BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Board of Directors Public Meeting
09.00, Wednesday 7 August 2024
Uffculme Centre
AGENDA

Ref	Item	Purpose	Report type	Time
	Service User 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 5 June 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 5 June 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
9	**Integrated Performance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	10.20
	Quality			
10	**Quality, Patient Experience and Safety Committee Report** *Linda Cullen, Non-Executive Director*	Assurance	Enc	10.30
	People			
11	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	10.40
12	**Guardian of Safe Working Q1 2024/25 Report** *Hari Shanmugaratnam, Guardian of Safe Working Hours*	Assurance	Enc	10.50
13	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report** *Jas Kaur, Associate Director of Equality, Diversity, Inclusion and Organisational Development*	Assurance	Enc	11.00
	Sustainability			
14	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.10
15	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.20
16	**Summerhill Services Ltd (SSL) Quarterly Report** *Shane Bray, SSL Managing Director*	Assurance	Enc	11.35
17	**Audit Committee Report** *Winston Weir, Non-Executive Director*	Assurance	Enc	11.45
18	**Caring Minds Committee Report** *Monica Shafaq, Non-Executive Director*	Assurance	Enc	11.55
19	**Trust Seal Report** *Kat Cleverley, Company Secretary*	Assurance	Enc	12.05
20	**Board Effectiveness Self-Assessment** *David Tita, Associate Director of Corporate Governance*	Approval	Enc	12.10
	Reflections			
21	**Living the Trust Values** *Lisa Stalley-Green, Executive Director of Quality and Safety/Chief Nurse*		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 2 October 2024, 09.00-12.30

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST Minutes of the Public Board of Directors Meeting Wednesday 5 June 2024, 09.00, Uffculme Centre			
Members	Philip Gayle	PG	Chair
	Sue Bedward	SB	Non-Executive Director
	Sarah Bloomfield	SBl	Interim Chief Nurse
	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
	Thomas Kearney	TK	Non-Executive Director
	Patrick Nyarumbu	PN	Executive Director of Strategy, People and Partnerships
	Lisa Stalley-Green	LSG	Executive Director of Quality and Safety/Chief Nurse
	Dave Tomlinson	DT	Executive Director of Finance
	Monica Shafaq	MS	Non-Executive Director
	Winston Weir	WW	Non-Executive Director
Attending	Alex Copello	AC	Associate Director for Research and Development (item 13 only)
	Kat Cleverley	KC	Company Secretary (minutes)
	Shay-Anne Pantall	SAP	Guardian of Safe Working Hours (item 15 only)
	Emma Patterson	EP	Head of Research and Development (item 13 only)
	Lisa Pim	LP	Acting Deputy Director of Nursing (item 11 only)
	Julie Romano	JR	Head of Quality Improvement and Clinical Effectiveness (item 12 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
	Vicky Webster	VW	Head of Pharmacy HMP Birmingham (item 1 only)
Observers	Two governors observed the meeting in person.		

Ref	Item
1	**Staff Story** The Board welcomed Vicky Webster, Head of Pharmacy at HMP Birmingham, to the meeting. VW shared her personal journey with the Board noting she had worked in the NHS for 32 years in a number of organisations, had been with the Trust for over 10 years, and really enjoyed her role. VW joined the Trust in 2014 during a difficult time whereby the prison service was reliant on the use of agency workers and confirmed over the years the team had been developed from five permanent staff to a workforce of 19. The team worked closely and collaboratively with the clinical leads and pharmacists, and this had significantly improved overall staff recruitment and retention over time. VW highlighted a number of challenges at the prison, noting the regime impacts on the access to patients with medicine routines needing to be scheduled twice a day, however wider impacts from delays at court, legal meetings, and security issues potentially affect the overall administration of medicines on a daily basis. The risk for highly tradable medicines remained a key area of focus and escalations to the prison continued. Medicine hatches remained an area of concern with the size and number of hatches causing ongoing issues alongside the need for improvements with the environment, including pest control and fridges. The prison estate in parts was under refurbishment, with staff welcoming 300 new prisoners within the next 12 months as the work was completed. It was noted that not all areas of the prison were fit for purpose and escalations to the prison continued to raise these key issues.

	The lack of basic equipment for some prisoners on intake was an area of concern, alongside the delays in courts and arrival times at the prison leaving some patients unseen by a member of the nursing team before admission. The Board was apprised on the early release scheme and the proposal for some prisoners to be released up to 70 days prior to their original release date. This would create additional work for the healthcare teams within the prison with the need for medication, accommodation and continuity of care to be arranged before early release. The importance of managing expectations for prisoners remained a key focus. VW advised that staffing remained a key topic and was impacted by all of the challenges that had been highlighted. The Board noted Pharmacy technicians were already supporting medication administration on two wings. A review into Primary Care Based Pharmacy Technician roles was an innovative solution to some of the current pressures, and the utilisation of funding from current vacancies would be reviewed. PG thanked VW for highlighting and escalating the ongoing challenges within the prison, and noted the issues with the estate. RFW thanked VW for her commitment and recognised the positive impact on the overall service and team culture during her time with the Trust. It was noted that, following a recent visit to HMP Birmingham, the sense of team had increased with staff feeling more supported. Both RFW and PG acknowledged and apologised for the ongoing issues in relation to the estate and confirmed the concerns would continue to be escalated appropriately. PN noted the positive recruitment at HMP Birmingham and queried the work that was underway to retain staff. VW confirmed there had been a sustained improvement in staff retention as the culture developed and staff felt supported and safe. PG encouraged and invited the Board members to visit the prison as part of their visiting schedule. The Board thanked VW again for attending and sharing her experiences.
2	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting, noting that it was LSG's first Board of Directors meeting as Executive Director of Quality and Safety/Chief Nurse.
3	**Apologies for absence** None.
4	**Declarations of interest** No new interests were declared.
5	**Minutes of meeting held on 3 April 2024** The minutes were agreed as a true and accurate record, subject to a minor correction under the Staff Survey item.
6	**Matters arising from meeting held on 3 April 2024** All matters arising were updated.
7	**Chair's Report** The report was provided to the Board for information and assurance. PG particularly highlighted the Trust's ongoing compliance with the Fit and Proper Persons requirements.
8	**Chief Executive and Director of Operations Report** The Board received the report and noted the following key points: • Work continued to mitigate against casework extensions, with the aim to reduce length of time to complete.

- There had been a number of successful recruitments to key consultant and specialty doctor roles. The Board thanked the People and Medical Staffing teams.
- The People and IT teams had implemented a chatbot to enable first line support to managers seeking answers to basic queries.
- The Board was assured by the planning in place for further industrial action.
- The Board was encouraged to review the presentation on the Mental Health Provider Collaborative (MHPC), one year on from its establishment, for an overview of the difference the work of the MHPC was making.
- The transformation programme for Children and Young People was launching on 6 June.
- The general election had been set for 4 July; the Trust was adhering to the requirements as a public body during the election period.
- The Trust's Values Awards would take place on 21 June.
- A story from the ICCR team had been received at Sustainability Board, with particular highlights on the impact of the work on service users in inpatient rehab beds and out of area placements noted.
- 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 Trust had been visited by the national Mental Health Improvement System Support team, who facilitated the implementation of the mental health urgent and emergency care assessment tool for the BSOL system.
- A new memory assessment pathway continued to be implemented, with the central booking system due to go live in the coming months.
- Continued improvements within Talking Therapies were noted, along with positive service user feedback.
- The Learning Disability and Autism Steering Group had been established.

MS asked whether a comparison tool was available in relation to the national mental health team visit. VD confirmed that this would be reviewed once the outcome report had been received.

MS also commented on the successful recruitment processes undertaken within IAPT, and whether this could be replicated across other areas of the organisation. VD acknowledged that a number of actions had been implemented over the last 18 months as part of a recovery plan which could be shared across the Trust.

LC queried the Trust's ambitions for its own local targets in relation to the early detection of dementia, particularly considering health inequalities within the city and access to the pathway. VD commented that there was more work to be done to review access rates and working closely with GP services. FA advised that this was a key topic regularly discussed with all partners within the system. PG noted that he had recently visited the memory assessment service and had been very impressed.

PG asked about pending industrial action and the potential impact of this. RFW advised that, as part of the planning, the Trust was able to track how many appointments were cancelled and focused on rescheduling these in a timely manner. The impact of delayed appointments was unknown, however teams had been proactive to limit any significant impact.

PG asked about the usability of the new e-rostering system for all doctors. RFW commented that the system would need to be adapted and a review of how e-rostering was utilised across services would be needed to improve staff experience and efficiency of organising shifts.

PG queried whether there had been any signs of negative impact of the Right Care Right Person approach. RFW advised that some concern remained around phase five, which needed to be addressed. A further wider concern about the general population who were not currently known to mental health services and presented through the Right Care Right Person route was also acknowledged. VD commented that regular reporting through the Trust's governance structure was being undertaken, along with regular contact and meetings with partners; there were no concerns being raised through these discussions.

TK asked about improvements to Community Mental Health Teams pathways and whether recruitment practices would make a key difference. FA commented that regular engagement with teams and the use of a quality

	improvement approach were provided ideas on how to improve pathways, including regular contact with GP colleagues and other partners.
9	**Board Assurance Framework** The Board received the Board Assurance Framework, noting its continued development, including refinement of the risks and presentational aspects, ahead of the Board strategy session in September. PG commended the work that DTi and KC continued to undertake to make improvements. WW commented that the recent internal audit review into the BAF had provided a rating of reasonable assurance, which highlighted the work that DTi and KC were doing. WW reflected on health inequalities and its alignment to the Quality, Patient Experience and Safety Committee; WW commented on the need for health inequalities to be owned by the organisation. RFW advised that the Board would receive a report on health inequalities at the next meeting, and conversations were ongoing as CEOs across BSOL to inform how organisations work together to ensure ownership.
10	**Quality, Patient Experience and Safety Committee Report** The Board received reports from April and May meetings. LC highlighted key points that had been discussed, including Community Treatment Orders and the greater proportion of BAME service users who were subject to them. The Committee had also discussed the Mental Health Act patient safety review, particularly the recommendation to enable Board members to understand decision-making processes for discharges by receiving lay manager training. The Committee had been assured on robust Prevention of Future Deaths processes, and was assured that all requirements were being met. In May, the Committee had reviewed key findings from the Greater Manchester review and the actions the Trust would undertake in relation to the findings. The Committee had recorded its disappointment that the Quality Account had not been received on time, however an extraordinary meeting had been scheduled in June to formally approve. LC advised that the Committee would undertake a deep dive of Board Assurance Framework risks in June. RFW commented on the recommendation that non-executive directors receive lay manager training in relation to discharge process hearings, noting that this would be a significant change. LC noted that a lot of consideration had been given to this, with potential conflicts of interest and concern raised about being involved. PG reflected on the practicalities of the recommendation, and noted that it was a recommendation and not a mandate. LC reflected that the Trust would need to embed learning and improvements from the review, however further consideration would be required as to what it would look like in practice. SBl advised that conversations were ongoing with teams around Community Treatment Orders and improvements that could be made. An improvement notice had been issued by the CQC and leadership teams were involved in producing a trajectory to ensure compliance by July.
11	**Patient Safety and Experience Report** The report provided an overview of patient safety and complaints activity during the quarter, outlining learning responses commissioned by local safety panels and associated outcomes. Performance against safety metrics was also set out, along with Customer Relations metrics and an associated quarterly thematic review. Key points were highlighted as follows: • There had been a reduction in overdue incidents, from 26 to 22 outstanding. • Safety summits had taken place and outputs from the sessions would be utilised to provide learning across the organisation. • An enhanced monitoring framework had been put in place for wards and clinical areas that needed immediate support. LP advised that this pilot had been very successful.

	WW commented that the report provided good assurance in relation to the Board Assurance Framework risk around reducing patient harm. BC commented on the quality metrics and improvements that were used to monitor the complaints process. LP advised that deep dives were used to ask teams for improvement trajectories in a format that was user friendly and easy to follow. LP also advised that the Trust was required to respond to complaints within six months, and noted that historic complaints would be closed by the end of June. LP noted that complaints should be responded to much sooner than six months, however the team was now fully recruited to, and improvements would be seen. SB sought assurance that local incidents escalations would be managed in a sustainable way. PN commented that these incidents align within areas of the Trust where colleagues were experiencing bullying and harassment, and targeted work was underway to support those areas. SBl advised that complaints had been a long-standing and challenging issue for the Trust, and wished to acknowledge the significant progress that had been made. The Board received the report for assurance.
12	**Quality Improvement Report** JR joined the Board to provide an update on the work that had taken place over the year, along with a Quality Improvement Vision engagement plan. JR advised the Board that 35 projects had been undertaken during the last twelve months, with the majority of quality improvement work from local teams. There had been significant changes made as a result of quality improvement projects. JR also advised that there were currently 33 projects underway, with a further 22 in development; 1800 staff had received some form of quality improvement training, either formally or through induction. PN asked whether any improvement opportunities had been identified across the BSOL system. JR commented that the approach to systemwide improvement was being reviewed, along with learning opportunities from partners within the system. JR advised that teams were already working collaboratively, with a number of projects taking place across the BSOL area. BC commented that it was encouraging to see the culture of continuous improvement developing, and asked how the Trust was monitoring the benefit and productivity gains of the different projects. JR advised that this would be developed for each project, alongside inclusion of elements such as net zero, health inequalities, and the Patient Safety Incident Response Framework. Board members were asked to comment on the engagement plan directly to JR. **Action**
13	**Research and Development Annual Report** EP and AC joined the Board to provide an update on the work that had taken place over the year. The Board had received the Annual Report for information and assurance. AC advised that it had been a busy year for the department, noting that 176 participants had been recruited for studies. There had been a lot of work undertaken to integrate research into the organisation, including embedded research governance. The Trust was also now a member of Birmingham Health Partners. MS asked how the team decided the research themes and how this aligned with wider conversations. AC advised that those funding the research led on the themes, however they were influenced by senior academics to ensure relevant research was undertaken. AC commented that further consideration was being given to how the impact of research work could be shared more widely across the organisation. PG commented that the Board was excited about the future, and members were advocates of the research and development team.
14	**People Committee Report**

	The Board received the report for assurance, with no further discussion.
15	**Guardian of Safe Working Hours Reports** The Board received the Guardian of Safe Working Hours Quarter 3 and Quarter 4 reports, along with the Annual Report, for assurance. Key points were highlighted as follows: • There were no immediate safety concerns raised during the quarter. • There had been an overall reduction in exception reporting in Q4. There had been 7 unique exception reports raised, of which 86% related to overtime working. This was another significant increase in use of exception reporting for overtime. • Two fines were levied against the Trust for breaches in safe working hours, a 60% decrease compared to Q2. • The number of vacant shifts continued to be high but stable. The majority of gaps were due to post vacancies and trainees off rota. All on-call locum vacancies during the period were filled. BC queried how closely shifts were monitored, as the Trust was potentially incurring fines through doctors working hours without breaks. SAP advised that rotas were completed with the appropriate amount of breaks and sleep factored in. SAP noted that focus was always to ensure patient safety and completing robust handovers, which sometimes meant members of staff worked over shift. FA commented that any safety concerns were escalated immediately. PG asked about the vacant shifts during 2023/24, which were significantly increased. SAP commented that the amount of vacant shifts was significantly less than the previous year, and provided assurance that all shifts were filled. The main reasons for vacant shifts were linked to national recruitment challenges, trainees on secondment, and working off rota which could occur for a number of reasons, including pregnancy. The Board recorded its official thanks to SAP, as it was her last meeting as the Guardian of Safe Working Hours.
16	**Finance, Performance and Productivity Committee Report** The Board received the report for assurance, with no further discussion.
17	**Finance Report** The Board received the report and noted the following key points: • The month one Group position reported a deficit of £422k, consisting of a £315k deficit for the Mental Health Provider Collaborative, a deficit of £83k for the Trust, and a deficit of £10k for Summerhill Services Limited (SSL). • The out of area expenditure plan for 2024/25 was £14m, including a £5m savings target. The month one position for out of area expenditure was £1.8m. • The savings target for 2024/25 was £17.8m. There was £1.8m unidentified within the savings plan. BC raised the issue of the Mental Health Provider Collaborative deficit that affected the Group financial position. DT commented that there were inherent cost pressures within the system that were outside of the Trust's control, and PN added that a robust governance structure was in place, consisting of a finance group that was dedicated to scrutinising and reviewing MHPC finances. BC commented that the Finance, Performance and Productivity Committee had raised the need for a single plan which brought together quality improvement, Cost Improvement Plans, performance and strategies. PG noted concern about the unidentified savings. DT advised that a report would be discussed by Executives next week. RFW commented that the level of identified savings was significant, however the financial year would be difficult.

	PG asked about the frequency of reporting on cyber and digital, including benefits of artificial intelligence. DT advised that these discussions took place at Finance, Performance and Productivity Committee every six months; it was due for discussion in June where this could be considered further, and would also be strengthened and highlighted through the continued refinement of the Board Assurance Framework.
18	**Trust Strategy Update** The Board received the report, which detailed the progress made against the strategy during 2023/24. The Trust was now entering its fourth year of the five-year strategy, and learning and feedback had been taken into account when setting the strategic goals for 2024/25. PN advised that goals had been set through engagement with service areas, leads, professions and experts by experience. Local and national context, internal and external drivers had also been considered. PN advised that, during May, each Committee had reviewed and approved the associated strategic goals for 2024/25. PG reflected that an infographic to visually demonstrate the strategic journey over the five-year period would be helpful. This would be included in future reports. The Board thanked the team for the work on the strategy, and formally **approved** the strategic goals for 2024/25.
19	**Integrated Performance Report** DT presented the Integrated Performance Report for information and advised the Board that a new set of metrics had been included. The metrics continued to be refined and would be discussed at the Board strategy session in July.
20	**Caring Minds Committee Report** The Board received the report for assurance. MS particularly highlighted that the grant application process had been revised to ensure greater access to and utilisation of available funds. WW asked about the investment portfolio and the assurance received that no inappropriate investments were made, e.g. into smoking companies. MS confirmed that the Committee ensured ethical investment in line with NHS values. PG thanked MS for her work on refreshing the Committee.
21	**Audit Committee Report** The Board received the report for assurance. WW particularly highlighted that the draft Head of Internal Audit Opinion had been received; it was a negative opinion based on the number of partial/minimal rated internal audit reviews that had taken place throughout the year. The Committee had received assurance during the year about the plans and recommendations in place for each review, with regular action tracking reports received and escalated where necessary.
22	**Living the Trust Values** TK reflected on his first two service visits to Juniper Centre and Grove Road, noting that all three of the Trust's values were demonstrable in each visit.
23	**Board Assurance Framework reflections** The Board discussed the need to ensure cyber security and utilisation of digital systems was appropriately reflected within the BAF.
24	**Any other business** None.
25	**Questions from Governors and members of the public**

	The Board received a question about how local communities and members of the public could navigate the different systems and health offers. RFW advised that a system strategy was under development and would help to address the points raised.
Close	

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Quality Improvement Report	Board members were asked to comment on the engagement plan directly to JR.	All Aug 24	
Trust Strategy Update	The Board approved the strategic goals for 2024/25.		

Report to Board of Directors							
Agenda item:	**6**						
Date	7 August 2024						
Title	**Chair's Report**						
Author/Presenter	Phil Gayle, Chair						
Executive 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**	✓

This report provides a summary on key items and updates to the Board from the Chair.

KEY POINTS

The report provides a summary update on:

- Oversight and governance
- Fit and Proper Persons Annual Declaration for 2023/24
- Listening to our patients and colleagues
- Partnership working with the Birmingham and Solihull Integrated Care System
- Working with stakeholders
- Awards

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

N/A

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

CHAIR'S REPORT

1. INTRODUCTION

I am pleased to provide a written report to the Board of Directors which covers some key updates for members' attention and assurance. I have been busy undertaking many site visits which I thoroughly enjoy and also representing BSMHFT at key events.

2. Governance Matters

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.

Our Council of Governors met in public on 11 July and amongst other important business, the Council approved in principle to progress with the significant transaction of the shared service model with an understanding that a formal request for approval from COG will be submitted full diligence is completed and the Board has approved the significant transaction.

The Board held their Board development session on the 3 July where we had the opportunity to review the effectiveness of the Integrated Performance report.

3. SERVICE VISITS

3.1 Visits to our Trust services are continuing to be scheduled with the NEDs, although both the NEDs and I would welcome more governors joining us on these visits over the coming months where possible. The visits schedule will focus on ensuring ward visits are scheduled and planned to ensure increased Board visibility. This is a really important element of our role as NEDs, as we are keen to see and listen to staff, patients, and service users about our services both positive aspects and areas of improvements.

Listening to staff

3.2 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. I always enjoy spending time with our staff, and patients to listen and understand what some of the challenges are but also hearing about the great work they are providing.

3.3 I was pleased to visit Ashcroft, a Mental Health service and Community base for older people. I met with staff from a range of services and was so pleased to see staff working together to deliver the best service possible for the older generation.

3.4 It was also a pleasure to visit with Roisin our CEO two of the Psychiatric Liaison service teams at the Queen Elizabeth and Birmingham City Hospitals to meet the teams and observe operations, speak with staff about the service and hear about some challenges they face related to team service location which are in different for each site.

3.5 I visited again with Roisin Recovery Near You, a substance misuse service in Wolverhampton, and was pleased to meet with a range of hardworking staff and great work they are doing and were able to showcase. It was great to be able to see the ongoing developments within these services.

3.6 I attended our first Medical Celebration Awards event held at the Orange Studio in Birmingham City Centre. It was a real pleasure to see the many awards presented to our clinicians recognising their work and accomplishments.

3.7 I look forward to visiting HMP Birmingham in the near future.

4. Partner and System Development / Stakeholders

4.1 I attend the weekly NHS Confederation Mental health Chairs Network meetings which is a great platform to hear and share learning from different mental health trusts across the country.

5. **BSMHFT Mental Health Provider Collaborative**

From 1st June 2024, the responsibilities for tactical commissioning of Learning Disabilities & Autism (LD&A) lie with the Bsol Mental Health Provider Collaborative.

In order to ensure we have the appropriate governance and oversight arrangements in place to deliver this new responsibility, a Learning Disability and Autism Executive Steering Group (led by Richard Kirby, Chief Executive of BCHC) has been established, which reports into the BSMHFT Commissioning Committee.

In addition, the Collaborative has also launched its Children & Young People's Transformation Programme to help shape a new model of care for children and young people across Bsol.

6. Stakeholder Engagement

6.1 I am pleased to continue to be able to Chair the Council of Governors meetings where we dedicate time to receiving assurances from the Non- Executive Director colleagues on key areas of focus for the Trust and engaging in productive discussions and development.

6.2 I visited Sir Bruce Keogh, Chair of Birmingham Women's & Children's NHS Foundation Trust at their Children's Hospital site where I had a tour of the hospital and met with a range of staff. BSMHFT and BWC continue to work closely together with ongoing shared projects.

6.3 I maintain my regular monthly meetings with Shane Bray from SSL which are helpful and informative.

6.4 I meet bi-monthly with Rebecca Farmer, Director of System Co-ordination and Oversight for NHS England where we discuss key areas of focus for the Trust.

7. PEOPLE / QUALITY

7.1 Regular 1:1's are held with Roisin, Chief Executive, and the Executive and Non-Executive Directors.

7.2 Regular people development and strategy sessions are held for our Corporate Team which I also attend.

7.3 I continue to meet with the Freedom to Speak Up Guardians 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.

7.4 I attended our Values Awards ceremony where staff from the Trust were recognized for their hard work and commitment to the services.

PHIL GAYLE

CHAIR

Report to Board of Directors						
Agenda item:	**7**					
Date	7 August 2024					
Title	**Chief Executive Officer and Director of Operations Report**					
Author/Presenter	Vanessa Devlin, Director of Operations Roisin Fallon-Williams, Chief Executive Officer					
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

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

CHIEF EXECUTIVE and DIRECTOR of OPERATIONS REPORT

PEOPLE

The next module of our new HR Toolkit Training will be released at the end of July, which will be related to the Trust Disciplinary policy.

The recently launched HR chat bot – 'Ask Ava' continues to grow and further reviews are due shortly to enhance the database of answers.

The Trust Wellbeing Steering group is currently reviewing the feedback from the Trust wide questionnaire alongside our Staff survey results to establish a wellbeing strategy. In addition, continuous evaluation is being conducted on our Occupational Health provision to ensure it is meeting the needs of colleagues.

The Learning and Development team have recently been approached by the ICB to lead on the implementation of a coaching and mentoring framework across the system. This work will feed into the wider Talent management agenda and the project plan will be developed by the end of August.

Locally the First line management programme continues to be reviewed and refreshed based on organisational need and local diagnostics. A Learning & Development service delivery plan is due to be published over the next quarter.

Workforce and Resourcing

Our vacancy rate for May was 13.69%. This is slightly ahead of the trajectory target of 14%.

Within this the vacancy rate for registered Nurses was 20.5%. We held a centralised recruitment event for band five nurses in May resulting in sixteen job offers being made.

In May, our turnover rate was 8.8%. This is a 0.2% reduction from April and below our target.

In a rolling 12-month period, 411 people have left the Trust (321 left and ninety have remained on the bank).

The only two directorates that are above the KPI are Acute and Urgent Care with 11.4% turnover and Strategy, People and Partnerships with 14.8% turnover.

Focused work going forward includes:

- Continued focus on improving the flexible working data. We are reviewing the reporting to make it more accurate and helpful to teams.
- We are looking at "Stay Conversations" – currently looking at some benchmarking across local Trusts. An update will be available during August.
- We are part of a "People Promise" system-wide group. As part of that group, we are looking at completing a self-assessment tool, the output of which will provide some further areas of focus, and this will be available in due course.
- The team are conducting monthly "career conversation" drop-in sessions and we are looking at how we can monitor the impact of these.

Bank and Agency

Bank WTE usage dropped by 14.58 WTE and agency usage dropped by 5.25 WTE in May. We are currently below our workforce plan trajectory.

Agency usage continues to be heavily monitored with Executive approval needed for HCAs and no agency administration posts. Significant reductions in our use of doctors via agencies and over cap have been made and further reductions are planned. This has in part been possible due to the progression of the transformation programme within the CMHTs and international recruitment activities, attracting Consultants from the USA, South Africa, and India.

We are shortly going live with the NHS Professionals National Bank which will provide an option to supply workers before going to agencies with significantly lower margins.

We are now live using the Direct Engagement model for doctors. This should provide some significant savings on VAT costs.

There is ongoing work with the Quality Improvement team looking at reducing bank usage. As part of this the Acting Deputy CNO is leading a project to reduce bank usage in Acute and Urgent Care and Secure Services.

From 1st July, we have not been able to use any off-framework agencies.

Doctors Industrial Action

The 11th period of industrial action by Junior Doctors took place at the end of June. An average of 55% of doctors took part in strike action across the 5 days. Throughout the Industrial Action, the lowest participation rate was 38% (16/06/23) and the highest participation rate was 65% (11/08/23)

The BMA Junior Doctors Committee has met with the Secretary of State for Health and Social Care and formal negotiations have led to a new pay offer which will now be recommended by the BMA to members for consideration.

On 18/06/24 Specialty and Associate Specialists (SAS) grades voted in favour to accept the government's pay offer.

GMC Sponsorship

Following a lengthy application process, we have recently been approved to act as a Sponsor for International Medical Graduates to gain registration with the General Medical Council. We have developed a two-year fellowship programme to support experienced, skilled overseas Psychiatrists to gain an understanding and experience of working in the NHS so that they can work towards building a portfolio of evidence of clinical work which will support a successful application for a Certificate of Eligibility for Specialist Registration (CESR) and eligibility for substantive Consultant appointment.

BSMHT Disability Works for Us Campaign

Our new 'Disability works for us' campaign was launched in July and aims to counter discrimination based on visible or invisible disabilities or health conditions, even when it is unintentional. Take the pledge to be disability-aware via the online form or use one of the leaflets distributed around the Trust.

We're encouraging colleagues to consider other people's challenges and to report any problems we identify and to be aware of how our language, behaviour and assumptions might affect people living with a disability or long-term illness.
A growing number of colleagues are signing the pledge, the campaign shares a strong message of taking a positive, inclusive approach to those with disabilities and long-term health conditions and understanding the barriers colleagues may face, so that we can ensure that we support these valuable colleagues to work effectively and successfully.

CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

Community Mental Health Teams (CMHTs) have been focused on improving standards for medication management and quality of Integrated Care Record. The establishment of a clear procedure for Management of Missed Depots sets out a clear escalation process and has been well received by teams. Work is also currently underway in developing Prescribing Standards to identify when the varying prescribing methods we have to use should be applied. Furthermore, a Standard Operating Procedure has been developed in relation to Safe and Secure Management of particular Prescriptions ensuring strong processes around usage and these are audited monthly.

Recovery Near You (RNY), supported by ring fenced funding, has commenced scoping to set up a dual diagnosis service for Wolverhampton. Referrals for Alcohol have increased through various service promotional events. The completion rate for opiates has increased to 7.8% in the first quarter. Recruitment continues for a new Dual Diagnosis team at RNY working with Black Country Healthcare NHS Foundation Trust, commissioned through Wolverhampton City Council.

The homeless teams continue to work collaboratively with partners across the city for people who are homeless and rough sleeping. Supported by an MDT approach people are supported holistically with their, mental health, financial and physical needs. The homeless CMHT is on target for their wait times and any person exceeding the waiting time is contacted for an assessment.

In our Steps to Recovery service, progress has been made in rolling out the Peer Review process around Quality Standards across the service and a defined delivery plan is being finalised. Strategic objectives have been finalised including the development of a co-production strategy within the service and considering ways to address health inequalities. Recruitment is progressing with good effect. Band 5 vacancies have been recruited to with only minor gaps remaining with an active plan to fill in place. A focus on the Integrated Care Record (ICR) - care planning and risk management, both quality and compliance has been closely monitored with all ICR domains now at 90%+. Waiting lists for the service is low, which is positive, particularly for our Community Rehab Units where the interface with Integrated Community Rehabilitation Team (ICRT) is having significant positive impact on diverting those from inpatient stays, along with shortening the Length of Stay through early discharge to ICRT. This has enabled bed capacity to effectively step-down individuals from Out of Area High Dependency Unit placements.

In Neighbourhood Mental Health Teams (NMHT) collaborative working continues with community and voluntary organisation partners to enhance the pathway and offer for service users. The service is currently developing a referral/triage hub to bring services together at the point of referral to support people to the right place at an early stage. The service is also looking at options, including a step-down clinic, for improved transitions from CMHT to Neighborhood Mental Health Teams (NMHTs).

The CQC recently reinspected the Community Mental Health Teams (CMHTs) and verbally shared feedback, the final report is awaited. The teams have worked incredibly hard to make improvements and we hope this will be reflected in the final report. A further transformation project involving the Longbridge Team has commenced, governance and reporting structures have been agreed for updates. The project will focus on trialing new roles, caseload review and a new management and demand led appointment approach.

CMHT roadshows in collaboration with the Transformation Team have reached out to CMHT colleagues, to provide updates and consider next steps for CMHTs in line with the Community Transformation programme. As part of this work ongoing work continues to improve the interface with CMHT and urgent care pathways and Forward Thinking Birmingham.

Long term sickness has reduced across ICCR following a focused effort from managers and HR to support staff back into work.

The North CMHT were successful at the Values Awards, receiving the Gold Award for Quality Improvement for their project around FP10 usage and the Community Transformation Team received a Gold Award for Support Team of the Year.

Secure Care & Offender Health (SCOH)

Child and Adolescent Mental Health Services (CAMHS) parents, carers and families are working with psychology colleagues to write articles around the reality of having a child in Secure Care. Positive initial feedback has been received from the Autism accreditation review. Staff and patients have also co-produced a project on LGBT awareness and their 'Young people's development of LGBT training package' has been nominated for the Reducing Inequalities and Improving Outcomes for Children and Young People HSJ Award.

Reaside Clinic has received extra funding to increase the health care assistant's establishment in line with the recent safer staffing recommendations, which will greatly improve the care provided to our service users and ease staffing pressures. A second Matron has been appointed to Reaside which will help to improve quality and experience. The divisional leadership team is continuing to work with the Reaside senior leadership team to address culture concerns and improve the staff engagement, involving our Freedom to Speak Up Guardians. Our Equality, Diversity and Inclusion Team, our Organisational Development Team and others to support this.

Tamarind have recently had a positive Reach Out Quality Review, with helpful feedback to improve quality. The Tamarind Carers evening event was well attended and received very good feedback from all involved. Nursing vacancies have significantly decreased in men's services and currently we have only one RMN vacancy per ward.

Our Forensic Intensive Recovery Support Team (FIRST) have now established their own Continuous Quality Improvement Initiative Committee (CQII). The team have received bespoke Bronze QI training and are developing new project ideas with the support of the QI team. FIRST have appointed a Recovery Lead and are working to increase service user involvement and collaboration in service development through the introduction of FIRST Recovery Outcomes and Wellbeing (ROW) committee, which met for the first time in July and plan to launch the FIRST service user forum in August. FIRST saw significant improvements in their staff survey results this year, and new communication initiatives have been well-received by the team, including a quarterly staff newsletters and service-wide meetings. The capital review group has now agreed to set aside a budget to renovate Main House which will enable the FIRST service to relocate, as space is a major issue currently for the team.

Offender Health is collaboratively working with Birmingham Community Healthcare Trust (BCHC) to support with vacancy challenges across the partnership. An initial meeting has taken place on a proposed QI project regarding an integrated healthcare handover approach, incorporating both BSMHFT and BCHC.

The Health and Justice Vulnerability Service (HJVS) are now live aiming to increase accessibility for those who have had contact with the Criminal Justice System within a 28-day period. Currently access arrangements have been rolled out to probation services, home treatment teams and a self-referral route established, with a view to extending to Liaison Psychiatry in the next 4 weeks. A Business case has been submitted for additional staff to support delivery of Primary Mental Health Treatment Requirements following the ongoing success of the Intensive Supervision Court pilot. HJVS has launched their first QI project focusing on improving the Youth Pathway and increasing engagement.

Our psychology Service has successfully recruited eight assistant psychologists across the division. Currently we have only four unfilled psychology vacancies across the division. Co-produced and co-delivered trauma informed care training between psychology and service users has been delivered.

Two of the Divisions consultants have received recognition awards at the Trust Medical Workforce Celebration event. In the recent trust value awards, colleagues from the division received seven awards across various categories.

The Affirm Probation team have been nominated for a national award in relation to their QI project on 'Supporting probation officers in their understanding on culturally informed formulations and its impact on risk assessment.' In addition, one of our transformation programmes 'Reducing inequalities through effective community integration – a co-produced approach' has been shortlisted to the finals of the Nursing Times (Dame Elizabeth Anionwu Award for Inclusivity) awards.

Acute and Urgent Care

The Out of Area (OOA) position had continued to improve throughout June reaching our planned trajectory position however we have faced significant challenge in July with regards to demand and flow, resulting in an upturn of inappropriate OOA admissions for both acute and PICU care. We continue to report the activity monthly into committee and drive the work through our weekly Out of Area Steering group and our productivity plan.

We have increased our focus in the working group around service users who are Clinically Ready for Discharge (CRFD) ensuring accurate recording as well as tightening up our clinical oversight and processes along with a face-to-face review of any service user with a stay of 21 days or more. With Executive support, we are working to create a Standard Operating Procedure (SOP) for CRFD, which was launched at a Procedure Development Session on 23 July. Colleagues joined us from our older adults' teams and Forward Thinking Birmingham, to share best practice, a Discharge Managers workshop will take place in August to complete work on the procedure, as well as recording, escalation processes, and discussion of some complex discharge examples, and solutions. These sessions have been greatly supported by our colleagues in Informatics to ensure that recording is of sufficient quality. A draft CRFD SOP will then be presented to Governance Groups in September for approval.

Our City Hospital Liaison Psychiatry Team are due to move to the new Midland Metropolitan Hospital (due to open October 2024, with our team due to move in on 10th November 2024). This is an integrated way of working with collaboration across organisations. The organisational change process for the transition of the City Hospital Liaison Psychiatry Team has commenced, with the support of the People team. Site visits and orientation are occurring ahead of opening and colleagues are being supported via a 30-day consultation period.

Following capital investment, work will commence on our acute inpatient sites with plans to complete by the end of March 2025. This will refresh some inpatient wards, change identified rooms to multi-purpose rooms and enhance the environment at the Urgent Care Centre, to improve service user experience.

Work has been completed along with the Quality Improvement team to identify health inequalities affecting our inpatient service user population, which identified variability in terms of smoking and alcohol consumption to a level of concern, BMI over 30 and pre-diabetic or diabetic status. Our inpatients are around four times more likely to smoke than the general population of Birmingham and Solihull. Service Users are offered Smoking Cessation support and colleagues have been working with the team who are working on the Trust No Smoking policy to solve specific issues including the prescription of Nicotine Replacement Therapy and availability of Electronic Cigarettes / Vapes.

Support to our North Acute Wards has been reviewed and actions taken to meet objectives around patient safety, quality, training and support. The team now have daily touchpoint / mitigation meetings Monday to Friday to update on environment checks, incidents, patient daily meetings, safeguarding, patient leaves etc. There was a recent patient council meeting on George ward with an Expert by Experience (EBE) with very positive feedback. Patient morning meetings are happening daily on both wards. The Ward Managers have developed a personal improvement plan on how to support wards to develop, to improve their skills and continue to share best practice across our inpatient wards.

Primary Care, Dementia Services & Specialties

The Older Adult Mental Health & Wellbeing Community Event held on 6th June 2024 was a great success. Members of the local community attended, and it provided an excellent networking opportunity for the providers. We are now preparing for a further older adult's event which will be in the East of Birmingham in October.
The bipolar service has been commissioned by two other Trusts so far and have had enquiries from several others, to deliver the Mood on Track programme. They continuing to work with Professor Paul Gilbert and the Compassionate Mind Foundation to bid for funding for a larger feasibility and acceptability study of Compassion Focused Therapy for Bipolar across our community services. This will take place in November, with outcomes announced in 2025. We have been approached to write a book chapter on Cognitive Functional Treatment for Bipolar Disorder as a joint venture and are excited to contribute to the knowledge base for new and emerging psychological interventions for this condition.

Within the Memory Assessment Service, implementation of the new memory assessment pathway has progressed further with the central booking system becoming live in July. It is envisaged that this will reduce the administrative burden on practitioners, reduce lost slots to non-attendance and increase capacity to see more patients. This is being monitored by the team.

Our Barberry, Senior Managers are attending monthly Action Learning Sets to strengthen working relationships across the teams. A Clinical Improvement plan is currently being developed for the Jasmine suite following an informal Quality Visit from our specialised commissioners which highlighted areas of improvement including improved communication across the MDT and a clearer referral process. The Cilantro wards recent CQC inspection was returned with a rating of Good. The CQC provided excellent feedback regarding the management of the ward. Areas of improvement included improved evidence of providing meaningful responses or actions following concerns or complaints raised.

The Veteran's service is pleased to hear that they are finalists at the Soldier-On-Awards for its partnership model and delivery across the Midlands partnering with Lincolnshire partnership trust.

Soldier-On-Awards is an unparalleled programme as The Armed Forces Community Awards, that recognises outstanding achievement in the Armed forces community, individuals, groups and organisations.

The Huntington's Disease team alongside the Huntington's Disease Association have won the 'Excellence in Media Award.' The film award came from the Smiley Charity Film Awards and was done at the Barberry in conjunction with the Huntingdon's Disease Association. Here is a link: https://smileycharityfilmawards.com/films/mindful-of-huntingtons-huntingtons-disease-awareness-month-2023. The Huntington's Disease Service at The Barberry has also been awarded a Centre of Excellence.

The East Perinatal Team were awarded with the Trust's Team of Year at our annual awards. The team are extremely proud of the work they do, especially in relation to health inequalities, focusing on how they engage and support local communities, reduce stigma and increase access. Solihull Perinatal Team will be moving into their dedicated team base at Maple Leaf Centre, following capital investment, with clinical rooms, a separate baby friendly access, parking and a waiting area. The service is very grateful for the support of colleagues at Maple Leaf in developing plans and look forward to the opportunity for closer working with Solihull based teams.

Birmingham Healthy Minds (BHM) continues to work towards new KPI trajectories for 2024-25. A deep dive around single contact has been undertaken and presented in the recent contract quality review meeting (July) with accompanying action plan for improvement and strategies of how we can increase contacts activities and decrease the single contact. Employment advisors continue to positively contribute to the BHM service seeing 89 clients in the month of June and offering 891 sessions.

A compliment via a card to one of our Psychological Therapist SC '*To the Most wonderful person 'S'. Thank you for all your support during such hard time in my life. You have no idea how much your support meant to me. I almost gave up, but you gave me hope. You are an amazing person'.*

Community Care Collaborative

Work continues to progress within the community Care collaborative (CCC). Our SRO, Keisha Dell has now had the initial meeting for the central Local Delivery Partnership with key partners in attendance. The partnership is reviewing priorities for the next 12 months with a clear aim of reducing A&E attendance rates during the winter months. The group are working with the Fairer futures team to secure funding for a number of initiatives.

Meetings have taken place with Birmingham Community Health Care Trust to review and agree the hub and integrated team models. The 'show and tell' sessions, described our service users' pathways from both a community and urgent and acute care perspective, with a collective view of improving the patient journey and ensuring they have the most appropriate support packages in place.

The Community Care Collaborative model was discussed at our last Senior leads meeting, the implementation plan was agreed, and it has now been brought to the BSOL PLACE committee for final sign off.

SUSTAINABILITY

Funding and Finances

The financial position across Birmingham and Solihull continues to be challenging with several providers seeing significant deficits already in this financial year. While BSMHFT is currently reporting

a small under-spend after three months, we know that there continues to be financial risks around the number of patients placed out of area as well as some challenges with the commissioning responsibility we now hold, specifically around the number of packages of care for patients. We continue to collaborate with partners across the system to explore opportunities for further productivity improvements as we know savings will be required for some time to come.

BSOL Mental Health Provide Collaborative Update

The BSOL Mental Health Provider Collaborative as from the 1 June 2024 has taken on the responsibilities for tactical commissioning of Learning Disabilities & Autism (LD&A) across BSOL. In order to ensure we have the appropriate governance and oversight arrangements in place to deliver this new responsibility, we have established a Learning Disability and Autism Executive Steering Group which reports into the BSMHFT Commissioning Committee.

This new Executive Steering Group is chaired by Richard Kirby, Chief Executive of Birmingham Community Healthcare as the Senior Responsible Officer for LD&A and has multi-agency representation.

This is an exciting opportunity to look at the way services for people with Learning Disabilities and Autistic people are supported across BSOL to access the right support at the right time, to enable them to live a good and fulfilling life as part of our diverse local communities.

In addition to the above, the collaborative launched its Children & Young People's Transformation Programme in June 2024 with a Stakeholder Launch and Ideas Forums helping to shape a new model of care for children and young people across BSOL.

Key activities currently underway include:

- Reviewing the draft of the Health Needs Assessment commissioned from the Centre for Mental Health and the findings of the Experience of Care campaign in order to help shape and inform the Mental Health Strategy.
- Continuing to review our governance and reporting arrangements for the collaborative.
- Developing our draft Inpatient Bed Strategy setting out our approach for the next three years.
- Undertaking an evaluation of bids received for the MHPC Innovation Fund.

QUALITY

Focused work continues on our Quality priorities and our action plans related to CQC reports. The report associated with the CQC inspection of our adult eating disorders in patient service was published in July and rated the service as Good, the report associated with their inspection of our CMHTs is still awaited.

Learning from the Manchester Report with Professor Oliver Shanley OBE

Over 60 colleagues attended our session on Learning from the Manchester Review last week. It was an excellent experience hearing directly from Oliver Shanley as lead reviewer, witness to the experiences of service users, families and staff, and an experienced and compassionate leader. Those that attended were able to ask question and took opportunity to reflect on and consider our own practice, governance and culture at the Trust.

A number of good suggestions were made during the discussion on how we might take the learning forward to strengthen our own leadership, culture, governance, voice of our service users and staff and professional voice.
A proposal was agreed to consider this further through discussion at the Senior Leadership Team (SLT) meeting in September, with a view to then collating the thoughts of this group, and others within the Trust, into a set of actions that will ensure we continue to learn and develop. This will be shared at Board in due course.

LOCAL NEWS

Celebrating the amazing contribution of our Experts by Experience

The Participation and Experience team held a celebration event for our Experts by Experience (EbE) at the Uffculme Centre on Friday 26 July. Kirstie Jones, Chief Allied Health Professional (AHP) and Associate Director for AHP, Recovery, Experience and Spiritual Care was the compère for the day and was joined by Lisa Stalley-Green, Executive Director of Quality and Safety and Chief Nurse.

Colleagues from our Strategy, Planning and Business Development, AVERTS and Quality Improvement (QI) teams thanked our EBEs for their expertise and the integral role they have played in the development of the Trust Strategy, the training we provide and our QI projects.
Those attending celebrated the positive achievements of the Recovery College which has been running for 10 years and owes much of its success to our EBE's. The event also provide opportunity to recognise the five-year anniversary of the Lived Experience Action Research group and their contributions.

Participation and Experience Manager and EBE Programme Manager, Sandra Baker closed the day by thanking the EBE's for their input and shared some facts about their amazing work including, that in the last year they have completed 2,449 hours of engagement and 1890 hours of attendance at Recruitment and Selection Panels, sitting on a total of 350 panels.

BSMHFT Asian Professionals' National Alliance awards

I would like to congratulate Dr Viba Pavan Kumar, Consultant Clinical Psychologist and Francesca Norouzi, Consultant Art Psychotherapist as they have both been shortlisted for this year's Asian Professionals' National Alliance (APNA) NHS awards. Both have been shortlisted for the Impactful Equality, Diversity Award and Inclusion Champion award. Viba has also been shortlisted for the Rising Star Award.

Team BSMHFT has also been shortlisted for for one of their awards - the Trust/ICB of the Year – Promoting the Equality, Diversity and Inclusion Agenda category.

APNA is a voluntary organisation made up of NHS health and social care leaders of South Asian descent who come together to share ideas and support each other. APNA established their awards to recognise the contributions of NHS colleagues who are making positive changes, driving inclusivity and supporting our communities and partnerships.

The Awards will take place on Friday 13 September.

NATIONAL NEWS

The NHS turns 76

In 1948, the NHS was born, providing healthcare services that are free for all at the point of entry. 5th July 2024 marked 76 years of NHS service.

News from NHS England

New Chief Nursing Officer for England announced

NHS England has announced that Duncan Burton has been appointed as Chief Nursing Officer for England.

A nurse of more than 25 years, Duncan was most recently Deputy Chief Nursing Officer where he led national work on the maternity and neonatal programme, workforce policies and the children and young people's transformation programme.

Chief Executive of NHS England Amanda Pritchard said about the appointment: "I would like to congratulate Duncan – this is a hugely important appointment for our patients and workforce. His extensive experience in local, regional, and national roles, along with his track record of delivery and leadership will be invaluable as he takes on this role at such a crucial time.

"Duncan has consistently achieved exceptional results – from the International Recruitment Nurse Programme, which ensured we met the 50k nurse commitment 6 months early, to the Health Care Support Worker recruitment programme, which resulted in the highest number of healthcare support staff employed in the NHS on record."

Dementia diagnoses in England at record high

Dr Jeremy Isaacs, national clinical director for dementia, NHS England, said: "Getting a diagnosis of dementia is the first step in supporting people, with a wide range of NHS services able to help.

"NHS staff have worked hard to recover services with the number of people with a diagnosis rising significantly over the last year, and now at a record level, but there is more work to be done.

"Thousands more individuals are being diagnosed each month and more medication reviews are being done within 12 months.

While dementia diagnosis rates are the highest since the start of the pandemic at 65.0%, the NHS has more to do to meet its ambition to diagnose 66.7% of the total number of people that estimates suggest are living with a form of the disease.

Latest data shows a record 487,432 people in England in June had a diagnosis.

Global IT Outage

A global IT outage and an issue with EMIS, an appointment and patient record system, caused disruption in most GP practices and administrative systems in Hospitals on 19th July 2024.

The NHS has long standing measures in place to manage disruption, including using paper patient records and handwritten prescriptions, and the usual phone systems for patients to contact GP's. In the majority of hospitals, care continued as normal.
Systems were back online by 22nd July 2024. An NHS spokesperson thanked the NHS staff work their hard work throughout the incident and stated that further disruption is hoped to be kept to a minimum but that there may be some delays as services recover.

NMC Independent Cultural Review

This Independeent review undertaken by Nazir Afzal OBE was published in July. It is a harrowing and very concerning report that sets out evidence and experiences of bullying, racism and a culture of not being heard or listened to. It also makes clear the extent of the backlog of cases a awaiting review and consideration and the impacts this is having on individuals.
We have engaged with regional colleagues on this report and have taken some immediate actions as a Trust to consider the wellbeing of individuals employed by the Trust who have been referred to the NMC and are awaiting review. We will be beginning to consider the wider cultural learning this report presents at the August meeting of the Trusts Senior Leadership Team.
The report can be found: https://www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf

General Practice (GP) Industrial Action

The result of the recent ballot of GPs regarding industrial action was announced on 1st August, the turnout was high and 98% voted for industrial action.

We will be working with BSoL colleagues to potential implications and mitigation plans for the planned working to rule approach that has been proposed.

ROISIN FALLON-WILLIAMS
CHIEF EXECUTIVE

Report to the Board of Directors							
Agenda item:	**8**						
Date	7 August 2024						
Title	Board Assurance Framework						
Author/Presenter	David Tita, Associate Director of 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:**

This report aims to reflect the current position of activities on the Trust BAF since its last review at Board Committees and the RMG. In reviewing the BAF, the Board should assure itself that principal risks to the achievement of the Trust`s strategic objectives have been identified, clearly articulated and are being mitigated and managed appropriately. `*The Healthy NHS Board*` while acknowledging that the format of the BAF could vary from organisation to organisation, argues that the most effective Boards use the BAF as a dynamic tool in driving their agendas, discussions and decision-making.

2. **Introduction:**

A robust BAF should underpin organisational strategy, better decision-making and effective allocation of resources. The BAF thus sets out the key risks linked to the delivery of the Trust strategy and provides assurance that such risks are effectively and efficiently mitigated and managed. The publication, `*Taking it on Trust*` makes the case that the aim of the BAF is to give confidence to the Board that the Trust is providing high quality care in a safe environment by staff who have received appropriate training, that it is complying with legal and regulatory requirements and that it is meeting its strategic objectives.

Members of Board Committees, comprising NEDs, Executive Directors and their ADs have over the last few months been working together and having conversations around the form, structure and content of their different cuts of the BAF with focus on re-structuring, re-framing and re-writing some of their BAF risks. The overwhelming aim is to streamline, simplify and make the BAF more user-friendly, easy to understand and navigate, more strategic and tailored to reflect the assurance required by the Board and its Committees. The fruits of these ongoing discussions on re-structuring, aggregating and re-defining the BAF will culminate in new BAF risks and/or a new BAF which will be presented at Board Committees in August ahead of presentation at the strategic Board development session in September for adoption and ratification for wider implementation.

As part of the ongoing conversations, the NEDs, Exec Director and their ADs on the FPP, recently met and identified the following three BAF risks which are being developed.

- Failure to maintain a sustainable financial position over the next three years.
- Failure to maintain acceptable governance and environmental standards (e.g. estate, digital).

- Failure to deliver optimal outcomes with available resources (e.g. performance, quality, VFM).

The NEDs, Exec Director and their ADs on the People Committee on the other hand, met and identified the following two overarching BAF risks which have been developed and were presented at their committee meeting on 24th August 2024 for review, scrutiny and feedback so these could continue to be fine-tuned.

- Failure to create a positive working culture that is anti-racist and anti-discriminatory.
- Inability to attract, retain or transform our workforce in response to the needs of our communities.

On the other hand, two meetings have been booked to enable NEDs, Exec Directors and their ADs on QPES to identify relevant overarching strategic risks linked to the Quality and Clinical Service strategic priorities and assess them bearing in mind the wider implications to other interdependences and strategic priorities i.e. Sustainability and People.

The Audit Committee reviewed the BAF at its last meeting on 26th July, noted and endorsed the changes and progress that have been made as well as requests for reduction in the current scores of some BAF risks and recommended the BAF to the Board.

It is worth noting that the current version of the Trust BAF will continue to be robustly implemented, mitigated, managed and updated to reflect a holding position while this piece of work on re-designing the new BAF is progressed at pace.

3. Key issues and risks:

The key issues are resource and time constraints due to annual leave and the need to incorporate multi perspectives, triangulation and to have a rounded view of the new BAF risks assessments which requires a collaborative MDT approach. These will be mitigated through better planning, optimisation and linking in with deputies where appropriate.

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*** *and* ***ENDORSE*** *the content of this report.*
2. ***NOTE Actions*** *which have been completed and are now `Green` as these will be removed from the next iteration of the BAF once they are approved at the RMG in August 2024.*
3. ***NOTE*** *requests for reduction in some risk scores and extension of due dates for some actions for the various reasons articulated herein, these will be presented at the RMG for approval and will be reflected in the next iteration of the Trust BAF.*
4. ***REVIEW, SCRUTINISE*** *and* ***ENDORSE*** *the Trust BAF.*

Enclosures

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

Updates on the Trust Board Assurance Framework:

1. Key updates from the QPES BAF:

The following updates have been made to this iteration of the BAF aligned to QPES (see appendix 1 for details). Key updates and changes have been captured in highlighted colours to enable members to easily identify and familiarise themselves with them.

1.1 **BAF01/QPES**

- Action **BAF01/QPES/006** has been updated.

1.2 **BAF02/QPES**

- Recommend that the score of this BAF risk be reduced from 4 x4 = 16 to Likelihood = 3 and consequence 4 = 3 x 4 = 12 in recognition of improvements made with some safety indicators (please see updates captured for BAF02/QPES on 12th July 2024 in appendix 1 for details).
- Risk has been reviewed and new **gaps in assurance**, **assurance** and **progress** against actions linked to this BAF risk added.
- **Request** for an extension of action due date for action **BAF02/QPES/010** from **Sept 2024** to **Oct 2024** due to clinical supervision action lead being off unwell.

1.3 **BAF03/QPES**

- Risk has been reviewed and new **controls** and **assurance** added.
- **Request** for an extension of action due date for action **BAF03/QPES/003** from **June 2024** to **Oct 2024** to enable full completion of action.

1.4 **BAF04/QPES**

- Risk reviewed and more assurance added.
- Request extension of due date form action BAF04/QPES/001 from 31st July 2024 to 31st Oct 2024 to enable the new Chief AHP Officer to refresh the Family Carer Pathway.
- Risk score has been reduced from 4 x 3 = 12 to 4 x 2 = 8 for accuracy and to reflect actual potential risk.

1.5 **BAF05/QPES**

- Risk reviewed and new elements of assurance added.
- Risk score has been reduced from 4 x 4 = 16 to 3 x 3 = 9 for greater accuracy and to reflect actual potential risk.

1.6 **BAF06/QPES**

- Risk reviewed and new elements of assurance added.
- Risk score has been reduced from 4 x 4 = 16 to 4 x 3 = 12 to reflect the great work that has been done in the collaborative space and to underpin the actual potential risk.

1.7 **BAF07/QPES**

- Risk reviewed and new elements of assurance added.
- Request extensions of action due dates for BAF07/QPES/001; BAF07/QPES/002; & BAF07/QPES/003 to enable completion of these actions.
- Risk score has been reduced to from 4 x 4 = 16 to 3 x 3 = 9 to reflect the huge work taking place in the collaborative space.

2. Key updates from the FPP BAF:

Members of the FPP at their June meeting gave some consideration to the need to capture a BAF risk around "Keeping the Trust safe" from cybersecurity risks (cyber security and Zero Day attacks), giving the recent cyber-attacks on some hospitals in London which brought down their systems, and led to service disruptions and cancellation of appointments/operations. The FPP received an ICT Cyber & Assurance Report from the Chief Information Officer (CIO), Joint Dir ICT & Programmes on the Trust`s cybersecurity resilience, members were assured, however, the CIO was open to the idea of adding a BAF risk around cybersecurity.

The following additional updates have been made to this iteration of the FPP BAF (see appendix 2 for details)

2.1 **BAF02/FPP**

- Risk reviewed and progress notes added.

2.2 **BAF03/FPP**

- Risk reviewed and progress notes added.
- New title has been suggested given new financial year and discussions around not making this BAF risk time specific.

2.3 **BAF04/FPP**

- Risk has been reviewed and progress notes added.
- Completed actions have been turned `green 'and two new actions added.
- Recommend reduction in risk score to reflect progress; suggest impact reduces from 5 to 4 while likelihood stays the same at 3. Hence, risk score will become 5 x 2 = 10.

3. **Key updates from the People Committee BAF:**

All 4 BAF risks on the current People Committee BAF (see appendix 3 for details) have been reviewed, updated and progress notes captured.

NB: The changes articulated in this report will be incorporated in the next iteration of the BAF once approved by the RMG at its meeting on 22nd August, 2024.

Trust Board Assurance Framework

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 Appendix I – BAF Risk Scores - July 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 & Productivity Committee (FPP)**
- **People Committee**
- **Audit Committee**

Table 1a: Trust 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 to 12	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 to 8	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 to 9	02/06/ 2023	↓
BAF06/ QPES	Potential failure to implement preventative and early intervention strategies in enhancing mental	Executive Director of Operations	QPES	ADs of Operations	16 to 12	02/06/ 2023	↓

	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 to 9	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 to 10	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 workforce culture	Executive Director of Strategy, People & Partnerships	People Committee	AD of EDI & OD	12	02/06/ 2023	

	and staff experience.						
BAF03/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 Trust 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			BAF04/QPES BAF01/FPP BAF02/FPP BAF01/PC BAF02/PC BAF03/PC	BAF03/QPES BAF03/FPP BAF05/FPP BAF04/PC BAF02/QPES BAF05/QPES BAF06/QPES BAF07/QPES	
3 Moderate				BAF01/QPES	
2 Minor					
1 Insignificant					

Appendix 1: Details of 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**	**12th July 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	The patient safety and QI teams are working in collaboration with the EBE safety plans to agree a strategy for the next 12 months.	

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.
24 June 2024	BAF Risk has been reviewed.

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**	**12th July 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 • Development and application of RRP Dashboard	Reporting/Data • . • 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.	Learning for improvement: • Structured Judgment Reviews reviewed at local safety panels • Corporate led learning from deaths meeting • Executive Medical Director's Assurance Reports to QPES Committee and Board • NHS Digital Quarterly Data. • Commissioner and NED quality visits • Trust Clinical Audit Programme reporting through to committee	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. This will be supported by a Patient Safety Dashboard similar to that of the format currently in place for

		• 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 (National Clinical Audit and Patients Outcome Programme) • Coroner's Reports • QSIS compliance	• 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. • 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	• NICE Guidance reported through updates to committee • Monthly reporting on quality safety metrics • PSIRF oversight • Safety Summit • 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	Reducing Restrictive Practice. Need to agree a Trust Data Style, move from run charts to SPC across the Trust, not in parts. Strengthening of processes is required for assuring that the learning from PFD, external reviews, incidents, and complaints is embedded. Quality Strategy, Quality Management System and Quality priorities not yet fully aligned and strengthening of infrastructure is required to deliver Need an identified NHS Impact Exec/Senior lead outside of QI Team. Currently no Trust wide Oversight Group for L&D

		• Shared Care Platform	RMS/Clinical Supervision	• 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.	Clinical System strategic approach could be strengthened to maximize effectiveness. AMaT procured and currently rolling out implantation across the Trust by CEM. Will need long term plan for management after initial implementation.
	• *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 CGC Local review has been completed - Outcome of Clinical Governance Review has informed any areas of inconsistency that will need be addressed.	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.
	• *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 for how action plans

			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	following MHA inspections are monitored/completed as completely devolved to local divisions. 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. QI resource and draft strategy PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data	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- This has been embedded from June 2024 with regular reports built into committee planning structures. Safety Summit Reporting is included in the Patient Safety	QMS is in its early adoption stage and requires trust-wide commitment and resource to embed. QMS will need a senior lead to implement alongside NHS Impact (outside of QI Team)- to be confirmed which Executive Team as change in Executive leadership in quarter.

		tracking/themes and trending and adoption of a QI approach to resolution.		Report to Trust CGC, QPES, and Board Independent annual assessment against the 68 NHS Core Standards for EPRR.	New QI resource has been realigned to be able to undertake Priority1 QI Workstreams 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	Upward 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 • Complaints, clinical incidents, adverse events Safety Huddle audit reports Executive Chief Nurse's Nursing Assurance Reports	New QI project has started with complaints/PALs team in Q1. QI Projects average 65-70% of projects with EBE/SU involvement as are a core ingredient when setting up a piece of continuous improvement with QI Team.

				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. 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- **Brief risk description**				

	Risk ID	
	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. Update 11/07/24 CGC review has been concluded and report completed. To be presented to relevant committees.	
		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, staff now inducted and being trained. • Will assure the Board of QI approach and embedding QI culture into the organisation. Year in QI document circulated and taken to Public Board in June 2024. • Dynamic Space event in March 2024 looking at Continuous Improvement approach at BSMHFT with PMO/QI/Research/Transformation teams- next event scheduled for June 26th has been cancelled by organiser- no update at present.	
	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	Deputy Medical Director for Safety and Quality	September 2024	• Ensures a clear roadmap for the delivery of quality over the next 12 months Update 12/07/24. A full update on this area of work will be provided in the next iteration of the BAF following full formal review by the DCMO and Acting DCNO.	
	BAF02/QPES/010	RMS and Clinical Supervision Workstream to be commenced with objectives to include;	Associate Director of	Request extension	• Will support engagement with RMS and Clinical Supervision enabling improved support	

		improvement in IT systems, compliance with policy requirements, and improved quality of supervision.	Clinical Governance	of action due date from Sept 2024 to October 2024	mechanisms for staff. Update 12/07/24. Clinical Supervision Project Lead has been off sick from work for some time. It is anticipated that a return date should be soon. The project has continued in their absence with agreed defined outputs and objectives. It is not anticipated that this workstream will be completed/concluded by September 2024. A clear timescale for conclusion of work is still to be clearly established. The operational lead for the RMS Project has now left the organisation. There have not been defined outcomes and timescales yet attached to the project. The QI team have been actively supporting some work on the RMS project but this has been challenging given an absence of direct leadership on the project.	
	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 Update 12/07/24 Improvement trajectories have been set for historic complaints and are monitored through CGC and QPESC. KPI's for Customer Relations are also overseen/monitored through monthly reporting to these committees – we have	

					seen increasing compliance with 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)*
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.
12th July 2024	**Progress** Additions Following review further changes have been made to controls, gaps in controls, assurance, and gaps in assurance. **Changes** Dates amended on the following actions; BAF02/QPES/010 – RMS and Clinical Supervision Workstreams: The date has been amended on this action due to the Clinical Lead for the Clinical Supervision Project being off for some time on unanticipated sick leave and the Project Lead for RMs having recently left the organisation and it is not evident that clear outputs and timelines have been assigned to this project. QI have worked extremely hard to maintain progress on this project, but further work needs to be taken to establish clarity of outputs. It is anticipated that revised/defined timelines for this work will be established by the next iteration of the BAF. **New Actions** No new actions have been added. **Completed/Embedded Actions** **BAF02/QPES/011:** Customer Relations KPI Improvement Plan will be devised and reported to QPESC on a monthly basis. This has been completed and KPIs are significantly improved. **Scoring** **It is recommended that the scoring is reviewed with a possibility of reduction in scoring. Rationale is detailed below;** Previous 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. Consider New Likelihood: 3: There is mixed evidence in relation to current outcomes with some improvements in sources of evidence and some sustained concerns. Improvements

	CQC: Recent CQC inspection of Eating Disorder Inpatient Unit rated as “Good”. Also evidence of significant and sustained improvement against the recent CMHT S29A’s and awaiting formal feedback from re-inspection. Complaints: Complaints KPI’s have continued to improve over the last 8 weeks as presented through QPESC and although some historic complaints remain these are being worked through in targeted timelines. Governance KPI’s/metrics: Specific metrics within the Patient Safety and Experience Report have remained consistently on or below the mean for the quarter including staff assaults and restraints over the quarter Sustained Concerns PFD’s: The Trust has received 2 further PFD’s in the last 6 weeks relating to issues of ongoing concern impacting patients safety. External Reviews: The Trust also has 7 ongoing homicide reviews with significant learning evolving through the review processes Consequence: 4: Internal data evidencing staff and patient harm including; patient assaults, a recent in-patient death, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB.

	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	**12th July 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 • CQC Steering Group	No organisational wide reporting of LFE metrics.	• Updates on PSIRF Implementation to QPES and Board. New processes have been devised to improve learning from deaths including improved oversight of Structured Judgement Reviews (SJR's) and associated learning/actions. Continued improvement evidenced against the CMHT Section 29A's as part of reporting to CQC Steering Group.	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. Work to be undertaken to embed human factors/just culture.

	• Variations in safety culture across the organisational at Divisional and Service Level. • Inconsistencies in governance arrangements at Divisional and corporate level.	• Enahanced Framework arrangements.	Enhanced framework is new and is being embedded – success of this framework is yest to be determined.		
	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	Request extension of action due date from	• Change requested to enable enaction of agreed options appraisal and subsequent survey requirements.	

				June 2024 to October 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)*
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

12th July 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** Nil **Scoring** **The scoring is unchanged at 16**. Rationale is detailed below; **Likelihood: 4:** PSIRF transition has only just occurred and is in its early adoption stages, new learning responses have not yet been formally/fully evaluated to see if they bring about meaningful learning. We have not yet progressed the Safety Culture work. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient death, 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**	
Title of risk	Potential inconsistency with the pace of implementing a recovery focus model across our range of services.	**Inherent Risk Rating**	4	4	16	Quality, Patient Experience and Safety Committee	
		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**	**27th June 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 Model is about and its expectations.	• 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 approaches. • Expert by Experience	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) Group. • Highlight and	Having a strong service user/carer voice across all of our governance forums.

	Inconsistency of Pathways maturity and availability.	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.		escalation reporting to Strategy and Transformation Board. • Reports to QPES Committee. • Co-produced Trauma informed recovery focussed training rolled out (NMHT)	
	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 Requesting extension of due to 31/10/2024 to enable the new Chief AHP Officer to refresh Family Carer Pathway.	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.
27th June 2024	New Chief AHP Officer currently reviewing the Family Carer Pathway Risk score has been reduced from 4 x 3 = 12 to 4 x 2 = 8 for accuracy and to reflect actual potential risk.

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**	**27th June 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. Demand for community services exceeding our	• 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 year 3 of	• Divisional inequalities plans not fully finalized for all areas. • Availability of sufficient capital funding for developments. • Capacity within teams to deliver transformation and service developments alongside day job. • Recruitment and	• 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	• 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.

	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	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	retention	structures. • 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. • Each division has its own health inequalities action plans that feeds to Inequalities board • Community collaboration with system partners • Pilot work has commenced in key areas across ICCR, adults and specialties through transformation programme	
	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) of the Trust and is progressing.	Head of Quality Improvement / Associate Directors of Operations	Ongoing process	Enables successful delivery of transformation plans and service developments.	
	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.
27th June 2024	Risk reviewed and new elements of assurance added. Risk score has been reduced from 4 x 4 = 16 to 3 x 3 = 9 for greater accuracy and to reflect actual potential risk.

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**	**27th June 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 health co-morbidities e.g., substance misuse, learning
		• 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.
		• Urgent care transformation plan
			• Capacity within teams to deliver transformation and service developments alongside day job.
			• Not enough beds for population when compared nationally.
			• Recruitment and retention
				• 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 Group “deep dives”.
				• Highlight and escalation
					• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.

	disability, autism etc.	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.	impacting delivery plans.	reporting into BSOL MHPC Executive Steering Group. • Clinical Effectiveness and Assurance Group. • Community collaboration with key partners • Implementation of NMHTs • Partnership working with VCFSE and council • Physical health connectors pilot • Working closely with public health • Full integration of community care pathways – SMI adults	
	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- Risk ID	**Brief risk description**			
	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.
27th June 2024	Risk reviewed and new elements of assurance added. Risk score has been reduced from 4 x 4 = 16 to 4 x 3 = 12 to reflect the great work that has been done in the collaborative space and to underpin the actual potential risk.

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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**	**27th June 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	• 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	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			

	initiatives e.g., development of 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.	about our population and needs.	• Productivity programme in acute urgent care • Community care collaboration • Full community pathway integration – SMI adults (community transformation programme) • CYP transformation programme • Continuous QI across the trust • Co-produced Digital transformation – patient portal	
	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 to enable completion of action.	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 to enable completion of action.	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 of action.	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.
27th June 2024	Risk has been reduced and more assurance added. Risk score has been reduced to from 4 x 4 = 16 to 3 x 3 = 9 to reflect the huge work taking place in the collaborative space.

Appendix 2: Details of the 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**	**17th July 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. • Operational and Strategic Health and	• 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, Trust	• 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 Group including SSL, Finance,	• 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.

		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.	Corporate Department delivery and Clinical/ Nursing service commitment making sustainability and net zero carbon part of our BAU.	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. Trust responsibility re the prioritisation and provision of capital funding. Given lack of funding then due consideration to the removal of this as risk as it may be beyond direct control	

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.

17th July 2024	As February 24 - Risks and controls remain as this represents a long-term strategic approach needed by the NHS to manage its Sustainability and Net Zero challenges, failure to deliver against the agenda in its entirety being a significant risk to all NHS organisations Continue to work across ICS and with NHS E re prioritisation of initiatives and joint working Long term planning needed re the refresh of the Green Plan and embedding Green and Sustainability as core to the Trust. Trust Strategic return completed re again the 'embedding' of Green Plan into core strategic organisational SSL/BSMHFT leading the ICB/ICS responses Nationally Low Carbon Skills Fund application submitted for revenue funding towards detailed design for Heat Decarbonisation schemes at 4 sites. Trust Green / Carbon Steering Group held 3 monthly with good corporate attendance, struggle re clinical attendance

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 operate within its financial resources.	**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**	**17th July 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 continues	HFMA sustainability audit has identified a number of development areas that

		ICS expectations and reporting requirements.	Trust has not been able to develop a pipeline for delivery of savings.	to meet its statutory financial obligations, including any shortfall in savings delivery.	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.
17/7/2024	The financial plan for 2024/25 has been reviewed and approved by FPP and Board. It includes elements of financial risk, especially around savings delivery, out of area reductions and programmes around temporary staffing, but the plan is to deliver a £2m surplus for which at Q1, the Trust remains on track to deliver.
17/7/2024	Internal Audit continue to review elements of financial performance and process – during 2023/24 they completed audits on our Cost Improvement Programme (4.2023/24) giving reasonable assurance, and also completed a financial culture review with some recommendations that will be followed up in a further culture review in 2024/25. The audit plan for 2024/25 also includes an audit around financial controls.

Executive Lead	Executive Director of Finance		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
		Inherent Risk Rating	5	5	25	Finance, Performance & Productivity Committee	
Title of risk	Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	**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**	**17th July 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.* *A weak governance infrastructure.*	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. Governance around compliance is weak.	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. Peer review not very regular.

	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.	Controls have not been embedded.	Board Assurance Framework Report.	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 the likelihood and impact were the risk to materialise.	

target risk score.	BAF04/FPP/ 004	Update the Trust Risk Management Policy and Risk Appetite Framework.	David Tita	30/09/2024	Risk Management will provide a framework to underpin effective risk management and prevent the likelihood of risk materialising.	
	BAF04/FPP/ 005	Re-design, redefine and re-structure the Trust BAF.	NEDs, EDs & ADs	31/10/2024	This will create a slim down BAF, enhance engagement, understanding and compliance.	

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.
17th July 2024	Risk has been reviewed and progress notes added. Completed actions have been turned `green ‘and two new actions added. Recommend reduction in risk score to reflect progress; suggest impact reduces from 5 to 4 while likelihood stays the same at 3. Hence, risk score will become 5 x 2 = 10.

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 resolution, suspension and termination, decommissioning, and conflicts of interest	• *Newly established groups which are working through their interface with the various governance structures.* • *Limited number of policies in place to support contract management, ie*	• Procurement Plan • CQC Reports • Other regulatory Reports. • CQRMs enabling effective management, oversight and collaboration.		• *Time to mature newly developing relationships with providers requiring trust and transparency.*	

		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.	*decommissioning.* • *Newly relationships take time to nurture, grow and mature.* • *Changes to the translation of the Procurement, Patient Choice and Competition Regs 2013.*		
	• *Poor Commissioning Committee decision-taking.*	• Evidential link between recommendations (decisions made) and decisions taken. • MHPC governance architecture. • Reach Out governance architecture. • Partnership Agreement • Memorandum of Understanding.	• Untested new structure, requiring time to nurture and mature.	• Signed Partnership Agreement • Signed Memorandum of Understanding • Escalation and assurance reporting from Reach Out Commissioning Sub-Committee • Escalation and assurance reporting from	• Delays in getting signed agreements.

				• 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 the 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**	**18th July 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 makeup of panel, and values-based questions – will be reported on a quarterly basis –

		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.	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. Membership of the ICS People Committee.		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE. • Greater **employability** in local population • Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover	• Falling to reassurance rather than assurance

		↓ Assertive recruitment to areas with chronic vacancy challenges. ↓ National payment mechanisms and banding panels. ↓ Remuneration Committee. ↓ Recruitment Policy and processes. ↓ Stabilisation Plan ↓ Retention Plan		• 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	Dec 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.
18/07/2024	Further modules have been released as part of the FLM programme and a revised model for leadership has been shared at internal committees, INR and student nurse recruitment continues to positively impact on band 5 vacancy rates. Task and finish groups have been established to have a focus lense of workforce initiatives such as grow your own and stay conversations

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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**	**18th July 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	• 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. • Social media policy ratified.	• Falling to reassurance rather than assurance.

		▪ Health & Wellbeing offer ▪ HR Toolkit training		• 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
Actions being	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 opportunities available, locally and systemically.	

implemented to achieve target risk score.	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.
18/07/2024	Staff survey details have been shared and teams are now developing local engagement plans with the support of the OD team. FLOUISH programme commencing over the next 3 months with the reframe of the leadership offer under a global lens. Colleague Engagement approach confirmed through TCSE Any updates on actions being implemented.

Executive Lead	Executive Director of Strategy, People & Partnerships.		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Inability to modernise our people practice.	**Inherent Risk Rating**	4	5	20	People Committee	
		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**	**18th July 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.	• 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. • New workforce digital group, project tracker on people goals		• Falling to reassurance rather than assurance. • Lack of engagement and buy-in from staff. • Built in evaluations to every large-scale project • Audits are not systematic as they are adhoc at the moment.	

		▪ QI Projects to address some of the 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.	• Trust wide audits are conducted in line with a forward planner learning lessons which will be considered for future activities.	• 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

Actions being implemented to achieve target risk score.	BAF03/PC/001	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 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.
18/07/2024	'Ask Ava' HR chatbot has now been fully launched and receiving initial positive feedback. Further work continues to be carried out on our quality of F/W data and leavers analysis. Wider project work around usage of ESR is due inline with national review. Rosters for our medics have now been moved to online through Allocate.

Executive Lead	Executive Director of Strategy, People & Partnerships		**Impact**	**Likelihood**	**Score**	**Oversight Committee**	
Title of risk	Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.	**Inherent Risk Rating**	4	5	20	People Committee	
		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**	**18th July 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 Behavioural 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 behaviours 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 to health inequalities.

				• Staff Survey results improving to top quartile performance. • EDI Improvement plan • Triangulating data in transforming culture reporting.	• 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.
18/07/2024	All Divisions now have reducing inequality plans, milestones are currently being reviewed. Anti Racist behavioural framework -colleague and practitioner currently being rolled out. Inclusive supervision model being developed.

Report to Board of Directors							
Agenda item:	**9**						
Date	7 August 2024						
Title	Integrated Performance Report						
Author/Presenter	Richard Sollars, Deputy Director of Finance Sam Munbodh, Clinical Governance Team Hayley Brown, Workforce Business Partner Tasnim Kiddy, Associate Director Performance and Information						
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**	

The key issues for consideration by the Board following discussion at Committees 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 these new metrics, reporting has been added to the IPD.

In addition, the Board 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 also 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.

The Board 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.

The Board is asked to note that from March 2024, a revised deep dive framework is being implemented with service areas as part of developing the performance framework following learning from previous approaches. 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 reviewed and completed. The process remains developmental and learning from these meetings will be utilised to shape the Trust's performance framework.

Members are reminded that it was agreed that more detailed updates will be provided on the key themes, factors affecting performance, actions and improvement trajectories relating to a number of metrics which were off track. 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 being monitored in Appendix I

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Talking Therapies – service users seen within 18 weeks			Improving trend (92.49%) in last 4 months, below improvement trajectory and 95% national standard.	4, 24-25
Talking Therapies – service users seen within 6 weeks			Continued improving trend and meeting national 75% standard at 82.30%.	4, 22-23
Inappropriate out of area Number of placements			**New metric –** deteriorating trend in last month and above trajectory	2-3, 13-15
Referrals over 3 months with no contact			Performance remains in line with previous month. Long waits over 18	4, 18-21

			weeks reduced.	
CPA 12-month reviews			Maintained - Improved trend in last 6 months and above Trust target of 95%.	4
People				
Vacancies			13.3%, staff in post up from 4,343.0 WTE to 4,362.7 in month	5-6
Sickness			Deteriorating trend in last month.	6, 30-31
Appraisals			Trend has remained stable in last month at 76.3% and remains below the 90% standard	6, 32-3
Sustainability				
Monthly Agency costs			Improving trend in last 6 months	5

Table 2: Performance

	On Track	Plan in Place	Progress	Page
Talking Therapies - Service users moving to recovery			Deteriorating trend in month (45.05%) below 50% target	
Talking Therapies Reliable Recovery Rate			**New metric -** Deteriorating trend in last month (42.05%) below target of 48%	26-27
Talking Therapies Reliable improvement rate			**New metric** – Deteriorating trend in last month to 60.27% below target of 67%	24-25
Clinically Ready for Discharge: percentage of bed days			**New metric –** Deteriorating trend in last 2 months. June at 9.81%	4, 14-15
Clinically Ready for Discharge: Number of delayed days			**New metric** – In line with previous month. June at 1546	4, 14-15
Eating Disorders CYP National Access Standard: Routine			Deteriorating trend this month at 66.6% below the national target of 95% - reviewing data recorded.	5

Table 3: People

	On Track	Plan in Place	Progress	Page
Fundamental Training			Deteriorating trend in last month (91.4%). Remains below target of 95%	32-33

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incident resulting in harm (patients)			Increasing trend in last 11 months. Small reduction in last month Reviewed via QPES.	5, 34-35
Reported incidents			Increase in last month to 2,470 remains above upper control limit. Reviewed via QPES.	5,36-37

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 receive the report for assurance.

Enclosures

- Performance Report and Integrated Performance Dashboard
- Appendix I July 24 Performance Improvement Metrics
- Appendix II July 24 Performance Framework Update

Integrated Performance Report

Context

The Integrated Performance Report, the associated Dashboard and supporting detailed reports, including the background to all, were discussed at the Board development session in July and committee chairs were asked to consider how to best to use and develop them to support their committees in providing assurance to the Board. If they require any further discussion or support, they should contact Dave Tomlinson or Tasnim Kiddy.

All SPC-related charts and detailed commentaries can be accessed via the Trust network via http://wh-info-live/PowerBI_report/IntegratedDashboard.html - please copy and paste this link into your browser.

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

It was agreed that more detailed updates will be provided on the key themes, factors affecting performance, actions and improvement trajectories relating to a number of metrics which were off track.

- Active Inappropriate Adult Mental Health Out of area Placements (Previously Inappropriate Out of Area Bed Days)
- Talking Therapies – service users seen within 6 and 18 weeks (** improving trends for 6 and 18 weeks**)
- Referrals over 3 months with no contact
- Service users with a CPA review in the last 12 months (** 95% target achieved for last 3 months. Will move to BAU reporting from next month**)
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

The Board is asked to note that the improvement plan metrics are discussed at Performance Delivery Group and service area deep dive meetings to assess progress and action plans to support delivery. Appendix 1 outlines an update on improvement plans provided by relevant Leads. This includes an update on the 2024/25 trajectory and improvement plans.

Summarised detail on the key issues is provided in the relevant sections below.

2024/25 NHS Planning guidance – national metrics

The 2024/25 national planning guidance has introduced a number of new mental health metrics and also updated the definition for some existing metrics.

A summary of the changes is outlined below:

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, Board 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.

Performance in June 2024

The key performance issues facing us as a Trust have changed little over the last 2 years, although there have been some improvements against some of the metrics in recent months:

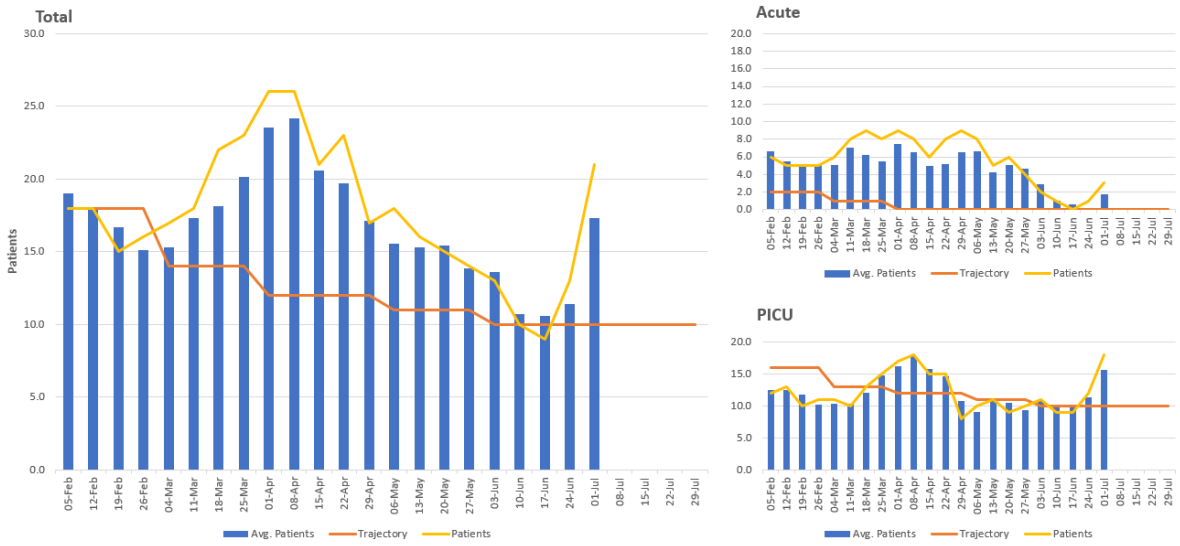
Active Inappropriate Out of Area placements – The 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of inappropriate out of area placements. This will now be based on the number of inappropriate out of area placements at each month end.

A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute inappropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards.

Process improvements being implemented as part of the Productivity action plan are helping to address underlying issues, but the level of demand and increased Clinically Ready for Discharge patients has impaired our ability to eliminate inappropriate out of area placements. In the last month there has been sustained demand for both acute and PICU beds leading to use of inappropriate placements during June. The granular level weekly data

is outlined below. As at the end of June 2024, there was 1 acute (target 0) inappropriate placements and 16 PICU (target 10) patients.

A detailed update on progress was provided by the Acute and Urgent care AD at the June FPPC meeting.



Out of Area Steering Group — Action plan updates:

- **Locality model** — Rolled out to all localities
- **Contract procurement** — extending Priory capacity to include an additional 20 beds for BSOL system.
- **Demand Management/Gatekeeping —** local pilot implemented in two localities to gatekeep all admissions and ensure that alternatives to hospital admission are reviewed and offered. Further meetings to consider how these gatekeeping principles can be implemented across all ‘doors’ to inpatient admissions.
- **Clinical Oversight Team —** senior medical cover to have oversight of patients on the bed list.
- **Reducing LOS/CRFD** — CRFD Policy development session planned in July – outlining roles and responsibilities across wards and discharge managers.

Longer term or requires additional support from ICB.

- Clinically Ready For Discharges (CRFD) — weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process in place.
- 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority.
- Discharge Team Manager proposal has been shortlisted for Inpatient Quality and Transformation Fund for 12-months.
- Joined up 18+ bed management process — options appraisal exercise in progress — due end of November 2024.

Talking Therapies waits — Trust performance has improved and has been above the national waiting time standard for 6 weeks since Apr-24 with June at 82.3% (national standard 75%) due to the successful drive of the action plan which has led to an over achievement of the trajectory.

The 18-week 95% standard was planned to be met by end of June 2024. Progress is being made but the position as Jun-24 was 92.45%.

Both recovery plans are heavily reliant on recruitment plans. New staff are beginning to embed and positively impact on the improving trends observed. This will be reviewed over the next few months as the impact of capacity is expected to continue to have a positive impact.

The 2024/25 NHS planning guidance has introduced 2 new metrics, reliable recovery and reliable improvement. These are in addition to the current recovery rate. The reliable improvement rate is above the national target and the other rates are currently below national targets.

New referrals not seen within 3 months – Both Adult and Older Adult CMHTs have made progress against their improvement plans focusing on reducing long waits, though the overall figure at 3,730 is at a new high. Challenges in both services remain in particular around managing high caseload levels and pressures arising from staffing levels. The national focus is to reduce long waiters over 104 weeks in 2024/25 in preparation for the new community waiting times metric. Neuropsychiatry remains the most significant issue.

- **ICCR Adult CMHTs** – Progress against the revised 2024/25 improvement trajectory to achieve a 20% reduction in new referrals not seen within 3 months has been slower than anticipated. The revised trajectory is to reduce the number of service users waiting over 3 months to 622 by June 2024. A reduction has been achieved but remains above trajectory. The service is reviewing its plan, and a revised trajectory will be provided next month.
- **Older Adult CMHTs** – the 2023/24 action plan focused on reducing long waits in the first instance and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024. Good progress has been made and the trajectory was achieved in April 2024. Progress has continued to be made and the position for June is at 149 service users waiting over 18 weeks. Focus remains on reducing long waits over 26 and 52+ weeks and the latter has reduced from 86 in November 2023 to 43 in June 2024. The service lead is in the process of reviewing the existing plan and updating the actions and improvement trajectories for 2024/25. This will be shared at the next FPPC meeting.

CPA with formal review in last 12 months — Performance has been on a gradually improving and upward trend following the implementation of recovery plans within adult and older adult CMHTs. The trust performance standard of 95% has been met and maintained for the last 3 months with June 2024 at 96.5%. As the 95% standard has been consistently maintained, this metric will be removed from the improvement plan report and be included with the IPD as BAU reporting from next month.

Clinically Ready For Discharge (CRFD) — bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 9.8%. The main drivers for this are the delays in both adult and older adult acute services. CRFD in June 2024 in Adult Acute &

Urgent Care is at 11.5% (39 patients) and in Older Adult Services at 23.5% (20 patients). The number of delays in Acute and Urgent care have increased this month. The main reasons for the delays in adult acute are lack of public funding and supported accommodation and in older adults is due to waits for a nursing home placement.

Eating Disorders – CYP National Access Standard: Routine – June at 66.6% below the target of 95%. This relates to 3 of 9 patients not being seen within 28 days of referral. The data is being reviewed with the service leads to ensure accuracy in recording as this standard is usually consistently maintained. A verbal update will be provided at the meeting.

Quality the detailed position on these metric areas is discussed at QPES committee. A summary of the metric outliers is outlined below.

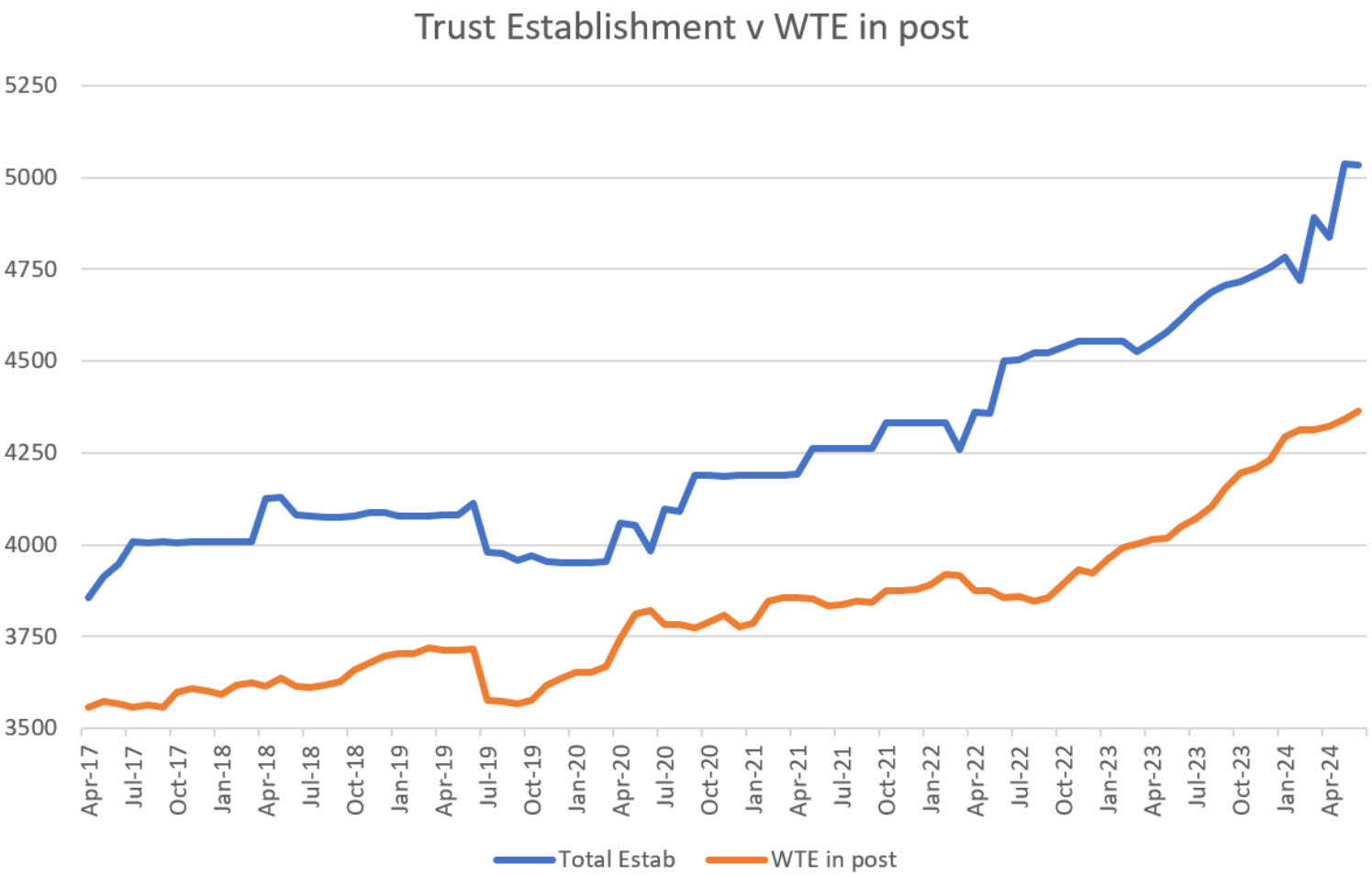
- Incidents resulting in harm (patients) has fallen from 31.2% to 29.6%, the second highest figure since Jul-20
- Reported incidents have increased from 2161 to 2470 in month. The highest figure since Oct-23

People Workforce measures – The detailed position on these metrics is discussed at the People Committee. FPPC is asked to note that there is an adverse variance against most of the set performance standards although there have been improving trends in reducing sickness absence and increasing bank and agency fill rates.

2024/25 action plans - The HR Leads have reviewed the metrics and provided updated trajectories for 2024/25 together with an outline of the key areas of action referenced in Appendix 1.

Summary position is outlined below:

- Staff vacancies — WTE in post has increased from 4,343.0 to 4,362.7 since May and is up from 4,070.3 in Jul-23. This is against a current establishment of 5,033.3 WTE with vacancies down from 13.8% in May to 13.3%, though this has worsened since Feb-24 (8.6%).
    - Acute & Urgent Care — Actual WTE 764.9 up from 761.9 in May against an establishment of 871.6 — 12.2% vacancies. Actual WTE are down from 776.7 in Mar-24
    - Secure — Actual WTE 994.8 down from 1004.0 in May against an establishment of 1142.2 — 12.9% vacancies. Actual WTE are up from 970.3 in Dec-23
    - ICCR — Actual WTE 947.7 up from 934.4 in May against an establishment of 1123.3 — 15.6% vacancies. Actual WTE are up from 899.4 in Oct-23
    - Specialties — Actual WTE 780.6 up from 772.1 in May against an establishment of 847.0 — 7.8% vacancies. Actual WTE are up from 719.9 in Aug-23
    - Qualified Nurses — Actual WTE 1250.9 down from 1279.9 in May against an establishment of 1562.2 — 19.9% vacancies. Actual WTE are up from 1108.2 in Aug-23



- Sickness — levels have increased to 5.1% in Jun-2024 and just above the improvement trajectory of 5.02%. Long term sickness has decreased to 3.3% and short-term sickness increased to 1.7%. Overall sickness is down from 7.2% in Dec-22
- Bank and Agency WTE reduction – bank usage reduced by 105 WTE and agency usage by 4WTE – both below trajectory for June.
- Staff Appraisals at 76.33% at Jun-24 and remains below the 90% Trust standard.
    - L&D QI appraisal project continues with focus on gathering qualitative data from staff.
    - Reminders being sent to staff.
    - Streamlined process for staff to access appropriate appraisal support e.g coaching, system walk though, ESR etc
- Fundamental Training at 92.0% - reduction this month due to two new Fundamental Training subjects, Soft Restraint System Conveyance and Oliver McGowan. The grace period has now ended on both, which has had an impact on our overall Trust compliance.

Sustainability – The detail on the relevant metrics are discussed at the FPP Committee and included within the Finance Report.
Performance is summarised below:

- Capital expenditure is ahead of plan YTD (£2.1m v Plan of £1.6m) with the overall programme under review to ensure we spend full capital allowance during 2024/25
- Cash is steady at £91m, though much of this relates to commissioning funds
- CIP achievement is £2.4m v YTD Plan £3.9m but there is sufficient flexible to ensure overall financial position maintained
- Information Governance remains comfortably above 90% at an overall level, with the only issue relating to FOIs completed within 20 working days (87% in June)
- Agency spend continues to operate at well below NHSE target (2% v 3.2% YTD)
- Operating surplus £346k v YTD Plan £525k, some pressures on Out of Area and unachieved CIP

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Top Line Commentary (Trust level)

Performance: IAPT waiting times, Out of Area

People: Appraisals

Quality: Incidents resulting in harm (patients)

Sustainability: Savings plans yet to be identified

Division: A: All

A: All

June 2024

Performance

Active Inappropriate Adult Mental Health Out of Area Placements	17 ↓
Clinically Ready for discharge, Number of Delayed Days	1546
Clinically Ready for Discharge, Percentage of Bed days	9.8%
CPA 3 day FU	86.0%
CPA 7 day FU	91.7% ↓
CPA with Formal Review last 12 mths	96.5% ↑
Eating Disorders Routine	66.7% ↓
Eating Disorders Urgent	100.0%
First episode psychosis	100.0%
Out of Area Bed Days	384 ↑
Referrals over 3 mths with no contact	3730 ↓
Talking Therapies into Recovery	45.1%
Talking Therapies seen in 18 weeks	92.5% ↓
Talking Therapies seen in 6 weeks	82.3% ↓
Talking Therapies, Reliable Improvement rate	60.3% ↓
Talking Therapies, Reliable Recovery Rate	42.1% ↓

People

Bank & Agency Fill Rate	90.0%
Fundamental Training	92.0% ↓
Rolling 12m Turnover	6.8% ↑
Staff Appraisals	76.3% ↓
Staff Sickness	5.1%

Quality

Absconsions from inpatient units	6
Commissioner reportable incidents	0
Community confirmed suicides	0
Community suspected suicides	0
Failure to return	17
Incidents of self harm	230
Incidents resulting in harm (other)	8.7% ↑
Incidents resulting in harm (patients)	29.6% ↓
Inpatient confirmed suicides	0
Inpatient suspected suicides	0
Ligature no anchor point	21 ↑
Ligature with anchor point	0
Patient assaults	39
Patient ssaults / 1000 OBD	2.1
Physical restraints	314
Physical restraints/ 1000 OBD	16.9
Prone restraints	41 ↑
Prone restraints/ 1000 OBD	2.2 ↑
Reported incidents	2470 ↑
Staff assaults	87
Staff assaults / 1000 OBD	4.7

Sustainability

CAP Ex	£557k
Cash	£90,881k ↑
CIP	£850k ↑
Info Governance	93.0%
Monthly Agency	£394k ↑
Operating Surplus	£493k ↓
SOF rating	3 ↑

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

Integrated Performance Dashboard

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Division

A: All

A: All

Measure	Latest Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Active Inappropriate Adult Mental Health Out of Area Placements	10.00	23	15	23	23	12	17 ↓
Clinically Ready for discharge, Number of Delayed Days					1334	1559	1546
Clinically Ready for Discharge, Percentage of Bed days					8.4%	9.5%	9.8%
CPA 3 day FU	80.00	78.9%	81.8%	82.5%	89.6%	83.9%	86.0%
CPA 7 day FU	95.00	89.8%	92.7%	91.7%	92.8%	93.4%	91.7% ↓
CPA with Formal Review last 12 mths	95.00	96.2%	96.2%	95.7%	95.6%	95.1%	96.5% ↑
Eating Disorders Routine	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	66.7% ↓
Eating Disorders Urgent	95.00	100.0%		100.0%	100.0%	100.0%	100.0%
First episode psychosis	60.00	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%
Out of Area Bed Days	328.00	561	519	578	730	520	384 ↑
Referrals over 3 mths with no contact		3310	3420	3623	3521	3708	3730 ↓
Talking Therapies into Recovery	50.00	45.0%	46.5%	45.3%	47.5%	48.0%	45.1%
Talking Therapies into Recovery	50.00	45.0%	46.5%	45.3%	47.5%	48.0%	45.1%
Talking Therapies seen in 18 weeks	95.00	85.3%	83.6%	87.5%	90.1%	90.6%	92.5% ↓
Talking Therapies seen in 6 weeks	75.00	67.2%	70.0%	74.8%	77.2%	81.4%	82.3% ↓
Talking Therapies, Reliable Improvement rate	67.00	68.3%	67.9%	64.0%	63.4%	67.4%	60.3% ↓
Talking Therapies, Reliable Recovery Rate	48.00	44.3%	44.8%	40.8%	43.4%	45.3%	42.1% ↓

Top Line Commentary (Trust level)

KEY CONCERN:

* Out of Area is improving
* IAPT
* New referrals not seen in 3 months

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division: A: All

A: All

Measure	Latest Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Staff Vacancies		10.2%	8.6%	11.9%	14.3%	13.8%	
Staff Sickness	4.28	5.6%	5.0%	4.7%	5.0%	4.8%	5.1%
Staff Appraisals	90.00	75.8%	76.7%	74.1%	75.6%	75.6%	76.3% ↓
Rolling 12m Turnover		7.4%	7.2%	7.5%	7.2%	7.0%	6.8% ↑
Fundamental Training	95.00	92.5%	92.3%	92.7%	93.4%	94.1%	92.0% ↓
Bank & Agency Fill Rate		90.3%	91.7%	93.5%	91.8%	88.2%	90.0%

Top Line Commentary (Trust level)

KEY CONCERNS

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

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

compassionate inclusive committed

Integrated Performance Dashboard

compassionate inclusive committed

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Division

A: All

A: All

Measure	Latest Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	
Absconsions from inpatient units		1	9	2	1	5	6	
Commissioner reportable incidents		0	0	0	0	0	0	
Community confirmed suicides		0	0	0	0	0	0	
Community suspected suicides		0	0	0	0	0	0	
Failure to return		17	10	20	15	22	17	
Incidents of self harm		160	160	198	162	165	230	
Incidents resulting in harm (other)		9.4%	9.5%	9.2%	11.2%	8.4%	8.7%	↑
Incidents resulting in harm (patients)		26.1%	27.3%	28.1%	28.1%	31.2%	29.6%	↓
Inpatient confirmed suicides		0	0	0	0	0	0	
Inpatient suspected suicides		0	0	0	0	0	0	
Ligature no anchor point		21	10	31	18	27	21	↑
Ligature with anchor point		0	0	0	0	2	0	
Patient assaults		44	27	46	38	28	39	
Patient ssaults / 1000 OBD		2.3	1.5	2.4	2.1	1.5	2.1	
Physical restraints		213	214	276	183	198	314	
Physical restraints/ 1000 OBD		11.0	11.9	14.4	9.9	10.3	16.9	
Prone restraints		50	44	46	35	49	41	↑
Prone restraints/ 1000 OBD		2.6	2.4	2.4	1.9	2.5	2.2	↑
Reported incidents		2404	2169	2354	2163	2161	2470	↑
Staff assaults		97	99	79	73	82	87	
Staff assaults / 1000 OBD		5.0	5.5	4.1	3.9	4.3	4.7	

Top Line Commentary (Trust level)

KEY CONCERNS

* Incidents resulting in harm (patients)

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

Integrated Performance Dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

HOME | PERFORMANCE | PEOPLE | QUALITY | SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	
CAP Ex		£394k	£704k	£1,157k	£1,213k	£333k	£557k	
Cash		£86,186 k	£92,306k	£92,228k	£83,423k	£88,969k	£90,881k	↑
CIP		£2,049k	£1,518k	£1,319k	£600k	£922k	£850k	↑
Info Governance		95.8%	94.5%	94.9%	92.5%	94.7%	93.0%	
Monthly Agency		£765k	£763k	£625k	£607k	£435k	£394k	↑
Operating Surplus		-£606k	-£616k	-£680k	-£422k	£275k	£493k	↓
SOF rating		3	3	3	3	3	3	↑

Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

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

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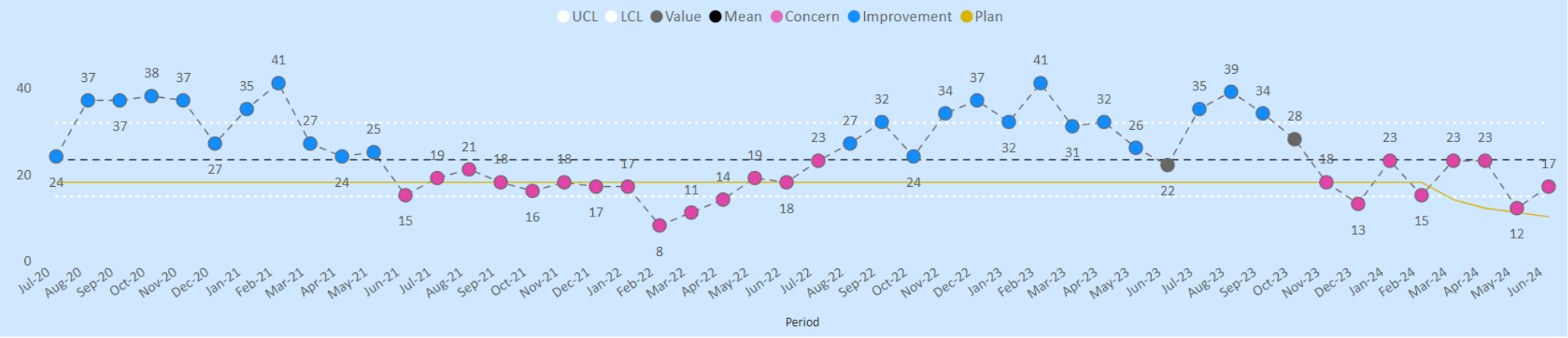
Birmingham and Solihull Mental Health NHS Foundation Trust

Active Inappropriate Adult Mental Health Out of Area Placements

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	23	15	23	23	12	17
B: Acute and Urgent Care	23	15	23	23	12	15

Commentary

From April 2024 the 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of Inappropriate Out of Area Placements. This will now be based on the number of inappropriate out of area placements at each month end. A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute in appropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards.

At the end of June there were 17 Inappropriate Out of Area Placements with 1 in acute beds and 16 in PICU beds above the trajectory of 10 for June 2024. There were 15 inappropriate admissions during June with 2 acute and 13 PICU. There were a total of 384 OOA bed days.

The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Active Inappropriate Adult Mental Health Out of Area Placements

June 2024

Question	Answers
A: What has happened?	From April 2024 the 2024/25 NHS planning guidance has introduced a revised metric for assessing the reduction of Inappropriate Out of Area Placements. This will now be based on the number of inappropriate out of area placements at each month end. A Trust trajectory has been agreed with NHSE as part of the 2024/25 national planning requirements. The trajectory is for zero acute in appropriate placements from April 2024 and to reduce and not exceed 10 PICU inappropriate placements from June 2024 onwards. At the end of June there were 17 Inappropriate Out of Area Placements with 1 in acute beds and 16 in PICU beds above the trajectory of 10 for June 2024. There were 15 inappropriate admissions during June with 2 acute and 13 PICU. There were a total of 384 OOA bed days. The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. The 2024/25 Standard Operating Protocols (SOPs) for the classification of appropriate Out of Area Placements is in the process of being agreed with NHSE. This enables a reclassification of such beds as being 'appropriate' as they meet the qualitative requirements of an 'appropriate' placement. Internal reporting reflects those currently identified as 'appropriate'. However, it should be noted that national reporting via the Mental Health Services Dataset (MHSDS) managed by NHSE currently does not recognise these bespoke SOP arrangements agreed via NHSE. NHSE and Commissioners are aware of these issues and acknowledge that until this issue is resolved, there will be differences between national reporting using MHSDS as the data source and local Trust reporting.
B: Why has it happened?	NHS Benchmarking data confirms that BSMHFT has one of the lowest number of inpatient beds per 100,000 population indicating the need for additional capacity to meet the needs of the BSOL population. In addition, the service continues to face pressure on its inpatient capacity, with bed occupancy levels consistently at 95%, the inpatient admission and discharge ratio largely on a 1:1 basis, lengths of stay generally higher than other Providers due to high levels of acuity requiring a higher number of observations and the challenges of reducing delayed transfers of care, where the reason for the delay is not in the Trust's immediate control. CRFD at 1243 overall in June, with adults at 756 lost bed days. Adult bed occupancy increased to 95.8% and length of stay decreased to an average of 104 days in June. The bed waiting list for service users being managed by Home Treatment Teams in the community are a further added pressure to capacity requirements. These combination of these challenges and their inter dependencies continually impact on creating sufficient flow within the acute and urgent care pathway in particular to allow repatriation of out of area placements. Demand for PICU beds remains high resulting in patients being placed in units further away from Birmingham. Staffing has also remained a challenge in terms of sickness and vacancies levels.
C: What are the implications and consequences?	Without a system wide approach and a review of patient flow across MH pathways, demand will continue to exceed available Trust capacity and risks to patients and staff potentially increasing without the reconfiguration of services needed to manage demand and manage patients in community teams that also have the staffing and skill mix levels to support. The bed waiting list identifies patients who are waiting to be admitted and are being risk managed in the community. Action plans continue to receive national and commissioner scrutiny which remain at a high level due to performance being above trajectory.

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Active Inappropriate Adult Mental Health Out of Area Placements

June 2024

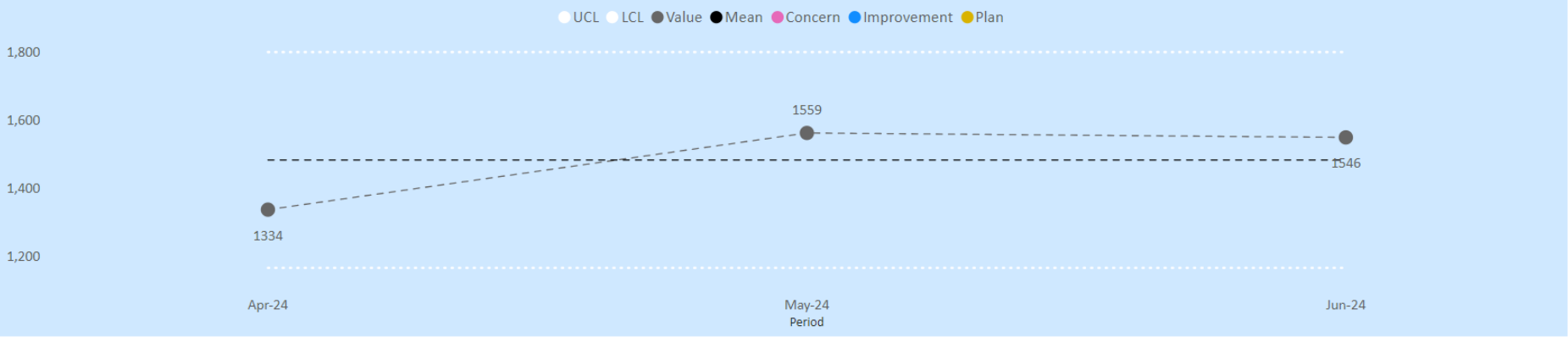
Question	Answers
D: What are we doing about it?	An update on the project plan was shared at the Performance Delivery group in November 2023 outlining progress within the 3 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services within the resources available. The 3 workstreams are : Demand Management/Gatekeeping • Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients. High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral • Clinical Oversight Team - senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients in area. Locality model development • There has been positive progress in East, with the bed waiting list reducing and repatriation to locality beds from other localities & OOA starting to take place. The locality model has now been rolled out to all other localities. New bed management function to support the locality model being developed. CRFD Workstream and length of stay • Renewed focus on Clinically Ready for Discharge (replaced DTOC). Action plan in place, and suggestions of how to improve internal management of CRFD being presented via OOA Steering Group. • weekly internal bed management, ICB deep dive weekly, Estimated Discharge Date confirm and challenge process (more proactive approach being taken for patients with longer Length of Stay. • Looking to embed social workers into the locality model. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority • CRFD Policy development session in July – outlining roles and responsibilities across wards and discharge managers including data quality, EDD, identifying CRFD – includes FTB. Work has been undertaken to extend the current contracts for appropriate placements with the number of beds available increasing for 2024/45, this should help reduce the number our of area placements in the future A new trajectory has been agreed with commissioners for reductions in inappropriate out of area placements for 2024/25. This is based on the new national metric introduced in April which will look at the number of OOA placements at month end.
E: What do we expect to happen?	Monthly use of inappropriate out of area beds is expected to continue but reducing as the range of actions being taken forward get implemented and embedded and progress is made toward achieving the agreed trajectory of using only 10 or less PICU placements.
F: How will we know when we have addressed issues?	When the numbers of inappropriate OOA placements reduce in line with the trajectory submitted in the action plan. Actions being taken forward by the workstreams begin to impact on creating capacity and flow to support repatriation of out of area placements.

Birmingham and Solihull Mental Health NHS Foundation Trust

Clinically Ready for discharge, Number of Delayed Days

Divisions

Statistical Process Control (SPC)



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

Division	Apr-24	May-24	Jun-24
A: All	1334	1559	1546
B: Acute and Urgent Care	545	671	756
D: Secure Serv & Offender Health	312	265	303
E: Specialties	477	623	487

Commentary

From April 2024 there has been a national move away from the current DTOC definition to Clinically Ready for Discharge (CRFD) which is a more tailored definition for mental health, covering both internal and external delays. The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

The number of CRFD bed days in June has remained in line with May 2024 at 1546. Adults moved from 545 days in May to 756 days in June, which related to 39 patients, with a main delay reason of awaiting supported accommodation and older adults moved from 561 days in May, to 464 in June and related to 20 patients, who were waiting for care home placements with nursing.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Clinically Ready for discharge, Number of Delayed Days

June 2024

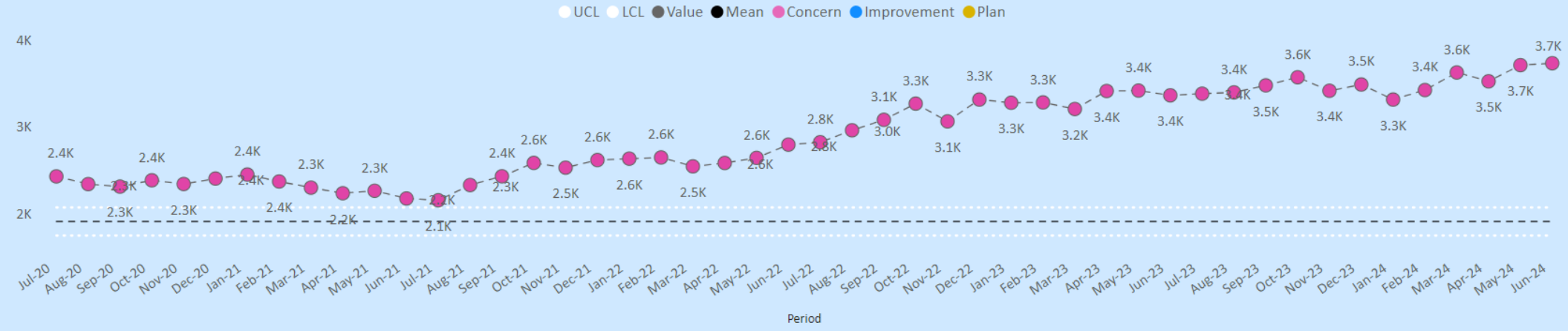
Question	Answers
A: What has happened?	From April 2024 there has been a national move away from the current DTOC definition to Clinically Ready for Discharge (CRFD) which is a more tailored definition for mental health, covering both internal and external delays. The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. The number of CRFD bed days in June has remained in line with May 2024 at 1546. Adults moved from 545 days in May to 756 days in June, which related to 39 patients, with a main delay reason of awaiting supported accommodation and older adults moved from 561 days in May, to 464 in June and related to 20 patients, who were waiting for care home placements with nursing.
B: Why has it happened?	The main reasons for the delays across both services include awaiting supported accomdoation and awaiting nursing home placements which requires social care input. These are system wide challenges and partnership working is taking place with local authority and ICS colleagues daily and weekly to review current barriers to discharge for each individual patient. However it is recognised that the ability of partners to aid timely discharge of service users is a continual challenge due to availability of appropriate alternatives. The majority of those CRFD are awaiting nursing home placements or care packages which requires social services input to facilitate this process.
C: What are the implications and consequences?	Failure to discharge patients in a timely way reduces the flow within in-patients, contributing to out of area placements and leads to an increased waiting time for beds and impacts on patient experience.
D: What are we doing about it?	Reviewing patient flow and activities as part of operational and strategic management of demand and capacity as part of both community and acute and urgent care transformation work plans. A multi-agency bed management meeting has been introduced to support improved bed flow across inpatient services, along with production boards which provide an update on each patient's delay, identifying progress and tasks required to support discharge. Regular discussions with colleagues in the ICS and local authorities to assist in addressing the 'system' wide challenges and identifying alternatives to aid discharge for service users waiting for social care and nursing home placements. More recently a 'system' wide CRFD task and finish group has been established to support partnership discussions to assist in facilitating discharges. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority. From April 2024 there is a national move away from the current DTOC definition to a more tailored definition for mental health. The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. Rio has been updated to capture this data and from April onwards we will be reporting on those Clinically Ready for discharge.
E: What do we expect to happen?	Via the partnership working, to begin to see reductions in delays due to availability of alternatives including social care support and nursing home capacity that is not in our immediate control.
F: How will we know when we have addressed issues?	Begin to see partnership and system wide solutions being implemented contributing to a reduction in these delayed discharges.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	3310	3420	3623	3521	3708	3730
C: ICCR	1245	1297	1365	1306	1323	1279
D: Secure Serv & Offender Health	79	77	75	75	80	82
E: Specialties	1951	2012	2143	2100	2265	2323

Commentary

The number of patients who have not been seen after 3 months of referral has fluctuated over the last 9 months with June 2024 in line with the previous month at 3730. The number of referrals not seen within 3 months of referral has increased in Neuropsychiatry and MAS and has decreased in adult CMHT, older Adult CMHTs, Perinatal Community and CAMHS Primary MH in Schools.
Neuropsychiatry service accounts for 25% and Adult CMHTs 19% of referrals open for over 3 months without a contact.

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

June 2024

Question	Answers
A: What has happened?	The number of patients who have not been seen after 3 months of referral has fluctuated over the last 9 months with June 2024 in line with the previous month at 3730. The number of referrals not seen within 3 months of referral has increased in Neuropsychiatry and MAS and has decreased in adult CMHT, older Adult CMHTs, Perinatal Community and CAMHS Primary MH in Schools. Neuropsychiatry service accounts for 25% and Adult CMHTs 19% of referrals open for over 3 months without a contact.
B: Why has it happened?	During the COVID period, face to face contacts reduced with staff using telephone contact and digital solutions such as AccruRx to conduct appointments. However a backlog was created as a result. In addition, in line with available research, new demand is also arising as a result of the impact from Covid -19 resulting in increased referrals to CMHTs adding pressure on ability to see service users within 3 months of referral. This indicator also relies on teams outcoming appointments on Rio and work is being undertaken with services on an ongoing basis to reduce the number outstanding. ICCR: Progress achieved with waits over 52 weeks reduced by 66% since November 2023 from 94 to 32 in June 2024. Only 5 CMHTS now have over 52-week waiters, a number of these are internal waits who are being treated by other teams such as AOT which require a care Co-ordinator. Caseloads in CMHT have increased by 4000 patients since 2019 but there has not been an increase in CMHT medical staffing to meet the need for appointments. The service has high rates of DNA for first and follow up appointments meaning appointment slots not being utilised (medical DNA rates for first appointments were 36% in June. Plans have been implemented to reduce DNA rates, actions include text message reminders, a review of hybrid mail as many patients say they do not receive appointment letters, increasing the capacity of admin staff to complete telephone reminders, discharging patients, if appropriate after repeat DNAs. We also see numbers within this category of patients who are transfers from other teams so are being seen in other services . Future reporting will enable us to identify those service users who have had no contact at all from mental heath services. Specialties: We currently have an aging population and better awareness of mental health concerns within the population and at primary care level. This has led to a consistent increase in number of referrals to our Older Adult CMHT, particularly for patients with dementia, but has not been accompanied with any increase in the Older Adult CMHT workforce. Caseloads of care coordinators are currently high (some CPNs have 50+ against an ideal maximum of 35) reducing CPN capacity to see new assessments and take new patients on. There has also been a reduction in the number of discharges with some patients being kept on for supportive monitoring where they could be appropriately discharged. There are discrepancies in medical workforce numbers between the teams causing higher waits for medical outpatient clinics in some teams. There is also a significant number of patients in care homes where, due to pandemic restrictions, our service was unable to see or communicate with service users directly however, through carers were able to provide consultation and commence treatment, however these have remained on the waiting list. For all services, it is important to note that where patients DNA, they are likely to have been provided with an appointment within 3 months - this is a particular issue for perinatal patients where due to having an infant, patients frequently cancel or DNA appointments prior to eventually being seen. In bi-polar service, patients will already be under a CMHT in order to access their service. Waiting times being over 3 months will be due to having to wait for the next group cohort to commence which may be after 3 months depending on when they are referred. Due to immediate staffing pressures Older Adults did not initially have a trajectory set, but due to an improved staffing position they are now aiming to focus on the long waits and to achieve a 20% reduction in the 18 week plus cohort by the end of April 2024 which has been achieved and numbers are continuing to fall.There are long waiting times within neuropsychiatry with the longest waits for the Epilepsy service at 35 weeks and the shortest waits are for Huntington's at 15 weeks. The average therapy times are between 4-6 months.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Referrals over 3 mths with no contact

June 2024

Question	Answers
C: What are the implications and consequences?	The implications are delayed assessment and therefore access to mental health services/treatments prolonging their difficulties. All referrals within ICCR are triaged and risk assessed at the point of referral, so although delays may occur for a first appointment, if risks are identified referrals are fast tracked for assessment. All referrals receive information around crisis access, should their situation deteriorate into crisis whilst waiting . Waiting times for neuropsychiatry are to be expected as this is a tertiary specialist service where patients are seen for highly specialist consultation and, if they require secondary mental health care, would be under a local CMHT service
D: What are we doing about it?	ICCR:Continue to review all CMHT activity via twice monthly waiting list & KPI oversight meetings, this includes reviewing waiting times and the number of slots being offered. The data will now be sent in advance to allow the clinical service managers time to review the detail and bring the narrative to the meeting to allow an informed discussion. • Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in. • Within Solihull there has been a focus on 26-52 week waits and appointments are being are booked 5 weeks in advance as part of the ongoing pilot with admin leads reviewing waits at 52 weeks to ensure plans are in place. Other areas are also focusing on reducing DNA rates, cleansing the data, discharging or prioritising appointments for service users who need an appointment with community mental health services. MDTs have been streamlined with a focus on DNAs, with agreement of clear follow up actions when DNA's occur. Demand: • All referrals are screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present and CMHT intervention is indicated. The service plan over the next 12 months as the NMHTs grow is that this will have a significant impact on reducing waits and capacity within CMHTs. Only 4% (data from Q4) are escalating into the CMHTs, CMHT caseloads however remain the same as overall demand across the system has increased (in line with the national position). • Testing due to take place in the East piloting discharge clinics to support step down/discharge. • Engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHTs to take on low level CMHT cases (the service leads have noted that 70% of referrals to the NMHTs are for presentations of depression & anxiety who should be signposted to talking therapies as the appropriate service to meet service user needs) • Early discussions are taking place as part of the NMHT development to move towards an MDT focussed Triage hub which will allow an MDT discussion to take place around formulation and where the best support might be offered for the service user. • The MDT Triage Hub would involve key contracted partners (Talking Therapies, CGL, SIAS, Shaw Trust, Mind) this will also enable the testing of trusted assessments. The aim is for clear patient centred DIALOG+ care plans to be created with service users at the earliest opportunity to capture their recovery focussed goals and improve engagement and outcomes. • To help increase capacity within CMHTs and to work towards 4 week waits (dependant on national guidance), current plans are that by end of 2024, complete coverage of all PCNs will have been achieved and this will therefore have greater impact on ability to manage referrals effectively. Work will continue alongside informatics lead to oversee the roll out across CMHTs to bring parity across the Community Mental Health and Wellbeing Service (CMHTs and NMHT), this work involves linking with national leads to understand the impact of ReQuol and GBO and DIALOG+ on the clock stop. Due to the high number of patients waiting to be seen for a first appointment, the initial focus for the ICCR CMHTs is to reduce the long waits. The revised trajectory is based on achieving a 20% reduction in the new referrals not seen within 3 months by the end of January 2024. Progress has been slower than expected and a revised trajectory has been put in place as the original trajectory to meet the 20% reduction at the end of January has not been achieved. June 2024 at 699. Solar: The service have created additional capacity to offer more frequent treatment sessions to service users and if this is successful, this approach will be rolled out to other teams in the service, addressing the longer waits for treatment. Specialties: Referrals in North Solihull and West are hotspots due to the numbers of referrals received. Caseloads remain high, resulting in patients waiting longer. Waiting times for first appointments with medical staff are between 4-6 months. They are being proactively managed by team managers to ensure that service users are being prioritised based on need and risk. The service are requesting a safer staffing review and formal demand and capacity assessments for the CMHTs, as caseloads are above recommended levels by the CQC and there is a need to make jobs manageable to aid retention. This includes; looking at impact of new roles, Workforce skill mix and Leadership development. They are aiming to achieving a 20% reduction in the 18 week plus cohort by the end of April 2024, which they have achieved. It should be noted that there are a number of service users who have commenced treatment who are living in care homes where Trust staff had contact with care home staff only. This occurred especially during Covid. A number of these have been reviewed regularly but have not been seen directly with a member of Trust staff and have therefore remained on the waiting list. Appointments have been offered in clinic to this group, however, it is difficult for care home staff to bring patient to clinics and there will need home visits to facilitate face to face contact. West HUB also have a number of long waiters who have been referred for dementia medication and as outlined above the initial assessment has been by phone with carers and have therefore remained on the waiting list. Plans are being made to book them into clinics for their next appointments. Within Memory Assessment service, triage is taking place with those on the waiting list and if any risks are identified they will be referred to an appropriate team or signposted to other services. Following the national planning guidance for 204/25 and the implementation of the waiting times, there is an ask to review all long waiters over 104 weeks in the first instance.

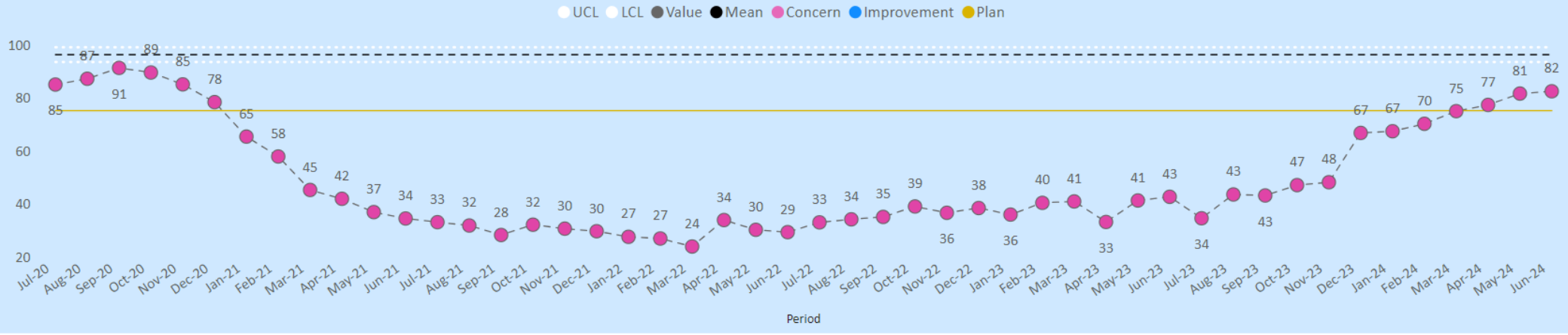
E: What do we expect to happen?	Within adult CMHTs we expect referrals for assessment to our Community mental health service to be reduced to meet the 4 week window as set out by the Long term plan, although this measure has not been implemented as yet we would hope to achieve this by end December 2024 when all new funding has been utilised to grow capacity in our community mental health services. We expect DNAs to be effectively managed and reduced to below 20% for both first appointments. The Neighbourhood function of our community mental health service is expected to divert activity for lower complexity work and to ensure referrals are signposted to correct services such as talking therapies rather than CMHT , this will lead to CMHT activity being reduced and support with ensuring timely access in the CMHT function. We will also be ensuring that NMHT data is included within the whole data set to give a complete picture for our Community mental health service. We are already noting that the majority of patients seen by the NMHT function are seen within 2- 4 weeks. Within older adult CMHTs we expect there to be some improvement in waiting lists, as staffing position has improved, however this remains challenging.
F: How will we know when we have addressed issues?	For adult services when we have reduced numbers being referred to the CMHT function and are seeing activity for the community mental health service (including NMHT function as a whole) and we have reduced the numbers not seen over three months by 20% by end January 2024. For Older Adults they would have seen a reduction of those waiting for more than 18 weeks by 20% by end April 2024.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies seen in 6 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	67.2%	70.0%	74.8%	77.2%	81.4%	82.3%
E: Specialties	67.2%	70.0%	74.8%	77.2%	81.4%	82.3%

Commentary

Performance has been on a gradual increasing trend for the last 12 months and remains above the 75% target for the third time in the last 3 years. June 2024 position has increased to 82.30%, which is above the recovery plan trajectory for June and the also the 75% target.

Detailed Commentary

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

Talking Therapies seen in 6 weeks

June 2024

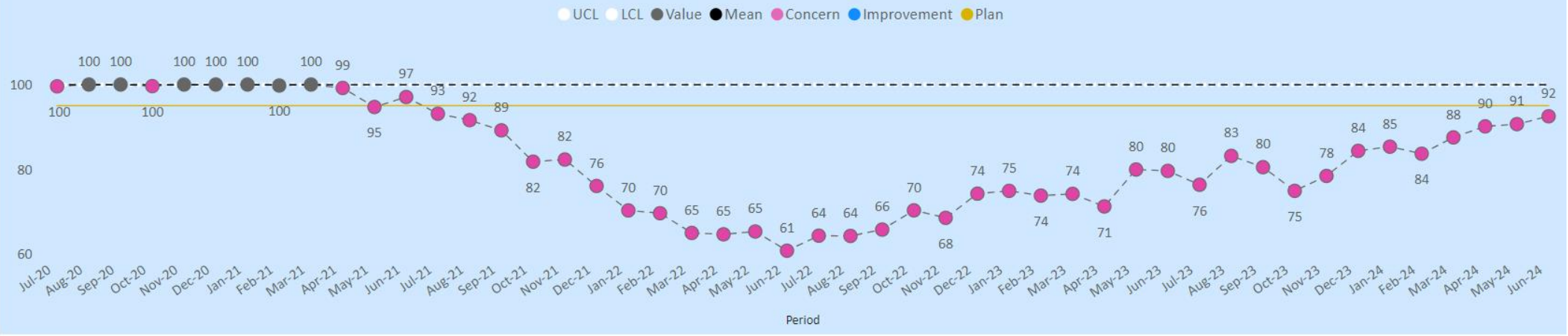
Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months and remains above the 75% target for the third time in the last 3 years. June 2024 position has increased to 82.30%, which is above the recovery plan trajectory for June and the also the 75% target.
B: Why has it happened?	The service plan was to reach the 75% target by January 2025. However, successful drive of the action plan focusing on the new referrals has led to overachievement of the planned trajectory. June 2024 performance is at 82.30%, a continued improving trend, above trajectory and continuing to meet the national 75% standard for the third month in a row which is the first time in the last 3 years. The Talking Therapies model relies on large group interventions to see the majority of patients at Step 2, with smaller numbers then requiring Step 3 - 1:1 intervention. The service however has a large number of vacancies following staff retirements and leavers impacting on ability to carry out the required activity levels. Over the past 5 years significant challenges have been faced around retention of staff who have left to take up further training, work outside of the NHS or move to posts which attract higher bandings in other Trusts. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. New staff have commenced, and this has been reflected in an increased number of contacts being recorded. However, as the waiting times are measured when therapy finishes it will take time for the improvements to come through in the data. Contact data for June 2024 shows a 15% increase compared to the same month in 2023.
C: What are the implications and consequences?	Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	The trajectory for 6 weeks is not due to be met until January 2025, but progress has significantly increased in the last five months. New staff commenced in October 2023 (including the trainees for the year), and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes and it will take time for this to come through into the data, but will help in the medium term. The increase in staff has had a positive impact on the waiting times for 6 weeks with an increase in June 2024 which has placed them ahead of the trajectory and now above the 75% target. The number of contacts in June were 15% higher compared to the same month in 2023. A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across BSol and to address how we can work together to address demand and capacity. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. There still remain challenges in staffing with a large number of vacancies which is impacting the level of activity which can be undertaken. A rolling programme of recruitment is in place and the managers are working hard to promote staff wellbeing with initiatives to foster retention within the service and the service are working with NHS Professionals Bank to temporarily recruit staff to vacant posts until substantive appointments can be made. A number of vacancies have been appointed to and staff will be commencing in the next 3 months, these include qualified step 3 workers which will help with the waits for Step 3 therapy. A clinical development lead is supporting the team to screen referrals and identify barriers to recovery planning and developing existing relationships with neighbourhood mental health teams to enable further support. A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff. Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate was initially affected, falling to 42% in August, below the 50% national standard and then improved but has remianed under the 50% threshold since January 2024. June at 45.05%. The change in recording of activity has been applied to internal and external reporting. BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean that waits for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
E: What do we expect to happen?	The service expects to see a continuing improvement and to reach the 75% target by end January 2025 as the contacts undertaken by the new staff begin to come through. April - June performance shows that they have reached the target and the focus will be to maintain this.
F: How will we know when we have addressed issues?	The national standard of 75% is met and maintained.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies seen in 18 weeks

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	85.3%	83.6%	87.5%	90.1%	90.6%	92.5%
E: Specialties	85.3%	83.6%	87.5%	90.1%	90.6%	92.5%

Commentary

Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. June 2024 has shown an improvement to 92.49%, and remains below the trajectory.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies seen in 18 weeks

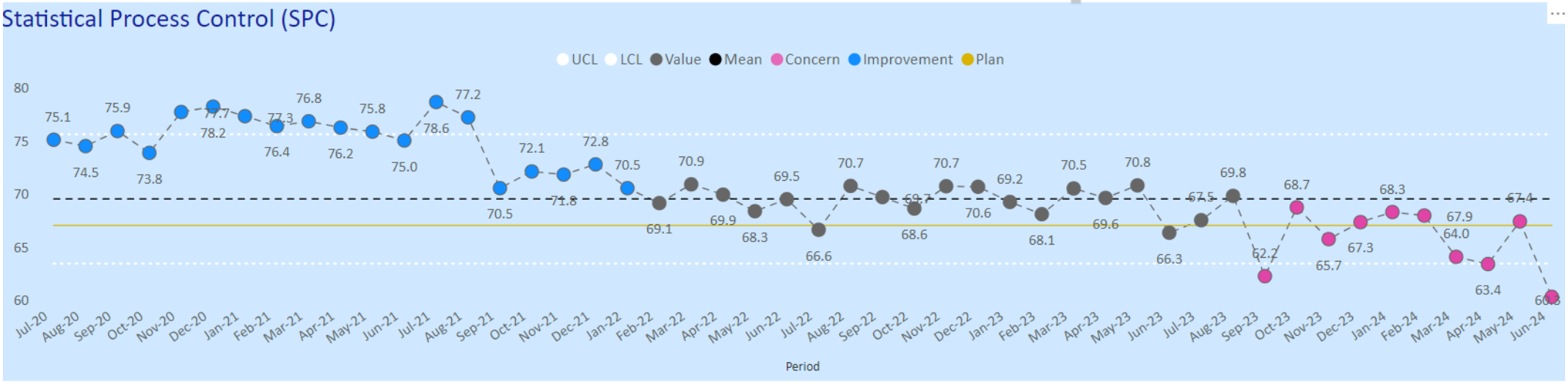
June 2024

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 12 months but remains below the 95% target. June 2024 has shown an improvement to 92.49%, and remains below the trajectory.
B: Why has it happened?	The service has a large number of vacancies following staff leavers and retirements. Significant challenges have been faced around retention with staff leaving to take further training and work opportunities outside of the NHS or moving to posts which attract higher bandings in other Trusts. This has particularly impacted our ability to retain trainees who complete their training with BHM but then take higher banded position in other Trusts. There is also a national workforce challenge in specialised IAPT roles meaning the service is limited to recruiting from existing trained staff and available trainees. There is an action plan in place which is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. New staff have commenced, and this has been reflected in an increased number of contacts being recorded. However, as the waiting times are measured when therapy finishes it will take time for the improvements to come through in the data. Contact data for June 2024 shows a 15% increase compared to the same month in 2023.
C: What are the implications and consequences?	Patients are not being able to access services in a timely way and are currently waiting longer than the national target.
D: What are we doing about it?	The trajectory for 18 weeks was due to be met by November 2023, but progress has been slower than anticipated due to staffing challenges and a revised trajectory has been put in place to reach 95% by the end of June 2024 to align with recruitment and retention plans. The action plan in place is heavily reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times. New staff have commenced in October (including the trainees for the year), and this has been reflected in an increased number of contacts being recorded, however as the waiting times are measured when therapy finishes it will take time for the increased staffing to take effect, and this will help in the medium term. The increase in staff has had a positive impact on the number of patient contacts with June 2024 seeing a 15% increase compared with the same month in 2023. There still remain challenges in staffing with a large number of vacancies which is impacting the level of activity which can be undertaken. A revised trajectory will be provided next month to reach the 95% target. A system wide forum has been set up with the support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across BSol and to address how we can work together to address demand and capacity. There still remain challenges in staffing with a large number of vacancies which is impacting the level of activity which can be undertaken. A rolling programme of recruitment is in place and the managers are working hard to promote staff wellbeing with initiatives to foster retention within the service and the service are working with NHS Professionals Bank to temporarily recruit staff to vacant posts until substantive appointments can be made. A number of vacancies have been appointed to and staff will be commencing in the next 3 months, these include qualified step 3 workers which will help with the waits for Step 3 therapy. A clinical development lead is supporting the team to screen referrals and identify barriers to recovery planning and developing existing relationships with neighbourhood mental health teams to enable further support. A bespoke CPD training package has been purchased to help contribute to recruitment and retention of staff. Following recommendation from the Talking Therapies lead for Commissioning, a change to the way that our data is recorded aligned to recording utilised by other trusts and services has been implemented and backdated to June 2023. Appointments with a treatment element will now be counted as 'treatment'. The effect of this change has improved the waiting times position. The moving to recovery rate was initially affected, falling to 42% in August, below the 50% national standard and then improved but has remianed under the 50% threshold since January 2024. June at 45.05%. The change in recording of activity has been applied to internal and external reporting. BHM are instigating a number of initiatives to reduce the waits for HI CBT and are in the process of registering this as a QI project. It is hoped this work, alongside the above, will mean that waits for HI CBT in the service are reduced, offsetting the negative impact on recovery and reducing the number of single session contacts.
E: What do we expect to happen?	The service expects to see a continuing improvement and to reach the 95% target by end June 2024 as the contacts undertaken by the new staff begin to come through. This will not be immediate due to working with service users to reach recovery and will take some months before progress through the data is visible.
F: How will we know when we have	The national standard of 95% is met and maintained.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Improvement rate

Divisions



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	68.3%	67.9%	64.0%	63.4%	67.4%	60.3%
E: Specialties	68.3%	67.9%	64.0%	63.4%	67.4%	60.3%

Commentary

This is a new national metric for 2024/25 with an increased focus on recovery. June 2024 at 60.27%, below the lower control llimit for the 5th month. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Improvement rate

June 2024

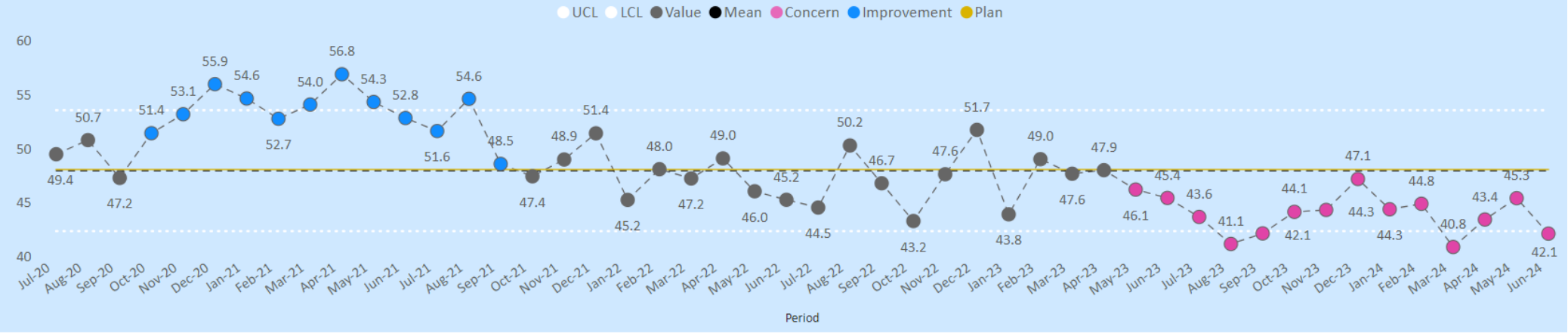
Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. June 2024 at 60.27%, below the lower control llimit for the 5th month. Reliable Improvement Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression has reliably improved at the end of their treatment.
B: Why has it happened?	The target for reliable improvement is 67% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria. A person has shown reliable improvement if their scores on the depression and/ or the relevant anxiety/ medically unexplained symptoms measure have reduced by a reliable amount, whether or not they met caseness at the start of treatment.
C: What are the implications and consequences?	Service users needs are not being met and the national 67% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable improvement rate.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid reliable Improvement.
F: How will we know when we have addressed issues?	Maintain/exceed the 67% Reliable Improvement rate.

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Recovery Rate

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	44.3%	44.8%	40.8%	43.4%	45.3%	42.1%
E: Specialties	44.3%	44.8%	40.8%	43.4%	45.3%	42.1%

Commentary

This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target with the June 2024 position at 42.05% remaining below the 48% target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies, Reliable Recovery Rate

June 2024

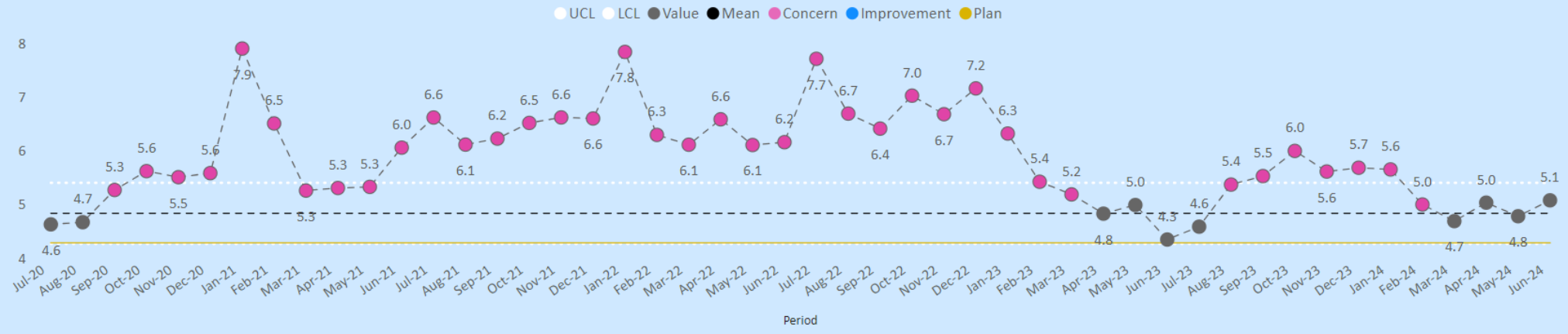
Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. The Reliable Recovery rate has fluctuated and is not meeting the 48% target with the June 2024 position at 42.05% remaining below the 48% target. Reliable Recovery Rate is the outcome measure to assess whether a service user who is being treated for anxiety or depression is no longer at clinical caseness at the end of their treatment.
B: Why has it happened?	The target for recovery is 48% of all patients who complete a course of therapy. A course of therapy in NHS TT teams is having attended 2 or more treatment appointments, so this includes all patients who meet this criteria that met caseness at the start of treatment. Patients are considered reliably recovered if they meet both criteria for reliable improvement and for recovery.
C: What are the implications and consequences?	Service users needs are not being met and the national 48% standard is not being met.
D: What are we doing about it?	The service is looking closely at the data to try to minimise any data quality issues and to improve recovery rates. Also, when there is a wait for treatment, follow-up appointments are offered, which is good practice, but as these are now being recorded as assessment and treatment, if a patient drops out before they start their course of treatment (and are above caseness) they will contribute negatively to the reliable recovery rate.
E: What do we expect to happen?	The local needs of service users and challenges presented are routinely discussed and monitored within the service to support actions to aid Reliable recovery
F: How will we know when we have addressed issues?	Maintain/exceed the 48% Reliable Recovery rate.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	5.6%	5.0%	4.7%	5.0%	4.8%	5.1%
B: Acute and Urgent Care	7.1%	6.2%	5.6%	5.7%	4.3%	6.1%
C: ICCR	5.2%	5.5%	4.9%	4.6%	4.0%	3.2%
D: Secure Serv & Offender Health	7.7%	6.2%	6.1%	6.4%	7.1%	6.6%
E: Specialties	5.1%	3.8%	3.5%	4.4%	4.3%	5.7%
F: Corporate	2.9%	3.1%	3.1%	3.7%	3.6%	4.1%

Commentary

Sickness absence rates are 5.07% trust wide, 1.7% for short term sickness and 3.3% for long term sickness absence. None of the data recorded have met the Trust's various sickness absence targets. The Trustwide sickness absence target should be 3.9%, short term sickness absence should be 1.3% and long term sickness absence should be 2.6%.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Sickness

June 2024

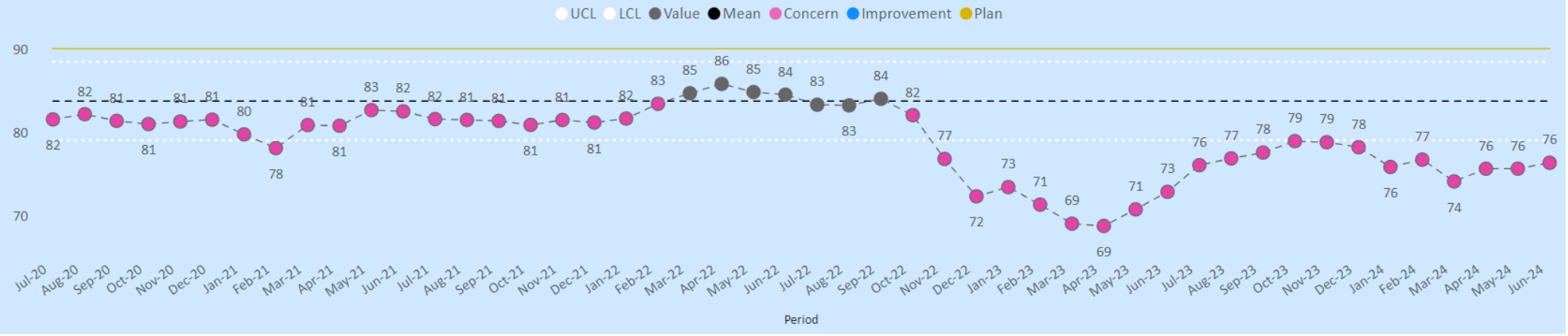
Question	Answers
A: What has happened?	Sickness absence rates are 5.07% trust wide, 1.7% for short term sickness and 3.3% for long term sickness absence. None of the data recorded have met the Trust's various sickness absence targets. The Trustwide sickness absence target should be 3.9%, short term sickness absence should be 1.3% and long term sickness absence should be 2.6%.
C: What are the implications and consequences?	The implications and consequences are that as Trust we still have not be able to meet our Trust targets for managing sickness absence in order to have a high performing workforce that is effectively able to deliver services to our patients and service users. We still have staff who continue to cover for absent staff. This can also have burnout effect on the staff who remain in work and trying to cover for others who are off sick either on short or long term.
D: What are we doing about it?	The Trust continues to work with different partners to support those off sick to return to work, the partners include our Occupational Health Provider, managers and the People team.The targeted work include preventative work to support those at work to look aftern their health and not go off sick because of burnout.
E: What do we expect to happen?	To continue to see more employees return to work and stay in work and be supported to have a healthy work environment.
F: How will we know when we have addressed issues?	The Trust will meet the Trust targets set for sickness absence.

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	75.8%	76.7%	74.1%	75.6%	75.6%	76.3%
B: Acute and Urgent Care	65.8%	67.7%	63.2%	71.3%	70.9%	71.8%
C: ICCR	81.6%	80.3%	79.3%	80.0%	79.8%	79.2%
D: Secure Serv & Offender Health	80.7%	82.3%	80.3%	81.2%	80.1%	81.0%
E: Specialties	79.9%	81.3%	78.6%	77.7%	79.4%	81.0%
F: Corporate	67.9%	68.3%	65.4%	64.9%	65.0%	66.3%

Commentary

The trust's Appraisal compliance for June is 76.3%. The trust remains below the Trust target of 90% and commissioner's target of 85%. This is a 0.8% improvement since May .
The teams within the Trust that are below the compliance trajectory of 75% are:
Acute and urgent care 71.4%
Executive Director - Medical - 73.7%
Executive Director of Nursing 64.7%
Executive director of resources 68.5%
New Care Models 60.5%

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff Appraisals

June 2024

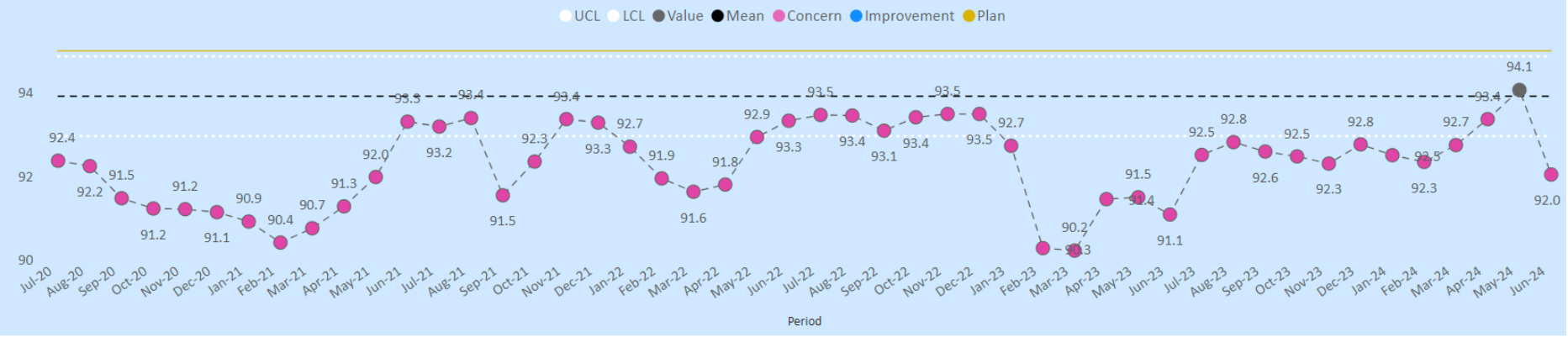
Question	Answers
A: What has happened?	The trust's Appraisal compliance for June is 76.3%. The trust remains below the Trust target of 90% and commissioner's target of 85%. This is a 0.8% improvement since May . The teams within the Trust that are below the compliance trajectory of 75% are: Acute and urgent care 71.4% Executive Director - Medical - 73.7% Executive Director of Nursing 64.7% Executive director of resources 68.5% New Care Models 60.5%
B: Why has it happened?	
C: What are the implications and consequences?	We are not meeting our commissioner target of 85% and the Trust fails to demonstrate a holistic approach to reward (through personal development) to all employees, address inequalities, reflect and represent the communities served by the Trust.
D: What are we doing about it?	L&D QI appraisal project continues with a focus on obtaining qualitative data through questions identified with the working group. We have obtained data from John regarding staff survey and we will be sending the agreed qualitative appraisal questions to staff through appraisal completion and trust-wide comms. Teams have been contacted within the Nursing Directorate to support the co-production of the QI project. In addition to the BAU activities, L&D have developed a streamlined process for staff to access the appropriate appraisal support e.g. appraisal coaching, system walk-through's, HR, ESR etc.
E: What do we expect to happen?	L&D consultancy support to continue to positively impact upons appraisal compliance and quality of appraisal conversation.
F: How will we know when we have addressed issues?	The overall aim will be aligned to the appraisal process in achieveing an improvement in the quality of values-based appraisal conversations, enabling the development of an inclusive, compassionate culture.

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	92.5%	92.3%	92.7%	93.4%	94.1%	92.0%
B: Acute and Urgent Care	91.6%	91.8%	92.1%	92.8%	93.5%	91.1%
C: ICCR	92.6%	92.7%	93.0%	93.5%	94.0%	91.3%
D: Secure Serv & Offender Health	92.8%	92.2%	92.7%	93.0%	93.8%	91.3%
E: Specialties	93.3%	92.7%	92.9%	93.5%	94.8%	92.6%
F: Corporate	91.9%	92.1%	93.0%	94.2%	94.5%	91.1%

Commentary

The overall Fundamental Training compliance decreased from 94% in May to 91.5% in June. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. Every area is still below the 95% Trust target. Temporary Staffing Compliance has decreased from 94.9% in May to 91.9% in June which remains above the Trust Target of 75%

Chief Executive Locality – 80.5%,

- Exec Director - Medical Locality –94%,
- Exec Director - Nursing Locality – 94.7%,
- Exec Director – Operations

o Acute and Urgent Care –91.1%,

o ICCR – 91.3%,

o Secure Services and Offender Health – 91.3%

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

June 2024

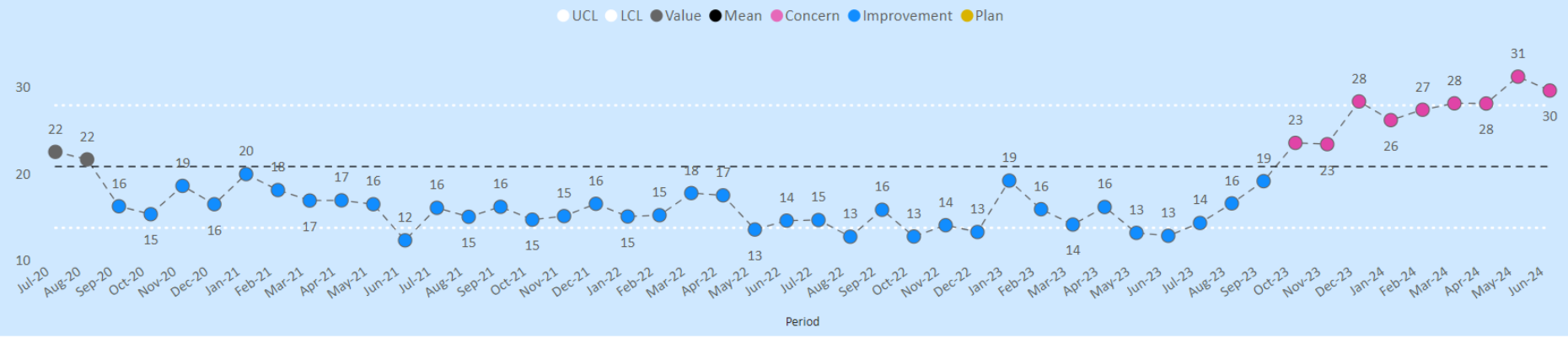
Question	Answers
A: What has happened?	The overall Fundamental Training compliance decreased from 94% in May to 91.5% in June. Overall, the trust has surpassed the Commissioners' target; nevertheless, we remain below of the 95% Trust target for substantive staff. Every area is still below the 95% Trust target. Temporary Staffing Compliance has decreased from 94.9% in May to 91.9% in June which remains above the Trust Target of 75% Chief Executive Locality – 80.5%, • Exec Director - Medical Locality –94%, • Exec Director - Nursing Locality – 94.7%, • Exec Director – Operations o Acute and Urgent Care –91.1%, o ICCR – 91.3%, o Secure Services and Offender Health – 91.3% o Specialties – 92.5% • Exec Director - Resources Locality – 92.6%, • Exec Director - Strategy People and Partnerships Locality – 88.3%
B: Why has it happened?	We have introduced two new Fundamental Training subjects, SRS and Oliver McGowan E-Learning earlier this year however their grace period has now ended which has had an impact on our overall Trust compliance
C: What are the implications and consequences?	• Low FT compliance is a risk to patient safety and the safety of our staff. There is a risk staff will not have the competence required to practice safely in clinical areas. • Breach of commissioners' compliance contracts which can result in financial penalties that can cost in excess of £210,000 per subject for every month that BSMHFT remains non-compliant. • TSS are not included in overall Trust compliance however are required to undertake training. The required training needs to provide TSS staff on time to be practice safely. If TSS staff cannot undertake the necessary training they will be unable to book to work on inpatient wards.
D: What are we doing about it?	• Updated trajectories have been made to accommodate for increased recruitment levels. • For Fundamental Subjects with less than 90% compliance, a recovery plan with monthly trajectories is in place. • External ELS, ILS, and DMI (AVERTS) training is purchased in order to meet compliance requirements. • Regular business operations, with L&D persistently chasing staff to fill spaces in order to maintain compliance at the necessary percentages. • Rapid Tranquilisation training is now available via webinar once a month in addition to in person multiple times a month • Extra notifications about upcoming training are being sent out by the Fundamental Training staff.
	• We are organising extra Oliver McGowan sessions to take place at the Uffculme Centre once a month
E: What do we expect to happen?	• We expect the overall Trust compliance will remain above 90% however our new Fundamental Training subjects including Oliver McGowan and SRS- Conveyance will decrease our overall compliance when the grace period ends in July 2024.
F: How will we know when we have addressed issues?	Once Substantive Fundamental Training compliance will reach 95% on Insight Reporting System

Birmingham and Solihull Mental Health NHS Foundation Trust

Incidents resulting in harm (patients)

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	26.1%	27.3%	28.1%	28.1%	31.2%	29.6%
B: Acute and Urgent Care	28.6%	24.8%	27.5%	29.1%	28.1%	29.7%
C: ICCR	32.7%	34.6%	36.5%	28.0%	44.8%	27.8%
D: Secure Serv & Offender Health	24.0%	26.9%	27.1%	29.3%	33.1%	35.0%
E: Specialties	29.1%	34.9%	32.3%	31.1%	38.6%	29.2%

Commentary

91% of our incidents reported during the month resulted in no harm. In cases when harm has been identified as moderate to our service users and meets the threshold for duty of candour, the appropriate actions and disclosures required by legal standards are enacted. These actions include open and honest communication with affected relevant parties and providing the necessary support and information to the individuals involved.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Incidents resulting in harm (patients)

June 2024

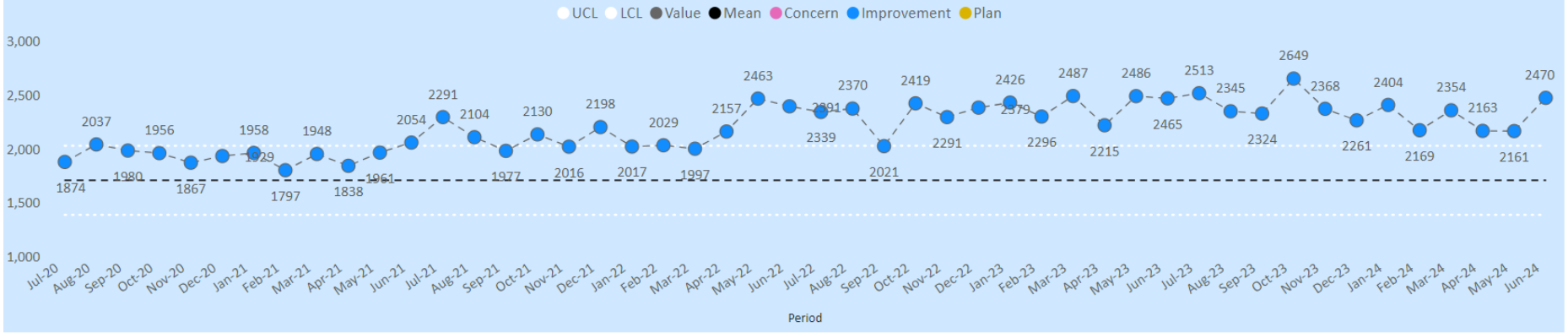
Question	Answers
A: What has happened?	91% of our incidents reported during the month resulted in no harm. In cases when harm has been identified as moderate to our service users and meets the threshold for duty of candour, the appropriate actions and disclosures required by legal standards are enacted. These actions include open and honest communication with affected relevant parties and providing the necessary support and information to the individuals involved.
B: Why has it happened?	The death of service user has occurred, unexpectedly
C: What are the implications and consequences?	High numbers of incidents alongside a low rate of harm indicate a learning culture.
D: What are we doing about it?	We continue to work hard to reduce harm caused to patients through incidents and this is a fundamental goal in our Quality Strategy supported by a range of quality improvement initiatives and improved safety culture initiatives.
E: What do we expect to happen?	A range of physical, relational and procedural changes are underway, with a particular focus on inpatient settings is designed to reduce harm levels.
F: How will we know when we have addressed issues?	Levels of harm will further reduce.

Birmingham and Solihull Mental Health NHS Foundation Trust

Reported incidents

Divisions

Statistical Process Control (SPC)



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

Division	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
A: All	2404	2169	2354	2163	2161	2470
B: Acute and Urgent Care	976	865	876	776	768	898
C: ICCR	192	179	192	192	166	195
D: Secure Serv & Offender Health	527	496	612	582	599	782
E: Specialties	485	439	470	397	425	388

Commentary

There were 2470 incidents reported during June and remains above the mean
Increased in reporting were noted in: Assault and Violence, Medications, Self Harm and Patient Behaviour

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

June 2024

Reported incidents

Question	Answers
A: What has happened?	There were 2470 incidents reported during June and remains above the mean Increased in reporting were noted in: Assault and Violence, Medications, Self Harm and Patient Behaviour
B: Why has it happened?	
C: What are the implications and consequences?	Reporting incidents allows us to be a learning organisation and identify those incidents that require a learning response
D: What are we doing about it?	Local safety panels commission learning responses, which are proportionate to the incident where there is the opportunity for learning
E: What do we expect to happen?	We continue to be a learning organisation which improves the quality of care it provides
F: How will we know when we have addressed issues?	Through the safety culture metrics within staff survey

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix I - Board 7 August 2024

2024/25 Performance metric Improvement Trajectory update

2024/25 Performance Improvement metrics

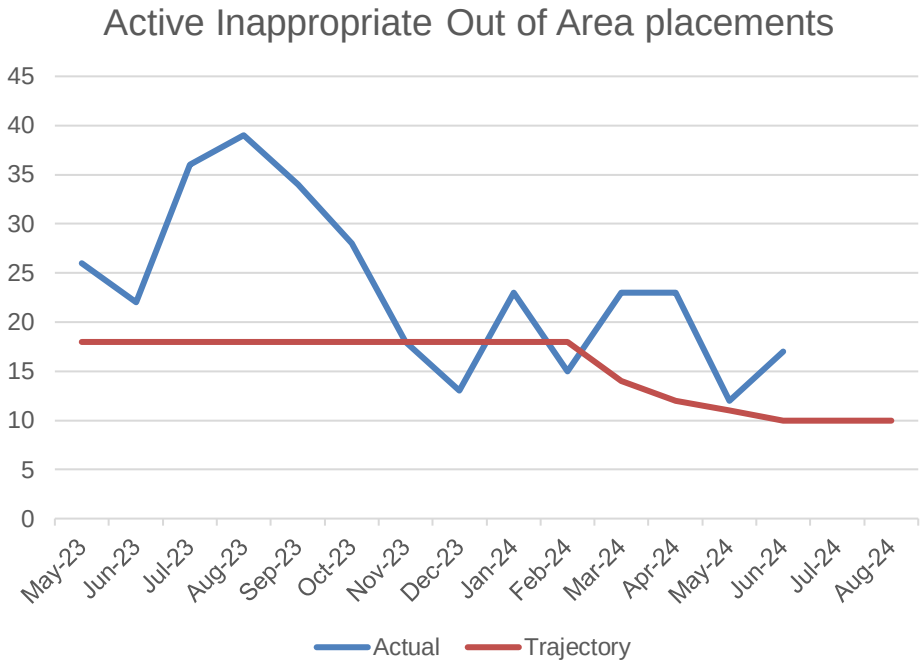
- During 2023/24 the following metrics were identified for improvement. Action plans and trajectory updates have been provided. The table below also outlines changes to national metrics arising from the 2024/25 planning guidance.

2023/24 metrics	2024/25 metrics
• Inappropriate Out of Area bed days	Replaced by Active Inappropriate Out of Area Placements
• IAPT waiting times 6 and 18 weeks	No change
• New Referrals not seen within 3 months	No change
• CPA 12-month Reviews	No change
• 7 Day follow up	Replaced by 3 day follow up
• Vacancies	No change
• Sickness	No change
• Appraisals	No change
• Bank and Agency fill rate	Replaced by reduction in bank and agency WTE used – People Committee

- The commentaries on the IPD and below have been updated for 2024/25 by the relevant service leads. A monthly update will continue to be provided on progress although as acknowledged there is unlikely to be significant change month on month due to the action plan timelines.

Active Inappropriate Out of Area Placements

New Metric for 2024/25



The 2024/25 planning guidance has introduced a revised metric for assessing the reduction of inappropriate out of area placements. This will now be based on the number of inappropriate Out of area placements at each month end.

A Trust trajectory has been agreed as part of the 2024/25 national planning requirements to reduce and not exceed 10 PICU placements from June 2024 onwards. The target for inappropriate acute placements is zero from April 2024.

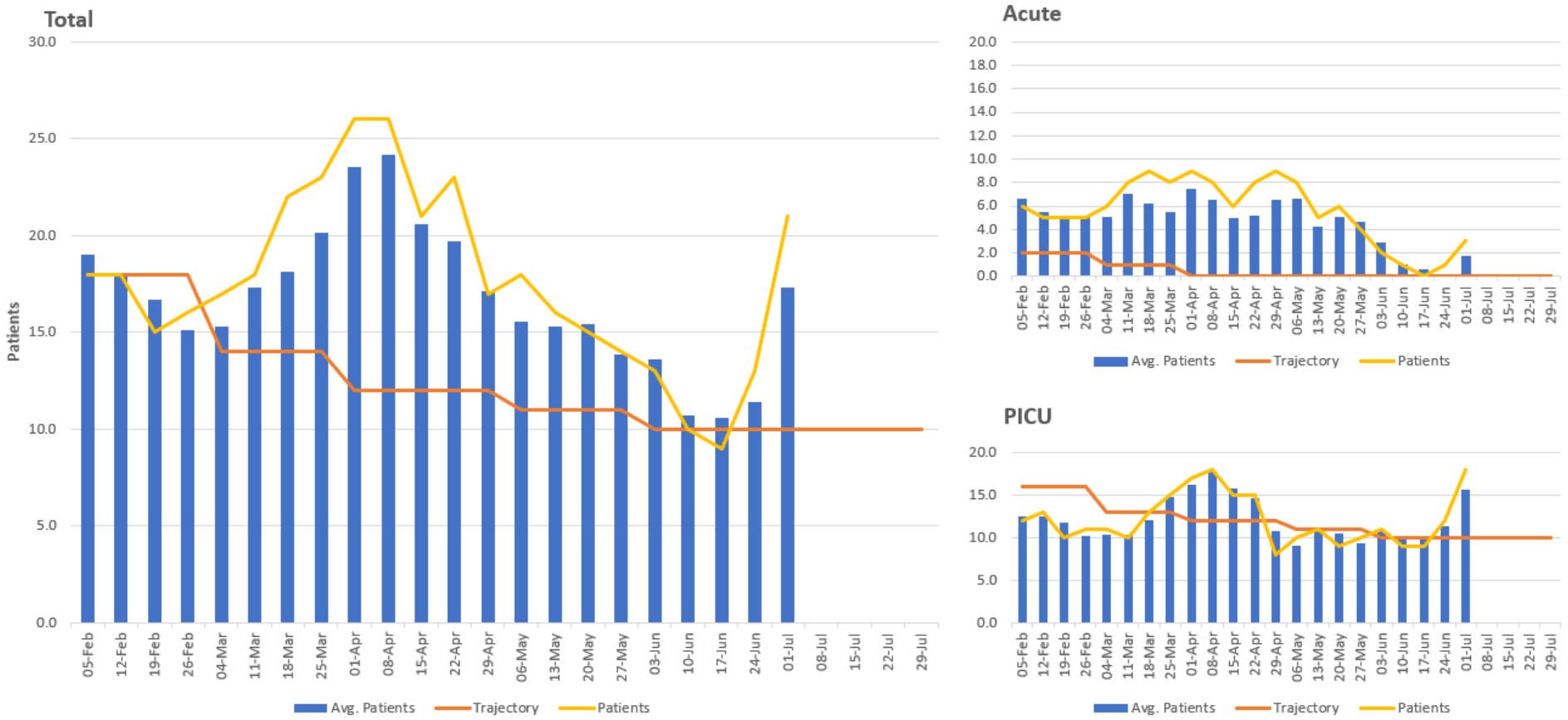
Performance at the end of June – Total of 17 (target 10) inappropriate placements, 1 acute (target 0) and 16 PICU (target 10).

The Trust's productivity action plan continues to focus on workstreams to better manage demand, reduce all OOA placements and related costs, improve patient experience and optimise services within the resources available.

A detailed update was provided to FPPC by the AD for Acute and Urgent Care at the June meeting.

Slide 4 below highlights the weekly progress being achieved, monitored via the out of area steering group. A key pressure point remains the impact of those Clinically Ready for Discharge (CRFD) that are not within Trust control, particularly social care and housing impacting on reducing the available Trust capacity to support repatriation.

2. Inappropriate Out of Area Bed Usage - BSMHFT



A dedicated workstream has been established to focus on addressing system and partnership wide barriers related to reducing clinically ready for discharge patients. Slides 5 outlines progress in each of the above workstreams.

Action Plan - update

Completed

- **Locality Model** – ensuring that teams work within locality across the patient pathway – This has now been rolled out across all localities and feedback is that this is working well. FTB aligning with model where possible
- **Contract procurement exercise** – This has now been completed, extending the Priory contract to include an additional 20 beds available for the BSOL system and are now being utilized (shared between BSMHFT and FTB)

In progress

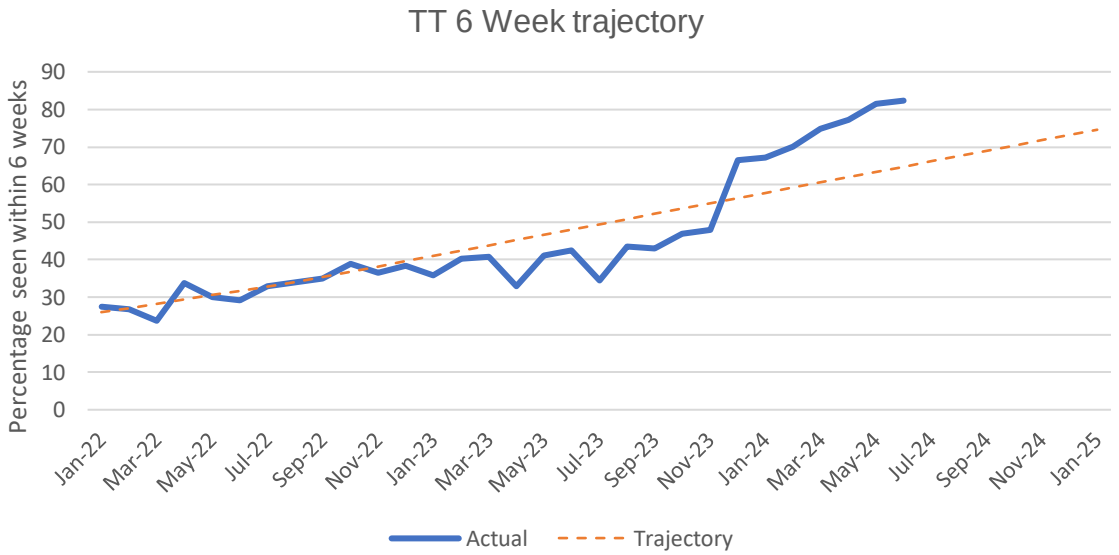
- **Demand Management/Gatekeeping -** Managing demand, with local pilot implemented in two localities now to gatekeep all admissions and ensure that alternatives to hospital admission are offered. Further meetings arranged to review how gatekeeping can be more thoroughly implemented across all 'doors' to inpatients, and more work on how we can capture this metric.
- High volume users project to identify high volume users and employ management plan to prevent admission and support/enable these users to avoid inpatient bed referral
- **Reducing LOS/CRFD** - CRFD Policy development session in July – outlining roles and responsibilities across wards and discharge managers including data quality, EDD, identifying CRFD – includes FTB.
- **Clinical Oversight Team -** senior medical cover to have oversight of patients on the bed list, meeting with Kings Norton medical team and Bed Management to discuss placement of patients – informal processes in place. Formal SOP was signed off, but capacity means that operationalisation of this has not been consistent.

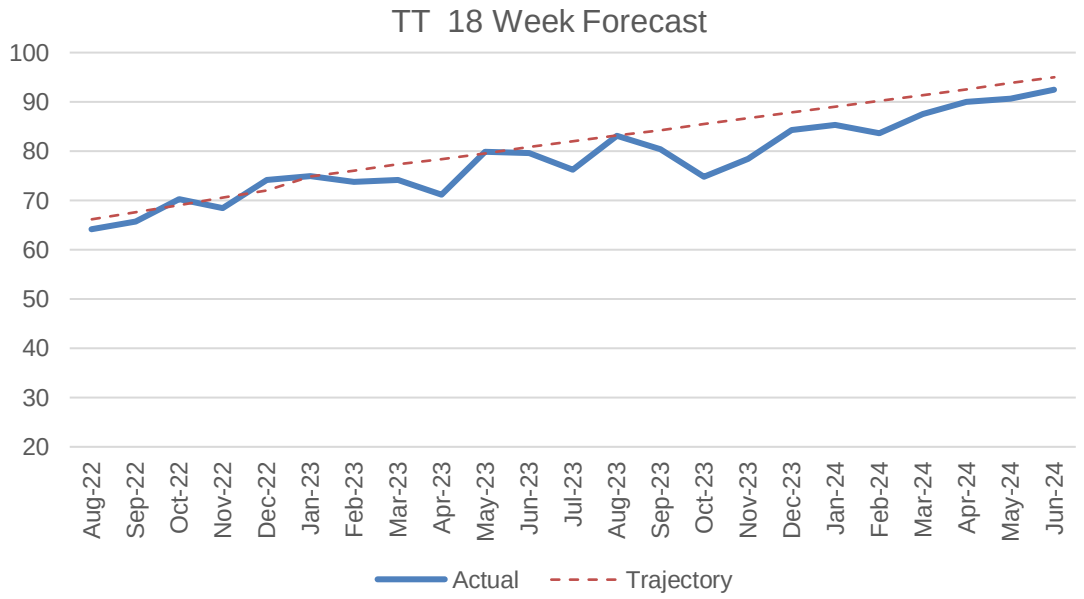
Longer term or requires additional support from ICS

- **Reducing LOS/CRFDs** - weekly internal bed management, ICB deep dive weekly, EDD Confirm and challenge process (more proactive approach for patients with longer LoS) Renewed focus on Clinically Ready for Discharge (replaced DTOC).
- Looking to embed social workers into the locality model. 5 hours of social work time has been agreed for locality CRFD bed flow meeting by Local Authority. BCC have provided timescales.
- Discharge Team Manager proposal has been shortlisted for Inpatient Quality and Transformation Fund for 12-months.
- **Joined up 18+ bed management process** – options appraisal exercise in process – due end of November 2024

Talking Therapies waiting times 6 &18 weeks

Birmingham and Solihull Mental Health NHS Foundation Trust





Trajectory provided by Associate Director for Specialties

Service users seen within 6 weeks - The service plan was to reach the 75% national target by January 2025. However, successful drive of the action plan focusing on new referrals has led to an improved position on the planned trajectory.
June 2024 performance is at 82.3%, a continuing improving trend, above trajectory and exceeding the national 75% standard for the third month in a row which is the first time in 3 years.

Service users seen within 18 weeks - The service plan improvement trajectory is to reach the 95% national standard by end June 2024 based on staffing plans being in place to support.
June 2024 performance shows an increase to 92.49% but remains marginally below the trajectory. This will be reviewed over the next few months as the impact of capacity is expected to continue to have a positive impact.

Talking Therapies – update on Service's action plan

- 6 week waiting time standard – ahead of planned trajectory, good progress and meeting the 75% national target for the first time in three years. The improvement also enabled the BSOL position to reach the 75% target in January 2024.
- 18 week waiting time standard - due to be met by June 2024, progress achieved and will be kept under review to assess impact of capacity plans in the next few months.
- The service is offering more follow ups appointments to patients who would ordinarily have been discharged after one session, as the service has a high number of single therapy sessions which then do not count towards waiting times.
- Significant improvements include - People joining the waiting list now for High Intensity CBT will wait less than 18 weeks to start treatment (previous wait was 6-12 months). However, patients are counted in the month they finish treatment, so this does not immediately show in current data.
- New staff have commenced, and this has been reflected in an increased number of contacts being recorded. However, as the waiting times are measured when therapy finishes it will take time for the improvements to come through in the data.
- A system wide forum has been set up with support from the national IAPT team which brings together Providers and the lead commissioner to work on an integrated approach across BSol with good practice being shared. Recovery action plans are monitored by the Mental Health Provider Collaborative Steering Group and the ICB's Contract meeting.
- The service level recovery plan remains reliant on the ability to recruit staff in order to carry out the activity required and to reduce waiting times and achieve improved outcomes. A number of vacancies have been appointed to. There are also plans to work with NHS Professionals Bank to temporarily recruit staff to vacant posts until substantive appointments can be made.

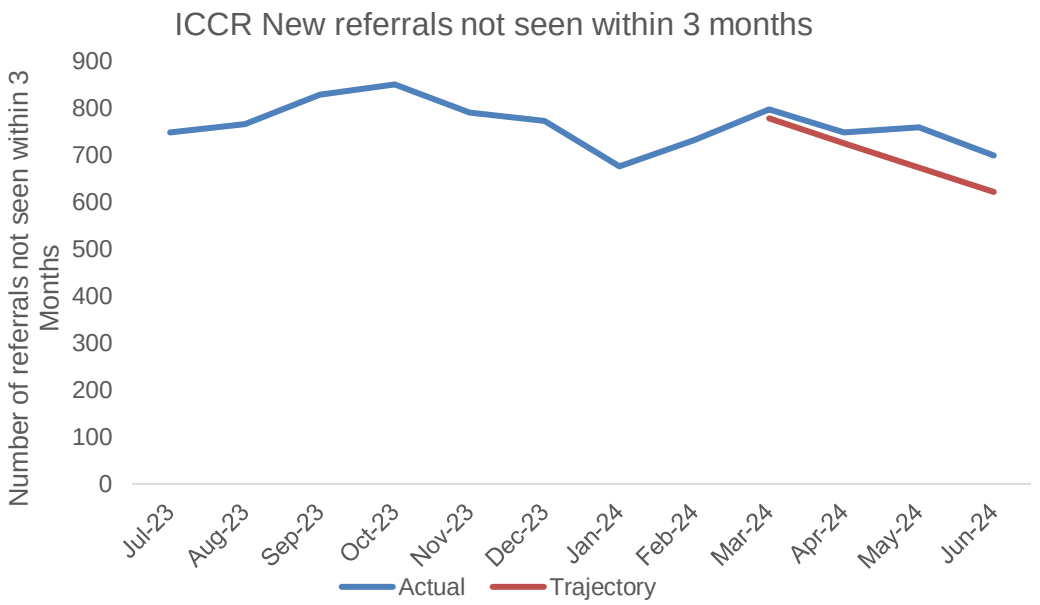
New Referrals not seen within 3 months

ICCR Due to the high number of patients waiting to be seen for a first appointment, the initial focus for ICCR CMHTs has been to reduce long waits. The service have been working to a revised trajectory to achieve a 20% reduction in new referrals not seen within 3 months by June 2024. Although progress continues to be made, this is above the current planned trajectory. The service is reviewing its plan and a revised trajectory will be provided next month.

Action Plan:

ICCR continue to review all CMHT activity via twice monthly waiting list & KPI oversight meetings, this includes reviewing waiting times and the number of slots being offered. The data will now be sent in advance to allow the clinical service managers time to review the detail and bring the narrative to the meeting to allow an informed discussion.

Note - ICCR Trajectory provided by Associate Director for ICCR.



New Referrals not seen within 3 months

Long Waits

- Progress achieved with waits over 52 weeks reduced by 70% since November 2023 from 94 to 32 in June 2024.
- Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in
- Within Solihull there has been a focus on 26-52 week waits and appointments are being are booked 5 weeks in advance as part of the ongoing pilot with admin leads reviewing waits at 52 weeks to ensure plans are in place. A number of these are internal waits who are being treated by other teams including AOT which require a Care Co-Ordinator.

DNA Rates

- Other areas are also focusing on reducing DNA rates, cleansing the data, discharging or prioritising appointments for service users who need an appointment with community mental health services. MDTs have been streamlined with a focus on DNAs, with agreement of clear follow up actions when DNA's occur.

Staffing

- The 5 NMHTs are at varying levels of staffing and are working through recruitment plans, the aim to have all NMHTs equipped with a baseline staffing number.

New Referrals not seen within 3 months

ICCR action plan cont:

<u>Demand Management:</u>

- All referrals are screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present. The service plan over the next 12 months as the NMHTs grow is that this will have a significant impact on reducing waits and capacity within CMHTs. Only 4% (data from Q4) are escalating into the CMHTs, CMHT caseloads however remain the same as overall demand across the system has increased (in line with the national position).
- Testing due to take place in the East - piloting discharge clinics to support step down/discharge from caseload**.**
- Engaging Talking Therapies to divert referrals from NMHTs thus creating capacity for the NMHTs to take on low level CMHT cases (the service leads have noted that 70% of referrals to the NMHTs are for presentations of depression & anxiety who should be signposted to talking therapies as the appropriate service to meet service user needs)
- Early discussions are taking place as part of the NMHT development to move towards an MDT focussed Triage hub which will allow an MDT discussion to take place around formulation and where the best support might be offered for the service user to avoid delays.

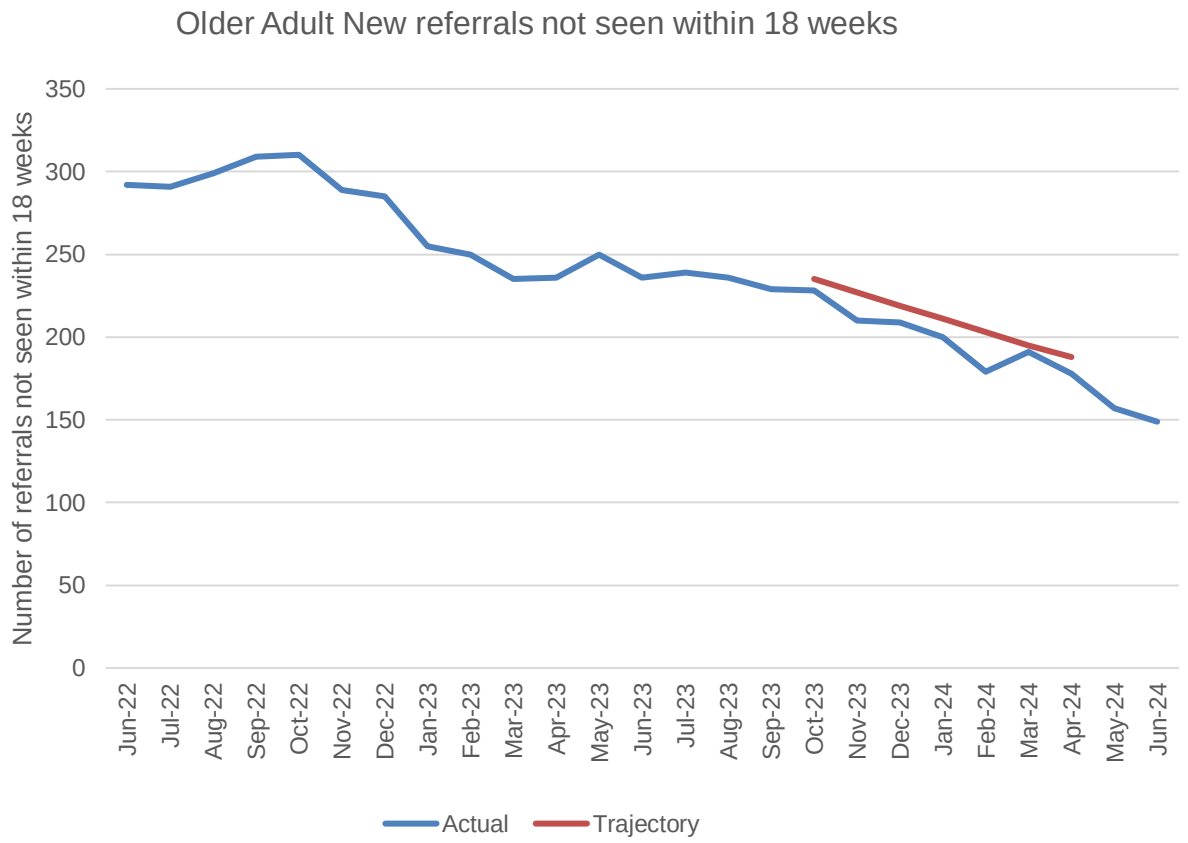
New Referrals not seen within 3 months- Older Adults

Birmingham and Solihull Mental Health NHS Foundation Trust

Older Adult CMHTs plan was to achieve a 20% reduction in those waiting more than 18 weeks by the end of April 2024. Good progress was made and the trajectory achieved.
Since April, progress continues to be made and the position for June is at 149 service users waiting over 18 weeks. The service's 2024/25 plan will be confirmed at the next meeting.

The service continue to monitor waiting times and have focused initially on waits over 26 and 52 weeks which have both seen reductions.

Note: This is different to the metric data for new referrals not seen within 3 months as focus of improvement is on reducing long waits.



Note - Older Adult CMHT position confirmed by the Associate Director for Specialities.

compassionate inclusive committed

New Referrals not seen within 3 months

Older adults CMHTs Action Plan:

Demand challenges: Referrals in North Solihull and West are hotspots due to the numbers received. Caseloads remain high, resulting in patients waiting longer. Waiting times for first appointments with medical staff are between 4-6 months. They are being proactively managed by team managers to ensure that service users are being prioritised based on need and risk.

Capacity challenges: The service are requesting a safer staffing review and formal demand and capacity assessments for the CMHTs, as caseloads are above recommended levels by the CQC and there is a need to make jobs manageable to aid retention. This includes; looking at impact of new roles, Workforce skill mix and Leadership development.

Where there are current vacancies and waits for staff to join, bank shifts are being used to help address those staffing gaps.

It should be noted that there are a number of service users who have commenced treatment who are living in care homes where Trust staff had contact with care home staff only. This occurred especially during Covid. A number of these have been reviewed regularly but have not been seen directly with a member of Trust staff and have therefore remained on the waiting list. Appointments have been offered in clinic to this group, however, it is difficult for care home staff to bring patient to clinics and there will need home visits to facilitate face to face contact. West HUB also have a number of long waiters who have been referred for dementia medication and as outlined above the initial assessment has been by phone with carers and have therefore remained on the waiting list. Plans are being made to book them into clinics for their next appointments.

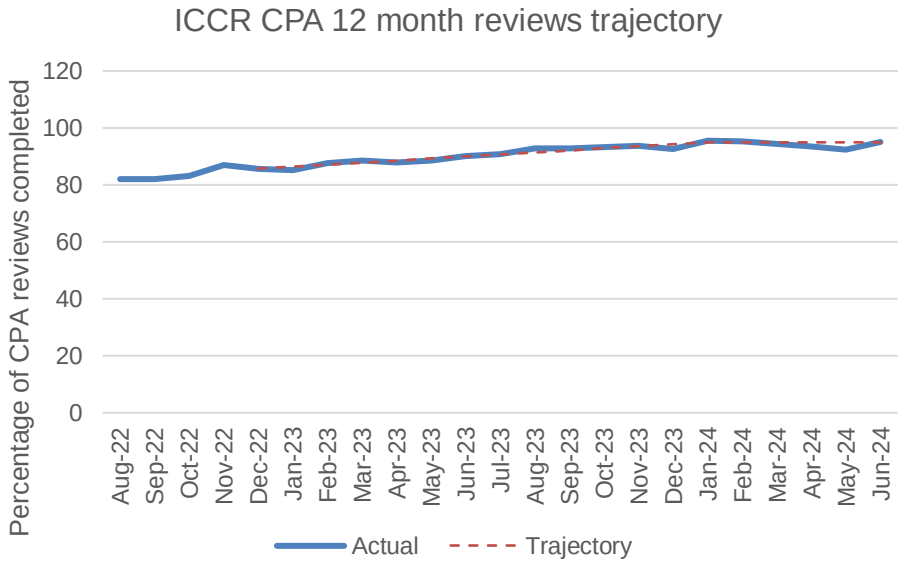
CPA 12-month reviews

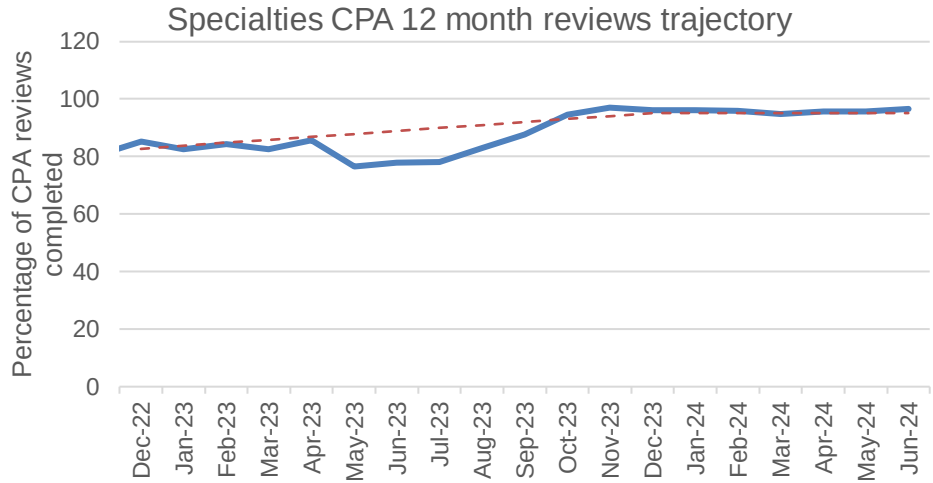
Overall trust performance for CPA reviews has been improving for the last 12 months, mainly due to the implementation of the improvement plans by ICCR CMHTs and Older Adult CMHTs in 2023/24.

The CMHTs had trajectories to meet the 95% target which has been achieved with the overall Trust figure for June at 96.51%.

The 95% standard has been met for this metric, with performance being maintained for the last 3 months and will now be monitored as BAU. This approach has been supported by both service ADs.

This metric will from next month be removed from the improvement plan update for FPPC.



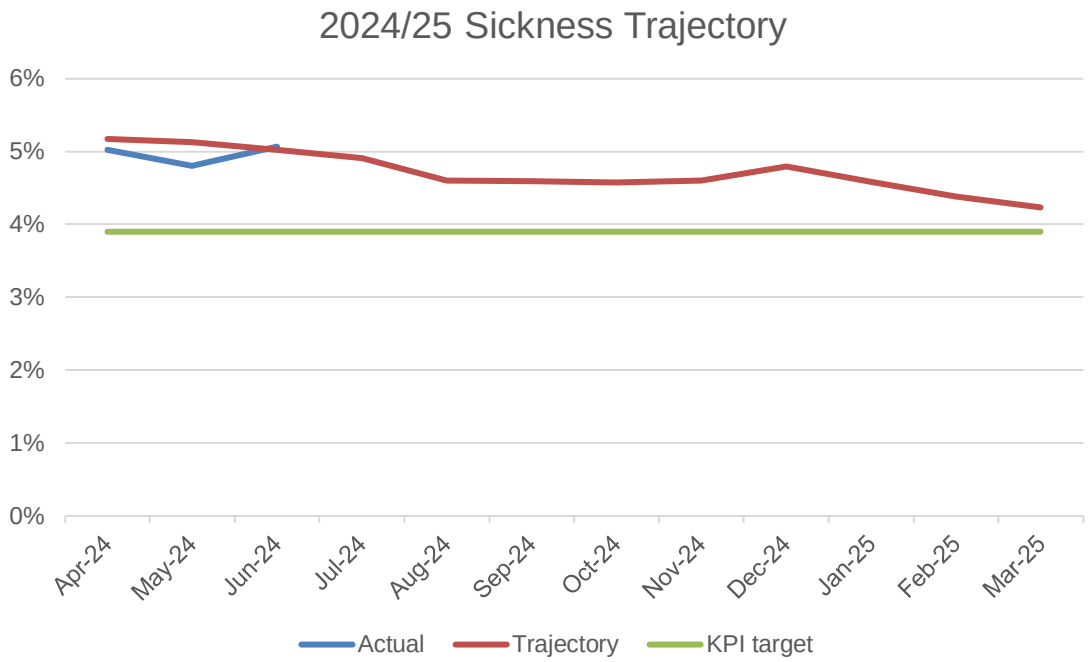


NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce trajectories – 2024/25 update

Sickness Absence

Updated 2024/25 Sickness trajectory in line with the workforce plan



Decreased trend in sickness levels observed with June 2024 at 5.07% just above the improvement trajectory of 5.02%. Long-term sickness decreased with June at 3.3% and short-term sickness increased to 1.7%.

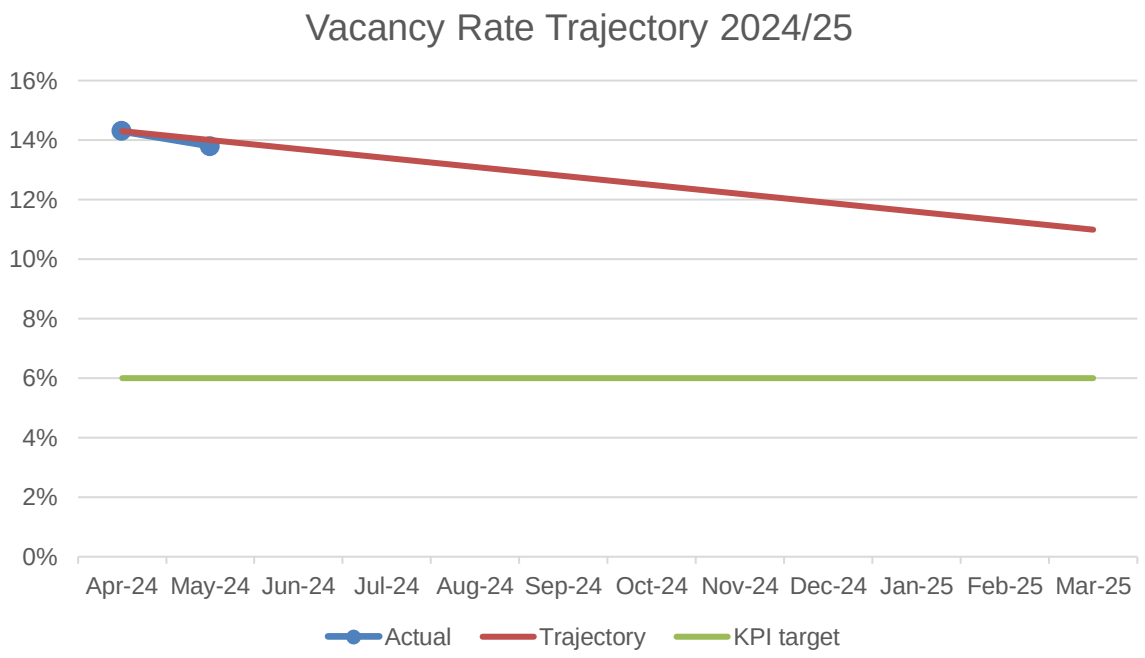
Action Plan:

- The Trust continues to work with different partners to support those off sick to return to work, the partners include our Occupational Health Provider, managers and the People team.
- Targeted work includes preventative work to support those at work to look after their health and wellbeing.

Note - Trajectory and commentary provided by People team

Vacancies

Updated 2024/25 vacancy trajectory in line with the workforce plan



Note - Trajectory and commentary provided by People team

The target to reduce the vacancy rate for 2024/25 is based on a reduction of 3.3% to reach 11% by March 2025. The KPI target is 6%. May vacancy rate at 13.8% just below the trajectory of 14% for May 2024. June data not yet available.

Actions to attract nursing professions include presenting to Nursing Students at the University of Birmingham and hosting stands at the Birmingham City University Nursing Careers event, University of Wolverhampton Nursing Careers Recruitment Event, and the RCNI Birmingham Recruitment event. Students in their final year have had offers made to them pending completion of their studies and acquiring their PIN's.

Following a centralised recruitment event for band 5 nurses in May, 16 offers were made.

Vacancies

Action Plan update:

The ICB and NHSE have introduced instruction on vacancy levels and agency reduction which are being actioned via the weekly vacancy control panel (now in its 10th full month).

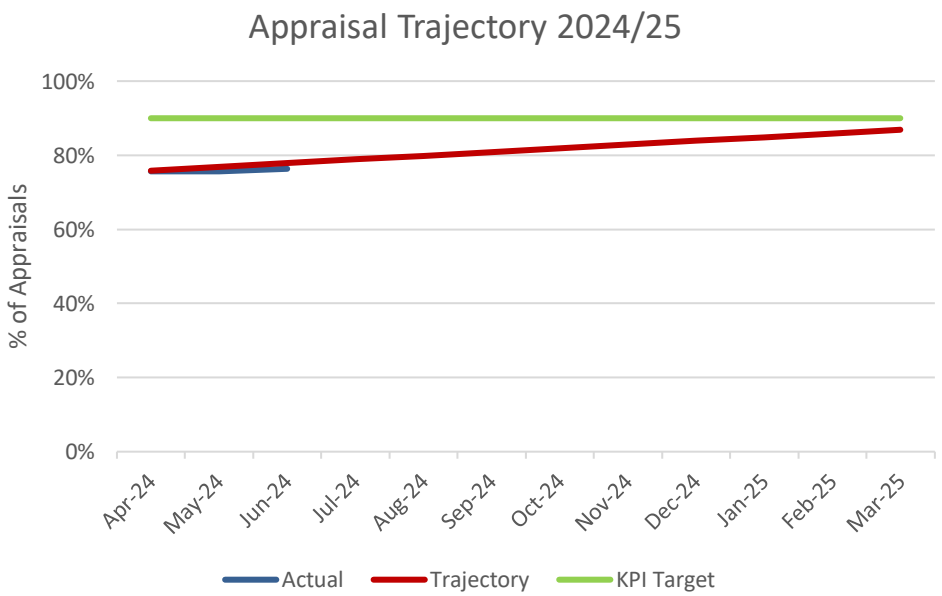
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- Ensure flexibility is promoted in internal advertisements and vacancy information.
- Enhance training for hiring managers to equip them to discuss flexible working at interview.
- Update recruitment processes and training to ensure that the drop-down menu for different types of flexible arrangement are used on NHS Jobs / TRAC when vacancies are created.
- Upskill hiring managers / resourcing teams to be able to identify which forms of flexibility are appropriate for roles.
- Draft and get sign off on an organisational statement about openness to flexible working arrangements, to be included in all vacancy packs.
- Start monitoring number of new joiners who are recruited flexibly and collate this centrally.

A tenth Recruitment Initiatives and Strategy meeting was held to ensure the department is maximising every opportunity to continuously improve processes and initiatives such as trac procedures, interview techniques training, flexible working, attraction strategy, social media, DBS expediency and proactiveness with vacancy filling.

Appraisals

Updated 2024/25 Appraisal trajectory



A revised trajectory has been agreed for 2024/25 to increase appraisal performance by 1% each month moving from 75.9% to achieving the Trust 90% standard in March 2025

June 2024 appraisal performance was at 76.3%.

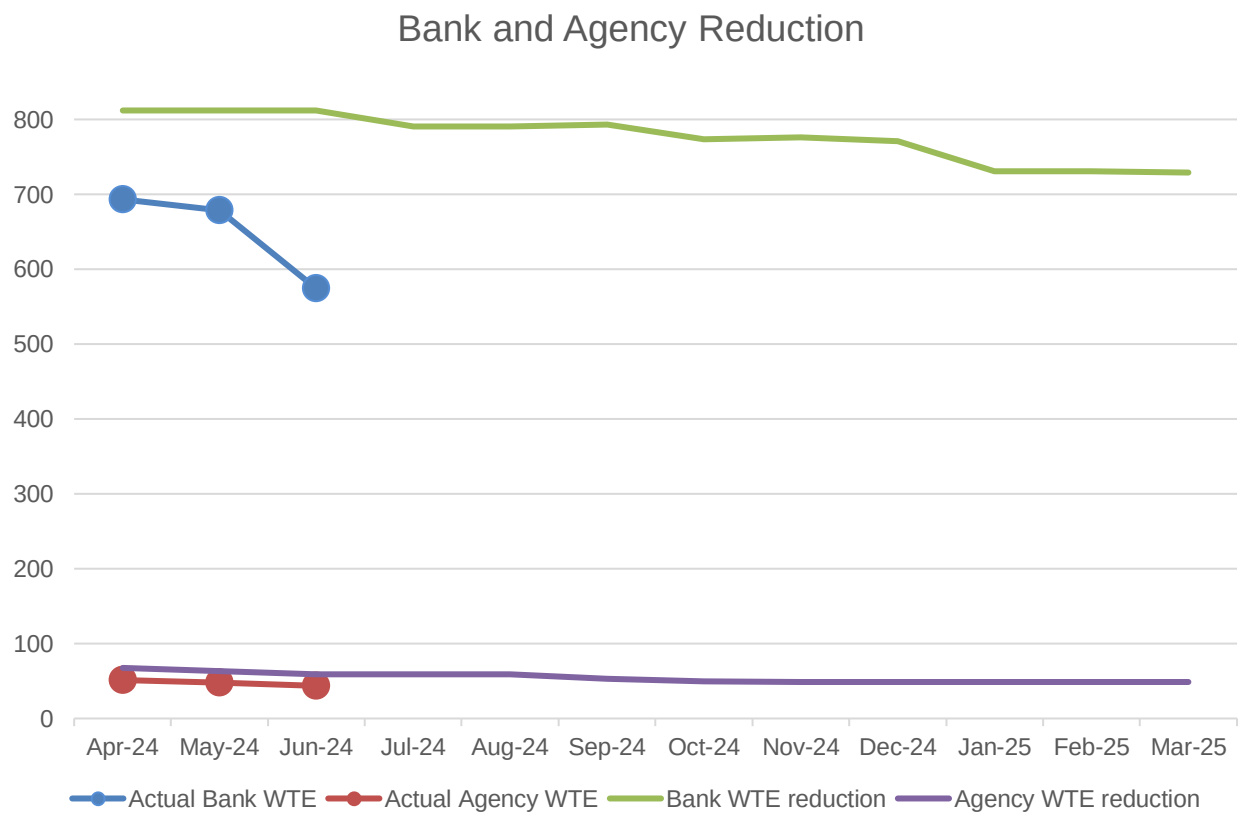
Actions:

- L&D QI appraisal project continues with a focus on gathering qualitative data from staff. This will be highlighted through Trust wide Comms.
- Teams have been contacted within the Nursing Directorate to support the co-production of the QI project
- In addition to the BAU activities, L&D have developed a streamlined process for staff to access appropriate appraisal support e.g. appraisal coaching, system walk-through's, HR, ESR etc.

Note - Trajectory and commentary provided by People team

Bank and Agency Reduction

Birmingham and Solihull Mental Health NHS Foundation Trust



The focus for 2024/25 has moved from monitoring the bank and agency fill rate to reducing the numbers of Bank and agency used within the Trust. The target is to reduce the use of bank workers by 85 WTE and 20 WTE in agency workers by March 2025.

June has shown a reduction in the bank use from 679 to 574 WTE this month and agency has moved from 48 to 44 WTE. Both are below the trajectories set.

Note - Trajectory and commentary provided by People team

Birmingham and Solihull Mental Health NHS Foundation Trust

Sustainability

Monthly Agency costs

- The number of agency shifts requested and filled has decreased from 995 in May to 831 in June. HCA's usage per week had seen a decrease from 25 shifts per week in November 2023 to between 3-7 for 2 of the weeks in June (the other weeks being zero). Agency above cap rate nursing placements have decreased from 16 in November 2023 to 5 in June. The overall non-medical weekly agency usage has fallen from 140 shifts per week on average in November 2023 to 83 in June.

- A detailed agency reduction programme is in progress working in conjunction with ICB policies and restrictions and the Midlands and Lancashire CSU. Two areas of renewed focus are the expediating of the TSS bank workers to substantive process and the reduced reliance on block bookings. Other initiatives to be considered include Finance, HR and AD sign-off being required for all future RMN agency block bookings that are not filled by the NHS Professionals process recently introduced (currently 80% of all expenditure via TSS is block bookings). Currently all HCA agency requests, and above cap block bookings require Exec approval.

- The TSS function has gone live with NHS Professionals – who have considerably less charge rates than agency – with a view to transferring over high cost and long-term block bookings, which can be recorded as bank spend, rather than agency.

- Direct Engagement for Medical Agency workers has also gone live, with the aim of meeting potential ICB and NHSE requirements. Direct Engagement will have a significant effect on fill rates and also have significant, tangible cost saving implications.

- In June, 24 bank workers started with the trust, helping to alleviate the need for agency.

We review Service Line performance on a cyclical basis to ensure that all services within the operational portfolios are covered over a period of time. The process remains developmental and learning from the meetings will be utilised to shape future meetings. As part of this framework, a service line RAG rating assessment covering each of the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance is completed and agreed as part of each deep dive meeting.

Trust Board Development session 3rd July 2024 and Performance Delivery Group meeting on 4th July 2024

Both sessions focused on performance reporting from Board to Service/Team Level with an outline of the performance accountability structure and process and also sharing example of reports available at Trust and Service level to support operational and corporate staff in managing activity and performance.

It was recognised that the performance metrics have been longstanding and require a review to update and align to changes implemented as part of the transformation agendas covering community and core inpatient acute services. In addition, work is also being taken forward to review and revise the care framework to support the transition away from the CPA framework and to identify the Trust standards for future care planning including the implementation of clinical and patient reported outcome measures. Changes to the Integrated Performance Dashboard (IPD) measures will be made on a phased basis to include incorporation of new measures as they are developed and there is also a planned programme of work to develop the IPD's functionality with the next development to enable drill down to service level within the performance domain.

A further phased development plan relates to inclusion of service level dashboards covering service specific pathway measures. These will be developed in conjunction with operational leads, with Phase 1 focusing on the Acute and Urgent care service. Timescales are dependent on the metrics identified and the level of new development work required.

Service Area Deep Dive Meetings – Update

1. Introduction

The Performance Delivery group has a rolling cycle of deep dives into services focusing on key operational issues and challenges. As part of this framework, a service line RAG rating assessment covering each of the four domains of Quality and Safety, Workforce and Culture, Operational Performance and Finance is planned to be completed and agreed as part of each deep dive meeting.

At the request of the Board, a summary of the deep dives is now being provided on a monthly basis.

Since the June 2024 FPPC meeting, the following service area deep dives have taken place:

- Secure and Offender Health deep dive on 21st June 2024, summary below.

2. Secure and Offender Health Deep dive – 21st June 2024

The focus for the service area deep dive this month was on the Ardenleigh, Offender Health and the Health and Justice Vulnerability Services. In addition, progress to address the cultural issues at Reaside was also discussed.

Reaside Clinic – cultural issues update

Quality and safety:

As the multi-disciplinary teams (MDTs) operate in different ways, a reflective day is planned for the Senior Leadership Team (SLT) to review and identify best practice to support practices at MDT level.

Clinical Educators have been working with staff on the wards focusing on nursing standards with further training planned on physical health management. The staff have been reassured that these areas of work are part of a learning period and that standards will then be put in place with expectations that these are practised going forwards.

Staffing levels have improved and following additional funding, recruitment has commenced. Training will also continue to focus on the effective use of e rostering.

It was noted that there are challenges with the environment, with lack of space for staff to take breaks and the building is being reviewed to see how these can be addressed.

Workforce and Culture Domain:

As part of the overall workplan and to support and reassure staff, the SLT are issuing communications regarding the actions being taken to address issues highlighted via staff feedback. The staff forum is also encouraging staff to use available Trust processes to provide feedback.

In addition, the staff Wellbeing and Recovery group meeting has been reinstated following a gap during COVID. This will also include service users.

Leadership - In terms of day-to-day management, unit managers have been asked to ensure that they are visible on the wards at least 3 times a day and a request was made to have a permanent Clinical Service Manager at Reaside as the current post is interim.

A first meeting has taken place with support from the Organisational Development (OD) Team and further areas of work with a continuing focus on culture are being considered.

It was also noted that a recent CQC report has highlighted racial tension with discrimination being raised by white staff. The Chief Executive outlined that ICCR division is doing 'Quality Improvement' (QI) work on cultural competencies and suggested that this could also be considered for Reaside.

Finance:

Concern was raised that the alarm system which needs to be replaced will take 50% of the estates budget and the team was reassured that the REACH OUT work plan includes a commitment to improving the estate.

HMP Birmingham service

Performance Framework Domain RAG Rating Assessment below:

Service	Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	External & Strategy
Prison	Amber	Red	Green	Amber	Amber	Amber

Quality and Safety Domain:

The physical environment remains a challenge and the Trusts Head of Health and Safety and Regulatory Compliance has been asked to undertake a review. The temporary Prison Governor will also be included.

Workforce and Culture Domain**:**

Prison service - It was noted that the Prison senior leadership team is in the process of change.

Staffing levels in the summer period will be challenging due to leave and managing with existing high vacancy rates for primary care nurses and Birmingham Recovery Team.

A key focus of the People work plan is managing sickness absence, with improvements expected in long term sickness next month.

Health and Justice Vulnerability Service: The number of vacancies in qualified nurses remains a key challenge. To try and address this, work has been undertaken on role clarity and an uplift to Band7 for a number of posts to improve the attractiveness and retention of staff.

Ardenleigh service

Quality and Safety Domain:

Observations requiring 5:1 and 4:1 have remained high at night, and wards are using significant higher numbers of staff than their WTE budget to cover this increased acuity and clinical need.

Citrine ward has been on enhanced monitoring, and it was noted that there had been improvements in leadership and after discussion it was agreed that this could be stepped down by the Executive Director of Quality and Safety.

Workforce and Culture Domain:

The number of vacancies are stable and through a CAMHS specific advert new staff have been recruited. The service are planning for and investing in growing their own nursing staff to support recruitment and retention. Agency use has ended, and staff have also been taken onto fixed term contracts to avoid further bank use.

To support internationally recruited nurses, a previous international nurse is supporting them and positive feedback received with staff beginning to lead shifts.

Challenges noted around appraisal completion, booking into ELS and ILS training and the traffic lights are not aligned in some cases.

Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**7 August 2024**
Date(s) of Committee Meeting(s) reported	**24 July 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • 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 • Integrated Performance Report • Clinical Governance Committee Report • Freedom To Speak Up • Deep Dive- Board Assurance Framework Risks# • Committee Effectiveness Survey Results
Alert:	Following the inquest into a service user that absconded from an inpatient ward last year a Prevention of Future Deaths has been issued to the Trust by the Coroner as there was a concern that a when a high-risk mental health service user is missing it requires effective and meaningful multi-agency co-ordination and the evidence at inquest highlighted gaps in knowledge, co-ordination, and application of policy. Right Care, Right Person dataset is in use on current activities and a live risk register. The remaining risk identified is in relation to agreeing processes and response in managing section 136's and maintaining shared understanding. Positive working relations continue to be developed and will strengthen the shared understanding going forward as Right Care, Right Person continues to lead improvements. The Committee were alerted to a suspected serious incident in relation to a sexual safety incident. There continues to be a focus on professional standards and boundaries in line with the Trust policy.
Assure:	The Committee was assured on the following key areas: • CQC visits feedback have been positive with teams being recognised for their hard work and dedication in providing the best possible services. Service users feedback to the CQC has been positive with notable improvements in care planning. • There have been notable improvements with the CQC responsiveness with positive working relations continuing to be developed as the Trust move towards the removal of s29a's. • Implementation of new weekly Trust safety huddle for initial review of incidents, safeguarding alerts, regulator escalations and complaints, will be incorporated into the PSIRF framework.

	• Positive Committee self- assessment review with the overall effectiveness of the Committee being positive.	
Advise:	• Freedom to Speak Up Guardian report was received and the committee approved the recommendations for senior leaders and divisional leads promote the use of the Champions available to support staff. The Committee endorsed the Freedom to Speak Up Guardian report to the Board of Directors. • Clinical Governance Committee review • Board Assurance Framework deep dive was positive with the Committee reviewing the 7 quality risks and the overall reduction is scores for BAF 02, BAF05, BAF06 and BAF07. Additional meetings have been scheduled throughout August and September 24 for further review and agreement for the development of a streamlined number of high level risks. • The Clinical Governance Committee meetings are being reframed to allow for a more focussed view on local divisions escalating challenges and concerns. The agendas and forward planners are being reviewed and revised. • The Committee were advised there continues to be a focus on Psychological harm for staff and there are now mechanisms in place to escalate and formally report incidents.	
Board Assurance Framework	The Board Assurance Framework continues to be reviewed with a number of quality risks being reduced in likelihood scoring.	
	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 August 2024**
Date(s) of Committee Meeting(s) reported	**19 June 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • 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 • Research & Development Update • Integrated Performance Report • Clinical Governance Committee Report • Health Inequalities • Deep Dive- Board Assurance Framework Risks
Alert:	The Committee noted the change in approach from the CQC as regulators with a focus on effectiveness and responsiveness being monitored. The Committee received the Infection Prevention & Control Team Report and noted the significant risks due to staff promotions and sickness meaning 50% of the team of the team are not in post. Vacancies have been recruited too and new staff will be joining in July 2024.
Assure:	The Committee was assured on the following key areas: • The Board Assurance Framework continues to be developed and a further deep dive has been scheduled for July's Committee meeting. • The Corporate Risk Register continues to be developed. • The ongoing action plans for the CQC continue to provide assurance. • The Integrated Performance report highlighted ongoing improvements. • The improved metrics for complaints have been significant.
Advise:	• The Committee received an update from Research and Development and an agreed focus on priorities for the Committee going forward was agreed. The Committee noted the positive pathways developed for staffing and current financial position. • The Committee received a detailed update on Health Inequalities and noted the plans for ongoing development of the report to highlight the milestones and timescales as Health Inequalities is embedded as business as usual.
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.
	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	**People Committee**
Report presented at	**Board of Directors**
Date of meeting	**7 August 2024**
Date(s) of Committee Meeting(s) reported	**24 July 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • People Dashboard • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report • Health Inequalities Report • Transforming our Culture and Staff Experience Group Assurance Report • Shaping our Future Workforce Committee Assurance Report • Medical Directorate Update Report • Freedom to Speak Up Governance Arrangements • Committee Effectiveness Self-Assessment
Alert:	The Committee wished to alert the Board of Directors to the following key areas: • The Trust was reporting above trajectory, but below the key performance indicator for fundamental training compliance. It was anticipated that compliance would be achieved in Quarter 4. • There had been a slight reduction in uptake of the First Line Management training programme. Support was in place to ensure all managers had completed the programme. • A steady increase in appraisal completion compliance had been reported, with targeted support provided in areas of concern.
Assure:	• The Committee was assured by the increased recruitment of international and student colleagues. • There had been an increase in the number of apprenticeships within the organisation. • The significant reduction in bank and agency use was commended, with further work and plans in place acknowledged. • A positive Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report was received. • The Committee was assured by high rates of compliance with doctor appraisals and revalidation, and robust job planning arrangements.
Advise:	The Committee had identified an issue with Freedom to Speak Up Guardian reporting and received a report on governance arrangements. The Committee was assured that the framework had been shared with the West Midlands Freedom to Speak Up Guardian office. The Committee approved the arrangements, and noted

	that the Quality, Patient Experience and Safety Committee would also receive the framework. The Committee noted the ongoing work to support more efficient Employee Relations processes. Work was underway to support sustainability and retention of staff through the development of a "grow our own" programme.	
Board Assurance Framework	The Committee had identified the following revised risks: • 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 draft risks were presented to the Committee for review. The Committee would receive further refined versions in August, along with the proposed summary of all refreshed BAF risks for organisational overview. The Board strategy session in September would focus on discussion and agreement of the new 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

Report to Board of Directors

Agenda item:	**12**					
Date	7 August 2024					
Title	**Guardian of Safe Working Hours: Doctors and Dentists in Training Q1 2024/25**					
Author/Presenter	Dr Shay-Anne Pantall, Guardian of Safe Working Hours Dr Hari Shanmugaratnam, Guardian of Safe Working Hours					
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**	✓

Quarterly 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.

- No immediate safety concerns were raised during this quarter.
- Exception reporting rates remain low. Only 6 unique exception reports were raised during this quarter, of which 83% related to overtime working.
- 50% of exception reports raised during Q1 related to a single department; liaison psychiatry at the Queen Elizabeth Hospital. A further 12 exception reports have since been raised by another doctor working in that department for dates in Q1; the delay in reporting within the usual timeframe was due to difficulties with log-in information for the Allocate system. 9 out of 12 (75%) of these reports also relate to overtime working or not being able to take natural breaks. These issues have been brought to the attention of the Clinical Director for Urgent Care and the Deputy Medical Director and the workload for postgraduate doctors in training is now under review.
- No fines were levied against the Trust for breaches in safe working hours, the first quarter this has happened since Q3 of 2022-23.
- 3 exception reports raised during this quarter (50%) were closed within 48 hours, representing a significant improvement in prompt review and closure.
- The number of outstanding reports carried forward has remained stable at 12.
- The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (52%). All on call locum vacancies during this period were filled.
- Dr Hari Shanmugaratnam, Consultant Psychiatrist, has been appointed as the Guardian of Safe Working from July 2024 and will commence in post following a period of handover.

Engagement activities included:

- Exception reports and themes are discussed in the Junior Doctors Forum on a regular basis. The JDF took place in Q1 on 5 June 2024.
- Doctors in training have bimonthly trainee council meetings. The meeting is open to all doctors in training in our Trust
- The Guardian of Safe Working Hours is invited to regular stakeholder meetings for the Trainee Raising Concerns QIP
- Collaboration with the trainee-led Exception Reporting Working Group
- I have met with postgraduate doctors in training on an individual basis where this has been necessary.
- I have regular meetings with the Freedom to Speak Up Guardians

The following are planned to improve engagement:

- Refresher training for Educational Supervisors and ST tutor regarding rota rules and exception reporting – in progress
- Updates to information held on Connect regarding the Guardian of Safe Working and Exception Reporting – in progress

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

N/A

Strategic Priorities

Priority	Tick ✓	Comments
Clinical services	✓	
People	✓	
Quality	✓	
Sustainability	✓	

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

April – June 2024

High level data

Number of doctors / dentists in training (total): 120

Number of doctors / dentists in training on 2016 TCS (total): 120

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	5	0	0	5
F2	0	0	0	0
CT1-3	3	1	1	3
ST 3-6	3	5	4	4
GPVTS	0	0	0	0
Total	11	6	5	12

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)	8	1	1	8
ST North	1	3	3	1
ST South	1	0	0	1
ST Forensic	1	2	1	2
Total	11	6	5	12

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	1	0	0	3
ST3-6	2	0	2	4
GPVTS	0	0	0	0
Total	3	0	2	12

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 (2 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	1 (1 L1; 1 pending)
GPVTS	0
Total	0

d) Locum bookings and vacancies

Locum bookings APRIL 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	20	20	203.50	203.50
Rota 2	12	12	122.50	122.50
Rota 3	3	3	36.00	36.00
Rota 4	20	20	203.50	203.50
Rota 5	10	10	90.00	90.00
Rota 6	15	15	135.00	135.00
ST4-6 North & East	21	21	239.50	239.50
ST4-6 Rea/Tam	4	4	80.00	80.00
ST4-6 South & Solihull	23	23	219.00	219.00
Total	128	128	1329.00	1329.00
Locum bookings MAY 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	10	10	97.50	97.50
Rota 2	13	13	103.75	103.75

Rota 3	6	6	73.00	73.00
Rota 4	19	19	183.50	183.50
Rota 5	8	8	82.00	82.00
Rota 6	18	18	164.00	164.00
ST4-6 North & East	27	27	251.00	251.00
ST4-6 Rea/Tam	9	9	168.00	168.00
ST4-6 South & Solihull	17	17	159.50	159.50
Total	127	127	1282.25	1282.25

Locum bookings JUNE 2024 by ROTA				
Rota	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Rota 1	8	8	88.50	88.50
Rota 2	12	12	107.00	107.00
Rota 3	4	4	42.00	42.00
Rota 4	18	18	165.00	165.00
Rota 5	11	11	116.75	116.75
Rota 6	15	15	166.00	166.00
ST4-6 North & East	32	32	283.00	283.00
ST4-6 Rea/Tam	3	3	48.00	48.00
ST4-6 South & Solihull	12	12	116.00	116.00
Total	115	115	1132.25	1132.25

Locum bookings APRIL 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	80	80	790.50	790.50
ST4-6	48	48	538.50	538.50
Total	128	128	1329.00	1329.00

Locum bookings MAY 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	74	74	703.75	703.75
ST4-6	53	53	578.50	578.50
Total	127	127	1282.25	1282.25
Locum bookings JUNE 2024 by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-3	68	68	685.25	685.25
ST4-6	47	47	447.00	447.00
Total	115	115	1132.25	1132.25

Locum bookings APRIL 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
NEW INTAKE	10	10	90.00	90.00

Vacancy	55	55	586.00	586.00
COVID	2	2	25.00	25.00
Sickness	8	8	78	78
Off Rota	28	28	330.50	330.50
Emergency Leave	1	1	4.50	4.50
Maternity Leave	17	17	160.50	160.50
Exam Leave	2	2	24.00	24.00
Acting Up Consultant	5	5	30.50	30.50
Total	128	128	1329.00	1329.00

Locum bookings MAY 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
Vacancy	78	78	818.25	818.25
Sickness	14	14	116.50	116.50
Not Contactable	2	2	8.50	8.50
Off Rota	18	18	187.50	187.50
Compassionate Leave	4	4	40.50	40.50
Paternity Leave	2	2	17.00	17.00
Emergency Leave	1	1	12.00	12.00
Acting Up Consultant	6	6	73.00	73.00
Total	127	127	1282.25	1282.25

Locum bookings JUNE 2024 by reason**				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Vacancies & Back Up Rota Used	8	8	89.00	89.00
Vacancy	79	79	738.00	738.00
Sickness	16	16	167.25	167.25
Off Rota	10	10	114.00	114.00
Emergency Leave	2	2	24.00	24.00
Total	115	115	1132.25	1132.25

Fines levied

No fines have been levied in Q1. Ideas for disbursement of previously accrued fines will be discussed and agreed at the Junior Doctor Forum.

Issues arising

The overall number of exception reports has remained low, with 6 unique reports submitted during the quarter. Similar to Q4, the majority of exception reports related to overtime (working beyond scheduled hours) or not achieving natural breaks rather breaches of core rest requirements overnight.

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. Outstanding reports awaiting payment have now been checked and are awaiting action by the Medical Workforce team.

Alternative rota patterns for the North, South and Solihull/East ST rotas have been reviewed. Although there has been a significant reduction in exception reports incurring fines, the workload has been reported to be high such that it is planned that three on call rotas will be in place from August 2024. Exception reporting data relating to out of hours work will continue to be monitored closely.

The number of outstanding exception reports has remained stable, increasing from 11 to 12. Of new reports submitted in this quarter however, 50% were closed within 48 hours, representing an improvement in efficiency of reviews.

The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (52%). All on call locum vacancies during this period were filled.

Liaison Psychiatry at the Queen Elizabeth Hospital

Concerns about working hours have been raised by postgraduate doctors in training working in liaison psychiatry at the Queen Elizabeth Hospital. It was noted in the GoSW report to the Board that in Q3 of 2023-24, the majority of exception reports for overtime were raised by Higher Trainees working in Liaison Psychiatry. Indeed, since October 2023, almost half (43%) of all exception reports within the Trust have related to working in liaison psychiatry and breaches of work schedules or contractual obligations regarding breaks and rest requirements at Queen Elizabeth Hospital. 4 Level 1 work schedule reviews took place with initially a subsequent reduction in exception reporting.

In June 2024 however, there was a marked increase in exception reports again being submitted for overtime and trainee doctors not being able to achieve their breaks. Dr Helen Campbell, ST Tutor, raised this with the Guardian of Safe Working again on 20 June 2024, noting that despite previous work schedule reviews, the workload remained extremely difficult to manage within normal working hours. Concerns were raised about the other medics within the team and whether they were being supported to submit exception reports. It has subsequently been noted that other trainee doctors within the department have wished to submit exception reports but experienced difficulties with their Allocate log-in. This was escalated urgently to Leonora Johnson, Medical Workforce Team, and rectified promptly.

It was agreed that a specific report addressing the ongoing issues in liaison psychiatry would be prepared and discussed with the Clinical Director for Urgent Care. This meeting took place on 10 July 2024 and Dr Krishnamurthy has subsequently met with consultants within the department. Dr Ruth Scally was also notified, due to the impact on the training experience and wellbeing of PGDiT working in the department.

Dr Pantall met with two of the affected trainees to discuss the issues raised in further detail. They reported frequently starting work early, finishing late and not taking breaks within the working day, only achieving a lunch break on one occasion in the preceding two weeks. One doctor advised that they had only been able to attend balint group, a requirement of their psychotherapy training, on

three occasions during the six month rotation. Trainee doctors were encouraged to continue to exception report, with an agreement that retrospective reports would be reviewed and actioned accordingly within reason, given the problems with accessing Allocate. 12 exception reports have subsequently been raised, 9 relating to working hours and 3 relating to impact on educational opportunities. These reports will be reviewed by the relevant Educational Supervisor, with support from the Guardian of Safe Working and included in the next quarterly report.

The incoming Guardian of Safe Working, Dr Hari Shanmugaratnam, has been made aware of the issues as part of the handover. It has been agreed that Dr Shanmugaratnam and Dr Krishnamurthy will meet again in October 2024 following junior doctor rotation to review any issues arising.

Actions taken to resolve issues

See above.

Summary

No immediate safety concerns were raised during this quarter. Exception reporting rates remain low. Only 6 unique exception reports were raised during this quarter, of which 83% related to overtime working.

50% of exception reports raised during Q1 related to liaison psychiatry at the Queen Elizabeth Hospital, a further 12 exception reports have since been raised by another doctor working in that department for dates in Q1; the delay in reporting within the usual timeframe was due to difficulties with log-in information for the Allocate system. 9 out of 12 (75%) of these reports also relate to overtime working or not being able to take natural breaks. These issues have been brought to the attention of the Clinical Director for Urgent Care and the Deputy Medical Director and the workload for postgraduate doctors in training is now under review.

No fines were levied against the Trust for breaches in safe working hours, the first quarter this has happened since Q3 of 2022-23.

3 exception reports raised during this quarter (50%) were closed within 48 hours, representing a significant improvement in prompt review and closure. The number of outstanding reports carried forward has remained stable at 12.

The number of vacant shifts continues to be high but stable, with gaps particularly prevalent on the ST North and East rota. The majority of gaps were due to post vacancies (52%). All on call locum vacancies during this period were filled.

Dr Hari Shanmugaratnam, Consultant Psychiatrist, has been appointed as the Guardian of Safe Working from July 2024 and will commence in post following a period of handover.

Questions for consideration:

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

Report to Board of Directors							
Agenda item:	**13**						
Date	7 August 2024						
Title	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report**						
Author/Presenter	Jas Kaur, Associate Director of EDI and OD						
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**	✓

As a Trust we are continually working towards becoming an anti racist, anti discriminatory organization and as part of our Strategic Priorities, Reducing Inequalities is one of them and we are wworking in a way that tackles discrimination, addresses stigma, and encourages equality for all

The WRES/WDES report sets out the current demographic of the Trust and where we can see positive or negative changes. The report also highlights the current workstream and priorities for the Equality, Diversity and Inclusion Team and where positive changes should be implemented.

WRES Key Points:

- Our black and minority ethnic workforce representation is **41.5%**, a small increase on the **39.1%**. reported in 2023 **(+ive)**.
- **52% (43% last year)** black and minority ethnic colleagues believe that our Trust provides equal opportunities for career progression **(+ive)**.
- Black and minority ethnic colleagues are **1.86** times more likely to enter formal disciplinary process than white colleagues. In 2023 it was reported at **2.02 (+ive)**
- **12.3% (last year 17.1%)** Black and minority ethnic colleagues experienced discrimination at work from other colleagues **(+ive)**.

Data is telling us we are moving in the right direction in improving experiences for our black and minority ethnic colleagues

WDES Key Points

- The likelihood of non-disabled colleagues being appointed from shortlist compared to colleagues with disabilities is **1.28** compared to **0.84** in 2023 (Colleagues with disabilities less likely to be employed) **(-ive)**
- Colleagues with disabilities are 5.33 times likely to enter the capability process then those without. **(Last year we reached equity) (-ive) This is against 16 members of staff from a total of 4652 and the reporting this year is over 2 years whereas previous years the data was collated yearly**
- Colleagues have shown an decrease in reporting bullying and harassment if they experience it **59.9%** to last year **65.1% (-ive)**.

The data is showing the experience of staff with disability has decreased.

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

WRES/WDES Annual Report 2023/24
Year on Year Analysis

Strategic Priorities		
Priority	**Tick ✓**	**Comments**
Clinical services		
People	✓	Reducing inequalities Working in a way that tackles discrimination, addresses stigma, and encourages equality for all
Quality		
Sustainability		

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WRES/WDES Data 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

Workforce Race Equality Standard WRES Data 2024

Workforce Race Equality Standard 2024

Data collated from WRES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

Staff representation

Our black and minority ethnic workforce representation is **41.5%**

In 2024 we showed a small increase on the **39.1%**. reported in 2023 **(+ive)**.

A Model Employer: Increasing Black and minority ethnic representation at senior levels across the NHS.
A stretching, and yet achievable aspiration for the NHS would be to have more BME representation across the workforce pipeline.

Currently the target we are trying to achieve is 40% BME staff in Band 8a roles and above.

Clinical / Non Clinical Staff Representation Band 8a +	
2023	**2024**
24%	**28%**

compassionate inclusive committed

Workforce Race Equality Standard 2024

Data collated from WRES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

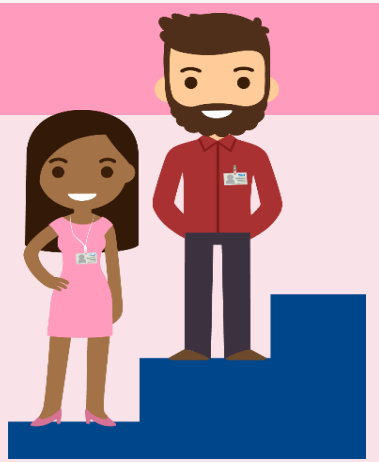
Shortlisting

White colleagues are **1.7** times more likely to be appointed from shortlisting.

In 2024 we have increased the gap on the **1.3** reported in 2023. **(-ive)**

Career progression

52% (43% last year) black and minority ethnic colleagues believe that our Trust provides equal opportunities for career progression as opposed to **56.4% (54.5%)** white colleagues **(+ive)**



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Workforce Race Equality Standard 2024

Data collated from WRES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

Professional development

White colleagues are **0.89 likely to undertake non-mandatory training and** development opportunities compared to black and minority ethnic colleagues. **(+ive) 0.77** last year.

Disciplinary investigation

Black and minority ethnic colleagues are **1.86** times more likely to enter formal disciplinary process than white colleagues.

In 2023 it was reported at **2.02 (+ive)**

Experiencing discrimination

12.3% (last year 17.1%) Black and minority ethnic colleagues experienced discrimination at work from other colleagues as opposed to **8.8%** (last year **11.5%)** white colleagues **(+ive) both improving, gap closing**

compassionate inclusive committed

Workforce Race Equality Standard 2024

Data collated from WRES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

Bullying and harassment

All colleagues experiencing harassment, bullying or abuse from patients, relatives or the public has improved compared to previous year and the gap remains **(+ive)**.

12.3% black and minority ethnic colleagues compared to **8.8%** white colleagues experienced discrimination at work from manager/team leaders (the gap has decreased from previous year, with the experience of all colleagues improving) **(+ive)**

Board membership

42.9% white colleagues

50% black and minority ethnic colleagues

7.1% unknown ethnicity

compassionate inclusive committed

Staff Voices – WRES 2024

Team are not culturally aware, negative experience for most staff and poor retention of staff. Treated differently if "face didn't fit" and if had differences. Not offered training/opportunities to develop.

I identify as white, having seen colleagues and friends having to relive trauma against racism again and again is very upsetting. I want to be able to challenge and support in a way that I am not coming across as white saviour

I feel that that there isn't just a black white issues, there are further issues within our black and minority ethnic staff, ie black on black and or Asian on Asian. This needs to be looked at.

As a trust I think we could do more around islamophobia and antisemitism. A lot of bad things are happening in the middle east and I don't feel there is anything around support or awareness that I can access to. Education is important

I feel being an Asian women I am treated unfavourable and often overlooked for promotion and development opportunities, if this continues I will have no choice by to look for employment elsewhere

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Workforce Disability Equality Standard
WDES Data 2024

Workforce Disability Equality Standard 2024

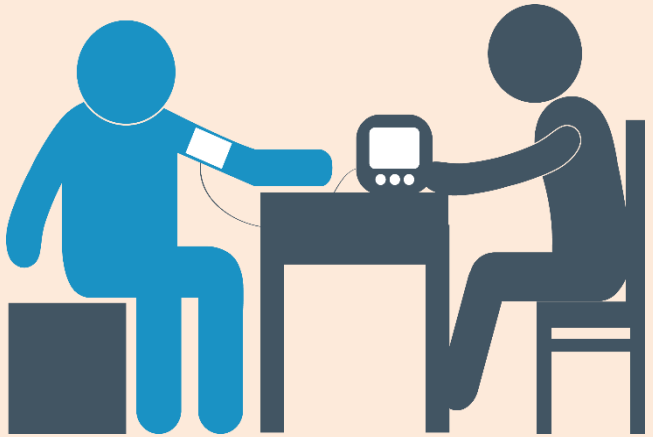
Data collated from WDES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

7.48% colleagues across our Trust report having a long-term condition or illness. Compared to the **9.65%** reported in 2023

Colleagues with long-term condition or illness are...

The likelihood of non-disabled colleagues being appointed from shortlist compared to colleagues with disabilities is **1.28** compared to **0.84** in 2023 (Colleagues with disabilities less likely to be employed) **(-ive)**



Colleagues with disabilities are 5.33 times likely to enter the capability process then those without. **(Last year we reached equity) (-ive)**

This is against 16 members of staff from a total of 4652 and the reporting this year is over 2 years whereas previous years the data was collated yearly

Workforce Disability Equality Standard 2024

Data collated from WDES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

Colleagues with long-term condition or illness are...

...more likely to experience harassment, bullying and abuse

from patients or relatives – this has numerically decreased to **37.1%** since last year **43.05% (+ive)**.

from other colleagues – this has numerically decreased to **24.5%** since last year **25.9% (+ive)**.

Colleagues have shown an decrease in reporting bullying and harassment if they experience it **59.9%** to last year **65.1% (-ive)**.

Workforce Disability Equality Standard 2024

Data collated from WDES and Staff Survey 2023

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

All colleagues have shown an increase in believing that our Trust provides equal opportunities for career progression or promotion **(+ive)**.

All colleagues have increased reporting the satisfaction with the extent to which their organisation values their work, bigger increase amongst colleagues with LTC or illness. **41.6%** compared to last year **34.81% (+ive)**.

Workforce Disability Equality Standard 2024

Data collated from WDES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

More colleagues with long-term condition or illness reported that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties since last year. **20.97%** compared to **19.87%** last year. **(-ive)**

There has been an increase to **76.9%** from **74.38%** from **(+ive)** of colleagues with long-term condition or illness saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Workforce Disability Equality Standard 2024

Data collated from WDES and Staff Survey 2023

Birmingham and Solihull Mental Health NHS Foundation Trust

Decrease from **6.9** to **6.6** in terms of engagement for disabled staff, compared to non-disabled staff for the organisation. (-ive)

Our Trust enables the voices of colleagues with LTC or illness via the Disability and Well Being Staff Network.

1 member on our Board of colleagues have declared a long-term condition or illness

Staff Voices – WDES 2024

Being almost blind I am required to have specialist software, this is installed on trust desktops where I am based but often I have to chase IT and ask for it be reinstalled as it is often removed without warning because the software slows down the machine. However without this software I am unable to work and getting the software reinstalled is never a quick process. The software is on desktops as carrying a laptop causes high levels of pain.

Because of mistreatment largely from a lack of good interactions to action this has left me feeling vulnerable to further mistreatment and discrimination which in turn increases my anxieties around workloads being managed fairly. I have no doubt I have faced and continue to be facing victimisations and indirect discriminations in the work place, enough is enough it needs to end as I have had better and deserve better. Why I am left to be victimised and at a distinct disadvantage due to my disability going unsupported and ultimately my dignity is affected

During a meeting I felt I had been targeted because staff do not agree with my reasonable adjustment and it felt like ablism due to my disability and the environment being inaccessible. If someone was racist would that be considered different? The experience was made worse by the fact no one else in the meeting said anything in response to the dislike of my reasonable adjustment. Plus the response afterwards demonstrates words and actions do not always match. I feel very stressful, draining and I feel the trust is not inclusive or compassionate towards people like me

Staff Voices – WDES 2024

I have fibromyalgia and due to this work 2 days a week. I have had to learn how to manage this illness and be at work and my experience with my own OT community team is very positive. Management are supportive of my needs and encourage me to take regular breaks and to not put too much stuff on myself. I am encouraged to ask for help if necessary and my managers are available for me to do this.
I struggle to share this diagnosis with the wider team as a lot of our patients have fibromyalgia and there are a lot of negative comments about it by other staff members. It feels as though people talk about this illness like it is made up and that people are malingerers, this upsets me.
I don't think it would be possible to work full time with this condition as do not feel that there are systems to support this as a way of working, due to the debilitating condition it causes. This is an issue as it feels that I cannot apply for promotion due to needing to be able to work full time.

I had a life changing riding accident in France, fracturing my skull with a bleed on the brain which nearly killed me. Due to my age (19), I eventually made a full recovery apart from a permanent hearing loss in my left ear and was treated for epilepsy for 2 years afterwards.

The effects of the accident are still felt. I have a very weird type of migraine called a Basilar migraine with some symptoms similar to a stroke, tumour and infection.

Without the support of my previous line managers and understanding of my colleagues I doubt I would be doing the job I am today. Migraine sufferers will know that migraines are a neurological condition and are not just a bad headache and the more you stress about being off sick the more your symptoms worsen and hang about.

My reasonable adjustment plan has helped me massively and provides me with the reassurance that I can continue doing my job and make a positive contribution despite having a disability

Success metrics will be collected, collated and presented through the EDI dashboard

Birmingham and Solihull Mental Health NHS Foundation Trust

High Impact Action	Success Metric	Activity To date	On target
HIA1: Measurable objectives on EDI for Chairs Chief Executives and Board members	1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).	CEO and Exec Teams all have EDI embedded within their objectives via Board Assurance Framework (BAF).	Ongoing
HIA2: Overhaul recruitment processes and embed talent management processes.	2a. Relative likelihood of staff being appointed from shortlisting across all posts 2b. NSS Q on access to career progression and training and development opportunities 2c. Improvement in race and disability representation leading to parity 2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity 2e. Diversity in shortlisted candidates 2f. NETS Combined Indicator Score metric on quality of training	Equity Panel Member on recruitment panels (additional to a panel that is gender and ethnicity diverse). Equity panel members will be required for all 8a and above roles to further exercise the principle of Equity as we work towards becoming a representative organisation. Equity Panel members are independent colleagues who should be integrated into the recruiting panel as a resource to ensure a fair and equitable process. Reasonable adjustment where required ie candidate who have declared a disability can ask for interview in advance Project Flourish QI Recruitment Project	Revamped recruitment policy, included equity panel members for all interviews Band 8a and above Project Flourish has started and monitored through L&D and OD QI Recruitment Project ongoing, support by QI team and Workforce Data Team

Success metrics will be collected, collated and presented through the EDI dashboard

High Impact Action	Success Metric	Activity To date	On target
HIA3: Eliminate total pay gaps with respect to race, disability and gender.	Improvement in gender, race, and disability pay gap	Improvement in gender, race, and disability pay gap. 2024 Gender Pay Gap reported	Ongoing
HIA4: Address Health Inequalities within their workforce	4a. NSS Q on organisation action on health and wellbeing concerns 4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training 4c. To be developed in Year 2	**PCREF** HI (Trust Strategy being developed). Each directorate has their own plan specific to their area. HI Conference Anti Racist Behavioural Framework completed ready for roll out. Fairer Futures Fund being actively scoped to support partnership working with a focus on racialised communities. PSIRF approach being developed to actively consider the racialised experience in relation to Patient Safety Data with Dignity (WRES/Model Employer/EDS) approach being used to inform Divisional reducing inequalities plans, to include PCREF, currently socialising PCREF locally. BLACHIR (Birmingham and Lewisham African & Caribbean Health Inequalities Review)	Associate Director of EDI and OD supported by Head of Programmes - Strategy, People & Partnerships, PMO and Medical Director. Associate Director of EDI and OD supported by Head of Programmes - Strategy, People & Partnerships,

Success metrics will be collected, collated and presented through the EDI dashboard

High Impact Action	Success Metric	Activity To date	On target
HIA5: Comprehensive Induction and onboarding programme for International recruited staff	5a. NSS Q on belonging for IR staff 5b. NSS Q on bullying, harassment from team/line manager for IR staff 5c. NETS Combined Indicator Score metric on quality of training IR staff	Trust has launched the Internationally Educated Nurse Recruitment Programme International Nurse Network to be established and a localised approach.	Ongoing and monitored by Corporate Nursing through Practice Placement Team
HIA6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs	6a. Improvement in staff survey results on bullying / harassment from line managers/teams (**ALL Staff**) 6b. Improvement in staff survey results on discrimination from line managers/teams (**ALL Staff**) 6c. NETS Bullying & Harassment score metric (NHS professional groups)	Cultural Competency, Cultural Humility and Microaggression Training Corporate support offer Anti Racist Behavioural Framework completed and socialised Anti Racist Policy going through ratification process. Anti Racist Behavioural Framework in 1st Phase of roll out Anti Racist Colleague indicators. Goes Live 1st March 2024. Behavioural guidance and toolkit being collated. Data with Dignity (WRES/Model Employer/EDS) approach being used to inform Divisional Active Bystander training 300+ colleagues trained.	Workstreams have started and ongoing – updates regularly shared at committees and Exec Meeting via Associate Director of EDI and OD

To date:

- Dedicated EDI Lead / ODBP for Directorates – **in place**
- EDI Lead taking a lead in Workforce and Health Inequalities – **in place**
- Additional Role Equity Panel Members, Cultural Ambassador and Buddy Roles embedded within the Trust – **EPM embedded, CA and BR to be rolled out**
- Corporate Support Offer – **in place**
- Anti Racist Framework Rollout – 3 parts (Colleague, Practitioner and Leadership) **– Colleague Guide socialised, other 2 to follow in June and August**
- Patient Carer Race Equity Framework Rollout - **Divisional reducing inequalities plans, to include PCREF, currently socialising PCREF locally.**
- Mental Health and LD Recruitment Programme – **launch in July**
- Cultural Competence / Cultural Humility Training **– in place**
- Microaggression Training – **in place**
- DND Network – split in 3 to ensure all voices are heard – **in place**
- Trust has launched the Internationally Educated Nurse Recruitment Programme **– in place**

Updates will be provided via the EDI Quarterly update through TCSE's

Action Plan 2024: WRES

Birmingham and Solihull Mental Health NHS Foundation Trust

How our strategic priorities align

One vision: improving mental health wellbeing

Reducing inequalities

Working in a way that tackles discrimination, addresses stigma, and encourages equality for all

People	Workforce planning across the system	Staff engagement; lived experience roles; co-production of our systems and processes	Evidence based people practice; using data and analytics	Embedding our value of inclusion; diverse workforce; just culture; safety to speak up

Action	By whom	Reporting Cyle
White Allies Network	External, EDI	Quarterly reviews through TCSE
Values in Practice	EDI/OD	Quarterly reviews through TCSE
Flourish	OD	Quarterly reviews through TCSE
International Nurses Network	EDI/OD	Quarterly reviews through TCSE
Active Bystander Training – Phase 2	EDI	Quarterly reviews through TCSE
The Race Code	EDI	Quarterly reviews through TCSE
Improved Self Declaration	All	Quarterly reviews through TCSE
Rewards and recognition to demonstrate fairness across the main protected characteristics	All	Quarterly reviews through TCSE

Action Plan 2024: WDES

How our strategic priorities align

One vision: improving mental health wellbeing

Reducing inequalities

Working in a way that tackles discrimination, addresses stigma, and encourages equality for all

People	Workforce planning across the system	Staff engagement; lived experience roles; co-production of our systems and processes	Evidence based people practice; using data and analytics	Embedding our value of inclusion; diverse workforce; just culture; safety to speak up

Action	By whom	By when
Disability and Wellbeing Network Campaign	EDI and DAWN Network	Quarterly reviews through TCSE
Disability Awareness Training	EDI	Quarterly reviews through TCSE
Reasonable Adjustment Process/Training	EDI	Quarterly reviews through TCSE
Launch Mental Health and LD Recruitment Programme	EDI	Quarterly reviews through TCSE
Improved Self Declaration	All	Quarterly reviews through TCSE

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Thank you

Workforce Race Equality Standard (WRES) Analysis from 2019 - 2024

Indicator number and description	2019	2020	2021	2022	2023	2024	Increase or decrease from 2019 - 2023	
	Indicator 1: Black and Minority Ethnic representation in the workforce by pay band							
Black and Minority Ethnic representation in the workforce overall			37%	37.6%	39.1%	41.5%		**Positive from previous year**
	Race disparity ratios Non Clinical/Clinical							
Black and Minority Ethnic	1339	1379	1513	1578	1686	1929	Increase 243	
White	2130	2072	2108	2106	2040	2128		
Unknown	472	495	523	513	582	595		
Total	3941	3946	4144	4209	4315	4652		
	Indicator 2: likelihood of appointment from shortlisting							
likelihood ratio White / Black and Minority Ethnic	1.57	1.44	2.02	1.52	1.30	1.70	Increased 8% Since 2019	**Negative from previous year**
	Indicator 3: likelihood of entering formal disciplinary proceedings							
likelihood ratio Black and Minority Ethnic / White	2.83	2.70	2.26	1.33	2.02	1.86	Decreased 29% Since 2019	**Positive from previous year**
	Indicator 4: likelihood of undertaking non-mandatory training							
likelihood ratio White / Black and Minority Ethnic	1.01	1.30	1.62	1.25	0.77	0.89	Decreased 12% Since 2019	**Positive from previous year**
	Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months							
Black and Minority	38.2%	42.3%	36.7%	37%	39.3%	35.8%	Decreased 2.4%	**Positive from previous**

Ethnic							Since 2019	**year**
White	32.5%	36.5%	31.1%	33.6%	34%	29.8%	Decreased 2.7% Since 2019	**Positive from previous year**
	Indicator 6: harassment, bullying or abuse from staff in last 12 months							
Black and Minority Ethnic	32.8%	34.3%	32.4%	25.5%	27.1%	24.0%	Decreased 8.8% Since 2019	**Positive from previous year**
White	28.6%	30.5%	25.9%	24.6%	21.8%	22.6%	Decreased 6% Since 2019	**Negative from previous year**
	Indicator 7: belief that the trust provides equal opportunities for career progression or promotion							
Black and Minority Ethnic	60.4%	60.6%	37.5%	41.2%	43%	52%	Decreased 8.4% Since 2019	**Positive from previous year**
White	78.5%	81%	55.3%	53.7%	54.5%	56.4%	Decreased 22.1% Since 2019	**Positive from previous year**
	Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months							
Black and Minority Ethnic	17.0%	18.6%	18.9%	16.4%	17.1%	12.3%	Decreased 4.7% Since 2019	**Positive from previous year**
White	9.4%	10.0%	8.8%	10.5%	11.5%	8.8%	Decreased 0.6% Since 2019	**Positive from previous year**
	Indicator 9: Black and Minority Ethnic representation on the board minus Black and Minority Ethnic representation in the workforce							
Overall	-19.7%	-4.2%	-7.9%	0.9%	6.4%	9%	Increased 10.7% Since 2019	**Positive from previous year**
Voting Numbers	0.0%	30.8%	28.6%	38.5%	46.2%	50%	Increased 50% Since 2019	**Positive from previous year**
Executive Numbers	25%	0.0%	0.0%	28.6%	33.3%	37.5%	Increased 12.5% Since 2019	**Positive from previous year**

Key

Showing an increase or decrease year on year

Workforce Disability Equality Standard (WDES) Analysis from 2019 - 2024

Indicator number and description	2019	2020	2021	2022	2023	2024	Increase or decrease from 2019 - 2024	
	Metric 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce							
Disabled	173	184	211	234	264	348	84	
Non Disabled	3399	3334	3468	3485	3473	3703		
Unknown	380	428	467	491	575	600		
	Metric 2 - Relative likelihood of non-disabled colleagues being appointed from shortlist compared to colleagues with disabilities							
	1.44	1.23	0.67	1.31	0.84	1.28	Decreased 11% Since 2019	**Negative from previous year**
	Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.							
	2.06	2.83	5.48	0	0	5.33	Increase 61% Since 2019	**Negative from previous year**
	Metric 4 - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:							
Patients/service users, their relatives or other members of the public	40.6%	45.8%	40.6%	41.5%	43%	37.1%	Decreased 3.5% Since 2019	**Positive from previous year**
Managers	22.4%	23.6%	17.8%	17.0%	14.1%	17.2%	Decreased 5.2% Since 2019	**Negative from previous year**
Other colleagues	34.3%	31.7%	27.5%	28.1%	25.9	24.5%	Decreased 9.8% Since 2019	**Positive from previous year**
	Metric 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it							
	56.6%	60.1%	61.7%	62.3%	65.1%	59.9%	Increased 3.3% Since 2019	**Negative from previous year**
	Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career							

	progression or promotion							
	46.0%	45.5%	47.8%	45.4%	47.1%	50.3%	Increased 4.3% Since 2019	**Positive from previous year**
	Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.							
	23.9%	26.6%	23.1%	22.7%	19.9%	21%	Decreased 2.9% Since 2019	**Negative from previous year**
	Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work							
	37.2%	37.4%	43.3%	35.3%	34.8%	41.6%	Increased 4.4% Since 2019	**Positive from previous year**
	Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.							
	70.5%	71.2%	82.7%	71.5%	74.4%	76.9%	Increased 6.4% Since 2019	**Positive from previous year**
	Metric 9 - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.							
	6.8	6.9	7.1	6.9	6.9	6.6 (725 staff)	Decreased 0.2 Since 2019	**Negative from previous year**

Key

Showing an increase or decrease year on year

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	**7 August 2024**
Date(s) of Committee Meeting(s) reported	**24 July 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • Board Assurance Framework Risks • Integrated Performance Report • Finance Report • Highcroft Business Case • Committee Effectiveness Self-Assessment Results
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • All corporate and operational areas had been asked to review the 1% savings target for 2024/2 to address the £1.8m unidentified savings target. A request had also been made for 2% savings plans for 2025/26, to be submitted in September. • The total 2024/25 plan for out of area expenditure, including a £5m savings target, was £14m. The month 3 out of area expenditure was a reported £5m. Non-Trust bed usage had increased in June and a year-end forecast spend of £20m was reported (a £6m overspend). • The Group position at Month 3 was a reported £346k surplus (comprising a £0.2m deficit for MHPC, £0.5m surplus for the Trust, a £14k surplus for SSL, and a £162k surplus for Reach Out). • The Committee endorsed the reprioritisation of the capital programme to address significant estates challenges. • The Committee acknowledged the £43m system deficit.
Assure:	The Committee was assured by the significant improvements made in relation to the reduction of agency use. Agency use now comprised 2% of the total pay bill. The Trust had not been affected by the recent CrowdStrike outage, which highlighted the effectiveness of the cyber security controls in place. The Committee was assured by a positive self-assessment of its effectiveness. Some improvements were recognised around increased visibility and continued development of reporting, however the Committee commended the governance work that had been undertaken to reach such a positive point.

Advise:	• The Committee would continue to review and support development of the performance metrics within the Integrated Performance Report. Following the Board strategy session in July, consideration would be given to the overarching outcomes, optimising metrics and effective reporting. • The Committee endorsed the approach set out within the business case for refurbishment of elements of Highcroft, which would contribute to a significantly improved experience for staff and service users.	
Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. Three revised risks had been identified: • Inability to deliver long-term financial sustainability. • Failure to develop a safe environment. • Inability to be recognised as a high-performing organisation. The Committee would receive draft versions of the risks in August, for discussion at September's Board strategy session.	
	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	**7 August 2024**
Date(s) of Committee Meeting(s) reported	**20 June 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 • Out of Area Performance Report • ICT and Cyber Assurance Report • Information Governance Annual Report 2023/24
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 2 reported expenditure of £3.4m, which was £1m adverse to plan. The current forecast spend was £18m. • The Group position at Month 2 was a reported £147k deficit (comprising a £0.4m deficit for MHPC, £0.3m surplus for the Trust, a £1k surplus for SSL, and a £42k surplus for Reach Out).
Assure:	The Committee formally received the Information Governance Annual Report 2023/24. The ICT and Cyber Assurance Report provided assurance on the activities being undertaken to utilise digital systems, improve infrastructure and safeguard the organisation from cyber attacks.
Advise:	• The Committee would continue to review and support development of the performance metrics within the Integrated Performance Report. The Board Strategy Session in July would explore performance metrics and how the Trust could utilise them, including the most effective way to report them. • The Committee retrospectively endorsed the 2024/25 financial plan which comprised a revenue plan of £2m surplus, and a capital plan of £11.9m. The plan had been submitted to NHSE on 12 June. • A deep dive into Out of Area performance was received. The Committee was assured by the work of the Out of Area Steering Group, including the workstreams that had been established in the

	following areas: Gatekeeping; Fidelity of Locality Model; Reducing delays for Clinically Ready for Discharge. Some key challenges remained, particularly in relation to out of area spend which was having a significant impact.	
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. Cyber security would be featured prominently on the BAF to highlight risks and assurances.	
	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

Report to the Board of Directors							
Agenda item:	**15**						
Date	7 August 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 3 consolidated Group position is a surplus of £346k. This is after adjusting for the £3.4m revenue impact of the PFI liability remeasurement under IFRS 16. The position comprises a surplus of £0.5m for the Trust, a £0.2m deficit for the Mental Health Provider Collaborative, a £14k surplus for Summerhill Services Limited (SSL) and a surplus of £162k for the Reach Out Provider Collaborative.

Alert:

The Committee 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 3 out of area expenditure is £5m, this is £1.5m adverse to plan. Non-Trust bed usage has increased in June. A straight line forecast of quarter 1 spend, suggests a total forecast of £20m (£6m overspend).
- Savings – The 2024/25 savings target is £17.8m, with £1.8m unidentified in the plan. The month 3 savings achieved is £2.4m, this is £1.5m less than plan. The majority of the slippage on achievement relates to the out of area savings target (£1.3m at month 3) and the unidentified savings target (£0.4m at month 3). This is partly offset by agency reduction delivering ahead of plan by £0.4m.
  All corporate and operational areas have been asked to re-visit the 2024/25 1% savings plan request, to address the £1.8m unidentified savings target. A request has also been made for 2% savings plans for 2025/26, to be submitted by 6.9.24.
- Cash – The end of June Group cash balance was £91m, with £9.5m held by Trust. The finance department continues to review options to increase the Trust balance.

Advise:

- Temporary staffing – The 2024/25 temporary staffing plan is £41.5m, including savings targets of £1.5m for bank and £1.8m for agency. Month 3 year to date temporary staffing expenditure is £1.9m less than plan.

Two initiatives have been introduced to help reduce reliance on agencies. NHS Professionals National Bank was launched on 12.7.24. This means that any bank duties that our internal temporary staffing service cannot fill will be transferred to NHS Professionals for their bank members to book into. This will act as an extension to our bank and a first alternative to external agencies. Direct engagement has also been introduced. This is an employment model for agency doctors which allows savings to be made by engaging contracted doctors for service directly rather than through an agency.

- With effect from 1 June 2024, the commissioning responsibility for Learning, Development & Autism (LD&A) transferred from BSOL ICB to the Mental Health Provider Collaborative. The part year effect for LD&A is £18m for NHS contracts and £7m for non- NHS contracts.

Capital position:

The month 3 Group capital expenditure is £2.1m year to date, this is £0.6m ahead of the capital plan re-submission on 12.6.24.

Cash position:

The month 3 Group cash position is £91m.

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 3 and discuss the key alerts.

Enclosures

Month 3 Finance Report

Capital Bid Form

Highcroft Business Case

Birmingham and Solihull Mental Health NHS Foundation Trust

Finance Report

Financial Performance:

1st April 2024 to 30th June 2024

Month 3
Group financial position

Birmingham and Solihull Mental Health NHS Foundation Trust

Group Summary	Annual Budget	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	619,270	154,814	161,040	6,226
Other Income	21,117	5,279	5,288	8
Total Income	**640,386**	**160,094**	**166,328**	**6,234**
Expenditure				
Pay	(289,257)	(72,289)	(70,713)	1,575
Other Non Pay Expenditure	(309,997)	(77,499)	(85,807)	(8,308)
Drugs	(7,150)	(1,788)	(1,772)	16
Clinical Supplies	(539)	(135)	(187)	(52)
PFI	(14,388)	(3,597)	(4,026)	(429)
EBITDA	**19,056**	**4,787**	**3,823**	**(964)**
Capital Financing				
Depreciation	(9,765)	(2,444)	(2,401)	43
PDC Dividend	(16)	(4)	(4)	-
Finance Lease	(8,479)	(5,301)	(5,306)	(5)
Loan Interest Payable	(972)	(243)	(253)	(10)
Loan Interest Receivable	1,899	475	1,230	756
Surplus / (Deficit) before taxation	**1,722**	**(2,731)**	**(2,911)**	**(179)**
Taxation	(380)	(95)	(100)	(5)
Surplus / (Deficit)	**1,342**	**(2,826)**	**(3,010)**	**(184)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	1	1	-
Adjust PFI revenue costs to UK GAAP basis	722	3,350	3,355	5
Adjusted financial performance Surplus / (Deficit)	**2,069**	**525**	**346**	**(179)**

Month 3 2024/25 Group Financial Position

The month 3 consolidated Group position is a surplus of £346k. This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£3.4m year to date).
The month 3 outturn is £179k adverse to the year to date plan submitted to NHSE on 12.6.24. The plan for the full financial year is a surplus of £2m.

The Group month 3 position is mainly driven by a £0.5m surplus in the Trust, partly offset by a year to date deficit in the Mental Health Provider Collaborative (MHPC) of £0.2m. The Summerhill Services Limited (SSL) position is a £14k surplus. The Reach Out Provider Collaborative month 3 position is £62k surplus in line with agreed contribution to Trust overheads.

The draft month 3 BSOL system position is a deficit of £43m which is £29m adverse to plan.

Month 3 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	91,199	-	42,864	103,047	(76,070)	161,040
Other Income	5,265	7,121	-	-	(7,098)	5,288
Total Income	**96,464**	**7,121**	**42,864**	**103,047**	**(83,168)**	**166,328**
Expenditure						
Pay	(66,789)	(2,988)	(429)	(576)	69	(70,713)
Other Non Pay Expenditure	(20,652)	(2,177)	(42,568)	(102,809)	82,399	(85,807)
Drugs	(1,850)	(525)	-	-	603	(1,772)
Clinical Supplies	(187)	-	-	-	-	(187)
PFI	(4,026)	-	-	-	-	(4,026)
EBITDA	**2,961**	**1,431**	**(133)**	**(338)**	**(97)**	**3,823**
Capital Financing						
Depreciation	(1,592)	(710)	-	-	(99)	(2,401)
PDC Dividend	(4)	-	-	-	-	(4)
Finance Lease	(5,299)	(95)	-	-	89	(5,306)
Loan Interest Payable	(253)	(512)	-	-	512	(253)
Loan Interest Receivable	1,371	0	196	176	(512)	1,230
Surplus / (Deficit) before Taxation	**(2,817)**	**113**	**62**	**(162)**	**(107)**	**(2,911)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(100)	-	-	-	(100)
Surplus / (Deficit)	**(2,817)**	**14**	**62**	**(162)**	**(107)**	**(3,010)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	1	-	-	-	-	1
Adjust PFI revenue costs to UK GAAP basis	3,355					3,355
Adjusted financial performance Surplus / (Deficit)	**539**	**14**	**62**	**(162)**	**(107)**	**346**

Commissioning overview

Mental Health Provider Collaborative (MHPC)

- Commissioning responsibility for Learning, Development & Autism (LD&A) transferred from BSOL ICB to MHPC from 1.6.24.
- The part year effect for LD&A NHS contracts is £18.4m, taking total expected income to £425m. An additional £7m part year effect for non-NHS LD&A contracts is expected to be transferred in month 4.

- Month 3 position £162k deficit – driven by packages of care pressures, part offset by interest receivable.

- Month 3 cash balance £25m (still being validated).

- Key risks:
- Infrastructure costs
- Packages of care (inflation and growth in numbers).

Reach Out

- £160m annual income in current plan.

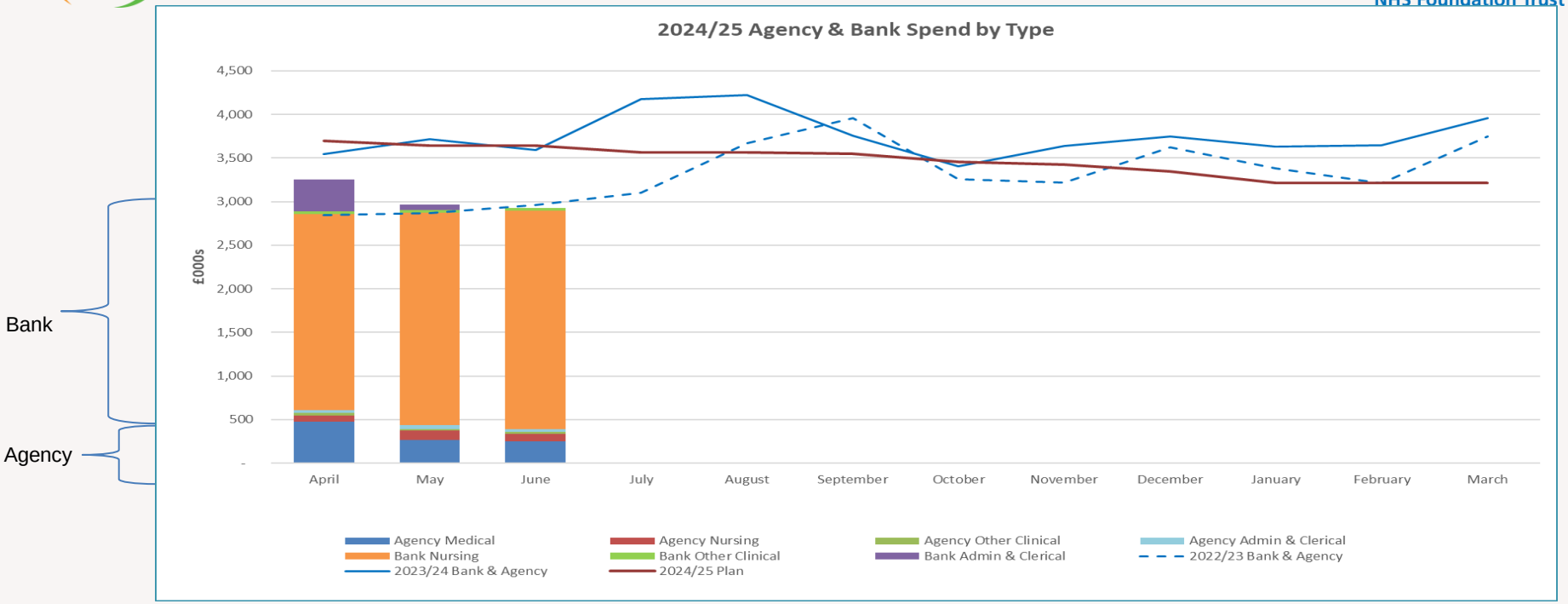
- Month 3 position £62k surplus – in line with agreed contribution to Trust overheads.

- Month 3 cash balance £52m (still being validated).

- Agreement of allocations of prior year underspends to decrease balance of cumulative deferred income. £3m deferred income released at month 3 towards partner cost pressures.

- Key risks:
- Clinical concerns around expected growth in out of area numbers, not realised in month 3 year to date activity and finance data.

Temporary staffing expenditure



Month 3 temporary staffing expenditure is £9.1m, this is £1.9m less than plan.

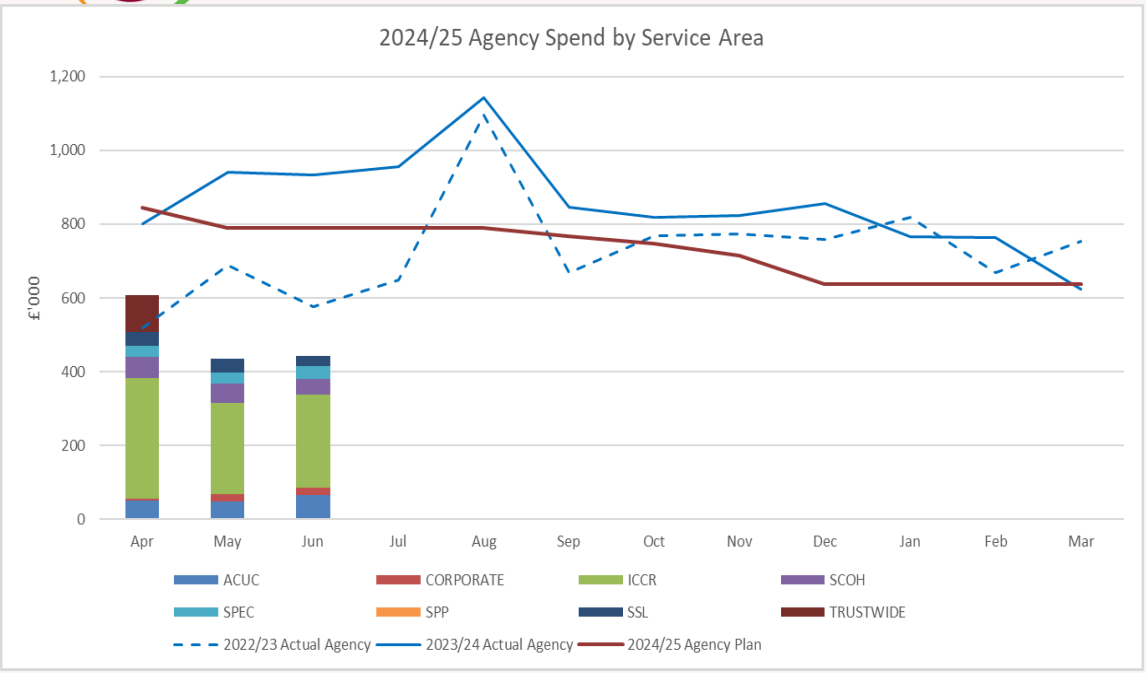
Bank expenditure £7.6m (84%) – the majority of bank expenditure relates to nursing bank shifts - £7.2m

Agency expenditure £1.4m (16%) – the majority of agency expenditure relates to medical agency - £1m.

For further analysis on bank and agency expenditure, see pages 6 to 7.

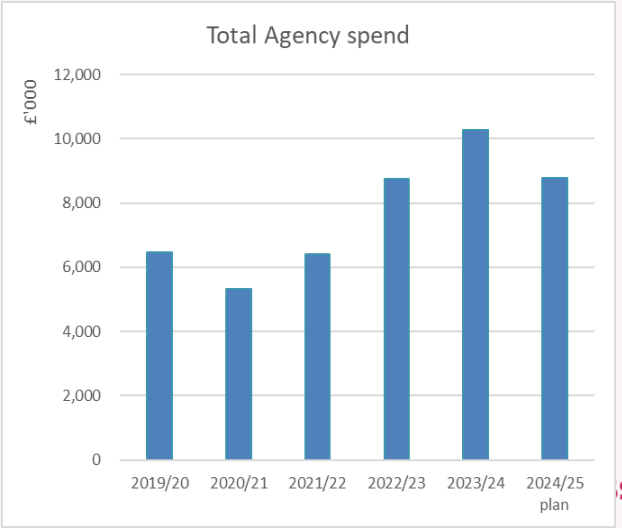
Agency expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust



KPIs	Target	Apr-24	May-23	Jun-23
Agency spend as % of pay bill (YTD)	3.2%	2.6%	2.2%	2.0%
Above price cap agency bookings - medical	0	15	14	14
Above price cap agency bookings -nursing	0	6	5	5
Admin & Estates bookings - Trust	0	1	1	0
Admin & Estates bookings - SSL	0	7	6	6

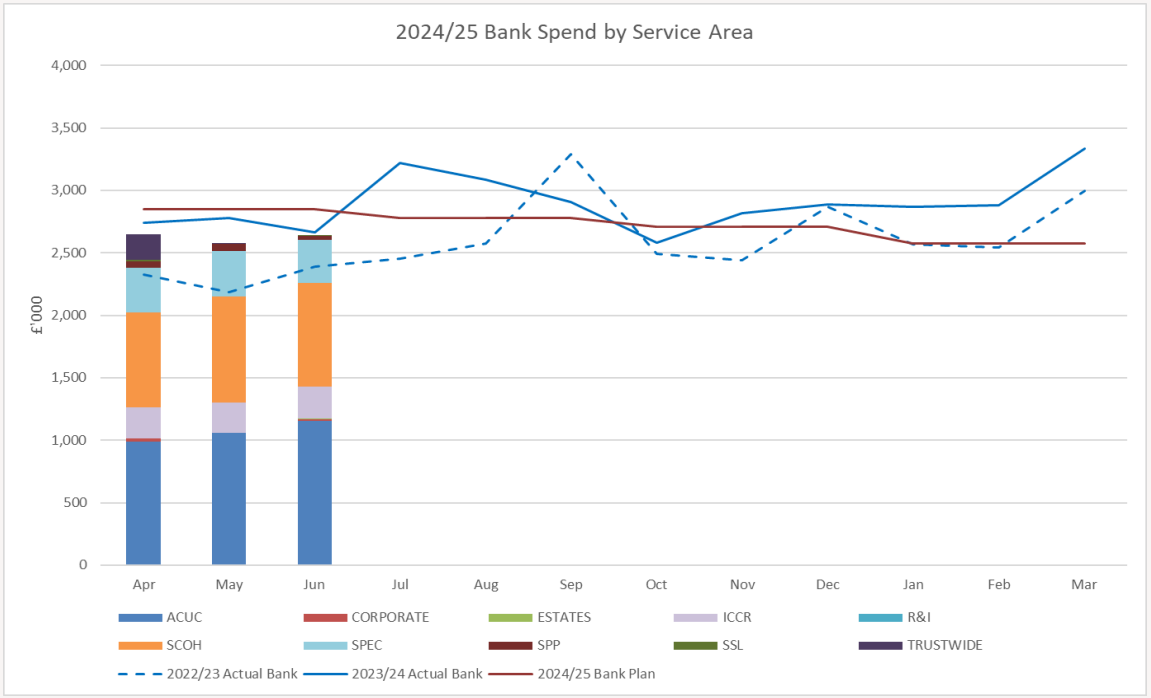
	2024/25 YTD
	£'000
Agency Expenditure	1,436
NHSE Ceiling	2,263
Variance to NHSE ceiling	827
Agency Medical	990
Agency Nursing (Registered)	269
Agency Nursing HCA	3
Agency Other Clinical	64
Agency Admin & Clerical	111
Agency Expenditure	1,436



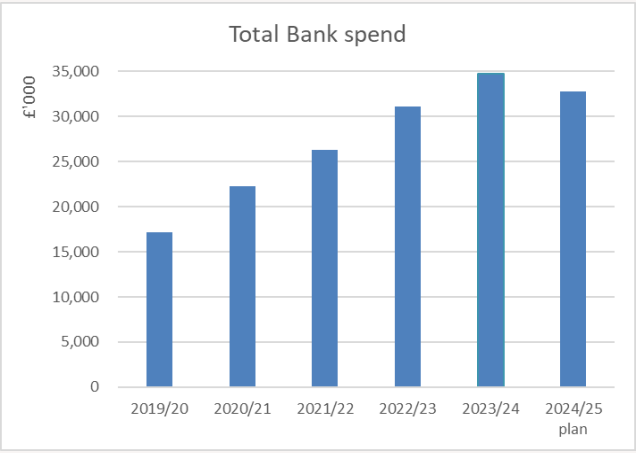
Agency expenditure

- The month 3 year to date agency expenditure is £1.4m, which is £989k less than plan.
- The NHSE intention for 2024/25 agency expenditure, is for aggregate agency spending to reduce to 3.2% as a proportion of the total pay bill. Year to date agency expenditure is 2% which is £827k below the threshold.
- 69% of the year to date agency spend relates to medical. Medical agency bookings paid over cap have reduced from an average of 21 for the second half of 2023/24 to 14 as at the end of June.
- Direct engagement was introduced in June, this is an employment model for agency doctors which allows savings to be made by engaging contracted doctors for service directly rather than through an agency.
- In June, the Trust non clinical agency bookings has reduced to zero in line with target, with 6 remaining in SSL.
- To date, £573k agency savings have been achieved (£362k ahead of plan).

Bank expenditure analysis



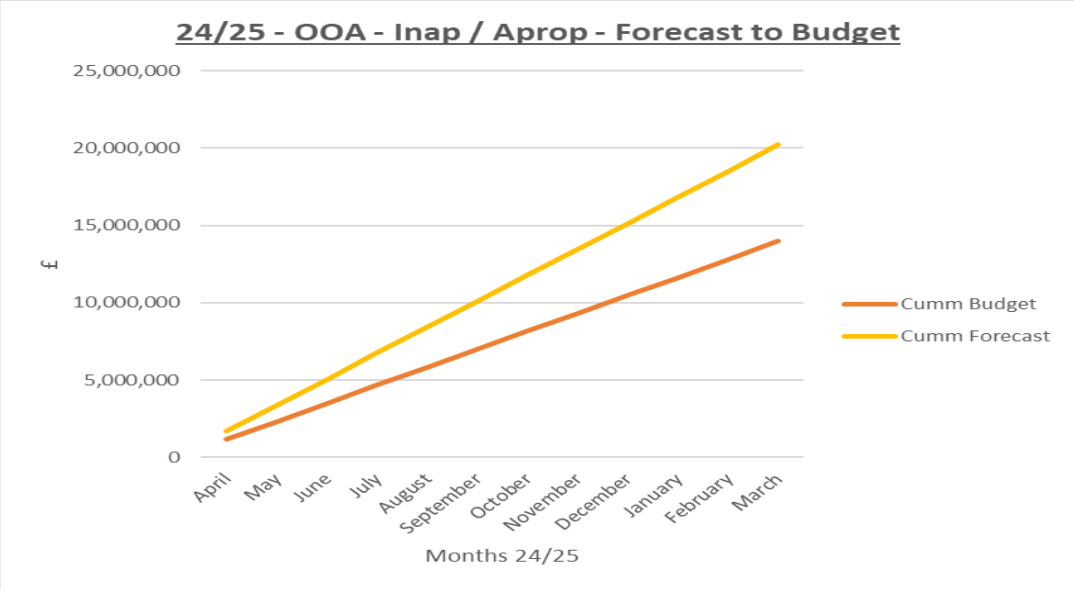
Type	YTD £'000	% of spend
Bank Nursing	4,692	91%
Bank Other Clinical	60	1%
Bank Admin & Clerical	427	8%
Grand Total	**5,179**	**100%**



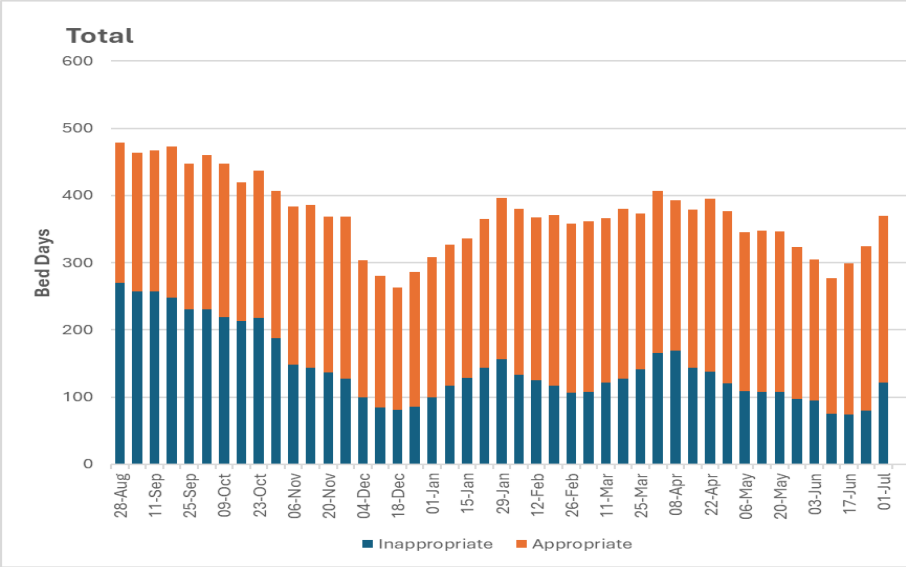
Bank expenditure

- The month 3 year to date bank expenditure is £7.6m which is £921k less than plan. 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 £3.2m, Secure and Offender Health £2.4m, Specialities £1m and ICCR £0.7m.
- As of 12.7.24, BSMHFT will be working in partnership with NHS Professionals to launch NHS Professionals National Bank. It is a workforce solution that integrates with our existing technology to provide an alternative to the use of agency staff. There will be no change to the way our temporary staffing services operates. Any unfilled bank duties will be transferred to NHS Professionals for their bank members to book into, acting as an extension to our bank and a first alternative to external agencies.

Out of Area overspend



Non-Trust bed days



- The total 2024/25 plan for out of area expenditure, including a £5m savings target, is £14m.
- Month 3 year to date expenditure is £5m which is £1.5m adverse to plan.
- There has been an increase in non-Trust bed days usage in June following reductions in both April and May.
- A straight line forecast of quarter 1 spend suggests a total forecast of £20m (£6m overspend). Work is ongoing to refine the forecast, taking into account predicted bed usage and the risk share regarding unutilised Priory contract beds.

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent						
Pay - Recurrent	279	641	(362)	3,489	3,489	-
Non-pay - Recurrent	2,003	593	1,410	8,013	8,013	-
Income - Recurrent	-	-	-	-	-	-
Total recurrent efficiencies	2,282	1,234	1,048	11,502	11,502	-
Non recurrent						
Pay - Non-recurrent	104	104	-	416	416	-
Non-pay - Non-recurrent	541	100	441	2,162	2,162	-
Income - Non-recurrent	934	934	-	3,735	3,735	-
Total non-recurrent efficiencies	1,579	1,138	441	6,313	6,313	-
Total Efficiencies	3,861	2,372	1,489	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 is £17.8m. This comprises £11.5m recurrent and £6.3m non recurrent targets. £8.9m are considered high risk and £1.8m are unidentified.

- The month 3 savings achieved is £2.4m, this is £1.5m less than plan. The majority of the slippage on savings achieved relates to the £5m out of area savings target (£1.3m) and the £1.8m unidentified savings target (£0.4m). This is partly offset by agency reduction delivering ahead of plan by £0.4m. For further detail on the 2024/25 savings schemes, see next page.

Savings plans requirement – 2024/25 and 2025/26

As agreed by the Executive Team in May 2024, all corporate and operational areas have been asked to re-visit the 2024/25 1% savings plan request, to address the £1.8m unidentified savings target. A request has also been made for 2% savings plans for 2025/26, to be submitted by 6.9.24, signed off by the relevant Executive Director. The focus should be on cash releasing transformational change. The Executive Team will lead a review of the proposals during September.

Savings schemes status

Scheme	Risk	Development	Total Plan £'000		YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Key Trustwide schemes							
Agency Reduction	Low Risk	Fully Developed	1,752		211	573	362
Bank Reduction	High Risk	Opportunity	1,465		-	-	-
OOA Spend Reduction	High Risk	In Progress	5,000		1,250	-	(1,250)
Technical savings							
New Recurrent Funding Stechford Custody Suite - OH	Low Risk	Fully Developed	60		15	15	-
New Recurrent Psychology Post Foston Hall - OH & Margin	Low Risk	Fully Developed	17		4	4	-
CYP Re-allignment - OH & Margin	Low Risk	Fully Developed	103		26	26	-
Prevent Additional Funding - OH & Margin	Low Risk	Fully Developed	93		23	23	-
Increase Recurrent Interest Receivable 3.5%	Low Risk	Fully Developed	900		225	225	-
E&U savings	Low Risk	Fully Developed	1,355		339	339	-
1% savings - ICCR	Low Risk	Fully Developed	115		29	29	-
SSL savings	High Risk	Opportunity	255		63	-	(63)
Procurement	High Risk	Opportunity	388		97	-	(97)
Recurrent total			**11,502**		**2,282**	**1,234**	**(1,048)**
Technical savings							
NHS Pension Review 24/25	Low Risk	Fully Developed	297		74	74	-
Non Recurrent 2 yr Pilot from Jan 24 Enhanced Reconnect - OH & Margin	Low Risk	Fully Developed	118		30	30	-
Non-Recurrent Income from Reach Out	Low Risk	Fully Developed	2,782		696	696	-
Non-Recurrent Income from Other External PC's	Low Risk	Fully Developed	953		238	238	-
Increase Non-Recurrent Interest Receivable 1%	Low Risk	Fully Developed	400		100	100	-
Unidentified Savings	High Risk	Unidentified	1,762		441	-	(441)
Non recurrent total			**6,313**		**1,579**	**1,138**	**(441)**
Total Efficiencies			**17,815**		**3,861**	**2,372**	**(1,489)**

Consolidated Statement of Financial Position (Balance Sheet)

Birmingham and Solihull Mental Health NHS Foundation Trust

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-24 £m's	NHSI Plan YTD 30-Jun-24 £m's	Actual YTD 30-Jun-24 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	218.0	220.4	217.8
Prepayments PFI	1.2	1.2	1.5	1.2
Finance Lease Receivable	0.0	-	0.0	-
Finance Lease Assets	-	-	0.0	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	219.2	221.9	219.0
Current assets				
Inventories	0.4	0.4	0.4	0.4
Trade and Other Receivables	21.4	21.4	30.6	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.6	90.9	93.1
Total Curent Assets	114.0	113.4	121.8	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(88.4)	(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)	(46.4)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(145.0)	(136.0)
Non-current liabilities				
Deferred Tax Liability	(0.1)	(0.1)	(0.1)	(0.1)
Loan and Borrowings	(23.0)	(22.2)	(21.9)	(20.8)
PFI lease	(78.3)	(81.9)	(81.6)	(78.8)
Finance Lease, non current	(6.8)	(4.5)	(6.7)	(5.8)
Provisions	(3.0)	(3.0)	(2.9)	(3.0)
Total non-current liabilities	(111.2)	(111.8)	(113.2)	(108.5)
Total assets employed	88.6	84.8	85.6	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)	(78.3)	(77.5)	(73.7)
Total taxpayers' equity	88.6	84.8	85.6	89.4

SOFP Highlights

The Group cash position at the end of June 2024 is £90.9m, 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 12 to 13.

Current Assets & Current Liabilities

Ratios

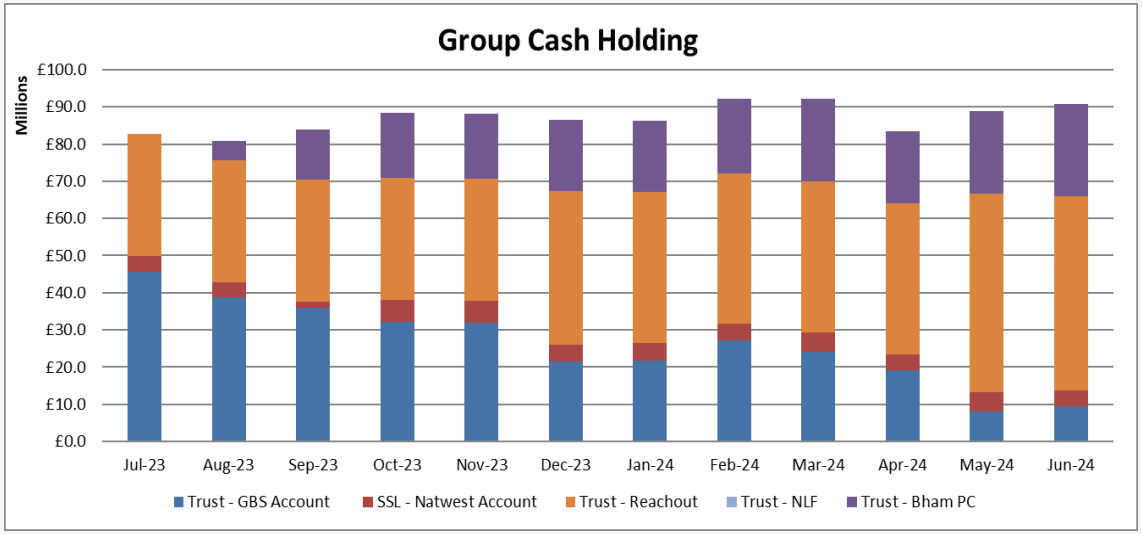
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

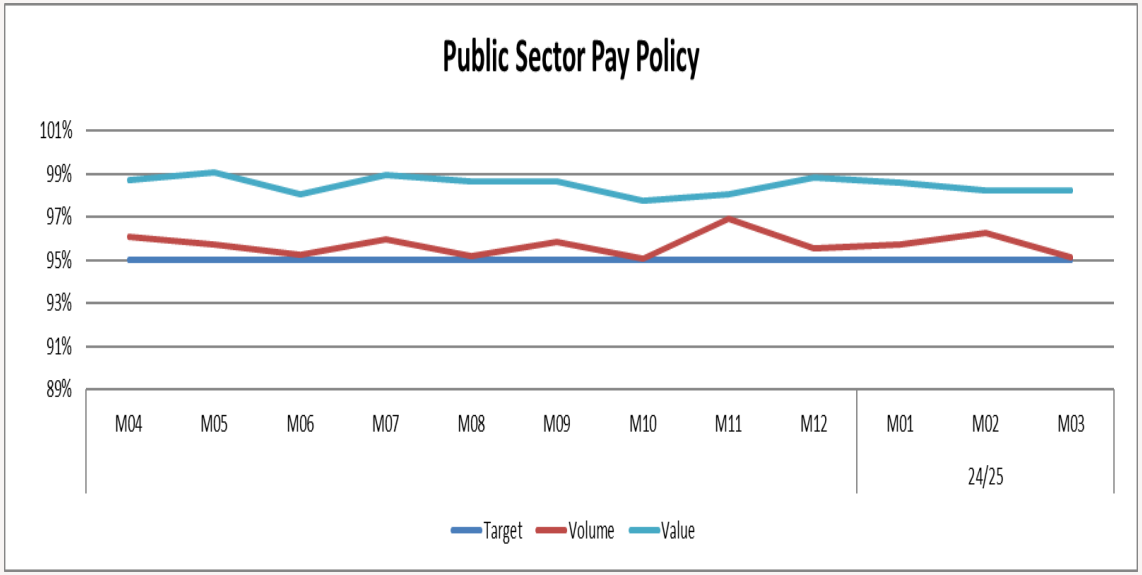
Current Ratio :	£m's
Current Assets	121.8
Current Liabilities	-145.0
Ratio	0.8

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

Cash & Public Sector Pay Policy

Birmingham and Solihull Mental Health NHS Foundation Trust





Cash

The Group cash position at the end of June 2024 is £90.9m. This comprises of Trust £9.5m, SSL £4.1m, Reach Out Provider Collaborative £52.3m and Mental Health Provider Collaborative £25m.

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.

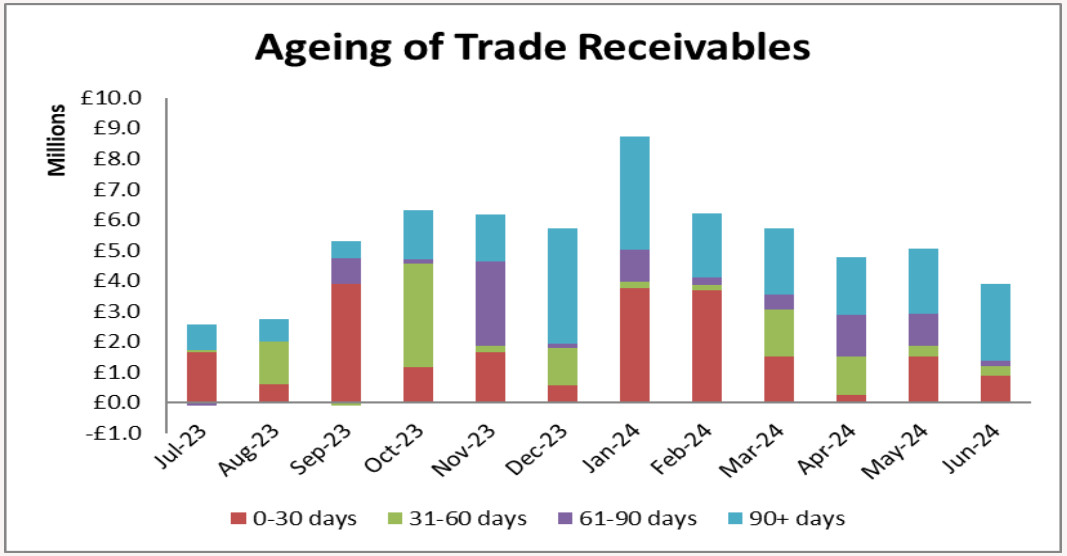
This performance has been consistent throughout 2023/24 and the aim is to maintain this during 2024/25.

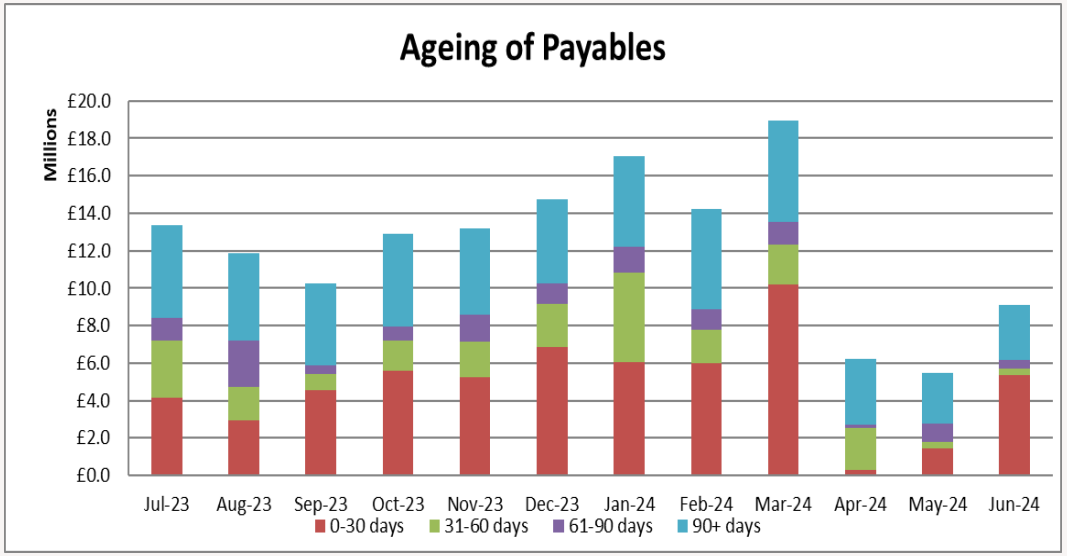
Better Payment Practice Code :

	Volume		Value	
NHS Creditors within 30 Days	97%	✓	100%	✓
Non - NHS Creditors within 30 Days	95%	✓	98%	✓

Trust Receivables and Payables

Birmingham and Solihull Mental Health NHS Foundation Trust





Trade Receivables & Payables

Trade Receivables :

- **0-30 days-** Decrease in Balance due to payments received from SSL for £882K & £235k from BWC, balance relates to monthly/quarterly & ad hoc invoices raised in month.
- **31-60 days-** decrease in balance – BSOL MHPC £175k awaiting processing, BWC £35k awaiting approval, UHB £11k, NHSE £10k on hold awaiting approval, Access To Work £15k slow processing of claims, Nacro £9k to be resolved internally. Balance staff overpayments (on payment plans).
- **61-90 days-** significant decrease in balance due to invoices relating to UHB moving to 90+ days, BWC £90k awaiting approval, Paraxel Inc Ltd £19k in query, Kings College £42k no PO. Balance staff overpayments (on payment plans).
- **Over 90+ days** –balance mainly due to outstanding UHB debt £2.2m-payment of £467k received in June 2024 – escalated to BSMHFT and UHB management, Kings College £27k no PO, UoB £22k no PO, BWC £13k awaiting approval, Ethypharm £44k in query, Bham Community £9k awaiting approval, Bita £4k paying in instalments, Access to work £9k in query. Balance staff overpayments (on payment plans).

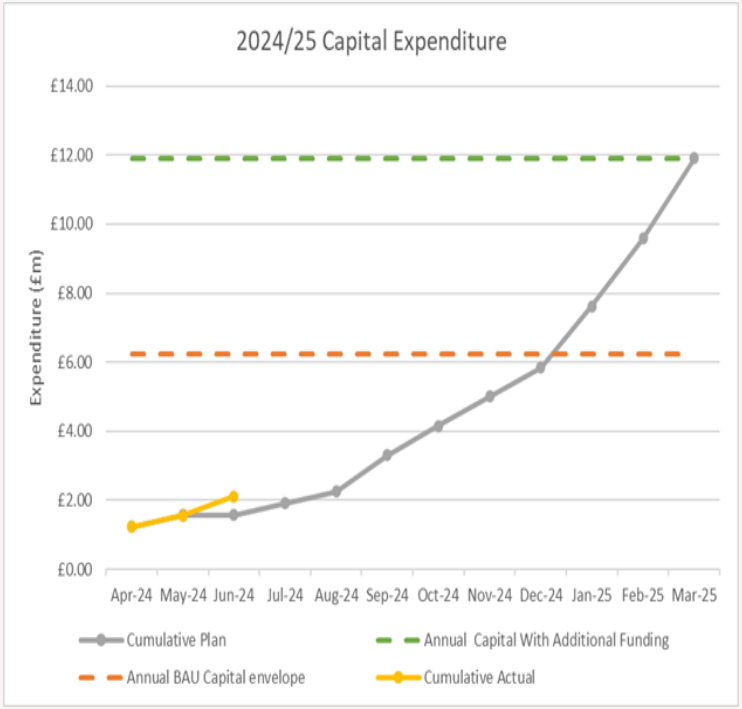
Trade Payables:

Over 90 days – Overall balance has significantly decreased since March 2024 due to settling of invoices relating to year end 2023/24.

- NHS Suppliers £1m- NHS Property £283k-historic invoices, UHB £589k in query with the contracting team.
- Non-NHS Suppliers (66+) £1.8m – 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 July 2024.

Month 3 Capital expenditure

Capital Scheme	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Minor Works	2.3	0.6	0.6	0.0
Stautory Standards & Backlog Maintenance	2.0	0.3	1.3	-1.0
ICT	0.4	0.0	0.0	0.0
Medical Device Replacement	0.1	0.0	0.0	0.0
Design Works	0.8	0.0	0.0	0.0
Doorsets	0.7	0.4	0.0	0.4
Total BAU Capital Plan	**6.3**	**1.4**	**2.0**	**-0.6**
R&D Medical Equipment - grant funded	**0.7**	**0.0**	**0.0**	**0.0**
Acute & Urgent Care - UEC capacity PDC funded	**0.8**	**0.0**	**0.0**	**0.0**
Total lease expenditure	**2.6**	**0.2**	**0.2**	**0.0**
Minor Works - £1.6m notional system allocation - TBC	*1.6*	*0.0*	*0.0*	*0.0*
Gross Capital Expenditure (excluding lease remeasurements)	**11.9**	**1.6**	**2.1**	**-0.6**



Group Capital Expenditure

Month 3 year to date Group capital expenditure is 2.1m, this is £0.6m ahead of the capital plan re-submission on 12.6.24, mainly due to statutory standards and backlog maintenance works progressing ahead of plan.

On 12.6.24, an updated capital plan was submitted to NHSE. The capital plan increased by £2.4m from £9.5m to £11.9m. £0.8m relates to the award of PDC funding for Acute and Urgent Care services. £1.6m relates to a notional share of additional system capital allocation. This was included as minor works for the plan submission. The final allocation agreement is subject to system CFO discussion and so commitments cannot be made against the £1.6m until confirmation is received.

At the July Capital Review Group meeting, the recommendation to repurpose £1.1m capital (originally planned for design works and ICT) was endorsed, in order to address the following priorities: Northcroft – cladding structural integrity, Small Health – heating system, Reaside - immediate backlog maintenance, Main House works (for FIRST Team and Recovery College), telephone lines - update from analogue to digital.

Trust Service Area analysis

NHS
Birmingham and Solihull Mental Health

Group Summary	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Commentary
	Actual	Actual	Actual	Actual	
	£'000	£'000	£'000	£'000	
Acute and Urgent Care Services					
Other Income	(148)	(37)	(230)	194	Specialling income - mainly Melissa ward & Eden PICU
Pay	47,887	11,972	13,251	(1,280)	£(1.6)m Inpatient ward overspend, £0.4m Urgent care underspend
Non Pay	18,578	4,645	5,929	(1,285)	£(1.5)m out of area overspend, £(0.2)m Inpatient overspend, £0.4m Urgent Care underspend
Acute and Urgent Care Services Total	**66,317**	**16,579**	**18,950**	**(2,371)**	**£(1.6)m Inpatients, £(1.5)m Out of area, £0.8m Urgent care underspend**
ICCR					
Other Income	(2,162)	(541)	(1,007)	466	Education & training income - CMHT £0.2m, Addictions & Inclusion service £0.2m
Pay	63,456	15,864	14,824	1,040	£0.6m CMHT, £0.1m Community transformation, £0.2m Solihull services
Non Pay	10,317	2,579	2,780	(200)	£(0.2)m CMHT - £0.1m drugs, £0.1m other non pay
ICCR Total	**71,611**	**17,903**	**16,597**	**1,306**	**£0.5m Addictions & Inclusion service, £0.5m CMHT**
Specialties Services					
Other Income	(3,751)	(938)	(799)	(139)	£(0.1)m Maternal Mental Health Services
Pay	47,798	11,950	11,972	(22)	£(0.6)m Older people, £0.3m BHM, £0.1m Health Psychology, £0.1m Specialties, £0.1m Veterans
Non Pay	3,440	860	1,000	(140)	Drugs £(0.1)m - Older people
Specialties Services Total	**47,487**	**11,872**	**12,173**	**(301)**	**£(0.7)m Older people, £0.2m BHM, £0.1m Veterans**
Secure Serv & Offender Health					
Other Income	(479)	(120)	(926)	806	Mainly specialling income - £0.4m Female Secure, £0.3m Male secure, £0.1m FCAMHS
Pay	60,404	15,101	14,831	270	£(0.5)m Male Secure, £0.4m FIRST, £0.2m Liaison & Diversion, £0.1m Female Secure
Non Pay	9,232	2,308	2,376	(68)	
Secure Services & Offender Health Total	**69,157**	**17,289**	**16,281**	**1,008**	**£(0.3)m Male secure, £0.4m FIRST, £0.4m Female Secure, £0.2m Liasion & Diversion, £0.2m FCAMHS**
Corporate Services					
Other Income	(15,657)	(3,914)	(3,608)	(306)	£(0.4)m Nursing (offset with pay and non pay underspend), £0.1m Medical
Pay	50,028	12,507	11,573	934	£0.3m Nursing offset with income shortfall, £0.2m Resources, £0.1m SPP, £0.1m R&I, £0.1m Medical
Non Pay	39,978	9,995	10,340	(345)	£(0.4)m Estates - SSL service charge
PFI	14,388	3,597	4,026	(429)	£(0.4)m Estates - PFI water cost pressure
Capital Financing	12,034	6,190	5,778	412	£0.4m Interest receivable - Resources
Corporate Services Total	**100,771**	**28,374**	**28,109**	**265**	**£(0.8)m Estates, £0.4m Interest Receivable (Resources), £0.3m Resources, £0.2m Medical**
Healthcare Income Total	**(358,810)**	**(89,700)**	**(89,885)**	**186**	**£0.3m NR cost pressure funding from Reach Out, £(0.1)m NHSE St Andrews FIRST underperformance**
Trustwide total	**2,055**	**488**	**476**	**12**	
Surplus / (Deficit) - Trust	**912**	**(2,934)**	**(2,817)**	**117**	
Technical adjustments	(727)	(3,351)	(3,356)	5	
Adjusted financial performance Surplus / (Deficit) - Trust	**1,639**	**417**	**539**	**112**	

CAPITAL/REVENUE INVESTMENT BUSINESS CASE

TITLE:	Refurbishment of Main House for FIRST Team & Recovery Team
DIRECTORATE:	Secure Care and Patient Experience & Recovery Team
PROJECT LEAD:	Simon Parkes - SSL Head of Capital Planning & Projects
SERVICE LEAD:	Marimouttou Coumarassamy - AD Secure Care/Nursing & Quality Lead

DESCRIPTION OF PROPOSED DEVELOPMENT

Refurbishment of part Ground Floor of Main House to provide accommodation for the Forensic Intensive Recovery Support Team (FIRST) currently based in the Community Services Building adjacent to Reaside and the Patient Experience & Recovery Team.

Two options have been considered, Option 1 provides 680.72 m2 of accommodation with a total cost of £1,270,287.26 inc. VAT and Option 2 provides 862.74 m2 of accommodation with a total cost of £1,579,029.59 inc. VAT.

DRIVERS FOR THE DEVELOPMENT

The Forensic Intensive Recovery Support Team (FIRST) are currently based on the Rubery Hill/Reaside Site in the former Community Services Building, situated opposite the Reaside Main Entrance.
The Team are currently at a head count of circa. 80 and continuing to expand.
The current Community Services Building is now overcrowded and does not comfortably accommodate the staff numbers or enable Team meetings to take place in a structured manner.
The increase in new staff appointments will only exasperate this issue.
Additionally, the building facilitates therapeutic interventions on-site and clinics for physical health monitoring, etc. and this is also being impacted upon.
A Pharmacy Service is also located within the Community Services Building.

The Patient Experience & Recovery Team are also currently in need of additional space and this development would provide a number of desks for their use.

CURRENT STATUS OF ASSET

Main House was constructed in 1925 (greatly extended and refurbished in early 2000's) and has a total Gross Internal Area of 1,291.00 m2.
It was a former 27 Bed Therapeutic Community Inpatient Unit and has been vacant for a number of years (approx. 12 years?).
It is of traditional brick construction, two storey, surmounted with a pitched tiled roof.
The Total Space Requirement for FIRST and the Patient Experience & Recovery Team is approximately half to three-quarters of the total ground floor area available at Main House and it would be possible to refurbish the required area 'cosmetically' (ie; decorations, ceiling tiles, floor coverings, window blinds, etc.) to reduce overall costs.

BENEFITS OF PROPOSAL

The FIRST Team are primarily a 'community based' Team, therefore much of their work is based within the community they serve.

Staff attend the base for morning handovers, team meetings, reflective practice and clinical team meetings.
Since Covid-19, 'MS Teams' has been used widely to ensure where physical space is not possible for meetings, etc. due to the current limitations of the base, staff and others can still be connected. MS Teams doesn't, however, replace the need to physically be in the same space for many activities. Desk space for the majority of the Team can be hot-desking, however there will still need to be a set amount of fixed desk space for those such as Administration, Team Managers, etc.

Additionally, the base facilitates therapeutic interventions on-site and clinics for physical health monitoring, etc.

The Patient Experience & Recovery Team would also benefit from additional accommodation in order to continue to provide their excellent service provision for Service Users.

RISKS

The FIRST Team are currently at a head count of circa. 80 and continuing to expand.
The current Community Services Building is now overcrowded and does not comfortably accommodate the staff numbers or enable Team meetings to take place in a structured manner.
The increase in new staff appointments will only exasperate this issue.
Additionally, the building facilitates therapeutic interventions on-site and clinics for physical health monitoring, etc. and this is also being impacted upon.

The Patient Experience & Recovery Team are also currently in need of additional space and this development would provide a number of desks for their use, without which their service provision for Service Users could be impacted upon.

SUMMARY PROGRAMME

Option 1

Main House
BSMHFT Refurbishment for FIRST Team & Recovery Team Option 1

Outline Programme

										24/25			25/26							
			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Activity		**Timescale**	**Months**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**17**
Brief from Trust		Start	>>																		
Procurement of Design Team		1 Month (minimum unless framework)																			
Design		3 Months																			
Building Regulations Submission & Approval		2 Months (1 month overlap with design)																			
Trust Sign-Off		1 Month (following design completion)																			
Procurement of Main Contractor/Tender		2 Months																			
Approval/Place Order		1 Month																			
Mobilisation		1 Month (concurrent with above)																			
Construction		7 Months																			
Technical Commissioning		1 Month (concurrent with above)																			
Trust/Clinical Commissioning/F&E/ICT		1 Month																			
Ready for Occupation & Use		**16 Months Total**																>>			

June '24

From Business Case Approval and "Brief from Trust" (assumed August '24) to "Ready for Occupation & Use" is 16 Months Total (End November '25).

Option 2

Main House

BSMHFT Refurbishment for FIRST Team & Recovery Team Option 2

Outline Programme

Activity	Timescale	Months	24/25 Aug 1	Sep 2	Oct 3	Nov 4	Dec 5	Jan 6	Feb 7	Mar 8	25/26 Apr 9	May 10	Jun 11	Jul 12	Aug 13	Sep 14	Oct 15	Nov 16	Dec 17	Jan 18	Feb 19	Mar 20
Brief from Trust	Start	>>																				
Procurement of Design Team	1 Month (minimum unless framework)																					
Design	3 Months																					
Building Regulations Submission & Approval	2 Months (1 month overlap with design)																					
Trust Sign-Off	1 Month (following design completion)																					
Procurement of Main Contractor/Tender	2 Months																					
Approval/Place Order	1 Month																					
Mobilisation	1 Month (concurrent with above)																					
Construction	9 Months																					
Technical Commissioning	1 Month (concurrent with above)																					
Trust/Clinical Commissioning/F&E/ICT	1 Month																					
Ready for Occupation & Use	18 Months Total																			>>		

June '24

From Business Case Approval and “Brief from Trust” (assumed August ’24) to ”Ready for Occupation & Use” is 18 Months Total (End January ’26).

SERVICE DELIVERY IMPACT DURING WORKS INC TEMPORARY BED REDUCTION	
No Service Delivery Impact during the works as Main House is currently vacant.	
ESTIMATED REVENUE COSTS AND FUNDING SOURCE	
Maintenance	
Capital Charges	
Other Non-pay	
Total Revenue Cost	
Revenue Savings/Income (specify)	
ESTIMATED CAPITAL COSTS INC VAT/FEES (OPTION 1) - See Attachment	
Capital Works Cost	£ 823,792.00
Design Fees	£ 98,855.04
Other Costs (specify)	£ 8,237.92 Planning/Building Control/etc. £ 61,784.40 Furniture & Equipment £ 82,379.20 ICT
VAT (20%)	£ 195,238.70
Total Capital Cost	**£1,270,287.26 24/25; £250,000.00 & 25/26; £1,020,287.26**

ESTIMATED CAPITAL COSTS INC VAT/FEES (OPTION 2) - See Attachment	
Capital Works Cost	£ 1,024,014.00
Design Fees	£ 122,881.68
Other Costs (specify)	£ 10,240.14 Planning/Building Control/etc. £ 76,801.05 Furniture & Equipment £ 102,401.40 ICT
VAT (20%)	£ 242,691.32
Total Capital Cost	**£1,579,029.59 24/25; £250,000.00 & 25/26; £1,329,029.59**

Signed by Executive Sponsor……Print……..

Signed by Service Director……Print……..

Decision of Capital Review Group:

Not supported	
Request further information	
Proceed to full Business Case	
Supported in full	
Supported in part	
Referred to Resource & Development	
Commentary:	
Date:	

Birmingham & Solihull Mental Health NHS Foundation Trust

Summerhill Services Limited

Main House - Part Minor Refurbishment/Conversion for FIRST Team & Recovery Team 1

Budget Capital Costs

Refurbish and convert the Ground Floor front area of Main House to provide accommodation and WC facilities for FIRST Team & Recovery Team.
Only minor refurbishment works costed for.

New-Build	-	m2
Upgrade/Refurbishment	680.72	m2
Total Area Available	**680.72**	**m2**

Construction Budget Cost

Upgrade/Refurbishment	680.72 m2 x £1,100/m2	£	748,792.00
Allowance for potential additional Car Parking provision		£	75,000.00
Construction Budget Total		**£**	**823,792.00**
Professional Fees (Design Team Members) @ 12.0%		£	98,855.04
Trust Costs/Fees (Planning/Building Control/etc.)@ 1%		£	8,237.92
Allowance for F&E @ 7.5%		£	61,784.40
Allowance for ICT @ 10%		£	82,379.20
VAT @ 20% (Professional Fees excepted)		£	195,238.70
TOTAL SCHEME BUDGET COST (inc. VAT @ 20%)		**£**	**1,270,287.26**

NOTES

i) Greatly reduced m3 rate used as only minor refurbishment works costed for.
ii) Assumed all mechanical and electrical services are in working order.
iii) Assumed 'Grasscrete' for any potential additional Car Parking provision.
iv) Capital Requirement to be split over two years as follows;
- 24/25 £ 250,000.00 Design, Procurement and Start-on-Site.
- 25/26 £ 1,020,287.26 Completion of Building Works, ICT Install and F&E.

v) Consider VAT Reclaim?

Birmingham & Solihull Mental Health NHS Foundation Trust

Summerhill Services Limited

Main House - Part Minor Refurbishment/Conversion for FIRST Team & Recovery Team 2

Budget Capital Costs

Refurbish and convert the Ground Floor front area of Main House to provide accommodation and WC facilities for FIRST Team & Recovery Team.
Only minor refurbishment works costed for.

New-Build	-	m2
Upgrade/Refurbishment	862.74	m2
Total Area Available	**862.74**	**m2**

Construction Budget Cost

Upgrade/Refurbishment	862.74 m2 x £1,100/m2	£	949,014.00
Allowance for potential additional Car Parking provision		£	75,000.00
Construction Budget Total		**£**	**1,024,014.00**
Professional Fees (Design Team Members) @ 12.0%		£	122,881.68
Trust Costs/Fees (Planning/Building Control/etc.)@ 1%		£	10,240.14
Allowance for F&E @ 7.5%		£	76,801.05
Allowance for ICT @ 10%		£	102,401.40
VAT @ 20% (Professional Fees excepted)		£	242,691.32
TOTAL SCHEME BUDGET COST (inc. VAT @ 20%)		**£**	**1,579,029.59**

NOTES

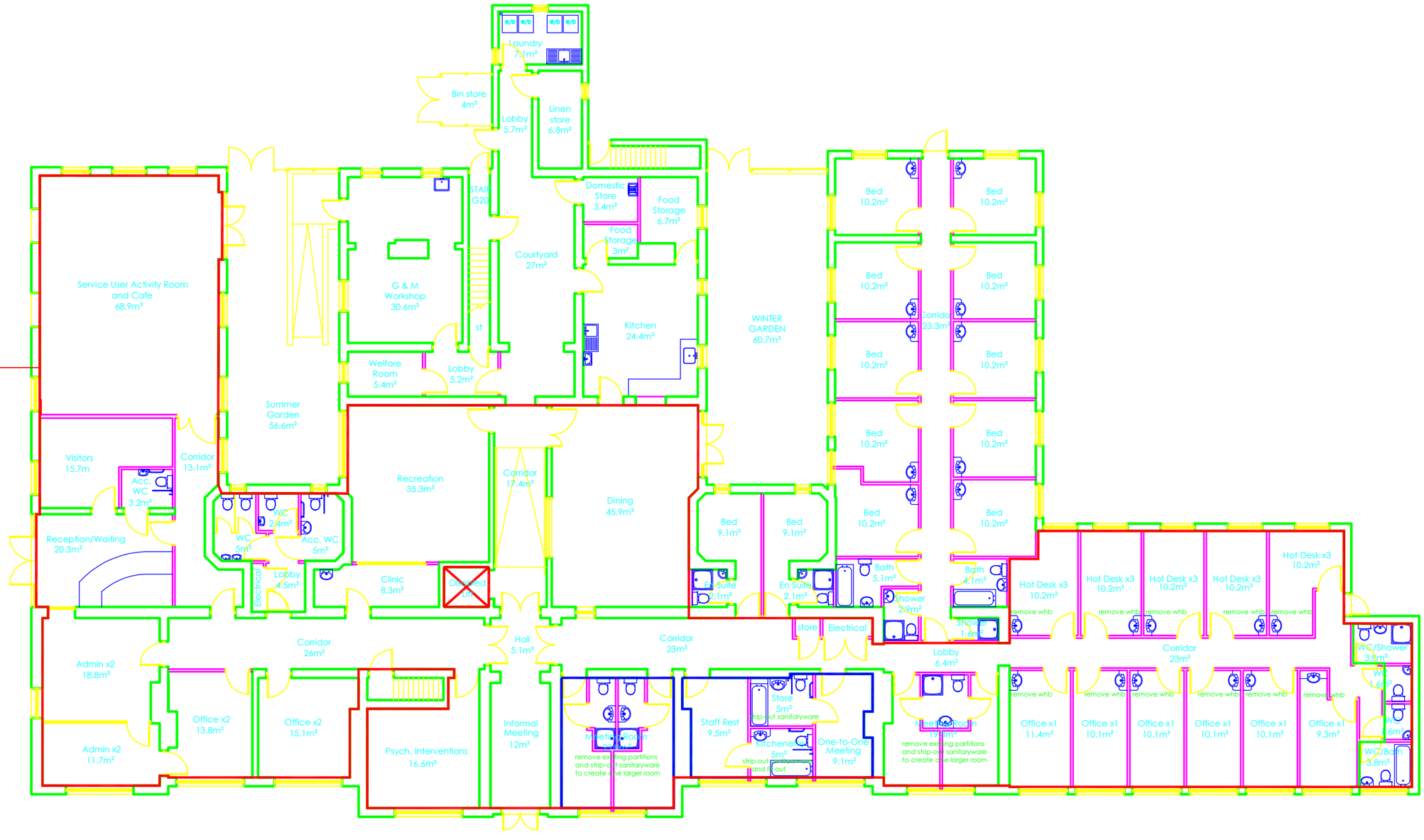
i) Greatly reduced m3 rate used as only minor refurbishment works costed for.
ii) Assumed all mechanical and electrical services are in working order.
iii) Assumed 'Grasscrete' for any potential additional Car Parking provision.
iv) Capital Requirement to be split over two years as follows;
- 24/25 £ 250,000.00 Design, Procurement and Start-on-Site.
- 25/26 £ 1,329,029.59 Completion of Building Works, ICT Install and F&E.

v) Consider VAT Reclaim?

MAIN HOUSE

Area identified by red boundary to be refurbished/converted into accommodation for FIRST Team & Recovery Team

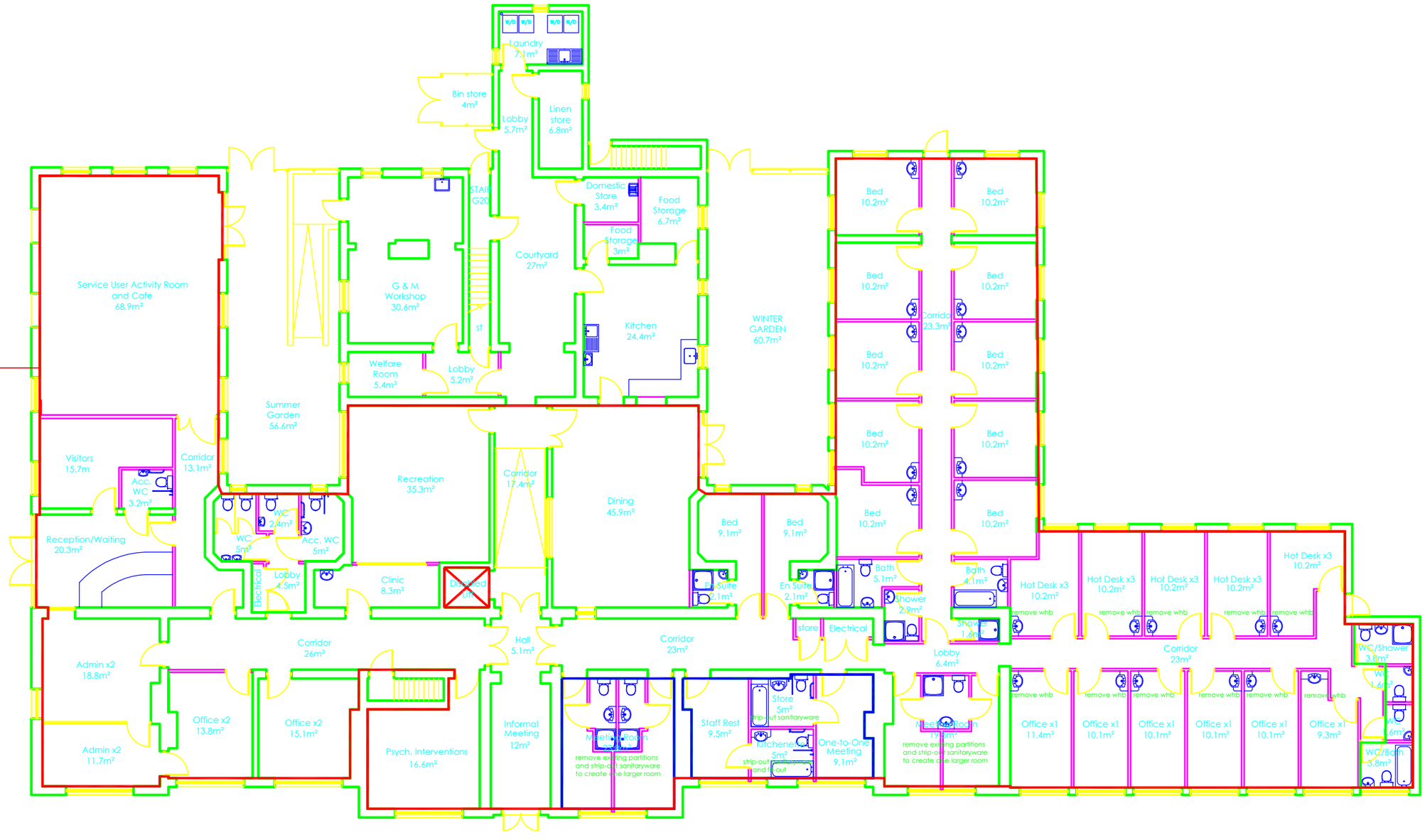
(680.72 m2)



MAIN HOUSE

Area identified by red boundary to be refurbished/converted into accommodation for FIRST Team & Recovery Team

(862.74 m2)



Report to the Board of Directors

Agenda item:	15					
Date	7 August 2024					
Title	Highcroft Business Case					
Author	Contributors from Finance, PMO, Estates, Acute & Urgent care					
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	✓

Purpose: This report updates the Committee on the situation regarding the Highcroft business case and asks for endorsement of the next steps.

Introduction: The reprovision of inpatient facilities at the Highcroft site in Erdington and Reaside has long been a priority for the Trust, as referred to in the Trust Strategy on an ongoing basis. Both are also a strategic priority for Birmingham and Solihull ICB/ICS and have been for several years. The costs of the overall schemes each run to £100m+. The original route to funding was via the Department of Health and Social Care's new hospital building programme. Expressions of interest were submitted in September 2021. The expression of interest set out details of a new 144-bedded development in respect of the Highcroft site to replace existing wards and additional wards to meet demand and capacity modelling.

In May 2023, the Department of Health notified via email the Trust that the scheme was not selected to join the programme. This means in effect, the only real means of funding the scheme is via the local Integrated Care System, though there are constraints to such funding. We have therefore been working on an initial phase for the provision of 2 * 16-bedded wards at Highcroft.

Current position: A short form business case has been developed by a multi-disciplinary team across the Trust, including significant clinical involvement. This business case is consistent with earlier versions of the business case that were endorsed by Board and FPP, though it is for the 32 beds noted above at a capital cost of just under £25m and an annual revenue cost of £7.3m. The revenue costs compare favourably with comparative costs from the private sector.

The business case was endorsed by Executive Directors for submission to the ICB's Investment Committee, who approved the case in principle on 12 June. They now need to identify how the capital funding can be provided.

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 asked to:

1. **NOTE AND ENDORSE** the business case, the preferred option and the financial implications.
2. **GAIN ASSURANCE** that the business case has been developed by a multi-disciplinary team and the clinical model and staffing has been approved by the Medical Director and the Chief Nurse.
3. **DELEGATE AUTHORITY** to the Director of Finance as Senior Responsible Officer for the scheme to take the necessary steps to move forward, including the provision of monitoring and progress reports.
4. **APPROVE** arrangements for ongoing governance and assurance by way of assurance reports

Enclosures

1. Short Form Business case for the development of two adult wards (separate reading pack)

Report to Board of Directors

Agenda item:	**16**					
Date	7 August 2024					
Title	**Summerhill Services Ltd (SSL) Quarterly Report**					
Author/Presenter	Shane Bray, Managing Director SSL					
Executive 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**	✓

The report details the performance and activities of SSL during April-June 2024.

The report provides further details of SSL's financial performance, HR activities and assurance, and the performance and activities of the services provided by SSL to the Trust and Primary Care. The key services include:

- Facilities Management
- Property Services and Sustainability
- Transport and Logistics Services
- Capital Projects

Recommendation

The Board is asked to receive the report for assurance.

Enclosures

SSL Quarterly Report (April-June 2024)

Strategic Priorities

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

Summerhill Services Limited (SSL) Business Report

April 2024– June 2024

This report summarises the performance and activities of SSL from April 2024 to June 24.

The first quarter of this year has been very busy, with implementing the numerous capital projects across the Trust, implementing a new estates management tool, which will provide more in-depth information on maintenance tasks, as well as developing a complexly new food and catering system for the trust called Symbiotics.

SSL is continuing to work hard to reduce our agency costs and as result we have created our own weekly bank, which has grown to 85 members of staff. Since its commencement we have seen further reductions in our overtime and agency costs.
Recruiting and maintaining our staff levels of 390 staff members is always a key priority. SSL uses a variety of recruitment avenues including our "refer a friend" scheme, working with charities, recruitment fairs, and external advertisement.
In addition, SSL now has 12 apprentices, which are a combination of internal staff and external recruitment, which enables SSL to develop new staff members in key harder fill roles.

SSL continues to work with partners across the BSOL healthcare system to identify new opportunities, which can deliver improved performance and service quality, increase revenue and provide financial benefits to the Trust and our healthcare partners. SSL has been working with BSol ICS to continue to develop the systems Green Plan, working with primary care to support over 270 GP's, as well as providing project management support for key capital projects. Nationally, SSL has worked with a number of trusts on capital projects and delivering our patented PFI HealthCheck.

SSL Pharmacy services continue to perform well. Our Pharmacy team have recently implemented a new prescription Tracker system which allows key healthcare staff to track their prescriptions through a dedicated portal. Also, after 8 productive and successfully years, we are now looking to upgrade our pharmacy robot to the latest model.

The report below gives further details of our financial performance, HR activities and assurance and the performance and activities of the services provided by SSL to BSMHFT and Primary Care. The key services include:

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

Birmingham and Solihull Mental Health NHS Foundation Trust

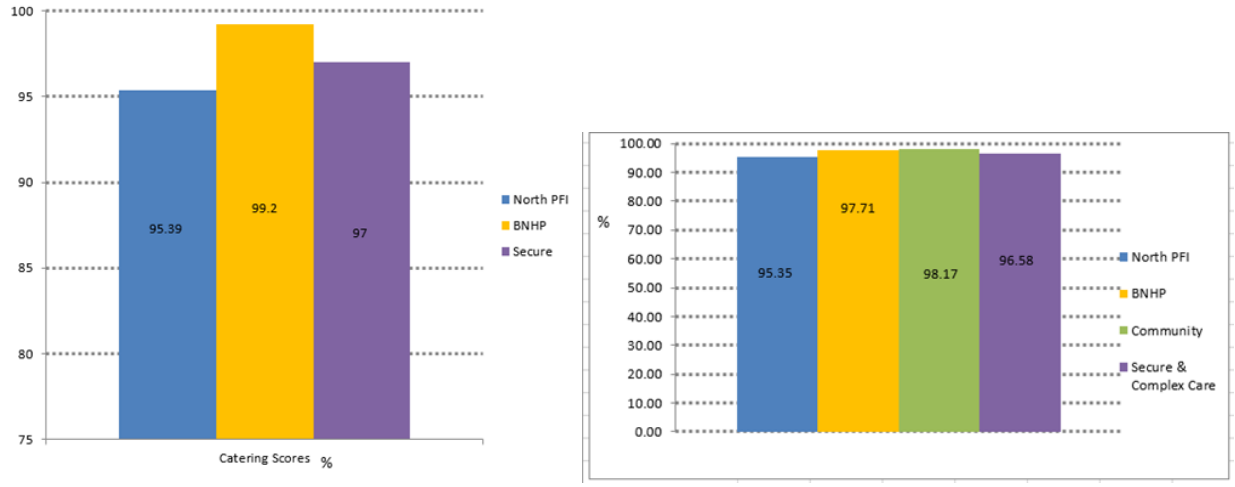
Facilities Management

Domestic and Housekeeping Services

- Successful implementation of the New National Cleaning Standards completed.
- SSL have an accredited training course– thought to be the only provider in the country with a fully accredited training course for the New National Cleaning Standards
- Level 2 Infection prevention in cleaning training offered to all Facilities teams.
- SSL have an approved NHS Cleaning Standards Training Course which is included in inductions.
- SSL- Sue Ladkin and Trust IPC-Zalika Geohaghon have won the ACHP Infection Prevention and Control Initiative award for their comprehensive work on the cleaning roadshows.
- Access Card Management review completed with additional resources required due to Trust demand on Agency and new staff.

Catering Services

- Master Catering Programme 23/24 project group has commenced, the programme of works includes:
    - New 4 weekly menu and recipe book – recipe book has been completed; menu developed with Trust dietician.
    - Implementation of new food management and tablet-based ward ordering software. – Implementation plan formulated.
    - Re branding of all SSL managed cafeterias.
    - Review of internal retail pricing underway across all sites
    - Revised and enhanced loyalty card scheme.
    - Production of Master Catering Folder underway.
- The EHO inspected kitchens all achieving a 5 star rating.
- Review of Cultural / Theme day menu is underway with discussions scheduled with Trust EDI lead and head of Spiritual Care – All meat purchased will be Halal.
- SSL have been working collaboratively with NHS Supply Chain; Food (Tower 10) integrating the Multi-Temperature Distribution model to achieve value for money.
- Compostable eco-friendly cutlery, takeaway containers, and carrier bags with approximately 80% of all disposable items purchased compostable, to support the NHS “Plastic Pledge”.
- Catering apprentice chef programme to commence (August 2023) across 5 production kitchens in partnership with Solihull College and Trust L&D
- Food Safety Specialist – Draft person spec and JD have been completed and circulated to the Trust for approval prior to the commencement of the recruitment process.



Laundry and Linen Management

Regular contract, service quality and performance meetings are conducted Trust wide supplier for laundry and linen Elis, by SSL, the Trust and PFI Partners with the supplier.

- Multiple meetings have been held with SSL / Trust procurement teams to review position, but the only viable option was to extend the contract with Elis temporarily.
- Specification and KPI's have all now been agreed with Oxwash, site visits have been carried out- once the contract is signed there is a 60 day mobilisation period.
- Standing order data has been reviewed and updated with unit price remaining the same.
- Awaiting BSOL procurement to align contract doc with Specification.
- IPC team have approved the Ozone disinfection method utilised by Oxwash.

Grounds and Gardens

- Ground Control have now replaced Goulds Landscapes across North PFI and Retained estate.
- Tree surgery works have been scheduled and underway across multiple sites.
- We have been successful in recruiting for a new Grounds and Gardens supervisor, Gary Knight who commenced his employment on the 8th July 2024. Gary was previously a lecturer at Warwich College (horticulture), managed his own business and is a Tudor Rose award winner.

Transport & Logistics

- Non Urgent Patient Transport (NEPT) – expansion of NEPT and Taxi core hours from 06:00 am to 22:00 is still available, proposal submitted to the Trust.
- We have progressed a NEPT vehicle replacement programme as the vehicles are over 5 years old and now starting to cost in downtime and extra maintenance. Minimum of 17 vehicles to be replaced 24/25.
- Tissue Viability Products, logistic contract 6-month trial agreed and progressing from August 23.
- SSL Warehouse – logistics, Trust uniforms, PPE, etc now operate from SSL HUB. Birmingham Community PPE service, possible Medical Devices, plus the Trust ICT team will operate from a purpose-built offices providing new device and support to all trust staff.
- Current Warehouse provision:

- PPE, Trust Uniforms,
- SSL Uniforms,
- Covid tests,
- Other: Blood pressure monitors, Bins for Recycling, Ecig, Food, and sharps, and Physical health equip.

- Potential future provision: Dressing, Nutrition's/ Supplements, SSL Dry Goods, Cleaning Products
- SSL still able to provide Trust General Transport service – pharmaceutical, specimen, samples, post – additional activity undertaken during COVID with delivery of samples for testing to acute hospitals.

Water Management
Water management is a well-documented and structured process for all members of the Trust and SSL staff. SSL and Trust operate and manage over 50 sites across BSOL, however, over the past year one building has been more challenging more than others – Forward House.

Forward House

- The building is fully open and occupied.
- Dosing levels are consistent to every outlet
- The site is now at circa 99% clear of Legionella, these outlets have 3 + consecutive Non – detected results.
- Trust Water Safety Group have approved for filters to be removed from these clear outlets.
- Trust WSG have approved testing to be moved to 3 monthly sampling
- There are 3 outlets with low legionella counts. Of these outlets have a program to have the local pipes replaced to eradicate this issue.
- Filters remain on these outlets
- These outlets will be sampled and assessed.

The Property as stated by various Authorised Engineers & Microbiologist is now in a good position.

The Water Safety Group comprises; Trust Nurse Management, Trust Clinical Management, SSL Estates, Trust appointed Microbiologist, Trust Infection Prevention Team, and Authorising Engineer. In addition, due to the challenges, SSL appointed a Water Safety Specialist (the appointed specialist is also a qualified Authorising Engineer) to add further experience and knowledge to options and decision making, in addition to give an informed but unbiased independent opinion.

SLAs in place for Juniper (on Moseley Hall Hospital site). SLAs haven't been reviewed by Community Trust since 2017. Considerable cost increases anticipated.

Trust Medical Equipment (EBME) 42% of equipment not presented by the Trust teams for SSL Contract service and PA Testing. Issue escalated within Trust.

Digital FM Progression

- CAFM system – Contractor element of the system is now live cross the community sites along with the compliance dashboard – Further development release is due 1st August which enables reactive contractor jobs to be linked to the corresponding contractor PPM in the dashboard and also interactive reports. Reaside data is currently being populated into the system in readiness for "Go Live" in September (due to annual leave) with Tamarind and Ardenleigh to follow close behind.

- Awaiting initial costs for the development of interactive FM auditing tool development via Asckey – this will be the next phase.
- Food Management System Implementation – Initial Go Live @ Ardenleigh proposed for - October 2024 –Initially a new 2 week menu (expanding to 4 week), clinical teams ordering food via the tablets on a ward, stock ordering, management and waste recording via X Cater food management system.
  Once we have implemented the system @ Ardenleigh we will test for a month to iron out any issues and collate any feedback which will then enable us to fix the Go Live days for the other sites (again phased over 4 months). – it all depends on the feedback we get from Ardenleigh on the new menu / system in general, if everything goes well then November – Feb 2025 across other production kitchen sites.

  Once we are ready for the go live on the food management system we have a whole comms package that we have been working on which we will present at the site in question.

  Clocking in systems (Secure Care and South PFI sites) – SSG have approved the clocking in system, draft formal process / procedure document has ben completion and is being reviewed by the operational teams prior to discussions with HR.

Capital Projects

- Capital Programme 23/24 completed successfully.
- Capital Programme 23/24 progressing ahead of plan.

Current Capital Programme - 2024/25 @ £11.91m

Following a recent re-submission of the Annual Capital Plan, group capital expenditure for 24/25 is expected to be £11.91m, which includes £1.60m of system capital.

This includes a BAU capital envelope of £6.25m, funding for R&D equipment of £0.66m, an IFRS 16 credit from the revaluation of B1 of £2.60m, an additional £0.80m of PDC funded works in Acute & Urgent Care and an additional £1.60m of System Capital. When re-submitting the plan, the cashflow phasing was amended so that spend is weighted towards the end of the Financial Year.

Capital Schemes	**Annual Plan**
Approved Schemes:	**£'m**
Minor Projects (inc. Carry-Forward)	2.29
SSBM Works	2.02
Doorsets	0.71
Lease Vehicle Renewals	1.00
NEPT Vehicle Replacement	0.44
Orsborne Car Park Lease Recognition	0.10
Phoenix House Lease Recognition	0.06
R&D rTMS Machines	0.66
Design Work/Start On Site - Forensics Capital Bid	0.75

Medical Device Replacement	0.10
CAMHS Seclusion Suite	0.08
AUC PDC Funded Programme Works	0.80
Unallocated IFRS16 Spend	0.99
Unallocated Core Spend	0.38
Unallocated Additional System Capital	1.60
Total	**11.91**

- A number of the Minor/Risk Projects have been split over two financial years following the Trust prioritisation process, due to the availability of insufficient funding.
- Project work associated with Main House, 24/7 Service, Northcroft Cladding, Acute bathroom upgrades, Reaside SSBM, etc.
- SSL supporting Black Country Healthcare FT on their Capital programme, on 6 schemes ·
- Highcroft several further options developed and commitment to deliver the Business Case for a 32 bed £25m facility.
- SSL to manage Design, Construction, Procurement & Contract stages; initially up to RIBA Stage2.
- Concern regarding securing of Capital funding for major Highcroft and Reaside developments
- Reaside project discussions begun with partner opportunities following Department of Health announcement of the next phase of major funded schemes, which doesn't include BSMHFT sites. Concern regarding age, functional suitability, lifecycle and High/ Significant Backlog Maintenance requirement of the current facility. To 'stand-still' (compliance, backlog, lifecycle) we need to invest hundreds thousands per annum, this doesn't address aged poor functional building.

SSL PFI/Contract Management

- ERIC has been challenging in gaining required data for submission, but this has been completed July 2024
- SSL contract and performance manages two significant and complex PFI contracts
- SSL finalised Settlement Agreements across both PFI's following performance management challenges of services. These agreements delivered high six figure settlement values. Plus Energy Management settlement of six figure sum. Total circa **£2m** income to the Trust.
- The SSL PFI Team have been invited by PFU to act as an exemplar Trust to support and share good practice with other Mental Health NHS Trusts with PFI Projects. SSL will continue to develop relationships with other trusts to assist them with their PFI needs and requirements.
- PFI Health Check Paper external projects underway with commissions from Trusts, DoH, and Private sector SPVs. Intellectual Rights achieved to protect the document for SSL.
- SSL are starting our 9th Market Test, this being the BNHP Joint Services Market Test. Challenging, with significant cost avoidance, whilst retaining positive relations with all stakeholders. Programme over 24/25 for conclusion March 2025.

ICS Primary Care

SSL provide the Estates Management and Strategic support across the Birmingham and Solihull ICS (former CCG) service area plus added West Birmingham geographical area.

- Significant progress has been made in the reporting period with the completion of Locality Clinical and separate Locality Estates Strategies.
- With focus on delivering the objectives detailed in the Fuller Report, SSL have been providing Estate support and advice to set up and support several Primary Care Hubs. These provide significant reduction to secondary care pressure by providing a clinical pathway for same-day urgent GP appointments.
- Void and Underused Bookable Space reports completed on CHP/ NHS PS properties.
- SSL is also leading a project to assess the accuracy of the information held for system wide void and bookable space. National rollout of ADEPT with BSol as a pilot in scope.

- Capital Programme, working in conjunction with NHS PS, SSL are overseeing the refurbishment circa 25 GP medical records rooms to become clinical rooms for circa £800k, which is incredibly cost effective verses building a new Health Centre at £20m for 15 Clinical room provision.
- In addition to the Primary Care Estates business as usual work plan SSL have continued to provide support for.
    - 2 Mobile clinics
    - Community Red sites
    - Vaccination Centres across Birmingham and Solihull
    - Primary Care Capital Works
    - Net zero Carbon projects
    - GP lease renewal negotiations etc

Outpatient Dispensing Services Apr-23 to Oct-23

- Summerhill Pharmacy dispenses 15,000 items on average per month accounting for 55% of medication items dispensed by the Trust pharmacy services.
- SSL had 8 externally reportable incidents during this period. No service users were harmed as a result of these externally reportable incidents and all of them have been dealt with promptly.
- SSL implemented an upgrade to its Prescription Tracker which tracks our pharmacy prescriptions (Please see Appendix D). The upgrade has improved accessibility, systems security, and provided resilience to staff members covering multiple sites.
- SSL Pharmacy is underway upgrading its compliance aid machine.
- SSL robot continues to deliver an accuracy of 99% on compliance aids (see appendices)

Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	June-24
99%	99%	99%	99%	99%	99%	99%	99%	99%

Financial Performance

SSL was adverse by 1% (£75K) ahead of budgeted revenue after the first 3 months of this financial year. This is mainly due to additional pay costs including agency and bank, and inflationary pressures. Revenue from External work is steady for our 3 main revenue streams , Primary Care, Trusts/ICS and PFI Consultancy.

- Primary Care – We continue support over 270 GPs across BSOL, The focus of work has now moved away from COVID and now more around monitoring Rent, Space Utilisation and Capital work
- Trust/ICS – We are supporting the ICB with their Sustainability/Green plan along with providing Project Management support for two key ICS developments. We continue to provide Consultancy Support to The Black Country NHS Trust Capital Team
- PFI Consultancy – We have been commissioned by 2 organisations to complete our patented "PFI HEALTHCHECK". There is an additional pipeline of projects for the 2nd half of the financial year which the team are working on

In line with the Trust, SSL remains focused on reducing its agency costs, which has been reduced to 3.4%. We have also implemented additional processes around recruitment to ensure strict financial controls are maintained.

We have included (appendix B) is a table detailing our 5 yr Forecast and a cost benefits statement which shows how SSL delivers over £4m in financial benefits to the Trust annually.

Resourcing

- SSL now has its own weekly bank and has grown it's bank from 35 people on the Truss to 85 members of staff since its commencement to 88 to reduce reliability on overtime and agency.
- SSL overall establishment has increased to 390 with vacant positions being filled through it's refer a friend scheme, working with charities, recruitment fairs, and also external advertisement.
- SSL now has 12 Apprentices, which are a combination of internal staff and also external recruitment.
- SSL is now carrying out a Strategic Review of its Resources and conducting a talent map across the organisation aligned to its business plan to identify where it will appoint future apprentice positions for commencement 2025.
- SSL has developed and approved its first Graduate Scheme. SSL is looking to commence 2 graduates 2024/2025, focussed on external PFI and commercial activities and Capital projects.
- SSL has assisted a new Early Years, Leadership and Training Manager to support it's development of its Future programme and ensure its Graduates and Apprentices are supported through their programme.

Reward and Recognition

- SSL held in July its 2nd People and Values award whereby it celebrated its staffs achievements across 12 categories, including an award for its values, Kindness, Inclusion, Respect, and Excellence in Survey Delivery. The event was extremely popular with representation from all SSL's Teams.
- SSL is currently reviewing our Pension Arrangements and looking to appoint Pension Advisors after a competitive process. This will see SSL improve its Pension Provision to employees and offer advice and guidance for future development.

Birmingham and Solihull Mental Health NHS Foundation Trust

Health Surveillance

- SSL Board has approved three new policies which are related to Health Surveillance: Health Surveillance Policy, Pre-employment Health Checks, and Vaccination and Immunisation Policy.
- SSL has produced a health surveillance matrix for all roles and has commenced an eight month health surveillance programme for all employees.
- SSL has also reviewed its pre-employment health profiles, and has commenced a programme of ensuring all its employees vaccinations records are upto date,

Equality, Diversity & Inclusion

- SSL EDI Forum goes from strength to strength with all advocates undertaking training on SSL policies, SSL has introduced a support pack for EDI advocates, and all advocates have undertaken a site visit programme again to support employees.
- SSL has also undertaken training with all Employees who wish to become recruitment buddies, whereby SSL will ensure for all F grade positions and above moving forward a recruitment buddy forms part of the panel

SSL YOURS+ Survey

- 74% of all SSL participated in SSL first staff perception survey entitled the Yours Survey.
- Staff were given time away from their duties to either complete electronically or a paper based survey. This was important for SSL staff due to a range not being IT literate and not having easy access to computers.
- Overall results were extremely positive and broken down into the following themes: Culture, Leadership, Enablement, Alignment, Development, Values, Satisfaction.
- Over 80% of participants agreed that they were satisfied with their job and 71% stated they would recommend SSL as a great place to work.
- Whilst all areas were extremely positive areas for SSL to review and consider are Staff Development and Pay and Reward.
- All Free Text fields have also been considered and an SSL Action Plan has been developed, with Heads of Departments also considering local action to be taken.

	Reaction	%
Values and Respect	Positive	73%
	Neutral	19%
	Negative	8%

	Reaction	%
Leadership and Company Direction	Positive	73%
	Neutral	16%
	Negative	11%

	Reaction	%
Training and Development	Positive	62%
	Neutral	25%
	Negative	13%

	Reaction	%
Job Satisfaction	Positive	67%
	Neutral	22%
	Negative	11%

Birmingham and Solihull Mental Health NHS Foundation Trust

Business Development, Opportunities and Plans

Corporate, Property and Sustainability

- SSL will be developing further the 'Green Plan' for the Trust set against baseline data & target.
- Birmingham Council leased premises- Phoenix used is being refurbished to create enhanced Secure service provision in Erdington.
- For the Trust and BSoL ICS – SSL have reviewed, gathered information and completed in full- and on-time returns required by NHSE. Including Transport, Green NHS, and Property.
- PAM submission returns complete containing 400+ compliance and assurance reviews.
- PLACE review completed 2024.

- It should be recognised that the volume and detail of the returns requested / required by NHSE is becoming ever more onerous to feed the NHSE 'machine'
- SSL will be introducing both food waste recycling (sites with preparation kitchens) and a 'OPT in' waste recycling option for the Trust
- SSL have been working with National Express regarding issue of free bus passes for all new SSL and Trust starters – encouraging sustainable travel
- SSL developing an EV charge-point option for Trust to consider for staff, visitors , and patients.
- SSL are developing its 'fleet' to support BSMHFT Services by adopting Plug in Hybrid and/or electric vehicles where it can, within costs and range permit.
- SSL has managed energy procurement on behalf of the Trust with 100% directly procured electricity from Zero Carbon sources.
- The B1 lease break has now been activated, with high level property negotiations underway, looking for Trust early exit from their lease obligations.
- Trust Strategic Property Group managing property occupation with recommendations to Trust Capital Review Group and OMT..
- SSL developed Sustainable Development Strategy & Action Plan (Green Plan) on behalf of Trust

Business Development, Opportunities and Plans

PFI Consultancy

- SSL continues to develop our PFI consultancy services which includes PFI Health check (Trademarked), PFI Handback and LIFT Co Consultancy.
- We have a number of contractual and performance commissions including
    - Newham
    - Gloucestershire
    - North Staffordshire
    - West Birmingham
    - Black Country
- We have also been approached by leading PFI finance providers SPVs to deliver healthchecks on their portfolios – we are evaluating the resources required and the potential contract value.

- In addition, we are supporting another local trust with their Capital programme, details to be confirmed.
- NHSE have contacted SSL to seek support at a struggling significant Midlands PFI- early days but this will be updated as the opportunity unfolds.
- NHSE have contacted SSL to seek support at a National conference in particular Primary Care- early days but this will be updated as the opportunity unfold

Training

- We have one of the first accredited training hubs to delivery the new National Cleaning Standards. This has given us an opportunity to develop further new business opportunities with external partners:
    - External Training courses underway with Amey for NHS Cleaning Standards & Level 2 Food Safety

Facilities Management

- We have quoted and been successful for several facility contracts within BSOL primary care.
- We are also delivering services for one of the largest PCN's in the UK

Governance and Assurance

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

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

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

SSL

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Appendix A – Financial Statement April 24 – Jun 24

SSL Financial Position	Annual budget	M3		
		Budget	Actuals	Variance
	£'000s	£'000s	£'000s	£'000s
Sale & Leaseback	15,095	3,774	3,882	109
Lease & Long License	3,135	784	813	29
Contract Management	2,071	518	490	(27)
Facilities Services	4,149	1,037	1,021	(16)
Grounds and Garden	399	100	58	(42)
PPE & Warehouse	166	42	74	33
Pharmacy	2,485	621	603	(19)
External Services - Head of Assets	289	72	88	16
External Services - STP	103	26	18	(8)
External Services - CCG Vaccine Pro	0	0	30	30
External Services - PFI	250	63	22	(41)
External Services - FM	40	10	22	12
Total income	28,181	7,045	7,121	75
Pay costs	(11,759)	(2,940)	(2,985)	(45)
Drug costs	(2,112)	(528)	(525)	3
Non pay costs	(8,114)	(2,028)	(2,175)	(147)
Clinical supplies costs	52	13	(5)	(18)
Total Expenditure	(21,933)	(5,483)	(5,690)	(206)
EBITDA	**6,248**	**1,562**	**1,431**	**(131)**
Depreciation	(2,886)	(721)	(710)	11
Interest Payable	(2,003)	(501)	(512)	(12)
Interest Receivable	0	0	0	0
Finance Lease	(369)	(92)	(95)	(3)
Profit / (Loss) before tax	**990**	**247**	**113**	**(134)**
Taxation	(380)	(95)	(100)	(5)
Profit / (Loss) after tax	**610**	**152**	**14**	**(139)**

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Appendix B – 5 Yr Forecast and Benefits Statement

SSL I&E 5 Year Forecast	21/22 Actual £000's	22/23 Actual £000's	23/24 Actual £000's	24/25 Forecast £000's	25/26 Forecast £000's	26/27 Forecast £000's
***Total Trading Income**	**26,610**	**28,070**	**29,417**	**28,181**	**29,590**	**31,070**
Pay Costs	(9,269)	(10,449)	(12,286)	(11,759)	(12,347)	(12,964)
Drug Costs	(2,820)	(2,980)	(2,645)	(2,112)	(2,218)	(2,329)
Non Pay Costs	(8,312)	(8,431)	(8,977)	(8,062)	(8,465)	(8,888)
Total Trading Expenditure	**(20,400)**	**(21,860)**	**(23,908)**	**(21,933)**	**(23,030)**	**(24,181)**
EBITDA	**6,210**	**6,210**	**5,509**	**6,248**	**6,560**	**6,888**
Depreciation	(3,984)	(3,377)	(3,105)	(2,886)	(2,706)	(2,706)
Interest Payable	(2,132)	(2,107)	(2,081)	(2,003)	(1,907)	(1,808)
Finance Lease	(389)	(380)	(382)	(369)	(388)	(407)
Total Capital Financing	**(6,505)**	**(5,864)**	**(5,569)**	**(5,258)**	**(5,001)**	**(4,921)**
Profit / (Loss) before Tax	**(296)**	**346**	**(61)**	**990**	**1,560**	**1,967**
Benefit to the Trust						
Tax Efficiency	994	1,336	1,261	1,120	1,239	1,282
Managed Service Operational Benefits	783	1,078	1,332	1,345	1,359	1,372
Staff/Operational Savings	1,148	1,550	1,648	1,468	739	786
Total Benefit to the Trust (Not in P&L)	**2,924**	**3,965**	**4,241**	**3,933**	**3,337**	**3,440**
Total Benefit after Tax	**2,629**	**4,311**	**4,181**	**4,923**	**4,897**	**5,407**

Birmingham and Solihull Mental Health NHS Foundation Trust

Appendix C: Dispensing Performance Community Teams

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

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

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

	May 2024	June 2024	Avg.
Compliance Aid	96	95	96
OUTPATIENT	95	97	96
OUTPATIENT (URGENT)	98	96	97
To-Follow	100	95	98
Repeatable Prescription	97	95	96
Repeatable Compliance Aid	96	95	96

Committee Escalation and Assurance Report

Name of Committee	**Audit Committee**
Report presented at	**Board of Directors**
Date of meeting	**7 August 2024**
Date(s) of Committee Meeting(s) reported	**26 July 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 • Internal Audit Progress Report • Internal Audit Action Tracking Report • Internal Audit Annual Report 2023/24 • Internal Audit Strategy 2024/25 • Internal Audit Reviews: Seclusion and Long-Term Segregation; DSP Toolkit; Bank Staff Management • Local Counter Fraud Specialist Progress Report • External Audit Report • Patient Transport Contract Procurement • Single Tender Waivers Report
Alert:	The Committee considered the **Bank Staff Management** internal audit review, which had been given a **minimal assurance rating.** Some issues related to clarity of procedures and documentation were raised, however assurance was received that the team had responded quickly to recommendations and a number had already been completed. The Committee received an advisory review into the level of awareness and knowledge of **Seclusion and Long-Term Segregation** amongst staff, conducted through a survey. Findings were broadly positive, although there had been a low response rate to the survey that identified more work was required to educate and raise awareness of the policy.
Assure:	The Committee was assured on the following areas: • The **Data Security and Protection Toolkit** internal audit review had been given a **Substantial** rating. • Positive assurance was received through the Local Counter Fraud Specialist Report, highlighting some good practice throughout the organisation and proactive work to continue to raise awareness. • The external audit report advised that the audit had been completed with no weaknesses identified in relation to Value for Money.

Advise:	The action tracking report highlighted a concern in relation to lengths of time for policy review. The Committee was assured by the increased scrutiny of action tracking at executive team meetings. The internal audit annual report 2023/24 was received, highlighting the Head of Internal Audit Opinion which was based on the five partial and two minimal assurance reports that had been undertaken during the year. The report would be provided to the Board of Directors.	
Board Assurance Framework	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. The Board strategy session would be held in September to review and agree the revised BAF. The Committee identified some issues to escalate to the Commissioning Committee in relation to the Commissioning BAF, which was also undergoing revision.	
	New risks identified: no additional risks were identified.	
Report compiled by:	Winston Weir Non-Executive Director	**Minutes available from:** Kat Cleverley, Company Secretary

Committee Escalation and Assurance Report

Name of Committee	**Caring Minds Committee**	
Report presented at	**Board of Directors**	
Date of meeting	**7 August 2024**	
Date(s) of Committee Meeting(s) reported	**29 July 2024**	
Quoracy	**Membership quorate: Y**	
Agenda	The Committee considered an agenda which included the following items: • Updated Criteria and Application process • Development plan for the aims and objectives 2024/2025 • Charity Update • Financial Update • Caring Minds Resource Plan • Cazenove (Schroders) Portfolio Update • Cazenove (Schroder's) BSMHFT comparison CMAF vs SMAF • Events and Engagement post – continued funding via Charity after 12 months funding from NHS CT is complete (Jan 2025)	
Alert:	The Committee noted there are no Trust funds available to support the charity due to the ongoing financial challenges.	
Assure:	The Committee was assured on the following key areas: • Away day scheduled and diarised for 30 September 24 for deep dive into agreeing the purpose, ambitions and objectives of the charity. • Caring Minds continue to support bids with feedback being showcased on the positive impacts for service users, carers, families and staff	
Advise:	• Events and Engagement post funding approved by charity funds on a permanent basis. • Updated criteria and application processes have been approved. • Cazenove (Schroder's) BSMHFT investment portfolio approved change from the current investment in the Charity Multi-Asset Fund (CMAF) into the Sustainable Multi-Asset Fund (SMAF).	
Board Assurance Framework	The Board Assurance Framework risks are being developed.	
	New risks identified: No new risks were identified.	
Report compiled by:	Monica Shafaq, Non-Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

Report to Board of Directors

Agenda item:	**19**					
Date	7 August 2024					
Title	Trust Seal Report					
Author/Presenter	Safia Khan, Head of Legal Services Kat Cleverley, Company Secretary					
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**	✓

Lease in relation to access to the electricity substation site at Parkview Clinic.

Trust Seal Number 1/2425.

The Trust Seal was used on 1 July 2024 and affixed to a lease for access to the electricity substation site at Park View Clinic, Queensbridge Road Birmingham B13 8QE. The lease is between the Trust, National Grid, Summerhill Services Limited and Birmingham Women and Children's Trust.

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

It is a constitutional requirement to report all uses of the Trust Seal to the Board of Directors.

The Board of Directors is asked to note and record the use of the Trust seal.

Enclosures

N/A

Report to the Board of Directors							
Agenda item:	**20**						
Date	7 August 2024						
Title	Board of Directors Effectiveness - Annual Self-Assessment Tool for 2023/24						
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**	✓

Purpose:

An annual self-assessment offers the Board an opportunity to evaluate its effectiveness, assess if it is appropriately constituted, gain assurance, identify areas that need strengthening and improving as well as ascertain if it is effectively performing its statutory roles. This report is intended to provide a simple and quick tool for members of the Board to use in evaluating and assessing its effectiveness.

Introduction:

An efficient and effective Board is a key requirement of good governance especially in performing its key roles of setting/formulating strategy, holding the organisation to account for its performance in delivering the strategy and shaping organisational culture (The Healthy NHS Board). The new Code of Governance for NHS Provider Trusts (2022) and the new UK Governance Code (2024) advise that the Board as a matter of principle and best practice should undertake a formal and rigorous annual evaluation of its own performance and that of its committees. This report notes that an efficient and effective Board is a key requirement of good corporate governance.

This SurveyMonkey has been structured under five broad themes as outlined below: -

1. Board composition, establishment and role.
2. Board Assurance Framework, Risk management and Assurance
3. Board visibility and Stakeholder engagement.
4. Strategy, Performance & holding to account.
5. Leadership and shaping organisational culture.

This report thus presents a SurveyMonkey as a tool for members of the Board to explore in evaluating and assessing its effectiveness and how well it is equipped to deliver its statutory roles.

Appendix 1 below sets out the structure and content of the SurveyMonkey in more details, however, the expectation is for the Board to decide on its preferred mode of implementation (i.e. paper-based or web-based).

Key Issues and Risks:

1. Potential low response rate, however, the plan is to encourage and remind all members of the Board to complete the SurveyMonkey and to provide qualitative comments to enable triangulation and enriched data analysis.

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.*
2. ***RECOMMEND*** *their preferred mode of implementation of the SurveyMonkey i.e. either paper-based or web-based system).*
3. ***REVIEW, SCRUTINISE and APPROVE*** *the content and structure of the proposed SurveyMonkey tool for implementation in evaluating and assessing its effectiveness.*

Enclosures

1. Appendix 1 – Details of the SurveyMonkey - Board of Directors Effectiveness - Annual Self-Assessment Tool for 2023/24.

Appendix 1: Board of Directors Effectiveness - Annual Self-Assessment Tool for 2023/24

Instructions: Please read through each statement set out below and tick the `dot` against the answer which best reflects your assessment of the situation articulated in the statement. You

could change your response by clicking on the `dot` against the one you wish to select, and your previous choice will automatically be unselected: -

Respondent`s Membership status

1. In what capacity are you completing the survey?

- Member of the Board of Directors.
- A regular attendee at the Board of Directors.

1. Board composition, establishment and role.

2. The Board of Directors has sufficient membership and authority to perform its statutory roles effectively.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

3. You are satisfied that the Board has delegated responsibilities effectively and appropriately.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

4. Members of the Board have the right balance of experience, knowledge and skills to fulfil its roles effectively.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

5. You are satisfied that the Board has clearly set out the roles and responsibilities of its committees and often receives chair`s assurance reports from them?

- Strongly agree
- Agree

- Neither agree nor disagree
- Disagree
- Strongly disagree

2. Board Assurance Framework, Risk management and Assurance

6. You are satisfied the Board regularly receives, reviews and scrutinises the Board Assurance Framework (BAF) and uses it in driving its agendas.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

7. The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

8. You are satisfied the Board is appropriately performing its oversight and scrutiny function of the BAF, CRR and reports presented to it.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

9. You are satisfied the Board receives sufficient assurance and good quality information from the reports it receives.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

10. You are satisfied that the Board systematically test and evaluate the sources of the assurance it receives.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

3. Board visibility and Stakeholder engagement

11. The Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

12. The Board ensures that relevant officers attend its meetings to enable it to understand the information it receives.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

13. The Board is visible, sufficiently and appropriately engaged with key internal stakeholders and system partners.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

4. Strategy, Performance & holding to account.

14. You are satisfied the Board provide sufficient scrutiny, constructive challenge and hold the Trust to account for performance and delivery of the strategy.

- Strongly agree

- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

15. The Board has a credible strategy to provide high quality, sustainable services to patients?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

16. There are clearly defined processes in place for timely escalation of risks and issues aligned to underperformance to the attention of the Board.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

5. Leadership and shaping organisational culture.

17. You are satisfied the Board support a culture of continuous learning and improvement across the Trust.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

18. The Board is committed to shaping and fostering an open, transparent and quality-focused culture.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

19. You are satisfied the Trust`s culture aligns with and supports the delivery of its strategy.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

20. Provide further comments on the overall effectiveness of the Board of Directors.
a. what`s working well.

20b. Areas the Board needs to improve or strengthen.