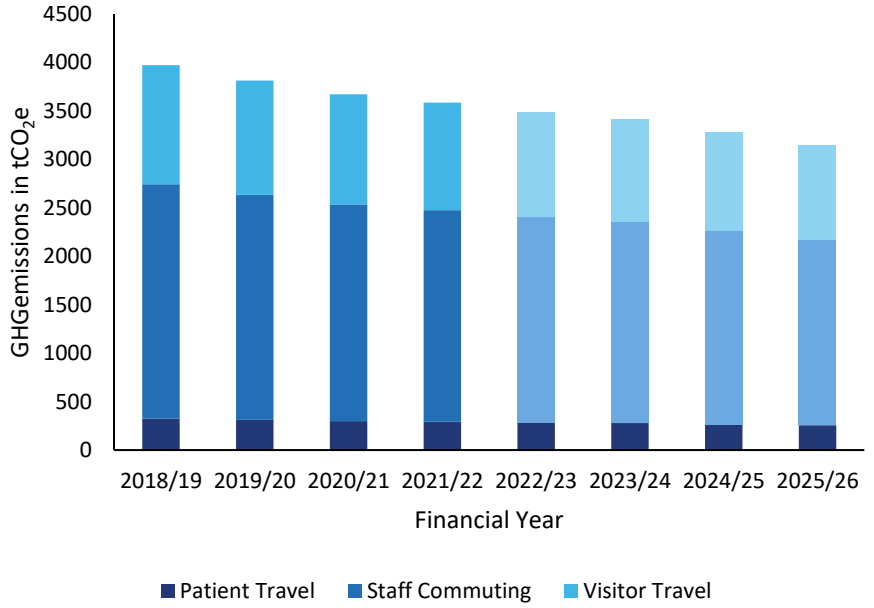


Figure 8 Stacked bar chart to show total emissions from patient, visitor and staff travel and emissions reduction trajectory to 2025/26

Air Quality

Air quality, climate change and health outcomes are highly interconnected, and the NHS Net Zero plan calculates that reaching UK ambitions on emissions reductions in line with Paris Agreement targets could save 38,000 lives with improved air quality.

According to the World Health Organisation (WHO), poor air quality leads to over 7 million deaths globally and that 9 out of 10 people worldwide breathe polluted air.

The topic of air quality is of particular significance in Birmingham as there is a Clean Air Zone (CAZ) that targets older, higher polluting vehicles and drivers. The zone imposes a daily levy to enter into or pass through a dedicated zone in the city centre.

Travel is a key contributor to air pollution, and with as many as 1 in 20 road journeys in the UK attributable to the NHS, the Trust's activity has enormous potential impact on local communities' air quality. Additionally, the gas-fired boilers that the Trust uses contribute to air pollution, and the decarbonisation of heating will address these pollutants in the future.

The Trust commits to tackling this issue through investment and engagement with staff, patients and partner local authorities. The Trust will give special consideration to the air quality surrounding the estate and opportunities to improve its impacts on care groups.

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Scope the need for and make decisions on whether Trust sites are to be developed to support public electric charging points and to develop appropriate Business Cases, Policy and Procedure.	21/22		£	✕	SSL	N/A
02	Use location as part of patient caseload planning to ensure effective journeys and routes, reducing time spent travelling.	21/22		£	✕	Finance	N/A
03	Review and enhance cycling facilities across the estate.	23/24		£		Estates and Facilities	N/A
04	Develop a car-sharing scheme for staff.	23/24		£	✕	Estates and Facilities	**NZ** 3.2, 3.2.2
05	Embed an updated sustainable travel plan, with new modal shift targets to be supported by an active travel expenses policy and facilities review.	23/24		£		Estates and Facilities	**LTP** 2.21, 3.82, 17 **SC** 18.4.1.3 **NZ** 3.2, 3.2.2
06	Conduct annual Travel Plan surveys to quantify staff commuting and visitor travel and verify HOTT Tool outputs.	Annual, ongoing		£	✕	Estates and Facilities	**NZ** 3.2, 3.2.2

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
07	Review existing staff lease scheme and incorporate additional incentives for the uptake of ULEV and ZEVs.	23/24		£		Finance	**NZ** 3.2, 3.2.2
08	Undertake a Green Fleet review of the fleet vehicles to ascertain usage and distance travelled, with a view to integrating ULEVs and ZEVs	23/24		£		Finance	**NZ** 3.2, 3.2.2
09	Ensure that any new vehicle purchased or leased are ultra-low emission (ULEV) or zero emission (ZEV) from 2023, in line with the latest NHS non-emergency transport guidance.	23/24		£		Estates and Facilities	**SC**.18.4.1.1, 18.4.1.4 **NZ** 3.2.1
10	Enhance the staff mileage reimbursement system to collate vehicle type/engine size and fuel type data to allow more accurate emissions foot printing, monitoring and reduction targets.	23/24		£	⊗	Finance	**NZ** 3.2, 3.2.2
11	Enhance the business travel expense system to capture the to- and from-destinations for rail, air, bus and taxi journeys and collate data from expenses.	23/24		£	⊗	Finance	**NZ** 3.2, 3.2.2
12	Improve stores provision and work with suppliers to consolidate goods orders through better planning wherever possible, reducing transport emissions.	23/24		£		Procurement	**NZ** 3.2, 3.2.2
13	Work with staff currently home-working under pandemic conditions to explore voluntary blended working.	23/24		£		HR	**NZ** 3.2, 3.2.2

Figure 9 Green plan actions for Travel, Logistics and Air Quality

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Estates and Facilities

As an NHS Trust, the carbon footprint of the built environment is significant. Overall, the health and care system in England is responsible for an estimated 4-5% of the country's carbon emissions.

As the Trust provides critical services 24 hours a day, energy and resource consumptions are substantial. Therefore, there is a need to optimise energy use in buildings and move away from using fossil fuels to meet NHS Net Zero goals.

The estate comprises several facilities housed in other Trusts' buildings. This presents challenges to retrofitting resource efficiency measures and heating improvements, and BSMHFT will work with other Trusts and the aims of their Green Plans to improve efficiencies at these sites.

The Trust will follow the four-step approach within the NHS' 'Estates 'Net Zero' Carbon Delivery Plan' to address the estate:

1. Making every kWh count: Investing in no-regrets energy saving measures

2. Preparing buildings for electricity-led heating: Upgrading building fabric

3. Switching to non-fossil fuel heating: Investing in innovative new energy sources

4. Increasing on-site renewables: Investing in on-site generation

Estates & Facilities: Energy

- **7,887 tCO_2e** emitted from buildings across the estate in **2019/20.**
- The Trust has procured 100% renewable electricity since April 2020.
- BSMHFT needs to continue reduce energy consumption – investing in renewable energy for example**.**

Energy and Emissions

In 2021/22, there were 41 active sites where BSMHFT was directly responsible for procuring the energy supply contracts. Buildings under the Trust's ownership can be targeted for energy efficiency improvements.

Figure 15 shows the total consumption and emissions liberated from electricity and gas use from 2019/20 to 2021/22. The Trust needs to reduce emissions by 3,319 tCO_2e by 2025/26 from the 2019/20 baseline (this includes the reduction in emissions from procuring renewable electricity).

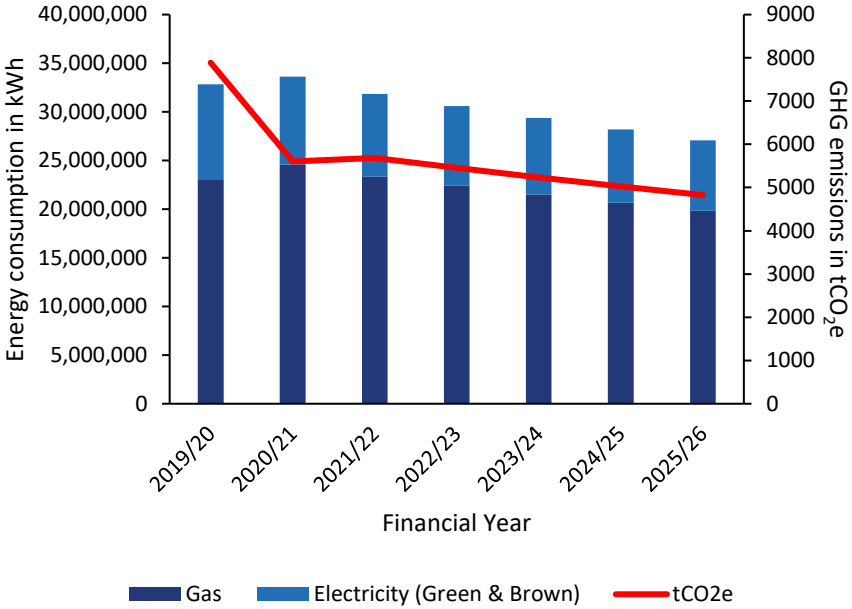


Figure 10 Energy consumption and related emissions from the built environment from 2019/20 to 2021/22 and forecast reductions until 2025/26

The Trust has procured 100% renewable and 'green' electricity from April 2020, resulting in an 80% reduction in emissions arising from procured electricity (as shown in the 'dip' of the red line in Figure 15).

Despite the negated emissions from renewable electricity procurement, there must be a reduction of both electricity and gas consumption at all of the sites, at a rate of 1,313,376 kWh per year.

Building Management Systems (BMS) are in place to regulate the heating and lighting of buildings across our sites. BMS set points are reviewed as part of Planned Preventive Maintenance (PPM) as necessary at all sites.

However, there needs to be a continual improvement and upgrade of the estate.

Detailed building energy surveys will be needed to provide robust energy efficiency recommendations at each of the Trust's sites, building upon the works already completed.

The decarbonisation of the Trust's heating systems will become increasingly important to reach net zero emissions.

This transition will inevitably result in much higher electricity consumption, and of particular concern is the viability of increasing the electrical site capacity (load in kilovolt-amps) from the electricity grid.

Extensive on-site renewable energy systems, such as solar photovoltaics and integrated large battery storage technologies, will help mitigate this, and provide additional resilience to power outages, with the potential to negate using the back-up diesel generators.

NHS LTP 17

NHS SC 18.4.1.2, 18.5

NHS NZ 3.1.1, 3.1.2

7 AFFORDABLE AND CLEAN ENERGY

Target 7.2 Increase global percentage of renewable energy

Target 7.3 Double the improvement in energy efficiency

13 CLIMATE ACTION

Target 13.2 Integrate climate change measures into policy and planning

Target 13.3 Build knowledge and capacity to meet climate change

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Move away from any coal or oil boilers as a primary heat / energy source	21/22		£		Estates and Facilities	N/A
02	Enhance Planned Preventative Maintenance (PPMs) of all facilities and assets to be proactively energy-focused and to identify opportunities to upgrade equipment/plant.	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
03	The Trust will procure 100% renewable electricity with Renewable Energy Guarantees of Origin (REGO) certificates backed by Npower.	22/23		£		Estates and Facilities	**SC** 18.5
04	Access the NHS Energy Efficiency Fund (NEEF) to upgrade all lighting to LED alternatives.	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
05	Follow Estates 'Net Zero' Carbon Delivery Plan guidance on efficiency and decarbonisation protocols for the built environment.	22/23 & ongoing		£		Estates and Facilities	**NZCDP** **NZ** 3.1.1, 3.1.2
06	Install solar photovoltaic meters and collate a monthly generation report.	22/23		£		Estates and Facilities	**NZCDP** **NZ** 3.1.1, 3.1.2
07	Optimise energy use by embedding networked Automatic Meter Readers (AMRs) across the Estate with appropriate controls to reduce energy consumption and report sub-metered data monthly.	23/24		£		Procurement	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
08	Conduct detailed building energy surveys to identify further energy/thermal efficiency opportunities, including the installation of heat recovery systems on Air Handling Units (AHUs).	23/24		£		Estates and Facilities	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
09	Develop a Decarbonisation of Heat Plan that focuses on the phase out of existing gas-fired boilers and replacement with low-carbon alternatives, where feasible.	Ongoing		£		Trust Board	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
10	Explore the possibility of creating District Heat Networks with neighbouring partners.	Ongoing		£		Infrastructure Services	**LTP** 17 **SC** 18.4.2.1 **NZ** 3.1.1, 3.1.2
11	Conduct a comprehensive review of the chiller and HVAC systems.	22/23		£		Estates and Facilities	**NZ** 3.1.1
12	Look to procure 'green gas' through the Green Gas Certification Scheme as and when existing energy contracts are due for renewal.	23/24		£		Procurement	**SC** 18.5
13	Incorporate energy conservation into staff training and education programmes and deliver behaviour-based energy saving campaigns.	23/24		£		HR	**NZ** 3.1.1
14	Develop communication materials for the patients that highlight energy efficiency projects, and discuss plans with the local community, including exploring potential community energy projects.	23/24		£	✕	Estates & HR	**NZ** 3.1.1
15	Explore how the Trust can implement an ISO 50001 Energy Management System.	24/25		£		Estates and Facilities	**NZ** 3.1.1

Figure 11 Green plan action table for Energy and Emissions from the built environment

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Capital Projects

The Built Environment of the NHS influences both the quality of care and environmental impact.

The Trust's design and construction of buildings will contribute to whether net zero can be achieved.

Buildings have significant environmental impacts in terms of emissions resulting from the use of gas, electricity and water. Improving the energy efficiency of a building is pivotal to reducing these impacts. However, there are embodied carbon emissions within materials, such as cements, steel and glass which are used in the construction of buildings. These indirect 'Scope 3' emissions are generally much greater than emissions caused by the operation of a building.

Cement and concrete production on its own accounts for a huge 8% of all global greenhouse gas emissions from all sources, according to the Dutch Environmental Assessment Agency.

The Trust, furthering a previous commitment to ensure all capital development complies with the 'Excellent' or above rating of the Building Research Establishment Environmental Assessment Method (BREEAM) ensures that the plans will focus on the reduction of building emissions from all sources.

Aside from new builds, rationalisation of the estate has been a key topic surrounding capital projects. BSMHFT works closely with local authorities and NHS Trusts to share property information and to minimise voids.

Estates & Facilities: Capital Projects

- Building energy efficiency standards should be considered for new builds and refurbishments. For example, BREEAM 'Excellent' rating, the Zero Carbon Hospital Standard, and implementation of on-site renewables.
- Construction supplier alignment to net zero commitments, such as on-site contractor measures on waste reduction and low emission construction plans.
- Low carbon substitutions and product innovation, such as lower embodied carbon construction materials.

NHS LTP 16

NHS SC 18.4.2.1, 18.4.2.3

NHS NZ 3.1.1, 3.3.1

8 DECENT WORK AND ECONOMIC GROWTH

Target 8.5 Full employment and decent work with equal pay

9 INDUSTRY, INNOVATION AND INFRASTRUCTURE

Target 9.4 Upgrade all industries and infrastructures for sustainability

13 CLIMATE ACTION

Target 13.1 Strengthen resilience and adaptive capacity to climate-related disasters

Target 13.2 Integrate climate change measures into policy and planning

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Implement the upcoming Net Zero Hospital Building Standard in any new builds and BREEAM 'Excellent' for any major refurbishments.	Ongoing		£		Estates and Facilities	**LTP** 16 **SC** 18.4.2.1 **NZ** 3.1.1
02	Achieve a target of 35 - 40* or better in GJ/100m^3 energy efficiency performance for the healthcare estate for all new capital developments and major redevelopments and/or refurbishments.	Ongoing		£		SSL	NZ 3.1.1
03	Explore options to achieve emissions reductions in smaller works and projects in the primary and secondary care estate.	22/23		£		Estates and Facilities	**NZ** 3.1.1
04	Encourage and measure local subcontractor and supply chain spend as part of the anchor institution approach.	22/23		£		Procurement	**NZ** 3.3.1
05	Ensure capital development accounts for risks identified in climate adaptation plans and addresses these in design/delivery.	23/24		£	⊗	Estates and Facilities	**SC** 18.4.2.3
06	Work with the Procurement team to enable specification of low and zero carbon materials and designs, as well as achieving waste reduction and other opportunities through contractor engagement.	23/24		£		Procurement	**NZ** 3.3.1
07	Continue to ensure that the design process is informed by staff, patients and community views for capital projects.	23/24		£	⊗	Estates and Facilities, Procurement & HR	**LTP** 16 **SC** 18.4.2.1 **NZ** 3.1.1
08	To install renewable energy / decarbonised heat supply on all significant New Builds / refurbishments	23/24		£		Estates and Facilities	NZ 3.1.1
09	Adapting premises and grounds (gardens / green spaces) and service delivery to mitigate risks associated with climate change and severe weather	23/24		£		Estates and Facilities	NZ 3.1.1

Figure 12 Green plan action table for Capital Projects

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Water Efficiencies

In 2019/20, the Trust used 96,896m^3 of water.

There are emission impacts associated with the supply of fresh water and treatment of wastewater, equating to 98.5 tCO_2e in 2019/20 (see Figure 18). It is worth noting that the government emission factors for water supply and wastewater dropped by 57% in 2021/22 compared to the previous 6 years. Water consumption has remained relatively stable since 2019/20, but emissions fell by 56 tCO_2e in 2021/22 due the change in emission factors.

Although the emissions are low compared to those produced by energy use, being water efficient is important to prevent and alleviate water stress.

As a water efficiency and leak preventative measure, the Trust will look to collate the data from the Automatic Meter Readers water network. This will help us pinpoint areas of high water usage, understand how and where water is being used, locate leaks and take remedial action.

Details of ongoing water efficiency measures the Trust is taking can be found in the Water Management Action Plan.

Water conservation and sustainable drainage shall also be explored. Rainwater harvesters collect rainwater for non-potable purposes, such as for flushing toilets. They will help reduce water stress and potentially alleviate flooding by attenuating surface water run-off in storm events.

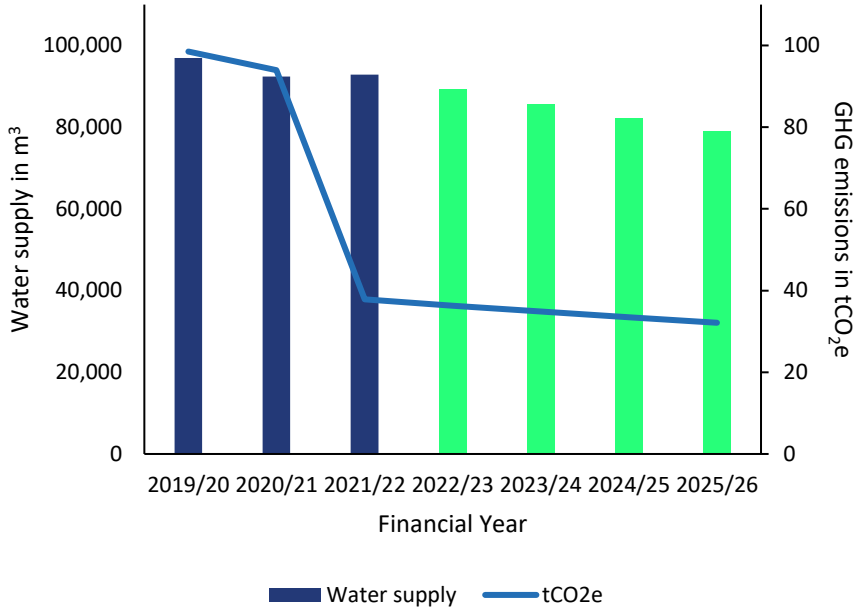


Figure 1 Stacked bar chart to show total water emissions from supply and wastewater treatment, and emissions reduction trajectory to 2025/26

Estates & Facilities: Water

- The Trust used **96,896 m^3** of water in 2019/20 – enough water to fill 37 Olympic-size swimming pools
- **98.5 tCO_2e** was attributed to the supply of water and wastewater treatment
- The Trust needs to reduce water consumption by 18,000 m^3 by 2025/26
- Water efficiency and sustainable drainage will become ever more important in the future

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Explore and implement water efficiency targets on areas of the highest impact in the estate and delivery of care.	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
02	Develop new water intensity metrics and incorporate these into greenhouse gas emissions reporting.	22/23		£	⊗	Procurement	**NZ** 3.1
03	Collate water Automatic Meter Reader to determine water use patterns and aid leak detection, and report monthly	23/24		£		Estates and Facilities	**NZ** 3.1
04	Utilise the most water efficient technologies, such as low flow taps throughout the estate, when replacing equipment and developing new sites	23/24		£		Estates and Facilities	**NZ** 3.1
05	Explore where rainwater harvesting and grey water systems can be installed and utilised.	23/24		£		Procurement	**NZ** 3.1
06	Look to consolidate the suppliers across the estate to choose one or two that can provide the service, price, and efficiency the Trust expects.	Ongoing		£	⊗	Procurement	**LTP** 17
07	Work with staff and patients by communicating the importance of water efficiency.	Ongoing		£	⊗	HR	**NZ** 3.1
08	Incorporate water efficiency measures within climate change adaptation work with the local community.	23/24		£	⊗	Business Continuity	**NZ** 3.1

Figure 14 Green plan action table for Water

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Waste and Recycling

The Trust collects eight main types of waste: general, clinical/offensive, medicines, mattresses, confidential paper, green and food waste, and electrical and electronic equipment (WEEE) waste. There are collections for other waste streams, such as metal, fluorescent lamps and waste cooking oil, though amounts collected are not reported.

Figure 20 shows the total waste arisings and emissions emanating from the waste streams. We stopped sending waste to landfill in 2019/20, with a corresponding drop in emissions. There has been little difference in total waste arisings in the last two years.

Standard waste is collected in general waste bins. This general waste is further segregated at the waste handling centre, with recyclable materials extracted, and non-recyclables sent for incineration as Refuse Derived Fuel (RDF) at an energy-from-waste centre. The Trust is enacting opt in dry mixed recycling (DMR) bins for our sites to increase our recycling rates.

Black bag waste goes to RDF whereas green waste is segregated for anaerobic digestion. Offensive waste either goes to deep landfill or high temperature incineration/RDF, depending on what the waste contains; less than 1% of all of our waste goes to landfill.

Food waste at patient sites is often fairly minimal as very little is wasted. However, food waste is collected at two of our sites at present.

Clinical waste volumes are also relatively low in mental health but have increased significantly in pandemic due to PPE. Some of the clinical waste is incinerated (sharps, medicines and offensive waste), whilst other types are ultra-high temperature processed (alternative treatment) before being further recycled.

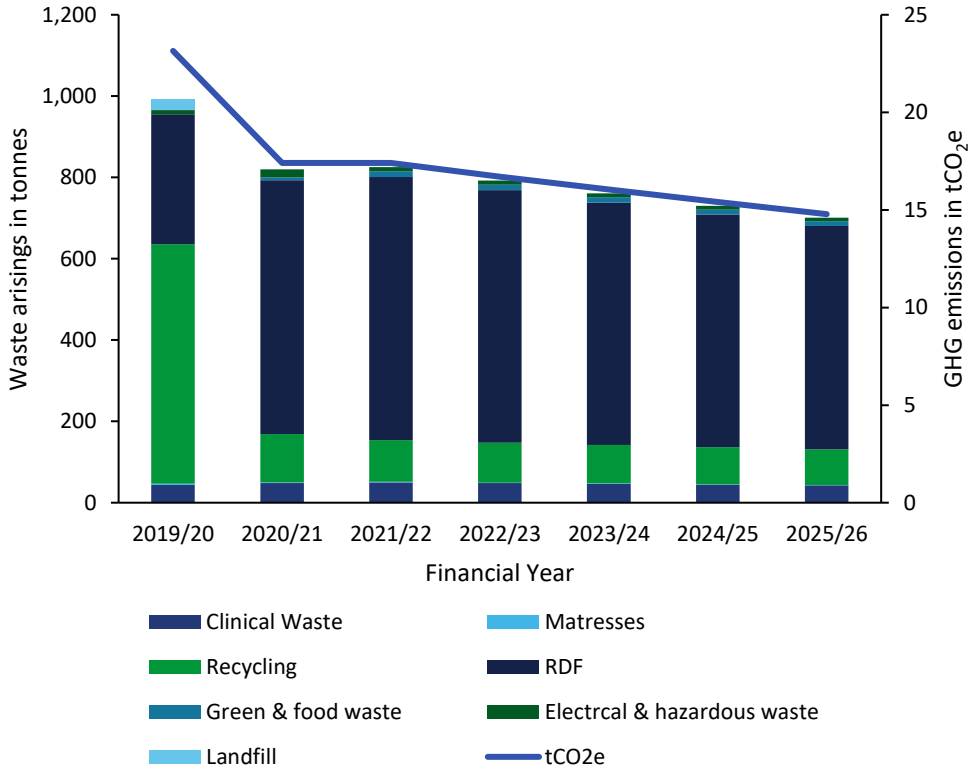


Figure 15 Waste arisings and emissions associated with waste streams and emission reduction trajectory to 2025/26

- **991 tonnes** of waste were produced, emitting **23.1 tCO_2e** in 2019/20
- **25 tonnes** of waste were landfilled in 2019/20, emitting **2.5 tCO_2e** (the last year we sent waste to landfill)
- Food waste bins and collections will ensure more waste food is used for energy and fertiliser generation

The COVID-19 pandemic has led to an increase in the usage of single-use plastic items; a necessary response to managing the crisis.

The Trust is mindful of the environmental impacts of single-use items throughout their lifecycle, from the crude oil used in their manufacture to the difficulty in recycling them at end-of-use.

Innovations are coming on to the market for reusable Personal Protection Equipment (PPE), such as face masks and aprons, that meet the various clinical safety standards. These alternatives should be explored to help reduce waste arisings.

The waste hierarchy of Reduce, Reuse, Recycle, Recovery (energy from waste) before disposal (landfill) must be embedded to ensure that waste duties of care and circular economic principles are being maintained. Recycling rates need to be improved. Shoring up the waste handling processes will ultimately reduce greenhouse gas emissions from waste treatment, other negative environmental impacts and disposal costs.

No.	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible Lead/Department	NHS Requirement
01	Collate *all* waste stream data from *all* sites (including sites where the Trust is not responsible for waste collection) and produce monthly reports.	22/23		£	✕	Estates and Facilities	**NZ** 3.1
02	Ensure that single-use items in catering adhere to current legislation and elect to use sustainable alternatives as listed by NHS Supply Chain,	22/23		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
03	Install Dry Mixed Recycling (DMR) bins across all sites and start DMR collections,	23/24		£		Estates and Facilities	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
04	Install food waste bins across all remaining sites and start food waste collections.	23/24		£		Estates and Facilities & Catering	**NZ** 3.1
06	Work with staff and patients by communicating the importance of waste segregation.	Ongoing		£	✕	Estates and Facilities & HR	**NZ** 3.1
07	Explore whether reusable alternatives to single-use PPE items (aprons, wipes, face masks) are clinically appropriate.	23/24		£		Clinical Teams & Procurement	**NZ** 3.1
08	Explore how the Trust can implement an ISO-14001 Environmental Management System.	23/24		£		Estates and Facilities & HR	**LTP** 17 **SC** 18.4.3.1 **NZ** 3.1
09	Send no waste to landfill, and reduce, re-use, recycle and/or recover energy and heat from waste.	23/24		£		Estates and Facilities	**NZ** 3.1

Figure 16 Green plan action table for Waste

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

✕ Not applicable

Biodiversity and Greenspace

"Access to greenspaces have positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to greenspaces." – **Delivering a Net Zero NHS**

The Trust wants to protect biodiversity within the estate and region and reduce any negative impact on biodiversity, both locally and globally.

Greenspace and nature are important for the health and wellbeing of patients and colleagues alike. At a global scale, greenspace affects the planet's ability to absorb carbon dioxide.

The Trust will promote access to greenspace, considering areas of operations where this may be lacking.

The Trust will also consider opportunities and risks for biodiversity in its sites, for example priority woodland areas in the region.

As part of the Project Dynamo initiative, there is a Gorgeous Gardens element that has tidied thirty four garden spaces across the three sites. The next phase is to begin renovations in a further eight gardens, to make them more inviting. At each of the three sites, there will be a dedicated patient and staff area.

NHS LTP 17

NHS SC 18.4.3, 18.4.3.1 to 18.4.3

NHS NZ 3.1.1, 3.3.2

11 SUSTAINABLE CITIES AND COMMUNITIES

Target 11.6 Reduce the environmental impacts of cities, focusing on air quality and waste

3 GOOD HEALTH AND WELL-BEING

Target 3.9 Reduce illnesses and deaths from hazardous chemicals and pollution

13 CLIMATE ACTION

Target 13.2 Integrate climate change measures into policy and planning

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	Review policies and practices around green space and biodiversity, to ensure that the Trust's impact on these is reduced. Identify opportunities to provide safe and easy access to green space, where appropriate.	23/24		£	⊗	Estates and Facilities	**LTP** 17 **SC** 18.1 **NZ** 3.5
02	Engage with regional partners to ensure that adequate green space and identified native species are considered and supported in planning and operations of the estate wherever possible. This includes supporting bees and other pollinators.	23/24		£	Moderate reduction	Estates and Facilities	**SC** 18.1 **NZ** 2.2, 3.5
03	Work to better understand biodiversity and habitat risks and opportunities in procurement. Where possible, apply evidenced standards or engage with suppliers to address issues, such as food production and provenance of meat, avoiding Palm Oil or limiting to RSCO-certified Palm Oil in food and cleaning products.	23/24		£	Moderate reduction	Procurement	**SC** 18.1
04	Continue to engage the staff, patients, and communities in green space initiatives.	Ongoing		£	⊗	Clinical leads & HR	**NZ** 2.2, 3.5

Figure 2 Green plan action table for Greenspaces

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Medicines – Volatile Anaesthetic Gases and Inhalers

In addition to carbon dioxide emissions, the NHS clinical activity and prescriptions, such as using inhalers, nitrous oxide and volatile inhaled anaesthetics like desflurane, contribute to a considerable proportion of the NHS' GHG footprint.

The Long Term Plan commits the NHS to reduce GHG emissions from anaesthetic gases by 40% (which on its own could represent 2% of the overall NHS England carbon footprint reduction target which the NHS must meet under Climate Change Act commitments) and significantly reduce GHG emissions by switching to lower global warming potential (GWP) inhalers.

Nitrous oxide & Anaesthetic gases

BSMHFT is a mental health trust, which means that we only prescribe medicines for related conditions. Volatile anaesthetics are not used at our Trust. and we do not prescribe inhalers, which eliminates the carbon footprint of these sources from our care.

Inhalers

As a mental health trust, we prescribe very few inhalers, however the small amount we do procure still have an impact on our carbon footprint.

Both Dry-powder (DPI) and Metered Dose Inhalers (MDI) are prescribed. Metered dose inhalers use fluorinated gases as the propellant: in 2019/20, TBC% of the inhalers prescribed were MDI's. However, emissions data for inhalers could not be determined at this time due to data verification. This will be amended in future carbon footprint reporting.

The NHS Standard Contract stipulates that 30% of all inhalers prescribed across NHS England should be DPIs, potentially saving 374 $ktCO_2e$ per year, according to the NHS Net Zero report.

New Impact and Investment Fund (IIF) indicators which have been released provide an additional steer on prescribing lower-carbon inhalers.

Dry-powder inhalers are an appropriate choice for many patients and contain as little as 4% of the GHGs emissions per dose compared with MDIs. Fluorinated gases in MDIs mean that each 10ml to 19ml inhaler cannister has the equivalent emissions of 30 to 80kg of carbon dioxide!

At the end of use, inhalers still contain as much as 20% of high-GWP propellant. Greener disposal of these items, where residual fluorinated gases are captured and destroyed, is therefore another key priority. Lastly, overuse of inhalers leads to 250,000 tonnes of equivalent carbon emissions (250 $ktCO_2e$) annually across the UK, according to a new study.

BSMHFT will work across the Trust to address disposal and overuse, and work with staff and patients through the NICE Patient decision aid to help increase the uptake of low-carbon inhalers wherever appropriate.

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	To continue to develop systems and controls re type and quantity of medications issued, to impact Procurement, Storage, Packaging and Waste	Ongoing		£	⊗	Trust / SSL Pharmacy	**LTP** 17
02	To increase the ability to re-use and re-issue oversubscribed medications.	Ongoing		£		Trust / SSL Pharmacy	**LTP** 17
03	To significantly reduce reliance on less ozone friendly products such as Inhalers (NOx) and seek to use suitable / viable alternates.	Ongoing		£		Trust / SSL Pharmacy	**LTP** 17
04	Collate inhaler prescribing data and report quarterly.	22/23		£	⊗	Clinical Pharmacy Team	**LTP** 17
05	Work with staff and the Pharmacy Team to enable uptake of alternative inhalers where appropriate.	22/23		£		Clinical Pharmacy Team	**SC** 18.6 **NZ** 3.4.1
06	Set a target of prescribing at least 50% DPIs for all inhaler types.	23/24		£		Clinical Pharmacy Team	**NZ** 3.4.1
07	Set a goal to reduce MDIs to 25% of all non-salbutamol inhalers by prescribing DPIs and soft mist inhalers, where clinically appropriate.	24/25		£		Clinical Pharmacy Team	**IIF** ES-01 **LTP** 17
08	Set a goal of reducing the average emissions from salbutamol inhalers to 11.1kg per inhaler, where appropriate.	24/25		£		Clinical Pharmacy Team	**IIF** ES-02 **LTP** 17

Figure 3 Green plan action table for inhalers

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Supply chain and procurement

The NHS is a major purchaser of goods and services, with NHS England alone procuring around £30 billion of goods and services annually. Procurement has major potential social, economic, and environmental impacts both locally and globally.

This includes the power of using local suppliers, the climate performance of equipment and the estate, and preventing modern slavery in supply chains.

BSMHFT is committed to engage with suppliers to meet the Green Plan and support the sustainable procurement objectives of NHS England wherever practicable.

Procurement and Climate Action

Supply chain emissions represent a huge portion of BSMHFT's overall carbon footprint. The Trust has baselined the estimated supply chain emissions from 2018/19 to 2021/22 utilising the GHG Protocol 'Scope 3' spend-based method. Spend-based emissions change yearly with total spend and will not help measure progress initially. However, they will help BSMHFT to identify the carbon hotspots to plan for actions.

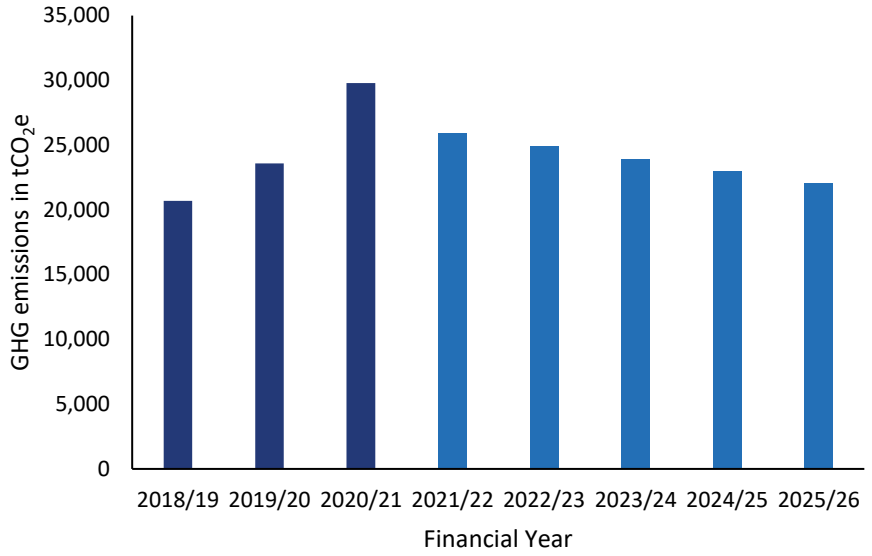


Figure 19 Emissions from the supply chain with reduction to 2025/26

Supply Chain and Procurement

- Emissions from the supply chain were estimated to be **23,596 tCO_2e** in 2019/20.
- A new NHS Sustainable Supplier Framework launched in January 2022 and will require all suppliers to publish progress reports and continued carbon emissions reporting by 2030.
- An ISO 20400 Sustainable Procurement Strategy would enhance the environmental and social performance of the Trust's supply chain.
- Ensure tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts in April 2022 and 2023 respectively.
- Reusable items such as face masks and aprons would reduce waste (as per the Waste section).
- Reclaiming mobility aids and other devices from patients will prevent waste and save money.

As a Trust, most items and services are procured through centralised NHS/government frameworks, such as NHS Supply Chain. These centralised frameworks already provide best value through bulk purchasing power and consolidation of orders. The Trust cannot control or influence the sustainability aspects of these routes of procurement and will benefit from the decisions made in how these frameworks operate.

In addition, the Trust is a signatory of the NHS Single Use Plastics Pledge and aims to reduce plastic catering consumables.

The NHS, in line with recent government requirements, is mandated to adopt a new social value and environmental standard in the future. A new Sustainable Supplier Framework launched in January 2022, and from April 2022, all NHS tenders will include a minimum 10% net zero and social value weighting (as per Policy Procurement Note 06/20).

From April 2023, contracts above £5 million will require suppliers to publish a carbon reduction plan for their direct emissions as a qualifying criterion (as per Policy Procurement Note 06/21).

By 2030, all suppliers will be required to demonstrate progress in-line with the NHS' net zero targets, through published progress reports and continued carbon emissions reporting.

PPN 06/020 & PPN 06/021 are procurement policy notices that relate to Central Government Departments, their Executive Agencies and Non-Departmental Public Bodies. However, BSMHFT as an organisation is not yet directly in scope.

These additional requirements will enable us to determine more accurately the carbon and social impact of the products and services that the Trust buys, and ensure suppliers are reducing the emissions associated with their operations and products.

In the interim, BSMHFT will explore ways to reduce single-use plastic items and research how reusable items can be incorporated such as masks and aprons into clinical practice.

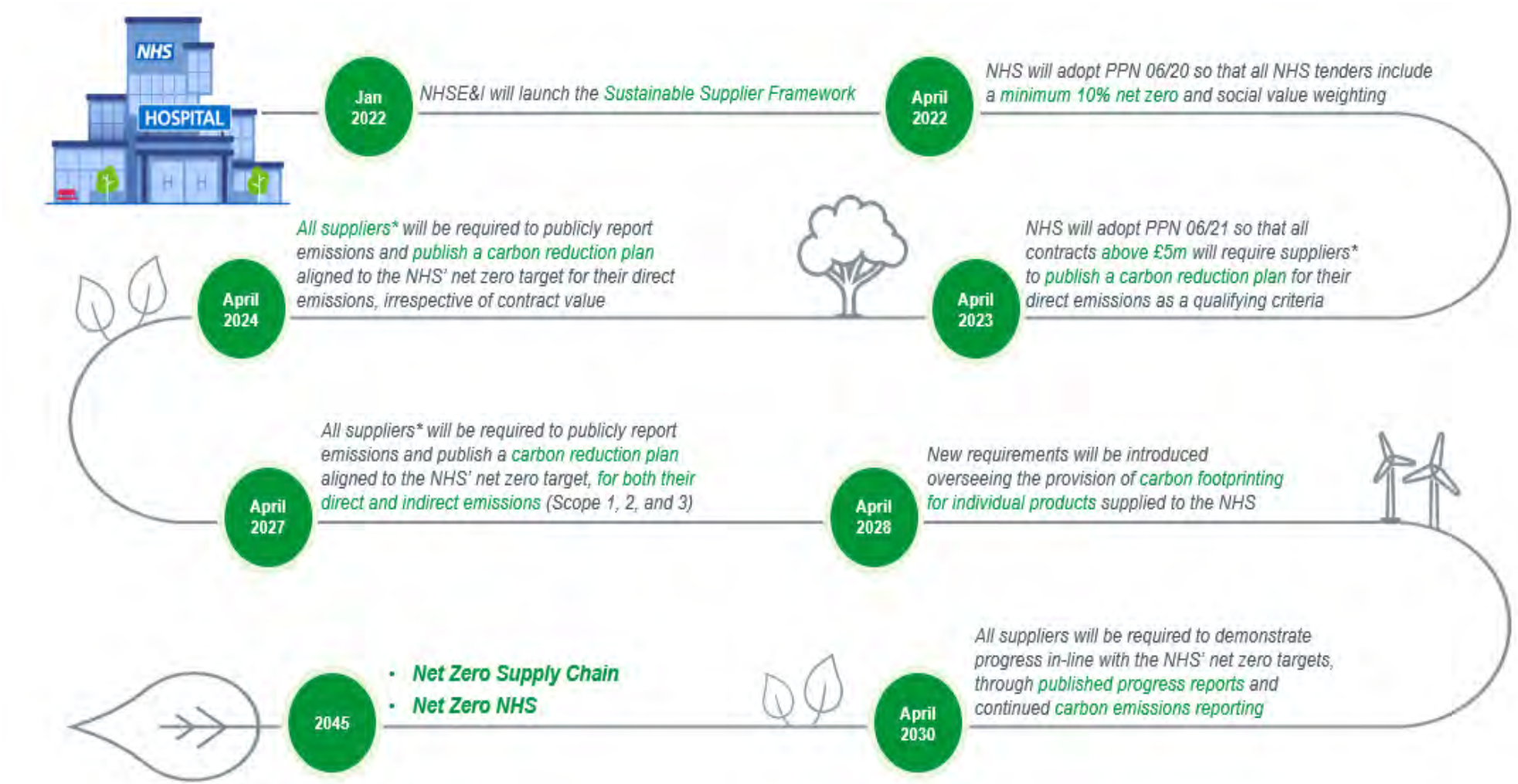


Figure 20 Building net zero into NHS Procurement – shows how NHS England will require all suppliers to provide carbon and social value reporting by 2030

Product retainment and lifecycle extension

Procuring well, ensuring best value for money and social and environmental benefits will remain a core principle for the wider NHS and the Trust.

However, keeping products in service for as long as possible, through maintenance and repair, is fundamental to a circular economy and drives down waste.

Mobility aids, such as walking frames, crutches and walking sticks, are given to outpatients where appropriate. Unfortunately, once issued, these items are no longer under the Trust's control. Though many outpatients will use mobility aids for the long term, many are only used for weeks or months, and for equipment with minimal use we can repair where possible and dispose as necessary.

Anchor trust role

This involves identifying opportunities for regional Small and Medium-sized Enterprises (SMEs), and engaging suppliers to ensure wider community benefits are met. Shared warehousing is already in place, with SSL running storage space for use by BCHFT and Primary Care Networks (PCN) for PPE during the pandemic.

While the Trust cannot reserve spend locally, proactive steps are taken to support inclusive growth, including a policy on the payment of the Real Living Wage for service suppliers

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NHS England Sustainable Procurement Objectives		
Net Zero	**Modern Slavery**	**Social Value**
Achieve the NHS Supply Chain Net Zero Targets	Eliminate Modern Slavery in the NHS supply chain both domestically and abroad	Ensure NHS procurement is a force for good helping local economies and improving wider determinants of health

Figure 21 Official NHS Sustainable Procurement Objectives Source: website

LTP 6.17, 17, 18

SC 18.6

Target 8.3 Promote policies to support job creation and growing enterprises

Target 8.7 End modern slavery,

Target 12.7 Promote sustainable public procurement practices

Target 13.2 Integrate climate change measures into policy and planning

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/department	NHS Requirement
01	To develop procurement processes and procedures that reduce wastage from the over-ordering / incorrect ordering of goods and or services.	Ongoing		£		Procurement	**SC** 18.6
02	To reduce all packaging as per the Plastics Pledge to stop using single use plastic items	Ongoing		£		Procurement	**SC** 18.6
03	Review the sustainable procurement approach to find relevant links that enable the Green Plan and work closely with NHS Supply Chain and NHS Improvement to promote their sustainability programmes.	Ongoing		£	✕	Procurement	**LTP** 6.17, 17
04	Adhere to the requirements of the NHS Sustainable Supplier Framework.	January 2022		£		Procurement	**SC** 18.6
05	Ensure tenders adopt the new social value procurement note PPN 06/20 and carbon management PPN 06/21 in major contracts from April 2022 and 2023 respectively.	April 2022		£		Procurement	**NZ** 3.3, 3.3.1
06	Ensure tenders adopt the carbon management PPN 06/21 in major contracts in April 2023.	April 2023		£		Procurement	**SC** 18.6
07	Ensure the purchase of 100% closed-loop recycled paper.	22/23		£		Estates and Facilities	**SC** 18.6
08	To ensure that standard quotation and tender documents ask the right questions re sustainability and carbon reduction, and that this is reflected within the scoring mechanism**.**	22/23		£	✕	Procurement	**SC** 18.6
09	Identify wider social, economic and environmental benefits for the local community and population when considering the purchase and specification of products and services.	23/24		£	✕	Procurement	**SC** 18.6
10	Create a new system for cataloguing and reclaiming mobility aids and other devices from patients.	23/24		£		Physio and Occupational Therapy	**NZ** 3.3, 3.3.1
11	Engage a key supplier on plans to align their operations and delivery with NHS Net Zero targets over time. Leverage NHS England and NHS Improvement Supplier Engagement Strategy approach for fostering partnerships.	23/24		£	✕	Estates and Facilities	**NZ** 3.3, 3.3.1
12	Work with NHS Supply Chain to address Modern Slavery and domestic and international supply chain environmental, and human rights risks, including those linked to PPE.	23/24		£	✕	Procurement	**SC** 18.6

No	BSMHFT Green Plan Actions	Target Year	Progress	Indicative Cost to achieve	Indicative Emissions reduction	Responsible lead/department	NHS Requirement
13	Explore the creation of an ISO 20400 Sustainable Procurement Strategy.	23/24		£		Procurement	**SC** 18.6
14	Work to identify impactful future supply chain emissions reductions opportunities and links to climate adaptation and other Green Plan commitments in procurement specifications and through contract delivery	24/25		£	⊗	Procurement	**NZ** 3.3, 3.3.1
15	Enable procurement to support Social Value and Anchor Institution NHS aims, e.g., understanding and increasing local, SMEs and social enterprise spend or collaborating with suppliers to promote positive action in equalities or to collaborate on innovation or climate action.	Ongoing		£	⊗	Procurement	**LTP** 18

Figure 22 Green plan actions for supply chain management and procurement

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

⊗ Not applicable

Food and Nutrition

Food illustrates the links between climate change and public health. The NHS Long Term Plan commits us to promoting plant-forward diets and reducing unhealthy options like sugary drinks on NHS premises.

Food production accounts for up to 26% of global greenhouse gas emissions[1]. Food and livestock production has a huge impact on biodiversity as well, and according to research collected by Our World in Data "of the 28,000 species evaluated to be threatened with extinction on the IUCN Red List, agriculture and aquaculture is listed as a threat for 24,000 of them".[2]

While promoting healthier foods and reducing emissions, the NHS can also source more food from local and regional producers where possible, increasing the positive economic impact for our communities and reducing the emissions associated with food transport.

BSMHFT will work to fulfil Long Term Plan priorities for food provision on the premises, promoting plant-forward diets, higher welfare and more sustainable food options, and supporting regional producers wherever possible.

[1] https://ourworldindata.org/environmental-impacts-of-food

[2] Source: Poore, J., & Nemecek, T. (2018). Reducing food's environmental impacts through producers and consumers. *Science*, 360(6392), 987-992. Via https://ourworldindata.org/environmental-impacts-of-food

From September 2020 until September 2021, the Trust served an average of 800,000 meals (3 meals per day). The Trust offers a wide choice of meals for inpatients, including vegetarian and vegan options and other dietary requirements. There are seasonal and themed menus available at sites, with rolling four week menus. We use a mixture of chill cook food from suppliers and fresh food prepared and cooked in production kitchens. Where kitchens are prep kitchens, chill cook food is ordered a week in advanced.

The Trust spent an average of £1,116,000 on food and catering procurement in the year 19/20, with related emissions reaching 471 tonnes of CO_2 equivalent.

We have catering leads and senior management leads responsible for ensuring our catering is in line with all standards and mandatory requirements.

After signing the NHS' Single Use Plastics Pledge, plastics are removed from catering services and are replaced by biodegradable equivalents.

No.	BSMHFT Green Plan Actions	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
01	Reduce single-use plastics throughout the supply chain This includes (barring medical or clinical need): • Ceasing use of single- use plastic straws and stirrers • Ceasing use of single- use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics Signing up to and observing the Plastics Pledge by 31 March 2021	Ongoing		£		Catering Services	**SC** 18.6
02	To introduce systematic approach to monitoring of both production food waste and in particular plate food waste and reduce accordingly.	Ongoing		£	✕	Catering Services	**NZ** 3.3.2
03	Review food and catering to explore opportunities to push forward Long Term Plan plans to address obesity, benefit BSMHFT's local area, and reach Net Zero emissions.	Ongoing		£	✕	Catering Services	**LTP** 2.18, 17 **SC** 19.1, 19.2 **NZ** 3.3.2
04	Explore a digital meal system for at least one NHS site to enable accurate meal planning and reduce food waste.	22/23		£		Estates and Facilities & Catering Services	**NZ** 3.3.2
05	Phase in more Plant-forward diets and other updated NHS requirements and explore greater seasonal menu changes.	23/24		£		Procurement & Catering Services	**LTP** 2.18

No.	BSMHFT Green Plan Actions	Target Year	Pro-gress	Indicative Cost to Achieve	Indicative Emissions Reduction	Responsible lead/dept.	NHS Req.
06	Limit sugary drinks sales at Trust facilities and fulfil other updated NHS requirements.	23/24		£		Catering Services	**SC** 19.3
07	Work with NHS Supply Chain to ensure positive impacts from contract management and maintain updates to Government Buying Standards sustainable food criteria.	23/24		£		Procurement & Catering Services	**SC** 19.3
08	Work with regional partners to identify opportunities for local and SME food producers.	22/23		£		Procurement	**NZ** 3.3.2
09	Ensure all food providers meet or exceed the requirements outlined in Report of the Independent Review of NHS Hospital Food	23/24		£		Facilities & Procurement	**SC** 19.3
10	Review internal and NHS strategies for sustainable food procurement, including sustainable fish, elimination of palm oil or limit to RSPC-certified palm oil and Fairtrade items where relevant.	23/24		£		Procurement	**LTP** 17
11	Continue to work with patients and partners on the link between food, health and obesity, as well as the emissions impact.	Ongoing		£		TBC	**LTP** 2.18 **SC** 19.1, 19.2 **NZ** 3.3.2

Figure 23 Table to show green plan actions for food and nutrition

Indicative cost:

£ No or low cost

£ Moderately expensive

£ Significantly expensive

Indicative emissions reduction:

Low or incremental reduction

Moderate reduction

Significant reduction

Not applicable

Adaptation

Climate change will make extreme weather, such as heatwaves, droughts and flooding, more prevalent. Sea-level rise and increased risk of Vector Borne Diseases, such as Lyme Disease, may also impact the communities of Birmingham and Solihull.

It is therefore important that the Trust examines the potential risks and ensure that buildings, systems and processes are adapted to cope with the possible impacts of increased flooding, heat waves and storm damage. This process has begun with our Adaptation Plan but will need to be updated going forwards.

The changing climate poses risks for vulnerable populations in the community, but also impacts the Trust's estate, its ability to operate and the supply chain.

The Trust already engages with other public authorities and partners in tackling extreme weather events, such as flooding. BSMHFT will analyse these risks and develop actions for care delivery, estate planning and management, including flood risks across the estate and service area.

Climate change has serious implications for health, wellbeing, livelihoods, and society. Its direct effects result from rising temperatures and changes in the frequency and strength of storms, floods, droughts, and heatwaves — with physical and mental health consequences (The Lancet, 2017)

The NHS Long Term Plan reinforces the requirement to embed resilience and sustainability into the Trust's healthcare services. Climate change adaptation is critical to achieving this. The impacts of climate change on health, services, infrastructure and BSMHFT's ability to cope with extreme weather events will place significant additional demands on services in the future.

Climate change adaptation in the NHS is about organisational resilience and the prevention of avoidable illness, embracing every opportunity to create a sustainable, healthy and resilient healthcare service. Reducing the Trust's impact on the environment may not only help to mitigate climate change, but reduce the organisational running costs, ensure business continuity, and reduce health inequalities. Above all, it's about ensuring that the NHS and the Trust's buildings, services, staff and patients are prepared for what lies ahead.

Birmingham and Solihull Mental Health NHS Foundation Trust will work with partner organisations and other public sector organisations to develop a climate change adaptation plan to mitigate the consequences of climate change in respect of health and service delivery.

"As climate change accelerates globally, in England we are seeing direct and immediate consequences of heat waves and extreme weather on our patients, the public and the NHS. Adaptation is the process of adjusting our systems and infrastructure to continue to operate effectively while the climate changes. It is critical that the NHS can ensure both continuity of essential services, and a safe environment for patients and staff in even the most challenging times." - **Greener NHS**

No	BSMHFT Green Plan Actions	Target Year	Pro-gress	Indicative Cost to Achieve	Responsible lead/dept.	NHS Req.
01	Appoint a Climate Change Adaptation lead and follow the recommendations of the third Health and Social Care Sector Climate Change Adaptation Report.	23/24		£	Trust Board	**LTP** 17 **SC** 18.4.2.3 **NZ** 1
02	Embed Climate Change as a strategic risk within the corporate risk register and manage appropriately	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1
03	Create an ISO14090 Climate Change Adaptation Plan, including plans for adapting the premises to mitigate climate change and extreme weather risks, using a recognised methodology, that is routinely reviewed considering the changing climate and scientific advancements.	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1
04	Work with NHS Supply Chain to better understand the climate change risks in the supply chain and proactively seek to make the supply chain 'climate-ready'.	23/24		£	Procurement	**SC** 18.4.2.3 **NZ** 1
05	Embed and adapt existing health-related contingency planning, such as Flooding Plans to reflect predicted climate change impacts.	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1
06	Incorporate newly emerging climate-related health care risks into contingency planning, such as the increasing prevalence of Vector Borne Diseases.	23/24		£	Business Continuity	**SC** 18.4.2.3 **NZ** 1

Figure 24 Table to show green plan actions for climate adaptation

Conclusion

The purpose of this Green Plan is to set out how our Trust will become more sustainable, reduce our greenhouse gas emissions and ultimately reach net zero emissions by 2040, and net zero plus by 2045. In the document, we have put forward our progress so far and the actions that will be necessary to drive change until 2025/26 and beyond.

This Green Plan is a living document and will be regularly reviewed for progress against the action plans. As such, actions and targets may be revised where necessary.

Adequate budgets and resources will be allocated to achieve the Trust's goals and deliver sustainable care. The Trust will look to achieve the 'quick wins' first, although significant investment will be required in future years, especially in making BSMHFT's buildings 'climate-ready'.

Climate Change poses many threats to the care population and how care is delivered. This Green Plan will enable us to become an adaptable and resilient organisation. It will help steer the direction of travel with other local anchor institutions, bolstering the Trust's ability to provide a continued critical service.

BSMHFT's dedicated workforce is core to its care provision and delivery of this Green Plan. With the necessary structures in place, it will be the people and service users who will drive the changes to make us a more sustainable organisation. The Trust will continue an open dialogue with all stakeholders to improve the Green Plans and the delivery of care.

For more information, please contact

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neil.cross@nhs.net

This Green Plan was created for Birmingham and Solihull Mental Health NHS Foundation Trust in partnership with Inspired PLC.

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**15**
Paper title	**INTEGRATED PERFORMANCE REPORT**
Date	25/5/2022
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Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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 – Commissioner reportable incidents and ligature incidents

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 April 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 in line with plan

Quality

- Commissioner reportable incidents up to 13, the highest figure since Jan-21
- Ligature incidents are high – with anchor point 4, all in Acute, no anchor point 49, 39 in Acute
- **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. The figure for April is 416 occupied bed days (13.9 patients), up from March 270 OBD (8.7). 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 33.7% 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 64.6%
- The % of service users on CPA having a formal review in the last 12 months remains a worry at 85.2%
- CPA 7-day follow up is little changed at 93.2%
- New referrals not seen within 3 months are of concern and are little changed at 2,577
- **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
- March vacancies are down from 9.5% to 8.0% (343.9 WTE). Actual WTE in post at 3,916.8 WTE is lower than February and % improvement relates to reduced establishment
- Sickness levels have risen from 6.1% to 6.6%. Variation: Corporate 3.3% v Secure 8.7%
- Appraisals up to 85.8% but still significantly below pre-COVID levels and target
- Fundamental training little changed at 91.8% and temporary staffing is a particular issue (49% for IG training, second lowest level since this has been separately analysed)
- Bank and Agency fill down to 82.2%
- **Key concerns: Vacancies, fundamental training, bank and agency fill rate, appraisal rates, sickness**

Sustainability

- Month 1 financial position is a deficit of £0.2m, in line with plan
- Month 1 capital expenditure is £50k, £110k less than plan due to delays in finalising priorities
- Information Governance position up to 91%, still held back by training of temporary staff
- Cash and property standards remain well above target

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

April 2022

Performance

CPA 7 day FU	93.2% ↓
CPA with Formal Review last 12 mths	85.2% ↓
Data Quality Maturity Index (DQMI)	98.4% ↑
Delayed Transfer Bed Days	1005
Delayed Transfer, percent of bed days	6.5%
Eating disorders routine	100.0%
Eating disorders urgent	100.0%
First episode psychosis	100.0% ↑
IAPT into recovery	52.6%
IAPT seen in 18 weeks	64.6% ↓
IAPT seen in 6 weeks	33.7% ↓
Out of Area Bed Days	416 ↑
Referrals over 3 mths with no contact	2577 ↓

People

Bank & Agency Fill Rate	82.2 % ↓
Fundamental Training	91.8 % ↓
Rolling 12m Turnover	10.2 % ↑
Staff Appraisals	85.8 %
Staff Sickness	6.6% ↓

Quality

Absconsions from inpatient units	3
Commissioner reportable incidents	13 ↘
Community confirmed suicides	0
Community suspected suicides	1
Failure to return	13 ↑
Incidents of self harm	167 ↑
Incidents resulting in harm (other)	16.8 % ↑
Incidents resulting in harm (patients)	17.0 % ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	1 ↓
Ligature no anchor point	49
Ligature with anchor point	4 ↓
Patient assaults	39

Sustainability

CAP Ex	£49k ↓
Cash	£53,617k ↑
CIP	£0k
Info Governance	91.1%
Monthly Agency	£542k
Operating Surplus	£157k ↓
Property	98.5% ↑
SOF rating	3 ↑

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

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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

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Sustainability: Savings plans yet to be identified

Division: A: All

A: All

April 2022

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People

Bank & Agency Fill Rate	82.2 % ↓
Fundamental Training	91.8 % ↓
Rolling 12m Turnover	10.2 % ↑
Staff Appraisals	85.8 %
Staff Sickness	6.6% ↓

Quality

Incidents resulting in harm (patients)	17.0 % ↑
Inpatient confirmed suicides	0
Inpatient suspected suicides	1 ↓
Ligature no anchor point	49
Ligature with anchor point	4 ↓
Patient assaults	39
Patient ssaults / 1000 OBD	2.1
Physical restraints	196 ↑
Physical restraints/ 1000 OBD	10.8 ↑
Prone restraints	41 ↑
Prone restraints/ 1000 OBD	2.2 ↑
Reported incidents	2026 ↑
Staff assaults	84
Staff assaults / 1000 OBD	4.6

Sustainability

CAP Ex	£49k ↓
Cash	£53,617k ↑
CIP	£0k
Info Governance	91.1%
Monthly Agency	£542k
Operating Surplus	£157k ↓
Property	98.5% ↑
SOF rating	3 ↑

	Not meeting target
↑	significant IMPROVEMENT
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HOME | **PERFORMANCE** | PEOPLE | QUALITY | SUSTAINABILITY

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
CPA 7 day FU	95.00	88.9%	90.7%	94.4%	92.0%	93.5%	93.2% ↓
CPA with Formal Review last 12 mths	95.00	87.1%	87.1%	85.9%	86.3%	86.5%	85.2% ↓
Data Quality Maturity Index (DQMI)	95.00	98.5%	97.8%	97.8%	97.5%	97.1%	98.4% ↑
Delayed Transfer Bed Days		1006	1070	954	751	1001	1005
Delayed Transfer, percent of bed days		6.5%	6.9%	6.1%	5.2%	6.3%	6.5%
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%	100.0%	50.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% ↑
IAPT into recovery	50.00	49.2%	54.0%	47.2%	51.2%	49.9%	52.6%
IAPT seen in 18 weeks	95.00	82.3%	76.0%	70.2%	69.6%	64.9%	64.6% ↓
IAPT seen in 6 weeks	75.00	30.5%	29.5%	27.4%	26.8%	23.7%	33.7% ↓
Out of Area Bed Days	270.00	591	583	553	332	270	416 ↑
Referrals over 3 mths with no contact		2523	2611	2627	2641	2538	2577 ↓

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

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Staff Vacancies		10.5%	10.4%	10.2 %	9.5%	8.0%	
Staff Sickness	4.28	6.6%	6.6%	7.8%	6.3%	6.1%	6.6% ↓
Staff Appraisals	90.00	81.5%	81.2%	81.6 %	83.4 %	84.7 %	85.8 %
Rolling 12m Turnover		9.8%	9.6%	9.7%	9.7%	10.2 %	10.2 % ↑
Fundamental Training	95.00	93.4%	93.3%	92.7 %	91.9 %	91.6 %	91.8 % ↓
Bank & Agency Fill Rate		82.5%	81.1%	84.2 %	85.1 %	83.0 %	82.2 % ↓

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

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Integrated Performance Dashboard

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Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
Absconsions from inpatient units		2	3	2	2	5	3	
Commissioner reportable incidents		7	8	5	7	8	13	↘
Community confirmed suicides		0	0	0	0	0	0	
Community suspected suicides		1	0	2	3	3	1	
Failure to return		11	12	8	6	11	13	↑
Incidents of self harm		163	151	134	137	166	167	↑
Incidents resulting in harm (other)		15.1 %	14.1%	13.1%	14.3%	16.2%	16.8%	↑
Incidents resulting in harm (patients)		15.0 %	16.5%	14.8%	15.0%	18.0%	17.0%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	1	↓
Ligature no anchor point		39	42	30	37	49	49	
Ligature with anchor point		3	3	5	2	2	4	↓
Patient assaults		47	41	41	38	43	39	
Patient ssaults / 1000 OBD		2.5	2.2	2.2	2.2	2.3	2.1	

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

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Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
		%						
Incidents resulting in harm (patients)		15.0 %	16.5%	14.8%	15.0%	18.0%	17.0%	↑
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	1	↓
Ligature no anchor point		39	42	30	37	49	49	
Ligature with anchor point		3	3	5	2	2	4	↓
Patient assaults		47	41	41	38	43	39	
Patient ssaults / 1000 OBD		2.5	2.2	2.2	2.2	2.3	2.1	
Physical restraints		213	214	193	207	223	196	↑
Physical restraints/ 1000 OBD		11.4	11.4	10.2	12.1	11.9	10.8	↑
Prone restraints		55	36	29	55	59	41	↑
Prone restraints/ 1000 OBD		2.9	1.9	1.5	3.2	3.1	2.2	↑
Reported incidents		1990	2160	1980	1978	1928	2026	↑
Staff assaults		81	83	92	101	102	84	
Staff assaults / 1000 OBD		4.3	4.4	4.9	5.9	5.4	4.6	

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

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
CAP Ex		£590k	£766k	£220k	£3,614k	£4,088k	£49k ↓
Cash		£51,252k	£52,956k	£55,797k	£59,011k	£54,799k	£53,617k ↑
CIP		£748k	£374k	£374k	£374k	£374k	£0k
Info Governance		92.1%	84.4%	87.4%	85.4%	89.5%	91.1%
Monthly Agency		£667k	£575k	£507k	£800k	£551k	£542k
Operating Surplus		-£645k	-£463k	-£681k	£456k	£3,406k	£157k ↓
Property		98.5%	98.5%	98.5%	98.5%	98.5%	98.5% ↑
SOF rating		2	2	2	2	2	3 ↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

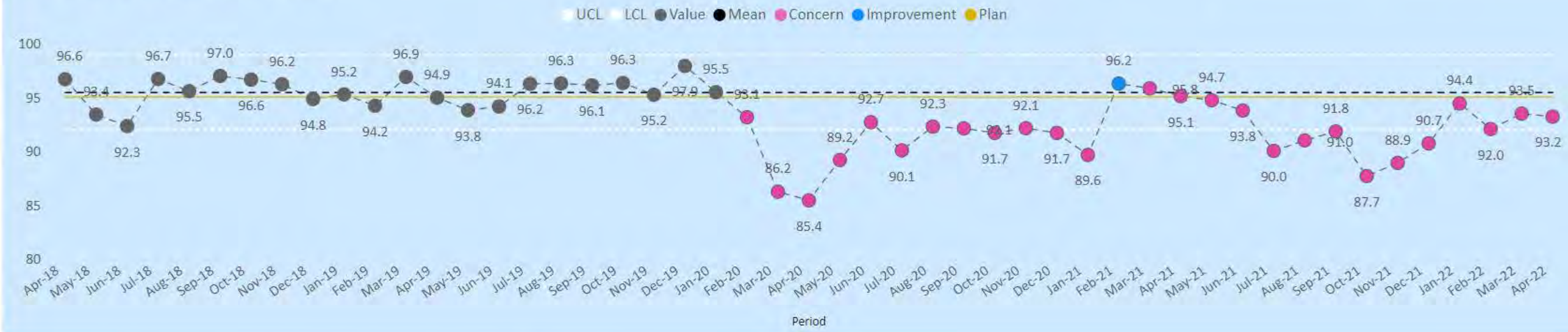
	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

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	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A: All	88.9%	90.7%	94.4%	92.0%	93.5%	93.2%
B: Acute and Urgent Care	83.6%	75.0%	84.6%	80.8%	51.9%	79.3%
C: ICCR	63.6%	75.0%	60.0%	57.1%	66.7%	40.0%
D: Secure Serv & Offender Health	0.0%	0.0%		100.0%	100.0%	50.0%
E: Specialties	87.5%	50.0%	66.7%	100.0%	50.0%	50.0%

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 92% for March 2022, and is currently outside control limits.

This relates to 10 outstanding follow ups from 154 discharges in March of which, 2 patients were discharged to the care of FTB, 2 patients were discharged to the care of another mental health trust, 2 patients did not return to the ward and were reported as missing to the police, attempts were made to see 2 patients but were unsuccessful and 2 patients ahve been seen but data entry is awaited. Of the 10 exceptions 9 were acute adult and 1 was from ICCR.

Detailed Commentary

CPA 7 day FU

March - 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 92% for March 2022, and is currently outside control limits. This relates to 10 outstanding follow ups from 154 discharges in March of which, 2 patients were discharged to the care of FTB, 2 patients were discharged to the care of another mental health trust, 2 patients did not return to the ward and were reported as missing to the police, attempts were made to see 2 patients but were unsuccessful and 2 patients ahve been seen but data entry is awaited. Of the 10 exceptions 9 were acute adult and 1 was from ICCR.
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.
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.

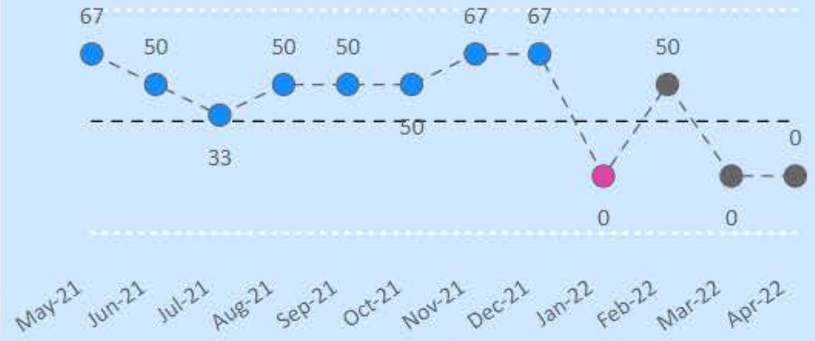
Birmingham and Solihull Mental Health NHS Foundation Trust

CPA with Formal Review last 12 mths

Trust level

A: All

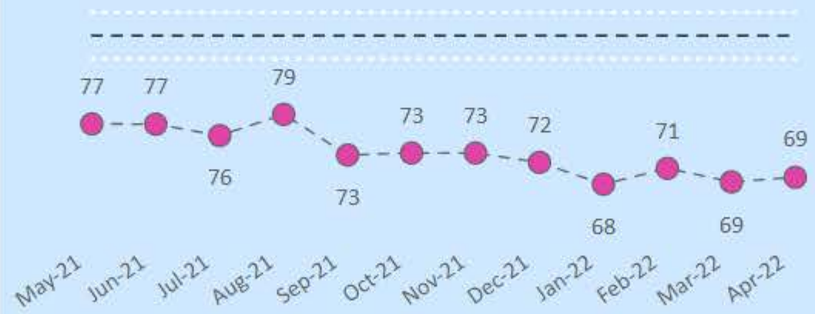
B: Acute and Urgent Care



C: ICCR

D: Secure Serv & Offender Health

E: Specialties



F: Corporate

Key

UCL LCL Value Mean Concern Improvement

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Detailed Commentary

CPA with Formal Review last 12 mths

March - 2022

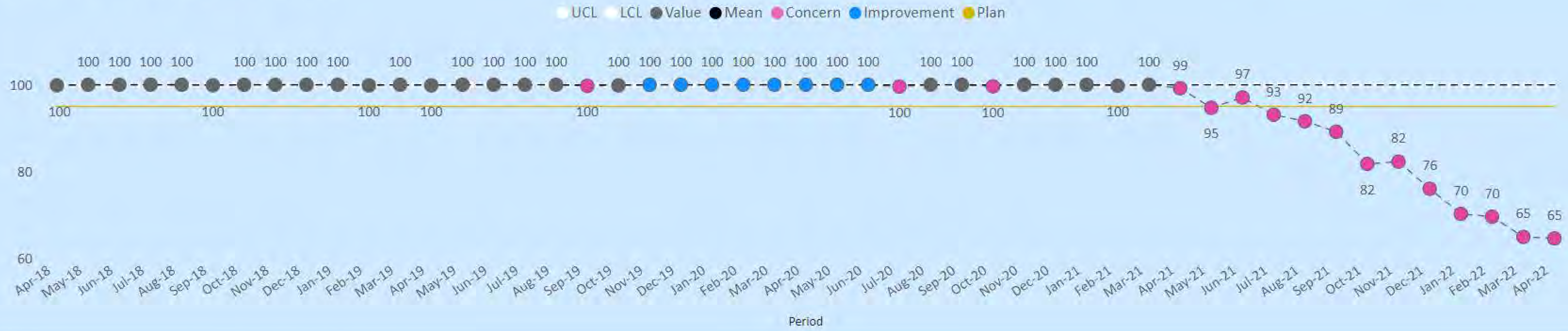
Question	Answers
A: What has happened?	Performance has consistently declined over the last year and has been outside the control limits since July 2019. The rate was maintained at an average of 89% since April 2021 until October which declined to 87%. This was sustained until January 2022 and has then reduced further to 86%. March 2022 has remained at 86%. Adult CMHT account for 56%, older adult CMHT for 4%, Secure for 14% and AOT for 21%.
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.
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

IAPT seen in 18 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A: All	82.3%	76.0%	70.2%	69.6%	64.9%	64.6%
E: Specialties	82.3%	76.0%	70.2%	69.6%	64.9%	64.6%

Commentary

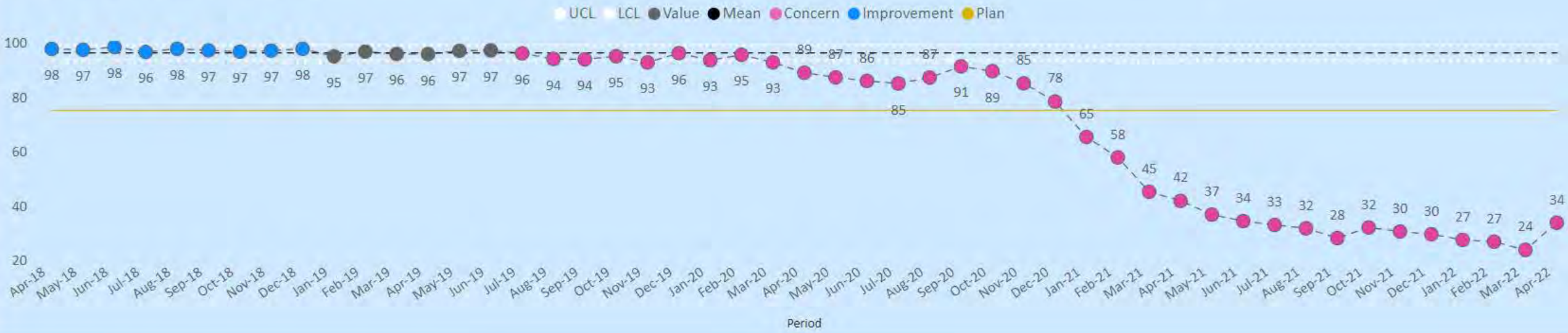
Performance has been on a reducing trend for the last 8 months and has been below the 95% target for the last 7 months. March 2022 has shown a further decrease to 64.92%. The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments in 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.

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	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A: All	30.5%	29.5%	27.4%	26.8%	23.7%	33.7%
E: Specialties	30.5%	29.5%	27.4%	26.8%	23.7%	33.7%

Commentary

Performance has been on a reducing trend since March 2020 below the 75% target. March 2022 has continued to reduce and is at 23.7%, the lowest percentage to date.
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

March - 2022

Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 below the 75% target. March 2022 has continued to reduce and is at 23.7%, the lowest percentage to date. 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

Out of Area Bed Days

Divisions

Statistical Process Control (SPC)

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

Division	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A: All	591	583	553	332	270	416
B: Acute and Urgent Care	591	583	553	332	270	416

Commentary

Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January at 575 bed days. Numbers have started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease has continued in March 2022 to 270 OOA bed days. The number of new OOA admissions has reduced from 9 in January to 3 in February 2022 taking the full month's number to 19 OOA placements.

From the 1st October 2021 NHSE have agreed a Standard Operating Protocol (SOP) with the Trust to enable 10 Priory acute beds based in Willenhall to be classified as 'appropriate placements' for 6 months until 31st March 2022 in addition to the same classification for the MERIT beds. Internal reporting and commissioner reporting from 1st October 2021 has been amended to reflect this change. It has also been agreed by NHSE that any patients admitted to

Out of Area Bed Days

March - 2022

Question	Answers
A: What has happened?	Key areas of the out of area implementation plan have continued to be implemented and in April 2021, a significant reduction in the number of OBDs was achieved, down to 643, below pre covid levels and the lowest number in the previous 16 months. This was sustained through to September 2021. As a result of the additional acute bed capacity commissioned from October, OOA bed days reduced further to 430 days. However due to demand and COVID pressures on ward closures has seen an increase with the average from November to January at 575 bed days. Numbers have started to fall with a significant reduction in February 2022 due to the increased PICU bed capacity to 332 days. This decrease has continued in March 2022 to 270 OOA bed days. The number of new OOA admissions has reduced from 9 in January to 3 in February 2022 taking the full month's number to 19 OOA placements. From the 1st October 2021 NHSE have agreed a Standard Operating Protocol (SOP) with the Trust to enable 10 Priory acute beds based in Willenhall to be classified as 'appropriate placements' for 6 months until 31st March 2022 in addition to the same classification for the MERIT beds. Internal reporting and commissioner reporting from 1st October 2021 has been amended to reflect this change. It has also been agreed by NHSE that any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements' from the 1st January 2022. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHS Digital currently does not recognise the bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The observed reductions are a combination of a range of actions that are being implemented within the urgent and acute care service including the daily bed state review meetings, weekly multi agency meetings, implementation of the crisis houses, use of respite beds and targeted support and action via the 2 discharge coordinators to review complex cases. In addition, additional bed capacity has been purchased with support from commissioners is being utilised. The additional investment includes the procurement of 22 additional beds with the Priory, 12 PICU and 10 acute beds with admissions to the Woodbourne Priory and Willenhall being counted as 'appropriate'. Latest available national benchmarking data continues to identify the Trust as having one of the lowest number of adult acute beds per 100,000 weighted population. During December and -March 2022 there have been a number of covid outbreaks on inpatient wards which have resulted in them closing to new admissions which has applied additional pressure. 1 ward has been closed since january which has reduced acute capacity. Of the 5 new OOA placements in March 3 were for an acute bed and 2 were PICU admissions.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans receive national and commissioner scrutiny which will increase if the Trust is unable to demonstrate continuing progress.
D: What are we doing about it?	See above for actions being taken. The out of area reduction plan is continuing to be implemented to support the repatriation of patients and increase the flow within existing trust beds. Additional bed capacity has been commissioned with commissioner support, and NHSE have agreed that Standard operating Protocol (SOP) to enable the 10 Priory acute beds based in Willenhall to be classed as 'appropriate placements' from 1st October 2021 for 6 months until 31st March 2022. It has also been agreed by NHSE that from the 1st January 2022 any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements'. Any patients admitted to PICU beds elsewhere will continue to be classified

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

March - 2022

Question	Answers
	the 1st January 2022. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHS Digital currently does not recognise the bespoke arrangements agreed via NHSE/I. Discussions are taking place with NHSE/I leads as to how these changes can be reflected in national MHSDS submissions as the Priory beds at Willenhall will continue to be classified as 'inappropriate'. As a result, until this issue is resolved, there will be a difference between national reporting using MHSDS as the data source and local Trust reporting. Commissioners are also aware of this anomaly.
B: Why has it happened?	The observed reductions are a combination of a range of actions that are being implemented within the urgent and acute care service including the daily bed state review meetings, weekly multi agency meetings, implementation of the crisis houses, use of respite beds and targeted support and action via the 2 discharge coordinators to review complex cases. In addition, additional bed capacity has been purchased with support from commissioners is being utilised. The additional investment includes the procurement of 22 additional beds with the Priory, 12 PICU and 10 acute beds with admissions to the Woodbourne Priory and Willenhall being counted as 'appropriate'. Latest available national benchmarking data continues to identify the Trust as having one of the lowest number of adult acute beds per 100,000 weighted population. During December and -March 2022 there have been a number of covid outbreaks on inpatient wards which have resulted in them closing to new admissions which has applied additional pressure. 1 ward has been closed since january which has reduced acute capacity. Of the 5 new OOA placements in March 3 were for an acute bed and 2 were PICU admissions.
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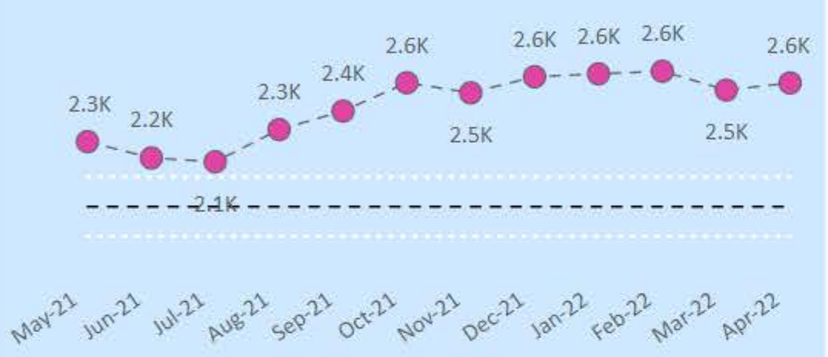
D: What are we doing about it?	See above for actions being taken. The out of area reduction plan is continuing to be implemented to support the repatriation of patients and increase the flow within existing trust beds. Additional bed capacity has been commissioned with commissioner support, and NHSE have agreed that Standard operating Protocol (SOP) to enable the 10 Priory acute beds based in Willenhall to be classed as 'appropriate placements' from 1st October 2021 for 6 months until 31st March 2022. It has also been agreed by NHSE that from the 1st January 2022 any patients admitted to a PICU bed at Woodbourne Priory will be classed as 'appropriate placements'. Any patients admitted to PICU beds elsewhere will continue to be classified as 'out of area' due to geographical distance. Longer term options include the potential for a capital build solution which is at an exploratory stage. Mary Seacole ward 2 has reopened at the end of March which will restore the level of acute beds internally.
E: What do we expect to happen?	Monthly use of Out of area beds is expected to continue but reducing as the range of actions get implemented and embedded and more recently as a result of the SOP agreed with NHSE. However, it should be noted that the service is currently facing significant Covid-19 pressures in terms of outbreaks on wards and impact on staff sickness absence levels.
F: How will we know when we have addressed issues?	When the numbers of OOA bed days reduce in line with the trajectory submitted in the action plan. Operational meetings have continued to take place to maintain the implementation of the actions required to support the actions on a sustainable basis. Stabilisation in terms of inpatient capacity and the Trust's plan to review new ways of working will further assist in taking forward this workstream.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

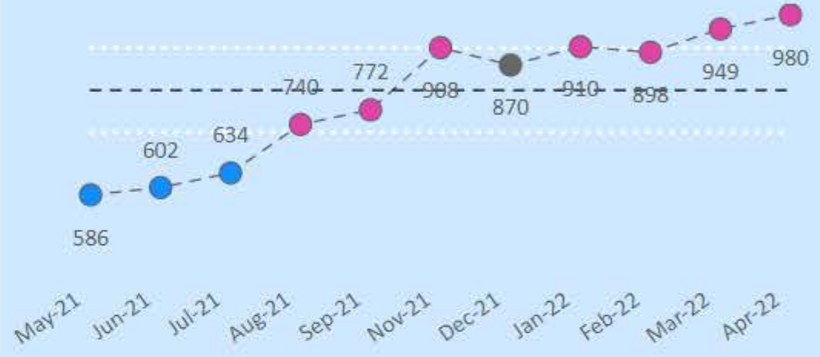
Trust level

A: All



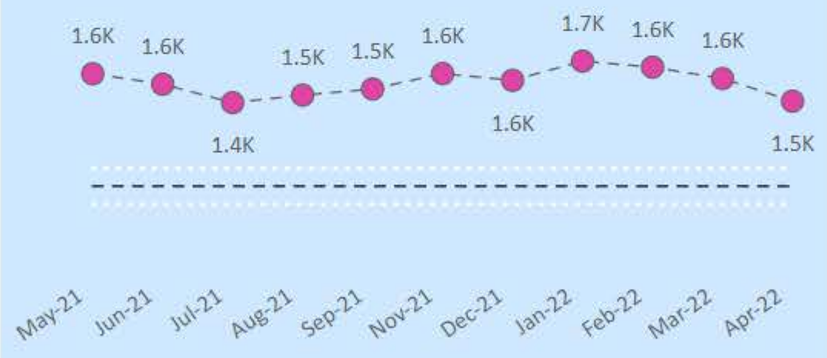
B: Acute and Urgent Care

C: ICCR



D: Secure Serv & Offender Health

E: Specialties



F: Corporate

Key

UCL LCL Value Mean Concern Improvement

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

March - 2022

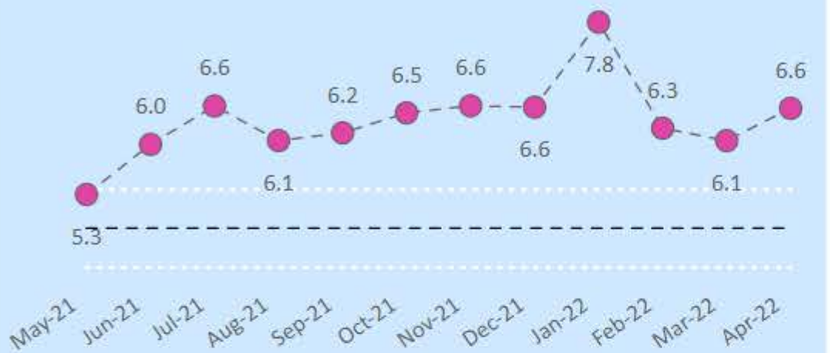
Question	Answers
A: What has happened?	The number of new referrals without a contact had been on an increasing trend pre Covid due to demand exceeding available capacity, with pressures in CMHTs and the neuropsychiatry service in particular. The number of patients who have not been seen after 3 months 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 2641 in Feburary 2022. March 2022 has seen a small decline to 2538. The number of referrals not seen within 3 months of referral have increased in all services with the exception of MAS and neuropsychiatry which have shown a slight decrease. 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 30% and Adult CMHTs 26% 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 increased 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.

Birmingham and Solihull Mental Health NHS Foundation Trust

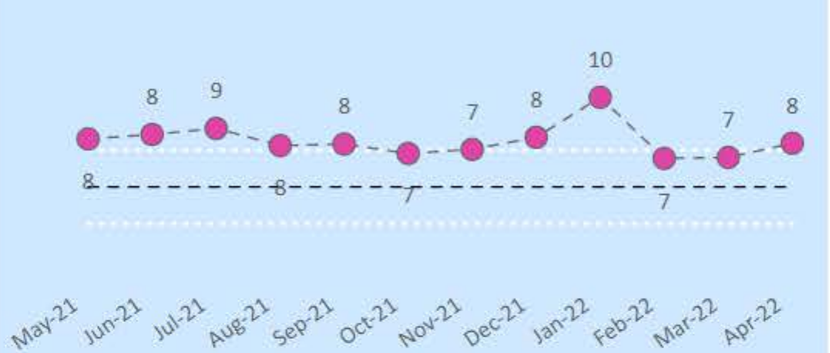
Staff Sickness

Trust level

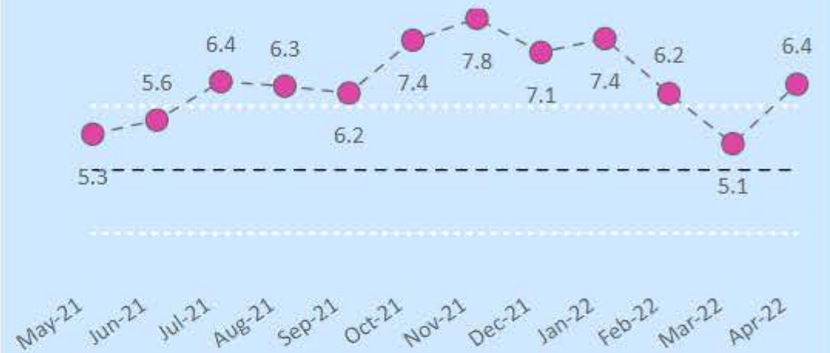
A: All



B: Acute and Urgent Care

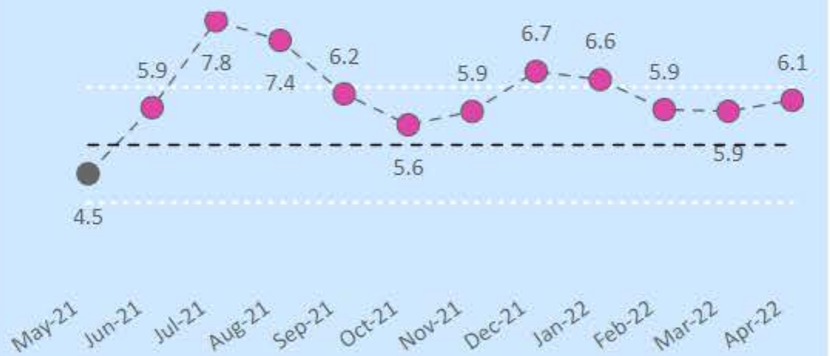


C: ICCR



D: Secure Serv & Offender Health

E: Specialties



F: Corporate

Key

UCL LCL Value Mean Concern Improvement

Detailed Commentary

Staff Sickness

March - 2022

Question	Answers
A: What has happened?	Sickness absence saw a decrease in March to 6.10% from 6.28% in February 2022. Non-covid related sickness absence slightly increased by 0.23% whilst Covid-19 related sickness absence slightly increased to 1.46% in March from 1.40% in February. There was a decrease in short term sickness absence by 0.09% whilst long term sickness absence also decreased by 0.09%. Overall sickness absence rates by division for March are as follows: Specialties – 5.89%; ICCR – 5.15%; Secure Services and Offender Health – 7.99%; and Acute and Urgent Care – 6.68%.
B: Why has it happened?	Covid related sickness decreased significantly in March. Covid-19 related sickness accounted for 31% of all sickness in March compared with 22% in February, 35% in January, 19.8% in December, 13.6% in November, 12% in October, 26% in September, 19% in August,17% in July, 14.3% in June, 16.9% in May, 18.1% in April, 21.3% in March, 35.0% in February and 41.4% in January. This will continue to be monitored and the potential impact of this on staffing levels. The top specified reasons for sickness absence in February were cold, cough, flu – influenza (accounting for 27.8% of all sickness absence which includes COVID-19); Anxiety/stress/depression/other psychiatric illness ; other musculoskeletal problem and Gastrointestinal problems;
C: What are the 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
D: 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. The People Team continue to deliver bite size training for managers around sickness absence monitoring whilst the full HR Toolkit training is being refreshed . This training is also available to individual teams if required. Monthly meetings with managers continue to be held between Divisional SMT's and the People Advisors/People Managers as a support measure in managing sickness absence. Weekly reports are being produced on the impact of Long Covid on our staff, with cases carefully managed to ensure individuals are receiving the right support. In response to feedback from staff and managers, psychological support in the form of workshops will be delivered by PAM late April to Sept 22. The People Team will continue to work with managers, staff and OH to support staff back to work where appropriate and develop wellness plans. The Trusts Flexible Working policy has recently been reviewed, this will be followed by a dedicated communication plan to promote flexible working and the benefits of a good work-life balance.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

March - 2022

Question	Answers
	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
D: 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. The People Team continue to deliver bite size training for managers around sickness absence monitoring whilst the full HR Toolkit training is being refreshed . This training is also available to individual teams if required. Monthly meetings with managers continue to be held between Divisional SMT's and the People Advisors/People Managers as a support measure in managing sickness absence. Weekly reports are being produced on the impact of Long Covid on our staff, with cases carefully managed to ensure individuals are receiving the right support. In response to feedback from staff and managers, psychological support in the form of workshops will be delivered by PAM late April to Sept 22. The People Team will continue to work with managers, staff and OH to support staff back to work where appropriate and develop wellness plans. The Trusts Flexible Working policy has recently been reviewed, this will be followed by a dedicated communication plan to promote flexible working and the benefits of a good work-life balance. The Trusts Sickness Absence Policy is currently under review and will be circulated for consultation in April 2022. The title and content has been reviewed to ensure there is a focus on preventative and wellbeing interventions following a number of engagement workshops with staff networks. The Trusts Health & Wellbeing Steering group continues to meet monthly to refresh and evaluate our H&W offer to staff. Additionally representatives from the People team continue to meet with the ICS H&W working group to share best practice and partnership working. Face to face health checks for staff will be stood back up from April 22. A key piece of work for the H&W Steering group for quarter 1 will be to improve our financial wellbeing support for staff
E: What do we expect to happen?	Sickness absence rates will come within the Trust's target percentage although may still be impacted by the trajectory of Covid-19 infections – whilst these are reducing we expect to see sickness absence reduce (although absence related to Covid-19 is already low). A change in trajectory of the virus however would impact figures. We will continue to undertake proactive work to improve health and wellbeing and support managers to actively manage sickness absence to reduce non-Covid absence. With the above measures in place we expect to see an improvement in the next 3-6 months.
F: How will we know when we have addressed issues?	A sustained reduction in sickness levels reaching the Trust's target figure and bank/agency bookings for sickness which will be monitored and reported monthly.

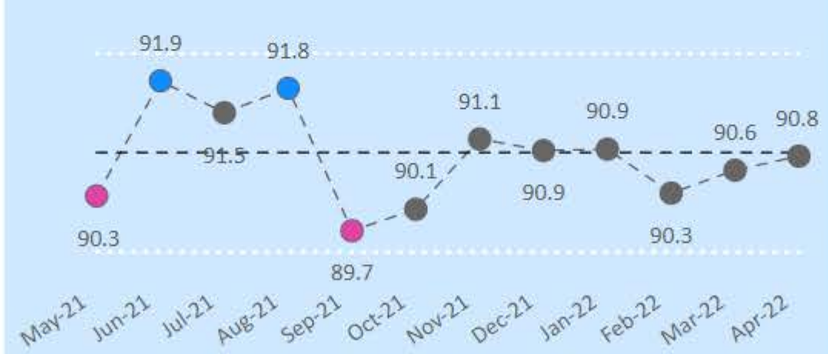
Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

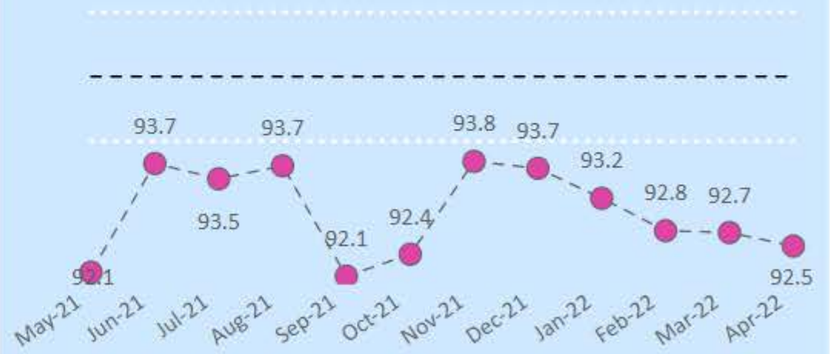
Trust level

A: All

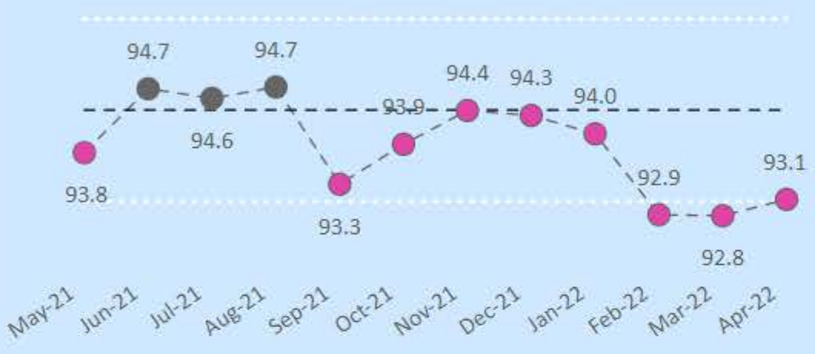
B: Acute and Urgent Care



C: ICCR



D: Secure Serv & Offender Health



E: Specialties

F: Corporate

Key

UCL LCL Value Mean Concern Improvement

compassionate inclusive committed

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

March - 2022

Question	Answers
A: What has happened?	Trust Target 95% Substantive staff Fundamental Training decreased to 89.3% from 91.9% in February, an decrease of 2.6% FT breakdown by division is as follows: All divisions are reported a decrease in March: Secure and Offender Health – down 1.8% to 91%; ICCR – down 2.6% to 90.3%; Specialties – down 2.2% to 90.3% and Acute and Urgent Care – down 2.8% to 87.6%. TSS Bank Workers Trust Target 75% Bank FT compliance has remained consistent at 62.7% in March.
B: Why has it happened?	Substantive staff FT compliance: FT compliance across all operational areas have remained consistent over Quarter 4 with all areas reporting an uptick in February. As a result of BAU and Fundamental Training Team processes. However, all areas remain below Trust target 95%. There are resource issues within training teams, due to trainer absenteeism and vacancies, however the FT team have worked within these restrictions to support clinical areas with bookings and availability, so we have now seen an uptick but still not enough to satisfy commissioners Withdrawals have decreased, however the volume of DNA's remain unsustainable & coupled with the increase in new starters compromises the agreed 12% buffer.
C: What are the implications and consequences?	Business, Administration and Financial Risks: Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. Breach of commissioners compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. Workforce growing but training resources unable to expand to offer the additional training needed to achieve sustain compliance. TSS are not included in overall Trust compliance however are required to undertake training, yet no additional training provision is available to increase capacity so as to include TSS staff- this results in either a drop in substantive compliance or a TSS workforce who do not have the skills to practice safely. Fails to develop an inclusive and compassionate working environment, resulting in demotivated workforce.
D: What are we doing about it?	FT Team will be reinstating FT compliance chase ups mid Feb FT have requested additional team resources to enable them to manage TSS compliance and alternate streamlined processes for booking and reaching compliance for all colleagues

Detailed Commentary

Fundamental Training

March - 2022

Question	Answers
	FT compliance across all operational areas have remained consistent over Quarter 4 with all areas reporting an uptick in February. As a result of BAU and Fundamental Training Team processes. However, all areas remain below Trust target 95%. There are resource issues within training teams, due to trainer absenteeism and vacancies, however the FT team have worked within these restrictions to support clinical areas with bookings and availability, so we have now seen an uptick but still not enough to satisfy commissioners Withdrawals have decreased, however the volume of DNA's remain unsustainable & coupled with the increase in new starters compromises the agreed 12% buffer.
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D: What are we doing about it?	FT Team will be reinstating FT compliance chase ups mid Feb FT have requested additional team resources to enable them to manage TSS compliance and alternate streamlined processes for booking and reaching compliance for all colleagues
E: What do we expect to happen?	Post Covid recovery plans and associated trajectories have calculated that FT recovery for substantive staff is being achieved, as long as the DNA rate and staff turnover does not exceed the Trust agreed 12%. Early indications show the comms is having a positive affect – staff are feeding back how useful the email is. The FT team are seeing a 50% increase in email traffic, staff booking training, reporting issues with traffic lights and querying relevant training. TSS Training and compliance is managed by the TSS administration team, with guidance from the Fundamental Training Team when required.
F: How will we know when we have addressed issues?	With uptake of training offers and when the trajectories offered to the executive team and commissioners are achieved on the cited date. With successful recruitment into Resus Training positions Engagement with relevant stakeholders to address issues as the emerge.

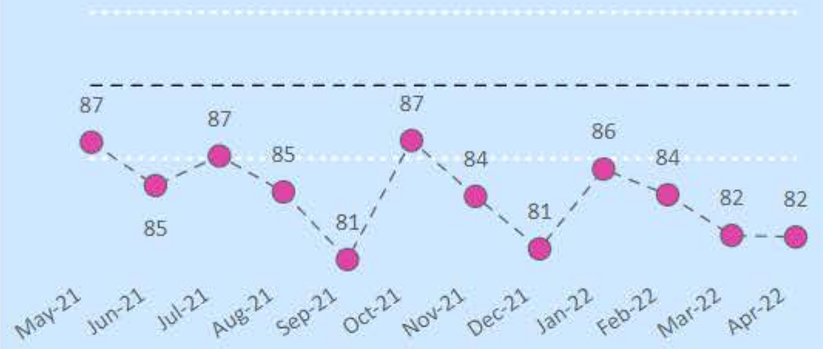
Birmingham and Solihull Mental Health NHS Foundation Trust

Bank & Agency Fill Rate

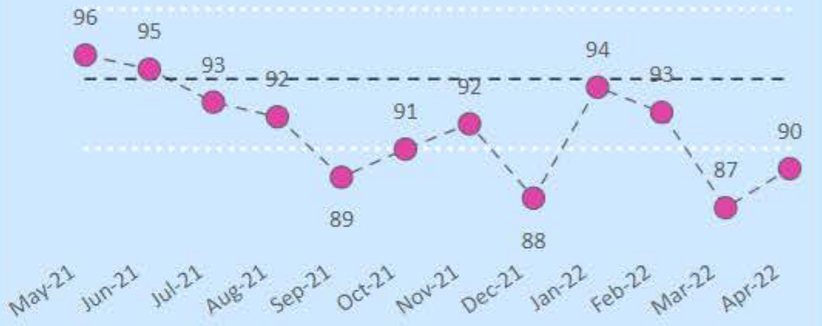
Trust level

A: All

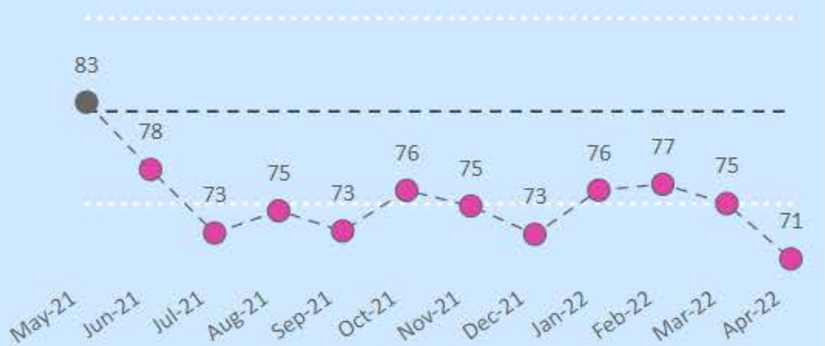
B: Acute and Urgent Care



C: ICCR

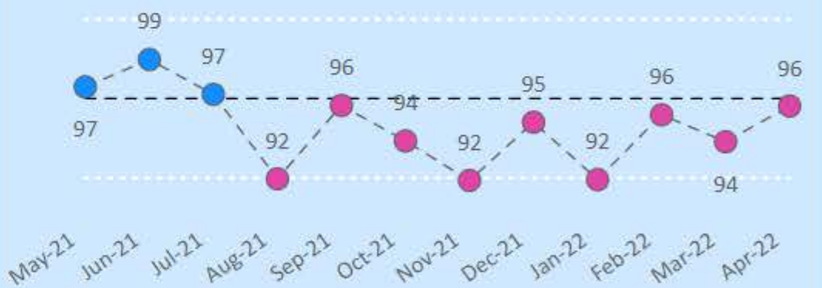


D: Secure Serv & Offender Health



E: Specialties

F: Corporate



Key

UCL LCL Value Mean Concern Improvement

compassionate inclusive committed

Detailed Commentary

Bank & Agency Fill Rate

March - 2022

Question	Answers
A: What has happened?	The bank and agency fill rate decreased to 83% in March from 85.2% in February. Although the bank fill rate remained relatively stable, the agency fill rate showed an decrease by 2.2% , accounting for the overall decrease in the combined bank and agency fill rate figure. The fill rate breakdown by division is as follows: ICCR – 88.7%; Specialties – 86.4%; Acute and Urgent Care – 83.2%; and Secure Services and Offender Health – 75.4%. The number of shifts requested in March increased by 2,465 compared to February. Bank filled 1,432 more shifts in March than February, and agency filled 279 more shifts. The breakdown of shifts requested by division is as follows: ICCR – 1,977; Specialties – 3,077; Secure Services and Offender Health – 5,455; and Acute and Urgent Care – 6,099.
B: Why has it happened?	18,104 temporary staffing shifts were requested in March. This is a significant increase from February and the highest number this financial year, higher than January when we have significant staffing issues. 15,034 shifts were filled in March (13,737 of these were bank). Despite a huge increase in shifts requested the fill rate has only slightly decreased (16% increase of shifts booked from February against 2.2% reduction in fill rates). The main reasons for requested shifts in March were: Clinical Activity (6,833 shifts requested); Additional Work (3,350 shifts requested); Vacancies (2286 shifts requested); Block booking (1,374 shifts requested) and sickness (1099). There has been a reduction in shifts requested for COVID-19 (from 913 in February to 694 in March)
C: What are the 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
D: What are we doing about it?	£5 enhancements as an incentive to fill shifts were offered to Ardenliegh RMN's midweek, for all shifts, for the first 10 days of March and £5 enhancements were offered to Lavender Ward for both HCA's and RMN's, for all shifts, including weekends, for the first 10 days of March. TSS leadership team held a second 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 In March 61 additional workers started with TSS, compared to 29 in February Despite a huge increase in shifts requested (the highest of the financial year) the fill rate has only slightly decreased (16% increase of shifts booked from February against 2.2% reduction in fill rates). Additional factors in March which increased shifts requested and decreased (slightly) fill rates was the unexpected good weather and a substantial number of substantive staff booking annual leave before the end of the financial year.
E: What do we expect to happen?	With the work ongoing to reduce agency spend we expect agency fill rates to decrease and bank fill rates to increase. However it should be noted that with the winter season nearly here and a predicted rise in the number of requested shifts may further impact on the Trust's fill rates
F: How will we know when we have addressed issues?	The overall bank and agency fill rate increases.

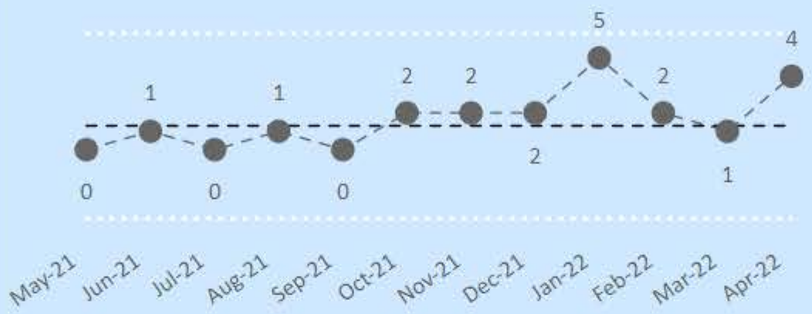
Birmingham and Solihull Mental Health NHS Foundation Trust

Ligature with anchor point

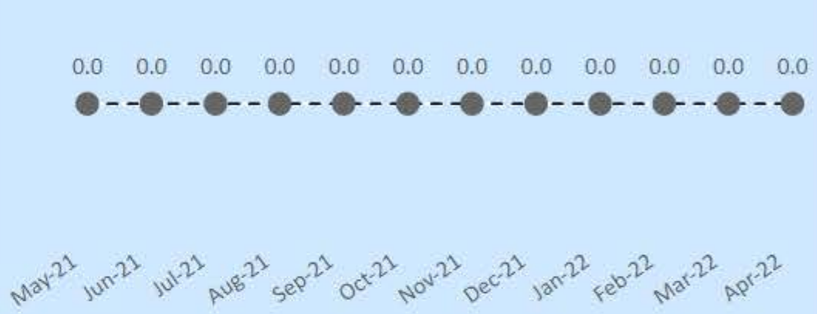
Trust level

A: All

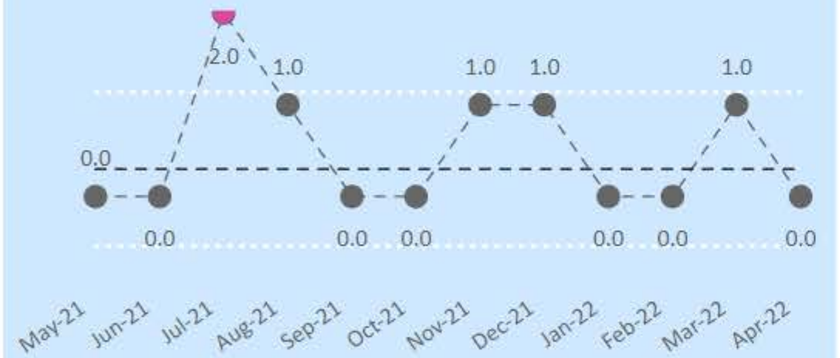
B: Acute and Urgent Care



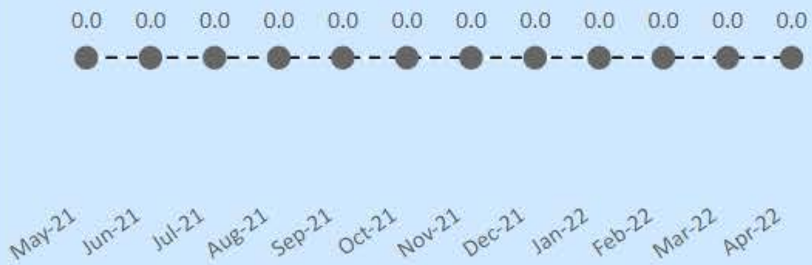
C: ICCR



D: Secure Serv & Offender Health



E: Specialties



F: Corporate

Key

UCL LCL Value Mean Concern Improvement

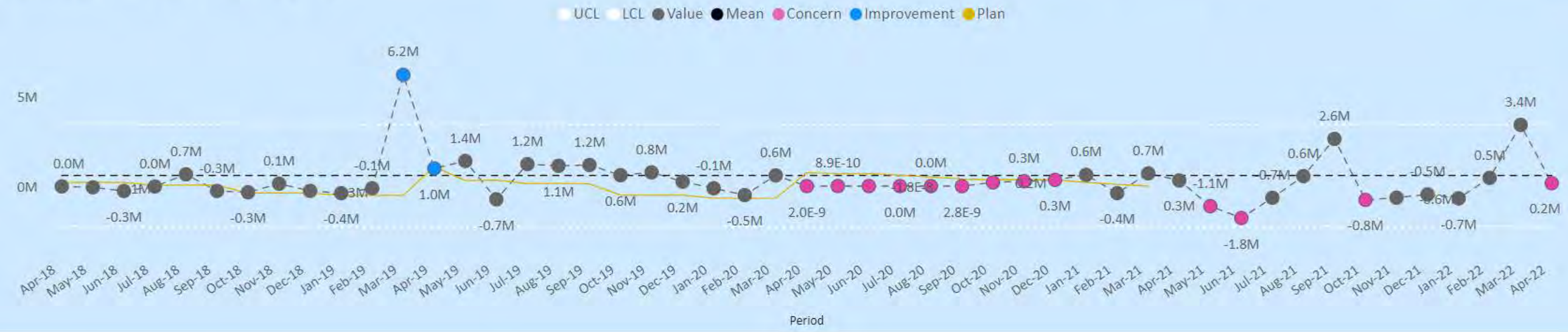
compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

Operating Surplus

Divisions

Statistical Process Control (SPC)



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

Division	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A: All	-£645k	-£463k	-£681k	£456k	£3,406k	£157k

Commentary

YTD surplus of of £2.1m v plan of breakeven

Detailed Commentary

Operating Surplus

March - 2022

Question	Answers
A: What has happened?	YTD surplus of of £2.1m v plan of breakeven
B: Why has it happened?	Delays in recruitment against additional income received for services, erformance slightly better than plan
C: What are the implications and consequences?	None as yet
D: What are we doing about it?	Developing savings plans
E: What do we expect to happen?	Trust to slightly better plan
F: How will we know when we have addressed issues?	Monthly underlying surplus returns to breakeven and remains in financial balance

Birmingham and Solihull Mental Health NHS Foundation Trust

MEETING	**BOARD OF DIRECTORS MEETING**
AGENDA ITEM	**16**
PAPER TITLE	**MONTH 1 2022/23 FINANCE REPORT**
DATE	25th May 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 1 Group position is a deficit of £0.2m, in line with plan. The position comprises 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.

2022/23 Planning
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 is a £0.4m improvement to the proposed plan of £3.1m presented at month 12 FPP and is 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 is subject to final system allocation).

Capital position
Month 1 Group capital expenditure is £50k, which is £110k less than plan.

Cash position
The month 1 Group cash position is £54m.

Reason for consideration:

Update on month 1 financial position and 2022/23 financial plan.

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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2022 to 30th April 2022

Month 1
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget £'000	YTD Position Budget £'000	YTD Position Actual £'000	YTD Position Variance £'000
Income				
Healthcare Income	293,205	24,434	23,858	(575)
Other Income	107,311	8,943	8,284	(658)
Total Income	**400,516**	**33,376**	**32,143**	**(1,234)**
Expenditure				
Pay	(236,738)	(19,728)	(18,877)	851
Other Non Pay Expenditure	(130,286)	(10,856)	(10,549)	307
Drugs	(5,956)	(496)	(542)	(45)
Clinical Supplies	(871)	(74)	(43)	30
PFI	(11,130)	(928)	(806)	122
EBITDA £'000	**15,534**	**1,295**	**1,325**	**31**
Capital Financing				
Depreciation	(9,983)	(832)	(823)	9
PDC Dividend	(1,930)	(161)	(161)	-
Finance Lease	(4,845)	(404)	(400)	3
Loan Interest Payable	(1,154)	(93)	(100)	(7)
Loan Interest Receivable	97	4	33	29
Surplus / (Deficit) before taxation	**(2,281)**	**(190)**	**(125)**	**65**
Taxation	(380)	(32)	(32)	(0)
Surplus / (Deficit) £'000	**(2,661)**	**(222)**	**(157)**	**64**

Month 1 2022/23 Group Financial Position

The month 1 consolidated Group position is a deficit of £0.2m, this is in line with plan.
The Trust month 1 position is a £0.2m deficit. Trust pay and non underspend is mainly driven by Service Development Fund (SDF) recruitment slippage as we awaited confirmation of final SDF allocation. SDF income has been deferred to offset this.
The Group position includes a £22k deficit for our wholly owned subsidiary, Summerhill Services Limited (SSL) and a break even position for the Reach Out Provider Collaborative.

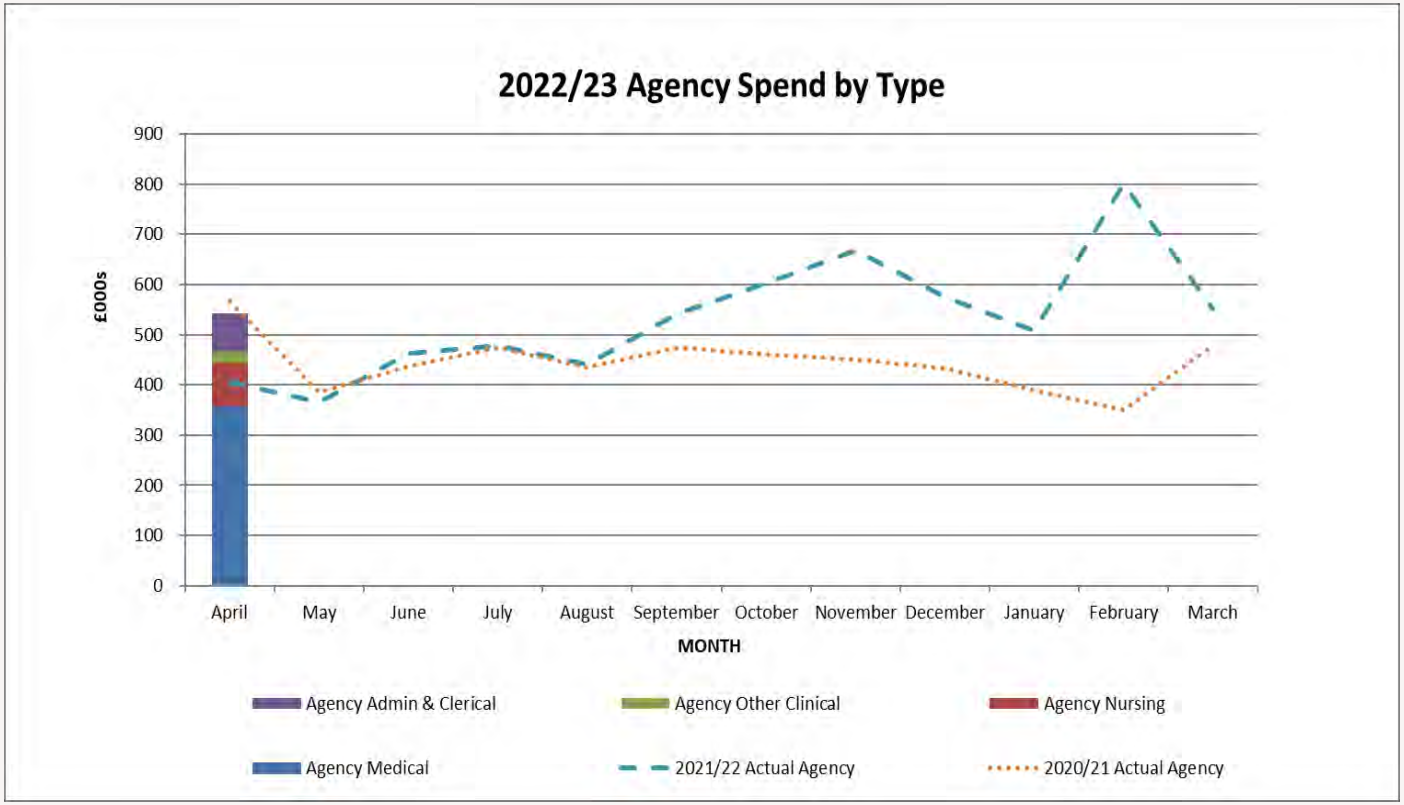
2022/23 Financial plan

The 2022/23 Group financial plan is a deficit of £2.7m as submitted to NHSEI on 28/4/22. For further detail on both the revenue and capital plan, see pages 10 to 13.

Agency expenditure

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)	542												**542**
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	(41)												(41)
Agency Medical	358												358
Agency Nursing	86												86
Agency Other Clinical	21												21
Agency Admin & Clerical	77												77
Agency Spend (£000s)	**542**												**542**



Month 1 agency expenditure is £542k. This is £74k less than the anticipated NHSEI ceiling and £41k above the internal stretch target.

The total expenditure in April of £542k is £137k above that in April 2021. It is £9k above the 2021/22 monthly average of £533k, mainly driven by medical agency, partly offset by nursing agency spend.

	2021/22 Average
Agency Medical	336
Agency Nursing	104
Agency Other Clinical	26
Agency Admin & Clerical	67
Agency Spend (£000s)	**533**

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

- We ceased paying the agency rate to cap on 7/2/22.
- Due to the current staffing pressures, twice monthly adverts are continuing for bank nurses, HCAs and administrators to increase capacity.

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Draft'* 31-Mar-22 £m's	NHSI Plan YTD 30-Apr-22 £m's	Actual YTD 30-Apr-22 £m's	NHSI Plan Forecast 31-Mar-23 £m's
Non-Current Assets				
Property, plant and equipment	186.5	204.0	203.9	201.9
Prepayments PFI	1.6	1.3	1.4	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	205.4	205.4	203.3
Current assets				
Inventories	0.4	0.4	0.4	0.4
Trade and Other Receivables	9.7	11.1	15.3	11.1
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	54.5	53.6	49.9
Total Curent Assets	38.9	66.0	69.2	61.5
Current liabilities				
Trade and other payables	(29.4)	(46.4)	(46.3)	(46.2)
Tax payable	(4.4)	(4.8)	(5.0)	(4.8)
Loan and Borrowings	(2.7)	(2.7)	(2.4)	(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)	(28.8)	(25.3)
Total Current Liabilities	(50.9)	(81.3)	(84.5)	(81.2)
Non-current liabilities				
Loan and Borrowings	(29.5)	(26.6)	(26.6)	(25.1)
PFI lease	(49.3)	(47.4)	(47.4)	(45.8)
Finance Lease, non current	-	(6.5)	(6.5)	(5.6)
Provisions	(2.4)	(4.3)	(4.3)	(4.3)
Total non-current liabilities	(81.3)	(84.9)	(84.9)	(80.9)
Total assets employed	94.9	105.2	105.2	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)	(44.6)	(44.6)	(47.1)
Total taxpayers' equity	94.9	105.2	105.2	102.7

SOFP Highlights

The Group cash position at the end of April 2022 is £53.6m (this includes Reach Out).

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 5 to 6.

Current Assets & Current Liabilities

Ratios

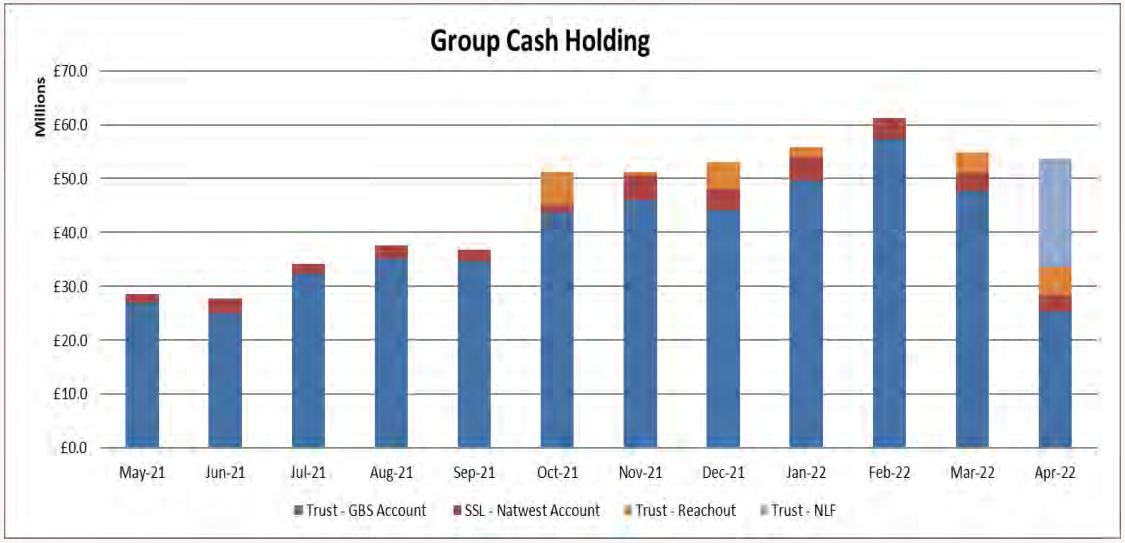
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

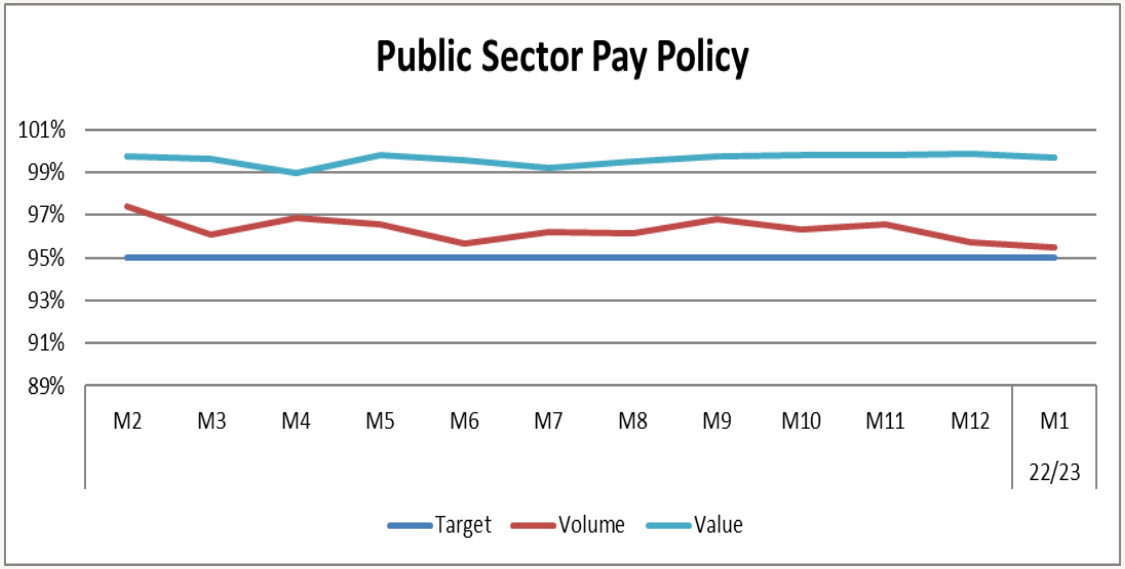
Current Ratio :	**£m's**
Current Assets	69.2
Current Liabilities	-84.5
Ratio	0.8

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

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of April 2022 is £53.6m.

In April 2022 we have 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

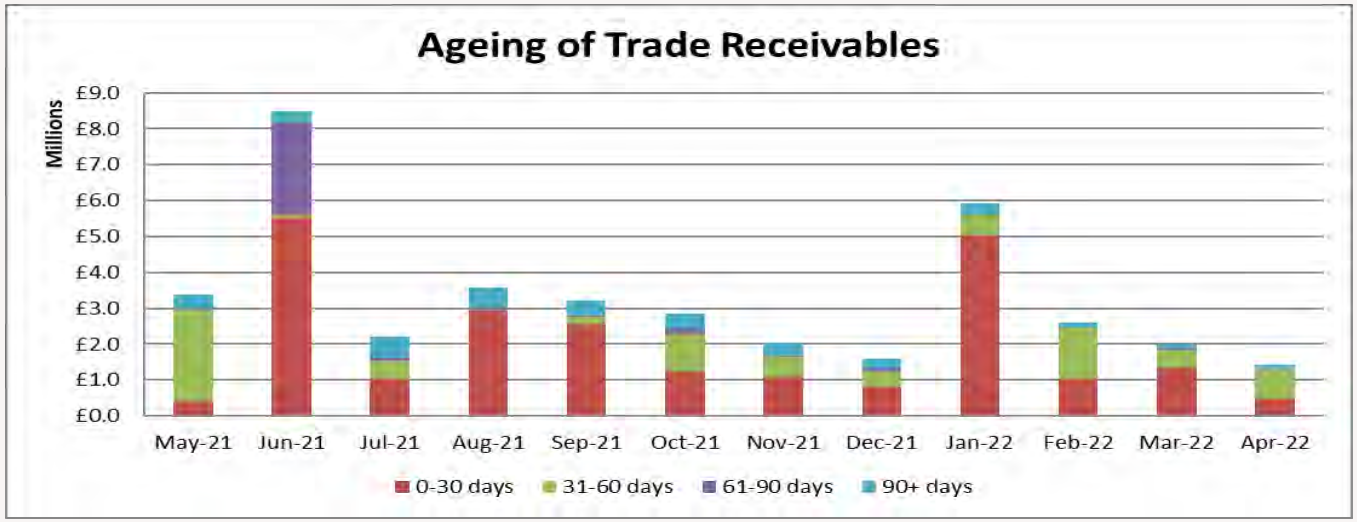
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

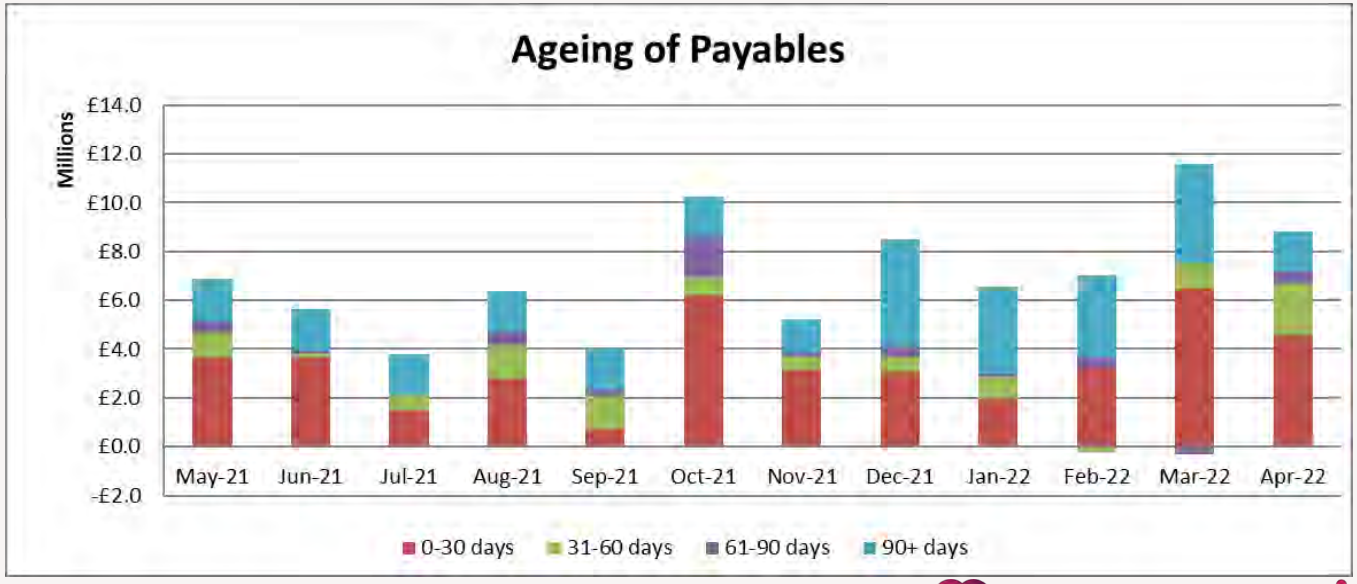
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	96%	✓	100%	✓
Non - NHS Creditors within 30 Days	95%	✓	98%	✓

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, STP and other partners where necessary for urgent and prompt resolution.

Receivables :

- **0-30 days-** decrease of balance due to year end invoices being settled
- **31-60 days- s**light increase of balance due to £463k SSL, £126k BCC, UHB £125k- no known issues
- **Over 90 days** -Staff overpayments (on payment plans)

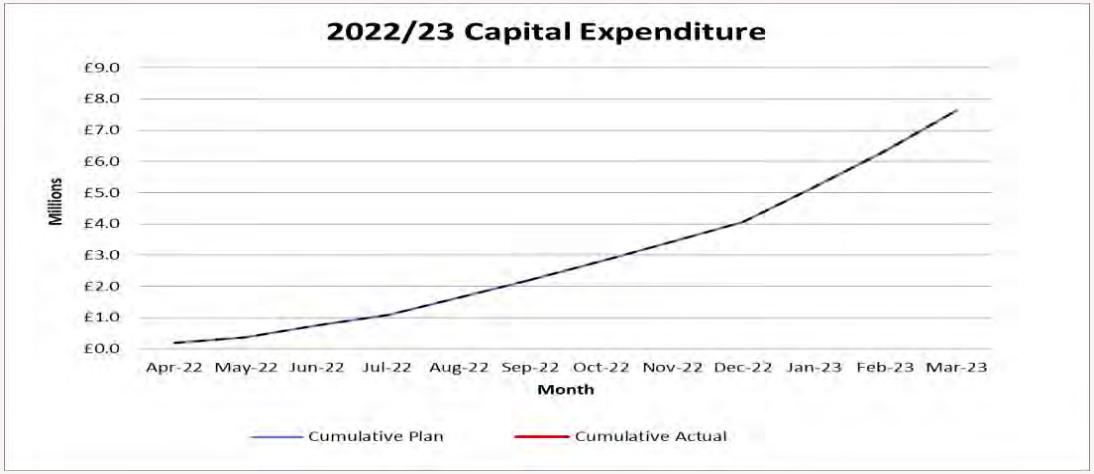
Trade Payables:

Over 90 days -

- NHS Property Services £568k– 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).
- Non-NHS Suppliers (40+) £7.1m – mainly Reach-out invoices in query, most accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in May 2022.

Month 1 Capital Expenditure

Capital schemes	Annual Plan	YTD Plan	YTD Actual		YTD Variance to plan
	£'m	£'m	£'m		£'m
Approved Schemes:					
Ligature / Doorset Works Phase 1 & 2	0.82	0.07	0.00		-0.07
Ardenleigh Coral Seclusion Suite	0.35	0.09	0.00		-0.09
SSBM Works	1.73	0.00	0.05		0.05
ICT Projects	0.75	0.00	0.00		0.00
Plan TBC:					
Risk Assessment Works	2.99	0.00	0.00		0.00
Reaside Reprovision Business Case	0.63	0.00	0.00		0.00
Total	**7.27**	**0.16**	**0.05**		**-0.11**



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 (further detail on page 12 and 13), 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. The plan for the remaining £3.6m, mainly relating to risk assessments is to be finalised.

Month 1 Group Capital Expenditure

Month 1 Group capital expenditure is £50k which is £110k less than 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 ICS Financial position Month 12

Birmingham and Solihull Mental Health NHS Foundation Trust

System revenue performance:

The 2021/22 system revenue outturn position was £19m surplus. This comprises an £0.8m surplus for H1 (April to September 2021) plus an £18m surplus for H2 (October 2021 to March 2022). This is a £19m variance to the break even plan and a £10m deterioration compared to forecast.

	H1 Actual £'000	H2 Actual £'000	Annual Actual £'000	Annual Plan £'000	Forecast £'000
B'ham and Solihull MH FT	20	1,250	1,271	0	2,000
B'ham Community Healthcare FT	0	57	57	0	0
B'ham Women's and Children's FT	393	5,149	5,542	0	10,238
Royal Orthopaedic Hospital FT	0	421	422	0	1,159
University Hospitals Birmingham	412	11,022	11,434	0	16,000
B'ham and Solihull CCG	0	276	276	0	1
System Total	**826**	**18,175**	**19,001**	**0**	**29,398**

System cash position:

As at month 12 2021/22, the system cash position was £546m. This was a £148m increase from the opening cash position and a £6m increase in month.

	Opening cash	M11	M12	Monthly movement	YTD Movement
Provider Cash	£'000	£'000	£'000	**£'000**	**£'000**
System Total	398,265	540,195	545,919	**5,724**	**147,655**

System capital performance:

The system capital plan for 2021/22 was £163m. Additional funding through PDC and donations was allocated totalling £35m, taking the capital resource available to £199m.

The month 12 system capital position was £2m underspend against the revised capital programme envelope (£32m above original programme).

		Initial Plan £m	Current Programme £m	Change £m
System Envelope		70.6	70.6	0
Outside of Envelope	ACAD	61.3	61.3	0
	Other	8.1	43.0	34.9
Funded via Donations/Disposals/Grants		16.6	17.4	0.8
PFI/LIFT		6.8	6.8	0
Total		163.4	199.1	35.7

System Capital position	2021/22 Variance	Forecast Variance
	£'000	£'000
CDEL	-31,952	-33,004
Total Programme	-32,107	-33,279

Please note, system financial reporting is one month in arrears

Birmingham and Solihull Mental Health NHS Foundation Trust

Financial Plan 2022/23

2022/23 Financial Plan - Revenue

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.

The final submitted system plan is a £5.5m improvement from the deficit plan agreed by CFOs on 13/4/22 (as reported at month 12 FPP). This is as a result of ongoing review across the system, mainly driven by increased savings requirement.

The system deficit plan of £35.8m for 2022/23 comprises:

- £31.7m inflationary pressures above the 2.8% included in the national tariff (with a further £5.5m being managed internally).
- £1.7m COVID pressures
- £2.3m specialised commissioning ERF funding reduction as a result of a national recalculation.

Changes to plan

The top table opposite shows the movement in total plan by organisation. In line with the agreement that each provider should have a fair share of the system deficit, the BSMHFT deficit plan has improved by £410k from a £3.1m deficit to £2.7m deficit. As shown in the second table opposite, this is due to an increased efficiency requirement of £410k. The SDF allocation has also been increased by £25k, this is offset by planned expenditure.

	BSMHFT £'000	BCHC £'000	BWC £'000	ROH £'000	UHB £'000	ICB £'000	Total £'000
Total relevant expenditure	287,232	314,150	461,464	113,056	1,730,437	955,595	**3,861,934**
Fair shares %	**7%**	**8%**	**12%**	**3%**	**45%**	**25%**	**100%**
Fair share of deficit (CFO agreed 13/4/22)	-3,071	-3,359	-4,934	-1,209	-18,502	-10,217	**-41,292**
Fair share of deficit (final plan submission 28/4/22)	**-2,661**	-2,910	-4,275	-1,047	-16,030	-8,852	**-35,775**
Movement	410	449	659	162	2,472	1,365	**5,517**

	Recurrent /Non Recurrent	Draft NHSEI submission 17/3/22 £'000	Adjusted plan post CFO review 13/4/22 £'000	Adjustments £'000	Final Plan submission 28/4/22 £'000
BSMHFT plan as at 4/3/22		**-8,203**	**-8,203**	**0**	**-8,203**
COVID	Non Rec	**6,048**	**6,048**	**0**	**6,048**
Recurrent reserves	Rec	807	807	0	807
Efficiency top up FIT target - fair share allocation	Rec	-1,774	-1,774	0	-1,774
Prior year Reserves		**-967**	**-967**	**0**	**-967**
System allocation - ERF	Non Rec	0	-20	0	-20
Growth - balance	Rec	0	-1,196	0	-1,196
Convergence	Rec	502	-270	0	-270
Community diagnostic growth balance	Rec	0	-6	0	-6
Health inequalites	Non Rec	520	-279	0	-279
System allocation reduction	Non Rec	-906	0	0	0
Distribution of reserves balance		**116**	**-1,771**	**0**	**-1,771**
Total system reserves applied		**5,197**	**3,310**	**0**	**3,310**
SDF income		12,023	12,023	25	12,048
SDF expenditure		-9,017	-12,023	-25	-12,048
Net SDF assumption		**3,006**	**0**	**0**	**0**
Increased efficiency requirement		**0**	**1,822**	**410**	**2,232**
Adjusted BSMHFT plan		**0**	**-3,071**	**410**	**-2,661**

2022/23 Draft Financial Plan Risks

System Risks

The following key risks have been identified for the system plan:

- Failure to deliver 104% of 19/20 elective activity by value will result in a clawback of 75% of the underperformance, up to a maximum of 75% of the system's ERF allocation. If costs do not reduce by an equivalent level, this would create a financial gap.
- Efficiency schemes are starting from a standing start this year, so supplemented by very little in terms of the full year effect of prior year schemes. The current system plan includes £33m of efficiency schemes that are unidentified, with £25m of the efficiency ask identified as a risk by organisations.
- A lack of clarity remains around the position on Specialised Commissioning income, with discussions between Providers and Specialised commissioners ongoing. Plans therefore include income assumptions which may not materialise.

BSMHFT Risks

- **Efficiencies:** the draft 2022/23 break even plan assumed delivery of an ambitious efficiency target of £8.6m, made up of a brought forward savings target and 1.1% efficiency target in line with national guidance. The final adjustments made to the system plan and the agreement that all organisations should have a fair share of the deficit, means that an additional efficiency target of £2.2m (£1.1m recurrent and £1.1m non recurrent) has been applied to the BSMHFT plan. This results in a total efficiency plan of £10.9m (£7.8m recurrent and £3.1m non recurrent).

BSMHFT 2022/23 Efficiency Target	£'000
Recurrent	6,640
Non recurrent	2,000
Efficiency plan per draft submission 17/4/22	**8,640**
Recurrent share of system efficiencies	298
Recurrent share of balance to bridge gap - fair shares	818
Non recurrent share of system £15m efficiency ask	1,116
Total Additional efficiency requirement	**2,232**
Total adjusted efficiency plan	**10,872**
Recurrent	7,756
Non recurrent	3,116

2022/23 Financial Plan - Capital

Birmingham and Solihull Mental Health NHS Foundation Trust

Capital Allocation
Birmingham and Solihull ICS has been issued with a 3 year capital envelope (years 2 and 3 indicative). For 2022/23 this is an indicative system envelope of £96m and comprises core envelope for BAU capital of £74m.

Distribution of core envelope – 2022/23 proposal:
On 13/1/22, system CFOs discussed a proposal to distribute the 2022/23 core envelope of £74m using a formulaic approach. This would result in 86% of the capital envelope being distributed with 14% (£10m) retained as a System Capital Investment Fund (SCIF).
Under this proposal, the BSMHFT share of the 86% core envelope distribution would be £5.8m. For planning purposes, a fair share of the SCIF was allocated across organisations, with our share being £0.9m. The total BSMHFT capital plan for 2022/23 as submitted in the draft planning submission on 17/3/22 was therefore £6.7m.

Birmingham and Solihull MH NHSFT	Provider Allocation	Fair Shares System Allocation
	£m	**£m**
Allocation	**5.8**	**0.9**
Pre Commitments		
Ligature / Doorset works Phase 1 and Phase 2 c/f	0.8	
Seclusion Suite - Ardenleigh Coral c/f	0.4	
Statutory Must Dos		
SSBM	1.7	
Urgent Equipment Replacement		
ICT	0.8	
Other		
Reaside Reprovision Business Case	0.6	
Risk Assessment	1.5	0.9
TOTAL	**5.8**	**0.9**

System capital prioritisation:
On 11/3/22, all system partners were required to submit prioritised capital plans to allow the System Investment Committee to review and prioritise the system capital envelope.

The BSMHFT submission is summarised opposite. This comprises schemes that have been supported by the Executive Team to allow capital planning works to commence, preventing slippage while final system capital allocation decisions are made. This includes:

- £1.2m pre-commitments for works commenced in 2021/22 (doorset works and Ardenleigh Coral Seclusion Suite)
- £1.7m essential Statutory Standards and Backlog Maintenance works
- £0.8m essential ICT capital requirement

A further £3m was identified, mainly relating to risk assessment works, taking the total submission to £6.7m in line with the draft capital plan submitted to NHSEI on 17/3/22.

2022/23 Financial Plan - Capital

System Investment Committee - Capital Prioritisation outcome

Following discussion at the System Investment Committee, funding of the £6.7m BSMHFT submission (outlined on page 12) was agreed.

In total, the Committee agreed £7.7m of system bids against the SCIF, leaving £2.4m of the total £10m SCIF to be held as a central risk reserve. For the final plan submission on 28/4/22, it was agreed that a fair share of the remaining risk reserve would be assumed in each organisational plan as summarised below. This results in a £6.9m capital plan for BSMHFT (with £0.2m notional allocation of risk reserve still to be formally allocated by the System Investment Committee).

22/23 Values		BSMHT	BCHC	BWC	ROH	UHB	System Total
Organisation Values		5,782	5,829	18,298	3,136	31,292	64,338
System Values (SCIF)	Proposed	900	300	1,785	600	4,100	7,685
	Notional	226	179	585	134	1,312	2,436
Total BAU Allocation		6,908	6,308	20,668	3,870	36,704	74,458

Asset Disposal – additional funding source

As the sale of Ross House has slipped from 2021/22 into 2022/23, the planned capital expenditure can be further increased by £0.4m as the disposal proceeds provide an additional funding source. The total capital plan included in the final plan submission for BSMHFT on 28/4/22 was therefore £7.3m (including £0.2m notional risk reserve allocation to be confirmed).

NB an additional £0.4m was included in the BSMHFT capital plan relating to system capital allocation for critical cybersecurity infrastructure risks – notionally allocated to BSMHFT for the plan submission – actual allocation across the system still to be determined.

Future years capital plans

For planning purposes, our allocated share of the 2023/24 and 2024/25 capital envelopes is £6m each year. The financial plan submission required a 5 year capital plan. For planning purposes, in the absence of capital envelopes for 2025/26 and 2026/27, a continuation of £6m per year has been assumed.