Board of Directors (Part I)

Schedule Wednesday 27 October 2021, 9:00 AM — 12:30 PM BST
Venue MS Teams
Organiser Sharan Madeley

Agenda

Agenda

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1. Opening Administration:
   Declarations of interest

2. Minutes of the previous meeting

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3. Matters Arising/Action Log

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4. Chair’s Report

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5. Chief Executive’s Report

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6. Board Overview: Trust Values: S Bloomfield

QUALITY

7. Quality and Safety Committee Chair Report

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8. Infection, Prevention & Control Annual Report

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9. People Committee Chair Report

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10. Finance, Performance & Productivity Committee Chair Report

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10.1. Audit Committee Chair Report

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13. SSL Quarterly Report

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14. West Midlands MH and LDA Provider Collab

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15. Charitable Funds Committee Chair Report

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GOVERNANCE & RISK

16. Board Assurance Framework: Quarter 2 Position

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

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

19. SNAPSHOT REVIEW OF BOARD PERFORMANCE
Were items appropriate?
Were timings appropriate?
Are there any items for inclusion on the action log?
Are there any items to be disseminated across the Trust?
Were the papers, clear, concise and aided decision making?

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

21. Date & Time of Next Meeting
- 09:00am
- 24 November 2021

AGENDA
BOARD OF DIRECTORS MEETING
WEDNESDAY 27th OCTOBER 2021 VIA VIDEO-CONFERENCING

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

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

Mr Bill Sant, Patient Story 9:30 start for this item

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Declarations of interest	*Chair*	09.00	-	-
2.	Minutes of the previous meeting		09.05	A	Approval
3.	Matters Arising/Action Log		09.10	A	Assurance
4.	Chair's Report		09.15	A	Assurance
5.	Chief Executive's Report	*CEO*	09.20	A	Assurance
6.	Board Overview: Trust Values	*S. Bloomfield*	09.25	V	Assurance
QUALITY					
7.	Quality and Safety Committee Chair Report	*L. Cullen*	10.10	A	Assurance
8.	Infection, Prevention & Control Annual Report	*S. Bloomfield*	10:20	A	Assurance
9.	Mental Health Legislation Committee Chair Report	*P. Gayle*	10:35	A	Assurance
PEOPLE					
10..	People Committee Chair Report	*P. Gayle*	10.30	A	Assurance
SUSTAINABILITY					
11.	11.1 Finance, Performance & Productivity Committee Chair Report 11.2 Audit Committee Chair Report	*G. Hunjan* *G. Hunjan*	10.40 10:45	A (to follow)	Assurance Assurance
12.	Integrated Performance Report	*D. Tomlinson*	10.50	A	Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
13.	Finance Report	*D. Tomlinson*	11.00	A	Assurance
14.	SSL Quarterly Report	*S. Bray*	11:10	A	Assurance
15. .	West Midlands MH and LDA Provider Collab	*P. Nyarumbu*	11:20	A	Assurance
16. .	Charitable Funds Committee Chair Report	*W. Weir*	11:35	A	Assurance
	GOVERNANCE & RISK				
17.	Board Assurance Framework: Quarter 2 Position	*Lead Executive Directors*	*11.45*	*A*	Approval
18.	Questions from Governors and Public (***see procedure below***)	*Chair*	*12:00*	V	Assurance
19	Any Other Business *(at the discretion of the Chair)*	*Chair*	*12:15*	*V*	-
20.	**SNAPSHOT REVIEW OF BOARD PERFORMANCE** Were items appropriate? Were timings appropriate? Are there any items for inclusion on the action log? Are there any items to be disseminated across the Trust? Were the papers, clear, concise and aided decision making?	*Chair*	*12:20*	*V*	-
22.	**RESOLUTION** The Board is asked to approve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted.				
23.	**Date & Time of Next Meeting** • 09:00am • 24 November 2021			*Chair*	

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

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

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.

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Minutes of the Trust Board Part I

Meeting	**Trust Board Part I**
Date	Wednesday 29th September 2021
Location	Via 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	Ms Danielle Oum - Trust Chair Mrs Roisin Fallon-Williams - CEO Mr David Tomlinson - Director of Finance Mr Patrick Nyarumbu - Director of Strategy, People & Partnerships Mrs Sarah Bloomfield - Director of Quality and Safety (Chief Nurse) Mrs Vanessa Devlin - Director of Operations Dr Linda Cullen- Non-Executive Director Mr Winston Weir - Non-Executive Director Mr Philip Gayle - Non-Executive Director Mrs Gianjeet Hunjan - Non-Executive Director Mrs Anne Baines – Non-Executive Director
In Attendance	Dr Renarta Rowe - Deputy Medical Director (deputising for Dr Hilary Grant) Dr Jeremy Kenney-Herbert – Reach Out Clinical Programmes Director Ms Ebru Oliver – Reach Out Associate Director Mr Richard Sollars – Deputy Director of Finance Mr Andrew Hughes – ANHH Consulting Ms Alex Rickard – ANHH Consulting Miss Sindy Jones – ANHH Consulting (Minutes) Ms Mihaela (Bianca) Khawaja – Finance Department (Staff Story) Mr Richard Prescod – Finance Department (Staff Story)
Apologies	Professor Russell Beale - Non-Executive Director Dr 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. Apologies for absence had been received from Professor R	

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	Beale, Non-Executive Director, Dr H Grant, Medical Director. No Declarations of interest were noted to be considered by the meeting.	
	Staff Story - Mihaela (Bianca) Khawaja, Finance and Business Admin Apprentice Ms B Khawaja described her experience of being a mature apprentice. She reinforced the significant support that she had received throughout her time at the Trust, both personally and professionally. She explained that she is currently undertaking a Level 3 Assistant Accountant Technician, a challenge which is compounded by the fact that English is not her first language. She highlighted how much she loves her job and values her line manager. She has gained knowledge and skills over the three years and hopes to continue to Level 4 as part of her journey to becoming a manager within the NHS. Ms D Oum said how inspirational she found the story and the commitment and hard work that Ms B Khawaja had demonstrated. She was pleased to hear that Ms B Khawaj would recommend the apprenticeship route. Ms Oum also congratulated Mr R Prescod for embodying the Trust values in his role as line manager, supporting and guiding an apprentice. In response to a question from a Governor, Ms B Khawaja confirmed that the training provider is excellent. Mr R Prescod said how much the Finance Department values its apprentices and was keen to retain them. Two current employees are former apprentices. Mr P Nyarumbu reported that the Trust had many positive experiences from its apprentices and that the role should be encourages. The challenge is to connect the Trust with the local communities and encourage young people to go down this route. The Trust currently has 110 apprentices but there is still further opportunity to create more roles. Ms D Oum thanked Ms B Khawaja for her inspiring contribution to the meeting.	
2	**Minutes of the previous meeting held on 28th July 2021** Signed as true record and approved.	
3	**Matters Arising / Action Log** Ms D Oum stated that the Action Log was missing and therefore the Board were unable to pick up any outstanding actions.	*Company Secretariat*

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4	**Chair's Report** Ms D Oum referred the Board to her Report.	
5	**Chief Executive's Report** Mrs R Fallon-Williams appraised the Board of the latest situation regarding Covid. She was delighted to report that colleagues have continued to keep people safe from covid. No patient cases have been reported. The staff absence statistics remain static at 7.6%, with 2.3% related to covid. Across the system, covid cases remain high with hospitalisation and critical care admissions. There is continuing focus on vaccination for both covid and flu. There has been limited impact of the fuel shortage on either the Trust or its wholly owned subsidiary. The Trust has responded well to the recent influx of Afghanistani refugees. The Trust continues to hold staffing huddles to respond to fluctuations in acuity and demand. The Trust is recognizing Black History Month with a series of materials and events around the "Proud to Be" theme. The position with regards to finances for the second part of the year remains unclear but the Trust is lobbying to try to make sure mental health receives as much as possible. The Trust was a highly commended finalist in the NHS Communicate Awards. The Trust won a National Services User Awards in the Breaking Barriers Category for its work with people in the Sumali community. In response from a question from Mrs G Hunjan, Mrs R Fallon-Williams committed checking the statistics around the number of staff vaccinated. Mrs R Fallon-Williams confirmed that the Anchor Employers' Pledge is being overseen by the System's People Board. Mrs R Fallon-Williams confirmed that there is a continued focus around mental health in the planning of the Commonwealth Games. Mr W Weir was pleased to hear about the Trust's involvement in Black History month and congratulated Amanda Pritchard's appointment as the first female CEO of the NHS. Mrs R Fallon-Williams reassured Mr W Weir that all employees have rigorous and appropriate DBS checks prior to their employment. The Trust is evaluating what more it	*Mrs R Fallon-Williams*

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	can do to employ ex-offenders. Mrs R Fallon-Williams and Mr D Tomlinson confirmed that there are several prioritised capital schemes in the system, two of which have been made by the Trust and are in the first stage of consideration. In response to a question from Mr P Gayle, Mrs R Fallon-Williams and Mrs V Devlin reported that the Trust continues to liaise with the police regarding Section 136 Referrals and the safest environment for patients to be seen in. In response to a question from Mr P Gayle, Mr D Tomlinson reported that transformation of the electronic shared care record is an open bid for capital funding. Digital funds are now mostly consolidated as a unified fund, and the Trust has benefited from that fund over the last three years. In response to a question from Ms D Oum, Mr D Tomlinson confirmed that the Trust is working to ensure that clinicians are central to the development of digital solutions. Mr P Nyarumbu reported that the Trust is developing a partnership with the Prince's Trust, which will be considered by the People Committee in November.	*Company Secretariat*
6	**Board Overview: Trust Values** Ms D Oum invited Mr W Weir, as a new member of the Board to reflect on his early impressions of the Trust as compassionate, inclusive, and committed. Mr W Weir cited his induction meeting with the CEO as an example of compassionate leadership. In his first meeting with the NED's, they had all shared personal testimonies around mental health with real compassion and empathy. The People Committee embodied the value of inclusivity, with all contributors treated fairly and with respect. There was a real commitment to challenging all forms of discrimination. The testimony of a service user at IQC helped the committee to retain its focus on service users. Discussion was wide ranging and non-judgmental. In conclusion, Mr W Weir reflected that his initial observations are extremely positive and the he believes individuals are demonstrating that they live the values of the Trust on a daily basis. Ms D Oum thanked Mr W Weir for his contribution and encouraged the Board to frame the rest of the meeting in the same manner.	
7	**Integrated Quality Committee Chair's Report** Dr L Cullen briefed the Board on 2 meetings in August and September. There are several consistent themes. The Committee discussed the imminent CQC Well-Led	

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	Inspection and the Improvement Plan in relation to the Section 31 Notice. Positive progress is being made across all key areas and the Estates team is on track with environmental improvements to address ligature hazards. The Committee continues to seek assurance in relation to care planning and MDT working. The CQC Steering Group is being reinstated to ensure that the Trust knows what it is doing well and what further challenges it needs to address. The Committee will ensure that there is clarity regarding what the Trust has done in response to the findings of the last inspection. With regards to Covid, staffing pressures have eased somewhat and there is no need to step down non-essential services. The Committee continues to focus on Learning from Deaths and to seek triangulated data from reports and clinical visits. Benchmarking data is being sought to learn lessons from absconsions from wards. Reports from sub-committees have been helpful to shape discussions at the Committee, but further understanding of trends, mitigations and actions will add yet further assurance. There are still some challenges around bed pressures, particularly in acute and high intensity care. There was an update on PEAR (People Experience and Recovery) and the Committee is assured that a recovery strategy is in place and being implemented. The Committee received and recommends for approval revised Terms of Reference that respond to Reach Out and incorporation of the work of the Mental Health Legislation Committee. The Committee received a detailed assessment of Readiness to Proceed with Reach Out and recommends its approval by the Board. Ms D Oum reflected that the Committee is getting stronger and welcomed the increased focus on service user and carer involvement. The reinstatement of service visits will enhance the Boards awareness of key issues. Mrs S Bloomfield reinforced that the reduction in the number of attendees on site visits was due to covid and the challenges of maintaining a safe environment. Governors were invited to contact Mrs S Bloomfield via her PA if they wish to participate in the visits. In response to a question from Mrs G Hunjan, Mrs S Bloomfield confirmed that the Clinical Educators Initiative was extremely popular with staff and that it had made a huge difference to care planning. It has also proven to be a way of increasing resilience within nursing teams.	

	Dr L Cullen highlighted that there are still workforce challenges with vacancies in acute areas. The 33% vacancy in band 5 key roles is a particular focus for the Committee. Mr D Tomlinson confirmed that the recommendation to amalgamate ICQ and MHLC was evidenced by a detailed analysis of MH trusts across the country. The results demonstrated an exact 50/50 split between those Trusts that do have a separate assurance committee and those that do not. Most of the Outstanding Trusts do not have a separate MHL Committee.	
8	**People Committee Chair's Report** Mr P Gayle briefed the Board on two meetings in August and September. He reported that the Committee on 18 August had decided to move to bi-monthly meetings, which would allow richer data to be generated and incorporated in reports to the Committee. The September meeting of the Committee received an update from the Shaping Our Future Workforce Sub-Committee. The People Strategic Priorities Implementation Plan has been reviewed and progress is being monitored on the 43 actions. Work continues to develop a Band 2-4 Staff Charter and, later in the meeting, the Committee suggested that this be extended to Band 5 to respond to the high nurse vacancy rate. The Committee received an update from the Transforming our Culture and Staff Experience Sub-Committee. Anxiety, stress, and depression remain the highest reason for sickness absence, and further work is being undertaken to identify any EDI or cultural trends. A provider has been appointed to deliver the senior leaders' programme. The Safer Staffing Report continues to evolve, and the Committee has asked for gaps in assurance to be filled. The Committee was encouraged to learn that staffing huddles have been introduced. The Committee and IQC will work collaboratively to understand the linking between temporary staffing and costs. Mr P Gayle confirmed that, following concerns raised at CoG, the Committee will be considering an assurance report on the management of change process at its next meeting. This will then be fed back to the CoG. In response to a question from Mrs A Baines, Mrs S Bloomfield advised that it was still too early to speak with confidence about the escalation process for staff to raise concerns about staffing levels. Staff are encouraged to	

	raise risk through Eclipse. Ms D Oum asked that the People Committee review this again before Christmas, to seek assurance about what happens when staff raise a concern. Mr P Nyarumbu introduced the Disciplinary Policy which had been reviewed by the Committee and the Sub-Committee. He confirmed, in response to a question from Mrs G Hunjan, that the policy's implementation will be led by the Deputy Director of Workforce via a Task and Finish Group. The policy had been developed through engagement across the organisation, had involved different stakeholders, and responded to the NHSEi guidance on good practice. **The Board approved the Disciplinary Policy.** Ms D Oum emphasised the good work that the Committee is now doing to seek assurance and identify assurance gaps on the challenging and important People agenda. Mr P Nyarumbu reinforced that the Committee's forward plan is aligned to the BAF.	*Mr P Gayle*
9	**Finance, Performance and Productivity Committee Chair's Report** In the absence of Professor R Beale, Mrs G Hunjan briefed the Board on 2 meetings in August and September. The Committee decided at its August meeting to retain its existing name rather than move to Sustainability Committee in response to the strategy. The financial plan for the first half of 2021/22 is a break-even outturn. Planning guidance for the second half of the year (H2) is subject to change. The capital position at month 5 shows expenditure at £1.1m, which is £0.7m less than plan. The total capital programme for 2021/22 is £10.3m. The cash position is £37.6m. The Trust aims to achieve zero out of bed use by September 2021 with additional beds being procured. A system wide forum has been established to develop an integrated approach to IAPT services across BSol. Internal audit had confirmed that compliance with Information Governance standards is broadly good, but training targets had not been met for a second successive year. The People Committee is reviewing the data in detail. The Committee received a detailed assessment of Readiness to Proceed with Reach Out and recommends its approval by the Board. This was supported by an assurance report from the Reach Out Commissioning Sub-Committee.	

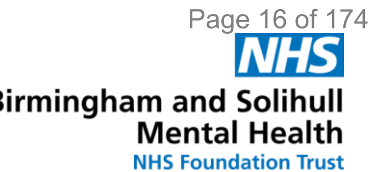
	In response from a question from Dr L Cullen, Mrs V Devlin confirmed that there is still insufficient bed capacity in Birmingham. The Trust is meeting with NHSEi to discuss a plan to precure additional beds through the re-modelling of a Priory bed unit. Patients are currently placed in beds in Bristol and Manchester. A refreshed plan will be considered at the October meetings of FPP and IQC. In response to a question from Mr W Weir, it was confirmed that the Trust is compliant with all other areas of information governance standards. It is only the training targets which need to improve, with a specific challenge for temporary staff. Mr P Nyarumbu confirmed that the aim must be to reduce reliance on temporary staffing. The Trust has to prioritise which training temporary staff receive, which has meant that IG training has slipped. There is also evidence that some people have joined the bank and worked a single shift but used the training passport to find work elsewhere. Mrs D Oum reflected that FPP is seeking assurance on a range of challenges. The quality of reports is improving so the Committee is now able to debate on the basis of trend analysis, but there is still work to be done in terms of understanding mitigations and what they add up to in terms of addressing risks.	*Mrs V Devlin*
10	**Integrated Performance Report** Mr D Tomlinson explained that the IPR is received by each of the assurance committees. Work continues on the quality metrics, which should be embedded by October. He suggested that the Board may wish to have a development session on the Dashboard. Ms D Oum supported this proposal.	*Company Secretariat*
11	**Finance Report** Mr D Tomlinson extracted the principal points in the Report: • The Trust will break even for the first half of 2021/22 (H1). • Planning guidance for the second half of the year (H2) is expected in mid-September, with submissions due in November. • The group position shows a surplus of £2.6 million year to date, which is mostly associated with slippage on recruitment against new investment. The Audit Committee in October will receive a report on financial treatment of the 2 possible redevelopment schemes at Highcroft and Reaside. The Trust can exercise a break clause on B1 Trust HQ in 2024, with the option for a complete closure in 2025. The Audit Committee will receive a proposal for early surrender of the lease. The Run Rate is demonstrating a surplus. The Trusts	

	financial position is significantly better than before Covid. A saving of 1.5 – 2% is probably achievable. The important message is that the Trust will not be destabilising or cutting services. Mr W Weir had several questions of detail, which it was agreed he would pick up with Mr D Tomlinson outside of the meeting, as part of his induction process.	
12	**Reach Out Readiness to Proceed Assessment, Commissioning and Contracting Intentions and Financial Plan** Mr D Tomlinson introduced Dr Jeremy Kenney-Herbert, Ms Ebru Oliver, Mr R Sollars, Ms A Rickard, Miss S Jones and Mr A Hughes who had all been working hard to conclude the process. Mr D Tomlinson reminded the Board that the service has been running since 2017 and that the change proposed from 1st October was in how the service will be commissioned. The supporting papers include a business case, which is NHSEi's description. This is intended to provide the Board with assurance in relation to the quality, financial and contracting elements of the proposed transfer. The issue has been considered in detail by the Reach Out Commissioning Sub-Committee, IQC and FPP. Mrs A Baines, as Chair of the Sub-Committee, reported that it was clear a great deal of preparation and due diligence had been undertaken, which should provide the Board with considerable assurance. The process has been risk based and there are plans in place to mitigate any impact on the Trust. Ms E Oliver introduced the Readiness to Proceed document. She reinforced that the Trust is ready to assume its role as Lead Provider. The Boards of the partner organisations have also received and approved the business case and supporting documentation. NHSE has been monitoring the process throughout. A Risk and Gainshare Agreement is in place. Mr R Sollars described the financial elements for both mental health and LDA services. Since the report was produced, further discussions have been held with CWPT as the Lead Partner for LDA, which adds further assurance for the Board. In response to a question from Mr W Weir, Mr R Sollars confirmed that risks have been costed and that a reserve of 2% is held within the budget. Dr J Kenney-Herbert referred to the quality and assurance framework, which is a continuously evolving document. He advised that the Provider Collaborative is at Level 2 of the Quality Maturity Framework, which means that it is ready to go live. Meetings will continue with NHSE on a	

	fortnightly basis. Governance processes continue to embed, particularly regarding LDA secure care. In response to a question from Mr Weir, Dr J Kenney-Herbert confirmed that TUPE applies to the case management team for LDA. Ms D Oum thanked the three leads for their contributions and for their hard work in achieving this position. She reminded the Board that the paper had already been assured in multiple governance forums. It is an initiative that will impact positively on the people who the Trust serves. **The Board approved the recommendations in the two reports.**	
13	**Independent Assurance Report** Mr A Hughes presented the Independent Assurance Report on Reach Out governance. He confirmed that this had not been through any other governance forum and had been produced exclusively to offer the Board assurance on the readiness to proceed. He highlighted the At a Glance Status on governance readiness, which shows that most key issues are green or blue, and those that are amber still have work to complete but would not prevent the process going ahead on 1st October. He advised that there is no specific guidance as to how the decision should be made, but that the two frameworks referred to in section 7 provide a powerful assessment and level of assurance. He invited the Board to consider how, procedurally, it should separate its duties as Provider and Lead Provider. In response to a suggestion from Mrs A Baines, the Board agreed that it should make a clear distinction between those responsibilities at Board and Assurance Committee level. The Board noted that Mr R Sollars is leading a review of Standing Financial Instructions and Reservations of Powers to the Board and Delegation of Powers, and that suggested changes will be presented to the Audit Committee in October. **The Board approved "Go-Live" on 1st October 2021 and the following additional items:** • Changes to the Constitution • Revised for Terms of Reference for FPP • Revised Terms of Reference for IQC, including the incorporation of duties formerly held by the MHL Committee • Terms of Reference for the Reach Out Commissioning Sub-Committee	

14	**Guardian of Safe Working** Ms D Oum welcomed Dr Sajid Muzaffar to the meeting. Dr S Muzaffar highlighted that the report was for the quarter ending June 2021. The number of exceptions reports had increased, but no safety concerns had been raised. The Associate Medical Director, Medical Education had addressed issues of senior support. Shift vacancies had all been filled by locums. Ms D Oum noted that it was good to see progress being made and the Board noted the report for assurance.	
15	**Questions from Governors and Public** In response to a series of questions regarding the involvement of people with lived experience in the shaping of services, Ms D Oum asked Mr P Nyarumbu and Mrs S Bloomfield to make contact outside of the meeting. It was also suggested that Dr K Allen should be approached. A Governor reinforced the importance of valuing service users and their experiences and highlighted the benefits of technology to enable this.	*Mr P Nyarumbu and Mrs S Bloomfield*
16	**Any Other Business** None raised.	
17	**SNAPSHOT REVIEW OF BOARD PERFORMANCE** Ms D Oum welcomed Mrs A Baines as a new Non-Executive Director and asked for her reflections on the meeting. Mrs A Baines commented that the meeting had demonstrated how well the Board works together. The vast majority of papers had been about assurance. They provided a great deal of detail and referred to key aspects and key issues in the right tone, which generated debate and discussion. Cover sheets were a wasted opportunity. They were slightly overlooked as a way of providing information in a structured fashion, and further work was needed to make best use of them. For instance, authors could be more clear about what they were asking the Board to do. She found the CEO's paper helpful in providing focus of what the Board needs to be considering. The Board had approved two important items – the Disciplinary Policy and the Go-Live for Reach Out. The culture of the meeting was good. Questions were well framed and appropriate and drew the conversation in the right direction, respectfully and responsibly. Dr R Rowe added that she had found the meeting beneficial, with a real focus on values.	

18	**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.	
19	**Date & Time of Next Meeting** 9:00am on 27th October 2021	

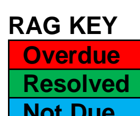


BOARD OF DIRECTORS

ACTION LOG

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
September 2021 3 Action Log	Action Log was missing, therefore unable to pick up any outstanding actions from previous meetings	Company Secretariat	October 2021		Actioned
September 2021 5 Chief Executive's Report	Check statistics around the number of staff vaccinated	CEO	October 2021		Currently being followed up – action to be updated before the meeting
September 2021 5 Chief Executive's Report	Partnership with the Prince's Trust to be considered at the People Committee in November	Mr P Nyarumbu	November 2021		
September 2021 8 People Committee Chair's Report	People Committee to review the escalation process for staff to raise concerns about staffing levels	Mr P Gayle	October 2021		At the October meeting, the Committee was presented with the Safer Staffing Report with the Chief Nurse reporting that staff were being actively encouraged to report formal incidents relating to concerns regarding staff levels
September 2021 9 FPP Chair's Report	Refreshed plan re bed capacity to be considered in October FPP and IQC	Mrs V Devlin	Moved to November Committees		
September 2021 10 IPR	Development session on finances to be arranged	Company Secretariat	November 2021		Currently arranged for the 17th November 2021

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
September 2021 15 Questions from Governors and Public	Question regarding the involvement of people with lived experience in the shaping of services. Further discussion to be had outside of the meeting with service user Amit Connection to be made with Amit and Dr K Allen.	Mr P Nyarumbu and Mrs S Bloomfield	October 2021		Followed up and actioned by S. Bloomfield



NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	4
Paper title	CHAIR'S REPORT
Date	27 October 2021
Author	Danielle Oum, Chair
Executive sponsor	Danielle Oum, Chair

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

Executive summary & Recommendations:

The report is presented to Board members to highlight key areas of involvement during the month and to report on key local and system wide issues.

Reason for consideration:

Chair's report for information and accountability, an overview of key events and areas of focus

Previous consideration of report by:

Not applicable.

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

Select Strategic Priority

Financial Implications *(detail any financial implications)*

Not applicable for this report

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

Not applicable for this report

Equality impact assessments:

Not applicable for this report

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

Engagement this month has been through introductory meetings with staff across the Trust.

CHAIR'S REPORT TO THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 Our vision is simple in that we are here to "*Improve mental health wellbeing*". I deliberately open with this statement, grounding this report in our 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. It has been a busy period, and I will limit this report to focus on just a few aspects of activity.

2. CLINICAL SERVICES

2.1 I was fortunate to meet colleagues and patients at the Tamarind Centre and to discuss the challenges and opportunities facing the services. I also visited the Women's Empowerment and Recovery Educators to learn about their recovery programmes for women who have experienced domestic violence.

2.2 I am excited to have the opportunity to visit more clinical services over the coming weeks with time scheduled to see teams at Zinnia, Oleaster, Barberry, Mary Seacole and Reaside.

3. PEOPLE

3.1 I met with Simon Johnson, who has been assisting the Trust with employee engagement and heard his feedback on team cultures for consideration for future working.

3.2 I am pleased to be contributing to the Birmingham and Solihull Integrated Care System Leadership and Wellbeing programme; I have delivered several sessions on the topic of Barriers to Equity.

3.4 I have presented at a range of Black History Month events including the NHS Confederation, Aston University and Birmingham and Solihull ICS.

4. QUALITY

4.1 I was pleased to speak at the National Housing Federation Smaller Housing Conference on the Mental Health Emergency and at the Housing 21 Conference on the connection between housing and mental health.

5. SUSTAINABILITY

5.1 In conjunction with governors I have been conducting non-executive appraisals

5.2 I was pleased to participate in the formal recruitment panel for the Birmingham and Solihull ICS, Chief Executive.

5.3 I participated in the second roundtable event to develop a Birmingham and Solihull provider collaborative.

DANIELLE OUM
CHAIR

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	5
Paper title	CHIEF EXECUTIVE'S REPORT
Date	27 October 2021
Author	Roisin Fallon-Williams
Executive sponsor	Roisin Fallon Williams

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

Executive summary
My report to the Board this month provides context of the ongoing pandemic, the resultant pressures and challenges and our response to these. It also provides information on focused work 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. CURRENT PANDEMIC SITUATION

The numbers of people with Covid 19 in the communities we serve is rising. We have made no changes to the guidance we expect colleagues to follow to ensure safety of patients and colleagues. At the time of writing our clinical colleagues continue to provide care and treatment in the safest possible way in relation to Covid 19 such that we only have one inpatient being cared for who has tested positive for Covid 19.

2. PEOPLE & ORGANISATIONAL DEVELOPMENT

2.1 Annual Staff Survey

As of 21st October, the Trust had a 30.3% response rate. This is above the average response rates for similar Trusts (Mental Health and Learning Disability and Mental Health, Learning Disability and Community Trusts) which is 27%, and is higher than our own response rate at this point in last year's survey of 19.3%..

The People Operations Team are communicating with all managers on a weekly basis and urging Teams/Directorate to encourage colleagues to reach at least 11. This then allows teams to have an individual breakdown of their survey results which provides a better insight for managers in terms of engagement and performance. The communication message is around "Time to Tell" where we are creating the expectation that all colleagues are given 15 minutes to complete the survey.

In addition to targeted work with directorates and teams to complete the survey by the close date of 26th November, we have put in place a prize draw with the opportunity to win £50 shopping vouchers as another incentive for colleagues to take part.

2.2 Recruitment Fares and Conferences

The recruitment team are attending a jobs fair at King Solomon school on 27th October. This is in partnership with a number of third sector organisations with a focus on 15–25-year-olds. It is led by the Community Engagement Team with support from the People & OD Directorate. The team is planning on sharing information on the Trust entry-level roles, including opportunities for Healthcare Assistant on Wards.

This will be first of a series of community engagement recruitment fairs, further ones are planned to focus on Healthcare Assistant recruitment for wards with high levels of vacancies. These are being planned to be held at our local sites or community venues.

The medical recruitment team will also be 'hosting' a recruitment stand to promote/showcase the Trust at the Silver Jubilee for the British Association of Physicians of Indian Origin (BAPIO) Conference being held on 22-24th October 2021 as requested by the Host.

2.3 Medical Workforce/Staffing – Workforce Planning Review Meetings

The team has recently introduced a three weekly Workforce Planning and Review Meeting chaired by the Deputy Medical Director. Key stakeholders include Medical Workforce Manager, People Partners, Clinical Directors and Finance.

The objectives of the meeting are to: -

- Address agency costs
    - Confirm vacancies within services
    - Confirm which roles with Agency or Locums are Short or Long Term and which roles, incl. end dates for short term placements
    - Plan for reductions in the number of Long-Term Agency Consultants
    - Verify/confirm vacancies and 'gaps'
    - Identify medical workforce gaps in provision that need addressing due to clinical or staff risk.

Updates on progress are reported via the 'Reducing Medical Agency and Locum Spend' Work Stream Lead to the Temporary Workforce CIP Project Team.

Through the meetings held thus far it has been acknowledged that Job descriptions need to be more 'attractive', and the roles need to be more flexible as candidates may wish to undertake more of a blended role, and the long-term vision of establishing a collaborative bank supported Health Roster's functionality has been identified.

2.4 BSOL Mental Health (M/H) System Workforce Workstream

The BSOL M/H System Workforce Workstream has been established and is chaired by the Deputy Director of People & OD. The workstream provides assurance to the BSOL M/H Transformation Board.

The objective of the work stream is to ensure a workforce fit for purpose to meet the mental health NHS Long Term Plan deliverables for Birmingham and Solihull; implementation of the workforce plan, monitoring progress and to ensure risks and barriers to the supply and deployment of a skilled workforce are identified and addressed; and workforce plans are developed in line with our shared values and principles.

Membership of the Work steam include representation from the following: NHS Providers; Clinical Commissioning Group; Health Education England; Health Education Institutes; Primary Care; 3rd Sector and Social Care. As well as representatives from our Integrated Care Sysytem People Board.

The work of this group will be reported through our People Committee.

3. CLINICAL SERVICES

3.1 Workforce Capacity – General

All our clinical services have continued to work above and beyond to ensure services are covered as safely as is possible. Absences have remained high. We have maintained the twice weekly Trust wide staffing huddles to ensure cross directorate consideration of safe staffing levels continues and each directorate holds their own staffing huddles on a daily basis.

3.2 Integrated Community Care & Recovery (ICCR)

Community teams are working towards increasing our face-to-face appointment offer. Teams are experiencing significant capacity issues which has led to longer waits for first appointments as well as follow up appointments. Pressures continue with recruitment to CMHT medical positions with hot spots in one of the Solihull CMHTs and South CMHT. We have locum and other arrangements in place whilst we recruit to the posts on a permanent basis.

Implementation of the community transformation is well under way. The first tranche of ARRs Mental health workers (Additional Reimbursed Roles) have been advertised, there have been 31 requests so far from Primary Care Networks (PCNS) for a mental health worker, these posts will support the newly developing primary care mental health teams. The team leading on this transformation work lead a Listen Up Live session during October to generate discussion on the model and share more details on the phased approach being taken to implementation.

All teams are continuing to prepare for CQC (Care Quality Commission) visits. Care planning resource packs have been issued to all colleagues, books of excellence are being refreshed and in addition to this teams are working on notice boards that will showcase their work. All teams have been encouraged to view the visit positively and to use it as an opportunity to be proud, open to any feedback and discussion on challenges.

Meetings have been held with all teams across ICCR to explore last year's staff survey results and to encourage feedback in this year's survey. Teams have been very engaged in this process and have given open feedback to enable the leadership team to support in addressing issues. ICCR currently have the highest level of responses to the staff survey.

Interviews are planned for the Head of Nursing and Allied Health Professionals (AHPs) for ICCR, this role will be a welcomed addition to the ICCR leadership team.

3.3 Specialties

All wards are open to admissions following an outbreak on one ward during last month. All wards have a number of patients requiring level 3 and 4 observations, and we continue to see a number of patients that have significant levels of acuity relating to both their physical and mental health. Workforce requirements are therefore high against the backdrop of higher rates of absences, this is being managed via regular staffing huddles.

This week one of our Matrons and nurse consultant for physical health are rolling out the yearly harm reduction training. The uptake has not been as high as previous years due to sickness absences and the high acuity levels described above, despite this it has been well received. The programme will continue throughout the autumn/ winter.

There is also continued pressure in our older adult Community mental health teams resulting in increasing waiting times which the service is looking to address. Medical staffing pressures in the north CMHT have resulted in an increased number of outpatient appointments being cancelled and re booked. Additional cover arrangements are being explored as an interim measure to help bridge the gap.

As we work towards recovery and to increase face to face contacts there is extreme pressure across our buildings especially ay the Barberry Centre as restrictions remain in place to ensure covid secure environments. This is being monitored closely to determine if alternative arrangements are required to support.

The Memory Assessment Service waiting list remains a concern however there is work internally and regionally to review pathways for dementia diagnosis and consider how best use can be made of available resources.

Our recently established Increasing Access to Psychological Therapies (IAPT) forum has agreed a work plan to promote a system partnership approach to enhance pathways and manage demand and capacity. An IAPT Service workforce steering group has been formed to look at results of the benchmarking exercise across all BSOL system IAPT providers to address challenges of recruitment and retention of IAPT compliant workforce.

Our Adult Eating Disorders service is part of the eating disorders provider collaborative. We are delighted that the collaborative has been shortlisted for the HSJ collaborative of the year award. Thanks are extended to all our colleagues who have contributed to this innovative work.

3.4 Acute and Urgent Care

The environmental safety improvement programme continues across acute care, replacement of ensuite doors and associated works are being completed to plan, Two of our wards in the North of the City will be piloting two proposed bedroom doors to enable the doors to be tested in operation before a final decision is made on which doors Acute and Urgent Care will install.

As part of our out of area plan and urgent care transformation, we have commenced test/pilot of our proposed local assessment beds on one of our male acute inpatient wards this involves 4 beds and on one of our female wards involving two beds, evaluation of the pilot is on going at this time.

Work continues on the crisis transformation programme; the Birmingham Integrated Map is being used across the system and four system wide workshops have now taken place to support more organisations to take part in the pilot.

The crisis house specification is currently out for invitations to Tender, with this due to close on 08 November 2021. The evaluation and award process will then follow.

Works continue to take place on the Urgent Care Centre. An early walk around has taken place to support with the operationalisation of the scheme. The Memorandum of Understanding has now had final sign off by the Trust Clinical Governance Committee. Unfortunately, the building works have been slightly delayed, with building handover scheduled for 6 December 2021. Operational plans are in place to support a phased operationalisation of the service at the Urgent Care Centre over December & January.

3.5 Secure Care & Offender Health

Reaside and Hillis Lodge staffing availability has been fluctuating with most shortfalls being seen in the afternoon, plans address this and managed via the daily staffing huddles. Patient acuity remains high.
A cultural deep dive through a staff engagement exercise undertaken independently of the Trust has now been completed at Reaside, feedback on the resulting findings has been shared with the senior management team at Reaside, with further events scheduled to do likewise with team colleagues. The senior leadership team has committed to make improvements in the unit and to work with all colleagues with regards to the deep dives finding. The Board will receive details on this via the People Committee in November.

Both Ardenleigh and Tamarind services continue to experience staffing pressures; covering Band 5 vacancies is often the most challenging. The sites are both clinically very busy resulting in increased workforce requirements. This is being addressed via the regular staffing huddles.

A number of events have taken place at Tamarind during the month, a well attended Friends and Family Day, an inter ward football competition and the commonwealth world record breaking event that was hugely successful and really inclusive with both service users and colleagues successfully breaking world records.

Black History Month is being celebrated by the CAMH service , who put on a Carnival with the young people on 15th October, and by the Women's service who held a celebration event on 20th October.

The FIRST service continues to do a mix of face to face and digitally supported visits. Meetings are carried out via Teams to reduce contact and we are encouraging face to face again although the office space has been challenging. Alternative accommodation is being explored. Staffing is improving and an Art Therapist has now been recruited. The service is undergoing a service refresh supported by Grant Thornton and the team are engaged in service redesign of the community pathway with the Reach Out Collaborative. The employment support officer has been made a substantive post after a successful pilot.

The Liaison and Diversion team has successfully recruited into the Outreach Band 7 role and will be welcoming this new practitioner in early December. The service has been given the go ahead from Birmingham Magistrates Court to undertake face to face assessments; the Trust environmental risk assessments will be completed prior to restarting this.

HMP Birmingham Covid vaccinations for service users continue with booster jabs imminent and the flu campaign commencing. Following on from the Liaison & Diversion CQC review, HMI Probation have approached the service lead to complete a piece of work in the area of mental health work with ethnic minority individuals as this was cited as an area of excellence in the service.

Psychology staffing is remains under pressure and recruitment continues across the portfolio. The service has recruited to three fixed term contract roles to cover maternity leaves, along with offers being made for three fixed term contract art psychotherapy roles to undertake a pilot of these roles within Reaside, Tamarind, and a split post between FIRST and Prosper. A further three people are due too be interviewed in the coming weeks and an agency colleague has been secured to provide cover on a part time basis.

4. QUALITY

4.1 Vaccinations

The Covid vaccination continues to be available for colleagues to access as a first and second dose. The system is now in place for all patient facing colleagues (including contractors) to book their booster vaccine via the national booking system. A gap of 6 months is required in between the 2nd and booster doses.

4.2 Flu

Flu vaccine clinics commenced within the trust on the 4th October and a schedule of planned clinics is available on Connect. This is also supplemented by local vaccinators providing roving clinics within their local teams.

4.3 CQC Inspection

We anticipate we will be subject to an inspection within the remainder of the financial year. As a Board we will consider our preparedness as part of our board development session later today.

5. SUSTAINABILITY

5.1 Finance

The Board will receive later in the meeting our financial report that will highlight the current financial position.

5.2 Integrated Care System (ICS) Development

Significant work continues to support the development of the ICS, much of which we are involved in. A further round table has been held to consider the nature and scope of the Provider Leadership Collaborative, further work is planned. The workstreams focusing on the Birmingham and Solihull Mental Health Collaborative have continued their work and we have received a paper on the next phase development of our existing West Midlands Mental Health Collaborative for our consideration at todays meeting.

Interviews for the ICS Chief Executive role have taken place.

6. OTHER MATTERS

6.1 Chair of the Coventry and Warwickshire Integrated Care System

As we are all aware work towards transition to Integrated Care Systems by April 2022 is well underway, including appointments to key roles. I was delighted to inform colleagues earlier this month that, following the national recruitment process, our Trust Chair, Danielle Oum has been appointed as the Chair of the Coventry and Warwickshire Integrated Care System. Danielle will be the chair designate, ready to take up the post in April 2022, if, as expected, Parliament confirm the current plans.

Danielle will be undertaking this role in conjunction with remaining as Chair of BSMHFT.

6.2 Birmingham & Solihull Integrated Care System Update

Attached to the report is the latest Birmingham and Solihull ICS Development Update for stakeholders, providing an update on the development of our Integrated Care System. The update includes:

- Latest national update – including central link to guidance
- Birmingham and Solihull progress – including Strategic Commissioning and development of our ICP/ICB
- System Spotlight – a new feature, shining a light on examples of system working, this month in relation to the vaccination programme

6.3 NHS system oversight framework segmentation

NHS England and NHS Improvement (NHSI) have recently consulted on the new NHS System Oversight Framework 2021/2022 which introduced a new approach to provide focused assurance to organisations and systems.

I have now received confirmation as expected from our regional team colleagues of our segmentation categorisation on the framework as a 3.

7. NATIONAL ISSUES

7.1 Government launches biggest review of NHS leadership since 1980s

The government is launching what it claims is the 'most far-reaching review' of NHS leadership since the seminal Griffiths report of the early 1980s.
To read more please use the link:
https://www.hsj.co.uk/workforce/government-launches-biggest-review-of-nhs-leadership-since-1980s/7031013.article

7.2 Coronavirus: lessons learned to date report published- UK Parliament

The House of Commons and Science and Technology Committee and Health and Social Care Committee have published their Report, Coronavirus: lessons learned to date, examining the initial UK response to the covid pandemic.

The 150-page Report contains 38 recommendations to the Government and public bodies and draws on evidence from over 50 witnesses—including Rt Hon Matt Hancock MP, Professor Chris Whitty, Sir Patrick Vallance, Sir Simon Stevens, Dame Kate Bingham, Baroness Harding of Winscombe and Dominic Cummings, as well as over 400 written submissions. To read more please use the link: Coronavirus Lessons Learned

7.3 Centre For Mental Health: Better Together: A public health model for mentally healthier integrated care systems (ICSs)

The Centre for Mental Health has issued the above report which can be found
https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_Briefing57_BetterTogether.pdf

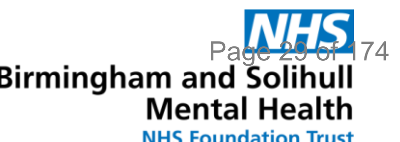
NHS Providers has issued a statement strongly supporting this new report's recognition that it's important for ICSs to focus on delivering parity of esteem between mental and physical health needs.

"There is a vital need for sustained investment beyond the end of the financial year in protecting and promoting people's mental health as well as their physical health. The role of wider public services in mental health should not be forgotten either and in particular, public health and social care. These services have a crucial part to play both in preventing mental ill health and avoiding deterioration and need to be adequately supported and resourced.

This report rightly highlights the need for 'resolute action' to tackle health inequalities, which should be a fundamental priority for the NHS.

But when public perception of the NHS' performance is a key concern, it will require dedication and courage from trust leaders, national bodies such as NHS England and NHS Improvement, and politicians to fulfil the commitment to reducing health inequalities and balance it with the desire to restore performance against operational targets as soon as possible."

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE



Meeting	BOARD OF DIRECTORS
Agenda item	7
Paper title	CHAIR'S ASSURANCE REPORT FROM THE QUALITY AND SAFETY COMMITTEE
Date	27 October 2021
Author	Dr L Cullen - Non-Executive Director and Chair of Committee
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 QSC met on 20 October. The attached Assurance Report is provided by the Committee Chair for the attention of the Trust Board.

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

Financial implications

Nonspecific.

Risks

Nonspecific.

Equality impact

Nonspecific.

Our values

Committed
Compassionate
Inclusive

CHAIR'S ASSURANCE REPORT FROM QSC

1. ISSUES TO HIGHLIGHT TO THE BOARD

1.1 CQC Section 31 Improvement Plan Report

The monthly submission was made on 30 September 2021 followed by a meeting with the CQC on 4 October 2021 where no concerns were raised or escalated. The committee were assured ligature works are underway across sites with several complete following installations.
Estates and facilities are working closely with service areas on 3–5-year programme of works with costings to be confirmed that will ensure all major works can been completed.

Chair's assurance comments:

The committee was assured about the physical environment and care planning and agreed action plans in response to the Section 31 notification.
In addition, existing quality improvement programme approaches are also progressing, and these will better enable staff to develop care plans and clinical practice that is driven by patient need and learning from others

1.2 Preparation for CQC Well-Led Inspection

The October Board Development session will be dedicated to well led preparations and Board members have received a survey for competition that is linked to the CQC key lines of enquiry. The self-assessment survey will provide the background for the development session.

1:1 preparation interviews will be offered to colleagues likely to be interviewed including brief notes for reference.

Chair's assurance comments:
The committee was assured that the first developmental session for board members is next week. Policies are being updated and approved.

1.3 Responding to COVID

The Committee received a verbal update noting there is currently one outbreak on Mary Seacole with one staff member and one service user being tested positive. Measures are in place to ensure this is contained.

The committee were assured Ultraviolet ventilation costings are being sought by the Infection Prevention team and will be approved by Ms S Bloomfield in the coming weeks.

Concerns regarding risk assessments were noted with the need for these to be updated and slippage on staff usage of PPE was highlighted.

Chair's assurance comments:
The committee was assured that the one outbreak we have had was very well contained
We noted the need to continue to maintain a focus through this prolonged pandemic on the safety of staff by use of the risk assessments and use of PPE

1.4 SI Escalation

The committee noted there have been eight serious incidents were reported throughout September 2021, five of which relate to September 2021 and three have been upgraded. All serious incidents are under investigation.

Key learning from closed incidents is being reviewed and will feed into the collaborative work going forward.

Chair's assurance comments:

The committee looks forward to receiving updates and further analysis of the themes identified in these incidents, how they link to existing QI projects and workstreams and also receiving a detailed paper on predictive analytics and how these will all combine to lead to a positive impact on care pathways

1.5 Health and Safety Annual Report

Ms N James was in attendance at the meeting and presented the Health and Safety Annual Report.

The committee had a detailed discussion regarding lone working and staff uptake of the lone working devices.
As Chair of the Health and Safety committee Ms S Bloomfield has asked member to complete plans on a page to address lone working and local protocols.

The committee were assured that engagement has improved, offers of support have been made to teams and staff are proactively being asked to engage with the message of safety being reinforced.

Chair's assurance comments:

The committee was assured as to how the recent restructure of the Health and Safety committee would lead to more consistency in ownership and accountability of issues.
Policies are up to date and clear messages and conversations are taking place with staff via local service leaders about the importance of safety. We were pleased to hear about the continued emphasis on personal and environmental Covid risk assessment and lone working safety and how teams are actively collating evidence of what they are practically doing to address these issues

1.5 Integrated Performance Report including quality and patient experience metrics

Key performance indicators and priorities for quality were presented and discussed.
The committee were assured going forward the data will be used to inform run charts in line with QI.

Ms J Clark was in attendance at the meeting and provided further oversight into the Family and Carer Pathway.

The committee noted the collaborative is working with Meriden and Experts by Experience to support the roll out of training to staff to support more effective engagement of families and carers in service user care plans.

Chair's assurance comments:
Discussion took place in the committee about the data presented in the integrated performance report. We appreciate we are moving towards the use of Statistical process control charts (SPC) to help us more easily identify and understand variations in the data presented and realise the key issues that we should be discussing from the data. The committee was assured by the new objective data we are now seeing in relation to how well services are engaging with families and carers

1.6 Board Assurance Framework: Quarter 2

The update for quarter 2 was received with the committee confirming an annual report will be received for patient experience and engagement and will highlight the activities and co- production.

IQC2, IQC3 and IQC4 all relate to workforce risks and this needs to be fully reflected in the BAF for the committee and People Committee as the Trusts largest risk.

Following two rounds of recruitment for the Freedom to Speak Up role have been unsuccessful. A solution has been sought and the team will be complete by December 2021.

Chair's assurance comments:
The committee discussed the pressing challenges and importance of the workforce risks and health inequalities and how these impact both the Quality and Safety and people committee

1.7 Infection Control Annual Report

Mr F Leitao was in attendance at the meeting and confirmed the Infection Control team were finalists on Nursing times excellence prizes due to work related to COVID during the first wave.

The committee noted the recommendations and approved the proposals for the IT team to produce electronic tools for monthly audits in the wards, this will enable teams to monitor real time results and ensure audits are accurate.

Chair's assurance comments:
The committee wished to commend the very important and effective work that both the infection control team and SSL have been doing during the past year during the pandemic

1.8 Chair's Assurance Report from the Reach Out Commissioning Sub-Committee

The committee noted the quality of the report with no concerns raised.

Chair's assurance comments:
The committee was assured by the report and discussed the usefulness of Mr Gayle being the link as vice chair to this committee

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Agenda Item No:	8
Report to:	Board of Directors
Meeting Date:	27th October 2021

Report provided (check necessary boxes):			
To Note	☐	For Assurance	☒
For Decision	☐	For Consent	☐

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2020-21

Board Director Sponsor:	Sarah Bloomfield, Executive Director of Quality and Safety
Report Author(s):	Filipe Leitao, Lead Nurse for Infection Prevention and Control
Appendices and References:	Infection Prevention & Control Annual Report 2020-21
Previously Discussed:	Infection Prevention Partnership Committee (IPPC) on 21.07.21 Clinical Governance Committee (CGC) on 03.08.21

Alignment to the Trust's Strategic Objectives: (check necessary boxes)			
SA1 - We will put service users first and provide the right care, closer to home, whenever it's needed.	☒	SA2 - We will listen to, and work alongside, service users, carers, staff and stakeholders	☒
SA3 - We will champion mental health wellbeing and support people in their recovery	☒	SA4 - We will attract, develop and support an exceptional and valued workforce	☒
SA5 - We will drive research, innovation and technology to enhance care	☒	SA6 - We will work in partnership with others to achieve the best outcomes for local people	☒
F.1 - Sustainability	☒		

Purpose of Report: (What do you want the Board or Committee to consider)	The Committee is asked to receive the report, discuss key findings, and support recommendations to discharge responsibility in meeting CQC compliance to promote safe practice and minimize the risk of avoidable infection and transmission of infectious conditions.
Summary of Key Issues:	The report gives a detailed account of infection prevention and control (IPC) activity. Essential items and achievements of note to the committee include: • IPC team finalist on Nursing times excellence prizes dur to work related to COVID during the first wave • Total of 21 reports of infection (excluding MRSA and COVID related). • The Trust final position following validation was submitted to Public Health England in March 2021. Our final staff flu vaccine uptake is 50.99%, a decrease of 11.82% compared to the 2019/20 final total of 62.81% • The flu portal made monitoring and reporting of flu vaccine uptake easier and more accurate than previous years and

	established a baseline to further electronic recording systems based on the same design concept, like the lateral flow test (LFT) result record. • The Trust reported a total of 43 COVID outbreaks (see outbreak table below) With a total of 201 service users affected during the outbreaks and 200 staff members • IPC team reduced capacity caused postpone of some of the planned activities on the annual work plan, such as mattress and sharps audits. Those two items have been undirectedly monitored by the local mattress audits performed on monthly by the wards and the needlestick injuries reports (that have shown a reduction on the number of incidents) • Water Safety group working in full capacity
Recommendation(s):	1. Development of an informatics 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 resilience audit; 3. Auditing control of legionella policy requirements undertaken by the Water Safety Group; 4. Recruit food safety advisor; 5. Develop a solution to centralize cleaning audit results with other IPC audits 6. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice; 7. 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, including COVID. 8. Ensure that all inpatient areas have up to date cohorting plans if necessary as well as identified contingency measures in case of an outbreak; 9. Ensure outbreak resilience tool/audit is in place in all clinical areas to identify aspects requiring improvement. 10. Ensure information given on training and link workers is cascaded to the team 11. Occupational Health to provide input to Seasonal Flu Planning; 12. Occupational Health to support staff testing for COVID when outbreak declared (presently, this is ensured by Birmingham Community Healthcare Trust)

	Q1	Q2	Q3	Q4
N Outbreaks	4	1	17	21
Outbreaks Cum	4	5	22	43

	13. Increase opportunities for staff to develop their infection control skills with courses as for ex Marion R. and/or providing opportunities to work closely with IPC with the aim of allowing the staff to take on the IPC course at Uni level (implies 2 previous years of experience on IPC)

Next Steps: (Subject to recommendation(s) being accepted)	• Ensure continuity of Face fitting program and records – Make face fit part of Trust induction for clinical staff; • Enable the IT team to produce electronic tools for monthly audits in the wards; • Work on pathways to enable staff to develop their knowledge/experience in IPC Next step – submission of the report to Board of Trustees.

Do the action(s) outlined in this paper impact on any of the following issues? (check necessary boxes)			
If 'Yes', outline the consequence(s) by providing further detail in the report			
Patient Safety ☒	Clinical Effectiveness ☒	Patient Experience ☐	Operational Performance ☒
CQC Compliance ☒	Legal Requirements ☒	NHS Provider license Compliance ☐	Resource Implications (financial or staffing) ☒

Equality and Human Rights Analysis THIS MUST BE COMPLETED	Yes	No	N/a
Do the issue(s) identified in this document affect one of the protected group(s) less or more favorably than any other?	☐	☒	☐
Are there any valid legal / regulatory reason(s) for discriminatory practice?	☐	☒	☐
If answered 'YES' to either question, please include a section in the report explaining why			

Does this paper provide assurance in respect of delivery of our Equality, Diversity and Inclusion (EDI) Framework goals and objective? THIS MUST BE COMPLETED			
Maximise our contribution to reducing inequalities and promoting equality of access, experience and outcomes.	☐	Become a model employer in respect of equality, diversity and inclusion in employment	☐
Comply fully with current and future equality and human rights legislation	☐	Ensure our services are accessible to all and support a diverse workforce that is capable of understanding the needs and culture of its service users and staff	☐
No assurance provided	☐	Not applicable	☒

Does this paper provide assurance in respect of a new / existing risk(s) (if appropriate) THIS MUST BE COMPLETED					
Area	New	Existing	N/A	If new or existing, please indicate where the risk is described	
Type of Risk	☐	☒	☐	Board Assurance Framework ☐	Organisational Risk Register ☒
Risk Reference / Description: (only include reference to the highest				The highest risk at the moment is related to COVID outbreaks since we still have sustained community transmission and we	

level framework / register)	will be facing another flu season next October which will create added risks and complexity.

Infection Prevention and Control

Annual Report 2020/21

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Executive Summary

The 2020/21 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 also 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 reecomendations for 2021-2022 work plan to strengthen assurance.

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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 2020-21 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of Trust compliance	Recommendation/action for 2021-22 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 • Link worker programme • Policy review programme • Water Safety Group. • Trust Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist. • Access to microbiological testing and system for timely reporting of results. • Seasonal Influenza Planning	1. Development of an informatics 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 resilience audit;

		• COVID vaccination planning. • Assurance framework tool completed and reviewed by Trust board quarterly.	
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.	3. Auditing control of legionella policy requirements undertaken by the WSG; 4. Recruit food safety advisor or procure external service; 5. Develop a solution to centralise cleaning 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.	6. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice; 7. Promote discussions between microbiologist and pharmacy lead to ensure antibiotic usage monitoring is resulting in lessons learnt. 8. 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/	• IPC representation at Service User Experience Group • IPC notice boards • Information on wellbeing and visiting • Hand washing notices. • BBV Screening secure care	9. Review of information available internal and external sites; 10. Provide information to be cascaded to clinical areas with relevant information displayed on the IPC boards at the clinical areas

	medical care in a timely fashion.	• Close work with comms to ensure adequate messages and information are available on internal and external sites. • COVID Lateral flow test available for staff •	11. Regular meetings with matrons/managers for COVID update
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	12. 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, including COVID. 13. Ensure that all inpatient areas have up to date cohorting plans if necessary as well as identified contingency measures in case of an outbreak; 14. Ensure outbreak resilience tool/audit is in place in all clinical areas to identify aspects requiring improvement. 15. Ensure information given on training and link workers is cascaded to 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.
7	Provide or secure adequate isolation facilities.	• Ensuite bedrooms to the majority of inpatient services. Dedicated toilet facilities made available in non-ensuite areas. • Management of Isolation Procedure in place and reviewed • Implemented admission area for dementia&frailty during COVID	16. Staff to return an electronic copy of the isolation checklist in accordance with isolation procedures. 17. IT development of a solution to capture and monitor isolation information/checklists. 18. Clinical areas to develop with IPC support contingency plans to ensure isolation of COVID confirmed/suspected SU –

			identification of possible admission areas/isolation pod areas and procedures to ensure this can be timely actioned
8	Secure adequate access to laboratory support as appropriate.	• Pathology services provided by Sandwell &West Birmingham Hospitals NHS Trust.	
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.	19. Policies/Procedures for review: • Trust Cleaning Policy (Estates & Facilities) – review delayed from April 2019 due to expected changes in Cleanliness Specification. • Standard Infection Prevention & Control Precautions • Hand Decontamination & Guidance on Glove Use • Clostridium Difficile • Multiresistant Organism • Food Hygiene Policy
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. • COVID vaccination plan and monitoring for staff	20. Occupational Health to provide input to Seasonal Flu Planning; 21. Occupational Health to support staff testing for COVID when outbreak declared (presently, this is ensured by Birmingham Community Healthcare Trust)

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.*

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3. Training activity

3.1 Training delivered

Q1	Q2	Q3	Q4
Infection Control Link Workers study day was delivered on 4 June 2020 in the form of a webinar. It was very well attended, +and positive feedback was received. Sessions covered IPC Link Worker role and responsibilities, decontamination, flu vaccinations, Covid-19 and surveillance. Webinar recording was made available online. The first webinar for flu vaccinators was delivered on 27 June, and the presentation was made available online. During this period, the IPC team provided tailored training and	Three-hand hygiene training sessions were arranged in September, but those were poorly attended. IPC Nurse delivered additional 1:1 training to some of the Hand Hygiene Trainers. Additional webinar for flu vaccinators delivered on the 24 September. It covered the flu portal, and the presentation was made available online. Regular drop-in support sessions were available to staff vaccinators. During this period, the IPC team has been providing tailored training and support to specific areas according to identified needs and	Infection Control Link Workers study day planned on 5th November 2020 was cancelled due to workload. Two hand hygiene training sessions have been delivered. Hand Hygiene training delivered by Teams, last one on 5th January 2021. IPC prepared several support videos around COVID, COVID vaccination, use of lateral flow portal. During this period, the IPC team has been providing tailored training and support to specific areas according to identified needs and joining teams'	Infection Control Link Workers study day delivered via Microsoft teams in February. Presentations delivered were: Infection Prevention & Control New Initiative, COVID-19 outbreaks, COVID-19 general information & water safety. The IPC team delivered the following: • Covid-19 vaccination presentation • Core hand hygiene training was delivered on 5th January • Junior doctors induction training on

support to specific areas according to identified needs and joining teams' handovers to discuss questions, issues, and anxieties related to IPC.	joining teams' handovers to discuss questions, issues, and anxieties related to IPC.	handovers to discuss questions, issues, and anxieties related to IPC.	COVID-19 in February

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
		23/11/20, 14/12/20 Leadership Development Program for Infection Control Nurses Working in Mental Health 1/12/20 Royal Society of Public Health - Source Tracking of Antimicrobial Resistance in Emerging Countries 2/12/20 Transforming conversations – Building a Coaching Culture	Leadership Development Program for Infection Control Nurses Working in Mental Health Mental Health Trusts & Independent Hospitals - Outbreak Management Webinar Mental Health Trusts & Independent Provider Webinar series - How to Contact Trace How to minimise errors during outbreaks IPS Mental Health/LD Special Interest Group Meeting

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3. 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. In general the IPC standards across the Trust have been improved.	Closer monitoring of cleaning standards by Facilities and IPC team Cascading findings to Matrons and link workers and request action plan Involve estates and facilities on the audits and action plans Monitoring improvements through inspections and actions in service area surveillance reports to IPPC
Dental Suite Checks	Dental suits have been closed during the year due to the COVID pandemic Concerns about ventilation when opening being discussed with health and safety	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 Develop a report for and hygiene monthly submission to ensure all teams report timely Bare Below Elbows to be promoted across all staff groups and audits undertaken more widely in community services.
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 sharps injury reports. The number of incidents continued to reduce	Keep increasing awareness through link workers and matrons/managers.

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		Re-instate 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.	Allergy information to developed and deployed in the Trust with cooperation with food safety advisor that conducted inspections (contracted from SSL) Matrons to keep updates on actions from inspections
Legionella Policy compliance	Re-instated water safety group with a new chair	Development of integrated record and testing system that allows the follow up of the situation in the different buildings

4.1 PLACE Scores

BSMHFT 2020PLACE scores are included within Estates & Facilities IPC 2020-21 Annual Report – attached to this report.

4.2 Hand Hygiene

4.2.1 Inpatient

The table below provides average Hand Hygiene scores broken down to each quarter:

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Inpatient Sites						
	2020/2021 Q1	2020/2021 Q2	2020/2021 Q3	Jan-21	Feb-21	Mar-21
Ardenleigh	91.4	95.3	95.8	96.7	96.8	94.3
Ashcroft	0.0	100.0	100.0	0.0	0.0	0.0
Barberry Centre	97.0	96.0	96.3	95.3	95.8	97.7
Dan Mooney House	100.0	100.0	100.0	0.0	93.0	100.0
David Bromley House	100.0	100.0	100.0	100.0	98.0	100.0
Endeavour Court	98.0	97.0	100.0	98.0	100.0	93.0
Endeavour House	100.0	86.0	100.0	100.0	100.0	100.0
Forward House	100.0	93.0	94.0	0.0	95.0	97.0
Grove Avenue	98.0	98.0	99.0	0.0	97.0	0.0
Hertford House	91.0	100.0	0.0	97.0	0.0	94.0
Highcroft	94.3	95.3	96.3	96.3	95.0	91.3
Hillis Lodge	95.0	99.0	89.0	98.0	100.0	0.0
HMP Birmingham	99.0	100.0	100.0	0.0	100.0	96.0
Juniper Centre	99.3	97.7	97.7	96.5	99.0	99.3
Mary Seacole	99.0	97.3	99.3	100.0	99.0	99.0
Newbridge House	95.0	98.0	97.0	0.0	97.0	100.0
Oleaster	98.3	94.0	92.7	92.3	96.4	96.0
Reaside Clinic	98.0	97.9	96.5	97.0	95.9	97.3
Reservoir Court	98.0	100.0	100.0	0.0	100.0	100.0
Tamarind	97.3	97.1	95.0	98.0	97.0	95.6
Zinnia Centre	99.0	92.0	97.5	94.0	97.0	98.0

Ashcroft has no submissions since January since the department is currently closed.

4.2.2 Community

The table below provides average Hand Hygiene scores broken down to each quarter:

Community Teams						
	2020/2021 Q1	2020/2021 Q2	2020/2021 Q3	Jan-21	Feb-21	Mar-21
Admiral Nursing Service	0	0	96	0	0	0
Aquarious Wolverhampton	92	97	98	100	100	100
Ardenleigh FCAMHS	0	78	80	0	80	0
Aston & Nechells CMHT	95	100	100	0	0	97
Barnardos	100	100	100	100	100	100
BHM BEN	0	75	0	0	0	0
BHM Central	74	75	0	0	0	0
Central HTT	0	98	98	97	0	100
Compass	0	100	0	0	0	0
East AOT	100	0	0	0	0	0
East HuB	0	95	0	0	0	0

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ECT Suite	0	100	0	0	0	0
EIS Solihull	100	100	92	100	100	100
Erdington & Kingstanding HTT	0	0	94	97	97	100
Erdington And Kingstanding CMHT	0	100	100	0	0	0
Forensic Outreach Service	100	100	100	97	100	100
Handsworth HTT	97	93	100	100	100	95
Homeless Mental Health Team	100	100	100	0	100	98
Homeless Primary Care Team	100	100	97	0	100	100
Ladywood & Handsworth CMHT	98	100	100	0	0	98
Ladywood HTT	97	97	97	0	98	100
Longbridge CMHT	100	100	100	100	100	100
Lyndon CMHT	0	0	95	0	0	0
Memory Assessment Service	0	94	0	0	0	0
Newington CMHT	98	100	100	97	100	100
North AOT	100	0	100	0	0	0
North HuB	100	100	100	98	100	100
Perinatal Community BWH	75	0	0	0	0	0
Perinatal Community East	84	100	98	100	100	100
Perinatal Community SWB	0	0	97	98	0	0
Phoenix House	0	94	100	97	100	100
Psychiatric Decision Unit	0	0	95	97	97	100
Riverside CMHT	92	97	100	0	0	98
Small Heath Day Unit	0	100	98	100	97	100
Solar Crisis Team	100	100	100	100	100	100
Solihull AOT	0	100	100	100	100	97
Solihull CAMHS	100	100	100	100	100	100
Solihull HTT	99	100	99	95	100	100
Solihull HuB	84	0	0	0	0	0
South AOT	100	100	98	0	0	0
South East HTT	100	100	100	0	0	0
South HuB	95	98	100	0	98	97
South West HTT	100	100	100	0	95	0
Sparkhill HTT	98	98	100	100	98	98
Sutton CMHT	0	100	0	97	0	0
Sutton HTT	0	0	92	94	100	100
The Bridge	0	86	100	0	0	97
The Eating Disorders Service	100	100	100	100	100	100
Warstock Lane CMHT	0	89	0	0	0	0
West AOT	99	97	100	0	100	97
West HuB	0	100	100	0	0	0
Yewcroft CMHT	100	100	100	100	100	100
Zinnia CMHT	93	95	97	0	0	0
Zinnia Day Service	0	91	100	100	100	98

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Several teams have a continuous score of zero. This has been identified and is in its majority because the teams ceased to exist and/or were incorporated in other teams. The list is currently being reviewed for an update.

4.2.3 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 nail varnish.

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 Trust decided to acquire varnish and false nails removal kits.

During the last quarter was decided to increase the hand hygiene audits' frequency to ensure a higher level of assurance. The IPC team is monitoring the compliance with the new guidance.

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

The audit system program has been changed, but this has not caused any disruption on the monitoring; nonetheless, we have identified that the list of teams is currently outdated, so working on getting an updated list.

The auditing results report is generated in a format that makes the monitoring difficult. The IPC team is working to find a solution with IT to centralise the information and allow easier monitoring of compliance by the teams.

5. External Inspections and Audit

No external inspections/audits to be reported. The Trust had several CQC inspections, but no IPC issues pointed.

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6. Surveillance of Alert Organisms and Outbreaks

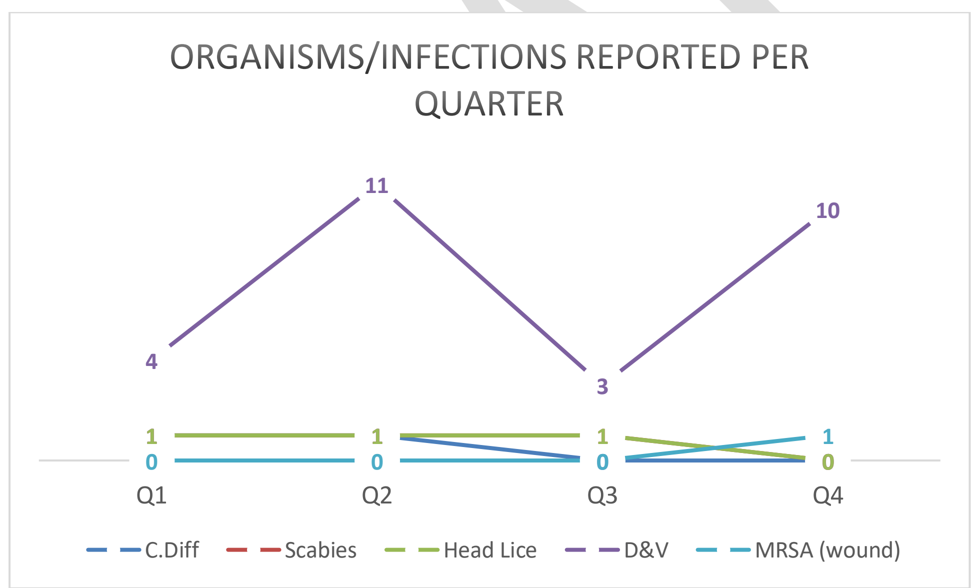
The IPC team have responded to numerous inquiries on the management of potential and actual infectious organisms; the following is a summary of the activity of individual cases and outbreaks.

6.1 Total number of organisms reported

We had a total of 21 reports of infection (excluding MRSA and COVID related).

Table 1 - Infections/organisms reported by quarter

	Q1	Q2	Q3	Q4
C.Diff	1	1	0	0
Scabies	1	1	1	0
Head Lice	1	1	1	0
D&V	4	11	3	10
MRSA (wound)	0	0	0	1



Graphic 1- Infections/organisms reported by quarter

We notice an overall reduced number of reports. This has been reflected by the IPC and discussed both within the organisation and with external stakeholders. This seems to be a common situation across the national healthcare scenario and likely related to increased IPC awareness across the organisation. The IPC team has not ruled out the risk of under-reporting; therefore they tried to increase awareness through IPC meetings with matrons, local managers and link workers.

6.2 Outbreaks (non COVID)

No Non-COVID related outbreaks declared

6.3 MRSA Admission Screening

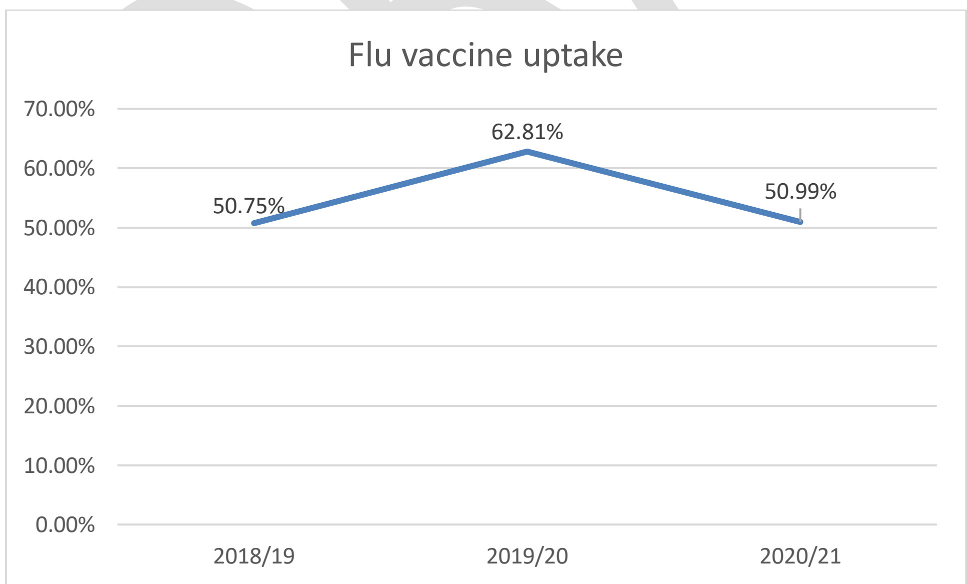
According to the Health and Social Care Act, the Trust continues to have management systems to ensure that MRSA colonisation is promptly identified. This includes screening patients admitted from other healthcare settings or have existing wounds or indwelling devices that could increase the risk to both the individual and other vulnerable patients of developing an MRSA infection. We had no patients MRSA colonised on admission. The policy has been revised, widening the scope of os service users tested to include those from Nursing and Care homes.

7. Seasonal Influenza Plan

The Trust final position following validation was submitted to Public Health England in March 2021. Our final staff flu vaccine uptake is 50.99%, a decrease of 11.82% compared to the 2019/20 final total of 62.81%, which represents a significant as we can see in Table 2 and Graphic 2.

Table 2 - Flu vaccine uptake since 2018/19

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



Graphic 2- Flu vaccine uptake since 2018/19

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Besides all the effort put into a successful flu campaign, it not met the intended success; this was a complex year with the COVID pandemic, which contributed to reducing the overall focus of staff on flu vaccination and consequent reduction in numbers.

Besides the lower result, some significant progress has been made during this flu campaign, in particular on what it relates to record and reporting of vaccination numbers, with the development of the flu portal that allowed vaccinators to record vaccination directly into the electronic systems as well as staff vaccinated outside the organisation was able to record their status using any electronic device with browser access.

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

The Trust has been reviewing the 2020/21 campaign in detail in terms of challenges and learning.

7.1 Actions were taken to reach 100% uptake ambition

- Proactive communications and engagement programme (dedicated pages on intranet, flyers, posters, health and wellbeing promotion, OH services promotion, myth-busting correspondence).
- 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)
- Additionally, staff vaccinators deployed across the Trust across all locations to support the vaccination programme.
- Deployed flu portal do ensure a more robust and precise recording of flu vaccination.
- 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.
- E-mail from Director of Nursing to all staff regarding intentions around flu vaccination in September, followed by weekly e-mails from November onwards to front line clinical staff encouraging take-up of the vaccination and follow up reasons for declining vaccination.
- IPC myth-busting intervention with several teams from community and inpatients;
- The campaign focused on the protection of individual, patients, family and community;

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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.

The IPC team has supported the Trust and, in particular, 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 extra staff members to cooperate with surveillance and local advice, freeing the team to provide specialised support to all Trust departments.

The original planning model utilised was the pandemic flu emergency planning policy due to the transmission characteristics of the virus.

Training has been offered to the staff about COVID-19, symptoms, isolation measures, and a broader face-mask fitting program being put in place. At first, the IPC team and soon after supported by Physical Heath and Professional Education teams. This allowed us to quickly face a significant portion of the face front staff but had severe limitations due to lack of testing solution availability. The Trust acquired a porta-count machine to ensure a more accurate fit testing and reduce reliance on the face fitting solutions.

During Q3 and Q4, the Trust had external support by the mask provider company

The Trust acquired 5 powered hoods. One is currently located at Juniper Centre, and the remaining at the ICT suite where training on how to use and maintain was given. 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 in the desired quantity and try to support the recognition of the areas in need of specific equipment.

During the pandemic besides national shortages of PPE, there were no reports of staff not having the adequate PPE at all times. This achievement is greatly due to the effort put by the procurement team.

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

We reported a total of 43 outbreaks, as displayed in Table 3 - Outbreaks per quarter

Table 3 - Outbreaks per quarter

	Q1	Q2	Q3	Q4
N Outbreaks	4	1	17	21
Outrbreaks Cum	4	5	22	43

On Table 4 - Quarter outbreak occurred the data is divided by area and quarter the outbreak was declared

Table 4 - Quarter outbreak occurred

	Q1	Q2	Q3	Q4
Reaside - Dove	1			
Hillis Lodge	1			
Newbridge House	1			
Reservoir Court	1			

Eden PICU		1		
Ardenleigh			1	
David Bromley & Dan Mooney			1	
Eden PICU			1	
Oleaster – Magnolia and Tazetta			1	
HTT Community Team			1	
Jasmine – The Barberry			1	
Tamarind – Hibiscus			1	
Tamarind – Lobelia			1	
Tamarind – Myrtle			1	
Tamarind – Laurel			1	
Larimar			1	
Reservoir Court			1	
Mary Seacole House – Meadowcroft PICU			1	
Maple Leaf - EIS, Newington, CMHT, Solihull Older Adults Team			1	
Reaside			1	
Mary Seacole Ward 2			1	
South West Home Treatment			1	
Oleaster – Melissa Ward				1
David Bromley House				1
Dan Mooney House				1
George Ward				1
Endeavour House				1
Endeavour Court				1
Larimar				1
The Barberry – Jasmine				1
The Barberry – Cilantro				1
Tamarind – Hibiscus				1
Tamarind – Lobelia				1
Tamarind – Myrtle				1
Tamarind – Laurel				1
Tamarind – Sycamore & Acacia				1
Juniper – Sage				1
Juniper – Bergamot				1
Juniper – Rosemary				1
Mary Seacole House – Meadowcroft PICU				1
Mary Seacole House Ward 1				1
Mary Seacole Ward 2				1
Solihull Home Treatment				1
TOTAL	4	1	17	21

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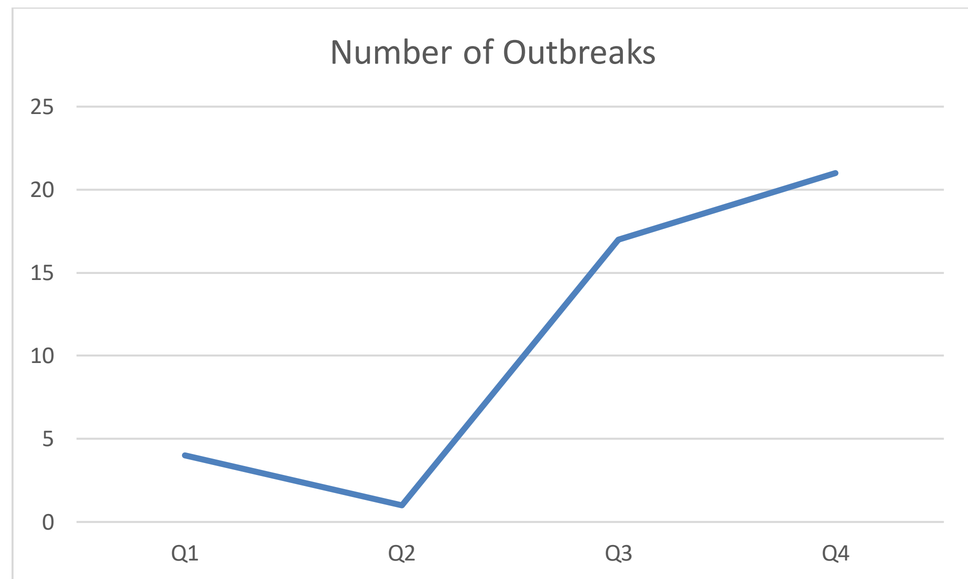
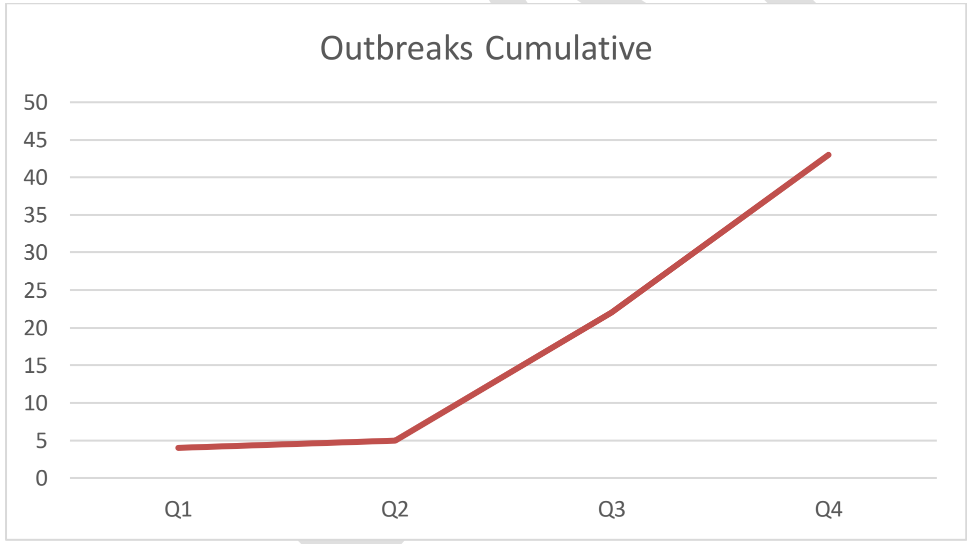
The highest number of outbreaks occurred in Q4, with 21, followed by Q3 with 17. This is in line with the development of the pandemic/community transmission across the year.

The following graphics present the distribution of outbreaks per quarter:



Graphic 3 - Number of Outbreaks per Quarter



Graphic 4 - Cumulative Number of Outbreaks per Quarter

During the outbreaks, we had a total of 201 positive service user cases (SU) distributed as presented in Table 5 - SU affected during outbreak per quarter

Table 5 - SU affected during outbreak per quarter

SU in outbreak	Q1	Q2	Q3	Q4
TOTAL	15	3	60	123
Total Cum	15	18	78	201

The following chart presents the data per area:

Table 6 - SU affected during an outbreak (per area)

SU in outbreak	Q1	Q2	Q3	Q4
Reaside – Dove	3			
Hillis Lodge	8			
Newbridge House	2			
Reservoir Court	2			
Eden PICU		3		
Ardenleigh				
David Bromley & Dan Mooney			1	
Eden PICU			1	
Oleaster – Magnolia and Tazetta			9	
HTT Community Team			0	
Jasmine – The Barberry			0	
Tamarind – Hibiscus			0	
Tamarind – Lobelia			0	
Tamarind – Myrtle			5	
Tamarind – Laurel			2	
Larimar			3	
Reservoir Court			1	
Mary Seacole House – Meadowcroft PICU			2	
Maple Leaf – EIS, Newington, CMHT, Solihull Older			2	
Reaside			32	
Mary Seacole Ward 2			2	
South West Home Treatment			0	
Oleaster – Melissa ward				5
David Bromley House				4
Dan Mooney House				1
George Ward				8
Endeavour House				9
Endeavour Court				13
Larimar				4
The Barberry – Jasmine				8
The Barberry – Cilantro				10
Tamarind – Hibiscus				8
Tamarind – Lobelia				3
Tamarind – Myrtle				7
Tamarind – Laurel				2
Tamarind – Sycamore & Acacia				14
Juniper – Sage				8
Juniper – Bergamot				1
Juniper – Rosemary				6
Mary Seacole House – Meadowcroft PICU				1
Mary Seacole House Ward 1				3
Mary Seacole Ward 2				8
Solihull Home Treatment				0
TOTAL	15	3	60	123

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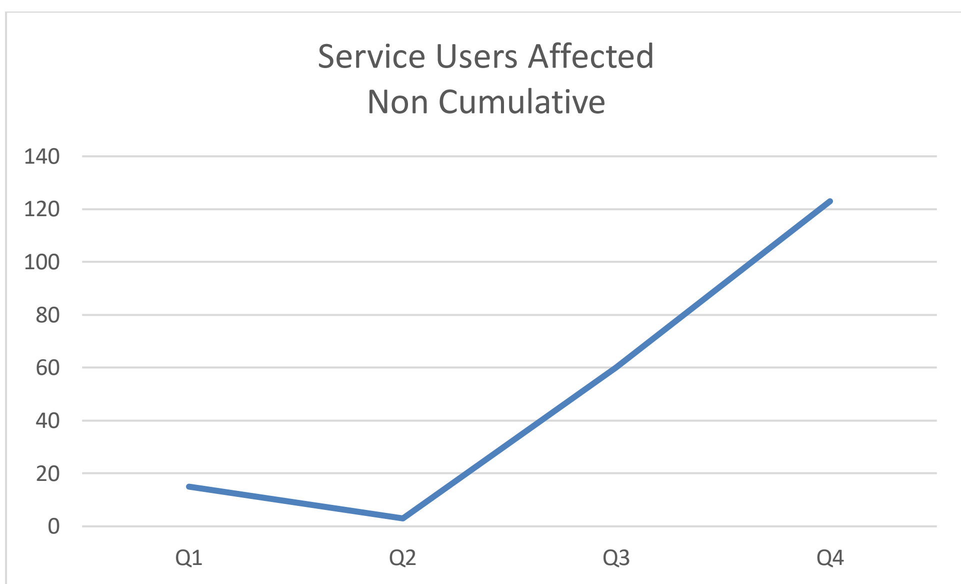
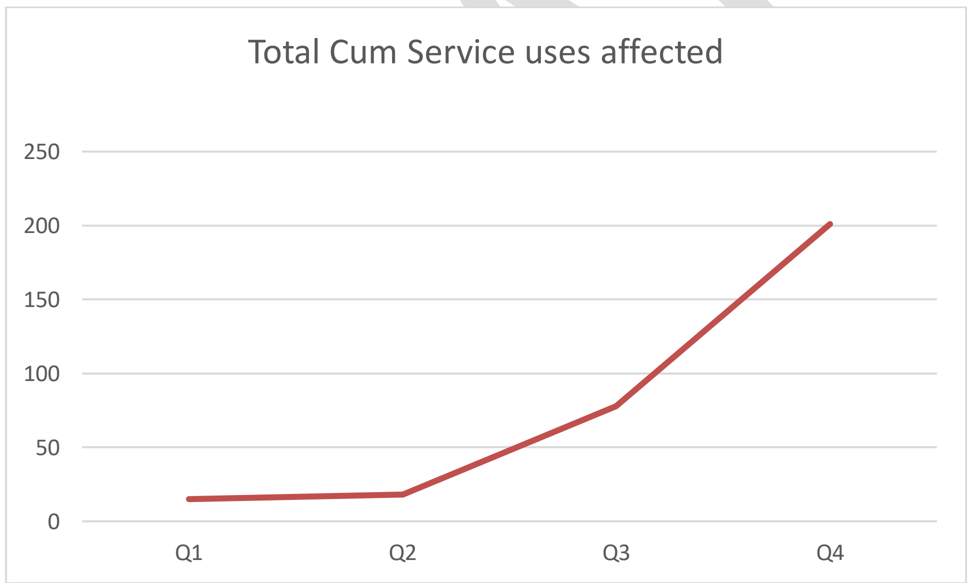
The total affected SU was 201 (during outbreaks), with Q4 having the highest count with more than double the number of affected SU on the previous quarter.

The same can be seen on the following graphics:



Graphic 5 - Service users affected - Non-Cumulative



Graphic 6 - Total Cumulative service users affected during outbreaks

On what concerns to staff affected during outbreaks, we had 200 staff members affected, with two staff members deceased.

The distribution per quarter can be seen in Table 7 - Staff affected during outbreaks

Table 7 - Staff affected during outbreaks

Staff in outbreak	Q1	Q2	Q3	Q4
TOTAL	0	1	69	130
Total Cum	0	1	70	200

It is important to refer that the number 0 for the first quarter is inaccurate. Due to not having promptly available testing to staff, the situation was resolved, and testing during outbreak investigation was done through PHE laboratories.

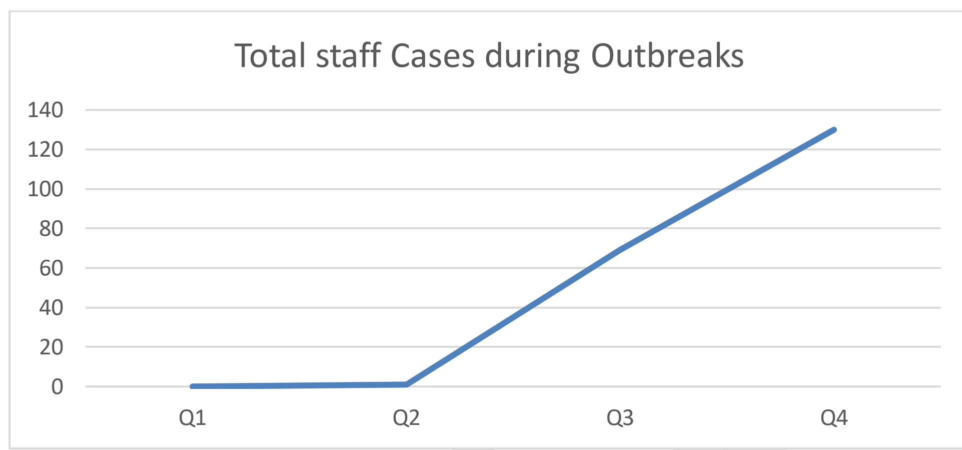
The following table (Table 8 - Staff affected by COVID during an outbreak) presents the information divided by areas:

Table 8 - Staff affected by COVID during an outbreak

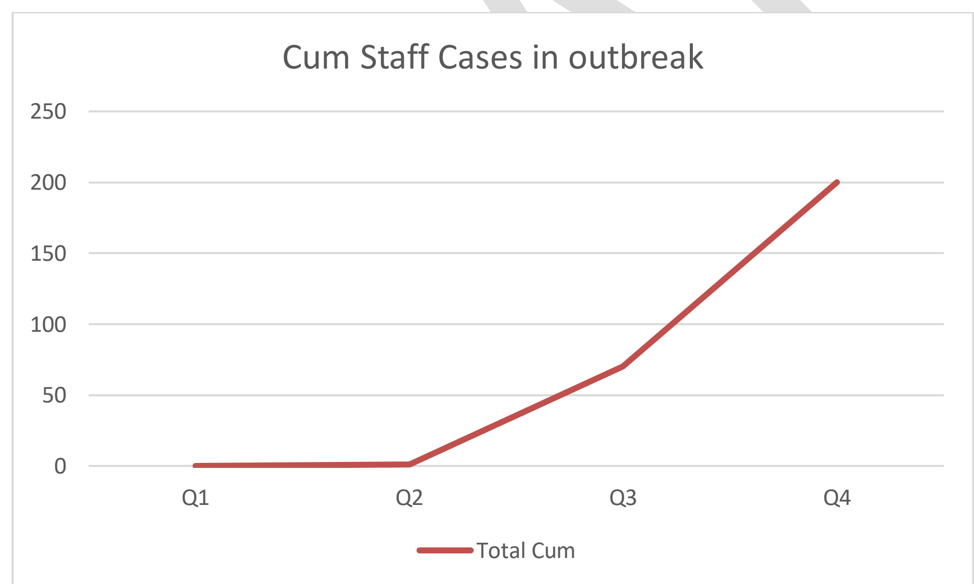
Staff in outbreak	Q1	Q2	Q3	Q4
Reaside - Dove				
Hillis Lodge				
Newbridge House				
Reservoir Court				
Eden PICU		1		
Ardenleigh				
David Bromley & Dan Mooney			9	
Oleaster – Magnolia and Tazetta			3	
Eden PICU			3	
HTT Community Team			3	
Jasmine – The Barberry			2	
Tamarind – Hibiscus			2	
Tamarind – Lobelia			2	
Tamarind – Myrtle			2	
Tamarind – Laurel			1	
Larimar			2	
Reservoir Court			4	
Mary Seacole House – Meadowcroft PICU			4	
Maple Leaf – EIS, Newington, CMHT, Solihull Older Adults Team			3	
Reaside			25	
Mary Seacole Ward 2			1	
South West Home Treatment			3	
Oleaster – Melissa ward				9
David Bromley House				2
Dan Mooney House				9
George Ward				13
Endeavour House				3
Endeavour Court				8
Larimar				6
The Barberry – Jasmine				16
The Barberry – Cilantro				6
Tamarind – Hibiscus				6
Tamarind – Lobelia				3
Tamarind – Myrtle				7
Tamarind – Laurel				1
Tamarind – Sycamore & Acacia				6
Juniper – Sage				11
Juniper – Bergamot				2
Juniper – Rosemary				6

Mary Seacole House – Meadowcroft PICU				4
Mary Seacole House Ward 1				3
Mary Seacole Ward 2				7
Solihull Home Treatment				2
TOTAL	0	1	69	130

The distribution of cases can be seen in the following graphics:

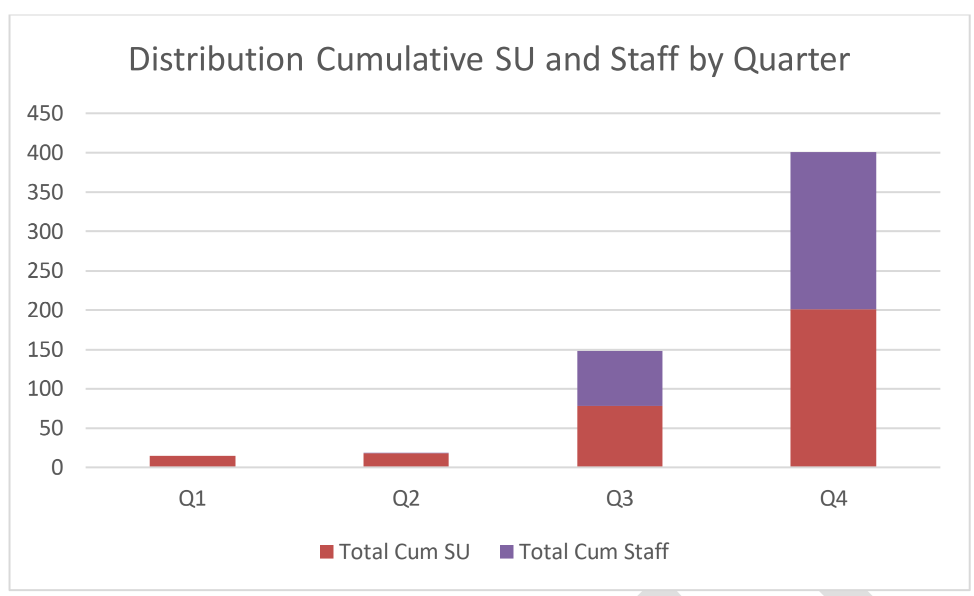


Graphic 7 - Total staff cases during outbreaks



Graphic 8 - Cumulative number of staff cases during COVID outbreaks

The total numbers of staff and SU cases during the outbreaks was very similar, as we can see on Graphic 9 - Cumulative distribution of cases SU and Staff.



Graphic 9 - Cumulative distribution of cases SU and Staff

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).

During Q4, 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. All parts accepted this option.

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

1. Sharing of mugs and cutlery
2. Service users sharing cigarettes
3. Breach of PPE policy: staffs identified were not using PPE correctly.
4. Likely exposure during AVERT
5. Different clinical issues across the services offering specific challenges, such as communicating with hearing impaired service users.
6. SU meeting in communal wards, not able to observe social distancing.
7. Delay in isolating service users on admission /test results;

For point 1, information was shared across the organisation, aiming to remove all shared cutlery/mugs/etc. All staff were asked to use either disposable items or use their own and store them apart from other staff items.

For point 2 – The work across the Trust was focused on raising awareness and avoiding SU's congregation for smoking, and preventing the possibility of sharing these items.

On what concerns to point 3, the identified breaches were discussed with the local area, on the matrons meeting, and incorporated in any training happening around PPE use. Some actions were also taken with the support of the comms team to ensure messages were widespread as effective and fast as possible.

This was particularly challenging, particularly during the first two quarters, due to not having specific advice for mental health organisations and the National Advice having frequent changes. Nonetheless,

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in general, the use of PPE across the organisation was successful. During periods of scarcity of PPE, the staff always had available the recommended PPE.

On point 4, this is a complex theme, being the national advice different from the one given by the RESUS council. National guidance only requires an IIR mask, gloves and apron, while second advised using equipment in line with AGP (aerosol-generating procedures). This was discussed with local managers and taken to the Ethical and Legal Committee for consideration, where it was decided that staff could use either PPE; nonetheless, the IPC team warned that regardless of the option, it was doubtful that FFP3 masks would be able to maintain an effective seal during restrain activities and also there was the risk of fatigue or even fainting due to an increased re-breath of CO_2. Therefore the areas where the restraints were happening needed to account for these risks.

On point 5, this was very complex across the organisation since we have an extensive variety of patient ages and health issues.

Arrangements were made for dementia and frailty to create an admission suite situated at Rosemary Ward – Juniper Centre. All new service users were admitted through this area, where they were tested and isolated on admission, day 3 and 5 to 7. After passing the isolation period and all negative swabs, if no positive cases were identified on the admission area, the SU would proceed to the destination area. This allowed to have a tighter control of admissions and aimed at the reduction of risk of COVID. The option was complex to implement because this area had male and female SU (all in individual ensuite rooms) and a mix of SU pathologies. The risk of increased aggressiveness was risen. To ensure the proper and safe management of this area, monthly evaluation meetings were held and as part of these meetings the number of incidents reviewed. The conclusion was that there was no significant increase in incidents, but there was a higher strain on staff due to this staffing (clinical and non-clinical was re-inforced). At the end of Q4, the admission suite is still operational and under review.

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 struggle with reading and writing. It is a fact that British sign language heavily relies on lip reading.

There has been only one brand of clear view masks approved in the country. The Trust acquired those masks for testing, and the conclusion was that they were not fit for purpose since the view window for lip reading was very small, constantly fogged, and very uncomfortable. Therefore the masks have not been adopted.

IPC conducted visits and several discussion meetings with the area and external stakeholders to identify solutions to mitigate the specific risks. We decided to create chat rooms, where a prospect screen was installed between 2 tables and allowed face to face conversation without a mask. These proven to be successful, but not enough to some periods of de-escalation or mundane quick discussions. We later asked the interpreters to interpret the interpretation from over 2 meters distance following National Guidance. Jasmine ward had a total of 2 outbreaks during the year. The first in Q3 with a student nurse and an interpreter that had been in contact with no PPE in the pause room, and the second one in Q4 with 16 staff members affected (in both outbreaks, no patients were involved). The conclusion of the investigation of this second outbreak also pointed to unprotected contact when staff were not in clinical areas besides advice given.

Point 6 was particularly complex to deal with in some areas due to the acuity and characteristic of the service users. After risk assessment, face masks were facilitated to SU in some circumstances. Also, we have services where service users can exit the department and go to cashpoint and shops, exposing them and further contacts to increased risk of infection. In areas where SU had regular leaves, the Trust opted to do weekly SU testing to look at early detection of new infections and quick isolation. Also, advice has been given to SU to avoid close contact. Services like occupational therapies and others kept running but attending social distancing and avoiding sharing of materials between SU.

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Point 7 – Because the Trust has no Lab and all testing had to be done through the city hospital pathology laboratory, there was reduced access to testing during the first quarter. Criteria had to be established to test suspected COVID patients. Also, a system was organised to collect samples twice a day to deliver to the laboratory and therefore maximise the number of tests received by them before they were sent to testing. Nonetheless, the turnaround of the tests was consistently around 48-72 hours, with some cases longer. Because we cannot impose isolation to SU if not symptomatic and there were no admission areas established except for dementia and frailty, this increased the risk of outbreaks, particularly during periods of higher community transmission rates. In this situation, a decision tree was produced to enable staff to negotiate isolation or, if not adhered to risk, assess the use of mask and social distancing while results were pending. During Q4, the Trust has been given access to a limited number of rapid PCR testing prioritised to acute areas during admission. This is not seen as a solution for the isolation of service users. At the same time, testing on day 1, 3 and 5 to 7 is being done but increases the possibility of earlier detection of admitted positive patients.

8.1 COVID guidance

The COVID National Guidance had constant revisions, particularly during the first 2 quarters, 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, there was no specific guidance to mental health organisations. Not all the advice provided was applicable in this kind of organisation. The most contentious issues were discussed through LEG (legal and Ethical Committee), like RESUS, AVERTS, etc.

To ensure the guidances changes were quickly cascaded, a bi-daily meeting between IPC and the deputy director of nursing was arranged and daily matrons meeting with IPC presence (later on moved to bi-weekly). This allowed us to cascade any changes, share learning and discuss challenges quickly.

The following tree guides the admission process for SU across the Trust (except for dementia and frailty):

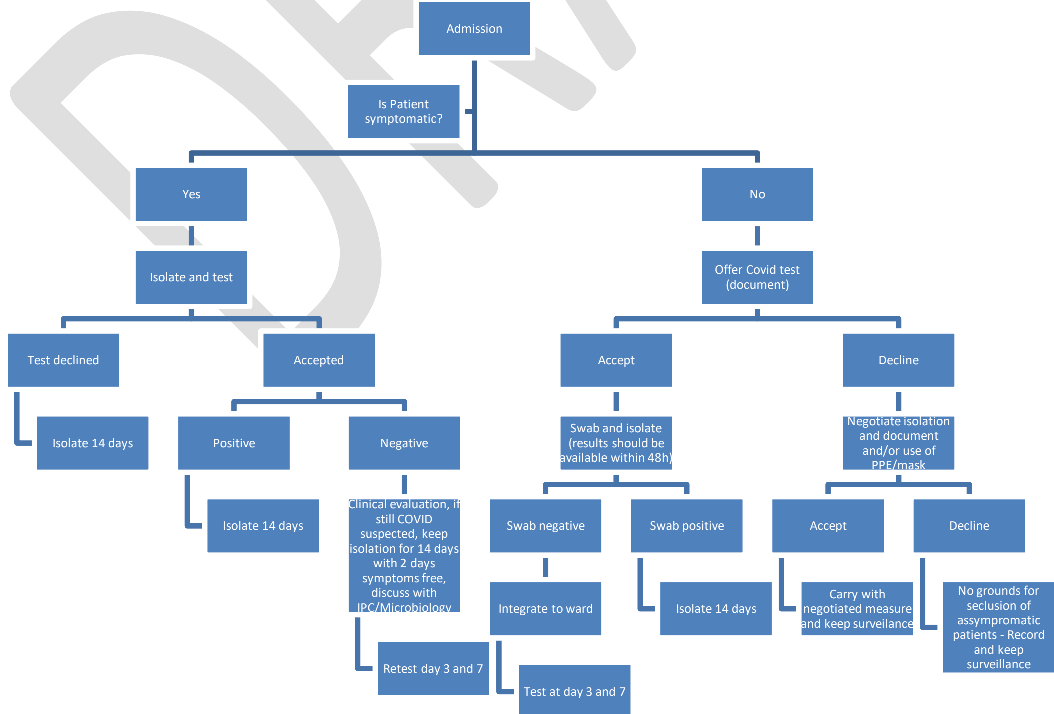

Figure 1 - Admission decision tree (except dementia and frailty)

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For dementia and frailty, a different arrangement than the other areas, due to the fact this group of patients in particular high risk of severe COVID consequences.

Dementia and frailty have an admission ward where all SU are first admitted and tested. They then stayed in this area for the first week (local SOP created) and tested on admission, day 3 and 5 to 7. Only after all negatives test and no clinical symptoms of COVID for this SU and any of the others located in this area, the transfer can be made to the destination ward. This ward also has the capacity of isolating some SU in a separate smaller area if needed.

During the pandemic, several guidance was produced and disseminated. Some videos have also been created as a way to disseminate information. Due to a large amount of documentation paid and the constant updates, the IPC team developed overarching guidance for COVID to unify the documentation/procedures in a single document that can be accessed from connecting and could be easily updated.

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.

Create a specific IPC training for matrons and managers to ensure they are fully aware of their role in IPC.

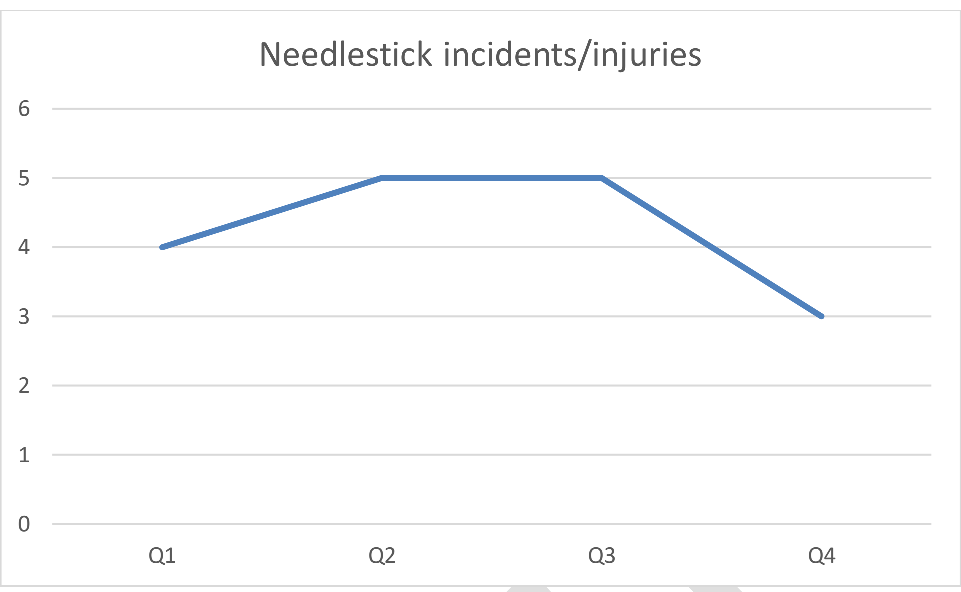
9. Incident Reporting

The IPC team also keeps a database of injuries to ensure that those affected are reported to Occupational Health. Occupational Health reports numbers of staff injuries to IPPC. There has been a reduction in needlestick injuries.
This year the sharps box audit was not possible due to COVID restrictions; nonetheless, the needle stick injure figures were used as an indirect indicator of the situation across the Trust.
The poster for needle stick injuries was revised, and the new one is now available on connect and being disseminated across the Trust.

Sharps injuries include needlestick injuries, bites, scratches, and bodily fluid exposure to mucous membranes (splash injuries).
During the year, we had 17 needle stick injuries reported (3 more than the previous year):

Table 9 - Needlestick incidents by quarter

Quarter	Needlestick incidents/injuries
Q1	4
Q2	5
Q3	5
Q4	3



Graphic 10 - Needlestick incidents by quarter

Occupational Health is responsible for advising and monitoring staff members with needle stick injuries and reporting to the IPPC committee every quarter in parallel with information obtained by RIO notifications.

10. IPC Team Response to Alerts and Directives

- Coronavirus outbreak – Information is given to all staff through direct communication from the IPC team, e-mails, and comms;
    - Advice given was extended to contractors like Amey to assure that in the case of having to deal with infected patients, the Trust would be able to function in an integrated way, reducing the risk of unnecessary exposure to staff, patients and visitors;
- Discussed with CCG the need to create coronavirus pods – This has been ruled out since it is a requirement for acute physical hospitals with A&E;
- IPC guidance continuously updated as it has been released. Created SOP IPC COVID to be updated quarterly if no significant changes in between.
- Discussion of IPC directives within LEG – Where legal and Ethical issues were identified, the National guidance implementation was discussed within LEG. Some of the talks were around forced isolation, AVERTS PPE, RESUS PPE, etc.

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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.

The main areas of concern were the food production sites across the Trust. In areas such as wards, the identified issues were lack of training, poor communication, and standard practices were obvious reasons that good food safety practices were not being followed.

These included:

- Out of date food
- No temperature probe records
- Unlabelled and decanted items with no date, allergen info, storage requirements
- Build-up of grease and dirt in microwaves
- ADL staff storing food incorrectly in fridges leading to possible risk of pathogenic cross-contamination
- Incorrect data in the HACCP folder

Where foods are reheated on the ward, the core temperature of the food should reach above 75°c, and this should be recorded

The comprehensive food safety review recommended that food production kitchens and ward kitchens have an announced and unannounced audit every six months to ensure monitoring and verification of food safety standards and practices are being followed. This will comply with the HACCP and Due Diligence legal requirements for Food Safety. Recommend that all ward matrons attend an Intermediate Food Safety course in those areas where foods are reheated and all ADL kitchen staff responsible for others when preparing and cooking high-risk foods.

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.

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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.

A new Chair has been nominated for the water safety group, following the estates department being managed by SSL from July 2019. It was agreed that the role would be shared between the Estates Manager and the Deputy Director of Nursing to cover the needs of the organisation and required knowledge.

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, with consistent low counts of legionella on site. Maintenance by estates continues works to look at a future possibility of discontinuation of the ORCA system.
The legionella count had elevated values were temporarily closed as per policy, and remedial works done as needed. At the present moment, there are no identified issues with high legionella counts across the Trust.

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 and Commissioners and excellent PLACE results, BSMHFT's overall organisational scores exceeded the National Average scores in all six categories.

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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.
Most significant works have been postponed due to the COVID pandemic, except for place of safety where restructuring works have started, and the unit moved to another area in the building. IPC visited the site and identified several issues that have been escalated, being the most significant:

- Insuficient ventilation
- Holes in a wall on one of the rooms
- No capacity to isolate service users
- Small space not making social distance possible
- Small a cluttered

IPC advised that the use of this area was problematic, and this place would not be suitable to receive SU with unknown COVID status or positive results. If a positive is identified post being here, it was essential to ensure it was possible to identify the potential contacts for screening.

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Infection Control Doctor – Annual Statement for 2020-2021

(Prepared by Dr Savita Gossain and Dr Gemma Winzor, Consultant Microbiologists, Public Health England Laboratory, Birmingham)

Overview

The past year has been one of the most challenging in memory for Infection Prevention and Control (IPC) practitioners; managing the demands posed by COVID-19 and its' impact on patients and staff. The requirements placed on the BSMHT IPC team have been constant and rapidly evolving. The IPC team has needed to adapt to a changing incidence of staff and patient COVID-19 cases, writing and reviewing of policies, managing outbreaks, organising and attending incident meetings and educating staff. For much of the year, there was little national IPC guidance for Mental Health and Learning Disability settings. Furthermore, the scientific evidence evolved during the year, creating a steep learning curve for IPC practitioners. This applied to COVID-19 diagnostic testing and asymptomatic screening, use of personal protective equipment (PPE), vaccination and broader IPC measures. This led to an inability to progress the scheduled IPC annual programme of work fully; with items being deferred (this was noted on the BSMHT risk register).

Staffing

In order to cope with the increased demand, the IPC team has expanded and now consists of a Band 8 Lead IPCN, a Band 8 IPCN, a Band 6 IPCN and a newly appointed substantive Band 7 IPCN. During the past year Lyndi Wiltshire (Physical Health lead) and Paula Ward (Clinical Nurse Manager) were redeployed to the IPC team to support on a temporary basis.

Governance

Leading into this year, the trust Director of Infection Prevention and Control (DIPC) and Chair of the Trust Infection Prevention Partnership Committee (IPPC) was Sue Hartley (Executive Director of Nursing). Sue retired at the end of the year and Sarah Bloomfield (Chief Nursing Officer) is now DIPC and will be chairing the IPCC going forward.

The IPPC continued (remotely) throughout the year (with one exception). Following previous feedback, attendance at IPPC has started to improve, with senior medical representation achieved in the January 2021 meeting.

COVID-19 Response

The IPCT has embraced the huge challenges of the COVID-19 pandemic and coped admirably during this time, despite being a small team. Throughout the year the team have worked in new ways to support the Trust in its emergency planning and IPC response to the pandemic whilst keeping in touch with continuously evolving science; national guidelines and access to testing. COVID-19 incident and outbreak meetings had to be scaled back to a weekly summary with external keyholders in January 2021 due to the high number of outbreaks and ward closures.

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Access to lateral flow testing (LFT) for asymptomatic staff was introduced this year, alongside vaccination for staff and patients (falling into priority groups). To date, uptake of LFT and vaccination amongst staff have been variable. Engaging with staff to promote vaccination has been prioritised to protect patients and increase staffing resilience going forward.

Timely access to SARS-CoV-2 testing (patients and staff) has been an issue. Slow turnaround times for result reporting have impacts for patient flow, risk of virus transmission and staff absence. This was recorded in the BSMHT risk register. The longstanding issue of disparate testing laboratories has been exacerbated by the pandemic. Routine Microbiology testing has continued to be provided by Sandwell and West Birmingham Hospitals, with a new "Rapid Covid-19" testing service being offered by University Hospitals Birmingham and outbreak associated testing has continued to be provided by Public Health England. Streamlining and unifying the provision of Microbiology testing and Infection Control support services would be desirable and is recommended.

Water Management & Legionella

In late 2019, a new structure was developed for water safety, with a senior Summerhill Services (SSL) manager and Deputy Director of Nursing & Quality co-chairing the Strategic Water Safety Group (SWSG). The group is accountable to the IPPC and further restructuring led to an operational subgroup of the SWSG. The SWSG terms of reference were reviewed and updated. The IPC team and Consultant Microbiologist/Infection Control Doctor continued to attend SWSG meetings quarterly whilst an IPCN is a member of the operational subgroup meetings (held monthly). A new BSMHT water safety plan is in development to deliver the goals of safe water and minimise the risk of infection from waterborne pathogens.

Given the issues regarding Legionella testing and reporting of results from Reaside in 2019/2020 there is a need to ensure a robust strategy for testing and reporting results in the new meeting structure so that there is assurance for the organisation. The Trust is sourcing an external Water Safety expert (Authorised Engineer, Water Hygiene Centre) to seek assurance that processes that are in place are sufficient, although this has been slightly delayed during the COVID-19 response. COVID-19 has also limited the access to buildings to allow risk assessments to be updated and audits to be completed.

Resource/resilience of the Infection Prevention and control team

Although the IPC team has expanded in 2020/2021, the small team has successfully managed a huge workload, but this is unsustainable on a long term basis. Further expansion is required to allow the team to re-focus away from reactive work and get back on track with the annual programme of work (i.e. teaching, reviewing of policies, risk assessments and audit) during the COVID-19 restoration phase. This would also build resilience within the team and allow for development of more preventative focussed opportunities i.e. antimicrobial stewardship.

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Education/Training

This was scaled back but the link worker days were held remotely and a lot of ad-hoc teaching around COVID-19 took place. Mask fit training was appropriately prioritised and progressed well throughout the year.

Occupational Health

The Occupational Health Service (OH) is provided through an external provider and regular reports around vaccination data and incidence of inoculation injuries continue to be provided on a quarterly basis to the IPPC. Staff COVID-19 vaccination rates are variable and it will be important to prioritise staff engagement in order to increase rates in preparation for a possible third wave of COVID-19.

Antimicrobial Stewardship

Pharmacy antibiotic audit demonstrated compliance with BSMHT antimicrobial guidance is just below the commissioner's target. An expansion of the IPC team would provide an opportunity to work more proactively alongside trust clinicians and pharmacists to improve antimicrobial stewardship. Antimicrobial resistance poses a significant threat to our patients and healthcare services, implementing strategies to address this risk should be a priority for all healthcare providers.

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Food Safety Audit Report – Trust Food Production and Ward Kitchens (20/21)

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 the 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 audits to be announced and schedule emailed to Infection Prevention teams by August 2020. Food safety ward kitchen audits start date 10/09/2020, end date 15/10/2020. This included Production kitchen audits to verify that a HACCP system is working across Barberry, Reaside, Tamarind and Zinnia.

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 has been updated in May 2020 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.*

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. 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.

Food Production Kitchen Audit scores	**September 2020**
Ardenleigh	90.9%
Barberry	94.1%
B1 Bistro (Trust Headquarters)	N/A -closed during COVID
Reaside	98.9%
Tamarind	98.9%
Zinnia	97.2%
	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, 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. (November 2020)

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. Amey site audits finds HACCP is current, valid and implemented.

Summary: kitchen areas were found in clean, safe and hygienic conditions. However, food storage and HACCP compliance are mandatory, and failures were observed in some sites. 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.

Sites that required verification audits due to audit failure:

Hillis Lodge ADL - food storage - perishable and high-risk foods found in unsatisfactory storage conditions. No opening and closing check documents of kitchen available for inspection.

Ardenleigh – Observations of over ordering of food and observation of out of date items in stock room at ward level.

Dan Mooney House - Missing HACCP documentation that is legally required for foods prepared and stored on weekends, no food temperature records available on inspection for high-risk foods cooked and prepared on site e.g., Sunday roast chicken dinner. Existing paperwork stored in unhygienic conditions, this was actioned immediately and removed from the area.

Zinnia ADL and Storeroom - Out of date perishable food items in fridge with visible spoilage. Spices in stock room dated as best before 2017.

These verification audits will take place once COVID restrictions are lifted. All audits have been sent to sites and Infection Prevention teams with photographic evidence to support the

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 polices 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, that 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 (currently in process of review by auditor and Learning & Development dept.). 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 serve others to complete the CIEH Level 2 Foundation in Food Safety. This training would also include the FSA allergen awareness course, with the introduction of Natasha's Law in October 2021. Toolbox training talks on Listeria awareness and prevention to be introduced Trust wide.

Catering teams across the Trust to undertake CIEH Level 2 Nutrition and special diets course as approved by Trust Dietitian team.

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 2021

Inspections & Audits:

Process controls

Actions on deviation

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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

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Unit name	Sites	Unit type	Audit date	Comments All audits announced under covid regulations
Ardenleigh	Main production kitchen Ward kitchens & meal service and COSHH including Rookery Gardens	Secure services	16th September 2020 1st October 2020	Verification audit Production kitchen (Oct 1st)
Reaside	Main production kitchen Ward kitchens & meal service and COSHH	Secure services	15th September 2020 24th September 2020	Verification audit Production kitchen
Juniper	All wards and ADL`s & Observation of meal service	Primary Care	22nd September 2020	
Tamarind & Newbridge House	Main production kitchen Ward kitchens & meal service and COSHH	Secure services	17th September 2020 10th December 2020 5th October	Verification audit Production kitchen
Barberry	Main production kitchen including observation of meal service	Acute	14th September 2020 23rd September 2020	Verification audit Production kitchen

	Ward kitchens & meal service and COSHH		3rd December 2020	
Zinnia production Kitchen	Main production kitchen Ward kitchen & meal service and COSHH	Acute	10th September 2020 14th December 2020 8th October 2020	Verification audit Production kitchen Required for ADL
B1 Bistro	N/A close covid		13th October 2020	
South Acute	Oleaster wards & COSHH audits	Acute	21st September 2020	
North Acute	North Acute Reservoir Court Ward Reservoir Court ADL Eden Female Acute Eden PICU George Ward Endeavour OT (CAC) Endeavour Court Endeavour House Forward House	Acute	6th October 2020	
North & South Acute	Newbridge House Newbridge House ADL Grove Avenue Grove Avenue OT		5th October 2020 8th October 2020	
Acute	Meadow croft ICU Mary Seacole House OT Mary Seacole House Ward 1 Mary Seacole House Ward 2 Ashcroft (wards closed)		30th September 2020 Ashcroft closed	
Solihull	Dan Mooney House David Bromley House		15th October 2020	Verification audit required

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	David Bromley House OT Hertford House Hertford House ADL Maple Leaf			
Uffculme Centre & Hillis Lodge	Training L & D – N/A covid		14th October 2020	Verification audit required

ESTATES & FACILITIES INFECTION PREVENTION & CONTROL ANNUAL REPORT 2020-21

1. CORONAVIRUS (COVID) PANDEMIC

❖ **Estates & Facilities COVID Programme of Works 2020/2021**
With collaborative support from Matrons, Ward Managers, and Estates Teams, Estates & Facilities devised 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:

- Procurement and Delivery of all Personal Protective Equipment (PPE) to all Trust Sites
- Enhanced Touchpoint Cleaning in accordance with the guidance provided by Infection Prevention & Control Team
- Procurement and Delivery of all COVID Signage
- Upgrading of additional areas which requires additional preventative measures such as screens.
- Providing additional sinks and soap dispensers at entrances to all Trust sites
- Daily 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 Transfer to Summerhill Services Limited (SSL)**
On 01 July 2019 Estates and Facilities BSMHFT were transferred to SSL with all “in-house” domestic services TUPE’d over to SSL leaving North PFI sites, B1 Trust HQ and Middlewood House as the outsourced domestic provisioning across the Trust for 2020/2021 reporting period.

❖ **NHSi – Revised National Standards for Healthcare Cleanliness**
During 2018-19 BSMHFT Facilities Team and BSMHFT PFI Contracts Management Team led on the pilot for the revised NHSi National Standards for Healthcare Cleanliness. The In-patient pilot sites were: Ashcroft, Juniper Centre and Zinnia Centre, with collaborative support from Matrons, Ward Managers, Infection Prevention & Control and Estates Teams. Results and feedback from the pilot was submitted to NHS Improvement early 2019. With COVID 19 these standards were delayed with its actual publication commencing in April 2021. 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 2021/2022 IPPC meeting.

❖ **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.

❖ **BSMHFT Facilities Rapid Response Team**
During 2020-21 BSMHFT Facilities Rapid Response Team continued to undertake a programme of regular scheduled deep cleaning across Trust In-patient and Community units however, some sites were delayed due to addition COVID 19 Cleans.

3. CLEANLINESS

3.1 Cleanliness Audit & Inspection Programme

During 2020-21 the programme of cleanliness inspections and audits was undertaken in full of cleanliness scores and reports 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 phases with audits being conducted at supervisor level only, however if any concerns was raised a member of the monitoring team would attend the site and give assurances.

The programme comprises 3 levels;

- Level 1 Monitoring by Domestic Supervisors
- Level 2 Trust-wide Management Audits
- Level 3 'External' Audits.

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 98% for Quarters 1 to 3 and 97.90% for quarter 4 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%).

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).

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Key Cleaning Performance Data for 2019-20

<table>
<tr><th colspan="2">Quarter 1
1 April – 30 June 2020</th><th colspan="2">Quarter 2
1 July – 30 September 2020</th><th colspan="2">Quarter 3
1 October – 31 December 2020</th><th>Quarter 4
1 January – 31 March 2021</th></tr>
<tr><td colspan="7">Trust Cleanliness Targets & Scores</td></tr>
<tr><td colspan="7">Trust Overall Cleanliness Target = 81%
Trust Commissioners' Target (95% of Trust's Overall Target) = 77%</td></tr>
<tr><td></td><td>Trust Average</td><td>North PFI</td><td>BNHP</td><td>Community</td><td>Forensics</td><td>Corporate</td></tr>
<tr><td>Quarter 1</td><td>98.58%</td><td>98.26%</td><td></td><td></td><td>98.83%</td><td></td></tr>
<tr><td>Quarter 2</td><td>98.58%</td><td>98.24%</td><td>96.22%</td><td>97.62%</td><td>98.15%</td><td>94.58%</td></tr>
<tr><td>Quarter 3</td><td>99.05%</td><td>98.94%</td><td>97.09%</td><td>99.13%</td><td>99.43%</td><td></td></tr>
<tr><td>Quarter 4</td><td>96.96%</td><td>98.70%</td><td>91.87%</td><td>99.67%</td><td>98.21%</td><td>97.48%</td></tr>
</table>

= No Audit undertaken due to Covid Restrictions

3.2 PLACE (Patient Led Assessments of the Care Environment)

- **2020 Cancellation of PLACE**

The 2020 PLACE assessment programme was cancelled due to the Pandemic. With this cancelled SSL conducted assurance visits across all inpatient sites communicating with Key Stakeholders and informing them of any concerns. With this mind the increase of cigarette butts was identified across sites and actioned accordingly

3.3 Cleaning Quality Operational Group

The Cleaning Quality Operational Group (established in September 2015) meets quarterly It comprises members from the Estates and Facilities Department, Infection Prevention and Control Team, Matrons, Service Partner SSL 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. Since the transfer of Estates and Facilities to SSL this group has not met as awaiting new Terms of Reference (TOR's) through IPPC. In the Q4 2020/2021 IPPC meeting it has been confirmed that IPPC will lead this group.

3.4 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. As previously mentioned, the new National Standards for Cleanliness have just been published (April 2021) so the existing Trust Cleaning Policy will continue to be used. SSL are currently revising the Trusts Cleaning Policy to align with the National Standards and will present the revised Trusts Cleaning Policy at the Q1 2021/2022 IPPC meeting.

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 and cleanliness standards Trust-wide (whether delivered through the Trust's in-house, SSL or PFI 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.

The Policy was scheduled to be reviewed June 2019. This was postponed due to new 2019 National Standards of Cleanliness being issued by NHSI/E (this has now been completed and is due to be ratified in May 2021 The new Standards have been published in April 2021 and the policy will receive further review during 2021)

3.5 Cleanliness Training

BSMHFT Facilities Department established an innovative accredited Training Hub at The Barberry which continues to provide education and training for SSL staff and 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 2019-20, 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 2020-21 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 2021-22 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.

2.6 Computerised Cleanliness Monitoring System

The Estates & Facilities Department operates a computerised cleanliness monitoring system "FM First" (based on the NHS Cleanliness Specification). This same system is used consistently across the Trust by

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the in-house, SSL and PFI Facilities Teams. The system generates cleaning scores and real time reports. It also provides automatic randomised scheduling to facilitate unannounced audits.

3. CATERING MANAGEMENT

3.1Trust Flu Vaccination Campaign

SSL Catering Department supported the Infection Prevention & Control Team with the Trust Flu Vaccination Campaign during 2020-21 where Trust staff were able to reimburse their 'flu vaccination thank you card' for a hot drink in Trust Restaurants.

3.2 Environmental Health Inspections

During 2020-21 the production kitchens at Tamarind were inspected by Birmingham City Council Environmental Health Officers. All production kitchens maintained their '5 H' rating (which is the highest rating awarded).

3.3 SSL Kitchen Inspections and SSL Food Safety and Quality Audits on behalf of BSMHFT

During 2020-21 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.

3.4 Allergy Awareness

With this legislation changing dramatically in this reporting period additional training has be 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.

4. WASTE MANAGEMENT

4.1 Waste Contracts

In 2018/19 the Domestic Waste Contractor Weir Waste sold its Business to Biffa Waste Services. This has seen services transfer from Weir Waste to Biffa Waste Services with no loss of operational service at Trust sites. The service has been market tested during 2019/2020 with the successful tenderer commencing the domestic waste service 01 April 2020. The Clinical tender was more complicated but has now reached a successful conclusion with the incumbent provider extending their service to the 30 June 2020 with the successful tenderer commencing service 01 July 2020.

The Domestic and Clinical Waste Contracts were established for a period of 3 years with the option to extend on a +1 year and +1 year basis. The Trust working with its PFI Partners Healthcare Support (Erdington) Limited and Amey Community Limited on Joint Market Testing had agreed to extend the current contracts until 31st March 2020. The Joint Market Testing work has already commenced to build on the success of the 2015 Joint Market Testing. The objective is to achieve scale economies and consistency across the Trust with a single specification. The new contract/s with the successful tenderer/s would commence 1st April 2020 with the exception of Clinical Waste which will commence 01 July 2020.

The current contracts for Domestic and Clinical Waste have continued to deliver an effective and compliant service whilst at the same time reducing costs. 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. Contract Review Meetings have been held regularly with a focus at each meeting of dealing with any isolated problems and seeking further service efficiencies. This will continue with the new contract.

4.2 Duty of Care Audits

Duty of Care Audits by external experts of the Trust's various waste contractors have concluded to ensure that the Trust's waste is managed effectively and compliantly from point of consignment to final disposal. In addition the Trust 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.

4.3 Waste Management Policy

The Trust's Waste Management Policy is in place and was ratified in 2018 by the Trust's Clinical Governance Committee. The 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 whom are custodians of healthcare within their sphere of influence to ensure that their staff manage waste safely and compliantly.

4.4 Waste Management Training

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. This offer has been well received where the offer has been taken up. However many sites have not at this time accepted the offer. This in itself is not a problem as it suggests to the Infection prevention Partnership Committee that these sites / clinical management are content that they already have a process and control measures in place to ensure that clinical / healthcare waste is managed compliantly.

In addition sharps management training has been 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 2021/22 under the terms of Infection Champions.

5. LAUNDRY & LINEN MANAGEMENT

5.1 Laundry & Linen Policy

The Trust Laundry & Linen Policy was due for review during 2017-18 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.

5.2 Laundry & Linen Contract

Following the successful joint market testing during 2019/20 by BSMHFT/SSL with its PFI Partners Healthcare Support (Erdington) Limited and Amey Community Limited for a Trust-wide supplier from 1 April 2020, the current supplier (Central Laundry) has continued to provide a good level of service throughout 2020-21. Regular contract meetings are conducted by the Trust and PFI Partners with the supplier. The Trust and PFI Provider undertake joint 6 monthly Duty of Care Visits to the supplier's laundry premises.

5.3 Duty of Care Audits

Two Duty of Care Audits were undertaken of the Trust-wide Laundry and Linen supplier (Central Laundry in Burton upon Trent) during 2020. (These audits Carried out remotely due to COVID) 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.

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6. SCHEMES AND PROJECTS

Capital/Revenue Schemes/Projects 2020-21 The following schemes (pertinent to Infection Prevention & Control) were completed during 2018-19;				
Location	**Description of Scheme**		**Location**	**Description of Scheme**
Major Projects			**Minor Projects cont'd**	
Highcroft Site Development	Reduce stand-alone wards and enhance Highcroft Site		Reaside	Additional sanitary ware
Hillis Lodge Replacement	Hillis Lodge Male Low Secure Unit Reprovision		Reaside	Facilities Equipment Replacement
Oleaster Scheme	Creation of Place of Safety and Psychiatric Decisions Unit		Reservoir Court	Anti-ligature Wash Hand Basins
Reaside Re-provision			Reservoir Court	New furniture
Solihull Hub	Creation of Solihull Community Hub		Trust Wide	Provision of Air Conditioning in Clinic Rooms
Minor Projects			Zinnia	Uplift to Catering /Facilities corridors
Ardenleigh	Seclusion Suite for a 5-bedded CAMHS Low Secure Service on Adriatic Ward		Zinnia	Facilities Equipment Replacement
Ardenleigh	Development of the existing decommissioned Swimming Pool and Changing Area – Conversion into Physical Health Suite		**Statutory Standards & Backlog Maintenance**	
Ardenleigh	Convert two existing bedrooms into Intensive Nursing Rooms (1 no. bedroom on Coral and 1 no. bedroom on Citrine)		Ardenleigh	Upgrade of flooring
Ashcroft	New furniture		Ardenleigh	Various Patient Safety Works
Barberry	Works to Chamomile Bedrooms		Ardenleigh	Various Health and Safety Improvement Works
Barberry	Uplift to Catering /Facilities corridors		Dan Mooney House	Various Health and Safety Improvement Works
Barberry	Facilities Equipment Replacement		David Bromley House	Various Health and Safety Improvement Works
B1	Upgrade of flooring		Eden Acute	Upgrade of WCs to Patient Bedrooms
Eden Acute	Extension to Ward to create a multi-functional room and ADL Kitchen for Service Users		Hillis Lodge	Replace heating and hot water pumps
Eden Acute	Upgrade of flooring		John Black Centre	Replace heating boilers and pumps
Eden	Upgrade of Domestic Hot Water Boiler		Little Bromwich Centre	Upgrade WCs x 2
Freshfields	Various Patient Safety Works		Lyndon Centre	Upgrade of flooring
Juniper	Upgrade of Sage Ward		Lyndon Centre	Legionella works – removal of dead legs
Little Bromwich Centre	Create Staff Area and Reception Upgrade		Newbridge House	Replacement of Water Heater
Mary Seacole House	Alterations to Wards 1 & 2 layout		Reaside	Upgrade of flooring
Middlewood House	Various Health and Safety Improvement Works		Reaside	Various Patient Safety Works
Oleaster	Creation of Seclusion Suite/De-Escalation/Assessment Area		Reaside	Various Health and Safety Improvement Works
Oleaster	First Floor Office Alterations to accommodate change in practice for CMHT		Reaside	Upgrade ADL Kitchen in Avon Ward
Oleaster	Facilities Equipment Replacement		Tamarind	Flooring and Redecorations to comply with Infection Control
Orsborne House	Upgrade of WCs		Uffculme Centre	Upgrade of flooring
Orsborne House	Upgrade of flooring		Uffculme Centre	Provision of Air Conditioning
Reaside	Seclusion Suite			

7. WATER MANAGEMENT

WATER SAFETY GROUP (WSG)

ESTATES ANNUAL WATER MANAGEMENT REPORT 2020/21

Introduction

- The trust's WSG was originally established in November 2008. The group was predominantly Estates driven – chaired by the Head of Estates and Facilities this has now changed and is being chaired by Deputy Director of Nursing. The WSG consists of Estates managers representing all areas of the trust, infection control, microbiology and clinical representation.
- The purpose of the group is to review HSE/DH/trust guidance and policy and advise/implement procedures across the trust, to maintain statutory compliance, with regard to the operation and management of water systems in all trust occupied premises.
- Since the group's inception in 2008, the following revised documents have been published, which give further guidance on the roles, responsibility and operational expectations, of an NHS WSG:
  - Health and Safety Executive "Legionnaires disease – The control of legionella bacteria in water systems" L8 – 2013
  - Department of Health – health technical memorandum 04-01: Safe water in healthcare premises (2016)
    - Part A - design, installation and commissioning
    - Part B – operational management
    - Part C – pseudomonas aeruginosa – advise for augmented care units
  - Department of Health – health technical memorandum 07-04: Water maintenance and water efficiency – best practice advice for the healthcare sector (2013)
  - Public Health England – responding to the detection of legionella in healthcare premises (2015)
  - British Standards Institution – BS 8580:2010 – water quality – risk assessments for legionella control – code of practice (2010)
  - BSMHFT "Legionellosis management and control" IC01Q – August 2013 – revised January 2016, second review ratified August 2018
  - Health and Safety Executive "Legionnaires disease – technical guidance" HSG274 – 2014
- The current WSG has reviewed the guidance detailed in the above, and propose terms of reference for the WSG be revised to reflect the guidance, as below.

Purpose of the WSG/Water Safety Group (WSG)

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP. The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with water borne 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.

Remit of the WSG

The following is a typical list of tasks assigned to the WSG:

- To work with and support the infection prevention and control (IPC) team.
- To ensure effective ownership of water quality management for all uses.
- To determine the particular vulnerabilities of the at-risk population.

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- To review the risk assessments.
- To ensure the WSP is kept under review including risk assessments and other associated documentation.
- To ensure all tasks indicated by the risk assessments have been allocated and accepted.
- To ensure new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required water standards.
- To ensure maintenance and monitoring procedures are in place.
- To review clinical and environmental monitoring data.
- 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.
- To determine best use of available resources.
- To be responsible for training and communication on water related issues.
- 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).
- To oversee adequate supervision, training and competency of all staff.
- To ensure surveillance of both clinical and environmental monitoring.

Membership

Membership will include:

- Deputy Director of Nursing BSMHFT –Joint Chair
- Director of Operations SSL –Joint Chair
- Senior Estates Manager – North
- Senior Estates Manager - BNHP
- Senior Estates Manager – South/Solihull
- General Manager – Summer Hill Services Limited (SSL)
- Infection Control Manager
- Senior Facilities Managers x 2
- Consultant Microbiologist
- Health and Safety Manager
- Authorising Engineer
- Matron Representative

Meetings

- Regular meeting will be held quarterly at Hillis Lodge. Agenda items will include the following:
- These were suspended due to COVID Restrictions, but regular liaison took place to insure water safety.
  - Compliance with legionella control policy
  - Operational report from each of the main areas of the Trust/SSL
  - Capital projects
  - Training
  - Report from Authorising Engineer
  - Any other business.

- Ad hoc meetings will be arranged as necessary to discuss and agree action as specific issues arise.

Quorum

Attendance to be no less than 40% of membership

Standing agenda items

- Reports on maintenance and activity regarding water systems, across all areas of the trust
- Audit reports regarding compliance with the trust's legionellosis management and control policy
- HSE/DH legislation and guidance

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- Capital projects
- Training
- Items for the risk register/actions from risk assessments.

Legionella control policy

- The trust's control of legionella policy has been revised and ratified in August 2018. Next review is due in August 2021.
- The policy was amended in August 2018 to reflect guidance provided in HTM 04:01 The Control of Legionella, Hygiene, "Safe" Hot Water, Cold Water and Drinking Water Systems – Part B; *"Domestic staff to undertake regular running of all outlets (showers, baths, toilets, basins, sinks etc.) in areas serviced by domestics as part of routine cleaning procedures. Little used outlets to be identified and flushed as detailed in the flushing log book (updated August 2018), by staff responsible for those individual areas.*
- Auditing of log books is to be:
  - ➢ Included on monthly control of infection checklist
  - ➢ Checked during annual environmental risk assessments.
- Flushing of outlets in areas taken out of commission i.e. closed units/wards – responsibility is with Estates/Capital team responsibility for particular area concerned:
  - ➢ Flushing records to be included within scheme health and safety file and audited by capital manager/officer responsible for scheme
  - ➢ Flushing records to be held by estates manager responsible for the area taken out of commission
  - ➢ Flushing records are to be audited by the estates manager responsible for the particular area, and details to be included in quarterly report to the Water Safety Group
- Running of outlets – works to be undertaken by Trust/Amey domestic staff:
  - ➢ To be included on domestics daily cleaning record sheets, to be audited by domestic supervisors
- Control of legionella maintenance works – works are the responsibility of the estates manager responsible for the particular area, and are undertaken through PFI contract or specialist sub-contractor accordingly:
  - ➢ To be included in report from specialist sub-contractor/PFI partner, to be discussed at monthly contract performance monitoring meeting
  - ➢ Estates manager to include summary details of contract performance monitoring meeting in quarterly report to Water Safety Group
- Reporting mechanism – the Water Safety Group is responsible for collating information from the auditing process, and producing quarterly reports to be presented to the trust's IPPC meeting.

Control of Legionella Procedures

- Control of legionella procedures relates to the operation management and maintenance of water systems across the trust, by the various trust representatives/trust partners, dependant on contractual requirements:
  - Former South/Solihull including Forensic Sites - Directly managed Estates team SSL
  - Former North - Managed by Amey
  - NHP - Managed by Engie (formerly Cofely)

Water Safety Plan

- The WSP has been developed in order to comply with the requirements of HTM 04-01: Safe Water in Healthcare Premises – July 2016, revised and ratified December 2018.
- 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 will include management and governance arrangements, together with details of training, professional support, maintenance regimes and supporting documentation.

Authorising Engineer (AE)

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- In April 2019, BSMHFT appointed the Water Hygiene Centre (WHC) on a 3 year contract as the trust's professional advisors on compliance with statutory legislation on the control of legionella, as advised by HTM 04-01.
  The role of the AE is to provide:
  - Advice to the appointed duty holders, responsible persons and their deputies on regulatory compliance, management procedures, procurement etc.
  - Assessment of the competence of employees and contractors involved in legionella control activities
  - Monitor the performance of employees and contractors with regards to their tasks in legionella management
  - Conduct regular compliance audits of single or multi-site facilities
- The AE will also become involved in developing staff training plans, reviewing commissioning works, construction design appraisals, mothballing of used premises and the development of specialist water safety policies and procedures etc.
- The AE will also provide the following services:
  - Attend quarterly water safety meetings at the trust HQ
  - Carry out annual audit on the Trust's control of legionella policy to ensure operational and management systems are in compliance with ACoP L8 and HTM 04-01; produce an audit report indicating areas of non-compliance; recommend actions and suggested improvements or amendments to policy and procedure documentation
  - Provide four half-day training sessions which include an update on the key principles 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)
  - Provide additional one day refresher's training for the trust's infection control team
  - 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
  - Annual review of water safety plan.

Training

- Throughout 2020/21, specific control of legionella training has been delivered to the following staff groups:
  - Estates managers/tradesmen/supervisors
  - Facilities managers/domestics/housekeepers
  - Infection control team
- Control of Legionella training is also included in the trust's induction package.
- Action has been undertaken following liaison with senior clinical staff, consultant microbiologist, AE et al to resolve issues experienced.

Risk Register

Due to issues experienced, in particular in buildings outside of BSMHFT Estates direct control, the Estates and Facilities risk rating regarding the control of legionella has increased from moderate 9 to moderate 12.

Priorities for 2020/21

Priority work streams for 2019/20 include the following:

- Operational
  - Set up new five yearly maintenance contract to commence 1st April 2019
  - Auditing control of legionella policy requirements – cleaning records/infection control records
  - Reporting process – to IPPC and CGC
  - Reviewing capital schemes – statutory standards/minor/major projects – to ensure water safety issues are duly considered
  - Formal reports from various "Estates" managed areas of the Trust, from Estates Managers to the WSG, to demonstrate compliance, raise concerns, show good practice etc.

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- Capital/Projects 2019/20 continued into 2021 due to COVID

  - **Callum Lodge** – legionella risk assessment remedial works
  - **David Bromley** - additional bedrooms and sanitary areas
  - **Eden Acute** - additional bedrooms and sanitary areas
  - **Eden PICU** - additional bedrooms and sanitary areas
  - **George Ward** - additional bedrooms and sanitary areas
  - **Grove Avenue** - additional bedrooms and sanitary areas
  - **Hertford House** - additional bedrooms and sanitary areas
  - **Hillis Lodge** – additional bedrooms and sanitary areas
  - **Little Bromwich** - additional bedrooms and sanitary areas
  - **Newbridge House** - additional bedrooms and sanitary areas
  - **Northcroft** - additional bedrooms and sanitary areas
  - **Small Heath** - additional bedrooms and sanitary areas.

DRAFT

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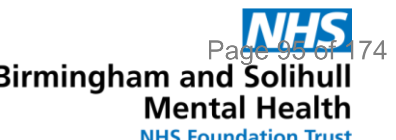

Meeting	BOARD OF DIRECTORS
Agenda item	9
Paper title	MENTAL HEALTH LEGISLATION COMMITTEE
Date	27th October 2021
Author	Phil Gayle, Chair
Executive sponsor	Hilary Grant, Executive Medical Director

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

Executive summary

The report provides assurance to the Board of Directors on the discussions held at the Mental Health Legislation Committee held on the 21st October 2021.

Reason for consideration

For assurance

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Quality

Financial implications

Not applicable for this report

Risks

Not applicable for this report

Equality impact

Our values

Committed
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Inclusive

REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Mental Health Legislation Committee met on the 21st October 2021 with a summary of the key discussions being detailed below:

1.1 Adherence to Mental Health Act Consent to Treatment (CTT) Certificates within BSMHFT Inpatient Units 2021

The Committee was presented with a very detailed report from Habiba Jabbar, Lead Pharmacist, which detailed the outcome of an audit which reviewed Mental Health Act Consent To Treatment paperwork for a total of 340 service users. In total, 374 CTT certificates were scrutinised for compliances of current prescriptions for mental health disorders.

A total of 50 inpatient wards were included from both secure and non-secure care. Total percentage compliance to MHA CTT paperwork for the sample size is calculated at 91%. This is marginally higher, thus an improvement in standards achieved in 2020 (90%) though 1% lower than the highest overall standard met, 92%, in 2018.

The results reflect a small overall improvement in standards from those achieved in prior years and the continuation of consistency in improvement seen over the last few years.

The presentation and dissemination of audit findings have been submitted to the MHL Committee, Pharmacological Therapies Committee, Clinical Governance Committees, Clinical Forums, approved clinicians, ward managers, and pharmacists.

The audit had a number of key recommendations which included completion of complete Eclipse reports; pharmacists to prioritise checking prescribing adhered to mental health act CTT paperwork on ward visits; ward managers to ensure hard copies of the current MHA CTT certificate was available to access on the ward and ongoing training on Mental Health Act CTT to be provided for medical and nursing staff.

Chair's assurance comments:
The annual CTT audit was presented and received noting an overall 1% improvement in compliance. There was a noted decline in compliance in south acute services and Specialties. Although there was a noted improvement in percentage compliance rate (80%) since 2020 (73%), they continue for the second year to be the service area with the greatest number of prescriptions breaching MHA CTT requirements and highest number of recorded unlawful administrations. The chair of the MHLC raised concerns that this was deeply concerning. The committee received some assurance that in most cases the prescribing was beneficial for the service user, but recognised procedures were not followed in accordance with legal compliance. Assurance was given that this would be raised with clinicians regarding ensuring we are adhering to legal compliance.

There was recognition of the difficulties faced both locally and at a senior level of recruiting and retaining both substantive RCs (prescribing) and nurses (administration) and the impact this is having on the lawfulness of CTT practices. Several recommendations came out of the audit some of which are already under way in terms of targeted training. The committee were partially assured and going forward Quality and Safety Committee will receive more assurance of the implementation of the full recommendations.

1.2 Mental Health Legislation Committee Integrated Report
The reporting period of July - September 2021 highlighted, the key areas reported included:

There were 76 MHA related incidents report Q2 compared to 42 in Q1, an increase of 34 (32%). The most reported category of incident was Medication and Consent 34 (compared to 8 Q1). There was also a marked increase in the second highest reported category of AMHP Related Issues, 26 (compared to 16 Q1). The Birmingham Local Authority continue to work with the Trust on reviewing all eclipse reports relating to them and acknowledge their lack of staff at present for the reason for the increase in incident reports.

There was a further reduction in Illegal Detentions from 11 to 6 in the quarter, following on from a marked reduction last quarter. These were all due to paperwork issues.
For noting, 0 of these were from Oleaster. Staffing issues at Oleaster and had been previously reported and it was had hoped the new personnel would result in a reduction in unlawful detentions. This has been demonstrated in the current quarter.

There had been 3 CQC MHA visits, all unannounced in and person to David Bromley and Dan Mooney house, Cilantro and all wards at Oleaster. All feedback has now been received and action statements submitted. There was a noted reduction in the number of issues raised on all these visits compared to previous visits. They key points raised for action were around blanket restrictions, care planning and lack of patient involvement and patient views on feeling valued / listened to / bullied. A breakdown of issues by visit is in the main body of the report.

There had been 2 deaths of a patient under MHA.

3 Complaints received related to: 1 Attitude Of Nursing Staff; 1 Admission Arrangements; and 1 Communication With Relative

***Chair's assurance comments**:*
Overall, there was an increase of 32% in MHA incidents reported for quarter 2 with the most reported category of incident being Medication and Consent 34 (compared to 8 Q1). The committee were informed that it was worth noting that the data collection period for the annual trust wide consent to treatment audit fell in this reporting period affecting the data. The nest biggest reporting category is availability of AMHPs. The committee heard of the LA service wide plans to address this, and the work being done with the Trust to support this. The chair asked if we could support in anyway given the LA AMPs appear stretched having the affect of potentially impacting on response to patients at A&E. The committee received assurance that we are supporting the LA AMPs in relation to this matter.

There were 3 CQC MHA visits this quarter with all action statements submitted on time. The committed were pleased about the reduction in the number of issues raised on all these visits compared to previous visits. They were keen to hear about the specific details related to feeling valued / listened to / bullied as CQC provided no specific details regarding this and the committee were informed that we have requested more information to allow the Trust to address the concern raised.

1.3 Mental Health Legislation Compliance
This report had previously been a standing agenda item on the Committee agenda but was temporarily stood down during the peak of the Covid pandemic and reintroduced at the start of the year. All areas had submitted data apart from Ardenleigh Women's service this quarter. The 2 key issues that have arisen in inpatient wards were:

- MCA assessments on admission and the RC not providing the patient with SOAD feedback. This has been addressed by the Chief MHL Officer with all medics, reminding of their CoP responsibilities.
- There were occasional s132 misses which were reported to be rectified and occasions where there were no photos for patients with s17 leave due to them refusing (mentally unwell)

Community Treatment Order reports demonstrated occasional issues with s132 rights addressed at the time of the monitoring being completed with improvement over the quarter.

Clinical Directors need to have ownership and accountability of the compliance in their areas, and the actions need to be formally monitored through local CGCs. The monthly reports should be reported into Clinical Governance Sub Committee for assurance.

Chair's assurance comments:
There were 2 areas noted as a deficit across the trust, MCA assessments on admission and the RC not providing the patient with SOAD feedback. The committee were assured that this has now been addressed with all medics, reminded of their code of practice responsibilities.

1.4 Mental Health Act Detention Data 2018 - 2021

The report to the Committee detailed that the Mental health act detention data during the Pandemic which reported that the pandemic had disproportionality impacted black and Asian population of all ages and elderly white population. During the pandemic there has been a marked increase in detentions under Section 3 of the Mental Health Act (for treatment) in the Black and Asian population with a marked reduction in the white population. This difference was stark in the working age population. This trend has reversed in the last 3 months. This highlighted:

- The need for a well-functioning community-based health and social care offer to reduce detentions in the black and Asian population.

- Return of admissions under the mental health act of white elderly post vaccination (which are vast majority white) shows a reversal of the trend of this group not accessing inpatient treatment fully during the pandemic.

- CTO detentions in the Black and Asian population continue to increase through the pandemic disproportionately

- There was no material change during the pandemic, in short term detentions (section 2, 5(2)) or other inpatient detentions under the Mental Health Act

There were no significant trend changes noted based on gender or sexuality or age during the pandemic in BSMHFT

Chair's assurance comments
Mental Health Act detention data during the Pandemic shows that the pandemic has disproportionality impacted the black and Asian population of all ages and the elderly white population. The committee were concerned about the marked increase in detentions under Section 3 of the MHA (for treatment) in the Black and Asian population with a marked reduction in the white population. The chair raised deep concerns that BME service users were disproportionately affected by the detentions although this trend has reversed during the last 3 months.

The Committee wanted greater understanding of the reasons behind this concerning data. We were not fully assured of this and this issue will be picked up in the sub committee to the Quality and Safety Committee.

1.5 S131 Informal Patient Policy

The section 131 Informal Admission Policy has been reviewed a year early due to some practice changes and a review of an serious incident. The key change to the policy was the removal of the operational detail of facilitation of leave for informal patients. It was identified that this would be more appropriate to be included in the C56 Section 17 Leave of Absence Policy so that all leave related policy requirements could be found together.

Chair's assurance comments:
The committee were pleased the policy has been reviewed and the necessary amendments made.

1.6 Legal Report

The Legal Report to the Committee reported that on 11 November 2021, the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 (the Regulations) come into force and require care home workers and visiting professionals to be fully vaccinated against COVID-19. This was subject to exemptions including if the individual is (a) exempt from vaccination; (b) providing emergency assistance and/or attending to carry out duties as a member of the emergency services; or (c) providing urgent maintenance assistance. The Department of Health and Social Care (DHSC) has provided:

- Operational Guidance aimed at helping care homes prepare for this change; and an
- Impact Statement which estimates that 3-12% (17,000 – 70,000) of care home workers will remain unvaccinated by 11 November 2021.

The Regulations apply to CQC registered adult care homes, so it follows that the CQC is responsible for monitoring compliance with the Regulations. To do this, the CQC will be seeking assurance from registered providers that they have robust processes in place to:

- monitor vaccination and COVID-19 status of staff;
- ensure staff maintain an up-to-date vaccination status and ensure staff maintain up to date best infection, prevention and control (IPC) practice
- monitor vaccination and COVID-19 status of personnel entering the care home, and
- where applicable, make reasonable adjustments to ensure people using the service receive safe care and treatment.

The DHSC is seeking views on whether or not to extend these vaccination requirements to other health and care settings, for both COVID-19 and flu. The consultation closes on 22 October 2021.

***Chair's assurance comments**:*
Report was noted by the committee and no issues of concern were raised.

1.7 Lay Manager Report

There had been no Lay Manager meeting to report from since the last MHLC.

During Q2 there were 1295 people held under detention at some point during the quarter, including CTOs (268) and Conditional Discharges (171); 927 on day 1 and 943 on the last day, meaning an average of 935 people detained at some point. Of those detentions, there were 360 hearings:

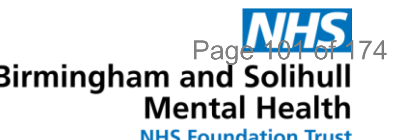
- 137 had renewal hearings and
- 6 had appeal hearings.
- There were a total of 4 discharged from detention (6%) by Lay Managers
- Tribunal appeal comparison - 217 hearings and 5 discharges (11%)

Chair's assurance comments:
The committee thanked the lay managers for the report and no concerns were raised

1.8 Future Governance Arrangements
The Committee discussed the dissolution of the Mental Health Legislation Committee with the incorporation of the duties of the MHL Committee into the Quality & Safety Committee and the establishment of a Sub-Committee that would discharge the operational implications of compliance. The Committee was presented with a draft Terms of Reference which would be presented for approval at the next Quality & Safety Committee. In addition, discussions would be held with the Head of Mental Health Legislation and the Medical Director regarding the formal reporting requirements into the Committee.

Chair's assurance comments:
The Committee were happy to approve most of the ToR and made 2 suggestions:
A monthly operational meeting and a formal subcommittee quarterly that reports quarterly to IQC; or the subcommittee to meet every 2 months with the same frequency of reporting to IQC. The Committee requested our executive MD and AD to confirm the arrangements.

PHIL GAYLE
CHAIR
MENTAL HEALTH LEGISLATION COMMITTEE



Meeting	BOARD OF DIRECTORS
Agenda item	9
Paper title	PEOPLE COMMITTEE
Date	21st OCTOBER 2021
Author	Phil Gayle, Non-Executive Director
Executive sponsor	Patrick Nyarumbu, Director of Strategy, People & Partnerships

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

Executive summary

The report provides assurance to the Board of Directors on the discussions held at the People Committee held on the 20th October 2021.

Reason for consideration

For assurance

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.

People

Financial implications

Not applicable for this report

Risks

Risks associated with safer staffing

Equality impact

N/A

Our values

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REPORT FROM THE PEOPLE COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The People Committee met on the 20th October 2021 with a summary of the key discussions being detailed below:

1.1 Report from the Shaping Our Future Workforce Sub Committee

The Committee received an update from the Shaping the Future Workforce Sub Committee where it was reported that job descriptions and person specifications were being reviewed to incorporate the values of the Trust. In addition, developing a values-based recruitment page for the intranet.

The Trust retirement process was being reviewed to create flexible opportunities for staff to consider returning and managers were being supported to have conversations with groups of staff who were 2-5 years of approaching retirement age.

Information was received regarding reviewing ethnic minority staff working in bands 8a and above, which was being led by the Head of EDI by undertaking a desk top analysis into the workstream with a report being received in January 2022. The Committee was informed of the work which was underway regarding the impact of current pension thresholds and the impact this may have on staff approaching retirement age and considering their future as part of the workforce.

Chair's assurance comments:
The Committee were informed that the Future Workforce Sub-Committee met in October 2021 and incorporated a revised standard agenda for their meetings. Updates on progress made against specific People Strategic Priorities including the implementation plan deliverables were received. Work streams leads provided their reports to the work force sub-committee. We were assured significant milestones have been achieved specifically related to the job description/person specification that have been incorporated into Trust values which have been completed. We were assured that the recruitment pack containing this information will be finalised by the end of October to fully build our Trust values into our on boarding process.

The committee received an update on fully implementing the Trust Workforce Transformation Retention Plan which includes clinical retention. The committee received assurance that the first draft of the plan will be developed by the end of October 2021.

Additionally, the committee were assured on the progress undertaken to review our Trust retirement processes that incorporates creating flexibility enabling staff to retire and return. The Strategy Analytical Resourcing and Transformation Team is currently reviewing staff who could potentially retire over the next 2-5 years and supporting to managers to have conversations with these individuals to raise awareness of options available to them when considering retirement.

We received an update on how the Trust disseminated information and letters regarding the increase in the annual allowance pension tax threshold. The chair of the People Committee raised concerns on clinicians potentially declining to take on additional shifts beyond their contracted hours due to the pension tax allowance that could affect their pension causing pressure and could this be a risk to some services. The committee received assurance that staff had been given all the necessary government guidance documentation in relation to this matter and there was no evidence that this has had an

impact on the Trust.
The committee received an update in relation to developing an EDI approach implementing a clear targeted action plan, detailing the approach to be taken with regards to representation of ethnic minority staff in Band 8a and above roles. We received partial assurance that research and desk top analysis had begun considering policy and actions related to this work. The head of EDI is confident the committee will receive a detailed report on activity in January 2022.

KPI – this data was not collated in time due to the timings of internal systems not able to get the data in time for this meeting. We will receive data in our November meeting which will cover the period of July – September 2021 which is disappointing for the People Committee not having real time data to review at the time of the meeting although understandable.

1.2 Employment Opportunities for local communities

The Committee was informed that there were a range of entry level vacancies within the Trust and as part of the recruitment strategy work was underway with multi-disciplinary teams across the organisation, to develop a range of job fairs targeting local communities. There would be an expressions of interest form to easily complete at the Fairs with staff available to support members of the public and this included volunteers from the people and OD department. The plan was to support people to apply on site or obtain contact information to provide support via appointment**.** In addition, interview support for candidates would be available.

It was confirmed that the venues for the Job Fairs would be within the areas where there were the largest number of vacancies and assurance provided that the Community Engagement Team were working with the HR team to identify the most appropriate communities to target. An update would be provided at the end of the programme on the outcomes of the work.

The Committee was informed that there were 110 apprenticeships across the Trust with the organisation keen to create more opportunities. The Trust was also working with the Princes Trust as working in partnership increased the chances and opportunities.

Chair's assurance comments:
The committee congratulated the team for the work carried out to date on this important agenda. We were assured of the progress made and the approach taken in working to becoming an anchor institution.

1.3 Transforming Our Culture and Staff Experience

J. Kaur was welcomed to the Committee to present the report from Transforming Our Culture and Staff Experience Sub Committee.

There was an update from compassionate workstream involving the needs of staff in any role with lived experiences to be incorporated and surveyed regarding how they have been supported in their work. The next conversations would entail how to ensure full integration and themes were embedded.

There was an update on the People Strategic Implementation Plan and the next step is to provide a progress report with the November meeting being data heavy to review the relevant KPIs.

The next steps for the Sub Committee would be to feed back on the refreshed Terms of Reference and a key point for consideration was to ensure that more colleagues voices

were captured throughout the conversations being held which would include administrative and non-professional registered members of staff.

Chair's assurance comments:
The committee is looking forward to receiving feedback form the sub-committee groups additional piece of work evaluating the quarterly dataset return with EDI and FTSU lens which will come back to the committee in November 2021. We received assurance that the subgroup will have a focus on confirming the KPI's to ensure that these are capturing impacts on culture and staff experience.

1.4 Ongoing Organisational Change Processes

The Committee received a report providing assurance on the active organisational change processes which have been undertaken.

There were currently 10 organisational change processes within the Trust which were all at different stages and would all be concluded within 3-4 months. The Committee was informed that it was not uncommon for an organisation of this size having change processes running concurrently. The strategy had been reviewed and it was reported that there were no identifiable risks identified.

Chair's assurance comments:
The committee were assured that the ongoing organizational change processes are being managed in line with corporate Trust policy. The Committee requested a review at the end of all organisational change processes to ensure learning was addressed regarding the impact on individuals.

1.4 Safer Staffing

The Committee had a lengthy and significant discussion regarding the safer staffing report, presented by the Chief Nursing Officer/Director of Quality & Safety. The report provided an overview of the workforce from April 2021 to August 2021 and had been reviewed and redeveloped to ensure that it provided a transparent view of the Trust's workforce. The report highlighted issues and areas of concern as well as an assurance on steps that are being taken to drive improvement.

Trust wide bank and agency fill rates are shown in the graph below. Across the reporting period Trust wide fill rates were at their lowest in August 21 at 82.9% which is slightly lower than previous Augusts (August 2020 fill rate of 88% and August 2019 fill rate of 88%) but comparable with 2018 fill rate of 84%.

The Committee was informed that there were a number of areas staffed at over 100% and areas below. For 100% this may mean that the establishment may be incorrect or that areas were using HCAs to backfill for registered staff or the level acuity was high.

The next report would include the actions and consequences of the staffing levels and the Committee would see the quality indicators overlayed with filled rates.

One of the requirements of Developing Workforce Safeguards is that an evidence-based tool is used to make decisions on establishment and staffing levels. The Trust has recently obtained a license for the Mental Health Optimal Staffing Tool (MHOST). MHOST calculates clinical staffing requirements in mental health wards based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses and ward based clinical staff in their safe staffing decisions. The Trust pre pandemic piloted the tool with a small number of inpatient units. Training is being scoped out by the CNO Safer Staffing Institute and is tentatively being scheduled to be delivered in October

/ November 2021.
Following the training a first full MHOST cycle is planned to take place January 2022, with biannual MHOST cycles thereafter. Below is a diagram that shows the process.

Staffing incidents have increased and the Chief Nursing Officer was ensuring that staff were clear of their responsibilities to formally report staffing incidents and they did not normalise incidents relating to staffing levels.

There had been 3 e-rostering projects which had been pulled together which would be a huge improvement for Ward Managers and Team Leaders and would free up time for clinical and leadership duties.

Chair's assurance comments:
There were concerns raised by members of the committee with regards staffing levels on some wards. We were assured that there are systems in place and the immediate staffing configurations were going to be reviewed based on professional judgements. A national tool MHOST will be used to undertake systematic reviews of the staffing establishment. This will provide the board with a level assurance and understanding on this matter. Discussions highlighted that there are several initiatives taking place and the Committee found this helpful. Although, the report was very stark highlighting several staffing challenges within the Trust the Committee did receive partial assurance and look forward to receiving future reports on the impact of these initiatives.

1.5 Freedom to Speak Up

Emma Randle, Freedom to Speak Up Guardian, provided a presentation and reported that there had been an significant increase in the number of concerns being raised. The themes being recorded echoed the information reported in the Safer Staffing Report of staff feeling stressed and "burnt out".

The Committee was informed that the Trust was now in the top 10 most improved Trusts in the Country in relation to reporting of concerns. In addition, the Trust had featured within national communications from the National Guardians office as the Trust had reported concerns which had been raised by junior doctors who had spoken up within the last two years. The would be a future Board Development session arranged in early 2022 regarding the role of the Board in Freedom to Speak Up.

Chair's assurance comments:
We were assured of the work carried out to date and the progress made of working towards fully embedding FTSU within the Trust. The committee were assured that the vacant posts currently adverstised will be filled by December 2021.

1.6 Board Assurance Framework: Quarter 2

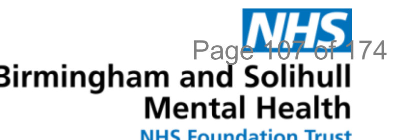
The Committee received the Quarter 2 Board Assurance Framework updates regarding the strategic risks allocated to each of the Board Committees which have been reviewed with the Executive's senior teams and is being presented to the Board in October.

Chair's assurance comments:
The committee were in full agreement that the update scoring for quarter 2 risks should not be altered but remain as listed. There have been some improvements but not enough to move the current quarter 2 risk ratings.

1.5 Any Other Business: ICS Update

An update was provided on the key discussions from the People Board where a report was received on the transition of the CCG staff to the ICS on the 1st April.

PHIL GAYLE
CHAIR
PEOPLE COMMITTEE



Meeting	BOARD OF DIRECTORS
Agenda item	10.a
Paper title	FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE
Date	
Author	Gianjeet Hunjan - Non-Executive Director (Chair for the meeting)
Executive sponsor	Dave Tomlinson- Executive Director of Finance

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

Executive summary

The report provides assurance to the Board of Directors on the discussions held at the Finance, Performance & Productivity Committee held on the 20th October 2021.

Reason for consideration

For assurance

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report

Risks

Financial risk relating to Reach Out provision is significant: management, mitigation and governance is still being worked on.

Equality impact

Our values

Committed
Compassionate
Inclusive

REPORT FROM THE FPP COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Finance, Performance & Productivity Committee met on the 20 October 2021 with a summary of the key discussions being detailed below:

1.1 Month 6 2021/22 Finance Report

The month 6 return had been submitted for H1 with a reported a £20k surplus. The Audit Committee would discuss the year end accounting issues at the October meeting, and these had been included in the month 6 position. In terms of the pay award for medics this equated to £2.3m however, the cash payment was yet to be received and would be included within month 7 figures.

In relation to agency spend, it had been a challenging month in terms of spend, at £542k in month 6 which was the first time above the internal stretch target. This was due to significant vacancies within the medical workforce; however, it was reported that there had been a drop in nursing agency bank pay.

The cash position remained in a healthy position at £37m for the Group.
There was £400m in the collective bank accounts across the health system and at the request of W. Weir, R. Sollars reported that contact had been made with peers across the economy to ascertain if higher interests' rates could be obtained with a piece of work undertaken to review any opportunities. The system had been asked the reason for an improvement in the cash position. In the Trust's case, there were three main drivers (a) £1m behind plan on capital (b) acting as bankers with the People Board and receiving £2m on behalf of system partners and (c) the balance correlates to the underspend on the new investments.

In relation to capital, the Committee was informed that there was strong system support, for the Reaside and Highcroft schemes. The main risk related to the amount of funding available nationally and the planning work required to address back log maintenance if this was not received.

The Trust was £1m behind plan at the end of month 6 and the Capital Review Group was meeting who were confident that the plan would be met with the possibility of bringing forward schemes. Discussions would be held regarding the potential capital for the shared care records.

Chair's assurance comments:

The Committee was assured that H2 implications were being worked through and discussions were being held with relevant colleagues in terms of accounting treatments, and ICS implications. In relation to the gaps in clinical vacancies, the Committee heard about the on-going discussions but were not assured as plans had yet to be shared. In relation to capital, the Committee was reassured that plans would be met. In summary, current finances are in a good position.

The next FPP Committee meeting on 17 November from 12 noon to 2pm will be a detailed finance session for all Board members.

1.2 Integrated Performance Report

The report this month contained more detailed commentary which was welcomed by the

Committee.

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Chair's assurance comments:

The Committee was pleased to receive the detailed commentaries relating to some of the metrics. Ensuing discussions identified further areas to consider within this evolving report in particular in relation to inequalities.

1.3 Digital Strategy Improvements and Assurance

The paper presented to the Committee consisted of three constituent sections: Strategic, Key Updates and Assurance. Section one Strategy consisted of three relevant papers, including the current national update, the regional (ICS) update and the direction of travel and the "What Good Looks like" from a BSMHFT perspective.

The Trust was broadly aligned with the National and Regional direction of travel and was leading on several pieces of work in these arenas. The "what good looks like" in BSMHFT provided a current perspective against the new framework. Section two provided updates from key programme and projects related to BSMHFT; Global Digital Exemplar (update, closure, and award), the new intranet "Connect" site, Electronic Document management, Media services for inpatients, Office 365 and document sharing. Section three offered assurance on all things cyber within the Trust and the ICT performance reports for September

A detailed presentation was provided and summarised all of the national priorities for the NHS. There were nine specific priorities to deliver, under three headings of:

- Build and understand on how data was used
- To make appropriate data sharing the norm and not the exception
- Build the right foundations to make all the priorities possible

The Committee supported in principle a proposal, subject to further engagement with clinicians, to pursue media services for inpatient wards. This would entail providing a service via a managed application, providing free services to inpatients via Trust or personal devices as well as the option for inpatients to use their personal devices with their own streaming services.

The Committee also supported in principle a proposal to move from NHS Net to a BSMHFT own email system with the Committee requesting further assurances regarding the communication and engagement with staff.

Chair's assurance comments:

The Committee heard about the Digital Strategy from a national viewpoint and was assured about the actions being progressed within Trust and the positive impact this is having across the Region. Much work had been undertaken since the last briefing to the Committee. The Committee sought further assurances in relation to two developments, inpatient hospitality services and NHS net, although both were supported in principle.

1.4 Board Assurance Framework: Quarter 2

The Committee received the Quarter 2 Board Assurance Framework update regarding the strategic risks allocated to each of the Board Committees which have been reviewed with the Executive's senior teams and is being presented to the Board in October.

Chair's assurance comments:
The Committee was pleased to receive of the Quarter 2 BAF listing all FPP risks, controls, and assurances. As some aspects needed further assurance, comments were coordinated after the meeting but ahead of the October Board meeting.

1.5 Reach Out Commissioning Sub-Committee Chairs report

The Committee received assurance that the risks and the approach to the risks within Reach-Out were being addressed with clear timings. In relation to workforce there was concern regarding staff feeling stressed with uncertainty regarding how this was being addressed across providers and would be discussed further at future meetings. In addition, the Committee requested clarity that any workforce issues should not impact on the provision of services. The Committee was working a month in arrears in relation to the provision of data which would be "real time" from November 2021.

Chair's assurance comments:

This service went live from 1 October 2021. Given this, no actual outturn figures could be presented but the Committee was assured any issues were being addressed, and risks and the approach to risks were being strengthened.

1.6 Committee Forward Plan

The business cases for Reaside & Highcroft were provisionally added to the agenda planner for December 2021 at the earliest.
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1.7 Next Meeting

There would be a detailed financial session in November, for Board Members which would include:

- Introduction and overview of the finance department
- Balancing the books element of the Trust Strategy
- Finance Training and Culture
- Current and emerging finance related risks
- Income analysis – where do we get if from
- History of Mental Health investment (including MH Investment Standard)
- Expenditure analysis – what do we spend our money/link between operational performance and finances
- BSMHFT as partner within BSOL

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**11**
Paper title	**INTEGRATED PERFORMANCE REPORT**
Date	27/10/2021
Author	Richard Sollars, Deputy Director of Finance Rob Grant, Interim Associate Director of Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information
Executive sponsor	David Tomlinson, Executive Director of Finance

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

Executive summary & Recommendations:

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:

- IQC - Staff and patient assaults
- FPP – Out of area bed use, IAPT, CPA 12-month reviews, new referrals not seen, financial position and CIP
- People - Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness. Also the divergence in performance between different teams

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 from January 2022. 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 ve 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.

Detailed commentaries for all metrics are included therein. Graphics and commentaries for some of the key metrics are attached as appendices to this report.

Performance in September 2021

The key performance issues facing us as a Trust have changed little over the last six 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. There have been good reductions over the last four months, but the figure is effectively static at 600+ occupied bed days (19 patients)
- **Workforce measures in general** – There is a significant adverse variance against most of the set performance standards. While this has deteriorated as a result of COVID, the divergence between individual teams is of concern:
- **Financial position and CIP** – Financial control totals have only just been set for 2021/22 and we are still developing plans. We have thus yet to identify savings, but are currently performing in line with plan

Quality

- A new set of Quality goals have been approved by IQC. They have now been incorporated in the dashboard
- The reported level of physical assaults on service users and staff has substantially fallen this month and remains below the 12-month median though both metrics are higher than Q1
- Levels of prone and physical restraint have increased, though they remain below the median
- Failures to return from leave have been trending upwards for the last seven months, although both this metric and absconsions have remained below the 12-month median
- Incident reporting levels have reduced for the last two months and are now below the 12-month median
- **Key concerns: Staff and patient assaults**

Performance

- The level of Out of Area Patients remains the main concern. The national requirement was for this to be eliminated by April, but this was renegotiated to September. The figure for September is 613 occupied bed days (18.5 patients). 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 fallen twelve months in succession to 28%, the lowest position in entire reporting period (66 months since Apr-16). It reflects large number of staff vacancies (13% - 19.3 WTE). This is being discussed across BSol to identify how to address underperformance
- The % of service users on CPA having a formal review in the last 12 months remains a worry at 89%
- New referrals not seen within 3 months are of concern and have increased in month to 2,423, the highest level since Jan-21
- **Key concerns: Out of Area, IAPT seen in 6 weeks, CPA 12-month review 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
- Sickness levels have risen to 6.2% but remains the second highest since Feb-21. Variation: Psychology 0.6% v FCAMHS 10.8%
- Return to work interviews improved to 74% (highest level since Jan-19), but still well below target of 85%. Variation: FCAMHS 33% on 18 people v AOT 100% on 13
- Shift Fill is at 80.7%, the lowest level since Feb-21, against a standard of 95% - the main issue is Secure (74%), which has the highest number of requested shifts (5,372 out of a total of 14,944)
- Fundamental training at 88.9% is at its lowest level since Mar-21 with temporary staffing a particular issue (55% for IG training, lowest level since this has been separately analysed). Variation: Medical directorate 76% on 168 people v NAIPS 95% on 162.
- Appraisals down to 81.4% and still significantly below pre-COVID levels and target. Variation: Psychology 50% on 30 v AOT 98% on 96
- Rolling 12-month turnover continues to be better than plan
- Monthly agency expenditure at £542,000 is at highest figure since Apr-20
- Vacancies remain high at 9.8% (419.0 WTE). Actual WTE at 3,844.7 WTE has changed little since Feb-21
- **Key concerns: Return to work interviews, shift fill rates, fundamental training, appraisal rates and sickness**

Sustainability

- The financial result to September is back in line with a planned YTD breakeven. This is made up of under spends resulting from delays in recruitment against additional funding for new services and over spends relating to property cost provisions. Savings plans are yet to be set for 2021/22. No savings have been identified as yet
- Cash and property standards remain well above target
- Cap Ex performance against plan remains a little down in month as a result of delays at start of year in agreeing capital programme, but is starting to catch up
- Information Governance position improved overall, but still held back by training of temporary staff
- **Key concerns: CIP under achievement impacting adversely on Operating Surplus, uncertainty regarding national financial ask**

Integrated Performance Dashboard

Top Line Commentary (Trust level)

* Performance: IAPT seen in 6 weeks worsen
* People: Continues to be adversely affected by COVID
* Quality: reported incidents

Division

A: All

A: All

September 2021

Performance

Measure	Value	Trend
CPA 7 day FU	91.8%	↓
CPA with Formal Review last 12 mths	88.7%	↓
Data Quality Maturity Index (DQMI)	98.4%	↑
Delayed Transfer Bed Days	724	
Delayed Transfer, percent of bed days	4.7%	
Eating disorders routine	100.0%	
Eating disorders urgent	100.0%	
First episode psychosis	100.0%	
IAPT into recovery	51.4%	↑
IAPT seen in 18 weeks	89.2%	↓
IAPT seen in 6 weeks	28.1%	↓
Out of Area Bed Days	613	↑
Referrals over 3 mths with no contact	2423	↓

People

Measure	Value	Trend
Bank & Agency Fill Rate	80.6%	↓
Fundamental Training	91.5%	↓
Rolling 12m Turnover	9.6%	↑
Staff Appraisals	81.3%	↓
Staff Sickness	6.2%	↓
Staff Vacancies	9.8%	↓

Quality

Measure	Value	Trend
Absconsions and Failures to Return	20	↑
Commissioner reportable incidents	5	
Community suicides	0	
Duty of Candour	1	↓
Falls resulting in harm	0	
Homicides	0	
Incidents resulting in harm	15.8%	↑
Inpatient suicides	0	
Never Events	0	
Patient Assaults / 1000 OBD	2.3	
Pressure Scores	3	↓
Prone restraints/ 1000 OBD	3.4	
Reported incidents	1865	↓
Staff Assaults / 1000 OBD	4.6	

Sustainability

Measure	Value	Trend
CAP Ex	£763k	↗
Cash	£36,798k	↑
CIP	£0k	↓
Info Governance	88.8%	
Monthly Agency	£542k	↑
Operating Surplus	£2,626k	
Property	98.5%	↑
SOF rating	2	↓

Key	Meaning
(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

Integrated Performance Dashboard

Division

A: All

A: All

Measure	Latest Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	
CPA 7 day FU	95.00	95.1%	94.7%	93.8%	90.0%	91.0%	91.8%	↓
CPA with Formal Review last 12 mths	95.00	88.3%	88.5%	88.6%	89.1%	89.2%	88.7%	↓
Data Quality Maturity Index (DQMI)	95.00	98.2%	98.6%	98.5%	97.4%	97.4%	98.4%	↑
Delayed Transfer Bed Days		797	922	997	1232	1007	724	
Delayed Transfer, percent of bed days		5.1%	5.7%	6.4%	7.8%	6.2%	4.7%	
Eating disorders routine	95.00	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	
Eating disorders urgent	95.00	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	
First episode psychosis	60.00	80.0%	100.0%	100.0%	85.7%	100.0%	100.0%	
IAPT into recovery	50.00	59.2%	55.1%	55.5%	52.3%	56.2%	51.4%	↑
IAPT seen in 18 weeks	95.00	99.2%	94.7%	97.1%	93.1%	91.6%	89.2%	↓
IAPT seen in 6 weeks	75.00	41.8%	36.7%	34.3%	32.9%	31.7%	28.1%	↓
Out of Area Bed Days		643	664	566	572	652	613	↑
Referrals over 3 mths with no contact		2227	2256	2167	2146	2322	2423	↓

Top Line Commentary (Trust level)

KEY CONCERN:

*** IAPT seen in 18 weeks and IAPT seen in 6 weeks**

*** New referrals not seen in 3M - down to 2,322 performance standard not yet agreed**

*** CPA 12 month review - standards under discussion**

SOME CONCERNS

* None

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

Integrated Performance Dashboard

A: All

Measure	Latest Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Staff Vacancies	6.00	8.2%	9.5%	10.0%	9.9%	9.7%	9.8% ↓
Staff Sickness	4.28	5.3%	5.3%	6.0%	6.6%	6.1%	6.2% ↓
Staff Appraisals	90.00	80.8%	82.6%	82.5%	81.6%	81.5%	81.3% ↓
Rolling 12m Turnover	11.00	8.9%	9.2%	9.5%	9.5%	9.5%	9.6% ↑
Fundamental Training	95.00	91.3%	92.0%	93.3%	93.2%	93.4%	91.5% ↓
Bank & Agency Fill Rate	95.00	89.3%	88.8%	86.3%	83.8%	82.9%	80.6% ↓

Top Line Commentary (Trust level)

KEY CONCERNS

* **Fundamental training at lowest level**
* **Sickness rate is increasing**
* **Appraisals remain very low**

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Absconsions and Failures to Return	0.00	15	25	22	15	17	20 ↑
Commissioner reportable incidents	0.00	3	7	5	8	3	5
Community suicides	0.00	2	3	0	0	0	0
Duty of Candour	0.00	0	0	0	1	1	1 ↓
Falls resulting in harm	0.00	0	0	1	0	0	0
Homicides	0.00	0	0	0	0	0	0
Incidents resulting in harm	0.00	16.8%	16.5%	12.2%	15.8%	15.0%	15.8% ↑
Inpatient suicides	0.00	0	0	0	0	0	0
Never Events	0.00	0	0	0	0	0	0
Patient Assaults / 1000 OBD	0.00	2.1	2.0	1.9	1.5	3.3	2.3
Pressure Scores	0.00	1	0	1	3	2	3 ↓
Prone restraints/ 1000 OBD	0.00	4.6	4.5	2.7	2.2	2.9	3.4
Reported incidents	0.00	1817	1936	2027	2250	2051	1865 ↓
Staff Assaults / 1000 OBD	0.00	3.4	4.2	4.8	4.8	5.5	4.6

Top Line Commentary (Trust level)

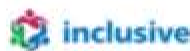
Reduction in reported incidents, however proportion of incidents resulting in harm have remained low (15%).

Key incidents seeing a reduction: self harm and patient behaviour, Assaults, violence and harrassment, unexpected deaths.

8 SI's reported in September (3 of which relate to previous months) 5 of the 8 were suspected community suicides.

Restraint and assault inicdents have remained below the median.

Key	
(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern



Integrated Performance Dashboard

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Trend
CAP Ex		£55k	£334k	£88k	£176k	£427k	£763k	↗
Cash	25,905,693.73	£28,160k	£28,642k	£27,830k	£34,188k	£37,630k	£36,798k	↑
CIP		£0k	£0k	£0k	£0k	£0k	£0k	↓
Info Governance	100.00	80.1%	88.6%	92.5%	86.6%	88.2%	88.8%	
Monthly Agency		£405k	£366k	£462k	£478k	£441k	£542k	↑
Operating Surplus		£315k	-£1,116k	-£1,776k	-£651k	£555k	£2,626k	
Property	95.00	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	↑
SOF rating	3.00	3	3	2	2	2	2	↓

Top Line Commentary (Trust level)

KEY CONCERNS:

*** Surplus, Cash, SOF figures artifically boosted by COVID**

- Surplus slightly better on mid-year forecast

*** Removal of top-up funding exposes underlying performance**

*** CIP will be an issue when national funding regime returns to normal**

*** SOF remains at 'normal' position**

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

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

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Out of Area Bed Days

Statistical Process Control (SPC)

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

Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
A: All	643	664	566	572	652	613
B: Acute and Urgent Care	643	664	566	572	652	613

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 has been sustained in May - September at 613 days. The number of new OOA admissions has reduced from 19 in August to 14 in September with a total of 42 OOA placements. A revised target has been agreed with NHSE/I to reduce OOA bed usage to zero by the end of quarter 2 (September 2021).

Detailed Commentary

Out of Area Bed Days

Sept - 2021

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 has been sustained in May - September at 613 days. The number of new OOA admissions has reduced from 19 in August to 14 in September with a total of 42 OOA placements. A revised target has been agreed with NHSE/I to reduce OOA bed usage to zero by the end of quarter 2 (September 2021).
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 appropriately 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, 12 PICU and 10 acute beds. This will enable further reductions in the number of inappropriate out of area placements. 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.
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. Progress achieved to date has been commended by commissioners and NHSE/I.
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. Reporting from 1st October has been revised to reflect this.
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 begin to get implemented and embedded and more recently as a result of the SOP agreed with NHSE. This will be further supported by the introduction of the additional bed capacity.
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.

IAPT seen in 6 weeks

Birmingham and Solihull Mental Health NHS Foundation Trust

Statistical Process Control (SPC)

UCL LCL Value Mean Concern Improvement Plan

Period

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

Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
A: All	41.8%	36.7%	34.3%	32.9%	31.7%	28.1%
E: Specialties	41.8%	36.7%	34.3%	32.9%	31.7%	28.1%

Commentary

Performance has been on a reducing trend since March 2020 and remains well below the 75% target at 28.09% and outside control limits.
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 space in primary care to offer face to face appointments.

Detailed Commentary

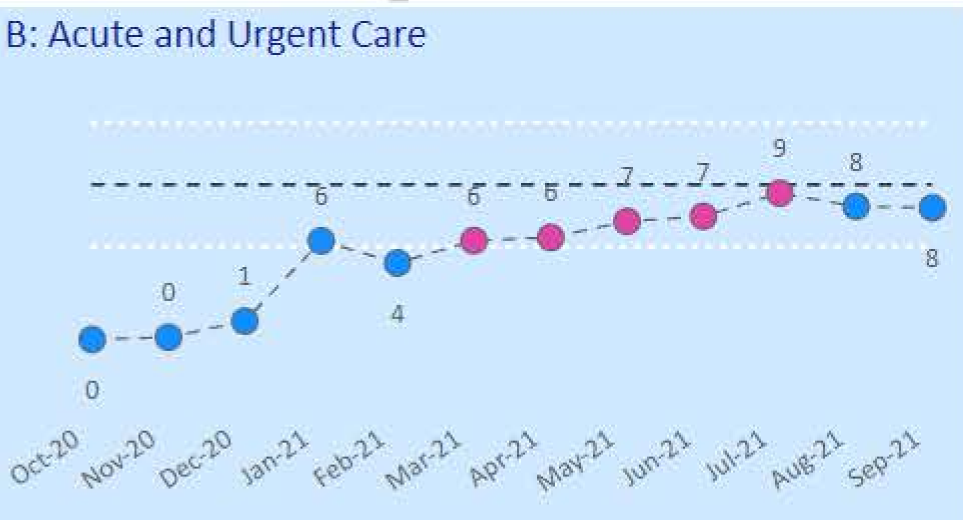
Sept - 2021

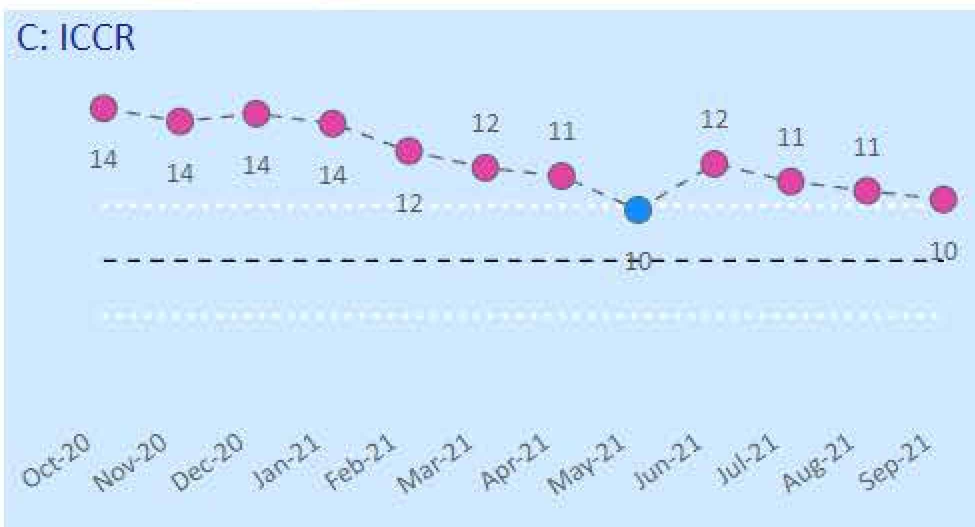
IAPT seen in 6 weeks

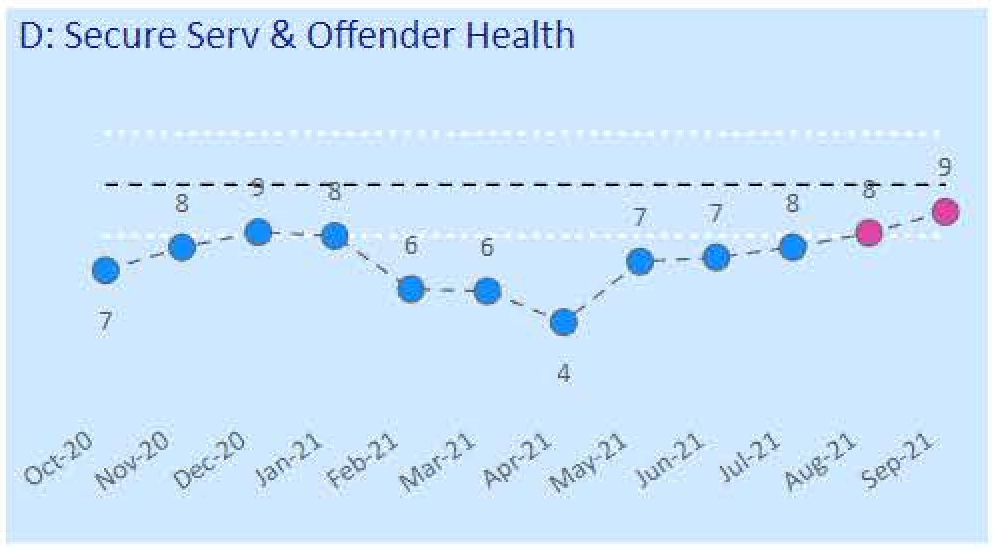
Question	Answers
A: What has happened?	Performance has been on a reducing trend since March 2020 and remains well below the 75% target at 28.09% and outside control limits. The service has a large number of vacancies which are difficult to recruit to which has made it difficult to offer appointments 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 space in primary care to offer face to face appointments.
B: Why has it happened?	Ability see patients face to face impacted by Covid as access to GP surgeries and community facilities were stopped. Face to face contacts have increased in BHM premises but need to be undertaken in a COVID secure way and capacity is reduced in number. The service has a large number of vacancies with additional challenges around retention, with staff leaving to take further training or moving to posts which attract higher bandings, which has made it difficult to offer appointments in a timely way.
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. On line digital therapies are also being offered and discussions are taking place with GPs to access clinical space. Weekly meetings to review current waits are also taking place.
E: What do we expect to happen?	To slowly increase the face to face offer and increase capacity.
F: How will we know when we have addressed issues?	The waiting times will be equal to or be above the 75% target.

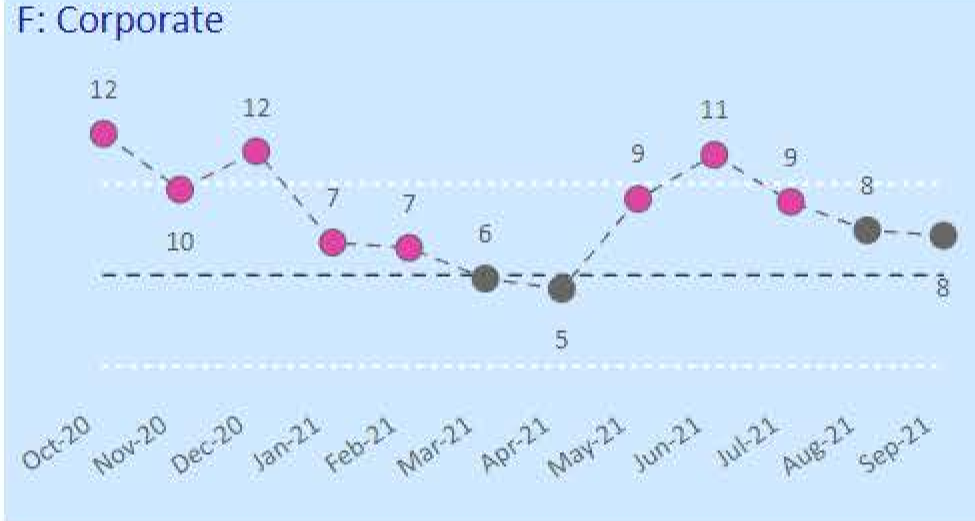
NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Staff Vacancies









Key

Detailed Commentary

Staff Vacancies

Sept - 2021

Question	Answers
A: What has happened?	The vacancy rate has stayed consistent in September and is above the KPI target of 6.0%. Vacancy rates have fluctuated over the last 12 months with an overall increase in vacancies since April 2020 when vacancies stood at 7.8%. The vacancy breakdown by division is as follows: Secure Services and Offender Health – 8.6%; Specialties – 10.2%; Acute and Urgent Care – 8.6%; and ICCR – 11.6%.
B: Why has it happened?	The Trust establishment grew in Q1 which has resulted in an increase in vacancy rates whilst newly established posts are recruited to and due to an increased demand on workforce supply - due to the amount of workforce growth planned for 2021/22 in response to the different funding streams available to the Trust, the establishment will continue to grow which may impact vacancy figures depending on the level of successful recruitment to new posts.
C: What are the implications and consequences?	Nationally there is a shortage of registered nurses and this is reflected in our local data; Band 5 nurses particularly are a key concern with a high vacancy rate at 37.2% for September. This is a significant number and the highest on record. Whilst the vacancy rate has improved in some areas, there is a variance in rates across teams and staff groups and it is important to note areas are experiencing severe staffing level challenges - lower staffing levels has an impact on the Trust's ability to provide high quality patient care and increases reliance on bank and agency usage – this in turn impacts continuity of care for patients. BAF Risk Fails to develop an inclusive and compassionate working environment, resulting in failure to attract talent.
D: What are we doing about it?	Approval has been received from the Executive team to create a "talent hub" within the Trust. The aims would be to create and manage a talent attraction strategy to support the Trust's plans for growth, align all talent attraction and recruitment processes throughout the Trust, lead on international recruitment activities, from sourcing through to appointment and pastoral care, recruitment pipeline management, which includes international recruitment activities, from sourcing to appointment and pastoral care, sourcing of high quality candidates for key positions and establish and grow a talent pool of passive candidates within key business areas and positions. The Trust, alongside the ICS to looking to recruit into 100 entry level roles a role which will be targeted at underrepresented groups across Birmingham and Solihull. This will launch in November. We continue to work with operational areas to convert long term temporary staffing bookings into substantive offers of employment - long term bookings for both bank and agency are reviewed weekly, with the Operational HR Team meeting with managers to understand the situation that has led to that long term booking and to assess the feasibility of the individual being offered a substantive role - a TSS and HR Operations task group are currently meeting weekly to review progress. Attending the RCN Jobs fair at the NEC on Wednesday 6th October. This has created a number of offers and a high number of leads from interested nurses which we are following up. We have started to do some targeted work around our nursing vacancies. Data shows that about 40% of our band 5 Staff Nurse vacancies are from 10 wards with the highest vacancy rate so are looking at some bespoke work around this.

Detailed Commentary

Staff Vacancies

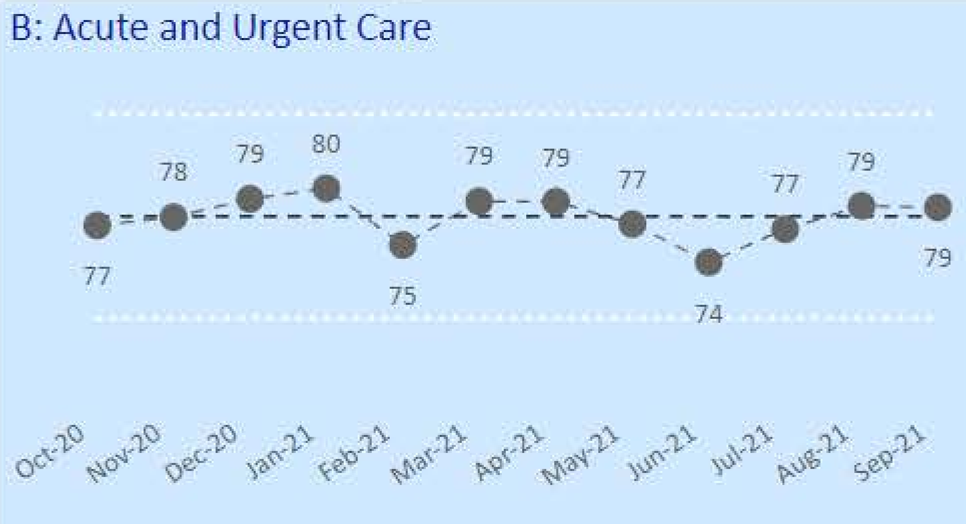
Sept - 2021

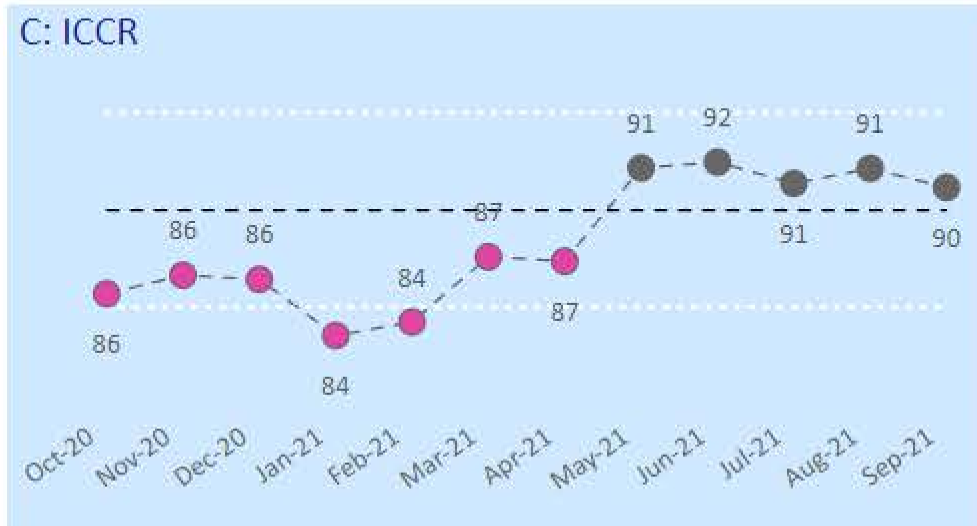
Question	Answers
	Fails to develop an inclusive and compassionate working environment, resulting in failure to attract talent.
D: What are we doing about it?	Approval has been received from the Executive team to create a "talent hub" within the Trust. The aims would be to create and manage a talent attraction strategy to support the Trust's plans for growth, align all talent attraction and recruitment processes throughout the Trust, lead on international recruitment activities, from sourcing through to appointment and pastoral care, recruitment pipeline management, which includes international recruitment activities, from sourcing to appointment and pastoral care, sourcing of high quality candidates for key positions and establish and grow a talent pool of passive candidates within key business areas and positions. The Trust, alongside the ICS to looking to recruit into 100 entry level roles a role which will be targeted at underrepresented groups across Birmingham and Solihull. This will launch in November. We continue to work with operational areas to convert long term temporary staffing bookings into substantive offers of employment - long term bookings for both bank and agency are reviewed weekly, with the Operational HR Team meeting with managers to understand the situation that has led to that long term booking and to assess the feasibility of the individual being offered a substantive role - a TSS and HR Operations task group are currently meeting weekly to review progress. Attending the RCN Jobs fair at the NEC on Wednesday 6th October. This has created a number of offers and a high number of leads from interested nurses which we are following up. We have started to do some targeted work around our nursing vacancies. Data shows that about 40% of our band 5 Staff Nurse vacancies are from 10 wards with the highest vacancy rate so are looking at some bespoke work around this. Targeted work is continuing between Recruitment and the Community Engagement Team to look at how we can increase supply into the organisation from our local communities. A new Safer Staffing committee has been established to focus on some of the challenges around vacancies. There will be sub-committees from this focussing on supply, upskilling and new roles. The first meetings of the BSOL Mental Health Systems – Delivery and Transformation Sub-Group take place on 23rd September 2021. Its purpose will be to ensure a workforce fit for purpose to the mental health NHS Long Term Plan. It will ensure that the risks and barriers to the supply and deployment of a skilled workforce are identified and addressed.
E: What do we expect to happen?	There are national supply issues in relation to certain staff groups e.g., registered nurses and IAPT meaning we do need to recognise that this will limit the improvements that can be made in relation to vacancy rates. However targeted work ongoing across the Trust should mean we see a reduction in vacancy rates over time.
F: How will we know when we have addressed issues?	Reduction in vacancy rate and maintenance of the vacancy rate at below the 6% Trust target.

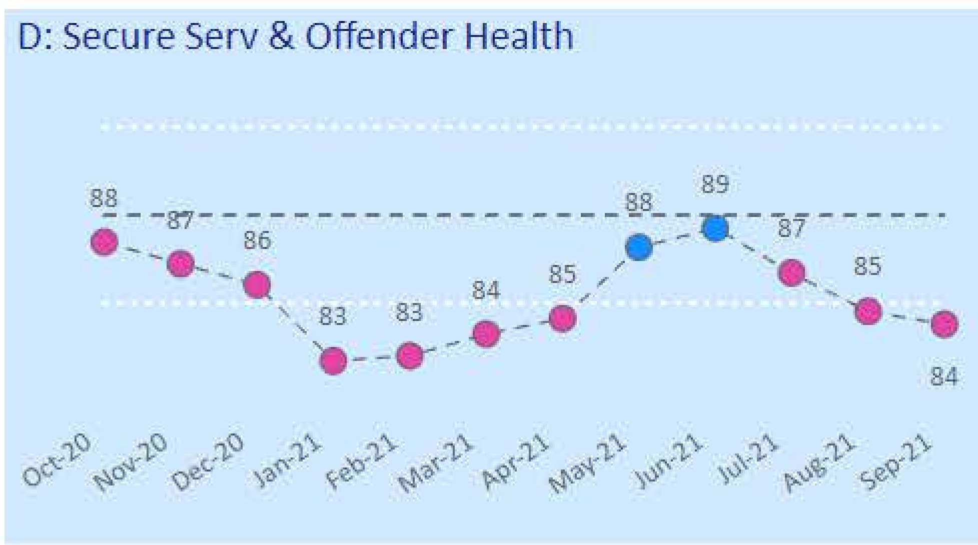
compassionate inclusive committed

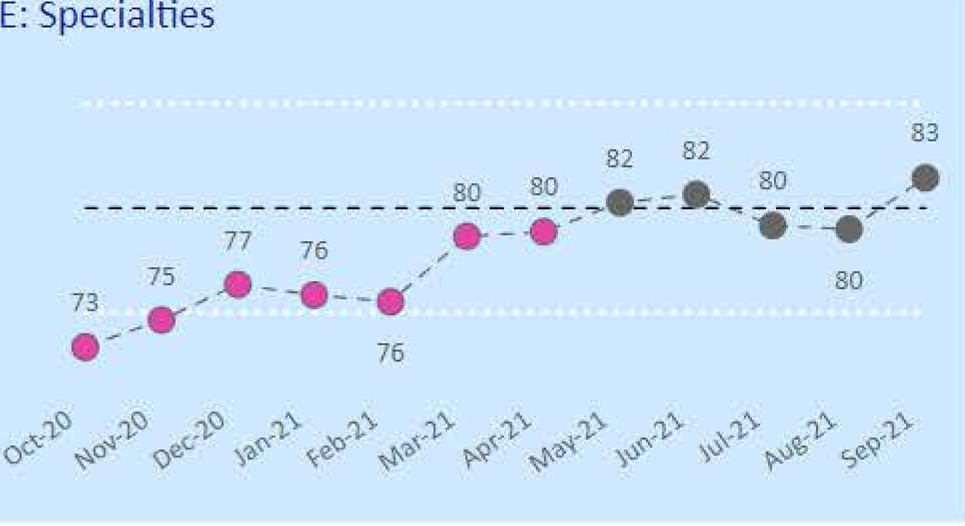
Birmingham and Solihull Mental Health
NHS Foundation Trust

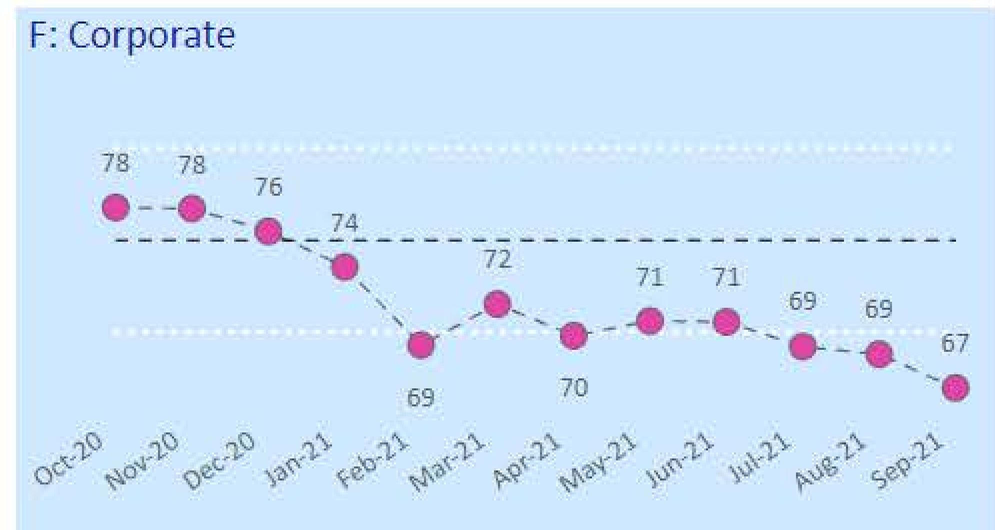
Staff Appraisals











Key

Detailed Commentary

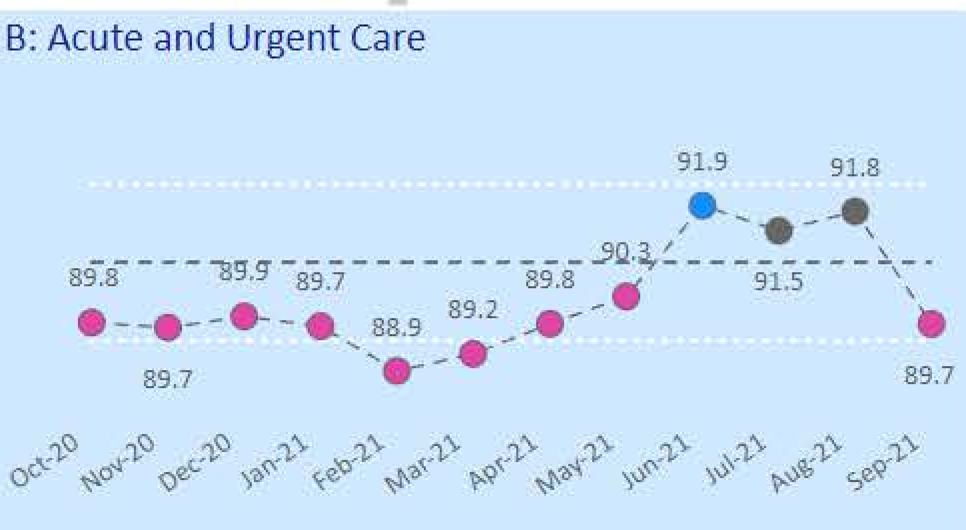
Staff Appraisals

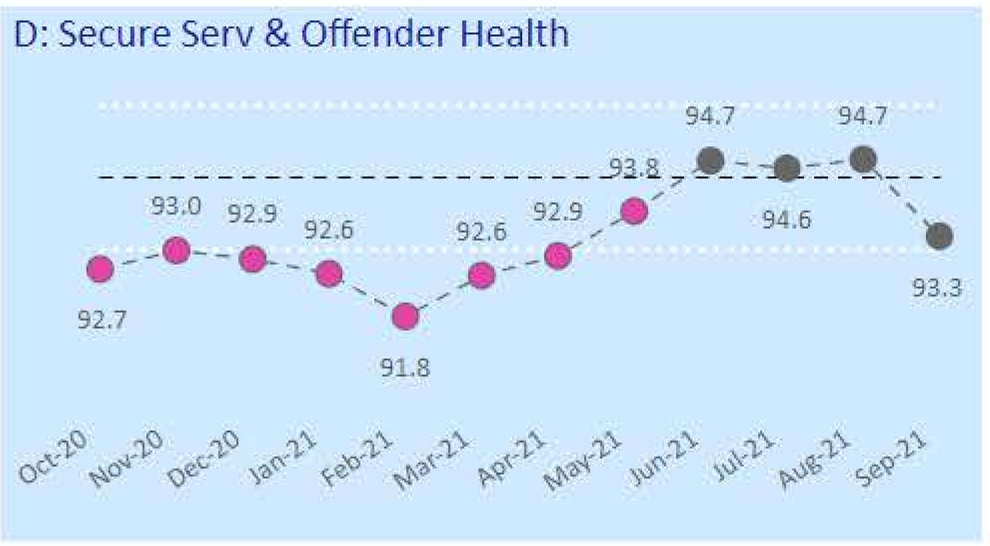
Sept - 2021

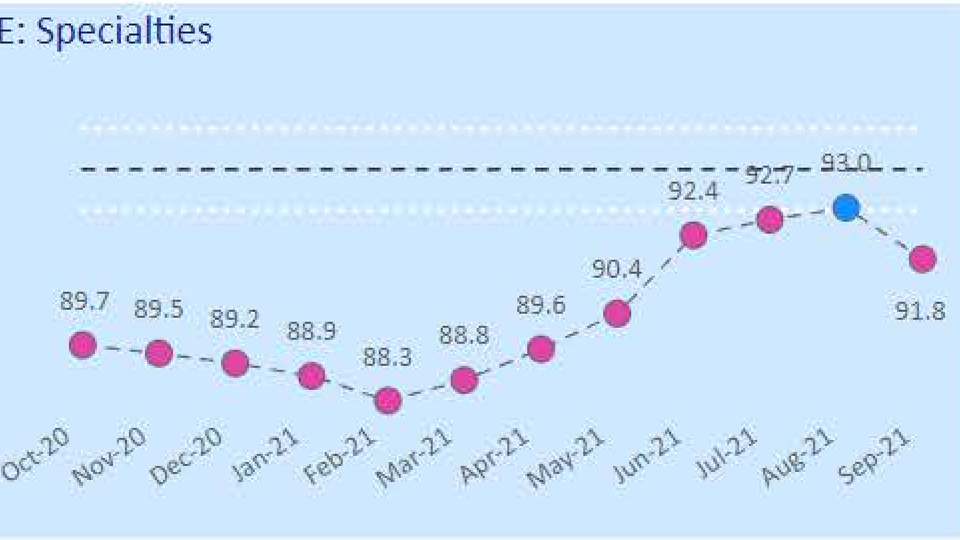
Question	Answers
A: What has happened?	Appraisal rates have decreased slightly to 81.4% in September from 81.5% in August. The appraisal rate had been maintained consistently above the 85% CCG target from November 2019 to March 2020, however fell below this in April 2020 and has remained consistently below this target since. The appraisal rate breakdown by division for September is as follows: ICCR – 89.8%; Secure and Offender Health – 90.9%; Specialties – 89.9%; and Acute and Urgent Care – 87.1%.
B: Why has it happened?	The main reason for the fall in appraisal compliance since April 2020 is the capacity challenge for staff caused by the Covid-19 response and the significant staffing shortages we have seen due to the pandemic. Appraisal rate recovery is starting to be seen linked to a reduction in Covid-19 staffing pressures and due to targeted work with managers on pay progression including training and communications detailing appraisal completion as a key element.
C: What are the implications and consequences?	Failure to meet our contractual requirements – this stands at an 85% target for completion from the CCG. Non-completion of appraisals and/or poor-quality appraisals has an impact on staff experience and development, potentially leading to reduced engagement from staff and increased turnover.
D: What are we doing about it?	An L&D Administrator is utilising the draft Appraisal Completion report (provided by the Informatics Team) to target those staff that are not completing their appraisals and support them in the completion of the ADR process; this approach was adapted throughout the pandemic to encourage supportive conversations as opposed to targeted work on recording appraisals recognising the significant staffing challenges - during the Covid period a best-practice appraisal guide was produced and made available on Connect to support all staff. As staffing pressures have reduced due to the pandemic, focused work on the recording of appraisals and a review of how staff are being supported is taking place. An Appraisal options paper has been presented to the Systems Strategy Group on the 6th May focused on the recommendation to update the Appraisal process in the existing Working Better Together System. Engagement sessions to gain feedback on the appraisal form have been completed throughout April; the redesign of the draft Appraisal form following feedback has been completed including further engagement with Unions, Staff Networks and professional groups. The Appraisal project group have developed specifications and explored suitable system options, an Appraisal Options paper has been presented at Strategy and Transformation Management Board on the 9th September with an agreement to proceed with the ESR system, however with further actions and a detailed plan to be considered e.g. resource and system requirements. The renewal date for the Appraisal Policy has been extended to December 2021 due to the current status of the Appraisal work. People and L&D Business Partners are working with relevant Ads and Team Leaders to improve the current completion rate.
E: What do we expect to happen?	Due to the reliance on historical, system driven processes there will be continued difficulties in trying to report accurately on RMS and ADR data. The Appraisal compliance figure will continue to fluctuate due to the impact on staffing levels and capacity due to Covid-19 but we expect to see some recovery due to a current reduction in staffing pressures related to the pandemic, the pay progression work and the new Appraisal process and form.
F: How will we know when we have addressed issues?	An improvement in appraisal completion rates to meet the 85% commissioner target; the appraisal project completion is ongoing and this will provide updates as the project moves forward.

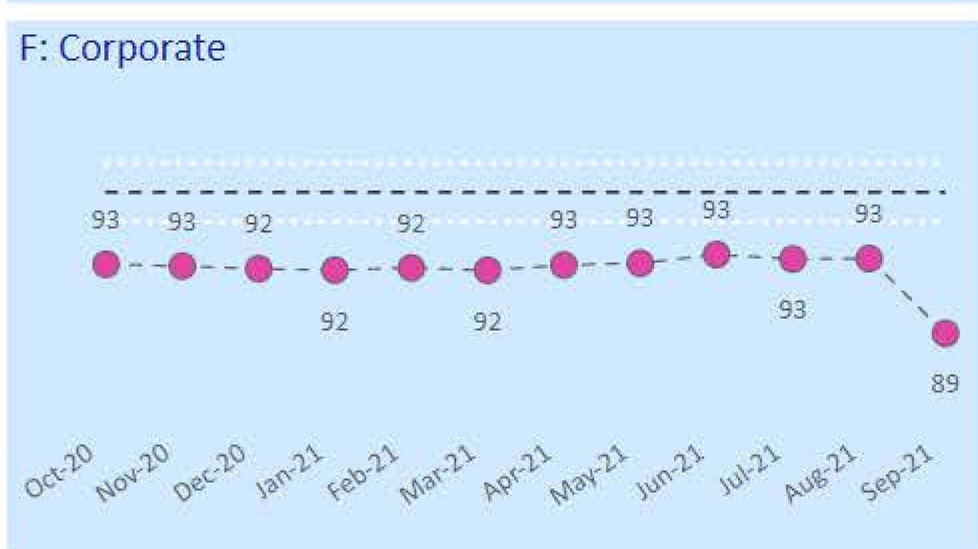
Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training









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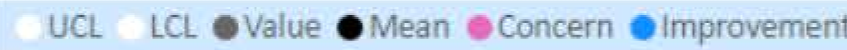

Detailed Commentary

Fundamental Training

Sept - 2021

Question	Answers
A: What has happened?	Fundamental Training decreased to 88.9% in September from 91.2% in August. This is the first decrease in fundamental training compliance this financial year, where until September we have seen a steady increase following Covid dip. FT breakdown by division is as follows: Secure and Offender Health – 90.9%; ICCR – 89.8%; Specialties – 89.9% and Acute and Urgent Care – 87.1%. Bank FT compliance decreased slightly to 65.25% in September from 65.62% in August. Bank FT compliance decreased over 2020/21 and have remained at just above 65% so far this financial year.
B: Why has it happened?	Substantive staff FT compliance: ADs have worked with Learning and Development to drive up compliance and continue to support for TSS bank workers to complete FT. The decrease in TSS compliance is in part a result of stepping down non-essential FT courses for all staff August 2021 due to impact of covid on workforce
C: What are the implications and consequences?	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. BAF Risks: Fails to develop an inclusive and compassionate working environment, resulting in demotivated workforce.
D: What are we doing about it?	A fortnightly report and newsletter is being sent to ADs regarding clinical FT and quarterly webinars/surgeries for areas are also being planned to meet operational needs. Monthly meetings with TSS to assess progress
E: What do we expect to happen?	Post Covid recovery plans and associated trajectories have calculated that FT recovery for substantive staff will be achieved between August and October 2021.
F: How will we know when we have addressed issues?	With the continued uptake of training offers and when the trajectories offered to the executive team and commissioners are achieved on the cited date.

NHS
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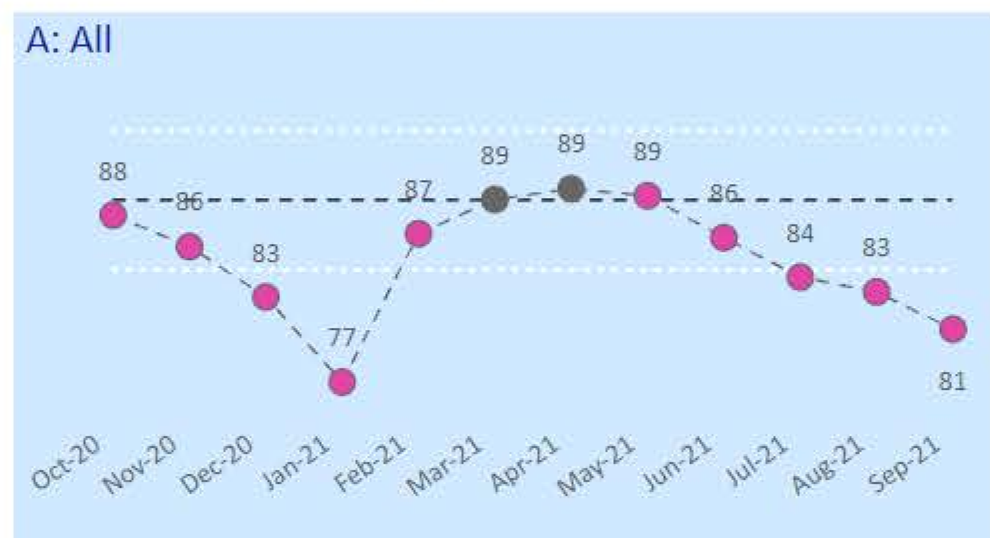
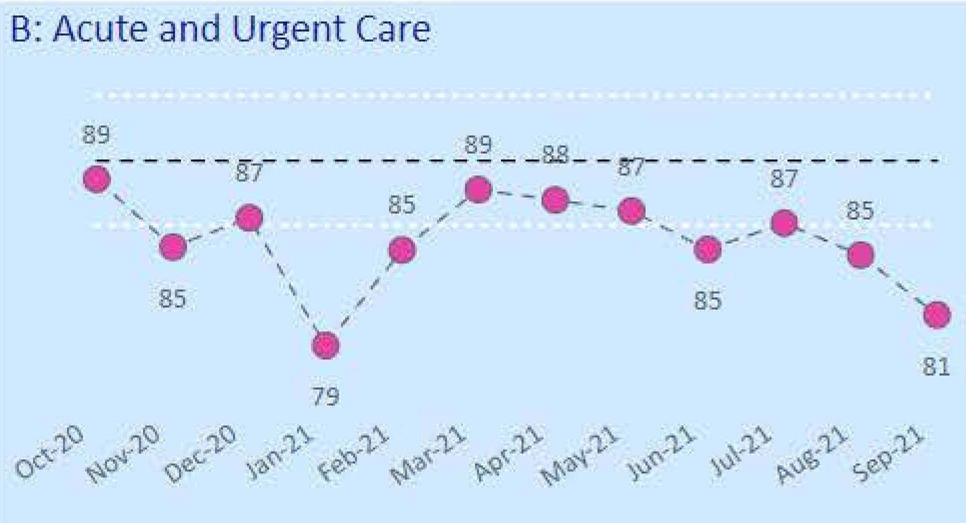
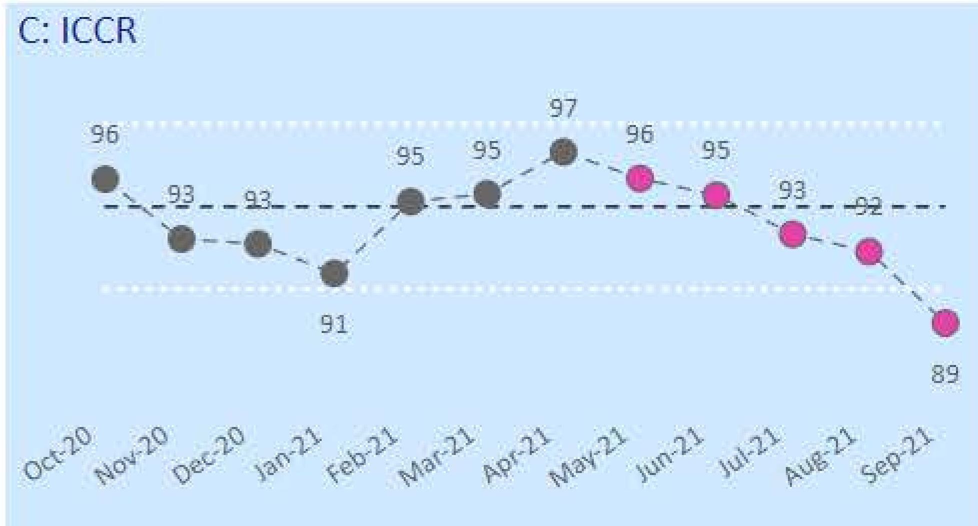
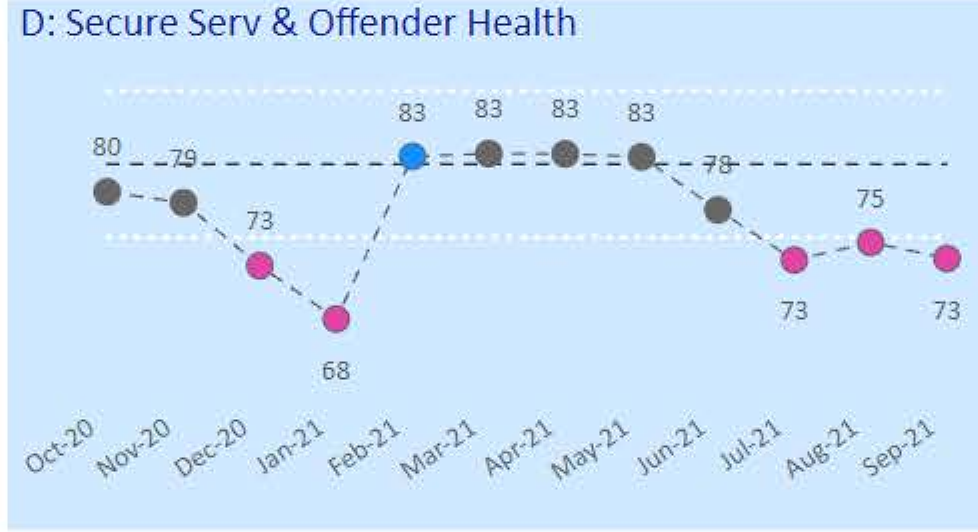
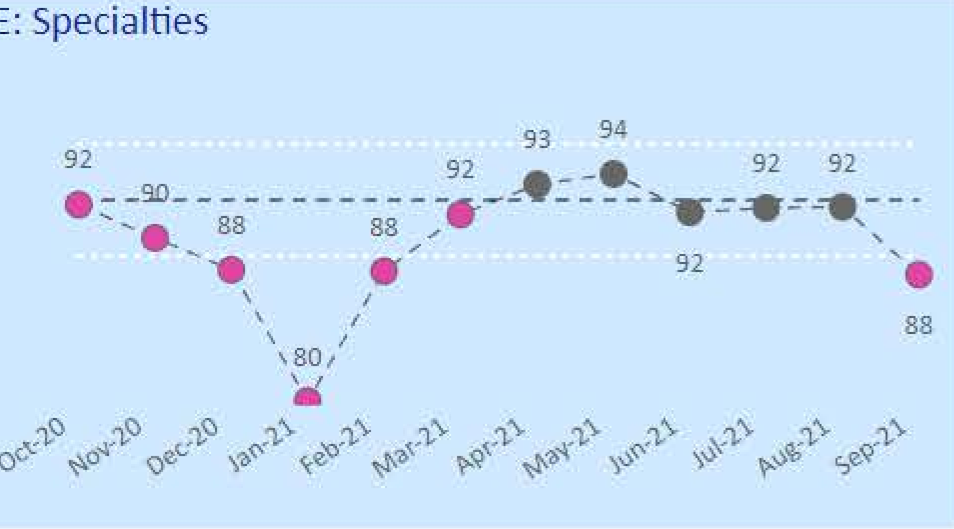
Bank & Agency Fill Rate

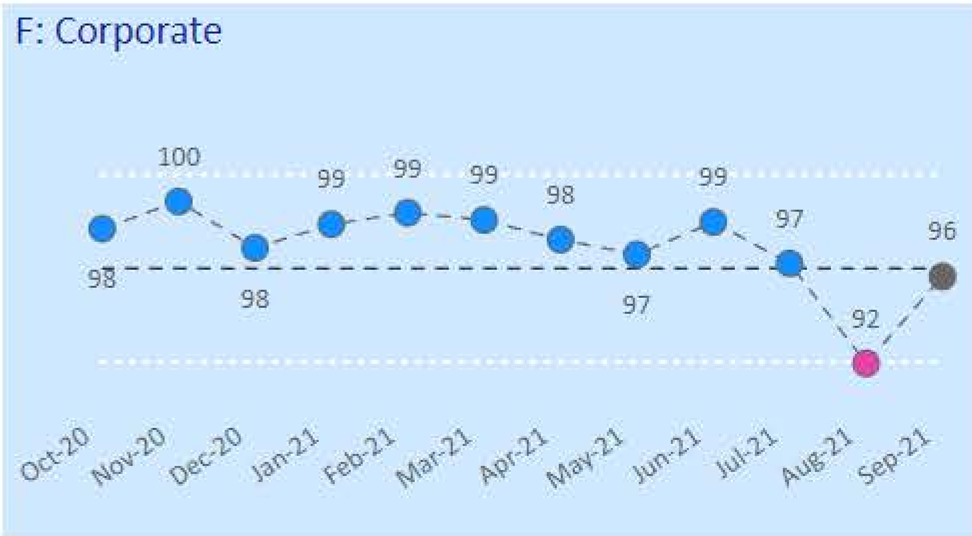












Key

Detailed Commentary

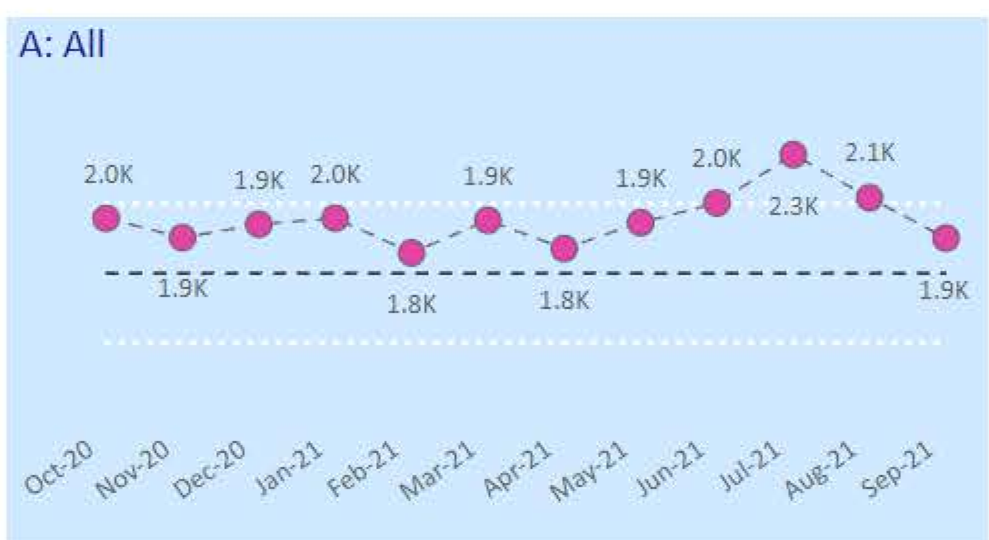
Bank & Agency Fill Rate

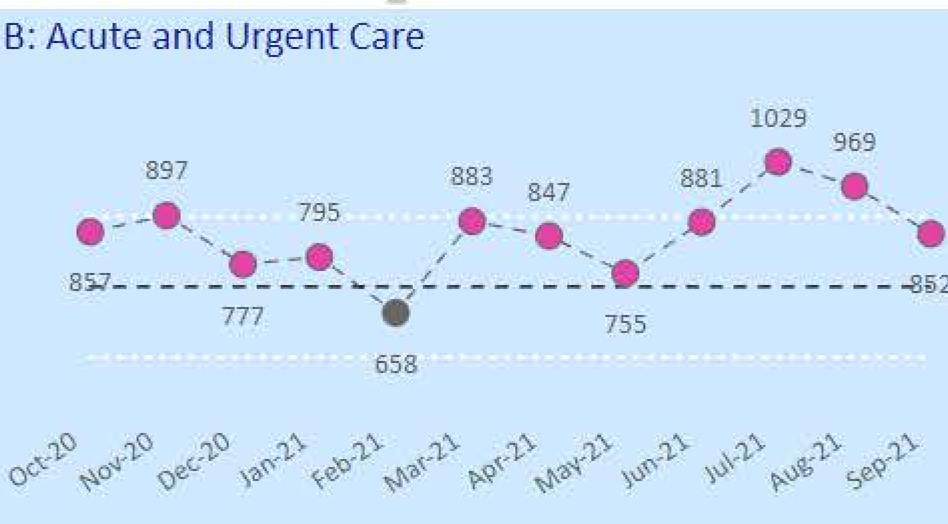
Sept - 2021

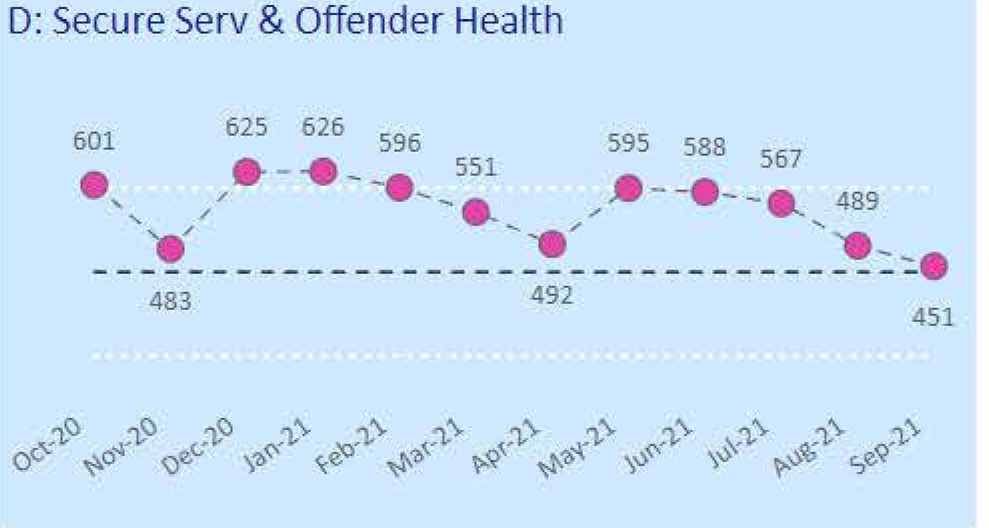
Question	Answers
A: What has happened?	The bank and agency fill rate decreased to 80.7% in September from 82.9% in August. The agency fill rate showed an increase by 1.3% whilst the bank fill rate decreased by 3.6%, accounting for the overall decrease in the combined bank and agency fill rate figure. The fill rate breakdown by division is as follows: ICCR – 89.9%; Specialties – 88%; Acute and Urgent Care – 81.6%; and Secure Services and Offender Health – 73.5%. Despite the decrease in fill rate, the number of requested shifts decreased in September to 14,944 which is a significant decrease from 16,084 in August. Bank filled 1,390 less shifts in September than August, hence the decrease in fill rates. The breakdown of shifts requested by division is as follows: ICCR – 1,677; Specialties – 2,024; Secure Services and Offender Health – 5,372; and Acute and Urgent Care – 4,593.
B: Why has it happened?	12,064 temporary staffing shifts were filled in September (10,768 of these were bank) – the number of filled shifts decreased in September from 13,339. Despite a 1,140 decrease in requested shifts for September, the fill rate has decreased by 2.2%. The main reasons for requested shifts in June were: Clinical Activity (6,703 shifts requested); Vacancies (1,842 shifts requested); Additional Work (1,809 shifts requested); Block booking (1,313 shifts requested); Sickness (1,034); and COVID-19 (602 shifts requested). This continues a consistent trend for the top request reasons.
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?	Twice weekly Staff Safety huddles are still being carried out with the Director of Operations, Chief Nurse, Associate Directors, Finance and HR to review the workforce issues on ward. In wards where there is deemed a high risk, incentive payments of £5 an hour extra are being offered to bank workers who work in these areas. This is having some positive effect on the fill rates for this ward. This is being reviewed every 4 weeks. A Temporary Workforce Cost Improvement Programme is taking place. There are 4 strands to the programme; 1) Medical workforce - The workstream focuses on reducing medic agency spend across the Trust. New processes to support recruitment and approval of agency requests will be implemented, with work ongoing to gather analytics and data to support these improvements. 2) Non-medical workforce - this looks at reducing bank and agency spend on non-medical staff. This will involve improvements to rostering (cross-cutting with the e-Rostering CIP project) 3) Support processes and practice - this looks at support processes within HR, recruitment, etc and is exploring the possibilities around substantive roles and more flexible working arrangements 4) Future Provision - This workstream looks at the future provision of temporary staffing. Options that may be more cost effective and efficient in terms of managing the service are being explored. A new Clinical Lead for TSS starts in October. This will be a pivotal role in terms of supporting our TSS only workers and will focus on engagement, development and support for our TSS colleagues. It is anticipated that there will be improvements in training rate of bank staff, and that the postholder will positively influence the conversion rates of bank staff to permanent. The Recruitment Team will advertise for additional roles within the team; namely Communications Lead, Pastoral Support and Team Leader roles by mid-October. These roles will help to further develop the service.
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.

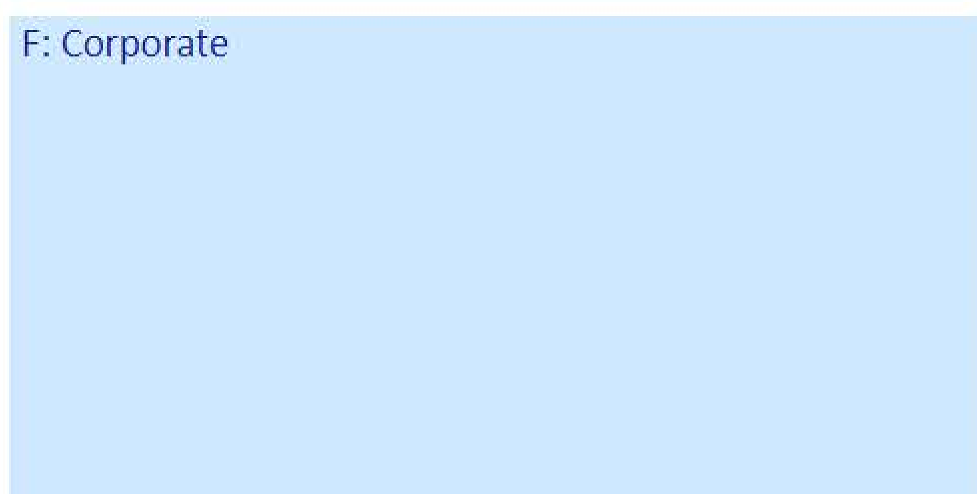
Birmingham and Solihull Mental Health NHS Foundation Trust

Reported incidents









Key

compassionate inclusive committed

Detailed Commentary

Reported incidents

Sept - 2021

Question	Answers
A: What has happened?	Over the past 12 months we have seen a positive shift in incident reporting levels representing an improvement in our safety awareness culture in the Trust. September has seen the first month since April that this has dropped below the median, with a total of 1865 incidents reported. The majority of incidents resulted in no harm to our staff or patients.
B: Why has it happened?	We have introduced daily safety huddles to support teams in recognising and mitigating risks locally. There are a number of areas where reported incident numbers have dropped during September these are: Self harm and patient behaviour Assaults, violence and harassment Unexpected deaths
C: What are the implications and consequences?	The reduction in incidents is now seen over two months, but is too early to confirm a trend. There have been notable reductions in key incident categories that have contributed to this overall reduction. It is most likely that this is due to a reduction in incidents rather than a reduction in reporting culture given the categories that have seen a reduction.
D: What are we doing about it?	Identifying services where reporting is lower than the norm to determine if there are barriers to reporting that can be unlocked.
E: What do we expect to happen?	To sustain and further improve on a learning culture where higher incident reporting is aligned to a low proportion of harm.
F: How will we know when we have addressed issues?	The Trust will improve its position in terms of NRLS benchmarking

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Cash

Statistical Process Control (SPC)

UCL LCL Value Mean Concern Improvement Plan

60M
40M
20M
0M

15M 11M 13M 16M 17M 17M 15M 15M 14M 10M 13M 18M 13M 13M 11M 17M 16M 14M 12M 12M 9M 9M 18M 14M 36M 34M 33M 33M 36M 39M 43M 46M 49M 46M 52M 29M 28M 29M 28M 34M 38M 37M

Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21

Period

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

Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
A: All	£28,160k	£28,642k	£27,830k	£34,188k	£37,630k	£36,798k

Commentary

Cash is down to £36.8m, down on Feb-21 (£52.5m), but up £10m since May-21 and still well above acceptable levels (18m)

Detailed Commentary

Cash

Sept - 2021

Question	Answers
A: What has happened?	Cash is down to £36.8m, down on Feb-21 (£52.5m), but up £10m since May-21 and still well above acceptable levels (18m)
B: Why has it happened?	Advanced contractual payments have ceased in line with national decisions
C: What are the implications and consequences?	Pressure on capital plans
D: What are we doing about it?	Reviewing and improving treasury management plans and forecasting
E: What do we expect to happen?	Cash to remain above acceptable levels
F: How will we know when we have addressed issues?	Cash remaining at acceptable levels

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	12
Paper title	MONTH 6 2021/22 FINANCE REPORT
Date	27/10/2021
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

Executive summary & Recommendations:

Revenue position

The month 6 2021/22 consolidated Group position is a surplus of £20k year to date. This is in line with the H1 break even plan.

There is a continuation of non-recurrent slippage on recruitment against new investment.

Two significant accounting adjustments have contributed to the month 6 break even position:

- £1m provision relating to early termination of a lease (£2m total year to date)
- £1.3m impairment relating to costs associated with preparatory works for the redevelopment of Reaside and Highcroft.

H2 Planning

The 2021/22 operational planning guidance and system envelopes for H2 (October 2021 to March 2022) were published on 30 September 2021. Work has commenced to assess the impact of the H2 settlement and to ensure that we are aligned across the system in terms of planning assumptions.

Capital position

Month 6 year to date Group capital expenditure is £1.8m, this is £1m less than plan. The total capital programme for 2021/22 is £10.3m.

Cash position

The month 6 Group cash position is £36.8m.

Reason for consideration:
Update on month 6 financial position.
Previous consideration of report by:
FPP and regular briefing on financial position with FPP chair.
Strategic priorities (which strategic priority is the report providing assurance on)
SUSTAINABILITY: Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population
Financial Implications *(detail any financial implications)*
Group financial position
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Linked to existing BAF2_0012
Equality impact assessments:
N/A
Engagement *(detail any engagement with staff/service users)*
Ongoing financial briefings via Operational Management Team and Sustainability Board.

Finance Report

Financial Performance:

1st April 2021 to 30th September 2021

Month 6
Group financial position

Group Summary	H1 Budget *Revised June '21 NHSEI submission* £'000	YTD Position		
		Budget £'000	Actual £'000	Variance £'000
Income				
Healthcare Income	143,980	143,971	147,071	3,100
Other Income	7,502	7,511	9,100	1,589
Total Income	**151,482**	**151,482**	**156,171**	**4,690**
Expenditure				
Pay	(109,400)	(109,400)	(113,201)	(3,801)
Other Non Pay Expenditure	(21,949)	(21,909)	(24,747)	(2,838)
Drugs	(2,959)	(2,959)	(3,192)	(233)
Clinical Supplies	(570)	(570)	(273)	297
PFI	(5,198)	(5,198)	(5,164)	34
Unallocated Budgets	(3,263)	(3,263)	-	3,263
EBITDA	**8,142**	**8,182**	**9,594**	**1,412**
Capital Financing				
Depreciation	(4,042)	(4,042)	(4,100)	(59)
PDC Dividend	(1,182)	(1,182)	(1,180)	2
Finance Lease	(2,183)	(2,183)	(2,187)	(4)
Loan Interest Payable	(631)	(631)	(631)	0
Loan Interest Receivable	49	49	(0)	(49)
Surplus / (Deficit) before taxation	**152**	**192**	**1,495**	**1,303**
Impairment		-	(1,283)	(1,283)
Profit/ (Loss) on Disposal	40	-	-	-
Taxation	(192)	(192)	(192)	-
Surplus / (Deficit)	**0**	**0**	**20**	**20**

Month 6 2021/22 Group Financial Position

The month 6 2021/22 consolidated Group financial position is £20k surplus, this is in line with the H1 break even plan.

In month 6, there is a continuation of non-recurrent slippage on recruitment against new investment. As discussed at Finance, Performance and Productivity Committee and Trust Board in September, we have now had the opportunity to inform external audit of the treatment of two significant technical adjustments which have contributed to the month 6 break even position as per forecast:
- £1m provision relating to early exit of a lease (£2m total year to date).
- £1.3m impairment relating to a prudent approach to costs associated with preparatory works for the redevelopment of Reaside and Highcroft. This formally recognises that the progression of these schemes is now possible rather than probable. We are currently awaiting feedback regarding the expressions of interest submitted to the DHSC for these schemes.

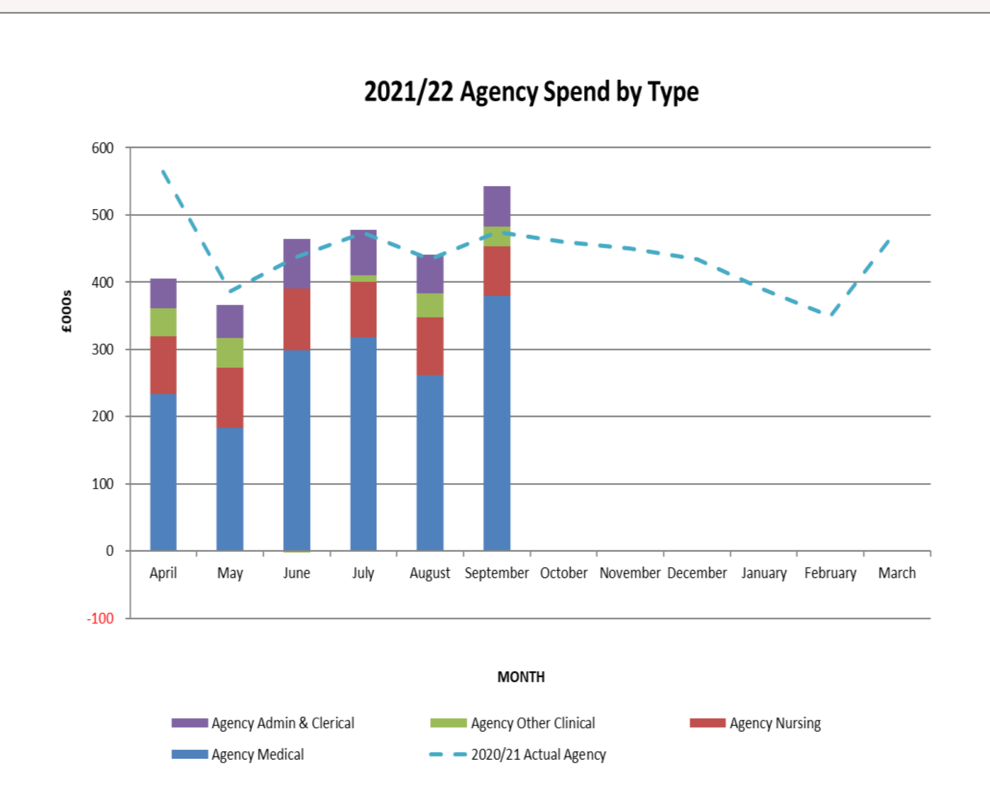
In month 6, the 3% pay award and the backpay (from April 2021) was paid, with £2.3m income accrued to cover the cost pressure to ensure nil bottom line impact. The income is expected to be received in month 7.

H2 Plan
The 2021/22 operational planning guidance for H2 (October 2021 to March 2022) was published on 30 September 2021. For further detail, see page 9.

Agency expenditure
Medical Agency increase in month

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 YTD
Agency Spend (£'000)	405	366	462	478	441	542						**2,695**
NHSEI Ceiling (£'000)	616	616	616	616	616	616						**3,698**
Stretch target (£'000)	501	501	501	501	501	501						**3,007**
Variance to stretch target	**96**	**135**	**39**	**23**	**60**	**(41)**	**0**	**0**	**0**	**0**	**0**	**312**

Agency Medical	234	183	298	318	261	379						1,673
Agency Nursing	86	91	92	82	87	75						512
Agency Other Clinical	42	44	(2)	10	36	29						159
Agency Admin & Clerical	44	49	74	68	57	59						351
Agency Spend (£000s)	**405**	**366**	**462**	**478**	**441**	**542**	**0**	**0**	**0**	**0**	**0**	**2,695**



Agency spend in September was £542k. This is an increase of £101k compared to August and 68k higher than agency spend in September 2020. The spend exceeds the monthly stretch target (based on prior year spend) for the first time this year. Year to date expenditure is £2.7m which is £312k less than target.

The significant increase in agency spend in September is mainly attributable to medical agency £118k; a 73k increase in Staff Grades and a 45k increase in Consultants, mainly in Acute & Urgent Care and ICCR. Agency Nurse and HCA spend reduced by £12k compared to last month and was at the lowest level for the year to date.

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

- The new cost improvement programme (CIP) for temporary staffing costs is focussing on four key areas:

1) Medical workforce - The workstream focuses on reducing medical agency spend across the Trust. New processes to support recruitment and approval of agency requests will be implemented, with work ongoing to gather analytics and data to support these improvements.

2) Non-medical workforce - this looks at reducing non medical bank and agency spend. This will involve improvements to rostering (cross-cutting with the e-Rostering CIP project)

3) Support processes and practice - this looks at support processes including HR and recruitment and is exploring the possibilities around substantive roles and more flexible working arrangements

4) Future Provision - This workstream looks at the future provision of temporary staffing. Options that may be more cost effective and efficient in terms of managing the service are being explored.

- Rapid, substantial recruitment to the bank took place in 2020/21 in response to Covid-19 which has greatly increased bank capacity and reduced reliance on agency. Bank recruitment continues to take place in 2021/22.
- The Trust is looking at over-recruiting HCAs again to help wards with significant vacancy challenges.
- Work continues with operational areas to convert long term agency into substantive offers of employment Trust-wide.
- Following the pilot of MHOST in 2020/21, work is continuing with the tool to roll out a bi-annual establishment review process.

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - Final 31-Mar-21 £m's	NHSI Plan YTD 30-Sep-21 £m's	Actual YTD 30-Sep-21 £m's	NHSI Plan Forecast 31-Mar-22 £m's
Non-Current Assets				
Property, plant and equipment	186.5	180.5	182.9	183.2
Prepayments PFI	1.6	1.4	2.0	1.4
Finance Lease Receivable	-	-	0.0	-
Finance Lease Assets	-	-	(0.0)	-
Deferred Tax Asset	0.1	(0.0)	0.1	(0.0)
Total Non-Current Assets	188.1	181.9	185.0	184.5
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	9.7	7.4	11.2	7.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	25.9	36.8	19.8
Total Curent Assets	38.9	33.7	48.3	27.6
Current liabilities				
Trade and other payables	(29.4)	(28.0)	(34.5)	(28.0)
Tax payable	(4.4)	(4.4)	(5.1)	(4.4)
Loan and Borrowings	(2.7)	(2.7)	(2.7)	(2.7)
Finance Lease, current	-	-	-	-
Provisions	(1.2)	(0.7)	(1.2)	(0.7)
Deferred income	(13.2)	(11.2)	(13.6)	(11.2)
Total Current Liabilities	(50.9)	(47.1)	(57.1)	(47.1)
Non-current liabilities				
Loan and Borrowings	(29.5)	(28.4)	(28.4)	(27.3)
PFI lease	(49.3)	(48.5)	(48.5)	(47.7)
Finance Lease, non current	-	-	0.0	-
Provisions	(2.4)	(1.8)	(4.4)	(1.8)
Total non-current liabilities	(81.3)	(78.8)	(81.3)	(76.9)
Total assets employed	94.9	89.7	94.9	88.1
Financed by (taxpayers' equity)				
Public Dividend Capital	110.5	110.5	110.5	110.5
Revaluation reserve	27.5	24.6	27.5	24.6
Income and expenditure reserve	(43.1)	(45.5)	(43.1)	(47.0)
Total taxpayers' equity	94.9	89.7	94.9	88.1

SOFP Highlights

The Group cash position at the end of September 2021 is £36.8m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 5 to 6.

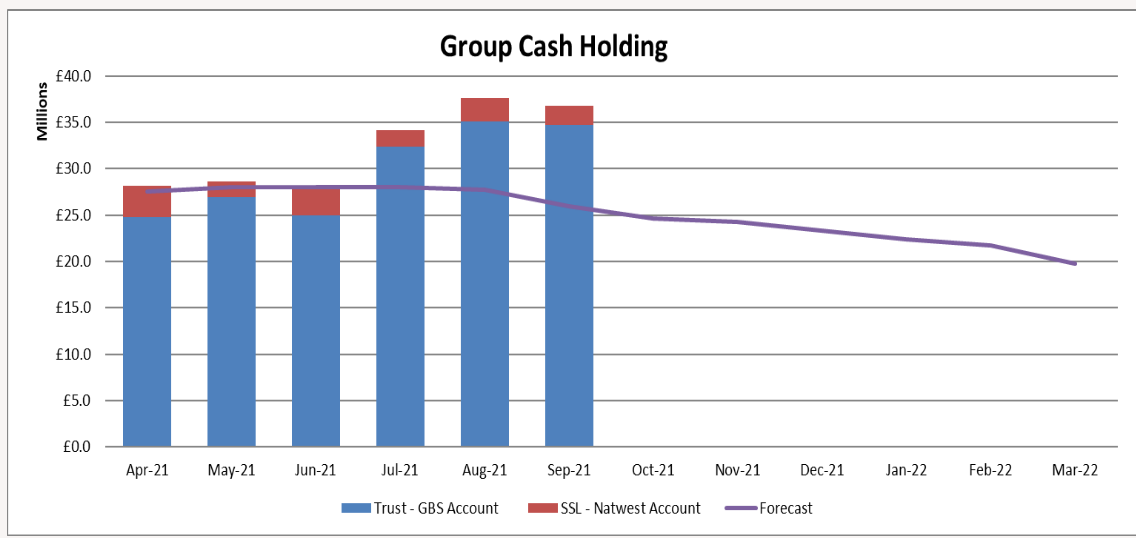
Current Assets & Current Liabilities

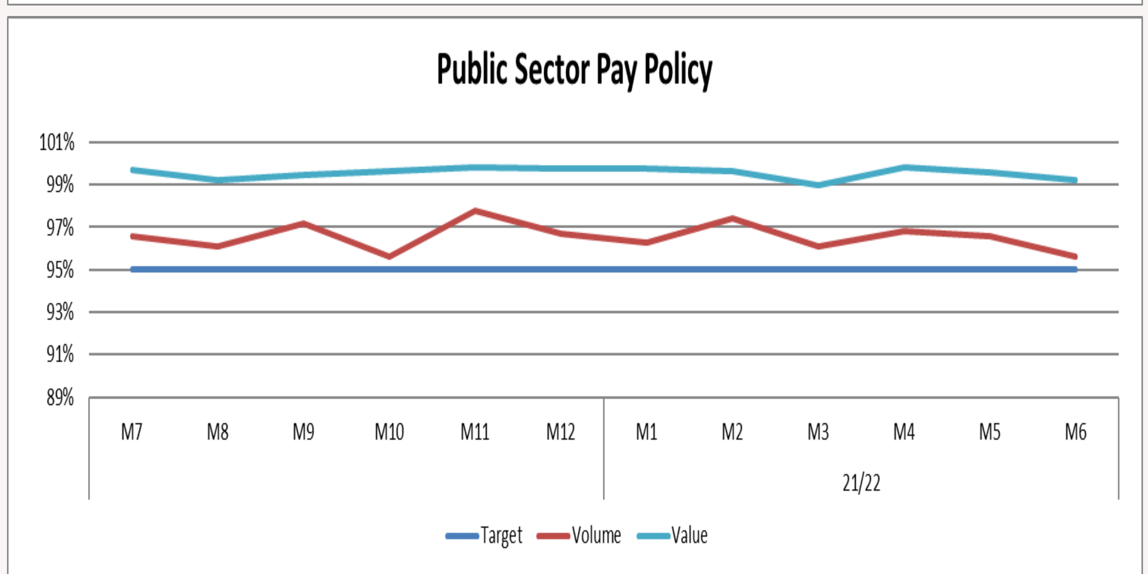
Ratios
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	48.3
Current Liabilities	-57.1
Ratio	0.8

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of September 2021 is £36.8m.

As per the financial regime introduced as a result of the pandemic, the majority of our NHS contracts are being paid on a block basis. The 2021/22 operational planning guidance for H2 (October 2021 to March 2022) was published on 30 September 2021. The block income arrangement will continue for the second half of the financial year with a reduction applied for general efficiency. The cash forecast currently remains in line with the original annual plan as submitted to NHSEI, with a year end cash forecast balance of £19m. We will re-forecast once we have clarity around the H2 settlement, recognising H1 recruitment slippage against new investment. For further detail on H2 planning, see page 9.

Better Payments

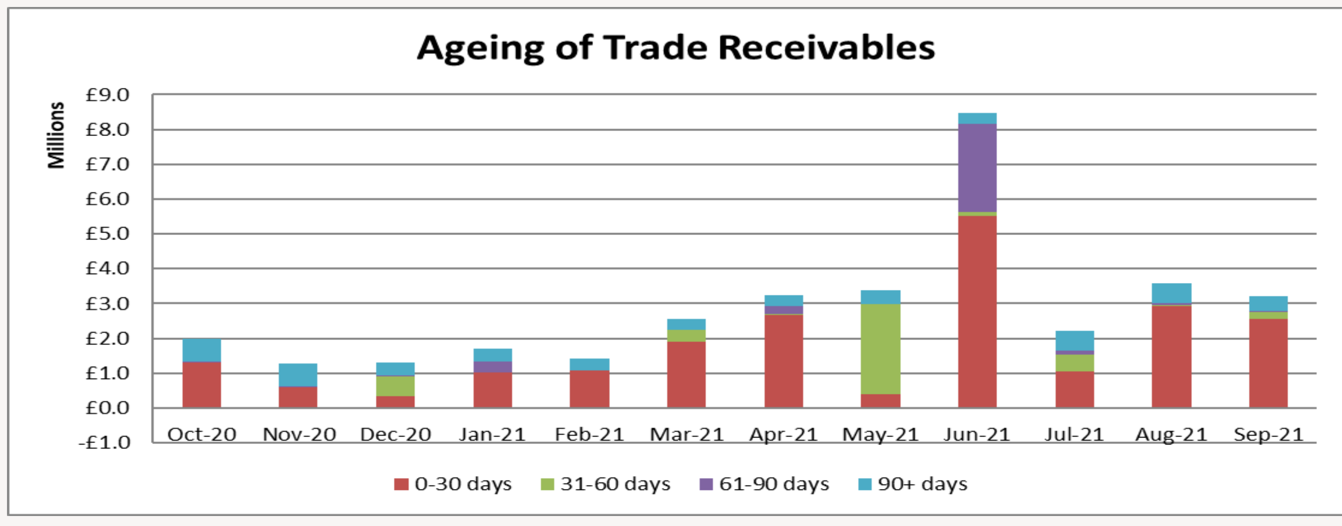
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

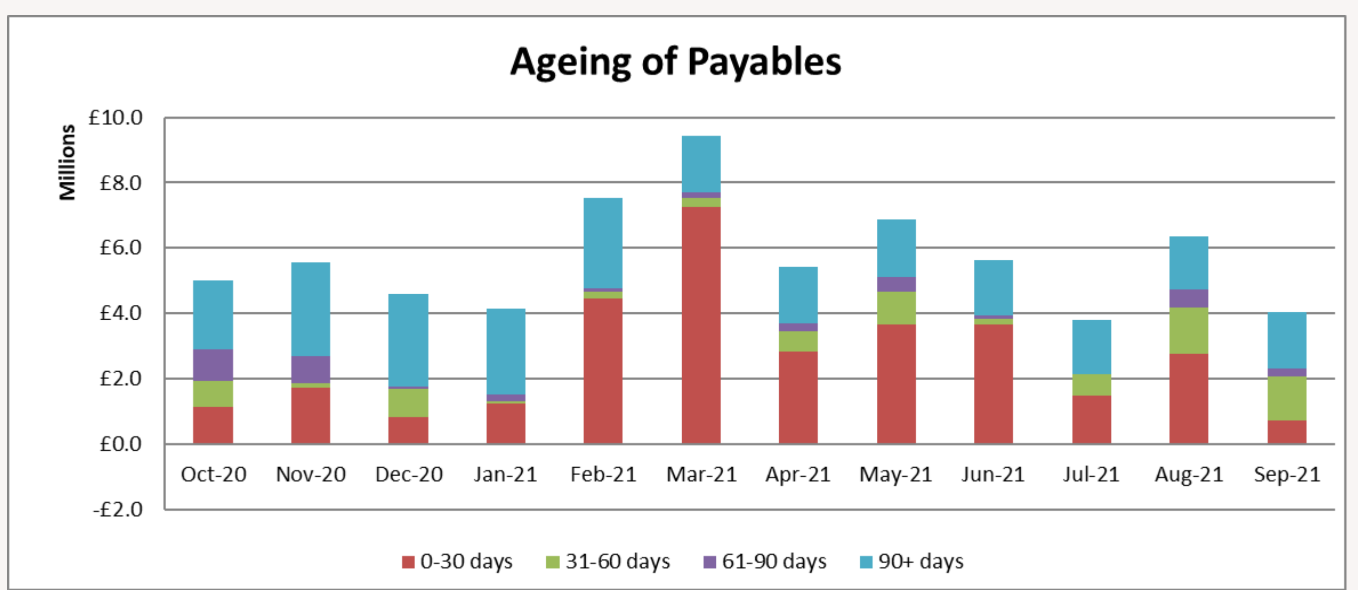
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables

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

Receivables :

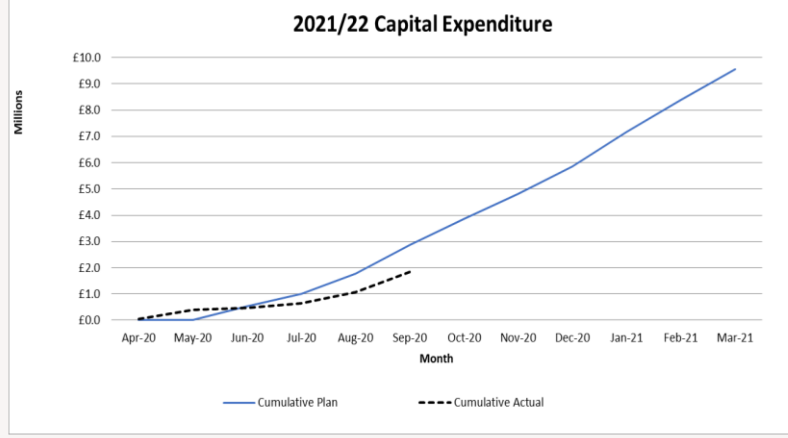
- **0-30 days** - mainly current Provider to Provider (P2P) period invoices
- **Over 90 days** - BSOL CCG £104k in relation to year-end balances. Escalated to management internal & external.

Trade Payables:

- **0-30 days** - BWCH £1.3m relating to the Priory contract.
- **Over 90 days** - NHS Property Services £466k– 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+) £888k – accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in October 2021.

Month 6 YTD Capital expenditure behind plan

Capital schemes	Total 2021/22	YTD plan	YTD actual	YTD variance
	£'m	£'m	£'m	£'m
Pre committed - major schemes c/f from 20/21- Urgent Care Centre	1.2	0.8	0.8	0.0
Pre committed - minor schemes c/f from 20/21	0.3	0.2	0.0	0.2
Pre committed - Ardenleigh Women's seclusion suite	0.5	0.0	0.0	0.0
Total Door Sets phase 1 and phase 2	4.4	0.6	0.6	0.0
Statutory Standards & Backlog Maintenance	1.8	0.3	0.3	0.0
ICT	0.8	0.6	0.0	0.6
Newington refurbishment	0.5	0.0	0.0	0.0
Risk Assessments - to be allocated	0.8	0.4	0.0	0.4
TOTAL	10.3	2.9	1.8	1.0



CDEL calculation	YTD		
Gross capital expenditure	Plan £'m	Actual £'m	Variance £'m
Property, land and buildings	2.3	1.8	0.4
IT	0.6	0.0	0.6
Gross capital expenditure	**2.9**	**1.8**	**1.0**
Disposals / other deductions	-0.4	0.0	-0.4
Charge after additions/deductions	**2.5**	**1.8**	**0.7**
Less PFI capital (IFRIC12)	-0.8	-0.8	0.0
Plus PFI residual interest	0.3	0.3	0.0
Sale of financial assets	-0.4	0.0	-0.4
Total CDEL	**1.6**	**1.3**	**0.3**
	0.0	**0.0**	**0.0**
Charge against Capital Allocation (internal funding)	**1.7**	**1.0**	**0.7**
Residual interest	0.3	0.3	0.0
Sale of financial assets	-0.4	0.0	-0.4
Net CDEL	**1.6**	**1.3**	**0.3**

Month 6 Group Capital expenditure

Month 6 year to date Group capital expenditure is £1.8m, this is £1m less than plan.

£0.6m underspend relates to slippage to date on ICT capital schemes. Business cases predominantly relating to equipment refresh and wireless expansion were approved at August and September Capital Review Group, with expenditure to be realised in quarter 3 and 4.

£0.4m underspend relates to risk assessments. The spend plan to be formalised at October Capital Review Group.

Although the variance to gross capital expenditure plan is £1m, the Capital Departmental Expenditure Limit (CDEL) variance is £0.3m. This is mainly due to slippage on the sale of Ross House. The proceeds of which are planned to contribute to the funding of the 2021/22 capital plan. The property is sold subject to contract with delays to date relating to planning.

Birmingham and Solihull ICS Financial position Month 5 YTD

System revenue performance:

The month 5 year to date system revenue position was £2.7m surplus, which was £5.2m better than year to date plan.
The system forecast position was a deficit of £0.64m after adjusting for an expected impairment in light of a planned asset disposal at BCHC. The month 6 reported forecast was for the system to achieve breakeven overall in line with the H1 plan.

Adjusted financial performance surplus / (deficit)	Year to date			Forecast			Fcast Var after revision for Impairment
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	£000s
B'ham and Solihull MH NHSFT	0	2,647	2,647	0	0	0	0
B'ham Community Healthcare NHSFT	-760	129	889	0	-760	-760	0
B'ham Women's and Children's NHSFT	1	245	245	0	393	393	393
Royal Orthopaedic Hospital NHSFT	102	-932	-1,034	0	-1,034	-1,034	-1,034
University Hospitals B'ham NHSFT	-1,888	-142	1,745	0	0	0	0
B'ham and Solihull CCG	0	756	756	0	0	0	0
System Total	**-2,544**	**2,703**	**5,247**	**0**	**-1,400**	**-1,400**	**-640**

System cash position:

As at month 5, the system cash position was £418m, a £20m improvement since the start of the year and a £45m increase in month, mainly attributable to UHB receipt of new PDC capital funding in August 2021.

Provider Cash	Opening Cash	M2	M3	M4	M5	Monthly Movement	YTD Movement
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
System Total	**398,265**	**388,979**	**380,543**	**373,570**	**418,030**	**44,460**	**19,765**

System capital performance:

The month 5 year to date system capital position was £27m underspend against the total capital programme and £14.5m underspend against the system CDEL target. The system is still forecasting breakeven against the capital envelope with the exception of a £9m overspend in respect of enabling works at UHB to support elective capacity and winter preparedness. This has been put forward as part of a priority list for funding from the recently announced capital fund available as part of the H2 funding settlement.

System Capital position	Year to Date Variance	Forecast Variance
	£'000	£'000
CDEL	14,530	-8,807
Total Programme	26,817	-9,044

Please note, system financial reporting is one month in arrears

H2 Planning

The 2021/22 operational planning guidance and system envelopes for H2 (October 2021 to March 2022) were published on 30 September 2021.

There will be a soft close for H1 meaning that the system position will be carried forward into H2, with a requirement that systems break even for the full twelve month period.

Key H2 planning timelines:

System submission due 16 November 2021, this will cover:

- Activity and performance
- Workforce
- Narrative
- System financial position

Provider submission due 25 November 2021

- Organisation financial plan submission (must reconcile to system submission).

System H2 Envelope

The BSOL system H2 envelope is £1.2 billion.

H2 System Envelope	£'m
Allocation	1,041.9
Top up	49.6
Covid	79.4
Growth	24.0
Total envelope	1,195.0
MH SDF	7.6
Other SDF	16.7
Total SDF	24.2
Total system allocation including SDF	**1,219.3**

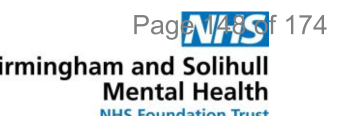
The £1.2 billion H2 system envelope is an increase of £23m compared to the H1 envelope, of which £16m relates to pay award back pay. The key changes are summarised below:

	H2 envelope increase £'m
o Growth funding on Core Contract and system allocations	13.6
o Contribution to H2 pay uplift re LA and HEE income	1.3
o Capacity Funding	9.0
o Reduction in COVID funding	-4.8
o Additional System efficiency linked to distance from target	-10.5
o Reduction of support for Provider income loss by 25%	-1.3
Total H2 specific envelope increase	**7.3**
Total funding for H1 backpay	**16.0**
Total H1 to H2 system envelope increase	**23.3**

Work has commenced to ensure that we are aligned across the system in terms of planning assumptions. System CFOs met on 13 October 2021 to review proposals for distribution of the H2 envelope increase. Detailed analysis is now being undertaken to assess the impact of the H2 settlement.

Efficiency

Given the additional efficiency requirement for H2, it is essential that progress on the four key efficiency schemes is expedited. The September Sustainability Board agenda was focussed on a detailed review of the four schemes: Transport, Rehabilitation, Temporary Staffing and E-rostering. CQEIAs and deliverables have been developed, key milestones are now being worked up.



Summerhill Services Limited (SSL) Business Report

April 2021–September 2021

This report summarises the performance of SSL from April 2021 to September 2021.

Once again during this period COVID support continued to be an important part of SSL services to the Trust and wider Birmingham health system. SSL supported over 22 COVID vaccine sites across Birmingham, managed and delivered all Trust PPE requirements, as well as operating 4 mobile vaccination vehicles.

During this period, SSL continued to work and support the Trust in the production of the Strategic Outline Business Cases for Reaside and Highcroft, these should be completed by early 2022. SSL is on schedule with the plan to complete the physical environmental works associated with the replacement of compliant anti-ligature doorsets with new anti-ligature doorsets incorporating alarm monitoring over the next 17 months.

Pharmacy services continue to improve and develop which can be demonstrated by the recent key performance indicators which details the pharmacy performance to the community teams. Due to COVID our planned trial of a pharmacy and drug service with a local nursing home has been put on hold until restrictions are lifted and pressures on the services reduce.

SSL has been awarded a 3 year contract from the BSOL CCG to provide Estates and Facilities to over 250 GP and Primary Care sites across. This contract will enable SSL to further support the wider health system and utilities our experience and expertise for a new range of clients.

SSL continues to look for new opportunities internally and externally with the wider healthcare system through the STP / ICS, which can deliver improved performance and service quality, increase revenue and provide financial benefits to the Trust and our healthcare partners.

Finally, SSL has implemented across the company our new brand image and logo. New staff uniforms have been ordered and will hopefully be implemented in December

The report details a financial overview, COVID Support, HR assurance and the performance and activities of the services provided by SSL to BSMHFT and Primary Care. The key services include:

- Facilities Management
- Property Services & Sustainability
- Transport and Logistics Services
- Capital Projects
- PFI Management
- Pharmacy Services

COVID 19

SSL continues work in partnership with the Trust supporting on all COVID related items such as PPE, Lateral Flow tests items, deep cleans, operational FM support and management of isolated clinical areas, canteen opening (with appropriate Risk Assessments), screens/ signage and vehicular cleanliness/ RA supporting in particular NEPT. These services were aimed to support the continued delivery of quality care for the Trusts Service Users.

Whilst adapting to support on COVID related matters the SSL team have also had staff and contractors who have had COVID positive issues, we have used Business Continuity plans however to continue to deliver the daily services for all inpatients for food, laundry and linen, transportation, environment management inc Estates, etc. and the management of the PFI Supply Chain FM Services through two different PFI Contracts.

- SSL supported the CCG and the Birmingham Health System to develop:
    - Primary Care Red Sites providing A&E referral and GP services.
    - 22 PCN COVID Vaccine sites including external shelters, generators and additional furniture
    - SSL are providing 24/7 call and weekly maintenance.
    - SSL has commissioned OCS Security to provide security services to the PCN COVID Vaccine Site network.

Facilities Management

- Laundry and Linen
    - We have experienced significant supplier issues following the take over of our existing supplier by another company called Ellis–
    - We have issued a 2nd Termination letter issued to supplier after additional KPI failures.
    - Review meetings continue to be held weekly with supplier, action plan is discussed and reviewed in detail.
    - SSL are exploring alternative laundry and linen providers.
    - SSL are confident that all linen and laundry meet the quality standards set out in the Services Specification.
- New National Heathcare Cleanliness Standards – SSL are looking at “Trial sites” through October 2021 to implement the new cleaning standards and ascertain if any variation in staffing is required, we shall use a secure, PFI and community site.
- New upgraded CAFM (computer aided facilities management):
  We are now utilising version 26.1 of Archibus which gives us tablet functionality and bespoke reporting capabilities. – Tablets will be rolled out October 2021 to test trade team members, Trust managers will be enabled to track and manage jobs requested.

Cleanliness Scores as @ Sept 2021

<table>
<tr><th>Sites Audited September 2021</th><th>LOCALITY</th><th>NORTH PFI LOCALITY BUILDINGS</th><th>BNHP LOCALITY BUILDINGS (Barberry, Oleaster & Zinnia)</th><th>COMMUNITY SITES Dan Mooney House, David Bromley House, Hertford House, Maple Leaf Centre Juniper</th><th>FORENSIC SITES Tamarind Ardenleigh Reaside</th><th>Corporate Buildings B1 Uffculme</th></tr>
<tr><td rowspan="2"><table><tr><th></th><th>September
%</th></tr><tr><td>Barberry</td><td>91.98%</td></tr><tr><td>George Ward</td><td>99.57%</td></tr><tr><td>Grove Avenue</td><td>97.36%</td></tr><tr><td>Hertford House</td><td>98.57%</td></tr><tr><td>Little Bromwich</td><td>98.35%</td></tr><tr><td>Lyndon Clinic</td><td>98.46%</td></tr><tr><td>Maple Leaf Drive</td><td>98.76%</td></tr><tr><td>Mary Seacole House</td><td>98.89%</td></tr><tr><td>Oleaster</td><td>96.33%</td></tr><tr><td>Reaside</td><td>98.57%</td></tr><tr><td>Reservoir Court</td><td>98.04%</td></tr></table></td><td>September 2021 Trust Score</td><td colspan="5">98.28%</td></tr>
<tr><td>September 2021 Individual Localities</td><td>98.76%</td><td>93.92%</td><td>98.17%</td><td>98.61%</td><td>No Audits Undertaken</td></tr>
</table>

Corporate, Property and Sustainability

- SSL supports the Trust in completing and returning numerous returns over the period including; PAM, ERIC, Capital Programmes annual and 5 year programme, Trust Fleet, Sustainability and Disposals. All submission have been completed on time to NHSI/E
- SSL have completed the first online draft iteration of the new online NHS Premise Assurance Model (PAM) – 400+ self-assessment questions required annually.
- SSL have produced a Trust Property Report separate document to challenge in particular on vacant buildings within BSMHFT.
- SSL developed and issued Sustainable Development Strategy and Action Plan on behalf of BSMHFT
- SSL have developed B1 Options proposals and are seeking to appoint Management Surveyors to carry out multi-million vacation negotiations, looking for Trust early exit from their lease obligations.

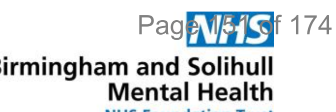
Transport & Logistics

- SSL continues to provide pick, pack and distribution of all PPE throughout the Trust, included Lateral Flow Kits from our warehouse. PPE – Stock levels regarding normal daily issue are where they need to be. Significant piece of work completed re the return of quarantined / surplus / incorrect stock as 'pushed out' to the Trust.

- The Trust has launched a PMO supported Transport review. They are to include many aspects including Hire / Loan cars, Pool cars, Taxi usage / rules / contracts / costs plus, and Secure Patient Transport (SPT). SSL is continuing to support with our "proof of concept" trial at Tamarind for a Secure Patient Transport service.
  SSL can support on the physical vehicle element and possibly even drivers but for example with SPT that SSL will not be taking any remit re the staffing / escorting and management thereof.

Capital Projects

- The 2021/22 capital plan as submitted to NHSEI on 12 April 2021, was £9.6m – this is double previous year.
- SSL has supported the Trust on the CQC required works and reports. SSL are managing the Physical Environmental works associated with the replacement of compliant anti-ligature doorsets with new anti-ligature doorsets incorporating continuous alarm monitoring over the next 17 months. The current program is valued c£6m which includes replacement of over 250 doors.
- SSL continues to support the development of the option appraisal information associated with Reaside and Highcroft and, ensures these projects remain at high level within the STP prioritised schemes.
- Additional Capital works are progressing around Ardenleigh Seclusion Suite, Newington refurbishment, Urgent Care Centre circa £2.5m, plus the SSBM programme.
- Month 6 Expenditure was in line with forecast plan.



SSL PFI/Contract Management

- Negotiations to agree Settlement Agreement have taken significant steps forward. This agreement will deliver a **six figure** settlement value.
- Oleaster Urgent Care Centre progressing well (despite issues with building materials and fuel) and is due to complete 6th December 2021.
- The SSL PFI Team was invited by PFU to act as an exemplar Trust to support and share good practice with other Mental Health NHS Trusts with PFI Projects.
- The SSL PFI Teams along with Amey were shortlisted finalists for an HSJ Award Sept 2021 (Great Ormond Street won in the end)
- Management resources effected by Amey internal HR investigation. Mitigation plans are in place. SSL in regular weekly dialogue at Director level with Amey & SPV. SSL reviewed contract, service delivery and preparing alternative delivery plans.
- New Menus previously issued to wards have been reissued with a list of what can be ordered each day, this gives the ward the ability to design their own menu within these parameters.

Outpatient Dispensing Services - April – September 2021

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 10 externally reportable incidents from 94,078 dispensed. No service users were harmed as a result of these externally reportable incidents and all of them have been dealt with promptly.
- SSL implemented a Prescription Tracker which tracks our pharmacy performance (Please see Appendix C,D & E).
- SSL robot maintained its performance and continues to deliver an accuracy of 99% on compliance aids,(see chart below):

Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sep-21
99%	99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance

There is loss after tax of £0.4m which is £0.2m better than plan as at M6. Alterations to budget have been made to reflect an adjustment to depreciation alongside recognition of a corporation tax budget within the I&E. Further adjustments will be made during the second half of the financial year to reflect both changes to external services and impact of pay award.

Income has over recovered by £1.2m which is mainly due to additional income from Birmingham & Solihull CCG for the Vaccine programme - this includes our management fee / margin.

The 5 year forecast demonstrates how SSL moves into good profitability to over £2m per yr over this period, as costs and deprecation reduces. In addition, to the profits generated, there are significant other benefits which SSL deliver to the Trust which don't appear on SSL profit and loss – these benefits also total over £2m annually, which could help to support the Trust CIP commitments. (see appendix A & B)

HR Strategy/People Plan
Staff

- SSL has now recruited their HR Team consisting, Head of HR, HR Advisor, and HR & Recruitment Co-ordinator. The Teams key focus will be the delivery of the People Strategy and Plan.
- SSL implemented a 3% pay ward across all staff groups – Agenda for Change and SSL employed staff.
- SSL has now digitalised all HR files working with Trust Files Digitisation Project team. Line manager training is being rolled out and will be completed by mid-November.
- SSL have over the last quarter, looked to enhance its employee benefits by introducing:
    - An enhanced employer pensions contribution by doubling contributions to 6%
    - Life assurance scheme
    - Medicash – Health and Wellbeing scheme
- SSL have now finalised the Band 1 to Band 2 project.
- SSL have launched their rebranding. Employee uniforms have been ordered and will be delivered in December 2021.
- SSL are also in the process of consulting with all employees concerning the organisations values. Once consultation has been concluded, SSL's values will be launched in January 2022.

Policy and Compliance

- SSL has revised our Recruitment and Selection Policy which has been launched across the organisation and reviewed by Inclusive Employers. Leaders involved in interviewing have been encouraged to take advantage and attend the Trusts training program. Training has been given to Senior Management on the policy by HR
- SSL Managers and staff who will deal with important data have received training on GDPR.

Employee Engagement (Communications)

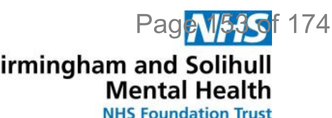
- Outbound communication to all staff has increased with communications being sent concerning benefits, pay, etc. The organisation is currently recruiting a Media and Communications Co-ordinator to develop an effective Communications Strategy moving forward.
- SSL is also reviewing how to engage with our staff more effectively and which communication channels/ media is most appropriate and effective.

Union

- Established a regular cadence of meetings with Unison and Unite. The meetings are proving to be of mutual benefit to both the Unions and the organisation and is having a positive impact on the relationship.
- Union recognition letter has gone back out to the unions for comment and feedback

Equality, Diversity & Inclusion

- SSL have engaged Inclusive Employers who have supported the SSL management to explore how we can continue to improve and embed revised processes and procedures. We will be using their services to:
    - Review and Revise our Equality Diversity and Inclusivity Statement
    - Support Equality and Diversity Policy Development
    - Challenging our equality impact assessment on all employment policies



  - Support Dignity at Work Training (General not just protected characteristics) – scope and delivery
  - Support Survey staff Development
- SSL have engaged with the Trust EDI lead to help ensure we have a consistent message across the Group and have taken their professional guidance as the Subject Matter expert

Development Benefits

STP/CCG

- Following the award of our new Primary Care contract, SSL will be working on Estates and project management support to the local Primary Care partners.
- Contract spend circa £2m/ annum, including service contract for SSL/CCG
- SSL are supporting key Primary Care projects such as
  - Bourne Road; first European Drive through GP service.
  - Dudley Park Medical Centre - New GP development requiring Investment/Joint venture to deliver Primary Care Facility for a GP practice leading a PCN.
- SSL is currently reviewing our business structure to enable SSL to be a successful ICS partner in the future ICS structure.

Internet Pharmacy & Dispensing FP10 prescriptions

- The Superintendent can confirm the Distance Selling Licence (DSL) was approved earlier in 2020.
- The DSL enables SSL to create one of the first NHS based internet pharmacies with the ability to accept FP10's from outside of the Trust.
- With the DSL, SSL can provide dispensing services to care homes, nursing homes and supported living units to generate external revenue.
- The Superintendent has a joint project with the ADHD service to reduce FP10 prescription expenditure, ADHD is considered the second highest spend area for FP10 prescriptions
- The Superintendent has further reduced FP10 expenditure in other high cost areas such as Neurology by processing these prescriptions through Summerhill
- SSL is upgrading the compliance aid robot software, which will create a hub and spoke model, allowing production of compliance aids from any location in the Trust.

Governance and Assurance

- SSL and Trust hold regular shareholders meetings to discuss strategy and business development. The last meeting was held in December which included the introduction to the new Trust Chair.
- SSL presented the external opportunities which are in development
- Both parties explored and discussed other opportunities where it was felt SSL could deliver additional value or improved performance.
- In addition, a quarterly Service Review Forum with the Trust operational team reviews current performance against agreed KPI's and discusses future operational developments.

Material Issues: There are no material issues for the Trust Board to consider.

Recommendation The Board is asked to receive and note the report.

Appendix A – Financial Statement April 21 to Sept 21

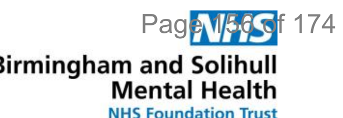
SSL Financial Position	Annual budget	M5 Budget	M5 Actuals	M5 Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	12,134	6,067	6,367	300
Lease & Long License	2,128	1,064	1,250	186
Contract Management	1,906	953	877	(76)
Facilities Services	2,567	1,284	1,355	71
Grounds and Garden	285	143	120	(23)
PPE & Warehouse	118	59	77	18
Pharmacy	2,864	1,432	1,571	139
External Services - Head of Assets	180	90	137	47
External Services - STP	95	47	26	(21)
External Services - CCG Vaccine Programme	886	886	1,431	545
Total income	23,164	12,025	13,209	1,184
Pay costs	(8,519)	(4,266)	(4,552)	(285)
Drug costs	(2,500)	(1,250)	(1,379)	(129)
Non pay costs	(6,067)	(3,470)	(4,029)	(559)
Clinical supplies costs	0	0	0	0
Total Expenditure	(17,086)	(8,986)	(9,959)	(973)
EBITDA	**6,079**	**3,039**	**3,250**	**211**
Depreciation	(3,982)	(2,133)	(2,133)	0
Interest Payable	(2,168)	(1,095)	(1,095)	0
Interest Receivable	0	0	0	0
Finance Lease	(390)	(195)	(195)	0
Profit / (Loss) before tax	**(461)**	**(384)**	**(173)**	**211**
Taxation	(384)	(192)	(192)	0
Profit / (Loss) after tax	**(845)**	**(576)**	**(365)**	**211**

Appendix B – 5 year Forecast 2021 to 2027

SSL I&E 5 Year Forecast	21/22 Forecast £000's	22/23 Forecast £000's	23/24 Forecast £000's	24/25 Forecast £000's	25/26 Forecast £000's	26/27 Forecast £000's
***Total Trading Income**	**25,694**	**26,048**	**23,747**	**24,066**	**24,390**	**24,720**
Pay Costs	(9,157)	(9,340)	(9,257)	(9,442)	(9,631)	(9,824)
Drug Costs	(2,629)	(2,645)	(2,661)	(2,676)	(2,693)	(2,709)
Non Pay Costs	(7,659)	(7,797)	(5,673)	(5,776)	(5,879)	(5,985)
Total Trading Expenditure	**(19,445)**	**(19,782)**	**(17,591)**	**(17,894)**	**(18,203)**	**(18,518)**
EBITDA	**6,249**	**6,266**	**6,157**	**6,172**	**6,187**	**6,203**
Depreciation	(3,982)	(3,037)	(2,124)	(1,944)	(1,943)	(1,940)
Interest Payable	(2,168)	(2,077)	(1,983)	(1,886)	(1,787)	(1,685)
Finance Lease	(390)	(390)	(390)	(390)	(390)	(390)
Total Capital Financing	**(6,540)**	**(5,503)**	**(4,497)**	**(4,220)**	**(4,119)**	**(4,014)**
Profit / (Loss) before Tax	**(291)**	**763**	**1,660**	**1,952**	**2,068**	**2,189**
Total Benefit to the Trust (Not in P&L)	**2,445**	**2,785**	**2,250**	**1,831**	**1,842**	**1,845**
Total Benefit after Tax	**2,154**	**3,548**	**3,909**	**3,783**	**3,910**	**4,033**

Notes:

- Forecast **does not** include any revenue from new business development opportunities.
- Forecast **does not** include any financial benefits or savings which are delivered by our PFI contracts management team.
- Capital expenditure reduced to normal levels after 2024, following the major door replacement programme.
- **No** major capital spend on New Reaside or Highcroft is included.



Appendix C: Dispensing Performance Community Teams

A RAG traffic light system to identify service performance against benchmarking:

As part of joint service development, Summerhill produces a monthly prescription report for all outpatient prescriptions to benchmark performance and improve service delivery. Below are the parameters set by the Superintendent at Summerhill Services ltd, the gold standard is 95% of prescriptions should be achieved to the required by date/time set by the team.

- **≥95% : Green Result**
  - Both the community team and pharmacy are performing to ensure all prescriptions are achieved to time

- **≥85% - <95%: Amber Result**
  - There are elements in either pharmacy or the community team which are preventing prescriptions achieving to time
  - If consecutive amber for 3 months completed an investigation of prescriptions for the current month within 10 days
  - Results shared with the community team manager by day 14
  - Agreed action plans to be generated thereafter

- **<85%: Red Result**
  - Investigation into failed prescriptions must be completed within 10 days
  - Results shared with the community team manager by day 14
  - Agreed action plans to be generated thereafter

Benchmarking Report for Outpatient Prescriptions

Compliance Aids	Achieved to date/time Aug-21	Not Achieved to Date/time Aug-21	Percentage Achieved to date/time Aug-21	Percentage Achieved to date/time Jul-21	Percentage Achieved to date/time Jun-21
Aston and Nechells Community Team	17		100%	100%	100%
Central Assertive Outreach	15		100%	93%	88%
East Assertive Outreach	22		100%	100%	96%
Handsworth AOT	25		100%	95%	100%
Kingstanding & Erdington CMHT	19	1	95%	95%	100%
Ladywood & Handsworth CMHT	17	2	89%	100%	97%
Longbridge CMHT	29	1	97%	100%	100%
Lyndon CMHT	22		100%	100%	100%
Newington CMHT	5		100%	100%	95%
Newbridge clinic	19		100%	94%	100%
North Assertive Outreach	29		100%	100%	89%
Reaside Community	32		100%	100%	97%
Riverside CMHT	1		100%		
Small Heath CMHT	3		100%	100%	
Solihull Assertive Outreach Team	14	1	93%	100%	100%
South Assertive Outreach Team	22		100%	96%	95%
Solihull Early Intervention Service	7		100%	100%	100%
Sutton Coldfield Community Team	5		100%	100%	100%
Warstock Lane CMHT	26	1	96%	94%	91%
Yewcroft CMHT's	12	2	86%	100%	100%
Zinnia CMHT'S	34		100%	98%	98%
Grand Total	**375**	**8**	**98%**	**98%**	**97%**

Benchmarking Report for Compliance aids

Team	Achieved to date/time Aug-21	Not Achieved to date/time Aug-21	Percentage Achieved to date/time Aug-21	Percentage Achieved to date/time Jul-21	Percentage Achieved to date/time Jun-21
West Hub Older Adults	5		100%	100%	100%
The Homeless Team	7		100%	100%	100%
South Hub Older Adults	2		100%	100%	100%
East Hub Older Adults	4		100%	100%	100%
Riverside CMHT	19	3	86%	100%	100%
North Hub Older Adults	7		100%	100%	100%
Aston and Nechells CMHT	108	2	98%	98%	99%
Lyndon CMHT	62		100%	99%	99%
Reaside Community	95	2	98%	97%	98%
Newbridge Clinic	178		100%	97%	100%
Warstock Lane CMHT	95	6	94%	96%	98%
Newington CMHT	38		93%	100%	98%
Solihull Assertive Outreach Team	39	3	93%	96%	90%
Solihull Early Intervention Service	89	3	97%	90%	93%
Longbridge CMHT	117	5	96%	100%	99%
Handsworth AOT	54	2	96%	98%	95%
Yewcroft CMHT's	82	3	96%	96%	99%
Kingstanding & Erdington CMHT	172	7	96%	95%	96%
Central Assertive Outreach	69	2	97%	98%	95%
East Assertive Outreach	40	2	95%	98%	98%
Ladywood & Handsworth CMHT	84	1	99%	100%	99%
North Assertive Outreach	59	1	98%	98%	93%
Small Heath CMHT	27	3	90%	97%	95%
South Assertive Outreach Team	29		100%	100%	97%
Zinnia CMHT'S	172	1	99%	98%	98%
Sutton Coldfield CMHT	48	1	98%	92%	94%
Wilson Lodge	6		100%	100%	100%
MHSOP Solihull Hub	7		100%		100%
Barberry Neuro EEG	1		100%		
Grand Total	**1715**	**50**	**97%**	**97%**	**97%**

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	14
Paper title	WEST MIDLANDS MENTAL HEALTH,, LEARNING DISABILITIES AND AUTISM PROVIDER COLLABORATIVE
Date	27th October 2021
Author	Patrick Nyarumbu
Executive sponsor	Patrick Nyarumbu

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

Executive summary

The report is to provide an update on the West Midlands Mental Health, Learning Disabilities and Autism Provider Collaborative which is a collective voice of NHS Trusts across our region, collaborating in the interests of ensuring safe, high quality mental health, learning disability and autism services with equitable access. The intention is that the collaborative is in a strong position by April 2022 to fully deploy the work of our regional Provider Collaborative in the new system, post legislation. Our Collaborative will work on behalf of the constituent ICS' to deliver transformation at scale, tackle inequalities and provide a vehicle to drive up quality of services.

Reason for consideration

It is recommended that partner Boards of the West Midlands Mental Health, Learning Disabilities and Autism Provider Collaborative support the ongoing development of the Collaborative, including the determination of the most appropriate form and governance to meet the shared objectives of the Collaborative.

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

WEST MIDLANDS MENTAL HEALTH, LEARNING DISABILITIES AND AUTISM PROVIDER COLLABORATIVE

1. INTRODUCTION

As the NHS begins to move out of the COVID-19 pandemic we anticipate a significant impact on Mental Health (MH), Learning Disabilities and Autism (LDA) services, including through the reemergence of service users who have delayed or deferred their care during the last 15 months. This will place real strain on an already pressurised workforce and require Trusts to find ways of working smarter to deliver high quality and timely care.

Equally, we are moving towards a new reformed system of integrated health and care, underpinned by new legislation and the creation of statutory ICSs. NHSE/I's 'Working together at scale: Guidance on Provider Collaboratives' (Aug 2021) restates the direction that all Trusts providing mental health services are expected to be part of one or more Provider Collaborative by April 2022, with partners across these arrangements working together to agree plans and deliver benefits of scale. Within Provider Collaboratives Trusts will work at scale (across multiple places and/or systems), with a shared purpose and agreed decision-making arrangements. They will collaborate in order to reduce unwarranted variation, inequality in health outcomes and in order to increase resilience and enable specialisation and consolidation where this will provide better outcomes and value.

The West Midlands Mental Health, Learning Disabilities and Autism Provider Collaborative is a collective voice of NHS Trusts across our region, collaborating in the interests of ensuring safe, high quality mental health, learning disability and autism services with equitable access. Our intention is that we are in a strong position by April 2022 to fully deploy the work of our regional Provider Collaborative in the new system, post legislation. Our Collaborative will work on behalf of the constituent ICS' to deliver transformation at scale, tackle inequalities and provide a vehicle to drive up quality of services.

Over the next few months and in line with the evolving policy guidance, our Collaborative will further develop our shared objectives and governance, including defining responsibilities and ways of working between the Collaborative, local systems and clinical networks. As we head towards the end of 2021 our intention is to confirm the intended operating model for the Collaborative, with the guiding principle of proportionate governance arrangements flowing from our shared purpose and objectives. It is not intended at this stage that our regional Collaborative will have a role in the management of the Mental Health Investment Standard (MHIS) compliant budget (non-specialised mental health commissioning budget) but will instead work collaboratively with '*local*' Mental Health Provider Collaboratives at ICS level.

2. WORK PROGRAMME

Crucial to the success of the reforms will be our ability to identify, plan and then deliver our work programme, with the consequent resources and accountability, at the optimal level in the new architecture. We will need to apply the test of 'added value' to justify why working collaboratively at any higher level than the constituent systems should take precedence and would support front line staff and place-based delivery.

The collaborative has been able to meet this test so far for key aspects of our work on the 'new models of care' that we believe can be best planned and delivered on a West Midlands basis, and this provides an excellent platform for accelerating joint working as we move forward.

New Care Models

New Care Models (under the Establishing Steady State Commissioning programme) is essentially the transfer of funding, commissioning, service redesign, quality improvement and performance oversight of specialised services from NHSE/I to Provider Collaboratives, with nominated lead providers allocated a budget for their population. These Collaboratives bring together an alliance of partners who collaborate to improve the whole pathway and reduce reliance on the most specialised services, supported by appropriate governance, contract and decision-making processes. Vanguards across the UK have shown success in repatriation of out of area patients, developing full pathway approaches, delivering financial efficiency and making investment in early intervention work.

Across the West Midlands this development has started in the three areas of Secure Care, CAMHS Tier 4 and Adult Eating Disorders.

New Care Model	Lead Provider	Go Live Date
Adult Eating Disorders	Midlands Partnership NHS FT	01 April 2021
Secure Care ('Reach Out')*	Birmingham and Solihull Mental Health NHS FT	01 October 2021
CAMHS Tier 4	Birmingham Women's and Children's NHS FT	01 April 2022 *(Clinical model is live)*

** In order to ensure an improvement in experience and outcomes for people using Learning Disabilities and Autism Secure Care services within the Reach-Out Collaborative, the West Midlands Learning Disabilities Partnership Alliance has been established, with Coventry and Warwickshire Partnership Trust the nominated Lead Partner.*

As our most established New Care Model the following summarises some of the achievements of the Adult Eating Disorders Provider Collaborative to date:

In addition to our success to date in developing the New Care Models, we believe that there is more that could be purposefully and effectively undertaken by the Collaborative by working across the regional footprint on issues that help us where we need to use scale, pool or access expertise, build resilience, and/or directly support front line staff to manage current pressures. In practice we believe

that these principles would shape our work at a West Midlands level into a number of key work tasks which would cover:

- **sharing approaches to local integrated care development** to ensure MH and LDA services are influential and positioned appropriately
- **developing a system wide standard for care and care pathways** that would allow constructively challenge and support to each other (specifically in the emerging areas of population health management, preventive care, and recovery)
- **developing and expanding the capacity and skills of the clinical workforce**, including more effective workforce planning (with specific reference to scarcity of staff in specialist areas)
- **identifying opportunities for extending the mutual aid** principle in terms of capacity deficits and short-term pressures
- **sharing best practice in tackling the key identified priorities** (starting with addressing inequalities of care, access and outcomes within our populations; and promoting staff wellbeing)
- creating a collective platform at ICS, West Midlands and national level for MH and LDA services through **representation on key boards and advocacy/campaigning for resource and influence**

We recognise that West Midlands is heterogeneous and that each Trust has its own starting point of resources, assets and interests. Therefore, we are proposing that not all our work is undertaken by all the constituent Trusts all of the time, but that we use the variable starting points to create programmes that could be universal or undertaken by groups of interested Trusts on behalf of the whole collaborative. In selecting priorities, the collaborative will ensure that their work dovetails with the planning and priority setting processes at regional level and in each of the ICSs and local Mental Health Provider Collaboratives. We recognise that the approach adopted will need to be cognisant of new emerging forms of governance and clinical collaboration, so we are proposing to design these in parallel and 'learn by doing' and with governance issues for the collaborative linked back to individual Trust Boards, ICS and place-based structures and roles. There is also an option as to whether the individual ICSs could sponsor workstreams of our Collaborative as this offers the best chance to standardise care and understand/tackle unwarranted clinical variation,

In further developing the programme of the Collaborative five key criteria would be considered - ***scale*** (the issue could be best undertaken at a West Midlands population level); ***expertise*** (the issue needed either collective expertise of the Trusts or access to specialist expertise); ***resilience*** (the issue related to scarce resources and/or workforce and so was appropriate to consider at West Midlands level); ***relevance*** to the immediate pressures facing staff; and ***feasibility*** in terms of its ability to generate a return on effort, the ability to secure the interest of a sufficient number of trusts and the consideration of any detrimental impact on business as usual (i.e. choosing to use psychologists to lead health and wellbeing strategies for wider NHS and care staff would potentially reduce their ability to deliver front line care to patients with immediate need).

At this current moment we believe that two additional areas of our work would benefit most - **addressing health inequalities** across the West Midlands and enhanced collaboration with regards to workforce, both in terms of **supporting staff health and wellbeing** and **developing our workforce for the future.**

The collaborative has developed and agreed the methodology set out in the table below to develop its programme of work. This would be applied to the consideration of any priority areas in the future and would be tested in the first two areas - reducing health inequalities and workforce (optimising staff wellbeing programmes and workforce development). This table also attempts to reflect the stages of activity that would be adopted and the approach to facilitating clinical engagement across the system:

Activity Stage	Addressing Health Inequalities	Staff - Health and Well Being / Development	Facilitating clinical engagement
Defining the Scope of the Work, applying a value adding test	- Special attention might be given to CYP - focus on MH inequalities not general inequalities - link to LTP commitments	- be clear about if this is for MH staff or all staff in the NHS or even wider staff groups - Define well being	- identify areas of high need - connect work programme to existing and recognised front line pressures - real concerns over CYP services
Horizon scanning for associated work	- National Pledges - Regional generic health inequalities programmes (in line with PPG) - link to Anchor Trust work	- link to generic staff wellbeing programmes in each ICS or Trust - link to national PPG - link to wider labour market work	- connect to clinical research and known programmes e.g., PCPsych programmes
Gathering data from each Trust and any research evidence	- precision in data requests to allow accurate comparison - may need resourcing	- HRDs to engage and link to existing WM MH Collaborative group - Consider if there are models against which to design and test the programme	- avoid new data reporting requirements if possible
Benchmarking and analysis	- differentiate between causation (e.g., access barriers v resource levels in each Trust) - Use academic centres and programmes such as the Keele work - differentiate what we are responsible for from social policy issues	- set expectations for uptake and measure uptake by cohorts and backgrounds of staff to highlight any inequalities - use an action learning approach	- use clinical input to ensure accurate interpretation of the data and not rely on statistical interpretation
Designing the service intervention to address the problem	- could be based in the work of an existing Trust - might be designed from scratch - must be co-produced	- use evidence and data to be precise about the interventions - build on service interventions underway during COVID-19 - use evidence-based models	- ensure co design with clinical input - ensure co design with users and carers - ensure co design with partner agencies and professionals
Identifying Trusts that wish to participate and positioning with ICSs/Region	- Trust participation determined by each with engagement dependent on relevance, resource levels, need	- Trust participation determined by each with engagement dependent on relevance, resource levels, need	- Whilst some Trusts may choose not to participate, they may have clinicians that have a special interest who could still be used

Activity Stage	Addressing Health Inequalities	Staff - Health and Well Being / Development	Facilitating clinical engagement
Delivering the Intervention	- would adopt a programme management approach - consistent application of a model to ensure valid learning	- would adopt a programme management approach - consistent application of a model to ensure valid learning	- need to recognise the impact of new approaches on highly pressurised front-line care - ensure there is training and support for any changes including good change management support
Evaluation and Review	- requires investment - huge opportunity to attract R&D investment	- bid to associated funding pots e.g., through AHSN and NIHR	- link evaluation into job planning and clinical audit - Develop R&D engagement across all staff
Roll out and spread of best practice, or programme close	- subject to the outcome of the work - would need adapting into each place/ICS - could have national impact	- link to national priorities and time scales for COVID-19 recovery e.g., ERF criteria	- recognise that nonparticipating clinical staff will need training and education along with a compelling business case for change
Use our findings to advocate for change in policies and resources	- highlight the impact of wider social policy issues on MH	- use data to bid for additional resource to support these programmes	- use clinical staff to advocate for changes (nb - they are very credible messengers)

One of the significant benefits of the work together at this level is the evidence it will provide the collaborative in terms of a stronger business case to influence ICS and regional spending. This will also therefore reinforce the individual Trusts' ability to be influential in their ICS, regional and national discussions on policy, priorities and resource. In order to create the best possible basis for this the Collaborative would be in a position to predict a set of common outcomes from their analysis. These would be useful in identifying the likely actions that would follow and offer the collaborative a clear agreement on how the Trusts will take forward their next steps. The table below sets out the range of findings from the analysis and the corresponding that would follow:

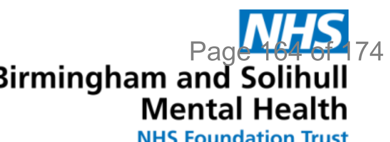
Analysis	Action	Consequence
Variability is within the gift of the Collaborative to address	Set up programmes of support for all Trusts Offer training and education to support progress	Needs a supportive culture
Variability is a result of differential resourcing policy	Identify if this is a choice of the Trusts or resources from the CCG/ICS	Agree an approach to peer reviewed performance assessment and challenge Make stronger resource case using benchmarked data and evidence

Analysis	Action	Consequence
Variability is due to workforce availability and scarcity	Seek to assess if mutual aid is possible Consider consolidation of services and sites	Would need strong governance and consultation processes
Variability is warranted	No further action	Continuing monitoring to assess best practice as it might emerge
The collaborative is underfunded against national expectations	Business case developed to regional and national bodies	Trusts establish an organised and impactful campaign

Provider collaboration is a fundamental building block of working successfully at scale and pace, and for clinically led transformation to enhance focus on population health, outcomes and innovative working. There is a strong commitment across the West Midlands, through the vehicle of the Mental Health, Learning Disabilities and Autism Provider Collaborative to work in partnership in the interests of ensuring safe, high quality mental health, learning disability and autism services with equitable access. In order to be in a strong position by April 2022 to fully deploy the work of our regional Provider Collaborative, we recognise the need for shared and dedicated capacity to progress both the development of the Collaborative itself, (including the joint governance arrangements with each ICS), as well as the programme of work. As such it is intended that a Programme Director will be engaged on a 12-month basis in the first instance, jointly funded by all partners within the Collaborative. Within the remit of this Programme Director will be to propose to the Collaborative any additional resourcing options that would add value in terms of accelerating the establishment, and impact, of the Collaborative (e.g., Programme Management Office).

3. RECOMMENDATION

It is recommended that partner Boards of the West Midlands Mental Health, Learning Disabilities and Autism Provider Collaborative support the ongoing development of the Collaborative, including the determination of the most appropriate form and governance to meet the shared objectives of the Collaborative.



Meeting	BOARD OF DIRECTORS
Agenda item	15
Paper title	CHARITABLE FUNDS COMMITTEE
Date	21 October 2021
Author	Winston Weir
Executive sponsor	Winston Weir

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

Executive summary

To provide the Board of Directors with a summary of issues and Chairs assurance relating to the remit of the Committee.

The Caring Minds charity has an action plan for the development of the presence of the Trust's Charity to staff, fundholders and service users. This action plan requires support from the Trust Board to raise the profile of the charity and in principle, pump priming funding for its action plan.

The committee noted the fund balances, the investment of these with the investment advisors and the spending/ activity of fund managers and fundraising.

Reason for consideration

To provide assurance to the Board of Directors.

Paper previous consideration

Not Applicable

Strategic objectives

Identify the strategic objectives that the paper impacts upon.
Sustainability

Financial implications

Not applicable for this report. Pump priming funding for a fund manager and support to be determined.

Risks

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

Equality impact

Not applicable for this report

Our values

Committed
Compassionate
Inclusive

REPORT FROM THE CHARITABLE FUNDS COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

The Charitable Funds Committee met on the 21 October 2021 with a summary of the key discussions being detailed below:

1.1 FUNDRAISING UPDATE

The committee heard the pandemic has had a significant impact on fundraising, performance for the last quarter has slightly improved.
A sponsored 100 mile cycle ride organised in September by Solihull based Prologis UK raised £5,500.

The committee approved the replacement service using the Just Giving platform.

Chair's assurance comments:
The progress on fundraising has been slow but important to note the activities that have been taking place in the strained context of the Health Pandemic.

1.2 FUND BALANCES AND FINANCIAL ANALYSIS

The committee were assured the fund balance remains positive at total £572k. Key highlights will be shared with the committee on a quarterly basis and Trustwide communications will be shared highlighting good news stories following approved bids.

Chair's assurance comments:
The committee noted the fund balances and the movement since the start of the financial period. There has been little movement in the receipts and spending of fund balances. The committee was assured that the funds are maintained.

1.3 CAZENOVE (SCHRODERS) UPDATE

The committee were assured the Trust is receiving value for money.
There was a detailed discussion regarding the need for further assurances on the environmental footprint on investments made by Schroders.
It was agreed they will be invited to attend the next meeting.

Chair's assurance comments:
The committee was assured that funds are invested and that the CFC are receiving a reasonable rate of return on investments held by our investment advisors.

1.4 FORWARD PLAN

The committee agreed the need to schedule an additional meeting in January 2022.

Chair's assurance comments:
More work needs to be done on a forward development plan. See Caring Minds review.

1.5 CARING MINDS REVIEW AND FUTURE

The committee noted there had been a review of Caring Minds earlier in the year in order to help the Charitable Funds Committee and Trust management decide how best to manage the Caring Minds Charity and how to maximise its potential to support patients and the Trust.All recommendations were approved, and it was agreed the Trust Board would be approached with the proposal for them to contribute towards the funding for the post.

Chair's assurance comments:

The committee confirmed the plans for the development of the Caring Minds charity and would wish pump priming support to take this Charity to the next step in respect of its vision, capacity and development.

Winston Weir
Non Executive Director
Chair of Charitable Funds Committee
24 October 2021

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	16
Paper title	BOARD ASSURANCE FRAMEWORK – Q2 UPDATE
Date	27 October 2021
Author	Company Secretariat
Executive sponsor	Executive Director of Finance

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

Introduction and context:

The Board Assurance Framework (BAF) brings together in one place all the relevant information on the risks to delivery of the Board's (Trust's) strategic objectives. Assurance is the bedrock of evidence that risk is being controlled effectively or, conversely, highlights if certain controls are ineffective or that gaps in assurance need to be addressed.

The BAF is part of the wider mechanism for managing the Trust's assurances, ultimately enshrined in the annual Statement of Internal Control.

The existing BAF has been in operation since the beginning of the 2021/22 financial year and was developed by the Board in the preceding months, in response to the new Trust Strategy. The BAF is **still an emerging document**, with work continuing to refine the relevant controls and assurances against the identified risks. The Company Secretary is confident that there will be further incremental improvements in reporting in Q3 and subsequently.

Each of the three functional Committees (FPP, People, and Quality and Safety) has a leadership responsibility for assurance against designated strategic risks. The BAF will, over the coming months, be increasingly aligned to the cycle of business for each Committee. Reports to the Board will continue quarterly, with this Report focused on a summary statement for activities during July to September 2021.

The Company Secretariat is responsible for coordinating reporting against the BAF, but it is for senior officers linked to the work of the Committees to provide the updates. This Report follows consideration of the Q2 updates at the Committees. A meeting has been scheduled for mid-November to agree what more can be done to reflect operational risks under the Clinical Services

Analysis and principal areas for consideration:

The BAF is attached for consideration by the Board. Both Q1 and Q2 updates are provided, to demonstrate progress in the previous 3 months.

Key messages are:

- The Committees are not proposing changes to any of the risk scores
- There is evidence of real progress with development of priorities for capital investment to address ligature hazards, but the plan is not yet fully defined
- The Trust needs to give continued focus to health inequalities, which have widened during the pandemic
- The uncertainty of NHS finances for H2 is a major focus for the system
- Workforce and demand challenges are highlighted as barriers to the delivery of high-quality services

Recommendations:

The Committee is asked to:

- **RECEIVE FOR DISCUSSION** the Q2 update
- **NOTE FOR ASSURANCE** the continuing work to address the Trust's strategic risks and the connection with the Committees' cycles of business
- **NOTE FOR ASSURANCE** that the Company Secretariat will work with each Committee's senior officers during Q3 to develop further controls and assurances for each risk

Strategic Priority People
Executive Owner Director of Strategy, People and Partnerships
Assurance Committee People
Risk Appetite Significant: We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive positve change.

	Risk Description	Controls	Assurances	Residual Risk Score L	Residual Risk Score C	Residual Risk Score Total	Target Risk Score L	Target Risk Score C	Target Risk Score Total	Update - Q1. 2021/22	Update - Q2. 2021/22
P1	Focus: Transforming our culture										
	The Trust fails to develop an inclusive and compassionate working environment, resulting in:			3	4	12	2	3	6	The Trust's position current position is not bad but more work is needed. The target consequence score should reduce to reflect how the risk would shift over time from a whole-Trust issue to pockets of poorer performance, i.e., it becomes an issue of scale.	The Trust has selected an organisation to provide a comprehensive, 13 month long, Senior Leadership Development programme. This will enable the Leadership Team to deliver the Trust's Five Year Strategy, including tranformation of the organisational culture to address the potential risks. Roffey Park will deliver this programme, and have a introductory and planning meeting with the Trust Executive Team on 18 Oct 21. The Trust has reviewed its Disciplinary Policy and Dignity at Work Policy, removing areas of potential bias and developing policies on the principle of Just Culture. The Freedom To Speak Up Service has been revamped during the financial year, and is making good traction in terms of overall awareness of the service, enabling staff to raise staff concerns in a confidential and safe way.
	- poorer quality patient services										
	- reduced productivity										
	- increased recruitment costs										
	- increased legal costs										
	- increased regulatory scrutiny, intervention and enforcement action										
	- increased levels of sickness absence	Integrated Dashboard (monthly)	% sickness rate								
	- unacceptable workforce retention	Integrated Dashboard (monthly) People Committee Slide Deck (quarterly)	% Employee Turnover Annual % of staff in post > 2 years Waterfall forecast report								
	- failure to attract talent	Integrated Dashboard (monthly) People Committee Slide Deck (monthly)	% of live vacant roles Time from vacancy approval to offer % of BAME staff successful in being appointed to internal roles % of BAME staff likely to be appointed into roles from shortlisting % of disabled staff successful in being appointed to internal roles % of disabled staff likely to be appointed into roles from shortlisting Workforce demand and supply waterfall (staff group and service)								
	demotivated workforce	Integrated Dashboard (monthly) People Committee Slidedeck (quarterly)	% Fundamental Training completion % Appraisal completion rates % of staff who have accessed clinical supervision in the last 12 months % of staff who have accessed leadership and management training modules in the last 12 months % of staff with a clear PDP agreed with their manager % of staff who have team related objectives % of return to work meetings undertaken within 7 days								
	absence of value-led culture										
P2	Focus: 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:			4	4	16	2	4	8	This will take time to address, and will never reach a "rare" likelihood rating. Cultural change will be protracted and a constant theme. The aim for this year, as measured by the Staff Survey, will be to reduce the likelihood score to a 3.	The Trust is in the process of embedding its values of Compassionate, Inclusive and Committed throughout the organisation. The Trust has implemented a line management and supervisor leadership development programme that is aligned to organisational values. The People and OD Team has re-organised, and integrated a Business Partnering service within the new structure. This service provides specific professional input to the organisation, and has a responsibility to promote, model, develop and influence the leadership behaviours aligned to organisational values. The Trust has invested heavily in the promotion of the NHS Staff Survey so that it is better informed of staff experiences that will inform evolving people and leadership organisational strategies. Staff Networks are well supported in terms of allocated time to Staff Network Chairs, with each having an Executive sponsor. In September 2021, the People Committee requested that the organisation develop a strategic communication plan that would involve all members of the Board. This plan will set out a clear range of communication activities, so that the Trust hears the message that its values are experienced through the leadership, management and care shown to colleagues by line managers, and that it is the expectation of all staff to display behaviours aligned to our organisational values at all times.
	- an unhealthy and poor leadership	Annual Staff Survery People committee Slide Deck (quarterly)	Staff Engagement Score Number of staff accessing: Occupational health referrals Psychology and wellbeing support Physiotherapy support Post incident support Other support from occupational health Psychological first aid support N = Health promotion and wellbeing sessions delivered N = Health promotion and wellbeing sessions attended Feedback on quarterly sessions								
	- an underperforming workforce	Integrated Dashboard (monthly)	% overall sickness rate								
	- sustained patterns of inequality and discrimination	People Committee Slide Deck (quarterly)	% of BAME staff in a role of 8A or above % of BAME staff entering disciplinary processes % of disabled staff entering formal capability processes compared to all other staff								
	- high turnover	Integrated Dashboard (monthly)	% employee turnover								
	- non-compliant behaviours	People Committee Slide Deck (quarterly)	Total number of disciplinary cases Total number of grievances Total number of dignity at work cases Total number of whistleblowing cases Total number of FTSU cases Feedback from exit interviews Employee lifecycle feedback								

	- Employee Relations cases	People Committee Slide Deck (quarterly)	Total number of disciplinary cases Total number of grievances Total number of dignity at work cases Total number of whistleblowing cases Total number of FTSU cases Feedback from exit interviews Employee lifecycle feedback								
P3	**Focus** **Communication, inclusion and wellbeing**										
	The Trust fails to engage effectively with its workforce through a dynamic, sustainable internal and external communication plan, resulting in:			4	4	16	2	3	6	As with PC1, the Committee believes that the scale of the issue will be limited and isolated in the future, meaning that a reduced consequence score is recommended. The results of the Staff Survey drive public and professional reputation and perception. Equality, Diversity and Inclusion will be a vital component of the Trust's response.	Staff engagement is a key feature of the People Strategy, corporate comms relates to the Trust's Value and Behaviours. There are active workstreams within the Trust and ICS that seek to improve the Health and Wellbeing of staff, and embed EDI within the Trust's service provision and employment practices.
	- diminished knowledge and education to make and take the right decisions	People Committee Slide Deck (quarterly)	N of development sessions attended: Schwartz rounds TRIM sessions Balint groups								
	- reduced productivity										
	- confusion										
	- fear of safety to speak up										
	- poor employer brand	People Committee Slide Deck (quarterly) Annual Staff Survey	% of Staff Friends and Family Test results % of sickness due to anxiety, stress and depression % of sickness due to musculoskeletal reasons n/10 Staff Engagement Score								
	- non-compliant behaviours										
P4	**Focus** **Modernising our people practice**										
	The Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and represent the communities served by the Trust, resulting in:			4	3	12	2	3	6	The Trust's Policies on this issue need to be clear and fully implemented. This will take time to address as recruitment from harder to reach communities, that represent the population served, is a challenge.	The Trust is participating in the NHSE/I Flex for the Future Programme, with a group of HR and Operational managers learning the principles and benefits of embedding flexible working arrangements within teams, e.g. enhaned recruitment and retention potential, less sickness absence, and a more engaged workforce. It is anticipated that this group of 6 staff will be able to help broaden this skill set throughout the Trust, through formal learning and development, or by buddying colleagues throughout the organisation. The Trust has submitted 15 staff to participate in the Elizabeth Garrett Anderson Programme. This NHS Leadership Academy programme will take this group of staff on a learning experience to increase the strategic understanding of healthcare leadership, culminating in a MSc in that discipline. The 15 participants are drawn from a broad range of divisions, and are diverse in terms of gender and ethnicity. Plans are in place to develop a Trust Talent Management and Succession Planning Strategy to ensure that all staff have recorded talent managment conversations that are subsequently linked to their development programme. The associated policy will enable the Trust to identify key posts in terms of succession planning, and to arrange the right development opportunities for staff to be able to move into these roles in a fair and transparent way.
	- a poor employer brand										
	- compensation costs										
	- unacceptable staff turnover										
	- increased regulatory scrutiny, intervention and enforcement action										
P5	**Focus** **Flexible, transformative workforce models**										
	The Trust fails to look holistically at flexible and transformative workforce models used across all services, resulting in:			3	4	12	2	4	8	The Risk Policy's thresholds for finanical consequence are driving a consequence rating of 4. Another risk that will take cultural change to address.	The Safer Staffing Sub-Committee has recently been established and reports through to the People Committee. Part of the Sub-Committee's responsiblities will be to oversee divisional workforce planning discussions, to develop transformative workforce models, utilising innovative skill mixes in the delivery of excellent patient and service user care. The ICS have agreed to develop a Talent Aqusition Hub from which elements of the new workforce models would be recruited.
	- a failure to take opportunities where positive gains are possible										
	- inefficiencies	Integrated Dashboard (quarterly) People Committee Slide Deck (quarterly)	% Bank fill rate % Agency fill rate % of rostas presented 6 weeks in advance								
	- unacceptable patient care										
	- a failure to address inequalities										
	- decreased staff retention	People Committee Slide Deck (quarterly)	Staff Experience survey (recruitment induction)								
	- missed opportunities for cost improvement										

Strategic Priorities Quality and Clinical Services
Executive Owner Executive Director of Quality and Safety (Chief Nurse)
Assurance Committee Quality and Safety Committee
Risk Appetite Open: We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.

	Risk Description	Controls	Assurances	Residual Risk Score			Target Risk Score			Update - Q1, 2021/22	Update - Q2 2021/22
				L	C	Total	L	C	Total		
QSC1	**Focus: Improving service user experience**										
	The Trust fails to co-produce with all people who use its services including their families, resulting in:			3	3	9	2	3	6	The Trust is making strides with co-production and involvement but with more still to do. Several EBEs are now active members of our QI programmes. During Q1 the co-production kitemark was awarded to our EBE QI Training Scheme and QI Branding. During Q2 we will establish a Patient Experience and Engagment Advisory Group with strong EBE membership in response to the findings of the quality governance review The use of Patient Stories will continue and be extended where possible to ensure that the voice of the service user is heard and learned from.	The People, Participation, Experience and Recovery Group (PEAR) has been established and is already driving the engagement and co-production agenda. Key developments are: - Recovery College, podcast training - EBE quality improvement advisers - Family and Carer Strategy, launched through Family Fortnight in November 2021 - Co-production in the review of therapeutic engagement policy In addition to this the involvement of EBE in QI collaboratives has been increased wit the recent addition of two EBE's An annual report will be received for patient experience and engagement, which will highlight the activities and co-production
	- a reduction in quality care	Experts by experience in QI	Patient stories at Board Complaints levels and themes PALS levels and themes Percentage of dissatisfied complainants Family and Friends Test scores National Community MH survey scores and benchmarking Postings on Patient Opinion/NHS Choices								
	- service users not being empowered										
	- services that do not reflect the needs of service users and carers	Peer Support Workers									
	- service provision that is not recovery focused	Recovery College Third sector partnership working									
	- increased regulatory scrutiny, intervention and enforcement action		CQC Caring and Safety domain ratings								
QSC2	**Focus: Preventing harm**										
	The Trust fails to focus on the reduction and prevention of patient harm, resulting in:			3	4	12	1	4	4	The aim must be to ensure, long term, that the likelihood of the risk occuring is rare.	The Trust continues to monitor and report incidents and SI's to identify emerging themes and any lessons that will reduce likelihood or harm level. Safety Huddles have been launched in Q2 and are monitored and reported against the Section 31 reporting each month. Ligature risk reduction work has been delivered including priority en-suite door alarm system fitting in seven acute wards. Work is underway led by the Chief Nurse to identify working requiring capital investments. Fuller updates on progress will be reported during Q3 The ligature reduction capital programme has developed a list of the remaining ligature risk works and their relative risk rating; the next stage is to cost this programme and build it into a 3-5 year prioritised capital works programme. QI collaboratives continue to deliver with early outcomes showing positive results in reducing key incident prevalence across participating wards for the Reducing Restrictive Practice Collaborative. The Trust has received confirmation that is has been designated as segment 3 under the new NHS System Oversight Framework.
	- variations in care	Incident Reporting Policy									
	- unwarranted incidents										
	- less safe care	Quality Improvement Programme Health and Safety Programme Ligature Risks Reduction Policy Fire Policy Quality Governance Structure Quality Improvement Collaboratives Patient Safety Collaboratives Safety Huddles MDT Working Thematic Reviews Learning Lessons Approach Serious Incident Reviews Mortality Case Note Reviews Patient Safety Specialist Role Medicines Safety Officer Role Serious Incident Report Intergrated Performance Dashboard Clinical Audit Programme	Patient Safety Advisory Grouop System Oversight Group Intergrated Quality Committee Clinical Governance Committee NRLS Benchmarking reports on harm levels and incident reporting National Confidential Inquiry Benchmarked levels for suicide and homicide National benchmarking for Restrictive Practice Environmental Risk Assessments Ligature Risk Assessment Fire Risk Assessments Security Risk Assessments								
	- increased regulatory scrutiny, intervention and enforcement action	Section 31 CQC Improvement Plan	CQC Safety Domain rating								
QSC3	**Focus: A patient safety culture**										
	The Trust fails to be a self-learning organisation that embeds patient safety culture, resulting in:			3	4	12	1	4	4	The aim must be to ensure, long term, that the likelihood of the risk occurring is rare.	The Trust is focused on a range of QI collaboratives that aim to bring staff and experts by experience together to examine existing practice and develop co-produced change. Early outcomes are showing promise. Whilst the reporting levels of incidents demonstrates an open reporting culture, there is more work to do to strengthen the sharing of lessons and embedding improvement. Two rounds of recruitment have been unsuccessful for the Freedom to Speak Up role. A solution has been sought and the team will complete by December 2021.
	- a culture where staff feel unable to speak up safely and with confidence	Freedom to Speak Up Guardian for Safe Working	Board reporting on Freedome to Speak Up								
	- variations in care	Quality Improvement Programmes System Oversight Group Learning lessons approach Learning from Excellence	National staff survey metrics for safety culture Incident reporting levels								
	- a failure to develop pathways of care within the Intergrated Care System										
	- increased regulatory scurtiny, intervention and enforcement action		CQC Well Led rating								

QSC4	**Focus** Quality Assurance										
	The Trust fails to be a self-learning organisation that embeds quality assurance, resulting in:			4	4	16	2	4	8	The use of high quality data to create intelligence and insight will be vital to an improvement in quality assurance and reduction in score for this risk.	The Trust is subject to increased surveillance from the CQC due to the section 31 requirements. The activity to gain assurance from previous regulatory driven actions has identified inconsistent achievement against them. The existing workforce and demand risks are a barrier to staff and leaders' capacity to deliver required changes in practice and process.
	- insufficient understanding and sharing of excellence in its own systems and processes	External Peer Reviews									
	- lack of awareness of the impact of sub-standard services	Learning from Excellence	Service Accreditations for quality								
	- variations in standards between services and partnerships	System oversight Group Patient Safety Bulletin Quality Improvement Programme									
	- demotivated staff										
	- increased regulatory scrutiny, intervention and enforcement action		CQC Insight Report CQC rating								
QSC5	**Focus** Leader in mental health										
	The Trust fails to lead and take accountability for the development of system-wide approaches to care, and to exploit its status and position to advocate for mental health services and service users, resulting in:			3	4	12	2	4	8	The Trust's role as system leader will develop through initiatives such as provider collaboratives. The strategy depends on greater and closer working with other providers, the third sector, and statutory agencies. This has a clear overalap with S1 and the focus on system and partnership.	The Trust has launched the Reach Out collaborative, and the Trust's leadership role in the transformation of mental health services across the system evidences the desire to participate in this area. The system rescognises the Trust's leadership role in the development of the ICS's Mental Health model. Existing workforce shortfalls and increased demand and acuity in services pose a risk to the Trust in providing high quality services.
	- inferior and poor care	Quality Improvement Programme Ligature Risk Reduction Policy Quality Governance Structure Quality Improvement Collaboratives Patient Safety Collaboratives Safety Huddles MDT working Patient Safety Advisory Group Integrated Quality Committee Clinical Governance Committee Thematic Reviews Learning Lessons Approach Patient Safety Specialist Role Integrated Performance Dashboard Clinical Audit Programme	NRLS Benchmarking reports on harm levels and incident reporting National Confidential Inquiry Benchmarked levels for suicide and homicide National benchmarking for Restrictive Practice Environmental Risk Assessments Ligature Risk Assessments								
	- detrimental impact for service users										
	- higher critical caseloads	Quality Improvement Programme Quality Governance Structure MDT working Learning Lessons Approach Mortality Case Note Reviews Serious Incident Report Intergrated Performance Dashboard Clinical Audit Programme	Caseload numbers per professional Length of time on caseload, linked to recovery focussed targets Partnership agreements								
	- missed income opportunities	Internal reports on financial position of the STP and Trust Bidding process embedded in SFIs CFO and FD system meetings influencing the system, and then the system influencing upwards	STP funding low MH share of that too low MH Investment Standard met with fair share to adult services Successful bid processes System financial target met (control total)								
	- limited brand awareness	Friends and Family Test Patient Survey Staff Survey	N = applicants for job								
	- unexploited research and innovation opportunties	Research database Annual R&I report R&I included in Annual Quality Report	No of patients recruited national research programmes No of patients recruited to local research programmes Research income (NIHR) Research income Isuppliers)								
	- breakdown in critical relationships with key partners	Stakeholder Map and Management Plan									
QSC6	**Focus** Major public health incident										
	The Trust fails to prevent and contain a major public health outbreak, resulting in:			4	5	20	2	5	10	COVID continues to demonstrate that the likelihood of this risk is weekly and that the consequence can be fatal. This drives a high residual score, even after initial controls and assurances.	Whilst the COVID pandemic continues, the Trust continues to engage in the system vaccination programme and has begun the roll-out of the staff booster vaccine. The Trust is working with all services to renew its local COVID environmental risk assessments to ensure environmental and PPE requirements are in place and site specific. The staff sickness rate related to COVID infections has reduced since the summer, and will remain closely monitored
	- death and uncompromised duty of care for staff's health and wellbeing	Business Continuity Plan Major Incident Emergency Preparedness, Resilience and Response (EPRR) Gold and Silver Command	Independent annual assessment against the 68 NHS Core Standards for EPRR								
	- fundamental breakdown of service provided for service users										

	- fundamental breakdown of the network of collaborative work with partners										reduced since the summer, and will [illegible] as Winter approaches. Wider EPRR arrangements are in place for other major incidents.
QSC7	**Focus** **Clinically effective**										
	The Trust fails to respond to service users' holistic needs, resulting in:			4	4	16	2	4	8	Parity of esteem remains a challenge. This risk links well with the advocacy role described in QSE5. The conseqence rating is driven by the implications for health and cost.	The learning from deaths group is established and feeds into governance reporting processes. The Clinical Effectiveness Advisory Group monitors the delivery of Quality Improvement collaboratives, together with the application of NICE guidance and audit. Inequalities in health existed before the pandemic but have been exacerbated through the pandemic with widening gaps in health access and outcomes. The Trust is focused on entwining equality improvement into all activity through its strategic priorities. The quality domain in the IPR will be more explicit on health inequality data, to allow IQC to scruitinse the data.
	- increased mental health and physical health morbidity	Physical Health Strategy and Policy									
	- potential increased mental and physical ill health	Learning from Deaths Policy Learning from Deaths Group Mortality Case Note Reviews	Mortality Reports to the Trust Board								
	- unacceptable patient experience	NICE compliance QSIS compliance for specialised services	Clinical Audit Programme								
	- missed opportunities for cost improvement	Clincial Effectiveness Advisory Group	GIRFT status CQUIN attainment								
	- a demotivated workforce										

Strategic Priority Sustainability
Executive Owner Executive Director Finance
Assurance Committee Finance, Performance & Productivity
Risk Appetite Finance, Governance and Environment — Open: We are willing to consider all potential delivery options and choose whilst alos providing an acceptable level of reward

Digital and Partnerships — Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

	Risk Description	Controls	Assurances	Residual Risk Score L	Residual Risk Score C	Residual Risk Score Total	Target Risk Score L	Target Risk Score C	Target Risk Score Total	Update - Q1, 2021/22	Update - Q2, 2021/22
FPP1	**Focus: System finances and partnership working**										
	The Trust fails in its responsibilities as a partner, and does not structure and resource itself properly to take advantage of new contractual mechanisms, resulting in:			4	5	20	2	5	10	The consequence would be >£2m, which delivers a consequence score of 5. Significant work is continuing to prepare the Trust for its new responsibilities as Lead Provider for Reach Out (secure care) from 1st October 2021. This will establish clear principles and a governance process that should allow the likelihood score to reduce during this finanical year.	The Trust continues to be an active participant at the highest level within the system, which has helped to attract additional capital into the Trust. Partners continue to work to understand the H2 position and the implications for the Trust. Planning guidance for 2022/23 is scheduled to be received in January 2022. The Reach Out Provider Collaborative went live on 1st October 2021, following detailed due diligence and governance development in Q2. This provides a template for future opportunities with contractual mechanisms. There is still work to be done, however.
	- an inability to support the system's medium to long term financial viability	Internal reports on financial position of the STP and Trust bidding process embedded in SFIs CFO and FD system meetings Influencing the system, and then the system influencing upwards	Mental Health investment standard met with fair share to adult services Successful bid processes System financial target met (control total)								
	- reductions in service provision as a result of insufficient funding										
	- continued inequalities in health status and outcomes										
	- inability to invest in improvement										
	- increased regulatory scrutiny, intervention, and enforcement action		CQC rating								
	- a breakdown in critical relationships with key partners										
FPP2	**Focus: Transforming with Digital**										
	The Trust fails to focus on the digital agenda and to harness the benefits of digital improvements, resulting in:			4	4	16	2	4	8	The Trust has much work to do to enable it fullly to realise the benefits of technology, although it is a Digital Exemplar. The risk consequence of 4 reflects how important technology will be to the delivery of the most effective care. This links to FPP1 as partners will need to be part of the efforts. The Board of Directors needs to own the ambition.	There is, at present, limited digital and data leadership expertise on the Board, although the Executive Director of Finance is au fait with the details. IT and information sit with the Director of Finance, and the Chief Clinical Information Officer (CCIO) reports to the medical director. The board has been involved in decisions around major new system implementations but most digital decisions are devolved. Board development sessions to develop confidence and foster understanding of risks, e.g., cybersecurity, have been held in the past, but not for some time, and a regular programme of these is indicated as part of the success measure.
	- less than optimal data security and sharing	Sustainability Strategy - Digital metrics	Digital Maturity Index								
	- not addressing cyber security threats	Digital Executive Group	GDPR Compliance - Annual Data Protection Reporting Downtime Core resolution time								
	- inefficiences and ineffectiveness in critical processes		Customer Satisfaction scores Help Desk Reporting								
	- unacceptable care for service users										
FPP3	**Focus: Caring for the environment**										
	The Trust fails to behave as a socially responsible organisation, resulting in:			2	3	6	1	3	3	The Trust performs well in this area. The challenge will come if or when the Government's targets become a statutory requirement. Aligned to FPP1, the Trust should aim to be an influencer in the system.	The Sustainability Strategy and Action Plan are at the final stages of ratification, in response to "Greener NHS" and carbon net zero. The Heat Decarbonisation Group, of which the Trust is part, has developed a draft SOC that would require massive capital invesment, but with significant revenue benefits. SSL is developing outline business case(s) to decarbonise heating.
	- poor waste management	Strategic Estates Board (ICS)	- Waste diverted from landfill (target 98%) - Electric vehicles as part of SSL fleet - 100% green renewable sources for electricity by April 2022, where directly procured by the Trust								
	- unnecessary journeys										
	- higher than necessary energy costs										
	- failure to hit zero emissions targets										
	- damage to reputation and public trust										
FPP4	**Focus: Caring for the environment**										
	The Trust fails to manage the safety and quality of its therapeutic environment, resulting in:			4	5	20	1	5	5	The consequence of weaknesses in the environment has sadly been shown to be fatal, so that domain score can only be 5. Capital expenditure will be needed to enhance physical security. The solution cannot just be a financial one, so the continuing work on relational and procedural security and mitigations must continue. The aim must be for incidents to be rare.	Regular reviews of the environment to identify ligature hazards, jointly delivered by clinical teams and SSL. Regular environmental audits are undertaken to ensure all areas are Condition B (functionally fit for use). More needs to be done to receive and act on staff and patient feedback. The Trust's response to weakness in the environment is not solely physical; there are also issues of relational and procedural security. This links to the Quality and Safety Committee.
	- increased maintenance costs	Capital Prioritisation Process	Balance of risk - safety vs quality								
	- Health and Safety Executive scrutiny	Customer Satisfaction (TBC)	PLACE scores Help Desk metrics								
	- failure to meet statutory standards	SLL Service Agreement Forum	Contract KPIs								
	- patient harm and increased untoward incidents related to the environment	Capital Programme Patient Safety Report (IQC)	Risk Assessments								
	- increased regulatory scrutiny, intervention, and enforcement action	CQC well-led and unannounced visits	CQC Rating Conditions on Licence								
	- damage to reputation and public trust										