Board of Directors (Part I)

Schedule	Wednesday 30 June 2021, 9:00 AM — 12:30 PM BST
Venue	Via Microsoft Teams
Organiser	Daniel Conway

Agenda

Agenda

Birmingham and Solihull Mental Health NHS Foundation Trust

AGENDA
BOARD OF DIRECTORS MEETING
WEDNESDAY 30th June 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

STAFF STORY – IT Team working through lockdown

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
1.	Opening Administration: Declarations of interest	*Chair*	09:30	-	-
2.	Minutes of the previous meeting held on the May 2021		09:35		Approval
3.	Matters Arising/Action Log		09:40		Assurance
4.	Chair's Report		09:45		Assurance
5.	Chief Executive's Report	*CEO*	09:50		Assurance
6.	Board Overview: Trust Values		10:05		Assurance
	QUALITY				
7.	Integrated Quality Committee Chair Report	*W. Saleem*			Assurance
8.	The Quality Account 2020/21	*S. Bloomfield*			Approval
9.	Serious Incidents Update	*S. Bloomfield*			Assurance
	PEOPLE				
10.	People Committee Chair Report	*P. Gayle*			Assurance
11.	Freedom to Speak Up Report	*S. Bloomfield*			Approval
	SUSTAINABILITY				
12.	Finance, Performance & Productivity Committee Chair Report	*R. Beale*			Assurance
13.	Integrated Performance Report – including cycle of business	*D. Tomlinson*			Assurance

ITEM	DESCRIPTION	LEAD	TIME	PAPER	PURPOSE
14.	Finance Report	*D. Tomlinson*			Assurance
15.	Highcroft and Reaside Stakeholder Engagement	*D. Tomlinson*			Assurance
	GOVERNANCE & RISK				
16.	Reach Out Governance Architecture	*D. Tomlinson*			*Approval*
17.	Questions from Governors and Public (***see procedure below***)	*Chair*			*Assurance*
18.	Any Other Business *(at the discretion of the Chair)*	*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?**	*Chair*			-
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.				
	Date & Time of Next Meeting • 09:00am • 30th July 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 or governor may ask more than one question at any meeting unless the Chair allows otherwise.

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 Chairperson may refer to the response recorded in the minutes rather than repeating the response.

1. Opening Administration: Apologies for absence: Declarations of Interest

2. Minutes of the previous meeting

Birmingham and Solihull Mental Health NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING HELD Wednesday 28TH May 2021
VIA VIDEO CONFERENCING, MICROSOFT TEAMS

PRESENT:	Ms D Oum	-	Chair
	Prof R Beale	-	Non-Executive Director
	Ms S Bloomfield	-	Interim Director of Quality & Safety *(Chief Nursing Officer)*
	Dr L Cullen	-	Non-Executive Director
	Mrs V Devlin	-	Executive Director of Operations
	Mrs R Fallon-Williams	-	Chief Executive
	Mr P Gayle	-	Non-Executive Director
	Dr H Grant	-	Executive Medical Director
	Mrs G Hunjan	-	Non-Executive Director
	Mr P Nyanrumbu	-	Director of Strategy, People & Partnerships
	Mr W Saleem	-	Non-Executive Director
	Ms J Warmington	-	Non-Executive Director
	Mr D Tomlinson	-	Executive Director of Finance

IN ATTENDANCE:

Mr D Conway	-	Deputy Company Secretary
Ms N Willetts	-	Deputy Director of Nursing

GOVERNORS OBSERVING:

Mrs M Johnson	-	Carer Governor
Mrs H Kench	-	Public Governor
Mr M Mirza	-	Service User Governor

1. SERVICE USER STORY: STAFF MEMBER

The Board received a detailed presentation from Katherine Allen (KA) who is the Trust Lead, recovery, service user, carer and family experience. Her story she shared was her experience as a service user not a member of staff. KA talked about her experience of becoming unwell as member of staff and having to access services. She felt that she wanted to share her story to support service users to talk to Board and in other arenas, so would like to personally experience it first hand, so she could support them better.

Also as part of the recovery for all strategy, her team are trying to bring about culture change so any staff member can be open about their mental health condition, should they wish to. Our recent staff survey about this shows that there is still a lot of stigma and fear of prejudice that prevents people being open. As strategy lead who has become a service user, she felt that by speaking to the Board, she would be putting out a clear message out about this.

KA said that did have concerns about talking today as she was worried about it being career limiting.

M. Johnson said she was amazed at the story and was proud to have worked with KA as part of the Lear Group. She could not believe her experience and that you kept it so quiet, whilst continued with your work in just the way you had always done.

H. Grant stated that for some reason I do not know why it was going through my mind was the song is going Super Trouper for some reason, and I you are amazing and how brave you are. I can totally empathise with you I had been in those places several times and I wish you the best with your recovery, and you are fantastic at work. The Trust are lucky to have you working with them, working with our service users doing all the things you do so well.

The Chair stated that it was important to underline the points about this not being career limited, and we absolutely need to hear if there was any sense of that. She felt that as through the insight that you had given us was only going to be beneficial for the organisation.

The CEO stated that she wanted KA to leave the meeting today, knowing that it was not career limiting for you. She was very proud to have you as a colleague and to have you doing the work that you are doing. She was also proud that even during her situation you had capacity to think about others, so you know you sent her some lovely pieces to really enjoy and keep her mental wellbeing going throughout COVID. She added that she felt that there are a few things that it would be helpful for us to have another conversation outside of the meeting.

ACTION: CEO and KA to have a 1:1 outside of the Board meeting.

M. Mirza said that he loved her compassion and did now know about what she was going through.

The Chair concluded by saying thank you for coming and sharing your story, so openly, so bravely. The Board really appreciate you putting in the work in to bring it to life for us. It will influence how we work together as a Board, and all the best for your recovery.

2. OPENING ADMINISTRATION

There were no apologies for absence.

There were no declarations of interest relevant to items on the agenda.

3. MINUTES FROM THE PREVIOUS MEETING & ACTION LOG

The minutes of the meetings held on the 28th April 2021 were approved as true and accurate records of the meetings.

4. CHAIR'S REPORT

The Chair's report providing an overview of key activities undertaken that month was received and noted by the Board.

. **5. CHIEF EXECUTIVE'S REPORT**

The Board was informed of an update on the vaccination programme in regards of service user uptake. The Trust continues to work with the system, utilising the mobile vaccination van to individuals who are less likely attend clinics.

In terms of colleague vaccinations, substantive staff are up to 76% take up overall, with 86% take up in ICCR, but only 57% in Acute Care. Next week, a process of deep dives will be undertaken to understand the barriers and best practices within services.

Previously there had been some NED and Governor challenge on the Skyguard (lone working device) uptake in terms of individuals, ensuring that they were using it. The CEO drew the Board's attention to the fact that weekly reporting was now in place, so all managers are able to monitor usage. She added that refresher training was available to all individuals.

Work around a mental health integrated care partnership continues and the Trust are expecting to be able to report something to the Board shortly. Likewise, quite significant progress had been made around Integrated Care System's (ICS) overall purpose. Work was also underway around values and behaviours associated with the ICS and what some of the governance processes might need to look like.

The Board were reminded of their sign up to the Synergy Pledge during last year. We have since been linking with others across Birmingham and Solihull and within the Trust to determine our actions to fulfil the associated commitments.

The Chair questioned whether the rise in both activity and acuity, which the Trust was seeing now was in line with our modelling of what was anticipated for this year.

The CEO stated that the levels are pretty much what was expected. The surge modelling continues in terms of thinking about what might happen and what might happen next. The expectation was always that, that we were going to be faced with a level of demand that had never been seen before with high levels of acuity that were suppressed due to lockdowns.

R. Beale queried whether, given previous significant challenges around the Flu vaccine uptake, the Trust was investigating, as many strategies as possible for addressing staff and service user concerns to ensure we have the highest possible coverage.

The CEO advised that the Trust had got to the stage that we have, which was significantly different to where we would be with the Flu uptake, by working differently and regularly questioning, what was working, what was not working. At the moment there was a very significant challenge in Acute and Urgent Care that we were not seeing elsewhere. That was why we wanted to do a deep dive to understand the perspectives from colleagues in that directorate that we had not considered.

W. Saleem questioned in regards the reducing ethnic inequalities pledge. Have many of the Trust stakeholders and partners signed up to this too.

The CEO said there are two ways that we think that we can work on the point that you made. We now have as a Birmingham and Solihull Health and Care System a real commitment to focus on inequalities, particularly around health and we know that would require the other partners to join forces. The other was that we focus on how we really get co-production, and how do we contract in a different way, particularly with community and social interest or organisations as equal partners.

The Chair concluded that she agreed in terms of the need to work in partnership on this agenda and to make sure that the frameworks and pledges that are established are actually used as touchstones to assess how the Trust are working and that, the Trust was delivering against these.

6. NON-EXECUTIVE OVERVIEW TRUST VALUES: J WARMINGTON NON-EXECUTIVE DIRECTOR

The Board received an update from J. Warmington, Non-Executive Director, on how he had seen the values of the Trust being demonstrated through the month.

J. Warmington informed the Board that she had attended the team meeting of Mr P Nyanrumbu Director of Strategy, People & Partnerships and within that meeting she had seen all of the values in action in the team meeting. One of the items on the agenda was discussing the Staff Wellbeing Strategy and how they could put interventions in places where people could access them. There was a lot of conversation about the colleagues that had recently had new children and how Acute and Urgent Care had been very impacted not only by the pandemic, but also by CQC. She added that there was so much compassion, about how they could actually support colleagues and how we can make this approach to wellbeing include, inclusive, and so much commitment from the team to try to get that right.

The Chair thanked J. Warmington and stated that this was a great set of examples of how the values can be brought to life.

7. QUALITY

7.1 Integrated Quality Committee Chair's Assurance Report

Mr Saleem presented the report from the Committee highlighting the Ligature Risk Review report. He thanked the Governance team for there hard work in pulling the report together on assessing how best to mitigate the physical ligature risk on our inpatient units. He added that IQC was assured about the robust process that was undertaken to come to the preferred option, which was to undertake a full programme of work to reduce all known ligature risks in our high risk impatient unit in this financial year and by July develop a 3 year capital programme for the rest of our estate. This was a departure from the current CQC action plan as the Trust

would not be doing all the en-suite doors, however, the meeting was assured that the CQC was comfortable with our risk based approach.

The Committee received a comprehensive report on the progress against the quality action plan for the Secure Provider Collaborative. It was provided with assurance that action plan was on track and would be delivered. An important challenge was provided on how the Collaborative will address the over representation of black men in secure accommodation and an update would be coming to the June 2021 meeting.

In regards to the CQC Section 31 Escalation and Forecast Report, the Committee was assured on the progress of the action plan, and formally agreed to the change of the action in relation to door alarms being rolled out to all inpatient ensuite doors.

The Committee were informed that the Learning from Deaths meeting should become more clinically led therefore mortality case note reviewers are now invited to attend on a regular basis. This means they can present the cases they have reviewed and provide rationale for their decisions; it also allows the Trust to work on improving the quality of reviews whilst maintaining consistency.

In regards to the Ligature Risk Review report, S. Bloomfield wanted to be clear, in terms of how the Trust manages the anchor point issue within the physical estate. It had been agreed that work will start, where our data tells us the highest clinical risk was and will continue in order of clinical risk. She added that we would need to continually monitor this, as we know risk changes and clinical risk moves in line with the needs of service users.

6.2 <u>COVID Thematic Review & Infection Control Board Assurance Framework</u>

The Board were presented with a report to fully appraise them of the relevant documents relating to Covid -19 and to give assurance that the Trust had reviewed these and ensured learning and actions have been put into place.

L. Cullen raised the capacity within the Infection Prevention Control Team, as she had previously understood that there had been an issue through the pandemic.

Control Team against the national benchmarking for infection control teams and identified the Trust were lower than most mental health trusts, using the model hospital data. So, we recruited an additional member. The plan is to again review the model to see if further recruitment was needed.

S. Bloomfield added that the Trust have challenges as a Mental Health Trust that Acute Trust do not have. The challenges are very different, but no less risk in each type of organisation. The team continually look externally, to test ourselves and challenge. They attend all manner of national and regional meetings and webinars, partly to put forward the mental health cause, but also to learn from what everyone else is doing and what the centre was recommending.

V. Devlin assured the Board that the Trust was planning for a potential 3rd wave planning and the centre control meetings continue and Road to Recovery Plan was being drawn up with IPC input.

The CEO said that there was a theme emerging around the need to ensure that the messaging from the control centres hits the right spots and is shared as wide as possible. N. Willetts agreed one of the assurance process that have been put into place was a infection control monthly audit. The Matrons will manage the process and identify a Infection Control Champion on each team and an area lead. She added that a COVID component has been included on the audit that uses a national message that 'every action counts' to make sure that some of those very fundamental things are asked directly. This will give the Trust an ability to get that feedback directly from the teams to infection control.

The Chair queried how the team was received on wards during the pandemic given that they could have been perceived as infection control Police by teams working under pressure.

N. Willetts stated that our IPC team have really good working relationships and they absolutely do not have the IPC police message. They were there as the IPC experts and to engage with the teams. For every outbreak or potential outbreak one of the team buddies up with operational area, to really understand the challenges that they had as individuals. This allowed them to really get the feel and tailor their IPC advice, rather than this very strict and rigid IPC principles.

6.3 Serious Incident Report

S. Bloomfield informed the Board that IQC will be receiving a report on how to get assurance once a root cause analysis had been completed.

7. PEOPLE

7.1 People Committee Chair's Assurance Report

The Board was informed that the Committee received the final version of the People's Strategy which had been brought here to this meeting today and the implementation plan.

The people committee now have two subgroups, these subgroups allow a wider membership of representation of staff from across the Trust.

The subgroups are fully operational, and part of their role, would be looking at specific KPIs, particularly in relation to the People Strategy, and whether the implementation plan at the KPIs was actually heading in the right direction.

These subgroups will intervene if they believe, particular KPIs are not heading in the right direction so that a further look or deep dive can be undertaken to understand what are the challenges.

The first subgroup Is Transforming our Culture and Staff Experience and included in their specific work stream is EDR II, compassion, wellbeing, safety to speak,

shared learning, evidence-based people practice, and anything to do with these agendas will be looked at in this particular subgroup.

The other subgroup is the Future Workforce Subgroup, and they will be focusing on attracting and retaining diverse talent, and all the resource work that was taking place. They would also focus on high performing workforce, agile working and digital enabled workforce and how the Trust was actually using this to modernise our people practice.

The Committee also received the workforce planning and was reasonably assured work was progressing in the right direction.

The committee received a presentation on the Culture Deep Dive Collaborative work being progressed on Newbridge House. This was one of the 10 teams who have been progressing work on Culture Deep Dive using Quality Improvement methodology. The aim of the project is to enable a better working environment which uses the skills, knowledge and experience of all of the team to provide the best care possible. The Committee were assured and encouraged by the work that had been carried out to date around team culture and embedding our values; following the reports presented and the discussion and clarity given at the committee meeting.

Further details of the annual NHS Staff Survey was provided to the Committee to provide assurance that the comments provided in the survey are being used to inform our work to make BSMHFT the best place to work.The Committee commended the progress made with regards to the slight increase in numbers of staff participating in the survey. It was felt further assurance was needed as recommendations from the staff survey were offered within the report. The Committee requested to see how these recommendations will be implanted, to provide confidence to our staff that their views have been heard and acted on.

H. Grant raised in terms of KPIs, was there a plan to understand how staff are accessing the wellbeing offers and if the issues of inequalities, do we have equity of access and was there any disparity. P. Nyanrumbu confirmed that these would be reviewed by the Committee on a quarterly basis.

7.2 Guardian of Safe Working

Dr S Muzaffar presented the Guardian Quarterly report and provided assurances of safe working hours and training opportunities for Doctors in Training. In the three months between January and March, new groups of trainees had joined the Trust. Exception reporting and role of Guardian was an active part of the induction. Trainees were encouraged from multiple fora to complete exceptions reports where exceptions arise and assured of support. The delay in resolution of exceptions will need to be resolved. A system was in place to remind individuals to complete exceptions on time but it might need to be reviewed.

G Hunjan commented that she was encouraged that more exceptions were being raised. But was concerned about the delays in getting the responses back, because that too can affect the subsequent raising of further concerns

7.3 Trust Strategy: Our Strategic Priorities and Our 2021/22 Goals

The Board was presented with the year one goals for each of the strategic priorities for approval, with associated measures of success. In recognition of reducing inequalities as 'golden thread' running through all of our strategic priorities we have also summarised all of our reducing inequalities goals for 2021/22, which had been mapped to NHS England and Improvement's Advancing Mental Health Inequalities Strategy, to bring together all of our aims for reducing inequalities into one place.

The Chair added that each of the Board Committees had an input into their relevant part of the Strategic Priorities.

D. Tomlinson felt it was important to see interconnection and linkages. In the previous ones we did this in 2017 It felt like there were very different things and they went their own route. I think it was really helpful as we go out into the organisation describe this to people why it was different and important we do it justice with the development, the implementation and delivery, because that's what it stands for falls on.

The CEO how this was a fabulous step for the Trust, in terms of being able to see in this way that it's been co-produced. More importantly was about what we do next. The strategy sets out how the assurance was going to be provided, what the goals that we are tracking for this first year are. The most important thing about this was the work that has been done in the background to get that ownership.

The Chair questioned how equality impact assessments would be part of each service design and each initiative that was involved in delivering the strategy.

The Board were informed that the Trust had really been trying to make sure that there was local ownership in how we was going to take this strategy forward, So it was not seen as a corporate document. The Trust had developed an engagement pack that will be going out to teams this week.

Some of the teams have already started to work with the draft strategic priorities and had starting to have the conversations to developing their local implementation and priorities. The engagement pack was really about people seem to have the conversations and thinking about the delivery of this strategy.

In terms of the accountability element. Several different forums ensure that we start to pull some of that information.

Decision: Trust Strategy: Our Strategic Priorities and Our 2021/22 Goals were approved by the Board.

8. SUSTAINABILITY

8.1 Finance, Performance & Productivity Committee Chair Report

R. Beale advised the Board that the Committee was assured of progress to address outstanding elements within the Reach Out Business Case. Work continues to finalise financial due diligence and validate the baseline to mitigate the associate financial costs and risks.

Risk and Gains Share model has been finalised and the formal model met by partners with the Trust being 50% accountable.

R. Beale gave the financial position and capital update, particularly on our capital spend. FPP had now endorsed the allocation of capital broadly across the major themes so that activities can commence in that part. The capital prioritisation process that was introduced last year had helped produce a lot of clarity but the committee planned to review that and see if we could come up with some learning to further improve the efficiency of the process.

8.2 Audit Committee

G. Hunjan informed the Board of the discussions at the Audit Committee on the 22nd April 2021 which included a clinical audit presentation detailing how clinical audit was undertaken within the Trust which was extremely helpful to see how the work was being aligned with the quality improvement framework to embed learning.

In relation to the internal audit report, various audits could not take place due to site visits not being available. There would be an "reasonable opinion" for the year end, however there were four outstanding audits which would be reported on at the next Audit Committee. G. Hunjan made a request to Executive colleagues that staff were able to ensure any outstanding audit recommendations were completed in a timely manner. D. Tomlinson assured the Board that there may be a potential risk on locality audits as they had not been undertaken due to the pandemic and V. Devlin would review where the audits were taking place to ensure appropriate support was allocated.

The internal audit contract had been extended for 12 months. In terms of the annual accounts, the finance team had been working extremely hard to ensure the completion of the year end of accounts. All the timescales would be met and accounts would be forwarded to the auditors and would return to the Audit Committee for approval in June. D. Tomlinson stated that formal authority was previously delegated to the Audit Committee to approve the annual accounts due to the tight deadlines associated with the submission of the Annual Report and Accounts in 2019/2020.

The Chair said that for all reports to Committees, assurance was narrative plus evidence and there was a need to avoid any sense that the Committees were accepting reassurance and not assurance.

8.2 Integrated Performance Report

The integrated performance report was received and noted and the Board were informed the out of area bed use had seen an improvement in the last month and plan to be at zero at the end of the last quarter. V. Devlin confirmed that the partnership agreement for additional beds was now completed.

H. Grant stated that the Board would also be aware that we previously have Prevent of Future Death reports around access to beds. There had been significant progress over the last number of months in the work the Trust was doing around flow and demand, so our service users can assess beds in a timely fashion.

Over the last couple months the new integrated reporting would enable drilling down into teams, . strengthening assurance through to the Board. One issue to address, was the Board/~Committee cycle. In some months that meant that work programmes were really tight, as there was little time in between the committee and the board to do anything that was required.

One of the proposals was that we look at that cycle, to make sure we have got time to do full justice to the analysis and the insight that comes through to the Committee and the Board.

The Chair stated that our role was to look at information and understand where there were gaps in assurance and make informed decisions that are going to move the services on. If the timing of meetings makes that impossible was something that we do need to take seriously, this will require making sure that people are involved in understanding the dates and the practical things about getting into people's calendar.

ACTION: A paper proposing date changes to go through ET and then to Board in June 2021.

8.3 Finance Report including Provider Collaborative: Reach-Out Update

A system-based approach was being taken to funding and planning. Birmingham and Solihull STP was issued an envelope of £1.17 billion for H1 with a requirement to submit a six month financial plan on 6 May 2021. The system plan submitted was a deficit of £28m. Included within this was BSMHFT's H1 projection of £1.6m deficit.

NHSEI have issued individual organisational control totals for H1, based on adjusted quarter 3 2020/21 actuals, with a single line entry to balance to the system financial plan. BSMHFT will take an opportunity to realign this plan in a non-mandated organisational plan submission due in the week commencing 24 May 2021.

The month 1 2021/22 consolidated Group position was a deficit of £0.3m, this is slightly better than the month 1 plan issued by NHSEI.

Month 1 Group Capital expenditure was £55k, this was in line with the plan profile as submitted to NHSEI on 12 April 2021; total capital expenditure plan was £9.6m. This was approved by Committee Chairs during April and confirmed following

discussions at IQC and FPP in May. The timeline was included in the attached report.

The Board was asked to formally confirm approval for this plan for absolute completeness.

Decision: The Board approved the proposed capital programme for 2021/22

9.1 Questions from Governors and Public

A member of the public asked: Recently the decision was made to drop a co-delivered training course which was fully funded by NHS England. This resulted in local Lived Experience facilitators who were paid £300 a day to deliver staff training to be laid off. They were replaced by an in-house training where service users have been used in an unpaid capacity to develop and facilitate the new staff training. How does the board respond to the:

a) Disrespect to Service Users KUF Trainers whose services have been dispensed of?
b) Exploitation of Service Users who have been paid £20 a day?

The CEO asked the member of the public to submit it to her in writing. Then she would get a response back to that back to them, as it was important that we do that. She added that the Board know that we would not always get things right and that we would be subject to challenge and so it was great that we are having challenge and that people are prepared to come forward and give their feedback and we cherish and invite feedback.

Another member of the public asked Recently a group of staff working on the transformative change strategy made the decision to turn down £52k worth of funding from NHS England.

a) The decision-making group convened a group that excluded LXPs to make this decision. How will you as a board ensure that this does not happen again, and that you remain committed and compassionate to our inclusion?
b) The rationale for not accepting funding was based on 'not being ready to meet funding criteria', despite having been given information about this funding and post over the last two years by an LXP. How will you as a board ensure that LXPs are part of our decision-making staff, and that there is a structure to prevent/hold to account instances where there has been dismissing, sabotaging or blocking the careers of LXPs?
c) Will the board pledge full support so that when funding is re-offered in Autumn, this will be accepted by the Trust?

The Chair advised that the role of the Board is to set the strategic direction and culture of the Board and then to seek assurance that the Trust is delivering what it needs to and has committed to do, drawing upon a range if sources including the voice of colleagues and service users. It was not the role of

the Board to approve operational level matters and so the Board would not be able to commit support for the next round of funding mentioned.

The CEO stated that she would add that as part of the written response that we share.

A member of the public stated the Trust do not have any posts for NXP beyond band 4, and we keep going on about racial equality where we do not employ people who are non-white beyond Band 8, and we don't employ people with lived experienced practitioners beyond band 4. I am mixed race, disabled, and gay. None of these staff networks support me on the NXP side, I cannot get beyond the band 4.

A member of public raised Members of the board and the organisation are accountable and liable in theory for our wellbeing. We have made you aware of some of the experiences and the impact of these, some are recorded in documents held by the trust. Do you feel liable for the harm we have experienced? If not, who is liable for these repeated experiences within the organisation?

The Chair commented colleague wellbeing is absolutely a priority for the Board, and have this running through everything that we that we say that we stand for, and we do expect to be held accountable for making sure that we set the environment where colleagues can thrive.

The CEO stated that individuals may well have already raised their concerns about this and they would be being looked at through our processes that we have got available to us. The Boardroom was not the place that we would enact those processes. So equally, there are individuals who had yet to be in a position to be able to do that. She was happy to look to try and determine how we support people to use the processes that we have to raise their concerns.

A member of the public asked LXP staff have been asking board members and senior managers to listen to and action changes that we need to ensure that we can work safely and effectively within the trust for many years, without this being done. At what point would you suggest that we stop using our valuable emotional labour doing this, and divert these conversations to external bodies that hold the trust accountable for our welfare and adequate use of resources?

The CEO commented the Trust are always sorry where we end up in a situation where our, our differences of opinion lead to people feeling unsupported and unwell, but we practically we will continue to have differences of opinion, and some of the asks that have been made, we have been in a position to agree to and some of them we are not ready to or not yet able to. She wanted to make that point really that differences of opinion, are something that we, the challenges are something that we need to work together on and we are not always going to be in a position to agree to everything that was asked, and the timing may not be quite right.

ACTION: A written response would be provided to the questions raised by colleagues during the Questions from the Public section of the meeting.

9.2 Snapshot Review of Board Performance

D. Tomlinson commented generally he found the level of questioning was much better and focused on assurance. He found the responses much more exact, and detail in providing that assurance. Additional assurance has come in from other people around the committees. I thought also the execs were coming in with questions as well which is not normally the case. He was really pleased by what came back in terms of assurance generally, in that it was not about what we know, but this is what we do, don't know and acknowledging that

There was lots of acknowledgement of that others are going through, I think that the detail was set right at the start with the staff story, and that gave us the context to always just bringing it back to our values.

He felt it was much more around assurance than reassurance and that is really what we were trying to look for going through.

10. RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC & MEMBERS OF THE PRESS

DECISION: ***It was resolved 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***.

3. Matters Arising/Action Log

Birmingham and Solihull Mental Health NHS Foundation Trust

BOARD OF DIRECTORS: ACTION LOG APRIL 2021

MONTH & AGENDA ITEM NO	TOPIC & AGREEN ACTION	LEAD	ORIGINAL TIMESCALE	RAG	COMMENT
Part II Agenda 24th February 2021	Reach-Out Final Business Case for Reach-Out to be presented to the public May Board meeting.	D. Tomlinson	May 2021		NHSE have moved implementation date to October. Update reports provided to FPP and IQC in May, final business case will now be taken to Board in August/September.
Part I Agenda Wednesday 28TH May 2021	Service User Story CEO and KA to have a 1:1 outside of the Board meeting.	R. Fallon-Williams	May 2021		Meeting took place
Part I Agenda Wednesday 28TH May 2021	Integrated Performance Report A paper proposing date changes to go through ET and then to Board in June 2021.	D. Tomlinson	June 2021		On the Agenda
Part I Agenda Wednesday 28TH May 2021	Questions from the Public A written response would be provided to the questions raised by colleagues during the Questions from the Public section of the meeting	D. Oum	June 2021		Response sent

RAG KEY

Overdue

Resolved

4. Chair's Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**4**
Paper title	**CHAIR'S REPORT**
Date	30 June 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 In our introductory meeting Munya Mwerenga, Service Manager gave an overview of work in Assertive Outreach and the drive to strengthen the connectivity with CMHT. Munya also emphasised the importance of the Trust prioritising the reduction of health inequalities.

2.2 My introductory meeting with Levi Rowe, Matron, covered the work he is leading to ensure high clinical standards. Levi also explained the increasing risks of colleagues experiencing burn out:

- increased level of exhaustion as it relates to the work environment
- increased level of cynicism, a sense of isolation from the community in the workplace
- a sense of inefficacy, feeling they're not making a difference no matter what they do
- risk of being labelled as lazy and or experiencing compassion fatigue

3. PEOPLE

3.1 I enjoyed meeting Romulus Campan, Assistant Practitioner, and having the opportunity to discuss ADHD and how the Trust can improve its support offer to staff and service users.

3.2 I had the privilege of chairing two panel discussions at the NHS Confederation conference on the issue of workforce and health inequalities.

4. QUALITY

4.1 I was pleased to be able to chair the interview panel for the Executive Director of Quality and Safety (Chief Nurse) and am very pleased to announce the successful appointment of Sarah Bloomfield.

4.2 It was my pleasure to open the memorial garden at the Uffculme Centre.

6. SUSTAINABILITY

6.1 I met with Judith Smith, of the Centre for Health and Social Care Leadership at University of Birmingham to discuss university provision for leadership development and partnership working.

7. COUNCIL OF GOVERNORS

7.1 Recruitment of Non-Executive Director
The Non-Executive Director recruitment process has commenced with shortlisting having taken place on 25 June 2021.

DANIELLE OUM
CHAIR

5. Chief Executive's Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**5**
Paper title	**CHIEF EXECUTIVE'S REPORT**
Date	30 June 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 on going. COVID-19 pandemic and our response to easement of lockdown restrictions. It also provides information on focused work of relevance to the Board. The key aim of my report is to provide the Board with an overall summary of our ongoing response to the pandemic and information on specific matters and key areas of interest for 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

At the time of writing I am pleased to report that the Trusts last recorded outbreak of COVID-19 was concluded on the 1st April and we have had no further outbreaks since this time. We continue to work as a Birmingham and Solihull system on our approach to lockdown easement, vaccination and recovery.

2. PEOPLE

Reflection / Take Time to Breath Spaces

Staff Wellbeing remains a key focus of our work. The working group is looking at how we extend our 'Take Time' spaces through a portable options, including an igloo. This is in response to reports in some service areas/sites of limited internal space to create these.

Wellbeing Conversations

The work that has been underway internally around further developing our framework for wellbeing conversations has now been paused whilst awaiting further external guidance. In July 2021 it is anticipated that HEE will be releasing an e-learning package to train managers to have wellbeing conversations and therefore this will inform any future internal work.

Mental Health Workforce Collection

The workforce planning round has been concluded and the Trust has successfully submitted two Mental Health returns:

- A provider level Mental Health workforce plan completed by individual Trusts
- A system level ICSs/STPs Mental Health workforce plan which will include workforce in Mental Health Trusts, Non-Mental Health Trusts i.e. Community, Ambulance, Acute and Primary Care and non-NHS organisations

The next stages will be to work with system partners and local managers to implement the plans and ensure that any workforce vacancies have an adequate plan to fill. It is recognised that this will involve non-traditional roles and an innovative approach.

Birmingham and Solihull ICS Bank Workforce

The Trust, as part the BSOL ICS is working in collaboration with other provider partners to develop an ICS Bank Workforce which will build on and extend the work undertaken by University Hospitals Birmingham NHS Foundation Trust in establishing, recruiting, and deploying the Covid Vaccine bank. The ICS Bank is intended to provide an additional group of staff and increase workforce capacity across the system. One of the principles of this, is that it will be distinct from existing provider banks (including our Trusts own Temporary Staffing Solutions Bank) and will not destabilise those banks, therefore enhancing current arrangements.

3. CLINICAL SERVICES

Recovery and Surge Planning

COVID-19 recovery and surge plans have been developed across all the Directorates. Plans were developed in consultation with individual teams to ensure plans are designed and implemented effectively and reflect the key issues for each service and Directorate.

Clinical activity has continued to rise during the month and acuity remains at a high level. Directorates are working collaboratively to manage pressure points and develop clinical protocols to support cross directorate interventions with service users. This includes a focus on whole pathways to support service areas where contacts and referrals are not at pre pandemic levels

Secure Care and Offender Health

Positive verbal feedback was received following the Royal Collage of Psychiatrists Quality Network visit with regards to leadership and development opportunities at Reaside/Hillis Lodge and Plans are in place to enhance the staff engagement across Reaside/ Hillis Lodge.

There has also been positive feedback from our Women's and CAMHS patients who participated in Race 4 Life and the Duke of Edinburgh Award scheme.

Acute and Urgent Care

The level of acuity across acute care has been high over the past weeks in relation to both male and female service users needing our care. Staff have worked extremely hard to ensure that service users remain safe and well cared for.

Progress continues to take place across acute care on moving to a localised bed base model. A number of engagement events have taken place with colleagues from all professions, discharge managers, matrons, home treatment team managers, bed managers and ward managers. Alongside the engagement events an eight week transition plan is well underway which supports the development of a localised bed base standing operating procedure.

The Clinical Services Manager for Urgent Care is now in post, and settling well into Urgent care, undertaking site visits and meeting team members.

Work is well underway in the Urgent Care Centre build, the noisy phase of work is now completed and the decanted South East and South West Home Treatment teams have now returned back to the Oleaster Centre.

The Crisis House pilot has been extended for a further four months; to date the intervention has seen more than 40 service users' access the crisis house. Initial feedback from service users has been extremely positive; with those using the service feeling it has supported them to avoid an acute inpatient stay.

The Integrated Birmingham Urgent Care Map is now being piloting across the system by a number of organisations including the Mental Health help line, Home Treatment Teams, Liaison Psychiatry Teams, IAPT teams and Forward Thinking Birmingham teams, use of the tool and the experiences of those using services will be collated

using a collaboratively developed user experience proforma.

The mental health hub at Heartlands hospital, along with the 'front door project' at City hospital have proved success in supporting service users attending A&E alongside the Hubs. Specialist workers have recently started in all four Psychiatric Liaison Teams to provide advice on housing, finance and other social aspects that impact on mental wellbeing.

Specialties

Suitable Clear face masks are now available and have been sourced for use in our deaf services/unit. Communication has been a key challenge for those working and receiving care within our deaf services over the course of the pandemic so this is a positive development.

All services across the directorate have completed COVID-19 recovery plans. There is currently a focus on opening up outpatient clinics and supporting more face to face contact. Required restrictions within our buildings mean there is increasing pressure to accommodate clinics and groups.

Plans are now in place to return Rosemary Suite at the Juniper Centre to its pre COVID use. Discussions will take place with staff from Monday the 21 June to ensure there is clarity on timescales. Staff have provided an exceptional service on the admission area with very low infection rates recorded over the course of the pandemic,

Our services are working collaboratively with system partners and colleagues in Integrated Community Care and Recovery (ICCR) to develop and implement community transformation plans. A key focus will be the development of an all age model and how this will be implemented across services.

Referrals to the older adult community mental health teams are increasing. This is adding to increasing waiting lists for the service which is a concern. Waiting lists are being reviewed and fixed term contracts in place to support capacity.

Directorate work to address issues related to equality, diversity and inclusion and the staff survey is progressing. A task and finish group has been established and an initial survey monkey to source staff views is due to close on the 18 June. The involvement has so far been good with 250 staff taking part. Information from the survey will help to inform directorate priorities.

A provider Improving Access to Psychological therapies (IAPT) forum has been set up to support the Birmingham and Solihull (BSoL) offer related to IAPT. The forum is supported by the IAPT national team.

Integrated Community Care & Recovery (ICCR)

Following risk assessments conducted as part of the creation of opening up plans, it has been identified that a number of areas require new furnishings that are wipeable, which are in the process of being ordered.

The ICCR senior leadership team (SLT) will be participating in their third Equality

Diversity and inclusivity (EDI) workshop on the 26 May and learning will be cascaded to teams. A bespoke EDI workshop is being created for ICCR SLT by Abdullah Mia and Stay Boghal who have run very successful and well evaluated EDI programmes that have aided a change in culture. This is planned for the autumn.

Implementation of the community transformation is underway and local Implementation groups are well represented. Posts have been advertised and relationships are being built with Primary Care Network (PCN) leads and others. Renu Bhopal - Padiar Transformation Project Lead will commence in post on the 21 June.

All teams across ICCR continue to prepare their areas for upcoming Care Quality Commission (CQC) inspections. CQC Inspectors have attended the Steps 2 Recovery (S2R) wards, Dan Mooney & David Bromley in an unannounced MHAct Review visit on the 17/18 June; we are currently awaiting feedback.

4. QUALITY

Vaccination

COVID-19 vaccination programs remain in place for both service users and and staff. Uptake of the offer from service users continues to be good. Significant increases in uptake amongst colleagues are now evident in most services, the areas where this is not the case are now subject to increased support and consideration of our approach.

5. SUSTAINABILITY

The Board will receive later in the meeting our financial report.

6. ICS PROVIDER COLLABORATIVE

The Board will later today in Part II have opportunity to consider the development of the ICS.

7. OTHER MATTERS

Executive Director of Quality and Safety (Chief Nurse)

I am pleased to publicly confirm that after two days of interviews earlier this month that Sarah Bloomfield has (subject to usual checks) been offered the role Executive Director of Quality and Safety (Chief Nurse) for Birmingham and Solihull Mental Health NHS Foundation Trust.

Sarah is a credible and transformational nurse leader with experience of operating strategically at Trust Board and executive level, ensuring that vision and strategy is translated and implemented across the organisation.
Sarah is a values driven leader with strong professional standards and expectations. She is driven by the delivery of safe, kind and effective care that supports patients and

their families and carers.

Our Academy is expanding!

Each year we host over 300 medical students from Birmingham University and this year we are hosting an extra 60 students from Aston medical school, making us one of the largest Psychiatry Teaching Academies in the UK. The extra funding generated has enabled us to employ 3 full time Clinical Teaching Fellows (CTFs) starting August 2021.

In addition, we have appointed 10 Senior Academy Tutors (SATus), to better support our students. These new post holders will help us develop innovative teaching methods such as simulation training and ensure students experience a diverse experience of psychiatry within BSMHFT. In the coming year the Academy aims to broaden our teaching staff to include nurse and expert patient educators as well as an Academy technician to support digital learning.

It is an exciting time for the Academy as we evolve into a pioneering centre of teaching excellence. This is fantastic news for BSMHFT and I'd like to thank the entire team for all their hard work in getting us to this excellent position.

8. NATIONAL ISSUES

NHS Providers- New ICS design framework offers clarity ahead of major reforms to health service but questions remain

- NHS England and NHS Improvement has published a new integrated care system (ICS) design framework, to support progression and development.
- It sets out some of the ways NHS leaders and organisations will operate with their partners in ICSs from April 2022.
- It is subject to legislation, which is expected to begin passage through Parliament before the end of summer.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

6. Board Overview: Trust Values

QUALITY

7. Integrated Quality Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**7**
Paper title	**INTEGRATED QUALITY COMMITTEE CHAIR REPORT**
Date	
Author	Waheed Saleem, Chair of IQC
Board sponsor	Waheed Saleem, Chair of IQC

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

Executive summary

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

Reason for consideration

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

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

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 IQC COMMITTEE

1. ISSUES TO HIGHLIGHT WITH THE BOARD

1.1 CQC Update

Executive Director of Quality and Safety (Chief Nurse) presented the report on the latest submission to the Care Quality Commission as part of our section 31 monitoring regime. She added that the Trust continue to provide weekly monitoring submissions in relation to the consistency and themes arising from safety huddles on our acute inpatient wards. Themes largely relate to the movement of staffing to respond to levels of acuity and seclusion activity.

Chair's assurance comments:
We received the latest response to the CQC against the action plan, which is being progressed. The Committee will continue to have oversight of the implementation of the action plan, however, as previously stated it is important that the improvements are embedded across the trust and a safety and quality culture exists in a consistent manner, and more work is needed in this regard.

1.2 Regulation 28 Prevention of Future Deaths Response

The Associate Director of Governance highlighted the response following discussions with stakeholders and internal colleagues and a copy of the response was submitted to HM Coroner on 19 May 2021. IQC was asked to note the completeness of actions will be tested and reported on in the six monthly PFD Assurance Report to the Committee.

Chair's assurance comments:
The response to the PFD from the Trust and Partners was noted and the Committee will receive an update on the actions in the 6 monthly assurance report.

1.3 Ligature Review update

IQC were informed that the Ligature Risk Review Group continues to meet weekly and the ligature adaptation work for inclusion in the 2021/22 capital review programme was now complete. The Trust are actively developing a rolling capital programme for the removal of ligature anchor points over the next 3-5 years and recommendations will be submitted to the Health and Safety Committee in September 2021.

Chair's assurance comments:
The paper provided an update on the work that is being undertaken on procedural and relational actions that are being considered to reduce ligature risks. A full report will be presented to the July committee. The Committee asked that this report includes the details on how the changes will make a difference, how they will be embedded and become part of the standard operating procedure of the trust and ensure that these are consistently implemented across the trust. It was noted that there have been numerous previous initiatives that have not had the impact envisaged and therefore robust systems and processes are required this time.

1.4 The Quality Account 2020/21

The Associate Director of Governance presented the Quality Account for the period 2020-2021. The account describes our performance against the quality goals that we set for 2020-2021 along with the goals we have agreed for delivery in 2021-22. IQC recommended the Quality Account for 2020-2021 for approval to the Board of Directors at its meeting at the end of June 202.

Chair's assurance comments:
The Committee recommended to the Board to approve the Quality Accounts 2020/21.

1.5 BAF

Andrew Hughes from AHNN Ltd who are supporting the Trust on the refresh of the BAF presented with the proposed initial and target scores for each of the risks associated to IQC and the additional 2 risks that have now been aligned to IQC.

It was agreed that a meeting would take place outside of meeting to discuss scoring and rational.

Chair's assurance comments:
The risk scoring presented required further calibration and therefore it was agreed a further meeting with the Chair, Vice Chair, DoN, MD and ADoG and AHNN is convened.

1.6 Integrated Performance Report

IQC considered the recommendations regarding monthly reporting cycles to committees and the Board, with aggregated Trust performance continuing to be reported to the current monthly cycle.

Key performance indicators and priorities for Quality were presented and discussed.

Chair's assurance comments:
The Committee noted the high level of absconsions, in particular Rockery Gardens. A detailed review was undertaken by the Local Governance Committee and Clinical Director, although no themes were identified it was a matter of concern to note and will require close attention by colleagues. The Committee was informed about a serious incident involving an informal patient. A full RCA is being undertaken. This does highlight the need to ensure robust early warning systems are in place to assess risk and support patients.

1.7 Health, Safety and Security Quarterly Report

The Associate Director of Governance highlighted to IQC an update on key health and safety activities since the last Trust Health & Safety Committee.

Chair's assurance comments:
The Committee noted that staff deaths from Covid will be classed as SI's and RCA's will be completed. We continue to be concerned about the lack of accurate data and take up of lone worker devises, the committee did not have sufficient

assurances that the policy is being adhered to and asked the Executive to revisit this. We noted that the potential additional responsibilities to the Trust as part of the Fire Safety Act, although further clarity will be required as further guidance is issued, a report will be presented to the Committee and Board if there are any implications for the Trust.

1.9 Safeguarding Six Monthly Report (Internal)

The Head of Safeguarding joined the meeting and apprised the Committee of current trends regarding safeguarding. She also presented on the Integrated Safeguarding System as an early adopter partnership.

Chair's assurance comments:
The Committee noted the key safeguarding issues and was pleased that the Trust is implementing the early adopter partnership. An update will be provided as part of the regular report on safeguarding. The Committee was concerned to note the low uptake on safeguarding training and asked the Director of Operations to take immediate action to rectify this.

1.10 Serious Incidents

The Associate Director of Governance and Head of Patient Safety presented an overview, trends and analysis of serious incidents reported during May 2021 and in quarter 4. IQC were informed of actions being taken to reduce harm and improve patient and staff experience and safety.

Chair's assurance comments:

The Committee was pleased to note the robust system and processes in place on investigation and sharing the learning from SI's. Further work is being undertaken to embed the learning across the Trust. It was agreed a joint letter from the Chair, DoN and MD to staff to acknowledge the work they have done.

8. The Quality Account 2020/21

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**TRUST BOARD OF DIRECTORS**
Agenda item	8
Paper title	**QUALITY ACCOUNT 2020-2021**
Date	June 2021
Author	Dawn Clift, Associate Director of Governance
Executive sponsor	Sarah Bloomfield, Interim Executive Director of Quality and Safety (Chief Nurse)

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

Executive summary & Recommendations:

This paper encloses our Quality Account for the period 2020-2021. The account describes our performance against the quality goals that we set for 2020-2021 along with the goals we have agreed for delivery in 2021-22.

The content of the Quality Account is prescribed by NHSE/I and includes a section of statements and declarations to be made by the Board of Directors. Please note that at the time of writing this report we have yet to receive our Head of Internal Audit Opinion. This will need to be added to the report prior to central submission to NHSE/I.

We are grateful for the stakeholder statements included in the document from the Health and Social Care Overview and Scrutiny Committee, Healthwatch Birmingham and Healthwatch Solihull, BSOL CCG and our Council of Governors.

The Foundation Trust Annual Reporting Manual for 2020-2021 confirmed that there was no requirement for auditing of the account this year due to Covid and as such the Council of Governors was not required to select an indicator to be subject to audit.

The Integrated Quality Committee considered the report at its meeting in June and agreed to make an addition to strengthen our commitment to inclusion and health inequalities in response to comments raised by Healthwatch. These additions have now been made.

The Integrated Quality Committee are recommending approval of the Quality Account for 2020-2021 to the Board of Directors, enabling central submission by the deadline of 20 June 2021.

Reason for consideration:
To enable the Board to review and approve the Quality Account for 2020-2021
Previous consideration of report by:
Working Group of the Council of Governors, June 2021 Health and Social Care Overview and Scrutiny Committee, Healthwatch Birmingham and BSOL CCG Integrated Quality Committee, June 2021
Strategic priorities (which strategic priority is the report providing assurance on)
QUALITY: Delivering the highest quality services in a safe inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve
Financial Implications *(detail any financial implications)*

Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
Equality impact assessments:
.
Engagement *(detail any engagement with staff/service users)*
Engagement in the content of the report can be demonstrated through the consultative approach to the development of the quality strategy and quality goals. Discussions with the Clinical Governance Committee, IQC and the working group of the Council of Governors.

Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY ACCOUNT REPORT

2020/2021

Contents

Quality Report

Part One

Statement on Quality from the Chief Executive

I am delighted to present our Quality Account for 2020/21. As I write this report, we are working hard to restore our services following the Covid 19 pandemic. 2020-2021 was one of the most difficult years in the history of the NHS with the outbreak of the COVID-19 virus. Firstly, I want to pay tribute to all our NHS, Care and key worker colleagues who have lost their lives, both here at Team BSMHFT and across the country, to this terrible virus. All of our staff, carers and volunteers have worked tirelessly since the outbreak and their amazing compassion, commitment and resolve has been focused on making sure that we keep everyone as safe as possible whilst maintaining the care and safety of all patients and staff. The unprecedented challenges posed by COVID-19 saw gigantic efforts made by all at Team BSMHFT and phenomenal collaborative focus of so many giving so much, above and beyond their day to day roles. I am grateful to our 4,200 strong workforce who, regardless of the challenge, strive to provide ongoing care for our patients and support to families, carers and each other as staff. The environments and context that we work within in ordinary circumstances are complex and challenging and we hugely proud of all of our staff for the valuable work that they have done in these unprecedented circumstances.

Despite the challenges of the pandemic we continued to deliver a range of quality improvements during the year to support our quality aims of:-

- Improving Patient Safety by Reducing Harm
- Focussing on a Positive Patient Experience
- Focussing on a Positive Patient Safety Culture
- Focussing on Quality Assurance
- Using our Time More Effectively

This account details the progress that we have made in delivering the above fundamentals that are the basis of our new five year Quality Strategy. It is an opportunity to reflect on the achievements that we have made and also the challenges we have encountered.

Our story of improvement whilst not without challenges is a positive one, and our commitment to further improvements is strong. During the year we had to change the way in which we worked to enable us to develop more skills and capability in our approach to quality improvement by conducting virtual training sessions with colleagues, stakeholders and with experts by experience. Many of our quality improvement projects were led virtually to ensure continued engagement, motivation and focus.

We have made good progress in delivering our goals linked to reducing harm with an average of 83% of all incidents resulting in no harm to patients compared to a national average of 62% according to the National Reporting and Learning System (NRLS).

We did experience an increase in the use of restraint in our inpatient units particularly during the first wave of Covid 19 however we have seen levels reduce again as the pandemic has eased. In March 2021 we launched our Reducing Restrictive Practice Quality Improvement Collaborative with more than 15 different projects operating in teams across the Trust to reduce restraint, seclusion and the use of rapid tranquilisation. We equally saw an increase in the number of physical assaults by patients on our staff during wave 1 and this often coincided with incidents of restraint. Since the late Summer however, we have seen levels of physical assault reduce significantly across the organisation and we are now reporting some of our lowest levels ever.

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

Our national benchmarking position for death by suicide was published in May 2021 by the University of Manchester National Confidential Inquiry into Suicide and Homicide. Latest published data tells us that 9.5 suicides per 100,000 people take place across the overall population of Birmingham and Solihull. Birmingham and Solihull has the joint 14th lowest suicide rate in England at the time of writing this report. When looking more closely at the number of suicides per 10,000 patients under our care, the latest National Patient Safety Scorecard shows that fewer patients under the care of our Trust die by suicide, compared to those seen on average in other mental health trusts across the country. Every suicide is a tragedy and we still have much improvement to make in this important area. We are working towards a zero ambition for suicide levels - and this forms a central part of aim to improve patient safety by reducing the harm to patients.

During the year, the Care Quality Commission took enforcement action against the Trust due to its concerns about ligature anchor point risks in our acute inpatient wards and also due to concerns about the quality of our care planning documentation. We have developed an improvement plan around these two areas which includes considerable investment in door alarm systems in our acute inpatient wards. Such alarms will trigger if any weight is applied to the door enabling immediate responses to be made by the clinical team. We have also revisited the way in which we develop our care plans and have developed and implemented minimum standards for multi-disciplinary team meetings. During the year we started to pilot some new approaches in some of our wards such as increased arts activities and this has proved to be a helpful aspect of therapeutic engagement for many patients. We also introduced daily safety huddles in our acute inpatient wards ensuring that teams come together regularly to review the safety of their environment and their patients in a multi professional way, enabling timely decisions to be taken in response to risk. As I write

this report, we continue to explore all other opportunities to strengthen the safety of our inpatient wards.

Our journey of recovery has moved at a great pace with the commitment and involvement of staff, patients, families, carers, governors and experts by experience. We have extended the Recovery College model to Solihull and to the North of Birmingham. 'Recovery for All' training now features on our mandatory training programme with good participation levels. The Recovery College has achieved IMPROC (Implementing Recovery through Organisational Change) accreditation and our co-production agenda is developing positively. We have established a Family and Carer Pathway Group who have overseen a number of positive developments - including the carer assessment tool, wording to be included in our complaint letters and serious incident investigation letters to families and the development of our Carers Strategy. During the year we worked closely with our Experts by Experience to co-produce our new Trust Strategy and our four strategic priorities of:-

- Quality
- Clinical Services
- People
- Sustainability

Experts by Experience awarded us the co-production kite mark in recognition of the joint approach that we took to our strategy development.

Ensuring quality for all service users is fundamentally important and this year we will take learning from a range of national reports on health inequalities in mental health so that we can ensure that we truly understand inequalities by race, gender and disability. This will enable us to work with experts by experience to co-produce improvements to their care. We would like to thank our Healthwatch Birmingham and Solihull Partners for reminding us in their stakeholder statement of the critical importance of understanding and responding to health inequalities.

As I close this introduction, I reiterate my thanks and that of the Board of Directors, to our compassionate and committed staff, our service users, families and carers, our stakeholders and our Council of Governors and look forward to continuing to tackle our challenges, build on our successes and make progress in 2021/22.

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

Roisin Fallon-Williams
Chief Executive

Background

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

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

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

What the Quality Report includes

- What we plan to do next year (2021/22), what our priorities are, and how we intend to address them.
- How we performed last year (2020/21), including where our services improved.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS trusts
- Stakeholder and external assurance statements.

Purpose and activities of our Trust

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

One vision

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

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

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

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

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

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

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

2.1 Priorities for improvement during 2021/22

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to continuous quality improvement. This section of the report describes areas for improvement in the quality of our health service provision during 2021/22. In creating our quality priorities and goals, we have considered the aspirations in the NHS Long Term Plan; NHS England's Five Year Forward View for Mental Health and NHS Improvement Planning Guidance. We have also engaged widely with our workforce and our service users and Experts by Experience to ensure that these goals will support the delivery of our Quality Strategic Priority which reflects the local needs of our service users and staff as well as national needs.

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

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

We want to ensure that our inpatients receive care in a 'safe and least restrictive environment'. Restrictive practice, including restraint and seclusion, can increase stigma, isolation and the risk of harm; it can adversely affect patients with a trauma background and it reduces the potential to 'share risk' between mental health practitioners and patients by reducing the opportunity to build trust and work collaboratively on safety planning that supports a patient's autonomy and development of coping strategies. Social isolation may actually serve to increase risk, as may having a staff member alongside a patient for a prolonged period of time when this is continually non-interactive. Increased or improved therapeutic intervention and activity may effectively reduce the need for restrictions on activity.

Evidence suggests that when incidents of violence are followed by containment measures, this can escalate to further violence. Preventative de-escalation measures are recommended here, including reducing the potential for conflict on wards, facilitating a calm, less rigid ward environment, and anticipating patients' needs and responding early to them.

During 2021/22 we will:

Preventing Harm	
Reduce levels of restrictive interventions in our inpatient units by completing year 1 of our QI Collaborative for Reducing Restrictive Practice	Measures of success:- Reduction in incidents of prone restraint Reduction in incidents of bedroom seclusion Reduction in incidents of assault on our inpatient wards
Improve the safety of our acute inpatient wards by installing ligature alarm systems on the ensuite doors and bedrooms doors of our highest risk acute inpatient wards	Measure of success:- Reduced level of ligature incidents utlising an anchor point which result in moderate, severe or catastrophic harm to patients
Scale up and spread Safety Huddles across all wards in the Trust	Measure of Success:- Reduced level of harm attributable to patients and staff through incidents
To improve the physical health monitoring of patients in our care	Measures of Success:- ensure relevant blood tests and ECGs

	are performed prior to initiation of anti-psychotic medication in all inpatient settings (to increase this by 100% over a three-year period) ensure relevant blood tests and ECGS are performed for outpatients prior to the initiation of antipsychotic medication and annually thereafter for outpatients prescribed clozapine or depot antipsychotic medication (including Home Treatment Teams) , increasing to 100% service users being offered this by the end of three years To ensure all episodes of Rapid Tranquilisation (RT) have appropriate physical health recording (as set out in the RT policy) by the end of the first year To ensure that all inpatients have the physical health assessment and systemic enquiry checks completed within 24 hours of admission by the end of the first year
To reduce the number of deaths of patients due to alcohol and substance misuse who are in our care	To increase the completion of the alcohol screening tool in our Home Treatment Teams with evidence of appropriate intervention against the March 2021 baseline level

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

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

During 2021/22 we will:-

Improving Patient Experience	
Improve the involvement of service users in MDT meetings and ensure that	Measures of success:-

all service users have a copy of their care plan	% of service users attending their weekly MDT % of service users in receipt of their care plan Qualitative measure to be established through EBE group and reporting to commence against this measure from January 2022
Improve the involvement of carers in service user care and recovery	Measures of success:- % of carers registered on RIO % of carers with a completed carer engagement tool
Pilot the role of Patient Safety Partner in patient safety and patient experience aspects of governance meetings to ensure that service users have equal voice around the table	Measures of success Number of patient safety partner roles established Feedback from patient safety partners on their experience

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

The link between workforce capacity, capability and safety has many factors, but workforce challenges clearly create pressures on the system. We must also recognise the importance of staff wellbeing to ensure a safe environment. This is becoming more and more important as we experience a significant increase in mental illness across our society which puts pressure on the services we provide. Many of our staff operate in a high risk environment and in the course of day-to-day work they could face traumatic or potentially traumatic situations. We want all of us to work in a way that keeps everyone safe. For this to happen we need to ensure that we treat each other equitably, well and have good working conditions.
During 2020/21 we will:

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

Strengthen the approach to confidence in incident reporting and learning from incidents resulting in an improved safety culture	Measures of Success:- Improvement in safety culture metrics in the national staff survey relating to incident reporting and learning from incidents

Priority for Improvement 4: A Focus on Quality Assurance

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

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

We will measure our success through improvements in the National Staff Survey metrics relating to the ‘Ability to Contribute to Improvements’ metric; the ‘Quality of Care’ metric and improvement in ratings awarded by the CQC.

During 2021/22 we will:

Improving Quality Assurance	
Pilot, evaluate and roll out an internal quality assurance peer review scheme across the Trust involving staff and experts by experience	Measures of success:- Number of peer review visits completed Improvement in national staff survey metrics relating to the ‘Ability to Contribute to Improvements’

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

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

By 2025:
We will have significantly reduced the amount of unwarranted variation, allowing us to focus on ensuring the right care and support is delivered for everyone at a consistently high standard. Unwarranted variation can be a sign of waste, missed opportunity and poor quality and can adversely affect outcomes, experience and resources.

During 2021/22 we will:

Using our Time More Effectively	
Implement a Community Care Planning Tool incorporating an outcome measure within our Community Services as an approach to improve the therapeutic effectiveness of service user interactions with our clinicians	Measures of success:- Clinical outcomes associated with service user satisfaction levels with life domains and treatment aspects of their care

2.1.2 Monitoring, Measuring and Reporting Progress on the Priorities

Monitoring measuring and reporting progress on the above priorities will take place through a quarterly report to the Integrated Quality Committee at Birmingham and Solihull Mental Health NHS Foundation Trust. Such reporting will include reference to relevant outcome measures reported through the National Mental Health Community Patient Survey which is published annually and also the Annual NHS Staff Survey. In addition, we will monitor our performance against a range of key indicators such as restraint levels, suicide levels, incidents of self harm and incidents of physical assault through a monthly integrated performance dashboard that is presented to our Trust Board meeting in public each month. In addition, we will develop our reporting around health inequalities in the delivery of health care by including quantitative and qualitative information about the clinical outcomes and the experience of different racial communities, those with disabilities and differing sexual orientations.

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

Priority for Improvement 1: Improve Patient Safety by Reducing Harm

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

- Incident reporting levels (an increased level of incident reporting demonstrates a positive safety awareness culture)
- The level of harm that came to patients from incidents that happened whilst they were in our care (a lower level of harm is good)
- The level of restrictive practice that occurred in our inpatient wards, particularly prone restraint and physical restraint (a lower level is good)
- The level of physical assault that took place on our inpatient wards (a lower level is good)
- The number of suspected and confirmed suicide levels and our nationally benchmarked position according to the National Confidential Inquiry Annual Report (a lower level is good)

We routinely report and review the levels of harm that come to patients from incidents that can occur during their care. We report these levels on a monthly basis to a range of forums within our governance structure including our Patient Safety Advisory Group, Our Integrated Quality Committee and our Trust Board.

During 20201-2021 incident reporting levels increased. This was in part influenced by Covid 19 and the associated level of Covid19 patients we were caring for and the risk of transmission of Covid19 in our working environment. Whilst we saw levels of harm increase in the stages of wave 1, these dramatically reduced from September 2020 and have remained at circa 17% since this time. This means that in 83% of incidents reported no harm came to our patients. National benchmarking levels published by the National Reporting and Learning System known as NRLS demonstrate that we have lower levels of harm arising from incidents than the national average of 39%. Levels of incident reporting and associated levels of harm are shown below in figures 1 and 2:-

Figure 1 – General Incident Reporting Levels

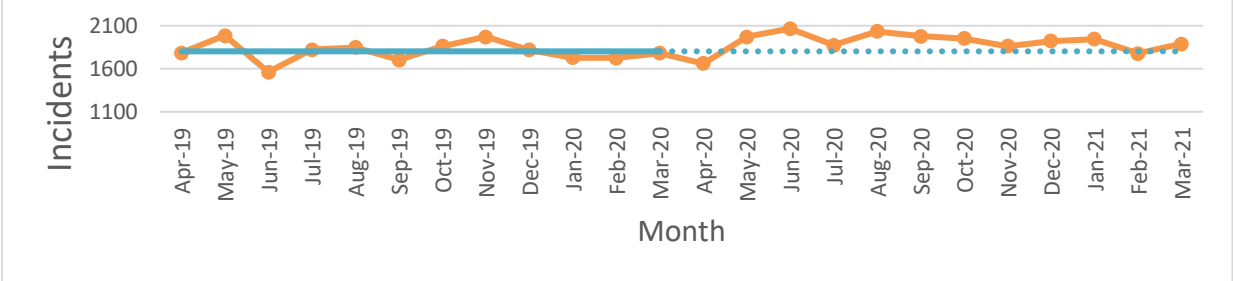
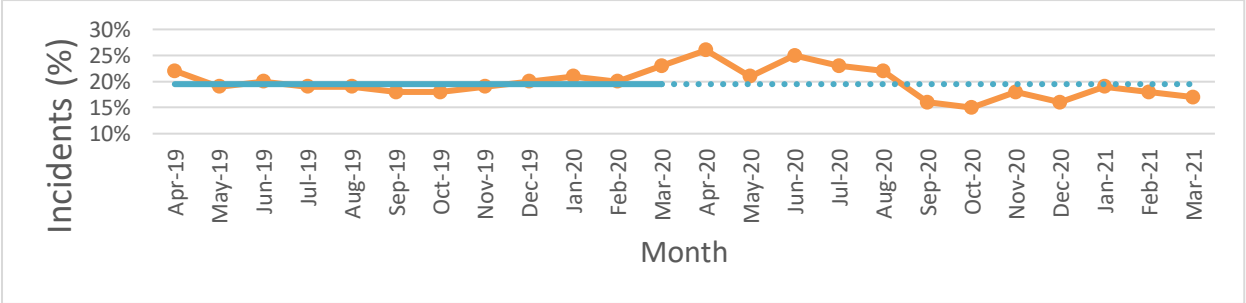


Figure 2 - %of incidents resulting in harm to patients

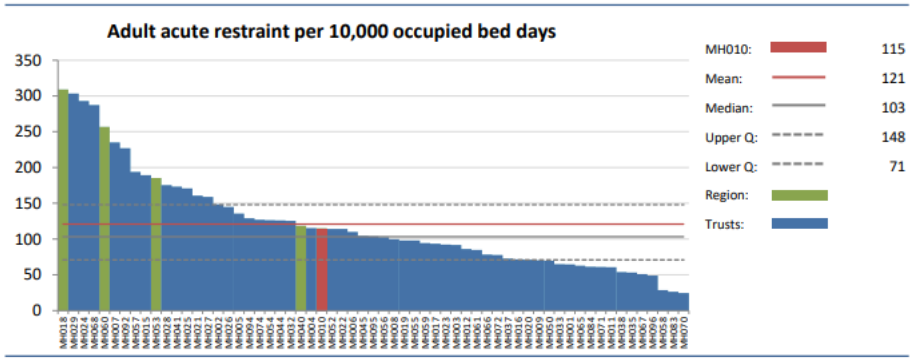


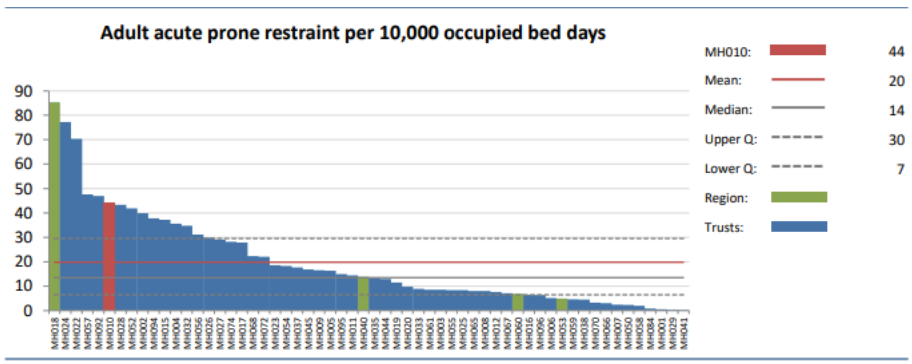
The level of restrictive practice that occurred in our inpatient wards, particularly prone restraint and physical restraint (a lower level is good)

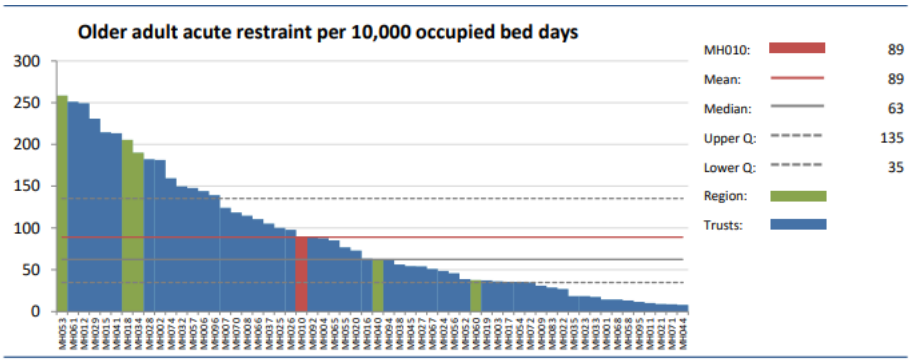
During 2020/21 we:

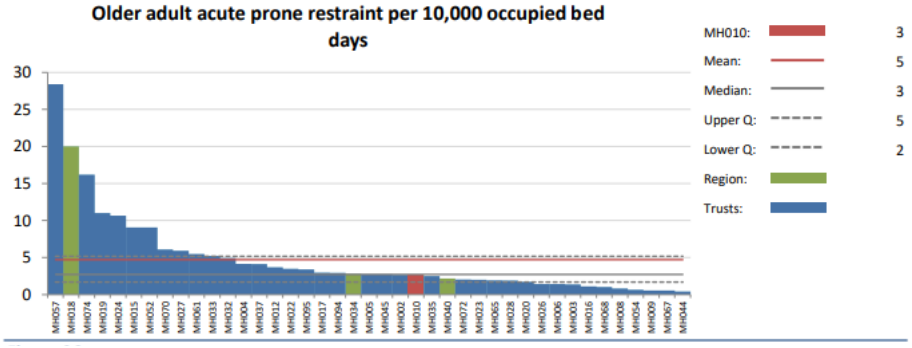
- Established our Quality Improvement Collaborative aimed at reducing levels of restraint and reducing levels of violence and aggression within on our inpatient wards. The programme has been designed in collaboration with experts and experts by experience, with the aim to support wards to carry out quality improvement through regular learning days and dedicated support from the BSMHFT Quality Improvement Team. This is being achieved by providing the tools and resources for selected teams to develop their own quality improvement plans. There are currently 18 projects registered as part of the Collaborative which launched in March 2021. Experts by Experience form a core part of the Collaborative. We had planned to launch the collaborative earlier in the year however this had to be re-planned due to the focus we needed to give to managing the Covid 19 pandemic.

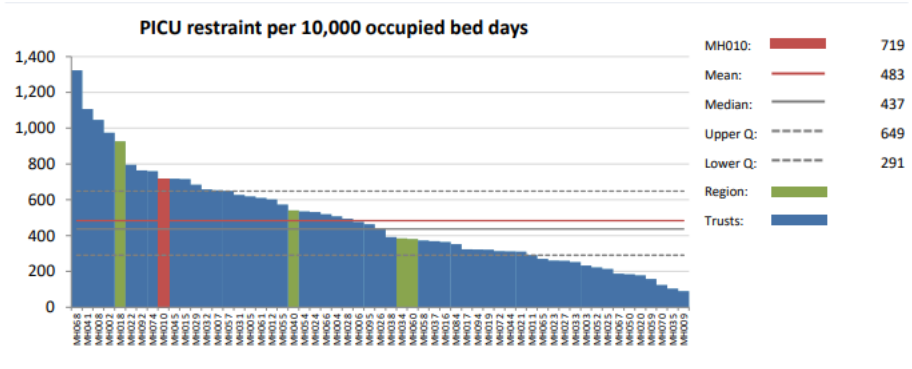
  During the year we did receive national benchmarking data telling us how our restraint levels compared to those seen in other mental health trusts during 2019/20. We are the Trust marked by the red bar below:-

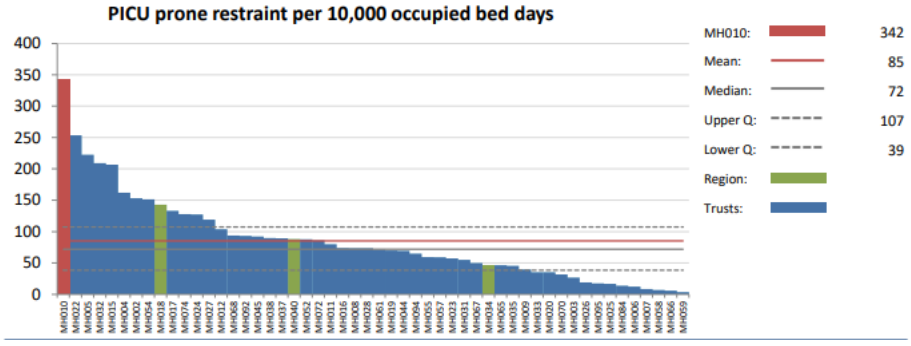










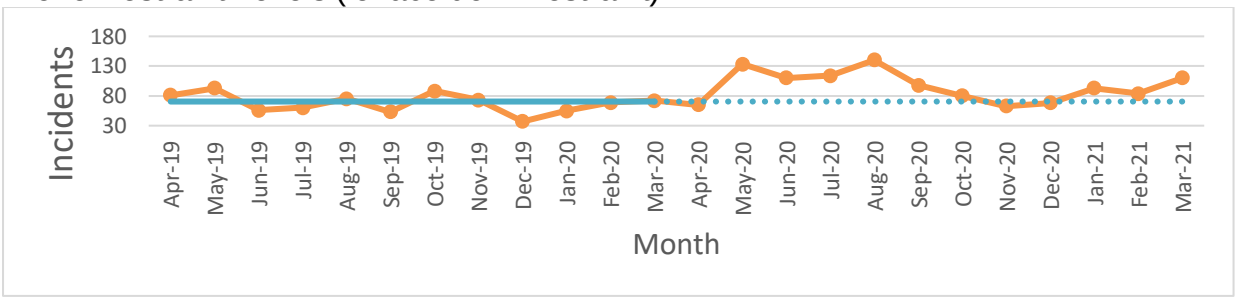


We did note that whilst we generally have an improved position nationally in comparison to previous years, we have more improvements to make, particularly within our Psychiatric Intensive Care Units (PICU), hence the important work of the collaborative that we have established. During wave one

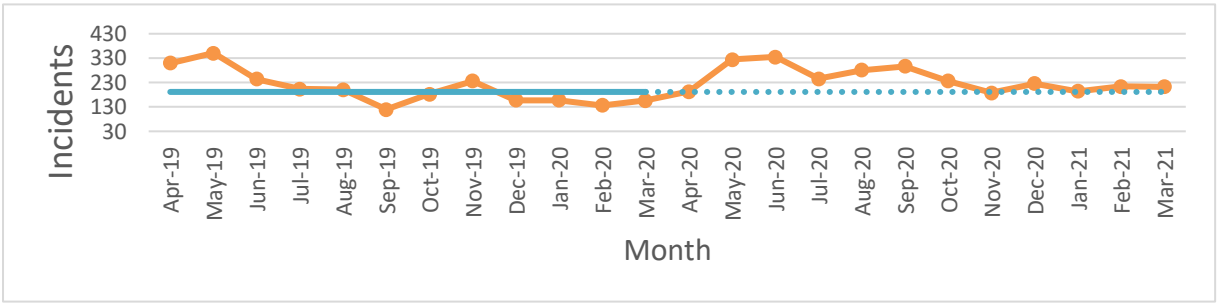
of Covid we saw levels of both prone and non-prone restraint increase. This was in part influenced by the increased acuity of patients on our wards and also the impact of some additional controls that we had to put in place to manage the spread of Covid 19 such as limited arrangements for visiting and more enhanced risk assessments for periods of absence from the ward environment.

Our prone and non-prone (physical) restraint levels are shown below and we can see that as restrictions have eased the levels of restraint have started to reduce.

Prone Restraint Levels (ie face down restraint)

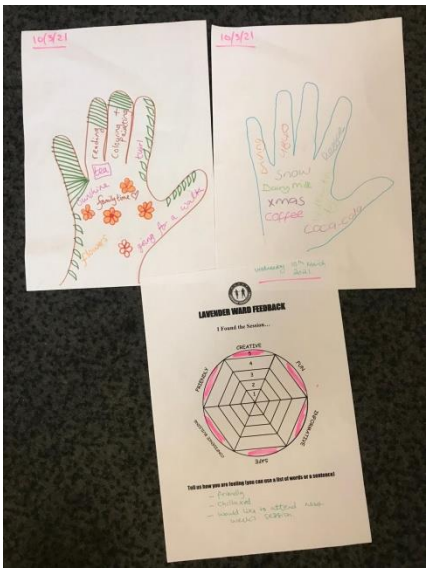


Non-prone Restraint Levels



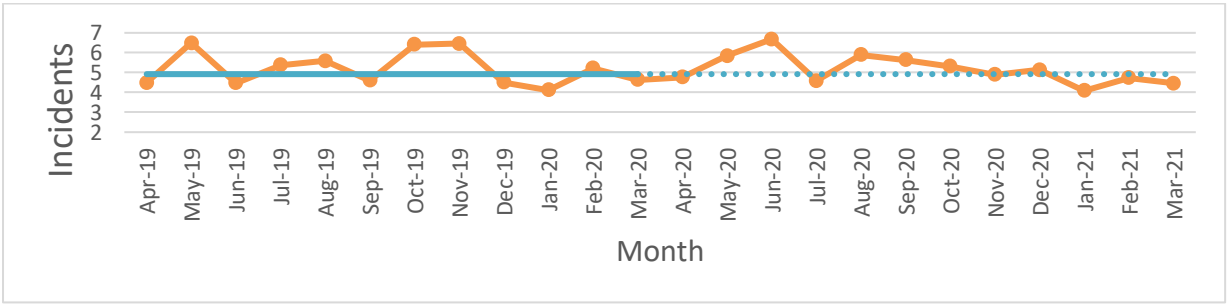
The level of physical assault that took place on our inpatient wards (a lower level is good)

We set ourselves a goal to pilot enhanced therapeutic activity models on 4 acute inpatient wards and 3 secure care inpatient wards with the aim of improving recovery, reducing incidents of physical assault, reducing incidents of restraint, reducing incidents of self harm. We did have to suspend some of the activity on our secure care wards during periods of very high acuity in the pandemic and it was in January 2021 that we began to introduce additional therapeutic activities to our four pilot wards in acute care. Our results from the 4 pilot wards in acute care have demonstrated some success with one of our pilot wards telling us '*Service users have engaged very positively with the therapeutic activities on offer on the ward and we have received some very positive service user feedback. 'Women in Theatre had their last session on Lavender last Friday and the sessions have been going really well and there has been a real positivity around the Drama sessions on the ward. Both staff and service users have approached me to ask for further information regarding these sessions. The have found both the facilitators and the content of the session fun and enjoyable. Several women were planning to only sit and observe however managed to stay throughout the sessions and actively engage in them also. Although the numbers attending the sessions are not large in quantity they have certainly had a positive impact on the service users and they have felt listened to and relaxed'.* Some examples of outputs of the sessions and a piece of service user feedback are shown pictorially below:

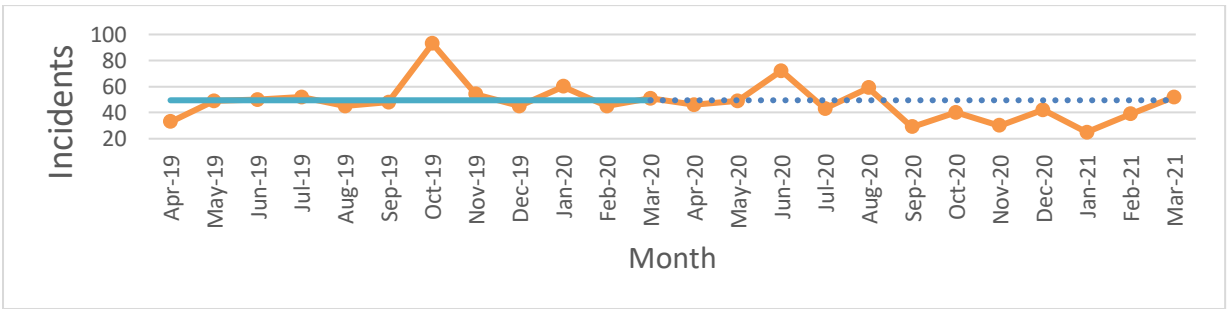


Levels of physical assault on staff and on patients are reviewed and reported on every month to a range of governance forums including our Patient Safety Advisory Group, our Integrated Quality Committee and our Trust Board. During the initial phase of Covid we saw an increase in assaults but as the wards stabilised and routines became more established we saw a reduction in such incidents.

Physical Assaults on Staff



Physical Assaults Patient on Patient

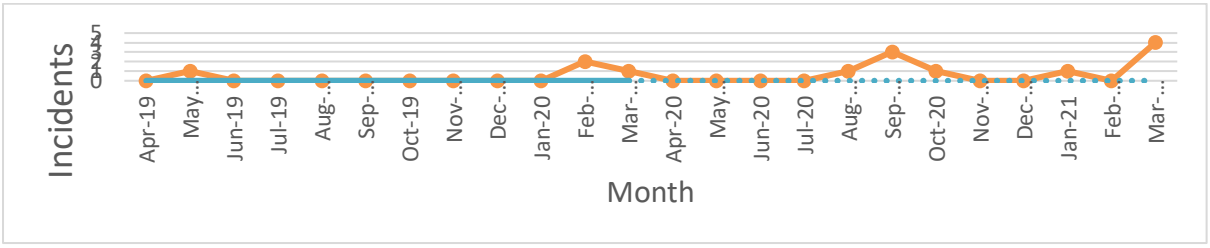


Suspected and Confirmed Suicide Levels

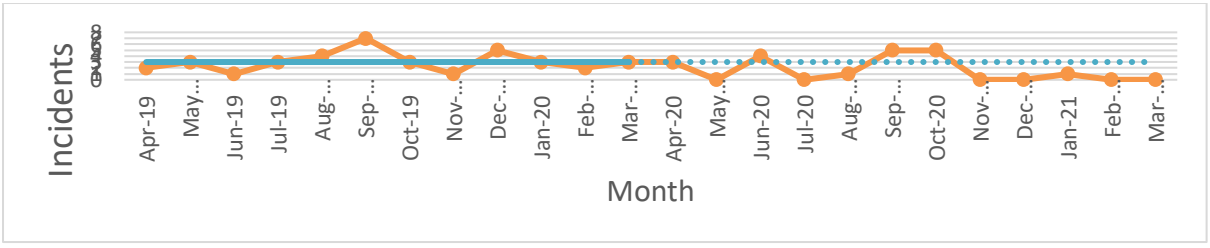
When we initially receive an incident report that suggests a service user may have died by suicide, we call this a ‘suspected suicide’. All suspected suicides are subject to a Coronial Inquest and it is at the closure of the inquest that the Coroner determines whether the cause of death was a ‘confirmed suicide’ or another cause. During the

Covid pandemic the Coroner saw a surge of deaths reported nationally which meant that it has taken longer than usual for some inquests to take place. We saw an increase in suspected suicide levels in patients that we were caring for in the community when the Covid wave 1 restrictions started to ease over the Summer months and again in March 2021 as wave 2 restrictions started to slowly be lifted. We undertake a root cause analysis investigation for every suspected suicide case of a patient in our care. Through this process we were able to see that lockdown restrictions had an impact on the mental health wellbeing of some of our patients, particularly the loss of social networks and supportive family networks.

Suspected Suicides in the Community

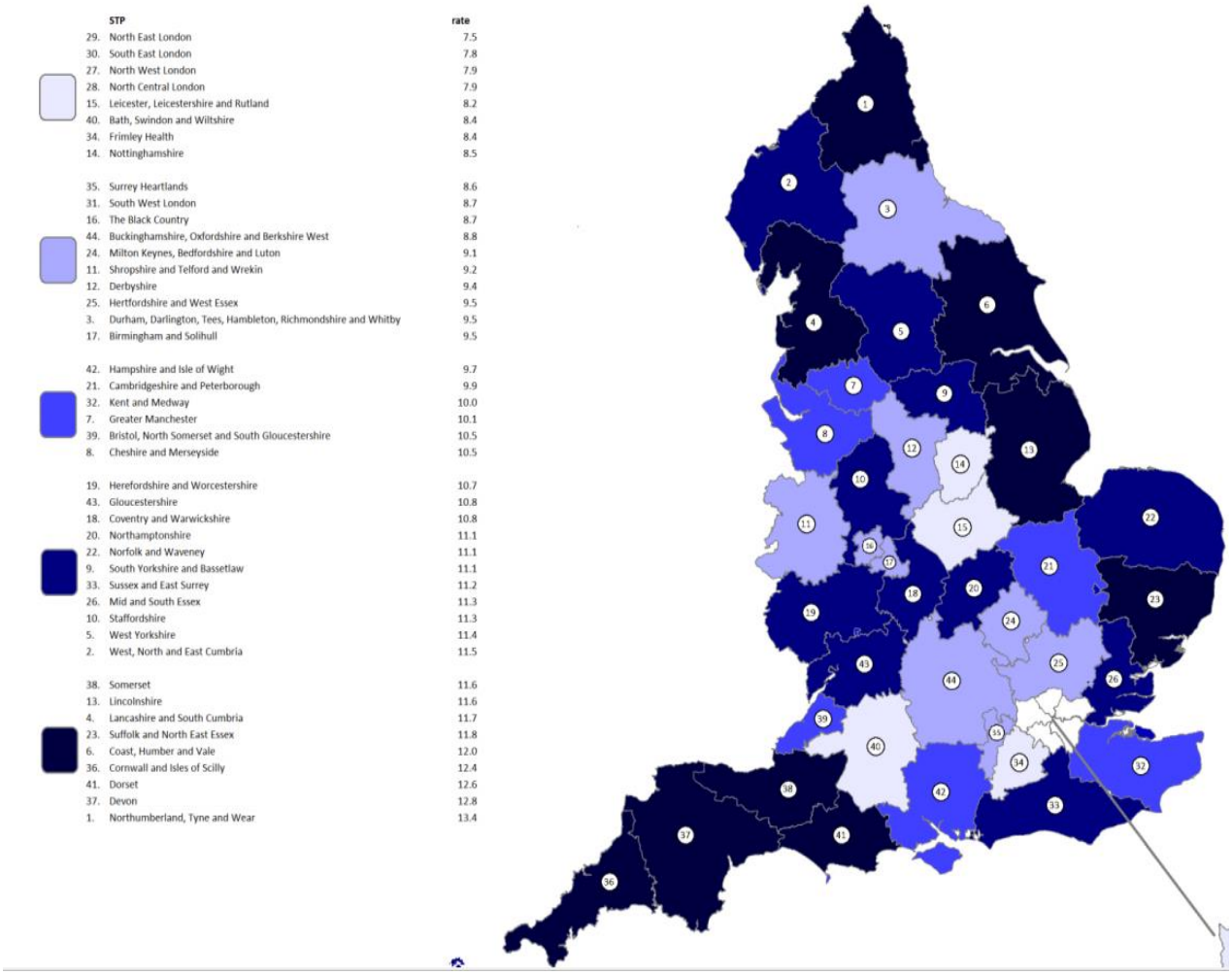


Confirmed Suicides in the Community



Each year the University of Manchester publishes a report called the National Confidential Inquiry into Suicide and Homicide. This report considers levels of suicide and homicide across varying geographical areas of England, Scotland, Ireland and Wales. The report is based on levels of suicide per 100,000 population and is not specific to patients in receipt of mental health care. The rate for Birmingham and Solihull is 9.5 per 100,000 population. The lowest rate is 7.5 in North East London and the highest rate is 13.4 in Northumberland Tyne and Wear. Out of 44 different geographical areas, we have the joint 14th lowest level of suicide in our population.

Figure 1: Rates of suicide per 100,000 population, by STP 'footprint' area of residence (average rate 2016-2018)



	STP	rate
29.	North East London	7.5
30.	South East London	7.8
27.	North West London	7.9
28.	North Central London	7.9
15.	Leicester, Leicestershire and Rutland	8.2
40.	Bath, Swindon and Wiltshire	8.4
34.	Frimley Health	8.4
14.	Nottinghamshire	8.5
35.	Surrey Heartlands	8.6
31.	South West London	8.7
16.	The Black Country	8.7
44.	Buckinghamshire, Oxfordshire and Berkshire West	8.8
24.	Milton Keynes, Bedfordshire and Luton	9.1
11.	Shropshire and Telford and Wrekin	9.2
12.	Derbyshire	9.4
25.	Hertfordshire and West Essex	9.5
3.	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	9.5
17.	Birmingham and Solihull	9.5
42.	Hampshire and Isle of Wight	9.7
21.	Cambridgeshire and Peterborough	9.9
32.	Kent and Medway	10.0
7.	Greater Manchester	10.1
39.	Bristol, North Somerset and South Gloucestershire	10.5
8.	Cheshire and Merseyside	10.5
19.	Herefordshire and Worcestershire	10.7
43.	Gloucestershire	10.8
18.	Coventry and Warwickshire	10.8
20.	Northamptonshire	11.1
22.	Norfolk and Waveney	11.1
9.	South Yorkshire and Bassetlaw	11.1
33.	Sussex and East Surrey	11.2
26.	Mid and South Essex	11.3
10.	Staffordshire	11.3
5.	West Yorkshire	11.4
2.	West, North and East Cumbria	11.5
38.	Somerset	11.6
13.	Lincolnshire	11.6
4.	Lancashire and South Cumbria	11.7
23.	Suffolk and North East Essex	11.8
6.	Coast, Humber and Vale	12.0
36.	Cornwall and Isles of Scilly	12.4
41.	Dorset	12.6
37.	Devon	12.8
1.	Northumberland, Tyne and Wear	13.4

Deaths by Suicide in Mental Health Inpatient Wards

National statistics reported by the National Confidential Inquiry into Suicide and Homicide demonstrate that whilst the number of deaths by suicide in mental health inpatient units is reducing, there is still opportunity to reduce these further. Evidence demonstrates that the majority of deaths by suicide in mental health wards were by hanging/strangulation from ligature points. Ensuring that our physical estate is as safe as possible is very important to us – particularly our inpatient wards where we know we care for patients who are at high risk of harm due to their mental illness.
During 2020-2021 we sadly reported 3 confirmed inpatient suicides occurring on our acute inpatient wards. I would like at this stage of this report to reiterate my sincere apologies and condolences to the families and friends of these patients. In all of these cases the service user utilised their en-suite bathroom door or bedroom door as a ligature anchor point. We had been piloting the use of continuous door alarm systems on some doors in our acute inpatient wards, however we had not made a final decision on which alarm system was the most suitable for our inpatient units until the Summer of 2020. Since making this decision we have:-

- Implemented door alarm systems on all en-suite bathroom doors at Mary Seacole House Ward 2 as part of our Physical Estate Ligature Risk Reduction Programme

- Established our roll out plan for en-suite door alarm systems across all acute inpatient wards and Psychiatric Intensive Care Units aligned to our capital investment programme. We anticipate that this will be complete by March 2022.
- Established a plan to place continuous door alarm systems on some of the bedroom doors of our highest risk wards during 2021-22
- Agreed to develop a 3-5 year ligature risk removal programme across our entire inpatient Estate to remove all ligature anchor points

During 2020/21 we also took forward a number of other initiatives to improve the safety of our services. These included:

- Participation in the National Sexual Safety Collaborative
- The establishment of our Safeguarding Partner roles in each of our service areas
- The appointment of a Patient Safety Specialist in line with the requirements of the National Patient Safety Strategy
- Strengthening our approach to the monitoring and management of haematological and other physical health investigations
- Reviewing the infrastructure of our electronic patient records to ensure that they are streamlined and minimise the risk of duplication of information
- Scoping the use of a Community Care Planning Tool incorporating an outcome measure within our Community Services as an approach to improve the therapeutic effectiveness of service user interactions with our clinicians Implementation of year one of our Personality Disorder Guidelines
- The piloting, evaluation and roll out a quality improvement project to establish minimum standards for multi-disciplinary Team (MDT) working across our Acute Inpatient Wards and Psychiatric Intensive Care Units
- The establishment of Safety Huddles on all of our acute inpatient wards and psychiatric intensive care units

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

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

During 2020/21 we set the following goals and I detail our achievement below:-

- Finalise a vision and a set of principles of Expert by Experience (EBE) participation, to work in conjunction with the Family and Carer strategy and Recovery for All Strategy. This will include a review and development of an experts by experience reward and recognition policy – we commenced the co-production of vision and principles of Expert by Experience (EBE) participation

including a review of our reward and recognition policy for Experts by Experience.

- Increase EBE participation in Level 1 Quality Improvement projects to 30% by March 2021 – we delivered dedicated Expert by Experience training sessions in Quality Improvement in a virtual manner due to Covid. These proved to be very successful and we now have experts by experience involved in core Quality Improvement work such as the therapeutic activities work on our wards & our Least Restrictive Practice QI Collaborative
- Develop the role of the Patient Safety Partner in accordance with the National Patient Safety Strategy and pilot this approach before scale up and spread – We started to scope the role of the Patient Safety Partner ensuring that our Experts by Experience have a stronger and equal voice within the governance of patient safety and patient experience – we are introducing this role in 2021/22
- Increase the number of Personal Health Budgets for service users who are eligible for section 117 after care as they are discharged from inpatient wards - . During 20/21 there has been a continued focus on personalised care and personal health budgets . These are continuing to be offered to service users with a particular focus on people leaving hospital as part of their Sec 117 after care arrangements. The impact of covid (in both the Trust and the CCG) has reduced the number offered this year although more sustainable mechanisms have been developed to ensure that this offer is available to all eligible people as we move forward. QI will be important in embedding this work across the Trust.

  Undertake baseline assessment, work with Family and Carer Pathway Group to determine key aims and deliverables to improve the Patient, Family and Carer experience of Serious Incidents and Complaints – we commenced recruitment of EBEs within a new Quality Improvement Project to improve the patient, family and carer experience of our complaints process

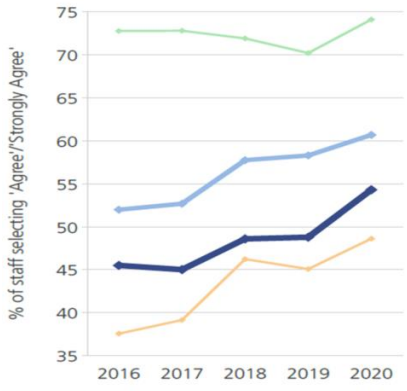
In addition, we engaged with experts by experience to develop a template for a care plan that can be shared with patients, families and carers. We also undertook work with some key experts to strengthen the patient, family and carer voice in care planning.

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

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

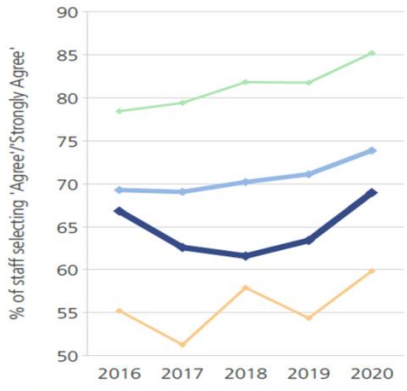
incidents fairly and that we make changes to improve care in response to incidents to try to ensure that they do not happen again. Each year there is a national NHS Staff Survey which takes a sample view of staff across the NHS to understand their experience of working in the NHS. As part of this annual review there are a number of safety culture metrics which give a view on how confident staff are in our incident reporting, investigation and feedback processes. Our results from the latest survey are shown below:-

Q16a
My organisation treats staff who are involved in an error, near miss or incident fairly



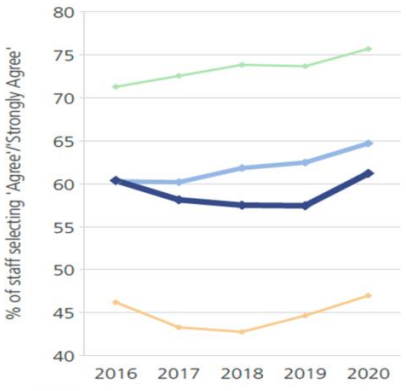
	2016	2017	2018	2019	2020
Best	72.8%	72.8%	71.9%	70.2%	74.1%
Your org	45.5%	45.0%	48.6%	48.8%	54.3%
Average	52.0%	52.7%	57.8%	58.3%	60.7%
Worst	37.6%	39.1%	46.2%	45.1%	48.6%

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



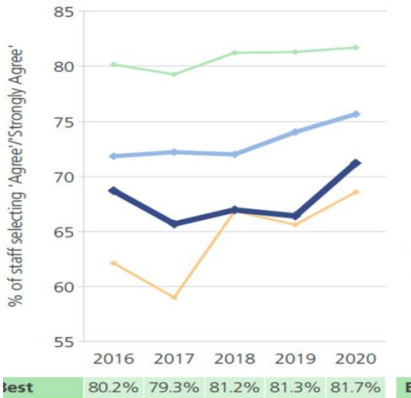
	2016	2017	2018	2019	2020
Best	78.4%	79.4%	81.8%	81.8%	85.2%
Your org	66.8%	62.6%	61.6%	63.4%	69.0%
Average	69.3%	69.1%	70.2%	71.1%	73.9%
Worst	55.2%	51.3%	57.9%	54.4%	59.9%

Q16d
We are given feedback about changes made in response to reported errors, near misses and incidents



	2016	2017	2018	2019	2020
Best	71.3%	72.6%	73.8%	73.7%	75.7%
Your org	60.4%	58.1%	57.5%	57.4%	61.2%
Average	60.3%	60.2%	61.8%	62.5%	64.7%
Worst	46.2%	43.3%	42.8%	44.7%	47.0%

Q17b
I would feel secure raising concerns about unsafe clinical practice

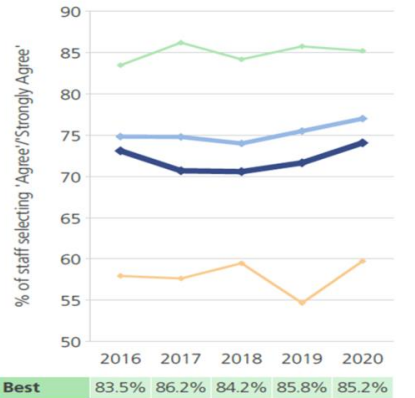


	2016	2017	2018	2019	2020
Best	80.2%	79.3%	81.2%	81.3%	81.7%
Your org	68.7%	65.7%	67.0%	66.4%	71.2%
Average	71.8%	72.2%	72.0%	74.0%	75.7%
Worst	62.1%	59.0%	66.8%	65.6%	68.6%

Q17c
I am confident that my organisation would address my concern

	2016	2017	2018	2019	2020
Best	69.6%	69.4%	74.9%	75.5%	76.5%
Your org	54.5%	49.0%	48.5%	50.7%	55.8%
Average	58.7%	59.4%	59.2%	60.5%	63.1%
Worst	43.6%	41.7%	46.2%	46.1%	46.8%

Q18b
My organisation acts on concerns raised by patients / service users



	2016	2017	2018	2019	2020
Best	83.5%	86.2%	84.2%	85.8%	85.2%
Your org	73.1%	70.7%	70.6%	71.6%	74.1%
Average	74.8%	74.8%	74.0%	75.5%	77.0%
Worst	57.9%	57.6%	59.5%	54.7%	59.7%

We can see from the results above that we have improved in all of the metrics in the latest survey which is a positive development. We still have much work to do to create a strong patient safety culture and during 2020 we took part in a new peer review scheme hosted by the Royal College of Psychiatrists which looks at the effectiveness of serious incident review processes. Colleagues who had been involved in serious incident reviews told the Peer Review Team that:-

- I feel that the support offered was of benefit and the guidance of the learning was clear. this enabled the team to understand the learning points.
- Much improvement happened in recent year regarding approach and sensitivity during the SI process.

- Very supportive process
- My experiences of being involved in SI reviews have been positive and feel that this is due to the professionalism of the individuals completing the review.
- I have always had a positive experience with the SI team who are always very clear, calm and compassionate
- An inclusive process with a nice feel of support
- Investigator was very compassionate to myself and the staff involved. Was also extremely flexible with arranging times to meet staff (i.e. early morning for night staff).
- During the recent SI review we were provided with a lot of support as a whole team due to the nature of the incident. Things were managed sensitively and recommendations were taken on board.

Some of the things that we have done during 2020-2021 to support our safety culture include:

- Included TRIM support as part of our support package to staff following traumatic incidents by developing a number of TRIM practitioners in the Trust who can support staff effectively. TRIM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. TRIM practitioners are clinical and non-clinical members of staff who have undergone specific training allowing them to understand the effects that traumatic events can have upon people. They are not counsellors or therapists, but understand confidentially and are able to listen and offer practical advice and assistance. During the year we have developed 25 TRIM practitioners across our Trust who have undertaken approximately 30 TRIM interventions to support staff
- Introduced the concept of civility saves lives as part of our safety culture. When incivility occurs in the workplace through poor behaviours such as rudeness, this impacts not only on the recipient but also on wider staff and patients, families and carers. National research shows that rudeness has a direct impact on reduced staff performance, a reduced commitment to work, increased staff absence, a reduced quality of work and an impact on the patient experience. When patients observe or experience incivility it can leave them feeling anxious and reduce their confidence and view of our Trust and the care they receive.
- Piloted Learning from Excellence in our Dementia and Frailty Services and issued 30 thank you letters of recognition of individual moments of excellence. We evaluated the success of the pilot and developed a scale up and spread plan so that we have a process to report, recognise and learn from excellent practice amongst our staff. Safety in healthcare has traditionally focused on avoiding harm by learning from error and whilst it is important that we continue to learn from error, this approach alone may miss opportunities to learn from excellent practice. We believe that developing and implementing a system to capture, celebrate and learn from excellent practice can create new opportunities for learning and improving resilience and staff morale.
- Developed and consulted on a service area level dashboard pulling together information on the quality of services delivered, workforce information, financial

information and information on access to services – we will implement this as part of our business as usual approach in early 2021/22

- Considered Human Factors as part of our incident processes ensuring that we understand any system issues that need attention
- Increase the level of clinical supervision training reported through our portal by at least 10% to ensure continued learning, reflection and support to our staff – we achieved our aim of a 10% increase with a an average rate for the year of circa 45% compared to 39%
- Our training in Appreciative Inquiry was stalled during Covid. We are now in active discussion with the Midlands Academic Health Science Network so that we can reintroduce this training in April 2021 to aid our development of a Just Culture.

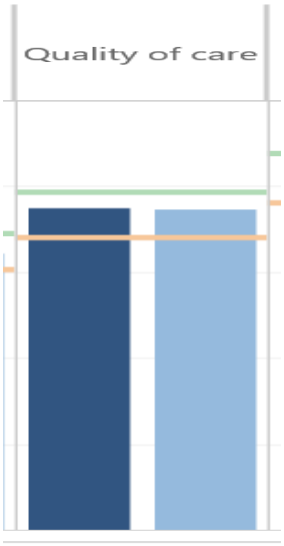
Priority for Improvement 4: A Focus on Quality Assurance

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

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

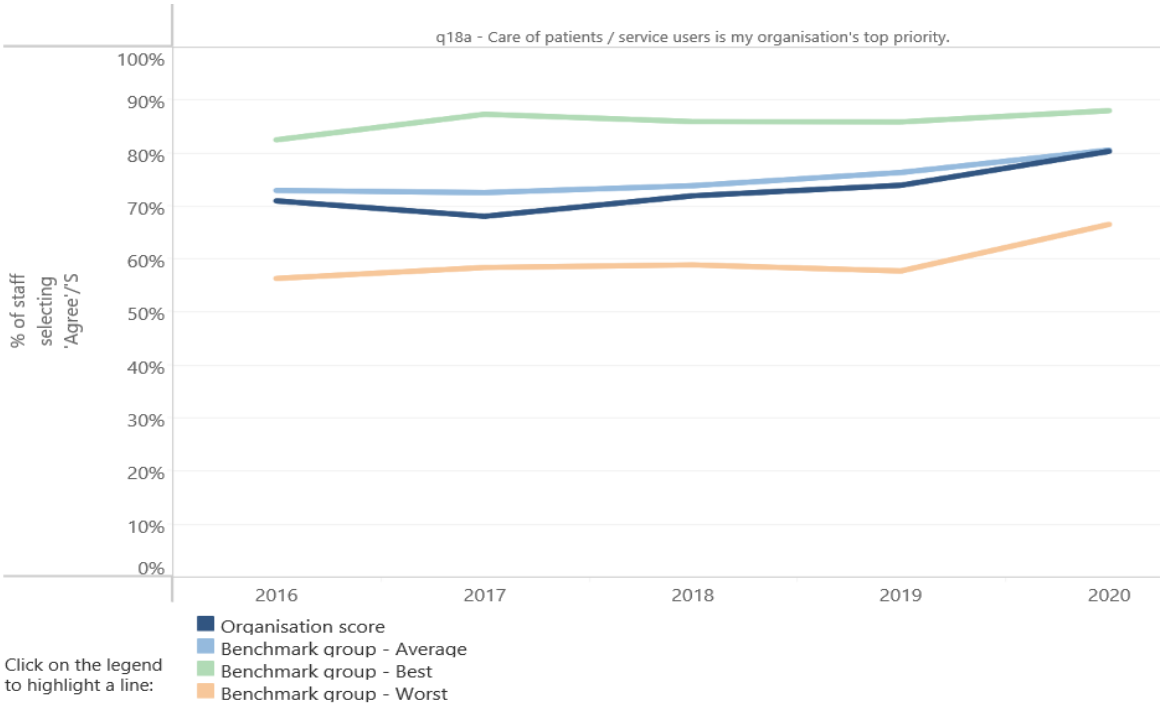
We will measure our success through improvements in the National Staff Survey metrics relating to the ‘Care of Patients/Service Users in my organisations top priority’ metric; the ‘Quality of Care’ metric and improvement in ratings awarded by the CQC.

Our quality of care domain in the national staff survey for 2020 was as follows:-



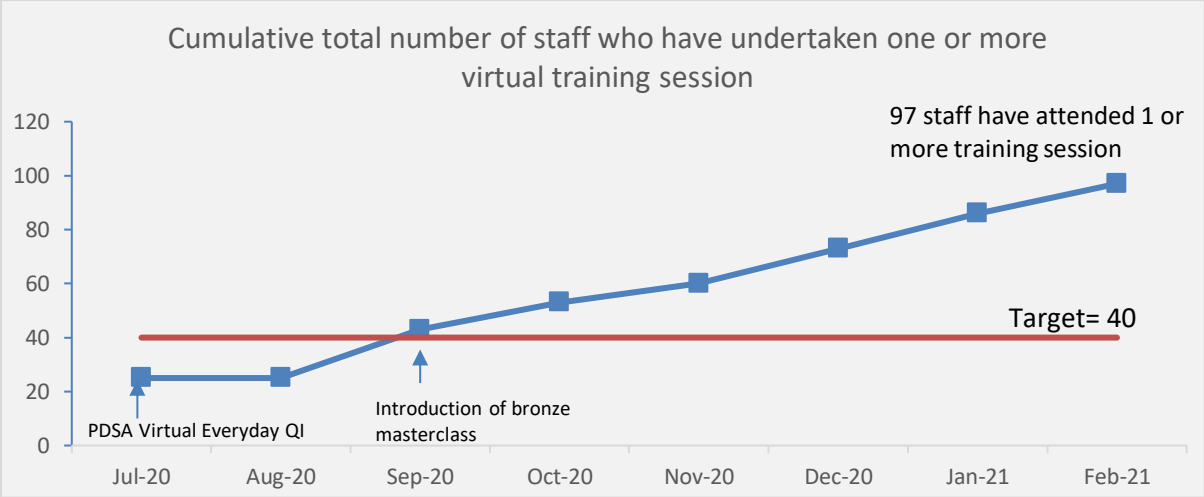
The green line shows the best and highest performing results in the Country. The orange line shows the lowest scores in the Country. We are the dark blue box which demonstrates that our staff results for quality of care reflect that seen on average across the Country (national average shown in light blue box).

Our result for the metric relating to the 'Care of Patients/Service Users is my organisations top priority' is shown in the graph below. Whilst we still have further improvements to make, it is positive to see a continual improvement in this metric over the past 3 years.



During 2020/21 we have taken forward the following developments to support an improved approach to quality assurance:

- Exceeded our 10% target of increasing the number of our staff who are trained in Quality Improvement methodology by over 100%



- We have standardised the way we present all of our quality data into 'run charts' enabling a better understanding of our performance and how changes we are making are successfully improving care or are encountering challenges. Run charts are now being used as our business as usual way of reporting on all quality improvement projects and quality and safety metrics. Run charts are graphs of data over time and are one of the most important tools for assessing the effectiveness of change. Run charts have a variety of benefits: They help improvement teams formulate aims by depicting how well (or poorly) a process is performing. They help in determining when changes are truly improvements by displaying a pattern of data that you can observe as you make changes. They give direction as you work on improvement and information about the value of particular changes.
- Developed process, outcome and balancing measures for all of our quality improvement projects. Measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement.
- Developed a peer review process to continually review our compliance levels with CQC regulations and encourage shared learning. We will implement this process in 2021/22.

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

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

By 2025:
We will have significantly reduced the amount of unwarranted variation, allowing us to focus on ensuring the right care and support is delivered for everyone at a consistently high standard. Unwarranted variation can be a sign of waste, missed opportunity and poor quality and can adversely affect outcomes, experience and resources.

During 2020/21 we:

- Procured and commenced implementation of continuous door alarms on all en-suite doors in our acute inpatient units. Such alarms will activate if any weight is applied to any aspect of the door enabling immediate staff response
- Explored the use of digital technology to enable the selection and future implementation of a digital Community Care Planning Tool incorporating an outcome measure within our Community Services as an approach to improve the therapeutic effectiveness of service user interactions with our clinicians

- We had also intended to develop the 'triple aim' approach to our quality improvement programmes and monitor and report efficiency impacts of the programmes, however due to the Covid pandemic we did have to put a number of our projects into 'hibernation' to enable staff to be able to directly respond to the rising demands that they were facing due to increased mental health and physical health acuity of our patients.

2.2 Statements of Assurance from the Board

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

	Prescribed information	**Form of statement**
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2020/21 BSMHFT provided the following mental health services: A&E Liaison Adult Acute Ward Adult CMHT Adult Day Care AOT CAMHS Deaf Community Deaf Inpatient Eating Disorders Community Eating Disorders Inpatient Early Intervention

		Forensic CAMHS Community Forensic CAMHS LOW SEC Forensic CAMHS MED SEC Forensic Outreach High Dependency Wards Home Treatment IAPT Justice Liaison Low Secure Perinatal Community Perinatal Inpatient Medium Secure Wards Neuropsychiatry Older Adult Acute Ward Older Adult Community Memory Services OPIP (Older Adult Day Care) PICU Primary Care Prison Mental Health Care Rehab Ward Substance Misuse Services
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	BSMHFT has reviewed all the data available to them on the quality of care in these services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2020/21 represents 90 % of the total income generated from the provision of relevant health services by BSMHFT for 2020/21

2. Participation in National Clinical Audits and National Confidential Enquiries

	Prescribed Information	Form of statement
2	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	During 2020/2021, 7 national clinical audits and 2 national confidential enquiries covered relevant health services that Birmingham and Solihull Mental Health NHS Foundation Trust provides
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2020/21 are as follows • POMH 20a: Prescribing Valproate • National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 18b: Use of clozapine • National Confidential Enquiry - 'Transitions' Child Health Clinical Outcome Review Programme - Adolescent Mental Health • National Audit of Care at End of Life. • National Audit of dementia • NCEPOD- Physical Health in Mental Health Hospitals • Falls and Fragility Fracture Audit Programme (FFFAP) • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2020/2021, are listed below : - • POMH 20a: Prescribing Valproate

		• National Clinical Audit of Psychosis (Early Intervention Services) (NCAP) • POMH 18b: Use of clozapine • Falls and Fragility Fracture Audit Programme (FFFAP) • National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during April 2020 to March 2021 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:-

Title of National Clinical Audit	Eligible	Participated	% *
POMH 20a: Prescribing Valproate	Yes	Yes	117[1]
National Clinical Audit of Psychosis (Early Intervention Services) (NCAP)	Yes	Yes	49%
POMH 18b: Use of clozapine	Yes	Yes	119[1]
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	Yes	N/A -Organisational questionnaire only 2
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Yes	Yes	

** Percentage of required number of cases submitted*

[1] POMH do not provide ascertainment rates. The figures provided are the number of cases submitted by Birmingham and Solihull Mental Health NHS Foundation Trust

[2] There were no inpatient Falls reported by Acute Hospitals for us to participate in the Case note Audit.

2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 2 national clinical audits were reviewed by the provider in 2021/21 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	

POMH 17b: Use of depot/LA antipsychotic injections for relapse prevention

Whilst the data collection for the audit of the use of depot and long-acting antipsychotic injections for relapse prevention took place in November 2019. The results were received in March 2020. At this time, the Clinical Effectiveness Committee (Now Clinical Effectiveness Advisory Group), which would usually have received the results, had paused due to urgent Covid19 work. The committee resumed its responsibilities in July 2020 and received the report.

This was the first re-audit for the Prescribing Observatory for Mental Health (POMH) Quality Improvement Programme 17b: The use of depot/long-acting injectable antipsychotic medication for relapse prevention.
The clinical standards for this audit were derived from national guidelines for the treatment of schizophrenia.
Patients eligible for inclusion in this audit were all those under the care of adult mental health services (with no age restrictions) including forensic services, who are prescribed depot/long-acting injectable antipsychotic medication. This did not include patients under the care of CAMHS, learning disability and older people's services.
This produced a population of 2108 eligible patients, of which we sampled 118 due to capacity constraints.

Key Success points:
99% of patients had a care plan which is better than the total national sample (TNS) of 92%.
In 97% of cases the care plan included a crisis plan which is significantly better than 77% of the TNS.
Areas of Improvement:
The areas in which BSMHFT were below the 2017 results and the TNS were the recording in the care plan for the clinical plan in response to default from treatment (16%).

BSMHFT scored 70% for the documentation of signs and symptoms in care plans. This had previously been 83%, although still higher than the TNS of 68%. This is part of the trust wide workstream looking at care plans and crisis plans.

Trust Response/Key actions:

Standard 1e: Care plans should include a clinical plan for response to default from treatment, i.e., if a patient fails to attend an appointment for administration of their depot/LAI antipsychotic medication injection or declines their injection:

- BSMHFT only scored 16% of the top criteria due to the clinical plan not being a part of the patient care plan, all patients had a clinical plan but for 84% this was not contained within the care plan. As it was this specific distinction POMH was looking for, we scored quite low for this particular standard.
- Whilst the compliance rate against the specifics (Clinical plan being in the care plan) of this standard were quite low, this represents the way in which our Trust uses care planning. Other Trusts use "template Care Plans" which are likely to involve this sort of information. Our Care Plans are more service user led and reflect other areas, as advised by CQC. It was noted that the Trust performed well in having clear statements in the patients notes regarding this area (actions to be taken in case of default from treatment), and in fact we were one of the best performing teams in this regard.

In response to this, inpatient settings and community clinical planning is also being explored.
However, over the past year care planning has been undergoing a complete re-design trust wide.

For inpatients:

- A new care planning process has been designed based on a MDT model
- Significant reduction in administrative burden
- Promotes patient engagement and MDT working
- New printed version developed in conjunction with Experts By Experience.
- Live on 16 acute wards with plans in place to extend to all other inpatient services over next 6 – 9 months

For outpatients:

- New care planning process designed linked to DIALOG outcome measure
- Significant reduction in administrative burden
- Care planning driven by needs identified by the patient
- Scope to include all community services beginning with CMHTs to be completed over next 9 – 12 months

NCAP EIS spotlight

In October 2020, the Trust participated in the 2020/21 National Clinical Audit of Psychosis. This audit focused on Service users with first episode psychosis receiving treatment from our early intervention in psychosis service (EIS). The audit included a review of Cognitive Behavioral Therapy (CBT) up take, Family intervention uptake, education and employment programme up take and whether service users who had not responded adequately to or tolerated treatment with at least two antipsychotic drugs are offered clozapine. The age ranges the audit explored were 14-35years.

There were also two physical health related domains which were

1. Physical health annual review, which included: smoking status, alcohol intake, substance misuse, BMI, blood pressure, glucose and cholesterol.
2. Physical health interventions, such as smoking cessation, substance misuse, weight gain/obesity, harmful alcohol use, Dyslipidemia, Diabetes/high risk of diabetes and Hypertension.

The report is due in Summer 2021 and will be reviewed by the Early Interventions Team, who will decide the actions we need to take and areas of focus, and then return to the Clinical Effectiveness Advisory group, where the actions will be overseen.

National Confidential inquiry (NCI) into suicide and homicide

The Trust as a matter of course, continually contributes to the University of Manchester National Confidential Inquiry into Suicide and Homicide. The latest National Confidential Inquiry Annual Report into Suicide and Homicide was published in May 2021. This report considers levels of suicide and homicide across varying geographical areas of England, Scotland, Ireland and Wales. The report is based on levels of suicide per 100,000 population and is not specific to patients in receipt of mental health care. The rate for Birmingham and Solihull is 9.5 per 100,000 population. The lowest rate is 7.5 in North East London and the highest rate is 13.4 in Northumberland Tyne and Wear. Out of 44 different geographical areas, we have the joint 14th lowest level of suicide in our population. We are currently considering our position against these findings, but can already see that some alignment between national findings and the local position relating to deaths by alcohol and substance misuse. We have therefore included a quality goal for 2021-22 around this matter within the earlier section of this report. With regard to inpatient suicides, the most common method was by ligature and in 2021-2022 we will complete the roll out of ligature door alarm systems to all en-suite bathroom doors in our acute inpatient wards and to bedroom doors in our highest risk areas. We will also develop a 3-5year rolling programme to removal all ligature anchor points in our inpatient estate.

2.7	The number of local clinical audit (a)	The reports of 37 local clinical audits were

	reports that were reviewed by the provider during the reporting period.	reviewed by the provider in 2020/2021 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

Rapid tranquilisation Audit	Background: Previous Trust audits have demonstrated improvements are needed in adherence to the Trusts' Rapid Tranquilisation (RT) policy, highlighting this as one of the major clinical risks within the organisation. These audits have demonstrated the importance of monitoring physical health following administration of medicine for RT, formal assessment of adverse effects in majority of RT episodes, and service user involvement to state their future treatment preference after being administered RT. This audit sought to elucidate compliance with BSMHFT RT policy with respect to the factors outlined above when RT is administered to a service user via the intramuscular (IM) route. Some of the results fell short of the policy expectations, and therefore the audit appeared to be the next plausible step to gain assurance on the organisations adherence to the policy. The aim of the audit was to determine whether the BSMHFT policy for RT is being adhered to when RT is administered to service users via the IM route. We felt this audit will benefit patient care by providing an opportunity to compare and improve standards of practice in RT with respect to efficacy and patient safety, with a consequent improvement in patient experience. The audit had a sample size of 131 patients from inpatient wards (52). These Included forensic units, intensive care units, acute units, and non-acute units. Episode Results: There were 131 separate administrations recorded in this 2-week period, however 22 of these administrations were either a duplicate record of administration or subsequently recorded as being over-ridden. This was either because the dose was not administered or because an oral dose was actually administered. Of the 109 separate administrations in fact given, there were 13 occasions when two medications were administered simultaneously, meaning that there were actually 96 episodes of RT in the two-week period reviewed to 37 service users across 16 wards. Eden Female Psychiatric Intensive Care Unit (PICU) had 26 episodes of RT, the highest number of episodes across the directorates reviewed. One service user on the unit received 18 episodes (18%) of RT. There were 46 episodes (47%) which took place on acute Adults of Working Age (AWA) inpatient wards. 46 (47%) RT episodes took place on Intensive Care Units (ICU), 5 (5%) episodes within secure care services and one RT episode took place on an Older Adults ward. Results against Standards: - Advance statements and directives: These are statements that would document the patients wishes and instructions, they should be

	used when patients are unable to articulate themselves and their wishes. - In 24% of instances of RT the patient had an advanced statement (n=23), 49% did not, in 8% of RT episodes the patient had been given the opportunity to record an advanced statement, but had declined to do so, and a further 19% had been unable to record an advance statement as they did not have capacity to do so. - Document of Physical health check prior to RT being prescribed and administered: In the majority of RT episodes, the physical health assessment (n = 86, 90%) was available prior to administration of the RT. On a few occasions these had been refused and documented on RiO. In just over ¾ of the RT episodes, an ECG had been performed prior to administration of RT medication (n = 76, 79%) with 4 documented refusals. 50% of these ECG's had been performed and results recorded with the 3 months prior to IM administration, 26% between 3 to 12 months prior, and 3% over 12 months prior. This is a significant increase in recording from the previous 2016 audit, where 55% of service users had an ECG preformed prior to an RT episode. Of the 20 episodes of RT which took place without baseline ECG, the majority utilised IM Lorazepam (n = 16, 80%), followed by IM Aripiprazole (n = 2, 10%) and IM Promethazine (n=2, 10%). - Other strategies and de-escalation: The policy gives reference to non-pharmacological interventions as being: '…de-escalation, distraction techniques, consideration of placement, physical restraint and seclusion.' - In just over half of the RT episodes (n=53,5%), there was documented evidence that a non-pharmacological intervention had been attempted to de-escalate the violence and aggression prior to using RT. - Patient Assessed for any adverse effects as a results of RT (and these were treated where relevant): This was documented in 31% (n=30) of administered RT, of those, there were no adverse effects recorded. Whilst this an improvement from the 2016, there remains significant opportunity for improvement. - Post RT monitoring (Physical health): 21% of patients had a post RT physical health check, whilst in 79% no record was found. - Post RT NEWS Score and Mental Health assessment: It was found that 34% of the sample received a mental state examination following RT (n=33), 31% received a NEWS Score (n=30) and 10% received a full physical health examination (n=10). This means that the majority of patients within the Trust do not receive these assessments following RT. Recommendations: - Our trust Reducing Restrictive Practice Quality Improvement Collaborative workstream have a change package to address debrief and care planning following RT. - Physical Health Committee to develop actions to address

	physical health monitoring and ECG monitoring. • RT policy to be re-written: Specific areas to be strengthened: prescribing practice, rationale, monitoring, risk. • RT messages to be strengthened in ILS training across the trust. • The trust will also explore ways to ensure medics are trained in RT standards This report gathered actions from various committees and returned to the Clinical Effectiveness Advisory Group for actions to be logged and overseen.
Clozapine Audit	Following the death of a patient on clozapine earlier this year the Coroner's office issued a Prevention of Future Death (PFD) notice. The notice raised several concerns around the management of clozapine patients including the management of clozapine plasma level assays. The main concern was the management of patients with clozapine levels identified as high (over 600mcg/L) and the subsequent management and review of the medication. At the time of the inquest, the patient had had a level done post mortem and this had come back as almost four times the normal top of the range. The patient had an assay completed about 9 months before his death, but there was no evidence that this was reviewed by the consultant and although it is likely that no changes would have been made at the time, it may have indicated a need for closer monitoring. The assay was not requested by the consultant and so they did not know to follow it up - this highlighted the fact that a large majority of requests have no basis in clinical management and are in fact errors by the person taking the sample. The lack of understanding at all levels as to the clinical significance of the normal full blood count for monitoring purposes and the need for a clinical plasma assay was also criticised. This audit was designed to capture a baseline level of compliance with the standards in place at the time in the BSMHFT guidelines, in order to ascertain gaps and possible future recommendations for clinical practice relating to the monitoring of clozapine. Results: 1. While not specifically collected during the audit, it was noted that of the 110 results, 22 (20%) were classed as high (above 600mcg/L) and 18 (16.4%) were low (below 350mcg/L). This means that 64% were within the specified therapeutic range. This provides a degree of reassurance that most patients are being managed satisfactorily. 2.When we look at the audit criteria, it is apparent that 80 samples (73%) were not taken as trough values and therefore have no clinical value; this indicates a very large waste of resources with the testing. This is a cost to service users, as well as a financial and time cost to our organisation and the Pathology service. 3. Of the samples, 29% were documented as having a valid reason for the sample in line with the 2018 BSMHFT guidance. While some of these will have been indicated and not documented, the majority are ordered either in error, or simply as a matter of incorrect practice. This highlights the concern raised by the coroner about the poor understanding by most staff as to why monitoring is needed and about clozapine processes in general. 4. There was a lack of documentation following the result being reported. 29% have such an entry and this may be in those cases where levels are within the normal range. Reading through the comments

	from auditors who looked at more entries than just those directly related to the sample, it seems as though most were ordered in error and therefore the clinicians had no expectation that they needed to review them. 5. The final question does not have a specific audit target as a repeat sample is not always warranted, especially if the care plan clearly outlines what the intention is and that the patient or their representative is involved in the discussion. A small number (12.7%) resulted in documented changes to the dose, though it is likely a small additional number were altered. This Audit was reported directly to our Trust Clinical Governance Committee and the following recommendation were made. Recommendations 1. For all clozapine blood level tests, the following must take place: a. the date and time of the sample must be recorded on the blood sample form. b. The sample must be taken 12 hours after the last dose of clozapine is taken by the service user c. The result must be reviewed by a clinician (ideally, the clinician who has requested the test) as soon as possible and a progress note made regarding the result and any required actions 2. All clinical staff will continue to be made aware of the difference between a full blood count (weekly, fortnightly or monthly) for monitoring the rare side effect of agranulocytosis, and a clozapine plasma level assay (checking the amount of clozapine in the blood stream) and how to request each test This learning from the above two points has been disseminated to all teams and discussed in Multi-Disciplinary Meetings. Assurance has been sought from Clinical Directors for this. 3. Consideration should be given by the Clozapine Monitoring Group of ways to identify when a clozapine plasma level assay has been requested but not taken – A QI project with ANP's, looking at the process of requesting clozapine levels, reasons, and actions is underway. (This includes the use of a checklist) 4. We will repeat this audit in June 2021 and consider the results at Trust Clinical Governance Committee. 5. An Insight report of high clozapine levels and the interim process of reporting these manually within the Pharmacy team, including the resource requirements for this has been developed, this is now being tested. 6. A Rio form for Services Suers with clozapine levels over 600 has also been built and is currently being tested. 7. Our trust Pharmacological Therapies committee are overseeing a review of all clozapine guideline to ensure clarity and consistency across.
	Across the course of the past year, we carried out several pharmacy and medicines related audits to assess various topics from inpatient controlled drugs, our inpatient medicines code, compliance with Mental Health Act forms and Antimicrobial prescribing. <u>Key finding and actions</u> • Antimicrobial prescribing had returned to normal levels compared to past audits in our June 2020 audit, but was a little higher than expected in the re-audit in September 2020.

Pharmacy/Medicines (Inpatient controlled drugs, Inpatient Medicines Code Audit, Prescribing compliance with MHA forms and Antimicrobial prescribing)	• The number of topical treatments remains comparatively high in both. • Compliance with antimicrobial guidance was just above the commissioner's target in our June 2020 audit, but just below in September 2020. • Clinical pharmacists will continue to work with medical staff to ensure that antimicrobial prescribing is appropriate, and the outcomes are documented. • Pharmacy staff have conducted an audit of controlled drugs across almost all of the Inpatient wards within the trust. Findings have been discussed with senior ward staff and each ward has a specific ward action plan for improving compliance with standards. • A key focus will be on the management of controlled drug registers and where necessary some brief training provided to existing or new staff on the management of controlled drugs. • Pharmacy Services, working with Inpatient wards will continue to support staff including training on key medicines safe and secure handling issues. • Pharmacy staff will work intensively with those wards showing the greatest non-compliance with standards. • Pharmacy staff will work with Estates to scope and develop the business case for procurement and installation of air conditioning units and/or temperature-controlled medicines cabinets to ensure ambient temperatures within the clinic rooms or medicines cabinets are maintained. • Pharmacy will work with wards and Estates to ensure that when medicines cabinets are non-compliant with BS2881 and are being replaced then suitable alternative cabinets that comply with the standard are sourced.
<u>Physical Health</u> *(Weight Management on Inpatient units, NEWS2)*	Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) uses the NEWS2 tracing and trigger system which is based on a simple scoring system in which a score is allocated to our routine observation of the six physiological measurements which can be taken – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. The score is placed on the digital ward platform and is used by clinical staff to record vital signs, assign each a score and monitor people's physical condition where necessary. The total score lets the practitioner know if a patient is deteriorating, prompting them to take urgent action, to review the care of the patient and call for specialist help if necessary. The NEWS2 has been shown to be a highly effective system for detecting service users at risk of clinical deterioration or death, prompting a timelier clinical response, with the aim of improving service user's outcomes in the trust. (NICE,2007 & Royal College of Physicans,2017). This scoring system is fundamental in the identifying and managing the deteriorating patient. <u>Key finding and Actions from NEWS2 Audit</u> • The COVID pandemic has increased the monitoring of basic physical health observations and NEWS2 scores. We have better methods for quicker reporting and are now quicker at reviewing the service user's observation and are acutely aware when there is deterioration. • We have more methods for training for all our staff, including face to face 'managing the deteriorating patient' (COVID-19) training ad-hoc training, eLearning and all the presentation and links on the COVID pages of our intranet. • Clinical Guideline awareness is to be promoted and understanding supported. The impact of medication and other factors has been a longstanding concern both in the wider MH community and in the Trust. A number of audits looking at BMI, or weight gain have been carried out over the last 5- 10 years. Collectively the results have shown an increasing problem with weight gain and high BMI in service users, particularly if they have had an inpatient admission. The impact of obesity is a contributory factor in reduced life expectancy in SMI, and as part of the Physical Health Strategy, the Physical Health Committee agreed it should be a leading priority.

	Key findings from Weight Management Audit: • As a Trust we are doing well with measuring and recording physical health data, this most recent data was enabled by a large set of data, collected during an admission. • The audit had two standards, to reduce weight gain during admission, and to support weight loss for those in an overweight or obese BMI category. • Although there have been differences in methodology, the 2020 audit showed some improvement in the numbers of service users who were able to maintain body weight during their admission. The action plan for each service area highlights where we can make further impacts by offering targeted programmes (in longer admissions) and increase the opportunities for physical activity. This has two main resource implications, firstly we need to support our clinical teams to have informed, confident, and supportive conversations in relation to weight management, and secondly, we need to carefully consider how we use our specialist resources such as Dietitians and health instructors for maximum impact.
<u>Safeguarding</u> *(Solihull Safeguarding Children Board Multi-agency case audit)*	BSMHFT participates in an annual multi-agency case audit in Solihull. This audit considers cases that are directly related to any of the Solihull Local Safeguarding Children Partnership (LSCP) priorities. The priorities this year centred on the areas of exploitation and neglect. The case audits help the LSCP with information about the quality of work being undertaken by professionals to safeguard children and young people. The Case Audit process identifies areas of good practice as well as identifying areas of improvement that can improve the lives of children and young people in Solihull. Due to the impact of the Covid pandemic on agencies the audit was scaled down. A reduced number of cases were selected for audit. The case selection is provided by the LSCP with suggestions for cases to audit made by agencies including BSMHFT. A number of cases are also taken through a deep dive process in preparation for a Joint Area Targeted Inspection audit. This year's case selection had a small number of cases open to BSMHFT (8 cases in total) which reduced the scale of the audit. In addition some of these cases had brief episodes of care. Of the case audit list provided there were 4 children and young people known to CAMHS and EIS and 4 parents open to adult services (CMHT, perinatal, Assertive Outreach Team) The LSCP made some recommendations for the partnership from this audit and this will feature in the Response and Delivery Groups work plan for the coming year. Good practice case: • An audited case was open to CAMHS and Early Intervention Service demonstrated good practice. Safeguarding concerns about criminal exploitation of the young person were picked up at the point of assessment and a prompt safeguarding referral was made to the Local Authority. At this stage, the mental health assessment found no needs requiring a CAMHS service but the service kept the referral open until the outcome of the MASH referral was known. There was good liaison when a social worker was allocated. Attendance at the local exploitation panel helped raise the understanding of risk and ensured subsequent consideration of exploitation risks and safeguarding needs as part of any future formulations. Having a BSMHFT CPN linked to the Youth Offending Service helped with information sharing and facilitated his mental health needs being assessed again. This facilitated the early identification of the onset of first episode psychosis and his route into Early Intervention. The Early Intervention Service kept his case open when he was moved to an out of area placement by the Local Authority and this helped maintain a continuity of care. There was good multi-agency working throughout.

	Key findings and Actions from the audit specific to BSMHFT: • Family composition details were not being consistently recorded on the electronic case recording system via the Children and Siblings form. A QI project was completed by the safeguarding lead to review this, from which a training video was recorded, which aims to support staff in improving recording of these details. We have also sent out communications to support staff in completing the Children and Siblings form, which will be periodically repeated to ensure all staff are aware of this and why consistent recording is important. LSCP Key findings and actions from multi-agency findings that we will be contributing to: • Agencies have been asked to "Audit whether the VOC/lived experience of children (including those who are non-verbal or have additional communication needs) influences interventions and decision making within their own organisations". We are waiting for the audit to come through to us (VOC = 'voice of the child') to complete. • Agencies have also been asked to "Define what early help looks like where there are concerns about exploitation to include clarity about the role of partner agencies in early intervention." - We are currently completing an all-age exploitation self-assessment for Solihull Local Safeguarding Children Partnership (LSCP) for BSMHFT. After obtaining the baseline from this self-assessment we will be implementing a work plan to help improve the response to exploitation across all BSMHFT Birmingham/Solihull services.

Quality Risk Assessment & Care Planning audits	Our CPA team carried out various Risk assessment and Care planning audits and developed reports which were sent out and, in most cases, discussed at local clinical areas.
	
	• Actions taken by the CPA team covered:
	  ○ Reviewing and updating the audit tools to better capture qualitative information
	  ○ Delivering an ongoing blended training package of focused team/service sessions and a rolling ½ day personalised care planning session,
	  ○ A review of clinical risk assessment and management training (CRAM), incorporating level 2 suicide prevention training, was completed, piloted, and implemented. Unfortunately, during COVID CRM training was suspended for a period of time and then in line with safety measures training is now delivered by e-learning and webinars.
	
	Care planning is undergoing a complete re-design trust wide.
	For inpatients:
	• New care planning process designed based on a MDT model
	• Significant reduction in administrative burden
	• Promotes patient engagement and MDT working
	• New printed version developed in conjunction with Experts By Experience.
	• Live on 16 acute wards with plans in place to extend to all other inpatient services over next 6 – 9 months
	For outpatients:
	• New care planning process designed linked to DIALOG outcome measure
	• Significant reduction in administrative burden
	• Care planning driven by needs identified by the patient

	• Scope to include all community services beginning with CMHTs to be completed over next 9 – 12 months

3. Research

	Prescribed Information	Form of statement
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by Birmingham and Solihull Mental Health NHS foundation Trust in 2020-2021 that were recruited during that period to participate in research approved by a research ethics committee 916.

4. CQUIN

	Prescribed Information	Form of statement
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of BSMHFT income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the Covid Pandemic. CQUINS were suspended for the financial year and funding was through block contract payments determined nationally.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	

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

	whether at end of the reporting period the provider is: (i) registered with CQC with no conditions attached to registration (ii) registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	BSMHFT has the following conditions on registration for all of its acute inpatient wards and one Dementia and Frailty Ward known as Reservoir Court:- 1. The registered provider must take steps to address the ligature risks across all wards by 18 June 2021 2. By 29 January 2021 the Registered provider must implement an effective system to improve risk assessments and care planning. The Registered Provider must report to the Commission on the steps it has taken in connection with this by 5 February 2021. 3. By 4 January 2021, the registered provider must inform the Commission of the order of priority in terms of addressing the ligature risks and timescales for addressing the ligature risks across each ward. 4. Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of including mitigating measures being put in place until all ligature risks are addressed. 5. Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective. The Care Quality Commission has taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2020 to 31 March 2021 under section 31 of the Health and Social Care Act 2008.

	Prescribed Information	**Form of statement**
7	Whether or not the provider has taken part in any	

	special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Birmingham and Solihull Mental Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission under section 48 during the reporting period.
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	

	Prescribed Information	**Form of statement**
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider	Birmingham and Solihull Mental Health NHS Foundation Trust did not submit records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	

	Prescribed Information	**Form of statement**
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.5	Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report for 2020 / 2021 is not due to be submitted until the 30th June 2021 following national agreement to extend the submission deadline for the Data Security and Protection Toolkit for all NHS organisations, recognising the unprecedented demand placed on NHS Trust's during the COVID-19

		pandemic. A baseline update was submitted as required in February 2021, and the final outcome for 2019 / 2020 was standards not fully met – plan agreed.

	Prescribed Information	**Form of statement**
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	

	Prescribed Information	**Form of statement**
11	The action taken by the provider to improve data quality.	Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality: Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed. Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information. On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up-to-date. Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using

		monitoring reports to identify and correct data errors. A range of data quality audits covering all key reporting data sets, with special in-depth audits and corrective work if significant data quality problems are identified. Maintaining work on completeness and validity of MHSDS submissions in relation to the Data Quality Maturity Index Maintaining work on completeness and validity of the IAPT submissions and assessing the new experimental data set items added to the Data Quality Maturity Index

27 Learning from deaths

	Prescribed information	**Form of statement**
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During April 2020 and March 2021 1473 of BSMHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 433 in the first quarter; 228 in the second quarter; 384 in the third quarter; 428 in the fourth quarter.
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 14th May 2021 18 case record reviews and 21 serious incident investigations have been carried out in relation to 1473 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was completed was: 22 in the first quarter; 14 in the second quarter; 2 in the third quarter; 1 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including	3 representing 0.20% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 1 representing 0.23% for the first quarter; 2 representing 0.88% for the second quarter; 0

	a quarterly breakdown), with an explanation of the methods used to assess this.	representing 0% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50) 4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	There is a need to improve the recording and monitoring of blood tests and ECGs – this is now being taken forward as a quality goal to improve physical health for 2021-22 There is a need to improve the recording of physical health checks of patients – this is now being taken forward as a quality goal to improve physical health for 2021-22 Anchor ligature points in acute inpatient wards remain a risk to patients and a planned approach to anchor ligature point reduction is required – this is now being actively addressed with significant capital investment made in continuous ligature door alarm systems for all acute ensuite doors and also for bedroom doors on high risk acute inpatient wards. A rolling capital programme to remove all anchor points from all aspects of the inpatient Estate over the next 3-5 years is now in development.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	There has since been an update to phlebotomy training to ensure electronic forms are being used to avoid risk of confusion Continuous door alarms have been fitted to all ensuite bathroom doors on two acute inpatient wards and a programme to complete these on all

		acute ensuite doors will conclude by March 2022 A holistic clinically risk based review of all physical, procedural and relational controls on our inpatient wards has commenced to identify further opportunities to improve patient safety
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Due to the Covid pandemic we have been unable to fully evaluate the impact of these actions, however in regard to safety of inpatients on acute wards, we do know that incidents of actual self harm have reduced by 50% since January 2021
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	27 case record reviews and 39 serious incident investigations completed after 23rd March 2020 which related to deaths which took place before the start of the reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	3 representing 4.55% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below: 1 Definitely avoidable 2 Strong evidence of avoidability 3 Probably avoidable (more than 50:50) 4 Possibly avoidable, but not very likely (less than 50:50) 5 Slight evidence of avoidability 6 Definitely not avoidable
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item	9 representing 1.08% of the patient deaths during April 2019 to March 2020 are judged to be more likely than not to have been due to problems in the care provided to the patient.

	27.8.	

27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	Three representing 0.48% of the patient deaths during April 2018 - March 2019 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

The NHS Outcomes Framework sets out a series of care outcomes services should strive for in relation to clinical quality, patient safety and patient experience. It defines measures related to those outcomes and we report regularly to the Department of Health on our performance against those measures. The Department of Health identified 15 of those measures that should be included in Trust Quality Accounts where relevant. Six are relevant to Birmingham and Solihull Mental Health NHS Foundation Trust services. These are:

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

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

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

This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2020-21	91.8%			
2019-20*	95.8% (94.7%)	95.0%	100%	85.9%
2018-19	96.1%	95.7%	100%	82.8%
2017-18	96.1%	96.1%	99.4%	79.9%

Data Source: RiO - our internal clinical information system
**Please note that national comparator figures for 2019-20 relate to the period Apr-Dec 2019 only as there was no national collection of this data for the last quarter of the financial year. No national comparator figures were collected or published for 2020-21.*

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

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

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

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

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by monitoring adherence to our Trust's policy on community follow-up of inpatient discharge, undertaking regular sample audits and feeding back results to clinical teams, and by ensuring oversight of this process is maintained through circulation of daily reports to senior managers and review at regular divisional performance meetings.
Whilst the trust has taken these actions to improve the percentage completion, 2020/1 compliance was significantly impacted by Covid -19 on the ability to carry out direct face to face contacts, particularly for older adults discharged to nursing and residential care homes. During this period an increased level of contacts were by telephone directly with service users or with care home staff where it was not possible to visit or talk to them directly in this setting.

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

This indicator identifies whether crisis resolution or home treatment teams had assessed people admitted to hospital and been involved in the decision to admit and, therefore, measures our success in ensuring that people are not admitted to hospital where they could be more appropriately cared for in their own home or another community location. As such, it is a measure of both quality of care and efficiency of resource use. National definitions exclude transfers from other hospitals, including A&E Departments, so the measure is looking at people admitted from their own homes or other community locations. Our local definitions would also

consider admissions as having been 'gate-kept' where there was involvement from an assertive outreach or Psychiatric liaison, as these teams also provide a crisis resolution service and consider alternatives to admission as part of their assessments. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2020-21	97.5%			
2019-20*	96.3% (96.0%)	97.9%	100%	91.9%
2018-19	97.1%	98.1%	100%	88.5%
2017-18	96.2%	98.6%	100%	93.8%

Data Source: RiO - our internal clinical information system

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

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

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

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

2.3.3 Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:

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

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

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

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

	Age 0-15	Age 16+
2020-21	0.0%	6.2%
2019-20	0.0%	5.8%
2018-19	0.0%	5.8%
2017-18	0.0%	5.6%

Data source: RiO – our internal clinical information system

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

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

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

2.3.4 Patient Experience of Community Mental Health Services

The Trust's mean 'Overall patient experience of community mental health services' indicator score (out of 10) as reported through the 2020 National Community Mental Health Service User Survey. The quoted national figures are for all mental health trusts.

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

Data source: National Community Mental Health Service User Survey 2019

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

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

2.3.5 Patient Safety Incidents

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

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

Reported Patient Safety Incidents	Percentage of Patient Safety Incidents

	per 1000 bed days				resulting in Severe Harm or Death			
	Trust	National Median	Highest National	Lowest National	Trust	National	Highest National	Lowest National
Oct 20 – Mar 21*	58				0.4%			
Apr 20 – Sept 20*	58				0.3%			
Oct 19 – Mar 20	49	53	146	18	0.4%	1.0%	4.2%	0.0%
Apr 19 – Sep 19	51	56	131	17	0.5%	0.9%	3.3%	0.0%
Oct 18 – Mar 19	44	53	119	15	0.6%	1.0%	4.3%	0.0%
Apr 18 – Sep 18	44	49	114	25	0.4%	1.1%	3.7%	0.09%
Oct 17 – Mar 18	41	45	97	15	0.4%	1.1%	4.38%	0.1%
Apr 17 – Sep 17	35	44	126	16	0.6%	1%	3.7%	0.0%
Oct 16 – Mar 17	36	46	88	11	0.6%	1.1%	4.7%	0.1%
Apr 16 – Sep 16	40	42	89	10	0.5%	1.1%	6.1%	0.3%
Oct 15 – Mar 16	40	38	85	14	0.5%	1.1%	6%	0.1%
Apr 15 – Sep 15	42	39	84	6	0.6%	1%	3.7%	0
Oct 14 – Mar 15	47	31	93	5	0.5%	1.1%	5.1%	0%
Apr 14 – Sep 14	43	33	90	9	0.8%	1.0%	5.9%	0%

*Please note that this national data is not due to be published until September 2021

	Patient Safety Incidents – Total Reported	Patient Safety Incidents per 1000 Bed days	Patient Safety Incidents resulting in Severe Harm or Death	% Patient Safety Incidents resulting in Severe Harm or Death
Oct 20 – Mar 21	6427	58	24	0.4%
Apr 20 – Sept 20	6588	58	23	0.3%
Oct 19 – Mar 20	5823	49	22	0.4%
Apr 19 – Sep 19	6188	51	31	0.5%
Oct 18 – Mar 19	5330	44	31	0.6%
Apr 18 – Sep 18	5233	44	22	0.4%
Oct 17 – Mar 18	4788	41	21	0.4%
Apr 17 – Sep 17	4013	35	24	0.6%
Oct 16 – Mar 17	4279	36	26	0.6%
Apr 16 – Sep 16	4681	40	21	0.4%
Oct 15 – Mar 16	4856	40	22	0.5%
Apr 15 – Sep 15	5040	42	29	0.6%
Oct 14 – Mar 15	5550	47	31	0.5%
Apr 14 – Sep 14	5086	43	39	0.8%

Data source: National Reporting and Learning System (NRLS)

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

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

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

- Continuing to deliver incidents reporting training via incidents awareness sessions and Incident Manager training.
- Continue our approach to governance and incident reporting at the junior doctors marketplace, preceptorship training and at Student Experiential Learning Pathway sessions.
- Constantly evolve incident types to be reflective of incidents occurring in the Trust.
- Continuing to develop and promote the utilisation of the Black Hole, our innovative governance intelligence analytics portal, providing in-depth automated analysis of incidents data from ward to board.
- Improving the learning lessons framework and promote adoption through new practice guidance.
- Thematic reviews of incidents and reporting trends.

Part three – Other Information

In this section of the report we share other information relevant to the quality of the services we have provided during 2020/21 which together with sections 1 and 2 of this report, provide an overview of the quality of care offered by our Trust during this period.

3.1.1 Safety

The three indicators selected for patient safety are:

- Serious Incidents
- Never Events
- Incidents of MRSA and Clostridium Difficile

3.1.1.1 Serious Incidents

During 2020/21 much work took place to improve our system for reviewing serious incidents with an added focus on thematic reviews and learning. We developed a centralised team of patient safety managers to lead reviews within our Trust working along clinicians and subject matter experts. We also undertook thematic reviews to understand any commonalities of findings between serious incidents so that we could be confident that we were addressing these through key programmes of improvement. This included a cluster review of all inpatient suicides that had occurred during the period 2013 to 2020 which resulted in a range of improvements being taken forward including adjustments to our physical environment, our relational controls and our procedural controls. In addition, we worked closely with partners across various agencies which support health and social care in Birmingham and Solihull to complete multi-agency reviews where it was evident that a patient involved in a serious incident was receiving care, support or advice from more than one agency. This enabled us to

take a system wide view on opportunities to improve how agencies can work together for the benefit of patients.

	2017/18	2018/29	2019/20	2020/21
Number of Serious Incidents Reported	100	91	78	96

3.1.1.2 Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. We are pleased to report that the Trust has not reported any Never Events during 2020/21.

	2017/18	2018/29	2019/20	2020/21
Number of Never Events Reported	0	0	0	0

3.1.1.3 Clostridium Difficile

C.difficile is a primary drug-resistant infection. Clostridium difficile is a bug that causes diarrhoea of varying severity, most usually after a course of antibiotics.
People who are already weak or frail can sometimes become seriously ill as a result of contracting it. We are pleased to confirm that there were no cases of Clostridium Difficile reported in the Trust during 2020/21.

3.1.2 Effectiveness

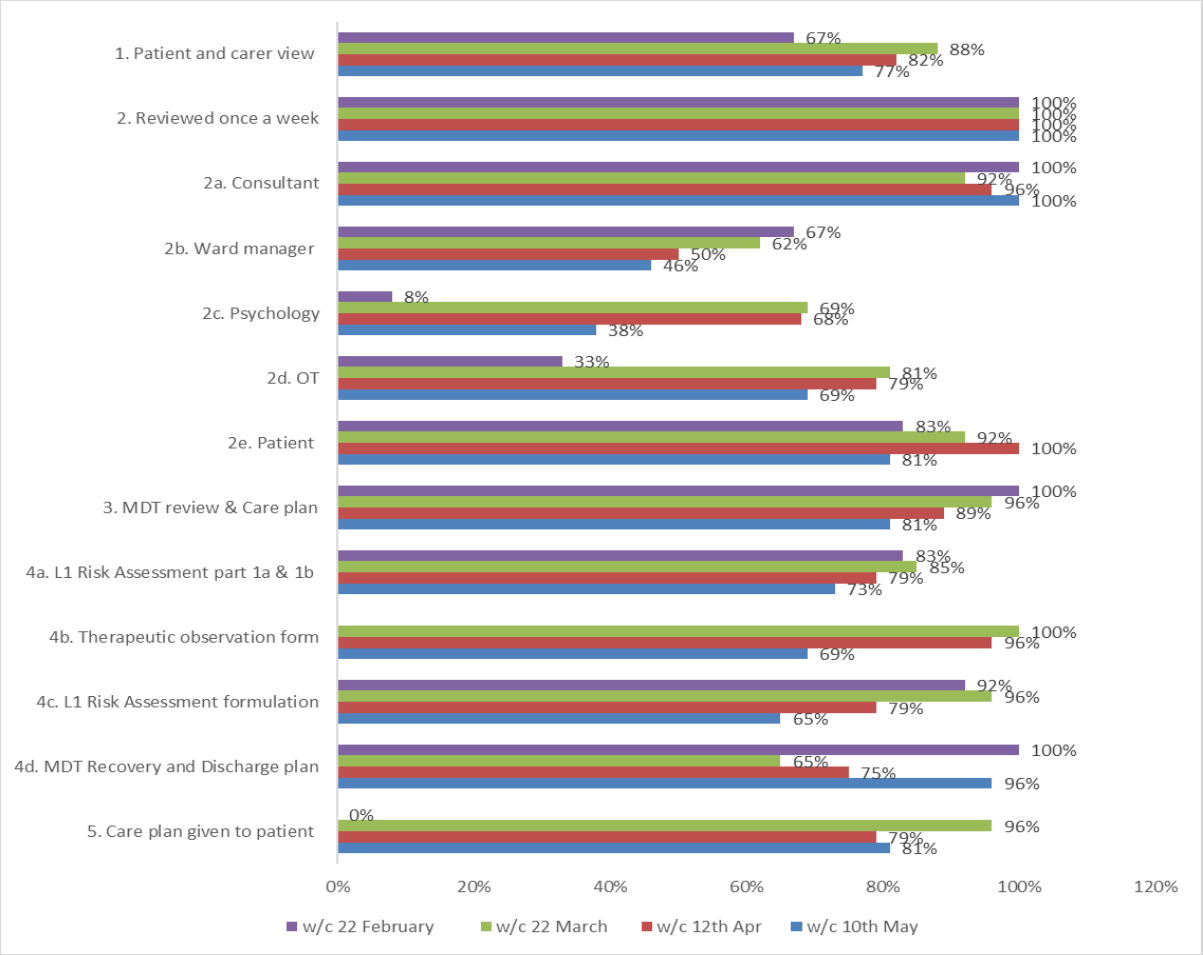
We identified the following key indicators for monitoring effectiveness. These are:-

- Multi Disciplinary Team Standards in our Acute Inpatient Wards
- PLACE Assessments*

3.1.2.1 Multi Disciplinary Team Standards in our Acute Inpatient Wards

We recognised from a range of serious incidents that occurred in 2019-2020 that we needed to develop some consistency and minimum standards for the quality of multi disciplinary team meetings. This included the range of attendees that should be present, ensuring the carer and patient voice was central and that relevant risk and actions translated into the patients care plan. This need was also reiterated when the CQC placed conditions on the registration of activities in our acute inpatient units citing the need for improved care planning. In the late Summer of 2020 we piloted a revised approach to such standards in one of our acute inpatient wards using Quality Improvement methodology. This was clinically led and subsequently evaluated and modified for use across all of our acute inpatient units. We commenced roll out of these standards to our acute inpatient wards at the beginning of the 2021 calendar year and started reporting against compliance with the standards in March 2021. For the

purpose of the quality account, we have included data covering end February 2021 to mid May 2021:-



3.1.2.2 PLACE Results 2018 (Patient Led Assessments of the Care Environment)

The aim of PLACE assessments is to provide a snapshot (on the day) of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care (cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink). The current PLACE assessment also covers criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia (introduced from the 2015 assessments) and how well equipped the premises are to meet the needs of people with disabilities (introduced from the 2016 assessments). It should be noted that these do not represent a comprehensive assessment relating to dementia or disability; rather these focus on limited ranges of aspects with strong environmental or building associated components.

Due to a national review of PLACE assessments, there were no assessments during 2020. We have therefore for the purpose of this account included our results for 2019.

As with the previous PLACE programmes, service user representatives must make up at least 50 per cent of each assessment team and where possible one should be appointed as the PLACE Assessment Team Lead. BSMHFT's PLACE programme again had excellent support from a highly motivated team of service user representatives and from the patient and public involvement team. It should also be noted that best practice suggests that an independent reviewer (who does not form part of the assessment team) is present at the assessments; this is not mandatory but is recommended.

For all of BSMHFT's 21 assessments service user representatives made up at least 50 per cent of the team and 100% of the assessments had an independent reviewer present.

The 2019 assessment demonstrated that BSMHFT's overall organisational scores exceeded the national average scores in all 6 categories.

For cleanliness BSMHFT scored 100% and is one of 20 NHS trusts who have scored 100% and are joint top scoring nationally.

BSMHFT's overall organisational scores are an increase on its 2018 scores for all of the other 5 categories (Food and Hydration, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability).

- BSMHFT is joint top scoring nationally of NHS trusts for Cleanliness.
- BSMHFT is in the top scoring 9% of NHS Trusts for Food and Hydration.
- BSMHFT is in the top scoring 4% of NHS Trusts for Privacy, Dignity and Wellbeing.
- BSMHFT is in the top scoring 6% of NHS Trusts for Condition, Appearance and Maintenance.
- BSMHFT is in the top scoring 3% of NHS Trusts for Dementia (Environment).
- BSMHFT is in the top scoring 6% of NHS Trusts for Disability (Environment.

See table overleaf.

BSMHFT's 2019 PLACE Scores

Cleanliness		Food & Hydration		Privacy, Dignity & Wellbeing		Condition, Appearance & Maintenance		Dementia (Environment) (introduced 2015)		Disability (Environment) (introduced 2016)	
BSMHFT Overall Score	National Average Score	BSMHFT Overall Score	National Average Score	BSMHFT Overall Score	National Average Score	BSMHFT Overall Score	National Average Score	BSMHFT Overall Score	National Average Score	BSMHFT Overall Score	National Average Score
100%	98.62%	97.97%	92.51%	97.43%	87.52%	99.96%	96.38%	99.48%	81.20%	95.96%	83.92%
BSMHFT's score is joint top score nationally of all NHS Trusts		BSMHFT's score is in the top 9% of all NHS Trusts		BSMHFT's score is in the top 4% of all NHS Trusts		BSMHFT's score is in the top 6% of all NHS Trusts		BSMHFT's score is in the top 3% of all NHS Trusts		BSMHFT's score is in the top 6% of all NHS Trusts	

BSMHFT's 2018 PLACE Scores

100%	96. 21%	96.87%	99.13%	95.58%	95.94%
BSMHFT's 2017 PLACE Scores					
100%	96.06%	94.12%	97.71%	93.64%	89.86%
BSMHFT's 2016 PLACE Scores					
99.60%	96.87%	93.90%	96.69%	84.83%	89.01%
BSMHFT's 2015 PLACE Scores					
100%	96.70%	94.25%	95.62%	94.65%	
BSMHFT's 2014 PLACE Scores					
99.67%	96.09%	91.82%	97.74%		
BSMHFT's 2013 PLACE Scores					
98.77%	92.34%	91.83%	91.43%		

3.1.3 Patient Experience

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

	2017/18	2018/19	2019/20	2020/21
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	60% (71%)	73% (71%)	68%	59%
Number of complaints	164	152	85	81
Timeliness of complaints	100%	100%	100%	100%
% of dissatisfied complainants	11 returned - 6%	7 returned – 4%	18 returned – 15%	9 returned – 7%
Number of referrals to the Ombudsman	5	8	2	2
FFT score	87%	88%	91%	94%*

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

It is crucial for the organisation to ensure we are continually improving service user experience from complaints received, we encourage feedback from service users, carers and families in order to achieve this from the services we provide. During 2020/2021 we have seen a further decrease in formal complaints, 85 in total, which is -4 from the previous financial year. We have also seen a reduction in returned complaints, 9 in total, which is -9 from the previous financial year. Preparatory works commenced during 2019/2020 to receive direct feedback and inclusion from families and carers, this work has continued during 2020/2021 where a process group has been devised with plans for completion by Q3.

3.2. Performance against the relevant indicators and performance thresholds

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

National mental health indicators

	NHSE/I Oversight Framework updated in November 2017: National Indicators – 2020/21	National Threshold	2020/21
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	60%	92.0%
2	Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	50% 75% 95%	52.1% 80.4% 99.9%
3	Inappropriate out-of-area placements for adult mental health services (average bed days per month) *	n/a*	1026
4	Admissions to adult facilities of patients under 16 years old	n/a	0%

Due to the impact of COVID-19 on the need for acute and urgent mental health services, it was recognised by NHSE/I that the national target to achieve 0 out of area placements by end March 2021 would not be possible.

Annex 1: Stakeholder Statements

1.1 Healthwatch Birmingham and Healthwatch Solihull Statement

Statement from Healthwatch Birmingham and Healthwatch Solihull on Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2020/21 dated 21 June 2021

Mental health is one of the NHS services that has been heavily impacted by the Covid-19 pandemic and is likely to face increased demand. Indeed, in Healthwatch Birmingham's report on *'what care and support did Birmingham citizens need during the Covid-19 lockdown?'*[1] mental health and emotional support was selected by the majority of respondents. People told us about increased stress, anxiety and depression; and that they were suffering from loneliness, a loss of a sense of identity and some were suffering emotionally.

Alongside the challenges and difficulties that the pandemic presented, has been the commitment and hard work of the Trust and its staff to support service users, their families and carers. We make our comments, to this Quality Accounts, cognizant of the important role that staff have played as well the impact Covid-19 has had on their health and wellbeing. Throughout the past year service users and their families have told us about the amazing work the trust and staff have carried out during this difficult time:

> *I finished my psychotherapy treatment several months ago and I am so glad that I was able to work with such a compassionate, highly-skilled, experienced professional. It took over a year to feel that his holding of boundaries, me & the therapy space was safe, allowing me to experience myself, him & then others in a different, much less defensive way. The therapist made every effort to hold this safe space during lockdown via telephone & online sessions. Psychotherapy is mysterious in that I know it's helped me but I'm not sure how! I will be forever grateful to him & the Specialist Psychotherapies Service (Callum Lodge Specialist Psychotherapies Service)*
>
> *Do they always get everything right, no, who does, but they show they really care every single day and that's all I ask (Solihull)*
>
> *I stayed alive because my nurse was an Angel (Parkview Clinic)*
>
> *Even though things are very different at the moment with lockdown, mental health services have gone out of their way to ensure that my daughter still receives the help and support that she needs (Solihull)*
>
> *I had home treatment with Ladywood Home treatment team, they are good at their job.*

Performance 2020/21 and Quality Priorities for 2021/22

Healthwatch Birmingham and Healthwatch Solihull are pleased see a continued focus on improving patient safety by reducing harm, positive patient experience, a positive patient safety culture, quality assurance, and using the Trusts time more effectively. Although there has been some improvement in some measures (e.g. 83% of incidents resulted in no harm), other measures, such as the use of restraints in inpatient units saw an increase during the pandemic.

[1] https://www.healthwatch.co.uk/reports-library/what-care-and-support-did-birmingham-citizens-need-during-covid-19-lockdown

It was of concern for Healthwatch Birmingham and Healthwatch Solihull to read about increase on incidents of patient assaults on staff that coincided with incidents of restraints, the 3 inpatient suicides, the number of patients (1473) who have died during the reporting period and the enforcement action taken by the CQC. As these areas form part of the Trusts 2021/22 priorities, we would like to read in the 2021/22 Quality Account the improvements made.

Improve patient safety by reducing harm
We welcome the Trusts recognition that restrictive practice including restraint and seclusion can increase stigma, isolation and risk of harm. We would like to read how the Trust has arrived at the interventions outlined in the Quality Account. We believe that it is important that service users are involved in developing these and that the Trust is collecting feedback from patients/their families to understand what works best. We suggest that one of the measures of success should be the extent to which Trust has engaged with patients/families and staff to understand the causes of restrictive practice, impact on service users and/or staff and an understanding of what would work for them in terms of interventions.

We note plans to improve the physical health monitoring of patients and the goal to ensure physical monitoring for 100% of the Trusts over the next three years. We would like to read, in the 2021/22 Quality Accounts progress made towards this and the percentage of patients having a physical health assessment. In particular, the percentage of episodes of Rapid Tranquilization (RT) that have had an appropriate physical health recording. We would also like to read the percentage of inpatients that have had a physical health assessment and systemic enquiry checks completed within 24 hours of admission.

Healthwatch Birmingham and Healthwatch Solihull agree with the establishment of the Quality Improvement Collaborative and plans to ensure quality improvement through learning days. We are pleased that experts by experience are at the core of this collaborative. We would like to see in the 2021/22 Quality Account examples of learning that has taken place during learning days, how learning is shared across the Trust and how the Trust communicates what learning has taken place with patients/families. Key to the success of this collaborative, will be how inclusive it is. We know through the feedback we hear that some groups face poorer mental health and barriers to accessing mental health services. We would like to see the involvement of patients by experience from diverse communities including disability and age. To what extent is the Trust using data (on who or which groups of service users are more likely to be restrained) to inform who gets involved in the collaborative? The Trusts response to Healthwatch Birmingham's recent report into health inequalities, the Trust outlined the work it has done with various ethnic group, in particular the Somali people. We would like to see how this work is informing the priorities the Trust has set out and the goal to reduce variability in the service.

We note the number of inpatient deaths that occurred in the past year and welcome the plans that have been put in place to make the inpatient environment safe. We would like to read in the 2021/22 QA the impact these actions have had on improving patient safety.

A focus on a positive patient experience
The actions set out by the Trust to ensure that patients have a powerful and equal voice in their care is welcome. We are pleased that the Trust has increased the level of participation of experts by experience in various quality improvement projects. We particularly welcome the introduction of the role of the patient safety partner to ensure that experts by experience have a stronger voice. We would like more information on how this will work in practice. We would like to read in the 2021/22 Quality Account how successful this has been in giving experts by experience an equal voice and examples of actions taken based on their views.

Involvement of service users in MDT meetings is important, more so ensuring that that they have a copy of their care plan. Feedback from service users has demonstrated the importance of care plans on the quality of care and outcomes for service users. We look

forward to reading in the 2021/22 Quality Accounts progress on the percentage of servicers users attending weekly MDT meetings and the percentage of those in receipt of care plan. We would also like to read in the 2021/22 Quality Account the number of care plans that include a clinical plan for response to default from treatment (use of deport/LA antipsychotic injections for relapse prevention.

We agree that it is important to include a qualitative measure as this will help the Trust to understand the experiences of using the care plans and how well they are being implemented including impact on outcomes. We look forward to reading in the 2021/22 Quality Account how the Trust has involved service users and their families in developing the qualitative measure.

In our conversations with carers we note that not feeling heard and involved is an important issue for them. We suggest that the Trust includes in the measure for involving carer something around communicating carers views in care planning and demonstrating the impact of their insight in the care planning process. We believe that continuous carer involvement would improve consensus on future decisions around actions to be taken, especially understanding of why decisions are taken and increase confidence in why decisions are being taken.

We note that the Trust is engaging with experts by experience to develop a template for a care plan that can be shared with patients, families and carers. We would like to read in the 2021/22 examples of the use of these templates and how many families are involved in care planning.

A focus on a positive patient safety culture
We note that there has been improvement in staff views in the survey about their ability to raise concerns and be assured that action has been taken (q16a, c, d; and Q17b, c; and Q18b). However, the Trusts performance remains below the Best Trust and below average. We welcome the Trusts involvement in the peer review scheme hosted by the Royal College of Psychiatrist. We note the positive experiences outlined by those involved in serious incident reviews. We would like to read in the 2021/22 Quality Account how these positive experiences are informing practice across the Trust. We would also like to read about how the Trust is acting and ensuring learning on things that did not work well.

A focus on Quality Assurance
Healthwatch Birmingham and Healthwatch Solihull welcome a focus on this priority and look forward to reading in the 2021/22 Quality Account how service users and staff have been involved in the development of the Quality Assurance framework. In particular, how the Trust has used this involvement to understand what good care looks like to service users and their families. We note the work that the Trust has planned to pilot, evaluate and roll out an internal quality assurance peer scheme across the trust. We would like to know how representative the experts by experience both in terms of conditions and ethnicity are. We look forward to reading in the 2021/22 Quality Account not only about the number of peer review visits but also about the people involved, their diversity and how is the Trust is using the information gathered through these peer review visits.

A focus on using our time more effectively
We welcome the Trusts aim to reduce unwarranted variations in care and support through the implementation of a Community Care Planning tool to improve the therapeutic effectiveness of service user interactions. We note the measures of success outlined, however, it is not clear how the clinical measures will be complemented by patient related measures.

CQC registration

Whilst we recognise the challenges the Trust has faced over the past year, we are concerned that the CQC has taken enforcement action against the Trust. We note that the Trusts registration with the CQC has the following conditions: – take steps to address ligature risks across all wards by June, implement an effective system to improve risk assessment and care

planning among others. We would like to read in this Quality Account progress made towards these conditions.

Reporting against core indicators

We note that the percentage of patients on the Care Programme Approach followed up within 7 days after discharge from psychiatric inpatient care is lower than in the past three years. We also note that Covid-19 impacted direct face-to-face contact following discharge, with contact mainly through telephone. Experiences shared with us show that the use of phone appointments and technology was appropriate during lockdown circumstances but as services are restored varied ways for engaging with the Trust are required. For some service users, the use of technology may enhance their use of mental health services, for other it may serve as a barrier. In our response to the Trust Strategy 2020-2025, we asked that the following be considered:

- Existing barriers such as language should not be ignored. It is therefore important that guides on how to access mental health services using digital technology are developed in various languages and accessible formats.
- The digital divide that exists among socio-economic classes in Birmingham and Solihull should be taken to account. People from lower socio-economic status often have reduced accessibility to digital technologies. In addition, due to lower household income, people from lower socio-economic status are likely not to have broadband, own a computer or smart phone or indeed afford credit for internet use on their phones.
- According to NHS Digital, one in ten people in England lacks basic digital skills and nearly six million people have never used the internet. Therefore, the number of people digitally excluded is significant and needs to be taken to account when considering transforming with digital. For instance, familiarity with new technology for the elderly and those with language barriers is difficult. It is important that the trust engages with various groups to ensure that their needs are met.
- It is important that the trust considers developing a digital communication strategy that identifies the different ways of engaging using digital technology alongside the relevance of these for different service users.

Equality and Diversity

The unequal impact of Covid-19 on people with a disability and Black, Asian and Ethnic Minority groups has further highlighted the important role of health and social care organisations in promoting equality for everyone. As the Nuffield Trust highlighted in their report inequalities persisted during the Covid-19 pandemic with some groups facing poorer mental health and barriers to accessing services. It is disappointing not to see no commitment from the Trust to inclusion and equality in the 2020/21 Quality Account. We believe that a focus on inequality is ever more important as the Trust works to restore services if it is to reduce variability. It will be important for the Trust to understand the various experiences of discrimination that lead to health inequality and use this to inform restoration of services. We believe that Covid-19 has changed how health and social care collects and uses feedback, and public health data to understand the community it serves. We believe that this should be a critical focus of the Trusts priorities. Healthwatch Birmingham recently shared our *'Health Inequalities: Somali people's experiences of health and social care services in Birmingham'* with the Trust. We would like to know how the findings of this report are continuing to informing the Trusts health inequalities work; how the Trust is improving its knowledge about the issues facing minority ethnic groups, improving engagement with ethnic minority groups, and how it is designing and delivering services in a manner that addresses issues of discrimination and stigma.

Andy Cave
CEO
Healthwatch Birmingham

1.2 Birmingham Health and Social Care Overview and Scrutiny Committee

The Birmingham Health and Social Care O&S Committee would like to take the opportunity to thank the Trust staff for their tireless commitment to support patients and families in the most challenging of circumstances during the Covid-19 pandemic.

The committee acknowledges the 5 priority areas for improvement in the forthcoming year, the associated goals and how success will be measured building on initiatives implemented in 2020/21. In particular, taking into account lessons learnt from deaths in 2020/21 and including these as goals for 2021/22 i.e. improving the recording and monitoring of blood tests and ECGs; improving the physical health checks of patients and improving patient safety by installing ligature alarm systems on ensuite bathroom doors by March 2022. Also, the aim to develop a quality assurance framework in coproduction with staff, service users, families and carers to assure quality of services and care.

Looking at performance against priorities during 2020/21 it is apparent that the Covid-19 pandemic did impact on performance against some of the priorities. Notably, levels of prone and non-prone patient restraint and physical assault on staff and patients which, in part, was due to restrictions put in place to manage the spread of Covid-19. Also, the reduction in personalised care and health budgets offered to service users leaving hospital as part of their after-care arrangement but note that, going forward, mechanisms have now been put in place to make the offer available to all eligible people.

On a positive note, the committee is pleased to see an improvement in the results from the NHS Staff Survey; the development of the support package to staff following traumatic incidents and the improvements made in standardising the way quality data is presented to enable a better understanding of performance.

It is also pleasing to see there were no Never Events or cases of Clostridium Difficile reported in the Trust in 2020/21, as was the further decrease in formal complaints from the previous financial year.

Finally, it is very encouraging to see that the Trust has performed above average against all of the reported national mental health indicators and note that NHSE/I recognised that, due to the impact of Covid-19, the national target to achieve no out of area placements by end March 2021 would not be possible

Councillor Rob Pocock

Chair Birmingham Health and Social Care O&S Committee

1.3 Birmingham and Solihull Clinical Commissioning Group Statement

Birmingham and Solihull Mental Health NHS Foundation Trust
Quality Account 2020/21

Statement of Assurance from NHS Birmingham and Solihull CCG

June 2021

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as co-ordinating commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for inclusion in the Trust's 2020/21 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 7th June 2021 and the review has been undertaken in accordance with the Department of Health and Social Care guidance. This statement of assurance has been developed from the information provided to date.

1.3 We acknowledge the significant ongoing challenges the Covid19 pandemic has presented throughout 2020/21 and the part the Trust has played in the mental health system response to these challenges.

1.4 We note the Trust's five quality priorities for 2021/22 and will continue to work with the Trust to maintain oversight of progress in delivery against these priorities.

1.5 The 3 inpatient suicides during the past year are tragic events. The Care Quality Commission has taken enforcement action against the Trust due to concerns around the management of environmental risks and care planning processes. We have worked closely with the Trust to seek assurance that appropriate actions are being taken in response to the concerns identified by CQC. This has included jointly undertaking a longitudinal review of past inpatient suicides to inform future actions.

1.6 The report contains a commitment to ensure that the Trust's physical estate is maintained as safely as possible and that ligature risks are minimised. This action is clearly vital in inpatient wards where patients who are at high risk of harm due to their mental illness are cared for, and where environmental risks must be mitigated as effectively as possible. We are aware that a very significant amount of work has been undertaken by the Trust to review options and plan for the necessary environmental work to be undertaken in a way that takes full account of risk, logistical and financial factors.

1.7 Alongside the environmental measures described in the report, there is a recognition that steps need to be taken to ensure that new and revised approaches to care planning, risk management and MDT working are as robust and effective as possible. We agree that this area needs to be a key quality priority for the Trust. To that end we are also pleased to see a focus on increased activity on a number of units. Relational and procedural controls are as important as environmental ones. Inpatient units have to be demonstrably therapeutic and supportive of a recovery journey, rather than simply environmentally safe and containing spaces.

1.8 We note the commitment to increase the involvement of families and carers in service user care and recovery. Taking steps to ensure that families and carers are consistently viewed as active and genuine partners in care across all Trust services is integral to developing new approaches to risk management and care planning.

1.9 We note the ongoing work to ensure quality metrics and quality data is being collated andpresented in ways that are meaningful to all parties and informs change.

1.10 We welcome the recognition that attention to physical health needs, particularly of personswith severe mental illness, is a continuing area of focus for the Trust moving forward.

1.11 We agree that reviewing the deaths of patients due to alcohol and substance misuse who are in Trust care is an appropriate area for quality focus. There are number of complex factors at play and a seeking an improved understanding of these factors, and how a rangeof services across our local system can work together to better support patients with this presentation, is important.

1.12 It is positive to see that the Trust has participated in the full range of national clinical audits and national confidential enquiries it was eligible to participate in, and that actions, learningand further work were identified as a result of these programmes.

1.13 As we move at pace toward the formation of an Integrated Care System in Birmingham andSolihull, the importance of driving new collaborative and partnership based approaches to quality assurance and quality improvement is paramount. To this end the CCG has undertaken a number of joint themed reviews with the Trust, based on themes identified from serious incident reports and other quality indicators. The Trust has been open and supportive to this process.

1.14 We will continue to build on existing relationships and new ways of working as we move forward into an ICS. We seek to ensure, as a local mental health system, that our approachto quality oversight demonstrably informs our local transformation work and has a clear focus on improved outcomes for the people who use our services.

Paul Jennings
Chief Executive Officer
Birmingham and Solihull
CCG

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

In opening this statement, we as the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust would like to formally give our thanks and pay tribute to all staff who have supported our service users, families, carers and each other throughout one of the most challenging years in the history of the NHS. Their ongoing commitment to provide care in this most challenging period has been remarkable. The covid pandemic has enabled an element of parity of esteem to be given to mental health due to the enormous impact that Covid 19 has had on the mental wellbeing of our population and as such we have seen demand for our services continue to increase due to economic climate changes, financial implications of loss/impact on employment, relationship breakdowns and pressures and bereavement. The pandemic has displayed and helped us all recognise the importance that our family, carer and social networks have on our ability to live our lives well. We have recognised that the removal of some of these networks during heightened Covid restrictions have contributed to an increased level of serious incidents which places more and more importance of the need for strong clinical risk assessments to be undertaken on an individualised basis. We are pleased to see that we recognise the importance of service user, family and carer engagement when we are discussing the care needs of individual patients in mental health care and the concerted efforts being made to ensure that improved engagement and 'voice' of patients, families and carers is a strong priority for 2021/22.

In relation to safety measures and reducing harm, we are pleased to see that our nationally benchmarked position for restrictive practice is largely improving, however we remain concerned about levels of restrictive practice in our Psychiatric Intensive Care Units (PICUs). As Governors, a number of us have taken part in Quality Improvement Training this year and we are represented on our Reducing Restrictive Practice Quality Improvement Collaborative ensuring that the 'expert by experience' voice is heard in any improvement ideas for change. We will be inviting the Collaborative to present on their work to us this year so that we can understand more of the barriers to improvement and contribute to small tests of change. We are pleased to see that since we have moved from wave one to wave two of Covid levels of restrictive practice generally appear to be sustainably reducing along with reduced levels of physical assault on our inpatient wards.

Despite the challenges that Covid has presented, we are pleased to see that the majority of the quality goals that we set for ourselves in 2020-2021 have been delivered. We have seen some great examples of co-production and a number of governors contributed to the development of the Trust Quality Strategy and goals. In recognition of this approach, we have awarded the co-production kitemark to our Quality Strategy.

We recognise the importance of ensuring a 'Just Culture' within the organisation so that staff feel safe to speak up about concerns relating to patient safety and feel confident that such concerns are heard and addressed. We are pleased to see the improvements that we have made in the Annual Staff Survey on all of our safety culture metrics. We recognise that we still have a journey of improvement ahead of us, however it is pleasing to see that we are moving in the right direction. We can also see that more staff agree that quality and safety of care is a top priority for our organisation which again is pleasing.

We are supportive of the priorities laid out for 2021/22 and believe that these are the right priorities for focus for the next 12 months. We would however in future years like to see more focus on

transition points within care as we know that when our service users move from team to team this can result in increased risk.

As the Council of Governors we would like to extend our apologies and condolences to all families affected by the suicide of loved ones this year. This must be an incredibly tragic time for all. We are supportive of the measures that the Trust is taking to invest millions of pounds in a safer physical inpatient environment through the installation of continuous pressure door sensors on all ensuite bathrooms in our acute inpatient wards during 2021/22. We are equally supportive of the measures to apply such alarms to bedroom doors of high risk wards. We are pleased to see that we are also developing a 3-5year capital investment programme to remove anchor points from our entire inpatient estate. We recognise that improving the physical safety of our wards is only one part of managing safety and are pleased to see that we are increasing the level of therapeutic activities in our inpatient wards to aid the recovery of our service users and that teams are also engaging in daily safety huddles to ensure improved communication of safety issues and management plans.

During the year, we have increased our involvement in research and were proud to present both nationally and internationally on the work of our LEAR group which focussed on the experience of lived experience practitioners. We hope that this will further aid the development and importance of coproduction across the organisation.

In concluding this statement, the Council of Governors would like to take the opportunity of thanking the Trust for their proactive approach to seeking the views of Council throughout the course of 2020/21 and the opportunities that this has brought about for service improvement, enhanced safety and quality of care. We look forward to making even more progress in 2021-2022.

Council of Governors of BSMHFT

June 2021

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

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

• The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed Requirements for Quality Reports 2019/20

- *The content of the Quality Report is not inconsistent with internal and external sources of information including:*

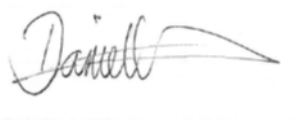
    - *Board minutes and papers for the period April 2020 to March 2021*
    - *Papers relating to quality reported to the Board over the period April 2020 to March 2021*
    - *Feedback from commissioners dated 21 June 2021*
    - *Feedback from Governors dated 15 June 2021*
    - *Feedback from local Healthwatch organisations dated 21 June 2021*
    - *Feedback from the local Health and Social Care Overview and Scrutiny Committee dated 21 June 2021*
    - *The Trust's complaints report published in February 2021 under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009*
    - *The 2020 national patient survey*
    - *The 2020 national staff survey*
    - *The Head of Internal Audit's annual opinion of the Trust's control environment dated XXXXXXXX*
    - *CQC inspection report dated 1 April 2019 and subsequent enforcement notice dated December 2020*

- *The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered*
- *The performance information reported in the Quality Report is reliable and accurate*
- *There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice*
- *The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and*

- *The Quality Report has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.*

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Roisin Fallon Williams
Chief Executive

Danielle Oum
Trust Chair

9. Serious Incident Update

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**TRUST BOARD OF DIRECTORS**
Agenda item	9
Paper title	**SERIOUS INCIDENT REPORT**
Date	JUNE 2021
Author	Samantha Munbodh, Head of Patient Safety
Executive sponsor	Sarah Bloomfield Interim Director for Quality and Safety (Chief Nurse)

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

Executive summary & Recommendations:

This document provides the Board with an overview of serious incidents and the characteristics of the service user both across the last year and also more specifically within Q4 of 2020-2021. It explores any trend areas evident from the information that we collate, output of investigations and actions/improvements taken in response.

- During quarter 4 of 2020/21 twenty-five serious incidents were reported by the Trust via the Strategic Executive Information System (STEIS), NHS England's web based serious incident management system. Variation in reporting during the quarter is attributed to the reporting of COVID outbreaks within the patient setting.
- The majority of Serious Incidents occurred within Integrated Community Care serves (ICCR), given ICCR have the highest number of service user population the correlation between the numbers of incidents is not surprising.
- Of the incidents reported, 9 were unexpected deaths and 6 were suspected suicides.
- Themes identified through Serious Incidents have been identified within this report, these findings are being addressed through co-ordinated plans of work to reduce risk and improve our systems and processes as efficiently and effectively as possible.
- Learning from Serious Incidents are cascaded through our clinical governance committees, learning lessons bulletin and our Kitchen Table events

Reason for consideration:

The Committee is required to consider the content of this report and provide assurance of the governance of serious incidents to the Trust Board.

Previous consideration of report by:

Patient Safety Advisory Group
Integrated Quality Committee June 2021

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

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

Financial Implications *(detail any financial implications)*

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

Equality impact assessments:

.

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

SERIOUS INCIDENT REPORT

1. Introduction

1.1. The Trust Incident and Serious Incident Policy is aligned with the NHS England: Serious Incident Framework 2015. Whilst there is not a definitive list of events /incidents that constitute an SI, the framework and Trust policy sets out circumstances in which a SI must be declared externally. Every incident must be considered on a case-by-case basis and there are inevitably cases that rely on the judgement of the people involved. Appendix 1 includes the full definition of an SI as detailed in the NHS England: Serious Incident Framework 2015.

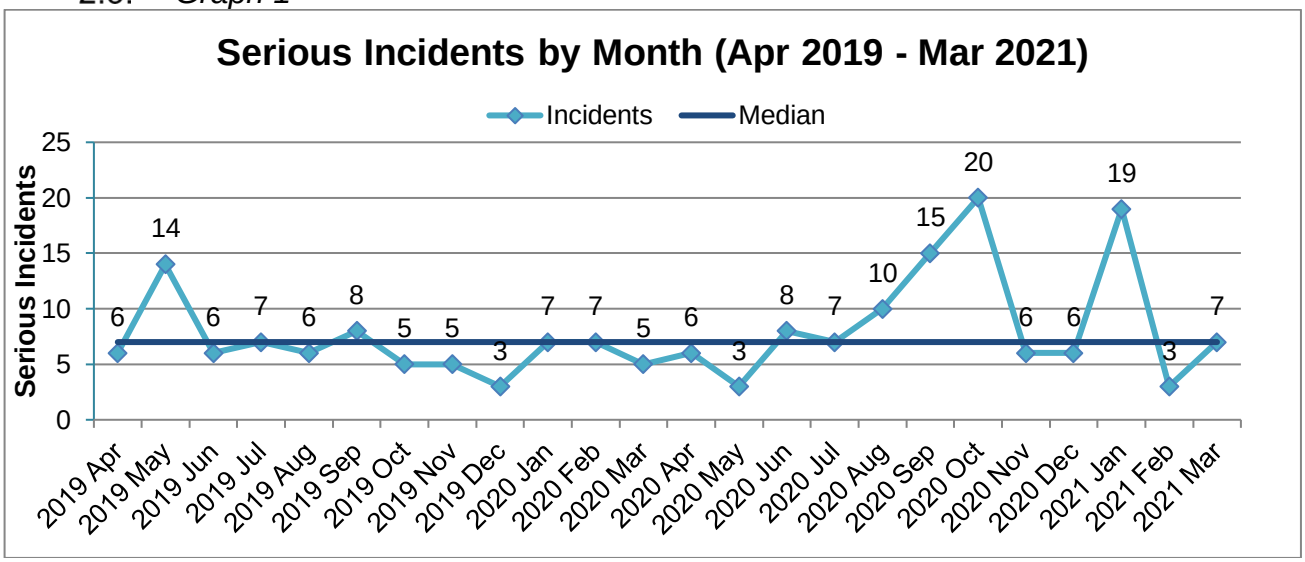
1.2. The objective of this paper is to provide an overview of serious incidents across the Trust for the quarter, identifying areas for improvement and supporting action against these by outlining specific focus areas or areas of concern through data analysis. This paper has been developed through a process of analysis of Trust wide data and investigation outcomes.

2. Trust wide Serious Incidents

2.1. During quarter 4, twenty-five serious incidents were reported by the Trust via the Strategic Executive Information System (STEIS), NHS England's web based serious incident management system. These incidents are investigated with the aim being to explore the care and treatment delivered by the Trust services to establish care and service delivery problems or contributory factors that may have directly impacted on the outcome. Investigators are supported to complete investigations in a thorough, but compassionate way, that both supports the patients, bereaved friends and family and also the staff who were involved in the care of the patient. Where contributory factors are identified or notable practice identified learning is shared across the Trust. Each learning point identified is addressed through recommendations and each report includes an action plan detailing these to support improvement in practice. Each Service Area is responsible for ensuring that actions and learning from the investigations into the SI that occur in the Service Area are embedded into clinical practice.

2.2. Graph 1 below presents data regarding the number of serious incidents reported across the Trust. As can be seen, there was a significant increase during January 2021 and this variation is partly attributed to the 7 COVID outbreaks reported within our inpatient settings during this period. However, it should be noted that Graph 1 also includes 4 incidents that occurred during Q4 but these weren't confirmed as SIs and reported via STEIS until Quarter 1.

2.3. *Graph 1*

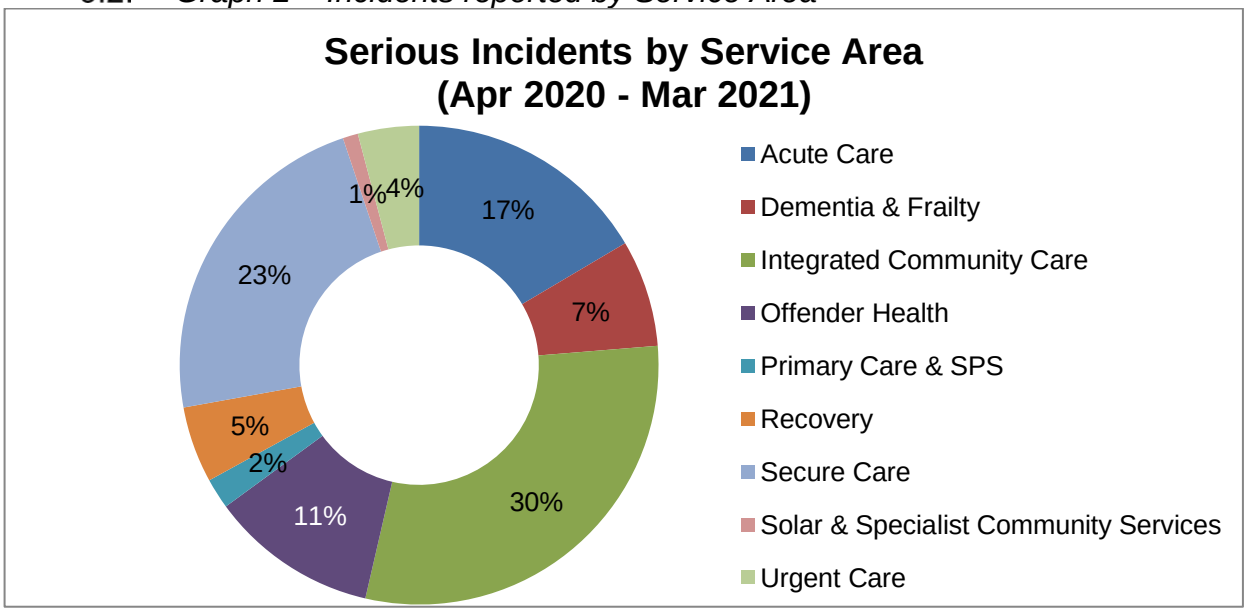


Please note that this graph includes 4 incidents that occurred during Q4 but weren't confirmed as SIs and reported STEIS until quarter 1

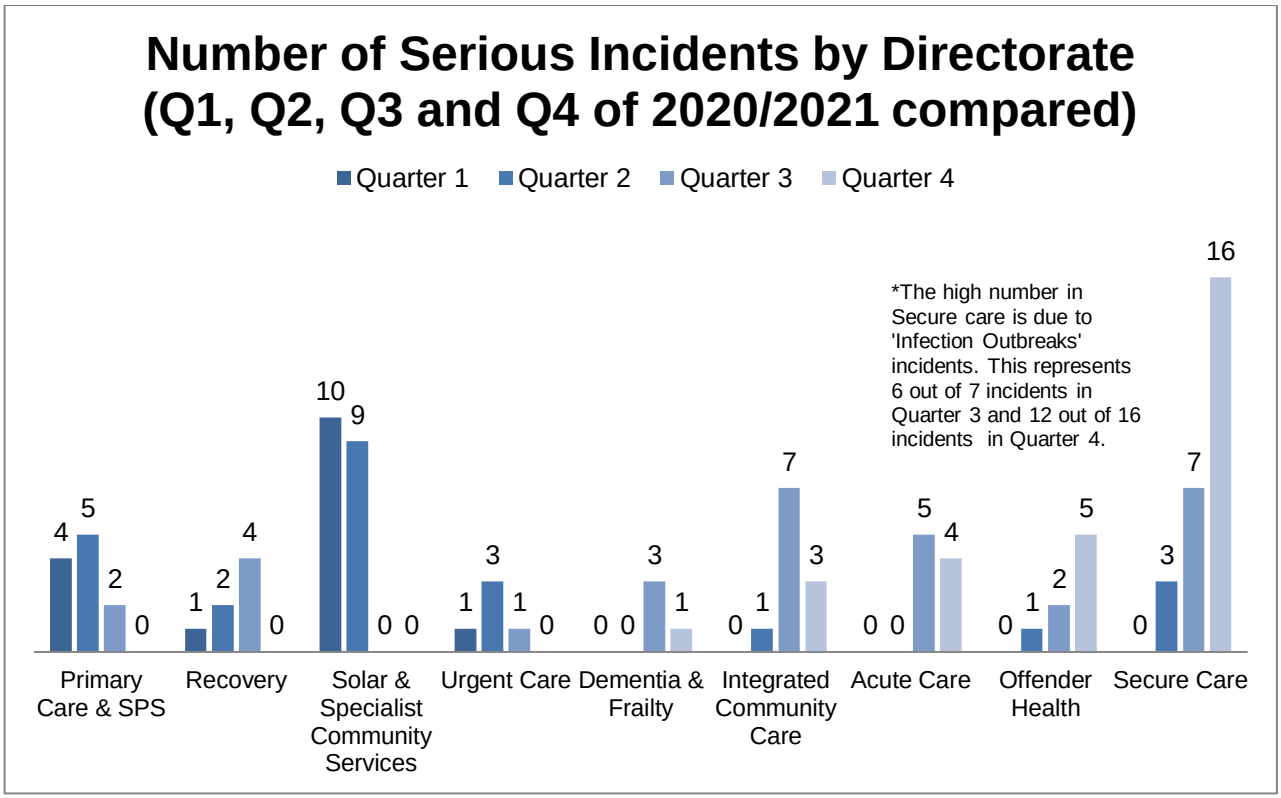
3. Service Area

3.1. Graph 2 depicts all of the serious incidents by service area. During the period April 2020 – March 2021, the majority of SIs occurred within Integrated Community Care (30%), followed by Secure Care (23%) and then Acute Care (17%). As Integrated Community Care serves the highest number of service user population the correlation between the numbers of incidents is not surprising. The Increase in incidents in Secure Care is due to 18 Ward Closures Due to Infection outbreak incidents, this represents 69% of the total incidents. We expect this number to fall in 2021/2022 as the vaccine program rolls out. It is worth noting that some SIs require cross-divisional input, the graph shows the lead service area but other divisions may have had had input into the patients care.

3.2. *Graph 2 – Incidents reported by Service Area*



3.1. *Graph 3 – Incidents reported by Service Area*



4. Breakdown of Incident types

4.1. Table 1 provides an overview of the incidents reported by category this quarter demonstrating that the death of our patients remains the highest reported category.

4.2. ***Table 1***

Incident Type	Number
Suspected suicide	6
Unexpected death	9
Death – natural causes	3
Infection control outbreak	7

4.3. <u>Unexpected death</u>
There has been an increase in the number of deaths, with nine incidents requiring review under the Serious Incident policy, at the time of writing this report this cause of death is unknown so as a consequence it is recorded as an unexpected death.

4.4. <u>Confirmed and Suspected Suicides</u>
This quarter there have been 6 suspected suicides reported which is a reduction compared to last quarter. Graph 4 provides an overview of the reporting trends month on month. The highest number of incidents was reported during May and September 2019.

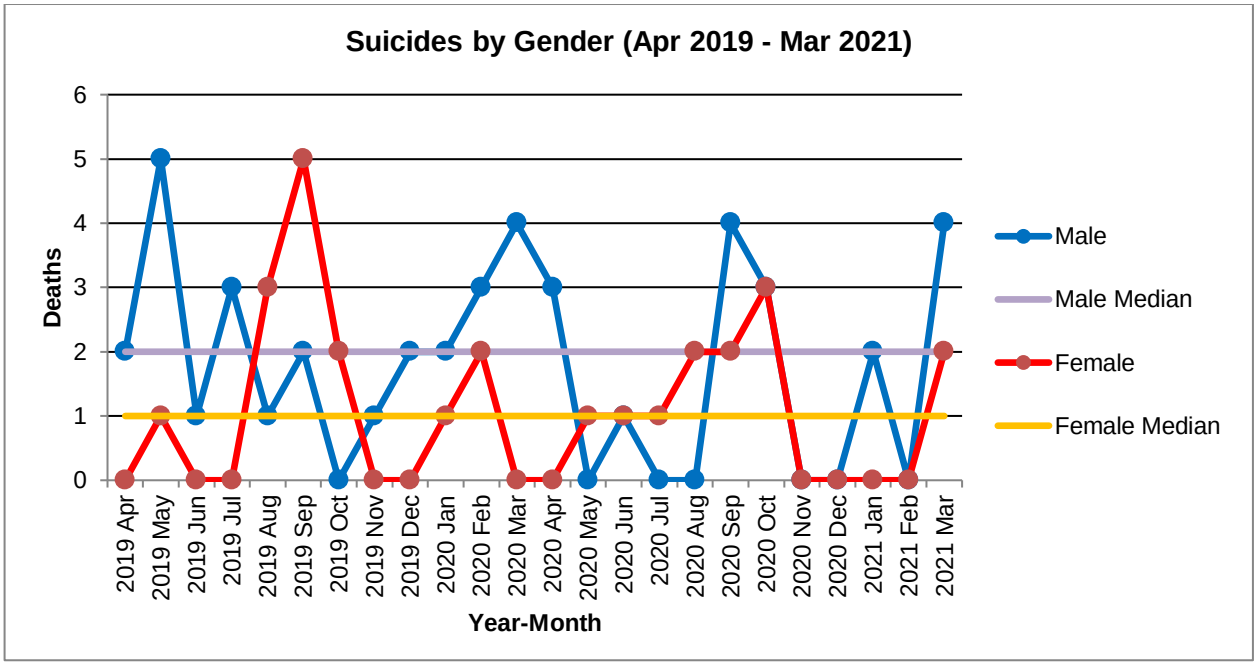
As can be seen the number of reported suspected suicides this quarter there

has been variation from the median for both men and woman during February which was below the median and then above it in March 2021 with 4 suspected suicides for men and 2 for women being reported.

It is to be noted that not all suspected suicides translate into confirmed suicides by the coroner. Of the 6 suspected suicides during this quarter none have been confirmed by the coroner to date, due to Covid-19 so we are unable to provide this data this quarter.

Those suicides that have been confirmed by the coroner previously correlate with the National Confidential Inquiry into Suicide in terms of gender, age and method.

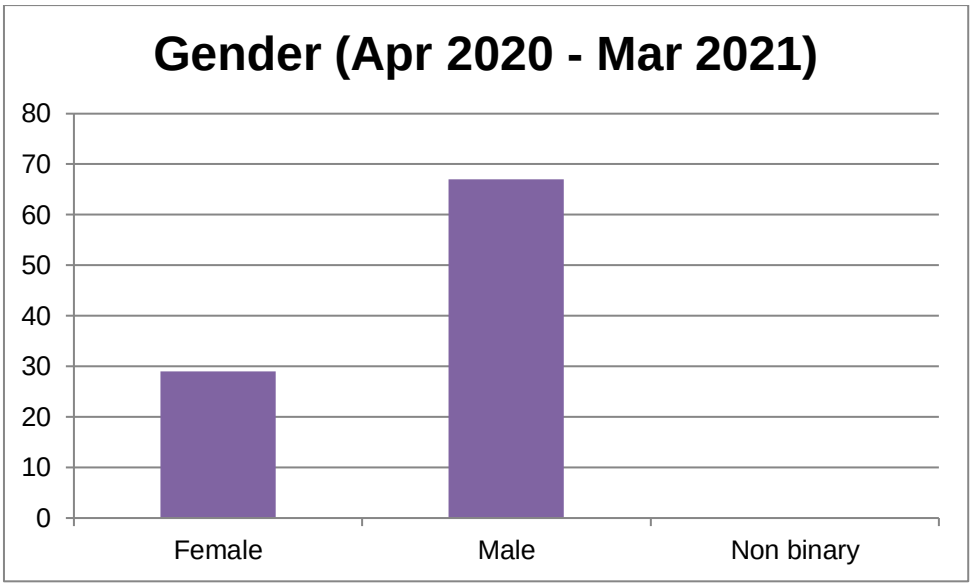
4.5. *Graph 4 – Suicides by gender over 2 financial years*



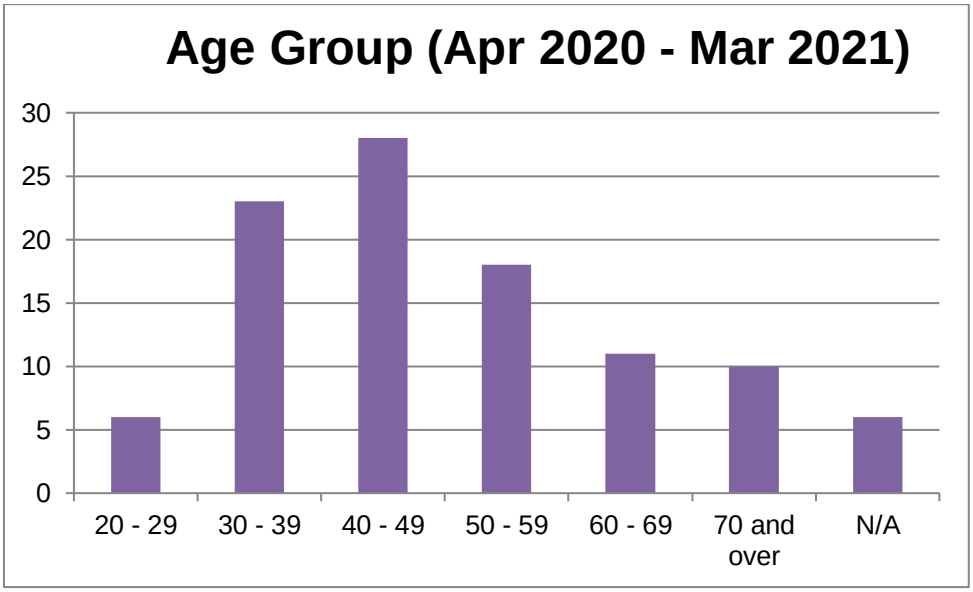
5. Social and clinical characteristics of patients

5.1. The charts below show the main social and clinical features of patients who have been involved in a serious incident over the last 2 years. Although there is a high number of unrecorded data (unknown) it can be seen that the majority of patients were white males, aged between 40-49 Christian and were on long term sick from work.

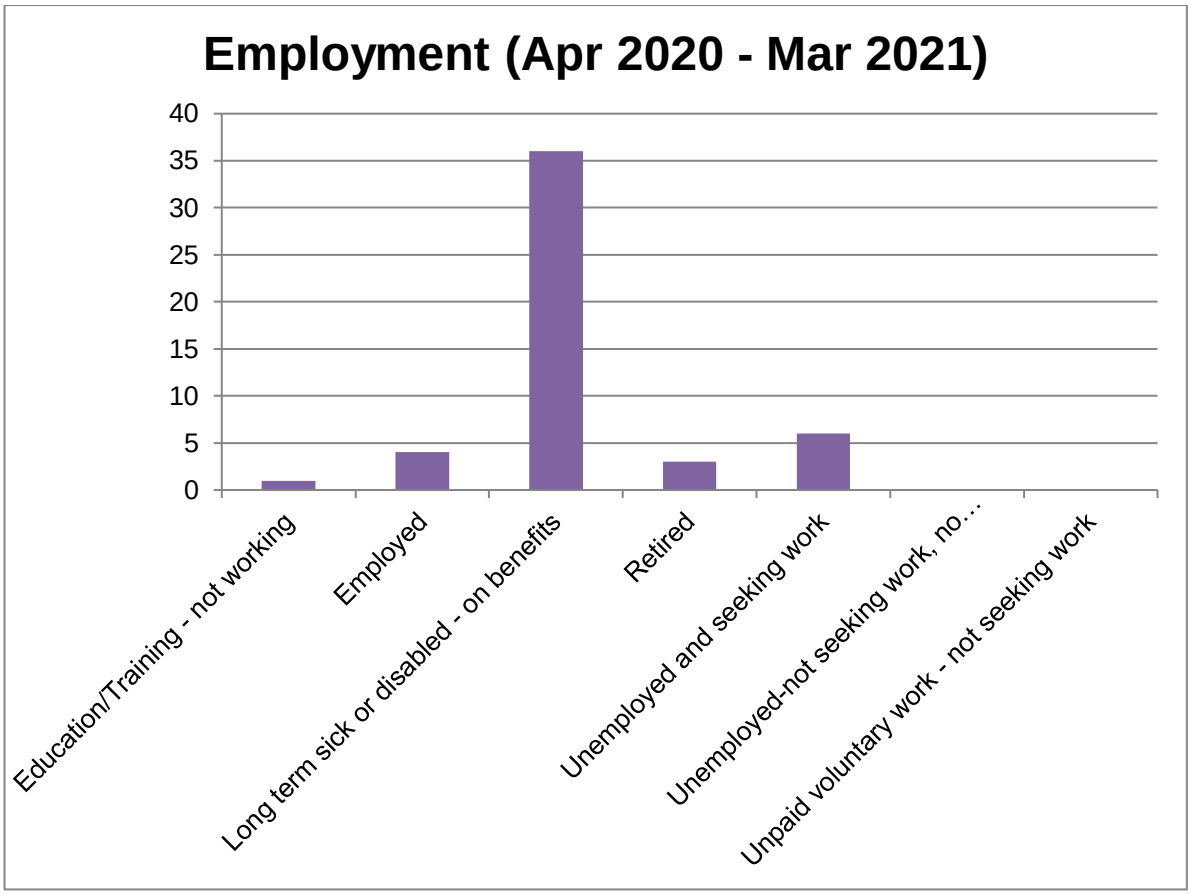
5.2. *Serious Incidents by gender*



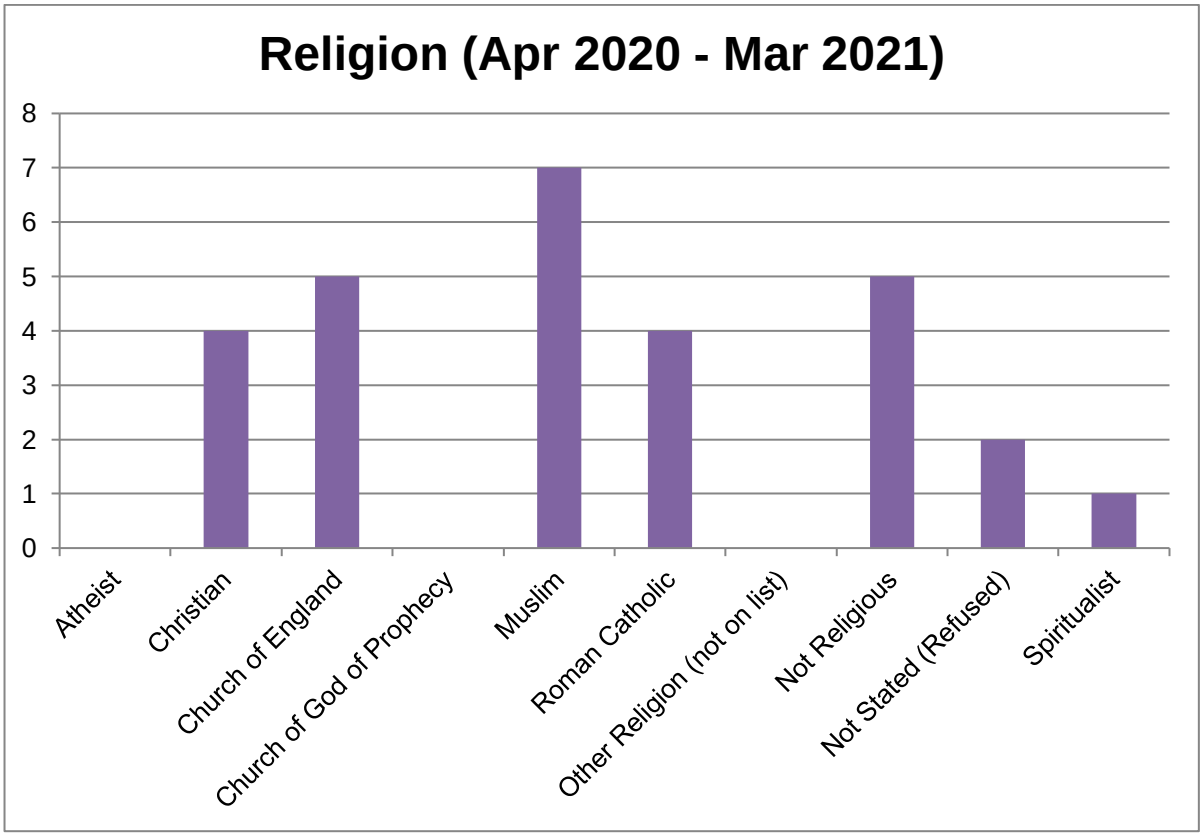
5.3. *Serious Incidents by age group*



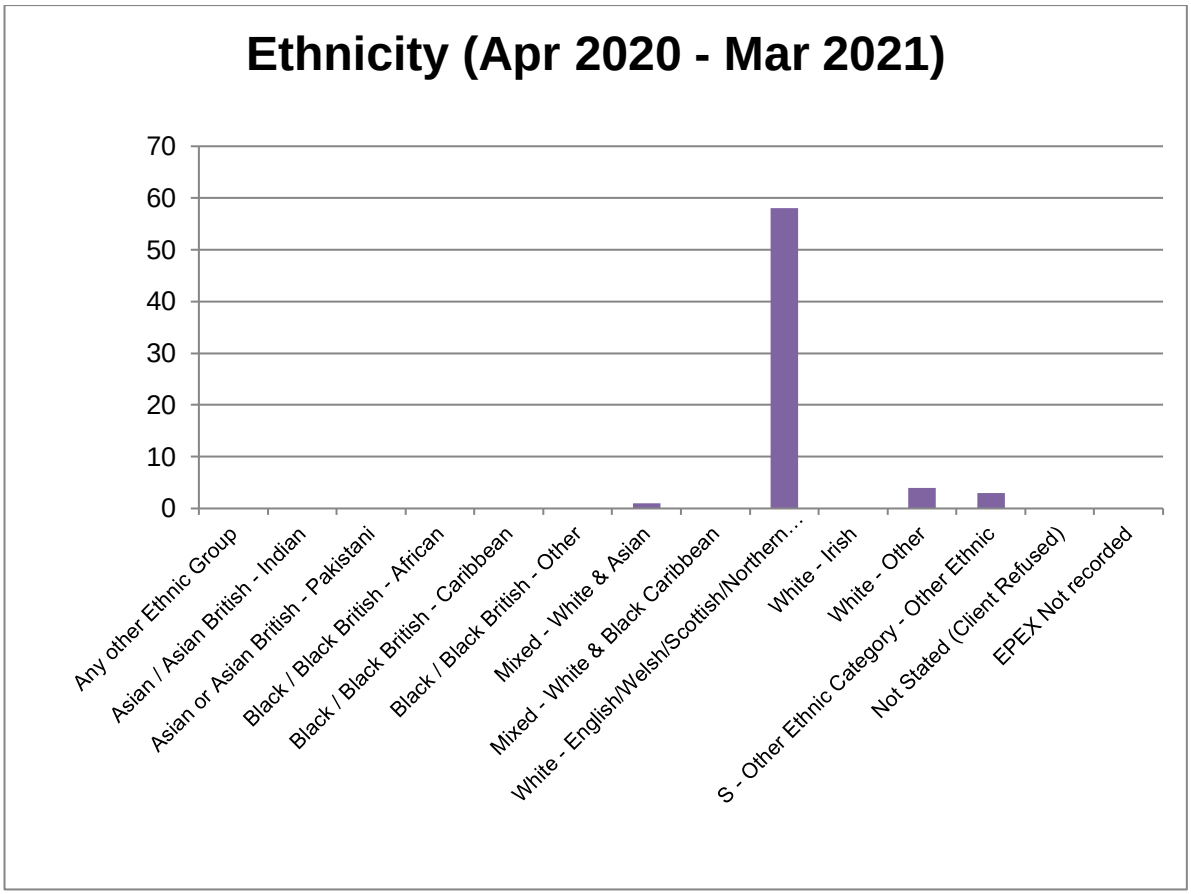
5.4. *Serious incidents by Employment status*



5.5. *Serious Incidents by Religion*



5.6. *Serious Incidents by Ethnicity*



6. Common themes from SI investigations and our response

6.1. We are committed to continually improving the safety of the services we provide to our patients and we recognise that one way of doing this is to ensure that SIs are identified correctly, investigated thoroughly and most importantly trigger actions to improve systems and processes.

6.2. Aggregate analysis of the investigation summaries has been undertaken in order to identify common themes

6.3. A number of our patients have who have died have experienced issues with drug and alcohol issues, this is also reflected in the National Confidential Inquiry into Suicides which was published earlier this year. In response to this we have included alcohol and drug misuse as one of our Trust Quality Goals. We have also agreed to undertake a thematic review in partnership with our Commissioners and other stakeholder in the health care system.

6.4. In response to patients who have died by using an anchor point in our inpatient settings we have committed to installing ligature alarm systems on all en-suite doors in our acute inpatient wards and bedroom doors of our highest risk acute inpatient wards during 2021-22. We have also committed to the development of a 3-5year rolling capital programme to eradicate

ligature anchor points from our inpatient Estate.

6.5. Physical health monitoring has been a theme identified within Serious Incidents. To help improve standards physical health monitoring has been included in the Trust Quality Goals and the Physical Health Advisory Group are overseeing this work.

6.6. It is not unusual for patients to confide in their relatives in the first instance; hence the emphasis on developing relations with families and carers who can pass on additional concerns to mental health practitioners to inform care and safety planning. Improving carer engagement is a Trust Quality Goal.

7. Sharing Learning

7.1. To enable staff to access learning easier we have updated our Patient Safety page on Connect, which allows staff to access various forms of information in different formats which includes incidents at a glance, categorised into service area, It Takes 3 videos and statistical information to help staff understand what is happening within their service area.

7.2. We have continued to produce our quarterly Learning lessons bulletin which can also be found on Connect and is circulated to all staff via email. The most recent bulletin was published in May 2021. Next quarter we will be focusing on the clinical messages identified in the National Confidential Inquiry into Suicide.

7.3. Sadly we had to cancel our scheduled Kitchen Table events due to Covid 19, which would have provided an opportunity for staff to discuss learning and safety issues within their local area. However, in are in the process of re-scheduling these events, with a learning event taking place at Maple Leaf Drive during August 2021.

8. Future plans

8.1. We have successfully introduced a Learning from Excellence (LfE) reporting form onto eclipse. LfE is a formal system to capture, understand and share examples of excellent practice. LfE reports are captured using Eclipse, in the same way that we capture incidents. Organisations that use this system have improved staff morale and created a culture where best practice is learnt LfE will be an important part of the NHSs' transition from Safety I to Safety II. Safety II is when an organisation learns from not only goes wrong but what goes well too. The Patient Safety Team will be reviewing the reports and sharing the learning, implementing and growing this concept more as a 'social movement' as opposed to a target driven, top down approach.

8.2. An actions module has been introduced within the eclipse system, this will give us greater oversight and assurance of the actions completed following a Serious Incident Review. The Standard Operating Procedure for the management of this process has been agreed by our Patient Safety Advisory

Group (PSAG)

8.3. Work on providing a thematic analysis of Serious Incidents is ongoing and will be included in the next paper.

8.4. As outlined in the NHS Patient Safety Strategy, NHS Improvement are in the process of developing a new Patient Safety Response Framework (PSIRF) to replace the current Serious Incident Framework. To ensure successful implementation of the PSIRF when rolled out later this year, we are currently working with our commissioners to complete our Patient Safety Incident Response Plan (PSIRP), which is a requirement for each provider delivering NHS funded care. The PSIRP will set out how we will seek to learn from patient safety incidents.

9. Recommendations

The Committee is required to consider the content of this report and provide assurance of the governance of serious incidents to the Trust Board.

PEOPLE

10. People Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	
Paper title	PEOPLE COMMITTEE
Date	30 June 2021
Author	Patrick Nyarumbu
Executive sponsor	Patrick Nyarumbu, Executive Director of Strategy, people and Partnerships

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

Executive summary
To provide the Board of Directors with an update relating to the people committee.

Reason for consideration
To provide the Board with a summary of issues and Chairs assurance relating to the remit of the Committee
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
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

ISSUES TO RAISE WITH THE BOARD

The People Committee met on 23 June 2021 and an exception report has been developed to update the Board.

The committee would like to bring the following areas of discussion to the attention of the Board:

1 SHAPING THE FUTURE WORKFORCE

1.1 Workforce planning

The committee received an update on the final narrative and numerical submissions for the workforce planning element of the 2021/22 planning round. The final submission was on 3rd June 2021 and plan was successfully submitted. The workforce plans are directly related to the financial allocation of the Mental Health Investment Standard, Service Development Funds and Spending Review Funding. Financial plans have been submitted alongside the workforce plans as part of the same planning round.

The Trust has worked closely with colleagues across the system to collate mental health workforce plans for BSMHFT, our Non-MH Trust workforce (Forward Thinking Birmingham and Primary Care) and our Non-NHS workforce (VCSE and third sector partners).

Chairs Reflections
The committee noted the critical organisational, system actions and risks to the delivery of the workforce plans. The committee will continue to receive assurance in relation to the delivery of the plan through the committee subgroups which are now established.

1.2 Shaping Our Future Workforce Sub group

The committee received any update from the newly established sub group. Its purpose is to lead on implementation and monitoring of the People Strategic Priorities and Implementation Plan which supports delivery of the Trust's strategy. An update was provided on the work of the Remote Working Task Group. There is further work that is being considered, in addition to the principles that have been developed, however; the committee was keen to see how the organisation could accelerate the development of flexible ways of working. The group received an update on an HEE funded project to develop a Trust Charter for band two to four staff. This is aimed at developing opportunities for career progression, wellbeing and personal development. The organisation will continue to offer personal development opportunities to colleagues however; the aim of the Charter is to enhancing the existing offer.

The Trust has signed up to the Midlands Charter which outlines a commitment to prioritise the restoration of postgraduate medical education and training impacted during the COVID-19 pandemic. A working group has been established to review the associated requirements and put actions in place across the Trust to deliver on the Charter.

Chairs Reflections
The committee were assured that the newly formed subgroup is focussing on the key areas of concern and workforce KPI's to feedback their findings to the People Committee. The group highlighted the vacancy fill rate and the bank and agency fill rate which were of concern. However, it was acknowledged that the Trust has responded to the increase in service needs resulting in expansion of services creating more vacancies. An additional part of the governance arrangements is the recently established workforce initiative group (WIG), which reviews the proposals we have in place and the vacancy gaps we need to fill. This is to ensure there are plans to fill each vacancy particularly where this may cause clinical issues. This group meets on a weekly basis.

2. TRANSFORMING OUR CULTURE AND STAFF EXPERIENCE

2.1 Workforce Partnerships update

The committee received an update on the current partnership workstreams namely:

- NHS cadets
- Volunteers
- Apprenticeships
- Special Educational Needs and Disability (SEND) schools – virtual work experience

The highlights included the work that had been done to attract, develop and prepare young people to access volunteering opportunities, provision of apprenticeships and also work experience. The work with SEND schools and provision of virtual work experience has enabled the organisation to listen to feedback on how we can improve access to work opportunities in an inclusive way.

Chair's reflection
The committee highlighted that the organisation should be more ambitious in addition to the ICS People Board 100 entry level jobs pledge. This ambition would be reviewed particularly from a Trust perspective and further steps will be reported and monitored through the committee.

2.2 Transforming Our Culture and Staff Experience sub group

The committee received an update on the work of the Transforming Our Culture and Staff Experience Sub-group in monitoring the implementation of the People Strategic Priority and Implementation Plan which support the delivery of the Trust's strategy.

Key highlights included:

- The Trust is now in the process of preparing to go out to tender for a new Occupational Health (OH) contract for 2022/23. A working group has been set up to take this project forward and the group is scoping ways for feedback to be gathered from Trust colleagues on what they are looking for from a OH provider. It was highlighted by the committee that consideration should be given to how we can work effectively with partners across the system and this will be explored.

- Following the successful launch of the Ardenleigh 'Take a Moment' / Reflecton space, work is being undertaken to look into the sustainability of this programme and a mobile option to widen the reach of support to colleagues. Space availability has been a key constrain however, the committee discussed that usage of our available spaces should be explored further by the working group.

- The sub group approved the Fundamental Training Policy and also highlighted key policies which are currently under review and these are Disciplinary Policy, The Pay Progression Policy, and The Dignity at Work policy and the Sickness Policy. Engagement with the Staff Networks has been undertaken and following a recent Disability and Neurodivergence Staff Network meeting, further information has been shared which will be taken into consideration as part of the policy reviews.

Chair's reflection
The committee were assured of the work progressed to date.

3. MODERNISING OUR PEOPLE PRACTICE

3.1 Anonymising Clinical Records for Patients (who are also Trust Staff)

The committee received a report from leading clinicians recommending ceasing of pseudo-anonymisation of records. There has been a longstanding practice within BSMHFT of allowing pseudo-anonymization of electronic health records. The rationale behind this is that at times patients are treated who either have a high public profile, or who are existing staff members or their relatives. In current practise the vast majority of records that are pseudo anonymised belong to BSMHFT staff. The benefits of anonymising records lie in effectively protecting the record from any attempts at illicit access either by other staff or family members.

There are considerable clinical risks associated with pseudo-anonymisation. Once a record has been pseudo-anonymised it is then difficult for staff who need to locate the record to find it (unless they are aware of the NHS number or Rio number). Those who are working directly with the patient would be aware of it, but staff from other services (e.g. urgent care or specialities) who encounter the patient will have no indication that a record exists and therefore will not have the benefit of all the available information when conducting their assessments unless informed by the patient. This is mostly likely to occur in a crisis when the potential impact of information being unavailable is the greatest.

It was agreed that pseudo-anonymisation should cease immediately and this should be replaced by offering patients access to their clinical record access data. It is suggested that this occurs in cases of NHS clinical staff who are particularly concerned regarding their clinical data being accessed in the first instance.

The Responsible Clinician for the patient will take responsibility for discussing this with the patient and a joint request from the Responsible Clinician and the patient is then made to the Deputy Caldicott for their patient access data.

This is likely to largely mitigate the current risk of ceasing pseudo-anonymisation as the request for pseudo-anonymisation is driven by anxiety and concern around unauthorised access and provision of access data is likely to alleviate this to a large extent and also bring the Trust's clinical record access in line with general practice and other NHS Trusts and international practice.

Chair's reflection
The committee approved the recommended approach of ceasing pseudo-anonymisation (anonymising clinical records for patients (who are also Trust Staff). A Non-executive raised concerns on the recommendation to cease pseudo-anonymisation, however, the committee agreed the continuation of anonymisation does present an ongoing clinical risk but further work will be explored in relation to access to Trust services for Trust staff.

3.1 Key Performance Indicators (KPIs)

The committee received assurance on actions being taken to address concerns around People KPIs aligned to the Trust's People Strategic Priority. Gaps in assurance were noted in relation to the training compliance for temporary staffing. The organisation will be focussing on work to reduce reliance on temporary staffing which has been the case in some service areas during the peak of the pandemic.

Chairs reflection
The committee highlighted that further work needs to be carried out in relation to safety issues connected to poor training compliance for temporary staff and assurance will be overseen through the committee.

3.2 ICS People Board update

The committee received a report on the work being undertaken by the Birmingham and Solihull People Board. Key highlights were as follows:

- The Regional People Board is also holding discussions about what metrics will be used to monitor the Regional People Plan
- HEE shared that the Workforce Development fund has been confirmed and there has been a three year CPD funding commitment which has been allocated to Trusts and Primary Care
- As a BSOL system it was agreed in March 2021 to deliver 100 entry level job opportunities each year for 3 years for unemployed and young people specifically from economically disadvantaged areas across Birmingham and Solihull. This approach compliments the mayoral manifesto pledge and the ask of both public and private sector organisations to create jobs to support economic regeneration. This also builds on the work of the BSOL careers and Learning hubs.

3.3 Data Reporting arrangements

The committee received a recommendation to revise the flow of information into committees to ensure detailed reporting is completed seven and eight weeks after the end of the reported month. This solution will allow for better triangulation, validation, and interpretation of data. It will allow for better trend reporting in the spirit of measurement for improvement, rather than reporting against target or threshold in the more limited spirit of measurement for assurance. This recommendation was approved.

4. Board Assurance Framework

The committee received a report with proposed initial and target scores for each of the risks. It was highlighted that further work was required and the Committee Chair and Executive Lead will be engaged to further support this work in preparation for presentation of final BAF to the Board in July 2021.

5. Disparity Ratio

The committee received a report outlining the organisation's disparity ratio. A Race Disparity Ratio is the difference in proportion of Ethnic Minority colleagues at various AfC bands in a Trust, compared to the proportion of White colleagues at those bands. Racial 'disparity ratios' have been created for each trust to root out discriminatory practice in NHS systems. The data shows:

- White colleagues are 1.88 times more likely to progress from lower to middle grades than Ethnic Minority colleagues.
- White colleagues are 1.74 times more likely to progress from middle to upper grades than Ethnic Minority colleagues.
- White colleagues are 3.22 times more likely to progress from lower to upper grades than Ethnic Minority colleagues.

Chair's reflection

The committee approved the publication of this information and will receive assurance on the actions being taken to improve the Trust's position.

11. Freedom to Speak Up Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Agenda Item No:	
Report to:	**BOARD OF DIRECTORS**
Meeting Date:	

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

FREEDOM TO SPEAK UP REPORT

Board Director Sponsor:	Sarah Bloomfield, Interim Executive Director of Nursing
Report Author(s):	Emma Randle, Lead Freedom to Speak Up Guardian
Appendices and References:	N/A
Previously Discussed:	None

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)	To provide the Board with an update on work being undertaken regarding Freedom to Speak up across the Trust. In addition, present to the Board the self-assessment undertaken
Summary of Key Issues:	
Recommendation(s):	
Next Steps: (Subject to recommendation(s) being accepted)	
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 (check necessary boxes)	Yes	No	N/a
Do the issue(s) identified in this document affect one of the protected group(s) less or more favourably 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 objectives (if it does please click the appropriate ones below)

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	☐

Does this paper provide assurance in respect of a new / existing risk(s) (if appropriate) (check necessary boxes)

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 level framework / register)				Not applicable for this report.	

Birmingham and Solihull Mental Health NHS Foundation Trust

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

When things go wrong, we need to make sure that lessons are learnt, and things are improved. If we think something might go wrong, it's important that we all feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we should feel able to say something and should expect that our suggestion is listened to and used as an opportunity for improvement. **Speaking up is about all of these things.**

2. BACKGROUND

Following the last Board update report in November 2020, Emma Randle and Di Phipps commenced their roles as a job-share. Unfortunately, in May 2021, Di Phipps stepped down. A replacement Guardian role will go out to advert shortly and Emma's seconded period will be extended to align with the new Guardian's tenure.

3. ASSESSMENT OF CASES

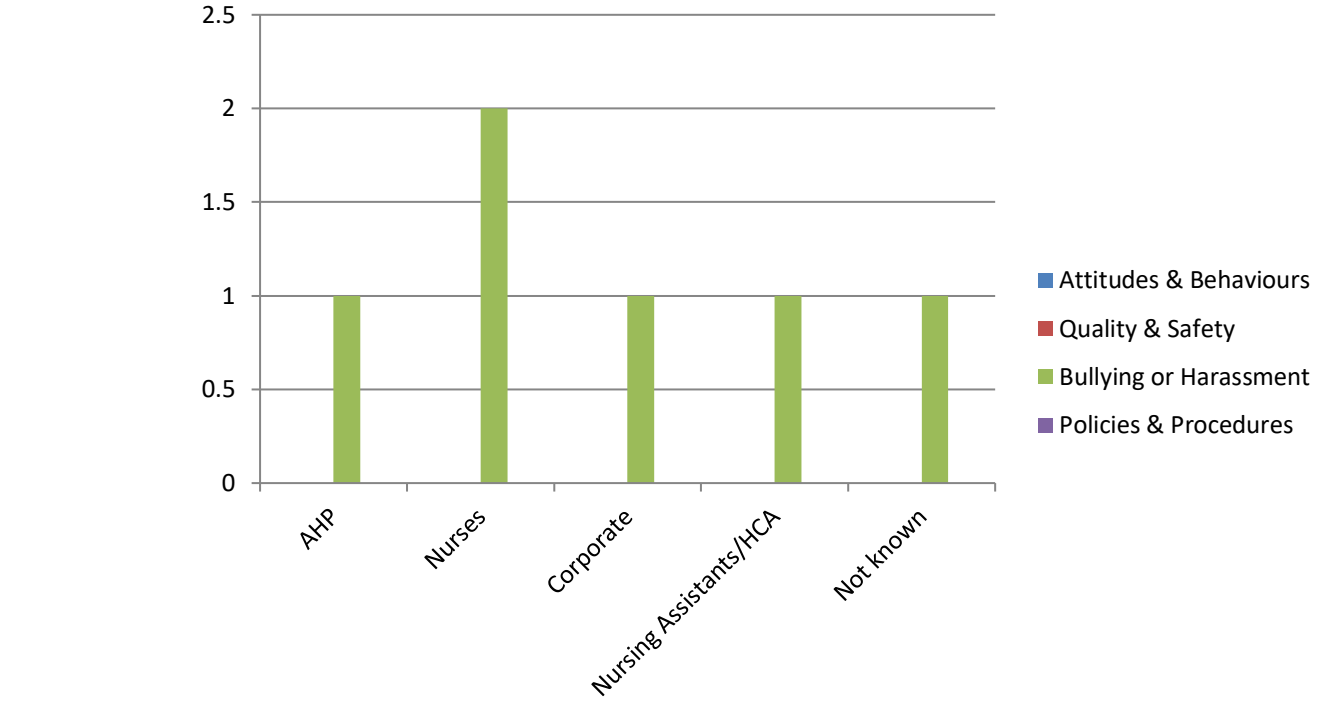
Cases brought to the Guardians in Q1 & Q2 compared to Q3 & Q4 have increased by 57%. Expectations are that cases will continue to increase as awareness in the Guardian service grows, roles become more established and better communicated, and staff begin to see the impact of speaking up. The Care Quality Commission assesses a Trust's speaking up culture under inspections as part of the well-led question. Having a healthy speaking up culture is an indicator of a well-led Trust.

In parallel with national trends Nurses continue to account for the biggest portion of cases raised. Post Q4 however, Psychology staff and Junior Doctors have started to raise concerns, which is a positive trend.

4. SUMMARY OF ISSUES RAISED TO DATE WITH THE FTSU GUARDIAN

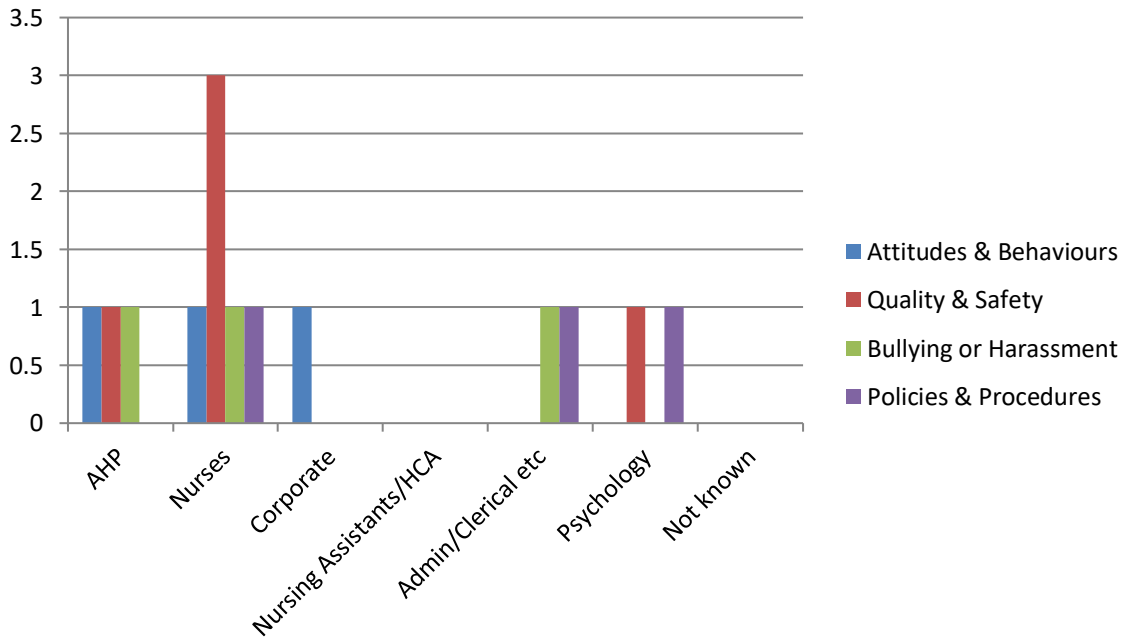
The Trust has submitted data relating to Q3 and Q4 for 2020/2021 to the National Guardian's Office.

For Q3 2020/2021, six cases were reported to the FTSU Guardian:



For Q4 2020/2021, fourteen cases were reported to the FTSU Guardian

This is a 57% increase in issues raised[i]



All cases from Q3 have concluded apart from one which was opened on 13.11.2020 which is still outstanding. In this case, the Guardian raised their concerns with the Lead Executive for FTSU highlighting the unacceptable delays and blockages in its progression and conclusion. In Q4, one further case is still outstanding and is on-going.

Key performance indicators for FTSU recommend that cases brought to the Guardians are concluded within three months and that any cases that exceed this are escalated to the Executive Guardian for FTSU and the CEO. Breaches of these timescales pose a risk to the credibility of FTSU as an independent and alternative route and may directly and or indirectly undermine staff confidence in speaking up.

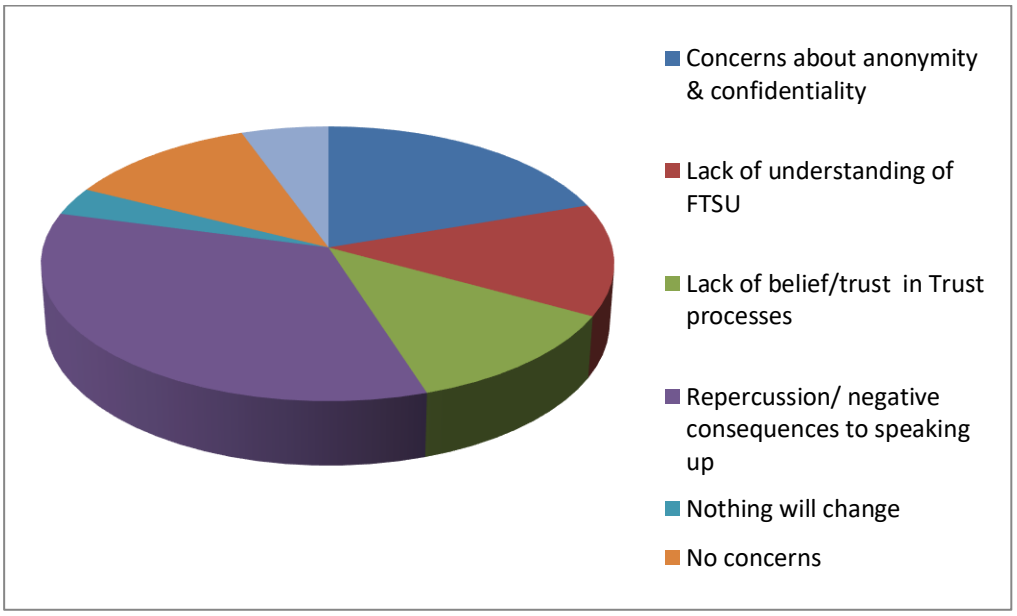
5. IDENTIFICATION OF KEY PRIORITIES

A gap analysis exercise comparing the Trust to mental health trusts with high levels of speaking up has helped us identify areas for improvement and establish good practice which has informed FTSU processes and guidance. Triangulation of the Care Quality Commission speaking up data, NHS Staff Survey 2020 and FTSU baseline survey has also enabled us to identify priority areas and staff groups that are less confident and appear reluctant to speak up.

6. STAFF CONFIDENCE IN SPEAKING UP

For the period covered (Q3 & Q4) three members of staff asked for anonymity. Anonymous cases where an individual is unwilling to reveal their identity to the Guardians or to others may be an indicator of the level of trust staff have in the speaking up culture. Our aim is have low levels of anonymity and a sustained increase in speaking up contacts over each quarter.

We explored some of the barriers to speaking up in a baseline FTSU survey in February 2021:



7. ACTIONS TAKEN TO IMPROVE FTSU CULTURE - AT A GLANCE

The Guardians have produced comprehensive procedural guidance aimed at senior managers, managers and HR to clarify roles and responsibilities of key stakeholders when a case is opened. It is intended that the guidance will also support colleagues operationally and help the Guardians and Trust to embed the principles and processes underpinning speaking up, listening up and following up. The Executive Lead for FTSU and the Guardian will be taking this guidance to the OMT in August 2021.

The Guardians will sit on the two sub-groups of the People Committee; Shaping the Future Workforce and 'Transforming Our Culture & Staff Experience.'

A video was recorded alongside the Trust 5 year strategy launch helping to raise awareness of what speaking up is and how it forms part of the 'People' priority.

As part of the continued raising awareness campaign the Guardians will be spending one day a week increasing their visibility and accessibility and will aim to meet with staff from every team across the Trust.

In July 2021, the Guardians will be piloting a drop in surgery and "walkabout" at Reaside for all staff across all shift patterns including night staff.

Strategic relationships are developing with the Trust staff networks and Staffside where we have agreed to share themes and barriers to speaking up. We will work together to reduce the barriers and also to increase confidence and credibility in the Guardian service for our staff with protected characteristics.

The National Guardian's Office in conjunction with Health Education England have produced training for everyone who works in healthcare about what speaking up is and its importance in creating an environment in which staff are supported to deliver their best. This training is now available on Connect and on the Learning Zone:

https://learning.bsmhft.nhs.uk/mod/scorm/view.php?id=3373 'Speak Up'- Core training for all workers

https://learning.bsmhft.nhs.uk/mod/scorm/view.php?id=3373 'Listen Up' – Training for all Line & Middle Management Training

The National Guardians Office has published their 2021 FTSU Index which looks at four questions from the NHS staff survey. The index continues to be positively correlated with Care Quality Commission ratings meaning that the higher the Index score, the higher the likelihood of a trust being rated "good" or "outstanding".

BSMHFT is starting to evidence signs of early positive change in that it was one of the top ten trusts to show the most improvement: https://nationalguardian.org.uk/wp-content/uploads/2021/05/FTSU-Index-Report-2021.pdf

8. LEARNING ACTIONS & IMPROVEMENTS

Embedded in the guidance mentioned above is a process whereby themes and learning are systematically identified with involved stakeholders following conclusion of a speaking up case. It is acknowledged that learning can sometimes 'get lost' in the trust and is not consistently shared with staff. This is a core principle of speaking up in that staff see it has had an impact, makes a difference and that the Trust learns as a result.

Consequently, connections have been made with QI and OD colleagues so that any learning can be incorporated into the Trust's on-going improvement work. Links have also been established with the Head of Safety and any themes arising from patient safety will be shared when they arise.

NHS E/I, the Guardians and our Exec Lead have undertaken a SWOT analysis to inform a FTSU strategy and also in readiness for celebrating 'Speak Up' month in October 2021. This is a national campaign, and an opportunity for the Trust to highlight the benefits of speaking up via case studies and testimonials.

All learning is now published on the FTSU Connect pages and work is in progress with key stakeholders in developing a Trust wide feedback loop demonstrating that the Trust has 'followed up'.

[i] Percentage increase of cases brought to the Guardians between Q1,Q2 compared to Q3,Q4

SUSTAINABILITY

12. Finance, Performance & Productivity Committee Chair Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS**
Agenda item	**10**
Paper title	**FINANCE, PERFORMANCE & PRODUCTIVITY COMMITTEE**
Date	
Author	Gianjeet Hunjan - Non-Executive Director
Executive sponsor	

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

Executive summary
The Reaside and Highcroft Stakeholder Engagement plans over the next few months were discussed and agreed *The ongoing work of the BAF was reviewed.* *The financial plan for the Trust and the resultant changes from system-wide working were reviewed and agreed.* *The proposal for greater detailed reports as part of the Integrated Performance Report were agreed.*

Reason for consideration
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
Reach Out programme assists us helping all sectors of the community.
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 23rd June 2021 with a summary of the key discussions being detailed below:

1.1 Reaside and Highcroft Stakeholder Engagement Plan

The Committee was appraised of the plan that sets out our communication and engagement objectives and describes how the Trust would work together to communicate and engage by identifying target audiences, key messages and appropriate channels. Details of the proposed timetable of activities designed to deliver these objectives were shared.

Chair's assurance comments:
We heard about the possible impact of services and the need for engagement with all stakeholders. We were assured of the timescales and recognized this journey may take 2 to 3 years depending on what may be required in terms of our engagement.

1.2 BAF

The committee discussed the proposed initial and target scores for each of the risks. The initial risk score is a view (from an inevitably less than fully informed perspective) of how the risk scores 'now'. The target risk score was a suggestion as to where the Trust might reasonably expect to be, with appropriate controls, within a year's time.

The members challenged how the risks could be improved and it was agreed that further work would take place before July 2021 meeting.

Chair's assurance comments:
The Committee highlighted the need to review the risk scoring matrix to ensure consistency with the matrix used elsewhere in the Trust, the resultant scores and targets. The Committee was assured this work is being prioritized to ensure its completion before the next meeting.

1.3 Financial Position and including Capital Update

FPP were informed that Birmingham and Solihull STP submitted a system financial plan with a deficit of £28m on 6 May 2021. The BSMHFT H1 projection was £1.6m deficit, this plan was submitted to NHSEI on 26 May 2021. Following the submission, there has been further review and challenge and system Chief Finance Officers and Chief Executive Officers have now agreed a break-even plan across all providers. This will be reflected in a mandated system financial plan re-submission on 15 June 2021. BSMHFT will submit a non-mandated organisational plan re-submission on 22 June 2021 with a break-even plan.

The month 2 2021/22 consolidated Group position is a surplus of £0.8m, mainly due to non-recurrent slippage on recruitment against investment. This is £1.3m better than the year-to-date plan as submitted on 26 May 2021. From month 3 onwards, the breakeven plan will be used for reporting purposes.

Month 2 Group Capital expenditure was £390k year to date, with works progressing ahead of plan. Capital expenditure was not profiled to commence until month 3. The total capital plan is £9.6m. On 28 May 2021, BSMHFT submitted a bid as part of the system capital prioritisation process to access funding from the system capital investment fund (SCIF). The panel has recommended an award that would result in a £0.6m increase to our capital envelope. This is subject to formal sign off by system Chief Executive Officers on 25 June 2021.

Details of the agency spend was shared and FPP were informed that the spend had decreased in May 2021.

Chair's assurance comments:
The committee were advised of the system discussions and plans for system financial balance and implications for the Trust. We recognized the issues and the need to continue working together with ICS partners.

1.4 Information Governance Annual Report

FPP were given details of the framework to ensure that all information held by the Trust is handled in a legal, secure, efficient, and effective manner, to meet organisational goals including the best possible care delivery. They were informed of the robust information governance framework including professional qualified staff and a committee structure for the development and management of policies, procedures, controls, and evidence-based assurance to the Trust Board and Committees on all matters relating to information governance.

There was an issue on temporary staff undertaking the training and this had been identified as a risk. There was a challenge to make sure that learning from risks were shared throughout the Trust.

The key areas of work for 2021/22 were detailed in the report and regular updates would be coming going forward.

Chair's assurance comments:
The committee confirmed this was helpful report and asked for updates every 6 months.

1.5 Integrated Performance Report

The Director of Finance asked FPP to consider recommendations regarding monthly reporting cycles to committees and the Board, with aggregated Trust performance continuing to be reported to the current monthly cycle (May reported in June) but supplemented by additional detailed reporting which will be based on the previous month (May analysed for July).

The Committee were given assurance on the delivery against its key performance indicators and priorities and seek support for recommended improvements.

Details of the challenges in Out of Area Bed usage were discussed and the actions taken forward were shared.

Chair's assurance comments:
The Committee agreed the additional detailed reports would support better understanding of the issues and facilitate appropriate follow-up actions.

13. Integrated Performance Report – including cycle of business

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS MEETING**
Agenda item	**14**
Paper title	**Integrated Performance Report**
Date	23/6/2021
Author	Richard Sollars, Deputy Director of Finance Dawn Clift, Associate Director of Governance Lizzie Prior, 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:

We are critically reviewing our performance management and reporting approaches as we begin to move forward with the new Trust Strategy. We will retain the positive intentions of the existing approach and enhance the process in a number of respects.

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

- IQC - Staff and patient assaults, commissioner reportable incidents, falls
- FPP – Out of area bed use, financial position and CIP
- People - Return to work interviews, fundamental training, appraisal rates and sickness. Also the divergence in performance between different teams

The committees are also asked to consider recommendations regarding monthly reporting cycles to committees and the Board, with aggregated Trust performance continuing to be reported to the current monthly cycle (May reported in June) but supplemented by additional detailed reporting which will be based on the previous month (May analysed for July)

Reason for consideration:

To assure the Board 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
June IQC, FPP and People Committee.

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

As has been outlined in previous discussions at Committee and Board meetings, we are critically reviewing our performance management and reporting approaches as we begin to move forward with the new Trust Strategy to ensure that:

- We focus on the priorities and key outcomes associated with the Strategy
- We develop our Board Assurance Framework to understand the strategic and emerging risks relating to the Strategy and the world around us
- We provide the right information at the right level of detail in the right format that helps us transparently explain what has happened and the implications and identify the action required to improve outcomes

We will retain the positive intentions of the existing approach:

- Balanced review of performance in the round rather than concentrating on one factor at the expense of others
- Use of graphics to make it easy to understand trends and distinguish between random variation and underlying issues
- Allow drill down from top level or average information to identify the underpinning detail

We will enhance the process in a number of respects:

- Improve the robustness of performance review by the Executive Team and performance Delivery Group
- Provide greater insight and intelligence to the Committees to allow them to better understand key performance issues and improve the level of assurance they provide to the Board
- Improve the integration and structure of data in different Trust systems to improve accuracy and integrity

Appendix I provides details regarding future reporting cycles to committees and the Board. The quality of the analysis, interpretation, triangulation and identification of team level issues is limited given the current monthly reporting cycles. It is proposed that while reporting at an overall Trust level continues to the current monthly cycles, this is supplemented by additional, detailed interpretation based on the previous month's data.

It is proposed that we would move to this new cycle from January 2022.

Performance in May 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. After a good improvement in April, the position has moved little in May (at 664, 21.4 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 better than plan as a result of delays in recruitment against additional funding for new services

Quality

- The reported level of physical assaults on service users has continued to reduce though this may be down to under reporting
- Assaults on staff are up but below median levels
- Levels of prone restraint at lowest level since Dec-20
- Failures to return at highest level since Sep-20 and absconsions highest since Jul-19
- The overall rate of falls has remained below the median but has risen two months in succession
- **Key concerns: Staff and patient assaults, commissioner reportable incidents, falls**

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 has been renegotiated as being by end of June. April has seen the figure significantly reduced at 643 occupied bed days (21.4 patients), the lowest level since Dec-18
- IAPT patients seen within 6 weeks of referral has consistently worsened over last five months to 42%, the lowest position in entire reporting period (61 weeks since Apr-16). It reflects large number of staff vacancies (14%)
- The % of service users on CPA having a formal review in the last 12 months remains a worry at 88%
- New referrals not seen within 3 months are of concern but have reduced in month to 2,227, the lowest level since Mar-20
- On the large majority of targets, the Trust achieves target or better on an ongoing basis
- **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 has seen 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
- Return to Work interviews have remained around or below 60% for last 9 months and show no signs of improvement - individual departments/teams vary between Specialties (28%) and Birmingham Healthy Minds (100%)
- Fundamental training remains below 90% for 9th successive month - varies between Medical directorate (75%) and Liaison & Diversion, AOT and NAIPS (all 95%)
- Appraisals at highest position since Mar-20, but still significantly below pre-COVID levels and target - varies between Psychology (53%) and AOT (96%)
- Sickness unchanged for three months and remain much higher than target – varies between ICCR Other (0.0%) and Home Treatment (12.8%)
- Rolling 12 month turnover and agency expenditure continue to be better than plan

- **Key concerns: Return to work interviews, fundamental training, appraisal rates and sickness**

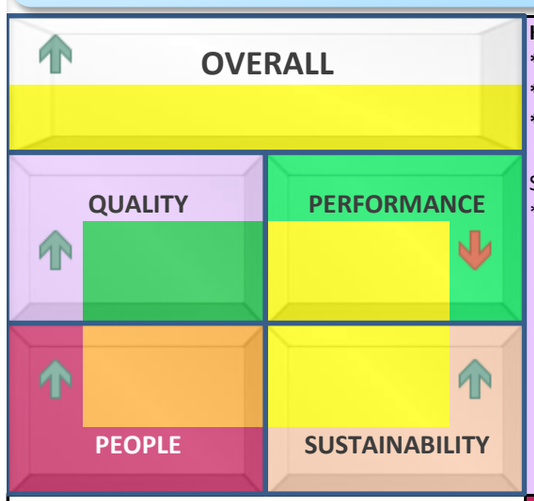
Sustainability

- The financial result for May is slightly better than plan at a surplus of £865k against a deficit of £521k, as a result of delays in recruitment against additional funding for new services. Savings plans are yet to be set for 2021/22. No savings have been identified as yet
- Cash, performance against the capital expenditure plan and property standards remain well above target
- **Key concerns: CIP under achievement impacting adversely on Operating Surplus, uncertainty regarding national financial ask**

INTEGRATED PERFORMANCE DASHBOARD

Overall Performance @ May-21

Birmingham and Solihull Mental Health NHS Foundation Trust



KEY CONCERNS:
* **Staff and patient assaults**
* **Commissioner reportable incidents**
* **Falls**

SOME CONCERNS:
* Restraints and failures to return

	Now	1m ago	12m ago
QUALITY		↑	↑
PERFORMANCE		↓	↓
PEOPLE		↑	↓
SUSTAINABILITY		↑	↓
OVERALL		↑	↓

KEY CONCERNS:
* **Financial position**
* **Some Quality metrics problematic**
* **Workforce metrics in general**
* **Out of Area bed usage**

KEY CONCERN:
* **Out of Area - absolute number of OBD little changed but no longer on track**
* **IAPT seen in 6 weeks - fallen for 8th successive month**
* **New referrals not seen in 3M - little changed**
* **CPA 12 month review - improved for 3rd successive month**

SOME CONCERNS:
None

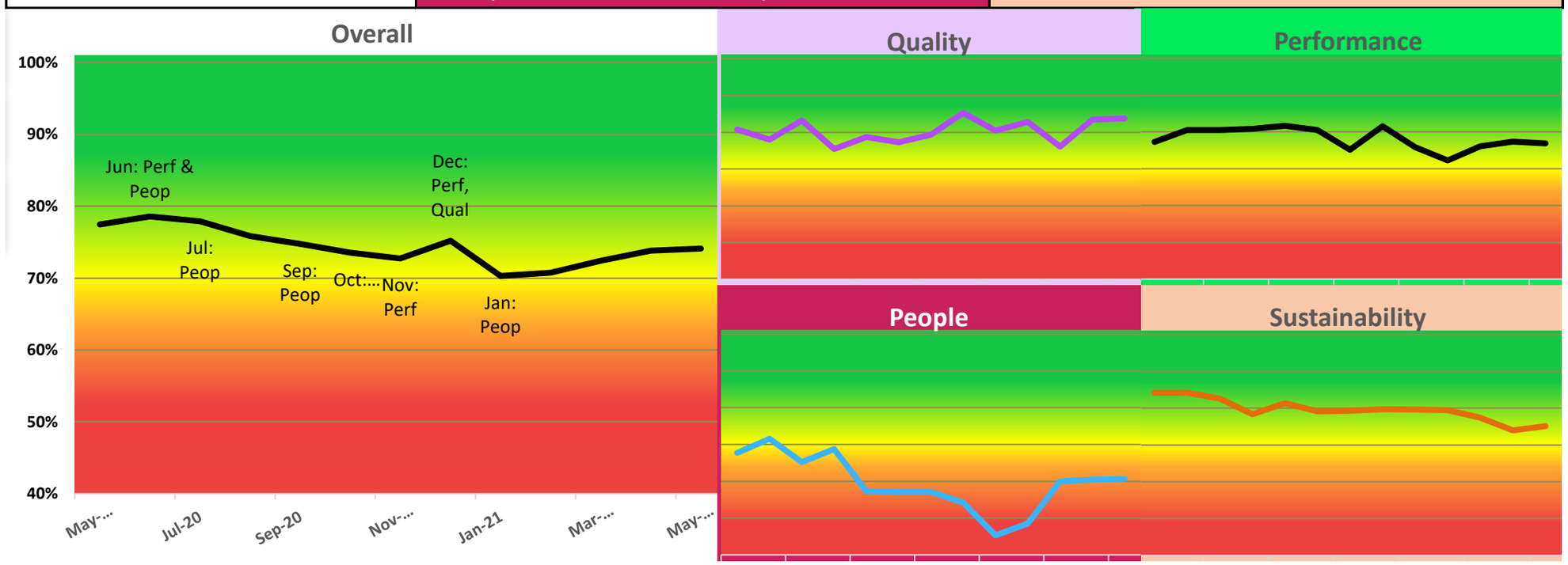
* Quality score remains highest scoring domain, reflects high incident reporting as positive outcome
* Performance stable - issues with capacity and new metrics
* People stable but significant under performance across the board
* Sustainability impacted by financial uncertainty

KEY CONCERNS
* **Return to Work interviews remained around 60% for last 9 months**
* **Fundamental training remains below 90% for 9th successive month**
* **Appraisals at highest position since Mar-20, but still significantly below pre-COVID levels and target**
* **Sickness unchanged for three months and higher than target**

SOME CONCERNS
* **Shift Fill Rate little changed and remains significantly below target**
* **Vacancy levels risen, but as a result of newly established roles**

KEY CONCERNS:
* **The Trust's financial position is better than plan, but this is mainly as a result of delays in recruitment around new services and remains subject to issue later in the year**
* **Savings plans have not yet been identified for 21/22**

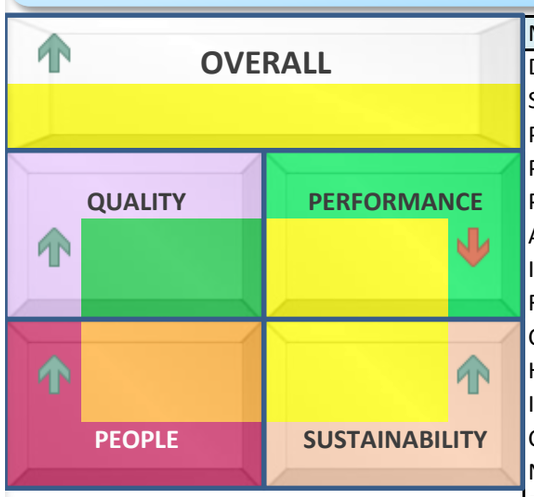
SOME CONCERNS: IG held down by poor compliance by temporary staff



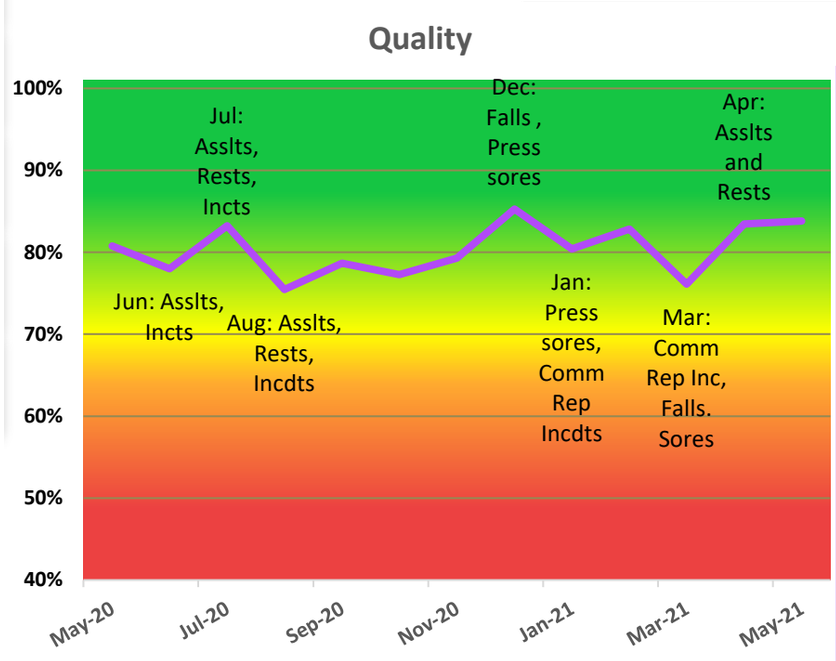
INTEGRATED PERFORMANCE DASHBOARD

Quality @ May-21

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
Duty of Candour	0	Target	0.5		→	→		DoC oversight
Staff assaults/ 1000 OBD	4.1	Target	0		↓	↑		Assaults on staff
Patient assaults/ 1000 OBD	2.1	Target	0		↑	↑		Assaults on patients
Prone restraints/ 1000 OBD	4.6	Target	0		↑	↑		Prone restraints
Physical restraints/ 1000 OBD	13.3	Target	8		↓	↑		Physical restraints
Abscon. and Fail to Return	24	Target	0		↓	↓		Fails to Return summary
Incidents resulting in harm	16.0%	Target	0		→	→		Incidents result. in harm
Reported incidents	1,848	Target	1,800		↑	→		Incidents reported
Comm report incidents	6	Target	0		↓	↓		Summary of CR incidents
Homicides in month	0	Target	0		→	→		Homicide analysis
Inpatient suicides	0	Target	0		→	↑		Inpatient suicides
Comm'ty suicides	0	Target	0.5		→	→		Community suicides
Never events	0	Target	0		→	→		Never events
Pressure sores (weighted)	0	Target	0		↑	↑		Pressure sores
Inpatient falls/ 1000 OBD	2	Target	0		↓	↓		Inpatient falls
Falls resulting in serious harm	0	Target	0		→	→		Serious harm falls
Qual BAF Score	9	5x5 matrix			→	↓		BAF Summary
QUALITY					↑	↑		



Headlines

KEY CONCERNS:

* **Staff and patient assaults**
* **Commissioner reportable incidents**
* **Falls**

SOME CONCERNS:

* Restraints and failures to return

NO CONCERNS:

All other metrics on or close to target

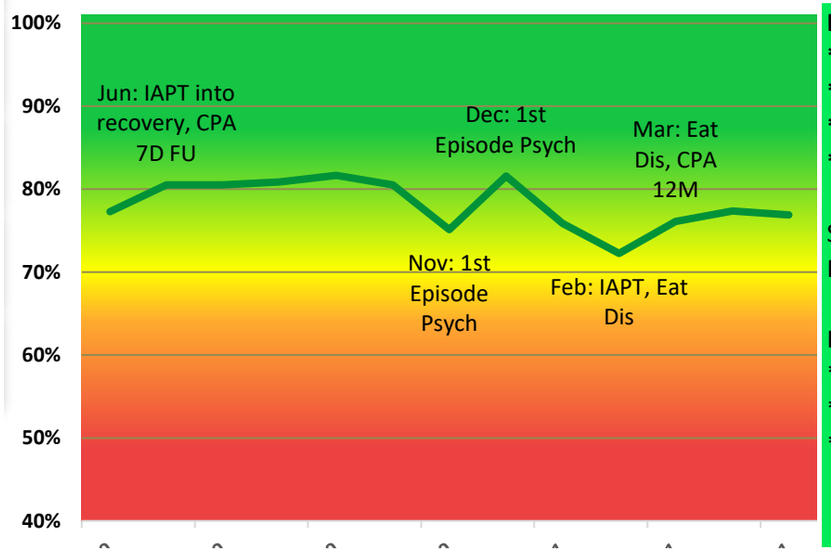
INTEGRATED PERFORMANCE DASHBOARD

Performance @ May-21

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
Data Quality Matur. Index	99%	Target	95%					DQMI summary
IAPT seen in 6 weeks	37%	Target	75%					IAPT <6 weeks
IAPT seen in 18 weeks	95%	Target	95%					IAPT <18 weeks
IAPT into recovery	55%	Target	50%					IAPT moving to recovery
1st episode psychosis	100%	Target	60%					1st Episode psychosis
Eating disorders urgent	100%	Target	95%					Eating disorders urg.
Eating disorders routine	100%	Target	95%					Eating disorders rout.
Out of Area Bed Days	664	Target	0					OAP bed days
Admissions gatekept HTT	97%	Target	95%					Gatekept admissions
CPA 7 day FU	94%	Target	95%					7 day follow up
CPA 3 day FU	84%	Target	80%					3 day follow up
CPA 12m Review	88%	Target	95%					12 month review
DTOC %	6%	Target	8%					DTOC
New Referrals not seen in 3m	2,256	Target	1,000					New refer not seen
Perf BAF Score	9	5x5 matrix						BAF Summary
PERFORMANCE								

Performance



Headlines

KEY CONCERN:

* **Out of Area - absolute number of OBD little changed but no longer on track to reach 0 by July**
* **IAPT seen in 6 weeks - fallen for 8th successive month, large number of staff vacancies**
* **New referrals not seen in 3M - little changed, performance standard not yet agreed**
* **CPA 12 month review - improved for 3rd successive month, standards under discussion**

SOME CONCERNS

None

NO CONCERNS

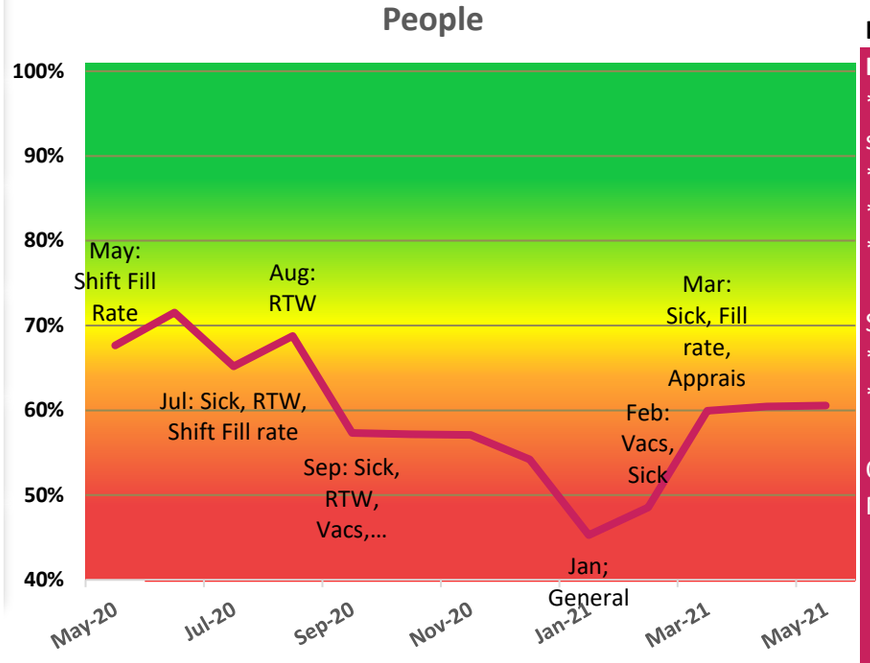
* DQMI score has sustained improvement and in top 7 nationally
* All other metrics are on or close to target
* BAF scores/risks based on new definitions, 2 risks in Performance domain

INTEGRATED PERFORMANCE DASHBOARD

People @ May-21

Birmingham and Solihull Mental Health NHS Foundation Trust

Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
Staff Sickness	5%	Target	4%					Sickness absence
RTW Contact	62%	Target	85%					Return to Work
Bank & Agency Fill Rate	89%	Target	95%					Shift fill rate
Rolling 12m Turnover	9%	Target	11%					Staff turnover
Staff Vacancies	10%	Target	6%					Staff vacancy rates
Staff Appraisals	83%	Target	90%					Staff appraisals
Fundamental Training	90%	Target	95%					Fundamental training
Monthly Agency £'000	£366	Target	£501					Agency expenditure £'000
Peop BAF Score	16	5x5 matrix						BAF Summary
Staff Well Being								
Staff Temperature								
PEOPLE								



Headlines

KEY CONCERNS

* Return to Work interviews have remained around or below 60% for last 9 months and show no signs of improvement
* Fundamental training remains below 90% for 9th successive month
* Appraisals at highest position since Mar-20, but still significantly below pre-COVID levels and target
* Sickness unchanged for three months and remain much higher than target

SOME CONCERNS

* Shift Fill Rate little changed and remains significantly below target
* Vacancy levels risen, but as a result of newly established roles

OTHER

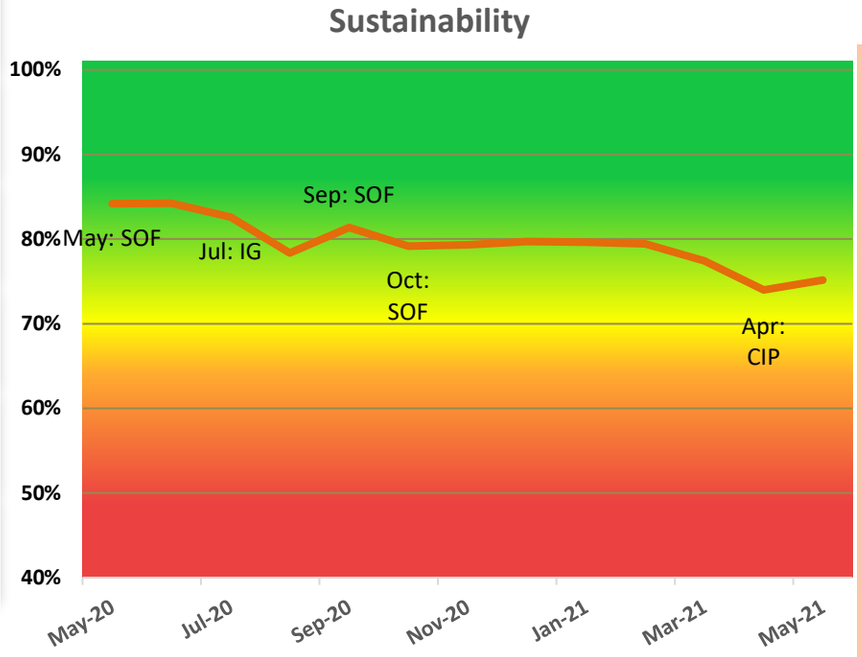
Metrics/data quality under review to ensure most relevant items of performance reported

INTEGRATED PERFORMANCE DASHBOARD

Sustainability @ May-21

Birmingham and Solihull Mental Health NHS Foundation Trust

Metric	Actual	Comparator		Now	1m ago	12m ago	4y Trend	Reference
YTD Operating Surplus £m	£0.9	Plan	-£0.5					Surplus details
SOF rating	3	1-4 matrix						SOF/Use of Resources
YTD CIP £'000	£0	Plan	£833					CIP details
Cash £'000	£26,962	Plan	£18,000					Cash details
YTD CapEx £'000	£390	Plan	£0					Capital Expenditure
Sust BAF Score	14	5x5 matrix						BAF Summary
Property	99%	Plan	95%					Property standards
Info Governance	89%	Target	100%					Info Governance
SUSTAINABILITY								



Headlines

KEY CONCERNS:

*** The Trust's financial position is better than plan, but this is mainly as a result of delays in recruitment around new services and remains subject to issue later in the year**

*** Savings plans have not yet been identified for 21/22**

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

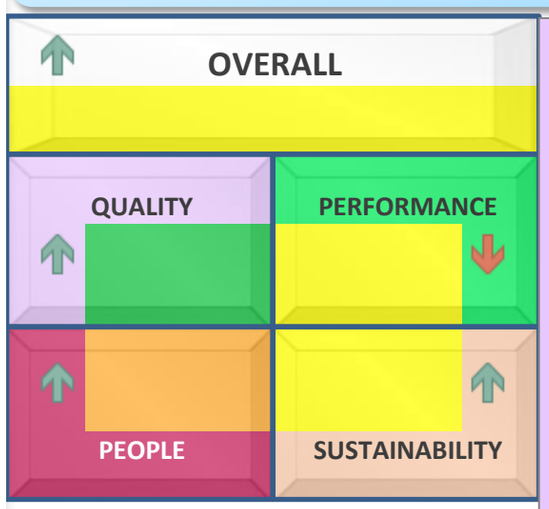
NO CONCERNS

* BAF score reflects revised strategic risks (4 in Sustainability domain) including financial position at score of 25

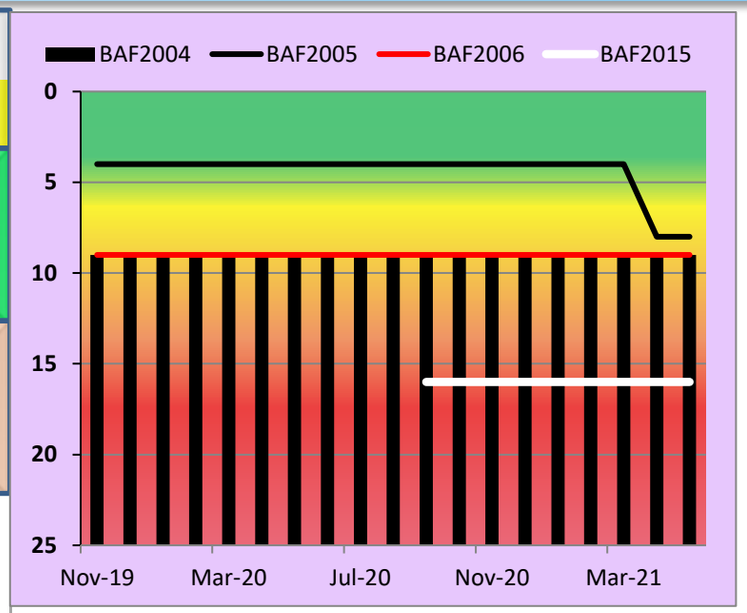
INTEGRATED PERFORMANCE DASHBOARD

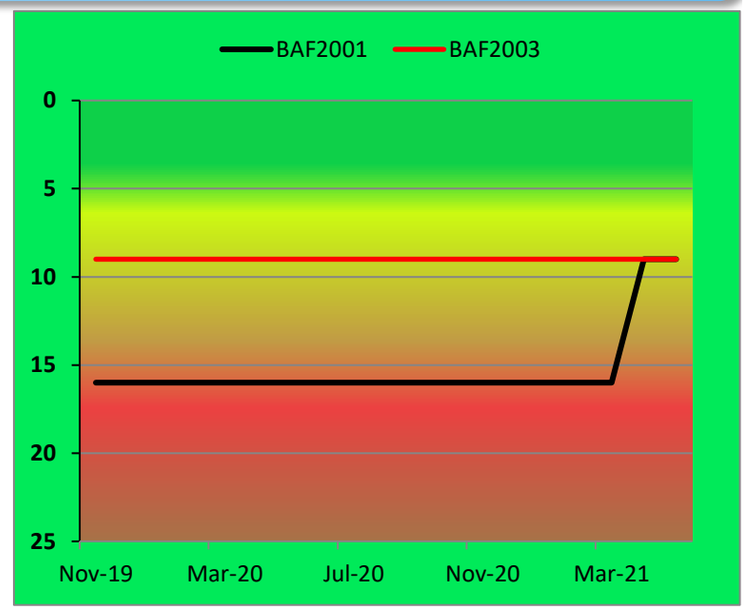
Board Assurance Framework @ May-21

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



Latest Board Assurance Framework

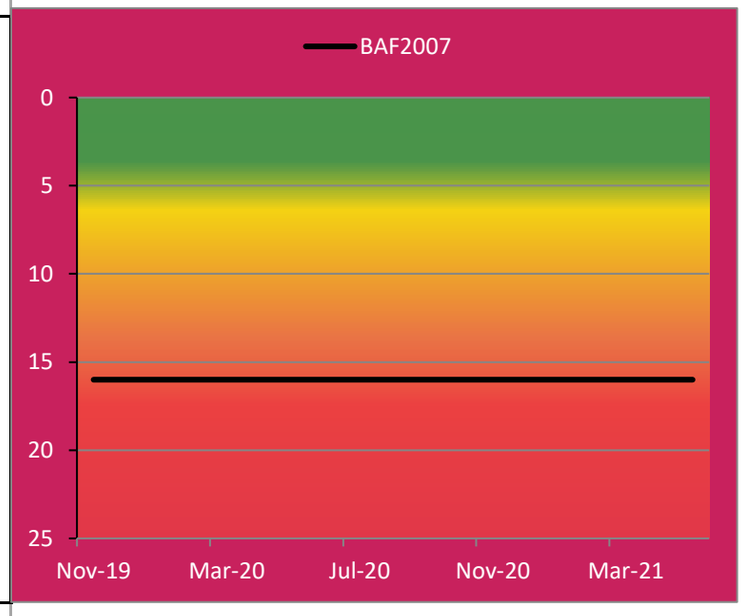


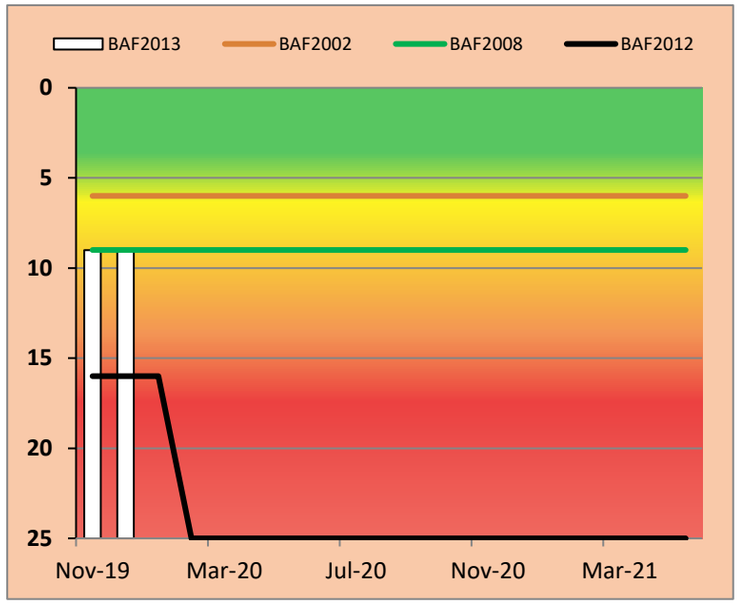


TOP RISKS (Impact * Likelihood)

BAF2012: Failure of medium to long term financial sustainability - 25
BAF2007: Unable to recruit staff – 16
BAF 2015 - Risk of pandemic - 16

MOVEMENTS
BAF2001 - risk reduced
BAF2004 - risk increased





APPENDIX I

REPORTING TO COMMITTEES AND BOARD

1. INTRODUCTION

For the purposes of this paper, two levels of reporting are being considered:

- 'Overall Trust reporting' - covers the aggregated Trust position, e.g. financial position and similar matters where we are looking at the overall position
- 'Detailed reporting' – allows for triangulation, more detailed trend analysis, consideration of balanced performance at a team level

The reporting of accurate, validated, timely, and relevant information to Committees and the Board of Directors is a vital element of good governance. The tension between timeliness and providing meaningful intelligence is a particular challenge and is a topic of discussion in Board rooms up and down the country.

This Report describes the details of the challenge as it presents for BSMHFT and proposes a solution to drive better governance and assurance.

The Committees and Board are asked to consider the recommendations at the end of the Report.

2. CONTEXT

The best decisions are made and then taken when informed by expert analysis. There is a continuum from data to information to intelligence to insight that is a useful measure of the effectiveness of performance reporting and the status of each Committee and the Board as a whole.

'Data' can only be elevated from the level of facts and figures to meaningful, action-oriented evaluation when it is accompanied by interpretation to define the 'so what?'. Such interpretation takes time, however. There needs to be a realistic and protected period between data availability (which relies on collection and inputting) and issue of papers (which relies on collation and as much explanation as time allows).

Board and Committee members will sometimes question why meeting packs continue to grow. Often this is simply because those who receive papers are unconvinced by or unable to interpret the papers that they receive, which causes them to ask for more evidence, which leads to more data, which leads to less time to analyse it, and so the circle continues.

In broad terms, BSMHFT is in a good place in terms of timing. Committees typically receive reports at week 3, i.e., reporting on data three weeks after the end of the corresponding month, with those reports then passed to Board at week 4.

That speed comes at a price, however.

Firstly, with data typically not available until week 2, there is extremely limited time for analysis. The meeting of the Performance Delivery Group (PDG) is a critical part

of the process, as it is there that the four domain leads and other corporate officers are first able to review outputs from the previous month. Required deadlines for papers restrict the optimal date for this meeting to only one or two days in the month, bearing in mind that reports sometimes first need to be seen at management groups or Sub-Committees before they are sent for top-level assurance, decision-making, and decision-taking.

Secondly, speed of availability inevitably delivers risks to data quality as not all data can be validated before it is included in Committee and/or Board papers. This is particularly true for people information related to sickness, agency use, and vacancies.

Thirdly, the PDG does not have time, to its own satisfaction, to triangulate the various sources and types of data. Triangulation is a vital part of performance and quality management, as it allows assessment of single issues from multiple angles to understand and address any reciprocal interdependencies. For instance, agency usage would be a key topic of consideration for each of the three functional assurance Committees – spend and impact on budget (Sustainability), recruitment and retention (People), and any link between temporary staff and undesired change in quality indicators (IQC).

For the purposes of this report there are two levels of reporting:

- Overall Trust reporting covering the overall financial position and similar matters
- Detailed reporting allowing for deeper analysis

3. OPTIONS

The existing arrangements have sustained, warts and all, for some time. As described above, there is a balance to be found and the Trust may choose to accept the extant position if speed is considered more important than the risks of accuracy, particularly if those risks are controlled as far as they can be. Reassurance remains a valid governance tool, and Board members (notably NEDs) may be happy to lean more heavily on that as a counter to limited assurance. Similarly, the Hot Topics initiative at the beginning of each Committee meeting allows responsible Executives to share the most up to minute issues.

The PDG does not believe that ‘do nothing’ is the right approach, however. Rather the Group proposes a choice between two options:

- Reporting at weeks 7 and 8
- Reporting at weeks at 5 and 6

Option One: Reporting at Weeks 7 and 8

Under this option, the Committees and Board would review intelligence and insight at weeks 7 and 8, e.g., at the end of July for May outputs.

The principal benefit of this approach is that there would be time to create that important triangulation through PDG and to discuss the 'so what?' at other governance forums. Whilst it would be later that the assurance forums receive evidence, that evidence would be fully analysed and triangulated, making it more likely to drive insightful discussion and decisions.

Some elements of reporting (Overall Trust reporting) – notably external financial returns and the full finance Committee report – would still be delivered to existing timelines and then would form part of the wider triangulation efforts in subsequent weeks.

Any risks around timing of reporting would be controlled, at least in part, by the Hot Topics initiative.

The other real benefit of this approach is that existing Committee and Board dates would not need to be changed.

Option Two: Reporting at Weeks 5 and 6

Many Boards around the country meet at the beginning or towards the middle of the month, as it allows those extra few days for analysis.

The benefit of this approach over option one is that reporting is less historic.

There are still problems with this approach, however.

Firstly, the PDG still believes that full triangulation would be a challenge within this timeline. This reflects the Trust's cultural approach to reporting, which still needs more work. Insightful reporting at week 5 might still be a few months away.

Secondly, Committee and Board meetings would need to change, which would be far from ideal, particularly for NEDs.

4. PREFERRED OPTION – Reporting at Weeks 7 and 8

The pragmatic preferred option is that Committees and Board receive 'Overall Trust reports' 3 and 4 weeks after the end of the reported month (i.e., no change to existing arrangements), and 'Detailed reporting' 7 and 8 weeks after the end of the reported month.

The flow of information is shown diagrammatically at **Appendix One**.

This solution will allow for better triangulation, validation, and interpretation of data. It will enable the Performance Delivery Group to create insightful analysis and should reduce the volume of papers.

It will allow for better trend reporting in the spirit of measurement for improvement, rather than reporting against target or threshold in the more limited spirit of measurement for assurance. The overall Trust position would be available for discussion to the normal timescales – the change relates to the more detailed underlying trends, performance at team levels and triangulation.

The use of Hot Topics reporting will enable extant issues to be raised at meetings.

The medium-term aspiration, from January 2022 from when diary dates still need to be scheduled, is to move to reporting at weeks 5 and 6.

5. RECOMMENDATIONS

The Board is asked to:

- **NOTE FOR UNDERSTANDING** the challenges and deficiencies in the present reporting process
- **APPROVE** a move to reporting at weeks 7 and 8 from August 2021, with the caveats of external reporting milestones, and the benefits of other governance techniques
- **SUPPORT** the aim to move to reporting at weeks 5 and 6 from the beginning of 2022.

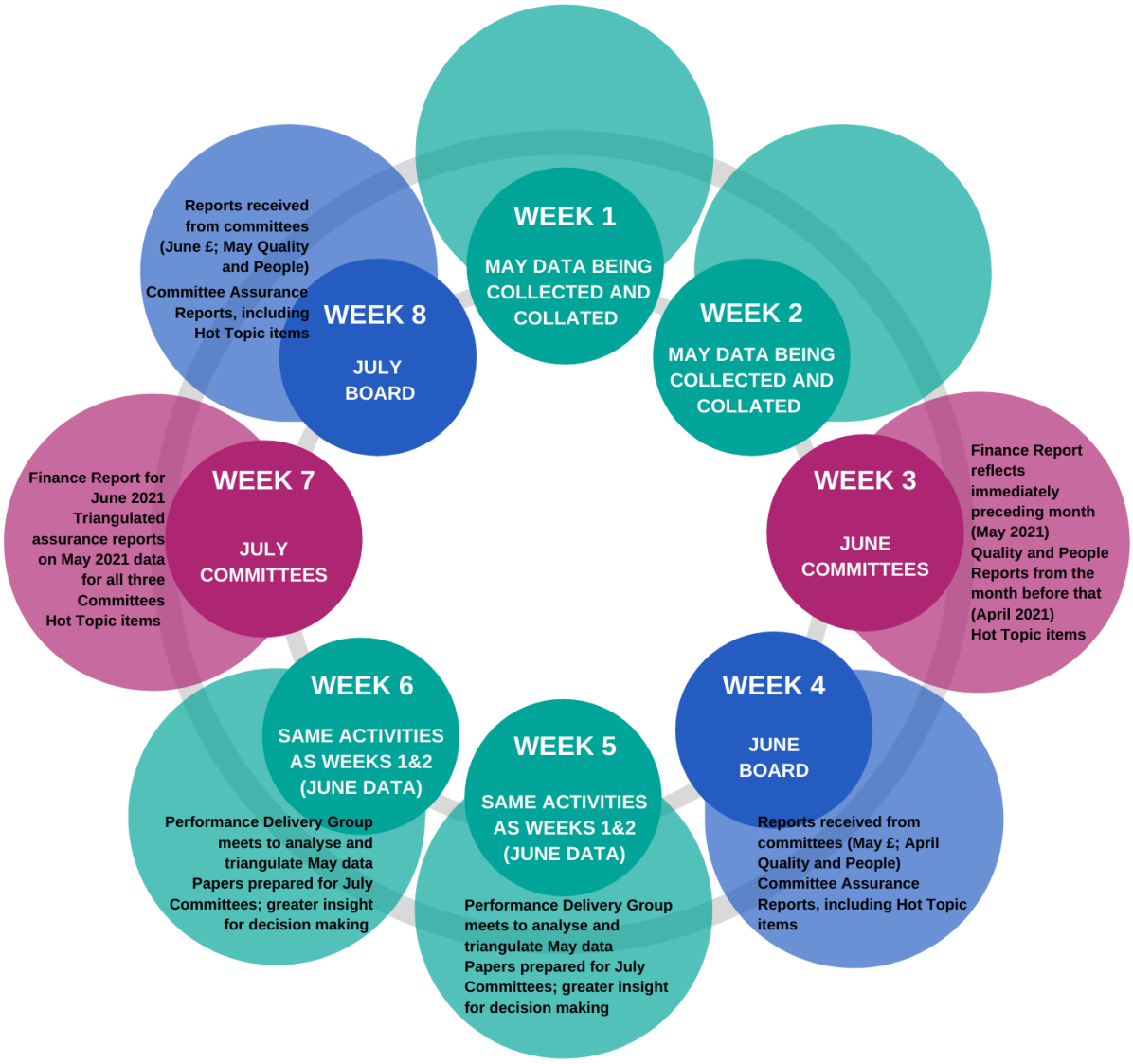
APPENDIX ONE

Process for reporting to Committees and Board

The diagram illustrates the flow and timing of data collation and insight reporting on an 8-week cycle (which might fluctuate to 9 weeks in some months). This is the recommendation for approval.

The diagram demonstrates activities from the first month that the move to the new cycle occurs. In subsequent cycles there will, of course, be other activities occurring at weeks 1 and 2, akin to what is shown at weeks 5 and 6.

The diagram uses May 2021 as the base month for **illustrative purposes**.



14. Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS MEETING**
Agenda item	**Financial Position and capital update**
Paper title	**Month 2 2021/22 Finance Report**
Date	30th June 2021
Author	Emma Ellis
Executive sponsor	David Tomlinson

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

Executive summary & Recommendations:

On 25 March 2021, NHSEI issued the 2021/22 priorities and operational planning guidance for the six-month period April to September 2021 (referred to as H1).

Birmingham and Solihull STP submitted a system financial plan with a deficit of £28m on 6 May 2021. The BSMHFT H1 projection was £1.6m deficit, this plan was submitted to NHSEI on 26 May 2021. Following submission, there has been further review and challenge and system Chief Finance Officers and Chief Executive Officers have now agreed a break even plan across all providers. This will be reflected in a mandated system financial plan re-submission on 15 June 2021.BSMHFT will submit a non-mandated organisational plan re-submission on 22 June 2021 with a break-even plan.

The month 2 2021/22 consolidated Group position is a surplus of £0.8m, mainly due to non-recurrent slippage on recruitment against investment. This is £1.3m better than the year to date plan as submitted on 26 May 2021. From month 3 onwards, the break even plan will be used for reporting purposes.

Month 2 Group Capital expenditure was £390k year to date, with works progressing ahead of plan. Capital expenditure was not profiled to commence until month 3. The total capital plan is £9.6m. On 28 May 2021, BSMHFT submitted a bid as part of the system capital prioritisation process to access funding from the system capital investment fund (SCIF). The panel has recommended an award that would result in a £0.6m increase to our capital envelope. This is subject to formal sign off by system Chief Executive Officers on 25 June 2021.

Reason for consideration:

Update on the system and organisational financial plans for April to September 2021 and update on month 2 capital and revenue position.

Previous consideration of report by:
Regular briefing on financial position with FPP chair. June FPP
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.

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2021 to 31st May 2021

Financial Plan (H1: April – September 2021)

On 25 March 2021, NHSEI issued the 2021/22 priorities and operational planning guidance. The guidance covered the first half of the financial year from 1 April to 30 September 2021 (referred to as H1). A system-based approach is being taken to funding and planning. The following key submissions regarding H1 plan have been submitted/are due:

- H1 System Financial Plan (mandated) – original submission 6 May 2021. Re-submission due 15 June 2021
- H1 Organisational plan (non-mandated) – original submission 26 May 2021. Re-submission due 22 June 2021.

H1 System Financial Plan (mandated)

6 May 2021 submission

On 26 March 2021, the Birmingham and Solihull STP envelope for H1 2021/22 was issued at £1.17 billion
The system financial plan submitted on 6 May 2021 was a deficit of £28m. The BSMHFT H1 projection was £1.6m deficit.

Re-submission 15 June 2021

Following submission, Birmingham and Solihull STP has worked collaboratively, to review and challenge the system plan, with an aim of reducing the deficit. System Chief Finance Officers and Chief Executive Officers have now agreed a break even plan across all partners. The break even plan will be reflected in the system plan re-submission on 15 June 2021.

H1 Organisational plan (non-mandated)

26 May 2021 submission

NHSEI issued individual organisation plans for H1, based on adjusted quarter 3 2020/21 actuals, with a single line entry to balance to the system financial plan. Organisations were given the option to submit plans to allow realignment of income and expenditure, ensuring bottom line position reconciled to system plan. The detailed £1.6m deficit plan for BSMHFT was submitted on 26 May 2021 and it is this plan that will be reported against for month 2. For further detail see page 3.

Re-submission 22 June 2021

Given the system plan re-submission described above, BSMHFT will re-submit the organisational plan to reflect break even on 22 June 2021. This plan will be used for reporting from month 3 onwards.

Month 2 financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	H1 Budget £'000	YTD Position		
		Budget £'000	Actual £'000	Variance £'000
Income				
Healthcare Income	144,841	48,277	48,238	(40)
Other Income	7,502	2,504	2,422	(81)
Total Income	**152,343**	**50,781**	**50,660**	**(121)**
Expenditure				
Pay	(111,639)	(37,213)	(36,754)	459
Other Non Pay Expenditure	(21,909)	(7,303)	(7,487)	(184)
Drugs	(2,959)	(986)	(1,057)	(70)
Clinical Supplies	(570)	(190)	(86)	104
PFI	(5,198)	(1,733)	(1,709)	24
Unallocated Budgets	(3,641)	(1,211)	-	1,211
EBITDA	**6,426**	**2,144**	**3,566**	**1,422**
Capital Financing				
Depreciation	(4,042)	(1,347)	(1,367)	(20)
PDC Dividend	(1,182)	(394)	(393)	1
Finance Lease	(2,183)	(728)	(729)	(1)
Loan Interest Payable	(631)	(213)	(213)	(0)
Loan Interest Receivable	49	16	(0)	(16)
Surplus / (Deficit) before impairment	**(1,564)**	**(521)**	**865**	**1,386**
Taxation		-	(64)	(64)
Surplus / (Deficit)	**(1,564)**	**(521)**	**801**	**1,322**

Month 2 2021/22 Financial Position

The month 2 2021/22 consolidated Group position is £0.8m surplus, this is £1.3m better than the month 2 year to date plan as submitted to NHSEI on 26 May 2021. This is mainly due to non-recurrent slippage on recruitment against investment.

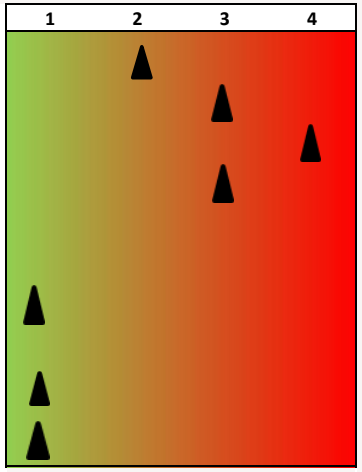
H1 Plan re-submission

Please note the current H1 plan is £1.6m deficit. This will be revised to break even in a re-submission of the plan on 22 June 2021, for further detail, see page 2.

Use of Resources rating 3

Birmingham and Solihull Mental Health NHS Foundation Trust

Single Oversight Framework (without Overrides)	
Single Oversight Framework (After Overrides)	
Financial Sustainability	Liquidity Ratio
	Capital Servicing Capacity
Financial Efficiency	I&E margin (%)
Financial Controls	Distance from Financial Plan
	Agency Spend



Month 2 Single Oversight Framework (SOF) rating is 3 (after overrides).

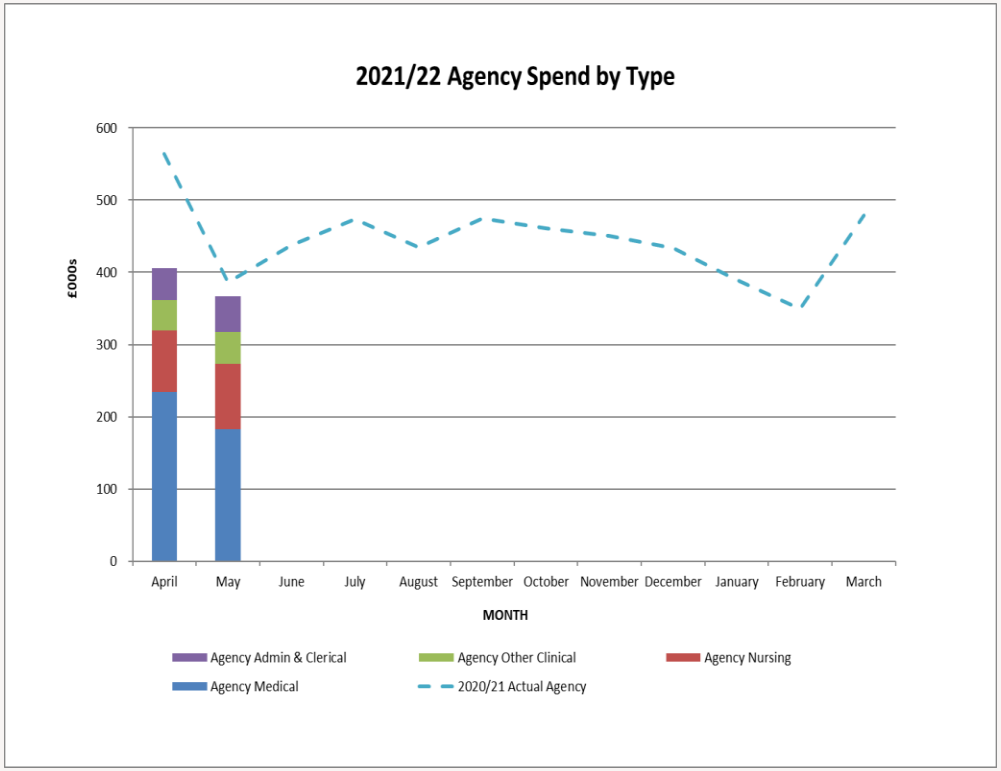
- Month 2 Liquidity rating is 4.
- Month 2 Capital servicing score is 3.
- Month 2 I&E Margin Rating is 1.
- Month 2 Agency spend is scored at 1.

Single Oversight Framework Risk Rating	**Month 2 2021/22**	**Plan 2021/22**
	Risk Rating	**Risk Rating**
Liquidity (Current Assets and Current Liabilities less inventories and assets held for sale / Operating Expenditure x No of days in financial year to date)	4	4
Capital servicing (EBITDA for year to date / capital servicing costs)	3	4
I&E Margin %	1	4
Distance from Financial Plan	1	1
Agency Spend	1	1
Rounded Average	2	3
Single Oversight Framework (without Overrides)	2	3
Single Oversight Framework (After Overrides)	3	3

Agency expenditure

	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 Total
Agency Spend (£000s)	405	366										772
NHSEI Ceiling (£000s)	501	501										1002
Net (£000s)	**96**	**135**										**231**

Agency Medical	234	183										416
Agency Nursing	86	91										177
Agency Other Clinical	42	44										86
Agency Admin & Clerical	44	49										93
Agency Spend (£000s)	**405**	**366**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**772**



Agency spend decreased from £405k in April to £366k in May. This is 20k less than agency spend in May 2020. Year to date expenditure is £772k; this is 230k below the estimated NHSEI year to date ceiling.

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

- 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.
- There are a number of bank staff currently unable to work in areas which require AVERTS due to an under-resource in AVERTS training capacity however, as more individuals complete their training, bank capacity is increasing. Guidance has been produced on where and how staff can work dependent on previous training whilst they are awaiting AVERTS training. Posts for core skills trainers that can deliver ELS and AVERTS skills training have been advertised a number of times, however recruitment has been unsuccessful – the poor response may be due to the posts being 6-month contracts and other options are being explored.
- In response to significant staffing pressures, HCA over-recruitment was stood back up for Q4 of 2020/21 with recruitment rounds taking place in February and March. The Trust has accessed national winter pressure funding in relation to this and a review is due to take place regarding how we can utilise this approach in other areas.
- Work continues with operational areas to convert long term agency into substantive offers of employment Trust-wide.
- Recruitment plans continue to be developed and reviewed with each service to address clinical vacancies and recruit to additional posts identified through the Long Term Plan expansion requirements and the 2021/22 Spending Review Funding.
- The Workforce Transformation workstream continues to focus on upskilling our current workforce, additional workforce supply, new roles and new ways of working and retention to address high levels of substantive vacancies and reduce reliance on agency.
- Following the pilot of MHOST in 2020/21, work is continuing to roll out a bi-annual establishment review process Trust-wide.
- The Trust continues to run processes to ensure the staffing impact of COVID-19 is minimised as much as possible to help prevent heavy reliance on agency workers. Covid-19 related staff absence has been decreased since January 2021 and a review of the staffing impact of long covid has been undertaken.
- The newly formed Workforce Initiatives Group (previously the Redeployment Group) is meeting weekly to respond to urgent workforce pressures that arise and to progress initiatives to drive up workforce supply and availability.

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - Final 31-Mar-21 £m's	NHSI Plan YTD 31-May-21 £m's	Actual YTD 31-May-21 £m's	NHSI Plan Forecast 31-Mar-22 £m's
Non-Current Assets				
Property, plant and equipment	186.5	180.8	185.5	183.2
Prepayments PFI	1.6	1.4	1.6	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	182.1	187.1	184.5
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	9.7	7.4	12.8	7.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	28.8	28.0	28.6	19.8
Total Curent Assets	38.9	35.8	41.8	27.6
Current liabilities				
Trade and other payables	(29.4)	(28.4)	(28.9)	(28.0)
Tax payable	(4.4)	(4.4)	(4.6)	(4.4)
Loan and Borrowings	(2.7)	(2.7)	(2.5)	(2.7)
Finance Lease, current	-	-	-	-
Provisions	(1.2)	(0.7)	(1.2)	(0.7)
Deferred income	(13.2)	(11.2)	(15.8)	(11.2)
Total Current Liabilities	(50.9)	(47.5)	(53.0)	(47.1)
Non-current liabilities				
Loan and Borrowings	(29.5)	(28.8)	(28.8)	(27.3)
PFI lease	(49.3)	(49.1)	(49.1)	(47.7)
Finance Lease, non current	-	-	0.0	-
Provisions	(2.4)	(1.8)	(2.4)	(1.8)
Total non-current liabilities	(81.3)	(79.7)	(80.3)	(76.9)
Total assets employed	94.9	90.8	95.7	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)	(44.4)	(42.3)	(47.0)
Total taxpayers' equity	94.9	90.8	95.7	88.1

SOFP Highlights

The Group cash position at the end of May 2021 is £28.6m.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 7 to 8.

Current Assets & Current Liabilities

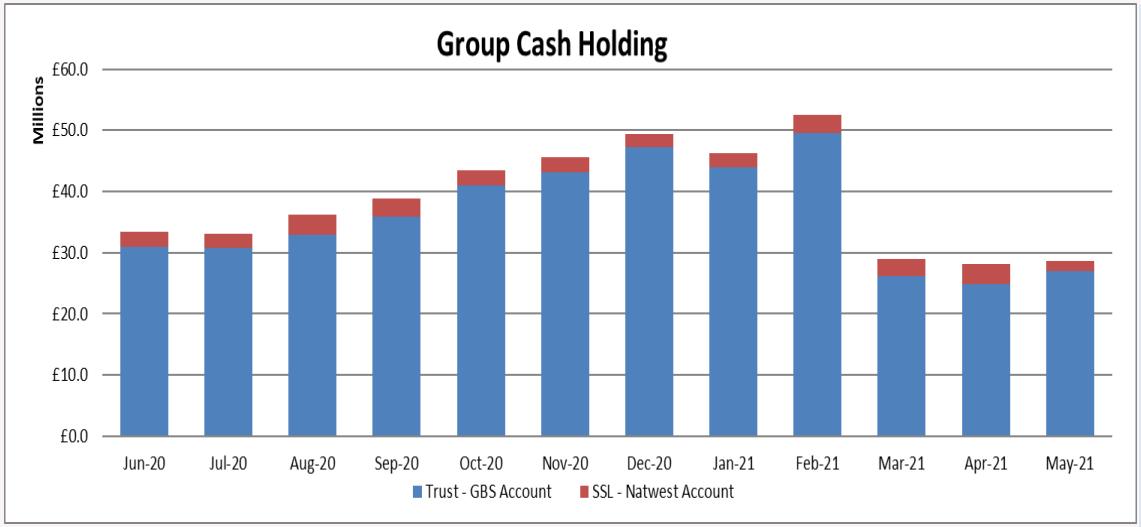
Ratios

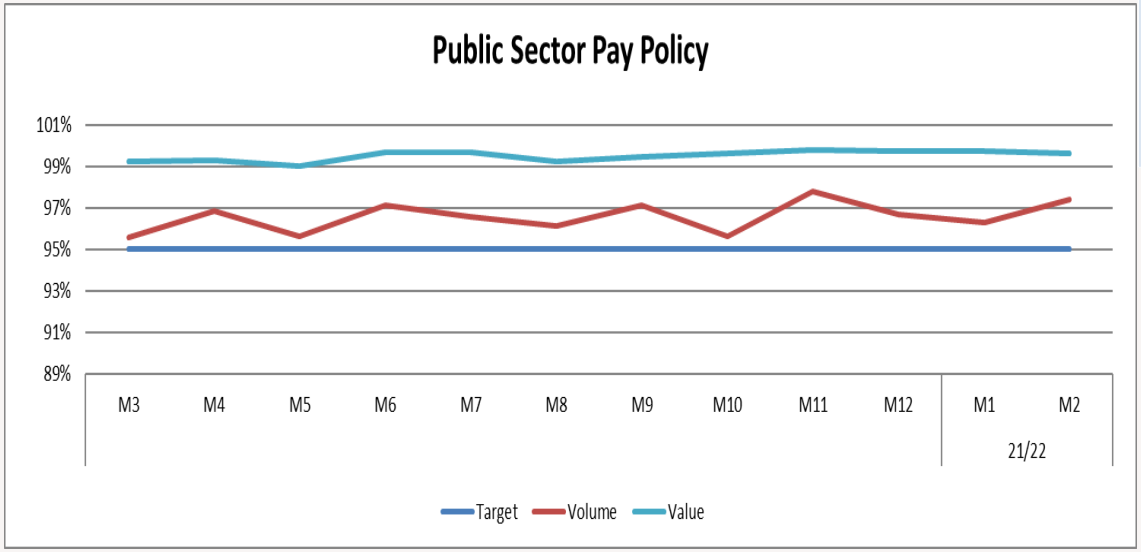
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	41.8
Current Liabilities	-53.0
Ratio	0.8

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

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of May 2021 is £28.6m.

As per last financial year the financial regime introduced as a result of the pandemic will continue for at least the first half of 2021/22, where the majority of our NHS contracts were paid on a block basis. Last year the payments were made in advance to bolster cash positions, this arrangement ceased in month 12, hence the reduction in cash balance from February 21 to current position.

Better Payments

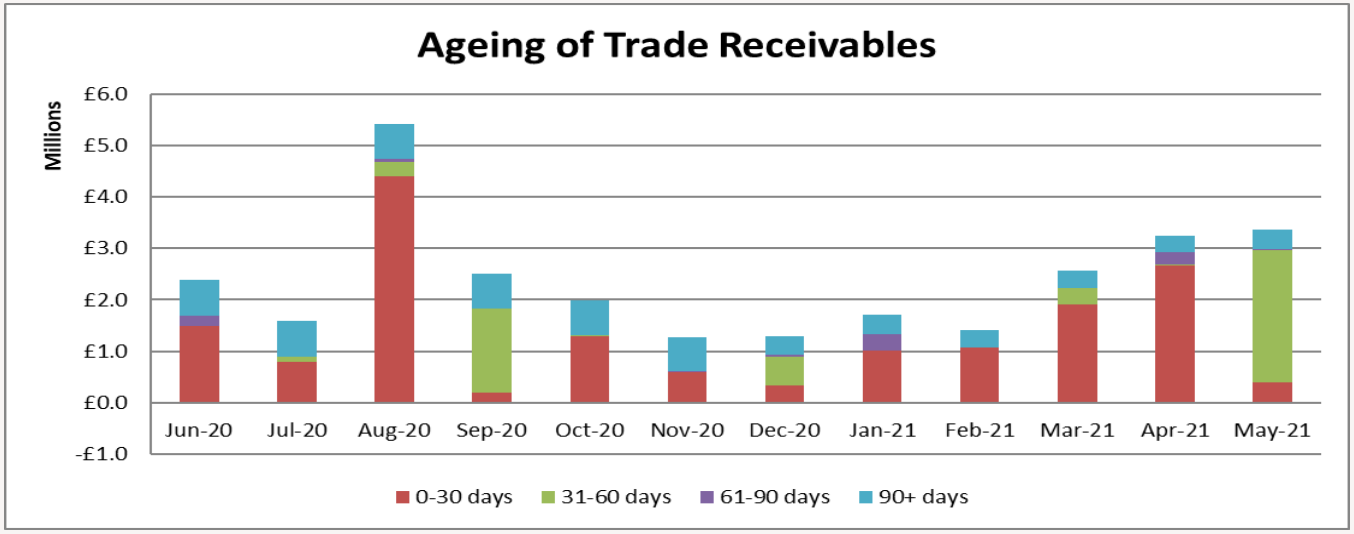
The Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers.

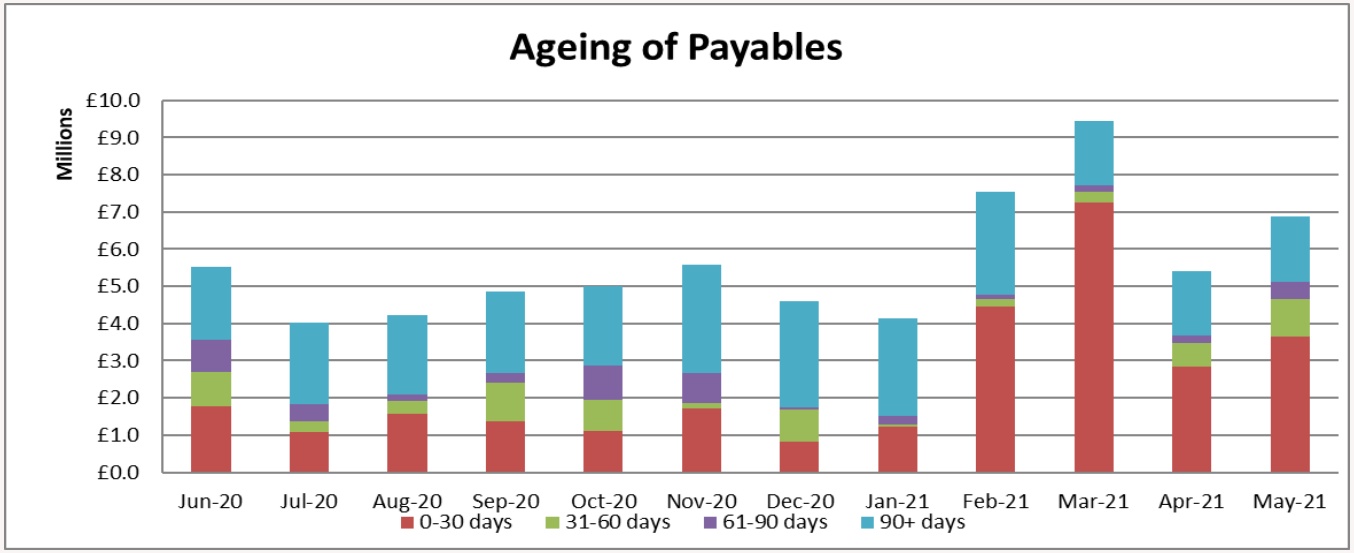
Performance against target is 98% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

Better Payment Practice Code :

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

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. This is to continue for the first half of 2021/22. 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 :

- **Over 30 days**-mainly intercompany. To be settled in June 2021
- **Over 90 days**-consists of outstanding NCA balances from 2 NHS bodies with some being settled in June 2021.

Trade Payables

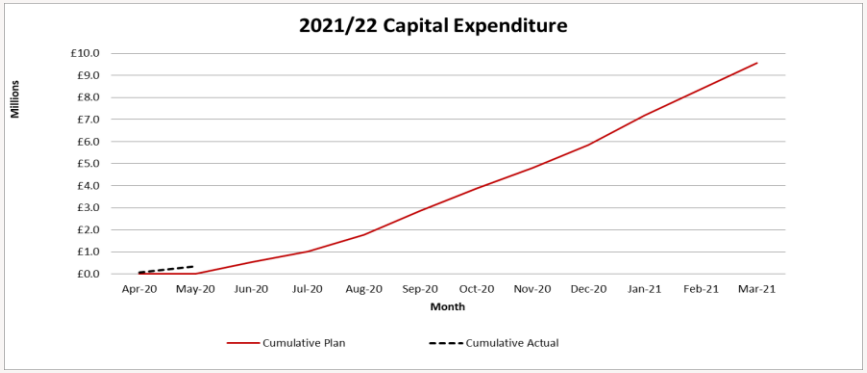
Payables greater than 90 days:

- NHS Property Services £344k– Awaiting lease agreement to be finalised to enable/facilitate payment. The Estates Dept are working with NHS Property to resolve this matter.

- Non-NHS Suppliers (44+) £1.2m – accounts are awaiting credit notes/ adjustments due to disputes/other. Some payments/queries settled in June 2021.

2021/22 Capital

STP ENVELOPE ALLOCATION - CFO agreement 7/4/21	£'m
System approved spend	6.7
Bids against SCIF (door sets) - to be approved by system	1.4
STP agreed adjustment	-0.1
Capital envelope excluding PFI Capital (IFRIC12)	**8.0**
Plus PFI Capital (IFRIC 12)	1.2
Plus planned disposal - NBV	0.4
Adjusted gross capital envelope - submitted to NHSEI 12/4/21	**9.6**



Capital schemes	Total 2021/22	Approval
	£'m	
Pre committed - major schemes brought forward - Urgent Care Centre	**1.2**	
Pre committed - minor schemes brought forward	**0.3**	
Pre committed - Ardenleigh Women's seclusion suite	0.5	
Pre committed Acute en suite door sets (CQC plan)	1.4	
Total Pre committed plans (Approved by Board March 21)	**3.4**	Approved by Board March 2021
Statutory Standards and Backlog Maintenance	**1.5**	Approved by Committee Chairs April 2021
ICT	**0.8**	Approved by Committee Chairs April 2021
Newington refurbishment	**0.5**	Approved by IQC May 2021
Risk Assessments	**3.4**	Prioritisation details TBC
TOTAL	**9.6**	

Month 2 Group Capital expenditure

Month 2 Group capital expenditure was £390k, this is due to expenditure on the Urgent Care Centre progressing ahead of plan. Capital expenditure was not profiled to commence until month 3.

System Capital Investment Fund Bid

The 2021/22 capital plan as submitted to NHSEI on 12 April 2021, is £9.6m. This includes £1.4m for en-suite doorsets across Acute and Urgent Care bedrooms (with a further £1.4m planned for 2022/23). The assumed funding for this within our capital plan is from the System Capital Investment Fund (SCIF). This fund was created for allocation to system priorities and was calculated based on 15% of the total system capital envelope.

A formal process was set up to review and agree system capital priorities. Each provider was requested to submit bids to the SCIF on 28 May 2021 for review by an agreed panel. BSMHFT submitted a bid of £2.4m to expedite the doorset works (bringing forward work planned for 2022/23). Initial feedback received is that the panel has recommended an award of £2m funding, this is subject to formal sign off by system Chief Executive Officers on 25 June 2021 and would result in a £0.6m increase to the total capital plan.

Trust Strategy - Sustainability

Birmingham and Solihull Mental Health NHS Foundation Trust

As approved at Trust Board on 26 May 2021
Our strategic goals indicate what we want to achieve in Year 1 of the Strategy and where we will be focussing our efforts and resources so we can prioritise where needed.
Goals have been aligned to the areas of focus for each of our four strategic priorities. Indicative measures of success have been given for the goals, these will be refined and finalised in Quarter 1 as the monitoring and reporting arrangements for the Trust strategy is finalised.

Sustainability Goals	
2021/22 Goal	**Measure of success**
Transforming with digital	
Bring together clinicians, ICT, service users and carers to develop a clear strategy and five-year roadmap for how digital and technology will enable clinical services, quality and people transformations and developments. *Link to Clinical Services*	Working/steering group established to identify digital improvements needed and confirm what is possible The roadmap focuses use of technology in key priority areas identified in our clinical services, quality and people strategic priorities. Developments identified will reduce and not exacerbate inequalities. Roadmap developed, consulted on, circulated and understood.
Develop our business intelligence capability to improve the information and insights available for developing services and user experience.	Increased provision of Power BI analysis reports to support service level strategic priorities and other critical areas
Develop a framework to ensure digital skills development for all staff who need skills update.	Number of staff accessing digital skills training. Number of requests to the helpdesk due to lack of knowledge of digital applications.
Make improvements to our workforce systems such as ESR and e-rostering. *Link to People*	Improvements to workforce systems and processes specified and delivered

Trust Strategy - Sustainability

Sustainability Goals	
2021/22 Goal	**Measure of success**
Changing through partnerships	
Work with local partners to develop the vision, approach and structure for the Birmingham and Solihull ICS including achieving economies of scale from greater collaborative working. *Link to Clinical Services*	ICS operating in shadow form from 1 October 2022 ICS fully operational from 1 April 2022
Develop a framework with our local partners for a mental health Integrated Care Partnership for BSOL, aligned to the ambitions of the ICS and supporting our key tests of reducing inequalities, managing demand, improving access, experience and outcomes, improving safety, and achieving value for money. *Link to Clinical Services*	Case for change approved. Meeting implementation plan milestones. Framework for partnership working in place. Finance and contracting structure to enable the ambitions of the ICP. Fully operational from 1 April 2022
Design and implement clear and robust governance processes that fulfil the Trust's Lead Provider responsibilities effectively for Reach Out, holding the system partners to account to improve quality of care and patient experience and outcomes whilst achieving financial sustainability. *Link to Clinical Services*	Commissioning function goes live on 1 October 2021
Work in partnership with system partners to redesign and integrate pathways between secure care and secondary care services to ensure care is provided in the right setting, improving patient experience and outcomes, achieving greater system efficiency. *Link to Clinical Services*	The system across the West Midlands is working towards an aligned outcomes framework to support the integration of pathways between secondary and secure care, and there are agreed priorities for local level interfaces and integration.
Continue to play an active role and contribute to the delivery of 2021/22 workplans for the Eating Disorders and CAMHS Provider Collaboratives. *Link to Clinical Services*	Provider Collaborative measures of success including numbers of out of area placements, length of stay etc.
Review and refresh our Partnership Framework to support the delivery of our strategy across regional, local (place), and neighbourhood partnerships with the NHS, local authority, voluntary and community sector, and other statutory bodies.	The Partnership Framework is aligned to our strategic priorities, is widely circulated and understood and enables us to set subsequent goals and measures of success.

Trust Strategy - Sustainability

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability Goals	
2021/22 Goal	**Measure of success**
Balancing the books	
Identify and focus on a small number of efficiency schemes where the Trust can deliver significant reductions and release money to invest in strategic priorities.	Utilising detailed run rate analysis, three schemes will be identified and plans developed with the intention of reducing spend by £1m on each against a 19/20 baseline.
Improve our short and medium financial planning for both revenue and capital to ensure that we have enough resources to fund improvements.	Funding is identified to enable Trust priorities to be developed. Medium term financial plan is developed and shared internally.
Create and deliver a training financial training package across the organisation, including roles and responsibilities in procurement.	Training implemented, with impact measured by number and roles of people undertaking the training.
Develop a suite of reports to enable the organisation to understand the financial position in detail, supplementing the existing budget reports.	Staff have greater understanding of and our financial position and performance, the longer-term outlook and implications.

Sustainability Goals	
2021/22 Goal	**Measure of success**
Caring for the environment	
Develop and implement a procurement strategy that focuses on minimising waste.	Reduction in the amount of waste. Funds released to invest in key strategic priorities
Develop and implement a green vehicle strategy aligned to wider ICS work on the environment.	Strategy developed that: • builds on reduction in journeys and emissions seen during the COVID pandemic • responds to the introduction of the Birmingham Clean Air Zone Implementation measured by number of journeys made by staff, analysed through expense claims.

Trust Strategy - Sustainability

Sustainability Goals	
2021/22 Goal	**Measure of success**
Good governance	
Define our approach to governance, including board, committees and structures/frameworks and explain these to stakeholders.	Completion of our governance improvement plan, including improved assurance from committees. Improved reporting to board and committees. Board Assurance Framework updated to reflect new strategy. Improvements in integrated performance reporting. Improvements in relationship and standing with CQC.
Develop a clear Corporate Social Responsibility framework so the Trust is contributing positively to the lives of local people and the environment in which they live.	The framework is co-produced with local community groups and voluntary sector organisations, is aligned to our aim of reducing inequalities, is widely circulated and understood and enables us to set subsequent goals and measures of success. A lead or champion for CSR and social value is in place.
Be an anchor organisation around procurement and employment, stimulating social value through our supply chain and a range of accessible and targeted employment opportunities, to improve the wellbeing of local people, reduce inequalities and contribute to the local economy. *Link to People*	Procurement staff are trained in CSR/Social value to increase knowledge and confidence. More goods and services are sourced locally and from organisations that offer a living wage. The number of new staff recruited analysed by protected characteristics and demographic data.

15. Highcroft and Reaside Stakeholder Engagement

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	**BOARD OF DIRECTORS MEETING**
Agenda item	**16**
Paper title	**Draft - Highcroft and Reaside Development Project** **Communications and Engagement Plan Summer 2021**
Date	30th June 2021
Author	Tim Hamilton – Interim Head of Communications
Executive sponsor	Dave Tomlinsion – Director of Finance

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

Executive summary & Recommendations:

These projects are recognised as equal priorities in our Trust Strategy, and, subsequently as priorities in the Birmingham and Solihull Estate Strategy. They are also recognised in the area STP planning.

Effective communications and engagement is key to these projects and will be integral to the work we do across various workstreams. It needs to be at the heart of the transformation we want to make so that all stakeholder groups understand the changes we are making, the rationale for them and ensure they are able to have appropriate and timely input and feedback.

This plan sets out our communication and engagement objectives and describes how we will work together to communicate and engage by identifying target audiences, key messages and appropriate channels. It then lays out a proposed timetable of activities designed to deliver these objectives

Reason for consideration:

The Board are asked to review and discuss the content of the report

Previous consideration of report by:

- June FPP

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)*

None highlighted, however the Sustainability Strategic Priority is a key enabler making sure resources are focused in the right areas to support delivery.
Board Assurance Framework Risks: *(detail any new risks associated with the delivery of the strategic priorities)*
No new risks associated with report.
Equality impact assessments:
N/a
Engagement *(detail any engagement with staff/service users)*
The Trust strategy including the four strategic priorities was developed through comprehensive engagement with staff, service users, carers and partners.

DRAFT

Highcroft and Reaside Development Project

Communications and Engagement Plan Summer 2021

Version 1 – June 2021

Communications and Engagement Plan

Trust Five Year Strategy (2021)

Our Trust Five Year Strategy outlines how in our clinical services we want to transform how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.

The ambitions for clinical services include:

- Being a leader in mental health, having smooth interfaces and transitions between our own services
- Delivering personalised, service user centred care
- Being recovery focussed
- Reducing out of area placements and providing personalised care in the least restrictive setting, by improving service user flow and length of stay in acute care.
- Having a model that considers all the needs of the service user: their mental, physical and social wellbeing; and wraps around the service user, working in partnership across professions and across other organisations to meet those needs
- Using the new build developments at Highcroft and Reaside as an opportunity to work in a better way

Background to developments

These projects are recognised as equal priorities in our Trust Strategy, and, subsequently as priorities in the Birmingham and Solihull Estate Strategy. They are also recognised in the area STP planning.

Highcroft

The layout and design of our current wards at Highcroft are not fit for purpose and do not meet national standards. This affects patient experience and often results in longer recovery times and patients being placed in out of area beds.

The buildings at Highcroft are many years old and do not reflect modern mental health services, having been designed in the 1970s when care delivery models were very different. Since the wards were constructed, a great deal of research has been undertaken which concluded that an effectively designed environment positively impacts on a service user's recovery journey and also reduced incidences of violence and aggression.

Re-designing Highcroft will help us to improve the clinical model of care and therapeutic environment, and reduce length of stay to whilst providing flexibility to future-proof the site as the clinical model develops further. It is a long term project, which will involve a number of approvals processes as it progresses. The planned completion date is summer 2026, however engaging a range of colleagues and stakeholders from an early stage is critical to our success.

The first phase of this development will involve the following wards:

- Eden Psychiatric Intensive Care Unit
- Eden ward
- Endeavour House
- George ward
- Larimar ward

Reaside

The Reaside Inpatients Development project will re-provide services at Reaside Medium Secure Unit.
The existing patient accommodation at Reaside (commissioned in 1987) and Hillis Lodge (commissioned in 2001) is not conducive to the delivery of modern mental health inpatient services and does not meet modern accommodation standards. The main environmental shortfalls include:

- No en-suites in any bedrooms
- Inadequate day space on inpatient ward areas and limited visiting areas for family and friends
- Four wards on first floor at Reaside which forms part of the external secure perimeter, with restricted access to external space
- Inadequate seclusion rooms and interview/therapy space on wards
- Hillis Lodge is a 15-bed stand-alone site
- Reaside has inadequate space for dining on inpatient wards

Communication and engagement

Effective communications and engagement is key to these projects and will be integral to the work we do across various workstreams. It needs to be at the heart of the transformation we want to make so that all stakeholder groups understand the changes we are making, the rationale for them and ensure they are able to have appropriate and timely input and feedback.

This plan sets out our communication and engagement objectives and describes how we will work together to communicate and engage by identifying target audiences, key messages and appropriate channels. It then lays out a proposed timetable of activities designed to deliver these objectives.

Expected benefits

Highcroft

New Build Highcroft

New Build all acute and urgent care adult inpatient services for the north of the city on the Highcroft site

- Includes provision of 30 beds for transfer of services from Forward Thinking Birmingham
- Will free up some PFI buildings for alternative use by the Trust or partners e.g. create a rehabilitation village

Design Criteria

Patient
- En-suite rooms
- Larger day time spaces
- Privacy during the day in communal areas
- Outside space
- Space for activities
- Space for visitors including children

Improved Care
- Enable safe observations
- Reduced harm risk e.g. ligature points
- Improved seclusion facilities
- Enabling rapid response

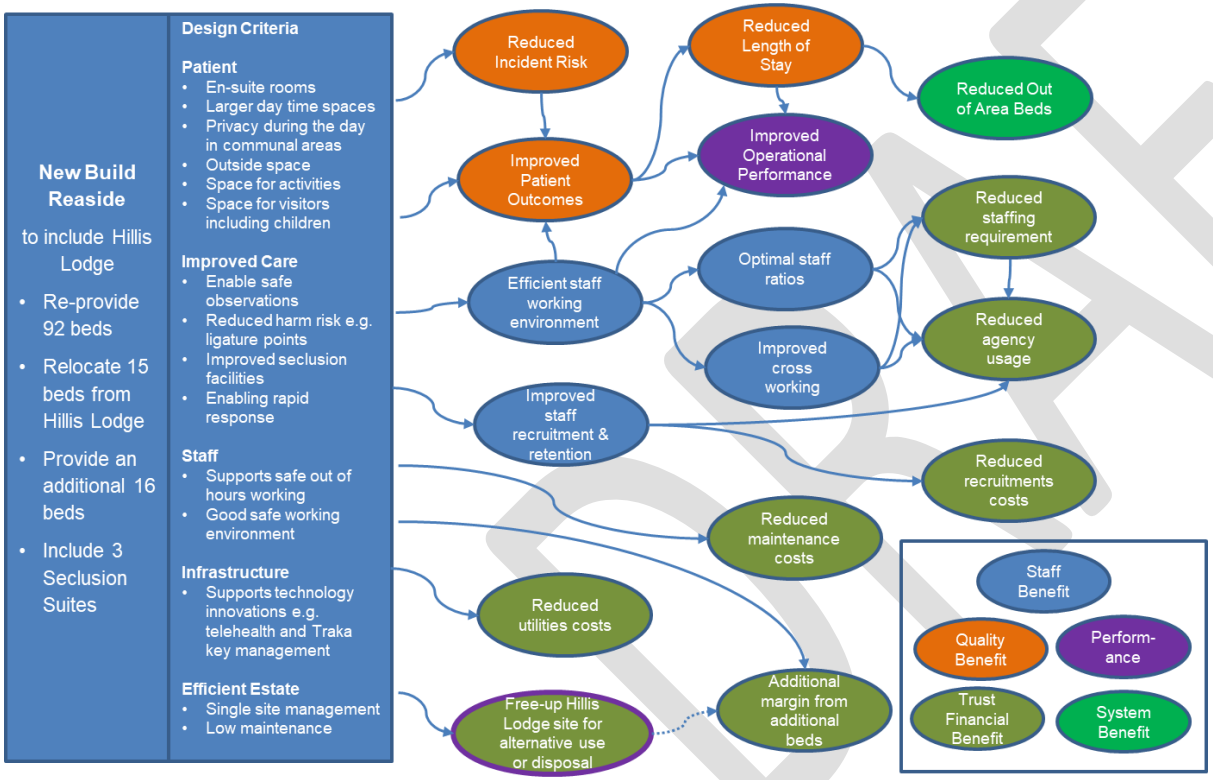
Staff
- Supports safe out of hours working
- Good safe working environment

Infrastructure
- Supports technology innovations e.g. telehealth

Efficient Estate
- Single site management
- Low maintenance

Expected Benefits

Reaside



Communications and engagement objectives

Highcroft

- To ensure that staff at Highcroft, Larimar, Newbridge House and Mary Seacole and the wider Acute and Urgent Care service area are fully engaged with and able to participate in the development of the Highcroft site.
- To provide a realistic timeline and reassurance of the Trust's commitment to this development, given previous engagement and potential scepticism.
- To inform all Trust staff about key developments and benefits.
- To ensure that all stakeholders are appropriately and regularly involved, engaged and informed about the work we are doing, the case for change and the benefits that will be realised through the development of Highcroft. This will work on the principle of 'no surprises'.
- To work with our patient engagement team and Highcroft management to build meaningful and two way communication and engagement with service users and carers to ensure that they have a genuine opportunity to influence the planning, development, design, production and evaluation of services.
- To ensure that equality, diversity and inclusion is considered and promoted in all communications and engagement activities, given the inequalities currently present in acute and urgent care services, for example that BAME service users are more likely to be subject to Mental Health Act detentions, restraint and seclusions. Reinforcing the Trust's commitment to improve equality, diversity and inclusion for service users, carers and staff.
- To ensure that the public, particularly local residents and communities, are informed and engaged about the development and have opportunities to provide feedback.
- To promote the development, both locally and nationally, as a state of the art facility that will have a positive impact on quality of care and service user recovery and rehabilitation, and in doing so grow and enhance the reputation of the unit and the Trust.
- To promote Highcroft as a great place to work with a positive staff experience and a wide range of career development opportunities.

Reaside

- To provide a realistic timeline and reassurance of the Trust's commitment to this development, to address a degree of scepticism amongst staff following a number of previous 'false starts'.
- To inform all Trust staff about key developments and benefits.
- To ensure that all stakeholders are appropriately and regularly involved, engaged and informed about the work we are doing, the case for change and the benefits that will be realised through the development of Reaside. This will work on the principle of 'no surprises'.
- To work with our patient engagement team and Reaside management to build meaningful and two way communication and engagement with service users, carers to ensure that they have a genuine opportunity to influence the planning, development, design, production and evaluation of services.

- To ensure that equality, diversity and inclusion is considered and promoted in all communications and engagement activities, given the inequalities present in secure care settings and over-representation of BAME service users, and the Trust's commitment to improve equality, diversity and inclusion for service users, carers and staff.
- To ensure that the public, particularly local residents and communities, are informed and engaged about the development and have opportunities to provide feedback.
- To promote the development, both locally and nationally, as a state of the art facility that will have a positive impact on quality of care and service user recovery and rehabilitation, and in doing so grow and enhance the reputation of the unit, the Trust and Reach Out.
- To promote Reaside as a great place to work with a positive staff experience and a wide range of career development opportunities.
- To support the Reach Out partnership through joint communication and engagement and promotion of the partnership, its objectives and achievements, through our communications and engagement activity.

Audiences

Key audiences for the projects include the following:

Internal audiences

- Reaside, Highcroft, Hillis Lodge, Larimar, Mary Seacole and Newbridge House staff
- Secure care staff more widely
- All Trust staff
- Executive Team
- Senior leaders
- Board members
- Governors
- Service users
- Carers and families
- Foundation Trust members

External audiences

- NHS England/Improvement
- NHS Birmingham and Solihull CCG
- Birmingham and Solihull and other West Midlands STPs
- Local healthcare partners

- Reach Out Commissioners
- Third sector partners
- Local populations and communities, including residents and community organisations, schools, colleges and other neighbouring organisations and businesses
- Partners in the criminal justice system
- Local authority planners
- Local MPs and councillors
- Health and Wellbeing Board and Health Overview and Scrutiny Committee
- Other Trust stakeholders
- Local and national media
- Trade media

A high level stakeholder map for the developments is below and this will need further review and development with the involvement of the project team:

Involve	**Partner**
• Acute and urgent care staff more widely • Secure care staff • Governors • Senior leaders • Birmingham and Solihull and other West Midlands STPs • Local healthcare partners • Local MPs and councillors • Third sector partners • Local residents and neighbouring organisations and businesses	• Highcroft, Larimar, Mary Seacole and Newbridge House staff • Reach Out staff • Service users, carers and families • Executive Team • Board members • NHS England/Improvement • NHS Birmingham and Solihull CCG • Health and Wellbeing Board • Health Overview and Scrutiny Committee • Local authority planners
Inform	**Consult**
• Foundation Trust members • Wider Trust staff • Other Trust stakeholders • Local and national media	• Schools • Colleges • Community organisations • Trade media

Power

Interest

Narrative and key messages

An agreed narrative for the project will be developed with the project team with high level messages across the project to include the following. Messages will be used as appropriate for different audiences.

Highcroft

Why we are redeveloping the Highcroft site:

- We are redeveloping Highcroft because the layout and design of our current wards are not fit for purpose and do not meet national standards. This affects patient experience and often results in longer recovery times and patients being placed in out of area beds. We will increase capacity and reduce out of area placements
- Re-designing Highcroft will help us to improve the clinical model of care and therapeutic environment, and reduce length of stay whilst providing care closer to home and flexibility to future-proof the site as the clinical model develops further.
- It is a long term project, which will involve a number of approvals processes as it progresses. The planned completion date is summer 2026, however engaging a range of colleagues and stakeholders from an early stage is critical to our success.

Which wards will this affect?

- The first phase of this development will involve the following wards:
    - Eden Psychiatric Intensive Care Unit
    - Eden ward
    - Endeavour House
    - George ward
    - Larimar ward

- With an eye to future phases of development in our inpatient services in the north of Birmingham and to ensure we get a wide range of input and views, it's very important to us that we continue to include and engage colleagues from our other inpatient units – Mary Seacole House and Newbridge House - in these developments.

Benefits for service users, carers and families:

The service user currently goes through a process of assessment, intervention and treatment during the acute phase/ exacerbation of their illness. The ability to undertake this in a more efficient and effective way will be greatly enhanced by the provision of this new facility as detailed below.

The design will allow patients to live on wards that are safe and spacious. Large day areas (broken up with use of pods), all bedrooms ensuite, quiet rooms and de-escalation / sensory spaces means that patients are less likely to be 'institutionalised' into a mental health environment, with the ability to undertake activities in privacy and with dignity.

Activities that take place in the new building should enhance the patients feeling of health and social wellbeing, with an environment that can support transition to community-based environments.

Patients will have access to a centralised off-the-ward therapy area. For those patients who do not have the required leave off the ward, the design of the ward will encourage on ward therapeutic activity with ADL kitchens and activity areas. Meeting rooms / interview rooms/small group teaching rooms on the ward will allow therapeutic sessions to take place in a more timely and comfortable space on the ward.

In the digital age, it is important that patients have appropriate access to the internet. The project seeks to use technology to assist with treatment and preparedness of patient care.

All patients will have access to safe outside green space directly from their ward and all patients will have access to physical health equipment from each ward in the form of a small cardio-vascular gym ensuring physical health equipment is available. Facilities for more accessible and comfortable family and friend visiting will improve the quality of the visiting experience for patients and their visitors.

- Create a more psychologically informed environment which will promote a sense of normal community and inclusion through shared activities e.g. mealtimes, physical activities and relaxation;
- Enable greater recognition of the trauma experienced by patients which are often exacerbated by current practice and infrastructure/building design. The new wards environment will help facilitate a more therapeutic reception and admission for service users;
- Ensure consistency in clinical practice (through flexible workforce across all wards on the site, investment in staff clinical development through the inception of regular, local teaching sessions themed around in-patient topics e.g. suicide prevention, assessments, substance misuse, personality disorders, recovery model, risk management (multi-discipline and discipline specific)
- Improve the understanding of the sensory processing difficulties experienced by many patients and designing a building and service to support this;
- Increase the understanding of the complexity of patients' needs and having an environment to support their recovery;
- Enable collaborative working with Third sector providers and Partners in engaging with service users in supporting their recovery and transition back to the community in an enabling space (e.g. Compass workers, AA/SMART, housing officers, debt advisors , charitable organisations)
- Provide a more coherent pathway of care reflecting the patient recovery journey in the design of the building with access to indoor and outdoor campus type spaces that are family friendly, but that maintains a sense of safety and therapy as opposed to feeling overly contained;
- Offer shared use of therapeutic facilities and reduce boundaries between in-patient care and community living. The clinical environment will take into account the needs of detained and informal patients in terms of therapeutic space (i.e. ADL's , leisure, visiting etc) . This will enable families to visit the wards in a safe and welcoming space;

- Improve patient satisfaction with the care environment; facilities, cleanliness, supporting access to interventions;
- Improve access to a range of physical health interventions on and off wards, with the space to deliver a range of physical interventions and activities e.g. a "health station" available to all service-users, staff and visitors, relaxation/yoga/mindfulness sessions
- Support and enhance the service users care, treatment and experience in a way that is therapeutic and reassuring. This will include instant electronic access to activities and psychological materials as part of the therapeutic offer e.g. care plans, a suite of tools and brief videos service users can utilise to support their recovery.
- Reduced Sis
- Reduced OOA placements and average length of stay

Benefits for staff:

Resourcing for mental health facilities is challenging. There is the hypothesis that moving to an improved working environment, especially one that has a treatment rather than containment focus and is a 'safer' working environment will improve staff satisfaction. The improved staff satisfaction should lead to reduced staff turnover which both increases the quality of care, based on the assumption that increased consistency and experience improves the care relationship, and reduces cost. Specifically,

- The improved working environment is designed to have better toilet, storage and rest rooms on the ward. Access into and exiting the building will be more technology based and therefore improve the working environment and conditions in reception.
- Modern technology will be used to enhance the efficiency and productivity of staff with a building that is able to facilitate enhanced connectivity, thereby reducing network issues prevalent in old buildings.
- Having all services on one site will allow for an accessible critical mass of staff for all wards and departments. There will be a more flexible and locally developed workforce, with opportunities for career progression.
- Improved staff security will result from unrestricted lines of sight. Better dining areas will be less resource intensive to manage. The provision of meeting rooms on the ward will allow for safe, confidential and secure handover of patient information and will improve information sharing and clinical decision making.
- The ability for staff to manage infection control related issues will be improved. This has been severely hampered by the restraints of the environment where sharing toilets and wash facilities is unavoidable.
- Improved staff satisfaction with the care environment; security, privacy, dignity, infection control, access to interventions
- Reduce administrative burden, e.g. uniform wifi access with no blackspots, use mobile devices to update patient records

Additional benefits for the Trust/system:

- There is the assertion that the new building and the clinical offer will allow workforce efficiencies to be gained through changing the skills mix and improving staff utilisation
- By removing the stand alone in patient units we currently have we will be improve the clinical safety of the wards within the new build (safer ward environment such as anti-ligature doors, improved observations and visibility, critical mass of staff through co-location of human resources, improving the ability to recruit and retain staff)
- A designated ward with the ability to "flex" such that an 18 bedded single gender ward could adapt to become a 3 x 6 bedded mixed gender ward as required
- Improve infrastructure management e.g. door security, alarms to minimise suicide attempts

Reaside

Why we are redeveloping the Reaside site:

- We are redeveloping Reaside because the environment is over 30 years old, with accommodation that is no longer fit for purpose for a modern 21st century secure care service.
- The services currently provided at Hillis Lodge will be brought into the Reaside development as this unit is 20 years old and is a standalone unit which is not able to provide a safe therapeutic environment for the treatment of patients who require secure care. This will enable more integrated care.

Benefits for service users, carers and families:

- Service users and carers will be involved in the design of the service to ensure it meets their needs.
- The proposed model will provide continuity of care for most patients throughout their inpatient treatment and across discharge into the community.
- Consolidating both medium and low secure services into one facility will reduce the stigma associated with the service users' acuity, levels of restriction and intervention needed within medium and low secure services.
- Compliance with the principle of least restriction will mean service users moving to lower levels of restrictions as soon as possible with well managed transition processes.
- A reduction in recovery times with fewer transitions in care, and therefore a reduced length of stay.
- Personalised intervention plans which will be co-constructed with service users' families and carers.
- More privacy and dignity through having ensuite rooms and larger day time spaces.
- More outdoor space to enable sports and leisure activities, and more space for increased therapeutic activities.
- A greater and more appropriate range of therapies across the whole pathway will include increased access to psychological and occupational therapy.

- Better opportunities to maintain physical health through provision of resources, equipment and space.
- More space for visitors, including children.
- More beds meaning fewer out of area placements and care closer to home with 16 extra beds.
- A safer environment that will reduce the risk of harm and enable a rapid response.
- Services will be designed to be inclusive and consider gender, ethnicity, age group, sexuality, disability, physical health and therapeutic need.
- Services will be designed to be flexible to allow for future changes in services, innovation in the way services are delivered and changes in the service user population and its needs.
- The environment and clinical model will address employment and housing opportunities for patients as part of their journey and recovery.

Benefits for staff:

- Staff will be involved in the design of the service to ensure it meets their needs.
- A safer working environment with staff wellbeing central to the delivery of care.
- Improved cross team working.
- The infrastructure will support innovations in technology such as telehealth and Traka key management to improve care, support recovery and improve safety.
- Increased staff satisfaction in the quality of care we are able to provide, leading to increased morale, engagement and staff retention.
- Reaside will be a more attractive place to work, leading to easier recruitment.

Additional benefits for the Trust/system:

- A single site leading to more efficient estate management and reduced utilities and maintenance costs.
- Financial benefit from increased bed numbers.
- Improved cross working and optimal staff ratios meaning reduced agency spend.
- Better staff retention leading to lower recruitment costs.

Activity Plan

The anticipated approach is to establish a rhythm of monthly communication following the monthly project board, augmented with communication activities that fir particular audiences, as outlined in the table below and to be discussed and agreed at the project board.

Project	Stakeholder group	Action	Owner	Deadline	Comments
Highcroft and Reaside	Board	Monthly update and ad hoc as required	Exec Lead DT	Next board 30/6	
	Exec Team	Update weekly/ as required	DT		
	Governors	Email update	TH/ DC	15/6	Following project board 11/6
	Senior Leaders	Email update	TH	15/6	Following project board (establish rhythm monthly, and ad hoc as required).
	NHSE/I	Email update	TH/ DT/ RFW	15/6	As above
	Medical Advisory Committee	Email update/ brief for agenda	Clinical lead	15/6	As above
	Nursing Advisory Committee	Email update/ brief for agenda	Clinical lead	15/6	As above
	Psychology Advisory Committee	Email update/ brief for agenda	Clinical lead	15/6	As above
	Allied Health Professionals Advisory Committtee	Email update/ brief for agenda	Clinical lead	15/6	As above
	Union representatives	Email update and core brief	Clinical lead	15/6	As above
	MPs and Councillors	Email update Site visits to orientate	TH/DT/ RFW	15/6	As above
	Local Authority and local healthcare partners and STP	Email update	TH/DT/ RFW	15/6	As above
	Health and Wellbeing Board	Send briefing	TH/DT	tbc	As required
	Overview and Scrutiny	Send briefing	TH/DT	tbc	As required

Project	Stakeholder group	Action	Owner	Deadline	Comments
	Committee				
Highcroft	Staff - Highcroft, Larimar, Newbridge House and Mary Seacole and	Staff briefings, email brief and feedback mechanism Dedicated intranet page	TH/ Staff engagement lead	tbc	As per board
	Wider Acute and Urgent Care staff	Staff briefings, email brief and feedback mechanism	TH/staff engagement lead	tbc	As per board
	All staff	Intranet, colleague brief, connect	TH	tbc	As per board
	Service user groups, Experts by Experience	Briefing by email, then through meetings as per their timetable	TH/ Patient engagement team	tbc	As per board
	Residents and local community groups	Letter outlining aspirations and feedback mechanism, meetings as per their requirement	TH/ Community engagement	tbc	As per board
	Ward councillor	Letter including core brief	TH/DT/ RFW	15/6	Following board
Reaside	Staff	Staff briefings, email brief and feedback mechanism Dedicated intranet page	TH/ Staff engagement lead	tbc	As per board
	Wider secure services staff	Staff briefings, email brief and feedback mechanism	TH/staff engagement lead	tbc	As per board
	All staff	Intranet, colleague brief, connect	TH	tbc	As per board
	Service user groups, Experts by Experience	Briefing by email, then through meetings as per their timetable	TH/ Patient engage	tbc	As per board

Project	Stakeholder group	Action	Owner	Deadline	Comments
			ment team		
	Residents and local community groups	Letter outlining aspirations and feedback mechanism, meetings as per their requirement	TH/ Community engagement	tbc	As per board
	Ward councillor	Letter including core brief	TH/DT/ RFW	15/6	Following board

GOVERNANCE & RISK

16. Reach Out Governance Verbal Update

17. Questions from Governors and Public

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

19. Snap shot review of Board Performance

20. RESOLUTION: To exclude members of the public from the remainder of the meeting due to the confidential nature of the business to be transacted

21. Date & Time of Next Meeting:

09:00am, 28th July 2021