BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Board of Directors Public Meeting
09.00, Wednesday 5 June 2024
Uffculme Centre
AGENDA

Ref	Item	Purpose	Report type	Time
	Staff Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 3 April 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 3 April 2024**	Assurance	Enc	
6	**Chair's Report** *Phil Gayle, Chair*	Assurance	Enc	09.40
7	**Chief Executive and Director of Operations Report** *Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Director of Operations*	Assurance	Enc	09.50
8	**Board Assurance Framework** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	10.10
	Quality			
9	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.20
10	**Patient Safety and Experience Report** *Lisa Pim, Acting Deputy Director of Nursing*	Assurance	Enc	10.30
11	**Quality Improvement Report** *Julie Romano, Head of Quality Improvement and Clinical Effectiveness*	Assurance	Enc	10.40
12	**Research and Development Annual Report** *Emma Patterson, Head of Research and Development*	Assurance	Enc	10.55
	People			
13	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	11.10
14	**Guardian of Safe Working Hours Reports** *Shay-Anne Pantall, Guardian of Safe Working Hours*	Assurance	Enc	11.20
	Sustainability			
15	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.30
16	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.40
17	**Trust Strategy Update** *Patrick Nyarumbu, Director of Strategy, People and Partnerships*	Assurance	Enc	11.50
18	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	12.00
19	**Caring Minds Committee Report** *Monica Shafaq, Non-Executive Director*	Assurance	Enc	12.05
20	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	12.10
	Reflections			
21	**Living the Trust Values** *Thomas Kearney, Non-Executive Director*		Verbal	12.15
22	**Board Assurance Framework reflections**		Verbal	12.20
23	**Any other business**		Verbal	12.25
24	**Questions from Governors and members of the public**			

Close by 12.30
Date and Time of Next Meeting: Wednesday 7 August 2024, 09.00-12.30

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Minutes of the Public Board of Directors Meeting
Wednesday 3 April 2024, 09.00,
Uffculme Centre

Members	Philip Gayle	PG	Chair
	Sue Bedward	SB	Non-Executive Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Linda Cullen	LC	Non-Executive Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	Lisa Pim	LP	Deputy Director of IPC, Patient Safety, and Clinical Quality/Governance
	Dave Tomlinson	DT	Executive Director of Finance
	Fabida Aria	FA	Medical Director
	Patrick Nyarumbu	PN	Deputy CEO & Executive Director of Strategy, People & Partnerships
	Winston Weir	WW	Non-Executive Director
	Monica Shafaq	MS	Non-Executive Director
Attending	Katherine Allen	KC	Lead, recovery, service user, carer and family experience
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
Observers	There were 2 Governors present and 6 others observing.		

Ref	Item
0	**Service User Story** Claire Israney, a service-user with treatment resistant bipolar disorder who has been in the care of the Trust for more than 20 years, delivered this meeting's Service User Talk. While she has extensive experience of inpatient services, her focus was on the extent to which outpatient care as offered at this time and in recent years by Community Mental Health Teams meets the Trust's own self-defined value-based standards. Claire began by noticing that the words 'compassionate, inclusive, committed' dominate many physical aspects of Trust buildings and literature, stating that though these terms are somewhat nebulous they remain a comforting presence in the Trust's ethos as perceived by herself and her peers. She was clear that to her these Trust Values promote abstract ideas of hope and future. However, Claire expressed a deep concern that her reality of being treated by psychiatrists at her local clinic is almost wholly at odds with these Trust Values. Through a detailed description of what she considers to be the norm in these appointments, she pointed out that it is clinicians' poor choices in language and self-presentation, their dismissive attitudes, and their often-inaccurate assumptions based on unchallenged prejudices, which can deny a service user the positive and productive interaction with the Trust that it is reasonable to expect. Claire did acknowledge the systematic challenges which a Trust faces but argued that currently the performance of this Trust in this area is inadequate, asking Board members directly to consider how these failures might be ameliorated and to action appropriate remedial changes. She ended with a reminder that it is the Board which has the responsibility to use the power and the knowledge they possess to meet the standards the Trust has set itself and to continue to better the experiences of those for whom they care. The Board noted their thanks to the service user for sharing their reality. They thanked them for their honesty and bravery in raising key concerns and provided assurances that the areas identified will be reviewed and investigated.
1	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
2	**Apologies for absence**

	Thomas Kearney, Kat Cleverley and Sarah Bloomfield, Interim Executive Director of Quality and Safety (Chief Nurse), Lisa Pim, Deputy Director of IPC, Patient Safety, and Clinical Quality/Governance was in attendance.
3	**Declarations of interest** None.
4	**Minutes of meeting held on 7 February 2024** The minutes of the meeting were approved as a true and accurate record.
5	**Matters arising from meeting held on 7 February 2024** All matters arising were updated.
6	**Chair's Report** The Board received the report for information. PG highlighted key points as follows: • Visits to the different services continue on a weekly basis. • Visited the Heath Exchange and was honoured to meet with staff who provide complex services including homeless provisions. The team ethics and culture were a privilege to witness, it was also inspiring to see how the team have developed. • Visited Ardenleigh and meet with the teams across the wards. It was great to see staff working together to deliver the best services possible whilst staff shortages remain a key issue and a challenge for them. • Visited Dan Mooney and David Bromley and was pleased to meet with a range of staff. It was great to be able to see the ongoing developments within the services. PG is looking forward to seeing the completed refurbishment work at Dan Mooney particularly the redesign of their garden. • Visited the Barberry Centre and meet with the teams across the wards. It was great to see staff working together to deliver services as demand continues to grow. • Visited the Oleaster and was pleased to be able to meet with staff from a range of services and learn of the positive improvements being developed. PG also met with patients who were very complementary of the staff and the service they receive which was heartwarming. • PG attended the NHS Integrated Care Board and Trust Chairs' event in London hosted by Amanda Pritchard NHS CEO and the chair and NEDs of NHSE Board. This was an opportunity for them to share with the chairs data around performance of regions and the challenges ahead for the NHS particularly around productivity and expenditure.
7	**Chief Executive and Director of Operations Report** Key points were highlighted as follows: • The independent review into Greater Manchester and rapid review of Nottingham have been received and the teams are working through the relevant actions and learning for our Trust. • Planning guidance has now been received from the national team and the finance department are reviewing the details to align to current plans. • The senior leaders team continue to review and identify areas for savings. • The Kings Fund report has been published and highlights an overall increase in vacancy rates for both NHS organisations and social care. In September 2023, the overall NHS vacancy rate was 8.4%, or 121,000 full-time equivalent (FTE) roles. In 2022/23, the overall social care vacancy rate was 9.9%, or 152,000 roles. These are substantially higher than the overall UK vacancy rate of 3.4% in 2022/23. • The Department of Health and Social Care and NHS England have now provided a definition of parity of esteem to the Public Accounts Committee as 'Everyone can access MH services in a timely way and waiting times are on par with physical mental health, and everyone can access evidence-based treatments'. This will require a focussed review and refresh of the five-year plan. • Every year, the NHS Benchmarking Network presents data to mental health services across the four UK nations, including the services they provide, the resources that go into them, and some of the issues they

face on a daily basis countrywide. The results for 2023 present a picture of services that are working at a relentless pace to keep up with growing demand for mental health support. As a Trust we have seen a significant increase in demand and continue to work through the transformational agenda to set expectations and ensure the best service possible is being delivered.

- Following a rigorous selection process for our new Executive Director of Quality and Safety (Chief Nurse) the Trust are pleased to announce that we have appointed Lisa Stalley-Green to this role in Team BSMHFT. Lisa is already familiar with BSMHFT in her current role of Deputy Chief Executive and Chief Nursing Officer at the Integrated Care Board.
- We launched our involvement in these in recent weeks and our LGBTQ+ and our Women's Staff Networks educating, raising awareness and celebrating colleagues across health services as part of this years LGBTQ+ theme of Medicine +underthescope and Women's theme of 'women who advocate for equity, diversity and inclusion'. Thank you to all staff who have been involved in celebrating and promoting this work.
- Nominations have now closed for our 2024 Values Awards. Judges have reviewed all 300+ nominations submitted and look forward to celebrating staff at the awards ceremony which will be held in June 2024.
- We are pleased to share that Renu Bhopal- Padhiar current community transformation lead has been successfully recruited into the role of ICCR Associate Director and will take up post on the 7th May when Elaine Murray retires.
- We are also delighted to share that both ICCR Clinical Directors, Sadira Teeluckdharry and Selvaraj Vincent have been successful in promotions to deputy Medical Director posts. Interviews to recruit to vacancies this creates for clinical director posts are planned.
- The neighborhood pathway of our community mental health and well-being services have now seen over 24,000 people which is phenomenal achievement in a 12month period. The services have received some wonderful feedback from service users about the service provided.
- Secure inpatient services continue to experience Registered Mental Health Nurse (RMN) shortages across the men's and women's services impacting on clinical activities. Continuous recruitment is taking place with new students and more internationally educated nurses taking up posts in our division. Ward managers and Clinical Service Managers/Matrons are meeting daily on each site to prioritise work and assess shortfalls. Ward Managers are working within numbers where necessary, and occupational therapists and activities workers are being used to support activities on wards.
- Tamarind are operating at capacity with high clinical activities. Cedar Ward won 'Team of the month' for its effective management of infection prevention and control measures following a case of measles. At Reaside and Ardenleigh acuity is high but managed well.
- Sam Bailey has been appointed as interim Clinical Service Manager for Ardenleigh as Emma Watts is moving to our Head of Quality role within the Provider Collaborative.
- Staff survey results have improved compared to the previous year. The division has made improvements in 45 out of 96 indicators. Staff survey action plans for 2024 have been developed. The division has submitted 86 nominations for value awards. Reaside had a positive quality visit from Reach Out which commended on significant improvements in the last 12 months.
- There is increasing pressure for beds within the Acute and Urgent Care directorate, with demand for beds increasing steadily since January. The directorate continues to work within the locality model which has now rolled out to all localities and the feedback from all staff groups has generally been positive, although there are still some improvements to be made. Through the Out of Area Steering Group, further opportunities for improvements are being identified and the focus is now on reducing DTOCs (to be classified under the new Clinically Ready For Discharge system from April) through collaborative working with colleagues from Birmingham City Council and Solihull Local Authority and MIND.
- The seclusion room on Caffra PICU (at Oleaster) is going to be offline for 4 weeks from June'24 whilst necessary improvement works occur. An options appraisal outlining mitigation plans has been developed to support during this period.
- The directorate are championing the introduction and expansion of the Professional Nurse Advocate (PNA) role within the Trust, recognizing the value this has for the individuals in these posts and also those who the PNAs can support.

	• Specialist inpatient wards have recruited a number of Internationally Educated Nurses to RMN vacancies and appropriate support is in place including to enable individuals to develop the additional UK MH specific competencies and confidence to undertake the role. • We are expanding our successful Silver Sunday event via roadshows. The service is in the process of scoping appropriate venues with good transport links and parking. The focus is to showcase the variety of services within the localities to support our service users and reduce health inequalities. We are also happy to announce we will have Birmingham Community Health Care and SDSmyhealthcare frailty team joining us to strengthen physical health offer. • The partnership collaborative are planning a whole Midlands Annual away day. The collaborative is planning to use underspend to finance additional third sector places for Veterans needing additional regional/national help and support that cannot be provided by our respective organizations. As we near the end of the financial year we want to prioritize staff training/wellbeing initiatives as identified in the staff survey. • The Barberry service is in the process of trialling the use of a Discharge Manager and there has already been a significant reduction in delayed transfers of care across the specialty wards. This will continue to be evaluated. The waiting list continues to improve for both neurology and eating disorders services following successful recruitment and the implementation of improved pathways. The Board were assured the emerging trends from the benchmarking report are tracked through the Performance Delivery Group and the work shared with the CQC to ensure collaborative oversight. It was agreed the formal oversight will be through the Finance, Performance and Productivity Committee. PN highlighted the opportunity to work collaboratively with the West Midlands Collaborative to review options for the seclusion room on Caffra PICU (at Oleaster). PG raised a question about the Doctors industrial action and what has been the impact on services of the continued junior Doctors industrial action. RW responded and said we acknowledged the impact will be long term as hundreds of appointments have had to be rescheduled, appointments are being tracked to ensure all service users receive the best service. Cover for staff taking action was initially positive, however, there is now less engagement. RW continued and said system wide discussions continue and all serious incidents and incidents of direct harm related to the impact of the industrial action will be escalated appropriately. BC mentioned the Trust currently has 30 agency locums engaged at BSMHFT, 21 of which are over the agency price cap. He queried whether all agency cover is related to vacancies? It was confirmed all agency use is related to vacancies and are individually signed off by the Chief Executive. The Board noted the concerns with agency use and the ongoing demand on services, recruitment workshops are planned and Dr Imran Waheed is leading the change in agency use. PG queried how the use of e-rostering is being monitored and how this is supporting flexible working for staff? It was confirmed oversight is maintained through the Safer Staffing Group reporting into the Quality, Patient Experience and Safety Committee quarterly. Rotas are planned 6 weeks in advance with KPIs monitoring progress. The Trust are not currently meeting the target, however, there remains a real focus on improvements to ensure sustainability. The MHOST tool is supporting the improvements and deep dive discussions continue with staff to ensure the efficient use of the systems available whilst supporting flexible working options. The Chair thanked both RFW and VJD for the detailed report and noted the improvements with the inclusion of positive feedback from service users being included.
8	**Board Assurance Framework** The Board received the BAF and took assurance from the ongoing development and work underway to reframe and revise the risks to ensure they were fit for purpose. The Board noted the purpose of the report being received was to gain assurance that principal risks to the delivery of the Trust`s strategic objectives/goals are effectively mitigated and managed in line with best practice and the Trust`s Risk Management Policy.

	The Board noted the changes to the a number of dates for risks and were assured controls are in place, a Board Strategic Session has been scheduled for September 2024 for a deep dive review into the framework to ensure the risks and associated dates are realistic. The framework will continue to develop and be simplified to ensure overall clarity. There was a detailed discussion in relation to inherent risks and the need to review this as a priority. PG asked the Board Committee Chairs to confirm if the BAF is driving discussions and triangulating actions at committee meetings and they confirmed this was taking place. The Board recognised the significant improvements and thanked the Corporate Governance Team for their continued support.
8.1	**Corporate Risk Register** The Board were assured the Corporate Risk Register comprises high operational risks to the delivery of local Directorate, Service and Divisional operational objectives which score ≥15 that have been escalated via the Divisional Clinical Governance Committees and approved by the Risk Management Group for inclusion onto the Corporate Risk Register. There was a detailed discussion in relation to risks rated >20 with the Board receiving assurances the risks are being reviewed and redefined with sufficient evidence to make the improvements. The register will be reviewed to ensure there are no duplications and include indicators to support each risk.
9	**Quality, Patient Experience and Safety Committee Report** The Board received both reports from February and March noting the salient points as: • Staffing: Whilst recruitment strategies have shown positive outcomes, staffing levels across the Trust have been highlighted as a cause for concern and are recorded on the risk register. Work streams are in place to mitigate against all risks. The Trust is continuing to use the MHOST tool that is defining a clear picture of workforce requirements to support acuity across inpatients areas. The Trust has successfully filled a number of vacancies as a result of international recruitment and recruitment programmes with further events scheduled. • Transport Issues: A number of concerns have been identified across the system regarding the safe and appropriate transfer of service users. Contracts and policies are currently under review with work being undertaken with system partners. • The Risk Management Group has been re-established with local divisions taking management. The Committee were assured the risk register reaffirms the Board Assurance Framework. • The Committee were assured that following regular updates provided to the CQC a further inspection took place between 17-19 October 2023 and it has been confirmed that the trust has delivered against all actions following the receipt of the Section 31 notice in December 2020, therefore the Trust has been served with a Notice of Proposal to remove the conditions imposed. • The Committee noted the improvements made with pharmacy staffing and the improvement this has had on the Pharmacy service during 2023 with further improvements anticipated during 2024. • The Committee heard the service user story and noted the concerns in relation to the falls policy not being adhered too and the long term impact of this for both staff and service users. The incident highlighted the need for further clarity for locum doctors, their responsibilities and their accountability. There have been a number of lessons learnt and the Committee were advised that further training has been implemented in line with PSIRF. It was agreed that an induction package for locum doctors would be developed. • Healthwatch survey: The Committee noted the significant increase in referrals and the ongoing impact from COVID whilst services continue to develop and improve whilst managing the increase in demands of over 10,000 cases. There was a detailed discussion in relation to the issues with the report that has been published and lack of understanding of mental health and the divisions and services associated. The Committee were assured communications are ongoing with Healthwatch to strengthen mental health understanding and partnership arrangements.

	• The Committee were informed there was a confirmed measles case on January 9th, following a rash detected on 7 January 2024. There was an immediate isolation, contact tracing, and deployment of PPE. Staff with unknown immunization status were temporarily restricted from work. Early detection and isolation, proactive staff engagement, and rapid deployment of protective measures highlighted the positive response from staff. The Committee noted the excellent response from staff. • Concerns raised in assurance regarding staff vaccination before starting job with the Trust regarding both Hep B and MMR. • A safety summit has been proposed to address any serious incidents. • The Committee endorsed the Capital Programme for 2024/25. BC about the transport provider. The Board were reassured the contract provider for transport remains in place and work continues with West Midlands Ambulance service to provide additional support when required. The Clinical Governance Committee have developed and approved a standard operating procedure and have confirmed with West Midlands Ambulance service they will support category two cases which is an improvement from category four only. PG confirmed partnership meetings with Healthwatch continue as a critical friend and will support future reports. PG also said he has spoken with RB from Healthwatch and said it would be beneficial for them to be updated on the community transformation programme and the different ways to access community services. He has suggested VJD, RW and PG if required can attend the Healthwatch Board in the coming months. PG said Healthwatch will inform him of suitable dates.
10	**People Committee Report** The Board received the report from March noting the salient points as: • A 3% increase in whole-time equivalents had been expected however a 6.8% had been reported. Considering the growth plan for the new financial year would be a significant challenge, however the ambition for 2023/24 had been achieved. • The target of 60 internationally recruited nurses had not yet been reached; currently the Trust had welcomed 32 nurses to the organisation. Plans continued to develop to achieve the target. • New data sets continued to be collated on flexible working; an increase in requests and approvals had been reported, and work continued to understand the reasons why some flexible working requests were rejected. A thematic analysis would be considered at Committee when the data was available. • Challenges remained in relation to spend on bank and agency staff, although significant improvements had been made in the medical workforce. • Sickness remained a key challenge for the Trust; some improvements had been seen however proactive work continued to support managers in areas of particularly high short-term sickness. • Turnover had reduced in January, and exit interview data was analysed to identify areas for improvement. • A positive staff story on fasting during the month of Ramadan was received. • The Committee heard from the LGBTQ+ Staff Network Chair and commended the network for the positive activities that had taken place over the last few months. • The Safer Staffing Report continued to highlight positive progress with MHOST and e-rostering plans. • The Staff Survey results highlighted an overall improved position, with increases shown in all nine People Promise elements and employee experience. No questions were “significantly worse” than the previous year, and 63 were “significantly better”. The Committee was encouraged by the results and assured by the plans in place to focus on areas that required additional improvement. The Board noted current reporting for recruitment is by profession rather than division, dashboards are available with further details however consideration will be given to reflecting divisional vacancies and recruitment plans in future reports to the Committee. Deep dives by divisions have been positive, trends have highlighted the need for balance of staffing due to high levels of acuity. Regular staffing huddles and use of the MHOST tool will positively impact in the long term.

	A review of the top areas of spend for bank staff will be undertaken through a deep dive in line with reviewing the rosters for the divisions and reported back to the Board of Directors meeting through the Committee in the coming months.
11	**Staff Survey Results** The Board received the report detailing the staff survey results for 2023. The survey ran between September – November 2023 with 55%, 2393, respondents in 2023 vs 55% 2230 respondents in 2022. Bank only colleagues also participated in the survey with 33.64%, 253, respondents. 112 teams received localised reports compared to 92 teams in 2022. The Board acknowledged the positive increase and noted their thanks to all staff that took the time to complete the survey. The Board were assured that no questions are "significantly worse" in comparison to 2022 and 63 are "significantly better". Overall employee experience has improved for both White colleagues and Black and Asian colleagues. The Board were assured there have been increases in all 9 People Promise elements and themes scores largest increase in 'we are compassionate and inclusive' and 'we work flexibly'. The Trust are above the average on learning and morale and seven of the nine themes are below average. The only theme which remains significantly below the average is 'We are compassionate and inclusive.' The key areas of achievements were noted including the positive understanding of the Trust values and what is expected from staff. ICCR remain outstanding in response rates and will lead a Listen Up Live session, as per last year, to encourage staff to complete the survey and highlight how the results can drive improvements. The key areas of improvement were noted including the need to address the data where 5.29% of staff have experienced unwanted behaviour of a sexual nature from other colleagues. The Trust have signed up the charter to address these concerns and will follow the 10 key stages of improvement and will triangulate progress with colleagues in the Integrated Care Board. There are no current thematic raising these concerns through Freedom to Speak Up. The Board acknowledged the next steps and recognised the need to balance the positive improvements. Overall, the Trust has ranked 31st out of 51 Trusts taking part in the survey and have ranked the second highest in the Midlands for improvement. There was a detailed discussion in relation to the trends and need for collaborative directions of travel. The Board recognised the need to celebrate the overall achievements whilst remaining focussed on the key areas of improvements. Thanks was noted to the staff who have supported the process.
12	**Finance, Performance and Productivity Committee Report** The Board received both reports from February and March noting the salient points as: • Updates on the Sustainability and Clinical Services strategy areas were received, noting the work that was taking place to measure the impact of the strategies and alignment with the performance framework, Quality Management System, and quality improvement approach. • Financial trajectory remain on track for the agreed end of year forecast and submission. • The Committee approved the Reach Out Commissioning Business Case and noted the positive good news stories within the report including the 70% reduction of out of areas, increase in quality of services for inpatients, reduction in health inequalities and positive example of collaborative working. • 24/25 capital planning risks remain a concern.

	• The capital spend envelope for 24/25 remains a challenge with £6.6m available. This includes a national allocation of £0.4m relating to the system capital investment fund, against which spend is to be prioritised across the system. • A review of the performance metrics in the Integrated Performance Report was underway to enhance triangulation of data. Further refinements would be made to ensure operational metrics were fully reflective of the key areas. • System call identified the challenges for savings and a break-even position for 2024-25. • The Committee endorsed the Capital Programme for 2024/25.
13	**Integrated Performance Report** The Board received the report for information noting that overall improvements have been sustained. Talking therapies, out of area and incidents resulting in harm remain key areas of focus. Positive feedback for deep dives has been received and they continue to be scheduled. Bank and agency fill rate metrics have improved in last month at 91.6% and above improvements in trajectory of 86%. Out of area is being monitored weekly and report monthly to ensure full oversight.
14	**Finance Report** Key points were highlighted as follows: • The month 11 2023/24 Group position is a surplus of £2m year to date. The position comprises a £2.4m surplus for the Trust, £391k deficit for Summerhill Services Limited (SSL) and a £229k surplus position for the Reach Out Provider Collaborative. The year-to-date position for the Mental Health Provider Collaborative is £147k deficit. • Year to date bank and agency spend is £41m. Forecast total spend is £45m which is almost double the spend in 2019/20. We remain in breach of all but one of the NHSE agency rules. • Year to date expenditure for Out of Area is £17m; an overspend of £9.6m. Following a reduction in run rate during quarter 3, non-Trust bed usage increased throughout January and has remained just below the peak January level during February. Total forecast expenditure for 2023/24 is £18m. • Month 11 2023/24 Group capital expenditure is £5.8m year to date. This is £1.7m adverse to plan. • We have been successful in securing additional capital funding from the system capital investment fund (SCIF) for 2023/24. £0.5m external PDC funding has also been secured in relation to the shared care record programme. Total 2023/24 capital forecast is now £9.1m. • Planning guidance for 2024/25 has now been received and so the projections are subject to change. • A total of £12.7m cost pressures were submitted as part of the planning process. to support the BSoL £70m plan to break even. This poses significant challenges for efficiency savings. • The ability to fund cost pressures is particularly challenging given the financial gap. • Following review at Sustainability Board and by the Executive team, it was agreed with the Director of Finance that £861k cost pressures would be funded, mainly related to inflationary pressures for services that we are required to use, where the cost increase in 2024/25 will exceed national tariff. • Both the Finance, Performance and Productivity Committee and Quality, Patient Experience and Safety Committee have endorsed the Capital Plan. There was a detailed discussion in relation to the ambition of the Trust in relation to capital and the need to balance the works with Summerhill Supplies Limited. It was agreed the Finance, Performance and Productivity Committee will lead on the review and opportunities. RFW highlighted the significant challenges for 2024/25 and confirmed the senior leaders team continue to review and identify areas for savings. She reiterated the importance of the strategy being delivered and not being compromised.

	It was confirmed the out of area costs have been deferred from 2023/24 and are not duplicated pressures. DET confirmed the planning guidance has now been received and he will therefore circulate the budget set positions for oversight and assurance. The Board recognised the need to balance the risk position in line with the increase in demand. PG highlighted the need to clearly communicate the message to staff across the Trust to confirm the financial position and reaffirm the Trust continue to review options for savings alongside work already undertaken to identify savings options. There was a detailed discussion in areas of highest spend and need to continue to support the cultural change within the Trust to support the recruitment and retention of staff in line with the transformational agenda. Collaborative work will continue to drive efficiencies at scale with using the quality improvement approach which will be supported by the Trust as Lead Provider for Mental Health in BSoL. The Board recognised the challenges and need to maintain the quality and consistency of care whilst supporting and listening to staff and being inclusive throughout. **ACTION: DET confirmed the planning guidance has now been received and he will therefore circulate the budget set positions for oversight and assurance.** **DECISION: The Board endorsed the Capital Plan.**
15	**Living the Trust Values** MS shared her experiences of staff including the Board of Directors and Council of Governors living the Trust values following a period of absence from work last year after an accident which had caused her significant injuries. MS highlighted the compassion from staff and person-centred approach allowing her to remain feeling involved and up to date on activities of the Board of Directors. MS thanked all members for their support.
16	**Board Assurance Framework reflections** The Board confirmed the ongoing risk for finance and capital positions should be reflected.
17	**Any other business** None.
18	**Questions from Governors and members of the public** A member of the Council of Governors highlighted staff at Ardenleigh living the Trust values and thanked the Trust for recognising staff over the Easter period. They highlighted the positive intake of international staff and noted the importance of staff well- being and support. They queried how the Trust plan to retain staff and ensure they have the best experience whilst at work? The Board confirmed levels of recruitment are improving and the use of agency is reducing and plans are in place to continue to reduce agency usage. The Board are committed to ensuring staff feel supported and the recent staff survey has highlighted staff are feeling bettered supported. The Board will reflect on all feedback and identify areas of improvement for staff. Exit interview data is recorded and reviewed to monitor feedback, current data highlights flexible working and carer development as key areas for improvement, these areas are being supported by the use of MHOST and E- Rostering.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
14- Finance Report	DET confirmed the planning guidance has now been received and he will therefore circulate the budget set positions for oversight and assurance.	DET June 2024	
14- Finance Report	The Board endorsed the Capital Plan.		

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**6**						
Date	5 June 2024						
Title	Chair's Report						
Author/Presenter	Phil Gayle, Chair						
Executive Director	Phil Gayle, Chair	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert		**Advise**		**Assure**	✓

Purpose

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

Recommendation

The Board is asked to receive the report for information and assurance.

Enclosures

N/A

BOARD OF DIRECTORS
CHAIR'S REPORT

Introduction

I am pleased to provide a written report to the Board of Directors which covers some key updates for members' attention and assurance. The reports on today's agenda highlight the continued work we are doing to meet our strategic objectives, deliver our ambition to change culture and sustained improvements for staff, patients and service users.

I appreciate the work undertaken by the Board's Committees, and their work can be seen in the 'Advise, Alert, Assure' reports on the agenda today. Non-Executive Director colleagues have also been active in a variety of site visits across the BSOL. I will report formally on what the Non-Executive Directors have been doing in future Chair's Reports to the Council of Governors.

Governance Matters

We are progressing addressing the requirements which the CQC laid out in their action plan following our last Well-led inspection.

Our committee chairs will be meeting regularly to discuss joint themes across committees and key areas of concern. It is important as a Board that we do cross reference, triangulate, and balance all the issues being dealt with by our committees, while trying to ensure that we minimise duplication and overlap, which is important.

The Council of Governors has also continued to be active and engaged. It is my intention that as Governors periodically attend committee meetings that they report back to the Council on their observations of the Non-Executive Directors at Board and Committee level. Our committees continue to provide oversight and assurance on matters of quality and safety, patient experience, of finance productivity performance, of people and culture, as well as audit and internal controls continue.

I meet with the Lead Governor monthly to discuss any issues or concerns raised with him by the members of the council.

Fit and Proper Persons Requirements

We have implemented the revised Fit and Proper Persons Test Framework as issued in August 2023 to ensure compliance with the CQC Fit and Proper Persons Requirement Regulations (effective from 2015). As part of our ongoing compliance a range of checks have been undertaken for all Board directors at the financial year end to inform the chairs annual declaration on Board members' fit and proper status as defined under the Fit and Proper Persons Regulations. This is a detailed and comprehensive process and, in addition to electronic and hard copy evidence files, we are required to record compliance on individual electronic staff records, and this process is underway.

Once completed, I am required to prepare an annual submission to NHSE regional office by the deadline of 30 June as formal confirmation that I have had effective assurance of compliance with the Fit and Proper Persons Regulations and implementation of our Fit and Proper Persons Test Policy

and that all Board members at the Trust are deemed Fit and Proper. My own Fit and Proper Person Test status is reviewed by Dr Linda Cullen in her role as the Trusts Senior Independent Director.

My annual submission will be circulated to all members of the Council of Governors to provide them with assurance that all Board members are deemed Fit and Proper under the current requirements. A report will be presented formally at its meeting following the regional submission.

Listening to staff

My visits to the different services continue on a weekly basis as they provide me with an opportunity as chair to see the great work we provide across both Birmingham and Solihull sites.

I visited Orsborne House and it was a pleasure to meet with staff from the homeless services. I learnt of the positive improvements being developed day by day.

Another visit I undertook was to the Solihull Integrated Addiction Services where I spent time meeting staff and service users.

I was pleased to visit our Lyndon service and meet with the teams across the wards. It was great to see staff working together to deliver the best services possible in the outpatient clinic, resource centre and caring for older adults, in addition.

I visited the inpatient units at Mary Seacole and Grove Avenue and met with staff from a range of services. It was great to see staff working together to deliver services as demand continues to grow.

It was also a pleasure to visit the Juniper Centre and Little Bromwich and I look forward to continuing to visit more sites throughout the year.

Partner and System Development / Stakeholders

I attend the weekly NHS Confederation Mental Health Chairs Network meetings and NEDs Forum meetings, which are fantastic platforms to hear and share learning from different mental health trusts across the country.

I attended the ICB NHS Confed NEDs forum with a focus on tackling inequalities in outcomes, experience and access to services.

I also attend the monthly Midlands Chairs meetings where it was agreed we should have Dedicated, quality time to discuss issues collectively as we believe this would add value and provide opportunity for wider system thinking.

I took part in a BSMHFT podcast recording for UHB alongside Patrick Nyarumbu. We discussed career paths, proudest achievements, inspirations and experiences that taught us valuable lessons. The purpose of the podcast was to have open conversation and inspire others.

BSMHFT Mental Health Provider Collaborative

The Commissioning Committee met on Wednesday 1 May. The BSol Mental Health Provider Collaborative celebrated its one-year anniversary in April 2024 following the transfer of NHS Mental Health commissioning and delivery responsibilities from the ICB.

The Provider collaborative have achieved several successes during this time, such as developing a 3-year mental health in-patient strategy, continuing to embed neighborhood mental health teams in all localities across Bsol, supporting shorter lengths of stay for those in rehabilitative beds and increasing the early help support offer to children and young people through the further establishment of MH support teams for schools.

We continue to engage in key activities such as reviewing governance structures and reporting arrangements into the wider Bsol system, development of Interim Strategies to respond to the ICB Strategic Commissioning intentions board and commencing a new Children and Young People's Transformation Programme with stakeholders showcasing our future model of care, to name a few.

Stakeholder Engagement

I met with Paul Johnson, Chief Executive of Solihull Borough Council at the Council House, and we had a productive and insightful discussion around our services, particularly our operations under Solar, for the children, young people and their families in the Solihull vicinity.

I also met with Justin Varney, Director of Public Health for Birmingham City Council. We had discussions around population health management with specific focus on mental health. We also spoke about health inequalities and I suggested it would be good for himself and the Director of Public health in Solihull to attend a Board development session to discuss these topics in more detail which he agreed this would be good and beneficial for all.

I maintain my regular monthly meetings with Shane Bray from SSL which I find very informative.

I continue to meet with Rebecca Farmer, NHS England, on a bimonthly basis, to discuss the key areas of focus for the Trust.

People / Quality

All Non- Executive Directors will have completed their mid-year point appraisal with me or have a date diarized during early June. This is a 1:1 time for us to have constructive conversations around personal and professional targets and aims to continue driving excellence in care, service improvement and shaping positive and inclusive working cultures. I also had my own appraisal in April.

Mental Health Awareness week was celebrated trust wide during the month of May.

I look forward to meeting hard working staff and presenting awards to our winners at the Values Awards which is being held at Villa Park later this month.

Meetings with the Freedom to Speak Up Guardians are still ongoing monthly to ensure I continue to have oversight of the key themes from concerns raised and offer my support where I can in addressing these.

Phil Gayle

Chair

Report to Board of Directors

Agenda item:	**7**					
Date	5 June 2024					
Title	Chief Executive and Director of Operations Report					
Author/Presenter	Roisin Fallon-Williams, Chief Executive Officer and Vanessa Devlin, Executive Director of Operations					
Executive Director	Roisin Fallon-Williams, Chief Executive Officer	**Approved**	**Y**	✓	**N**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert		**Advise**	✓	**Assure**	✓

Our report to the Board provides information on our areas of work focused on the future, our challenges and other information of relevance to the Board, in relation to our Trust strategy, local and national reports and emerging issues.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

N/A

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

Training

The relaunch of the new Health and Wellbeing training for all managers has been going well and is well attended. The People team are currently working on the next training package which will include Disciplinary, Grievance, Dignity at Work and How to conduct Investigations. Once these are ready to be rolled out the training package will become a full day Human Resources training for all managers including refresher or update for existing managers.

Job Evaluation

Good progress has been achieved in our Job Evaluation process with significant improvements in the quality of panels and reduction in delays. This has been achieved by working collaboratively with our management and Staff-side colleagues.

Chatbot

The People Team were able to launch a pilot of its Chatbot. This will provide a first line support for managers and employees to answer queries 24/7. This is aimed at reducing delays in responding to basic queries.

Diagnostic tool – Organisational Health & Wellbeing diagnostic tool

NHS England have developed this diagnostic tool that provides an easy way to self-assess each element of the Health and Wellbeing Framework. Via the Health and Wellbeing Steering Group, the Trust have been using the tool to assess our employees' well-being. The results of the assessment will be shared in due course.

Case work

The People Team continue to deal with casework, with a collective team focus on closing cases in a timely manner. Recently, additional resource via Bank investigating officers has aided the team in completing long outstanding cases. The team will continue to train additional investigation officers and encourage local resolution where appropriate to assist with closing cases as quickly as possible.

Learning and Development Team

NHS England will be leading workstreams to rationalise and reform StatMand, in partnership with the national bodies and in consultation with all other relevant organisations and staff side groups. The Learning and Development team will take the lead on ensuring that the training alignment to the core skills training framework is completed as stipulated. A recommendation to start the work to ensure readiness for the Digital Staff Passport roll out has been made to the Trust Workforce systems and process group and with a recommendation that this work is managed through with support from our PMO colleagues. Further work is scheduled around the roll out and embedding of

the First Line management programme that encompass a range of operational and leadership modules for managers.

Workforce and Resourcing

We have developed the final version of our workforce plan for 2024/25, with an overall focus around reducing Bank and Agency usage across the Trust. This has been submitted to NHSE as required as part of our system-wide plan.

Our planned establishment growth is 4.2% (210 WTE) and staff in post growth for planning is 2.1%. We are forecasting a 27.7% decrease in agency and 10.5% decrease in bank usage.

Our third centralised recruitment day for Nurses was held in April. We interviewed 25 candidates and made 14 offers. We are now looking at reviewing the model going forward. We are also about to go live with two initiatives to help our bank and agency reduction strategy along with a Direct Engagement model for agency doctors which will provide significant savings for the Trust.

Doctors Industrial Action

Consultants in England have accepted the latest Government offer on pay and DDRB reform. This will be reflected in May 2024 pay, backdated to 1st March 2024.

A further pay offer has been made to Specialty and Associate Specialists (SAS) doctors which BMA members will vote on between 31st May 2024 – 14th June 2024.

The Junior Doctors Committee of the BMA had agreed to enter into mediation with an independent external party to progress talks with the Government, however last week an eleventh period pf industrial action was announced for 27th June – 2nd July 2024. We are therefore commencing reinstatement of our industrial action planning processs.

Consultant recruitment

Within the last 3 months, we have appointed to 9 Consultant posts and 5 Specialty Doctors posts. 5 of these posts have been through international recruitment.

HealthRoster

In February we rolled out e-rostering for all doctors in BSMHFT to replace the previous Excel spreadsheets held on Connect. The functionality of HealthRoster will continue to be developed over the coming months.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

We are pleased to share that interviews for our two ICCR Clinical Director posts have been completed and we have appointed to both roles on a job share basis; Liz Thurling and Dr Sunday Olotu for our Neighborhood Mental Health Teams (NMHTS) and Community Mental Health Teams (CMHTs) and Richard Salkeld and Dr Ola Ajileye for our Steps 2 Recovery and AOT teams.

We have successfully recruited to all qualified nurse vacancies in Steps to Recovery (S2R) units with majority being Internationally Educated Nurses (IENs).

Our Integrated Community Rehabilitation Team (ICRT) has started to have a positive impact as the service continues to divert service users from inpatient rehabilitation, resulting in reductions in OOA placements. The team provide intensive rehabilitation similar to our open inpatient rehabilitation units, but within the service user's home. This enables less restrictive care options and has diverted over 30 service users so far from requiring an inpatient rehabilitation placement, along with providing early discharge for 5 service users from placements outside of Birmingham and Solihull for 5 service users at present.

Assertive Outreach Team's (AOT) have been proactively managing access to acute beds through the introduction of a revised locality bed plan supported by a dedicated capacity manager which has proven beneficial in optimising bed usage. Early results are very positive, and teams are working within their allocated bed capacity based on the effective discharge to the community by the capacity manager.

Waiting times for the Attention Deficit Hyperactivity Disorder (ADHD) Service have reduced despite continued increase in referrals. The service has received regional recognition for the processes being implemented, with other ADHD services seeking to take learning from the developments.

The out of hours CMHT duty line pilot successfully continues with good uptake from service users.

Solihull Integrated Addiction Service (SIAS) alongside other substance misuse providers, has developed a Memorandum of Understanding with West Midlands Police for front line police to carry naloxone, supported by SIAS with training.

The Homeless Teams continue to offer a range of support (mental and physical health) to those facing homelessness. Multiagency working has been effective, with more people being supported for accommodation, physical / mental health, and other social needs.

Secure Care & Offender Health (SCOH)

Our Ardenleigh Child and Adolescent Mental Health Services (CAMHS) service users have completed the Duke of Edinburgh Award which is a brilliant achievement. Our staff from the CAMHS service engaged in a charity football match to raise money for their Astroturf. The event was successfully attended by many external providers all of whom contributed to the success of the event and raise awareness of mental health in both the private and public sector.

Reaside completed an employability workshop project, which is a partnership project with Voluntary, Community and Social Enterprise (VCSE). A Culturally Appropriate Advocacy service has been established within Reaside and the Birmingham Community Advocacy service has also been relaunched.

The FIRST Clozapine Clinic Quality Improvement project was showcased at the International Forum on Quality and Safety in Healthcare and received positive feedback from other NHS trusts across the country.

The Intensive Supervision Court (ISC) pilot is successfully addressing the support needs for female offenders. Sixty six percent of people coming through this pathway are now on a Mental Health

Treatment Requirement (MHTR) order as opposed to receiving custodial sentences, which is more conducive with our treatment focus.

The Prosper Integrated Intensive Risk Management Service celebrated its fifth birthday and continues to support service users through their pathway.

The Division is proud to have had six staff/teams shortlisted for Trust values awards from the eighty staff nominated from across the division's services.

Acute and Urgent Care

We continue to drive our productivity plan to enable us to eliminate our inappropriate out of area placements. We have shared good practice across divisions and undertaken a peer review to support our current discharge and flow processes, the outcome will be supported through our quality improvement framework.

BSMHFT hosted a workshop on Pathways Transformation led by Fabida Aria (BSMHFT Medical Director) and Ian Davison (NHS England Quality Improvement team). The workshop focused on understanding the mental health needs and the required transformation for BSol population. The event was well attended with multi-disciplinary professionals, service users, VCSFE professionals all being represented. The feedback will be further developed into a plan and will feature in our clinical strategy goals going forward.

During March and April, we were joined by the National Mental Health Improvement System Support Team (MHIST) who facilitated the implementation of the MH urgent and emergency care assessment tool for our BSOL system. They are a small, quality improvement team who support the NHS to deliver improvements in population health, quality of care and value-for-money in mental healthcare. The workshops looked at the views of system stakeholders and allowed the opportunity for professional discussions and constructive challenge. Areas of improvements were discussed along with the opportunity to showcase good practice. The improvement tool has been built around 12 domains, with key statements and KLOES with the objective of creating a quality improvement plan. These include Access and Waits, Strategy and Sustainability, Workforce, Evidence Based Practice, The Pathway, Environment, Involvement and Participation, Productivity, Outcomes, Data Quality, Culture, Digital and Informatics. The outcome plan will sit with our Urgent Care Pathways group with key partners and report through our established governance structures for assurance.

We note continued success in medical recruitment at all levels improving medical leadership and reducing locum agency usage. We are continuing with our efforts to deal with the recruitment challenges in psychological professions workforce by reviewing the roles, splitting the posts, and updating the adverts to highlight the specific projects within areas to generate interest.

Both of our acute wards on our north site continue to be supported via our enhanced monitoring framework with notable improvements recognised. The wards on these sites have successfully embraced our new locality model and all wards are now using our Safe Care approach. Staffing in the North has significantly improved, including through the recruitment of Internationally Educated Nurses who are integrating and settling into their teams.

Urgent care transformation continues, with the successful launch of NHS 111, Option 2 for Mental Health since 29th April. Staff have been proactive in implementing the new service and are keen to make further improvements to enhance the quality. There is a weekly group reviewing implementation and data, over time as the service embeds, we will highlight any specific trends.

Specialties

We have recruited to all qualified vacancies with many Internationally Educated Nurses (IENs) joining the teams. There are plans to arrange action learning sets for our IENs to support with their transitions into their new roles.

We successfully held an Admin Celebration Day (24th April) an International Nurses Day (13th May). We continue our wellbeing support to our workforce with many staff members attending our weekly Yoga session facilitated by our Occupational Therapy Consultant.

The Older Adult Mental Health & Wellbeing Community Event is scheduled for 6th June 2024. This is to showcase the variety of services within the West of Birmingham to support the community and our service user health and wellbeing and try to reduce health inequalities, in line with the 5-year plan for Older People.

Implementation of the new memory assessment pathway has progressed further with the central booking system due to go live in the forthcoming months. A 6-month pilot project is in progress with the aim of increasing the Dementia diagnostic rates for our residents of Birmingham and Solihull. The pilot will ensure that all patients diagnosis is recorded in the right place, ensuring that patient care becomes more joined up between primary and secondary care.

New targets are in place for Birmingham Talking Therapies for the current financial year, along with confirmed trajectories. On going recruitment remains in place to fill vacant roles with seven candidates due for interview in May. The vacancy rate continues to improve and is currently at 13%. We received excellent feedback from a service user "…JK has been so kind and understanding, in fact, she understood me more than my family did. I cannot fault any part of her input. Thank you…" highlighting staff's positive input in their experience.

Veterans Op Courage service have designed a midlands partnership Newsletter to help build an inclusive culture across the Midlands provider collaborative. This will support in sharing good practice, news stories for staff, patients, and their families/carers. The newsletter will be published in July.

We are very pleased to welcome Dr Angela Foster to the Bipolar service in the role of Clinical lead who joins us from Specialist Psychotherapy Services. In Sept we will be offering four Mood on Track (MoT) groups for the first time in Birmingham and Solihull. We have also agreed a training package with a neighboring mental health trust, and we extended our service to Northwest of England and received fantastic feedback ("*…Lizzie Newton and the Bipolar service from BSMHFT have now helped us train 50+ staff in the intervention and we have completed 12 groups across the trust. The feedback from staff and service users has been overwhelmingly positive...*"- Consultant Clinical Psychologist & Professional Lead for Cumbria, Northumberland, Tyne, and Wear NHS foundation trust)

A successful service evaluation in art psychotherapy demonstrated improved access, increased engagement and responsiveness which supports our work to reduce our health inequalities. We

successfully sourced extra funding for art psychotherapist support to steps to recovery units. The team has been successful in its bid for a NIHR (National Institute for Health and Care research) Senior Clinical and Practitioner Research Award. This grant will enhance the research activity within the service and ensure that the service is at the forefront of diagnosis, treatment, and prevention of relapse.

The perinatal service has achieved all flexible NHSE Long Term plan ambitions, now offering comprehensive psychological interventions for parent and infant mental health needs, as well as extending provision to women for up to 2 years. Challenges remain in the annual access target and a recovery plan has been co-produced to increase the access (from 1660 to national target of 1959 for BSol). As part of the recovery plan, we are launching an Improvement project to reduce DNAs (Did Not Attends) and improve the quality of the therapy. The Perinatal Health Inequalities workstream has also implemented direct referrals from partnered third sector organisations to increase referrals from marginalised communities and improve the awareness of the service.

Learning Disability and Autism (LDA)

Our LDA Steer Group is now up and running and continues to finalize its membership. Workstreams have now been identified and work is underway to confirm our programme leads to ensure work is progressed as identified within our LDA Action Plan. This includes our Dynamic Support Register (DSR) for adults goes "live" from 28th May. The register is reviewed at regular meetings with partners and a RAG rating tools has been developed to enable clinical colleagues to identify risk level for admission to hospital.

Our 2024-25 admission and discharge trajectory work as part of the BSOL Transformation Programme work continues to be discussed and monitored at Executive level to identify support needs to enable continues improvements. Oliver McGowan mandatory training is now on training traffic lights system. We continue to work as part of the regional stakeholder group to feed into the quality, uptake, and future plans for this training.

SUSTAINABILITY

Funding and Finances

The Trust submitted its annual plan in line with national deadlines at the beginning of May following multiple discussions across the system on how to deliver the expected financial performance for this new financial year. While levels of inflationary funding at just 0.6% remains extremely challenging, the funding available to support Trust cost pressures such as Out of Area bed spend is also extremely limited which means that the savings target for the year and ability to deliver our financial plan mean difficult decisions will need to be made throughout the year.

West Midlands Mental Health, Learning Disabilities & Autism Provide Collaborative Update

The BSOL Mental Health Provider Collaborative celebrated its one-year anniversary in April 2024 following the transfer of NHS Mental Health commissioning and delivery responsibilities from the ICB.

During the first twelve months of delivery, the Provider Collaborative has achieved several successes, including:

- Increasing the early help support offer for children and young people across BSOL through the further establishment of Mental Health Support Teams for Schools
- Continuing to embed neighborhood mental health teams in all localities across BSOL, which is supporting shorter lengths of stay for those people in rehabilitative beds
- Delivered an SMI Annual Physical Health Check Campaign during September 2023 including the development of animation
- Worked alongside partners to develop a housing with support strategy recognizing the need for appropriate and available housing across BSol
- Developed a draft 3-year mental health in-patient strategy
- Expanded the call before you convey for West Midlands Ambulance Service Crews to 24/7 and facilitated system wide planning for the implementation of the NHS 111 Mental Health Option from April 2024
- Working alongside the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) commenced the development of a VCFSE charter
- Increased the number of people accessing Talking Therapies by around 20% on the previous year's performance

Key activities currently underway include:

- Developing our Interim Strategy to respond to the ICB Strategic Commissioning Intentions
- Building our plan to ensure the co-production of our longer-term strategy for the BSOL Mental Health Provider Collaborative including how we use the knowledge and insight gathered through the Health Needs Assessment and Experience of Care to inform the vision and priorities of the collaborative
- Reviewing our governance structure and reporting arrangements into the wider BSOL system
- Commencing a new Children & Young People's Transformation Programme with stakeholders to inform our future model of care

QUALITY

The Board will note that we have a separate report on Quality and Safety on today's agenda.

We had two positive CQC Mental Health Act visits during the month of May where service users were complementary about feeling safe, being treated with respect and kindness, coproducing care plans, planned activities and understanding discharge pathways.
We await reports following a focused inspections to our Eating Disorder's service in recent weeks.

LOCAL NEWS

BSoL Community Collaborative

We continue to be a key partner in the development and implementation of the BSOL system Community Care Collaborative. The Community Care Collaborative brings together primary care, community health services, community mental health services, social care and the community and voluntary sector to support people to stay well in their own homes.

The Collaborative has developed a draft Locality Operating Model to guide the work to establish integrated teams in neighborhoods and localities and continues to test the key elements of this in practice through six integrated neighborhood teams. The work progresses the transformation of intermediate care on "home first" principles and aims to bring together all the elements of community-based provision into a more co-ordinate single team serving each locality. System

partners have nominated senior responsible officers for each of the team, with Keish Dell, our AD for primary care, dementia services and specialties taking a lead as SRO the central region.

Right Care Right Person (RCRP)

The 'Right Care Right Person' programme is designed to ensure that people of all ages, who have mental health and/ or social care needs are responded to by the right person with the right skills, training, and experience to best meet their needs. Following a rigorous strategic stakeholder engagement with system partners, we established the BSol Mental health Provider Collaborative task and finish group for effective operational oversight. We successfully implemented the first three phases (engagement, welfare checks & AWOL) and continue to monitor progress. Plans are in place to fine tune data collection for effective operational oversight. Required changes to practice, policies, and procedures are going through our governance process as we prepare for further workshops and planning in preparation of phase 4 & 5.

Executive Director of Quality and Safety (Chief Nurse)

Our new Executive Director of Quality and Safety (Chief Nurse), Lisa Stalley-Green started her role this week and we wish her a warm welcome to BSMHFT. Lisa's deep nursing ethos, values and caring nature shone through during the intensive recruitment process. She demonstrates strong skills, knowledge, and great ambition to lead our Nursing portfolio. We are sure that Lisa will be a huge asset to our Executive Team and the Trust Board driving excellence in care, service improvement, and shaping positive and inclusive working cultures.

Mental Health Awareness Week – 13-19 May 2024

BSMHFT celebrated Mental Health Awareness Week between 13 - 19 May. This year's theme was 'Moving more for our mental health' and we shared tips on how we can build more activity into our lives by finding 'moments for movement', setting small, achievable goals and finding the fun in activity.

Health Instructor, Chekaine Steele understands the benefits that physical exercise can have on our mental wellbeing, and we shared his Five Minutes With feature, setting readers the task of moving more for their mental health.

We also shared service user Nicola's positive experience of therapy with Clinical Psychologist, Holly Edwards and how it was a real turning point in her life.

NHS England also featured Psychological Wellbeing Practitioner, Jasmin Knight talking about the benefits of Talking Therapies, and flying the Team BSMHFT flag at the same time!

NATIONAL NEWS

News from NHS England

Record numbers of women accessing Perinatal Mental Health support

More than 57,000 new and expectant mums have received specialist support for mental health problems over the last year, up a third on 2022, NHS figures show.

Every part of England now has a specialist mental health team thanks to the NHS Long Term Plan with experts offering women with moderate to severe or complex mental health needs support, including on how to develop the relationship between parent and baby.

All new mums are also offered a comprehensive mental and physical check-up within six weeks of giving birth from their GP.

"The NHS Long Term Workforce Plan is growing the number of NHS staff working in mental health, primary and community care, ensuring specialist services like these continue to be available. The Government has also significantly increased spending on mental health to support these ambitions."

The General Election

The next General Election will take place on 4th July 2024. Parliament was suspended on 24th May before being formally shut down on 30th May, entering the purdah period. Purdah describes the period between the time an election is announced and the date the election is held.
Ministers, civil servants, and local authorities will soon be required to exercise caution in making announcements or decisions that might affect the election campaign. This is known as purdah (the pre-election period).

NHS England released guidance to NHS organisations here.

Report to Board of Directors							
Agenda item:	**8**						
Date	5 June 2024						
Title	Updated Board Assurance Framework						
Author/Presenter	David Tita – AD Corporate Governance						
Executive Director	David Tomlinson – Executive Director of Finance	**Approved**	**Y**		**N**	✓	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

Alert		**Advise**		**Assure**	✓

1. **Purpose:**

The GGI argues that the Board Assurance Framework (BAF) reflects an organisation`s strategic or principal risks as defined by its Board. Principal risks comprise those risks which are aligned to the Trust`s strategic objectives or priorities that could prevent it from delivering its strategy. The GGI further recommends that a BAF shouldn`t contain more than ten BAF risks to ensure it really remains strategic, as lengthy BAFs risk becoming operational in scope and tone, which is the territory of the corporate or operational risk register.

2. **Introduction:**

The BAF thus serves as an effective tool for members of the Board and its Committees to assure themselves that the Trust has appropriate, dynamic and comprehensive arrangements i.e. systems, processes and infrastructure in place for robustly mitigating, managing and governing risks which are linked to the delivery of its strategic objectives or priorities. Members of the RMG at their last meeting on 10th May, and members of Board Committees at their meetings in May, reviewed of the BAF and noted with satisfaction progress with the ongoing piece of work aimed at reviewing and defining some of the risks on it.

Changes to the BAF since it was last received by the Board:

I. Completed actions have been removed and archived from this iteration of the BAF following their approval at the RMG. This has been done to create space for new ones to be added in view of facilitating the achievement of the target BAF risk scores.

II. Action such as, aligning target risk scores with the Trust`s risk appetite framework and addressing outstanding actions, arising from the recent Internal Audit review of the Trust`s Risk Management and BAF arrangements have been completed on this enclosed version of the BAF.

III. **BAF03/PC** has witnessed a reduction in score from 16 to 12 due to the work that has been completed since the last update around increasing the accuracy of data and demographics of flexible working requests, leavers and honorary contract status. Some funding has been received from NHSE to improve ESR data quality while work is underway on a People chat box similar to `Ask Jake`.

IV. It's worth underlining that a further update of the BAF will take account of the ongoing piece of work around refreshing the Trust`s strategic priorities for 2024/25 and 2025/26.

V. Members of Board Committee (NEDs, EDs and other members) are getting together in groups to discuss the content, structure, form and presentation of their BAF within the context of re-designing and simplifying the BAF template to improve understanding. The plan is for the final proposal to come to the Strategic Board Development session in September for wider discussion, shared learning, agreement and adoption for use across all Board Committees.

VI. The outcome of the above piece of work will engineer some work around re-designing and simplifying the CRR template to further ease and facilitate understanding, useability and engagement.

3. Key issues and risks:

The main issue to note with the BAF is the drive to continuously improve on its content, form and structure as well as to align and embed it into the operationalisation of Board and Board Committee deliberations, discussions and debates.

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	**Reducing pt death by suicide / safer and effective services**
People	✓	**Staff wellbeing and experience (impact of death by suicide)**
Quality	✓	**Preventing harm / A pt safety culture**
Sustainability	✓	**Inability to evidence and embed a culture of compliance with Good Governance Principles.**

Recommendation

The Board *is requested to:*

1. ***NOTE*** *the content of this report and the enclosed BAF.*
2. ***REVIEW, SCRUTINISE and ENDORSE*** *the content of the updated BAF (see appendixes 1, 2 & 3 for details).*
3. ***GAIN ASSURANCE*** *that principal risks to the delivery of the Trust`s strategic objectives/priorities are robustly mitigated and managed in line with best practice and the Trust`s Risk Management Policy.*

Enclosures

Appendix 1: Details of updated QPES Board Assurance Framework
Appendix 2: Details of updated FPP Board Assurance Framework
Appendix 3: Details of updated People Committee Board Assurance Framework

Updated Board Assurance Framework Report

OUR VALUES

Compassionate. Inclusive. Committed.

VISION

Improving mental health wellbeing.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board, we are willing to take decisions that are likely to bring scrutiny of the organisation.

We outwardly promote new ideas and innovations where potential benefits outweigh the risks.

NB All risk scores detailed in Appendixes I, 2 & 3 – BAF Risk Scores May 2024

QUALITY AND CLINICAL SERVICES

Strategic Priority (Quality): *Delivering the highest quality services in a safe and inclusive environment where our service users, their families, carers and staff have positive experiences, working together to continually improve.*

Strategic Priority (Clinical Services): *Transforming how we work to provide the best care in the right way in the right place at the right time, with joined up care across health and social care.*

Assurance Committees: Quality, Patient Experience and Safety Committee (QPES)
Finance Performance and Productivity Committee (FPP)
People Committee
Audit Committee (AC)

Table 1a: Updated Board Assurance Framework summary showing movements in risks since last review:

Risk Ref.	Title of Risk	Executive Lead	Oversight Committee	Lead or Doer	Current risk score	Date opened	Movements in risk score
QPES BAF							
BAF01/ QPES	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/Lead, recovery, service user, carer & family experience/AD for Allied Health Professions & Recovery.	12	02/06/ 2023	⟷
BAF02/ QPES	Potential failure to focus on the reduction and prevention of patient harm.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance.	16	02/06/ 2023	⟷
BAF03/ QPES	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	Executive Director of Nursing	QPES	Interim AD of Nursing & Governance/ AD of Clinical Governance.	16	02/06/ 2023	⟷
BAF04/ QPES	Potential inconsistency in the pace of implementing a recovery focus model across our range of services.	Executive Director of Operations	QPES	Assoc. Dir. for Allied Health Professions & Recovery/ Lead, recovery, service user, carer & family experience / AD of Operations	12	02/06/ 2023	⟷
BAF05/ QPES	Potential failure to be rooted in communities and tackle health inequalities.	Executive Director of Operations.	QPES	AD of EDI/ Head of Community Engagement/ ADs of Operations.	16	02/06/ 2023	⟷
BAF06/ QPES	Potential failure to implement preventative and	Executive Director of Operations	QPES	ADs of Operations	16	02/06/ 2023	⟷

	early intervention strategies in enhancing mental health and wellbeing.						
BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.	Executive Director of Operations	QPES	Head of Strategy, Planning and Business Development/ ADs of Operations	16	26/06/ 2023	
FPP BAF							
BAF01/ FPP	Failure to focus on and harness the wider benefits of digital improvements.	Executive Director of Finance	Chief Information Officer (CIO) Joint Dir ICT & Programmes	Finance, Performance & Productivity Committee.	12	02/06/ 2023	
BAF02/ FPP	Potential failure in the Trusts care of the environment regarding implementation of the Green Plan	Executive Director of Finance	Dir. of Operations SSL	Finance, Performance & Productivity Committee.	12	08/06/ 2023	
BAF03/ FPP	Failure to operate within its financial resources.	Executive Director of Finance	Deputy Dir. of Finance	Finance, Performance & Productivity Committee.	16	09/06/ 2023	
BAF04/ FPP	Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	Executive Director of Finance	AD Corporate of Governance	Finance, Performance & Productivity Committee.	15	25/04/ 2023	
BAF05/ FPP	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Executive Director of Finance	Deputy Dir. of Commissioning & Transformation	Finance, Performance & Productivity Committee.	16	02/06/ 2023	
	People Committee BAF						
BAF01/ PC	Potential failure to shape our future workforce.	Executive Director of Strategy, People & Partnerships	People Committee	AD OD	12	02/06/ 2023	
BAF02/ PC	Failure to deliver the Trust`s ambition of transforming its	Executive Director of Strategy,	People Committee	AD of EDI & OD	12	02/06/ 2023	

	workforce culture and staff experience.	People & Partnerships					
BAF0 3/PC	Inability to modernise our people practice.	Executive Director of Strategy, People & Partnerships	People Committee	Head of People & Culture	12	02/06/ 2023	
BAF04/ PC	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI	16	06/07/ 2023	

1b. <u>Updated Board Assurance Framework Report showing Heat Map</u>

Impact	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic			BAF04/FPP		
4 Major			BAF01/FPP BAF02/FPP BAF01/PC BAF02/PC BAF03/PC	BAF02/QPES BAF03/QPES BAF05/QPES BAF06/QPES BAF07/QPES BAF03/FPP BAF05/FPP BAF04/PC	
3 Moderate				BAF01/QPES BAF04/QPES	
2 Minor					
1 Insignificant					

Appendix 1: Details of updated QPES Committee BAF

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	Quality, Patient Experience and Safety Committee	
Title of risk	Potential failure to utilise incident data in maximising benefits for EBEs, patient safety partners and improving service user experience of care.	**Current Risk Rating**	3	4	12		
		Target Risk Score	3	2	6	**Date added**	**02nd June 2023**
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date reviewed**	**05th April 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF01/QPES	**There is a risk that the Trust may fail to explore and respond to incident data in appropriately optimising the role and benefits that EBEs, patient safety partners and driving improvements in service user experience of care.** This may be caused by: -				
	• Inability to effectively collate and understand intelligence from incident data in improving patient experience. • A workforce that requires greater knowledge about recovery and personalised care. • Increased turnover. • An overwhelmed workforce unable to embrace new and innovative ways of working. • Lack of a cultural shift	• Community transformation • The design of a Community engagement Framework being led by the ICB. • QI Programmes with our EBE`s. • Ongoing work around preventative needs and stigma. • The developing	• Changes in the Policy landscape and the creation of ICBs and system working. • Challenges around workforce as genuine engagement	• Quarterly reports on participation and engagement presented at Trust Clinical governance and QPES. • QI Reports • Executive oversight of the engagement activities.	• Lack of regular and frequent governance reporting and oversight. • Inability to integrate and effectively use data in reporting. • Lack of EBE Strategy • Patient safety

	required to capture the needs of families and carers. • A stretched workforce that hasn`t always got the capacity to make these relationships. • Difficulties with sharing good practice and duplicating it. • The lack of a central hub to capture all engagement activities which could be accessed by services once they`re designing services. • The diversity of our communities means Communities can find us hard to reach. • Lack of consistency and burnt-out workforce in some of the services. • High use of bank and agency staff can impact on our capacity to build relationships with families.	Participation and experience team is providing support on the wards. • Review, development, and implementation of a Family Pathway. • Recovery College • Community engagement programme. • Community transformation and working with the Third Sector. • An asset-based Community approach. • Patient Carer Race Equality Framework • Synergy Pledge. • Recruitment of 5 Patient Safety Partners	requires sufficient and consistent staff.		partners are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised.

	This may or result in: -	
	• A reduction in quality care. • Service users not being empowered. • Services that do not reflect the needs of service users and carers. • Service provision that is not recovery focused. • Increased regulatory scrutiny, intervention, and enforcement action. • Failure to think family. • Inequality across patient population. • Workforce that is not equipped or culturally competent to support populations and colleagues. • Failure to provide resources that support health, wellbeing, and growth. • Lack of engagement. • Reactive rather than proactive service model. • Increased service demand.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented	BAF01/QPES /001	Need to review how Community engagement and patient experience data is captured and reported.	AD for AHP and Recovery/ Head of Community Engagement.	31 August 2024	Implementation of action will enable likelihood of risk crystallising to be mitigated.	

to achieve target risk score.	BAF01/QPES /002	Better integration of Community engagement and patient experience.	AD for AHP and Recovery/ Head of Community Engagement.	31 October 2024	Implementation of action will enable likelihood of risk crystallising to be mitigated.	
	BAF01/ QPES/006	Identify a clear strategy for the next 12 months on how we will use EBEs to inform improved patient safety and experience outcomes	AD Clinical Governance with support from Head of Patient Safety.	30 Sept 2024		

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
15.05.2023	We have been doing some engagement with refugees which has resulted in the Therapeutic model. Community engagement team have a well-developed a creative Art development programme in partnership with the Art programme across the city.
30.6. 2023	A quarterly report from the Participation and Experience team is now being reported to both Trust Clinical Governance and QPESC.
27.09.2023	Five Patient Safety partners have now been successfully recruited and are undergoing induction currently. With the implementation of PSIRF in the next few weeks there will need to be a clear strategy for the implementation of the role including phased inclusion at relevant meetings, input into learning responses and ensuring the voice of the SU is understood and considered. Action Leads have been identified and a meeting with leads will be arranged to discuss requirements and agreed timescales.

18/12/2023	**Progress** **Changes** Dates amended on the following actions; BAF01/003/QPES changed from 31st December 2023 to February 2024. **New Actions** No new actions added **Closed/Completed Actions** The following actions has been closed/completed; BAF01/002/QPES **Scoring** **The scoring is unchanged at 12**. Rationale is detailed below; **Likelihood: 4:** Limited progress has been made against the Patient Experience actions since original scoring was made meaning likelihood remains unchanged. **Consequence: 3:** Actions underway and complete ensure/mitigate against a higher consequence to end-user.
05th April 2024	***Updates on progress with implementing action BAF01/QPES /001*** • Review of Quality process within AHP / Recovery teams to ensure reporting is aligned to Trust processes and has triangulation opportunities. • KPIs to support impact and improvement methodology. • Refresh of PEAR meeting with increased division / clinical team attendance to support with triangulation of data. **Updates on progress with implementing action BAF01/QPES /002** • Review data for themes related to patient experience which could link with community engagement work eg service access, transport links, service refresh, industrial action elements. • Develop joint QI project to test mechanisms for improvement. **Updates on progress with implementing action BAF01/QPES /006** • HOPE (Health, Opportunities, Participation, Experience) strategy launch. • HOPE action group to act as co-productive spaces with representation from EBEs, carers, Senior Leaders, clinical team members and all staff groups.

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	3	4	12	Quality, Patient Experience and Safety Committee	
Title of risk	Failure to focus on the reduction and prevention of patient harm and at enhancing its safety culture.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	2	6	**Date added**	02nd June 2023
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date reviewed**	**10th April 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF02/QPES	***There is a risk that the Trust may fail to focus on the reduction and prevention of patient harm and at enhancing its safety culture.*** ***This may be caused by: -***				
	• *lack of implementation of a quality improvement process* • *unwarranted variation of clinical practice outside acceptable parameters* • *insufficient understanding and sharing of excellence and learning in its own systems and processes*	Internal: • Process in place to review and learn from deaths. • Clinical Effectiveness process including Clinical Audit, NICE • Transition to PSIRF • Transition to LFPSE • Patient safety education and training • Mental Improvement Programme work as defined in the Patient Safety Strategy	Mortality: • Executive Medical Director's Assurance Reports to QPES Committee and Board • Reports. • NHS Digital Quarterly Data. • Commissioner and NED quality visits.	Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting • Trust Clinical Audit Programme reporting through to committee • NICE Guidance reported through updates to committee • Monthly reporting on quality safety metrics • PSIRF oversight • Safety Summit	Learning From Improvement The availability of real time safety data to triangulate information Analysis and triangulation of data across different sources needs to be strengthened and made more consistent. Content, format, and flow.

		• Development and application of RRP Dashboard • Process in place to for staff, service users and families to raise concerns • Programme of external audit • Executive oversight of National Patient Safety Alerts • Physical Health Strategy and Policy. • Patient Safety Advisory Group (PSAG). • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Internal adoption of a transparent Quality/assurance process (AMaT implementation now resourced.) <u>External</u>: • CQC Insight Data • CQC Alerts • Public View • Healthcare Quality Improvement – NCAPOP	• Gap in MHA Action Plan oversight arrangements from CQC inspections • Insufficient resource within the L&D Team to provide robust oversight of Quality and consistency of training delivery. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR is highlighted as being protracted and difficult and so compliance with use of ESR is low across most professional disciplines.	• Patient Safety Advisory Group • Medicines Safety • RRP Steering Group • • Learning from Peer Review/National Strategies shared through PSAG. • Legal Quarterly Report • Commissioner and NED quality visits • Trust Quality Strategy. • L&D Business Case submitted for CRAM Trainer to increase resource • ROAD Group (Rio delivery Group) provides trustwide oversight of changes to Rio • Clinical Systems Group • CCIO and 2 x Deputy CCIO's in place <u>Third level assurance</u>: • CQC planned and unannounced inspection reports. • Internal and External Audit reports.	Need to agree a Trust Data Style, move from run charts to SPC across the Trust, not in parts. No resource or process for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded Quality Strategy, Quality Management System and Quality priorities not fully aligned and lack of infrastructure to deliver Need a QMS identified Exec/senior lead. Need an identified NHS Impact Exec/Senior lead outside of QI Team. Currently no Trustwide Oversight Group for L&D

		(National Clinical Audit and Patients Outcome Programme) • Coroner's Reports • QSIS compliance • Shared Care Platform	• Perceived lack of training and support for supervision training at local level. • The action plan amnesty thematic review has highlighted a gap in staffs understanding of the importance of RMS/Clinical Supervision		Business Case for CRAM Trainer not yet approved. Clinical System strategic approach could be strengthened to maximize effectiveness AMaT procured and rolling out implantation across the Trust.
	• *lack of self-awareness of services that are not delivering.*	Clinical Governance meetings Directorate/Specialty governance meetings Improvement Programme.	Improvement Plans oversight Inconsistency in approach of local CGC arrangements	Standardized QPESC agenda item enabling escalation reporting to Trust CGC Triple A reporting to QPES from CGC Commenced CGC Local review-	Inconsistency in what type of information is reported/escalated to Trust CGC by local CGCs. This impacts what is then upward reported to QPESC and Board. Insufficient reporting from Board back to service areas.
	• *poor management of the therapeutic environment.*	Capital prioritisation process SSL Service Agreement Forum CQC well-led and unannounced visits.	Gap in MHA Action Plan oversight	Quarterly reporting to Trust CGC on overall MHA compliance – high level reporting	Trust focus on MHA compliance at CGC is broad – no current assurance framework

			arrangements from CQC inspections	Health and Safety committee reporting and oversight of Ligature and Environmental Risk Assessments Audits Results CQC Steering Group – oversight of Action Planning	for how action plans following MHA inspections are monitored/completed as completely devolved to local divisions. Current CQC Reporting is very inspection focused and does not encompass the broader CQC/regulatory compliance agenda. Whilst reporting on Ligature and Environmental RA is in place – there is not a robust accountability framework in place for how actions from the assessments are overseen/managed at Divisional level with stratification of associated risk at trust level.
	• *insufficient focus on prevention and early intervention.*	Implementation of QMS including assimilation of action plan amnesty identifying themes/trends across broad spectrum of quality/governance portfolio across the organisation.	No consistent quality planning process Availability of data and varied – no Trust Data Style identified.	QMS update reporting to QPES QI reporting to Trust and Local CGC's, STMB and requested for regular QPES/Board	QMS is in its early adoption stage and requires trust-wide commitment and resource to embed QMS will need a senior lead to implement

		QI resource and draft strategy PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data tracking/themes and trending and adoption of a QI approach to resolution.		Safety Summit Reporting is included in the Patient Safety Report to Trust CGC, QPES, and Board Independent annual assessment against the 68 NHS Core Standards for EPRR.	alongside NHS Impact (outside of QI Team) New QI resource has been realigned to be able to undertake Priority1 QI Workstreams Lack of upward reporting from PSAG to Trust CGC Committee structure between local CGC and Trust CGC needs strengthening and clarity regarding roles, responsibilities, and decision-making authorities.
	• *limited co-production with services users and their families.*	Patient Safety Advisory Group Patient Stories. Carer Strategy PEAR Group LEAR Group Service Area – Service User Forums EBE programme Recovery College Patient Safety Partners EBE consultation and participation in specific trust-wide groups/forums	PSAG do not send exception reporting to QPESC Reporting of associated forums/committees not consistent/lack of awareness-embedding of work	FFT Scores Exception reports: • Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board • Safe Staffing Report • FFT reports Internal inspection and review reports: Data sets: • PALS contacts data	Poorly functioning complaints function disenabling learning/triangulation from complaints and patient feedback.

				• Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board.	
	• *insufficient staff with the correct skill set*	Improvement Programme Improvement Plans <u>Governance Forums</u>: • Clinical Governance meetings • Directorate/Specialty governance meetings • Safer Staffing Committee Safety Huddles Professional Codes of Conduct • NMC Code • GMC Good Medical Practice Guide. • HCPC Standards of Conduct, Performance and Ethics. Health Roster Stat and Mandatory Training	Poor adherence to Healthroster rules and management requirements Under use of ESR Insufficient resource within the L&D Team. Insufficient oversight of Quality and consistency of delivery.	Report on safer staffing levels to Safer Staffing Committee, TCGC, and QPESC. Safety Huddles review staffing on a daily basis Roster Clinics in place led by the Trust Safer Staffing Lead	Gaps in assurance: Safe staffing data for medical and nurse staffing. Currently no Trustwide Oversight Group for L&D Business Case for CRAM Trainer not yet approved. No corporate oversight for the quality of safety huddles.
	This may result in: -				

	• Failure to meet population needs and improve health. • Variations in care. • Unwarranted incidents. • Less safe care.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/QPES /003	Comprehensive Review of Governance Arrangements from Ward to Board – TOR will be approved including methodology of approach – to be presented to ET and QPESC.	Deputy Director of Nursing /Company Secretary Associate Director of Nursing and Governance	31st May 2024	• Change requested due to change in ToR and consultation by Committees prior to agreement.	

		Action Plan amnesty has revealed 2 main themes from the MHA Inspections; • Rights being read • Associated documentation of mental capacity act MHL Team to identify group of bespoke actions to address thematic review.	MHL Team	September 2024.	• Will support urgent action against 2 of the strongest themes of non-compliance.	
	BAF02/QPES/006	Draft QI Strategy to be approved. Approved in January but in draft as rolling co-production events to garner Staff awareness/ideas and in line with Trust Strategy review in April.	Deputy Medical Director for Patient Safety and Quality and Associate Director of Governance	September 2024.	• Will enable QI resource to be allocated most usefully to the organisation alongside being a key function of the QMS. New starters for QI onboard 8th April 2024. • Will assure the Board of QI approach and embedding QI culture into the organisation. • Dynamic Space event in March 2024 looking at Continuous Improvement approach at BSMHFT with PMO/QI/Research/Transformation teams	
	BAF02/QPES/009	At start of the new financial year, to have a clear implementation plan linking the Quality Strategy, QMS, NHS Impact and Quality priorities for 24/25 with approved dedicated resource	Executive Director of Nursing and Quality Executive Medical Director	September 2024	• Ensures a clear roadmap for the delivery of quality over the next 12 months	

	BAF02/QPES/010	RMS and Clinical Supervision Workstream to be commenced with objectives to include; improvement in IT systems, compliance with policy requirements, and improved quality of supervision.	Associate Director of Clinical Governance	September 2024	• Will support engagement with RMS and Clinical Supervision enabling improved support mechanisms for staff.	
	BAF02/QPES/011	Customer Relations KPI Improvement Plan will be devised and reported to QPESC on a monthly basis	Head of Customer Relations	June 2024	• Will support QPES Oversight of improvements to KPI's	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27th Sept 2023	Due to deep dive review by the Associate Director of Nursing and Governance new emergent hazards have been identified that later the risk rating of this BAF risk from 9 to 16. Broadly these are identified as; • Whilst a quarterly MHA report is delivered to QPESC there is an absence of a robust framework to monitor and report upon CQC MHA inspections *action planning* leading to a lack of oversight that actions from these inspections are completed robustly. This could lead to a higher risk of lack of learning at local and trust level and patients being at risk of harm and reputational damage to the trust. • Whilst the CQC report is action plan focused, there are gaps in reporting more widely on the CQC framework. alongside regulatory compliance more broadly to QPES. This highlights a noted gap in oversight and assurance to QPESC and the Board leading to a higher risk of lack of learning at local and trust level. • Whilst reporting on Ligature and Environmental RA is in place – there is not a robust accountability framework in place for how actions from the assessments are overseen/managed at Divisional level with stratification of associated risk at trust level. Areas of Achievement. Safety priorities identified – approved at PSAG, and Executive Team. To be shared through Trust Committees CGC and QPES in October and up to Board.

	Draft Patient Safety Incident Response Plan and Policy prepared. To be shared through Trust Committees CGC and QPES in October and up to Board. PSIRF Operational delivery plan prepared in draft. Suite of new Quality Metrics for Directorate Deep Dives prepared and shared with CNO, COO, DOF, and Head of Performance. Pending comments. TOR for Governance Review has been prepared including options appraisal for delivery. Cohesive working arrangements between Safeguarding and Patient safety have been strengthened including shared learning as a standardised agenda in PSAG.
18/012/23	**Progress** **Additions** Multiple additions made to controls, gaps in controls, assurance, and gaps in assurance. 3 further actions added to BAF action plan to support progress around current gaps **Changes** Dates amended on the following actions; BAF02/QPES /002 – Changed from October 2023 to February 2024. This is a new agreed implementation date from PDG. BAF02/QPES /003 – Changed from February 2024 – April 2024 – In line with approved TOR BAF02/QPES/008 – Changed from November 2023 – January 2024. This was due to PDMG being cancelled. Group will re-sit in January with 1st upward report presented then. **New Actions** BAF02/QPES/009, 010, 011 have been added to the BAF **Closed/Completed Actions** The following actions have been closed/completed; BAF02/QPES/005, BAF02/QPES/006, BAF02/QPES/007 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics.

	Consequence: 4: Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT.
Feb 2024	Updates on progress with mitigating and managing this BAF risk.
10th April 2024	**Progress** **Additions** Multiple additions made to controls, gaps in controls, assurance, and gaps in assurance. This is following a BAF Review Meeting with all of the heads of corporate services. **Changes** Dates amended on the following actions; BAF02/QPES/004 – Action Plan Amnesty Outputs - Changed from March 2024 – September 2024. Change of date for this action requested to enable QI Projects to be robustly set up, implemented and early data reviewed against success measures. BAF02/QPES/010 – Trustwide Workstreams Clinical Supervision and RMS - Changed from April 2024 – September 2024 – Change of date requested as both projects have been defined as complex and having cross-organisation dependence. It is anticipated that the increased timeline will enable meaningful updates and improvements. BAF02/QPES/011– Customer relations KPI Plan Changed from January 2024 – May 2024. Increase in date requested as Part 1 plan for timeline of completion of historic complaints (greater than 6 months) has been submitted to QPESC for April. Part 2 of the plan will be submitted in May. **New Actions** No new actions have been added. **Completed/Embedded Actions** 7 Actions have closed/been embedded as part of the review of the BAF. Embedded BAF02/QPES /001 BAF02/QPES/005 BAF02/QPES/007 Completed BAF02/QPES /002 BAF02/QPES /004a

	BAF02/QPES/008 BAF02/QPES/012 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to reduce and prevent patient harm to patients. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB and requires improvement rating from CGC following themed inspection of CMHT.

	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	2	6		
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date added**	2nd June 2023
						Date reviewed	**10th April 2024**
Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***		**Gaps in assurance What are the weaknesses in the assurance?**	
	There is a risk that the Trust may fail to effectively use time resource and explore organisational learning in embedding patient safety culture and providing quality assurance. This may be caused by: -						
BAF03/QPES	• Inability to effectively use time resource in driving improvements and safety. • Failure to use QI approaches to develop pathways to improve access to services. • Inability to develop and embed an organizational learning and safety culture.	• SI oversight Group • Patient Safety Advisory Group (PSAG). • Internal governance structures associated with learning groups and forums are standardised with ToR and set agendas to address learning activity. • Clinical service structures,	Limited assurance from current approach to review of quality and governance metrics at Divisional level. Limited reporting of Divisional quality reviews to QPES and Board.	• Learning from Peer Review/National Strategies shared through PSAG. • Serious Incident Reports. Increased scrutiny and oversight through SI Oversight Panel. • Executive Chief Nurse's Assurance Reports to CGC, QPES Committee and Board.		The Trust currently has no baseline to understand the organisations view on safety culture. An options appraisal on how this could be undertaken is being prepared for the Board. Senior leader session/Board meeting- to discuss how to use QI methodology- driver	

	• Inability to review the Trust`s safety culture so as to identify and address any gaps. • Failure to identify, harness, develop and embed learnings from deaths processes. • Failure to develop and embed `Think Family Principle`. • Failure to fully address the improvements against the CQC action plan.	accountability & quality governance arrangements at Trust, division & service levels including: • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Implementation of Learning from Excellence (LFE). • PSIRF Implementation Strategy including PSIRF Implementation Group and PMO support. • Freedom to speak up processes. • Cultural change workstreams including Just Culture. • NHS staff survey	No organisational wide reporting of LFE metrics.	• Updates on PSIRF Implementation to QPES and Board.	diagrams, plan, and risk asses, etc. Check knowledge. New First line manager QI training now in place: QI methodology in day-to-day leadership- using process mapping, driver diagrams, read data etc. The Safety Summits are in their early conception and may not be adopted well by Divisions/services.

	• Variations in safety culture across the organisational at Divisional and Service Level. • Inconsistencies in governance arrangements at Divisional and corporate level.				
	This may result in:				
	• A culture where staff feel unable to speak up safely and with confidence. • Failure to learn from incidents and improve care. • A failure to develop pathways of care within the Integrated Care System. • Increased regulatory scrutiny, intervention, and enforcement action. • Insufficient understanding and sharing of excellence in its own systems and processes. • Lack of awareness of the impact of sub-standard services. • Variations in standards between services and partnerships. • Demotivated staff. • Missed opportunities for System Engagement.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	There is no current CRR	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF03/QPES /003	Organisational Safety Culture Assessment will be completed, and Divisional led action plans put into place to address safety culture concerns.	Deputy Director of IPC, Patient Safety, Clinical Quality and Governance	June 2024	• Change requested to enable enaction of agreed options appraisal and subsequent survey requirements.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	PSIRF update as above. - Options appraisal to support organisational safety culture assessment has been devised for presentation to ET.
18/12/2023	**Progress** **Additions** 1 further actions added to BAF action plan to support progress around current gaps **Changes** Dates amended on the following actions; BAF03/QPES /003– Changed from October 2023 to June 2024. This is a new agreed implementation date as will require substantial roll out plan. BAF02/QPES /003 – Changed from July 2023 – February 2024 – PSIRF Implementation/transition was required before considering new TOR/Agenda for PSAG **New Actions** BAF03/QPES/002 has been added to the BAF **Closed/Completed Actions** The following actions has been closed/completed; BAF03/QPES/002 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to learn from previous incidents of harm to patients and staff. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. PSIRF transition has only just occurred and is in its early stages, new learning responses have not yet to be fully trialled to see if they bring about meaningful learning.

	Consequence: 4: Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT
Feb 2024	Updates on progress with mitigating and managing this BAF risk.
10th April 2024	**Progress** Additions No further additions added this month, Changes No changes to action dates this month **New Actions** No new action has been added. **Completed/Embedded Actions** The following actions has been closed/completed during this review: BAF03/QPES /004 **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to learn from previous incidents of harm to patients and staff. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. PSIRF transition has only just occurred and is in its early stages, new learning responses have not yet to be fully trialled to see if they bring about meaningful learning. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, requires improvement rating from CGC following themed inspection of CMHT

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	4	16	Quality, Patient Experience and Safety Committee	
Title of risk	Potential inconsistency with the pace of implementing a recovery focus model across our range of services.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date reviewed**	**09th April 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF04/QPES	**There is a risk that the Trust may inconsistently implement a recovery focus model at a varied pace across our range of services.** This may be caused by: -				
	Lack of opportunities for service user participation. Lack of employment opportunities for those with lived experience. Lack of support for and involvement of families and careers. Lack of effective partnership working with Community agencies. Lack of effective understanding by staff of what the Recovery	• BSOL Provider Collaborative Development Plan. • Experience of Care campaign. • Health, Opportunity, Participation, Experience (HOPE) strategy. • Family and carer strategy. • Implementation of Family and carer pathway. • BSOL peer support	Family and carers pathway not consistently applied or suitable for all services. Performance in these areas is not effectively measured.	• Integrated performance dashboard. • BSOL MH performance dashboard. • Outcomes measures, including Dialog+ • BSOL MHPC Executive Steering Group. • Participation Experience and Recovery (PEAR)	Having a strong service user/carer voice across all of our governance forums.

	Model is about and its expectations. Inconsistency of Pathways maturity and availability.	approaches. • Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Recovery training part of fundamental training.		Group. • Highlight and escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee.	
	This may result in: -				
	• Inferior and poor care. • Lack of equity for service users across our diverse communities. • Ineffective relationships with key partners. • Lack of continuity of care and accountability between services. • Negative impact on service user access, experience and outcomes. • Negative impact on service user recovery and length of stay/time in services.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status

Actions being implemented to achieve target risk score.	BAF04/QPES /001	Review and refresh of the family and carer pathway	Associate Director for Allied Health Professions and Recovery	31st July 2024	Families and carers will be routinely identified, and better supported or involved in care planning as appropriate.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Updating access to information policy by service users and carers and following a QI co-production approach.
29/11/2023	Updates on progress made so far.
29th Feb 2024	Updated, title and risk description modified, and new controls added.
9th April 2024	BAF04/QPES/001 Request extension of due date to 31st July 2024 to enable design of pathway following presentation following presentation of a paper at the Operations Management Team (OMT) today. It is worth recognising that the BSMHFT's Family and Carer Strategy which is out of date is being reviewed to enable a co-design and co-production of this pathway.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to be rooted in communities and tackle health inequalities.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8***.			**Date reviewed**	**08th April 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF05/QPES	**There is a risk that the Trust may fail to be rooted in communities and tackle health inequalities.** This may be caused by: -				
	Lack of engagement with our local communities. Services that are not tailored to fit the needs of our local communities or aligned to local services. Lack of understanding of our population, communities and health inequalities data. Not working together to tackle inequalities across the BSOL system Inadequate partnership working leading to barriers between services e.g., primary care, social care.	• Data with Dignity sessions. • Divisional inequalities plans. • PCREF framework • Synergy Pledge. • Provider Collaborative inequalities plans. • System approaches to improving and developing services. • Community Transformation Programme – now in	• Divisional inequalities plans not fully finalized for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service	• Integrated performance dashboard. • BSOL system mental health performance dashboard. • Health Inequalities Project Board. • Community Transformation governance structures. • Out of Area Steering Group. • Reach Out governance structures.	• Inability to engage with all parts of the Trust. • Local meetings not feeding into higher level. • Relevant people not present at deep dives; includes consistency of how these are carried out and how KPIs are monitored.

	Demand for community services exceeding our capacity to deliver good quality, timely care. People having to go out of area for inpatient care due to inadequate service provision in area. Failure to have appropriate quality and modern estates and facilities	year 3 of implementation. • Community caseload review and transition. • Out of Area programme. • Transforming rehabilitation programme, including new of Intensive. Community Rehab Teams. • Reach Out strategy and programme of work. • Redesign of Forensic Intensive Recovery Support Team. • BSOL MHPC Commissioning Plan. • BSOL MHPC Development Plan. • Joint planning with BSOL Community Integrator and alignment with neighborhood teams. • Development of community collaboratives. • Community engagement team	developments alongside day job. • Recruitment and retention	• Local FPP and CGC meetings. • Highlight and escalation reporting into Strategy and Transformation Board. • Performance Delivery Group “deep dives”. • Highlight and escalation reporting into BSOL MHPC Executive Steering Group.	

	This may result in: -	
	• Some communities being disengaged and mistrustful of the Trust. • Negative impact on service user recovery and length of stay. • Increased local and national scrutiny. • Increased risk of incidents due to inappropriate physical environments. • Poor reputation with partners. • Negative impact on service user access, experience and outcomes.	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	N/A

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/QPES /001	Work ongoing to keep down capital costs of major developments, e.g. assessing potential use of a modular build.	Deputy Director of Estates / Associate Directors of Operations	31st Dec 2024	Affordable capital plans with identified funding.	
	BAF05/QPES /002	Quality improvement approaches being embedded to support transformation. Above action modified to read as thus: - Work to address inequalities has commenced on certain parts (e.g. Secured Care & Perinatal Services)	Head of Quality Improvement / Associate Directors of Operations	Ongoing process	Enables successful delivery of transformation plans and service developments.	

		of the Trust and is progressing.				
	BAF05/QPES /004	Support for development and implementation of divisional health inequalities plans from EDI team	Jas Kaur / Associate Directors of Operations	Ongoing process	Services will understand their current gaps and have actions in place to improve access, experience, and outcomes.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Co-produce approach with patients and carers and Voluntary Sectors and have devised a plan to integrate our patients successfully in the Communities.
29/11/2029	Updates on progress made so far.
29th Feb 2024	Updates on various works happening in other parts of the Trust have been considered. Actions reviewed and new one added.
08th April 2024	For BAF05/QPES/001 & Estates and Facilities element proposal completed; Plans proposed for new Highcroft 32 bed ward following Modern Methods of Construction- modular build. Awaiting Business Case approval.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	2nd June 2023.
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date reviewed**	**29th February 2024.**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF06/QPES	**There is a risk that the Trust may fail to implement preventative and early intervention strategies which can help enhance mental health and wellbeing.** This may be caused by: -				

	Demand for services exceeding our capacity to deliver good quality, timely care.
	.
	Lack of admission alternatives, including full range of crisis support services.
	Waiting times to access Solar services in Solihull.
	Waiting times to access Birmingham Healthy Minds.
	Inadequate support for our service users with mental
		• System approaches to improving and developing services.
		• Solihull Children and Young People Transformation Programme including:
		  ○ Transition workers
		  ○ Mental health support in schools.
		• Talking therapies recovery plan.
			• Capacity within teams to deliver transformation and service developments alongside day job.
			• Not enough beds for population when compared nationally.
				• Integrated performance dashboard.
				• BSOL system mental health performance dashboard.
				• BSOL Talking Therapies Steering Group.
				• Solihull CYP Board.
				• Highlight and escalation reporting into Strategy and Transformation Board.
				• Performance Delivery
					• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.

	health co-morbidities e.g., substance misuse, learning disability, autism etc.	• Urgent care transformation plan including:
		  ○ Heartlands mental health hub
		  ○ Additional Place of Safety and PDU capacity/staffing
		  ○ Call before you Convey
		  ○ Crisis house
		  ○ Psychiatric liaison.
		• Partnership working re dual diagnosis processes and pathways.
		• LDA training for staff
		• Sensory friendly wards
		• LDA reasonable adjustments tool.
			• Recruitment and retention impacting delivery plans.	Group “deep dives”.
				• Highlight and escalation reporting into BSOL MHPC Executive Steering Group.
				• Clinical Effectiveness and Assurance Group.	

	This may result in: -				
	• Service users being cared for in inappropriate environments when in crisis. • Increased pressure on A&E in acute hospitals. • Increased risk of incidents. • Individuals’ mental health issues escalating leading to increased need for secondary care. • Negative impact on recovery and length of stay/time in service. • Increased local and national scrutiny. • Negative impact on service user access, experience and outcomes.				
	Linked risks on the CRR-	**Brief risk description**			

	Risk ID	
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc. due to the lack of AMHP availability, particularly out of hours.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF06/QPES /001	Quality improvement approaches being embedded to support transformation.	Head of Quality Improvement / Associate Directors of Operations	*Ongoing process*	Enables successful delivery of transformation plans and service developments.	
	BAF06/QPES /002	Divisional workforce planning to improve recruitment and retention.	Associate Directors of Operations	*Ongoing process*	Enables successful delivery of transformation plans and service developments.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: ***(Please enter initials and progress that has been attained)***
02/06/2023	New risk which has just been added.
29/11/2023	Updates on progress made so far.
29th Feb 2024	Risk including actions reviewed and updated.

Executive Lead	Executive Director of Operations.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.	**Inherent Risk Rating**	4	5	20	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	4	2	8	**Date added**	**26th** June 2023.
		Risk Appetite	**Cautious:** Our preference is for risk avoidance. However, if necessary, we will take decisions on quality and safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. ***Target risk score range 6-8.***			**Date reviewed**	**15th May 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF07/QPES	**There is a risk that the Trust may fail to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.** This may be caused by: -				
	Not thinking as a system in developing priorities and improvement plans Lack of appropriate partnerships Ineffective partnerships e.g., lack of trust, collaboration, engagement, being seen as equals etc. Pathways and interfaces that are fragmented not joined up – both internally and externally Not being involved in system wide developments and initiatives e.g., development of	• Trust is a representative on key system groups e.g., ICB Board, Place Committees, Inequalities Committee. • Lead provider for BSOL mental health provider collaborative. • Lead provider for Reach Out (secure care) and a partner in CAMHS, eating disorders and perinatal provider collaboratives.	• Partnerships strategy is currently being refreshed – containing gap/opportunity analysis of current pathways. • Needs assessment for BSOL is not up to date, which weakens our intelligence about our	Reports on system and partnership activity to: • WM Provider Collaborative Board • Provider Collaborative governance structures (BSOL and specialist services) • Operational Management Board • Strategy and Transformation Board • Board Committees • Trust Board	

	place, wider health inequalities work etc. Not having service user voice to inform transformation and development plans	• Partner in West Midlands Provider Collaborative. • Strategic partnerships with local authorities, VCFSE, NHS providers, primary care, police. • System wide approach to transformation e.g., community. transformation, urgent care pathway, talking therapies. • Internal project commenced scoping how we can be more integrated in our pathways and teams.	population and needs.		
	This may result in: -				
	• Lack of joined up pathways and care. • Service users falling between gaps. • Poor service user experience. • Poor service user outcomes. • Negative Trust reputation. • Loss of confidence in the Trust by partners. • Potential duplication of effort and services. • Poor value for money.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF07/QPES /001	Refresh Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Sept 2023 Requesting extension of due date to 31st Dec 2024	We will have a clear direction of travel, with our gaps identified and ambitions articulated to address the gaps and respond to our opportunities.	
	BAF07/QPES /002	Develop implementation plan for Partnerships Strategy	Head of Strategy, Business Development and Partnerships	End Dec 2023 Requesting extension of due date to 30th Sept 2024	We will have a coherent plan of how we are going to strengthen our partnership working.	
	BAF07/QPES /003	Commission Needs Assessment	Associate Director of BSOL MH Provider Collaborative	End Dec 2023 Requesting extension of due date to 31st Aug 2024 to enable completion.	We will understand the needs of our core population and its diverse communities and can make sure our strategies and plans address these.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
26/06/2023	New risk which has just been added.
27/09/2023	Board session held on 6 September, led by P. Nyarumbu to discuss direction of travel for elements of the Partnerships Strategy. Further work to be undertaken following the session and feedback to be incorporated into the current draft strategy. Agreed that completion will be put back pending this. High level implementation plan is included in the draft strategy.
15th May 2024	Discussing the next step at the moment and requesting extension of action due dates as set out above due to capacity issues in the team. **As concerns action BAF07/QPES/003-** The Centre for Mental Health were awarded the contract to develop an All Age Mental Health HNA. Work is progressing with the development of the HNA which is due for completion in August 2024. This builds upon the existing work that has taken place across the system and brings it together in one place.

Appendix 2: Details of updated FPP Committee BAF

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
Title of risk	Failure to focus on and harness the wider benefits of digital improvements.	**Current Risk Rating**	4	3	12		
		Target Risk Score	3	3	9	**Date added**	2nd June 2023
		Risk Appetite	**Open:** Systems / technology developments considered to enable improved delivery. Agile principles may be followed. ***Target risk score range 9-10.***			**Date reviewed**	**11th March 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF01/FPP	*There is a risk that the Trust may fail to focus on the digital agenda and to harness the wider benefits of digital improvements.* *This may be caused by: -*				
	• *Teams and individuals don't know how to engage around the digital ask.* • *Teams and individuals don't know the art of the possible.*	The Trust has a System Strategy Group that has representation from the • Director of Finance • Chief Clinical Information Officer, • Chief Nursing Information Officer, • Chief Information Officer, • The Head of IT, • The Head of R&I, • The Head of Informatics, • L&D,	The group needs to promulgate ideas and act as champions, wider representation would help. • It still requires non-technical staff to recognise a digital solution may be an option.	• Minutes show that last year 42 teams came to the system strategy group to discuss ideas and issues where digital, data and technology could offer a solution. • DOF chairs and attends SSG and reports to FPP with CIO.	

		• Estates, • Governance, • Operations • Offering a one stop show to help engage around all things Digital, Data & technology. • We can help teams scope the problem and look at a myriad of solutions before settling on the right approach. • The System strategy group is the gatekeeper for all things Digital, data and technology in the Trust.	• Communications around the offering.		
	• *There may not be the financial support or budget to look at digital solutions.*	• All capital business cases go to the Capital Review Group, and this offers the ability for new ideas to be looked at through a lens keeping digital on the agenda.	• Only new Business case projects go thorough the Capital Review Group, existing services are not considered unless	• Minutes • Reports to FPP committee • Business cases	• Does not apply to existing or service redesign if no funding is required

		• The DOF Chairs, CIO is included in the distribution of all new business cases.	capital investment is required.		
	• *Teams and services are not aware of digital solutions within the Trust.*	• System strategy group produces an annual update to the Trust (Digital newsletter). • The PMO ensures all digital projects have a case study and project on a page submitted to Connect and the staff briefing as they occur. Individual projects are discussed at FPP in the quarterly assurance update. • Strategy and Transformation Board receive a monthly update on all live projects.	• Articles, minutes, papers are predominantly digital media. • Those systems in place for a while no longer get entered into the papers or articles unless it is a significant change.	• Connect • Digital newsletters • Minutes of FPP • FPP Papers • System strategy minutes and papers. • Strategy and Transformation Board, minutes, and papers.	• Does not apply to existing products / systems.
	This may result in: -				

	• *Inability for services to innovate.* • *services do not engage with the digital first agenda.* • *Efficiencies and savings are not realised.* • *Quality improvements are not optimised.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	N/A	**N/A**

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	**BAF01/FPP/ 001**	Wider communication across the Trust regarding the Systems Strategy Group, including its role.	James Reed / Carl Beet	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	
	BAF01/FPP/ 002	Raise awareness of the ability for the Systems Strategy Group to help in service redesign and re-imagining service delivery. Start with Senior Leadership Team meeting and professional user groups	James Reed / Carl Beet / Shaun Kelly	ongoing	Wider awareness will help raise the profile of the digital agenda, help foster better utilisation of services and provide an avenue for discussion for clinicians across the Trust	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
12/06/2023	This is a new risk which has been recently added.
19/09/2023	Updates to FPP have taken place in line with the quarterly cycle, 9 comms articles have gone out in the last quarter lifting the profile of digital projects and services featured in the weekly brief. The Digital strategy is in draft and has been shared with FPP and circulated through wider meetings as part of a general digital awareness. We have dedicated snap comms for all things digital and have used the snap comms to promote campaigns on cyber awareness, general digital updates, and system upgrades. We have expanded the use of

	the virtual agent / chat bot “Ask Jake” which now covers the majority of password resets in the organisation and we are looking to expand that in to other departments such as HR and Estates.
14/12/2023	Members of the FPP and the various BAF leads at the BAF review meting queried if the lack of a Trust-wide transformation/continuous improvement piece or operational driver for digital shouldn`t be the focus of this risk considering the fact that digital is only an enabler with the aim of maximising the benefits of the transformation agenda. The Trust thus needs to demonstrate clarity around what it wishes to achieve through its clinical services transformation agenda with digital supporting as an enabler. Members agreed that this BAF risk is around failure to maximise the benefits from the investments in IT and that it should be widened to include cyber security and recommended the following new BAF risk for consideration: - • Potential failure to reap the added value of and embed a Trust-wide culture of continuous improvement and transformation. This underpins the risk of not delivering the outcomes linked to the transformation Strategy as reflected in our inability to define how things will look like in say 3years time.
11/03/2024	Digital, data and technology presentations have taken place with exec colleagues and a dedicated session at the senior leaders’ briefings. The System Strategy group continues to be the core group for all Digital, data and technology asks within the Trust, we have increased the areas represented and the diversity of the group to ensure greater collaboration and awareness takes place across the organisation. We are moving on to the national tenant for Office 365 to aid with the wider system collaboration piece across the ICS, this should aid with integration across our own organisational boundaries and help with accessing data from other organisations in the ICS. We have published our Microsoft roadmap on connect under the PMO and ICT pages, to aid the wider communications piece. The HR chatbot is under development to help with all Digital HR matters across our teams and we continue to automate the onboarding work for TRAC and ESR.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure in the Trust's care of the environment regarding implementation of the Green Plan.	**Inherent Risk Rating**	4	4	16	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	3	3	9	**Date added**	8th June 2023
		Risk Appetite	**Open:** Consider benefits of agreed environmental-friendly actions and solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements. **Target risk score range 9-10.**			**Date reviewed**	**26th Feb 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF02/FPP	There is a risk that the Trust may fail to meet national and regional sustainability, net zero carbon and its green plan objectives. This may be caused by: -				
	• *Management of vacant properties.* • *Management of Owned, Retained, PFI and landlord facilities.*	• Shareholder, Liaison, Contractor and Operational Management Team Meetings and Committees are all in place to ensure communication, Service delivery, and physical aspects and priorities are delivered to meet all quality requirements.	• Provision of Service Strategy across Trust per service, per team and per premises. • Commitment to delivery of the Green- Action Plan through Capital and Revenue programmes,	• Physical Environment considered within Estates and Facilities Risk Schedule with mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability	• Risk of lack of ownership and prioritization. across the Trust • Risk of lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply.

		• Operational and Strategic Health and Safety Committee, Infection Control Group, Capital Review Group and Divisional FPP Meetings to ensure technical, compliance, and physical environmental performance is addressed. • Trust Sustainability and Net Zero Group established. • Heat De-carbonisation reviews across sites. • Listen-up Trust wide communication sessions. • Reporting on progress through Annual Reports inc 2022 and 2023.	Trust Corporate Department delivery and Clinical/ Nursing service commitment making sustainability and net zero carbon part of our BAU.	Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Trust Board Executive named responsible. • Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan. • Condition Surveys, review of premises statutory standards and compliance assessments / independent AE audits ensure standards are met and maintained. • Trust Green Plan signed off at Board level. With all National Returns completed on time and accurately.	• Risk of lack of leadership across the Trust to maintain momentum on the agenda and ensure it is sufficiently resourced and embed in core activities and behaviours. • External changes in legislation and mandates that lead to undue pressure on the organisation.

				• Trust Green Plan in line with ICS Green Plan.	
	• *Performance of owned/ PFI premises.* • *Achievement of the Action Plan set out in the Trust Green Plan across Trust multi-service suppliers.*	• Trust prioritisation of Risk Assessments, Statutory Standards and Backlog Maintenance Programme. • Revenue Programme. • Incident reviews and actions. • PFI Lifecycle Programme. • PPM, reactive and planned works • Delivery of the Trust Green Plan and the built in Action Plan	• Allocation of resource as necessary, but focused response to Audits and controls.	• Risks allocated inc mitigation, action and review. •	• Encourage - Clinical Management to liaise with Risk Management on all Sustainability issues. • Engage with Risk / Health and safety team; regular meetings.
	• *Service provision to premises both hard and soft FM. Examples; Waste Management, Cleanliness, Food Management, etc.*	• Trust Food Group- multi disciplinary team inc Clinical, Dietetic lead, SSL FM leads • Balanced menu provision designed by SSL and their Supply Chain. • Provision of food from Conventional	• Communication of care of the environment message and target to support Service Users and Clinicians at ward level.	• Risk and Policy, Risk Assessments, National Ward / Production kitchen audits. • EHO inspected Production Kitchens. • Cleanliness and efficacy audits of cleaning standards.	

		in-house compliant facilities. • Operational and Strategic Water Management Groups. • Infection Control Committee.			
	This may result in: -				
	• The environment does not support delivery of first class Clinical services. • Service User safety, care and ability to receive the best therapeutic care is compromised. • Quality provision of the physical environment is challenging. • National Green Agenda targets not achieved				

	Linked risks on the CRR- Risk ID	**Brief risk description**
	85	Non-compliance with E and F statutory standards in external landlord-controlled buildings.
	97	Poor cleanliness standards leading to infection control risks.
	1459	Reaside- backlog condition and clinical functionality.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	BAF02/FPP/ 001	Trustwide Sustainability/ Green Group. With representation Corporate and Clinically.	Trust/ SSL	On-going	Full Action Plan schedule established, set against Regional and National objectives.	
	BAF02/FPP/ 002	Development of Business cases and securing of major capital to address Reaside functional suitability.	Trust	August 2024	The development of a business case will allow the planning of lifecycle/ maintenance responses on Reaside premises and ultimately address the replacement of the	

target risk score.					premises supporting safe, and sustainable care environment.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
11/05/2023	Full review of all 31 Estates and Facilities Risks, 12 Risks accepted and closed these will be reviewed annually to ensure circumstances and mitigation remains in place. The remaining 19 Risks have been re-assessed for content, mitigation, likelihood, and impact.
12/09/2023	Strategic Trust Sustainability/ Green Meetings BAU. Works underway to draft achievement against NHS E MOU. Comms Plan for Autumn/ Winter 23 underway. Liaison with Trade Unions on information and details for Green initiatives.
14/12/2023	Members at the BAF review meeting argued that this risk around the `Green Agenda` and should include the fact that it is driven by three things i.e. standards set by the quality improvement piece, the therapeutic environment and safety of patients. Members then recommended that this risk should be refined with clarity of purpose to include elements around transformation, compliance and the need to maximise benefits to patients and avoid harm.
26th Feb 2024	Risks and controls remain as this represents a long-term strategic approach needed by the NHS to manage its Sustainability and Net Zero challenges. It does not represent a short-term project or programme of works. Indeed, failure to deliver against the agenda in its entirety being a significant risk to all NHS organisations. In terms of long-term planning very significant financial resources will need to be made available to allow for fundament challenges such as Heat Decarbonisation. BSMHFT full Regional and National engagement. SSL/BSMHFT leading the ICB/ICS responses Nationally.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Failure to operate within its financial resources during financial year 2023/24.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	3	9	**Date added**	09/06/2023
		Risk Appetite	**Open:** Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels. **Target risk score range 9-10.**			**Date reviewed**	**14th May 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF03/FPP	*There is a risk that the Trust may fail to operate within the financial resources available to it.* *This may be caused by: -*				
	Poor financial management by budget holders	Governance controls (SFIs, SoD, Business case approval process) Financial Management supporting teams Reporting to FPP and Board on Trust performance. Continued review and utilisation of balance sheet flexibility.	Consequences of poor financial performance do not attract any further review. Requests for cost pressure often made without following agreed process.	Ability to deliver planned financial position dependent on sufficient controls – Trust continues to meet its statutory financial obligations Internal and External Audit review. Audit Committee and FPP oversee financial framework and monthly reporting of financial position and any deviation from plans for 23/24.	Trust continues to be given assurance through audit reports. HFMA sustainability audit has identified a number of development areas that would improve controls and performance.
	Inadequate financial controls				
	Cost pressures are not managed effectively				
	Savings plans are not implemented	Savings Policy Sustainability Board review.	Attendance at Sustainability Board variable.	Ability to deliver planned financial position dependent on sufficient controls – Trust	HFMA sustainability audit has identified a number of development

		ICS expectations and reporting requirements.	Trust has not been able to develop a pipeline for delivery of savings.	continues to meet its statutory financial obligations, including any shortfall in savings delivery.	areas that would improve controls and performance.
	This may result in: -				
	• *Trust not meeting its financial targets limiting available funds for investment in patient pathways.*				

	Linked risks on the CRR- Risk ID	**Brief risk description**
	108	Savings schemes are not delivered in full meaning the Trust may fail to meet its financial plan leading to a deficit in year, a fall in financial risk rating or inability to fund capital programme.
	112	The Trust does not secure the growth funding we require.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF03/FPP/ 02	To develop a financial management policy – work is underway to progress this	Deputy Director of Finance	31/10/2024	Action will mitigate the impact of the risk were it to crystallise.	
	BAF03/FPP/ 03	To roll out of new finance reports – work is ongoing to identify the capability within the ledger system, the training and resource requirement including specialist expertise.	Deputy Director of Finance	31/10/2024	Action will mitigate the impact of the risk were it to crystallise.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
25/04/2023	25 actions confirmed closed through April Audit Committee for HFMA Sustainability Audit.

01/09/2023	Communications issued to whole Trust re financial position – number of initiatives implemented to increase controls including Vacancy Control Panel and Investment Oversight Group. Work ongoing to identify further opportunities for efficiencies and work by KPMG at system level now being finalised which offers some further options
14/12/2023	Members at the BAF review meeting argued that this risk is around compliance and the need to avoid financial failure and queried in the light of the previous discussions on digital and the green agenda if it has been appropriately framed? They also argued that this risk should specify which year it is referring to and how finance is enabling investments in clinical care and transformational change. Members also agreed that the Trust needs to generate financial efficiency in order to have the financial headroom to invest in the things that we want and to maximise benefits from the investments we make.
12/2/2024	BAF risk title amended to include reference to financial year 23/24 in light of discussions around when the risk relates to. Likely that the score will need to be amended to reflect the outcome of the planning round and certainty in income for 24/25 but position not yet confirmed. Additional element added within controls around utilisation of balance sheet flexibility as this is how the position is being managed in this financial year as reported and agreed by Board as part of the NHSE financial reset. Proposal for Risk Management Group to review how the risk is framed for 2024/25 financial position once there is more certainty around plan for next year.
14/05/2024	The majority of actions are now completed; however, the above two outstanding actions have been added and are ongoing.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	**Inherent Risk Rating**	5	5	25	Finance, Performance & Productivity Committee	
		Current Risk Rating	5	3	15		
		Target Risk Score	2	2	4	**Date added**	25/04/2023
		Risk Appetite	**Minimal:** Willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Organisational controls maximise fraud prevention, detection and deterrence through robust controls and sanctions. **Target risk score range 2-4.**			**Date reviewed**	**8th March 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF04/FPP	There is a risk that the Trust may not sufficiently evidence, demonstrate and embed a culture of compliance with the requirements of Good Governance such as CQC Regulatory provisions, standards and Notices, safety practices, the new NHS Provider Licence, the Nolan Principles, good corporate governance codes and principles and best practice. This may be caused by: -				
	Lack of good intelligence on the current governance arrangements from Ward to Board. *Regulatory burden and pressures including ad hoc requests from regulators.* *A fluid regulatory landscape.* *A non-compliance mindset or mentality.*	Regular and planned external inspections from the regulators e.g. CQC. Self-assessment, accreditation and self-certification. Setup a strong governance infrastructure to underpin compliance.	Operational pressures negatively impacting on staff capacity to fully implement these controls. Self-assessments, accreditation and self-certification processes aren`t strong.	Inspection reports. Compliance audits. Self-assessment, accreditation and self-certification reports. External visit reports. Peer Reviews.	Poor learning from previous regulatory inspections. Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance.

	A weak governance infrastructure. *Excessive emphasis on compliance leading to a `tick-box` culture.* *Poor perception of compliance leading compliance overload or fatigue.* *Human factors, poor attitudes, human behaviours and desire to circumvent due process.* *Weak internal systems, processes and procedures.* *Lack of awareness of the added value of regulatory compliance to the business.* *Requirement to meet the statutory duty to `breakeven`* *Staff circumventing due process or taking `shortcuts`.* *Managers making decisions above their competence or powers without due regards to the Scheme of Delegation.*	Regular audits on compliance. Staff training and awareness sessions to tackle poor behaviour around compliance. Strengthen the internal control systems and processes. Regular horizon scanning for cases of non-compliance. Savings Policy in place and implemented. Regular process audits e.g. Accounts or medication reconciliations. Awareness and Comms to be circulated. Populate the Scheme of Delegation and SFI.	Governance around compliance is weak. Controls have not been embedded.	Board Assurance Framework Report.	Peer review not very regular. The culture of BAF not fully developed and embedded.

	Lack of openness, fairness, transparency and non-adherence to the Nolan Principles. *Poor risk management arrangements.* *Inability to harness the benefits of good risk management in strengthening decision making.* *Lack awareness of the new NHS Provider Licence Conditions.*	Awareness of the Nolan Principles Training; organisational capacity and capability building in risk management. Embedding and prioritisation of risk management. Use of intelligence from risk management in driving organizational safety culture. Annual Self-certification to be published on Trust intranet. New NHS Provider Licence has been disseminated across the Trust. Conditions in the new licence mapped out for teams to consider evidencing compliance at a micro level. Annual compliance report provided to Board C`ttees and Board.	Still early days as the new NHS Provider Licence is sufficiently known across the Trust.	Annual Self-certifications. Local evidence at team and micro levels on compliance. Teams regularly discussing and evidencing how they are supporting the Trust meet relevant conditions. Annual Compliance Reports.	Culture of evidencing and demonstrating compliance not fully developed and embedded into business as usual.

	This may result in: - • *Regulatory action – penalty, notice etc.* • *Reputational damage to the Trust.* • *Poor patient care, safety and experience.* • *Loss of some business operations or Licence for the provision of some services.* • *Legal actions in some extreme cases.* • *Disciplinary actions for negligence or wilful failure to comply with key standards, Conditions of the Licence and other important aspects of Good Governance.*	
	Linked risks on the CRR- Risk ID	**Brief risk description**
	1049	Failure to recruit and retain staff to enable safe staffing levels could result in a breach of HCSA regulation 18 (staffing). Risk of increasing reliance on agency and temporary workforce, will result in poor continuity of care and impact on safer staffing requirements.
	950	There is a risk that CMHT caseloads will continue to be above 35 which will breach regulation 18 HSCA (RA) Regulations 2014 Staffing. Caused by CMHT having 3 workstreams being: primary care talking therapies, memory drug prescribing & monitoring and core secondary mental health provision. This may result in higher risk of clinical incidents, increase in staff sickness, poor work-home-life balance, service users not receiving a quality service and increased waiting lists and waiting times for service users.

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	BAF04/FPP/002	Review of the Trust`s governance arrangements from `Ward to Board`.	David Tita & Lisa Pim	31/05/2024	This action will create a better understanding and help reduce the likelihood and impact were the risk to materialise.	
	BAF04/FPP/003	Review of the Trust`s Risk Management arrangements.	David Tita	31/05/2024	This action will create a better understanding and help reduce	

target risk score.					the likelihood and impact were the risk to materialise.	

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	This is a new risk that has been recently added and is being appropriately mitigated and monitored.
19/09/2023	ToR for the review of the Trust`s governance arrangements have been finalised and are progressing through governance for approval and implementation. ToR also include a schedule for undertaking the governance review and an options appraisal reflecting potential options that have been considered and a recommendation of the preferred option. Timescales for delivering the various actions have been reviewed to align with the ToR.
14/12/2023	Risk description strengthened to focus on the lack of a culture around compliance and other aspects of compliance. Some fresh causes, controls and assurance have also been added especially around the requirements which underpin the new NHS Provider Licence. Request change of due date for action BAF04/FPP/ 003 to enable aligning its implementation to the ongoing review of the Trust`s governance arrangements.
8th March 2024	A CQC Steering Committee that regularly meets has now been created to monitor and oversee ongoing pieces of work around compliance with CQC regulatory provisions, standards and Notices and safety practices.

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	Oversight Committee	
Title of risk	Potential failure to harness the dividends of partnership working for the benefits of the local population.	Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	3	9	Date added	2nd June 2023
		Risk Appetite	**Open:** Receptive to taking difficult decisions to support the achievement of the Partnership or Provider Collaborative when benefits outweigh risks. Processes, oversight / monitoring and scrutiny arrangements in place to enable considered risk taking. **Target risk score range 9-10.**			Date reviewed	**13th March 2024**

Reference / Risk ID or Number	Risk Description	Controls *Things in place to address the cause*	Gaps in Controls What are the weaknesses in the controls?	Assurances *Triangulated evidence that the controls are in place, being followed, and making a difference*	Gaps in assurance What are the weaknesses in the assurance?
BAF05/FPP	*There is a risk that the Trust may fail to harness the opportunities and dividends provided by partnership working within the system and collaborative space in delivering high quality patient-centred mental health services to the local population of Birmingham and Solihull.* This may be caused by:				
	• *Inability to embed BSOL Mental Health Provider Collaborative*	• MHPC governance architecture. • Reach Out governance architecture. • Appropriate contractual arrangements – procurement, dispute	• *Newly established groups which are working through their interface with the various governance structures.*	• Procurement Plan • CQC Reports • Other regulatory Reports. • CQRMs enabling effective management, oversight and	• *Time to mature newly developing relationships with providers requiring trust and transparency.*

		resolution, suspension and termination, decommissioning, and conflicts of interest policies. • Enhanced relationships with partners. • Multi-partner Hub. • Better engagement with partners and shared governance arrangements. • Establishment of Memorandum of Understandings. • VCFSE collective and Panel embedded into governance structure in the Collaborative. • Implementation of Data Sharing Agreements.	• *Limited number of policies in place to support contract management, ie decommissioning.* • *Newly relationships take time to nurture, grow and mature.* • *Changes to the translation of the Procurement, Patient Choice and Competition Regs 2013.*	collaboration.	
	• *Poor Commissioning Committee decision-taking.*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out	• Delays in getting signed agreements.

		architecture. • Partnership Agreement • Memorandum of Understanding.		Commissioning Sub-Committee • Escalation and assurance reporting from Executive Steering Group • Auditable process for decision-taking • Consistent attendance at CoCo Sub-Committees	
	• *Poor engagement with partners*	• Commissioning & Transformation Framework. • Co-Production Strategy.	• Co-Production Strategy yet to be developed.	• Specifications which have been co-produced • Peer Review Framework • Minutes from Executive Steering Group.	• Time required to commission effective frameworks. • Time to build trust, faith and confidence.
	This may result in:				
	• *Poor quality of services to the local population including poor patient experience.* • Dysfunctional relationships with partners and the potential reputational damage. • Failed collaborative ventures. • *Poor patient outcomes, and increased regulatory scrutiny, intervention, and enforcement action.* • *poor system engagement.* • Lack of trust, faith and confidence in BSMHFT.				
	Linked risks on the CRR-Risk ID	**Brief risk description**			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF05/FPP/004	Ownership of new and emerging risks and reporting within the Collaborative	JW	31/05/2024	This action will create awareness and help reduce the likelihood and impact of the risk were it to crystallise.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	Not applicable at this moment as risk has been newly identified.
28/09/2023	• There have been two workshops facilitated by Korn Ferries with the CYP Transformation Boards in both Birmingham and Solihull to support a re-set of the Boards including the positioning within the MHPC Governance Architecture. • Continued engagement with the VCFSE forum. • Multi-agency working groups have been established to take forward the commissioning of the Health Needs Assessment and Campaign to support the development of the BSOL MHPC Strategy.
14/12/2023	Members at the BAF review meeting recognised that partnership working is a means to an end and argued that the risk here is around the inability to land a system-wide strategy for BSOL, with enablers such as the BSOL MHPC, effective commissioning and working across the system and co-producing solutions while delivering health services to our populations in a much more impactful way.
Feb 2024	Updates on progress with mitigating and managing this BAF risk. • All Age MH HNA has been commissioned from the Centre for Mental Health which will be delivered in August 2024. • Experience of Care campaign led by Rethink Mental Illness will underway and due to be completed May 2024. • Interim Strategy for BSOL MHPC to be available in draft end of March 2024. • Co-produced All Age MH Strategy to be developed by end of March 2025. • Ongoing engagement with VCFSE Panel and Collective. • MHPC attendance at Birmingham City Councils Strategic Commissioning Group.

	• MHPC attendance at Solihull Commissioning Group meetings – monthly. • Review of governance arrangements for the inclusion of Learning Disabilities & Autism. • Determining new arrangements surrounding introduction of Procurement Selection Regime 1/1/24.

Appendix 3: Details of updated People Committee BAF

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to shape our future workforce.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	3	12	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**6 March 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF01/PC	There is a risk that the Trust may fail to deliver its ambition to shape its future workforce. This may be caused by: -				
	• *Inability to deliver the commitments of our workforce plan.* • *Difficulties with recruiting and retaining staff.* • *Staff shortage with demand outstripping supply.* • *A shrinking UK workforce market and the lack of long-term planning by government as enough staff aren`t being trained.*	Embedding of a values-led culture: • Values and Behavioral Framework • Restoration and Recovery Group • NHSE&I Quarterly Pulse Check Survey • National Annual Staff Survey • Friends and Family Test	Colleagues not completing staff and pulse surveys. Not following values and behaviours framework. People processes not being adhered to.	• Values-based recruitment • Trend for days lost to sickness absence. • Signature to the NHS Compact. • Inclusive health and wellbeing offer. • Trend for pulse check staff engagement. • Scores for motivation, ability to contribute to improvements, and	• Despite our value-based recruitment approach, some recruiting managers aren't reflecting these yet. • Feedback form, new guidance re

		Leavers surveys (exit questionnaires) Health & Wellbeing offer Model Employer	Recruiting but not retaining colleagues Turnover rate is below KPI, and staff in post is significantly increasing. Still losing staff within first 2 years, some staff groups i.e psychology and pharmacy are above turnover KPI.	recommendation of the organisation. • Staff Survey results improving to top quartile performance.	makeup of panel, and values-based questions – will be reported on a quarterly basis – possible conflict of interest as person filling in form is the chair of the interview panel, also feedback is reviewed possibly 3 months after the event • Staff survey results still reflect some gaps.
	• *Less attractive pay for some staff groups.*	Management of the workforce market: ICS workforce programme to manage demand and competition in the system in collaboration with partners.		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population	• Falling to reassurance rather than assurance

		• Membership of the ICS People Committee. • Assertive recruitment to areas with chronic vacancy challenges. • National payment mechanisms and banding panels. • Remuneration Committee. • Recruitment Policy and processes. • Stabilisation Plan • Retention Plan		• Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover • Analysis of exit interviews. • % staff who leave for a higher banded job. • Now part of a number of ICS working groups that have links to pay i.e. agency rates. • Working with NHSP to look at directly engaging with agency workers.	
	This may result in: -				
	• Failure to recruit a workforce that supports the values of the organisation. • Support the progression and development of the workforce. • An underperforming workforce. • Failure to represent the profile of the organisation within the workforce. • Sustained patterns of inequality and discrimination. • High turnover • Non-compliant behaviours. • Employee relations cases.				
	Linked risks on the CRR-Risk ID	**Brief risk description**			
	1058	Shrinking supply of mental health nurses nationally. Additionally, Difficulties in recruiting to and retaining Band 5 Registered Mental Health Nurse and shortage of experienced Band 6 Registered Mental Health Nurses continues to be a challenge (4x4=16)			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF01/PC/001	Deliver our workforce plan through: Increasing workforce supply to address workforce gaps across the organisation.	Head of Workforce Transformation	March 25	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF01/PC/002	Progressing the retention activities and improve our turnover rate.		Dec 24		
	BAF01/PC/003	Support delivery of service specific recruitment and retention plans.		Ongoing		
	BAF01/PC/004	Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.		March 25		
	BAF01/PC/005	Develop and roll out a package of First Line Management (B5-7) training that supports all aspects of the role and is supported by an action learning set infrastructure	Head of People & Culture	June 24	Training has now launched although not all modules are up and running, this is being monitored via Shaping Our Future Workforce Committee.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Work predominately in this area is progressing as planned. Volumes in relation to INR has not been achieved as projected, however this is being addressed. Despite continuous IA around junior doctor and consultant pay, recruitment to consultant posts has increased. Retention is healthy within the Trust, priority is with attraction and onboarding. Score remains the same.
12/12/2023	The likelihood score has reduced to a 3 bringing the overall risk score down to a 12, International recruitment is continuing at a steady pace. A full onboarding review has taken place with improvements identified. Work is continuing to move bank workers onto substantive contracts. Working with the ICS on areas of priority such as agency pay. Directly engaging with agency workers.

	A request for an extension of the deadline for risk BAF01/PC/005 is sought due to the delay in finalising some of the modules, therefore this is being rolled out on a phased approach with a final launch date of March 2024.
7/03/2024	A revised launch date for the first line management training programme has been identified for Apr 24. This will be monitored through Shaping the Future Workforce Committee. There have been significant numbers of Internationally educated nurses arriving who have completed or currently completing their OSCE training and are being inducted into the organisation. The workforce planning round has commenced for 24/25. Staff in post continues its upward trajectory and turnover continues to improve. Head of Workforce Transformation has started in post and will lead on this BAF risk.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Failure to deliver the Trust`s ambition of transforming its workforce culture and staff experience.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	3	12	**Date added**	**02nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**6th March 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF02/PC	There is a risk that the Trust may fail to deliver its ambition of transforming its workforce culture and staff experience. This may be caused by: -				
	• *Inability to deliver and embed staff engagement programmes.* • *Inability to improve staff engagement scores to the NHS staff survey.* • *Inability to provide a comprehensive Health and Wellbeing offer.*	• Roffey Park Leadership Programme • Active bystander training • Flourish programme. • Enough is Enough campaign. • Staff Survey • Pulse check • Patient Safety Incident response framework • Health & Wellbeing offer • HR Toolkit training	• Limited attendance at training programmes • Limited sustainability of ALS • No adherence to principles of Flourish. • Not accessing health & wellbeing offers	• Values based 360-degree feedback for senior leaders. • FTSU quarterly reports to committees. • HR casework tracker. • Staff survey results are improving in some areas. • HR KPI reports • Bespoke health & Wellbeing survey. • HR Toolkit now launched, number of key policies revised, and language changed to reflect values.	• Falling to reassurance rather than assurance.

				• Social media policy ratified. • Reframed values in practice process • Pulling together EDI and OD in relation to restorative learning and Just Culture. • Development of the corporate psychology offer.	
	This may result in: -				
	• Lack of recruitment • Reduce trust and confidence in communities. • Unmotivated workforce. • Increased bullying and harassment claims. • Increased sickness • Increased turnover				
	Linked risks on the CRR-Risk ID	Brief risk description			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
	BAF02/PC/001	Provide continuous support to operational divisions in improving the experience of our workforce.	AD OF EDI and OD	June 24	Periodic set of actions to identify and address barriers in a timely manner with escalation	

Actions being implemented to achieve target risk score.					opportunities available, locally and systemically.	
	BAF02/PC/002	Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme.	AD OF EDI and OD	Sept 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	
	BAF02/PC/003	Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes	AD OF EDI and OD	Dec 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional factors have been highlighted that add to the risk without increasing the score
12/12/2023	Likelihood risk score has been reduced due to a number of activities that have taken place over the last quarter, The HR Toolkit now launched with a number of key policies revised, and language changed to reflect values. Social media policy has been ratified and due to launch shortly. We have reframed values in practice process. Pulling together EDI and OD in relation to restorative learning and Just Culture and there has been the development of the corporate psychology offer.
March 2024	BAF02/PC/002 BAF02/PC/003 timelines may need to be extended as although underway resource to develop the infrastructure for delivery has only been fulfilled in the last 8 weeks.

Executive Lead	Executive Director of Strategy, People & Partnerships.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Inability to modernise our people practice.	**Current Risk Rating**	4	3	12		
		Target Risk Score	4	3	12	**Date added**	**2nd June 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**6th March 2024**

Reference / Risk ID or Number	Risk Description	**Controls** ***Things in place to address the cause***	**Gaps in Controls What are the weaknesses in the controls?**	**Assurances** ***Triangulated evidence that the controls are in place, being followed, and making a difference***	**Gaps in assurance What are the weaknesses in the assurance?**
BAF03/PC	There is a risk that the Trust may fail to modernise its people practice in ensuring the achievement of its operational objectives. This may be caused by: -				
	• *Inability to deliver digital solutions.* • *Inability to foster a psychologically safe environment.*	• Staff survey • Pulse check • Reflective HR casework • Transforming culture sub-committee • Systems strategy board • A range of digital platforms through which colleagues can escalate and feed in centrally. • QI Projects to address some of the	• Colleagues not completing surveys. • Capacity to undertake this work. • Low trust and confidence. • Lack of digital infrastructure.	• 360-degree feedback for senior leaders • FTSU quarterly reports to committees • HR casework tracker • Staff survey results are improving in some areas. • Improved HR KPI reports. • Audit reports • Digital Staff management system.	• Falling to reassurance rather than assurance. • Lack of engagement and buy-in from staff. • Built in evaluations to every large-scale project

		concerns raised by staff. Research and benchmarking against what good looks like. Working with ICS partners to identify shared digital solutions. Use of integrated digital solutions e.g. Digital passports.	• Lack of sufficient funding. • Lack of digital competence. • Lack of digital expertise within existing workforce resources to deliver training. • Digital solutions haven`t been embedded.	• New workforce digital group, project tracker on people goals • Trust wide audits are conducted in line with a forward planner learning lessons which will be considered for future activities.	• Audits are not systematic as they are adhoc at the moment. • local audits are more sporadic.
	This may result in: - • Poor employer brand limiting recruitment. • Staff feeling vulnerable and unable to speak up resulting in missed opportunities to improve practice. • Increased retention of a valuable workforce. • Compensation costs. • Increased regulatory scrutiny, intervention, and enforcement action.				
	Linked risks on the CRR-Risk ID	Brief risk description			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
	BAF03/PC/	Develop a range of digital solutions to streamline or automate people processes	Head of People & Culture	March 25	Periodic set of actions to identify and address barriers in a timely manner with	

Actions being implemented to achieve target risk score.	001				escalation opportunities available, locally and systemically.	
	BAF03/PC/002	Ensuring that ESR holds accurate and credible workforce data	Head of Workforce Transformation	Dec 24	Periodic set of actions to identify and address barriers in a timely manner with escalation opportunities available, locally and systemically.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
09/06/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
21/09/2023	Progress in relation to developing a range of digital solutions for our people processes has been slow due to staffing shortages, however some local work has been completed. Work is underway to address the accuracy within our ESR data and this now will be overseen by an internal workforce systems group. Score has not changed.
12/12/2023	Risk score remains the same as this is the area with least progress. A new workforce digital group has been set up, and trust wide audits are in place for any large-scale changes so lessons can be learned, however as this work has only just started we are not able to assess the impact to reduce the risk scoring.
07/03/2024	Risk score has reduced slightly, due to the work that has been completed since the last update to increase the accuracy of data and demographics of F/W requests, leavers and honorary contract status. We have received a small amount of funding from NHSE to improve ESR data quality and currently reviewing options. Work is underway on a People chat box similar to Ask Jake which will provide automated responses and sign posting for HR related queries, which is due to launch the end of March 24. Other suggested areas of improvement are now being presented and reviewed regularly by internal groups.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	4	5	20	People Committee	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Current Risk Rating**	4	4	16		
		Target Risk Score	3	4	12	**Date added**	**6th July 2023**
		Risk Appetite	**Eager:** Innovation pursued – desire to `break the mould` and challenge current working practices. High levels of devolved authority – management by trust rather than close control. **Target risk score range 12.**			**Date reviewed**	**6th March 2024**

Reference / Risk ID or Number	**Risk Description**	**Controls** *Things in place to address the cause*	**Gaps in Controls** **What are the weaknesses in the controls?**	**Assurances** *Triangulated evidence that the controls are in place, being followed, and making a difference*	**Gaps in assurance** **What are the weaknesses in the assurance?**
BAF4-PC	There is a risk that the Trust may fail in addressing racism and discrimination both behavioral and systemic across people and process. This may be caused by: -				
	• lack of focus on an enabling a anti racist, anti-discriminatory culture. • Inability to change processes that enhance discrimination. • Lack of focus on identifying and addressing workforce inequalities. • Lack of focus on identifying and addressing health inequalities.	• Values and Behavioral Framework. • FLOURISH • Data with Dignity. • Divisional Reducing Inequalities Plans. • Restorative Learning and Just Culture programme. • No Hate Zone. • Community Collaborative.	• Colleagues not engaging in controls set. • Lack of local accountability. • Not following values and behaviors framework.	• Values-based recruitment. • Workforce Race Equality Standard. • Workforce Disability Equality Standard. • Model Employer • NHSE High Impact Actions. • Pay Gap • Public Sector Equality Duty Report. • Reducing Health Inequalities Program • Patient Carer Race Equality Framework.	• Gaps in ensuring appropriate capacity and resource is assigned and maintained to mitigate the risk. • Gaps currently in maintain pace and sustainability of positive changes. • Gaps in ensuring measurements are fit for purpose, particularly relating

				• Staff Survey results improving to top quartile performance. • EDI Improvement plan • Triangulating data in transforming culture reporting.	to health inequalities. • Falling to reassurance rather than assurance.
	This may result in: - • *Sickness and recruitment challenges.* • *Lack of engagement.* • *Loss of trust and confidence with communities.* • Services that do not reflect the needs of service users and carers. • Inequality across patient population. • Workforce that is not culturally competent to support populations and colleagues.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			
	N/A	N/A			

Actions implemented to mitigate risk to attain target risk score and to address the gaps in the controls and assurance.

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve	BAF04/PC/ 001	Develop and implement a clear reducing health inequalities programme, moving from programmes approach to BAU.	AD OF EDI	31/07/2024	Action will mitigate potential likelihood of risk materialising.	
	BAF04/PC/ 002	Develop and implement infrastructure to identify and address Racism and Discrimination across the Trust.	AD OF EDI	30/09/2024	Action will mitigate potential likelihood of risk materialising.	

target risk score.	BAF04/PC/ 003	Take PCREF from pilot to full implementation.	AD OF EDI	31/03/2025	Action will mitigate potential likelihood of risk materialising.	

Progress since last Board/Committee review/scrutiny of risk:

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
06/07/2023	This risk has been newly identified; hence, no progress has been made of now with mitigating and managing it as of now.
22/09/2023	Additional assurance available from the NHS EDI Improvement plan, score remains.
12/12/2023	PCREF is currently only understood fully in our pilot areas of secure care, talking therapies and perinatal. Further work is required to socialise to the rest of the organisation by way of communications plan, launch event and EDI team site visits.
March 2024	BAF04/PC/001 Delays with engagement have resulted in a timelapse with projected end date of May 2024. BAF04/PC/002 Anti Racist infrastructure being socialised via the behavioural framework, 1st element has been released, with roll out being spread across the year. BAF04/PC/003 Some delays experienced with the co-production, full implementation will be realised by April 2025.

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 June 2024**
Date(s) of Committee Meeting(s) reported	**22 May 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Review of the Trust Corporate Risk Register • CQC Update and Action Plan Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control Team Report • Right Care Right Person • Integrated Performance Report • Clinical Governance Committee Report • Findings from the Manchester and Nottingham Review • Safeguarding Management Board Update • PFD Review Update • Community Mental Health Service User Survey 2023 • Mental Health Legislation Update • Quality Improvement Update • Strategy update – Clinical Services Priority – Q4 2023/24 and 2024/25 goals • Strategy update – Quality Priority – Q4 2023/24 and 2024/25 goals • Quality Account
Alert:	The Committee received the key findings from the Greater Manchester Mental Health Trust and Nottinghamshire Healthcare NHS Foundation Trust Special Reviews and actions being taken by the BSMHFT in light of the findings. Given the seriousness of the reviews, the applicable findings, and likely national impact on how mental health services are viewed/reviewed the Committee noted and approved the recommendation actions. The Committee received the Mental Health Community Service User Survey 2023 noting the Trust has been identified as performing 'worse than expected'. The Committee noted concerns within the Infection Prevention Control specialist capacity will soon be reduced to 25% due to 2 staff members leaving the Trust and 1 maternity leave. Recruitment has taken place, timelines being agreed. The Committee noted serious concerns as the Quality Account Report was not submitted for approval. An extraordinary Committee would be arranged to review the accounts and approve before final submission to the Board of Directors.

Assure:	The Committee was assured on the following key areas: • The Board Assurance Framework continued to be developed and a deep dive had been scheduled for June's Committee meeting. • The Corporate Risk Register continued to be developed and risks have been reviewed and a number reduced in score rating. • The Committee was assured that the Right Care Right Person pilot had been successful with a number of improvements being made alongside strengthening partnerships with West Midlands Police. The Committee was assured there had been a number of tactical workshops and a Strategic Board established with representation across a variety of key stakeholders. • The Committee was assured that although Quarter 4 remained a very busy period for the department, 67% of all admissions being detentions under the MHA and an average of 940 people under detention per month of the quarter, there was a continued reduction in the number of incidents reported and only 1 formal complaint from detained patients. • The Committee was assured having received the overview of Quality Improvement activity across the Trust in Quarter 4 that the processes were underpinning overall improvements across the Trust and divisions were being supported by the teams with individuals nominated for service areas. • The Committee was assured although there have been recent Preventing Future Deaths received from the Coroner, the Trust had robust systems in place to address the concerns and recommendations and all timelines for responses have been met. • The Committee was assured by the Clinical Services and Quality strategy update and approved the goals for 2024/25.	
Advise:	• The Committee received the Safeguarding Management Board Update with no concerns and agreed to receive this on a quarterly basis.	
Board Assurance Framework	The Committee acknowledged the need for the Board Assurance Framework to be simplified at pace using the intelligence from the Risk Management Group. The group are leading on the changes to review the current ratings and recommendations for closure of risks.	
	New risks identified: No new risks were identified.	
Report compiled by:	Linda Cullen, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**7 June 2024**
Date(s) of Committee Meeting(s) reported	**17 April 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Review of the Trust Corporate Risk Register • CQC Update and Action Plan Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control Team Report • Board Briefing: Jacob Billington Inquest • Right Care Right Person • Integrated Performance Report • Clinical Governance Committee Report • Community Treatment Order • Quality Account schedule
Alert:	The Committee received the Community Treatment Orders (CTO) report noting the Trust undertook a comprehensive service evaluation involving separate focus groups of patients, carers, RCs (consultant psychiatrists), AMHPS, lay managers and mental health legislation administrators and a psychiatrist led case note review of 40 case notes of patients on CTO. The Trust's specific results clearly demonstrated that the Trust clinicians adhere to the Mental health act and its code of practice in nearly all cases. Strong adherence to the Mental health act and code of practice in itself does not reduce the racial disproportionality in the use of CTOs. The Committee acknowledged the recommendation to nominate at least half of Non-Executive Directors to act as Hospital Managers in lay manger hearings in making discharge or detention decisions. Further discussions in relation to which Non- Executive Directors will support are ongoing. The Committee noted the additional costs required and need to confirm the timescale for implementation. A full report will be shared with the Board of Directors in the coming months. The Committee received the Infection Prevention & Control Team Report and noted the significant risks due to staff promotions meaning 75% of the team will be leaving the Trust. Vacancies have been advertised and the team are exploring opportunities for internal secondments.

	The Committee noted the ongoing concerns in relation to supervision. The Committee highlighted the need for accountability and agreed expected improvements to be reported by July 2024.	
Assure:	The Committee was assured on the following key areas: • The Board Assurance Framework continues to be developed and a deep dive has been scheduled for June's Committee meeting. • The Corporate Risk Register continues to be developed and risks rated 15 and above will be reviewed through a deep dive. • The ongoing action plans for the CQC continue to provide assurance. • The formal response to the Coroner in relation to the Jacob Billington request will be submitted in line with the deadline set. • The Integrated Performance report highlighted ongoing improvements.	
Advise:	• The Committee received a verbal update on 'Right Care, Right Person' and acknowledged the ongoing work being developed to provide the Trust with assurances that the relationships with police colleagues will remain positive and support will be in place for section 135/ 136's. Risks were noted and a full report will be bought to the Board of Directors in June to highlight further developments in line with good governance.	
Board Assurance Framework	The Committee acknowledged the need for the Board Assurance Framework to be simplified at pace using the intelligence from the Risk Management Group. The group are leading on the changes to review the current ratings and recommendations for closure of risks.	
	New risks identified: No new risks were identified.	
Report compiled by:	Winston Weir, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Report to Board of Directors							
Agenda item:	**10**						
Date	5 June 2024						
Title	Patient Safety and Experience Report						
Author/Presenter	Lisa Pim, Acting Deputy Chief Nurse						
Executive Director	Sarah Bloomfield, Interim Chief Nurse	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report					
Alert		**Advise**		**Assure**	✓

Purpose

This report provides an overview of patient safety and complaints activity within the quarter, whilst also addressing health inequalities where possible.

Introduction

This quarterly report will outline the learning responses commissioned by the local safety panels and any associated learning outcomes. Additionally, it will provide commentary on the safety metrics defined by the Trust. Further information is highlighted in relation to Customer Relations metrics including a quarterly thematic review.

Key Areas of Note

Patient Safety

- The Trust adopted various PSIRF learning responses in line with its Patient Safety Incident Response Plan, this includes After-Action Reviews, MDT Reviews, and Structured Judgement Reviews. There are 36 active learning responses, encompassing a diverse range of incidents and patient deaths, which aim to enhance patient safety through in-depth analysis and improvement strategies. All learning responses are commissioned directly through Local Safety Panels.
- Learning analysis to date, shows a recurring theme is that although staff undergo specialised training, the infrequency of its application results in gaps in knowledge. This has resulted in staff being asked to work with service users when they do not always feel adequately equipped to do so or up to date in their knowledge. For instance, topics such as wound care prevention in acute wards, trauma informed skills in PICU and drug and alcohol management have been highlighted as areas of concerns.
- There are currently 26 overdue serious incident actions a reduction from 72 in previous quarter.
- Seven external reviews are summarised as part of the paper, including a number of ongoing and completed reviews. In-depth reviews, including the H review, uncovered a number of systemic issues. Actions taken include updating operating procedures for prisoner discharge and redefining roles within mental health services. Other reviews highlight gaps in service delivery, communication, and documentation.
- A high-profile inquest held in March related to JB has resulted in the coroner issuing a multi-agency

Prevention of Future Deaths Notice. Key concerns relate to Management of prisoner release and lack of interagency working; SystemOne details of the perpetrators GP and local CMHT not recorded in an easily accessible format; Cross agency guidance regarding release of high-risk prisoners with mental health difficulties at their sentence end date; Lack of understanding of the MAPPA prison discharge role.

- A thematic summary of eight PFD's issued to the Trust over the last 2 years, three within the last quarter, is also contained within the report.
- 8897 incidents were reported on the eclipse system, since the transition to LFPSE (Learning From patient Safety Events), staff have been able to report psychological harm, which has resulted in an increase in the harm level.
- There is a dashboard now available on insight for RRP (reducing restrictive practice) for all to access. This dashboard approach is being considered for patients safety incidents overall.
- The use of restraint continues to be reported within the mean, with 10 consecutive months below the mean
- The number of prone restraints has also seen a downward trend
- There has been a reduction in staff assaults reported during the quarter
- It has been highlighted in some clinical areas that staff are becoming disheartened with reporting such incidents to the police
- A number of local incidents are awaiting managerial closure, application of the new Quality Metrics Dashboard to improvement of these metrics has now been rolled out and commenced in all Directorates.
- The report further details the success of the implementation of Safety Summits across the Trust. Safety Summits were introduced as a strategic initiative. These summits offer a structured environment for senior leaders to collaboratively address concerns, share information, and review safety-related issues. The paper elaborates on the Safety Summits conducted on Eden PICU, Zinnia, Reaside, and a focused summit on Clozapine including the outputs from the process.
- As a further safety initiative, the Trust has introduced the Enhanced Monitoring Framework for wards or clinical areas in need of immediate intervention and support. The next Board Report will elaborate on this framework in more detail including areas within the Trust that have piloted this approach, the outcomes of this initiative, and the feedback of staff involved.

Customer Relations

- The Customer Relations Team are focusing on trying to address the majority of concerns via PALS in order to improve service user and family response times and reduce the number of formal complaints. It is hoped that there will be a sustained increase in PALS cases, which will lead to a reduction in formal complaints reflected in the figures in coming months. It is noted that this month the Trust have had 3 newly registered complaints which is the lowest monthly level seen in the last 2 years and is part of a continued downward trend in formal complaints over the last 3 months.
- There are currently 38 open formal complaints, with 16 awaiting allocation of an investigating officer (IO), this amounts to 42%, and this is a decrease of 1 since the previous month, and an improvement in overall performance from 68% awaiting an IO.
- The average number of working days to allocate an IO is 79.3 which is a large improvement of 19.4 working days from the previous month (98.7 last month). The average age of a case has also improved it is now 79.3 a decrease of 8.3 working days (87.6 last month)
- A trajectory for closure of aged complaints over 6 months is detailed within the paper and is on track
- The position for open complaints actions is also evidencing a positive picture peaking at 60 open actions within the Trust 5 months ago to a current position of just 9 this month. This evidences the hard work and focus of the Divisions working in collaboration with the Customer Relations Team in overseeing and closing complaints actions promptly.

- The quarterly thematic review from Customer Relations reveals the following;
    - In quarter 4 the team registered 221 PALS cases, which is 60 more than the previous quarter, and 19 formal complaints. Proportionately, 8% of concerns were formal complaints, in comparison to 11% in the previous quarter.
    - 54% of complainants were female, this is reflective of the previous quarters data
    - The overall majority of complainants are recorded as white. When understanding the ethnicities of service users who have accessed the Trust within the last 12 months, we know that 19.9% were Asian/Asian British, whereas only 14.7% of the complainants were Asian/Asian British. Furthermore 7.9% of service users who have accessed the Trust within the last 12 months were Black/Black British, but 12.9% of complainants were Black/Black British.
    - The most common theme for all concerns and complaints is communication, this is reflective of previous months reports. Followed by Access to Treatment or Drugs, and Staff Values and Behaviours.
- On initial review of the data around ethnicities, it is apparent there are some disparities between the number of complaints received, compared to the proportion of different ethnicities the Trust serves. The Team have also received qualitative feedback around access and patient experience of the complaints service, particularly for those who are from a BAME (Black & minority ethnic) background. For this reason, the team are going to undertake a deep dive analysis into the data around ethnicities and the type of complaints received, in order to improve the customer relations service as well as provide thematic feedback to clinical services.
- In FFT, staff was the main positive theme with 133 (45%) of the positive feedback. Waiting time was the main improvement theme with 21 (18%), support had 14 (12%) and environment had 13 (11%).
- To support triangulation of the report the Patient Experience Team have been asked to contribute to monthly reporting to CGC and QPESC, this will commence from July.

Recommendation

Trust Board are asked to asked to note the contents of the report and agree the level of assurance that can be taken from the detailed analysis of activity and learning in the report

Enclosures

N/A

Patient Safety and Experience Report

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	
People		
Quality	✓	
Sustainability		

Patient Safety

1.0 Introduction

As a Trust we prioritise delivering person centred care, continually learning from incidents, and adapting our service to address the way we care for people. Service user demographics play a crucial role in tailoring healthcare so that it is safe and effective, recognising our service user protective characteristics and diverse need is crucial to this.

In our trust, service user demographics vary:

- Age 16 or less: Less than 2%
- Age 25-34 and 45-54: Highest
- Age 85 and plus: Approximately 4.9%
- Just over 50% are women
- 59.73% of our service users are white
- 16.91% Asian
- 7.1 % Black/Black British
- 4.2% with a recorded disability

Furthermore, our trust operates in Birmingham, a city that faces its own set of challenges. According to the latest Index of Multiple Deprivation (IMD) Birmingham is ranked as the 3rd most deprived core city in the country, where 54% of our service users coming from the most deprived areas. This information demonstrates the importance of our desire to provide equitable and accessible services, especially to those who may be disproportionately affected by socio-economic disparities and as a Trust we have identified a number of work streams to support the reduction of health inequalities.

In this quarter's report, an overview of the safety metrics for Quarter 4 will be provided, highlighting trends and patterns. While efforts have identified health inequalities in certain areas, the ability to offer thorough insights into these metrics is currently limited, given the absence of automated data analysis dashboards. However, it is important to acknowledge the work that the Information Team have undertaken to successfully develop the RRP dashboard, with plans to expand its capabilities to include searches and staff and service user assaults. However, to

extend these insightful analytics to cover additional incident types, executive sponsorship is essential, to ensure we are using data driven approaches to address health equalities and enhance patient safety.

2.0 Serious Incidents

During the quarter 10 serious incident reports were closed, including 4 during March from which there was learning identified surrounding the management of wounds and wound care. At the time of writing this report there is 1 incident which remains open, which is due for closure at the end of May.

All families where details are available will be invited to participate in the review and offered the support of the Family Liaison Officer. Staff involved will be provided with literature signposting them where they access support and reminded of the 'Just Culture' within which the Trust operates.

There are currently 26 overdue actions a reduction from 72 in previous quarter. A new Quality KPI Dashboard has been created and is shared as part of Directorate Deep-Dives. This dashboard details metrics including overdue SI Actions where Directorates are required to produce trajectories for improvement.

3.0 PSIRF – Learning Responses

PSIRF allows the trust to apply the most proportionate response to each event, without just focussing on the harm caused. Newly Adopted Learning Responses

The Board may recall that a number of defined "Learning Responses" were approved as part of the Trust Patient Safety Incident Response Plan (PSIRP). These were;

After Action Reviews

This is a method used for evaluating the outcomes of healthcare activities or events, especially those that were particularly successful or unsuccessful. It aims to capture essential learnings from these experiences to avoid future failures and promote success. AARs are included in the PSIRF as a tool to enhance learning from incidents and events in healthcare settings.

The process involves four key questions:

1. What was the expected outcome?

2. What was the actual outcome or what actually happened?

3. What went well and why?

4. What can be learned and how can it be applied?

AARs have been proven to be effective because they involve active self-learning, have a developmental intent rather than being punitive, focus on specific events for deeper examination, and utilize multiple information sources for a comprehensive understanding of incidents. This approach not only improves individual and team performance but also contributes significantly to patient safety.

Multi-Disciplinary Team (MDT) Reviews

This approach involves a collaborative team from various professional groups, such as doctors, nurses, and pharmacists, to evaluate and learn from patient safety incidents.

The MDT review is designed to support these teams in identifying learnings from multiple patient safety incidents. It focuses on recognising key contributory factors and gaps in the system related to patient safety. This can involve exploring specific safety themes, pathways, or processes, and gaining insights into the actual workings of the health and social care system.

The overall goal of the MDT learning response under PSIRF is to create a more comprehensive and system-wide understanding of patient safety incidents. By involving a diverse group of professionals, it allows for a richer understanding of the various factors contributing to such incidents and the development of more effective strategies to prevent them in the future.

Structured Judgement Reviews (SJRs)

Whilst not strictly a "learning response" as a process held within the Learning From Deaths process it enables wider learning and may be a trigger for the application of a further detailed learning response. It is a method used in healthcare for reviewing patient deaths. It is conducted by an individual and comprises two main components: providing explicit judgment comments on the quality of care and applying care quality scores. This process is applied to various phases of care, such as admission, ongoing care, end-of-life care, and an overall assessment of care. The aim is to review the care received by patients who have died, enabling learning, and supporting quality improvement initiatives, particularly when issues in care are identified

At the time of writing the AAR (after action review) and MDT (multi-disciplinary team) approach are the most utilised. As the safety panels mature, we will look to see how we introduce Hot Debrief, Horizon Scanning and Thematic Reviews as learning responses.

3.1 After Action Reviews and MDTs

The table below shows the number of AARs, and MDTs commissioned during quarter 4, all staff are invited to participate, and sign posted to well-being support. However, there is a review of the offer of post incident support to staff.

	ACUTE CARE	ICCR	SCOH	D&S	URGENT CARE	TOTAL
AAR	2	0	1	5	0	8
MDT	3	0	0	1	1	5
TOTAL	5	0	1	6	1	13

Learning analysis to date, shows a recurring theme is that although our staff undergo specialised training, the infrequency of its application results in gaps in knowledge. This has resulted in staff being asked to work with service users when they do not always feel adequately equipped to do so or up to date in their knowledge. For instance, topics such as wound care prevention in acute wards, trauma informed skills in PICU and drug and alcohol management have been highlighted as areas of concerns.

It was highlighted in one review there was an absence of assessment tools in the clinical system in RIO, as well as prompts within forms. Furthermore, shortcomings in the governance of secure transport have been highlighted. All learning has associated local improvement plans which will be monitored through local governance arrangements.

To date there have been 3 PSII (patient safety incident investigations) commissioned by the Oversight Panel which relate to the following priorities within the Response Plan:

- Incidents where harm has occurred where care is fragmented/multiple contacts across the pathways.
- Lack of family involvement, not taking on board warnings or concerns.
- Harm to a service user with an emerging risk and no management/escalation plan in place.

4.0 Local Incident Reporting

There were 8897 incidents reported during the quarter, with increases in assaults and self-harm noted. It is noted that since the transitioning to LFPSE, staff are now able to identify both physical and psychological harm, leading to an increase in reported harm levels, particularly in psychological harm, which historically had not been accounted for. The incident management system has recently received an update that allows physical and psychological harm to be reported separately, providing more accurate insights, however, we need to construct the report within the system to utilise the capability effectively. It is anticipated that this work will be completed by the end of May 2024.

Among the reported incidents 16 suspected suicides have been reported, as well as 1 death whilst on S17 leave, 1 death following transfer to general hospital and 1 death where concerns have been raised by the family, each of which will undergo a Structured Judgement Review (SJR), which will be covered in the separate Learning from Deaths report.

Graph 1 – Incident Reporting

Graph 2 - Incidents resulting in harm

Since the transition to Learning From Patient Safety Excellence (LFPSE), staff have been able to report psychological harm, which has resulted in an increase in the harm level. For further assurance, in the next report to Trust we will look to break down the data further to evidence the percent of moderate harm identified as “psychological harm”

4.1 Community Suicides

In the 12 months preceding March 2024, 8 suicides have been confirmed through the inquest process. There are 14 inquests scheduled to take place for those incidents reported as a suspected suicide. There is a more detailed report surrounding inquests produced by the legal team.

Historic information has evidenced established risk factors for suicide, such as previous self-harm, drug and alcohol misuse, multiple mental health diagnoses. In addition, suspected suicides during the pandemic show experiences of isolation or disruption in care may have contributed to some of the suspected suicides.

Confirmed suicides have shown a correlation with the findings of the National Confidential Inquiry into Suicide particularly in relation to being more prevalent among white male in middle age.

The Trust has a suicide prevention strategy led by CD (Clinical Director) Kerry Webb and progress on outcome will feed regularly into Clinical Governance Committee and QPESC.

Graph 3 – Confirmed Suicides

4.2 Restraint

The use of restraint continues to be reported below the mean, marking the 10th consecutive reporting period below the average, with a total of 850 incidents being recorded during the quarter and 15 per 1000 bed days.

There are various clinical factors to account for the use of restraint, for example IM (intra-muscular) medication being used instead of the oral form, due to the service user not accepting the oral medication, to administer NG (nasogastric tube) feed. There are often other specific factors that underlie increases of use of restrictive interventions and the local services, along with the AVERTS consultants, review this on a regular basis, in addition to the RRPSG (reducing restrictive practice steering group).

Additionally, a new dashboard is now available in Insight. The dashboard is designed to be accessible, enabling everyone from ward staff to board members to view, analyse their data effectively to facilitate proactive measures to enhance safety and care.

The data reveals that out of the 850 incidents, 545 of the service users were white and the majority of incidents occurred amongst people aged between 19-44 with a higher proportion being women. According to the IMD (indices of multiple deprivation – official measure of relative deprivation for small areas in England based on a number of domains), a significant proportion of people involved in these incidents live in the most deprived postcodes.

Prone: Prone restraint continues to be decrease below the mean this quarter, reflecting ongoing efforts to minimise the use of this intervention. The service users involved in these incidents were mainly between the ages of 25-34, with a high number being white (69) followed by Asian/Asian British (24) and Black/Black British (28). Furthermore, many of these service users live in the most deprived postcodes according to IMD data.

Graph 4 – Prone Restraint

Physical: There were 703 reported incidences of restraint during the month which includes the prone incidents documented above. Of the 596 non prone restraints the majority involved female service users, with 20 incidents involving non-binary service users. Amongst these service users the largest demographic group was people aged between 19-34 making up the majority. Following this age group, there were 78 incidents involving people aged 65-74. Once again the IMD data indicates a high proportion of service users involved in these incidents living in the most deprived postcodes, followed by service users living in areas ranked within the fifth area of deprivation.

Graph 5 – Physical Restraint (Non-Prone)

4.3 Inpatient Assaults Staff and Inpatients Assaults on Patients

The RRP steering group reviews staff and patient assault data. The evidence from the data shows the current trends regarding assaults of staff, are above the mean- this is a statistically significant increase compared to the baseline.

To reduce the number of staff assaults there has also been the introduction of a staff assault work stream through the RRP as many assaults result from some form of restrictive intervention. The key themes of work are:

- to fully implement processes of Operation Stonethwaite
- to reduce the risk factors leading to conflict and staff assault
- improve access to clear data of staff assaults and process monitoring
- ensure that there is a robust learning system from assaults, leading to improvements

During the recent RRP meeting, concerns were raised regarding staff perceptions of reporting incidents of to the police, as there were some doubts about the effectiveness of reporting, believing that little action was taken, or they became disillusioned due to the length of time prosecution takes. It was highlighted that assaults reported to the police are now investigated under general investigation procedure since the model change in the police force in April 2024. To support the culture of reporting, Ardenleigh has introduced champions which has played a vital role in encouraging and supporting staff. Furthermore, there plans for Ardenleigh team to have anti-racism supervision

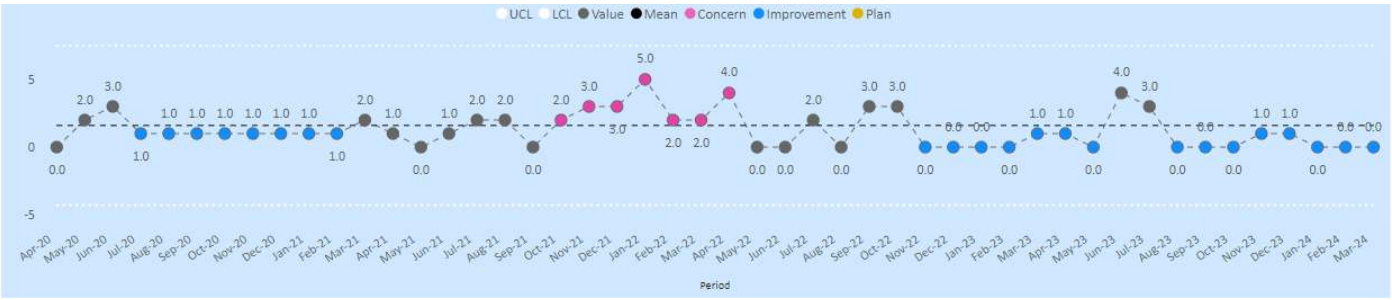
facilitated by the EDI (equality, diversity & inclusion) team, to address staff concerns and promote a supportive working environment.

Patient Assaults: During the quarter, there were 117 reported patient assaults, with a monthly mean of 46, consistently occurring at or below this average. These incidents predominately took place in acute care and secure care settings. Further in-depth work will be undertaken through the RRP which operates as part of the health inequalities work stream.

4.4 Ligature Incidents

During the quarter there were 87 ligature incidents reported, predominately occurring in acute and forensic female services, which is below the monthly mean of 35. Notably, none of these incidents involve anchor points.

Graph 6 – Ligature Incidents (With Anchor)



Current work underway.

- Roll out of ensuite door alarm systems.
- Roll out of bedroom door alarm system on high-risk wards (Larimar, Melissa and Citrine all programmed for this financial year)
- Reviewing therapeutic observation practice
- Reviewing safe staffing levels and implementing daily staffing huddles
- Rolling out additional therapeutic activities

Graph 7 – Ligature Incidents Overall

4.5 Absconsions

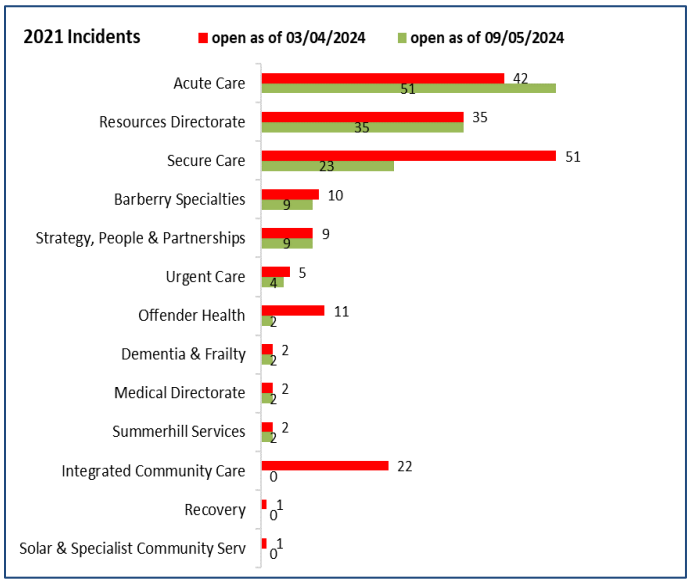
During the quarter there were 12 reported absconsions from inpatient units, with incidents been recorded above the mean in February 2024, with no incidents being recorded, 7 of which were within Acute Care Services. No harm was caused to these service users and policy was followed on all occasions.

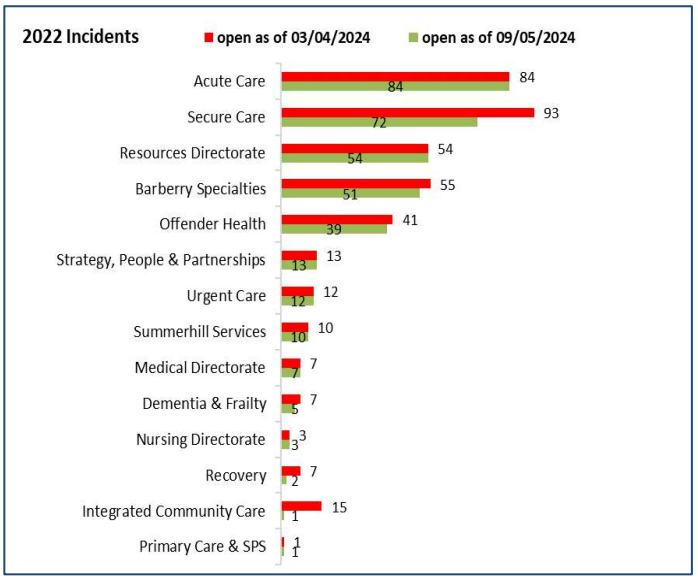
Graph 8 - Absconsions

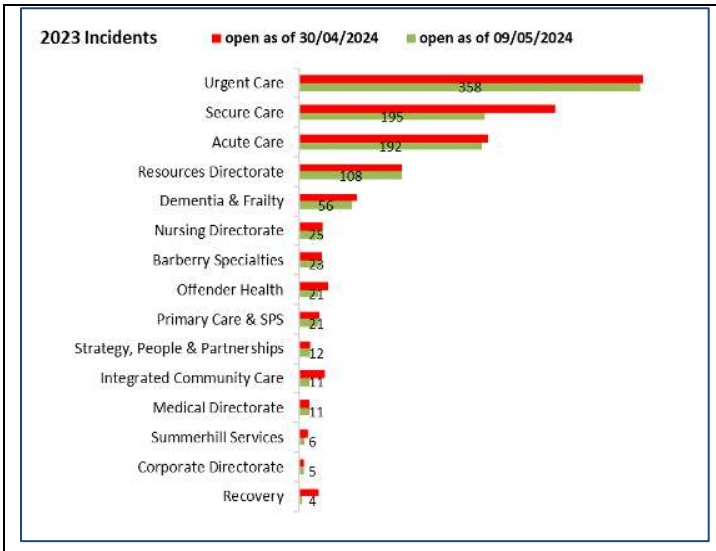
4.6 Delayed Closure of Local incidents

There are currently 3863 incidents identified as currently awaiting managers sign off. Delay in timely closure of incidents leads to staff not feeling valued, a lack of assurance regarding lessons learned and leads to a risk of increased incidence of harm. The graphs below indicate the current numbers of incidents awaiting closure by Division;

Graph 9, 10, and 11 – Open Incidents by Year







Trajectories for closure of local incident investigations are tracked and monitored through the Directorate Deep-Dive Process.

5.0 External Reviews

A summary of seven external reviews are detailed as part of this paper, including one that has been recently published.

Review of H (Birmingham City Centre Stabbings)

- Incident: Multiple stabbings by a service user, H, on September 6, 2020.
- Key Findings For the Trust: Outdated service description for BSMHFT Prison Discharge Service, unclear roles, and responsibilities of CPNs and CMHT care coordinators, ineffective liaison with prison MHITs and MAPPA.
- Action Taken: Review and drafting of a new SOP for the prison discharge service, addressing identified gaps. This has been completed and is now going through Trust governance processes.

This incident has also the subject of an inquest held in March for the victim JB. A PFD has been issued to the Trust following the inquest and will be detailed later in the paper.

Pathway Audit for AOT and FIRST (Domestic Homicide Incidents)

- Background/Incident: Response to two domestic homicide incidents in 2014.
- Audit Findings: Low compliance in areas such as up-to-date CPA care plans, risk assessments, information on carers, and adherence to medication plans.
- Learning Points: Issues in recalling service users on CTOs, lack of updated care plans, noncompliance in risk assessment, and inadequate domestic abuse risk identification and management.
- Progress: A pre-publication meeting was held on the 29th of January 2024, and it was proposed that the report be published the week commencing the 8th of April 2024. It was agreed that the Trust would draft an executive summary and include the action plan detailing progress made to date, with the intention of publication on the NHSE and Trust website. An action plan in place, monitored through the Patient Safety Advisory Group and led by the safeguarding team.

Pathway Audit for Acute and Urgent Care

- Focus: Review of service provision and risk escalation processes in response to a 2018 homicide.
- Key Areas: Access to AMHP services, listening to relatives, and Regulation 28 report requirements.

- Status: Report is currently delayed, pending interaction with local authorities and the victim's family.

Homicide Review for Young Person at Ardenleigh

- Incident: Attempted murder by a young person on extended Section 17 leave in November 2022.
- Focus: Quality of NHS care, treatment, discharge arrangements, and service availability.
- Current Status: Initial draft received, under review for clinical feedback.

Death of a Baby – Review of Mother HS

- Incident: Death of a 14-month-old baby, with mother HS detained under the Mental Health Act.
- Investigation: Conducted alongside LCSPR by NICHE.
- Findings: 16 recommendations, six relating to BSMHFT, focusing on perinatal mental health service assessment, contingency planning, policy on working with interpreters, CPA and RCP standards, clinical formulation, and risk management.
- Progress: Safeguarding team reviewing the report for accuracy.

Homicide within the Community (STEIS 2023/13405)

- Incident: Arrest for murder by a service user in July 2023.
- Investigation: Under the guidance of NHS Serious Incident Framework and Article 2 of the ECHR.
- Current Status: Draft report under review, completion anticipated by end of March.

Homicide within the Community (STEIS 2022/14284)

- Incident: Arrest for murder following an assault on a male partner in July 2022.
- Status: Awaiting findings of NHSE's Domestic Homicide Review to avoid duplication.

6.0 Prevention Of Future Deaths Reporting (PFD)

The Coroners and Justice Act 2009 enables coroners to issue Prevention of Future Deaths (PFD) reports to various entities including individuals, organisations, and government departments. These reports are issued when a coroner identifies actionable measures that could prevent future deaths. Over the past two years, the HM Coroner has issued eight PFD notices to the Trust, three of which were issued in the last quarter. It is crucial to recognize that the issues identified equally transcend our organisation, involving adjacent healthcare trusts and other government agencies, NHSEI (NHS England & Improvements), and the Integrated Care System (ICS).

6.1 Themes and Learning from PFD Reviews

More in-depth analysis of the PFDs reveal further themes and trends emerging from the reports;

- Communication and Information Sharing: Enhancements in shared care platforms and clarification of roles are recommended to bridge gaps in patient care.
- Resources and Capacity: Addressing limitations in inpatient beds, care coordination, and pharmacy resources to improve service delivery.
- Assessments and Monitoring: Implementing comprehensive risk assessment processes and improving monitoring protocols.
- Policies and Procedures: Updating and reinforcing compliance with established medical protocols and procedures.

- Training and Education: Strengthening staff training on critical areas such as medication management and inter-agency operations.

6.2 Actions and Progress

The Trust has initiated several actions in response to PFD notices, with significant progress made in 14 out of 20 actions. These include:

- Enhancing the S136 process with police collaboration.
- Implementing the Dialog Plus Care Planning tool across the Trust.
- Developing a systematic safety incident response plan.
- Comprehensive thematic reviews to enhance learning and prevent recurrence of incidents.
- Specialised training and the establishment of dedicated teams for medication management.

Despite this progress, challenges remain in identifying responsible leads for five actions, primarily involving system-wide responses. Efforts are ongoing to define accountability and ensure comprehensive resolution.

6.3. Governance and Oversight

The variability in the quality of action plans and oversight has prompted the introduction of a standard operating procedure (SOP) for managing PFDs, which is in the draft phase and will soon be integrated into Trust governance frameworks. This SOP aims to standardise responses and improve monitoring and compliance.

It is also proposed that oversight of PFDs and associated actions is moved to the Learning From Deaths Advisory Group where scrutiny of actions stemming from PFDs can be applied with rigour alongside the monitoring of regular updates on progress.

Where Divisions have nominated actions from the PFDs, strengthening of local divisional oversight will be facilitated through the Clinical Governance Facilitators and their monthly reports to local CGCs.

In addition, action plans stemming from PFDs will be captured on a specific module attached to Eclipse which will also act as a central repository for evidence.

Upward reporting from LFD Group to CGC and QPESC will enable ward to board reporting on PFD progress and learning at regular intervals.

6.4 New PFD – JB Inquest

Following the inquest into JB, a multi-agency Prevention of Future Deaths (PFD) was issued by the Coroner to;

- G4S
- Birmingham and Solihull NHS Foundation Trust
- HMPPS
- Chief Constable for West Midlands Police
- Swansea Bay University Health Board

Matters of Concern included;

- *Management of release and lack of interagency working*

The management of the perpetrators release was not coordinated and there was inadequate communication between relevant agencies. In effect agencies worked in silos. The failure to share information led to a concern of future deaths as high risk seriously unwell prisoners may be released without key agencies knowing where they are meaning they are not traced and treated assertively in the community.

- *SystemOne Details of the perpetrators GP and local CMHT were not recorded in an easily accessible format*
- *Cross agency guidance regarding release of high-risk prisoners with mental health difficulties at their sentence end date.*
  There were no provisions available nor any cross-agency guidance in place for when a high-risk prisoner is released at sentence end date to ensure that there is adequate release planning and maximum support in the community.
- *West Midlands MAPPA has a prison discharge coordinator role.*
  It was clear from the evidence at the inquest that this role was not fully understood by other agencies and what information needed to be shared was not clear.

A response has now been submitted to the Coroner on behalf of the Trust and work is being led by the Deputy Medical Director for Quality and Safety.

7.0 Safety Summits

To enhance patient safety within the organisation, Safety Summits were introduced as a strategic initiative. These summits offer a structured environment for senior leaders to collaboratively address concerns, share information, and review safety-related issues.

7.1 Objectives and Methods

Safety Summits aim to:

1. Provide focused attention to raised concerns, sharing intelligence and information with service providers where quality risks are identified.

2. Encourage open, honest discussions about concerns.

3. Foster open and constructive challenges.

4. Agree on necessary actions in response to identified risks.

Since their inception, four summits have been conducted, with continuous refinement of our approach based on insights from participating teams and feedback from the Patient Safety Team.

7.3 Key Summits and Outcomes

<u>Eden PICU Summit (May 2023)</u>

Focused on evaluating the safety climate within the ward environment. Outcomes included a quality improvement project for skill mix in safe care, piloting PSIRF learning responses, and enhancing skills in therapeutic observations.

Follow-up Meeting: Reviewed progress on safer staffing models and piloting of pharmacy technicians, impacting medication management and MDT reviews. This progress is due for further impact assessment. Clinical educators have also worked on improving therapeutic observation practices.

Clozapine Summit (June 2023)

Triggered by a Prevention of Future Deaths notice, this summit led to the formation of a working group to review guidelines and monitoring practices for clozapine management.

Zinnia CMHT Summit (January 2024)

Addressed concerns from a recent Prevention of Future Deaths notice and serious incident clusters. Focus areas identified include training for reception staff, assigning dual staff members for support, and reflective practice sessions.

Safety Summit at Reaside (January 2024)

Following a serious incident involving a staff member and a sharp object, this summit addressed concerns in sharps management and the broader aspects of secure care.

Outcomes from the Summit have included;

Service Plan Review: Integration of 21 action plans into 6 workstreams: Staff Experience, Service User Experience, Family and Carer Experience, Clinical Effectiveness, Communication, and Reaside Development.

Implementation Strategy: Use of 'plans on a page' and driver diagrams for each workstream, overseen by task and finish groups.

Governance and Sponsorship: Recommendation for each workstream to have a designated sponsor. Review of governance structures for effective oversight.

7.4 Future Direction

Safety Summits will continue in the next financial year as a core component of the safety and improvement framework. Anticipated to be integral to our quality goals for 2024/25, these summits will play a crucial role in enhancing organisational safety culture and patient care quality.

8.0 Enhanced Monitoring Framework

As a further safety initiative the Trust has introduced the Enhanced Monitoring Framework for ward or clinical areas in need of immediate intervention and support. The next Board Report will elaborate on this framework in more detail including areas within the Trust that have piloted this approach, the outcomes of this initiative and the feedback of staff involved.

Patient Experience and Complaints

9.0 Patient Experience and Complaints

9.1 April Data

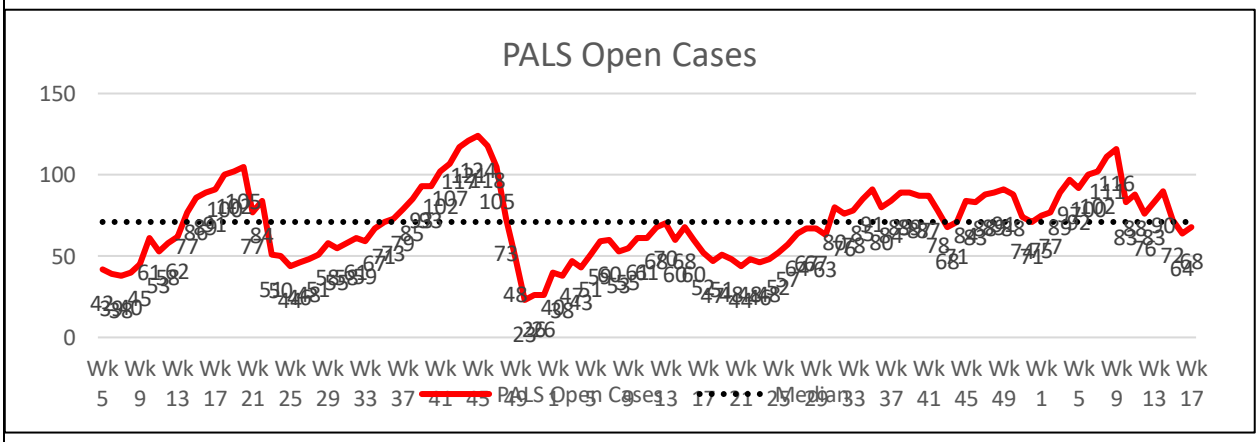
9.11 PALS Resolution

The team are focusing on trying to address as many concerns as possible via PALS in order to provide a swifter and more satisfactory response for service users and their families and to reduce the number of formal complaints. It is hoped that there will be a continued increase in PALS cases, which will lead to a reduction in formal complaints reflected in the figures in coming months. The below graph depicts the number of PALS cases opened over the last two years. In April this year 78 PALS cases were opened which is the second highest level seen over the two-year time frame.

Graph 12 – PALS Opened Cases

Whilst there is a focus on increasing the number of PALS cases, the team are also ensuring timeframes are managed appropriately in order to ensure early resolution and avoid a build-up of open cases. The below table demonstrates the number of open PALS cases reported through time. As shown, there is a trend in number of open cases reducing, therefore demonstrating that early resolution is being successfully sought and cases are being closed efficiently.

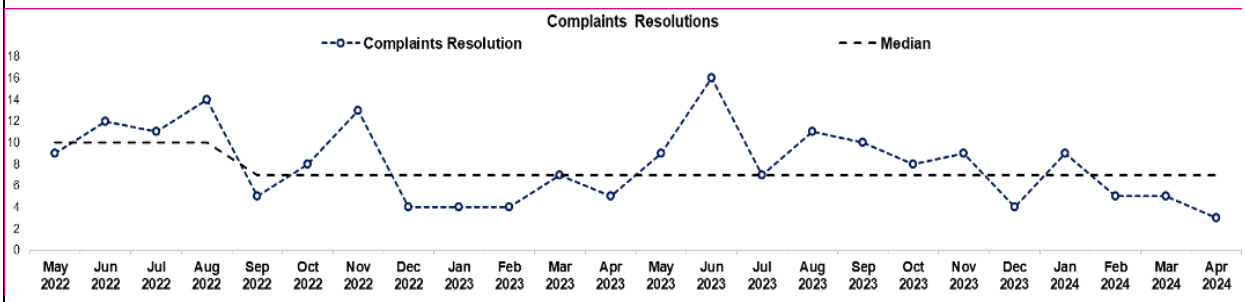
Graph 13 – PALS Current Open Cases



9.2 Formal Complaints

This month the Trust has had 3 newly registered complaints. This is the lowest monthly level seen in the last 2 years, as demonstrated in the graph below.

Graph 14 – New Registered Complaints



9.21 Formal Complaints Current Position

(Information provided as at 23/05/2024)

There are currently 38 open formal complaints, with 16 awaiting allocation of an investigating officer (IO), this amounts to 42%, and this is a decrease of 1 since the previous month.

The average number of working days to allocate an IO is 79.3 which is a large improvement of 19.4 working days from the previous month (98.7 last month). The average age of a case has also improved it is now 79.3 a decrease of 8.3 working days (87.6 last month)

9.23 Trajectory for Open Complaints

At time of reporting there are currently 3 open complaints that are 8 months old, 1 that is 7 months old and another 6 that are 6 months old. As the NHS Complaints Standards outline that all complaints should be responded to not later than 6 months after they have been raised, this is a continued area of focus for the team.

It is believed that this particular rise in protracted response times comes from a period of time when the team were experiencing a high level of sickness absence, along with significant gaps in recruitment. The team are now in an improved position, having no sickness absence at the time of writing, and almost a full complement of staff.

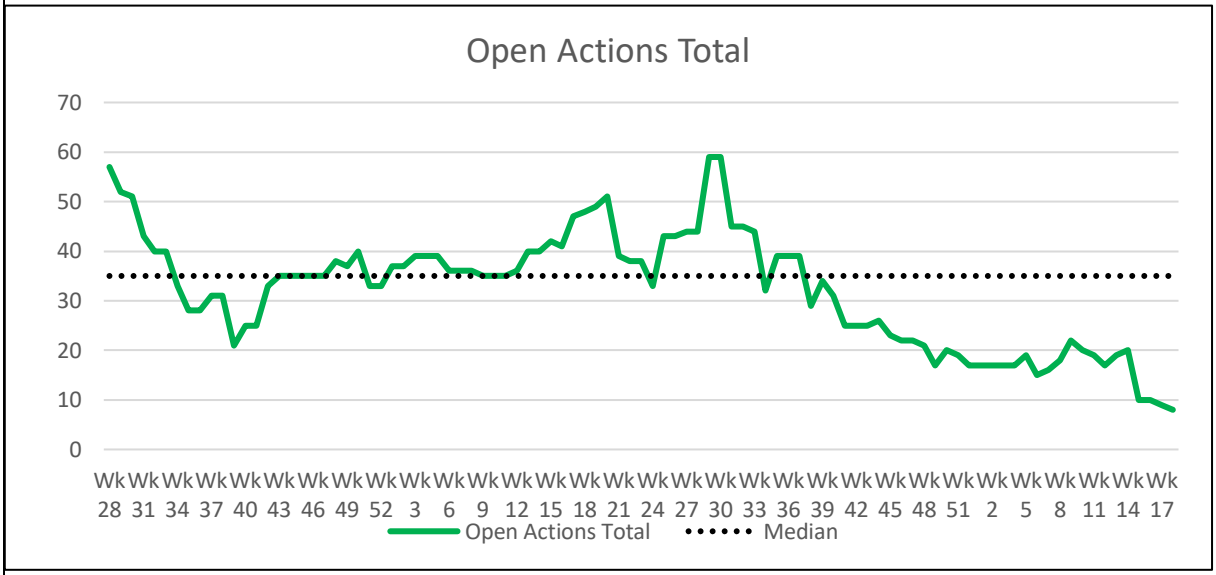
There is also a proposal under way for an improved complaints process which will involve more input from service areas. It is felt this will significantly improve the quality of complaint responses, the value of lessons learnt, as well as response time frames.

The target dates for addressing open complaints beyond 6 months old are as follows:

- 24/05/24: all complaints over 8 months old to be completed
- 15/05/24: all complaints over 7 months old to be completed
- 05/06/24: all complaints over 6 months old to be completed

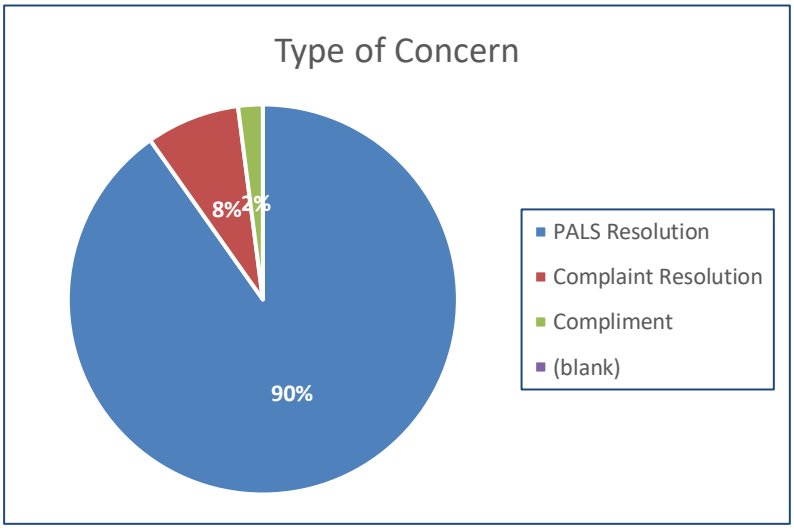
9.24 Complaints Actions

The position for open complaints actions is also evidencing a positive picture peaking at 60 open actions within the Trust 5 months ago to a current position of 9 this month. This evidences the hard work and focus of the Divisions in collaboration with the Customer Relations Team overseeing and closing complaints actions.



10. Quarter 4 Thematic Review Complaints and PALS

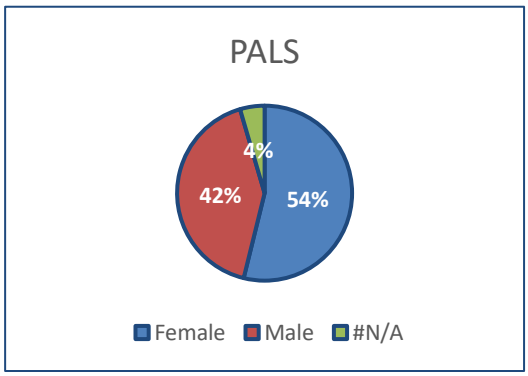
10.1 By Category

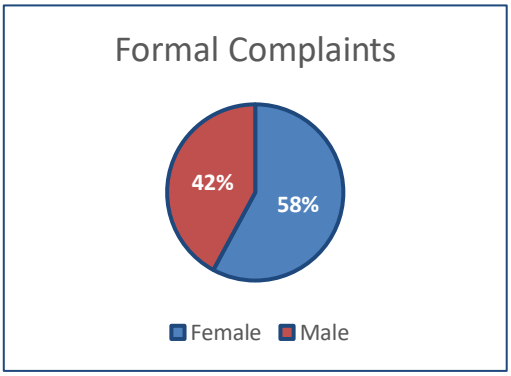


In quarter 4 the team registered 221 PALS cases, which is 60 more than the previous quarter, and 19 formal complaints.

Proportionately, 8% of concerns were formal complaints, in comparison to 11% in the previous quarter.

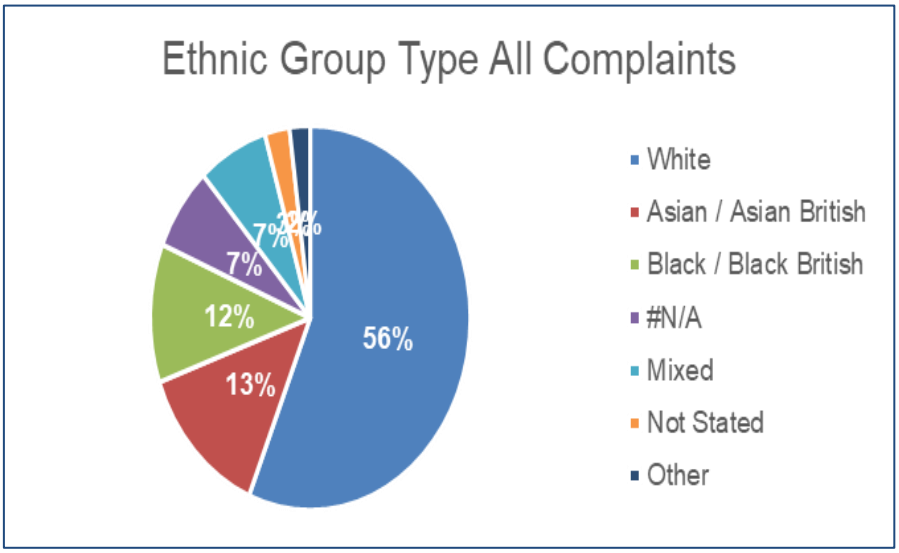
10.2 Protected Characteristics – Gender





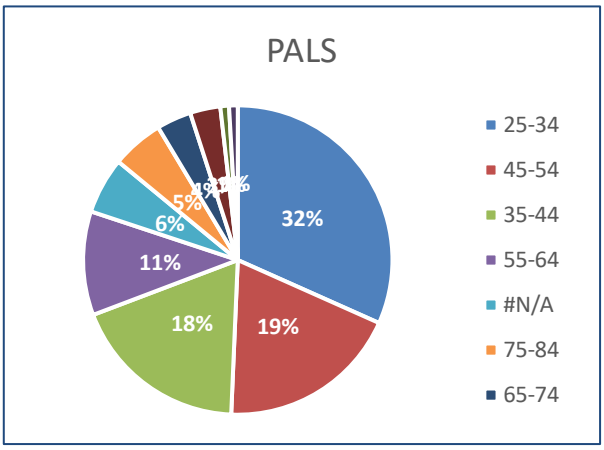
It can be seen that there is a slightly higher proportion of female complainants, this is reflective of the previous quarter's data.

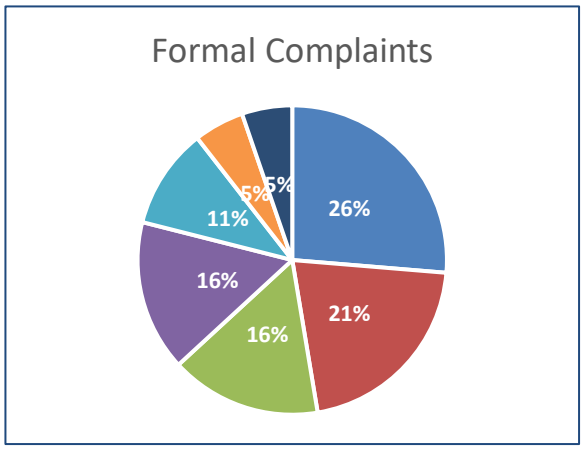
10.3 Protected Characteristics – Ethnicity



The above chart demonstrates that the overall majority of complainants are white. When understanding the ethnicities of service users who have accessed the Trust within the last 12 months we know that 19.9% were Asian/Asian British, whereas only 14.7% of the complainants were Asian/Asian British. Furthermore 7.9% of service users who have accessed the Trust within the last 12 months were Black/Black British, but 12.9% of complainants were Black/Black British.

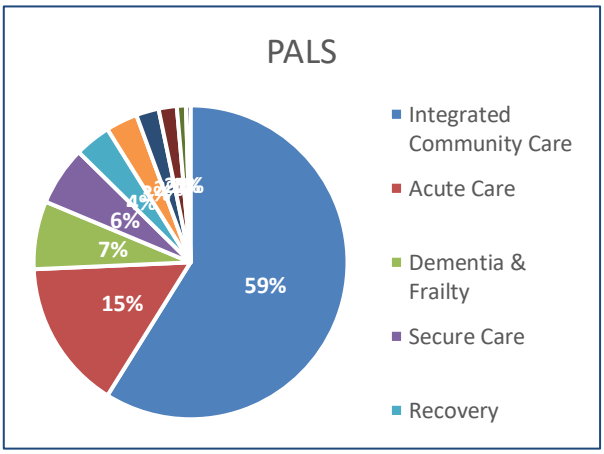
10.4 Protected Characteristics – Age

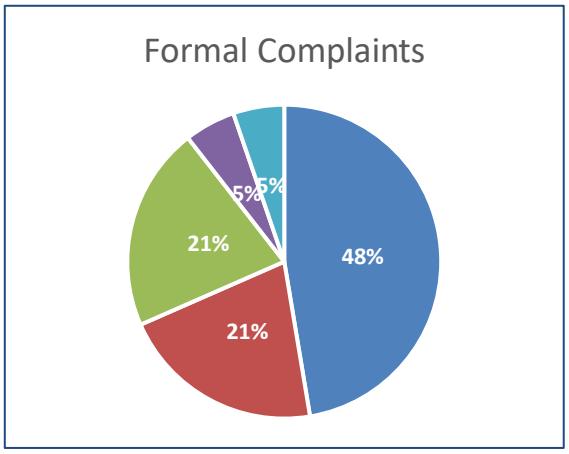




There is a much broader spread across age groups for formal complaints when compared to PALS cases. Most concerns have been received from people aged between 25 and 54 in Quarter 4.

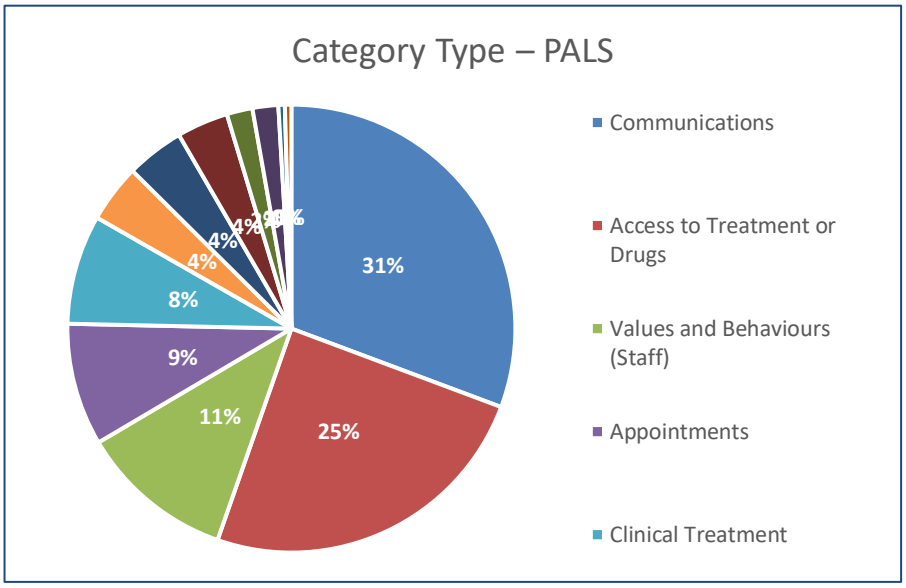
10.5 Breakdown by Directorate

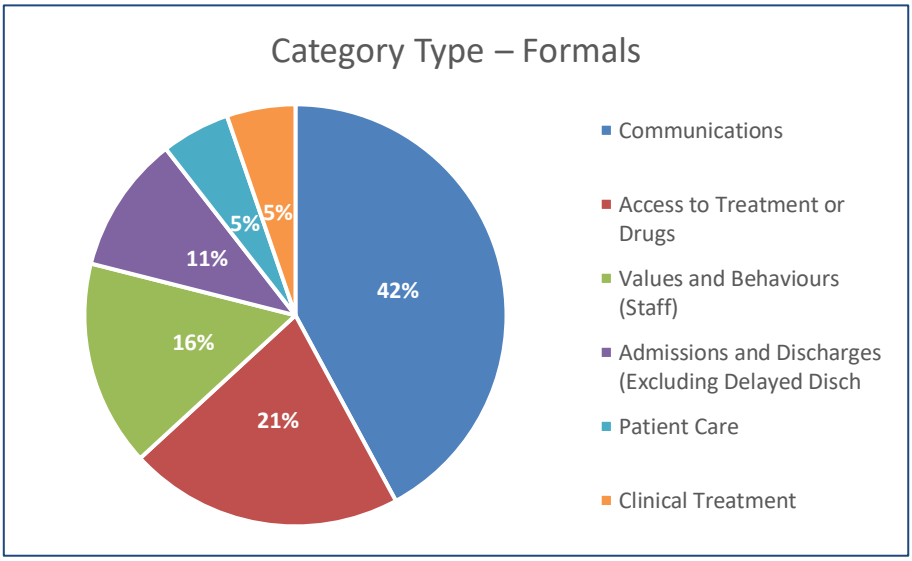




As demonstrated in the charts, most of the complaints are regarding ICCR, which is reflective of the large population they serve. There has been a higher proportion of Formal complaints for Dementia and Frailty since Quarter 3; 10% in Q3 and 21% in Q4.

10.6 Breakdown by Category





The most common theme for all concerns and complaints is communication, this is reflective of previous months reports. Followed by Access to Treatment or Drugs, and Staff Values and Behaviours.

10.7 Next Steps

-On initial review of the data around ethnicities, it is apparent there are some disparities between the number of complaints received, compared to the proportion of different ethnicities the Trust serves. The Team have also received qualitative feedback around access and patient experience of the complaints service, particularly for those who are from a BAME background. For this reason the team are going to undertake a deep dive analysis into the data around ethnicities and the type of complaints received, in order to improve the customer relations service as well as provide thematic feedback to clinical services.

Following improvements to our quarterly thematic reporting it is felt there is a great value in the information provided around protected characteristics, and themes of complaints raised. The team will therefore be producing an annual review of a similar structure

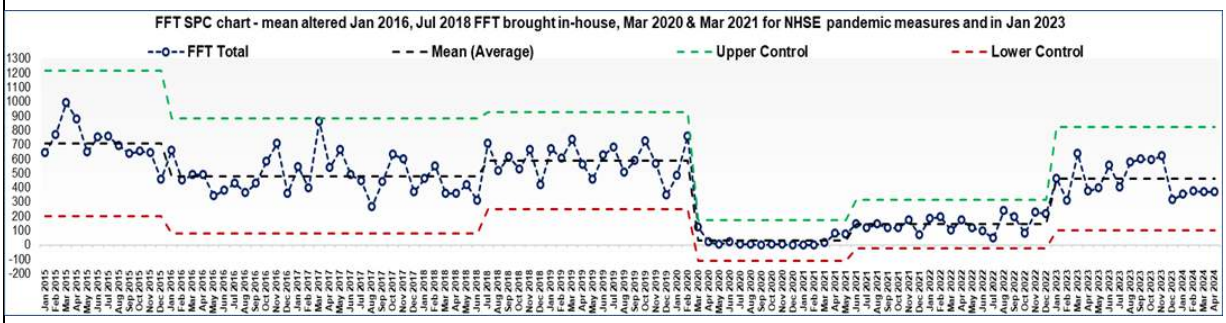
11.0 Friends and Family Test (FFT) Scores

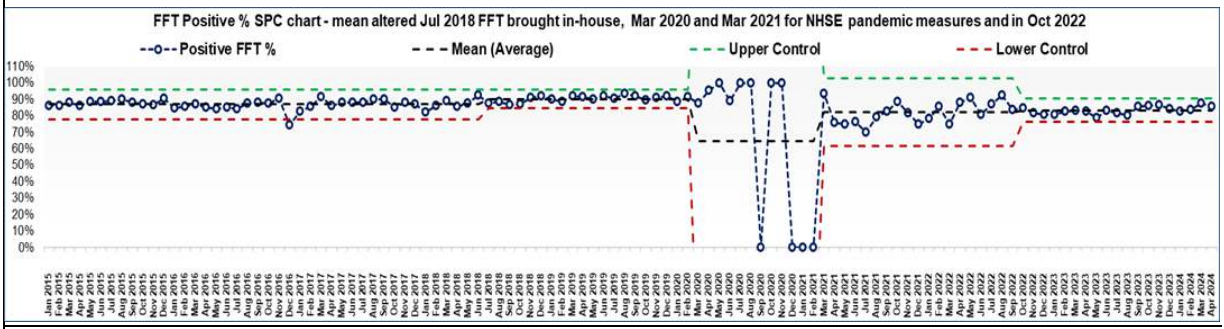
In April 367 FFT were captured which is 1 fewer than last month. FFT distribution for April is less in line with pre pandemic levels with 16% of FFT being collected by Acute and Secure Care. Integrated Community Care (ICC) collected the most FFT and accounted for 55% (202) of the FFT collected. Acute Care collected 15% (56) FFT and Recovery collected 14% (51) FFT.

Staff was the main positive theme with 133 (45%) of the positive feedback. Waiting time was the main improvement theme with 21 (18%), support had 14 (12%) and environment had 13 (11%). Waiting time issues are almost all for ICC (86%) and are around waiting a long time for appointments, long wait between appointments, waiting times when on site to be seen and to receive medication. Information from services can take a long time and comments about a long wait to access gym equipment and new accommodation. Support issues are mainly for ICC (71%) but are small numbers and relate to not being heard or listened to, needing more support for a longer duration and more support earlier. There are some comments about not being assigned a CPN. Environment issues are for a few services and are small numbers. These are issues raised regarding wanting wards to be safer, having better parking, better internet as well as requests for more space for quiet time and a sensory room.

Currently we are not seeing a spread of FFT collection as we had pre pandemic. The consequences are we may gather FFT disproportionally to those who use or access our services the most which may impact the results and FFT scores.

We have online, tablet, QR Code and postcard FFT collection options available. Quarter 3 2023/24 data has gone to Clinical Governance meetings. February monthly FFT reports have gone to services. Weekly FFT reports continue to go to services and weekly Connect updates are ongoing. FFT reports are available on Connect.





Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors							
Agenda item:	**11**						
Date	5 June 2024						
Title	Quality Improvement Report						
Author/Presenter	Julie Romano, Head of Quality Improvement and Clinical Effectiveness						
Executive Director	Sarah Bloomfield, Interim Chief Nurse	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report					
Alert	✓	**Advise**		**Assure**	

Purpose

The report provides an overview of Quality Improvement activity across the Trust over the last twelve months.

Introduction

The report covers a range of elements that the Quality Improvement team support and champion. Highlights include:

- Experts by Experience progress
- Training status and Quality Improvement training dates
- Quality Improvement project status
- Quality Improvement communications update
- Good news and positive reputational update
- LCGC and Corporate Quality Improvement project overviews
- Quality Improvement team infrastructure changes
- NHS Impact update

An update on the co-production campaign for the Quality Improvement Strategy is also included. This supports the overall Trust Strategy.

Recommendation

The Board is asked to:

- note the great practice across the Trust with Quality Improvement methodology and projects supporting teams and individuals in a flexible approach.
- note the new modules in the QI Academy to approach engagement with continuous improvement through a new lens.

- note that the team works collaboratively with other improvement teams in the Dynamic Space Events, supporting the Trust Strategy objectives whilst continuing with a coproduction model of engaging teams with the QI Strategy.
- be aware of the upcoming meeting with NHS Impact Clinical Director to discuss Quality Management Systems at BSMHFT and a planned QICE Workshop in May with a focus on combining QI and PSIRF collaboratively developing our learning approaches together.
- view the video links and team updates from our staff and EBE. I would engage you to have a view as these are accounts of what it is like to be part of a QI Project or use QI methodology at BSMHFT.

Enclosures

- A Year in QI 2023-24 (in reading pack)
- Co-production of QI Strategy

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	
People		
Quality	✓	
Sustainability		

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**
BAF03/QPES	✓	Potential failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.

QI VISION

Quality Improvement BSMHFT

Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY IMPROVEMENT (QI)

NOW AND NEXT FIVE YEARS STRATEGY

What has been happening ….

Foundations for QI

Pandemic impact

Building capacity and capability

Governance framework

Willingness and acceptability

Partnerships and collaborations

Birmingham and Solihull Mental Health NHS Foundation Trust

QUALITY IMPROVEMENT (QI)
NOW AND NEXT FIVE YEARS

Why still more needs to happen….

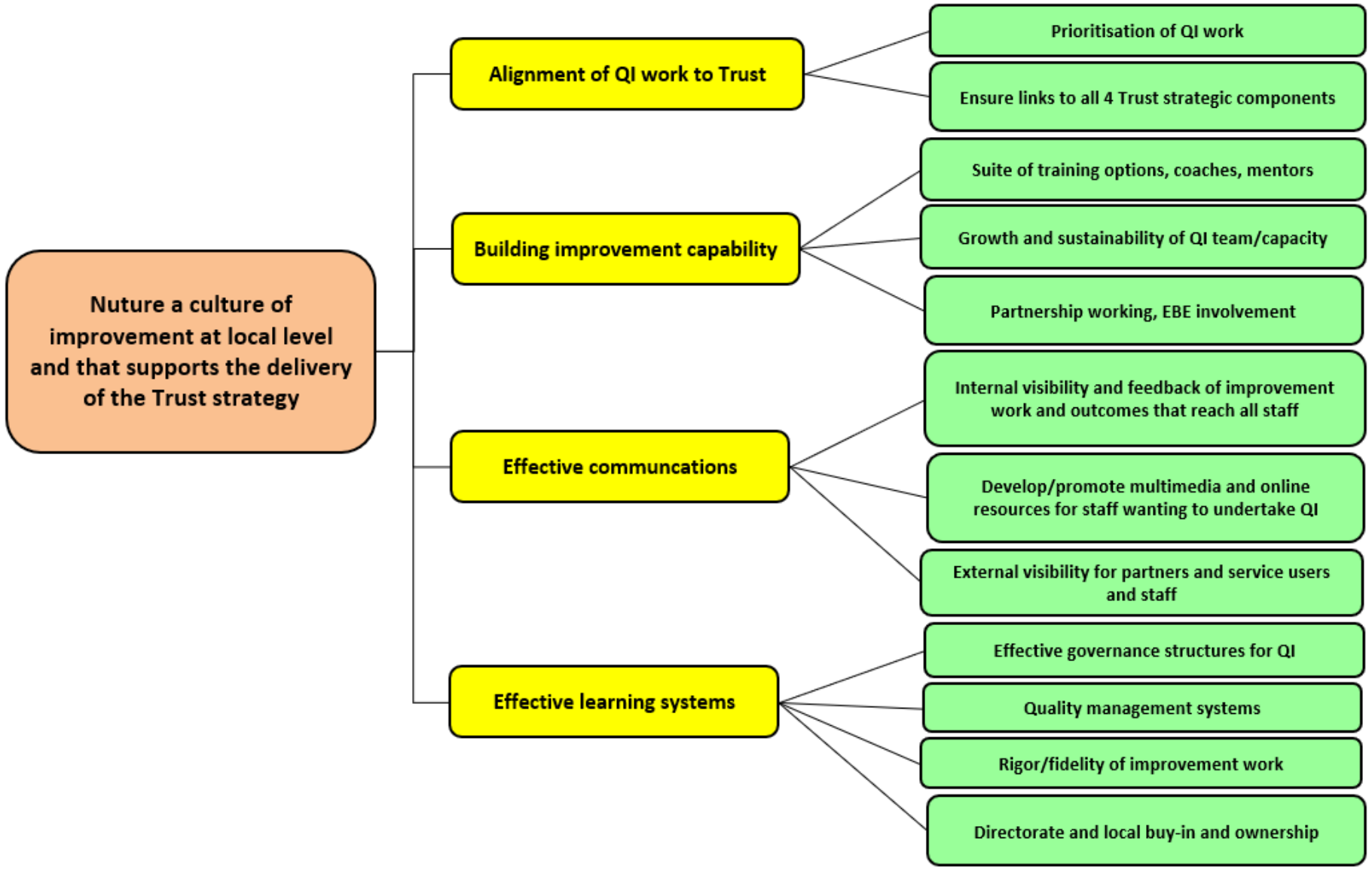
BSMHFT

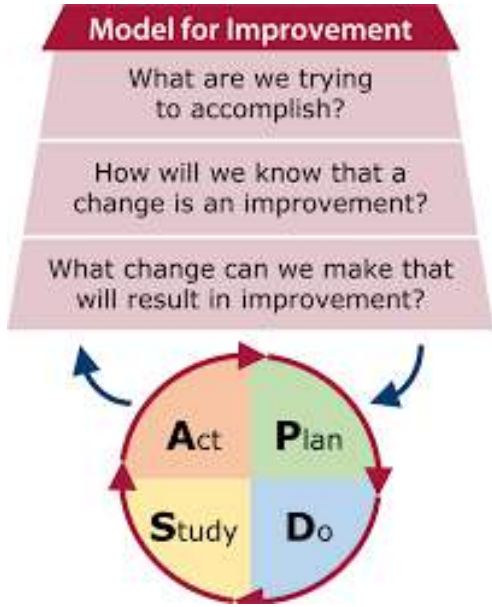
Best for healthcare quality
Best place to work
Best for Co-production

- Health inequalities
- Reducing Restrictive practices
- Waiting times
- Primary and Secondary care gaps

- New ways of working
- Staff experience
- Patient Experience
- Technology challenges

Five-year strategy for Continuous Improvement culture Driver diagram





Delivering a 5-year strategy: Vision

- Leadership for improvement from the Trust Board, senior leaders and Experts by Experience
- QI embedded into clinical roles, inc. doctors, heads of nursing/AHP, matrons, service leads.
- Centralised QI capability/capacity maintained within the organisation
- Each directorate has local QI capability including trained and experienced QI coaches/mentors to support local level 3 and level 4 projects.
- Innovation for improvement is encouraged and supported at all levels of the organisation
- QMS (Quality Management System)
- Finance support to deliver triple aim (improved population health, quality of care and cost-control)
- Data analytics support available for local and large-scale improvement collaboratives
- Central budget or directorate budgets to support project requirements/resources.

What you will see over the next 12 – 24 months

Birmingham and Solihull Mental Health NHS Foundation Trust

National and Regional	Local/Trust level
• NHS Impact • West Midlands Regional NHS Impact Group (Co-designing Midlands improvement priorities) • BSOL ICS Improvement group • PSIRF (Patient Safety Incident Response Framework) • CQC (Emphasis on assessing the presence and maturity of a quality improvement approach)	• Alignment with Trust goals/objectives • Supporting directorate priorities • QI support – QI advisors and QI facilitators • QI Academy training courses • Dedicated data support • Support for transformation • QI Co-production with EBE, carers and families • Recognition and celebrating improvement work

Birmingham and Solihull Mental Health NHS Foundation Trust

Join us

It'll be fun too ….
Let's make this happen!

The ASK

How do WE ensure a high-quality sustainable future for our services?

What does good look like and how can QI support you to get there?

bsmhft.qualityimprovementteam@nhs.net

X/Twitter: @BSMHFT_QI

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**12**					
Date	5 June 2024					
Title	Research and Development Annual Report 2023/24					
Author/Presenter	Emma Patterson, Head of Research and Development and Prof Alex Copello, Associate Director for Research and Development					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

Purpose of Report			Tick all that apply ✓
To provide assurance		**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report					
Alert	✓	**Advise**		**Assure**	

Purpose

The report provides an overview of the work undertaken by the Research and Development department on behalf of Birmingham and Solihull Mental Health NHS Foundation Trust in 2023/24, together with future plans for 2024/25.

Key Issues and Risks

None.

Recommendation

The Board is asked to receive the Annual Report for information and assurance.

Enclosures

Research and Development Annual Report 2023/24 (in reading pack)

Research and Development Annual Report 2023/24

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	Improved patient outcomes and clinical care
People	✓	Staff retention and development
Quality	✓	Increase rapid access to evidence-based interviews
Sustainability	✓	Retention of staff, ability to generate more income

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**

Summary: 2023/4 has been an exceptionally successful year for the R&D team. We have grown our Research Capabilities exponentially through new partnerships and collaborations and by attracting more income to invest in the Trusts research infrastructure.

We brought in £0.9m income within the financial year from grants, bids and trial activity and this is set to increase to a minimum of £1.1m in the new financial year. We have invested in new staff appointments and have developed and planned new posts meaning that by the end of the next financial year, we will have a clear career development pathway within R&D in either delivery or governance roles from Band 4 through to Band 7. We regularly attract high calibre staff and it's hoped that with more opportunities for development, we will retain them.

Our researchers have successfully been awarded grant funding in excess of £5m and infrastructure funding of £11.5m. Of this, £1.9m (inc. £0.6m capital) will come directly to the Trust. Of the remaining awards, approximately £3m will be subcontracted to the department to cover the costs of collaboration and/or to provide the infrastructure required to deliver the research. When we are not in direct receipt of the income, R&D include a charge to host and manage the delivery of the grant to make sure that this remains sustainable. We will be discussing, reviewing and firming this up with our academic partners and collaborators to ensure that the ongoing management of grants and trials remains sustainable now and in the future.

To date we have recruited 276 participants to a number of complex National Institute for Health Research portfolio trials. Trusts that are research active have better outcomes for all patients, reduced mortality and improved overall quality of care not just those who are participating in clinical trials. Delivering these complex trials cannot be done in isolation and we have worked with a large number of our clinical colleagues and teams to get the studies out and make the studies available to our service users. We have highlighted the need to expand our reach within the organisation beyond that of the research delivery team within this report so that we can reach more service users. Service users want to be treated by

clinicians in a research active Trust; they feel heard and valued and know that their care team want to provide them with the best evidence based available care. It improves Trust. In addition, it reduces burnout amongst staff and benefits the wider care system, transforming care by improving clinical practice and ultimately reducing the cost of healthcare.

Our governance team have supported over 100 different research teams during the financial year, across all stages of the research pathway from protocol development support, costing advice, through to regulatory approvals and delivery set up. Studies are approved and set up in an average of 53 days with amendments to projects being arranged in 24 days. Whilst we perform better than the national average in terms of amendments (n35 calendar days) we are below the average for project approval (n40 calendar days) and will look to improve on this within the next year.

We have clinical academics (i) representatives on International Groups who are advising on guidelines for the use of Valporate in Epilepsy and NICE technology assessments for new antiseizure medicines and novel applications; (ii) leading on the development of national policy and guidelines for the improvement of access to mental health services for people with Huntington's Disease; (iii) developing Occupational Therapy guidelines in collaboration with the European Huntington's Disease Network (iv) we have research leaders who have developed

guidance for NHS talking therapies to support family members affected by relatives with alcohol problems. Our leadership and knowledge in these areas bring significant local improvements in clinical care in line with developing evidence.

We are participating in addictions research that is impacting the UK national drug treatment programme for opioid addiction and lastly, by recruiting to a study to review the effectiveness of take-home/lay delivered naloxone, we have as a minimum provided service users across the midlands who have an opioid addiction access to potentially lifesaving medicines. Through research, we are actively improving our patient outcomes.

We are developing neuromodulation research services to support people with Treatment Resistant/Difficult to Treat depression and once established, we will be the only NHS site in the West Midlands with the ability to offer these novel treatments. Through research, we are leading the way with our clinical care.

Our Art Psychotherapist researcher won the NHS Improvement Award and Markel 3rd Sector Development and Innovation award for his work, "No barriers here!" and the' Mood on Track' tool was a finalist in the 2023 HSJ awards in the category of improving mental health through digital.

We have become official partners of the Mental Health Mission, Oxford Biomedical Research Centre and Birmingham Health Partners and continue to work closely with the Institute for Mental Health at the University of Birmingham. As a result of these new partnerships, we have access to substantial funding to develop new clinical research services for Difficult to Treat Depression, to enhance our capacity to deliver commercially funded income generating research and to explore the opportunities for developing research careers. We are in a position to be central to the improvement of the health of the communities we serve.

Educating researchers of the future, our clinical academics and clinical researchers are supporting six Post Doctoral students and almost twenty master's students. We will look to enhance this through the exploration of attaining Teaching Trust/University Hospital status. Such status will allow us to attract high quality, passionate students and clinicians of the future, to attract highly trained academic and research leaders allowing us to increase both our reputation as a leading provider of research and teaching and our capacity to generate

more income. In summary, through research and teaching, we will deliver improved care and outcomes making us reputationally, the leading place to work and to be cared for.

Finally, our Lived Experience Action Research Group (LEAR) continue to be a critical friend to R&D, ensuring that research priorities are focussed, that research is designed with the needs of the service user in mind, and by allowing the group to develop research based on their priorities. In addition, we want to build on this fantastic infrastructure by identifying sustainable and supportive pathways for our service users to be involved in research delivery and in paid employment.

Future Plans: The table overleaf outlines the goals for the department as outlined in this annual report and identifies the lead member of staff to take each item forward. This is effectively the departments Business Plan for 2024/25, the delivery of which will be overseen by the R&D Management Board

Goals for 2024/25:

Finance and Resources:	
- R&D and Finance joint SOP - Pharmacy to use EDGE - Implementing the NIHR income distribution model	Research Governance Manager
- New departmental appointments: Delivery Team Manager (B7)	Head of Research & Development
- New departmental appointments: Clinical Research Nurse (B6), R&D Assistant (B5), Project Support Officer (B4), EBE Research Delivery Post (band tbc)	Delivery and Performance Manager
- Working with Academic Partners and Collaborators to ensure costs of ongoing management and support of trial delivery staff are covered.	Head of Research & Development
Research Governance:	
- National Data Opt out – improved management on Rio/Electronic Health Record - Updated National Data Opt Out SOP - Research Passport SOP	Research Governance Manager
NIHR Objectives:	
- Implement Research Champion programme - Strategy to engage all research teams in PRES	Delivery and Performance Manager
Service Evaluations:	
- HSCE (MSc and MNurs) projects	Research Governance Manager
- Delivering psychological therapies Service Evaluation	Delivery and Performance Manager
- Implementation of AMAT, tracking and capturing outputs - Updating the Service Evaluation SOP	Research Governance Manager
Birmingham Health Partners:	

- Ensuring BHP is included in the R&D Governance Structure - Regional bid to host a Commercial Research Delivery Centre	Head of Research & Development
Mental Health Mission:	
- Difficult to Tread Depression Research Platform – build platform begin regulatory approvals, data collection and testing - Ketamine Clinic protocols, SOPs and guidelines to be developed - Clinic established, up and running and being evaluated (research grade) - rTMS machines procured with protocols, SOPS and guidelines to be developed - Building works undertaken to house the rTMS machines finalised - rTMS research service running and being evaluated (research grade)	Mood Disorders Project Manager
Oxford BRC:	
- Digitising data collection in line with the standard DTD dataset	Mood Disorders Project Manager
UK-CRIS:	
- IG arrangements with FTB due to shared Rio/explore FTB usage - Revisit and revamp governance processes - Identify designated staff to undertake CRIS admin and daily operations	Research Governance Manager
- Consider linkage to Primary Care data for all of our service users via the Optimum Patient Care Research Database (OPCRD), this comes with a cost of £10K	Mood Disorders Project Manager
Increasing our local investigator pool:	
- Locally developed PI training	Delivery and Performance Manager
Application for University/Teaching Trust Status:	
- R&D Management Board Sub-Committee/working group established - Benefits/options appraisal to be completed within 6 months	Associate director for Research and Head of Research & Development
LEAR (Lived Experience Action Research) Group:	
- Develop a business case to obtain funding to make the group sustainable in the long term	Delivery and Performance Manager

- To update the evaluation documentation used by the LEAR group to monitor their impact on research grants and proposals
- To co-produce a revamped Research Strategy and to explore key areas of research that align to the Trust's strategic priorities as well as areas of those that are of importance and interest to the group. These include:
  ○ Reducing digital exclusion
  ○ Demand signalling- identifying key areas of research whereby expert by experience collaboration and co-design is paramount
  ○ Reducing restrictive practices
  ○ Treatment resistant depression and the development of improved service user care pathways in this speciality
- To hold an EBE research celebration event	

R&D Profile and Communications:	
- R&D Communications – social media scoping & Trust Inductions - R&D Showcase 2025 - Seminar Series	**Delivery and Performance Manager**
Impacts on national/local guidance, changes to local practice and key achievements:	
- Follow up and ongoing monitoring of activity as outlined in each programme area	Associate Director for Research
Impact of NIHR Portfolio Participation on staff, service users and/or carers:	
- Maintain an ongoing assessment for each NIHR project supported by the Research Delivery team to monitor intended and unintended impacts	Delivery and Performance Manager

Committee Escalation and Assurance Report

Name of Committee	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 June 2024**
Date(s) of Committee Meeting(s) reported	**22 May 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • Corporate Risk Register • People Dashboard • Workforce Plan • People Strategy Update Q4 2023/24 and 2024/25 Goals • Freedom to Speak Up Guardian Quarterly Report • Sexual Safety Charter • Transforming our Culture and Staff Experience Group Assurance Report • Shaping our Future Workforce Committee Assurance Report • Safer Staffing Report • Internal Audit Review: Sickness Absence • Internal Audit Review: Disciplinary Process
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • Employee relations case work data for 2023/24 highlighted that Black, Asian and Minority Ethnic colleagues were more likely to be subject to a Dignity at Work complaint, and White colleagues were more likely to be complainants in Dignity at Work cases. For the same period, 55% of staff subjected to disciplinary processes were from Black, Asian and Minority Ethnic backgrounds. The Trust had included goals in the strategy for 2024/25 related to these areas, and would focus on supporting managers with training to understand and effectively implement policies. The Trust would also focus on supporting staff from Black, Asian and Minority Ethnicities by working collaboratively with People, Organisational Development and Freedom to Speak Up teams. • The Committee discussed concern in relation to the length of time taken to conclude Employee Relations cases, however a number of actions were being taken to support more efficient processes. • A deep dive into leavers data had been undertaken; a high number was driven by retirement, and work would be undertaken to promote the retire and return and flexible working options available to staff. Data also showed that a high number of leavers left the Trust during the first three years of employment; a newly established Workforce Initiative Group was reviewing the implementation of "stay" conversations as part of the retention strategy.

	• Flexible working data continued to be refined, with some challenges in relation to the quality of the data platform (ESR).	
Assure:	• The Committee was assured by the progress made against the People strategy and approved the goals for 2024/25. • The sexual safety charter was approved. • The international nursing recruitment target had been achieved. • Sickness reduction of 2% was reported. • The Committee was assured by the reduction in bank and agency usage.	
Advise:	Internal audit reviews into Sickness Absence and Disciplinary Processes were received. Both had been given partial assurance ratings and the Committee received information on the actions and improvement plans in place. The final submission of the Workforce Plan was due by end of May. The Committee received highlights on the submission, including planned increase in substantive workforce and reduction in bank usage. A deep dive into workforce transformation was planned for July. The Freedom to Speak Up Guardian Quarterly Report was received; it highlighted themes from the quarter, including that there were no particular hot spots for concerns, however there were issues highlighted around decision-making processes for on-call rotas, incivility and bullying behaviours from ward managers, and a variance in how line managers were implementing reasonable adjustments at work.	
Board Assurance Framework	The Committee had considered the Board Assurance Framework risks during a development session in February and the following risks had been identified: • Inability to attract, retain or transform our workforce in response to the needs of our communities. • Failure to create a positive working culture that is anti-racist and anti-discriminatory. The risks were currently in development and would be reviewed by the Committee in June in preparation for recommendation to the Board. A Board Strategy Session had also been planned for later in the year to review and approve the revised Board Assurance Framework.	
	New risks identified: No additional risks were identified.	
Report compiled by:	Sue Bedward, Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**					
Date	5 June 2024					
Title	Guardian of Safe Working Hours: Doctors and Dentists in Training (Q3 2023-24)					
Author/Presenter	Shay-Anne Pantall, Guardian of Safe Working Hours					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert	✓	**Advise**		**Assure**	✓

Purpose

Quarterly reports to the Trust Board are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

Key Issues and Risks

- No immediate safety concerns were raised during this quarter.
- 14 unique exception reports were raised during this quarter, of which 64% related to overtime working. This is a significant increase in use of exception reporting for overtime.
- The majority of exception reports for overtime were raised by Higher Trainees working in Liaison Psychiatry. 4 Level 1 work schedule reviews took place with a subsequent reduction in exception reporting.
- 5 fines were levied against the Trust for breaches in safe working hours, a 45% decrease compared to Q2
- No exception report raised during this quarter was closed within 7 days
- The number of outstanding reports carried forward has increased, from 9 to 16
- There are delays in exception reports being reviewed for Foundation and Core Trainees.
- The number of vacant shifts continues to be high but stable (362 compared to 363 in Q2). The majority of gaps were due to post vacancies. All on call locum vacancies during this period were filled.

Recommendation

The Board is asked to note this report and the progress that has been made in encouraging postgraduate doctors in training to raise concerns. This report is for assurance to the Board that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions are being taken in response to concerns raised.

Enclosures

N/A

Quarterly Report on Safe Working Hours: Doctors and Dentists in Training

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**

October - December 2023

High level data

Number of doctors / dentists in training (total): 142

Number of doctors / dentists in training on 2016 TCS (total): 142

Amount of time available in job plan for guardian to do the role: 1 PA per week

Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	3	0	3
F2	0	0	0	0
CT1-3	6	0	0	6
ST 3-6	3	11	8	6
GPVTS	0	0	0	0
Total	9	14	8	15

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding

FY2 – CT3 (Rotas 1-6)	6	3	0	9
ST North	1	5	5	1
ST South	1	2	1	2
ST Solihull/East	0	1	1	0
ST Forensic	1	3	1	3
Total	9	14	8	15

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	3
F2	0	0	0	0
CT1-3	0	0	0	6
ST3-6	0	0	8	6
GPVTS	0	0	0	0
Total	0	0	8	15

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 16 exception reports were raised in total; two were duplicates and have not been included within the data hence there were 14 unique exception reports within Quarter 3.

Of the 14 exception reports; 4 related to breaches of continuous rest requirements overnight during non-resident on calls, 9 related to working overtime and one exception report did not report any breach of contractual requirements on further review. One exception report for breach of continuous rest also noted a second breach of safe working hours within the same submission, for not achieving minimum rest requirement of 8 hours within a 24 hour on call period.

c) Work Schedule Reviews

Status (9 exception reports - figures include 5 exceptions carried forward);

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	4 (1 L1, 3 L2; 4 pending)
ST3-6	5 (5 L1; 1 pending, 4 completed)
GPVTS	0
Total	0

4 pending work schedule reviews relating to CT1-3 trainees were addressed directly by the Guardian of Safe Working with the affected doctor, with no further action to be taken. The exception reports were not able to be closed on Allocate however due to a technical issue.

d) Locum bookings and vacancies

Locum bookings OCTOBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	24	24	215.50	215.50
Rota 2	15	15	152.00	152.00
Rota 3	9	9	108.50	108.50
Rota 4	10	10	90.00	90.00
Rota 5	14	14	131.50	131.50
Rota 6	23	23	224.50	224.50
ST4-6 North	5	5	72.00	72.00
ST4-6 Rea/Tam	4	4	80.00	80.00
ST4-6 Sol/East	11	11	200.00	200.00
ST4-6 South	12	12	177.00	177.00
Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	187.50	187.50
Rota 2	5	5	52.50	52.50
Rota 3	3	3	36.00	36.00
Rota 4	13	13	128.00	128.00
Rota 5	20	20	203.50	203.50
Rota 6	17	17	155.50	155.50
ST4-6 North	11	11	165.00	165.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	7	7	120.00	120.00
ST4-6 South	4	4	57.00	57.00
Total	109	109	1273.00	1273.00

Locum bookings DECEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	26	26	262.00	262.00
Rota 2	15	15	151.00	151.00
Rota 3	6	6	64.50	64.50
Rota 4	21	21	217.50	217.50
Rota 5	10	10	83.00	83.00
Rota 6	6	6	57.00	57.00
ST4-6 North	10	10	145.00	145.00
ST4-6 Rea/Tam	7	7	136.00	136.00
ST4-6 Sol/East	12	12	240.00	240.00
ST4-6 South	13	13	173.50	173.50
Total	126	126	1529.50	1529.50

Locum bookings OCTOBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	95	95	922.00	922.00
ST4-6	32	32	529.00	529.00

Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	78	78	763.00	763.00
ST4-6	31	31	510.00	510.00
Total	109	109	1273.00	1273.00

Locum bookings DECEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	84	84	835.00	835.00
ST4-6	42	42	694.50	694.50
Total	126	126	1529.50	1529.50

Locum bookings OCTOBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	46	46	534.00	534.00
COVID	6	6	72.50	72.50
Sickness	33	33	345.50	345.50
Off Rota	42	42	499.00	499.00
Acting Up Consultant	0	0	0	0
Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	45	45	507.50	507.50
Sickness	18	18	225.00	225.00
COVID 19	0	0	0	0
Off Rota	36	36	400.00	400.00
Emergency Leave	4	4	48.00	48.00
Bereavement	1	1	4.50	4.50
Acting Up Consultant	5	5	88.00	88.00
Total	109	109	1273.00	1273.00

Locum bookings DECEMBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	7	7	46.50	46.50
Vacancy	59	59	675.00	675.00
Sickness	11	11	142.00	142.00
COVID 19	0	0	0	0
Paternity Leave	5	5	61.00	61.00
Off Rota	36	36	445.00	445.00
Emergency Leave	1	1	16.00	16.00
Acting Up Consultant	7	7	144.00	144.00

Total	126	126	1529.50	1529.50

Data specifically relating to locum bookings to cover periods of industrial action has not been provided.

Fines levied

Rota	October 2023	November 2023	December 2023
ST North	0	2	0
ST Solihull and East	1		0
ST Forensic	0	1	1

5 fines have been levied in Q3 totaling 7.25 hours payment at enhanced rates. 4 fines were related to breaches of core rest requirements for overnight working for doctors working non-resident on calls (not achieving a minimum of 5 hours consecutive rest between 22:00 and 07:00) and 1 for breach of total rest requirements within a 24 hour period (minimum 8 hours rest not achieved).

Ideas for disbursement will be discussed and agreed at the Junior Doctor Forum. Trainee reps have been invited to develop a fine disbursement working group; no interest has been shown thus far.

Issues arising

The number of exception reports raised continues to increase, demonstrating positive engagement with exception reporting. More reports have been received by Foundation Trainees than in previous quarters.

In a change to the pattern of exception reporting, the majority of exception reports related to overtime (working beyond scheduled hours) rather breaches of core rest requirements overnight during non-resident on calls. This was in relation to both planned and out of hours work. Work schedule reviews were triggered for two trainees working in liaison psychiatry who reported repeatedly staying longer than their working hours during the day; no further exception reports were raised in relation to this issue following the reviews.

Alternative rota patterns for the North, South and Solihull/East ST rotas continued to be discussed during Q3 and have since come into effect from February 2024.

The number of outstanding exception reports has increased in Quarter 3 from 9 to 15. Half of these newly outstanding reports are reports raised by Foundation doctors. Additional support will be offered to the Educational Supervisor with responsibility for Foundation Doctors to ensure that future reports can be addressed promptly. The time to review and close reports persists above 14 days from submission; common causes for delays include inaccurate supervisor information, delays in arranging review meetings due to trainee or supervisor leave, delay in doctors accepting the outcome of the review discussion on Allocate and technical issues.

There continues to be a high number of shift vacancies. The largest proportion of the vacant shifts have been due to post vacancies. Industrial Action by junior doctors took place in October and December 2023; data specifically relating to locums required to cover during the strike period has not been provided by Medical Workforce. All vacant shifts in this period were filled, primarily by internal locums.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. 14 unique exception reports were raised during this quarter, of which 64% were related to overtime. 5 fines were levied against the Trust for breaches in safe working hours, a 45% decrease compared to Q2.

No exception reports raised during this quarter was closed within 7 days and the number of outstanding reports carried forward has increased. There are delays in exception reports being reviewed for Foundation and Core Trainees.

The number of vacant shifts continues to be high, but stable (362 compared to 363 in Q2). The majority of gaps were due to post vacancies. All on call locum vacancies during this period were filled.

Questions for consideration:
Ongoing support from senior leaders in encouraging raising concerns through use of exception reporting system is appreciated.

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	14						
Date	5 June 2024						
Title	Guardian of Safe Working Hours: Doctors and Dentists in Training (Q4 2023-24)						
Author/Presenter	Shay-Anne Pantall, Guardian of Safe Working Hours						
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert	✓	**Advise**		**Assure**	✓

Purpose

Quarterly reports to the Trust Board are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

Key Issues and Risks

- No immediate safety concerns were raised during this quarter.
- There has been an overall reduction in exception reporting in Q4. 7 unique exception reports were raised during this quarter, of which 86% related to overtime working. This is another significant increase in use of exception reporting for overtime.
- Only 2 fines were levied against the Trust for breaches in safe working hours, a 60% decrease compared to Q2
- Only 1 exception report raised during this quarter was closed within 7 days
- The number of outstanding reports carried forward has decreased, from 16 to 11
- There are delays in exception reports being reviewed for Foundation Trainees.
- The number of vacant shifts continues to be high but stable (406 compared to 362 in Q3). The majority of gaps were due to post vacancies and trainees off rota. All on call locum vacancies during this period were filled.

Recommendation

The report is for assurance to the Board that there is oversight of safe working hours for junior doctors in the Trust and that appropriate actions were being taken in response to concerns raised.

Enclosures

N/A

Quarterly Report on Safe Working Hours: Doctors and Dentists in Training

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**

January – March 2024

High level data

Number of doctors / dentists in training (total): 142

Number of doctors / dentists in training on 2016 TCS (total): 142

Amount of time available in job plan for guardian to do the role: 1 PA per week

Admin support provided to the guardian (if any): No specific admin support provided.

a) Exception reports

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	3	2	0	5
F2	0	0	0	0
CT1-3	6	0	3	3
ST 3-6	6	3	6	3
GPVTS	0	2	2	0
Total	15	7	11	11

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding

FY2 – CT3 (Rotas 1-6)	9	4	5	8
ST North	1	1	1	1
ST South	2	0	1	1
ST Solihull/East	0	0	0	0
ST Forensic	3	2	4	1
Total	15	7	11	11

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	5
F2	0	0	0	0
CT1-3	0	0	3	3
ST3-6	1	0	5	3
GPVTS	0	0	2	0
Total	0	0	8	11

b) Type of exceptions in the quarter:

There were no immediate safety concerns raised. 8 exception reports were raised in total; one was a duplicate from Q3 and has not been included within the data hence there were 7 unique exception reports within Quarter 4.

Of the 7 exception reports; 1 related to breaches of continuous rest requirements overnight during non-resident on calls and 6 related to working overtime. One exception report for overtime also reported a breach of maximum shift length of 13 hours and minimum rest of 11 hours between shifts.

c) Work Schedule Reviews

Status (3 exception reports - figures include 2 exceptions carried forward);

Work Schedule reviews by grade	
F1	0
F2	0
CT1-3	1 (1 L1,1 pending)
ST3-6	2 (2 L1; 1 pending, 1 completed)
GPVTS	0
Total	0

d) Locum bookings and vacancies

Locum bookings JANUARY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	33	33	301.50	301.50
Rota 2	16	16	147.50	147.50
Rota 3	7	7	61.50	61.50

Rota 4	20	20	174.00	174.00
Rota 5	17	17	160.00	160.00
Rota 6	18	18	157.00	157.00
ST4-6 North	11	11	150.50	150.50
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	13	13	240.00	240.00
ST4-6 South	8	8	124.50	124.50
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	15	15	158.50	158.50
Rota 2	9	9	79.00	79.00
Rota 3	3	3	21.50	21.50
Rota 4	15	15	136.50	136.50
Rota 5	12	12	108.50	108.50
Rota 6	8	8	51.00	51.00
ST4-6 North & East	18	18	195.00	195.00
ST4-6 Rea/Tam	7	7	144.00	144.00
ST4-6 South & Solihull	19	19	233.00	233.00
Total	106	106	1127.00	1127.00

Locum bookings MARCH 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	189.50	189.50
Rota 2	8	8	96.00	96.00
Rota 3	14	14	161.50	161.50
Rota 4	23	23	220.00	220.00
Rota 5	8	8	82.50	82.50
Rota 6	9	9	94.50	94.50
ST4-6 North & East	34	34	299.50	299.50
ST4-6 Rea/Tam	8	8	144.50	144.50
ST4-6 South & Solihull	24	24	237.00	237.00
Total	148	148	1525.00	1525.00

Locum bookings JANUARY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	111	111	1001.50	1001.50
ST4-6	41	41	683.00	683.00
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	62	62	555.00	555.00
ST4-6	44	44	572.00	572.00
Total	106	106	1127.00	1127.00

Locum bookings MARCH 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	82	82	844.00	844.00
ST4-6	66	66	681.00	681.00
Total	148	148	1525.00	1525.00

Locum bookings JANUARY 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	74	74	791.00	791.00
COVID	1	1	16.00	16.00
Sickness	19	19	186.00	186.00
Off Rota	42	42	455.00	455.00
Emergency Leave	5	5	52.50	52.50
Paternity Leave	1	1	16.00	16.00
Exam Leave	2	2	24.00	24.00
Acting Up Consultant	8	8	144.00	144.00
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	1	1	4.50	4.50
Pre-agreed A/L	2	2	16.50	16.50
Vacancy	59	59	653.00	653.00
Sickness	6	6	61.50	61.50
Off Rota	30	30	292.50	292.50
Maternity Leave	5	5	54.50	54.50
Emergency Leave	1	1	12.50	12.50
Acting Up Consultant	2	2	32.00	32.00
Total	106	106	1127.00	1127.00

Locum bookings MARCH 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	62	62	646.50	646.50
Sickness	17	17	192.50	192.50
Maternity Leave	6	6	72.00	72.00
Paternity Leave	3	3	36.00	36.00
Off Rota	56	56	544.00	544.00
Emergency Leave	1	1	4.50	4.50
Previously Agreed AL	3	3	29.50	29.50
Total	148	148	1525.00	1525.00

Data specifically relating to locum bookings to cover periods of industrial action has not been provided.

Fines levied

Rota	January 2024	February 2024	March 2024
SHO Rota 1-6	1	0	0
ST Forensic	1	0	0

2 fines have been levied in Q4 totaling 3.75 hours payment at enhanced rates. 1 fine was related to breaches of core rest requirements for overnight working for doctors working non-resident on calls (not achieving a minimum of 5 hours consecutive rest between 22:00 and 07:00) and 1 for breach of maximum shift length (13 hours) due to overtime. This report also breached minimum rest requirements (less than 11 hours between shifts), however as per the TCS only one fine was levied.

Ideas for disbursement will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has decreased, but there is improved engagement with exception reporting across trainee grades and stages of training (Foundation, GPVTS and ST).

Similar to Q3, the majority of exception reports related to overtime (working beyond scheduled hours) rather breaches of core rest requirements overnight during non-resident on calls. This was in relation to planned work taking longer than within the work schedule. L1 work schedule review was triggered again for one trainee working in liaison psychiatry who reported repeatedly staying longer than their working hours during the day; no further exception reports were raised in relation to this issue following the review and the trainee and ST Tutor were satisfied that this issue is resolved.

In light of the change in pattern of exception reporting, it has been noted that there is an increase in outcomes agreeing payment for overtime. Trainees are offered the choice between TOIL (in agreement with their Clinical Supervisor) and payment. The guidelines suggest that the Clinical Director of the relevant service will need to be made aware by an email of any decision to offer payments due to budget implications. The process for doing so is not yet robust. In a meeting between Dr Pantall as the Guardian of Safe Working and Leonora Johnson, Medical Workforce, on 17 April 2024, the outstanding reports were reviewed and it was agreed that Ms Johnson would collate those awaiting payment. This was completed on 2 May 2024; the data requires to be checked and then actioned.

Alternative rota patterns for the North, South and Solihull/East ST rotas have come into effect from February 2024. The three ST rotas were re-orgainsed into two full shift rotas (North and East, and South and Solihull), with a third ST doctor working at the weekends in the day time and evenings. Feedback regarding this change will be sought in the coming months.

The number of outstanding exception reports has decreased in Quarter 4 from 16 to 11. 45% of the outstanding reports are reports raised by Foundation doctors. The time to review and close reports persists above 14 days from submission; common causes for delays include inaccurate supervisor information, delays in arranging review meetings due to trainee or supervisor leave, delay in doctors accepting the outcome of the review discussion on Allocate and technical issues.

There continues to be a high number of shift vacancies. The largest proportion of the vacant shifts have been due to post vacancies. Industrial Action by junior doctors took place in January and February 2024; data specifically relating to locums required to cover during the strike period has not been provided by Medical Workforce. All vacant shifts in this period were filled, primarily by internal locums.

Actions taken to resolve issues
See above.

Summary

No immediate safety concerns were raised during this quarter. 7 unique exception reports were raised during this quarter, of which 86% were related to overtime. 2 fines were levied against the Trust for breaches in safe working hours, a 60% decrease compared to Q3.

Only 1 exception report raised during this quarter was closed within 7 days. The number of outstanding reports carried forward has decreased. There are delays in exception reports being reviewed for Foundation Trainees.

The number of vacant shifts continues to be high, but stable (406 compared to 362 in Q3). The majority of gaps were due to post vacancies. All on call locum vacancies during this period were filled.

Questions for consideration:
Ongoing support from senior leaders in encouraging raising concerns through use of exception reporting system is appreciated.

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**					
Date	5 June 2024					
Title	Guardian of Safe Working Hours: Annual Report on Rota Gaps and Vacancies Doctors and Dentists in Training 2023/24					
Author/Presenter	Shay-Anne Pantall, Guardian of Safe Working Hours					
Executive Director	Fabida Aria, Executive Medical Director	**Approved**	**Y**	✓	**N**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert	✓	**Advise**		**Assure**	✓

Purpose

Annual reports to the Board of Directors are mandated by the Terms and Conditions of the Junior Doctor Contract. Safer Staffing and issues related to rotas and training are under the remit of Medical Workforce and Education.

Key Issues and Risks

The number of vacant shifts has been lower in 2023-24 compared to the previous financial year remained persistently high throughout the year 2022-23, over half of which were due to post vacancies. Only three shifts went unfilled. The vast majority were filled with internal locums.

Vacancies were fairly evenly distributed across most rotas, with the highest number of gaps on the ST North rota and the lowest on the ST Forensic rota.

The on call rota structure continues to be reviewed with the aim of reducing rota gaps and improving working hours. 12 new ST doctor posts were created from August 2023; however not all of these were filled during the national recruitment process.

Recommendation

The Board is asked to note the report. The report is for assurance that there is oversight of junior doctor vacancies and rota gaps within the Trust, and that appropriate actions were being taken to encourage recruitment and cover vacant shifts, ensuring patient safety.

Enclosures

N/A

Annual Report on rota gaps and vacancies: Doctors and Dentists in Training 2023/24

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

Board Assurance Framework		
Strategic Risk	**Tick ✓**	**Comments**

High level data (from August 2023 onwards)

Number of doctors / dentists in training (total): 416 training posts available

Number of doctors / dentists in training on 2016 TCS (total): 349

Annual vacancy rate among this staff group: 16.1%

Annual data summary

Foundation and GPVTS

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Apr-23	FY1	14	13	n/a	0	1
	FY2	7	6	1	0	0
	GPVTS	25	14	10	1	1
Aug-23	FY1	15	13	N/A	2	0
	FY2	13	10	3	0	0
	GPVTS	20	20	0	0	2
Dec-23	FY1	15	14	n/a	1	0
	FY2	13	10	3	0	0
	GPVTS	20	20	0	0	0

Core Psychiatry

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Feb-23	CT1	19	13	4	2	1
	CT2	9	9	0	0	2
	CT3	19	12	3	4	3
Aug-23	CT1	18	19	0	0	3
	CT2	10	10	0	0	3
	CT3	21	20	1	0	5
Feb-24	CT1	18	14	2	0	3
	CT2	9	9	0	0	1
	CT3	21	18	3	0	2

Higher Training

Rotation	Grade	Total available posts	Total posts filled by trainees	Total vacant posts filled by locums	Vacant posts not filled	Total LTFT
Feb-23	ST GA	20	13	0	7	2
	ST OA	4	4	n/a	0	1
	ST Forensic	12	9	0	3	2
	ST CAMHS	2	1	0	1	0
	ST Psychotherapy	2	2	n/a	0	0
Aug-23	ST GA	25	19	0	5	2
	ST OA	5	5	0	0	1
	ST Forensic	12	11	0	1	4
	Psychotherapy	3	3	0	0	0
Feb-24	ST GA	25	21	0	4	5
	ST OA	5	5	0	0	0
	ST Forensic	12	10	0	2	2
	Psychotherapy	3	2	0	0	0

Rota gap summary

Rota	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)	Number of shifts uncovered (over the year)
1	19	49	70	68	4.0	0
2	33	23	35	33	2.4	0

3	78	36	18	24	3.0	0
4	36	49	44	58	3.6	0
5	50	47	44	37	3.4	0
6	78	49	46	35	4.0	0
ST North	41	25	26	63*	3.0	0
ST South	17	20	29	51*	2.25	0
ST Solihull and East	71	54	30	13**	3.2	0
ST Forensic	29	11	20	24	1.6	0
TOTAL	**452**	**363**	**362**	**406**	**30.4 (37.5 in 2022-23)**	**0**

* North and East, South and Solihull from February 2024
** No Solihull and East rota from February 2024

Reason for rota gap	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average no. of vacant shifts (per week)
Vacancy	315	176	150	195	16.1
Sickness	22	71	62	42	3.8
COVID-19	8	16	6	1	0.6
Parental Leave	3	3	5	15	0.5
Off Rota	45	74	114	128	6.9
Compassionate Leave	6	1	1	0	0.2
Training/Exam	0	1	0	2	0.1
Acting Consultant	25	9	12	10	1.1
New Intake	23	10	7	1	0.8
Emergency Leave	11	2	5	7	0.5

Issues arising

The number of vacant shifts has remained persistently high throughout the year 2023-24, with an average of 30.4 vacant shifts per week. However, there has been a reduction in vacant shifts of 291 (15.5%) in this financial year. 52.8% of these shifts were due to post vacancies. There are also a high number of trainees 'off rota', contributing to 22.8% of rota gaps.

High vacancy rates are multi-factorial in cause. Training post recruitment is via a national rather than local process.

Despite 1583 vacant on call shifts across the year, no shifts went unfilled. The majority were filled with internal locums.

Actions taken to resolve issues

From August 2023, changes were made to the number of training posts available. The conversion of previously unfilled GPVTS posts to posts for Foundation doctors resulted in a reduction in locum use. There was also an increase in the number of Higher Training posts available from August 2023. Despite this increase in available posts, not all posts were recruited to. There was still an overall reduction in vacant posts from Q2 onwards.

Due to the high volume of exception reports, work schedule reviews and fines levied, the ST North and South on call rotas were revised, reducing the number of rotas from three to two

General Adult rotas during weekdays from February 2024. It is anticipated that this will reduce the number of shifts required and hence reduce vacant shifts across General Adult ST on call rotas, although this impact is yet to be seen.

Summary

The number of vacant shifts has remained persistently high throughout the year 2023-24, over half of which were due to post vacancies. All vacant shifts were filled, the vast majority with internal locums.

Vacancies were fairly evenly distributed across most rotas, with the highest number of gaps on the SHO rotas 1 and 6, and the lowest on the ST Forensic rota.

The on call rota structure continues to be reviewed with the aim of reducing rota gaps and improving working hours. 12 new ST doctor posts were created from August 2023; however not all of these were filled during the national recruitment process.

Questions for consideration:

Whilst vacancy numbers and rota gaps were high in 2023-24, there was improvement compared to the previous financial year. Action has been taken which aims to remediate some of these issues and the impact of these should be monitored. The Board is requested to note this report.

Appendix 1: Locum Bookings By Rota

Locum bookings APRIL 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	70	70
Rota 2	13	13	134.50	134.50
Rota 3	34	34	338.00	338.00
Rota 4	15	15	144.00	144.00
Rota 5	22	22	220.50	220.50
Rota 6	29	29	284.50	284.50
ST4-6 North	10	10	135.50	135.50
ST4-6 Rea/Tam	12	12	248.00	248.00
ST4-6 Sol/East	24	24	464.00	464.00
ST4-6 South	6	6	82.00	82.00
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	7	7	51.00	51.00
Rota 2	15	15	158.50	158.50
Rota 3	19	19	172.00	172.00
Rota 4	12	12	122.50	122.50
Rota 5	12	12	108.50	108.50
Rota 6	28	28	286.00	286.00
ST4-6 North	19	19	276.00	276.00
ST4-6 Rea/Tam	8	8	152.00	152.00
ST4-6 Sol/East	24	24	456.00	456.00
ST4-6 South	6	6	78.50	78.50
Total	160	160	1861.00	1861.00

Locum bookings JUNE 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	5	5	60.50	60.50
Rota 2	5	5	45.50	45.50
Rota 3	25	25	256.00	256.00
Rota 4	9	9	78.50	78.50
Rota 5	16	16	163.50	163.50
Rota 6	21	21	201.50	201.50
ST4-6 North	12	12	163.00	163.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	23	23	416.00	416.00
ST4-6 South	5	5	64.00	64.00
Total	130	130	1616.50	1616.50

Locum bookings JULY 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	9	9	79.50	79.50

Rota 2	8	8	74.50	74.50
Rota 3	31	31	305.00	305.00
Rota 4	16	16	148.00	148.00
Rota 5	20	20	188.50	188.50
Rota 6	19	19	161.50	161.50
ST4-6 North	16	16	240.00	240.00
ST4-6 Rea/Tam	3	3	56.00	56.00
ST4-6 Sol/East	21	21	376.00	376.00
ST4-6 South	3	3	48.00	48.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	19	19	191.00	191.00
Rota 2	8	8	73.50	73.50
Rota 3	4	4	33.00	33.00
Rota 4	15	15	121.00	121.00
Rota 5	16	16	156.50	156.50
Rota 6	15	15	129.50	129.50
ST4-6 North	4	4	52.00	52.00
ST4-6 Rea/Tam	5	5	88.00	88.00
ST4-6 Sol/East	18	18	336.00	336.00
ST4-6 South	12	12	165.50	165.50
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	21	21	200.50	200.50
Rota 2	7	7	69.00	69.00
Rota 3	1	1	4.50	4.50
Rota 4	18	18	168.50	168.50
Rota 5	11	11	117.00	117.00
Rota 6	15	15	167.00	167.00
ST4-6 North	5	5	76.50	76.50
ST4-6 Rea/Tam	3	3	46.00	46.00
ST4-6 Sol/East	15	15	264.00	264.00
ST4-6 South	5	5	65.00	65.00
Total	101	101	1178.00	1178.00

Locum bookings OCTOBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	24	24	215.50	215.50
Rota 2	15	15	152.00	152.00
Rota 3	9	9	108.50	108.50
Rota 4	10	10	90.00	90.00
Rota 5	14	14	131.50	131.50
Rota 6	23	23	224.50	224.50
ST4-6 North	5	5	72.00	72.00

ST4-6 Rea/Tam	4	4	80.00	80.00
ST4-6 Sol/East	11	11	200.00	200.00
ST4-6 South	12	12	177.00	177.00
Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	187.50	187.50
Rota 2	5	5	52.50	52.50
Rota 3	3	3	36.00	36.00
Rota 4	13	13	128.00	128.00
Rota 5	20	20	203.50	203.50
Rota 6	17	17	155.50	155.50
ST4-6 North	11	11	165.00	165.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	7	7	120.00	120.00
ST4-6 South	4	4	57.00	57.00
Total	109	109	1273.00	1273.00

Locum bookings DECEMBER 2023 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	26	26	262.00	262.00
Rota 2	15	15	151.00	151.00
Rota 3	6	6	64.50	64.50
Rota 4	21	21	217.50	217.50
Rota 5	10	10	83.00	83.00
Rota 6	6	6	57.00	57.00
ST4-6 North	10	10	145.00	145.00
ST4-6 Rea/Tam	7	7	136.00	136.00
ST4-6 Sol/East	12	12	240.00	240.00
ST4-6 South	13	13	173.50	173.50
Total	126	126	1529.50	1529.50

Locum bookings JANUARY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	33	33	301.50	301.50
Rota 2	16	16	147.50	147.50
Rota 3	7	7	61.50	61.50
Rota 4	20	20	174.00	174.00
Rota 5	17	17	160.00	160.00
Rota 6	18	18	157.00	157.00
ST4-6 North	11	11	150.50	150.50
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 Sol/East	13	13	240.00	240.00
ST4-6 South	8	8	124.50	124.50
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by ROTA

Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	15	15	158.50	158.50
Rota 2	9	9	79.00	79.00
Rota 3	3	3	21.50	21.50
Rota 4	15	15	136.50	136.50
Rota 5	12	12	108.50	108.50
Rota 6	8	8	51.00	51.00
ST4-6 North & East	18	18	195.00	195.00
ST4-6 Rea/Tam	7	7	144.00	144.00
ST4-6 South & Solihull	19	19	233.00	233.00
Total	97	97	1055.00	1055.00

Locum bookings MARCH 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	189.50	189.50
Rota 2	8	8	96.00	96.00
Rota 3	14	14	161.50	161.50
Rota 4	23	23	220.00	220.00
Rota 5	8	8	82.50	82.50
Rota 6	9	9	94.50	94.50
ST4-6 North & East	34	34	299.50	299.50
ST4-6 Rea/Tam	8	8	144.50	144.50
ST4-6 South & Solihull	24	24	237.00	237.00
Total	148	148	1525.00	1525.00

Appendix 2: Locum bookings by grade

Locum bookings APRIL 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	120	120	1191.50	1191.50
ST4-6	52	52	929.50	929.50
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	93	93	898.50	898.50
ST4-6	57	57	962.50	962.50
Total	150	150	1861.00	1861.00

Locum bookings JUNE 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	81	81	805.50	805.50
ST4-6	49	49	811.00	811.00
Total	130	130	1616.50	1616.50
Locum bookings JULY 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	103	103	957.00	957.00
ST4-6	43	43	720.00	720.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	77	77	704.50	704.50
ST4-6	39	39	641.50	641.50
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	73	73	726.50	726.50
ST4-6	28	28	451.50	451.50
Total	101	101	1178.00	1178.00

Locum bookings OCTOBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	95	95	922.00	922.00
ST4-6	32	32	529.00	529.00

Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	78	78	763.00	763.00
ST4-6	31	31	510.00	510.00
Total	109	109	1273.00	1273.00
Locum bookings DECEMBER 2023 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	84	84	835.00	835.00
ST4-6	42	42	694.50	694.50
Total	126	126	1529.50	1529.50

Locum bookings JANUARY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	111	111	1001.50	1001.50
ST4-6	41	41	683.00	683.00
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	62	62	555.00	555.00
ST4-6	44	44	572.00	572.00
Total	106	106	1127.00	1127.00
Locum bookings MARCH 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	82	82	844.00	844.00
ST4-6	66	66	681.00	681.00
Total	148	148	1525.00	1525.00

Appendix 3: Locum Bookings by Reason

Locum bookings APRIL 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	110	110	1368.00	1368.00
NEW INTAKE	23	23	271.50	271.50
COVID	6	6	113.00	113.00
Sickness	9	9	96.00	96.00
Maternity Leave	3	3	36.00	36.00
Off Rota	16	16	140.50	140.50
Emergency Leave	1	1	16.00	16.00
Acting Up Consultant	4	4	80.00	80.00
Total	172	172	2121.00	2121.00

Locum bookings MAY 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	114	114	1432.50	1432.50
Sickness	6	6	57.50	57.50
COVID 19	0	0	0	0
Off Rota	14	14	125.00	125.00
Emergency Leave	4	4	38.00	38.00
Acting Up Consultant	12	12	208.00	208.00
Total	150	150	1861.00	1861.00

Locum bookings JUNE 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	91	91	1142.50	1142.50
Sickness	7	7	69.50	69.50
COVID 19	2	2	24.00	24.00
Off Rota	15	15	158.50	158.50
Emergency Leave	6	6	69.50	69.50
Acting Up Consultant	9	9	152.50	152.50
Total	130	130	1616.50	1616.50

Locum bookings JULY 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	100	100	1138.00	1138.00
COVID	3	3	36.00	36.00
Sickness	20	20	213.00	213.00
Off Rota	14	14	138.00	138.00
Acting Up Consultant	9	9	152.00	152.00
Total	146	146	1677.00	1677.00

Locum bookings AUGUST 2023 by reason**

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	10	10	45.00	45.00
Vacancy	48	48	669.00	669.00
Sickness	24	24	242.00	242.00
COVID 19	3	3	36.00	36.00
Off Rota	25	25	277.50	277.50
Paternity Leave	3	3	36.00	36.00
Emergency Leave	1	1	16.00	16.00
Bereavement	1	1	12.50	12.50
Training	1	1	12.00	12.00
Total	116	116	1346.00	1346.00

Locum bookings SEPTEMBER 2023 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	28	28	382.50	382.50
Sickness	27	27	235.00	235.00
COVID 19	10	10	105.00	105.00
Off Rota	35	35	439.50	439.50
Emergency Leave	1	1	16.00	16.00
Total	101	101	1178.00	1178.00

Locum bookings OCTOBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	46	46	534.00	534.00
COVID	6	6	72.50	72.50
Sickness	33	33	345.50	345.50
Off Rota	42	42	499.00	499.00
Acting Up Consultant	0	0	0	0
Total	127	127	1451.00	1451.00

Locum bookings NOVEMBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	45	45	507.50	507.50
Sickness	18	18	225.00	225.00
COVID 19	0	0	0	0
Off Rota	36	36	400.00	400.00
Emergency Leave	4	4	48.00	48.00
Bereavement	1	1	4.50	4.50
Acting Up Consultant	5	5	88.00	88.00
Total	109	109	1273.00	1273.00

Locum bookings DECEMBER 2023 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	7	7	46.50	46.50

Vacancy	59	59	675.00	675.00
Sickness	11	11	142.00	142.00
COVID 19	0	0	0	0
Paternity Leave	5	5	61.00	61.00
Off Rota	36	36	445.00	445.00
Emergency Leave	1	1	16.00	16.00
Acting Up Consultant	7	7	144.00	144.00
Total	126	126	1529.50	1529.50

Locum bookings JANUARY 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	74	74	791.00	791.00
COVID	1	1	16.00	16.00
Sickness	19	19	186.00	186.00
Off Rota	42	42	455.00	455.00
Emergency Leave	5	5	52.50	52.50
Paternity Leave	1	1	16.00	16.00
Exam Leave	2	2	24.00	24.00
Acting Up Consultant	8	8	144.00	144.00
Total	152	152	1684.50	1684.50

Locum bookings FEBRUARY 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	1	1	4.50	4.50
Pre-agreed A/L	2	2	16.50	16.50
Vacancy	59	59	653.00	653.00
Sickness	6	6	61.50	61.50
Off Rota	30	30	292.50	292.50
Maternity Leave	5	5	54.50	54.50
Emergency Leave	1	1	12.50	12.50
Acting Up Consultant	2	2	32.00	32.00
Total	106	106	1127.00	1127.00

Locum bookings MARCH 2024 by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	62	62	646.50	646.50
Sickness	17	17	192.50	192.50
Maternity Leave	6	6	72.00	72.00
Paternity Leave	3	3	36.00	36.00
Off Rota	56	56	544.00	544.00
Emergency Leave	1	1	4.50	4.50
Previously Agreed AL	3	3	29.50	29.50
Total	148	148	1525.00	1525.00

Locum bookings APRIL 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	89	89	1075.50	1075.50
Sickness	11	10	91.50	91.50
COVID 19	17	17	216.50	216.50
Off Rota	53	53	721.00	721.00
Compassionate L	2	2	25.00	25.00
NEW INTAKE	4	4	40.50	40.50
Total	176	176	2170.00	2170.00

Locum bookings MAY 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	85	85	1060.50	1060.50
Sickness	21	21	261.50	216.50
COVID 19	5	5	73.00	73.00
Off Rota	43	43	557.50	557.50
Compassionate L	1	1	12.50	12.50
Total	155	155	1965.00	1965.00

Locum bookings JUNE 2022 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancy	96	96	1163.50	1163.50
Sickness	16	16	186.50	170.50
COVID 19	6	6	59.00	59.00
Off Rota	77	77	1000.00	1000.00
Total	195	195	2409.00	2409.00

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 June 2024**
Date(s) of Committee Meeting(s) reported	**23 May 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Corporate Risk Register • Integrated Performance Report • Finance Report • Planning and Budget Setting 2024/25 Report • Business Development and Partnerships Report • Clinical Services Priority Q4 2023/24 Report and 2024/25 Goals • Sustainability Priority Q4 2023/24 Report and 2024/25 Goals • NHS Oversight Framework Segmentation
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The total plan for out of area expenditure, including a £5m savings target, was £14m. Month 1 reported expenditure of £1.8m which was £0.6m adverse to plan. The Committee requested an out of area improvement plan for review in June. • The Group position at Month 1 was a reported £422k deficit (comprising a £315k deficit for MHPC, £83k deficit for the Trust, and £10k deficit for SSL). Key drivers for this position were out of area performance, bank and agency spend, and packages of care related to S117. • A savings target of £17.8m for 2024/25 had been confirmed. A total of £1.8m was currently unidentified, with some high-risk plans received. • The need for an overarching improvement plan was discussed, to align the quality improvement work, strategies and CIP; benchmarking data would be utilised to identify gaps and opportunities. The Committee suggested this for a future Board strategy session.
Assure:	The Committee wished to assure the Board of Directors on the following areas:

	• The Committee approved the Sustainability and Clinical Services strategic goals for 2024/25. • Positive progress had been made on the reduction of medical agency staff. • The Committee retrospectively endorsed the BSMHFT Group financial plan submission for 2024/25, which confirmed a £1.5m surplus.	
Advise:	The NHS Oversight Framework segmentation letter was received and the Committee noted that the Trust remained in segment 3. Positive feedback was noted, and the Committee was confident that improvements were already underway on the actions raised within the letter. The Committee would continue to review and support development of the performance metrics within the Integrated Performance Report.	
Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. A workshop had been agreed to review and agree new, fit-for-purpose risks in preparation for the Board Strategy Session in September.	
	New risks identified: The Committee noted that the Risk Management Group was operating well and supported the embedding of risk management processes throughout the organisation. No additional risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Report of the Finance, Performance and Productivity Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 June 2024**
Date(s) of Committee Meeting(s) reported	**17 April 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Corporate Risk Register • Integrated Performance Report • Finance Report • Planning and Budget Setting 2024/25 Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The current 2024/25 planning assumption was a savings target of £15.7m, including a £5m target for out of area reduction which would be brought forward from 2023/24. Savings plans had been identified, however £7.1m of the plans were considered high risk. • The above target underpinned a system deficit of £71m. The Committee considered the risk of additional savings targets (c£6m) due to the system submitting a breakeven position. The Committee recognised that system-wide conversations were very fluid and further updates would be provided. • Cost pressure funding requests of £12.7m had been submitted as part of the planning process. Due to the challenging financial position for 2024/25, only £861k of the requests could be funded. • The capital plan submission was currently £6.6m. There was some uncertainty around the final capital allocation for 2024/25 related to the system 2023/24 revenue position. To date, £5.3m capital pre-commitments had been identified and approved for 2024/25.
Assure:	***2023/24*** The Committee was assured by the positive year-end position, with a £2.7m surplus reported. There had been a reduction in year-to-date agency spend as a percentage of the pay bill (3.6%), which meant the Trust was now below the NHSE cap. The continued development, realignment and focus of corporate and strategic risks supported the triangulation of information across key areas.

	The cash position remained strong, although this also included the provider collaboratives' budgets. ***2024/25*** The Committee was assured that, unlike previous years, the £15.7m savings target was fully underpinned, with 71% of the challenge coming from recurrent savings opportunities. It was recognised that the percentage of recurrent savings ideally needed to be as close as possible to 100%.	
Advise:	Work continued to reduce agency usage; above cap medical agency had reduced by one, with above cap nursing agency consistent with February's position.	
Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. The Committee agreed to hold a workshop in May to discuss and agree new, fit-for-purpose risks in preparation for the Board Strategy Session in September.	
	New risks identified: The Committee reviewed the corporate risk register and was assured by the ongoing work to align operational risks to the BAF. No additional risks were identified.	
Report compiled by:	Bal Claire Deputy Chair/ Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Report to the Board of Directors							
Agenda item:	**16**						
Date	5 June 2024						
Title	Finance Report						
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy Director of Finance						
Executive Director	David Tomlinson, Executive Director of Finance	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

Alert	✓	**Advise**	✓	**Assure**	

Revenue position:

The month 1 consolidated Group position is a deficit of £422k. This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16. The position comprises a £315k deficit for the Mental Health Provider Collaborative, a deficit of £83k for the Trust, £10k deficit for Summerhill Services Limited (SSL) and a £21k surplus position for the Reach Out Provider Collaborative.

Alert:

The Board is asked to note and discuss the following key financial alerts:

- Out of area – The total 2024/25 plan for out of area expenditure, including a £5m savings target, is £14m. The month 1 out of area expenditure is £1.8m, this is £0.6m adverse to plan.

- Savings – The 2024/25 savings target is £17.8m (£11.5m recurrent and £6.3m non recurrent). £1.8m is unidentified in the savings plan. The month 1 savings achieved is £600k, this is £651k less than plan. The majority of the slippage on achievement relates to the £5m out of area savings target (£417k in month 1) and the £1.8m unidentified savings target (£147k in month 1).

Advise:

- Temporary staffing – The 2024/25 temporary staffing plan is £41.5m. This includes bank and agency reduction savings targets of £1.5m and £1.8m respectively. In month 1 temporary staffing expenditure is £440k less than plan. The number of over cap medical agency bookings has reduced from 20 in March to 15 in April.

- Capital position:
  The month 1 Group capital expenditure is £1.2m, this is £0.4m ahead of plan.
- Cash position:
  The month 1 Group cash position is £83m which comprises £19m Trust cash balance.

Approve:

For year-end audit purposes relating to decisions taken by the Board in 2023, the Board is asked to confirm the following to be included in the minutes for this meeting

- As at the 31st March 2024 there is a Deed of Variation of Lease Terms (in Principle) between SUMMERHILL SERVICES LIMITED incorporated in England and Wales with company number 8015667, whose registered office is at SSL Hub, Unit 7 Junction 6 Industrial Estate Off Electric Avenue, Aston, Birmingham B6 7JJ(Landlord); and BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST of Uffculme Centre 52 Queensbridge Road, Moseley, Birmingham B13 8QY (Tenant) to extend leases in relation to Ardenleigh, Tamarind, Juniper, Maple Leaf/John Black and Reaside to November 2043. The Landlord and Tenant have mutually agreed to extend the term of the leases to 30th November 2043 on the same terms and conditions as in the original lease as dated for each property (site). These are in the final stages of completion with both parties and Mills & Reeve Solicitors.

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services		
People		
Quality		
Sustainability	✓	Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.

Recommendation

The Board is asked to review the financial position at month 1 and discuss the key alerts.

Enclosures

Month 1 Finance Report

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2024 to 30th April 2024

Month 1
Group financial position

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	618,759	51,563	50,640	(923)
Other Income	21,117	1,760	1,741	(19)
Total Income	**639,876**	**53,323**	**52,380**	**(942)**
Expenditure				
Pay	(289,257)	(24,339)	(23,558)	781
Other Non Pay Expenditure	(310,055)	(25,838)	(26,153)	(315)
Drugs	(7,150)	(596)	(609)	(13)
Clinical Supplies	(539)	(45)	(52)	(7)
PFI	(14,388)	(1,199)	(1,330)	(131)
EBITDA	**18,487**	**1,306**	**678**	**(629)**
Capital Financing				
Depreciation	(9,765)	(814)	(797)	16
PDC Dividend	(16)	(1)	(1)	-
Finance Lease	(8,479)	(4,595)	(4,594)	1
Loan Interest Payable	(972)	(81)	(86)	(5)
Loan Interest Receivable	1,899	158	465	307
Surplus / (Deficit) before taxation	**1,153**	**(4,027)**	**(4,335)**	**(309)**
Taxation	(380)	(32)	(32)	-
Surplus / (Deficit)	**773**	**(4,058)**	**(4,367)**	**(309)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	0	0	-
Adjust PFI revenue costs to UK GAAP basis	722	3,944	3,944	-
Adjusted financial performance Surplus / (Deficit)	**1,500**	**(114)**	**(422)**	**(309)**

Month 1 2024/25 Group Financial Position

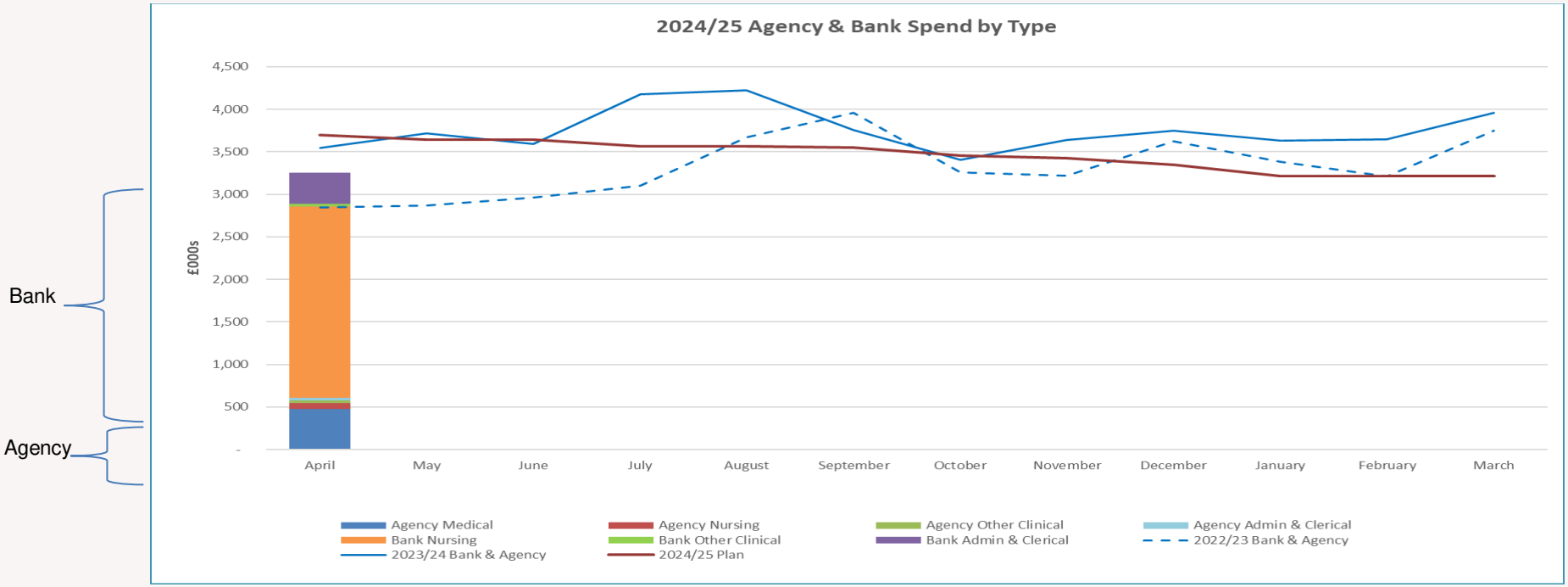
The month 1 consolidated Group position is a deficit of £422k. This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£4m in month 1). In 2024/25, for the purposes of the calculation of adjusted financial performance, PFI schemes will be measured on a UK GAAP basis.

The month 1 outturn is £309k adverse to plan. The Group month 1 position is mainly driven by the Mental Health Provider Collaborative (MHPC) which is at a deficit of £315k. This is predominantly due to section 117 packages of care pressures. The Trust position is a deficit of £83k and there is a £10k deficit for the wholly owned subsidiary, Summerhill Services Limited (SSL). The Reach Out Provider Collaborative month 1 position is £21k surplus in line with agreed contribution to Trust overheads.

Month 1 Group position
Segmental summary

Group Summary	Trust	SSL	Reach Out	BSOL PC	Consolidation	Group
	Actual	Actual	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
Patient Care Activities	30,156	-	12,247	33,316	(25,079)	50,640
Other Income	1,928	2,431	-	-	(2,618)	1,741
Total Income	**32,084**	**2,431**	**12,247**	**33,316**	**(27,697)**	**52,380**
Expenditure						
Pay	(22,427)	(1,013)	(142)	(175)	198	(23,558)
Other Non Pay Expenditure	(7,101)	(768)	(12,084)	(33,456)	27,256	(26,153)
Drugs	(630)	(189)	-	-	211	(609)
Clinical Supplies	(52)	-	-	-	-	(52)
PFI	(1,330)	-	-	-	-	(1,330)
EBITDA	**543**	**461**	**21**	**(315)**	**(32)**	**678**
Capital Financing						
Depreciation	(528)	(237)	-	-	(33)	(797)
PDC Dividend	(1)	-	-	-	-	(1)
Finance Lease	(4,592)	(32)	-	-	30	(4,594)
Loan Interest Payable	(86)	(171)	-	-	171	(86)
Loan Interest Receivable	636	0	-	-	(171)	465
Surplus / (Deficit) before Taxation	**(4,027)**	**21**	**21**	**(315)**	**(36)**	**(4,335)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(32)	-	-	-	(32)
Surplus / (Deficit)	**(4,027)**	**(10)**	**21**	**(315)**	**(36)**	**(4,367)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	0	-	-	-	-	0
Adjust PFI revenue costs to UK GAAP basis	3,944					3,944
Adjusted financial performance Surplus / (Deficit)	**(83)**	**(10)**	**21**	**(315)**	**(36)**	**(422)**

Temporary staffing expenditure

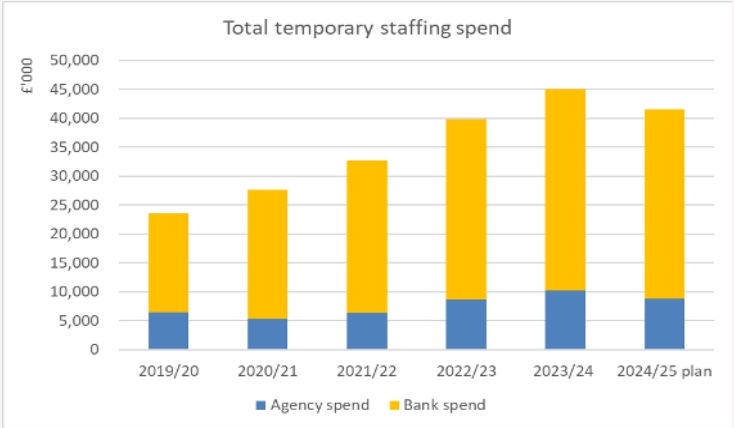


Month 1 temporary staffing expenditure is £3.3m, this is £440k less than plan.

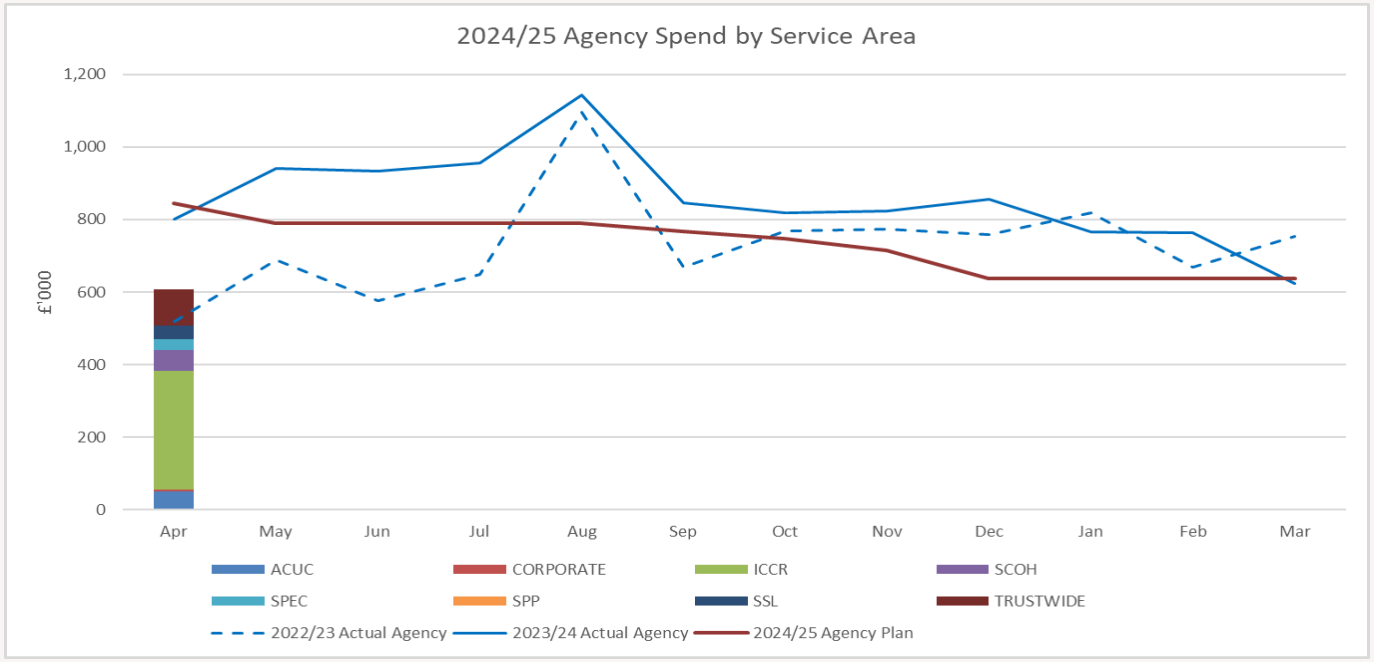
Bank expenditure £2.6m (81%) – the majority of bank expenditure relates to nursing bank shifts - £2.3m

Agency expenditure £0.6m (19%) – the majority of agency expenditure relates to medical agency - £0.5m.

For further analysis on bank and agency expenditure, see pages 5 to 6.



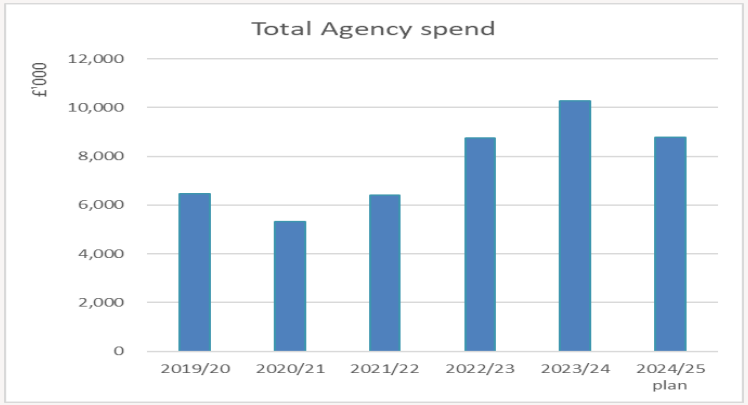
Agency expenditure



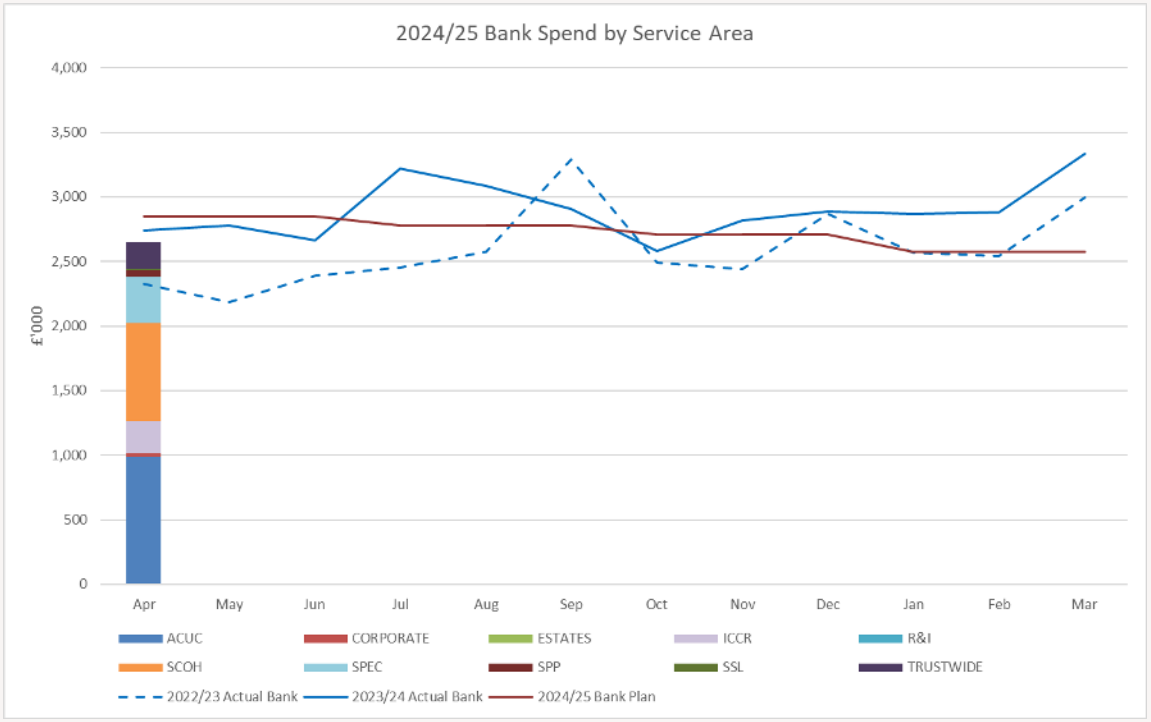
Agency expenditure

- The month 1 2024/25 agency expenditure is £607k, this is £236k less than plan.
- The NHSE planning guidance states that the intention for 2024/25 agency expenditure is for aggregate agency spending for all trusts to reduce to 3.2% as a proportion of the total pay bill. Agency expenditure is £146k below this threshold in month 1.
- An agency reduction savings target of £1.8m has been included in the 2024/25 financial plan.
- 78% of the month 1 agency spend relates to medical. There has been a significant amount of work undertaken in recent months to reduce the number of over cap medical agency bookings. There are 15 over cap as at the end of April, which is a reduction of 5 since March.

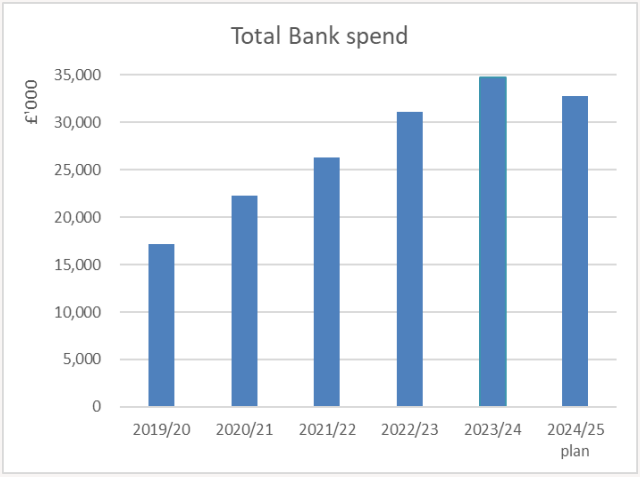
	2023/24 YTD
	£'000
Agency Expenditure	**607**
NHSE Ceiling	**754**
Variance to NHSE ceiling	**146**
Agency Medical	472
Agency Nursing (Registered)	77
Agency Nursing HCA	0
Agency Other Clinical	25
Agency Admin & Clerical	34
Agency Expenditure	**607**



Bank expenditure analysis



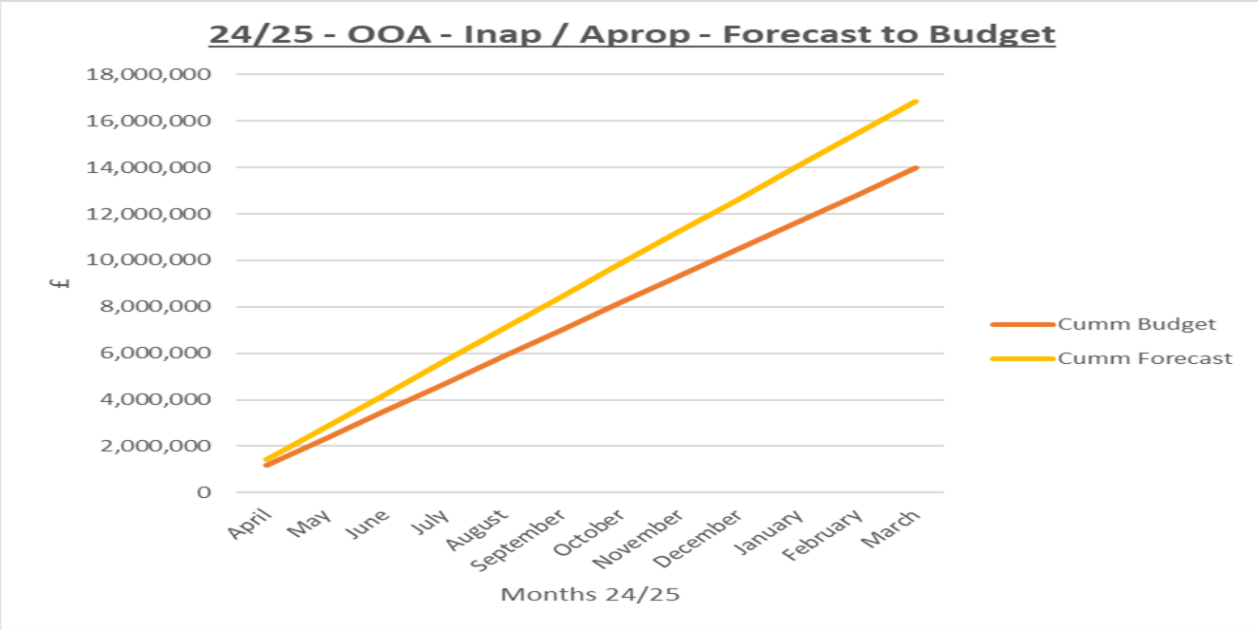
Type	YTD £'000	% of spend
Bank Nursing	2,251	85%
Bank Other Clinical	28	1%
Bank Admin & Clerical	368	14%
Grand Total	**2,648**	**100%**

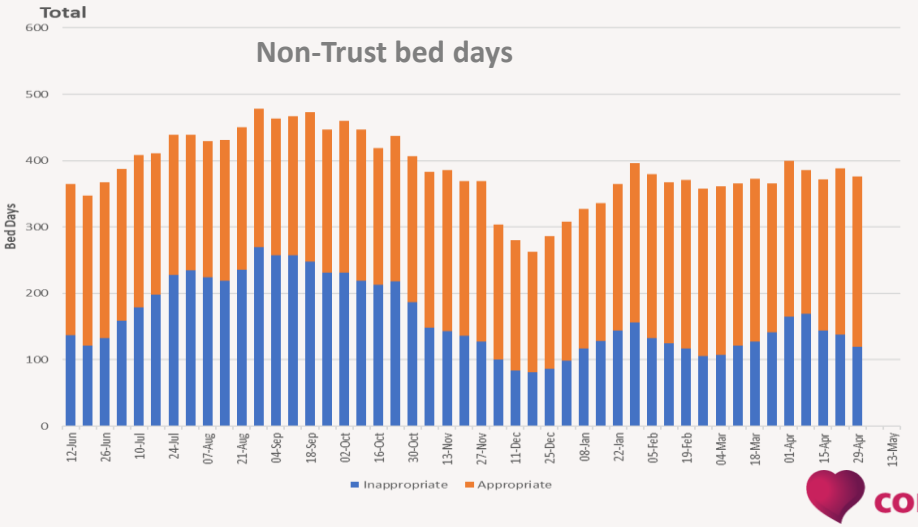


Bank expenditure

- The month 1 bank expenditure for 2024/25 is £2.6m which is £203k less than plan. It is £249k less than the average 2023/24 run rate. We are working with workforce colleagues to test out improvements regarding the methodology for the bank accrual.
- The 2024/25 bank expenditure plan, including a £1.5m savings target is £32.7m.
- Bank expenditure has predominantly been incurred within the following service areas: Acute and Urgent Care £1m, Secure and Offender Health £0.8m, Specialities £0.4m and ICCR £0.2m.

Out of Area overspend





- The total 2024/25 plan for out of area expenditure, including a £5m savings target, is £14m.
- Month 1 expenditure of £1.8m is £0.6m adverse to plan.
- The first draft year end forecast based on month 1 bed usage is £17m which would be a £3m overspend.

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Pay - Recurrent	57	23	(34)	3,489	3,489	-
Non-pay - Recurrent	668	198	(470)	8,013	8,013	-
Income - Recurrent	-	-	-	-	-	-
Total recurrent efficiencies	**725**	**221**	**(504)**	**11,502**	**11,502**	**-**
			-			-
Pay - Non-recurrent	35	35	-	416	416	-
Non-pay - Non-recurrent	180	33	(147)	2,162	2,162	-
Income - Non-recurrent	311	311	-	3,735	3,735	-
Total non-recurrent efficiencies	**526**	**379**	**(147)**	**6,313**	**6,313**	**-**
			-			-
Total Efficiencies	**1,251**	**600**	**(651)**	**17,815**	**17,815**	**-**

Savings plan 2024/25	£'000
Recurrent/Non-recurrent	
Recurrent	11.5
Non-recurrent	6.3
Total	17.8
Developed Status	
Fully Developed	8.9
Plans in Progress	5.0
Opportunity	2.1
Unidentified	1.8
Total	17.8
Risk Status	
High Risk	8.9
Medium Risk	0.0
Low Risk	8.9
Total	17.8

- The 2024/25 efficiency target (as submitted to NHSE as part of the financial plan on 2.5.24) was £17.8m.
- 2024/25 savings target comprises £11.5m recurrent and £6.3m non recurrent targets. £8.9m are considered high risk and £1.8m are unidentified. For further detail on the 2024/25 savings plans, see planning and budget setting 2024/25 update paper.
- The month 1 savings achieved is £600k, this is £651k less than plan. The majority of the slippage on savings achieved relates to the £5m out of area savings target (£417k) and the £1.8m unidentified savings target (£147k).

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - *'Draft'* 31-Mar-24 £m's	NHSI Plan YTD 30-Apr-24 £m's	Actual YTD 30-Apr-24 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	220.6	225.9	217.8
Prepayments PFI	1.2	1.2	1.3	1.2
Finance Lease Receivable	0.0	-	0.0	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	221.8	227.2	219.0
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	21.4	21.4	27.6	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.5	83.4	93.1
Total Curent Assets	114.0	113.3	111.4	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(79.0)	(80.0)
Tax payable	(5.8)	(5.8)	(5.3)	(5.8)
Loan and Borrowings	(2.6)	(2.6)	(2.3)	(2.6)
Finance Lease, current	(1.1)	(1.1)	(1.1)	(1.1)
Provisions	(1.3)	(1.3)	(1.3)	(1.3)
Deferred income	(45.2)	(45.2)	(46.2)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(135.3)	(136.0)
Non-current liabilities				
Deferred Tax Liability	(0.1)	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(23.0)	(22.2)	(22.2)	(20.8)
PFI lease	(78.3)	(82.2)	(82.2)	(78.8)
Finance Lease, non current	(6.8)	(6.9)	(11.2)	(5.8)
Provisions	(3.0)	(3.0)	(3.0)	(3.0)
Total non-current liabilities	(111.2)	(114.6)	(118.8)	(108.5)
Total assets employed	88.6	84.5	84.5	89.4
Financed by (taxpayers' equity)				
Public Dividend Capital	114.7	115.1	115.0	115.1
Revaluation reserve	48.0	48.0	48.0	48.0
Income and expenditure reserve	(74.1)	(78.5)	(78.5)	(73.7)
Total taxpayers' equity	88.6	84.5	84.5	89.4

SOFP Highlights

The Group cash position at the end of April 2024 is £83.4m, this includes Reach Out and the Mental Health Provider Collaborative.

For further detail on the current month cash position and movement of trade receivables and trade payables, see pages 10 to 11.

Current Assets & Current Liabilities

Ratios

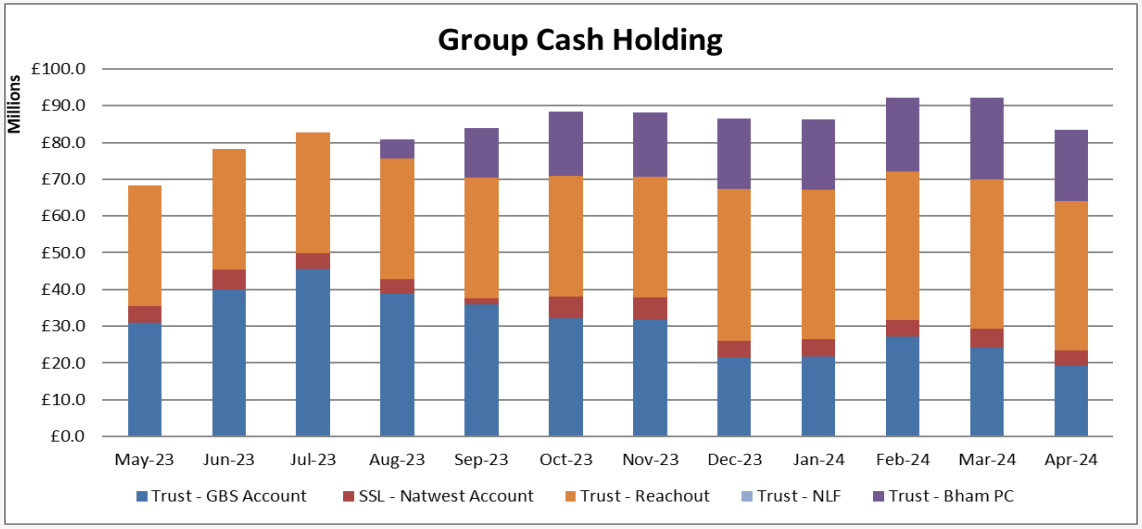
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

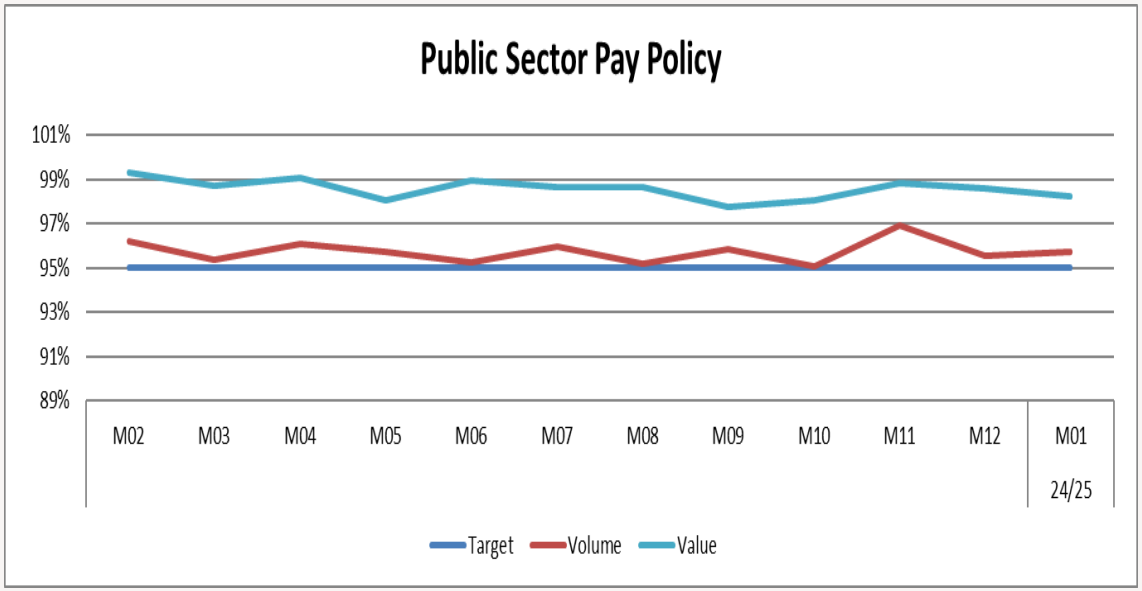
Current Ratio :	**£m's**
Current Assets	111.4
Current Liabilities	-135.3
Ratio	0.8

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of April 2024 is £83.4m. This comprises of Trust £19m, SSL £4m, Reach Out Provider Collaborative £41m and Mental Health Provider Collaborative £19m.

At this present time, the National Loan Fund (NLF) is not offering a more favourable interest rate than the Government Banking Service (GBS) hence we have not placed any short-term/long-term deposits.

Better Payments

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

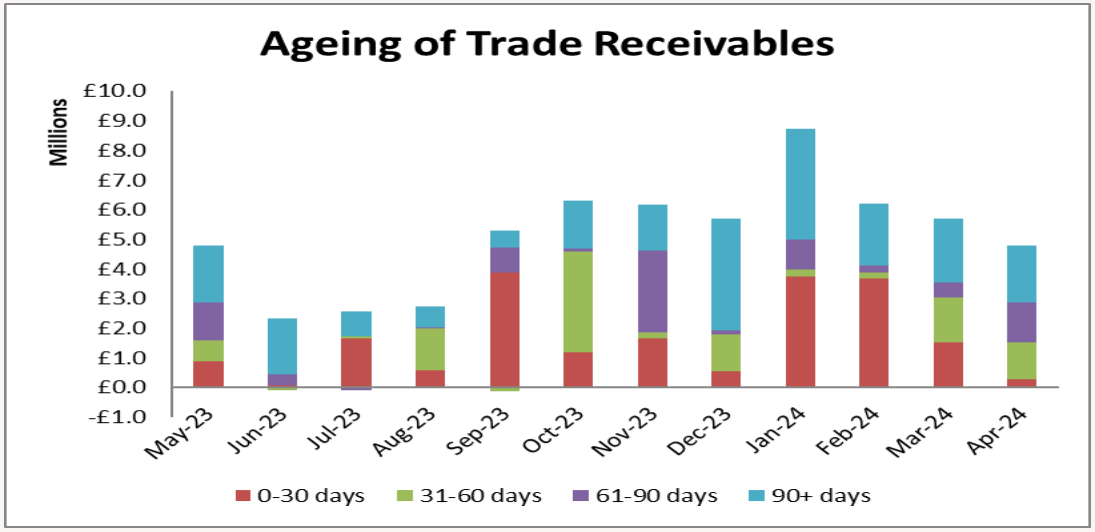
Performance against target is 97% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

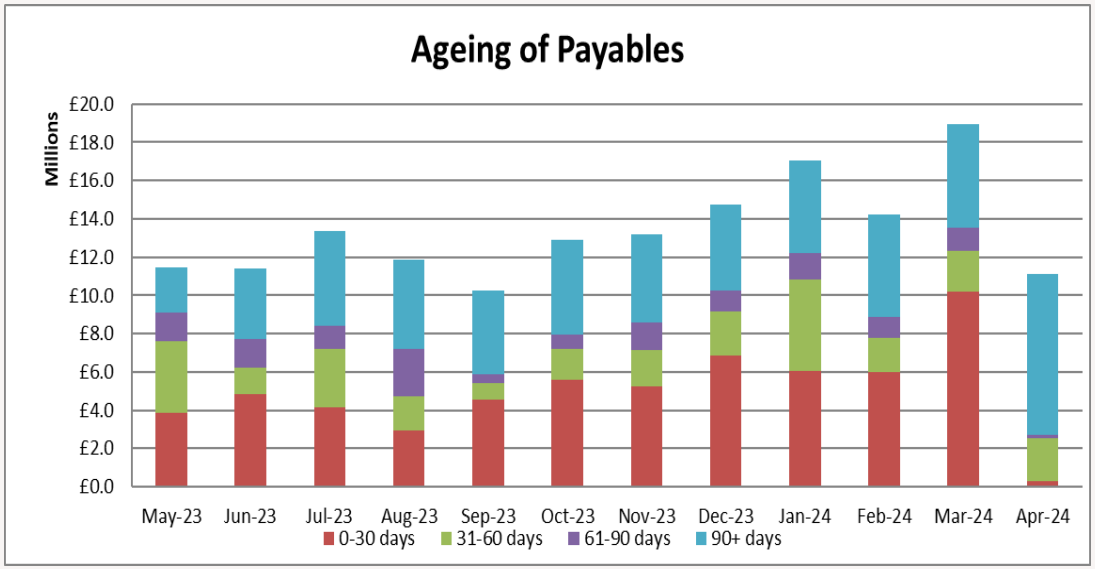
This performance has been consistent throughout 2023/24 and the aim is to maintain this during 2024/25.

Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	96%	✓	100%	✓
Non - NHS Creditors within 30 Days	96%	✓	98%	✓

Trust Receivables and Payables





Trade Receivables & Payables

Trade Receivables :

- **0-30 days-** Balance due to monthly/quarterly/year end and ad hoc invoices raised in month with no known disputes. payments received up to 08/05/24 £459k.
- **31-60 days-** slight decrease in balance mainly due to slow resolution of invoices from BWC & UHB which have moved to 61-90 days. Balance staff overpayments (on payment plans).
- **61-90 days-** increase due to invoices moving from 31-60 days. BWC £848k – paid £619k on 1/5/24, UHB £464k escalated to BSMHFT and UHB management. Balance staff overpayments (on payment plans).
- **Over 90+ days** –balance mainly due to the outstanding UHB debt £1.39m – escalated to BSMHFT and UHB management, BWC £224k, South Warwickshire FT £46k. Balance staff overpayments (on payment plans).

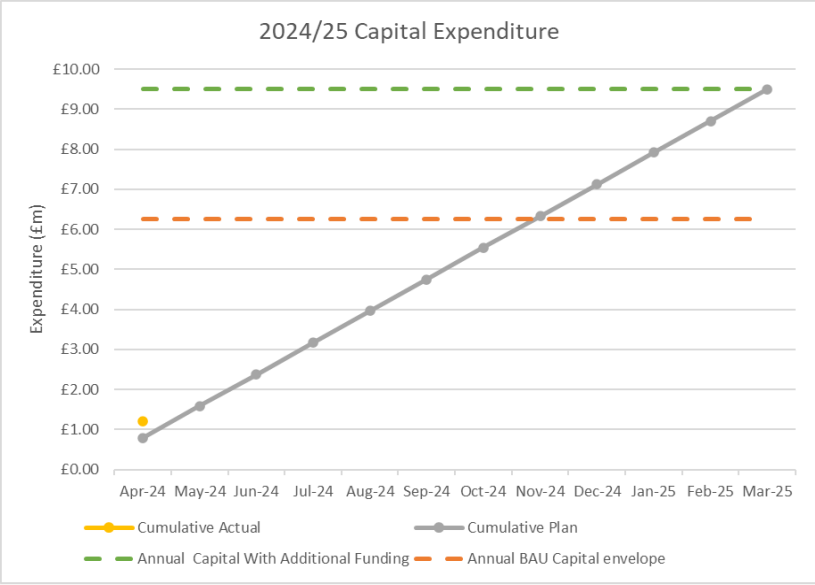
Trade Payables:

Over 90 days – Overall balance has significantly decreased due to settling of invoices relating to year end 2023/24.

- NHS Suppliers £923k- NHS Property £284k-historic invoices, UHB £446k in query with the contracting team.
- Non-NHS Suppliers (67+) £2.5m – mainly bed/out of area fees invoices in query/awaiting approval, most accounts are awaiting credit notes or adjustments due to disputes/other. Some payments/queries settled in May 2024.

Month 1 Capital expenditure

Capital Scheme	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Minor Works	1.8	0.1	0.0	0.1
Stautory Standards & Backlog Maintenance	2.0	0.2	1.2	-1.0
ICT	0.9	0.1	0.0	0.1
Medical Device Replacement	0.1	0.0	0.0	0.0
Design Works	0.8	0.1	0.0	0.1
Doorsets	0.7	0.1	0.0	0.1
Total BAU Capital Plan	**6.2**	**0.5**	**1.2**	**-0.7**
R&D Medical Equipment - grant funded	**0.7**	**0.1**	**0.0**	**0.1**
Total lease expenditure	**2.6**	**0.2**	**0.0**	**0.2**
Gross Capital Expenditure (excluding lease remeasurements)	**9.5**	**0.8**	**1.2**	**-0.4**



Group Capital Expenditure

Group capital expenditure is 1.2m in month 1 which is £0.4m ahead of plan.

Planned capital expenditure for 2024/25 is £9.5m. This consists of:

- £6.2m business as usual capital plans equal to the BSMHFT share of the system capital envelope. It mainly relates to minor works, statutory standards and backlog maintenance and ICT expenditure.
- £0.7m R&D medical equipment to be funded by a capital grant awarded in 2023/24 which will be payable in 2024/25.
- £2.6m lease expenditure. It is planned that the break clause on the lease of B1 (previous Trust headquarters) will be exercised in 2024/25. The resulting £2.6m credit on lease revaluation will be utilised against other lease expenditure in year, predominantly the renewal of lease vehicles.

In addition to the capital plans outlined above, a capital business case is with NHSE, awaiting approval for £0.8m works in the Acute and Urgent care service area.

Report to the Board of Directors							
Agenda item:	**16**						
Date	5 June 2024						
Title	Planning and Budget Setting Report						
Author/Presenter	Emma Ellis, Head of Finance and Contracts Richard Sollars, Deputy Director of Finance						
Executive Director	David Tomlinson, Executive Director of Finance	**Approved**	**Y**	✓	**N**		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

Alert	✓	**Advise**	✓	**Assure**	

Advise:

The Board is asked to note the following:

- The first full financial plan submission to NHSE was submitted on 21.3.24. This comprised a £71m deficit for the BSOL system as a whole and a £6m deficit for BSMHFT. Following further review and challenge, the final plan submission to NHSE on 2.5.24 was £6.6m deficit for the system, which comprised a £1.5m surplus plan for BSMHFT.

The Board is asked to retrospectively endorse the 2024/25 BSMHFT Group financial plan submission of £1.5m surplus.

- The capital plan submitted in the first financial plan submission was £6.6m. This included a notional allocation of £0.4m relating to the system capital investment fund (SCIF). This has been removed for the final plan submission. The whole of the SCIF is now planned as funding for Sutton Cottage Hospital which is an agreed system capital priority for 2024/25. As such, the business as usual capital plan for 2024/25 is £6.2m. Additional to this, there is £660k capital plan for R&D medical equipment funded by a capital grant awarded in 2023/24. It is also planned that the break clause on the lease of B1 will be exercised in 2024/25. The resulting £2.6m credit on lease revaluation will be utilised against other lease expenditure in year, predominantly the renewal of lease vehicles.

Alert:

The Board is asked to note and discuss the following key financial alert:

- The BSMHFT financial plan now comprises a £17.8m savings target for 2024/25. This is an increase of £2.1m compared to the first plan submission, following adjustments made to meet the system commitment to break even. £1.8m of the total savings target is unidentified and £8.9m of plans are considered high risk.

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People		
Quality		
Sustainability	✓	Being recognised as an excellent, digitally enabled organisation which performs strongly and efficiently, working in partnership for the benefit of our population.

Recommendation

- The Board is asked to review the planning and budget setting update and discuss the key alerts.
- The Board is asked to retrospectively endorse the 2024/25 BSMHFT Group financial plan submission of £1.5m surplus.

Enclosures

Planning and Budget Setting 2024/25 Report

Birmingham and Solihull Mental Health NHS Foundation Trust

2024/25
Planning & Budget Setting update

BSMHFT 2024/25 financial plan submission

NHS
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The BSMHFT first draft plan, submitted to NHSE on 21.3.24, was a deficit of £5.8m (BSOL system: £71m deficit). All partners across the system were requested to identify a 'roadmap to break even' to be reviewed at confirm and challenge meetings ahead of the final plan submission.

Following this review, the financial plan position at 30.5.24 was:

- BSMHFT - break even. The improvement in plan was achieved by including £1.5m balance sheet flexibility, £3.6m non recurrent income from provider collaboratives (£1.7m Reach Out, £0.25m Tier 4 CAMHS, £1.7m MHPC) and £0.65m additional savings target.

- System - £31m deficit. This included a £6.6m pressure relating to a technical issue regarding PFI accounting, under discussion with NHSE.

Final plan submission 2.5.24:

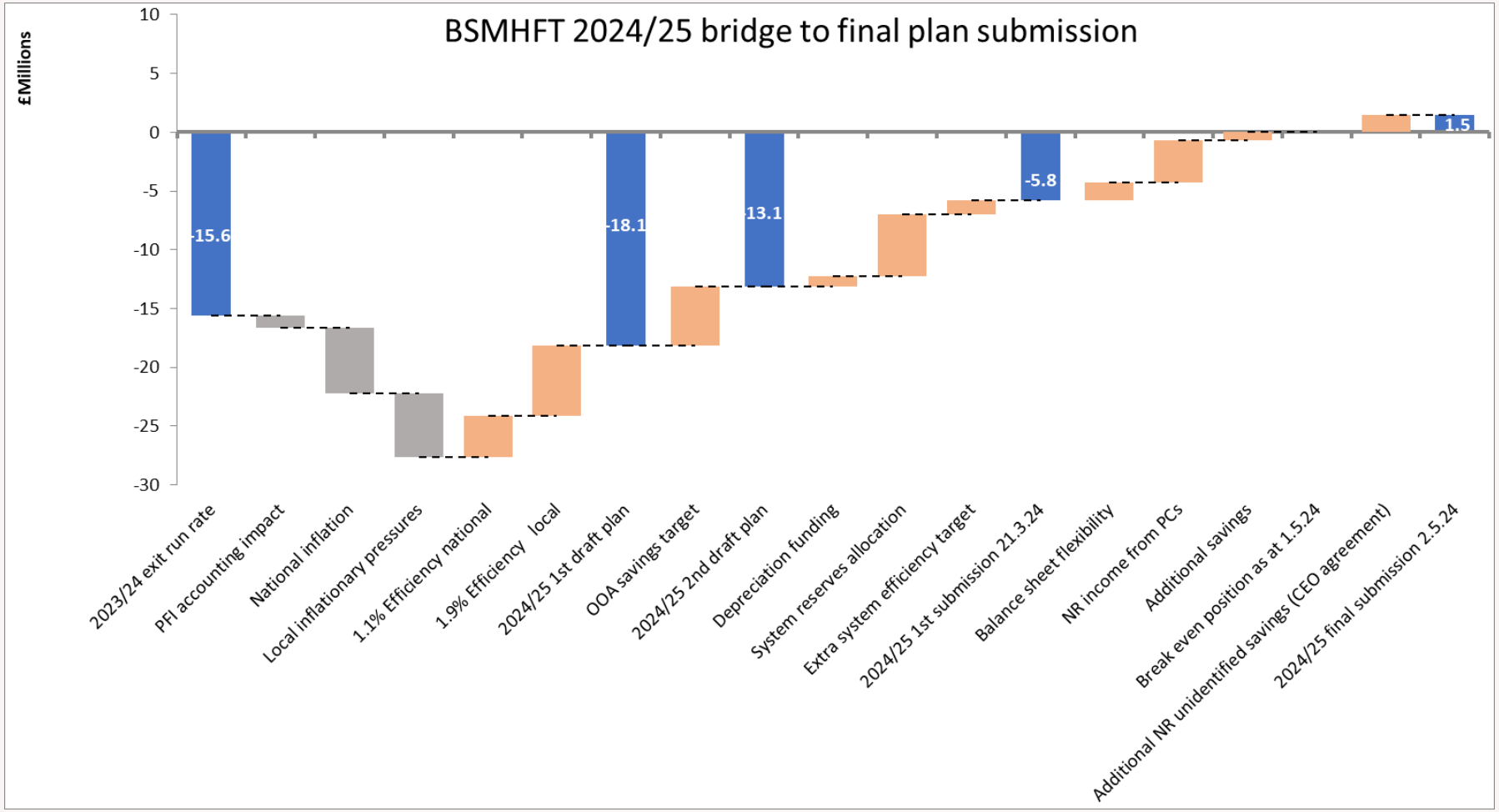
- System CEOs met on 1.5.24 and agreed adjustments to offset £24m of the system deficit, leaving the £6.6m PFI technical pressure as the overall system position to be included in the final submission on 2.5.24.
- The impact on BSMHFT was a further £1.5m improvement to plan, taking the final plan to £1.5m surplus. This has been achieved by planning for an additional £1.5m non recurrent savings target, currently classed as unidentified. For bridge of the BSMHFT plan, see next page.

Recommendation: The FPP Committee is asked to retrospectively endorse the 2024/25 BSMHFT Group financial plan submission of £1.5m surplus.

2024/25 Financial Plan	Position as at 30/4 prior to NHSE resolution of PFI issue	Adjustments agreed by CEOs	Revised position to be included in submission 2.5.24	PFI adjustment assuming approval from NHSE	Post-submission adjusted position if NHSE approve
	£'000	£'000	£'000	£'000	£'000
BSMHT	-	1,500	1,500	569	2,069
BCHC	(821)	-	(821)	821	-
BWC	-	3,000	3,000	-	3,000
ROH	-	-	-	-	-
UHB	(29,699)	8,000	(21,699)	5,225	(16,474)
ICB	-	11,405	11,405	-	11,405
Total BSOL ICS	**(30,520)**	**23,905**	**(6,615)**	**6,615**	**-**

BSMHFT 2024/25 financial plan submission

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust



2024/25 Efficiencies

Birmingham and Solihull Mental Health NHS Foundation Trust

Efficiency target 2024/25	£'000
National Efficicency target 1.1%	3,486
Local BSOL Efficiency target 1.9%	6,035
Out of Area reduction target	5,000
Additional local efficiency requirement	1,167
Additional savings as part of roadmap to BSMHFT break even	627
Additional savings following CEO discussion 1.5.24 re system break even	1,500
Total efficiency target 2024/25	**17,815**

A £15.7m savings target was included in the first draft BSMHFT plan submitted to NHSE on 21.3.24. This comprised £3.5m national efficiency target (1.1%), £6m BSOL local efficiency target (1.9%), £5m out of area reduction target carried forward from 2023/24 plus an additional system efficiency requirement of £1.2m. A further £2.1m savings targets has now been included in the plan as submitted to NHSE on 2.5.24, as part of the commitment to system break even. This takes the final 2024/25 efficiency target to £17.8m.

The table below shows the proposal of savings plans to meet the total £17.8m requirement (£11.5m recurrent and £6.3m non recurrent). £8.9m of the plans are considered high risk and £1.8m is unidentified.

Organisation	Scheme	Value £000s	Recurrent / Non-recurrent	Developed Status	Risk
BSMHT	New Recurrent Funding Stechford Custody Suite (NHSE H&J)	60	Recurrent	Fully Developed	Low Risk
BSMHT	New Recurrent Psychology Post Foston Hall (NHSE H&J)	17	Recurrent	Fully Developed	Low Risk
BSMHT	CYP Re-alignment	103	Recurrent	Fully Developed	Low Risk
BSMHT	Prevent Additional Funding	93	Recurrent	Fully Developed	Low Risk
BSMHT	Agency Reduction Saving to meet 3.2% target	1,752	Recurrent	Fully Developed	Low Risk
BSMHT	Out of Area Spend Reduction (brought forward target from 23/24)	5,000	Recurrent	Plans in Progress	High Risk
BSMHT	Non Recurrent 2 yr Pilot - Enhanced Reconnect	118	Non-recurrent	Fully Developed	Low Risk
BSMHT	Non-Recurrent Income from Reach Out	2,782	Non-recurrent	Fully Developed	Low Risk
BSMHT	Non-Recurrent Income from Other External PC's	953	Non-recurrent	Fully Developed	Low Risk
BSMHT	Increase Recurrent Interest Receivable 3.5%	900	Recurrent	Fully Developed	Low Risk
BSMHT	E&U reduction	1,355	Recurrent	Fully Developed	Low Risk
BSMHT	Procurement	388	Recurrent	Opportunity	High Risk
BSMHT	NHS Employee Pension Scheme Review 24/25	297	Non-recurrent	Fully Developed	Low Risk
BSMHT	Increase Non-Recurrent Interest Receivable 1%	400	Non-recurrent	Fully Developed	Low Risk
BSMHT	SSL savings	255	Recurrent	Opportunity	High Risk
BSMHT	Bank Reduction	1,465	Recurrent	Opportunity	High Risk
BSMHT	1% savings ICCR	115	Recurrent	Fully Developed	Low Risk
BSMHT	Unidentified	1,761	Non-recurrent	Unidentified	High Risk
		17,815			

Savings plan 2024/25	£'000
Recurrent/Non-recurrent	
Recurrent	11,503
Non-recurrent	6,312
Total	17,815
Developed Status	
Fully Developed	8,946
Plans in Progress	5,000
Opportunity	2,108
Unidentified	1,761
Total	17,815
Risk Status	
High Risk	8,869
Medium Risk	0
Low Risk	8,946
Total	17,815

Capital Plan

Capital Scheme	Plan 31/03/2025 Year Ending £'000
Minor Works	1,755
Stautory Standards & Backlog Maintenance	2,000
ICT	931
Medical Device Replacement	100
Design Works	750
Doorsets	710
Total BAU Capital Plan	**6,246**
R&D Medical Equipment - grant funded	**660**
Leased Property	**985**
Lease Renewals - buildings	**165**
Lease Renewals - Vehicles	**1,441**
Total lease expenditure	**2,591**
Gross Capital Expenditure (excluding lease remeasurements)	**9,497**

Capital Funding	£'000
Funding: BSMHFT share system capital envelope	(6,246)
Funding: NIHR Grant	(660)
Funding: Lease Revaluation - B1	(2,591)
Total Funding source	**(9,497)**

The 2024/25 Capital plan as submitted to NHSE on 2.5.24 is shown in the table opposite.

2024/25 Capital Plan
£6.2m business as usual (BAU)
This is planned expenditure against the BSMHFT share of the system capital envelope and mainly relates to minor works, statutory standards and backlog maintenance and ICT expenditure. A notional allocation of the system capital investment fund (SCIF) of £0.36m was included in the submission to NHSE on 21.3.24. This has been removed for the final plan submission; the whole of the SCIF has been included in the Birmingham Community Healthcare NHSFT capital plan as funding for Sutton Cottage Hospital which is an agreed system capital priority for 2024/25.

£660k R&D medical equipment
A £660k R&D capital grant for the purchase of repetitive transcranial magnetic stimulation (rTMS) machines for use in the treatment of depression was awarded in 2023/24 but will be received and utilised in 2024/25. This funding is additional to the system capital envelope.

£2.6m lease expenditure
It is planned that the break clause on the lease of B1 (previous Trust headquarters) will be exercised in 2024/25. The resulting £2.6m credit on lease revaluation will be utilised against other lease expenditure in year, predominantly the renewal of lease vehicles.

Future years capital plans
For the submission to NHSE on 2.5.24, there was a requirement to include capital plans for the four years following 2024/25. We have included future years capital plans at £6.2m per year for 2025/26 to 2028/29. This is in line with the BSMHFT share of the system capital envelope for 2024/25.

Birmingham and Solihull Mental Health NHS Foundation Trust

Report to Board of Directors

Agenda item:	17					
Date	5 June 2024					
Title	Trust Strategy: Year End Update and 2024/25 Goals					
Author/Presenter	Abi Broderick, Head of Strategy, Planning and Business Development Louise Butler, Strategy and Business Development Manager					
Executive Director	Patrick Nyarumbu, Executive Director of Strategy, People and Partnerships	**Approved**	**Y**	✓	**N**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	✓
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Alert	✓	**Advise**		**Assure**	

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. It comprises four strategic priorities - Clinical Services, People, Quality, Sustainability each of which has a number of strategic aims.

Each year we agree goals for each strategic priority. The goals for 2023/24 (year 3 of the strategy) were developed through engagement with teams, service leads and experts by experience and this included reviewing the previous year's goals, any internal or external changes that might impact plans and any new drivers we need to respond to. The 2023/24 goals were approved by Committees and Board at the beginning of the financial year.

As previously agreed by Trust Board, a prioritisation exercise was carried out on the Trust goals, and goals prioritised as level 1 are reported to Board twice yearly. A mid-year update was reported to Board in December 2023 and the attached report is the year end update.

For 2023/24 we had a total of 97 goals, of which 39 were prioritised as level 1. The report contains narrative about our achievement against the milestone plans for each of these goals, including a rating of red, amber or green which reflects the status of the goal against the set milestones and indicates if it is where we expected it to be at year end.

During the last quarter we have been developing our goals for 2024/25. As outlined in the enclosed report, this has involved consideration of the local and national context, internal and external drivers and continued engagement with service areas, leads, professions and experts by experience. We have also taken learning and feedback from the last 3 years in considering our approach to goal setting for 2024/25 and this is also covered in the report.

The purpose of this report is to:

Part A – Provide an update on level 1 goals at the end of Quarter 4 of 2023/24 for assurance about how we are delivering the strategy.

Part B – Seek approval of the strategic goals for 2024/25 and describe how they have been developed so that we can demonstrate accountability, progress, achievements, impact and outcomes.

Detailed reports relating to each strategic priority were taken to the relevant Board sub-committees on 22/23 May 2024 as follows:

- Clinical services: FPP and QPES Committees
- People: People Committee
- Quality: QPES Committee
- Sustainability: FPP Committee

Recommendation

The Board is asked to:

- Note the contents of the report
- Be assured that good progress has been made in Quarter 4 and that plans were in place to monitor goals that were not on track against milestones
- Approve the Clinical Services goals for 2024/25

Enclosures

Trust Five Year Strategy: 2023/24 Goals Year End Update and 2024/25 Goals

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services	✓	The report covers all Clinical Services goals for 2023/24 and 2024/25, encompassing all 6 strategic aims for clinical services.
People	✓	The report covers all People goals for 2023/24 and 2024/25, encompassing all 6 strategic aims for clinical services.
Quality	✓	The report covers all Quality goals for 2023/24 and 2024/25, encompassing all 6 strategic aims for clinical services.
Sustainability	✓	The report covers all Sustainability goals for 2023/24 and 2024/25, encompassing all 6 strategic aims for clinical services.

Our Trust Five Year Strategy

2023/24 goals – year end update and 2024/25 goals

Trust Board, 5 June 2024

compassionate inclusive committed

1. Purpose of this report

Our Trust Five Year Strategy was developed during 2019/20 and launched across the organisation April 2021. The Strategy was co-produced with colleagues, service users and carers, and partners. It comprises **four strategic priorities – Clinical Services, People, Quality and Sustainability**, each of which has a number **of strategic aims** which describe our particular areas of focus.

Each year we agree goals for each strategic priority. The goals for 2023/24 were approved by Committees and Board at the beginning of the financial year and we report on them quarterly to Committees and bi-annually to Board.

During Quarter 4 we have been developing our strategic goals for 2024/25. As outlined in this report, this has involved consideration of the local and national context, internal and external drivers and continued engagement with service areas, leads, professions and experts by experience. We have also taken the learning from the last 3 years, resulting in an approach that will better demonstrate accountability, progress, achievements, impact and outcomes.

The purpose of this report is to:
Part A: Provide an update on 2023/24 goals as at the end of Quarter 4 for assurance about how we are delivering the strategy.
Part B: Seek approval of the strategic goals for 2024/25 and describe how they have been developed so that we can demonstrate accountability, progress, achievements, impact and outcomes.

Detailed quarterly reports relating to each strategic priority have been taken to the relevant Board sub-committees in August and November as follows:

- **Clinical services**: FPP and QPES Committees
- **People**: People Committee
- **Quality**: QPES Committee
- **Sustainability**: FPP Committee

2. Our Trust Strategy

NHS
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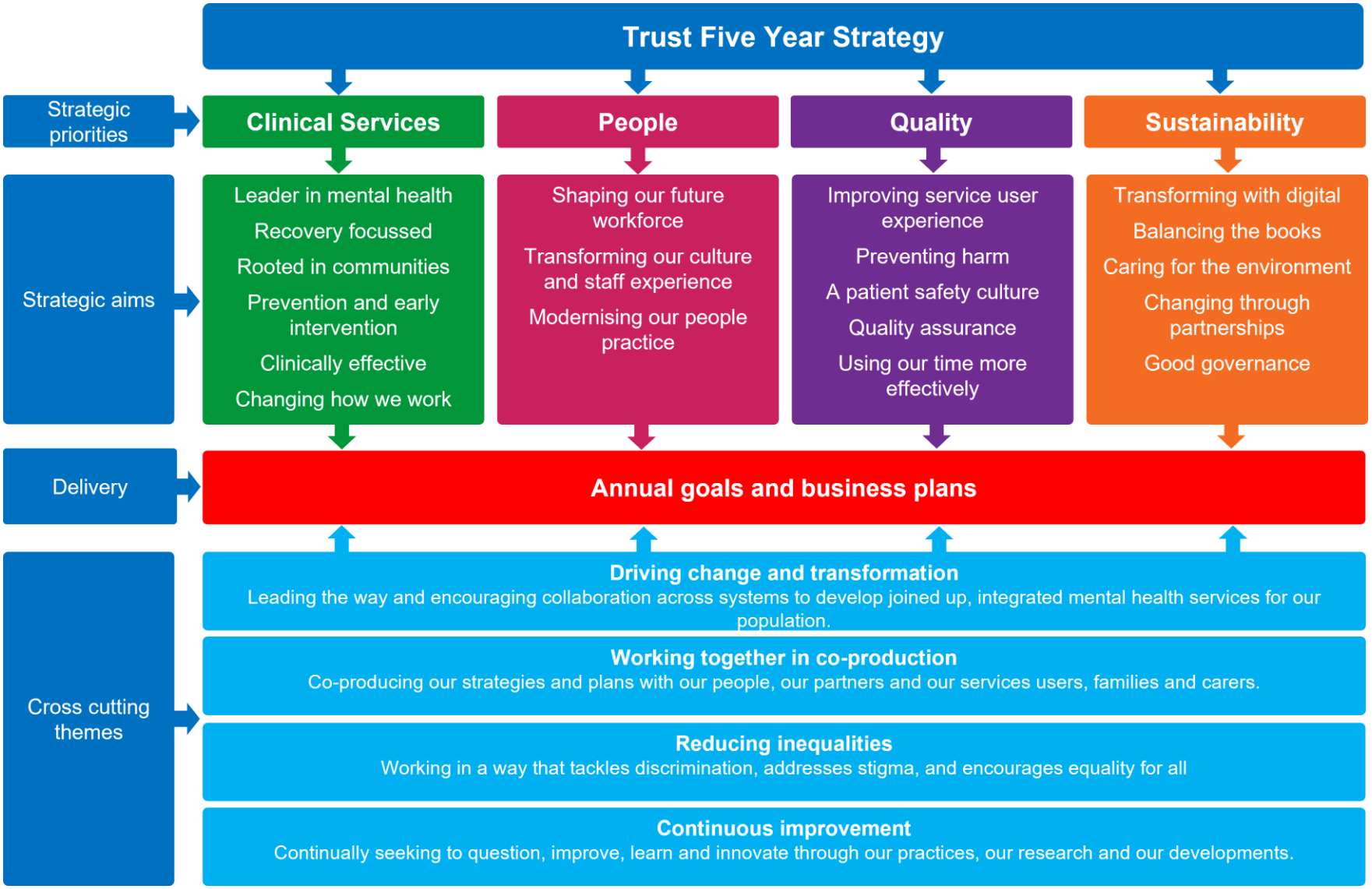
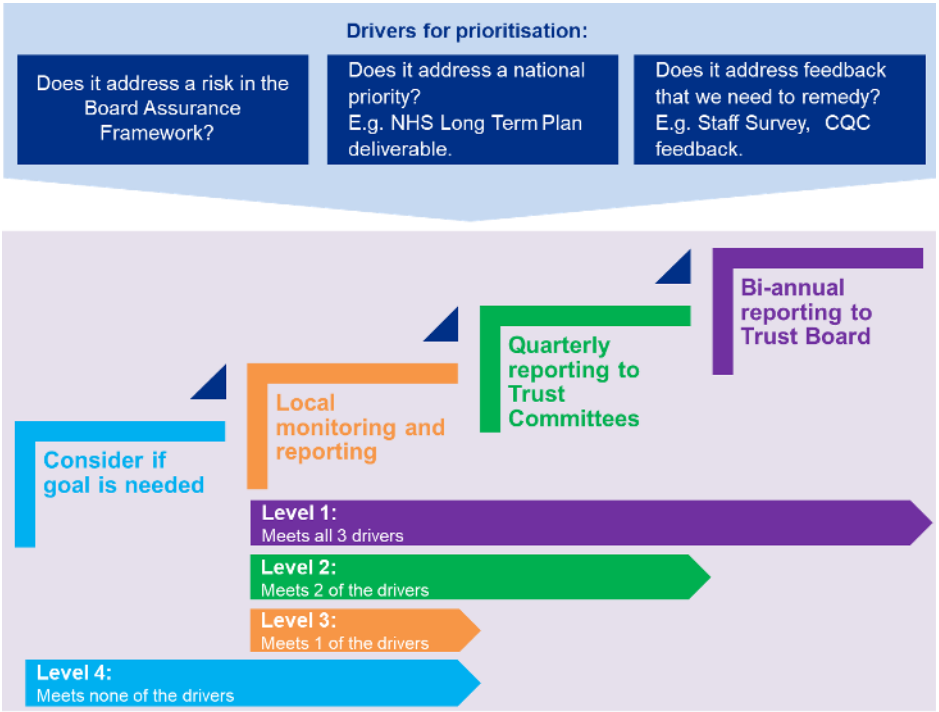
NHS Foundation Trust



compassionate inclusive committed

3. Prioritisation of goals

- We have an ambitious Trust strategy with a number of aims across our four strategic priorities.
- Our **annual strategic goals** for each aim are set through engagement with senior leaders, management teams, relevant committees/groups and experts by experience.
- A **prioritisation framework** is used to assess each goal and assign it a priority level between 1 and 4. This uses three drivers to assess the priority level of each goal:
    1. Does it address a risk in the Board Assurance Framework?
    2. Does it address a national priority? E.g. NHS Long Term Plan deliverable.
    3. Does it address feedback that we need to remedy? E.g. staff survey, CQC feedback.
- Prioritisation in this way helps to:
    - Inform what the most important goals are.
    - Define what is reported to Board and Committees for monitoring and assurance.
    - Make decisions about use of resources.
    - Identify whether any goals can be moved to subsequent years of the strategy.



Based on this prioritisation, Trust Board will receive information to give assurance about the level 1 goals.

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Part A:
2023/24 year end review

4. Level 1 goals for 2023/24

* Inequalities goals highlighted in blue text
** *Following a review this goal was removed at the end of Q1 as it was deemed to be business as usual*

Level 1 priorities : Report to Trust Board, QPES/FPP/People Committees, local governance structures

Clinical Services (11 goals)

Leader in mental health
- Implement divisional health inequalities plans*
- Engagement and scoping for more integrated Trust services

Recovery focussed
- Family and carer pathway – review and refresh

Rooted in communities
- Community transformation programme year 3
- Out of area placement reduction
- Partnerships with local communities to reduce inequalities*

Prevention and early intervention
- Transformation plans for children and young people in Solihull
- Urgent care transformation programme
- Birmingham Healthy Minds waiting times

Changing how we work
- Reaside re-provision
- Highcroft redevelopment

Quality (12 goals)

Improving service user experience
- Population profile of incident data*
- Expert by Experience observers project
- Patient Safety Partners in the patient safety framework

Preventing harm
- Implement Patient Safety Incident Response Framework
- *Ensure capital programme supports harm reduction**
- Ensure safe staffing model across all inpatient wards

Patient safety culture
- Review of organisation's safety culture

Quality assurance
- New learning from deaths processes
- Develop and embed Think Family principles
- Improvement against CQC action plans

Using our time more effectively
- Introduce Quality Management system, including embedding strategic approaches to Quality Improvement
- Use QI approaches to develop pathways for improved access

People (9 goals)

Shaping our future workforce
- Delivering the commitments of our workforce plan
- Developing a Just Culture*

Transforming our culture and staff experience
- Embed staff engagement programme
- Improve engagement scores to NHS staff survey
- Improvement in the four key areas identified within the NHS staff survey*
- Providing a comprehensive Health & Wellbeing offer
- Equal opportunities offered via Flourish programme*
- Anti-racist framework and systems*

Modernising our people practice
- Developing digital solutions

Sustainability (8 goals)

Transforming with digital
- Shared Care Record across BSOL
- Clinical engagement in ICT strategy and developments

Balancing the books
- Implement framework for transformational change.

Caring for the environment
- Implement the Green Plan

Changing through partnerships
- Embed BSOL Mental Health Provider Collaborative*
- Deliver West Midlands Provider Collaborative strategic priorities*

Good governance
- Review of governance arrangements from Ward to Board
- Review of risk management arrangements

5. Trust goals: an overview at end of Q4

Birmingham and Solihull Mental Health NHS Foundation Trust

Each year we set annual goals which underpin our strategic priorities and their aims. These align to the ambitions of what we want the future to look like as set out in our strategy. The annual goals have quarterly milestones which are regularly monitored and RAG rated throughout the year. The RAG ratings reflect the progress of each goal against the milestones set for them, e.g. a 'Green' RAG rating tells us that the goal is on track and progressing as we expected at the end of Quarter 2.

RAG definitions:
Red = not started / seriously behind / major issues
Amber = partially met / moderate issues
Green = fully met / fully on track / minor issues

There were **97 Trust goals in total** for 2023/24, which was year 3 of our strategy. There were **39 goals prioritised as Level 1** and are reported in detail to Trust Board in this report. A summary of the overall status at the end of Quarter 4 compared with the last Board report at the end of Quarter 2 is shown below.

Strategic aim		Red		Amber		Green	
	Q4 Total	Q2	Q4	Q2	Q4	Q2	Q4
Clinical Services	11	3	2	4	5	4	4
People	9	0	1	3	3	6	5
Quality	11	1	1	3	3	7	7
Sustainability	8	1	0	3	5	4	3
Total	39	5	4	13	16	21	19
		13%	10%	33%	41%	54%	49%

6. Overview at end of Q4 (continued)

Birmingham and Solihull Mental Health NHS Foundation Trust

It is encouraging that **90% of the level 1 priority goals are rated 'Green' or 'Amber'** which means they are where we expected them to be in relation to their milestone plans or have moderate issues impacting delivery that are being addressed to bring them on track.

During this year we have seen further evidence that the Trust Strategy has become more embedded. We are hearing the strategy referenced in meetings and used to frame conversations more than ever before. We have also been approached by a number of Trust teams to support them to collectively think about how their work connects to the achievement of our strategic aims and identify their priorities i This connection with the strategy in turn means that they and others can recognise and describe the wider contribution they make.

"It helped me understand how I contribute to the trust's goals."

"They could relate to the strategy rather than it feeling disconnected."

This achievement is against a continued backdrop of significant pressures on services, which is a testament to the **commitment** of our teams to provide high quality, **compassionate** and **inclusive** care through driving improvement and transformation.

★ Just some highlights of achievements during the year ★

Transforming community services continues at pace across the BSOL footprint.	Targeted divisional health inequalities plans developed	Improvements against Birmingham Healthy Minds trajectories	Progress on workforce initiatives including international recruitment	Staff engagement plan and incase in engagement scores in NHS Staff Survey	Development and launch of the anti-racist framework
PSIRF launched and implemented in line with national timescales	Awareness of Think Family increased through targeted campaign and ongoing engagement	Quality Improvement Strategy developed and engaged on	MHPC live for 12 months and a number of achievements recognised	FTB now on RiO – there is a single mental heatlh care record across BSOL	Shared Care Record roll out across all primary and secondary NHS organisations

7. Overview at end of Q4 (continued)

Birmingham and Solihull Mental Health NHS Foundation Trust

⚠ Red goals ⚠

Four level 1 priority goals were rated 'Red' (10%) at the end of quarter 4 which means they are not where we wanted them to be in relation to their milestone plans. This compares to five reported at the mid-year point. These are shown below:

Strategic priority	Goal	vs Q2 rating
Clinical services	*Reaside re-provision,* which was not successful in being awarded Department of Health and Social Care (DHSC) funding.	↔
Clinical services	*Review and refresh the family and carer pathway,* which has been impacted by delays in reviewing the governance of the family and carer pathway. This goal will carry over into 2024/25.	↓
People	*Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme,* which has seen slippage due to team redesign and review of programmes. This work will carry over into 2024/25.	↓
Quality	*Use data to understand health inequalities in relation to incidents,* which is dependent on development of a dashboard, with work progressing	↓

We are closely monitoring areas where although progress has been made and they are currently rated as amber, we are not achieving performance trajectories, and recovery plans developed with system partners are in place.

Conversely, the following level 1 priority goals have **moved from 'Red'** since the last Board report:

- **Clinical Services:** *Highcroft Redevelopment – now green for the 'interim' 30 bed development*
- **Clinical Services:** *Birmingham Healthy Minds workforce and waiting times - now amber*
- **Quality:** *Experts by Experience observer project - now amber*
- **Sustainability:** *Framework for transformational change.- now amber*

8. Strategic priority: Clinical services

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Goal: Engage on and scope potential for more integration between Trust services to avoid silo working and fragmentation of care.

Leader in mental health

Progress update:

- ✓ A 'dynamic space' workshop was held on 17 October to identify key areas for improvement; c50 attendees included relevant executives, Associate Directors, heads of professions, matrons, clinical nurse/service managers.
- Further work planned to:
  - Establish regular steering group meetings.
  - Develop a clear vision and purpose.
  - Seek PMO project management support.
  - Develop project initiation document (PID).
  - Consider how this fits with other place-based work, e.g. links with the Community Care Collaborative.

Risks and issues:

- Capacity for leaders and teams to engage and participate in this work.
- Lack of clarity over the purpose
- The lead for this work has been appointed to a new role in the Provider Collaborative potentially meaning uncertainty re project leadership.

Goal: Implementation of divisional health inequalities plans, following data with dignity sessions held in 2022/23, to ensure services are built on reducing inequalities data.

Leader in mental health

Progress update:

- ✓ All divisions have developed their divisional inequalities plans and key priorities, based on their own data and identified needs of their service users.
- ✓ The Health Inequalities Project Board membership has now broadened to include ADs or nominated representatives to update on progress alongside specific health inequalities projects.
- ✓ Each division will report on their plans' progress and impact during 2024/25.

Risks and issues:

- None identified.

Goal: Review and refresh the family and carer pathway, ensuring consistent ownership and application across all service areas

Recovery focussed

Progress update:

- It was agreed earlier in the year that responsibility for the pathway and engagement tool would move from the Meriden Programme to the Participation and Experience Team.
- While this has been delayed, it also needs to be aligned to the implementation of Dialog+ and the timeline for that.
- It is therefore envisaged that this will launch in September 2024 to coincide with the transition to Dialog+.

Risks and issues:

- Risk of further delay and impact on family and carer strategy refresh.

9. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Continue to progress our detailed and wide-ranging plan to transform community services across all geographical areas within the BSOL footprint, across young people, adult and older adult services. Areas of focus include:

- Personality disorder
- Eating disorders
- Psychosis
- Rehabilitation
- 18-25
- Older adults

Rooted in communities

Progress update:

- ✓ Productive Talking Therapies / NMHT Strategic Working Groups took place to discuss thematic issues and improve communication across the pathway.
- ✓ Four core areas of interest for Bipolar and Psychosis identified, and inaugural bipolar and psychosis project group meeting held on 31 January and first theme being looked at is early identification, engagement and transition.
- ✓ Caseload review and transition – desktop reviews are continuing to progress.
- ✓ Suite of digital guided self-help resources have been developed for Eating Disorders.
- ✓ Eating disorders – First Steps provision is live and referrals are being received across Neighbourhood Mental Health Teams and the Barberry.
- ✓ Launch of FREED (early intervention for eating disorders) with engagement call targets 100% being met.
- ✓ EBE Work has been progressing on community podcasts and videos as part of health inequalities work.
- ✓ Community Mental Health & Wellbeing Service animation video launched - co-designed and co-produced with EBEs
- ✓ Peer Support Lead started in post to develop BSol-wide Peer Support Programme and Hub; has continued to embed across teams and services, and consultancy agreement with ImROC in place to guide evidence-based developments.
- ✓ The Psychological Services Index is to be socialised and consulted on
- ✓ 'Exploring Depression' pilot has finished in East and started in the North in March.
- ✓ The number of physical health connectors able to fully deliver has increased,
- ✓ Discussion took place around ideas for the final element of 18-25 funding and mapping working group set-up to support mapping wider offer for 18-25's in Solihull internally and externally.
- ✓ Discussions with local authority and addiction services re collaboration opportunities to improve physical health outcomes for those with a SMI.

Risks and issues:

- High Dependency Unit still on hold due to CQC issues with the provider.

10. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Develop and implement plans, building on work already undertaken, to eradicate acute inpatient out of area placements.

Rooted in communities

Progress update:

- ✓ Overall the project progress of BSMHFT inappropriate OOA beds against trajectory is on downward trend over the last few weeks as at April, however the Trust is still above trajectory figures.
- ✓ Locality Workstream - roll out to all localities has been completed. Standard Operating Procedure is scheduled to be resubmitted for sign off in October due to feedback from the Urgent Care CGC.
- ✓ Work is being undertaken to understand good practice within the south locality which will be imbedded into the other localities for sustainability.
- ✓ Market engagement for the Crisis/Recovery House commenced in March 2024.
- ✓ Quality improvement project commenced to map the flow of admissions, to inform areas of improvement for gatekeeping.
- ✓ Bed management audit being undertaken to review allocation time, in or out of hours variation and point of access
- ✓ OOA page designed on Connect.
- ✓ Clinically Ready For Discharge (CRFD) workstream - proposal regarding Social Workers was presented to local authority but could not be agreed due to a lack of staffing in December 2023, since then recruitment has been taking place with regular meetings between the Council and the Trust.
- ✓ Discharge Managers and data colleagues held a workshop on RiO data capture and CRFD recording on the 29 April
- ✓ Localities introduced weekly CRFD meetings to ensure any escalations are identified
- ✓ Review of respite contracts to ensure contract and service is fit for purpose ongoing and meeting arranged for May 2024.
- ✓ Home Treatment Team Business Case presented at Safer Staffing Committee.

Risks and issues:

- Length of Stay/ Clinical Oversight workstream is rated red due to the Clinical Oversight Group meeting no longer taking place due to capacity issues. Approach is currently being reviewed and planning to re-establish the group with the support of the Clinical Lead.
- The Trust is sighted on capacity issues but no funding has been identified to uplift nursing establishments.
- Impact of not meeting the OOA trajectory.
- Continued local and national scrutiny.

11. Strategic priority: Clinical services

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal Work in partnership with our local communities to deliver and embed our commitment to reducing racial inequalities and ensuring cultural competencies across service delivery, through programmes and initiatives such as the BLACHIR Review, Patient Carer Race Equality Framework (PCREF) and Synergi Pledge.

Rooted in communities

Progress update:

- ✓ Anti-racist framework developed, which is informed by the PCREF work and Phase 1 - Anti Racist Colleague - rolled out across BSMHFT
- ✓ A campaign is being developed for the roll out to include resources and roadshows at Trust sites.
- ✓ Fairer futures applications being mapped with Nishkam
- ✓ Culturally appropriate advocacy pilot worked on in partnership with Catalyst and Powher.

Risks and issues:

- None identified.

Goal: Progress urgent care transformation to relieve pressure on Emergency Departments and beds in acute hospitals.

Prevention and early intervention

Progress update:

- ✓ Gatekeeping and Locality Standard Operating Procedure (SOP) launched.
- ✓ Clinical Ready For Discharge metric introduced.
- ✓ Upskilling of staff plan for Psychiatric Decisions Unit under way.
- ✓ Working closely with West Midlands Police (WMP) and West Midlands Ambulance Service (WMAS) under the Right Care, Right Person (RCRP) initiative and Right Care Right Person Mental Health Collaborative Task Group established.
- ✓ Locality bed flow meetings established.

Risks and issues:

- Gatekeeping and locality model will take time to fully establish and the change will not be immediate.
- PDU capacity may not be sufficient.
- Staffing numbers are an ongoing risk with challenges around getting appropriate cover.

12. Strategic priority: Clinical services

Goal: Continue to deliver transformation plans for children and young people in Solihull.

Prevention and early intervention

Progress update:

- ✓ Transition worker role is proving effective and has been presented in a number of forums. .
- ✓ Successful recruitment to 2 manager posts.
- ✓ Development of a clinical lead post within Latch to support with certain complexities.
- ✓ ARFID (Avoidant restrictive food intake disorder) pathway is fully embedded and there is a planned meeting to review the reporting in line with the national requirements. There is also a discussion of having a new pathway set up on RiO for ARFID to help distinguish this.
- ✓ FREED role (early intervention in eating disorders) now fully established in adult services and working into children and young people service.
- ✓ New consultant in post who has returned to the service.
- ✓ Quality improvement (QI) project around waiting list management. This will also include a pilot for Dialog+ with a view of suitability for CYP.
- ✓ Review of reporting which can be used at a local level as the requirements are slightly different to that of the requirements of NHS England reports.
- ✓ Staff recruited for wave 10 Mental Health School Teams (MHST) have and are finishing their training
- ✓ Wave 12 of the MHST application submitted and was granted with the addition of 1 new school, giving a MHST coverage of approx 80%.

Risks and issues:

- Possible changes associated to the contracts for Solar as a result of the new BSOL CYP transformation.
- Locum doctor has given notice and no replacement identified as yet.
- Long waiting lists for interventions. QI project to help resolve.

13. Strategic priority: Clinical services

Goal: Expand and support the Birmingham Healthy Minds workforce and improve waiting times to meet national trajectories by April 2025.

Prevention and early intervention

Progress update:

- ✓ The moving to recovery rate has fluctuated and largely meets the 50% national target. The March 2024 position was below the target at 45.27%.
- ✓ Performance against the seen in 18 weeks targets has been on a gradual increasing trend for the last 12 months, despite significant vacancies, although remains below the 95% target. March 2024 increased to 87.5%, remaining below trajectory. The service expects to see a continuing improvement and reach the 95% target by June 2024.
- ✓ For the seen in 6 weeks target, performance has been on a gradual increasing trend for the last 12 months but remains just below the 75% target. The March 2024 position increased to 74.81% which is above the trajectory for March and just below the target.
- ✓ The trajectory for 6 weeks is not due to be met until January 2025 but progress has significantly increased in the last four months and the service expects to see a continuing improvement to reach the 75% target by the end of January 2025.
- ✓ Increase in staff has had a positive impact on number of patient contacts with March 2024 seeing a 10% increase compared with the same month in 2023, however it will take time for staff to build up caseloads.
- ✓ A rolling programme of recruitment is in place and managers are working hard to promote staff wellbeing and initiatives to foster staff retention, including purchase of a bespoke continuing professional development (CPD) training package to support retention and recruitment.
- ✓ A clinical development lead is supporting the team to screen referrals and identify barriers to recovery planning and is developing existing relationships with neighbourhood mental health teams to enable further support.
- ✓ The team are instigating a number of initiatives to reduce the waits for high intensity cognitive behavioural therapy (CBT), including registering a QI project.
- ✓ BHM has been allocated 11 high intensity trainee places at University of Birmingham and is working with the university to recruit trainees to start in autumn 2024.

Risks and issues:

- Impact of not meeting trajectories and national/local scrutiny.
- Action plan is heavily reliant on the ability to recruit staff.
- Digital partner not achieving as high a recovery rate as our therapists is having an impact on overall recovery rate and as a result of the high cost per case we have ceased outsourcing to them.
- Client group becoming more complex; more interventions and referrals to other Trust services take additional time.
- Challenges in meeting new KPIs with present workforce.

14. Strategic priority: Clinical services

Goal: Progress with the developments for Highcroft redevelopment.

Changing how we work

Progress update:

- ✓ No change in the original project following notification from the Department of Health and Social Care in May that Highcroft has not been selected for funding from the New Hospitals Programme.

In terms of the 'Interim' option of a modular build creating an 18 Bed Acute Ward and a 12 Bed PICU Ward:

- ✓ The short form business case was presented at the ICB Investment Committee on 22 March 2024 where it was approved in principle. There are additional areas that require further detail and this is being worked through currently.
- ✓ A further project plan has been developed and shared with project board members so that is clear what is required, by whom and for when.
- ✓ Appointment of the healthcare planner has been delayed due to the procurement process required, this is being worked through.
- ✓ Benefits have been reviewed, amended, shared and worked through during a benefits workshop with the project team - further benefits were also identified.

Risks and issues:

- The priority remains to reduce the revenue costs to prove the scheme is affordable, with the staffing model needing to be reduced further. A reduction has been identified with Psychology and Occupational Health, although not a significant reduction it is awaiting costing to provide a revised figure.
- Appointment of the healthcare planner has been delayed due to the procurement process required, this is being worked through.

Goal: Progress with the developments for Reaside re-provision.

Changing how we work

Progress update:

- ✓ No further update following notification from the Department of Health and Social Care in May that Reaside has not been selected for funding from the New Hospitals Programme.
- ✓ PMO project is on hold and the project plan will be re-baselined if/when a decision is made to proceed.

Risks and issues:

- Availability of funding.

15. Strategic priority: People

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Deliver our workforce plan through:

- Increasing workforce supply to address workforce gaps across the organisation.
- Progressing the retention activities and improve our turnover rate.
- Support delivery of service specific recruitment and retention plans.
- Deliver the recruitment and retention priorities for BSOL in our partnership arrangements.

Shaping our future workforce

Progress update:

- ✓ International recruitment is continuing and we now have 58 arrivals.
- ✓ Staff in post numbers have increased far above the target with an increase of 7%.
- ✓ As part of the Safer Staffing work, we have piloted the centralised recruitment process for band 5 nursing vacancies in Q4.
- ✓ Appointed experienced nurses and nurses from universities outside of BSOL i.e. Derby and Wolverhampton.
- ✓ Significant progress has also been made in medical recruitment with a number of long term vacancies being filled notably Longbridge CMHT and CAMHs Consultants in SOLAR.
- ✓ A Trustwide Workforce Initiatives Group has been established to look at recruitment, retention and transformation projects that can impact across the organisation.
- ✓ Developing a 'grow your own' workforce strategy and a process for 'stay with us' conversations.

Risks and issues:

- Overall figures are really positive. However there are still hotspot areas within the Trust

Goal: Develop and implement a Just culture that addresses racism, bullying, harassment and discrimination, measured by reduction in formal HR processes and increase in informal processes

Shaping our future workforce

Progress update:

- ✓ A new group of 10 mediators have now completed the ACAS mediation training which has triggered a review of the mediation referral and engagement process.
- ✓ OD team are currently developing a mediation skills development session that will formulate part of the reviewed leadership programme as a central thread.
- ✓ Restorative Justice and Learning Culture (RJLC) train the trainer has been undertaken and a local offer developed. Priority has been given to the People Function so that colleagues supporting People processes can all engage and lead from a RJLC lens.
- ✓ A roll out plan is currently being developed for the wider organisation.

Risks and issues:

- Colleague engagement and team capacity.

16. Strategic priority: People

Goal: Continue to embed staff engagement programme to ensure that Flexible Working is routinely promoted throughout the year using data and multiple channels

Transforming our Culture and Staff Experience

Progress update:

- ✓ 'We work flexibly' is one of our highest improved scores reported in the national staff survey 2023 results
- ✓ A revised flexible working policy has been created and disseminated. Toolkits, template letters and lunch and learns were created and held to educate employees and managers of the changes.
- ✓ There was a sharp rise in flexible working requests in January 2024 reinforcing the communication of the revised policy and toolkits, which alongside the lunch and learns resulted in an increase in flexible working requests.

Risks and issues:

- Some areas still are reluctant to accept flexible working requests.
- Lack of engagement from operational areas on supporting the engagement plan.

Goal: Demonstrating improvement in the key areas Identified within the 2022 NHS staff survey which require improvement. Discrimination, recognition, health and wellbeing and Inclusion.

Transforming our Culture and Staff Experience

Progress update:

- ✓ We have made some notable improvements across all nine areas of the People Promise.
- ✓ We have increased on Q14b related to bullying and harassment from managers by 0.04%, although a very small increase it would be enough to encourage the carrying of this goal forward for 2024/25.
- ✓ Q14c relating to bullying and harassment from other colleagues has reduced by 0.84%, again suggesting the maintained focus on the area of bullying, harassment and civility.

Risks and issues:

- Lack of local engagement and ownership.

Goal: Black, Asian and Minority Ethnic colleagues are provided with equal opportunities for career progression or promotion, via resources developed as part of the Flourish programme.

Transforming our Culture and Staff Experience

Progress update:

- ✓ Programmes are currently being designed in order of priority.
- ✓ The current leadership offer is being reviewed through the lens of FLOURISH to ensure positive action is built into the central offer.
- ✓ The team are also in the process of pulling together a 12 month plan, it is recommended that this goal be carried forward with a clear milestone plan.

Risks and issues:

- Slippage due to ream redesign.

17. Strategic priority: People

Goal: Develop and Implement a clear and regular engagement plan that seeks to Improve overall engagement scores to NHS Annual Staff Survey - measures of success via recommendations of a great place to work and receive care.

Transforming our Culture and Staff Experience

Progress update:

- ✓ Developed a staff engagement plan to share National Staff Survey results.
- ✓ Developed a manager's toolkit which guides/informs managers to understand and analyse their own results locally and how to start a conversation about the results.
- ✓ Developing more aligned communications and engagement strategies to consider how we can reconnect with “hard to reach” areas in the Trust and improve overall engagement score.
- ✓ We have seen an increase in our engagement score now 7.03/10 slightly below the average score of 7.11
- ✓ 62.9% of staff would recommend BSMHFT as a place to work. We have seen a 5.8% increase from 57.1% in 2022.
- ✓ 55% of staff would recommend BSMHFT as a place for care. This is a 4% increase from 51%.

Risks and issues:

- Lack of local engagement and ownership.

Goal: Continually review and update the comprehensive and inclusive health and wellbeing offer (including cost of living) that meets the needs of our diverse workforce.

Transforming our Culture and Staff Experience

Progress update:

- ✓ 13 Champions are now in place within the Trust and a number of these have also enrolled on the apprenticeship qualification with external provider BeReady.
- ✓ The next quarterly edition of ‘All about you' newsletter has been delivered to all sites.
- ✓ Plans are in place for the annual bespoke Health & Wellbeing survey to go out in Q1 to assess impact of hard copy information being available.
- ✓ Work is in development to write a health and wellbeing strategy and framework to support securing a dedicated budget to continue to provide a comprehensive offer.

Risks and issues:

- No budget associated with the health and wellbeing offer.

18. Strategic priority: People

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: As we continue our journey to become Anti Racist, Anti discriminatory we will embed achievements from 22/23, launch the Anti Racist framework and modernise our systems to enable the culture shift.

Transforming our Culture and Staff Experience

Progress update:

- ✓ Anti-racist framework consultation took place across the Trust with the support of roadshows.
- ✓ Feedback from consultation was been considered and framework has been updated accordingly.
- ✓ Plan for rollout developed and colleagues from EDI team have been attending professional forums to launch the anti-racist framework in bite size chunks, the first element being Anti Racist colleague.

Risks and issues:

- Adverse responses across engagement.

Goal: Develop a range of digital solutions to streamline or automate people processes.

Modernising our people practice

Progress update:

- ✓ A full revamp has been undertaken on all employee relation trackers and improvements made to dashboards.
- ✓ Soft launch of the People Team chatbot took place which will streamline advice line service.
- ✓ Ongoing local evaluation takes place each month and a fuller evaluation will be undertaken after one year.

Risks and issues:

- None identified.

19. Strategic priority: Quality

Goal: Empowering patients through inclusion of Patient Safety Partners in the patient safety framework.

Improving service user experience

Progress update:

- ✓ EBE Patient Safety Partners are in post, have completed training and induction and have work plans.
- ✓ They are now meeting monthly.
- ✓ The Patient Safety Team will be inviting them to a number of forums including two governance meetings.
- ✓ They have begun to participate in local initiatives to improve safety and participate in conversations and meetings within the Trust that address patient safety.

Risks and issues:

- None identified.

Goal: Complete Expert by Experience (EBE) observer project, utilising EBEs to assess ward culture to reduce restrictive practice and improve quality and experience.

Improving service user experience

Progress update:

- ✓ Job matching for this role is complete and approval has been received to recruit.
- ✓ Agreement to carry over the funding to ensure the project can go ahead.

Risks and issues:

- Previous risk around the timescale for funding has been addressed.

Goal: Use data to understand health inequalities in relation to incidents.

Improving service user experience

Progress update:

- The patient safety report to QPES includes limited health inequalities information, pending development of a dashboard in collaboration with the Performance and Information Team.
- No further work has been done on this in Quarter 4.
- The dashboard has not yet been developed - work is being progressed but this is not yet linked to incidents.

Risks and issues:

- Information is limited at this stage as the dashboard is needed to fully realise this goal.
- Use of data and knowledge of delivering system changes.

Goal: Implement the Patient Safety Incident Response Framework (PSIRF) to pursue excellence in learning and understanding of incidents including cross-organisational learning.

Preventing harm

Progress update:

- ✓ The PSIRF went live in November 2023.
- ✓ The response plan was previously approved and the policy has been approved following consultation.
- ✓ Improvement cycles have been developed to drive change.
- ✓ All arrangements are now in place.

Risks and issues:

- None identified.

20. Strategic priority: Quality

Goal: Review and implement a safe staffing model across all inpatient wards.

Preventing harm

Progress update:

- ✓ The roll out of Safe Care training has been completed; weekly compliance reports are being sent and additional support offered to teams.
- ✓ Improving roster education and check and challenge are in progress and rosters are being checked weekly to ensure there is an RMN on every shift.
- ✓ Roster dashboard in place to be utilised for clinical manager review and reporting.
- ✓ Bi-annual MHOST/establishment reviews commenced in February and showed that not all wards are consistently using MHOST; further work is being done with these teams.
- ✓ Centralised recruitment events took place early 2024 and as at year end 20 appointments had been made.

Risks and issues:

- New tools/processes are dependent on clinical buy-in and operational management support.
- If staff don't proactively undertake training, the roster data won't improve.

Goal: Review the organisation's safety culture to understand how safe our staff feel at work and engage with them to provide a safe working environment where they can flourish.

A patient safety culture

Progress update:

- ✓ A review has been undertaken from the last staff survey with work led through the HR and OD teams.

Risks and issues:

- Capacity and engagement.

Goal: Implementation of new learning from deaths processes aligned with PSIRF.

Quality assurance

Progress update:

- ✓ Following previous difficulties in recruitment, the analyst for the Governance Intelligence Team has now been recruited and commences in May, meaning work to build the structured judgement review into Eclipse will commence.

Risks and issues:

- Capacity issues now alleviated through the analyst recruitment.

21. Strategic priority: Quality

Goal: Demonstrate improvement against CQC action plans.

Quality assurance

Progress update:

- ✓ For Care Plans and Risk Assessments we have seen general improvement in compliance with the completion of these documents.
- ✓ For Medicines Management, the local audits have shown an increase from 74.68% in September 2023 to 98.67% at the end of February.
- The Compliance team continues with its programme of assurance testing to review those actions marked as complete
- While we have seen activities to bring a focus to improving compliance in clinical and managerial supervision, most teams remain below the expected levels.
- There is a now a Psychology Lead in place on a fixed term contract to oversee clinical supervision and required workstreams to improve uptake and recording and a Clinical Supervision Practice Placement Manager commenced in January 2024 for a period of 18 months to support transition in practice.
- A QI group has been established to discuss the requirements of operational staff and the options for recording supervision that is more accessible to all staff.

Risks and issues:

- We cannot demonstrate sustained improvement without ongoing peer reviews, assurance testing, improvement/changes in incident data, improvement/changes in staff and service user experience.

Goal: Develop and embed the principles of 'Think Family'.

Quality assurance

Progress update:

- ✓ Awareness campaign started November 2023 and included a dedicated Listen Up Live and presence at every induction.
- ✓ The suite of information we have produced has been distributed to Heads of Nursing and is available on Connect.
- ✓ The Safeguarding Team produced a standard and leaflets which they are incorporating into training and supervision.
- ✓ Following the awareness campaign, the safeguarding team have continued to build relationships across all services with dedicated practitioners.
- ✓ This work will continue into 2024/25 to provide assurance around safeguarding practice.

Risks and issues:

- Risk that Think Family will not be embedded into practice locally.

22. Strategic priority: Quality

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Scope, introduce and embed a Quality Management System (QMS), including our strategic approach to Quality Improvement (QI) with our new Quality Improvement strategy.

Using our time more effectively

Progress update:

- ✓ Action plan amnesty and analysis completed and themes arising from this presented to:
  - Senior Leaders' Forum
  - Executive Team
  - Strategy and Transformation Management Board
  - Clinical Governance Committee
  - Trust Board
- ✓ Quality improvement training session delivered to Senior Leaders' Forum using the action plan themes as working examples.
- ✓ Action plan themes considered as part of strategic planning for 2024/25.
- ✓ Engagement on the Quality Improvement Strategy undertaken at the four professional committees – Medical Advisory Committee, Nursing Advisory Council, Psychological Professions Advisory Committee and Allied Health Professionals Advisory Committee.
- Work to continue on moving towards use of SPC charts across the Trust.
- The new Deputy Medical Director for Quality and Safety commenced in April and is reviewing next steps and future approach for the QMS.

Goal: Use quality improvement approaches to develop our pathways to improve access to services.

Using our time more effectively

Progress update:

- This goal is a workstreams that sits within the overarching QMS goal and is part of the Quality Improvement Strategy which is due to be finalised and signed off in June 2024.

Risks and issues:

- System engagement, pace of change required.

23. Strategic priority: Sustainability

Goal: Connect the Trust and the Shared Care Record for BSol to all NHS primary and secondary care providers and the local authorities, to improve data sharing across our organisations for direct patient care

Transforming with digital

Progress update:

- ✓ All Primary and Secondary NHS organisations are connected to the ShCR for provision of their data and we have continued to onboard organisations throughout the year.
- ✓ The only gap we have currently is that Royal Orthopaedic Hospital (ROH) are provisioning data but unable to view the Shared Care Record.
- ✓ All other primary and secondary care organisations are consuming and provisioning the Shared Care Record.
- ✓ Usage stats have steadily increased with over 100,000 accesses each month.
- ✓ We have gone further than originally planned and now have data from Sandwell / City Hospital which was originally outside of the scope but with redrawing of GP boundaries it was felt this should be included
- ✓ We continue to expand the data sets and enrich the offering, including discharge medications and structured data for meds and allergies and vaccinations.

Risks and issues:

- ROH are still unable to view the Shared Care Record through their in-context link, they are relying on work from University Hospitals Birmingham (UHB) to be carried out.

Goal: Embed clinical engagement and influence in relation to ICT and digital strategy, transformation and developments

Transforming with digital

Progress update:

- ✓ Following engagement and review across the organisation, the joint Digital Strategy for BSMHFT and Birmingham Community Healthcare (BCHC) has been agreed within BSMHFT and ratified accordingly at FPP committee for Trust Board.
- ✓ Discussions were held with Board and Senior Leaders' Forum on how we can make better use of digital, and particularly artificial intelligence, to achieve our strategic aims, given demand and workforce pressures.
- ✓ This included posing questions around how we can augment the services to improve outcomes, what services could do differently if they were better supported by a digital offering, and what repetitive tasks could be automated.
- ✓ The Clinical Digital Transformation team is well established. and clinical engagement continues to grow.
- ✓ Current focus is producing the digital improvement plan and roadmap for delivery of the strategy.

Risks and issues:

- Making sure we routinely consider and embed digital innovation and improvements within our service transformations.

24. Strategic priority: Sustainability

Goal: To implement the framework for transformational change.

Balancing the books

Progress update:

- Plans for £15.688m savings requirement for 2024/25 have been developed in full.
- However there has been limited input from organisation in terms of submitting ideas for schemes and lack of clarity around the transformational elements of savings plans.
- Going forwards we need to make sure we are maximising and linked in with commissioning opportunities. The development of the BSOL Mental Health Provider Collaborative longer-term strategy in 2024/25 will describe the system ambitions for transformational change.

Risks and issues:

- Capacity and capability of organisation to consider new ways of working that will deliver efficiency savings.

Goal: Implement the Green Plan

Caring for the environment

Progress update:

- ✓ Small steps being made towards the Green Plan's ambitious set of NHS targets up to 2040. These include:
  - ✓ Bid for National Energy Efficiency Fund (NEEF) funding for an LED lighting project (decision awaited).
  - ✓ Looking to work with National Express to expand current offers and incentives for staff.
  - ✓ Awaiting green light from pharmacy for a pilot project re delivery of products and re-usable packaging.
- ✓ A Green Plan Action Tracker has been established which is monitored at the Green Plan Steering Group. There is good attendance from corporate leads, however clinical/operational representation is currently lacking which has been highlighted as a risk opposite.

Risks and issues:

- Currently lacking Trust clinical /operational representation at BSMHFT Green Plan Steering Group.
- Funding to invest and manage initiatives - capital and revenue.
- Prioritisation – having a number of valid priorities and deciding what to focus on first.

25. Strategic priority: Sustainability

Birmingham and Solihull Mental Health NHS Foundation Trust

Goal: Embed the BSOL Mental Health Provider Collaborative (MHPC), including clinical engagement and clinically informed models, corporate governance, finance, contracts, quality arrangements etc

Changing through partnerships

Progress update:

- ✓ The BSOL MHPC has now been operational for 12 months.
- ✓ The focus in 2024/25 has been to embed the formal governance arrangements and commissioning, finance, quality and contract functions.
- ✓ Particular achievements have been:
  - ✓ Relationships between partners have evolved and matured, with increasing trust and confidence.
  - ✓ Making decisions together as a collaborative about the best way to develop and transform mental health services for our communities.
  - ✓ Strengthened voice for the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector through our new Panel and Collective as part of our MHPC formal governance.
  - ✓ Tackling challenges together, working collaboratively from a system perspective rather than in organisational silos has led to some real positive changes, for example improving access to talking therapies and transformation of community mental health services.
- ✓ The BSOL MHPC Interim Strategic Framework for 2024/25 has been drafted and is going through the appropriate governance and sign off routes. This includes MHPC Governance Groups and via local commissioning groups with Local Authorities.
- ✓ Plans are being developed for the co-production of a five year BSOL All-Age Mental Health Strategy to be launched from April 2026.

Progress update (continued):

- ✓ Financial commitments and cost pressures for 2024/25 have been reviewed and prioritised taking into account the national planning guidance and strategic commissioning intentions from the ICB.

LD&A transfer

- Following an options appraisal carried out by BSOL ICB which has been agreed by all parties, responsibility for the tactical commissioning of LD&A services will be transferred to the MHPC from 1 June 2024 with BSMHFT as Lead Provider (subject to approvals from all parties). This will extend the Collaborative members to also include Birmingham Community Healthcare NHS Foundation Trust and Coventry and Warwickshire Partnership NHS Trust. .
- ✓ We have successfully progressed through the ICB's Assurance Processes.
- Our due diligence for the LD&A transfer is still underway as we await the financial breakdown from the ICB.
- ✓ A mobilisation plan to get us to the 1 June 2024 and a development plan (for post mobilisation) have been drafted.

Risks and issues:

- Internal capacity to deliver lead provider requirements
- Internal capacity to complete the LDA assurance process and readiness activities.
- Managing the financial position and cost pressures.
- Ensuring robust governance.

26. Strategic priority: Sustainability

Goal: Deliver strategic priorities agreed by the West Midlands Provider Collaborative (WMPC).

Changing through partnerships

Progress update:

- ✓ A second dynamic space event has taken place with executives from all providers in the region with the purpose of developed shared priorities. Four action groups have been agreed:
    1. Evidencing the value of MHLDA investment
    2. Use of PICU bed capacity across the region
    3. Addressing key workforce challenges at scale
    4. Meeting the needs of all our communities
- ✓ All areas have a nominated CEO sponsor and an Executive/Director Lead.
- • A further follow up workshop will be held in the summer to present progress against actions.

Risks and issues:

- • Agreement of strategic priorities and areas for action across the provider collaborative.
- • Buy in and resource committed from all partners.

Goal: Review of the Trust`s Risk Management arrangements including risk appetite, training, escalation/de-escalation, governance, oversight and assurance.

Good governance

Progress update:

- ✓ Risk Management Group (RMG now up and running with terms of reference and forward plan.
- ✓ Divisions are now presenting their risk register performance reports at the RMG for review and scrutiny.
- ✓ Divisions are escalating their high-level operational risks to the RMG for consideration and approval for inclusion onto the Trust Corporate Risk Register (CRR).
- ✓ Following approval of some high operational risks presented at RMG a Trust CRR has been designed and will regularly be presented to relevant Board Committees for review, scrutiny and oversight going forward.
- ✓ This goal is now complete and risk management arrangements considered to be BAU

Risks and issues:

- • N/A. – this goal is now complete

Goal: Undertake a review of the governance arrangements of the organisation from ward to Board, including standardisation of reporting mechanisms.

Good governance

Progress update:

- • Review of Trust`s governance arrangements is ongoing.
- • Report of findings and recommendations is at writing stage following extension of due date to 31 May 2024.

Risks and issues:

- • Potential risk of not meeting timescales due to capacity issues and increase in clinical activities leading to inability to implement all the recommendations at pace.

Part B:
An outline of 2024/25 goals

27. How we have developed our goals

Moving into Year 4 of our Strategy…

National

- NHS Long Term Plan priorities
- 2024/25 Planning Guidance priorities

System

- Alignment to Mental Health Provider Collaborative strategy / priorities
- Alignment to commissioning intentions

Trust

- Status of 23/24 goals
- Discussions with divisions/services about priorities and challenges
- Engagement across Trust – OMT, professional forums, PEAR
- Quality Management System action plan analysis areas for improvement

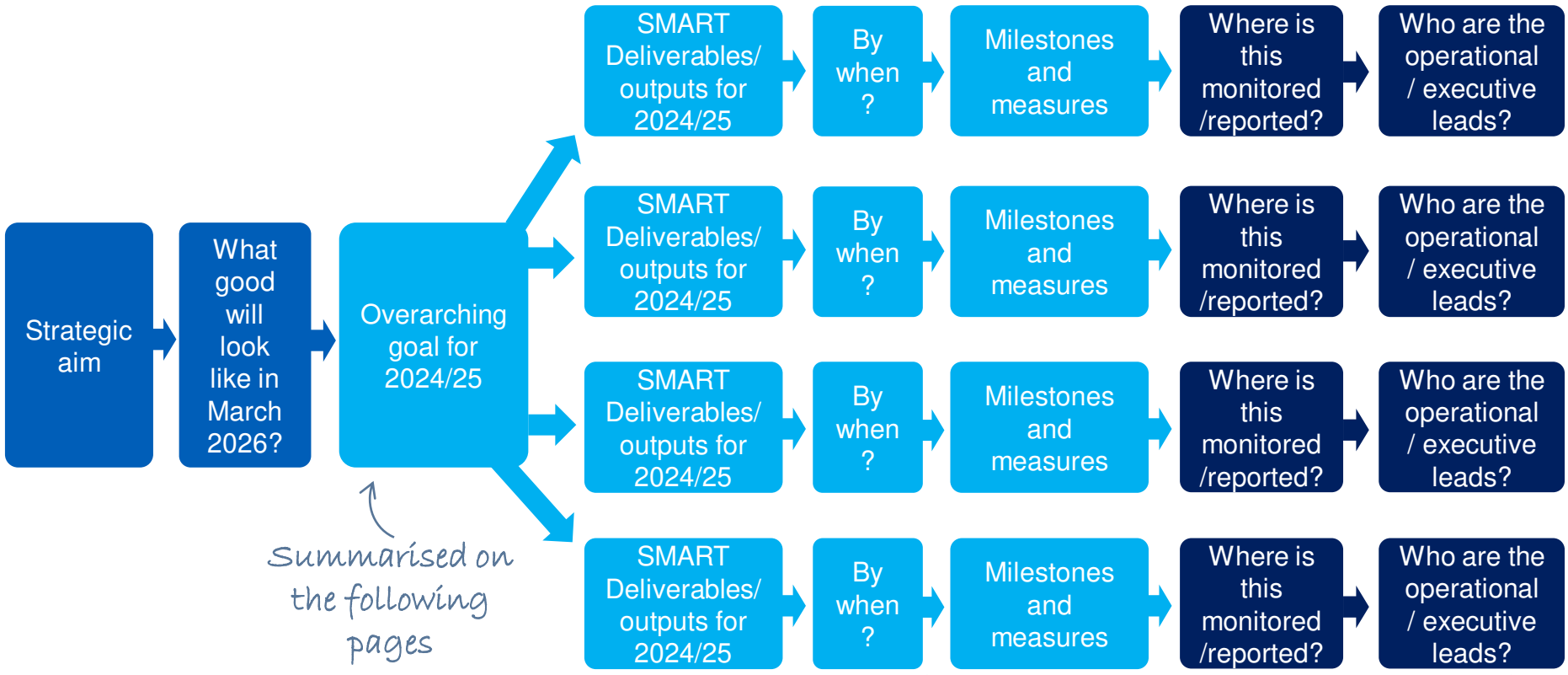
Interdependencies between strategic priorities and goals

Discussions and engagement with service areas, professions and experts by experience, have encompassed all four strategic priorities to ensure goals are joined-up and interdependencies are identified, e.g.

- Conversations with clinical service areas highlighted priorities relating to workforce, estates, ICT and quality improvement to support delivery of the Clinical Services goals, and these have fed into goal setting for People, Sustainability and Quality.
- Developing cross cutting goals, e.g. we have a goal around financial sustainability and savings, which will be supported by goals around delivery of clinical service transformations. quality improvement programmes and work led by the people team to reduce bank and agency spend.

We are looking at how we prioritise activities to ensure we are realistic about capacity/resource to deliver.

28. Ensuring SMART goals that are linked back to the aims in our Strategy…



Summarised on the following pages

Detailed in Appendix and reported to Board Committees in May

Developed with service areas/leads. Outputs/owners could be within one service area/department or across multiple areas depending on the goal

Demonstrating accountability, progress, achievements, impact and outcomes

29. Why this approach for 2024/25?

- To address the learning and feedback from the last 3 years on how we set and report strategic goals.
- To focus more on the outcome/impact rather than individual actions, meaning that we have fewer overarching strategic goals (35 vs 97 in 2023/24), with a range of measurable actions contributing to each, and each goal is clearly linked to what we set out to achieve in our Trust Strategy.
- To support our Trust's quality improvement methodology by using a driver diagram style approach.
- To be more robust, so that we can assess not only progress on actions but their impact. Specifically, we will ensure that all deliverables:
  - Are SMART (specific, measurable, achievable, realistic/relevant and timed) with clearly defined quarterly milestones.
  - Have clear ownership and oversight.
  - Have measures in place, which could be process, outcome and/or balancing measures per our quality improvement methodology.
- This approach was outlined in a paper to the Executive Team in March 2024 and was supported and was agreed at the Board Committees in May 2024.

30. Summary of goals

- In total across our four strategic priorities, we have 35 overarching goals for 2024/25, which is year 4 of our strategy. These include a number of goals and deliverables that have been carried forward from the previous year. In most cases this carry forward was predicted and reflects the longer term and complex nature of our transformation work and service developments rather than any lack of progress.
- As mentioned earlier, we are looking at how we prioritise activities to ensure we are realistic about capacity/resource to deliver and are developing our approach to reporting on 2024/25 goals given the different approach taken to goal setting.
- The total number of goals is shown in the table below and goals are summarised on the next page, with the full wording and deliverables for each goal detailed in the Appendix.

	Clinical Services	People	Quality	Sustainability	Total 2024/25	Total 2023/24
Total 2024/25	**13**	**9**	**6**	**7**	**35**	
Total 2023/24	**38**	**16**	**16**	**27**		***97***

31. 2024/25 goals at a glance

*** Addressing inequalities is woven throughout our strategic goals for 2024/25***

Clinical Services (13 overarching goals)

Recovery focussed
- Support to ensure involvement of families and carers
- Consistent approach to developing peer support roles

Rooted in communities
- Community transformation programme year 4
- Access to beds and eliminating out of area placements
- Targeted work in divisions to reduce inequalities
- Access to joined up place-based health and care

Prevention and early intervention
- Transform urgent care pathways
- Transforming and improving children and young people's services
- Service/pathway development to meet agreed trajectories
- Specialist pathways to better meet needs of specific groups

Clinically effective
- Co-produced and personalised care plans to improve outcomes
- Better support for learning disability and autism
- Equip all staff with knowledge of trauma informed approaches

***NB: Leader in mental health** and **Changing how we work** are enablers that run across the other strategic aims.*

Quality (6 overarching goals)

Improving service user experience
- All QI projects and programmes to be co-produced with EBEs

Preventing harm
- Assurance of safeguarding practice and Think Family approach

Patient safety culture
- Use a variety of channels to identify and share learning Trust-wide
- Access to high quality supervision for all clinical staff

Quality assurance
- Effective use of data to identify gaps and improve quality

Using our time more effectively
- Implement our Quality Improvement Strategy

People (9 overarching goals)

Shaping our future workforce
- Reduce vacancy and turnover rates
- Reduce bank usage and agency spend
- Increase fundamental training compliance

Transforming our culture and staff experience
- Reduce sickness levels
- Increase number of staff who would recommend the Trust
- Maintain staff engagement scores using relevant digital solutions
- Reduce disproportionality of racialised groups in people processes

Modernising our people practice
- Work with finance and ESR team to improve data quality
- Reduce response times to common casework

Sustainability (7 overarching goals)

Transforming with digital
- Operationalise the digital strategy and improvement plan
- Improve information and insights through business intelligence

Caring for the environment
- Refresh strategy to ensure estates and facilities are fit for the future.

Changing through partnerships
- Ensuring the right partnerships to improve access, experience and outcomes and address inequalities.

Balancing the books
- Confirm ambition and timescale to achieve recurrent financial balance with identified cost savings.

Good governance
- Ensure Trust processes and systems are IG compliant
- Establish and implement performance accountability process

32. What is not in our 2024/25 goals and why

We have not included…

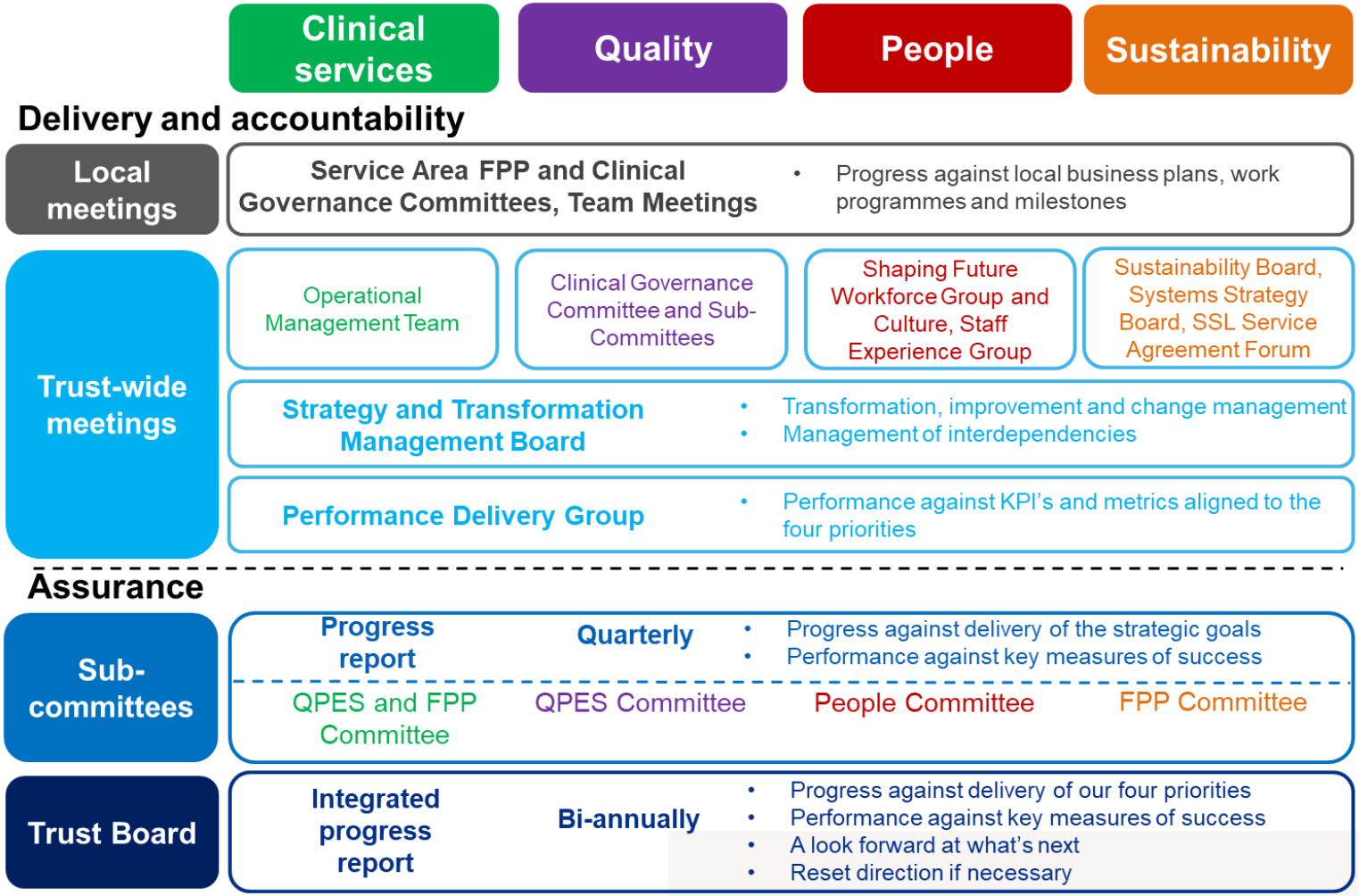
- Where a project/piece of work has **been implemented and/or become 'business as usual'** and routinely monitored, it is not included in this year's strategic goals, e.g.
  - HOPE strategy (Health, Opportunity, Participation, Experience)
  - Patient Safety Incident Response Framework (PSIRF)
- Where an activity is about **compliance with routine/expected processes or procedures** it is only included as a strategic goal if there is a systemic issue across the Trust or significant programme of work around it, otherwise it will be monitored via the usual metrics and channels.
- Where a project/piece of work currently has **little prospect of being achieved in year** and is likely to remain 'red' for the foreseeable future, it has not been included at this point, e.g.
  - Reaside redevelopment – PMO project is on hold
  - High Dependency Unit – remains on hold and was for the whole of 2023/24

However…

- Goals are **regularly reviewed** and can be:
  - Removed if **circumstances/priorities change** to the point where they are no longer desirable or achievable.
  - Added if new **requirements/targets/funding arise** or if previous **barriers to progress are unblocked**.

33. Strategy Governance Framework

The diagram below sets out our framework for monitoring delivery of our strategy and providing assurance through the organisation by describing the role of different groups and forums and the role they play.



34. Strategy developments for 2024/25

- Continuing to embed our strategy throughout divisions/ services.
- Supporting services to develop a ‘strategy on a page’.
- Establishing HOPE Actions groups centred about the strategic priorities so that we can more systematically involve experts by experience in our strategic developments.
- Looking at how we can better support change and improvement – dynamic space approach:
  - Governance and role of Strategy and Transformation Management Board
  - Systems and processes
  - Comms and stakeholder management
  - Outcomes and learning lessons
- Bringing achievement against strategic goals into Performance Delivery Group/ Deep Dives to join up conversations about strategy and performance.
- Demonstrating how our strategy has had an impact.
- Starting to think about the refresh of our strategy ready for April 2026, planning for how we gather information about our baseline and how we want to engage with colleagues, experts by experience and stakeholders.

Appendix

A full list of our 2024/25 goals and deliverables

Strategic aim: Recovery focussed

Clinical services

Our Trust Five Year Strategy

What are we trying to achieve?

All of our service users, their carers and families supported to live fulfilling lives, with hope, meaning, purpose and opportunity. This means supporting and enabling them to flourish in whichever way is important to them.

What will good look like by March 2026?

We will demonstrate our commitment to recovery for all through health and opportunities, participation and experience.

Families and carers will be supported and routinely and appropriately involved in care planning and decisions.

Service users will have choice, control and self-management of their care based on what matters to them.

2024/25 strategic goals

Our overarching goals for 2024/25

Provide support to ensure families and carers are routinely and appropriately involved in care planning and decisions.

Develop a consistent approach for developing clear roles for peer support workers across the Trust to bring about positive recovery and experience outcomes

Outputs/deliverables that will achieve this goal

- Redesign the family and carer pathway and carer engagement tool in line with Dialog+
- Refresh the Family and Carer Strategy, with new pathway design embedded
- Peer workforce review across BSOL
- Test and roll out the peer support hub as part of community transformation.

Leader in mental health

Changing how we work

Strategic aim: Rooted in communities (1)

Our Trust Five Year Strategy

What are we trying to achieve?

Services provided close to home in the least restrictive setting, reducing inequalities, and linking closely with and drawing on the strengths of our diverse local communities.

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What will good look like by March 2026?

Our services will be anti-racist, anti-discriminatory and trauma-informed.

Services will be co-designed and co-delivered with local communities and organisations so that they are centred around local needs

No one will be admitted to an inpatient bed outside of our area unless this is deemed appropriate.

2024/25 strategic goals

Our overarching goals for 2024/25

Continue to progress year 4 of the transformation of community services across all geographical areas within the BSOL footprint.

Implement plans to ensure timely and appropriate access to inpatient beds within Birmingham and Solihull and eliminate inappropriate out of area placements.

Outputs/deliverables that will achieve this goal

- Use of Patient Reported Outcome Measures
- Single MDT triage hub
- Review of NMHT demand, capacity and workforce
- NMHT and CMHT closer working
- Review of CMHT caseloads, discharges and waiting lists
- Retain ARRs roles
- Productivity plan – impact of locality model, demand and gatekeeping, reducing CRFDs
- 30 bed unit at Highcroft – business case
- Reduce older adult inpatient length of stay
- Reduce long term out of areas in rehab beds

Leader in mental health — Changing how we work

Strategic aim: Rooted in communities (2)

Our Trust Five Year Strategy

What are we trying to achieve?

Services provided close to home in the least restrictive setting, reducing inequalities, and linking closely with and drawing on the strengths of our diverse local communities.

.

What will good look like by March 2026?

Our services will be anti-racist, anti-discriminatory and trauma-informed.

Services will be co-designed and co-delivered with local communities and organisations so that they are centred around local needs

No one will be admitted to an inpatient bed outside of our area unless this is deemed appropriate.

2024/25 strategic goals

Our overarching goals for 2024/25

Undertake targeted work to reduce unfair and avoidable inequalities in access, experience and outcomes within Birmingham and Solihull.

Make it easier for service users to access joined up place based health and care services in their local communities

Outputs/deliverables that will achieve this goal

- Key priorities from each division's inequalities plan.
- Work with VCFSE organisations to support 8 identified communities of focus as part of community transformation.
- Progress the project to support better integrated place based working across Trust services.
- Work with the Community Care Collaborative to ensure mental health support at place level
- Improve transitions and pathways between secure care and offender health services and secondary care

Leader in mental health — Changing how we work

Strategic aim: Prevention and early intervention (1)

Our Trust Five Year Strategy

What are we trying to achieve?

Help available at the earliest opportunity before mental health problems escalate or become more complex, through access to a range of treatment options whether with us or one of our partners.

What will good look like by March 2026?

Everyone who becomes unwell, or whose illness worsens, will be able to access support quickly and easily.

People will access care in the most appropriate setting, whether that's primary, community or inpatient care, and at a time and place that works for them.

There will be specialist pathways in place to address the specific needs of a range of vulnerable groups in our population.

2024/25 strategic goals

Our overarching goals for 2024/25

Transform our urgent care pathways and services to eliminate inappropriate attendances and waits in acute care settings.

Transforming and improving services for children and young people

Outputs/deliverables that will achieve this goal

- Implementation of Right Care, Right Person
- Review of usage of the Psychiatric Decisions Unit
- Fully engage in the system work to transform the offer for children and young people across Birmingham and Solihull
- Digital transformation in our Solar service.
- Development of our offer for 18-25 year olds.
- Work with the CAMHS provider collaborative on developments in light of new NHSE guidance on Tier 4 beds.

Leader in mental health — Changing how we work

Strategic aim: Prevention and early intervention (2)

Our Trust Five Year Strategy → **2024/25 strategic goals**

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2024/25*	*Outputs/deliverables that will achieve this goal*
Help available at the earliest opportunity before mental health problems escalate or become more complex, through access to a range of treatment options whether with us or one of our partners.	Everyone who becomes unwell, or whose illness worsens, will be able to access support quickly and easily. People will access care in the most appropriate setting, whether that's primary, community or inpatient care, and at a time and place that works for them. There will be specialist pathways in place to address the specific needs of a range of vulnerable groups in our population.	Develop our services and pathways to ensure that we meet the required access and outcomes performance standards and trajectories	Birmingham Healthy Minds to meet agreed trajectories Perinatal community services to meet LTP commitments ADHD processes and BSOL system business case Memory Assessment Service access and waiting times Clinical Health Psychology review and decision on contracts Neuropsychiatry bed use and waiting times
		Make sure we have specialist pathways to better meet the specific needs of a range of groups in our population	Specialist bipolar and psychosis pathway Support for service users with complex emotion and trauma, including personality disorder. Links into mainstream services across West Mids for veterans Redesign of deaf pathway Redesign of women's secure pathway

Leader in mental health — Changing how we work

Strategic aim: Clinically effective

Our Trust Five Year Strategy

What are we trying to achieve?

Service users consistently receiving high quality multi-disciplinary care based on models and pathways that consider their holistic needs and meet national standards and guidelines. A focus on measuring and improving outcomes will provide evidence that we are being clinically effective.

What will good look like by March 2026?

Our services will be evidence based and comply with NICE guidance and national standards.

Service users' needs will be considered as a whole, including mental health, physical health, substance use, neurodiversity and social needs as well as individual characteristics.

Service users will get the best outcomes from medicines they are prescribed.

Outcome measures will be inclusive and part of routine care planning and monitoring of effectiveness.

2024/25 strategic goals

Our overarching goals for 2024/25

Outputs/deliverables that will achieve this goal

- Ensure that our service users' care plans are co-produced and personalised to improve outcomes and quality of life
  - Dialog+ rolled out and implemented across BSMHFT
  - Dialog+ embedded in all relevant teams.
- Better support for service users with learning disability or autism
  - Reduce unnecessary admissions and improve discharge experience
  - Full engagement with national programmes.
  - Staff awareness of developments including more effective transition and partnership working
  - Enhanced co-production with Experts by Experience
- Equip all clinical staff across the Trust with knowledge of trauma informed approaches.
  - Staff in all areas to be trained in trauma informed care.

Leader in mental health

Changing how we work

Strategic aim: Shaping our future workforce

Our Trust Five Year Strategy

2024/25 strategic goals

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2024/25*	*Outputs/deliverables that will achieve this goal*
A diverse, innovative, and agile workforce with the right skills and experience to meet our changing demands and where differences are valued to enhance service user experience and recovery	All colleagues will have appropriate training to support them to be effective in their role. Flexible working arrangements available to all colleagues We will recruit and retain the right workforce to meet the needs of our local population. No colleagues will experience discrimination or its effects in recruitment and career progression	Aim to reduce the vacancy rate to 11% with a target of 9% turnover	Recruitment - school and university engagement, recruitment events, apprenticeships, grow your own
			Retention - stay conversations, flexible working programme
			Workforce planning - affordable plan, workforce planning training, looking at specific roles e.g TNAs, NDAs etc
			Representative workforce - attracting a diverse workforce to meet the needs of the organisation and service users.
		Reduce bank usage by 10% and agency spend to 3.2% of total paybill	Ensure maximum effectiveness from contingent workforce.
			Decrease use of bank in line with growth of substantive workforce
		Aim to increase our fundamental training average compliance by 3%	Undertake a Trustwide training needs analysis

Strategic aim:
Transforming our culture and staff experience (1)

Our Trust Five Year Strategy

What are we trying to achieve?

A culture of inclusivity, compassion and shared learning that fosters a psychologically safe climate to support us to demonstrate our Trust values and behaviours in everything we do.

What will good look like by March 2026?

We will have a strong culture of engagement where we all feel involved, listened to and valued

We will have a comprehensive wellbeing offer that supports the individual requirements of our diverse workforce

All colleagues will be supported to be the best version of themselves irrespective of background

All colleagues have the confidence and feel safe to speak up

Our culture will be of kindness where we are supported to challenge behaviours that are not in line with our values

All people processes will be developed and implemented free from bias

2024/25 strategic goals

Our overarching goals for 2024/25

Reduce sickness levels by 1%

65% of staff would recommend BSMHFT as a place to work in the staff survey 2024/25

Outputs/deliverables that will achieve this goal

- Identify gaps in current health and wellbeing provision and develop and implement a health and wellbeing strategy to meet identified needs
- Develop and implement comprehensive post incident support offer
- Embed and encourage uptake of the HR Toolkit Training
- Implement improvements to workforce inequalities across access, experience and outcomes of an employee lifecycle
- Support for managers to fulfil their potential through an effective leadership development programme
- Compliance with Trust policies for formal employee relations processes.
- Create safe reporting cultures through roll out of just culture and PSIRF

Strategic aim:
Transforming our culture and staff experience (2)

Our Trust Five Year Strategy

What are we trying to achieve?

A culture of inclusivity, compassion and shared learning that fosters a psychologically safe climate to support us to demonstrate our Trust values and behaviours in everything we do.

What will good look like by March 2026?

We will have a strong culture of engagement where we all feel involved, listened to and valued

We will have a comprehensive wellbeing offer that supports the individual requirements of our diverse workforce

All colleagues will be supported to be the best version of themselves irrespective of background

All colleagues have the confidence and feel safe to speak up

Our culture will be of kindness where we are supported to challenge behaviours that are not in line with our values

All people processes will be developed and implemented free from bias

2024/25 strategic goals

Our overarching goals for 2024/25

Maintain staff engagement scores at 55% in the staff survey 2024/25 utilising relevant digital solutions.

Reduce the disproportionality of racialised groups involved in people processes.

Outputs/deliverables that will achieve this goal

- Implement and operationalise an employee engagement strategy
- Implement the Trust communications strategy
- Effective implementation of the corporate support offer
- Increase appraisal compliance by 3% with positive experience
- Focussed approach in Acute and Urgent Care and Secure Care and Offender Health

Strategic aim: Modernising our people practice

Our Trust Five Year Strategy		2024/25 strategic goals	
What are we trying to achieve?	***What will good look like by March 2026?***	***Our overarching goals for 2024/25***	***Outputs/deliverables that will achieve this goal***
People practices that meet the evolving needs of our workforce, supported by integrated working	We will have a range of digital solutions that will streamline our people processes Our workforce information systems will be improved and more reflective to support patient care effectively We will effectively analyse data to gain insight and truly understand the needs of our workforce and improve staff experience	Work collaboratively with finance and ESR team to improve data quality	Ensure our ESR platform holds accurate and credible workforce data
		Reduce response times to common employee relation casework by 30 days	Embed and encourage uptake of the HR advice line chatbot

Strategic aim: Improving service user experience

Our Trust Five Year Strategy → **2024/25 strategic goals**

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2024/25*	*Outputs/deliverables that will achieve this goal*
Shared decision-making with service users and families about their treatment and care to aid their recovery. Service users empowered to be active participants and partners in their own care, enabling self-care. Co-production is business as usual	• Experts by Experience will be core members of all service user, family and carer facing quality improvement projects • Service users will be supported to participate in care plan co-production and families and carers will support and participate in care plan production (where appropriate)	All quality improvement projects and programmes to be co-produced with experts by experience.	All quality improvement projects and programmes to be co-produced with experts by experience QI team facilitators embedded into clinical teams to support and develop relevant QI projects and support EBE engagement

Strategic aim: Preventing harm

Quality

Our Trust Five Year Strategy		2024/25 strategic goals	
What are we trying to achieve?	***What will good look like by March 2026?***	***Our overarching goals for 2024/25***	***Outputs/deliverables that will achieve this goal***
Reduction in: - unwarranted variations and harm across our services. - level of harm and suicide rate amongst our service users. - harm that sometimes comes to our staff during the delivery of care.	• We will have compassionate engagement with those affected by patient safety incidents • We will have a suite of learning from safety methods, to include learning from everyday work.	Provide assurance of safeguarding practice and the adoption of the Think Family approach.	Build a relationship with all service areas through visits and each service area having an identified lead for safeguarding. Review of data on referrals, incidents, compliments and complaints

Strategic aim: A patient safety culture

Our Trust Five Year Strategy

What are we trying to achieve?

A culture where we are:
- treated fairly if things go wrong and feel confident to speak up about something we think is wrong.
- inclusive, recognising and respecting all of the different experiences, diversity, views and contributions that each other can bring.
- recognised and celebrated when we achieve something really good.
- kind to each other and always treat service users and each other with kindness and respect.
- always learning and using new ways to do things more safely including learning from things that work well as well as what goes wrong.

What will good look like by March 2026?

- All clinical staff will be accessing high quality and meaningful clinical supervision
- Services will have access to intelligence systems and data to help them understand where teams are facing challenges in real time and where they have great success
- There will be an embedded approach to post incident support
- Our work to create a Just Culture will continue and Civility Saves Lives methodology will be in use across the Trust

2024/25 strategic goals

Our overarching goals for 2024/25

Use a variety of channels to identify and share learning outcomes Trust wide

Ensure all clinical staff have routine access to high quality, meaningful clinical supervision

Outputs/deliverables that will achieve this goal

Safety summits in place across directorates and learning shared through local CGC meetings.

Further development of deep dives in each directorate to review quality data.

Seek feedback on provision of clinical supervision and reflective practice

Working group to recommend best practice

Identify learning and development needed

Deliver training

Strategic aim: Quality assurance

Our Trust Five Year Strategy

What are we trying to achieve?

A quality assurance framework to underpin and assure us of the quality of our services and care on a continual basis, developed with staff, service users, families and carers, that helps us to act quickly to recognise good care and practice, and equally act quickly where improvement is needed.

What will good look like by March 2026?

- We will be using a range of data to understand our outcomes, recognise success and identify opportunities for improvement
- We will be able to evidence sustainability of good practice and improvement through local audits and a quality assurance framework
- Our quality assurance peer review processes will be in place across teams and will include a role for service users, families and carers

2024/25 strategic goals

Our overarching goals for 2024/25?

Ensure effective use of data to identify gaps and improve quality

Outputs/deliverables that will achieve this goal?

- Development of a quality dashboard incorporating quality metrics
- Roll out of Audit Management and Tracking tool (AMaT),
- Progress from using RAG rating and run charts to SPC charts across the Trust

Strategic aim: Using our time more effectively

Our Trust Five Year Strategy → **2024/25 strategic goals**

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2024/25*	*Outputs/deliverables that will achieve this goal?*
Use of technology and quality improvement approaches to manage resources well without impacting on the quality of care we deliver. This includes improvements in the way that service users are able to easily move through and access our services and increasing clinical time to care.	• Staff will be supported with quality improvement and continuous improvement methodologies • We will be using evidence-based practice and research as a routine way to inform transformation of care and services • We will have a triple aim approach to our quality improvement programmes	Implement our Quality Improvement Strategy	Alignment and prioritisation of QI work in line with the Trust priorities Building improvement capability through training and partnership working Effective communications to raise visibility and accessibility of QI work Ensure effective governance structures for QI to ensure rigour, buy-in, ownership and learning.

Strategic aim: Transforming with digital (1)

Our Trust Five Year Strategy

What are we trying to achieve?

Being a leader in digital innovation in health care, transforming the way that services are delivered and care is experienced and maximising the benefits of cutting-edge technology as an organisation and a system to improve efficiency, quality, health outcomes and decision-making

What will good look like by March 2026?

We will be clear and specific about the value that technology can offer in health care

Digital leaders will work regularly and openly with clinicians and others in developing and implementing joined up plans for the exploitation of technology

We will have established a track record of delivering meaningful improvement in efficiency, quality and health outcomes by use of technology

Managers and staff will be satisfied that Trust systems are intuitive, efficient and provide value to them

2024/25 strategic goals

Our overarching goals for 2024/25

Operationalise the Digital Strategy and deliver the digital improvement plan, in line with the strategy.

Outputs/deliverables that will achieve this goal

- Develop a roadmap for delivery of the strategy.
- Increased storage network for the Trust
- Increased cyber protection and resilience
- Move to the national tenant for Office 365
- Increase the utilisation of Office 365 products

Strategic aim: Transforming with digital (2)

Our Trust Five Year Strategy

What are we trying to achieve?

Being a leader in digital innovation in health care, transforming the way that services are delivered and care is experienced and maximising the benefits of cutting-edge technology as an organisation and a system to improve efficiency, quality, health outcomes and decision-making

What will good look like by March 2026?

We will be clear and specific about the value that technology can offer in health care

Digital leaders will work regularly and openly with clinicians and others in developing and implementing joined up plans for the exploitation of technology

We will have established a track record of delivering meaningful improvement in efficiency, quality and health outcomes by use of technology

Managers and staff will be satisfied that Trust systems are intuitive, efficient and provide value to them

2024/25 strategic goals

Our overarching goals for 2024/25

Develop our business intelligence capability to improve the information and insights available for developing services and user experience.

Outputs/deliverables that will achieve this goal

- Provide informatics support to key operational development programmes meeting national and local objectives
- Provide informatics support to the Care Planning, Outcomes and Clinical Pathways development programme, ensuring performance measures and reporting are developed to match new clinical care frameworks
- Complete next phase of the Integrated Performance Dashboard development,
- Establish automation infrastructure to improve efficiency.
- Develop informatics relationship with Forward Thinking Birmingham
- Contribute actively to development of the ICS Intelligence Function

Strategic aim: Caring for the environment

Our Trust Five Year Strategy

What are we trying to achieve?

Caring for the environment by managing our buildings and the way we operate to reduce negative impacts on the world around us, including travel, waste, pollution and energy usage, while improving the experience of service users and staff and partners.

What will good look like by March 2026?

We will make best use of the buildings in which we work and deliver high standards of accommodation for staff and service users.

We will be routinely doing strategic estates forward planning, working with the system and local communities so that we have flexible and adaptable estate.

We will build on our track record of delivering on and leading the Green agenda in BSOL

Clinicians and staff will understand the Green agenda and the part they play in it and recognise the value delivered by SSL

2024/25 strategic goals

Our overarching goals for 2024/25

Development of a refreshed Estates and Facilities Strategy to ensure our estates and facilities are fit for the future

Outputs/deliverables that will achieve this goal

- Wide engagement with Trust stakeholders including experts by experience
- Development and approval of the draft strategy and delivery plan
- Mainstreaming of the Green Plan

Strategic aim: Changing through partnerships

Our Trust Five Year Strategy

What are we trying to achieve?

Effective and efficient formal partnerships, strategic alliances and provider collaboratives with local and regional organisations from within and outside the NHS where this transforms services and improves pathways and service user outcomes, sharing of expertise and spread of best practice between partners.

What will good look like by March 2026?

The BSol Mental Health Provider Collaborative will be regarded as an exemplar in the area of provider collaboratives

We will be seen as a proactive and constructive business partner by a wide range of bodies

Reach Out will have continued to develop positively and will work well with its LDA partners

The relationship with the voluntary sector will be seen as strong and mutually beneficial and delivering meaningful outcomes for service users

Summerhill Services Ltd (SSL) will be seen as a key component in the delivery of BSol ambitions and plans and cited as good business partner

2024/25 strategic goals

Our overarching goals for 2024/25

Making sure we have the right partnerships in place to progress our shared ambitions to improve access, experience and outcomes and address inequalities for our diverse population and staff.

Outputs/deliverables that will achieve this goal

- Development of the BSOL Mental Health Provider Collaborative (MHPC) strategy
- Incorporate learning disability and autism into the MHPC
- Implement long term sustainable development plans for Reach Out, aligned to the new Reach Out Strategy
- Complete and implement the Business and Partnerships Development Strategy

Strategic aim: Balancing the books

Our Trust Five Year Strategy

What are we trying to achieve?

Spending less than we earn on an ongoing basis and generate sufficient cash to invest in the transformational development of facilities, technology and clinical services for the benefit of our staff, service users and carers, and the local system.

What will good look like by March 2026?

We will provide assurance that public resources are used effectively for the benefit of service users, carers and families

We will be seen as a low-risk organisation by CQC, NHS England and BSol ICB, giving us more freedom to develop and deliver high quality and innovative health care.

We will have an effective and efficient corporate infrastructure.

2024/25 strategic goals

Our overarching goals for 2024/25

Confirm underlying financial position, ambition and timescale for achieving recurrent balance, with identified proposals for generating cash releasing cost savings

Outputs/deliverables that will achieve this goal

Ensure that the finance department has a budget model that allows the underlying financial position to be accurately determined, and monitored on a monthly basis

Develop a set of financial reporting tools that allow for scenario planning to give the Trust options for how / when it can achieve recurrent balance

Issue clear guidance and expectations to the organisation around approach to savings delivery in sufficient time for schemes to be implemented before April 2025

Strategic aim: Good governance

Our Trust Five Year Strategy → **2024/25 strategic goals**

What are we trying to achieve?	*What will good look like by March 2026?*	*Our overarching goals for 2024/25*	*Outputs/deliverables that will achieve this goal*
Robust and transparent governance arrangements to provide assurance that public money is being used well and deliver positive improvements, while guarding against adverse incidents, outcomes and failures, ensuring a safe and supportive environment in which high quality and innovative health care can be provided and our ambitions achieved.	We will provide assurance that public resources are used effectively for the benefit of service users, carers and families We will be seen as a low-risk organisation by CQC, NHSE and BSol ICB, giving us more freedom to develop and deliver high quality and innovative health care. We will have an effective and efficient corporate infrastructure.	Ensure Trust processes and systems are information governance compliant	Develop the Information Governance Framework
		Establish and implement a performance accountability process so that we can take proactive action where improvement is required	Develop the Trust's Performance Framework

Report to Board of Directors							
Agenda item:	**18**						
Date	5 June 2024						
Title	Integrated Performance Report						
Author/Presenter	Richard Sollars, Deputy Director of Finance Gill Mordain, Associate Director of Clinical Governance Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance & Information						
Executive Director	Dave Tomlinson, Director of Resources	**Approved**	**Y**		**N**	**X**	

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	
To provide advice		**To highlight patient or staff experience**	

Summary of Report *(executive summary, key risks)*

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

The Trust's Performance Management Framework has been reviewed and a number of improvements are being made, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement
- Bringing all performance management matters (People, Quality, Performance, Finance) through a single set of forums

The 2024/25 national planning guidance has introduced a number of new metrics specific to the Trust and updated the definition for some existing metrics, a summary of the changes is as follows:

National metrics	Replaces/ changes	2024/25 Target	IPD
Active Inappropriate Adult Mental Health Out of Area Placements	Inappropriate Out of Area bed days	Trajectory agreed with NHSE is zero acute (from April 2024) and 10 inappropriate PICU placements only from June 2024	✓
3 day follow	7 day follow up	80%	✓
Talking Therapies - Recovery Rate (50%)	Target change	52% by March 2025	✓
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness	New metric	48%	✓

Talking Therapies - Reliable improvement rate for those completing a course of treatment	New metric	67%	✓
Other Changes			
Clinically Ready for discharge – new definition	Delayed Transfers of care definitions	Not applicable	✓

For the new Trust specific metrics in the above table, reporting of these has been added to the IPD.

In addition, FPPC is asked to note that population health-based access measures for transformed community mental health services, Talking Therapies and Children and Young People will be assessed on a system wide basis. Additional metrics have been added which include: , Adults and older adults with long length of stay (over 60/90 days for adult/older adult admissions), People with severe mental illness receiving a full annual physical health check and Number of people accessing Individual Placement and support.

FPPC is asked to note that relevant metrics are discussed at Performance Delivery Group and service area deep dive meetings to assess progress and action plans to support delivery.

FPPC is asked to note that from March 2024, a revised deep dive framework is being implemented with service areas as part of development following learning from previous rounds. The main change is the introduction of a service line review process to ensure that all services within the operational portfolios are covered and a service line RAG rating assessment for each of the domain areas to be completed and reviewed. The process remains developmental and learning from these rounds of meetings will be utilized to shape the ongoing deep dive review framework.

Members are reminded that at the February 2023 FPPC meeting, a specific request was made for the provision of action plans and improvement trajectories related to 11 of the IPD metrics. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is a possible concern or a deteriorating trend.

Relevant Leads have provided an update on each area. The detailed summary of progress against action plans is included as Appendix I.

Table 1: Improvement Metrics identified by FPPC at February 2023 meeting

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
CPA 3 DFU			**New metric** - Above the 80% standard at 89.6%.	8
Talking Therapies – service users seen within 18 weeks			Improving trend (90.11%) marginally below improvement trajectory of 92.6% and below 95% national standard.	4, 19-21
Talking Therapies – service users seen within 6 weeks			Improving trend and meeting national 75% standard at 77.16%.	4, 19-21
Inappropriate out of area Number of placements			**New metric** - Remains in line with last month and above trajectory	2-4, 12-14

Referrals over 3 months with no contact			Improving trend in last month. Long waits over 18 weeks reduced.	4-5, 16-18
CPA 12-month reviews			Maintained - Improved trend in last 6 months and above Trust target of 95%.	5
People				
Vacancies			Reducing trend for last month April data not available	6, 26-27,
Sickness			Declining trend in last month.	5, 28-29
Appraisals			Improving trend in last month to 75.58 and remains below the 90% standard	6, 30-31
Sustainability				
Monthly Agency costs			Improving trend in last 6 months	6

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Improving trend in month (47.48%) below 50% target	
Talking Therapies Reliable Recovery Rate			**New metric -** April data at 43.36% below target of 48%	24-25
Talking Therapies Reliable improvement rate			**New metric** - April data at 63.36% below target of 67%	22-23
Clinically Ready for Discharge: percentage of bed days			**New metric –** April at 8.42%	5, 15
Clinically Ready for Discharge: Number of delayed days			**New metric** – April at 1334	5, 12-13

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 2 months. Remains below target. A plan has not been provided for inclusion in this report	32-33

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incident resulting in harm (patients)			Increasing trend in last 9 months. A plan has not been provided for inclusion in this report – reviewed via QPES.	5, 34

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

Recommendation

The Committee is asked to review the report.

Enclosures

- FPPC May 2024 Performance Report and Integrated Performance Dashboard
- Appendix I FPPC May 24 FPPC Performance Improvement Metrics
- Appendix II FPPC May 24 Performance Framework Update
- Appendix IIa 2024/25 National Planning Guidance – National Mental health Metrics update
- Appendix IIb 2023 National NHS Benchmarking – Adult and Older Adult Inpatient and Community
- Appendix IIc 2023 National NHS Benchmarking – Workforce
- Appendix IId Specialties Deep Dive Deaf Services presentation – 2nd May 2024
- Appendix IIe Specialties Deep Dive Neuropsychiatry presentation – 2nd May 2024

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**	
Report presented at	**Board of Directors**	
Date of meeting	**5 June 2024**	
Date(s) of Committee Meeting(s) reported	**29 April 2024**	
Quoracy	**Membership quorate: Y**	
Agenda	The Committee considered an agenda which included the following items: • Updated Criteria and Application process • Charity Update • Cazenove Portfolio Update April 2024 • Financial Update	
Alert:	The Committee noted the ongoing need for additional resources within the Charities Team and have agreed a further discussion to review the available options at the July meeting. The Committee received a detailed presentation from Cazenove noting the ongoing uncertainty within investment portfolios and agreed to review the recommendation to move the current investments into a sustainable multi- asset fund.	
Assure:	The Committee was assured on the following key areas: • Robust processes are in place with solid foundations being built to support charitable funds bids with guidance underpinning the timescales for submissions and approvals.	
Advise:	• The Criteria for applications has been reviewed and guidance is being developed to support the process and simplify the form whilst supporting staff through the Charities Team.	
Board Assurance Framework	The risks are in development and will be approved in July 2024.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Monica Shafaq, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Governance and Membership Manager

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**5 June 2024**
Date(s) of Committee Meeting(s) reported	**19 April 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework • Commissioning Board Assurance Framework • SSL Risk Register • Corporate Risk Register • Draft Annual Report and Accounts 2023/24 • Internal Audit Progress Report • Action Tracking Report • Internal Audit Reviews: Clinical Governance Committee Effectiveness; Disciplinary Process; Sickness Absence Management; Board Assurance Framework; Finance Culture • Draft Head of Internal Audit Opinion • Local Counter Fraud Annual Report 2023/24 • Local Counter Fraud Communications and Training Plan 2024/25 • External Audit Strategy Memorandum • Single Tender Waivers Report • Patient Transport Contract Procurement • Declarations of Interest Policy • Terms of Reference and Forward Planner 2024/25
Alert:	The Committee considered two internal audit reviews with a **partial assurance** rating: • **Disciplinary Process** • **Sickness Absence Management** The Committee welcomed the reviews which highlighted issues with timeliness and compliance, and acknowledged the comprehensive action plans in place to complete recommendations and make improvements. The **action tracking** report highlighted concern with 13 incomplete actions related to the Complaints internal audit review. The Committee noted that there had been no response to the actions, however assurance that there was executive oversight on the actions was received.

	A partial assurance **Head of Internal Audit Opinion** was received in draft; weaknesses in internal controls were identified through the internal audit reviews carried out during the year.	
Assure:	The Committee was assured on the following areas: • The Counter Fraud Annual Report 2023/24 highlighted a number of positive activities that had taken place during the year, particularly the number of referrals received which reflected a greater use and understanding of the process from members of staff. • The Committee received the draft Annual Report and Accounts 2023/24 and was assured by the timetable for completion. • The Committee approved the Terms of Reference and Forward Planner for 2024/25.	
Advise:	The Committee considered two internal audit reviews with a **partial assurance** rating: • Clinical Governance Committee Effectiveness • Finance Culture The Committee welcomed the reviews and took assurance from the work that was already underway to make significant improvements.	
Board Assurance Framework	The Committee considered the **Board Assurance Framework internal audit review**, which had been given a **reasonable assurance** rating. The Committee was encouraged by the continued improvement and development of the BAF and noted the ongoing work to review and refine risks and format to ensure a fully fit for purpose BAF.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary