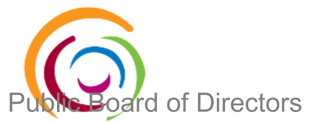


NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST
Board of Directors Public Meeting
09.00, Wednesday 2 October 2024
Uffculme Centre
AGENDA

Ref	Item	Purpose	Report type	Time
	Staff Story 09.00-09.30			
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of meeting held on 7 August 2024**	Approval	Enc	09.35
5	**Matters arising from meeting held on 7 August 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	10.35
11	**Infection Prevention and Control Annual Report 2023/24** *Zalika Geohaghon, Lead Nurse Consultant for IPC*	Assurance	Enc	10.50
	People			
12	**People Committee Report** *Sue Bedward, Non-Executive Director*	Assurance	Enc	11.00
13	**Freedom to Speak Up Guardian Report** *Emma Randle, Freedom to Speak Up Guardian*	Assurance	Enc	11.15
	Sustainability			
14	**Finance, Performance and Productivity Committee Report** *Bal Claire, Non-Executive Director*	Assurance	Enc	11.30
15	**Finance Report** *Dave Tomlinson, Director of Finance*	Assurance	Enc	11.45
16	**Emergency Preparedness, Resilience and Response Annual Report 2023/24** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	12.00
17	**Terms of Reference** *David Tita, Associate Director of Corporate Governance*	Assurance	Enc	12.10
	Reflections			
18	**Living the Trust Values** *Bal Claire, Deputy Chair/Non-Executive Director*		Verbal	12.15
19	**Board Assurance Framework reflections**		Verbal	12.20
20	**Any other business**		Verbal	12.25
21	**Questions from Governors and members of the public**			

Close by 12.30
Date and Time of Next Meeting: Wednesday 4 December 2024, 09.00 12.30

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

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

Members	Philip Gayle	PG	Chair
	Sue Bedward	SB	Non-Executive Director
	Bal Claire	BC	Deputy Chair/Non-Executive Director
	Linda Cullen	LC	Non-Executive Director
	Vanessa Devlin	VD	Executive Director of Operations
	Roisin Fallon-Williams	RFW	Chief Executive Officer
	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
	Fabida Aria	FA	Medical Director
Attending	Shane Bray	SBr	Summerhill Supplies Limited (SSL) Managing Director (item 16 only)
	Jas Kaur	JK	Equality, Diversity and Inclusion Lead (item 13 only)
	Hari Shanmugaratnam	HSh	Consultant Psychiatrist- Guardian of Safe Working (item 12 only)
	Hannah Sullivan	HS	Governance and Membership Manager
	David Tita	DTi	Associate Director of Corporate Governance
	Katherine Allen	KA	Lead, recovery, service user, carer and family experience (item 1 only)
Observers	One governor observed the meeting in person. Two members of staff observed the meeting in person.		

Ref	Item
0	**Staff Story** The Board welcomed KA who was supporting Maxine, who was in attendance to share her mental health journey and experiences with the Trust. Maxine shared personal experiences that have impacted on her mental health and recognised the impact this has had on her journey over the years. She confirmed her first experience of mental health services was through Main Street noting staff were supportive, kind and compassionate in supporting her to recognise her diagnosis. Maxine was pleased to be able to share that the staff that have supported her have been consistent over the years, helping her to build trusting relationships with professionals. She noted her thanks to the Trust and the staff quoting ‘they have pieced back together my shattered mind’. Maxine highlighted two concerns to the Board for their considerations in making a difference for others in the future. She shared her personal experience of being restrained and need for staff to consider alternative options before restraining service users as this can escalated anxieties and fear. She noted the need for staff to remain and communicate calmly in the first instance as this can deescalate the need for restraints. Maxine shared her experiences of food and catering services on the wards noting there is a lack of variety and options available alongside small portions sizes which leads to service users ordering take aways or using their time and money to purchase food from shops to bring onto site. Some options are of poor quality and this impacts on the overall mood of service users. Maxine recognised her own resilience in understanding her mental health journey and proudly spoke of her children and grandchildren being able to grow up in a safe environment due to the help she has received from the Trust.

	KA thanked Maxine for continued contribution to the Trust and for making a difference to the journey for other service users. SB thanked Maxine for being vulnerable and sharing her traumas. RFW queried what can be done to support service users during restraint? Maxine shared her experiences with Promethius as frightening and noted the need for clear communication with service users to ensure the situation remains calm and does not become overwhelming. The Board thanked Maxine for sharing her powerful personal journey.
1	**Chair's Welcome and Introduction** PG welcomed everyone to the meeting.
2	**Apologies for absence** Apologies noted from Winston Weir, Non- Executive Director and Kat Cleverly, Company Secretary.
3	**Declarations of interest** DET confirmed his interest in Summerhill Supplies Limited.
4	**Minutes of meeting held on 5 June 2024** The minutes were agreed as a true and accurate record, subject to a minor correction under the Staff Survey item.
5	**Matters arising from meeting held on 5 June 2024** All matters arising were updated. PG noted DT had advised that a report would be discussed by Executives next week regarding cost improvement programmes and what level of savings had been identified albeit this being difficult. DT confirmed the discussion with Executive Directors has taken place and programmes of work are being developed.
6	**Chair's Report** The report was provided to the Board for information and assurance. PG particularly highlighted our Council of Governors (CoG) 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. PG confirmed he and RFW have completed a number of service visits together including Recovery Near You where staff remain dedicated to delivering the best possible service. The current contract is up for renewal in the coming weeks. PG confirmed he had visited the Psychiatric Liaison service teams at the Queen Elizabeth and Birmingham City Hospitals with RFW 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. LC highlighted the ongoing challenges with the environment at the Queen Elizabeth for the Psychiatric Liaison service. RFW confirmed the challenges remain and that work is underway to address the concerns with the environment and cultures. PN confirmed work for the tender for Recovery Near You is underway. PG noted the service can demonstrate value for money.
7	**Chief Executive and Director of Operations Report**

Birmingham and Solihull Mental Health NHS Foundation Trust

| | The Board received the report and noted the following key points:

• 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.
• 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.
• 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.
• 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. All Board members have signed up to the pledge.
• The financial position across Birmingham and Solihull continues to be challenging with several providers seeing significant deficits already in this financial year. The Trust remains on track with the agreed trajectory.
• 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. 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.
• 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.
• 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.
• NMC Independent Cultural Review published
• 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.
• Thank you to our ICT colleagues who ensured the Trust was not affected by the recent cyber attacks
• The Trust has lots to celebrate with a number of teams being shortlisted for awards in the coing months
• 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.
• 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.
• 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.

- 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.
- 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.
- 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.
- 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).
- 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.
- Within the Memory Assessment Service, implementation of the new memory assessment pathway has progressed further with the central booking system becoming live in July.
- 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.

RFW acknowledged the ongoing protests and riots across the country and recognised the need to support staff, service users and communities as anxieties escalate. Safety remains a high priority for all staff and service users with communications clarifying the support available in line with Trust values.

PG endorsed recent communications recognising the need to remain mindful of the magnitude of demonstrations across Birmingham. He confirmed the Trust remains in close contact with Police colleagues for support.

BC noted the positive CQC feedback for Cilantro and echoed the findings from a recent visit.

PG noted the Trust is due to go live shortly with the NHS Professionals National Bank and queried whether this is being utilised?

PN confirmed the Trust and professionals are utilising the tier system that allows the Trust to claim back VAT that will accumulate over time. He confirmed all agency consultants are registered on the system.

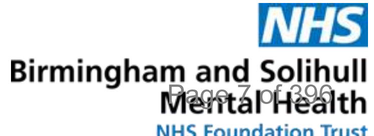
PG noted the Health and Justice Vulnerability Service (HJVS) are now live aiming to increase accessibility for those who have had contact with the Criminal Justice System within a 28-day period and queried the benefits for the Trust. He also asked if this service would be available to all of the psychiatric liaison teams across the four acute Trusts.

It was confirmed this will support quicker access to services with referrals being escalated to the appropriate teams to support pathways with all teams having a development plan in place that will support health inequalities.

LC highlighted the need for all literacy to co- produced and meaningful for the populations as this was raised at a recent Trust induction.

Birmingham and Solihull Mental Health NHS Foundation Trust

8	**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. The Board were assured both the Finance, Performance and Productivity Committee and People Committee have redefined their risks. The Quality, Patient Experience and Safety Committee have a scheduled meeting later today 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. DET confirmed the Board strategy session in September will allow the Board the opportunity to review the risks in detail and ensure they are fit for purpose including the need to review the current and historical scores for the risks to provide clarity and assurance on the ratings as appropriate. PG highlighted the need for cyber risks to be sighted and recorded as a national risk. It was confirmed this is an operational risk that is registered on the Corporate Risk Register which can be viewed within the BAF. DTi confirmed the cyber resilience report is escalated and reported to the Finance, Performance and Productivity Committee for assurance. BC requested the Corporate Risk Register as sighted alongside the Board Assurance Framework and queried where the current oversight is for the Corporate Risk Register? DET confirmed the Corporate Risk Register is received and reviewed at all Board Committees. The Board endorsed the content of the report and the current Board Assurance Framework noting the ongoing development of overarching risks that will be reviewed in September 2024.
9	**Integrated Performance Report** The Board received the Integrated Performance Report noting 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 Board noted the significant improvements in relation to Talking Therapies and service users seen within 18 weeks, with an improving trend (92.49%) in last 4 months. The Board acknowledged the dependency of Birmingham Healthy Mind colleagues in meeting the improvement trajectory and 95% national standard. Out of area placements continue to be monitored through a weekly steering group as numbers continue to fluctuate. Winter planning is underway and locality working is supporting the overall driver to reduce out of area placements. The Board noted 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. PN highlighted that following a centralised recruitment event for band 5 nurses in May, 16 offers were made. There is a continued focus to meet the trajectory for both international and internal recruitment through intentional reporting through People Committee.



	PG noted there are a number of key indicators that have remained static over a few years with what appears to be little progress showing in the data and queried whether Board Committees continue to have oversight and are reviewing these particular areas namely Out of Area, Appraisals, Mandatory Training and sickness levels. It was confirmed there are a number of deep dives across the divisions that are focussing on key indicators to ensure there are ongoing improvements being made. SB confirmed People Committee remain focussed on appraisal rates and the constraints with the system. BC confirmed Finance, Performance and Productivity Committee have oversight of the appropriate metrics and are supporting innovative ways of working across system partners to make improvements and align to the overall strategic objectives. TK noted the ongoing pressures for acute wards and the opportunity to build opportunities for admission avoidance through measuring performance. The Board were assured teams are working within localities and metrics are being measured through KPIs. PG noted the importance of utilising the Integrated Performance Report and agreed the report should feature earlier, on future agendas.
10	**Quality, Patient Experience and Safety Committee Report** The Board received reports from June and July meetings. LC highlighted key points that had been discussed, including; • 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. • 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. • 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. • 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. PG queried whether the Committee continues to focus and have oversight of PCREF? LSG confirmed the Committee continue to have oversight and there is a continued focus on safeguarding and patient experience. The Patient Experience Group will be co- chaired with LSG going forward and will report directly to the Quality, Patient Experience and Safety Committee to strengthen the focus on service user experience.
11	**People Committee Report** The Board received reports from June and July meetings. SB highlighted key points that had been discussed, including; • 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. • 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. • The Committee was assured by high rates of compliance with doctor appraisals and revalidation, and robust job planning arrangements. • 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 noted the ongoing work to support more efficient Employee Relations processes. PN confirmed the performance target for fundamental training compliance is set at 95%, the Trust is currently at 94% with a continued focus on supporting staff to meet the target in quarter 4.
12	**Guardian of Safe Working Q1 2024/25 Report** The Board received the Guardian of Safe Working report noting the salient points as; • 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. • 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. • 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. FA thanked Dr Hari Shanmugaratnam for the update.
13	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report**

	The Board received the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports presented by JK with a number of areas identified for development with dedicated equality, diversity and inclusion support. The Board were assured on the following points: • Anti Racist Behavioural Framework completed and is now ready for roll out • Phase three of the Disability pledge has launched • Data informing us we are moving in the right direction in improving experiences for our black and minority ethnic colleagues. The Board recognised the data is showing the experience of staff with disability has decreased with colleagues with disabilities are 5.33 times likely to enter the capability process then those without. The team will continue to support staff with reasonable adjustments and continue to develop support offers efficiently. The Board recognised the challenges for staff with disabilities and need for further focus on work to be done to support staff. RFW queried what can be done to support the team in addressing the challenges and disparities? JK confirmed teams are taking local ownership and there has been significant corporate support. She recognised the need for continuous change through concise ownership and positive change. RFW queried whether the data for the Trust Board has been submitted? JK confirmed the Trust Board have made full declarations and this will be reported in future data. LSG queried what else can do be done to support the recruitment process? JK confirmed the Flourish project plan has been developed and will support localised discussions for inclusive recruitment and supportive action. She noted the growing disparities and support offers being developed for centralised, dedicated support that needs to be actioned at pace to address the backlog of concerns. PG highlighted concerns in relation to the high level of disparities particularly in relation to workforce disability and the rising number of capability interviews, recognising the Trust needs to do more. He queried what support is in place for managers and ensuring managers are retained? PN confirmed there is a programme to support first line managers that offers support for understanding HR processes, mediation techniques and promote a just culture. RFW recognised the need for actions to be escalated to ensure appropriate oversight. MS noted appraisals will support escalations and capability concerns through a just culture and recognised the need for staff to be supported when using the system. TK highlighted the need to recognise all protected characteristics and include flexible arrangements in future data reported. JK confirmed all protected characteristics are included, she noted maternity and pregnancy data is dependant on staff declarations and agreed to follow up on reportable data for future reports. PN confirmed the current target we are trying to achieve is 40% BME staff in Band 8a roles and above. He noted the trajectory for achieving the target is 2028. PG thanked JK for the update and recognised the areas of challenge and progress whilst recognising the ongoing support from the Trust Board in supporting improvements.
14	**Finance, Performance and Productivity Committee Report** The Board received reports from June and July meetings. BC highlighted key points that had been discussed, including;

- 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 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.
- Out of area remains a key concern.
- 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 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.
- 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.
- 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. The Trust had not been affected by the recent CrowdStrike outage, which highlighted the effectiveness of the cyber security controls in place.

15 **Finance Report**

The Board received the report and noted 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.

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.

The month 3 Group cash position is £91m.

The Board received the Highcroft Business Case for approval, noting 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.

DET confirmed the Business Case has been co- produced with staff, service users and the local community with the timeline approximately 18 months for the redevelopment.

DECISION: The Board approved the Highcroft Business Case.

The Board received the Business Case for the Refurbishment of Main House for FIRST Team & Recovery Team, noting the drivers for the development and the current status of the assets.

DECISION: The Board approved the Business Case for the Refurbishment of Main House for FIRST Team & Recovery Team.

The Board received the proposal for rephasing capital and noted the recommendations.

DECISION: The Board approved the proposal for rephasing capital.

	The Board noted the ongoing hard work and dedication of the Finance Team in developing the proposals and maintain the financial position during the ongoing challenges.
16	**Summerhill Services Ltd (SSL) Quarterly Report** SBr was in attendance at the meeting to present the Summerhill Services Ltd (SSL) Quarterly Report noting the salient points as; • 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 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 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. • After 8 productive and successfully years, we are now looking to upgrade our pharmacy robot to the latest model. • 74% of all SSL participated in SSL first staff perception survey entitled the Yours Survey. 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. BC noted the high compliance with the staff survey and queried of there is any learning for the Trust to encourage staff to respond? SBr confirmed all 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 ICT literate and not having easy access to computers. He noted there are a small number of staff working within SSL therefore there has been the ability to engage directly with staff. BC noted the Sustainability Framework 2025 is fast approaching and queried how SSL can influence and support? SBr confirmed SSL will be developing further the ‘Green Plan’ for the Trust set against baseline data & target. He confirmed SSL have reviewed, gathered information and completed in full and on-time returns required by NHSE. The Board were assured SSL have ordered 13 electric/ hybrid vehicles that will be delivered with 12 months and food wastage is being monitored with the new system being able to support the reduction in waste. DET noted SSL are in a positive sustainable position. SB highlighted the concerns in relation to catering in the North of the city and queried whether the new system will consider dietary requirements and nutritional value? SBr confirmed SSL continue to work closely with the Trust dieticians and newly appointed Food Safety Officer. He acknowledged the ongoing issues in relation to catering in the North and confirmed capital spend is being reviewed to consider opportunities to improve. SB queried whether there is any cost saving with the robot in pharmacy? SBr confirmed the original robot has made recurrent savings of £150k a year and the new robot will be more efficient therefore there is potential for further savings. SB queried whether there has been any learning from the staff survey? SBr confirmed there have been a number of important learnings from the results with the main focus on being able to create career development opportunities for staff as SSL continues to grow. 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.

	PN requested could future reports include the recruitment data for equality, diversity and inclusion to be able to measure successes. SBr confirmed SSL has a strong equality, diversity and inclusion group that continues to grow. There is a equality, diversity and inclusion forum that meet quarterly as a staff forum. LSG queried whether the robot will highlight and bring back medicines that are disposed or collected? SBr confirmed the robot dispenses the medicines to each team and returns are sent back to the pharmacy. LSG and SBr agreed to meet to discuss options for further opportunities. **ACTION: LSG and SBr agreed to meet to discuss options for further opportunities.**
17	**Audit Committee Report** The Board received the Audit Committee Report with no further comments. DET confirmed Internal Audit will be attending the Executive Team meeting on a regular basis going forward to ensure further assurances. RFW highlighted the positive assurances in relation to the recent cyber attacks and need for Audit Committee to continue oversight.
18	**Caring Minds Committee Report** The Board received the Caring Minds Committee Report noting the alert from Committee that there are no Trust funds available to support the charity due to the ongoing financial challenges. The Events and Engagement post funding approved by charity funds on a permanent basis. 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). The Board were assured an away day scheduled and diarised for 30 September 24 for deep dive into agreeing the purpose, ambitions and objectives of the charity. DET queried the alert from Committee in relation to the funding from the Trust as the charity is independent. PN confirmed there needs to be further discussions at the away day to determine the investment appetite to support the Charity as this continues to develop. PG noted there is an increased presence across the Trust and events from Caring Minds and was pleased to confirm the Charity are also promoted at Trust induction.
19	**Trust Seal Report** The Board noted in line with the constitution 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.
20	**Board Effectiveness Self-Assessment** The Board received the Board Effectiveness Self-Assessment report for approval. 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. The Board agreed the survey will need to be the collective view as a unitary Board and data will be available for comparison between responses from Executive Directors and Non- Executive Directors. The Board approved the proposed survey via Survey Monkey with the agreement that each question will require the comment box to be completed before submission.

	DTi to circulate the survey to Board members and regular attendees and share results at Board in October 2024. **ACTION: DTi to circulate the survey to Board members and regular attendees and share results at Board in October 2024.**
21	**Living the Trust Values** LSG reflected on her first two months, noting that all three of the Trust's values have been demonstrated through her interactions with both staff and service users. She noted the focus across the Trust on working as a team to ensure the commitment to delivering the best possible services.
22	**Board Assurance Framework reflections** There were no additional risks to be added to the Board Assurance Framework. The Board will review the refreshed Board Assurance Framework at the Board Strategy session in September 2024.
23	**Any other business** PG summarised the overall assurances and challenges highlighted throughout the meeting.
24	**Questions from Governors and members of the public** MM noted his thanks to LSG as the newly appointed Executive Director of Quality and Safety (Chief Nurse) as she has demonstrated the Trust values in her first interactions with both staff and service users.
	Close

Actions/Decisions			
Item	**Action**	**Lead/ Due Date**	**Update**
Summerhill Services Ltd (SSL) Quarterly Report	LSG and SBr agreed to meet to discuss options for further opportunities.	LSG/ SBr October 24	Complete
Board Effectiveness Self-Assessment	DTi to circulate the survey to Board members and regular attendees and share results at Board in October 2024.	DTi October 24	Complete
Finance Report	The Board approved the Highcroft Business Case.		
Finance Report	The Board approved the Business Case for the Refurbishment of Main House for FIRST Team & Recovery Team.		
Finance Report	The Board approved the proposal for rephasing capital.		

Birmingham and Solihull Mental Health NHS Foundation Trust

Meeting	BOARD OF DIRECTORS
Agenda item	Item 6
Paper title	CHAIR'S REPORT
Date	2 October 2024
Author	Phil Gayle, Chair
Executive sponsor	Phil Gayle, Chair

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

Executive summary & Recommendations:

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

Reason for consideration:

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

Previous consideration of report by:

Not applicable.

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

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

Financial Implications *(detail any financial implications)*

Not applicable for this report

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

Not applicable for this report

Equality impact assessments:

Not applicable for this report

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

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

COUNCIL OF GOVERNORS 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 representing BSMHFT at key events.

As you will be aware the Darzi report published on the 12th of September set out a series of important challenges for the NHS. The report includes a lot of detail about NHS mental health services and rightly notes where investment in mental health services can make a difference and gives some examples of where expansion is working. Inequalities in both health and mental health are noted throughout the Darzi report, including the disproportionately coercive treatment of Black and other racialised communities in mental health services and the shortened life expectancy of people with a mental illness.

On the 17th of September I attended a national meeting with chairs and chief executives hosted by NHS Providers to discuss and work through the implications of Darzi's recommendations for the leaders of NHS trusts.

I must mention in the week beginning 4 August many parts of the country including Birmingham were impacted by demonstrations and threatened demonstrations by far-right activists. I'm pleased to say that our Trust ensured we had arrangements in place to keep our staff and patients safe from threatened action. I would like to extend thanks to our staff and managers for keeping our services safely functioning during a potential volatile period even though many of our staff felt anxious during this time.

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 particularly look forward to our remaining 2024 planned Quality, Patient Experience and Safety Committee's being held at different sites, Juniper and Dan Mooney.

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

3. SERVICE VISITS

3.1 Visits to our Trust services continue 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, 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 Reaside, an inpatient unit for male mental health patients. I visited the Trent and Avon wards on site, meeting with our staff and service users. The visit was productive and insightful.

3.4 I was pleased to visit HMP Birmingham where I met the hard-working staffing team and observed operations, which are, of course, in a very different setting to the usual services. The visit was constructive for both myself and the team where we had some good discussions around ideas for future and ongoing developments within these services.

3.5 I am looking forward to my planned visits at the SIAS services, Small Heath Health Centre & Hills Lodge, to name a few.

3.6 I visited the Tamarind Centre Friends and Family Day September this is an event that takes place three times a year, with nursing, occupational therapy and psychology each organising. Their theme was the *Tamarind community*. The focus was on building a sense of community across staff and service users, to enhance relationships that will encourage recovery and change for systems and make a better environment for service users mental health and wellbeing. I was part of the judging panel and awarded the prizes for art work pieces created by the different wards which was great. I also had the opportunity to speak with family members who were complimentary about the service at the Tamarind.

4. Partner and System Development / Stakeholders

4.1 On the 20 August I met with the other BSOL Chairs to discuss key issues impacting on the BSOL system and the priorities for system working.

4.2 I attended the NHS Providers' Chairs and Chief Executives Network day in London, chaired by Sir Ron Kirr. The day was constructive and valuable. We had the pleasure of listening to many speeches throughout the day, with speakers to include Sir Julian Hartley, Chief Executive of NHS Providers, Department of Health & Social Care, Universities UK, UCL Partners and different NHS Trust's around the UK.

4.3 I attended the Midlands NHS Leadership meeting at Leicester City Football Club where there was an engaging agenda, to include discussions around the needs and challenges of future Health, and Collective Leadership discussions where we actively participated in practical breakout sessions. Roisin presented at this meeting and the content of her presentation was well received.

5. **BSMHFT Mental Health Provider Collaborative**

The BSOL Mental Health, Learning Disabilities & Autism Provider Collaborative have undertaken the following key activities over the past quarter:

The collaborative has launched a 3-year strategic vision for inpatient beds across Birmingham and Solihull. It sets out an approach to both inpatient adult acute and psychiatric intensive care unit beds and rehabilitation provision ensuring that the patient is always placed at the center of decision making. The strategy focuses on ensuring care is closer to home, ensures least restrictive practice and focuses on prevention and early intervention.

Following the launch of the Provider Collaborative Innovation Fund; a funding opportunity for providers to bid for funding to help deliver the ambitions of the inpatient bed strategy, focused on admission avoidance and reduced length of stay, the collaborative have evaluated all bids and awarded to 9 providers who will be coming together to launch their new service offers.

A review of the current draft All Age Mental Health, Health Needs Assessment is underway which will help inform the development of our All-Age Mental Health Strategy which is on track for delivery from April 2025.

A decision in principle has been reached by both Birmingham & Solihull Mental Health NHS Foundation Trust Board and Birmingham Women's & Children's NHS Foundation Trust Board to move to a single provider of care for Children & Young People across Birmingham & Solihull which will offer an integrated and graduated model of care and support.

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

6.3 I continue to meet bi-monthly with Andy Cave and Richard Burden from Healthwatch Birmingham.

6.4 I also continue to 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 I also meet with the Trust's Governor's to maintain regular communication and working relationships and to discuss ongoing developments.

7.3 People development and strategy sessions are held for our Corporate Team regularly, which I also attend.

7.4 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.

7.5 Congratulations also go to our governor Mustak who has been shortlisted for patient contributor of the year for Royal College of Psychiatrists awards which is well deserved.

PHIL GAYLE
CHAIR

Report to Board of Directors

Agenda item:	7					
Date	2 October 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

People Team

Ask Ava

Ask Ava went live on 3rd June 2024 and currently has 94 topics with hundreds of specific questions and answers built in.

Promotional comms and a questionnaire were sent out in August 2024 to improve current topics and answers.

Over the next quarter, phase two will commence to expand the chatbot to include other People Departments, for example in relation to our Temporary Staffing Service (TSS) and Recruitment.

HR Toolkit Training

Last month, following a successful launch of the Health Wellbeing & Attendance training earlier this year, the team released the Disciplinary training for managers.

Both sets of training have received good feedback and good attendance rates.

This will be closely followed by the launch of the investigating officer training before the end of the year.

Resourcing, Projects and Analytics

Recruitment activity remains high. Following successful centralised recruitment campaigns, newly qualified nurses are being allocated to posts. Our overall number of vacancies continues on a downward trajectory.

Agency reduction targets are being exceeded due to a combination of Medical Agency reduction, moving medical agency to a direct engagement model and using NHS Professionals as a step between Bank and Agency for other staff groups. Bank usage remains high and unpredictable, and team continue to support areas to look at reduction and this is now a major workstreams of focus across departments.

There are several HR Projects underway including the digital passport, training needs analysis, flexible working and the completion of the People Promise self-assessment tool. The workforce analytics team continue to support further developments of the dashboard and benchmark reporting.

Widening Participation Team

The Team are working in collaboration with corporate nursing on improving our grow your own offer and infrastructure. We held an engagement event for the Nursing associate role in August and are

Public Board of Directors

also holding monthly career drop-in sessions. A project is underway to look at the band 2-4 offer, the group was surveyed, and the response rate was 30% and this data will be used to develop an action plan. Engagement with schools continues to grow, we recently supported 6 schools with mock interview sessions increasing awareness of NHS careers and the Trust as a local employer.

Medical Staffing

Staff Direct

Staff Direct is being successfully implemented for our Medical Agency Locums. Allocate Staff Direct is a provider that fills vacant shifts by sourcing temporary staff from agencies and changes the way that we engage with staff and enables us to achieve financial savings. IAs a result of all the positive work to reduce agency usage, we currently only have 17 agency locums working within the organisation.

HealthRoster

In February e-rostering was rolled out for all doctors in the Trust to replace the Excel spreadsheets held on Connect. The team are completing a phased transition to HealthRoster which will allow for the correct entitlement and smooth booking of annual leave, this phased transition will continue over a 12-month period to capture all renewal dates.

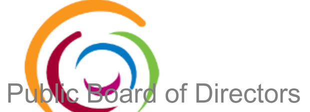
CLINICAL SERVICES

Integrated Community Care and Recovery (ICCR)

Work is underway embedding the Matron roles across the Community Mental Health Teams (CMHTs). Oversight of monthly audits is ongoing with an intention to redesign the Integrated Care Records Quality Monitoring Tool to improve its' value. Focus continues on improving medication management; Prescribing Standards are now approved, and plans have been discussed for the development of a wider Standard Operating Procedure regarding Pharmacy/CMHT activities.

The Neighbourhood Mental Health Teams enhanced service offer for Primary Care Networks (PCNs) with Additional Reimbursement Role Scheme (ARRS) roles is being finalised, providing clarity around role expectations and assurance of the offer across BSol PCNS. Collaborative working with the Community Care Collaborative (hosted by Birmingham Community Health Care Trust) is underway developing an aligned community provision to support service users, focusing on physical health, mental health and social needs.

Steps to Recovery services have made progress rolling out the Peer Review process around Quality Standards and the delivery plan is being finalised. Strategic objectives have been finalised including the development of a co-production strategy encompassing ways to address health inequalities. Waiting lists are low, and the interface with Integrated Community Rehab Team (ICRT) is having significant impact by diverting inpatient stays and shortening the LoS through early discharge. The ICRT create bed capacity by enabling step down from out of area (OOA) high dependency unit placements, reducing the number of independent OOA spot purchases.



Recovery Near You (RNY) are developing their service improvement priorities with a focus on the findings from CQC visits and training. Intense work is underway with Change Grow Live (CGL) in relation to criminal justice referrals and we continue to work closely with our 5 main prisons to increase pick up rate.

The COMPASS Dual Diagnosis Team are working with our acute care division revising their offer to the original COMPASS model of training and supervision. This has now gone live with an aim to increase capacity within the team to focus on delivery of training and supervision across the trust and allow an equitable service to be offered to all areas.

Solihull Community Mental Health and Wellbeing Service (CMHWBS) are undertaking an evaluation of the locality approach to ensure an enhanced service offer. Our Solihull CMHWS is working to enhance the offer for 18-25yrs, including transfer from CAMHS, family and carer interventions, and developing the workforce via both designated roles and enhanced training.

We are pleased to announce that Sharon-Nira King from our Aston and Nechells CMHT has been shortlisted in the Groundbreaking Researcher Category at the 5th Annual B.A.M.E Health and Care Awards. At the time of writing, the awards are yet to take place, on the 26th of September in London, and we wish Sharon the very best of luck. In addition, Carolyn Musgrave from the Recovery Near You teams has been accepted as a Queens Nurse, the official awards ceremony will be taking place on 29th November in London, huge well done also to Carolyn.

Secure Care & Offender Health (SCOH)

Ardenleigh achieved the Autism Spectrum Disorder Accreditation and all the young people on the site who took their GCSE's this year have passed. The implementation of a Positive Behavioral Support (PBS) Quality Initiative project has commenced to reduce restrictive interventions through identifying and managing behaviour.

The divisions Youth First team were shortlisted for team of the month.

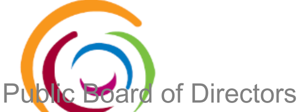
Reaside Clinic received additional funding to increase the health care assistant establishment in line with safer staffing recommendations and recruitment to the posts is now taking place.

The divisional leadership team continues to work with Reaside senior leadership team to address culture concerns and improve staff engagement in conjunction with Freedom to Speak Up Guardians, the Equality, Diversity and Inclusion Team and Organisational Development Team.

Forensic Intensive Recovery Support Team (FIRST) have several Quality Improvement (QI) projects ongoing. The Main House relocation project has commenced. Community redesign work is on-going, and the new referral documentation has been implemented.

Offender Health is collaboratively working with Birmingham Community Healthcare Trust (BCHC) to support vacancy challenges across the partnership. Joint Organisational Development work between the two Trusts is planned for September/October. A meeting is being arranged with the prison and NHS England to discuss plans to improve the environment.

The Health and Justice Vulnerability Service workforce reconfiguration has been supported by commissioners, which will support recruitment challenges within the team. We continue to work positively with our Organisational Development colleagues to support building team morale and culture. A business case has been accepted for 2 additional staff to support delivery of Primary Mental Health Treatment Requirements following the success of the Intensive Supervision Court



pilot. The youth pathway quality improvement project is looking at increasing the engagement of the youth population following release from custody.

Psychology colleagues continue the trauma informed care work across the division. Additional funding has been secured for the Affirm team to support their work delivering training and supervision to probation officers and to the Prosper service for a Support time recovery worker. The Enhanced Reconnect Service building has now been handed over to the service and a 'soft launch' is planned.

Occupational Therapy services continue to embed a culture of service improvement and development through division wide clinical training programmes. Programmes are co-produced and delivered by staff and service users. Ongoing audits of the Secure Inpatient OT Pathway have seen improved clinical outcomes and a Recovery Charter is being co-produced with a view to developing a Secure Care specific Recovery College.

Acute and Urgent Care

The Out of Area (OOA) work programme has advanced with the development of revised trajectories under key performance indicators (KPIs) relating to our productivity plan, along with a stock take and reset of the out of area steering group. The group will be supported more robustly through our quality improvement framework to ensure that the improvements are made and celebrated and sustained.

Our Business Intelligence (BI) data team is in the process of developing a locality-level data dashboard. This tool will enable us to monitor the agreed KPIs effectively and provide crucial information to support locality teams in their decision-making processes, enhance flow and improve the service user outcomes.

A clinically ready for discharge Policy Development Group has been established to finalise a new policy aimed at standardising discharge practices, being clear about roles and responsibilities and enhancing service user care and experience. We will be working to this as we progress daily locality reviews of admissions and discharges and escalation of any discharges which may be delayed.

Despite progress, challenges regarding capacity remain within our acute care discharge managers team. Meetings are scheduled with senior clinicians to review how we can increase locality working, capacity and oversight, along with ensuring we have senior clinical oversight of our service users who are placed out of area.

As we are approaching winter the teams are collecting their plans with a focus on admission avoidance, reducing length of stay and facilitating quicker discharge. We are pleased that we have been successful in securing additional funds to support some of these going forward, which include an enhanced clinical oversight in our bed management function, a specialist learning disability role, and an expansion of our dementia and frailty pathway.

Regular reviews of the Enhanced Monitoring Implementation Plan show good progress, with wards actively participating in daily touchpoint meetings focused on patient safety and care quality. A 12-month secondment for a Clinical Quality Assurance Manager has been advertised to provide leadership and support in these areas.

Primary Care, Dementia Services & Specialties

The West Older Adult Community Mental Health Team were awarded with the Trust's Team of the month. The team have been recognised for being a hardworking, supportive team who go above and beyond for their service users and the community they serve. *"I just wanted to express my enormous gratitude for the unfailingly support you've shown my sister over the last couple of years. I can't believe how much better she is these days. I feel I have my sister back and you are a huge part of that recovery."* Service user feedback (West OA CMHT).

The 'it's not just your age' campaign animation has now been finalized. NHS Mental Health - Depression Anim v7 on Vimeo.

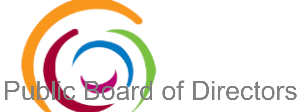
The campaign has been developed to support older people to access services. Once presented at the transformation programme board, this will be circulated across BSOL health and social care services to be played on all social media platforms including screens within our waiting areas, GP and VCSE partners waiting areas and within Birmingham City Council.

In Older Adult Inpatient services, the CQC conducted a mental health visit to Sage Ward, and initial verbal feedback was positive. The well-being programme for staff continues to offer various activities, including yoga, football, and a sponsored Zumba event. Additionally, the Carers group, led by ward and community team staff with support from Meridan, has commenced at Reservoir Court. Families involved have provided positive feedback, expressing the value of both professional and peer support - *"this is the best unit (Reservoir Court) my dad has been admitted to; the staff are really helpful".*

Birmingham Healthy Minds continue to increase the number of people having contact with the service to receive treatment. Successful recruitment continues with five psychological therapists commencing in posts in October and interviews that took place in August will secure roles for the remaining vacancies. The service receives good feedback, an example received via the friends and family test to a South team counsellor and receptionist : *"It is a calm environment to wait, staff (receptionist) kind smiley and welcoming. Counsellor listened to me, and I felt safe. I feel I have the tools and skills to move forward. I am sad my counselling has come to an end. I feel I know and trust myself better. Thank you".*

The Perinatal service has reviewed data on the access rate. Whilst the service is currently 132 below the target of 1953, plans are in place to achieve the target by Mar'25. Work continues with 8 workstreams to increase the number of referrals and women subsequently seen, through a focus on reducing health inequalities by reducing stigma and raising awareness of the service, improving the accessibility, reducing DNAs and providing a consistent offer within the pathway. The service is pleased to see the month-on-month improvement and is proud of its achievements as it moves towards the target. The service had a successful 'deep dive' meeting with the Trusts exec team in July 24, where achievements were celebrated.

Dr. Jed Jerwood, Principal Art Psychotherapist with the Community Art Psychotherapy Team has been nominated and shortlisted for the British Association of Art Therapists (BAAT) Innovation in Practice Award. This is a new award, developed by the Association to celebrate innovation in practice. Jed was nominated in relation to his outstanding work over the last 5 years, where he has utilised his knowledge skill and experience as an art psychotherapist and creative arts methods researcher to work with The Mary Stevens Hospice and co-develop the 'No Barriers Here' approach.



No Barriers Here is a co-produced approach to advance care planning that uses arts-based methods to deepen conversations, build relationships and gain understanding of the experience and preferences of people and communities often excluded in healthcare. www.nobarriershere.org

SUSTAINABILITY

Funding and Finances

The local system continues to face significant financial challenges across all providers. Oversight is increasing from local and regional partners to ensure that all of the relevant controls are in place in an attempt to bring the system back into financial balance.

We are awaiting confirmation of the funding allocated to us for all of the pay awards that have been announced over the summer, as these will be paid to relevant colleagues over the coming months.

BSOL Mental Health, Learning Disabilities & Autism Provider Collaborative Update:

The BSOL Mental Health, Learning Disabilities & Autism Provider Collaborative have undertaken the following key activities over the past quarter:

The collaborative has launched a 3-year strategic vision for inpatient beds across Birmingham and Solihull. It sets out an approach to both inpatient adult acute and psychiatric intensive care unit beds and rehabilitation provision ensuring that the patient is always placed at the center of decision making. The strategy focuses on ensuring care is closer to home, ensures least restrictive practice and focuses on prevention and early intervention.

Following the launch of the Provider Collaborative Innovation Fund; a funding opportunity for providers to bid for funding to help deliver the ambitions of the inpatient bed strategy, focused on admission avoidance and reduced length of stay, the collaborative has evaluated all bids and awarded to 9 providers who will be coming together to launch their new service offers.

A review of the current draft All Age Mental Health, Health Needs Assessment is underway which will help inform the development of our All-Age Mental Health Strategy which is on track for delivery from April 2025.

A decision in principle has been reached by both Birmingham & Solihull Mental Health NHS Foundation Trust Board and Birmingham Women's & Children's NHS Foundation Trust Board to move to an all age model of provision and a single provider of care for Children & Young People across Birmingham & Solihull which will offer an integrated and graduated model of care and support.

QUALITY

The Trust has implemented significant enhancements to its Learning from Deaths (LFD) process to improve oversight, assurance, and learning opportunities.

Key changes include:

- Putting in place a Learning/Oversight Group: A new group chaired by the Deputy Medical Director, focusing on reviewing the quality of Structured Judgement Reviews (SJRs) and

deriving actionable learning points; Strengthened Functions of the Learning from Deaths Group
- Weekly Safety Huddle: This newly introduced meeting highlights incidents of unexpected deaths of service users, alongside upcoming inquests of note or concern, providing a real-time platform for information sharing, action, and escalation;
- Enhanced Preventing Future Deaths Management (PFDs): The process for managing PFDs has been strengthened with two key meetings: one to review the response and actions required, and another to develop a SMART action plan and Quality Improvement (QI) workstreams;
- A Dynamic Space Event is scheduled to look at the whole inquest process including preparation and support of witnesses prior to attendance at Coroners.

The Board has been aware of the improvement plan put in place regarding our response to Complaints. The current overview is as follows

- Numbers of formal complaints registered rose over July and August
- Key Performance Indicator's around allocation of an investigating officer remain positive with only 17-21% of complaints currently awaiting an IO
- length of time to investigate complaints has continued to improve with the exception of a small number of complex complaints
- There are currently 46 open formal complaints overall, 8 of which are over 6 months old. Of these, 4 are in the final stages of quality assurance, while the remaining 4 are complex concerns that are being closely monitored on a weekly basis

Following recent focused Care Quality Commission (CQC) inspections initially of our CMHTs and more recently of the services at Reaside, we have now received drafts of both reports.

Our factual accuracy in relation to the draft CMHTs report has been submitted and await confirmation of its publication.

The draft Reaside report has been received in recent days and our factual accuracy response is being prepared.

LOCAL NEWS

Social Unrest and Riots

The Board will be very much aware of that during August across the country racially motivated riots and unrest and incidents arising from communities setting out to prevent these arose. Birmingham and Solihull was not alone in witnessing and experiencing the immediate and lasting impacts of racism and Islamophobia.

Many collaegues were clearly anxious and concerned, some were personally targeted and others in light of their lived experiences experienced trauma triggered by the events.

As a part of our response we ensured timely communication and support to teams located and operating in areas believed to be at risk of unrest, established a number of specific and focused listening spaces, offered wellbeing support and ensured our Anti racist Anti discrimination stance as a Trust was reinforced.

The on going impact on some of the people and communities we serve as well as our colleagues in Team BSMHFT can not be underestimated, racial tensions and historic experiences as well as though in the immediacy, impact on social cohesion and as both a large employer and key public service we have a role to play in working with partners to support greater cohesion.

Whilst our immediate response was welcomed by most and contributed to keeping people informed and safe, these events raise more questions for us in terms of our anti racist ambition and make clear we need to consider as a Trust and with others their implications on how we take forward our anti racist anti discrimination commitment.

BSMHFT formally recognised at APNA Awards 2024

Team BSMHFT nominees had the pleasure of attending the Asian Professionals National Alliance (APNA) Awards at Warwick University Conference Centre.

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. The APNA Awards aim to recognise the contributions of NHS colleagues who are making positive changes, driving inclusivity, and supporting our communities and partnerships.

Team BSMHFT was shortlisted across five out of the 10 categories including Trust of the Year – Promoting Equality, Diversity and Inclusion Agenda Award, Impactful Equality, Diversity Award, Inclusion Champion Award and Rising Star Award. Although we did not win, we did receive commemorative certificates for outstanding achievement. The recognition our teams received was well deserved and we are incredibly proud to be acknowledged formally at such an important event. Congratulations again to all our shortlisted colleagues and we extend our thanks as a Board for all their efforts in supporting our Trust to become more inclusive.

Launch of BSMHFT White Allies Network

18th September 2024 saw the launch of our BSMHFT White Allies Network. The network is a place where white colleagues can explore what it means to be an effective ally against racism. It is about white people stepping up and is a positive and productive step forward.

The first meeting of the network will be on Monday 5th November 2024 at the Juniper Centre.

Veterans Minister visit to the Barberry

Veterans Minister, Alistair Carns, visited our Barberry Centre on 13th September to find out about the incredible work of the Midlands Op COURAGE mental health and wellbeing service.

During the two-hour visit, we had a national update from Op-COURAGE, the latest news and partnership working with our regional service (which is one of five nationally) and two very moving stories from veterans Steve and Will.

Op-Courage was set up in 2017 by Veterans themselves. Last year alone there were 7000 referrals with over 1700 to our regional Midlands service.

NATIONAL NEWS

The Darzi independent investigation of NHS England

Sourced from The Darzi Review and its implications for mental health - Centre for Mental Health and The Darzi investigation: what you need to know | NHS Confederation

Lord Darzi's investigation, commissioned by the new Government, laid bare the current challenges, and some of the strengths, of the NHS at the current time. It was produced as a precursor to a proposed ten-year plan for the NHS next spring. So, its findings and conclusions will have a major bearing on the priorities for that plan, which will likely determine the levels of investment and therefore ambition in mental health services for the decade to come.

the report positions the performance of the NHS within the changing and challenging external environment it has operated in over the last few decades. It recognises that many of the factors that have contributed to the NHS's current challenges are outside of its direct control. We also welcome the spotlight on several significant issues facing the NHS now: finances, staff experience and the lack of management capacity.

Unusually for a report covering the whole spectrum of health care, it includes quite a lot of detail about NHS mental health services.

The Darzi report also looks beyond the NHS to understand and put its challenges into context. It explores how the nation's health has deteriorated over recent years, finding that the biggest increases in ill health have been in mental health, especially depression.

NHS Chief Executive signs pledge to support armed forces and veterans

The chief executive of the NHS has signed a public pledge to people in the armed forces and their families to ensure they get the support they need from local health services.

Amanda Pritchard signed the Armed Forces Covenant on behalf of NHS England at the Royal Hospital in Chelsea on 5 September 2024.

The Covenant is a commitment from the nation that those who serve or have served, and their families, are treated fairly and not disadvantaged in their day-to-day lives as a result of their military service. It is supported by a wide range of organisations including the UK Government and Devolved Administrations, local government, businesses of all sizes, schools, charities and the NHS.

Flu Vaccinations

Millions of people in England can book flu and COVID-19 vaccinations from Monday, 23 September as the NHS rolls out additional protection for those most at risk ahead of winter.

Anyone eligible can book their vaccinations via the NHS website here, by downloading the NHS App, or by calling 119 for free if they can't get online.

The vaccinations provide vital protection to keep people from developing serious illnesses and ending up in hospital during busy winter months.

ROISIN FALLON-WILLIAMS

CHIEF EXECUTIVE

Report to Board of Directors						
Agenda item:	8					
Date	2 October 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 reflects the current position of activities on the Trust Board Assurance Framework since it was last received, reviewed and scrutinised at the RMG on 22nd August and at Board Committees on 18th September 2024. In reviewing the BAF, the Board would seek to assure and satisfy itself that principal risks to the achievement of the Trust`s strategic objectives have been identified, clearly articulated, scored and are timely mitigated and managed in a dynamic, proportionate and appropriate way.

2. Introduction:

The BAF sets out and brings into one place all the key risks linked to the delivery of the Trust strategy and provides assurance that such risks are effectively and efficiently mitigated and managed. Members of the Board at their last strategic development session received presentations on the structure of the new BAF that is being designed which incorporated, a refreshed heat map, a summary table showing all BAF risks at a glance and a template for more details BAF risk entries.

Members also reviewed, scrutinised and confirmed the following new BAF risks as set out below for the different committees and advised that these be progressed and thoroughly assessed, described, and articulated through a comprehensive, multi-dependency, muti-priority lens.

New QPES BAF risks:

- Failure to provide safe, effective and responsive care to meet patient needs for treatment and recovery.
- Failure to listen to and utilise data and feedback from patients, carers and staff to improve the quality and responsiveness of services.
- Failure to provide timely access and work in partnership to deliver the right pathways and services at the right time to meet patient and service use needs.
- Failure to continuously learn and improve and transform mental health services to promote mentally healthy communities and reduce health inequalities.

New FPP BAF risks:

- Failure to maintain a sustainable financial position.
- Failure to maintain acceptable governance and environmental standards
- Failure to deliver optimal outcomes with available resources.

Members of the FPP at their last meeting noted the following requests for extension of the due dates of some actions which will be discussed and considered for approval at the next RMG planned for 24th October 2024: -

- BAF04/FPP/004 - Request extension of action due date from 30/09/2024 to 31/12/2024 to enable the Board to ratify the updated Risk Management Policy at its December meeting.
- BAF04/FPP/005 - Request extension of action due date from 31/10/2024 to 31/12/2024 to enable finalisation and ratification of the new BAF by the Board at its December meeting.

New People Committee BAF risks:

- 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.

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.

The plan is for Executive Directors and their ADs/deputies to progressively develop their respective BAF risks in line with the following timeline: -

- 23rd – 11th October 2024 – Executive Directors and their ADS/Deputies undertake a comprehensive assessment of their BAF risks.
- 23rd October, presentation of draft BAF risks at the different Board Committees for scrutiny and feedback.
- 24th October, presentation of draft BAF risks at the Audit Committee for further scrutiny and feedback.
- 24th October, presentation of draft BAF risks at the Risk Management Group for further scrutiny and endorsement.
- 28th October – 21st November, Final review and presentation of agreed version of the BAF to Board Committees for endorsement.
- 4th December, presentation of the new BAF to the Board for ratification and wider implementation across the Trust.

3. **Key issues and risks:**

The key issues include the need to robustly frame and describe BAF risks accurately and appropriately score them while ensuring that such risks draw from various sources of evidence in enhancing triangulation and assurance to the Board and its Committees.

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. ***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

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.	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	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.	9	02/06/ 2023	↓
BAF06/ QPES	Potential failure to implement preventative and early intervention	Executive Director of Operations	QPES	ADs of Operations	12	02/06/ 2023	↓

	strategies in enhancing mental health and wellbeing.						
BAF07/ QPES	Potential failure to act as a leader in mental health and drive delivery, improvement and transformation of mental health services across our systems.	Executive Director of Operations	QPES	Head of Strategy, Planning and Business Development/ ADs of Operations	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.	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	Executive Director of Strategy,	People Committee	AD of EDI & OD	12	02/06/ 2023	

	transforming its workforce culture and staff experience.	People & Partnerships					
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 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	BAF06/QPES BAF01/QPES BAF02/QPES BAF01/FPP BAF02/FPP BAF01/PC BAF02/PC BAF03/PC	BAF03/QPES BAF03/FPP BAF05/FPP BAF04/PC	
3 Moderate			BAF05/QPES BAF07/QPES		
2 Minor					
1 Insignificant					

Appendix 1: Details of QPES Committee BAF

Executive Lead	Executive Director of Nursing		**Impact**	**Likelihood**	**Score**	**Oversight 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.	**Inherent Risk Rating**	4	4	16	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	3	12		
		Target Risk Score	4	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 requires	• 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 partners

	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	sufficient and consistent staff.		are new to the organisation and at early stages of implementation – there is an absence of defined strategy for how they will be utilised.

<table>
<tr><td></td><td colspan="2">This may or result in: -</td></tr>
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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.

</td></tr>
<tr><td></td><td>Linked risks on the CRR-
Risk ID</td><td>Brief risk description</td></tr>
<tr><td></td><td>N/A</td><td>N/A</td></tr>
</table>

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: 3:** Limited progress has been made against the Patient Experience actions since original scoring was made meaning likelihood remains unchanged. **Consequence: 4:** 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**	
Title of risk	Failure to focus on the reduction and prevention of patient harm and at enhancing its safety culture.	**Inherent Risk Rating**	3	4	12	Quality, Patient Experience and Safety Committee	
		Current Risk Rating	4	3	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?**	
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	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	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		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	

		• Development and application of RRP Dashboard • Process in place to for staff, service users and families to raise concerns • Programme of external audit • Executive oversight of National Patient Safety Alerts • Physical Health Strategy and Policy. • Patient Safety Advisory Group (PSAG). • Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. • Internal adoption of a transparent Quality/assurance process (AMaT implementation now resourced.) External: • CQC Insight Data • CQC Alerts • Public View • Healthcare Quality Improvement –	training delivery. • Structure of recording on Rio means duplication and gaps – high admin burden. • Usability of ESR is highlighted as being protracted and difficult and so compliance with use of ESR is low across most professional disciplines. • 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	• Trust Clinical Audit Programme reporting through to committee • NICE Guidance reported through updates to committee • Monthly reporting on quality safety metrics • PSIRF oversight • Safety Summit • 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	that of the format currently in place for 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.

		NCAPOP (National Clinical Audit and Patients Outcome Programme) • Coroner's Reports • QSIS compliance • Shared Care Platform	importance of RMS/Clinical Supervision	• Clinical Systems Group • CCIO and 2 x Deputy CCIO's in place <u>Third level assurance</u>: • CQC planned and unannounced inspection reports. • Internal and External Audit reports.	Currently no Trust wide Oversight Group for L&D 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		Quarterly reporting to Trust CGC on overall MHA	Trust focus on MHA compliance at CGC is

		SSL Service Agreement Forum CQC well-led and unannounced visits.	Gap in MHA Action Plan oversight arrangements from CQC inspections	compliance – high level reporting Health and Safety committee reporting and oversight of Ligature and Environmental Risk Assessments Audits Results CQC Steering Group – oversight of Action Planning	broad – no current assurance framework for how action plans 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	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.	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

		PSAG – sharing learning across the MDT and trust-wide Patient Safety Summits identify early concerns/data tracking/themes and trending and adoption of a QI approach to resolution.		Safety Summit Reporting is included in the Patient Safety Report to Trust CGC, QPES, and Board Independent annual assessment against the 68 NHS Core Standards for EPRR.	change in Executive leadership in quarter. 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	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.

				Executive Chief Nurse's Nursing Assurance Reports to QPES Committee and Board Executive Medical Director's Assurance Reports to QPES Committee and Board.	
	• *insufficient staff with the correct skill set*	Improvement Programme Improvement Plans Governance Forums: • 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-Risk ID	**Brief risk description**
	1545	There is a risk to patient safety, the quality of care and patient experience due to high waits across all Older Adult CMHTs, this includes waits for new assessments, follow ups and patients awaiting care coordination.
	868	There is a risk of undue and inadequate delays in timely mental health act assessments of patients presenting at Liaison Psychiatry general hospitals, Place of Safety, PDU & bed management etc due to the lack of AMHP availability, particularly out of hours.

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

Risk Response Plan	Action ID or number	Actions	Action Lead / Owner	Due date	State how action will support risk mitigation and reduce score.	RAG Status
Actions being implemented to achieve target risk score.	BAF02/QPES /003	Comprehensive Review of Governance Arrangements from Ward to Board – TOR will be approved including methodology of approach – to be presented to ET and QPESC.	Deputy Director of Nursing /Company Secretary Associate Director of Nursing and Governance	31st May 2024	• Change requested due to change in ToR and consultation by Committees prior to agreement. 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; improvement in IT systems, compliance with policy requirements, and improved quality of supervision.	Associate Director of Clinical Governance	October 2024	• Will support engagement with RMS and Clinical Supervision enabling improved support 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.	

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	**<u>Progress</u>** **<u>Additions</u>** 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 **<u>Changes</u>** 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. **<u>New Actions</u>** BAF02/QPES/009, 010, 011 have been added to the BAF **<u>Closed/Completed Actions</u>** The following actions have been closed/completed; BAF02/QPES/005, BAF02/QPES/006, BAF02/QPES/007 **<u>Scoring</u>** **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	**<u>Progress</u>** **<u>Additions</u>** 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	**<u>Progress</u>** Additions Following review further changes have been made to controls, gaps in controls, assurance, and gaps in assurance. **<u>Changes</u>** 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.

<table>
<tr><td></td><td>Executive Director of Nursing</td><td></td><td>Impact</td><td>Likelihood</td><td>Score</td><td colspan="2">Oversight Committee</td></tr>
<tr><td rowspan="4">Title of risk</td><td rowspan="4">Failure to effectively use time resource and explore organisational learning in embedding patient safety culture and quality assurance.</td><td>Inherent Risk Rating</td><td>4</td><td>5</td><td>20</td><td colspan="2" rowspan="3">Quality, Patient Experience and Safety Committee</td></tr>
<tr><td>Current Risk Rating</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target Risk Score</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Risk Appetite</td><td colspan="3">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.</td><td>Date added
Date reviewed</td><td>2nd June 2023
12th July 2024</td></tr>
<tr><td>Reference /

Risk ID or Number</td><td>Risk Description</td><td>Controls
Things in place to address the cause</td><td>Gaps in Controls
What are the weaknesses in the controls?</td><td colspan="2">Assurances
Triangulated evidence that the controls are in place, being followed, and making a difference</td><td colspan="2">Gaps in assurance
What are the weaknesses in the assurance?</td></tr>
<tr><td></td><td colspan="7">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: -</td></tr>
<tr><td>BAF03/QPES</td><td>• 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.</td><td>• 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.</td><td>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.</td><td colspan="2">• 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,</td><td colspan="2">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 diagrams, plan, and risk</td></tr>
</table>

	• 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.	• Clinical service structures, 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.	QPES Committee and Board. • 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.	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.	• Enhanced 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	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	October 2024	• Change requested to enable enaction of agreed options appraisal and subsequent survey requirements.	

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

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

	Consequence: 4: Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, new requires improvement rating from CGC following themed inspection of CMHT
Feb 2024	Updates on progress with mitigating and managing this BAF risk.
10th April 2024	**Progress** Additions No further additions added this month, Changes No changes to action dates this month **New Actions** No new action has been added. **Completed/Embedded Actions** The following actions has been closed/completed during this review: BAF03/QPES /004 **Scoring** **The scoring is unchanged at 16.** Rationale is detailed below; **Likelihood: 4:** Current multiple sources of evidence indicate a consistent failure to learn from previous incidents of harm to patients and staff. Sources include numerous PFD's, increased inquests, multiple CQC section 29A's and external notifications, increased complaints, and internal reporting on safety and governance KPI's/metrics. PSIRF transition has only just occurred and is in its early stages, new learning responses have not yet to be fully trialled to see if they bring about meaningful learning. **Consequence: 4:** Internal data evidencing staff and patient harm including; staff assaults, patient assaults, in-patient deaths, increased suicides, RRP data, staff vacancies, staff turnover, prevalence of drug and alcohol use in in-patient service users. Quality Summit conditions with ICB, requires improvement rating from CGC following themed inspection of CMHT
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	2	8		
		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.	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.	Having a strong service user/carer voice across all of our governance forums.

	Inconsistency of Pathways maturity and availability.	• Expert by Experience Reward and Recognition Policy. • EbE educator programme. • EbE's involved in recruitment, induction, recovery college, service developments, QI projects etc. • Recovery training part of fundamental training.		• Highlight and 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 October 2024	Families and carers will be routinely identified, and better supported or involved in care planning as appropriate.	

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

Date	Progress made since last Board/Committee review/scrutiny of risk: *(Please enter initials and progress that has been attained)*
02/06/2023	New risk which has just been added.
27/09/2023	Updating access to information policy by service users and carers and following a QI co-production approach.
29/11/2023	Updates on progress made so far.
29th Feb 2024	Updated, title and risk description modified, and new controls added.
9th April 2024	BAF04/QPES/001 Request extension of due date to 31st July 2024 to enable design of pathway following presentation following presentation of a paper at the Operations Management Team (OMT) today. It is worth recognising that the BSMHFT's Family and Carer Strategy which is out of date is being reviewed to enable a co-design and co-production of this pathway.
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	3	3	9		
		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 retention	• 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		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	
		Inherent Risk Rating	4	5	20	Quality, Patient Experience and Safety Committee	
Title of risk	Potential failure to implement preventative and early intervention strategies in enhancing mental health and wellbeing.	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?**	

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.	• System approaches to improving and developing services. • Solihull Children and Young People Transformation Programme including: o Transition workers o Mental health support in schools. • Talking therapies	• Capacity within teams to deliver transformation and service developments alongside day job. • Not enough beds for population when compared	• Integrated performance dashboard. • BSOL system mental health performance dashboard. • BSOL Talking Therapies Steering Group. • Solihull CYP Board. • Highlight and escalation reporting into Strategy and	• Currently reviewing governance structures to ensure robust BSOL system oversight of performance and transformations e.g., urgent care, talking therapies, CYP.

	Inadequate support for our service users with mental health co-morbidities e.g., substance misuse, learning disability, autism etc.	recovery plan. • Urgent care transformation plan including: ○ Heartlands mental health hub ○ Additional Place of Safety and PDU capacity/staffing ○ Call before you Convey ○ Crisis house ○ Psychiatric liaison. • Partnership working re dual diagnosis processes and pathways. • LDA training for staff • Sensory friendly wards • LDA reasonable adjustments tool.	nationally. • Recruitment and retention impacting delivery plans.	Transformation Board. • Performance Delivery Group "deep dives". • Highlight and escalation 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	3	3	9		
		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	• Trust is a representative on key system groups e.g., ICB Board, Place Committees, Inequalities Committee. • Lead provider for BSOL mental health provider collaborative.	• 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	Reports on system and partnership activity to: • WM Provider Collaborative Board • Provider Collaborative governance structures (BSOL and specialist services) • Operational Management Board	
	Lack of appropriate partnerships				
	Ineffective partnerships e.g., lack of trust, collaboration, engagement, being seen as equals etc.				
	Pathways and interfaces that are fragmented not joined up – both internally and externally				

	Not being involved in system wide developments and initiatives e.g., development of place, wider health inequalities work etc. Not having service user voice to inform transformation and development plans	• Lead provider for Reach Out (secure care) and a partner in CAMHS, eating disorders and perinatal provider collaboratives. • 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.	intelligence about our population and needs.	• Strategy and Transformation Board • Board Committees • Trust Board • 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

	BAF07/QPES /001	Refresh Partnerships Strategy	Head of Strategy, Business Development and Partnerships	31st Dec 2024	We will have a clear direction of travel, with our gaps identified and ambitions articulated to address the gaps and respond to our opportunities.	
	BAF07/QPES /002	Develop implementation plan for Partnerships Strategy	Head of Strategy, Business Development and Partnerships	30th Sept 2024	We will have a coherent plan of how we are going to strengthen our partnership working.	
	BAF07/QPES /003	Commission Needs Assessment	Associate Director of BSOL MH Provider Collaborative	31st Aug 2024	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.

compassionate inclusive committed

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.*	The Trust has a System Strategy Group that has representation from the • Director of Finance	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. • Communications around the offering.	• Minutes show that last year 42 teams came to the system strategy group to discuss ideas and issues where	

	• *Teams and individuals don't know the art of the possible.*	• 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, • Estates, • Governance, • Operations • Offering a one stop show to help engage around all things Digital,		digital, data and technology could offer a solution. • DOF chairs and attends SSG and reports to FPP with CIO.	

		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.			
	• *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	• Only new Business case projects go thorough the Capital Review Group, existing services are not considered unless capital investment is required.	• Minutes • Reports to FPP committee • Business cases	• Does not apply to existing or service redesign if no funding is required

		through a lens keeping digital on the agenda. • The DOF Chairs, CIO is included in the distribution of all new business cases.			
	• *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	• 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.

		discussed at FPP in the quarterly assurance update. • Strategy and Transformation Board receive a monthly update on all live projects.			
	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

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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?**	

	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.

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.*	• Shareholder, Liaison, Contractor and Operational Management Team	• Provision of Service Strategy across Trust per	• Physical Environment considered within Estates and Facilities Risk Schedule with	• Risk of lack of ownership and

	• *Management of Owned, Retained, PFI and landlord facilities.*	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 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.	service, per team and per premises. • Commitment to delivery of the Green- Action Plan through Capital and Revenue programmes, Trust Corporate Department delivery and Clinical/ Nursing service commitment making sustainability and net zero carbon part of our BAU.	mitigation, actions and reviews. • All properties reviewed by professional Estates and Facilities Managers. • Multi-disciplinary Trust Sustainability Group including SSL, Finance, Procurement, Clinical/ Nursing Teams, etc. • Trust Board Executive named responsible. • Named Non-Executive Lead for Sustainability, Net Zero Carbon and Green Plan. • Condition Surveys, review of premises	prioritization. across the Trust • Risk of lack of prioritisation of capital investment in matters regarding the Green agenda and Decarbonisation of Heat Supply. • 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

		• Heat De-carbonisation reviews across sites. • Listen-up Trust wide communication sessions. • Reporting on progress through Annual Reports inc 2022 and 2023.		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. • Trust Green Plan in line with ICS Green Plan.	mandates that lead to undue pressure on the organisation.
	• *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.	• 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;

		• PFI Lifecycle Programme. • PPM, reactive and planned works • Delivery of the Trust Green Plan and the built in Action Plan			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 in-house compliant facilities. • Operational and Strategic Water Management Groups.	• 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.	

		• 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 target risk score.	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 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

Birmingham and Solihull Mental Health

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Failure to operate within its financial resources.	**Inherent Risk Rating**	4	5	20	Finance, Performance & Productivity Committee	
		Current Risk Rating	4	4	16		
		Target Risk Score	3	3	9	**Date added**	09/06/2023
		Risk Appetite	**Open**: Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels. **Target risk score range 9-10.**			**Date reviewed**	**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 *Inadequate financial controls* *Cost pressures are not managed effectively*	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.
	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 to meet its statutory financial	HFMA sustainability audit has identified a number of development areas that would improve controls and performance.

		ICS expectations and reporting requirements.	Trust has not been able to develop a pipeline for delivery of savings.	obligations, including any shortfall in savings delivery.	
	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.

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	**Oversight Committee**	
Title of risk	Potential failure to evidence and embed a culture of compliance with Good Governance Principles.	**Inherent Risk Rating**	5	5	25	Finance, Performance & Productivity Committee	
		Current Risk Rating	5	2	10		
		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**	**10th September 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.*	Regular and planned external inspections from the regulators e.g. CQC. Self-assessment, accreditation and self-certification. Setup a strong governance infrastructure to underpin compliance.	Operational pressures negatively impacting on staff capacity to fully implement these controls. Self-assessments, accreditation and self-certification processes aren`t strong.	Inspection reports. Compliance audits. Self-assessment, accreditation and self-certification reports. External visit reports. Peer Reviews.	Poor learning from previous regulatory inspections. Self-assessment, accreditation and self-certification culture not strong enough to be relied upon for assurance. Peer review not very regular.

	A non-compliance mindset or mentality. *A weak governance infrastructure.* *Excessive emphasis on compliance leading to a `tick-box` culture.* *Poor perception of compliance leading compliance overload or fatigue.* *Human factors, poor attitudes, human behaviours and desire to circumvent due process.* *Weak internal systems, processes and procedures.* *Lack of awareness of the added value of regulatory compliance to the business.* *Requirement to meet the statutory duty to `breakeven`* *Staff circumventing due process or taking `shortcuts`.*	Regular audits on compliance. Staff training and awareness sessions to tackle poor behaviour around compliance. Strengthen the internal control systems and processes. Regular horizon scanning for cases of non-compliance. Savings Policy in place and implemented. Regular process audits e.g. Accounts or medication reconciliations. Awareness and Comms to be circulated. Populate the Scheme of Delegation and SFI.	Governance around compliance is weak. Controls have not been embedded.	Board Assurance Framework Report.	The culture of BAF not fully developed and embedded.

	Managers making decisions above their competence or powers without due regards to the Scheme of Delegation. *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.	Culture of evidencing and demonstrating compliance not fully developed and embedded into business as usual.

				Annual Compliance Reports.	
	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

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

Actions being implemented to achieve target risk score.	BAF04/FPP/ 004	Update the Trust Risk Management Policy and Risk Appetite Framework.	David Tita	30/09/2024 Request extension of action due date to 31/12/2024 to enable ratification of Policy.	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 Request extension of action due date to 31/12/2024 to enable new BAF to be finalised.	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.

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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 likelihood reduces from 3 to 2 while impact stays the same at 5. Hence, risk score will become 2 x 5 = 10.
10th Sept 2024	All Board Committees and the CoG have completed their annual self-assessments. Clinical Governance workshop held on 3rd September to work through the recommendations from the recent Focused Review of Directorate Governance Arrangements and IA Review of the Trust CGC. Recent CQC inspection of the CMHT services was rated as `Good`. Risk Management Policy has been refreshed and endorsed by the Board pending inclusion of the updated risk appetite framework (currently under construction) and ratification at the full Board on 4th Dec 2024. • BAF04/FPP/004 - Request extension of action due date from 30/09/2024 to 31/12/2024 to enable the Board to ratify the updated Risk Management Policy at its December meeting. • BAF04/FPP/005 - Request extension of action due date from 31/10/2024 to 31/12/2024 to enable finalisation and ratification of the new BAF by the Board at its December meeting.

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

Executive Lead	Executive Director of Finance		Impact	Likelihood	Score	Oversight Committee	
		Inherent Risk Rating	4	5	20	Finance, Performance & Productivity Committee	
Title of risk	Potential failure to harness the dividends of partnership working for the benefits of the local population.	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.	• *Newly established groups which are working through their interface with the various*	• Procurement Plan • CQC Reports • Other regulatory Reports.		• *Time to mature newly developing relationships with providers requiring trust and transparency.*	

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

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

	Linked risks on the CRR-Risk ID	Brief risk description
	N/A	N/A

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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.*	Embedding of a values-led culture: • Values and Behavioral Framework	Colleagues not completing staff and pulse surveys. Not following values and	• Values-based recruitment • Trend for days lost to sickness absence. • Signature to the NHS Compact.	• Despite our value-based recruitment approach, some recruiting managers aren't

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

	• *A shrinking UK workforce market and the lack of long-term planning by government as enough staff aren`t being trained.*	✚ Restoration and Recovery Group ✚ NHSE&I Quarterly Pulse Check Survey ✚ National Annual Staff Survey ✚ Friends and Family Test ✚ Leavers surveys (exit questionnaires) ✚ Health & Wellbeing offer Model Employer	behaviours framework. People processes not being adhered to. 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.	• Inclusive health and wellbeing offer. • Trend for pulse check staff engagement. • Scores for motivation, ability to contribute to improvements, and recommendation of the organisation. • Staff Survey results improving to top quartile performance.	reflecting these yet. • Feedback form, new guidance re makeup of panel, and values-based questions – will be reported on a quarterly basis – possible conflict of interest as person filling in form is the chair of the interview panel, also feedback is reviewed possibly 3 months after the event • Staff survey results still reflect some gaps.
	• *Less attractive pay for some staff groups.*	Management of the workforce market: ✚ ICS workforce programme to manage demand and competition in the		• Reports to People Committee. • Close collaboration with universities. • Close collaboration with HEE.	• Falling to reassurance rather than assurance

		system in collaboration with partners. - Membership of the ICS People Committee. - Assertive recruitment to areas with chronic vacancy challenges. - National payment mechanisms and banding panels. - Remuneration Committee. - Recruitment Policy and processes. - Stabilisation Plan - Retention Plan		• Greater **employability** in local population • Recruitment times: advert to in-post. • Number of applicants • Trend in staff retention rate. • Trend in staff turnover • Analysis of exit interviews. • % staff who leave for a higher banded job. • Now part of a number of ICS working groups that have links to pay i.e. agency rates. • Working with NHSP to look at directly engaging with agency workers.	
	This may result in: -				
	• Failure to recruit a workforce that supports the values of the organisation. • Support the progression and development of the workforce. • An underperforming workforce. • Failure to represent the profile of the organisation within the workforce. • Sustained patterns of inequality and discrimination. • High turnover • Non-compliant behaviours. • Employee relations cases.				
	Linked risks on the CRR- Risk ID	**Brief risk description**			

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	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)

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

Birmingham and Solihull Mental Health

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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: -

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

<table>
<tr>
<td rowspan="3"></td>
<td>• Inability to deliver and embed staff engagement programmes.</td>
<td rowspan="3">• Roffey Park Leadership Programme
• Active bystander training
• Flourish programme.
• Enough is Enough campaign.
• Staff Survey
• Pulse check
• Patient Safety Incident response framework
• Health & Wellbeing offer
• HR Toolkit training</td>
<td rowspan="3">• Limited attendance at training programmes
• Limited sustainability of ALS

• No adherence to principles of Flourish.

• Not accessing health & wellbeing offers</td>
<td rowspan="3">• 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.
• Reframed values in practice process
• Pulling together EDI and OD in relation to restorative learning and Just Culture.
• Development of the corporate psychology offer.</td>
<td rowspan="3">• Falling to reassurance rather than assurance.</td>
</tr>
<tr>
<td>• Inability to improve staff engagement scores to the NHS staff survey.</td>
</tr>
<tr>
<td>• Inability to provide a comprehensive Health and Wellbeing offer.</td>
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<tr>
<td></td>
<td colspan="5">This may result in: -</td>
</tr>
<tr>
<td></td>
<td colspan="5">• Lack of recruitment
• Reduce trust and confidence in communities.
• Unmotivated workforce.
• Increased bullying and harassment claims.</td>
</tr>
</table>

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	• 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 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.

UPDATED TRUST BOARD ASSURANCE FRAMEWORK

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?**	

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.

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.*	Staff survey Pulse check Reflective HR casework	• Colleagues not completing surveys.	• 360-degree feedback for senior leaders • FTSU quarterly reports to committees	• Falling to reassurance rather than assurance.
	• *Inability to foster a psychologically safe environment.*				

		- Transforming culture sub-committee - Systems strategy board - A range of digital platforms through which colleagues can escalate and feed in centrally. - QI Projects to address some of the 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.	- Capacity to undertake this work. - Low trust and confidence. - Lack of digital infrastructure. - 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.	- 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 - Trust wide audits are conducted in line with a forward planner learning lessons which will be considered for future activities.	- 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. - 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.

<table>
<tr><td>Executive Lead</td><td>Executive Director of Strategy, People & Partnerships</td><td></td><td>Impact</td><td>Likelihood</td><td>Score</td><td colspan="2">Oversight Committee</td></tr>
<tr><td rowspan="4">Title of risk</td><td rowspan="4">Potential failure to realise our ambition of becoming an anti-racist, anti-discriminatory organisation.</td><td>Inherent Risk Rating</td><td>4</td><td>5</td><td>20</td><td colspan="2" rowspan="2">People Committee</td></tr>
<tr><td>Current Risk Rating</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target Risk Score</td><td>3</td><td>4</td><td>12</td><td>Date added</td><td>6th July 2023</td></tr>
<tr><td>Risk Appetite</td><td colspan="3">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.</td><td>Date reviewed</td><td>18th July 2024</td></tr>
<tr><td>Reference /

Risk ID or Number</td><td>Risk Description</td><td>Controls
Things in place to address the cause</td><td>Gaps in Controls
What are the weaknesses in the controls?</td><td colspan="2">Assurances
Triangulated evidence that the controls are in place, being followed, and making a difference</td><td colspan="2">Gaps in assurance
What are the weaknesses in the assurance?</td></tr>
<tr><td></td><td colspan="7">There is a risk that the Trust may fail in addressing racism and discrimination both behavioral and systemic across people and process.</td></tr>
</table>

<table>
<tr><td rowspan="2">**BAF4-PC**</td><td colspan="5">This may be caused by: -</td></tr>
<tr><td>• 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.</td><td>• Values and Behavioural Framework.
• FLOURISH
• Data with Dignity.
• Divisional Reducing Inequalities Plans.
• Restorative Learning and Just Culture programme.
• No Hate Zone.
• Community Collaborative.</td><td>• Colleagues not engaging in controls set.
• Lack of local accountability.
• Not following values and behaviours framework.</td><td>• 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.
• Staff Survey results improving to top quartile performance.
• EDI Improvement plan
• Triangulating data in transforming culture reporting.</td><td>• 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.
• Falling to reassurance rather than assurance.</td></tr>
<tr><td rowspan="2"></td><td colspan="5">*This may result in: -*</td></tr>
<tr><td colspan="5">• *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.</td></tr>
<tr><td></td><td>Linked risks on the CRR-Risk ID</td><td colspan="4">**Brief risk description**</td></tr>
</table>

	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/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.	
	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	2 October 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 & Information
Executive Director	Dave Tomlinson, Director of Finance — **Approved** Y x 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)*

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

The Trust's Performance Management Framework has been reviewed and a number of improvements are being made, including:

- Tighter, more formalised approach with alignment of assurance to committees
- Wider Executive involvement
- Bringing all performance management matters (People, Quality, Performance, Finance) through a single set of forums

The 2024/25 national planning guidance 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, FPPC is asked to note that population health-based access measures for transformed community mental health services, Talking Therapies and Children and Young People will be assessed on a system wide basis. Additional metrics have 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.

FPPC 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 utilized to shape the Trust's performance framework.

Members are reminded that at the February 2023 FPPC meeting, a specific request was made for the provision of action plans and improvement trajectories related to 11 of the IPD metrics. Table 1 provides a summary of the progress related to these metrics in line with plans and trajectories provided by the service leads. Tables 2-4 includes all the other domain metrics within the IPD where there is a possible concern or a deteriorating trend.

Relevant Leads have provided an update on each area. The detailed summary of progress against action plans is included as Appendix I.

Table 1: Improvement Metrics identified by FPPC at February 2023 meeting

Domain and metric	On Track	Plan in Place	Progress	Pages
Performance				
Talking Therapies – service users seen within 18 weeks			Improving trend (95.88%) in last 6 months, above revised improvement trajectory and 95% national standard.	3, 25-26
Talking Therapies – service users seen within 6 weeks			Continued improving trend and meeting national 75% standard at 88.34%.	3, 23-24
Inappropriate out of area Number of placements			Improving trend in last month remains above trajectory	2-3, 12-14
Referrals over 3 months with no contact			Deteriorating performance in previous month. Long waits over 18 weeks reduced.	4, 19-22
People				
Vacancies			August data not available (July at 13.7%)	5
Sickness			Figure has remained the same as previous month.	5, 31-32
Appraisals			Deteriorating trend in last month at 76.6%	5, 33-34

			and remains below the 90% standard	
Sustainability				
Monthly Agency costs			Improving trend in last month	5

Table 2: Performance

	On Track	Plan in Place	Progress	Page
CPA 3 Day Follow Up			Deteriorating trend in last month (73.98) below 80% target	17-18
Talking Therapies - Service users moving to recovery			Improving trend in last 2 months (48.3%) below 50% target	
Talking Therapies Reliable Recovery Rate			Improving trend in last 2 months (44.53%) below target of 48%	29-30
Talking Therapies Reliable improvement rate			Improving trend in last month to 61.06% below target of 67%	27-28
Clinically Ready for Discharge: percentage of bed days			Improving trend in last month. August at 9.82%	4, 15-16
Clinically Ready for Discharge: Number of delayed days			Improving trend in last month. August at 1603	4, 15-16

Table 3: People

	OnTrack	Plan in Place	Progress	Page
Fundamental Training			Improving trend in last 2 months (93.28%). Remains below target of 95%	35

Table 4: Quality

	On Track	Plan in Place	Progress	Page
Incident resulting in harm (patients)			Reducing trend in last 3 months. Reviewed via QPES.	5, 36
Reported incidents			Reduction in last month to 2,442 remains above upper control limit. Reviewed via QPES.	5,37

Strategic Priorities

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

Recommendation

Enclosures

FPPC September 2024 Performance Report and Integrated Performance Dashboard

Appendix I FPPC September 24 FPPC Performance Improvement Metrics

Appendix II FPPC September 24 Performance Framework Update

Appendix IIa Waiting Times

Appendix IIb ICCR Deep Dive (CMHT & NMHT)

Appendix IIc Specialties Deep Dive (Eating Disorders)

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 In appropriate 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- now both above target**)
- Referrals over 3 months with no contact
- People metrics – Vacancies, Sickness absence, Appraisals and Bank & Agency fill rates

Committees are 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 related action plans.

Due to the level of detail within the overall IPD, at the October 2023 FPPC meeting, members asked that summarised detail on the key issues is provided. The report content below has therefore been included to address this feedback.

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, FPPC is asked to note that population health-based access measures for transformed community mental health services, Talking Therapies and Children and Young People will be assessed on a system wide basis. Additional metrics have been added which include: Adults and older adults with long length of stay (over 60/90 days for adult/older adult admissions), People with severe mental illness receiving a full annual physical health check and Number of people accessing Individual Placement and support.

Performance in August 2024

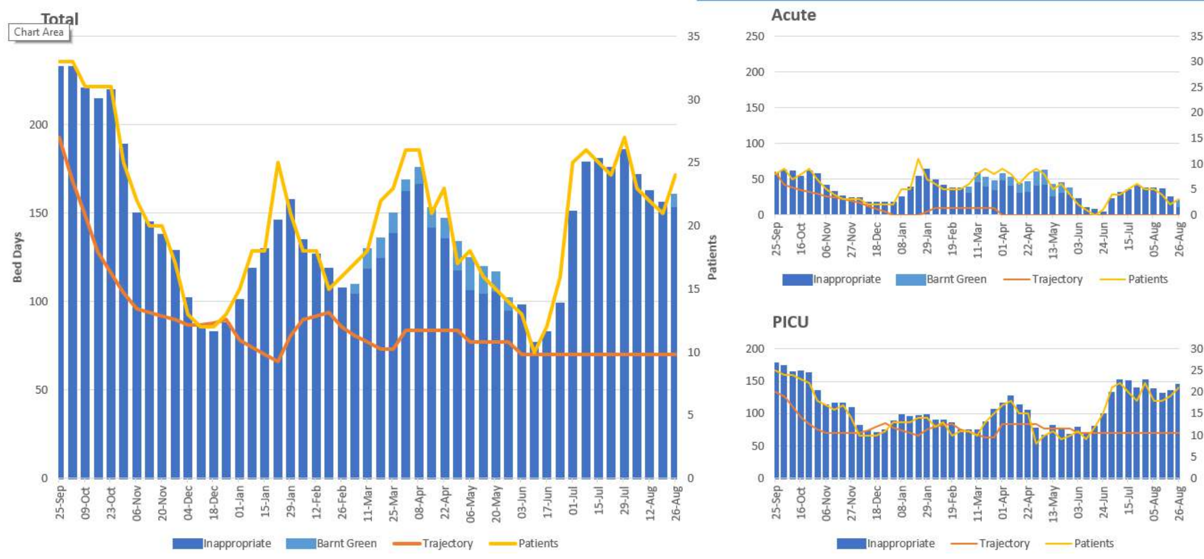
The key performance issues facing us as a Trust have changed little over the last 2 years, although there have been some improvements against some of the metrics in recent months:

Active Inappropriate Out of Area placements

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 as part of the Productivity action plan are continuing to be implemented and have helped to address some underlying issues, however in the last month there has been a continuing number of service users requiring admission and this together with increased Clinically Ready for Discharge patients continues to impair our ability to eliminate inappropriate out of area placements. In the last month there has high demand for both acute and PICU beds leading to use of inappropriate placements and being above the trajectory for August. The granular level weekly data is outlined below. As at the end of August 2024, there was 3 acute (target 0) inappropriate placements and 20 PICU (target 10) patients.

A detailed update on the action plan was provided by the Acute and Urgent Care AD at the June 2024 FPPC meeting.



Out of Area Steering Group -Action plan updates:

- **Locality model** – Renewed action to progress.
- **Contract procurement** - extended 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 and out of hours.
  Clinical Oversight Team – renewed action to progress.
  Reducing LOS/CRFD – A session to finalise the CRFD Policy is being held in September, action plan being developed.

Longer term or requires additional support form ICB.

- **Clinically Ready for Discharges (CRFD)** - internal bed management led review and partnership led meetings held weekly, Estimated Discharge Date confirm and challenge process being taken forward.
- 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. Outcome awaited.
- **Joined up 18+ bed management process** – options appraisal exercise in progress – due end of November 2024.

Talking Therapies waits – Trust performance has improved and is now above the national waiting time standards for 6 weeks with August at 88.34% (national standard 75%) due to the successful drive of the action plan which has led to an over achievement of the improvement trajectory.

The 18-week 95% standard was planned to be met by end of June 2024 and has been extended to be achieved in December 2024. Good progress is being made and the position as at August 2024 was 95.88%, above the 95% national standard.

Both recovery plans are heavily reliant on recruitment plans. New staff are commencing in October and will take time to embed. Previous recruitment has had a positive impact demonstrated by the improving trends observed.

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. All the rates are below the 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. Challenges in both services remain in particular around managing high caseload levels and pressures arising from staffing levels.

FPPC is asked to note a related area of work being taken forward which aligns to the national 2024/25 operational guidance that focuses on community mental health waiting times. The initial focus is to review all long waiters over 104 weeks including completion of a data validation exercise to support. The requirements and reports to support services in this work has been shared with both the ICCR and Specialties at their FPPC meetings in July and Operational Management Team meeting in August.

ICCR Adult CMHTs – 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. Although progress was made, the service did not meet their original improvement plan to achieve a 20% reduction in new referrals not seen within 3 months by June 2024. Having reviewed their action plan, the service lead has extended the trajectory to December 2024. Progress has slowed this month with August at 627 remaining below trajectory.

Older Adult CMHTs – The service continues to focus initially on the long waits over 26 and 52 weeks which have both seen reductions. Older Adult CMHTs original plan was to achieve a 20% reduction in those waiting over 18 weeks by the end of April 2024 which was achieved. Good progress continues to be made and as part of their ongoing improvement plan, a new trajectory has been set to achieve a further 20% reduction by October 2024. Progress as at August of 129 is only below the planned trajectory.

Clinically Ready For Discharge (CRFD) - bed days lost to CRFD have been on an increasing trend, with the latest Trust position at 9.82%. The main drivers for this are the delays in both adult and older adult acute services. CRFD in August 2024 in Adult Acute & Urgent Care is at 12.07% (40 patients) and in Older Adult Services at 21.6% (18 patients). The number of delays in Acute and Urgent care have decreased 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.

Trust and Partnership wide discussions to support the identification of plans to assist discharge continue to be prioritised by weekly meetings and daily reviews discussing individual patient needs, however traction to improve the position remains challenging.

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 decreased to 27.1%.
- Reported incidents have decreased from 2653 to 2442 in the last month.

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 fundamental training 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 reduced from 4,362.7 to 4,346.0 since June and is up from 4,070.3 in Jul-23. This is against a current establishment of 5,036.5 WTE with vacancies up from 13.3% in June to 13.7%, though this has worsened since Feb-24 (8.6%).
    - Acute & Urgent Care — Actual WTE 761.4 down from 764.9 in June against an establishment of 871.6 — 12.6% vacancies. Actual WTE are down from 776.7 in Mar-24
    - Secure — Actual WTE 989.7 down from 994.8 in June against an establishment of 1142.2 — 13.4% vacancies. Actual WTE are up from 970.3 in Dec-23
    - ICCR — Actual WTE 938.8 down from 947.7 in June against an establishment of 1123.3 — 16.4% vacancies. Actual WTE are up from 899.4 in Oct-23
    - Specialties — Actual WTE 779.1 down from 780.6 in June against an establishment of 847.0 — 8.0% vacancies. Actual WTE are up from 719.9 in Aug-23
    - Qualified Nurses — Actual WTE 1296.6 up from 1250.9 in June against an establishment of 1633.9 — 20.6% vacancies. Actual WTE are up from 1108.2 in Aug-23

- Bank and Agency WTE reduction – bank usage increased by 313 WTE (above trajectory) and agency usage by 0.9WTE (below trajectory) for July.

- Staff Appraisals at 76.6% as at August 2024 below improvement trajectory and remains below the 90% Trust standard.

- L&D QI appraisal project continues with focus on gathering qualitative data from staff. Questionnaire is being finalised.
- Reminders being sent to staff.
- Streamlined process for staff to access appropriate appraisal support e.g. coaching, system walk though, ESR etc

- Staff vacancy levels Vacancy data for August 2024 not available at time of writing. July at 13.6%

  Mandatory Training at 93.3% - An increase this month due to improvements in the level of Oliver McGowan training now the grace period has now ended. Additional training requirements have been added in August and will impact in future months.

Sustainability – (details in finance report)

- Capital expenditure - No major issue with achieving the agreed capital programme is envisaged at this stage
- Cash balance continues to be high, although the element relating to provider alone is very low.
- CIP - YTD efficiencies are £3,664k against plan of £5,238k. Majority of slippage relates to out of area spend and unidentified savings
- YTD agency expenditure now below NHSE ceiling (£2,215k v £3,781k). Level of medical staff expenditure significantly down on 23/24
- Operating Surplus - YTD deficit of £249k against plan of £999k surplus. Significant pressures in terms of out of area bed usage, temporary staffing and undelivered recurrent savings.

Integrated Performance Dashboard

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

August 2024

Performance

Metric	Value	Trend
Active Inappropriate Adult Mental Health Out of Area Placements	23	
Clinically Ready for discharge, Number of Delayed Days	1603	
Clinically Ready for Discharge, Percentage of Bed days	9.8%	
CPA 3 day FU	74.0%	↓
CPA 7 day FU	88.6%	↓
CPA with Formal Review last 12 mths	95.9%	↑
Eating Disorders Routine	100.0%	
Eating Disorders Urgent	100.0%	
First episode psychosis	100.0%	
Out of Area Bed Days	712	↑
Referrals over 3 mths with no contact	3821	↓
Talking Therapies into Recovery	48.3%	↓
Talking Therapies seen in 18 weeks	95.9%	↓
Talking Therapies seen in 6 weeks	88.3%	↓
Talking Therapies, Reliable Improvement rate	61.1%	↓
Talking Therapies, Reliable Recovery Rate	44.5%	↓

People

Metric	Value	Trend
Bank & Agency Fill Rate	89.8%	
Fundamental Training	93.3%	
Rolling 12m Turnover	6.7%	↑
Staff Appraisals	76.6%	↓
Staff Sickness	5.2%	

Quality

Metric	Value	Trend
Absconsions from inpatient units	6	
Commissioner reportable incidents	0	
Community confirmed suicides	0	
Community suspected suicides	1	
Failure to return	17	
Incidents of self harm	208	
Incidents resulting in harm (other)	7.0%	↑
Incidents resulting in harm (patients)	27.1%	↓
Inpatient confirmed suicides	0	
Inpatient suspected suicides	0	
Ligature no anchor point	21	↑
Ligature with anchor point	0	

Metric	Value	Trend
Patient assaults	37	↑
Patient ssaults / 1000 OBD	1.9	
Physical restraints	358	
Physical restraints/ 1000 OBD	18.5	
Prone restraints	35	↑
Prone restraints/ 1000 OBD	1.8	↑
Reported incidents	2442	↑
Staff assaults	117	
Staff assaults / 1000 OBD	6.0	

Sustainability

Metric	Value	Trend
CAP Ex	-£2,102k	↓
Cash	£93,790k	↑
CIP	£947k	↑
Monthly Agency	£375k	↑
Operating Surplus	-£432k	↓
SOF rating	3	↑

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

Integrated Performance Dashboard

Division
A: All

A: All

Measure	Latest Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Active Inappropriate Adult Mental Health Out of Area Placements	10.00	23	23	12	17	27	23
Clinically Ready for discharge, Number of Delayed Days			1334	1559	1546	1689	1603
Clinically Ready for Discharge, Percentage of Bed days			8.4%	9.5%	9.8%	10.4%	9.8%
CPA 3 day FU	80.00	82.5%	89.6%	83.9%	86.0%	85.8%	74.0% ↓
CPA 7 day FU	95.00	91.7%	92.8%	93.4%	91.7%	93.3%	88.6% ↓
CPA with Formal Review last 12 mths	95.00	95.7%	95.6%	95.1%	96.5%	96.7%	95.9% ↑
Eating Disorders Routine	95.00	100.0%	92.9%	100.0%	85.7%	100.0%	100.0%
Eating Disorders Urgent	95.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
First episode psychosis	60.00	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Out of Area Bed Days	328.00	578	730	520	384	775	712 ↑
Referrals over 3 mths with no contact		3623	3521	3708	3730	3646	3821 ↓
Talking Therapies into Recovery	50.00	45.3%	47.5%	48.0%	45.1%	47.8%	48.3% ↓
Talking Therapies seen in 18 weeks	95.00	87.5%	90.1%	90.6%	92.5%	93.4%	95.9% ↓
Talking Therapies seen in 6 weeks	75.00	74.8%	77.2%	81.4%	82.3%	83.2%	88.3% ↓
Talking Therapies, Reliable Improvement rate	67.00	64.0%	63.4%	67.4%	60.3%	59.1%	61.1% ↓
Talking Therapies, Reliable Recovery Rate	48.00	40.8%	43.4%	45.3%	42.1%	43.7%	44.5% ↓

Integrated Performance Dashboard

A: All

Measure	Latest Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Staff Vacancies		11.9 %	14.3%	13.8%	13.3%	13.7 %	
Staff Sickness	4.28	4.7%	5.0%	4.8%	5.1%	5.2%	5.2%
Staff Appraisals	90.00	74.1 %	75.6%	75.6%	76.3%	78.6 %	76.6 % (significant CONCERN)
Rolling 12m Turnover		7.5%	7.2%	7.0%	6.8%	6.8%	6.7% (significant IMPROVEMENT)
Fundamental Training	95.00	92.7 %	93.4%	94.1%	92.0%	92.8 %	93.3 %
Bank & Agency Fill Rate		93.5 %	91.8%	88.2%	90.0%	87.8 %	89.8 %

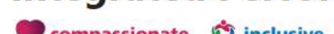
Top Line Commentary (Trust level)

KEY CONCERNS

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

(pink)	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	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Absconsions from inpatient units		2	1	5	6	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	2	3	3	1
Failure to return		20	15	22	17	16	17
Incidents of self harm		198	162	165	230	225	208
Incidents resulting in harm (other)		9.0%	10.8%	7.8%	8.4%	8.4%	7.0% ↑
Incidents resulting in harm (patients)		28.0%	28.1%	31.1%	29.4%	28.0%	27.1% ↓
Inpatient confirmed suicides		0	0	0	0	0	0
Inpatient suspected suicides		0	0	1	0	0	0
Ligature no anchor point		31	18	27	21	34	21 ↑
Ligature with anchor point		0	0	2	0	3	0
Patient assaults		46	38	28	39	37	37 ↑
Patient ssaults / 1000 OBD		2.4	2.1	1.5	2.1	1.9	1.9
Physical restraints		276	183	198	314	312	358
Physical restraints/ 1000 OBD		14.4	9.9	10.3	16.9	16.2	18.5
Prone restraints		46	35	49	41	67	35 ↑
Prone restraints/ 1000 OBD		2.4	1.9	2.5	2.2	3.5	1.8 ↑
Reported incidents		2372	2200	2233	2526	2653	2442 ↑
Staff assaults		79	73	82	87	69	117
Staff assaults / 1000 OBD		4.1	3.9	4.3	4.7	3.6	6.0

Top Line Commentary (Trust level)

KEY CONCERNS

* Incidents resulting in harm (patients)

Integrated Performance Dashboard

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

HOME

PERFORMANCE

PEOPLE

QUALITY

SUSTAINABILITY

Division

A: All

A: All

Measure	Latest Target	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
CAP Ex		£1,157k	£1,213k	£333k	£557k	-£56k	-£2,102k ↓
Cash		£92,228k	£83,423k	£88,969k	£90,881k	£85,539k	£93,790k ↑
CIP		£1,319k	£600k	£922k	£850k	£1,292k	£947k ↑
Monthly Agency		£625k	£607k	£435k	£394k	£404k	£375k ↑
Operating Surplus		-£680k	-£422k	£275k	£493k	-£162k	-£432k ↓
SOF rating		3	3	3	3	3	3 ↑

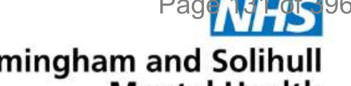
Top Line Commentary (Trust level)

KEY CONCERNS:

* CIP under achievement
* National financial uncertainty

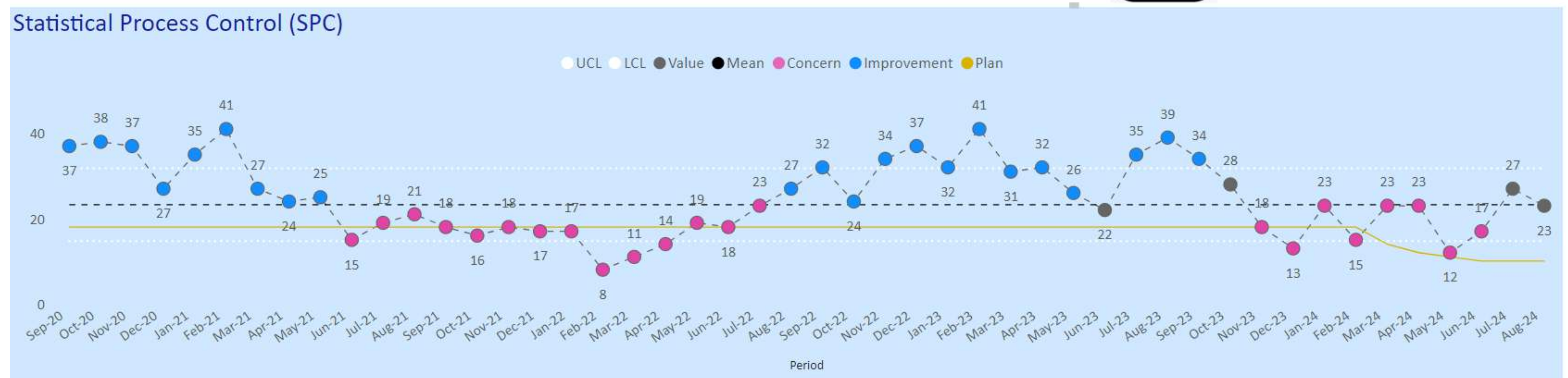
(pink)	Not meeting target
↑	significant IMPROVEMENT
↓	significant CONCERN
↗	possible improvement
↘	possible concern

compassionate inclusive committed



Active Inappropriate Adult Mental Health Out of Area Placements

Statistical Process Control (SPC)



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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	23	23	12	17	27	23
B: Acute and Urgent Care	23	23	12	15	27	23

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.

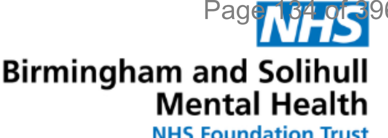
At the end of August there were 23 Inappropriate Out of Area Placements with 3 in acute beds and 20 in PICU beds significantly above the trajectory of 10 for August 2024. There were 15 inappropriate admissions during August with 3acute and 12 PICU

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

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 August there were 23 Inappropriate Out of Area Placements with 3 in acute beds and 20 in PICU beds significantly above the trajectory of 10 for August 2024. There were 15 inappropriate admissions during August with 3acute and 12 PICU 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 1603 overall in August, with adults at 833 lost bed days. Adult bed occupancy increased to 97% and length of stay increased to an average of 117 days in August. 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.

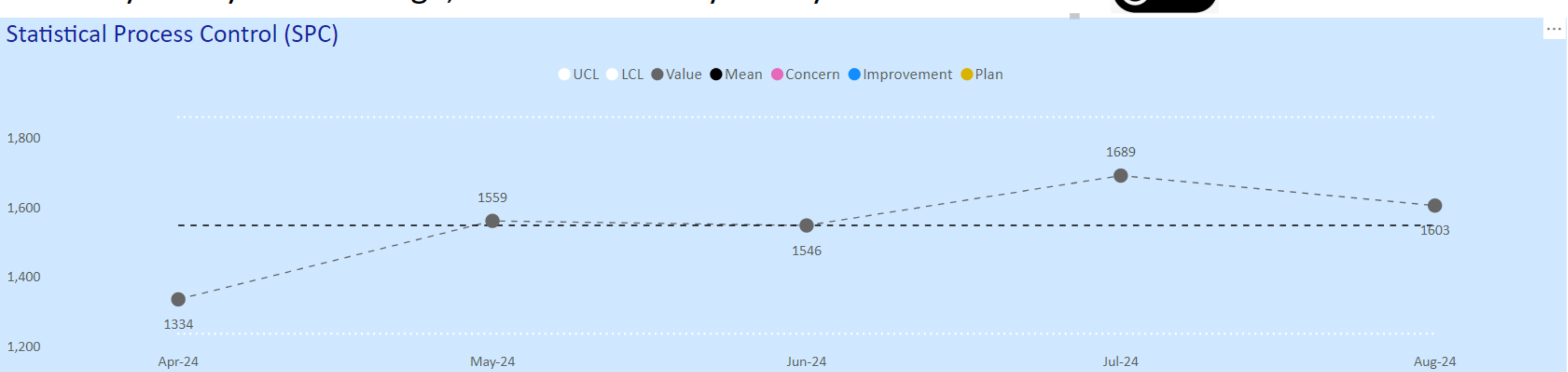
Question	Answers
D: What are we doing about it?	An update on the project plan was shared at the Performance Delivery group in November 2023 outlining progress within the 3 key workstreams to better manage demand, reduce inappropriate OOA placements and costs, improve patient experience and optimise services 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 September to finalise policy. • A Discharge Manager Away day has been held to identify issues and formulate questions which have been sent to social care • An audit has been undertaken by RSM Uk and the outcome is awaited 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.

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.



Clinically Ready for discharge, Number of Delayed Days

Divisions



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

Division	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	1334	1559	1546	1689	1603
B: Acute and Urgent Care	545	671	756	927	833
D: Secure Serv & Offender Health	312	265	303	318	310
E: Specialties	477	623	487	444	460

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 August has decreased to 1603 bed days. Adults moved from 927 days in July to 833 days in August, which related to 40 patients, with a main delay reason of awaiting supported accommodation and public funding and older adults moved from 438 days in July to 460 in August and related to 18 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

August 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 August has decreased to 1603 bed days. Adults moved from 927 days in July to 833 days in August, which related to 40 patients, with a main delay reason of awaiting supported accommodation and public funding and older adults moved from 438 days in July to 460 in August and related to 18 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, funding 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

CPA 3 day FU

Divisions

Statistical Process Control (SPC)

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	82.5%	89.6%	83.9%	86.0%	85.8%	74.0%
B: Acute and Urgent Care	86.4%	90.4%	91.2%	91.1%	87.4%	80.7%
C: ICCR	50.0%	66.7%	61.1%	64.3%	55.6%	50.0%
D: Secure Serv & Offender Health	50.0%	100.0%	60.0%	66.7%	80.0%	20.0%
E: Specialties	93.3%	94.1%	77.3%	85.7%	94.1%	66.7%

Commentary

The follow up rates from January 2024 onwards have been just above the 80% contractual target. However, August has seen a fall to 73.9% below the 80% target. This relates to 4 service users from 123 discharges in August not being followed up within 3 days, of which, 3 patients were seen outside 7 days, 13 patients were seen between 4-7 days, 1 patient was discharged and has refused to talk to care co-ordinator, 1 patient was discharged to the care of an acute trust and contact was with staff only, 1 patient was transferred to prison, there was no follow up arranged for one patient, attempts were made to see 2 patients which were unsuccessful, 1 patient was admitted to an acute trust whilst on leave and refused to return to the ward, 1 patient was located by Police and sent in a taxi to London, 1 patient was admitted to an acute hospital after discharge and 7 cases will be a passes when data entry is completed. Of the 32 exceptions 17 were in adult acute, 4 were in ICCR, 3 in older adults, 4 in specialties and 4 in secure services. When data entry is completed, performance will increase to 87.3%

Late data entry within services is also a factor and final performance post end of the month usually exceeds what is reported within the IPR due to timelines to produce the IPR.

Detailed Commentary

CPA 3 day FU

August 2024

Question	Answers
A: What has happened?	The follow up rates from January 2024 onwards have been just above the 80% contractual target. However, August has seen a fall to 73.9% below the 80% target. This relates to 4 service users from 123 discharges in August not being followed up within 3 days, of which, 3 patients were seen outside 7 days, 13 patients were seen between 4-7 days, 1 patient was discharged and has refused to talk to care co-ordinator, 1 patient was discharged to the care of an acute trust and contact was with staff only, 1 patient was transferred to prison, there was no follow up arranged for one patient, attempts were made to see 2 patients which were unsuccessful, 1 patient was admitted to an acute trust whilst on leave and refused to return to the ward, 1 patient was located by Police and sent in a taxi to London, 1 patient was admitted to an acute hospital after discharge and 7 cases will be a passes when data entry is completed. Of the 32 exceptions 17 were in adult acute, 4 were in ICCR, 3 in older adults, 4 in specialties and 4 in secure services. When data entry is completed, performance will increase to 87.3% Late data entry within services is also a factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD.
B: Why has it happened?	The number of service users not followed up sucessfully in August has moved from 19 in july to 32 in August. 1 patient was transferred to prison which requires the staff to check to see whether they have been seen by the local MH team/ prison healthcare. There were also 13 cases where teams did not see the patient until days 4-7, outside the target of 3 days. 7 Cases will be a pass and are awaiting data entry and when this has been completed will move performance to 79.5%. Late data entry within services is also a factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD.
C: What are the implications and consequences?	Service users are at a higher risk of suicide or self harm within the first 3 days of discharge and follow up is important to minimise this risk.
D: What are we doing about it?	Daily notifications of discharges are sent to the responsible team to alert them to plan follow up and this is monitored by the CSM for Home Treatment. Teams continue to require support from the information team regarding data entry on RIO. Late data entry within services is an ongoing factor and final performance post end of the month usually exceeds what is reported within the IPD due to timelines to produce the IPD. The addition of FTB data to Rio now enables staff to see whether the patient has been seen, but we will still be required to complete a 3 day follow up form to capture this data. The shared care record can also be used for those discharged to the care of local trusts to check whether patients have been seen.
E: What do we expect to happen?	We expect the 3 day follow up standard of 80% to be maintained with HTTs acting on the daily discharge notification.
F: How will we know when we have addressed issues?	Standard is being maintained with minimal or no input required from the information team to review data entry.

Referrals over 3 mths with no contact

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	3623	3521	3708	3730	3646	3821
C: ICCR	1365	1306	1323	1279	1174	1242
D: Secure Serv & Offender Health	75	75	80	82	85	88
E: Specialties	2143	2100	2265	2323	2344	2443

Commentary

The number of patients who have not been seen after 3 months of referral has fluctuated over the last 12 months with August 2024 showing an increase to 3821, the highest number in the last 4 years. The number of referrals not seen within 3 months of referral has increased in MAS, Neuropsychiatry and Solar, adult CMHTs and has decreased in older adult CMHTs.

Neuropsychiatry service accounts for 24.5% and Adult CMHTs 16.4% of referrals open for over 3 months without a contact.

Detailed Commentary

Referrals over 3 mths with no contact

August 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 12 months with August 2024 showing an increase to 3821, the highest number in the last 4 years. The number of referrals not seen within 3 months of referral has increased in MAS, Neuropsychiatry and Solar, adult CMHTs and has decreased in older adult CMHTs. Neuropsychiatry service accounts for 24.5% and Adult CMHTs 16.4% 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: • The service has high rates of DNA for first and follow up appointments meaning appointment slots not being utilised. 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. Future reporting will enable us to identify those service users who have had no contact at all from mental heath services. Specialties: Better awareness of mental health concerns within the population and at primary care level 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 were able aiming to focus on the long waits and have achieved a 20% reduction in the 18 week plus cohort. A further trajectory has been set to reduce by a further 20% by october 2024 and is currently below trajectory in August. 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.

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: A trajectory was in place to meet a 20% reduction by June 2024, however progress has been slower than expected and this has been extended to December 2024. 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. Long Waits: • Progress achieved with waits over 52 weeks reduced by 78% since November 2023 from 94 to 21 in August 2024. Only 4 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. • Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in. 10/12 teams have all reduced those not seen within 3 months which has contributed to a reduction of 42 patients in the last month. • 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. Progress has been made with reducing waits over 26 weeks and 52-week waits have been removed. 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, CMHT caseloads however remain the same as overall demand across the system has increased (in line with the national position). • Demand and capacity work is being planned within the CMHTs and NMHT to help understand the impact of the current caseload and rate of referrals. • 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.

Referrals over 3 mths with no contact

August 2024

Question	Answers
	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 have achieved a 20% reduction in the 18 week plus cohort and have now set a further trajectory to reduce it by a further 20% by the end of October 2024. August shows that they are below the trajctory. 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 and work has commenced with services to identify these (based on meaningful activity and not just contacts).
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.

Divisions

Talking Therapies seen in 6 weeks

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	74.8%	77.2%	81.4%	82.3%	83.2%	88.3%
E: Specialties	74.8%	77.2%	81.4%	82.3%	83.2%	88.3%

Commentary

The numbers of service users seen within 6 weeks has been on an increasing trend for the last 12 months and remains above the 75% threshold at 88.3%, for the fifth time month in a row and is the highest performance in the last 3 years.

Detailed Commentary

Talking Therapies seen in 6 weeks

August 2024

Question	Answers
A: What has happened?	The numbers of service users seen within 6 weeks has been on an increasing trend for the last 12 months and remains above the 75% threshold at 88.3%, for the fifth time month in a row and is the highest performance in the last 3 years.
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. August 2024 performance is at 88.33%, a continued improving trend, above trajectory and continuing to meet the national 75% standard for the fifth month in a row which is the highest performance 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 August 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 eight months. New staff continue to be recruited with 9.8 higher intensity workers at step 3 and 8 Psychological wellbeing Practitioner (PWP) step 2 who will be starting in October 2024. The PWP will be newly qualified and will be on preceptorship for a period so will only have 80% of their caselaod allocation initally. This recruitment should continue to increase the 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 previous increase in staff has had a positive impact on the waiting times for 6 weeks with an increase in July 2024 which continues to place them ahead of the trajectory and above the 75% target. The number of contacts in August 2024 shows a 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 band 5 staff commencing their Higher Intensity training in the Autumn which will impact 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 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 are now be counted as 'treatment'. 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 - July 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.

Talking Therapies seen in 18 weeks

Divisions

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	87.5%	90.1%	90.6%	92.5%	93.4%	95.9%
E: Specialties	87.5%	90.1%	90.6%	92.5%	93.4%	95.9%

Commentary

Performance has been on a gradual increasing trend for the last 10 months and is now above the 95% target and trajectory at 95.8% for the first time in 3 years.

Detailed Commentary

Birmingham and Solihull Mental Health NHS Foundation Trust

Talking Therapies seen in 18 weeks

August 2024

Question	Answers
A: What has happened?	Performance has been on a gradual increasing trend for the last 10 months and is now above the 95% target and trajectory at 95.8% for the first time in 3 years.
B: Why has it happened?	The service plan was to reach the 95% target by June 2024. However, despite continued improvments the 95% target was not acheieved, and a revised trajectory has been put in place to meet the 95% target by December 2024. July 2024 performance is at 93.38%, a continued improving trend, which is the highest performance 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 August 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 June 2024 (originally 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 December 2024. However, successful drive of the action plan focusing on the new referrals has led to overachievement of the planned trajectory with the 95% target being achieved in August 2024. 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 continue to be recruited with 9.8 higher intensity workers at step 3 and 8 Psychological wellbeing Practitioner (PWP) step 2 who will be starting in October 2024. The PWP will be newly qualified and will be on preceptorship for a period so will only have 80% of their caseload allocation initially. This recruitment should continue to increase the 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 number of patient contacts with August 2024 seeing a 15% increase compared with the same month in 2023. There remain challenges in staffing with band 5 staff commencing their Higher Intensity training in the Autumn which will impact the level of activity which can be undertaken. 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 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' and 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 December 2024 as the contacts undertaken by the new staff begin to come through. August performance has shown the that they have met the target and will continuie to focus on maintaining this.
F: How will we know when we have addressed issues?	The national standard of 95% is met and maintained.

Talking Therapies, Reliable Improvement rate

Divisions

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	64.0%	63.4%	67.4%	60.3%	59.1%	61.1%
E: Specialties	64.0%	63.4%	67.4%	60.3%	59.1%	61.1%

Commentary

This is a new national metric for 2024/25 with an increased focus on recovery. August 2024 at 61.06% below the lower control limit for the 7th 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

August 2024

Question	Answers
A: What has happened?	This is a new national metric for 2024/25 with an increased focus on recovery. August 2024 at 61.06% below the lower control limit for the 7th 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

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	40.8%	43.4%	45.3%	42.1%	43.7%	44.5%
E: Specialties	40.8%	43.4%	45.3%	42.1%	43.7%	44.5%

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. August 2024 position has improved and remains just below the 48% target at 44.53%. 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

August 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. August 2024 position has improved and remains just below the 48% target at 44.53%. 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

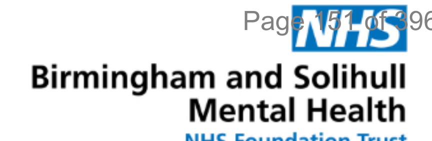
Statistical Process Control (SPC)

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	4.7%	5.0%	4.8%	5.1%	5.2%	5.2%
B: Acute and Urgent Care	5.6%	5.7%	4.3%	6.1%	5.2%	5.2%
C: ICCR	4.9%	4.6%	4.0%	3.2%	4.2%	4.1%
D: Secure Serv & Offender Health	6.1%	6.4%	7.1%	6.6%	7.2%	6.6%
E: Specialties	3.5%	4.4%	4.3%	5.7%	5.3%	6.4%
F: Corporate	3.1%	3.7%	3.6%	4.1%	4.0%	3.5%

Commentary

Our sickness absence data has not changed much since the last update. In August 2024, total sickness absence rate (trust wide) was 5.1%, long term sickness absence was 3.7% and short term sickness absence was 1.4%. We will continue to build on this to improve the rates.



Detailed Commentary

Staff Sickness

August 2024

Question	Answers
A: What has happened?	Our sickness absence data has not changed much since the last update. In August 2024, total sickness absence rate (trust wide) was 5.1%, long term sickness absence was 3.7% and short term sickness absence was 1.4%. We will continue to build on this to improve the rates.
C: What are the implications and consequences?	The implications are the costs to the Trust in managing sickness absence. The cost ranges from the cost in Occupational health support, cost to cover sick pay and back fill for long term sickness absence. We have seen the increase in the cost of the usage of OH services, this is good in one sense in that staff are using the help and support provided. The expectation is that the support provided are effective and beneficial to staff and assisting to improve their health and well being.
D: What are we doing about it?	There is a focus for the People team to reduce sickness absence rates. To reach the target, there is continued focus to work with managers to increase the levels of return to work meetings, sustain the management of long term sickness, and to enable employees who are on long term sickness absence to return to work. Managing short term sickness absences is aslo crucial and the management of these have to be sustained. We continue to work with PAM to publicise the OH support available for staff so staff find these and can access these in a timely manner. Lunch time workshops are being run to publicise all the offer that OH has for employees. Workshops also provide support for managers to understand how to use OHIO (the OH system) to make referral. Making timely referral is also vital for suuportive health and wellbeing.
E: What do we expect to happen?	The expectation is to see staff being supported with their health and well being and that we see a reduction in sickness absence levels.
F: How will we know when we have addressed issues?	When we are able to reach the Trust KPIs and we see the reduction in sickness absence rates, particularly for stress, anxiety and depression and other Musculoskeletal issues .

Staff Appraisals

Divisions

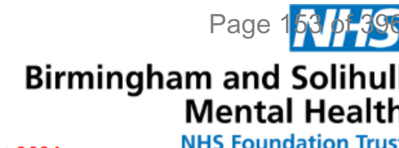
Statistical Process Control (SPC)

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	74.1%	75.6%	75.6%	76.3%	78.6%	76.6%
B: Acute and Urgent Care	63.2%	71.3%	70.9%	71.8%	68.4%	65.6%
C: ICCR	79.3%	80.0%	79.8%	79.2%	84.2%	81.3%
D: Secure Serv & Offender Health	80.3%	81.2%	80.1%	81.0%	87.5%	85.2%
E: Specialties	78.6%	77.7%	79.4%	81.0%	83.6%	82.6%
F: Corporate	65.4%	64.9%	65.0%	66.3%	64.3%	62.7%

Commentary

The trust's Appraisal compliance is 76.6% which is a small decrease from July which was 78.6%. The trust remains below the Trust target of 90% and commissioner's target of 85%.



Detailed Commentary

Staff Appraisals

August 2024

Question	Answers
A: What has happened?	The trust's Appraisal compliance is 76.6% which is a small decrease from July which was 78.6%. The trust remains below the Trust target of 90% and commissioner's target of 85%.
B: Why has it happened?	The teams within the Trust are below 75% compliance are: Acute and Urgent Care 66.9%, Exec-Nursing 62.7%, Exec - Resources - 63.3%, New Care Models 56.8%, and Strategy, People and Partnerships 70%
C: What are the implications and consequences?	We are not meeting our commissioner target of 85%
D: What are we doing about it?	QI appraisal project continues with a focus on identifying key teams within Insight to support co-production. The working group have rescheduled a meeting to confirm appraisal questions to be sent to staff. In addition to the BAU activities, L&D have developed a process flow to support staff experience and clear signposting to support. For instance, L&D , ESR, People team for specific bespoke support.
E: What do we expect to happen?	The QI appraisal project and BAU appraisal work will continue to positively support staff in achieving quality values based appraisal conversations and also improve compliance.
F: How will we know when we have addressed issues?	The review of appraisal compliance data (Insights reports), Ms forms survey data and staff survey data. The appraisal QI project also provides staff feedback from a qualitative perspective from the working group. Our aim is to ensure all staff will receive a values based appraisal, empowering staff to take ownership for their personal development and the trust will be able to demonstrate a holistic approach to staff members personal development.

Birmingham and Solihull Mental Health NHS Foundation Trust

Fundamental Training

Divisions

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	92.7%	93.4%	94.1%	92.0%	92.8%	93.3%
B: Acute and Urgent Care	92.1%	92.8%	93.5%	91.1%	91.5%	91.5%
C: ICCR	93.0%	93.5%	94.0%	91.3%	93.2%	93.6%
D: Secure Serv & Offender Health	92.7%	93.0%	93.8%	91.3%	93.5%	94.0%
E: Specialties	92.9%	93.5%	94.8%	92.6%	93.3%	93.9%
F: Corporate	93.0%	94.2%	94.5%	91.1%	92.2%	92.8%

Commentary

The overall Fundamental Training compliance increased from 92.8% in July to 93.3% in August. 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 except for Executive Director - Resources. Chief Exec - 81.5%, Exec Dir - Medical - 94.9%, Exec Dir Nursing - 93.7%, Exec Nursing - 93.4%, Exec Ops - 93.4%, New Care Models - 80.1% Temporary Staffing Compliance has increased from 92.1% in July to 91.9% in August which remains above the Trust Target of 75%

Incidents resulting in harm (patients)

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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	28.0%	28.1%	31.1%	29.4%	28.0%	27.1%
B: Acute and Urgent Care	27.5%	29.0%	28.3%	29.4%	29.4%	21.7%
C: ICCR	36.8%	26.7%	43.5%	27.5%	35.4%	27.4%
D: Secure Serv & Offender Health	25.7%	28.2%	27.9%	31.4%	27.3%	34.5%
E: Specialties	31.5%	30.0%	37.5%	26.9%	23.3%	23.0%
F: Corporate	7.1%	4.2%	0.0%	0.0%	0.0%	9.1%

Commentary

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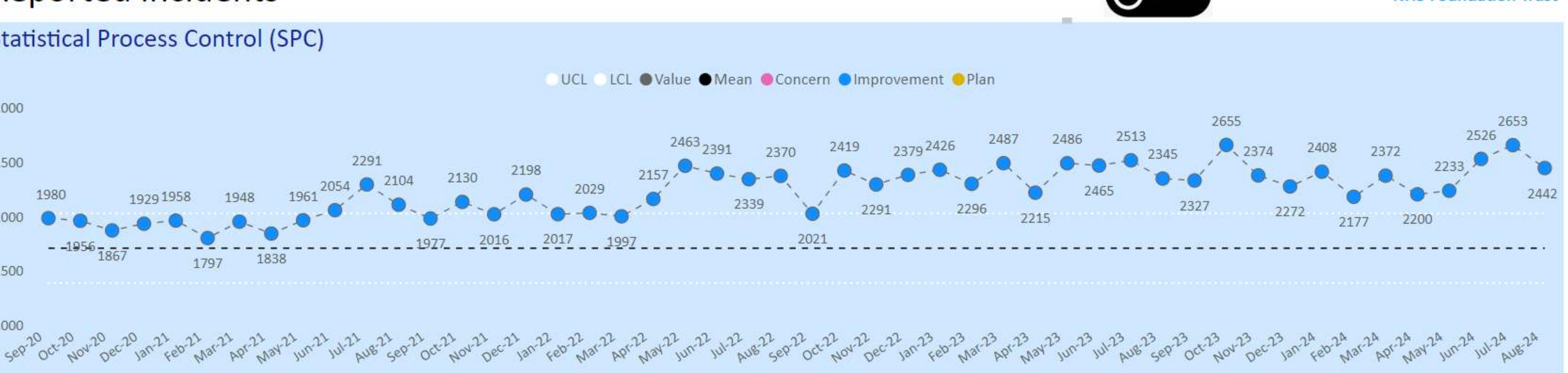
Birmingham and Solihull Mental Health
NHS Foundation Trust

Reported incidents

Divisions



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

Division	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
A: All	2372	2200	2233	2526	2653	2442
B: Acute and Urgent Care	894	794	790	917	968	813
C: ICCR	208	206	185	218	268	291
D: Secure Serv & Offender Health	739	716	720	905	894	878
E: Specialties	500	444	500	446	495	428
F: Corporate	27	34	26	30	18	26

Commentary

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Appendix I - FPPC 18th September 2024

2024/25 Performance metric Improvement Trajectory update

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2024/25 Performance Improvement metrics

- During 2023/24 the following metrics were identified by FPPC 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.

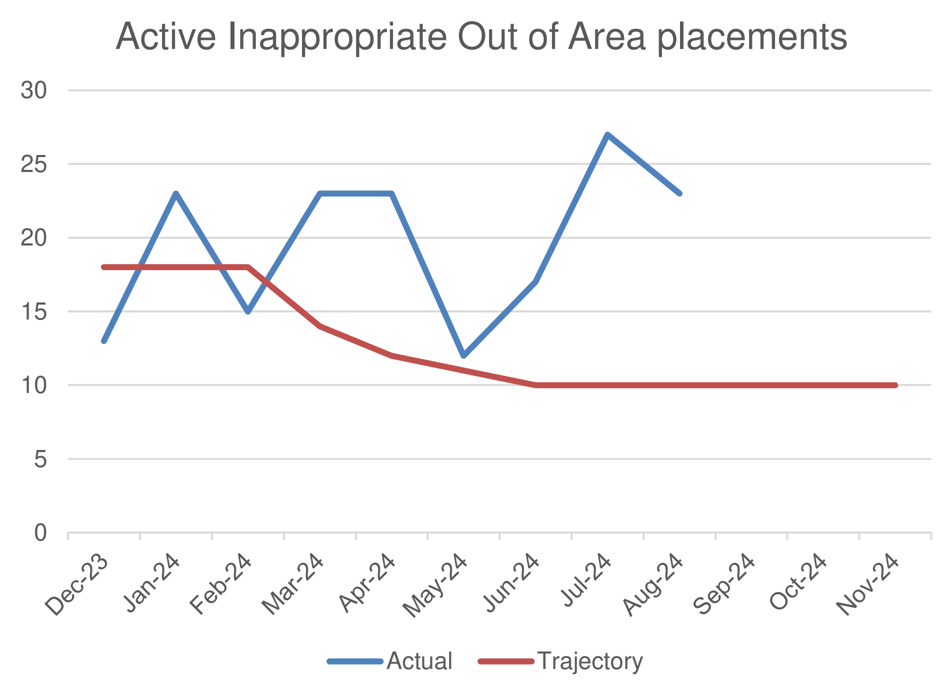
2023/24 metrics	2024/25 metrics
• Inappropriate Out of Area bed days	Replaced by Active Inappropriate Out of Area Placements
• IAPT waiting times 6 and 18 weeks	No change
• New Referrals not seen within 3 months	No change
• CPA 12-month Reviews	No change
• 7 Day follow up	Replaced by 3 day follow up
• 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

Birmingham and Solihull Mental Health NHS Foundation Trust

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 August – Total of 23 (target 10) inappropriate placements, 3 acute (target 0) and 20 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.

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

Total

Chart Area

Bed Days

Patients

25-Sep 09-Oct 23-Oct 06-Nov 20-Nov 04-Dec 18-Dec 01-Jan 15-Jan 29-Jan 12-Feb 26-Feb 11-Mar 25-Mar 08-Apr 22-Apr 06-May 20-May 03-Jun 17-Jun 01-Jul 15-Jul 29-Jul 12-Aug 26-Aug

Inappropriate Barnt Green Trajectory Patients

Acute

25-Sep 16-Oct 06-Nov 27-Nov 18-Dec 08-Jan 29-Jan 19-Feb 11-Mar 01-Apr 22-Apr 13-May 03-Jun 24-Jun 15-Jul 05-Aug 26-Aug

Inappropriate Barnt Green Trajectory Patients

PICU

25-Sep 16-Oct 06-Nov 27-Nov 18-Dec 08-Jan 29-Jan 19-Feb 11-Mar 01-Apr 22-Apr 13-May 03-Jun 24-Jun 15-Jul 05-Aug 26-Aug

Inappropriate Trajectory Patients

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

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Completed

- **Locality Model** – a renewed focus for action is being planned to support teams to work within localities across the patient pathway.
- **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)

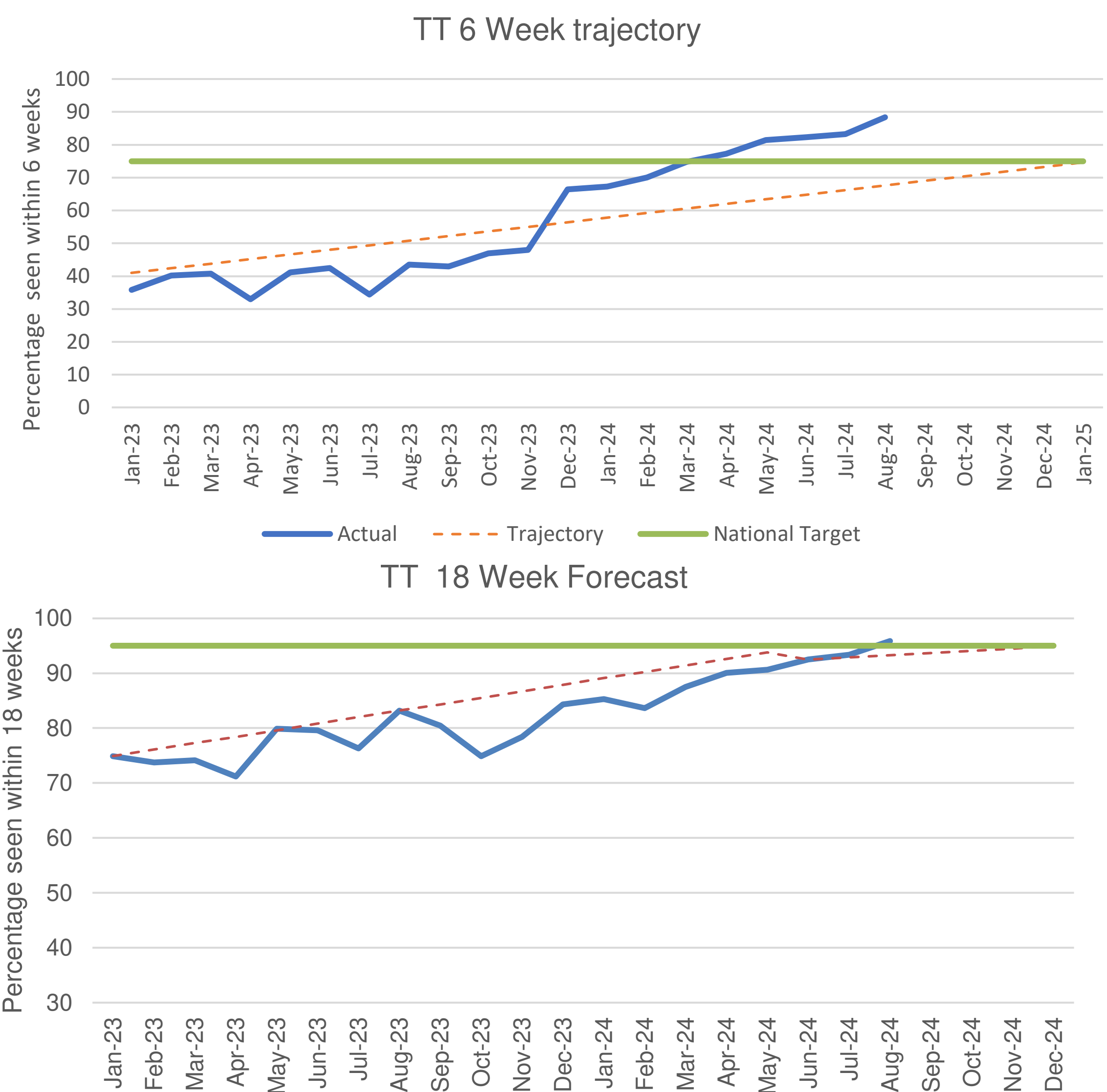
In progress

- **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, out of hours and more work on how we can improve recording of this metric.
- High volume users project to identify high volume users and establish a management plan to prevent admission and support/enable these users to be supported in the community where appropriate.
- **Reducing LOS/Clinically Ready for Discharge (CRFD)** - CRFD Policy session in September to finalise policy.
- **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.
- 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. Outcome awaited.
- **Joined up 18+ bed management process** – options appraisal exercise in process – due end of November 2024

Talking Therapies waiting times 6 &18 weeks



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 a continued improved position exceeding trajectory.
August 2024 performance is at 88.3%, above trajectory and exceeding the national 75% standard for the fifth month in a row which is the highest performance in the last 3 years.

Service users seen within 18 weeks – A revised trajectory was put in place by the service to meet the 95% target by December 2024 based on staffing plans being in place to support. Good progress has been made over the last 9 months due to increased capacity and August has met the 95% target for the first time in 3 years at 95.88%.

Improvements in both waiting times has contributed to the ICS now meeting the thresholds.

Talking Therapies – update on Service's action plan

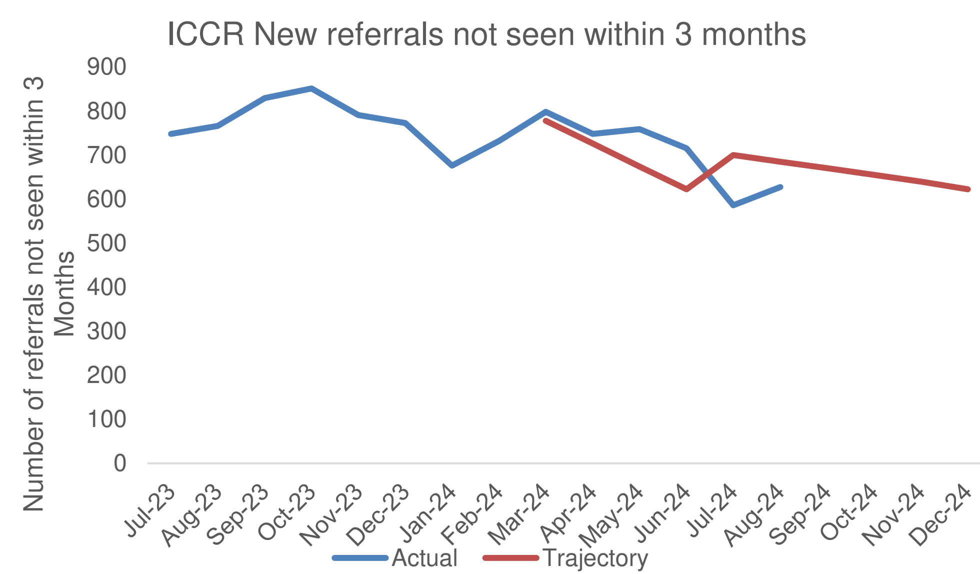
- 6 week waiting time standard – ahead of planned trajectory, good progress and meeting the 75% national target for the first time in three years.
- 18 week waiting time standard – Progress made, with performance at 95.88% and now above the 95% national standard. Improved capacity is assisting in the progress being achieved.
- New staff continue to be recruited with 9.8 higher intensity workers at step 3 and 8 Psychological Wellbeing Practitioners (PWP) step 2 who will be starting in October 2024. The PWP will be newly qualified and will be on preceptorship for a period so will only have 80% of their caseload allocation initially.
- The service is offering more follow up 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. Data shows the number of single therapy session discharges has fallen in May (latest national data available)
- 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.
- 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.
- 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. Although progress was made, the service did not meet their original improvement plan to achieve a 20% reduction in new referrals not seen within 3 months by June 2024. Having reviewed their action plan, the service lead has extended the trajectory to December 2024. Progress has slowed this month with August at 627 below the trajectory.

A related area of work aligns to the national 2024/25 operational guidance that focuses on community mental health waiting times.

The initial focus is to review all long waiters over 104 weeks including completion of a data validation exercise to support. The requirements and reports to support services in this work have been shared with both the ICCR and Specialties FPPC meetings in July and Operational Management Team meeting in August. Waiting times have also been discussed at September Performance delivery group.



Note - ICCR Trajectory provided by Associate Director for ICCR.

New Referrals not seen within 3 months

Birmingham and Solihull Mental Health NHS Foundation Trust

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.

Long Waits

- Progress achieved with waits over 52 weeks reduced by 78% since November 2023 from 94 to 21 in August 24.
- Focus has now moved to waits over 18 weeks with Clinical Service Managers working with teams to ensure appointments are booked in. 10/12 teams have all reduced those not seen within 3 months which has contributed to a reduction of 42 patients in the last month.
- 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. Progress has been made with reducing waits over 26 weeks and 52-week waits have been removed.
- A number of those waiting 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.

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New Referrals not seen within 3 months

ICCR action plan cont:

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.

Demand Management:

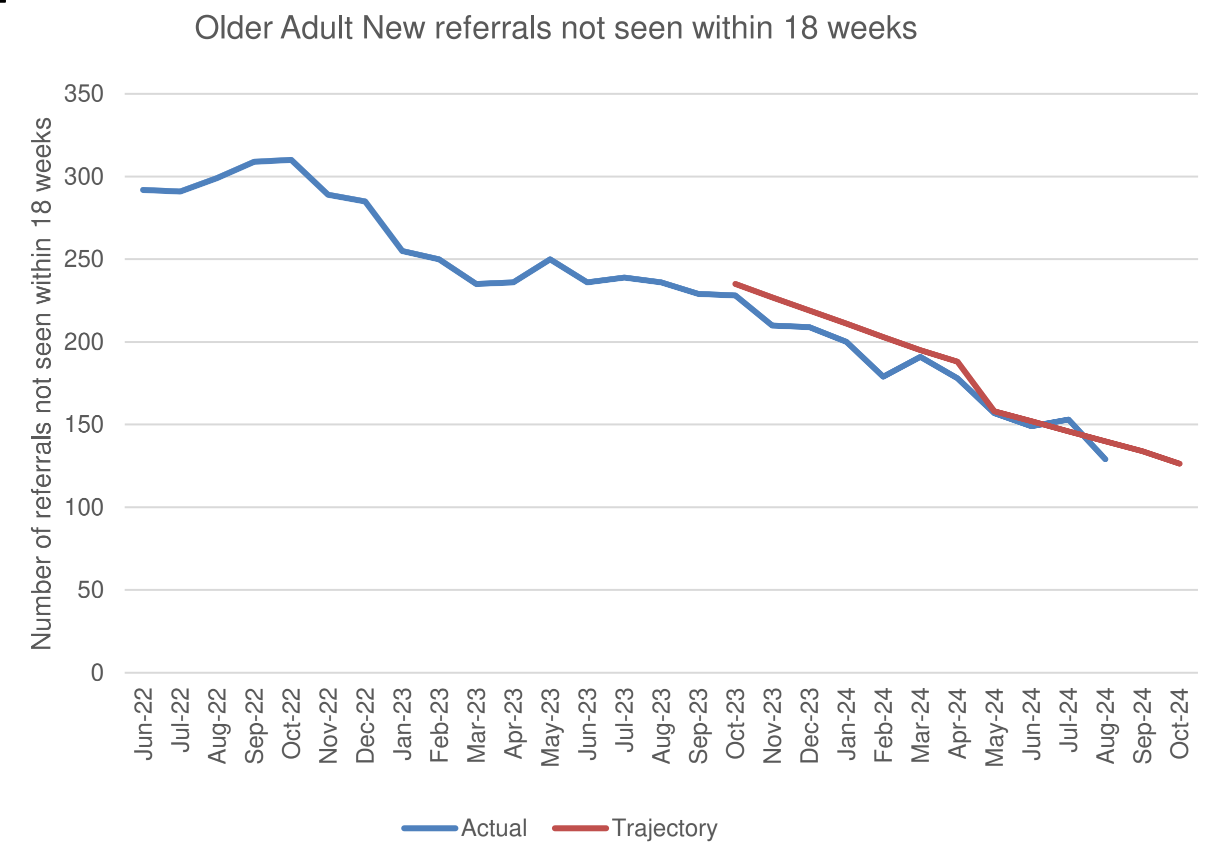
- All referrals are screened by the NMHT and only referred into CMHT if SMI, complexity or risk is present. CMHT caseloads remain the same as overall demand across the system has increased (in line with the national position). Demand and capacity work is being planned within the CMHTs and NMHT to help understand the impact of the current caseload and rate of referrals.
- 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

Older Adult CMHTs original plan was to achieve a 20% reduction in those waiting over 18 weeks by the end of April 2024 which was achieved. Good progress continues to be made and as part of their ongoing improvement plan, a new trajectory has been set to achieve a further 20% reduction by October 2024. Progress as at August of 129 now below the trajectory.

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.

New Referrals not seen within 3 months

Birmingham and Solihull Mental Health NHS Foundation Trust

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.

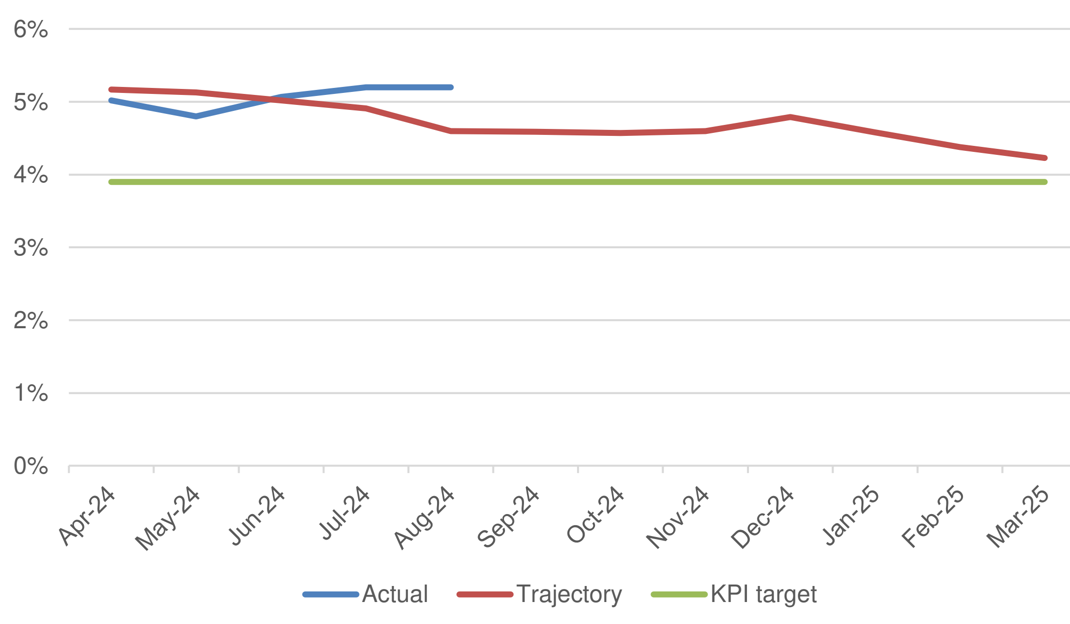
Where there are current vacancies and waits for staff to join, bank shifts are being used to help address those staffing gaps.

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 have 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 to be 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.

Workforce trajectories – 2024/25 update

Sickness Absence

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



Note - Trajectory and commentary provided by People team

Sickness levels have remained at 5.2% in August 2024 above the improvement trajectory of 4.6%. Long-term sickness increased with August at 3.76% and short-term sickness also decreased to 1.39%.

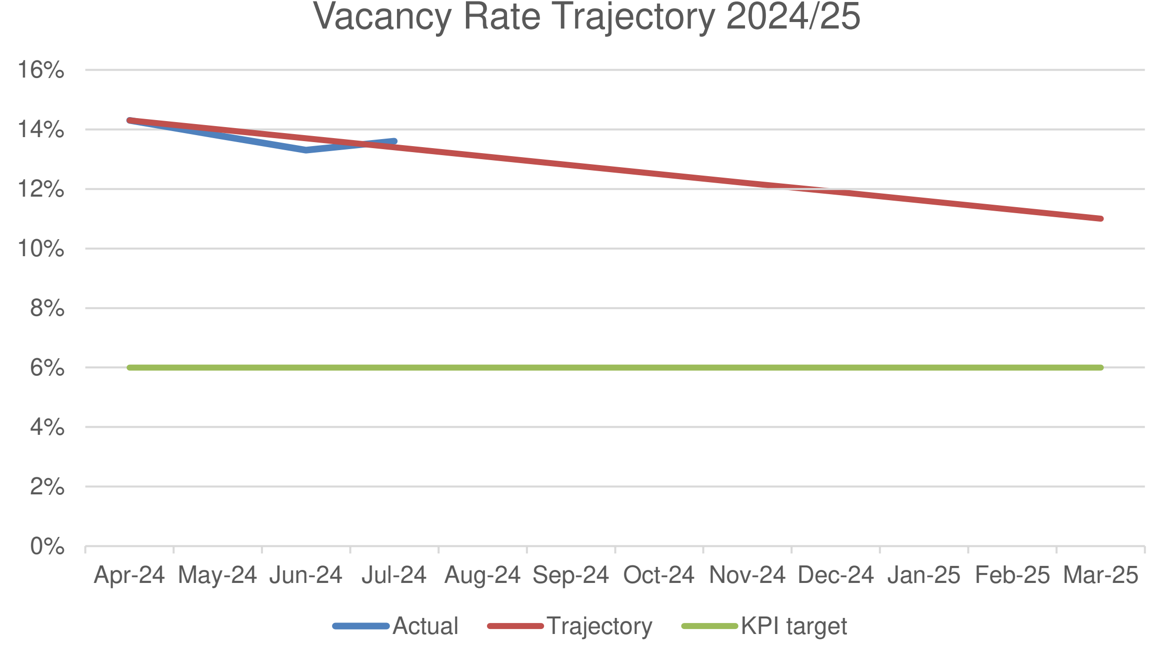
Action Plan:

To reach the target, there is continued focus to:

- work with managers to increase the levels of return-to-work meetings
- sustain the management of long-term sickness, and to enable employees who are on long term sickness absence to return to work.
- Managing short term sickness absences is also crucial and the management of these have to be sustained.
- We continue to work with PAM to publicise the OH support available for staff so staff find these and can access these in a timely manner. Lunch time workshops are being run to publicise all the offer that OH has for employees. Workshops also provide support for managers to understand how to use OHIO (the OH system) to make referral. Making timely referral is also vital for supportive health and wellbeing.

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%. July vacancy rate at 13.6% just above the trajectory of 13.4% for July 2024. August data not yet available.

- Following on from 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 who had offers made to them pending completion of their studies and them acquiring of their PIN's are being slotted into our vacancies.
- A considerable centralised recruitment event for band 5 nurses across the year has resulted in multiple offers being made and slotted into our vacancies.
- The trust, in conjunction with universities, education facilities, and with the assistance of ICB members, is currently planning it's fourth working group meeting for the Careers Event Process for the Psychological Professions.

Vacancies

Action Plan update:

The ICB and NHSE have introduced instruction on vacancy levels and agency reduction - A by-product of the weekly vacancy control panel (now in its 12th full month) is the highlighting of if the correct processes and procedures are being used to ensure like for like permanent / fixed term vacancies are being requested and put in place.

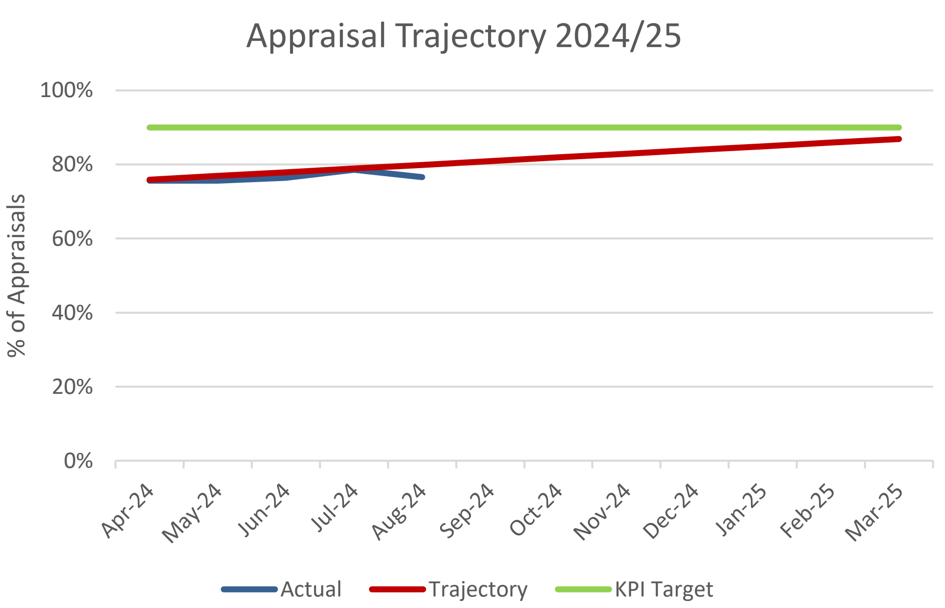
Working in conjunction with BSMHFT's projects and transformation department, flexible working initiatives are continuing to be rolled out throughout the recruitment process to:

- 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 Recruitment Initiatives and Strategy meeting will be held at the end of September 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.

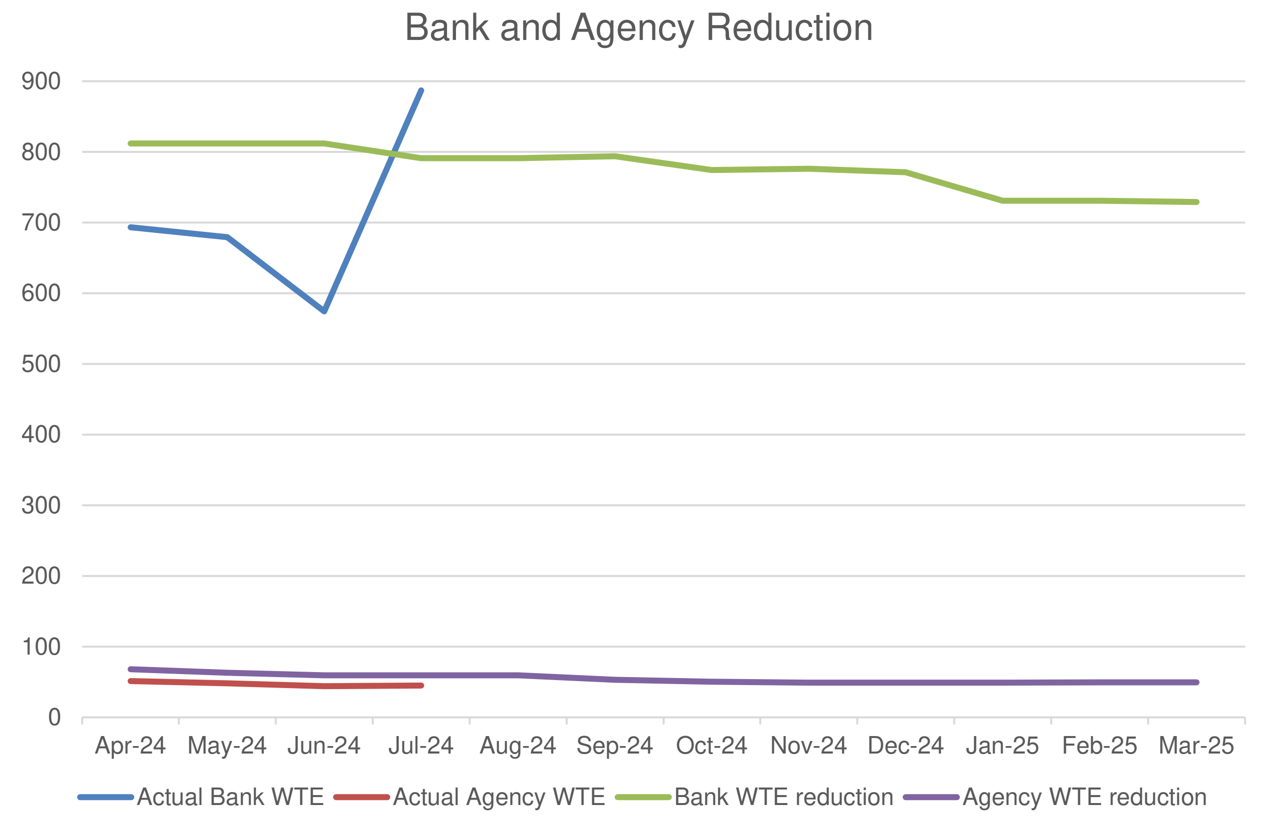
August 2024 appraisal performance was at 76.6% below trajectory.

Actions:

- L&D QI appraisal project continues with a focus on gathering qualitative data from staff. The questionnaire is in the process of being finalised.
- 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



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.

August figures are not available yet.
July has shown an increase in bank use from 574 to 887 WTE, above trajectory and agency has moved from 44 to 44.3 WTE, remaining below trajectory.

Note - Trajectory and commentary provided by People team

Sustainability

Monthly Agency costs

- The number of agency shifts requested and filled has decreased from 922 in July to 894 in August. HCA's usage per week has seen a decrease from 25 shifts per week on average in late '23 to 0 for most weeks in August. Agency above cap rate nursing placements have decreased from 16 in November '23 to 7 in August (there were admittedly 5 placements in June but completing more hours than July's 7). Whilst the overall non-medical weekly agency usage has fallen from 140 shifts per week on average in November '23 to 105 shifts in August, it was 83 in June '24. Overall agency usage (including medical) at the start of August accounted for 1.9% of the overall pay bill (below an ICB target of 3.2%), compared to 3.7% at the end of the financial year 2023/2024.

- 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.
- In August 27 bank workers started with the trust, helping to alleviate the need for agency.

Monthly Agency costs

- A deadline will be given to areas to transfer over their non-medical agency block bookings and regulars to NHSP otherwise they will not be able to use them in their areas. This would hopefully also stimulate the areas to organise and put out any vacancies (either perm or fixed term) that are outstanding, plus encourage the updating of their rota's long-term, which is of course the preferred option than simply transferring agency block booking's over to NHSP.

- 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.

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Appendix II – Performance Management Framework

FPPC is asked to note that from March 2024, a revised framework is being implemented with service areas as part of the deep dive meetings. A service line review process has commenced to ensure that all services within the operational portfolios are covered. The process remains developmental and learning from the meetings will be utilized 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 planned to be completed and agreed as part of each deep dive meeting.

Performance Delivery group - 6th September 2024

The meeting focused on waiting times actions arising from the August 2024 Trust QPES meeting and from the internal audit regarding waiting times. A presentation was shared (see Appendix IIa) which outlined what is currently reported via the IPD, focusing on national access standards and adult and older adult CMHT s waits for referrals not seen within 3 months. The local service level reports that are available to support internal monitoring and decision making to address waiting times was also shared. Appendix IIa includes examples of the service level reports available which can be drilled down to team and patient level.

In addition, the 2024/25 NHS operational plan outlines actions to review long waits and address data quality as part of progressing work towards the NHS Plan ambition to achieve a 4-week waiting time standard for non-urgent community mental services. Trust actions to support this have been shared with the ICCR and Specialties local FPPC meetings and informatic reports developed to assist this workplan.

Action agreed that the agendas for the deep dive reviews going forwards will include a request for updates on plans to address long waits and feedback on utilisation of benchmarking data.

Service Area Deep Dive Meetings – Update

1. Introduction

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

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

- Secure and Offender Health deep dive on 16th August 2024 focussing on Men's secure Reaside and Tamarind Teams.
- ICCR Deep Dive on 20th August 2024 focusing on Adult Community Mental Health teams (CMHTs) and Neighbourhood Teams (NMHTs).
- Specialties Deep Dive on the 5th September 2024 focusing on Eating Disorder services.

2. Secure and Offender Health – Men's Medium Secure (Reaside and Tamarind) Deep Dive – 16th August 2024

Domain Level RAG rating Reaside:

	Service	Overall	Quality and Safety	Operational Perf	Workforce	Culture	Finance	Strategy, Transformation & External
11/04/24	Reaside	Red	Amber	Green	Red	Red	Red	
16/08/24	Reaside	Red	Amber	Green	Amber	Red	Amber	

Despite the combination of challenges in terms of quality, environment, workforce and culture, it was noted that Reaside continues to operate at full occupancy and remains functional. It was recognised that two-way sharing and learning between Reaside and Tamarind is also being taken forward.

Domain level RAG Rating Tamarind:

	Service	Overall	Quality and Safety	Operational Perf	Workforce	Culture	Finance	Strategy, Transformation & External
11/04/24	Tamarind	Green	Green	Green	Green	Green	Green	
16/08/24	Tamarind	Green	Green	Green	Green	Green	Green	

Actions Summary:

- FIRST Accommodation – provision of space/estate for the team has now been identified.
- An Interim CNM post at Reaside to be recruited to support the actions required with recruitment to commence in September.
- Attack Alarm System – funding allocated to support.
- Reaside Staffing levels – Approval given to recruit 26 HCAs, recruitment due to commence.
- In terms of the new build, Executive level escalation has been made at the West Midlands level and with NHSE team for support to address.

Domain Updates

Quality and safety

A self-assessment and peer review assessment planned using the 34 CQC quality statements to effect future service model changes.

- Reaside - Leadership Team Visibility also raised by the CQC – action plans in place to address and increase visibility at meetings and on the wards.
- Reaside - CQC visit highlighted the known environment challenges, including issues with bathrooms, lack of clinical rooms impacting on service provision. Capital funding to support is being discussed as part of the estate requirements.

Workforce

Reaside:

- Staffing levels – culture and behaviours impacting on service provision.
- Qualified nursing staff provision to be considered as part of overall safer staffing review.
- Recruitment to the HCA posts due to commence.
- A new Head of secure Care covers both Reaside and Tamarind
- Psychology are aiming to create a pathway post

Tamarind:

- Challenge to retain experienced staff who can then also support training of new staff to maintain quality of care, culture and safer staffing levels.
- Some cultural/behaviour issues being addressed via the Leadership Team.

Culture:

The following actions are being undertaken to address cultural issues:

- Cross working across both sites including the development of a sexual safety charter, sharing of practise between security teams, matrons and CNMs highlighted as examples of good practise.
- Reaside - Working with L&D and EDI teams to do some targeted work with teams on culture and behaviour.
- Reaside - Working with the Staff Survey lead to take forward the outputs and plans.
- Reaside - A number of Freedom to Speak up drop-in sessions have been arranged for staff across all shifts

Service User Engagement

A co-production lead recently in place, the post being funded by Reach Out. Plans to focus on patient feedback, developing an Experts by Experience (EBE) pathway and plan to provision representation at meetings.

3. Integrated Community Care and Recovery Deep Dive – 20th August 2024

The focus for the service area deep dive this month was on Neighbourhood Mental Health Teams (NHMH) and Community Mental Health Teams (CMHTs). Details of the presentations shared are included as Appendix IIb.

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
NMHT	Amber	Amber	Amber	Amber	Amber	Green
CMHT	Amber	Amber	Amber	Amber	Amber	Amber

Neighbourhood Mental Health Teams (NMHTs)

Summary of Challenges/Actions discussed:

- Demand outweighing capacity, plans to support include recruiting which will increase staffing capacity levels.
- As the 'Additional Roles Reimbursement Scheme' (ARRS) roles are dependent on Primary Care Network (PCN) agreement and funding, some PCNs do not have these roles in place, and some may withdraw the roles. There are challenges as a result to flex and move resources as ARRS staff are linked to particular PCNs.

  It was recognised that PCN support is required to maintain NMHTs and agreed that system wide discussions should be utilised to take this forward including via the Mental Health Provider Collaborative.

- Estate/space for NMHT staff at the Trust and in GP practises is becoming a challenge.
- Known impact arising regarding duplication of recording on GP systems and Trust RIO system to maintain accurate patient records.

Community Mental Health Teams (CMHTs)

Summary of Challenges/Actions discussed:

- Management of Missed Depots in Community Teams procedure approved ensuring a standardised process and escalation pathway for those service users who do not attend for planned depot appointments.

- A Medication/Clinic audit has shown improved compliance. Prescribing Standards for CMHTs are currently in the process of being approved.
- CMHT KPI's are monitored on a fortnightly basis with leads from across the directorate, further work is taking place supported by informatics colleagues to utilise existing reports to support and target actions required.
- Vacancies – overspend on medical workforce due to reliance on use of agency locums. Active recruitment is being taken to address this pressure.
- The Directorate are taking forward the 'Just Culture' approach and responding to issues raised completing informal fact finds and working with OD and EDI colleagues to support teams.
- CMHTs have all undergone DIALOG+ care plan training and are actively working to roll out fully across teams with initial focus on service users on CPA.
- The NMHTs have not facilitated a reduction in demand in CMHTs as originally envisaged as part of the CMHT transformation agenda. This is due to higher levels of previously unmet needs arising.
- Caseload stratification work is underway across all CMHTs to identify service users who are suitable for step down transition to NMHTs.
- Both Longbridge and Solihull are trialling needs led appointment systems in an aim to improve availability of appointments slots for service users promptly and to move away from current 6/12 month appointment offers. if successful this will be rolled out across CMHTs
- Roadshows across CMHTs have now been completed with all teams to focus on the key areas of transformation for the next 12-18months, focus will be on:
    - Bridging the gap between Primary Care and Secondary Care
    - Caseload and Flow

4. Specialties Deep Dive – 5th September 2024

The focus for the service area deep dive this month was on the Eating Disorders (ED) service. Details of the presentation shared by the service leads is included as Appendix IIc.
Eating disorders service includes an Inpatient, Outreach and Day Treatment service (DTS).

Domain Level RAG rating review:

Service	Overall	Quality & Safety	Operational performance	Workforce & Culture	Finance	External & Strategy
Eating Disorders	Green	Green	Green	Amber	Green	Green

Summary:
Example of good practise work in place and being taken forward shared by the service leads, including Experts by Experience recruitment, the DTS service developing new treatment pathways to support specialised services such as the binge eating, ARFID (Avoidant restrictive food intake disorder) and development of the Severe and Enduring ED (SEED) pathway and First Episode Early Intervention for Eating Disorders (FREED) pathways.

Challenges

- Medical Workforce due to specialised service requirements.
- Outpatient therapy waiting times – a QI project has been successful in reducing waiting times from 6 months to 1 month, but there are still long waits for a second appointment due to lack of ED trained psychological therapists.

PDG – 5th September 2024

Waiting Times in non-urgent community mental health services

Tasnim Kiddy – Associate Director Performance and Information
Julie Keith – Performance manager
5th September 2024

For PDG Discussion

- Actions arising from August 2024 Trust QPES regarding waiting times (my understanding tbc)

i) Clarity on wating times reporting in the integrated performance report and actions/improvement plans in place.

ii) Risk management of long waits TBC

- Actions arising from internal audit regarding waiting times

i) Consider each service presenting their service to the Performance Delivery Group and shared with Trust Board for information.

ii) This should include waiting times including longest waits and recovery plans.

Outstanding Internal Audit actions

- Actions arising from internal audit regarding waiting times:

i) Consider each service presenting their service to the Performance Delivery Group and shared with Trust Board for information.

This action is complete although the service level discussions are now via the Service Area Deep Dive meetings. A summary of the Domain level discussion, Domain RAG ratings and actions arising are provided to Trust FPPC each month.

Confirm above action agreed. Audit report states reporting to Trust Board, does Trust FPPC suffice?

ii) This should include waiting times including longest waits and recovery plans.

To date this is not routinely covered at all service area deep dive meetings. It is therefore proposed that going forwards where relevant all service area deep dive meetings should include this as an agenda item. TO BE AGREED VIA PDG

Waiting Times reporting – Current Position

Birmingham and Solihull Mental Health NHS Foundation Trust

- **Waiting times reported to Trust FPPC includes:**

➢ Existing National Access Standards: Talking Therapies (6 & 18 weeks), First Episode Psychosis (2 weeks) and Eating Disorders (urgent 1 week and routine 4 weeks)

➢ Local Trust Waiting times for service users not seen within 3 months of referral focusing on adult and older adult CMH services - Improvement plans and reduction trajectories in place. Focus is on reducing long waits.

- **Bespoke waiting times reports** developed with service leads for Solar, MAS, ADHD, neuropsychiatry based on pathways
- **For other services, proxy waiting times, Trust InSight reports** showing:

➢ Length of wait from referral to first contact (proxy for assessment)

➢ Length of wait from first contact to second contact (proxy for commencement of treatment)

➢ Length of wait from referral to second contact – proxy for full wait

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Current Position cont:

- **2024/25 NHS Operational Plan:** NEW & Draft national guidance to progress the NHS Plan ambition to achieve a 4 week waiting time for non urgent community mental health services requiring recording of the assessment, care plan formulation and outcome measures – **requirements for action shared with ICCR and Specialties FPPC including local report on InSight to assist.**

➢ Focus for this year to address data quality & reduce long waits, initially over 104-week waits. Improvement trajectories expected to be submitted in the autumn.

➢ For adults this will only cover the following team types:

CMHTs (Functional)	Primary care MH Service
Assertive Outreach	Community rehabilitation
Psychotherapy	Psychological therapies
Personality disorder	Adult Eating Disorder

➢ This will mean that several services including Older Adult CMHTs, Deaf, Perinatal, ADHD, Homeless and Neuropsychiatry will be excluded from the new national standards.

Demonstration of informatic reports to support service level review and action planning

(Reports available on InSight)

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Summary Waiting Time Position Referral to First Contact/Appointment

Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
									104 weeks+		
Adult CMHT	193	154	123	309	350	249	153	192	200	18	**1941**
Older Adult CMHT	83	78	63	165	145	80	47	66	52	28	**807**
Memory Assessment	33	52	61	133	174	174	154	352	396	0	**1529**
ADHD	69	56	81	281	396	364	396	369	1144	1363	**4519**
SOLAR	8	15	4	43	50	34	19	32	65	43	**313**
Perinatal	52	28	36	75	68	20	8	6	1	0	**294**
Deaf	1	0	1	1	1	3	2	1	3	1	**14**
Neuropsychiatry	32	62	37	76	123	138	123	216	391	125	**1323**
Adult Psychological services	0	0	0	0	0	0	0	0	3	7	**23**
OAKS Group Therapies Solihull	4	5	4	14	13	13	6	31	68	8	**162**

Summary Waiting Times From First to Second Contact/Appointment

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Adult CMHT	85	104	69	240	253	174	174	248	420	219	**1986**
Older Adult CMHT	68	52	62	117	136	136	123	122	182	167	**1165**
Memory Assessment	23	27	18	56	40	21	11	8	5	0	**209**
ADHD	8	16	17	41	88	42	16	29	71	47	**375**
SOLAR	14	13	9	22	25	20	20	52	98	223	**496**
Perinatal	16	19	13	45	16	4	5	6	0	1	**125**
Deaf	1	0	0	2	2	2	1	2	1	1	**12**
Neuropsychiatry	16	12	17	52	66	46	38	70	131	0	**687**
Adult Psychological services	0	0	0	0	0	0	0	0	3	7	**10**
OAKS Group Therapies Solihull	4	3	1	1	6	8	3	5	16	0	**47**

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Current waiting times – Service Level Reports

ADHD,SOLAR, perinatal, memory Assessment Service, older Adult CMHT, Deaf service, Adult CMHT, Psychological therapies and Neuropsychiatry.

ADHD (1)

Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
ADHD Referral In	69	56	81	281	396	364	396	369	1144	1363	4519

Fig 1: Waiting for first appointment as of 23rd August 2024

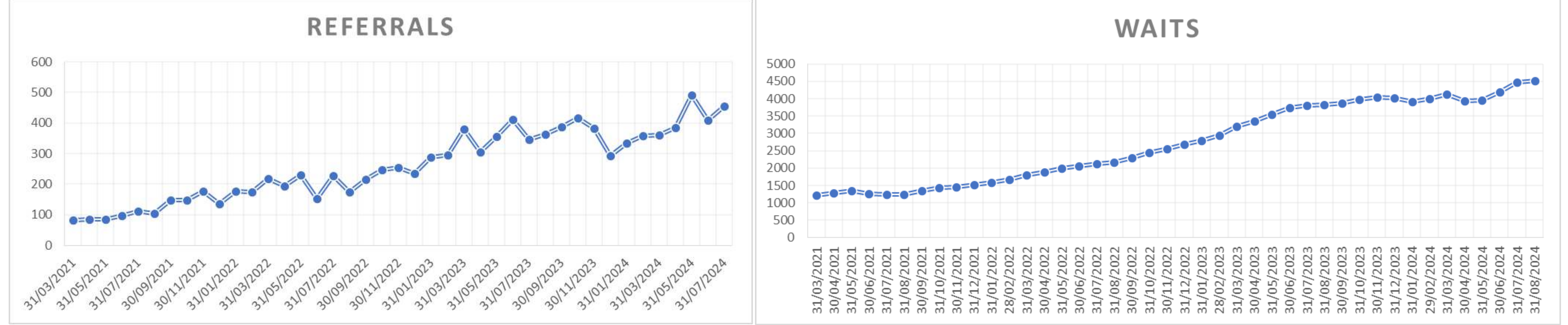


Fig 2: Referral trends 3 years (Mar 2021 - Current)

Fig 3: Wait trends (Mar 2021 - Current)

Solar – CYP in Solihull

WAITS FOR CHOICE AND PARTNERSHIP IN SOLAR

Waits for Partnership — Waits for Choice

1800
1600
1400
1200
1000
800
600
400
200
0

31/10/2017 30/11/2017 31/12/2017 31/01/2018 28/02/2018 31/03/2018 30/04/2018 31/05/2018 30/06/2018 31/07/2018 31/08/2018 30/09/2018 31/10/2018 30/11/2018 31/12/2018 31/01/2019 28/02/2019 31/03/2019 30/04/2019 31/05/2019 30/06/2019 31/07/2019 31/08/2019 30/09/2019 31/10/2019 30/11/2019 31/12/2019

Pre-COVID Period

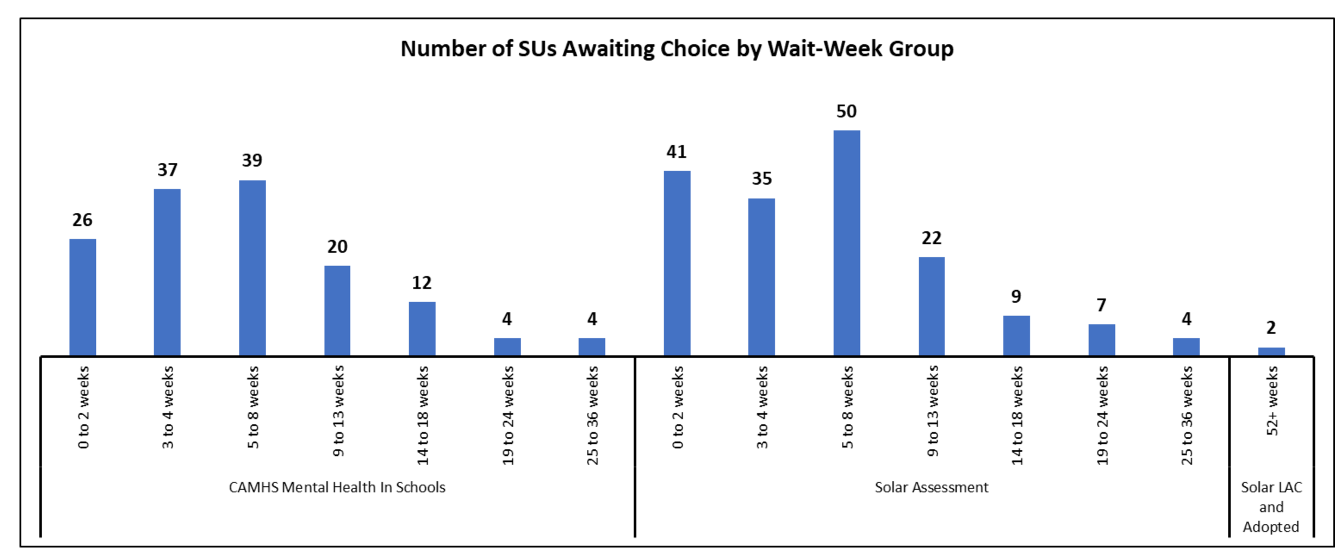
31/01/2020 29/02/2020 31/03/2020 30/04/2020 31/05/2020 30/06/2020 31/07/2020 31/08/2020 30/09/2020 31/10/2020 30/11/2020 31/12/2020 31/01/2021 28/02/2021 31/03/2021 30/04/2021 31/05/2021 30/06/2021 31/07/2021 31/08/2021 30/09/2021 31/10/2021 30/11/2021 31/12/2021 31/01/2022 28/02/2022

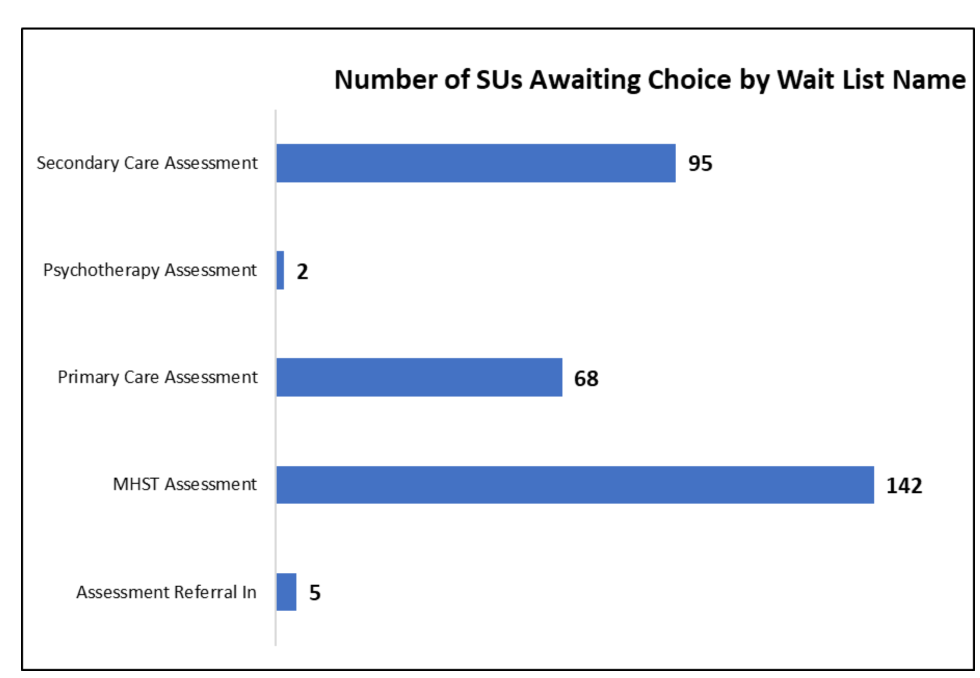
COVID Period

31/03/2022 30/04/2022 31/05/2022 30/06/2022 31/07/2022 31/08/2022 30/09/2022 31/10/2022 30/11/2022 31/12/2022 31/01/2023 28/02/2023 31/03/2023 30/04/2023 31/05/2023 30/06/2023 31/07/2023 31/08/2023 30/09/2023 31/10/2023 30/11/2023 31/12/2023 31/01/2024 29/02/2024 31/03/2024 30/04/2024 31/05/2024 30/06/2024

Post-COVID Period

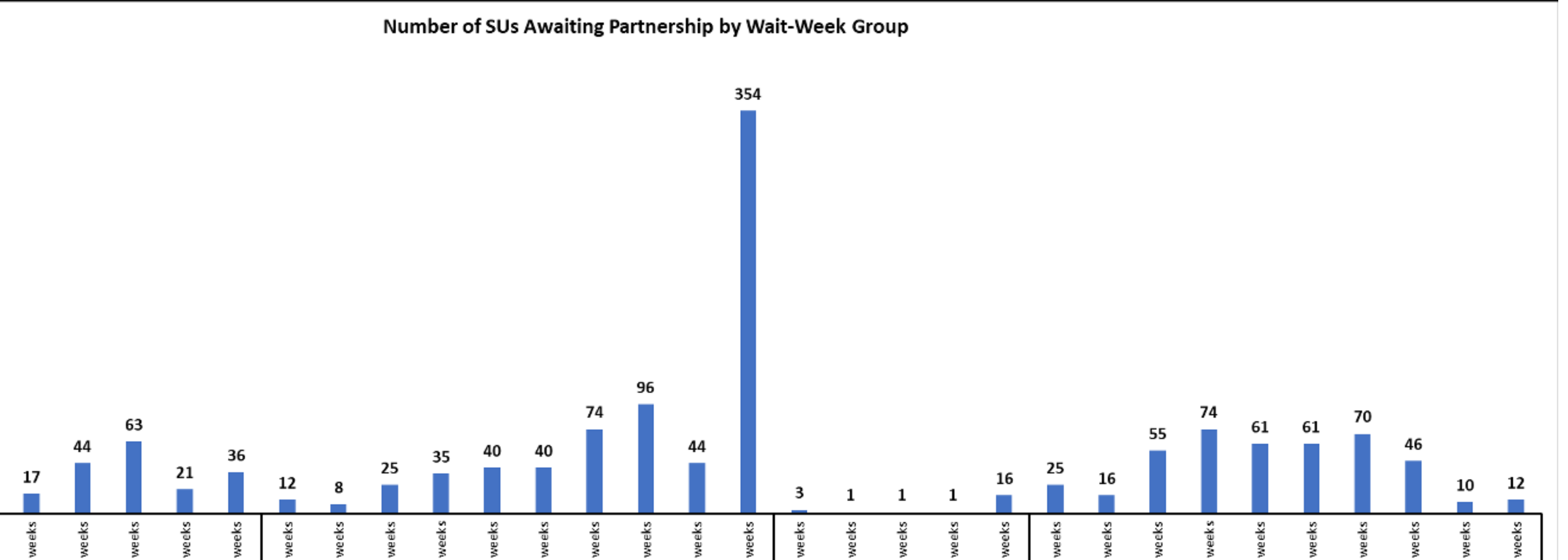
Solar Choice Waits (Assessment)

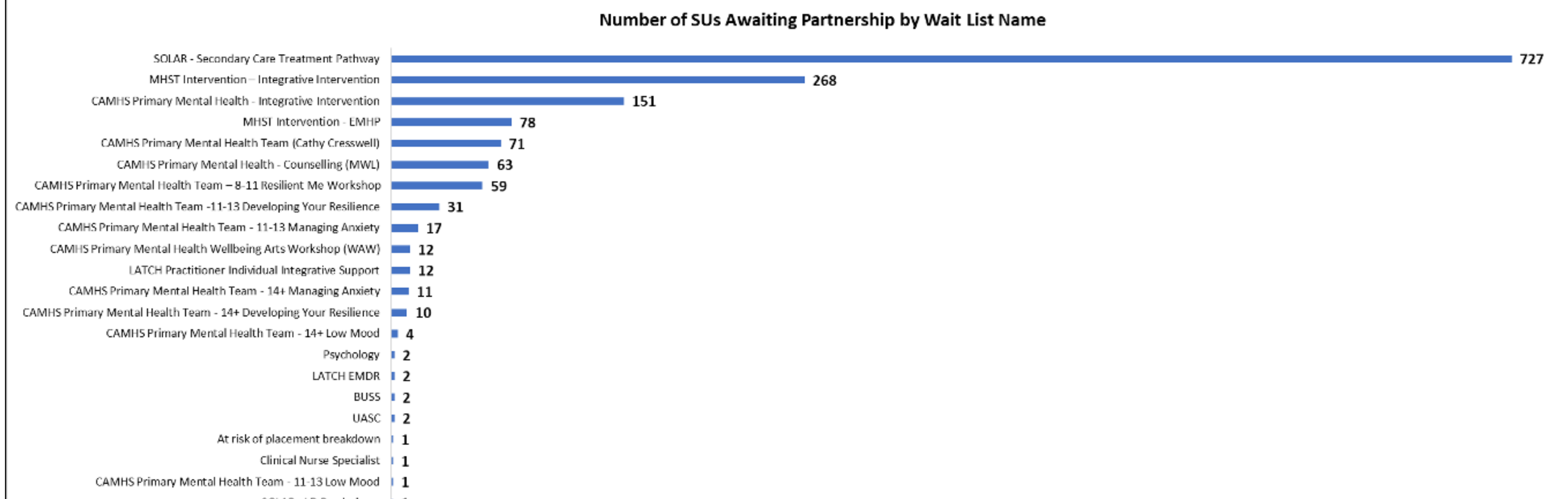




The service had a circuit breaker and commissioned additional capacity via Helios. This has resulted in the treatment waits increasing. To address this, additional capacity has been created to offer more frequent treatment sessions to service users and if this is successful, this approach will be rolled out to other teams in the service, addressing the longer waits for treatment.

Partnership waits (Treatment)





Perinatal
Waiting times for 1st Contact/Appointment following referral as at 27th August 2024.

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	Total
Perinatal community	**Service Total:**	**52**	**28**	**36**	**75**	**68**	**20**	**8**	**6**	**1**	**294**
	Perinatal Community - East	17	11	12	23	13	5	3	1	0	**85**
	Perinatal Community - Outreach	1	1	0	0	2	0	0	1	0	**5**
	Perinatal Community - Solihull	12	5	9	11	2	0	0	0	0	**39**
	Perinatal Community - South	9	5	4	14	22	11	3	2	0	**70**
	Perinatal Community - West	12	5	9	19	19	3	2	2	0	**71**
	Perinatal Maternity Mental Health	1	1	2	8	10	1	0	0	0	**23**
	Specialist Maternity Psychology (City)	0	0	0	0	0	0	0	0	1	**1**

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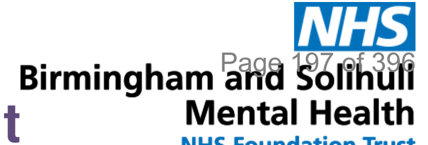
Perinatal

Waiting times from 1st Contact/Appointment to 2nd Contact/Appointment

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	52+ Wks	Total
Perinatal community	**Service Total:**	16	19	13	45	16	4	5	6	1	125
	Perinatal Community - East	5	9	4	15	5	2	1	0	0	41
	Perinatal Community - Outreach	2	0	0	1	0	0	0	0	0	3
	Perinatal Community Solihull	0	2	2	8	5	0	1	0	0	18
	Perinatal Community - South	4	6	5	10	3	0	3	2	0	33
	Perinatal Community - West	3	0	1	6	3	2	0	4	0	19
	Perinatal Maternity Mental Health	2	2	1	5	0	0	0	0	0	10
	Specialist Maternity Psychology (City)	0	0	0	0	0	0	0	0	1	1

As of 27th August 2024



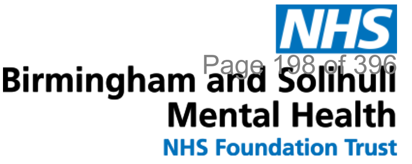
Older Adult CMHTs – Waiting Times for 1st Contact/Appointment following referral

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Older Adult CMHT	**Service Total:**	**83**	**78**	**63**	**165**	**145**	**80**	**47**	**66**	**52**	**28**	**807**
	DIADEM Assessment	1	3	4	9	8	1	0	0	0	0	26
	MHSOP East HUB	16	12	8	26	19	17	13	13	5	1	130
	MHSOP North HUB	15	23	20	39	45	15	12	11	7	1	188
	MHSOP Solihull HUB	19	13	14	42	48	25	12	18	13	11	215
	MHSOP South HUB	19	7	5	20	4	2	0	1	0	0	58
	MHSOP West HUB	13	20	11	28	19	18	10	23	27	15	184
	MHSOP Moseley Hall	0	0	1	1	2	2	0	0	0	0	6

Reducing long waits is part of the services improvement plan submitted to Trust FPPC.

Note: A number of older adults have commenced treatment but as the majority are in care homes, contact has been with the staff in the care home due to Covid-19 impact, and as a result, there are a cohort of service users who have not come off the waiting list as the requirement is for the contact to be with the service user rather than a third party.

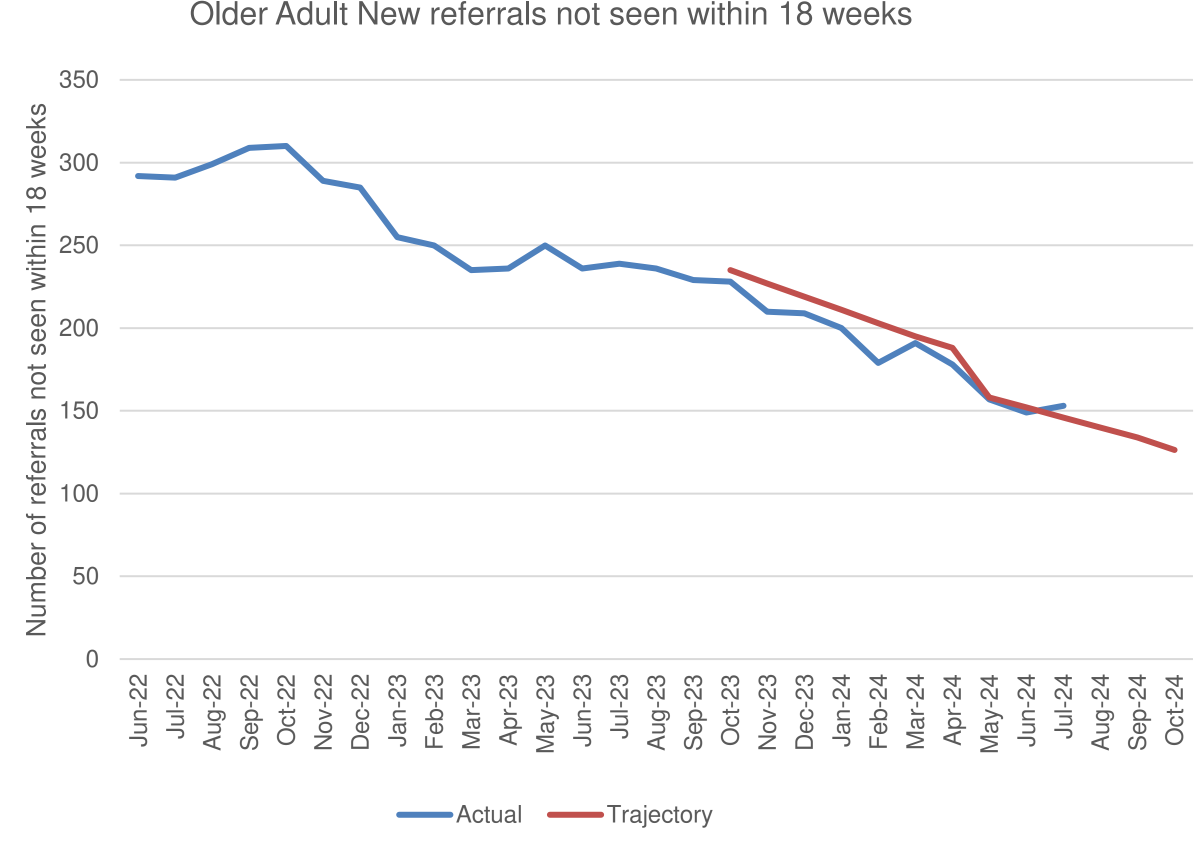
New Referrals not seen within 3 months- Older Adults – Trust FPPC report



Older Adult CMHTs original plan was to achieve a 20% reduction in those waiting over 18 weeks by the end of April 2024 which was achieved. Good progress continues to be made and as part of their ongoing improvement plan, a new trajectory has been set to achieve a further 20% reduction by October 2024. Progress as at July of 146 is only marginally above trajectory.

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.



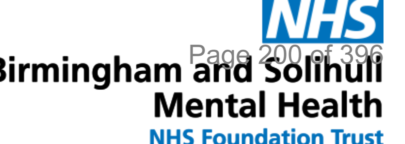
Note - Older Adult CMHT position confirmed by the Associate Director for Specialities.

Older Adult CMHT – Waiting time from 1st Contact/ Appointment to 2nd Contact/Appointment

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Older Adult CMHT	**Service Total:**	**68**	**52**	**62**	**117**	**136**	**136**	**123**	**122**	**182**	**167**	**1165**
	DIADEM Assessment	0	2	3	2	3	0	1	1	0	0	**12**
	MHSOP East HUB	12	4	11	21	26	23	18	36	33	35	**219**
	MHSOP North HUB	17	9	11	33	24	26	40	21	32	22	**235**
	MHSOP Solihull HUB	8	14	9	23	34	27	25	18	36	16	**210**
	MHSOP South HUB	7	12	12	16	21	18	12	12	29	19	**158**
	MHSOP West HUB	24	11	16	22	28	41	27	34	52	75	**330**
	MHSOP Moseley Hall	0	0	0	0	0	1	0	0	0	0	**1**

Waiting times for 2nd Appointment as of 23rd August 2024

CMHT waiting times to 1st appointment



Service												
Adult CMHT												
	CMHT Aston & Nechells	18	8	8	35	31	16	9	14	27	5	**171**
	CMHT Erdington & Kingstanding	23	13	16	35	24	15	12	4	5	0	**147**
	CMHT Ladywood & Handsworth	22	20	9	41	49	28	22	34	75	6	**306**
	CMHT Longbridge	13	17	10	18	35	30	33	43	16	0	**215**
	CMHT Lyndon	16	8	8	18	31	36	18	18	10	0	**163**
	CMHT Newington	12	7	5	11	18	10	5	4	4	1	**77**
	CMHT Riverside	20	15	5	30	23	24	10	5	5	0	**137**
	CMHT Sutton	12	8	10	24	23	11	4	1	1	0	**94**
	CMHT Warstock Lane	8	18	10	31	20	20	11	12	12	5	**147**
	CMHT Yewcroft	14	13	5	21	38	33	19	33	34	0	**210**
	CMHT Zinnia	23	20	14	22	31	7	6	10	1	1	**135**
	CMHT Small Heath (O'Donnell)	11	7	23	23	26	19	4	14	10	0	**137**
	University Medical Practice	1	0	0	0	1	0	0	0	0	0	**2**

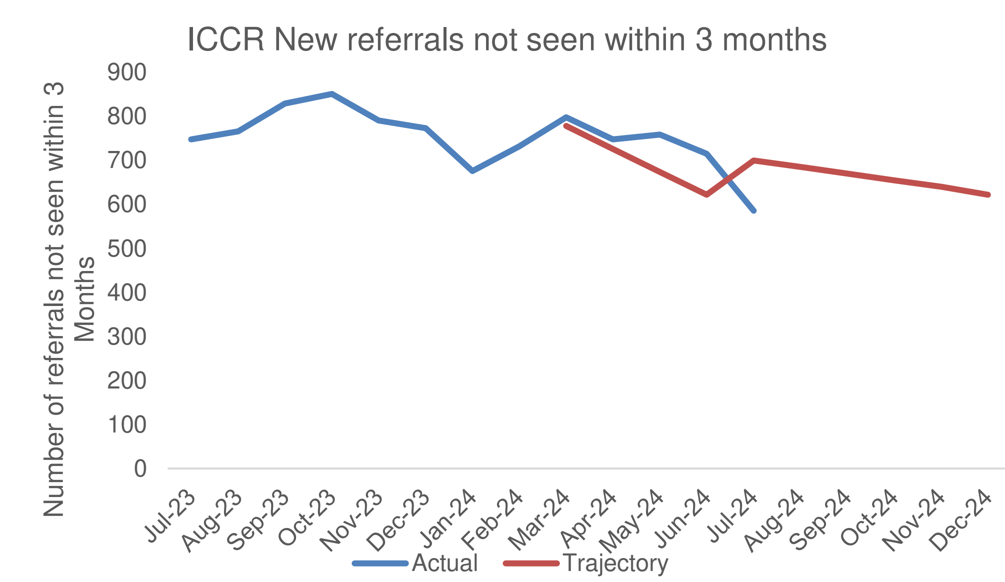
Waiting times for 1st Appointment as of 23rd August 2024

Reducing long waits is part of the services improvement plan submitted to Trust FPPC.

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. Although progress was made, the service did not meet their original improvement plan to achieve a 20% reduction in new referrals not seen within 3 months by June 2024. Having reviewed their action plan, the service lead has extended the trajectory to December 2024. Progress has been better than expected and July is at 586 and below the trajectory.

A related area of work aligns to the national 2024/25 operational guidance that focuses on community mental health waiting times. The initial focus is to review all long waiters over 104 weeks including completion of a data validation exercise to support. The requirements and reports to support services in this work have been shared with both the ICCR and Specialties FPPC meetings in July and Operational Management Team meeting in August.



Note - ICCR Trajectory provided by Associate Director for ICCR.

Adult CMHT waits for second appointment

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Adult CMHT	**Service Total:**	**85**	**104**	**69**	**240**	**253**	**174**	**174**	**248**	**420**	**219**	**1986**
	CMHT Aston & Nechells	4	8	1	19	12	16	9	12	20	11	**112**
	CMHT Erdington & Kingstanding	3	6	5	18	19	15	15	19	34	13	**147**
	CMHT Ladywood & Handsworth	15	13	6	22	35	16	22	13	45	58	**245**
	CMHT Longbridge	11	20	3	29	23	16	21	48	89	24	**284**
	CMHT Lyndon	11	9	12	24	24	18	19	14	61	49	**241**
	CMHT Newington	6	5	4	10	15	7	16	22	42	4	**131**
	CMHT Riverside	4	10	9	12	30	17	10	13	13	2	**120**
	CMHT Sutton	3	2	3	17	16	9	14	27	29	10	**130**
	CMHT Warstock Lane	4	9	3	19	18	17	16	16	17	2	**121**
	CMHT Yewcroft	4	5	5	11	7	13	9	11	15	25	**105**
	CMHT Zinnia	13	9	13	22	21	15	14	30	37	14	**188**
	CMHT Small Heath (O'Donnell)	6	8	5	37	32	14	9	22	17	7	**157**
	University Medical Practice	1	0	0	0	1	1	0	1	1	0	**5**

Waiting times for 2nd Appointment as of 23rd August 2024

Memory Assessment Service – Waiting times for 1st Contact/Appointment following referral

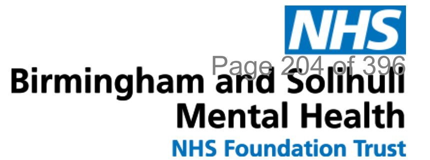
Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	Total
Memory Assessment service	**Service Total:**	**33**	**52**	**61**	**133**	**174**	**174**	**154**	**352**	**396**	**1529**
	Memory Assessment - Psychology	0	0	0	0	0	1	0	0	0	**1**
	Memory Assessment- Complex Formulation	0	1	3	2	3	4	9	12	15	**49**
	Memory Assessment- Complex Mainstream	13	31	31	70	89	77	68	193	222	**794**
	Memory Assessment- Complex Psychology	1	3	7	7	13	12	14	26	35	**118**
	Memory Assessment- Non-Complex	11	17	20	50	69	80	63	121	124	**555**
	Memory Assessment -TRIAGE	8	0	0	4	0	0	0	0	0	**12**

Waiting times for 1st Appointment as of 23rd August 2024

The service are working with the digital transformation team to review the pathway, actions include:

- Recording on RIO to capture the key outcomes from screening including suitability/pathway/suitability for an early scan
- A new process for making and monitoring scan requests
- More efficient processes for booking appointments
- Creation of bespoke forms to match the process of assessment and diagnosis

Deaf community service waiting times



Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Perinatal community	**Service Total:**	**1**	**0**	**1**	**1**	**1**	**3**	**2**	**1**	**3**	**1**	**14**
	Deaf Community Service	1	0	1	1	1	3	2	1	3	1	**14**

Waiting times for 1st Appointment as of 23rd August 2024

Waiting Times from 1st contact/appointment to 2nd contact/Appointment

Service	Team	0 1 Wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Perinatal community		**0**	**1**	**0**	**2**	**2**	**2**	**1**	**2**	**1**	**1**	

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Adult Psychological services

Waiting times for 1st Appointment as of 27th August 2024

Service	Team	14 18 Wks	52+ Wks	Total
AWA Psychological Services	**Service Total:**	1	22	23
	Psy Programme - Psychosis	0	6	6
	Psy Programme - Psychotherapy	1	16	17

Waiting times for 2nd Appointment as of 27th August 2024

Service	Team	26 52 Wks	52+ Wks	Total
AWA Psychological Services	**Service Total:**	3	7	10
	Psy Programme - Psychosis	1	4	5
	Psy Programme - Psychotherapy	2	3	5

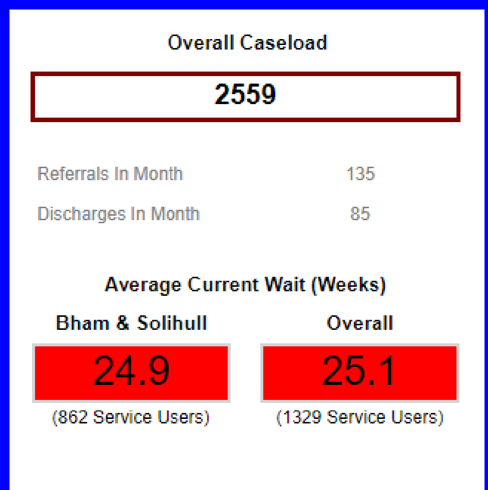
Team	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	52+ Wks	Total
Service Total:	**5**	**4**	**14**	**13**	**13**	**6**	**31**	**68**	**8**	**162**
OAKS Group Therapies - Solihull	5	4	14	13	13	6	31	68	8	162

Team	0 1 wks	1 2 Wks	2 3 Wks	3 6 Wks	6 10 Wks	10 14 Wks	14 18 Wks	18 26 Wks	26 52 Wks	Total
Service Total:	**4**	**3**	**1**	**1**	**6**	**8**	**3**	**5**	**16**	**47**
OAKS Group Therapies - Solihull	4	3	1	1	6	8	3	5	16	47

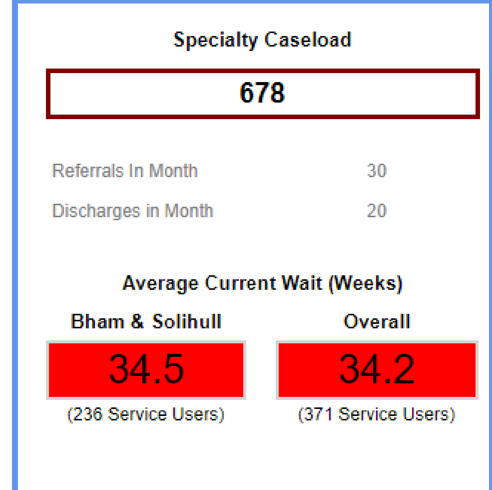
Neuropsychiatry – Referrals by pathway

Birmingham and Solihull Mental Health NHS Foundation Trust

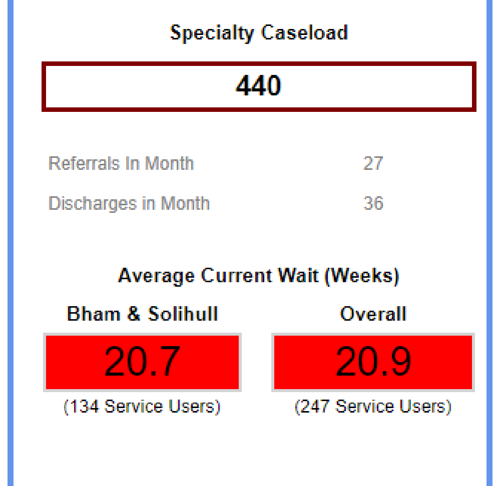
Overall



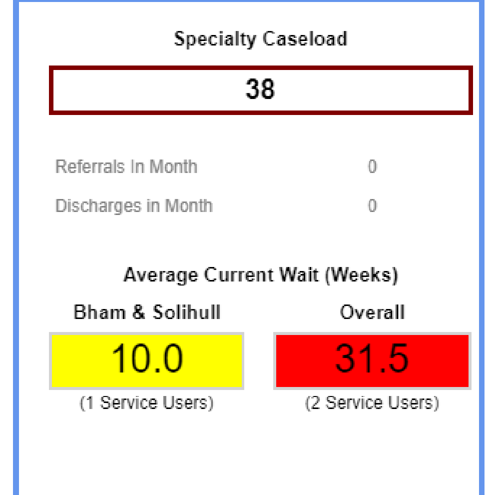
Epilepsy



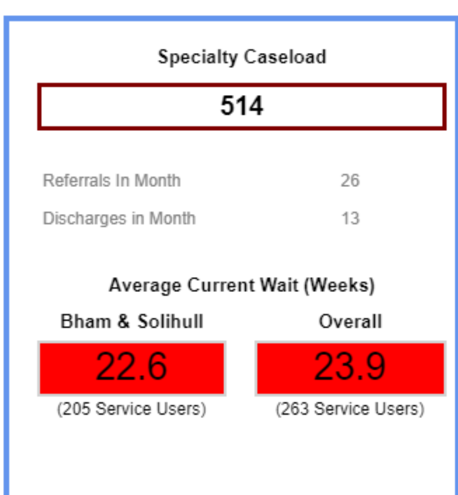
General Neuro



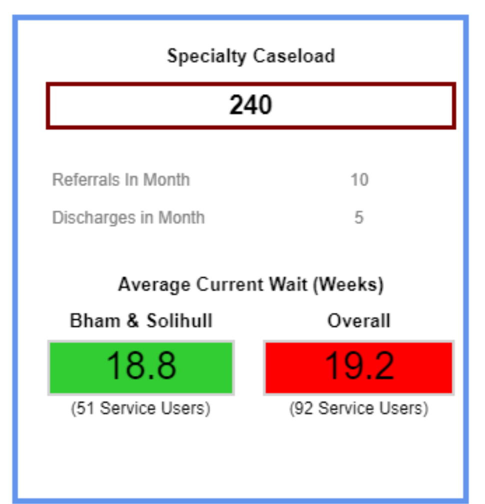
Neurodevelopmental



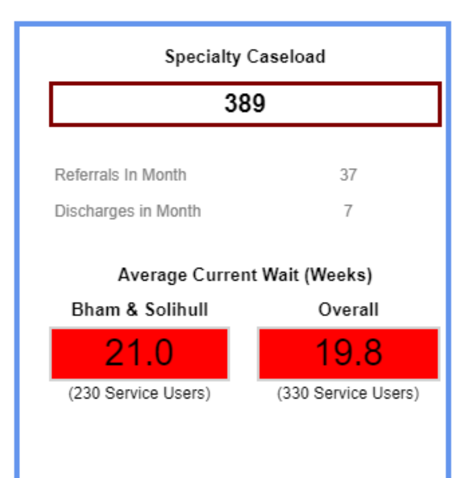
Sleep Disorder



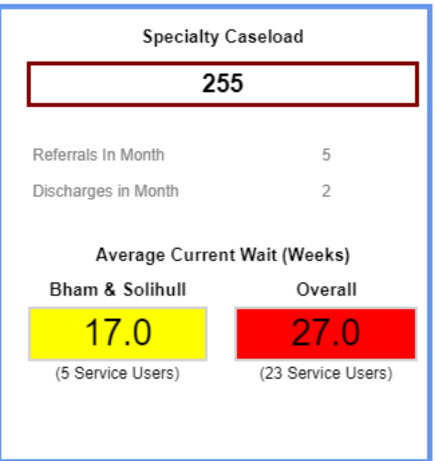
Tourettes Syndrome



Chronic Fatigue



Huntingtons



New National Non Urgent Community Mental Health Waiting Times

InSight Reports available to assist (based on understanding of national methodology to date – subject to change) – snapshot of report below

CYP waiting times as of 23rd August 2024

Birmingham and Solihull Mental Health NHS Foundation Trust

Patients Currently Waiting

0 Adult reporting pathway

995 CYP reporting pathway

View My Patients

Select reporting pathway: CYP

Reporting pathway selected: **CYP**

Select service: All

Services selected: **More than 3 services selected**

Select team: All

Teams selected: **More than 3 teams selected**

Patients Waiting for Care Activities

Care activity	Patients
Not Yet Seen	426
No Recorded Assessment	0
No Outcome Measure	661
No Intervention/Care Plan	922

Current Waiting Times

Waiting time	Number of patients
4 weeks or less	95
4-8 weeks	167
8-12 weeks	156
12-16 weeks	123
16-20 weeks	126
20-24 weeks	85
24-28 weeks	60
28-32 weeks	47
32-36 weeks	24
36 weeks-1 year	39
1-2 years	46
More than 2 years	27

Waiting 4 weeks or less	Waiting more than 4 weeks
95	900

Patients Currently Waiting

7771
Adult reporting pathway

0
CYP reporting pathway

View My Patients

Select reporting pathway:
Adults

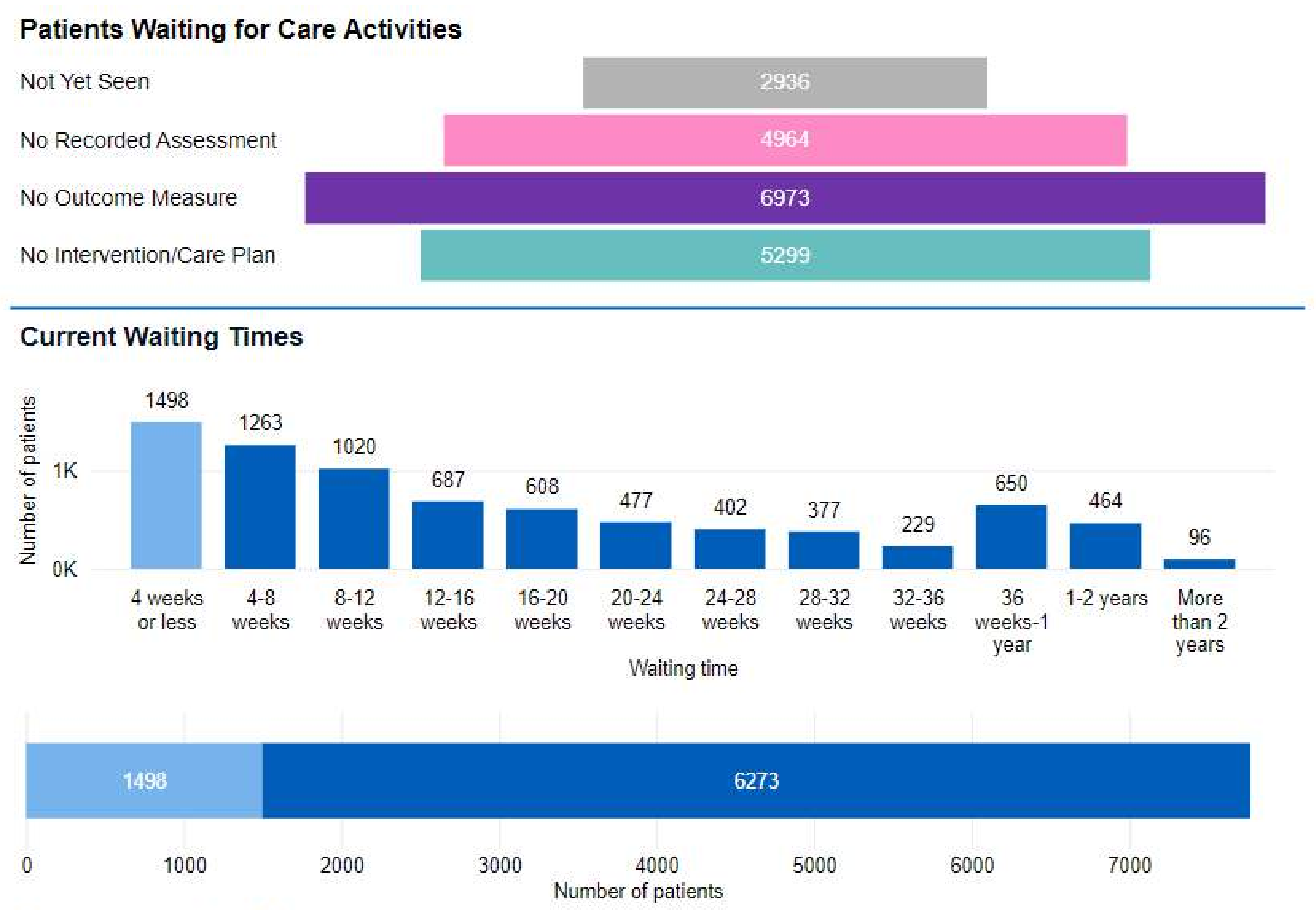
Reporting pathway selected:
Adults

Select service:
All

Services selected:
More than 3 services selected

Select team:
All

Teams selected:
More than 3 teams selected



Adult CMHTs: Care Plans and DIALOG+ – Current Position

CPA

Row Labels	Caseload	Any Care Plan	Any CP (%)	Dialog	Dialog (%)
CMHT Adult Yewcroft	147	145		75	**51.02%**
CMHT Adult Newington	73	71		44	**60.27%**
Chapman Road	347	333		165	**47.55%**
CMHT Adult Warstock Lane	112	107		69	**61.61%**
Northcroft	292	274		153	**52.40%**
CMHT Adult Lyndon	109	102		62	**56.88%**
Osborne House	288	268		151	**52.43%**
CMHT Adult Longbridge	183	166		88	**48.09%**
CMHT Adult Zinnia	201	180		94	**46.77%**
Grand Total	**1752**	**1646**	**93.95%**		**51.43%**

Care Support

Row Labels	Caseload	Any Care Plan	Any CP (%)	Dialog	Dialog (%)
CMHT Adult Yewcroft	923	903	97.83%	15	**1.63%**
Chapman Road	2690	2469	91.78%	33	**1.23%**
CMHT Adult Warstock Lane	1049	942	89.80%	30	**2.86%**
CMHT Adult Newington	1510	1348	89.27%	19	**1.26%**
CMHT Adult Longbridge	1888	1656	87.71%	27	**1.43%**
Northcroft	3387	2969	87.66%	28	**0.83%**
CMHT Adult Zinnia	1982	1697	85.62%	20	**1.01%**
Osborne House	3189	2615	82.00%	25	**0.78%**
CMHT Adult Lyndon	2299	1797	78.16%	57	**2.48%**
Grand Total	**18917**	**16396**	**86.67%**	**254**	**1.34%**

The tables show the current level of care plans for those on CPA and the Care Support Plans for those on CS.
The number and level of DIALOG outcome measures completed are in the final columns. This includes those completed in the last 12 months which also include an action/ safety plan.

Next steps

- Service Level action plans have been requested to address long waits – what/how & when?
- Deep Dive agendas going forward to include waiting times, focusing on long waits and action plans to address including risk mitigation
- Going forwards need to ensure focus and completion of an assessment, care plan formulation and recording of outcome measures ie Implement Dialog+
- Informatics support available to go through available reports and to encourage proactive use to aid discussion and action planning at service level

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ICCR Deep Dive – Community Mental Health and Wellbeing Service

Neighbourhood MH Teams (NMHTS)
Community MH Teams
(CMHTs)

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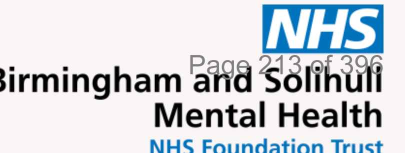

Neighbourhood Mental Health Teams (NMHTs)

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Neighbourhood Mental Health Teams

- Introduced as part of Community Mental Health Transformation
- Aims to bridge the gap between GP only mental health provision and CMHT, increase access to services, provide place-based care in local communities, bolster resource at primary care level, and provide prevention and earlier intervention.
- Locality based teams – North, South, East, West and Solihull (Solihull is currently split into North Solihull and South Solihull due to a pilot which integrates the Neighbourhood Mental Health Team and the Community Mental Health Team)
- Many staff based in GP surgeries
- Great emphasis on partnership working with community assets

NHS
Birmingham and Solihull Mental Health NHS Foundation Trust

Neighbourhood Mental Health Teams

Referral Demographics

Referrals by Ethnic Group

White 14,384
Asian / Asian British 5,887
Not Known 5,190
Black / Bl... 1,599
Mixed 1,384
Other 812
(Blank) 633
N... 501

Referrals by Gender

Female, Male, Unknown, Non binary
Unknown 639 (2.1%)
Male 12184 (40.09%)
Female 17547 (57.74%)

Referrals by Age Group

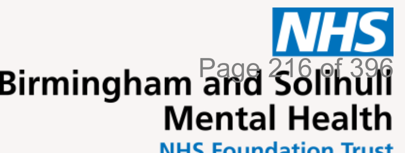
85 plus 199
75-84 532
65-74 1,156
55-64 4,127
45-54 5,275
35-44 7,432
25-34 7,838
16-24 3,069
<16 175
Notknown 633

Referrals by Index of Multiple Deprivation (IMD)

IMD 0 10
15,000
10,000
5,000
0
1: 14161
2: 4735
3: 3069
4: 2442
5: 1978
6: 1145
7: 720
8: 433
9: 352
10: 566
Not Known: 789

We know that these vary in different localities. Each team has developed an understanding of need and resource in their areas to improve targeted work.

compassionate inclusive committed



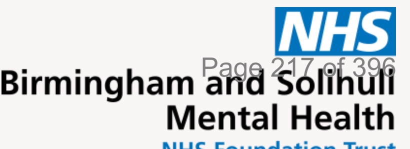
Quality and Safety

- Regular Management Supervision (RMS) is at 80% and Clinical Supervision is at 81%. A supervisor in the South team has had difficulty getting RMS onto the system due to ESR access which is lowering their current percentage.

- Clinical recording systems can be challenging for staff as they record on both GP systems and our Trust system. We have experienced some difficulties in consistently accessing the GP systems, and it is duplication.

- We are currently reviewing resources/staffing model to ensure that we have a standard offer so that people will receive the same service whether or not there is a staff member based in their referring GP surgery.

- We have received excellent service user feedback.



Operational Performance

Referrals by team (July'23 to June '24)

Team	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Total
North	316	257	254	264	261	233	343	336	285	230	191	250	**3220**
East	254	238	268	296	277	209	288	298	277	304	278	265	**3252**
South	382	535	433	456	484	386	578	567	471	585	470	496	**5843**
West	158	123	143	170	220	162	238	216	186	209	203	194	**2222**
Solihull	272	162	259	175	177	136	248	202	160	181	166	167	**2305**
Total	**1382**	**1315**	**1349**	**1361**	**1419**	**1124**	**1694**	**1619**	**1378**	**1509**	**1306**	**1371**	**16820**

Discharges by team (July '23 to June '24)

Team	2023 Jul	2023 Aug	2023 Sep	2023 Oct	2023 Nov	2023 Dec	2024 Jan	2024 Feb	2024 Mar	2024 Apr	2024 May	2024 Jun	Total
North	196	417	332	269	259	243	289	277	272	419	298	223	**3494**
East	250	162	231	293	253	237	262	302	272	285	256	248	**3051**
South	409	456	471	493	502	488	471	488	426	558	496	491	**5749**
West	65	139	93	90	238	187	243	238	143	176	252	231	**2095**
Solihull	208	244	317	135	176	183	230	220	182	200	216	163	**2474**
Total	**1128**	**1418**	**1441**	**1280**	**1428**	**1337**	**1495**	**1524**	**1295**	**1638**	**1517**	**1355**	**16840**

Operational Performance

DNA rates by team (October ‘22 to June ‘24)

Team	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Total
North	31.9%	32.4%	31.6%	30.4%	30.3%	32.5%	29.3%	26.9%	27.1%	25.1%	26.1%	23.6%	**29.1%**
East	30.5%	33.7%	28.8%	32.6%	28.4%	34.6%	32.5%	31.7%	30.8%	33.8%	28.7%	28.3%	**31.2%**
South	28.5%	29.4%	30.8%	33.0%	32.9%	33.5%	30.3%	29.4%	30.3%	29.0%	29.7%	27.0%	**30.3%**
West	44.1%	26.6%	27.2%	23.6%	28.4%	33.4%	28.9%	26.5%	24.1%	29.8%	24.9%	26.6%	**28.2%**
Solihull	25.5%	23.6%	24.1%	21.7%	26.7%	29.1%	22.3%	20.3%	27.6%	25.1%	27.6%	25.6%	**24.8%**
Total	**31.1%**	**29.5%**	**29.1%**	**29.9%**	**29.9%**	**33.0%**	**29.3%**	**27.7%**	**28.1%**	**29.1%**	**27.7%**	**26.5%**	**29.2%**

Work to improve DNA rates

- Teams are increasing the use of accurx messaging service to inform of appointments and send reminders – we are just about to go to recruitment for admin staff who will then be able to offer this more consistently.

- Many of our triage appointments are booked directly into clinics by GP surgeries – we are therefore exploring the methods used to inform people of their appointments.

Workforce and Culture

Teams are made up of these roles –

- Mental Health Practitioners (can have backgrounds in nursing, social work or occupational therapy)
- Clinical Leads
- Advanced Nurse Practitioners
- Advanced Clinical Practitioners
- Mental Health Connectors (embedded in our teams but provided by our contract with MIND and Living Well Consortium)
- Physical Health Connectors (cover certain PCNs as part of a 12 month funded pilot in partnership with The Active Wellbeing Society)
- Mental Health Pharmacists
- Social Workers (embedded in our teams but provided by our contract with Birmingham City Council)
- Consultant Psychiatrists
- Hub Managers

Workforce and Culture

Each team has a mixture of ARRS (Additional Roles Reimbursement Scheme) roles which are 50% funded by PCNs, and non-ARRS roles.

	BUDGETED TOTAL WTE	BUDGETED ARRS WTE	BUDGETED NON-ARRS WTE
NORTH	18	7	11
SOUTH	31	12	19
EAST	19	7	12
WEST	16	6	10
SOLIHULL	Currently under review		

Workforce and Culture

Challenges

- Demand is outweighing capacity in all areas at the moment, however, we will now be recruiting to some of the non-ARRS roles that have recently been confirmed, which will bolster resource.
- ARRS roles are dependent on PCN agreement and funding, therefore we do not have ARRS roles in all PCNs and it can be a changing picture. There can also be some inflexibility in moving resources as ARRS staff are linked with particular PCNs.
- Estate/space as our non-ARRS workforce grows.
- Requests for resource into the Community Provider Collaborative.

Positive culture demonstrated in Staff Survey

At the last staff survey, staff numbers in our teams were low so were weren't able to get a breakdown of results for each team, however, with all 5 teams combined…

100% - 'Enjoy working with colleagues in team'

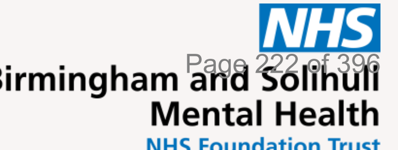
100% - 'Colleagues are understanding and kind to one another'

100% - 'Feel my role makes a difference to patients/service users'

100% - 'Opportunities to show initiative frequently in my role

93.8% - 'Often/always enthusiastic about my job'

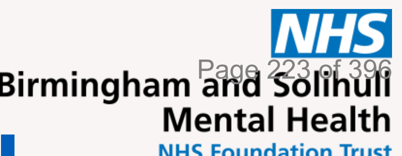
93.8% - 'Immediate manager values my work'



Finance

- All Neighbourhood Teams are performing within budget, and there are no particular hotspots or areas of concern. Baseline staffing continues to be monitored as we understand demand.

- Because ARRS roles are 50% funded by PCNs there is potential for this to be a changing picture (i.e. if a PCN withdraws or a PCN requests a further ARRS role), potential cost pressure, reviewed on an ongoing basis.



Strategy, transformation and external

Partnership and transformation work

- MAT (Multi-Agency Team) meetings – all localities have one, led by NMHT – clinical discussion including NMHT, CMHT, talking therapies, drug and alcohol services, support into work services, other VCSFE in locality.
- LIG (Local Implementation Group) meeting – all localities have one, led by NMHT – brings various partners together to discuss pathways/partnerships/ barriers, thinking of the local demographic and need.
- All teams have Mental Health Connectors (MIND or living Well Consortium) who support people with social needs and accessing further community support, meaningful activity, and overcoming barriers that can prevent this.
- CMHT MDT (Multi-Disciplinary Team) meetings – all NMHTs are attending some of these to foster better relationships and understanding across teams, and to provide smoother pathways for cases that could potentially be transitioned to/from each other.
- All NMHTs are working closely with many VCFSE organisations.

Strategy, transformation and external

Current pilots/workstream

- Solihull – with an aim of bringing more integration of NMHTs and CMHTs, Solihull are piloting a model whereby the locality is split into a North team and South team. Each team has one manager and incorporates both the NMHT function and the CMHT function.

- Managing Emotions Programme – adapted from Surrey and Borders, South NMHT have completed the first run of a 2 hour group session and we have planned sessions to include all teams and deliver alongside Peer Support Workers.

- Exploring Depression Group – North NMHT teamed up with recovery college to successfully deliver this 3-session group in a local community venue. We are now looking to re-run incorporating some evaluation points.

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Strategy, transformation and external

Current pilots/workstreams

- Physical Health Connector pilot – contracted to The Active Wellbeing Society. In a few PCNs, looking at SMI registers, with focus on those who GPs have not managed to engage with annual physical health checks. They use a relational approach to overcome barriers to engaging in checks and subsequent health improvement intervention. We have had some excellent feedback from one of our East GPs.

- Community Provider Collaborative – INT (Integrated Neighbourhood Teams) – these are teams based around a PCN population and made up of representatives from BCHC, BCC, VCFSE, and mental health. NMHTs are each providing staff for 2 days to support the collaboration, which aims to look at high intensity users of services, and prevention into urgent and acute care. We are currently in discussions around 'Locality Hubs' which are an extension of this model.

- The Longbridge project – South NMHT are involved in many aspects of this project, including a joint referral meeting, and review and step-down of cases from CMHT and NMHT.

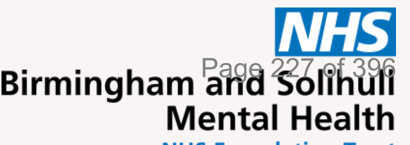
- East Step Down Clinic – Working with two consultant caseloads from East to test a MDT discharge clinic

- Triage Hub – MDT Triage Hub to move service users to the right provision from the front door

Strategy, transformation and external

Next steps

- Dialog+ - we are currently working on how this will be embedded in NMHT as a universal needs assessment, along with our partners, to support people to the right place and intervention.
- Referral/triage hub – we are working on a model which will bring partners together to look at referrals, to support people to the best service/intervention at an early stage, and to prevent referrals being passed between services.
- Step-down clinic – we are looking at testing a clinic in East for CMHT to NMHT transitions.
- Peer Support Workers – will be embedded within our teams to enhance our workforce and service offer.
- Bids – we have submitted bids to the Mental Health Collaborative to support with VCSFE into referral/triage hubs, and to provide preventative mental health outreach to communities.



RAG ratings for Neighbourhood Mental Health Teams

Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
AMBER	AMBER	AMBER	AMBER	AMBER	GREEN

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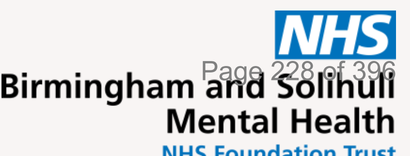


Community Mental Health Teams

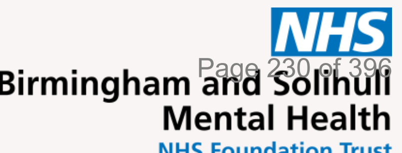
There are 4 CMHT hubs and 4 single CMHTs across Birmingham and Solihull.

The CMHTs consist of the following roles:

- Psychiatrists
- Psychological Practitioners
- Mental Health Nurses (including ANPs and ACPs)
- Occupational Therapists
- Support Time and Recovery Workers
- Administrative Support
- Health Instructors

CMHTS

- The teams work 5 days a week (Monday to Friday 9 to 5) and are based at multiple sites across BSol. In addition, we have an OOH duty line that operates 17:00 – 21:00 weekdays and 09:00 to 21:00 on weekends and bank holidays.
- The CMHTs provide a service for those aged 18+ in Solihull and 25+ in Birmingham for individuals who have a severe and enduring mental illness with an associated complexity and risk.
- Each care coordinator can hold a case load of up to 30 service users, however this is weighted against complexity and risk so may vary slightly.
- Referrals come via Neighbourhood Mental Health Teams, GPs, police, other BSMHFT teams, and external partners.
- When benchmarked against other Mental Health NHS Trusts, the CMHTs within BSMHFT have the 6th highest Caseload above the mean and are in the top quartile for weighted population at 1,240 compared to the national average of 788. In addition, BSMHFT CMHTs had the lowest total number of staff (16.25) at 31.03.2023 compared to a national average of 39.26 based on weighted population.



Quality and Safety

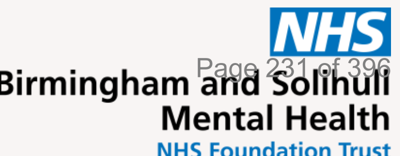
- All reports are up to date and recorded. This includes all IPC Audits and Hand Hygiene, Business Continuity Plans.

- RMS, appraisals and clinical supervision meet a minimum of 80% for each CMHT, this continues to be monitored on a monthly basis and reported through to local FPP.

- CMHTs have been focussing on the Quality of ICR Documentation through an ICR Quality Monitoring Tool for service users managed under a Care Programme Approach

- Having adapted a nursing metrics tool that was being used to monitor Assessment Summaries, Risk Assessments and CPA Care Plans, we now also monitor the quality of Dialog+ care plans. This is an early version of the document as we embed Dialog+ within the service, allowing us to understand what is important when producing a quality Dialog+ care plan

- Standards have been introduced to improve the quality and safety of medicines management due to existing concerns which were further highlighted by the CQC's inspection in August 2023



Quality and Safety

- A Management of Missed Depots in Community Teams procedure was approved through Community CGC, ensuring that there is a clear process (and escalation pathway) for those service users who do not attend for their planned depot appointments.

- A Medication/Clinic audit was introduced in September 2023, this is also reported through Community CGC and FPP. Between September 2023 and May 2024 compliance with the audit areas improved from 74.68% overall, to 97.3% overall. Pharmacy also noted an improvement in their audit from 80% in September 2023 to 92% in March/April 2024.

- Prescribing Standards for Community Teams are currently in the process of being approved, pending the next Community CGC meeting. These have been developed to give clear guidance as to the appropriate method for prescribing within our community teams based on the BSol IMOC Formulary.

- Matron role continues to be embedded within the CMHTs and consideration being given as to how they can be furthered developed focussing on Quality and Safety.

Operational Performance

- Key Performance Indicators have consistently improved however there continues to be fluctuations requiring targeted work to bring these back up to target.
- KPI's are monitored on a fortnightly basis with leads from across the directorate, further work is taking place supported by informatics colleagues to support local manager with responding to metrics (CPA, Care Support, Unoutcomed appointments)
- As of June 2024, CPA reviews were 93.5% completed.

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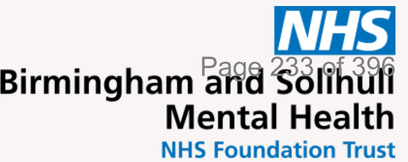

Workforce and Culture

- Staff Survey showed an improvement upon the previous year, and Senior Leads are in the process of meeting with all teams to identify areas where we can improve their well-being.
- We continue to hold vacancies, particularly for our medical posts, which results in reliance on the use of agency locums. This can lead to instability and reduced morale within the teams. However, we have reduced our bank and agency usage overall. There is active recruitment taking place to recruit substantively to the Consultant posts currently covered by Locums
- We are currently in the process of reviewing longstanding vacancies with a view to skill mix and consider alternative roles such as Medical Support Workers.
- CMHTs also have 12 Mental Health Wellbeing Practitioners who provide psychological support. The expansion of this workforce as vacancies arise are also being reviewed.
- Sickness overall across ICCR has reduced and in June we were in line with the trust target
- As a directorate we have embraced the just culture approach and have moved swiftly when FTSU's have been raised, completing informal fact finds and working with OD and EDI colleagues to support teams.
- CMHTs have all undergone DIALOG+ care plan training and are working towards the September deadline for CPA cases, which will be followed by plans for Care Support cases.

Finance

- There continues to be an overspend on medical workforce, clinical directors are working with finance leads to review roles and reduce non budgeted roles and also consider alternative roles to support the medic workforce (medical support workers)

- Nursing workforce spend fluctuates. This is typically due to difficulties filling vacant posts (mainly Band 6 roles) or providing backfill for LTS, maternity, secondments , etc (however targeted work on sickness is starting to see this reduce)

- The non-pay spend for medications is over the projected budget, which then contributes to an overall overspend.

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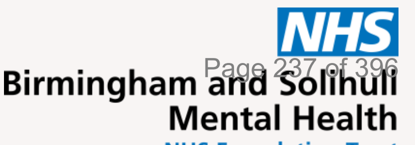
Strategy, Transformation & External

- The NMHTs have seen circa 30,000 service users since the service inception with only between 3-9% requiring secondary care, this currently hasn't seen a reduction in demand in the CMHTs, this is due in part to the Neighbourhood Mental Health Teams identifying a population of service users where there were unmet needs.
- There has not been a consistent cross service reduction of the CMHT caseloads and there remains some areas where the caseloads have increased despite the NMHTs being in place. Caseload stratification is underway across all the CMHTs, to identify those who are suitable for transitions and these have then been successfully handed over to either the NMHTs or GPs. In addition, the collaborative working between CMHTs and NMHTs has allowed for much improved transitions between the two functions. Further work to support caseload reduction
- Further work around caseloads in now being piloted to review a wider section of caseloads to indefinity suitability for step down.
- The flow across the CMHTs in being focussed on as part of transformation and Discharge Clinics in East are due to commence with a MDT (including VCFSE partners) approach to safely stepping service users in to Primary Care supported by the NMHTs.

Strategy, Transformation & External

- Both Longbridge and Solihull are trialling needs led appointment systems in an aim to improve availability of appointments slots for service users and to move away for 6/12 monthly appointment being booked in and reducing capacity to respond to immediate needs. if successful this will be rolled out across CMHTs
- Roadshows across CMHTs have now been completed with all teams to focus on the key areas of transformation for the next 12-18months, focus will be on:

1. **Bridging the gap between Primary Care and Secondary Care**
2. **Caseload and Flow**
3. **Transitions**



RAG ratings for Community Mental Health Teams

Overall	Quality and Safety	Operational Performance	Workforce and Culture	Finance	Strategy, Transformation & External
AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

compassionate

Cilantro Suite, Eating Disorders Day Treatment Service & Eating Disorders Outreach

Eating Disorders Outreach & Day Treatment Service Purpose and Current State

- The Outreach team provide urgent response for patients presenting with significant risk in the community to support their symptoms and aim to reduce the need for hospital admission.
- The team operates Monday to Friday 9am – 5pm and clinicians also contribute to the duty system which acts as a mechanism for professional advice.
- This service has been commissioned as part of ICB & BSMHFT Community Transformation and currently consists of two Specialist Eating Disorder Practitioners and two Support Time Recovery Workers (STRW's).
- The Day Treatment Service (DTS) are commissioned by the Provider Collaborative and offer up to 6 spaces for day patients suffering from anorexia or bulimia. This is staffed by two RMN's (B6 & B5) and one healthcare assistant.
- Recent pilot project trialling a DTS model for treatment of Binge Eating Disorder – first NHS treatment of this nature

Eating Disorders Outreach & DTS
Future State

- Further funding has been provided for Outreach for two WTE Peer Support Workers (PSW) – 1.5 posts have been recruited to and onboarding is in process. Engaging with local Trusts to help build the PSW pathway.
- Additional STRW employed to cover maternity absence.
- Working groups in place to explore new treatment pathways within DTS – binge eating pilot treatment and ARFID (Avoidant restrictive food intake disorder) pathway.
- Assistant psychologist employed (fixed-term) to increase access in DTS.
- Working groups around EBE recruitment and development of the SEED pathway
- FREED pathway in development and referral routes to be extended

Eating Disorder Inpatient unit – Cilantro Suite

A 10 bedded mixed-gender unit, funded by the Provider Collaborative. Referrals for admissions come from the Trusts involved so often the unit has a high proportion of out of area admission.

- Staffing – current vacancies: 2 x B6 posts, 2 x international nurses recruited and remain supernumerary at this time. Business case to be completed to increase B3 staffing numbers – on-going.
- Assistant Psychologist employed to increase psychology provision on the ward and support access to clinical supervision/reflective practice.
- Non-recurrent funds – decoration and furniture to be selected for the ward. Quiet room to have new body imaging equipment installed.
- Sensory room project ongoing due to other Trust areas completing work on this. Working group identified to help move the project forward – aim for completion by Spring 2025.
- Cilantro unit received a “good” CQC rating. Clinical improvement plan is currently in place to address areas of constructive feedback.
- QED accreditation to be presented to the board – likely to receive feedback in November.

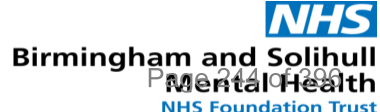
Work planned for next 3-5 months

Appraisal Figures 85.7%, RMS 62% and Clinical Supervision 71.4%

- Implement changes from the clinical improvement plan.
- Aim to maintain higher compliance with KPIs
- Improve carer engagement on the unit (lead roles in place on the ward) and coproduction with service changes
- EDS specific training to be completed for TSS workforce and new starters
- Environmental changes
- Improve quality of MDT recording & digital pathway
- EDI project to commence in the coming months – staff recruited to champion this project

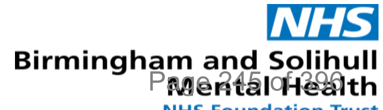
Other:

- Two risks currently on the register – medical workforce and outpatient therapy wait times.
- Provider Collaborative functioning well – no use of beds outside of West Midlands area, patient admissions within 20 miles of home address. Finances are being reinvested in the NHS inpatient services.



Committee Escalation and Assurance Report

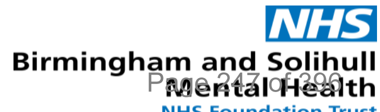
Name of Committee	Quality, Patient Experience and Safety Committee
Report presented at	Board of Directors
Date of meeting	2 October 2024
Date(s) of Committee Meeting(s) reported	18 September 2024
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Corporate Risk register • Board Assurance Framework Risks • Regulatory Compliance report • Reaside single improvement plan • Eden PICU Alert Report • Patient Safety Incident Responses Framework (PSIRF), SI Reviews, Patient Safety Alerts, Complaints and PALS • Infection Prevention & Control Team Report • Safeguarding Annual Report • Learning from Deaths Report including Improvements to Our Approach • Integrated Performance Report • Clinical Governance Committee Workshop and Internal Audit Presentation • Freedom To Speak Up
Alert:	The Committee were appraised of the ongoing concerns in relation to waiting times with concerns being raised in relation to ADHD and SOLAR waiting times for 52+ weeks remain high and clinical risks across the divisions need to be explored to ensure appropriate support is in place.
Assure:	The Committee was assured on the following key areas: • CQC draft report has been received for the CMHT with an improved rating of 'good' • Safeguarding annual report provided assurance with leadership improvements addressing and supporting the increase in activity • Freedom to Speak Up report provided assurance on identifying themes and increasing champions across the divisions for support • Weekly safety huddles have been established • PEAR group will be reporting into Committee for enhanced expert by experience learning going forward
Advise:	• Flu campaign has been launched successfully in September 24 • Reaside single improvement plan has been developed and Committee will maintain oversight of progress • Clinical governance review workshop identified a number of opportunities for improvement in focus, delivery of strategic quality priorities, use of data, 'closing the loop' and identifying and disseminating learning, managing risks, reducing duplication and strengthening assurance within Committee for the Board.



Board Assurance Framework	The BAF risks for QPES have been updated.	
	New risks identified:	
Report compiled by:	Winston Weir, Non Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager

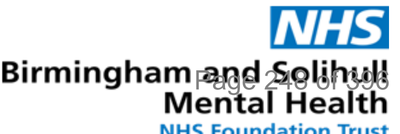
Committee Escalation and Assurance Report

Name of Committee	**Quality, Patient Experience and Safety Committee**
Report presented at	**Board of Directors**
Date of meeting	**2 October 2024**
Date(s) of Committee Meeting(s) reported	**21 August 2024**
Quoracy	**Membership quorate: Y**
Agenda	The Committee considered an agenda which included the following items: • 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 • Safeguarding Report • Integrated Performance Report • Clinical Governance Committee Report • 24/7 • Clinical services Q1 strategy update • Quality Q1 strategy update • Action Plan from Internal Audit Review of the Clinical Governance Committee
Alert:	The Committee were appraised of the two-day CQC inspection at Reaside where significant issues were escalated regarding leadership and cultural challenges, staff shortages, high levels of acuity and drugs being bought onto site. Executive Directors continue to meet and support the Reaside leadership team who are being supported by Lisa Pim and the clinical governance team to develop a single improvement plan. The Trust Clinical Governance Committee will review the plan and it will be shared with both the CQC and QPES Committee in September. Infection Prevention Control specialist capacity was reduced from 4 specialist nurses to 2 specialist nurses in the first quarter and this impacted the service delivery. Recruitment has taken place to ensure the team are back to full capacity in the coming weeks. Patient safety report identified a significant number of unclosed eclipse reports. Trajectories for closure of historical incidents have been requested through the Directorate Deep Dive Meetings and will be monitored closely through this process. The Internal Audit Review of Clinical Governance Committees identified a number of areas for strengthening the governance. Whilst some progress has been made, there remain a number of key areas of concern – in particular the terms of reference of the various committees feeding into the Clinical Governance Committee. A workshop in September 2024 will be conducted with the committee



	to pick up these concerns and other improvements to the way Clinical Governance committees across the Trust operate.
Assure:	The Committee was assured on the following key areas: • CQC action plan continues to be reviewed and any slippage has been highlighted to the committee. The committee noted the changes to the CQC Operational Effectiveness. • Clinical services Q1 strategy update was received with positive assurance. The Committee endorsed the report to Board. • Quality Q1 strategy update was received with positive assurance. The Committee endorsed the report to Board. • The Trust brings 24/7 world-leading mental health care pilot to Birmingham. We have been named as one of six providers nationally, to lead the development of a 24/7 mental health service pilot. The Committee noted this as another great opportunity for us to work with our local communities and Experts by Experience to shape the services of the future and build on the successful community transformation work that we have already achieved. • The committee received an update on Patient Safety Incident Response Framework. The committee noted the only going work to reduce the number of complaints. • Integrated Performance Report metrics are being reviewed and current data improvements were received.
Advise:	• Safeguarding: Case Arthur Labinjo-Hughes recommendations were confirmed to be embedded following National Review. Assurance and closure report to be bought to QPES Committee in October.
Board Assurance Framework	The BAF risks for QPES had been updated but not discussed at this meeting due to time constraints. **New risks identified: CRR was not reviewed at this meeting.**

Report compiled by:	Winston Weir, Non Executive Director	**Minutes available from:** Hannah Sullivan, Corporate Governance and Membership Manager



Report to Board of Directors						
Agenda item:	**11**					
Date	2 October 2024					
Title	Infection Prevention & Control Annual Report 2023-2024					
Author/Presenter	Zalika Geohaghon, Lead Nurse Consultant for IPC					
Executive Director	Lisa Stalley-Green, Executive Director of Nursing & Quality, DIPC (Chief Nurse)	**Approved**	**Y**	✓	**N**	

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

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

Purpose

The purpose of this report is to provide a comprehensive overview of the activities and outcomes related to infection prevention and control (IPC) within BSMHFT over the last financial year. It aims to document key findings, trends, challenges, and successes across various areas of IPC, including outbreak surveillance, response to alerts and directives, food safety, water management, cleaning standards, capital developments, and the annual program of work. By detailing these aspects, the report serves as a valuable resource for stakeholders, including management, staff, external agencies, and regulatory bodies, to understand the organization's efforts in safeguarding against infectious diseases and maintaining high standards of infection control. Additionally, the report outlines recommendations for improvement and future actions, contributing to ongoing efforts to enhance IPC practices and ensure the safety and well-being of all individuals within the organization's care.

Introduction

The Infection Prevention and Control (IPC) Annual Report 2023/24 is a comprehensive document that encapsulates the diligent efforts, critical insights, and significant achievements of our IPC team throughout the past year. Through meticulous surveillance, proactive measures, and collaborative initiatives, we have navigated various challenges, upheld stringent standards, and safeguarded the health and well-being of our patients, staff, and community. The report aims to enable reflection, analysis, and strategic planning as we review our accomplishments, address areas for improvement, and chart a course toward continued excellence in infection prevention and control.

Key Issues and Risks

Key Issues

- Team resilience very small and inadequate to support the Trust adequately, leaving the IPC team mainly in a reactive role rather than being able to work proactively and move towards a more supportive model.
- Need to ensure ownership for IPC by the clinical areas and therefore clinical leads such as Heads of Nursing, reporting of IPC position must be part of their portfolio and included on regular reporting.

- IPC Environmental audits and hand hygiene average scores consistent with uncertainty margin that puts the Trust in red to amber scores due to low compliance, in particular community teams.
- COVID-19 outbreaks shorter in duration and affecting less staff and SU, but still in a significantly high number (peak was in December 2023)
- Trust has no food safety expert and no governance structure to support the post – Record of 2 anaphylaxis reactions recently.
- No decontamination officer in the Trust - Trust not compliant with Health and Social care Act 2008
- No air safety group in the Trust
- Low FFP3 face fitting coverage (program now being put in place)
- Lack of IT solutions to support IPC work – AMaT system acquired that will cover the auditing program, but no support for the IPC records and surveillance in place.
- Trust Microbiology support is done through Heartlands – PHE but pathology laboratory is City laboratory, which creates challenges on Microbiologist to access the required data and advice and also on outbreak management due to lack of communication between the lab and microbiology.
- Legionella counts still elevated in some Trust sites – Dosing plants implemented on most concerning sites and new water safety plan due for approval – Clarity needed towards Hydrop report due to IPC concerns the IPC team has expressed regarding its accuracy, which can have significant operational implications for the Trust.

Recommendation

Based on the identified Key issues in infection prevention and control (IPC) within the Trust, the following recommendations are proposed to enhance IPC practices and mitigate risks:

- IPC Specialist Capacity: Ensure support on review on team capacity and resilience, on ensuring the expectations are in line with the team capacity to deliver the service – Consider support expansion of the team to increase capacity and resilience and actions for expanding the role of the IPC champions with protected time for IPC activities; Ensure IPC capacity can be focused in pro-active actions such as support on action plans implementation.
- Hand Hygiene and Environmental Audits: Support the development of accountability for IPC by the clinical areas with the recommendation of the Heads of Nursing to include on their reporting IPC aspects such compliance on environmental audits and Hand Hygiene
- Prevalent Conditions and Microorganisms: Support recommendation for the Trust to acquire IPC systems such as ICNet to ensure IPC can monitor microbiology results and follow up on support given as well as being able to audit IPC work.
- Confirmed Cases of Measles and TB: Ensure dissemination of lessons learned.
- Specialized Expertise and Resources: Support prioritization of recruitment of food safety expert and discuss governance structure and human resources needed to support the post.
- Specialized Expertise and Resources: support the recruitment of a decontamination officer for the Trust to ensure compliance with the Health and Social Care act2008: Code of Practice on the prevention and control of infections and related guidance.
- Air Safety Group: Support the creation of an Air Safety Group in the Trust
- BAF – Ensure the IPF BAF is incorporated into the Trust BAF to ensure there is IPC visibility at Trust board
- Re-evaluate laboratory contract to ensure there is full access from the microbiologist to the results and decisions taken.
- Clarify the Trust position regarding the Hydrop report sponsored by estates, having in mind the concerns from IPC regarding the accuracy of the report and the operational implications of it.

By implementing these recommendations, the Trust can strengthen its infection prevention and control measures, enhance patient safety, and minimize the risk of healthcare-associated infections. These actions should be undertaken collaboratively and with a commitment to continuous improvement in IPC practices.
Enclosures
None.

INFECTION PREVENTION & CONTROL ANNUAL REPORT 2023-2024

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

Infection Prevention and Control

Annual Report 2023/24

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Executive Summary

The 2023/24 annual report outlines the Trust's continued commitment to minimising the risks of Healthcare Associated Infection (HCAI) on our services and to promote best practice in infection prevention and control, as well as the response to the COVID pandemic.

It details the activities undertaken by the Infection Prevention Partnership Committee (IPPC) and the Infection Prevention and Control team (IPCt) to lessen the risk of avoidable harm to service users and promote safe working practices for Trust staff.

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

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

The report follows the format of the Health and Social Care Act (2008) Code of Practice of the prevention and control of infections and related Guidance (Department of Health 2015) to demonstrate our compliance with the criteria and recommendations for 2023-2024 work plan to strengthen assurance.

Introduction

The IPC team workload has had a substantial challenge during this reporting period, in particular, due to the ongoing staffing challenges, recovery from pandemic and new challenges mostly related with the rise of monkeypox and measles.

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

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

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

The table below sets out the actions taken by the Trust to evidence compliance with the code of practice and actions for 2023/24 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of Trust compliance	Recommendation/action for 2024-25 work plan
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• Director for Infection Prevention and Control • Infection Prevention Partnership Committee (IPPC). • Annual Programme of Work. • Annual Audit Programme • Annual Report to Trust Board. • Monthly report to Clinical Governance Committee. • Risk Register review ongoing and presented monthly at IPPC (strategic and operational). • Monthly environmental undertaken locally hand hygiene audits submitted monthly to IPC and monthly report produced to heads of Nursing, managers, matrons and deputy DIPC and concerns discussed at monthly IPPC • IPC champions programme which includes three study days/year delivered by the IPC team.	1. Incorporate all auditing system into the AMaT system if found fit for purpose. 2. Acquire electronic system for management and records purpose for IPC (e.g., ICnet®), including recording and management of outbreaks – Single point of access for IPC information. 3. Ensure Heads of Nursing include IPC in their reporting (governance pathway to be agreed with DIPC) to ensure that there is adequate oversight of the current situation and actions in place are followed up. 4. Trust to ensure there is a clear leadership and governance structure for food safety in place

		• Policies, procedures, SOP's development and review programme • Water Safety Group (WSG) (quarterly and when needed) and Water strategic meeting monthly. • Trust Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist. • Access to microbiological testing	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	• Monthly reports on cleanliness standards to IPPC • Annual PLACE inspections (by estates and facilities) – Reported through IPPC • Monitoring of contractors cleaning performance though reporting to the IPPC by contractors and indirectly through IPC environmental audits. • Cleaning Policy • Decontamination Policy. • Quarterly Dental Suite audits • Waste Management Policy • Access to Food Safety Advisor • Water Safety Group • Control of Legionella Policy • IPC input to the built environment new build and refurbishment projects.	5. Auditing control of legionella policy requirements undertaken by the WSG. 6. Ratify Water safety plan through strategic WSG 7. Trust to recruit food safety advisor or procure external service and ensure an adequate governance structure is put in place to support and escalate any issues. 8. Food safety policy to be updated as soon as food safety expert in place (consider using expertise of external food safety expert to reduce any delays on the policy review). 9. Agree on governance structure for food safety and required support network to ensure deployment of service and its sustainability. 10. Recruit decontamination officer for the Trust. 11. Create ventilation safety group.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	• Electronic prescribing. • Quarterly Antibiotic Audit Report to be presented at IPPC. • Trust antimicrobial guidance document. Access to microbiological advice.	12. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice (Chief Pharmacist); 13. Include SEPSIS awareness training for IPC champions; 14. Ensure Trust Pharmacist antimicrobial use report is presented quarterly to IPC committee.

4	Provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• IPC notice boards (IPC support bundle in place to support this) • Hand washing notices. • BBV (Blood borne Virus) Screening secure care • Close work with communications department to ensure adequate messages and information is available on internal and external sites	15. Provide information to be cascaded to clinical areas with relevant information displayed on the IPC boards in the clinical areas – Discuss processes to ensure information can be successfully cascaded when needed (e.g. – measles alerts, etc.). 16. Regular meetings with matrons/managers/Heads of nursing for IPC update (previously was through weekly matrons meeting), currently monthly through IPPC and ad-hoc when necessary. 17. Review internal and external web page and discuss with Comms process to ensure the pages are curated and timely updated. 18. Currently reviewing internal and external web pages.
5	Ensure prompt identification of people who have or are at risk of developing infection so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people	• Electronic notification forms to the IPC team from RiO patient record. • Electronic pathology reports • Expert infection Control advice from the Trust IPCN's and contracted service of a Consultant Microbiologist. • Access to specialist TB service at Birmingham Chest Clinic. • BBV screening • Sepsis awareness of risk associated conditions such as pneumonia, urinary tract, and wound infections.	19. Ensure information given on training IPC champions is cascaded to the team – Discuss processes to make this feasible. 20. Consider acquiring ICNet or similar system to monitor infections across the Trust and enable traceable advice and monitoring of actions. 21. Consider acquiring ticket system to monitor and record information/advice given to areas when IPC is contacted to ensure traceability and quality evaluation of the advice provided and also allow a smarter allocation of resources. 22. Discuss team structure and staffing to ensure that is able to provide agreed level of service and has built in resilience.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.	• IPC fundamental care e-learning for all staff on induction and updates. • Link worker training x3 per annum. • Infection Control responsibilities included in job descriptions. • Infection control training of contractors included in estates and facilities	• Discuss update of local risk assessments to ensure staff are aware of national guidance and enable to make informed risk assessments in the workplace (with support from Health and safety). • Ensure FFP3 mask fitting program is continued and compliance is improved to

		report to IPPC (report in appendix). • Core Hand Hygiene Trainers Training delivered by IPC team alongside IPC champions training and ad0hoc as needed.	ensure adequate coverage is achieved. • Consider expanding link workers program to create weekly protected time for IPC and agree a support structure for IPC team reference member to support the link worker.
7	Provide or secure adequate isolation facilities.	• Ensuite bedrooms to most inpatient services. Dedicated toilet facilities made available in non-ensuite areas. • Management of Isolation Procedure in place and reviewed.	23. IT development of a solution to capture and monitor isolation information/checklists (within the integrated solution proposed in point 1) – Explore AMaT solution
8	Secure adequate access to laboratory support as appropriate.	• Pathology services provided by Sandwell & West Birmingham Hospitals NHS Trust.	24. Consider reviewing contract. Currently our microbiologist works for PHE labs at Heartlands and the results go through City Hospital which can create challenges on communication since the microbiologist will not have direct access to the result.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	• Suite of procedures and policies aligned to the Trust Overarching Infection Prevention and Control Policy. • Annual plan of policy/procedure review in line with national standards and guidance and monitored through IPPC.	25. Policies/Procedures are reviewed according to annual plan of work.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	• Occupational Health provides vaccination at employment screening. • Flu Vaccination plan for employees driven by the Trust and supported by Occupational Health.. • Liaison with Birmingham Chest Clinic in response to staff exposure to TB. • Occupational Health activity reported to IPPC quarterly.	26. Occupational Health to provide input to Seasonal Flu Planning. 27. Occupational Health to support staff in vaccination as well as sharp injuries and any further needed support regarding infectious diseases. 28. Ensure the accuracy of the records regarding new starters and all other members of staff is monitored and information can be rapidly accessed in case of need (e.g. measles case)

2. Compliance with Key Performance Indicators

Standard	Progress
Compliance with national mandatory surveillance for bloodstream infection MSSA and E.coli.	*E. Coli Bacteraemia (0)* – NIL *Clostrifium diffcille (0) - NIL*
Zero tolerance of MRSA bloodstream infection, minimise rates of *Clostridium difficile* (C. diff)	*Nil to report*
Completion of Root Cause Analysis (RCA)/Post Infection Review (PIR) and other significant HCAI's within set time scales.	*Clinical reviews were undertaken in line with trust risk management policy – PSIRF to be deployed with Governance support*
Compliance with Hand Hygiene Audit. 95% threshold	*The Trust has met its overall compliance of 95% when excluding non-submissions,. If included the non submissions (scored 0%), the average annual score for community settings lowers to 84.08% due to an average uncertainty of 13.46%*
Compliance with Antibiotic Audit. 80% Threshold	*Quarterly reports on usage and recommendations/actions presented to IPPC by Chief Pharmacist. There have been gaps on this were pharmacy does not attend and does not present the report to IPPC (50% failure)*
Compliance with national cleaning standards/British Standards 90% threshold.	*The Trust has consistently met its overall compliance of 90% or above.*

3. Training activity

3.1 Training delivered:

Q1	Q2	Q3	Q4
• Core Hand Hygiene Training on 11/04/23 and 28/04/23 - via MS Teams • Core Hand Hygiene Training on 14/06/23 – face to face at the Uffculme Centre • IPC Champions Study Day on 14/06/23 – face to face at the Uffculme Centre.	• Legionella and Water Safety webinar – 08/08/24 – via MS Teams • Core Hand Hygiene Training on 20/07/23, 24/07/23, 18/08/23 11/09/23 and 19/09/23 - via MS Teams	• Core Hand Hygiene Training on 13/10/23 - via MS Teams • Core Hand Hygiene Training on 22/11/23 – face to face at the Uffculme Centre • IPC Champions Study Day on 22/11/23 – face to face at the Uffculme Centre	• Core Hand Hygiene Training on 15/01/24 - via MS Teams • Core Hand Hygiene Training on 07/02/24 – face to face at the Uffculme Centre • IPC Champions Study Day on 07/02/24 – face to face at the Uffculme Centre

Core Hand Hygiene Training	
Date	No of staff trained
11/04/23	4
28/04/23	5
14/06/23	2
20/07/23	5
24/07/23	1
18/08/23	1
11/09/23	1
19/09/23	1
13/10/23	1
22/11/23	22
15/01/24	6
07/02/24	6

3.2 Training attended:

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

Q1	Q2	Q3	Q4
25-26 April 2023: Infection Prevention & Control Conference 19 May 2023: Marian Reed Development Programme (Study Day) 13-14 June 2023: LCA 9010 Responsible Person – Hot & Cold Water & Other Risk Systems Training 22 June 2023: Marian Reed Development Programme (Study Day) Elizabeth Anderson Programme (University MSc/ Apprenticeship) 20/4/23 Understanding th practicalities of managing climate change	05 July 2023: IPS West Midlands Branch - Annual One Day Conference 17 July 2023: Marian Reed Development Programme (Study Day) 21 July 2023: BSMHFT Safeguarding L3 28 July 2023: Midlands IPC collaborative event Elizabeth Anderson Programme (University MSc/ Apprenticeship) IPS West Midlands Conference IPC Route to Net Zero Association of Healthcare Cleaning	Elizabeth Anderson Programme (University MSc/ Apprenticeship) 14/12/23 IPS Environmen Cleaning & Decontamination Webinar. IPC in the built environment. Mechanical ventilation: What do we need to know? 27 to 29/11/23 Positive Behaviour Support (PBS) leading to a Level 2 Accreditation by the The Association for Psychologi Therapies (APT). 17 to 19/10/23 Infection Prevention Society's Annu Conference 2023.	29 January 2024: BSMHFT IPC training with Dr Winzor Midlands IPC In Person Collaboration Event 14/2/24 Joint IPS/HIS webinar – Measles

water safety - the move towards carbon zero in healthcare, delivered by the Royal Society for Public Health.	Professionals (AHCP) Conference		

Additionally, the IPC team received recognition for their collaborative efforts in conducting clinical cleaning roadshows across all trust inpatient sites, emphasizing the importance of teamwork between facilities and Infection Prevention & Control. With the implementation of the New National Cleaning Standards, which resulted from extensive work by a working group, the team aimed to ensure that clinical staff were well-informed about the changes and understood the requirements related to these standards. Considering staffing limitations and capacity constraints, it was decided to visit each area with a pop-up trolley, offering information on cleaning procedures, documentation, auditing, hand hygiene, and water safety.

4. Annual Audit and Inspection Programme

Audit/Inspection	Findings	Recommendations/Actions
IPC Standards	The IPC team continued the IPC audit program above the established KPI of 5 audits per quarter, aiming at visiting all areas at least once during the financial year. A total of: • 67 IPC spot-checks were conducted with an average score of 90.72%. • 7 Community settings audited with average score of 90.17% • 62 inspections to inpatient areas with average score of 87.95% • 8 Dental suits audits conducted with average score of 91.48% This makes a total of 120 inspections conducted by the IPC team. This does not have in account other visits done in partnership or as part of specific auditing such as PLACE, needlestick, efficacy audits, and mattress audits. All areas received a report of the performed audits and d were asked to produce an action plan within 10 working days of receiving the report. As we have discussed along the quarterly reports presented at IPPC and previously annual report, the size of the IPC team makes it challenging to ensure that all the issues identified are actioned and adequately followed up. For this, the IPC team has implemented a monthly spreadsheet to aggregate the scoring of the auditing of the monthly community and inpatient settings, with non-compliances and low scores being discussed at monthly IPC committee. The findings of the audits and	Cascading findings to Matrons and link workers and request action plan – Discuss communication routes to ensure flow of information is optimum. Monitoring improvements through inspections and actions in service area surveillance reports to IPPC Move all the audits to an electronic platform – AMaT system being explored for this. Continue to utilize the iAuditor platform for IPC audits until AMaT has proven to be a sustainable and adequate solution. Consider creating protected time for IPC champions where they can work with the IPC team on monitoring standards in their areas. Reconsider effectiveness of IPC driven audits and reducing the number of audits since there has not been a correlation with the number of audits and the outcome due to small capacity of the IPC team. It is important to shift the

	challenges will be further discussed along this report.	existing paradigm to "start smart and focus" where the areas visited should be less but targeting areas identified as concern from intelligence from several sources such as outbreak spot-checks, monthly local submissions and work with IPC champions
Dental Suite Checks	8 Dental suits audits conducted with average score of 91.48%	HTM 01-05 requirements to be designed into any new build/ upgrade. This will ensure that new builds and Reaside Dental suite are suitable and safe when it comes to undertaking aerosol-generating procedures (AGPs). Currently only the existing dental suite in Tamarind Centre meets these requirements
Hand Hygiene	The quarterly hand hygiene overall Trust score met the threshold of 95% (if not taking in account the areas of non-submission) There are concerns, in particular in community settings where while the average annual score is 97.54%, there is a 13.06% error margin due to non-submissions. If this is taken into account the score uncertainty can vary from 84.08% to 97.54%, therefore we must consider that there is a degree of false assurance to assume that the score is above 95% threshold for the community settings and more work will need to be done to ensure the adequate level of assurance is provided. On what concerns to the inpatient settings, the error margin is of just 2.83% average/year with a range of score from 95.5% to 97.96%, which gives the desired level of assurance.	Hand Hygiene audits are now submitted monthly and weekly during outbreaks. Bare Below Elbows to be promoted across all staff groups. Approved ¾ sleeves recommendation through IPC committee when not engaging in direct patient care – this will need to be reflected into the Trust HR uniform policy. Review lonely work teams and consider removing them from list of teams to submit score. Discussion to happen at IPCC on mitigation measures when those teams are removed. Work to be done with the support of Heads of Nursing to increase compliance with the auditing for hand hygiene with the community teams.
Cleaning Standards	Trust KPI of 90% consistently surpassed.	Actions monitored through IPPC where standards fall below those required – Reports presented by estates and facilities. There is also a cleaning group chaired by IPPC.

Antibiotic Use	Antimicrobial use across the Trust is low and reflects the fact that in our client group, whilst there are infection risks, the incidence of infection is low compared to many other healthcare settings. All mental health services, in keeping with national guidance, have a responsibility to use antimicrobials judiciously. Antimicrobial audits suggest that antimicrobials are primarily used in line with the antimicrobial prescribing guidance. Currently there is a Gap in assurance e due to inconsistent presentation of antimicrobial stewardship reports by pharmacy to IPPC.	Medicines Management Committee to be informed of audit results and support the improvements and optimise the low usage level. Antimicrobial report to be quarterly presented to IPPC.
Sharps Safety	Fifty seven (57) Wards/Departments were visited during the audit and one hundred and forty nine (149) sharps containers were sighted. This is significant because the rate of non-conformity was 38.26% which is significantly high and correlated with the issues that have been found relating to sharps injuries across the Trust that will be explored later on this document. The audit found one (1) sharps container with protruding sharps (these were not necessarily overfilled, but had long objects protruding from them), seven (7) that were not properly assembled, (these were immediately assembled properly and staff were informed that sharps containers which are not assembled properly could lead to the lids coming off if dropped or during transportation) and two (2) that were more than three quarters full, (staff were advised to only fill to the line). Two (2) sharps container had the wrong lid on the wrong base. Staff were advised to check the colour of the lid and label. Two (2) sharps containers were sited on the floor or at an unsuitable height or place, staff were advised to have them bracketed if possible or put in a mobile holder dependent on size and space available in the vicinity. If not these two options, then placed on a flat surface. All staff should understand that the label on the sharps bin has to be completed at assembly as eleven (11) containers were not signed or dated whilst in use. Thirty two (32) sharps containers had significant inappropriate non sharp contents. Staff were advised not to put packaging or non-sharp items in sharps containers. Eleven (11) sharps containers did not have the temporary closure in place when the container was left unattended or during movement. *Graphic 1 - Sharps bins audit findings*	Sharps injuries and findings of the audit have been shared with IPC champions by including these findings in Q4 training. These are also regularly shared and discussed during IPPC. Findings shared to clinical areas but a more structured approach to disseminate the issues and training will need to be agreed. Include/develop regular sharps audit into AMaT system to be done regularly at clinical area level.

Mattress Inspection	Mattress audit inspected a total of 660 mattresses and had no access to 37 mattresses during the visits (those were inspected in subsequent visits but not included in the final report). Rejection rate was higher than last year's 15% with 22.4% rejection this year, which is significantly higher. This is particularly concerning to patient safety, not just from an IPC perspective but also tissue viability.	Matrons to continue to report against mattress standards/replacements in quarterly reports to IPPC. All wards to ensure that correct mattresses for service need are ordered and monthly matress audits are completed (currently there is no estabilished process to monitor compliance, the use of AMaT system is being explored as a possible way to obtain the needed assurance in the future. Mattresses to be stored off the floor. Develop Mattress audit into mandatory AMaT system and discuss reporting/governance structure. This should be a primary focus of the tissue viability department due to the potential consequences of poor mattress compliance, and, therefore the reporting focus should be shifted to the physical health committee.
Food Safety	Completion of annual food safety audits by an independent food safety advisor. Several issues have been identified during the food safety expert visits. The Annual Food Safety Report 2023-24 is attached to this report as an appendix 5 for further details. Trust does not have a food safety advisor. This has is in the IPC risk register.	External food safety expert conducted audits across the Trust. IPC advises the Trust to recruit a food safety advisor, since currently the Trust has no staff with this expertise and relies on ad-hoc support from Amey. Therefore, there is no way to ensure the findings of the actions are cascaded and acted upon adequately. There is no clear governance structure to monitor and escalate food safety issues, and this is a concern.
Legionella Policy compliance	Water Safety Group (strategic and operational) in place There was an external review of IPC and Estates that now needs to be analysed and an action plan put in place to ensure the lessons learned are incorporated in the daily practice. A new WSP is due for approval. At the present moment the elements of sampling and actioning results have been approved by the WSG due to the urgency to have those in place.	The WSP must ensure that it covers all necessary actions to be triggered automatically and extraordinary. IPC role in the WSG needs to be clarified. The IPC team is not a decision maker, but instead it plays a role as part of a wider panel of expertise and with the role

		of scrutinizing any concerns raised, and provide risk assessment regarding exposure risks for service users, staff, visitors, etc. Currently all members of the IPC team have legionella responsible person training as well as the Deputy DIPC.

4.1 PLACE Scores

BSMHFT 2023 PLACE scores are included within Estates & Facilities IPC 2023-24 Annual Report – attached to this report.

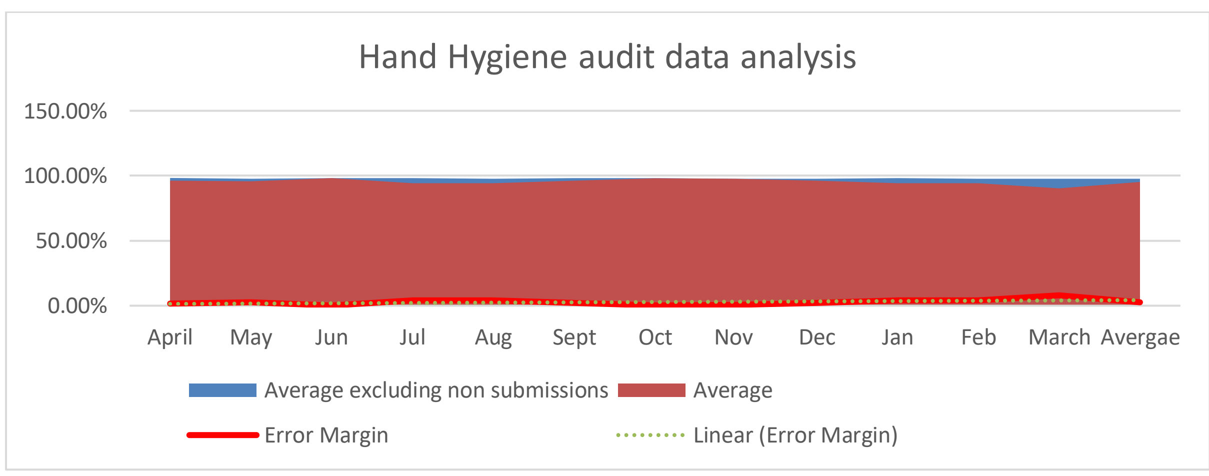
4.2 Hand Hygiene

4.2.1 Inpatient

The Trust has consistently kept the Hand Hygiene score above the 95% threshold when not having in account the non-submissions.

The following tables and graphics provide detailed monthly and annual information regarding Hand Hygiene scores. We opted to include scoring with and without removing the non-submissions so we can have oversight of the error margin of the information available.

4.2.1.1 Inpatient settings



Graphic 2 – Hand Hygiene scores – Inpatient

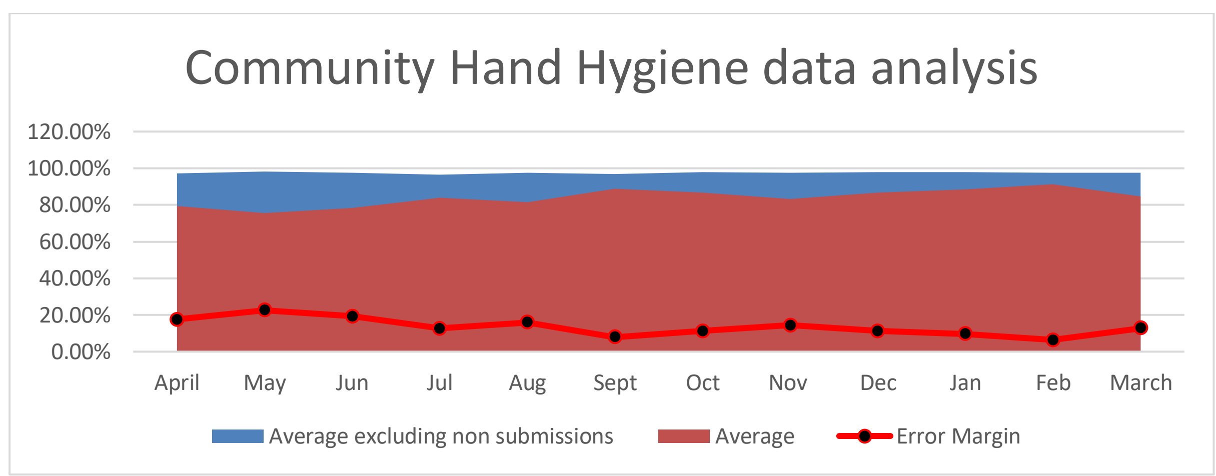
Type of calc	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Averga
Average excluding non submissions	98.33%	97.79%	98.06%	97.98%	97.94%	98.19%	98.08%	97.66%	97.90%	98.18%	97.76%	97.69%	97.96%
Average	96.47%	95.94%	98.06%	94.28%	94.25%	96.34%	98.08%	97.66%	96.05%	94.47%	94.08%	90.32%	95.50%
Error Margin	1.86%	2.38%	0.27%	4.04%	4.08%	1.99%	0.25%	0.67%	2.28%	3.86%	4.25%	8.01%	2.83%

Table 1 – Hand Hygiene – Inpatient settings

Concerning Hand Hygiene in inpatient settings, the subsequent graphic and table display a notable convergence between average scores with and without exclusion of non-submissions. This convergence offers a satisfactory level of assurance, despite a minor upward trend observed,

particularly evident since November, reaching its peak in March. Heightened awareness is crucial to ensure accurate auditing submissions and uphold the current level of assurance regarding Hand Hygiene in inpatient settings, without compromising it. With an average error margin oof 2.83% the score for inpatient settings falls between 95.5% and 97.96% which keeps above the 95% threshold.

4.2.1.2 Community settings



Graphic 3 – Hand Hygiene – Community Settings

Type of calc	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Averag
Average excluding non submissions	97.04%	98.21%	97.65%	96.49%	97.59%	96.88%	98.02%	97.67%	97.96%	97.96%	97.68%	97.38%	97.54%
Average	79.54%	75.67%	78.44%	83.84%	81.59%	88.93%	86.77%	83.26%	86.72%	88.33%	91.28%	84.61%	84.08%
Error Margin	17.50%	22.54%	19.21%	12.65%	16.00%	7.94%	11.25%	14.41%	11.24%	9.64%	6.41%	12.77%	13.46%

Table 2 – Hand Hygiene – community Settings

In terms of Hand Hygiene, there's a significant disparity. In March, the variance between the overall average and the average excluding non-submissions was 12.77%. It's crucial to take steps to further diminish this margin of error to ensure the Trust can deliver dependable assurances. Currently with an average error margin of 13.46%, the average score for the year was between 97.54% and 84.08%, which leaves the Trust likely under the agreed KPI regarding the community settings.

More than the investment in training and awareness, it is important to understand that this error margin is strongly conditioned by the number of areas that are not submitting the scores on a monthly basis. It is essential that the community team leaders and heads of nursing are involved in this process to enable a more accurate reporting, without which it is very difficult to do a correct assessment of the Trust position and plan efficiently to support where it is really needed. Having this in consideration, we cannot accept that we have enough assurance from the community settings regarding compliance with hand hygiene.

4.2.1.3 Training provided

To enable the hand hygiene to be adequately monitored in the areas and local training delivery, the IPC team provides regular training to staff. Hand hygiene training is always part of the training package offered to the IPC champions during the IPC champions days. The following table shows the hand hygiene specific trainings promoted by the IPC team:

Core Hand Hygiene Training	
Date	No of staff trained
11/04/23	4
28/04/23	5
14/06/23	2
20/07/23	5
24/07/23	1
18/08/23	1
11/09/23	1
19/09/23	1
13/10/23	1
22/11/23	22
15/01/24	6
07/02/24	6
TOTAL	55

Table 3- Hand Hygiene trainings sessions delivered by the IPC team and attendance

There are several teams with lone workers where undertaking hand hygiene audits is not possible. The IPC team has been working towards ensuring those teams have up to date training on hand hygiene, but the auditing process will not be possible to undertake due to the fact they are lone working teams and, therefore, they would be auditing themselves, which fails to give us any assurances. A discussion needs to be held to find an alternative way to gain the required assurance from those teams since auditing monthly is not feasible. This will be taken to IPCC to discuss options. Despite being mentioned in the previous report, the challenges associated with obtaining reliable reporting data from the community teams (as explained in 4.2.1.2), make it difficult to understand the full picture and make plans to cover this gap in an effective way. The success of any measure will be strongly dependant of the engagement of the local managers as well as Heads of Nursing on the process, with support from the DIPC.

4.2.2 Reasons for non-compliance

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

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

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

There seems to be some issues within some community teams on their requirement to also be bare below the elbows when in clinical settings.

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

To ensure inclusivity without compromising patient and staff safety, an options appraisal was presented to the IPPC with the support for allowing the use of ¾ sleeves when not in direct patient care. Uniform policy sits under HR and therefore the IPC team communicated this advice to the HR team so this policy can be amended accordingly.

4.3 IPC auditing program

4.3.1 Auditing results and analysis

A total of:

- 67 IPC spot-checks were conducted with an average score of 90.72%.
- 7 Community settings audited with average score of 90.17%
- 62 inspections to inpatient areas with average score of 87.95%
- 8 Dental suits audits conducted with average score of 91.48%

This makes a total of 120 inspections conducted by the IPC team. This does not have in account other visits done in partnership or as part of specific auditing such as PLACE, needlestick and mattress audits.

All areas received a report of the performed audits and d were asked to produce an action plan within 10 working days of receiving the report.

As we have discussed along the quarterly reports presented at IPPC and previously annual report, the size of the IPC team makes it challenging to ensure that all the issues identified are actioned and adequately followed up. For this, the IPC team has implemented a monthly spreadsheet to aggregate the scoring of the auditing of the monthly community and inpatient settings, with non-compliances and low scores being discussed at monthly IPC committee.

The following table shows the visits undertaken to inpatient settings:

Team visited	Location	Audit date	Score	Revisit date	Result
Grove Avenue	Grove Avenue	05/06/2023	85.78%		
Avon	Reaside	12/06/2023	84.22%	15/11/2023	90.00%
Blythe	Reaside	12/06/2023	88.03%	06/12/2023	97.60%
Severn	Reaside	12/06/2023	74.01%	25/10/2023	82.52%
Trent	Reaside	12/06/2023	88.31%	06/12/2023	94.83%
Lavender	Zinnia	12/06/2023	88%		
Saffron	Zinnia	12/06/2023	84%		
Eden Acute	Northcroft	23/06/2023	84.20%	23/08/2023	88.52%
Reservoir Court	Northcroft	23/06/2023	91.46%	25.11.22	88.55%
Larimar	Larimar	28/06/2023	89.80%		
Endeavour House	Northcroft	28/06/2023	90.50%	02.12.22	83.02%
Dental Suite	Tamarind Centre	30/06/2023	90.48%	12/09/2023	09/04/1900
Forward House	Forward House	11/08/2023	92.59%		
Hertford House	Hertford House	16/08/2023	90.29%	24/01/2023	96.27%
Eden PICU	Northcroft	23/08/2023	87.66%		
Citrine (Women's Ward)	Ardenleigh	29/08/2023	83.40%	30/11/2023	85.08%
Coral (Women's Ward)	Ardenleigh	29/08/2023	88.55%		
Dental suite	Reaside	27/09/2023	91.30%		
Newbridge House	Newbridge House	27/09/2023	90%		
Hillis Lodge	Hillis Lodge	02/10/2023	82.32%	10/01/2024	94.66%
Dove	Reaside	03/10/2023	72.80%	16/01/2024	93.83%
Kennett	Reaside	03/10/2023	77.01%	16/01/2024	86.69%
Swift	Reaside	03/10/2023	83.82%	16/01/2024	92.67%
Magnolia	Oleaster	10/10/2023	66.62%	12/01/2024	98.45%
Caffra	Oleaster	16/10/2023	85.66%		
Tazetta	Oleaster	16/10/2023	85.65%		
Tourmaline (Women's Ward)	Ardenleigh	01/11/2023	86.01%		
Japonica	Oleaster	07/11/2023	85.66%		
Melissa	Oleaster	07/11/2023	78.92%	26/02/2024	89.19%
PDU	Oleaster	07-Nov-23	75.92%	26/02/2024	83.23%
George Ward	Northcroft	16/11/2023	90.80%	24.11.22	93.03%
Bergamot	Juniper Centre	29/11/2023	94.08%		
Rosemary	Juniper Centre	29/11/2023	94.95%		
Dental suite	Reaside	06/12/2023	100.00%	06/03/2024	
Sage	Juniper Centre	14/12/2023	94.92%		
Acacia	Tamarind Centre	21/12/2023	94.35%		
Laurel	Tamarind Centre	21/12/2023	94.50%		
Dan Mooney House	Dan Mooney House	05/02/2024	89.32%		
David Bromley House	David Bromley Hous	05/02/2024	92.86%		
Endeavour Court	Northcroft	23/02/2024	87.69%	02.12.22	86.46%
Dental suite	Reaside	19/03/2024	87.50%		

Table 4 - IPC team conducted audits to inpatient settings

The following table summarizes the audits performed to community settings by the IPC team:

Team visited	Ward	Audit date	Score	Score Revisit
Central HTT	Reaside	30/06/2023	100.00%	95.24%
Sparkbrook and Sparkhill HTT	Tamarind Centre	30/06/2023	90.48%	
Reservoir Court CMHT	Zinnia Centre	17/11/2023	90.51%	
Reaside First	Oleaster	26/02/2024	89.25%	
Callum Lodge	Barberry	07.02.23	96.77%	
EIS Maple Leaf Centre	Ashcroft Unit	10.08.22	86.04%	

Table 5- IPC team conducted audits to community settings

The following summarizes the spot-checks visits performed:

Team visited	Ward	Audit date	Score
Larimar	Larimar	06/04/2023	89.19%
Reaside	Dove Unit	11/05/2023	94.60%
Reaside	Dove Unit	18/05/2023	83.78%
Barberry	Chamomile	24/05/2023	91.89%
Reaside	Dove Unit	24/05/2023	92.11%
Reaside	Blythe ward	26/07/2023	89.19%
Reaside	Swift ward	26/07/2023	86.49%
Reaside	Blythe Ward	02/08/2023	97.30%
Juniper Centre	Rosemary Ward	02/08/2023	94.60%
Juniper Centre	Sage Ward	02/08/2023	94.60%
Reaside	Swift Ward	02/08/2023	94.60%
Reservoir Court	Reservoir Court Inpatients	07/08/2023	91.89%
Reaside	Swift Ward	09/08/2023	94.60%
Reaside	Avon Ward	09/08/2023	83.78%
Juniper Centre	Rosemary Ward	09/08/2023	94.60%
Juniper Centre	Sage Ward	09/08/2023	94.60%
Barberry	Chamomile	09/08/2023	94.60%
Reaside	Avon	15/08/2023	86.49%
Barberry	Chamomile	15/08/2023	100
Juniper Centre	Rosemary Ward	16/08/2023	100
Reaside	Avon ward	22/08/2023	83.78%
Reaside	Trent ward	22/08/2023	86.49%
Reaside	Kennet Unit	25/08/2023	91.89%
Reaside	Trent ward	30/08/2023	89.19%
Reaside	Kennet Unit	30/08/2023	97.30%
Juniper Centre	Bergamot	12/09/2023	97.3
Dam Mooney House	Dan Mooney House	12/09/2023	89.19
Newbridge House	NBH Inpatiets	27/09/2023	97.50%
Small Heath HC	Small Heath CMHT	27/09/2023	83.33%
Reservoir Court	Reservoir Court Inpatients	28/09/2023	89.19%
Juniper Centre	Sage Ward	10/10/2023	94.60%
Reservoir Court	Reservoir Court Inpatients	12/10/2023	86.49%
Ardenleigh	Tourmaline	01/10/2023	94.69%
Mary Seacole 1	Ward 1	21/12/2023	86.49%
Barberry	Cilantro	28/12/2023	91.89%
Ardenleigh	Tourmaline	28/12/2023	89.19%
Ardenleigh	Coral	28/12/2023	91.89%
Juniper Centre	Sage Ward	11/01/2024	91.89%
Juniper Centre	Sage Ward	17/01/2024	86.49%

Table 6- Spot-checks performed by the IPC team

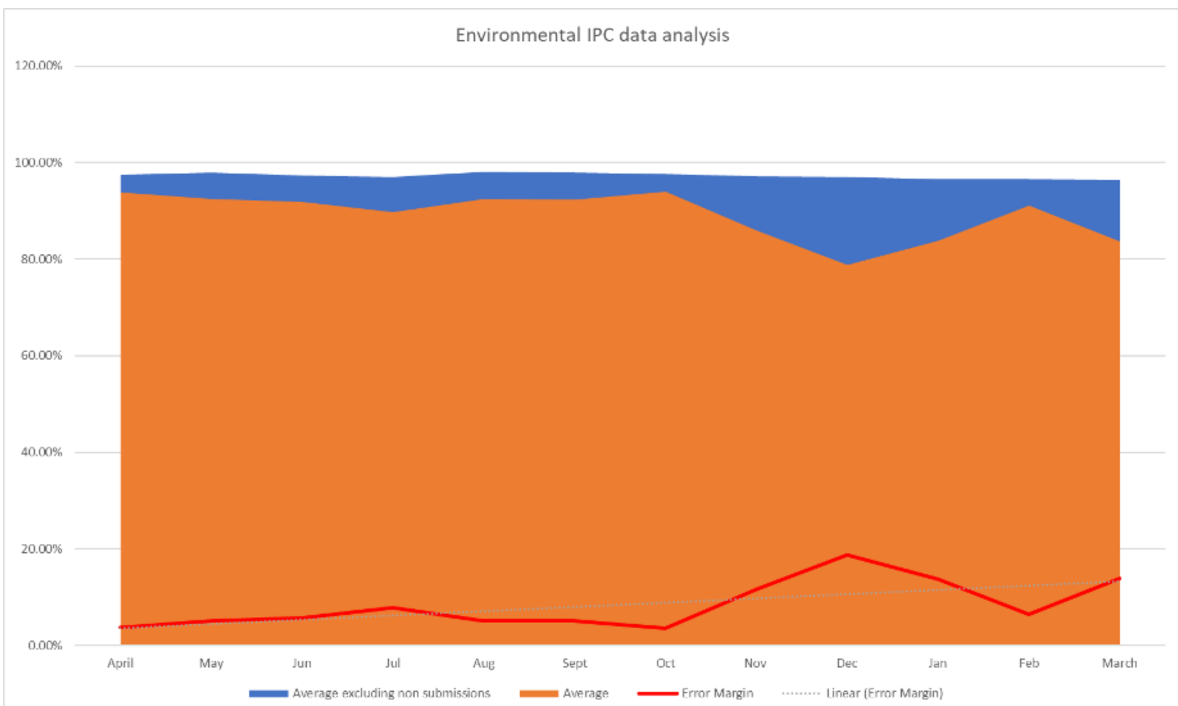
The overall average of all the inspections conducted during the financial year was 89.54% for the 144 inspections conducted during the financial year which leaves the overall Trust in Amber. This is now important to correlate with the local IPC environmental audits being monthly performed by the clinical settings.

To ensure that there was wider capacity to monitor all clinical areas across the organization, a dashboard was implemented to monitor the monthly environmental IPC audits submitted by inpatient and community settings.

Regarding the inpatient settings the average scores are as follows on the following table and graphic:

Type of calc	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Average
Average excluding non submissions	97.54%	97.95%	97.36%	97.08%	98.04%	97.93%	97.62%	97.15%	97.05%	96.60%	96.56%	96.42%	97.27%
Average	93.86%	92.41%	91.85%	89.75%	92.49%	92.38%	94.01%	85.94%	78.74%	83.84%	91.09%	83.69%	89.17%
Error Margin	3.68%	5.13%	5.69%	7.79%	5.05%	5.16%	3.53%	11.60%	18.80%	13.70%	6.45%	13.85%	8.37%

Graphic 4 - IPC Ward led environmental audits



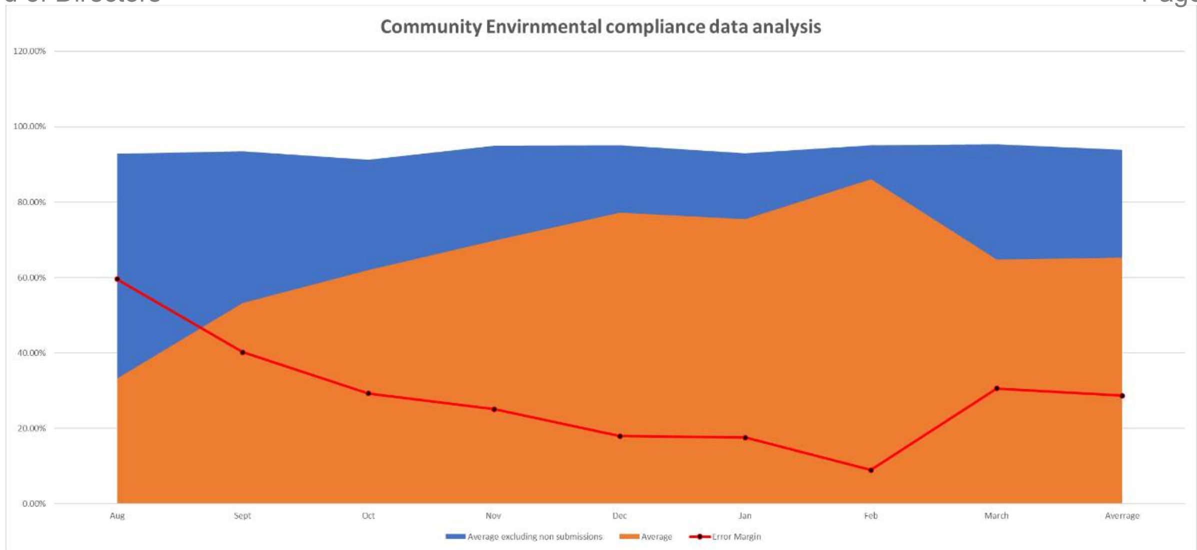
Graphic 5 - IPC ward led environmental audits

As we can see, there is an uncertainty average of 8.37%, leaving the overall score between 89.17% and 97.27%. If we correlate this data with the 87.95% average obtained from the sample visited by the IPC team, it is clear that the overall score sits on the amber category (>85% and <95%), which is lower than the desirable for the Trust and will require deeper reflection on strategies to ensure better adherence to IPC practices and ways of more closely monitor and support the clinical areas.

When looking to the community settings table and graphic:

Type of calc	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Averra
Average excluding non submissions	92.84%	93.46%	91.31%	94.92%	95.14%	93.04%	95.10%	95.33%	93.89%
Average	33.28%	53.27%	62.02%	69.85%	77.19%	75.49%	86.13%	64.75%	65.25%
Error Margin	59.55%	40.19%	29.29%	25.07%	17.95%	17.55%	8.97%	30.58%	28.65%

Table 7- IPC community setting led environmental audits.

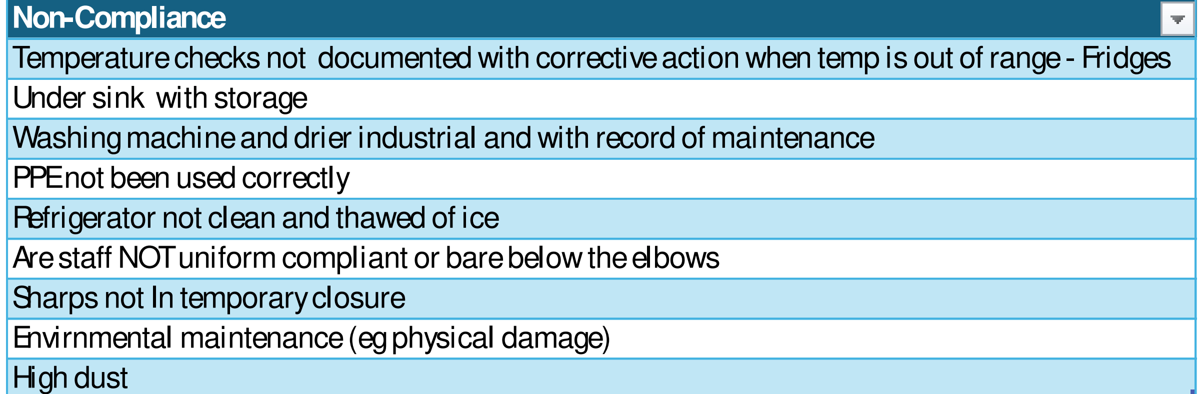


Graphic 6- IPC community setting led environmental audits.

We can see that the error margin is significantly higher than for inpatient settings with an average of 28.65%. This is particularly concerning since it denotes a much lower willingness from the community settings to comply and work with IPC, which can have unpredictable consequences for the welfare and safety of both service users and staff. While the sample visited by the IPC team had an average score of 90.17%, the sample was too small to be significative and we still face an uncertainty score that goes from 65.25% to 93.89% which leaves the community settings in general between red and amber scorings.

4.3.2 Most common findings/non-compliances

The most common non-compliances during the IPC audits performed during the financial year were:



Non-Compliance
Temperature checks not documented with corrective action when temp is out of range - Fridges
Under sink with storage
Washing machine and drier industrial and with record of maintenance
PPE not been used correctly
Refrigerator not clean and thawed of ice
Are staff NOT uniform compliant or bare below the elbows
Sharps not In temporary closure
Envirnmental maintenance (eg physical damage)
High dust

4.3.3 Conclusion and recommendations regarding auditing findings

The IPC team conducted a total of 120 inspections across various settings, revealing an overall average score of 89.54%, categorizing the Trust as "Amber." However, there remains an uncertainty average of 8.37%, necessitating closer scrutiny.

Community settings exhibit a concerning error margin averaging at 28.65%, indicating lower compliance willingness. Despite the IPC team's efforts yielding an average score of 90.17%, the uncertainty score suggests a need for urgent attention.

Recommendations:

3. Increase resources: Allocate additional resources to the IPC team to enhance monitoring and follow-up on identified issues.
4. Strengthen collaboration: Foster stronger collaboration between IPC teams and community settings to improve compliance and safety measures.
5. Training and education: Matrons and team/ward managers to take part on the IPC Champions days and ensure presence of those teams on the IPPC's.
6. Continuous monitoring: This is in place but non-compliance needs to be addressed through the heads of nursing to ensure IPC is a core part of the work practice.
7. Regular review: Ensure a program of "audit the audit" is in place. Consider cross area audits to ensure the information recorded is accurate – ask the question – "If someone else did this audit, would the score be the same or similar?"
8. Stakeholder engagement: Engage stakeholders at all levels to promote a culture of accountability and adherence to IPC guidelines – It is fundamental to ensure the engagement of the clinical teams and this needs to be supported/driven by the heads of nursing, managers and matrons to ensure IPC standards are monitored and kept as well as there is adequate reporting and actions are adequately taken when non-compliances are identified.

By implementing these recommendations, the Trust can enhance IPC practices, mitigate risks, and improve overall safety for service users and staff.

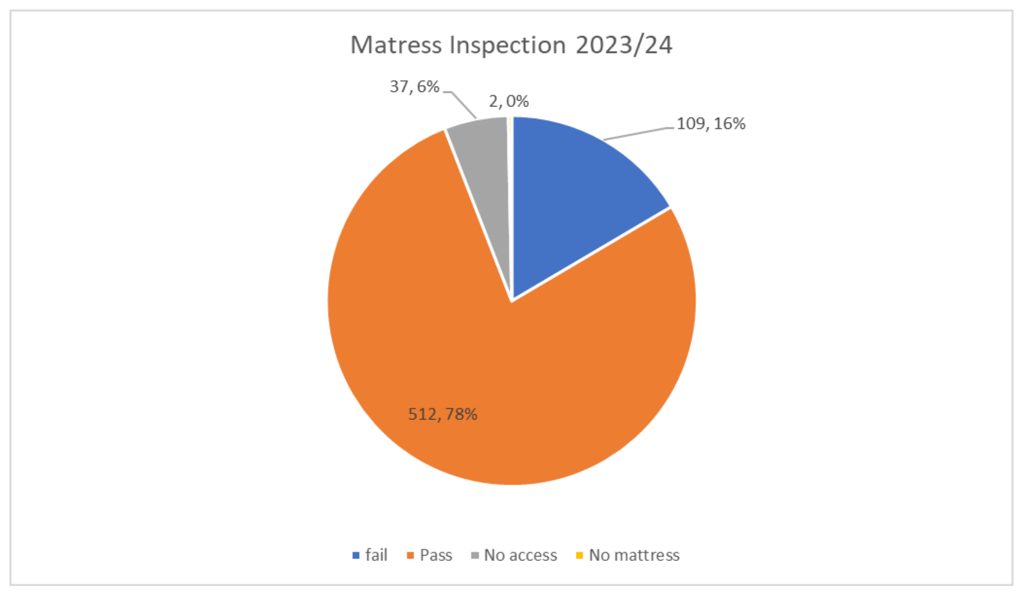
5. External Inspections and Audit

5.1 Mattress Audit

Mattress audit inspected a total of 660 mattresses and had no access to 37 mattresses during the visits. Rejection rate was higher than last year's 15% with 22.4% rejection this year, which is significant.

This is particularly concerning to patient safety, not just from an IPC perspective but also tissue viability and health and safety of the service users.

The results of the audit are summarized on the following graphic:



Graphic 7 - Mattress Audit

This is clear an area of concern that will need to be addressed during the next financial year, and therefore, the following actions should be put in place:

- Matrons to continue to report against mattress standards/replacements in quarterly reports to IPPC.
- All wards to ensure that correct mattresses for service need are ordered.
- Mattresses to be stored off the floor.
- Develop Mattress audit into mandatory AMaT system and discuss reporting/governance structure. This should be a primary focus to tissue viability due to the potential consequences so likely should be considered the reporting through physical health committee.

At the present, besides the requirement of locally audit of mattresses, there is no centralised record or reporting system, which seems to have contributed to the increase of this problem. It is therefore essential that the Trust agrees in a monitoring and reporting strategy, that must include monthly auditing of the mattress to ensure that they are replaced at the first opportunity without the risk of causing harm due to becoming contaminated due to lack of imperviousness or inadequate for preventing pressure ulcers and other complications.

5.3 Sharps Audit

The Infection, Prevention & Control Team at Birmingham & Solihull Mental Health Trust requested that Daniels Healthcare (manufacturers of sharps bins) undertake a sharps safety audit of their sites.

During the audit, fifty-seven (57) Wards/Departments were visited, and one hundred and forty-nine (149) sharps containers were observed. This is of notable significance due to the high rate of non-conformity, which stands at 38.26%, correlating with the issues uncovered regarding sharps injuries across the Trust, to be further explored in this document.

Specifically, the audit identified one (1) sharps container with protruding sharps, seven (7) improperly assembled containers (promptly rectified with staff informed of the associated risks), and two (2) containers exceeding three-quarters capacity (staff were reminded to adhere to the fill line). Additionally, two (2) containers were found with mismatched lids, prompting staff to verify lid colour and labelling.

Moreover, two (2) containers were improperly positioned, either on the floor or at an unsuitable height, with staff advised to bracket or place them in mobile holders where possible, or on a flat surface if not feasible. It was emphasized that the label on the sharps bin must be completed upon assembly, as eleven (11) containers were found lacking signatures or dates while in use.

Furthermore, thirty-two (32) sharps containers contained significant inappropriate non-sharp contents, prompting staff to refrain from disposing packaging or non-sharp items in sharps containers. Finally, eleven (11) containers lacked temporary closure when left unattended or during movement, necessitating adherence to proper closure protocols.

The following table shows the detailed scoring of the visited areas:

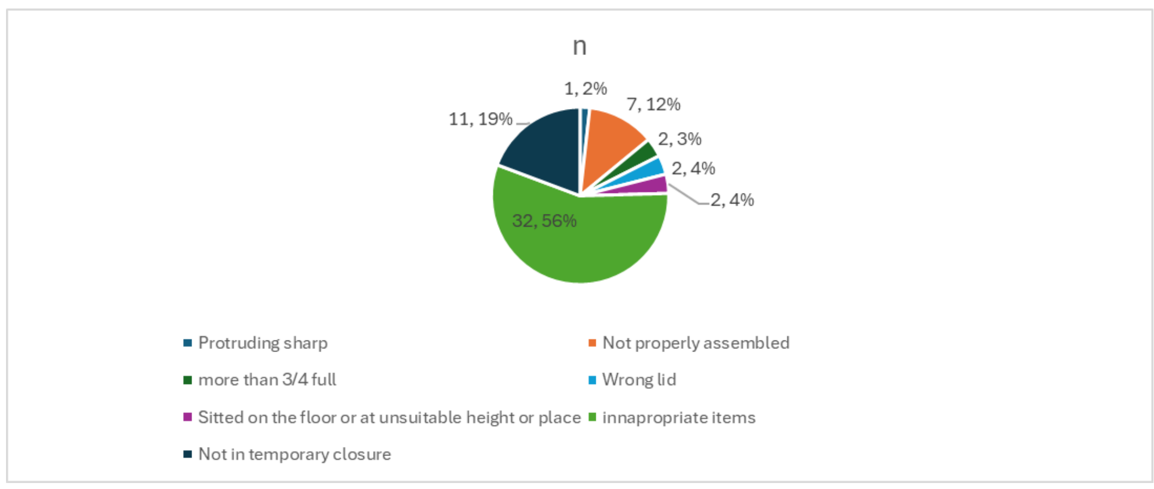
No.	AREA	Number of sharps / speciality containers inspected	POSSIBLE SCORE	ACTUAL SCORE	PERCENT COMPLIANT
1	DAN MOONEY/DAVID BROMLEY Inpatient Wards	6	48	46	95.83%
2	LYNDON CENTRE	9	72	72	100.00%
3	HERTFORD HOUSE Inpatient Ward	2	16	16	100.00%
4	MAPLE LEAF	5	40	36	90.00%
5	NEWINGTON CENTRE	3	24	24	100.00%
6	OSBORNE HOUSE - ALT	2	16	15	93.75%
7	CHMT	4	32	27	84.38%
8	CHMT - West	1	8	8	100.00%
9	MARY SEACOLE HOUSE - Meadowcroft	2	16	13	81.25%
10	Ward 1/Ward 2	5	40	36	90.00%
11	TAMARIND CENTRE - Sycamore	2	16	16	100.00%
12	Hibiscus	2	16	15	93.75%
13	Myrtle	3	24	23	95.83%
14	Laurel	1	8	8	100.00%
15	Cedar	2	16	16	100.00%
16	Acacia	3	24	23	95.83%
17	Lobelia	4	32	32	100.00%
18	LITTLE BROMWICH CENTRE	2	16	15	93.75%
19	NEWBRIDGE	2	16	16	100.00%
20	SMALL HEATH CENTRE	4	32	31	96.88%
21	OLEASTER - Japonica Suite	2	16	15	93.75%
22	Melissa Suite	2	16	16	100.00%
23	Tazetta	2	16	15	93.75%
24	Magnolia Suite	3	24	23	95.83%
25	Caffra Suite	2	16	14	87.50%
26	BARBERRY CENTRE - Neuropsychiatry	0	0	0	N/A
27	Mother & Baby Service - Chamomile Suite	2	16	15	93.75%
28	Eating Disorder Service - Cilantro Suite	2	16	16	100.00%
29	Outpatients	1	8	8	100.00%
30	National Deaf Services	4	32	31	96.88%
31	JUNIPER CENTRE - Rosemary Suite	2	16	16	100.00%
32	Sage	2	16	13	81.25%
33	Bergamot Suite	2	16	15	93.75%
34	GROVE AVENUE - Inpatient Ward	1	8	7	87.50%
35	ZINNIA CENTRE - Lavender Suite	2	16	15	93.75%
36	Saffron Suite	2	16	15	93.75%
37	LONGBRIDGE - CMHT	1	8	8	100.00%
38	REASIDE CLINIC - Swift	3	24	23	95.83%
39	Trent	2	16	11	68.75%
40	Dove	2	16	16	100.00%
41	Kennet	4	32	31	96.88%
42	Avon	2	16	15	93.75%
43	Blythe	3	24	22	91.67%
44	Severn	3	24	22	91.67%
45	HILLIS LODGE	4	32	29	90.63%
46	WARSTOCK LANE	2	16	15	93.75%
47	NORTHCROFT - CMHT	7	56	55	98.21%
48	AOT & HTT Clinic	2	16	14	87.50%
49	ENDEAVOUR COURT	2	16	12	75.00%
50	ENDEAVOUR HOUSE	2	16	15	93.75%
51	RESERVOIR COURT - Inpatient Unit	2	16	15	93.75%
52	CMHT	6	48	46	95.83%
53	GEORGE WARD	0	0	0	N/A
54	EDEN - PICU Female	3	24	22	91.67%
55	Eden - Acute Male	2	16	15	93.75%
56	FORWARD HOUSE	2	16	16	100.00%
57	ARDENLEIGH/ROOKERY GARDENS/LARIMAR	0	0	0	N/A

Table 8- Sharps audit scoring by Clinical setting

The object of the site survey was to establish whether sharps are disposed of in a safe manner, containers are correctly used from the point of storage, assembly, security during use and dispose as well as if they are being used for the correct purposes.

The method used was to visit wards and departments and observe existing practices.

The following graphic summarizes the findings:



Graphic 8- Sharps audits non-conformities

The most significative finding was the dispose of inappropriate items, which can have significant economic impact to the Trust due to the costs associated with the transport and incineration of this kind of waste – 32.56%.

The second most significative was sharps containers not in temporary closure when not in use, which increases the risk of accidental inoculation injury – 11.19%. Albeit significative, there was a significant improvement on this item, since last year the non-correct temporary closure was the most frequent fault identified with 33.52% of the total issues identified.

During IPC visits the sharps compliance is always monitored and on spot education is given as well as escalated as part of the wider audit to the ward manager and matron/manager.

IPC continues to monitor this finding and will include them to the IPC champions program of training towards increasing awareness across the Trust. Comms supported campaign must also be considered to ensure a wider spread of awareness.

6. Surveillance of Alert Organisms and Outbreaks

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

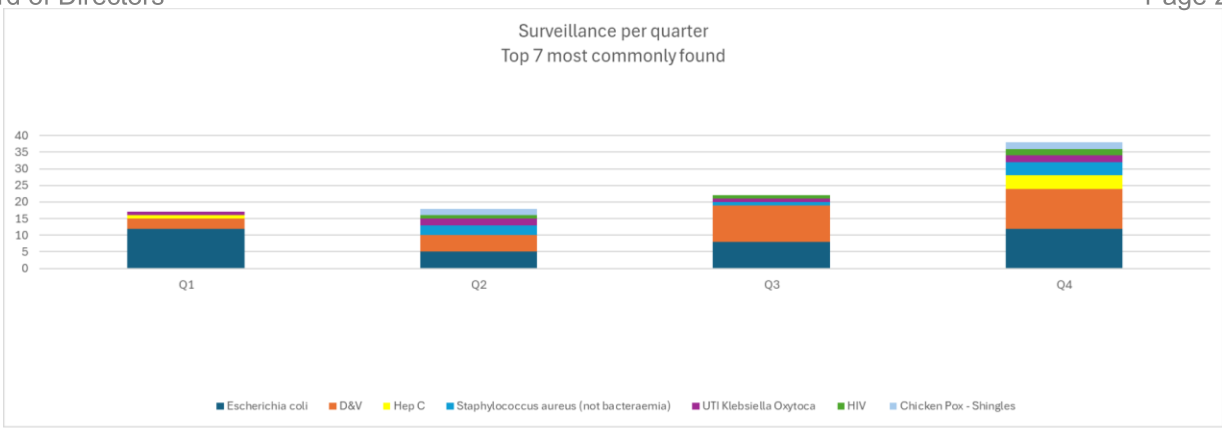
6.1 Total number of organisms reported.

We had a total of 151 reports of infection (excluding MRSA and COVID related), an increase of 53 from last year, which corresponds to 35.1% increase. This was expected having in account the end of the COVID pandemic (albeit still a significant number of COVID-19 cases).

The following table and graphic shows the conditions reported to IPC during the financial year as well as the following graphic:

Microorganism/Condition	Q1	Q2	Q3	Q4	Trend
Escherichia coli	12	5	8	12	
D&V	3	5	11	12	
Hep C	1	0	0	4	
Staphylococcus aureus (not bacteraemia)	0	3	1	4	
UTI Klebsiella Oxytoca	1	2	1	2	
HIV	0	1	1	2	
Chicken Pox - Shingles	0	2	0	2	
Flu (non specified)	0	0	2	2	
Scabies/Lice	0	0	0	2	
Streptococcus agalactiae	3	1	0	1	
Syphillis	0	1	0	1	
Influenza type B	0	0	1	1	
Enterococcus Faecalis	2	3	0	1	
Carbapenemase producing Enterobacteriaceae	0	1	0	1	
Hep B	0	0	1	1	
TB	0	0	0	1	
Mycobacterium Gordonae	0	0	0	1	
Proteus Mirabilis	3	0	1	0	
Citrobacter koseri	1	2	1	0	
Enterobacter Cloacae	1	1	2	0	
Beta Haemolytic Streptococcus Group C	1	0	0	0	
Candida Albicans	1	0	0	0	
Threadworms	0	1	0	0	
Morganella Morganii	0	1	0	0	
Campylobacter	0	1	0	0	
Stenotrophomonas maltophilia	0	1	0	0	
Serratia marcescens	0	1	0	0	
C.Diff	0	1	0	0	
Haemophilus Influenzae	0	0	1	0	
Respiratory syncytial (sin-SISH-uhl) virus	0	0	1	0	
Influenza type A	0	0	4	0	
Hep E	0	1	0	0	
Klebsiella pneumoniae	0	2	0	0	
	29	**36**	**36**	**50**	

Table 9 - Reported microorganisms/conditions



Graphic 9 - Reported microorganisms/conditions

D&V and E-coli in usine had the highest prevalence, flollowed by blood borne virus infections (BBV) and influenza.

On what concerns to D&V there does not seem to be a pattern in the cases with exception than that most of the cases were reported during the last 2 quarters of the year as in the past year. Echoli in urine had a higher rate in the first and fourth quarters but no trends have been identified.

All reported cases had IPC advice and follow-up as needed.

6.1.1 Measles

After UKHSA issued a communication on October 17, 2023, regarding measles escalation, the IPC team ensured that necessary preparations were in place to manage any suspected or confirmed cases within the Trust. Multiple communications were disseminated via COMMS to raise measles awareness among Trust members. Additionally, a measles risk assessment and guidance document, version 1 published in November 2023, along with a poster, were distributed across all clinical settings.

The working group, comprising the Deputy DIPC, Occupational Health, pharmacy, IPC, Health and Safety, and Physical Health leads/representatives, convened to discuss various scenarios and plan actions in response to identified positive or suspected cases within the Trust. As part of this planning, the Occupational Health provider was tasked with reviewing the MMR vaccination status of staff, and a communication was sent to all clinical staff, including medical personnel, to ensure that the immunization status of service users was recorded in their notes.

A confirmed case of measles was reported on January 9, 2024, at (one of our secure care wards, following the identification of a rash on January 7 (with a sample taken on the 8th). Immediate measures, including isolation and contact tracing, were implemented, along with the provision of appropriate PPE such as FFP3 masks and powered hoods.

Individuals with unknown immunization statuses were restricted from working starting from day 5, and some were permitted to return to work before the 14-day post-vaccination period (or 21 days from exposure) upon positive IgG testing on days 6 and 7 following the first possible contact day.

Service users were promptly vaccinated, and vaccination clinics were set up for staff members. UKHSA, ICB, and NHSE/I were informed of the positive result on the same day it was received, and an external meeting was convened the following day. Daily internal follow-up meetings were conducted, and no further cases were identified after the 21-day period.

6.1.1.1 Measles positive case – Lessons learned and recommendations

Following the positive case management, the IPC team proceeded to a review of the incident with lessons learned and recommendations for future actions.

What went well?

- Early detection and isolation.
- Timely IgG test for staff with unknown immunizations status (done locally)
- Prompt external reporting and communication
- Prompt internal meetings deployment
- Fast deployment of powered hoods
- Staff FFP3 clinics quickly deployed with UHB support.
- Available vaccine in stock for immediate SU vaccination
- Engagement with the IPC team
- Pre-work by the measles work group enabled quick deployment of actions.

What did not go well?

- Failure on Heartlands contact tracing on informing the Trust of the contact.
- Occupation Health Provider (PAM) inaccurate records regarding staff immunization
- Occupational Health Provider (PAM) delay on deploying vaccination clinics after pre-warned of possible case.
- No immunization records on SU notes

What could have been done differently?

- Better immunization records for SU – Recorded on SU notes on admission.
- Improved Occupational health immunization records and quick release of information.
- Quicker deployment of immunization clinics for staff by Oc. Health Provider (PAM)
- IgG testing of staff supported by Oc. Health Provider (PAM)
- Pro-active staff immunization plan

Certainly, based on the review of the management of the measles, here are some overall advice and recommendations:

1. **Address Occupational Health Challenges:**
   - Work with the Occupational Health Provider (PAM) to improve the efficiency of timely delivering immunization records and above all ensuring that records are accurate. Address confidentiality concerns to expedite the sharing of critical information.

2. **Enhance Service User Immunization Records Management:**
   - Develop strategies to obtain and maintain accurate records of service users' immunization status. SU immunization status should be part of admission clinical evaluation and recorded in the patient notes for easy access.
   - Consider vaccination deployment for non-immunized SU.

3. **Improve Staff Immunization Clinics Deployment:**
   - Strengthen the responsiveness of PAM in deploying immediate vaccination clinics for staff. Proactive measures should be in place to ensure a swift response in potential outbreak scenarios. Situations like measles have very short response times and the occupational health provider must be able to respond within time constraints.
   - Ensure non vaccinated staff across the organization are contacted for vaccination and that non-compliance is flagged to the manager.

4. **Increase Staff Face Fitting and Training:**
   - Ensure the full deployment of FFP3 face fitting to cover all staff possible (acknowledging that some staff will not be able to be face fitted – those will need to have access to powered hoods pending risk assessment)

5. **Streamline Matron-Led Organizational Efforts:**
   - Acknowledge and support the effective leadership of the matron in organizing the ward. Encourage the continuation of such initiatives and consider documenting best practices for future reference.

6. **Encourage Collaborative Initiatives:**
   - Promote collaborative initiatives between different departments such as Pharmacy, FFP3 deployment project lead, and UHB face fitting clinics. This collaboration proved effective in the quick deployment of resources.

7. **Consider obtaining more powered hoods and identify responsibilities on maintaining and deploying the equipment.**
   - While there were no issues while deploying the powered hoods, there is the risk that those may be in short supply, also there are no clear responsibilities identified regarding maintenance and deployment, which can constitute a challenge in future situations. It is important to point out that powered hoods may not always be possible to be deployed in some of the clinical settings, exacerbating the challenges regarding resilience due to low numbers of staff face fitted with FFP3.

8. **Conduct Post-Incident Review and ensure deployment of actions:**
   - After the resolution of the measles case, conduct a thorough post-incident review. Identify lessons learned and areas for improvement to enhance the overall preparedness and response capabilities of the ward and the entire healthcare system.
   - Ensure lessons learned are shared across the organization

9. **Share lessons learned with external stakeholders.**
   - One of the main contributing factors for this incident was a failure on the contact tracing team from Heartlands on informing the Trust of the contact. If this had happened, it might have been possible to pre-emptively isolate the SU (depending on compliance) and deploy early identification of non-immunised staff and SU and proceed to early vaccination. This has been escalated with the ICB and the health protection team.

By addressing these points, the Trust can strengthen its overall response capabilities, improve coordination, and ensure a more effective management strategy in the face of similar infectious disease incidents in the future.
Unexpected risks and deviations emerged, notably linked to deficiencies in contact tracing by Heartlands Hospital. This lapse had the potential to prevent the incident altogether or facilitate the swift deployment of immunization protocols upon identifying non-immunized staff and service users.

Another identified issue pertained to Occupation Health's (PAM) incapacity to respond promptly and provide accurate records in a timely manner. This constituted a significant deviation from the anticipated course of action, resulting in delayed deployment of staff vaccination clinics. The inability to swiftly obtain and relay vital immunization information hindered the timely implementation of preventive measures.

The management response was notably swift and efficient, particularly under the direction of the matron for the area. This expeditious approach facilitated the rapid identification of the case, immediate isolation, and the prompt deployment of IgG tests for staff (and some Service Users). Considering the infectious period of a measles patient, extending four days before the rash, by January 9th, we were already at day 6. Vaccinating staff within the ideal 72-hour window became unfeasible, a timeline that could have been achieved with timely contact tracing by Heartlands Hospital. Despite this, blood samples were successfully collected from a significant number of staff with unknown immunization statuses.
The quick response at ward level was likely a consequence of the pre-work developed by the measles group during the previous months, deploying several awareness messages through comms, providing

written guidance to staff (available on connect) and on-call specific guidance as well as measles related poster with immediate actions to be available on all clinical settings. Also as part of this work, the Trust had a permanent stock of vaccines available that allowed a quick deployment of vaccines for the SU's. Considering the inaccuracies and delays in information provided by the Occupation Health Provider (PAM), the active engagement of staff became pivotal to mitigate the potential escalation of resource depletion. Their involvement played a crucial role in preventing further strain on resources during this critical period.
Communication was both prompt and efficient. External stakeholders were engaged on the very day the result was confirmed, and the Infection Prevention and Control (IPC) team presented the situation and action plan in external meetings the following day. Simultaneously, internal meetings occurred daily to verify the adherence to the plan and facilitate the execution of identified actions. The communication team's consistent presence ensured the regular dissemination of Trust-wide communications.
An additional noteworthy factor was the inclusion of a temporary staff lead in the meetings. This not only allowed to block contacts to solely work in the area as also facilitated tailored communication with temporary staff members. Consequently, this approach reduced the risk of potential spread to other Trust areas while ensuring that safe staffing levels were maintained.

The most significant lessons derived from the management of the measles case at Cedar Ward underscore the importance of several key measures:

1- Comprehensive FFP3 Deployment:
- Recognize the critical need for the full deployment of FFP3 across the entire Trust. This ensures resilience in facing similar challenging situations.

2. - Inclusion of Immunization Records in Service User Data:
- Acknowledge the vital role of including immunization records in the service users' health records. This inclusion streamlines and expedites the response process, facilitating a quicker and more efficient approach to managing potential outbreaks.

3. - Utilization of IgG Testing:
- Acknowledge the effectiveness of IgG testing in the response strategy. This testing proved invaluable in identifying staff with unknown immunization statuses who could safely return to work after obtaining positive results.

4. - Strategic Deployment of Powered Hoods:
- Recognize powered hoods as crucial assets for staff protection. Consider the deployment of additional units across the entire organization to bolster the overall level of preparedness. Develop a structured plan for the maintenance and rapid deployment of powered hoods to ensure their effectiveness during critical situations.

5 – Pre-planning on Measles work Group

- Through the measles work group it was possible to deploy guidance and raise awareness regarding measles across the Trust, which played a crucial role in the quick response we saw from staff. Also as part of the work done through this group, there was an available stock of vaccines that were promptly deployed to vaccinate the service users.

These lessons learned highlight the significance of proactive measures in response planning, the integration of technology for efficient testing, and the strategic allocation of resources. Applying these insights can contribute to a more robust and resilient organization, better equipped to navigate and mitigate the impact of infectious disease incidents in the future.

6.2 Outbreaks (non-COVID)

All but one outbreak were COVID-19. There was only 1 D&V outbreak at Tazetta Ward (Oleaster Centre) during Q4. No microorganism was isolated due to the reduced number of cases (2). Staff were unable to collect samples. The fast identification and isolation of the affected service users allowed to

control this outbreak at first opportunity. A review meeting was held to discuss the outbreak and lessons learned.

6.3 MRSA Admission Screening

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

7. COVID-19

All but one of the reported outbreaks were COVID-19 related, with a total of 30 COVID-19 outbreaks.

In general, the outbreaks had a significant smaller impact in the number of SU affected and even more on the number of staff affected. Several factors have likely contributed to this and were reflected during the outbreak closure meetings, such as quick identification and isolation and a higher level of immunity within the population either due to previous exposure or by vaccination.

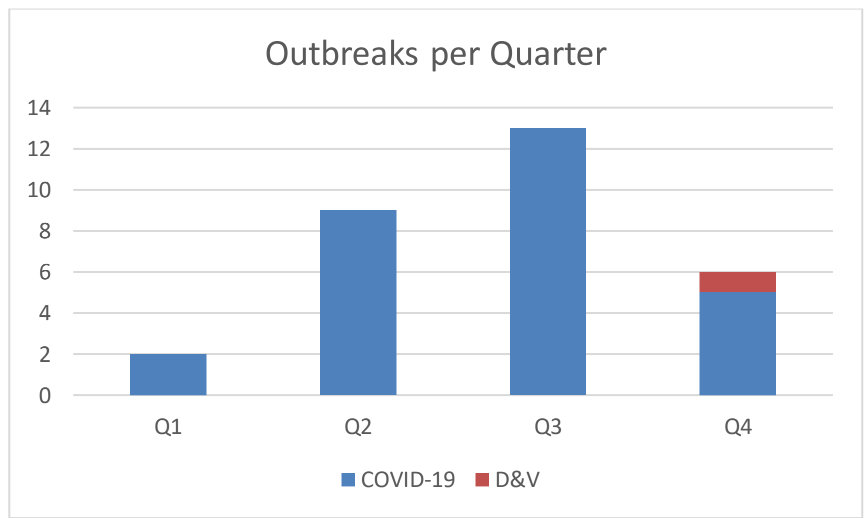
7.1 Reported outbreaks.

We reported a total of 30 outbreaks (-17 than last year).

The following table and graphic illustrates the number of outbreaks per quarter:

Type	Q1	Q2	Q3	Q4
COVID-19	2	9	13	5
D&V	0	0	0	1

Table 10- Outbreaks per quarter

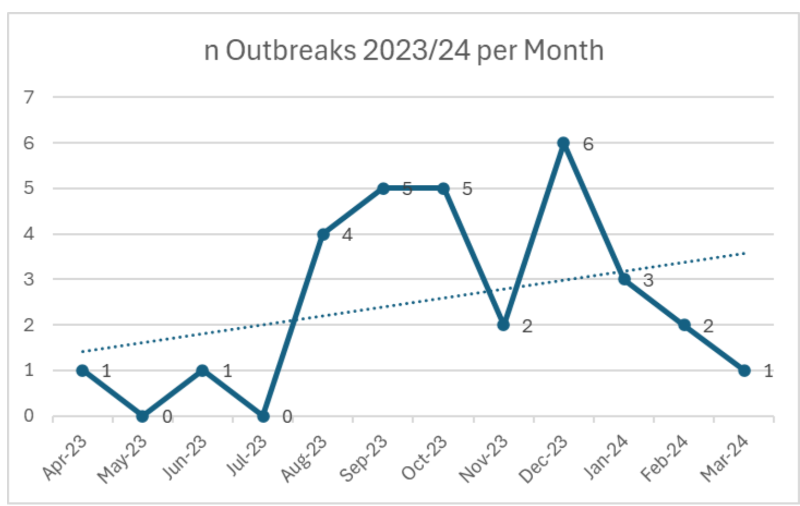


Graphic 10- Outbreaks per quarter

If we look at the month distribution:

Month	n Outbreaks
Apr-23	1
May-23	0
Jun-23	1
Jul-23	0
Aug-23	4
Sep-23	5
Oct-23	5
Nov-23	2
Dec-23	6
Jan-24	3
Feb-24	2
Mar-24	1
TOTAL	30

Table 11 - COVID-19 outbreaks per month



Graphic 11 - COVID 19 outbreaks per month

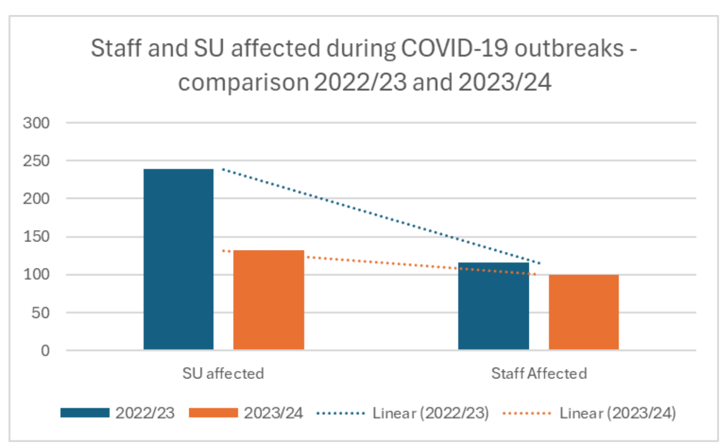
From this data, it is evident that there were two peaks: one during September and October 2023, and the most significant occurred in December 2023. This appears to align with the general decrease in temperatures, particularly with the highest peak coinciding with the Christmas and New Year festivities, when gatherings both inside and outside the organization were notably more frequent and crowded.

It is crucial to examine the Trust's position relative to the previous year. The subsequent table and graphic illustrates the demographic changes from the preceding year:

.	SU affected	Staff Affected
2022/23	239	116
2023/24	132	100

Variance	107	16
% var	-44.80%	-6.70%

Table 12 - SU and staff affected - comparison with previous year.



Graphic 12 - SU and staff affected - comparison with previous year.

The data clearly indicates a substantial decrease in the percentage of Service Users (SU) affected by COVID-19 outbreaks, with a reduction of 44.8%. Although the reduction concerning staff was comparatively smaller at 6.7%, both demonstrate a consistent trend of fewer outbreaks, showing a reduction of 36.1% overall, with a notable decrease in the number of affected Service Users. The lesser reduction among staff is likely attributable to their prolonged contact with the general community, where containment measures may not be as stringent. Nevertheless, both categories exhibit a declining trend.

Another significant factor contributing to this reduction is the improved detection and isolation of suspected cases, which has significantly enhanced the containment efforts, thereby reducing the overall impact of COVID-19.

The following table summarizes all outbreaks along the financial year:

Site	Reported	Last +	SU affected	N of bed	Total SU in are	% SU affected	Staff affecte	Total staf	% Staff affect
Dove Unit	09/05/2023	22/05/2023	8	14	12	66.67%	2	25	8.00%
Reaside Clinic: Blythe Ward	17/07/2023	26/07/2023	7	13	11	63.64%	6	28	21.43%
Reaside Clinic: Swift ward	20/07/2023	29/07/2023	5	15	15	33.33%	9	28	32.14%
Juniper Centre, Rosemary Ward	31/07/2023	08/08/2023	4	18	18	22.22%	5	36	13.89%
Juniper Centre, Sage Ward	31/07/2023	31/07/2023	0	17	17	0.00%	6	38	15.79%
Reaside Centre: Avon ward	08/08/2023	15/08/2023	5	14	12	41.67%	2	40	5.00%
Reservoir Court Inpatients	03/08/2023	08/08/2023	0	18	18	0.00%	5	45	11.11%
The Barberry: Chamomile Suite	08/08/2023	08/08/2023	1	10	8	12.50%	3	28	10.71%
Reaside - Trent Ward	16/08/2023	16/08/2023	2	14	13	15.38%	0	23	0.00%
Kennet Unit, Reaside	23/08/2023	23/08/2023	2	14	14	14.29%	0	27	0.00%
Bergamot Ward, Juniper	01/09/2023	07/09/2023	4	18	15	26.67%	3	35	8.57%
Dan Mooney House, S2R	04/09/2023	03/09/2023	2	15	15	13.33%	0	23	0.00%
Newbridge House	25/09/2023	27/09/2023	4	16	16	25.00%	3	28	10.71%
East Hub CMHT, Small Heath Health Centr	25/09/2023	27/09/2023	0	0	0	N/A	10	50	20.00%
Reservoir Court Inpatients	27/09/2023	06/10/2023	11	18	18	61.11%	4	37	10.81%
Endeavour Court	02/10/2023	30/09/2023	3	14	14	21.43%	0	33	0.00%
Chamomile Mother and Baby Unit	02/10/2023	02/10/2023	0	6	5	0.00%	3	32	9.38%
Mary Seacole Ward 2	03/10/2023	02/10/2023	3	14	12	25.00%	0	21	0.00%
Sage ward, Juniper	04/10/2023	03/10/2023	3	17	17	17.65%	1	38	2.63%
Ardenleigh Secure, Citrine ward	13/10/2023	21/10/2023	6	8	6	100.00%	4	28	14.29%
The Barberry, Jasmine ward	16/10/2023	17/10/2023	7	12	12	58.33%	4	20	20.00%
Tourmaline ward Ardenleigh secure care	30/10/2023	31/10/2023	2	14	12	16.67%	2	22	9.09%
Bergamot ward, Juniper	06/11/2023	06/11/2023	3	18	17	17.65%	0	33	0.00%
Hertford House	06/11/2023	06/11/2023	2	10	9	22.22%	0	16	0.00%
Eden acute ward	06/12/2023	06/12/2023	2	15	15	13.33%	0	22	0.00%
Mary Seacole House Ward 1	13/12/2023	17/12/2023	4	16	15	26.67%	0	30	0.00%
Tourmaline, Ardenleigh	22/12/2023	29/12/2023	5	14	14	35.71%	2	22	9.09%
Coral, Ardenleigh	27/12/2023	23/12/2023	2	8	8	25.00%	0	27	0.00%
Cilantro (Barberry)	22/12/2023	26/12/2023	3	5	10	30.00%	1	14	7.14%
Reservoir Court	29/12/2023	28/12/2023	2	18	18	11.11%	0	37	0.00%
Eden PICU	02/01/2024	07/01/2024	2	8	6	33.33%	5	30	16.67%
Sage ward (Juniper)	08/01/2024	15/01/2024	9	17	17	52.94%	8	38	21.05%
Avon ward (Reaside Clinic)	18/01/2024	18/01/2024	3	14	14	21.43%	0	25	0.00%
Bergamot ward (Juniper)	06/02/2024	20/02/2024	12	18	18	66.67%	5	36	13.89%
George ward	04/03/2024	04/03/2024	3	16	15	20.00%	4	23	17.39%
Newbridge House	11/03/2024	11/03/2024	1	16	16	6.25%	3	25	12.00%

Table 13 - Outbreaks during the financial year - SU and Staff affected

The average of SU affected was 29.06% and staff affected 8.91% during outbreaks.

The following table compares the average with the median in both cases:

Metric	SU affected	Staff affected
Average	29.06%	8.91%
Median	22.22%	9.09%

Table 14- Average and median of SU and Staff affected during COVID-19 outbreaks

The difference between the 2 metrics regarding staff is small but significant for the SU due to some outbreaks having affected a particular high portion of SU as can be seen on the following graphic:

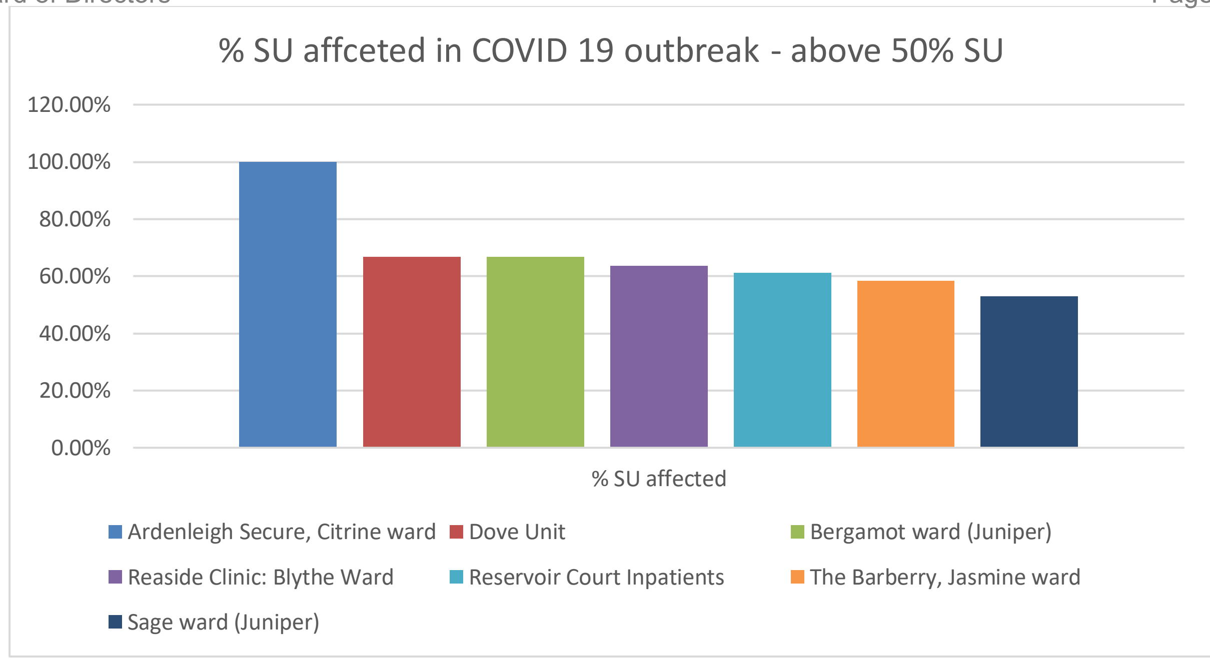


Table 15 - % SU affected in COVID 19 outbreak - above 50% SU

This visual representation also underscores the heightened risk of COVID-19 transmission in both Secure Care Inpatient settings and among individuals with Dementia and Frailty. This correlation can be attributed to the complex dynamics of the environment, particularly evident in medium secure facilities where Service User (SU) movement is restricted, and in Dementia and Frailty cases where the SU population tends to be more susceptible to infections.

There were also 3 COVID-19 outbreaks that only affected staff:

Site	Reported	Last +	SU affected	N of beds	Total SU in area	% SU affected	Staff affected	Total staff	% Staff affected
Juniper Centre, Sage Ward	31/07/2023	31/07/2023	0	17	17	0.00%	6	38	15.79%
Reservoir Court Inpatients	03/08/2023	08/08/2023	0	18	18	0.00%	5	45	11.11%
Chamomile Mother and Baby Unit	02/10/2023	02/10/2023	0	6	5	0.00%	3	32	9.38%

Table 16 - Outbreaks of COVID-19 that only affected staff

In summary, there appears to be a declining trend in the number of Service Users (SU) affected by COVID-19, and while the outbreaks continue to pose a significant burden to the Trust, there is evidence of reduction in both SU and staff affected, with no reported cases of severe acuity.

For future reports, engaging the expertise of a data analyst would be advantageous to delve deeper into understanding the factors that may have influenced these findings, particularly pertaining to the implementation of Trust policies in these areas.

7.1.2 Outbreak surveillance

Each outbreak was promptly addressed through collaboration with the local management area, the Director of Infection Prevention and Control (DIPC), the IPC team, Trust Microbiologist, and external stakeholders invited to outbreak meetings (including UK HSA, NHSE/I, ICB, and Health Protection Team).

Furthermore, the Trust has maintained weekly review meetings where all outbreaks were thoroughly discussed, and assurances were provided. During the year, the Themes identified relating to the COVID Outbreaks were:

1. SU sharing communal areas.
2. Personal protective equipment (PPE) breaches by staff
3. Staff not bare below the elbows
4. High dust
5. IPC boards not up to date
6. Physical damage

Point 1 – In numerous areas within our organization, Service Users (SUs) may have extended lengths of stay or may be too acutely unwell to avoid congregating, given the nature of our work within a mental health setting, which heavily relies on human interaction. Infection Prevention and Control (IPC) has advised all inpatient areas to maintain high standards of cleanliness, ensure continuous use of personal protective equipment (PPE) by staff, and conduct individual and global risk assessments for each SU to determine their suitability for wearing a mask (without compromising the safety of other SUs) when necessary (e.g. outbreaks). The outcome of the risk assessment and the SU's compliance should be documented in the care plan by the clinical team.

Point 2 and 3 – Instances of personal protective equipment (PPE) breaches and staff failing to adhere to the "bare below the elbows" policy - have been frequently observed. The Human Resources (HR) team engaged in discussions regarding strategies to address this issue, resulting in the creation of a letter to be issued to staff members exhibiting repeated non-compliance (limited to substantial staff, temporary staff were dealt through temporary staff management team). This letter serves as a reminder of potential disciplinary actions in the future. Prior to the letter's delivery, a conversation is held with the staff member to ensure full understanding of Trust guidelines and expectations.

Furthermore, PPE non-compliance, particularly regarding mask usage, continues to be a common observation during Infection Prevention and Control (IPC) visits. Additionally, instances of staff wearing cardigans or failing to adhere to the "bare below the elbows" policy are still frequently noted. The IPC team addresses these instances with the respective areas of non-compliance and raises concerns during internal and external outbreak meetings.

To enhance hand hygiene practices, the IPC team has incorporated a dedicated hand hygiene session into the training provided to new Core Hand Hygiene and Trust IPC Champions.

During outbreaks, compliance with PPE usage is recorded through daily spot checks conducted by ward managers. Any findings are subsequently discussed during weekly outbreak meetings with the IPC team.

Point 4 – Instances of high dust have been frequently noted. Upon detection, an immediate escalation to the Estates and Facilities team ensues to ensure that cleaning meets the expected standards. The Estates and Facilities teams have been actively involved during Infection Prevention and Control (IPC) visits, particularly in areas deemed more problematic. Nonetheless, the overall cleanliness level of the Trust remains consistently high, as evidenced by Key Performance Indicators consistently surpassing the 90% mark.

During outbreaks, Estates and Facilities have consistently demonstrated proactive measures to facilitate prompt and adequate responses.

Point 5 – The IPC team has found that IPC boards regularly have information that is out of date. This is part of the IPC audits. The findings are escalated to the area Matron and local managers. Teams are frequently reminded of the importance of updating the information in the IPC boards.

During IPC champions training sessions, the IPC team reiterates this message. On Q4 IPC training, the boards standard was discussed with the IPC champions to then be cascaded to the clinical areas.

Point 6 – The physical damage encountered mostly relates to wear and tear and planned upgrades/maintenance. Regardless of the challenges encountered during the COVID-19 pandemic, all measures have been taken to reduce risk of cross contamination between contractors, staff and SU's. During outbreaks only essential work has been carried out. Estates and Facilities keep a log of all works

undertaken and outstanding. IPC supported on the planning of these activities, when contractors had to go to areas with known COVID-19 cases.

8. IPC Team Response to Alerts and Directives

The IPC team monitors all new alerts and directives released and ensures new guidance is adapted for the Trust. This has been particularly evident with Monkeypox and Measles.
IPC led on discussions internally and externally to ensure best practice was always adopted.

The IPC team cascaded the information to the clinical areas and other areas of the Trust through the Deputy Director of Nursing IPC champions during the training sessions and with the support of the Comms team.

9. Food Safety

Ward managers undertake quarterly food service audits and monthly activity kitchen audits. Findings are included in matrons service area reports to the IPPC, and checks are also included in IPCN inspections. Food safety advice and audit is provided externally.
At present, the Trust has no food expert, so the annual audit had to be externally sourced. It is recommended that the Trust contracts a permanent food safety expert to allow continuous monitoring and training of staff as well there is an agreement in a governance structure that will support and monitor the food safety expert and ensure that there is board level visibility of any issues/risks.
The Food Safety Report is attached to this document.

10. Water Management

Water surveillance is conducted by the Water Safety Group (WSG), a multidisciplinary team tasked with overseeing the commissioning, development, implementation, and review of the Water Safety Plan. The primary objective of the WSG is to ensure the safety of all water sources used by patients/residents, staff, and visitors, with the aim of minimizing the risk of infection associated with waterborne pathogens.

The WSG serves as a platform for individuals with diverse competencies to collaborate, sharing responsibility and collectively ensuring the identification of water-related hazards, risk assessment, implementation and monitoring of control measures, and development of incident protocols.

Certain areas within the Trust have reported elevated levels of legionella in the water, a matter being addressed by the Water Safety Group, which includes representation from Infection Prevention and Control (IPC). The approval of the water safety plan is pending review by IPC to confirm the incorporation of changes/comments into the final version. This process has been prolonged due to limited team capacity and the extensive nature of the work involved.

11. Cleaning Standards

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

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

12. Capital Developments

The IPC team has worked with Estates and clinical staff to ensure that standards to meet the requirements of the document Health Building Note 00-09: Infection control in the built environment have been incorporated into refurbishments and works undertaken.

13. Annual Programme of Work

The Annual Programme of Work document will be attached to this report. After analysing the past year's activity, the IPC team advises on the following:

- Revise team scope, capacity and structure.
- Audit ownership monthly into clinical areas and aggregated in IPC dashboard.
- All policies, guidelines and SOP's to be reviewed and have included auditing criteria/KPI.
- IPC audits planning to include monitor implementation/adherence to IPC policies (according to policies KPI).
- IPC team to target areas of concern instead of blanket auditing all Trust areas and sites.
- Full review of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (commonly known as the "Hygiene code") to be continued and discuss plan of action to overcome any identified gaps with the deputy DIPC/DIPC.

Appendix 1

Infection Control Doctor – Annual Statement for April 2023 - March 2024

Dr Gemma Winzor. Consultant Microbiologist, UKHSA Laboratory, Birmingham

Overview

2023/24 has been a year of consolidation and concerted efforts to improve quality from the Infection Prevention and Control Team (IPCt) within Birmingham and Solihull Mental Health Trust (BSMHT). Issues around water safety have continued to predominate, but significant changes have been made to governance around water safety, including the drafting of an updated Water Safety Plan. Further changes in BSMHT senior leadership (including the DIPC) have posed ongoing challenges to creating sustainable change and improvement. As outlined in the 2022/23 report, to make sustainable progress within the Trust, the IPCt need continuity of line management and leadership within the organisation.

Staffing

The IPC team is small and currently consists of a Lead IPCN (Band 8B, FL), a Senior IPCN (Band 8A, ZG) and two IPCNs (Band 7, CPDO and AP). They are supported by a part time team secretary (Band 4, GS) and an administrator (Band 3, RS). Sadly, the Lead IPCN and a Band 7 IPCN have resigned, and their loss will lead to a deficit of skills, experience, knowledge and resource for IPC at BSMHT. Therefore, the team are considering team structure, skillsets and experience prior to advertising the posts. Secondment of other BSMHT nursing staff is being considered as an interim measure. It is important that appropriate replacements are found and recruited because without sufficient members the IPCt lack the resilience and resource required to perform their role within BSMHT. An under-resourced IPCt has the potential to pose clinical risk to patients and staff.

The absence of a food safety officer within BSMHT is an ongoing concern.

Governance

The IPCt continue to report to Lisa Pim (Interim Associate Director of Nursing and Governance and Deputy Director of Infection Prevention and Control (DIPC)), who was appointed in December 2022. Under Lisa’s management the team have made sustainable improvements in governance, quality and leadership. I feel that Lisa should continue to line manage the IPCt and have direct and regular contact with the DIPC and Executive Board. Until recently, Lisa Pim reported to Steve Forsyth (DIPC and Executive Director), however he is no longer in this role and Sarah Bloomfield is newly covering the role as Interim Chief Nursing Officer and DIPC.

The IPCC has remained quarterly and has continued to be held virtually; this works well. At present, Lisa Pim chairs this meeting, but engagement from the DIPC should be encouraged and ideally the DIPC should chair this meeting going forward. Under Lisa’s leadership, the IPCt have implemented a new monthly, operational IPC meeting to ensure regular contact and accountability of BSMHT Matrons.

During 2023/24, BSMHT and UKHSA re-negotiated the "*Infection Prevention & Control Support Services*" contract, which is to be reviewed on an annual basis. An alignment of diagnostic Microbiology and Virology services (with clinical advice) to this IPC contract should be considered and has been discussed within the negotiation discussions.

Pathogens of Infection Prevention and Control Concern

This year has posed IPC challenges caused by re-emerging infectious diseases that are highly transmissible. This has been due to regional and national increases in incidence/incidents/outbreaks of measles, whooping cough and diphtheria, to name a few.
For example, the IPCt successfully managed a case of measles (identified promptly, allowing for swift IPC measures and prevention of any secondary cases) and pulmonary tuberculosis within BSMHT. Managing these incidents has highlighted the risk posed to BSMHT by:

- Poor compliance with fit testing of staff for FFP3 masks – to prevent airborne transmission of pathogens from patients to staff.
- Poor documentation of vaccination status of staff (i.e. MMR) and challenges in acquiring vaccination status of patients.
- Barriers to urgent occupational health clinics to provide staff vaccination, when required.

In addition to the threats posed by ad-hoc re-emerging infections there have been the usual winter pressures of COVID-19 and Influenza. COVID-19 has continued to cause outbreaks within BSMHT and this has caused operational issues for the Trust.

Water Management & Legionella

Previous concerns around water safety across BSMHT estates have started to be addressed in 2023/24. The SWSG continues to meet quarterly and report to the IPCC, it is chaired by Lisa Pim. BSMHT have an authorised engineer (AP of LRA Services LTD).
The SWSG have gone through a robust process of re-drafting the BSMHT Water Safety Plan and relevant stakeholders have been consulted. This is expected to be ratified in the next month. All water safety risk assessments were updated by July 2023 and remedial work completed. Enhanced "intrusive" reviews have been undertaken in certain retained estates and any issues detected are being remedied in a programme of works in the next six months.

<u>Forward House</u>

Forward House had a history of systemic Legionella colonisation. Ongoing high counts from multiple outlets led to closure of the unit in November 2022 and a programme of extensive remedial work and risk mitigation followed. Ultimately (in January 2024), due to ongoing high Legionella counts, a stabilised, liquid Chlorine Dioxide dosing system was installed into

Forward House. A system wide disinfection was undertaken followed by ongoing dosing. Thus far, Legionella counts from most outlets have fallen in response to the dosing plant regime.

Food Hygiene

National standards for healthcare food and drink propose eight standards including "*Organisations must nominate a food safety specialist*" and *"Organisations must have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item".* At present the absence of a food safety officer within BSMHT is a concern.

Education/Training

In response to a request from the IPCt I provided face to face teaching on serological tests (viral hepatitis, HIV, syphilis), this included the indications and limitations of testing, alternative methods of diagnosis and interpretation of serology results.

Occupational Health

Occupational Health report to the IPCC, this includes incidence of inoculation injuries (by type) and vaccination rates (i.e. COVID-19).

IPC incidents during 2023/24 have highlighted gaps in the provision of occupational health services in BSMHT (i.e. availability of staff MMR vaccination records and ability to delivery staff vaccine clinics following occupational exposure). These concerns have been escalated by the IPCt as it is not within the resource of the IPCt to provide Occupational Health advice to staff and this issue will become more acute as IPCNs leave the team.

It is vital that Occupational Health hold up to date staff records (i.e. immunisations) to allow for accurate and timely risk assessments from the IPC team following incidents (e.g. inoculation injuries, exposure to infectious diseases such as measles or rubella). Lastly, there is a high proportion (19%) of DNA'd Occupational Health appointments and efforts should be made to address this to reduce waste and increase efficiency within the team.

Antimicrobial Stewardship (AMS)

Pharmacy should report to the IPCC, but representation at the meeting is inconsistent. An antibiotic audit was undertaken in March 2023, approximately half of the prescriptions were entirely consistent with the antimicrobial guidance. The IPCC await a report of the annual 2023/24 antibiotic audit. Education to raise awareness of antimicrobial resistance and a more in-depth review of the BSMHT use of the WHO's AWaRe category of antibiotics would be welcomed by the IPCT.

Appendix 2

ESTATES & FACILITIES INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2023-24

1. CORONAVIRUS (COVID)

➢ **Estates & Facilities COVID Programme of Works 2023/2024**
With collaborative support from Matrons, Ward Managers, and Estates Teams, Estates & Facilities continued to run a programme to assist in maintaining a safe environment for all staff, Service Users, and 3rd party visitors for example contractors across all sites by:

- Enhanced Touchpoint Cleaning in accordance with the guidance provided by Infection Prevention & Control Team
- Provided Post Infection cleans and deep clean of sites when requested by Infection Prevention & Control Team and Clinical Staff.

2. DOMESTIC & HOUSEKEEPING MANAGEMENT

➢ **Estates & Facilities**
All domestic services continue to be provided by SSL with the North PFI sites services being provided by a third party outsourced provision. This means that all Estates and Facilities domestic service provision across the Trust is outsourced for 2023/2024 reporting period.

➢ **NHS England –National Standards for Healthcare Cleanliness**
NHS England National Standards for Healthcare Cleanliness were implemented in April 2022. The Trusts Cleaning Policy was updated and ratified to align with the National Standards. This was updated during 2023/24 to take into account the change in the Functional Risk category for Dementia wards to FR2.

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

➢ **SSL Facilities Rapid Response Team**
During 2023/2024 SSL Facilities Rapid Response Team continued to undertake a programme of deep cleaning across the Trust.

3. CLEANLINESS

- **Cleanliness Audit & Inspection Programme**

During 2023/24 the programme of cleanliness inspections and audits was undertaken. Cleanliness scores and reports were provided to the Trust Infection Prevention & Control Team each month and the Trust Infection Prevention Partnership Committee each quarter.

The programme comprises 2 levels with additional spot checks.

- Level 1 Monitoring by Domestic Supervisors
- Level 2 Trust-wide Management Audits

Cleanliness scores were reported against the thresholds in the National Standards for Healthcare Cleanliness, Dementia wards – 95%, Inpatient building's - 90% and Outpatient and Offices 85%.

During 2023/24 the cleanliness scores throughout the Trust (BSMHFT, SSL and Amey Community Limited) can be seen below and were consistently above the thresholds set in the National Standards for Healthcare Cleanliness.

All special cleaning activity (including Isolation Cleaning, Post-Infection Cleaning and scheduled Deep Cleaning) was undertaken in compliance with the Trust Infection Prevention & Control Policy and was reported monthly to the Infection Prevention & Control Team and to the Infection Prevention Partnership Committee each quarter. The Trust's Deep Cleaning Programme is an integral element of the Trust Cleaning Policy and responds to the National Standards for Healthcare Cleanliness.

Key Cleaning Performance Data for 2023/24

Technical Audits

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	1 April – 30 June 2023	1 July – 30 Sept 2023	1 Oct – 31 Dec 2023	1 Jan – 31 Mar 2024
	Trust Cleanliness Targets & Scores			
	Trust Overall Cleanliness Target = 95% Dementia Units, 90% inpatient Units, 85% Outpatient Units			
Trust Average	95.81%	95.65%	94.75%	95.95%
North PFI	95.23%	94.86%	94.45%	94.72%
BNHP	93.63%	96.87%	93.61%	95.51%
Community	96.61%	98.26%	98.07%	97.51%
Secure	97.77%	97.82%	92.88%	96.07%

Management Audits

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	1 April – 30 June 2023	1 July – 30 Sept 2023	1 Oct – 31 Dec 2023	1 Jan – 31 Mar 2024
	Trust Cleanliness Targets & Scores			
	Trust Overall Cleanliness Target = 95% Dementia Units, 90% inpatient Units, 85% Outpatient Units			
Trust Average	96.01%	94.48%	92.61%	96.02%
North PFI	92.63%	92.01%	94.16%	91.91%
BNHP	No Data	No Data	93.01%	91.84%
Community	No Data	No Data	94.26%	97.10%
Secure	99.40%	96.96%	89.00%	99.15%

- **PLACE (Patient Led Assessments of the Care Environment)**
  The 2023 PLACE assessment programme took place during September – November 2022. The results have been published and scores are;

BSMHFT's PLACE Scores - Nationally															
Cleanliness		Combined Food		Organisational Food		Ward Food		Privacy, dignity & Wellbeing		Condition, Appearance & Maintenance		Dementia		Disability	
BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score	BSMHFT Score	National Average Score
99.12%	98.10%	90.97%	90.90%	88.90%	91.20%	92.91%	91.00%	94.43%	87.50%	96.31%	95.90%	93.03%	82.5%	81.77%	84.30%

BSMHFT's PLACE Scores - Mental Health and Learning Disabilities															
Cleanliness		Combined Food		Organisational food		Ward Food		Privacy, dignity & Wellbeing		Condition, Appearance & Maintenance		Dementia		Disability	
BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score	BSMHFT Score	MH & LD Average Score
99.12%	98.10%	90.97%	91.80%	88.90%	90.40%	92.91%	93.00%	94.43%	94.50%	96.31%	95.80%	93.03%	90.4%	81.77%	89.60%

BSMHFT's overall organisational scores are an increase on its 2022 scores for 7 of the 8 domains.

- **Cleaning Quality Operational Group**
  The Cleaning Quality Operational Group has been re-established. It is led by Infection Prevention & Control and comprises of SSL Estates and Facilities Department representatives, Matrons, and PFI Partner Amey Community Limited and reviews all issues (and implements actions) regarding cleanliness within the Trust. The group reports into the Infection Prevention Partnership Committee.

- **Cleaning Policy**

  The aim of the Trust Cleaning Policy is to demonstrate compliance with the assessment criteria detailed in "The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (DOH, July 2015) on the standards of cleanliness that facilitate the prevention and control of infections and improve the quality of health service provision by ensuring that all cleaning related risks are identified and managed.

  The policy requires delivery of consistent and compliant cleaning practices and cleanliness standards Trust-wide (whether delivered through SSL or PFI providers).

  Compliance with the policy is monitored through the following.

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

- **Cleanliness Training**

  SSL Facilities Department manage an established Facilities Training Hub at The Barberry which continues to provide accredited education and training for SSL and Trust staff, as well as external companies. The Facilities Training Hub provides dedicated education and builds awareness of the cleaning profession through accredited training. Courses are delivered by Sue Ladkin (SSL) ranging from local induction training to higher level accredited training, whilst working alongside BSMHFT's Infection Prevention & Control Team and nursing colleagues. The Hub's syllabus also includes Level 2 in the Principles and Control of Infection in Healthcare Settings, Food Safety, Legionella and Water Safety and Biohazard Decontamination Training. During 2022/23, the Facilities Training Hub delivered FM training to Trust staff, SSL (Summerhill Services Limited) and PFI Partner Amey Community Limited.

  The Trust's PFI Partner (Amey Community Limited) has contracted with the Trust's Accredited Training Hub to provide training to all of their Domestic Staff and Supervisors. The Trust's PFI Partner is also using the Training Hub to provide Level 2 Food Hygiene for their Domestic Assistants and Domestic Supervisors.

- **Computerised Cleanliness Monitoring System**

  SSL Estates & Facilities Department and PFI teams operate a computerised cleanliness monitoring system "FM First" (based on the National Standards for Healthcare Cleanliness). The system generates cleaning scores and real time reports. This system was updated in April 2022 in line with the new Cleaning Standards.

4. CATERING MANAGEMENT

- **Environmental Health Inspections**

  During 2023/24 Inspections by Birmingham City Council Environmental Health Officers carried out 7 visits.

  Juniper Café (3rd party) - 1 star - measures have been established with limitations on service offering.

  Barberry – 5 stars

  Reaside – 5 stars

Zinnia – 5 stars
Uffculme - 5 stars
Juniper – 1 star which was upgraded to a 4 star on a subsequent visit.
Sue Ladkin supported the team on site to achieve this.

- **SSL Kitchen Inspections and SSL Food Safety and Quality Audits on behalf of BSMHFT**
  During 2023/24 a programme of kitchen inspections and food safety and quality audits were undertaken once a quarter across the production kitchens with scores and reports provided to the Trust Infection Prevention Partnership Committee and the SSL/Trust Food Safety and Quality Group each quarter.

- **Allergy Awareness**
  Since changes in Food Safety Legislation in the UK, food businesses must inform you under food law if they use any of the 14 allergens as ingredients in the food and drink they provide. This list has been identified by food law as the most potent and prevalent allergens. SSL staff that handle food are required to complete the FSA online training. As this training has recently been updated in line with changes to the most recent legislation. It has been recommended that all staff that handle or serve food complete this training and the link has been added to the Trust eLearning food safety level 2 package.

- **Allergen Policy**
  Allergen Policy/process is out for review.

- **Food Safety Training**
  However, is a requirement for all staff who handle food to have Food Safety level 2 training. Clinical staff on the North PFI sites, serve the food to the Service Users.

- **Food Safety Policy**
  This has not been updated to cover the above requirements. Review was due March 2024.

- **National Standards for Healthcare Food and Drink**
  The National Standards were implemented in November 2022, there are 8 standards that all NHS organisations are required to meet:
  - Organisations must have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.
  - Organisations must have a food and drink strategy.
  - Organisations must consider the level of input from a named food service dietitian to ensure choices are appropriate.
  - Organisations must nominate a food safety specialist.
  - Organisations must invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services.
  - Organisations must be able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.
  - Organisations must monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals.
  - NHS organisations must be able to demonstrate that they have suitable 24/7 food service provision, which is appropriate for their demographic.

The Trust has a Food Group which meets regularly, however some of the standards above are not currently being met by the Trust.

5. WASTE MANAGEMENT

- **Waste Contracts**
  The contract with the Violia for Domestic waste commenced 1st April 2020 and the Clinical Waste contract with Tradebe commenced 01 July 2020. These contracts were established for a period of 3 years with the option to extend on a +1 year and +1 year basis. These contracts for Domestic and Clinical Waste have continued to deliver an effective and compliant service during 2023/24 whilst at the same time keeping costs to a minimum.

  Inpatient sites are now having to weigh food waste as part of the Estates Return Information Collection (ERIC).

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

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

- **Waste Management Training**
  SSL's Estates and Facilities Department has supported clinical / healthcare colleagues by offering refresher training at their request. SSL has also attended the Linek workers study days to complete refresher training on waste management and segregation.
  In addition, sharps management training was provided both by the Trust and its sharps supplier to the Trust's Infection Control Link Workers to allow them to disseminate best practice at their respective sites. This training will continue in 2023/24.

- **Waste Management Strategy 24/25**
  Infection Control Committee need to consider its Clinical waste disposal as per the NHS E Waste Strategy. This determines that NHS Trusts should aim for 20% of it waste treated by incineration, 20% by alternative treatment and 60% managed as non-infectious (offensive) healthcare waste. At the current time BSMHFT 'orange' bags the majority of its clinical waste as being infectious healthcare waste – whereas much of the this (where there are no BBV for example) including that of even PPE should be classified as non-infectious offensive waste.

SSL will be keen to work with and support the Trust to make necessary changes and re classify as necessary its waste, remaining compliant.

6. LAUNDRY & LINEN MANAGEMENT

- **BSOL Laundry & Linen Consortium**
  SSL Facilities Managers and SSL Procurement have and continue to work with the BSOL Laundry and Linen Consortium. The aim to retender the laundry and linen services across the BSOL consortium and have one contract specification and standards.

- **Laundry & Linen Contract**
  Following issues with our current laundry supplier Elis, we are exploring the option to move to a new laundry supplier, Oxwash. We are currently reviewing service requirements with the procurement team and the South. A Duty of Care visit has been undertaken.

- **Duty of Care Audits**
  A Duty of Care Audit was undertaken of the Trust-wide Laundry and Linen supplier Ellis in 2022. These were to the Coventry plant and the team observed the supplier's compliance with the service contract, the Trust's Laundry & Linen Policy, and Health Technical Memorandum (HTM) 01-04 "Decontamination of Linen for Health and Social Care". The Duty of Care visit also observed standards, quality systems, risk assessments and standard operating procedures as well as Laundry Staff Training Records to ensure compliance.

7. PEST CONTROL

- Trust Pest Control Policy, drafted by SSL Facilities Management, ratified in April 2022.

Appendix 3

ANNUAL EFFICACY REPORT 2023-2024

PAPER TITLE	Annual Efficacy Audit Report 2023 - 2024
DATE	01st April 2024
AUTHOR	Jessica Clarke / Susan Ladkin

Overview

The Efficacy Audit is completed on an annual basis for all patient facing areas. The purpose of Efficacy Audits is to provide assurance that;

- Cleaning standards are met using good practice.
- The correct cleaning procedures are being consistently undertaken to comply with Infection Prevention and Control and Safety Standards.
- The correct training, Infection Prevention and Control, Health & Safety and safe systems of work are being used.

The Efficacy Audit is broken down into 3 areas of responsibility, Cleaning, Nursing and Estates to create the overall score for each site.

Key Themes across Trust

Cleanliness Charters

- Incorrect functional risk ratings (e.g. FR4 in FR3 area)
- Two Functional risk ratings displayed – Should only be one as we do not have blended sites within the Trust
- Cleanliness charters not available or not displayed in reception / entrance areas

STAR ratings

- Had expired or had no expiry date detailed
- Were not visible / displayed

Waste Management

- Numerous sites with open lidded bins in toilet and kitchen areas
- Sharp boxes open and being stored on floors
- Domestic items found in clinical waste bins

IPC Practices

- Staff not bare below the elbow in clinical areas

Recommendations / Actions Taken

- All reports sent to Matrons, nurisng teams, estates and facilities to action and rectify as appropriate
- Chemical competency refresher training for all clinicians including safe use of chlor clean
- Waste management refresher training for all staff
- Review of Commitment to cleanliness charter and Star ratings across all site

Escalation

Due to capacity issues the majority of audits undertaken have compromised of Susan Ladkin, Training and Quality Compliance Manager and Jessica Clarke - Soft FM Contacts Officer with support from Domestic Team Leaders/Managers.

The Cleaning Policy states that the Efficacy Audit Team/s will comprise: Training & Quality Compliance Manager, Soft Facilities Monitoring Officer, and Infection Prevention & Control Team Representative. Patient Representatives may also be invited to attend.

Location	Survey Date	Available Score	Achieved Score	Score Value	Audit Completed By:
Reaside	27/02/2024	43	38	**88.37%**	Sue Ladkin - SSL Quality Compliance & Training Manager Jessica Clarke Soft FM Monitoring Officer Susan Hill, Domestic Team Leader
Northcroft Hospital	25/03/2024	43	35	**81.40%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office
Endeavour Court	25/03/2024	43	36	**83.72%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office
Juniper Centre	29/08/2023	43	37	**86.05%**	Susan Ladkin - Training and Quality Compliance Manager Jessica Clarke - Soft FM Contacts Officer Aimee Perrin - IPC Nurse
Tamarind Centre	30/08/2023	43	38	**88.37%**	Jessica Clarke - Soft FM Contracts Officer Susan Ladkin - Training and Quality Compliance Manager Aimee Perrin - IPC Nurse
Newbridge House	19/12/2023	43	43	**100.00%**	Sue Ladkin - SSL Quality Compliance & Training Manager Jessica Clarke Soft FM Monitoring Officer
Oleaster	08/01/2024	43	39	**90.70%**	Jessica Clarke - Soft FM Officer Susan Ladkin - Training and compliance manager
Eden PICU	09/01/2024	43	39	**90.70%**	Jessica Clarke-Contract Officer Marie Mason-Supervisor Michelle Thacker -Housekeeper
Eden ACUTE	09/01/2024	43	36	**83.72%**	Jessica Clarke-Contract Officer Marie Mason-Supervisor Kerry Edwards -Housekeeper
William Booth HC	25/03/2024	43	38	**88.37%**	Jessica Clarke - Soft FM Contracts Officer

Ardenleigh	21/03/2024	43	38	**88.37%**	Sue Ladkin - SSL Quality Compliance & Training Manager Jessica Clarke Soft FM Monitoring Office Clinical HC.
Ardenleigh	22/03/2024	43	36	**83.72%**	Susan Ladkin, Training and compliance manager Jessica Clarke, soft FM Monitoring officer Joshua Andoh, Domestic Supervisor
Reservoir Court	20/03/2024	43	33	**76.74%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office
Ashcroft	24/03/2024	43	36	**83.72%**	Jessica Clarke - Soft FM Officer
Endeavour House	25/03/2024	43	38	**88.37%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office
Venture House	25/03/2024	43	36	**83.72%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office Heather Layton - Domestic Team Leader
George Ward	09/01/2024	43	40	**93.02%**	Jessica Clarke - Soft FM Officer Susan Ladkin - Training and compliance Manager
Callum Lodge	08/02/2024	43	40	**93.02%**	Jessica Clarke -
Small Heath HC	23/02/2024	43	41	**95.35%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office Marie Mason - Domestic Team Leader
Osborne House	08/03/2024	43	34	**79.07%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office Marie Mason - Domestic Team Leader
Little Bromwich	20/03/2024	43	41	**95.35%**	Jessica Clarke - Soft FM Contracts Officer Marie Mason - Domestic Team Leader
Forward House	18/03/2024	43	35	**81.40%**	Jessica Clarke - Soft FM Contracts Officer Clare Round -Soft FM Contracts Office
Reaside	17/07/2023	43	37	**86.05%**	Facilities manager and domestic supervisor attended the audit, non attended Estates and IPCT.
The Barberry (1 Ward & Communal)	09/01/2024	43	43	**100.00%**	Jessica Clarke - Soft FM Officer Susan Ladkin - Training and compliance manager

Dan Mooney House	15/08/2023	43	41	**95%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse
David Bromley House	15/08/2023	43	40	**93%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse
Grove Avenue	16/08/2023	43	39	**91%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse, Donna Henry - SSL Domestic Supervisor
Hertford House	16/08/2023	43	38	**88%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse, Donna Henry - SSL Domestic Supervisor
Hillis Lodge	18/10/2023	43	39	**91%**	Sue Ladkin - SSL Quality Compliance & Training Manager
Longbridge HC	18/10/2023	43	37	**86%**	Sue Ladkin - SSL Quality Compliance & Training Manager
Lydon Clinic	22/08/2023	43	40	**93%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse, Caine Jordon - Site IPCT Lead
Mayple Leaf House	22/08/2023	43	37	**86%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse
Mary Seacole House	23/10/2023	43	35	**81%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse, Jessica Clarke, Soft FM Monitoring Officer
Newington	03/01/2024	43	41	**95%**	Sue Ladkin - SSL Quality Compliance & Training Manager
Shenely Fields	18/10/2023	43	39	**91%**	Sue Ladkin - SSL Quality Compliance & Training Manager
SSL HUB	16/10/2023	43	40	**93%**	Sue Ladkin - SSL Quality Compliance & Training Manager
Uffculme	03/01/2024	43	39	**91%**	Sue Ladkin - SSL Quality Compliance & Training Manager
Zinnia Centre	10/07/2023	43	35	**81%**	Sue Ladkin - SSL Quality Compliance & Training Manager, Aimee Perrin - Infection Prevention and Control Nurse, Donna Henry Domestic Supervisor

Pass
Room for improvement
Fail

OBSERVATIONS

Functional area					Comments
FR2	**Highcroft \ Reservoir Court**	**Survey Id: 11990**	**20/03/2024**	**Cleanliness Assurance - Quality**	No STAR rating visible on ground floor. FR3 still displayed - This should be FR2 Wall washer needs to be colour coded Advised that domestic staff are using pillowcases to clean glass. Some warning signs left out. Review cleaning equipment. No STAR rating visible FF.
				Environment	Access ceiling panels in various areas, handprints found. Strong odour in bedroom 2 ensuite.
				Infection Prevention and Control Assurance	No water running documentation found. Stagnant water left in mop bucket.
				Waste Segregation and Management	Open domestic bins with clear linens
FR2	**Juniper Centre \ Juniper Centre**	**Survey Id: 513**	**29/08/2023**	**Cleanliness Assurance - Quality**	Cleanliness charters read FR4 and FR3 - Need updating to FR2 Blinds in Bergamot dining room need wiping PAT test out of date for floor machine cleaning equipment
				Environment	There is sufficient lighting for cleaning to take place, however a number of lights were out across site - Estates to review
				Infection Prevention and Control Assurance	Domestic teams unaware of isolation cleaning for area with C-Diff. IPC have sent email to clarify to all teams No documentation of infection cleans for area with positive c.diff case
				Waste Segregation and Management	Recycling bin near back entrance being used for face masks recycling bin at back entrance being used for face masks

FR3	**Ardenleigh \ Ardenleigh Hospital**	**Survey Id: 11989**	**22/03/2024**	**Cleanliness Assurance - Quality**	FR3 and FR4 displayed in reception areas - FR4 to be removed Cleaning in progress/warning signs left out in some areas after activities had finished. Domestic supervisor asked to remind staff to remove after cleaning has been completed/floors dried. Vacuum in Citrine domestic cupboard PAT test out of date and scrubber No expiry dates on STAR ratings in Adriatic, Pacific Coral - no STAR rating Citrine - wrong target score of 85% - should be 90% Larimar - no STAR rating available
				Consumables	Build up of hand gel on barrier Matt at reception entrance
				Environment	Citrine - Sellotape and sticky residue in various areas Floors need replacing and decoration works Pacific - damp smell in room 07. mould found in shower/bathrooms Citrine domestic cupboard - very cluttered, blinds left on floor clinic by reception - thick dust on trolley- room cluttered
				Infection Prevention and Control Assurance	Assurance given and recent scores provided by nursing team Staff reminded of safe use of chlor clean Staff on Citrine gave verbal assurance of processes in place Nursing staff on Larimar not BBE
				Waste Segregation and Management	Clinical waste bins left open, some found without lids- Nursing teams to review in their areas Clinical bin in CHAMS sluice - loose rubber gloves and items not in bin liner as per process Feminine Hygiene bins found bagged with domestic liner - this should be offensive or clinical liner domestic items found in clinical waste bin at entrance clinical waste bin outside external entrance - dirty
	Ardenleigh \ Rookery Gardens	**Survey Id: 11984**	**21/03/2024**	**Environment**	Some cigarette marks found in the bathroom edge and floors.
				Infection Prevention and Control Assurance	Discussed with staff on site.

				Waste Segregation and Management	Domestic items found in clinical waste bins and Sharp bin on floor.
	Highcroft \ Eden Unit \ Ground Floor \ Eden ACUTE	**Survey Id: 640**	**09/01/2024**	**Cleanliness Assurance - Quality**	STAR Rating 2 days out of date Re-audits are carried out to rectify any failures identified in audit Pink bucket used for dirty mope - this is to Cleaning trolley needs full clean and bag replaced. Old buffer needs PAT testing.
				Environment	Access issues for ward office, staff advised very busy. Some toilets lights very dull. Improvement needed for overall cleanliness and estate items.
				Infection Prevention and Control Assurance	I-5 documentation needs reviewing, couldn't find. Nail polish and watches observed.
				Waste Segregation and Management	Not observed.
	Highcroft \ Eden Unit \ Ground Floor \ Eden PICU	**Survey Id: 639**	**09/01/2024**	**Cleanliness Assurance - Quality**	Need to be closer to ward entrance. Vacuum PAT test out of date.
				Environment	Toilet lights in WC2 very dim. A few lights out in various areas, Estates to review. Hand print on ceiling panels by bedroom 6.
				Infection Prevention and Control Assurance	Staff seen wearing watches and jewelleries.
				Waste Segregation and Management	FH bin in WC2 broken, needs replacing.
	Highcroft \ Endeavour Court	**Survey Id: 14591**	**25/03/2024**	**Cleanliness Assurance - Quality**	Yellow disposable mop in blue bucket
				Environment	Several bedrooms are cluttered with personal belongings. these need moving to allow areas to be cleaned clutter in bedrooms needs reviewing
				Infection Prevention and Control Assurance	Last week water running sheets missing for w/c 18/03 No 1-5 documents found some staff wearing long sleeved tops/jackets over uniform

				Waste Segregation and Management	Clinical waste bins have got general waste in External domestic bin has been overfilled in waste hold and needs reviewing as there was an empty bin available
	Highcroft \ Endeavour House	**Survey Id: 14574**	**25/03/2024**	**Cleanliness Assurance - Quality**	Wet mop left on floor and wet used mops left in bucket - discussed with nursing team
				Infection Prevention and Control Assurance	Ward manager confirmed recent hand hygiene audit 98% Water running sheets not found for WC 18/03 - discussed with staff on site 1-5 documentation not found Nursing teams observed with long sleeves
				Waste Segregation and Management	Sharps bin open and on floor Domestic euro bin overfilled - One empty in far corner
	Highcroft \ Forward House	**Survey Id: 11983**	**18/03/2024**	**Cleanliness Assurance - Quality**	Bedrooms not being cleaned daily as per schedule. Chemicals use in unlocked trolley. Trolley stored outside needs cleaning. Few shower curtains needs cleaning. PAT test Out of date STAR rating out of date.
	Highcroft \ George Ward	**Survey Id: 641**	**09/01/2024**	**Cleanliness Assurance - Quality**	Advised domestic to use 8 sides of cloth for each surface Spray bottle not labelled - Discussed with Domestic at point of audit bag ripped STAR rating says audit due 01st Jan - Advised Amey to record month only
				Infection Prevention and Control Assurance	Discussed ward processes with staff nurse Discussed ward processes with staff nurse
				Waste Segregation and Management	Clinical waste bin in reception area - broken needs replacing

	Newbridge House \ Main Building	**Survey Id: 628**	**19/12/2023**	**Cleanliness Assurance - Quality**	Cleaning trolley bags damaged - Domestic team leader advised that these are on order All electrical cleaning equipment observed was in date for PAT testing
				Environment	Dining tables are very heavy - Domestic Team leader advised 2 members of staff move table together to allow for a full clean and weekly machine clean as per standards
				Infection Prevention and Control Assurance	No infections on ward however staff are aware of process
	Reaside	**Survey Id: 10824**	**27/02/2024**	**Cleanliness Assurance - Quality**	FR4 poster to be removed from all walls as this site if FR3 Microfibre cloths in use these have not been approved by IPCT - remove and use NHS cleaning methods as directed for glass and mirrors Curtain cleaning on a rolling programme
				Waste Segregation and Management	Bins in foyer- Domestic rubbish found in clinical waste bin Bins in hold found unsecured

	Reaside	**Survey Id: 182**	**17/07/2023**	**Cleanliness Assurance - Quality**	FR3 and FR4 cleanliness charters in place - This needs to be FR3 only. Cleaning schedules observed Toilet and limescale remover used in some handwash sinks as some service users use sinks to urinate in - This is then rinsed and cleaned following NHS method statement Airline air freshener found on domestic trolleys, this chemical is provided by hygiene and is for use in wall unit dispensers and is controlled via a timer. Where staff are using this chemical manually the dose and frequency we would bae classed as a cleaning method failure as it may leave residual contaminants on surfaces. Domestic trolleys unlocked at ward level, one found with chlorclean tablets on Trent ward which were accessible to acute service users. Trolleys found is clean, satisfactory condition all wards checked. curtains on Avon ward dated February 22 see image attached for failure 04/23 on equipment checked across site
				Environment	Stairway by gym blocked with boxes Reception area clean , however cluttered with traffic cones ,wheelchairs and barriers . Blythe door to courtyard ,courtyard has group of ducks which may encourage feeding and other pest activity. There will also be a risk of heavy contamination. due to amount of duck droppings etc.
				Infection Prevention and Control Assurance	3 water dispenser units found with bath towels around the base as they are leaking Blythe Ward COVID outbreak Records checked where access allowed. Cleaning documents for outbreaks 4 and 5 in domestic folder for whole site ,ward infection cleans in yellow folders. 100%

	Tamarind Centre	**Survey Id: 519**	**30/08/2023**	**Cleanliness Assurance - Quality**	FR2 and FR3 ratings displayed in areas - FR4 to be changed to FR3 Supplier issue with colour coded gloves and brush heads Cleaning practices observed and practical given by auditors
				Consumables	x1hand gel empty outside Acacia ward - hand soap available opposite
				Environment	Entrance to site, heavy build up of dirt and cigarette butts
				Infection Prevention and Control Assurance	Gloves being used appropriately however issues with colour coded gloves due to supplier issues Laurel ward - 4/5 clinical staff on ward not bare below the elbow, fleece jackets, watches and nail polish observed. It was also noted that there was no engagement from team as audit team approached the unit. All other wards compliant
				Waste Segregation and Management	Waste bins in foyer found with wrong liners in clinical waste bin. Waste not segregated
	The Barberry	**Survey Id: 638**	**09/01/2024**	**Cleanliness Assurance - Quality**	Black bags should be in lockable trolley at ward level due to ligature and risk from suffocation Ratings are accurate for this ward - chamomile only
				Infection Prevention and Control Assurance	no infection on ward today verbal assurance given
				Waste Segregation and Management	Food waste from patients meals is on increase waste bins are full in waste hold at rear of Barberry and have pest damage .This has been reported by porters

FR3 Blended	**Oleaster**	**Survey Id: 637**	**08/01/2024**	**Cleanliness Assurance - Quality**	Magnolia and Melissa ward Manger confirmed furniture not being removed to clean and weekly scrubbing not taking place . Magnolia ward manager raised concerns regarding consistency of housekeeping staff and associated tasks Aerosol air fresheners found in cleaning cupboard - disposed of at point if audit and discussed with domestic staff Melissa ward Manager advised sluice between Melissa and Japonica is left open - reminder to be sent to all staff to keep locked at all times Bin liners to be stored in the !lockable drawer on the cleaning trollies at all times - Discussed with domestic staff and ward manager's - ligature and suffocation risk no. curtains observed Melissa ward domestic cupboard X2 scrubbers PAT test out of date Chamomile domestic cupboard x1 scrubber PAT test out of date
				Consumables	Hand gel at reception not filled and requires cleaning - Build up of gel
				Environment	Lighting in entrance lobby area very dim and few lights out throughout site
				Infection Prevention and Control Assurance	Verbal assurance was given from Tazetta deputy ward manager, Japonica ward manager and Melissa ward manager Verbal assurance was given from Tazetta deputy ward manager, Japonica ward manager and Melissa ward manager

FR4	**Ashcroft \ Main Building**	**Survey Id: 11994**	**24/03/2024**	**Cleanliness Assurance - Quality**	Red, green and blue cloths found in blue cleaning bucket. Discussed with domestic on site. Amey to purchase colour coded hand buckets Domestic cupboard left unlocked Cleaning trolley build up of dirt and debris in crevasses cleaning equipment PAT Test out of date STAR rating out of date (May 2023)
				Environment	Hand prints on ceiling access panels by E0125
				Infection Prevention and Control Assurance	Domestics carrying out water running- documentation reviewed
				Waste Segregation and Management	Domestic items found in clinical bins open bins needed in toilet and kitchen areas - need replacing
	Callum Lodge	**Survey Id: 6524**	**08/02/2024**	**Cleanliness Assurance - Quality**	Charter needs to be displayed at entrance of the building cleaning schedules need to be visible to visitors No blue gloves available
				Infection Prevention and Control Assurance	No recent outbreaks or infections
				Waste Segregation and Management	Hand towels and domestic items found in clinical waste bin
	Highcroft \ Northcroft Hospital	**Survey Id: 14554**	**25/03/2024**	**Cleanliness Assurance - Quality**	No STAR rating visible microfibre equipment tabs not colour coded Equipment needs reviewing. old dust pan and brush and equipment not stored correctly including high level cleaning equipment, scrubber dryers build up of dirt and debris fabrics blinds cons room 2 No STAR rating visible
				Environment	Clutter in some areas needs removing Floors need scrubbing
				Infection Prevention and Control Assurance	No outbreaks at Northcroft for long period

				Waste Segregation and Management	Reception domestic bin lid is broken Open lidded bins in wc - need relacing with lidded bins domestic waste in clinical waste bin in reception
	Highcroft \ Venture House	**Survey Id: 14577**	**25/03/2024**	**Cleanliness Assurance - Quality**	No commitment to cleanliness charter available fabric blinds stained - beyond cleaning no PAT test info on cleaning equipment
				Environment	Stains on ceilings in various areas
				Infection Prevention and Control Assurance	Discussed with staff on site - Assurance given
				Waste Segregation and Management	Open bins in WC's very cluttered, leaves and cobwebs present
	Little Bromwich \ Main Building	**Survey Id: 11925**	**20/03/2024**	**Cleanliness Assurance - Quality**	Observed. Discussed with domestic supervisor. Checked in domestic cupboard. All cleaning equipment checked and in date.
				Environment	Old ceiling tiles stained and damaged throughout building.
				Infection Prevention and Control Assurance	Domestic running water sheets in place. Statement water left in cleaning buckets No outbreak in 12 months, cleaning teams discussed process.
	Osborne House	**Survey Id: 10841**	**08/03/2024**	**Cleanliness Assurance - Quality**	STAR rating out of date Cleanliness charter not found TASKI not stored properly - brushes on floor Both cleaning trollies dirty - needs full clean STAR rating out of date
				Consumables	No hand gel available at entrance
				Environment	Ceilings in group room heavily stained from leak

				Infection Prevention and Control Assurance	Cleaning buckets left with stagnant water in them
				Waste Segregation and Management	Open bins found in toilets- needs to be replaced with lidded
	Small Heath HC \ Main Building	**Survey Id: 7244**	**23/02/2024**	**Cleanliness Assurance - Quality**	Cleaning processes discussed with domestic on shift
				Environment	Some rooms not accessible for cleaning. keys needed for f51 and f22
				Infection Prevention and Control Assurance	cleaning practices observed no outbreak/infections on site
				Waste Segregation and Management	Domestic items found in clinical waste bin Estates works being carried out - could not observe waste compound
	William Booth HC \ Main Building	**Survey Id: 14578**	**25/03/2024**	**Cleanliness Assurance - Quality**	No cleanliness charter or STAR rating visible Domestic observed following procedures Cleaning equipment stored ad best as can be given space capacity No cleaning trolley used No STAR rating visible
				Environment	Clinical store cupboard very cluttered - does not allow for effective cleaning.
				Infection Prevention and Control Assurance	Water running checks checked Documents in place but no outbreaks recently Domestic wearing long sleeves
				Waste Segregation and Management	Sharp bin placed on floor in domestic sluice and room very cluttered

Appendix 4

Summerhill Services

Annual Water Management Report 23/24

April 24

- **Authorising Engineer:**

  Water Hygiene Centre remained our AE's for the financial year 23/24 with LRA services appointed for the upcoming financial year, Antony Paskin will remain as our AE.

- **Water Safety Plan**

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

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

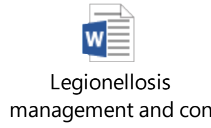
  The content of the WSP includes management and governance arrangements, together with details of training, professional support, maintenance regimes and supporting documentation.

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

  A full re write of the WSP has been completed with all comments added following a lengthy consultation period. Next steps are ratification by the SWSG – update required on further comments from IPC.

- **Legionellosis Management and control Policy**

  Legionellosis Management and control Policy was reviewed, updated and ratified in September 2021.



Legionellosis management and con

Once the Water Safety Plan is fully ratified the Legionellosis Management and Control Policy will be updated to mirror key elements of the WSP.

- **Training (Estates):**

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

Water RP's

- Lee Gough – Head Of Facilities Management.
- Simon Epstein – Head of PFI.
- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).
- Tarnjit Singh – Estates Manager (Ardenleigh).
- Paul Tranter – Estates Manager (Tamarind).
- Martin Spiers – Estates Manager (Reaside).
- John Mead - Senior Estates Manager – PFI South.
- Martin Germaney - Senior Estates Manager – PFI North.
- Gary Stanton – Estates Contracts Officer – PFI North.
- Nicky Bowen – Senior Contracts & Commercial Services Manager – PFI North.
- Clive Round – Contracts Officer – PFI North.
- Yvonne Kelly - Contracts Officer – PFI South.

Water AP's:

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

Water CP's:

Training completed by Admin and Trade Teams across various sites in April 2023 to include:

- Malcolm Linton.
- Stan Millwood.
- Mark Seymour.
- John Johnstone.
- Liam Crowe.
- Oliver Higgins.
- Derek Harley.
- Mark Barrett.
- Adrian Flanaghan.
- Daniel Wise.
- Mohammed Ifzal.
- Tyrone Williams.

- Lisa Flavell.
- Asif Quayam.
- Kevin Richards.
- Howard Moore.

➢ **Appraisals:**

Appraisals and Certificate of Appointments issues as below by AE:

Lee Gough:

BSMAE38952C22_RP
_Certificate of Appoin

Simon Epstein:

BSMAE24395C23_RP
_Certificate of Appoin

➢ **Risk Assessments:**

Retained Estate:

Updated Legionella Risk assessments have been completed for all sites as per the below:

Ref	Property		Postal Address	Gross internal floor area (m2)	Date of Survey
1	Adams Hill	Outpatient	190 Adams Hill, Bartley Green, B32 3PJ	180	29/06/2023
2	Ardenleigh inc Thomas Telford and Training Centre	Inpatient	385 Kingsbury Road, Erdington, B24 9SA	8,598	17/07/2023
3	B1	Corporate	Unit 1 B1, 50 Summer Hill Road, B1 3RB	3,039	29/06/2023
4	Dan Mooney House	Inpatient	1 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	26/06/2023
5	David Bromley House	Inpatient	2-4 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	26/06/2023
6	Grove Avenue	Inpatient	32 Grove Avenue, Moseley, Birmingham, B13 9RY	397	27/06/2023
7	Hertford House	Inpatient	29 Old Warwick Road, Olton, Solihull, B92 7JQ	484	26/06/2023
8	Hillis Lodge	Inpatient	Hollymoor Way, Northfield, B31 5HE	1,095	29/06/2023
9	Juniper Centre	Inpatient	Moseley Hall Hospital site, Alcester Road, Moseley, B13 8JL	5,246	28/06/2023
10	Longbridge Health & Community Centre	Outpatient	10 Park Way, Birmingham Great Park, Rubery, B45 9PL	1,414	29/06/2023
11	Lyndon Resource Centre	Outpatient	Hobs Meadow, Solihull, B92 8PW	888	26/06/2023
12	Maple Leaf Centre		2 Maple Leaf Drive, Marston Green B37 7JB	1,752	29/06/2023
13	Newington Resource Centre	Outpatient	Newington Road, Hamar Way, Marston Green, B37 7RW	850	28/06/2023
14	Orsborn House	Outpatient	55 Terrace Road, Handsworth, Birmingham, B19 1BP	1,659	28/06/2023
15	Reaside Clinic	Inpatient	Birmingham Great Park, Bristol Road South, Rubery, B45 9BE	7,084	26,27,28 /06/2023
16	Reaside Community Building		Birmingham Great Park, Bristol Road South, Rubery, B45 9BE		26,27,28 /06/2023
17	Rookery Gardens	Inpatient	385 Kingsbury Road, Erdington, B24 9SA	1,239	28/06/2023
18	Shenley Fields	Outpatient	15 Shenley Fields Drive, Northfield, B31 1XH	487	29/06/2023
19	Tamarind	Inpatient	165 Yardley Green Road, Bordesley Green, B9 5PU	8,261	18/07/2023
20	Uffculme Centre inc (Main Building, Tall Trees / Estates, Staff Support, Gate House	Corporate	52 Queensbridge Road, Moseley, B13 8QY	2,166	27/06/2023
21	Uffculme site (Tall Trees)	Mixed use	52 Queensbridge Road, Moseley, B13 8QY	628	27/06/2023
22	Warstock Lane	Outpatient	Warstock Lane, Billesley, B14 4AP	577	28/06/2023

Minor remedial works were identified across the estate with work nearing completion.

Written schemes have also been developed for all sites.

North PFI:

All WRA's are being updated in 2024.

South PFI:

Property	Address	Gross Area	Date of Last Survey
Barberry	25 Vincent Drive, Edgebaston, B15 2SY	8,913m2	Q4 22
Oleaster	6 Mindlesohn Crescent, Edgebaston, B15 2SY	7,200m2	Q4 22
Zinnia	100 Showell Green Lane, Sparkhill, B11 4HL	4,331m2	Q4 22

Remedial works are currently being reviewed / undertaken across all sites.

➢ **Authorising Engineer Audits:**

Audits have recently been carried out by water AE across the following areas:

- South PFI.
- Community Sites – only outstanding recommendations are reliant on WSP being ratified.

BSMAE38952C13_Au
dit Community updat

- Secure Sites – only outstanding recommendations are reliant on WSP being ratified.

BSMAE38952C14_Au
dit Secure Unit update

➢ **Independent Water Safety Review (Hydrop):**

Due to the closure of Forward House SSL commissioned an independent review of the Water safety processes used by BSMHFT/ SSL and their Supply Chain, this was carried out by Hydrop. The Audit included include both Operational and Governance Audits along with analysis of specific actions on Forward House and the North PFI premises in particular.

The report generally notes the below, with any actions included in the re written WSP.

- **General summary** - This detailed review did not identify a single acute incident which caused the identified Legionella contamination within Forward House. Instead, a building, typical in its management of Water Quality Risk Management regimen was observed. Whilst improvements can be made, to ensure tighter control of identified failures in control measures, can be instigated, it is doubtful that such improvements in the overall control measures would have prevented the incident.
- **Usage evaluation and flushing** – The process for the identification / notification to estates by the clinical teams of infrequently used outlets needs to be improved with the clinical teams taking ownership.
- **Sampling –** Carry out a review of the sampling process including which outlets and frequency of sampling inc methodology for when filters are installed – the full methodology has been reviewed and incorporated into the latest WSP.

- **Training of Trust Staff –** Training of all none estates members of the Strategic Water Safety Group is to be reviewed as in recent months we have had some new members. – The Trust water AE is going to carry out reviews and review training needs.
- **Formal suitability assessment and appointment of Responsible and Competent Persons -** Review and complete suitability assessments for all key Amey / Severn Trent personnel. – The Trust AE is going to carry out suitability assessments.
- **Water Safety Group (WSG) –** Review the attendees of the Strategic water safety group including TOR. – A revised TOR and attendance list has been included in the latest WSP.
- **Water Safety Plan –** An existing water safety plan is in place but this has been enhanced from lessons learned over the past 12 months.

Report was formally presented on 13/09/2023 to SWSG members.

➢ **Water Sampling Results and General Overview**

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

Combined Results.xlsx

➢ **Water Sampling Results and General Overview:**

<u>Secure / Community Sites:</u>

<u>Reaside:</u>

Results are all clear throughout the year

<u>Hertford House:</u>

In November 2023 we sampled the cold outlets due to some elevated cold water temperatures on site – results below:

- 10/11/2023 – **100 CFU count PRE flush** - 1st Floor Flat 10 WHB Cold.
- 20/11/2023 – ND on both PRE and Post flush samples.
- 06/12/2023 – **500 CFU's on a PRE flush – POST ND.**

Since these results were noted we have completed the below remedial works / actions:

- Commissioned an invasive survey of the site – all remedial works completed.
- Carried out sampling of the hot water system – all clear at 4 outlets.
- Continued to monitor the cold water system through sampling (see floor plan below).
- Replaced aerators on the wallgate units – 10/01/2024.
- Carried out a system wide chlorination – 03/02/2024.
- Replaced the main cold water pipework run and insulated the pipework, Chlorinated the cold water pipework post remedial works– 13/03/2024 – 16/03/2024
- Replaced the Tap Block to Flat 10 – 21/03/2024
- Carried out site wide Chlorination – 23/03/2024

Latest Results (samples taken 15/03/2024) – Received 28/03/2024

- Flat 7 (cold) pre and post – in line filter installed
- Flat 7 (mixed) pre and post – in line filter installed
- Flat 10 WHB (cold) pre and post – Samples were not taken as the WHB was disconnected
- Flat 10 WHB (mixed) pre and post – Samples were not taken as the WHB was disconnected
- Bathroom WHB near flat 10 WHB (cold) pre and post – in line filter installed
- Bathroom WHB near flat 10 WHB (mixed) pre and post – in line filter installed (pre TMV on the cold)
- Bathroom near flat 10 shower (mixed) pre and post – in line filter installed

Hertford House Plan 08.04.2024.pdf

Positives only noted below – ND's are noted on the spreadsheet and also the plans attached to make it clearer:

Room No.	Room Description	Type	Water	Type	Lab Ref	Temp Celsius	Leg MW28	Leg SG 1	Leg SG 2-14	ACTION TAKEN
	1st floor bathroom cold tap	WHB	Cold	Pre	246-2024-00065726	18.7	600	ND	ND	
	1st floor bathroom cold tap	WHB	Cold	Post	246-2024-00065727	12.1	75	ND	ND	
	1st floor bathroom mixed tap	WHB	Mixed	Pre	246-2024-00065728	37.9	750	ND	ND	
	1st floor bathroom mixed tap	WHB	Mixed	Post	246-2024-00065728	39.9	175	ND	ND	
	1st floor bathroom Shower	Shower	Mixed	Pre	246-2024-00065720	40	1000	ND	ND	
	1st floor bathroom Shower	Shower	Mixed	Post	246-2024-00065721	40	50	ND	ND	
	Flat 7 Cold Pre Flush	WHB	Cold	Pre	246-2024-00065722	19.4	ND	ND	ND	
	Flat 7 Cold Post Flush	WHB	Cold	Post	246-2024-00065723	13	250	ND	ND	
	Flat 7 Mixed Pre Flush	WHB	Mixed	Pre	246-2024-00065724	40.1	1250	ND	ND	
	Flat 7 Mixed Post Flush	WHB	Mixed	Post	246-2024-00065724	40.1	1000	ND	ND	

Actions:

As per the WSP and discussions with Antony Paskin we have since completed / have planned the below:

- On Thursday (21st March) the Wall gate Tap block in Flat 10 was replaced (including pipework leading to it) and the TMV's will be serviced across site.
- On Saturday 23rd March a site wide Chlorination was carried out to both hot and cold water systems not that all works are complete – we await those results.

Sampling will continue to the below outlets until we get 3ND's in a row.

- Flat 7 (cold) pre and post – in line filter installed
- Flat 7 (mixed) pre and post – in line filter installed
- Flat 10 WHB (cold) pre and post - isolated
- Flat 10 WHB (mixed) pre and post - isolated
- Bathroom WHB near flat 10 WHB (cold) pre and post – in line filter installed
- Bathroom WHB near flat 10 WHB (mixed) pre and post – in line filter installed (pre TMV on the cold)
- Bathroom near flat 10 shower (mixed) pre and post – in line filter installed

Orsborne House:

The landlord has taken samples (23/02/2024) due to the failure of their hot water calorifier on site which they have since replaced, below are the sampling results, all PRE flush and not we do not occupy all of the locations sampled below as we only occupy part first and second floors.

1. GF cleansers Hot – 160 CFU
2. GF Kitchen Hot – 200 CFU
3. 1st Floor Kitchen Hot – 800 CFU
4. 1st Floor FD36 Hot – 240 CFU
5. 2nd Floor SF21 Hot – 280 CFU
6. 2nd floor kitchen Hot – 40 CFU

Actions:

This is the landlords responsibility as the hot water calorifiers serve multiple units in the block, a tank clean and Chlorination was completed Wednesday 27th March with additional samples taken – twice weekly flushing of positive outlets has been instigated.

General:

As part of a robust RFQ exercise from July 2023 the contractor that we use for legionella management and control will be changing from IWS to Acquiesce Environmental Compliance.

North PFI:

Meadowcroft:

NOTE all outlets sampled show None Detected on the latest sample results.

Phoenix:

NOTE all outlets sampled show None Detected on the latest sample results.

Ashcroft:

NOTE all outlets sampled show None Detected on the latest sample results.

Callum Lodge:

NOTE all outlets sampled show None Detected on the latest sample results.

Venture House:

NOTE all outlets sampled show None Detected on the latest sample results.

Reservoir Court:

NOTE all outlets sampled show None Detected on the latest sample results.

Small Heath

NOTE all outlets sampled show None Detected on the latest sample results.

Endeavour House

NOTE all outlets sampled show None Detected on the latest sample results.

Endeavour Court

NOTE all outlets sampled show None Detected on the latest sample results.

Eden Acute:

Assisted Bathroom remains with positive results and 1 week of ND. All pipe work is due to be completely removed back to source, so WSG to approve stopping daily flushing and any further weekly samples

Eden PICU:

NOTE all outlets sampled show None Detected on the latest sample results.

Forward House:

Regular engineers meetings are scheduled to discuss results and the next steps. Any actions are taken to the SWSG for instruction and authorisation.

- Installation of Klarolax dosing system completed as per the below:

- Delivery of Chemical – Week Commencing; Monday 13th Nov'23
- Installation of Ad-hoc dosing plant (1 day) – Week Commencing; Monday 13th Nov'23
- Removal of In-line filters on Empty Flats (1 day) – (08:00) Monday 20th Nov'23
- NOTE – all Flats and Rooms to be emptied & locked-off and building empty of all staff and SU's – (08:00) Tuesday 21st Nov'23
- Isolate outlets & Removal of In-line filters all rooms & Occupied Flats (x 6) (1 day) – (08:00) Tuesday 21st Nov'23
- Shock Dosing/Disinfection (12 Hours) – (08:00 to 20:00) - Tuesday 21st Nov'23
- Installation of In-line filters (20:00) Occupied Flats (x 6) - Tuesday 21st Nov'23
- Hand-back Occupied Flats (x 6) to Clinical (20:00) - Tuesday 21st Nov'23
- Installation of In-line filters on Empty Flats & all remaining Rooms (1 day) – Wednesday 22nd Nov'23
- Hand-back Empty Flats & all Rooms – Wednesday 22nd Nov'23
- 1st Samples to all outlets (1 day) – Monday 27th Nov'23
- 2nd & 3rd Samples to all outlets (1 day) – Monday 4th Dec'23 & 11th Dec'23

- Slow dosing to commenced immediately,
- Engineer meeting held with Amey, STS and Synthesis and all agreed that chemical is working to the correct parameters at every outlet and trend of sample results are showing encouraging pattern but after one month is too early to determine absolute effectiveness and agreed that a recommendation of 3 to 6 months review should give us better understanding of trends.

George Ward;

George Ward have affected outlets on;
Bedroom 3, 18 and Shower Rooms 35 & 37 – all pipework to be replaced (back to source) and is position continues, proposed works to introduce chemical dosing plant do to the longevity of the problem.

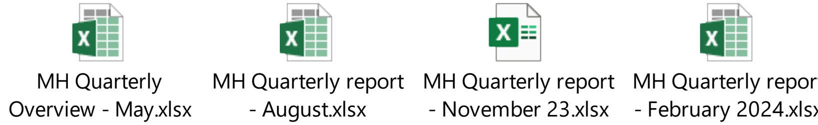
William Booth:

NOTE all outlets sampled show None Detected.

South PFI

The South PFI sites have continued to show clear results over the past quarter, below are the quarterly reports / sampling results formulated / taken by Equans.

Quarterly Sampling Results below:



Capital projects of note:

Location:	Description of works:
Ardenleigh	CAMHS Seclusion Suite new build project
Ardenleigh	Replacement Hot water cylinder to Prosper Building
Hertford House	Boiler Replacement works / various pipework replacement
Dan Mooney / David Bromley	Boiler Replacement works
Uffculme	Replacement Boilers to Vibe, Womens Therapy and Coach House
Warstock Lane	Replacement water Cylinders
Forward House	Installation of Klarolax dosing system / various works / Clinic room creation / Flat 1 – removed all associated services / sanitary ware.
George Ward	Removal of redundant Bath and removal of all associated services.
Eden PICU	Reinstated water cooler
Eden Acute	Removal of redundant Bath and removal of all associated services / replacement of toilets.
William Booth	Installation of independent hot water system / refurb of bathrooms
Reservoir Court	Removal of redundant Baths and removal of all associated services.
Little Bromwich	Carried out refurb works to various kitchens
Newbridge	Removal of redundant Baths and removal of all associated services.

LEE GOUGH

Head Of Facilities Management

Appendix 5

Food Safety Audit Report for IPCT

Trust Food Production and Ward Kitchens (2023/2024)

Author: Sue Ladkin

SSL Quality Compliance & Training Manager

Introduction

BSMHFT has its Catering Services delivered by In-house Service Partner SSL, PFI Partner Amey ('North' PFI Premises), Service Partner SSL and through SLAs with Birmingham Community Health NHS Trust (BCHT) for Juniper. PFI Trust sites on the North of the City are catered for by Bon Culina supplier changed in November 2023.

SSL food manufacturing facilities continue to implement and comply with the Food Safety Standards; they are also required to conduct internal audits of their Food Safety Management Systems. Lack of a properly designed or implemented internal audit program is one of the most common food hygiene non-conformances.

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

Key issues such as training of clinical staff in food handling, allergen awareness and the reporting and investigations following an eclipse, may contribute to the drop in standards which were a factor in the report findings. Food allergen management systems should be part of good hygiene practices and, where appropriate, HACCP systems. To mitigate or eliminate risks of food allergen cross-contact and inaccurate labelling issues, food allergen management systems should be in place. They should form part of good hygiene practices (GHPs) and, where appropriate, HACCP systems.

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

However, it is important to benchmark this report against the recommendations in the NHS 2019 Hospital Food Review. The Trust has well-established systems in place but, when under scrutiny, are found to be inadequate and require significant improvements. For the Trust to make advancements in food safety controls and compliance, our existing systems require constant application via the Trust Food Safety Group and IPCT, giving reassurance and verification that the system is working.

Ref - National Standards for Hospital Food and Food Safety, 13.2.2023 Phil Shelly.

"One of the eight standards included a requirement for organisations is to have a nominated food safety specialist. A number of questions have been asked by trust catering managers on how best to support structures on food safety expertise and how best to provide the experience and qualifications to protect the most vulnerable in our society when being in healthcare settings.

Our expectations are that trusts have a named Responsible Person, Competent Person, and Authorised Person with the Chief Executive Officer (CEO) being notified for assurance:

•*Responsible Person*: Catering Team Leaders/Managers should be trained to a level that provides a suitable responsibility to make day to day food safety and hygiene decisions on the catering activity within a healthcare setting. This level of staff would normally be trained at an intermediate level (Level 3 Food Safety Training).

•*Competent Person*: Catering Managers/Facilities topic leads should be trained to a level that provides an accountability for food safety systems, Hazard Analysis and Critical Control Point (HACCP) decision making and with the ability to train staff at a level 2. (Advanced – Level 4 Food Safety Training).

•*Authorised Person*: Food Safety Leads/Consultants/Ex-Environmental Health Officers (EHO)s that will be trained at the highest level. Able to lead training for managers, lead external audits and lead the decision making on Food Safety Management procedures/policies."

Plan

Audits -Food Safety planned audit calendar 2024, Production kitchens once quarterly, ward kitchens where practicable twice a year. Plan and reviewed the FM first and excel audit tools, used in ward kitchens and therapeutic kitchens (ADL), this audit shows a percentage score. It will identify any food safety hazards, where applicable photo supporting evidence, the potential risks and recommended control measures to reduce any potential hazards.

Establish the objective or define the scope of the audit and create an annual schedule. Selecting and training of the internal auditors are also key components of the planning step. Audits included are all the central production kitchen to verify that a HACCP system is working across Ardenleigh, Barberry, Reaside, Tamarind and Zinnia.

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

Allergy Policy - Waiting Approval from Trust. This policy now includes a Process due to EHO comments on failures found at Juniper in December 2023.

Final Draft due to be sent out April 2024 for final review.

Waste Planning -A Strategic Food Waste pilot scheme was introduced at The Barberry by SSL on 11/1/2022, to comply with the removal of macerators across the Trust. This will support data required for the ERIC return and aim to reduce food waste across the Trust, especially at ward levels, as recommended in the NHS Hospital Food Review 2019. This has been rolled out at all CPU units and Juniper, over 2023. Food waste recording at all Trust sites ongoing depending on site catering services and provision.

Planning Strategy -Trust Food Group Meetings. These are now in the calendar for bi-monthly meetings across 2023/2024. BSMHT Implementation Plan August 2023.

IPCT have not attended these meetings.

Do

- Implement the plan or execute the process, which involves the collection of information for evaluation. *The audit version was updated to include menus for allergen information data as legally required from Oct 2021.*
- SSL HACCP policy is under review, this commenced in Jan 2023 aiming to completed by May 2024 and will sit as part of the Food Safety Policy and once approved, will be included with the introduction of the electronic food ordering system. This should support the accurate allergen information being available on menus 24/7.
- The HACCP review also includes many changes to the HACCP CODEX General Principles of Food Hygiene code of practice,2020 which includes:
- New requirement for a positive food safety culture across the Trust
- New and revised HACCP definitions
- Enhanced training requirements to include allergen awareness.
- Enhanced Good Hygiene Practices requirements (inc. control of operations)
- New allergen awareness/management/controls
- New requirement for product traceability
- Enhanced customer education requirements
- Changes in HACCP principles and new requirement for validation of the HACCP plan: Source ref CIEH, WHO. codex@fao.org-www**codex**alimentarius.org

- SSL Management team has collaborated with suppliers of digital electronic food ordering systems that will be linked to patient records. One of the key recommendations for the implementation of this should be a reduction in waste. This method of food ordering should prevent food waste, in particular overflow in waste containers which will attract pests. Ref Regulation (EC) No.852/2004 on the hygiene of food stuffs requires that food premises be designed, constructed, and maintained in good repair and condition to prevent contamination by pests. In 2023 it was agreed that **Synbotix** would be the approved electronic meal ordering system provider for SSL and CPU units.

- Synbiotx "menuPick is an Electronic Patient Bedside Food Ordering System that can run off of any mobile device. The tool is a vehicle for creating an innovative, cutting edge & quality led patient catering experience. Food orders are taken electronically with the orders transmitted in real time to an operations console controlled by the catering department.

  - The system improves patient satisfaction by always delivering the first choice, & improves patient safety with digitally hosted diet, allergen, and nutritional information.

  - The system has been shown to greatly reduce food waste both in production and at the point of service." Catering/menuPick (synbiotix.com)
  - The system includes recipes and cooking stages which highlight allergens in dishes and cooking temperatures sign off as a CCP stage in meal production to maintain and follow HACCP principles and support Due Diligence.

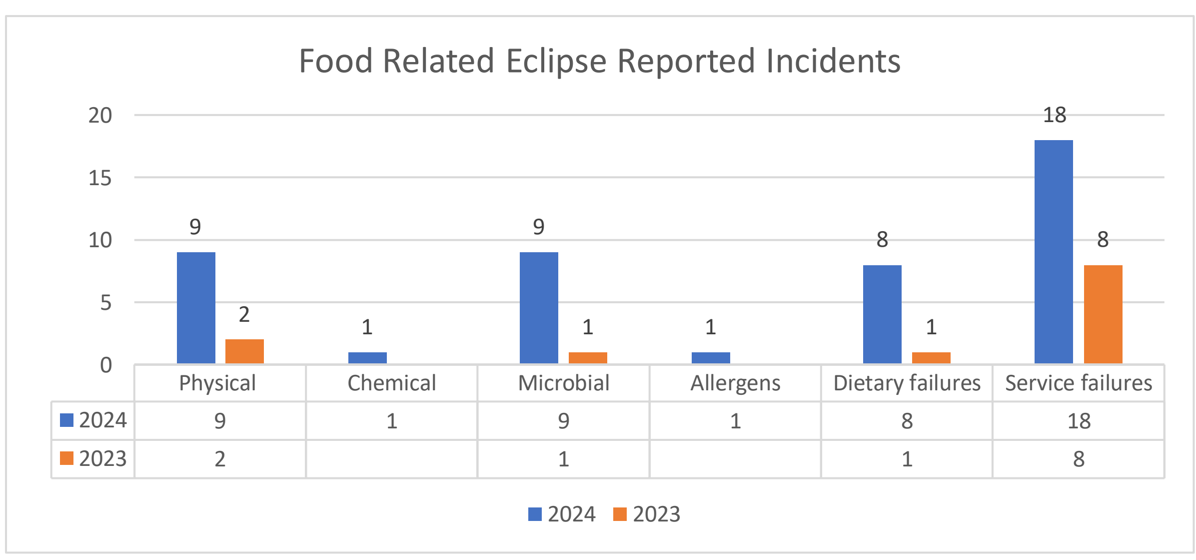
Check

- HACCP-This step includes writing the non-conformity report and assigning responsibility and deadlines for conducting root cause analysis and corrective action. The audit check included confirmation that CCPs (critical control points) are under control, reviewing any deviations and details of corrective actions taken, such as changes in food service at Trust sites where service users meals are being served at ward level, and not dining areas.
-

- (Currently an ongoing practice at **Reaside Clinic**, where meals are sent to ward in individual boxes similar to take away meals where **no** probing or recording of food temperatures are being monitored or recorded as is **legally** required). This is due to short staffing levels in clinical departments.
- All site HACCP documentation checks to be verified, this will support due diligence and ensures the food safety management system is compliant. The HACCP SSL (started January 2023 predicted completion April/May 2024 to coincide with Synbotix. This includes kitchen opening and closing checks, allergen information of service users, food, traceability, purchase, storage and correct labelling of foods, temperature checks cleaning schedules and training records to establish control methods are assured. Main SSL food production sites on inspection were found to have robust HACCP documentation, all have a system however documentation varies between sites. Standardization of the HACCP documentation is required. This is planned to be approved in 2024 and approved by the Trust Food Safety Specialist (**Post still outstanding March 2024**)

ECLIPSE

- Food Hazards, from March 2023– March 2024 all food related eclipse reports have increased from 12 total incidents to 46, by March 23/ March 24.



	Physical	Chemical	Microbial	Allergens	Dietary failures	Service failures
2024	9	1	9	1	8	18
2023	2		1		1	8

The Chart above illustrates the Food Safety Eclipse reports from March 2023 to March 2024, this has increased from 12 to 46 incidents since the last report. The hazards have been grouped as follows:

Physical Hazards:
Choking risks from incorrect level of blended/ textured meals being sent to wards.
Insects and other foreign objects found in food.
Chemical:
Unlocked Trolley at ward level where SU could have access to cleaning chemicals.
Microbial:
Under cooked foods concerns when high risk items were probed at ward level
Incorrect reheating of high-risk items in ADL kitchens by SU
Poor food handling practices observed in CPU kitchen around hand hygiene and gloves.
Allergens:
SU had severe allergic reaction after eating nuts – admitted to hospital.
Dietary Failures:
No Vegan Meals sent when requested.
Gluten free meals incorrectly labelled.
Vegan meal contained beef marked on label.
Halal meals incorrectly marked.
Service Failures:
Burnt items, inadequate quality of dishes.
Cold finger foods served for those in isolation, when requested hot items.
Short delivery of meals and late delivery
Change in service provision over Christmas.
Not enough food being sent down to wards.

Act

Follow-up with the corrective actions in the check step and verify that the corrective actions are effective and will prevent future re-occurrence. All inspections are reported with supporting evidence that the program audited either complies with or does not comply with the established Trust requirement or standards.

All audit summary reports were sent to management within 24 hours of audit that included findings from observations and any recommended actions. Where any breaches in the Trust Food Safety policy, Food Safety Legislation are identified action

will be taken immediately by IPCT and SSL Facilities Management (all food safety hazards to be eclipsed), see above table of results.

It was evident from the eclipse responses to the contamination hazards found in food from catering teams, that a more robust investigation process was required. The Catering Management are expected to study the findings so that assurance can be given to all involved, and that food produced for the Trust is safe. A Food Hazard Investigation Report for Food Related Incidents document is used for all Eclipse incidents dependent on the severity of hazards. As the Trust does not as yet have a named Food Safety Specialist the action for investigation has been reported to the Board and is listed on the Risk Register, 2023/24.

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

Other Actions

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

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

All production sites are given a minimum of seven days or less depending on severity to take appropriate actions on any recommendations. All site managers are given a verification audit date in advance, as recommended by HSE/EHO. (No audits were unannounced).

EHO Review 2023/24

All previous EHO inspections of food production kitchens, scores on the doors across SSL have been 5/5.) Amey site audits finds HACCP is current, valid, and implemented.

In 2023/24 The Barberry Centre, Zinnia, Uffculme, Reaside and Juniper Centre were inspected by the EHO Birmingham Dept. All sites scored 5/5 with the exception of Juniper Centre that scored 1/5 in December 2023 along with the Juniper Café Shop 1/5.

Both Ardenleigh and Tamarind CPU are due an EHO visit in 2024 as last visits to these sites was in 2019.

Actions

A team of Clinical Staff and SSL, E&F departments worked with Moseley Hall (Meal provider to Juniper) to review all the findings and implement a sturdy action plan which included the training and review of HACCP, purchase of new probes, food service and handling across the site. Juniper Centre on re inspection was rescored 4/5 in Feb 2024. The Juniper shop, which is independently managed, still shows a score of 1/5 and is under review by SSL/Trust/ IPCT and is currently not serving any hot food. All cooking ceased in the ADL Therapeutic kitchens at Juniper immediately after the inspection. All staff that handle food completed the CIEH Foundation Level 2 Food Safety Training and the FSA Allergy Online training. SSL produced ward and Ward ADL HACCP daily food safety books to be implemented and used as daily food safety monitoring documentation. Another food safety action introduced to this site was to prevent the risk of cross contamination and mis labeling information on cereal boxes, staff were instructed to order cereals in individual boxes for breakfasts. Allergen Matrix posters are used for breakfast service to denote which allergen may be present in the items.

Inspection Observations & Recommendations

SSL Food Production Kitchens

The inspections include both food safety/hygiene and food allergens labelling and available information. They are based on the following topics of which are currently considered by the local EHO when undertaking an audit inspection:

- Food hygiene and food safety procedures
- Cleanliness and structural compliance
- Confidence in Management
- Additional information on food safety procedures at ward level, therapeutic kitchens and community sites may be found in the relevant sections of this report.

Production Kitchens – Food Safety & Food Hygiene.

SSL Management teams are working towards the implementation of an electronic Catering Management System so that all sites observe the recommendations in the hospital food review 2010. This includes a HACCP review for 2023/2024 which includes food safety assurances from the supplier base and drives improvements where necessary, Synbotix is the approved supplier. A standardized HACCP daily document is required across all CPU units.

Changes due in 2024.

- Sandwich Provision – since the 2019 Hospital Food Review, sandwich production and safe handling and storage of chilled items has been under review and challenged by audits. SSL have decided that moving into 2024 that Real Wrap Company will provide all sandwiches.

This will ensure that all prepacked ready to eat items are labeled correctly to meet current legislation under Natasha's Law. All sites **must**:

- A provide allergen information to the consumer for both prepacked and non-prepacked food and drink.
- handle and manage food allergens effectively in food preparation.
- "Foods that are Pre-Packed for Direct Sale Food is considered prepacked when it is put into packaging before being offered for sale and:
  a) is either fully or partly enclosed by the packaging; and
  b) cannot be altered without opening or changing the packaging; and
  c) is ready for sale to the final consumer." FSA website.

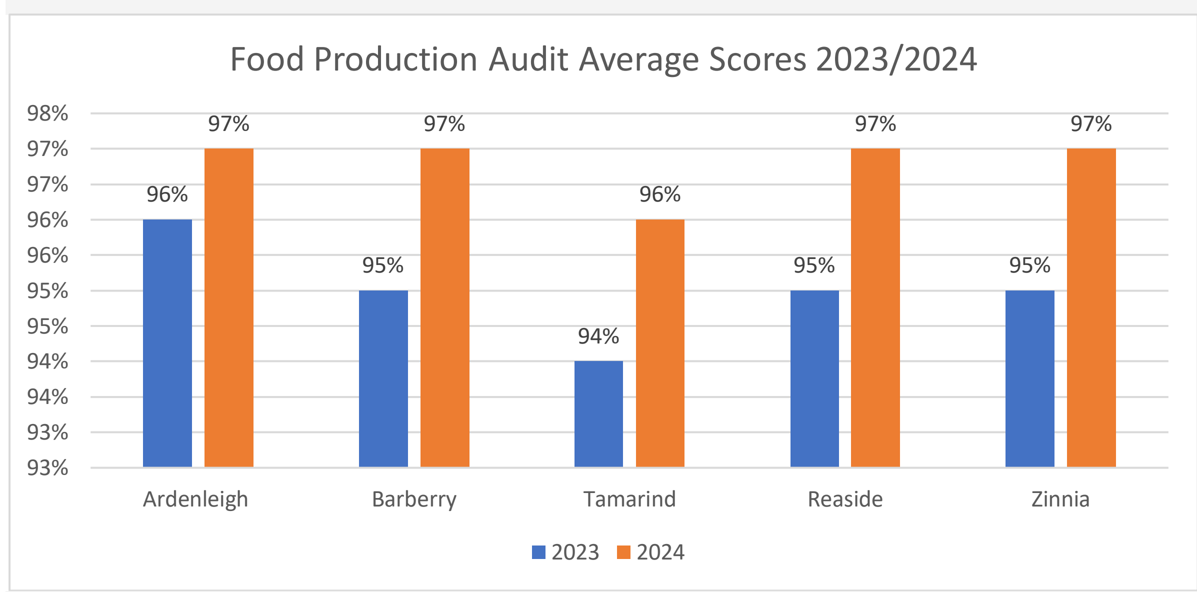
- Some considerations for food allergen management include, but are not limited to, equipment, segregation, cleaning, and training.

- Laundry – due the ongoing issues with the Trust Laundry Services Provider some catering staff were washing chef uniforms and aprons etc at home. This is not part of the linen contract and has been highlighted to IPCT . New Laundry and Linen services are due to start with a new provider in April/May 2024,this issue will be monitored and is ongoing. Personnel and their protective clothing can unintentionally act as allergen cross-contact vectors within a food processing environment, so it is vital that personnel are well-trained in, and adhere to, best practice processes and procedures.

- SSL Production kitchens are reviewing recipes that use blast chilling as a stage to limit the dishes that use this method of cooking and preparation to lower the risks when reheating high risk food items . The items where this method of cooking and chilling dishes such as joint of meat, meat pie fillings have been added to the reviewed recipes as a HACCP stages that requires sign off , this has been migrated into the Synbotix system.

- Hygiene standards are maintained and on quarterly inspections have increased over the last 12 months.

Food Safety Quarterly Audits CPU March 2023 – March 2024



CPU SSL Sites

ARDENLEIGH – Last EHO inspection 5/6/2019 scores 5/5

The production kitchen is lacking in storage space. Correct food storage is essential for a hygienic efficient food business because the rate of food spoilage is affected by temperature, humidity, stock rotation practices and the integrity of packaging. The current dry goods are stored in 2 rooms adjacent to the back delivery area which are full and at capacity. The poor design and layout of the kitchen in general, and the food waste weighing area is likely to lead to cross contamination and to food safety being compromised in the future. Limited space results in inadequate control measures in place to prevent cross contamination, especially when deep frying foods. There is only one fryer on site, and verbal reassurance that frying baskets, tongs and known food allergens are segregated on Fridays was given on audit. However, when battered items and chips are on at the same time of day there runs a high risk of cross contamination. Other audit observations found frozen items unlabeled and not dated (bread rolls) when items have been decanted from original packaging in freezers.

Observations from audits raised concerns that residual food allergens can remain on equipment, so cleanable and/or dedicated equipment should be used. The site

generally fit-for-purpose, but requires hygienically designed equipment, such as sink and another fryer which does not allow for food allergens to get stuck or accumulate and facilitates effective cleaning with appropriate agents.

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

There is only one main food preparation sink where salad items are washed and then cooked items such as rice are drained. At the start of 2023, a new hot counter and service point was fitted, and a chilled bespoke salad bar is now located in the dining area. When sandwiches are provided by Real Wrap (expected to commence April 2024) this hazard should be considerably reduced.

Rookery Gardens now employ housekeepers since Feb 2023, that are responsible for completing the relevant HACCP documentation. As a recovery site the correct guidance and monitoring of service users continues to support food safety and issues and any areas of concern are raised on an eclipse as standard. Last audit in March 2024, verified that monitoring of kitchens is ongoing in a supportive environment and SU are encouraged to maintain a safe, hygienic kitchen area. Recommendations are that all housekeepers have Level 2 in Food Safety and FSA Allergy Awareness Training.

BARBERRY – Last EHO inspection 14/7/2023 scores 5/5

Production kitchen has no major concern in food production. On closer inspection, however, sandwiches and items made for buffets and wards were not clearly marked for allergens. This required immediate action, hence Realwrap are now providing sandwiches and salads at The Barberry. Ward level salads and jacket potato fillings are portioned and dated but were found not labelled with known allergens which requires immediate actions.

The personal hygiene of staff requires strict enforcement by supervisors and daily monitoring. The correct use of PPE, including wearing use of hair nets and hats is

required as part of the Trust Food Safety Policy, and this practice is sometimes not always observed.

Housekeeping teams have been trained to try and reduce waste through portion control. The food waste project to recycle food and reduce food waste across the Trust commenced in Jan 2023, as food waste macerators are removed from sites. There has been no increase in pest activity recorded by the change in this process. This system of food waste management has been rolled out across all SSL food production kitchens and wards. This training will be ongoing along with the Electronic Food Ordering system – Synbotix during 2024.

REASIDE – Last EHO inspection 16/5/2023 scores 5/5

Production kitchen found with sinks out of order in the cold preparation area, this has been ongoing throughout 2021/2022/2023 and is still ongoing. Drains and sinks across this site are a continuing problem, the concerns about safe water management have been reported to Estates. The roof above the main kitchen dishwasher had also been repaired a few times and on last audit was still found with large hole in ceiling. At certain times during this period all meals for service users were being served at wards levels, due to short staffing levels. This started in the first lockdown and is continuing as observed on 11/04/2022. Meals are selected from the menu by service users and are then sent in individual take-away boxes, wrapped onto cling film trays, and carried to wards by porters. Having monitored the process I am reassured that safe hot holding temperatures above 63◦c is being maintained when serving food, but this site is not a takeaway, and this practice is unacceptable in the long term. Recommend business as usual, this site does not have the capacity or facilities to use hot trolleys and employs no housekeepers, therefore high risk hot and cold items of food are not probed and temperatures at ward level, which is a major breech in **HACCP legislation**, CCP controls (with the exception of Severn ward.)

This requires action to address the non – compliance of food service. The significant food safety hazards are not fully understood, as not all controls are in place at ward level. It also contributes to an increase in waste collections due to meal packaging.

The HACPP review is actioned with the washing of salads and fruit items in a chlorine-based wash. (Currently this stage has been removed and items are washed in cold water only as a precautionary control method).

Meals are produced by Reaside for Hillis Lodge and conveyed by SSL.

TAMARIND - Last EHO inspection 31/10/2019 scores 5/5

Main production area, no areas of food safety major concerns, some areas of cleaning needed minor improvements. Site produces a large quantity of sandwiches in a chilled room and is producing own labels. Audit findings show no major concerns, at this site some meals are served at ward level and in the dining room. Tamarind catering provide meals to Newbridge House and any food incidents are recorded or eclipsed depending on severity.

ZINNIA – Last EHO inspection 6/6/2023 scores 5/5

Main production kitchen no food safety concerns. This site had a rodent infestation which was reported in Feb 2023, no pest evidence since activity was actioned. The food production site used environmental controls, and pests were eradicated by the contractor. This situation is monitored and regularly verified by the Pest Prevent Contactor as part of the daily routine site kitchen checks.

AMEY- Since January 2023, the housekeeping staff at Amey commenced training in CIEH Foundation level 2 and NHS new cleaning standards training. Amey requires a review of their HACCP as they move from cook/chill to cook /freeze meal provisions.

Duty of Care visit conducted by SSL staff to Bon Culina site in November 2023 as new supplier to Amey sites a report was sent to IPCT on visit results.

COMMUNTITY SITES

Juniper – review of EHO findings, requires an action plan for improvements in food operations, handling, and management. Collaboration between SSL, Trust, and Moseley Hall to provide assurance and due diligence to EHO.

The findings from audit observations recommend that all community sites and ADL/ Therapeutic kitchens follow the same HACCP guidelines as advised in SFBB via the Food Standards Agency. In particular information that should be site specific on:

- Ingredients/recipes/formulation
- Purchasing of food items – listed reputable suppliers (most when questioned said "Tesco online"
- Raw materials
- Storage conditions – not following Manufactures instructions on packaging.
- Processing conditions
- Packaging
- Shelf life – use by and best before dating in ADL kitchen.
- Service user instructions.
- Housekeeper instructions on regeneration and cooking, defrosting etc.
- Textured meal provision
- Intended use of the products for vulnerable groups
- HACCP flow diagram – site specific as the Trust sites are diverse in their nature.
- Control measures for potential hazards: Microbial, Physical, Chemical and Allergenic
- Determine and establish the critical control points.
- Monitoring and documentation required to verify the safe processes.
- Determine roles and responsibilities at each site for food safety.
- All sites to order individual boxes of cereals to prevent allergic reactions and risks from cross contamination.

There may be other requirements for ADL kitchens and sites where service users purchase food that may be stored in bedrooms or accept foods from friends and family and takeaway delivered foods. These may also be a route cause of potential food safety hazards.

Across the community sites where meals are prepared and cooked by HCA, Housekeeping and SU, staff should segregate their processes according to different aspects, including, where feasible:
• **Space** — Place foodstuffs that do not contain allergens on shelves above those that do contain allergens and, if possible, separate their storage and handling areas. If possible, use dedicated equipment and processing machinery.

• **Time** — Where it is not feasible to have designated times for products of differing allergen profiles such as making toast for those who require gluten free bread, pay attention to the sequence of different processing steps, such as the order of different meals and where cleaning falls within this, aware that cloths and other materials are used to prevent contact with those items containing those food allergens.

• **Personnel** — Where possible, dedicate different personnel to tasks involving foodstuffs that do not, and those that do.
For foods served at Ward level by housekeepers, SSL have produced a draft ward food safety book that would be completed monthly. This has been trialed in April/May 2023 and has been adapted to be site specific, for ADL activities and used at community sites to give assurance to Food Safety Management across BSMHFT sites. To introduce a HACCP book at all sites will require sign off from the Food Quality Group, IPCT and the Food Safety Specialist.

- There are also amounts of milk and bread at ward levels, on inspection found past best before and not following FIFO principles. This was found to be a Trust wide issue and stricter stock controls and ordering has been raised to the Management Teams at SSL and Amey, for these items.
- Birthday Cakes – SSL have limited the choice of frozen birthday cakes that are available to service users (from March 2024) to prevent risk of allergic contamination and standardization across the Trust.

The Sandwich HACCP audit findings

A review of sandwich production across SSL was conducted alongside the planned audits. After the outbreak of listeriosis in 2019 hospitals cannot contract out their food safety responsibilities and take into consideration all stages of the supply chain and service.

The making of sandwiches tends to be an assembly -only type of operation, with food service outlets purchasing ready cooked items such as cooked meats and cheeses, which are then assembled into finished products. Across SSL sites it is recognised that some outlets will be making sandwiches from scratch and in some sites provide a hot eat option (for example toasties and panini's). Bread carriers such as rolls, wraps and buns are also used and often salad items and vegetables are added. These are often purchased raw and then washed on site before used in the

final product. This HACCP document will be used from October 2022 in light of the recommendations from the NHS Food review 2019. The information will support the Food Safety Management Audit, giving comprehensive information on the safe production, handling, storing and principles of HACCP of sandwich production.

On inspection of HACCP temperature records, audits found that eggs cooked for salads and sandwich fillings were not probed once cooked to ensure core temperature of 75◦C and above. Audit recommends that all sandwich fillings that contain eggs are to be purchased from Trust nominated supplier and chilled to 8◦C and below on receipt, delivery, and storage. (Report available on request)

Other items

- All SSL staff have been trained in Acrylamide as a toolbox talk with reference to the information on FSA. Oct 2022
- Food Safety presentation on Listeria Awareness in support of Trust IPCT Link worker day. (Completed 10/02/2022 Sue Ladkin)
- All ward and food production kitchen audits are sent to sites and Infection Prevention teams with photographic evidence to support the Food Safety of BSMHFT.
- CIEH Food Safety Level 2 training delivered to HCA and Housekeepers at Hillis Lodge, Juniper and Amey as requested by their individual Matrons and Managers.
- Where sites prepare, produce, or sell food items for charity events such as bake sales and BBQs a HACCP has been produced for such an event. The draft copy is attached and has been used as a trial at Barberry (March 2023). This document covers areas such as traceability, allergen information etc.
- Trust Food Safety Policy review due date March 2024, which currently sits with IPCT Department.

Recommendations:

- That all food handlers have a legal responsibility to make sure the food they prepare and serve is safe to consume. The role of any supervisor across the Trust is to help to establish, implement and communicate policies and procedures on supplier and customer specifications, delivery, storage, stock rotation, dating systems, cleaning, and temperature control. They should train

staff to check deliveries and respond to anything unsatisfactory, for example signs of spoilage or damaged/contamination of stock including takeaway foods and items to be cooked in ADL by service users themselves.

- Managers have a duty to monitor staff as they carry out food handling procedures and give disciplinary and corrective actions if necessary. By checking, auditing, and reviewing the systems, and where appropriate, taking corrective actions food safety standards will be maintained.
- The Independent Review of NHS Hospital Food (2020) summarises the main legislation related to food safety which Trusts must be aware of
- The review recommendations states:
- *"The outbreak of listeriosis in 2019 has led to a thorough investigation of what happened and why. To help avoid a repeat episode, purchasers must have an effective mechanism in place to assure food safety within their supplier base and drive improvements where necessary to ensure all businesses supplying high -risk foods meet the highest standards.*

a. There must be open and speedy communication channels for food safety concerns between auditors, local authorities, Public Health England, Food Standards Agency, suppliers, and trusts, with appropriate governance structures to ensure concerns are acted upon swiftly.

b. Every Trust must have a nominated food safety specialist and a named board member responsible for food service.

c. A mandated reporting procedure for food safety concerns for trusts and suppliers must be established, with penalties for not reporting issues.

d. Raise standards of food safety audits for high-risk food manufacturers, so that they give confidence that the legal and contractual requirements are being met.

*e. **Trust must recognise their obligations as food business operators** and ensure effective compliance with robust food safety procedures in place at all levels, which must be understood, enacted, and verified."*

Going forward the review recommends:

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

b. The expert group maintains momentum and provides support for hospital caterers, dietitians, and nurses.
c. The expert group to be responsible for propagating the core principles of good food service throughout the NHS.
d. The expert group to be funded and staffed.
e. The expert group to be accountable to the Secretary of State for Health and Social Care.
f. The expert group to publish a post-implementation review."

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

- Training- CIEH Level 3 Intermediate in Food Safety for Ward managers and all staff that prepare, cook, support, and supervise others.
- Training - CIEH Level 2 Foundation in Food Safety for all staff that handle food and to complete the FSA online allergen training Food Standards Agency food allergy online training
- Standardisation of meal service – Through the expert food safety group especially in community kitchens, OT/ ADL areas where HACCP assurance is considerably variable and inconsistent across the sites.
- Control of documentation and supportive information – such as allergens on menus and traceability of food items, take aways, just eat etc.
- Testing methods – Food sampling for Listeria in pre prepared food items such as sandwiches and salads to be outsourced.
- Documentation procedures – HACCP policy review 2024
- Food Safety Policy – Review due March 2024
- Inspections & Audits: Review as part of ongoing due diligence when and where needed.
- Actions on deviation, follow up and verification reports required by all parties.
- Eclipse – requires standardised investigation reporting documentation (draft attached) and the correct escalation of the process.
- Trust Food Safety policy – to include amendments **Allergen Policy**, HACCP updated policy and procedure.
- Chemical standardisation (COSHH regs) across all Trust sites to continue to assure the correct methods of cleaning and disinfection are observed.
- Salad washing in chlorine-based wash to be reviewed with IPCT and guidance from EHO.

- Ward food service HACCP books to be implemented across the Trust to standardised food safety. The audits identified that where foods are served at ward level there is inconsistency in hand hygiene, bare below the elbow, and food safety knowledge . Ward fridges have contained items of food that are unlabelled, undated, and incorrectly stored. Standardisation of HACCP is essential, and the Trust is aware of the variability of employers of housekeepers, SSL, Amey, and Trust HCA etc.
- Fund raising events – guidance catering pack and HACCP required to include Risk Assessments sign off from Trust H&S department.
- Where sites have pets in the community, they require preventative control measures in place to prevent any hazards from contamination.
- The expert group to maintain momentum and provide support to hospital caterers, dietitians, and nurses. The Trust has a Food Group where food safety issues are reported to . This group is not attended by IPCT and is not classified as such . **Meetings have been cancelled for this group and are currently planned Bimonthly.**
- Food Safety Group implement one of the eight standards included a requirement for organisations to have a **nominated food safety specialist.**

Author Susan Ladkin SSL Facilities Training and Quality Compliance Manager (Estates & Facilities) March 2024.

References

Report of the Independent Review of NHS Hospital Review, 2020

Hospital Caterers Association

Food Standards Agency

Chartered Institute of Environmental Health

Codex Alimentarius CX 1-1969 revised 2011

BSMHFT Trust Food Policy

NHS website https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food

Regulation (EC) No.852/2004 Article 5 HACCP

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Website: www.bsmhft.nhs.uk

Committee Escalation and Assurance Report

Name of Committee	People Committee
Report presented at	Board of Directors
Date of meeting	2 October 2024
Date(s) of Committee Meeting(s) reported	18 September 2024
Quoracy	Membership quorate: Y
Agenda	The Committee considered an agenda which included the following items: • Staff Story • Board Assurance Framework • People Dashboard • People Strategy Update • Transforming our Culture and Staff Experience Group Assurance Report • Freedom to Speak Up Guardian Report • Women's Network Report • Shaping our Future Workforce Committee Assurance Report • Safer Staffing Report • Internal Audit Review: Bank Staff Management
Alert:	The Committee wished to alert the Board of Directors to the following key area: • Concern was noted around levels of sickness absence, particularly as a high proportion of absence was related to anxiety, stress and depression. The Committee highlighted concern about staff wellbeing. Some assurance was provided on sickness absence management, including training and coaching to support employees and managers. The Committee would receive further updates on the implementation of actions to support staff wellbeing.
Assure:	• The Committee was assured by the management responses and actions that had already been implemented from the internal audit review into Bank Staff Management. • Assurance was provided on the delivery and monitoring of the People strategic goals. • The Committee was assured that internationally recruited nurses were well supported, with focus on retention, preceptorship and pastoral support. • Assurance was received that all staff who accessed the e-rostering system would be required to complete e-learning on SafeCare and e-rostering by 3 January 2025; this would provide assurance that staff were trained and understood how to complete a safe and effective roster. New staff would be required to complete this training before system access was granted.
Advise:	The Committee received an update on activities and plans from the Women's Network, which would be celebrating its second anniversary in November. The Network had developed some very positive initiatives for the Trust, including the implementation of breathable uniforms as part of the Menopause Project. The Network was discussing other support offers, including baby loss and caring for

Birmingham and Solihull Mental Health NHS Foundation Trust

<table>
<tr><td></td><td colspan="2">elderly relatives. The Committee also noted the Network's first Women's Conference scheduled for 7 March 2025.

The Committee received some assurance on the introduction of 'stay' conversations with potential leavers and how soon these took place as part of the Trust's retention strategy.</td></tr>
<tr><td rowspan="2">Board Assurance Framework</td><td colspan="2">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 risks would be presented to the Committee in November, in preparation for Board approval in December.</td></tr>
<tr><td colspan="2">New risks identified: No additional risks were identified.</td></tr>
<tr><td>Report compiled by:</td><td>Sue Bedward, Non Executive Director</td><td>Minutes available from:
Kat Cleverley, Company Secretary</td></tr>
</table>

<table>
<tr><td colspan="6">Report to Board of Directors</td></tr>
<tr><td>Agenda item:</td><td colspan="5">13</td></tr>
<tr><td>Date</td><td colspan="5">2 October 2024</td></tr>
<tr><td>Title</td><td colspan="5">Freedom to Speak Up Guardian Report</td></tr>
<tr><td>Author/Presenter</td><td colspan="5">Emma Randle, Lead Freedom to Speak Up Guardian</td></tr>
<tr><td>Executive Director</td><td>Lisa Stalley-Green (Director of Quality and Safety & Chief Nurse.</td><td>Approved</td><td>Y</td><td>✓</td><td>N</td></tr>
</table>

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

Summary of Report					
Alert		**Advise**		**Assure**	☒

Purpose

To provide an update to the Board of Directors on the reporting of concerns to the Freedom to Speak Up Guardians. Learning from cases handled by the Guardians is shared for continuous learning and improvement. Recommendations to improve the Trust's speaking up arrangements and removal of barriers to speaking up have already been addressed and assurance provided in September's TOCSE Committee.

Introduction

Freedom to Speak Up Guardians are responsible for taking action to promote the following:

Colleagues throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up

Speaking up policies and processes are effective and constantly improved

Senior leaders role model effective speaking up

All colleagues are encouraged to speak up

Individuals are supported when they speak up

Barriers to speaking up are identified and tackled

Information provided by speaking up is used to learn and improve

Freedom to speak up (FTSU) is consistent throughout the health and care system, and ever improving

Key Issues and Risks

Themes from our casework highlighted that staff were facing barriers in securing exit interviews prior to their departure. Managers provided assurance in the TOCSE committee in September 2024, that uptake of exit interviews and analysis of any barriers is already monitored and reported on as a KPI in the SFW committee. Action is already being taken and includes trialing whether colleagues themselves can enter their termination date versus their managers.

Improvement action has also been taken to increase the low uptake of staff who remain in bank positions. The team expect to see improvement in the number of returned exit questionnaires shortly.

Recommendation

Our recommendations in seeking to unblock barriers to speaking up when staff leave the organisation has been addressed by managers who have since provided assurance that work to address this is currently underway.

Therefore, there are no further recommendations in this report.

Enclosures

N/A

FREEDOM TO SPEAK UP GUARDIAN REPORT

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

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

1. INTRODUCTION AND BACKGROUND

1.2. This report provides an update on activity from the Trust's Lead Freedom to Speak Up Guardian (FTSUG) following the previous People and QPES reports. This report covers Quarter 1 (April-June 2024).

2. WHO IS SPEAKING UP TO THE SPEAK UP GUARDIANS?

2.1 The Freedom to Speak up Guardians have received **110** speaking up concerns. Last quarter this was 93 cases suggesting we continue to be perceived as a trusted alternative route.

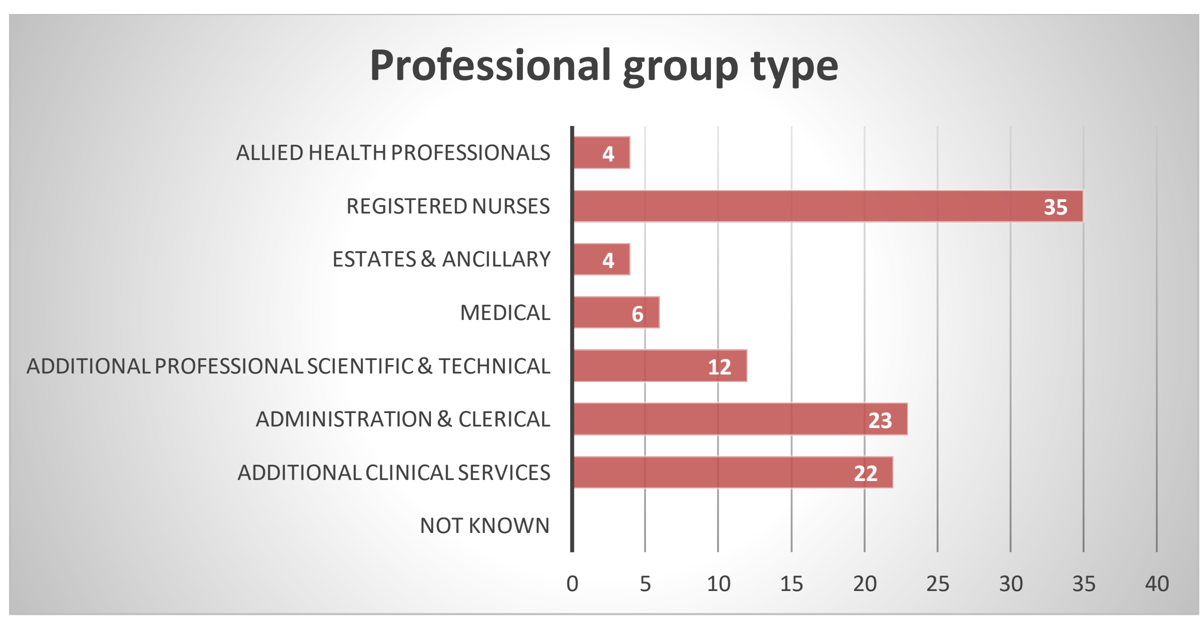
2.2 Guardians are only one route of speaking up and other routes are embedded within the organisation.

2.3 Two colleagues who sought support and guidance were signposted to the Values in Practice initiative.

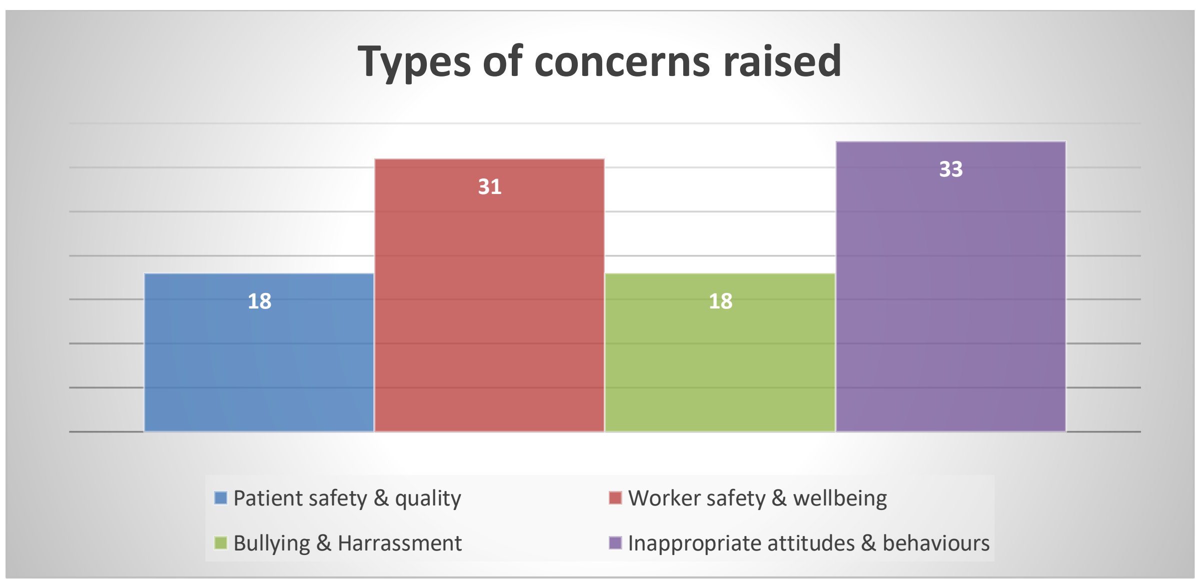
2.4 Guardians seek information on actions taken by managers and leaders and feed this back to speakers. This evidences that concerns have been actioned and provides assurance to the Guardian who reports on learning and improvement.

2.5 This quarter we received five enquiries from our Champions seeking further advice and guidance regarding speakers who had contacted them. If enquiries appeared to involve more than signposting and listening, speakers were directed to the Guardians.

2.6 Below is a breakdown of data; with concerns raised by professional grouping:



Colleagues from a range of professional backgrounds have raised concerns but our Nurses continue to account for the biggest proportion overall. Administration and clerical are second largest then followed by Additional Clinical Services with this group including Health Care Assistants and other patient facing staff. This is in line with 23/24 national figures [1]



The above graph shows that concerns that have an element of inappropriate attitudes and behaviours make up the highest proportion this quarter. This category includes themes such as disrespectful attitudes, incivility, micro-aggressions, unhelpful communication styles, relational conflict and unprofessional behaviour contrary to our values.

The next highest category is worker safety which includes themes such as stress and anxiety, burning out, the effects of bullying and harassment, inappropriate attitudes and behavior's affecting health, wellbeing, and performance at work.

3. ANALYSIS OF OUR TRUST WITH NATIONAL COMPARATORS

3.1 Seventeen percent of concerns featured an element of patient safety and quality this quarter roughly in line with last quarter (19%) and in line with the national figure of 18.7%.

1 FTSU-Case-Data-Annual-Report-23-24-1.pdf (nationalguardian.org.uk)

3.2 Bullying and harassment remains a cause for concern reported to make up about 16% of our enquires, against 22% nationally. We have seen a 6-percentage point fall from last quarter.

3.3 Worker safety and wellbeing was a feature for almost one in every three cases like the national figure. Staffing levels remain challenging in some areas and increased workloads are common themes reflecting the known system pressures. Incivility, poor behaviours including bullying and harassment can result.

3.4 Few colleagues raise concerns anonymously amongst the cases we handle. We received one anonymous voicemail this quarter, significantly below the national figure of 9.5%. Most colleagues raise concerns confidentially with us suggesting we are seen as a trusted and independent route.

3.5 Only 2% of enquiries we handled this quarter indicated detriment. This is half the national figure of 4%.

4. TYPES AND THEMES OF ISSUES RAISED

4.1 Hotspots where patient safety/ quality issues were concentrated have been fed back to the Emerging Risks group with intelligence held by the Patient Safety team. This information has been triangulated with legal and inquest data, safeguarding, complaints, pharmacy, health and safety compliance and patient safety. Other themes are as follows:

- Recruitment concerns to include one anonymous voicemail about a team manager appointment at a CMHT hub.
- Incivility and bullying behaviors
- The handling of reasonable adjustment requests by line managers
- High acuity and insufficient staffing levels on Coral ward, Ardenleigh
- Descriptors leading to the risk of developing a “closed” culture across North wards.
- The timeliness and responsiveness of managers in acknowledging concerns raised by staff at Reaside.
- Staff unable to access exit interview
- A lack of ownership as to who is responsible for updating the out-of-date Patient and Carers leaflets on display around the Trust.

- Negative feedback from a range of staff who have been through a formal HR process. Examples include insufficient feedback; protracted timelines, and poor communication throughout the investigation life cycle.
- Several staff have said that they would not speak up again through a formal process about bullying and harassment as it is “damaging” and “harmful to their mental wellbeing” and workplace relationships.

5. IMPROVING OUR SPEAK UP CULTURE AND ARRANGEMENTS

5.1 We have held drop in FTSU surgeries, and listening events at Mary Secole, Venture House pharmacy and Eden and George wards. We also hosted an Open Day at Ardenleigh on April 9th followed by night surgeries at *F*CAMHS and *C*AMHS.

5.2 We adopt an intelligence led approach when planning surgery work. This work is also informed by the NHS Staff Survey results.

5.3 We continue to raise awareness of the Guardians as an alternative route and attended the Maternal Mental Health Service MDT, the Perinatal MDT, the business development meeting at Longbridge Health & Wellbeing hub, and manned a stall at the Medical Celebration event on June 24th. In April, Lucy was a guest speaker at the operational Criminal Justice Recovery Service meeting.

5.4 Our induction activity has seen us take part in the corporate and student nurse induction events.

5.5 We are making progress with our FTSU improvement plan. Agreed at Board level, this plan sets out a number of objectives enabling the organisation to gain greater assurance about our speaking up culture, improving quality and consistency of how we embed speaking up into everyday practice, creating an excellent place to work, and providing high quality care for our service users and families.

5.6 On-going actions include work on an accessible FTSU handbook for managers (Listen Up toolkit); plans to relaunch the “Pull Up A Chair” initiative in the autumn; reviews of FTSU closed cases with key stakeholders such as Non- Executive Directors for learning and improvement; re-established links with CQC inspectors and the updating of comms plan ensuring targeted key messages and campaigns are shared within the system.

5.7 NHS England required all Trusts to adopt the new template of the Speak up policy for the NHS. This has now been integrated into the existing policy and is available to all staff.

5.8 At July's People Committee, the FTSU Governance framework for reports was agreed. In summary, the TOCSE committee will receive the FTSU Guardian`s reports, for noting, information and to identify suitable actions to address any concerns that have been raised as well as prepare relevant management assurance for the People and QPES committees respectively. It has been agreed that this instrument will be in place as a safeguard to protect the independence and integrity of the FTSU Guardian from any undue influence and/or pressure or requests to amend their reports or direct work.

6. SUPPORTING AN INCLUSIVE SPEAK UP CULTURE

6.1 We continue our out of hours surgery work targeting our clinical areas capturing our colleagues on nights and long days as well as bank, estates, and facilities staff who may find it harder to speak up and do not have regular access to Trust comms and a computer.

6.2 This quarter we received a high number of enquiries from TSS bank staff.

6.3 Our student nurses face unique barriers to speaking up. This quarter we have worked in partnership with the Practice Placement Team (PPT) seeking to broaden their understanding of the roles and responsibilities of the Guardians and FTSU Champions. Our first student nurse Champion is actively supporting her peers on placement.

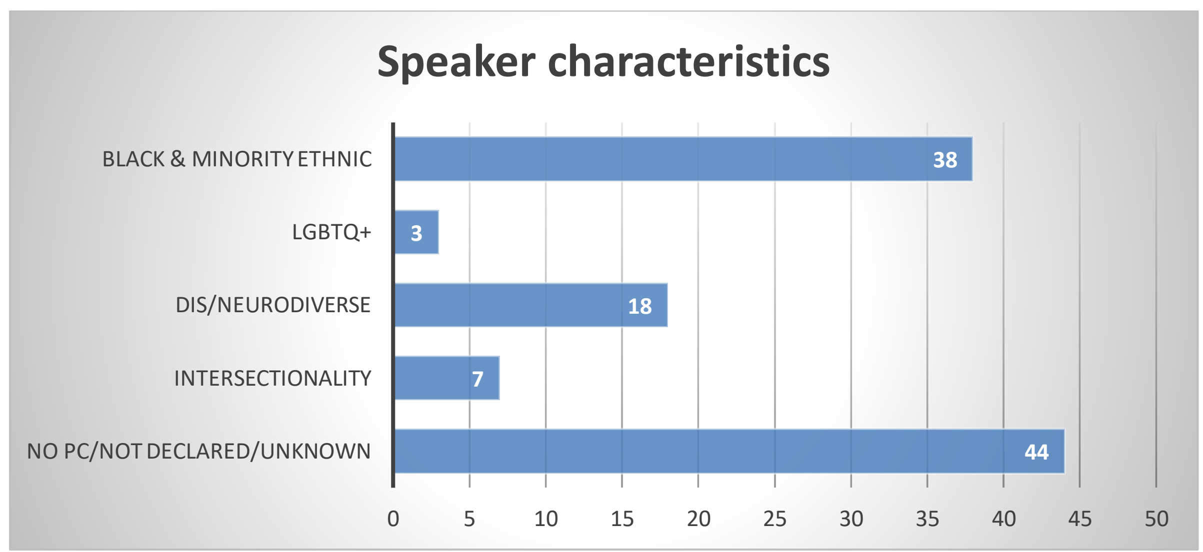
6.4 Increasing their cultural competency, the FTSU team have undertaken the Transgender Awareness training.

6.5 We continually monitor the protected characteristics[2] of our speakers, committed to ensuring our arrangements are inclusive. This quarter, more of our Black and minority ethnic speakers accessed the service compared to the last quarter (35% versus 22%- of those we recorded and knew about).

[2] The PC we monitor are, race, disability, sexual orientation and pregnancy/maternity as defined under the Equality Act 2010.

Birmingham and Solihull Mental Health NHS Foundation Trust

Below is a breakdown of this data:



6.6 Our staff that identity as having a disability or long -term health condition is nearly double (16% versus 9%) with the overall year on year trend increasing. There is a small decrease this quarter amongst our colleagues who identify as being part of the LGBTQ community, with 3% of all speakers accessing the service versus 5% last quarter.

6.7 Seven colleagues with intersectional characteristics accessed the service nearly double the amount of last quarter. Most reported having a disability and being part of the Black and minority ethnic community, with one colleague reporting to have a disability and being part of the LGBTQ+ community, and one Black & ethnic minority colleague belonging to the LGBTQ+ community.

6.8 We now have 17 Champions in our inclusive network, welcoming three more colleagues this month after their national foundation training, with one Champion leaving the Trust. Of our new recruits, one is our first international nurse based at Ardenleigh, one works in HMP Birmingham, and the other is our first Champion based in the Commissioning and Transformation Division.

6.9 We constantly evaluate where our Champions are located and the nature of their substantive posts. This enables us to identify where and what type of gaps there are enabling us to tailor recruitment.

7. ORGANISATIONAL LEARNING – originating from FTSU enquires/ concerns

7.1 A new initiative called "Today's outlook" has been launched across the Ardenleigh site. Critical real time information about staffing levels, updates from daily staff huddles and other relevant safer staffing intelligence is provided in this email briefing. Managers and leaders have developed this communication as a response to continued staffing concerns and enquiries.

7.2 Our Exec Lead for FTSU and the Head of HR and other stakeholders will be developing a joint professional performance pathway which will focus (among other issues) on strengthening the operations and handling of formal casework processes.

7.3 An independent review was commissioned by the previous Associate Director of ICCR after a number of alleged concerns, including an anonymised letter seen by the Guardians, was brought to their attention. Concerns were raised about the CMHT West Hub. Involving 49 staff, a set of recommendations focusing on staff dynamics, morale, cohesiveness, team working, management arrangements and daily operations will now be implemented.

7.4 A team in the North is completing Transgender training after concerns were raised about cultural competency when addressing a patient. Learning from this case will also be applied to the compilation of the manager's handbook (Listen Up toolkit) for supporting staff.

7.5 Themes, learning and intelligence from FTSU cases was fed through to the PSIRF emerging risks group. This information will help to identify local hot spots and will inform any proactive patient safety and quality work.

9. NATIONAL DEVELOPMENTS

9.1 The National Guardians Office has developed a film which brings together information to help Non-Executives and Trustees understand their remit, promote their role, and set up positive working relationships New information film for Freedom to Speak Up Non Executive Directors and Trustees - National Guardian's Office

9.2 In May, the National Guardian for the NHS announced her refreshed vision for the work of the National Guardians Office. This includes providing additional expert guidance and

support for organisational leaders, and for the network of Guardians NGO Strategy - National Guardian's Office

10. RECCOMENDATIONS

10.1 Assurance has been provided by managers in the TOCSE committee that action is already being taken to address the recommendations we suggested.

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	2 October 2024
Date(s) of Committee Meeting(s) reported	18 September 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 • Non-NHS Inpatient Beds Report
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The Group position at Month 5 was a reported £249k deficit, mostly driven by significant out of area expenditure and slippage on savings delivery. • The Committee discussed the Waiting Times deep dive and highlighted concern in relation to the number of people waiting for first assessments, and the number of people waiting for further assessments after first contact. The Committee acknowledged the national concern around waiting times, particularly for ADHD assessments. The Trust continued to review how this was addressed with clinical and operational colleagues, with clear emphasis on keeping patients safe from harm.
Assure:	The Committee was assured by significant reductions in agency and bank usage, with very good performance around medical staffing. Nursing remained below plan due to clinical acuity and vacancies. The planned £2m surplus was forecast to be achieved for year-end, mainly based on sustained improvement on agency expenditure, no further increase in out of area run rate, and utilisation of remaining balance sheet flexibility.
Advise:	Progress on winter planning was received. The Committee noted that Home Treatment Team capacity had increased, and the Clinically Ready for Discharge Policy was under review. Escalations were discussed at the System Oversight Group. The Committee was advised that partnership discussions around increased clinical space to support mental health assessments were ongoing.

Board Assurance Framework	The Committee discussed the continued development and refinement of the BAF risks. Three new risks had been identified: • Failure to maintain a sustainable financial position • Failure to maintain acceptable governance and environmental standards • Failure to deliver optimal outcomes with available resources The detail for each risk was currently being written and would be presented for review in October. The Committee reflected on the need to highlight the medium-term financial position and how this would be achieved, and the risks around inappropriate out of area placements.
	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. The Committee highlighted Digital and Cyber risks as an area of focus.

Report compiled by:	Winston Weir 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	2 October 2024
Date(s) of Committee Meeting(s) reported	21 August 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 • Business Development and Partnerships Report • Trust Strategy: Sustainability Update • Trust Strategy: Clinical Services Update • Emergency Preparedness, Resilience and Response • Winter Planning
Alert:	The Committee wished to alert the Board of Directors to the following areas of performance and financial sustainability: • The total 2024/25 plan for out of area expenditure, including a £5m savings target, is £14m. The month 4 year to date out of area expenditure is £7.3m, this is £2.7m adverse to plan. Non-Trust bed usage has increased by 43% in July compared to June. The current full year forecast is £21m (£7m overspend).
Assure:	• The 2024/25 temporary staffing plan is £41.5m, including savings targets of £1.5m for bank and £1.8m for agency. Temporary staffing is £1.6m underspent at month 4 year to date, driven by agency reduction ahead of plan. • 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. • Trust Strategy: Sustainability Update was received with positive assurance. The Committee endorsed the report to Board. • Trust Strategy: Clinical Services Update was received with positive assurance. The Committee endorsed the report to Board. • The month 4 consolidated Group position is a surplus of £184k.
Advise:	• The Committee received the Business Development and Partnerships Report noting there are no formal tenders currently in progress, but we are expecting information about the procurement process for both Wolverhampton drug and alcohol services in the near future

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The Committee received the first draft of the winter plan noting the current plan on a page for the 100 days UEC Improvement Challenges visions, aims and objectives. The Committee were assured a more robust plan will be submitted in September.
The Committee received the Emergency Preparedness, Resilience and Response noting our auditors RSM UK Risk Assurance Services LLP conducted the EPRR internal audit during September 2023. The Committee endorsed the report to Board of Directors subject to the changes reflected for the core standards following the audit.

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<tr><td rowspan="2">Board Assurance Framework</td><td colspan="2">The Committee endorsed the proposal for the revised Board Assurance Framework risks.</td></tr>
<tr><td colspan="2">New risks identified:</td></tr>
<tr><td>Report compiled by:</td><td>Bal Claire
Deputy Chair/
Non Executive Director</td><td>Minutes available from:
Hannah Sullivan, Corporate Governance and Membership Manager</td></tr>
</table>

<table>
<tr><td colspan="6">Report to Board of Directors</td></tr>
<tr><td>Agenda item:</td><td colspan="5">15</td></tr>
<tr><td>Date</td><td colspan="5">2 October 2024</td></tr>
<tr><td>Title</td><td colspan="5">Finance Report Month 5</td></tr>
<tr><td>Author/Presenter</td><td colspan="5">Emma Ellis, Head of Finance and Contracts and Richard Sollars, Deputy Director of Finance</td></tr>
<tr><td>Executive Director</td><td>David Tomlinson, Executive Director of Finance</td><td>Approved</td><td>Y</td><td>✓</td><td>N</td></tr>
</table>

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	

Revenue position:

The month 5 consolidated Group position is a deficit of 249k. This is £1.2m adverse to plan and is mainly driven by significant out of area expenditure and slippage on savings delivery which is part offset by agency reduction ahead of plan and a favourable interest receivable position.

It is currently forecast that the planned surplus of £2m will be achieved mainly based on sustained improvement on agency expenditure, no further increase in out of area run rate and utilisation of remaining balance sheet flexibility.

Alert:

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

- **Out of area** – The 2024/25 out of area expenditure plan is £14m. Year to date expenditure at month 5 was £9m. The current full year forecast is £22m (£8m overspend).

- **Savings** – The 2024/25 savings target is £17.8m. The month 5 savings achieved is £4.6m year to date, this is a slippage of £2m. It is currently forecast that the full target will be achieved, with £6.3m being non recurrent savings. All corporate and operational areas have been asked to re-visit savings plans, in particular to identify 2% savings plans for 2025/26. Some plans have been submitted and the first review is being undertaken.

- **Underlying deficit** - The underlying financial position for 2024/25 has been assessed as a deficit of £14m. It is forecast that a surplus of £2m will be achieved in year but this is predominantly via non recurrent means. Financial mitigations are required to improve the underlying position including the development of a recurrent savings pipeline.

NHS Birmingham and Solihull Mental Health NHS Foundation Trust

Advise:

- **Temporary staffing** – The 2024/25 temporary staffing plan is £41.5m. Temporary staffing is £1.9m underspent at month 5 year to date, driven by agency reduction ahead of plan.

- **PLICS National Cost Collection –** The Committee is asked to note that the Patient Level Information and Costing System (PLICS) National Cost Collection was submitted in June 2024. Initial indications suggest that our costs are 15% above the national average overall, we await the publication of formal results.

Capital position:

The month 5 Group capital expenditure is £2.6m year to date, this is £0.3m ahead of plan.

Cash position:

The Group cash position at the end of August was £94m, with £17m relating to the Trust.

Recommendation

The Board is asked to review the month 5 financial position and discuss the key alerts.

Enclosures

Month 5 Finance Report

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.

Finance Report

Financial Performance:

1st April 2024 to 31st August 2024

Month 5
Group financial position

Group Summary	Revised Plan	YTD Position		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income				
Patient Care Activities	645,099	265,992	268,240	2,248
Other Income	21,117	8,799	10,080	1,281
Total Income	**666,216**	**274,791**	**278,320**	**3,529**
Expenditure				
Pay	(290,114)	(120,731)	(118,141)	2,590
Other Non Pay Expenditure	(334,969)	(136,768)	(144,914)	(8,146)
Drugs	(7,150)	(2,979)	(3,279)	(300)
Clinical Supplies	(539)	(225)	(289)	(64)
PFI	(14,388)	(5,995)	(6,350)	(355)
EBITDA	**19,056**	**8,093**	**5,347**	**(2,746)**
Capital Financing				
Depreciation	(9,765)	(4,069)	(4,002)	67
PDC Dividend	(16)	(7)	(7)	-
Finance Lease	(8,479)	(6,007)	(6,024)	(16)
Loan Interest Payable	(972)	(405)	(417)	(12)
Loan Interest Receivable	1,899	791	2,260	1,469
Surplus / (Deficit) before taxation	**1,722**	**(1,604)**	**(2,842)**	**(1,239)**
Taxation	(380)	(158)	(163)	(5)
Surplus / (Deficit)	**1,342**	**(1,762)**	**(3,005)**	**(1,243)**
Adjusted Financial Performance:				
Remove capital donations/grants/peppercorn lease I&E impact	5	2	2	-
Adjust PFI revenue costs to UK GAAP basis	722	2,759	2,755	(5)
Adjusted financial performance Surplus / (Deficit)	**2,069**	**999**	**(249)**	**(1,248)**

Month 5 2024/25 Group Financial Position

The month 5 consolidated Group position is a deficit of £249k. This is after adjusting for the revenue impact of the PFI liability remeasurement under IFRS 16 (£2.8m year to date).

The month 5 outturn is £1.2m adverse to the year to date plan submitted to NHSE on 12.6.24. This is mainly driven by significant out of area expenditure and slippage on savings delivery which is part offset by agency reduction ahead of plan and a favourable interest receivable position.

It is currently forecast that the planned surplus of £2m will be achieved mainly based on sustained improvement on agency expenditure, no further increase in out of area run rate and utilisation of remaining balance sheet flexibility.

The Group month 5 position is mainly driven by a £158k deficit in the Trust and £100k deficit for the Mental Health Provider Collaborative (MHPC). This is partly offset by an £83k surplus for Summerhill Services Limited (SSL) and a surplus of £104k for the Reach Out Provider Collaborative in line with agreed contribution to Trust overheads.

Birmingham and Solihull ICS position

The draft month 5 BSOL system position is a deficit of £61m which is £44m adverse to plan. This is mainly driven by £60m deficit for UHB.

Month 5 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	151,664	-	69,330	176,119	(128,874)	268,240
Other Income	10,013	11,895	-	-	(11,829)	10,080
Total Income	**161,677**	**11,895**	**69,330**	**176,119**	**(140,702)**	**278,320**
Expenditure						
Pay	(111,493)	(5,001)	(718)	(1,047)	117	(118,141)
Other Non Pay Expenditure	(35,873)	(3,553)	(69,118)	(175,752)	139,382	(144,914)
Drugs	(3,419)	(902)	-	-	1,041	(3,279)
Clinical Supplies	(289)	-	-	-	-	(289)
PFI	(6,350)	-	-	-	-	(6,350)
EBITDA	**4,254**	**2,440**	**(505)**	**(680)**	**(162)**	**5,347**
Capital Financing						
Depreciation	(2,653)	(1,184)	-	-	(165)	(4,002)
PDC Dividend	(7)	-	-	-	-	(7)
Finance Lease	(6,012)	(159)	-	-	148	(6,024)
Loan Interest Payable	(417)	(850)	-	-	850	(417)
Loan Interest Receivable	1,921	0	610	580	(850)	2,260
Surplus / (Deficit) before Taxation	**(2,914)**	**246**	**104**	**(100)**	**(179)**	**(2,842)**
Impairment	-	-	-	-	-	-
Profit/ (Loss) on Disposal	-	-	-	-	-	-
Taxation	-	(163)	-	-	-	(163)
Surplus / (Deficit)	**(2,914)**	**83**	**104**	**(100)**	**(179)**	**(3,005)**
Adjusted Financial Performance:						
Remove capital donations/grants/peppercorn lease I&E impact	2	-	-	-	-	2
Adjust PFI revenue costs to UK GAAP basis	2,755					2,755
Adjusted financial performance Surplus / (Deficit)	**(158)**	**83**	**104**	**(100)**	**(179)**	**(249)**

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.
- Current expected income, including LD&A is £431m.
- Month 5 position £100k deficit – driven by packages of care pressures, part offset by interest receivable.
- Month 5 cash balance £25m.
- Key risks:
  - Infrastructure costs
  - Packages of care (inflation and growth in numbers).
- Awaiting confirmation of 2024/25 pay award impact.

Reach Out

- £160m annual income in current plan.
- Month 5 position £104k surplus – in line with agreed contribution to Trust overheads.
- Month 5 cash balance £47m.
- Key risks:
  - Clinical concerns around expected growth in out of area numbers and EPC costs.
- Awaiting confirmation of 2024/25 pay award impact.

Temporary staffing expenditure

2024/25 Agency & Bank Spend by Type

£000s

4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-

Bank

Agency

April May June July August September October November December January February March

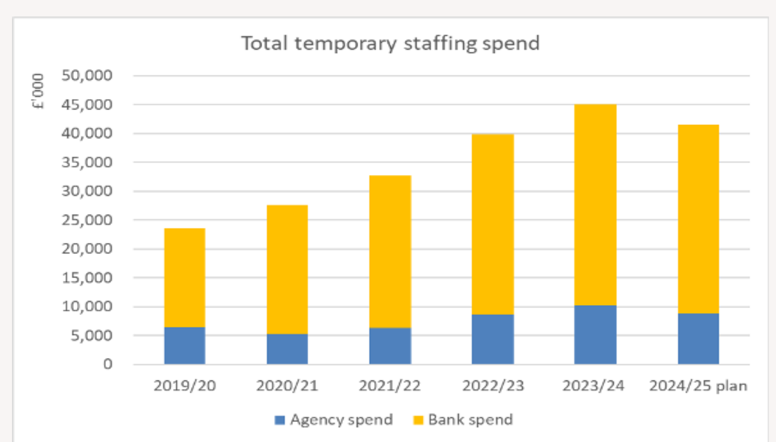
Agency Medical
Agency Nursing
Agency Other Clinical
Agency Admin & Clerical
Bank Nursing
Bank Other Clinical
Bank Admin & Clerical
2022/23 Bank & Agency
2023/24 Bank & Agency
2024/25 Plan

Month 5 temporary staffing expenditure is £16.2m, this is £1.9m less than plan.

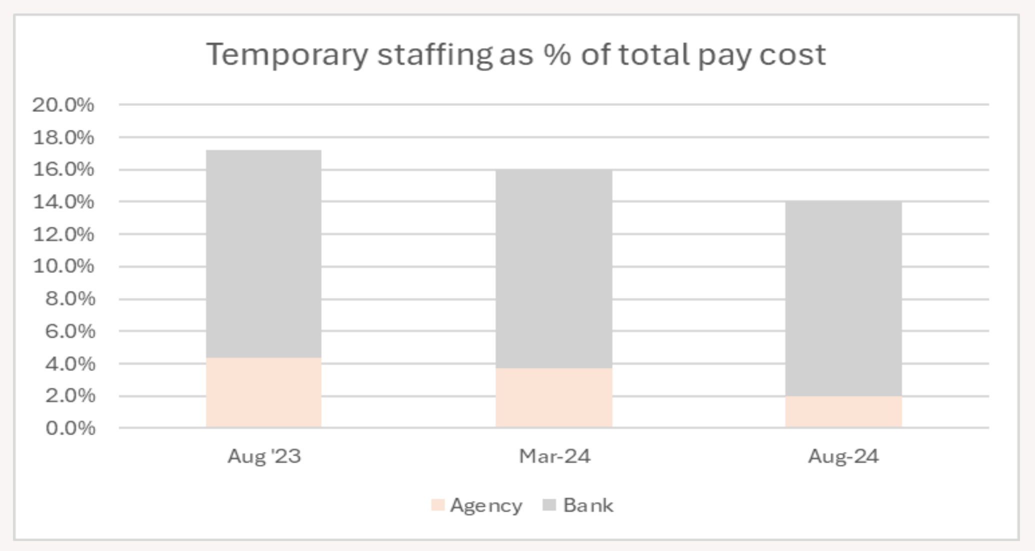
Bank expenditure £14m (86%) – the majority of bank expenditure relates to nursing bank shifts - £13.2m

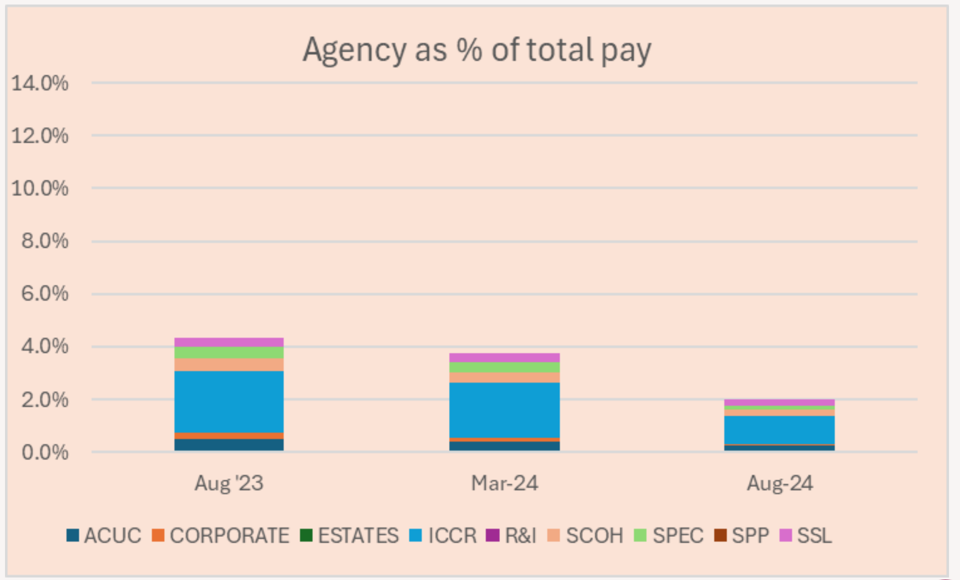
Agency expenditure £2.2m (14%) – the majority of agency expenditure relates to medical agency - £1.5m.

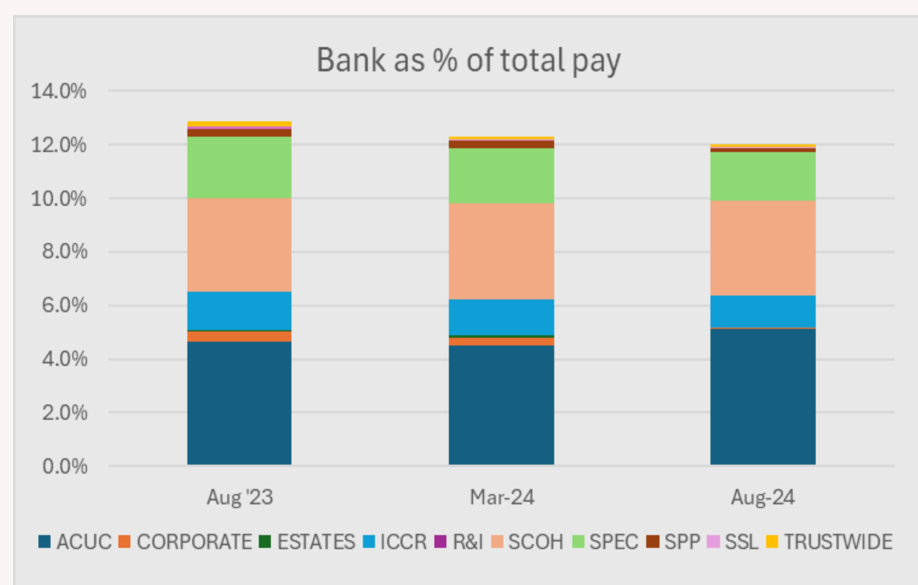
For further analysis on bank and agency expenditure, see pages 6 to 8.



Temporary staffing spend as % of total pay

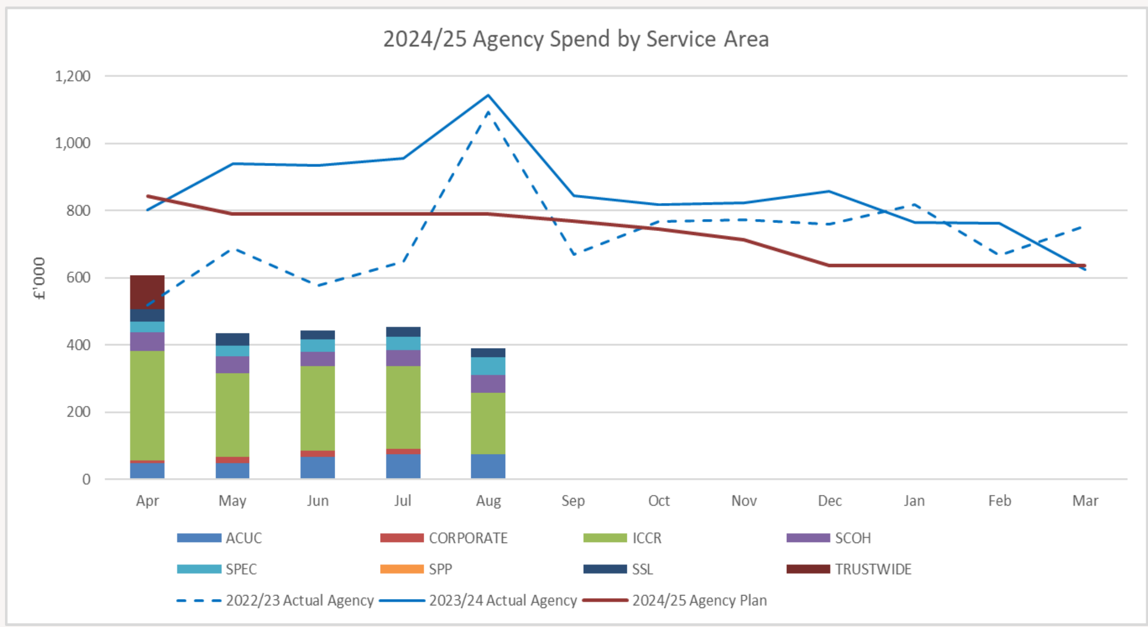






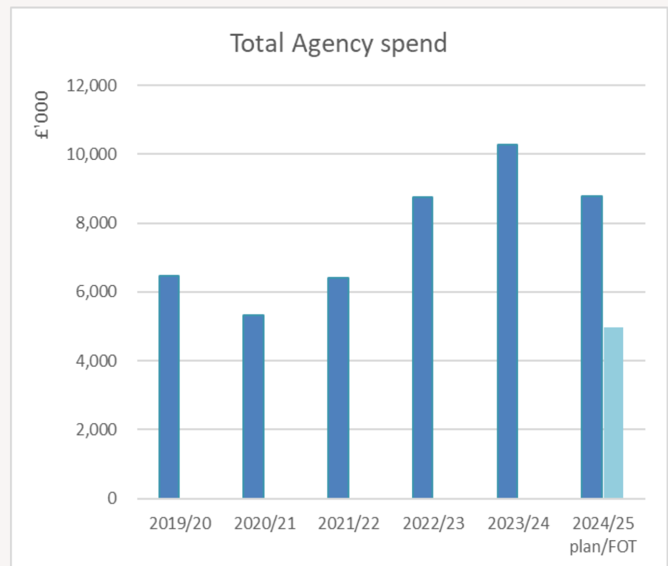
compassionate

Agency expenditure



KPIs	Target	Apr-24	May-23	Jun-23	Jul-23	Aug-23
Agency spend as % of pay bill (YTD)	3.2%	2.6%	2.2%	2.0%	1.9%	1.9%
Above price cap bookings - medical	0	15	14	14	12	11
Above price cap bookings -nursing	0	6	5	5	7	7
Admin & Estates bookings - Trust	0	1	1	0	0	0
Admin & Estates bookings - SSL	0	7	6	6	6	5

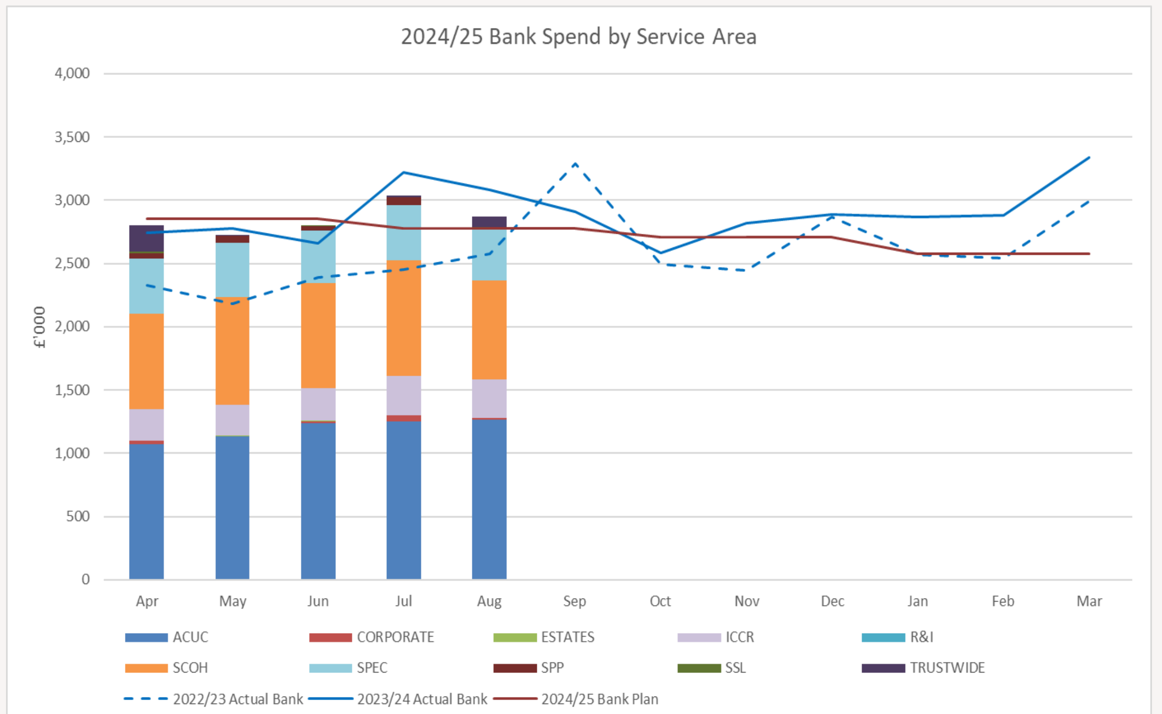
	2024/25 YTD
	£'000
Agency Expenditure	2,215
NHSE Ceiling	3,781
Variance to NHSE ceiling	1,566
Agency Medical	1,462
Agency Nursing (Registered)	474
Agency Nursing HCA	5
Agency Other Clinical	139
Agency Admin & Clerical	135
Agency Expenditure	2,215



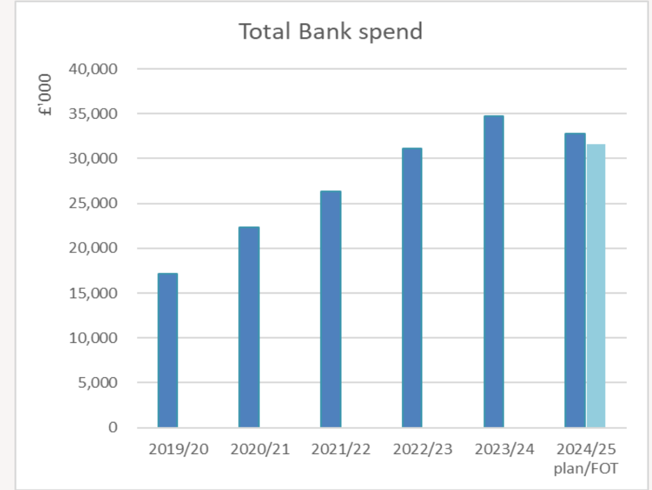
Agency expenditure

- The month 5 year to date agency expenditure is £2.2m. This is an underspend of £1.8m and is £2.6m less than year to date spend at month 5 in 2023/24.
- Year to date agency expenditure is 1.9% of the total pay bill which is £1.6m below the NHSE threshold (3.2% of pay bill).
- To date, £1.6m agency savings have been achieved (£1.2m ahead of plan).
- Given the significant reduction in agency to date, the full year forecast spend is now £5m which is £3.8m less than plan.
- 66% of the year to date agency spend relates to medical. Medical agency bookings paid over cap is 11 which is a reduction of 1 since July and is now almost half the 2023/24 average.

Bank expenditure analysis



Type	YTD £'000	% of spend
Bank Nursing	13,163	94%
Bank Other Clinical	180	1%
Bank Admin & Clerical	651	5%
Grand Total	**13,994**	**100%**

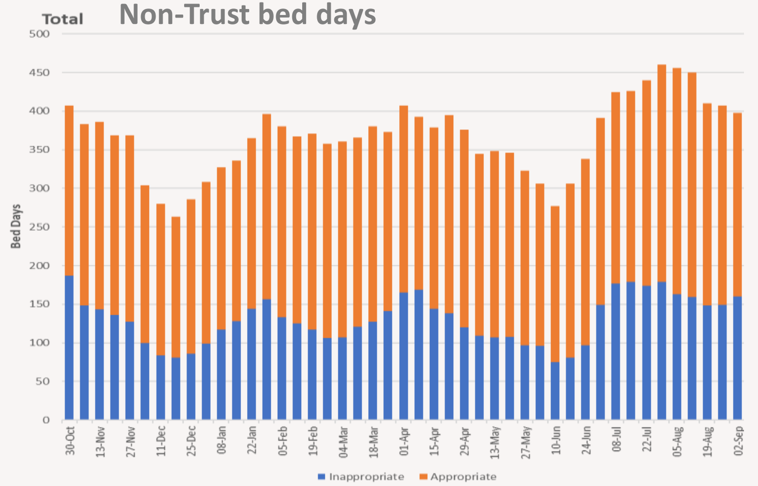


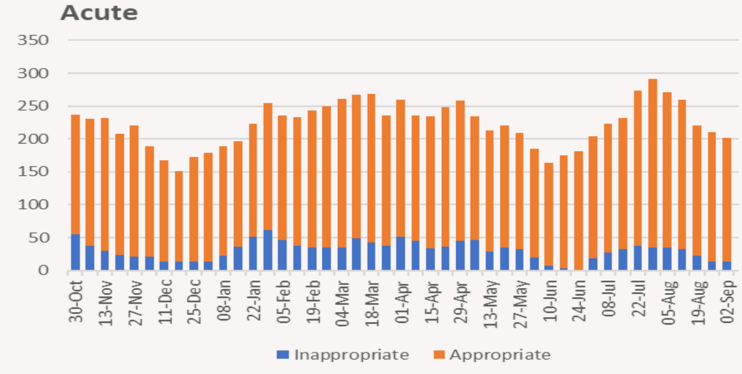
Bank expenditure

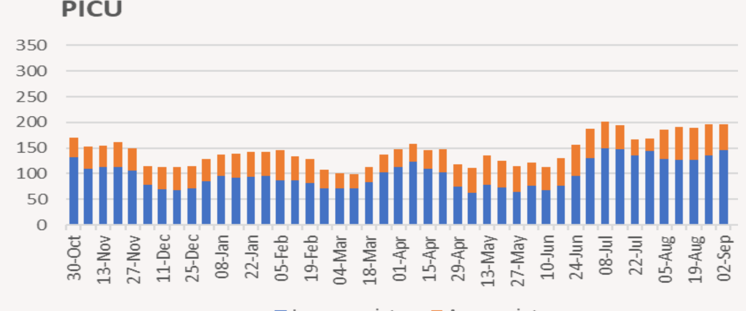
- The month 5 year to date bank expenditure is £14m, this is £117k less than year to date plan. The 2024/25 bank expenditure plan is £32.7m.
- Bank expenditure in August is £85k above the average for the previous four months of the year, with the increase mainly in Acute and Urgent Care.
- 71% of year to date bank spend was incurred in Acute and Urgent Care (42%) and Secure and Offender Health (29%).

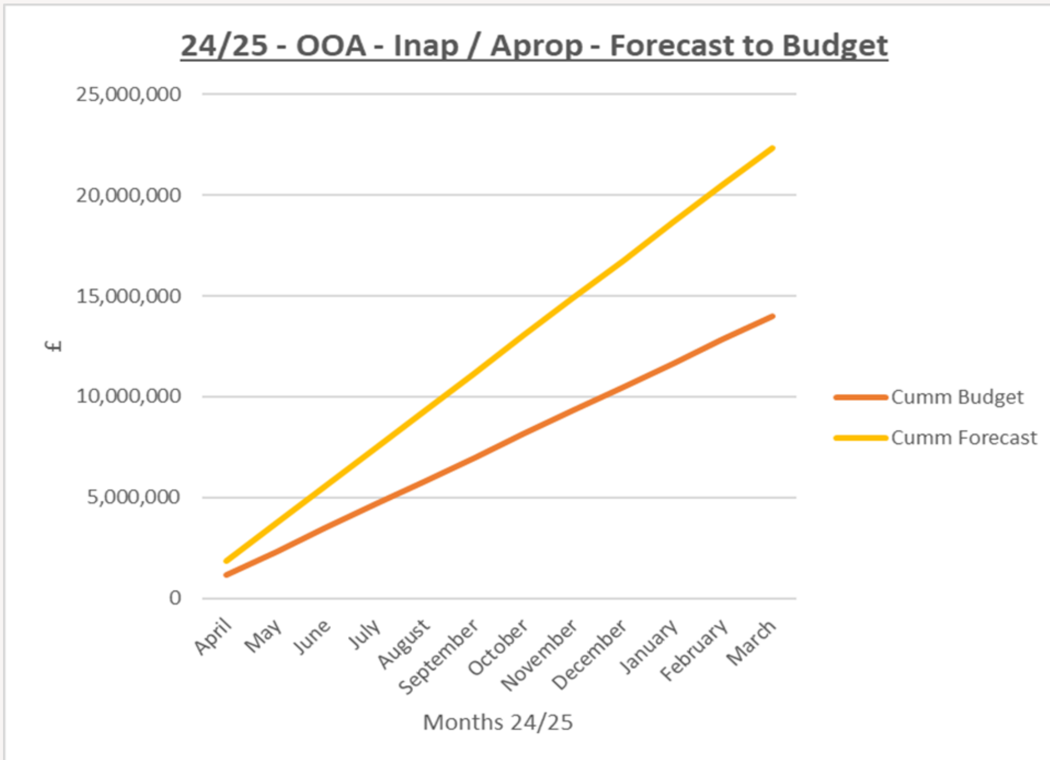
Operational service areas	YTD Bank spend £'000	Bank as % of service area pay
Acute & Urgent Care	5,967	27%
Secure & Offender Health	4,129	19%
Specialties	2,118	22%
ICCR	1,358	5%

Out of Area overspend









- The total 2024/25 plan for out of area expenditure is £14m.
- Month 5 year to date expenditure is £9.3m which is £3.5m adverse to plan.
- There has been a 4% increase in non-Trust bed days usage in August compared to July, making August the highest monthly bed usage in the year to date.
- The current full year forecast is £22m (£8m overspend).

Efficiencies

	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan FOT £000	Forecast FOT £000	Variance FOT £000
Recurrent						
Pay - Recurrent	645	1,726	1,081	3,489	3,700	211
Non-pay - Recurrent	3,339	989	(2,350)	8,013	7,802	(211)
Total recurrent efficiencies	3,984	2,715	(1,269)	11,502	11,502	-
Non recurrent						
Pay - Non-recurrent	174	174	-	416	416	-
Non-pay - Non-recurrent	901	166	(735)	2,162	2,162	-
Income - Non-recurrent	1,556	1,556	-	3,735	3,735	-
Total non-recurrent efficiencies	2,631	1,896	(735)	6,313	6,313	-
Total Efficiencies	**6,615**	**4,611**	**(2,004)**	**17,815**	**17,815**	-

Savings 2024/25	Plan £ 000	Forecast £ 000
Recurrent/Non-recurrent		
Recurrent	11.5	11.5
Non-recurrent	6.3	6.3
Total	17.8	17.8
Developed Status		
Fully Developed	8.9	8.9
Plans in Progress	5.0	5.0
Opportunity	2.1	2.1
Unidentified	1.8	1.8
Total	17.8	17.8
Risk Status		
High Risk	8.9	7.4
Medium Risk	0.0	1.5
Low Risk	8.9	8.9
Total	17.8	17.8

- The 2024/25 efficiency target is £17.8m. This comprises £11.5m recurrent and £6.3m non recurrent targets.
- £8.9m of savings plans were considered high risk at plan submission. In month 5, the bank reduction savings target of £1.5m has been re-classified from high to medium risk given the pilot work that has commenced within Acute and Urgent Care on rostering practice.
- £1.8m of the savings target remains unidentified.
- The month 5 savings achieved is £4.6m, this is £2m less than plan. The majority of the slippage on savings achieved relates to the out of area savings target (£2m) and the unidentified savings target (£0.7m). This is partly offset by agency reduction delivering ahead of plan by £1.2m.

Savings plans requirement – 2024/25 and 2025/26
In May 2024, the Executive Team agreed that all corporate and operational areas should re-visit the 2024/25 1% savings plan request, to address the £1.8m unidentified savings target, they should also develop 2% savings plans for 2025/26, to be submitted by 6.9.24. Some savings plans have been returned to date and the first review is being undertaken.

Consolidated Statement of Financial Position (Balance Sheet)

Statement of Financial Position - Consolidated	EOY - *'Audited'* 31-Mar-24 £m's	NHSI Plan YTD 31-Aug-24 £m's	Actual YTD 31-Aug-24 £m's	NHSI Plan Forecast 31-Mar-25 £m's
Non-Current Assets				
Property, plant and equipment	220.7	218.0	216.6	217.8
Prepayments PFI	1.2	1.2	1.8	1.2
Finance Lease Receivable	0.0	-	0.0	-
Finance Lease Assets	-	-	-	-
Deferred Tax Asset	-	-	-	-
Total Non-Current Assets	221.9	219.2	218.4	219.0
Current assets				
Inventories	0.4	0.4	0.3	0.4
Trade and Other Receivables	21.4	21.4	39.3	21.4
Finance Lease Receivable	-	-	-	-
Cash and Cash Equivalents	92.2	91.6	93.8	93.1
Total Curent Assets	114.0	113.4	133.3	114.9
Current liabilities				
Trade and other payables	(80.0)	(80.0)	(88.3)	(80.0)
Tax payable	(5.8)	(5.8)	(5.5)	(5.8)
Loan and Borrowings	(2.6)	(2.6)	(2.5)	(2.6)
Finance Lease, current	(1.1)	(1.1)	(1.1)	(1.1)
Provisions	(1.3)	(1.3)	(1.2)	(1.3)
Deferred income	(45.2)	(45.2)	(57.8)	(45.2)
Total Current Liabilities	(136.0)	(136.0)	(156.4)	(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)	(81.0)	(78.8)
Finance Lease, non current	(6.8)	(4.5)	(3.9)	(5.8)
Provisions	(3.0)	(3.0)	(2.8)	(3.0)
Total non-current liabilities	(111.2)	(111.8)	(109.7)	(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 August 2024 is £93.8m.

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

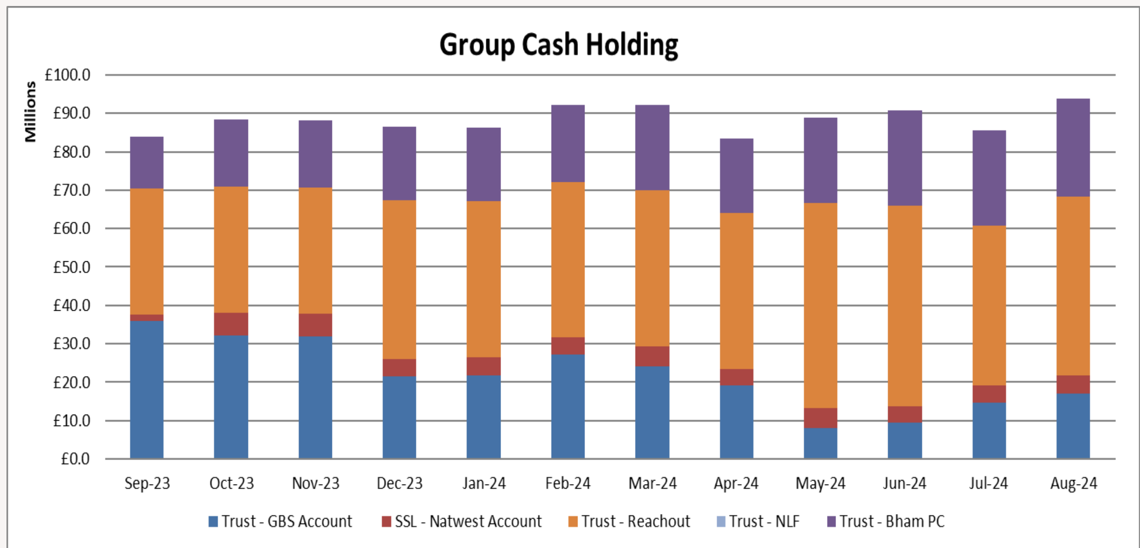
Ratios

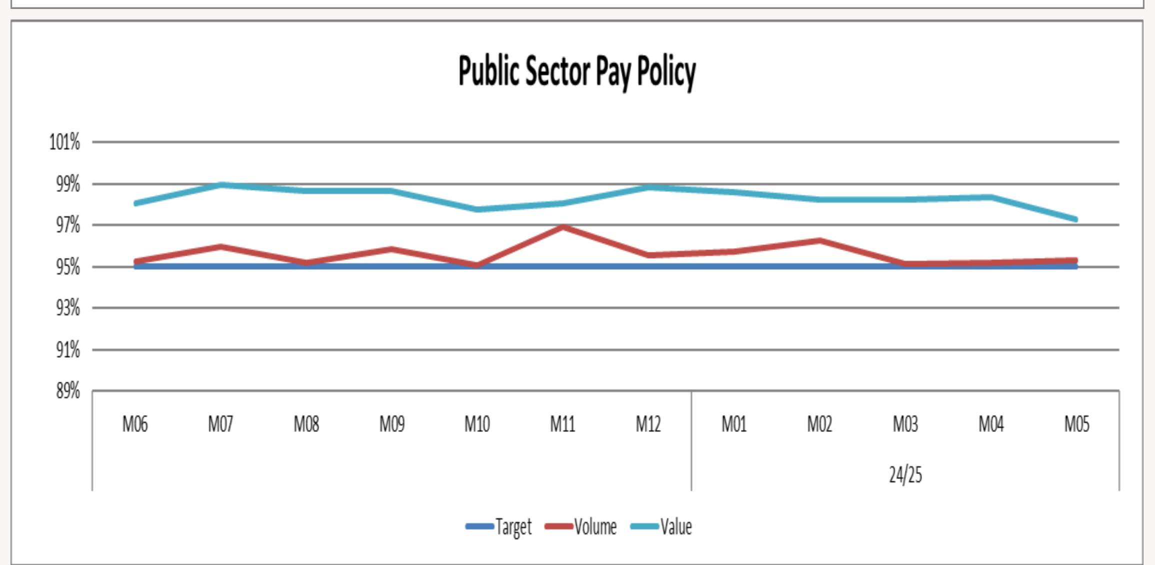
Liquidity measures the ability of the organisation to meet its short-term financial obligations.

Current Ratio :	**£m's**
Current Assets	133.3
Current Liabilities	-156.4
Ratio	0.9

Current Assets to Current Liabilities cover is 0.9:1 this shows the number of times short-term liabilities are covered.

Cash & Public Sector Pay Policy





Cash

The Group cash position at the end of August 2024 is £93.8m. This comprises of Trust £17m, SSL £4.7m, Reach Out Provider Collaborative £46.7m and Mental Health Provider Collaborative £25.4m.

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.

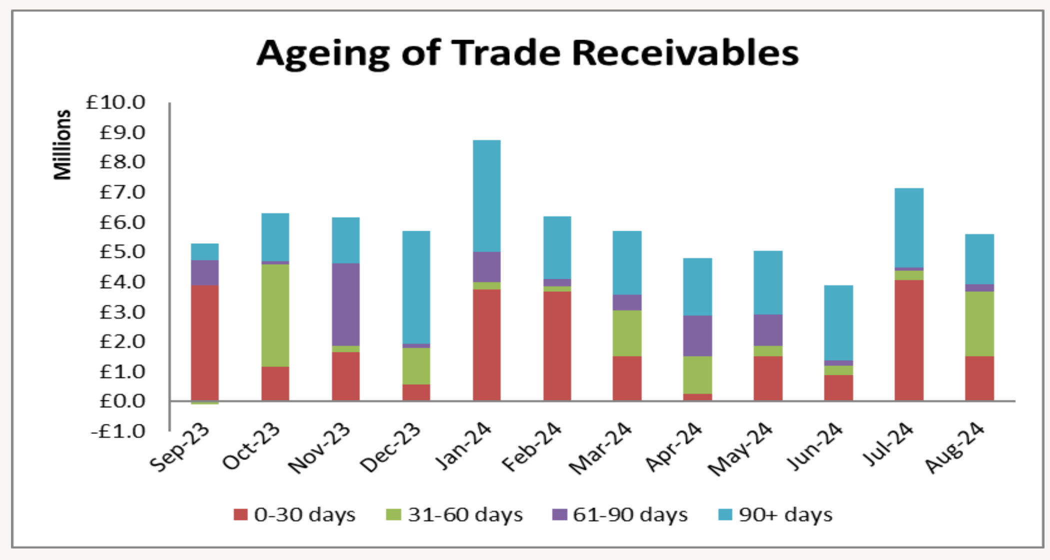
Performance against target is 96% for the month, based on an average of the four reported measures. Payment against value remains particularly high.

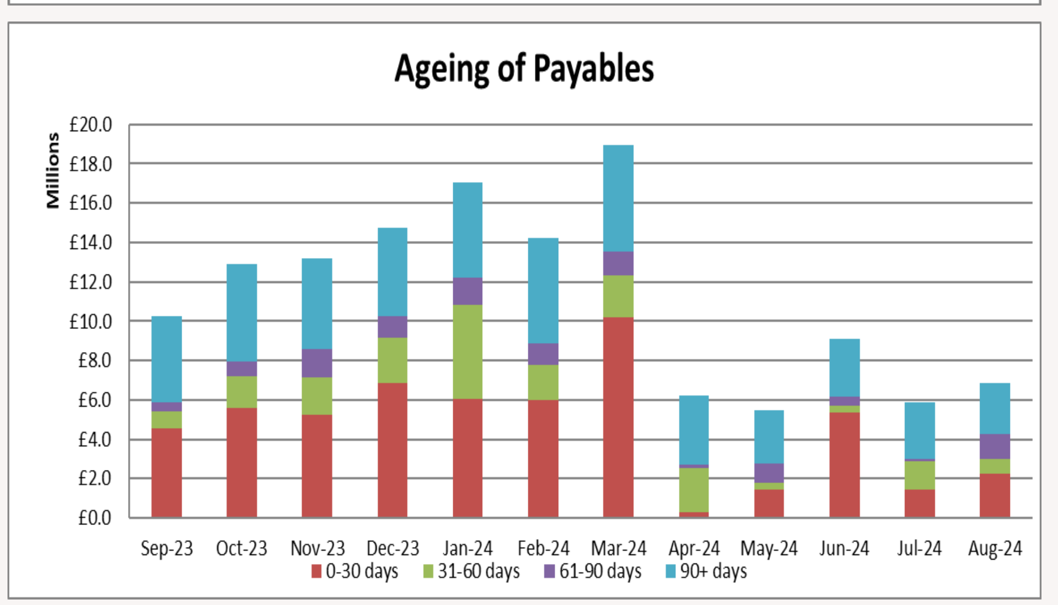
This performance was consistent throughout 2023/24 and the aim is to maintain this during 2024/25.

Better Payment Practice Code :

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

Trust Receivables and Payables





Trade Receivables :

- **0-30 days-** decrease in balance. Balance relates to monthly/quarterly and ad hoc invoices raised in month.

- **31-60 days-** increase in balance. UHB £35k overall account escalated to management. *Awaiting authorisation*-BWCH £289k, South Warwickshire FT £760k, Royal Wolverhampton FT £90k, Hereford & Worcester ICB £722k, Reach Out £173k. *In query*: BCHC FT £16k, Amey £13k. Balance mainly relates to staff overpayments (on payment plans).

- **61-90 days-**increase in balance. *Awaiting authorisation:* Ethypharm £87k. *In query*: Amey £23k, UOB £57k , Birmingham City Council £30k, Parexel £21k. Balance mainly relates to staff overpayments (on payment plans).

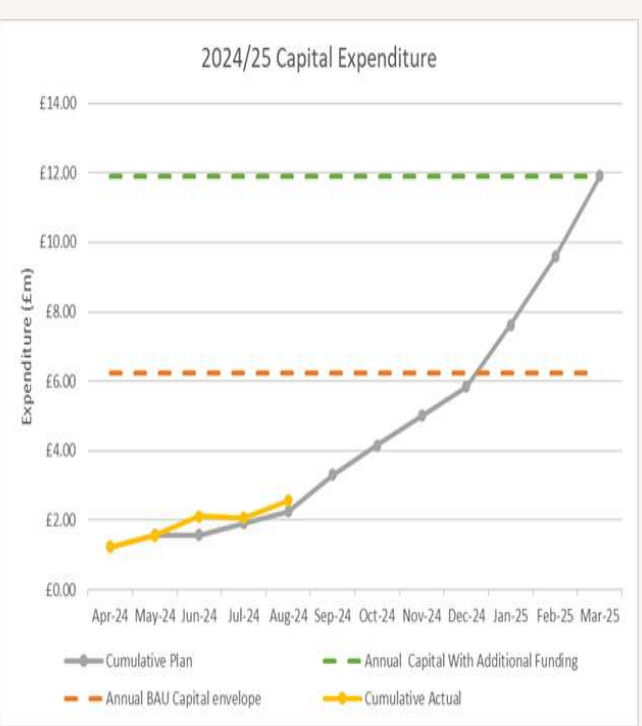
- **Over 90+ days-**overall balance mainly due to outstanding UHB debt £2.2m (escalated to BSMHFT and UHB management) -one payment of £34k received in August24, received notification of £1.9m payment to follow. *Awaiting authorisation:* BWCH £104k, BCHC £9k. *In query:* UOB £22k, Access to Work £24k, Parexel £24k, Kings College £69k. Balance mainly relates to 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 and reporting Reach Out separately. NHS Suppliers £1.0m: NHS Property £147k-historic invoices with Estates & Facilities, UHB £653k in query with the contracting team. Non-NHS Suppliers (58+) £1.6m: 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 September 2024.

Month 5 Capital expenditure

Capital Scheme	Annual Plan 12.6.24 £'m	Revised Annual Forecast £'m	Movement £'m	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m
Minor Works	2.3	3.3	1.0	0.8	1.7	-0.9
Stautory Standards & Backlog Maintenance	2.0	2.0	0.0	0.5	0.3	0.2
ICT	0.4	0.1	-0.3	0.0	0.0	0.0
Medical Device Replacement	0.1	0.1	0.0	0.0	0.0	0.0
Design Works	0.8	0.0	-0.8	0.1	0.0	0.1
Doorsets	0.7	0.7	0.0	0.5	0.4	0.1
Total BAU Capital Plan	**6.3**	**6.3**	**0.0**	**1.9**	**2.4**	**-0.5**
R&D Medical Equipment - grant funded	**0.7**	**0.7**	**0.0**	**0.0**	**0.0**	**0.0**
Acute & Urgent Care - UEC capacity PDC funded	**0.8**	**0.8**	**0.0**	**0.1**	**0.0**	**0.1**
Total lease expenditure	**2.6**	**2.6**	**0.0**	**0.2**	**0.2**	**0.0**
Minor Works - £1.6m notional system allocation - TBC	*1.6*	*1.6*	*0.0*	*0.2*	*0.0*	*0.2*
Gross Capital Expenditure (excluding lease remeasurements)	**11.9**	**11.9**	**0.0**	**2.3**	**2.6**	**-0.3**



Group Capital Expenditure

Month 5 year to date Group capital expenditure is 2.6m, this is £0.3m ahead of the capital plan re-submission on 12.6.24. The capital plan of £11.9m includes £1.6m related to a notional share of additional system capital allocation. Preliminary indication is that this has been set against planning works for Highcroft development and discussions are ongoing to determine what can be incurred this financial year. Additional national capital allocations have been released and we have submitted bids to Birmingham and Solihull ICB for inclusion in the BSOL system submission to address capital infrastructure risk, further updates will be provided when available.

<table>
<tr><th colspan="7">Report to Board of Directors</th></tr>
<tr><td>Agenda item:</td><td colspan="6">16</td></tr>
<tr><td>Date</td><td colspan="6">2 October 2024</td></tr>
<tr><td>Title</td><td colspan="6">Emergency Preparedness, Resilience and Response Annual Report 2023/24</td></tr>
<tr><td>Author/Presenter</td><td colspan="6">Louise Flanagan, Head of Emergency Preparedness, Resilience and Response
David Tita, Associate Director of Corporate Governance</td></tr>
<tr><td>Executive Director</td><td>Dave Tomlinson, Executive Director of Finance</td><td>Approved</td><td>Y</td><td>✓</td><td>N</td><td></td></tr>
</table>

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

Summary of Report

Alert		Advise	✓	Assure	✓

Purpose

This annual report provides an overview of the Trusts emergency preparedness and covers the activities the Trust has undertaken during 2023/24 to ensure the Trust's resilience in the event of a business continuity, critical or major incident, a mass casualty event, pandemic, or other severe disruption occurring.

Introduction

This report is to provide the Board with an update regarding activities undertaken in relation to emergency preparedness and business continuity, and to ensure that the Trust can meet its responsibility to provide an effective incident response, while maintaining the services the Trust is commissioned to provide.

Key Issues and Risks

The EPRR function within the Trust continues to be provided by a single individual. This continues to represent a single point of failure for the organisation and allows for no cover arrangements in the event of the absence of that individual (annual leave/sickness/study etc.). Identification of a designated deputy for the EPRRO was the only high priority recommendation from the internal EPRR audit and an action which remains outstanding.

Recommendation

The Board is asked to receive the Annual Report 2023/24 for assurance, noting key issues.

Enclosures

EPRR Annual Report 2023/24

Emergency Preparedness, Resilience & Response (EPRR) Annual Report

August 2024

Louise Flanagan, EPRR Officer

1. INTRODUCTION

Under the NHS Constitution 2015, the NHS is there to help the public when they need it most; this is especially true during a significant incident or an emergency. Each NHS funded organisation must therefore ensure it has robust and well-tested arrangements in place to plan for, respond to and recover from these situations. The Civil Contingencies Act 2004 (CCA) outlines a single framework for civil protection in the United Kingdom. The Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. Whilst Mental Health Trusts are not specifically noted to be Category 1 responders, as defined by CCA, subsequently issued guidance such as the EPRR Framework and the NHS Standard Contract make it clear that as an NHS funded organisation we are obligated to plan and respond as though we were Category 1 responders. As such BSMHFT is subject to the full set of civil protection duties and are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency.

The NHS England Emergency Preparedness Framework (2022) provides strategic national guidance for all NHS funded organisations to help with meeting the requirements of these statutory obligations.

This annual report provides an overview of the Trusts emergency preparedness and covers the activities the Trust has undertaken during 2023/24 to ensure the Trust's resilience in the event of a business continuity, critical or major incident, a mass casualty event, pandemic, or other severe disruption occurring.

This report is to provide the Finance, Performance and Productivity Committee/Trust Board with an update regarding activities undertaken since the previous report (March 2024) in relation to emergency preparedness and business continuity, and to ensure that the Trust can meet its responsibility to provide an effective incident response, while maintaining the services the Trust is commissioned to provide.

2. GOVERNANCE ARRANGEMENTS

The overall responsibility for complying with the CCA 2004 and EPRR Framework rests with the Chief Executive Officer who is responsible for ensuring, through appropriate delegation of responsibility, that we comply with our statutory requirements and that NHS England Core Standards for EPRR are met.

The Trusts designated Accountable Emergency Officer (AEO) is the Executive Director with delegated responsibility for ensuring resilience across the Trust and the delivery of safe and robust responses to all

kinds of emergency disruptions, supported by the Emergency Preparedness, Resilience & Response Officer (EPRRO). Our AEO is currently the Executive Director of Operations.

Operational management support is provided by the EPRRO. The AEO represents the Trust at regional forums including the Local Health Resilience Partnership (LHRP). The Trust has an internal Emergency Planning and Business Continuity Committee (BCEPC) which meets on a quarterly basis. An assurance position will be provided to the Finance, Performance & Productivity (FPP) Committee on an annual basis which is then reported to Public Board, as required by NHSE Core Standards for EPRR. An update report will also be provided on a quarterly basis.

The EPRR function sits in the portfolio to the Corporate Governance portfolio under the management of the Associate Director of Corporate Governance.

3. RISK

The National Risk Register (NRR) for Civil Emergencies provides a national picture of the risks of emergencies occurring. The most recent NRR includes a broader range of risks to the safety and security of the UK than previous iterations, reflecting technical improvements to risk assessment approaches and demonstrating the full range of challenges facing the UK.

These risks are taken into consideration in line with the risks identified on the Local Community Risk Register, to ensure that there is an appropriate level of preparedness to enable an effective response to emergency incidents, which have a significant impact on the communities of the West Midlands Conurbation. The Trust must have suitable, up to date, exercised plans which set out how they plan for, respond to, and recover from major incidents and emergencies as identified in the national and local community risk registers (as appropriate to our organisation). The Local Health Resilience Partnership (LHRP) considers all local risks within the West Midlands and has developed an agreed risk register which NHS provider Organisations should align to. On this basis, the Trust has recorded EPRR risks on our internal risk register to ensure that it is compatible and that we have plans in place to ensure that we can respond.

Further detail on the risks highlighted in both the national and community risk registers can be found at the following links:
National risk register: Preparing for national emergencies - House of Lords Library (parliament.uk)
preparing-the-west-midlands-for-emergencies.pdf (wordpress.com)

Summary of EPRR Risks*

Risk ID	Title of Risk	Lead	Current risk score	Movement in risk score
1167	Risk of widespread fuel shortage, caused by a number of factors resulting in impact to service delivery	EPRR Officer	9	↓
1174	Risk to staff and inpatient health and wellbeing caused by extreme weather related to heatwave	EPRR Officer	12	⟺
1175	Risk of losing essential power/ heating/ communications/ ICT network and critical systems/ water caused by regional failure of utilities	EPRR Officer	12	⟺
1176	Risk that staff will be unable to attend work and premises will be rendered unusable due to the excess surface water or widespread flooding.	EPRR Officer	6	↓
1177	Risk of staff not being able to attend their normal place of work caused by pollution or widespread toxic release of substance resulting in a CBRN Incident and/or the potential closure of Trust site.	EPRR Officer	8	↓
1738	Risk that the Trust will not be able to maintain compliance with NHSE EPRR Core Standards and its statutory duties caused by a lack of capacity and resource within the EPRR portfolio	EPRR Officer	12	⟺
1769	Risk to the ability to run outpatient clinics, operate safely on the wards, and providing quality of care to patients as post-graduate doctors in training will be absent from work due to industrial action.	Medical Director	20	⟺
1828	Risk to staff and inpatient health caused by extreme cold weather and snow with low temperatures	EPRR Officer	4	↓
1830	Risk that there will be an outbreak of an influenza-type pandemic affecting the UK population resulting in large scale staff absence, increased pressure on the system wide health service and increased mortality.	IPC Lead	12	⟺
1891	Risk of Flu outbreaks across the Trust due to very low flu vaccine uptake	IPC Lead	6	⟺
1892	Risk to staff and community patient health and wellbeing, this is caused by extreme cold weather and snow	EPRR Officer	3	↓
1893	Risk to staff and community patient health and wellbeing. This is caused by extreme weather related to heatwave	EPRR Officer	12	↑

*please refer to ICT report to FPP for details of ICT based risks

4. PLANNING AND PREPAREDNESS ACTIVITIES

In accordance with NHSE Core Standards requirements, all EPRR related plans must be reviewed annually as a minimum, following any activation or major organisational changes. A number of documents have therefore been reviewed and updated throughout 2024 as part of the EPRR Workplan schedule:

- BSMHFT Emergency Preparedness and Business Continuity Policy
- BSMHFT Incident Response Plan
- BSMHFT Adverse Weather Plan
- BSMHFT Fuel Disruption Plan
- BSMHFT Initial Operational Response (IOR) to Incidents Suspected to Involve Hazardous Substances or CBRN Materials
- Local site/service Business Continuity Plans (including local major incident plans as business impact analysis, Evacuation & Shelter Plans (where relevant))
- BSMHFT Mass Countermeasure Distribution Plan (new plan)
- BSMHFT Incident Communications Management Plan (new plan)
- BSMHFT Lockdown Guidance

As part of ongoing delivery of emergency preparedness and business continuity management and in line with Core Standards requirements, the Trust has also reviewed its Emergency Preparedness and Business Continuity Policy GC 09, and this was ratified in August 2024 following approval at the Policy Development Management Group (PDMG) and the Trust Clinical Governance Committee (CGC).

The Incident Response Plan has been subject to a wide review, following feedback from the EPRR internal audit, NHSE Core Standards feedback 2023 and also as a result of the internal and external consultation process.

The Trusts Infection Prevention Control Plan for Pandemic Influenza is currently under review and is due to be ratified by the IPC Committee in August. This policy sits in the portfolio of the Executive Director of Quality & Safety (Chief Nurse).

New Plans:

- Mass Countermeasure Distribution Plan
- Incident Communications Management Plan

The Mass Countermeasures Plan was developed collaboratively with the Infection Prevention & Control Team, Pharmacy and EPRR following feedback from Core Standards.

The Incident Communications Plan was developed collaboratively with the Communications Team and EPRR, in response to Core Standards feedback.

Plans in development:

- Trustwide Staff Redeployment Plan – this plan has been developed by the Deputy Chief Operating Officer in response to the challenges experienced during the response to Covid 19 and also feedback from the EPRR internal audit. It is hoped that the plan will be finalized by the end of August 2024.

Document Review Compliance

Site/Service specific plans:

SITE/SERVICE BASED PLANS	BCP	MIP	BIA	EVAC & SHELTER	MIB AUDIT	IOR AUDIT
TOTAL	32	69	32	22	31	12
COMPLETED	32	69	32	22	29	12
% COMPLETION	100%	100%	100%	100%	94%	100%

Trustwide plans:

	LAST REVIEW	NEXT REVIEW
BSMHFT EMERGENCY PREPAREDNESS & BUSINESS CONTINUITY POLICY V5.2	July 2024	July 2025
BSMHFT INCIDENT RESPONSE PLAN V7.8	July 2024	July 2025
BSMHFT ADVERSE WEATHER PLAN V1.5	March 2024	March 2025
BSMHFT FUEL DISRUPTION PLAN	March 2024	March 2025
BSMHFT IOR RESPONSE TO INCIDENTS SUSPECTED TO INVOLVE HAZARDOUS SUBSTANCES OR BCRN MATERIALS PLAN V1.0	March 2024	March 2025
BSMHFT LOCKDOWN GUIDANCE (IN MIP) V1.0	March 2024	March 2025
BSMHFT MASS COUNTERMEASURE DISTRIBUTION PLAN V1.4	March 2024	March 2025
BSMHFT PANDEMIC FLU PLAN	Feb 2016	August 2024
BSMHFT EMERGENCY COMMUNICATIONS MANAGEMENT PLAN V1.0	July 2024	July 2025
ICT/POWER/COMMS OUTAGE BCP - A&UC	June 2024	June 2025
ICT/POWER/COMMS OUTAGE BCP - SPECIALTIES	June 2024	June 2025
ICT/POWER/COMMS OUTAGE BCP - SCOH V1.1	April 2024	April 2025
ICT/POWER/COMMS OUTAGE BCP - ICCR V1.1	April 2024	April 2025
TOTAL	13	
TOTAL IN DATE	12	
% COMPLETION	92%	

5. TRAINING AND EXERCISING

Training

On-Call Standard Operating Procedure – The Trusts on-call pack has been reviewed and revised and includes some specific EPRR related on-call guidance.

EPRR On-Call e-learning package has been reviewed and updated. The EPRRO is currently working with the Learning & Development Teams so this can be made available in the Learning Zone. This will allow for better tracking and reporting of compliance and easier access to the module for staff.

Incident Response Training - The EPRRO is in the process of implementing Personal Development Portfolios (PDP's) for staff who would be called upon to undertake roles within an Incident Management Team (as per our Incident Response Plan). It is a requirement of Core Standards that we have appropriately trained staff to be able to respond to incidents. These PDP's are being developed in line with the Skills for Justice National Occupational Standards for Civil Contingencies and will help to identify gaps in training for key staff. Template PDP's are available via the EPRR training page on Connect.

Principles of Health Command Training – This is mandatory training for all staff who undertake duties on the strategic on call rota and also those who could be called upon to hold the role of Incident Director in or out of hours. The training is delivered by NHSE in line with the Skills for Justice National Occupational Standards for Civil Contingencies. There is currently a lack of availability for this course, an issue which has been escalated to NHSE. We expect more places to be released in Autumn 2024.

Decision Loggist Training - The Trust has increased its number of trained decision loggists during 2024 with the support of the ICB EPRR Team and we are now in a position of having sufficient trained loggists who would be called upon to support a Major Incident Management Group in the event we needed to stand up our ICC, particularly out of hours. Each operational directorate should maintain a minimum of 2 trained loggists to support a Trust-wide response.

Exercising

The Trust is required to undertake a 'live' exercise in 2024 and the EPRRO is in the process of developing the scenario for this. This will require support from senior leaders to form an incident response team and also from the directorates who will need to make staff available to support the exercise. Unfortunately, this has been delayed due to lack of capacity of the EPRRO.

Exercise Baby Toucan – Internal Communications Exercise run by the EPRRO every 6 month's. Working from home arrangements of the staff who support our Executive Team did present some initial issues with communication in hours. This issue has been temporarily resolved and further solutions are being scoped to make the in hours process clearer and more robust as switchboard staff were not clear on the process to contact the in hours designate director. Out of hours we have a well-rehearsed process for contacting both strategic and tactical on call managers.

Cyber Security Exercise – Internal exercise based on a supply chain attack scenario – this exercise was conducted in May 2024 with and action plan for recommendations developed by the ICT Cyber Security Officer.

The Trust participated in Exercise Toucan – a regional communications exercise. Report is available on the Business Continuity and Major Incident Planning section of Connect.

Current compliance with training and exercising requirements are monitored by the EPRRO and reported to BCEPC quarterly and as part of our evidence for Core Standards.

6. ASSURANCE AND OBLIGATIONS

NHSE Emergency Preparedness Resilience and Response Core Standards for EPRR

As previously reported BSMHFT initially submitted a position of partial compliance for 2023, however following the confirm and challenge process we accepted a number of standards being downgraded by NHSE and received a final compliance rating of non-compliant. A significant action plan was developed by the EPRRO which has been the focus of their capacity during 2024. Capacity of the EPRRO to complete all of the action plan has been a challenge.

The Trust received the 2024 formal notification of the requirement to complete the annual Core Standards self-assessment on 17 July 2024, with the deadline for submission of the assessment template and supporting evidence being 30 August 2024. No changes have been made to the standards for 2024. The Deep Dive subject for 2024 is Cyber Security. The Trust has submitted an initial compliance rating of 'substantially compliant', having assessed ourselves as being fully complaint with 52 of the 58 standards which are applicable to mental health trusts, 6 where we have assessed ourselves as partially complaint and 0 standards were assessed to be non-complaint. This gives us an overall compliance percentage of 89.6%.

Individual Standard Compliance Criteria:

NON COMPLIANT	Not evidenced in EPRR arrangements
PARTIALLY COMPLIANT	Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months
FULLY COMPLAINT	Evidenced in plans or EPRR arrangements and are tested/exercised as effective

Overall Compliance Criteria:

FULLY COMPLIANT	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
SUBSTANTIALLY COMPLIANT	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
PARTIALLY COMPLIANT	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
NON COMPLAINT	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

EPRR Internal Audit

Our auditors RSM UK Risk Assurance Services LLP conducted the EPRR internal audit during September 2023. The aim of the audit was to determine the level and robustness of the Trust's procedures, processes and plans that are in place to mitigate against the risk of disruption to normal service delivery in the event of an unforeseen circumstance / eventuality occurring. This audit was part of the approved 2022/23 internal audit plan. It has to be carried forward into the 2023/24 workplan the audit was unable to completed as planned due to the long-term absence of a key staff member.

Audit Conclusion (as reported by RSM UK)

Taking account of the issues identified in the final report, in our opinion, the Trust has demonstrated **Good Progress** in implementing agreed management actions.

Of the 15 management actions considered:

- One had not been fully implemented (High priority). The action has been reopened on the action tracker (previously reported as closed to the July 2024 Audit Committee). See section 2 below.
- One was being implemented (Medium priority) with this being the position reported to the last Audit Committee meeting.
- 13 have been confirmed as fully implemented through review of the supporting evidence provided (seven Medium and six Low priority).

7. RESOURCES/RESILIENCE

The EPRR function within the Trust continues to be provided by a single individual (EPRRO). This continues to represent a single point of failure for the organisation and allows for no cover arrangements in the event of the absence of that individual (annual leave/sickness/study etc.). Identification of a designated deputy for the EPRRO was the only high priority recommendation from the internal EPRR audit and an action which remains outstanding.

NHSE Core Standard 5 requires the Trust Board to be “satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties” and this is currently an area of concern and makes delivery of the annual work program unsustainable. The EPRRO now has temporary admin support to the EPRR function, however this still leaves a lack of suitably trained and experienced EPRR staff in the absence of the EPRRO, as highlighted in both Core Standards and the Internal Audit recommendations. The EPRRO has provided a draft business case to the Associate Director for Corporate Governance for consideration of increased resource to the EPRR function.

8. PARTNERSHIP WORKING

The Trust continues to participate in a series of groups/committees, in encouraging a joint approach to emergency preparedness for planning, response and recovery. This includes:

- Local Health Resilience Partnership – Executive Group (LHRP) – quarterly, attended by AEO (or nominated Executive cover)
- Health Emergency Planners Operational Group (HEPOG – formerly LHRF) – monthly, attended by EPRRO
- Community & Mental Health Network Group – this is a newly established group attended by EPRRO

System wide Task and Finish Groups have been set up for the following areas of priority:

- Training
- Evacuation & Shelter
- Mass Countermeasures
- Mass Casualty

As of August 2024 we were notified by NHSE/ICB of the NHS EPRR Exercise Program 2024 – 2030 which sets out 7 exercise themes for NHS organisations to exercise in turn on a yearly basis:

- casualty and mass casualty
- HAZMAT and CBRN
- business continuity
- cyber and digital
- infectious disease and pandemics
- adverse weather
- security, shelter and evacuation

Infectious Disease and Pandemics is the designated area of focus for the NHSE Midlands region. We will be working in collaboration with Birmingham & Solihull Integrated Care Board and NHSE Midlands to plan, exercise and report on our capabilities within this theme.

9. PRIORITIES FOR 2024/5

- On-going delivery of statutory requirements under the CCA 2004, the Framework for EPRR and Core Standards and NHS Standard Contract requirements
- Completion of Core Standards Action Plan to improve and maintain Core Standards compliance position
- Improve power/systems outage plans – develop suite of paper-based record templates
- Development/completion of our tri-annual live play internal exercise and annual business continuity exercises
- Increase capacity and resilience to the EPRR function

Report to Board of Directors

Agenda item:	17					
Date	2 October 2024					
Title	Board of Directors Terms of Reference					
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	✓

- **Purpose:**

This report provides an overview of the updates of the ToR of the Board of Directors as this was last reviewed in 2023.

- **Introduction:**

It is important for the ToR of the Board of Directors to be reviewed annually as a reflection of good governance and to ensure it is still fit-for-purpose and aligned to the Standing Orders. The changes that have been made to this updated version of the ToR of the Board of Directors are highlighted in `orange`.

- **Key issues and risks:**

The key issue here is to ensure that the updated ToR of the Board of Directors is sufficiently populated to all members of the Board.

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 updates to its Terms of Reference
2. **REVIEW, SCRUTINISE and APPROVE** its updated Terms of Reference as set out in appendix 1.

Enclosures
Appendix 1: Details of updated ToR of the Board of Directors.

BOARD OF DIRECTORS

TERMS OF REFERENCE

1. VALUES

The Board of Directors will role model the Trust values:

Compassionate

- Supporting recovery for all and maintaining hope for the future.
- Being kind to others and myself.
- Showing empathy for others and appreciating vulnerability in each of us.

Inclusive

- Treating people fairly, with dignity and respect.
- Challenging all forms of discrimination.
- Listening with care and valuing all voices.

Committed

- Striving to deliver the best work and keeping patients at the heart.
- Taking responsibility for my work and doing what I say I will.
- Courage to question to help us learn, improve, and grow together

2. AIM

The main aim of the Board of Directors is to work in partnership with stakeholders and provide active leadership ~~in~~ to the organisation by undertaking three key roles:

- Formulate Strategy; ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented within a framework of prudent and effective controls, enabling risk to be assessed and managed.

- Ensure accountability by holding the organisation to account for the delivery of the strategic objectives and through seeking assurance that systems of control are robust and reliable.

- Shaping a positive culture for the Board and for the organistion.
- Provide leadership to the Trust with the view of promoting its success and achievement of its Principal Purpose as set out in its Constitution while always ensuring that it operates in accordance with all statutory instruments, relevant Codes of Governance and its licence.
- Ensure the Trust is effectively governed and oversee the delivery of planned results by monitoring performance against agreed strategic objectives while ensuring effective financial stewardship through value for money, financial control and financial strategy.

3. AUTHORITY

The powers of the Trust are to be exercisable by the Board of Directors on its behalf. Any of those powers may be delegated to a committee of Directors or to an Executive Director.

The Chair of the Trust or, in their absence, the Vice Chair is to preside at meetings of the Board of Directors and will have a casting vote.

The Board of Directors, in consultation with the Council, will adopt Standing Orders covering the proceedings and business of its meetings to include the values and standards of conduct for the Trust and staff in accordance with NHS values.

4. MEMBERSHIP AND ATTENDANCE

Chair
Minimum of 5 and maximum of 7 Non-Executive Directors
Chief Executive (and Accounting Officer)
Executive Director of Finance
Executive Medical Director
Executive Director of Quality & Safety *(Chief Nursing Officer)*
Executive Director of Operations
Deputy CEO & Executive Director of Strategy, People & Partnerships

In attendance:
Company Secretary (CoSec)
Associate Director of Corporate Governance (ADCG)

Governors are welcome to observe part one of the Board meeting. Governors only attend meetings and parts of meetings that are held in public.

5. MEETINGS AND QUORUM

At least one third of the whole number of the Directors appointed, (including at least two non-executive Directors and two voting Executive Directors).

Meetings shall be held bi-monthly in public. Formal Board meetings are formed of two parts, part one is held in public and part two is used to discuss confidential business, for which the Board is asked to approve that representatives of the press and other members of the public are excluded from.

All public Board meetings are opened to members of the public. ~~There will be an open meeting during the year for members and the public when the Board of Directors will present the Annual Report and Accounts to the Council.~~

6. SUPPORT ARRANGEMENTS

6.1 The Company Secretary shall be responsible for providing support to the Chair and to the Board. Agendas for forthcoming meetings will be agreed with the Chair and nominated Executive Director on the first working day of the month, and papers will be distributed to members ~~one week~~ five working days in advance of the meeting.

7. DECLARATION OF INTERESTS

7.1 All members must declare any actual or potential conflicts of interest relevant to the work of the Board.

7.2 Where a member is conflicted, the Board shall adopt a sensible and pragmatic approach to managing conflict of interest, as it may allow them to participate in the discussions on the conflicted item so as to inform better decision making but may ask them to leave the room, recuse themself or abstain from any voting in relation to the conflicted item. The Chair will manage this process during the meeting to ensure a smooth outcome (Check section 3.12 – Managing conflict of interests during meetings in the Trust`s Declaration of Interest Policy for more details).

8. DUTIES

8.1 Define the direction of the Trust, setting policy and strategy regarding future development, having regard to the views of the Council of Governors.

8.2 ~~Manage the day-to-day operation of the Trust~~ Ensure that adequate systems and processes are ~~maintained~~ in place to measure and monitor the NHS foundation trust's effectiveness, efficiency, and economy as well as the quality of its healthcare delivery and governance arrangements.

8.3 Monitor progress and achievements against regulatory requirements and approved plans and objectives, ensuring the effective management of the Trust by maintaining the appropriate balance of skills and experience.

8.4 Ensure compliance with the Trust's Terms of Authorisation and all obligations lawfully imposed upon the Trust by the Independent Regulator and any other statutory body or agency.

8.5 Ensure appropriate arrangements are in place to manage and support the Council and information needs are agreed.

8.6 Address workforce issues, workforce planning and people development.

8.7 To work in partnership with service users, carers, local health organisations, to reduce health inequalities; provide safe, accessible, effective, and well governed services for patients, maintaining and improving the quality of care and have regards in its decision-making to the `triple aim duty` of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of Trust resources.

8.8 Ensure exception reporting procedures are in place to ensure any risks that could materially impact compliance and potential compliance failures are remedied.

8.9 Ensure submission of all mandatory returns, the Trust's annual report and accounts and forward plans, and appropriate action is taken on issues raised from assessments, to present a balanced and understandable assessment for all public statements and reports to regulators and inspectors, as well as information to be presented by statutory requirements.

8.10 To formulate, implement and review Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of foundation trust business.

8.11 Ensure adequate systems and processes are maintained to measure and monitor the Board's own performance and that of its committees and planned and progressive refreshing of the Board of Directors.

8.12 Annual evaluation of individual directors to ensure contributions remain effective and commitment to the role is demonstrated.

8.13 Maintain formal and transparent arrangements for considering how financial reporting and internal control principles are applied and for maintaining an appropriate relationship with the Trust's auditors.

8.14 Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality and review at least annually.

8.18 Ensure suitable delegation of powers and responsibilities to committees of the Board and the Trust Executive to enable the effective and efficient discharging of Board responsibilities. Delegation must pay regard to the duties outlined above.

8.19 Maintain oversight of the Trust’s wholly owned subsidiary company SSL and any similar ones that may be setup.

9. REPORTING

9.1 Committees reporting to the Board of Directors are:

- Audit Committee
- ~~Charitable Funds~~ Caring Minds Committee
- Finance, Performance & ~~Resources~~ Productivity Committee
- NED-led Nomination Committee
- Quality, ~~Safety and Service User~~ Patient Experience and Safety Committee
- People Committee

10. PROCESS FOR MONITORING EFFECTIVENESS OF THE BOARD

10.1 The Chair of the Board will seek feedback on the effectiveness of meetings following each meeting during the period of Board governance review.

10.2 The effectiveness of the Board will be reviewed annually as part of the annual self-assessment of the Board and its Committees and also as part of any wider review of the full Board governance process. ~~This review will be carried out by the Audit Committee eight months following implementation of the new process.~~

10.3 Annually, the Trust must produce an Annual Report and Accounts. This includes an assessment of the effectiveness of the Board and information on compliance, with the requirement that members should attend regularly and should not be absent for more than two consecutive meetings.

10.4 The Company Secretary will assess agenda items to ensure they comply with the Board's responsibilities. The secretary will monitor the frequency of the Board meetings and the attendance records to ensure attendance figures are complied with.

10.5 Terms of reference are to be reviewed at least annually.

11. REVIEW

Date Reviewed: September 2024
Ratified by the Board: October 2024
Date of Review: September 2025